

HEALTH CARE

FINANCING

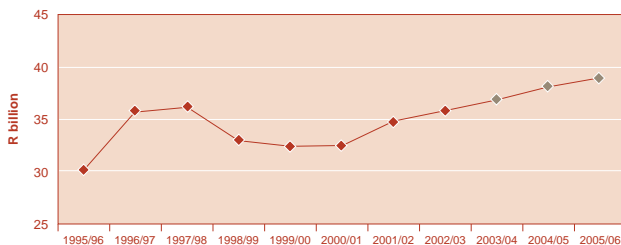


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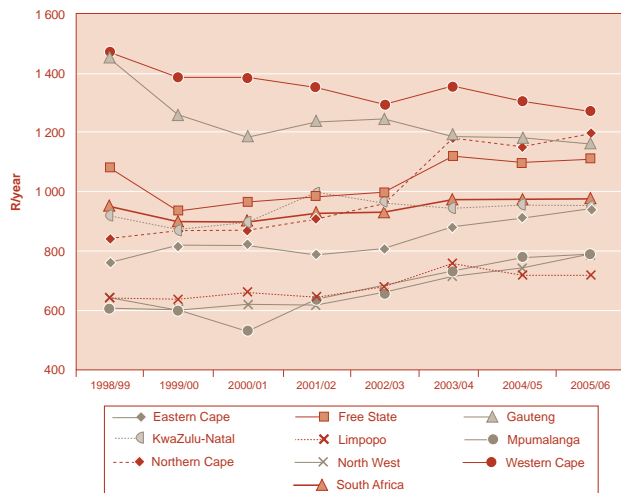
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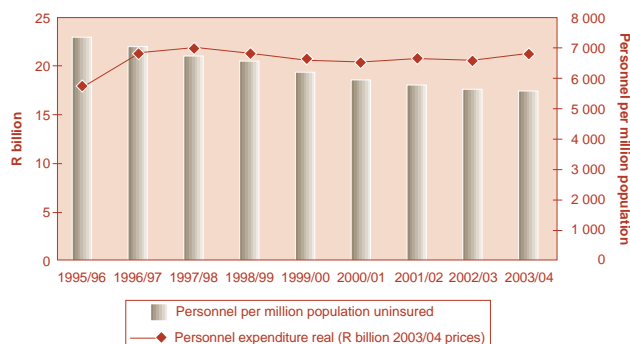
Total provincial health expenditure (real 2003 prices)



Per capita expenditure (R/year, real 2003 prices)



Expenditure on personnel vs personnel per population



Key Messages

- By 2005/06 there is projected to be an increase in real funding of R8.7 billion over a decade earlier.
- Nevertheless, real spending per person has struggled to match levels in the mid to late 1990s.
- The uninsured population grew by almost 7 million between 1995 and 2005.
- More recent data on the size and distribution of the public sector dependent population are urgently needed so that inter- and intra-provincial equity can be measured over time.
- Real growth of R3 billion in personnel expenditure has masked a decline of 19 000 filled posts.
- The HIV/AIDS epidemic is estimated to be costing around R6 billion per year and the sector has been incompletely compensated for this.

Framework for Monitoring and Evaluation

Global:

National Health Accounts

South Africa:

Health Goals, Objectives and Indicators 2001-2005

Key Indicators

Per capita health expenditure

Medical Aid coverage

Uninsured (Public sector dependent) population

Ratio of public to private sector per capita health expenditure

Key References

- National Treasury financial databases and publications
 - Intergovernmental Fiscal Reviews
- Statistics South Africa
- Medical Schemes Council Annual Reports

Introduction

Understanding health financing and expenditure trends over the past decade is complex. The health financing challenges facing the new government in 1994 were immense.¹ Ten years on, there are both positive and negative stories. Certainly far more funds in real terms have been directed to health care in the public sector. By 2005/06 there is projected to be an increase in real funding of R8.7 billion over a decade earlier. Furthermore, after the stagnation in health funding in the late 1990s, there has been a turn-around in real spending levels from 2000/01, leading to a projected real growth of R6 billion from 1998/99 to 2005/06 especially in the areas of capital and non-personnel expenditure. Nevertheless, real spending per person has struggled to match levels in the mid to late 1990s, as the uninsured population grew by almost 7 million between 1995 and 2005. Further, real growth of R3 billion in personnel expenditure has masked a decline of 19 000 filled posts, largely because of a 28% increase in average wages. Finally, the HIV/AIDS epidemic is estimated to be costing around R6 billion per year and the sector has been incompletely compensated for this.

The Review of 2002² presented a useful summary of the National Health Accounts project data, detailing the intricate flow of finances particularly for the period 1996-98. It described two eras of public health financing, a period of substantial growth from 1992/93 to 1997/98 and then a period associated with falling funding and a reversal in interprovincial redistribution trends in 1998/99.

The analyses presented here confirm and build on this earlier work. The data utilised are the most recently available. They build on the most recent sectoral analyses of the National Treasury and Department of Health^{3,4} and cover in detail an eight year period from 1998/99 (the last year covered by the National Health Accounts project) to 2005/06 (figures contained in the Medium Term Expenditure Framework (MTEF) budget). In some cases (and particularly in the figures) a longer period from 1995/96 is shown. Information is presented on financing of health services for the three levels of government: national, provincial and local.

We show that a phase of increased real spending commenced in 2000/01, after the declines in the late 1990s, and that spending in 2005/06 is projected in real terms to be R8.7 billion higher than in 1995/96. However we examine the extent to which health inflation and increasing wages may have eroded these apparent gains and absorbed increased funding. We demonstrate, by

economic classification, province and programme, how additional funding has been spent. We show that the public sector user population has grown by 7 million since 1996 and that per capita expenditure is above the 1995/96 level but below its 1996/97 peak. We show that expenditure on HIV/AIDS has consumed a substantial proportion of additional funding allocated since 2000/01. Recent data are used to present a new perspective on interprovincial equity.

The chapter goes on to examine primary health care spending, showing data from the first country-wide analysis of expenditure by health district⁵ and on the first national study of expenditure on environmental health services.^a We discuss the financial implications of the new dispensation for primary care services delivery specified in the National Health Bill⁶ and examine these in the context of trends in PHC funding and in inequities in district funding.

Public sector financing of health amounts to around 41% of overall funds in the South African health sector.² Therefore in the final section, we explore recent trends in expenditure in the private medical scheme financing environment. Medical schemes are the largest financing intermediary in the private sector. We compare the levels and trends of expenditure in public sector provincial health services and private medical scheme environment and discuss potential implications for reforms such as establishment of a public sector medical scheme and social health insurance.

a Haynes R, Health Systems Trust, 2003, personal communication.

Framework for monitoring and evaluation

Health Goals, Objectives and Indicators relating to financing⁷

Goal	Objective	Indicator	Numerator	Denominator
Strengthening planning and budgeting and monitoring inter and intra-provincial equity				
Achieve equity in distribution of resources for service delivery in all provinces	Reduce disparity (ratio) between provincial and national average expenditure per capita	Ratio between provincial health per capita and national average	Provincial per capita health expenditure	National average per capita expenditure
	Reduce % disparity between hospital budgets	Hospital patient expenditure ratio	Average patient day equivalent (PDE) per level of hospital	National average cost per PDE
	Reduce disparity in public and private funding of health care	Ratio of public to private per capita health expenditure	Total public health sector expenditure divided by the population covered	Total medical scheme expenditure divided by number of beneficiaries
Medical Schemes and Social Insurance				
	Implement Social Health Insurance			
Revenue Generation and Retention				
	Increase revenue generated and retained	Revenue generated as a percent of health budget	Number of facilities with revenue targets that were reached	Total number of facilities that were given revenue targets

Indicator Definitions

Medical aid coverage: Proportion of population covered by medical schemes.

Per capita health expenditure: Amount spent on health per person (in Rands). For the public sector, this is often calculated for the population without medical aid coverage (public sector dependent population). For the private sector this is usually calculated for the number of medical schemes beneficiaries.

Public sector dependent (uninsured) population: This is an adjustment of the total population to the number assumed to be dependent on services in the public health sector based on medical scheme (health insurance) coverage.

It is calculated by subtracting the number of people with medical scheme cover (determined from medical scheme membership reports, or surveys indicating percentage of population on medical schemes) from the total population to obtain a population assumed to be dependent on the public sector.

