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Please note our new contact details:

Street address
2 Clamart Road
Richmond
Johannesburg
2092

Postal address
P O Box 291722
Melville
Johannesburg
2109

Fax
(011) 482-7690

Telephone
(011) 482-7221

*Email**
sairr@sairr.org.za
*unchanged

Health

EXCELLENCE AT RISK

This issue of *Fast Facts* focuses on health care in South Africa. The first article looks at the public sector, the second at the private sector, and the third at proposals for a national health insurance system. The fourth article looks at medical aid and the African middle class.

One of the amazing things about public health care in South Africa is how dedicated professionals are able to stick it out under appalling conditions many employees would simply not tolerate. These include poor pay and excessive working hours, never mind the corruption and mismanagement that seem so prevalent. The very high levels of trauma in this violent society, along with abnormally high mortality levels thanks to AIDS and tuberculosis, must make working in most of our public hospitals among the most gruelling jobs in public health care anywhere outside war zones and disaster areas. Yet complicated surgery is successfully performed and lives saved.

The other side of the public health care story is the never-ending reports of yet more preventable deaths of infants and mothers — the tip of an iceberg of the failings of public health care. For most people who have to rely on it, public health care is probably now worse than it was under National Party rule. The World Health Organisation some years ago found that our public health care system was one of the worst in the world.

Yet the Government responsible for public health care now wishes to introduce some sort of national health insurance system. The details are murky, but it appears that neither the financial nor the human-resource implications have been properly considered, let alone the technical and managerial capacity of a failing state.

There are four great risks in what the African National Congress (ANC) and the Government seem to have in mind. One is that further interference in the private health care sector will damage that sector without fixing the failings of the public sector. The second is that we will lose one of the advantages South Africa can offer to skilled immigrants, which is a top-quality private health care system. The third is that we will encourage emigration of our own health care professionals. The fourth is that some of our private hospital groups will devote more resources to foreign acquisitions than to expansion in South Africa.

What the Government needs to do to improve public health care in South Africa is to reduce the role of the State and expand that of the private sector — including private medical insurance — not the other way around. — ***John Kane-Berman***

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1. Public healthcare unwell

Despite pockets of quality, negative features permeate the South African public healthcare system. Dismal services, decrepit infrastructure, shortages of staff and supplies, and deteriorating conditions are some of the challenges that accompany any public hospital stay. These problems do not stem solely from deficiencies in financial resources. Rather, they are multi-faceted.

South Africa's public health-care system receives 41% of total healthcare expenditure and caters for about 64% of the population. In 2006/2007 the South African national budget allocated R60.3 billion to health.[1] State expenditure on health has since increased by 76.6%. The 2010/2011 budget allotted R106.5 billion to health.[2]

Since 1994, great strides have been made towards developing an integrated and progressive health service available to all South Africans. However, the challenges facing public health continue to mount and in so doing jeopardize the functioning of the system.

Organizational weaknesses

Among the major impediments to an effective public health service are resource mismanagement, inappropriate deployments, poor management, and centralized decision-making.

Mismanagement of funds

In 2006 public and private health expenditure (private and public) as a proportion of GDP stood at 8%.[3] Compared with other countries, South Africa's total health expenditure is high, as illustrated in Table 1.

In spite of South Africa's comparatively high level of health expenditure, deficiencies persist and the standard of health ranks among the worst in the world. According to the World Health Organization's 2000 World Health Report, South Africa's performance on level of health ranked 182nd out of the 191 member states measured. This position was worse than Sudan's at 149th.[4]

Mismanagement and under-utilization of funds are increasingly cited as the source of the health department's financial challenges.[5]

The 2008/2009 report of the auditor-general (AG) for the Gauteng Department of Health (DoH), for example, found several financial concerns. These included the irregular expenditure of R1.9 million, inefficient spending of R2.2 million, under-expenditure of R6.8 million on HIV/AIDS, and unauthorized expenditure of over R1 million.[6] The spending of R1 million on the offices of the Gauteng member of executive council (MEC) for health, Brian Hlongwa, happened to coincide with the financial irregularities found by the AG.[7]

Other provincial departments have also been guilty of financial irregularities. In October 2009 the Eastern Cape DoH announced that 25 officials would face disciplinary action for the irregular expenditure of R24 million.[8]

In view of such improper resource management, it comes as little surprise that blame is increasingly aimed at corruption and inefficiency rather than lack of resources. As stated by Dr June Fabian of Charlotte Maxeke Academic Hospital in Johannesburg: 'Poor leadership and mismanagement of funds' have created a 'crisis of care'.[9]

TABLE 1: HEALTH EXPENDITURE, SELECTED COUNTRIES, 2006

Country	*Total health expenditure as a proportion of GDP*	*Per capita health expenditure (PPP$)**
China	4.6%	1 124
Ghana	5.1%	214
UK	8.2%	4 259
India	3.6%	426
Brazil	7.5%	1 460
Mexico	6.6%	1 208
South Africa	*8.0%*	*1 100*
Sweden	9.2%	4 588

Source: *World Health Organization Statistical Information System* (WHOSIS), 2006 indicators

* Purchasing Power Parity (PPP) is a theory that adjusts the exchange rate between countries so that an item in one country will have the same price as the same item in another country when expressed in the same currency.

Centralization

One of the first moves of the new ANC-led government in

1994 was the adoption of a district-level primary health care (PHC) system. This shift entailed the widespread construction and upgrading of PHC facilities and free primary care for everyone using the public health sector at the point of delivery. For this community-based plan to be implemented, resources were transferred from urban hospitals to community-based clinics.[10] But the promise of effective PHC has fallen short.

Attempts to decentralize decision-making have been largely ineffective due to the failure of many provinces to enact the necessary legislation.[11] Operational decisions such as the appointment of staff, maintenance, and conditions of service in practice remain centralized.[12]

Attempts to decentralize district-based PHC have been particularly problematic. Efforts at reform were accompanied by increasing bureaucratization that in turn led to an overemphasis on authority and organization rather than service delivery and quality.[13]

Poor management

Poor management and weak leadership have stunted the integration of various health programmes as well as inter-sector collaboration.[14] For instance, those working in nutrition programmes do not cooperate with those working on programmes of health promotion despite the overlap in subject matter. Health concerns do not exist in isolation. Non-communicable diseases and primary school nutritional programmes, for example, are related.[15] However, inter-sector cooperation regarding shared issue areas often does not occur.

District PHC hospitals are particularly vulnerable to the negative effects of poor implementation. For instance, community-based participation is an essential element of PHC. However, failure to implement legislation has stunted community involvement. In fact, certain areas lack clinic committees entirely and in others hospital boards have not yet been established. As a result, community-based PHC is yet to be driven by the community.[16]

Inappropriate appointments

Appointments in the public health system have come to be associated with lack of appropriate qualification, inexperience, and a lack of expertise.[17] One example is the employment in 2005 of Thami Mseleku as the health department's director-general. Not only are his qualifications in the field of linguistics, but his professional career was in education.[18] Many senior individuals in the health system are similarly not suited to the work they are employed to do.

The employment of unqualified individuals in key health positions is accompanied by an equally persistent tendency to prolong the employment of staff despite continued incompetence. For instance, in 2007 the large number of infant deaths at Frere Hospital in East London and the role of negligence in those deaths made headline news. However, two years later, Luvuyo Mosana, CEO of the East London Hospital Complex, which includes Frere Hospital, remains in his position. Not only is Mr Mosana unqualified for his position (he has no administrative, managerial, or medical qualifications), but he has yet to be held accountable for what occurred at Frere Hospital.[19]

In September 2009, *Business Day* reported that Madwaleni Hospital in Elliotdale in the Eastern Cape had appointed 41 individuals for just 18 vacancies. It was then revealed that of the 41 appointments 23 were the relatives of either hospital managers or board members.[20]

In this climate of incompetent managerial employment, the necessary accountability does not exist and therefore the rectification of current shortcomings remains out of reach.

