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**IMPLEMENTATION OF A SOCIAL HEALTH  
INSURANCE SCHEME IN SOUTH AFRICA**

**BY**

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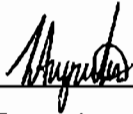
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**DECLARATION**

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I hereby declare that this research has not been previously accepted for any Degree and is not being currently submitted in candidature for any Degree. This Dissertation contains research compiled by me except where specifically acknowledged.

Signed: \_\_\_\_\_



**Dr Leon Augustine (Reg. No: 203520095)**

Date: 02 February 2006

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I would like to acknowledge the assistance rendered by the following people in enabling me to complete this dissertation:

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## ABSTRACT

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The Department of Health (DOH) has embarked on a noble initiative to address the disproportionate distribution of resources and spending within the public and private healthcare sectors. Social Health Insurance (SHI) has thus been mooted as the vehicle to obtain a more equitable healthcare dispensation. This thesis explores the state of preparedness of the DOH, for the implementation of SHI. Ten aspects of health have been identified which will assist in determining if sufficient reforms have been implemented to facilitate the successful implementation of SHI. The prospective mechanism of financing of SHI is compared to the highly acclaimed model employed by the Australian Department of Health.

Two research methodologies have been utilized viz. the case study approach and semi structured interviews, to provide comprehensive data. This enabled the researcher to adequately answer the research question. The responses from the respondents on the 10 aspects of healthcare have been arranged into themes to facilitate a greater understanding of the issues being highlighted. Established strategic management instruments have been utilized to analyze the data obtained and evaluate the preparedness of the DOH for the implementation of SHI.

Following the data analysis, recommendations are proposed that would facilitate the successful implementation of SHI, thereby promoting its viability and sustainability in providing quality healthcare to all who call South Africa home.

## TABLE OF CONTENTS

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<b>Declaration</b>	<b>i</b>	
<b>Acknowledgements</b>	<b>ii</b>	
<b>Abstract</b>	<b>iii</b>	
<b>CHAPTER ONE:</b>		
<b>Introduction</b>		
1.1.	Introduction	1-3
1.2.	Purpose of the Study	3
1.3.	Research Question	3
1.4.	Motivation for the Research	4
1.5.	Objectives of the Study	5
1.6.	Research Methodology	5
1.7.	Conclusion	6-7
<b>CHAPTER TWO</b>		
<b>Literature Review</b>		
2.1.	Introduction	8-10
2.2.	Structure of Public Health Care	10
2.2.1	Community Level	10

2.2.2	District Level	11
2.2.3	Provincial Level	11
2.2.4	National Level	11
2.3.	Reform of Health Care	12
2.3.1.	Improvement of Public Hospital Infrastructure	12
2.3.2.	Augmentation of the District Health System	12
2.3.3.	Improving the Quality of Care	12
2.3.4.	Interventions to improve child health	13
2.3.5.	Interventions to improve maternal and women's health	13
2.3.6.	HIV and AIDS	14
2.3.7.	Chronic Disease	14
2.3.8.	Communicable Diseases	15
2.3.9.	Affordable Drugs	15
2.3.10.	Human Resource Deployment and development	15
2.4.	Highlights:The White Paper for the Transformation of Health	16
2.5	Disparities between the Public and Private Health Sectors	16
2.6	Distribution of the types of medical aids as at 2003	17
2.7	Reform of Private Healthcare in South Africa	17
2.7.1	Prescribed Minimum Benefits	18-19
2.7.2	Community Rating and Open Enrollment	19-20
2.8.1	The current health insurance market	20
2.8.2	Overview of Private Health Insurance membership	21
2.8.3	Membership Distribution of Private Health Insurance	22
2.9	Social Health Insurance (SHI)	23-25
2.10	The SHI proposed by the DOH has three points of reference	25-27
2.11	The Evolution of SHI in South Africa	28
2.12	The Risk Equalization Fund (REF)	29
2.13	SHI – The Legal Obligation	30
2.13.1	Direct membership of the SHI scheme	30
2.13.2	Indirect participation in the scheme	30-31
2.13.3	Membership of non – reinsured medical schemes	31

2.14	Obtaining SHI Coverage	31-33
2.15.1	Characteristics of NHI and SHI	33
2.15.2	NHI vs SHI	33
2.16	Commentary by South African Institute of Race Relations	34-35
2.17	An Independent Perspective	35-37
2.18	The International Healthcare Environment – Australian NHS	37
2.18.1	Introduction	37-39
2.18.2	Structure of the Australian Healthcare System	39-40
2.18.3	The National Healthcare Funding System	40-41
2.18.4	Medicare	41-42
2.18.5	The Pharmaceutical Benefit Scheme (PBS)	42-43
2.18.6	Medicare Levy	43-44
2.18.7	Health Insurance Commission (HIC)	44
2.18.8	Private Health Insurance	44-45
2.18.9	Summary: The Australian National Health System	46
2.19	Conclusion	47

## **CHAPTER THREE**

### **Research Methodology**

3.1.	Introduction	48
3.2	Case Studies	48-50
3.3.1	Interviews	50-51
3.3.2	Data Quality of Interviews	51-52
3.3.3	The Interview Process	52-53
3.3.4	Advantages and Disadvantages of Tape Recorded Interviews	54
3.4	Conclusion	54-55

## **CHAPTER FOUR**

### **Research Data**

<b>4.1.</b>	<b>Introduction</b>	<b>58</b>
<b>4.1.1</b>	<b>Improvement of Public Hospital Infrastructure</b>	<b>56-57</b>
<b>4.1.2</b>	<b>Augmentation of the District Health system</b>	<b>57-58</b>
<b>4.1.3</b>	<b>Improving the Quality of Care</b>	<b>58-59</b>
<b>4.1.4</b>	<b>Interventions to improve child health</b>	<b>59-60</b>
<b>4.1.5</b>	<b>Interventions to improve maternal and women's health</b>	<b>60</b>
<b>4.1.6</b>	<b>HIV and AIDS</b>	<b>61</b>
<b>4.1.7</b>	<b>Chronic Diseases</b>	<b>62</b>
<b>4.1.8</b>	<b>Communicable Diseases</b>	<b>63</b>
<b>4.1.9</b>	<b>Affordable Drugs</b>	<b>64</b>
<b>4.1.10</b>	<b>Human Resource Development</b>	<b>65</b>
<b>4.2</b>	<b>Enviromental Analysis - STEEP Analysis</b>	<b>66</b>
<b>4.2.1</b>	<b>Social</b>	<b>66</b>
<b>4.2.2</b>	<b>Technological</b>	<b>66-67</b>
<b>4.2.3</b>	<b>Ecological</b>	<b>67</b>
<b>4.2.4</b>	<b>Economic</b>	<b>67</b>
<b>4.2.5</b>	<b>Political</b>	<b>68</b>
<b>4.3</b>	<b>Stakeholders Analysis</b>	<b>68-69</b>
<b>4.4</b>	<b>Strategic Evaluation and Selection</b>	<b>69</b>
<b>4.4.1</b>	<b>GAP Analysis</b>	<b>69-70</b>
<b>4.4.2</b>	<b>Strategic Choice</b>	<b>71</b>
<b>4.4.3</b>	<b>Grand Strategy Selection Matrix</b>	<b>71</b>
<b>4.5</b>	<b>COSATU's Position on SHI</b>	<b>72</b>
<b>4.6</b>	<b>Conclusion</b>	<b>72-74</b>

## **CHAPTER FIVE**

### **Recommendations and Conclusions**

5.1.	Introduction	75-76
5.2.	SWOT Analysis	76-79
5.3.	Challenges facing the Medical Insurance Industry	79
5.3.1	Age Distribution of Beneficiaries	79-80
5.3.2	Unemployment	80-81
5.4	Recommendations – To facilitate the implementation of SHI	82
5.4.1	Development of Infrastructure	82
5.4.2.	Human Resource Development	82-83
5.4.3.	HIV/AIDS	83-84
5.4.4.	Maintenance of a Patient database	84
5.4.5.	Collaboration at Management Level	85
5.4.6.	Medical Scheme Reforms	85-86
5.4.7.	Income Cross Subsidies in Medical Schemes	86
5.4.8	Health Promotion	86-87
5.4.9	Augmentation of Rural Health Facilities	87
5.5	Limitation of the Study	88
5.6	Future Research Areas	88
5.7	Conclusion	88-90
6	References	91-94
7	Appendix : List of Participants Interviewed	95

# **CHAPTER ONE**

## **INTRODUCTION**

### **1.1. INTRODUCTION**

Prior to the 1994 democratic elections, the South African Health System was founded on apartheid ideology and characterized by racial and geographical disparities. There was fragmentation and duplication of critical health centres and a flagrant disregard for primary health care initiatives. There were fourteen departments of health, each pursuing their own objectives.

Access to adequate levels of healthcare for rural communities was difficult. In addition the financial burden of finding and financing transport to health facilities, the cost of services rendered at these facilities acted as barriers to access to care. Many rural hospitals laboured with poorly equipped facilities and critical shortages of medical personnel.

Good health is recognized as a prerequisite for social and economic development. Initiatives instituted by the National Minister of Health; Dr. Manto-Tshabalala Msimang and her predecessor Dr. Nkosazana Dlamini Zuma, have resulted in the creation of a co-coordinated national health system with solid co-operation between national and provincial health departments. The public health system has thus been transformed from a fragmented, racially divided, hospital centred service favouring the urban population into an integrated comprehensive national service driven by the needs to redress historical inequalities and to give priority to the provision of essential health care to disadvantaged people, especially those residing in rural areas.

The Department of Health (DOH) has a 10 Point Strategic initiative to guide its operation. This initiative has culminated in the proposed Social Health Insurance (SHI). The Minister of Health approved the policy framework for Social Health Insurance (SHI) in 2003([www.doh.gov.za](http://www.doh.gov.za)), following which the department established a Risk Equalization Fund Task Group (REFTG). A major achievement of this task group has been the general acceptance and support of all major stakeholders for the establishment of the Risk Equalization Fund, which is a tool used internationally to successfully effect cross subsidies in the medical schemes market (Armstrong, 2004).

### **Key Objectives in Establishing a Social Health Insurance Include**

- To improve access of lower income groups to quality health care.
- To reduce the inequalities in health care financing by improving income and risk related cross subsidies.
- To strengthen the public health system by increasing revenue.
- To obtain prepaid contributions from those who are able to pay for health care ([www.doh.gov.za](http://www.doh.gov.za)).

As at 2005, South Africa had an estimated population of 46.9 million, with Africans constituting 79.4% (Approximately 37.2 million), of the total South African population ([www.statssa.gov.za](http://www.statssa.gov.za)). The total national budget for 2005/2006 tabled by the Minister of Finance; Mr. Trevor Manuel amounted to R369.9 billion, with R48.1 billion allocated to the Department of Health. This represented 13% of the national budget, and an increase of 9.4% to the amount allocated in the 2004/2005 budget ([www.treasury.gov.za](http://www.treasury.gov.za)).

South Africa has a sophisticated and expensive private health sector, which consumes 60% of the total health care expenditure, whilst providing healthcare for less than 20% of the population. It is largely due to the gross inequalities between the public and private sector that the World Health Organization (WHO)

has ranked South Africa 175<sup>th</sup> out of 191 countries in terms of health systems performance ([www.doh.gov.za](http://www.doh.gov.za)).

The Department of Health has thus embarked on a noble mission to provide quality healthcare to a larger proportion of the population, through attempting to address the deficiencies of the public health care system. Despite the private healthcare system being largely self-funded, the DOH has also planned reforms that aim to make private healthcare more affordable and accessible. The next step would be the implementation of a Social Health Insurance (SHI). This however, must be preceded by significant reforms to enable its successful implementation and progression to a National Health Insurance.

This study will address the Department of Health's state of preparedness, for the implementation of a Social Health Insurance. The mechanism of financing of the SHI will be explored and reference will be made to the established health care system employed in Australia.

## **1.2. PURPOSE OF THE STUDY**

The purpose of this study is to conduct an exploratory canvass of some respondents in the private and public health sector; in respect to ten aspects of health, on the preparedness of the public health sector to implement a SHI on 1<sup>st</sup> January 2006

## **1.3. RESEARCH QUESTION**

To what extent is the Department of Health prepared for the introduction of a Social Health Insurance System?

#### **1.4 MOTIVATION FOR THE RESEARCH**

The World Bank classifies South Africa as a middle-income country. South Africa is burdened with high levels of unemployment (26.2% according to Statistics South Africa) and high levels of poverty. As a result of this, the majority of South Africans will continue to depend on the public health system for the foreseeable future. In addition the high levels of unemployment and poverty suggest that this majority will not be able to make any significant contribution towards the cost of their health care.

The scourge of apartheid has resulted in the African National Congress (ANC) inheriting a highly fragmented health care system with huge disparities and inequalities in health service delivery and access to quality health care. The Department of Health believes that the implementation of SHI will seek to address these inequalities, and make quality health care accessible to its indigent population (Gilson, 2000).

The Health Charter released by the Department of Health in July 2005, was intended to be a blueprint for increasing black ownership in the healthcare sector, and improving the standard of medical care provided to patients. Criticism has been forthcoming for this much anticipated policy regulation reform. Mr. Collen Bullen, head of specialized consulting at Lekana Employee Benefit Solutions believes that "it seems almost crass to push the equity issue in advance of meeting the healthcare needs of low income and poverty stricken groups. The Free Market Foundation has added its voice to criticism of the health charter, by saying that: "patients would be better served if the government fixed the public health system before turning its attention to the private sector" The Health Charter therefore needs to be transformed from being merely a policy statement to being the ethical foundation that drives service delivery in the public health sector. (Ryan: Business Times, 11<sup>th</sup> September 2005)

## **1.5 OBJECTIVES OF THE STUDY**

***The analysis of the above mentioned problem statement is further broken down into the following objectives:***

**Objective 1:** An environmental survey of the public health care system in South Africa, with specific reference to the reforms that have been effected.

**Objective 2:** Based on a literature review, certain criteria are identified that will permit the successful implementation of a Social Health Insurance.

**Objective 3:** Recommendations are proposed in terms of the perceived shortcomings of the implementation of the SHI.

## **1.6. RESEARCH METHODOLOGY**

This report utilized the case study approach to analyze the reforms instituted by the Department of Health, and semi structured interviews to test the Department of Health's state of preparedness for the implementation of a SHI. This qualitative method of data analysis, which was explorative orientated, permitted a holistic perspective of the study.

Data was collected utilizing primary and secondary data collection techniques. Primary data was collected using twenty semi - structured interviews with medical professionals, hospital and medical managers in both the public and private health care sectors. Secondary data was collected from the Internet, journal articles, published books and government publications. Established strategic management instruments were employed to conduct an environmental survey of the public health care system.

## **1.7 CONCLUSION**

This report provides an evaluation of the preparedness of the Department of Health, to implement a SHI system on 01<sup>st</sup> January 2006. Chapter 1 has presented a brief overview of the disparities between the public and private health sectors. The motivation, objectives of the study and the research question were defined; and the research methodology clarified.

Chapter 2 explores the structure of the public health sector, and 10 aspects of reform in health care, which may facilitate the implementation of SHI. Review of current literature is undertaken to provide a basis for this study. Reference is made to the health care system of a developed nation, viz. Australia, in an attempt to contrast the mechanism of health service delivery in a developed and a developing nation. A brief outline of the strategic management instruments that were utilized is provided to enhance the data analysis process.

Chapter 3 provides an overview of the two research methodologies used in this study, viz. the case study approach and semi structured interviews. The case study approach was used to analyze reforms implemented by the Department of Health, in preparation for the implementation of SHI. The semi – structured interviews were used to elicit valuable insight from medical professionals at management level within the private and public health sectors.

Chapter 4 utilizes established strategic management instruments to evaluate the preparedness of the Department of Health for the implementation of SHI. The STEEP analysis was used to analyse the wider macroeconomic environment within which the DOH operates. The Stakeholder Analysis assisted in identifying important groups of people who had the potential to exert a significant amount of influence on the DOH and its operations. This permitted the proposal of a turnaround strategy for the DOH, in order to achieve its goals pertaining to SHI.

Responses from the respondents on the 10 aspects of health care are arranged into themes to facilitate a greater understanding of the issues being highlighted. The subsequent analysis reveals that SHI has the ability to address the inequalities between the ailing public health sector and the flourishing private health sector, albeit only once significant reforms are implemented.