Ratio of public to private sector per capita health expenditure: Total public health sector expenditure divided by the population covered (public sector dependent population) : total medical scheme expenditure divided by number of beneficiaries.

Data Sources

The chapter draws on the latest available financial databases of the National Treasury and a range of Treasury publications^{3,8,9}. These financial databases are supplemented by findings from academic research.^{4,10} Expenditure figures from Treasury sources for all years up to 2001/02 are audited; those of 2002/03 are for most provinces final audited figures. Figures for 2003/04 are projections based on expenditure for the first five months of the financial year (end August). Data for 2004/05 and 2005/06 are taken from provincial MTEF budgets. Data from the national Department of Health is drawn largely from the Treasury Estimates of National Expenditure of which the most recently published is of 2003.¹¹ These are in turn drawn amongst others from the audited financial statements of the Department as shown in its annual reports.¹² Data has been included for the Medium Term Expenditure Framework (MTEF) up to 2005/06. Additional allocations up to 2006/07 which will be included in the 2004 budget, as signalled in the 2003 Medium Term Budget Policy Statement,¹³ such as for the national antiretroviral programme, have not been included.

Inflation data uses the CPIX¹⁴ (consumer price index less mortgage interest). However this index only commenced in 1997, and real comparisons prior to this have been constructed based

on the CPI.¹⁴ Data on the Medical care and health care products component of the CPIX and CPI has been obtained from Statistics South Africa.

Demographic data have been drawn from the 2001 census¹⁵ and years between 1996 and 2001 recalculated based on an exponential function. In some cases this makes a significant difference to previous estimates of population and impacts on analyses of health financing per person and equity, as will be shown. Data for 2003 are taken from mid-year estimates.¹⁶ Coverage by medical schemes by provinces is taken from the 1995 and 1999 October Household Surveys. The decision to use the 1999 survey has been based on its closer approximation of beneficiaries to data from the Registrar of Medical Schemes¹⁷ and recent data from Census 2001 and the Income and Expenditure survey showing significant growth of population in low income quintiles in Gauteng.¹⁸

Data on filled posts have been drawn from Vulindlela and other reports over several years. For some provinces, where data were incomplete for 1995/96 or 1996/97 constant post numbers have been assumed in these years.

Expenditure on HIV/AIDS has been drawn from actual expenditure on conditional grants and a model of AIDS expenditure constructed by one of the authors. The latter is based on projections of hospital workloads arising from AIDS derived by the Abt group,^c adjusted downwards for home based care and costed at typical public sector hospital cost structures.

Data on private sector medical scheme financing is drawn mainly from reports of the Registrar of Medical Schemes, including the recently published 2002 report.¹⁷

Data

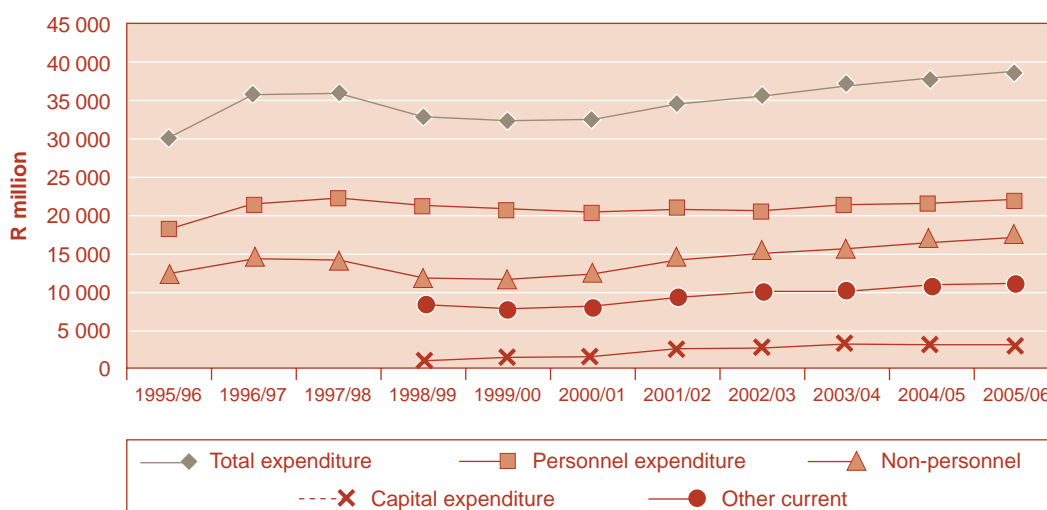
Provincial Health Expenditure

Provincial departments of health control by the far the largest proportion of public health finances, around 82% (including Works Departments, 2.7%).² An examination of their spending trends will tell us much about the overall pattern of public sector health expenditure.

In 1996/97 expenditure of provincial health departments increased 18% in real terms, largely due to the large wage increases of 1996 and rank and leg promotions. However the GEAR policy was introduced within a year and real budgets declined over the period 1998/99 to 1999/00 as government sought to stabilise the macro-economy. Table 1 shows real trends^b in provincial spending and forward budgets from 1998/99 to 2005/06 in 2003 prices. A more expansionary fiscal stance was adopted from the latter part of 2000/01 and real expenditure is projected to rise by R6.5 billion from 1999/00 to 2005/06 (by an average of 2.4% per year).

Figure 1 shows a longer term trend, highlighting three phases of real expenditure: increasing until 1997/98 then decreasing to 1999/00 and then re-establishing an upward trend from 2000/01. By 2005/06 real spending is expected to be R8.7 billion higher than in 1995/96.

Figure 1: Trends in real provincial health expenditure (R million, real 2003 prices)



b The chapter presents prices in real 2003 terms unless otherwise indicated. Real prices mean 'prices adjusted to remove the effect of inflation'.

c Abt group, personal communication.

Table 1: Trends in provincial health expenditure (R million, real 2003 prices)

	1998/99 Actual	1999/00 Actual	2000/01 Actual	2001/02 Actual	2002/03 Actual	2003/04 Project ⁱ	2004/05 MTEF	2005/06 MTEF	Real change annual (%)
Eastern Cape	4 364	4 682	4 708	4 536	4 767	5 138	5 434	5 716	3.9
Free State	2 422	2 128	2 208	2 276	2 328	2 596	2 588	2 657	1.3
Gauteng	7 843	7 505	7 382	7 968	8 157	8 316	8 259	8 257	0.7
KwaZulu-Natal	7 015	6 843	7 170	8 193	7 995	8 555	8 256	8 336	2.5
Limpopo	2 980	2 974	3 135	3 104	3 359	3 709	3 658	3 773	3.4
Mpumalanga	1 515	1 536	1 388	1 697	1 791	1 987	2 203	2 266	5.9
Northern Cape	561	580	581	603	646	787	770	806	5.3
North West	1 921	1 853	1 940	1 980	2 135	2 351	2 477	2 682	4.9
Western Cape ⁱⁱ	4 334	4 185	4 287	4 319	4 186	4 539	4 427	4 382	0.2
Total	32 953	32 287	32 799	34 676	35 365	37 978	38 073	38 875	2.4

Notes: i 2003/04 projection is based on 5 months expenditure (end August).

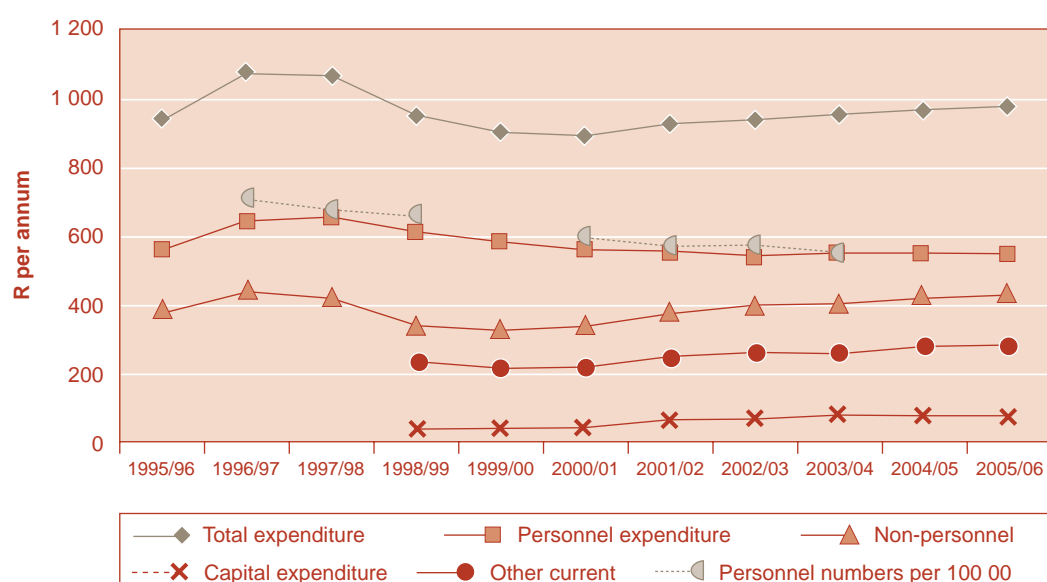
ii Including relevant Works Department expenditure in Western Cape. Works expenditure in other provinces has already been included in the Health vote for several years.