Poor hospital conditions

Poor hospital conditions are endemic in the public healthcare system. Deteriorating buildings, neglect, overcrowding, inadequate sanitation, poor disease and infection control, failing infrastructure, and poor working conditions exacerbate the already worrying state of public hospitals.[21]

Accounts of such disastrous conditions are plentiful. For instance, in 2005, five babies died at Mahatma Gandhi Hospital in KwaZulu-Natal (KZN) from an outbreak of klebsiella stemming from poor infection control and contaminated equipment.[22] In 2007, a Hurlingham woman told *The Star* that upon admitting her terminally ill son to Chris Hani-Baragwanath Hospital in Johannesburg she discovered the ward to be infested with mice.[23]

In December 2009, surgeons at Ngwelezane Hospital in Empangeni (KZN) were forced to operate by torchlight when electric power was cut during surgery and the hospital's uninterrupted power supply (UPS) back-up failed to take over. Doctors there stated that despite their numerous requests for a UPS upgrade, the KZN health department had failed to respond for 10 years.[24]

As previously mentioned, in 2007 hundreds of babies in Frere Hospital were dying from avoidable causes such as bacterial infections. The Government sent a team to investigate. According to the then minister of health, Dr Manto Tshabalala-Msimang, the findings of the team included concerns regarding maintenance, infection control and hygiene, severe neonatal and intensive care nurse shortages, and a broken electronic nurse-calling system.[25]

Overcrowding is a constant challenge facing public hospitals. In some cases patients arrive as early as 1am in an attempt to avoid lengthy queues. Overcrowding and long queues can have fatal consequences. For example, in March 2009, baby Mali died after his grandmother was refused entry to three different clinics.[26] In September 2009 the CEO of Helen Joseph Hospital in Johannesburg, Gladys Bogoshi, was suspended after a patient died while waiting in a queue for treatment.[27]

Patient congestion is particularly intense in tertiary hospitals because patients bypass PHC clinics which are also overloaded. It has been suggested that this trend indicates the dwindling confidence patients place on such clinics.[28]

The ability of public health sector practitioners to provide quality care is undermined by their long hours and poor remuneration. For instance, Marinus van der Westhuizen, an intern at Helen Joseph, said he often worked 36-hour shifts, leading to 'severe lack of concentration' while 'internationally, shifts of up to 13 hours are acceptable'. Van der Westhuizen said he and his colleagues were often left alone to look after as many as 40 patients each during shifts.[29]

Finally, the salaries received by medical practitioners in the public sector do not relate to the level of services provided or the day-to-day responsibilities. PE Corporate Services conducted research on behalf of the South African Medical Association (SAMA) and found that when compared with other public sector workers, doctors were underpaid by 50% to 70%.[30] In response to such poor remuneration and the failure of the Government to implement the occupation specific dispensation (OSD) for pay, doctors went on strike across the country in 2009. The health minister admitted that 'the medical profession is underpaid, and that is not up for debate because we know and accept it'.[31]

Shortages of healthcare workers

One of the most significant impediments to efficient public healthcare is a severe shortage of healthcare staff. Physician and nurse densities are a primary indicator of healthcare performance.

Although South Africa compares well to low- and middle-income economies, the number of healthcare workers remains low. For instance, in 2004 South Africa had 8 physicians and 41 nurses for every 10 000 people. Compared to other sub-Saharan African countries this density is adequate. Botswana had 4 physicians and 27 nurses per 10 000 people. However, countries such as France exhibited a far greater physician-nurse density with 34 physicians and 80 nurses per 10 000 people in 2006.[32]

In 2008, 34% of medical practitioner posts in the public sector and 40% of professional nurse posts were vacant. In total, there were 136 985 vacant health professional posts in 2008.[33] Compounding the human resource deficiency is low production of healthcare professionals. For instance, there are only eight medical schools countrywide. In 2008, the total number of registered medical students was just 7 557.[34]

Health worker shortages are especially acute in nursing. The public sector nurse-to-population ratio has declined from 149 per 100 000 in 1998 to 110 per 100 000 in 2007.[35] Furthermore, in 2008 some 40% of professional nursing posts were vacant compared with 32% in 2006.[36] The output of nurses from the public sector also exhibits deficiencies. Although initially the public sector produced more nurses than the private sector, this trend has since been reversed. In 2000 the public sector produced 1 217 nurses compared to 702 nurses from the private sector, 63.4% of the total of 1 919. However, since 2002 the public sector has fallen behind the private sector. Of the 7 493 nurses produced in 2009, 68.4% were private sector outputs.[37]

Another problem is an unequal distribution of healthcare workers across the public and private sectors. In 2008 there were 34 687 medical practitioners registered with the Health Professions Council of South Africa.[38] Of registered doctors, only 30% (10 653) were working in the public sector. In that same year the South African Nursing Council recorded 212 806 registered and enrolled auxiliary nurses.[39] Of that total just 11% (22 707) worked in the public sector.[40] In 2007 there were 4 219 people per medical practitioner in

the public sector while there were 601 medical aid beneficiaries per medical practitioner in the private sector.[41]

Emigration is one of the chief reasons behind South Africa's deficiency in public healthcare workers. A recent survey by the South African Migration Project revealed that 37% of South African medical students in their final year of study said they would emigrate within six months of graduation, while 40% maintained they would emigrate after two years of practice.[42] Table 2 illustrates the number of health workers practising abroad.[43]

In addition to those who emigrate, large numbers of healthcare professionals are leaving the public sector for the higher pay, better working conditions and advanced technology offered by the private health sector.[44]

Shortages of supplies and equipment

Public hospitals in South Africa are plagued by shortages of vital medical supplies and equipment, the consequences of which are severe and in some cases fatal.

Public hospitals routinely experience bed shortages. In 2002 public hospitals had 106 084 beds available for more than 50% of the population. By 2005 the number of beds had declined to 87 870.[45] Professor Bongani Mayozi, head of internal medicine at the University of Cape Town, told the parliamentary portfolio committee on health that 'it takes about 24 hours… for us to put 50% of people into a bed… some people wait up to three days to get into a bed'.[46] In July 2009, the *Mail & Guardian* were taken on a tour of the Rahima Moosa and Helen Joseph hospitals in Gauteng. In the maternity ward of Rahima Moosa, eight women, already in labour, were sitting on plastic chairs while waiting for beds to become available.[47] At a debate on strategic health reform organised by the Helen Suzman Foundation in December 2009, Professor Joe Veriava, a specialist physician in public hospitals, stated that these hospitals were running at 100% occupancy and were therefore completely overwhelmed.[48]

Other areas experiencing chronic shortages are medication, equipment, and basic supplies. The availability of medication in the public sector is unreliable, with many hospital pharmacies entirely without drug supplies.[49] Charlotte Maxeke has been forced to implement a 'first 500' rule whereby all patients arriving after the first 500 at the hospital pharmacy are sent home without medication.[50]

Antiquated equipment or an entire lack of equipment has frequently left public hospitals with little choice but to close operating theatres and trauma units. In May 2009, the emergency rooms at South Rand Hospital in Johannesburg were incapable of functioning due to faulty life-saving equipment such as ventilators and heart-restarting defibrillators.[51] Chris Hani-Baragwanath often experiences ventilator shortages that compel staff to turn patients away.[52]

Some hospitals lack even the most basic medical stockpiles. For instance, the acting head of the school of medicine at the University of the Free State, Andries Stulting, stated, 'We don't have basic things like eye pads, eye shields and medications.'[53]

TABLE 2: DISTRIBUTION OF SOUTH AFRICAN HEALTH PRACTITIONERS ABROAD, 2006

	Practitioners	*Nurses/Midwives*	*Other health professionals*	*Total*
Australia	1 114	1 085	1 297	3 496
Canada	1 345	330	685	2 360
New Zealand	555	423	618	1 596
UK	3 625	2 923	2 451	8 999
USA	2 282	2 083	2 591	6 956
Total	**8 921**	**6 844**	**7 642**	**23 407**

Source: South African Health Review (SAHR), 2007, Khan & Wadee: 145

Research

Clinical research is a building block of any effective healthcare system. Yet, an overemphasis on and diversion of funds to PHC has allowed medical research and academic medicine to deteriorate.[54] The number of PhD students has decreased from 62 in 2006/2007 to 55 in 2009/2010.[55]

In addition, there is little professional turnover whereby younger researchers replace the older generation of researchers. According to Professor Mayozi, researchers under the age of 30 conduct less than 1% of all medical research. He maintained that this was a significant impediment to the pursuit of clinical research.[56] Furthermore, if such a trend continues no one will be conducting clinical research in 10 years' time.

Crime and theft

Crime and theft frequently compromise the effective running of South Africa's public health system. State hospitals often fail to account for hospital equipment and medical supplies as well as non-health items such as cutlery.

In 2005, for instance, a team was established by Dr Manto Tshabalala-Msimang to investigate allegations of theft by hospital staff at Townhill Hospital in Pietermaritzburg.[57] Among other allegations were theft of patients' food and belongings. The investigation found overwhelming evidence to support the allegations.[58]

Theft of medicines is prevalent. In 2006, two nurses and one hospital clerk from Grey Hospital in King William's Town in the Eastern Cape were arrested for selling stolen medicines. According to a spokesperson for the Eastern Cape Department of Health, theft of medical supplies is a major problem, which required the 'public to blow the whistle on corrupt officials who steal and sell medical supplies for personal gain'.[59]

Infectious diseases

South Africa is confronted by the rampant spread of infectious diseases. The epidemics of HIV/AIDS and tuberculosis (TB) place an enormous burden on an already ailing public health system.

In 2009, some 5.7 million South Africans were living with HIV/AIDS. They constitute nearly 12% of the South African population[60] and about 17% of the global HIV/AIDS burden.[61] The number of adults (15+) and children living with HIV in 2001 was estimated to be 4 700 000. That number increased by 21% to 5 700 000 in 2007. The total number of deaths in a year due to AIDS was estimated to be about 180 000 in 2001 and had risen to 350 000 by 2007.[62]

The Government's previous HIV/AIDS approach undermined all efforts to control the virus. Failures in the provision of anti-retroviral drugs have not only aggravated the HIV/AIDS situation but also worsened the country's TB pandemic.[63]

TB is one of the greatest challenges to the South African health system. The total number of TB cases increased from 279 260 in 2004 to 353 879 in 2007. This is an average annual increase of 8.2%,[64] against population growth of 1.1% a year since 2004.[65] Table 3 illustrates the severity of the tuberculosis pandemic in South Africa.

