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Stewardship: Protecting the Public's Health

Abstract

South Africa has a large private health sector, dominated by medical schemes, which cover about 14% of the population. Transformation efforts in the health sector have spanned more than a decade, but the problems of inequity remain acute between the public and private sectors. This chapter provides an assessment of how well the Ministry of Health is doing on stewardship of the private health sector in South Africa. The 2000 World Health Organization concept of stewardship emphasises four elements which are used in this chapter to analyse health sector developments in South Africa through a 'stewardship lens'. These elements include: 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 chapter concludes that stewardship is sub-optimal and that there is scope for improvement, given the huge levels of health inequity and disparities between the public and private sectors.

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Introduction

The democratic South African government inherited a highly fragmented health system with wide disparities in health spending, inequitable distribution of health care professionals and poor access and quality of care between and within provinces; between Black and White; urban and rural areas; and the public and private health sectors.[1,2,3,4]

South Africa has a large private health sector, dominated by medical schemes funded primarily by contributions from employers and employees.[5] Medical schemes cover about 14% of the population.[6] The private health sector includes private health service providers (e.g. doctors and nurses), institutions that represent health professionals, private health facilities (e.g. hospitals, laboratories), other funding mechanisms such as life and short-term insurance and traditional health practitioners.[7] Transformation efforts in the health sector have spanned more than a decade and included numerous structural, legislative and policy changes, implementation of programmes for priority health conditions and improvements in access to health care services.[8,9] There have been many positive developments and improvements in the lives of South Africans since the country's democratic transition however, the problem of inequity remains acute.[10,11,12]

This chapter provides an assessment of how well government and the Ministry of Health are doing on stewardship of the health system as it pertains to the private health sector. The chapter reviews developments over a 15 month period (April 2006 to June 2007) and draws on relevant historical data. The primary focus of this chapter is on the private-for-profit health sector and the key sources of information for the chapter include:

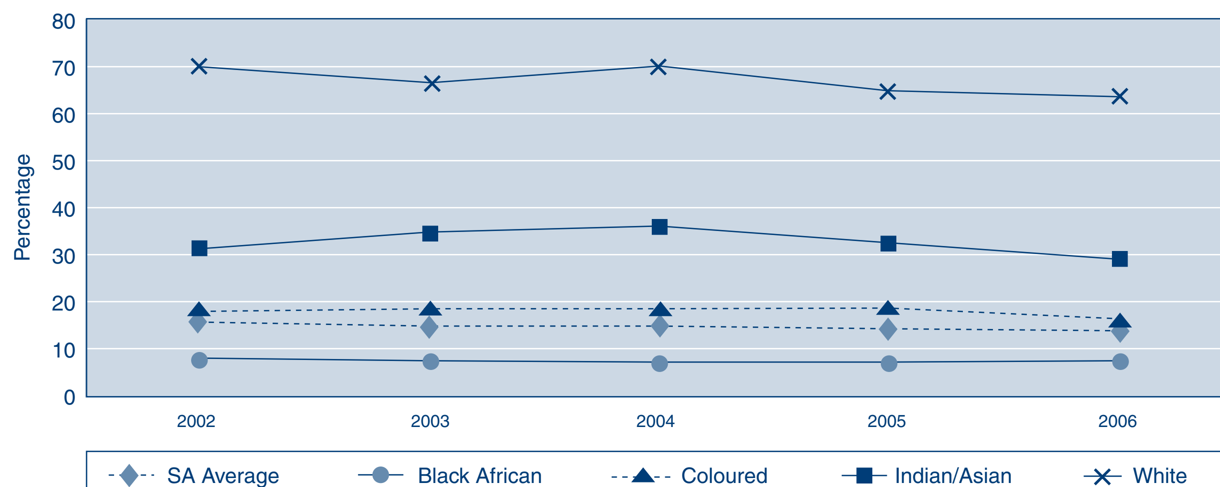
- A formal literature search of published material focusing on the private health sector in South Africa covering the 15 month period outlined above.
- Analysis of the 2005/06 annual reports of the national and provincial health departments and the 2007/08 budget speeches of the national Minister of Health and the provincial Members of Executive Committees (MECs).
- A scan of relevant newspaper articles and review of annual reports, briefing documents, position statements of the Board of Healthcare Funders (BHF); Council for Medical Schemes (CMS); Health Professions Council of South Africa (HPCSA); South African Medical Association (SAMA); Hospital Association of South Africa (HASA) and many of the major private hospital groups.

Key features of the country's private health sector are summarised and a brief overview of the notion of stewardship is presented. This is followed by an analysis of health sector developments over the past 15 months through the 'lens' of stewardship, with a particular reference to the private health sector. Other issues discussed include: regulatory tools applied by government; the degree to which institutions for implementation of private sector regulation and policy are exercising effective stewardship; statutory initiatives to transform some of these institutions; and the initiatives to develop consensus on transformation of the private health sector. The chapter concludes with the main observations emerging from the analysis and key recommendations.