However this recovery in real funding, while welcome and providing much greater stability, is offset by several factors which are discussed below. Population growth over the period, associated with a declining proportion of the population covered by medical schemes, has placed a larger load on government. Real per capita expenditure trends are shown in Figure 2.

This shows that projected expenditure levels in 2005/06 exceed those of 1995/96, but are still below the 1996/97 peak. When funding does not match increases in the population dependent

on the public sector, then public health services are bound to be squeezed and quality compromised. It is probably worth noting that the 1996/97 peak was associated with high wage increases, over-expenditure, once-off severance costs and three provinces being placed under national supervision (section 100 of the constitution). However, the subsequent dip is not simply a correction of this, but also a reflection of reducing finances for provincial departments over that period.

Figure 2: Trends in real expenditure per capita



Interested readers may want to compare Figure 1 and Figure 2 with analysis by the Department of Health,⁴ the National Health Accounts Project¹⁹ and the 1995 Health Expenditure Review.¹ These show strong growth in health expenditure from 1992/93 to 1997/98. Depending on which year is used as a baseline for comparison, different results are obtained.

HIV/AIDS has placed an increasing load on services, estimated at around R5.4-7 billion annually by 2003/04.²⁰ An estimate of expenditure devoted to HIV/AIDS related activities is shown in Figure 3. Funding made available specifically to the health sector to compensate for HIV/AIDS will reach R3.3 billion in 2005/06, as shown in Table 2.

The paradox caused by wage drift and health inflation

When budgets rise or fall, this is immediately apparent to all. However when input prices rise above the general inflation level, purchasing power may decrease in a substantial and insidious

way that is not fully apparent or understood by managers and funders. There is fairly strong evidence that health inflation does indeed exceed general inflation.

Firstly, there is the paradox that real health budgets have increased by R8.7 billion from 1995/96 to 2005/06 but the sector has 19 000 fewer employees. How can this be possible? The answer is that although personnel budgets have gone up by around R3 billion over the period to 2003/04, average wage cost (including benefits) has increased by around 28% in real terms. This is shown in Table 3. The average wage of a health sector employee is R98 153 in 2003, despite, somewhat surprisingly, that 57.6% of employees are at salary levels 5 or below (of 14 salary levels in the public service). The data show that 35.5% are at salary levels 6-8 (76 861 persons, mainly nurses) and only 6.9% (14 912 persons, mainly doctors) are at salary level 9 and above (Source: Vulindlela, October 2003).

Figure 3: Trends in total expenditure and AIDS expenditure (R million)

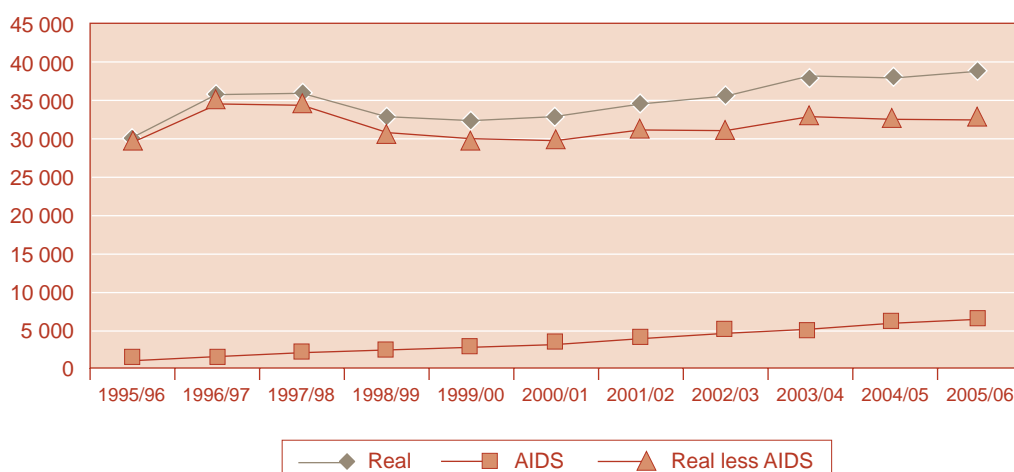


Table 2: National funding allocated for HIV/AIDS related expenditure in the health sector (R thousand)

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
National Department of Health (core)	74 480	164 329	211 441	248 419	332 165	369 356	368 236
HIV/AIDS conditional grant (health)		16 819	54 398	210 209	333 556	481 612	535 108
Equitable share 2002				400 000	600 000	900 000	954 000
Equitable share 2003					500 000	1 000 000	1 500 000
	74 480	181 148	265 839	858 628	1 765 721	2 750 968	3 357 344

Source: National Treasury 2003

Table 3: Trends in personnel expenditure, filled posts, and average salaries

	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	Change over period (%)
Personnel expenditure real (R million, 2003/04 prices)	18 016	21 408	21 876	21 224	20 719	20 383	20 712	20 498	21 226	17.8
Personnel (filled posts)	235 182	232 698	228 248	228 444	222 701	216 958	216 822	214 538	216 251	-8.0
Average cost of employment	76 606	92 001	95 844	92 908	93 037	93 949	95 523	95 546	98 153	28.1
Personnel per million population uninsured	7 330	7 051	6 734	6 559	6 217	5 934	5 810	5 650	5 600	-23.6

Note: The personnel information included here (which includes all categories of personnel) may differ from that reported elsewhere in this Review that focuses only on professional categories of health sector personnel.

The health component of CPIX (and CPI prior to 1997) has persistently run above the overall index (around 3% on average). Figures are shown in Table 4. The health component of CPIX is composed also of private sector costs and may also, like CPIX itself, not accurately reflect public sector cost pressures. Other evidence includes the findings of a study on health inflation conducted by the Department of Health (4.5% above general inflation.^d There has been a great discrepancy between rising per capita expenditure in the public and private sector (5.7% average annualised from 1997/98 to 2002/03 and as shown later in Figure 7) which provides further evidence of the existence of health inflation, although over-provision and excess profit may also be factors in the private sector. The health sector has also experienced similar cost pressures internationally.²¹

The final factor, which is an important issue that must be resolved in the sector, is that health inflation almost certainly exceeds general inflation over the long term. If this is true then this and all previous studies of financing trends have over-emphasised growth in health financing and expenditure. This emphasises the need for the development of a sector specific inflation indicator, similar to that used in several other countries.²²

Pulling all this together, while there have been real increases in the funding of health care it is apparent that they have not been able to keep pace with the population increases, particularly in relation to those dependent on the public sector. Much of the increases may have been absorbed by increased wage costs and high medical inflation, rather than by improved service coverage and quality.

Composition of expenditure

Table 5 shows trends in real expenditure by functional area from 1999/00 to 2005/06 for provincial Departments of Health. The largest percentage increases have been for HIV/AIDS programmes, facilities (capital works) and Emergency Medical Services. These reflect policy directions such as for HIV, facilities to improve infrastructure and for PHC expenditure. Recurrent funds for hospitals have taken the lion's share of funding but this is projected to decline from 68% to 61% between 1999/00 and 2005/06. The limited funding increase for hospitals associated with the bulk of the HIV/AIDS workload will have inevitably placed strain on hospital services.

Table 4: Health component of CPIX vs CPIX by financial year

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03
CPIX	8.1	7.8	12.3	6.9	7.8	6.6	9.8
CPIX Medical	10.3	17.5	12.3	10.2	10.5	10.9	12.1

d National Department of Health, 2002, personal communication.

