

EVALUATION OF THE GREEN PAPER ON NATIONAL HEALTH INSURANCE

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ABOUT THIS REPORT

Health policy, as with all social security policy, is complex and often far removed from the people carrying on their daily lives. This applies equally to those working within the health system who find it difficult to engage outside of their particular focus area. However, poor health policy design affects everyone, and weak participation in policy debates reduces Government accountability and responsiveness. These circumstances make it possible for consent to be given to policies that with greater scrutiny should never be implemented. It is with this in mind that this relatively detailed evaluation of the Green Paper has been drafted. Two purposes are essentially served. Firstly, it provides a response to the Green Paper in terms of the related consultation process. Secondly it provides a resource that can be used to stimulate ideas and debate regarding reforms to the health system. Hopefully it will help encourage more such reviews reflecting other expertise, views, and experiences of the health system. The views and analyses reflected in this evaluation are however affected by time availability and resource constraints. However, every attempt has been made to provide accurate and reliable information. Nevertheless, readers are encouraged to scrutinize any information provided and to form their own views. It is particularly important to be aware that neither this author or any other participant in health policy debates has a monopoly on the truth. And all views must be challenged.

EXECUTIVE SUMMARY

Overview

This paper provides an analysis of the Green Paper on a “*Policy on National Health Insurance*” published in August 2011. Its purpose is both to respond to the Green Paper’s proposals as well as to deepen discussion on much needed health reform in South Africa.

What is proposed?

The central diagnostic offered in the Green Paper is simply that South Africa has a two-tier health system when it should have a single-tier system called National Health Insurance (NHI). Consequently its key recommendation is that South Africa should implement a single-tier system. The terms single- and two-tier are not defined and neither is the mechanism NHI.

Taking account of the rest of the paper it appears a two-tier system refers to instances where private funding for healthcare, seen as commercial in nature, coexists with public funding. A single-tier system is, by a process of elimination, one where all health financing occurs through a single government-organized system. The reform proposals however do not conform to what is understood generally as NHI but appears to be just the name given to the reform framework. The paper therefore implicitly seeks to address the institutional architecture of the health system.

Although no systematic evaluation of any form is provided by the Green Paper, it builds a case on the grounds that medical schemes face increasing costs, and provide their members with better access to healthcare than the state. The case for the proposed reform therefore rests on two arguments. Firstly, that systemic medical scheme cost increases are prejudicing their members, through benefit denials, and becoming unsustainable; and secondly that the better access to healthcare by medical scheme members distorts health resources away from public sector users. The latter is therefore an equity argument.

On the strength of this, the Green Paper recommends that the public health system be centralized under the control of a “national fund” (under a chief executive appointed by the Minister of Health) with regional offices, effectively removing the health function from provincial governments. This restructuring of the public health system, which is unrelated to the conduct of medical schemes, is not motivated on the basis of any situation analysis of the public system or any formal rationale.

The achievement of the “single-tier” health system as goal is therefore premised on a strategy to consolidate existing financing through a single source. The Paper sees this as achieved through a general tax increase equivalent in aggregate value to existing medical schemes’ expenditure of the order of 3% of Gross Domestic Product (GDP). The additional funds, together with the existing public sector budget, are intended to purchase both existing public and contracted private healthcare providers.

For the consolidation to avoid a net decrease in disposable incomes due to the tax increase, however, all medical scheme members and their dependents, numbering 8.3 million at present, would need to voluntarily transfer their complete coverage to the public health system. Alternatively, if only some medical scheme members transferred, a

substantial drop in out-of-pocket expenditure would be required. It is implicitly acknowledged by the paper that this consolidation will not work if the public health system remains dysfunctional.

How should the proposal be evaluated?

Confirmation of the implicit (as the paper is not explicit) business case for the proposed reforms consequently requires:

1. A strong strategic case based on clear evidence of institutional failures within both the public and private sectors and their causes;
2. A set of feasible options that could address the institutional failures in the short- medium- and long-term;
3. An appraisal of the options, including economic and financial evaluations, which identify a preferred approach; and
4. An in-depth analysis of the preferred option, including an economic evaluation, a financial evaluation, and a risk analysis.

The above constitute the minimum requirements for any policy to be regarded as rationally formulated, regardless of its scale. The degree of rigour applied is however appropriately dependent on scale, with a stronger rationale required the larger the project or policy impact.

Given that the Green Paper proposes to increase taxes by equivalent to 3% of GDP (or roughly R100 billion per annum in 2011), and to completely alter the institutional architecture of the public health system, government is obligated to present a very sound and well-developed case. The policies so proposed must be demonstrably rational and have a proper government purpose.

Evaluation and discussion

Despite the scale of the proposals the Green Paper does not provide a rational business case, with not one of the above-mentioned four requirements adequately addressed. As the reform framework affects the existing and future right to healthcare of all public and private sector users of the health system this is worrying.

No comprehensive situation analysis is provided that isolates institutional failures with the existing architecture of the health system, whether public or private. Instead the diagnostic sections, to the extent they can be referred to as such¹, only ever discuss the private health system. Consequently, the proposed elimination of the provincial health system and the establishment of a central fund, which are public sector reforms, lack any explicit rationale.

The analysis of the private sector provided in the Green Paper, upon which the entire reform framework appears to be based, relies on factually incorrect information which in

¹ It appears the “Problem Statement” in the Green Paper is meant to serve this function.

some instances appears, worryingly, to be deliberate. This includes suggesting that medical scheme per capita contributions have doubled over a seven-year period when they have in fact increased by only 3.7%.² It also refers to hospital and specialist cost increases that are incorrect and do not exist in the report referred to.³

Factually incorrect and misleading statements are also made regarding health workforce differentials between the public and private sectors. For instance, it is stated that “*A larger part of the financial and human resources for health are in the private health sector serving a minority of the population.*” However, it is estimated that there are 238,596 (73%) health professionals in the public sector and only 89,183 (27%) in the private sector.^{4 5} The catchment populations are estimated to range from 76% to 70% for the public and 24%⁶ to 30%⁷ for the private. No systematic distortions in the health workforce can be determined other than those caused by decisions of the public sector itself.

In fact, according to the recently published human resources strategy for health, the distributions for both professional nurses and general practitioners are nearly equal between the public and the private sector according to the Department of Health.⁸ However a Department of Health pamphlet on NHI released to coincide with the Green Paper (in all official languages) reflects workforce information known to be incorrect, and furthermore contradicts data produced in independent studies and its own human resource strategy.⁹

The existence of crude per capita expenditure differentials between medical scheme members and public sector users are incorrectly regarded as evidence of an equity differential. For this to be valid some feedback effect from private expenditure to public sector access would need to be shown. No such analysis or reasoning is however provided.

It however could occur for services which face medium-term supply constraints, such as human resources. It could be argued that a burgeoning private sector could make them unavailable for public services. There is however no evidence that this is occurring. The public sector is also well supplied in hospital beds and clinics, which are very close to the

² See **par 6.32**.

³ See **par 6.31**.

⁴ All the estimates took account of estimates from Persal, Discovery Health Ltd, Colleges of Medicine of South Africa.

⁵ See **section 6** for a more complete analysis of the workforce.

⁶ This is based on the General Household Survey utilisation for 2006 converted into a value equivalent to 100% use of the private sector. The resulting value is lower than stated by the Department of Health.

⁷ This is the figure provided by the Department of Health. See **box 6.11**.

⁸ This is acknowledged in the human resource strategy published by the Department of Health in October 2011. Department of Health, Human Resources for Health, South Africa, HRH Strategy for the Health Sector: 2012/13 – 2016/17, 11th October 2011, p. 28 and 30. [http://www.doh.gov.za/docs/stratdocs/2011/hrh_strategy.pdf].

⁹ See **pars 6.41 - 6.46** and **table 6.3**.

World Health Organisation norm (when the public sector catchment population is used as the denominator).

However, medical products are *not* supply-constrained and any level of demand in the private sector will have no impact on public sector provision. The private sector however pays a higher price for medical products and demands higher volumes. Both contribute to the cost differential and neither has anything to do with equity. At best it could be argued that consumers in the private sector are exploited. An argument supported by analysis produced by the Council for Medical Schemes.¹⁰ This is however not an equity argument and merely suggests that Government should regulate the sector properly.

Even in the face of cost distortions in the private sector, medical scheme members are quite evidently prepared to pay a premium not to use public sector services. The General Household Survey also shows a high level of patient satisfaction with 94.9% of private sector users very satisfied relative to only 60.4% for public sector services.¹¹

Over a period of seventeen years (since 1994) the Department of Health has however never intervened in the market or through the competition authorities (who have extensive powers to deal with such issues), proposed any coherent legislation, changed any problematic legislation, or used its powers to apply conditions to hospital licensing. It has also not implemented recommendations from regulatory authorities and stakeholders explicitly requesting interventions of this nature.¹²

The exaggerated language on costs used by the Green Paper, combined with the use of inaccurate information, *raised belatedly in 2011*, is questionable as prevalent problems exist because of government's failure to properly intervene.¹³

Taking account of the above, the Green Paper offers no diagnostic foundation upon which to build a strategic case for reform, whether applicable to the institutional design of the public sector or to levels of taxation. Also, no options are presented, or reasons provided why particular proposals are selected over others. It appears as though this work was not done.

The proposal to eliminate the provinces and establish a central fund involves significant institutional risk and could unhinge an already under-performing poorly performing public sector. Performance weaknesses within the public sector are likely to be exacerbated on two counts: the centralization of functions that need to be decentralized to work well; and the application of a political governance model to a fund with major procurement and administrative responsibilities. The services have to date floundered for these exact two reasons.¹⁴

¹⁰ Council for Medical Schemes, 2008.

¹¹ Statistics South Africa, 2010, p.18.

¹² Council for Medical Schemes, 2008.

¹³ See **par 6.12** for a discussion of the failure of the Department of Health to intervene.

¹⁴ See **pars 6.16 - 6.20** and **6.29**.

On the tax increases and resulting proposed expenditure:

- No usable information on the assumptions for the costing is provided;
- The unit cost information assumes public sector resource costs at current prices, which is implausible given the real increases in public sector costs over time and the fact that the proposals envisage buying services from the more highly priced private sector;
- The utilization change estimates (which build up to some overall cost) are based on reforms to the Thailand health system and bear no relation to the South African experience;
- No confirmation is provided that for the tax increases a single-tier health system results; and
- No useful information is provided on what the additional funds are to be spent.

Given the scale of the proposed outlay, and the macroeconomic risks involved, it is crucial that the emergence of a single-tier system be shown to be plausible. As the Paper provides no definitive evaluation of this central assumption, a negative inference can only be drawn. Were a strong case possible it would no doubt have been included in the Green Paper.¹⁵

Any failure to achieve a single-tier health system, which depends crucially on medical scheme members transferring in large numbers to public sector coverage, will have macroeconomic effects due to net reductions in disposable income and the transfer of consumption and production from more productive sectors to the health sector. This could see overall health expenditure rising to in excess of 11% of GDP¹⁶ and a decline in GDP growth.¹⁷

Uncertainty surrounding the achievement of a single-tier system is reflected in the Green Paper itself, which states that the implementation of NHI “*could have positive or negative implications, depending on the model utilized and its outcomes.*”¹⁸ This refers to a “*draft report*” by the National Treasury. However, no further information or analysis is provided. An evaluation is therefore still required to demonstrate that the reforms will serve rather than harm the public interest.

Given that the central premises of the business case cannot be confirmed, it is premature to talk about methods of taxation or public sector restructuring. All South Africa’s health objectives can plausibly be achieved with the existing architecture of the system, and

¹⁵ See **section 16** for a discussion on the costing.

¹⁶ See **section 16**.

¹⁷ Due to the transfer of production from productive sectors to a less productive sector.

¹⁸ GP, par 61, p.21.

existing levels of finance. Importantly, no evidence has in fact been produced in the Green Paper to contradict this view.

What should be reformed?

South Africa however cannot avoid its obligations to reform the health system. And it would be negligent of Government to presume that the NHI proposals reflect a satisfactory response to the current state of affairs.

The way forward can be divided into three categories: recommended interventions that should not be pursued; recommended interventions that should be pursued but require more work; and interventions that have not been mentioned but should be pursued.

Interventions that should not be pursued on the basis that no rationale has been provided or are not in the public interest:

- The establishment of a central fund and all its associated recommendations.
- The removal of health as a concurrent function of the provinces.
- The removal of academic hospitals from provincial supervision.
- The national registration of the population (as this will in any case occur through other government interventions as part of the social security reform process).
- The removal of the tax expenditure subsidy for medical scheme contributions (however, it should be modified to take the form of a refundable tax credit¹⁹).

Interventions proposed that should be pursued, subject to proper review and development:

- South Africa should consider improving the public health budget to a level of 4% of GDP. As South Africa grows the capacity to extend and deepen benefits will then grow with GDP.
- A decentralized district health system with de-politicized governance and accountability structures should be implemented. District authorities established under this framework should be permitted to appoint and remove the chief executive and chief financial officer. These authorities should be given the autonomy to develop strategies within the context of a coherent district financing system, national and provincial norms and standards, and agreements established between provincial authorities and district authorities. District boards should not be appointed exclusively by the political head of a provincial health department.
- Autonomous public hospitals with independent and de-politicized governance and accountability structures should be a priority. The proposed

¹⁹ This would allow subsidies to be provided to families below the tax threshold.

frameworks that have been gazetted by the Minister of Health however fall far short of the requirements of a public hospital system.

- The complete implementation of the human resource strategy as published needs to proceed in conjunction with the development of support structures to guarantee its sustainability.
- A centralized funding framework for emergency-related trauma insurance should be implemented. Although sponsored by government, it needs to operate as an independent social security agency supervised by an independent board that reflects South Africa's social partners as well as specialist expertise.
- The Office of Health Standards Compliance (OHSC) should be implemented. However, it needs to be independent of government, with an independent board and executive. Government should not appoint or remove the executive. This should be the responsibility of the board.

Interventions that are required but upon which the Green Paper is silent:

- Existing regulatory structures supporting the health system need to be de-politicized and made properly independent, with all conflicts of interest removed. Appropriate cooling off periods are required for any person in a position to influence a regulatory decision.
- As proposed by the Department of Health in 2010, a price regulator needs to be implemented capable of supervising a system of centralized price negotiations for: hospital tariffs; professional fees; medical devices and medical products. The regulator should also take over the functions of the medicines Pricing Committee operating in terms of the Medicines and Related Substances Control Act.
- The means test for access to public hospitals needs to be removed for anyone not able to access a medical scheme. In order to prevent any dilution of the funding for the public system through the removal of the means test, persons above the tax threshold should be required to take up medical scheme coverage. Medical schemes should be required to fund all public sector utilization. This is an efficient way to harmonize the public and private funding and provider systems and strengthen universal coverage.
- As medical schemes plainly provide critical social protection to income earners, and will continue to do so indefinitely, it is essential that they are well regulated. Any failures within this system will expose gaps in the achievement of universal coverage in South Africa. Required reforms include:
 - Implementation of the governance reforms proposed in the Medical Schemes Amendment Bill of 2008;
 - Implementation of the risk-equalization fund proposed in the Medical Schemes Amendment Bill of 2008;

- Implementation of medical scheme benefit arrangements as proposed in the Medical Schemes Amendment Bill of 2008;
- Coherent and responsible clarification of the demarcation between the business of a medical scheme and the business of ordinary commercial insurance is required;
- The system of waiting periods and late joiner penalties needs to be better constituted to prevent unfair discrimination against vulnerable applicants;
- The distinction between medical savings accounts and risk-pooled benefits needs to be clarified;
- The regulation of administrators and brokers needs to be reconfigured to remove conflicts of interest and properly distinguish between marketing activities and advice; and
- The prescribed minimum benefits framework needs to be made watertight while also giving schemes the ability to manage costs (which requires that government set up the proposed price regulator).

Conclusion

Taken at face value the Green Paper does not provide a strong basis for improving the South African health system. Important areas of reform are not mentioned or incompletely discussed, while speculative and untested proposals are given undue weight.

The financing and institutional proposals contained in the Green Paper also involve significant risks for the country and the health system. Despite this, no diagnostic, feasibility analysis, business case, or risk analysis is thought necessary.

Overall, the standard of workmanship that went into the Green Paper is a cause for concern with numerous factual and logical errors reflected throughout. As many of these errors affect the main recommendations, a re-thing of the policy options is in order.

Government consequently needs to consider the development of a new Green Paper that holistically responds to the known and prevalent institutional challenges in the health system. It should furthermore present valid and distinct business cases for: any alteration in the system's architecture .; any substantial institutional change; and any proposal to substantially alter levels of taxation.

PART A –

INTRODUCTION AND CONTEXT

1. BACKGROUND

- 1.1 The term National Health Insurance (NHI) has been used to describe various reform proposals from 1994. Within the 1994 Health Plan of the African National Congress (ANC) it was applied (inconsistently) to a *system of regulated medical schemes* seen largely as residual to the public system. The over-riding approach adopted for the public system by the plan was however referred to as a National Health System (NHS)²⁰, a model generally regarded consistent with publicly funded and delivered health services.
- 1.2 The ANC Health Plan of 1994 consequently appeared to simultaneously recommend two competing forms of national system, which would be irrational and was clearly not the intention.²¹ This was however cleared up with the publication of the White Paper of 1997, which drew on the findings of the 1995 Committee of Inquiry (inappropriately named the NHI Committee) when the medical schemes reforms envisaged in the 1994 ANC health plan were contextualized as complementary to the development of a coherent NHS.
- 1.3 With varying degrees of enthusiasm from 1997 South Africa tried to implement reforms needed to optimize both the public delivery system and the system of medical schemes. However, whereas the implemented regulatory framework for medical schemes (in place from 2000) successfully stabilized certain negative trends, only a partial framework was ever implemented.²²
- 1.4 Virtually no implementation of the public sector reforms envisaged in the 1997 White Paper however occurred. This together with the politicization of the public services led to the capture by private interests of all points of accountability in eight out of nine provinces and a rapid deterioration in performance and health outcomes.
- 1.5 In 2002 the Taylor Committee of Inquiry recommended the decentralization of public services and the introduction of proper governance structures, together with structural improvements in the regulation of medical schemes and a long-term institutional reform of the public system. It saw the general tax funded public system as the dominant mechanism for providing coverage over time. The Committee implicitly saw reform as an incremental process supported by medium-term institutional interventions to achieve coherent resource allocation, and the implementation of a separation of the purchaser and provider within provinces.²³

²⁰ African National Congress, April 1994.

²¹ van den Heever AM, 2010, pp.7-8.

²² Department of Health, May 2002.

²³ Department of Health, May 2002.

- 1.6 Although the medical scheme reforms recommended by the Committee were taken forward, they were never implemented as the relevant legislation dealing with risk-equalization, minimum benefits, benefit structures, and scheme governance mysteriously did not pass through Parliament in 2008.²⁴
- 1.7 No movement of any kind occurred on the public sector proposals, or any public sector proposals of any period. The 1997 recommendations, which specifically proposed the implementation of decentralized hospitals and districts, were never implemented. *The rationale for this change of heart appears to be that the original proposals contradicted the politicization of health services, often now referred to as cadre deployment, which had by now become firmly entrenched.*
- 1.8 After a decade of stagnation in health policy an ANC resolution at the Polokwane conference proposed to implement an NHI “*by further strengthening the public system*”.
- 1.9 At face value this statement incorporates many terminological contradictions, as more technically correct language would have referred to an NHS rather than an NHI. From this period the terminological distinction between an NHI and an NHS has confused the ruling party and all subsequent processes. In reality these are different mechanisms and it makes little sense to convert South Africa’s public system, which takes the form of an NHS, into an insurance arrangement which takes the form of an NHI.
- 1.10 Public discussion ensued with various ANC documents made public recommending centralized insurance mechanisms to perform the functions of a NHS (which invariably involve decentralized delivery mechanisms and regional planning and accountability structures).
- 1.11 This together with the assumption that increased taxes equivalent to medical schemes expenditure would provide sufficient funds for a “universal system” raised concerns that the policy process had largely lost touch with reality. *Especially when it became clear that some proponents felt that full implementation of such a framework was possible in a relatively short period of time.*²⁵
- 1.12 However, public concern caused a more cautious approach to be adopted, resulting in proposals that the reform could be fully implemented over five years.²⁶
- 1.13 After it became clear that the technical considerations had not really been properly thought through, and the timelines shifted again, to fifteen years, with five years now allocated just to turn around the public sector.²⁷

²⁴ Draft Medical Schemes Amendment Bill of 2008.

²⁵ African National Congress, 16 February 2009, p.176.

²⁶ The Star (Business Report), 1 September 2009. Olive Shisana informed a BHF conference that “*five years have been set aside to fully implement the NHP*”.

- 1.14 The institutional and financial proposals however remained quite unrealistic at the time of an ANC National General Council (NGC) document in September 2010 proposing that public health expenditure be increased from 3.4% to 7.8% of GDP over fifteen years.²⁸
- 1.15 The Green Paper however made two key modifications to the NGC document. It reduced the proposed tax increase from 5% to 3% of GDP. It also downplayed a potential contradiction between the logic of a public health system and the central fund by proposing a district health system (DHS) as a decentralized purchaser of sorts. However, the proposed *central fund* with *regional offices* is controversially supposed to replace provincial health departments, although this is never explicitly stated or motivated.

²⁷ GP, par 162, p.52.

²⁸ African National Congress, 2010, p.29.

2. PROCESS TO DATE

2.1 On 12 August 2011 a Green Paper on health reform titled “*Policy on National Health Insurance*” was released by the Minister of health which seeks to provide detail on policy pronouncements in this regard flowing from the 52nd Annual Conference of the African National Congress (ANC).

2.2 The ANC conference resolved to:

*“Reaffirm the implementation of the National Health Insurance System by further strengthening the public health care system and ensuring adequate provision of funding.”*²⁹

2.3 To give substance to the resolution various party political processes developed papers, a final version of which was ultimately made available to the Minister of Health to consider in June 2009.³⁰ This was based on an initial report completed in February 2009.³¹

2.4 A number of public statements during the course of 2009 indicated an intention to fast-track implementation based on the initial proposals.

4 June 2009: *“Plans are advanced to finalise base documents on the NHI by the end of June 2009. This will make it possible for public and community consultations to start in earnest. We are convinced that you will enjoy and participate meaningfully in the processes of designing and implementing this all important program that is aimed at providing universal coverage.”*³²

2 September 2009: *“We are busy preparing a submission on the NHI in consultation with our colleagues in the Cabinet and relevant government departments towards eventual approval by the national Cabinet,” Deputy Health Minister Dr Molefi Sekularo told a conference marking the 10th anniversary of the Board of Healthcare Funders in North West this week. “Once approved, the document will be released for public debates and consultations.”*³³

2.5 Notwithstanding the above, no documents were finalized for public consultation. Instead on **11 September 2009** an NHI advisory committee was established tasked with the production of a report, legislation, and strategies by **June 2010:**

- *“Finalisation of public consultation process on the draft NHI Policy within 3 months of publication.”*
- *“Draft proposals on NHI legislation to be submitted to the Minister within 3 months of the Cabinet approval of the NHI Policy.”*

²⁹ African National Congress resolutions: [<http://www.anc.org.za/show.php?id=2536#social>]

³⁰ African National Congress, 22 June 2009.

³¹ African National Congress, February 2009.

³² Address by the deputy minister of health, Dr Molefi Sekularo, to the Hospital Association of South Africa’s Annual General Meeting, 4 June 2009, Durban.

³³ Mail and Guardian online, 2 September 2009.

- “Finalisation of the NHI system implementation plan proposal, including transitional arrangements, by June 2010.”
 - “Provide regular reports to the Minister on the progress of the implementation of NHI over the five year period.”
- 2.6 No report however emerged from the Advisory Committee and no consultative processes ensued.
- 2.7 Unusually, however, a document was released by the Chairperson of the Advisory Committee at the NGC meeting of the ANC in **September 2010**.³⁴
- 2.8 Although the report apparently contained work from the government’s Advisory Committee, it was not *their* report. The status and relevance of the document was consequently unclear and caused some reaction from stakeholders. However, civil society groups supported *some* public document and raised concerns about the secrecy surrounding the activities of the Advisory Committee.
- “The South African Medical Association (SAMA) has noted with interest the National Health Insurance (NHI) document of the ANC, which was released during its recent National General Council (NGC) and welcomes the debate that will emanate from this document. In a sense, a process that to date has been essentially secretive, has in part been opened up. The ANC is at liberty to voice its opinion on NHI and as such the document presented at the ANC NGC is an ANC contribution on NHI. However, SAMA remains mindful of the processes in place and still underway with regard to NHI.”*³⁵
- “The NHI Campaign, whose members include the Congress of Trade South African Unions and the Treatment Action Campaign, said the NHI was “potentially” an important reform that could promote equitable access to appropriate healthcare for all. The group said there had been critical responses to the ANC’s support for the NHI from those with vested interests in the current health system, as well as some South Africans who were opposed to the high taxation that the NHI would require. It said there was room for greater taxation without reverting to regressive taxation like VAT. It welcomed the ANC discussion document on the NHI as a good step towards opening the debate up to the public, adding that the proposed NHI had to be informed by a wide public debate and not, as had been the case, characterised by “secrecy” imposed by the Ministerial NHI Advisory Committee.”*³⁶
- 2.9 The Green Paper on NHI was however only released roughly twelve months later on **12 August 2011** with a surprisingly confined two month consultation period. After concerns were raised with the Minister of Health, this was extended to **31 December 2011**.

³⁴ African National Congress, September 2010.

³⁵ South African Medical Association, 29 September 2010.

³⁶ Tamar Kahn, 30 September 2010, and SAPA, 29 September 2010

2.10 The Green Paper itself provides a timeline for the “Phasing-in of National Health Insurance”³⁷ which oddly provides for a *White Paper*³⁸ to be released in **August of 2011**:

- “*Release of White Paper for Public Consultation* *10 August 2011*”;
- “*Launch of Final NHI Policy Document* *December 2011*”
- “*Commencement of NHI Legislative process* *January 2012*”

2.11 The process thus far has largely been characterized by ambitious timelines unsupported by strong and open processes. According to the gazette of 11 September 2009 the Ministerial Advisory Committee was charged with developing an open and transparent process to discuss documents it was responsible for producing. This was meant to include some form of consultation process within three months “of publication”³⁹.

2.12 To date the gazetted processes have not materialized or the timelines met. The Green Paper has also exceeded its deadlines.

³⁷ GP, Table 1, p.48.

³⁸ Although unclear, it appears the original intention may have been for the Green Paper to be a White Paper. This may therefore be an editing error.

³⁹ It is unclear whether the gazette refers to publication of the gazette or of a discussion document. The former interpretation makes more sense than the latter.

3. WAY FORWARD

- 3.1 Going forward, it is unclear what role is played by the Advisory Committee in the production and dissemination of public information. The irregular publication of information from the Advisory Committee in the September 2010 ANC NGC meeting confused the roles of government and the ruling party and undermined its status.
- 3.2 The method by which the Advisory Committee carries out its responsibilities and makes decisions is unclear. For instance, how decisions are made on the advice to put before the Minister or on external consultation would require a formal decision-making process. There is however no evidence that the Committee makes decisions of any sort.
- 3.3 On the strength of the Green Paper timelines none of the envisaged consultative processes are to be established by the Advisory Committee, as required within three months of its establishment, and that after a token comment period legislation is to be drafted.
- 3.4 The timeline suggests a two-month comment period is/was regarded as appropriate to finalize a policy document presumably within a few days, and to commence with legislation some weeks later.
- 3.5 Logistically it is not clear how the information from the comment period could be assimilated and properly taken into account in any final “policy document”. The timeline would however work if the intention was to completely ignore external comment.
- 3.6 To date therefore the process has been essentially top-down and closely tied to political stakeholders. The focus has been on generating consent for pre-packaged, but lightly drawn, proposals rather than active engagement and learning. This approach has generated defensiveness in which valid and normal critique of all kinds is actively discouraged.
- 3.7 Optimistically set milestones are therefore never adhered to as technical considerations, essential to any policy process of substance, surface and become unavoidable. Many feasible policies that should or could be considered are also never tabled, due to the insularity the process.
- 3.8 The Advisory Committee, which offers the possibility of a properly considered process, however appears irrelevant as they are evidently ignored, make no decisions, and consequently seem unable to carry out a relatively straightforward set of explicit tasks. If the process remains closed and defensive it is likely that little will change in the medium-term and many possible and needed reforms will never be considered or implemented. Alternatively, if a more open debate is permitted, it could considerably strengthen the quality of work, and the workability of tabled policies.

4. APPROACH TO EVALUATION

- 4.1 The detailed evaluation provided in **Part B** largely follows the flow of the Green Paper. Not all sections are reviewed, as the focus is on the key thematic arguments and the more important recommendations. The headings of Part B are mostly those of the Green Paper, with discussion on the content linked to quoted statements. This is to limit the need for a reader to constantly refer back to a separate report to understand the content. A summary of the findings is provided in **Part C** which tries to encapsulate the issues raised in a more coherent format for readers.

PART B –

**DETAILED REVIEW
AND EVALUATION**

5. INTRODUCTION (page 4)

Overview

- 5.1 The introduction to the report summarizes the central themes of the Green Paper and sets out a case for proposed reforms on the basis that a privately funded health system is against the public interest. It is argued that the private system is not accessible to those without income and absorbs the bulk of the health professionals in South Africa.
- 5.2 South Africa's poor health outcomes are therefore implicitly identified as an equity problem resulting from what is regarded as differential access to health resources between those using the public system and those on medical schemes.
- 5.3 The policy response is identified as National Health Insurance (NHI) which it is argued will provide coverage to the entire population. The term NHI is not defined, however, either in this section or the rest of the Green Paper.
- 5.4 Distilling the argument, therefore, the Green Paper makes the following four assertions:
- The system of privately funded medical schemes has caused inequity in the South African health system and is unsustainable;
 - South Africa's poor health outcomes are directly attributable to the inequity resulting from the private system of medical schemes;
 - The only policy solution is (the mechanism) NHI described as "innovative; and
 - NHI is well accepted and promoted by the World Health Organisation as "universal coverage".
- 5.5 These assertions are discussed below in response to relevant statements made in the text roughly in the order in which they occur.

Review

- 5.6 The introduction characterizes the overall reform framework as innovative. "*South Africa is introducing an innovative system of healthcare financing*".⁴⁰
- 5.6.1 The Green Paper as a whole is opaque, with many of the strategic proposals outlined in general terms with no references to evidence or any rationale. It is consequently not clear which proposals are considered innovative.
- 5.6.2 The main strategic recommendations involve the centralization of functions presently residing with provinces, the *centralization of academic hospitals*, vague mention of a system of *district health authorities* system, the introduction of autonomous public hospitals and the introduction of a tax

⁴⁰ GP, par 1, p.4.

equivalent to 3% of GDP. Not one of these recommendations proceeds from a diagnostic or is based on a business case.

- 5.6.3 The proposed functional *centralization* of the public sector contradicts the required design which should *devolve* and *decentralize*.
- 5.6.4 The proposal to centralize purchasing (contracting and procurement) with a *weak governance model* is also counterintuitive and not consistent with international benchmarks. The district and public hospital proposals, which are potentially consistent with benchmark approaches, are vague and were already made thirteen years ago in the 1997 White Paper but never implemented (as they contradicted moves to politicize health services).
- 5.6.5 The tax and spend recommendation is also not supported by technical work and very likely to prove macroeconomically counterproductive.
- 5.6.6 *The proposed framework consequently cannot be characterized as innovative. Much more work is also required just to clarify what is actually being proposed and why.*
- 5.7 Throughout the Green Paper medical schemes are repeatedly mentioned. All of it negative in nature. The comments however do not arise from a systematic analysis of the health system, and are in almost *every* instance inaccurate.⁴¹

“It [medical schemes system] only benefits those who are employed and are subsidized by their employers...”⁴²

- 5.7.1 Medical schemes cover both the employed and their *dependents*, most of whom *are not employed*. The regulatory framework for medical schemes prevents medical schemes from limiting coverage to only the employed individual.
- 5.7.2 By contributing to a medical scheme from their own income, income earners remove 8.3 million people from using state services improving the targeting of state resources.
- 5.7.3 This is despite the fact that both directly and indirectly these income earners fund the free state services through their tax contributions.
- 5.7.4 Importantly, individuals earning more than R6,000 per month or families earning more than R8,333 per month must pay the full cost of public hospitals services regardless of whether or not they have medical scheme cover. *The means test has not been adjusted since 2006. In this time inflation has increased by 36%. This (See **box 5.1**).*

⁴¹ See **pars 6.11, 6.31, 6.32, 6.35, 6.40, 6.41, 6.42, 6.48, 6.49, 6.50, 6.51, and 6.52.**

⁴² GP, par 3, p.4.

