

ABSTRACT

Public sector health care funding continues to stabilise, with provincial expenditure growing by 5.6% annually above inflation (i.e. real terms) from 2002/03 to 2008/09. The main areas which have benefited from funding growth are primary health care (8.5% annually), HIV and related illnesses (30.1%), infrastructure (14.3%) and emergency medical services (14.3% annually). With the exception of capital expenditure, hospital funding, particularly for central hospitals, has been constrained for a decade. Spending in under-resourced provinces such as Limpopo and Mpumalanga is growing strongly.

Improved funding has supported an increase in primary care visits by 20 million since 2000 and public sector health personnel numbers have recovered by almost 20 000 over the past two years to reach 235 000. However despite various funding, service and public health improvements, mortality is increasing largely driven by the HIV epidemic and resultant TB. Greater attention to improving effectiveness and outcomes is required.

Private medical scheme beneficiary numbers increased marginally, by 2.7% in 2005. This is associated with lower than usual contribution increases, given the high solvency margins that have now been achieved by schemes.

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INTRODUCTION

South Africa's health care financing system is characterised by a public sector, financed through general tax revenue, and a private system dominated by medical schemes covering 15% of the population. In 2006, South Africa (SA) will see approximately R135 billion or 8% of Gross Domestic Product (GDP) flowing through health sector financing intermediaries, an intermediary step in the financing pathway such as medical schemes and provincial Departments of Health (DoH), which lie between financing sources (e.g. households, employers) and expenditure areas (doctors, clinics). Of this R59 billion will flow through public sector intermediaries (44%) and the remaining R75 billion through private financing intermediaries, of which about R59 billion will go through medical schemes.^a Out of pocket expenditure and use of private out-of-hospital services by households is substantial but perhaps the least well quantified form of financing and was estimated in the National Health Accounts report to comprise 30% of funding flowing through private financing intermediaries.¹

The inequities which result from the coexistence of the public and private health systems in SA are a matter of policy concern. The Draft Health Charter released by the DoH in 2005 states that the "most significant challenge facing the South African health system is to address the inefficient and inequitable distribution of resources between the public and private health sectors relative to the population served by each".²

The public health system provides virtually universal coverage i.e. all citizens are entitled to use, service points are widely distributed and primary health care services are free at the point of service. There are over 4000 public health facilities and the public health sector employs 235 000 personnel. Health services are a basic constitutional right and access appears reasonably good with rising PHC utilisation and hospital utilisation rates fairly comparable with similar income countries. However quality of care is sometimes sub-optimal, public facilities often have long waiting times and primary care facilities tend to have few doctors.

The private health sector provides expensive but relatively high quality services to a minority of the

population. The high cost of medical schemes and private hospitals significantly limit access. However the fact that the majority (55.6%)^a of funds flow through private funding streams, also attracting skilled health personnel from the public sector, has stimulated an engaging debate on the potential for social health insurance to be a redistributive mechanism to improve equity.

Several years of strengthening public budgets has enabled progress in a range of programmes critical to public health including extension of basic income protection through social assistance grants (especially for child support, pensions and disability) to over eleven million persons, universal primary and improving progress through secondary education and substantive water supply, electrification and housing construction programmes.

However despite a number of significant positive financial, fiscal, service delivery and public health developments, health status is being substantially undermined by the effects of the maturing HIV epidemic and its effects on mortality, tuberculosis and other diseases. This poses a huge challenge to accelerate a wide set of interventions against HIV at the same time as strongly pursuing a broad developmental agenda.

