

PRIVATISATION AND THE HEALTH CRISIS IN POST-APARTHEID SOUTH AFRICA

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INTRODUCTION

South Africa has officially become the most unequal society in the world. This trend has been created by a number of contemporary and historical factors. The most obvious one is the implementation of neoliberal economic policies. A number of analysts have highlighted the negative effects of economic liberalism in post-apartheid SA. For example, the nation's unemployment rate increased from 17% in 1995 to 23% by 2003 (Hodge 2009). By 2012 the expanded or wide unemployment rate stood at 36%, with the youth constituting a large section of the unemployed (COSATU 2012:6) Inequality has also grown in the post-apartheid era. The gini coefficient increased from 0.57 in 1992 to 0.70 in 2008 (DuToit and Van Tonder 2009: 16-17).

The high levels of socio-economic disparities can be observed in all areas of social development. South Africans have unequal access to essential social services such health, housing, water and electricity. This article will discuss the challenges related to the health. This area of social policy is crucial improving the levels of human development in the country. South Africa is currently rated number 118 out of 187 countries on the Human Development Index (2013). This is

quite worrisome if one considers the amount of money spent on health services in the past couple of years.

Former Minister of Finance: Pravin Gordhan, highlighted this in his final budget speech by stating that: *"We have spent R39 billion on 1 879 hospitals and other health facility projects, and R26 billion is allocated over the MTEF period ahead"* (Gordhan 2014). The difference between expenditure and outcomes indicates that there are underlying structural problems associated with poor health provision. This article will argue that the expansion of the private sector has had negative effects on health provision in the country. It will illustrate how the commercialization¹ of this public good has denied most citizens access to quality and affordable health care.

SOUTH AFRICA'S HEALTH PROFILE

According to the Department of Health (DOH), South Africa suffers from the quadruple burden of disease. This term describes the prevalence of the following main types of illnesses in the country: (a) HIV/AIDS; (b) Maternal, Infant and Child

¹ Commercialization: business practice that turns public goods and services into products for the sole purpose of generating profits

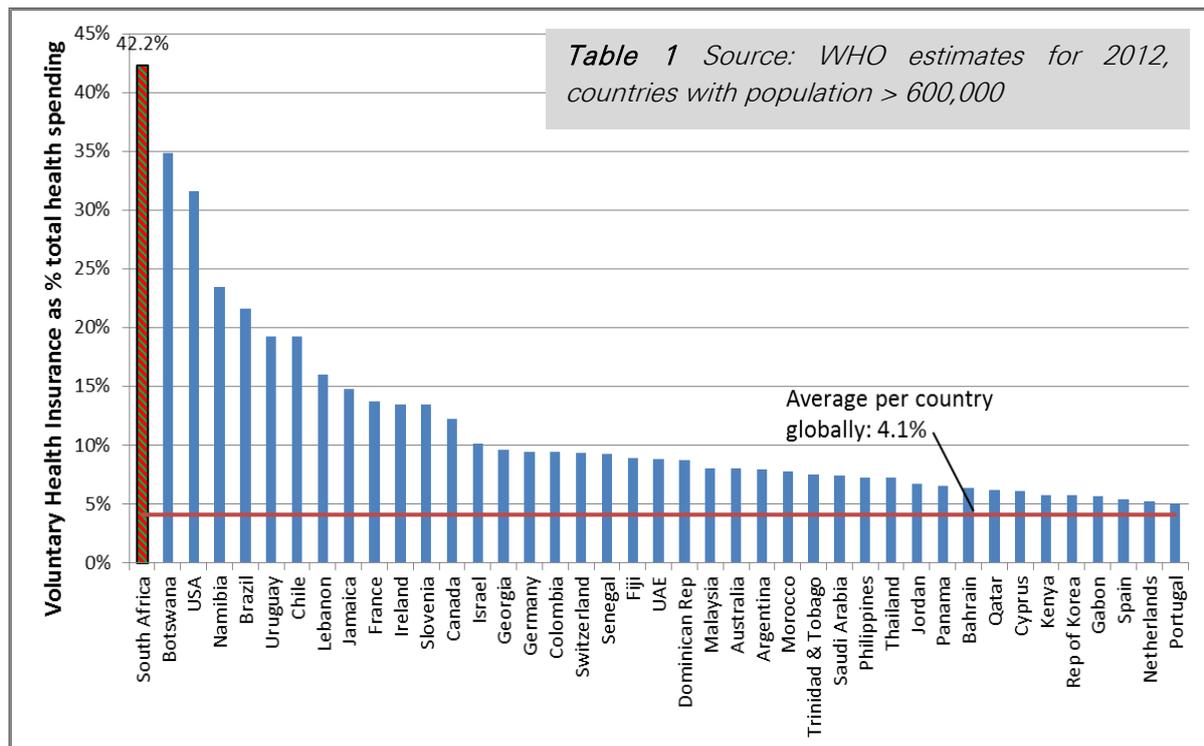
Mortality; (c) Non-Communicable Diseases; (d) Injury and Violence (2011: 8-9). The DOH acknowledges that the country's deaths associated with the above-mentioned categories of diseases are higher than most middle-income countries (DOH 2011: 8-9). For example, the levels of maternal mortality increased from 81 to 400 (per 100,000) between 1997 and 2005. Child mortality has decreased; however, it remains high at 68 (per 1000 live births). Other developing economies have managed to lessen the number of child deaths. The clearest improvement occurred in Brazil, which reduced its deaths from 58 in 1990 to 22 in 2007(COSATU 2012; Presidency 2009).

