Editorial

The Role of the Private Sector within the South African Health System

Introduction

The provision and financing of health care in South Africa occurs within two fundamentally different 'systems'; the public health system and the private health system. This however, is an oversimplification, because within the private health system, the traditional health sector stands apart from the formal private health sector from perspectives of organisation, financing and health care delivery.

The socio-economic status of an individual in South Africa is the primary determinant of the system through which he or she will receive access to health care. Given vast and growing discrepancies in resources spent between both sectors, socio-economic status is very often also a determinant of the level and quality of health care that a person is able to access. As the right of access to health care is a constitutionally protected basic human right, the resultant inequities in access to health care undermine and impede the objectives of transformation of South Africa to a more just and equitable society.

Government has initiated various policy and legislative measures to improve access to health care in the public sector and to bring a measure of rationality to the expansion of the private sector. The private sector has typically vociferously backed civil society efforts to pressure government into improving equitable access to care in the public sector. Calls for greater access to antiretroviral therapy are a case in point.

Societal pressure on government in relation to its response to public sector delivery issues, including HIV and AIDS, is of course to be welcomed. But the focus of attention on shortcomings in public sector delivery has also wittingly or unwittingly served the agenda of the private sector of diverting attention of government, civil society and the media from asking critical questions relating to the role and function of the private sector. The provincial and national Departments of Health (DoH) have all too often been relegated by stakeholders to custodians of the public health sector, as opposed to recognising the stewardship role of government in relation to the overall health system.

Where government has introduced interventions aimed at curbing abuses in the private health sector or shaping the private health sector to contribute to overall national health policy objectives, this has typically been met by fierce resistance from the private health sector or alternatively measures to dilute regulatory efforts with a focus on broader intractable issues. Industry responses to the introduction of the Medical Schemes Act (Act 131 of 1998), the medicine pricing Regulations and statements of intention to regulate private health costs, are cases in point.[a]

a This attitude is illustrated in the following quotation from a statement issued on 10 June 2007 by Democratic Alliance spokesperson, Gareth Morgan: "It is outrageous for the Minister of Health to threaten further legislative control over the private sector, as she did during her closing remarks in the Health Department Budget debate this past week (June 7, 2007). Firstly, the money spent on these private hospitals and doctors is not the government's to control; it is the disposable income of the people who choose to spend it – and these people already subsidise the public sector through their taxes. Secondly, it is a fallacy that the pool of people using the private sector is limited to those with medical aids... There are numerous poor South Africans who recognise the frustrations and poor quality of care that comes with going to public hospitals and clinics and choose, at great expense to themselves, to access private facilities. ... Public health care requires greater transfers from the treasury to deal with the human resources crisis, that includes over 40000 vacancies for nurses, and to increase the rate at which hospitals are revitalized. Better management of this money is also needed. Perhaps once these problems are solved the Minister will be in a better situation to pass judgment over the private sector." (Manto must fix public health care system before passing judgment on private health care. Available at: http://www.da.org.za/da/Site/Eng/News/print-article.asp?ID=7756)

This response raises a number of questions. Do private sector models of health service financing and delivery represent the 'gold standard' to which our entire health system should strive? In the absence of government intervention, is the private sector sustainable in the medium to long-term in South Africa? Can some of the challenges faced by the public health sector be laid at the door of an under-regulated private sector? How should government exercise its stewardship role to ensure that the country's health resources as a whole are optimally and equitably used to protect and promote the health of all South Africans?

The 2007 edition of the South African Health Review (SAHR) aims to put these and other questions in the forefront of public discourse, by creating a repository of information and perspectives on a wide range of issues relating to the private health sector. Given the fact that the private health sector consumes approximately 60% of the health spend in South Africa, it may be argued that the SAHR theme for 2007 is long overdue.

This introductory chapter of the SAHR begins by contextualising the discussions in the remaining chapters within a brief description of how the South African private health sector is structured and funded. The organisation of the chapters is then discussed, and a brief overview is provided of the main areas of focus of each of the chapters. Finally, there is a discussion of some of the key findings and recommendations of the authors, which in the opinion of the editorial team must form part of a blueprint for conceptualising the role of the private health sector as the country moves forward.

Overview of the South African private health care system[b]

South Africa has a large, well-developed, resource intensive and highly specialised formal private health sector. This sector is primarily funded through contributions to medical schemes, which provide health insurance coverage to some 7 million beneficiaries (of a total South African population of approximately 47 million). In addition, it is estimated that some 72% of the Black population in South Africa use traditional health practitioners. These traditional health practitioners are paid for on an out-of-pocket basis.[c]

b The data in this overview are drawn from the various chapters of the SAHR, and for this reason specific references are not included.

c The bulk of their clientele are not members of medical schemes, and medical schemes in general do not currently cover services provided by traditional health practitioners because most of these practitioners are not yet registered in terms of any law – a precondition for payment in terms of the Medical Schemes Act (Act 131 of 1998).

