In this chapter, private sector stakeholders are identified and categorised according to their respective roles in revenue collection, pooling, purchasing and delivery of health care. Representatives of key stakeholder organisations were contacted to elicit information on their organisation’s responses to NHI and a desktop search was conducted. An overview of the key concerns of and arguments raised by the private sector regarding the rationale for reform, the goals of reform, the reform process as well as responses to the various ANC proposals are provided. The various models and proposals that the private sector have mooted in response to the NHI proposals are set out, and the role that the private sector could play in a future mandatory system is considered. It is clear that the debate cannot be clearly defined in the absence of official government policy. Concerns about the lack of consultation and transparency have been broadly expressed. However, it is clear that there remains substantial goodwill from all stakeholders to see reform and to participate in the reforms. Statements from stakeholders reveal a commitment to the goals of achieving universal access to quality health care for all South Africans as well as a commitment to open engagement and debate.

In recognising both the willingness of the private sector to engage and participate in improving health care for all South Africans and the strengths of this sector in delivering services, pooling funds and managing benefits, there is an opportunity for government to embrace and harness this goodwill and capacity...
Introduction and stakeholders

As South Africa contemplates moving towards the implementation of a unified health system, debate continues to be polarised along the lines of the ‘public sector’ and the ‘private sector’. In the minds of many, private sector health care refers to cover provided by medical schemes, but the extent of the private sector is not always clear.

McIntyre and Thiede reported, using 2005 data, that 60% of total health care funds in South Africa flow via private intermediaries.¹ Medical schemes account for 76% of private expenditure, with household out-of-pocket expenditure contributing 23%. Employers fund health care for their employees either indirectly through subsidies for medical schemes or directly through workplace-based health services, but these direct payments from firms for health care account for less than 1% of private expenditure.¹² There is also a small amount of expenditure via short-term and long-term insurance companies on health insurance policies, but this is probably less than 0.5% of private health expenditure.

A substantial item often excluded from analysis, and from the figures above, is private expenditure on African Traditional Healers. Previous research for the South African Health Review showed that trade in traditional medicines in 2006 was estimated to be worth R2.9 billion per year, representing 5.6% of the National Health budget: “[w]ith 27 million consumers, the trade is vibrant and widespread”.³ This expenditure should form part of household out-of-pocket expenditure on health care, as traditional medicine is rarely included in medical scheme benefits.

In attempting to provide an overview of the private sector response to National Health Insurance (NHI) in South Africa stakeholders comprising the private sector were identified. Key private stakeholders, listed by their functional role in the health system, include:

- Revenue Collection: individual members of the public, organised labour, employers, brokers and all taxpayers (including those paying income tax, value added tax, fuel levy and customs and excise taxes);
- Pooling: medical schemes and medical scheme members;
- Purchasing: medical schemes, medical scheme administrators, managed-care organisations; and
- Delivery: private hospitals, pharmaceutical industry, medical practitioners, nurses, traditional healers, pharmacists and pharmacy owners.

![Figure 1: Stakeholders in medical schemes](source: Adapted from Council for Medical Schemes, 2010.⁴)
Figure 1 indicates the numerous lobby groups, industry associations and regulators that surround the medical schemes industry.

Representatives of key stakeholder organisations were contacted via email to elicit information on their organisation’s responses to NHI. Information on the following activities was requested from the key stakeholders:

- The convening of, or contributions to, discussion forums, workshops and conferences;
- The establishment of a web-portal for NHI-related information or publication of material on the internet;
- The funding of NHI-related research;
- The creation of, or improvement to, NHI models;
- Documents prepared for email distribution (e.g. research notes, policy briefs);
- The submission of proposals to policymakers, government departments or other decision makers;
- Representation on the Ministerial Advisory Committee on NHI;
- The establishment of sub-committees, working groups or research units to focus on NHI;
- Publications in academic forums or journals;
- Articles in industry publications; and
- Quotes or commentary in the popular press.

Supporting documentation for the activities was also requested. In addition, a desktop search was carried out to identify additional material.

A total of 28 organisations were surveyed, including representatives of health-care providers (including traditional healers and the pharmaceutical industry), professional bodies, funders, medical scheme administrators, managed care organisations, brokers and research consultancies. Academic institutions were also included in the survey. Eighteen responses were received, representing a response rate of 64%.

In the rest of this chapter the key concerns and arguments raised by the private sector regarding the NHI are provided. The various models and proposals that the private sector have mooted in response to the NHI proposals are set out, and the role that the private sector could play in a future mandatory system is considered.