5.7.5 *The quoted remark consequently fails to recognize the important role played by medical schemes in providing social protection to those contributing. It also fails to understand the role of medical schemes within a holistic strategy required to achieve social protection and sustainable universal coverage. (See **box 5.3** for the World Health Organisation view).*

Box 5.1: Public hospital means test and tariff subsidies

Table 3: Categories for Partial Subsidisation

Category	Means Test	Subsidisation (% of UPFS)
H1	Individual: Income less than R36 000 per annum Household: Income less than R50 000 per annum	Consultations: 20% with no differentiation for emergency consultations Inpatient: 1% of the UPFS general ward day tariff summed for 7 days for each 30 days or part thereof (Note 1). No differentiation on the basis of bed type. Patient and Emergency Transport: 5% Assistive devices: 25% All other services: Free Calculated amounts should be rounded to the nearest R5 to facilitate cash accounting.
H2	Individual: Income less than R72 000 per annum Household: Income less than R100 000 per annum	Consultations: 70% with differentiation for emergency consultations Inpatient days: 7% per day with differentiation on the basis of bed type Procedures, imaging and oral health: 50% Patient and Emergency Transport: 15% Assistive devices: 75% All other services: Free Calculated amounts should be rounded to the nearest R5 to facilitate cash accounting.
H3	Individual: Income greater or equal to R72 000 per annum Household: Income greater or equal to R100 000 per annum	All services listed in the UPFS at full price

Source: Department of Health, Uniform Patient Fee Schedule, appendix H (applicable to all provinces) [<http://www.doh.gov.za/docs/programmes/2006/appendix-h.pdf>]

The above table implies that any individual earning more than R6,000 per month, or any household earning more than R8,333 pm must pay in full when using public hospitals.

This fee schedule has not been adjusted since 2006! This means wage inflation has progressively increased the number of individuals and households who have no free access to public hospitals.

If individuals earning more than R6,000 per month or families earning more than R8,333 do not have a medical scheme they are required to pay for public hospital services on an out-of-pocket basis.

- 5.8 A further comment on medical schemes again seeks to place them in a negative light: “...those with medical scheme cover have a choice of providers operating in the private sector which is not extended to the rest of the population.”⁴³
- 5.8.1 This view, which provides no contextual information or evidence, implies that unfairness results from medical scheme beneficiaries having a choice of provider. A benefit for which they however pay for from their disposable income.
- 5.8.2 *It is however unclear what public interest case is being made.* If the implicit logic were accepted, any private purchase of any good or service also offered through the state (e.g. education, security, housing, disability protection, contributory retirement provision, transportation, etc.) could be regarded as harmful to the public interest. *Such an extreme view for public intervention cannot however be sustained on rational grounds.*
- 5.8.3 As already noted, the public health system excludes many income earners from free access to public hospital services (**box 4.1**). As this has always been the case, people with income have been compelled to purchase their own services, whether in the public or private sectors despite contributing the taxes that fund the public services.
- 5.8.4 To date the common-sense principle has been implicitly applied that higher-income groups require less support from the state as they are able to contribute toward their own healthcare from their disposable incomes. They also generally have a greater capability to control their own health status. Those that are not in this position, i.e. those families with insufficient income, are consequently supported through the state with services funded through redistributive taxation.
- 5.8.5 This is not to say that government intervention is not required to protect income earners. Government should ensure that those people purchasing their health protection privately are protected from abuse by providers of insurance and healthcare products and services.
- 5.8.6 *The implicit logic underpinning the quotation, when taken to its conclusion, represents an extreme view of government’s role in society which is not generally shared in relation to goods and services that have public interest aspects to them (which is just about everything). Importantly, no support for such extreme views can be found in health systems design globally, apart from Cuba.*
- 5.9 Central to the strategic case for the specific institutional and financial proposals in the Green Paper is the view that privately funded health services lead to negative feedback effects for public provision. Much reliance is placed on the view that health workforce distributions are systematically skewed in favour of

⁴³ GP, par 3, p.4.

people with income. However, no evidence on whether and how this is happening is provided.

*“A larger part of the financial and human resources for health are in the private health sector serving a minority of the population”.*⁴⁴

*“The public sector has disproportionately less human resources than the private sector yet it has to manage significantly higher patient numbers”.*⁴⁵

*“The South African health system is inequitable, with the privileged few having disproportionate access to health services”.*⁴⁶

5.9.1 These views, although presented as factual, are not supported in the text by evidence or analysis. Repeated statements along these lines found in the rest of the text are similarly not supported.

5.9.2 The failure to provide supporting workforce data is surprising as expert knowledge of this type falls within the expected competency of the Department of Health.

5.9.3 Health workforce studies, which make use of reliable estimates and assumptions, show the distribution of health professionals between the sectors to be far more even than made out.⁴⁷ (Also see the review provided below in **par 6.41**).

5.9.4 In fact the larger part of the country’s health professionals⁴⁸ are located in the public health system:⁴⁹⁵⁰

- Public: 238,596 (73%); and
- Private: 89,183 (27%).

5.9.5 When weighted for actual private sector utilization, the catchment populations for the public and private sectors are:

- Public: 38 million⁵¹ – 35 million⁵² (76% - 70%); and
- Private: 12 million – 15 million (24% - 30%).

⁴⁴ GP, par 4, p.4.

⁴⁵ GP, par 4, p.4.

⁴⁶ GP, par 5, p.5.

⁴⁷ Econex, October 2010.

⁴⁸ This includes medical, nursing, allied, and clinical support staff.

⁴⁹ All estimates took account of information from Persal, Discovery Health Ltd, Colleges of Medicine of South Africa.

⁵⁰ See **section 6** for a more complete analysis of the workforce.

⁵¹ Own estimate based on the General Household Survey of 2005 and included in van den Heever AM, May 2007, par. 109, p.48.

⁵² This is the figure provided by the Department of Health. See **box 6.11**.

- 5.9.6 The Green Paper misleads where it refers to the private sector population as the medical scheme population (16.8% of the total), while nevertheless counting the public sector population's out-of-pocket expenditure as part of the private sector.⁵³ It also contradicts the information provided by the Department of Health in a pamphlet supporting the Green Paper (see **box 6.11**) and expert evidence it relied upon in court cases against the Pharmaceutical Society of South Africa (see **par 5.9.5**).
- 5.9.7 Accurate data on both the different catchment populations and distributions of workforce indicate significantly less variation between the sectors than implied in the above quotation.⁵⁴
- 5.9.8 *In particular 77% of all nurses (professional, enrolled, and enrolled assistants) work in the public sector⁵⁵, serving 73% of the population. Overall 61.3% of general practitioners work in the public sector⁵⁶.*
- 5.9.9 More conservative estimates are provided in **table 6.4** which have 63.8% of all nurses in the formal public sector and 35.2% in the private. In both latter instances the private sector effectively includes local authority and non-government organization nurses and doctors who serve the public sector population but are not captured on the PERSAL system.
- 5.9.10 The lower proportion of specialists in the public sector (43%)⁵⁷ reflects the policy of the past 17 years to de-prioritize public hospital services in favour of primary care. If specialists did not set up private practices they would have needed to leave the country to find employment. This distribution consequently reflects a government policy choice⁵⁸ on the configuration of the public health system rather than an equity distortion.⁵⁹
- 5.9.11 There are also 86,774 (74%) hospital beds in the public sector relative to 31,067 (26%) in the private sector. The public sector has apparently

⁵³ See GP par 4, p.4 (line 3).

⁵⁴ See **section 6, par 6.41**.

⁵⁵ Based on information provided from PERSAL (public sector payment system), medical scheme billing, and private hospital groups.

⁵⁶ See **table 6.3**.

⁵⁷ See **table 6.3**.

⁵⁸ This is an *allocative efficiency* choice which seeks to maximise the health outcomes for a given level of expenditure by focusing on those parts of the health system that save more lives for the funds spent. Although these objectives were not achieved due to planning and implementation challenges, the underlying prioritisation approach is standard for public systems.

⁵⁹ See **figure 6.9** for the relative changes in public sector per capita expenditure on hospitals relative to district services and clinics and community centres. This shows how hospital services have received a relatively low priority relative to primary care services since 2000. This reduced prioritization was also prevalent prior to 2000 as demonstrated in **box 5.2**.

reduced its numbers from 107,634 in 1998.⁶⁰ This is consistent with the policy pronouncements of 1995 reflected in the newspaper article shown in **box 5.2**.

- 5.9.12 Private hospital services serve around 16.8% of the population⁶¹, services which are predominantly paid for through medical schemes. However, some people not on medical schemes are funded specifically for hospital trauma-related services through the Compensation Fund, the Road Accident Fund, Rand Mutual, and Mine Hospitals.
- 5.9.13 Extrapolations from the General Household Survey suggest that despite this, the private hospital catchment population is largely that for medical schemes (i.e. 16.8% of the total population).⁶² *It is worth noting however that both the public and private bed numbers arise from government policy decisions as no private bed can be established without a license issued by one of the provincial health departments.*
- 5.9.14 Overall, therefore, the resource distribution between the public and private arrangements are far less distorted than implied by the vague wording of the Green Paper, and in reality a far more complex story than made out. However, as the Green Paper proposals are heavily dependent on narrowly framed equity arguments, it overstates disparities and the lines of causality. *The views do not derive from a dispassionate and objective review of the true state of affairs. In fact, the absence of any information on these issues in the Green Paper suggests that the Department of Health itself has very limited knowledge of the true state of affairs.*
- 5.10 After making the case that the private health system is largely responsible for equity distortions in the country, an undefined mechanism identified as NHI is proposed as a corrective.⁶³
- 5.11 Unusually for a context such as South Africa, which already offers well-funded access to free services, the need to minimize co-payments is raised as a further rationale.

“NHI will provide coverage to the whole population and minimize the burden carried by individuals of (sic) paying directly out of pocket for healthcare services.”⁶⁴

⁶⁰ All numbers from Health Systems Trust. [<http://www.healthlink.org.za/healthstats/112/data>].

⁶¹ The 25% - 30% catchment population estimates only apply to out-of-hospital services. People without medical scheme cover cannot access private hospitals unless through social insurance funds such as the Road Accident Fund and Compensation Fund, or when funded by a provincial health department.

⁶² van den Heever AM, May 2007, pars. 99-100, p.44.

⁶³ GP, par 5, p.5.

⁶⁴ GP, par 5, p.5.

- 5.11.1 Co-payments are typically⁶⁵ raised as a serious concern in very low-income settings where the only available sustainable service providers occur in the private sector, e.g. Ghana and Vietnam. They don't apply to countries with well-funded free public services such as South Africa and those in Latin America with a similar level of development.
- 5.11.2 South Africa's levels of out-of-pocket expenditure are in fact normal by international standards (see **figure 5.1**). Improving the efficiency and quality of free health services is a far greater priority for South Africa.

Box 5.2: Newspaper report from 1995 indicating the initiation of the process to de-prioritize hospital and specialist services

2 BUSINESS DAY, Monday, March 27 1995

Govt's provincial health plan 'crude'

KATHRYN STRACHAN

GAUTENG's health budget cut was a "complete catastrophe" for services in the province, a health analyst said on Friday.

The only way in which savings could be made was through staff cuts, he said.

Central government allocated Gauteng's health services only R3,17bn.

Wits University Centre for Health Policy researcher Alex van den Heever said this allocation implied a nominal cut of 10% — which in real terms amounted to a cut of about 22%. The budget has been cut to allow increases to more underresourced provinces.

Van den Heever said the cut was unsustainable. A cut of these proportions was beyond the ability of the public sector to achieve in such a short period.

To keep health services running at the same level, a budget of from R3,7bn to R3,8bn was needed.

Government had allocated R300m to Gauteng health services to help them bridge the transition phase, but a further R290m was needed to keep the service constant. The bridging finance was a one-off allocation, and Gauteng health services faced potential disaster unless a similar allocation was made next year.

There were many constraints on the public sector which needed longer to put in place changes which would lead to savings.

The cuts could be made only in personnel, which took up about 67% of Gauteng's health budget.

Gauteng was expected also to achieve savings by rationalising its academic hospitals, but to make these savings would take about six years.

Van den Heever said awarding Northern Transvaal an increase of 20% was as illogical. This allocation was for running costs only and did not represent a capital allocation for building new facilities.

It was better to first set up new facilities and then increase recurrent expenditure.

The new plan also failed to take into account the fact that both Gauteng and Western Cape treated many patients who flocked from across their borders.

"This is poor financial management, based on a crude and hopelessly inadequate formula," he said.

Gauteng health minister Amos Masondo said that while he recognised the need to share resources equitably between provinces, Gauteng needed to be given the space to make the transition.

DP health spokesman Jack Bloom said: "The central government objective of 'parity' between provinces is nonsensical in view of the substantial numbers of patients from other provinces who utilise specialist hospitals in Gauteng."

GaRankuwa Hospital cost the province R300m a year, yet 90% of its users were not Gauteng residents.

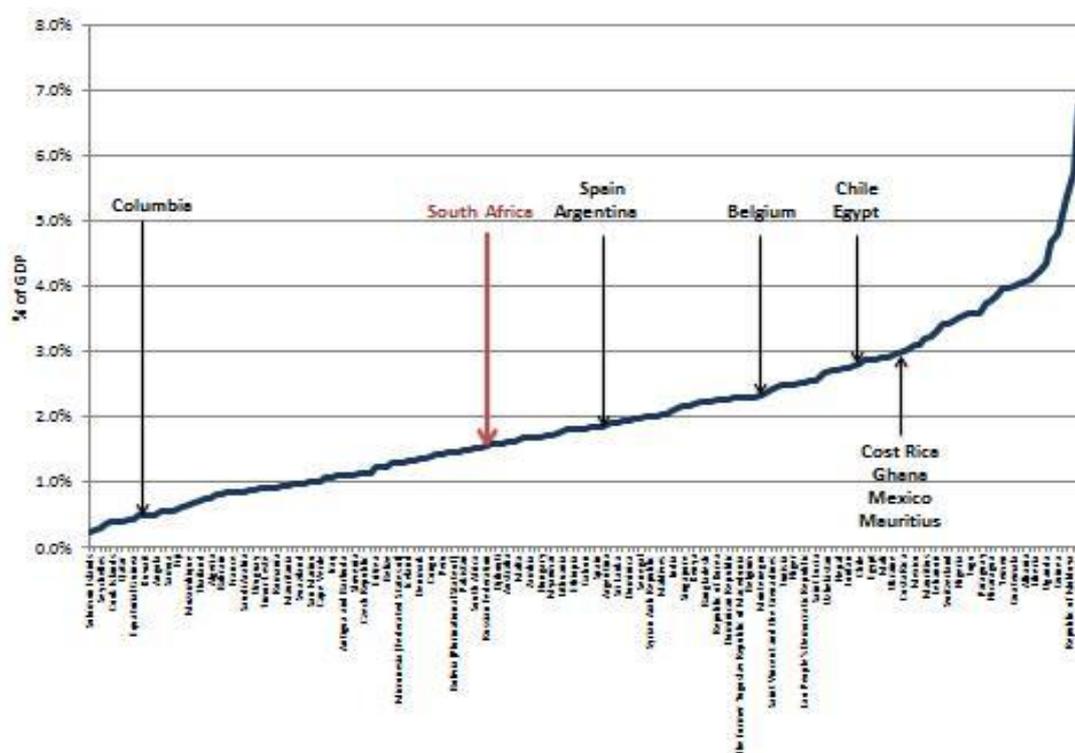
⁶⁵ An instance of a high-income setting would be the United States where incomplete universal coverage will result in excessive out-of-pocket-payments for uninsured catastrophic expenses. All other high-income countries have eliminated these gaps.

- 5.11.3 **Figure 5.1** shows the out-of-pocket expenditure expressed as a percentage of GDP for all countries and clearly shows that at around 1.5% of GDP South Africa *performs well by international standards and should be considered normal for a country of its level of development*. Importantly countries such as Spain, Argentina, Belgium, Chile, Egypt, Cost Rica, Ghana, Mexico, and Mauritius spend significantly more on out-of-pocket expenditure than South Africa.
- 5.11.4 It is also worth noting that Cuba has out-of-pocket expenditure of 0.9% of GDP, only 0.6% of GDP less than South Africa. This despite spending 11% of GDP on health through general government expenditure.⁶⁶
- 5.11.5 South Africa's levels of out-of-pocket expenditure *are also better than countries with higher per capita GDPs that have implemented single-payer National Health Insurance arrangements, such as South Korea and Taiwan*. Importantly a country such as Columbia, which operates a multi-tier multi-payer health insurance system⁶⁷, has out-of-pocket expenditure of only 0.5% of GDP.
- 5.11.6 Several important findings can be made from this information:
- *South Africa is already performing well in terms of reduced out-of-pocket expenditure and this does not represent a severe social problem at present;*
 - *Developing countries with multi-tier and multi-payer health insurance are able to achieve lower levels of out-of-pocket payments than single-payer National health Insurance systems; and*
 - *Levels of out-of-pocket are affected by health systems design, but not the designs regarded as important by the Green Paper.*
- 5.11.7 *The Green Paper's stress on minimizing out-of-pocket payments as a public policy objective appears to arise from a confusion of contexts.* The general literature on insurance mechanisms, including that referring to social and universal insurance, do need to deal with minimizing out-of-pocket payments as the affected countries have typically not developed sustainable free public services (e.g. Ghana, Vietnam, Taiwan and South Korea). *As South Africa has a free and sustainable public health service, its objectives are different. It needs to ensure that they are well run and accessible.*

⁶⁶ See **figure 6.5**.

⁶⁷ Equivalent to regulated medical schemes in South Africa.

Figure 5.1: Out-pocket-expenditure by country (2009) expressed as a percentage of Gross Domestic Product



Source: World Health Organisation, <http://apps.who.int/ghodata/#>.

5.12 Although no definition is provided, based on the equity considerations already discussed, NHI is motivated on the basis that it is a “well-accepted” approach promoted by the World Health Organisation as “universal coverage”.

“Therefore, NHI is intended to ensure that all South African citizens and legal residents will benefit from healthcare financing on an equitable and sustainable basis. NHI will provide coverage to the whole population and minimize the burden carried by individuals of (sic) paying directly out of pocket for healthcare services. This model of delivering health and healthcare services to the population is well accepted, and described and widely promoted by the World Health Organisation as universal coverage.”⁶⁸

5.12.1 This statement appears to provide the strategic conclusion to the entire Green Paper. It however contains serious and inexplicable errors of fact relating to the position of the World Health Organisation and the policy priority regarding out-of-pocket payments.

5.12.2 The World Health Organisation has *never* promoted NHI as “universal coverage” or in any other guise (see **box 5.3** for the position of the World

⁶⁸ GP, par 5, p. 5.

Health Organisation). If evidence of such a position exists it should be referenced and rationally motivated.

- 5.12.3 The World Health Organisation has never specified NHI (however defined) as the mechanism whereby universal coverage is to be achieved. *Instead it outlines a range of mechanisms including tax-based regimes, social health insurance (SHI), enterprise-based health insurance together with risk-equalization, and mixed funding mechanisms.* (See **box 5.3**).
- 5.12.4 Consistent with common sense, the World Health Organization adopts a non-ideological approach to mechanisms, focusing instead on universal coverage.
- 5.12.5 Universal coverage has an altogether different meaning from NHI and refers instead to an *objective* (i.e. to ensure universal access to a minimum level of pre-paid healthcare within a country) and not to a *mechanism* (such as an institutional design or health systems “model”).
- 5.12.6 As noted above, the Green Paper furthermore refers to NHI repeatedly as if it is a well understood term with no requirement for definition or elaboration.
- 5.12.7 However, the term NHI does not categorically apply to any specific form of health system. Recent articles on this issue only regard the systems of Taiwan and South Korea as potentially falling within such a definition.⁶⁹ The Green Paper proposals however bear no relation to these systems and fail to even discuss them.
- 5.12.8 Countries providing universal insurance through regulated private schemes, as in the Netherlands, Germany and Columbia, are classified as Social Health Insurance (SHI) as their governments *socialize* the private funding of insurance through regulation.
- 5.12.9 Countries such as Canada and the United Kingdom, which operate *universal decentralized public systems*, could be described as National Health Services (NHS)⁷⁰ adopting the (typological) name applied to the post war health system reforms of the United Kingdom. Purchasing services from the private sector does not make these systems into an NHI. *They are characterized by a high degree of regionally-based decentralized decision-making, service planning and delivery.*

⁶⁹ Lee SY, *et al*, pp.105–113.

⁷⁰ As with NHI, the term NHS is an imprecise health systems type and could cover a wide range of quite different health systems.

- 5.12.10 South Africa's public system and the Green Paper proposals⁷¹ are consistent with NHS-type *decentralized design* characterized by service configurations that can be *customized to specified regional populations*.
- 5.12.11 The Green Paper however implies that South Africa has not yet achieved universal coverage.⁷²
- 5.12.12 South Africa has for some time achieved *universal coverage* through the combination of a tax-funded public system and subsidized contributions to private insurance (medical schemes). As one way or another the whole population is covered, i.e. they are protected by one or other form of *pre-paid healthcare*⁷³, the objective of universal coverage is achieved as actually stated and promoted by the World Health Organisation (also see **par 8.5** and **box 5.3**).
- 5.12.13 As already discussed, the references to out-of-pocket payments cannot be the primary purpose of any reform in South Africa, as these are at normal levels.
- 5.12.14 It is furthermore important to note that the bulk of out-of-pocket expenses in South Africa are for non-catastrophic medical expenses⁷⁴ incurred by families in the top income decile (i.e. families covered by medical schemes)⁷⁵.
- 5.12.15 As already noted in the discussion on catchment populations, many people without medical schemes make use of private services on an out-of-pocket basis despite having free access to public sector facilities. Free services are therefore only one facet of accessibility, and without addressing the other facets people will continue to purchase services privately. However, the elimination of all out-of-pocket expenditure on health is neither technically feasible nor a rational government policy objective. *It should instead prioritize the reduction of barriers to needed health services*. Mostly this is achieved by progressively removing access obstacles to expressly prioritized services.

⁷¹ The proposed district health authorities, which appear consistent with the 1997 Department of Health White Paper proposals, are consistent with a decentralised strategy. However, the introduction of a national fund with regional offices, apparently to substitute for provincial health departments, is at odds with a decentralised approach.

⁷² This view was confirmed in an exchange with the Minister of Health between the author on SABCtv who indicated that South Africa only had 16% of the population with coverage, i.e. the number of people on medical schemes. He apparently did not regard users of free public health services as "covered".

⁷³ Pre-paid healthcare refers to both tax funded and insurance funded health care. In both cases risk pooling occurs that improves access relative to out-pocket-payments. Particularly for catastrophic health expenses.

⁷⁴ Catastrophic medical expenses are by law covered in medical schemes. Out-of-pocket payments are largely for day-to-day expenses.

⁷⁵ This is shown in the various General Household Surveys.

5.12.16 In a definitive statement on policy, therefore, the Green Paper incorrectly attributes positions of the World Health Organisation to its proposals. *The error is sufficiently glaring to raise questions about the integrity of the work carried out on this process.* This is further confirmed by the out of context references to out-of-pocket payments as an apparent policy priority.

Box 5.3: World Health Organisation regarding the objective of Universal Coverage

“Countries that have achieved universal coverage have developed prepayment systems that are commonly described as tax-based or social health insurance-based (SHI). In a tax-based system, general tax revenue is the main source of financing, and the available funds are used by the government to provide or purchase health services. In an SHI system, contributions come from workers, the self-employed, enterprises and government. In both, the contributions made by all contributors are pooled and services are provided only to those who need them. The financial risks associated with ill health in the population as a whole are shared by all contributors, and the pooled funds therefore perform an insurance function. In tax-based systems, however, the insurance is implicit (in general, people do not know how much of their taxes they are contributing to fund health services), whereas in SHI it is explicit (in general, people know what they are paying for health). In both systems, the funds are usually used to purchase or provide services from a mix of public and private providers. In an SHI system, the individual contributors generally have the right to a specific, defined benefit package; in a tax-based system, benefit packages also exist in terms of the type of services available, or the time at which services can be accessed, but details are not always explicit.

It is quite common for countries to have a mixed financing system, with specified groups covered by health insurance and the remainder of the population by general taxes. In almost all systems, individuals or households are still required to make some out-of-pocket payments when receiving selected services (e.g. fees or co-payments for consultations, medication, tests, hospitalization etc.), although the contribution these payments make to total health expenditures is generally small compared to countries that have not yet attained universal coverage.

Transition to universal coverage

The financing systems required to achieve universal coverage in countries that have not yet done so will need to evolve over a number of years. At the beginning of the transition, population coverage is incomplete, with the poorest groups often the least likely to be protected. There is high reliance on fees and charges households must pay to receive services. In the early phases, it will be necessary to move away from direct payment for services by households to forms of prepayment, which might combine different approaches to protecting people from financial risks while ensuring adequate funds are available to provide services. These might involve community-, cooperative- and enterprise-based health insurance, other forms of private health insurance, and compulsory SHI-type coverage for particular population groups. It will almost certainly require some continued tax-based funding (see Figure 1).

The mechanisms that exist in the intermediate stage do not necessarily disappear when universal coverage has been achieved. Indeed, they can be important institutional mechanisms to build upon. In addition, within each of the universal coverage mechanisms, private health insurance can be used to finance health services that are not part of the universal health care package.

A crucial issue in the transition phase is "pool fragmentation", in which many small fund pools exist at

the same time. They might be so small that a few people requiring expensive care will bankrupt the scheme or put it at financial risk. Policy-makers should ensure at an early stage that organizational mechanisms – known as risk equalization measures – are in place to allow funds to be transferred from schemes with relatively low risk exposure to those at greater risk. In addition, where funds are geographically-based, or are allowed to restrict access to rich or healthy people, some funds will be wealthy while some are poor. This leads to inequitable access to services, inviting governments to redress this inequity via regulation.”

Source: World Health Organisation, 2005, pp.1-3.

- 5.13 The introduction concludes with four proposed interventions to resolve the institutional challenges of the health system.
- 5.14 “*To successfully implement a healthcare financing mechanism that covers the whole population such as NHI, four key interventions need to happen simultaneously: i) a complete transformation of healthcare provision and delivery; ii) the total overhaul of the entire healthcare system iii) the radical change of administration and management iv) the provision of a comprehensive package of care underpinned by a re-engineered Primary Health Care (sic).”⁷⁶ [Underline added].*
- 5.15 This concluding paragraph to the introduction to the Green Paper proposes to change every aspect of the health system to introduce a financing *mechanism*. Common-sense would however subordinate health reform to the achievement of *objectives*, with *mechanisms* a means to that end. Here however the mechanism appears to be the end, with objectives, such as improved health outcomes, subordinate.

⁷⁶ GP, par 6, p.5.

6. PROBLEM STATEMENT (page 5)

Overview

- 6.1 The Green Paper's problem statement falls into two parts. An initial unheaded section which outlines the key "problem", seen as the existence of a "two-tier health system", is followed by a number of subsections that raise general concerns regarding the health system.
- 6.2 No apparent connection however exists between the various sub-sections, many of which also fail to isolate or even raise *institutional weaknesses* within the health system. There is also no apparent relationship between this section and the equally disconnected policy recommendations in later sections.
- 6.3 It would have been more logical for this section to provide a definitive situation analysis of the institutional architecture of the current health system and any shortcomings. The purpose should have been to identify systemic problems, of an institutional nature, sufficient to for motivate the reform options.
- 6.4 The existence of a so-called two-tiered health system in South Africa is instead framed as the exclusive over-arching policy imperative. This idea is however raised in abstract and without any context, analysis, or review of comparative systems.
- 6.5 As this section should clarify the central argument for the proposed institutional interventions, upon which substantial changes to the public health system and levels of taxation are premised, considerable attention to detail and accuracy is required. However, no systematic analysis is offered and *all* data and references presented are factually incorrect.
- 6.6 *The inaccuracies, which are both glaring and material to the case constructed for reform, are difficult to understand as in all instances they involve either data reported directly to the Minister of Health or information that should form part of the specialist knowledge of the Department of Health.*

The main "problem" – the two-tier health system

- 6.7 The problem statement identifies the existence of a two-tier health system as the over-riding problem of the health system. The sub-section is characterized by a number of emphatic declarations seeking to make a case for this central premise.
- "Problems linked to health financing that are biased towards the privileged few have not been adequately addressed."*⁷⁷
- 6.7.1 This statement lacks any context or supporting information and is not referenced. The contestable nature of this pronouncement however establishes a clear obligation for Government to provide a strong case supported by *evidence* and *rational argument*. None is provided.

⁷⁷ GP, par.8, p.5.

6.8 The Green Paper mysteriously suggests that a single-tier system was tabled in 1994 and somehow undermined.

“Post 1994 attempts to transform the healthcare system and introduce healthcare reforms were thwarted.”⁷⁸

6.8.1 This unreferenced statement is unusual and not supported by any report or documented history of the South African health system. The period from 1994 to 1997 involved the translation of policy proposals arising from the ANC Health Plan of 1994, through various committees, into the White Paper of 1997. Many of the White Paper reforms (post 1997) were however never properly implemented. *These genuine performance failures do not appear to be what was thwarted.*

6.8.2 The inclusion of unsubstantiated and vague statements in what should be a clear and unambiguous technical communication of reforms to the public is questionable.

6.8.3 It would be useful to know therefore:

- What this statement refers to?
- What proposals were thwarted?
- Who thwarted the reforms?
- What relevance those reforms have to the problem statement?

6.9 *“This has entrenched a two-tiered health system, public and private, based on socioeconomic status and it continues to perpetuate inequalities in the current system. Attempts to reform the health system have not gone far enough to extend coverage to bring about equity in healthcare.”⁷⁹*

6.9.1 The Green Paper implies a causal relationship between the “thwarting” of some initiative and the entrenching of a two-tiered system. Setting aside the intriguing mystery of who thwarted who or what, this statement implicitly and controversially presumes that the establishment of a single-tiered health system is *a simple policy choice*.

6.9.2 As with the term NHI the Green Paper fails to define or provide any information on what is understood as a single- or two-tier health system. It would also be useful to have international examples. *There is an apparent presumption that ordinary members of the public understand this term implicitly and that this is a valid concept used to evaluate health systems.*

6.9.3 In the absence of this clarification, it is necessary to attempt an interpretation.

⁷⁸ GP, par 9, p.5.

⁷⁹ GP, par 9, pp.5-6.

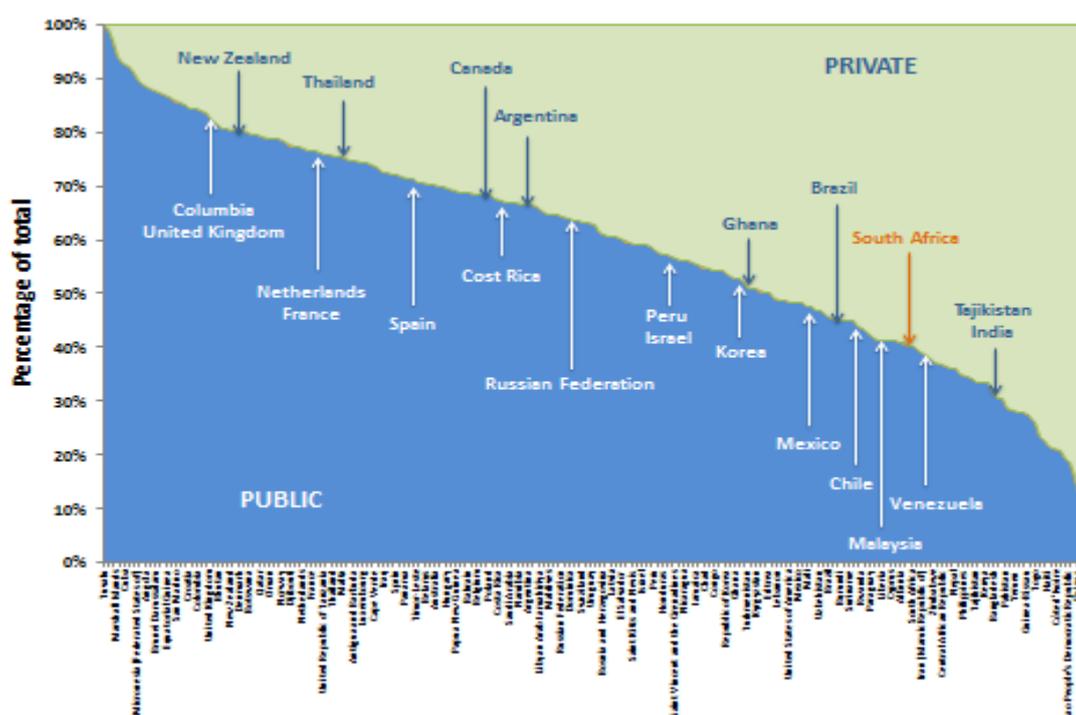
- 6.9.4 The Green Paper appears to equate the term with public and non-public financing mechanisms, with the first-tier applicable to the tax funded publicly delivered system and the second-tier to the privately funded system.
- 6.9.5 Using this understanding, however, *all countries have multiple tiers*, with private expenditure occurring as both insurance contributions and out-of-pocket payments. Developing countries generally tend to have a higher percentage of total expenditure occurring in the private sector due to limited resources available to government through the tax system. (See **figure 6.1**).
- 6.9.6 A review of the literature reveals very little discussion on multi-tier versus single-tier systems except in context-specific discussions⁸⁰. In large part the existence of multiple tiers is accepted as a feature of all health systems and is broadly uncontroversial.
- 6.9.7 *Public choice questions largely focus on what government should be ensuring as a universal minimum and the applicable funding and rationing mechanisms*. Within this discussion there is a strong international focus on the achievement of *universal coverage* (see **box 5.3**), *which is not in any way contingent on the achievement of a single-tier system*.
- 6.10 The arguments in favour of a “single-tier” system are broadly framed as questions of equity. However, the notion of equity is not a simple one and requires clear arguments explaining what principles of equality or equity are applied in framing public policy choices. They are however raised in very vague terms as both “*principles*” and “*noble goals*”.
- “The two-tiered health system of healthcare did not and still does not embrace the principles of equity and access and the current health financing mode does not facilitate the attainment of these noble goals.”*⁸¹
- 6.10.1 In the absence of an evidence-based benchmark on what constitutes acceptable levels of equity and access, this is empty rhetoric which allows for interpretations that would in some cases result in absurd policy prescriptions.
- 6.10.2 For instance, the statement appears to imply that *any private demand* for healthcare is a deviation from “*equity and access*”. Although individuals can hold such a view, this is not a useful or realistic point-of-departure for the development of public policy.

