



STRATEGIC HEALTH REFORM


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QUARTERLY

roundtable

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To be a leader in public service research.

Mission

To defend the values that underpin our liberal constitutional democracy and to promote respect for human rights. The work of the Foundation will be driven by the principles that informed Helen Suzman's public life, and to this end a research profile will be developed that will focus on public service in all its constituent parts.

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- informed and reasoned discourse;
- fairness and equity;
- the protection of human rights.

The Foundation is not aligned to any political party and will actively work with a range of people and organisations to have a constructive influence on the country's emerging democracy.

Hosted in association with our partner the Open Society Foundation for South Africa

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Profiles

Tebogo Phadu

Tebogo is the policy research co-ordinator for the African National Congress (ANC). He has been involved in policy research for the in various areas and positions for the ANC from 1995. He has also been centrally involved in developing the health policy positions for NEHAWU and the ANC over the past two years.

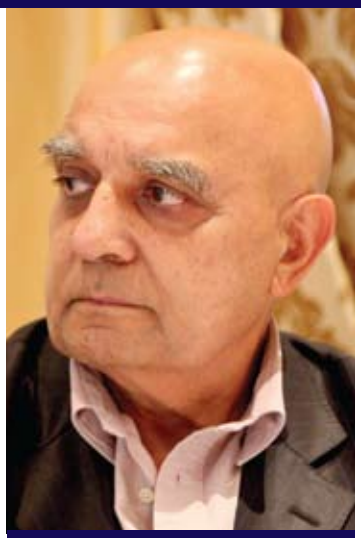
Alex van den Heever

Alex is an economist, with a Masters degree from the University of Cape Town, with twenty years experience in public policy, health policy, social security policy, and public finance. His experience includes working for the Department of Finance, the Industrial Development Corporation, the Centre for Health Policy, the Gauteng Department of Health and the Council for Medical Schemes. He has participated in the various policy processes including inter alia: consultant to the Melamet Commission of Inquiry, member of the technical task team developing the Medium-term Expenditure Framework for government, member of the technical task team that developed the Medical Schemes Act, and member of the Taylor Committee of Inquiry.

Hein van Eck

Hein van Eck is a healthcare actuary and General Manager, Health Policy at Medi-Clinic Southern Africa, an international private hospital group with facilities in South Africa, Namibia, Switzerland and the United Arab Emirates (Dubai). He studied actuarial science at the University of Stellenbosch and the Institute of Actuaries in London.

Hein started his career as an actuarial consultant with Sanlam in the field of employee benefits. In 2000, he transferred to Sanlam Health where he was employed as an actuarial consultant to medical schemes. During 2002, Medscheme bought Sanlam Health and Hein subsequently performed a similar role, but to a larger client base. Moving into the position of Network Contract Manager at Medscheme in 2004, he focused on provider contracting, including private hospitals. In 2005, he took up the position of Research and Development Manager at Medi-Clinic. In 2008 and 2009, he was involved with South Africa's Private Hospital Review. Since January 2009 he has been responsible for Health Policy at Medi-Clinic, with specific focus on National Health Insurance. He is a member of both HASA's National Health Reference Price List and National Health Insurance Sub-committees.



Joe Veriava

Professor Veriava has worked as a specialist physician in public sector hospitals linked to to the University of the Witwatersrand for over 40 years Now retired, he has been Professor and Head of Internal Medicine at Wits University for the past four years. He also provides expert assistance to the university in his capacity as special advisor to the Vice Dean in the School of Clinical Medicine.

Trevor Terblanche

Dr Terblanche grew up in in the Eastern Cape. He qualified as a doctor in 1981 and his post-internship was spent working in paediatrics at Livingstone hospital, Port Elizabeth. For the next twenty years, he was a general practitioner.

Terblanche has an Advanced Management Diploma from the Foundation for Professional Development; he has served as an executive member of National Medical and Dental Association Eastern Cape; Chair of South African Medical Association and served on the boards of the General Practitioner Private Practice Committee, SAMA. He has been an Exco member of The Health Policy Committee of SAMA, and an executive member of the Society of General and Family Practitioners and the National Convention on Dispensing. He has in addition served as Executive Officer for the Clinical and Hospital Risk-Manager for Ecipa Managed Healthcare from 2006 to 2009.

In 2009, Terblanche joined SAMA as its Secretary-General. He has a keen interest in dismantling silos and dislodging hardened managerial positions in general, and particularly in Health

Jonathan Broomberg

Dr Broomberg is Deputy CEO of Discovery Health. He qualified in medicine at the University of the Witwatersrand in South Africa, and subsequently obtained an MSc and PHD in health economics from the University of London and Oxford. He has spent most of his professional career working in health economics and finance, both in the public and private sectors, and in South Africa and abroad. In 1994, he co-chaired the Committee of Inquiry appointed by the Minister of Health to propose reforms to the funding and delivery of health care in South Africa. In 2005, he coordinated the Low Income Medical Schemes investigation on behalf of the Ministerial Task Team on Social Health Insurance. He is also active in international public health, and served as a member of the Technical Review Panel of the Global Fund to fight AIDS, TB and Malaria for five years, including two years as Chair. He currently serves on the Board of the Alliance for Health Systems and Policy Research, based at the World Health Organisation in Geneva.

Profiles

Chris Archer

Dr Archer was born in Johannesburg but grew up and was educated in the former Rhodesia. He studied medicine at UCT and after his housemanship he spent 4 years serving as a medical officer in the Rhodesian Army before entering private practice in Harare. In 1983 he returned to South Africa and to Groote Schuur Hospital to train in obstetrics and gynaecology. In 1990, he entered private practice as a specialist in Johannesburg.

During his tenure as a registrar, Archer was a founding member and representative of the Junior Hospital Doctors Association of the South African Medical Association (Sama) – JUDASA – and in 1994 became the South African Society of Obstetricians and Gynaecologists (SASOG) representative on the Specialist Private Practice Committee (SPPC) of SAMA and served in that capacity until the SPPC became the SAPPF in January this year.

He has been the CEO of the South African Private Practitioners Forum (SAPPF) since its inception and is also the CEO of the Gynaecology Management Group (GMG) and currently the Vice Chairman of the Netcare Park Lane Hospital Physicians Advisory Group.

Francis Antonie

Francis Antonie is the Director of the Helen Suzman Foundation. He is a graduate of Wits, Leicester and Exeter Universities. He was awarded the Helen Suzman Chevening Fellowship by the UK Foreign Office in 1994. From 1996 to 2006 he was senior economist at Standard Bank; thereafter he was director of the Graduate School of Public Development and Management at Wits University. He was the founding managing director of Strauss & Co.

Executive Summary

The Round Table on Health Reform, part of the HSF's Quarterly Round Table series held in association with the Open Society Foundation For South Africa, was attended by some one hundred and sixty members of the public, health practitioners, government officials, financial analysts, bankers and members of the insurance industry.

Headline presenters Tebogo Phadu of the ANC policy unit and Alex van den Heever, an independent health economist led the discussion. Francis Antonie chaired the Round Table and Jonathan Broomberg, Chris Archer, Trevor Terblanche, Joe Veriava and Hein van Eck were discussants.

Tebogo Phadu gave the ANC overview and rationale for the implementation of national health insurance and Van den Heever offered an alternative perspective. Phadu was quick to assert that the national health insurance policy work currently on the table was an ANC initiative, and not a government one. He expressed appreciation for being able to address a civil society grouping as he said that a national dialogue on health delivery was now at a critical juncture. The ANC were clear in its vision that health reform would be based on a ten point plan covering all aspects of health delivery, with national health insurance one component of that plan. He said that the ANC was determined in its efforts to transform the public-private reality of current healthcare and develop a universal system of healthcare for all South Africans. The focus of its policy direction involved an interconnected path of reform that would not simply try to 'fix' the public sector, but would see a unification of what he referred to as an existing two tier health system in the country (privately funded and publically financed health systems). This path would see the creation of a public national health insurance fund that would be pooled to pay for services that would cover every South African citizen. This would include a free point of service with access to public and private healthcare providers. Phadu argued that an NHI would cut out wastage in the current system and control costs through cost effective practices, capitation fees and bulk buying. The institutional framework supporting this fund Phadu likened to a SARS-type organisation that would work outside the national budgetary system, have high levels of accountability and be managed by specialists and dedicated professionals. It would not be highly bureaucratic and running costs would be fixed at 3-4% of total cost, the level he said which was to be found in most countries. Under the health system, there would be scope for medical aids to operate within an integrated system of provision. This system would put the entire health system in a better position to influence behaviour of providers with the majority of funds flowing through one single channel.

Van den Heever pointed out that the debate surrounding health reform had become complex, so much so that one is not sure whether the various parties are talking at cross purposes or whether they are disagreeing. For this reason it is very important to clarify the key conceptual elements that make up health reform, namely the financial issues and the institutional design.

Institutional design is about the type of health system chosen. The financial aspect of the health system occupied an entirely different area in macro health management. Van den Heever sketched out the difference between national health service (NHS) and national health insurance (NHI) with the former being typically a base system or a publically delivered tax funded system and the latter not a system at all, but an insurance model that fell outside the tax funded system. NHI and NHS he said represent competing models with NHS about decentralising operations and accountability through a well- constructed institutional design, and NHI an ancillary system pulling healthcare in the opposite direction with a centralising agenda that, he asserted, was an illogical social delivery model. What was needed was a holistic approach in the reform of the existing system. This approach would have to take into consideration:

- allocative efficiencies - value for tax spend, achieving the best returns;
- resource allocation – the distribution mechanism (an institutional aspect) which he said would involve rationing (more clinics versus more cardio units);
- budgeting and reimbursement.

Van den Heever asserted that the two tier system standpoint is a false debate and takes attention away from what is actually needed in the health system. What was needed for South Africa he argued was a competent authority that since 1994 had not existed. He cited for example many mechanisms including legislation that could be implemented to integrate health systems that had not been applied. Many tools were available in the existing system whose ineffective usage had strongly contributed to the skewed growth of the private sector to the disadvantage of public health services. Trying to impose a financial model to fix an institutional problem he added created a false debate and was a non-starter. The overriding issue of health reform is the design of the structure governing health provision – a structure that had to be neutral and depoliticised

Introduction

On behalf of the Helen Suzman Foundation and our partner, the Open Society Foundation for South Africa, I'd like to welcome you all to this first Roundtable on Strategic Health Reform.