Hampering attempts to combat South Africa's TB epidemic is the dual impact of HIV/AIDS co-infection and the emergence of drug-resistant TB. The incidence of TB-HIV/AIDS co-infection is extremely high, with over 50% of TB cases occurring in HIV infected patients.[66]

Drug-resistant TB is another serious factor facing South Africa's health system. Since 2006, cases of both multi-drug-resistant TB (MDR) and extensively drug-resistant TB (XDR) are said to have increased considerably. The danger of this type of TB was illustrated in 2005 when an outbreak of drug-resistant TB in Kwa-Zulu Natal proved to be almost uniformly fatal.[67]

Maternal and child mortality

The rates of maternal and child mortality in South Africa are extremely high and show little sign of improvement.

Maternal deaths are 'the deaths of women while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes'.[68] According to a 2007 report by the government-appointed National Committee on Confidential Enquiries into Maternal Deaths, some 4 077 maternal deaths were reported between 2005 and 2007 compared with 3 406 between 2002 and 2004. This constitutes a 20% increase.[69]

HIV/AIDS is the leading cause of maternal death with 44% of such deaths being AIDS-related. However, the report found that 38% of the deaths could have been avoided.[70] Some of the factors of concern that contributed to the avoidable deaths were incorrect diagnoses, inappropriately trained staff, failure to follow standard protocol, and lack

TABLE 3: TUBERCULOSIS INDICATORS, SELECTED COUNTRIES, 2007

	South Africa	*Neighbours*					*Other developing countries*	
		Botswana	*Malawi*	*Mozambique*	*Namibia*	*Zimbabwe*	*Brazil*	*India*
TB incidence (per 100 000 per year	948	731	346	431	747	782	48	168
TB mortality (per 100 000 per year)	230	194	102	127	102	265	4	29
HIV prevalence in incident TB cases (%)	73%	68%	68%	47%	67%	69%	14%	5%

Source: *Churchyard, Karim, Karim & Lawn, 2009*: 929

of healthcare facilities. The report thus stated that 8.6% of the maternal deaths resulted from a lack of specific healthcare facilities, while 8.9% resulted from inappropriately trained staff.[71]

Child and infant mortality rates are equally alarming, with 20 000 stillborn babies annually, 21 900 deaths before the age of one month, and 52 600 before the age of five years.[72] Furthermore, international comparisons reveal that South Africa not only has one of the highest infant mortality rates but also that the rate is increasing (Table 4).

As with maternal mortality, the leading cause of infant and child mortality is HIV/AIDS, yet large numbers die each year from preventable or treatable causes too. The government-appointed National Perinatal and Neonatal Morbidity and Mortality Committee 2008 found that 43% of neonatal deaths were preventable.[73] Similarly, the government-appointed Committee on Morbidity and Mortality in Children under Five Years found that HIV was a leading cause of death in only 50% of cases. Malnutrition constitutes a major cause of child mortality along with inadequate skills of doctors and nurses, substandard post-natal care, and inferior reproductive health services.[74]

Good things

Although the public health system faces large challenges, since 1994 a number of positive changes have occurred. These include the provision of free primary healthcare (although this has contributed to overcrowding), the introduction of essential drug programmes, the Choice on Termination of Pregnancy Act of 1996, the improved immunization programme, clinic expansion and improvement, and the hospital revitalisation programme.[75] In addition, public hospitals exhibit areas of world-class healthcare and expertise.

The Pregnancy Act is designed to stem the number of illegal, unsafe abortions and the resulting unnecessary deaths. It was estimated that 425 females died each year from 'backstreet abortions'. However, since the implementation of the legislation, there has been a significant reduction in abortion-related deaths, with just 40 deaths recorded per year between 1999 and 2001.[76]

Under the clinic upgrading and building programme initiated in 1994, some 460 clinics and 810 clinic residential units were built in just four years. The hospital rehabilitation and reconstruction programme, implemented in 1998, encompassed the improvement and replacement of both hospital services and hospital equipment across the country.[77]

In 1995, an upgraded programme of immunization introduced the country to a number of new and improved vaccines, including the Hepatitis B vaccine and a pneumococcal vaccine. This programme was subsequently followed by the first national vaccination campaign in 1996 and 1997.[78]

Public sector hospitals continue to display pockets of excellence. For instance, early this year nine-day-old Ashleigh Louw underwent an extremely complex heart operation at Chris Hani-Baragwanath. The procedures necessary to repair her condition and its associated defects are complicated and require staggered phases. Concerns were raised regarding the capability of the public hospital to conduct such intricate and challenging surgeries. However, the multi-disciplinary team were successful in the first surgical step. In response to the success of the initial operation, the Democratic Alliance's (DA) Jack Bloom stated 'I was very impressed by the high standard of care that she is receiving. It is comparable to the best in the world for this type of condition, and I congratulate the surgeons and other medical staff.'[79]

Unfortunately Ashleigh subsequently died of pneumonia. Bloom, however, was quick to

TABLE 4: INFANT MORTALITY RATE (PER 1 000 BIRTHS) BOTH SEXES, SELECTED COUNTRIES, 2000 AND 2006

Country	*2000*	*2006*
Brazil	27	19
China	30	20
Germany	4	4
India	66	57
Japan	3	3
Mexico	32	29
Mozambique	112	96
Namibia	50	45
South Africa	*50*	*56*
UK	6	5
Zimbabwe	58	55

Source: World Health Organization Statistical Information (WHOSIS), 2006

emphasize that the 'tragic ending…not detract from the superb care provided by the doctors at Chris Hani-Baragwanath'.[80]

The public health sector is home to many excellent medical practitioners. For instance, Professor Ken Boffard, trauma surgeon at Charlotte Maxeke, was elected president of the International Society of Surgery for 2010-2011. This position is highly regarded in international medical circles and therefore the election of Professor Boffard reflects the high level of expertise and competence in areas of South Africa's public health sector. Upon his appointment, Professor Boffard stated: 'I regard my election as a direct compliment to Charlotte Maxeke and its staff, for the work they have achieved.'[81]

Finally, the *2007 General Household Survey* conducted by Statistics South Africa found that patient satisfaction levels in the public sector were not only rather high but were in fact increasing. For instance, satisfaction levels amongst public sector patients rose from 81.6% in 2002 to 87.6% in 2007.[82]

2. Private healthcare in pretty good shape

South Africa's private healthcare sector displays continuous commitment to efficient services, quality care, and internationally accepted standards. These positive attributes are made possible by the combined characteristics of large financial resources and small beneficiary numbers. However, accelerating prices combined with stagnating membership levels create an environment that is thought to be unsustainable.[83]

South Africa's private health sector is proficient, highly specialised, and of a world-class standard. Additionally, it is extremely well-financed, for it receives more than 50% of total healthcare expenditure.[84] The chief paymasters of this sector are medical aid schemes, which are voluntarily funded through contributions by employers and house-holds.[85] These schemes benefit about 7.9 million people who are reimbursed for most of their healthcare spending. In 2008 medical schemes spent R64.7 billion on their beneficiaries.[86] With just 15% of the population benefiting from such a well-resourced system, per capita expenditure far exceeds that of the over-burdened public sector. For instance, in 2005 per capita expenditure in the private sector was about R9 500 per annum. Conversely, just R1 300 was spent per public sector beneficiary per year. Finally, annual out-of-pocket expenditure per capita was about R1 500.[87]

Treatment and care within the private sector is typically the responsibility of short-stay private hospitals. These private hospitals are, on average, small in size and accommodate patients for less than 30 days. Although these hospitals may alleviate some of the public sector load, the services they provide are expensive and are usually purchased by medical scheme beneficiaries and/or wealthier individuals.[88] The major participants in the private hospital industry are the three largest hospital groups, namely Netcare, Medi-Clinic, and Life Healthcare. These groups control the largest number of private hospitals, hospital beds, and theatres in the country.[89]

The combination of a depth of financial resources and a small beneficiary pool has allowed this sector to develop and cultivate a number of assets, which include quality care, an array of hospital services, and adequate human resources and capacity.

