POLICYbrief

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Health Care Reform in the US and in South Africa:

Does New Policy Cure the Disease or Merely Alleviate the Symptoms?

Madeline Venturino

Both South Africa and the United States (US) have proposed and implemented extensive health care reform in their respective countries within the last two years. For the US, the Patient Protection and Affordable Care Act (PPACA) was meant to overhaul the health insurance industry and change the focus of care to primary health services, in order to contain the astronomical costs associated with health care. For South Africa, 2012 marked the second major health care reform for the country since the abolishment of apartheid. The first of these reforms, in 1994, did not have the desired effect. This brief analyses the reasons for this failure and predicts whether the new reform will have greater success. Comparison of the socio-historical stage that each of the two countries is currently experiencing reveals that South Africa has unique burdens that must be overcome before real reform can take place. This paper makes general recommendations but ultimately aims to reveal important elements that may undermine the success of this new reform.

Introduction

The current US health-care system is a fee-for-service model in which the payer (either insurer or health plan) pays per visit or per service.[1] There are many problems with the current health care system, but the most immediate are those regarding health insurance and the lack of emphasis on primary care. According to the US Census conducted in 2011, some 48,6 million people in the US, or 15,7 per cent of the population, are uninsured.[2] Most of these people cannot afford coverage or do not qualify for coverage because of pre-existing conditions. Furthermore, not all insurance policies include preventive benefits, and those without insurance do not seek medical care until the problem has become very serious and requires expensive diagnostic and treatment procedures. There is a shortage of primary-care providers in the US, as doctors gravitate towards more lucrative specialities and private practices.

Proposed reform

On 23 March 2010, President Barack Obama signed into law the Patient Protection and Affordable

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Obama's 2010 Patient Protection and Affordable Care Act hopes to provide access to affordable care for most individuals

Care Act, better known as the ACA.[3] Essentially, the ACA will make some key reforms to the health insurance system and the health-care system to overcome the astronomical costs and provide wider access to health care. There will be new individual and employer mandates; most people will be required to purchase health insurance or pay a tax based on their income, and employers with more than 50 full-time employees will be required to provide coverage for their employees. Expansion of public insurance, as well as changes to private insurance, will make health insurance more accessible for most people.

Ultimately, the aim of the ACA is to provide access to affordable health care for most individuals. Under this new system, insurance companies will be better regulated and will shoulder more risk. Health-care providers will experience a large influx of patients needing primary and preventive care. Insurance companies will decrease the amount they pay to high-earning specialists, and bonuses will be awarded to providers that accept and treat patients with public insurance. The National Health Service Corps (NHSC) will pay off medical school debts for graduating medical students that choose to work in primary care in under-served areas throughout the country.[4]

South Africa and post-apartheid reform

Since apartheid, South Africa has gone through a transformation spearheaded by the newly democratic South African government at a remarkably rapid pace. Efforts to find a new equilibrium following a period of vast inequities proceeded immediately and simultaneously. This brief will focus on health-care reforms proposed since apartheid and evaluating or predicting the effectiveness of such reforms.

In 1994 the newly elected South African government proposed the Reconstruction and Development Programme (RDP) and the National Health Plan

Immediately following apartheid, the health-care system in South Africa was highly fragmented, favouring a 'white, urban, wealthy and medically-insured clientele'. The unequal distribution of resources between the private and public sector exacerbated shortages of resources within the country as a whole. Furthermore, health-care providers in South Africa focused on expensive and curative services rather than preventive services.[5] Finally, a unique 'quadruple burden' emerged in South Africa and still exists today. This refers to the 'increased burdens of chronic diseases, maintenance of poverty-related diseases, injuries and … a rise in infectious diseases associated with HIV [and AIDS] at the same time'.[6]

In 1994 the newly elected South African government proposed the Reconstruction and Development Programme (RDP) and the National Health Plan, two new policies to, among other things, aggressively combat the problematic and disparate health-care system that had resulted from apartheid. These were multi-faceted plans to unify and equalise care. First, to shift the focus of care to preventive and community-based participatory care, the government placed less emphasis on tertiary academic and specialised hospitals and allocated more funds to primary health care (PHC) providers. To decentralise and regionalise health care, a district health system (DHS) was implemented, which divided the existing health provinces into 50 health regions, and again into 170 health districts. The provincial governments would communicate with each other to ensure unity within the entire system.