Just over R100 billion was spent on health care in South Africa in 2005, equivalent to some 7.7% of the country's Gross Domestic Product (GDP). These figures, however, mask a massive distortion in the allocation of financial resources between the public and private sectors. Only about 40% of total health care funds in South Africa are spent in the public sector, while 60% flow through private intermediaries.

Households' out-of-pocket payments directly to health care providers account for nearly 14% of all health care expenditure. However, the main financing vehicle for private health services are medical schemes, which cover a relatively small and declining portion of the total South African population (currently approximately 14%).

As spending of financial resources for health has increasingly been skewed towards the private sector, this has increasingly drawn health professionals away from the public sector to the private sector. These health professionals have been attracted by higher remuneration, better working conditions and more ready access to advanced technology in the private sector. This migration of professionals to the private sector has been a major causal factor of the human resource crisis in the public sector.

Non-price competition between major private hospital groups in South Africa is a contributor to the migration of specialists to the private sector. Following a period of rapid consolidation of the private hospital sector through takeovers and mergers since the late 1990s, ownership of more than 75% of private hospital beds and 80% of private hospital theatres rests in the hands of three major private hospital groups (i.e. Netcare, Medi-Clinic and Life Healthcare). Private hospitals are licensed by provincial health departments, but this licensing process and the oversight of the competition authorities have been ineffective in preventing the formation of an oligopoly of private hospital groups in the country.

A major component of the competitive strategy of these hospital groups is to attract doctors (particularly specialists) to their hospitals, as a means of increasing patient referrals to their hospitals as opposed to those of their competitors. This is achieved through a variety of incentives, as well as the provision of state-of-the-art facilities and the latest medical technologies. This strategy, while rational from a business perspective, does not lend itself to the rational allocation of health resources on a national basis and contributes to massive escalation of private hospital costs, which are passed onto consumers.

Nevertheless, the concentration of financial, human, technological and infrastructural resources in the private health sector compared to a comparatively under-resourced public health sector results in a greater number of consumers exercising a preference for obtaining health care in the private rather than the public health sector.

Private health care is expensive and out-of-pocket payments for major medical expenses are likely to be financially catastrophic, even for the relatively well-off. To protect themselves and their families against such financial loss, approximately 3 million South Africans make monthly contributions to medical schemes. In terms of the Medical Schemes Act of 1998, contributions to medical schemes must be community-rated rather than risk-rated. This means that contributions cannot be determined on the basis of underwriting factors such as age and health status, as with ordinary insurance arrangements. This requirement is intended to promote social solidarity in the financing of health care. Medical scheme contributions are sometimes subsidised by employers. A portion of medical scheme contributions is also tax deductible, with the result that the general fiscus also partially subsidises the contributions of members of medical schemes.

The business of a medical scheme is essentially to defray the medical expenses of its beneficiaries[d] in return for their regular contributions. The extent to which a medical scheme will cover the medical expenses of its beneficiaries is defined and limited in terms of the 'rules' of a medical scheme, which essentially constitute the terms of the contract between member and medical scheme. The discretion of a medical scheme to determine its benefits is to some extent circumscribed by the provisions of the Medical Schemes Act, which amongst other things provides for a minimum set of benefits that every medical scheme must provide, the so-called 'prescribed minimum benefits' or 'PMBs'. One of the intentions of the PMBs is to ensure that benefit attrition within a medical scheme cannot take place to the extent that members are purchasing a diminished benefit and will be left out of cover (and dependent on the public sector) in the event of clinically necessary major medical expenses.

Medical schemes are governed by boards of trustees, of whom at least 50% must be elected from amongst the scheme's membership. They are not-for-profit entities. However, medical schemes are surrounded by a myriad of for-profit entities, which provide services to medical schemes in return for a share of their contribution income. These entities include third-party administrators, brokers, managed care companies, reinsurance houses, actuaries, audit firms and so on. The notion that the medical schemes industry operates on a not-for-profit basis is therefore something of a misnomer.

Containing non-health expenditure of medical schemes to acceptable levels is a constant battle of the medical schemes regulator, the Council for Medical Schemes (CMS). But the major driver of medical scheme contribution increases is health care costs, most notably a trend of higher than inflationary increases in private hospitals and medical specialist costs. The trend of massive escalation in medicine prices has largely been contained by medicine pricing Regulations promulgated by the Minister of Health, although some of the profit-making on medicines has been shifted to charging for other services.