Strengths

Quality care

The quality of South Africa's private healthcare is high and improving. For instance, the *2007 General Household Survey* conducted by Statistics South Africa found that patient satisfaction levels in the private sector rose from 95.4% in 2002 to 95.5% in 2007.[90] Furthermore, South Africa's private healthcare quality is high relative to other countries. A study by the Monitor Group in 2008 compared South Africa's private health system to the health systems in 43 countries and found that it ranked among the top five. Consequently, the quality of care and level of sophistication provided by private hospitals is on a par with those in the United Kingdom, the United States, and Australia.[91]

The expanding number of foreign patients treated in South Africa's private hospitals is another indication of the quality care provided. South Africans living abroad frequently return to the country to use private health services. Furthermore,

South Africa is fast becoming a popular destination for medical tourists who are attracted by the excellent and affordable care. The annual revenue contributed to private hospitals by foreign patients was estimated to be R280 million in 2007.[92]

South Africa's private hospitals continuously strive to improve the quality of the services they provide. The introduction of 'centres for excellence' reflects additional steps taken by the private hospital industry to provide superior care. The Walter Sisulu Paediatric Centre for Africa, situated within Netcare's Sunninghill Hospital in Johannesburg, is one such centre, performing cardiothoracic operations and procedures on infants and children.[93]

The Medi-Clinic group has seventeen multidisciplinary hospitals belonging to the Vermont-Oxford Network (VON) database, which is a collaboration of healthcare professionals and institutions committed to improving the quality of healthcare available to newborn babies. With a membership of over 800 neonatal intensive care units worldwide, the network database provides quality information and data in the pursuit of excellent care.[94]

Diversification and specialization

The variety of services offered by the private hospital industry is wide-ranging and of a high standard.

The services accessible to private hospital patients are diverse and include cardiothoracic, maternity, neo-natal care, wide-ranging intensive care units (ICUs), trauma and emergency care, wide-ranging surgical care such as neurosurgery, paediatric care and psychiatric services. For instance, Life Healthcare's Vincent Pallotti Hospital in Cape Town boasts a high-tech oncology centre which offers brachitherapy and stereo-tactic radiotherapy;[95] Medi-Clinic's Morningside Clinic in Johannesburg offers specialised clinics such as a children's kidney treatment centre and a diabetic clinic;[96] and Netcare's Milpark Hospital is known for its level 1 trauma care facility.[97]

Capacity

According to the Hospital Association of South Africa (HASA), the number of private hospital beds has increased by 38.6% from 20 908 in 1998 to 28 980 in 2008.[98] These beds provide for just 15% of the population. According to Hein van Elk of Medi-Clinic, private hospitals run at just 60% bed occupancy, which limits waiting periods, overcrowding, and the work load of health workers, especially nurses.[99] The ability of private hospitals to provide waiting patients with beds speedily is an advantage they have over public hospitals. For instance, the population per hospital bed in the private sector in 2005 was 194, compared with 399 in the public sector for that same year.[100]

Human Resources

Unlike the public health sector, the private health sector has a high health worker density. In 2005, the population per GP and per pharmacist in the private sector stood at 243 and 765 respectively. Conversely, the population per GP and per pharmacist in the public sector were 4 193 and 22 876 respectively.[101]

The greater density of doctors within the private health sector is related to the large financial resources there. Higher remuneration and superior working conditions constitute powerful pull factors for health practitioners and are frequently the reason why they leave the public sector. Ethical rules laid down by the Health Professions Council of South Africa (HPCSA) prevent private hospitals from employing doctors directly. Consequently, private hospitals use a number of incentives to attract medical practitioners.[102] These incentives range from significant infrastructure investments to the availability of high-tech and advanced facilities. This practitioner-orientated approach is followed by major hospital groups. According to its business strategy statement, 'Netcare places physicians at the centre of its business model, providing them with state-of-the-art facilities, skilled nurses, and the latest medical technologies.'[103]

Finally, the output of medical practitioners from the private sector is increasing and in some instances exceeds that of the public sector. For instance, the output of nurses from the private sector surpasses the nursing output from the public sector. In 2009, the nurses produced by the private sector stood at 5 128 while those from the public sector stood at 2 365.[104]

Assets abroad

Private hospital groups have been expanding overseas. Medi-Clinic spent R17 billion buying Switzerland's largest hospital group and has also invested heavily in the United Arab Emirates.[105] In 2008, Medi-Clinic's offshore operations contributed 37% to its R9.6 billion in revenue. Similarly, Netcare has extended its operations abroad to the UK and bought the

UK-based General Healthcare Group. Some 52% of Netcare's group revenue and 58% of its operating profit came from its UK operations in 2008.[106] This diversification of assets reflects a possible backdoor option for private hospital groups if government regulations become intolerable.

Weaknesses

South Africa's private health sector may provide world-class care and sophisticated service, yet cost issues call into question the sustainability of the entire system.

Rising costs

Perhaps the greatest challenge facing South Africa's private health sector is excessive financial strain. Expenditure in the private sector continues to increase each year at rates that surpass the inflation rate. Expenditure on medical aid beneficiaries increased by 13.7% from R56.9 billion in 2007 to R64.7 billion in 2008.[107] Such increases in expenditure are related to increases in contribution rates. The Gross Contribution Income (GCI) for all medical schemes increased by 13% from R65.5 billion in 2007 to R74.1 billion in 2008.[108] In 2009 the average monthly gross contribution for a medical scheme member was R1 280, while a family of three, on average, paid R2 497 per month.

The biggest impediment to growth in the number of medical scheme beneficiaries is lack of affordability.[109] In 2008 average monthly earnings in South Africa (current prices) were R9 495 per month, which clearly precludes a significant part of the population from participating in medical schemes. In fact, medical aid beneficiaries as a proportion of the population decreased from 17% in 1997 to 15% in 2007.[110]

Accelerating costs have various causes, some legitimate. Others, however, are less legitimate and therefore appear to be unjustly driving up cost.

Hospital costs

Dramatic increases in private hospital fees constitute a primary driver behind increased medical scheme expenditure. Between 2000 and 2006 hospital costs per beneficiary increased at an average yearly rate of 8.3%.[111] Consequently, private hospital expenditure by medical schemes has also risen. In fact, since the mid-1990s private hospitals have encompassed the largest component of medical scheme expenditure at over 35%.[112] In 2008, medical schemes spent R23.8 billion on private hospitals compared with R5.2 billion on general practitioners, and R14 billion on specialists.[113]

The hospital industry maintains that increasing costs are to be expected given certain circumstances. For instance, the HASA argues that some of the reasons behind private hospital price increases include unavoidable cost pressures such as nurses' salaries and utilisation changes resulting from HIV/AIDS, ageing, and technology developments. For example, research conducted by Mike Schussler for the HASA (2008) found that staff costs accounted for 50% of total hospital costs.[114] Furthermore, the HASA maintained that increased patient admission rates by private hospitals are responsible for changing utilisation trends and therefore increased expenditure by medical aid schemes per beneficiary. In fact, South African private hospital admission rates are far higher than those of the United States.[115]

Based on these rationalizations, it would appear that such increasing costs are legitimate.

Consolidation

In opposition to the hospital industry's reasons for cost increases, the Council for Medical Schemes (CMS) maintains that acceleration of expenditure on private hospitals is the result of private hospital consolidation. Since the 1990s, the majority of private hospital beds, private hospitals, and theatres have fallen under the control of three major hospital groups: Netcare, Medi-Clinic, and Life Healthcare. These three hospital groups account for 76% of all private hospital beds, own 80% of all private theatres, and account for 66% of all private hospitals (Table 5).[116]

The concern raised by the CMS is that concentration allows increased market power of the hospital groups and the occurrence of non-price competition. Private hospitals implement a number of incentives to attract practitioners. This constitutes a key area of non-price competition, which is said to drive up hospital costs. These costs are in turn passed on to the medical schemes.[117] Indications of non-price competition are evident not only in the high concentration of hospital beds, but also in the high equipment-to-population ratio. For instance, the South African private health sector has more Magnetic Resonance Imaging units (MRIs) and Computed Tomography Scanners (CT scanners) per million people than the United Kingdom, Canada, Germany, and France.[118]

The CMS has therefore involved the Competition Tribunal in matters of hospital group pricing power and the resultant high

hospital costs.[119] Although the private hospital industry consistently denies that it has market power, increased interference by competition authorities has been one of the drivers behind hospital group expansion overseas.[120]

More use of technology

Increased utilisation constitutes another major cost driver in the private healthcare environment. The fee-for-service method embodied by the private health sector plays a role in increasing the use of expensive equipment such as MRIs and CT scans.[121] Although difficult to confirm, it is widely believed that private hospitals tend to depend heavily on medical specialists to increase the utilisation of equipment and technology in an effort to generate revenue.[122]

Prescribed Minimum Benefits (PMBs)

Prescribed Minimum Benefits (PMBs), introduced under the Medical Schemes Act of 1998, are perhaps one of the most significant drivers behind escalating medical aid costs and therefore one of the major impediments to the sustainability of the medical scheme environment.

PMBs were launched in an attempt to ensure efficient public-private healthcare resource allocation and to restrict the possible unloading of seriously ill medical aid beneficiaries on to the public sector in the event that their medical aid runs out. PMBs constitute a minimum package of benefits that medical aid schemes are compelled to offer to all beneficiaries. This package includes full coverage of all emergency medical conditions, the diagnosis and treatment of 270 diagnosis and treatment pairs (PMB-DTP), and the diagnosis and treatment of a list of 25 chronic diseases (PMB-CDL).[123]

As the law currently stands, service providers decide on the cost of PMB diagnosis and treatment, while medical schemes are required to cover those costs irrespective of what they may be.[124]

The expense of covering PMBs in conjunction with high rates of PMB utilisation leads to a situation of cost-escalation as medical schemes are forced to increase their fees.[125] Consequently, medical aid is becoming increasingly unaffordable as a result of government regulations.