The Roundtable Series serves as a forum to discuss and debate topics of public interest, thereby helping to realise the Foundation's mandate of public service. Helen Suzman was passionate about public service, and the guiding principle that informed Helen's life, an unwavering respect for human rights, underpins the work of the Foundation. Its research focuses principally on state institutions and delivery and the relations between state and civil society. Health is one of these research areas. The Foundation works from the premise that health provision represents not only an important developmental issue but is also a key human rights concern.

The first comprehensive initiative to consider a national health service in South Africa was undertaken in 1942 by the Smuts government. A commission led by Henry Gluckman was appointed to consider the possibility of establishing a national health service for all the people of the Union.

It was tasked with reviewing the administrative, legislative and financial measures necessary to provide for such a service. The Gluckman Report represented the first effort by a national government in South Africa to undertake a nation-wide survey of existing health needs and services. Notwithstanding the Gluckman Report, the institutional approach to health care followed by successive governments post-1945, when the Report appeared, involved the establishment of integrating mechanisms between different tiers of government. Gluckman proposed two models: an integrated model and an amalgamated model. I hope that the presenters and discussants will elaborate on this. If we fast forward to more recent times, in the post 1990 period original ANC policy approaches followed the proposals for institutional amalgamation as per Gluckman, rather than integration. In the deliberations at the time, the favoured system for achieving universal access to health care was a national health system. However, the new constitutional dispensation followed the approach that health care effectively continues the historical approach that provinces should share the authority with national government.

In October this year, the Minister of Health appointed a national advisory committee to advise him on the implementation of a national health insurance system.

The committee is tasked to advise the Minister on aspects of policy development and implementation of the NHI system. It appears that the policy developers do not consider the NHI as a stand-alone but rather as part of a major 10-point overhaul of health provision that

It seems to us at the Foundation that there are two important questions: firstly, what are the key drivers of strategic health reform; and, secondly, what should this reform entail?

works concurrently with other health provision systems. The goal of the process is to seek an institutional model which can deepen universal access to health care by integrating public and private providers of health care.

Membership of private medical schemes will be permitted, but only after the mandatory health levy is paid. Certain categories of low income earners will be exempted from this contribution. Thus far, the policy processes underpinning national health reform appear to be fragmented; hence the Foundation's interest in providing this platform to enable a wider engagement, in an open and transparent manner, on the major questions facing health reform.

It seems to us at the Foundation that there are two important questions: firstly, what are the key drivers of strategic health reform; and, secondly, what should this reform entail?

In order to help us in our deliberations this evening, it gives me great pleasure to introduce our participants. They are Tebogo Phadu of the ANC's policy unit and Alex van den Heever, an independent health economist. The discussants are Hein van Eck (Medi Clinic), Professor Joe Veriava (Wits Medical School), Jonathan Broomberg (Discovery), Chris Archer (South African Private Practitioners Forum) and Trevor Terblanche (SAMA). I'm not unaware that all our participants are male. I'm sure that Helen Suzman would have raised her eyebrows at that, but I hasten to add that this has not been by design. Likewise, there is a preponderance of participants from the private sector. My hope is that as this process of discussion unfolds, other voices will come forward. I want to thank all the participants for their willingness to be here this evening.

Tebogo Phadu

Tebogo Phadu

This is an opportunity for the ANC to share with you its thinking about health care reform, and in particular what has now become known as the 10 Point Plan. However, because of time, I'm not going to look at every area but just to give you an overall framework, with specific attention to the area of national health insurance.

National dialogue on health care reform is now at a critical juncture. Under the leadership of Minister Motsoaledi and his counterparts in the provinces, there is a process of engaging all stakeholders in a constructive debate on the implementation of what is known as the 10 Point Plan for health care reform. Some of these proposals, once finalised, will go to Parliament for reform legislation.

We can summarise this 10 Point Plan as follows: First is the need for strategic leadership and the creation of a social compact for better health care outcomes. This is born of the fact that if we really are to raise high the health care agenda, leadership is required at the highest level, and leadership will also require co-operation and involvement of all types of stakeholders through the social compact. This is something that you will constantly hear from the President, and from the ministers, namely, the need for a social compact for a national consensus on the kind of health care we want to build for the future.

The second component of the plan is the introduction or implementation of national health insurance.

The third is improving the quality of services. There has been acknowledgement on the part of the ANC that there has been neglect of the public health care sector at least in the last past decade.

But at the heart of the programme is the overhaul of the health care system, understood in broad terms to include both public and private sectors, including issues of management, public hospitals and so on.

Then there is a human resource challenge, which is the fifth strategic objective in the 10 Point Plan. Other objectives include the revitalisation of infrastructure, the HIV challenge, the mobilisation of our society, a review of drug policy and a strengthening of research and development.

I thought it was important also to highlight these points to provide context. Sometimes these important strategic measures that the ANC has identified are seen as isolated from one another – a collection of different challenges put in a form of a plan. However, from our point of view they cannot be considered in isolation from one another. What is required going forward is how to ensure that these critical challenges are integrated and that implementation takes place in a logical sequence.

But the contextual situation aside, we know that

the impact of the global economic crisis poses a serious challenge to the extent to which we can implement the 10 Point Plan. Also, our challenge is not just threatened by the current economic crisis, but also by the weight of the apartheid past in the present. It is also challenged by the highly-skewed distribution of health services and funding – that is, the provision of health care services between the public and the private sector and (to a large extent) within the public sector.

The Plan is also threatened by human resource challenges and a range of other social forces determined to defend their sectoral interests. To a considerable degree, our health care transformation is encumbered by the very things that it seeks to overcome.

Our point of departure with regard to health care transformation is what we call the two-tier system in South Africa. The two-tier system is one where you have parallel development of the public and private sectors. This vigorously reproduces itself, characterised by the reproduction of racial, and class inequalities, and stratified access and skewed funding of health care provision.

The public/private reality from the ANC's point of view is that this system needs to be transformed. It cannot be business as usual. We believe that the two tier system is a reality that has underpinned the direction of our health care system over the last 15 years and has resulted in the reproduction of the very inequalities in our society with regard to health that we all seek to redress. Therefore our strategic objective is basically to provide quality health care to all South Africans. This has to be addressed in the context of overcoming gender, racial and class inequalities. As we discuss the issue of health care transformation, the interconnected inequalities cannot be ignored. In fact, gender, race and class provide a strategic framework for how to approach health care reform.

It is important however to emphasise here that we must guard against a mechanical approach to addressing these interconnected challenges. There is a view, and this the ANC has also observed in the current debates, that one should try to confine the present phase of health care reform to simply fixing the public sector and then postpone reform of a seemingly workable private sector.

To improve the public sector within the current framework of the two-tier health care system will only scratch the surface of the legacy of inequalities in our society. Post-1994 health care reform has involved the depletion of health resources in the public sector. But it has equally seen the expansion and accumulation of these resources by the market-driven yet relatively regulated, health care sector – the private health care sector.

It is this reality that is still with us – the reality of human resource shortages, the reality of the quality of the health care infrastructure in our country. The perpetuation of the two tier system will not take us anywhere. We have to connect public sector reform with major reform in the private sector and this is what the 10 Point Plan is all about.

What are the key drivers or the major forces that are influencing our strategic health care reform? I think we are proceeding from a point that the ANC has been emphasising throughout in our various policy positions – starting with the Freedom Charter, the national health plan and the RDP – that we should work towards a universalised health care system.

In the last 15 years, there have been achievements particularly in health financing, but this has provided such mixed results. For example, there has been a near universal protection against financial risk for the majority of our people who rely on the public sector. Eighty five percent of our people rely on public services, so it is fair to say there is a high degree of protection against financial risk for the majority of the population. This has been the starting point for the ANC in transforming our health system.

However, it has become very clear that the idea of universalisation of health care has been resting on a very, very weak base. And what is that weak base? Firstly, we are saying that there are inefficiencies in the organisation of service delivery; there are inequities within the public sector between provinces, within regions – rural and urban; and also between public and private sectors, and that is between the resources commanded by each sector relative to the size of the population. There are also inequities in the distribution of health spending and services, with even a strong bias towards curative care.

Tebogo Phadu

Tebogo Phadu

"I must emphasise that the NHI is an ANC proposal, not a government proposal. First we are proposing the creation of a public national health insurance fund which will receive the majority of health care funds."

While some progress has been registered in addressing inequity in public financing, and within the context of fiscal austerity, there are still huge inequalities between public and private service provision, and the consequences of these are strongly evident. So reducing fragmentation, principally overcoming the two tiers is a big issue for us. Addressing these structural inefficiencies will require a realignment of reform instruments. Conceptually, there are many approaches to how we reduce fragmentation in financing, but it also includes changing provider payment incentives.

What is important therefore is not just how conceptually sound these approaches are, but also how practically and politically feasible they are. Prior to looking at these important elements of our proposals, I would like to highlight two or three important pitfalls that we may want to avoid. Pitfall number one is starting insurance with the formal sector and hoping that economic growth will eventually progress towards universal coverage, as it did in many Western countries. This has been a view that has been advanced for low- and middle-income countries like ourselves, where the path towards universalising the system was that we should follow the same steps that were followed by Western European countries like Germany or the United Kingdom.

Based on the historical experience of these countries, it was argued, and it still is, that developing countries should start with voluntary health care insurance and eventually scale up the coverage as the economy and formal sector employment grows. The ANC views this as a fundamentally flawed approach because it fails to appreciate the context of developing countries, and of South Africa in particular. We are faced with a very different context from the European countries 60 or 70 years ago. Taking the route of gradual insurance will lead to segmentation of the health care system and this is exactly what the ANC is trying to change. Conversely, evidence demonstrates that there is considerable scope for low income countries (with the availability of modern medical technologies) to apply rational health care system decisions which are quite different from those faced by Western European countries in the middle of the 20th century.