The reform of private sector health care

Initial path of reform

The possible trajectory for the reform of private health care was outlined in the African National Congress (ANC) Health Plan of 1994. A committee of enquiry was to be formed to consider possible structures for a mandatory NHI system under the following principles:

- The current medical schemes could form the basis of the NHI, provided they met with specified statutory conditions governing the NHI system;
- Membership would be compulsory for all formal sector employees and their dependants;
- Schemes which form part of the NHI should be prohibited from excluding any member (e.g. on the basis of high risk);
- The basic package of care to be covered by the NHI should be statutorily defined;
- Contributions to cover the basic package would be income-related, probably determined centrally, and should be jointly paid by employers and employees;
- This contribution revenue (covering the basic package) should be pooled in a central equalisation fund out of which every scheme would be paid in terms of its overall risk profile, i.e. a risk adjusted capitation fee;
- Existing health insurance companies and medical schemes would be free to offer ‘top-up’ cover for services not covered in the NHI essential package; and
- The long-term goal would be for all citizens, including the unemployed, to be covered under the NHI system.

This path for reform was subsequently confirmed by several commissions and reports, including the Health Care Finance Committee (1994), the Broomberg-Shisana Committee of Inquiry (1995), the Department of Health Social Health Insurance (SHI) Working Group (1997), the Taylor Committee (2002) and the Ministerial Task Team on SHI (2005). A particularly useful summary of the proposals and points of commonality is provided by McIntyre and van den Heever. Commentary on the politics and process of reform has been provided by McIntyre et al. and Thomas. Essentially all these documents confirmed that medical schemes, under revised legislation to ensure the public good, would be the vehicles to achieve mandatory health insurance. This would begin by covering those employed and their families and would expand over time to include the whole population.
The last publicly available Government documents (as opposed to ANC party documents) on reform of the private health care sector were those prepared by the Department of Health for submission to the Taylor Committee in 2002. Since then there have been several stakeholder engagements on aspects of reform, including the design of the Risk Equalisation Fund and proposals for Low Income Medical Scheme options, but with no official Government response. Extensive documents produced for implementation of the reforms in 2005, including a report to Cabinet, were never made public.

Changing direction on the reform of private sector health care

The ANC National Conference in Polokwane in December 2007 resulted in a renewed focus on NHI but with a different vision.

The February 2009 draft NHI proposal from the ANC task team consisted of some 200 pages in which the phrase ‘medical scheme’ was not mentioned. Comments by alliance partners suggested that private health insurance, that is medical schemes, could be closed down completely. In contrast, the June 2009 NHI proposal from the ANC task team, reduced to some 64 pages, deals with medical schemes extensively and their perceived role in the problems in health care financing in South Africa. This document, as well as the September 2010 ANC document, envisages a single national fund that is responsible for all revenue collection, pooling and purchasing. Medical schemes may continue, but only on a voluntary basis, as at present. It is proposed that future members will pay for NHI through taxation and a social security contribution and will need to pay, in addition, for any medical scheme they join. This is expected to mean that private health care will become less affordable for many members, although the extent of their withdrawing from cover is a subject of much debate.

Issues with the reform process

Transparency and information sharing

The time-period between the December 2007 ANC National Conference and the first publicly available ANC discussion document released in September 2010 was characterised by secrecy. The first two documents produced by the ANC task team were not made publicly available. This not only hampered any analysis but increased mistrust and made for some heated exchanges by stakeholders. This lack of transparency allegedly also extended to the work of the ANC committee itself.

There have been references to NHI in government statements, for example, in the 10 Point Plan for the health sector and the 2010 State of the Nation address. However, despite repeated promises in the media since June 2009, a Government document on the NHI reforms has still not been forthcoming. In the absence of official government policy on NHI the debate has been poorly informed and media debates based mainly on speculation.

The formation of a Ministerial Advisory Committee (MAC) on NHI in September 2009 has not served to improve communication with stakeholders. A blurring of the boundaries between the MAC and the ANC has raised further questions about the reform process. For example, the chair of the MAC was present when the 2010 discussion document was announced, yet both the Minister of Health and the Director-General of Health were not.

The most recent ANC document has been both welcomed and criticised. As described by the South African Medical Association, “a process that to date has been essentially secretive, has in part been opened up”. The criticisms, from a process point of view, are that the document was not circulated to branches, the authorship of the document is unclear and there remains a lack of detail.

The potential impact of regulatory uncertainty on the investment climate for private health care is of concern, as this could lead to lower investment than there would otherwise be in building and maintaining much-needed capacity in South Africa.

Time-lines

Stakeholders have expressed concern with both the time-lines for implementation and the time-lines for achieving universal coverage.

Concerns about time-lines for implementation relate to the lack of consultation, a sentiment echoed by civil society and labour. The Hospital Association of South Africa (HASA) comments that they have:

Unfortunately ... not been formally approached to discuss the NHI topic with the national Department of Health at this stage, although it is expected that once a document is published, such an invitation will be extended to the Association.

