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The WCape DOH's critique of the NHI Green Paper

Western Cape Department of Health |

15 March 2012

SA's most functional health dept explains what actually needs to be done

Official comment from the Western Cape Government on the proposed Green Paper on National Health Insurance (NHI)

Our conviction is that every resident of South Africa should be able to enjoy high-quality healthcare that is affordable, responsive and sustainable.

The major obstacle to realizing this goal, thus far, has been a public health system that delivers low-quality healthcare to the majority of our population. This is a tragedy, and it is unnecessary. South Africa has the resources and skills-base to provide excellent healthcare for all who need it. However, the only way to improve the system is to make sure we understand the nature of its problems and respond with solutions that will lead to superior health outcomes.

So, what is to be done?

The Minister of Health, Aaron Motsoaledi have proposed the creation of a National Health Insurance (NHI) policy to fix our public healthcare system based on the belief that the establishment of a single, centralised fund through which all healthcare costs are administered will ensure greater accessibility, social solidarity, equity, affordability and efficiency for all who seek health services.

It is further proposed that the failures of the public healthcare system are primarily a result of the successes of the private healthcare sector, in that the government is not able to use the money spent on private medical aid schemes in its own sector. NHI would thus seek to take the money that people spend on private healthcare and draw it into the central fund, thereby disincentivising the use of private medical schemes.

In order to justify this, the Green Paper contends that government failure is due to the private sector's success. This does not make sense. It is like saying that public schools perform poorly because private schools perform well, or that Telkom's inefficiency is a result of Vodacom's efficiency. This is a misreading of reality. Indeed, the promotion of such an argument suggests that the Health Ministry not only misunderstands what is wrong with healthcare, but remains blind to its own responsibility in creating the problems the health system now faces.

However, the Western Cape Government believes there is a better alternative, not only to the current state of public healthcare, but to the incumbent National Government's Green Paper on NHI.

In the Western Cape we offer a model of healthcare provision that leverages our system's strengths, minimizes its deficiencies and delivers good health services in a responsible and sustainable manner. We do not blame the private sector for any difficulties we face; rather, we seek out public-private partnerships so that we can both participate in the improvement of the province's total health service effort to the benefit of all people. At the heart of our provincial system is a commitment to accountability, affordability and efficiency - all necessary elements for high-quality health outcomes.

In this document, we outline the problems in South Africa's health system, then we assess whether NHI has the potential to fix it. We evaluate the potential and pitfalls of the NHI proposal, then discuss the alternative healthcare plan which we believe will provide better health outcomes for the nation.

The state of South African healthcare

According to the World Health Organization, a healthcare system should include "all activities whose primary purpose is to promote, restore or maintain health."[\[1\]](#) It should strive to:

- Improve the health of the population
- Protect people financially
- Respond to the expectations of the population

At present, these goals are only being partially met through our National healthcare system. The public sector, which serves the majority of the population (65%), scores high marks on accessibility, but low marks on quality. The private sector, which serves a growing minority of the population (35%), scores high on quality, but low on accessibility.[\[2\]](#) Together, they provide an uneven health service for the country. But if we assess it according to the three criteria above, we can get a better sense of where we should be focusing our health interventions.

1. Improving the health of the population

According to the Development Bank of South Africa's Health Roadmap report, the health status of South Africa has worsened considerably over the past twelve years.[\[3\]](#) While the health system has helped some people maintain decent health, we cannot yet say that it has "improved the health of the population." According to numerous health indicators, South Africa's health standards are falling in absolute and comparative terms. The 2011-12 World Economic Forum Global Competitiveness Report[\[4\]](#) shows that we rank near the bottom of the world in terms of public health:

Indicator	Numerical value	Rank out of 142 countries
TB incidence / 100,000 people	971 / 100,000	141 st
HIV prevalence, % adult population	17.8%	139 th

Life expectancy, years	51.6	130 th
Infant mortality, deaths / 1,000 live births	43.1 / 1,000	111 th

Some of this is understandable given our history and current social challenges. We face a very high disease burden, coupled with the effects of physical inactivity and physical danger. Hence, according to the National Planning Commission's National Development Plan, the four major threats to health in South Africa are:

- HIV/AIDS and TB
- high maternal and infant mortality
- non-communicable (lifestyle) diseases
- injuries through violence^[5]

Many of these health problems stem from larger social issues, such as sexual behaviour and crime, which require more than just good health policies to solve.

The only way to improve the health of the population is to make sure that healthcare is fully-accessible and of a high-quality. While the public sector provides the requisite level of accessibility, it does not offer enough quality. This is why so many people seek private healthcare, despite its costs.

This, then, is the great challenge for the public sector: to enhance its level of quality so that it can actually improve the health of the population.

2. Protecting people financially

The public sector, which is funded from the general fiscus through a progressive taxation system, provides free healthcare for those lacking the funds to pay for themselves. A means-test determines who is eligible for free public healthcare and who must seek additional support from private medical insurance. This has reduced out-of-pocket expenses for the poor to a minimum, but it has left some low-wage and middle-income earners vulnerable to the vagaries of co-payments that can sometimes arise from medical procedures.

Financial fairness is best achieved from a mix of pre-payment systems and the pooling of funds. The ideal in healthcare financing is for the ratio of total health contributions to be identical for all households irrespective of their income, health status or use of the health system.^[6] This means that out of pocket payments, which are payments made directly to the healthcare provider from the patient, should be kept to a reasonable level for those who can afford it.

