

**SUBMISSION TO THE NATIONAL DEPARTMENT OF HEALTH:
THE WHITE PAPER ON NATIONAL HEALTH INSURANCE FOR SOUTH
AFRICA**

1 Introduction

This submission is a response to the invitation¹ to interested persons to submit substantiated comments or representations on the policy proposed in the White Paper.

The Helen Suzman Foundation has worked on health policy for some time. It held a round table on the National Health Policy Document in 2009. It submitted comments on the Green Paper of 2011. It has recently completed a major study of the distribution of pharmaceuticals. It has been following the Competition Commission's market enquiry into the private health sector. It has published work analysing systems of universal health care in a number of countries. It has also analysed the implications of the Medium Term Expenditure projections published as part of the 2016 Budget for primary health and hospital care.

In brief, our response to the White Paper is that it contains valuable material on developing the supply of health care and on regulation of the sector. However, we are critical of the identification of universal health care with a single payer system and believe that there has been inadequate consideration of alternatives, we find the approach to financing inadequate and unhelpful, we regard the approach to medical aid and medical insurance too restrictive, and we think that the issue of catastrophic health expenditure needs analysis rather than just a mention. Finally, we suggest a much tighter integration between the resource envelope and the public health care system.

We elaborate on all these points below.

2 The supply of health care

2.1 Primary health care

We are in support of the following proposals for the development of primary health care.

¹ See Government Notice 1230, published in the Government Gazette 39506 on 11 December 2015

The Brazilian experience shows the benefits of *PHC Outreach Teams*. The evidence suggests across-the-board improvement in child health and infant mortality, as well as a sharp reduction in post-neo-natal death due to diarrhoea and infection. There is also evidence suggesting a marked reduction in mortality from cardiovascular and cerebro-vascular diseases and reduced rates of chronic conditions like diabetes. Even rates of tropical diseases have noticeably dropped².

The *Integrated School Health Programme* is commendable, both in its impact on the health of school children as well as its impact on improving educational outcomes. Identifying and dealing with problems of sight, hearing and tuberculosis at an early stage are key investments which will produce lasting returns, both in childhood and adulthood.

Improved contracting in of private general practitioners is desirable. There are clear complementarities between conditions in clinics and the willingness of doctors to work in them, and improvements in record keeping will make their contributions more efficient. We return to both points below.

However, we are concerned about the quality of reporting on progress in implementing these programmes and the almost complete absence of information about both total costs and costs per unit of service delivered. The most recent progress report on the *Status of NHI Pilot Districts* is dated 25 May 2015 and there is a National Treasury power point presentation entitled *Expenditure Trends on NHI conditional grants* dated 9 June 2015. Both documents were tabled at a meeting of the Health Committee of the National Assembly on 21 August 2015.

We know that there is a Section 5A grant to the Provinces (the ‘direct’ grant) of R 85 million in 2016/17, with no plan to continue this grant beyond the current financial year. There is also a Section 6A grant (the ‘indirect’ grant) whose benefits accrue to Provincial health systems, but which is administered by the National Department of Health. The value of this grant is R 1 261 million in 2016/17, with projections of R 1663 million in 2017/18 and R 1765 million in 2018/19. We also know that the direct and indirect grants have been substantially under spent up to 2014/15, with under spending worse on the indirect grant (21% of which was spent in 2014/15, compared with 69% of the direct grant), even though the indirect grant was supposed to work around Provincial spending constraints.

What we do not know, but should, are the following:

- *The allocation of these grants across the various functions identified as their purposes.* This matters, for instance, because the 2015 status report informs us that engagement of new contracted doctors had to be stopped after budget

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See the HSF brief *Community Primary Health Care Outreach Teams: a Game-Changer?*, published on 17 May 2016 on our website www.hsf.org.za [Publications: Briefs]

cuts in February 2015. The question is why, given that implementation of innovative models for contracting of health practitioners was assigned to the radically under spent indirect grant.

