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OPINION

Value can be added to the health care system

A B van As, M Blecher

'Health is infinite in its needs but limited in its resources.'

Recently there has been an increasing global trend towards assessing governmental institutions, universities and hospitals from a business perspective.^{1,2} Added value, which in the business sector is measured mainly in monetary terms, is usually assessed indirectly in governmental institutions.^{3,4} South Africa's changing health system has unquestionably achieved important successes.^{5,6} However, we wish to argue that in the process of prioritising, insufficient attention has been directed to value for money, effectiveness and efficiency. This has been compounded by weaknesses in implementation and planning, lack of creativity in designing incentive frameworks, and shortfalls in management and information systems.

The South African health care situation

Provincial budgeted expenditure for public sector health care in South Africa amounted to R33.2 billion in 2002/03 (source: National Treasury, Intergovernmental Fiscal Review, 2003),

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R911 (\$100) per capita per year, and around 3% of gross domestic product (GDP). In contrast, contributions to private medical schemes amounted to R37 billion in 2001 (R5 270 (\$585) per capita and 3.7% of GDP).⁷ Approximately 16% of the South African population has private medical aid and this group has access to health care systems comparable with the world's best.

Nevertheless, South African indicators of health and wellbeing are poor for a middle-income country.⁸ This is usually attributed mainly to extreme inequity. South Africa's Gini co-efficient, a commonly used international indicator, is one of the highest globally, and this has led to substantial emphasis on redress. Child mortality for the various provinces is likely, at least in part, to reflect the unequal distribution of health services (Fig. 1).

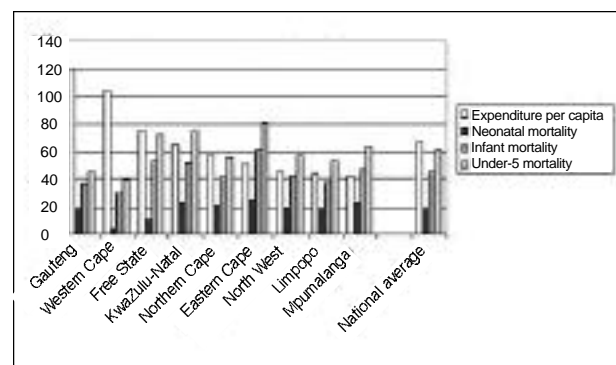


Fig. 1. Child mortality rates (neonatal, infant and under-5, /1 000) and public expenditure on health services (rands per capita per year) in South African provinces in 1998.



The consistency of underlying theory pertaining to equity, basic needs, allocative efficiency and primary health care (PHC) has provided a theoretical and philosophical framework for health system restructuring and reallocation of resources. Notions of human rights and social justice have also been key in inspiring health policy to provide equitable basic health services for all. Utilitarianism is generally understood as the justification of an action that is right when it produces the greatest benefits at the lowest cost to society as a whole.^{9,10} Here alternatives for certain actions may be identified and the costs and benefits of each assessed. The alternative that produces the greatest good for the greatest number of stakeholders has to be chosen. This ethical paradigm is consistent with standard health economic techniques of cost-effectiveness analysis, cost-benefit analysis and cost-utility analysis.³

The policy of the new South African government has included shifting resources from tertiary institutions to promote primary and secondary health care, particularly in rural areas. Expenditure on the Academic Health Services programme (an indicator of tertiary health care) will decrease from 23% of consolidated provincial health expenditure in 1997/98 to 16.6% in 2004/05. Introduction of an equitable share formula between provinces and recent reconfiguration of conditional grants were intended to lead to a progressively more equitable distribution of resources between provinces.¹²

Deficits in the present health care system

Fundamental reform of the South African health care system has been absolutely essential. Why then is our health care system — which has achieved real successes — still beset with problems? As is so often the case, part of the difficulty lies in the long chain between theory and implementation. A number of key issues include:

1. Health information systems are still so substandard that meaningful evaluation remains difficult. For example, the country is still unable to produce reliable multiyear trends in key outputs such as hospital admissions. Information systems are insufficiently used to link performance to resource allocation as part of control processes.

2. While funds have been shifted to (PHC)¹¹ and over 500 new primary level facilities have been constructed,¹³ there are still major shortcomings in PHC services.⁶ These services are largely nurse-driven and effectiveness is suboptimal, with skills shortages, poor supply chains and inadequate support for nurse-based services. Whereas PHC services have been made free to the user, there has been too little systematic planning of resources required for implementation.

3. Quality of care in many public hospitals is widely considered to be suboptimal, with the large majority of higher

paid public sector employees themselves using private health services, and private sources of financing having been reduced.⁷ Very few public hospitals have been externally accredited — only 10 public sector hospitals have been formally fully accredited by the Council of Health Accreditation of Southern Africa (COHSASA), although it is encouraging that 60 public hospitals have entered into the process.