The extent and nature of this phenomenon will be explained below.

FINANCING INEQUALITY

South Africa has the most skewed distribution of health finance in the world². This is illustrated in the Twenty Year Review, which states that:

Although South Africa spends about 8.5 percent of GDP on healthcare, the country has poor health outcomes, compared with other countries with similar, and in certain instances lower, national income and health expenditure per capita. This is attributed to two main factors. The first is the gross



This burden of disease can only be addressed by increasing citizens' access to quality and affordable healthcare. South Africa's constitution instructs government to: *take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of this right*" (South Africa 1996). This constitutional right has been undermined by the commodification of health in South Africa.

inequality where 5 percent of GDP is spent on 16 percent of the population while the remaining 3.5 percent of GDP is spent on 84 percent of the population. The second factor is the high cost of healthcare in the private sector." (Presidency 2014: 61).

More worryingly, these disparities have both racial and class dimensions. The five percent mentioned in the quote is mainly spent on the

² See Table 1

rich white population of the country; whilst the mostly poor African population has to rely on the remaining three percent. The General Household Survey (GHS) of 2003 revealed this inequality by reporting that only 8% of Africans had medical cover in 2003, while 65% of their white counterparts had access to medical aid. The GHS of 2012 indicated that the situation had not changed. According to this report, only 10.4% of the African population had medical insurance and 75 % of the white population was on medical aid (GHS 2012).

Both surveys also revealed that most of the African population is dependent on the public sector. White citizens use private doctors, clinics and hospitals. In 2003, 63.4 % percent of the Africans used public health services; while 84% of the white citizens used private facilities (GHS 2003).

The health care expenditure trends also exacerbate the public and private divide. Econex's (2013:11) study of SA's private health care sector reveals that it accounts for 50% of the total expenditure. This is quite worrisome, because it only supports 16% of the population. Most South Africans (84%) are dependent on 47% of the nation's health expenditure (Presidency 2014:14).

The following sections will highlight how the expansion of private health provision has commercialised health care services.

PRIVATE HEALTH FACILITIES: PROFIT BEFORE HEALTH

According to the Econex (2013:6) report, South Africa had more than 300 private hospitals by 2013. Moreover, it is estimated that over 3500 of the nation's clinics are in private hands. (Econex 2013:6). This illustrates that the moratorium placed on the growth of private facilities in the early 1990s has not been effective. Proponents of economic liberalism have argued that the expansion of this sector will lead to improved access and health outcomes.

However, most studies illustrate that private hospitals are responsible for the exorbitant charges in the health care sector (DBSA 2008; Harrison 2009; McIntyre and Gilson 2002; Van Den Heever 2000; Wadee 2003). The Developmental Bank of Southern Africa's (2008: 27) report on restructuring health care in SA proved that the increased acquisition of acute beds and expensive technology are the primary drivers of private health care costs. For example, the private sector had a bed over-supply of 10 000 by 2008 (DBSA 2008:27). This is very concerning because the public sector is plagued by bed shortages.