Table 5: Trends in expenditure by functional area (R million, real 2003 prices)

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	Change	Change annual (%)
Hospitals	21 958	22 857	22 861	21 572	22 606	23 217	23 580	1 622	1.2
PHC	4 906	4 961	5 295	5 701	5 955	6 183	6 346	1 440	4.4
HIV/AIDS	83	74	104	750	680	813	880	797	48.2
Nutrition	617	619	673	760	834	841	833	215	5.1
EMS	911	955	942	1 362	1 471	1 485	1 507	595	8.7
Admin	1 244	1 187	1 377	1 427	1 593	1 540	1 574	329	4.0
Training	654	621	757	899	920	969	995	341	7.2
Support	456	458	484	577	586	645	647	191	6.0
Facilities	1 199	722	1 789	1 935	2 012	2 122	2 152	953	10.2
Other	183	276	308	134	224	201	191	7	0.7
Total	32 212	32 730	34 589	35 117	36 881	38 016	38 702	6 491	3.1

Table 6 provides an analysis of trends in provincial health expenditure by economic classification. The recovery demonstrated in other current expenditure (e.g. medicines) and capital expenditure (capex) is encouraging. However limited personnel expenditure growth associated with lack of growth in health professional numbers employed by the public sector over the decade, despite population growth of 7 million, is likely to be mean under-staffing in certain areas.

Table 6: Provincial health spending trends by economic classification, 1999/00 - 2006/06 (R million, real 2003 prices)

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	Change	Change annual (%)
Total expenditure	32 112	32 392	34 513	35 500	36 852	38 000	38 691	6 579	3.2
Personnel expenditure	20 622	20 287	20 614	20 402	21 226	21 556	21 810	1 188	0.9
Non-personnel	11 490	12 105	13 899	15 099	15 627	16 444	16 881	5 391	6.6
Capex	1 310	1 406	2 398	2 662	2 945	2 880	2 998	1 688	14.8
Other current	7 604	8 011	9 128	9 888	10 002	10 801	11 073	3 469	6.5

Note: Totals do not match exactly with Table 1, due to differences from sources.

Population growth

Real funding growth has been largely offset by population growth. The uninsured population has grown almost 7 million from 1995 to 2005 at a rate of 2.2% annually. This is shown in Table 7. This reduces the effect of real growth in funding. Gauteng's population has grown at a rate of 5.2% per year and has increased from 13.3% to 17.3% of the total uninsured in 2001. Real per capita expenditure trends are shown in Table 8. This shows low per

capita growth averaging 0.4% but with significant differences between provinces, ranging from Northern Cape (+5.2% per year) to Gauteng (-3.1%) per year. This variation in per capita expenditure growth is due both to progressively more equitable financing (i.e. larger real increases in previously disadvantaged provinces) along with migration into urban provinces.

Table 7: Uninsured (public sector dependent) population

	1995	1997	1999	2001	2003	2005	Annual increase (%)	2001 % distribution
Eastern Cape	5 642 762	5 721 758	5 719 329	5 780 213	5 839 874	6 087 105	0.8	15.5
Free State	2 113 546	2 207 726	2 276 032	2 306 172	2 332 973	2 392 325	1.2	6.2
Gauteng	4 267 595	5 013 026	5 986 200	6 459 977	6 882 534	7 095 743	5.2	17.3
KwaZulu-Natal	7 113 607	7 460 418	7 846 509	8 228 913	8 521 381	8 756 207	2.1	22.0
Limpopo	4 382 082	4 555 330	4 671 814	4 814 835	4 942 604	5 237 827	1.8	12.9
Mpumalanga	2 330 209	2 443 867	2 558 240	2 679 525	2 785 693	2 891 917	2.2	7.2
Northern Cape	653 400	667 616	670 149	665 586	662 448	674 508	0.3	1.8
North West	2 823 706	2 948 914	3 072 635	3 192 334	3 299 026	3 391 176	1.8	8.6
Western Cape	2 758 468	2 873 819	3 021 246	3 194 181	3 347 133	3 445 684	2.2	8.6
Total	32 085 375	33 892 474	35 822 154	37 321 736	38 613 666	39 972 492	2.2	100.0

Sources: Stats SA, October Household Survey 1995 and 1999

Table 8: Provincial public sector expenditure per capita (Rand per year, real 2003 prices)

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	Annual change (%)
Eastern Cape	761	819	819	785	808	880	911	939	3.0
Free State	1 083	935	964	987	997	1 120	1 095	1 111	0.4
Gauteng	1 450	1 254	1 187	1 233	1 244	1 185	1 182	1 164	-3.1
KwaZulu-Natal	917	872	892	996	958	945	956	952	0.5
Limpopo	645	636	661	645	678	756	719	720	1.6
Mpumalanga	606	600	530	633	656	730	776	784	3.7
Northern Cape	840	865	871	906	961	1 180	1 153	1 194	5.2
North West	639	603	619	620	660	713	741	791	3.1
Western Cape	1 469	1 385	1 380	1 352	1 292	1 356	1 304	1 272	-2.0
Total	948	901	897	929	931	969	969	973	0.4

Figure 4: Projected average annual increases in population and funding between 1998/99 and 2003/04

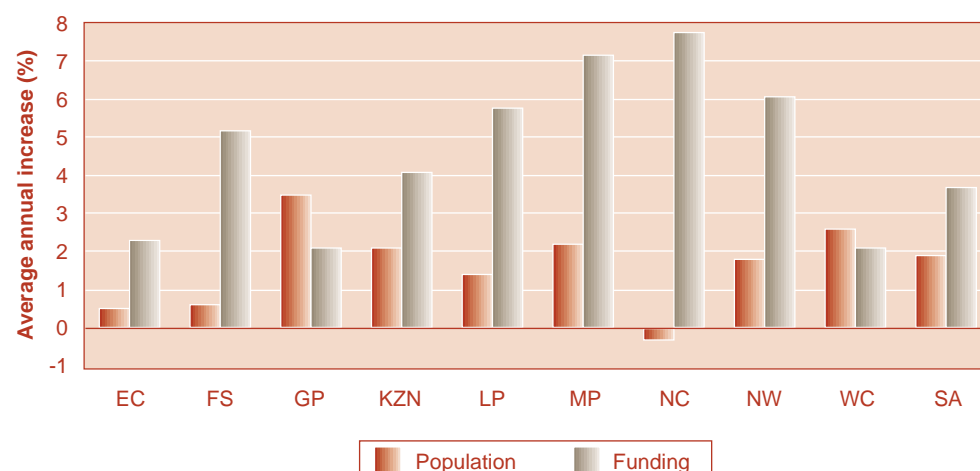


Figure 4 highlights the changes that have occurred between 1998/99 and 2003/04 in terms of funding and population growth across the provinces. Several provinces have been clear winners including the Northern Cape, Mpumalanga, North West and Limpopo, which is encouraging since these provinces were the lowest funded at the beginning of the period. Funding of health care has failed to match population increases in Gauteng and Western Cape.

Interprovincial equity

Table 8 shows trends in provincial health per capita expenditure over an eight year period in real 2003 prices. Overall Western Cape is the best funded and Limpopo the lowest funded province per capita. Table 9 shows interprovincial per capita spending less conditional grants as a percentage of the national average. These figures show much less interprovincial inequity than is generally believed. The figures show significant per capita reductions in Western Cape and Gauteng. In Western Cape this has been reflected through substantial downsizing of personnel²³ and population growth exceeding funding growth, and in Gauteng substantial in-migration and decreasing medical scheme coverage has occurred. At the same time the 2003/04 budget contained significant budgetary increases for Mpumalanga, Eastern Cape and North West (Table 1). There has been no change in Limpopo's position relative to the mean.

This analytic perspective of progress towards interprovincial equity is very striking, but is substantially based on the demographic and medical scheme coverage changes reflected in census 2001 and OHS 1999. If the 1995 October household

survey is used as a measure for medical aid coverage, as was shown in the analysis of the Intergovernmental Fiscal Review 2003,³ and analysis by the DoH,⁴ then Gauteng appears substantially better funded. This uncertainty about population denominators should ideally be resolved through more accurate assessment both by surveys, such as the Demographic and Health Survey, and by data collected by the Registrar of Medical Schemes. If the data are correct and that there has indeed been substantial progress towards equity in interprovincial financing, then this raises important questions about why services and services standards are so different between provinces and about what efficiencies are needed to improve quality and access.

