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The Nation's State of Health

1. Introduction

As the fourth Parliament of South Africa came to the end of its mandate, there was a flurry of activity as all outstanding matters needed to be finalised and Bills passed, reports tabled and adopted, and finality brought to all matters. The state of health services came under particular scrutiny, and health minister Aaron Motsoaledi, and deputy minister Gwen Ramokgopa, turned up several times with high powered teams from the various councils, commissions and offices of the Department of Health to deal with reports, including those from the Finance and Fiscal Commission (FFC) and from the Auditor General. What these provided was a fairly comprehensive view of the state of South Africa's health services, which shows very serious challenges and weaknesses, but which also gives hope of improvement from some of the direst conditions.
Overall comment about the National Department of Health was very positive from both the FFC and the Auditor General. The provincial departments, which carry out most of the work of health services provision, and which spend most of the money, appear to be the sites where the greatest challenges remain.

The Auditor General's report at the end of 2013 shows a mixture of both extraordinary improvement and some areas of serious concern. The worst problem was on irregular expenditure, which has been steadily increasing to a present high of R7.8 billion. In 2012 about 25% of all spending was classed as irregular. This does not mean that money was stolen or misused, but simply that proper spending processes were not followed. Unfortunately, it also means that systems guarding against wasteful expenditure were not followed: in one example, a hospital was paying R300 for a bag of potatoes, while the average price is less than R50.[i]

2. Finance

The health budget for 2012/13 was R134.3 billion, with the budget for 2014/15 set at R145.7 billion and the estimate for 2015/2016 R155.1 billion.[ii] To avoid under-spending, the treasury has asked all provinces to submit spending plans two years before any financial allocations are made to them. R41 billion was spent on HIV/Aids programmes over the past five years, and R43.5 billion is budgeted over the next three years. R39 billion was spent on 1 879 hospital and other health facility projects, and R26 billion is allocated over the MTEF period ahead.[iii] The funds allocation to HIV/Aids programmes reveals the tragic crisis that still burdens the country and explains why, even though South Africa spends more money on health than comparable countries, it has worse health outcomes: the burden of HIV/Aids distorts expenditure and its impact.

3. A Paradigm Shift

Since 1994, the main theme in health has been to shift the focus of health provision from one that was hospital centred to one that is more primary care based. The idea behind this is that if health services provision could address health problems closer to communities, and before they become serious, there would be far less need for expensive tertiary care; society would be much healthier and high medical care costs could be reduced. The setting up of primary health care centres and clinics has been a mark of this shift in focus. However, there has been an even more radical shift behind the scenes. The creation of a Deputy Director General of primary health care is seen as a huge change in the importance of primary care. For example, new guidelines and rules have been put forward, drastically reducing the levels of salt in processed foods in an attempt to reduce cases of high blood pressure, strokes, and kidney failure.

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According to the Heart and Stroke Foundation South Africa, reducing salt intake by 2 grams a day reduces chances of cardiovascular event by 20%.[iv] South Africans consume an average 8 grams of salt per day, with some consuming up to 40 grams, while the World Health Organisation (WHO) recommends less than 2 grams per day.[v]

Beyond promoting dietary changes, the Department of Health has been promoting changes in the training of doctors, with a greater focus on primary care training. The training of South African medical students in Cuba, which focuses greatly on primary care, and the recruiting of many Cuban doctors to work in the country, has also been part of that strategic shift towards primary health care.

This allocation of Cuban doctors to rural health centres has been another strategic response from the Department; but this response is more complex than simply supplying doctors for 'dorpies'. One of the biggest problems in health is the issue of the migration of skilled African health professionals, including South Africans, to more developed countries. In turn, doctors and nurses from poorer African countries have been attracted to South Africa. In 1998 the Department of Health introduced rules designed to discourage the recruiting of African health professionals, but this has created conflict as African health professionals, legally settled and living in South Africa, have found it extremely difficult to be employed in the health sector. On the one hand the demand to employ foreign African professionals has increased, but on the other, some African countries are calling on South Africa not to 'poach' their professionals and to send them back home. Looking for a solution, the Department has made agreements with some other African countries to help secure Cuban doctors to work elsewhere on the continent. This is welcome but it still does not deal with the major question of how to deal with migrating health professionals. There is hope that with the introduction of the National Health Insurance scheme (NHI), and the improvements that will hopefully go with it, more South African professionals will be encouraged to stay and work in the domestic health service.

