Free Market Foundation

submission on

The Charter of the Public and Private Health Sectors of the Republic of South Africa

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1 INTRODUCTION

South Africa's health care sector consists of a taxpayer-funded public health sector providing for the needs of those who cannot afford private care, or who are too poor to pay for any form of health care, and a private sector catering for members of medical aid funds and for those who choose to pay out of pocket for private care.

Under South Africa's apartheid system health services were racially segregated, with hospitals and clinics reserved for the exclusive use of specified race groups. The demise of apartheid and the system of independent homelands combined with rapid urbanisation have resulted in an ever-increasing mismatch between the location of hospitals and clinics and the geographical distribution of the population. In particular, major public hospitals in the cities, which were previously reserved for use by the white population, now provide care for all race groups. Because of the rapid transition from a system of segregation to one of integration the hospitals in urban centres are struggling to cope with the demand for health care.

As part of the process of transforming the former racially segregated public health system into an integrated one, government has adopted the National Health Act 2003, which establishes a unified national health system in terms of which it intends to tightly regulate, plan and manage the entire health system, both public and private.

In addition government proposes a Health Charter, to be adopted by the public and private health sectors, with the ostensible aim of facilitating and effecting transformation of the health sector in the key areas of access to health services, equity in health services, quality of health services and Black Economic Empowerment.

This document provides a comment on the proposed Charter. The comment is not intended to cover the full spectrum of matters dealt with in the Charter, but rather concentrates on questioning and analysing selected items and their possible consequences for health care in South Africa.

Many of the most fundamental difficulties with the proposed Charter have more to do with the harm it will do to South Africa's people, especially the poorest and most vulnerable of them, than with the interests of the affected health-sector firms.

2 TRANSFORMATION OF THE PUBLIC HEALTH SECTOR

The public health sector appears to be in most need of transformation. There are standard economic explanations for the problems it is experiencing as well as solutions to those problems. Government should consider those solutions in the interests of current and future patients.

2.1 The failing public health sector

The public health sector is, by government's own admission, not coping with its responsibilities in the delivery of health-care. The Minister of Health, Dr Manto Tshabalala-Msimang, has been quoted as stating the health system was 'in shambles'[1] and Dr Kgosi Letlape, chairman of the South African Medical Association, has described the situation in the public health sector as 'horrendous'.[2]

The system is under strain, suffering problems such as shortages of medicines, poor and unclean facilities, poor service delivery, rude personnel, and a shortage of doctors and staff.[3] In 2002, of the 197,898 provincial staff positions across the various health professions 84,205 posts were vacant.[4]

Large numbers of medical personnel have left, and are leaving the country for Australia, New Zealand, Canada, the United Kingdom and the United States. There are 600 South African doctors registered to practice in New Zealand; 10% of Canada's hospital-based physicians and 6% of the total health workforce in Britain is South African.[5]

Associated with staff shortages, there is a severe lack of skills across the spectrum of health services provision, with the public sector lacking highly trained personnel, sophisticated technology and managerial skills.[6]

The proposed Charter does not address these issues yet the empowerment process appears to offer the opportunity to simultaneously carry out substantial BEE, transform the public

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[1] Deadly Denial, Time - Europe Edition: 19 April 2004, Volume 163, No 16. Also see: John Kane-Berman, *Beyond a Joke* (Johannesburg: South African Institute of Race Relations, Fast Facts No3/March 2004.)

[2] John Kane-Berman, *Beyond a Joke* (Johannesburg: South African Institute of Race Relations, Fast Facts No3/March 2004.)

[3] See the National Department of Health Discussion Document: *Inquiry into the various Social Security Aspects of the South African Health System* (Pretoria: National Department of Health, May 2002), p. 38.

[4] See: Health Systems Trust, South African Health Review 2002 (Durban: Health Systems Trust, 2003), p. 477, Note 2.

[5] Health Systems Trust, *South African Health Review 2003-2004* (Durban: Health Systems Trust, 2004), p. 300.

[6] Health Systems Trust, South African Health Review 2002 (Durban: Health Systems Trust, 2003), p. 51.

sector and solve many of the current problems. What government should consider is a separate Public Sector Health-Care Charter.

2.2 Public Sector Health-Care Charter

There would be a great deal of merit in preparing a Public Sector Health Care Charter giving BEE rights of ownership in public health-care assets. Such a Charter would have several benefits:

2.2.1 BEE equity between Public and Private sector employees

The Health Sector Charter currently proposed by the Department of Health fails to grasp the opportunity to empower the large number of employees in the public sector. The government could transfer ownership and control in the state institutions (hospitals, clinics, laboratories etc) to public health sector workers on a preferential basis, ensuring equity between public and private sector employees. The very large facilities, such as major hospitals, could be split according to their functional divisions and transferred to separate companies to make the operations more manageable. The facilities would continue to carry out the same functions, serving largely the same people, under contract to the government. Such a process would provide equity between private and public employees in the asset empowerment process and have other substantial advantages.

2.2.2 Ownership rights will empower public sector employees

If public health sector employees do not receive ownership rights in the facilities in which they are employed, many will transfer to private firms, which will be under severe pressure to meet the BEE staffing percentages required by the Health Charter. The public health sector will be the obvious source of the additional trained staff they will require to meet their quota requirements.

2.2.3 Contracts to provide services and a change in incentives

Current state health sector employees, as owners, would have very different incentives to those they have as employees. At the outset, every facility transferred to BEE owners would be transferred together with a reasonably long-term government contract. Thereafter, renewals would be subject to normal tender procedures. In hiring contractors, the DOH would set strict requirements for the quality of care, insert provisions for the cancellation of contracts if the requirements are not met, and carefully monitor compliance. The dynamics within the facilities would change dramatically due to the fact that each facility would be competing with all other similar facilities for government contracts.

