The UK NHS: a model for the South African health system?

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Andrew Barlow looks at the UK's NHS and proposals to implement a similar system in South Africa

In December 2015, the Government released the long awaited National Health Insurance (NHI) White paper. The paper represents the blueprint for implementing single-payer health care in South Africa: an entirely government-funded system in which all South African citizens have free access to health care services at the point of service. The paper treats health services as public goods [1] – like literacy, street lighting and a competent police force. [2] As such, health service provision is argued to be a "social investment" that should not be treated as a private commodity "subjected to market forces". [3] Simply put, the only factor determining your access to health care should be the state of your health, not the size of your wallet.

This resonates with the instinctive morals the majority of us have. When we see another human being in pain, impulse directs us to help them. This urge to come to the aid of our fellow man is basic to the human condition. It is as primitive as our desire to procreate. This is why stories of people suffering because of a lack of access to health care repulse so many of us, and why the idea of UHC is so intuitively appealing. The problem is: seven per cent of over fifteens in South Africa remain illiterate, street lighting regularly fails due to load shedding and a lack of adequate maintenance, and the police force is not only largely incompetent but riddled with corruption. So if the Government fails to deliver on these public goods, what reason do we have to trust in their ability to implement and manage a single payer system?

The National Health Service (NHS) has been providing publicly funded health care in the UK since 1948. With the exception of certain services, such as prescriptions and dentistry, the NHS is free at point of use for any and every UK resident. Services offered range from emergency treatment to organ transplants to palliative care for the terminally ill. The NHS deals with over a million patients every 36 hours. [4] To do this it employs more than 1.6 million people, putting it in the top five largest global workforces – along with McDonalds, Walmart, the US Department of Defence and the Chinese People's Liberation Army. [5] NHS funding comes directly from taxation. For 2015/16 its overall budget totalled just over £115 billion.

In 2014, the Commonwealth Fund – a US-based health foundation despite the name – declared the NHS overall the most impressive UHC system globally when compared to that of Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, and Switzerland. [6] The NHS was judged to perform best in terms of efficiency, effective care, safe care, co-ordinated care, patient-

centred care and cost-related problems, as well as second best in terms of equity. [7] Overall, the Commonwealth Fund concluded that the NHS "outperforms all countries" by providing "universal coverage with low out-of-pocket costs while maintaining quick access to specialty services". [8]

Yet to think the NHS devoid of fault or flaw would be both mistaken and deeply naive. There are four major issues facing the NHS currently, each of which is relevant to the white paper proposals to introduce a similar system here in South Africa.

1. *Funding*. The NHS ran a £1.6 billion deficit in the first half of the 2015/16 financial year, and is expected to finish £2.2 billion in the red. [9] This is unprecedented in NHS history. Professor John Appleby, the chief economist at the Kings Fund, a UK health policy think tank, stated that standards within the NHS were slipping at rates worse than the early 90's – an apparently notorious low point in NHS history. [10] A report mandated last year by the British Parliament noted, amongst other things, that: waiting time targets for A&E, hospital treatment and cancer care were all being missed; bed occupancy was increasing to "very high levels"; and delays in discharging patients were significantly rising. [11]

The South African economy is already under tremendous pressure – it is unlikely it could cope with a public sector drain comparable to that of the NHS this year. Because of this, standards will slip even more than they have already if the government is forced to choose between adequately funding the NHI or shoring up public funds elsewhere (think education, think annual civil service pay increases, think nuclear power plant proposals, think anything in fact).

2. *Outsourcing*. The NHS has always worked alongside a large and highly effective private health care sector (for those who can and wish to pay for the various benefits this brings). In recent decades, it has increasingly commissioned a proportion of health care services from for-profit companies when under pressure and unable to meet demand or standards. In the 2014/2015 financial year, around 10% of the total budget was spent on outsourcing to the private sector. [12] Due to legislation introduced in 2012, which was aimed at increasing private sector access to service provision within the public sector to accelerate patient choice and competition, this is only expected to increase in the coming decade. Many worry that this represents the beginnings of creeping NHS privatisation under the current Conservative government.

The wording of the white paper makes clear that it is hostile to working with – nay the very existence of – the private sector. It is described as preserving the inequity in health care inherited from apartheid. [13] It is argued to be one of the main causes of the dire straits the public health care sector is currently in. [14] To correct this, the private sector will be limited to complementary service

provision – i.e. only those services not provided by the NHI. [15] Furthermore, private health service providers will be mandatorily co-opted to work within the NHI for a fixed fee significantly lower than what they charge at present. [16] So if the NHS – and its enormous budget – relies heavily on the private sector, how feasible is the idea of an NHI that almost entirely excludes it?