Momentum comments that:

Since no official policy document has been released we do not feel that we can, at this time, comment on specific details of any proposals. We are of course eagerly awaiting this document. The chief concern is that all stakeholders must be given sufficient opportunity to comment on any document that is published.
and that critical medical scheme reforms must not be delayed or abandoned while the NHI policy is being developed.36

The Secretary General of the Congress of South African Trade Union (COSATU) in the Western Cape indicated that they felt sidelined from the policy discussions and planned to raise the issue with government. He stated:

It is of great concern to us. There is a lot of silence around the NHI and consultation has been inadequate from the side of government.33

The latest ANC document envisions the extension of coverage occurring over a 14-year period which is more realistic than the five-year period put forward in the first post-Polokwane documents. Discovery commented:

In particular, we welcome the focus on a progressive and gradual implementation of the proposed health reform, as well as the focus on the most underserved areas during the initial five-year period of the health reform.44

There remains, however, a concern that the major component of the increased funding and utilisation would take longer than the initial five years.

Econex highlight the relatively long implementation periods required to implement universal coverage elsewhere in the world.38 This is echoed by Ernst & Young who suggest that “a stepwise approach to implementing the programme is recognition of the realities of such a massive reform”.39

Private sector stakeholder engagement

Despite the lack of consultation and transparency there remains substantial goodwill from all stakeholders to see reform and to participate in the reforms. Statements from stakeholder groups representing the hospital industry, the pharmaceutical industry, the medical scheme industry and the actuarial profession reveal a commitment to the goals of achieving universal access to quality health care for all South Africans, as well as a commitment to open engagement and debate.40-43

Private sector stakeholder engagement is motivated by a recognition “that the status quo is untenable and that health care reform is urgently needed”.36 Private sector stakeholders bring a perceived “responsibility to engage in debates critically affecting the future of the entire country”, an ability to contribute data, extensive expertise and an in-depth understanding of the South African private health sector to discussions of national health system reform, and also a recognition that major health sector reforms are likely to dramatically affect the stakeholders involved.44

The absence of a forum to provide constructive comment has resulted in a proliferation of newsletters, policy briefs and research notes funded by the private sector and academics in 2009 and 2010. Much of the research done has been commissioned from consultancies and research entities, such as Deloitte, Econex, Econometrix, Eighty20 and Genesis Analytics. Additional research has also occurred within organisations. For example, Medi-Clinic established a Health Policy Unit in January 2009 to conduct NHI and other health system related research.43 Research findings from the process of private sector collaboration are discussed below under several themes.

A positive outcome of the government’s limited information sharing is that the private sector has adopted an open and transparent process of sharing research. Examples of collaboration include the informal meetings of interested researchers, independent and private sector, organised by Medi-Clinic which aim to “share research, critique each other’s work, ensure no duplication and foster collaboration”.43 The meetings are held every six months and are hosted by various parties.

The NHI web-library, created by Innovative Medicines South Africa (IMSA) for NHI research and documents, is a powerful example of endeavours to place material and evidence in the public domain in order to progress the technical work of developing a mandatory health insurance system.42 A series of policy briefs on NHI has been produced on a monthly basis and the website is open to any organisation to report their research findings or deposit documents. The research produced by Econex has also been placed in the public domain and widely disseminated via email to stakeholders including the media, medical scheme officials, medical scheme administrators, providers, the Council for Medical Schemes (CMS), the Department of Health and the business community.43 The Health Economics Unit (HEU), based at the University of Cape Town (UCT), has also published a series of policy briefs and information sheets.

As a funder of NHI research, HASA has stated that:

It is critical that all aspects of the NHI proposal be addressed empirically ... accurate studies and research should be conducted to augment the debate and develop South African centred deliverables.45

HASA have made commissioned research available to the public for their benefit, critique and understanding. This is done via the IMSA portal, as well as through its own publications such as the Private Hospital Review 2009, the HASA Newsletter and the HASA Annals.

There have been a large number of public fora that have addressed issues relating to NHI, including conferences, workshops and seminars involving players from the public sector, unions and private sector, and independent academics and
consultants. These fora have been organised by private sector stakeholders (such as the annual Board of Healthcare Funders (BHF) conference and the HASA conference), by academic institutions (such as the Witwatersrand University NHII workshop and the UCT Global Health Initiative seminar, both in 2009) and by Civil Society (such as Helen Suzman Foundation, Institute for Democracy in Africa (IDASA)), the Black Sash and the Centre for Development and Enterprise).

Issues with the rationale for reform

The June 2009 proposal by the ANC task team on NHI says:

Key to differential access to quality health care and hence poor health outcomes is the maldistribution of human, financial and physical resources between the public and private sectors.22

This sentiment was echoed in the January 2010 National Executive Committee statement:

The current command of health resources by the private health sector, which serves a minority section of the population, has been to the detriment of the public sector.

Inequity in provider distribution

The illustration of inequity in provider distribution that has been used by all the post-Polokwane proposals for NHI, including the most recent ANC discussion document, was initially developed by the HEU and is shown below, extended to include traditional healers.23,46

The key figures for the number of doctors, nurses and pharmacists have also been reported elsewhere and rely on the registration information for health professionals from the Health Professions Council of South Africa, the South African Nursing Council and the South African Pharmacy Council.47,48 The number known to work in the public sector is then deducted from the total registered to obtain what is thought to be the number working in the private sector. However, this is overstated due to the very high numbers on the professional registers who are no longer working as professionals or have emigrated.