This chapter draws on the latest primary and secondary data available in data-bases and publications of the National Treasury and Council for Medical Schemes to analyse recent health sector financing trends. The data draw significantly on over a decade of publications of the Intergovernmental Fiscal Review, Budget Review and Estimates of National Expenditure series by the National Treasury covering the period 1995/96 to 2008/09 and Annual Reports of the Council for Medical Schemes. In particular this chapter draws substantially on the most recent 2006 publications from these series.^{3,4} The Treasury data series are drawn in turn, from published budget statements of the nine provinces for current and future budgets, audited financial statements for past expenditure and pre-audited financial statements for 2005/06. A standardised budget programme and sub-programme structure has been adopted by provincial DoH as well as a standard charter of accounts, which facilitates

^a Calculation by the authors based on wide range of latest data sources available to National Treasury and Council for Medical Schemes.



TABLE 1:
Comparative analysis of health expenditure in middle income countries

	US\$ GDP per capita	Government expenditure on health / GDP %	Population	Total expenditure on health as % of GDP	Government expenditure on health as % of total expenditure on health	General government expenditure on health as % of total government expenditure	Per capita government expenditure on health (US\$)	Per capita government expenditure on health at International dollar IS rate
Colombia	1 816	6.4	44 915	7.6	84.1	20.5	116	439
Cuba	2 890	6.3	11 245	7.3	86.8	11.2	183	218
Turkey	3 382	5.4	72 220	7.6	71.6	13.9	184	378
Poland	5 446	4.5	38 559	6.5	69.9	9.8	248	521
Namibia	2 266	4.5	2 009	6.4	70.0	12.4	101	252
Argentina	3 427	4.3	38 372	8.9	48.6	14.7	148	518
Romania	2 607	3.8	21 790	6.1	62.9	10.9	100	340
Brazil	2 789	3.4	183 913	7.6	45.3	10.3	96	270
Algeria	2 171	3.3	32 358	4.1	80.8	10.0	71	150
Russian Federation	2 982	3.3	143 899	5.6	59.0	9.3	98	325
Botswana	4 143	3.3	1 769	5.6	58.2	7.5	135	218
South Africa	3 512	3.2	47 208	8.4	38.6	10.2	114	258
Iran	2 015	3.1	68 803	6.5	47.3	10.3	62	235
Chile	4 623	3.0	16 124	6.1	48.8	12.7	137	345
Mexico	6 000	2.9	105 699	6.2	46.4	11.7	172	270
Mauritius	4 649	2.2	1 233	3.7	60.8	9.2	105	261
Malaysia	4 289	2.2	24 894	3.8	58.2	6.9	95	218
Guatemala	2 074	2.1	12 295	5.4	39.7	15.3	44	93
Peru	2 227	2.1	27 562	4.4	48.3	10.7	47	112
Thailand	2 303	2.0	63 694	3.3	61.6	13.6	47	160
Kazakhstan	2 086	2.0	14 839	3.5	57.3	9.0	42	180
Venezuela	3 244	2.0	26 282	4.5	44.3	6.4	65	102
Ecuador	2 137	2.0	13 040	5.1	38.6	8.7	42	85
Total	3 257	3.4	999 682	6.4	54.1	11.0	112	N/A
Median	2 936	3.2		5.7	58.6	10.3	103	256

Source: World Health Organization, 2006.⁵

comparisons across provinces and compilation of a national picture of programme expenditure. Population data are drawn from Statistics South Africa's census and General Household Survey series adjusted for insurance coverage. The data presented in this chapter are drawn from overall data-bases compiled from the abovementioned sources and will not be separately sourced throughout the chapter. Expenditure numbers are presented in nominal prices except where specifically labelled as real or real 2005/06 prices.