Currently, South Africa's out-of-pocket expenditure for healthcare - 18.1% of all total health expenditure - is comparatively low by international standards. It is lower than countries like Taiwan and South Korea (30% and 36.8% respectively), both of which have NHI-based healthcare systems.^[7] Thus, together, our public and private systems do well to protect people financially, though more attention should be given to the challenges facing low- and middle-income families that earn too much for free medical care, but too little for comprehensive private care.^[8]

3. Responding to the expectations of the population

While the private health sector is highly responsive to patients' expectations and desires, the public sector is less so. This is due largely to the fact that the private sector must compete for customers, making them responsive to patients' desire. There is less of an incentive to be so responsive in the public sector where patients are essentially captive clients. This different level of responsiveness explains why many people - even those who have access to free public healthcare - choose to use private healthcare when possible.

All patients want their health practitioners to respect their dignity, autonomy and confidentiality. They want them to reduce their anxieties and handle their concerns with empathy. Unfortunately, many patients in the public sector complain of long queues, disinterested staff and - in the case of refugees - discrimination and denial of services. Such maltreatment compounds the vulnerability these patients already feel and can drive individuals away who desperately need treatment.

This image is reinforced by patient satisfaction surveys which reveal that private medical aid patients report far greater satisfaction with their healthcare experiences than those who use the public sector. According to data from the Ministerial Task Team, private patients reported satisfaction levels of 88-92% for hospital and doctor/specialist services while public healthcare patients reported only 57-60% for the same services in their sector.^[9]

This suggests that the government needs to incentivise better treatment of patients in the public sector by holding health practitioners accountable for their actions. Their behaviour with patients has a major impact on whether patients feel that healthcare is responsive to their expectations.

The National Government's proposal: National Health Insurance (NHI)

The National Minister of Health acknowledges that the public health system experiences "notable quality problems", and listed the most commonly cited problems as "cleanliness, safety and security of staff and patients, long waiting time, staff attitudes, infection control and drug stock-outs."[\[10\]](#)

It is argued that these problems do not stem from bad management, poor oversight or the lack of proper accountability measures. Rather, they claim that "This poor performance has been attributed mainly to the inequities between the public and private sector."[\[11\]](#)

This sentiment - that the failure of the public healthcare system is due to the success, or simply existence, of the private healthcare sector - underpins every aspect of the government's National Health Insurance plan.

According to the NHI Green Paper, the objectives of NHI are:

- *to provide improved access to quality health services for all South Africans*
- *to pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund*
- *to procure services on behalf of the entire population and efficiently mobilize and control key financial resources*
- *to strengthen the under-resourced and strained public sector*[\[12\]](#)

The rationale for these changes is to "eliminate the current tiered system" which the Minister says is "inequitable".[\[13\]](#) Thus NHI would try to homogenize the differences between the public and private sectors so that there is a uniform standard of service quality across the system.

To achieve this, the Green Paper calls for the establishment of a central National Health Insurance Fund which would pay the bulk of healthcare costs for all South Africans and legal residents. The Fund would receive its money from the general tax system (as public healthcare is currently financed) and a mandatory contribution to the NHI Fund through a payroll tax on all formally employed people.[\[14\]](#) This additional tax would not only increase the amount of money available to the public system, but dissuade employed people from paying for private medical aid (which the National Minister of Health believes receives an "unfair" proportion of healthcare funds).

The Green Paper provides no indication of the basket of services that will be covered through public funding, but suggests that it aspires to eliminate all forms of co-payment. Despite this lack of clarity on what procedures or treatments NHI will cover, the Green Paper says that, during the 14-year phase-in period of NHI, the government budget for healthcare will increase from R103bn (2011) to R125bn (2012) to R213bn (2020) to R255bn (2025). No explanation is given for how the National Department of Health arrived at these numbers.

Despite the fact that the Green Paper is unclear about the costs involved, it is quite definitive about what will improve healthcare. It will require nothing less than "a **complete transformation** of healthcare service provision and delivery, the **total overhaul** of the *entire* healthcare system, the **radical change** of administration and management, and the provision of a *comprehensive* package of care underpinned by a **re-engineered** Primary healthcare."[\[15\]](#)

In a word, healthcare requires a "revolution" - one that will apparently be won through centralised funding and higher taxes.

10 Reasons why NHI is not the answer to our National healthcare problems

We believe that National Government and the National Minister of Health have misdiagnosed the healthcare system's ailments, and that the current approach proposed in the Green Paper on NHI will not cure it. It is the conviction of the Western Cape Government that there are at least ten reasons why NHI is not the answer to the problems in our National public healthcare system.

1. The private sector is not responsible for the low-quality outcomes of the public health sector

The Minister of Health blames the private healthcare system for the poor health outcomes of the public system that he is in charge of. Yet there is no relationship between private healthcare's higher quality and the public system's lower quality. They are separate sectors that complement each other, but do not determine each other's outcomes. This should be common sense. After all, if private healthcare ceased to exist tomorrow, public healthcare would not suddenly improve. Yet the whole justification for NHI rests on this argument.

