

2 **South Africa's healthcare under threat**

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Introduction

South Africa's health care is provided by the government (public) health sector, funded by taxpayers, and a private sector that is financed in various ways. The government sector provides care to those who cannot afford private care and are not beneficiaries of private philanthropy. The private sector provides services to members of medical aid funds, those who choose to pay out of pocket for health care, employees of companies in company-owned and funded facilities, government contract patients, and those who benefit from private philanthropy.

Under South Africa's apartheid system, health services were racially segregated. The demise of apartheid combined with rapid urbanisation resulted in an ever-increasing mismatch between the location of government hospitals and clinics and the geographical distribution of the population. Large centrally situated government hospitals in the cities, previously reserved for use by the white population, now serve everyone and are struggling to cope with the demand for health care.

The government health sector is under strain, suffering from shortages of medicines, poor and unclean facilities, poor service delivery, rude personnel and a shortage of doctors and staff (National Dept of Health, 2002). In 2002, of the 197,898 provincial staff positions across the various health professions 84,205 (42 per cent) posts were vacant (Health Systems Trust, 2002).

Large numbers of medical personnel have left, and are leaving

the country for Australia, New Zealand, Canada, the United Kingdom and the United States. There are 600 South African doctors registered to practise in New Zealand while 10 per cent of Canada's hospital-based physicians and 6 per cent of the total health workforce in Britain is South African (Health Systems Trust, 2004).

Associated with staff shortages, there is a severe lack of skills across the entire spectrum of health services provision, with the government sector lacking highly trained personnel, sophisticated technology and managerial skills (Health Systems Trust, 2003).

By contrast, South Africa's private health-care sector is one of the best in the world. It provides health-care services to a large cross-section of the population and attracts foreigners as health tourists because it offers an excellent service at internationally competitive prices. South African private hospital groups have won tenders to provide health services in the United Kingdom. Medical schemes are innovative and are exporting some of their ideas to other countries. The world's leading pharmaceutical companies are represented in the country and many have manufacturing plants and carry out clinical trials in South Africa. Most governments of developing countries would welcome a private health-care sector of the high quality that exists in South Africa and to see such substantial investments in health care in their own countries since a relatively large private health-care sector allows a government to utilise its scarce tax resources to provide better health care for the poor. Counter-intuitively, the South African National Health Department does not seem to recognise either the value of the private health-care sector to the people and the economy of South Africa, nor the benefit to poor South Africans. This must be puzzling to an impartial observer.

The government is disturbed by the rapid growth of what it regards as an expensive private health sector, which it believes is providing superior health care to the affluent few while the under-resourced and under-staffed government health sector is stagnant and struggles to provide care to the many. In response, it has adopted legislation that aims to establish a unified national health system in which the government's health department will

tightly regulate, plan and manage public and private health-care provision.

This paper examines the threat to health-care delivery posed by South Africa's recent health legislation, particularly the National Health Act 2003, and offers suggestions for an alternative health-care dispensation in which all patients, rich and poor, would receive high-quality private care.

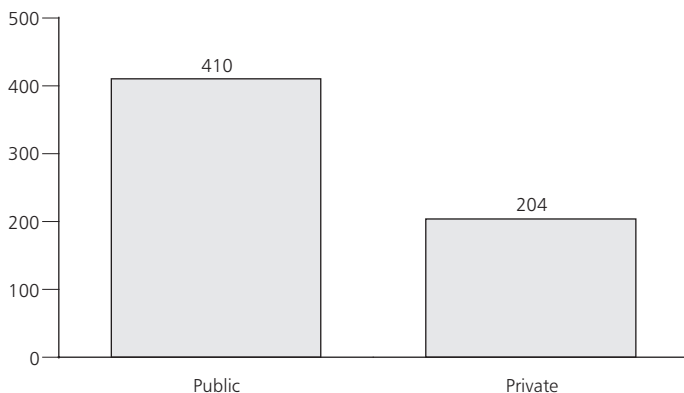
South Africa's health-care challenge

One of the basic assumptions that characterises the debate about South Africa's health care is the respective proportions of the population that are served by the government and private sectors. The government's policy documents claim that 84 per cent of the South African population depend on the government health sector (National Treasury, 2001; Ornell et al., 2001). This figure is apparently based on the assumption that the approximate 16 per cent of the population who are members of private medical schemes, are the only patients treated in the private health sector.