INTERNATIONAL COMPARISON

South Africa's per capita GDP locates it firmly in the centre of the middle income country group. Table 1 compares health expenditure in SA against other countries in this group. The data have been drawn from the latest World Health Report using countries with income levels comparable to SA and either population above 10 million or located in the southern African region. In the table, countries are ordered in terms of government spending on health as a proportion of GDP. The data show that SA is very average in terms of this parameter (3.2%), the proportion of government expenditure spent on health and on spending on health care in US dollar and international dollar terms (i.e. adjusted for purchasing power parity). However, SA is

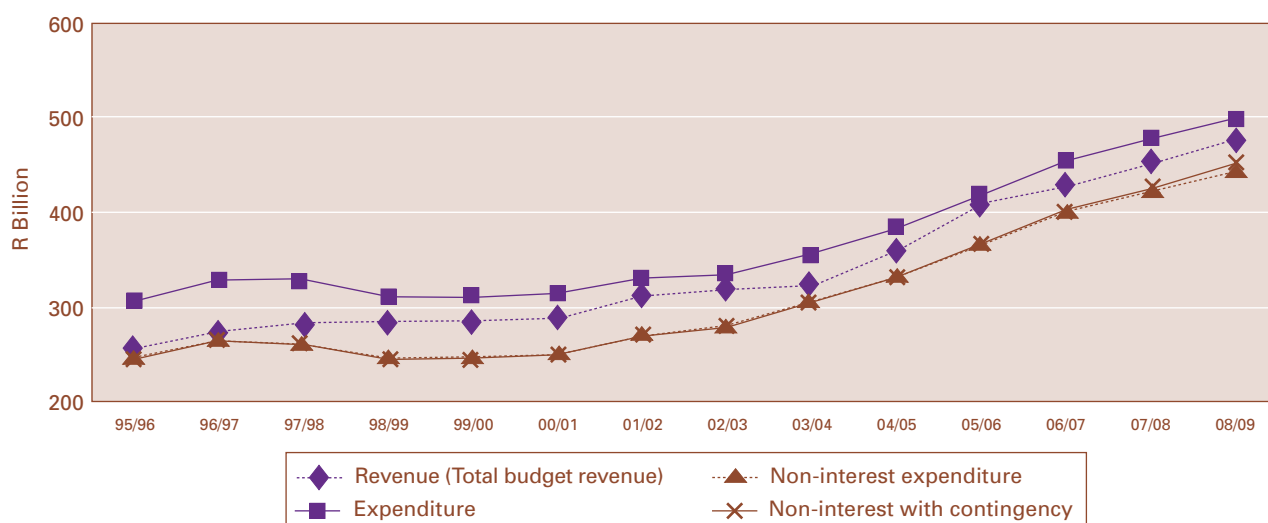
second highest (after Argentina) on total expenditure on health service because of high levels of private expenditure. Although public health spending in SA is comparable with other middle income countries, there is some evidence that its large private sector causes the country to have relatively high unit costs. See Table 1.

PUBLIC SECTOR FINANCING TRENDS

FISCAL TRENDS

The 2006 budget was framed in a context of fiscal stability, strong revenue performance, positive economic growth and the beginning of an encouraging turnaround in employment growth. Strong fiscal growth is shown in Figure 1 demonstrating an increase of total public expenditure (main budget, all sectors) by almost R200 billion since 2000/01. The lines in Figure 1 depict total government revenue, expenditure, expenditure less interest payments on national debt and including the unallocated contingency reserve. The main budget consists of funds allocated by the national government to the national, provincial and local spheres and excludes their own revenue and social security funds such as the Unemployment Insurance Fund.

FIGURE 1:
Fiscal trends: total government revenue and expenditure* (Main budget Rand billion real 2005/06 prices)



Source: National Treasury – drawn mainly from Budget Review series.⁶

* Figure 1 depicts total government revenue, expenditure, non-interest expenditure with and without the contingency reserve in the main budget.