According to recommendations made by the Ministerial Task Team's report on funding healthcare - all of which were ignored by the authors of the Green Paper - "the historical debate that has focused on polarized elements of the public and private sectors is not constructive, and does not lead to optimal policy discussions and outcomes."[\[16\]](#)

The reason for this there is "no evidence available to the Task Team to suggest that the expansion or conduct of the private sector has played any material role in this deterioration [of the public healthcare system], as adequate resources and staff were at all times available to respond to existing and changing public needs. The mere factual statement that a differential level of per capita expenditure exists between the public and private systems does not constitute evidence of a negative impact on the performance of the public system. Nor is it indicative of public sector under-funding."[\[17\]](#)

2. NHI does not fix the real problem, which is low-quality provision in the public sector

The primary problem with the public health system is not accessibility. The public system provides free healthcare to all who cannot afford private medical care. Between the public and private systems, everyone in South Africa enjoys access to formal healthcare.

The real problem with the public healthcare system is that it offers low-quality healthcare outcomes. This compromises the health of the nation and makes it virtually impossible to achieve the developmental improvements that we desire.

The government's own National Planning Commission explains that the healthcare system is "fractured, with pervasive disorder and multiple consequences: poor authority, feeble accountability, marginalisation of clinical processes and low staff morale. Centralised control has not worked because of a general lack of discipline, inappropriate functions, weak accountability, lack of adherence to policy, inadequate oversight, feeble institutional links between different levels of services (especially hospitals) and defensive health service levels increasingly protective of turf and budgets."[\[18\]](#) But these issues which lower quality barely even rate a mention in the NHI proposal.

Quality is ultimately a question of standards, targets and accountability. The Green Paper focuses little time on the question of what minimum norms and standards are required to achieve high-quality outcomes. It does not set targets for health improvements that the system must attain. And because no one is held accountable for failing to achieve the non-existent targets, the public sector continuously disappoints.

3. NHI does not adequately attend to accountability and management structures

According to the Ministerial Task Team, "No part of the health system is held properly accountable for poor health outcomes or poor service delivery."[\[19\]](#) This fact alone makes it virtually impossible for the system to improve since no one in it has an incentive to perform better.

Indeed, "The absence of a statutory body and independent quality assurance regulator further reduces the imperative of any health authority or service provider to become overly concerned with gaps in the standard of care offered, as they face few consequences and can avoid the publication of embarrassing information on their performance."[\[20\]](#) And because the public sector does not assess itself according to any known benchmarks or targets, the government does not know how to evaluate its own healthcare performance. This is a problem.

The Green Paper proposes the creation of an Office of Standards Compliance to accredit and regulate institutions, performing a crucial oversight function. This is a start, but since the members of that body will be appointed by, and answer to, the Minister of Health, it will not be a truly independent body. It will be open to political pressure and influence, as much a tool of politicians as an instrument of healthcare oversight. This is undesirable and unnecessary. As the National Planning Commission states, there needs to be a "clear separation of policy making from oversight and operations."[\[21\]](#) To create effective accountability and governance structures requires an independent, neutral and transparent body.

4. Centralisation of healthcare funding will be bureaucratic and inefficient

The Green Paper proposes that a single National Health Fund be established to fund all healthcare outlays in the country. The value of such a large fund would be that it pools risk, reducing the possibility that individual health catastrophes overwhelm the fund's viability (as they can do with smaller medical scheme funds). It also gives the government greater strength at the negotiating table when buying healthcare goods for hospitals, clinics and pharmacies.

As sensible as this proposal might sound, the centralisation of healthcare funding into a single pool carries its own risks. First, the logistical requirements of using a centralised fund would be daunting. The National Fund proposes to contract all individual facilities into NHI. In the Western Cape alone there are 52 hospitals and 477 primary healthcare facilities, currently managed by the province. Whether a single centrally-managed fund could have the capacity to assess, accredit and individually contract with each of the facilities across the country is highly doubtful.

Second, the creation of a single pool reduces any incentive to save costs through efficient administration. Indeed, according to the WHO, "competition among pools...can increase the responsiveness of pooling organizations to their members and provide an incentive for innovation. It can also offer incentives reducing costs....[In one example,] 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." [22]

Lastly, any maladministration or corruption by the Fund managers would have a disproportionate impact on healthcare since the whole population would be directly affected by their actions. Taking into considering that the National Department of Health cannot get its own finances in order - earning four qualified audits in the last five years - the Minister's desire to take over all healthcare funding sounds more ominous than ideal. Indeed, the National Department of Health is one of the worst performers in terms of financial affairs: just this past year, it racked up R43 million in irregular expenditure. [23]

5. We lack the human resources to implement NHI

According to the Minister, we need "at least" triple the number of doctors that we currently have to implement NHI. Right now we only produce 1,200 from our eight medical schools (compared to 4,000 from tiny Cuba's 21 medical schools), far below what is required. [24] Considering that 25% of all doctors who get their degrees in South Africa emigrate abroad, and that the number of doctors in our healthcare system has remained virtually static for more than a decade, it is highly unlikely that we will be able to radically increase the number of doctors available, let alone double or triple their numbers. [25]

Worse still, we already face a deficit of 83,000 healthcare professionals. It would cost R40 billion just to fill the healthcare vacancies that are currently listed. [26] The National Department of Health does not have the capacity to overcome this problem. Nor does the Department of Higher Education and Training, which runs the universities that are producing our meagre crop of doctors and nurses each year. This suggests that the bloated requirements of NHI are not realistic from an Human Resource (HR) perspective.