⁸⁰ For instance debates in the United States involve discussions about whether they should have the same system as in Canada.

⁸¹ GP, par 10, p.6.

- 6.10.3 The vague and unclear language used for what is meant to be the Green Paper's defining set of principles is also a problem. Proper communication with the public requires that the *principles* and the *rationale for any principles* be made explicit and clear.
- 6.10.4 Omitted from the "implicit" understanding of equity and access, however, is any recognition that the differential access to services in South Africa is largely due to *the mismanagement of resources within the public sector due to politicians and public officials using the public sector for personal gain*. A risk that can at least be mitigated by people able to use the private sector.
- 6.10.5 Evidence on the performance of the public health system suggests that resource constraints are not the determinants of poor health outcomes.⁸² The relative disadvantage faced by lower-income groups is consequently their relative inability to avoid using poorly managed and corrupt public sector services by opting into the private sector. For such reasons corruption is a central driver of inequity and unequal health outcomes. (See **box 6.1**).

Figure 6.1: Public and private expenditure within all countries in the world



Source: World Health Organisation, [<http://apps.who.int/ghodata/#>].

- 6.10.6 However, not all provinces perform badly, with the Western Cape demonstrating a superior capability to perform than the other eight provinces.

⁸² See **figures 6.3** and **6.4** and the associated discussion.

- 6.10.7 If resource constraints were the determinant of inequitable access, the Western Cape would perform at the same level as, for instance, Gauteng. However, performance differences are stark and cannot therefore be attributed in linear fashion to the architecture of the health system or resource differentials, *as these are the same for the Western Cape and other provinces.*

Box 6.1: Corruption and its effect on health and education outcomes

“The empirical analysis shows that a high level of corruption has adverse consequences for a country’s child and infant mortality rates, percent of low-birthweight babies in total births, and dropout rates in primary schools. In particular, child mortality rates in countries with high corruption are about one-third higher than in countries with low corruption; infant mortality rates and percent of low-birthweight babies are almost twice as high, and dropout rates are five times as high. The results are consistent with predictions stemming from theoretical models and service delivery surveys.”

“...improvements in indicators of health care and education services do not necessarily require higher public spending. It is equally, if not more, important to institute transparent procurement procedures and enhance financial accountability of public spending. ... it is likely that a reduced level of corruption in the provision of services would help improve their quality.”

Source: Gupta S, *et al*, June 2000.

- 6.11 The Green Paper regularly invokes the World Health Organisation to validate strategic positions or points of view. The following quotation from the paper sets out major themes for the entire reform approach purportedly adopted from the World Health Organisation. However, the actual text from the World Health Organisation is quite different (see **box 6.2**).

“The 2008 World Health Report of the World Health Organisation (WHO) details three trends that undermine the improvement of health outcomes globally, namely:

- *Hospital centrism, which has a strong curative focus*
- *Fragmentation in approach which may be related to programmes or service delivery, and*
- *Uncontrolled commercialism which undermines the principles of health as a public good*⁸³

- 6.11.1 No wording equivalent to the above can be found in the 2008 World Health Report. **Box 6.2** provides the section of the report that most closely resembles the words contained in Green Paper. Although some relationship exists with the three bullets in the World Health Report, the meaning and emphasis is materially altered in the Green Paper.

- 6.11.2 *On bullet 1*, the World Health Organisation is warning against an excessive focus on curative care, but at no time mentions “*hospi-centrism*”. Curative care is actually provided on both an in- and out-of-hospital basis, and is

⁸³ GP, par 11, p.6.

extensively offered in a primary care setting. The World Health Organisation is in fact warning against a focus on, for instance, the treatment of diabetes (that can be provided by the primary care system) rather than interventions to prevent it. The Green Paper, by way of contrast, implies that all curative care is provided in hospitals. This is clearly not what the World Health Organisation is saying.

Box 6.2: What the World Health Organisation actually said

“Three particularly worrisome trends can be characterized as follows:

- *health systems that focus disproportionately on a narrow offer of specialized curative care;*
- *health systems where a command-and-control approach to disease control, focused on short term results, is fragmenting service delivery;*
- *health systems where a hands-off or laissez-faire approach to governance has allowed unregulated commercialization of health to flourish.”*

World Health Organisation, 2008.

6.11.3 *On bullet 2, the World Health Organisation warns against a “command and control” approach to disease control which leads to fragmentation. This is apparently a reference to vertical programmes for specific diseases that operate in parallel to integrated delivery platforms. In South Africa examples include the treatment of HIV and AIDS and TB.*

6.11.4 *The Green Paper, by way of contrast, refers to some general notion of fragmentation apparently failing to recognize that this is mentioned by the World Health Organisation as a consequence of a “command and control approach”.*

6.11.5 *On bullet 3, the World Health Organisation warns against any failure to exercise proper stewardship over the private sector. This is a persistent theme of the World Health Organisation since their 2000 report.*

6.11.6 *Unregulated private systems are well known to result in the exclusion high risk groups and systemic cost increases. The focus of the World Health Organisation is therefore on ensuring their proper regulation. By way of contrast the Green Paper uses very different wording. For instance, the word “unregulated” is replaced with “uncontrolled”, materially altering the meaning of the statement.*

6.11.7 *The World Health Organisation is not concerned with the existence of a commercialized health system, only one which is “unregulated”.*

6.11.8 *The Green Paper, by way of contrast, attacks the very notion of a commercialized health system, suggesting that it is something to be eliminated. This interpretation is supported by public statements made by the Minister and Deputy Minister of Health where the private sector is described as a “monster” and “brutal”. In the 2010/11 health budget speech the Minister identifies all expenditure occurring in the private sector as*

“*unfair*”. These views differ from the more reasonable statements made on 11 August 2011. However, from 10 September 2011 the rhetoric (from both from the Minister and the Deputy Minister) reflect the views of 31 May 2011 and the Green Paper. (See **box 6.3**).

6.11.9 Consistent with this interpretation, *commercialism* is contrasted with the notion of “*health as a public good*” (also see **box 6.3**).

6.11.10 Healthcare is however not a public good, or at least not in the sense understood in the economic literature (see **box 6.5**). It is in fact a *private good* as it is subject to the principle of *excludability*, i.e. it can be priced and sold to individual purchasers. *A public good cannot be sold to individual purchasers and therefore suffers from a free-rider problem – usually requiring government involvement to ensure sustainable availability.*

Box 6.3: Public statements made by the Minister of Health regarding private sector coverage

“Having said so honourable speaker, this (sic) four pandemics are occurring in the face of a reasonable amount of health expenditure as a proportion of the Gross Domestic Product (GDP). Available evidence indicates that we spend 8,7 % of our GDP on health (the bulk of which, as is commonly known, is unfairly spent in the private sector). This expenditure is significantly more than any other country on the African continent and in some instances even outside our continent. A serious anomaly here is that our health outcomes are much worse than those of countries spending much less than us.” [Underline added].

Minister of Health, 31 May 2011.

“NHI is not a war between the public health sector and the private healthcare sector – it is not even a competition or a beauty contest between these two healthcare delivery systems. If we view matters in this light, and if we try to tear each other apart, the people of South Africa will be the real losers. The challenge and the intent of NHI is to draw on the strengths of both healthcare sectors to better serve the public.”

“The private sector is held up as an example of good service and quality of care – and this is mostly justified. What is not justified is the price tag that comes with certain forms of private healthcare provision. This is not only a burden to people using private health services, but a disservice to our country as a whole because it distorts pricing across the board. And, there are clear signs that it is simply unsustainable.”

Statement by Aaron Motsoaledi, Minister of Health, on the release of the green paper on National Health Insurance, 11 August 2011

“Jobannesburg - South Africa's private healthcare system is a monster that will swallow the country whole, Health Minister Aaron Motsoaledi said on Tuesday.”

Sapa, 10 September 2011, [<http://www.news24.com/SouthAfrica/Politics/Private-healthcare-a-monster-20111011>]

“This country has a “brutal” private healthcare system that has commercialized an essential service, Health Minister Aaron Motsoaledi said. “How can we run such a brutal system ... the government will not fold its arms when there is such rampant commercialism in the healthcare sector,” he said at a general practitioners conference in Durban. He said the use of a public good for excessive profit was unacceptable, which was why the state had proposed a national health insurance scheme.”

Sapa 10 October 2011, Michael Kimberly

[<http://www.timeslive.co.za/local/2011/10/10/private-healthcare-is-brutal>]

“Cape Town - A month after Health Minister Aaron Motsoaledi called the private health care system a “monster”, his deputy re-applied the label. “The system is monstrous and brutal,” Deputy Health Minister Gwen Ramokgopa said in the National Assembly on Wednesday. In October, Motsoaledi controversially described private healthcare in South Africa as a “brutal system”, and a monster “that will swallow us whole”. Ramokgopa, responding to a question in the House about the remarks, told MPs there was a need to deal with the “uncontrolled, unregulated commercialisation of health care” in the country. This undermined the principle of health care as a public good. She offered examples of the private sector charging exorbitant amounts for treatment, saying such “high and unjustifiable” charges had thrown even financially stable families into poverty.”

Report on Speech by Deputy Minister of Health Gwen Ramagkopa, SAPA, 2 November 2011 [<http://www.news24.com/SouthAfrica/Politics/Brutal-private-healthcare-attacked-again-20111102>]

6.11.11 This does not mean that government should not intervene to deal with market failures (such as the inability of the market to resolve redistributive objectives), only that government’s basis for intervention is not tied to the public good nature of healthcare (as healthcare is not a public good).

6.11.12 In all three of the bullets discussed above the *words and the meaning* of the original statements made by the World Health Organisation have been materially altered. References to the World Health Organisation are used to validate the Green Paper positions in the general absence of evidence. *The misrepresentation of their views in this way however raises serious questions about the reliability of the Green Paper’s positions and the thought gone into them.*

Box 6.4: World Health Organisation views on PHC Reforms

“At the same time, PHC reforms, and the PHC movement that promotes them, have to be more responsive to social change and rising expectations that come with development and modernization. People all over the world are becoming more vocal about health as an integral part of how they and their families go about their everyday lives, and about the way their society deals with health and health care. The dynamics of demand must find a voice within the policy and decision making processes. The necessary reorientation of health systems has to be based on sound scientific evidence and on rational management of

uncertainty, but it should also integrate what people expect of health and health care for themselves, their families and their society. This requires delicate trade-offs and negotiation with multiple stakeholders that imply a stark departure from the linear, top-down models of the past. Thus, PHC reforms today are neither primarily defined by the component elements they address, nor merely by the choice of disease control interventions to be scaled up, but by the social dynamics that define the role of health systems in society.”

Source: WHO, 2008, p.9.

Box 6.5: Public and private goods

A public good is regarded in economics as associated with joint consumption or non-excludability.

“This is the concept of collective or joint consumption with nonexclusion. The primary characteristic of collective consumption with nonexclusion is the fact that the “jointly consumed” economic goods are indivisible in the important sense that their benefits cannot be priced in the market. In the extreme case of all benefits being indivisible, the good is normally called a “pure public good”. If such a good is supplied in the economy, it is consumed in an equal amount by all consumers. Moreover, no one can be “excluded” from its consumption by a failure to voluntarily pay for it.

On the other hand, a divisible “pure private good” is subject to the exclusion principle. That is, an individual can be “excluded” or “prevented” from consuming the good because he does not voluntarily pay for it. Such a good is completely subject to the pricing mechanism. All of the benefits are “private” to its purchaser. None are “collectively” consumed.”

Source: Herber PE, 1975.

Thus health care goods and services are private goods, as the exclusion principle applies, while national defense is not, as it is not possible to exclude some from its consumption. Public goods are more naturally provided by the state and funded from coercive taxes as it is not possible to prevent free-riders, i.e. people who would consume the good or service without paying for it.

6.12 Reliance on the purported position of the World Health Organisation for positions adopted in the Green Paper are given weight by further references to the three bullets discussed above.

“An analogy (sic) of the previous description can be drawn with the negative attributes of the South African two-tier healthcare system, which are unsustainable, destructive, very costly and highly curative or hospi-centric.”⁸⁴

⁸⁴ GP, par 12, p.6.

- 6.12.1 This statement draws on the high-level comments *incorrectly* attributed to the World Health Organisation (discussed above) and applies them to South Africa.
- 6.12.2 Four catchall terms are used to characterize the South African health system: “*unsustainable*”, “*destructive*”, “*very costly*”, and “*curative or hospi-centric*”. All apparently (but not explicitly) directed at South Africa’s regulated private health system. However, the extreme language used generates a sense of imminent crisis which is not supported by the evidence.
- 6.12.3 On *sustainability*, the broad expenditure levels expressed as a percentage of Gross Domestic Product (GDP) have demonstrated a high degree of stability over the period from 1995 to 2009. Going forward very little is expected to alter. Given this, it is hard to see what aspects of the system are unsustainable at the macro level. (See **figure 6.2**).
- 6.12.4 On “*destructive*”, very little can be said. This is not a technical term and is not based on any evidence. What is being destroyed and how?
- 6.12.5 On “*very costly*”, no evidence is provided as to what areas of the health system this applies. High cost increases have been identified and commented on independently in both the public and private sectors.⁸⁵
- 6.12.6 There are no systematic analyses or reviews on costs published by the Department of Health or referred to in the Green Paper which clarify exactly what is referred to and their causes.
- 6.12.7 Cost problems can result from a wide range of potential areas: demographic change; morbidity change; technology change; price changes; and changes to costs of employment.
- 6.12.8 Costs can also be seen as high in a static sense, such as excessive in comparison to some benchmark considered reasonable.
- 6.12.9 They could also be seen as problematic in a dynamic sense, as in the case of excessive year-on-year increases where annual price setting negotiations are affected by imbalances in market power between providers and funders.
- 6.12.10 Each area requires a specific diagnosis and intervention strategy. The term “*very costly*” is consequently imprecise.
- 6.12.11 The absence of technical work in the area of costs or any meaningful interventions (apart from some useful but quite limited ones in the area of

⁸⁵ Council for Medical Schemes, 2008.

medicines)⁸⁶ by the Department of Health suggests that cost issues of any form *have never been a genuine policy priority*.

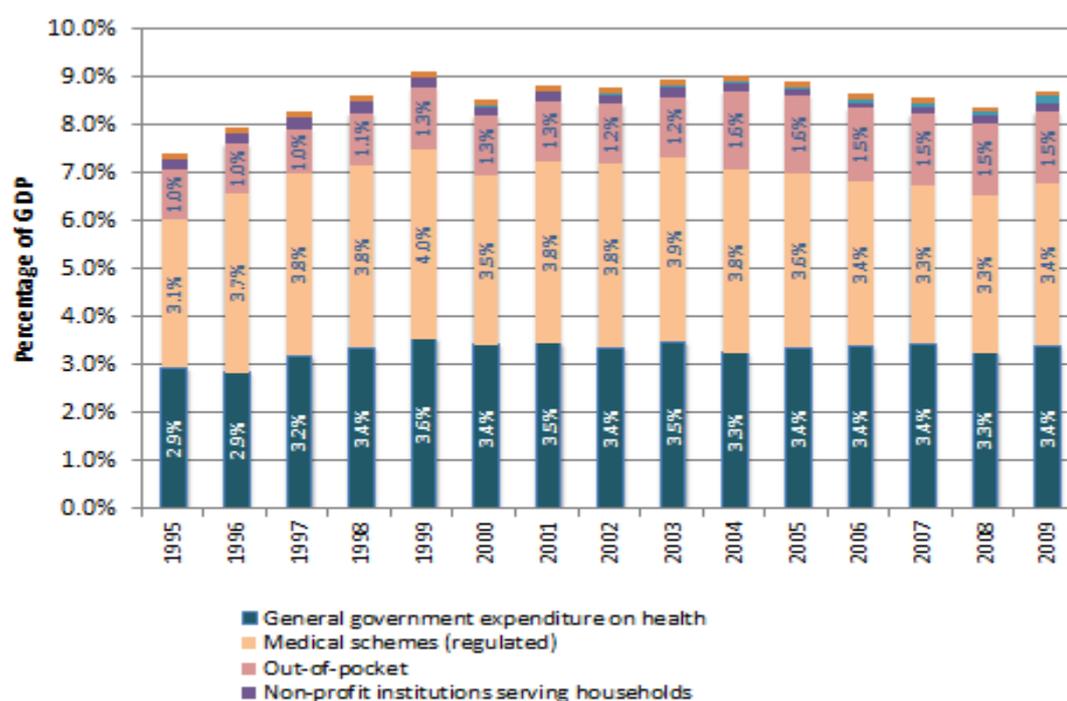
- 6.12.12 Over a period of seventeen years (since 1994) the Department of Health has never intervened in the market or through the competition authorities (who have extensive powers to deal with such issues), proposed any coherent legislation, changed any problematic legislation, or used its powers to apply conditions to hospital licensing. It has also apparently ignored recommendations from regulatory authorities and stakeholders explicitly requesting interventions of this nature.⁸⁷
- 6.12.13 This exaggerated language on costs, combined with the use of inaccurate information, *raised belatedly in 2011*, is questionable as prevalent problems exist because of government's failure to properly intervene.
- 6.12.14 *A more responsible approach would be for Government to develop an informed and properly researched response to private sector costs.*
- 6.12.15 Dramatic cost increases have however impacted on the public health system when government implemented two poorly thought through interventions: the automatic rank and leg promotions of 1997/98 and the occupational specific dispensation for nurses in 2007/08.
- 6.12.16 In the former case the cost increases resulted in the loss of around 50,000 staff members from the public system from 1998/99 to 2003/04 (see **figure 5.11**). In the latter instance an unplanned cost impulse amounting to around R8 billion hit the provincial health system in the 2008/09 financial year. Only the Western Cape appeared to avoid this problem by properly implementing the changes.
- 6.12.17 The consequences for the other provinces, in particular Gauteng, KwaZulu Natal, Free State and Eastern Cape, have however carried through from 2008. To date this crisis has not been officially reported on or properly addressed, despite an evident impact on service quality. *No inquiry into the causes and consequences of these interventions have been performed, and no-one held accountable.*

⁸⁶ This involved the implementation of the Single Exit Price (SEP) system which materially impacted on medicine prices. The prohibition on discounting and bonusing also removed many of the kick-back-related abuses rife in the markets for medicines. However, the Department of Health failed to implement the complete system of medicine price reform which should have largely removed dispensing doctors and manipulation by logistics suppliers. The international benchmarking of medicines was also inexplicably delayed after initial proposals in 2007. The failure of the Department of Health to consider a comprehensive strategy to private sector cost containment meant that abuses by private hospitals in taking kickbacks from pharmaceutical and other medical products manufacturers could be transferred into facility fee increases with impunity in 2004 and 2007/8.

⁸⁷ Council for Medical Schemes, 2008.

6.12.18 On “*curative or highly hospi-centric*” the Green Paper appears unaware that government allocations for hospital services have been consistently deprioritized since 1994. A factor undoubtedly contributing to their low popularity with income earners. (See **figure 6.2**). Also, as already indicated the term “*hospicentric*” is not a proxy for curative services, and there is no evidence to suggest that South Africa’s hospital services, whether in the public or private sectors, are in any way excessive relative to primary care services. *There is also no technical report produced by the Department of Health demonstrating this to be the case.*

Figure 6.2: South Africa’s National Health Accounts from 1995 to 2009



Source for data: WHO, 2011, [<http://www.who.int/nha/country/zaf/en>].

6.12.19 When extensive evidence exists of serious failures in the public delivery of all curative services, it appears inconsistent for them to be de-prioritised. Given the vague manner in which these issues are discussed it is not clear how to respond.

6.12.20 In summary, *the four issues raised lack sufficient precision and evidence upon which to base coherent policy recommendations.* The tone appears designed to construct a false sense of *impending crisis*. The paper should however have focused on a measured and objective evaluation of the facts to be used as a basis for policy options.

The Burden of Disease in South Africa (page 7)

6.13 The problem statement proposes that the NHI “*should take into account the burden of disease the country is experiencing*”. Why this is placed in the problem statement is unclear as all country health systems must address their burden of disease.

- 6.14 As the Green Paper ostensibly deals with proposals to change institutional mechanisms, the problem statement should *identify what is wrong with current institutional model(s)* so that a coherent policy response can be motivated. Instead a superficial and largely irrelevant summary of burden of disease issues is provided that does not indicate which *institutional mechanisms* are failing.
- 6.15 To illustrate what should have been included in the Paper examples of institutional issues related to the burden of disease areas raised are provided below:
- *HIV and AIDS*: the existing programme is vertical and divorced from the rest of the health system. Although this proved useful in getting the programme off the ground, every effort must now be made to establish an integrated health system with HIV and AIDS treatment offered effectively in the primary care setting. However, the absence of a functioning district health system seriously undermines what is achievable. A clear roadmap for the achievement of a capable primary care system is therefore required.
 - *Maternal, infant and child mortality*: serves as a proxy indicator of the general capability of the South African health system to deliver preventive and curative care. Abysmal maternal and newborn mortality rates are largely attributable to poor quality nursing, poor clinical management, and the widespread absence of governance and accountability. Turning around poor maternal and newborn mortality ratios can be achieved as a targeted vertical (command and control) exercise focused on these indicators alone. Alternatively attention could be paid to the institutional weaknesses of the system as a whole. Adopting the latter approach requires that health services be made accountable at every level of the system, with staff management and training issues properly addressed.
 - *Non-communicable diseases*: are presently managed in a chaotic and disorganized manner throughout the public health system. This is largely a reflection of the weak district health system platform which lacks the capability to achieve basic levels of disease management. As non-communicable diseases largely involve chronic conditions, treatment needs to be *patient centred*. However, the pre-requisites for a patient-centred approach to managing chronic conditions are not in place and should include: decentralized management; the monitoring of patient information and treatment; outreach to patients; properly trained staff; proper management of staff; continuity of care; fast turnaround of tests; and easy availability of essential medicines. It is also worth noting that the Roadmap process of 2008 recommended that non-communicable diseases form part of the 10 point plan of the Department of Health (see **box 6.6**). For some reason this was not accepted, suggesting that Government does not see this area as a priority.

Box 5.6: Roadmap Report – recommended objective regarding communicable diseases

“OBJECTIVE 8: DEVELOP A STRATEGIC FOCUS ON NON-COMMUNICABLE DISEASES FOR IMPLEMENTATION WITHIN THE DISTRICT HEALTH SYSTEM

Non-communicable diseases require the implementation of structured programmes of prevention and treatment at the district level.

These are required to reduce preventable mortality from conditions such as hypertension and diabetes. In addition, a strategic policy framework dealing with mental health is needed to deal with both acute and chronic psychiatric conditions.”

Development Bank of South Africa, 2008, pp.58-59.

- *Injury and violence:* as the Constitution has correctly made access to emergency care an absolute right (not subject to the qualification of progressive realization), government has an obligation to ensure that this right is available to all. However, there is substantial fragmentation in emergency medical services both within the public sector and between the public and private sectors. Although it may be possible for some people to enforce their right to access, no framework has been established to deal with the financing of this obligation to ensure that patients are not left with catastrophic out-of-pocket liabilities or that healthcare service providers, particularly hospitals, are incentivised to act defensively to maintain their financial sustainability. Emergency health care is distinct from other conditions as immediate access is required to protect life and limb. The existing institutional framework falls far short of this requirement and a coherent institutional response is required. Consideration must therefore be given to the consolidation of existing funding and reimbursement mechanisms; uniform access requirements for all residents to all available services; and a coherent model of supervision.

Quality of Healthcare (page 9)

- 6.16 This section fails to adequately specify the problem causing poor health service quality in the public sector. In particular why a quality of care failure exists which cannot be explained by resource constraints.⁸⁸
- 6.17 The cause can however be attributed to the collapsed accountability framework within the public health system resulting from the politicization of government structures and the resulting capture of procurement systems by private interests operating through the ruling party.

⁸⁸ There is extensive evidence confirming this conclusion. This was raised as a particular issue in Development Bank of South Africa, 2008.

- 6.18 The Green Paper's silence on the systemic causes of performance failure is a concern and suggests that no response of substance will be developed.
- 6.19 Rather than diagnosing this central quality assurance problem, the Green Paper focuses instead on the fact that poor quality public health care is driving people to the private sector.⁸⁹ It therefore states that "*improvement in the quality of the public system is at the centre of the health sector's reform endeavors.*" However, readers are none the wiser about *what institutional drivers are affecting quality and where the solutions may lie.*
- 6.20 *The apparent avoidance of the quality assurance failures in the public health system strongly suggests that no meaningful strategy will in fact be implemented.*

Healthcare Expenditure in South Africa (page 9)

- 6.21 The central thrust of this section is that there is higher per capita health expenditure in the private sector resulting in poor health outcomes due to the unequal distribution of resources between the public and private sectors.
- 6.22 The section begins by again invoking (without referencing) the World Health Organisation who are purported to remark that "*countries spend at least 5% of their GDP on health care.*"
- 6.23 It then argues that South Africa spends way in excess this figure at 8.5% of GDP (also unreferenced). However, the Green Paper appears to have missed the strong possibility that the World Health Organisation is referring to a *minimum* that should apply to all countries regardless of their level of per capita GDP. It is making no comment about the appropriateness or otherwise of expenditure in excess of 5% as most industrialised countries spend in excess of 8% of GDP, with low-income countries often below 5%.
- 6.24 The World Health Organisation is plainly attempting to advocate for *low-income countries* to improve the prioritisation of health care to at least 5% of GDP and is making no other statement. As with other instances in this paper, a contrary meaning is attributed to statements made by the World Health Organisation.
- 6.25 The Green Paper also misleads where it continues to state that "*Despite this high expenditure the health outcomes remain poor when compared to similar middle-income countries.*"⁹⁰ A causal relationship is implied here between expenditure equity (between the public and private sectors) and health outcomes.
- 6.26 *High expenditure in the private sector however has no bearing on public sector performance, and no evidence has been presented (within the Green Paper or out of it) to demonstrate one.*

⁸⁹ GP, par 23, p.9.

⁹⁰ GP, par 24, p.9.

- 6.27 Poor health outcomes that are related to the services⁹¹ result exclusively from the manner in which the public system is managed and have little or nothing to do with the private system.
- 6.28 It is through public funding that all countries, including South Africa, seek to address their main *public health* priorities. South Africa's public health expenditure compares well with its peers (Brazil, Cuba, Mexico, and Chile) as well as many countries with far lower incomes. (See **figures 6.3** and **6.5**). Public sector per capita expenditure has in fact exceeded that of Cuba from 1995.
- 6.29 *What South Africa has to explain, however, is why its performance is so poor despite spending the same, or more, on its public system than other developing countries.* See **figures 6.3** and **6.5** which compare South Africa's maternal mortality ratios or MMRs (per 100,000 live births) with other developing countries. South Africa is shown to have the worst MMRs (red bar in **figure 6.3**) for countries close to it in terms of per capita GDP. (Also see **box 6.7**).
- 6.30 As the public sector's levels of expenditure and services (personnel and medicines) are normal (see **figures 6.3** and **6.5**), there is no *negative feedback effect* from the private system. *In fact the opposite is true as increased private sector participation allows public sector resources to be spread over a smaller population, increasing the redistributive effect of general taxes for healthcare.* As the public sector budget has not been reduced despite fewer people using it, the remaining beneficiaries are directly advantaged.⁹²

Box 6.7: South Africa's public health system performance compared with its peers

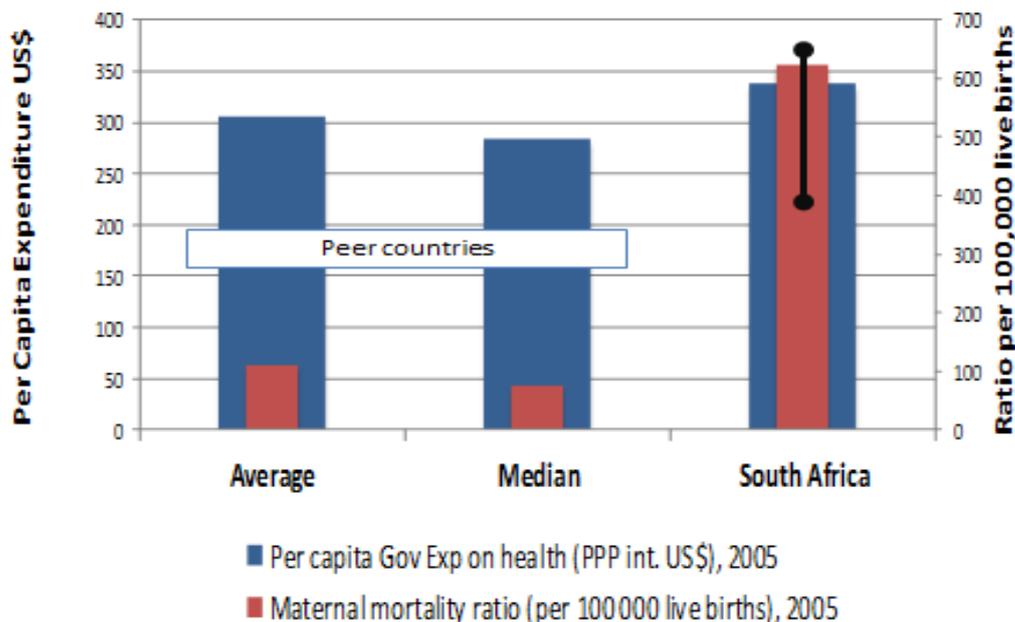
“As South Africa performs poorly relative to its peer countries, including many with far lower levels of per capita health expenditure and GNI per capita, its performance cannot properly be explained by the levels of government expenditure on health. The health system appears to be under-performing with its given level of expenditure.”

Development Bank of South Africa, 2008, p.15.

⁹¹ Not all health outcomes are addressed or affected by health services.

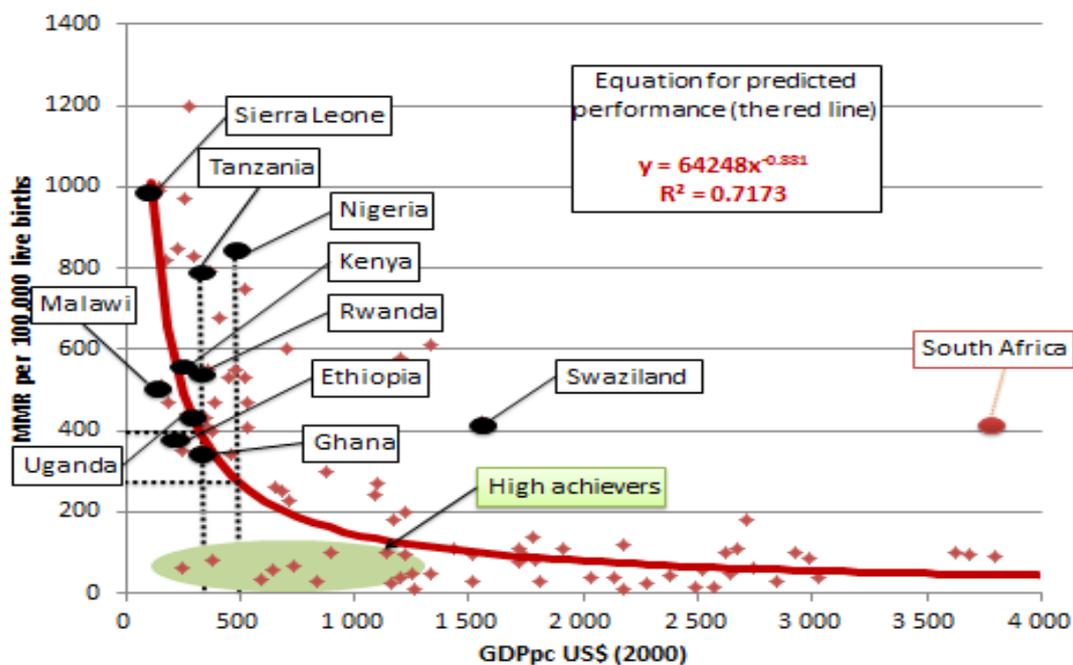
⁹² Such an effect may be offset by excessive unit cost increases in the public sector. Serious policy mistakes in 1997 and 2007 resulted in such increases. However, these effects are unrelated to the conduct of the private sector.