However, as explained below, the fact that approximately 16 per cent of the population are members of private medical schemes does not necessarily mean that the remaining 84 per cent are treated in the government health sector. This automatic but incorrect assumption is perpetuated in the Draft Charter of the Health Sector of the Republic of South Africa, published in 2005, which claims that there is a small minority of South Africans (between 15 and 20 per cent of the population), who have a high degree of access to health services and a large majority (between 75 and 80 per cent of the population), who have either limited access to health services or no access at all (National Department of Health, 2005). The "high degree of access" refers to that proportion of the population who can afford private health care and the "large majority" to those who, if they needed it, would obtain health care in the government health sector.

Accurately determining the percentage of the population that is dependent on the government health sector is of vital importance.

Figure 1 Number of public and private hospitals in South Africa 2004

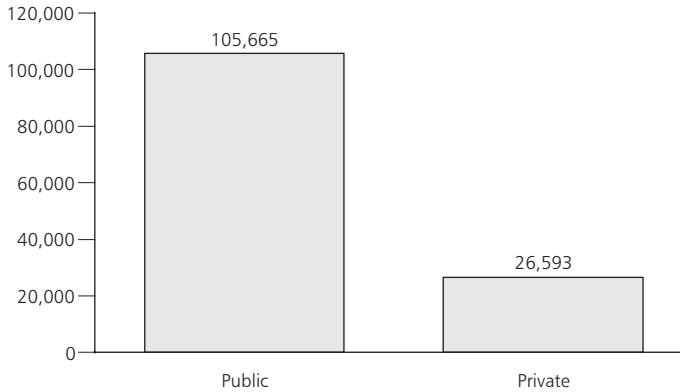


It is even more important to determine how many people actually use government health services, the frequency of that use, and nature of the services they utilise. The possibility that some people may, or are entitled to, use a particular service does not mean that they will do so. If future policies are to be based on incorrect figures for the respective quantities of services provided by the government and private health services, it will have serious consequences for future health policies. It is thus essential that an effort be made to obtain a better understanding of the existing situation.

A cursory glance at the available hospital and hospital bed statistics would appear to support the government's claim that the government sector supplies health-care services to all but a small proportion of the population. In 2004 there were 410 public hospitals with 105 665 beds (79.6 per cent), and 204 private hospitals with 26 593 beds (20.4 per cent)¹ (Figures 1 and 2)

Despite the fact that only about 20 per cent of the hospital beds

Figure 2 Number of public and private hospital beds in South Africa 2004



are private, there are indications that close to half the population may use private health services. This can be shown by building a picture of the South African health market, bearing in mind that accurate numbers are not available and wide variations are found in population and poverty statistics.

According to official figures, South Africa had a population of 44.8 million people in October 2001 (Statistics South Africa, 2003). Poverty estimates range from 40 per cent (Government Communication & Information System 2002) to as high as 60 per cent (Department of Provincial & Local Government, 2001) of the population. Based on a poverty datum line of R800 per month for a household, 52 per cent of households lived in poverty in 1996 (Health Systems Trust, 2003). It would thus be safe to conclude that at least half the population, or 22.4 million people in 2001, could not afford comprehensive formal health care.

Research shows that in 1999 about 20 per cent of the population

Table 1 **Comparison of sectors used by medical aid and non-medical aid members (Doherty et al. 2002)**

<i>Place of consultation</i>	1995		1998	
	<i>Without medical scheme</i> %	<i>Medical scheme members</i> %	<i>Without medical scheme</i> %	<i>Medical scheme members</i> %
Government sector	71.2	32.6	68.5	20.5
Private sector	28.8	67.4	31.4	79.5

had private medical insurance cover, consisting of medical scheme membership (which covered an estimated 16 per cent of the population), other forms of health insurance, and workplace health services provided by private firms (National Treasury, 2001; National Treasury, 2003; Cornell et al., 2001). At that time it was estimated that potentially 30 per cent of non-scheme members (nearly 25 per cent of the total population) used private health services on a direct payment basis (National Treasury, 2001; National Treasury, 2003; Cornell et al., 2001). Furthermore, those who paid out of pocket used either private or government care, while some used both, as did members of medical schemes. This was confirmed by surveys conducted in 1995 and 1998 (Doherty et al., 2002), summarised in Table 1.

These figures reflect a slight trend towards greater use of private health-care services.

An important consideration too is that many South Africans consult traditional healers and use traditional remedies. According to the Minister of Health traditional healers are the first to be consulted in as many as 80 per cent of all consultations.² Also, there are many people who make little or no use of the services of health-care providers.