The government introduced 'forceful affirmative action', so that the health-care workforce more accurately represented the racial and gender demographics of South Africa. The unequal distribution of care – geographically, racially, and socio-economically – between provinces was to be remedied by reallocation of resources, health-care workers, and health facilities. Various combinations of options to persuade providers to work in under-served areas and to limit opportunities to work in the private sector were considered. Finally, the socialisation of health care in the form of the implementation and expansion of free services was aimed at providing more accessible and affordable services for all income levels. The government planned to amend access to health insurance by introducing certain areas of mandatory health insurance coverage, ensuring risk-pooling, and enhancing efficiency and cost-containment in the insurance market.

These reforms had many positive outcomes, such as less discrimination in the public health sector, accessibility for disadvantaged groups, inter-provincial equity, and the overall unification of the system, as well as the introduction of programmes that targeted acute health problems like tuberculosis and HIV/AIDS. However, the reforms did not have the desired effect, according to an analytical report[7] written five years after implementation of the reforms. The author of the report, Van Rensburg, noted that health care in South Africa lost its priority when the central government focused on eliminating inter-provincial inequities, forcing provinces to divide up limited funds between their different departments. The health-care

system itself still held its 'notorious two-class character', meaning a private sector servicing a small, wealthy upper class, and a public sector responsible for the care of the majority of the population. The race, gender, and class inequalities still persisted, despite strict affirmative-action efforts. Moreover, the effects of free health services had not been sufficiently predicted nor planned for; the influx of patients led to overcrowding of facilities, shortages of resources, poor working conditions for staff and an overall decline in the standard of care in the public sector.

Though there are new challenges in the private sector, like the rising cost of care and the changing demographics of the insured population, the private sector has experienced growth since the dismantling of apartheid.[8] This is precisely the opposite of the trend that the democratic South African government was hoping for. Why are these trends emerging, and what can South Africa do to reverse these developments?

The socio-economic status of individuals plays an important role in their health-care-seeking behaviour, especially in seeking primary care. A study conducted in the United Kingdom (UK) and published in the *Social Science and Medicine* journal revealed that black respondents, respondents from lower socio-economic groups, and women were less likely to report immediate health-care seeking in response to given clinical scenarios than white respondents, those from higher socio-economic groups, or men. This finding was consistent across all scenarios after adjustment for interpretation of the different scenarios, access to health services and attitudes to health and health care.[9] Thus, before the government can reform the health care system, the socio-economic disparities in South Africa must be addressed.

New policy proposed by the African National Congress

Fast-forward to 2012, when the African National Congress (ANC) submitted the White Paper on National Health Insurance (NHI). According to the national Department of Health (DoH), the objectives of the reform are to improve access to quality health services for all, pool risks and funds in order to achieve equity and social solidarity, procure services on behalf of the entire population and to efficiently mobilise and control key financial resources, and finally, to strengthen the public health sector so as to improve health systems performance.[10] The goals are similar to those of the National Health Plan and the RDP of 1994. Will this new proposed reform succeed?

In the 2012 Reconciliation Barometer report submitted by the Institute of Justice and Reconciliation (IJR), a population of South African youth was polled on what they felt was the biggest dividing factor in South Africa at the time: 25,4 per cent of the polled population felt that economic and income inequalities were the most divisive factors.[11] In 1998, the mean annual household income was R17 900 for black South Africans and R59 800 for white South Africans.[12] The ratio of mean annual household income of white people to that of black people for 1998 was about 3,3:1. According to the IJR report published in 2012 (the most recent data), the mean annual household income for blacks and whites was R69 632 and R387 011, respectively.[13] The current ratio is thus about 5.5:1 for mean annual household income. Comparison of these two ratios, one based on data immediately following apartheid and one almost 20 years after apartheid, indicates that the gap between white South Africans and black South Africans is still widening. The trends established during apartheid continue to permeate the South African socio-economic climate, which does not bode well for health care reform.