Chapter 5 utilizes the data obtained via the case study approach and the semi – structured interviews to make recommendations on the implementation of SHI, which would promote its viability and sustainability in providing quality health care.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

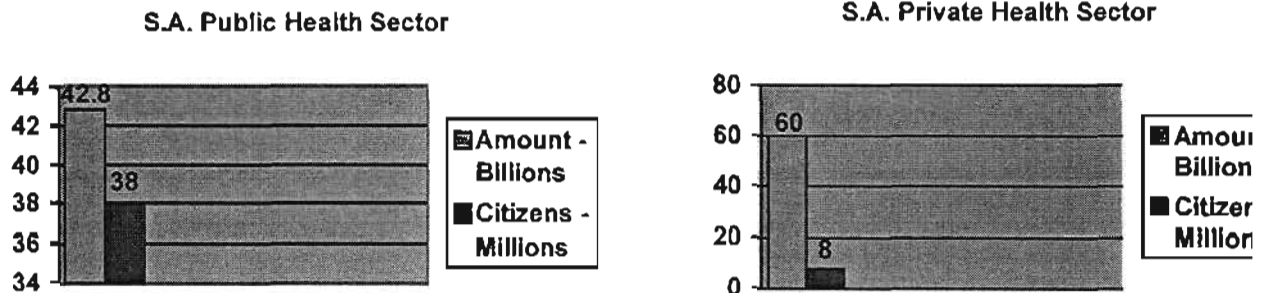
#### **2.1 INTRODUCTION**

Gross income inequalities and a disproportionate distribution of resources between the public sector and the private sector have resulted in large disparities in health status among different socio-economic groups. Out of the total population of approximately 46.9 million people (Statistics South Africa), less than eight million enjoy private medical scheme cover. An estimated 80% of the population relies on public sector health services. This problem is aggravated by the inefficient utilization of resources within the public sector and an emphasis on hospital-based care

In essence, the population consists of a minority receiving First World care, living alongside a majority receiving Third World care. The rift between South Africans who have access to premium quality private health care and the majority who are dependant on the ailing public health service seems to be widening. In 2004 South Africa spent approximately 8% of the GDP on health care. The private sector tasked with providing health care to its 8 million beneficiaries spent approximately R60 billion, whilst the Department of Health received a budget of R42.8 billion to cater for 38 million citizens ([www.doh.gov.za](http://www.doh.gov.za)).

In addition, a large proportion of the population, particularly those living in rural areas and informal urban settlements, are subject to extremely poor living conditions, due to inadequate access to water, sanitation and electricity as well as a shortage in housing. These factors are known to have a direct effect on health (DOH: Healthcare in South Africa, 1997).

**Figure 1: HEALTH POLICY IN CONTEXT**



Adapted: [www.doh.gov.za](http://www.doh.gov.za)

A major challenge in terms of healthcare delivery by healthcare providers and the state is to respond to major changes in demographics and disease profiles, to address lifestyle and cultural differences and to improve access to healthcare. According to the Department of Health, the nearly 8% of GDP which South Africa spends on health is more than it can afford. The World Health Organization's target for South Africa in year 2000 was only 5%. Alternatively 13.0% of total state income for 2005 was spent on health, which is close to the average of 12.6% for developed countries (WHO: World Health Report, 2000)

The Charter of Patient's Rights, introduced by the Department of Health dictates that: "every person has the right to achieve optimal health and it is the responsibility of the state to provide the conditions to achieve this". The Vision and Mission statements of the Department of Health serve to firmly reinforce this ideology [([www.doh.gov.za](http://www.doh.gov.za)) - 2005].

## **Vision Statement**

A caring and human society in which all South Africans have access to affordable, good quality health care [([www.doh.gov.za](http://www.doh.gov.za)) - 2005].

## **Mission Statement**

To consolidate and build on the achievements of the past five years in improving access to health care for all and reducing inequity, and to focus on working in partnership with other stakeholders to improve the quality of care of all levels of the health system, especially preventive and promotive health, and to improve the overall efficiency of the health care delivery system [([www.doh.gov.za](http://www.doh.gov.za)) - 2005].

## **2.2 STRUCTURE OF PUBLIC HEALTH CARE**

The reorganization of the health services in the South African public sector has resulted in the implementation of a primary health care approach that is centred on the individual, the family and the community.

***The Structure of the Department of Health is as follows:***

### **2.2.1 COMMUNITY LEVEL**

The foundation of the National Health System (NHS) is based on Community Health Centres (CHC's). These clinics provide comprehensive services including promotive, preventative, curative and rehabilitative care. These centres are responsible for primary healthcare initiatives in its designated catchment area. The Community Health Committee, whose members are elected from the designated community, provides management of these CHC's.

### **2.2.2 DISTRICT LEVEL**

The main functions of the District Health Authority (DHA), is to promote primary health care and to plan, coordinate, supervise and evaluate services, based on national and provincial norms, policies and guidelines. Community hospitals (also referred to as district level hospitals) are an important component of district health care. They are staffed by general practitioners, who provide basic anaesthesia and surgical skills.

### **2.2.3 PROVINCIAL LEVEL**

The Provincial Health Authority (PHA) is responsible for the health of all people residing in that province. Its main task remains the support and supervision of the DHA's. Vital components of this support include specialist hospitals and services, the organization of training and the coordination; evaluation and planning of primary health care initiatives. The PHA is also tasked with facilitating multisectoral collaboration for the development of health programs and healthy lifestyles.

### **2.2.4 NATIONAL LEVEL**

The National Health Authority (NHA) is responsible for the development and provision of all health care in South Africa. It is responsible for policy formulation and strategic planning, as well as coordination of planning and the functioning of the overall health system in the country. The NHA is tasked to allocate and distribute the health budget, and coordinate both public and private health care. The NHA is chaired by the Minister of Health, and includes the Secretary of Health, Heads of the National Divisions and representatives from the PHA's and DHA's ([www.doh.gov.za](http://www.doh.gov.za)).

## **2.3 REFORM OF HEALTH CARE**

### **2.3.1 IMPROVEMENT OF PUBLIC HOSPITAL INFRASTRUCTURE**

A 1996 audit found that one third of hospitals needed replacement and a further one third needed upgrading. The Department of Health has responded to the challenge by constructing 18 new hospitals since 1999. In addition 190 hospitals were upgraded. The hospital revitalization programme is currently focused on improving the infrastructure, equipment, management and quality in 27 hospitals. This will assist in strengthening the referral system between the different levels of health care ([www.doh.gov.za](http://www.doh.gov.za)).

### **2.3.2 AUGMENTATION OF THE DISTRICT HEALTH SYSTEM**

Since the ANC assumed control of the Department of Health in 1994, more than 1 345 new clinics have been constructed, and 263 clinics were upgraded. This is in keeping with its Primary Health Care Approach, which advocates the promotion of health through prevention and education. The PHC approach remains the underlying philosophy for the restructuring of the health system. It aims to reduce inequalities in access to health services, especially in the rural areas and deprived communities ([www.hst.org.za](http://www.hst.org.za)).

### **2.3.3 IMPROVING THE QUALITY OF CARE**

The Patients Rights Charter, which was launched in 1999, clearly outlines the rights of the patients and the complaints mechanism that is available to them, should they be dissatisfied with the quality of care that they receive. In 2001 all provinces adopted a National Policy on Quality. At hospital level, the Hospital Management and Quality Improvement Grant have made clinical audits and client satisfaction surveys possible. Many provincial hospitals are also enrolled with the Council for Health Services Accreditation of South Africa (COHSASA).

#### **2.3.4 INTERVENTIONS TO IMPROVE CHILD HEALTH**

Special attention has been focused on initiatives to promote maternal and child health. The Department of Health advocates the rights of children as articulated in the UN Convention on the Rights of the Child. The Extended Program on Immunization (EPI) has ensured improved immunization coverage in both urban and rural areas. Disease surveillance and management systems have been strengthened to significantly decrease the incidence of polio by December 2005.

Free health care services have been made available to all children under the age of 6 years, thereby eliminating financial barriers to seeking appropriate medical care. The expansion of the Prevention of Mother to Child Transmission (PMTCT) program has yielded positive results with decreased neonatal transmission in HIV infected mothers (DOH: Health Sector Strategic Framework 1999 - 2004, 1999)

#### **2.3.5 INTERVENTIONS TO IMPROVE MATERNAL AND WOMEN'S HEALTH**

Key initiatives in promoting maternal and women's health include the confidential inquiry into maternal deaths, and the emphasis on early identification of high-risk pregnancies, improved antenatal care and the provision of emergency obstetric services to reduce maternal mortality. The public sector also provides free antenatal care, delivery and postnatal care to women.

The increased incidence of cervical and breast cancer have resulted in screening programs, that enable early diagnosis and treatment, and therefore reduce the impact of the disease. The implementation of the Choice on Termination of Pregnancy Act serves as a viable alternative to unplanned pregnancies and thus reduces the burden on the health and social services (DOH: Health Sector Strategic Framework 1999 - 2004, 1999)

### **2.3.6 HIV AND AIDS**

The estimated prevalence rate of HIV in adults in South Africa is 9.8% of the total population (Statistics South Africa). Results from the annual Antenatal Survey suggest that the overall prevalence of HIV is stabilizing. The South African National AIDS Council (SANAC) was established in 2002, and together with the Khomani Social Mobilization Campaign, has made an impact with regard to advocacy and social mobilization. Condom distribution has increased from 150 million male condoms in 1998, to 270 million male condoms and 1.3 million female condoms in 2003 ([www.doh.gov.za](http://www.doh.gov.za)).

The AIDS pandemic has motivated the implementation of promotive and preventative programs that are directed at adolescents regarding high-risk behavior and sexuality. Essential life skills are being advocated, including safer sexual practices and educational programs that promote health within schools.

The implementation of the Anti Retroviral (ARV) rollout, has given many patients, an opportunity to enjoy a better quality of life, whilst delaying the progression of the disease. The Prevention of Mother to Child Transmission Program has also been beneficial in reducing the rates of transmission from mother to child.

The Treatment Action Campaign (T.A.C) has been a consistent critic of the governments' response to the HIV/AIDS pandemic and has repeatedly used court action to force the government and pharmaceutical companies to provide anti retrovirals at affordable rates (Boyle, 2005).

### **2.3.7 CHRONIC DISEASES**

Management and treatment of chronic diseases has significant cost implications for the public health sector. National guidelines have been implemented for the management of hypertension and diabetes mellitus, with these guidelines being utilized at more than 80% of public health facilities, thus facilitating more cost effective management (DOH: A National Health Plan for South Africa, 1994)

### **2.3.8 COMMUNICABLE DISEASES**

Communicable diseases, both among adult and childhood populations, are one of the leading causes of mortality and morbidity in South Africa. Due to its association with HIV the tuberculosis (TB) control program has enjoyed only limited success. The reported incidence of TB in 2003 was, 551/100 000 population. Despite such a high prevalence the current cure rate is only 53.8% ([www.doh.gov.za](http://www.doh.gov.za)). Severe burden has been placed on the public hospitals with the resurgence of Multi Drug Resistant TB (MDR-TB), which may require up to six months of hospital confinement.

### **2.3.9 AFFORDABLE DRUGS**

An amendment to Medicines and Related Substances Control Act, in the guise of Single Exit Pricing (SEP), was legislated in June 2004, to curb spiraling drug costs. The SEP is the price at which any person may purchase any medication. For prescription drugs, health care workers in the private sector may add a dispensing fee capped at R26.00; if the cost of the medication is greater than R100.00, or 26% if the cost of the medication is less than R100.00 ([www.doh.gov.za](http://www.doh.gov.za)).

### **2.3.10 HUMAN RESOURCE DEVELOPMENT**

The Department of Health has instituted substantial policies and initiatives to promote more equitable distribution of resources geographically. This includes the successful implementation of compulsory community service programs for newly qualified health care professionals. In 2004 a unique system of allowances for health professionals in rural areas (rural allowance) and professionals with skills in short supply (scarce skills allowance) was implemented. This initiative serves to address the critical shortages of health care workers in the rural areas, where they are required the most. New reforms aimed at improving the exposure of rural hospitals to specialist medical practitioners have also been mooted by the Department of Health in the guise of a compulsory community service for newly qualified specialists ([www.doh.gov.za](http://www.doh.gov.za)).

## 2.4 HIGHLIGHTS OF THE WHITE PAPER FOR THE TRANSFORMATION OF HEALTH: 1997

- The health sector must play its part in promoting equity by developing a single unified health system.
- The health system will focus on districts as the major locus of implementation, and emphasize the Primary Health Care (PHC) approach.
- The three spheres of government, non-government organizations and the private sector will unite in the promotion of common goals.
- The national, provincial and district levels will play distinct and complementary roles. A package of essential PHC services will be available to the entire population at the first point of contact.

## 2.5 DISPARITIES BETWEEN THE PUBLIC AND PRIVATE HEALTH SECTOR

	PUBLIC SECTOR	PRIVATE SECTOR
Cover	<ul style="list-style-type: none"> <li>□ Indigent (pop. growth)</li> <li>□ Low – income (pop. growth)</li> </ul>	<ul style="list-style-type: none"> <li>□ High income (no change)</li> <li>□ Goods risks (no change)</li> <li>□ Poor risks (decrease)</li> </ul>
Burden of Disease	<ul style="list-style-type: none"> <li>□ HIV / AIDS</li> <li>□ Infectious</li> <li>□ Communicable</li> <li>□ Chronic</li> </ul>	<ul style="list-style-type: none"> <li>□ HIV/ AIDS (limited cover)</li> <li>□ Infectious (na)</li> <li>□ Communicable (na)</li> <li>□ Chronic (reduce cover)</li> </ul>

**Adapted: SHI Policy Direction (AIDS Law Project) - 2004**

## 2.6 DISTRIBUTION OF THE TYPES OF MEDICAL SCHEMES AS AT 2003

	<b>Number of Medical Aids</b>	<b>Proportion by Number of Medical Schemes</b>	<b>Proportion by Number of Beneficiaries</b>
Open Schemes	49	32.9%	68.1%
Restricted Membership	88	59.1%	28.2%
Bargaining Council Schemes	12	8.0%	3.7%

**Adapted: SHI – Doherty 2000**

## 2.7 REFORM OF PRIVATE HEALTH CARE IN SOUTH AFRICA

Reforms introduced by the Medical Schemes Act of 1998 serve as an important building block for Social Health Insurance. The most significant reforms include:

- Prescribed Minimum Benefits.
- Community Rating and Open Enrolment.

### **2.7.1 PRESCRIBED MINIMUM BENEFITS (PMB)**

The Medical Schemes Act, No 131 of 1988, reintroduced prescribed minimum benefits as a policy instrument for defining minimum levels of medical scheme cover. The act dictates that these PMB's have to be provided in at least one network setting and that diagnosis and treatment must be covered in full, without financial limits or co-payments.

*Specification of Prescribed Minimum Benefits serves to:*

- Avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilization of public hospitals.
  
- Encourage improved efficiency in the allocation of private and public healthcare resources.

The PMB's were extended from January 2004 with the introduction of the Chronic Disease List (CDL). This defines twenty-five chronic conditions, considered to be life threatening and which are explicitly regulated in order to prevent late sequele and complications. The cost of diagnosis, treatment and medication for these conditions must be covered in full by the medical scheme, subject to published treatment algorithms (Giese, 2000).

The Taylor Committee, which was appointed by the DOH, released a report in May 2002 that recommended there be a policy process for defining and implementing basic essential healthcare services that would be available in both public and private sectors. It is proposed that both sectors need to provide a minimum core set of services. Within medical schemes these are regulated as

Prescribed Minimum Benefits (PMB's), whereas within the public sector these are framed as Minimum Norms and Standards.

Benefits in respect of HIV/AIDS provide a good link between public norms and standards and private PMB's. Initially the PMB for HIV/AIDS covered only secondary opportunistic infections (eg. PTB, Cryptococcal Meningitis). Once these benefits were made available in the public sector, it was extended to cover mother to child transmission and rape prophylaxis. Now that the public sector is committed to the rollout of anti-retroviral treatment, medical schemes will have to include anti-retroviral treatment in its PMB's (DOH: Health Sector Strategic Framework 1999 - 2004, 1999)

## **2.7.2 COMMUNITY RATING AND OPEN ENROLMENT**

*There are currently three types of Medical Schemes operating in South Africa:*

- Restricted Membership Schemes: Are allowed to restrict who may become a member. Restrictions include employment in a particular profession, trade or industry, employment by a particular class of employer or membership of a professional association or union. Example: Profmed.
- Open Schemes: The remaining medical schemes are termed open schemes. Example: Discovery.]
- Bargaining Council Schemes: These schemes were initially developed under the Labour Relations Act and typically offer limited benefits-often only primary health care. They are not able to comply fully with the Medical Schemes Act and are typically granted exemptions from providing the PMB's. Example: Furniture Workers Medical Scheme.