This led the Board of Healthcare Funders (BHF) to meet the minister of health earlier this year in a bid to seek amendments to the PMB regulation.[126]

Non-health care costs

Although medical schemes function as not-for-profit bodies they work in tandem with auxiliary bodies that are profit-driven. These companies provide non-health services which include administration, marketing, managed care, and consultancy and advisory services.[127] These non-healthcare costs add momentum to the medical scheme cost spiral.

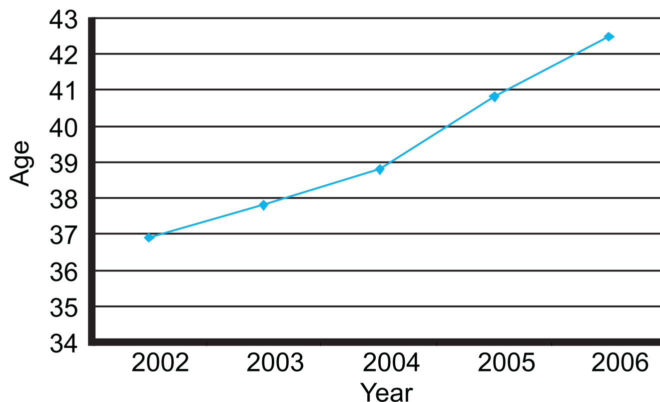
Medical scheme expenditure on administration increased by 6% from R6.4 billion in 2007 to R6.8 billion in 2008. Expenditure on managed care increased by 13% from R1.5 billion in 2007 to R1.7 billion in 2008 and expenditure on broker fees by 20% from R1 billion in 2007 to R1.2 billion in 2008. Overall,

TABLE 5: DISTRIBUTION OF PRIVATE HOSPITALS, BEDS AND THEATRES BY OWNERSHIP, 2006

Hospital Group	*Number of hospitals*	*Proportion of hospitals*	*Number of beds*	*Proportion of beds*	*Number of theatres*	*Proportion of theatres*
Community Health Care	4	1.9%	467	1.7%	18	1.9%
Clinix Health Group	4	1.9%	511	1.9%	10	1.0%
Independent	54	25.0%	3 417	12.3%	125	12.9%
Joint Medical Holdings	4	1.9%	367	1.3%	20	2.0%
Life Healthcare	56	25.9%	7 300	26.4%	257	26.5%
Medi-Clinic	44	20.3%	6 401	23.2%	234	24.2%
Melomed	3	1.4%	351	1.3%	12	1.2%
Mining	5	2.3%	1 470	5.3%	16	1.7%
Netcare	42	19.4%	7 302	26.4%	276	28.5%
TOTAL	**216**	**100.0%**	**27 586**	**100.0%**	**968**	**100.0%**

Source: *South African Health Review (SAHR), 2007. Matsebula & Willie: 163*

FIGURE 1: AGEING PROFILE OF PRIVATE HOSPITAL ADMIMISSIONS 2002–2006



Source: *Hospital Association of South Africa (HASA): US-Africa Private Health Forum, 2008*

expenditure on non-health items increased by 8% from R9 billion in 2007 to R9.7 billion in 2008.[128]

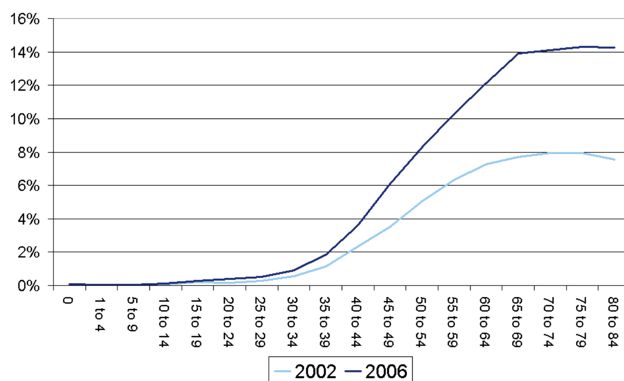
In 2008 the inflation rate was 11.5%.[129] Consequently, although some non-health care costs appear to be large when viewed in isolation — notably brokers' fees — the overall acceleration of these non-healthcare costs was less than the inflation rate and so cannot be considered exorbitant.

Chronic diseases and ageing beneficiaries

Another justifiable cost driver is the growing prevalence of ageing beneficiaries and chronic diseases. According to Dr Jonathan Broomberg, deputy CEO of Discovery Health, 'the medical scheme population is ageing, the prevalence of chronic disease is increasing, and doctors are identifying chronic diseases earlier and are aggressively treating them… Our cancer spending has doubled over the last four years.'[130] In 2006, the average age of a private care patient was 42.5 years compared with 36.9 in 2002 (Figure 1), which constitutes an average annual increase of 15.1%. People living longer cause beneficiaries' collective costs to increase. According to the HASA, between 2002 and 2006, this so-called patient 'age creep' cost medical schemes R936 million.[131]

Increasing levels of non-communicable diseases also exert a large amount of pressure on the private sector. The World Health Organization (WHO) maintains that 28% of the total disease burden in South Africa is comprised of non-communicable diseases, with cardiovascular diseases, diabetes mellitus, respiratory diseases, and cancers contributing a combined 12% of the overall disease burden.[132] Figures 2 illustrates the growing proportion of cardiac admissions.

FIGURE 2: CARDIAC AS A PROPORTION OF TOTAL HOSPITAL ADMISSIONS



Source: *Hospital Association of South Africa (HASA): US-Africa Private Health Forum, 2008*

3. NHI: The healthcare remedy

South Africa's public health system in its present state is dysfunctional, inefficient, and in desperate need of improvement. The solution put forward to repair the damaged system is National Health Insurance (NHI). However, the implementation of NHI and its suitability for the South African health context has been called into question.

The right of every South African citizen to healthcare has been cemented in a number of legally binding documents, namely the Constitution, the Medical Schemes Act of 1998, and the National Health Act

of 2003. However, the challenges facing the health sector as a whole and the public health sector in particular have prevented many from obtaining quality healthcare. Therefore, National Health Insurance (NHI) has been proposed whereby a single pool of funds will be distributed equally among all South Africans in a bid to achieve quality and equitable care.[133]

Origins

The suggestion of a tax-funded national health service was initially introduced as far back as 1944 when the Gluckman Commission proposed a network of primary healthcare (PHC) centres. The proposals were never implemented and health restructuring ideas lay dormant for the next five decades. The idea resurfaced in 1994 in the form of the African National Congress (ANC) national health plan. This advocated that all formal sector employers and employees contribute to a fund which would in turn cover a range of benefits for the contributor and any possible dependants.[134]

In 1995 a committee of inquiry, led by Dr Jonathan Broomberg and Dr Olive Shisana, was charged with the task of assessing the economic viability of NHI. Concerned with the possible cost of such a system, the committee recommended limiting coverage to hospital care alone.[135] The recommendations of the committee were never implemented and by 1997 another committee — the SHI working group — had been established by the Department of Health. This group proposed that coverage and contributors be confined to those employed in the formal sector above the income tax threshold. Those belonging to this category could then decide whether to belong to a state fund or to a medical scheme.[136] Again, implementation failed to occur.

In 2002, the Taylor Committee of Inquiry into a Comprehensive System of Social Security for South Africa was established. The recommendations of this committee were the first call for an NHI system. Specific ideas included universal coverage of a package of services, regulated private sector activities, and a phased approach in which major preparation would precede implementation. Foundation requirements would include wide-spread public hospital improvement and revisions to the medical scheme tax subsidy.[137]

A ministerial task team (MTT) was created in order to assess which Taylor Committee proposals were to be implemented. It was decided that implementation of NHI was not immediately practical.[138]

Present policy

NHI re-emerged in the public domain when, at the conference of the ANC in 2007 in Polokwane, mention was made of reaffirming commitment to an NHI system.[139] The ANC's NHI plan was further elaborated in the party's manifesto for the 2009 general election. The document stated that a publicly-funded and publicly-administered system would be implemented over a period of five years. The system would provide the nation with access to free quality health care at the point of service.[140]

The issue of *ANC Today* of 23rd January 2009 included a description of the NHI plan. Inter alia, payment arrangements would be structured in a manner that would deter the over-utilization of services and thus control the cost spiral.[141] Both public and private healthcare practitioners and public and private hospitals would be accredited by the NHI to provide NHI services. Patients could then choose from the accredited providers within their area. Health packages would include hospital in-patient and out-patient care and PHC services.[142]

Further details of the proposed NHI model appeared later that year in the July 24th issue of *ANC Today*. Funding would involve a combination mechanism whereby existing government health expenditure (general tax revenue) would be added to a small employer-employee compulsory insurance fee and pooled in a single fund. This single reserve would then fund all health care in both the public and the private sector.[143]