2.2.4 Increased efficiency and quality

Employees as shareholders would not be as easily enticed away as they would be without ownership rights. Salaries within the new companies would be dependent on profitability and it would be in the interests of owner-employees to reduce waste, increase efficiency and increase quality of care. In addition to their contract patients,

they would be attempting to attract additional paying patients in an effort to increase turnover and profitability.

Competition with all other providers for retention and acquisition of contracts and paying patients would achieve what threats and pleas do not achieve; improve the quality of service provided by health-care workers. By transferring assets to its employees the DOH would therefore simultaneously bring about BEE, and improve access, equity and quality.

3 THE CHARTER

The document entitled *The Charter of the Public and Private Health Sectors of the Republic of South Africa* deals with political, philosophical and economic issues rather than with health care. Precisely because it is dealing with such issues, the content has far-reaching implications for the provision of health care in South Africa.

3.1 Democratic rights of providers of health care

The document relies on sections of the Constitution to guide the Department of Health in the approach it has adopted in its preparation. Yet in the process it appears to have neglected to take account of the democratic rights of providers of health care, which are enshrined in the Founding Provisions, particularly section 1, and the Bill of Rights, particularly section 7(1), of the Constitution, which guarantee "Human dignity, the achievement of equality and the advancement of human rights and freedoms" of "Non-racialism and non-sexism" and "Supremacy of the Constitution and the rule of law" and the Bill of Rights, which "enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom." This oversight needs to be remedied for the sake of all the inhabitants of the country; not least those who are in greatest need of health care. The economist, Don Lavoie, had this to say about democracy and politics:

> Democratic discourse … serves a knowledge-generating function: It allows for peaceful resolution of disputes and for an evolutionary learning process. Public political dialogue creates and communicates knowledge in a way that the politics of secret intrigue and power cannot. The unhampered give and take during the free exchange of ideas is what brings order to public discussion, not the intelligence of any one person. What makes democracy work is the multiplicity and autonomy of the voices it permits, which propels a rivalrous discovery process among the voices. Our attempts, from our divergent perspectives, to persuade one another result, cumulatively, in a discovery process from which all of us learn.

Page 4 of the Charter mentions the need for the kind of dialogue described by Professor Lavoie. It also mentions the necessity for "the interests and views of the private sector to be taken into consideration by the government when introducing legislative and other reform." A crucial factor in the process is that the dialogue should occur before proposals are formulated and that consensus should be aimed at, even if it is difficult to attain. Despite the inclusion of these objectives in the Charter document, the necessary dialogue has, according to all reports, not occurred. The process followed appears to be in conflict with both the Bill of Rights and section 33 of the Constitution, which requires just administrative action.

3.2 Political and philosophical aspects of the Health Care Charter

The business people who are involved in the provision of health care cannot be expected to grapple with the fundamental political and philosophical concepts that underlie the thrust of the Charter. Their studies, training and focus of attention are on how to make and supply goods and services that people want, in doing which they supply an exceptional service to

the people of South Africa. When they are confronted with the force of political power, demanding of them what no government has the right to demand in a truly just society, most business people do not challenge that political power, they concentrate on the technical aspects of attempting to meet the demands that are being made on them, no matter how unjust those demands may be. At most they will attempt to persuade government to reduce the damaging effects of what is being imposed on them.

However, in the interests of all the people of South Africa, especially for the sake of the poorest and most vulnerable of them, and of future generations, the content and implications of the charter must be challenged. We are dealing here with two concepts of justice. The first concept of justice is encapsulated in section 9(1) of the Constitution, which says “Everyone is equal before the law and has the right to equal protection and benefit of the law” and in the first sentence of section 9(2), which says “Equality includes the full and equal enjoyment of all rights and freedoms.” Read together with section 1(c) of the Constitution, which enshrines “Supremacy of the Constitution and the rule of law”, the rights of producers of health care goods and services to equal justice with consumers of those services, and their right to ownership and control of their property and the means of production, would appear to be assured.

The other concept of justice, known as “social justice” or “distributive justice”, which is diametrically opposed to the first, is however contained in the thrust of the Health Care Charter, and is used as a basis for attempting to justify the pervasive control that the Department of Health wishes to exercise over private health care providers and their assets. Nobel laureate in economics, Friedrich von Hayek, had this to say about “social justice”:

> I believe that “social justice” will ultimately be recognised as a will-o’-the wisp which has lured men to abandon many of the values which in the past have inspired the development of civilisation – an attempt to satisfy a craving inherited from the traditions of the small group but which is meaningless in the Great Society of free men. Unfortunately, this vague desire which has become one of the strongest bonds spurring people of good will to action, not only is bound to be disappointed. This would be sad enough. But, like most attempts to pursue an unattainable goal, the striving for it will also produce undesirable consequences, and in particular lead to the destruction of the indispensable environment in which the traditional moral values can flourish, namely personal freedom.

In the Charter the concept of “social justice” or “distributive justice” is conveyed in the use of the terms “access” and “equity” which essentially means being provided, at somebody else’s expense, with a level of health care that you cannot afford to pay for yourself. Inevitably, if that “somebody else” is unwilling to voluntarily assume the burden, a “central authority” will decide what that level of health care will be (as in “an affordable package of quality health care”), forcibly take money from the “somebody else” and provide you with the package of health care it has decided you should receive.

The Constitution contains elements based on the concept of “social justice” in section 26 (housing), section 27 (health care, food, water, and social security), and section 29

(education). It appears to be generally accepted that the obligations imposed by these "positive" rights are regarded as being imposed on the state and not on any private individual or firm, in other words, on the general taxpaying public and not on arbitrarily selected individuals or firms. If this were not so, there would be endless court actions over these conflicting concepts of rights.