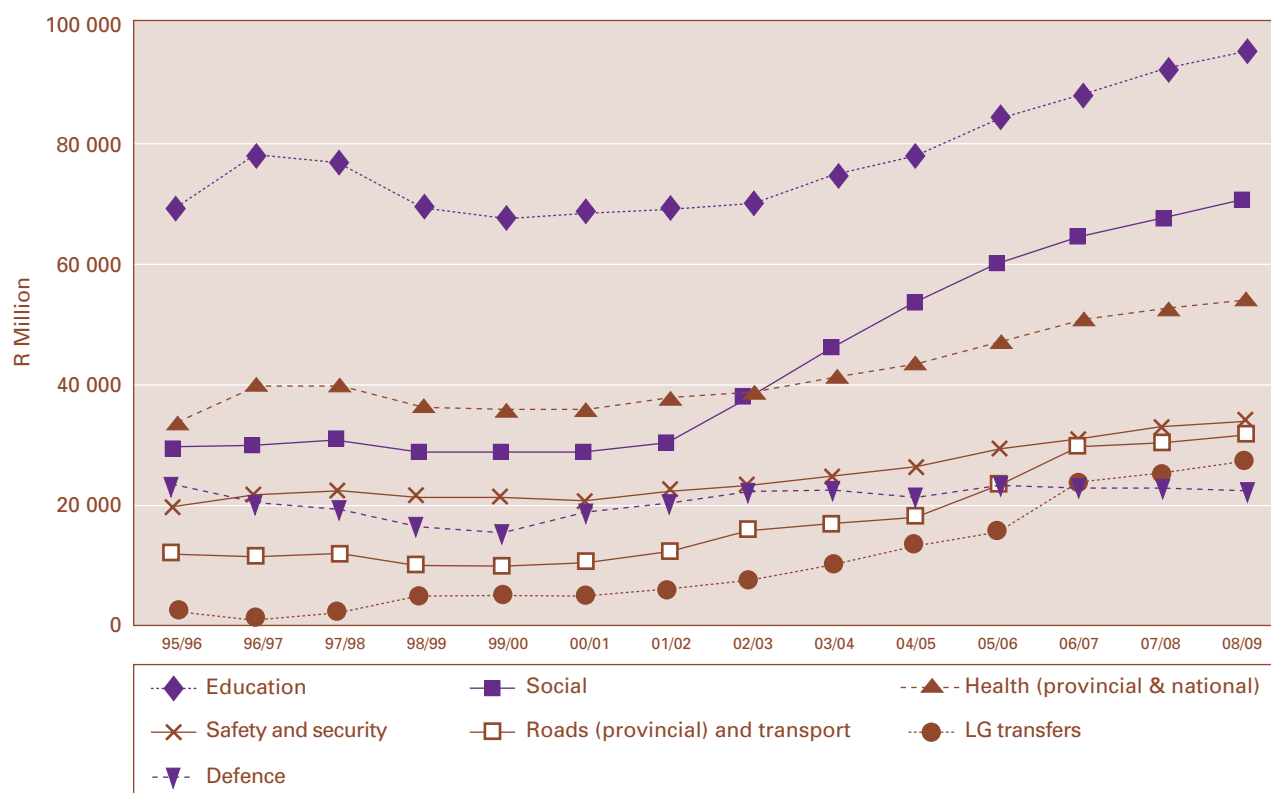
Figure 1 shows that expenditure dipped significantly after 1996. The resource envelope for spending was constrained in the late 1990s associated with a macro-economic policy of fiscal constraint, partly aimed at reducing the national debt burden and because of low economic growth partly linked to the Asian economic crisis. This dip reflected an impact on funds available for spending on social services including health care.

However the period since 2000/01 has seen a series of more expansionary budgets under-pinned by a higher tax to GDP ratio, improved revenue collection, lower debt payments, a more sustainable fiscal position and emphasis on addressing a range of spending needs.