Pitfall number two is treating a benefit package as a solution to accounting problems rather than as a policy instrument. Here I am touching on issues to provoke discussion about how we want to approach the whole issue of benefit packages. There are pressures for the health system to calculate the true and real costs of benefit packages, and large scale disease burden or costing/cost effective studies should be undertaken that combine estimated utilisation levels and revenue projections. It is theoretically possible to determine the threshold of what services are included in the package and which are excluded. The ANC is of the view that a different approach should be looked at because the current practice is fraught with problems.

In conclusion, I must emphasise that the NHI is an ANC proposal, not a government proposal. First we are proposing the creation of a public national health insurance fund which will receive the majority of health care funds. It will pool these funds and pay for the health services on behalf of the population. It will provide universal coverage to every South African citizen, and the provision of such services will be free at the point of service. A range of services will be provided, with public sector services as our benchmark for the kinds of benefits that can be provided at all levels of health care. Access to this service will be provided by public and private health care providers. In other words our proposal proposes a public fund where delivery remains with the private sector.

We will also try to save enough by cutting out a number of inefficiencies that are inherent in the current system, and control cost through cost-effective payment methods such as capitation fees, global budgeting and bulk buying. This will be funded from a mix of funding sources, the existing public budget, but also from mandatory contributions. There are other sources within the public domain that can be looked at, but those are the principal sources for funding health care.

Alex van den Heever

Alex van den Heever

The discussion on strategic health reform is in essence a very complex debate, and I think one of the concerns I have with a large part of the debate is whether or not one is talking at cross purposes or whether one is disagreeing. It's going to be very important to try and get the key conceptual elements of the debate as clear as possible in order to make sure that people are actually on the same page.

A lot of what I'll be talking about is what I think are the key aspects of the debate.. I think the first key element to understand in a discussion on the strategic framework of the health system, is the distinction between the financial elements and the institutional design of the system. Reform includes talking about these two crucial key elements. However a large part of the current debate is really about institutional design.

On financing, one must look at resource levels, how much society can be taxed and how much you can allocate to health care, as well as resource allocation mechanisms. However, starting with the question of institutional frameworks, the questions one has to ask is what is the base system needed from an institutional perspective to achieve universal access? What alternatives are there? If we look at our existing institutional framework, what is wrong with it, if at all?

Within a developing country context, and in many developing countries, what is often referred to as a national health service is actually typically proposed as the base system. A national health service can be funded by various mechanisms, including general taxes and sometimes supplemented on a minor scale by earmarked taxes. But in essence a national health service is a publicly delivered system which can have a number of models.

The question therefore really is, what is NHI in relation to an NHS? There is a clear distinction and it needs to be articulated. In essence a national health insurance system refers to a tax-funded system where reimbursement mechanisms and modalities by which you relate to service providers are very different. NHI and NHS are competing models, The 1994 ANC health plan has references to a national health service as its base system and a very detailed, explicit enunciation of that plan followed by a marginal section that deals with national health insurance. Given that these are

Alex van den Heever

"Publicly-driven health systems are made responsive through institutional design."

in essence competing institutional designs. it is very confusing to have them both in the same document. However, it is important to note that the NHI is mentioned, albeit peripherally.

The real issue is that at the end of the day – and this would certainly be what I would postulate within the discussion – is that South Africa cannot talk about any other model for its base system for achieving universal access other than a national health service design. And the question really is: what goes into that?

In essence a national health service as a base system for providing universal access typically involves asking questions about decentralising operations and development of accountability mechanisms. No matter what base system is considered, it has to have all components well-designed in order to make sure that it is responsive. Its design is central to its ability to deliver. Publicly-driven health systems are typically not naturally responsive: they have to be made that way through the institutional design.

Virtually every single developing country, and most industrialised countries, essentially have an ancillary part to their health system design. In fact within all of the debates about South Africa, the issue of contributory health insurance (or even social insurance) and the framework for medical schemes are framed within the context of ancillary systems, not within a core health system, in order to achieve universal access. It is here that one of the key confusions arises. It is in fact an illogical proposal to promote an ancillary system (such as NHI) as a basis for universal access.

In a social insurance model one should not confuse the mechanisms and modalities associated with ancillary systems with the type of system introduced as a base model. There would typically be a voluntary payment system, including out-of-pocket payments, as well as voluntary private insurance. This is what makes up a health system. Every developing country includes these three components. The questions to ask are, how well have you designed them, do they pre-date each other, do they undermine each other, and how sensible are they?

If you don't have a properly regulated ancillary system, it will be unregulated, but it will still exist and this is typically what you find everywhere. So it is very important to look at creating an entire system in which you've thought through every element, and as Tebogo correctly says, you do not only focus your reforms on one part of the system. The approach to the system design has to be holistic with a clear understanding of all of its components, their design and how they relate to each other.

The base part of the system that's intended to provide universal access has no option but to be funded through redistributive sources of revenue, i.e. taxation, because quite a large proportion of people who will use that system do not earn sufficient incomes to be able to pay for health care services.

Therefore, base systems are funded through redistributed funding. No matter what modality you use to actually purchase the services, funding has to be redistributive. Any form of taxation is subject to key constraints, one being macro economic considerations. But there is only so much you can tax society using a redistributive tax approach, because people are getting nothing back. A large group of people who are paying taxes and getting nothing in return creates major disincentives within society to both produce and to participate, or whether or not to evade the tax system, depending on what the tax demands are, or how one part of the tax system is loaded against another part of the tax system. There's a natural constraint as to how much you can tax. You can't just go up to 90%.

Once macro economic constraints are understood, there is a second problem, whether or not health care is actually a higher priority than others. That's often referred to as allocative efficiency – decisions that get made by government deciding whether in fact you're getting a better social return from the marginal rand taxed from education than you do from health care. So you cannot actually see health care as a silo. Health care forms part of an overriding series of social goods and services, where the overriding constraint on the amount

Alex van den Heever

of revenue that is raised still has to be assessed as to whether or not the allocation that is made is in fact achieving a better return going to health care than to other priorities.

A further issue is how resources are allocated. Resource allocation decisions involve rationing. Having earmarked a proportion of funds, they must be appropriately allocated and this requires a distributive mechanism. This mechanism covers institutional arrangements although it falls within the financing component. Because resource allocation systems involve rationing, no health system, no public system of any kind, can offer its services free to everybody and expect that it will support unlimited demand. Health care can be provided that offers very little social return, or it can offer a very high social return. Government has to decide, with limited resources, where it draws that line and it will draw that line in relation to competing uses, including competing uses within the health spend itself. So for instance government might say it's better to spend more on clinics than on additional heart transplant units. That's an allocative efficiency decision.

The method of rationing is very important. A national health service rations very differently from an insurance-based system. A national health service basically provides physical resources and services which an insurance system typically cannot do. Budgeting and reimbursement will take place within the distributive rationing exercise. Having decided what to buy there are limits to what can be procured.

The ancillary parts of the health system requirements are different. The overall taxation system is not important because one of the benefits of the ancillary systems (and this is something that's often not well understood) is that it is a method of generating resources over and above what people are willing to pay in taxes. That is why it exists. It is often referred to as a resource mobilisation mechanism. Mobilising resources in this way will happen if you satisfy what's often referred to as the benefit principle – that people get something back for what they contribute. This is not redistributive; it is more of a benefit, that with regulation will become an additional pool. People will be encouraged to pay for something they otherwise might not have paid for which can be seen as revenue over and above what you would typically tax.

It is for this reason that in many developing countries ancillary systems exist that are designed to attract this form of surplus funding. Which brings to the fore the issue of tier systems. The issues around two-tier systems that are being raised create a false debate. Within the international context of developing countries, every one of them has multi-tier systems because it is very difficult in resource-constrained environments to provide, through a tax based system, something that will satisfy everybody within that society. Therefore you'll find all the way through South America, all the way through Asia, that multiple systems exist. And as you go to the most highly-industrialised countries, it's only in those countries that you will typically find some form of a predominantly single tier because there's no pure example of a single-tier system.

In ancillary systems, (an insurance based system), minimum packages, non-discriminatory contributions, income cross subsidies, a degree of integration of multiple pools, (if it's a multiple pool system) predominate. Default state funds would be also be introduced. Barack Obama is proposing many of these types of measures. The application of a minimum package, and rationing within an ancillary system, is not necessarily the same package that would exist within a universal access system. So a national health service is invariably tax funded.

Ann Mills has this to say: *"Tax funded systems have the potential for higher levels of allocative efficiency than insurance based or purely private*

Alex van den Heever

"However, public systems also have the potential for poor operational efficiency because of lack of incentive to use resources well and bureaucratic constraints."

systems, not least because greater control is feasible over investment decisions, and planning procedures are available for control duplication. The whole service can be planned and managed in order to maximise impact on health within the funds available.

"However, public systems also have the potential for poor operational efficiency because of lack of incentive to use resources well and bureaucratic constraints. Major improvements are likely to be difficult unless there are changes in the incentive structures faced by facilities, so, for example, through decentralisation and greater autonomy in managing budgets."

Mills' statement is important because one of the core evaluations of the South African health system is in developing a national health service within South Africa. Her second paragraph reflects what we as a country have not done.

What creates confusion in the South African health reform debate is the proposal that national health insurance becomes the base system for achieving universal access. This assertion confuses the institutional model for the ancillary health system (which is typically insurance-based) with the base system (which is typically supply rationed). These two systems represent completely different modalities of funding and systems.

As initially proposed, and this is within the sort of ANC plan proposal now, it assumes – and it may be naively – that the base system will be a total system for everyone. But even as a long-term objective this is almost inconceivable, and it's an unreasonable point of departure for policy discussions. Tabling this point is important because if it's not a reasonable point of departure the question is really what is the important health problem that we are trying to solve, and is that what we need as our primary objective and point of departure for moving forward?

Even as a long term objective, equalising and giving citizens greater access is a good policy, but to say that this is basically our absolute priority, our number one objective, is very strange indeed. The confusing diagnostic which NHI proponents put forward is that it motivates for the establishment of a national health insurance using the standard arguments used to justify the implementation of a base system for universal access. In other words, it uses the motivations that are used for any health system, any base system (which is fine) but it raises the question: what's has it to do with the modality being proposed? The diagnostic assumes in addition that a well-organised ancillary system is superfluous, despite the fact that one will continue to exist in one form or another regardless of whatever base system is in place.