Open enrolment compels all open schemes to accept anyone who wants to become a member, at standard rates. Underwriting with premiums calculated according to the risk of the individual or group is no longer permitted.

The new amendment to the Medical Schemes Act No 131, dictate that everyone must be charged the same standard rate, regardless of age or state of health. This practice is termed community rating and applies to all medical schemes.

Open schemes thus have a strong financial incentive to attract a younger age profile and thereby reduce their industry rate to the market. Therefore medical schemes that can attract a younger and healthier profile derive a substantial competitive advantage (Doherty, 2000).

The Department of Health believes that community rating should apply not only to options within the schemes but also to the industry as a whole. Members should be facing a common community rated price for the PMB package and not a price determined by each scheme according to its distinctive age and health profile. This creates a strong foundation for the introduction of the Risk Equalization Fund ([www.doh.gov.za](http://www.doh.gov.za)).

### **2.8.1 THE CURRENT HEALTH INSURANCE MARKET**

South Africa has a population that exceeds 46.9 million, the vast majority of which has no medical insurance and is thus dependant on the state for healthcare benefits. There are substantial inequalities within the current system due to the historical imbalances around the allocation of health resources and benefits. Research conducted by the Council for Medical Schemes; suggest that despite significant attempts to address the medical insurance industry through legal reform the insured market has remained relatively stagnant.

## 2.8.2 OVERVIEW OF PRIVATE HEALTH INSURANCE MEMBERSHIP

<b>Year</b>	<b>Private Health Insurance Membership</b>	<b>Percentage Change</b>
2000	7020233	-
2001	7020806	↑ 0.23 %
2002	6963189	↓ 0.89 %
2003	6924686	↓ 0.55 %

**Adapted from: The Council for Medical Schemes Annual Report: 2003-2004**

Concern has also been raised with regard to the impact of medical inflation and whether it has negatively impacted on the growth of the medical insurance industry. There has been no significant growth in the insured sector and accordingly one could argue that despite the positive developments in legal reform, they have not had a real impact on growth.

It is further estimated by the Department of Health (DOH), that there will be a consistent decline in the total number of restricted schemes as the market attempts to look to more open membership. ([www.doh.gov.za](http://www.doh.gov.za)).

### 2.8.3 MEMBERSHIP DISTRIBUTION OF PRIVATE HEALTH INSURANCE

Type of Scheme	2003	2002	Percentage Change
Registered Scheme	6671801	6714145	- 0.63 %
Open Membership	4718797	4731211	- 0.26 %
Restricted Membership	1953004	1982934	- 1.51 %
Bargaining Council	252885	249044	+ 1.54 %
<b>Total</b>	<b>6924686</b>	<b>6963189</b>	<b>- 0.55 %</b>

**Adapted from Council for Medical Schemes Annual Report: 2002-2003**

Therefore the DOH recognizes that the legislative reform within the medical scheme sector has not had the desired impact of improving access to healthcare. Therefore SHI seeks to create an alternative form of health insurance, primarily aimed at the employed but currently uninsured market.

## **2.9 SOCIAL HEALTH INSURANCE (SHI)**

The Government's policy document, *A Social Health Insurance Scheme for South Africa: September 1997*, indicates Government's intention to initiate a Social Health Insurance Scheme.

Under the Social Health Insurance (SHI) policy, formal sector employees earning more than the tax threshold, would be required to have coverage for themselves and their dependents for treatment in public hospitals. The tax threshold for 2004/2005 below which individuals do not have to pay income tax is R35 020.00 ([www.sars.gov.za](http://www.sars.gov.za)). Initially informal sector employees with income below the tax threshold will not be targeted. Contributions to the SHI would be shared between employers and employees (Alexander Forbes Diagnosis, 1998).

The focus on all formal sector employees may not be equitable, as a large number of informal employees are major income generators. This means that a small pool of contributors will now have to pay higher contributions, whereas increasing the pool of contributors could reduce premiums.

The Department of Health prefers the route of an earmarked tax, which would be utilized specifically for funding SHI. This is in contrast to the Department Of Finance's proposal for a reform of the current tax subsidy, as a mechanism for financing the SHI. The sliding scale, which has been proposed, is based on the income earned by an individual. Funds generated in this way will be used to finance a Basic Benefit Package (BBP) for the uncovered – which is estimated to extend medical scheme cover to a further 3 to 4 million lives (Khunoane, 2005).

Total medical scheme contribution income is estimated at R 48 billion per annum. The estimated cost of the current PMB package for existing medical scheme members is R16 billion per annum. By introducing a 4.5% SHI tax on medical scheme members, R17 billion will be raised; R1 billion more than is required.

However this excess is insufficient to extend cover to the estimated 4 million uncovered lives, in families who earn above the tax threshold. The cost of extending a basic benefits package (BBP) to these uncovered employees is estimated at R10 billion per annum, with R6 billion raised via the 4, 5% SHI tax on non-medical scheme members.

In total, R26 billion is required to provide PMB cover to 11 million medical scheme members, with a total of R23 billion raised from the 4, 5% SHI tax. The result is a significant shortfall of R3 billion (Cloete, 2003).

The funds generated by the SHI tax will be supplemented by the restructured medical tax subsidy, which was announced by Treasury. It is hoped that the combination of these initiatives would enable Treasury to mitigate the R3 billion shortfall. However if a budgetary shortfall remains, a scaled-down version of the Basic Benefits Package (BBP) for targeted low-income groups would need to be considered.

With the lack of consensus within Government as how best to achieve the objective of expanding cover to the uncovered, implementation of a fully-fledged SHI system is likely to take longer than originally timetabled. In the meantime, the Department of Health is keen to explore short to medium term solutions within the current voluntary medical scheme environment to extend access to the low income employed population, without an extensive income cross subsidy restructure ([www.doh.gov.za](http://www.doh.gov.za)).

### Calculation of Estimated Shortfall in the Provision of PMB's

Cost of PMB package for existing 7 million medical scheme lives	R 16 billion
Cost of PMB package for 4 million uncovered lives	R 10 billion
Total cost of PMB package for 11 million scheme members	R 26 billion
4.5% SHI tax raised by existing medical scheme tax payers	R 17 billion
4.5% SHI tax raised by non medical scheme tax payers	R 6 billion
Total 4.5% SHI tax raised by tax payers	R 23 billion
<b><i>Shortfall in cost of PMB benefit provision</i></b>	<b><i>R 3 billion</i></b>

Adapted: Alexander Forbes Diagnosis

#### 2.10 THE SHI PROPOSED BY THE DOH HAS THREE POINTS OF REFERENCE

The first point is that the public health system provides essential health services to the population, irrespective of their ability to pay. The use of the public health system, however, is not restricted to the poor, in the subsistence and informal sectors.

It is widely utilized by formal sector workers who become unemployed, by previously employed pensioners and by those in private medical schemes who have exhausted their benefit cover or who would exhaust their cover if they used costly private medical services. In doing this the South African public health system provides a safety net of health care for the majority of South Africans, many of whom are or have been workers in the formal sector. Therefore the first policy objective of the SHI scheme is that it will support the public health system, which is widely viewed as the healthcare system of ultimate resort (DOH: SHI Scheme for South Africa).

The second point is that in the context of increasing government resource constraints, patients who can afford to pay for services at public health care institutions, should do so. In line with the DOH's emphasis on pursuing a primary health care policy, health care to pregnant women and young children are free at the point of service, but those patients with incomes above a defined threshold are expected to pay for public hospital care (DOH: SHI Scheme for South Africa).

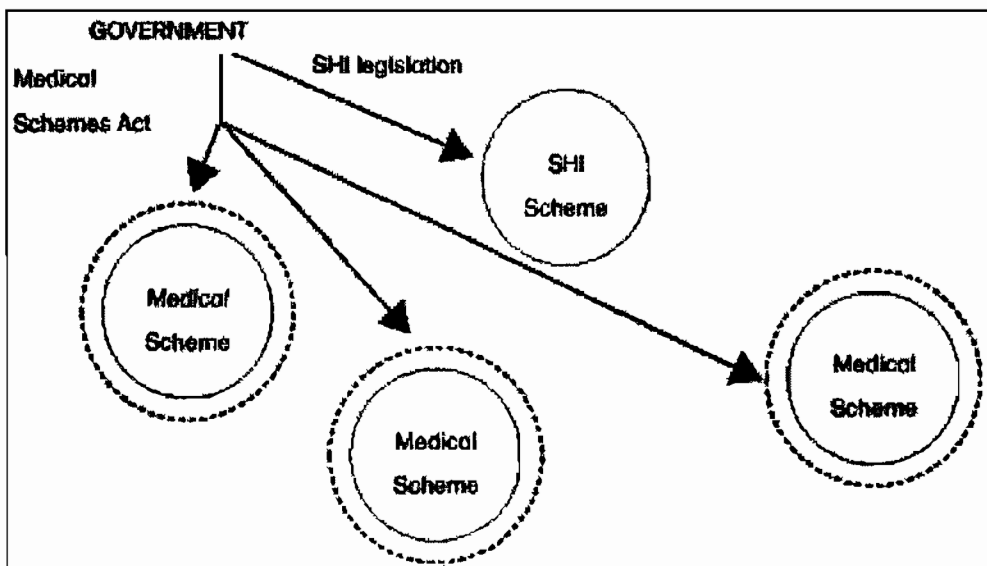
User fee revenue is greatly needed by public hospitals especially by those at higher levels, to compensate for constrained budgetary allocations. The large number of lower and middle-income families that utilize public hospitals aggravates the problem. Many of these patients do not have private medical scheme cover and do not pay the prescribed fees, which are based on their level of income. In addition, medical scheme beneficiaries, especially the sick and elderly who require expensive health care interventions and who have exhausted their insurance cover, present themselves at public hospitals and do not pay the prescribed fees that they are liable for. This results in a dumping syndrome. Therefore the second policy objective of the SHI is to provide an effective mechanism for collecting public hospital fees, by ensuring that all formal sector employees and their dependants are insured for public hospital treatment.

The third point of the SHI scheme is the spiraling costs of private health care and the deregulation of the medical insurance industry. Increasing medical scheme contributions have been accompanied by declining scheme memberships. With the introduction of non-indemnity medical insurance in South Africa, new insurance products are being introduced, that seek to attract a young and healthy membership. This has resulted in adversely affecting the risk pool in traditional medical schemes where risk rating has become more common. As a result, benefit coverage is reduced and premiums are increased especially for the old and the chronically ill. Therefore the third policy objective of the SHI scheme is to provide formal sector employees with state sponsored insurance cover for essential hospital care at low cost (Doherty, 2000).

**Figure 2** represents the current official policy position of the Department of Health. The Medical Schemes Act may increase the membership of medical schemes. A competing SHI fund is presented as an alternative. Membership of one or the other is compulsory, however cross - subsidising between the array of small "risk pools" is not achieved.

This is a compartmentalized system that fails to achieve the main objective of SHI as it was proposed in the past, namely the tapping of resources currently spent in the private sector in order to enhance cross-subsidisation between the rich and the poor ([www.doh.gov.za](http://www.doh.gov.za)).

**Figure 2: CURRENT SHI PROFILE**



(Adapted: Health Systems Trust – 2000)

## 2.11 THE EVOLUTION OF SHI IN SOUTH AFRICA

FEATURES	NATIONAL HEALTH INSURANCE BEFORE 1994	SOCIAL HEALTH INSURANCE 1994-1996	SOCIAL HEALTH INSURANCE IN 1997
Contributors	All employed people	Formally employed only.	Only formally employed above the income tax threshold and not on medical schemes.
Beneficiaries	The entire population.	Contributors and their dependants.	Contributors and their dependants.
Cover	Comprehensive	Hospital care only.	Hospital care only.
Providers	Mainly public, but role for the private sector (especially GP's).	Mainly public, but role for the private sector.	Public Hospitals
Administration	Potentially large role for medical schemes administrators.	Potentially large role for medical scheme administrators.	Government agency

**Adapted: SHI - Doherty (2000)**

## **2.12 THE RISK EQUILIZATION FUND (REF)**

A major reform proposed by the DOH is the Risk Equalization Fund (REF). The REF will be introduced as an integral component of the SHI scheme. Risk equalization is a mechanism to ensure that everyone pays the same industry community rate for the common package of benefits provided by the medical scheme; not the rate determined by the age and health profile of the medical scheme they have chosen to join. Medical aid schemes are based on the principle of cross subsidization, where healthy members subsidize sickly members. The healthy people get out less than they put in; the sick members, however, consume more than they contribute. This can incentivise schemes to selectively enroll low-risk members, which means that risky groups like the elderly struggle to find cover. Government has partially addressed this problem by introducing open enrolment and community-based rating; where schemes are now compelled to accept anyone who applies.

However, after years of schemes cherry-picking the best risk, there are a number of schemes with wildly divergent risk profiles. The Department of Health (DOH) has argued that managing small groups of people with diverse risk profiles is inefficient; therefore it plans to introduce the REF to balance things out.

In its current version, schemes will pay money in to the REF based on a flat rate per member, and then will draw money according to their risk profile. Schemes with many young, healthy members will probably be net contributors to the REF, while schemes with an older population will be net drawers (Armstrong, 2004).

Brenda Khunoane, the director of Social Health Insurance, believes that the environment is unstable and there is an imbalance in the medical scheme market around profile pools. This has resulted in the market becoming stagnant because schemes are targeting young and healthy members to keep costs down (Moodley, 2005).

## **2.13 SHI – THE LEGAL OBLIGATION**

Following the implementation of the SHI scheme, formal sector employees earning above the income tax threshold will have a legal obligation to be insured against the costs of themselves or their dependants requiring care in public hospitals. There are three routes for complying with the SHI legal obligation ([www.hst.org.za](http://www.hst.org.za)):

1. Direct membership of the SHI scheme.
2. Indirect participation in the SHI scheme, via “reinsured” medical schemes.
3. Membership of non-reinsured registered medical schemes.

### **2.13.1 Direct Membership of the SHI Scheme:**

Employees and employers will share the direct contributions of the SHI scheme. The contributions payable will be a fixed percentage of the payroll. Members will be at liberty to purchase their own private medical insurance for additional benefit cover (example: for general practitioner care) if they desire. The SHI scheme will provide members and their dependants with acute outpatient and inpatient care in public hospitals free at the point of service. Beneficiaries will be entitled to receive the basic therapeutic interventions from public hospitals with a limited list of exclusions, such as cosmetic surgery.

### **2.13.2 Indirect Participation in the SHI Scheme, via “reinsured” registered medical schemes:**

Registered medical schemes may choose to re-insure themselves with the SHI scheme for the expected use of public hospital services by their beneficiaries. This would result in the medical schemes forward funding the SHI scheme. The size of the forward funding is dependant on the average actual utilization. The level of forward funding will be based on the full actual cost of public hospital services and will be adjusted annually for changes in patterns of use and cost.

This will assist in revenue collection, as the use of public hospitals by medical scheme beneficiaries will be prepaid.

### **2.13.3 Membership of Non-reinsured Medical Schemes:**

Medical schemes, which opt not to reinsure themselves with the SHI scheme, will be billed on a per patient basis for public hospital treatment. Their medical schemes will be obliged to pay the full price for public hospital care, which will be calculated from the top tariff rates. Costs will be allocated using patient day equivalents and will provide for full cost recovery ([www.hst.org.za](http://www.hst.org.za)).

Medical schemes, that specialize in high-income members, who are unlikely to ever use public hospitals, may prefer this option. However choosing this option will increase the risk of having to pay for expensive interventions at full price if their beneficiaries choose or are compelled to use public hospital services.

## **2.14 OBTAINING SHI COVERAGE**

*Coverage under the SHI could be obtained in two ways:*

- Membership in a private medical scheme that offers the minimum coverage but 'reinsures' (or more accurately, prepays) the public hospital portion through the SHI scheme. The DOH estimates that the reinsurance mechanism would cost private medical schemes about R1.6 billion in aggregate to fully cover their 8 million beneficiaries. In terms of the 'reinsurance', medical schemes would pay "x rand" per member belonging to the medical scheme, towards the SHI. The reasoning behind this is that when members reach limits on a private medical scheme, they then transfer to the state system for "free" treatment.

- Through direct membership to the SHI scheme, established solely to finance public hospital coverage. There seems to be uncertainty around the administration of Option 2 (direct membership to SHI). Whether there will be one separate national fund, or whether administration would be contracted out to various medical scheme administrators that will have a separate SHI option for direct members, is still being considered. Medical aid administrators and some of the countries largest hospital groups are currently compiling proposals, to include the administration of the SHI initiative within their scope of activities (DOH: A SHI Scheme for South Africa, 1997).