The private health sector at a glance

There is a substantial body of literature on the private health sector in South Africa describing its nature, characteristics and challenges, its impact on the public sector and on the health system as a whole.[1,5,7,13,14,15,16] South Africa has a large, well developed, resource intensive and highly specialised private health sector. In 2006, approximately 56% of health care expenditure was funded from private sources however, it is estimated that only about one fifth of the population has routine access to private health sector providers.[17] The 2006 General Household Survey (GHS) released by Statistics South Africa (StatsSA) found a decrease in the percentage of persons covered by a medical scheme (13.7% in 2006 compared to 15.2% in 2002).[6] Variations in access to medical scheme coverage by race, and the trends in South Africa from 2002-2006 are shown in Figure 1.

Figure 1: Trends in medical scheme coverage by race, 2002-2006



Source: StatsSA, 2007.[6]

Figure 1 shows that in 2006 the medical scheme coverage of the White population (63.1%) was about nine times the percentage of the Black African population (7.2%). Not only are there racial inequities in medical scheme coverage, but also geographical inequities with higher coverage in the urban provinces of Gauteng (21.8%) and the Western Cape (18.8%), compared to the more rural provinces such as the Eastern Cape (10.2%) and Limpopo (6.7%).[6]

The debate about the public-private mix in health care predates democracy in South Africa and has occupied the policy agenda for more than a decade.[18,19,20,21] The White Paper for the Transformation of the Health System in South Africa highlighted a wide range of possible cooperation, from the delivery and management of services, through to standardised clinical management protocols and the provision of information to the National Health Information and Audit Systems.[22] The National Health Act (Act 61 of 2003) provides the legislative framework for addressing the inequities of the past and section 45 of the Act refers to a coordinated relationship between private and public health establishments in the delivery of health services.[23]

Despite many laudable large scale policy and programme initiatives since 1994, wide scale disparities continue to exist between the public and private health sectors in health spending, health care professionals, access to and quality of care and racial representativity.[24] Many have argued that the disparities in health spending, health care professionals and access to care between the public and private health sectors are one of the most serious impediments to an equitable health system in South Africa.[25,26,27] The disparities also explain the relatively poor performance of South Africa in the 2000 World Health Organization's (WHO) health system ranking.[28]

The private sector continues to face a number of challenges, including the pressure of rising costs, affordability and decreasing access to care. In 2005, the Minister of Health warned that if there was no change in the manner in which the private and public health care sectors in South Africa interacted, there would be a decline in access and quality of care. She also noted that the health funding for 2005 of approximately R100 billion was not benefiting the country's citizens in an equitable manner.[29] In the 2007 budget speech, the Minister of Health highlighted the urgent need to address inequities between the public and private sectors.[30]

The 2006 GHS results suggest that most medical consultations take place in public sector rather than in private sector institutions.[6] The GHS also suggests that over the period 2002 to 2006, each year a larger percentage of persons who were injured or ill in the month prior to the survey interview used public sector institutions rather than private sector institutions.[6]

In Table 1, the key challenges facing the South African private health sector are highlighted.

Table 1: Key challenges facing the South African private health sector

Challenge	Key elements
Lack of affordability and sustainability	• Large annual increases in medical scheme contribution rates • Declining benefit packages • Increased co-payments • Membership decline • Multiple benefit options and fragmented risk pools creating greater instability within individual schemes • Rising hospital and specialist costs
Inequity	• Private sector resources only available to minority and not to all country's citizens • Urban-bias in distribution of facilities and technology • Majority of health professionals are in the private sector • Government subsidy through tax exemptions on medical scheme contributions and training of health workers • Government charges below cost-recovery fee levels to medical scheme members using public hospitals
Lack of universal coverage of essential services	• Bias towards provision of hospital care, rather than preventive care • Over-servicing • Little if any attention to essential services in support of meeting the Millennium Development Goals (MDGs)
Inadequate competition	Difficulty of majority of schemes in bargaining with the supply side due to: • consolidation of private hospitals • under-supply of medical specialists

Source: Adapted from multiple sources.[a]

The notion of stewardship

The goal of national health systems is to improve and promote people's health, ensure responsiveness to citizens access to and quality of health care services and to protect citizens against the financial costs of illness through fair or equitable financing mechanisms.[28] The 2000 World Health Report by the WHO introduced the concept of stewardship as the most fundamental function of a health system, above service delivery, input production and financing as it makes possible the attainment of each health system goal.[28] Key stewardship issues identified in the 2000 World Health Report are highlighted in Box 1.

Box 1: What is stewardship?

Stewardship in health is the very essence of good government i.e.