No part of the diagnostic provides or motivates why any reasonable government would choose NHI over NHS, because the particular issues within the diagnostic don't create the differentiating criteria. Particularly mystifying is why the concerns with medical schemes in any way justify national health insurance over a national health service. Medical schemes have nothing to do with whether or not you choose NHI over NHS. One has nothing to do with the other. The desire for a single pool for everybody is understandable but it should not affect a National Health Service choice versus NHI.

NHI over NHS means that residents will be required to enrol to obtain cover when at present they access the services for free. National health insurance is inherently an enrolment-based system. Why would one wish to go this route when services are currently free with no constraints imposed on access – a practice consistent with an NHS?

The creation of a highly centralised parastatal, with massive procurement responsibilities and no corporate governance has no bearing on medical schemes. It also has no bearing on the failure of the current public system to deliver effectively.

The corporate governance mechanism that has been proposed for the parastatal to run a national health insurance system, involves a ministerially-appointed Chief Executive Officer. Internationally this is recognised as the wrong

governance model because it is not possible to get efficient conduct out of any kind of parastatal institution unless you have a strong and devolved governance structure that allows for independent decision- making under a system of high accountability.

The absence in the ANC's reform proposals of any mechanism to achieve local accountability or any form of accountability regarded as standard practice is a matter of concern. It tends to perpetuate the practice in the current health system, namely a wholesale lack of accountability mechanisms. In 1994 this was strongly put forward as a significant part of the health plan proposals, which included accountability, local accountability, and elected officials at all levels of the health system.

With respect to the overall governance of the health system, the National Health Act promotes health governance as being effectively a function of tier one and tier two. The problem with implementation to date is that none of the mechanisms that are typically used to integrate these different tiers of the health system with the three spheres of government have actually been used. This is despite the fact that legislation offers a wide range of tools to assist officials in this task. These tools include the establishment of various bodies and the establishment of different governance structures.

Provincial structures have immense legal powers, the national government has immense legal powers, and these are not used to integrate the system. The financing mechanisms and the establishment of direct financing systems within the overall system, to connect the top with the bottom, are not exercised or used effectively. So what has tended to happen is that because people don't use the tools available to them effectively, they tend to default to what they think is a simpler model, which is "let's put everything at the first tier". It doesn't solve any of these problems; it just means that if you weren't able to solve them in the other structure, you won't solve them when you put everything under one tier. You're just pretending you're going to solve them. It's an important debate in terms of the design of the base system and I think it's going to be a key area that has to be resolved if we are to succeed in effectively reforming our health system.

Tebogo Phadu

RESPONSE

TEBOGO PHADU: this is not the first time I'm exchanging ideas with Alex on these issues. But I think the conflation of NHI and NHS to us is a non-starter, even from a conceptual point of view. Before, traditionally, this tended to be separated and you have got the Bismarck model and you have the Beveridge model. The UK and even Cuba fall under those areas of NHS, respectively. For developing countries you will want to have an innovation that combines the best elements of contribution of Bismarck and of Beveridge so they don't actually conflict with each other or compete, but they complement each other in that context.

Then there's an issue about an institutional framework. I think even there, this is a universal process. What South Africa is doing, many countries are working towards doing too, namely establishing a viable, durable NHI fund, separate from the Department of Health. This implies an off-budget status of the fund, with high levels of accountability. How should accountability arrangements or mechanisms be structured? There is no best model to guide us. Possibly a board would provide the best mechanism. The current proposals envision an institution much like SARS, that reports directly to the Minister but is still efficient, still accountable, still transparent.

It is simply scaremongering to say that what is being proposed here is a huge unwieldy bureaucracy. In fact all national health insurance fund administrators all over the world constitute less than 3% to 4% of the total costs of health care. This can be compared with the country's current system of administration of health insurance.

Hein van Eck

I really have three points to make. First point: Costing of the benefit package. We have been to previous presentations, where some officials from the Department of Health mentioned that you can't cost the NHI because you can't cost it accurately.

This is true because you don't know what the future is going to hold; you don't know what's going to happen to utilisation rates once people have greater access to care, so all these things play a role. But I think it is very important that we create some benefit package scenarios. You can never be 100% accurate but you can have a conservative scenario, a mid-level and a high range scenario. I think that's very important, because once you do that and you put that in the public domain and you state what your assumptions are, then you have a very good debate around the assumptions. And I think that's something that we all look forward to, to seeing those costings and having a good debate around them. One example of these assumptions would be the assumptions around the efficiencies and inefficiencies within the system.

Second point: The human resource issue. Much has been said about the inefficiencies in the private sector and in the public sector, but I think one thing that few people know is the fact that the databases that get used in this country to count health care professionals are hopelessly inadequate and inaccurate. However, working off the Health Profession Council database and the South African Nursing Council database gives one some idea of numbers. The Council is very good at registering people, because you have to be registered in order to practice in South Africa, but they're not very good at taking people off the system. The health profession council says there are 36 000 doctors in the country and 213 000 nurses in the country.

If you look at Persal, the government database, the payroll talks to roughly 10 000 to 11 000 doctors in the public sector and some 105 000 nurses in the public sector. The assumption then gets made that of the 36 000 doctors, 10 000 public doctors [should be] deducted. Therefore the private sector is sitting with the balance, and that is very far from the truth. The private sector is evidently better resourced, but we need to get to an accurate number of how many health care professionals we actually have in this country and what their ages are (because a lot of them are close to retirement age), by discipline, and by region where they practise. On the nursing side, the number, if you take 213 000 and deduct 105 000 is 108 000. However, where I work at Medi Clinic, taking our number of nurses as a baseline and increasing the number as a ratio of market share and adding some nurses that practice in doctors' practices in the primary care setting, you're looking at no more than 35 000 nurses. This is very important information, because it influences the whole debate around the private sector being extremely inefficient.

Final point: The very interesting point that Tebogo and Alex raised about the insurance model versus the supply-driven model. I'm not a health economist, so I can't speak as eloquently but I do have a question to ask.

If you look at all developing countries around the world, every single one of them has got a very, very strong private sector, and the reason why they have that strong private sector is that the private sector is the pressure valve. If you're not happy with what you get in the public sector, you can use your own money and you can buy something better. Now the reason why this occurs more in developing countries is because of skewed income distribution. The people who can afford to, choose to buy something better. It's about choice.

In the earlier debates about the NHI plan, it was all about one funder, a single funder, and everybody would be part of it. In other words there would be no medical schemes. In the latest debates, Dr Olive Shisana acknowledged at the Board of Healthcare Funders Conference that medical schemes will be allowed to carry on. My question is if you're going to allow medical schemes to continue operating on the side, why do you want to change your current budgetary-driven system, which you have a lot of control over, and change it to an insurance model? No matter how efficiently you run an insurance model, it is new costs that you're adding to the system. It is important to remember that the medical schemes' non-health care expenditure may be high, but you're not saving that money. You are looking at the public sector and you're changing it from a supply-driven system to a demand driven system. In sum my question is, why would we want to do that if it is going to add new costs to the system?

Joe Veriava

I am going to talk as a very simple doctor. I have lots of difficulty in coping with health economists' jargon. I am right at the coal face, and we are being totally overwhelmed by the large number of patients who come to the hospital. This is the problem: we are totally overwhelmed.

Our hospitals are not coping, make no mistake about it. Our hospitals are running at the present moment virtually at 100% bed occupancy – especially the medical wards, and Internal Medicine. So how can we provide universal access? It is clear that providing universal access is in fact entrenched in our Constitution, it is part of the Bill of Rights that every person shall have access to health care. Currently we are not providing access to health care to everybody.

We have very high mortalities in our wards. In some of our wards the mortality of patients, of admissions – can be as high as 15%. Patients are being sent away, and there are horror stories that are emerging everywhere. So whilst we're playing around with economic jargon and all that, we need a simple solution that will bring about access. And how can we? That requires redistribution – we need more beds.

The government will not at the present moment be able to increase the bed capacities and many of these other aspects at our existing hospitals. The total number of beds in the private sector amounts to 28 000 or thereabouts. Maybe the figures are wrong. Figures seem to be always problematic. Then we know that there are in fact 10 000 private beds empty, because the bed occupancy at many of these private hospitals overall is approximately 65%. If that is so, and working at 100% occupancy in the public sector, we really need to have a system that allows public sector patients to occupy private sector beds.

The issues are clearly around funding. I see the NHI system being able to integrate both public and private systems so that we can provide universal access. I think we should also take into account that we are at the present moment in a historical phase, post apartheid phase and many of the problems that we inherited are a legacy of the past. But we should not dwell on this and say that's all there is and we can't do a thing about it. We need change.

We are in the reconstructive era and as doctors we expect that all the health economists provide solutions very quickly so that those of us who are right at the coal face don't drown in all the work and all the misery that is occurring in our communities.

RESPONSE

Although this is a debate, some of these questions are pointed questions about what the ANC's position is. I think on medical schemes the ANC is very clear that there is a role for the medical aids even under the NHI system, and that even though health care insurance will be compulsory, we will not go the route of those which have prohibited the activities of voluntary health insurance.

But at the heart of the NHI, it's also about expanding the pool of people, of resources required to integrate both the provision of private and public [services] together. It is strongly demonstrated that if you have it publicly funded and publicly administered for purpose of efficiency, you are in a better position to leverage allocations of resources. If you have a very strong purchasing capacity as well, it's very, very important that even in the initial stages your purchasing capacity is strengthened, and you are in a better position to influence the behaviour of the providers, whether they be public providers or private providers.

So I think it is within that particular context that the ANC still believes that the greater majority of the funds for health care could be better delivered if they flow via one single channel, from a central pool or central fund. It would seem that with the range of services that will be provided through the NHI fund, there will be little scope for what medical schemes are currently engaged in. In other words, if I'm a member of a medical scheme and I get almost the same benefits that I get in my medical schemes through an NHI fund, I might want to make an economic choice of whether a double contribution works.

A few points: When we look at the performance of our public health system, one of the concerns that I'd have is why aren't the doctors pitching up for work? Where are the consultants after 12 o'clock?

There is moonlighting that is extensively distributed throughout the system. It is particularly prevalent in certain provinces, with the exception of one province where it's not significantly prevalent. That suggests there is a governance problem and there's an oversight problem at hospitals. There is a problem with the way academic departments are overseeing their staff. So part of the problem in the overall system is really how we oversee staff and how we incentivise staff within the public health system. Failures in the system arise because of institutional problems, not necessarily financial problems.

