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# CHAPTER 14: BURDEN OF DISEASES, HEALTH FINANCING AND FISCAL IMPACTS

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## 14.1 Introduction and Background

The South African public sector health care system is faced with profound challenges, mainly because of a double burden of infectious and chronic[179] diseases. In responding to health sector challenges, the National Department of Health (DoH) in line with the 2009–2014 Medium-Term Strategic Framework (MTEF), released a Health 10 Point Plan for the same period. The Plan's main aim is to pursue a unified health sector, and its fundamental goal is to have equity in the delivery of health services. The priorities of the 10 Point Plan are intended to assist the country to meet the Millennium Development Goals (MDGs) and monitor improvements in the health system (see Table 14.1).

**Table 14.1 Health 10 Point Plan**

| | |
|---|---|
| 1. Provision of strategic leadership and creation of a social compact for better health outcomes | 6. Improved human resources planning, development and management |
| 2. Implementation of a national health insurance for South Africa | 7. Accelerated implementation of the HIV/AIDS and sexually transmitted infections<br>National Strategic Plan and the increased focus on tuberculosis (TB) and other communicable diseases |
| 3. Improving the quality of health | 8. Mass mobilisation for the better health of the population |
| 4. Overhaul the health-care system and improve its management | 9. Review of drug policy |
| 5. Revitalisation of physical infrastructure | 10. Strengthening research and development |

*Source: Department of Health*

Substantial increases in mortality and morbidity threaten to overwhelm the health system and undermine attainment of the MDGs. Communicable and non-communicable diseases, injury and trauma continue to prevent faster development. HIV/AIDS, tuberculosis (TB) and malaria pose the greatest challenges. However, health analysts caution that these diseases should not overshadow the severe burden of communicable diseases including pneumonia, diarrhoea and measles in children, and other diseases that severely debilitate communities (McIntyre and Thiede, 2007). Despite good plans and strategies, this ever-increasing disease burden is cause for concern for policy-makers. Despite existing policy and legislation, an assessment of the South African health care system by various analysts brings great concern about the levels of access to health care services and the quality of care provided in the public health care system (Okorafor *et al*., 2005).

Disease-driven health care financing and expenditure is a further challenge. Although government health expenditure grew by an average annual rate of 17.6% between 2006/07 and 2009/10, from R11.3 billion to R18.4 billion, and is projected to amount to R25.8 billion in 2012/13, the public sector health care system remains under severe pressure. This chapter reviews health policy developments in South Africa and provides an overview of health care financing and expenditure, mainly in the public sector health care system. It is proposed that health systems be strengthened through improved policy, resources, and management. The goal of the Health 10 Point Plan is to significantly improve accessibility, the depth and breadth of health care services packages, and the quality of care provided.The burden of disease is putting pressure on provincial health budgets and raises concerns around the financial instability and capacity of provinces to cope. Therefore, this chapter focuses on the successes and challenges of health financing and provisioning from the equity, efficiency and quality dimensions of health services by:

178 Financial and Fiscal Commission.

179 Chronic diseases are often referred to as 'non-communicable diseases' to distinguish them from communicable diseases and as 'diseases of lifestyle' to distinguish them from diseases with environmental causes (Gilson *et al*., 2007).

- Presenting an analysis of the allocation of health care resources in South Africa.
- Analysing the health resources allocation formula (in terms of equity and outcome) in order to address the health care spending inequities between provinces.
- Examining the elements of an equitable and fully functional health system necessary for a country to deliver basic health care to its people.



## 14.2 Literature Review

Literature on health equity issues in South Africa draws substantially on the work done by researchers and analysts from the University of Cape Town: Health Economics Unit (HEU), the University of the Witwatersrand Centre for Health Policy (CHP), and the Health Systems Trust (HST). The economic statistics and budget trends have been drawn from the National Treasury Budget and Expenditure Reviews, and the health statistics from the DoH, Statistics South Africa (StatsSA) and the World Health Organisation (WHO). International literature on equitable health financing was also reviewed.

The financing of health care is of major concern throughout the world. This includes taxation, social health insurance, private health insurance and out-of-pocket payments (Schoen *et al*., 2000). Financing arrangements are likely to have a substantial impact on equity in terms of access, financing and provisioning. Although equitable financing is a key objective of health care systems, apart from a select few technocrats and policy-makers, there has been little debate on tensions between the principles of equitable financing of health and equal opportunity of access, or to the fact that, in practice, these principles are difficult to reconcile.

