WOLPE TRUST – 80TH OPEN DIALOGUE

WILL NHI SOLVE HEALTH PROBLEMS

Background

Our heath sector- both public and private sector needs to be reformed. No one will argue with that. The calls for reform are not new. There has been consistent and widespread support since the early 1990s for the introduction of a mandatory health insurance rather than retaining the current disparate private medical scheme for a minority and tax funded health services for the rest of the population. Our health system is highly inequitable and unsustainable. We need to build a health system that meets the health care needs of all South Africans in an efficient and sustainable way. The country needs an efficient health system that will use the available resources efficiently and give us all value for money.

The move towards mandatory health insurance should be seen in the context of government's development of a comprehensive social security system, as was envisaged by the Taylor Committee of Inquiry. Government has to date taken practical steps for moving ahead with a "mandatory contributory earnings-related savings and benefits" social security system. There is an inter-departmental task team discussing comprehensive social security, overseen by an Inter-Ministerial Committee.

South Africa is one of the unequal societies in the world. The inequities are evident in income, but also in health, education, access to basic services, i.e. water, electricity, etc. The Constitution directs the state to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the rights to water, health care, food and social security.

The state of our health sector

The inequities

There are massive public-private health sector mix disparities in South Africa. The divide between private and public care is grossly inequitable. More specifically, the greatest disparities are seen in the distribution of financial and human resources between the public and private health sectors relative to the population served by each sector.

Over 40% of health care funds are in the medical schemes for about 16% of the population. And yet those in the schemes are on average much healthier because of their socio-economic status. Those who have the greatest need for health care do not get their 'fair share' of benefits from using health services. In a study undertaken by the Health Economics Unit at UCT, it was revealed that the richest 20% of the population receive 36% of the benefits from using health services (public and private) although they only account for 10% of health care needs (or the burden of poor health). On the other hand the poorest 20% of the population receive less than 13% of the benefits but have more than 25% of the need for health care.

In addition there are the tax breaks for private health insurance, which were estimated to amount to over R10 billion, which was equivalent to 20% of the public sector health budget in 2005.

There is more than twice as many hospital beds per beneficiary of private sector hospital services as there are for those dependent on the public sector. The disparities are even greater in relation to health professionals; each pharmacist in the public sector serves 12 to 30 times, and each generalist doctor in the public sector serves 7 to 17 times, more people than those in the private sector (depending on whether one focuses only on the medical scheme population or assumes that up to 35.8% of the population use private pharmacists and private general practitioners). There is a six fold difference in the number of people served per nurse, and a 23 times difference in the number of people served per specialist doctor, working in the public and private sectors in South Africa.

The split between private and public care is also evident in their focus. Medical schemes have gradually shifted funding away from PHC, the centrepiece of all public health policies and focus in public care, towards funding major medical benefits like hospitals and specialists, chronic disease, etc. For those in medical schemes, PHC is regressively funded by individual members. This practice undermines income and risk cross-subsidisation, posing a significant danger to the overall health system. Thus public and private sector health systems are moving in different directions.

The inefficient and inequitable distribution of resources between private and public health sectors relative to the population served by each justify an existence of a publicly funded health system that meets the needs of the entire population.

Sector specific challenges and concerns

The problems in the public sector health system are all too familiar to all given the media attention they get. Prof. Sanders has touched on some of these in his presentation and I will not repeat them. I however want to highlight some of the private sector challenges that concern government and should concern us all:

- Rapid spiral of medical scheme contributions and expenditure
- Membership have declined in percentage terms – medical schemes are either unaffordable or unattractive for many people
- The proportion of the population served by the medical schemes is declining despite the fact that the quantity of financial and human resources available is increasing
- Non health care items have increased much more rapidly – administration costs, managed care initiatives and brokers fees. More money is spent on these activities than is spent on general practitioners and dentists combined.
- A quarter of private health care financing is direct out- of- pocket payments. The most regressive form of health care
- Processes and premium setting are not transparent and therefore there is little competition
- There are too many schemes and inefficient health care delivery

These are just some of the financing challenges and concerns regarding the private health sector.

Health outcomes

Health outcomes are a function of a number of factors, health system is but only one of these, including, housing, water, nutrition, education, sanitation, etc. all of which need to

work together to improve health outcomes. There is enough evidence to show the link between poor health and low socio-economic status.
Our health outcomes are poor. The inequalities in health outcomes between the rich and the poor are just unacceptable. Undoubtedly poverty and inequality have a significant role to play here. HIV also has a dramatic impact and distorts the picture significantly, especially in the public health sector. But we can do better to improve the health outcomes.