Researchers in the private sector were not convinced of these reported inequities and further detailed work has been done by Econex on the number of nurses, doctors and specialists.49 Figures were cross-checked against other surveys and against information from the major medical scheme administrators. Table 2 shows a different picture of public and private staffing levels that has emerged from the research.

The difference between the 2005 and 2008 tables is not reflective of actual changes in the numbers practising but rather of the impact of better estimates of private sector practitioners. The differences are dramatic in the case of General Practitioners (GPs) where the 2005 estimates that suggest one GP per 243 people in the private sector are replaced with 2008 estimates of one GP per 1138 people for medical schemes. This compares to one GP per 2612 people if the roughly 20% of the population who purchase private GP services out-of-pocket are included. The public sector figure has also been revised from one GP per 4193 people to one GP per 3838 people. While this is still higher than in the private sector, the gap between the two services is not as large as reported in 2005.

Table 1: Original table on inequity in provider distribution in 2005

<table>
<thead>
<tr>
<th>Delivery of health care</th>
<th>Private Health Insurance</th>
<th>Some Private + Public</th>
<th>Public Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Private primary care and private hospitals</td>
<td>Private primary care and public hospitals</td>
<td>Public primary care and public hospitals</td>
</tr>
<tr>
<td>Population covered</td>
<td>7.0 million</td>
<td>9.8 million</td>
<td>30.2 million</td>
</tr>
<tr>
<td>Proportion of population</td>
<td>14.8%</td>
<td>21.0%</td>
<td>64.2%</td>
</tr>
<tr>
<td>Per capita expenditure per annum</td>
<td>R9 500</td>
<td>R1 500</td>
<td>R1 300</td>
</tr>
<tr>
<td>Proportion of total expenditure</td>
<td>55.0%</td>
<td>12.3%</td>
<td>32.7%</td>
</tr>
<tr>
<td>Population per primary care practitioner</td>
<td>(243)*</td>
<td>588</td>
<td>4 193</td>
</tr>
<tr>
<td>Population per pharmacist</td>
<td>(765)*</td>
<td>1 852</td>
<td>22 879</td>
</tr>
<tr>
<td>Population per specialist</td>
<td>470</td>
<td>10 811</td>
<td></td>
</tr>
<tr>
<td>Population per nurse</td>
<td>102</td>
<td>616</td>
<td></td>
</tr>
<tr>
<td>Population per hospital bed</td>
<td>194</td>
<td>399</td>
<td></td>
</tr>
<tr>
<td>Proportion of population using Traditional Medicine</td>
<td>not covered</td>
<td>72.0%</td>
<td>informal and isolated integration</td>
</tr>
<tr>
<td>Population per Traditional Medicine practitioner</td>
<td>182</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Estimates in brackets are if only used by private health insurance
Econex produced new figures for doctors and specialists in 2010, which are reflected in Table 2, and stated the following:\textsuperscript{50}

Our estimates show that there are at least 2 723 people per GP in the private sector and 2 861 people per GP in the public sector. This is a very important result as the distribution of the population between GPs in the public and private sectors are then almost equal, and not as skewed as the ANC proposal suggests.

The ANC responded to the publication of these updated numbers, acknowledging that the data used in the discussion document was not 100\% accurate.\textsuperscript{51}

Inequities in provider distribution is, at least in part, attributable to government policy and public sector working conditions. It is widely acknowledged that there is a human resource shortage in the public sector, that there is a large number of vacant posts and that there is insufficient training of nurses occurring due to the closure of nursing colleges. Poor working conditions in the public sector relate inter alia to the lack of equipment, the unavailability of drugs, the prevalence of HIV and the attitudes of co-workers. Emigration of health workers has also had a significant impact.

Differences in private sector and public sector hospital capacity are also put forward as evidence of inequity, this despite stated government policy to focus on primary care and a conscious decision to not invest in hospitals and to shut down beds.

### Inequity in finance

The following illustration is frequently used to depict the inequity in public and private health care expenditure. These figures were recently revised to 2008:\textsuperscript{52-54}

- R\textsuperscript{1} 300 per beneficiary, per annum for those belonging to medical schemes (this includes both medical scheme spending of R\textsuperscript{9} 600 and estimated out-of-pocket payments of R\textsuperscript{1} 700);
- R\textsuperscript{2} 500 per beneficiary, per annum for the middle group (includes out-of-pocket payments to private primary care providers and government spending on hospital care); and
- R\textsuperscript{1} 900 per beneficiary, per annum for those using government primary care and hospital services.