The Green Paper, for instance, draws heavily from the Brazilian model for its HR strategy. Brazil has done well to enhance its healthcare system over the years, but unlike South Africa which has only 55 doctors per 100,000 people, Brazil has 185 doctors per 100,000 people. To get to Brazil's level we would need another 65,000 doctors on top of the 27,500 that we now have. [27] This is simply not possible. Furthermore, Brazilian doctors earn about half of what our doctors earn. It would strain the fiscus to bursting point if we had to pay triple the number of doctors that we now have.

This discussion shows why it is so important to construct solutions that are practical, viable and locally meaningful. With regard to HR matters - and many others - NHI fails to remain connected to the realities that shape our possibilities.

The comparative information relied upon is outdated, insufficient and not relevant to South Africa. Save for jurisdictions in Mexico, Canada and India, no other comparative analysis is referred to. The reference to, for example, Canada at paragraph 60 on page 23 states that if the NHI is introduced, the country will have a healthier workforce at a lower cost in the long term, which will increase employment and attract direct foreign investment, like Canada when the NHI was introduced there between 1961 and 1975.

Canada is not an emerging market economy like South Africa and global investment trends have certainly changed since 1961 - 1975. The policy paper assumes that the result achieved by the NHI in Canada will occur once the NHI is implemented in South Africa. This assumption is not necessarily correct and further investigation is needed.

The policy paper also does not reflect contemporary, recent information on a country that has a NHI and its successes or failures.

6. NHI eradicates freedom of choice for healthcare consumers

Freedom of choice is an integral part of a well-functioning healthcare system. That is why, according to the Ministerial Task Team, "Although an option exists to establish a single risk pool, which covers everyone, this would significantly undermine the rationale for the emergence of medical schemes in the first place, ie. to exercises preferences." [28] Yet, the NHI proposal includes a punitive restriction on patients who currently use the private sector, essentially forcing them to register with the public health system and use its referral system, thereby limiting their power and autonomy. It's a strikingly anti-democratic aspect of NHI, one that compromises the "fairness" principle that it claims to promote.

Again, as the Task Team states, "Health systems...must respond to need as well as demand. The system should strive to ensure equity in the distribution of publicly financed healthcare benefits, while affording people the opportunity to

pool risk for services outside of the public system should they choose to do so." [29] NHI goes against the spirit of these recommendations.

7. The true cost of NHI is unclear

One of the most problematic aspects of the NHI proposal is that the Health Ministry has not conducted a proper costing of it. The Green Paper does not list the basket of services that it will offer patients. Nor does it include accurate data on the infrastructure, training and administrative costs that will surely rise under NHI. Given the scale of this project, it would be reckless to implement NHI without having a comprehensive understanding of its costs.

The policy paper at page 39 refers to how the NHI will be funded. The paper then states that the National Treasury will have to do further costing and that it is likely that the preliminary costing will increase rather than decrease. Bearing in mind that it is envisaged that NHI will be phased in over 14 years, it will not be completely possible to know what NHI will cost or whether it is affordable. The policy paper lacks any certainty on one of the most important aspects on NHI. The issue of costing is crucial in order to estimate whether such a policy as NHI is implementable and sustainable.

Unfortunately, the Green Paper states that the funding model will only be clarified in the next 6 months, by which time it is supposed to be in the early implementation stage. Moreover, the numbers provided that suggest that NHI will cost R255 billion by 2025 emerge from nowhere. Why this would be the cost is unexplained. It appears that the government wants NHI no matter the costs.

Yet, someone will have to underwrite this blank cheque, and that someone will be the increasingly burdened residents who earn taxable incomes - such as teachers, mineworkers and nurses. Essentially, NHI would require them to pay a mandatory National Health Fund payroll tax on top of the general taxes that they already pay (and which already funds public health care). This is a bad idea.

The Task Team warns, "Payroll taxes are seen as an explicit charge on labour and, unless they are perceived as a substitute for other charges, are often perceived as increasing the cost of formal employment....Where payroll taxes are large, therefore, incentives to avoid the tax through the informalisation of labour increase." [30] Because of this, it "strongly recommends that the publicly financed component of the healthcare system continues to be funded through general tax revenues." [31]

The Western Cape Government agrees that it is better to continue using the fair progressive general tax system rather than the unfair regressive payroll tax system to fund healthcare. [32]

8. NHI creates a massive risk of unintended consequences

Any kind of reform will see unintended consequences that must be monitored and addressed so as to avoid potentially catastrophic consequences. In order for a reform to be successful it should be implemented one element at a time. A single reform should be introduced, followed by a period of monitoring, evaluation and control. Then there must be space to deal with whatever consequences arise. It is crucial to ensure that knock-on effects of one reform do not result in the destruction of another element. Once this reform has been effectively implemented and all the consequences dealt with, the next reform should be implemented in the same manner. This is an evolutionary - as opposed to "revolutionary", all-at-once - approach. It provides greater stability and sustainability to reform efforts.