- *The expenditure on individual services and the expenditure per unit serviced.* For instance, we know that the number of ward based outreach teams, based on one per 1 500 households, needed in the eleven pilot districts was 1 976, and that 752 such teams were registered in January 2015. But we know neither what these cost, nor how many households they visited in a given period of time, so it is impossible to work out the cost per household visited, much less the cost per referral. We know, too, that there were 444 school-based teams led by a nurse at the time the report was written, and that 54 238 children were identified as having sight, hearing, dental, TB and speech problems in the second half of 2014, but not how much these teams cost, nor the number of school children assessed.

The purposes of a pilot project are to learn efficient ways of delivering programmes, to overcome system constraints on implementation and to estimate unit costs of service delivery to serve as a basis for estimating the cost of a national roll out. It appears that the system constraints on implementation remain severe³ and that unit cost information is not being generated. Without an estimate of costs, fitting and sequencing the programmes within a resource availability envelope is impossible. We shall return to this point below.

2.2 *Expanding access to pharmaceutical, laboratory and emergency medical services*⁴

We are in support of the White Paper's principle that clinics be decongested by making it possible for stable patients on chronic medication to acquire their medicines elsewhere. The White Paper refers to the Centralised Chronic Medicine Dispensing and Distribution (CCMDD) programme, consisting of two components: the Central Medicines Dispensing and Distribution mechanism and Pick up Points (PuP). PuP contracts can be entered into with any number of vetted private sector retail pharmacies. The contract for CCMDD has been awarded to three service providers who are responsible for the collection, preparation and delivery of scripts to health facilities and other designated collection sites⁵. The *Status Report* finds that the CCMDD is more expensive in personnel costs than the old system of distributing medicines at clinics, but the justification lies in a quality controlled system and saving of time by stable patients. Good inventory control is also much easier in the CCMDD.

³ Problems identified in the *Status Report* include lack of co-ordination between the National and Provincial departments of health, and problems with the contracting of general practitioners

⁴ The White Paper makes a brief reference to radiological services but says nothing useful about them

⁵ The Western Cape has a variation on this model

The White Paper's views on the National Health Laboratory Services (Section 6.8) seem confused to us. Consider the following passage:

A strong criticism of the NHLS's use of the fee for service model is that it produces financially driven perverse incentives, i.e. tests are conducted as a means of revenue generation and not from an appropriateness of need of care perspective.

But who is acting inefficiently and why? The NHLS laboratories simply carry out tests on request from medical practitioners. The medical practitioners receive no income from tests. Even so, the White Paper asserts that there are unnecessary test requests and wants a gate keeping tool to identify them, by identifying an essential set of tests which will be funded, volume being an important determinant. This it proposes to do by putting

restrictions on each test method by using evaluation criteria as well as multiple conditions for when a test is allowed. Authorization levels will also be specified by category of health professional, seniority and type of facility. The laboratory investigations to be covered by NHI would be requisitioned for a particular clinical indication and not merely as a routine procedure.

Moreover,

A service specification outlining a volume threshold for each specific test will be developed. A 5% margin of fluctuation is proposed as acceptable. When the volume exceeds the threshold by more than 5% monthly or quarterly, fee for service will apply.

All this raises the following problems:

- The White Paper is concerned with one kind of error: a test performed when it is not necessary. But there is a second kind: a test not performed when it is necessary. And the costs are asymmetric. In the first case, the cost is the cost of the test. In the second case, the cost can be failure to detect a problem early, necessitating costly later treatment and increasing morbidity and mortality risk.
- The judgement of a medical practitioner about a patient in front of her can be overridden by impersonal 'evaluation criteria', 'multiple conditions' and 'authorization levels'. This happens with some medical aids at present and it is a leading cause of friction with doctors.
- The particular clinical indication criterion is not rational, since doctors may in a routine check up identify risk factors which make a particular test rational as a precautionary measure even though symptoms are not present.

- And what are we to make of the volume limitation? Will all tests in the time period chosen be subject to fee for service? Will only those tests which come in after the limit is exceeded be subject to fee for service? Who will pay the fee for service? And how will this payment affect behaviour?

Our view is that the whole section needs a major reconsideration.

