National Health Insurance

Remedy for equity in health care

In its submission to the Department of Health on the National Health Insurance (NHI) green paper, the **National Education Health and Allied Workers Union (Nehawu)** argues that NHI will improve access to health for workers and the poor who have been left stranded by the current health policies.

Nehawu welcomes the NHI as a cornerstone to providing access to health care. More so because it is based on the principles of universal access for all South African citizens and recognises health as a human right as defined in the Constitution.

The creation of NHI and the broader transformation of the health system in terms of the 10-point plan of government must be prioritised. Health is also one of the five priorities of the African National Congress's (ANC) 2009 manifesto. The ANC's decision at Polokwane in 2007 to implement NHI was ground-breaking as it departed from just carrying out research on it.

However, universal access can only be achieved when government provides resources and capacity that is needed to transform the health system. Whilst Nehawu agrees with government on the importance of NHI, it must be remembered that this is but only one aspect of a comprehensive social security system.

LABOUR CAMPAIGNS

As early as 1997 a Congress of South African Trade Unions (Cosatu) policy conference called for 'a national health care system' and 'affordable medicines for all.' In 2000 the Cosatu 7th National Congress adopted a resolution that committed to fight for NHI. Cosatu also objected to Social Health Insurance (SHI) implementation, citing that the policy would make the poorest in society and the working class pay more for health care. SHI and the Medical Schemes Act also ignored the principles of social solidarity and providing subsidies that are important in ending inequality.

Subsequent congresses and policy conferences have continued to position the organisation at the forefront for the fight for an NHI.

Since 2000, at each of its national and provincial congresses Nehawu has consistently called for the implementation of an NHI as the only sustainable route towards universal access to health care.

Nehawu has also served on the ANC national executive committee sub-committee on health and education and participated in the technical task team of the same committee. The sub-committee developed a policy document that was adopted at the National General Council of the ANC in 2010.

To inform its position and that of its affiliates, Cosatu established a technical working group on the NHI. This group commissioned research on costs/benefits estimates, long-run effects, and human resources requirements for the scheme.

POLITICAL CONTEXT

From 1948 when the National Party came into power, the state policy of apartheid consolidated political exclusion, economic marginalisation, social separation and racial injustices. The racial hierarchy had black people at the bottom and white people at the top. This influenced resource allocation to education, health care and pensions for the different racial groups.

Black people were denied citizenship and were forcibly settled in bantustans. As the main value of bantustans for apartheid South Africa was the physical labour of the men, during any period 60% to 80% of economically active men who lived in the bantustans were away from home leaving the women, very young, elderly, sick or disabled behind in the rural areas. For the minority who were able to live in towns and cities, the failure to provide proper housing for migrant workers led to the creation of overcrowded unsanitary hostels and slums in the urban areas.

William Matlala

Nurse attends to patient at clinic.

After 17 years, South Africa is still grappling with the legacy of apartheid and the challenges of transforming institutions and promoting equity in development. Although South Africa is considered a middle-income country, its health outcomes are worse than in poorer countries.

ECONOMIC POLICIES

In real terms (i.e. after inflation) the South African economy grew between 2% and 8% per year between the late 1940s and mid-1970s benefitting largely the white population. The wealth gaps continued after the democratic change although the post-1994 government announced reducing wealth disparities as a key goal. Statistics South Africa indicated in 2005/2006 that the richest 10% accounted for 51% of income, whereas the poorest 10% only got 0.2% of income sourced from work as well as social security.

In 1994 the democratic government introduced the Reconstruction and Development Programme, which recognised that all socio-economic problems were connected – housing, shortage of jobs, inadequate education, health care and living conditions.

However in 1996, the Growth Employment and Redistribution (Gear) strategy was introduced. The embracing of economic neo-liberalism under Gear and the Accelerated and Shared Growth Initiative South Africa worsened inequalities and made attempts to reduce poverty more difficult.

These policies focussed on rapid trade liberalisation and fiscal deficit reduction and replaced national development goals with export-led growth and global market participation. Since then economic policies have continued to favour this approach. The focus has been on cuts in state spending (including health and education) resulting in job losses in the public sector through right sizing. A shifting of resources from the public to the private sector and reducing benefits to recipients has also affected the lives of clients and workers alike.