At face value this inequity in spending is held up as the problem to be resolved by a NHI system by pooling all of the above expenditure. However, the analysis seldom makes a clear distinction between public money and voluntary private expenditure. The necessary comparison is the expenditure by Government on someone using public sector facilities compared to the subsidy given by Government for private

<table>
<thead>
<tr>
<th>Delivery of health care in 2008 unless otherwise specified</th>
<th>Private Health Insurance</th>
<th>Some Private + Public</th>
<th>Public Sector</th>
<th>Total population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Private primary care and private hospitals</td>
<td>Private primary care and public hospitals</td>
<td>Public primary care and public hospitals</td>
<td></td>
</tr>
<tr>
<td>Population covered</td>
<td>7.9 million</td>
<td>10.2 million</td>
<td>30.8 million</td>
<td>48.9 million</td>
</tr>
<tr>
<td>Proportion of population</td>
<td>16.1%</td>
<td>20.9%</td>
<td>63.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Per capita expenditure per beneficiary per annum</td>
<td>R11 300</td>
<td>R2 500</td>
<td>R1 900</td>
<td></td>
</tr>
<tr>
<td>Per capita Government expenditure per beneficiary per annum</td>
<td>Limited to tax break on medical schemes</td>
<td>R1 900</td>
<td>R1 900</td>
<td></td>
</tr>
<tr>
<td>Per capita Government expenditure (2010)\textsuperscript{50} per beneficiary per annum</td>
<td>R1 730</td>
<td>R2 500</td>
<td>R2 500</td>
<td>R2 374</td>
</tr>
<tr>
<td>Proportion of total expenditure</td>
<td>51.4%</td>
<td>14.7%</td>
<td>33.8%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Population per primary care practitioner</td>
<td>(1 138)*</td>
<td>2 612</td>
<td>3 838</td>
<td>3 270</td>
</tr>
<tr>
<td>Population per primary care practitioner (2010)\textsuperscript{50}</td>
<td>2 723</td>
<td>2 861</td>
<td>2 812</td>
<td></td>
</tr>
<tr>
<td>Population per pharmacist</td>
<td>(1 567)*</td>
<td>3 594</td>
<td>16 626</td>
<td>7 105</td>
</tr>
<tr>
<td>Population per specialist (2008)</td>
<td>1 521</td>
<td>10 184</td>
<td>5 311</td>
<td></td>
</tr>
<tr>
<td>Population per specialist (2010)\textsuperscript{50}</td>
<td>1 767</td>
<td>9 581</td>
<td>5 198</td>
<td></td>
</tr>
<tr>
<td>Population per nurse</td>
<td>197</td>
<td>394</td>
<td>339</td>
<td></td>
</tr>
<tr>
<td>Population per hospital bed</td>
<td>303</td>
<td>482</td>
<td>440</td>
<td></td>
</tr>
<tr>
<td>Proportion of population using Traditional Medicine</td>
<td>72.0%</td>
<td>72.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population per Traditional Medicine Practitioner</td>
<td>190</td>
<td>190</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Estimates in brackets are if only used by private health insurance
health insurance. This is the so-called Tax Expenditure Subsidy (TES) which arises because of the tax break given to people who belong to medical schemes.55 This incentive has been in place since well before 1994.

The Ministerial Task Team on SHI reported in 2005 that the TES was estimated in 2005 to be R10.1 billion, which in that year was equal to some 20% of the public health budget.12,22 Despite 15 years of commissions and reports,6,7,11,12,22,26,57 all arguing for the abolition of the tax break for medical scheme membership, this incentive to join the private sector has been left in place each year, albeit that the subsidy has been capped in Rand terms per beneficiary. It is this expenditure on a per person basis in the private sector that needs to be contrasted to the public expenditure per person and made more equitable.

**Issues with the goals of reform**

**Universal coverage for health care or health insurance?**

There appears to be some confusion in the debate about the goals of NHI. In a description of NHI in July 2009 the ANC indicated that the NHI will “expand health coverage to all South Africans”.53

The June 2009 NHI proposal indicates the following:

> The goals of the national health insurance include ... providing universal coverage for all South Africans, irrespective of whether they are employed or not ...

The introduction of a national health insurance system has been on the agenda of government since 1994. The key objective of such a system is to address the problems of the dual health system by promoting social solidarity in order to achieve universal coverage.22

It seems that there is confusion in the debate between universal coverage for health care and universal coverage for health insurance. It is estimated that only some 16.4% of South Africans had health insurance cover in 2008.53 However everyone in the country has access to health care, either in the public sector or through medical schemes, bargaining council funds or other employer-based arrangements.

Research by Servaas van der Berg of the University of Stellenbosch shows the degree to which South Africans are able to access health care by income group (see Figure 2).a

Across all income groups about 80% of the population who needed care were able to access care while a further 9-14% decided they did not need to see a health-care practitioner. Physical constraints (the distance that needs to be travelled) affected 5% of the lowest income group, reducing as income increases. Financial constraints affected only 6% of the lowest income group and this does not vary as much by income as might be expected.