Despite substantial progress in reducing inequities in funding over the decade (as shown in Table 9), inequities in high level professional personnel deployment are still great, as shown in Table 10 and this demonstrates the necessity for the South African health system to focus on getting its professional human resources right. These human resource inequities may initially appear surprising given the progress towards equity in financing described above. However Table 10 includes services funded by conditional grants and should be viewed along with the financial distribution shown in Table 8. Furthermore the professional groups shown in the table, excluding professional nurses, total only 16 000 out of 216 000 health sector employees and these somewhat scarce categories of personnel are difficult to recruit and retain in several provinces. Inequities in professional nurse distribution (1.6 ratio of highest to lowest) are lower than for other professional groups and tend to follow the budgetary distribution.

Table 9: Provincial expenditure less conditional grants per capita as a % of mean of all provinces

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	Real per capita % change annual
Eastern Cape	96	108	104	99	101	100	102	104	1.4
Free State	116	100	106	106	109	113	109	110	-0.5
Gauteng	124	113	108	109	116	105	107	105	-1.9
KwaZulu-Natal	100	101	108	114	104	105	105	104	0.8
Limpopo	82	85	84	79	81	88	83	82	0.3
Mpumalanga	76	80	66	78	80	83	89	89	2.6
Northern Cape	103	107	107	104	111	120	115	118	2.3
North West	82	81	81	78	82	82	85	90	1.8
Western Cape	116	115	121	114	112	115	111	109	-0.5

Table 10: Public sector health workers per million uninsured population, February 2003ⁱ

	EC	FS	GP	KZN	LP	MP	NC	NW	WC	SA	Ratio of highest : lowest
Dental Specialists	0	0	4	4	0	1	0	0	1	2	>100
Medical Specialists	24	89	208	60	12	7	27	15	339	92	27.9
Occupational Therapists	2	26	22	12	15	15	11	10	28	15	13.7
Dieticians and Nutritionists	2	15	13	6	10	16	15	9	15	10	6.4
Physiotherapy	5	22	24	22	11	13	20	11	29	17	6.0
Oral Hygiene	2	4	5	2	4	2	2	2	9	3	5.7
Speech Therapists	1	6	9	6	6	6	5	4	7	6	5.7
Dental Practitioners	6	14	28	6	8	18	17	13	33	15	5.5
Pharmacists	21	32	37	35	23	28	33	20	68	33	3.2
Radiographers	43	71	87	44	19	19	44	19	135	54	3.1
Dental Therapists	1	1	2	0	6	3	2	5	4	2	2.8
Medical Practitioners	129	240	259	215	131	170	319	117	313	199	2.5
Professional Nurses	891	1 286	1 166	1 043	1 117	872	1 377	895	1 169	1 058	1.6

Note: ⁱ Ranked in order of ratio of highest to lowest staffing distribution.

National Department of Health (NDoH)

The NDoH is the apex of the policy and legislative pyramid, but comprises only a small part of total expenditure on health. Although technically the NDoH has R8.4 billion on its vote in 2003/04 over 88% of this will be transferred to provinces as conditional grants leaving R973 million. Contained within this are a range of specifically earmarked funds such as for the Medical Research Council (R157m), condoms (R108m) and forensic mortuaries (R87m). The vote contains R610 million after transfers.

Table 11: Expenditure by national Department of Health (R million, real 2003 prices)

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
Total expenditure	7 809	8 234	7 813	8 035	8 387	8 775	8 924
Conditional grants	7 120	7 456	6 941	7 203	7 414	7 780	7 933
Difference	517	637	752	788	973	1 047	1 101

Conditional grants have been substantively reformed over the period. Table 12 shows trends in expenditure. Conditional funding for tertiary hospital services was previously routed via the Central Hospitals and Redistribution of Specialised Services (RSS) grants. These have been incorporated, from 2002/03, into a National Tertiary Services grant which provides funding for specific tertiary service units. The basis for funding was actual costs initially, is being changed to outputs and standardised unit costs but will progressively be reformed towards a desired future configuration of tertiary health services. Teaching costs incurred by provinces are funded by the Health Professions Training and Development grant. Capital grants, (including the previous Albert Luthuli, Pretoria and Nelson Mandela hospital construction grants), have been incorporated into a single Hospital Revitalisation grant, focusing on the complete upgrading

or replacement of whole hospitals (27 in progress in 2003), and have grown strongly over the period. The Integrated Nutrition programme has also grown strongly and its largest Primary School Nutrition component will be shifted to the education sector in 2004. The Hospital Management and Quality Improvement grant was initiated to promote management strengthening and quality of care programmes in hospitals. The HIV/AIDS grant has grown strongly over the period and has been used to support initiation and roll-out a range of aspects of this national programme.

The two large hospital grants (for tertiary services and teaching) have declined as a proportion of total expenditure from 17.7% of total expenditure in 1998/99 to 14.1% in 2005/06. This has contributed to improved equity.

Table 12: Trends in conditional grants (R million, real 2003 prices)^{i, ii}

Conditional grants	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	Change annual %
National Tertiary Services grant (previously Central Hospitals+RSS)	4 304	4 168	4 104	3 999	4 443	3 995	4 058	4 081	-0.8
Health Professions Training and Development (previously training and research)	1 510	1 490	1 452	1 431	1 340	1 333	1 362	1 370	-1.4
Hospital Revitalization and other capital grants (Albert Luthuli, Pretoria, Nelson Mandela hospitals)	425	493	609	1 042	967	810	866	926	11.8
HIV/AIDS	0	0	13	53	218	334	458	482	
Integrated Nutrition Programme	403	613	660	567	678	809	902	939	12.8
Hospital Management and Quality Improvement	0	0	0	144	121	133	135	135	
Total	6 642	6 764	6 837	7 236	7 767	7 414	7 780	7 933	2.6

Notes: *i* This table presents each existing grant and its predecessors within a single row.

ii Differences in total conditional grant amounts between Table 11 and Table 12 are because the first shows transfers from the NDoH, whereas the second table shows expenditure by provinces including rollovers and reported over/under expenditure.

Local Government Health Services

Local government is the most difficult level of government to collect expenditure and financing data, because of the large number of authorities and lack of standardisation in systems. Nevertheless, there have been a few important studies in this area. These suggest that local government spends approximately R2 billion per year on health services (2003 prices) of which around R800m are transfers from provinces and R1.2 billion is own revenue. Data suggest that this local

government source of income for health grew rapidly in the 1990s and stagnated in the early 2000s.^{3, 5, 23}

A recent study^e provided the first national estimates of expenditure on environmental health services, an important construct, since this will become the definition of municipal health services when the National Health Bill becomes law.⁶ Table 14 shows sources of financing. These are similar to expenditure except for district councils which spend R105 million, of which R77 million is financed from provinces.

^e Haynes R, Health Systems Trust, 2003, personal communication.

Table 13: Local government expenditure - comparison of four studies (R million, real 2003 prices)

Year of original study		LGH 2001/02	NHA 1998/99	DPLG 2001/02	IGFR 03 2002/03
Total	LG health exp	1 974	2 182		
	Transfers from provinces	767	836		
	Own revenue	1 207	1 347		
	Provincial direct	4 805			
	Provincial total	5 572			5 955
	Total PHC out of hosp	6 779			
A - metro	LG health exp	1 295			1 191
	Transfers from provinces	411			393
	Own revenue	884			798
B municipalities	LG health exp			571	
	Transfers from provinces			248	
	Own revenue			323	
C - District Councils	LG health exp			135	
	Transfers from provinces			101	
	Own revenue			34	
Non-metro (B+C)	LG health exp	679		707	
	Transfers from provinces	356		349	
	Own revenue	323		357	

Note: Studies are, in order of columns, Local Government and Health - Thomas *et al* (2003),⁵ National Health Accounts - Thomas and Muirhead (2000),¹⁹ the Department of Provincial and Local government (DPLG) database (2001) and Intergovernmental Fiscal Review 2003.³

Table 14: Financing of municipal health services, 2002 (R million)

	Metros	District LG (C)	Local (B)	Prov- incial	Total
Eastern Cape	9	3	12	8	33
Free State	0	0	18	5	23
Gauteng	86	11	10	1	108
KwaZulu-Natal	28	0	19	26	74
Limpopo	0	0	3	23	27
Mpumalanga	0	0	11	12	23
Northern Cape	0	4	6	1	10
North West	0	0	5	11	15
Western Cape	44	11	25	3	82
Total	167	29	107	92	395

Source: Personal communication: Haynes R, Health Systems Trust, 2003

Table 15: Potential financial implications to provinces of new PHC dispensation (R thousand, real 2003 prices)

	LG own revenue (total)	Metros	District LG
Eastern Cape	50 105	27 876	22 229
Free State	28 450	0	28 450
Gauteng	376 694	360 242	16 452
KwaZulu-Natal	222 030	138 941	83 089
Limpopo	16 417	0	16 417
Mpumalanga	32 843	0	32 843
Northern Cape	3 740	0	3 740
North West	27 807	0	27 807
Western Cape	208 787	153 508	55 279
Total	966 873	680 567	286 306

Some of the financing issues arising from the National Health Bill include:

- ◆ The likelihood that provinces will need to progressively replace LG own revenue financing for health services. The financial implications (own revenue less environmental health) are shown in Table 15.
- ◆ How C municipalities need to be funded or gain revenue raising capacity to take up MHS from B municipalities and provinces in accordance with the prescripts of the Municipal Structures Act.²⁴

Primary Health Care Services

A recent study⁵ has provided the first national picture of expenditure by health district and inequities across districts. Expenditure ranged from under R50 per capita per year to R389 in the highest district. This strongly suggests a serious problem of intra-provincial inequities.

