2025 Pholela Lecture
"Health Systems Reform in South Africa: The indispensable role of medical specialists"?

Nicholas Crisp
MBChB, Dip Occ Health, MMed(CH)
Deputy Director General: National Health Insurance
National Department of Health
Hon Professor in Public Health Medicine (University of Pretoria)
nicholas.crisp@health.gov.za

ABSTRACT

The lecture focused on three elements. The first is a factual look at the need to reform the South African health system, looking at the problems with the current arrangements. It is argued that massive systemic health sector reform is needed. The second is an examination of what needs to be reformed and what National Health Insurance aims to do. The reform focusses on changing the way that health care is funded (through a single purchaser model) which contracts with public and private providers. The reform also aims to move from a medical model to a multi-disciplinary primary health care approach. The third focus is on a brief interrogation of the role that medical specialists should play in the health system, both in terms of clinical specialists and Public Health Medicine specialists in particular.

INTRODUCTION

The National Assembly passed the amended National Health Insurance Bill in June 2023, after which the National Council of Provinces (NCOP) took over the process. Some 60 community consultations were held in all nine provinces. The NCOP adopted the Bill by a majority of eight provinces to one in December 2023. President Ramaphosa assented to the National Health Insurance Act (NHI), 2023[1], on 15 May 2024. This marked the culmination of a lengthy legislative process that commenced in 2019 with the tabling of the Bill in Parliament. The NHI can now be gradually phased in. The Act requires that this be a 'progressive and programmatic approach based on financial resource availability' and that there be two phases to the implementation. Phase 1, from 2023 to 2026 is purse administrative capacity building and phase 2, from 2026 to 2028 will see commencement of new health care purchasing methods being introduced.

SPENDING ON HEALTH

The digital World Bank Report dated 07 April 2023 showed that the global average percentage of Gross Domestic Product (GDP) on health was 11%. At that date South Africa's GDP spend on health was 8,5% and the United States of America over 20%, which equates to over 40 % of global spending on health.[2]

[1] https://www.gov.za/documents/acts/national-health-insurance-act-20-2023-english-afrikaans-16-may-2024
[2] https://databank.worldbank.org/reports.aspx?source=2&series=NY.GDP.MKTP.CD

South Africa's unique position as the most unequal society in the world, with a Gini coefficient reported to be around 0,63 (2014) and worsening, is reflected in the health system[3]. The Gini coefficient is an index[4] which ranges from 0 to 1 (or 0% to 100%) which measures income and wealth distribution, with higher values representing greater inequality. No other country is reported above 0,6, meaning a huge portion of the country's income and wealth is concentrated in the hands of a small percentage of the population.

An analysis of domestic health spending shows a steady growth of spending from 7% of GDP in 2008/2009 to 8,5% now. Both public and private spending increased until 2020/21 but both are predicted to decrease in the near future, public faster than private. Averages, percentages and numbers can be difficult to interpret and, when aggregated, can hide the real challenges. This lecture attempts, at least at a high level, to show the challenges when the data is disaggregated.

INEQUITY

More than half of South Africa's health financing is private (not spent through the fiscus) and has shown steady linear growth while the growth in public financing has decreased, especially since the COVID pandemic. Public health spending has increased from 14% of government spending to 15,5% during COVID but is again below 15%. Real public health expenditure (allocations from fiscus) per capita has been decreasing since 2019/20.

Meanwhile the public sector-dependent population has increased. Around 86% of the population has no medical aid cover and only 9,1 million people do. This number is not growing because the pool of employed people has stagnated and the cost of voluntary health insurance (VHI), or medical schemes, has increased beyond people's ability to pay.

Spending in the private healthcare system is heavily skewed to hospitals, specialists and medicines. General practitioners were paid only 5,2% of total benefits paid out by all schemes in 2023.[5] Very little is spent on prevention and there are no published statistics on health outcomes so there is no evidence for the quality of the clinical care provided. However, the complexity of the financing of the private system, which currently has 71 medical schemes, offering 311 different 'options', opens perverse incentives which patients, practitioners and other providers exploit. The resultant estimated fraud, waste and abuse is reportedly R30 billion per annum, which dwarfs the reported corruption in the public sector.