![Figure 2: Proportion of those ill who consulted a health worker and reasons why not](source)

**Quality of health care delivery**

The perception that a large group do not have access to health care is related to the type of practitioner accessed. In many people’s minds, quality care is primary care provided by doctors rather than nurses. Research (see Figure 3) shows that the highest income group seldom see a nurse and have become used to going to a GP or directly to a specialist. Amongst the lower income groups, a nurse practitioner is the most common point of entry to the health system. The inference then is that dissatisfaction with the current national health system refers to dissatisfaction with the quality of the care provided in the public sector.

This viewpoint is further supported by Econex research which found that the poorest households, who are eligible for free public health care, pay considerable sums for private health care.60 They found that user dissatisfaction in the public sector stemmed mainly from long waiting times, unavailable medicines and rude staff, while in the private sector dissatisfaction was mainly attributed to the price of the service. A comparative study of the quality of health systems in 48 developed and developing countries, undertaken by the Monitor Group in 2008, found that the public sector ranked eighth from the bottom, while the private sector ranked sixth from the top.60

On the issue of quality of care, a representative of MediClinic commented that:

> Any planning towards an NHI system should not only focus on the inputs, such as financial aspects, technology and infrastructural improvements that will lead to improved access, but also the quality of care.

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a Personal communication: Servaas van der Berg, August 19, 2009.
If quality doesn’t improve, it’s not much use for the nation ... We also believe that NHI must bring about change. Our people must perceive change at the point of service in terms of quality.61

The core of the promise made for the 2009 elections was that National Health Insurance will allow patients to choose whether to see a public or a private health-care provider. If this promise were to be fulfilled, the overwhelming choice is expected to be private GPs rather than nurse-staffed clinics.62

This has significant implications for both human resource requirements and the cost of implementation. In a review of international approaches to patient choice and referral, Econex found that restrictions on choice do prevail.63

The demand modelling carried out by Econex shows that the proposed expansion of coverage and elimination of co-payments would result in a sharp rise in the demand for doctors and specialists.38

The major constraint remains the short supply of doctors and nurses. The research shows that the private sector would need 3 700 more nurses to keep nursing ratios where they are now, if 2 million more people were brought into private hospitals.64

The current shortage of doctors in South Africa in the public and private sectors, coupled with the long development lead-time for specialists in particular, is of great concern and will need to be addressed if quality of care standards are to be maintained alongside an increased demand for private hospital care.64

Financial cost of proposals

The original costing for the post-Polokwane NHI proposals was prepared for COSATU in August 2008. A more recent version has been presented in various fora in 2010. According to this model, the projected cost of NHI is just over R150 billion in 2006 terms. The model assumes significant savings arising from bulk-buying, administrative efficiencies, gatekeeping and capitation. The currently uncovered population is also assumed to pose significantly lower costs than the currently covered population.65

The assumption of reduced utilisation is a contentious one, with other stakeholders arguing that the combined effect of freedom of choice and no co-payments at the point of service is likely to be increased demand for health care services.38 In addition, the effects of an ageing population and changing burden of disease on future utilisation are also ignored.66-69

Work done by Econex was based on the broad parameters set out in the February 2009 ANC document.38 They provide full annual cost estimates based on comprehensive coverage for the entire population, but also provide estimates for alternative scenarios with varying levels of benefits. The demand model produces cost estimates which range between R174 billion and R251 billion. The fiscal constraints and the associated equity implications are also considered, with the conclusion that “an increased financing requirement of the extent discussed here is not affordable”.

Figures presented at an IDASA Roundtable held in early 2010 are even higher than those put forward by Econex.70 A full costing, including the resources required to address public health system priorities, is estimated at R358 billion. This equates to 15.7% of GDP and is in stark contrast to the assertion by the HEU that implementation of a NHI will translate
Van der Berg and McLeod published results of a costing model based on an actuarial methodology applying price curves (based on age and gender) to the South African population. They produced a range of estimates from R109 billion to R334 billion (in 2009 terms) assuming different benefit packages and different levels of efficiency gains.

The Actuarial Society of South Africa (ASSA) has established a task team to oversee the development of a model that can quantify the costs and funding implications of various NHI scenarios. Deloitte were initially commissioned by Discovery to construct an early version of the model, with the aim of determining the NHI structure and benefits that would be both affordable and attainable with the current supply of health resources. This model was reviewed by an independent actuary and then handed over in its entirety to ASSA to modify, add other schemes’ data and publish results as they saw fit.

As one of the administrators committed to contributing to the ASSA model, Momentum has commented that “it is critical to have a robust model when different reform proposals are being assessed. This relates not just to costs and funding, but also health outcomes and the impact on the economy”.

Discovery also funded work by Genesis Analytics to investigate the possible impact of payroll taxes (which may fund NHI) on wages and employment. This research was also handed over to the ASSA as part of the NHI model.

The most recent ANC discussion document contains a costing model based on work done by the HEU. The estimated cost in 2025 is R376 billion (in 2010 terms). A report is available on the assumptions used, but the underlying spreadsheet model has not been made public. This hampers comment and critical analysis.