We support the development of norms and standards for emergency medical services and emergency care and that these should be provided by both the public and private sectors.

2.3 *Hospitals*

We have no objection to the categorization of public hospitals and allocation of functions to each category, though we doubt that the scheme will be fully realized in practice. We note that there is no proposal for categorization of private hospitals, and we consider this wise.

We note the proposal that public hospitals, starting with central hospitals, are intended to become 'semi-autonomous'. It appears from the context that 'semi-autonomous' entails that individual hospitals will have full control over financial management, human resource management, infrastructure, technology, planning and decision making, under the control of Hospital Boards. But they will not have control over their revenue stream. We support the development of the capacity of individual hospitals to manage themselves.

2.4 *Human resources for health*

We have no objection to what is written in Section 6.6 of the White Paper, but we regard this section as over-general and seriously incomplete. Specifically, we should like to see the following added:

- A record of the annual graduations in recent years of health professionals of different types from South African institutions which train them.
- Estimates of the number of health professional of different types currently in practice in the public sector only, in the private sector only and in both sectors.
- A set of benchmarks of the number of health professionals of different types required for a given population size.

- Based on the above and an estimate of the attrition rate of health professionals of different types, an assessment of the numerical adequacy of current training levels, and a plan of action where inadequacy is found.

3 Regulation

3.1 The Office of Health Standards Compliance⁶

We support this institution in its functions to develop norms and standards for quality delivered by health establishments and to inspect health facilities' compliance with them. However, we are alarmed to read the following in the OHSC Annual Performance Plan for 2016/17 presented to the Health Committee of the National Assembly on 7 April 2016:

Over the five year period covered by the OHSC's strategic plan, the OHSC has set itself the inspection targets of 20% of health establishments in the public sector, as well as 30% of health establishments in the private sector.

This inspection rate is far too slow. It implies that public sector health facilities would be inspected once every twenty-five years and private facilities once every seventeen years.

3.2 The Ideal Clinic model

We support this model, the current version of which involves assessment of clinics against 183 criteria, fifteen of which are regarded as vital, 87 as essential and 81 as important. Recognition of achievement is classified into four categories: diamond, platinum, gold and silver. To achieve the silver standard, 100% of vital indicators, 70% of essential, and 65% of important indicators must be rates as positive.

There is clearly much to be done. 1142 clinics were assessed in 2015/16. Of them, 405 scored less than 60% on all the indicators taken together, 344 between 60% and 80% and 393 above 80%. Only just over a quarter of them achieved silver status or better.

⁶ Chapter 10 of the National Health Act of 2003 as amended provides for the establishment and functioning of the OHSC. Norms and standards regulations in terms of Sections 90 (1)(b) and (c) of the Act, applicable to certain categories of health establishments were published for comment in February 2015

3.3 *The Health Patient Registration System*

We support the HPRS and we commend the progress made so far in registering patients on it. Valuable health facility time is wasted on dealing with inadequate record keeping and the problems of transferring manual records from one facility to another.

3.4 *Combating excessive pricing in private health*

In the provision of health care, excessive pricing can occur as a result of the exercise of market power by suppliers. The remedy for this is appropriate competition policy and for this reason we welcome the Competition Commission's Market Enquiry into the private health care sector. Once competition policy is optimised, we do not believe that price levels in the private sector can be used as an argument against provision of health services by it.

4 Where we differ from the White Paper

4.1 *Health care: a public or a private good?*

In the White Paper we read:

Health care as a public good.

Health care shall not be treated like any other commodity of trade, but as a social investment.

There are two confusions here. Whether health care is a public or private good is not a matter for normative specification. It depends on the facts of the case, specifically on whether it is rival in consumption and whether people can be excluded from access to it. Health is promoted sometimes by the provision of public goods, such a clean air, or mosquito and vermin control. One person's enjoyment of the benefits does not detract from anyone else's enjoyment and nobody can be excluded from them. The White Paper is not concerned at all with these aspects of health promotion. There are also cases where there are positive externalities from health care: one person's inoculation against an infective disease lowers the chances of other people contracting it. The existence of positive externalities creates a case for subsidised or free provision of services. But most of the health care discussed in the White Paper is a private good. Indeed, the White Paper as a whole makes no sense unless this premise is accepted.