This is why, according to the Ministerial Task Team, "radical restructuring of the health system is unwarranted and will harm the performance of the health system." [33] This was the conclusion reached by the National Planning Commission as well when it assessed earlier health reform efforts made by the National Government after it first took power in 1994: "There was a misguided attempt to change everything simultaneously, when many aspects of the system were not faulty." [34]

Unfortunately it appears that the incumbent government has not learned from its own history of "radical" reforms. Nor does it seem willing to learn from the lessons provided by provincial experimentation and success, as in the Western Cape example. Instead, it is moving ahead with yet another "comprehensive" overhaul of the healthcare system - just as it is in the education system (again) - putting everyone at risk if this nationwide effort fails. If the government would experiment through the provincial systems first and make incremental adjustments in a sustained and monitored fashion, it would move forward with greater certainty of success.

9. NHI believes that money is the answer to all of our healthcare problems

A good healthcare system requires a certain minimum level of expenditure to be effective, depending on its level of development and expectations. [35] However, greater expenditure beyond that minimum level does not guarantee better

results. Other factors - such as accountability, governance and functionality - determine whether a healthcare system can go beyond simply maintaining a health status quo and actually improving it.

The Green Paper focuses almost exclusively on the provision of more money as the answer to South Africa's healthcare woes. The fact that the Minister is promoting a funding mechanism as the primary answer to our health care needs suggests that he sees money as the key arbiter of health.

However, the Task Team states that "The failure to achieve substantial health status improvements appears unrelated to South Africa's allocation of public funds, which are not low by international standards. Seen together with the fact that substantial health status improvements are possible with a limited financial outlay, *the most likely causes are the present systems of oversight and management of service delivery.*"[36]

Indeed, South Africa spends about US\$862 (R7,000) on healthcare per person each year, while regional neighbours like Namibia spend less than half that, but we still have a higher death rate from infectious diseases than they do.[37] We also spend about 8.7% of our GDP on healthcare, a good deal more than comparable middle-income countries such as Mexico, Thailand and Malaysia, whose populations nonetheless enjoy life expectancies of more than 20 years longer than ours.[38] This supports the WHO's contention that "It is not always better to spend more on health because at high levels of expenditure there may be little additional health gain from more resources." [39]

Money isn't always the answer. Based on international expenditure norms, South Africa should have eliminated the basic healthcare problems we continue to face. Other factors, like education and development, are crucial to leveraging the strengths of a healthcare system once a certain minimum level of expenditure is attained. Though we have surpassed that spending requirement, we have failed to create the other conditions necessary to improve healthcare.

10. NHI may be unconstitutional, as it threatens provincial authority

The constitutionality of NHI as proposed in the Green Paper is questionable in that the current legal framework allows for health services to be a concurrent function between the national Department of Health and the nine provincial departments of health, while municipal health services are the responsibility of local government. This allows the decentralised authorities to answer to the specific needs of their communities which differ from municipality to municipality and from province to province. Decentralisation is a normal feature of successful healthcare systems globally and provides a sound mechanism for ensuring that the diverse health needs of the population are attended to.[40]

The implementation of NHI in its current proposed form might affect legislative amendments to the suite of national legislation, which could be rendered unconstitutional.

Proposed alternative to NHI: Universal Healthcare

High-quality healthcare that is accountable, affordable and efficient

By strengthening the positive elements of the public sector and removing its deficiencies in a planned and sustained way, we can improve healthcare for everyone. That is the lesson we have learned governing the Western Cape. By focusing on accountability, management and governance structures, we have already achieved impressive results with our healthcare interventions.

The Western Cape has some of the highest health indicators in the country:

- Life expectancy in the Western Cape is currently 61.6 years for men and 67.9 years for women while the national average is 52.7 for men and 56.4 for women.
- Maternal mortality rates in the Western Cape stand at 98 deaths per 100,000 live births, while the national average is 140-160 deaths per 100,000 births.
- Child mortality rates in the Western Cape are 38.8 deaths per 1,000 live births while the national average stands at 69 deaths per 1,000 births.
- The Western Cape has antenatal HIV prevalence rate of 18.5% while the national average is 30.2%.
- The TB cure rate in the Western Cape is 79% while the national average is only 65%.[41]

These positive health outcomes are a result not only of the good work we have done over the last two years, but also of the fact that healthcare in the Western Cape has been based on good policies, showing that radical overhauls are not necessary to improve healthcare outcomes.

Unfortunately, most of the Western Cape's healthcare strategies are absent from the Green Paper. Although our experience in the Western Cape offers the Health Minister a home-grown solutions that could be replicated across

South Africa, the Minister has sought a "solution" based on an ideological commitment to centralized control, a model that is inappropriate for the complex and diverse health needs of our population.

As mentioned above, the health policy in the Western Cape focuses on strengthening the governance and accountability mechanisms of the public health system. This policy creates the necessary incentives for ensuring that healthcare practitioners deliver optimal performance at every level. Based on the solid results we have achieved from this approach, we believe that it should form the cornerstone of a proper national health policy.

Below is the Western Cape Government's alternative proposal for national healthcare. In it, we define the roles that we believe each stakeholder in the system should play.

1. The national Department of Health must create an enabling environment for quality healthcare

The national Department of Health (DoH) should create a national health framework in which all of the different elements can function harmoniously. It must develop appropriate policies, set national health targets, establish minimum norms and standards for healthcare providers and provide effective oversight to both the public and private sectors.