With this system in place, income would no longer determine access to quality healthcare. Healthcare, both public and private, would be equally accessible by all South Africans.[144]

NHI services would be based on the principle of social solidarity whereby need rather than ability to pay would define access to care. Consequently, those who were unemployed or unable to pay would be subsidized by those who were able to pay.[145]

Implementation would follow an incremental process. For instance, prior to the actual institution of the system, different affected sectors would be consulted and improvements to the existing health system would occur.[146]

Main NHI characteristics

An assessment of the few publicly available NHI documents reveals four major features of the proposed system: first, a

publicly administered National Health Insurance Authority (NHIA) funded through a combination of employer-employee contributions, additional tax for all taxpayers, and existing government revenue (which is predominantly income tax); second, universal coverage with no co-payments, built on the primacy of need over ability to pay; third, a comprehensive benefit package encompassing almost every medical condition, including primary care and preventive services, in- and out-patient care, prescription medication, and mental health services; and fourth, public and privately delivered care whereby all service provides are accredited by the NHI and the patient may choose a preferred one.[147]

Details regarding the actual cost of the system have been absent as the ANC has decided to tackle cost projections at a later date. However, general estimates have been in the area of R100 billion to R300 billion.[148]

State of play

Government documents regarding the NHI system have thus far been withheld from the public, and concrete information regarding the details of the system remains elusive. The government's programme of action for 2009 stipulated that the NHI policy document would be released to the public in November that same year. This did not occur. Draft legislation will supposedly be presented to the cabinet in July 2010.[149]

On 11th September 2009 the health minister, Dr Aaron Motsoaledi, declared the establishment of a national health insurance advisory committee ('the committee') to guide the minister on the development of NHI policy and legislation.[150] On 5th November 2009, the DoH announced the names of the 25-member committee, with Dr. Olive Shisana in the chair. She later said that the five-year implementation phase would continue to be followed.[151]

Finally, the 2010 Budget Review released in February stated that NHI proposals were still under review. The reviews further reiterated the need for several reform processes before the system could be established in South Africa.[152]

Debate and criticism

The secrecy that has thus far surrounded the NHI has not stemmed the wave of debate and criticism from public interest groups, political parties, and tripartite alliance members.

Financial feasibility

One of the greatest concerns regarding the implementation of an NHI system is its economic feasibility. A number of financial impracticalities stand in the way of a universally accessible system. It is important to distinguish between national health insurance and social health insurance (SHI), as the terms are often mistakenly used interchangeably. SHI benefits only those who contribute to it. These defined beneficiary groups differ and may include for example all employed people in the formal sector or all taxpayers. Conversely, NHI brings coverage to the entire population, even if only certain groups contribute toward it.[153] At a debate organized by the Helen Suzman Foundation in Johannesburg in December 2009, Alex van den Heever, an independent health economist, stated that South Africa simply could not afford an NHI option.

The NHI proposal is designed to replace an inequitable private-public system, which is a two-tier system, with a more equitable single-tier system.[154] Yet the practicality of a single-tier system is called into question on the grounds that it is unaffordable. Converting the two-tier system to a single-tier mandatory health insurance should not isolate those in the higher income bracket or diminish the present quality of care they are paying for. However, providing a universal benefits package of a private-care-standard is not possible in the context of South Africa.[155]

In 2005, per capita expenditure (by themselves) on medical aid beneficiaries (14.8% of the population) per year was estimated to be around R9 500.[156] If the Government were to allocate the same amount of money to all South Africans, total health expenditure would rise to about R465 billion. Public health expenditure as a proportion of GDP would increase from 3.4%[157] to over 20%.[158]

The alternative is to redistribute the existing pooled resources equally among the population, which would result in a per capita expenditure of about R2 540. This figure, although an improvement for those entirely dependent on public care, is significantly smaller than expenditure per medical aid beneficiary. Consequently, those in the high-income bracket would be required to continue paying contributions but would receive benefits worth R2 540 instead of R9 500.

An economic consultancy group, Econex, uses various alternative cost estimation methods in an attempt to calculate the cost of implementing the proposed NHI. The study showed

that the NHI would cost between a more conservative estimate of R197 billion and a more likely estimate of R216 billion.[159] This is over and above the R99 billion that the government was estimated to have spent on health in 2009/2010.[160] Furthermore, Econex maintains that its estimates are conservative and will realistically fall around the R244 billion mark or more. Consequently, based on the 2009/2010 expenditure figures, government health expenditure would increase to R343 billion. This figure exceeds the total estimated health expenditure (public, private, and out-of-pocket spending) of R201 billion in 2009/2010.[161]

The country's young population, large numbers of unemployed and social welfare recipients, and a significantly small tax base exacerbate the financial difficulty connected to the proposed NHI system.[162]

South Africa has an extremely young population. In 2008, the total population was 48.6 million. Some 42.8 % (20.8 million) were under the age of 20 while 70% (34 million) were under the age of 34. While a relatively youthful population may exert less pressure on a health system than the elderly, the age of the population has important implications for levels of employment, tax revenue, and social assistance. For instance, there are 18.3 million people between the ages of 15 and 34 and only 33% (6 million) of that number are employed.[163]

When one examines these socio-economic characteristics with the entire population in mind, the economic impracticality becomes even more apparent. For the year 2007/2008 there were only 5.3 million registered taxpayers.[164] In other words just 11% of the population earned a taxable income.

Implementation period

The planned five-year implementation period proposed by the Government appears rather ambitious when considered alongside the period it has taken other countries to progress from initial legislation to actual universal coverage.[165] A World Health Organization (WHO) discussion paper found that the average period of time it took from the first health insurance related law to the final law enacting full coverage was 70 years. For instance, Austria took 79 years (1888–1967) to implement universal coverage, Germany 127 years (1854–1988), and Belgium 118 years (1851–1969). Only Japan and the Republic of Korea achieved universal coverage in less time, with Japan achieving coverage in 36 years (1922–1958) and the Republic of Korea 26 years (1963–1989).[166]

Affordability

Nations that have implemented functioning health insurance systems are united by common characteristics, such as developed economies, high levels of income, low unemployment levels and large and stable taxpayer bases.[167]

South Africa suffers from massive unemployment levels, low monthly income levels, and a very small tax base. In 2008, South Africa's Gross Domestic Product (GDP) was $276 billion. In that same year, Japan had a GDP of $4 910 billion and Germany of $3 673 billion.[168] The discrepancy between South Africa and other health insurance countries becomes even more palpable when comparing wages and levels of unemployment.

In 2010, 25% of South Africa's population (4.3 million people) were unemployed based on the official definition.[169] Conversely, Germany had an unemployment rate of 8% while Austria had one of 5%.[170]

The average monthly wage of a South African is also relatively small. The 2009 edition of Prices and Earnings by the Union Bank of Switzerland (UBS) conducted a wage comparison of 73 international cities. In terms of gross income per hour employees in Johannesburg receive $6.70, compared with $32.80 in Copenhagen, and $30.30 in Zurich.[171]

Finally, the greatest cause for concern is South Africa's tax base. As previously mentioned, just 5.3 million people are registered taxpayers.[172] By contrast, there is an expanding social welfare group. For example, the number of social grant recipients increased by 5.7% from 12.3 million in 2007/2008 to 13 million in 2008/2009. The latter figure constitutes 26.5% of the population. The financial responsibility for these social grant recipients falls primarily on the shoulders of the 5.3 million individual taxpayers as personal income tax (PIT) constitutes the greatest proportion of total tax revenue (29.5%). Value added tax (VAT), which constitutes the second largest portion of tax revenue (26.3%), and corporate income tax (CIT), which constitutes the third largest proportion of total tax revenue (24.5%), also share the financial burden.[173] Basically, universal health coverage will increase the financial load on taxpayers.

Calculations by Professor

Servaas van der Berg and Professor Heather McLeod of Stellenbosch University revealed that a conservative estimate of required revenue would entail a more than 17% increase in payroll tax. On the other hand, if the NHI is to be funded by income tax alone, a blanket 85% increase in tax rates would be required.[174]

The development gap between South Africa and developed countries with universal health coverage is extremely wide. As Renfrew Christie, dean of research at the University of the Western Cape concluded, NHI is a 'rich country solution'.[175]

Human Resources

The South African health sector suffers from significant shortages of healthcare workers. The current strain exerted by these shortages will become more severe under the NHI system, as the demand for healthcare providers is anticipated to increase dramatically. According to Econex, the application of universal coverage and the elimination of co-payments under NHI would require 10 000 more GPs and between 7 000 and 17 000 more specialists.[176] The number of health professionals graduating from South African universities is insufficient for current health demands, let alone anticipated increases under the NHI system.