The second confusion is about the health care as an investment good. The opposite of an investment good is not a public good, but consumption good. A great deal of health care is an investment good as it yields benefits over an extended period of time, but the benefits are rival in consumption so that the health care is a private

investment. The only difference between a private and a social investment is when externalities are involved.

4.2 *The White Paper tends to conflate the concepts of universal health care and a single payer system*⁷.

The two concepts are logically distinct, and it is perfectly possible to have UHC without a single payer system. Austria and Germany have mandated insurance systems. Israel and the Netherlands have two-tier health care, so named because it involves a publically funded basic health package being provided, with a secondary private tier of additional – and often better quality – services available for those who can afford it. The White Paper has not explored the options in sufficient detail, and too much has been closed out *ex ante*, with damaging consequences.

4.3 *We do not know how much NHI will cost.*

All available estimates indicate that NHI will require a very large increase in health expenditure, but they differ wildly. . These include:

- A study commissioned by COSATU, authored by Sule Calikoglu and Patrick Bond
- Work carried out by the National Health Unit, University of Cape Town and supervised by Professor Di McIntyre
- A study from Stellenbosch University, authored by Professors McLeod, Grobler and Van der Berg, commissioned by the National Treasury
- A model developed jointly by the Actuarial Society of South Africa, Deloitte South Africa and Discovery Health Model
- A study commissioned by ECONEX, a firm specialising in competition and applied economics
- Analysis carried out by Professor Alex van den Heever, School of Governance, University of the Witwatersrand

These studies show a wide divergence in cost estimates. For instance, van der Berg and McLeod point out that the costing by Sule Calikoglu and Patrick Bond offers a range from R134 billion to R231 billion, with a preferred model of R205 billion for 2006. A costing by Di McIntyre, John Ataguba and Sue Cleary produced a cost of R77 billion in 2010, escalating to R169 billion at current values by 2020. Van der Berg and McLeod themselves offer three estimates in 2010 prices:

Prescribed Minimum Benefits only: R156 billion

⁷ This section draws on a series of five briefs on Universal Health Care, published on the HSF website at www.hsf.org.za [Publications: Briefs]

Basic Benefit Package (PMBs plus primary care): R251 billion
Fully Comprehensive Benefit Package: R334 billion.

The White Paper itself estimates that the additional funding required in 2025/26 needed if baseline (i.e. pre-NHI) health expenditure increases at 3.5% per annum in real terms is R71.9 billion in 2010 prices. The source for this is a National Treasury projection of 2012, not available for public inspection.

It should be noted in passing that even a 3.5% real increase in health expenditure between now and 2025/26 looks demanding. The International Monetary Fund projects the growth rate of the economy at 1.85% between 2016 and 2021.

We have been repeatedly promised (and recently by the Minister of Finance in the 2016 Budget speech) publication of a Treasury document on financing aspects of the White Paper. No such document has yet been released and, until it is, we have no prospect of understanding the government's cost assumptions.

4.4 The implicit assumptions about consumer choice and the explicit assumptions about public finance in the White Paper are both seriously flawed.

Start from the basics. Incomes from factor payments and non-government transfers are modified by government taxation and expenditure. Income after direct taxation is known as disposable income, while the benefits from government expenditure form what is sometimes called the 'social wage'. Changes in direct taxation alter disposable income, but once it is determined, individuals choose between saving and consumption, and between consumption of different categories of consumption, including health care. Depending on their preferences and circumstances and the prices they face, people will choose the level of health care they want⁸. And they will want insurance against the necessity of receiving expensive care for conditions they might want. Now it is true that taxation via its effect on disposable income will affect decisions about health care, but the decisions themselves are not in the nature of the case, redistributable. It is also true that should free health services become available as part of the social wage, the availability of these services can affect spending on health care if they comply with the level of health care they want.