Another fundamental component of the South African health system is the African traditional medicine sector. There are estimated to be between 150 000 and 200 000 African traditional healers in South Africa, including diviners, herbalists, prophets and faith healers, traditional surgeons and traditional birth attendants. Twenty-seven million Black South Africans, from a diverse range of socio-economic groupings, make use of traditional healers, although typically not to the exclusion of western medicine. Many consumers perceive traditional healers to provide more holistic treatment than practitioners of western medicine. The Traditional Health Practitioners Bill was recently passed by Parliament and at the time of writing this editorial, awaited signature into law by the President. Once enacted, the Bill will regulate the practice of traditional medicine and will provide registered traditional healers with the same legal recognition as other health care providers. This will also create the legal basis for medical schemes to provide benefits for traditional healers.

Finally, there are a relatively small number of practitioners of complementary and alternative medicine in South Africa, including other forms of traditional medicine. Currently, there are some 3 600 practitioners registered with the Allied Health Professions Council to perform one or more of the following treatment modalities: ayurveda; traditional Chinese medicine; osteopathy; chiropractice, homeopathy, naturopathy, phytotherapy, aromatherapy, massage therapy and reflexology. Although there are relatively few practitioners in these disciplines, the market for complementary medicines and health products is large and growing. Many of these prod-

d The term "beneficiaries" refers collectively to both the principal members (who enter into a contract with the medical scheme, and undertake to pay the regular contributions) and those dependants of the principal members who are enrolled on the scheme and are therefore also entitled to receive medical scheme benefits.

ucts are currently sold without regulatory control, although there are plans to effectively regulate them in the future.

Synopsis of Chapters

The first three sections of the SAHR focus on various aspects of the private health sector, namely: oversight; pooling of resources and purchasing of care; and health care delivery. In addition, as in previous years, the final section on indicators provides a broad range of demographic and health related indicators which have significant bearing on the health system as a whole.

Oversight: Principles and Policy

This section includes chapters on stewardship and health legislation and policy; the latter being a specific component of the stewardship function of government.

The discussion on *Stewardship: Protecting the Public's Health* (Chapter 1) draws on the World Health Report 2000 to argue that the role of government includes setting the direction for both the public and private health sectors to ensure that the health system contributes to socially desired goals of good health outcomes and equity in access to care and resources. With specific reference to the private health sector, the authors assess the Ministry of Health's progress in relation to the following elements of stewardship: careful and responsible management of the well-being of the population; establishing the best and fairest health system possible; concern about the trust and legitimacy with which activities are viewed by the citizenry; and maintaining and improving national resources for the benefit of the population.

The authors conclude that since 1994, there have been numerous structural, legislative and policy changes in the health system, which have contributed to improving the lives of South Africans. However, the problem of inequity between public and private sectors remains acute and is growing. Certain important pro-equity measures, such as the certificate of need provisions of the National Health Act, have not been implemented. The authors identified the process for adoption of the HIV & AIDS and STI National Strategic Plan (NSP) as the 'gold standard' of stewardship, demonstrating that it is possible to build consensus among stakeholders in public and private sectors to advance the public good. They urge the Ministry of Health to similarly use the opportunity presented by the Health Charter process to exercise effective stewardship and to use the process as a catalyst to implement universal health coverage and address the inequitable allocation of human resources between public and private sectors. Amongst other recommendations, they advocate for a dedicated unit focused on private sector transformation to be established in the national DoH.

The discussion of *Health Policy and Legislation* (Chapter 2) provides an overview of health policy and legislation since 1994 in so far as it is relevant to the private health sector. The chapter also documents various legal challenges to the legislative reform agenda, including challenges to the Choice on Termination of Pregnancy Act (Act 92 of 1996), and protracted attacks on the amendments to the regulations seeking to introduce a transparent, non-discriminatory pricing system for medicines. The author concludes that, while there has been significant progress in the area of private health regulation, there are still several gaps and work that must be completed. Delays in implementation of key portions of the National Health Act, and the absence of Regulations promulgated in terms of that Act, are cases in point. The need for these Regulations to be promulgated without further delay is a key recommendation of the chapter. Other recommendations include the need for an Office of Standards Compliance to be established within the DoH and for the PMB package in the Regulations to the Medical Schemes Act to be reviewed urgently in the manner contemplated in those Regulations.