4. 'Lawyers Are Killing Doctors'

Minister Motsoaledi has expressed great concern about the crisis in securing and training obstetricians and gynaecologists. He told Parliament's committee on health[vi] that South Africa is going through a crisis in these specialities as doctors are leaving them and younger doctors are reluctant to enter them. This he attributed to an explosion in litigation against medical practitioners, especially neurosurgeons, obstetricians and gynaecologists, and to the fact that the insurance required to cover a practice has increased to prohibitive levels. This is due mainly to the complex nature of medical procedures in these areas, which opens doctors up for accusations of malpractice. The minister places the blame on lawyers, accusing them of shifting from 'litigating the Road Accident Fund to bankruptcy' to litigating doctors out of these specialities.

The US experience with litigation in the health field should be a warning to South Africans. When medical practitioners begin to over-prescribe and to recommend that every conceivable medical test be done, simply to cover the possibility of being sued for negligence, the cost of health care will rise to crisis levels. When doctors are afraid to treat patients for fear of lawsuits, the law stops being a vehicle for upholding standards and punishing negligence, and becomes instead a source of fear and of improper health provision. With the advent of the NHI it would be a tragedy if the resources of the state went to paying legal fees and not to health provision. Towards the end of 2012, the Gauteng Provincial Department of Health was facing over a billion rand in legal costs.[vii] This is simply unacceptable in a country where access to health care is so inadequate, with a life expectancy allegedly lower than that of Zimbabwe or Afghanistan.[viii]

There are two issues here. The first is whether South Africa is in the grip of a culture of greed where the making of as much money as possible trumps all other values. If profiteering and collusion constitute 'business as usual', then the country has no right to complain about litigation. The second is whether the country has public servants (not just in the health services) who have no sense of professionalism, who are often lax in standards, and who fail to carry out simple tasks diligently. If so, then the country has no right to complain about litigation.

5. Private Health Care

Besides generally rising legal costs, accusations of profiteering have been made against the private health care sector due to care costs that have been escalating quickly and becoming prohibitive. Since

the private sector caters for 17% of the population[ix], its role is crucial, especially going into the future with the NHI. Responding to these concerns, the Competition Commission is conducting a full-scale market inquiry into the private health care sector, similar to the inquiry into banking charges. This began in November 2013 and is expected to take up to two years.

Several studies have been undertaken in preparation for the competition commission inquiry, looking into the nature and dynamics of the private health care industry[x] in order to gather foundational information. These reviews give a fairly good picture of the state and nature of the private health sector. The many issues raised can be grouped into three categories: 1. Healthcare Providers; 2. Financing, administration and managed care services; 3. Consumables.

1. Healthcare providers: This category covers primary healthcare providers; specialists; hospitals; emergency service providers; and supplementary service providers.
2. Financing, administration, and managed care services. This includes medical scheme administrators, the managed care providers, and the brokers who market schemes and advise individual and corporate customers.
3. Consumables. This includes pharmaceutical products and other medical consumables, including their wholesale and retail distribution.

The category of consumables has come under considerable regulation and discussion, especially regarding the pharmaceutical industry, with the passing of the Medicines Act of 1997, and the rules allowing for parallel importing of medicines. In this category the question of the cost of support services might have to be looked at, especially in terms of hospital costs beyond simply pharmaceuticals.

The question of financial issues and administration, especially in relation to the medical aid schemes, has also been an ongoing discourse. The fact that medical aid schemes are non-profit and exist within a fairly competitive market has made the discourse less controversial, but the question of escalating cost is one that is still in need of serious discussion.