A compulsory contribution to a health fund is a tax, whether or not it takes the form of a health insurance contribution or surcharges on existing taxes. But it does not follow that health spending by individuals will diminish by the size of the compulsory contribution. Because it means that disposable income decreases, there will be a

⁸ Certainly, expenditure on health care rises as disposable income rises. Health care is not an inferior good. Whether the share of disposable income devoted to health care rises as disposable income rises remain a controversial issue, though a study by the US Department of Agriculture of data in 2003 of data from 114 countries found that, without exception, health expenditure rose as a proportion of income as income rose.

retrenchment across the savings and consumption board. A substantial demand for privately provided health care will remain and, provided that private provision of health care remains, it will be met. The only way of avoiding this is to forbid the private practice of medicine altogether, a level of coercion not contemplated in the White Paper. There is proposed coercion at the level of insurance, a point which will be discussed further below.

Now consider the matter from a public finance point of view. A tax which is automatically paid over to support a given government function is known as an earmarked tax. And a general public finance proposition is that earmarked taxes should be used with extreme caution. Why? It is the function of a government to decide on the level and type of taxation and government spending. Suppose that taxes are increased. Then it is generally not optimal to assign the increase to one item of expenditure, such as health. Other forms of government expenditure such as education, social grants and housing have to be considered as well. An earmarked tax is a constraint on the ability of the government to optimise its expenditure pattern, leading to a lower level of social welfare.

4.5 The issues of out of pocket expenditure and catastrophic health care expenditure are not adequately dealt with

The definition of catastrophic health expenditure in the White Paper is:

Health care expenditure resulting from severe illness/injury that usually requires prolonged hospitalisation and involves high costs for hospitals, doctors and medicines leading to impoverishment or total financial collapse of the household.

The definition of out of pocket expenditure is:

There are three forms of out-of-pocket payments namely:

- a) Every time a patient has to pay cash when they seek health care whether in the public or private sectors;
- b) Additional payments (co-payments or levies) for those on medical schemes but whose benefit option does not cover all the costs; and
- c) Cash payment for those on medical schemes whose benefits are prematurely exhausted before the end of the year.

These definitions are appropriate and the definition of out of pocket expenditure is in line with the World Health Organisation's definition. How extensive are out of pocket expenditures in South Africa?

The WHO estimated that in South Africa in 2014, out of pocket payments constituted 6.5% of total health expenditure in 2014. Only ten countries, out of 178, had lower percentages⁹. Why is the South African percentage so low?

The answer is that the public and private sectors are better articulated than many think when it comes to protection of the public against out of pocket expenses. Fees at public clinics and hospitals are regulated by the Uniform Patient Fee Schedule which divides patients into five categories:

- H0: Social pensioners who receive the following grants: Old age, child support, veterans, care dependency, disability grant, foster care. The formally unemployed, which means persons supported by the Unemployment Insurance Fund (UIF) who can produce a formal document issued by the Department of Labour.
- H1: Patients with an income of less than R 36 000 per annum for a single person or R 50 000 for a family unit
- H2: Patients with an income of between R 36 000 and R 72 000 per annum for a single person or between R 50 000 and R 100 000 for a family unit
- H3: Patients with an income of more than R 72 000 per annum for a single person or more than R 100 000 for a family unit

Full paying patients: A full paying patient is one is externally funded (by the Compensation for Occupational Injuries and Diseases Fund, the Road Accidents Fund, medical aid schemes, another state department, a local authority, a foreign government or an employer) or a private patient (a patient treated in a government institution by a private practitioner) or a non-South African (Patients are treated as South African if they are South African citizens, permanently resident in South Africa, visitors or foreigners with study permits, temporary work permits or temporary visitor permits, Persons from neighbouring states or asylum seekers and refugees)

Patients in categories H0 to H3 are subsidised, the degree of subsidy dropping as one ascends the categories. The degree of subsidisation is intended to minimise the risk of catastrophic health expenditure. And subsidisation is very great: in 2014/15, sales of goods and services by provincial departments accounted for 1.45% of provincial expenditure on primary health care and hospitals. Moreover, the White Paper estimates that R 451 million is collected annually from H0 to H3 patients. It does not state the year for which this estimate has been made, but assuming it is for 2014/15, this accounts for 27% of total sales.

