THE MANDELA INITIATIVE

Dialogue and action to overcome poverty and inequality

Theme: Health

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Assessing the Redistributive Potential of the South African Health System

Structural poverty and persistent inequalities from a health sector perspective: Key issues and underlying factors

There is an inter-relationship between poverty and inequality on the one hand and health and the health system on the other. Health status is strongly influenced by what are termed 'social determinants' (e.g., income, employment status, education, gender, living conditions, etc.); the distribution of these variables across the population influences the distribution of ill-health. There are also relationships in the other direction, in that good health status can contribute to improved socio-economic status (e.g., children derive greater benefits from education; productivity is greater etc.) while there are potentially severe impacts of ill-health on household livelihoods (both through productivity losses and the costs of using health services).

While conducive socio-economic conditions can contribute to improved health status, the health system is a key contributor in this regard. Importantly, the health system can also play a role in addressing structural poverty and persistent inequalities. In particular, the way in which the health system is financed determines the extent to which there is

About this brief

This brief was commissioned by the Mandela Initiative to help inform a synthesis report on its work since the 2012 national conference, Strategies to Overcome Poverty and Inequality, organised by the University of Cape Town. The MI provides a multi-sectoral platform to investigate and develop strategies to overcome poverty and reduce inequality in South Africa. While the Nelson Mandela Foundation is a key partner, the Initiative has relied on collaborations between academics and researchers, government, business leaders, civil society, the church and unions.

The synthesis report serves as a framework for reporting on the work of the MI at a national gathering on 12 – 14 February 2018 at the University of Cape Town. The MI Think Tank has identified the objectives for the gathering as:
- to anchor the contributions of the MI within an analysis of the current South African political and economic context;
- to share the recommendations emanating from the MI-related work streams at a policy/strategic level to advance the goal of eliminating poverty and reducing inequality;
- to critically engage with the potential impact of the recommendations on eliminating structural poverty and inequality; and
- to discuss ways of promoting popular conversations and debate about what needs to be done to eliminate poverty and reduce inequality, beyond the MI.

The synthesis report aims to assist participants to prepare for the national gathering. The report drew on findings from the sectoral research projects of Think Tank members; the MI's Action Dialogues; a report on an MI Community of Practice workshop with research chairs from different universities to identify cross-cutting themes emerging from the MI's research programme; and the work programmes of others who have expressed an interest in contributing to the goals of the MI.

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financial protection from the costs of seeking care (which could otherwise impoverish households), and public spending on health services is an important redistributive mechanism. Equitable access to services that address the health care needs of the population and that are of sufficient quality to be effective is also critical in redressing inequalities. A well-designed health system has the potential to redistribute incomes, both directly through using progressive health financing mechanisms and 'in kind' through the use of health services, in favour of the poor and vulnerable.

Health care financing mechanisms in South Africa are not realising their redistributive potential. There has not been a statistically significant change in income redistribution related to overall health care financing between 2005/06 and 2010/11. However, indirect taxes (such as VAT and excise) have become more regressive and funding of health services through this component of general tax revenue has contributed significantly to widening income inequality over this period. In contrast, medical scheme membership has become even more concentrated among higher income groups; the burden of financing medical schemes is currently largely borne by richer groups.

There is an even greater failure in realising the health system's redistributive potential in relation to use of quality health services based on need for care. Although a far greater burden of illness is borne by the lowest income groups, use of health services is far lower amongst these groups. There are higher levels of unmet need for health care among lower than higher socio-economic groups, among rural compared to urban dwellers, and among those who are not covered by medical schemes compared to medical scheme members.

These inequalities in utilisation reflect underlying inequalities in health service access. There remain considerable disparities in public health budgets, expenditure and the availability of health services in relation to adequately staffed and equipped health facilities, across provinces and health districts within provinces. A key constraint to promoting an equitable geographic distribution of public health services is the fiscal federal resource allocation approach whereby provinces have considerable autonomy in determining the allocation of budgets across sectors. Many public health facilities also face considerable service quality challenges such of lack of availability of routine medicines and poor patient–provider engagement and other effects of low staff morale. While there have been a range of initiatives to address poor service quality in recent years, there are implementation challenges.

There are also large disparities in the availability of health care resources across socio-economic groups. This is particularly evident when comparing the financial resources devoted to medical scheme members relative to the rest of the population. Total funding via medical schemes is of the same magnitude as that allocated to the health sector from government revenue. As the health sector is a human resource intensive sector, this has implications for the distribution of health professionals serving scheme members, who comprise only 16% of the population, compared with the rest of the population.

Macro policy/strategic level recommendations to deal with these challenges and potential impact on poverty and inequality

Many of the needed interventions to reduce health inequalities and to break the vicious cycle of poverty and ill-health are outside of the health sector; the full range of social determinants of health must be addressed. From the health system perspective, analysts in South Africa have consistently pointed to the need for *fundamental institutional reform* to achieve extensive and sustained improvements in access to quality health care. As the public health sector is the main provider of health services in South Africa, and public health services are used by the full range of socio-economic groups (albeit that the highest income groups tend to use mainly central hospital services), reform efforts need to focus on this sector. Key reforms required include:

- Centralised allocation of funds for health services to promote an equitable allocation of resources across health districts and individual facilities.
- Delegation of management authority to individual public hospitals and to sub-district management teams for primary health care services. Many of the persistent challenges that face public sector health facilities, such as poor staff morale, which impacts on the quality of services provided, and perceived lack of responsiveness to patients, can only be addressed in a comprehensive and sustainable way through increased management authority at facility level combined with strong governance and accountability structures.
- Strategic purchasing of health services, including explicit service level agreements with all providers to clarify expectations in terms of the range and quality of services, combined with monitoring of provider performance, and changing provider payment mechanisms to promote the efficient provision of quality services. Given the substantial service delivery capacity in the private health sector, services could be purchased from both public and private providers to meet the health needs of South Africans. A single, centralised agency would be able to exert considerable purchasing power to ensure that provider payment rates are affordable and sustainable. However, impeccable governance and accountability mechanisms are required for such an agency.

These reforms are in fact at the core of the initial conceptualisation of the National Health Insurance (NHI) policy proposals. The NHI policy has not been specified adequately and there is considerable confusion and contestation around it. This lack of clarity should be addressed and steps taken to introduce the required institutional reform, such as piloting the delegation of management authority to facility level, if we are to make progress to achieving equitable access to quality health care for all.

From the financing perspective, a key reform to promote financial protection from the potentially catastrophic costs of health care is the removal of user fees at public hospitals. There is global consensus that direct out-of-pocket payments are regressive and are not a desirable means of funding health services. Additional public funding of health services will be required over time. To promote

the redistributive effect of health care financing, increases in indirect taxes such as VAT should be avoided to generate additional funding.

There is an urgent need for open engagement about the future role of medical schemes. In recent months, the Department of Health has suggested making medical scheme membership mandatory for all formal sector workers and their dependants. This would seriously undermine the redistributive potential of the health system for the following reasons:

- Although medical scheme contributions are currently progressive when considered from the perspective of the whole population, as only richer groups contribute at present, they have a regressive distribution across medical scheme members, i.e. contributions account for a larger income share of lower-income than higher-income scheme members. This is due to contributions not being income-related but rather a flat amount for the selected scheme option.
- Mandatory extension of medical scheme membership to all formal sector workers will reduce the progressivity of scheme contributions at a population level, as new members will be drawn from lower income employee categories than current scheme members.
- Inequalities in benefits from using health services are likely to grow as only those who contribute to schemes benefit from these resources.

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