Figure 6.3: Per capita public health expenditure and maternal mortality ratios of peer countries (15 above and 15 below South Africa in per capita GDP) compared with South Africa



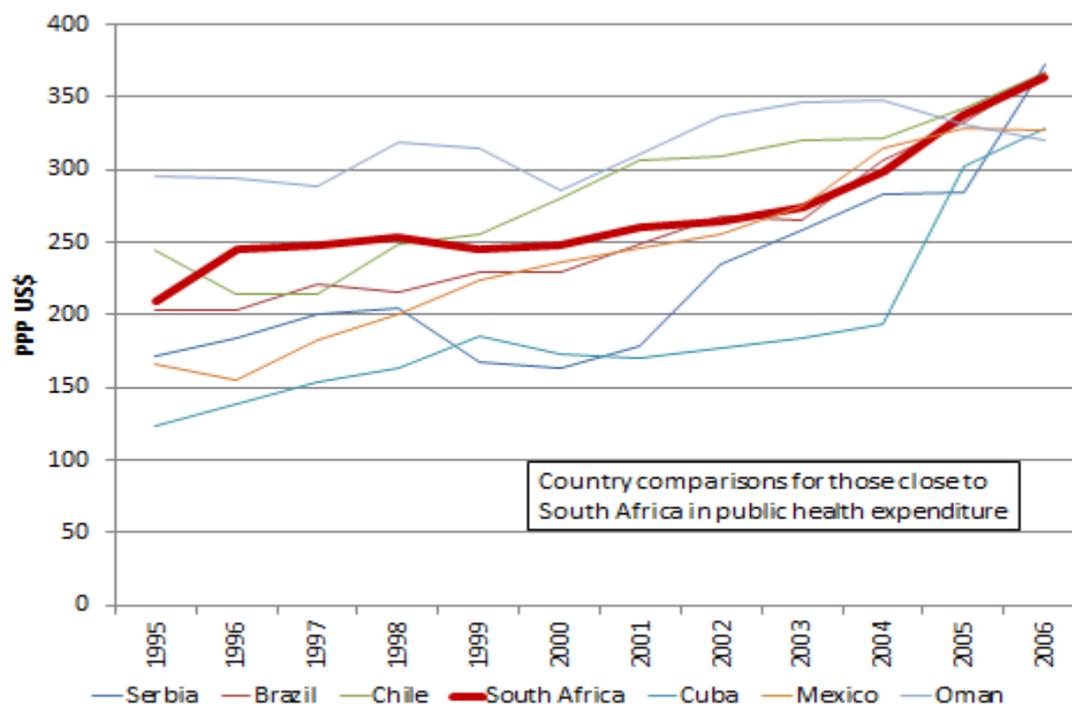
Source: Adapted from Development Bank of South Africa, 2008.

Figure 6.4: Maternal Mortality Ratios compared to Per capita GDP for all Countries up to South Africa's Per Capita GDP



Sources: MMRs for 2008 from the World Health Organisation. Per capita GDP World Bank World Development Indicators. The figures are for 2008 but in 2000 prices.

Figure 6.5: Per capita public health expenditure for countries roughly with South Africa's per capita GDP (1995-2006)



Source: World Health Organisation.

6.31 Consistent with the general thrust of the Green Paper information is provided suggesting that private healthcare costs are wildly out of control. The central case is presumably that medical scheme funding mechanisms drive up costs systemically and uncontrollably. Such arguments seek to justify the position that the privately funded health system is unsustainable in its current form. However, the information presented, once checked against the source, is found to be both misleading and factually incorrect. The following quotation, which is central to the Green Paper's case, serves to illustrate this point.

“Over the past decade, private hospital costs have increased by 121% whilst over the same period, specialist costs have increased by 120% (CMS Report, 2008).”⁹³

6.31.1 Both the above are referenced to the 2008 Annual Report of the Council for Medical Schemes (CMS).

6.31.2 However, by the time of drafting the Green Paper two further CMS reports had been made public and provided to the Minister of Health containing information for 2009 and 2010.

⁹³ GP, par 27, p.10.

- 6.31.3 The information quoted above is incorrect and it is unclear what data series has been used. If the cost trends of the *past decade* from the actual figures from the CMS are used, hospitals have shown an increase of 72% (which although unacceptably high is not 121%) and specialists 46.2% (not 120%).
- 6.31.4 The data also does not match any information provided in the CMS Annual Report for 2008. The actual real increases for hospitals and specialists over the period 1999 to 2008 is 67.1% and 60.7% respectively, roughly 50% of the increase stated by the Green Paper *as coming from the same source material*. (See **table 6.1** and **figure 6.6**).
- 6.31.5 The Green Paper also does not match the nominal increases over the same period, which are however of a similar order. It is unclear where the information provided in the Green Paper actually comes from.⁹⁴ (See **table 6.1** and **figure 6.6**).
- 6.31.6 A trend change in cost increases also occurred after 2004 which has seen increases structurally moderated. Over the *seven-year* period 2004 to 2010 hospitals and specialist costs have increased by only 12.7% and 26.7% respectively. (See **figure 6.7**).
- 6.31.7 *The incorrect representation of data on cost increases within the diagnostic part of the Green Paper is a serious error and requires an explanation.*

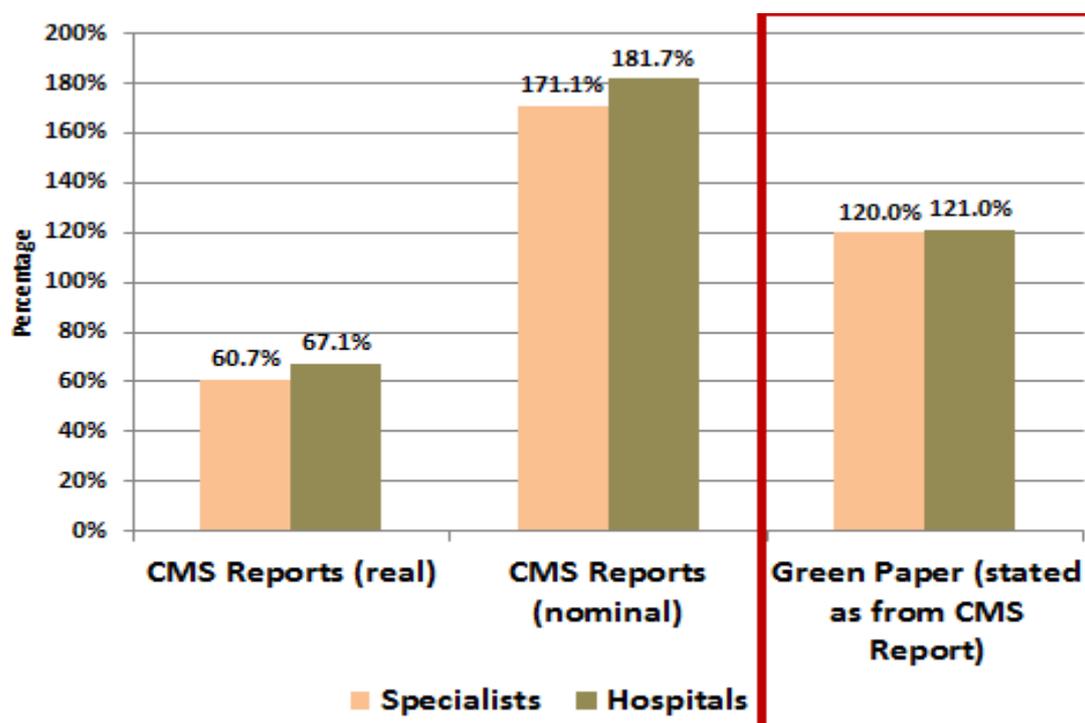
Table 6.1: Actual real increases in specialist and hospital cost increases from 1999 to 2008

Year	Nominal		2008 prices	
	per average beneficiary per month			
	Specialists	Hospitals	Specialists	Hospitals
1999	56.0	92.0	94.4	155.1
2008	151.8	259.2	151.8	259.2
	Percentage change			
2008	171.1%	181.7%	60.7%	67.1%
	<i>Green Paper : supposedly sourced from the CMS 2008 Annual Report</i>			
2008			120.0%	121.0%

Source: Council for Medical Schemes, Annual Reports for the years 2000 and 2008, Green Paper, par 27.

⁹⁴ The Council for Medical Schemes Annual Reports also do not report ten-year time series for provider costs (except in line graphs). To get this information the reports for the relevant years must be examined. It is therefore not clear why the Green Paper only refers to the 2008 report, which would be insufficient to generate the percentage changes. It appears as though the authors of the Green Paper did not actually consult the source material.

Figure 6.6: Real and nominal increases in hospital and specialist costs (per average beneficiary) for the ten year period from 1999 to 2008, comparison with the numbers presented in the Green Paper



Source: Council for Medical Schemes, Annual Reports for the years 2000 and 2008

6.32 Another concerning inaccuracy however involves references to medical scheme contribution increases. As already noted, a central pillar of the Green Paper's case is what it regards as unsustainable medical cost increases translating into unsustainable medical scheme contribution increases.

*"Contribution rates per medical scheme beneficiary have doubled over a seven-year period."*⁹⁵

6.32.1 It is unclear what period this refers to, or why a seven year period is suddenly selected rather than a ten-year period (as used above for hospital and specialist costs).

6.32.2 Regardless of whether a seven or ten-year period is used *there has been no doubling of contribution costs in real terms.*

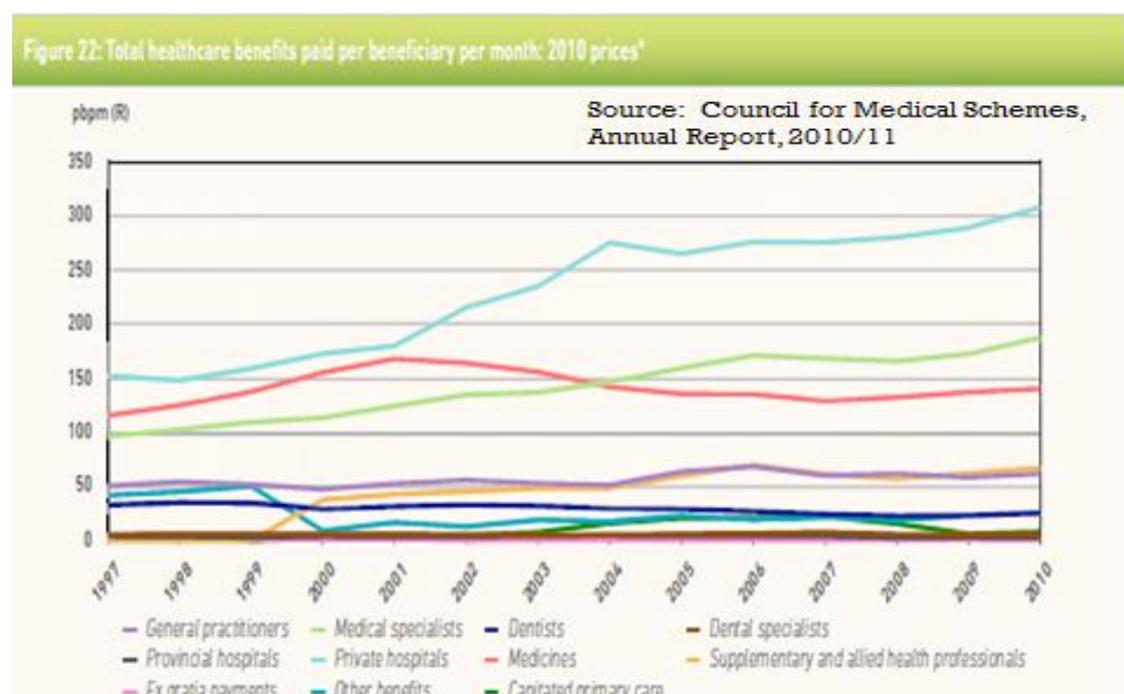
6.32.3 According to the CMS Report (snapshot shown in **figure 6.8**) since 2002, i.e. for a period of *nine years*, medical scheme contributions have, in the CMS's own words, *"been similar to inflation"*.⁹⁶ In fact over the past decade (to 2010) there has been a real increase of *only 27.3%*.

⁹⁵ GP, par 27, p.10.

⁹⁶ Council for Medical Schemes, 2011, p.37.

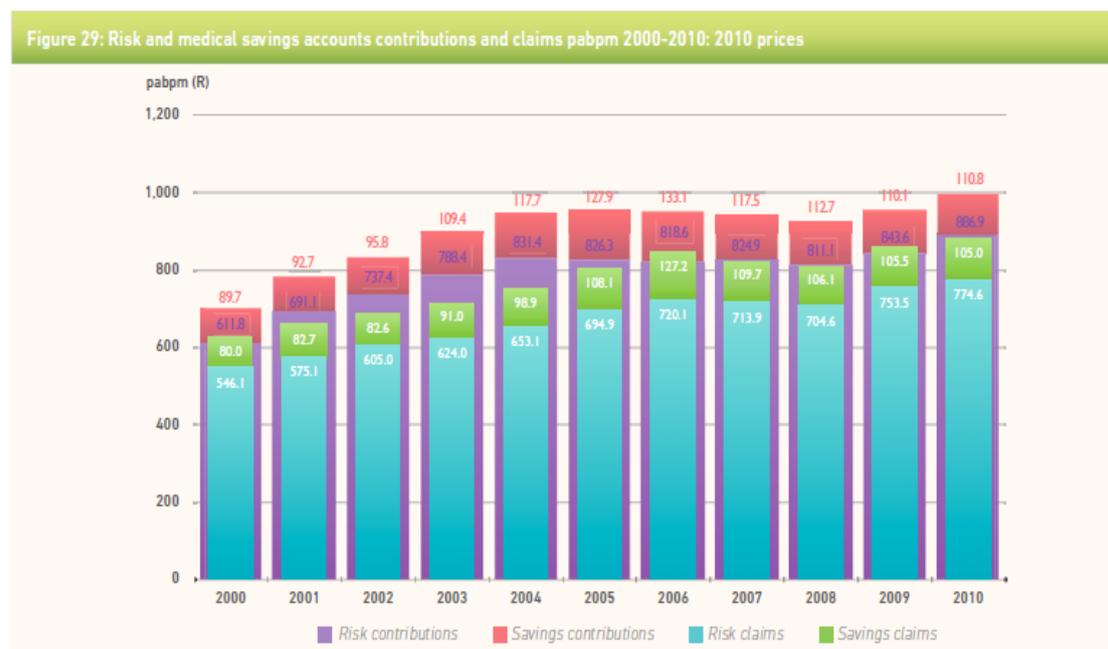
- 6.32.4 If the *past seven years* is taken, i.e. from 2004, the real increase in per capita contributions has been *only 3.7%*.
- 6.32.5 Contribution increases have in reality been stable for an extended period, i.e. from 2002. This coincided with the implementation of the regulator for medical schemes (begun in 2000), the CMS, which was able to better manage scheme costs. Given this, the central thrust of the case made regarding the sustainability of medical schemes in the Green Paper is false and bears no relation to reality.
- 6.33 *The use of such evidently inaccurate information in a Green Paper is negligent for three reasons:*
- 6.33.1 *Its central role in driving key policy recommendations;*
- 6.33.2 *The fact that the accurate information is publicly available and also reported officially to the Minister of Health, the Department of Health, and Parliament every year; and*
- 6.33.3 *It misleads government and non-government actors who rely on the face value of the Green Paper as a basis for providing an informed response.*
- 6.34 *As this information is contained within the problem statement it directly affects the ultimate policy recommendations. It also reflects poorly on the work being carried out by the Department of Health which should be of a far higher standard after apparently working on this framework for more than two years.*

Figure 6.7: Council for Medical Schemes Reported Information on Benefit Costs for the period 1997 to 2010 (snapshot from report)



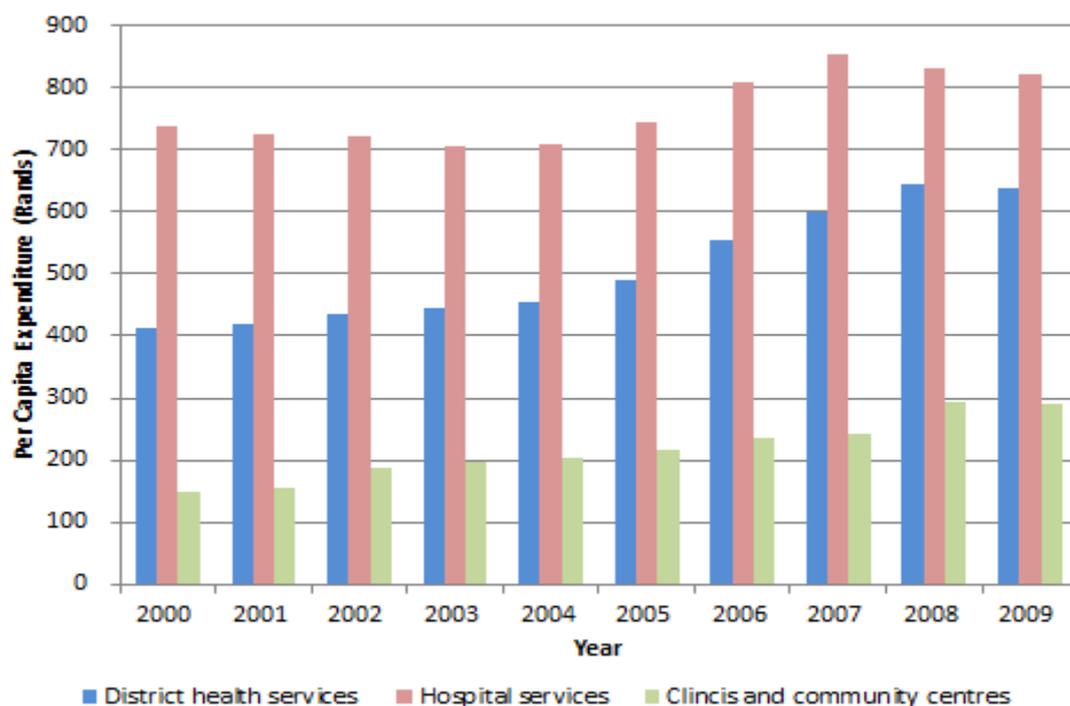
Source: Council for Medical Schemes, 2011.

Figure 6.8: Risk and Savings Account Contributions and Claims for the period 2001 to 2010 (2010 prices) (snapshot from report)



Source: Council for Medical Schemes, 2011.

Figure 6.9: Per capita public health expenditure on hospitals, clinics and community centres, and health districts from 2000 to 2009 (2009 prices)



Sources: Budget information from the provincial budget statements; real values were obtained using the consumer price index and the wage index.

- 6.35 The reliance on the inaccurate cost information leads the Green Paper to conclude that the private sector is in such crisis that it will cease to be viable within the “*medium-term*”.

“Similarly to the public health system, the private sector has its own problems albeit these are of a different nature and mainly relate to the costs of services. This relates to the pricing and utilization of services. The high costs are linked to high service tariffs, provider-induced utilization of services and the continued over-servicing of patients on a fee-for-service basis. Evidently, the private health sector will not be sustainable over the medium to long term.”⁹⁷

- 6.35.1 Here the Green Paper appears to assert that the private health system is *systematically unstable*, an evident requirement to make a case for its absorption into the public system (through the NHI mechanism).

- 6.35.2 However, although there are cost and risk-pooling problems in the medical schemes system, both of which are avoidable through properly considered government interventions (see **box 6.8** for the position of the World Health Organisation), the system is sustainable and not in crisis.

- 6.35.3 Although sustainable, the medical schemes system exhibits standard problems which can only be mitigated through proper regulation. These include, but are not limited to, cost. Unregulated health insurance markets also systematically exclude persons with poor health status. The standard response is to restrict the ability of health insurers to risk-rate (charge premiums on the basis of health status), and to risk-select (choose whom to cover based on their health status).

- 6.35.4 This is achieved through the introduction of risk-equalization (see **box 5.8**), open-enrolment (which removes the ability to risk-select from schemes, mandatory minimum benefits (which removes the ability of schemes to indirectly discriminate using health benefit design), and community rating (which removes a scheme’s ability to set premiums *on the basis of health status*).

- 6.35.5 South Africa’s system however presently lacks *a complete system of mechanisms* to eliminate avoidable risk-selection and manage costs.

- 6.35.6 *Government’s failure to address these problems has contributed directly to rising costs and the exclusion of vulnerable groups.* (See **box 6.8** for the position of the World Health Organisation in their own words). The **Medical Schemes Amendment Bill of 2008** would have addressed many of these concerns, but was inexplicably not debated or passed.

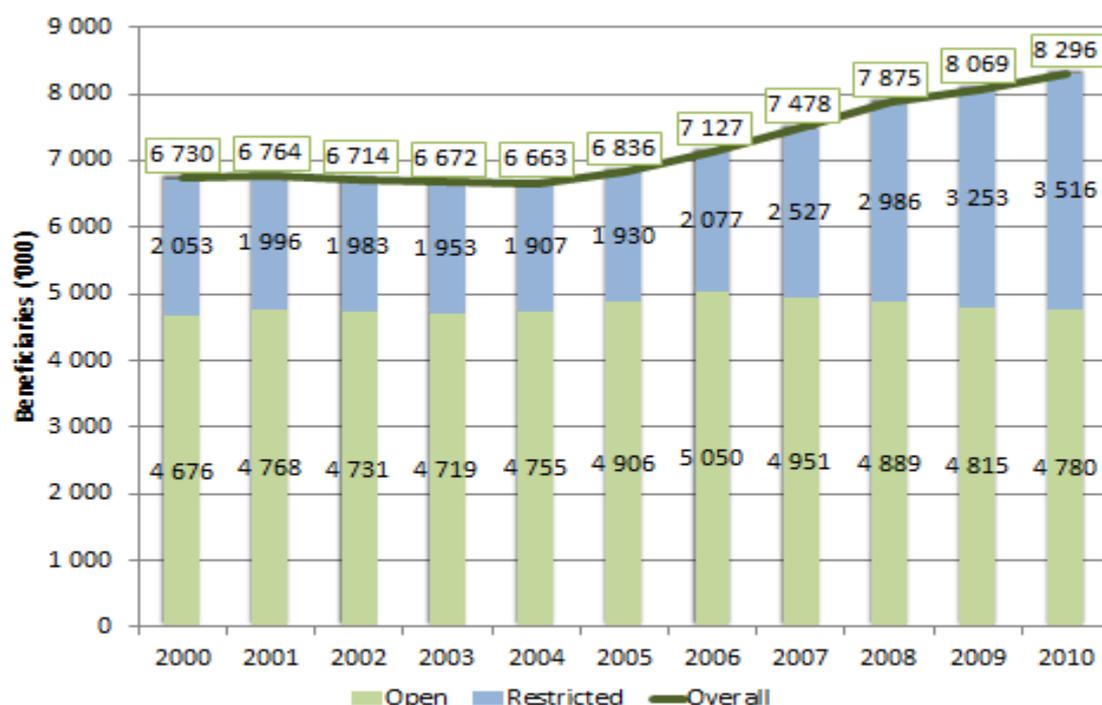
- 6.35.7 *Risk pooling and cost failures within the medical schemes system, to the extent that they exist, therefore arise predominantly as a consequence of a failure of the Government to act.*

⁹⁷ GP, par 15, p.7.

6.35.8 *Although the private sector is characterized by high relative costs, its sustainability is plainly not in question. There is no evidence of any expenditure blow-out in the system (figure 6.2) and membership continues to rise (figure 6.4).*

6.35.9 *The failure of Government to address cost and risk-pooling problems, while not affecting the sustainability of the system, harms the prospects of individuals and families who fall through the resulting avoidable and predictable cracks.*

Figure 6.10: Medical scheme membership from 2000 to 2010



6.36 The Green Paper's blind spot on medical scheme risk-pooling considerations may arise from the implicit view that the establishment of a one-size-fits all health system will suffice and replace every alternative funding source in South Africa. However, if this proves not to be feasible (which is very likely), it would be *irresponsible* of government not to protect people through the full range of feasible mechanisms, e.g. free tax-funded public provision, medical schemes, and social insurance funds. This approach is explicitly supported by the World Health Organisation (see **boxes 6.8** and **6.9**).

6.37 *It is however quite plausible that the Department of Health lacks the capacity to develop a coherent policy framework for the contributory system. This problem in fact may be systemic given that its priority focus is on service delivery rather than insurance mechanisms. Consideration consequently needs to be given to a consolidation of insurance functions into a specialist department with the required capabilities.*

Box 6.8: World Health Organisation on Risk-pooling Arrangements

“Larger is better for pooling and purchasing. But economies of scale show diminishing returns and, beyond a critical size, marginal benefits may be negligible. The argument for large pools is therefore not an argument for single pools when multiple pools can exist without fragmentation, and when their size and

financing mechanisms allow for adequate spreading of risk and subsidization of the poor.

“Health system policy with regard to pooling needs to focus on creating conditions for the development of the largest possible pooling arrangements. Where a particular country for the moment lacks the organizational and institutional capacity to have a single pool or large pools for all citizens, policy-makers and donors should try to create the enabling conditions for such pools. Meanwhile, policy-makers should promote pooling arrangements whenever possible, as a transitional stage towards the future aggregation of pools.

“Even small pools or pools for segments of the population are better than pure out-of-pocket financing for all. Opposing or neglecting such arrangements until the capacity exists for the establishment of an effective single pool has two drawbacks. It deprives consumers of improved protection. And it may prevent the state from regulating such initiatives and steering them towards future large or single pool arrangements. Introducing regulations such as community rating (adjusting for the average risk of a group), portable employment-based pooling (insurance that a worker keeps when changing jobs) and equal minimum benefit packages (access to the same services in all pools), in addition to protecting members of the pools, may pave the way for larger pooling in the future.”

“However, competition among pools is not entirely bad. It can increase the responsiveness of pooling organizations to their members and provide an incentive for innovation. It can also offer incentives for reducing costs (to increase market share and profits), for example through mergers, as in the reform of the quasi-public health insurance organizations (Obras Sociales) in Argentina in 1996. Lack of competition meant that the administrators were little concerned about high administrative costs and small benefits for their members, as they had in any case a captive group of contributors. Competition and the resulting mergers, together with explicit subsidies for low-income beneficiaries, have allowed members of small pools to join larger pools and obtain better benefits for the same level of contributions.”

World Health Organisation, 2000, p.103.

6.38 The incorrect emphasis on high year-on-year increases is repeated in the text, with the hectoring tone seeking to frame the problem of cost as one deriving from conduct. Cost problems within the health system are however primarily systemic and require *smart interventions* that achieve containment by leveraging off commercial imperatives rather than seeking to dull them (which usually occurs with simple administered price approaches)⁹⁸.

6.39 The language of the paper appears out of step with the sophistication required for such interventions, with no policy proposed apart from broad declarations that the private healthcare sector has to be “*radically transformed*”.

⁹⁸ The Department of Health has largely failed to successfully implement an administrative price system (the so-called reference price list or RPL). This failure resulted from the lack of technical skills required to carry out the task together with an inability to comply with stringent requirements of administrative fairness. The resulting court action ended the process.

“This means that the private healthcare sector will have to accept that the charging of exorbitant fees out of all proportion to the service provided have (sic) to be radically transformed.”⁹⁹

- 6.39.1 As already noted, any excessive cost increases, to the extent that they have occurred, *directly result from the failure of Government to implement reasonable cost management measures, many of which have been on the table since 2004.*
- 6.39.2 Despite the exaggerated language used in this paragraph no specific proposals are made anywhere in the Green Paper on what is to be done to *“radically transform”* the fee setting arrangements.

Box 6.9: World Health Organisation on Regulating Private Health Insurance

“Often, as was the case with unregulated private health insurance in Argentina until 1996 (23), private insurance responds to consumer demand by focusing benefit packages on low-cost and high frequency interventions, and excluding very high-cost and low frequency interventions (catastrophic events) which are most appropriately included in pooling arrangements. Regulating minimum benefits for all members, including coverage of catastrophic events by each fund or through re-insurance, is necessary in these circumstances.”

World Health Organisation, 2000, p.111.

Distribution of Financial and Human Resources (page 10)

- 6.40 Consistent with the view expressed in the Green Paper that the private health sector is a cause of inequity in South Africa, various declarations are made regarding per capita spending differentials, and health workforce differentials. Mostly without any references or accurate technical analysis.
- “The maldistribution of healthcare resources described above leads to a skewed distribution of key healthcare professionals in favour of the private sector.”¹⁰⁰*
- 6.40.1 The references to “above” in this paragraph apparently refer to the high costs in the private sector discussed under the heading *“Healthcare Expenditure in South Africa”*.
- 6.40.2 As noted earlier the concept of *“resource distribution”* cannot be conflated with *“high costs”*. This language attempts to make an equity-related case based on high private sector costs as *it is implied that high private costs result in an unequal distribution of critical health care services between the public and private sectors.*
- 6.40.3 Higher expenditure in the private sector resulting from higher unit costs have *little* to do with the distribution of resources between the public and private sectors or poor health outcomes in the public sector.

⁹⁹ GP, par 27, p.10.

¹⁰⁰ GP, par 29, p.10.

- 6.40.4 Medicines and health personnel merely cost more in the private sector which also uses more expensive and less cost-effective models of service provision. Expenditure cannot therefore be equated with the availability of resources (health professionals and medical consumables and equipment).
- 6.40.5 For the sentence to make sense a case must be made to demonstrate the *transmission mechanism* whereby someone spending their own income on medicines or medical equipment stopped the state from obtaining medicines and equipment for someone without adequate income. It is however not possible to reach such a finding on rational grounds *as these resources are not constrained within a zero-sum game*.
- 6.40.6 With respect to health professionals, the state has shown ample capacity to attract staff when it has budget (see **box 6.10** and **figure 6.11**).
- 6.40.7 South Africa's private sector per capita expenditure is also well below the per capita cost of public health systems in high-income countries (**figure 6.12**). Higher levels of health expenditure will always occur where the resource constraints are less, as with higher income groups and countries.

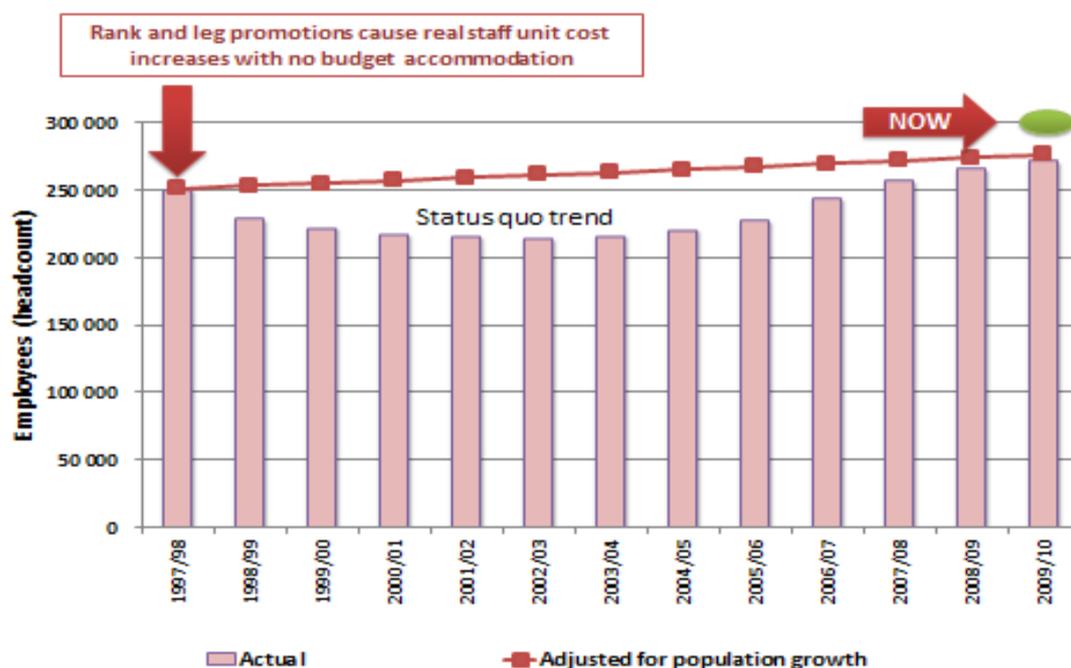
Box 6.10: Ability of Government to Attract Health Professionals

“The reductions in staff correlate with periods of budget austerity, with growth correlated with real increases in budget. This shows that public health staffing levels reduced due to constrained budgets and increased unit costs rather than from any other cause (such as an increase in the private sector). It also shows that the public system can attract staff back if improved budgets are allocated.”