Based on the available evidence, a range of between 16 per cent and 45 per cent of the population use private health care, and potentially between 55 per cent and 84 per cent use the government health sector.

Table 2 Estimate of South African Medical Scheme Market 2001

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

This can be compared to a study of the market potential for medical schemes, undertaken by a private medical insurer, which estimated that 16 per cent of the population was covered by medical insurance in 2001, that a further 30 per cent could afford medical insurance but was not insured, and that 54 per cent of the population was unable to afford medical insurance (Gore, 2002). Among this last group are some who purchase private health care on an irregular basis and would not automatically become government health-service patients.

As the estimates quoted in the above study are in broad agreement with medical scheme membership and poverty estimates they are used to construct a broad picture of the South African health-care market in 2001. This is shown in Table 2 above.

If the composition of the health-care market set out in the table is correct, the government health sector spends its money on a potential 54 per cent of the population (24 million people) and not 84 per cent as claimed. However, this makes the challenge of providing health care to the poor no less daunting. It is huge, not only in terms of the number of poor people, but also in terms of difficulty of delivery as 75 per cent (Government Communication & Information System, 2002) of the poor live in rural areas where health services are least developed.

The National Health Act 2003

By the government's own admission its health sector is not coping with the demand for health care. The Minister of Health, Dr Manto Tshabalala-Msimang, has been quoted as stating that the health system was 'in shambles'³ and Dr Kgosi Letlape, chairman of the South African Medical Association, has described the situation in the government health sector as 'horrendous'.⁴

In response to the situation, the government has embarked on an ongoing programme of expanding and upgrading government health facilities and services, while, on the regulatory level, it has adopted the National Health Act 2003, which seeks to establish a unified national health system over which the National Department of Health will wield enormous power.

The ostensible aim of the new health legislation is to allow the health department to control and manage the entire health system, so that it can reallocate and redistribute private and public health resources in a "more equitable" manner. The unified national health system envisaged in the legislation is to be characterised by (National Health Act, 2003; National Department of Health, 200?):

- ◆ Planning interventions in the form of national, provincial and district health plans.
- ◆ Economic interventions in the form of price controls, compulsory minimum benefit requirements for medical schemes, limitations on risk rating of patients by medical schemes, prohibitions on re-insurance by medical schemes, and the establishment of a system of social health insurance.
- ◆ Licensing in the form of certificates of need (CON) requirements for the establishment or expansion of facilities and the introduction of new technologies, enabling the Minister of Health to control the number of private hospitals and beds, the location of new hospitals, where doctors may practise, and the dispensing of medicines by general practitioners.
- ◆ Compulsory public service for medical graduates, prescribed medical education curricula emphasising primary health care

over specialist care, prohibition of insurance policies that cover medical expenses, compulsory acceptance of members by medical aid funds, compulsory membership of medical aid schemes and limitations on medical aid funds and insurers, restricting their ability to introduce innovative and more cost-effective services.

The Act introduces South Africa's own version of a centrally planned, socialised health system, in which the facilities, the equipment, the doctors, nurses and other medical professionals, and services, whether in the public or private sector, have been regulated, licensed, certified, approved and price-controlled by the government.

A critique of the recent legislation

The unified national health system envisaged in the National Health Act 2003 ignores the failures of the country's existing government health sector and the evidence from other countries with government (socialised) health systems which shows that these systems are inefficient, expensive, lack sophisticated medical equipment, have long waiting lists for medical procedures and appointments with specialists, do not provide equal access to and equal treatment for all citizens, provide lower quality health care than private systems, control costs by rationing care and medical technology, and fall far short of attaining their lofty ideals. The experience in the countries that serve as role models for South Africa's health-care plans, such as the United Kingdom and Canada, is particularly relevant (Goodman & Herrick, 2002; Esmail & Walker, 2005; Piper, 2002).

Centrally planned health care

In a fully socialised health system everything is centrally planned, controlled and co-ordinated. The government owns all the hospitals and medical facilities and government health planners determine

how many hospitals and beds there should be, where they should be located, the type and quantity of services and medicines that will be available, the salaries health-care professionals may earn, the amount of money that may be spent on particular procedures and technologies, the type of equipment that may be installed at hospitals and clinics, and the prices that will be charged for health-care procedures and medicines.

South Africa's new National Health Act subjects its private health-care providers to the same controls applied in a socialised health system. Private care, from now on, will thus be private only insofar as health establishments will be privately owned. The government will be planning the entire health-care system, with dire consequences for all patients, rich and poor.