Specifically, the department should do the following:

- Subsidise healthcare for the poor. For the many residents who are unemployed - or who work in the informal sector - the government must continue to ensure that enough funding is distributed to the provincial health departments to see to these people's needs.
- Monitor all data and healthcare information. This is to ensure effective policy implementation which has, thus far, suffered from a chronic lack of information. Such data shortfalls mean that it is impossible to set standards and targets, hold providers accountable for meeting those standards and targets, or draft an evidence-based health policy.
- Create a policy framework which allows all healthcare providers to function optimally and in harmony with each other. This also means regulating the price framework in the private sector to protect consumers.
- Create an effective system of standards and targets to be met by agents in the public and private health sectors, as well as a monitoring framework to ensure compliance.
- Intervene in provinces whose health systems are dysfunctional and grossly mismanaged. Section 100 of the Constitution provides that, "when a province cannot or does not fulfil an executive obligation in terms of the constitution of legislation the national executive may intervene by taking any appropriate steps to ensure fulfilment of that obligation." This is a last resort, but a necessary one for the patients of the relevant provinces.

2. Provincial Departments of Health must be strengthened for better delivery

The concurrent competence between the national and provincial governments is crucial for a strong and responsive public healthcare system. A certain level of decentralisation is necessary for greater response to the needs of local peoples.

We also believe that the provinces should have strong oversight capacity. Every public healthcare provider should be monitored and held to account for meeting minimum norms and standards.

Provincial health departments should:

- Be free to implement national policies and targets in a manner that is most effective for the province.
- Be able to draft and implement policy.
- Monitor and collect healthcare data.
- Implement and enforce minimum standards.
- Sign and monitor performance agreements with healthcare providers.
- Allocate funds to hospitals and healthcare providers on the basis of their compliance with performance agreements and minimum norms and standards. The province should be able to withhold funding from providers that fail to comply with their agreements until they implement an effective turnaround strategy.
- Establish an office of quality standards controller. This office should post officers in healthcare stations, on a full-time or part-time basis, depending on the quality and functionality of the hospital/clinic.

Measures like these have made the Western Cape Department of Health an example of what strong governance can do for healthcare outcomes. The annual reports of the last several years have shown service delivery excellence, coherent functionality and capable financial management (with year-on-year unqualified audit reports as well as expenditure within 1-2% of the allocated budget).

Moreover, some of the initiatives pioneered in the Western Cape could be replicated by other provincial governments. For instance, the Western Cape Department of Health has implemented an extensive district-level home-based care program with over 2,500 care workers assisting in the provision of community-based services (CBS) with a headcount of over 4 million people in the last financial year. This programme has shown great success over the last several years. The training is well-established, allowing individuals who embark on this training to earn a Level 4 NQF Qualification and enter professional courses such as nursing.

Also, the Western Cape initiated a chronic medications dispensing unit that pre-packages 1.7 million prescriptions to ease dispensing at primary healthcare facilities and reduce waiting times there.

3. The autonomy of health providers must be supported

If hospitals are to become more effective, they must be given more capacity to manage themselves. Healthcare providers should be given greater decision-making powers while also being held accountable for their performance. While they should have to operate under a clear regulatory regime, they should not be micro-managed by a central authority.

Therefore it is recommended that:

- Healthcare providers - such as hospitals and clinics - should operate as non-profit entities. Each would be obliged to accept all patients and to make a prescribed package of free services available to all indigent patients. This would be funded at national level.
- Providers should be able to set their own rates for patients with incomes above a certain prescribed level. It should also be allowed to appoint staff, collect fees and respond to the health needs of the area they serve. They would be free to attract as many fee-paying patients as they wish and employ more staff and upgrade their facilities if they can generate the means to do so.
- Providers should be required to sign performance agreements with the provincial health departments.
- Providers should have to meet clearly defined sets of health and welfare outputs within a defined community. Enforcement mechanisms should include sanctions if agreed performance targets are not met. The Minister and MECs would retain residual powers that could be enacted under conditions of noncompliance with regulations.
- Funding for providers should be linked to proper management processes and positive health outcomes.

4. Healthcare standards need to be monitored by independent bodies

Along with strong performance monitoring and accountability standards within the National and Provincial Departments of Health, South Africa needs strong, independent health institutions. A strong system is one that can run smoothly irrespective of the government of the day.

At the national level, it is recommended that the following structures be established:

- An independent complaints system, allowing patients to bring their concerns before an impartial and independent tribunal.
- Oversight structures with the power to hold service delivery executives to account.
- Community representation posts located in oversight structures such as district councils and hospital boards. Elected members of the community, preferably unaffiliated with any political party, should sit on hospital boards and give input on key issues, such as service costs, services rendered and responses to service failures.
- An independent regulator responsible for quality assurance.
- An effective monitoring and evaluation system.
- A policy framework which sets routine performance targets for public providers and authorities to reach.
- A quality rating system applied across the board to all hospitals and healthcare providers in both public and private sectors. It should be made publicly available.

These efforts would require significant technological and administrative improvements to the management and reporting systems, but we believe that the investment for these improvements would be worthwhile.

5. Patients must be protected financially

A good healthcare system has an obligation to ensure that all citizens and residents of the country are financially protected from catastrophic out-of-pocket healthcare costs. The payment structure for public hospitals works on a means test, through which the poorest are covered by government funding while the more financially able have to rely on medical schemes to protect them from overwhelming out-of-pocket expenses. However, many working- and middle-class people who earn too much for free public health care, but barely enough for private medical coverage, can be financially vulnerable to a health catastrophe. These people need better financial protection.