Summary results are shown in Table 16. In Figure 5 the financing per capita of non-hospital PHC services in each health district is compared with the need in each district, calculated using a deprivation index. Financing per capita is shown by the curve

from top left to bottom right. For each district, the deprivation score is also shown, ranging from +6 to almost -8. A trend line has been added to the deprivation scores to make the relationship clearer between financing and need. As can be seen, as financing per capita decreases there is an overall trend for the district to have a higher deprivation score. In other words, in general, the most needy districts get the least funding and vice versa.

The sheer scale of the imbalances would seem to indicate that financing of non-hospital PHC is currently done without reference to the principles of equity. Still, it may be possible to argue that more funds are needed in more urban provinces or districts because of higher costs. It should be noted that in some provinces, such as the Eastern Cape and KwaZulu-Natal, hospitals are an important alternative mode of delivery of PHC services. Based on historical expenditure data between 1996/97-1998/99 estimates of district hospital spending were added in to the non-hospital PHC spending to see whether inequities are reduced. Figure 6 presents the results in index form, where the province with the least funding has a score of 100 (Mpumalanga).

Figure 5: Financing per capita vs Deprivation Index Score (DIS) across health districts in South Africa

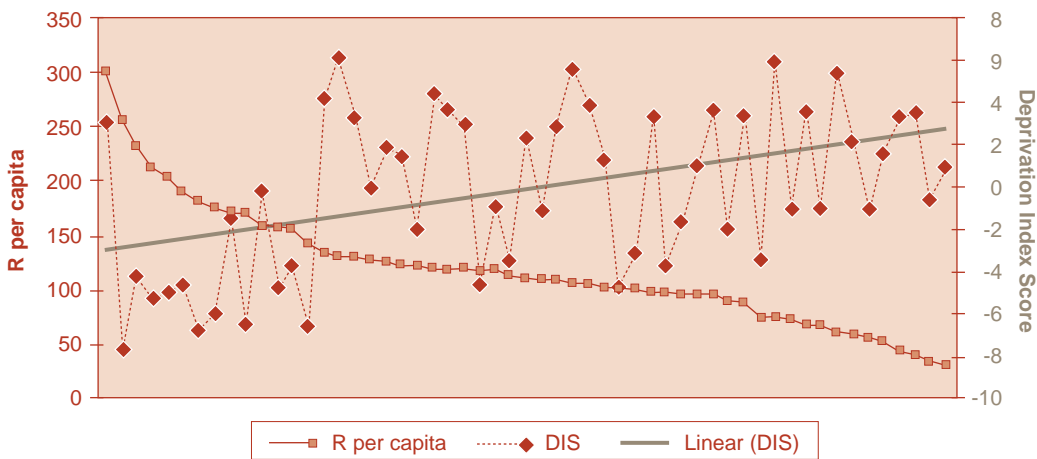
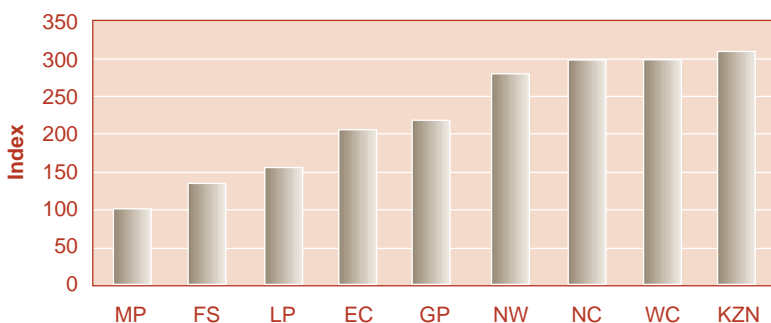


Figure 6: Index of primary health care funding including a district hospital component



The results suggest a narrowing of differential between the best and worst funded provinces. Further it is interesting to see that KwaZulu-Natal, Western Cape, Northern Cape and North West provinces have very similar funding levels. Nevertheless, there are still substantial inequities in terms of overall funding of PHC between provinces, with PHC funding in Mpumalanga, and Limpopo appearing very low. Indeed, it is questionable whether some of these provinces would be able to afford the PHC package advocated by the NDoH²⁵ and costed at approximately R220 per capita in 2002/03 prices.

Further, it is unclear that a channelling of PHC resources through hospitals is allocatively efficient given that the biggest potential gains in health status may be achievable in rural, under-served areas. Such a mode of provision is also less likely to be technically efficient, given the higher costs that are typically incurred at the hospital level. While hospital funding of PHC may boost the apparent PHC expenditure figures in some provinces this may be deceptive as hospital delivery of PHC services may be both inequitable and inefficient.

Table 16: Expenditure by health district on non-hospital PHC, 2001/02

	Prov - Direct	Prov - Health	LG - Health	LG total	Provincial total	Total	Total/ uninsured pop ⁱ
	Exp (a)	Transfer (b)	Own Re (c)	(b+c)	(a+b)	(a+b+c)	
	(R thousand)						R per capita
Eastern Cape							
DC10 Cacadu	14 653	5 526	3 151	8 677	20 179	23 330	69
DC12 Amatole	193 047	5 790	9 112	14 902	198 838	207 950	137
DC13 Chris Hani	65 984	14 536	2 053	16 589	80 520	82 573	109
DC14 Ukhahlamba	11 538	2 264	780	3 044	13 801	14 581	48
DC15 OR Tambo	122 828	4 649	6 979	11 628	127 477	134 456	91
DC44 Alfred Nzo	37 270	0	0	0	37 270	37 270	75
Nelson Mandela / Port Elizabeth	57 284	39 436	32 922	72 357	96 720	129 642	129
Eastern Cape total	502 603	72 201	54 997	127 198	574 805	629 801	107
Free State							
DC16 Xhariep	5 804	7 638	1 061	8 699	13 443	14 504	145
DC17 Motheo	46 724	9 680	14 880	24 560	56 404	71 284	128
DC18 Lejweleputswa	32 499	19 934	3 173	23 107	52 433	55 606	96
DC19 Thabo Mofutsanyane	26 100	5 892	7 575	13 467	31 993	39 568	71
DC20 Northern Free State	22 099	13 216	-2 275	10 941	35 316	33 041	89
Free State total	133 227	56 361	24 414	80 775	189 588	214 002	99
Gauteng							
CBDC2 Metsweding	9 995	1 488	-287	1 201	11 483	11 196	151
CBDC8 West Rand	35 163	26 784	8 700	35 484	61 947	70 647	163
DC42 Sedibeng	34 619	38 348	16 705	55 053	72 968	89 673	190
Ekurhuleni	280 223	81 100	157 721	238 821	361 323	519 044	389
Johannesburg	389 558	45 407	159 473	204 880	434 965	594 438	342
Tshwane	89 958	19 130	77 941	97 071	109 088	187 029	169
Gauteng total	839 516	212 258	420 253	632 510	1 051 773	1 472 026	285