Pooling of Resources and Purchasing of Health Care

This section covers issues on health care financing and expenditure. It also deals with how financial, informational and other resources are obtained and distributed in the private sector in order to make possible the obtaining and provision of health care services.

Chapter 3 provides a brief overview of *Health Care Financing and Expenditure* in South Africa, in both the public and private sectors. The discussion notes that South Africa's overall level of health spending is relatively high by international standards; it exceeds that in the majority of countries of a similar level of economic development and is similar to that in some high income countries. In spite of this, health status indicators in South Africa, such as infant mortality, are far worse than in other upper-middle income countries. The authors conclude that the key challenge facing the South African health sector is not one of a lack of resources, but rather a great need to use existing resources more efficiently and equitably. The authors note progress toward addressing allocative efficiency and geographic equity challenges in the public health sector, but are of the view that there still appears to be inadequate public sector health care

funding for the population served. On the other hand, since the 1980s, expenditure in the private sector has continued to increase at rates far exceeding the annual inflation rate. This has contributed to an affordability crisis in the private sector, which has resulted in a declining proportion of the total population being covered by medical schemes.

Cumulatively, these factors have contributed to a widening public-private mix gap. The authors note that while per capita health expenditure in medical schemes was five times greater than public sector expenditure in 1998, this had increased to 6.6 times greater in 2005. In the view of the authors, these differentials are even more concerning due to the fact that tax resources are devoted to supporting this expensive private medical scheme system through tax deductibility of medical scheme contributions and the purchasing of medical scheme cover for civil servants. The chapter concludes that the diverging trends in the public-private health sector need to be urgently addressed through increased tax funding of public sector services, efforts to improve efficiency in the private health sector and mechanisms to promote increased cross-subsidisation in overall health care financing and expenditure.

The chapter on *Medical Schemes* (Chapter 4) critically evaluates the role of medical schemes in revenue collection, pooling of contributions and purchasing of health care. The authors identify the problem of affordability of medical schemes as the greatest obstacle to growth in the industry. To date, solutions to problems of declining affordability of medical schemes have not been addressed and industry proposals for the establishment of conditions for the emergence of Low Income Medical Schemes (LIMS) have not received a formal response from government.

The authors subscribe to the view that declining employer subsidies for post-retirement medical expenses have created a 'future time bomb', which will have a devastating impact on pensioners 10 to 30 years from now, unless effective measures are taken to address this issue. The opportunity to find a solution to this problem is presented by the current evaluation of retirement reform proposals by the Department of Social Development, which could form the basis of a mandatory social security system for retirement. A positive development has been the establishment of the Government Employees Medical Scheme (GEMS), which in the view of the authors, sets an example to other employers and medical schemes by demonstrating that it is possible to develop packages that can be made affordable to all employees.

The authors note with concern the fragmentation of risk pools in the medical schemes environment caused by churning of members by brokers and medical scheme benefit options, which create separate risk pools in medical schemes, thereby undermining the legislative intent of promoting community-rating. The implementation of the intended Risk Equalisation Fund (REF), which allows for financial transfers from medical schemes with better risk profiles to schemes with poorer risk profiles, will contribute to addressing this issue. However, the authors note that delays in implementation of the REF is having very adverse consequences for schemes with higher than average age profiles.

Medical schemes are urged to shift their focus from being passive purchasers of health care to becoming strategic purchasers of health care on behalf of their members, which entails formation of provider networks, selective contracting, risk-sharing, and greater attention to ensuring and measuring the quality of health care. However, obstacles to this approach are noted, including reluctance of providers to change their fee-for-service reimbursement mechanism. In the medium-term, the authors identify the solution to many of the identified problems as the establishment of a mandatory social insurance system with both risk and income-based cross-subsidies. In the interim, the authors identify three areas of reform that need to be prioritised: simplified and standardised benefit design; coherent and coordinated health care provider legislation; and support for low income workers.

In the chapter on *Social or National Health Insurance* (Chapter 5), the authors postulate that one of the factors hampering progress on alternative health care financing mechanisms is a lack of clarity on key health insurance concepts. The authors seek to demystify some of the terminology around health insurance, and to summarise the South African debate about mandatory health insurance, which has continued for more than two decades without achieving a clear policy framework for the future. The authors note that the distinction between Social Health Insurance and National Health Insurance has been unhelpful in South African debates, because the concepts have often been confused. They prefer to examine underlying principles using the more inclusive term 'mandatory health insurance'. The chapter traces the development of mandatory health insurance proposals emanating from a variety of committees and policy development processes since 1994. Similarities and differences of these proposals are compared in relation to the features of revenue collection, pooling of funds, purchasing and provision.