- 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 its activities are viewed by the citizenry
- Maintaining and improving national resources for the benefit of the population

Source: Adapted from WHO, 2000.[28]

The 2000 World Health Report highlights that health policy and strategies need to cover the private provision of services and private financing, as well as state funding and activities in order to ensure that the health system is orientated towards achieving goals that are in the public's interest. The report further suggests that stewardship requires more than an exclusive focus on legislation and the issuing of Regulations, decrees and public orders as means of health policy. *"Good stewardship needs the support of several strategies to influence the behaviour of the different stakeholders in the health system. Among these are a better information base, the ability to build coalitions of support from different groups, and the ability to set incentives, either directly or in organisational design".*[28]

The following comments are made in relation to the private sector:

Stricter oversight and regulation of private sector providers and insurers must be placed high on national policy agendas. *"Good policy needs to differentiate between providers (public or private) who are contributing to health policy goals and those who are doing damage or having no effect and encourage or sanction appropriately. Policies to change the balance between providers' autonomy and accountability need to be monitored closely in terms of their effect on health, responsiveness and the distribution of the financing burden".*[28] Since the 2000 World Health Report, stewardship has also been explored in the health strategy of the New Partnership for Africa's Development (NEPAD) and at the international technical consultation on stewardship in September 2001.[31,32,33]

a This table was adapted from Table 1 in Reference 5, and complemented with information from the Health Charter and from the following documents: Wolvaardt G, Palmer N. The private sector In: South African Health Review 1997. Durban: Health Systems Trust; 1997. Pearmain D. Medical Schemes and competition, unpublished presentation. Johannesburg: Board of Health Care funders; 2007.

In line with the 2000 World Health Report, it is argued that the extent to which government executes its stewardship role on the private health sector can influence all aspects of health system performance. This chapter is therefore premised on the belief that government should set 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.

Analysing key health sector developments through a 'stewardship lens'

Careful and responsible management of the well-being of the population

In analysing stewardship of the private health sector by the Ministry of Health, it is useful to briefly examine key health status indicators and the country's progress towards the MDGs. This is to ensure that a focus on the overall goal of improved health outcomes is not lost in a stewardship review.

The South African 2005 MDG Country Report indicated that the country is on course to meet all MDG targets and some MDGs have already been met.[34] The sustained reduction in the number of nationally reported malaria cases from 64 622 in 2000 to 13 232 in 2004 is a success story, as is the dramatic reduction in the prevalence of syphilis cases among pregnant women. Similarly, deaths due to malaria have decreased from 2.6 per 100 000 population in 1999 to 1.8 per 100 000 population in 2002. However, the child mortality indicators contained in the report, as shown in Table 2, leave little room for complacency.[34]

While there have been many positive financial, fiscal, service delivery and public health developments, health status is being undermined by the severe generalised HIV and AIDS epidemic and its effects on mortality, tuberculosis and other diseases.[4,35,36] In 2006, the Human Development Report ranked South Africa 121 out of 177 countries and the Human Development Index (HDI) decreased from 0.691 in 2000 to 0.653 in 2004, mainly due to the HIV and AIDS epidemic.[37] The report on mortality and causes of death in South Africa for 2003 and 2004 by StatsSA showed that the leading natural underlying cause of death for males and females in 2004 was tuberculosis, followed by influenza and pneumonia which accounted for approximately one fifth of all deaths.[11] The report also confirmed previous trends described by Bradshaw et al.[38] As Kirby has noted, the health of the population is an *"ascertainable criterion against which to measure the effectiveness of the provision of health care services"*[39] albeit not the only factor.

A critical issue that has received little attention thus far is the role of the private sector in contributing to the achievement of the MDGs. Currently, the majority of services provided by private providers are curative and / or hospital biased. Primary care is not contained in the current Prescribed Minimum Benefits (PMB) and there is little emphasis on preventive and promotive services. The Health Charter notes that the lack of availability of a defined basic package of health services accessible to all, irrespective of ability to pay, is one of the challenges with regard to equity in health services.[24] The intention is to develop a defined basic package of care that is available to all patients in both the public and the private sectors regardless of the ability to pay. Such a basic package must conform to principles of increasing accessibility and affordability to meet the needs of the majority.[24] However, *"the basic package, the delivery thereof and the funding mechanism(s) will be developed by way of an open and consultative process by a task team under the auspices of a Charter Council within a reasonable period of time after the adoption of the Charter"*.[24] Many aspects of this statement in the Charter are open to interpretation (e.g. the definition of 'need' and a 'reasonable' time period). In February 2007, the BHF released a draft document on an essential health care

Table 2: Summary of child health indicators

Indicator	1998	2003 (preliminary)	2015 MDG Target
Neonatal mortality rate (per 1 000 live births)	20	-	-
Infant mortality rate (per 1 000 live births)	45	44	15
Child mortality rate (per 1 000 live births)	59	60	20
Proportion of 1 year old children immunised	72	78 (2003 estimates)	90

Source: DoH, 2005.[34]

package for South Africa, driven in part by the requirements of the draft Health Charter.[40] The MDG is only mentioned once in the document under mandatory reporting, where it notes that *"To assure accountability and good governance, medical schemes must report on: ... health status indicators (WHO and MDG aligned)"*.[40]

While this draft BHF document is a potentially important development, there should be greater emphasis by government, through the Health Charter, to emphasise the role of the private sector in improving health status and contributing to the achievement of the MDGs. The definition of the basic package of services that every citizen should be entitled to should be prioritised, with a clear timeframe for completion and with the MDGs being among the key criteria.

