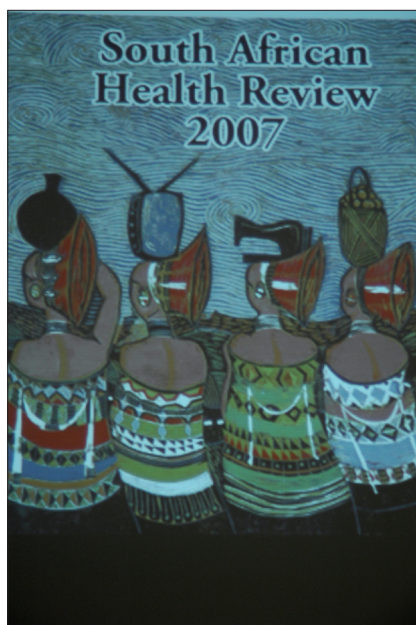




PRIVATE SECTOR CANNOT BE LEFT TO 'OWN DEVICES'



The government must develop a 'clear road map with time frames' for harnessing the resources of both public and private sectors, while the latter 'cannot be left to its own devices' to exercise the progressive realisation of the right to health care for patients.

Unlike previous years, the latest Health Systems Trust (HST) document focuses sharply on the role of the private sector within the national health system, described by several HST academics at the launch as 'long overdue'.

This is one of the core 'take home messages' of the 2007 *South African Health Review (SAHR)*,¹ launched at the Cape Town waterfront in early December last year.

Other core messages included the urgent need for greater clarity on government's intentions for mandatory health insurance, supported by risk and income-based cross-subsidies.

The authors maintain that all stakeholders 'need to recognize the national health ministry's responsibility

to exercise stewardship of the entire health system, public and private'. Unlike previous years, the latest Health Systems Trust (HST) document focuses sharply on the role of the private sector within the national health system, described by several HST academics at the launch as 'long overdue'. The predominant civil society/media focus had long been on public sector shortcomings, diverting attention from 'critical questions' relating to the role and function of the private sector. These include whether private sector models of health service represent the 'gold standard', whether the private sector is sustainable in the medium-to-long term, and whether some challenges in the public sector cannot be laid at the door of an under-regulated private sector.

Significant gaps that remained in health policy and legislation included the 'urgent finalisation' of a Certificate of Need and other National Health Act regulations, an urgent review of the prescribed minimum benefit package in the Medical Schemes Act regulations and the establishment of an office of Standards Compliance in the Department of Health. Health expenditure on medical scheme beneficiaries is currently 6.6 times greater than that on persons wholly dependant on the public sector.

Private sector 'fiercely resisting' change

In their editorial the compilers say that whenever government introduced interventions aimed at curbing private health sector abuses or shaping it to contribute to overall national health policy objectives, 'this was typically met (with either) fierce resistance or alternatively measures to dilute regulatory efforts'. They cite the Medical Schemes Act, the medicine pricing regulations and statements of intention to regulate private health costs.

While the private health sector consumed 60% of the health spend

it was primarily funded through contributions to medical schemes, providing health insurance coverage to just 7 million beneficiaries (of the 47 million population). The review says that over R100 billion was spent locally on health care in 2005 – equivalent to some 7.7% of the country's GDP, 'reasonable by international standards' but with relatively poor health outcomes. This masked a 'huge distortion' in the allocation of financial resources between the public and private sectors.

In the private sector, cost escalation and affordability were the 'key issues'.

The private sector needed to play a 'far greater role' in HIV/AIDS and TB prevention strategies and there was a need to model partnerships to deliver comprehensive disease management programmes.

Authors of the chapter on private hospitals recommend greater transparency in pricing, prohibitions on perverse incentives for doctors and measures to redress imbalances in negotiating power between medical schemes and private hospitals.