	Prov - Direct	Prov - Health	LG - Health	LG total	Provincial total	Total	Total/ uninsured pop ⁱ
	Exp (a)	Transfer (b)	Own Re (c)	(b+c)	(a+b)	(a+b+c)	
	(R thousand)						R per capita
<i>KwaZulu-Natal</i>							
DC21 Ugu	77 257	5 005	9 795	14 800	82 262	92 057	165
DC22 Umgungundlovu	120 734	10 892	20 815	31 707	131 626	152 441	200
DC23 Uthukela	64 452	3 542	4 236	7 778	67 994	72 230	150
DC24 Umzinyati	39 428	2 492	7 825	10 317	41 920	49 745	134
DC25 Amajuba	47 579	1 409	3 615	5 024	48 988	52 603	148
DC26 Zululand	87 768	965	5 034	5 999	88 733	93 767	151
DC27 Umkhanyakude	72 597	0	40	40	72 597	72 637	166
DC28 Uthungulu	91 231	4 152	3 740	7 892	95 383	99 123	150
DC29 Ilembe	39 644	2 975	14 762	17 737	42 619	57 381	124
DC43 Sisonke	30 701	2 232	1 439	3 671	32 933	34 372	169
eThekwini	281 220	39 420	147 230	186 649	320 640	467 869	179
KwaZulu-Natal total	952 611	73 084	218 531	291 614	1 025 695	1 244 225	165
<i>Limpopo</i>							
CBDC3 Sekhukhune	73 096	0	0	0	73 096	73 096	87
CBDC4 Bohlabela	32 151	0	0	0	32 151	32 151	55
DC33 Mopani	107 894	103	4 799	4 902	107 997	112 796	140
DC34 Vhembe	121 351	252	3 638	3 890	121 603	125 241	124
DC35 Capricorn	75 881	332	-332	0	76 213	75 881	77
DC36 Waterberg	54 452	1 439	5 983	7 422	55 891	61 874	125
Limpopo total	464 825	2 125	14 088	16 213	466 950	481 038	102
<i>Mpumalanga</i>							
DC30 Gert Sibande	7 394	7 094	13 965	21 059	14 488	28 453	42
DC31 Nkangala	20 140	3 245	13 331	16 576	23 385	36 716	44
DC32 Ehlanzeni	90 021	3 241	888	4 129	93 262	94 150	134
Mpumalanga total	117 555	13 579	28 184	41 763	131 135	159 319	72
<i>Northern Cape</i>							
CBDC1 Kgalagadi	3 688	120	113	233	3 808	3 921	27
DC6 Namakwa	20 937	917	170	1 087	21 854	22 024	254
DC7 Karoo	21 681	710	341	1 051	22 391	22 732	163
DC8 Siyanda	15 546	1 682	-508	1 174	17 228	16 720	100
DC9 Frances Baard	26 152	1 593	7 093	8 686	27 745	34 838	135
Northern Cape total	88 004	5 023	7 209	12 232	93 026	100 235	126
<i>North West</i>							
CBDC1 Kgalagadi	17 242	0	816	816	17 242	18 058	
DC37 Bojanala Platinum	135 577	2 754	4 828	7 582	138 331	143 159	143
DC38 Central	88 968	3 200	2 577	5 777	92 168	94 745	159
DC39 Bophirima	135 429	3 192	594	3 786	138 621	139 215	378
DC40 Southern	67 831	20 521	15 047	35 568	88 352	103 399	216
North West total	445 047	29 667	23 862	53 529	474 714	498 576	204

	Prov - Direct	Prov - Health	LG - Health	LG total	Provincial total	Total	Total/ uninsured pop ⁱ
	Exp (a)	Transfer (b)	Own Re (c)	(b+c)	(a+b)	(a+b+c)	
	(R thousand)						R per capita
Western Cape							
Cape Town	412 552	125 073	175 730	300 803	537 625	713 355	357
DC1 West Coast	20 085	15 302	10 681	25 983	35 387	46 068	275
DC2 Boland	46 092	16 074	25 877	41 951	62 166	88 043	201
DC3 Overberg	20 473	5 410	3 772	9 182	25 883	29 655	240
DC4 Eden	34 283	21 403	16 436	37 839	55 686	72 122	265
DC5 Central Karoo	6 975	4 384	1 671	6 055	11 359	13 030	325
Western Cape total	540 460	187 646	234 167	421 813	728 106	962 273	317
Overall Totals	4 083 848	651 944	1 025 704	1 677 648	4 735 792	5 761 496	168
Metros	1 510 794	349 566	751 016	1 100 582	1 860 361	2 611 376	268
Non-metros	2 573 053	302 378	274 688	577 066	2 875 431	3 150 119	124

Source: Thomas et al.⁵

Note: ⁱ Population based on 1996 Census since Census 2001 data were not available in disaggregated form at time of writing report.

Medical Scheme Financing

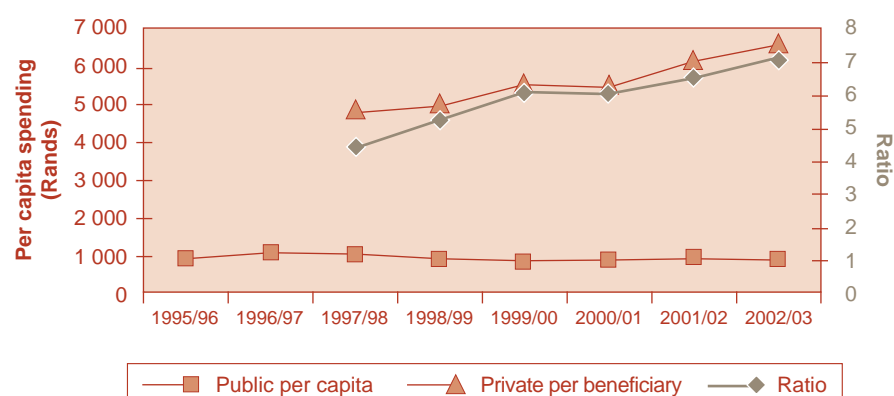
Medical scheme contributions have increased by 12.4% in real terms (i.e. over and above inflation) in 2001 and 71% in 2002. While some of this has gone to build reserves, administration fees (2001) and private hospital costs (2002) continue to drive up costs. The ratio of expenditure per capita by medical schemes: public sector provincial health spending has risen from 4.5 in 1997/98 to a staggering 7.1 in 2002/03. This is shown in Figure 7.

This increase in costs is making medical scheme coverage progressively more expensive resulting in lower coverage. Figure 8 shows medical scheme expenditure as a proportion of income

by income group for all provincial employees in the Western Cape.^e For employees with income less than R50 000 per annum, over 25% of salary was spent on medical scheme cover (employer + employee contributions).

Government is currently considering establishment of a public sector medical scheme and social health insurance, thus extending cover to lower income groups. However both of these clearly hold significant risks if the medical schemes environment continues this relentless cost spiral.

Figure 7: Ratio of expenditure per capita by private medical schemes and public sector provincial health



^e McLeod and Du Toit, February 2004, personal communication.

Figure 8: Medical scheme contributions as a proportion of income

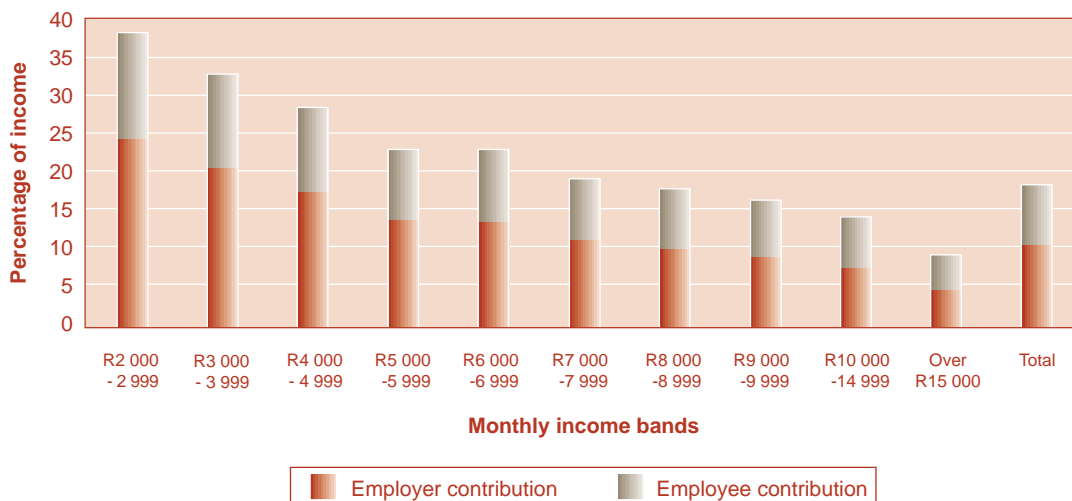


Table 17: Trends in private medical schemes (real 2003 prices)