EXPENDITURE BY GOVERNMENT

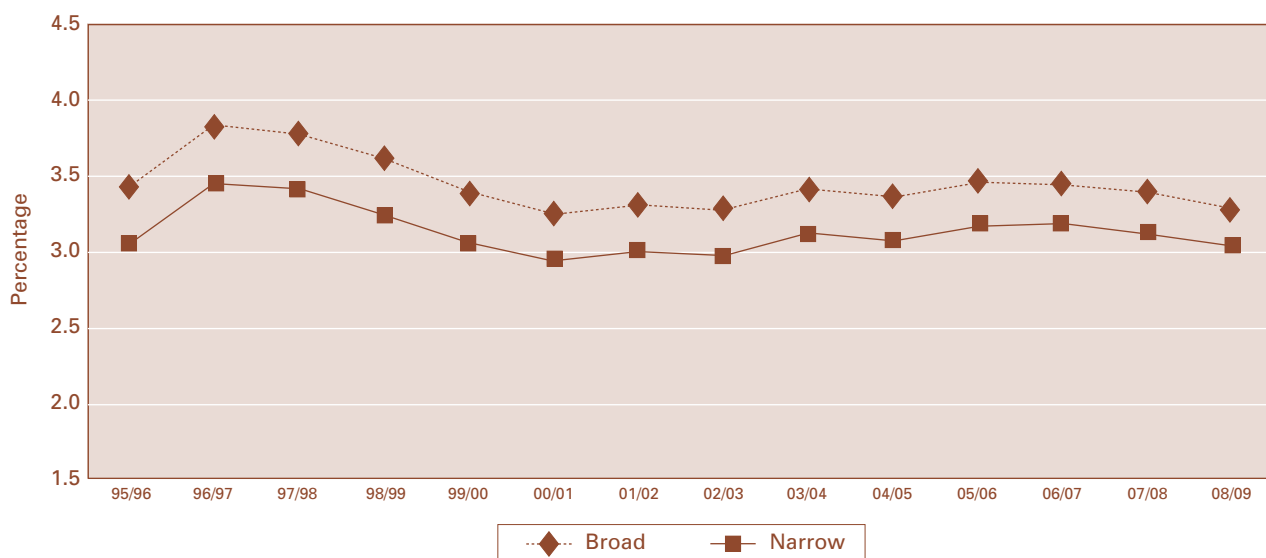
The more positive fiscal climate and expansionary fiscal stance has enabled spending increases in many areas of public expenditure. Figure 2 shows spending across the seven largest areas and demonstrates particularly strong growth in social security expenditure and on local government. Education is the largest spending area of government and social grant expenditure has been the area of greatest funding growth in the first decade of democracy, overtaking health services. Health services are shown as the third largest function. Figure 2 shows growth of public health expenditure by over R15 billion over the past decade. Increases in spending on basic income security, education, local government, water and sanitation are important for public health.

FIGURE 2:
Expenditure trends across major government sectors (Rand million real 2005/06 prices)



Source: National Treasury based mainly on Treasury data-bases and Intergovernmental Fiscal Review³ and Estimates of National Expenditure⁷ series.

FIGURE 3:
Public health spending as a proportion of GDP^{b,c}



Source: National Treasury.

PUBLIC HEALTH CARE EXPENDITURE

This strong overall fiscal position of government has enabled public sector health care funding to recover significantly since the declines in the late 1990s. Expenditure is growing fairly strongly in real terms and will amount to R59 billion in 2006/07 of which R51.7 billion will be by provincial DoH. Funding growth is particularly strong in previously disadvantaged provinces reflecting equity improvements. Funding for primary health care services, capital, medicines and HIV has grown strongly. Personnel numbers in the health sector have recovered by 20 000 over the past two years and are likely to reach new peaks in 2006/07 (see section on personnel spending below).

Figure 3 shows trends in health care expenditure in the public sector. Public health expenditure has remained fairly constant around 3% or 3.3% as a proportion of GDP.

Although public health expenditure is growing fairly strongly (Figure 2) its share on total government non-interest expenditure declines from 14% to 12.2% over the period from 2002/03 to 2008/09, mainly driven by strong growth in social grant expenditure (Figure 4).