They also called for a national private hospital licensing framework and a review of the Health Professions Council of South Africa's restrictions on the salaried employment of doctors by private hospitals. The review says the private sector needed to play a 'far greater role' in HIV/AIDS and TB prevention strategies and that there was a need to model partnerships to deliver comprehensive disease management programmes. There was also a glaring lack of an integrated and comprehensive sexual and reproductive health care approach in the private sector.



Dr Thobile Mbengashe, CEO of the Health Systems Trust, at the annual SA Health Review launch.

Picture: Chris Bateman

Recognise traditional medicine

Guest editor Stephen Harrison pointed to the 27 million black South Africans (72%) 'from a diverse range of socio economies' who made use of traditional healers.

There are estimated to be 150 000 diviners, herbalists, prophets, faith healers, traditional surgeons and birth attendants. Some 20 000 tons of medicinal plants were consumed annually, most of them harvested in the wild and not replaced, creating a trade worth R2.9 billion annually. There was little public or private investment for an industry on which 133 000 households were dependant.

The authors of this section recommended that existing market players develop their own industry and technology for wild plant harvesting, farming, storage, packaging and treatment. This could be done via bursaries, research funds, market infrastructure development and processing facilities. 'Where appropriate' pharmaceutical manufacturers should be encouraged to

secure ownership rights of technologies that are developed.

While there had been 'significant' legislative and policy progress in integrating traditional and complementary medicine into the health system, 'more must be done'.

They recommended full integration of these practitioners into the system.

In his response to the SAHR, Advocate Kurt Worrall-Clare, chairperson of the Public Healthcare Forum (PHF) (representing the key private health care stakeholders), said his organisation was identifying processes for increased affordability of health care.

The PHF backed efforts to establish medical schemes for low-income earners but he stressed that the 'overarching principle' should be one of partnership. His organisation was 'eager' to contribute to discussions on changes to the regulatory framework, best achieved when all stakeholders were 'fully engaged in the process of formulating applicable law'. The PHF 'reaffirmed' the need for critical partnerships and strategic uniformity among stakeholders.

He ended by saying he hoped the review would stimulate more informed debate and inspire closer working relationships between the private and public health care sectors.

In the review's section on health indicators, African women still bore the brunt of nearly all major health problems, with over half expected to die by the age of 60 – compared with just 15% of white women.

Caesarean rates dramatically illustrated the gap between private and public health care services, with 62% of births by this method in the private sector and just 17.7% in public hospitals (UK, USA and Australia caesarean rates are just over 20%).

HIV/AIDS killed triple the number of women between the ages of 20 and 39 from 1997 to 1994, while the death

rate for men between 30 and 44 doubled over the same period.

HIV reflects segregated past

South Africa's racial legacy was dramatically highlighted in a breakdown of the HIV rate. Among blacks it was double that of whites and Indians, with an estimated 16% of blacks aged 15 - 49 living with HIV, compared with 5.6% of whites and 2.7% of Indians. By February 2007 just over one-third of those in need of antiretroviral medicine were actually on treatment, with children particularly underserved.

HIV/AIDS killed triple the number of women between the ages of 20 and 39 from 1997 to 1994, while the death rate for men between 30 and 44 doubled over the same period.

Between 2001 and 2005 the rate of children whose mothers had died doubled.

There are now an estimated 1.2 million maternal orphans, with black children in KwaZulu-Natal (KZN) worst affected. Some 8.3% of children (mainly Zulu) in KZN under 14 are motherless, while this figure for black children nationally stands at 6%.

The Eastern Cape had by far the worst infant mortality rate (68.3 deaths per 1 000 births) in 2003, and although this had improved to 60 per 100 000 three years later, it remains the worst in the country.

The homicide death rate for men in 2004 (96 per 100 000) was the second highest in the world, after Columbia. South Africa had 9 times the global average for violent deaths of young men aged 15 - 29, with assault rates the worst in the Northern and Eastern Cape.

1. Health Systems Trust. *South African Health Review 2007*. <http://www.hst.org.za/publications/711>

Chris Bateman