Medical aids play the key role in preventing catastrophic health expenditures at higher levels of income.

⁹ These were Botswana, Brunei, France, Netherlands, Oman, Seychelles and four Pacific Island States (Samoa, Solomon Islands, Tuvalu and Vanuatu)

Of course, a relatively low average level of out of pocket expenditure says nothing about the distribution of it. The White Paper cites South African Human Rights Commission findings as follows:

It was found that only half of those who visited a public hospital obtained an exemption despite all being eligible. The research also found that general private facilities were more popular than public hospitals despite the costs involved with the former. Of the households interviewed, 20% incurred “unaffordable” costs.

The remedy for eligible households not claiming exemptions is more extensive communication of their availability. And the definition of “unaffordable” is not stated.

All this does not mean that improvement is not possible. Electronic records of patients can record payments made for services in public facilities, and it would be quite possible to exempt H0 to H3 patients completely for any further, once cumulative payments in a year reached an affordability threshold defined in relation to income. The cost of this measure would be modest.

4.6 The policy proposed by the White Paper towards medical aids is inappropriate

The White Paper correctly identifies three roles which can be played by private health insurance:

- *Substitutive.* This provides coverage that would otherwise be available from the state. It is purchased by those who choose to opt out of statutory health insurance or are excluded from participating in some or all aspects of the national health insurance system.
- *Supplementary.* This usually covers the same range of services as statutory health insurance, aims to increase the choices of provider (e.g. private providers or private facilities in public institutions) and level of inpatient amenities (e.g. a single room). By increasing the choices of provider it may also provide faster access to health care.
- *Complementary.* This provides coverage for services excluded or not fully covered by statutory health insurance. It sometimes covers whole areas of care, such as dental care in many European systems or outpatient pharmaceuticals in Canada. It can also cover the cost of statutory user charges, where cost sharing exists (e.g. France).

The White Paper proposes that all medical schemes be limited to the provision of complementary cover under National Health Insurance.

Substitutive cover is allowed under some national health systems. For instance, Germany requires people earning less than 54 000 euros per year to have social health insurance. People earning more are not required to do so and may choose to take out private health insurance. Substitution is hardly an issue in South Africa. It is true that PAYE income tax payers can claim a small deduction from income for membership of a medical aid, presumably to encourage them not to become burdens on the public health system in the event of large medical expense, but the impact of this deduction on health expenditure is minimal. Indeed, those with high income make a large contribution to financing public health services they use very little.

Supplementary cover is usually allowed in national health systems, even in the single payer systems of the United Kingdom and Canada. We are opposed to its prohibition in South Africa. We do not believe that the prohibition will work. People will want to insure against high medical expenses at the level of medical care they want and there will be an incentive for insurers to offer them. If medical aids are prevented from offering supplementary health cover, insurers and other financial institutions will start to offer it in one form or another. Then will start a round of innovation in insurance contracts followed by further prohibitions, leading to frustration all round, rising costs and a rising risk of catastrophic out of pocket health expenditures, all eroding support for the national health system.

4.7 The advantages of multiple payers have been overlooked.

In some countries, competition between payers is encouraged to promote innovation in packages of health care. In Israel, for instance residents choose from one of four private but non-profit Kupot Cholim (sick funds). These funds are obliged to accept all, regardless of risk or age or pre-existing conditions. The funds must provide a basic basket of services stipulated by law, but can compete on what additional services are provided – such as English language service providers. One can change funds once a year. This creates an element of market style competition that promotes efficiency. In the Netherlands, health insurers have to offer the basic benefit package. Citizens are allowed to swap insurers each year. Insurance companies are non-profit, and compete only on service, price and quality of care. Germans have been allowed to switch between the 166 sickness funds. Although privately operated and competitive, the funds are non-profit and obliged to accept everyone that applies for membership regardless of risk.