The authors conclude that mandatory health insurance can be an effective way of dealing with the many problems currently being experienced in the private health insurance market and the disparities in the distribution of health care resources between the public and private health sectors. The timing of the review is considered to be opportune given that practical steps for moving ahead with a 'mandatory contributory earnings-related savings and benefits' social security system were announced by the National Treasury earlier this year. The authors assert that if this window of opportunity is missed to initiate a mandatory health insurance scheme, another opportunity may be long in coming.

Chapter 6 provides an overview of *Health Information Systems in the Private Health Sector*, covering a broad range of issues from the purposes for which health information is collected, the systems which are used to collect and use the data, and protection of confidentiality in relation to personal medical information. The authors raise a significant concern that there is little integration between information systems in the public and private sectors, which are developing on different tracks. This compromises proper planning, management, policy development and performance evaluation of the South African health care system. The authors recommend that measures should be urgently implemented to ensure the integration of public and private health information systems. These measures should include the establishment of a dedicated national health information standards body, representative of all relevant stakeholders, to coordinate key processes in the development of public and private health information systems.

The chapter on *Health and Health Care in the Workplace* (Chapter 7) provides a useful overview of demographic and health status indicators of the South African workforce. The authors note that changes in the socio-economic and employment patterns of the workforce may manifest in changing and new requirements for health care provision. The concern is noted that, with the exception of HIV and AIDS, little data are available on disease profiles of the South African workforce. Occupational disease and injury is identified as a major cost to the South African economy, translating to some 3.5% of the national GDP. There are also indications of worsening occupational health and safety standards in the non-mining sector. In mines, however, both injury and fatality rates have shown a downward trend from 1994 to the present. In relation to addressing the HIV and AIDS epidemic, the financial, mining, manufacturing and transport sectors seem to have made significant progress in the implementation of HIV workplace strategies. Smaller companies, however, lag behind the provision of HIV programmes due to financial constraints and lack of perceived long-term risk to business operations.

The chapter also provides an overview of employer interventions aimed at improving the health of their workforce, including workplace-based occupational health services and various types of employer subsidies for the obtaining of health services by employees, including medical scheme subsidies and bargaining council subsidies. Finally, the Workers' Compensation Fund and disability grants are reviewed as models of social security and disability care for workers.

The authors make certain recommendations to promote a more proactive approach to preventing ill-health, limiting mortality and disability and enhancing access to health services among the South African workforce. These recommendations include more effective enforcement of health and safety programmes and the expansion of workplace-based health services and programmes, particularly in high risk employment sectors. This should, in the view of the authors, be complemented by mandatory rehabilitation and vocational training programmes to reintegrate injured or diseased workers into the workplace. In addition, it is proposed that the existing compensation system for occupational injuries and diseases should be expanded to include currently excluded workers, notably domestic workers, informal sector employees and self-employed persons.

The author of the chapter on *Rationing of Medicines and Health Care Technology* (Chapter 8) makes the point that while advances in medical technology may enhance patient care, most are associated with incremental costs to the health care system. Furthermore, the introduction of many technological developments is difficult to justify given marginal clinical value. Ultimately, given the fact that limited budgetary resources are available for health care, difficult choices need to be made in relation to the allocation of funds in the purchase of new technologies.

The chapter provides an overview of government efforts to achieve more equitable access to health care which impact on the acquisition and use of new technology in the private health care sector. The author argues that the design of the PMB package, and in particular the inclusion of a Chronic Disease List (CDL) within that package, has made the appropriate rationing of health care technology difficult and has in certain respects detracted from the equitable allocation of health care resources. The introduction of a Single Exit Price (SEP) for medicines resulted in a marked reduction in

medicine prices, but the beneficial impact of these reforms was compromised to some extent by health care providers adjusting pricing structures to offset the loss of profit on medicines through other cost structures. In addition, the continued absence of a fixed dispensing fee has resulted in lower savings being passed on to consumers.

The author acknowledges that overall reforms, such as the mandatory offer of generic substitution, phasing out of perverse incentives and the introduction of the SEP have had a positive effect on affordability of medicines. Nevertheless, the author argues that there is a need for an integrated national strategy for the introduction of new drugs and technologies, which will include careful assessment of options for the financing of expensive biopharmaceuticals and the introduction of novel technologies through Centres of Excellence with appropriate peer review. On the health financing side, the author argues for an overhaul of the PMB package in a manner that includes well-defined budgetary boundaries within which certain health care services will be prioritised.