Braveman and Gruskin (2003) argue that equity in health is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage, i.e. wealth, power, or prestige. Schoen *et al*. (2000) also note that concern about equity was a motivating force behind the creation of universal, equal health coverage for all in Australia, Canada, Great Britain, New Zealand and the United States. The intention is to provide treatment to every citizen without exception, without remuneration limit and without economic barrier. Equity is an ethical principle; it is also consonant with and closely related to human rights principles (Braveman and Gruskin, 2003). Assessing health equity requires comparing health and its social determinants between more and less advantaged social groups.

Reliance on the private health market, based on private insurance and patient out-of-pocket costs, incurs social costs and raises access barriers for those with the greatest health care needs, while reform policies divide communities (Chetty, 2007; McIntyre and Thiede, 2007; Harrison, 2009;). As lower and higher income groups have different access experiences, they are likely to view their nation's health system differently (Schoen *et al*., 2000). Inequities in health puts already socially disadvantaged groups at further disadvantage.

Health is essential to well-being and to overcoming other effects of social disadvantage. Poor people are more sickly and die more quickly "from the premature cradle to the early grave" (Everette, 2008:1). The poor have the highest rates of death due to diabetes, heart disease and breast, lung, and colon cancer (Oliver, 2003). While equity on its own will not eliminate health problems, it is the most important step toward eliminating health care disparities and should support the right to the highest attainable standard of health as indicated by the health status of the most socially advantaged groups.

Distribution of limited health care resources is another topical issue. Asthana and Gibson (2008) argue that in order to promote an "equal opportunity to be healthy", funding needs to be targeted to reduce the health gap between the most advantaged and least advantaged groups. This implies that resources should not necessarily be directed at populations with the highest absolute burden of ill-health, but at those with the worst health based on age-standardised measures. "The point is that a population with a high absolute burden of need (perhaps because it comprises a large proportion of older people) may well, in age-standardised terms, be relatively healthy. Thus depending on whether crude or standardised measures are used, the distribution of 'need' is very different." *(ibid.)*.

Literature on equitable financing of health care systems is important to consider when trying to resolve the tension of distributing limited resources for health care in South Africa.

## 14.3 Performance of the Public Health Care System

South Africa has a dual health care system of public and private health services. The government provides health care services to the nation through public hospitals and health clinics throughout the country. Services range from in- and out-patient care to preventive care and promotion of health. Schedule 4 (A and B) of the Constitution lists health services and municipal health services (MHS) as functional areas of concurrent national and provincial legislative competence. The National Health Act (No. 61 of 2003) gives provinces bulk responsibility for primary health care and defines MHS narrowly to encompass environmental health services only. According to the Municipal Structures Act (No. 117 of 1998), MHS are a function of metro and district municipalities. However, this is historically a local municipality function, with minimal services outside the cities and main towns.

Fiscal transfers are core funding instruments of the South African public sector health system, with the exception of local government which funds this function from its own revenue sources. Fiscal transfers can be either conditional or unconditional and are allocated through the annual Division of Revenue (DOR), within the context of the three-year MTEF (National Treasury, 2009).

They fund expenditure assignments given to provinces and municipalities through the Constitution and take into consideration the capacity of sub-national governments to raise revenue. Health services are funded mainly through the provincial equitable share (PES) formula. However, other national health priorities are funded through conditional grants (e.g. health revitalisation programme, comprehensive HIV/AIDS programme, forensic pathology services, health professions training and development programme, and national tertiary services).

Prior to the 2011 MTEF, the health component of the PES was weighted at 26%, and favoured people without medical aid. In the 2010/11 DOR, the Financial and Fiscal Commission (the Commission) made recommendations for a review of the PES, noting challenges in the funding of education and health by provinces. The 2011 DOR Bill reflects the government's intention to implement substantial changes to the PES. Data in Table 14.2 shows that the weights to the education component are reduced downwards (from 51% to 48%) and increased upwards to health (from 26% to 27%). The basic component was revised upwards (from 14% to 16%). The rest of the seven components in the formula are unchanged.