Whether provided through private schemes or direct membership to the SHI, coverage for acute outpatient and in-patient care at public hospitals would be free at the point of service, i.e. a 100% benefit is offered with no limits. The DOH has stated that SHI has the potential to attract 6.9 million members, who would be in formal employment; earning a current annual salary above the tax threshold of R35 020. The DOH has indicated that a 4, 5 % tax on payroll for these individuals would cover all public hospital costs. For employed members, contributions would be shared with employers. This plan has the potential to generate R3 billion for public hospital care (Alexander Forbes: Diagnosis, 1998).

The DOH acknowledges that contributions to the SHI fund may not be adequate to recover all public hospital costs for treating members. Nevertheless, the revenues collected will be an improvement over the current situation (Alexander Forbes Diagnosis, 1998). There is no indication that public hospitals will be subject to any type of processes designed to ensure that only appropriate and cost-effective treatment is being delivered (Alexander Forbes Diagnosis, 1998).

Due to the anticipated structure of this system, the employers and the employees will effectively be paying for two medical insurance programs - their private cover and their SHI cover. Understandably this has the potential to result in a relative mass withdrawal from the private funds. It is estimated that approximately 30% of medical scheme membership will migrate to the SHI. The Social Health Insurance Proposal and White Paper on Health (1997) do not consider the cost of 2.25 million people turning away from medical schemes and private care and returning to the public sector for their medical needs (Meaklim, 1998).

#### **2.15.1 CHARACTERISTICS OF NHI AND SHI**

- Mandatory contributions for the entire population or certain groups like (public sector employees).
- Usually employment related with payroll deductions.
- Contributions from employers and employees.
- Premiums are income related and benefits are standardized.
- Creates large risk pool and avoids adverse selection.
- Cross subsidization (healthy and the sick, wealthy and the poor).  
(AIDS Law Project, 2004)

#### **2.15.2 NHI vs. SHI**

- National Health Insurance
  - Benefits for contributors and non-contributors.
  - Cross subsidies, dedicated health tax.
- Social Health Insurance
  - Benefits contributors only.
  - Can increase resources available for public health care.  
(AIDS Law Project, 2004)

## **2.16 COMMENTARY BY SOUTH AFRICAN INSTITUTE OF RACE RELATIONS (SAIRR)**

The rift between the public and private health sectors in South Africa is firmly entrenched. John Kane Berman of the South African Institute of Race Relations reported “the minister of health wants to assume dictatorial powers over the private medical profession which she seems to loathe” (Berman, 2004).

In terms of the National Health Act, which was passed in 2003, doctors practicing in South Africa without a “Certificate of Need” may be jailed for up to five years. Berman believes that this is a penalty of “astonishing severity for something that should not be a crime at all”. Much attention has been devoted to health minister Manto Tshabalala Msimang’s stated desire to use this reform to ensure that more doctors (and other health providers) operate in rural areas.

The minister has stated “Healthcare has become a lucrative business where profits are made at the expense of patients. She described the private healthcare system in South Africa as “a ravenous monster that preys on our people in the form of corrupt professional and establishments”.

Official antipathy to private healthcare is also evident in the differential treatment of private and public sector doctors. Whilst the Certificate of Need propagates the imprisonment of private doctors for practicing in the wrong area, public sector doctors are rewarded with rural allowances (Berman, 2004).

Dr. Kgosi Letlape, Chairman of the South African Medical Association stated, “Improving healthcare in South Africa requires a vibrant and efficient public health system working in partnership with the private sector”. He believes that for South Africa to cope with its mounting health challenges, especially the HIV/AIDS pandemic it requires efficient public hospitals and clinics, working in collaboration with a network of private general practitioners (GP’s) who can prevent the spread

of HIV/AIDS, counsel AIDS victims and monitor the response of patients receiving anti retrovirals. Dr. Letlape believes that if GP's are not accorded this role, the HIV/AIDS pandemic has the potential to paralyse medical facilities in public hospitals. In addition despite the overwhelming need for a powerful partnership against AIDS the health department is busy enacting laws that could spell the end of private healthcare for South Africa (Letlape, 2004).

Substantial numbers of South Africans have emigrated in recent years. Whilst this is not a new occurrence, the SAIRR believes that there is currently not enough immigration to compensate the country for the skills lost through emigration. In addition a greater number and proportion of emigrants than immigrants are highly skilled. This mass exodus of medical personnel is a critical part of this brain drain. Currently more than 75% of anaesthetists work exclusively in the private sector and 67% of all medical specialists are employed in the private sector. This skewed distribution of critical medical personnel needs to be addressed (SAIRR, 2001).

The Minister of Health has stated that the National Health Act will lead to a unified health system. However many critics view her dictatorial attitude and lack of consultative processes with key stakeholders in the private sector as a major hurdle in the pursuit of a unified health system. Both the public and private health sectors have much to contribute towards a National Health System, but this can only be achieved if collaborative consultation occurs between key stakeholders with a patient centered approach being adopted (SAIRR, 2001).

## **2.17 AN INDEPENDENT PERSPECTIVE**

Social Health Insurance promoted by government in the guise of the Government Employees Medical Scheme (GEMS) presents a lucrative opportunity for existing medical schemes, to become designated administrators. The scale of the project

and its potential to become the country's largest medical scheme largely drives this. Adele Shevel of the Business Times believes that several existing schemes will have to find new ways of operating or face closure due to the high proportion of government employees in their schemes. The motivating factor behind the new scheme is the potential to manage healthcare costs and have stronger negotiating powers with service providers. (Shevel, 2005)

As of January 2006, all new government employees, and existing employees who voluntarily opt to join, will belong to the scheme. Government employees tend to be younger and have a lower claim rate than non-governmental employees, thereby cross subsidizing older, sicker members. The Medical Schemes Act requires that schemes be legally compelled to hold 25% of premium contributions as reserves. Movement of younger patients with lower claim ratios will therefore adversely affect the maintenance of reserves by many of the schemes whose membership is terminated by civil servants (Shevel, 2005).

#### **MEMBERSHIP PROFILE OF LEADING PRIVATE MEDICAL INSURERS**

<b>Medical Scheme</b>	<b>Civil Service Membership</b>	<b>Non-Civil Servant Membership</b>	<b>Total Membership</b>	<b>Percentage Civil Service Membership</b>
Bonitas	104 000	102 145	201705	50.64
Polmed	98 000	32 562	130 462	68.93
Medshield	71 000	4 418	75 418	94.14
Spectramed	38 000	30 302	68 302	55.63
Discovery	34 000	625 000	659 000	51.59

**Adapted: Discovery Health Review: 2005**

GEMS will start to drive costs down, due to the magnitude of members that it will cover. Some commentators expect that the lower costs will also be passed on to the other private sector schemes. Critics, however, believe that the opposite will apply, where service providers may attempt to compensate for the loss of margins resulting from GEMS, by increasing rates in the private sector.

The Department of Health is currently working on improving its hospitals, many of which are under-resourced and over burdened. The government intends using these hospitals as competition to the private hospitals. This will seek to address the skewed distribution of resources between the public and private healthcare sectors. GEMS is also expected to drive consolidation and amalgamation within the medical schemes industry, as some schemes will require assistance to weather the storm (Shevel, 2005).

A major pre-requisite of SHI is strong collaboration between the private and public sector to ultimately achieve equity and provide a superior level of health service delivery for all.

## **2.18 THE INTERNATIONAL HEALTHCARE ENVIRONMENT - THE AUSTRALIAN NATIONAL HEALTH SYSTEM**

### **2.18.1 INTRODUCTION**

Australia's health system has its historical origins in the United Kingdom. The public health and hospital systems of Australia are modeled on their British counterparts and the overall organization of health services revolves around the central role of the general practitioner. Though Australian health systems are founded on the British model, they have evolved into an Australian version that is currently known as Medicare. The principles of Medicare are similar to those that

underlie the National Health System (NHS) in Britain, namely equitable access of all citizens to government funded quality health care ([www.health.gov.au](http://www.health.gov.au)).

In Australia most medical services, are provided by private general practitioners and specialists on a fee-for-service basis that is reimbursed by Medicare. Although public hospitals provide open access to all citizens at no cost beyond the universal taxation levy for Medicare, there are private hospitals for those who have private health insurance. Pharmaceuticals are supplied at marginal cost to the citizen through a government subsidised pharmaceutical benefit scheme (PBS).

The Australian National Health System is visionary due to the fact that financing is spread across the entire population as part of their tax, and the low unemployment rate ensures that significant funds are collected. Australia's private doctors consult with patients and bill the National Health system on a fee-for-service basis. This vastly improves the accessibility to primary healthcare. In addition, by billing to a central pool, it assists health insurance administrators in being able to monitor costs and identify overuse and abuse.

The Australian Department of Health and Ageing administered a budget of \$32.8 billion in 2004. This represented an increase 9% over the health expenditure for the 2002-2003 fiscal period. This represents 4% of Australia GDP and includes support for all Australians through the various programs that define Medicare. Australia's health system continues to be amongst the worlds most effective in delivering good health outcomes. Approximately 70% of total health expenditure in Australia is funded by government, with the Australian government contributing two thirds of this; and state, territory and local governments the other third. The two main vehicles through which the subsidies are affected are Medicare and the Pharmaceutical Benefit Scheme (PBS).

Australians continue to live longer and the current life expectancy at birth is 80 years, ranking their life expectancy at fourth in the world in 2002 (WHO 2003). Despite the accolades, there is a realization that persistent poor health among indigenous Australians, both in terms of mortality and life expectancy needs to be addressed. Australia has a strong focus on primary health care and emphasizes a holistic and multidisciplinary approach to the management of medical conditions ([www.health.gov.au](http://www.health.gov.au)).

Heart, and vascular disease, stroke, chronic respiratory and lung conditions and cancer are the leading causes of non-communicable disease and death worldwide. The National Health Priority Action Council (NHPAC), in conjunction with the Australian Department of Health, has developed a National Chronic Disease Strategy to ensure the most efficient expenditure on chronic illness.

Due to high public health standards the incidence of illness and death from communicable diseases is much lower in Australia as compared to developing countries such as South Africa. In addition childhood immunization coverage rates in Australia have increased to an all time high with over 90% of children at 12 months of age fully immunized.

### **2.18.2 STRUCTURE OF THE AUSTRALIAN HEALTHCARE SYSTEM**

The Commonwealth displays a strong leadership role in policy making, and particularly in national issues like public health, research and national information management. The States and Territories are primarily responsible for the delivery and management of public health services and for maintaining direct relationships with most health care providers, including the regulation of health professionals.

The States and Territories deliver public acute and psychiatric hospital services and a wide range of community and public health services including school health, dental health, maternal and child health and environmental health programs. The States and Territory governments directly fund a broad range of health services. The Commonwealth funds most medical services out of hospital, and most health research. The Commonwealth, States and Territories jointly fund public hospitals and community care for aged and disabled persons.

There is a large and vigorous private sector in health services. The Commonwealth Government considers that strong private sector involvement in health services provision and financing is essential to the viability of the Australian health system. Therefore the Commonwealth Government provides a 30% subsidy to individuals who acquire private health insurance and has introduced additional arrangements to foster lifelong participation in private health insurance ([www.health.gov.au](http://www.health.gov.au)).

Private health insurance can cover private and public hospital charges (public hospitals charge only patients who elect to be private patients in order to be treated by the doctors of their choice), and a portion of medical fees for inpatient services. Private insurance can also cover allied health/paramedical services.

### **2.18.3 THE NATIONAL HEALTH CARE FUNDING SYSTEM**

The aim of the national health care funding system is to give universal access to health care while allowing choice for individuals through a substantial private sector involvement in delivery and financing. The major part of the national health care system is called "Medicare". Medicare provides high quality health care which is both affordable and accessible to all Australians, often provided free of charge at the point of care. It is financed largely from general taxation revenue, which includes a Medicare levy based on a person's taxable income.

*Commonwealth funding for Medicare is mainly provided as:*

- Subsidies for prescribed medicines (with a safety net providing free medicines for the chronically ill) and free or subsidized treatment by practitioners such as doctors, participating optometrists and dentists.
- Substantial grants to State and Territory governments to contribute to the costs of providing access to public hospitals at no cost to patients; and
- Specific purpose grants to State/Territory governments and other bodies

#### **2.18.4 MEDICARE**

*All people eligible for Medicare are entitled to a choice of:*

- Free accommodation, and medical, nursing and other care as public patients in State/Territory-owned hospitals, designated non-governmental religious and charitable hospitals, or in private hospitals which have made arrangements with governments to care for public patients; or
- Treatment as private patients in public or private hospitals, with some assistance from governments.

State and Territory governments are responsible, under agreements with the Commonwealth Government, for ensuring that services adequate to meet public patient entitlements are available to all people eligible for Medicare. This component of Medicare is funded jointly by the Commonwealth Government and State and Territory governments under the Australian Health Care Agreements.

On admission to public hospitals, patients may choose to be public (Medicare) patients, or private patients. If they choose to be public patients, they receive free medical and allied health/paramedical care from doctors nominated by the

hospitals, as well as free accommodation, meals and other health services while in hospital.

Medicare-eligible patients who choose to be private patients in public hospitals are charged fees by doctors, and are charged by the hospital for hospital care, usually at a rate less than the full cost of providing these services. If the patient holds private insurance, this will usually cover all or nearly all of the charges by a public hospital. Medicare pays benefits, subsidizing part of the cost of doctors' fees and private insurance pays an additional amount towards doctors' fees. Private insurance benefits can also contribute to payment of the costs of allied health/paramedical and other costs (for example, surgically implanted prostheses) incurred as part of the hospital stay ([www.health.gov.au](http://www.health.gov.au)).

#### **2.18.5 THE PHARMACEUTICAL BENEFIT SCHEME (PBS)**

The Pharmaceutical Benefits Schemes (PBS) aims to provide all Medicare-eligible persons with access to effective and necessary prescription medications at a reasonable cost to the patients and to the nation. The PBS provides subsidies for about 600 kinds of drugs in nearly 1500 formulations. Additional drugs are added when assessed as meeting safety, quality, effectiveness and cost-effective criteria.

Pharmaceutical benefits are paid as cash transfers directly to around 4800 approved community pharmacies that dispense PBS medications on a claims reimbursement basis. The PBS also provides other forms of assistance to improve affordable access to medicines, for example specific funding for public hospitals for certain high cost drugs, such as immunosuppressants used in transplantation. It is estimated that around 75 percent of all prescriptions dispensed in Australia are subsidized under the PBS. The other major source of subsidized medicines is public hospitals, where medicines are provided free to

in-patients. The total cost of PBS prescription drugs dispensed from community pharmacies each year is nearly \$3.9 billion. The Commonwealth pays approximately 83% of this cost. The remainder is funded by patient co-payments.

The percentage of the cost of PBS prescriptions covered by the Australian Government remained constant at 84.2% between 2002-2003 and 2003-2004. There is however a discrepancy in the distribution of pharmacies across rural and urban areas. In 2003-2004 there were an average of 3717 people per pharmacy in urban areas and 4467 people per pharmacy in rural areas.

To assist the future sustainability of the PBS, legislation was passed on 26 June 2004 to increase PBS co-payments; which have not increased since 1996-1997. Increasing patient co-payments for PBS medicines is part of the overall strategy to contain the costs to government of the PBS.

#### **2.18.6 MEDICARE LEVY**

When Medicare began in 1984, the Medicare levy was introduced as a supplement to other taxation revenue to enable the Commonwealth Government to meet the additional costs of providing the same level of care for the whole population, over the previous system, which focused on subsidies for health care to groups with low incomes. Medicare levy revenue provides the equivalent of only around 27 percent of Commonwealth funding for Medicare.

Medicare is funded by a range of taxes such as income tax, taxes on sales of goods and services, and non-tax revenue, which together form consolidation revenue. Parliament appropriates funds for most government programs from consolidation revenue. The Medicare levy is paid by individuals at a basic rate of 1.5 percent of taxable income above certain income thresholds. Taxpayers on

high incomes who do not have private health insurance pay an additional 1 percent of taxable income as part of the levy.

### **2.18.7 HEALTH INSURANCE COMISSION (HIC)**

The Health Insurance Commission (HIC) is a statutory authority created by the Health Insurance Commission Act 1973 (the HIC Act). As a decentralized organization the HIC operates from 226 Medicare offices and from state offices, processing centers and a national office in Canberra ([www.hic.gov.au](http://www.hic.gov.au)).