3. *Staffing*. In January 2016, British doctors went on strike for the first time in 40 years. Tens of thousands of junior doctors walked out in response to the government's policy proposals to amend their contracts. Previously, junior doctors' working hours extended from 7am - 7pm from Monday to Friday; any work done outside of this was classed as 'unsociable' and reimbursed with extra pay. Since junior doctors work long hours, and often seven days a week, a large part of their salary comes from working 'unsociable' hours. It also represents a safeguard that financially penalises hospitals for overworking such a crucial part of the work force. The proposals will see sociable hours extended to 7am – 10pm from Monday to Saturday. This not only hits overworked and underpaid doctors financially, but it potentially poses a danger to the patients – who will be treated by doctors lacking adequate rest. [17]

The first concern here is that striking is not a tool used infrequently by unions in South Africa. In fact, the nation has one of the highest rates of industrial action in the world. In 2012, 17 million working hours were lost as a result of industrial action as a result of 99 strikes. [18] The SA Medical Association (SAMA) last walked out in 2009, over similar objections to pay and unfair working hours. In a likely strained and underfunded NHI, working conditions will deteriorate, and striking will be commonplace. The second concern is that with such unattractive job prospects within a dysfunctional public sector, and with no real private sector to look to as alternative, junior doctors will increasingly move abroad for career advancement. This is an existing and highly undesirable phenomenon; exacerbating it should be avoided at all costs.

4. *Regional Variation in Standards*. There are wide variations in standards of care between the countries of England, Scotland, Wales and Northern Ireland that make up the UK. As each country's respective legislative body manages its own branch of the NHS, this directly impacts on the way it is directed and managed. Due to the socialist-leaning Labour majority in the Welsh Assembly and outright socialist Scottish National Party's dominance in Holyrood, standards such as waiting times to procedures and to be seen in casualty are markedly different in these countries compared to those in England and Northern Ireland – largely due to their unwillingness to use any private sub-contractors or initiatives.

On a smaller scale, neighbouring hospitals are regularly recorded has having widely different performances due to different leadership and governance standards within their respective managing

Hospital Trusts. The most extreme example of this was the scandal surrounding the Mid Staffordshire NHS Trust in 2009. Long plagued by financial difficulties and mired by mismanagement and maladministration, hundreds of patients were reportedly left "lying in their own urine and excrement for days, forced to drink water from vases, given the wrong medication or sent home with life-threatening conditions". [19] Overall, an investigation calculated that during 2005 - 2008 between 400 and 1,200 more people died at Stafford Hospital than should have been expected.

Provision of health in South Africa is currently a largely provincial function. Due to differences in infrastructure and socioeconomic conditions between provinces, and differences in competency, honesty and experience between provincial governments, there is already a marked variation in regional standards of provision. During 2014/15, the Western Cape recorded 0.16% child diarrhoea case fatality rate; Mpumalanga recorded 5.26%. [20] In the same time period, the Western Cape's maternal mortality in facility ratio was 54 per 100 000 live births, Gauteng's was 113, and the Northern Cape was 254. [21] The Western Cape and Gauteng consistently outperform the poorer provinces, usually to a factor of four to five.

The white paper proposes a heavily centralised NHI fund, possibly in an attempt to mitigate this very problem. However, because this administrative structure will be so complex, and because severe discrepancies in socioeconomic conditions and infrastructure will remain between the provinces, this issue will be both significant and unavoidable. It will be practically impossible to make standards uniform over such a heterogeneous landmass. Moreover, it is certainly possible that the Government will extend its policy of cadre deployment to local hospital administration positions. If this proves to be the case, the variation of standards between each hospital will rest entirely on the character of the women or men deployed there. Opportunities for personal enrichment will be ample, maladministration and misgovernance widespread.

The NHI White Paper outlines plans for a UHC system that is both admirable and ambitious. The standard of care within much of the public sector currently leaves much to be desired. The discrepancy between the qualities of service offered in the public sector compared to that of the private is an issue which demands addressing: adequate health care should be available to all who need it. Yet disregarding the many issues and concerns with the paper's proposals themselves – a lack of any clarity on the source and method of funding; the issues surrounding private sector involvement; the nature of the proposed centralised administrative structure and the enormous bureaucracy and communicative confusion in management that this will no doubt entail – we see that even within the best single payer system currently in place globally, there are significant and varied obstacles that threaten performance, standards and delivery of service.

The NHS has decades of experience to draw upon, an enormous budget, a relatively stable economy, and a managing government unhindered by a retrograde commitment to outdated ideology or a culture of nepotism, rent-seeking and graft. The same cannot be said about the ruling party in South Africa. Moreover, it seems probable, when all things are considered, that the government is over reaching with the NHI proposals. Although admirable, it is simply unfeasible that it will have the capacity to deliver on its promises and implement an effective, efficient and uniformly accessible single payer system, entirely publically funded. Burns' warning is entirely appropriate here.

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