**Table 14.2 The revised provincial equitable share formula for the 2011 MTEF**

| Equitable share component | Data used | Source |
|---|---|---|
| Education (48%) | Total enrolment numbers<br>School-age cohort (6 - 17 years) | National Department of Education: enrolment figure<br>Census 2001 |
| Health (27%) | Risk adjusted capitation (75%)<br>Hospital output (25%) | Risk Equalisation Fund<br>District Health Information System |
| Basic Share (16%) | Population per province | StatsSA: Mid Year Estimates |
| Institutional (5%) | Independent of data | |
| Poverty (3%) | Income<br>Basic component | IES Survey<br>StatsSA |
| Economic activity (1%) | Gross geographic product | StatsSA: GDP-R<br>: Mid Year |

*Source: National Treasury, 2011*

A step in the right direction is the consideration of utilisation rates and hospital case-mix. However, the data is not always reliable, and data regarding the uptake in health treatment in the public health care system is barely collected. A key question is whether the revised provincial equitable share formula will lead to equity, achieve quality and move to a better provincial health expenditure control and less waste.

Various health and budget analysts in South Africa, including the Commission, criticise the fact that most provincial hospital budgets (and staff establishments) are based on historical allocations and adjusted for inflation. This practice perpetuates previous policies, depriving former homelands and poor rural areas of necessary health services (Chetty, 2007). The majority of provinces overspend on personnel costs, mainly because they implement the occupational specific dispensation (OSD), although vacancy rates remain high in public hospitals (National Treasury, 2010a). Budget, drug and staff shortages are becoming the norm in provincial hospitals. The system of transfers, from national to provincial and from provincial to actual health centres, is not functioning efficiently. Fiscal and health decentralisation needs to

be accompanied by the provision of adequate financial, human and physical resources. Since 1994, one of the greatest challenges facing the government is addressing inequities in the public sector health financing system. The DoH is only responsible for national policy making and determining norms and standards, and much of the operational and financial decision-making in health care delivery is decentralised to provincial level, (Okorafor *et al*., 2005).

Depending on provincial priorities and pressures, Provincial Executive Councils and Legislatures determine how much money goes to each function. The allocation also depends on the capacity of each provincial department to motivate for funding. In essence, fiscal decentralisation or the intergovernmental relations system in South Africa limits the role of national government (i.e. DoH) in determining actual health resource allocations across provinces, except for conditional grants.

## 14.4 Budget and Economic Analysis of Health Resource Allocations

On average, about 56% of total health financial flows (from 2005/06 to 2010/11) continues to be channelled to the private sector, 41% to the public sector, while non-governmental organisations (NGOs) contribute 2%. A detailed analysis of the private sector health expenditure is made later in this section.

**Table 14.3 Consolidated funding flows in the South African health sector**

| R million | 2005/06 | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Avg. annual nominal growth 2005/06 - 2011/12 |
|---|---|---|---|---|---|---|---|---|
| Public sector | | | | | | | | |
| National Department of Health (core) | 1,030 | 1,132 | 1,210 | 1,460 | 1,480 | 1,601 | 1,691 | 8.6% |
| Provincial Departments of Health | 47,071 | 53,649 | 62,582 | 75,030 | 82,359 | 91,999 | 99,140 | 13.2% |
| Defence | 1,557 | 1,705 | 1,878 | 2,128 | 2,441 | 2,606 | 2,792 | 10.2% |
| Correctional services | 211 | 234 | 261 | 282 | 300 | 318 | 339 | 8.2% |
| Local government (own revenue) | 1,317 | 1478 | 1,316 | 1,342 | 1,369 | 1,396 | 1,480 | 2.0% |
| Workmen's Compensation Fund | 1,310 | 1,415 | 1,287 | 1,415 | 1,529 | 1,651 | 1,718 | 4.6% |
| Road Accident Fund | 356 | 488 | 764 | 797 | 740 | 860 | 980 | 18.4% |
| Education | 1,565 | 1,721 | 1,833 | 2,134 | 2,350 | 2,503 | 2,653 | 9.2% |
| **Subtotal** | **54,417** | **61,822** | **71,131** | **84,588** | **92,568** | **102,934** | **110,793** | **12.6%** |
| Private sector | | | | | | | | |
| Medical schemes | 54,905 | 58,349 | 65,468 | 74,089 | 80,320 | 86,841 | 9,3441 | 9.3% |
| Out of pocket | 23,470 | 26,596 | 31,997 | 35,468 | 37,386 | 39,300 | 41,108 | 9.8% |
| Medical insurance | 1,956 | 2,056 | 2,179 | 2,452 | 2,660 | 2,870 | 3,089 | 7.9% |
| Private employer | 935 | 982 | 1,041 | 1,172 | 1,271 | 1,372 | 1,476 | 7.9% |
| Subtotal | 81,266 | 87,983 | 100,685 | 113,181 | 121,637 | 130,383 | 139,114 | 9.4% |
| Donors or NGO's | 1,944 | 2,503 | 3,835 | 5,212 | 6,910 | 6,319 | 5,787 | 19.9% |
| **Total** | **13,7627** | **152,308** | **175,651** | **202,981** | **221,115** | **239,636** | **255,694** | **10.9%** |
| Percentage shares | | | | | | | | |
| Public sector | 40% | 41% | 40% | 42% | 42% | 43% | 43% | |
| Private sector | 59% | 58% | 57% | 56% | 55% | 54% | 54% | |
| Donors or NGOs | 1% | 2% | 2% | 3% | 3% | 3% | 2% | |