Furthermore, this complex financing environment comes with large administrative costs for maintaining medical schemes. At the start of 2024 the 71 schemes had 833 trustees who cost the scheme members over R104 million for the year. The Principal Officers cost their members almost R140m[6]. The gross administration cost of schemes was almost R21 billion, or 9% of the R230 billion collected from members in that year. Despite this cost the reported fraud, waste and abuse in 2023 was R28bn in one year[7] (around 6 times the AGSA reported unauthorised expenditure in the public sector). The problem is that the massive perverse incentives that are created by the complex pathways are easy to defraud.

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[3] https://data.worldbank.org/indicator/SI.POV.GINI
[4] https://databank.worldbank.org/metadataglossary/world-development-indicators/series/SI.POV.GINI
[5] CMS Industry Report 2023 https://www.medicalschemes.co.za/the-cms-2023-industry-report-is-here/
[6] CMS data
[7] https://www.corruptionwatch.org.za/private-health-sector-corruption-to-be-exposed/

The fact is that there is an enormous gain to be made from achieving efficiencies in the whole health system.

The spending in the public health system is about one fifth per capita of the spending in the private health sector. Public sector spending includes all public health programmes for the entire population like immunization, port health services, malaria control and the HIV and TB programmes, so the ratio is probably worse. The present average spend in the public sector (2023) is around R5,300 per person per annum while it is about R28,700 per person per annum in the private sector.[8]

While this all points to inequity between those with resources and those that do not, the inequity is far deeper.

DISAGGREGATED PUBLIC SECTOR INEQUITY

Analysis of where the money is spent in the public health service reveals severe inequity.[9] The nine provincial health departments have maintained spending on clinic services since 2004/05. As a proportion of the whole public health expenditure clinic services spending has risen from 40% to 45% since 2004/05. Simultaneously, in a decreasing total expenditure, hospital spending decreased from about 27% to below 20% by 2023. It is no surprise that public hospitals receive bad press.

There has been little redress of equitable distribution of public health service hospital beds over the past 15 years. Inequity between provinces ranges from 25,9 beds per 10 000 uninsured people in the Free State province to only 11,2 beds per 10 000 uninsured people in Mpumalanga.[10] Further disaggregation of the data shows deepening inequity. Access to public hospitals differs greatly from one district to another, whether urban or rural. Ekurhuleni and Johannesburg metropolitan areas have amongst the lowest bed availability per public sector dependent population. The ranges are stark. Mangaung boasts 50,4 beds per 10 000 uninsured people while Bojanala District in North West has a paltry 4,7 beds per 10 000 uninsured people. This is a ten-fold difference.

District Health Service spending was growing between 2014 and 2020 but per capital spending in primary health care (PHC) is now decreasing despite the population increasing. Here too the District Health Barometer reflects similar unequal access to PHC. Spending per capita ranges from R2,726 per capita per annum in Limpopo in 2022/23 but only R1,771 in Gauteng. If the data is disaggregated to district level, then Central Karoo's R4,777 as opposed to Johannesburg's R1,396 shows starkly different prioritization. It is true that local governments do provide some PHC services in Metros, but the inequity remains. Total PHC expenditure varies enormously. The inequity in resource spending is three times (R1'500 toR4,500) and it cannot all be attributed to differences in physical distances and population density.

SUMMARY OF THE STATUS QUO

There is plenty of money being spent on health care in the country. The 8,5% of GDP amounted to R543,246 billion combined expenditures of the public and private sectors for

[8] National Treasury data

[9] https://www.hst.org.za/publications/Pages/District-Health-Barometer-202324.aspx

[10] https://www.hst.org.za/publications/District%20Health%20Barometers/DHB%202022-23%20Section%20A,%20chapter%204%20-%20Service%20capacity%20and%20access.pdf

2021/22. If donor partner spending is included it came to R554,341 billion that year. What is abundantly clear is that duplication is costly. There are twelve public departments of health including those of the Correctional Services and the Defence Force. Private funding suffers from 71 medical schemes, and their 311 options, plus a plethora of 'gap' cover and other insurance products. This complexity increases administration, creates perverse incentives, increases opportunity for fraud, and results in poor coordination of care.