A government attempting to plan and/or provide health care to an entire nation is confronted by the insurmountable obstacles faced by centrally planned and co-ordinated systems: the impossibility of knowing everything necessary to ensure effective, efficient and equitable delivery of goods and services, the ignoring or obliteration of signals provided by prices, the complexity of centralised planning, the difficulty of forecasting the future, and the inefficiency of governments in general.

Centrally prohibited health care

When governments impose plans on their citizens, whatever does not fit in with those plans becomes illegal. This observation led the economist Murray N Rothbard to remark that a centrally planned economy is a centrally prohibited economy (Rothbard, 2004). Socialised care becomes government-prohibited health care: nothing may be done without prior government approval. So, for example, South African doctors will be prohibited from opening medical practices in areas that government health-care planners believe are adequately served. The planners will somehow know exactly where all doctors should practise and what procedures and equipment they should use in order to meet the needs of all patients.

Government health systems are inefficient

Compared to its private health-care providers, South Africa's government health sector is slow, unwieldy and inefficient because it is not subject to the discipline entailed in making profits, avoiding losses, and earning an adequate return on capital invested. The government sector can always obtain more funds from taxpayers, or, if government health costs and demands for service get really out of hand, ration health care.

The proponents of government health care regard the economic rationing of health care as inequitable, but regard rationing of health care by governments as justifiable, notwithstanding the promises to provide health-care services to all who need them. A health department discussion document makes this admission:

Consequently, the achievement of equity within the context of a budget constraint implies the conscious application of a limit on the services that are made available on an equitable basis. In addition, the introduction of new services would have to be on the basis that they lower the costs and improve the outcomes of existing interventions. As the wealth of a country increases, it will become feasible to increase the amount of services provided on an equitable basis. (National Department of Health, 2002)

In the government health-care sector, therefore, it is said to be for reasons of equity that health services are either limited or not available. However, when economic rationing occurs in the private health sector the proponents of socialised health care describe such rationing as inequitable.

Government health systems, like all government activities world wide, are encumbered by bureaucratic procedures and are consequently unavoidably inefficient. They cannot compete with private providers. The contracts awarded to private health-care providers by the British National Health Service (NHS), which is under severe pressure to speed up the provision of medical care for the more than one million NHS patients who are on waiting lists for surgical pro-

cedures, provides an illustration of the greater efficiency of private providers.

South African private hospital groups, Netcare and Life Healthcare are among the companies to whom contracts have been awarded.⁵ The contracts require the performance of thousands of medical procedures annually, such as cataract procedures, orthopaedic surgery (including hip and knee replacements), ambulatory surgical procedures (including arthroscopies), general surgical procedures, and ear, nose, throat and oral procedures. Life Healthcare, in a joint venture with Care UK PLC, has been contracted to construct and operate three Diagnostic Treatment Centres in England, which include consulting rooms, radiology (including X-ray, CT scanner, MRI and ultrasound), pathology laboratories, theatres, ICU beds, general beds and a rehabilitation gymnasium.

The contracts awarded confirm the superiority of private care over government care as well as the competency of South African companies in providing world-class medical care. It is unfortunate for government sector patients that these resources are not being used locally to alleviate the pressure on the government sector.

The quality of care and the competitive cost of private health care have made South Africa a destination for medical tourism. Patients come to South Africa from the United Kingdom, where they are entitled to free health care, and pay for medical treatment out of their own resources to avoid the long waiting times for medical care in the British National Health Service (NHS).⁶

The knowledge problem

Proponents of government health systems argue that such systems ensure the optimal and productive utilisation of the country's health-care resources. Their arguments are based on the fallacy that there is someone who actually knows how to allocate health-care resources in an equitable manner and what optimal utilisation of health resources would comprise. However, as explained by Nobel laureate Friedrich Hayek, such a person or organisation cannot exist. Hayek's writings teach us that government planning cannot achieve

the efficiency in the use of resources which market processes make possible because the knowledge required to do so is dispersed among thousands or millions of individuals (Hayek, 1944; 1976). All government enterprises and state-controlled economies fall prey to what has become known as “the knowledge problem” and South Africa is no exception.

To see why it is impossible for government to centrally plan the entire health-care system, let us turn to the National Health Act 2003 to see what the Act requires the health planners to take into account when granting or refusing an application for a certificate of need.