*HIC is commissioned to administer the following organizations:*

- Medicare
- Pharmaceutical Benefit Scheme
- Federal Government 30% rebate on private health insurance

The HIC is tasked with the processing and payment of claims and benefits. Through this process it records and maintains data and is thus able to make information available relating to patterns and trends, which enable health care professionals to base their decisions on better information and evidence.

### **2.18.8 PRIVATE HEALTH INSURANCE**

Private Health Insurance is an important component of health care funding in Australia, providing approximately 11% of the total national health care funding. For the insured subscriber it provides added benefits such as the choice of doctor, choice of hospital and choice of timing of procedure. Private health insurance can also assist with meeting the costs of private sector services that are not covered by Medicare, such as dental, optical, physiotherapy and podiatry services. The Commonwealth regulates the insurance offered by registered health insurance organizations to ensure that the principle of community rating is

observed. This ensures that private health insurance is open to a wide range of people in the community and that the aged and the chronically ill are not priced out of private health insurance.

In order to support community rating there is a mechanism of "reinsurance" in place, which redistributes the costs of claims for the elderly and those in hospital for an extended period across all private health insurance funds. This ensures that health funds with a high proportion of these higher cost members are not disadvantaged.

In order to ensure that there is a balance between the public and private health sectors in Australia, the Commonwealth Government has introduced a number of measures to address the affordability, stability and attractiveness of private health insurance. These measures are designed to encourage people to take out private health insurance, thus decreasing the burden on the public health system. The most notable incentive is the 30% rebate on private health insurance that was introduced in January 1999.

Another initiative introduced by the Government is Lifetime Health Cover, which is a new system of private health insurance designed to encourage people to take out hospital cover early in life and maintain their cover. People who join a health fund before the age of 31 years and who stay in private health insurance, will pay a lower premium throughout their lives as compared to people who delay joining. People over the age of 30 years will face a 2% increase in premiums over the base rate for every year that they delay joining.

The advantage is that in the medium to longer term the rate of premium increases will be slowed by discouraging "hit and run" behaviour (where someone joins a health fund just before requiring treatment and then leaves soon thereafter) and by improving the overall health of membership of private health insurance funds, thereby reducing the rate of claiming (Woodrow, 1997).

### **2.18.9 SUMMARY: THE AUSTRALIAN NATIONAL HEALTH SYSTEM**

The Australian National Health System has evolved into a world-class entity both in terms of its effectiveness and efficiency. This has resulted in Australia being ranked among the best performing group of countries in terms of life expectancy and health expenditure (World Health Organisation 2003).

*The three pillars that define the Australian National Health Insurance include:*

- Medicare: Free treatment in public hospitals.
- Pharmaceutical Benefit Scheme: A large percentage of the cost of prescription drugs are subsidized by the state.
- Private Health Insurance Rebate: Government based initiative that rewards citizens that take up and retain private health insurance, with a 30% rebate of their subscriptions.

*Despite the positive impact of Medicare and its associated reforms on the delivery of health services in Australia, it must be noted that there are fundamental differences to the political, social and economic climate in South Africa. These disparities include:*

- Australia has an unemployment rate of 6%, compared to South Africa's unemployment rate of 26.2%.
- South Africa with its developing country status is burdened with a rising prevalence of HIV/AIDS, which is estimated at 16.7% by Statistics South Africa, compared to a prevalence rate of 0.065% in Australia.

## **2.19 CONCLUSION**

Recognizing the need to improve access to health care, as well as developing a comprehensive strategy with regards to the financing of health care; the Department of Health has instituted significant reforms to permit the implementation of a social health insurance system. This was as a direct result of inherent failings within the current system of health care delivery, as well as the public and private sectors inability to appropriately respond to those failings.

The disproportionate distribution of resources between the public and private healthcare sectors, coupled with gross income inequalities, has resulted in large-scale disparities between different socio economic groups. Within the health sector there are numerous local as well as international factors that affect the financing of appropriate levels of health care. A major obstacle has, however, been the failure of the public and private health sectors to embrace each other. Within such a fragmented system, health care funding continues to be a hurdle.

This study has focused on 10 areas of reform within the healthcare industry, which will influence the successful implementation of SHI. The mechanism of financing of SHI was then compared to that of that of the Australian Healthcare System. The study suggests that despite the noteworthy efforts of the Department of Health to effect transformation that would make health care more accessible and equitable; it remains to be seen if sufficient reforms have been implemented to ensure the successful implementation of a Social Health Insurance System, that will provide the foundation for the implementation of a National Health Insurance (NHI).

# **CHAPTER THREE**

## **RESEARCH METHODOLOGY**

### **3.1. INTRODUCTION**

This report will utilize the case study approach to analyse the reforms implemented by the Department of Health, in preparation for the implementation of SHI. A second methodology, namely semi - structured interviews will be used to elicit valuable insight from medical professionals at management level, within both the private and the public health sectors. This data will be used to assess the preparedness of the national health system for the implementation of SHI.

Primary data was collected by conducting 20 semi-structured interviews, 10 of which were in the private health sector, and 10 within the public health sector. Secondary data was collected, by accessing relevant information in journal articles, published books, government publications and the Internet.

Extensive review of the data collected using these primary and secondary data collection techniques will facilitate the use of strategic management instruments to complete an analysis of the preparedness of South Africa for the implementation of SHI.

### **3.2. CASE STUDIES**

Robson (Saunders 2003, P93) defines case study as “strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context, using multiple sources of evidence”.

The case study approach is often linked to descriptive or exploratory research; however, its usefulness is not confined to the realm of descriptive or exploratory

research. The case study approach presents with significant benefits when the phenomenon under investigation is difficult to study outside its natural setting, and also when the concepts being studied are difficult to qualify. A large number of variables, which may preclude the use of experimental or survey methods, favour the use of a case study approach. The case study approach relies on the integrative powers of research, which is the ability to study an object with many dimensions and thereafter draw an integrative interpretation (Robson, Lewis and Townhill, 2003).

The case study approach was used in this determination, as the implementation of SHI is a current phenomenon and the reforms implemented within the private and public health sectors are outside the control of the researcher. These qualitative methods of data analysis, which were explorative orientated, permitted a holistic perspective of the study.

A dimension of the comparative case study will be utilized to compare the structure and operational performance of the healthcare industry in Australia and South Africa. This will permit the exploration of different dimensions within the research problem. The case study approach, which relies on a review of existing historical material and interviews, is similar to historical review. However it is fundamentally different in that it permits direct observation and interaction. Therefore the case study method is not limited to qualitative research, and may be used in settings that are entirely quantitative. The data collection methods employed in a case study approach include interviews, observations, documentary analysis and questionnaires. A well-constructed case study may therefore enable the researcher to challenge existing theory and provide a source of new hypotheses.

One major hurdle in analysing the qualitative data derived from the interviews during this study was, despite conducting only twenty interviews, the volume and depth of information gathered was daunting.

Triangulation will be used to improve the accuracy of the data collection process during the study. In some institutions medical personnel in different levels of management were interviewed to produce a more complete, holistic and contextual portrait of the healthcare system in South Africa.

### 3.3.1 INTERVIEWS

Khan (Saunders 2003, P245) defines interviews as “the purposeful discussion between two or more people”. Interviews are often considered by academics to be the best data collection method. There are three types of interviews employed in the scope of research viz. structured, semi-structured and unstructured interviews. Structured interviews are questionnaires based on a predetermined and standardized or identical set of questions. Semi-structured interviews contain a list of themes and questions to be covered; although these may vary from interview to interview. This would require that the researcher omit some questions in particular interviews, given the specific organizational context that is encountered in relation to the research topic. Unstructured interviews occur where the respondent is given almost full liberty to discuss reactions, opinions and behaviour on a particular issue.

The advantage of in depth interviews is that it provides the researcher with a more accurate and clear picture of the respondent’s behaviour or position. This level of clarity is facilitated by the open ended questions and the fact that respondents are free to answer according to their own thinking as the researcher had not constrained answers by providing a limited number of alternatives. The disadvantages of interviews are that they require increased level of skill from the interviewer, who should be empowered with a complete understanding of the research problem. In addition to interviews taking a long time to complete, they are often difficult to interpret and analyze.

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In this study semi-structure interviews were used to explore the preparedness of the national health system for the implementation of SHI. The difficulty in trying to design a viable questionnaire schedule to cope with the magnitude of complex and open-ended questions generated by this study and the time constraints imposed by the study, dictated that interviews were the best method of acquiring primary data. This scenario also provided the opportunity for interviewees to receive feedback and personal assurance regarding the way in which the information supplied was to be used.

### **3.3.2 DATA QUALITY OF INTERVIEWS**

The data quality issues that pertain to the use of semi-structure interviews include issues related to:

- Reliability
- Forms of bias
- Validity and Generalisability

The lack of standardization in semi-skilled interviews leads to concerns regarding the reliability of the data that is obtained. Reliability is therefore concerned with whether alternative researchers would reveal similar information. In response it is argued that the findings derived from non-standardized research methods, are not necessarily intended to be repeatable since they reflect reality at the time in which they were collected, in a situation, which may be subject to change.

These are various types of bias that impact on the quality of data collection. Interviewer bias occurs where the researcher attempts to impose their own beliefs and frame of references, through the questions that are being asked. Interpreter bias may also adversely affect the interpretation of the respondent's responses. Interviewee bias may be precipitated by the perceived lack of credibility of the interviewer in the eyes of the interviewee. Bias may also result

from the nature of the individuals or the organizational participants that submit to being interviewed.

The generalisability of findings derived from qualitatively based interview studies is related to the validity of the data collected. In this context validity refers to the extent to which the researcher gains access to their participant's knowledge and experience and is able to infer a meaning that the participant intended.

### **3.3.3. THE INTERVIEW PROCESS**

Twenty respondents were identified in management positions in both the public and private healthcare sector. A list of themes and questions to be covered was formulated bearing in mind the differences that define the private and public healthcare sectors. Secondary data and the literature review provided the researcher with a knowledge base that was relevant to the context in which the interview was conducted. This assisted greatly in the researcher being able to draw on that level of knowledge, which demonstrated an increased level of credibility and resulted in the interviewee offering a more detailed explanation of the issues presented during the interview; thus promoting validity.

The respondent's were supplied with a list of the interview themes prior to the interview being conducted. This assisted in promoting the validity and reliability of the study by enabling the interviewee to contemplate the information that is requested of them. Permission was also sought to use a tape recorder, with the interviewee maintaining control of the information that was to be recorded. In addition the researcher supplied a declaration confirming the confidentiality of the information provided via the interview.

At the commencement of the interview, respondents were re-assured that no confidential information was being sought and that all information supplied was to be utilized entirely for research purposes. They were informed that they would

receive a copy of the research study on completion, in addition to any relevant information that the researcher would be able to provide.

Questions were phrased in a neutral tone of voice to avoid issues of interviewer bias. Long questions were avoided in favour of shorter questions that prompted crisp direct responses. Questions of a sensitive nature were asked near the end of the interview as this allowed the respondent to develop trust and confidence in the researcher. This level of confidence resulted in more detailed explanations being provided by the individual respondents.

Comments and non-verbal behaviour that may have indicated any bias of the researcher were avoided. The researcher, to facilitate the open flow of information from the respondents, adopted a neutral response with an open posture. Summarizing the information provided by the interviewee at periodic intervals assisted the researcher in testing the understanding of the themes expressed by the interviewee. This permitted the interviewee to evaluate the adequacy of the interpretation and to correct misunderstandings where necessary.

Following the conclusion of the interview, a brief descriptive report was compiled highlighting the salient points of the interview. A detailed transcript of the tape recording was then prepared. This permitted a holistic analysis of the interview and a comparison to the views raised by other respondents in the study. "Thank You" letters were also provided to each respondent with a re-assurance that all information supplied would only be used for the purpose that it was intended for.

### **3.3.4. ADVANTAGES AND DISADVANTAGES OF TAPE RECORDED INTERVIEWS**

#### **Advantages:**

- Allows the interviewer to concentrate on questioning and listening.
- Allows questions formulated at an interview to be accurately recorded for use in later interviews where appropriate.
- Allows the interviewer to re-listen to the interviews.
- Provides an accurate and unbiased record.
- Allows direct quotes to be used.
- Provides a permanent record for others to use.

#### **Disadvantages:**

- May adversely affect the relationship between the interviewer and interviewee.
- May inhibit interviewee responses and reduce reliability.
- Introduces the possibility of technical problems.
- Disruption to the discussion, when tape changes become necessary.
- Time required transcribing the tape (Saunders, Lewis and Townhill, 2003).

### **3.4 CONCLUSION**

For the purpose of analysis or drawing conclusions, the cases that display contrast or an extreme situation (example: Performance and Failure) are useful. The health care industry in South Africa was compared to the model employed in Australia. This provided a stark contrast to a successfully implemented health dispensation in Australia compared to the ailing health service of South Africa. This proved to be a successful approach as it was easier to find differences or determine the distinguishing factors that define healthcare delivery in South Africa and Australia.

This report utilized the case study approach to analyze the reforms implemented by the DOH, in preparation for the implementation of SHI. In addition semi – structured interviews were used to elicit valuable insight from medical professionals at management level, within both the private and public healthcare sectors. Primary data was collected, by conducting 20 semi-structured interviews, 10 of which were in the private health sector, and 10 within the public health sector. Secondary data was collected, by accessing relevant information in journal articles, published books, government publications and the Internet.

Interviews proved to be a superior method of data collection, as this study generated several questions that were both complex and open ended. The semi-structured interviews also permitted the order and logic of questions to be varied as dictated by the scenario and individual participant. The diligence of the researcher in following established protocols during the interview process further promoted the validity of the research findings. This coupled with the case study approach proved to be a viable method of data collection within this context.

## **CHAPTER FOUR**

### **RESEARCH DATA**

#### **4.1 INTRODUCTION**

Views of respondents, obtained via the 20 semi - structured interviews have been grouped into themes, as pertaining to the 10 aspects of health that have been defined. Supporting and contradictory views as expressed by the respondents will be used in the analysis of data that was collected. Strategic management instruments have been employed to facilitate data analysis.

##### **4.1.1 IMPROVEMENT OF PUBLIC HOSPITAL INFRASTRUCTURE**

The Department of Health has engaged in a public hospital revitalization programme to address the infrastructure development that is required for the implementation of SHI. The respondents' views pertaining to the improvement of public hospital infrastructure were as follows: Dr. S. Kader said: "The hospital revitalization programme is limited to select hospitals within the Department of Health and insufficient infrastructure development has occurred for the successful implementation of SHI by January 2006" (Kader, 2005). Dr. D.L. Bruwer remarked that: "The implementation of SHI will require significant structural reforms that the government has not adequately addressed. SHI should not be prematurely introduced before the Department of Health has done its homework" (Bruwer, 2005). Dr. Bam believed that: "Conditions in public hospitals are deplorable and the Department of Health is a long way from being prepared for the implementation of SHI. The Department of Health will not have an easy task in attracting potential patients back into the public health arena",

(Bam: 2005). Mr. M.R. Khan said that: "Despite the Department of Health's good intentions in improving the state of the public health services, there remains a lot of work that is still to be done in preparation for SHI" (Khan, 2005).

Dr. Myeni believed that: "The poor access that rural hospitals have to adequate levels of funding in preventing them from providing a good service top their patients. Requests for many aspects of infrastructure development pass through several levels of authorization, before being declined" (Myeni, 2005).

Prof. A. Reddy however remarked that: "The Department of Health is making an attempt to improve service delivery and the patients must work with the Department of Health to ensure better health service delivery", (Reddy: 2005).

Dr. Govender was of the opinion that: "Working conditions in public hospitals is stressful with high patient volumes and over crowded wards. The Department of Health must invest heavily in improving the current infrastructure to allow the smooth implementation of SHI" (Govender, 2005).

#### **4.1.2 AUGMENTATION OF THE DISTRICT HEALTH SYSTEM**

The Department of Health has committed itself to promoting the primary health care approach and promotion of the district health system, (Department of Health: A National Health Plan for South Africa 1994). The respondents' views on the district health system were as follows: Dr. Dube said: "The rural hospitals are in dire need of upgrade, because we are often short staffed and don't have medical essentials. The patients do not make adequate use of district clinics because they want to be treated at the hospital" (Dube: 2005). Dr. Myeni believed that: "There remains a lot of work still to be done to prepare the district health services for SHI. Rural hospitals should have a gateway clinic to prevent the strain on public hospitals" (Myeni: 2005). Dr. N. Bhana remarked that: "Strengthening of the district health system will provide a good foundation for the implementation of SHI" (Bhana: 2005). Mrs. T.R. Zondo said that: "More input is required from the Department of Health for the promotion of the District Health Services" (Zondo: 2005). Mr. R. Passmore remarked that: "The Department of

Health must put in more reforms to support their policy promotion of a primary health care approach", (Passmore: 2005). Miss. B. Khunoane believed that: "Promotion of the district health services is an integral part of the SHI scheme" (Khunoane: 2005). Prof. A. Reddy said that: "Improving rural health care structures should be a priority. Provided that these rural hospitals are well staffed, the levels of care provided should be similar to that of central hospitals- but whether it is perceived as such remains to be seen" (Reddy: 2005). Mr. N. Bechan remarked that: "Several levels of the public health service are in need of management support. The district health services are probably worst affected" (Bechan: 2005).