The second point is that in Costa Rica in 1994 they had a similar range of institutional reforms that South Africa had mentioned in its plans in 1994. The interesting point is that after 15 years they complain about the pace at which they reformed, but they pretty much introduced everything in the ANC health plan in that period and South Africa didn't. Now that's got nothing to do with apartheid, and I think it's very important to get that straight. This has got to do with having a plan, having the leadership involved to focus on the right issues, and to get them correctly prioritised. The question is, why has that not happened? It is important not to start seeking scapegoats.

The last point is about the issue of integrating private and public providers. It is common knowledge that the provincial health governments have the ability to contract with anybody, and they can make laws to regulate within their regions. The proposals of the ANC health plan for over 15 years have been to devolve governance to the district system so that the districts become direct purchasers with the specific purpose of integrating public and private providers. Why is this not being done?

It's not that these proposals are not on the table. They don't have to be within the construct of so-called national health insurance; they're in the institutional model currently on the table. An integrating mechanism is about creating a competent authority that is able to contract with people as well as to render a service, to plan that service and to be accountable and held accountable, and to procure. The question is why are they not being done?

You don't need national health insurance to do this. You need competent authorities. National health insurance has got nothing to do with that. Creating funds and single funds has got nothing to do with it. It's very important to distinguish these things in the debate about health reform because they are false debates.

Jonathan Broomberg

In response to some of the points that have been made: Tebogo, you made the point about the interconnectedness of the reforms and the importance of focusing on public and private. I think I'd strongly agree with that. The fact that people are raising questions about the particular reform model isn't the same as saying leave the private sector alone to do business as usual. It's certainly not what I would argue.

There's no doubt reform within the current ancillary private health system, as Alex describes it, could make things more efficient. There is in fact a reform trajectory that was agreed and debated by the Taylor Committee several years ago, some of which has been caught up in the legislative process and needs to be implemented. And there's no doubt that reform of both sectors is needed.

But I'd make a different point about interconnectedness, which is that one of the critical reforms that I think we don't spend enough time on, is the sort of nuts and bolts question of how do you optimise the public/private interface? How do you optimise the ability of the public sector to take advantage of the resources and skills and goodwill in the private sector for the benefit of those who use the public system? My concern with the way the current debate is going is that we're focusing just on this idea that we can create a huge central purchaser and that will somehow magically solve all these problems and optimise that interface. I'll come back to that point in a minute because I think it's a lot more complicated than that.

But what we're not debating is, as I say, the nuts and bolts, which is at the public hospital level. For example, at Chris Hani Baragwanath, why don't we go there and contract with Lesedi Clinic to deliver CT and MRI scans, because there's a massive waiting list; or with the local private hospital to cut down the waiting list of cataract operations? In other words there are hundreds, thousands of interventions that could be made within the current public budget, or with an increased budget, that could make a huge impact on the daily lives and health status and health outcomes of South Africans and that is about the public/private interface. To me, there hasn't been enough discussion in the health reform debate about the nuts and bolts of that interface and how to improve it.

And I can tell, as a result of the last ten years in the private sector – and I've been many years in the public sector as well – we have been banging our heads against a closed door in our attempts to work with and try and collaborate with the public sector. I have to give great credit to the new Minister. He is entirely more open – open to discussion and to collaboration. I think his focus on this broad 10 Point Plan is highly commendable. It confronts the right issues and focuses on right set of areas.

Benefit packages: There is no doubt it is complicated to cost these things and no doubt difficult to just assume current utilisation rates or prices, but we cannot use that as an excuse not to cost this. We're making a huge promise to the people of this country which we cannot afford to make as it creates a long-term unfunded liability going forward. I think our Cabinet and our President won't endorse such policy.

We need to work together to come up with costs. Many of us are working on models, and we're happy to make them publicly available. As Hein says, you can play with assumptions. So you can assume, if you're brave enough. that provider prices can drop by having this very strong central purchaser. I think it will be pretty tough to do that, to be honest. I think it will be hard to persuade private practitioners to take a 30% cut in their fees, or any drop, because today, if you look at the recent history, we've had several years in which private practitioners have been struggling with the Department of Health, to persuade the Department that they need an increase in their reimbursement, an increase in their reference price list, that they believe that the current fees are below their cost of practice, and [require] a reasonable salary. And the same is true of pharmacists. If that's the current debate, I don't think we can confidently assume that creating a central purchaser will automatically give you the ability to cut those tariffs. I think my concern is that providers will exit the market rather than work for less than they're currently getting because they believe they should currently be getting more. So I think with respect to costing, we cannot say that we cannot cost and therefore we should not. We have to, and we have to make reasonable assumptions when we do so.

About the rationale for creating this large public sector purchaser. One point has been made

Jonathan Broomberg

already by Hein and Alex, which is that we already have a large public sector purchaser. It is the public health care system. It's got an R80 billion budget, and it could purchase from private providers as well.

My second point is that we must be careful of oversimplifying the ease of contracting with providers, be they public or private, using alternative reimbursement. It's a very complicated, difficult exercise to do. At Discovery we have spent 10 years trying to do this and have found it is enormously complex. It requires huge expertise and trust, and it does not always work. So we should be conscious that the glib use of alternative reimbursement capitation group practice that's currently in the debate is difficult and complicated to implement.

Further, I would be very keen to hear Tebogo's views on the following, coming as he does from the trade union movement originally: If one follows this reform proposal through to its logical conclusion – creating an insurance model – which I think as Alex describes is a demand-driven model – what is happening is that a medical scheme card, an NHI card, is being put in the hands of the citizens of the country, and they are being told: Go to private or public providers because the state will be going to contract with them and thus go where you need to go.

My prediction for a model like that is that over time – and it may not take much time – most people, wherever they have an opportunity, will go private. Obviously in rural areas there won't be that much opportunity. But for a long time, if we're having a real discussion, the public sector will not, on a quality or access level, be able to compete with the private, and what I think you then get is a picture in which money and resources will flow from the public to the private sector.

So my concern about that model is you're actually promoting what could turn into a privatisation of the public health system. I find it strange that I'm trying to persuade you of that, but it is a problem. It is a genuine concern, and I've made this point in public with the Minister. At risk of being misinterpreted, I need to stress that this is not an argument against health reform.

I think in all of these points I'm raising, I'm trying to raise one general concern which is we must not be glib. Some of the ideas we're talking about are much harder to do and some of them will have consequences that I think have not really been thought about thoroughly.

The Polokwane Resolution says the ANC will implement the NHI system by strengthening the public health system and raising additional funding. My question is that I am not sure that the NHI model that is being described will actually strengthen the public health system.

RESPONSE

On the public/private interaction, and the last question of whether this will not actually strengthen the public sector: It depends on how you construct the model that we are talking about. In the first place, the sequencing of the reform itself will be very, very important in the initial phasing-in of the process. When the ANC talks about "private", however, who are we talking about? We are talking about a very small geographic area where the private sector is predominant.

How providers are contracted, how contracts are negotiated, will shape the outcome. I take your point about whether the model itself could not contribute to the expansion of the private sector. The very role of the private health sector will not be the same as it is under present circumstances. There will have to be negotiated rules with practitioners having to meet certain criteria for them to be part of the health-care sector.

Also, your argument assumes that the whole issue of accrediting providers will ignore the quality question. In fact the very idea of interconnectedness means that as we phase in NHI, we are going to improve the infrastructure – in the language of the private sector – hotel services. Part of the major programme of government is a public/private infrastructure programme.

The benefit package: The ANC is not saying that there is no need for costing. I think that is very important. In fact a lot of work has been done and a much more sophisticated costing is being worked on than that which has been reported in the media, which one journalist referred to as hysterical accounting. One must look at the various scenarios that are available for costing NHI, because there is no one model. It is not just assumptions that should be made, but also the model decided upon. The extent to which you want to structure your costing is very, very important.

The other important part about this package is that one will want to avoid ending up with a detailed service package (which is also typical of these scientific calculations of costs) where you end up with something the size of an encyclopaedia, which can be manipulated by providers. In fact there's a lot of literature just recently published by the World Health Organisation which actually discourages countries to move towards detailed accounting, but recommends a basic package as a policy instrument.

Chris Archer

I come from the supply end of the equation and from right at the end of the equation because I'm a specialist in the private sector. My major concern is accepting that the two-tier system currently in place is inequitable, and whether the change to a national health insurance system will make it more equitable? Will NHI improve the access of services for the majority of South Africans? Universal access is a laudable objective, but the question I keep on asking myself is: Access to what?

At the moment if you look at the private sector, private sector beneficiaries enjoy a facility valued at approximately R9 000 per capita per annum. If you compare that with the public sector that figure is something like R1 300. But what one must not lose sight of when one looks at those broad statistics is that the private sector beneficiary is also currently contributing something like 78% of the tax that underpins the public sector.

Now if you take all of that money and you redistribute it across the whole country, which is in essence what an NHI will try and do to improve the equity situation, you'll end up with a figure where each per capita member of South Africa will have a benefit valued at something of the order of R2 000. But you will still have people at the top end of the financial ladder contributing what they are currently contributing. Instead of receiving R9 000 worth of value, they're going to be receiving R2 000 worth of services. Is that equitable? Is it sustainable?

There is the presumption that there is a lot of spare capacity in the private sector and that there are inefficiencies in the private sector. The presumption also is that through changing the system access will improve too. I wonder whether that is actually true as this presumption needs to be tested. My experience of my colleagues is that most of them are practising with long waiting lists. There are waiting lists that are manageable at the moment. Come change, current medical scheme members who may have to wait four or five days to see a GP or three or four weeks to see a specialist will suddenly find themselves in a situation where they're possibly waiting five or six weeks to see a GP and 10 to 12 weeks to see a specialist, and probably having to wait another five or six months to get a procedure that at the moment they can access fairly readily.

What is going to happen to those people? Perhaps I'm labouring the point but I think it is these people who are the engine that is driving the economy of this country – they are paying the taxes and we need to ensure that the tax payer remains in this country. We have an inordinately small tax base for such a large country – only about 5 million people actually pay personal income tax and we are already sitting with a marginal tax rate of about 40%. It's difficult to see how you can tax those individuals further, and at the same time give them less than they're currently getting, and not have a major problem on your hands.