Legislated Black Economic Empowerment (BEE) is obviously also based on the concept of "social justice" and the same constitutional difficulties arise in its implementation. While the Constitution is explicit regarding the positive rights to housing, health care, education etc, it is not explicit regarding BEE (the second sentence in section 9(2) cannot be seen to require legislative action to remedy past discrimination, overriding the equal rights enshrined in the Founding Provisions and the Bill of Rights, including the prohibition against unfair discrimination). If the Constitution is seen to impose an obligation to remedy the harm caused by past discrimination, once again that obligation should rest upon the state, to be carried out with funds supplied by general taxpayers and not on arbitrarily selected individuals or firms.

3.3 Advancement of black South Africans must proceed as rapidly as possible

A statement that legislated BEE would appear to be in conflict with the constitutional rights of all South Africa's people to non-racialism and non-sexism, supremacy of the constitution and the rule of law, equality before the law, the right to the full enjoyment of all rights freedoms, the injunction that the state may not unfairly discriminate directly or indirectly against anyone, is not a statement against the most rapid possible advancement of the people intended to be advantaged by the BEE legislation. It is a question about the manner in which the process is being carried out, the inevitable trampling on the rights and freedoms of the firms and individuals who are being subjected to deprivation of their property without due process and unwarranted intrusions into the manner in which they conduct their businesses. It is a defence of the Constitution of this great country and the future freedoms of all who live in it.

The Free Market Foundation has demonstrated very clearly in its dedicated opposition to apartheid, its proposals for massive wealth transfers from the state to those who were previously discriminated against, its constant advocacy on behalf of the poor and most disadvantaged, its urging that high economic growth is essential to lift the poor out of poverty, its advocacy on behalf of the unemployed, that our organisation has the welfare of the people of South Africa at heart in all its actions, and all its interactions with government. In querying the process being followed in the administration of health-care, and the implementation of BEE, this submission expresses reservations over the consequences for all South Africans regarding the constitutionality of the steps that are being taken and the manner in which they are being carried out.

3.4 The economics of health care

A market in health care is essential if patients, and especially poor patients, are to receive an increasing range of health care options and choices, as well as steadily increasing quality as

technology and techniques improve. In a market, consumers are sovereign, in that their decisions prevail as to what should be produced, how it should be produced, and where it should be produced. Most importantly, if an economy is to function effectively, prices must be the consequence of the subjective value judgements of consumers.

The purpose of production is consumption, and if consumer decisions in the form of freely formed prices are not directing the production, resources will be utilised inefficiently and consumers (which means everyone) will not be as well off as they would otherwise have been. In a command economy, where government and its officials take away the consumer's right to direct the utilisation of resources, inefficient investments occur. At the extreme, when government monopolises all property and the means of production, economic calculation becomes impossible and responsible officials have no way of knowing what to produce, what priorities to place on the production of various forms of goods and services, and most importantly, what the consumer wants.

Interfering in the peaceful and legal functioning of firms that supply health care goods and services may appear to be a simple matter of passing a law or regulation that compels them to act in a certain way or prohibits them from acting in a certain way. However, there is no way of knowing what the economic repercussions will be from such forced changes. Usually, optimum results for consumers will not be achieved, bearing in mind that firms are constantly striving to provide consumers with the goods and services they want. Instructing health care providers where they may operate, what prices they may charge, and whom they must employ, inflicts long-term harm on the consumer.

South Africa's private health care sector is one of the best in the world. It provides health care services to a large cross-section of the population. The largest pharmaceutical companies in the world are represented in the country and many have manufacturing plants and carry out clinical trials in South Africa. Most governments of developing countries would welcome such substantial investments in health care in their countries. The most important reason for a government to welcome such a relatively large private health care sector is that it allows the government to utilise its scarce tax resources to provide better health care for the poor. Yet the impartial observer cannot fail to gain the puzzling impression that the health administration does not recognise the value of the private health care sector to the people and the economy of South Africa, not least the benefit to poor South Africans.

4 WHAT HEALTH CARE ENVIRONMENT SHOULD THE CHARTER SEEK TO CREATE?

4.1 The Opening Declaration in the Health Charter

Chapter One of the Health Charter describes the Fundamental Principles upon which it is to be based. The Opening Declaration states that –

> The parties to this Health Charter earnestly and sincerely desire to facilitate and effect transformation of the health sector in the following areas:
>
> - Access to health services
> - Equity in health services
> - Quality of health services
> - Black economic empowerment
>
> They acknowledge that it is essential to ensure the sustainability and efficiency of the health sector in order to achieve the transformation goals of each of these areas.
>
> They further acknowledge the urgent need to effect transformation of the national health system in a co-operative, constructive and mutually beneficial relationship in such a manner as to reflect the diversity and meet the various health care needs of the total population of South Africa.

On the surface this opening statement appears reasonable enough. However, on closer examination we find that it contains disturbing anomalies that could have negative repercussions for health care in South Africa:

4.2 A co-operative, constructive and mutually beneficial relationship

The opening statement gives the impression that the Health Charter was prepared by the private health sector working in close collaboration with officials of the Department of Health (DOH) “in a co-operative, constructive and mutually beneficial relationship”. It was not. It was prepared by a team appointed by the DOH, including a small minority of private health sector members who were, by the terms of their appointment, prohibited from speaking to their colleagues about the nature and content of the discussions. The process was therefore a negation of part of the opening statement, which does not augur well for the establishment or continuance of a “co-operative, constructive and mutually beneficial relationship” between the DOH and the country’s health care providers.