Health Care Delivery

This section on health care delivery considers issues of availability of human resources for health, private hospitals, public-private partnerships, and the provision of services for HIV and AIDS, sexually transmitted infections (STIs) and tuberculosis (TB) in the private sector. In addition, there is a specific focus on traditional and complementary medicine. In a slight departure from the predominantly health focus of the review, the focus on traditional medicine includes some interesting discussion on the economics of the traditional medicine trade, as well as the environmental effect of the traditional medicine trade on vulnerable species of fauna and flora. It is hoped that these inputs will add a dimension to the review which will demonstrate the need to integrate health policy discussion within broader socio-economic debates.

The authors of the chapter on *Human Resources for Health* (HRH) (Chapter 9) characterise shortages of various categories of health personnel in South Africa as a crisis, and identify the production, recruiting and retention of health professionals as key challenges for the health system. These challenges are compounded by the massive skewed distribution of HRH between public and private sectors – although paucity of data makes the true public-private distribution of HRH difficult to accurately quantify. The authors explore three focal areas, which in their opinion need further research and consideration as possible means to address the shortage of HRH in South Africa and the maldistribution of resources between public and private sectors. These include: lifting the restrictions on the employment of doctors by private hospitals by the Health Professions Council of South Africa (HPCSA); remunerative work outside the public service; and the development of private medical schools. A key recommendation of the authors is the development of a national database on public and private health care providers.

One of the means of sharing human and other resources between public and private sectors is by way of *Public-Private Partnerships* (PPPs). In Chapter 10, a case study is provided of the Pelonomi and Universitas Hospital co-location project in the Free State. The authors explain National Treasury's preconditions for PPPs in the health sector, and then go on to explain the process which gave rise to the Free State initiative, and some of the key objectives of the project. In evaluating the project, the authors conclude that it has benefited both parties from a health service delivery perspective, while also providing broader social and economic benefits to the province. The authors identify certain preconditions for successful PPPs: objectives must be established upfront, which are measurable and unambiguous; there must be regular monitoring to ensure that the objectives are being satisfactorily met; and an effective and supportive institutional framework must be established to support the implementation phases of the PPP.

The chapter on *Private Hospitals* (Chapter 11) recognises the significant role which private hospitals play in delivering relatively high quality services to a portion of the South African population. In the past two decades, this has contributed to a clear shift of preference by medical scheme members to obtain services from private rather than public hospitals, which has fuelled growth of the private hospital industry and has rendered medical scheme income to public hospitals virtually negligible. At the same time, the authors point out that there has been a dramatic increase in per capita private hospital costs, which have consumed an ever increasing proportion of total medical scheme benefits. Private hospitals point to high nursing costs, changes in patient demographic and disease profiles, and unavoidable costs of new technology as some of their key cost drivers. Stakeholders such as the CMS, on the other hand, point out that the dramatic increase in private hospital costs has coincided with massive market consolidation in the industry since the late 1990s, which has led to an effective oligopoly between the three major hospital groups: Netcare, Medi-Clinic and Life Healthcare. The concern is also expressed that the strategy of the hospital groups to attract market share through attracting doctors to their hospitals creates perverse incentives for over-

servicing and inappropriate hospitalisation, which adds to cost escalation. In relation to Black Economic Empowerment, the authors observe that the industry has demonstrated serious commitment to improving the representation of Black persons in its ownership structure.

The authors recommend a comprehensive approach to regulating private hospital services, which prioritises issues of cost and quality. From a quality perspective, the authors express a concern that there is limited regulatory oversight of infection control in private hospitals. In relation to costs, the authors advocate for placing requirements for far greater transparency in pricing by private hospitals, prohibitions on perverse incentivisation of doctors by hospitals, and measures to redress imbalances in negotiating power between medical schemes and private hospitals. The authors also call for a national private hospital licensing framework, and for the review of the HPCSA restrictions on the salaried employment of doctors by private hospitals.

The chapter on *Traditional and Complementary Medicine* (Chapter 12) provides an overview of the range and number of practitioners of African traditional medicine and complementary medicine in South Africa. African traditional medicine is a source of health care to a large proportion of the Black South African population, and there are some 190 000 traditional healers in the country. The Traditional Health Practitioners Bill (Bill 20 of 2007), once signed into law by the President, will for the first time create a national statutory council for the registration of these practitioners, and provide for a regulatory framework for the efficiency, safety and quality of traditional health care services. There is growing evidence of cooperation between practitioners of traditional and allopathic medicine. There are fewer practitioners of other forms of traditional and complementary medicine in the country, such as homeopaths, naturopaths and osteopaths, who are registered in terms of the Chiropractors, Homeopaths and Allied Health Service Professions Second Amendment Act (Act 50 of 2000). The Medicines Control Council is gearing up for the regulation of complementary and African traditional medicine products, many of which are currently sold without regulatory control. This is important particularly in the light of phenomenal growth in the market for complementary medicines and health products in recent years.