Finally, the issue of the actual cost of private health care provision has yet to be addressed adequately. On the one side there are the health professionals who sometimes complain that they are not remunerated enough for their skill, professional work, and their long, stressful years of training, often at great cost. On the other side are their patients, who often complain that some of the service providers charge extraordinarily high prices because they know that the patient has little choice, since the service they require is often at a critical time of illness.

Finally, a lack of transparency in terms of the pricing of services, where the users of medical services are often making decisions without the ability to compare pricing, is a controversial issue. The question of competitive pricing has both positive and negative sides. Driving up prices might exclude many from receiving care, while driving prices down might mean sub-standard care. Finding the right balance lies at the heart of a sustainable health care system.

6. Statutory Bodies

6.1. The Compensation Commissioner for Occupational Diseases (CCOD)

The CCOD, which is responsible for the payment of benefits to injured miners, and active and ex-mine workers who suffer from lung-related diseases as a result of exposure to hazardous conditions at work, has come in for serious criticism. The commission failed to submit annual financial statements for 2011-12 and for 2012-13; even the 2010-11 audit report had still not been tabled in Parliament in 2013. The Department of Health is in the process of trying to sort out the mess; it has brought in the former executive director for the National Institute of Occupational Health (NIOH), Barry Kistnasamy, to try to turn things around. In simple terms, there was a serious breakdown and the department has had to be rebuilt almost from scratch. Dr Kistnasamy will be responsible for improving co-ordination between the NIOH, the Medical Bureau for Occupational Diseases and the CCOD.[xi]

6.2. The Council for Medical Schemes

The Council for Medical Schemes is a statutory body established by the Medical Schemes Act 131 of 1998 to provide regulatory supervision of private health financing through medical schemes. There are some 97 medical schemes with around 8.7 million beneficiaries.

In its 2012 annual report, the Council noted with concern the ever-escalating costs in the industry, exceeding inflation, and apparently driven by hospitals and specialists. It proposes the establishment of a price regulator to oversee price determination in the private health sector.
The medical aid sector, according to the Council, is in a very sound condition. The prescribed minimum benefits are revised by the Department of Health every two years, and the minister has indicated that primary health care services should be included as prescribed minimum benefits. This, and many other aspects of the medical aid schemes, will probably have a great effect on the final shape and working of the NHI.

A note of caution comes from the Board of Healthcare Funders, which has noted a rise in organised crime within the industry.[xii] But despite this, the Council itself has received its 12th unqualified audit in a row. Thus, if the Council is anything to go by, it seems that at least this sector is in a good position to provide the kind of supportive collaboration, expertise, and experience that the NHI will need going forward.

6.3. The SA Medical Research Council

There was a very good report from the Auditor General about the Council, and the Minister was very positive and happy about not only the progress that the Council had made in rebuilding itself as an organisation in terms of public management efficiencies, but also that the Council was involved in new research projects of national benefit.

6.4. The National Laboratory Health Services

The NLHS provides the largest diagnostic pathology service in South Africa, to about 80% of the population. The National Institute for Communicable Diseases, the National Institute for Occupational Health, the National Cancer Registry and the South African Vaccine Producers, which houses the Antivenom Unit, are all divisions of the NHLS. The NLHS received a clean 2012/2013 audit from the Auditor General, but the service is facing a great challenge of getting provincial departments to pay billions owed for services rendered.

7. National Health Insurance (NHI)

Though the Minister and the national Department of Health re responsible for health, actual delivery is in the hands of the provincial departments, and thus their failures are at the heart of many of the problems and challenges facing health provision in the country. Unfortunately, the problems in the provinces are issues of both skill and political will. 60% of provincial budgets are spent on human resources, and this means that improvements in human capacity and efficiencies will be the biggest determinant of cost to the NHI.

Some provinces are failing on audits, with Limpopo being in the worst condition. However, the Minister has given as assurance that national government intervention had reinforced reporting structures and that the situation is not as dire as before. For example, the Northern Cape, though it received a qualified audit, was praised for breaking 11 years of disclaimers by significantly improving systems and processes.