In issuing or renewing a certificate of need for a new hospital, clinic, day-care facility, or expanding an existing one, the introduction of new technologies such as CAT, Sonar and MRI scanners, or employment of more nurses and doctors the Director-General of Health, under **Section 36(3)**, must take into account:

- ◆ The need to ensure consistency of health services development in terms of national, provincial and municipal planning.
- ◆ The need to promote an equitable distribution and rationalisation of health services and health-care resources, and the need to correct inequities based on racial, gender, economic and geographical factors.
- ◆ The need to promote an appropriate mix of public and private health services.
- ◆ The demographics and epidemiological characteristics of the population to be served.
- ◆ The potential advantages and disadvantages for existing public and private health services and for any affected communities.
- ◆ The need to protect or advance persons or categories of persons designated in terms of the Employment Equity Act, 1998 (Act No. 55 of 1998), within the emerging small, medium and micro-enterprise sector.
- ◆ The potential benefits of research and development with respect to the improvement of health service delivery.

- ◆ The need to ensure that ownership of facilities does not create perverse incentives for health service providers and health workers.
- ◆ If applicable, the quality of health services rendered by the applicant in the past.
- ◆ The probability of the financial sustainability of the health establishment or health agency.
- ◆ The need to ensure the availability and appropriate utilisation of human resources and health technology.
- ◆ Whether the private health establishment is for profit or not.

Section 36(4) of the Act empowers the Director-General to investigate any issue relating to an application for the issue or renewal of a certificate of need and may call for such further information as may be necessary in order to make a decision upon a particular application. **Section 36(5)** stipulates that the Director-General may issue or renew a certificate of need subject to:

- ◆ Compliance by the holder with national operational norms and standards for health establishments and health agencies, as the case may be.

Any condition regarding:

- ◆ The nature, type or quantum of services to be provided by the health establishment or health agency.
- ◆ Human resources and diagnostic and therapeutic equipment and the deployment of human resources or the use of such equipment.
- ◆ Public private partnerships.
- ◆ Types of training to be provided by the health establishment or health agency.

Section 37 stipulates that a certificate of need is valid for a prescribed period, but such prescribed period may not exceed 20 years.

When an application for a certificate of need is received the

health planners in the offices of the Director-General of Health are faced with an impossible task. To properly process an application the health planners have to be all but omniscient, an impossible expectation. They need to know the health needs of everybody in a given geographical area: the number likely to fall ill, the type of illnesses likely to befall them, the existing number of facilities, beds, and equipment, the rates of utilisation of services and facilities, how effective the doctors are, the effectiveness of treatments and medicines, and so on. The equation becomes even more complicated when one considers that people do not necessarily use the health services located closest to them. How does the health planner then determine the trading area for a particular facility?

Let us assume that a gynaecologist applies for a certificate of need to purchase a new sonar scanner. The health planner has to determine the existing number of scanners serving the area, the number of women likely to fall pregnant, the number and utilisation of existing sonar scanners, the number of medical personnel and services available for maternity purposes, the financial sustainability of existing gynaecological practices, and so on. And, once that is done, how does a health planner or the Minister of Health determine for how long a certificate of need should be valid?

Add the policy considerations prescribed in the Act (such as the "appropriate mix" of public and private facilities, compliance with the national, provincial and municipal health plans, correcting inequities based on race, gender, and economic and geographical factors) and a realistic assessment of all the factors becomes impossible. Since there is no objective way to decide on these issues, decisions will ultimately be based on ideological and political expediency.

In view of the complexities, applicants will be required to motivate their applications and provide the information and statistical data necessary to enable the health planners to make decisions. Doctors and service providers will have to pay consultants to prepare applications on their behalf, increasing the cost of providing medical care. However, no matter what information is provided,

health-care providers will be at the complete mercy of the health bureaucracy.

Planning and prices

South Africa's health planners are instructed by the new laws and regulations to ignore demand, prices, and the wishes of patients. But, if prices are interfered with, or a market is not allowed to function, there is no way of reconciling supply with consumer demand.

The market and prices make the discovery process possible that allows people to utilise more facts than any other known system. By means of prices we constantly discover new facts that improve our adaptation to the ever-changing circumstances of the world in which we live. (Hayek, 1976)

In the absence of prices determined in a competitive market, economic calculation becomes not merely difficult, but impossible (Von Mises, 1990). To overcome this problem in the former communist countries, economic planners had to copy prices set on world markets. When one considers that central planners in the Soviet Union had to fix 24 million⁷ prices, and had to keep adjusting them, relative to all other prices, as conditions changed, one realises that central planning did not just happen to fail, it was impossible for it to succeed.