Establishing the best and fairest health system possible

The 2000 World Health Report notes that a 'good' health system must contribute to good health and must take the responsibility for reducing inequalities by improving the health of the worse-off (i.e. at both the level and distribution of health matters).[28]

In commenting on stewardship for improved health, it is important to delve deeper into the inequities that are hidden by only looking at averages. The second district barometer provides useful comparisons of all 53 districts across a number of socio-economic input, output and outcome indicators using routine data collected in the public sector. It demonstrates the stark inequities between rural and urban areas.[41] The recently released 2007 World Health Statistics report presents health statistics for the WHO's 193 Member States, disaggregated by gender, age, urban versus rural setting, wealth, and educational level (see Table 3).[42]

Table 3 clearly illustrates that health inequities are influenced by level of wealth, rural residence and educational level achieved by mothers. The probability of dying before the age of five is four times higher for a poor child (who is likely to depend on the public sector for care), compared to a wealthy child (who is likely to depend on the private sector for care). Similarly, children whose mothers have a low educational level are 1.8 times more likely to die before the age of five than those whose mothers have the highest educational level.

The legal framework for the overall transformation of the health system, the establishment of the district health system and the provision of equitable health services are enshrined in the National Health Act.[23] The certificate of need (CoN), an important clause in the National Health Act that relates to the private sector, which aims to address the skewed urban-rural distribution of medical establishments (general practitioner surgeries, private hospitals, etc.) as well as promote an appropriate mix of public and private health services, has not been implemented. Importantly, two years after the National Health Act came into effect, a functional district health system is yet to be implemented, with many aspects having not been defined and a comprehensive set of Regulations, remaining outstanding. Gray and Pillay have pointed out that Regulations, which must be published for comment at least three months before their contemplated date of commencement, present an important opportunity for public participation to inform such Regulations.[43]

Table 3: Inequities in health in South Africa, 2007

Criterion	< 5 mortality rate (per 1000 live births)	Births attended by health personnel (%)	Measles immunisation (%)
Rural residence	71.2	75.5	79.3
Urban residence	43.2	93.4	85.1
Ratio rural to urban	**1.6**	**1.2**	**1.1**
Lowest wealth quintile	87.4	67.8	73.5
Highest wealth quintile	21.9	98.1	84.5
Ratio between lowest and highest wealth quintile	**4.0**	**1.4**	**1.1**
Lowest educational level of mother	83.8	59.7	64.0
Highest educational level of mother	45.6	91.4	85.6
Ratio between lowest and highest education level of mother	**1.8**	**1.5**	**1.3**

Source: WHO, 2007.[42]

The CMS, although narrow in its focus of providing regulatory supervision of private health financing through medical schemes, continues to do good work in its area of focus.[44,45] The CMS focuses on the key areas of governance, including the effective and fair exercise of its powers, reviewing constraints that affect development of medical scheme options for low income earners and assistance to the Department of Health (DoH) in developing the policy on a risk equalisation mechanism for medical schemes.[45] The Medical Schemes Amendment Bill, published in November 2006, gives effect to the establishment of the Risk Equalisation Fund (REF), proposes tighter governance measures within schemes and allows for the establishment of schemes for lower income beneficiaries. However, the amendments on risk equalisation and improving access have been criticised for its exclusive and continued focus on the private sector, given the problems in the public sector.[46] The CMS published a final governance report in 2006, which outlined the policy and legal frameworks underpinning governance of medical schemes. This report also made recommendations for greater member involvement in governance, improved accountability of trustees and the effectiveness of the current governance model.[45]

In Table 4, the progress regarding regulatory tools applied by government as it pertains to the private sector is highlighted.

Table 4 shows that a wide range of regulatory tools are available to government and there has been progress in some important aspects. However, there are implementation delays of key aspects such as the CoN. Many of the Regulations to implement critical clauses on human resources in the National Health Act that are likely to facilitate transformation of the overall health system, including the private sector, remain outstanding.

A further aspect is the degree to which provincial departments of health, who are responsible for broad implementation, including the implementation of regulation and policy in the private sector, are exercising effective stewardship. While an in-depth analysis goes beyond the scope of this chapter, an analysis was conducted of the 2007/08 budget speeches of the national Minister of Health and the provincial health MECs for reference to and / or focus on the Health Charter as it is seen as an important tool for transforming the interaction between the public and private health sectors. The budget speeches were selected as they review progress against the budget for the past year (2006/07) and they map out key strategic priorities for the current financial year (2007/08). Statements were also examined on public-private partnerships and any outline of private sector strategies. Table 5 summarises the findings from this analysis.