*Source: Provincial Budgets & Expenditure Review: 2005/06 - 2011/12*

The health sector's share of total government expenditure has been increasing since 2004/05 but from a lower base than the allocation for education, social security and built environment (Figure 14.1).

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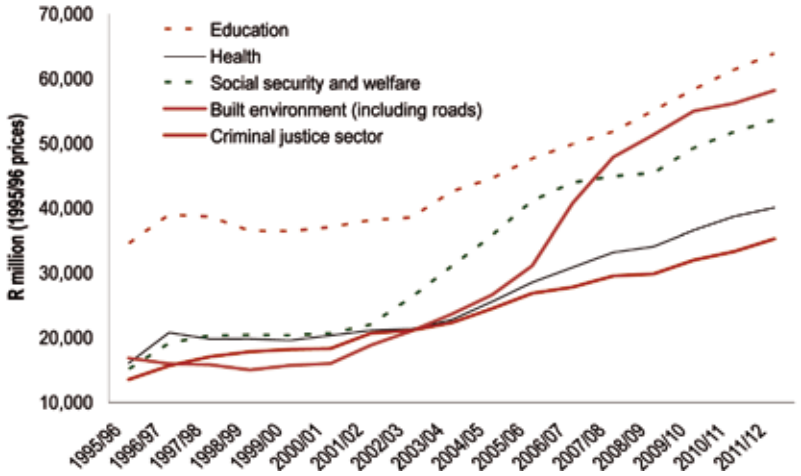
**Figure 14.1 Government spending trends on policy priorities, 1995/96–2011/12**




*Source: National Treasury (2000; 2010b)*

The major areas of growth for health budget allocations are in HIV/AIDS, where increasing patient uptake has resulted in greater anti-retroviral treatment costs. Other health cost drivers are hospitals and the health facilities management revitalisation programme, and the provision of OSD for health professionals (National Treasury, 2010b). Within the public health sector system, 88% of government health expenditure is allocated to provinces. On average, provinces spend 40% of their budgets on health services (National Treasury, 2009). Over one-third of provincial health expenditure is at district level i.e. primary care and district hospitals, followed by provincial hospitals at almost a fifth of total expenditure and finally by tertiary and central hospitals (McIntyre and Thiede, 2007; National Treasury, 2009).

Despite real increases averaging around R4 billion annually, correspondingly large improvements in health outputs, outcomes or quality are not in evidence. In South Africa, total health care expenditure (including private health expenditure) was slightly more than R115 billion in 2007 but less than half for public health care. This level of health expenditure was equivalent to 8.6% of gross domestic product. Table 14.4 compares health care expenditure in South Africa and other countries. This expenditure is at similar levels to that of Australia (8.9%), United Kingdom (8.4%), Brazil (8.4%), and above that of China (4.3%), India (4.1%) and Russia (5.4%). However, Russia spends more per capita than South Africa.