#### **4.1.3 IMPROVING THE QUALITY OF CARE**

The Department of Health is hopeful that the implementation of SHI will improve the quality of service delivery at public hospitals. The respondents' views on the quality of care at public hospitals were as follows: Dr. Bhoola believed that: "A serious lack of resources in the public sector presents a hurdle to improving the quality of care" (Bhoola: 2005). Prof. A. Reddy said: "Patients believe that they receive a better level of care at Inkosi Albert Luthuli Hospital than at King Edward because it is more pleasing for the eye. This however is not the case", (Reddy: 2005). Mr. G. Kendall remarked that: "If the public health sector works in collaboration with the private health sector, it will result in improved levels of patient care" (Kendall: 2005). Mr. N. Bechan concurred that: "The Department of Health must work more closely with the private health sector to improve the quality of patient care" (Bechan: 2005). Mr. P. Oehley was disturbed that: "In drafting the Patients Rights Charter (1999) which outlines the rights of patients, there was very limited consultation with the private health sector. This was unfortunate as the Patients Rights Charter is applicable to all patients" (Oehley: 2005). Mr. M.R. Khan believed that: "More funds should be diverted from defense spending to the Department of Health to allow the DOH to make quality healthcare a reality" (Khan: 2005). Mr. J. Pooran said that: "To improve the

quality of patient care at public hospitals, the government needs to increase spending especially if SHI is to be implemented” (Pooran: 2005). Mr. R. Passmore believed that: “Despite SHI being a noble initiative the Department of Health needs to implement reforms at various levels of their organizational structure to increase the quality of care provided at public hospitals to allow for the implementation of SHI” (Passmore: 2005). Dr. Behadur however believed that: “Through its current initiatives the Department of Health is working at improving the quality of care provided to patients at public hospitals” (Behadur: 2005).

#### **4.1.4 INTERVENTIONS TO IMPROVE CHILD HEALTH**

The Department of Health advocates the rights of children as articulated in the UN convention on the rights of the child. The respondents’ views on the Department of Health’s interventions to improve child health are as follows:

Dr. Bruwer said: “The strength of a health system is reflected in the health status of the children that it serves. The Department of Health has implemented several policies to improve child health, such as free treatment for children under 6 years of age, but it has to do more to eradicate malnutrition and diseases related to poverty” (Bruwer: 2005). Miss. B. Khunoane believed that: “We have significantly improved immunization coverage via the Extended Program on immunization (EPI) and provided social support via grants to improve child health” (Khunoane: 2005). Dr. Kader said that: “The Department of Health has made strides in addressing child health requirements, but they must work in conjunction with the social services to reduce the incidence of preventable diseases by eradicating poverty” (Kader: 2005). Mr. M.R. Khan remarked that: “ The Department of Health had made significant improvements in the health status of children but that it must maintain the momentum or else the children will suffer”, (Khan, 2005). Dr. G. Govender believed that: “A shortage of medical personnel trained in paediatrics and child health is preventing us from optimizing child health” (Govender: 2005). Dr. Bam agreed and remarked that: “The scenario that the

Department of Health propagates is very different to what we encounter at public hospital level. Thousands of children are dying because our health system is failing the children” (Bam: 2005). Dr. Dube said that: “The way forward is for the Department of Health to get more doctors, improve immunizations and decrease the rate of mother to child transmission of HIV” (Dube: 2005).

#### **4.1.5 INTERVENTIONS TO IMPROVE MATERNAL AND WOMENS HEALTH**

The Department of Health has made improvement of maternal and women's health a priority, (National Health Plan for South Africa: 2004). The views expressed by the respondents in relation to the interventions implemented by the Department of Health, to improve maternal and women's health are as follows:

Dr. Kader said that: “The Department of Health is making the effort to improve maternal and women's health but the patients also have a role to play in disease prevention and health promotion” (Kader: 2005). Mrs. T.R. Zondo believed that: “The Department of Health must do more to educate the rural patients on initiatives to promote maternal and women's health” (Zondo: 2005). Dr. Bam remarked that: “Screening programmes by the Department of Health, to allow early diagnosis and treatment of malignances needs to be more wide spread” (Bam: 2005). Dr. Bhana said that: “The Department of Health could subcontract its workload relating to maternal and women's health to the private sector to reduce the burden on the state” (Bhana: 2005). Mr. J. Pooran concurred that: “A greater level of collaboration between the public and private sector will result in improving maternal and women's health” (Pooran: 2005). Mr. Kendall said that: “Educating patients on contraceptive use and the choice on termination of pregnancy, will decrease unwanted pregnancies and lead to an improved health status” (Kendall: 2005). Dr. Myeni remarked that: “There should be a concerted effort by the Department of Health to increase capital investment, especially at rural hospitals, in an effort to improve facilities and equipment. This will allow us to provide a better service to the female patients and promote the Department of Health's directive” (Myeni: 2005).

#### **4.1.6 HIV AND AIDS**

The AIDS pandemic remains a mayor scourge facing the Department of Health. The respondents views on HIV and AIDS as related to the Department of Health are as follows: Dr. Behadur said that: "The prevalence of HIV in South Africa is starting to plateau, and the ARV rollout program instituted by the Department of Health is producing results" (Behadur: 2005). Dr. Dube believed that: "The Department of Health's delayed implementation of the ARV programme has resulted in thousands of premature deaths" (Dube: 2005). Mr. P. Oehley said that: "The management of HIV needs to occur within a multidisciplinary setting that involves medical and support personnel; as is the case in the private sector" (Oehley, 2005). Mr. R. Passmore remarked that: "The Department of Health must provide adequate nutritional supplementation in addition to the ARV's to reduce the incidence of HIV/AIDS" (Passmore: 2005). Mr. Pooran believed that: "The Department of Health has a duty to educate the adolescents about safe sexual practices and the benefits of abstinence; as prevention is better than cure" (Pooran: 2005). Dr. Bruwer said that: "The Department of Health does not have the personnel to conduct the monitoring and disease surveillance that the ARV programme requires. The Department Of Health will have to engage general practitioners in the private sector to fulfill this task. They can be compensated on a fee for service basis" (Bruwer: 2005). Miss. B. Khunoane remarked that: "The government and the Department of Health are committed to expanding the ARV programme to obtain broader coverage. New infrastructure and human resource development is planned to facilitate broader coverage" (Khunoane: 2005). Mr. N. Bechan believed that: "More funding should be allocated to promoting responsible sexual practices to produce positive outcomes in the future", (Bechan: 2005).

#### **4.1.7 CHRONIC DISEASES**

Management and treatment of chronic diseases such as hypertension and diabetes mellitus has significant cost implications for the Department of Health. The respondents' views pertaining to the Department of Health's management of chronic diseases is as follows: Dr. Bhana said: "A major component of the management of chronic diseases is lifestyle modification and disease monitoring. If this is adequately addressed it will reduce the cost of management of chronic diseases" (Bhana: 2005). Mrs. T.R. Zondo believed that: "Local clinics have a large role to play in monitoring the patients compliance with regard to the treatment supplied at hospitals" (Zondo: 2005). Dr. Kader remarked that: "Patients must also assume responsibility for the control of their chronic conditions. They can easily influence the outcome of their condition by lifestyle modification" (Kader: 2005). Dr. Govender said that: "Lifestyle diseases or chronic diseases are largely influenced by our westernized lifestyles. The Department of Health must promote the importance of a healthier lifestyle and this will result in decreases pharmaceutical spending" (Govender: 2005). Mr. M.R. Khan believed that: "People should assume more responsibility for their own health and not expect state to exclusively provide for the complications of a destructive lifestyle" (Khan: 2005). Dr. Bruwer said that: "The Department of Health is failing to adequately manage the large volume of patients that present with chronic diseases. The overflow of these patients could be professionally managed by general practitioners in the private sector at a cost effective rate" (Bruwer: 2005). Mr. G. Kendall concurred that: "Significant scope exists for co-management of patients with chronic ailments jointly by the Department of Health and participants within the private sector (Kendall: 2005).

#### **4.1.8 COMMUNICABLE DISEASES**

The reported incidence of TB in 2003, was 551/100 000 population. The high incidence of this communicable disease makes it one of the leading causes of mortality and morbidity in South Africa. The respondents' views pertaining to TB are as follows:

Prof. A. Reddy said: "The dismal cure rate of TB in South Africa is cause for concern. The Directly Observed Treatment (DOT) Programme is not providing a significant enough impact. The Department of Health should consider TB confinement wards to ensure compliance of treatment" (Reddy: 2005). Dr. Bruwer believed that: "The financial incentive of the social grant which TB patients receive may cause some patients to default treatment in order to prolong the grants. This contributes to the poor TB cure rate" (Bruwer: 2005). Dr. P. Myeni said that: "Diagnosis of TB in rural areas is difficult as many patients do not follow up the results of blood and sputum investigations. This prevents them from being commenced on anti TB treatment" (Myeni: 2005). Mrs. T.R. Zondo remarked that: "Combining patients with non-communicable diseases with patients infected with TB is resulting in cross infection. This further exacerbates the problem" (Zondo: 2005). Dr. Dube said that: "As a result of HIV/AIDS there is an epidemic of TB. By reducing the incidence of HIV/AIDS we will achieve a lower incidence of TB and thereby reduce the burden on state services" (Dube, 2005). Dr. Govender believed that: "The Department of Health has treatment protocols in place for management of TB. This however, is not increasing the TB cure rate", (Govender: 2005). Dr. Bam remarked that: "TB is a disease related to poverty and overcrowding. If the government addresses these social problems, it will reduce the incidence of TB and its related complications" (Bam: 2005). Dr. Behadur however said that: "The Department of Health is applying itself to curb the high incidence of TB and this should yield positive results in the near future" (Behadur: 2005).

#### **4.1.9 AFFORDABLE DRUGS**

The introduction of Single Exit Pricing in June 2004 by the Department of Health, to arrest spiraling drug costs has caused much controversy. The respondents views pertaining to the Department of Health's initiatives to make prescription drugs more affordable are as follows: Mr. N. Bechan said: "The current pricing regulation in the guise of SEP was not well thought out by the Department of Health. The impact on retail pharmacists will be catastrophic. It will force large scale closure of many pharmacies" (Bechan: 2005). Mr. J. Pooran remarked that: "It is a noble gesture to make drugs more affordable, but can it be accomplished without the trained professionals to dispense these drugs?" (Pooran: 2005). Dr. Kader believed that: "The mark ups on prescription drugs have been exorbitant. SEP will bring these prices in line and make the drugs more affordable" (Kader: 2005). Dr. Dube concurred that: "SEP addresses the need to make quality medications more accessible to the poor. Perverse incentives by drug manufacturers are depriving the poor of medical intervention" (Dube: 2005). Dr. Govender remarked that: "There should have been more discussions with key stakeholders to determine the parameters that the SEP would operate within. It is a good reform, but it must be implemented in consultation with all those that will be affected by the legislation" (Govender: 2005). Dr. Bruwer believed that: "SEP removes all financial incentives for a general practitioner to dispense medication. It might be acceptable for the Department of Health to regulate the prices of drugs in the private sector, but not for it to impose its dictatorial beliefs on highly trained medical professionals" (Bruwer: 2005). Dr. Myeni however believed that: "SEP is a workable solution, as doctors need to reconsider their motivation for practicing medicine ~ to heal the sick" (Myeni: 2005).

#### **4.1.10 HUMAN RESOURCE DEVELOPMENT**

The Department of Health has instituted substantial policies and initiatives to promote more equitable geographical distribution of human resources. The rural allowance, scarce skills allowance and compulsory community service have begun to address the imbalances. The respondent's views on human resource deployment and development within the Department of Health are as follows:

Prof. A. Reddy said: "Compulsory community service for newly qualified medical personnel is a good initiative, as it provides staffing to rural hospitals, which are in dire need of medical personnel. The proposed community service for newly qualified medical specialists will allow them to give something back for the excellent academic training that they received" (Reddy: 2005). Dr. Bhana believed that: "There is great scope for a public-private partnership in the health sector. Managed healthcare provides the vehicle for effective public-private partnership" (Bhana: 2005). Dr. Kader remarked that: "The Department of Health should incentivise general practitioners to utilize the public health sector for hospitalization of their patients. This will lead to increased revenue for the Department of Health, from SHI, and result in improved relations between medical personnel in the public and private sector" (Kader: 2005). Dr. Bhoola believed that: "SHI is a step in the right direction but cannot work if only the public sector is involved. New Zealand for instance out-sources work to the private sector. This public-private partnership has yielded good results" (Bhoola: 2005). Mr. P. Oehley remarked that: "There are certain aspects that we can learn from through interactions with our colleagues in the private health sector, and likewise they can benefit from our management experiences", (Oehley: 2005). Mr. G. Kendall concurred that: "Hospital managers in the private sector have become extremely skilled at income generation and cost containment" (Kendall, 2005). Dr. Dube remarked that: "The Department of Health must do more to prevent highly trained medical professionals from leaving the country and pursuing greener pastures. They can only do this by improving working conditions and making the local option more financially viable" (Dube: 2005).

## **4.2 ENVIRONMENTAL ANALYSIS: STEEP ANALYSIS**

### **4.2.1 SOCIAL**

The recently conducted South African Demographic and Health Survey (SADHS) found that South Africans are not very healthy, even though we are classified as an upper middle income country and despite the fact that we spend a considerable amount of our GDP on health services.

Approximately 45 babies out of every 1000 born live, die in infancy. Fifty-nine children per 1000, die before their fifth birthday. Many mothers die delivering babies – estimated to be 150 per 100 000 women. It is projected that our current life expectancy of 60 years will reduce to 40 years by 2008, as a consequence of the impact of AIDS. The number of AIDS orphan is projected to grow from 250000 in 1999 to 750 000 in 2005.

Clearly the scourge HIV/AIDS needs to be halted. The Medical Research Council estimates that due to the effect of HIV/AIDS the current Tuberculosis (TB) Epidemic will increase four fold over the next decade. In this social context, health promotion remains vitally important. Promoting good health and preventing disease is central to the success of Primary Health Care. Health promotion combines diverse approaches such as legislation, fiscal measures such as taxation, controls on advertising, community action and development, inter-sectoral programs, environmental monitoring and education.

### **4.2.2 TECHNOLOGICAL**

An important factor for the success of adequate healthcare delivery is the appropriate use of health technology, by which is meant the association of methods, techniques and equipment, which together with the people using them, can contribute significantly, to resolving health problems. One of the major cost drivers in the health sector is the cost of expensive health technology. It is

important that the Department of Health introduce a more rational system of purchasing, deploying and utilization of appropriate health technology.

Advancement of medical science requires continuous innovation in the field of medical technology to adequately deliver health services and improve clinical outcomes. The public health sector is burdened with the outdated and poorly maintained medical technology that often contributes to poor clinical outcomes. In contrast the private care health sector equips their health care institutions with cutting edge medical technology and appropriately trained operators to deliver a premium service. This discordance in technology facilitated service delivery between the public and private health sectors need to be addressed.

#### **4.2.3 ECOLOGICAL**

There is an increased awareness of the impact of Governmental and Industrial Actions on the environment. The focus on Corporate Social Responsibilities (CSR) serves to firmly establish this trend. The Department of Health is committed to providing efficient and accessible health service delivery to all the citizens whilst reducing the environmental impact of these interventions.

#### **4.2.4 ECONOMIC**

Economic factors concern the nature and direction of the economy in which a firm operates because the consumption patterns are affected by the relative affluence of various market segments. These are gross inequalities in the accessing of health care in South Africa. The economic component of the macro-environmental analysis indicates the distribution and use of resources within a society. Premium quality healthcare, provided by private hospitals that emphasize the "hotelier" experience and are funded largely by patients who have access to private health insurance is a stark contrast to the inefficient public health sector that is plagued by poor service delivery.

#### **4.2.5 POLITICAL**

The direction and stability of political factors are a major consideration for all stakeholders involved in health service delivery. This will guide the formulation of objectives and policies both within the private and public health sector. Several new legislative reforms pertaining to healthcare delivery have been introduced within the pre-ceding five years ([www.anc.gov.za](http://www.anc.gov.za)). These include:

- The National Health Bill (which replaced the current National Health Act).
- The Mental Health Care Bill (which replaced the Mental Health Act).
- The South African Medicines and Medical Devices Regulatory Authority Act.