The authors argue that while there has been significant progress in relation to the integration of traditional and complementary medicine into the South African health system, more should be done by government and other stakeholders. This includes removal of barriers to reimbursement for these services by medical schemes, followed by much more advocacy work among medical scheme trustees.

An interesting adjunct to chapter 12 is the chapter on the *Economics of the Traditional Medicine Trade in South Africa* (Chapter 13), which shows the interrelatedness of the health sector with other spheres of the South African economy. The authors point out that trade in African traditional medicines contributes an estimated R2.9 billion to the national economy annually (in 2006 prices). This has important benefits for the livelihood of people dependent on this sector, with at least 133 000 households being dependent on the trade in medicinal plants in South Africa. However, the consumption of some 20 000 tons of largely indigenous plant material is not sustainable indefinitely unless efforts are made to cultivate these plants. The authors point out that there is currently little public or private sector investment in the support and development of the current industry, which has negative implications for quality. Large pharmaceutical manufacturers are adopting a cautious approach to investment because of uncertainty in the future of intellectual property rights legislation, and there is limited academic research in the field.

The authors recommend the creation of incentives to encourage existing market players to develop their own industry, while at the same time encouraging appropriate technology for wild plant harvesting, farming, storage, packaging, dosage and treatment. These incentives should be established by various tiers of government by way of bursaries, research funds, market infrastructure development and processing facilities. At the same time, the authors recommend the encouragement of investment by pharmaceutical manufacturers through enabling them to secure ownership rights of technologies developed, where appropriate. A first step in the process would be for a strategic role-player to lead an initiative to create dialogue between all relevant stakeholders.

While Chapter 13 is concerned mainly with the use of plant materials in traditional medicine, a fascinating case study is provided focusing on traditional medicine use as a major cause of the rapid decline of vulture populations and other rare species of animals in the country. The case study reports on research recently conducted by Ezemvelo KZN Wildlife. The research found that the trade in vultures is not sustainable at present harvest levels, and supplies of different species of vulture could be exhausted in the next 10 to 30 years. The authors advocate for the development of a cooperative effort between traditional medicine market players,

rural farmers and conservation agencies in South Africa.

The chapter on *HIV and AIDS, STIs and TB in the Private Sector* (Chapter 14) provides an overview of the private sector response to these conditions. The HIV & AIDS and STI National Strategic Plan (NSP) identifies the importance of increasing the contribution of, and building partnerships with, the private sector as a means to respond to these epidemics. Certainly, in the treatment of TB, partnerships between government and private sector role players have proved to be important. In addition, some 100 000 patients are currently receiving HIV and AIDS care through disease management programmes in the private sector, of whom some 67 600 are currently receiving Highly Active Antiretroviral Therapy (HAART). A case study of the Aid for AIDS disease management programme is provided in the chapter.

The authors note clear limitations on the response of the private sector to these epidemics. The private sector has had a curative agenda and has not focused much on prevention efforts. In the case of the treatment of STIs, there has also not been sufficient financial incentive for private providers to maintain uniformly high standards of care. The authors report on research, which showed that 58.5% of GPs in South Africa had not heard of the syndromic approach to management of STIs despite the fact that the public sector has adopted the syndromic management drug protocols advocated by the World Health Organization. This is a serious indictment on private sector care provision given the fact that it is estimated that half or more of STI episodes in the South African formal health sector are treated in the private sector. Furthermore, there is no integrated and comprehensive sexual and reproductive health care approach in the private sector, with each disease being treated vertically as a discrete episode without there necessarily being continuity of care between different service providers.

The authors argue that, due to the interaction of these diseases with each other and the reality that many affected patients are mobile between the public and private sectors, it is important to model partnerships to deliver comprehensive integrated disease management programmes. The private sector is also urged to play a far greater role in prevention activities than it is currently playing.

Indicators

The final chapter on *Health and Related Indicators* (Chapter 15) provides a comprehensive overview of data available to assess the status of the health system, ranging from health determinants and socio-demographic issues, inputs to the system in the form of financing and human resources, to indicators of the coverage, efficiency and effectiveness of the health system and the ultimate impacts on health status. In line with the focus on the private health care sector, this chapter sought to gather the best available data on that sector, and also to highlight the extent to which available national health information systems include or exclude the contribution of the private sector. In most cases, systems for gathering health-related information from the private and public sectors are not integrated or even coordinated, making comparison across the sectors difficult.