**Table 14.4 Comparison of health care expenditure and health status indicators in developed and developing countries**

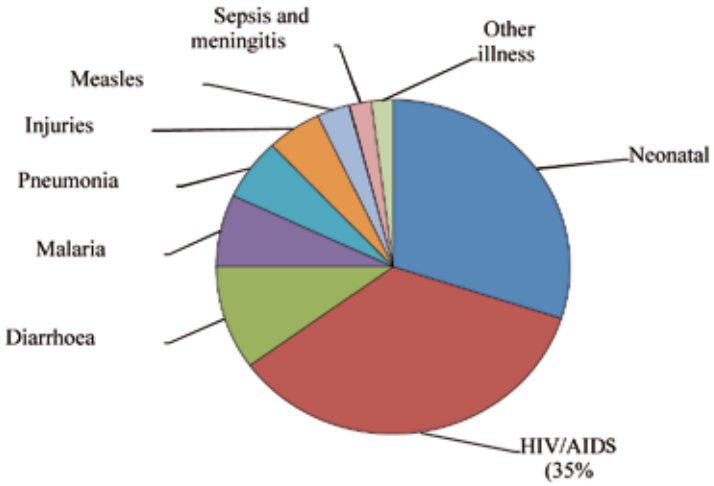
| Country | Health care expenditure as % GDP, 2007 | Per capita govt expenditure on health (PPP int $) | Life expectancy at birth, 2008 | Infant mortality rate per 1000 live births, 2008 (MDG 4) |
|---|---|---|---|---|
| South Africa | 8.6 | 340 | 53 | 48 |
| High income countries | | | | |
| Australia | 8.9 | 2,266 | 74 | 4 |
| Canada | 10.1 | 2,730 | 73 | 5 |
| United Kingdom | 8.4 | 2,446 | 72 | 5 |
| USA | 15.7 | 3,317 | 70 | 7 |
| BRIC member states | | | | |
| Brazil | 8.4 | 348 | 64 | 18 |
| China | 4.3 | 104 | 66 | 18 |
| India | 4.1 | 29 | 56 | 52 |
| Russia | 5.4 | 512 | 60 | 9 |
| Middle income countries | | | | |
| Chile | 6.2 | 507 | 70 | 7 |
| Cuba | 10.4 | 875 | 69 | 5 |
| Egypt | 6.3 | 118 | 60 | 20 |
| Malaysia | 4.4 | 268 | 64 | 6 |
| Thailand | 3.7 | 209 | 62 | 13 |
| **Average** | **7.49** | **1005** | **65** | **16** |

*Source: World Health Organisation estimates for country Health Account, 2010*

Table 14.4 also shows South Africa's challenges of declining life expectancy and high infant mortality rates. This is against the backdrop of globally improved health: people's health has improved more in recent decades than in the whole span of human history. However, life expectancy in South Africa is 53 years (52 for males and 55 for females), the lowest in Table 4.1 Many health analysts and official health reports cite HIV/AIDS as the main reason for South Africans dying younger and in greater numbers.

The causes of infant mortality are listed in Figure 14.2. The under-five infant mortality rate per 1,000 lives (i.e. the probability of dying by age 1 per 1,000 live births) is 48 per 1,000 live births in South Africa compared to India's rate of 52 per 1,000 live births. Children aged less than 12 months are at greater risk of dying than older children (Norman *et al*., 2006).

**Figure 14.2 Causes of infant mortality in South Africa, 2000–2005**




*Source: Norman et al., 2006*

Deaths in the neonatal period contribute substantially to under-five deaths, with the majority of these deaths being attributed to pre-term birth, birth asphyxia and infections. Outside the neonatal period, HIV/AIDS and childhood infections (most commonly diarrhoea and lower respiratory infections) are the major causes of death, responsible for the majority of childhood illness in South Africa (Sanders *et al*., 2010).

In trying to understand variations in health expenditures and South Africa's relatively poor health outcomes, Woolard (2002) notes that the poor have particular difficulties in accessing health care because of economic reasons and social standing, and finds strong links between poverty, morbidity and mortality. A study of poverty and chronic diseases in South Africa also reveals complex patterns of mortality, morbidity, risk factors and unhealthy lifestyles among the poor, with the poor areas suffering premature mortality due to chronic disease including HIV/AIDS, stroke, asthma, epilepsy and cervical cancer (Bradshaw and Steyn, 2001). Most health analysts agree that poor maternal and child health, infectious diseases and malnutrition are associated with poverty. Many poor families end up using all their resources, indebting themselves and mortgaging assets to fund health care in catastrophic situations (Bradshaw and Steyn, 2001; MRC, 2008).

This state of affairs is also blamed on inequities in the country's health care system. Resources are allocated inequitably between the private and public sectors as well as within the public sector itself (among provinces and different levels of health care). Since the 1980s, expenditure in the private sector health care system has continued to increase annually, at rates far exceeding the inflation rate. Increases are associated with a concomitant increase in contribution rates or premiums charged by medical schemes. As a result, membership of medical schemes has become increasingly unaffordable for most South Africans. In 2009 a relatively small proportion (16.9%) had medical aid coverage (StatsSA, 2010). Gilson *et al*. (2007) estimate that 21% of the population not covered by health insurance prefer to use private primary care doctors and pharmacies on an out-of-pocket basis. Some of the most important current policy debates on health finance reform in South Africa pertain to the introduction of mandatory national health insurance (NHI), user fee reforms and reforms to the intergovernmental system to better align policy and budgets.

