

## Bridging the gap in South Africa

The South African government's proposed national insurance scheme aims to tackle the stark divide in health care between rich and poor. Claire Keeton reports.

When she was four years old, Thando (not her real name) came for treatment at a public hospital in Johannesburg because she was very ill with AIDS. "I first saw her in 1998 with advanced disease and her CD4 count was less than 50," says Professor Ashraf Coovadia, a paediatrician at the Rahima Moosa Mother and Child Hospital. "In 1999 we managed to get her antiretrovirals (ARVs) through a research project."

Prior to 2003, ARVs were not available in the public health system in South Africa, the country with the highest number of people with HIV/AIDS in the world. As a result, private patients could get the life-saving drugs and buy their survival while many patients in the public sector died.

It is this stark public-private divide that the South African Government hopes its proposed National Health Insurance (NHI) scheme will deal with by providing universal access to health care "based on need rather than ability to pay". Thando was lucky to get therapy in time and this "lovely teenager", raised by her aunt, is the longest attending patient at the hospital's paediatric clinic. "Prior to the rollout, we had a handful of children accessing ARVs, less than 5%. Now the majority who need it are on ARVs and doing well," says Coovadia.

Access to HIV/AIDS treatment has expanded dramatically in the past decade and, since the 1994 democratic elections, access to health services in general have improved for poorer South Africans. However, the standard of care in the public sector has been steadily deteriorating.

"South Africa has had difficulty post 1994 in grappling with the HIV epidemic – that was a real curveball," says Professor Helen Schneider, chief researcher at the University of Cape Town's (UCT) Centre for Infectious Diseases Epidemiology and Research. She identifies the failure of the district health system and poor governance and management of hospitals as some of the major challenges.

Recent research reports also cite underfunding and mismanagement, shortages of health professionals and deteriorating infrastructure as contributors to the decline in the quality of public health services.

"The past 15 years have shown how quickly a reasonably well-functioning health infrastructure can be run down and how expensive it is to build up again," stated Dr Mamphele Ramphele, a former UCT vice-chancellor and former managing director of The World Bank, in a report urging the public and private sectors to join ranks to deliver better care.

South Africa's public sector strike in August, which involved the withdrawal of care by striking health workers, is alleged to have caused dozens of patient deaths and required the transfer of high-care patients to private hospitals, thereby highlighting the gulf between these parallel systems.

Health Minister Dr Aaron Motsoaledi told the *Bulletin*: "the starting point for the NHI is to close the increasing gap between the rich and the poor. If I am sick, I get the best care. If people are unemployed, they can forget it." He describes the existing health-care system as "very expensive, destructive, unaffordable and not sustainable".

"We are spending more money (8.6% of gross domestic product in 2007) than many middle-income countries and our outcomes are poor." For this he blames the way funds are distributed and escalating costs.

UCT's Health Economics Unit reports that private health insurance spending per member almost doubled between 1996 and 2003, while public health sector spending per patient decreased.

Dr Mphata Norman Mabasa, chairman of the South African Medical Association, finds the disparity in access and care between public and private sector patients jarring.

"I've seen many instances of patients in the public health system dying when hospitals can't keep them longer. If you've got money, you can buy and save lives. In the public sector, for example, kidney dialysis is rationed." He adds that even within the private sector, members on low-cost schemes come off worse, with a narrower range of services covered and patients needing to spend a higher proportion of their incomes. Mabasa also points out the marked disparity between urban and rural care, with many rural patients having to travel into cities to access services.

Government spending on health care comprises less than half of total health expenditure even though the public system serves more than 80% of the population (i.e. around 40 million South Africans) without private health insurance. Around 70% of all doctors and most special-



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Patients wait for treatment during the recent strike at Chris Hani Baragwanath Hospital in Johannesburg.

ists only work in the private sector, the remaining 30% serve the public sector.

Sixteen per cent of the population use private doctors and hospitals which are covered by their health insurance, often with a monthly contribution from their employers. Their premiums and direct payments to health providers (about a third of which are not reimbursed) cost in total about 11 000 South African rand (R), (US\$ 1571) each year.

The public sector covers 68% of people who do not use any private care at all, spending about R1900 per person. Another 16% of the population rely on the public sector for hospital care but use the private sector for primary care, paying out of their own pockets, with total spending about R2500 per person.

In September, the ruling African National Congress (ANC) released its current proposals for the NHI for wide consultation. According to Dr Zweli Mkhize, chairman of the ANC's health committee, the scheme is expected to cost an extra R11 billion on top of the R117 billion in the government's health budget for 2012. Taxation to pay for this compulsory medical insurance scheme is expected to start in 2012, with a plan to phase it in over 14 years.

Mike Waters, health spokesman from opposition party, the Democratic Alliance, expressed reservations about the NHI. "The priority in providing quality public health care is not to change the financing mechanism for the public health

#### Box 1. The key goals of the national health insurance scheme

- to provide universal coverage for all South Africans;
- to pool risks and funds;
- to improve negotiations with providers for supply of services and rational payment levels with quality assurance;
- to create one public fund with adequate reserves and funds for high-cost care;
- to promote efficient and effective service delivery in both public and private sectors; and
- to assure continuity and portability of national health insurance within the country.

system, as the ANC believes, but rather to improve the basics of delivery and ensure that the money available is used for its intended purpose."

He raises concerns that the NHI "represents more bureaucracy and more centralization, and therefore in fact will only worsen the problems that public health care faces". Waters also suggests that the burden of added taxes could force middle-income earners back into the public system, which is already overextended.

"Data from the Health Department at the end of last year showed a 35% year-on-year increase in nurse and doctor vacancies...Hospersa (the health worker trade union of South Africa) argued that a staggering 80 000 new posts would have to be created."

On the other end of the spectrum, analysts are concerned that NHI proposals could transfer a significant part of the burden of the public health problems to the private sphere.

A private economic consultancy, Econex, has published an extensive critique of the proposals, teasing out some

of the implementation challenges, chief among them the enormous anticipated cost of the system as currently conceptualised. In April Dr Nicola Theron, director of Econex, warned that the envisaged cost of funding an NHI could total R216 billion per annum. "Even if the most economical model were to be applied, the figure would still equate to a total of R197 billion; a number close to South Africa's entire personal income tax contributions," she says.

Even cost models produced for the Congress of South African Trade Unions, which strongly supports the introduction of NHI, suggest an additional funding requirement of around R189 billion, before administrative savings. According to Theron, anticipated savings are likely to be less than currently assumed, while usage pressures and capacity constraints are likely to place the system under enormous stress.

Factors that have not been given sufficient attention, says Theron, are the cost and administrative complexity, South Africa's unique disease burden and the enormous demand pressures that are likely to be unleashed by the introduction of a comprehensive benefit package with zero co-payments.

On the other hand, NHI would introduce other new dimensions to the South African health financing system, notably the possibility of using public resources through strategic purchasing of services for the population. "International experience clearly demonstrates that changing the way of paying providers is necessary to secure greater value for money," Professor Di McIntyre, from UCT's Health Economics Unit, states in a recent analysis. "An integrated pool of funds is the only way to ensure that all the available human resources are used more effectively and efficiently. Then everyone will be able to access health services on the basis of their need for care and not on the basis of their ability to pay." ■



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The national health insurance scheme aims to create a pooled fund with reserves for high-cost care.