To deal with this, it is recommended that the means test is revised, so that more people are fully covered by free public healthcare. It is further recommended that everyone who earns an income above that threshold be required to pay for a certain minimum level of coverage from a private medical aid scheme so that no one is ever bankrupted through a catastrophic health emergency.

This is a solution which ensures that all members are covered for basic health needs, but which still enables a degree of accurate pricing of risk that is necessary to ensure the overall profitability and survival of properly funded and managed schemes.

6. The private sector should be regulated through national guidelines

Private health insurance schemes form a welcome part of our national healthcare landscape, but they need to be regulated through appropriate government policies. This would create an environment where these private businesses may compete for customers, but without abusing them financially.

The fee-for-service reimbursement system used by most public and private hospitals has been cited as one of the primary cost-drivers for private medical care. It creates incentives for providers to over-supply services. Meanwhile, the system of third-party payment means that both providers and patients are shielded from the true costs of services.

This could be addressed by developing mechanisms to promote risk-sharing between medical schemes and hospitals. At present, schemes carry all the risk and hospitals are incentivised to maximise the services delivered. Doctors in the private sector should be funded by medical aids on the basis of a stipend for each of their patients. It should be larger for patients with complicated medical conditions and smaller for those who are healthy, and it should not be influenced by the number of services or tests a doctor orders.

For overhead costs, doctors should be paid an amount that covers the typical cost of tests and treatments needed to address a patient's condition. The hospital receives a payment for dealing with a patient's underlying condition rather than individual payments for each test and treatment. This approach offers no incentive to run unnecessary tests.

7. Public-private co-operation should be promoted

The public and private sector should work together more often to create better quality healthcare outcomes for all South Africans. For instance, the management of public hospitals and clinics should be put out to tender. This tender would be subject to review every year to ensure that performance continues to comply with requirements. The service provider could be any group of individuals capable of meeting the qualifying requirements, and the door would be open to any of South Africa's current private healthcare providers to submit tenders for a contract to run any of these hospitals.

It is recommended that a system whereby groups or individuals would be able to claim benefits be implemented, including subsidies and VAT exemptions, if they choose to adopt one of several levels of involvement with health-related public-private initiatives. Thus hospitals or private hospital networks would be able to make resources and equipment available to public sector patients on a lease or service basis, such as the use of private hospital beds for public patients at specially negotiated DOH rates.

Doctors who work in the private sector would be able to claim tax rebates and/or obtain CPD (Continued Professional Development) points for conducting a certain amount of work in the public sector. The Western Cape Government further suggests that continued registration with the Health Professions Council be required and tied to a certain annual provision of *pro bono* work (similar to what is required of attorneys and advocates).

Private providers should also enhance capacity within the public sector by providing managerial and administrative support. This could include seconding managers to the public sector for a defined period in return for state compensation or the twinning of facilities or provision of in-service training by the private sector. There are numerous ways to enhance national health care through such public-private partnerships. It should be a key policy of national government to make this happen.

8. Human Resources must be capacitated to meet growing needs

Our healthcare system suffers from key human resources shortages that must be overcome to keep pace with the needs of a growing population with a particularly high disease burden. Herewith some recommendations:

- Establish partnerships between academic/training institutions and the private sector. Since we require thousands of doctors and nurses to keep up with the needs of our system, private hospitals should be allowed to train more than just a limited quota of nurses, as is now the case. Moreover, the government should allow for the creation of private medical schools to supplement the public ones.

- Develop creative mechanisms to support trainee medical staff in the workplace through mentoring, apprenticeship and on-going support. Training programmes should look beyond just delivering qualified graduates and make sure to look after the doctors and nurses we train so that they stay in South Africa.
- Redistribute teaching and research funds to lower levels of care so that not all teaching is done at hospitals. Not only does this allow for more affordable training opportunities, but it distributes the skills of trainers and trainees more widely through the system, giving medical trainees a wider range of experiences to suit their needs and ambitions.
- Allow flexible approaches to training so that the contents of courses can be adapted to changing needs. This will require a change in the approach of accreditation bodies such as the South African Qualifications Authority (SAQA) and the South African Nursing Council (SANC).
- Promote public-private partnerships to enlarge and enhance our medical training capacity so as to boost the number of doctors available.

Conclusion

The Centre for Development and Enterprise states that, "Since 2007 there has been a tendency to see the introduction of NHI as the endgame in healthcare reform. Proponents of NHI see no reason to think creatively and comprehensively about the terms of coexistence between public and private sectors since, in their view, NHI will solve all problems."

[\[42\]](#)

Indeed, NHI is being promoted as if it were a cure-all for the healthcare system. But as our analysis shows here, it is far from that. It promises to make our healthcare problems even worse because it delays focusing on the important aspects of the system - such as accountability - while drawing money away from other crucial development programmes. Indeed, the massive amount of money that NHI will cost - with little appreciable yield - will jeopardize the country's ability to achieve an 8% economic growth rate, the type of growth that would lead to massive, sustained job creation.

There is a much cheaper, more practical and, indeed, proven strategy for improving health outcomes. It revolves around making healthcare accountable, affordable and efficient. Our policies in the Western Cape are working to achieve this for our provincial population, but we believe that our strategies can work for the rest of the country as well.

Source: Western Cape Department of Health.