The majority of the population depends on the public sector for conventional health care services. Government alone cannot afford and assure the health of the entire population. With eight physicians, 41 nurses, one dentist and three pharmacists per 10,000 people, South Africa does not perform badly compared to other middle-income countries in terms of medical personnel; only Egypt bypasses South Africa. South Africa has more physicians than Australia, Chile,

Malaysia and Thailand, more nurses than the latter three countries and the United Kingdom, but less dentistry personnel than most countries listed in Table 14.5.

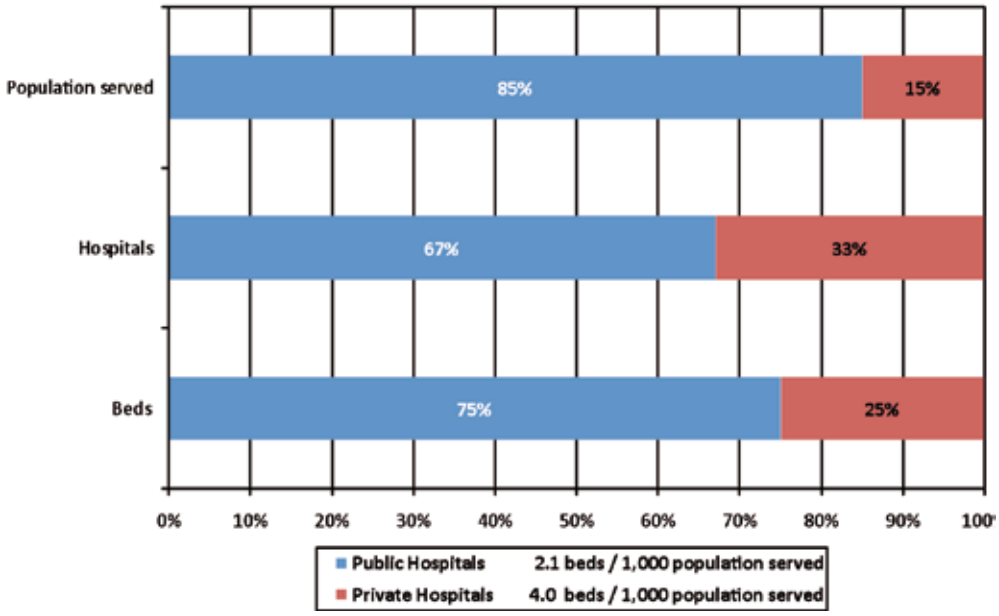
**Table 14.5 Medical personnel and hospital facilities utilisation rates in developed and developing countries**

| | Physicians | | Nursing and midwifery personnel | | Dentistry personnel | | Pharmaceutical personnel | | Hospital beds |
|---|---|---|---|---|---|---|---|---|---|
| Countries | Number | Density (per 10 000 population) | Number | Density (per 10 000 population) | Number | Density (per 10 000 population) | Number | Density (per 10 000 population) | (per 10 000 population) |
| South Africa | 34,829 | 8 | 184,459 | 41 | 5,995 | 1 | 12,521 | 3 | 28 |
| High income countries | | | | | | | | | |
| Australia | 19,612 | 10 | 222,133 | 109 | 29,624 | 15 | 15,339 | 8 | 39 |
| Canada | 62,307 | 19 | 327,224 | 100 | 38,310 | 12 | 27,078 | 8 | 34 |
| United Kingdom | 126,126 | 21 | 37,200 | 6 | 25,914 | 4 | ... | ... | 39 |
| USA | 793,648 | 27 | 2,927,000 | 98 | 463,663 | 16 | 249,642 | 9 | 31 |
| BRIC member states | | | | | | | | | |
| Brazil | 320,013 | 17 | 549,423 | 29 | 217,217 | 12 | 104,098 | 6 | 24 |
| China | 1,862,630 | 14 | 1,259,240 | 10 | 136,520 | 1 | 351,620 | 3 | 30 |
| India | 643,520 | 6 | 1,372,059 | 13 | 55,344 | 1 | 592,577 | 6 | 9 |
| Russia | 614,183 | 43 | 1,214,292 | 85 | 45,628 | 3 | 11,521 | 1 | 97 |
| Middle income countries | | | | | | | | | |
| Chile | 17,250 | 11 | 10,000 | 6 | 6,750 | 4 | ... | ... | 23 |
| Cuba | 72,416 | 64 | 97,800 | 86 | 20,158 | 18 | 7,047 | 6 | 60 |
| Egypt | 179,900 | 24 | 248,010 | 34 | 25,170 | 3 | 92,540 | 12 | 21 |
| Malaysia | 17,020 | 7 | 43,380 | 18 | 2,160 | 1 | 2,880 | 1 | 18 |
| Thailand | 18,987 | 3 | 84,683 | 14 | 4,471 | 1 | 7,350 | 1 | 22 |
| **Average** | **341,603** | **20** | **612,636** | **46** | **76,923** | **7** | **122,851** | **5** | **34** |