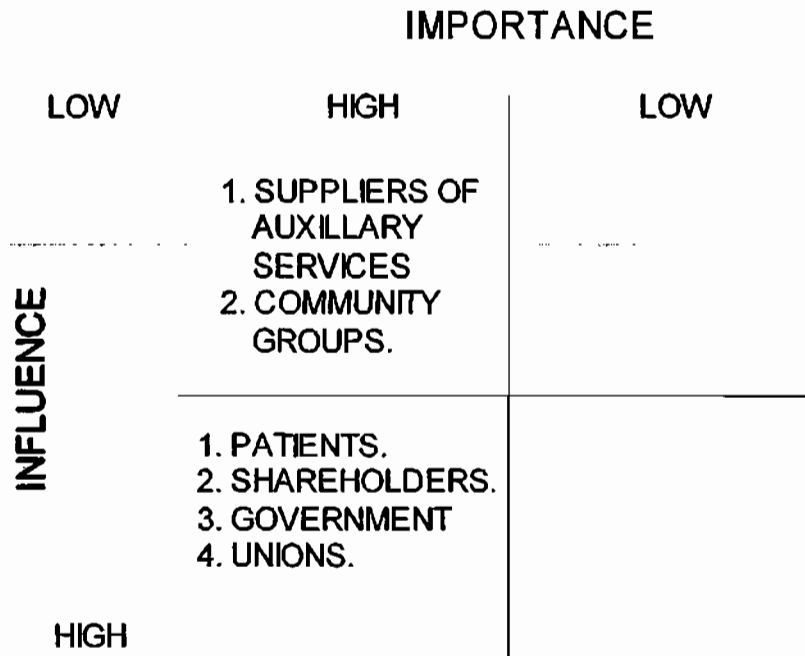
The launch of the Patients Charter that dictates the rights and obligations of patients was a major achievement of the Department of Health, and served to re-enforce the tenets of the “Batho Pele” program that had been previously introduced (DOH: A National Health Plan, 1994).

#### **4.3 STAKEHOLDER ANALYSIS**

Stakeholders Analysis systematically identifies important groups of people or individuals who can exert significant amount of influence on an organization or its competitors (Gilson, 2001). The most important stakeholders in the South African Healthcare industry are:

- The shareholders in private hospital conglomerates.
- Suppliers of auxillary services.
- Patients.
- Medical and paramedical personnel.
- Government.
- Union community groups.

## Stakeholders Analysis: Healthcare in South Africa



Adapted: Fleisher and Bensoussan: 2003

### 4.4 STRATEGIC EVALUATION AND SELECTION

#### 4.4.1 GAP ANALYSIS

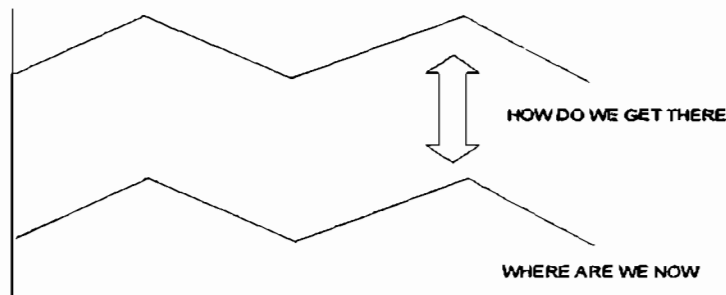
South Africa can utilize the GAP analysis to identify deficiencies in their comprehensive strategy of health service delivery. The National Health Act (Act No. 61 of 2003) replaced the last trace of apartheid in health policy - the Health Act of 1977 (Fleisher and Bensoussan, 2003).

It provides a framework to unite the various elements of the national health system, in a common goal to improve universal access to quality health services taking into account the obligations imposed by the constitution. The public

healthcare sector is rated poorly by the WHO, in terms of health system performance - largely due to the gross inequalities between the public and private healthcare sectors.

The country ranked 175<sup>th</sup> out of 197 in the 2000 survey (Basset: 2003). In contrast, the Australian Health System has established itself as the benchmark in terms of efficiency and effectiveness (WHO). The Gap Analysis featuring South Africa and Australia may be represented as follows:

### Gap Analysis – A Comparison of the South Africa and Australia



**Adapted: Fleisher and Bensoussan: 2003**

*Initiatives that would support bridging the gap:*

- Effective collaboration between key stakeholders in the public and private sectors.
- Incentives to retain medical personnel and prevent them being poached by developed countries (Myeni, 2005).
- A more focused approach to improve the dismal care rate of pulmonary tuberculosis (PTB).
- Increased funding of programs to reduce the prevalence of HIV/AIDS and other communicable diseases (Bruwer, 2005).
- Increased emphasis on human resource and infrastructure development in rural areas.



#### 4.5 COSATU'S POSITION ON SHI

- Agree in principle on the need to regulate the private health sector, although government must be more careful – consult users, not just providers.
- COSATU rejects the position that taxation should be increased to force workers into medical aid schemes.
- Government must improve resourcing for public health, and not push people into private health sector.
- Recent increased budget spending has helped.
- SHI Proposal would increase the cost to the economy – SA spends relatively more on healthcare per GDP than most middle-income countries.
- A more holistic approach is required, including management and service delivery rather than just financing ([www.anc.gov.za](http://www.anc.gov.za))
- Contradictory impact of changes in tax subsidies and other measures.
- No net costing provided by the Department of Health (SHI – COSATU's Position, 2005).

#### 4.6 CONCLUSION

The data analysis of the 20 semi structured interviews as pertaining to the 10 aspects of health that have been defined revealed the following:

➤ *Improvement of hospital infrastructure:*

Despite the noteworthy reforms instituted by the DOH, the implementation of SHI , requires additional structural and functional reforms that the DOH has not adequately addressed.

➤ Augmentation of the district health system:

Augmentation of the district healthcare system is crucial to the successful implementation of SHI, as primary healthcare forms the foundation of the current model promoted by the DOH.

➤ Improving the quality of care

The DOH needs to invest in upgrading the infrastructure of healthcare institutions within the public sector, in order to reduce the disparity that exists between the public and private sectors. This will assist in revenue generation.

➤ Interventions to improve child health:

The eradication of childhood diseases related to poverty and AIDS, will assist the DOH in their drive to promote pediatric health, and reduce the incidence of preventable mortality.

➤ Interventions to improve maternal and women's health:

Patient education and widespread screening programs, will assist in improving maternal and women's health; which will lead to a healthier family unit .

➤ HIV and AIDS:

The AIDS pandemic has proved to be a daunting challenge for the DOH. Effective partnerships between medical and support personnel, within the public and private healthcare sectors will enable the successful rollout of ARV's.

➤ Chronic Diseases:

Lifestyle modification and disease monitoring, forms the foundation for the management of chronic diseases. The DOH must promote the importance of a healthy lifestyle, to reduce the pharmaceutical spending on the management of these chronic diseases.

➤ Communicable diseases:

The high incidence of TB, which is related to the HIV pandemic, makes it one of the leading causes of mortality and morbidity in South Africa. The government has to address the underlying poverty that is associated with an increased incidence of TB and increase the depth of coverage of the ARV rollout, to increase the TB cure rate.

➤ Affordable drugs:

The introduction of single exit pricing of pharmaceuticals in 2004 has assisted in making quality medication accessible to the poor. This will no doubt assist in developing a healthier nation with reduced morbidity.

➤ Human resource development:

The introduction of a rural allowance, scarce skills allowance and compulsory community service for newly qualified medical personnel, will serve to promote a more equitable distribution of medical personnel.

An analysis of the implementation of SHI in South Africa, with its mechanism of prospective financing, reveals that it has the ability to address the inequalities between the failing public health sector and the flourishing private health sector; albeit only once specific reforms are implemented that will facilitate the operational management of a SHI. The stagnant growth in the medical insurance industry, despite the legislative reforms of community rating, open enrollment and prescribed minimum benefits; and its failure to improve access to health care serve to reinforce that additional reforms are required to improve universal access to health care.

## **CHAPTER FIVE**

### **RECOMMENDATIONS AND CONCLUSIONS**

#### **5.1 INTRODUCTION**

This exploratory canvass of some respondents in the health sector on the preparedness of the public health sector to implement a SHI on 1<sup>st</sup> January 2006; in respect to, 10 aspects of health that have been defined; has revealed that whilst the DOH has initiated reform in health service delivery, further reform must be embraced to facilitate the successful implementation of SHI.

Chapter 1 has presented a brief overview of the disparities between the public and private health sectors, and the motivation for a more equitable distribution of health services. The motivation, objectives of the study and research question were also defined.

Chapter 2 defined the structure of the South African health sector, and compared it to the model employed in Australia. Due to the inherent failings within the current system of healthcare delivery, the DOH has recognized the importance of improving access to quality healthcare, as well as developing a comprehensive strategy regarding the financing of healthcare. SHI will greatly assist the DOH in realizing its goals.

Chapter 3 provided an overview of the two research methodologies used in this study, viz. the case study approach and semi structured interviews. The case study approach was used to analyze reforms implemented by the Department of Health, in preparation for the implementation of SHI. The semi – structured interviews were used to elicit valuable insight from medical professionals at management level within the private and public health sectors.

Chapter 4 utilized established strategic management techniques to evaluate the preparedness for the implementation of SHI. A comprehensive data analysis of the implementation of SHI revealed that due to its mechanism of prospective financing, it has the ability to address the inequalities inherent in health service delivery in South Africa, albeit only once significant reforms are implemented.

The successful implementation of SHI requires the development and sustainability of a conducive enabling environment. Protection of the budget allocated to the DOH and adoption of measures to ensure that additional revenue remains in health, will assist in providing financial support for SHI initiatives. The public hospital system will also benefit from a substantial injection of financial resources to assist in service delivery. The development and implementation of minimum norms and standards, coupled with the employment of additional medical personnel will result in improved levels of patient care. This has the potential to increase SHI membership.

## 5.2 SWOT ANALYSIS

### Strengths:

- The private healthcare sector in South Africa has received international acclaim for its infrastructure and superior levels of service delivery.
- Foreigners who access the private healthcare services can obtain surgical interventions for a fraction of the cost when compared to their countries of origin (O'ehley, 2005).
- The private hospital conglomerates have strong management structures in place, which allow them to continually invent ways to increase revenue generation whilst reducing expenditure (Kendall, 2005).

- The public health sector has world-renowned medical academics attached to training institutions (Bechan, 2005).
- The public sector has developed skills that permit the facilitation of broad based health service delivery within limited human resource and budgetary constraints.
- Strong emphasis on research- particularly in regard to HIV/AIDS and communicable diseases.

Weaknesses:

- The public health sector is plagued by a shortage of suitably trained medical and nursing personnel.
- The implementation of SHI will increase utilization of public health services
- There is widespread perception of poor service delivery at public health institutions. This is aggravated by long waiting times to access medical care, long delays for elective surgical interventions and restricted access to certain medical interventions (Bechan, 2005).
- The cost of private health insurance and access to private healthcare institutions remains exorbitant for most South Africans. This has resulted in membership of private health insurance being relatively stagnant.
- Poor staffing of rural healthcare facilities (Dube, 2005).
- Significant control between key stakeholders in the public and private healthcare sectors.

Opportunities:

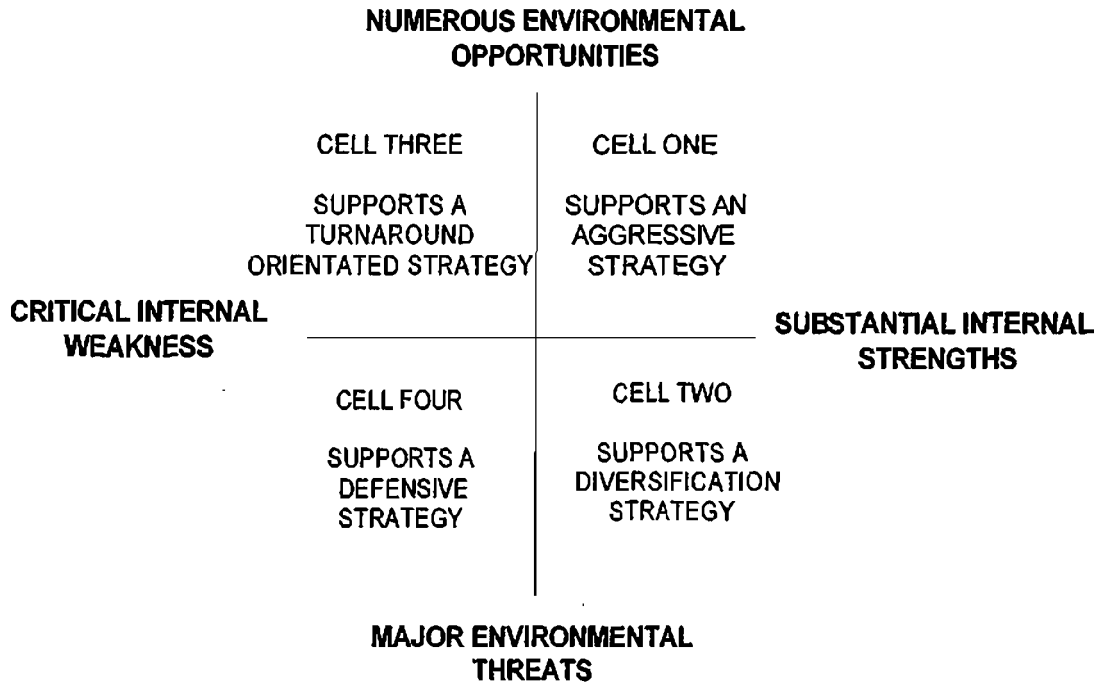
- Significant opportunity exists for establishing a partnership between the public and private healthcare sectors. The government will benefit from the strong management experience contained within the private sector and the private sector will benefit from gaining access to world-renowned academics within the public sector (Reddy, 2005).
- SHI seeks to make access to healthcare more equitable by increasing the number of patients with private health insurance.
- Collaboration between the public and private health sectors will seek to correct the mal-distribution of service delivery institutions.
- SHI will increase revenue collection by the Department of Health and limit discriminatory practices by private health insurers (Kader, 2005).

Threats:

- South Africa is burdened with an unemployment rate of 26.2% (Statistics S.A.). Patients may therefore not have the means to access health facilities.
- The cure rate of Pulmonary Tuberculosis (PTB) is dismal.
- Increasing prevalence of HIV/AIDS. Statistics S.A. estimates that the prevalence of HIV/AIDS is 16.7% among adults.
- Brain drain: Emigration of medical and nursing personnel to U.S.A., U.K., Canada and Australia as they seek more attractive remuneration and working conditions (Bruwer, 2005).

From the detailed SWOT analysis carried out, the South African Healthcare industry supports a turnaround-orientated strategy. The country has many environmental opportunities, but is also plagued by critical internal weakness. Therefore a turnaround strategy would be most appropriate to facilitate the successful implementation of a Social Health Insurance.

## SWOT Analysis of the DOH



Adapted: Fleisher and Bensoussan: 2003

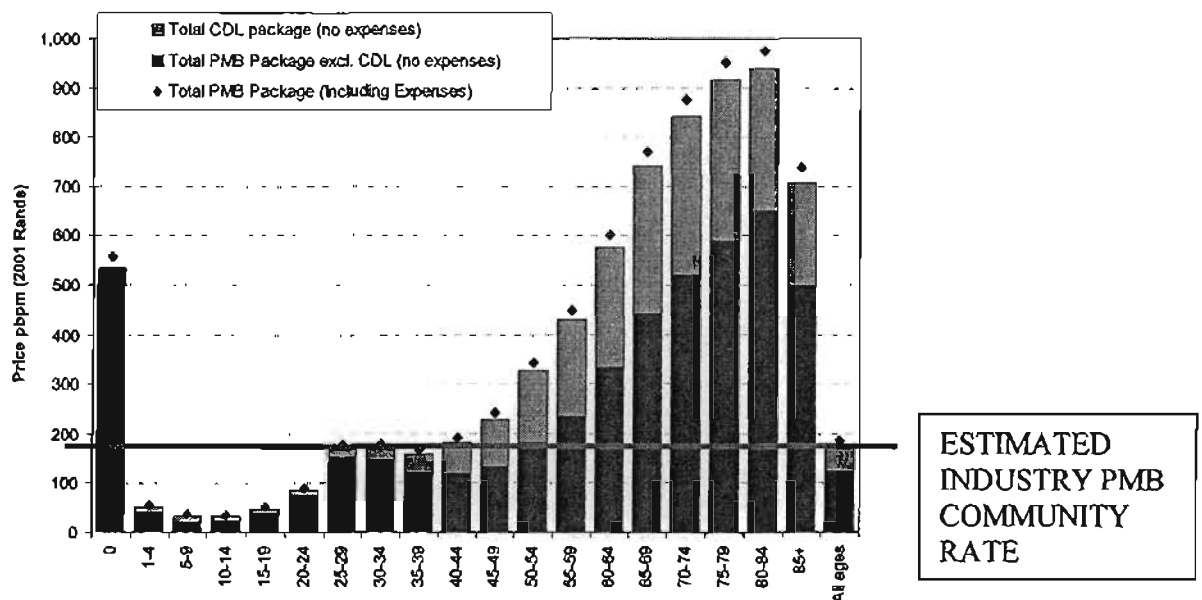
### 5.3 CHALLENGES FACING THE MEDICAL INSURANCE INDUSTRY

#### 5.3.1 AGE DISTRIBUTION OF BENEFICIARIES

Internationally concern has been raised within developed countries, as well as within the WHO, as to the impact of an ageing population. Within South Africa preliminary figures indicate, that a similar challenge is facing the insured market, with the number of pensioners (beneficiaries) having increased from, 5.8% in 2002 to 6.3% in 2003.