Development Bank of South Africa, 2008, p.20.

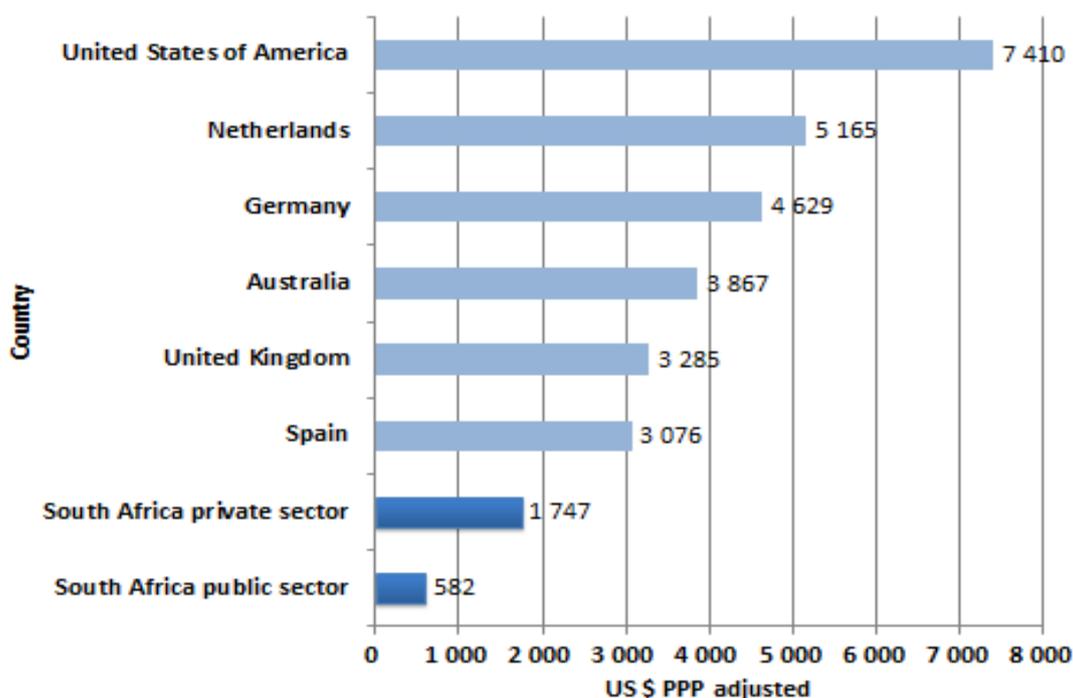
This comment relates to **figure 6.11** below which is an updated version of the figure 8, p.19, of the original report and to which this comment refers.

Figure 6.11: Public sector headcount trends from 1997/98 to 2009/10



Source: Updated version of the data presented in the report Development Bank of South Africa, 2008, p.19 (figure 8). The data comes from Persal, the government payroll management system.

Figure 6.12: Per capita health expenditure in industrialized countries compared to South Africa's public and private sectors (2009)



Source: Based on WHO, 2011. [<http://www.who.int/nha/country/zaf/en>].

6.41 Consistent with remarks made in the introduction a case is made that health professionals are not distributed equitably between the public and private systems. No evidence is however provided to support these declarations. A separate pamphlet on NHI was however published by the Department of Health together with the Green Paper which reproduced erroneous numbers previously only published in party political publications on NHI by the ANC¹⁰¹ (see **box 6.11**).

*“Recent estimates show that the ratio of patients to health professionals (specialists, general practitioners, pharmacists) is lower in the private sector than in the public sector.”*¹⁰²

6.41.1 The reference to “recent estimate?” is unacceptably vague for a Green Paper which seeks to base its entire case on a maldistribution of resources.

6.41.2 The listed professionals (in the brackets) oddly exclude nurses which are the backbone of the health system, and are well represented in the public sector relative to the private sector.

6.41.3 Pharmacists do not participate in private dispensaries because of a distorting private sector. The public sector has failed to offer career paths or decent working conditions for them. As a result many leave the public sector and the profession. *Despite this, according to recent estimates, there are more pharmacists in the public sector 3,285 (55.5%)*¹⁰³ *than the private sector 2,631 (45.5%)*¹⁰⁴.

6.41.4 As noted in **par 5.9** above when health professionals are aggregated, 73% are in the public sector and 27% in the private sector. This compares well with the relevant public and private sector catchment populations.

6.41.5 As with earlier sections, therefore, the resource differentials between the public and private sectors are misrepresented.

6.41.6 As to what evidence the Green Paper relies upon, **box 6.11** provides a copy of the human resource information contained in a Department of Health Publication marketing the NHI and published to coincide with the Green Paper. Unlike the Green Paper this pamphlet *produces explicit numbers* to back up the human resource claims. However the numbers do not stand up to scrutiny.

- The reference given for the data (in **box 6.11**) is the *South African Health Review of 2008*. Thus, not only is the data well out of date, but

¹⁰¹ African National Congress, September 2010.

¹⁰² GP, par 20, p.10.

¹⁰³ Sourced from Persal through the Department of Health and applicable to 2010.

¹⁰⁴ Discovery Health and applicable to 2010.

fails even to rely on official sources at the disposal of the Department of Health which should provide accurate information into 2011.¹⁰⁵

- The Green Paper and the NHI pamphlet, both of which are published in September 2011, fail to draw on various published estimates of human resource data made available in October, November, and December of 2010.¹⁰⁶ These studies identify generally accepted shortcomings in the data supplied by the professional councils and contained in the South African Health Review. They also provide realistic estimates of the data for the main health professionals. These analyses found substantial differences between the ANC NHI paper published in September 2010¹⁰⁷ and data adjusted to the actual number working in the public sector.
- The catchment populations for the public and private sectors, which are used to determine population to staff ratios, are also naively reflected in the Green Paper as the medical scheme population (for the private sector) and the rest for the public sector. This gives a distribution of 16% using the private sector and 84% using the public sector¹⁰⁸.
- It is unclear why a specialist department such as the Department of Health is unable to present a coherent set of catchment populations on a matter that materially impacts on *the only substantive diagnostic point affecting relative resource allocations to the public and private sectors as well as their core business*.
- The NHI Pamphlet (produced by the Department of Health) however contradicts the Green Paper on catchment populations, but still fails to cite a reference, “*Although nearly 70% of our people depend entirely on public health facilities ...*” (See **box 6.11**). The existence of such an important discrepancy between the Green Paper and the Department of Health NHI pamphlet on the Green Paper plainly *requires clarification*.

¹⁰⁵ This includes the PERSAL data which is the payroll system of the public sector. Although the data requires cleaning to produce accurate estimates, it remains the only source of accurate public sector data on the health system. Private sector information cannot rely exclusively on the official registrations with the various professional councils as many people maintain their registrations after having left the country or stopped working. More accurate information can be obtained from the Practice Code Numbering System maintained in terms of regulations to the Medical Schemes Act (No.131 of 1998) modified for actual billing occurring using a large administrator such as Discovery Health Ltd. This information has been made available to the Department of Health prior to the publication of the Green Paper and the NHI pamphlet.

¹⁰⁶ Three studies by Econex reviewed existing data on workforce numbers for doctors, specialists, and nurses. Econex, October 2010, November 2010, and December 2010.

¹⁰⁷ African National Congress, September 2010.

¹⁰⁸ GP, par 26, pp.9-10.

6.42 To further deepen the case on equity, the Green Paper discusses the expenditure split between the public and private sectors. Again the analysis is very thin, with secondary sources cited (such as National Treasury) suggesting that no primary work went into the production of the Green Paper.

“The 8.3% of GDP spent on health is split as 4.1% in the private sector and 4.2% in the public sector. The 4.1% spend covers 16.2% of the population, (8.2 million people) who are largely on medical schemes. The remaining 4.2% is spent on 84% of the population (42 million people) who mainly use the public healthcare sector (National Treasury: Intergovernmental Fiscal Review)”.¹⁰⁹

6.42.1 Aside from points already raised regarding catchment populations, the unreferenced numbers here do not match existing data and contain material errors of logic.

6.42.2 This quotation explicitly allocates expenditure equivalent to 4.1% of GDP to almost the exact number of medical schemes beneficiaries¹¹⁰ despite the fact that the 4.1% includes out-of-pocket expenditure which *by definition* cannot be attributed to medical scheme coverage.

6.42.3 It should in fact have allocated the 4.1% of expenditure to at least 24% of the population or 12 million people. The Department of Health’s NHI pamphlet would require 15 million people (or 30% of the population).

6.42.4 Medical schemes’ expenditure is in fact equivalent to roughly 3.4% (not 4.1%) of GDP with around 1.5% out-of-pocket (see **figure 6.2**). It is only the former that can be attributed to the 8.3 million medical scheme beneficiaries (the correct number applicable to 2010).

6.42.5 It is not clear where the 4.2% of GDP figure attributed to the public sector comes from, which is not referenced or backed up by any analysis. The World Health Organisation more accurately puts public sector expenditure at 3.4% of GDP in 2009 (**figure 6.2**).

6.42.6 *Irrespective of whether the previously referred to external studies¹¹¹ or most recent analysis (reported in **tables 6.2 and 6.3 and figure 6.13**) is used, the ANC and DOH data materially overstate the resource differential between the public and private sectors and the implications thereof.*

Table 6.2: Population to staff ratios in the public and private sectors: a comparison between the estimates in the DOH NHI Pamphlet, the ANC NHI proposal, and ECONEX

¹⁰⁹ GP, par 26, pp.9-10.

¹¹⁰ The Council for Medical Schemes Annual Report puts the number in 2010 at 8,315,718 and in 2009 at 8,068,505. This information was available prior to completion of the Green Paper. It is unclear where the number of 8,200,000 used in the Green Paper comes from.

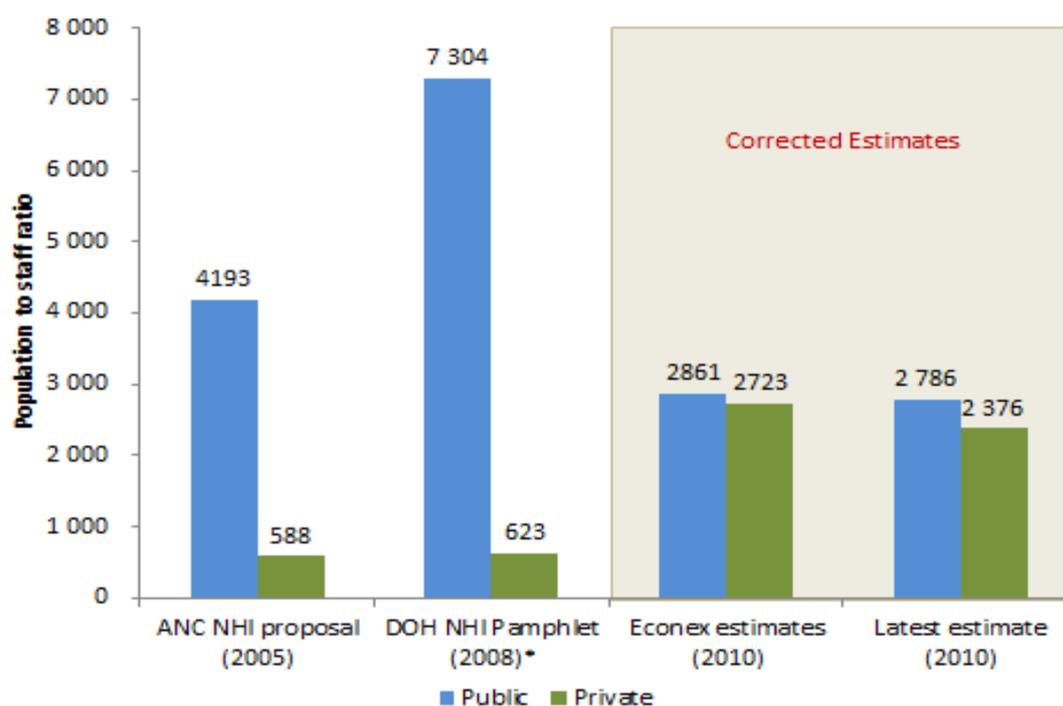
¹¹¹ Econex, October 2010, November 2010, and December 2010.

	Public	Private
General Practitioners		
ANC NHI proposal (2005)	4,193	588
DOH NHI Pamphlet (2008)*	7 304	623
Econex estimates (2010)	2,861	2,723
Latest estimate (2010)	3,301	1,561
Specialists		
ANC NHI proposal (2005)	10,811	470
DOH NHI Pamphlet (2008)*	No estimates provided	
Econex estimates (2010)	9,581	1,767
Latest estimate (2010)	8,559	1,921

*Calculation based on the proportions given.

Source for “actual”: All the estimates took account of estimates from Persal, Medical scheme billing information, Colleges of Medicine of South Africa, and Econex (see **table 6.4**).

Figure 6.13: Comparison of the ANC and DOH NHI pamphlet population to staff ratios with estimates corrected to actual numbers



Source for “actual”: All the estimates took account of estimates from Persal, Medical scheme billing information, Colleges of Medicine of South Africa, and Econex (see **table 6.4**).

- 6.43 The human resource information produced in the NHI pamphlet by the Department of Health (**box 6.11**) however raises serious concerns about the integrity of the authors. Under a heading “*Where our health professionals work*” numbers are presented deliberately to create the impression that the people not working in the public sector are working in the private sector. The information carried in the chart is prefaced by the statement “*The chart below shows the unequal spread of other types of health professional.*”
- 6.44 However, when the data is referred to (using the example of general practitioners) it states “*only three out of every 10 doctors on the professional register work in public hospitals and clinics*” [underline added].
- 6.45 The unqualified reference to the *professional register*, which is repeated throughout, together with the introductory statements creates the impression that people not working in the public sector on the professional register are actually working in the private sector. *It appears plain that this was deliberately designed to mislead.* Especially as the critique of these numbers was made very public in response to similar numbers published in the ANC National General Council meeting document of September 2010.¹¹² Importantly, data provided in the human resource strategy published on 11 October 2011 contradicts the information provided in the pamphlet.¹¹³
- 6.46 **Table 6.3** provides a comparison of accurate estimates of health professionals working in the public and private sectors with figures published by the Department of Health (**box 6.11**). *These differ substantially from those derived from the professional register.*

¹¹² Tamar Kahn, 6 October 2010.

¹¹³ Department of Health, 11th October 2011.

Table 6.3: Department of Health reported human resources in the public and private sector versus actual estimates based on Persal, analysts and medical schemes

Health professionals	DOH		Actual (corrected)				
	Public	Private	Public	Private	Total	Public	Private
Doctors	30.0%	70.0%	11 664	7 366	19 030	61.3%	38.7%
Specialists	35.0%	65.0%	4 365	5 709	10 074	43.3%	56.7%
Dentists	10.0%	90.0%	828	2 133	2 961	28.0%	72.0%
Professional nurses	40.0%	60.0%	55 309	35 956	91 265	60.6%	39.4%
Enrolled nurses	50.0%	50.0%	25 338	14 085	39 424	64.3%	35.7%
Pharmacists	10.0%	90.0%	3 285	2 631	5 916	55.5%	44.5%
Physiotherapists	20.0%	80.0%	970	1 866	2 836	34.2%	65.8%
Psychologists	5.0%	95.0%	600	1 746	2 346	25.6%	74.4%

Source for “actual”: All the estimates took account of estimates from Persal, Medical scheme billing information, Colleges of Medicine of South Africa, and Econex (see table 6.4).

Source for DOH: **Box 6.11.**

Table 6.4: Estimate of nurses for the public and private sectors

	Total on register (2009)	Actual working*	Public**	Private***
Professional nurses	111 299	91 265	55 309	35 956
Enrolled nurses	48 078	39 424	25 338	14 086
Enrolled nursing assistants	62 440	51 201	35 376	15 825
Total	221 817	181 890	116 023	65 867
		Percentage of total working		
Professional nurses		100.0%	60.6%	39.4%
Enrolled nurses		100.0%	64.3%	35.7%
Enrolled nursing assistants		100.0%	69.1%	30.9%
Total		100.0%	63.8%	36.2%

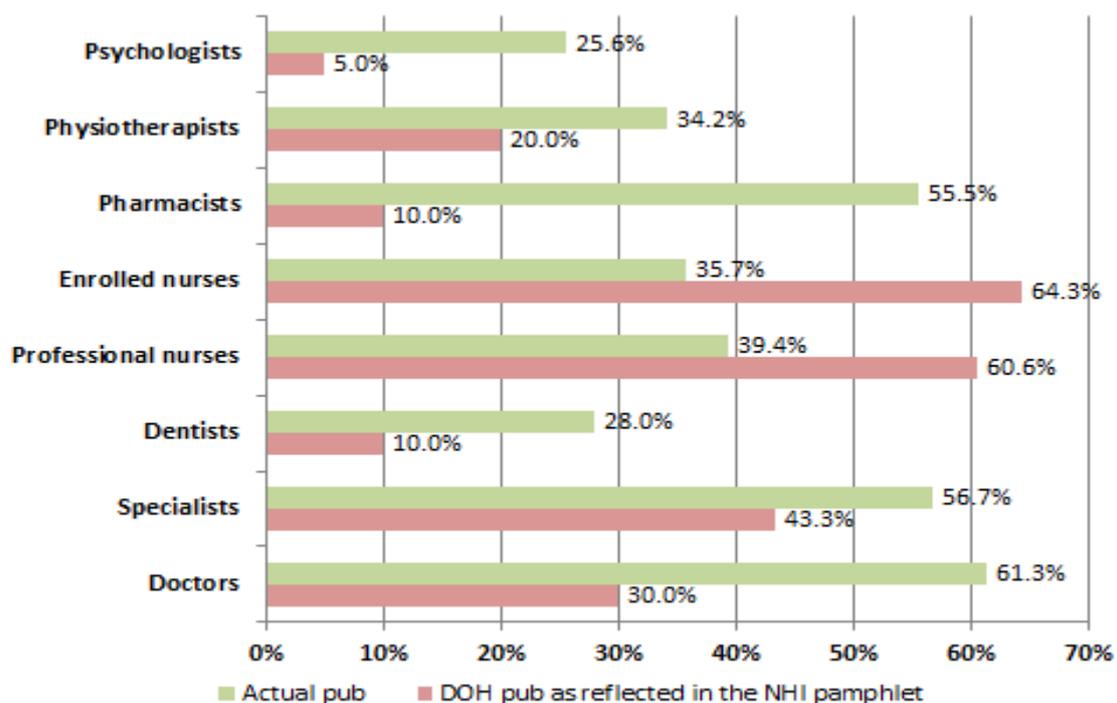
*Adjusted down by 18% in accordance with the work of Econex.

**Based on Persal data applicable to 2010.

***Calculated from the difference of the total actually working and those working in the public sector.

Source: Based on Econex, December 2010.

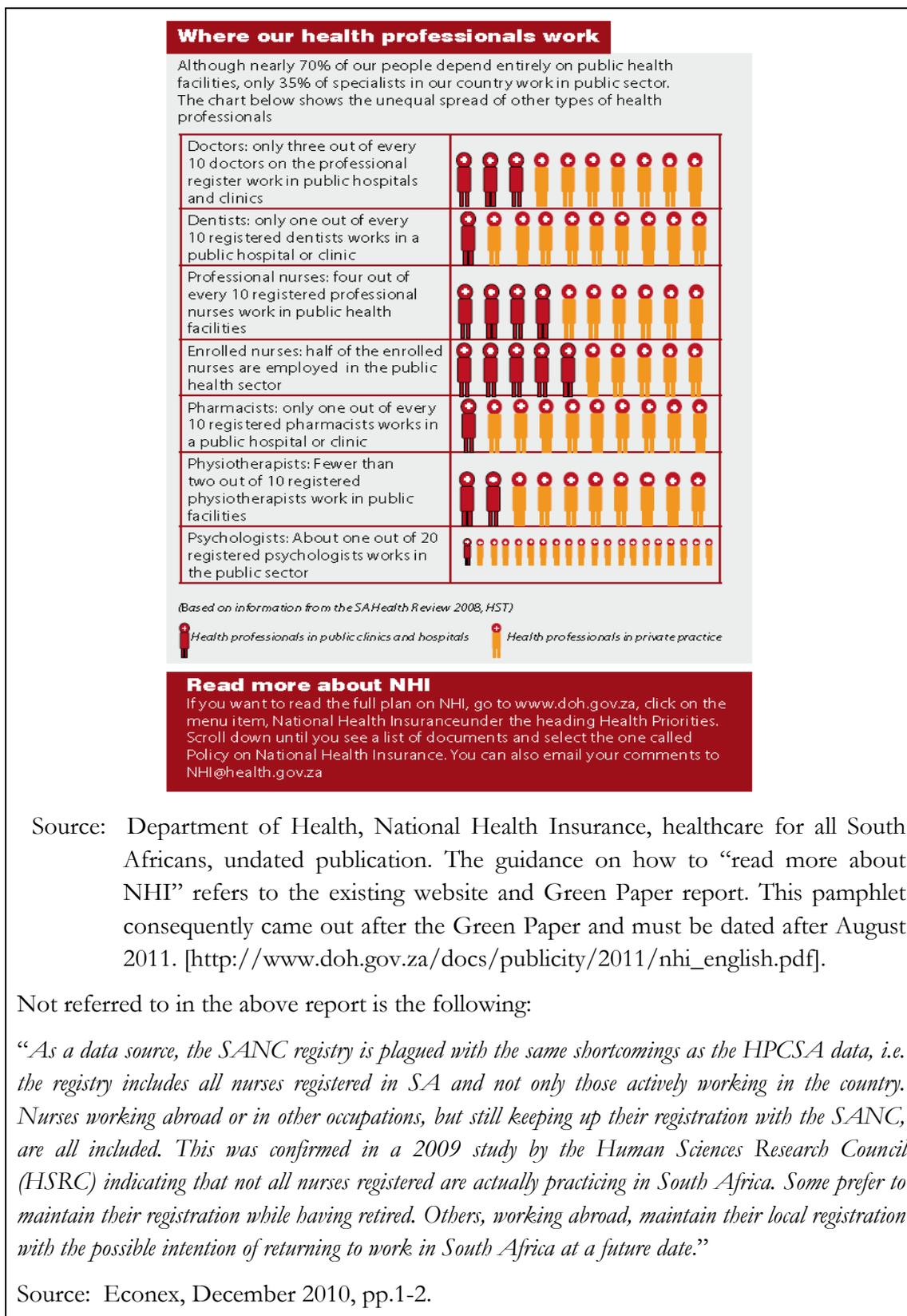
Figure 6.14: Department of Health reported human resources in the public Sector versus actual estimates based on Persal, analysts and medical schemes



Source for “actual”: All the estimates took account of estimates from Persal, Discovery Health, Colleges of Medicine of South Africa, Econex.

Source for DOH: **Box 6.11.**

Box 6.11: Human Resource Information Distributed by the Department of Health as Motivation for National Health Insurance



- 6.47 Whereas human resource variations between the public and private sectors could have fairness implications, expenditure variations mean little as they involve different unit costs resulting mainly from demand-related preferences and poor regulation. The Green Paper however makes the case that per capita expenditure variations indicate equity problems in the health system. This appears to be a central theme in the (implicit)¹¹⁴ business case for the proposed institutional reforms.

“The amount spent in the private health sector relative to the total number of people covered is not justifiable and defeats the principles of social justice and equity. Per capita annual expenditure for the medical aid group has been estimated at R11,150.00 in contrast to public sector dependent population where the per capita annual health expenditure is estimated at R2,766.00. This is not an efficient way of financing healthcare.”¹¹⁵

- 6.47.1 As already discussed, the Green Paper consistently conflates differential costs with resource distributions. Unit cost differentials between the private and public systems do not and cannot by themselves defeat the “*principles of social justice and equity*”. The only reasonable policy conclusion that can be drawn is that consumers may not be receiving value for money in the private sector or that they prefer a more costly configuration of services. *Despite this they may be receiving greater value for money than the superficially cheaper public sector due to the latter’s low productivity levels.*
- 6.47.2 The Green Paper constantly refers to principles of equity and access without ever specifying a concrete normative standard of any form. Merely stating these terms in abstract offers no policy guidance as to what is considered socially fair. *By failing to do so the Green Paper implicitly presumes that any deviation in health expenditure and resource distributions from equal per capita allocations is distributionally unfair.*
- 6.47.3 Unless there is a demonstrable feedback effect on access to healthcare for low-income groups, higher voluntary per capita expenditure on private health is irrelevant in any calculus of equity. Medical scheme contributions are made voluntarily in excess of redistributive tax payments for a relatively well-resourced public health system. The redistributive effects are also magnified through the application of a means test which excludes income earners and their families from free access to public hospital services.

Medical Schemes Industry (page 11)

- 6.48 This section makes out a case that medical schemes are failing, face increased contribution costs, benefit reductions, and are going insolvent. The section

¹¹⁴ As there is no actual business case.

¹¹⁵ GP, par 31, p.10.

however provides no references or evidence despite having official reports with this information to draw on.

*“...over the years many of them [medical schemes] have experienced problems of sustainability. A number of medical schemes have collapsed, been placed under curatorship or merged. They have reduced from over 180 in the year 2001 to about 102 in 2009. This was mainly due to over pricing of health care.”*¹¹⁶

6.48.1 It was the policy of the Department of Health from 1998 to reduce the number of medical schemes¹¹⁷, which were seen as too many to achieve efficiencies in the purchasing of healthcare. This was given effect to through the **Medical Schemes Act No.131 of 1998** and its associated regulations implemented in 1999, whereby minimum membership requirements of 6,000 were placed on medical schemes to remove small unsustainable schemes from the system.¹¹⁸ The process of removal would involve amalgamation with larger schemes or liquidation. Small schemes are typically not viable due to claims variability. (See **box 6.12**).

6.48.2 This, together with the shift away from occupational medical schemes to multi-employer open schemes, began a healthy process of consolidation. This policy-supported and reinforced process has been successful and improved the risk-pooling for members. Large- and medium-sized schemes have therefore largely remained unchanged in number over the period 2000 to 2010, while small schemes have reduced considerably. (See **figure 6.15**).

Box 6.12: Reasons for medical scheme consolidation

“Despite effective monitoring and intervention by the office of the Registrar, the past five years have seen a number of medical schemes failing financially, resulting in liquidations or amalgamations with other medical schemes. This is regarded as inevitable due to the fact that our assessment is that South Africa has too small a medical scheme population to accommodate viably the number of medical schemes that currently exist. In this scenario, sizes of risk pools become too small to spread risk effectively, and medical schemes become unsustainable. A process of natural attrition has therefore led to an overall reduction in the number of medical schemes over the past fifteen years, and this trend has continued in the period under review. From more than 300 medical schemes in 1974, by the end of 2003 there were 149. Between 2000 and 2003, there was a 12.9% decline in the number of registered medical schemes.” (p.11)

“From 2000 to 2003, 26 amalgamations took place and 23 medical schemes were wound-up or

¹¹⁶ GP, par 32, p.11.

¹¹⁷ The author formed part of the process to establish the **Medical Schemes Act No.131 of 1998** and the subsequent regulations. It was the understanding at the time that there were too many small schemes to remain viable.

¹¹⁸ Medical schemes are required to have a minimum of 6,000 members to remain registered. This was introduced through the Medical Schemes Act No.131 of 1998.

dissolved. During the same period, 17 new medical schemes were registered. In virtually every case of an amalgamation or liquidation, we believe that satisfactory arrangements were in place to ensure that members were not unduly prejudiced through unpaid claims or the imposition of new waiting periods by schemes to which they transferred.” (p.11)

“As of 1 January 2006, the Public Service intends to establish its own medical scheme. This will raise particular challenges from a regulatory perspective, as it is likely to result in considerable consolidation of membership giving rise to increased numbers of amalgamations of schemes.” (p.42)

Council for Medical Schemes, 2005, p.11.

- 6.48.3 The consolidation of schemes therefore *has nothing to do with the sustainability of the medical schemes industry*, which has shown considerable improvement in solvency and beneficiary growth from 2000, mainly due to regulatory interventions. The solvency trends were reinforced by the introduction of minimum solvency requirements which had to be phased in to 2005. (See **figure 6.16**).
- 6.48.4 The relationship between pricing (as stated) and scheme consolidation is not clearly motivated. No study or evaluation of the South African health system has shown this to be the case. As pointed out in **figures 6.7** and **6.8**, contributions and *benefit costs have not increased in an unsustainable manner*, and have in fact demonstrated a high degree of consistency since 2002.
- 6.48.5 Were there to be a relationship between *over-pricing* and sustainability in the manner argued, solvency would decline with consolidation, as would beneficiary numbers. In fact the opposite has happened. Solvency has increased consistently to 2005 and then been maintained at healthy levels. Beneficiary numbers have increased to 8.3 million in 2010 and have not declined even following the economic downturn of 2008 (see **figure 6.10**).
- 6.48.6 Consolidation has also been greatly boosted by the establishment of the Government Employees Medical Scheme (GEMS), which grew from zero beneficiaries in 2005 to 1.3 million by 2010. This very successful intervention reversed a 1993 decision which allowed civil servants to choose their own private scheme. The resulting fragmentation of risk pools weakened the overall system. *Since 2006, therefore, GEMS has been the most important driver of scheme consolidation and new membership.*

Figure 6.15: Trend in number of schemes by size from 2001-2010 (snapshot from report)

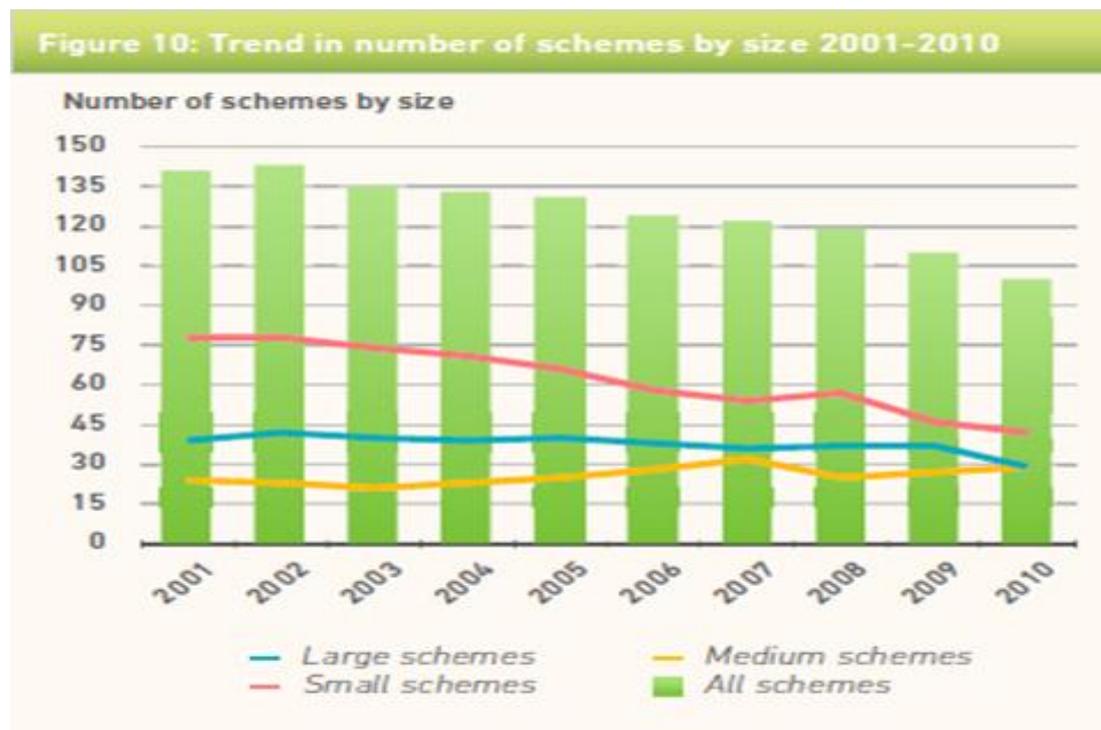
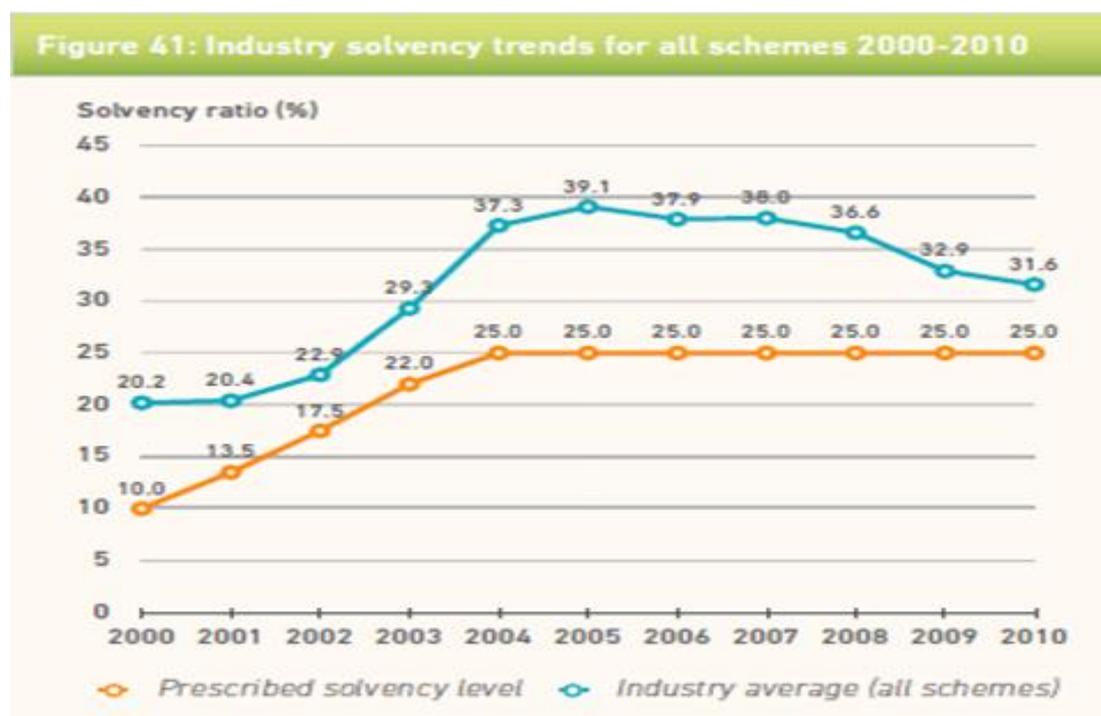


Figure 6.16: Industry solvency trends from 2000 to 2010 (snapshot from report)



Source: Council for Medical Schemes, 2011.