In a market economy the task of "fixing" prices is undertaken by hundreds of millions of people individually keeping track of the relatively few prices they need to know for their own decision-making.

In a health-care system under political and bureaucratic domination, price controls are invariably introduced, supposedly to make care affordable and to contain costs. This obliterates the very price information system that would allow health-care resources to be utilised most efficiently. By ignoring prices, politicians, health-care planners and policy makers have no means of knowing what the optimal allocation of health resources should be and the fact that

they are generally driven by non-economic motives makes matters worse. As a result, health-care delivery becomes a product of political and bureaucratic expediency rather than a response to real health-care needs. Equity, efficiency and effective delivery become the casualties of the absence of market prices to co-ordinate production, supply and delivery of health care to consumers. This is what South Africa's citizens will face if its health department continues on its current course.

Dealing with complexity

The proponents of government health care argue that the market cannot be relied on to allocate health-care resources equitably and efficiently. For example, while in the cities there are a number of private hospitals, most rural towns have none. This leads to the conclusion that urban dwellers are over-served due to a duplication of services and as a result rural residents are under-served and deprived of the care they need. Planners then conclude that government should take over the planning and direction of health care in order to resolve what they view as market failure. They ignore the reality that the spatial distribution of economic activities, including private health-care facilities, are the result of a virtually endless number of variables, impossible to be grasped by any individual or planning agency. Modern economic activities are so complex that no government can successfully centrally plan and direct them or any of their components, including health-care delivery.

Evidence of the order achieved by the market surrounds us in South Africa. A patient can make an appointment to see a general practitioner or specialist at a scheduled time, leave the doctor's rooms with a script and present it to his or her pharmacist of choice. The pharmacist, not knowing that a patient would require that particular medicine that day, would in almost all cases be in a position to immediately supply the required product. In the case of a dispensing doctor the patient has the added convenience of purchasing the medicine directly from the doctor. Even in non-emergency

cases advanced diagnostic procedures, such as Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scans are available within hours.⁸ Compare this level of availability with that found in socialised health-care systems. Across Canada the median waiting time for CT scans is 5.2 weeks and that for MRI 12.6 weeks.⁹ In the United Kingdom patients wait six months or more for MRI scans in 40 per cent of NHS trusts and four months or more for CT scans in almost a third of NHS trusts.¹⁰

Life for patients in South Africa's centrally planned government health facilities is very different from that in the private health-care sector, with public facilities exhibiting many of the problems common to socialised health systems. Patients wait for hours, and sometimes days, to see a doctor, and medicines may or may not be available. If patients require specialised treatment they are referred to "higher order" facilities, such as district hospitals, where the waiting starts all over again. However, while cross-country comparisons are difficult, waiting times for services in South Africa's government health-care facilities appear to be shorter than those in the national health systems of both the United Kingdom and Canada. In real emergencies patients also have the option of scraping together the cash to utilise private services. The difficulties experienced by patients using South Africa's government health-care facilities do not, however, indicate that the people who work in our government sector have no concern for their patients' welfare. Provide the same people with the same incentives and disincentives they would have in a private facility and there would be a total transformation. The failure of any government health system to deliver adequate and effective health care is inherent in central planning.

No mathematical equation or formula is available to assist our health department to calculate what the health needs of the country's 44.8 million people are at any time, nor what resources to provide, where to provide them and in what quantities. They face the same insurmountable obstacles as all other countries with government provided or controlled health systems and experience the

same problems: patients waiting weeks and even months for treatment, a lack of modern equipment and resources, rationing of care, rising costs, budget constraints, and the like.

The private health sector is superior to the government health sector because complexity is reduced through the price system. Private doctors, medical practices and private hospitals make only their own plans, which they constantly adjust and improve to attract and retain patients so as to stay in business. They respond directly to the needs of their patients and have, until recently, not been compelled to fit into any government plan dictating what they may do or not do. The National Health Act 2003 is scheduled to change the situation and as a consequence the convenience and quality of care currently offered to private patients will be in jeopardy.

The problem of introducing new technology

Inventions, innovations and technological developments cannot be predicted in advance and therefore cannot be centrally and bureaucratically planned (Rothhard, 2004). Government health department planners not only do not know what will be invented and when; they also do not know who will do the inventing. Medical advances make a mockery of health plans produced under a national health system and the planners are therefore likely to oppose the introduction of new techniques and equipment.