A further consequence of this duplication is inequity of access to resources with concentration in the private sector, but unjustified intra-provincial and inter-provincial public inequity of resource allocation. There is massive quality disharmony. All of this is acerbated by poor systems for coordinated data management which makes it difficult to plan holistically, difficult to change direction, plan strategically, and to purchase healthcare strategically.

NATIONAL HEALTH INSURANCE REFORMS

The World Health Organisation defines UHC as "Every person gets the quality health care that they need, when they need, where they need, and without incurring financial hardship"[11].

The NHI aims, through a statutory mandate, to address both equity and equality. If fairness is the goal, equality and equity are two processes through which to achieve it. Equality simply means everyone is treated the exact same way, while equity means everyone is provided with what they need to succeed. The NHI is a vehicle to achieve Universal Health Coverage (UHC) for all who live in South Africa. NHI is a health financing system that is designed to pool funds to provide access to quality affordable personal health services for all South Africans, based on their health needs, irrespective of their socio-economic status. It must be noted that the NHI Act goes beyond enabling financing. It mandates the enhancement and amendment of the National Health Act but does not repeal it. The NHI Act also enhances and amends other health Acts, including the Medical Schemes Act but does not repeal them.

The essential features of the NHI are few. It will pool the vast majority of health resources into one NHI Fund. This will be publicly funded, the implication of which is that the collection will not be voluntary but through the tax system instead of medical schemes. The NHI Fund will purchase services, which are called 'benefits' in the Act, on behalf of the whole nation from both the public and private health sectors. The NHI Fund is mandated to contract directly with service providers so that there is direct reimbursement for work done. This introduces administrative complexity but substantially increases transparency and fairness. The public, termed 'Users' of the health system, must register with clinics and doctors who are family practitioners to obtain services, and must start their care at this primary health care (PHC) level. The arrangements lead to a purchaser-provider split.

It should be clear from the previous section that it is not possible to address one part of the existing health dichotomy without addressing the other, they are mutually dependent and the whole system needs reform. There is a need for both systemic change and local changes to how services are paid for and provided.

The President will proclaim sections on different dates as required but the mandate is to implement in two phases with Phase 1 running from 2023 to 2026 and the Phase 2 commencing in 2026/27 through to 2028/29. It is only after that period that the system-wide changes will be progressively rolled out, within the funding provision.

[11] https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

CLINICAL MEDICAL SPECIALISTS

With this background the question for members of the Colleges of Medicine of South Africa (CMSA) is what role should specialists play in this reformed health system? We should note that there are 29 Colleges and 27 registerable specialties in the country.

Clinical medical specialists will continue to play a vital role in healthcare by providing expert diagnosis and treatment for specific diseases and conditions, complementing the work of general practitioners. Specialists contribute to the overall health system by offering specialized care, participating in research, and educating future medical professionals.

More specifically, the additional training and focus on specific areas of care means that specialists should have in-depth knowledge**,** allowing them to diagnose and treat complex or uncommon conditions that may be beyond the scope of general practitioners, and frequently they utilize specialized diagnostic tools and techniques to accurately identify the root causes of illnesses, enabling them to develop targeted treatment plans. It is also expected that specialists provide tailored treatment plans based on their expertise, including medical, surgical, or other therapeutic interventions, and manage patients with chronic, severe, or rare conditions, often requiring a multidisciplinary approach involving collaboration with other specialists and healthcare professionals.

Besides the direct specialised care of patients, specialists should also contribution to the efficiency and sustainability of the health system. Examples of this are that specialists should receive referrals from general practitioners, ensuring that patients with specific needs receive the appropriate level of care, they are ideally placed to contribute to the education and training of future doctors, including registrars and medical students, passing on their knowledge and expertise. Many specialists see patients with conditions that are uncommon or complex and this makes involvement in medical research important.

Because of the complex nature of specialised care, it is often essential to work in a multi-disciplinary team where a specialist is often the coordinator of comprehensive and coordinated patient care. Some specialities lend themselves to involvement in public health initiatives, such as disease prevention programmes or health promotion campaigns, leveraging their expertise to improve the overall health of the population. Some specialists may hold leadership positions in hospitals or other healthcare organisations, shaping policies and practices to enhance the quality of care.