The ageing population as referred to above tends to make greater use of medical services, especially hospitalization as indicated in the graph, than do the younger members. Therefore, hospitalization expenditure will continue to increase at a greater rate as the existing pool of medical scheme members continues to age as a group. This impacts significantly on those medical schemes that have an older profile, and accordingly there is consensus that the establishment of a risk equalization fund, will assist in spreading the risk over the entire population of beneficiaries ([www.hst.org.za](http://www.hst.org.za)).

**Price by Age for the Complete PMB Package (In 2001 Rands)**



**Adapted: Council for Medical Schemes Annual Report 2003 – 2004**

### 5.3.2 UNEMPLOYMENT

A serious challenge facing the implementation of Social Health Insurance is the impact of South Africa's unemployed. It is not possible to have medical insurance, when there is no income to support such an initiative (Khan, 2005). It

is largely for this reason that the employed market is targeted, and in particular, those employed individuals who currently do not have health insurance. It is for this reason, that certain aspects of the Social health Insurance recommendations are criticized, in that it merely addresses a small component of the Republic's population, and certainly does not target the many unemployed.

#### **Labour Force Survey – September 2004**

LABOUR FORCE SURVEY (September 2004)	
Total Population 15-65 years.	29.30m
Total employed.	11.64m
Economically active.	15.78m
Unemployed.	4.14m
Medically insured (2003)	6 924 686

#### **Adapted from Council for Medical Schemes Annual Report 2003 – 2004**

The Labour Force Survey (LFS) latest results indicate the total number of unemployed South Africans number 4.4 million. Out of a total working population, this constitutes a figure of 26.2%. This determination may be conservative due to the narrow definition and interpretation unemployment. This in turn impacts directly on the number of persons who are able to access medical insurance, even within the current recommendation of the Social health Insurance package.

## **5.4 RECOMMENDATIONS TO FACILITATE IMPLEMENTATION OF SHI**

### **5.4.1 DEVELOPMENT OF INFRASTRUCTURE**

The hospital revitalization program, which has resulted in the construction of 18 new hospitals since 1999, has not had the broad based positive impact that it sought to achieve. This program is viewed as a failure, especially with reference to the upgrading of rural healthcare facilities.

The Department of Health has focused on a primary healthcare approach, but many of its rural healthcare centers are dilapidated with poor access to electricity and diagnostic services such as laboratory services. The implementation of SHI will require a complete refurbishment of state health centres to make them more aesthetically appealing and thus influence the migration of the patients from the private to the public sector. Patients belonging to a SHI system will therefore require a superior level of services at state hospitals compared to those patients who do not pay any fees (Govender, 2005). A substantial investment is required by the DOH, to upgrade existing health care facilities and construct new facilities to accommodate the projected increase in utilization, which will follow the implementation of SHI.

### **5.4.2 HUMAN RESOURCE DEVELOPMENT**

South Africa is currently experiencing a severe shortage of medically trained personnel; in the public sector. This is primarily as a result of poor working conditions and remuneration within state structures.

To prevent the mass exodus of medical professionals to developed countries, the Department of Health needs to restructure the current remuneration packages offered to the healthcare providers. This will allow the government to retain the

professionals within the public sector and reduce the risk of losing them to the private sector or developed countries. Inadequate housing and security provision remains an obstacle to attracting doctors to rural hospitals. These rural hospitals are in dire need of senior medical personnel, but will have little hope of attracting this scarce commodity if the housing and security concerns are not addressed. The Department of Health has recently introduced a rural allowance and a scarce skills allowance, which is payable to medical personnel working in rural hospitals.

This has no doubt made the positions available at these institutions more attractive, but further reform is required. New legislation requiring newly qualified specialists to complete a compulsory "community service" will provide much needed specialist medical exposure, to rural health centers. The established policy of community service for all newly qualified medical doctors and other allied health professionals has had a positive impact on service delivery at rural hospitals. An established SHI system will result in increased patient volumes at public hospitals. This will require additional medical personnel. Therefore for the system to function effectively - it requires the retention and augmentation of the current workforce. The DOH should intervene to improve working conditions and remuneration within the public sector, to retain medical personnel working in this sector and attract potential employees from the private sector to fill the magnitude of vacancies that remain unfilled.

#### **5.4.3 HIV/AIDS**

The increasing incidence of HIV/AIDS remains a cause of concern for the Department of Health (DOH). It is estimated that HIV affects 16% of health workers. The Prevention of Mother to Child Transmission (PMTCT) program instituted by the DOH has had a positive impact on the under 5 mortal rate.

The Anti Retroviral (ARV) rollout has begun, but many patients are not able to obtain the life sustaining drugs due to the stringent admission requirements to the ARV program. This has resulted in only a small percentage of the population deriving benefit from the ARV rollout. The opportunistic infections that HIV positive patients succumb to is a cause of major concern. The commonest cause of death in HIV infected patients is PTB. These conditions place added strain on an ailing health system and consume scarce resources. The Department of Health need to ensure that its ARV rollout is more broad based, thus providing benefit to all those infected with HIV. The SHI will require that patients be accommodated within reasonable levels of comfort in public hospitals. This will not be possible if the hospitals are filled to capacity with HIV infected patients ([www.doh.gov.za](http://www.doh.gov.za)). The HIV/AIDS pandemic demands that the DOH make available life sustaining ARV's to all HIV positive patients. The current ARV rollout is inadequate to control the pandemic.

#### **5.4.4 MAINTENANCE OF A PATIENT DATABASE**

The private healthcare sector makes use of sophisticated network enabled patient databases that make patient information routinely accessible to all hospitals within their organization. In contrast the public healthcare system has no effective patient database, which makes it impossible to ascertain a patient's eligibility to pay for services rendered, based on their level of income. This has led to a situation of many patients accessing the public health system along various points of service delivery, without contributing to the cost of those services (Kader, 2005).

The founding principle of SHI; prospective financing, will increase revenue collection for the DOH. A network enabled database linking all DOH hospitals, will assist in the collection of additional revenue, and facilitate the operational activities of the SHI scheme.

#### **5.4.5 COLLABORATION AT MANAGEMENT LEVEL**

The implementation of SHI presents significant opportunities for collaboration between the public and private health sectors. The apparent lack of consultative processes by the Department of Health in key policy determinations has fostered a rift between the Department of Health and the private healthcare sector.

The private hospital groups have management teams in place that have established themselves as cost drivers. They could provide valuable lessons to their management colleagues in the Department of Health. State hospitals are plagued with long waiting lists for elective surgical procedures due to theatre constraints. Private hospitals and their associated medical specialists could alleviate this burden by performing these procedures for the state at a reduced fee (Kendall, 2005). Netcare, which is South Africa's largest private hospital and doctor group, has embarked on a project to provide cataract surgery and elective orthopaedic surgery (total hip/knee replacements) to Britain's National Health Service (NHS), at a cost effective rate, thus reducing the strain on the NHS. If the SHI can result in such effective levels of collaboration, between the public and private sector in South Africa, it will result in increased levels of service and shorter waiting periods for elective surgical procedures. An increased degree of collaboration is required between key stakeholders in the public and private health care sectors to improve service delivery and attract additional members to the SHI scheme (Passmore, 2005).

#### **5.4.6 MEDICAL SCHEME REFORMS**

Reforms introduced by the Medical Schemes Act have been implemented to ensure that individuals burdened by disease are not unfairly discriminated against. These include requirements of open enrollment, community rating and prescribed minimum benefits (PMB), as well as recent innovations such as the

inclusion of a chronic disease list in the PMB's. These reforms made possible by the Department of Health have paved the way for the implementation of SHI. Risk equalization should ensure that all medical scheme members face the same community price for PMB's. It should remove the incentives for medical schemes to select preferred risk, by ensuring that each scheme must bear the cost of a risk profile equal to the risk profile of all covered lures. It should also create incentives for schemes to improve its efficiencies and cost controls, by not incorrectly penalizing efficient schemes. Risk equalization will therefore assist in the risk management by smaller medical schemes. This will assist them to efficiently compete in retaining and attracting new members to their schemes; whilst remaining profitable.

#### **5.4.7 INCOME CROSS SUBSIDIES IN MEDICAL SCHEMES**

*In most countries with social insurance systems, contributions tend to be based on income. High-income earners cross subsidize low-income earners. In South Africa, medical scheme contributions are community rated. Income related cross subsidies is difficult to achieve and a change in the tax subsidy is required to improve income cross subsidies. There is general concern that the current tax subsidy needs to be restricted to achieve greater subsidies for lower income earners. A review of the current tax subsidy is required to private health insurance membership more attractive to lower income earners. (Katz, 1995).*

#### **5.4.8 HEALTH PROMOTION**

Promoting good health and preventing disease is central to the Primary Health Care Policy developed by the Department of Health. District level health promotion campaigns with strong community participation will provide a foundation for the implementation of national healthcare initiatives. Cost effective

management of non-communicable diseases, especially the lifestyle diseases (eg. Hypertension, Diabetes Mellitus and Hypercholesterolaemia) will reduce the financial burden in providing pharmaceutical intervention in preventable diseases. The construction of additional community based clinics, especially in the rural areas, will assist in reducing the unwarranted abuse of public hospitals. The DOH should invest in high visibility health promotion campaigns, that target not only urban residents but also rural residents, to assist in building a healthy nation.

#### **5.4.9 AUGMENTATION OF RURAL HEALTH FACILITIES**

There is a dire need to provide adequate and equitable services in the rural areas. The Department of Health should play an advocacy role in ensuring that adequate attention is given to the provision of water, sanitation, roads, communication systems, housing, schools and health facilities in rural areas. The provision of travel allowances, children education allowances and enhanced promotion credits may serve as an incentive to attract scarce medical personnel to rural hospitals. Health education institutions should provide rotation of their students and staff through rural facilities for all categories of health workers, thus improving interdisciplinary learning activities at rural community based primary care facility. Rural health care centres require additional funding to improve facilities and infrastructure; and to attract additional medical personnel. This will facilitate improving overall access to quality health care (Reddy, 2005).

## **5.5 LIMITATIONS OF THE STUDY**

*The limitations imposed on this research may be summarized as follows:*

- Paucity of public sector management regarding the concept of SHI and its proposed implementation by the Department of Health.
- Due to time constraints imposed by the research project, only twenty semi-structured interviews were conducted. A larger number of interviews would have provided a greater depth of knowledge.
- South Africa is regarded as a third world country, whereas Australia is a first world country. Therefore the complex that defines the healthcare systems in each country is vastly different.
- The HIV/AIDS pandemic has produced a unique requirement for health service delivery in South Africa.

## **5.6 FUTURE RESEARCH AREAS**

Further research using quantitative research methods is proposed to determine the extent to which *doctors and allied medical personnel administering services within a SHI scheme, believe in the scheme.*

## **5.7 CONCLUSION**

The constitution of South Africa and the recently introduced Charter of Patients Rights, dictate that "every person has the right to achieve optimal health and it is the responsibility of the state to provide the conditions necessary to achieve this". The Department of Health have introduced significant reforms to further their aim of quality accessible healthcare, but additional reforms are required to permit the successful implementation of SHI.

Free healthcare is currently provided in the public sector for children less than six years of age, pregnant and nursing mothers, the elderly, the disabled and certain

categories of the chronically ill ([www.doh.gov.za](http://www.doh.gov.za)). This creates a severe financial burden, for the Department of Health, with its constrained budgetary limitations. In addition poor patient information systems result in many patients accessing the public health service without paying for services, even though they are eligible for payment (Kader, 2005).

This study sought to determine if South Africa was adequately prepared for the implementation of a SHI system. South Africa has a population of approximately 46.9 million citizens, but less than 8 million citizens enjoy private medical schemes cover. An estimated 80% relies on the public sector for health service delivery. In 2004 the private sector, which is tasked with providing healthcare to its 8 million beneficiaries, spent approximately R60 million whilst the Department of health received a budget of only R42.8 million to provide health services for its 38 million citizens. This disproportionate distribution of resources between the public sector and the private sector, have resulted in large disparities in health status among different socio economic groups. This scenario is contradictory to that enshrined in our constitution.

The implementation of SHI in South Africa will assist in addressing aspects of affordability and access to health services. The depth of the impact thereof however, remains to be seen. In contrast to the private or commercial insurance plans where premiums are actuary based (higher risk patients pay more for their medical cover), contributions in a social health insurance are based on the member's ability to pay a required contribution. South Africa is plagued with high levels of poverty and unemployment; therefore even with low contribution levels many citizens may not be able to join the SHI system.

In the South African context it would be beneficial if the SHI were rolled out gradually in terms of population coverage and benefits. This would accommodate the resource constraints, anticipated excess demand; which requires expansion

and development in provider and administrative capacity and consensus amongst all stakeholders. As outpatient cover is more likely to be prone to abuse than inpatient cover. It may be beneficial to first provide the latter, while the former is pilot tested for later introduction and implementation (Bruwer, 2005).

*The level of economic progress of a country has a bearing on the extent to which a SHI scheme can be successful and sustainable. Therefore in the guise proposed by the Department of Health; SHI is no doubt a noble initiative but has to be preceded by significant structural, functional and organizational reforms to make quality, affordable, accessible healthcare a reality.*

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## 7. APPENDIX

### SUMMARY OF INTERVIEWS CONDUCTED FOR MBA DISSERTATION:

RESPONDENT	ORGANIZATION	POSITION HELD	DATE
DR PATEL	R.K. KHANS	HOD - OBSTETRICS	19/09/05
DR MYENI	ST MARYS	MEDICAL MANAGER	29/08/05
MR J. POORAN	MEDICAL TOWERS	GENERAL MANAGER	18/08/05
DR MULLER	KINGSWAY HOSP.	OPHTHALMOLOGIST	17/08/05
MR R. PASSMORE	ST AUGUSTINES	GENERAL MANAGER	22/08/05
DR BEHADUR	R.K. KHANS	HOSPITAL MANAGER	17/08/05
PROF. A. REDDY	ALBERT LUTHULI	CARDIOTHORACICS	20/08/05
DR. KADER	WENTWORTH	MEDICAL MANAGER	17/08/05
DR. BAM	PRINCE MYSHENI	ORTHOPAEDIC REG.	23/08/05
MR G. KENDALL	PARKLANDS HOSP.	GENERAL MANAGER	22/08/05
MISS B. KUNENE	SHI NATIONAL OFF.	DIRECTOR	22/08/05
MR N. BECHAN	UMHLANGA HOSP.	GENERAL MANAGER	19/08/05
MR G. KENDALL	ENTABENI HOSP.	GENERAL MANAGER	27/08/05
MR. M.R. KHAN	M.R. KHAN OPTOM.	OPTOMETRIST	30/08/05
DR DUBE	ST MARYS HOSP.	CHIEF MED. OFFICER	29/08/05
DR BHOOLA	CITY HOSPITAL	MEDICAL MANAGER	24/08/05
DR G. GOVENDER	R.K. KHANS HOSP.	MEDICAL MANAGER	24/08/05
MRS T.R. ZONDO	ST MARYS HOSP	HOSPITAL MANAGER	29/08/05
DR BHANA	ISIPINGO HOSPITAL	MEDICAL MANAGER	17/08/05
DR D.L. BRUWER	DR D.L. BRUWER	PRIVATE PRACTICE	20/08/05