Words have meaning, and to the general patient public the words promising a “co-operative, constructive and mutually beneficial relationship” between the country’s health department and the providers of health care appear to be indicative of a highly desirable state of affairs. That departmental officials write these words, do not live up to them, and give every indication of not having any intention of living up to them, is most disturbing, raising serious

concerns regarding the future of health care provision. The statement in the Charter is correct. If South Africa is to have any chance of developing health care provision that provides good quality care to the entire population there has to be a “co-operative, constructive and mutually beneficial relationship” between the DOH and private health care providers but then those words must have meaning. “Co-operate” means “to work together”: not one instructing and another obeying. “Constructive” means “tending to construct, helpful”: not one imposing and another reluctantly complying. “Mutually” means “giving and receiving” and “beneficial” means “doing good: useful: advantageous”: not one giving and the other receiving to the disadvantage of one and the advantage of another.

There have been reports in the press that the relationship between the DOH and health-care providers generally has not been good. Relations are bound to become strained If the department is in the habit, as appears to be happening in the case of the Health Charter, of imposing measures on the diverse health care sector without wide and real consultation. As far as the general public is concerned, and patients in particular, it is vitally important that the department and health care providers should have a cordial, co-operative and constructive relationship, not merely for their mutual benefit, but for the benefit of the health of the entire nation. The nation has a right to expect that such a positive relationship be established.

4.3 Government responsibilities regarding health care and BEE

The Health Charter is an unhealthy mix of government responsibilities regarding health care and demands from the Department of Health regarding BEE. Examination of the items “access”, “equity”, and “quality”, as described in the proposed Charter document, reveal that they refer principally to the constitutional responsibilities of government in terms of the Bill of Rights. The inclusion of government responsibilities in the Charter is inappropriate and the BEE aspects of the Charter do not appear to have been dealt with in terms of the BEE Act.

4.3.1 Charter or Social Contract

The inclusion of a long list of aspirations, and implied and real commitments in the Charter document is inappropriate. The document is written in the form of a social contract and about 75% of it has nothing whatsoever to do with BEE. That 75% appears to be an attempt to use the Charter as a mechanism to put pressure on the private health care firms to share the responsibilities of the public health care sector without compensation. The private Health Sector should therefore separate itself totally from the Public Sector and prepare a Private Health Sector Charter dealing solely with the BEE issues for which the charter process was conceived.

If the private firms are wise they will insist that the non-BEE elements of the proposed Charter document be stripped out completely and that it be confined to dealing with the issue of BEE. In fact, anyone who is a future BEE beneficiary of the Charter will have every right to be displeased with current management of private health sector firms if they do not insist that the socio-economic and welfare burdens implicit in the non-BEE parts of the document be removed. If they are not removed the potential

BEE beneficiaries will receive less value from their investments, lower salaries and fewer jobs because of the future costs the signatories will have assumed.

4.3.2 Charters are intended to be voluntary agreements

Charters are supposed to be implemented as a result of voluntary agreements between government and industries on the nature of the BEE measures to be implemented by the industries after consensus has been reached in detailed negotiations. They are not intended to be in the form of prescriptions worked out behind closed doors without proper consultation, dropped on an entire industry at short notice, together with a demand that firms respond within 30 days of publication.

Authoritarian action never achieves the best outcomes, whether by government in a society, management in a firm, or parents in a home. Such actions may appear to provide immediate solutions to perceived problems but there is inevitable long-term harm. The heavy-handed manner in which the charter is being dealt with has all the potential signs of causing long-term harm to the provision of health-care in South Africa, including harm to the poorest members of society, to the intended BEE beneficiaries of the charter, and to the entire economy.

4.4 Government funding without government provision

Governments are subject to enormous disadvantages as providers of services in competition with private providers. That is why, in a competitive environment, governments invariably prohibit or limit the entry of firms wishing to compete with them. The most important disadvantage governments suffer is the “unwritten prohibition” on government risk-taking. No government can allow its officials to embark on risky undertakings that may fail badly. The result is that government cannot innovate, it is compelled to wait until a private firm has proved beyond doubt that something works before it can follow.

Another problem that government faces, in its role as service-provider, is that there is no scientific or economic way of setting priorities for investment. At the macro level, no calculation will assist government in deciding between the purchase of a fighter jet and the building of ten new clinics. At the micro level, government does not have the figures that will assist it in deciding whether or not it should purchase an MRI scanner because it does not have the economic motives that should be involved in the purchase of such equipment. The kind of problem it faces is that private hospitals purchase MRI scanners to attract more business, even if the cost of the machine itself is initially not fully covered by charges for its use. Government hospital administrators cannot think like that. If they function, as government hospitals theoretically should, caring principally for patients who cannot afford to go elsewhere, they don’t want more patients.

Acting purely as a funder, government is in a much stronger position. It can sit back and watch private entrepreneurs try new things, many of which fail and lose money, and purchase services solely from the firms that succeed. Government as a purchaser benefits most when there are a large number of firms competing fiercely among each other for the

business of caring for the ill, or a few competitors who are so efficient, keep costs so low, and quality so high, that no one is able to compete with them. Fierce competition between suppliers, together with the absence of barriers to entry preventing alternative suppliers from entering the market, is what keeps suppliers “honest”. In such a market, government is able to get a much better deal for poor patients, on whose behalf it wishes to purchase care, than it is able to provide itself.