Government expenditure was lower in this period than during the apartheid era despite Gear having pointed out that government spending on social services as one of the ways to distribute wealth. However, as mentioned earlier spending in the apartheid years focused on providing services for whites and building/upgrading tertiary hospitals. According to South Africa Health Review 1998 spending on social services, especially health, diminished in the 1990s and only increased from 2007 onwards. An example is the decline in real per capita government budgets from R3 960 in 1995/96 to a projected R3 720 in 2000/1.

South Africa has four epidemics that are happening at the same time. These are a health profile which includes poverty-related illnesses and infectious diseases such as HIV and AIDS. TB continues to be the major cause of death while there are illnesses related to disabilities. Maternal and child deaths (due to lack of access to care and high levels of malnutrition), violence and injury and a growing burden on non-communicable diseases are some of the health issues in South Africa.

HEALTH FINANCING

The crisis afflicting the health system is a result of the persisting legacy of apartheid and the impact of Gear on public health infrastructure, staffing and funding. This has been made worse by the on-going attempt to phase in a SHI system without any fundamental transformation in the provision and funding of the health

system. Gear instructed us to cut health budgets including human capacity, cutback on infrastructure building and maintenance of infrastructure thus inhibiting the building of an equitable, accessible and affordable health system.

It also strongly promoted the private health care sector mainly through deregulation. An element of private health-care also surfaced in public hospitals with the extensive creation of private wards within public hospitals, in particular.

However during 1994 to 1996 the main health financing system was a SHI as a result of the well-established private medical insurance industry. Post 1996, SHI was formally introduced by the Department of Health as its preferred funding model. It was essentially about providing free health care at the point of delivery for employed people and their dependents, but excluded those in the informal sector.

Whereas in 1994 the private health industry covered about 20% of the population, in 2011 no more than 16% of the population are covered, 21% use the private sector on an out-of-pocket basis and 64% are entirely dependent on the public sector.

HEALTH SERVICE DELIVERY

A notable feature of the history of health services has been the fragmentation, not only within the public sector, but also between public and private sectors. This fragmentation was further entrenched when the bantustans were created each with its own health department and then flowing from the three parliamentary system a further three health departments were created.

Health services in bantustans were significantly underfunded and varied widely. The small number of clinics (especially in poor and rural areas) forced people to become used to going straight to hospitals where it is more expensive to treat patients. This translated into a health system which allowed for high levels of funding to be used on curing illnesses rather than to preventing ill-health.

In the main, curative services were a provincial responsibility and prevention services a local government responsibility; training institutions were segregated with a medical school for black students in Durban; the private sector was dominant and public-sector funding was predominantly directed to tertiary services. The state also took over missionary hospitals, which had been the backbone of curative health services in areas which were to become the bantustans.

PRIVATE SECTOR

During the 1980s private health care was promoted particularly through deregulation. As previously indicated, Gear extended this through its explicit policy of privatisation of health services. The depletion of resources in the public sector also had the consequence of driving people to the private sector paying for these private services from their own pockets if they were not covered through medical aid.

Over servicing in private health due to the flourishing of medical aid schemes drove medical inflation to over 300% in real terms between the 1980s and 2001 pricing the poor out of the private health market.

This emphasis on privatisation meant that private health-care companies moved to the richest regions, setting up new infrastructure, since people in these regions could pay for it.

This imbalance persisted as the table below reflects the differences in 2007 between a historically well-resourced province (Western Cape) and a province made of the joining of a number of bantustans (Limpopo).

	Western Cape	**Limpopo**
Private hospitals	60	6
Public hospitals	55	44
Doctors	1 246	882
Population	4.8 million	5.7 million

In an article published in *the Star* and *Cape Times* newspapers, health economist Gavin Mooney stated: 'The private sector needs to be reformed as it is grossly expensive for what it does. There are two major reforms necessary'.

Mooney suggested the removal of tax breaks for private health insurance as they are unjustified in health terms. These tax breaks amounted to over R10-billion in 2005, which was equivalent to 20% of the public health sector budget. His other suggestion was to force the private sector's pricing processes to be much more transparent. Nehawu supports this view as the private sector pricing is an extremely opaque process.

Between 1994 and 2007 inflation averaged 6% annually, private health costs increased by 15% yet service provision has been deteriorating in the private health industry, costs of medical insurance have risen more than inflation and scheme exclusions increase each year. This is clearly unsustainable as it results not only in wage inflation for medical scheme members, but also either in additional out-of-pocket payments or having to use public sector services when medical aid funds run out. This forces the public sector to become the dumping ground for medical aid members. It is therefore important to avoid the NHI strengthening the private health industry which, according to indications, is in itself in financial crisis.