We know, if we look at what's happening to the medical profession at the moment, that we are losing doctors every single day. This country is haemorrhaging medical skills, and it's haemorrhaging them for a number of reasons, not purely the threat of NHI. But nonetheless we need to be very concerned about why doctors are leaving and what we can do about keeping them here. Most doctors would prefer to remain here. We need to ask the question why are they leaving? Certainly, I think if you look at doctors who have migrated from the public sector to the private sector, they have not necessarily migrated from the public sector because they see the private sector as a better option. It's been more of a negative perception of their future in the public sector rather than a positive attraction of what's available in the private sector that has caused them to go.

So I think one should examine very carefully the assumption that the private sector is attracting away resources from the public sector and if the private sector wasn't there, or if everybody was on the same footing, those services would naturally flow back to the public sector.

Trevor Terblanche

Hopefully one of the side effects of all these NHI debates will be that we have a focus and an end point of developing and arriving at a common national vision, a shared national vision for health care in our country, because if we do that, we'll have done something for important our country.

Secondly, from a SAMA perspective, SAMA is very clear that it supports universal access to health care for all our people in this country. The challenge always lies in the detail of how to achieve that. SAMA is also clear that it says it's not either private or public sector oriented, but watches over both private and public sectors. SAMA says that we already have a national health system. Yes, it may be fractured, it's not ideal, it's fragmented in so many ways, but we have one. What we should do is to take the best from each sector and build on those positives in each, and not just in an airy-fairy way. Let's get real.

We should all be ashamed of our national development goals for health. Our mothers are dying and our children are dying unnecessarily. What are we doing about it? And are all of us taking joint responsibility for that situation? So while we theorise about whether you call it NHI or NHS, the babies are in fact dying and the mothers are dying. What are we doing about it?

There are simple interventions, where, if state bureaucracy can be decreased and private sector goodwill is harnessed, a lot can be done. The ophthalmologists have shown that in the sight campaigns what they have done traditionally over the years. The orthopaedic surgeons are standing by to replace hips at a very high rate. The GPs are prepared to be involved on the funding side of relieving pressure at clinics and sessions in hospitals and those kinds of things.

Instead of being grandiose and talking about the mechanism of funding, let's talk about delivery and how we can do things better and make a difference. Health is never going to be a bargain under any circumstances, because what matters you pay for, and this whole issue of services being free at point of service – we must stop talking about free services because somebody pays. And generally, all our people value what they pay for. I'm not saying that we must be a ridiculously capitalist or altruistic society, but we must say: The reason why you don't pay is that somebody is paying for you, therefore don't interpret this freedom of use as licence to do what you want to.

I worked at state clinics in Port Elizabeth for many years, and the level of liberality of use that some people engaged in was in fact horrifying, simply because it was free. For example, before I used to use buchu at home for my colds and flu. Now because it's a state service and someone must pay because I'm entitled to these free services, I come for those. Those expectations must in fact be addressed in a very realistic way.

The Minister made the point that when you look at your costing models you cannot assume that everybody who has minor ailments will go to a tertiary or quarterly institution, and the Ministry is right in that. But at the same time, when politicians make pronouncements about free health, that you can go anywhere you like, that is irresponsible. What we should say is, appropriate care at the appropriate level by the appropriate professionals.

One very important point is that it doesn't matter how fancy your systems and your funding model are – if you don't have the people to deliver those services you've got nothing. And part of our challenge is we must create a PRISA for our country, a- Professional Retention Institute of South Africa. That really is my appeal. I'm sure many people will be interested in that, because seen in the context of, for example, the OSD – Occupation Specific Dispensation – where the state said: We know we're underpaying our doctors in the public sector and we must do something about it.

Yes, it has taken some time and industrial action may have contributed to the solution, at least in part. The action raised tremendous ethical debates, which I won't go into now, but remember in that situation, don't think there will be a price war on professional services. It isn't going to happen. Your state doctors know they are worth what they are worth, and the same thing for private sector doctors. The profession is the profession, the same for nursing, and the same for our pharmacists.

Our pharmacists were paid a pittance over the years. I think up to about two or three years ago a qualifying pharmacist was paid R84 000 a year. We really should say: what's wrong with us, and how do we in fact assign value to our professionals in this country? So my appeal really is to say let's get real, let's focus on service delivery, let's go out and be mad – make a difference but in measurable ways.

Questions Answers Comments

DAVID SPARROW: **(Centre for Development and Enterprise)** *In the field of education school vouchers are used., Vouchers are funded by public funding directly from the government. Individuals manage their voucher use through their own decision on how to use them. What I want to know is whether members of the panel in general think something like that could be useful in the health setting?*

If you just replace national health with national insurance, then the scenario sketched by Jonathan Broomberg is likely to result in a stampede towards using private services where they're available. But if bits of the public system are partly rewarded for the decisions made by individually-empowered consumers, then that seems like it might not necessarily follow. I hope that came out clearly.

MICHAEL RUDOLPH: **(Wits School of Public Health)** *Professor Joe said he was just a simple doctor at the coal face. I'm a simple dentist, but I am in the School of Public Health at Wits University. In the debate, a lot of it is also not always familiar to me in terms of the economics, I hear about health care and health reform and overwhelming numbers of patients and costs. But the current government policy is primary health care, and one of the pillars of the primary health care approach is promoting health. There is extensive evidence to show that even the most efficient health services and health care contributes only one-third or one-quarter towards the health status of the population. So my appeal to put into this debate is, how we can introduce health promotion, because the effectiveness and the efficiency of the best national health system or national health service will be lost if we do not take into account the environmental and the social aspects of what's happening in our country.*

I feel that, coming back to one of the 10 Point Plans, Leadership, we need to have the leadership that has the guts to say that the current system needs to be improved. But we also have to have new attitudes, new mindsets, a new philosophy and a new approach to enhancing health, because improved health will have economic benefits. It will increase productivity and it will help build a stable society.

UNKNOWN: *I'm a specialist in private practice. I was a classmate of Joe Veriava we're from the same class. Hein is quite correct about the number of doctors. The Health Professions Council agrees with you. I saw in the paper today they have struck 12 800 doctors off the register for not paying. Those have all gone overseas.*

To Joe I just want to say one simple thing: Yes, I know doctors are very overloaded in the public sector, but we are in the private sector as well. My standard waiting list at the moment is four months for an appointment, and no new cases are being seen, or are even being booked for the next three months. We're also overloaded, so you can't rely on the private sector to supply these large numbers of doctors.

Tebogo was talking about a body being developed with a board that would not be part of the government,that would run the NHI and would be responsible to government – almost like a semi-state organisation. Your description Tebogo drew up a vision of Eskom, and I thought: "Oh my God, not another one".

NICOLA THERON: (Econex): *I have a question for Tebogo on the design of the benefit package. I think you said that you do not want to engage in detailed accounting and you quoted the WHO on that. The issue there is that if you promise a total comprehensive benefit package at zero cost at the point of service, then it's actually not that difficult to cost because you also referred to a person having a choice between what is offered then under NHI and what is being offered under a normal medical scheme package.*

Well, we know that there are 49 million people in this country, and we have a fairly good idea of what a comprehensive package costs. If you do those sums, you can see that that it is not fiscally affordable, and then we're back into the realm of scarcity, rationing – the normal economic concepts. I think going around creating those expectation, is not responsible, because one is creating expectations when it will be the market that will determine how rationing will solve expectations that have been created.

Comments

In essence this is a discussion about portable subsidies, and people can have choices. I think that you can have that as part of a system, but it's not necessarily the entire solution. At the end of the day, one needs to look at failures in the delivery of systems which actually are not adequately catered for by markets. I think within health care that is a central problem. Markets don't solve everything, they're part of the overall solution within the structure, part of an overriding institutional design.

There is a major flaw in our current subsidy framework, in that essentially you have a means-tested access to the public system, and if you do not use the public system then you cannot claim your subsidy because it's an in-kind subsidy. It in effect promotes inflexibility which is really an issue about the design of the system.

On the benefit package. one comment: The issue about costing and the ways you design benefit packages are fundamentally different between public systems and private systems. In fact that's part of the conundrum – that actually the way that benefit packages are determined within all health systems is that you've got so much budget, you chip away and you come intuitively toward what you can actually afford as a mechanism.

You have two choices. You can either do that as a prioritisation mechanism, operating within a public system by means of budgeting, or an insurance modality, which involves a completely different way of trying to chip away to come up with your package. The package will be a very different. The way that I'd actually contrast it is the way that you ration on a supply basis, the way that public systems typically do – the way the NHS does – it is right in front of you so determining the package is fairly straightforward. But if you try through an insurance modality, it's like having a dart board far away and you try to throw a dart and hit it. It's a much more difficult and complex mechanism to prioritise services effectively through an insurance modality. Therefore, both the costs and contents of the package are affected by the institutional model you choose. The problem really is that there has been a lot of confusion about what institutional model is being proposed.

Comments

As a matter of correction, I did not say that the NHI will have a Board, but this is one of the proposals. We actually will be happier for this NHI to look like SARS for instance in terms of its efficiency.

The other important point: I think you're quite correct about is the costing issue. There is a debate about costing. What Nicola Theron has just presented could be one of the crude ways of estimating health care, because it doesn't discount any underlying cost efficiencies, which are very high. It runs into billions and billions of rands in the current system. There are studies that have been done, that show different calculations of what NHI will cost and that forms part of the debate about how you will fund and cost health care.

The other important point David Sparrow talked about – vouchers. I would like to emphasise the importance and the principle of freedom of choice, and that this is also in the ANC's proposal. In this case freedom of choice is limited to providers, which I think is linked to the issue of whether that freedom of choice will lead to expansion of the private sector. But what we have been stressing very strongly is: It is a limited choice, so if you are in the Johannesburg health district, the only choice you have will be the choice of providers within that particular district.
However, the proposals will allow for portability. Thus the importance of electronic cards for example, so that one can allow portability of services between one province to the other.