The rapid introduction and usage of complex diagnostic technology has also caused price increases (DBSA 2008; McIntyre and Thiede 2005). This practice is not motivated by the need to improve health outcomes. It is informed by the fee-for service principle, which encourages facilities to recommend health services that generate larger amounts of profits. This trend is highlighted in the Council of Medical Schemes 2013 report, which illustrates that most funds were spent on the following services:

Speciality	Payments
Pathologists	R 5.12 bn
Radiologists	R 4.27 bn
Anaesthetists	R 2.06 bn

Table 2 Source: Council for Medical Schemes Report 2013.

It should be noted that this trend is related to a deeper structural problem within the health system. The private health care market is characterized by information asymmetry, which allows health service providers to manipulate the diagnosis process in order to generate extra profits. This then results in users paying large amounts of money for

health care services which they don't necessarily need. McIntyre and Thiede (2005:42) explain this well by arguing that: *"When expensive high-technology equipment is purchased by owners of private hospitals, substantial pressure is applied on clinicians to use this equipment to earn revenue for the hospital"*.

Another factor contributing to the commercialization of health is the concentrated nature of ownership in the private sector. According to SAMJ (2012), there are three major groups which dominate the private hospital sector: Netcare, Mediclinic and Life Health Care. These entities own 80 % of the private health care facilities in South Africa. More worryingly, 3 out of 4 beds in the private sector belong to these major groups (SAMJ 2012). Their joint market capitalisation is estimated to be worth 83,688 billion (Econex 2013:7). All of them are listed on the Johannesburg Stock Exchange.

These groups market power has been enhanced by the following factors. Firstly, medical schemes cannot engage in "selective contracting" which could possibly decrease costs (Van Den Heever 2000:11). Secondly, the Competition Commission ruling of 2004 barred medical schemes from collective price bargaining and thirdly, the decision taken by the courts to declare the National Health Price List unconstitutional. The concentrated ownership and above-mentioned factors have given private hospitals the power to unilaterally dictate prices in the sector.

This has resulted in these groups making super profits. According to Econex (2013), expenditure on private hospitals was way above inflation between 2000 and 2010. In this period the consumer price index (CPI) was 6%; hospital inflation was 8.5%; but private hospital expenditure exceeded 12.2%. Moreover, recent financial reports indicate that these groups are accumulating large amounts of profits. This was highlighted in a Mail and Guardian (June 2013) article, which provided the following figures:

Hospital group	% profit increase
Netcare	7.9 %
Life healthcare	12.7 %
Medi-Clinic	15 %

MEDICAL SCHEMES AND OVER-FINANCIALISATION

According to Harrison (2009:24), the expenditure on one medical scheme member is five times more than the amount spent on an individual using the public health system. This is quite alarming when one considers the fact that public money subsidises medical aid contributions. This indirect subsidisation of the private sector is encouraged by the tax incentive. The elimination of this incentive would generate R10-15 million (PHM 2011:4).

Harrison (2009:24) also notes that the number of citizens on medical schemes has not grown significantly since 1994. The primary cause is the high costs of medical cover in SA. This raises the following important question: Which factors have contributed to the increased medical aid costs?

The first is the increased administration costs, which are much higher than those in the public sector (Wadee et al 2003:13). These costs are created by the outsourcing of administrative functions to large entities. The Econex (2012:32) study states that 30 medical scheme administrators operate in the sector. These are owned by 3 large companies who service 3/4 of medical scheme beneficiaries. These administrative costs indicate that managerial activities have been prioritised over the provision of increased health benefits. In simple words, resources are being diverted to management rather than service provision.

The second contributor is deregulation which occurred between 1989 and 1999. This was informed by the dominance of neoliberal policy prescripts, which prioritize minimal

state intervention. During this period the costs of medical schemes increased drastically, as a result of the shift from restricted to open medical schemes (DBSA 2008:25). The latter schemes are associated with high non-medical costs, and are not incentivised to reduce or regulate medical fees (Van Den Heever 2000: 10-11).