**Complexity and cost of administration**

The ANC’s proposed NHI plan requires compulsory accreditation of health providers as a pre-requisite for contracting with the NHI authority (NHIA) and receiving payments for claims related to NHI patients. Econex notes the many benefits that result from accreditation, including reduced costs for consumers in locating an appropriate provider, improved quality through standard setting and strengthened public confidence. This is counter-balanced by the observation that mandatory accreditation is usually linked to financial reward and is exceedingly resource-intensive and burdensome for the accreditation authority.

Econex estimates that at least 168 staff members would be required if the proposed Office of Standards Compliance (OSC) were to accredit all hospitals and all GP and specialist practices within five years (the proposed time-frame).

It is envisaged that the health sector will contract on standard terms with a central organisation like the NHIA under the proposed NHI. However, at present, the private and public sectors differ in their contracting mechanisms and regulatory frameworks which poses potential barriers to a unified system.

The private sector is currently characterised by freedom of choice of provider, as well as allowing patients to enter the system at any level of care. The NHI system will involve unrestricted choice at the primary care level with careful management of referral from primary health care to secondary, tertiary and quaternary levels of care. The implied shift could have a large impact on how the private sector operates, either positively or negatively affecting the numbers of visits to GPs, secondary and tertiary levels. Further work on this referral mechanism and its implications is required.

A review of international experience by Econex identified the key problem areas of referral mechanisms in developing countries, which include hospital congestion due to incorrect referrals and inappropriate self-referrals, barriers to access due to travel distance, transport and payment, a lack of confidence in public primary health care and inadequate transfer of information to and from the hospital.

The payment system, which currently for private sector doctors is predominantly fee-for-service, is proposed to be changed to a system of mainly capitation for primary care and global budgets for hospitals. This proposal will change the incentives of doctors and introduce a disincentive to contract with the NHIA if private providers know they will still be able to serve the same volume of private patients under a NHI system.

The cost of administration is estimated at around R10.9 billion (in 2010 terms) in the latest ANC discussion document. Given the administrative functions outlined, the current cost of medical schemes administration and the sophisticated electronic health record technology proposed, this estimate appears unrealistic.

Administrators and managed care organisations have noted the existing capacity in the private sector. The industry has built up extensive expertise in managing the provision of health benefits to millions of South Africans and, as such, has an in-depth understanding of the South African private health sector and its dynamics, drivers and issues. The industry has expressed its willingness to contribute this expertise to discussions of national health system reform.
The future role of the private sector in South Africa

Multi-tier systems

McIntyre and van den Heever identified as one of the outstanding areas of major debate in 2007, the issue of a single tier versus a multi-tier system. "A key area of ongoing debate is the extent to which it is feasible to have a single tier system (where all South Africans have access to exactly the same range of services and types of health-care providers) or whether a multiple tier system (where there are differences, particularly in terms of the type of provider that can be used by different groups) is inevitable. Given the political history of legislated discrimination on the basis of race under apartheid, there is clearly a desire to avoid health system differentials on the basis of class.” The authors found that, “A single tier system, whereby all South Africans have access to private sector services, is simply unaffordable in the context of South Africa’s level of economic development”.

Universal coverage does not necessarily mean a single tier system. Universal coverage can be achieved through a combination of funding methods (i.e. a multi-tiered system). The World Health Organization (WHO) urged governments in Africa to develop plans for universal protection against the financial burden of illness, that might include a combination of tax-based financing, mandatory social health insurance and private insurance in a multi-tier system. Much careful work is needed to find an equitable solution that accommodates a multi-tier system.

While it is necessary to be careful not to conflate multi-tier systems and multiple purchasers, the arguments from Hussey and Anderson on social solidarity are also relevant to the debate on tiering. “A single-payer insurance system can ... foster citizens’ trust in the ability of the government to protect their welfare, enhancing the population’s view of the legitimacy of the government. However, in some cases multiple insurance pools might impact on the political support of the government. For example, better-off individuals who feel that they are contributing more than their fair share towards insuring the health risks of others may oppose the health insurance system. Allowing them to opt out of a single-payer insurance system may provide greater social solidarity in a normative sense, by securing the political support of high-income earners for the public insurance system. This is particularly important in low and middle-income countries where the high-income individuals and large industries must be willing to pay most of the cost of the reforms.” The BHF has put forward a proposal that supports a multiple-payer system.

The Organisation for Economic Co-operation and Development (OECD) initiated the Health Project in 2001 “to address some of the key challenges policymakers face in improving the performance of their countries’ health systems.” The three-year initiative provided substantial comparative information on the role of private health insurance across the OECD. “Governments in several OECD countries have used or considered using private health insurance (PHI) as a policy lever to promote certain health system goals, such as reducing financing pressures on public health systems, promoting individual choice and improving efficiency.”