I want to raise a point on the governance model and accountability. Devolved structures and decentralised arrangements promote the right kind of accountability. Ministerial appointment does not: The SARS' model and the SASSA model – the Social Security Agency (whose CEO is currently suspended) are problematic because as has been pointed out internationally, the people who are CEOs do not feel accountable downwards. They feel accountable upwards to the political structure because they're effectively a political appointment. That's actually the problem, and that's why they don't work.

SARS works because of the people that got appointed into that particular organisation. It is a fairly unique position that fairly responsible people for periods have been Ministers of Finance and heads of SARS. The moment you change that and you appoint somebody irresponsible into that position or into the ministerial position then you'll have an institutional collapse.

It is important that the institutional model is sustainable; that when a bad CEO is appointed s/he gets removed by the system, not retained, as is the case with the current type of system.

On freedom you cannot say there is freedom of choice and then tell people that they are limited to a particular region. It is the standard post code lottery that is being proposed, and it implies that there is not a supply constraint model in place. The reality is – and I think this is what is correct – you cannot make that promise because you will have to ration one way or another, and the system will be heavily rationed.

I think going back to the point Michael made about prevention being better than cure, our whole premise, the way we talk about costing here, is based on our existing model, which is essentially based on an investigative curative model. When somebody walks into the surgery nowadays it is not: 'Hello Doctor'; it is: 'I've got a headache, can I have my booking for my CT scan or my MRI, because just yesterday I read the Rooi Rose or YOU or Fair Lady and they told me that it's very dangerous when you have a headache for half-a-second, and you must do something about it'.

Now the reason why I'm making what sounds like a facetious remark is that we leave out the co-responsibility of care-seekers within these equations. If we don't make this debate real to the person in the street and say 'this is just not what we bigwigs are deciding, the economists and the actuaries and God knows what else, but this is your health. When the foot vrots, it's your foot that vrots, and it's your responsibility'.
We must move away from the model of

being where we are now, which is very much consumerist based. It's based on dramatic stuff; it's based on calling me a good doctor if I give you 12 medicines, or if I do 10 investigations, instead of sitting down to listen to you. And your tummy pain is probably just because you're full of crap and you need a plain abdominal x-ray, not an ultrasound and a CT scan and another thing.

So these are the kinds of real things we should be discussing with our people. Because if you add the cost of those wasteful interventions, it comes to many millions per day and per month and per year, and it can make a very, very real difference. I mean people in power must mean precisely that: inform, educate and take our people along with them. Don't speak for them all the time, speak with them. We all can do what we call value-based decision making. Whether I'm an individual doctor or an individual patient, I can ask one simple question: Will this intervention add value in line with its cost?

PEPESILE MASEKO (Traditional Healers Association): *I represent the Traditional Healers' organisation. The first comment the association would like to make is that in 1994, when the ANC government came into power, there was one strong statement that they made as part of a promise to the people of South Africa. They said they are going to establish a health care system that will be considerate of people's culture, traditions and way of life.*

Now what happened we don't know, as practitioners of African traditional medicine, because currently, as we are, the status quo says we are seeing a lot of people that are sick coming to traditional health practitioners. About 72% of the general public, which is mainly black Africans, are coming to traditional health practitioners, and it's regardless of these people's educational or economic status. They do see traditional health practitioners, and the South African health review studies suggest that.

Now, the Traditional Healers' organisation for instance does not necessarily dispute that such a universal approach to health care is not important. We are saying, as practitioners of African traditional medicine, that it is indeed a very progressive step, and it will be useful for the people of South Africa. But now the comment is, if government has to decide on such a progressive health care system, why has government left the traditional health practitioners out of the debate? Why is complimentary health practice not involved in this, because a lot of countries in the world are looking at holistic healthcare? Why is government not considerate of the fact that a lot of people are coming to us? It's very important that government considers that, in particular the current ANC-led government.

HEATHER CUNNINGHAM (Dental Association of South Africa): *If every individual in this wonderful country would do an honest day's work, be accountable, and do everything with honour, like Helen Suzman used to tell me, then our country wouldn't have this problem, there would be enough money, and our health system would work, whether we are private or government. Everybody must be honourable and honest, and that would solve all our problems.*

SERANNE DARREN (Idasa): *I'd like to highlight three points that were made. Firstly, the off-budget status of the fund; secondly, no detailed package; and thirdly, problems of costing packages. My question is: How do we ensure accountability and transparency of a large number of resources and funds without addressing any of these issues?*

To explain the institutional arrangements in the ANC proposals for the new fund and agency – the National Health Insurance Fund – its role will basically have the important function of pulling funds and also of purchasing. A sub-set is proposed as there is no one model for organising institutional and governance arrangements around the fund. There are many countries that have gone this route; we are not the first country to establish such a fund, or even to propose such a fund. The questions of accountability and transparency, because what we are proposing is that from the word go, this is a fund that must be run by specialists and dedicated professionals. It is not a structure for buddies. From the word go, it has to enjoy national and also international credibility as such. So that is a very, very important point.

Comments

From a governance point of view, the ANC envisages a model much like one which is working in Thailand where reporting mechanisms are very open. Their annual reports do not just provide the financials – how much they have used, and how they have used the funds – but they also indicate performance indicators – for instance what level of coverage they have reached, and important issues such as payment levels that have been negotiated with the providers. The performance indicators are quite comprehensive and, importantly, the process is very open.

Do not confuse detailing and a package. There will be a package, but what we are saying is that you don't want to end up disempowering the very consumer, where you end up with bible-sized or encyclopaedia-sized detail. That will empower the providers, because they can say, no, it's not covered, and therefore they can manipulate the process. There are best examples of that, of having a detailed package that clearly defines what your benefits are, without necessarily going into much more detail than other practices have done.

I think Pepsile Maseko has raised an important point, and I think this is the third time I have encountered the issue concerning traditional healers. In the ANC Task Team process it was an issue that was indeed raised, and the question was particularly in terms of how to expand benefit packages to cover services provided by traditional medicine? I know that it is part of that engagement, and I think as the engagement proceeds, the ANC is very open to further discuss the implications of that in the NHI system. But I think it's a very important question to take note of.

I think one of the concerns that I have – and I'm going to go back on the discussion of the package in relation to the comments that were made. Firstly, the notion of listing things in packages, as if this is a medical scheme benefit list, is probably one of the most insane things I can think of. You cannot do that for a public fund. What you can do is fund an overall allocation and have a budget mechanism, and you determine basically how much you've got according to how many funds you have got. But it's not going to work in the other direction because you end up creating a contingent liability. If you had to put the list of benefits

"The international model that is generally accepted is a tripartite governance model, in which effectively you involve a kind of structure which gives people an incentive to oversee the executive structure. It is not akin to the Eskom board, it is a different type of board. This kinds of structure works very well because it depoliticises the delivery of health care, and it works because it can actually remove a CEO if s/he's not doing very well."

for a universal entitlement to pick your service provider in a National Health Act, you're creating a contingent liability for government second to none. Nobody is ever going to allow that.

The issue of the overriding structure is important, and I go back to the governance structure. Accountability comes from the design of the accountability mechanism. It must be politically neutral, and it must be neutral of private interests. The international model that is generally accepted is a tripartite governance model, in which effectively you involve a kind of structure which gives people an incentive to oversee the executive structure. It is not akin to the Eskom board, it is a different type of board. This kinds of structure works very well because it depoliticises the delivery of health care, and it works because it can actually remove a CEO if s/he's not doing very well. It's very easy to have whistle-blowers in that system and the accountability is much stronger than within a system incorporating politically-appointees.

Finally, we already have a public system which involves specialists and dedicated professionals who run it, and yet it is not running very well. The solution for health lies in the governance model. It is the governance model that's drives institutional performance, and it's absolutely imperative that any parastatal, regulator or any structure follows this rule so that health provision may indeed become universal.

Department of Health: 10 Point Plan

Priority	Key Activities
1. Provision of Strategic leadership and creation of Social compact for better health outcomes	• Ensure unified action across the health sector in pursuit of goals • Mobilise leadership structures of society and communities • Communicate to promote policy and buy in to support government programmes • Review of policies to achieve goals • Impact assessment and programme evaluation • Development of a social compact • Grassroots mobilisation campaign
2. Implementation of National Health Insurance (NHI)	• Finalisation of NHI policies and implementation plan • Immediate implementation of steps to prepare for the introduction of the NHI, e.g. Budgeting, Initiation of the drafting of legislation.
3. Improving the Quality of Health Services	• Focus of 18 Health Districts • Refine and scale up the detailed plan on the improvement of Quality of services and directing its immediate implementation • Consolidate and expand the implementation of the Health Facilities Improvement Plans • Establish a National Quality Management and Accreditation Body
4. Overhauling the health care system and improve its management	• Identifying existing constitutional and legal provisions to unify the public health service; • Draft proposals for legal and constitutional reform • Development of a decentralised operational model, including new governance arrangements • Training managers in leadership, management and governance • Decentralisation of management • Development of an accountability framework for the public and private sectors
5. Improved Human Resources Planning, Development and Management	• Refinement of the HR plan for health • Re-opening of nursing schools and colleges • Recruitment and retention of professionals, including urgent collaboration with countries that have excess of these professionals • Specify staff shortages and training targets for the next 5 years • Make an assessment of and also review the role of the Health Professional Training and Development Grant (HPTDG) and the National Tertiary Services Grant (NTSG) • Manage the coherent integration and standardisation of all categories of Community Health Workers
6. Revitalisation of infra-structure	• Urgent implementation of refurbishment and preventative maintenance of all health facilities • Submit a progress report on Revitalisation • Assess progress on revitalisation • Review the funding of the Revitalisation programme and submit proposals to get the participation of the private sector to speed up this programme
7. Accelerated implementation of the HIV and AIDS strategic plan and the increased focus on TB and other communicable diseases	• Implementation of PMTCT, Paediatric Treatment guidelines • Adult Treatment Guidelines • Urgently strengthen programmes against TB, MDR-TB and XDR-TB
8. Mass mobilisation for the better health for the population	• Intensify health promotion programmes • Strengthen programmes focusing on Maternal, Child and Women's Health • Place more focus on the programmes to attain the Millennium Development Goals (MDGs) • Place more focus on non-communicable diseases and patients' rights, quality and provide accountability
9. Review of drug policy	• Complete and submit proposals and a strategy, with the involvement of various stakeholders • Draft plans for the establishment of a State-owned drug manufacturing entity
10. Strengthen Research and Development	• Commission research to accurately quantify Infant mortality • Commission research into the impact of social determinants on health and nutrition • Support research studies to promote indigenous knowledge systems and the use of appropriate traditional medicines