Furthermore, in 2007 public sector spending was R1 880 per person compared to R11 390 per person in private medical schemes as found by D McIntyre and others. The major cost drivers in medical scheme expenditure are private hospitals (over 35%) and specialists (almost 21%) and medical aid administration costs account for between 6% and 23% among the medical schemes.

HUMAN RESOURCES

The legacy of maldistribution of staff and poor skills of many health personnel had its origins in the fragmentation of the health system under apartheid.

Patrick Bond writes that in the years immediately following the introduction of Gear, social spending cuts as a percentage of the overall budget were accompanied by intensified annual job losses of 1–4% a year.

The application of neo-liberalism in the public sector also left hospitals with fewer human and financial resources to meet the deepening needs of their patients and led to several unfortunate policy decisions. For example, the offer of voluntary severance packages to public sector staff in the mid-1990s moved skilled staff out of the public sector. Thereafter, the combination of poor working conditions and low pay also caused health-care workers to leave their jobs in search of better pay and working conditions in the private sector or abroad, placing health services in danger.

This danger reduced the skills level of the public-sector workforce and enlarged the workload of public sector health-care workers. This caused burnout, turned stress into a major occupational hazard for public sector health-care workers, increased the risk of occupational injuries and exposures to HIV, TB and other infectious diseases. Poor and unemployed people, particularly women, who are the majority of patients and care workers in health, bore the brunt of neo-liberal policies.

There was a substantial decrease in the nurse-to-population ratio from 149 public sector professional nurses per 100 000 population in 1998 to 110 per 100 000 population in 2007. According to the *Lancet*, the percentage of nurses working in the private sector rose from about 40% in the 1980s to 79% in 2007.

This was worsened by a decline in the number of nurses graduating because of the closure of the public nursing colleges in the late 1990s, migration from the public sector to private sectors and to jobs abroad. Retirement also took its toll as well as HIV and AIDS (which affects 16% of the nursing profession). The closure of the public nursing colleges gave birth to a mushrooming of private-sector nursing colleges, particularly those located within private hospitals.

Private-nursing institutions are often linked to private hospitals producing nurses for their own needs. There is little, if any, training related to primary health-care needs. This affects the suitability of the nurses for work within a primary health-care setting.

In the late 1980s about 40% of doctors worked in the private sector. A decade later 62.5% of general doctors and 66% of specialists were in private practice. The non-filling of specialist vacancies has been a major contributing factor. With specialists locating their consulting rooms within private hospital buildings, this has led to an increase in the number of private hospital beds, which in turn contributed to further movement of specialist doctors into the private sector. This led the government to introduce systems such as Remuneration of Work outside of the Public Service and Limited Private Practice allowing publicly employed specialists to take private-patient work whilst in government employ as one of the ways of keeping them in the public sector.

PERSPECTIVE ON HEALTH TRANSFORMATION

Despite the ANC government's commitment to major changes in the health system since 1994, South Africa's chances of achieving the Millennium Development Goals became slim between 2001 and 2007.

The main disease burdens: AIDS/TB; mother and child deaths; violence and injury – are more common in poorer and rural communities. With lifestyle changes, the impact of non-communicable diseases has risen and is now among the top four disease burdens. Clearly this requires change and a focus towards implementing Primary Health Core (PHC). Therefore the NHI can be used to focus the funding on prevention and health promotion services on priority health needs while still having access to good quality care if needed.

The NHI is but one aspect of the transformation of the health system. In fact it is the creation of a fund intended for pooling resources for equitable distribution in buying medicine and supplies and paying for the cost of services. There are many challenges in the public-health system such as the poor state of infrastructure, human resources, management failure, patients subjected to long queues, low levels of cleanliness and dirty laundry, shortage of doctors etc. As a union we are committed not only to the creation of the NHI, but also to the transformation of the health system including the operations of institutions.

Over the past 17 years PHC has been the focal point of the health system and much has been done to gear up the health system in that direction. However, insufficient attention has been given to the implementation of PHC. For example, emphasis has not been put on disease prevention, health promotion and community participation. LB

This article is an extract from Nehawu's submission to the Department of Health on the National Health Insurance green paper and is the first in a three part series.