Table 4: Progress in regulatory tools and other tools applied by government

Regulatory tool	Brief description of aspects specific to private sector	Developments in the period of the review (April 2006-June 2007)
National Health Act (Act 61 of 2003)	• Sections 36 to 40: Provision for certificate of need (CoN) for health establishments and renewal of such certificates • Section 45: Relationship between public and private establishments, including mechanisms for public-private collaboration • Section 46: Obligations of private health establishments regarding insurance cover • Section 47: Compliance with quality requirements and standards • Chapter 7: Human resource planning	• Chapter 6: Dealing with CoN has not come into effect • Regulations for many aspects of the Act remain outstanding
Medical Schemes Act (Act 131 of 1998)	Regulates medical schemes and aims to: • Provide for registration and control of medical schemes • Coordinate medical schemes • Protect the interests of members of medical schemes and obliges medical schemes to accept all eligible applicants • Establish a Council for Medical Schemes (CMS) • Make provision for package of Prescribed Minimum Benefits (PMBs)	• Draft Medical Scheme Amendment Bill published in 2006. • Draft Bill deals with Risk Equalisation Fund (REF), including its governance measures, calculation of financial transfers / methodology, exemptions from the REF, Low Income Medical Schemes (LIMS)
National Health Reference Price List (NHRPL)	• CMS administers the NHRPL • All providers have to negotiate independently with the CMS and agree on reasonable tariffs for services rendered	• The NHRPL schedules released in March 2006 departed from those published previously in that values were cost-based
Risk Equalisation Fund (REF)	• Intention of REF is to level the playing fields between schemes with different membership (risk) and solvency profiles • Medical schemes with a younger and 'healthier' membership profile (with less 'risk') will contribute financially to a REF that will be administered by the CMS • The REF will pay amounts to those schemes with an older or more 'unhealthy' membership profile (those with greater 'risk') • Theoretically, the introduction of REF should mean that schemes will have to compete on the delivery of quality care at lower costs thus reducing their community rating, rather than relying on their membership profile	• REF proposals contained in the draft Medical Schemes Amendment Bill • Implementation date not clear
Government Employees Medical Scheme (GEMS)	• GEMS aims to become a single scheme for all public servants and came into operation in January 2006 • Mandatory for any new public service employee to be a member • Civil servants who are members of other schemes are not being forced to join GEMS	• Other medical schemes see GEMS as a potential threat • Has encouraged greater competition • Some schemes have claimed that 'our strategy now is not to canvass any new government employees'[47]
Medicines pricing regulations (Single Exit Price)	• Implemented in 2005, the 'Single Exit Price' means that there is a single price for each medicine • Eliminated the system of bonuses, rebates and discount practices that had previously affected the cost of medicines	• Board of Healthcare Funders (BHF) reported decrease in cost of medicines[48] • DoH commenced an international price of medicine benchmarking exercise • Allegations of over-charging for medical materials, devices and anaesthetic gases, with national DoH announcing a probe into pricing malpractice[49]

Source: Derived using multiple sources.[7,23,45,46,47,48,49]

Table 5: Provincial departments of health and stewardship of the private health sector

Institution	Key elements contained in the budget speech pertaining to the private sector
National Department of Health[50]	• Urgent need to address inequities between the public and private health sectors • Strategies to reduce inequities and to reduce the cost of health care in South Africa include amendments to the Medical Schemes Act to enable Risk Equalisation Fund (REF) implementation • Highlighted the need to finalise the Health Charter • Gazetted proposed methodology to benchmark the prices of medicines in South Africa against a comparable basket of medicines in other countries • Noted that the private hospital sector increased hospital charges to counter the reduction in cost of medicines
Eastern Cape[51]	• No mention of the Health Charter • Refers to the need for public sector, private sectors and civil society to work together in addressing priority health programmes
Free State[52]	• No mention of the Health Charter • Refers to pilot project of contracting with independent private practitioners' groupings to extend clinical services to the small rural hospitals and community health centres
Gauteng[53]	• No mention of the Health Charter • Mentioned that specialists, who practise in the private health sector, were trained in Gauteng hospitals • Announced Public-Private Partnership (PPP) to perform the revitalisation and upgrading of the Chris Hani Baragwanath Hospital
KwaZulu-Natal[54]	• No reference to the Health Charter or the private health sector
Limpopo[55]	• No mention of the Health Charter • Private sector mentioned in relation to the 'State of the Province Population' report and urging them to study the report • Refers to appointment of nursing auxiliaries trained in private institutions
Mpumalanga[58]	• No reference to the Health Charter or the private health sector
Northern Cape[56]	• No mention of the Health Charter or private health sector • Refers to establishment of Office of the Inspectorate of Health establishments
North West[57]	• No mention of the Health Charter • Refers to inequity of 'middle and upper class population' preference for private practitioners and hospitals • Health professionals preference for the private sector • Difficulty in sexually transmitted infections management and the need for partner tracing and treatment to be a concerted effort between the public and the private sectors • Announced resolution of legal issues surrounding public-private partnerships at Victoria Hospital
Western Cape[59]	• No reference to the Health Charter • Announced commencement of the Western Cape Rehabilitation Centre PPP on 1 March 2007, the aim of which is the provision of equipment, facilities management and all associated services for the Western Cape Rehabilitation Centre and Lentegeur Hospital • Mentioned the number of laundry items that will be done by the private sector