Source: Department of Health, Strategic Plan 2009-2011

Health Statistics

Comparative Data

Physicians (ie medical graduates) per 1000 people, selected countries 2002-2007	
Chile	1.1
Hungary	3
South Africa	0.8
Turkey	1.6
Germany	3.4
UK	2.2
US	2.3

Source: SA Institute of Race Relations SA Survey 2008/2009

Tax Revenue and business tax as a percentage of GDP, selected countries (2007)	
Chile	21.5%
Hungary	21.5%
South Africa	29.1%
Turkey	18.5%
Germany	11.8%
United Kingdom	28%
United States	12.2%

Source: SAIRR South Africa Survey 2008-2009

Health Expenditure, selected countries, 2006				
	Total health expenditure as a proportion of GDP	Public health expenditure as a proportion of total health expenditure	Out of pocket expenditure as a proportion of total private expenditure	Per capita health expenditure (PPP$)
Chile	5.3%	52.7%	54.8%	1 290
Hungary	8.3%	70.9%	77.6%	2 761
South Africa	8.1%	37.7%	17.5%	1 100
Turkey	4.8%	72.5%	84.2%	866
Germany	10.6%	76.9%	57.1%	5 210
UK	8.2%	87.3%	91.7%	4 259
United States	15.3%	23.5%	23.5%	6 719

Source: SAIRR South Africa Survey 2008/2009

SA Macro Economic Profile

8m people in voluntary Medical Schemes using private primary care and private hospitals
R9,500 per person pa

8.8m people using private ambulatory care out-of-pocket in addition to public services
R1,500 per person pa

30.2m people using public clinics and hospitals — **R1,300** per person pa

Source: McLeod.H & Grobler. P (2009) (Box 1 and 2 provide adjusted figures based on updated information from the Council for Medical Schemes. The per capita figure however is not based on the updated information.)

Taxable income group	Number of taxpayers	
	2003 - 95.1% assessed	2006 - 71% assessed
0-123 000	1 924 662	1 382 675
120 001 - 500 000	787 186	1 133 273
500 001 - 750 000	27 269	43 714
750 001 - 1 000 000	9 093	13 888
1 000 001 - 2 000 000	8 573	12 261
2 000 001 - 5 000 000	2 221	2 817
5 000 000 +	368	420
Total	**3 352 190**	**3 215 192**

Source: SAIRR South Africa Survey 2008/2009

Employment Profile

Economically active population 2009 (including discouraged work seekers)	19 012 000
Employment 2009 (all occupations)	13 369 000
Employment formal	8 334 000
Employment informal*	4 356 000
Unemployment 2009 (wide definition)**	5 642 000
Unemployment rate (wide definition)	29.7%

* Identifies persons who are in precarious employment situations; persons not entitled to basic benefits eg pension, medical aid, contributions, no written contract of employment.
** Term employed by the SAIRR to include discouraged work seekers.

Source: SAIRR South Africa Survey 2008/2009

Health Data

Public sector doctors by province (2008)	
Eastern Cape	1 157
Free State	609
Gauteng	2 196
KwaZulu Natal	3 044
Limpopo	883
Mpumalanga	567
North West	498
Northern Cape	275
Western Cape	1 418
South Africa	10 653

Source: Health Systems Trust in SAIRR SA Survey 2008/2009

Number of public sector professional nurses by province (2008)	
Eastern Cape	7 386
Free State	2 485
Gauteng	7 663
KwaZulu Natal	11 973
Limpopo	6 471
Mpumalanga	3 184
North West	2 862
Northern Cape	1 193
Western Cape	4 615
South Africa	47 834

Source: Health Systems Trust in SAIRR SA Survey 2008/2009

Public sector people-to-doctor and people-to-nurse ratios by province	P-Doctor	P-Nurse
Eastern Cape	5 687 : 1	891 : 1
Free State	4 725 : 1	1 158 : 1
Gauteng	4 757 : 1	1 363 : 1
KwaZulu Natal	3 320 : 1	844 : 1
Limpopo	5 974 : 1	815 : 1
Mpumalanga	5 549 : 1	1 128 : 1
North West	6 878 : 1	1 197 : 1
Northern Cape	4 094 : 1	944 : 1
Western Cape	3 710 : 1	1 140 : 1
South Africa	**4 570 : 1**	**1 018 : 1**

Source: Health Systems Trust in SAIRR South Africa Survey 2008/2009

Medical Aid beneficiaries 2004-2007	As proportion of population
Eastern Cape	8.8%
Free State	11.5%
Gauteng	29.3%
KwaZulu Natal	11.7%
Limpopo	5.9%
Mpumalanga	14.0%
North West	11.4%
Northern Cape	14.1%
Western Cape	26.6%
South Africa	15.6%

Source: Health System's Trust in SAIRR SA Survey 2008/2009

HIVAIDS			
Present number of HIV infections (2009)	High	5 728 711	ASSA 2003
	Low	5 700 000	UNAIDS
Total HIV infection rate (2008)		10.90%	HSRC
HIV infection rate by 2025	HIgh	18%	Metropolitan
	Low	7%	Metropolitan
Life expectancy at birth in 2026	High	59	ASSA2003
	Low	51	Metropolitan
Adults with AIDS not on ART (2009)		470 379	ASSA2003
Children with AIDS ot on ART (2009)		26 391	
Aids deaths as a proportion of total deaths	High	57.20%	Metropolitan (2005)
	Low	48.50%	ASSA2003

Tuberculosis (reported cases - TB & Pulmonary TB)	
2000	150 696
2007	353 879
% increase	134.80%

Source: SAIRR SA Survey 2008/2009

Population segments living with HIV/Aids	
Adults (20-64)	5 186 072
Women (child bearing 15-49)	2 970 696
Youth (15-24)	1 026 109
Children (0-14)	341 495
Total	**5 728 711***
% of population	11.70%

* The figures do not add up as the categories overlap

Projected prevalance rate	2008	2015
	11.60%	12%

Source: SAIRR SA Survey 2008/2009

Media coverage

INSIDE TRACK - MONEY WEB
09 December 2009 12:29
Maya Fisher-French|

NHI anyone? Expect waiting lists to grow and grow

Taxpayers will receive substantially less healthcare benefits.

JOHANNESBURG – With only 5.3m taxpayers in South Africa, a national health plan will either have to limit the services available or provide substandard healthcare to all South Africans.

At a round table discussion on health reform held by the Helen Suzman Foundation, Chris Archer of the South African Private Practitioners Forum gave some very sobering figures on what exactly equal access would mean to people who currently use the private sector.

The private sector enjoys a healthcare spend per capital of around R9 000 per annum. This is a stark contrast to the R1 300 per capita spent by the public sector. Keep in mind that the people who pay for their healthcare in the private sector are the same people who fund the public sector. Archer argues that if you redistribute all of these funds between the 49 million South Africans, you end up where each person receives R2000 of medical spend per year.

The low end has benefited by 50% but the private sector will see their healthcare benefits decimated; yet they will still be contributing the same amount which currently buys them R9 000 of healthcare per year. In other words redistribution will leave users of private healthcare significantly poorer. Even if, as government argues, the NHI will bring greater efficiencies, it would be impossible to make up R7 000 of value.

Archer argues that the idea that the private health sector has excess capacity, and can absorb the tens of millions of people being treated in the public sector, is a myth. Already the private sector is facing a shortage of doctors and specialists and waiting lists are growing. However, this will be pushed to breaking point with the addition of millions of people who will be provided with free healthcare at private practices. Waiting lists will increase to four or five months and people who now access procedures fairly easily will have to wait months, if not years, to be treated. “The top tax rate is already sitting at 40%, how are you going to tax people further and given them less than they are getting and not have a problem on your hands?” says Archer.

However, if government does not do something to address the complete breakdown of the public sector, it will face an even greater problem. Professor Joe Veriava, whose work in the public sector puts him at the coal face, says the reality is that the hospitals are not coping. “We are running at 100% bed occupancy so how can we provide universal access? It is part of the bill of rights but we are not providing it. We have very high mortality rates on admissions and we have to send people away. So play around with economic jargon, but we need to increase access, we need more beds and we can’t do that at the existing hospitals”.

That we need health reform is a given, just exactly how it is going to be achieved and what resources we realistically have at our disposal is what needs to be debated. It certainly seems idealistic to offer every South African equal healthcare no matter how noble the sentiment, but improving the public sector and creating private-public partnerships is a start so that at least decent basic care is available to those who need it most.

Write to Maya Fisher-French: maya@moneyweb.co.za

BusinessDay
NEWS WORTH KNOWING

Proposed national health insurance ‘inappropriate for SA’

09 December 2009 12:29
Wilson Johwa

The proposed national health insurance (NHI) scheme would be too expensive for SA and an appropriate model, says health economist Alex van den Heever.

He said as a base system the NHI model would be too inefficient to provide access to universal healthcare, one of the Zuma administration’s election promises.

Last month, Health Minister Aaron Motsoaledi announced an advisory body to drive consultation on the NHI scheme.

Van den Heever said that to speak interchangeably of a national health service (NHS) and national health insurance was confusing the debate in SA as the terms referred to two different models. “They are technically competing institutional models,’ he said at a roundtable discussion arranged by the Helen Suzman Foundation on Tuesday.

Van den Heever said SA had no option but to implement an NHS model but, “the question is, what are the institutional components?” The 1997 white paper on health had already proposed what could be a workable system which, however, was never implemented, he said.

An NHS would be funded through tax while the proposed NHI would operate much like the Road Accident Fund.

He also described as a “false debate”, the view that an NHI would solve some of SA’s healthcare problems, such as poor performance in the public sector. “In essence SA cannot talk about any other model for its base system for achieving access other than a national health service design,” he said.

The African National Congress policy research co-ordinator Tebogo Phadu said the party was in favour of creating an agency, like the South African Revenue Service, to spearhead the provision of healthcare.

helen.suzman.foundation

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