6.48.7 Most curatorship applications have little to do with systemic industry-wide solvency concerns and are related predominantly to regulatory action against improper conduct by board members and unviable schemes due to demographics and scheme size. When a scheme is no longer sustainable, which tends to occur with small schemes, they are either amalgamated with larger schemes or liquidated. Members are transferred to other schemes.¹¹⁹

6.49 Relying upon the factually incorrect information regarding scheme costs, consolidation, and contribution increases the Green Paper makes a number of claims regarding medical scheme behavior. It suggests that the systemic consequence of all the stated negative trends has been that members run out of benefits part of the way through the year. In other words, it is asserted that medical scheme members suffer from reduced social protection as a consequence of the increasing year-on-year costs.

*“In a bid to sustain their financial viability, many medical schemes resorted to increasing premiums, in many cases at rates higher than CPIX. When this was not successful, the schemes resorted to decreasing members benefits. This has led to an increasing number of members exhausting their benefits midyear or towards the end of the year.”*¹²⁰

6.49.1 It is not clear where this information or analysis comes from. As noted earlier, this is contradicted by official reports submitted to the Minister of Health and available in the public domain. There is no evidence of the kind of contribution increases indicated. As noted in **figure 6.17**, the CMS explicitly states that *“Our research shows that since the year 2002 medical scheme contributions have been similar to inflation.”* Related information is also provided in **figures 6.2, 6.8 and 6.18**.

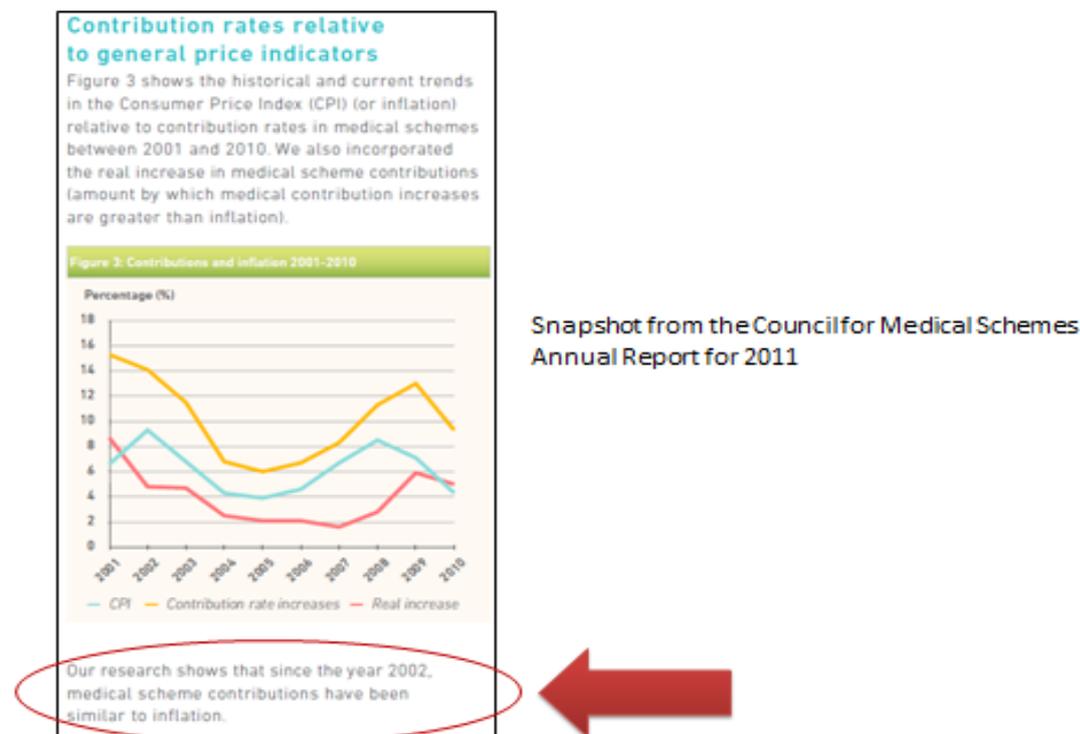
6.49.2 Aside from the absence of above-inflation contribution increases, there is also no evidence provided of the *benefit shortfalls* indicated. This assertion in the Green Paper appears to arise from a naïve understanding of how benefits within medical schemes are actually determined.

6.49.3 It should be noted that where medical schemes offer risk-pooled benefits, which constitute the *bulk of benefits covered*, benefits are typically not exhausted. Non-risk-pooled benefits (such as medical savings accounts) are equivalent to an excess (self-insurance) arrangement in standard insurance vehicles and can be exhausted. Many of these benefits are high-frequency low-cost events which are normally left out of insurance as they are technically uninsurable and impose minimal hardship on higher income members when funded out-of-pocket.

¹¹⁹ The author has first-hand knowledge of these procedures.

¹²⁰ GP, par 33, p.11.

Figure 6.17: Council for Medical Scheme’s evaluation of contribution increases from 2001 to 2010 (snapshot from report)



Source: Council for Medical Schemes, 2011.

- 6.49.4 In addition a system of mandated minimum benefits (which focus on catastrophic risks) compels schemes to risk-pool (insure) for important health benefits that should never be exhausted. (Also see **box 5.11** for the World Health Organisation view on mandatory minimum benefits and their need to focus on catastrophic expenses).
- 6.49.5 *The Green Paper appears to be unaware, or have a naïve understanding, of how medical schemes are run and regulated. This is a concern as the Department of Health, as a specialist department, should demonstrate strong technical competence in this area. Not only is the baseline information used to form this view incorrect, but the understanding of how medical schemes operate is uninformed. This is concerning as these conclusions are directly responsible for the Green Paper’s policy prescriptions.*
- 6.50 Continuing with the theme of unsustainable medical schemes, the Green Paper asserts that non-health care expenditure (mainly various forms of administrative expenses) by medical schemes, are the direct cause of “*huge wage inflation*”. Although no distinction is made between static levels of cost or year-on-year increases the reference to *inflation* suggests there is a concern with annual cost changes.

*“This has been worsened by non-health related exorbitant administrator’s fees, oversupply of brokers, disproportionate to the membership, and managed care costs. As a result, increased deductions of medical scheme contribution (sic) from member’s salaries have resulted in huge wage inflation.”*¹²¹

- 6.50.1 The basis for the assertions made regarding non-health medical schemes expenses are not provided and are contradicted by official reports available to the Minister of Health and the general public.
- 6.50.2 **Figure 6.18** shows that real per capita non-health expenses in 2010 are virtually the same as in 2002. There were *virtually no real increases since 2002*, which is when the new regulatory regime began to take effect.
- 6.50.3 The statement that medical schemes contributions and non-health costs have *“resulted in huge wage inflation”* cannot be inferred from the facts and is *completely untrue*.
- 6.50.4 If medical scheme contributions have not increased significantly in real terms over a ten year period, they cannot possibly have caused *“a huge increase in wage inflation”*.
- 6.50.5 *The incorporation here of fabricated information (while presented as factual) again raises questions about the integrity of the process. Firstly, the inaccuracies indicate that the policy framework is not well researched. This raises questions about the ultimate policy prescriptions and whether Government truly understands the terrain. Secondly, and more seriously, as with the workforce-related information, the errors appear to be deliberate.*
- 6.51 Drawing together the various threads of its analysis of medical schemes the Green Paper concludes that the cost escalations result from the uncontrolled commercialism described by the World Health Organisation. This conclusion, with the purported authority of the World Health Organisation, is meant to assert that private forms of funding healthcare are systemically unstable.
- “However, it is evident that the above did not improve or have worsened the cost-escalation because at the centre of this problem is the uncontrolled commercialism of healthcare as described by the World Health Organisation.”*¹²²
- 6.51.1 Not only are the conclusions contained in this sentence not consistent with the facts, as noted above, but the Green Paper inaccurately attributes views to the World Health Organisation. (See **para 6.11** above).
- 6.51.2 *This fundamentally impacts on the policy prescriptions of the Green Paper.*

¹²¹ GP, par 33, p.11.

¹²² GP, par 34, p.11.

Figure 6.18: Gross per capita contributions separating out gross claims and gross non-healthcare claims for the period 2000 to 2010 (snapshot from the report)

Table 24: Trends in contributions, claims and non-healthcare expenditure 2000-2010: 2010 prices						
	Gross contributions		Gross claims		Gross non-healthcare	
	pabpa R	% growth	pabpa R	% growth	pabpa R	% growth
2000	8 168.1	6.4	7 290	6.1	1 101.1	28.2
2001	9 218.2	12.9	7 726	6.0	1 341.1	21.8
2002	9 810.8	6.4	8 090	4.7	1 340.7	0.0
2003	10 570.4	7.7	8 411	4.0	1 460.3	8.9
2004	11 175.5	5.7	8 845	5.2	1 547.1	5.9
2005	11 224.4	0.4	9 445	6.8	1 661.7	7.4
2006	11 003.6	-2.0	9 769	3.4	1 588.5	-4.4
2007	10 954.0	-0.5	9 552	-2.2	1 508.7	-5.0
2008	10 736.6	-2.0	9 400	-1.6	1 410.3	-6.5
2009	11 138.4	3.7	10 015	6.5	1 419.7	0.7
2010	11 703.9	5.1	10 300	2.9	1 402.9	-1.2
Since 2000		43.3		41.3		27.4

pabpa = per average beneficiary per annum

6.52 To further bolster the case made it is asserted that the Competition Commission implicitly supports the foregoing analysis.

“The intervention by the Competition Commission was also clearly based on the understanding that the scenario is as mapped out above.”¹²³

6.52.1 It is unclear what interventions of the Competition Commission are referred to. For this statement to have been included in the Green Paper the Competition Commission should have acquiesced or produced some publicly available report of substance.

6.52.2 *There is however no analysis produced by the Competition Commission that supports the positions of the Green Paper.* Furthermore, the only official document produced on private sector costs, that of the CMS in 2008, raises a completely different set of issues.

6.52.3 *There is no evidence that the Competition Commission has ever or would ever agree with the factually inaccurate views provided in this section of the Green Paper.*

6.53 The Green Paper suggests the need for a policy response based on its analysis of medical scheme costs, contribution costs, and scheme consolidation.

6.54 *“Clearly something completely different is needed in the South African health sector.”¹²⁴*

¹²³ GP, par 34, p.11

¹²⁴ GP, par 34, p.11

6.54.1 Given that no single statement in this section is accurate, no coherent policy conclusions can be drawn.

6.54.2 *It is clear that the Department of Health, or the drafters of the Green Paper, need to put more effort into their technical work before drawing policy conclusions.*

Out-of-Pocket Payments and Co-payments (page 11)

6.55 This section of the Green Paper contains no evaluation, making comment difficult. Most of the paragraphs are general comments without any policy relevance.

6.56 For instance, paragraph 37 refers to some research on uninsured people by Meng but hangs in the air without any clarification of context justifying its relevance to the Green Paper.¹²⁵

“Evidence has demonstrated that those who are not adequately covered by any form of health insurance are among others women; children; the elderly; low income groups etc. It is for this reason that coverage should be extended to all these populations (Meng, 2011).”¹²⁶

6.56.1 The article by Meng *et al*¹²⁷, published in Health Policy and Planning in September of 2010 (advance publication) provides a review of strategies to extend *health insurance* coverage to those without alternative protection (such as free publicly provided care through the state).

6.56.2 Despite reviewing numerous developed and developing countries the article never mentions South Africa. This is because it discusses the extension of health insurance mechanisms, while South Africa has a free general tax funded public health system, i.e. *a completely different mechanism*.

6.56.3 *The reference to this article and the comment made about coverage is essentially irrelevant and adds no value to the Green Paper.*

6.56.4 *Moreover, this serves to confirm the point made in **par 5.11.7** that the drafters of the Green Paper have confused the context within which out-of-pocket payment issues are raised. Given the vast literature on these matters, this again raises questions about the quality of the work performed in developing the Green Paper.*

6.57 As noted earlier, South Africa’s levels of out-of-pocket payments are in fact normal from an international context (see **figure 6.3**). The levels are unlikely to change materially irrespective of any health systems reform.

¹²⁵ GP, par 37, p.12

¹²⁶ GP, par 37, p.12

¹²⁷ Meng Q *et al*, 2010, pp.1-12.

7. POLICY RECOMMENDATIONS¹²⁸

Policy rationale

- 7.1 Policy recommendations should derive from a diagnostic with clear and unambiguous findings. Although no explicit diagnostic is provided in the Green Paper there is belatedly a problem statement. However, as the problem statement relies substantially on factually inaccurate information *the line between the diagnostic, findings and policy prescriptions is irretrievably broken.*
- 7.2 National Health Insurance (NHI) is introduced on p.15 of the Green Paper without any preceding analysis indicating what it is, or what relationship it has with the diagnostic. As the term NHI does not accurately describe any health system these sections are confusing. Similar concerns apply to the opening sections of the Green Paper.
- 7.3 The rationale for NHI is merely a declaration, unconnected to any systematic evaluation of the health system and the causes of its poor outcomes.
- “The rationale for introducing National Health Insurance is therefore to eliminate the current tiered system where those with the greatest need have the least and have poor health outcomes.”¹²⁹*
- 7.3.1 Aside from the absence of any clarification of what NHI is, there are many health systems mechanisms, including South Africa’s existing ones, which address these objectives.
- 7.3.2 *To make a sensible case for reform the Green Paper needs to indicate how the proposed mechanisms rationally achieve the stated objectives better than other mechanisms, including what exists.*
- 7.4 The above rationale is bolstered with reference to a number of *objectives* which are nevertheless embedded within the existing health system through existing mechanisms.
- “Such a system will provide a mechanism for improving cross-subsidization in the overall health system, whereby funding contributions would be linked to an individual’s ability-to-pay and benefits from health services would be in line with an individual’s need for care.”¹³⁰*
- 7.4.1 This framework already exists and is achieved both through the public system and medical schemes. All people pay taxes on an ability-to-pay basis. Furthermore, some people pay taxes while being excluded from state hospital benefits – increasing the vertical subsidies involved.
- 7.4.2 Given the absence of a technical diagnostic explaining shortcomings with the current system, it is unclear what is to change and why.

¹²⁸ Covers the section headed “National Health Insurance”.

¹²⁹ GP, par 50, p.15.

¹³⁰ GP, par 50, pp.15-16.

- 7.5 *“NHI will ensure that everyone has access to a defined comprehensive package of healthcare services. The covered healthcare services will be provided through appropriately accredited and contracted public and private providers and there will be a strong and sustained focus on the provision of health promotion and prevention services at the community and household level.”*¹³¹
- 7.5.1 It is unclear how this differs from the existing situation where services are provided through the state either directly or (at least potentially) on contract with the private sector.
- 7.5.2 The emphasis on accredited services only has meaning if a *truly independent body* is to accredit and maintain standards. However, the proposed Office of Health Standards Compliance (OHSC) does not meet this requirement as it will be conflicted as all appointments are to be political.
- 7.5.3 The sustained focus on the provision of *“health promotion and prevention services”* poses the risk that acute care services at the primary care level will be de-prioritised. The poorly managed de-prioritization of hospital services, in order to fund primary care services, carried out from 1994 severely harmed the public hospital system.
- 7.5.4 There is some risk that a poorly informed strategy could see funds wasted on programmes that are not cost-effective or well-run while functional public services are downgraded. Given historical experience this result is more likely than not.
- 7.5.5 *The allocation of resources to new programmes needs to be evidence-based and implemented together with strong management, proper supervision, and competent monitoring and evaluation mechanisms. These are presently not in place and the Green Paper makes no provision for them.*

Principles of National Health Insurance (page 16)

- 7.6 The principles outlined in the Green Paper apply to any health system. As the public system will never cover the entire population for all services and conditions, *a more coherent set of principles needs to be framed encompassing the overall system including regulated medical schemes.*
- 7.7 As medical schemes are a fact of life in perpetuity, and provide important social protection to income earners, it is critical that the system be properly regulated, in accordance with the recommendations of the World Health Organisation. *If the Department of Health fails to see medical schemes as part of their brief, the function should be removed from them and shifted to a department more able to perform this function.* This will at the very least ensure that system is properly regulated.

¹³¹ GP, par 51, p.16.

- 7.8 The principle of “*social solidarity*”¹³² typically refers to ties between people and communities. These principles are already in place in South Africa with respect to healthcare. *The system is failing in delivery and not solidarity.*
- 7.9 If this Green Paper is anything to go by, the principle of “*Effectiveness*” which is to be achieved through “*evidence based interventions*” has a long way to go.¹³³ *This Green Paper itself provides no actual evidence to justify a single proposal.*
- 7.10 Missing from the principles are the requirements for *good governance and accountability*, normally crucial to the institutional integrity of health and social security systems.¹³⁴ *This is also noticeably missing from the problem statement despite its central role in the systemic corrosion of the public health system.*

Objectives of National Health Insurance (page 18)

- 7.11 The objective of Universal Coverage is supported. This however exists at present, although is *compromised by the poor performance of the public system.*
- 7.12 Universal coverage within developing countries is invariably achieved through the use of more than one mechanism, e.g. public delivery, social insurance funds and regulated private insurers.¹³⁵
- 7.13 The listed objectives in par 55 are however out of place as they primarily refer to *mechanisms* rather than *objectives*. For instance “*pooling risks*” is an objective. Through “*a single fund*” is a mechanism. To “*procure services on behalf of the entire population*” is a mechanism and not a systems objective. In fact these are really objectives to achieve mechanisms, confusing the purpose of an objective.
- 7.14 An expected set of objectives would look as follows:
- All residents must have access to a minimum level of health protection without facing an income barrier;
 - All health services must be provided at a high standard of care;
 - All health services must be provided efficiently and at reasonable cost;
 - Access to all health services must be fair; and
 - The supply of health services must be responsive to the expectations of all residents.

Socioeconomic Benefits of National Health Insurance (page 19)

- 7.15 This section largely outlines the potential socioeconomic benefits of a well-functioning health system and not the *mechanism* NHI. Had this section been

¹³² GP, par 52, p.16.

¹³³ GP, par 52, p.16.

¹³⁴ International Labour Organisation, 2010.

¹³⁵ See **box 6.3**.

properly constructed it would provide an appraisal of alternative options for reform showing why one mechanism is better than the other options.

- 7.16 The suggestion that “*public financing of health services frees the poor to use more money to improve their welfare...*”¹³⁶ characterizes the general weakness of this section as no meaningful information is provided on the policy.
- 7.17 Free services provided to anyone, especially the poor, do free up income to fund other preferences. The real question though is, how much can be taxed and funded free? Furthermore, how should these services be prioritized? And which services should be excluded? These issues are particularly relevant in South Africa as the services are already free.
- 7.18 It is the nexus between *needs* and *resource constraints* that policy is actually made. The section consequently fails to deal with the fact that public services are already free through the state and appears to suggest that people do not already have this coverage. The issues are consequently more relevant to countries such as India and Vietnam where services are not universally free and available.
- 7.19 The unreferenced remarks about India and Mexico¹³⁷ fail to provide any information to inform strategies for South Africa. Both appear to be making some point about universal coverage, but have little to do with the institutional reforms proposed in the Green Paper.
- 7.20 South Africa’s *per capita public health expenditure* also exceeds that of Mexico (see **figure 6.5**) and India.
- 7.21 Many developing countries, including South Africa, already have universal coverage. It would have been more useful to provide a comparative review of developing country interventions to achieve and deepen universal coverage, including countries with mechanisms equivalent to what exists and is proposed for South Africa.
- 7.22 *This section should have dealt with the benefits of specific proposals being made for South Africa. Instead the difference between the concepts of Universal Cover and NHI are conflated confusing the purpose of this section and what it is trying to show.*
- 7.23 *For instance, it appears to be arguing that there are socioeconomic gains to implementing universal coverage when universal coverage already exists. The question that should have been answered is whether there will be net social and economic gains from the institutional proposals made in this Green Paper.*

Economic Impact Modeling (page 21)

- 7.24 This section refers to a “*draft*” report by the National Treasury that has not been made available to the public, and which apparently and unhelpfully states that the

¹³⁶ GP, par 58, p.20.

¹³⁷ GP, par 58, p.20.

implementation of NHI “*could have positive or negative implications, depending on the model utilized and its outcomes.*”¹³⁸

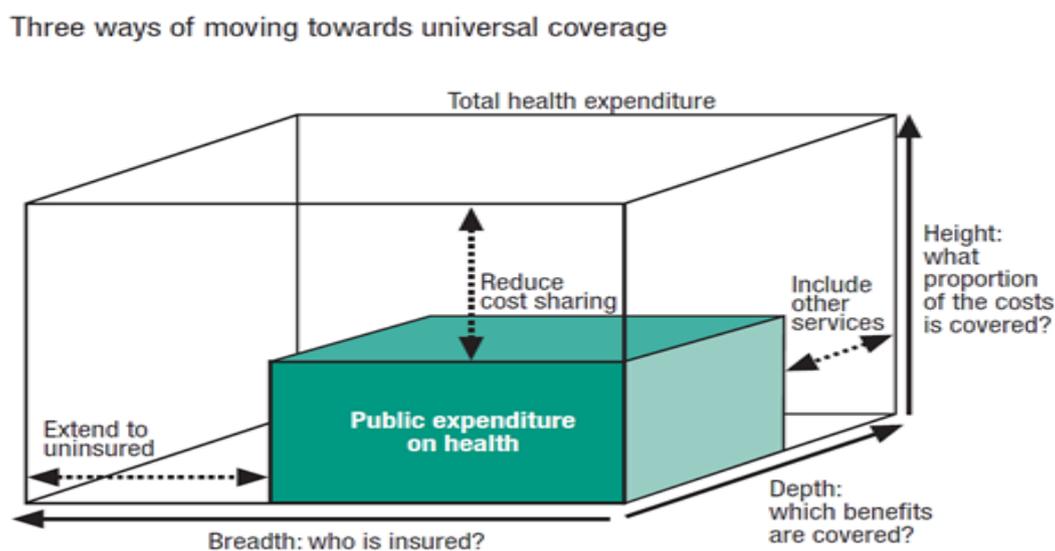
- 7.25 As the reforms could have either “positive” or “negative” implications depending on unknown variables no value is added by this section. *However, it does clarify that the Government has no real idea what the implications of this reform are or what model is being proposed.*
- 7.26 For this section to have been of any use it should have provided the following information:
- The alternative models evaluated;
 - Assumptions underpinning each model; and
 - The pros and cons of each model.
- 7.27 *Notwithstanding the above, if a report has been developed and referred to, it should be made public and released by the Minister of Finance so that proper comment can be made.*

¹³⁸ GP, par 61, p.21.

8. THE THREE DIMENSIONS OF UNIVERSAL COVERAGE (page 23)

- 8.1 This section of the Green Paper lacks coherence by providing little more than a restatement of some basic World Health Organisation policy illustrations.
- 8.2 The Green Paper should instead provide information relevant to South Africa and to the policy proposals being tabled. As South Africa has attained the objective of universal cover, any general statement on the principles and objectives of universal cover *fails to differentiate current from future policy imperatives*.
- 8.3 The dimensions of Universal Coverage provide a useful benchmark for health systems reform – mainly for low-income countries (Ghana, Nigeria, Sierra Leone, India, Vietnam, etc.) that lack the coverage provided by South Africa’s public system and medical schemes.
- 8.4 **Figure 8.1** provides the illustration used by the World Health Organisation in its 2008 report on primary health care. It should be noted that references to “insured” in the figure reflect a *broad* interpretation of the term. For instance, someone with access to free services without having to contribute is also regarded as “insured”, i.e. public sector users in South Africa are regarded as insured.

Figure 8.1: World Health Organisation illustration of how countries should move toward universal coverage

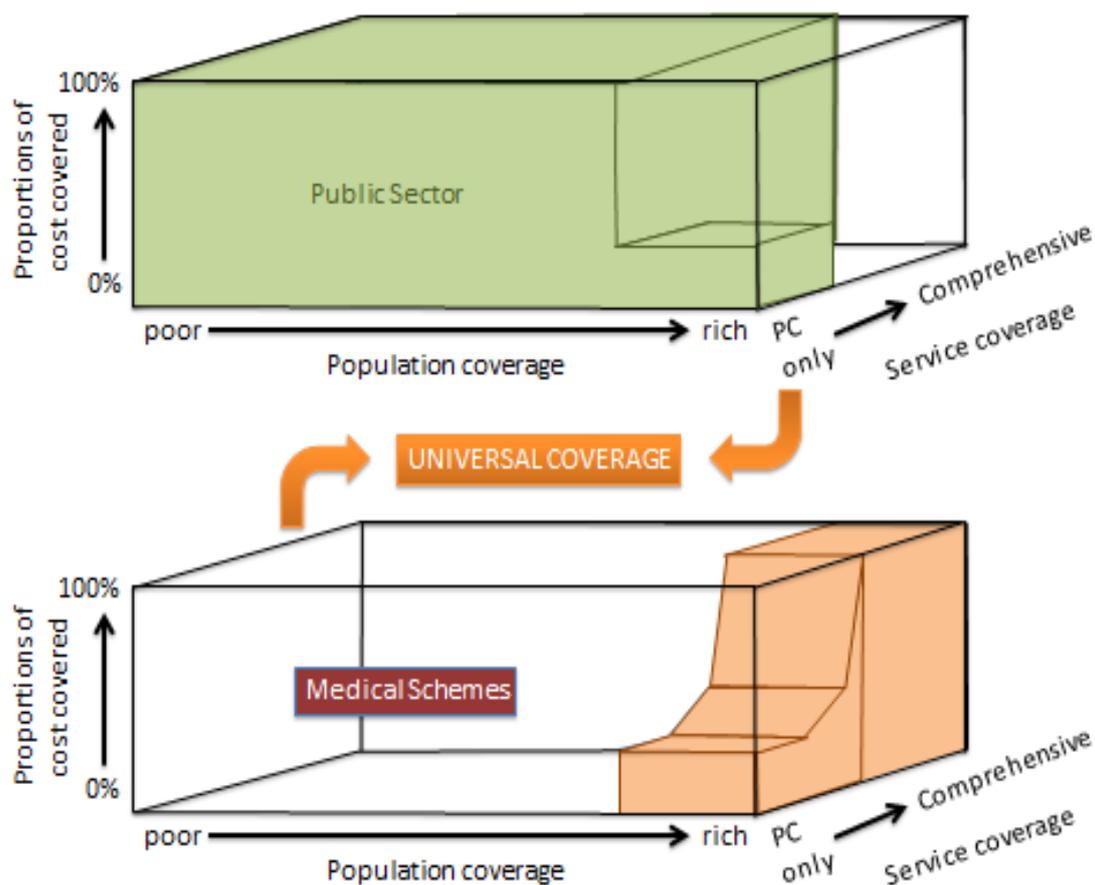


Source: World Health Organisation, 2008, chapter 2, figure 2.

- 8.5 South Africa already provides universal coverage. Using the framework from **figure 8.1**, **figure 8.2** illustrates the South African case.
- 8.5.1 On the vertical access South Africa has eliminated cost sharing and fees for everyone but the top 10% of income earners. These earners access coverage through medical scheme contributions.
- 8.5.2 On the third dimension, South Africa provides comprehensive health services through both the public sector and medical schemes.

8.5.3 The residual out-of-pocket expenses (or cost sharing) is normal for a developing country and primarily effects ambulatory care – mostly for high income groups (i.e. the top decile). Catastrophic health expenses are well covered in South Africa – although the quality of public hospital services is low relative to their levels of expenditure (using maternal mortality ratios as a proxy indicator for quality of care).

Figure 8.2: Universal Coverage in South Africa using the World Health Organisation framework



8.6 *South Africa's central policy imperatives derive not from the absence of universal coverage, which has been attained, but rather from the quality of public services and the cost of private coverage.*

9. POPULATION COVERAGE UNDER NATIONAL HEALTH INSURANCE (page 23)

- 9.1 This section should refer to coverage of the South African health system. The entitlements to use the public health system need to be properly provided for in the National Health Act and need not await some future institutional mechanism (i.e. NHI) which, in reality, is really the public system by another name.

10. THE RE-ENGINEERED PRIMARY HEALTH CARE SYSTEM (page 23)

- 10.1 The general statements on a primary health care approach in this section reflect policy positions outlined from 1994 and are not new. The section however provides only general statements of intent without concrete proposals. And although a primary health care approach is appropriate, little more can be said until proposals and their trade-offs are laid out.
- 10.2 However, given the failure to date to effectively implement a high standard of primary care service, despite significant budget improvements, means Government has much to prove.
- 10.3 The section also refers to the establishment of the district health system (DHS) “*which will be the vehicle by which all PHC is delivered*”. Not mentioned, however, is the fact that in 1996 the DHS was prioritized for urgent implementation. Functioning districts were meant to be in place from the “*end of May 1996*” (see **box 10.1**). Quite evidently this has not occurred. A framework was also outlined on the Health White Paper of 1997 (see **box 10.1**) which has also never been implemented.
- 10.4 The failure to properly implement a DHS with significant decentralization and strong localized governance potentially explains many of the delivery shortcomings at this level of the current system. However, as a DHS has always been a priority, its inclusion in this Green Paper is an anomaly as it is already contained in a fourteen-year-old White Paper.

Box 10.1: Past policy statements by the Department of Health on the Primary Healthcare Approach and the District Health System

*“The health district will be the building block of the National Health System, and a unified, integrated health management structure at local level, to be known as the district health authority (DHA) will play the key administrative role within the publicly funded PHC system. The DHA will be responsible for all district primary health care and hospital services. It is planned to begin introducing functioning DHAs from the end of May 1996, and that the district based system should be fully developed within 5 years. In the development of the district health system, it will be vital to build in a meaningful ‘bottom up’ component, with the active participation of users, communities, NGOs and community based organizations. Particular attention should also be paid to the involvement of disadvantaged groups, including women and the poor.”*¹³⁹ [Underline added].

Source: Department of Health, January 1996.

“The establishment of the DHS is at the core of the entire health strategy, and its rapid implementation, therefore, is of the highest priority.”

“This level of the health care system should be responsible for the overall management and control of its

¹³⁹ Department of Health, 1996, p.12.

health budget, and the provision and/or purchase of a full range of comprehensive primary health care services within its area of jurisdiction. Effective referral networks and systems will be ensured through co-operation with the other health districts. All services will be rendered in collaboration with other governmental, non-governmental and private structures.”

“All South Africans should be equipped with the information and the means for identifying behavioural change conducive to improvement in their health.”

“People should be afforded the opportunity of participating actively in various aspects of the planning and provision of health services.”

“The Department of Health should provide the public with regular updates on progress, results and emerging issues related to its work, and should ensure that people participate in the development of national policy.”

Source: Department of Health, 1997.

10.5 *“All members of the population will be entitled to a defined comprehensive package of health services at all levels of care namely: primary, secondary, tertiary and quaternary with guaranteed continuity of healthcare benefits.”¹⁴⁰*

10.5.1 It is not clear how this differs from existing entitlements, apart from the fact that they are not “*defined*” prospectively.

10.5.2 However, as it is next to impossible to prospectively define a categorical public sector package of services it is not clear what is in fact proposed apart from some version of what exists.

10.6 The Green Paper identifies “*Primary health care services*” that “*shall be delivered according to three main streams*”.¹⁴¹ These are district-based clinical specialist support teams, school-based primary health care services, and municipal ward-based primary health care agents.