4.5 Options for government as a purchaser of health care from private suppliers

As a purchaser of health care rather than a provider, government would be able to examine innovative methods of providing funding for such care. The most serious problem government faces, is the question of unlimited demand when health care is provided “free” to the user. Countries that have adopted “national health systems” are constantly plagued by the problem of demand exceeding supply, even in exceptionally wealthy countries such as the United Kingdom and Canada. Their response to the problem is the vexatious and cruel system of queuing for services – not in a physical queue – but on a waiting list that requires appalling waiting times that neither poor nor affluent patients experience in South Africa.

If government were to transfer its facilities to BEE beneficiaries, its contracts would probably contain a mixture of capitation funding (fees for number of patients served) and tables of fees for advance-approved treatment of more serious conditions. Another possibility is capitation funding for all services up to a specified level for a pool of patients in particular area, which would require prior registration of qualifying patients.

Government could also look at paying the medical scheme fees of poor patients for a package of services, allowing the patients to co-pay for services not fully covered by the scheme. Another possibility is to empower patients by giving them medical cards allowing them to purchase medical services and medicines up to allowed limits from accredited suppliers.

4.6 Transformation of the health care sector

The proposed Health Charter, although described as a charter covering both the private and public health sectors, focuses entirely on the private sector. This occurs despite clear evidence that the private sector, by international standards, is providing its patients and clients with above average service. The public health sector, on the other hand, appears to be beset by a multiplicity of problems.

Instead of spending so much time on attempting to change the private sector, the DOH should seriously consider the possibilities described above for changing the public health sector by empowering the people employed in it. Real empowerment will change their incentives and encourage them to provide the quality care to the poor that we would all like to see them receiving.

The most important task facing the DOH is how to best utilise available resources to provide poor South Africans with the best possible health care within the limitations of those resources. This will not be achieved by burdening the private sector with costly regulations or additional costs. It will also not be achieved by denigrating those who are paying for their own health care. On the contrary, the DOH should encourage as many people as possible to do so. Instead of creating disincentives for self-funding, the DOH should create an environment that is as conducive as possible for health care independence.

5 ALLEGED INEQUITY IN THE PROVISION OF HEALTH SERVICES

The Charter makes many references to the inequitable distribution of health resources in terms of access to care, human resources, and financing. Paragraph 2.2.3 perpetuates an often repeated claim by government that there is a small minority of South Africans, (between 15 and 20 percent of the population) who have a high degree of access to health services and a large majority (between 75 and 80 percent of the population) who have either limited access to health services or no access at all. According to the Charter the state currently spends R33.2 billion on health care for 38 million people while the private sector spends some R43 billion servicing 7 million people.

There are three areas of concern here. Firstly, the claim that government is responsible for providing care to about 80% of the population, while the private health sector takes care of the apparently wealthy remaining 20%, will be shown below to be incorrect. Secondly, there is the implication that, to obtain an equitable distribution of resources, money spent on private patients must be redirected to the public health system, which ignores the fact that the private sector is the source of public sector funds. Thirdly, the Charter does not draw a distinction between inequities that result from a badly managed public health system and the economic realities that private health providers face in providing care to patients.

5.1 The private-public split

Because of the wide variations in available population, poverty and health-care statistics it is difficult to make an accurate assessment of the number of people served by the public and private health sectors. There are however sufficient grounds for questioning the claim made in the Charter.

According to official figures, South Africa had a population of 44.8 million people in October 2001.[7] Poverty estimates range from 40%8 to as high as 60%[9] of the population. Based on a poverty datum line of R800/month for a household, 52% of households lived in poverty in 1996.[10] It would thus be safe to conclude that at least half of the population, or 22.4 million people, cannot afford comprehensive formal health care.

In 1999 less than 20% of the population had private medical insurance cover. This included medical scheme membership, which covered an estimated 16% of the population, health

[7] Republic of South Africa, *Census 2001: Census in Brief* (Pretoria: Statistics South Africa, Pretoria, 2003).

[8] Republic of South Africa, *South African Year Book 2002-2003* (Pretoria: Government Communication and Information System, 2002), p. 340.

[9] Department of Provincial and Local Government, Planning and Implementation Management Support System (Pretoria: Department of Provincial and Local Government, 2001).

[10] Health Systems Trust, *South African Health Review 2002* (Durban: Health Systems Trust, 2003), p.428.

insurance products, and workplace health services provided by private firms[11]. At that time it was estimated that about 30% of non-scheme members (nearly 36% of the total population) may use private health services on a direct payment basis.[12]

Government's policy documents infer that 84% of the population depend on the public health system[13], a figure based on the estimated 16% of the population who are members of medical schemes. However, considering the estimated 30% of non-scheme members who pay out-of-pocket for care this is unlikely. Furthermore, those who pay out of pocket for care may use private or public care, and some patients will obviously use both, as do members of medical schemes. This was confirmed by surveys conducted in 1995 and 1998 and is depicted in Table 1.

Table 1: Comparison of sectors used by medical aid and non-medical aid members[14]

Place of consultation	1995		1998	
	Without medical scheme %	Medical scheme members %	Without medical scheme %	Medical scheme members %
Public sector	71,2	32,6	68,5	20,5
Private sector	28,8	67,4	31,4	79,5

The figures reflect a trend towards greater use of private health-care services. In addition, many South Africans consult traditional healers and use traditional remedies. According to the Minister of Health traditional healers are the first to be consulted in as many of 80% of all cases.[15] There are also many people who make little or no use of the services of health-care providers.

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[11] Republic of South Africa, *Intergovernmental Fiscal Review 2001* (Pretoria: National Treasury, 2001), p.41. Also see: Republic of South Africa, *Intergovernmental Fiscal Review 2003* (Pretoria: National Treasury, 2003), p. 73 and Judith Cornell, Jane Goudge, Di McIntyre and Sandi Mbatsha, *National Health Accounts: The Private Sector Report 2001* (Cape Town: University of Cape Town, Health Economics Unit, March 2001), pp. i-ii.