*Source: World Health Organisation estimates for country Health Accounts, 2010*

Health inequities in South Africa are exacerbated by the fact that the private health care system caters for seven million people while the public sector caters for 30.2 million people. The public sector is under pressure and cannot cope with the rising demand, as the premature exhaustion of benefits results in private insurance holders either foregoing private health care or using the public health sector system (Sishana, 2007). Figure 14.3 shows the mean bed/population ratio is 2.1 per 1,000 people in public hospitals and 4 per 1,000 people in private hospitals.

**Figure 14.3 Ratios for health services in South Africa**




*Source: McIntyre and Thiede, 2007*

With the over-resourcing of private health insurance and under-resourcing of the public sector, health care practitioners have been attracted to the more lucrative private health system (McIntyre and Thiede, 2007). The migration of doctors and other health professionals from the public to the private sector produces gross inequities in health care provisioning and explains low-density levels of health service provision in South Africa.

Placing health equity as the central goal of health systems requires substantial reforms of policy, institutional arrangements and funding. The adequacy of fiscal transfers is critical if problems of equitable access to the health care system are to be addressed (McIntyre, 2005). Increasing spending inequalities among sub-national governments translates into widening spatial inequalities in access to health care. There are health spending and service-level inequities between rural and urban areas, and people still have to travel long distances for health service delivery, especially for primary health care. Inadequate provincial budgeting for primary health care leads to a shortage of community health centres with access to full-time doctors, radiology, laboratory services, rehabilitation, and obstetric services. Fiscal transfers and adequate health budgets must cater for dynamism and should factor in and attend to such underlying changes that affect the provision of health services.

## 14.5 Observations and Recommendations

Equitable health reforms take years to implement and unfortunately the task of improving the health service is dogged by what Oliver (2003) calls the "two time-scales problem". One time-scale is that of the five-year parliamentary electoral cycle, expressed in the annual State of the Nation address by the President. The other time-scale is that required to remedy the current gross inequities in health care services (huge shortages of funding, personnel and modern facilities and equipment) and is not tied to the elective cycle; but health reforms can take more than 20 years.

South Africa has limited public sector health resources and faces an enormous burden of disease. Without structural reforms, the system will be inadequate to deal with the competing demands of public health care and more acute and urgent conditions such as trauma or infectious diseases (Sanders *et al*., 2010). Health analysts have urged the South African government to review the current public and private health delivery models and financing frameworks, with the object of increasing the per capita expenditure so that a greater proportion of the population has access to the essential package of health services. In order to achieve this, the following recommendations are made.

### 14.5.1 Reduce the incidence of high infant mortality rate

Over the past 15 years, the high infant mortality rate in South Africa has shown no signs of improvement, which is cause for concern. The under-five mortality rate is a key indicator of child health, and the MDG 4 commits countries to reduce the under-five mortality rate by two-thirds between 1990 and 2015. Government has a duty to improve the delivery of child health services and to address the underlying social determinants of health, which are the central pillars of the United Nations Convention on the Rights of the Child (Sanders *et al*., 2010). The General Household Survey (2009) found that children are slightly less likely to be covered by a medical aid programme than the population as a whole. Less than 14% of all children had access to medical aid in 2009, compared to about 17% for the total population. The medical fee exemption should be extended to needy children under the age of 18 in line with social security insurance.