These systems recognize that the claim that centralization and standardization of everything will lead to greater efficiency is outdated and exploded. The knowledge needed cannot be assembled in a single place, bottlenecks are certain to emerge, the incentives to innovate disappear and individual choice is suppressed.

4.8 In the end, a choice has to be made between suppression of the private sector and intelligent co-operation with it. The White Paper fails to make a clear choice between these options.

It is possible to conceive of a coherent, fully nationalised provider system, without private practice, without any form of medical insurance, and without special favours for the politically connected. This would result in equal treatment, but of a very low standard. It would struggle to keep health care professionals in practice in South Africa, and capacity would melt away. If that is where National Health Insurance is ultimately headed, we should be told so. It would mean that everyone would have to seek health care in the first instance through the primary health care system. If necessary, they would have to move on to general practitioners, specialists and a hierarchy of hospitals, according to rigid protocols. Individual judgement about where to find health care would be replaced, and existing relationships between providers and people seeking to maintain and improve their health would be disrupted. We are opposed to such a system.

If, as we believe should be the case, the long-term intention is retain a private health sector and allow people to insure against the risks that they face, then the provision of health care has a different logic. As it stands, the White Paper tries to ride both horses, by relying on private practice and then restricting the insurance that users of it want. This incoherence needs to be rethought.

5 In the light of its critique of the White Paper, what does the HSF propose?

Our normative starting point is that the platform of health services accessible to all South Africans should be as high as it possibly can be, and that no-one should have to choose between foregoing necessary health care and financial ruin. In these respects, we believe we are in agreement with the White Paper.

But we also maintain, as the White Paper does not, that there are no prizes for guessing solutions which lie outside the budget constraint, and that chasing shadows diverts attention from the improvements which can be made. From this point of view, there are two problems with the White Paper proposals.

The first is that it requires a great fiscal leap at a time of weak economic growth. We have looked at real expenditure per capita on both primary health care and government hospital care, from 2011/12 and projected forward to 2017/18, the projections based on the 2015 provincial budgets and the national 2016 budget. It finds that the government is making good on its re-orientation from hospital care to

primary health care. Over the period, expenditure on primary health care will have risen from 43% to 51% of expenditure on hospitals.

As a result, expenditure per capita on primary health care rose from R 594 (in 2015 prices) in 2011/12 to R 709 in 2015/16. But it will stay at this level, reaching R 712 in 2017/18. Expenditure per capita on hospital care rose slightly in real terms from R 1 383 in 2011/12 to R 1 457 in 2014/15, but is projected to fall back to R 1 393 in 2017/18¹⁰. These developments indicate how tight the current medium term expenditure framework is, despite the imposition of higher taxes from this fiscal year onwards. These estimates do not take into account the Section 5A and 6A grants for National Health Insurance, but these grants are modest, apply in pilot districts only (containing about 20% of the population) and even then not completely throughout them when it comes to innovations driven at the clinic level. The hard fact of the matter is that the financial basis for moving the platform up significantly will not exist until South Africa again grows at a rate faster than that projected by the IMF for any year up to 2021. This will mean that the government will be forced to postpone aspects of its programme, disrupting the phasing of the programme proposed in the White Paper.

The second problem is that the White Paper proposes a major restructuring of publicly provided health care through its proposed purchaser/provider split, entailing major restructuring of funding flows. This is at a time when organization of existing provision needs considerable work – recall the findings of the ideal clinic programme. This reorganization will impose costs, not only in terms of funding, but also of management attention and health professional skill development, better, we believe, focused on the efficiency of delivery.

Accordingly, we believe that the resource envelope, defined by the Medium Term Expenditure Framework should define the context of everything that is done in the public provision of health care. This will involve much greater attention to costing units of provision, cost effectiveness studies and cost-benefit analysis. Only in this way can a better service be developed with the resources which the country has, and is likely to have in the medium term future.

Finally, we hope that the Department of Health will publish a document setting out the issues raised in its April consultation of the White Paper.

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¹⁰ These estimates do not include the Section 5A and 6A grants