4. While progress has been made in redistributing finance across provinces, service restructuring has been insufficiently sophisticated to accommodate this. Redistribution or accumulation of professional skills is a far more difficult process. There are 38.5/100 000 medical specialists in the Western Cape compared with 0.9/100 000 in Mpumalanga. When redistribution of funds precedes improved distribution of human resources, potential for mismatches arises in both the receiving and the downsizing provinces. For example, the Eastern Cape Health Department underspent by R329 million Rand in 2001/02,¹⁴ while the Western Cape downsized by over 9 000 health workers and is experiencing significant imbalances in factor inputs.¹⁵ Neither province is functioning optimally.

5. Tertiary hospitals have in certain cases been downsized rapidly and have imbalances in staff mix and between staff and other factor inputs. These are likely to have increased unit costs, creating significant inefficiencies.

6. Effectiveness and efficiency are barely measured. There are few benchmarks or norms.

7. Incentive systems for performance are poorly developed in the public sector.

We believe that a key aspect underlying these problems is an inadequate conceptualisation of what constitutes value for money or what the current Minister of Finance calls 'quality of spend' as well as inadequate incentives to reward facilities and individuals who perform.

The Viable System Model as conceptual tool

Reports indicate that about 70% of all attempts using downsizing, re-engineering and other strategies to improve the efficiency of private business fail, leaving behind a demoralised work force.¹ There are many reasons for this, but one of the main factors is that the people involved do not see the (direct) benefits of the changes and become disillusioned. In 1985 Stafford Beer¹⁶ developed a viable system model with the specific aim to understand organisations, to redesign them and to support the management of change.¹⁷ A model for the South African health care system is provided in Fig. 2. The essence of the model is that all systems are far more complex than often assumed. Therefore, taking funding away from (well-working) functional health care units can have unexpected detrimental effects on other health care units within the health care system and thereby counteract the original idea of saving. This model

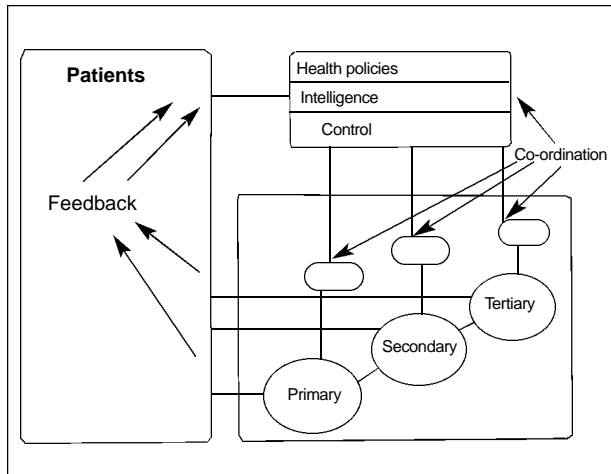


Fig. 2. A value-adding model of the South African health care system. Key areas where value can be added are direct feedback from the provided health care to the upper echelons, and improved co-ordination between the various components of health care institutions.

stresses the importance of close co-ordination between the several levels of health care provided as well as co-ordination between these levels and the control systems over them. Finally, it stresses the importance of client feedback to the intelligence level within government. This level decides on priorities and therefore where funds are most needed. Only when feedback from patients is incorporated in the health care management is there a good chance of fulfilling the variety of needs. Information regarding outputs, quality and where possible outcomes as well as patient satisfaction should be used to influence funding of the various centres as well as influencing the health policies.

Recommendations

- Existing hospital and clinics should be assessed on a range of value-for-money criteria, including performance against efficiency benchmarks and quality standards. Facilities that are performing well should be strengthened. Data on the above should be widely available for scrutiny.
- Changes from the status quo should be incremental, well-controlled and monitored carefully,
- The ability to attract and satisfy patients along with

performance in a range of areas should in some way be linked to funding as opposed to simplistic application of demographic and equity measures. Perhaps a method should be developed in which the hard-working and effective clinics and hospitals are rewarded with extra funding, while those that do not deliver have their funding progressively cut.

- If we take South Africa as a true democracy, users should have a say as to which clinics and hospitals the government should support. Policies drawn up and designed in bureaucratic ivory towers will not be able to contribute positively as long as they are not closely embedded in knowledge of what takes place at grass-roots level.

Conclusions

Although there is a strong tendency to equate poor health care with a lack of funding, there are options to improve the South African health care system by improving the use of feedback, strengthening incentives for performance, and linking funding more explicitly to efficiency and quality. Invigorating management and co-ordination at various levels is critical. We can be far more effective with the R32.9 billion we are spending annually.

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