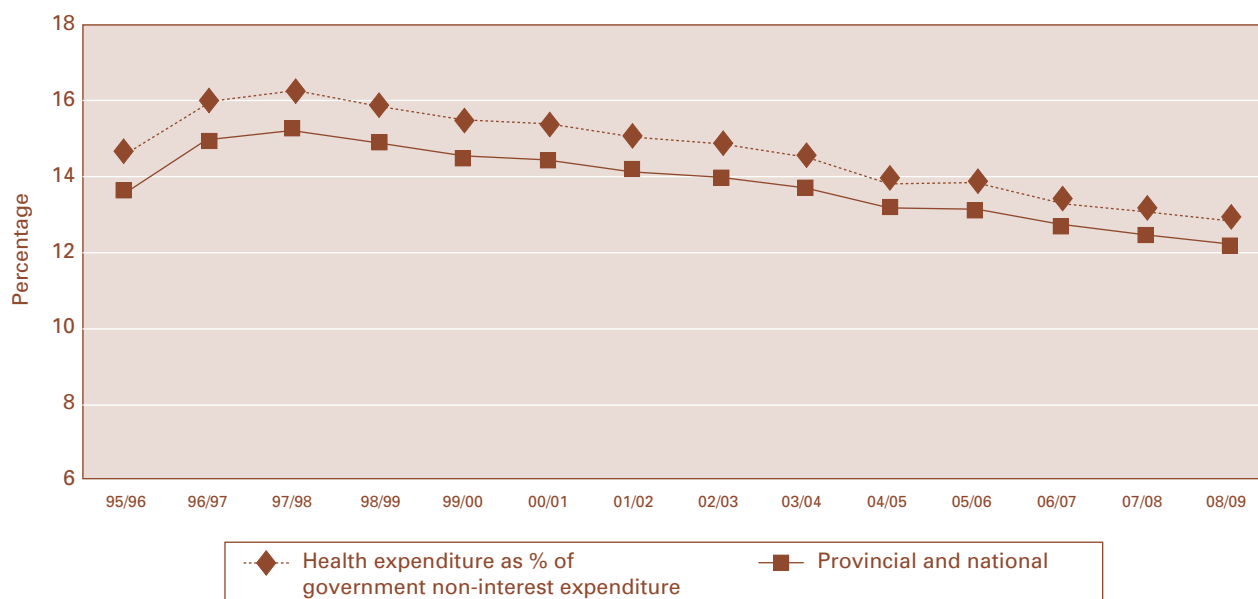
Spending increased sharply following the large public sector wage increases of 1996, which in retrospect appear to have been unsustainable in the context of the fiscal constraints of the late 1990s.

b Defined narrowly here as expenditure by the provincial and national DoH.

c Using a broader definition (which includes local government, other departments and social security funds)



FIGURE 4:
Health expenditure as a proportion of total government non-interest expenditure



Source: National Treasury.

Health budgets declined in the late 1990s in a period of fiscal and debt restructuring and low economic growth. The more expansionary phase of fiscal policy commenced in 2000/01 and provincial health expenditure began recovering from then surpassing previous (real) peaks by 2003/04 (Figure 2). However given population growth, per capita expenditure (excluding uninsured persons) has exceeded past peaks only from 2005/06 onwards (Figure 5).