The third factor is the nature of ownership and management in the medical scheme subsector. For example, the country's biggest scheme: Discovery Health Medical Scheme (2.4 million members) is managed by Discovery Health, which is company owned by private investors. The majority of its profit is derived from admin fees. According to SAMJ (2012), these fees accounted for 90 % of the company's operating profit between 2010 and 2011. This trend illustrates that ownership also influences the operation of medical schemes. Most of the administrators are owned by private investors, who seek to maximize profit and returns on investment. Thus, they divert medical schemes away from benefit provision to profit-driven commercial activity.

Fourthly, medical aid members are required to pay large amounts of co-payments. These are based on a uniform fixed rate, which does not consider income disparities. This results in low-income earners spending a large portion of their salary on medical aid. Moreover, the legislative loopholes on prescribed minimum benefits have also failed to protect consumers from out-of-pocket payments.

Fifthly, the trustees of medical schemes pay themselves exorbitant amounts of money. This is highlighted in the Council of Medical Scheme report of 2013. It states that the total costs of payments to trustees of the top 6 medical schemes was R25 021 000. According to the report, Bonitas, Fedhealth, Hosmed and Discovery pay trustees an average of R3 600 000 per year (CMS 2013). In other words, medical schemes are reducing benefits; but trustees are being paid a lot of money. This illustrates that the functioning of medical schemes is prioritizing

profit and management fees over health provision.

The last cause of increased medical aid costs is the over-financialisation of the South African economy. According to Khan (2012 570-580), this term refers to the dominance of a privately-owned financial sector in the economy. It directs all financial activity towards profit making, speculation and quick returns on investments. In other words, the character of private health care funding cannot be separated from the investment and expenditure patterns observed in the general financial architecture of the country. The logical conclusion of this observation is that the nation cannot achieve equal access to health care if finance is dominated by the private sector.

TOWARDS THE FUTURE: NATIONAL HEALTH INSURANCE

Many civil society groups have advocated for the introduction of a single national health insurance. This intervention will improve access to quality and affordable health care in the country. As argued earlier, most citizens in South Africa are deprived of this fundamental right. The primary cause is the commercialisation of health services in the post-apartheid era. This trend has denied many citizens, especially the working class, the opportunity to access quality health services. The World Health Report (2008) explains this well by stating that: *"commercialisation has consequences for both quality and access to care. The reasons are straightforward: the provider has knowledge; the patient has little or none. The provider has an interest in selling what is most profitable, but not necessarily what is best for the patient"* (WHO 2008:14).

Health commercialisation in South Africa has been driven by the expansion of the private sector. This article has identified a number of negative effects of privatisation. Furthermore, it illustrates the deeper structural problems within South Africa's health system. These cannot be resolved through market

mechanisms. Our health system requires intervention from a capable developmental state that views health as a public good. The first step is the introduction of the National Health Insurance which advocates for the following:

- providing universal access to quality health services
- the creation of single fund to decrease financial risks associated with accessing health care
- procurement of services on behalf of the entire population and effectively mobilize and control key financial services
- improve the under resourced public sector.

The successful implementation of NHI will require a total overhaul of the health finance system in the country. This is integral for improving health outcomes, and decreasing the financial burden incurred when accessing health care. Many analysts have started to formulate various models on how to finance the NHI. Health civil society groups representing the poor and working class have argued for progressive taxation, which is linked to the payroll system. They have also called on employers to contribute to this general health revenue. These groups oppose the use of co-payments, multi-payer systems and Value Added Tax (VAT). Various civil society commentators believe that these measures will have adverse financial effects on the poor.³

However, the NHI Green Paper (2011) mentions investigations into multi-payer systems and the use of co-payments in certain instances. Treasury has also notified the public that VAT may also be used to generate revenue for NHI. This illustrates that most citizens and government agree on the introduction of this programme. But there is no consensus on how to fund it. This debate or impasse must be resolved urgently in order to ensure speedy implementation. In the end, the interests of the poor and most marginalised in our society must be prioritized over profit.

³Civil Society Response to NHI 2011