	1997	1998	1999	2000	2001	2002
Beneficiaries	6 965 002	6 991 511	6 989 139	7 004 636	7 025 262	6 962 914
% population covered	16.9%	16.6%	16.3%	16.0%	15.7%	15.3%
Pensioner ratio				6.25	5.90	5.90
Dependent ratio (Dependents/members)				1.59	1.56	1.52
Gross contribution income (R million)	34 870	34 795	38 573	38 340	43 230	45 908
Gross contributions pbpm	417	415	460	456	513	549
Gross contrib. pbpa	5 006	4 976	5 519	5 474	6 154	6 593
Gross contrib. pmpm					1 315	1 385
Benefit payments (R million)			34 869	33 736	35 892	37 772
Non-health expenditure (R million)				4 939	6 214	6 193
Of which: Administration fees (R million)				3 104	4 110	4 331
Benefits+ non-health expend (R million)				38 675	42 105	43 965
Operating surplus				-1 293	198	1 205
Nett profit (includes investment income)				236	1 687	2 649
Accumulated funds (R million)				7 578	8 143	10 182

Conclusions

There has been a substantial increase in real funding of health services over the decade. However, given population growth of 7 million, per capita funding is similar to 1995 levels, and lower than its peak in the 1990s. Further, some of the gains in health sector funding may well have been eroded by high medical inflation and wage increases. Also, given that the HIV/AIDS epidemic is estimated to cost around R6 billion per year, this suggests that the sector is not optimally funded. Still, the period of real and projected increases of R6 billion starting in 2001/02 is likely to be more sustainable than the increases associated with rapid wage growth in the 1996-97 period because of the improved debt position and macroeconomic stability, compared to the late 1990s.

The sector is also better positioned now in terms of a more equitable interprovincial funding distribution, though some of this is undoubtedly linked to population movements into better resourced provinces as revealed by the 2001 census. It is vital to confirm available data on public sector dependence by province as this is critical to discussions of equity. Nevertheless, there is clearly a more efficient distribution of funds across levels of care, a recovery of capital financing and some improved efficiencies in patterns of care such as shortened length of stay in hospitals. It is likely that further improvement in efficiency is required to improve quality and extend coverage. Problems include the financing implications of HIV/AIDS, higher average wages and shortages of skilled professionals. Further, to achieve the provision of a PHC package across the country attention will need to be paid to intra-provincial inequities and a review of funding requirements.

Finally, the private sector has expanded rapidly, but with rampant cost escalation. This is making medical scheme cover increasingly unaffordable to lower income earners and social health insurance more difficult to achieve. This suggests the transition path to these policy objectives must include measures to make medical scheme coverage more affordable and sustainable.

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Commentary

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My perspective arises from my roles over the last decade, inter alia as a clinician in public service, a rural medical superintendent, an academic, a researcher and an activist for rural health.

Amongst other things, this decade saw the birth of the Rural Doctors Association of Southern Africa (RuDASA), which has played an increasingly important role.

There has been significant **progress** in a number of areas.

Integration of the health service

Amalgamation of the multitude of different departments of health operating in the public sector into one, essentially unified health service, has been an enormous task which is largely complete. This integration provides a framework within which planning and policy development can take place, referral systems can be worked out and patient care can be efficiently and effectively delivered.

The district health system

The establishment of the district health system as the basic building block for the delivery of health care in SA has been important. The system creates the potential for increased community involvement and more accountable health service delivery as well as improved access to care. It has allowed the health service to be built around principles of primary health care. This provides the basis for a much more stable period in the years ahead and a foundation for better service in the future.

Clinic building

The clinic upgrading and building programme throughout the country has established large numbers of new clinics in areas which never had them before. There is no doubt that many people in SA, particularly in rural areas, now have access to clinics who had none before. These clinics have enormous potential to serve as foci for the broad delivery of health care and for community development.

Essential drugs programme

The establishment of the essential drugs programme, with the development of an essential drugs list (EDL), has served to rationalise the use of drugs at district level. While there are challenges making sure these drugs are always available, the principle remains important and the EDL guidelines provide a useful framework for care.

Norms and standards

The development of the Primary Health Care Package of norms and standards for clinics, community level activities and district hospitals is an important foundation for improving the health service. The work that is ongoing in terms of tertiary and secondary hospitals will further add to this. Although there are huge challenges in terms of implementing these norms and standards, they provide a useful basis for planning and for improving quality of care.

While there are issues I could highlight in respect of each of these achievements, I will focus on

different aspects in terms of five **challenges** in the next decade. I have deliberately chosen not to include the single major challenge, i.e. HIV/AIDS, because it underlies all others.

Equity

The biggest challenge, I believe, is successfully achieving one of the foundational principles of the district health system i.e. equity. The difference in access to affordable, acceptable and appropriate health care for people in rural areas compared to urban areas remains very significant. This will continue to be a major problem until a clear strategy has been put in place for developing rural health care. The area which highlights this most starkly is the implementation of the ARV roll-out plan. Under the current plan, I cannot see any way in which rural people living with AIDS will not be disadvantaged compared to their urban counterparts. The success of the ARV roll-out will be measured by the extent to which people living in remote rural areas are able to access ARVs.

“The difference in access to affordable, acceptable and appropriate health care for people in rural areas compared to urban areas remains very significant.”

Commentary

Ian Couper – Professor of Rural Health, University of the Witwatersrand

Rural workforce shortages

This underlies the equity challenge. Despite some attempts by the Department of Health, the situation in rural hospitals in terms of health professional staffing has continued to deteriorate and we are in a worse position now than we were ten years ago. Rural hospitals have lurched from one crisis to another, often kept going only by short-term stop-gap measures such as community service professionals and Cuban doctors. The backbone of long term senior staff, whether local or expatriate, has steadily decreased. This problem is not only in terms of doctors but also very significantly amongst professional nurses - a new problem in the last decade. Rural allowances may help but will not solve the problem. The challenge is to develop a clear, long term strategy that focuses on education and training on the one hand and also on recruitment and retention of health professionals, particularly doctors, on the other. In terms of nurses, restoring training to district hospitals and reversing the centralisation trend could also make a difference.

Bureaucratisation of the Health Service

There are increasing numbers of managers at all levels within the health service, with resulting over-management, yet there is a lack of leadership with vision to take the service forward into the new decade, and it is difficult to attract and retain skilled managers. For many reasons, including the negative attitude of doctors towards management and the shortage of doctors, management structures have less and less input from clinicians. Often the focus of management is on numbers and statistics rather than on quality of care, and on budgets rather than who is available to deliver health care and whether patients are getting appropriate assistance. The challenge is to turn these around and to change the focus.

Quality of Care

There has been a very important focus on increased delivery of care to increased numbers of people. The challenge now

is to ensure that the care delivered is of a good quality. Good concepts such as Batho Pele and the Patients' Rights Charter need to be implemented in practice rather than being restricted to fine sentiments on posters decorating offices. An attitude of care, concern and courtesy towards patients in the public health service is sorely lacking. The delivery of standardised, high quality and patient-centred health care, based on evidence, is desperately needed in our health service.

Educational Initiatives

In order to meet some of these challenges, the importance of training health professionals, and particularly medical practitioners, in community based PHC is increasing. There are moves to do this more, but the Faculties of Health Science are very slow to change. One of the factors that makes change difficult is that there is not specific budgetary provision from the Department of Education to do this. Community based medical education (CBME) is more expensive than the traditional form, because students need transport, accommodation, supervision etc. If CBME is indeed the goal of the DoH, as it should be, there needs to be a clear agreement between the DoH, the Department of Education and the Treasury to ensure it is specifically funded, and incentives must be built into health professional education programmes so that medical schools are encouraged towards this model.

Ultimately, the biggest challenge is ensuring the implementation of many of the good policies already developed by the DoH in the decade ahead. Getting alongside health professionals to make sure they contribute to this implementation is part of the challenge.

“There has been a very important focus on increased delivery of care to increased numbers of people. The challenge now is to ensure that the care delivered is of a good quality.”

A personal reflection on 10 years of health care transformation: achievements and challenges ahead