[12] Republic of South Africa, *Intergovernmental Fiscal Review 2001* (Pretoria: National Treasury, 2001), p.41. Also see: Republic of South Africa, *Intergovernmental Fiscal Review 2003* (Pretoria: National Treasury, 2003), p. 73 and Judith Cornell, Jane Goudge, Di McIntyre and Sandi Mbatsha, *National Health Accounts: The Private Sector Report 2001* (Cape Town: University of Cape Town, Health Economics Unit, March 2001), pp. i-ii.

[13] Ibid. Also see National Department of Health, Risk Equalisation Task Group, *The Determination of the Formula for the Risk Equalisation Fund in South Africa (Extended Executive Summary)* (Pretoria: Risk Equalisation Fund Task Group, January 2004), pp. 6-7, and the speech by the Minister of Health, Dr M Tshabalala-Msimang, at the 14th Annual South African Health Care Structure Symposium, 28 January 2004.

[14] Jane Doherty, Stephen Thomas and Debbie Muirhead, *The National Health Accounts Project: Health Financing and Expenditure in Post-Apartheid South Africa, 1996/7-1998/99* (Cape Town: University of Cape Town, Health Economics Unit, final Draft, April 2002), Table 2.6, p. 24.

[15] *Traditional medicine helps with Aids*, Mail and Guardian, 30 March 2004.

Considering the evidence, there is a range of between 16% and 52% of the population who use private health care and potentially between 48% and 84% who use the public health system.

A study of the market potential for medical schemes, undertaken by a private medical insurer, estimated that 16% of the population was covered by medical insurance in 2001, that a further 30% could afford medical insurance but was not insured, and that 54% of the population was unable to afford medical insurance.[16] Among this last group are some who purchase private health-care services on an irregular basis and would not automatically become public health-service patients.

As the estimates quoted in the above study are in broad agreement with medical scheme membership and poverty estimates these are used to construct a broad picture of the South African health-care market (Table 2).

Table 2: Estimate of South African Medical Scheme Market 2001

	% Of RSA Population	Persons
Member of medical scheme	16	7 272 640
Not a member but potential member of medical scheme	30	13 636 200
Poor (unable to afford medical scheme membership)	54	23 891 160
Total	**100**	**44 800 000**

If the composition of the health-care market set out here is correct, the public system can claim responsibility for, at most, that part of the 54% of the population (a percentage of 24 million people) that actually makes use of its health care services and not the 75 % to 80% claimed in the Charter. However, this makes the health-care challenge no less daunting. This challenge is huge, not only in terms of the number of poor people, but also in that 75%[17] of the poor live in rural areas where health services are least developed.

Based on the evidence it would be helpful if government would stop claiming credit for providing care to people who don't use their services. The private sector, which includes traditional healers, obviously serves a much larger proportion of the total population than the number belonging to medical schemes. Encouraging those who can afford health insurance to become medical scheme members is a challenge for the private sector, which private firms would meet more readily if they were allowed to create the products that more closely suit the needs of their potential members.

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[16] Information contained in a presentation by Adrian Gore entitled *Future Trends for Medical Schemes in South Africa*, Health Wise Seminar held at Midrand 2002. (Sandton: Discovery Health, 2002.)

[17] Republic of South Africa, *South African Year Book 2002-2003* (Pretoria: Government Communication and Information System, 2002), p. 340.

The Charter should rather focus on the longer-term health challenge, which is to reduce dependency on government-funded health care. This requires the adoption of economic policies that lead to rapid economic growth, increased per capita incomes, and a reduction in unemployment and dependency on taxpayer-funded social services, such as health-care.

5.2 A funding perspective

There are several grounds for questioning both the logic behind the “inequity arguments” regarding funding and any proposals for “rectification”. If we analyse the argument carefully, we see that it is saying that some members of the population spend a lot more of their own money on their own health care than the government, utilising taxpayers’ money, spends on people who are unable to purchase health care. Now compare this to a statement that “some members of the population spend a lot more of their own money on their own food and clothing than the government, utilising taxpayers’ money, spends on people who are unable to purchase clothes and food”. There is an undoubted food and clothing “imbalance of resources”, but the government does not feel compelled to increase the regulation of private-sector providers of these essential commodities, limit the expansion of their production facilities, and require them to obtain official consent before purchasing new equipment for use in their businesses. The effect of such an approach by government would be to reduce rather than to increase the quantity of food and clothing available to the poor. The economic rules for the supply of health care are the same as those for food and clothing. Reduce investment, increase costs, and the supply will diminish.

The imbalance of resources argument creates the impression that a huge amount of money is floating around in the private health sector, just waiting for someone to use it. This is simply not true. Most of the funds are used annually on the medical expenses of those who use private medical care, on government imposed reserve requirements, administrative costs, and the like. Redirecting any of these monies to the public health sector would mean reduced care, less technology, lower quality and less efficient private health services. Should this be done, there is no guarantee that anything in the public health sector would actually improve.

However, the most important factor in the “inequity of resources” claims is the fact that almost all the funding for both sectors comes from the same people, who pay all their own health-care costs either directly or through medical schemes, and then as taxpayers provide almost all of the resources that government uses to pay for health-care services in public facilities. Thus, when the argument is stripped down to its bare bones, what it actually says is that people must be denied the quality and quantity of services they currently purchase with their own money so that government can take even more of their money to spend on government-provided health care for others.