New technologies are expensive and as a government health system cannot make them available to the whole population at once, it either finds a way to severely limit their use or does not introduce them at all. The higher the cost of the new technologies, the more difficult it becomes for a national health system to make quality health care available to everyone. The only exception is when a new technology reduces the cost of treatment and improves the outcomes of existing treatments (National Department of Health, 2002). If there are no private health-care providers to demonstrate to government planners that new technology improves outcomes and lowers costs, they will have no way of knowing, and will have to make political rather than economic decisions in introducing new technology.

Inequitable distribution of resources

The South African government is concerned by what it views as an inequitable distribution of health-care funding and resources between the private and government sectors. Officials claim that the private health sector consumes more than half the total health expenditure yet provides care for less than 20 per cent of the population. The validity of these generally quoted numbers for the split between government and private health-care provision was earlier shown to be questionable yet, disturbingly, the figures are persistently quoted in government policy statements. According to the Minister of Health, the private health sector spent R43-billion on 6.9 million people in the 2003/2004 financial year while public spending was R33.2-billion for 37.9 million people.¹¹ Anyone who is not a member of a medical scheme is by this logic automatically considered to be dependent on public sector health care, whether or not they use the services. Basing policy proposals on this flawed logic is intended to justify government intervention. The implication is that, to obtain an equitable distribution of resources, money spent on private patients must be redirected to the government health system.

There are several grounds for questioning both the logic behind the "imbalance of resources argument" and any proposals for "rectification." If we analyse the argument carefully, we see that the officials are saying that some members of the population spend a lot more of their own money on their own health care than the government, utilising taxpayers' money, spends on people who are unable to purchase health care. Compare this to a statement that "some members of the population spend a lot more of their own money on their own food and clothing than the government, utilising taxpayers' money, spends on people who are unable to purchase clothes and food". There is an undoubted food and clothing "imbalance of resources," but the government does not feel compelled to increase the regulation of private-sector providers of these essential commodities, limit the expansion of their production facilities, and require them to obtain official

consent before purchasing new equipment for use in their businesses. If government interfered in the same way in food and clothing production it would reduce rather than increase the quantity of food and clothing available to the poor. The economic rules for the supply of health care are the same as those for food and clothing. Reduce investment, increase costs, and the supply will diminish.

The imbalance of resources argument creates the impression that huge amounts of money are floating around in the private health sector, just waiting for someone to use it. In fact, the R43 billion spent annually on private health care is money spent by people paying out-of-pocket for care, and by medical schemes paying for the medical expenses of their members and the cost of providing for government-imposed reserve requirements, administration, and the like. The medical schemes are funded entirely by their members who contribute either directly or through their employers. There is no surplus for government to plunder and spend in the government health sector.

Private health-scheme members, by and large, also pay most of the taxes that government collects to fund its health system. Thus, what the imbalance of resources argument actually says is that members of medical schemes must be denied the quality and quantity of services they currently purchase with their own money so that government can take even more of their money to spend on government-provided health care for others.

Everyone pays when government forecasters get it wrong

When private health-care providers make mistakes in their predictions, they bear the costs of those mistakes. For example, when a private provider over-invests in hospital facilities, when medical equipment remains unused, or when the provider overestimates the quantity of medicines needed over a given period, it loses money. To continue operating, a private provider has to remain profitable, or at least break even financially, and therefore has every incentive to make accurate forecasts and reduce mistakes.

When government health planners make similar mistakes, the monetary costs are inflicted on the taxpayers. The responsible planners are seldom held accountable since they are "hidden" behind a veil of bureaucracy.

Poor patients depend on wealthy patients

Not surprisingly, most new medicines and medical technologies are produced in the USA because there are enough affluent American patients who can afford to pay the high prices manufacturers charge to recover the costs of research and development. Once the sales volumes increase, the prices come down and the medicines and technologies become more widely accessible. Without the wealthy countries to pioneer technology and drug production, poorer countries, such as those in Africa, would never gain access to them because they would not be produced.

South Africa's wealthier patients perform the same function for the poor that wealthy Americans perform for poorer countries: they pay to maintain the highly skilled professionals who carry out high-quality, high-cost procedures, using expensive equipment. In South Africa, without a pool of wealthy patients, skilled professionals would leave for greener pastures and would no longer be here to pass their skills on to others, and expensive equipment would no longer be available. The notion that the wealthy deprive the poor of health services is wrong. Wealthy South Africans "ensure" that poor South Africans have access to better health care.