It is unacceptable that preventable and controllable diseases contribute a significant share in mortality rate. Children should not die due to preventable causes, i.e. unsafe water, sanitation, inadequate immunisation, etc. and diseases such as measles, polio, or preventable mother to child transmission of HIV, etc. Maternal deaths due to preventable causes also need attention. Health care workers should be able to respond to pregnancy and its complications

Efficiency comparisons between the public and private systems are difficult due to lack of data as well as completely different structure and focus of the two sectors. The popular belief is that health outcomes in the private sector are better than in the public sector. But is that true? The truth is that there is little to compare. From the public health system we have activity level data and patient day equivalents, whose usefulness as measures of outcomes in the public health system is limited. In the private sector quality data is incomplete and not comparable to that of the public health system. Comparisons between the two sectors are largely on cost, with anecdotal quality comparisons. Therefore quality of care in the private system relates as much to 'perceptions' of quality of care as to structural, clinical quality of care, given that there is no evidence to demonstrate a significant difference in clinical quality of care between the public and private sectors despite 'perceptions' of higher quality within the private sectors. The public health sector thus also has to improve on the perceptions held on the quality of care it offers. For the vision of the NHI to be fulfilled, it is critical that the services that South Africans will be entitled to under the NHI are seen to be of acceptable quality. The public should see the public health sector as a provider of choice.

We also cannot overlook some of the positive facts with regard to the public health sector. South Africa has made improvements in the provision of health services; decline in fertility, utilization of public health system has improved, with the majority residing near a health center (within a 5 km radius). Despite high mortality rates, significant progress has been made in the area of maternal and child health, through free health care to children under age of six and to pregnant and lactating women, abolishing of user fees, expanded programme of immunization, integrated nutrition programme, cervical cancer screening, choice of termination on termination of pregnancy, etc . Progress has also been made on improving the living conditions through provision of access to water, sanitation, electricity, housing and social grants, extending household security, social services and employment related social insurance and income. Quality with regard to these is however, sometimes substandard.

Data issues
The famous quote 'If you can't measure it, you can't change it' is very applicable to the health system. Regular consistent measurements along with accountability for defined metrics are the best way to improve results. We need to be able to measure the problems and the solutions through improved health information systems and population

health data, to enable us to monitor progress and inequities. Monitoring and evaluation is an important component of the health sector. The use of good quality routine data for evidence based decision making cannot be overstated, and can lead to better health and management systems. Management of finances and budgeting should be closely linked to other health status, resources and performance information. Concerns at management level should therefore be to manage funds and budgets as well as healthcare or outcomes.

Conclusion

The beauty of NHI is a country can design and implement it in such a way that is applicable to its context and will meet its needs. So there is no blue print!
We need to achieve a balance between the types of health services that are affordable and sustainable given our macro-economic context. The basic principle underlying the mandatory insurance is the pooling of resource and cross subsidisation. Given the stark inequalities in this country, we cannot afford to not do something.

Government is taking critical steps in laying the foundation for NHI.

- It is instituting major efforts to dramatically improve public sector hospital services through the revitalisation of health infrastructure programme.
- It also aims to reform the existing governance model for public hospitals. It aims to delegate management of hospitals to hospital CEOs so that problems arising in the hospital (e.g. cleanliness, repairs, maintenance, etc.) can be immediately resolved rather than having to send requests through to the provincial head office.
- Alongside these are plans to strengthen health-specific management capacity for programs and facilities, especially hospitals
- Develop a comprehensive HR plan for the health sector, in collaboration with the departments of education and other stakeholders.
- Review the HR management and retention strategies in the health sector.

And many other initiatives are being put in place.

One of the priorities of government in the health sector is to develop a plan for the provision of strategic leadership and creation of a Social Compact for better health outcomes. This will include actively engaging with public perceptions about the quality of care in public hospitals; to identify what is contributing to the negative perceptions and improve public trust in the public sector.

Both the public and private sectors are part of the problems in our health sector, and both should be part of the solution.

On issues related to cost, any country can afford an NHI if it places enough weight on social cohesion and equity. It is in fact more costly for the country to continue with the status quo.

With total health care expenditure of about 8% of GDP, (which is high compared to other middle income countries) the challenge is not financial resources but improving the efficiency and equity of these resources.

THANK YOU