Comment by political parties

The South African Communist Party (SACP) firmly supports the proposed NHI system with its universal coverage and no up-front payments. The general secretary of the SACP, Blade Nzimande, referred to those opposing the NHI as 'capitalist vultures' that 'thrive on people's illness to make huge profits'.[177] He called on people to mobilize in an effort 'to counter the reactionary efforts by the capitalist classes in the private health sector to defeat or undermine government's efforts towards the establishment of the NHI'.[178]

The Democratic Alliance (DA) strongly objects to certain aspects of the ANC's NHI proposal. In a press release in June 2009, the shadow minister of health, Mike Waters, highlighted a number of concerns such as the cost of the system, the lack of transparency surrounding its development, and the five-year implementation period. Waters is particularly critical of the lack of consultation and discussion surrounding the proposal, calling the process 'fundamentally undemocratic'.[179]

4. No medical aid for the emerging African middle class

The removal of economic constraints and the subsequent integration of all population groups into South Africa's economy has enabled an African middle class to emerge. However, in spite of increasing income levels and growing purchasing power, medical aid has not featured heavily in African middle class consumption.

The reasons behind such an inconsistency may find their root in an asset deficit. Until the African middle class has acquired assets already owned by the established middle class groups, they may continue to neglect medical aid as a consumption priority.

Rising income levels in recent years among the emerging African middle class have not been accompanied by typical middle-class spending patterns. Medical aid is one area that does not feature largely in African middle-class spending habits.

The rate at which the emerging African middle class is growing is extraordinary. As shown in Figure 3, in 2004, Africans, as a proportion of South Africa's total core middle class,[ii] stood at 11%. By 2006 this share had grown to 15%, by 2007 to 20%, and by 2009 to 31%. The growth of the African middle class continues to set new international records for emerging middle class expansion.[180]

Personal disposable income (PDI), which refers to income in cash after income tax,[181] has exhibited steady increases across all population groups. The

African share of total PDI has risen significantly. As shown in Figure 4, the African population group's share of total PDI was 23% in 1960 compared with 69.4% for the white population group. Since then, African PDI share has risen by 100% to 46.5% in 2007, while the white PDI share has decreased by 71% to 40.4% in 2007[182] (Figure 5).

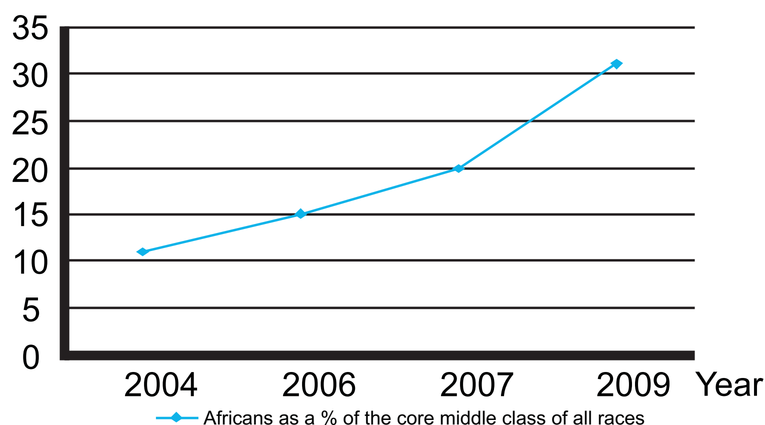
Increases in income have been accompanied by increases in the number of African bank accounts. In 2006 some 10.7 million Africans had bank accounts. This number grew by 26.2% to 13.5 million in 2007. Consequently, 56% of the African population had bank accounts in 2007.[183]

The Mzansi bank account programme has been particularly successful in increasing the number of African bank accounts with 12% of the African population holding Mzansi accounts.[184]

The African contribution to total household consumption increased from 36% in 1993 to 42% in 2003. Furthermore, it is the African middle class that has driven the expenditure increases credited to African households.[185] A study conducted by the UCT/Unilever Institute of Strategic Marketing and TNS Research Surveys showed that just 12% of the country's African population (the emerging African middle class) were responsible for 54% of all African buying power.[186]

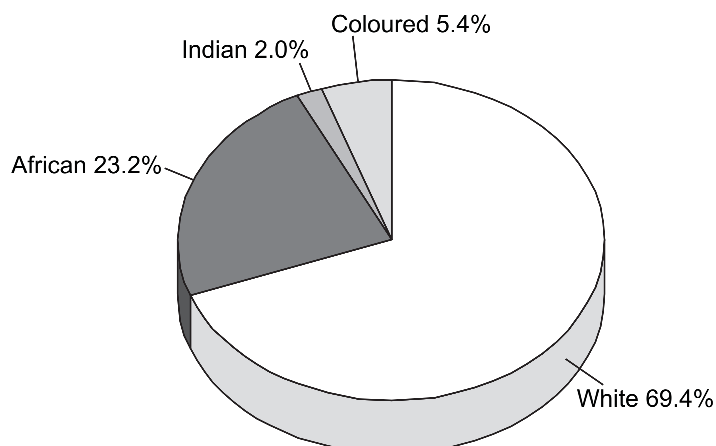
The growing purchasing ability of African households has made possible increased African ownership of various assets. For instance, the number of vehicles owned by African urban households increased from 2 854 000 in 2004/2005 to 4 196 000 in 2006/2007.[187] This is an increase of 47% over just three years. In 1996 only

FIGURE 3: AFRICANS AS A PERCENTAGE OF THE CORE MIDDLE CLASS OF SOUTH AFRICA



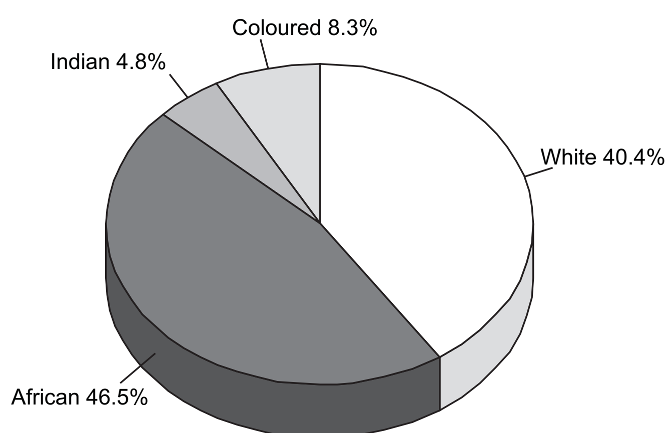
Source: *Schlemmer, 2009*

FIGURE 4: PERSONAL DISPOSABLE INCOME (PDI) SHARE BY RACE, 1960



Source: *South Africa Survey 2008/2009: 283*

FIGURE 5: PERSONAL DISPOSABLE INCOME (PDI) SHARE BY RACE, 2007



Source: *South Africa Survey 2008/2009: 283*

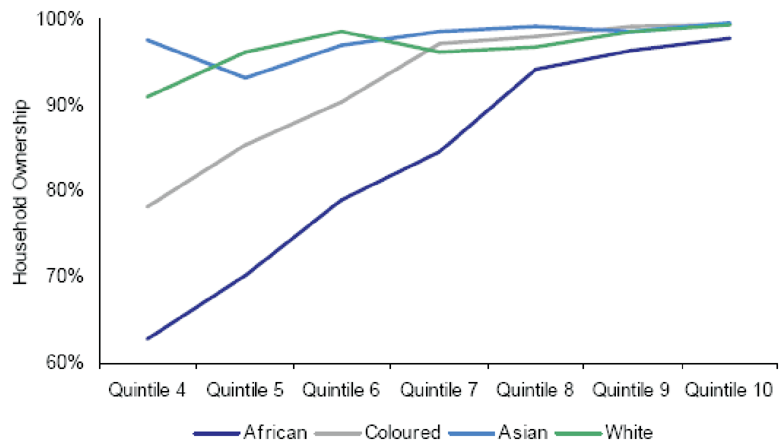
0.4% of the African population had access to cellular phones. However, by 2007 this number had expanded to 70.8%.[188]

The same upward trend is reflected in the ownership of semi-durable goods such as television sets and washing machines. Standard Bank published a paper on African consumption using data from the All Media and Products Survey (AMPS) by the South African Advertising Research Foundation (SAARF). The AMPS data assessed the ownership of certain goods over a period of time and across population groups. The data divided the population into ten income quintiles.[189] Figures 6, 7, and 8 illustrate the ownership trends of certain semi-durable goods among African households compared with other population groups.

The figures show that the highest income quintile has the highest ownership percentage of goods. The white population group consistently displays the highest prevalence of goods ownership across each quintile, while the African population displays the lowest ownership of goods. However, the figures show that as African income levels increase, so too does their consumption of semi-durable goods.