The public health sector is made possible by the fact that there are productive people in the country, whose incomes are taxed to pay for, among other things, care delivered in the public health sector. The public health sectors in wealthy societies, which have more resources

than similar sectors in poorer countries, have been unable to attain an equitable distribution and access to health services, after decades of trying.[18]

5.3 An economic perspective on "imbalances" between provinces and sectors

An analysis of available statistics reveals apparent "imbalances' among provinces in respect of funding, personnel and facilities, with the two wealthier provinces, Gauteng and the Western Cape generally being substantially "better off" than a poorer province such as Limpopo.

The figures show, for example, that the geographical distribution of facilities is not consistent with an even supply of health care according to population numbers, and this uneven spread applies to both the public and private sectors. In the public sector the per capita spending in the wealthier provinces, Gauteng and the Western Cape, is much higher than the average per capita spending for the country as a whole.[19] In the private health sector, Gauteng, South Africa's wealthiest province, has the most private hospitals and beds of all the provinces. It has more than double the number of hospitals and nearly three times the number of beds of the second placed Western Cape Province. The country's poorest province, Limpopo, had only one private hospital in 2002.[20]

Policy makers believe that state intervention is required to correct the "imbalances" in health-care provision and resources between provinces and between the private and public sectors, ignoring the fact that there may be good economic reasons why the provision of health services manifests in a pattern different to what the policy makers expect, or even prefer.

While real imbalances in health care provision between the provinces do exist, the reasons for this range from deficiencies in bureaucratic processes (bad planning, -decision-making and -budgeting processes and political expediency) to economic realities.

Economic factors determine the choice of sites for the building of private health-care facilities, while both economic and political factors are involved in the establishment of public sector facilities.

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[18] On this see: John C Goodman and Devon M Herrick, Twenty Myths about Single-Payer Health Insurance, International Evidence on the Effects of National Health Insurance in Countries Around the World (Dallas, Texas: National Center for Policy Analysis, 2002); Nadeem Esmail and Michael Walker, How Good is Canadian Health Care? (Vancouver, British Columbia: Fraser Institute, 2004); and, Sally C. Pipes, The False Promise of Single-Payer Health Care (Pacific Research Institute, 2002).

[19] See Republic of South Africa, Intergovernmental Fiscal Review 2001 (Pretoria: National Treasury, 2001), Table 5.3, p.77. Also see: Health Systems Trust, South African Health Review 2002 (Durban: Health Systems Trust, 2003), p.27.

[20] Calculated from South African Statistics 2002 (Pretoria, Statistics South Africa, 2002), p. 4-7, Table 4.3.

Health-care provision costs money, whether it is provided by the taxpayers or by private individuals as patients, but there are stark differences in the decision-making processes applied by government on the one hand and business on the other.

5.3.1 Private hospitals and facilities

Private providers have to justify the cost of establishing a new facility by showing that it will be a viable business, which means that it will be expected to show a reasonable return on the funds invested in it. Surveys and estimates will have to reflect that the facility is likely to have a certain minimum number of clients and volume of transactions per given period. This is often referred to as achieving an economy of scale. The approach to establishing a hospital or other health-care facility is no different from the approach adopted in starting any other kind of business. A good location for a private facility is therefore one that will show a good return. A consequence of this logical and sensible approach is that there will be more private health facilities in high-density urban areas than in sparsely populated rural areas. There will also be more facilities in bigger cities than in smaller towns.

5.3.2 Government hospitals and facilities

Government health planners are driven by different imperatives in deciding on the location or size of new public hospitals and other health-care facilities as well as the type of medical services to be offered in them. Such facilities are intended to serve those members of the population who are unable to pay the fees charged by private providers or who are unable to pay anything at all. A good location for a public facility is therefore one that will serve the largest number of people, whether or not they can pay for services.

At least that is the theory. In reality, however, ruling political parties tend to site government facilities, such as hospitals and schools, in places that are politically most beneficial for them so that the best quality of service is provided to their political supporters. In apartheid-era South Africa the major public hospitals for the white population group were located in the major cities, while hospitals serving the Black, Coloured and Indian population groups were built in the geographical areas reserved for them.

There is naturally also a great difference between the health-care desires of the electorate and government’s economic ability to deliver those services. The disparity between demand and delivery increases exponentially as the gap widens between the amounts charged to patients and the real cost of providing services. Demand takes a giant leap when health-care charges are low or zero, eliminating the price-barrier to frivolous use. However, the costs of travel to and from facilities and of total time per visit remain factors that will reduce potential usage, probably acting as a greater deterrent in rural areas. These factors are likely to result in greater per capita use of urban than of rural facilities.

5.3.3 Specialised services

Rare medical conditions require more specialised treatments, which are inevitably more expensive. As such conditions occur more infrequently than common diseases, fewer

facilities and specialist professionals exist to deal with them. Not surprisingly, advanced facilities and medical specialists are more likely to be found in cities than in rural areas.

Some of the reasons are:

- A greater incidence of complex medical problems can be expected in cities because of the greater population densities.
- Medical specialists will show a preference for working in the same environment as other similarly skilled professionals, and for living where there are higher quality amenities.
- City hospitals can generally afford to have better and more modern equipment than rural hospitals.
- Many highly skilled specialists pass on their knowledge by teaching medical school students, invariably to be found at city-based universities.
- Patients are able to travel relatively long distances to receive treatment in what could be called “medical hubs” and do this more economically than if the specialist, together with all the necessary specialised staff and equipment were to travel to the patient.
- Cities provide medical specialists with a greater supply of affluent patients who can afford their fees and justify the substantial investment they have to make in acquiring their above-average skills.
- Some medical conditions are so rare that specialised diagnostic equipment and treatment are available only in a few cities in a country. In some instances there are only a few experts in a particular field worldwide, which means that treatment in their specialities is available in only one or two countries. This is a fact of economic life. The so-called imbalances, whether in the private or public health sectors, cannot be regarded as a deliberate strategy to deny anyone access to health care.