However, as we have seen in the heavy concentration of expenditure on hospital care, mostly provided by specialists, it is important to ask if specialist care is always appropriate.

There is no dispute that specialisation is needed to improve national clinical “competitiveness, ability to innovate, extend life and explore the frontier of science and knowledge” and there are good clinical arguments for specialisation, such as that procedures have become more complex and effective and may produce better outcomes for patients. It is also recognised that patients drive specialisation because of a belief that it is naturally better.

But we also know that supplier-induced demand, rear of litigation and often financial reward induces specialist care with no evidence to justify the use of specialist care and time.

Mark Britnell has noted that “left unfettered and not harnessed to the role of the generalist in healthcare, we can look forward to painful debates about rationing, professional ‘turf-war’ and

suboptimal patient care".[12] There is ample evidence that better teamwork between the generalist and specialist is good for the patient and reduces costs. Since there is always a shortage of specialist skills, we should preserve them and work together to serve our patients and the population at large. There will be pressure to change the pattern of healthcare that has built up over many years. Specialisation is not always appropriate for patient and population needs and the rapid growth of patients presenting with long-term conditions threatens to challenge the conventional wisdom on hospital-based, specialist care.

There is an example of specialists working to use their knowledge and skills to improve clinical governance right here on our doorstep. The District Clinical Specialist Teams (DCSTs)[13] were implemented to improve quality of care outcomes by supporting medical officers and other health professionals. The structure for a DCST consists of seven specialists in each district, comprising three medical and three nurse specialists from obstetrics and gynaecology, paediatrics and family medicine/PHC, and one anaesthetist. The roles of the DCSTs include:

- providing clinical training and monitoring and evaluation
- supporting district-level organisational activities
- ensuring collaboration, communication and reporting
- ensuring implementation of the four tiers of clinical governance; and
- supporting the strengthening of management systems

PUBLIC HEALTH MEDICINE SPECIALISTS

Finally, we come to the orphan speciality of Public Health Medicine, which appears to not be well understood. The practice of Public Health Medicine focuses on the delivery of population-oriented clinical services aimed at promoting the health of communities and prevention of diseases, teaching in public health and preventive medicine across disciplines and research to advance population health. Some Public Health Medicine specialists provide clinical services broadly grouped into disease prevention (communicable diseases, non-communicable diseases, maternal and child health), clinical public health (clinical health informatics, medical management, clinical economics), occupational and environmental health and social medicine.

The qualification is a Master of Medicine (MMed) in Public Health Medicine. Specialists are trained in:

- Epidemiology
- Biostatistics
- Public Health and Society
- Quantitative Research Methods
- Health Systems
- Health Policy and Planning
- Economics of Health Systems
- Evidence-Based Health Care
- Epidemiology of Communicable Diseases and Non-Communicable Diseases

As we seek to create a more responsive health system, which will intervene early with preventive care, and as funds become more constrained, it is the skills of the Public Health Medicine specialist that will become critical to evidence based decision-taking, hard economic

[12] https://pmc.ncbi.nlm.nih.gov/articles/PMC5873739/ (Mark Britnell)
[13] https://www.hst.org.za/publications/Kwik%20Skwiz/KWIK%20SKWIZ_Vol3_Iss5.pdf

decisions and formulation of agile, targeted policies. The NHI Branch in the National Department of Health has actively sought to recruit Public Health Medicine specialists. There is a case to be made for this to be a compulsory qualification for many management and policy positions in the health system.

KEY PRINCIPLES OF THE CMSA PLEDGE

We should all remind ourselves regularly of the pledge because it encapsulates the essence of the medical specialist!

- I shall always advance and uphold the core ethical values of social justice and health equity.
- I shall always act in the best interests of my patients and respect their autonomy and rights and treat them with care and compassion.
- I shall never allow considerations of financial reward, career advancement, or reputation to compromise my judgement or care to my patients.
- I shall continue to advance my knowledge and skills to offer my patients the best care.
- I shall continue to learn and teach for the benefit of my patients, my trainees, my community, and my country.
- I shall respect my mentors and colleagues and readily offer them assistance and support.