The June 2009 NHI proposal from the ANC task team envisaged that medical schemes will continue but on a voluntary basis. It is proposed that members will pay for NHI and, additionally, for any medical scheme they join. Everyone earning above the income tax threshold will have to make this NHI contribution (i.e. no one may ‘opt-out’). The amount of the mandatory contribution was not determined in that report. These proposals on NHI from the ANC effectively relegate existing medical schemes to a ‘duplicate’ or parallel role which would mean that those covered by medical schemes could fall well below the eight million people currently covered.

Figure 4 provides an overview of the role PHI can play in health systems.

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b Social security systems have components that are commonly grouped into three tiers, defined by the way individuals contribute to each tier and draw benefits from that tier. In a single tier system there is only one system for everyone; this is typically found in the industrialised developed countries. In developing countries it is common to find multi-tier systems, for example a public health system as Tier 1; a mandatory contributory fund or funds for those employed as Tier 2; and purely private insurance and out-of-pocket spend in Tier 3.
Further work is required on the possible impact of selective drop-out of members from the medical scheme environment under some NHI scenarios which would destabilise remaining risk pools and lead to unintended cost or cross-subsidy dynamics in the NHI.

Another possible position is for medical schemes to provide ‘substitute cover’ where people may choose to belong to the NHI or to a medical scheme providing that the equivalent cover has a minimum set of benefits. The medical scheme could also offer ‘supplementary cover’ not otherwise included in the NHI package, a possibility that has been supported by the BHF.78

Medical scheme reform

An important component of the future role of medical schemes, particularly until the NHI policy is finalised by government, consulted on and implemented, is the incompleteness of the existing regulatory environment. The combined effect of voluntary membership with community rating and open enrolment has a destabilising effect on the medical scheme market. The introduction of mandatory membership based on income and employment status would help reduce the cost of medical scheme coverage, as would reform of the prescribed minimum benefit regulations, as these effectively place a minimum cost on scheme membership and limit access to schemes for low income individuals. The absence of a risk-equalisation mechanism creates a strong incentive for medical schemes to compete on risk selection and not on efficiency. Reforms on the Risk Equalisation Fund have been stalled since early 2008. This reform was regarded as urgent when deliberated in 2003/4.

Other private sector entities

There is a wide range of alternate roles the private sector could play in NHI that would harness the expertise and capacity available in the private sector. The potential for selective contracting of private sector entities requires further attention. For example, there may be scope for private doctor sessions and the contracting of private hospital groups to manage state facilities.

In the purchasing of health care, the expertise of medical scheme administrators and managed-care organisations could be leveraged. For example, medical scheme administrator expertise could be used to conduct strategic purchasing of health services on behalf of a population.

Van Eck makes the comment that, rather than viewing the private sector as a threat, it can be seen as a “report card” in that the size of the private sector reflects the quality of services available in the public sector.38 The role of medical schemes and private providers in future will be driven largely by the relative performance of these entities and the public alternative. To the extent that the public alternative fails to deliver to expectations, the role of the private sector will be more prominent. Similarly, should the public alternative deliver to expectations the private sector will tend towards becoming more complementary or supplementary.
Conclusions and Recommendations

The atmosphere of secrecy and mistrust surrounding the reform of the health care system is a serious hindrance to policy implementation. Both the lack of official policy, which would have served to enable and channel constructive comment, and the mismanagement of the process of reform need to be rectified.

Whilst there is a lack of agreement on the extent of inequities in provider distribution and health care financing, there is agreement that reform is much needed and now long overdue. However, agreement on the nature and extent of the problem is necessary to allow reasonable and practical solutions to be found.

Stakeholders differ on the quantum of the financial implications of NHI proposals but it remains clear that the proposals are both financially significant and complex. Given the far-reaching consequences of NHI, it is critical for all stakeholders to find solutions based on evidence-based arguments and for the debate to move beyond ideological positioning.

Whilst there have been a number of efforts at constructing costing models, the divergence in the results produced points to the need for the Department of Health to take responsibility for ensuring that the models used, together with the requisite technical data, are publicly available for critical analysis.

The precise form that private health insurance is to take still requires much research and debate amongst all stakeholders. It is clear, however, that without critical elements such as the Risk Equalisation Fund and mandatory membership of medical schemes, the current medical schemes environment is inherently unstable.

As the details of the NHI plans emerge, there will be a number of other issues that will require further interrogation. For providers, the issue of how they could contract with a single-fund purchaser, the process for determining the price of medical services, the likely payment terms and the split between private and public work will all need consideration.

Debates around the issue of private sector participation tend to become politically and ideologically heated but there are strong economic arguments for looking at the public private mix in technical terms and playing to the strengths of each sector. Research in sub-Saharan Africa indicates that greater private sector participation is “associated with favourable intermediate outcomes in terms of access and equity”.80

In recognising both the willingness of the private sector to engage and participate in improving health care for all South Africans and the strengths of this sector in delivering services, pooling funds and managing benefits, there is an opportunity for government to embrace and harness this goodwill and capacity.


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