It is not only the private sector that locates specialist medical services and equipment in the cities. Regional government hospitals are also compelled to transfer patients requiring the highest level of specialist services to city hospitals, perhaps in other provinces. This makes eminent economic sense and a politically motivated geographical dispersal of personnel and equipment could prove exceedingly counter-productive.

5.3.4 Provincial “imbalances”

As a result of the various factors involved in decisions regarding the establishment of health-care facilities, it would be surprising if there were not more beds per medical scheme member in the large urban centres than in towns and rural areas. It would also be surprising if the location of public hospital beds did not follow a similar pattern. City hospitals will generally offer a wide range of general and specialised medical procedures compared to hospitals in small towns. Major cities also have specialised hospitals dealing in only one or

two medical specialities, such as orthopaedics, urology and maternity, a development that small populations could not sustain.

Apartheid policies, without doubt, left gaps in the supply of services. However, a large part of what is considered to be an unwarranted urban bias can be explained by economic realities.

5.4 The equity myth

The notion of and arguments for equitable health-care delivery ignore the reality that achieving equity in anything, including health care, is impossible. Health-care technology and medicines are dynamic and advancing fields and, as Nobel laureate Friedrich Hayek observed, in every progressive field what is objectively possible to provide for all depends on what has already been provided for some.[21] A new product or service becomes available to a few people first, and, if successful, becomes available to more and more people over time (cell phones are a good example.). In a sense, inequity is the driving force of progress and development.

Furthermore, the optimal allocation of health care resources implies inequality in health care delivery. Consider the fact that medical treatments differ in their effectiveness, that some illnesses are easier to cure than others, that some treatments, while reducing suffering, do not actually cure the patient and that spending a specific amount of money on one disease may save more lives than pending the same amount of money on another disease and one realises that equality in health care delivery will forever remain an elusive goal.[22]

[21] F A Hayek, *The Constitution of Liberty* (Chicago: University of Chicago Press, 1978).

[22] For a discussion on the inevitable inequitable allocation of health care resources under the assumption that given health care resources should be used to maximise the health of the community see W Duncan Reekie, *Health Care Options for South Africa: Lessons from the UK and the USA* (Sandton, South Africa, FMF Books, 1995), pp. 25-27.

6 CONCLUSION - QUALITY HEALTH CARE FOR ALL

There are two very different approaches to the problem of ensuring that people have adequate access to health care. One approach is for the government to attempt to gradually nationalise all health-care services with a view to ultimately ending with fully taxpayer-funded state-owned health services. This is the apparent aim of the National Health Act of 2003 and also of the proposed Health Charter, which economics and world experience tell us will not work, for three major reasons. The first is that national health systems are not the consequence of the day-to-day decisions of consumers and therefore fail totally to supply the needs of consumers. The second is that they invite unlimited demands, which they cannot meet with limited resources. The third is that relatively poor South Africa cannot hope to achieve success at implementing a system that some of the wealthiest countries, such as the United Kingdom and Canada, have for decades been trying to make succeed, without success.

The other approach is to establish a health-care environment in which private health-care funding and provision can grow rapidly, serving an increasing percentage of the population to the point where all health-services are privately provided. This option will work, as the quality and efficiency of the existing health-care providers have ably demonstrated, as long as they are not burdened with government demands that detrimentally affect their efficiency.

Whichever approach is chosen, one aspect will not change, one hundred per cent of the funding will be from private sources, firstly through taxes, and secondly through voluntary medical aid or insurance schemes and through voluntary out-of-pocket payments.

Citizens have the right to expect that the taxes that they pay to fund the health care of the poor will be used in a cost-effective, efficient and equitable manner. They can rightly demand that government health policy be conducive to the continued growth and development of private health care.

South Africa’s health-care challenge will be best met if government exchanges its role in health care provision for that of funder of health care for the poor from competing private health care providers, including from the empowered new owners of existing government facilities. The most effective mechanism to achieve the empowerment of the poor is to provide them with resources to purchase health care directly from service providers of their choice. The implications for health-care reform are that government should:

- Refrain from unnecessarily interfering with and micro-managing private health care provision and should encourage those who can afford to pay for their own health care to do so.

- Direct its resources to ensuring that the poor receive adequate care from providers of their own choice.

- Fund the needy directly through vouchers, smart cards, contributions on their behalf to competing medical aid funds, and/or other appropriate means that will allow poor patients to purchase quality health care.

- Encourage the development of health-care insurance products for the emerging market.

- Remove controls that increase health care costs or prevent the provision of care by scrapping all requirements for certificates of need, price controls, compulsory community service, registration requirements for medicines already approved in the European Union, the United States, Canada, Australia and New Zealand, and such other countries that meet certain defined standards

This would relieve government of the burden of providing health care and would enable it to put substantial financial resources directly in the hands of those who need them most. The essence of the reform programme would be to maximise the role of the private health sector and for government to relieve itself of the liability of providing health care.

The main beneficiaries of such a reform programme would be the poor, who would be given a wide range of health care choices. Benefits to the taxpayers would be greater efficiency in the use of taxpayer funds and certainty that tax monies earmarked for funding of health care for the poor reaches them directly. State assistance to those who should be self-supporting would be eliminated, allowing greater assistance to those who really need it. A further benefit is that over time, those people who prosper sufficiently to take care of their own health care would be removed from the health care support list.

The DOH would have responsibility for a thriving, growing, health care sector that would be the envy of the developing and the developed world. Health professionals would start flowing back to South Africa and stop leaving the country.

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