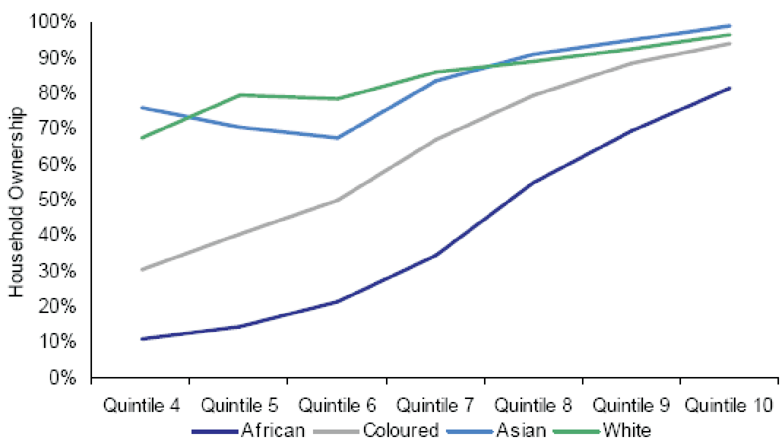
Rising African income levels and patterns of consumption and expenditure have not, however, been matched by increasing levels of medical aid expenditure. According to the *2005/2006 Income and Expenditure of Households* survey released by Statistics South Africa, Africans spend the least on insurance associated with health (see Figure 9). While the numbers in this survey are hotly contested, the figures do give an

FIGURE 6: OWNERSHIP OF A TELEVISION SET, 2006



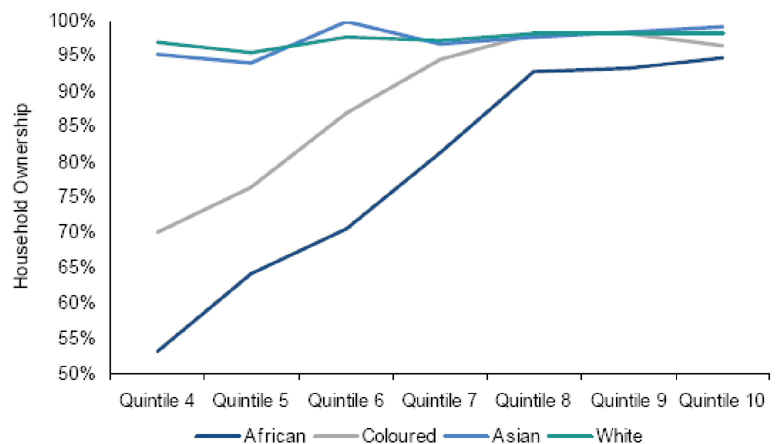
Source: *Standard Bank, Research Economics, 2007: 27*

FIGURE 7: OWNERSHIP OF A WASHING MACHINE, 2006



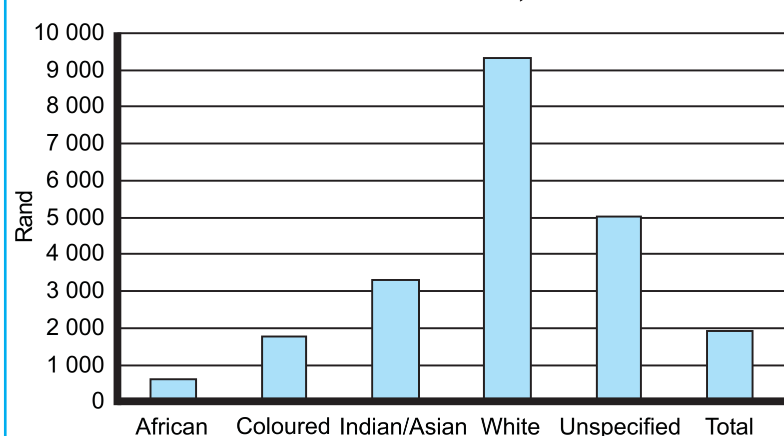
Source: *Standard Bank, Research Economics, 2007: 28*

FIGURE 8: OWNERSHIP OF A REFRIGERATOR, 2006



Source: *Standard Bank, Research Economics, 2007: 27*

FIGURE 9: AVERAGE HOUSEHOLD CONSUMPTION EXPENDITURE ON INSURANCE ASSOCIATED WITH HEALTH BY POPULATION GROUP, 2005/2006



Source: *Statistics South Africa, Income and Expenditure of Households 2005/2006, 2008*

indication of levels of expenditure across population groups.

The recorded number of African medical aid beneficiaries reflects this limited expenditure. For instance, in 1999 some 2 810 000 Africans were covered by medical aid.[190] In 2004 some 2 665 000[191] Africans were so covered. This number decreased to 2 623 000 in 2005[192] before increasing slightly to 3 223 000 in 2008.[193]

Consequently, in 2008 just 8.4% of the African population was covered, compared with 64.8% of the white population and 21.5% of the coloured population. Furthermore, the proportion of the African population covered by medical aid in 1999 is almost identical to the proportion covered today.

Since the late 1990s, the number of African medical aid beneficiaries has remained stagnant, rising from 8.3% of the African population in 1999 to just 8.4% in 2008. This small proportion seems at odds with the growth in African income and the subsequent rise in expenditure and consumption.

One possible explanation is the asset deficit resulting from the socio-economic constraints of apartheid. In a working paper for the Bureau of Economic Research of the University of Stellenbosch, Sihaam Nieftagodien and Servaas van der Berg maintain that different consumption patterns illustrated by the African middle class compared to their counterparts in other population groups may stem directly from previous material deficiency rather than a difference in consumer preference.[194]

Rising levels of African income are accompanied by spending patterns based on acquiring certain assets that have not previously been owned. As a result, the purchasing of health insurance is put on hold until they are able to 'catch up' on other areas of consumption. The economic backlog created by apartheid has meant that while the African middle class may mirror other middle class groups with regard to income they do not do so with regard to their collection of assets.[195]

Medical scheme contributions are expensive. As noted previously, in 2009 the average monthly gross contribution for a medical scheme member was R1 280, while a family of three would on average pay R2 497 per month.[196] This expenditure is typically confined to those with middle to higher income levels. Therefore, the African middle class may forgo purchasing medical aid while it sets about acquiring assets such as refrigerators and vehicles that they have yet to own. Other population groups, and in particular whites, have had time to accumulate certain assets. As a result, their consumption priorities differ from those new members of the middle class.[197]

In light of this asset deficit, African middle-income consumers may choose to settle their medical needs through out-of-pocket spending. Although accurate data is elusive, it is estimated that out-of-pocket payments for healthcare account for more than 14% of all healthcare expenditure.[198] Equally poor data exists with regard to the number of individuals utilizing this form of healthcare financing, yet it is estimated to be a sizeable portion of the population. Johan Biermann of the Free Market Foundation maintained that at the turn of the century 36% of the population paid directly for their health needs.[199]

WRITTEN BY LISA HAAGENSEN

References available on request from Martin Matsokotere E-mail: *martin@sairr.org.za*

Fast stats

LATEST FORECASTS

GDP growth 2010	3.3%	Barnard Jacobs Mellet: no change; OECD[a]
	3.0%	Reuters Econometer: revised upwards from 2.9%; FNB
	2.8%	Nedbank: no change
Headline inflation rate (CPI) 2010 (average)	5.4%	Nedbank: revised downwards from 5.5%
	5.2%	Standard Bank: no change; Barnard Jacobs Mellet
	5.0%	FNB: no change
Expected CPI (business) 2010 (average)	7.1%	BER: revised downwards from 8.6%
(trade unions)	7.0%	BER: revised downwards from 8.2%
Producer price inflation 2010 (average)	6.6%	Standard Bank: no change
	5.3%	Reuters Econometer: no change
Imported producer inflation 2010 (average)	4.9%	Absa: no change
Gross fixed capital formation 2010	up 2.0%	Standard Bank: no change
	up 1.7%	Barnard Jacobs Mellet: no change
	down 1.6%	Nedbank: no change
Final consumption expenditure by households 2010	up 2.4%	Standard Bank: no change; Nedbank
	up 1.6%	Barnard Jacobs Mellet: no change
Government consumption expenditure 2010	up 4.2%	Barnard Jacobs Mellet: no change
	up 3.0%	FNB: no change
Gross domestic expenditure 2010	up 4.2%	Nedbank: no change
	up 3.5%	FNB: no change
Exports 2010	up 15.0%	FNB: no change
	up 4.6%	Nedbank: no change
Imports 2010	up 12.0%	FNB: no change
	up 7.3%	Barnard Jacobs Mellet: no change
Current account deficit 2010	R119.5bn	Nedbank: revised downwards from R120.3bn
	R103.8bn	Absa: no change
— as proportion of GDP 2010	4.5%	Nedbank: no change; Reuters Econometer
	3.7%	Standard Bank: no change
Capital account surplus 2010	R135.0bn	Nedbank: no change
Prime overdraft rate 2010 (year end)	10.0%	Barnard Jacobs Mellet; FNB; Standard Bank; Nedbank
R/€ exchange rate 2010 (average)	10.10	Barnard Jacobs Mellet: revised from 10.62
	9.50	FNB: revised from 10.00
R/$ exchange rate 2010 (average)	7.85	Nedbank: revised from 7.67
	7.50	Barnard Jacobs Mellet: revised from 7.51; FNB
Gold price per ounce 2010 (average)	$1 181	Barnard Jacobs Mellet: no change
	$1 100	FNB: no change
Nominal wage rise 2010	8.1%	BER: revised upwards from 7.8%

a The Organisation for Economic Co-operation and Development (OECD).

These forecasts contain the highest and lowest estimates available to us.

Our Fast stats pages are compiled by Tamara Dimant, Head of Information, phone (011) 482-7221 x 2016, fax (011) 482-7690, e-mail tdimant@sairr.org.za