10.7 The paper however does not identify ambulatory care as a stream (i.e. the core service provided within the notion of primary health care). The report should probably have stated that these are to be included as additional services rather than reflecting all of primary health care as stated. As with other sections of the Green Paper it is really difficult to work out what is really proposed. *The impression is created that these proposals have not really been thought through. Given this, they should not have been included in the Green Paper.*

District Clinical Specialist Support Teams (page 24)

10.8 It is not entirely clear how these teams will operate and what their specific function is. Are they meant to provide services? Are they standing teams or only

¹⁴⁰ GP, par 69, p.24.

¹⁴¹ GP, par 70, p.24.

part-time? Are they available on referral only? Where will they be physically located?

10.9 It is also unclear why this intervention has been prioritized over others to deal with high maternal and child mortality.¹⁴² Also no mention is made of the shortcomings in the general package of services for mothers and newborns. For instance:

- *Antenatal care and family planning*: major failures exist in these services although the required numbers of skilled birth attendants meet international norms.
- *Nurse training*: caregivers presently cannot manage complex obstetric cases;
- *Referral arrangements*: there are inadequate measures in place to provide emergency transfers in cases of complex obstetric emergencies (this remains a severe problem in some parts of the country);
- *Postnatal care*: measures are needed to standardize and support mothers and babies in the postnatal period (poor postnatal care is potentially responsible for many non-facility-based deaths); and
- *Monitoring and evaluation*: existing monitoring and evaluation procedures are grossly inadequate and do not feed back into accountability mechanisms.

10.10 A full package of maternal and newborn health services sufficient to reduce mortality ratios to a 10th of current levels can be implemented with existing resources. The failure to do so is inexcusable when all South Africa's peer countries have been able to (see **figures 6.3 and 6.4**).

10.11 *The introduction of specialist teams is a strange intervention to deal with the high mortality associated with deliveries. A more appropriate package and programme needs to be identified and implemented as a matter of priority.* This should perhaps be the subject of a separate policy report and is out of place in this Green Paper which to address institutional concerns.

School health Services (page 25)

10.12 As with the previous sub-section it is not clear why this issue is contained in a report dealing with institutional restructuring of the public system.

Municipal Ward-based Primary Health Care Agents (page 26)

10.13 Again, it is also not clear why this is contained in a report dealing with institutional restructuring of the public system.

10.14 No evaluations or evidence have been provided to show that the expense incurred with this programme will deliver results. It is also unclear how the programme will be managed given the weak state of the district health system.

¹⁴² GP, par 71, p.24.

Primary health care benefits for mandatory insurance

- 10.15 In an extremely vague statement the Green Paper argues in par 68 for the inclusion of Primary Health Care services within the “*benefit package for mandatory insurance*”.
- 10.16 “*It has been shown that there is a strong support for inclusion of primary Health care services within the benefit package for mandatory insurance. This should include private sector primary care services. This has the potential to reduce the disparities that exist in the distribution of human resources between the public and private sector.*”¹⁴³
- 10.17 It is not clear what the above text refers to. Is it mandatory medical scheme benefits or public sector benefits. If the former, it would require the incorporation within insurance-based risk-pools of uninsurable benefits. If the latter, primary health care is already universally free through the public sector.

¹⁴³ GP, par 68, p.24.

11. HEALTHCARE BENEFITS UNDER NATIONAL HEALTH INSURANCE (page 26)

- 11.1 This section is vague and says little about what concrete choices need to be made regarding public sector service priorities.
- 11.2 A set of benefits are outlined that are in fact indistinguishable from existing entitlements. The service descriptions are furthermore at such a level of generality that no comment is possible.
- 11.3 The Department of Health needs to provide specific proposals on services to be provided by the public sector and to differentiate these from what exists. The continued reference to NHI benefits is furthermore confusing; as these are plainly little more than public services provided either directly or on contract through the private sector.
- 11.4 There are however serious problems with the delivery of public services at present. Despite this, no mention is made as to why these services are failing and what is planned to address the problems.
- 11.5 Furthermore, the public sector is barely able to cope with the ordinary provision of public services, let alone contract with the private sector. Despite this no clear roadmap is provided anywhere in this section as to how South Africa will get from its present poor delivery to desired levels.
- 11.6 No indication is provided of how the different service levels, as designated, are to be prioritised. Lists of services are provided with no planning content offered.
- 11.7 *Overall this section provides no practical information on what Government actually intends. A real plan is required with real figures and priorities.*

**12. ACCREDITATION OF PROVIDERS OF HEALTH CARE SERVICES
(page 31)**

- 12.1 The proposal for an Office of Health Standards Compliance (OHSC) has long been in the pipeline and is needed. Draft legislation also exists. However, the authority, as provided for in draft legislation, is *not independent of political interference* and is consequently *incapable of serving its desired purpose*.
- 12.2 The central purpose of an OHSC is to supervise any health service providing services to the public. The linkage to an accreditation process for contracting to the state appears somewhat superfluous as no health service should be permitted to operate in South Africa if it fails to achieve accreditation.
- 12.3 Proposals to accredit private practitioners also make little sense and are neither needed nor practical.
- 12.4 *As the accreditation and various other supervisory processes of the OHSC will impact on stakeholders with political influence, it needs to be fully independent of government and the entities it regulates. Unfortunately the proposed legislation is deeply flawed in this respect and will systemically undermine the functionality of this intervention. It furthermore raises the worrying prospect that improper private interests that operate through political structures will invariably influence regulatory decisions.*

13. PAYMENT OF PROVIDERS UNDER NATIONAL HEALTH INSURANCE (page 32)

Overview

- 13.1 This section provides a list of general mechanisms used to pay providers of various forms through what is stated as NHI (in reality the public system). The South African public system is however years away from being able to consider most of these mechanisms, even the simple ones associated with formulae-based allocations.
- 13.2 Given the lack of any implementation roadmap or practical detail very little can be said except that more work is required before comment can be provided. Nevertheless, some guidance can be provided.

Risk-adjusted capitation

- 13.3 The context for this proposal is missing in the Green Paper. Is it intended that a general entitlement to use primary care services will be provided? For instance equivalent to that in the United Kingdom and Australia? If so, this is financially unaffordable and unlikely to materialize even were government to increase public health expenditure to 6.2% of GDP as proposed later in the Paper.
- 13.4 South Africa cannot introduce an entitlement to private general practitioners or specialists except on referral from a public sector clinic. *If any other system is proposed feasibility studies need to be generated and made public along with the proposals.*
- 13.5 It appears that individual practitioners are to receive allocations based on risk-adjusted allocations. It is not clear how this would work as it is impossible to weight populations for utilization for such small catchment populations. In any case such proposals are premature.
- 13.6 *It is not possible to comment on this section as the information required to evaluate the appropriateness of these proposals has not been provided.*

Diagnostic-related groupers (DRGs)¹⁴⁴

- 13.7 The introduction of proper public hospital reimbursement is a necessary reform for the public system which has nothing to do with any NHI.
- 13.8 Although a DRG reimbursement system is a requirement down the line, the existing system of public hospital reimbursement is so crude that major work is required before more sophisticated mechanisms can be considered.
- 13.9 Present hospital budgeting is chaotic and needs to follow an incremental reform process to better management. Only the last stage of a complete reform process

¹⁴⁴ A DRG is a costed group of diagnoses that can be used to determine how much a hospital should be paid for the patients it has treated. The DRG allows the reimbursement to be more sensitive to the actual case mix experienced than would be the case with a conventional budget allocation. It also helps to curb unnecessary reimbursement that results from conventional fee-for-service occurring within private insurance systems.

would introduce DRGs – which in reality only addresses *fiscal fairness* between hospitals and useful information for management and policy purposes.

13.10 Suggested steps in a hospital reform process:

- *Step 1*: Implement hospital autonomy;
- *Step 2*: Develop hospital-based service norms and standards (otherwise no standard costs and service levels can be prospectively determined and agreed in any contract);
- *Step 3*: Develop quasi-contracts between provincial departments and hospitals, with funding based on the norms and standards;
- *Step 4*: Implement ICD 10¹⁴⁵ coding of patient admissions and discharges and an associated reporting system;
- *Step 5*: Develop costed DRGs; and
- *Step 6*: Adjust contracts to incorporate casemix adjusted allocations based on the DRGs.

13.11 Steps 1-3 would probably take between 5-8 years to achieve. Stages 4-6 would probably only require 2 years thereafter. However, without stages 1-3 in place the DRG system cannot be effectively introduced. *Overall the process could take approximately 10 years.*

13.12 The reform of the public system of hospital reimbursement is long overdue and was recommended in 1996 (Hospital Strategy Project), and the Taylor Committee of Inquiry in 2002 and the Roadmap Report of 2008. The failure to initiate these reforms has contributed to the progressive decline in the quality of public hospital services.

13.13 *It is therefore critical that government prioritize the complete reform (not just DRGs) as a matter of urgency.*

Emergency services

13.14 The proposals in this section are unclear.

13.15 A reform framework needs to properly consider a holistic strategy to deal with emergency care in South Africa. This sub-section however falls far short of this.

13.16 *A proper response from government to the absolute Constitutional right of access of all residents to emergency care is required. This section of the Green Paper is not it.*¹⁴⁶

¹⁴⁵ This refers to the International Classification of Diseases (version 10). Without coding system in place it is impossible to implement DRG-based reimbursement.

¹⁴⁶ Section 27 (4) reads, “No one may be refused emergency medical treatment.”

14. UNIT OF CONTRACTING PROVIDERS OF HEALTH SERVICES (page 34)

- 14.1 The Green Paper proposes that an undefined structure, the *District Health Authority* (DHA) will be the “*unit of contracting*” supported by “*sub-national offices*” of an undefined structure, the “*National Health Insurance Fund*”.¹⁴⁷
- 14.2 In a remarkably opaque piece of writing, the Green Paper describes the role of the districts in contracting as follows:
- “*It is envisaged that the District Health Authority, as part of the health service provision system (sic), will be established (sic) and given the responsibility of contracting with the National Health Insurance (sic) in the purchasing decisions (sic) for services.*”¹⁴⁸
- 14.2.1 This sentence is unintelligible.
- 14.2.2 Is the District Health Authority purchasing health services? Or a health service which has to contract with something called the “National Health Insurance” to purchase services?
- 14.2.3 Is “*District Health Authority*” a single authority with responsibility for a demarcated area, or an entire district system? For the sentence to make any sense at all it would need to be the latter.
- 14.2.4 What does “*given the responsibility of contracting with the National Health Insurance in the purchasing decisions for services*” mean?
- 14.3 The section makes no mention of provincial governments, i.e. the devolved tier of government which through the Constitution has concurrent powers over the health function with national government. *Presumably this implies they cease to exist.*
- 14.4 At no point however does the Green Paper present any *institutional argument* or *evidence* that motivates for this startling proposal.
- 14.5 The problem statement, which focuses heavily on private sector costs and equity issues, is completely silent on any institutional gap that would necessitate such a drastic shift of government functions. *In fact no evaluation of the public system and its challenges is ever provided.*
- 14.6 *Although it makes sense for a new tier of the health system to be developed, i.e. the district health system, the establishment of a national fund with regional offices cannot be logically defended when provincial administrations already exist.*
- 14.7 Although provincial health services have been run badly, the institutional shortcomings are known and correctable. These are mainly attributable to a breakdown of accountability structures, a failure to implement workable

¹⁴⁷ GP, par 110, p.34.

¹⁴⁸ GP, par 110, p.34.

accountability structures, and excessive centralization (command and control) in decision-making.

- 14.8 *South Africa already has a National Department of Health and provinces which serve the purposes of national and regional co-operation. In the absence of any coherent institutional rationale to eliminate provincial structures in favour of regional offices of a national fund these proposals should be rejected.*
- 14.9 The more sensible route forward is to build an accountable DHS as a third-tier of the health system, with provincial governments continuing to raise revenue, allocate budgets, contract where appropriate, and supervise the achievement of strategic goals and general performance.
- 14.10 This approach would allow for the progressive strengthening of the health system. *It is to be preferred to the Green Paper's vaguely expressed, unusual and untested institutional constructs which lack any form of business case or feasibility study.*
- 14.11 Importantly, no definition of a DHA is provided. No clarity is provided on its: roles and responsibilities; powers (and where these would be derived from); supervisory structures; and reporting mechanisms.
- 14.12 Without this information no proper comment can be made on the adequacy of this proposal, even though a DHS is needed. It is unfortunately quite possible that the proposed DHAs will have the wrong design and deliver very little. The 1997 White Paper provided several pages on DHA options, none of which were debated or ultimately materialized.
- 14.13 *It is therefore recommended that the Department of Health provide proper proposals on the DHS and place this in a new policy paper.*
- 14.14 *It is furthermore recommended that instead of the unclear proposals for a central fund, that a coherent strategy be framed for getting the eight dysfunctional provinces to work in conjunction with the development of a properly framed DHS.*
- 14.15 *Key parts of this section of the report are unintelligible and cannot meaningfully be commented on.*

15. PRINCIPAL FUNDING MECHANISMS FOR NATIONAL HEALTH INSURANCE (page 35)

- 15.1 Pre-payment of health systems for most healthcare services through general taxes, payroll taxes, and insurance contributions are generally regarded as uncontroversial. To achieve universal coverage within developing countries a mix of arrangements is however needed to optimize social protection rather than a single monopoly public supplier. Even within developed economies very few adopt the single supplier model.
- 15.2 Although this section appears to recognize this reality, it makes out a general case for a broad revenue base for one system – referred to as the NHI (or the public system). *The public health system is however already funded using the broadest revenue base possible, i.e. general taxes.*
- 15.3 There are however limits to the revenue that can be generated from the general tax system.
- 15.4 There are furthermore severe limitations on the general acceptability of one-size-fits-all public delivery systems, even where they contract with the private sector. Higher income groups will invariably prefer service configurations that respond as much to demand as need. These dynamics are well understood (see **box 15.1**) and need to be accommodated in a health system’s design.

Box 15.1: Balancing the design of public and private sectors developing country health systems

“Contrary to what might be expected, the share of private health financing tends to be larger in countries where income levels are lower. But poorer countries seldom have clear lines of policy towards the private sector. They thus have major steps to take in recognizing and communicating with the different groups of private providers, the better to influence and regulate them.

“The private sector has the potential to play a positive role in improving the performance of the health system. But for this to happen, governments must fulfil the core public function of stewardship. Proper incentives and adequate information are two powerful tools to improve performance.”

World Health Organisation, 2000, p.xvi

“In middle income countries the policy route to fair prepaid systems is through strengthening the often substantial mandatory, income-based and risk-based insurance schemes, again ensuring increased public funding to include the poor. Although most industrialized countries already have very high levels of prepayment, some of these strategies are also relevant to them.”

World Health Organisation, 2000, p.xviii

- 15.5 Failures to accommodate systems that respond to demand as well as need, particularly in developing countries, will invariably result in poor designs where neither *need* nor *demand* is efficiently accommodated. Such approaches can result in unresponsive public systems, as they are monopoly service providers, leaving demand-driven systems to evolve without regulation.

- 15.6 Unregulated private healthcare markets are as problematic as unaccountable public monopolies but manifest different pathologies. Unregulated private markets systematically exclude poor risks from risk pools and can generate excessive cost increases (as occurred during the 1990s in South Africa).¹⁴⁹ Poorly managed public systems deliver poor care with resulting poor health outcomes.
- 15.7 Within a developing economy, attempts to place all the eggs in one healthcare basket, impacts negatively on the *efficient mobilization of additional revenue* for healthcare. Residual contributions through contributory social and private insurance schemes are characterized by a stronger willingness-to-pay than is the case with general taxes as benefits accrue more directly to contributors.
- 15.8 Although contributory arrangements are less directly redistributive they are powerful mechanisms for resource mobilization and risk-pooling¹⁵⁰ which, together with the design of the public system, can optimize both redistribution and risk-pooling goals.
- 15.9 Redistribution is primarily the role of the general tax system and the services so funded. The redistributive effect can be strengthened directly using explicit mechanisms which exclude high-income users, such as means tests for access to free or subsidized services. Here the people paying the bulk of taxes by law receive no benefits (this is the situation in South Africa with public hospital services).¹⁵¹
- 15.10 The exclusion of higher income groups from public services also occurs naturally where they exercise their choice to pay for services that respond better to their preferences. Provided higher income groups pay their taxes and the distribution of healthcare service providers is not systematically skewed, the social returns of the overall system can be optimized.

¹⁴⁹ Department of Health, May 2002, pp.27-30.

¹⁵⁰ Risk pooling here refers to the cross-subsidy that occurs from contributing non-claimers to contributing claimers and from contributing healthier groups to contributing sicker groups.

¹⁵¹ See **box 5.1**.

16. HOW MUCH WILL NATIONAL HEALTH INSURANCE COST? (page 36)

16.1 Overall this section raises more questions than answers. It purports to cost a system which the Green Paper has failed to define. For a system to be costed, the following must be made explicit:

- The benefits to be provided and the entitlements to them;
- The range of unit costs¹⁵² of the benefits (through time);
- The benefit outcomes;
- The beneficiaries likely to use the benefits;
- The beneficiaries excluded from or unlikely to use the benefits; and
- Governance arrangements, which will affect the efficiency of delivery.

16.2 No material or useful information is however provided on what is costed and what assumptions are used.

*“The costing estimates presented in this section focus on providing an indication of the estimated resource requirements for achieving universal coverage, based on cost effective delivery of health services.”*¹⁵³

16.2.1 It is unclear what this statement means.

16.2.2 What is being costed? A mechanism? An entitlement? An entitlement provided through a mechanism?

16.2.3 What is meant by “cost-effective” service delivery? And how has this been determined?

16.2.4 What are the services costed?

16.2.5 What services are universal?

16.2.6 Which services, due to rationing, are not universal?

16.2.7 On what basis can assumptions be made that the “costing” is realistic?

16.3 The equation provided in par 119, which is supposed to clarify what work was carried out is indicated as coming from an ILO text. However, no reference is provided.

*“Total expenditure = user population X service utilization rates X unit costs”*¹⁵⁴

16.3.1 This equation can only be used for the most simple of evaluations.

¹⁵² A range is required as the unit costs will vary depending upon the contracting and delivery modes used.

¹⁵³ GP, par 117, p.36.

¹⁵⁴ GP, par 119, p.36.

16.3.2 The only substantial book on health care modeling produced by the ILO (together with the International Social Security Association or ISSA) outlines in substantial detail more comprehensive requirements for modeling health systems.¹⁵⁵ *At no point in this book is such a simple approach motivated.* Instead see **box 16.1** for the far more comprehensive requirements expressed at a high level.

Box 16.1: High level advice on health system modeling by the ILO

“health care modellers need to identify the factors that influence the financial equilibrium of a healthcare financing scheme, translate them into concrete model variables, and build them into the model. The factors that influence the financial equilibrium can be grouped roughly into four categories:

- *Demographic and labour force factors, such as developments in the total population, the population structure, and the economically active population.*
- *Economic factors, such as employment, wage and income levels, as well as prices and interest rates*
- *Factors affecting health status, medical technology and medical practices, such as certain morbidity rates or the availability of certain medicines and technologies*
- *Governance factors, such as decisions on eligibility for coverage under the scheme and the range of benefits to be provided to the covered population and the effectiveness with which contributions are collected.”*

Cichon M, et al, July 1999, p.20.

16.4 The model apparently makes use of a simple unit cost structure based on “*public sector unit costs, but at substantially improved resourcing levels than at present*”.¹⁵⁶ However, the following is unclear:

- What is understood as current public sector resourcing?
- What is understood as the proposed public sector resourcing?
- What are the unit costs of the resources (as it appears that the unit cost used is an aggregation of resource costs and resourcing rates)¹⁵⁷ and do they remain constant through time (which is not the experience of the past thirteen years)? For instance is it assumed that in real terms staff will be paid the same in 2011 as in 2025 and that equipment costs will remain the same?

¹⁵⁵ Cichon M, et al, July 1999.

¹⁵⁶ GP, par 120, p.37.

¹⁵⁷ Any costing should separate the resource costs (e.g. salaries of the workforce) from the resourcing rates (e.g. numbers of nurses per bed).

16.5 Given that the model has assumed *public sector unit costs*¹⁵⁸, the costing referred to in par 122 and table 1 potentially underestimates any given set of entitlements, as contracts with the private sector for professional services will not be at the same value as public sector staff due to their higher remuneration and practice costs.

16.6 The utilization assumptions are unusually drawn from a pre- and post-reform analysis of Thailand.

*“The model makes allowance for large increases in utilization when financial barriers to service use are removed under the National Health Insurance (of over 70% in outpatient care and about 80% in inpatient care for those who are currently ‘uninsured’ relative to their current utilization levels). These increases in utilization are comparable to the extent of utilization increases experienced in Thailand when a universal coverage system was introduced.”*¹⁵⁹

16.6.1 These assumptions are confusing, as is the reference to an unrelated context and set of reforms in Thailand.

16.6.2 Thailand introduced basic insurance coverage for people who previously had no coverage. This differs from South Africa where people already have free access to health services, i.e. they are already “covered”.

16.6.3 Thailand’s public health expenditure increased to 3.3% of GDP in 2009 from around 2% in the pre-reform period, which is slightly lower than South Africa’s present levels of public health expenditure. (See **figure 16.2**).

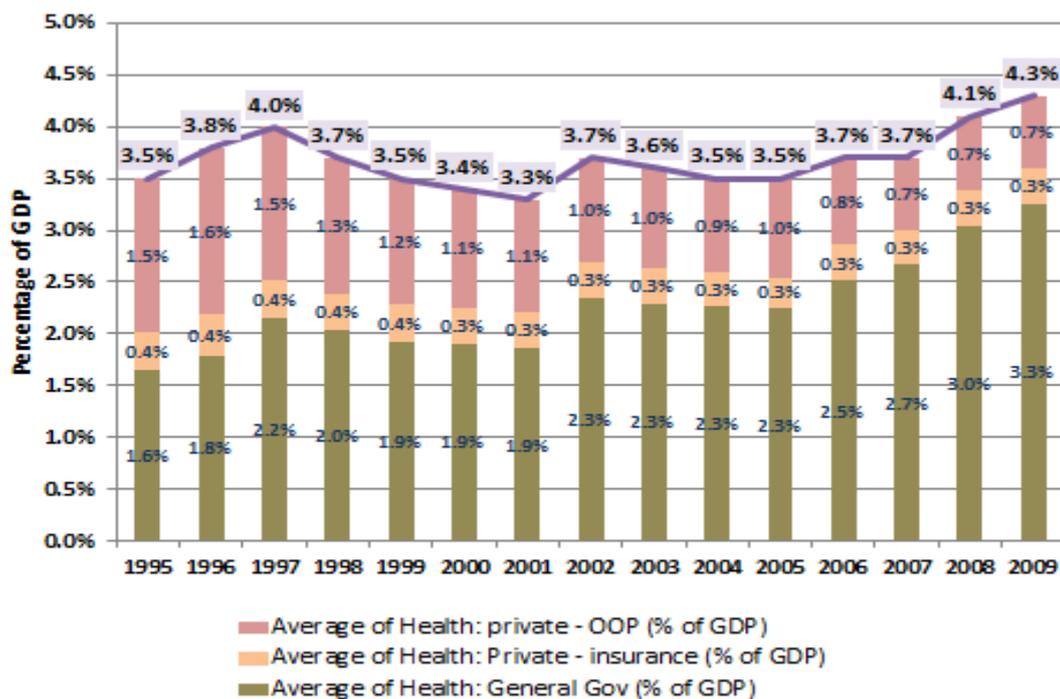
16.6.4 South Africa has exceeded Thailand’s public health expenditure expressed as a percentage of GDP over the entire period from 1995 to 2009 (see **figure 6.2**). In 2009 South Africa’s per capita public health expenditure of US\$195, expressed at the average exchange rate in US\$, exceeded that of Thailand at US\$127.

16.6.5 *The utilization rate changes arising from the reforms in Thailand consequently bear no relation to the South African context and cannot be used for any modeling in South Africa.*

¹⁵⁸ This is based on the assumption that the study held resource costs constant in 2010 prices and merely escalated some quantum of resource inputs. The wording of the document is too imprecise to work out what was done. This assumption was clarified with persons from National Treasury who were familiar with the assumptions actually made but for some reason not disclosed in the Green Paper.

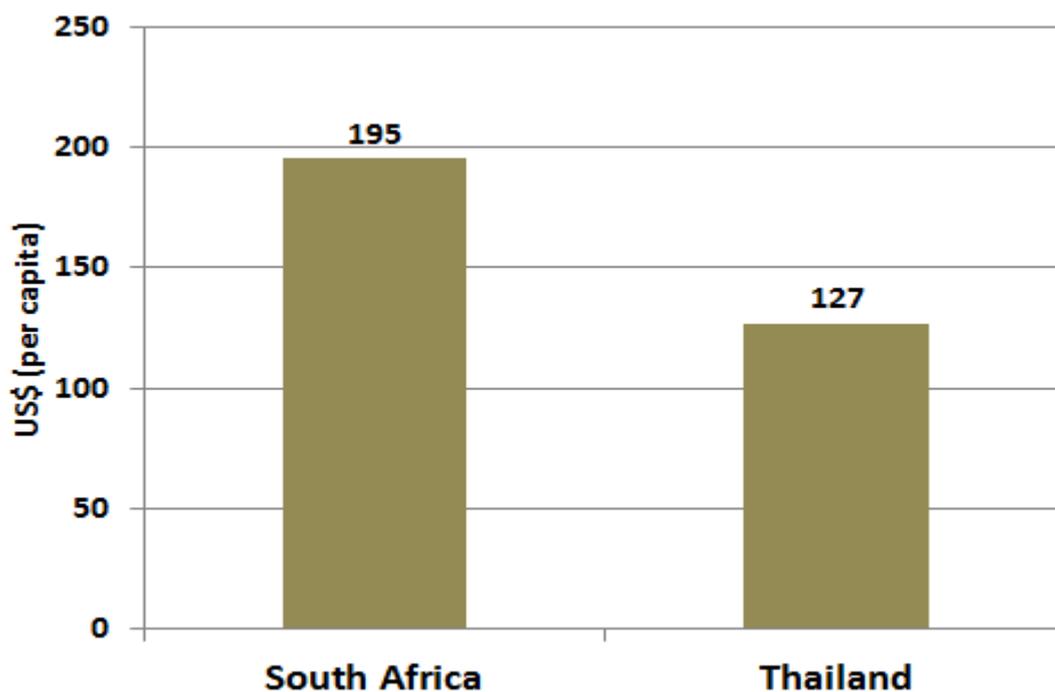
¹⁵⁹ GP, par 121, p.37.

Figure 16.1: Thailand: National Health Accounts expressed as a Percentage of GDP from 1995 to 2009



Source: World Health Organisation data, [<http://apps.who.int/ghodata/#>].

Figure 16.2: Per capita public health expenditure for South Africa and Thailand in 2009 (US\$ based on the average exchange rate)



Source: World Health Organisation data, [<http://apps.who.int/ghodata/#>].

- 16.7 *“This model indicates that resource requirements under this model increases (sic) from R125 billion in 2012 to R214 billion in 2020 and R255 billion in 2025 if implemented gradually over a 14-year period.”*¹⁶⁰
- 16.7.1 Reference is made to “model” twice in this sentence. It is not clear whether both refer to a computer model, or only one, possibly the latter, refers to a proposed model of the health system.
- 16.7.2 As no information has been provided on the “model” it is impossible to comment on the credibility of these numbers or what services they would buy and for whom. It is also not possible to ascertain whether they will achieve the proposed “single-tier” system motivated for in the problem statement.
- 16.7.3 They nevertheless imply vast increases in public health expenditure without actually indicating what services are changing and why.
- 16.7.4 A model of this form should have some form of probabilistic function based on statistical information which is used to determine a result based on variations in some variable. No information is however provided on model parameters or assumptions.
- 16.7.5 The “model” results are not consistent with what would be expected from a real model, i.e. with results linked to variable assumptions.
- 16.7.6 The only conclusion that can be drawn regarding the numbers are that they reflect phased budget increases, with the ceiling increase reached in 2025 equivalent in value to medical schemes’ expenditure expressed as a percentage of GDP (which is roughly 3% of GDP).
- 16.7.7 *This analysis is therefore neither a costing nor a modeling exercise. It is only a net budget increase with the net value of the increase designed to fit current medical schemes’ expenditure.*
- 16.7.8 *The limited information provided here suggests that very little work of substance has been performed to date.*
- 16.8 *“It should be noted that increased spending on the National Health Insurance will be partially offset by the likely decline in spending on medical schemes (as all South Africans will be entitled to benefit from National Health Insurance Services).”*¹⁶¹
- 16.8.1 Given the absence of model assumptions and parameters in the Green Paper it is unclear on what grounds this claim is based.

¹⁶⁰ GP, par 122, p.37.

¹⁶¹ GP, par 125, p.40.

- 16.8.2 An offset presumably refers to a potential substitution away from benefits presently obtained largely from the private sector and funded by way of medical scheme contributions.
- 16.8.3 The use of “will” suggests a degree of certainty which however cannot be supported from the information provided, and which is at odds with the *uncertainty* implicit in the (unquantified) reference to “*partially offset*”.
- 16.8.4 Were no substitution to occur, the proposed 3% increase in taxation would result in total health expenditure rising to around 12% of GDP. Such an eventuality would have severe macroeconomic implications, impacting on economic growth and the overall sustainability of government finances.
- 16.8.5 *Achieving certainty on the assumed offset is therefore a central consideration that determines the validity of the financial proposals outlined in the Green Paper, irrespective of how far into the future they have been pushed.*
- 16.8.6 For income earners to make use of public services it is not sufficient merely to contract with private providers. Public sector contracts with private providers may be on terms that fail to satisfy their demands in comparison to contracts that are more in their control (such as those occurring through medical schemes).
- 16.8.7 Income earners primarily require health insurance protection for *catastrophic expenses* and not primary health care, for which they are in any case prepared to pay out-of-pocket (as it represents an insignificant proportion of their income).
- 16.8.8 If government fails to invest in the services (such as specialist and hospital services) for which income earners presently demand insurance (via medical schemes), they will inevitably continue to seek that insurance.
- 16.8.9 It is however the explicit policy of the Green Paper to avoid investments in exactly those services which would achieve a substitution, and to focus instead on those services for which substitution is unlikely to occur (i.e. primary care promotive and preventive services) (see **box 16.2**).
- 16.8.10 *Higher income groups will invariably have little interest in government’s proposed outreach services and will not make use of them, i.e. no-one will stop using private services in exchange for these public services.*
- 16.8.11 Expenditures on HIV and AIDS and TB services (estimated to constitute 17.5% of the total public health budget in 2025)¹⁶², although critical from a public health perspective, are not needed by the vast majority of medical scheme beneficiaries with a very different burden of disease pattern to

¹⁶² GP, Table 1, p.39.

public sector users. *Investments in HIV and AIDS services, although critically needed, will consequently not cause a voluntary transfer to state services.*

Box 16.2: Primary Health Care approach in the Green Paper

“...the negative attributes of the South African two-tier healthcare system, which are unsustainable, destructive, very costly and highly curative or hospit-centric.” [Underline added]

GP, par 12, p.6

“The strengthening of the South African health system will be based in a Primary Health Care approach. This will be rooted in the primary health care philosophy.”

GP, par 66, p.23

“In South Africa, PHC services will be re-engineered to focus mainly on community outreach services. Ongoing efforts to reengineer the PHC approach will ensure that the composition of a defined comprehensive primary care package of services extends beyond services traditionally provided in facilities such as clinics, community health centres and district hospitals.”

GP, par 66, p.23

“Primary health care services will be re-engineered to focus mainly on health promotion, preventive care, whilst also ensuring that quality curative and rehabilitative services appropriate to this level of care are rendered.”

GP, par 67, pp.23-24.

16.9 *“However, the ultimate level of spending on a universal health system relative to GDP (of 6.2%) is less than current spending by government and via medical schemes (of 8.5%)”.*

16.9.1 This statement incorrectly asserts that the current expenditure by government and medical schemes adds up to 8.5% of GDP. In fact they only add up to around 7% of GDP with the rest out-of-pocket.

16.9.2 This statement appears to be claiming that South Africa’s total expenditure will ultimately settle at 6.2% of GDP, down from 8.5% of GDP. No rationale is however provided for this surprising claim, which is contradicted elsewhere in the Green Paper. For instance the additional taxation of around 3% of GDP, which is nearly equivalent to medical scheme expenditure (but excludes out-of-pocket expenditure of 1.5% of GDP) will only be *“partially offset”* by a reduction in medical scheme expenditure according to par 125 (p.43). Using simple arithmetic the resulting overall health expenditure (public and private) would need to exceed 6.2% of GDP spent by the public sector.