Added to this is the huge need for upgrading the provincial support infrastructure necessary for proper functioning of all health services. Water; electricity; roads; maintenance and repair services; communications services; access to basic supplies such as pens and paper: all depend on integrated provincial services without which the NHI will end up as a service to urban areas, and the poor in the rural and outlying areas will continue to suffer substandard health care.

From May 2011 to May 2012, an audit of public health facilities was done[xiii]. The audit assessed infrastructure; classification of facilities; compliance to priority areas of quality and function; human resources; access and range of services offered; and geographic positioning (GPS) for location of facilities. The picture painted was a mixed one, revealing what everyone already knew about the dire state of health services in general and in specific areas. In general, Gauteng seemed to fare better and the Northern Cape fared worst. The Eastern Cape also had huge challenges.

In response to this, 11 pilot districts were identified and over a R1 billion was spent on upgrading facilities as part of the first phase of the NHI. The upgrading and improvement of facilities, some of which were in a terrible state, is a major step in ensuring that people actually use public health facilities and services, and that the facilities can offer quality service of a high standard.
An Office of Health Standards Compliance has been established and tasked with monitoring health norms and standards. This is intended to ensure that there is a level of uniformity of service across the NHI. It will also ensure that the kinds of

litigation seen in the basic education sector regarding norms and standards will be avoided.

8. Conclusion

While recognising the enormous challenges the country faces regarding health, it can be safely agreed that the general direction adopted is the right one. Success will require the buy-in of all stakeholders, including the security services to ensure that precious resources are not stolen, and that those given the responsibility of carrying out the work do it with professionalism and dedication.

At the heart of the National Development Plan is a vision of reducing income poverty and inequality, and of bringing down the Gini coefficient. Providing affordable access to quality health care, promoting primary health and overall wellbeing, and building the NHI, are the means to achieve this vision. Moreover, there should be a change in the social perception of what health care means, changing the idea that good health care means expensive tertiary hospitals, and increasing the value of preventative health practices. The improvement of the quality of public health facilities; the reduction of health care costs; and finally the improvement of the general health of the population, are goals we urgently need to achieve. In doing this, the country would be taking a major step towards a more equal and more just society to be enjoyed by all.

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[i] National Department of Health Report submitted to Parliamentary Portfolio Committee on Health in 2013
[ii] http://www.treasury.gov.za/documents/national%20budget/2014/review/FullReview.pdf
[iii] http://www.treasury.gov.za/documents/national%20budget/2014/speech/speech.pdf
[iv] http://www.heartfoundation.co.za/media-releases/salt-killing-south-africans-and-it-time-take-action
[v] SA News http://www.sanews.gov.za/world/new-guidelines-dietary-salt-potassium
[vi] Portfolio Committee on Health, Parliament, October 2013
[vii] Times Live newspaper http://m.timeslive.co.za/thetimes/?articleId=7267242
Gauteng Provincial Government
http://www.gautengonline.gov.za/Publications%20and%20Reports/FINAL%20Annual%20Report%20OOP.pdf
[viii] Index Mundi http://www.indexmundi.com/g/r.aspx?c=sf&v=30
NOTE: Life expectancy has increased significantly in 2013, rising to 57,7 years for males and 61,4 years for females according to Stats SA. http://www.statssa.gov.za/publications/P0302/P03022013.pdf This is due mainly to successes in Hiv/Aids programmes
[ix] Paragraph # 1.2
http://www.compcom.co.za/assets/Healthcare-Inquiry/Review-of-Competition-in-the-South-African-Health-System.pdf
[x] Three studies referred to are:
A competition Commission of South Africa Review by: PAMELA HALSE, NONKULULEKO MOEKETSI, SIPHO MTOMBENI, GENNA ROBB, THANDO VILAKAZI and YU-FANG WEN.
A study by: GENESIS ANALYTICS
A Study by: Prof Alex van den Heever, Chair of Social Security, Graduate School of Public and Development Management, University of the Witwatersrand.
[xii] http://www.samj.org.za/index.php/samj/article/view/5693/3905
[xiii] All health centres across the country, except 20 in the Western Cape were audited.

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