Despite the fact that human resources are a key input to the health system, detailed information on their distribution geographically and between the sectors remains very poor. Data on the distribution of health facilities are more readily available and are included for both sectors alongside the section with provincial maps down to sub-district level.

New interactive data products released by Statistics South Africa this year have enabled estimation of both medical scheme coverage and usage of the public and private sectors according to coverage at district level for the first time. This information has also enabled more accurate calculation of public sector expenditure on non-hospital primary health care at the district level, which is a key input indicator for monitoring equity.

Data from the REF Study has provided a snapshot of chronic disease prevalence in the private sector, enabling a comparison to general population data for the first time. Despite the substantial contribution of chronic diseases to morbidity and mortality, information systems and indicators remain weak, except for mortality data from the vital registration system.

Analysis of selected indicators which are available from a variety of data sources suggests that the routine aggregated health information system (i.e. the District Health Information System) has good coverage and reasonable results, aside from known areas of concern with data quality (which are common to administrative systems globally). Since it already designed to accommodate data from both sectors (and indeed already includes some private sector data) this is a tool that has the potential to provide comprehensive information on the health system. Stewardship of health information

systems is also critical; worrying discrepancies were noted by the authors between the notifiable diseases system and vital registration, illustrated using malaria and TB mortality.

The chapter also provides a synopsis of the latest research in health metrics, and how some of these principles of monitoring and evaluation can assist those using health statistics to interpret and apply them appropriately. Data from over one hundred sources were used to compile the current chapter, and much of this is made available in the electronic version and through the HST web site.

Conclusion

It is clear from the above discussion that the authors of this 12th edition of the SAHR have made a wide range of important recommendations, all of which require serious consideration by government and relevant stakeholders. It is not intended in this concluding section to comment on the merits of all these recommendations. There are, however, certain cross-cutting themes relating to the South Africa health system, which emerge throughout the chapters and which warrant emphasis.

All stakeholders need to recognise the Ministry of Health's responsibility to exercise stewardship over the entire health system, both public and private. In exercising the constitutional requirement to take legislative and other measures to achieve the progressive realisation of the right to health care, the private sector cannot be left to its own devices for the following reasons.

The first reason for this is that in health care, market forces tend not to give rise to an optimally efficient and competitive market. This is evident, for example, in the rapid consolidation of the private hospital market over the past decade into the hands of three major market players, who have little need to engage in price competition and instead compete largely for the allegiance of doctors. The creation of an oligopoly in the private hospital market is in all likelihood a major contributor to health care cost escalation in the private sector.

The second reason for intervention in the private health market is because the uncontrolled development of this sector has negative impact on resources in the public sector. The most important example of this is the massive migration of health personnel from the public sector to the private health sector, resulting in critical human resource shortages in the public sector. The answer to this does not necessarily lie simply in restrictions on professional practice, but it provides a basis for approaching the issue of supply and distribution of human resources between public and private sectors in an integrated and coordinated fashion.

The third reason for intervention is that if cost trends in the private health sector continue to be unchecked, the private sector is unlikely to be sustainable in the future. Already, the proportion of the population who are covered by medical schemes is diminishing, resulting in a growing proportion of the population which is reliant on the relatively under-resourced public sector. For the private sector to play a valuable role in the development of the South African health system, they should be lessening the burden on the public sector rather than adding to it.

Perhaps the most important reason why the private sector cannot be left to an unregulated market is that it is intolerable from a public policy perspective that the socio-economic status of an individual is a primary determinant of the level of access to health care that the individual can receive. The achievement of equity and social solidarity in access to health care is a fundamental imperative of the right of access to health care. The hugely skewed distribution of health care resources between persons dependent on public and private sectors is inequitable and has no place in a society trying to shake off the remnants of a history of social injustice.

What is required now is a clear road map to be developed by government, in consultation with all relevant stakeholders, in terms of how it sees the ongoing development of the health system in a manner which harnesses the resources of both public and private sectors to the equitable benefit of all South Africans. Among other things, this road map needs to clarify government's intentions in relation to the various proposals that have been made for the implementation of mandatory health insurance in South Africa supported by risk- and income-based cross-subsidies. The foundation of this discussion needs to be based on principles rather than on protracted and ongoing debates regarding loosely-used terminology like 'social health insurance' versus 'national health insurance'. The roadmap must be accompanied by clear timeframes. Without clear direction on these critical issues, private sector players may well be tempted to take a short-term view of getting as much out of the system as possible on the basis that they do not know what the future may hold.

The Editorial Team