Table 5 indicates that not a single provincial health budget speech made reference to the Health Charter and only peripheral reference was made to the private health sector in relation to major implementation strategies or initiatives. The rapid appraisal has shown that there is an enabling legislative framework and many useful tools to assist private sector transformation. However, there are delays in implementation of key transformation aspects and inadequate coordination between the national and provincial departments of health, regarding private health sector policy implementation. Priority attention needs to be given to ensure that the provincial departments of health buy-in to major transformation initiatives such as the Health Charter. Implementation may also benefit from a more coordinated attempt at national level to bring together the implementation of various elements of transformation such as the National Health Act, medical scheme amendments, human resource planning and pharmaceutical cost containment.

Concern about the trust and legitimacy with which its activities are viewed by the citizenry

Good stewardship includes the ability to build supportive coalitions for specific policy initiatives.[28] Schneider et al. have argued that both the capacity and legitimacy of the Ministry of Health to provide stewardship has diminished over time due to its approach and management of complex changes, stakeholders and interests.[4] At face value, many of the legislative and policy initiatives are laudable, but the approach and implementation process remains problematic. Consequently, there has been a general tendency to resolve matters via the rule of law, as opposed to building alliances and achieving consensus, thus using time and energies more productively.

The 2005 Regulations relating to a Transparent Pricing System for Medicines and Scheduled Substances were mired in controversy right into 2006 and was the subject of litigation between pharmacies and the Minister of Health.[60] Pharmacies challenged the constitutionality of the Regulations and questioned whether the price of medicines would be lowered. They further argued that the dispensing fee had been set arbitrarily and inappropriately and would have the effect of driving smaller retail pharmacies out of business. The pharmacies succeeded at the Supreme Court of Appeal and the Minister of Health appealed to the Constitutional Court. On 30 September 2005, the Constitutional Court ruled that the dispensing fee was inappropriate and ordered that the fee be referred back to the Pricing Committee, stating that the Minister of Health *"evinced a deplorable lack of respect for the Supreme Court of Appeal which is the highest court in this country in respect of all matters other than constitutional matter"*.[61] As Pile noted, *" ... combined with a nasty court battle between some hospital and pharmacy groups and the Health Minister over controversial medicine pricing regulations, meant relationships between government and the private health sector hit a record low"*.[61] In March 2006, the DoH announced a new draft dispensing fee and gave a period of 15 days for interest groups to provide further input before they could be promulgated.[62]

Amendments to the health professionals' legislation have also been met with major controversy, missing a golden opportunity to build broad coalitions of support for what is a critical area in the country. The Health Professions Amendment Bill (Bill 10 of 2006) makes provision for the Minister of Health to appoint Council Members and Registrars. SAMA has opposed the proposed Health Professions Amendment Bill which gives the Minister of Health powers to appoint members to the Council and its professional boards.[63] The AIDS Law Project (ALP), while supporting the stated transformation objectives of the Health Professions Amendment Bill, raised concerns that a number of the provisions in the Bill work against the stated aim of the Bill and have the potential to erode the powers and / or independence of the Health Professions Council.[64]

The Health Charter development process that commenced in 2005 has reached an impasse between government and the private sector on one side and labour and civil society on the other.[24] The ALP argued that *"key structures of cooperative governance established in terms of the National Health Act – in particular the National Health Council and National Health Consultative Forum – are failing to ensure transparency and communication, and follow through on resolutions"*.[12]

Despite these challenges, there are signs and hope for more constructive relationships between government, the private sector and civil society. The civil society conference held in Randburg in September 2006 was one of the promising events indicating willingness for cooperation between the government, civil society and private health sectors. The 'gold standard' of stewardship has been the process for the adoption of the HIV & AIDS and STI National Strategic Plan (NSP), which demonstrated that it is possible to build consensus and bring together different stakeholders across sectors, including the public and private sectors, in the interests of public good to overcome challenges of the HIV and AIDS epidemic.