Application to the US?

The US and South Africa exist in two very different socio-historical stages. The US has long since been considered a fully developed nation, while post-apartheid South Africa has only existed for two decades. Despite these differing situations, a closer look reveals that similar socio-economic disparities are present in both countries. Analysis of the current socio-economic climate in South Africa reveals that the country has not yet remedied the income inequalities that have emerged along racial lines. Therefore, the NHI proposed by the ANC will meet a fate similar to that of the National Health Plan and the RDP of 1994. Because the US is a more developed country as a whole, the PPACA has greater potential for success. Though there are socio-economic disparities in the US, the divergence of groups is not nearly as racially driven nor as drastic as it is in South Africa. The aforementioned quadruple burden does not apply to the US as it does to South Africa. This burden is unique to South Africa and poses a particular barrier to the supply and demand of care, one that is not present in the US.

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The trends established during apartheid continue to permeate the South African socio-economic climate, which does not bode well for health care reform in the form of the NHI

Evaluation and recommendation

The failures in the health care reforms of the National Health Plan and the RDP of 1994 can be attributed to the fact that, despite the abolishment of apartheid, the socio-economic climate was still one of immense inequalities that were highly racially driven. More recent statistics suggest that this climate has not improved. The success of the NHI proposed by the ANC in 2012 will be hindered by these socio-economic disparities, just as reform was ineffective in 1994. The ANC must first focus on curing the underlying condition, meaning social and economic inequality, before it can move forward with treating the symptoms, like health care reform.

Specific recommendations may include using funds from new taxes placed on individuals of higher income and investing in education and job creation so that those in dire economic situations may improve their economic status. Measures to reduce the racial stigmas that fuel these inequalities must be taken, in the form of reconciliation activities and community-based peacemaking.

Notes and references

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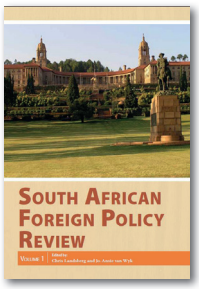
13 See Institute for Justice and Reconciliation, 2012. *South Africa Reconciliation Barometer 2012*. Meet our respondents, p.16.



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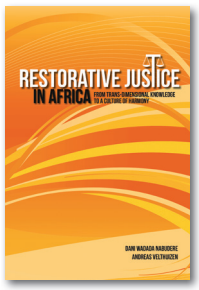

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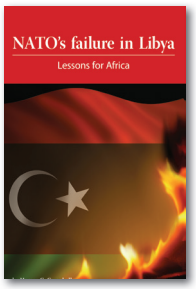

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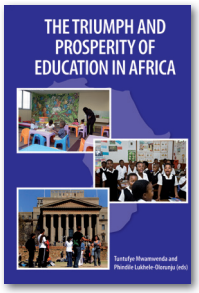

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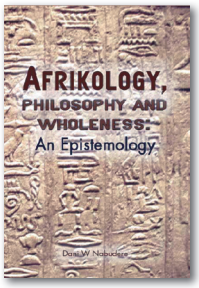

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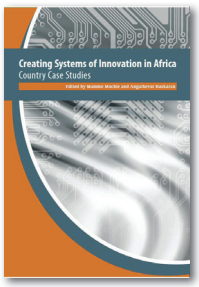

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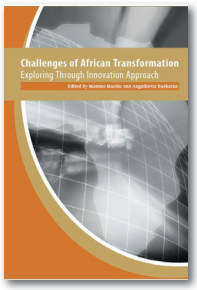

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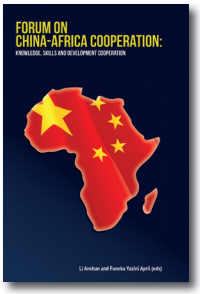

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