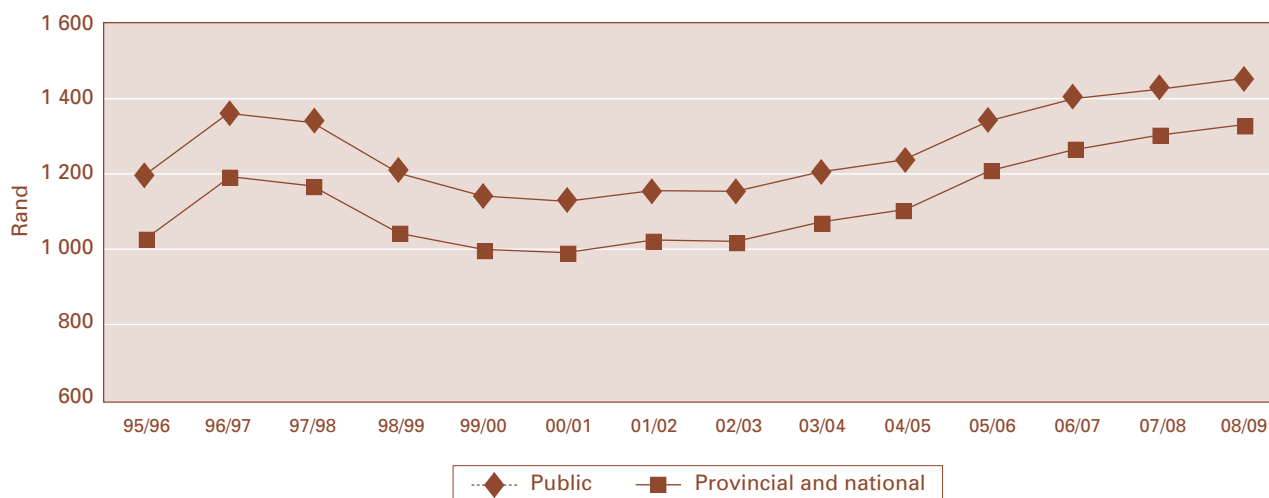
POLICY FRAMEWORK FOR 2006/07 BUDGET

In the budget process, key policy imperatives are raised within the context of sectoral MinMECs (national Minister and provincial Members of the Executive Councils), 10 by 10 meetings between sectors and national and provincial treasuries, the Budget Council (Minister of Finance and provincial Treasuries), the Medium term expenditure committee (Treasury technical committee which evaluates budget bids), the Ministers Committee on Budget (Minister of Finance and other national Ministers), Cabinet and various Parliamentary Committees.

In Budget 2006, which covers the three year Medium Term Expenditure Framework (MTEF) period to 2008/09, key priorities included:

- ◆ Stepping up the Hospital Revitalisation programme to include more hospitals into this large capital upgrading and rebuilding programme. This programme was initiated following the National Health Facilities audit which found large backlogs in health infrastructure. The programme focuses on the upgrading or rebuilding of whole hospitals. These are expensive projects which provinces would find difficult to undertake without national support.
- ◆ Strengthening primary health care (PHC) services. PHC is seen as the key entry point to the health system and areas of focus include addressing gaps in the delivery of a core PHC package, upgrading selected clinics to community health centres, increasing doctor support for clinics and operating gateway clinics within in the proximity of hospitals.
- ◆ Boosting the numbers of professional health workers. This was a key recommendation of the National Human Resources for Health Plan which envisaged employing an additional 30 000 health workers over five years.⁸

FIGURE 5:
Real per capita provincial health funding (05/06 prices)



Source: National Treasury.

- ◆ Implementation of improved national emergency medical (ambulance) service model with shorter response times. The new model envisages response times of under 15 minutes in urban areas and 45 minutes in rural areas and focuses on improved communication systems, improved location of ambulances for shorter response times, two-person ambulance crews, improved training and an ongoing vehicle replacement programme.
- ◆ Support for initiating community health worker programmes as part of the Extended Public Works programme. The national policy on community health workers has placed renewed emphasis on the role of this cadre in the health system and is consistent with the employment creation focus of the Extended Public Works Programme.
- ◆ Initiation of early phases of the Modernisation of Tertiary Services programme. The Modernisation of Tertiary Services Report developed in collaboration with over forty specialist sub-groups provides a costed model for building up regional and tertiary specialist hospital services over the coming decade.
- ◆ Preparation for implementation of the Risk Equalisation Fund (REF) which will level the playing fields across private medical schemes. This is the next step in a series of industry reforms which aim to achieve community rating, greater equity and solidarity across schemes and for schemes to

