The South African health system after Covid-19

By Alex van den Heever

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Health systems in countries such as South Africa are invariably characterised by a mix of public authorities with wider social obligations and private arrangements, such as insurance and service provision, responsive to individual demand and need.

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Getting the public and private sectors to serve the public interest depends on the conscious organisation of the health system by the state. Naïve policy debates however tend to fixate on simplistic distinctions between public sectors, assumed to be virtuous by nature, and private sectors, assumed to be driven exclusively by transactional values.

For a considerable time in South Africa it has been evident that public authorities do not naturally act in the public interest. Far from being inherently virtuous, they are highly susceptible to capture by private interests where institutional designs fail to avoid this possibility. A poorly designed public health system will reflect the worst of all worlds. It will serve private interests without any of the benefits of a private market.

However, in the absence of a well-designed regulatory framework, private systems will also fall short of the achievement of wider social goals. Unregulated private health markets suffer from market failures that remove many of the positive outcomes markets can deliver. Three deviations from competitive markets serve as explanation.

First, the need for health insurance interrupts the relationship between household budget constraints and the cost of healthcare services leading to supplier-induced demand.

Second, market-related incentives do not exist to offer relevant information on the quality of health services to users, thereby removing product quality as a basis for informed consumer choice.

Third, health insurance product complexity impairs the ability of consumers to make informed decisions about their choice of insurer, perverting the incentives for efficient healthcare service purchasing.

As noted by the Health Market Inquiry the South African private health system reflects all the expected outcomes arising from the failure of government to regulate for the above well-understood weaknesses.

Despite these market failures the private health system has important features useful to any future organisation of the health system. First, it has substantial assets in the form of facilities equipment and a relatively well organised and trained workforce. Second, it has capable organisations and institutions that contribute towards its resilience and adaptability as a sector.

So, what did the pandemic reveal about the South African health system?

First, the public health system has fewer critical care beds than the private sector, despite having more overall beds. This is largely due to the closure of hospital-based services in the public sector from 1994 to the present in the absence of any national public hospital strategy. Remarkably, in March 2020 the public sector did not even have an inventory of public and private facilities despite running all public facilities and licensing all private facilities.

Furthermore, apart from the Western Cape, the public hospital system was not even able to report on Covid-19 hospital activities to the National Institute of Communicable Diseases (NICD). The private health system however reported all Covid-19 hospital activities to the NICD from 1 April 2020. According to the NICD the private hospital system also treated more Covid-19 patients than the public health system.

If the excess death information reported by the South African Medical Research Council accurately reflects Covid-19 deaths, then thousands of public sector patients were either not treated or not reported. Irrespective, were it not for the substantial capabilities of the private hospital system all the private patients would have required accommodation in the plainly fragile public hospital system.

Second, operating through the centralised state laboratory services the public health system at no point exceeded the Covid-19 testing capacity of the private health system. The public system was also apparently unable to implement a coordinated testing and tracing strategy that utilised the combined capabilities of the public and private sectors. Testing and tracing therefore never formed part of a strategy to suppress transmission at times when prevalence was low.

Third, the rampant corruption in the procurement of Covid-19 supplies by provincial governments derives from the patronage-based governance design of the public health system where posts and tenders are exchanged for political advancement and kick-backs. Patronage-based systems occur where political office-bearers are able to capture the appointment, procurement and licensing decisions of public organisations. In South Africa this has led to the collapse of performance at all levels of government.

The pandemic has therefore revealed nothing surprising about the South African health system. The failure to regulate either the public or private systems properly is arguably causally related to the patronage model of governance that has depleted the capabilities of the state. Unfortunately, all evidence suggests that for the foreseeable future no meaningful reform of the health system will occur aside from populist rhetoric about the un-implementable National Health Insurance.

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