16.9.3 The proposed level of 6.2% of GDP for the public health system is also unusual within an international context.

- 16.9.4 For developing countries with populations exceeding 10 million¹⁶³ only two have government expenditure in excess of 6% of GDP, Argentina and Cuba (**figure 16.3**). Both have extraordinary levels of overall expenditure expressed as a percentage of GDP, with Argentina at 9.5% (**figure 16.4**) and Cuba at a startling 11.8% (**figure 16.5**). Despite the levels of government expenditure on health neither country has eliminated private expenditure which stands at 3.2% of GDP in Argentina and 0.9% of GDP in Cuba (despite public expenditure at 11% of GDP). Argentina's out-of-pocket expenditure, expressed as a percentage of GDP also exceeds that of South Africa.
- 16.9.5 Most developing countries, and some developed countries, experience general government health expenditure in the range of 2-4% of GDP, with 16 countries (the second highest number), including South Africa, spending in the 3-4% range. (See **figure 16.3**).
- 16.9.6 Only three countries, all developing, spend in the 5-6% of GDP range, while six fall into the 4-5% range. (See **figure 16.3**).
- 16.9.7 Columbia, which falls into the 5-6% range is interesting in that it spends a total of 6.4% of GDP on health despite financing its entire system *through regulated health insurance arrangements (equivalent to medical schemes in South Africa)*.
- 16.9.8 Columbia has a two-tier health system which requires persons with income to contribute to a risk-equalized multi-fund environment, and a subsidized non-contributory insurance pool. Together these fund the system. *This contradicts suggestions implicit in the Green Paper that only centralized publicly driven arrangements contain costs and minimize out-of-pocket payments.* Decentralised medical-schemes-based arrangements are evidently highly effective at containing costs and reducing out-of-pocket expenditure. (See **figure 16.6**).¹⁶⁴
- 16.9.9 *The claim that overall health expenditure will only be 6.2% of GDP by 2025 with the proposed strategy cannot be derived from any analysis provided in the Green Paper and is contradicted both within the text and by common sense references to international evidence.*
- 16.9.10 *Were South Africa to drive up general government expenditure on health to 6.2% of GDP it would join only two other developing countries, both of which are anomalies and spend in excess of 9% of GDP on health. In the case of Argentina private expenditure of 3.2% of GDP is responsible for driving up total expenditure to these levels. Cuba, by*

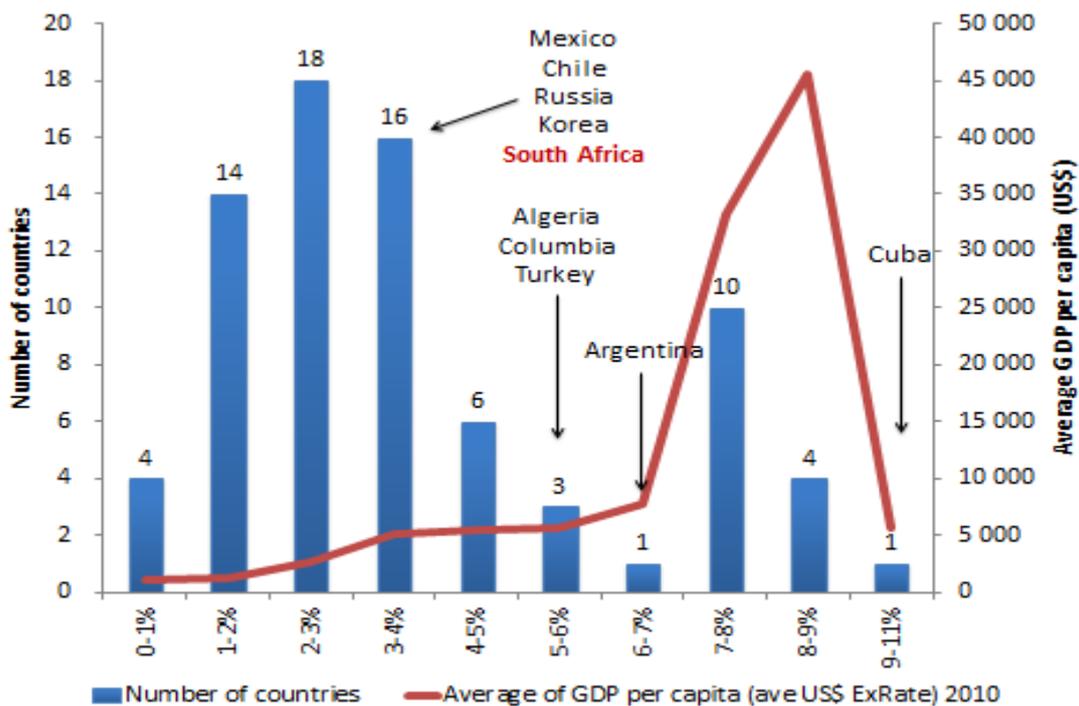
¹⁶³ This is done to remove distortions from countries with very small populations.

¹⁶⁴ Within the top twenty countries by per capita GDP no difference can be found between tax funded public systems (equivalent to the NHS in the United Kingdom) and those based on regulated schemes (equivalent to Germany, the Netherlands, and Belgium).

way of contrast spends what must be an unsustainable 11% of GDP on public health services and is still unable to eliminate out-of-pocket expenditure equivalent to 0.9% of GDP.

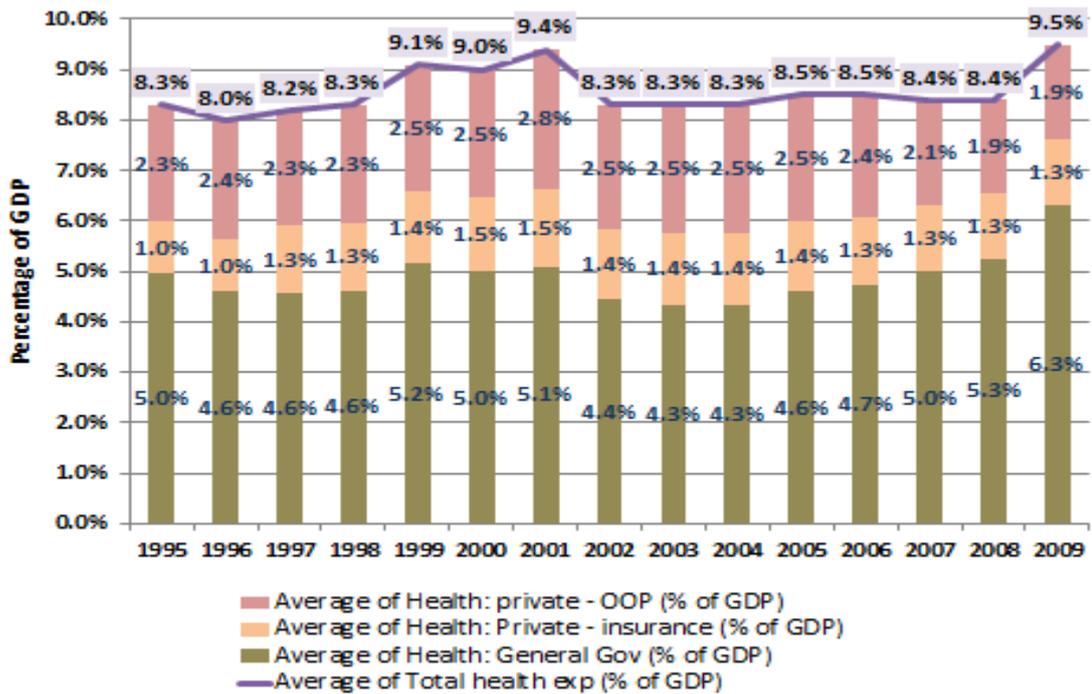
16.9.11 By way of contrast, Columbia, which mandates contributions to regulated medical schemes and explicitly operates a segmented and decentralized health system, only has total health expenditure equivalent to 6.4% of GDP. This contradicts the entire thrust of the Green Paper which implicitly asserts that such systems are inherently expensive and prone to systemic cost increases. Such systems are clearly only subject to excessive cost increases if they are not properly regulated.

Figure 16.3: Distribution of countries with populations exceeding 10 million by general government expenditure on Health Expressed as a percentage of GDP



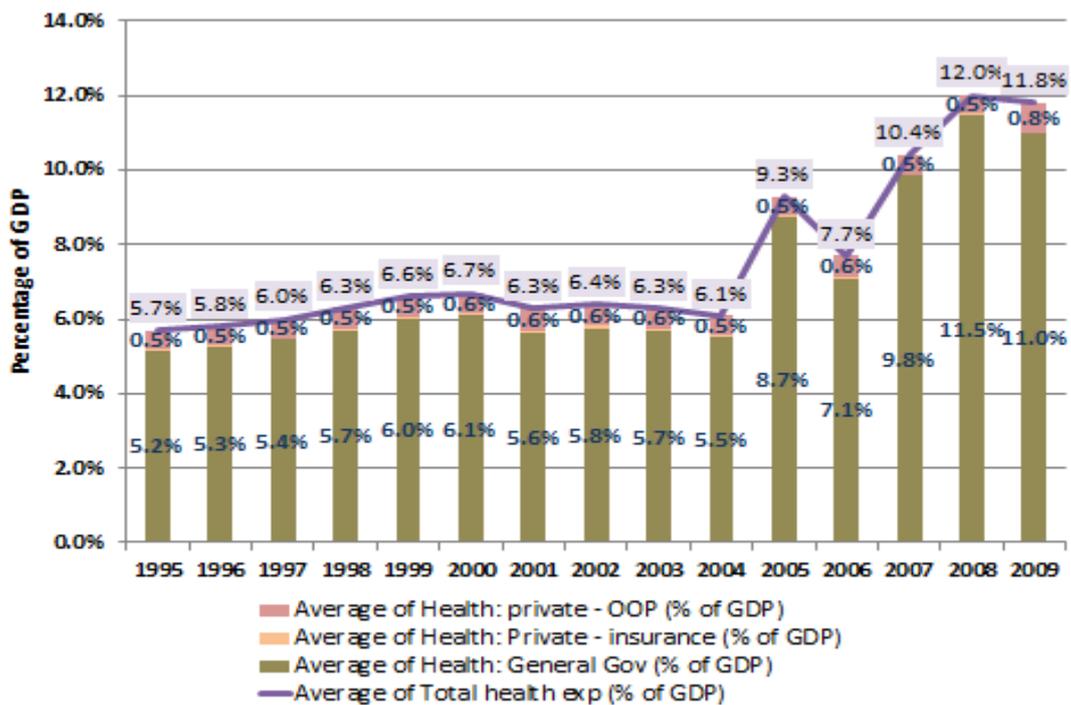
Source: Developed using the data from the World Health Organisation database, [\[http://apps.who.int/ghodata/#\]](http://apps.who.int/ghodata/#).

Figure 16.4: Argentina: National Health Accounts expressed as a Percentage of GDP from 1995 to 2009



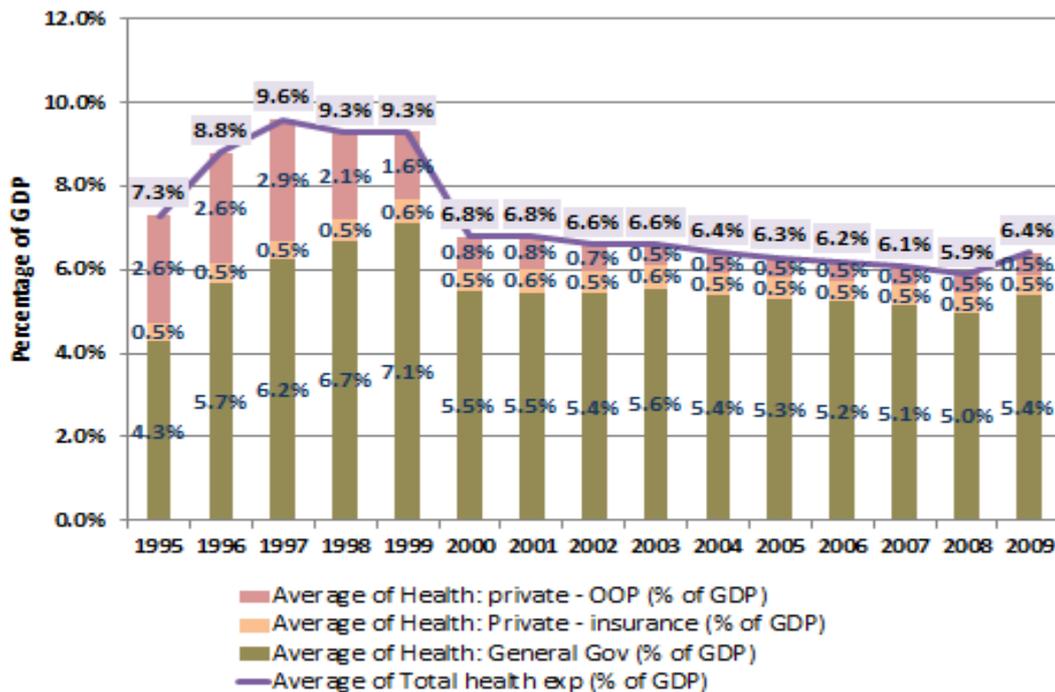
Source: World Health Organisation data, [<http://apps.who.int/ghodata/#>].

Figure 15.6: Cuba: National Health Accounts expressed as a Percentage of GDP from 1995 to 2009



Source: World Health Organisation data, [<http://apps.who.int/ghodata/#>].

Figure 16.6: Columbia: National Health Accounts expressed as a Percentage of GDP from 1995 to 2009



Source: World Health Organisation data, [<http://apps.who.int/ghodata/#>].

16.10 The absence of any specific analysis and content with quantification suggests that the strategic work has not been done to differentiate between three critical areas of health policy:

- *Area 1*: Services which are *needed* by people with insufficient income and are largely irrelevant to the majority of income earning families;
- *Area 2*: Services which will benefit from a *universal mechanism of protection*, such as for example emergency-related hospital-based care; and
- *Area 3*: Services where *private demand factors* rather than need predominate, such as general practitioner services, specialist services, and elective hospital-based treatment.

16.11 *Services in area 1* require redistributive taxes for their funding and are never aimed at more affluent communities. This includes primary promotive and preventive services, ambulatory primary care services, and comprehensive curative services rationed on the basis of cost-effectiveness.

16.12 *Services in area 2* are *non-elective* (i.e. patient-related discretionary demand is virtually zero) in nature and close to true public goods, i.e. excludability is not entirely possible (see **box 6.5** for the definition of a public good). Access to emergency services fall into this category as *no provider can refuse access in terms of the Constitution*.

However, the absence of mechanisms to reflect the public good nature of this entitlement results in incoherent responses from both the public and private sectors as both attempt to apply the principle of excludability.¹⁶⁵

- 16.13 *Services in area 3* are those where private preferences will invariably predominate or win out over any configuration of public services. This will include standards of access and customized convenience not generally regarded as cost-effective by even a well-run public system. Thus although these services form part of needed care, they will be purchased in such a way that both *need* and *demand* (consistent with private preferences) are satisfied.
- 16.14 Of the above only areas 1 and 2 fall neatly into public mechanisms, while area 3 requires mechanisms able to simultaneously accommodate both *need* and *demand-related preferences*. However, as services falling into area 3 are susceptible to market failure, resulting in the exploitation of those covered in private markets, commercial excesses need to be properly regulated to protect access to needed services.
- 16.15 Areas 1 and 2 also potentially benefit from different public coverage and delivery mechanisms, with the former more oriented to a general tax funded global budgeting mechanism and public service delivery, and the latter more to an earmarked tax funded insurance-based arrangement.
- 16.16 *Government's role in the health care system and health sector is not uniform. Failing to distinguish between these areas, as is the case in the Green Paper, will result in the wrong mix of mechanisms with government attempting to establish publicly driven universal mechanisms for the wrong mix of services and a failure to properly regulate coverage for services which are inevitably private in nature.*

¹⁶⁵ The public sector tries to exclude medical scheme patients, while the private sector attempts to exclude uninsured patients.

17. THE ESTABLISHMENT OF THE NATIONAL HEALTH INSURANCE FUND (Page 41)

- 17.1 The rationale for the proposed National Health Insurance Fund (NHIF) has not been provided anywhere in the report.
- 17.2 The recommendation implicitly assumes that the functions of provincial health departments will be transferred to the NHIF. This implies a substantial change to the functions of Government which, in terms of legislation provided for in the Public Service Act of 2008, requires the development of a business case by the Minister of Public Service Administration. There is however no evidence that any form of evaluation has been performed.
- 17.3 Importantly, the Constitution allocates the health function concurrently to both the first and second tiers of government. The requirement for a change to the Constitution clearly requires careful consideration and the generation of substantial consent in order to avoid inevitable and successful legal challenges.
- 17.4 Public health systems furthermore perform best with decentralized and devolved arrangements. By pushing accountability and decision-making closer to the people served, responsiveness and operational efficiencies are enhanced. The proposal for a NHIF proposes instead to do the opposite. These inefficiencies will only be exacerbated by politicizing the governance structure which exposes public organizations to private interests operating through political structures.
- 17.5 *The proposal for a NHIF adds no value to the health system and holds out the strong possibility that corruption and inefficiency will be exacerbated. Before any such proposal is taken seriously, therefore, a valid business case is required demonstrating what institutional weaknesses in the public system it seeks to address. As things stand this proposal fails the test of rationality, which adds to its legal vulnerability.*
- 17.6 *Government should nevertheless proceed with reforms that genuinely address systemic failures in the provinces and local government. Success is possible provided the will exists to confront the accountability challenges that have resulted from the politicization of the health service and the improper capture of points of procurement by private interests.*

PART C –

SUMMARY FINDINGS AND DISCUSSION

18. OVERALL FINDINGS

Overview

- 18.1 As a reflection of public policy the Green Paper raises a number of concerns.
- 18.2 Firstly the central premises upon which the policy framework is based derive from factually incorrect data and misleading reflections on the positions of the World Health Organisation.
- 18.3 Secondly, the factually incorrect information appears to have resulted from a deliberate attempt to exaggerate flaws in the system of medical schemes and the private health sector.
- 18.4 Thirdly, the proposed public sector institutional reforms lack any rationale or business case.
- 18.5 Fourthly, many required institutional reforms of the health system are missing.
- 18.6 Overall the Green Paper is difficult to read, with the relationship between the diagnostic sections (to the extent they could be found) and the policy proposals largely missing.

What is proposed? An evaluation

- 18.7 The primary focus of the Green Paper, although rarely stated clearly, involves an institutional restructuring of the public health system. Although much is said (critically) about medical schemes, no policy interventions of any form are proposed.
- 18.8 This presumably arises from the primary reform assumption that the combined effect of the proposed public health system restructuring and budget increases, amounting to an additional 3% of Gross Domestic product (GDP), will subsume into the public system a meaningful portion of the coverage presently offered through medical schemes.
- 18.9 The reform of medical schemes may be seen as a passive reaction to the active intervention in the state system. However, for this policy assumption to be valid the proposed trajectory of reform would need to be achievable in the medium-term. Failing which social protection obtainable through medical schemes will be *harmed by the resulting policy vacuum*.
- 18.10 The Green Paper implicitly (for it is rarely explicit) argues that a social imperative exists for an *expanded pooling structure or mechanism* capable of consolidating the fragmented coverage presently dispersed between the public and private sectors.
- 18.11 By putting the entire population into a single risk-pool, it is argued, several broad goals can be achieved, *inter alia*: more efficient management of cross-subsidies for the achievement of equity and risk sharing; more efficient administration; a more efficient configuration of services through central planning; and better cost management through the resulting monopsony power of a large central purchaser.

- 18.12 The Green Paper also discusses a number of interventions that are not institutional in nature, such as *district clinical support specialist teams*, *school health services*, and *municipal ward-based primary health care agents*. No substantive comment is however possible on these proposals as they are discussed superficially and have limited relevance to the central thrust of the Green Paper which deals with changes to the system's architecture.
- 18.13 As the proposals rely on an implied *consolidation of coverage*, two critical conditions would need to be met for success to be achieved:
- 18.13.1 *Condition 1*: The public sector restructuring must enhance the efficiency of management, administration, and service delivery; and
- 18.13.2 *Condition 2*: The proposed tax increase (equivalent to 3% of GDP) must achieve a substantial consolidation (substitution) of coverage (from medical schemes to the public sector) to offset the effect of the tax increase.
- 18.14 There is also interdependency between the two conditions.
- 18.15 If condition 1 is not met condition 2 *will never be met* as income earners will not transfer to the state system. As a consequence, the proposed additional tax equivalent to 3% of GDP would be felt entirely as a net reduction in disposable income by tax payers.
- 18.16 However, even where condition 1 is met, condition 2 may not be met, as a highly rationed, efficient and cost-effective public system may not prove attractive to income earners who will consequently continue with their private coverage. Such an eventuality would also see the tax increases reduce *disposable income* with all the consequential macroeconomic impacts and risks.
- 18.17 If the tax were raised entirely from private households, existing taxation levels would need to rise by between 20% (if from VAT and personal income tax) and 35% (if from personal income tax only).
- 18.18 Although not clear, the Green Paper *appears* to suggest that not only will this consolidation take place (i.e. that condition 2 will be achieved), but that there will be a reduction in overall health expenditure to 6.2% of GDP.¹⁶⁶ No evidence is however provided to validate this assumption upon which the reform rationale appears to rest.
- 18.19 A more reasonable test would however be whether overall health expenditure remains at 8.5% of GDP after the 3% tax. However, even for this less extreme assumption to be valid, all medical scheme members (as they as they are contributing at roughly 3% of GDP, would need to stop contributing.

¹⁶⁶ GP, par 125, p.40. "However, the ultimate level of spending on a universal health system relative to GDP (of 6.2% of GDP) is less than current spending by government and via medical schemes (of 8.5%)."

Alternatively, all out-of-pocket expenditure and 50% of medical scheme contributions (which would just about equal 3% of GDP) would need to shift all coverage to the public sector.

- 18.20 However, if out-of-pocket expenditure were unaffected and, for arguments sake, medical scheme expenditure equivalent to 1% of GDP were only affected (possibly due to the drop in household disposable income affecting lower income medical scheme members), overall health expenditure will increase to a worrying 10.5% of GDP. In contrast to the two scenarios presented above, this is very plausible, with the risk remaining that no material substitution will occur resulting in expenditure of 11.5% of GDP.
- 18.21 Apart from the two above-mentioned conditions, an important question is whether the Green Paper effectively addresses the weaknesses in coverage of the health system. If not, it is likely that achieved coverage levels within the public and private sectors will deteriorate further. *As the Green Paper implicitly assumes that no gaps exist in its framework such eventualities are not outlined or evaluated.*
- 18.22 The overall (implicit) reform business case is however not helped by the glaring factual errors affecting certain of the core reform arguments. These mainly apply to assessments of the sustainability of medical schemes and resource disparities between the public system and privately paying catchment populations.
- 18.23 When the facts are considered, medical schemes' real per capita contribution increases have not exceeded inflation since 2002¹⁶⁷, underlying medical cost increases have moderated (particularly from 2004)¹⁶⁸, and the distribution of the workforce between the public and private sectors is not inequitable or reflective of a systemic problem (see **pars 5.9, 6.41; tables 6.2, 6.3, and 6.4; and figures 6.13 and 6.14; and box 6.11**).
- 18.24 The factual errors regarding medical schemes and private coverage made in the Green Paper suggest an underlying incentive to exaggerate pieces of evidence to bolster a pre-determined policy recommendation that may otherwise lack substance.
- 18.25 If medical schemes and private sector costs are not spinning out of control, and the workforce distribution between the public and private sectors is reasonable, a very different diagnostic is in play.
- 18.26 In particular, government must explain the poor health outcomes of the public health system despite the substantial resources at its disposal. It must also explain how countries spending far less through their public health systems substantially outperform South Africa in health outcomes.

¹⁶⁷ See **figure 5.15**.

¹⁶⁸ See **figure 5.7**.

- 18.27 The performance failures of the public health system are invariably institutional in nature and require an institutional response. *However, while the Green Paper dwells inexplicably on medical schemes it is silent on the performance failures of the public sector and the likely institutional causes.* Given this, the policy prescriptions bear no relation to the systems actual institutional failures.
- 18.28 The central public sector institutional reforms proposed, couched as they are in ambiguous and vague language, propose a central fund and a district health authority system (which would “purchase” services). Central academic hospitals, a major function of provincial governments, are also to be run from national government. *The role of provinces is not mentioned.*
- 18.29 Not one of these proposals however arises from a diagnostic or the problem statement (which focuses exclusively on the private sector). There is in fact no business case or feasibility study that has been performed.
- 18.30 Given implied transactions costs (both financial and non-financial) involved in eliminating provincial administrations and constituting (basically the same) structures in another form, a *value-for-money* case is required to justify the change. *One can only speculate on the reasons for the absence of any rationale for such a major restructuring of the public sector.*

Consequences of the proposed public sector reforms if implemented

- 18.31 The proposed institutional reforms, if implemented, would however further weaken the public health system structurally, while at the same time failing to address the present failures. *They are in fact more likely to deepen the crisis in the public system than alleviate it:*
- 18.31.1 The proposed central fund with regional offices, which apparently seeks to replace provincial administrations, centralizes decision-making in the health system. This *command-and-control* centralization militates against efficient decision-making as well as accountability to the populations served.
- 18.31.2 The political appointment of a Chief Executive to this fund further distances the structure from the people and increases the risk of corruption and inefficiency. The failed accountability structures at all tiers of government and within many parastatals can largely be traced to such political appointments and improper interference.
- 18.31.3 As provincial governments are elected separately from national government, and basic education and health represent between 70% and 85% of what they provide, they can be held specifically accountable for performance in these areas than would be the case for national functions.
- 18.31.4 Placing the entire health function under the control of central government consequently reduces political accountability to the electorate with consequential effects on levels of efficiency and corruption.
- 18.31.5 Although to date political competition has been minimal in most provinces, apart from the Western Cape (whose performance is vastly

better than any other province), this is likely to change materially over the next 5 to 10 years. Poorly performing provincial health systems will become a major focus of political competition, increasing political incentives to make public health services more efficient, less corrupt and more responsive to the population served.

- 18.31.6 Aside from the dulling of political accountability, the centralization of academic health complexes, if implemented, would fragment service delivery at a provincial level. Only a portion of what these hospital do involve national functions (such as education, training, and a few supra-regional¹⁶⁹ services). The rest relates entirely to the regional population. The national functions are however easily addressed through minimum norms and standards and conditional grants. If placed at the national level the health service would be further fragmented and break up the possibility of coherent service planning for designated catchment populations.
- 18.31.7 The proposed establishment of a district health authority system is needed. However, whether it achieves anything depends fundamentally on its design. No proposed design is provided in the Green Paper apart from the strange proposal to make districts report to the “national fund”. *A district health system should however fall under the supervision of provincial governments and not the national government.* Not only do they require structures to make them specifically accountable to the communities served, *but the province should be held accountable for their performance.*
- 18.31.8 The proposed Office of Health Standards Compliance (OHSC), although a needed institutional reform to increase accountability within both the public and private sectors, also has a political governance model. This creates an untenable conflict of interest which will materially diminish the accountability effect of this organisation and its operational capability. As the organisation will accredit health facilities, the risk of politically protected kick-backs is high, as is the inevitable blind eye turned to politically connected individuals. Aside from this, political appointments detrimentally affect the leadership function of an organization as invariably the wrong person for the position is appointed.
- 18.32 *On the whole, no rational reason can be found either within or outside of the Green Paper for: the proposed national fund and its regional offices; the removal of the health function from provinces, and for the centralization of academic complexes. Although there are good reasons to introduce a district health authority system, its success depends on what is actually proposed. Unfortunately no proposals in this regard are made. The institutional restructuring, far from*

¹⁶⁹ This occurs where the catchment population for a particular hospitals extends beyond the provincial boundaries of its location.

improving performance, will, through centralization, dull accountability effects and further entrench prevalent inefficiency and corruption.

What should happen?

- 18.33 Public sector reforms need to follow a different path from that proposed, with institutional changes that *deepen* rather than *dull* accountability affects. There is nothing inherently flawed with the provincial model of health service delivery, provided the provinces are made to feel accountable to their electorate. Health systems around the world function exceedingly well with such arrangements as local responsiveness is enhanced.
- 18.34 The role of the national government with respect to health is clear. It should focus its attention on the development of strategic policy and legislated national norms and standards to be implemented in all provinces.
- 18.35 In seventeen years, the National Department of Health, despite having significant powers in this regard and no financial constraints, has failed to produce *any* policy-related norms and standards with respect to services, the workforce, reporting, and information technology. Such highly leveraged interventions are relatively straightforward to develop and implement and institutionally leaner and more effective than the centralization of the full health function.
- 18.36 Were the Department of Health to focus exclusively on its current mandate it would be able to achieve many gains within the medium-term. However, if it focuses on centralizing the health function, it is unlikely that any meaningful service improvements will be possible.
- 18.37 Deepening accountability within the public health system should involve the following:
- 18.37.1 Depoliticizing hospital service delivery through the establishment of autonomous public hospitals with *independent* boards that appoint and remove the hospital executive;
 - 18.37.2 Depoliticizing district service delivery through the establishment of *independent* district boards that can appoint and remove the district executive;
 - 18.37.3 The establishment of an *independent* board of oversight for emergency medical services; and
 - 18.37.4 The establishment of an independent OHSC with an *independent* board that appoints and removes the senior executive.
- 18.38 Deepening accountability should go together with the decentralization of *decision-space* within the public health system. It is however not appropriate to merely hand down delegations to hospital managers and districts without establishing strong localized governance structures. If done, inefficiency and corruption will be exacerbated and lead to failed institutions.
- 18.39 Resource allocation within the public health system will be greatly enhanced by the development of meaningful minimum norms and standards. Such

information would invariably serve as weighting factors to allocate certain funding on a formula basis where required.

- 18.40 The policy vacuum regarding medical schemes and the private sector, resulting from exaggerated optimism regarding the NHI proposals, is technically flawed and irresponsible.
- 18.41 Consistent with the positions of the World Health Organisation private health systems *must be properly regulated*. This requires that valid proposals need to be tabled to strengthen risk pooling within schemes and to manage costs where these are caused by market failure. Important gaps in social protection offered by medical schemes need to be addressed, especially those which cannot be resolved through incremental adjustments to the public sector.
- 18.42 These include:
- 18.42.1 The introduction of risk-equalization;
 - 18.42.2 The removal of parallel insurance for the regulated benefits of medical schemes (which undermine risk pooling);
 - 18.42.3 The strengthening of medical scheme governance (to further remove improper conflicts of interest and prevalent corruption);
 - 18.42.4 The strengthening of the prescribed minimum benefit framework to remove gaps in benefits with catastrophic financial implications for members;¹⁷⁰
 - 18.42.5 To implement a coherent negotiating framework to determine prices charged by providers to both the general public and medical schemes; and
 - 18.42.6 To restructure the tax expenditure subsidy to favour lower-income contributors.
- 18.43 Government also needs to consider the establishment of a coherent national framework for funding and ensuring universal free (at point of service) access for emergency services. The failure to establish such a system over the past seventeen years raises questions about the responsiveness of government to key social imperatives and its understanding of its Constitutional obligations. The Green Paper inexplicably fails to deal with this contingency.

Concluding statements

- 18.44 The Green Paper is plainly deeply flawed, suggesting weaknesses in the policy process thus far. The inclusion of gross errors of fact and misleading information,

¹⁷⁰ There is a strong medical scheme lobby seeking to eliminate the application of prescribed minimum benefits to contingencies with catastrophic medical and financial implications for members. Were this to be conceded to, medical schemes would use benefit design to exclude bad risks from schemes. This is what the commercial medical schemes are seeking, particularly as it permits them to sell for profit gap insurance into the resulting benefit gaps.

some of which looks deliberate, as well as the failure to provide rational arguments for the public system reforms, are unacceptable for a Green Paper.

- 18.45 A Green Paper should properly communicate policies to the public and include their underlying rationale. Any failure to do this undermines the consultation process and serves to actively deceive the general lay public who cannot be expected to pick up distortions of fact on their own.
- 18.46 In a number of instances this Green Paper has presented factually incorrect information in such a way that the integrity of the drafters has to be questioned. In particular, the incorrect references to the positions of the World Health Organisation, the incorrect statements regarding workforce disparities between the public and private sectors, and the false information and statements regarding the sustainability of medical schemes *are sufficiently egregious to require a clarification from Government.*
- 18.47 The policy prescriptions, which depend for their sustainability on the substitution of coverage from medical schemes to the public system, are far from convincing.
- 18.48 Quite reasonably, before a request is made to increase taxes by 3% of GDP the public requires a thorough business case. Particularly those who are designated to pay the tax. However, in what should have been the most carefully thought out part of the Green Paper, the public sector institutional reforms, no rationale is offered and no clear reflection is provided of what is proposed.
- 18.49 This gap is not appropriate given that the Paper proposes to change a public sector arrangement that works perfectly well in other countries, and should work well in South Africa, to one that will dull accountability and service responsiveness. *If a case is to be made, however, it should be transparently presented for comment.*
- 18.50 *It is consequently necessary that Government substantially re-draft the Green Paper before proceeding further with the major policy commitments. Any failure to do so will expose Government to legal challenges inter alia on the Constitutional grounds that the proposals are not rational and are inconsistent with the institutional aspects of the Constitution.*

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