The NSP initially released for comments and discussion in October 2006 was weak with numerous gaps with respect to the sectors involved, civil society consultation, identified priorities and strategies for addressing the HIV and AIDS epidemic. Following extensive civil society and stakeholder lobbying, advocacy and critique, the Deputy President released a broad framework on 1 December 2006 and announced a three month period, until March 2007, for the development and consultation on the NSP.[65] A two-day consultative meeting in March 2007 provided stakeholders the opportunity to make further inputs to the NSP and the final version was released at the launch of the South African National AIDS Council (SANAC) on 30 April 2007.[66] The government's efforts to engage the private sector included bilateral meetings between the Deputy President and the sector in order to obtain their views and to discuss ways to facilitate meaningful participation. The private sector is repre-

sented in the SANAC by the South African Business Coalition on HIV/AIDS (SABCOHA) and their role is to contribute to the overall strategic direction and to support and monitor HIV/AIDS/STI programmes in the private sector.

Maintaining and improving national resources for the benefit of the population

South Africa spends about 8% of its Gross Domestic Product (GDP) on health, with the public sector accounting for only 44% of all expenditure on health. This percentage is likely to decline if spiralling costs in the private sector are not contained.[17]

Most resources are concentrated in the private health sector and there has been a decline in the proportion of the total South African population covered by medical schemes over the last few years.[6] In 2006, about 13.7% of the overall population was covered by private health insurance schemes.[6] The public sector carries the burden of providing care to an increasing proportion of the total South African population.[6] The high cost of private health care creates inequalities even among those who are members of medical schemes, with lower income earners contributing disproportionately to medical schemes.[7]

Van Rensburg argues that there is an increase in public-private disparities and a deteriorating situation in the public sector.[67] The majority of medical practitioners and specialists work in the private sector (62% and 75% respectively). In the case of medical specialists, the proportion has dropped from 34% to 25% in the public sector, with a concomitant increase in the private sector.[67] Even though historically, the majority of professional nurses worked in the public sector, the public ratio has deteriorated from 12.0 per 10 000 population to 10.7 per 10 000 population. Van Rensburg further highlights the emerging private-international drain, as the private sector expands its markets internationally.[67]

The vicious cycle of human resource disparities between the public and private sectors, better working conditions in the private sector, migration of skilled professionals to the private sector and critical shortages of health professionals in the public sector exacerbate inequities in care and access to care between the two sectors.

The Public Service Commission released its sixth annual State of the Public Service Report for 2007 and concluded that the skills shortage in the DoH is at the centre of the public service's inability to implement policies.[68] The report notes that the skills dearth is further exacerbated by the competition for scarce skills from the private sector and other countries.[68] The Department of Public Service and Administration revealed that in some provinces vacancies in the health sector were as high as 40%, with 'job hopping' a serious concern.[69] Turnover of professionals is high, with the turnover rate of health professionals, other than nurses at 24% and nursing professionals at 10.7%.[69] At the end of May 2007, an estimated 42 000 nursing posts were unfilled and health services were buckling under a massive and acrimonious public sector strike.[70] Issues at the core of the strike were improvement of working conditions, including salary adjustments, pay progression and occupational-specific dispensation.[71]

The Strategic Framework for Human Resources for Health was launched by the DoH in April 2006.[72] The plan highlights many challenges relating to human resources for health such as training, distribution, skills and conditions of service and migration to the private sector and to developed countries where salaries and conditions of service are far more competitive than in the public service.[72] However, since its launch, the details of the framework have not been finalised with respect to clear targets for training, strategies for retention of skilled health professionals, improvements in poor working conditions in the public health sector and guidelines for supportive management. Clause 50 of the National Health Act which makes provision for the establishment of the Forum of Statutory Health Professional Councils has not come into effect as yet.

Important lessons can be learned from the analysis of the Health Charter efforts to transform the health sector. South Africa's proposed health sector charter is envisaged to focus on the inequities between the public and private health sectors and to assist with the transformation of the latter.[73] The process to develop a Health Charter for South Africa was initiated in 2005, however by the middle of 2007 it had not been completed. Initially criticised by private health industry players for not being participatory enough, the process was subsequently expanded and at the beginning of 2006, a negotiating committee was set up consisting of 40 people comprising three negotiators and two observers from eight health sectors, including: pharmaceutical; hospitals; logistics; health care financing; support and technology; labour; civil society; and health professionals.[24]

The Health Charter focuses on four key areas: access to health services; equity in health services; quality of health services; and Broad-Based Black Economic Empowerment

(BBBEE).[24] Reynolds et al. argue that the fundamental flaw of the Health Charter is that it appears to be preoccupied with BBBEE, instead of being committed towards people's health.[74] Others have argued that private health sector reform cannot be separated from the need for institutional changes within the public health system.[75] Private ownership of health care institutions appeared to contradict the Charter's fundamental goal of improving people's health and access to health care and implies a fundamental conflict of interest between meeting the needs of people's health and having to provide profits for shareholders and owners.[74] This market-based approach creates and widens inequities in access between the rich and poor and is anathema to the ideal of health as a fundamental human right. It is noted that while it was important to redress the imbalance of apartheid in terms of ownership and control of business and economic activity in the health sector, the undue focus of this component may lead to a substantial expansion of the private sector.[74] Furthermore, the Department of Trade and Industry has already published BBBEE codes and this emphasis is not truly transforming the health sector.