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[\[1\]](#) World Health Organization (2000), "World health report 2000: health systems - improving performance" Geneva: WHO. Available from: www.who.int/whr/2000/en/index.html

[\[2\]](#) Alex van den Heever (2011), "Evaluation of the Green Paper on National Health Insurance," p.36. The Department of Health sometimes makes it appear that only 16% of the population uses private health care because that is the percentage enrolled in full-time medical aid schemes. However, another 19% also purchase private health care out-of-pocket, though most also have access to public health care.

[\[3\]](#) Development Bank of South Africa (2008), "Health Roadmap", available from: www.dbsa.org/Research/Documents/Health%20Roadmap.pdf

[\[4\]](#) World Economic Forum, "Global Competitiveness Report 2011-2012," p.323. Available from: www.weforum.org/reports/global-competitiveness-report-2011-2012

[\[5\]](#) National Planning Commission (2011), "National Development Plan: Vision for 2030", p. 299. Available from: www.npconline.co.za/medialib/downloads/home/NPC%20National%20Development%20Plan%20Vision%202030%20lo-res.pdf

[\[6\]](#) World Health Organization (2000), *op cit*.

[\[7\]](#) Alex van den Heever (2010), "A Financial Feasibility Review of NHI Proposals for South Africa," *South African Health Review* 10:16, p.163. Available from: www.healthlink.org.za/uploads/files/sahr10_16.pdf

[\[8\]](#) Finance Technical Task Team (2009), *Financing Health Care for all in South Africa: A situation assessment and proposals for the future*, Report of the Minister's Advisory Committee on Health, p.14.

[9] Finance Technical Task Team, *op cit.*, pp.12-13.

[10] Department of Health (2011), "National Health Insurance Green Paper", p.9. Available from: <http://images.businessday.co.za/NHI.pdf>

[11] NHI Green Paper, *op cit.*, p.9.

[12] NHI Green Paper, *op cit.*, p.18.

[13] NHI Green Paper, *op cit.*, p.15.

[14] NHI Green Paper, *op cit.*, p.41.

[15] NHI Green Paper, *op cit.*, p.5. Emphasis in original.

[16] Finance Technical Task Team, *op cit.*, p.26.

[17] Finance Technical Task Team, *op cit.*, pp.11-12.

[18] National Planning Commission, *op cit.*, p. 301.

[19] Finance Technical Task Team, *op cit.*, p.29.

[20] Finance Technical Task Team, *op cit.*, p.10.

[21] National Planning Commission, *op cit.*, p.298.

[22] World Health Organization (2000), *op cit.*, p.103.

[23] Department of Health (2011), *Annual Report*, p. 142. Available from: www.doh.gov.za/docs/reports/annual/2011/annual_report2010-11.pdf

[24][24] Mia Malan (22 July 2011), "NHI: Behind the proposals", *Mail & Guardian Online*, available from: <http://mg.co.za/article/2011-07-22-behind-the-proposals>

[25] Department of Health (2011), "Human Resources for Health South Africa: HRH Strategy for the Health Sector: 2012/13 - 2016/17", available from: www.info.gov.za/view/DownloadFileAction?id=152486

[26] Department of Health (2011), "Human Resources for Health South Africa", *op cit.*, p.34.

[27] Dianne Hawker (25 Sept 2011), "Doctor shortage to hit NHI" *Sunday Independent*, available from: www.iol.co.za/sundayindependent/doctor-shortage-to-hit-nhi-1.1144133

[28] Finance Technical Task Team, *op cit.*, p.18.

[29] Finance Technical Task Team, *op cit.*, p.27.

[30] Finance Technical Task Team, *op cit.*, p.43.

[31] Finance Technical Task Team, *op cit.*, p.44.

[32] The National Planning Commission also agrees, stating in its "National Development Plan" that general taxation is "more progressive than collecting comparable resources through NHI contributions as these are based on fixed contributions according to the requirements of the NHI and not by income," p.313.

[33] Finance Technical Task Team, *op cit.*, p.3.

[34] National Planning Commission, *op cit.*, p.302.

[35] This is a general philosophical statement. There is no exact figure for what minimum amount is necessary to establish a subjectively "good" healthcare system. It is simply a truism that, after a certain, point, there is a law of diminishing returns for healthcare expenditure beyond a certain point.

[36] Finance Technical Task Team, *op cit.*, p.6. Emphasis added.

[37] World Health Organization (2009), country profiles. For South Africa, see: www.who.int/countries/zaf/en/

For Namibia, see: www.who.int/countries/nam/en/

[38] National Planning Commission, *op cit.*, p.310.

[39] World Health Organization (2000), *op cit.*, p.26.

[40] The National Planning Commission, *op cit.*, also desires that "authority is decentralised and administration developed to lowest levels", p.298.

[41] Provincial Government of the Western Cape (2011), "The Western Cape's Draft Strategic Plan," p.31. Available from: www.westerncape.gov.za/Text/2011/2/dsp_complete.pdf - for latest antenatal HIV prevalence statistics, see Bua News Online (29 Nov 2011), "Antenatal HIV prevalence up," available from: www.buanews.gov.za/news/11/11112915451002

[42] Centre for Development and Enterprise (2011), "Reforming Health Care in South Africa: What role for the private sector?" *CDE Research Report No 18*, p.8. Available from: www.cde.org.za/article.php?a_id=413

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