### 14.5.2 Comprehensively review provincial health costing, budgeting and expenditure frameworks and practices

Even though the health component of the PES has been reformed, provincial health budgets are still not based on an estimation of the needs of health service users. Nor do the budgets adequately account for the magnitude of the HIV/AIDS epidemic and South Africa's other growing health challenges. To deal with health inequities and finance challenges, government has proposed the NHI, which will have an impact on the role of provinces in delivering health services. However, with or without the NHI, provinces must still attend to the challenges of delivering health care services by provinces. These challenges centre on funding and also relate to managerial, systematic and process issues concerning resource provisioning (staffing, procurement, information systems and reporting). Institutional arrangements between provincial treasuries, provincial departments of health and service centres (hospitals and clinics) also need attention to improve hospital performance.

Public hospitals consume approximately half the total provincial allocation for health services, but there is very little evidence that these allocations have an impact. Hospital budgets are determined according to different methodologies

across provinces. However, budget allocations for public hospitals need to be set and overseen in a consistent manner. In the past the Commission recommended that minimum norms and standards be set to guide the delivery of hospital services with respect to staffing, facilities, equipment and other aspects that affect the provision of quality care. Norms and standards exist for primary health care (clinics and community services) but not for hospitals offering more specialised levels of care. It is therefore important to design norms and standards that will inform the equitable formulas for budget allocations to hospitals and clinics. The government must institutionalise oversight of the budgeting process of hospitals and clinics, while provincial government must be held accountable for the underfunding of hospitals and clinics. The organisational form of hospitals is also an important determinant of performance. The Commission has made a recommendation that devolving certain functions such as procurement, human resources and financial management may lead to greater efficiency and better performance in public hospitals. It is hoped that the establishment of the Office of Health Standards Compliance will assist with effective interventions that improve service coverage and ensure patient/client access is adequate and of good quality.

### 14.5.3 Reform fiscal frameworks for public sector health care system

Health budgets are disease driven, and so funding models must take into account the budget pressures resulting from the burden of diseases, including both communicable and non-communicable conditions. Funding HIV/AIDS treatment through conditional grants, in isolation from other infectious and opportunistic diseases, is not the best way to deal with the growing burden of diseases in South Africa. Funding other diseases through the equitable share (and HIV/AIDS through conditional grants) creates two parallel funding systems in the public health care system. The delayed funding of HIV/AIDS in South Africa has confirmed that failure to tackle epidemics results in considerable costs. Therefore, utilisation costs and district-level data need to be reviewed for chronic disease (HIV/AIDS and TB) services and maternal and child health. Such information should be integrated in the funding for health services.

The rapid rise in demand for chronic care for HIV/AIDS and TB, and non-communicable diseases, emphasises the need for a strong and modernised primary and community health care system. The public sector health care expenditure is dominated by tertiary-level hospitals, with 30% of the total public health expenditure being spent on super tertiary hospitals in Johannesburg, Pretoria, Cape Town and Durban. While tertiary hospitals play an important referral and educational role, the same effort needs to be directed towards primary health care facilities. Resource distribution between the different levels of care needs to be re-examined in order to strength primary health care, without weakening the role played by tertiary hospitals. A sound health system can dramatically curb the spread of the burden of the disease, but a health system that is not securely financed or well managed can cripple a nation's health care.

### 14.5.4 Resolve costly approaches to health personnel funding and management

Health personnel costs are the major cost drivers for the public health care system in South Africa. Provinces habitually overspend their health budgets and build up large debts, and yet there is a chronic shortage of medical staff in both hospitals and clinics. Provinces should not be allowed to overspend on personnel unabatedly while there are acute shortages of medical personnel. National and Provincial Treasuries should ensure proper financial management, which suggests an urgent need to implement and fund the 2004 National DoH Human Resources plan for staffing norms in hospitals and clinics. This will enable provincial health departments to schedule and shift tasks, introduce financial incentives, balance the skill sets of medical personnel and create conducive working conditions. There must also be controlled monitoring within a specific timeframe.

## 14.6 Conclusion

This chapter has reviewed the key health policy challenges for promoting equity in health services in South Africa. The allocation of health care resources in South Africa was compared to the allocation within other countries. Analysis shows that the South African health system is fraught with gross inequities in the provision of health services. Public sector health challenges are not only financial but also encompass institutional challenges, burden of diseases with growing demand for services, access to quality services and equitable provision of services. The Health 10 Point Plan is necessary but insufficient to deal with health challenges in South Africa. To realise the plan's objectives, the public health sector requires adequate resourcing of the public health sector through the fiscus and other funding mechanisms. The South African government needs to urgently review the current public and private health delivery models and financing frameworks with the aim of increasing the per capita expenditure so that a greater proportion of the population has access to the essential package of health services.

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