The fears of health system analysts on the unintended consequence of the Health Charter having the effect of significantly expanding the private sector seem to be a reality. The end of 2005 and beginning of 2006 saw a number of empowerment deals in the health sector, driven mainly by the spectre of the Health Charter.[61] The analysis conducted by Pile for the Financial Mail noted empowerment deals of the major hospital groups Netcare and Medi-Clinic in excess of R1 billion. The R3 billion purchase of Afrox Health by black-owned Mvelaphanda was also finalised.[61] Pile noted that *"Netcare chose a 'feel-good' deal in which it gave nurses and caregivers 3.75% of the total group; doctors 3%; management and staff 2%; women's groups 0.75%; and a trust encouraging healthy lifestyles and sponsoring soccer teams until 2010, 0.5% of the shareholding. Combined with Netpartner's share holding in Netcare, this takes Netcare's empowerment share holding to 27%. Netcare's rival Medi-Clinic's R1bn deal was completed, leaving no big players for smaller hospital groups to court. Medi-Clinic sold a stake to Phodiso Holdings and Circle Capital Ventures, which will acquire 11% of Medi-Clinic shares and Mpilo Trust, an employee share trust, which will hold a further 4%".*[61] Allowing nurses and doctors to own shares in a private hospital group, is likely to make the private sector even more attractive for skilled health professionals.

It is therefore not surprising that media reports suggest that the private sector representatives were ready to sign the Charter in its present form and that they were resisting the Health Charter process being completed at the National Economic Development & Labour Council (NEDLAC). Important issues aimed at addressing access, equity and quality in the health sector, such as a basic package of health care proposed by civil society, were given less prominence in the Charter discussions.

The Health Charter presents the DoH with a golden opportunity to transform the health sector. The DoH should exploit its stewardship advantage and use this process as a catalyst to implement universal coverage and address inequitable resource allocation in the private sector to solve South Africa's health human resources crisis.

Conclusion

The massive inequities in health status, access to services and resource distribution between the public and private sectors have been highlighted in this chapter. Despite legislative and other government interventions over the past year, the private sector remains strong, with indications of empowerment expansion, but the sector is only accessible to a small proportion of the population. The public sector remains the main provider of health services to the population with lesser financial and human resources. The rising cost and declining benefits offered by the private sector and the geographic maldistribution of health services remain the main obstacles to equity, quality and access to health services. Although there are many powerful interest groups in the private sector, the DoH should harness all the tools at its disposal, notably the National Health Act, amendments to the Medical Schemes Act and the Health Charter to strengthen its stewardship role, with the aim of achieving universal coverage and eliminating the wide-spread disparities between public and private health providers.

The process for the adoption of the NSP was a resounding success in bringing together all health stakeholders in the public and private sectors and provided a useful case study on how to proceed with transformation of the public-private divide.

Recommendations

Recommendations are premised on the critical stewardship role of government in the overall transformation process of the health system.

The Health Charter must be informed by the key principles of improving the health status of the population, the reduction of health inequalities and inequities, and the achievement of the MDGs. This implies the need for serious discussion and debate around the finalisation of the essential package of health care services and achieving universal access. The definition of the basic package of services that every citizen should be entitled to should be prioritised, with a clear time-frame for completion and with the MDGs being among the key criteria for defining the package.

The debate regarding South Africa's choice of health financing system should be re-opened. A high level political champion should be appointed to drive an initiative which aims to achieve universal coverage given the current realities, and taking into account the massive public-private sector disparities. The critical and thorny issue of human resources should be a key priority of the Ministry of Health. It is critical to develop a clear, implementable human resource plan that applies to both the public and private sectors, gives effect to the provisions of the National Health Act and involves relevant stakeholders.

Greater effort should be made in bringing the provincial departments of health on board regarding key public-private sector transformation initiatives, as implementation is primarily at this level. At a structural level, a dedicated unit focusing on private sector transformation should be established in the national DoH by bringing together existing initiatives and staff dealing with the private health sector. This unit should ensure that there is a coordinated strategic plan with timeframes for implementation and with involvement from various implementing agencies and stakeholders. An alternative option is to broaden the scope of the CMS to be the key implementing agency for the transformation of the public-private sector divide in South Africa. The MDGs for health will succeed only if we recognise the interrelatedness of public-private health sectors and strengthen the health systems capacity to move rapidly with the implementation of the many laudable transformation strategies.

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