The "certificate of need," introduced to control the purchase of new equipment by private health-care firms, is ostensibly aimed at controlling costs and the alleged "over-servicing" of patients by rationally allocating scarce resources. However, new technologies that begin as luxuries available only to the wealthy quickly become standard procedures in a rapidly evolving field such as medicine. The National Health Act will have the effect of delaying the introduction of new medical technologies and, therefore, will ultimately have a detrimental effect on health care for all South Africans.

Politicisation of health care

As the government health sector is under political control, the views of key government officials on a particular medical issue directly affect the manner in which the government health sector deals with it. The views of the South African President and Minister of Health on HIV/Aids are considered to have been the main reason¹² for the country's slow response in dealing with the HIV/Aids problem despite the government's commitment¹³ to decreasing the incidence of infection.

In a government planned and controlled health system, patients are at the mercy of politicians and those appointed by them to control the system.

The "free health care" myth

Government health policy entitles certain categories of patients, including pregnant women and children younger than six years of age, to receive "free" general care, while "free" primary health care is available to every citizen (Health Systems Trust, 2004). However, the health care is not free. It is provided to patients at the expense of the taxpayer.

The day after Nelson Mandela, during his presidency, announced that "all pregnant women and children under the age of 6 years" would be entitled to "free" health care; some public hospitals could not cope with the large number of women and children who arrived on their doorstep seeking medical care. The event dramatically demonstrated that if the cost is reduced, especially if it is reduced to zero, the demand increases exponentially. To cope with this demand, government health-care providers have no option but to reduce availability or deny health care to patients.

However, the difficulties that arise as a result of the introduction of so-called "free" care are not limited to rationing – it also means less efficient and more expensive health care (Reisman, 1996). A large bureaucracy is needed to administer a socialised health system, which together with the built-in bureaucratic inefficiencies, add even more to the costs of so-called "free" health care. To control

costs, officials oppose the introduction of advances in medical technology. Advanced technologies and procedures such as MRI scanners and the implantation of artificial hearts, are a major threat to their budgets.¹⁴

“Free” health care is therefore not only, not free, it is expensive, it inevitably denies patients access to the latest medical procedures and technologies, and it is not freely accessible..

Quality health care for all

There are two very different approaches to the problem of ensuring that people have adequate access to health care. One approach is for the government to attempt to gradually nationalise all health-care services, ultimately ending with fully taxpayer-funded state-owned health services. This is the apparent aim of the National Health Act of 2003 and also of the recently proposed “Health Charter.” But economics and world experience tell us that nationalised health care does not work, for three major reasons. The first is that national health systems do not respond to the day-to-day decisions of consumers and therefore fail totally to supply their needs. The second is that they invite unlimited demand, which cannot be met with limited resources. The third is that a relatively poor South Africa cannot hope to achieve success at implementing a system that some of the wealthiest countries, such as the United Kingdom and Canada, have for decades been trying vainly to make succeed.

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

Whichever approach is chosen, one aspect will not change, one

hundred per cent of the funding will be from private sources, firstly through taxes, and secondly through voluntary medical aid or insurance schemes and voluntary out-of-pocket payments.

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

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

- ◆ Refrain from unnecessarily interfering with and micro-managing private health-care provision and encourage those who can afford to pay for their own health care to do so.
- ◆ Direct its resources to ensuring that the poor receive adequate care from providers of their own choice.
- ◆ Fund the needy directly through appropriate means such as vouchers, smart cards, or contributions on their behalf to competing medical aid funds, to allow poor patients to purchase quality health care.
- ◆ Encourage the development of health-care insurance products for the emerging market.
- ◆ Remove controls that increase health-care costs or prevent the provision of care by scrapping all requirements for certificates of need, price controls, compulsory community service, registration requirements for medicines already approved in the European Union, the United States, Canada, Australia and New Zealand, and such other countries that meet certain defined standards.

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

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

The government would have responsibility for a thriving, growing, health-care sector that would be the envy of the developing and the developed world. Health professionals would start returning to South Africa instead of leaving it.

Conclusion

Government's policy and discussion documents do not explain how South Africa, a relatively poor country, will succeed in providing equitable health care to all through the envisaged national health system, when wealthy countries have failed in their attempts to do this.

If government's health-care plans continue in the direction of nationalisation, which appears to be the ultimate goal, South Africans will lose their world-class private health-care firms. Patients will lose the freedom to choose their own health care, which is such a vital and personal service, and bureaucratic health-care planners will be making decisions for them. This happens in

Canada, the United Kingdom and other countries that have national health systems. The whole national health system will function badly, just as it does in those countries.

The health of the whole South African nation is threatened by the centrally planned health system envisaged in the National Health Act 2003.