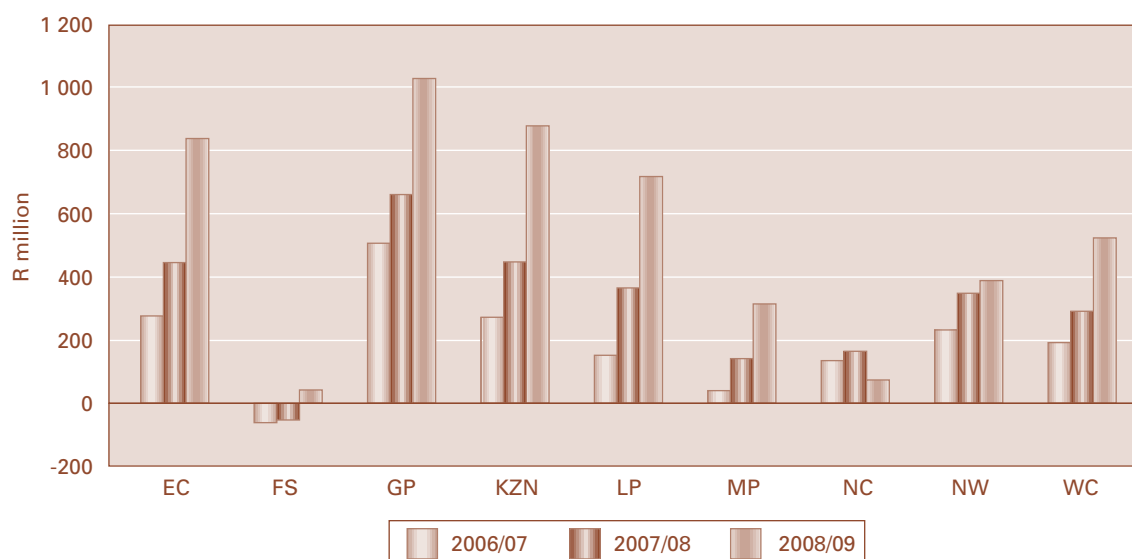
compete on the basis of efficiency as opposed to cream skimming. The REF is discussed further in a later section.

- ◆ Transfer of Forensic Pathology services from the South African Police to provincial Departments of Health and strengthening these services. This follows a Cabinet decision to transfer these services to Health Departments given that the function is provided mainly by health workers e.g. forensic pathologists and that the health sector already operates a set of facilities in hospitals for post-mortem examination and to avoid possible conflicts of interest.

In order to deliver on these and other priorities, amounts of R1.7 billion, R2.7 billion and R4.7 billion were added to provincial budget baselines as part of Budget 2006. This is shown in Figure 6. The Free State province is the only province to receive a lower budget than previously published. This happened mainly because of its low spending on infrastructure grants which resulted in a re-allocation towards other provinces.



FIGURE 6:
Additions to budget baselines Budget 2006



Source: National Treasury.

PROVINCIAL HEALTH SPENDING

Table 2 shows the provincial health expenditure and budget trends. Numbers are shown in nominal terms but the table also shows real changes in 2005/06 prices. The figures for 2005/06 are final pre-audited figures and thus differ slightly from provincial budget statements, which are compiled before the end of the financial year. Figures for 2006/07 are budgeted amounts (prior to rollovers and adjustments). The data show a recovery of health funding by R13.7 billion in real terms over this period, with funding rising to R60.6 billion in 2008/09 or an annualised real increase of 5.6%. The total annual increase is 5.7% in 2006/07 and averages 4.2% over the three years to 2008/09.

Longer term funding trends from 1995/96 to 2008/09 were shown in Figure 2 in real 2005/06 prices. Over the long term, real funding increases have amounted to 3.8% per annum. However this figure is somewhat distorted by the large wage increases of 1996, and over the period from 1996/97 to 2008/09 annual increases have averaged 2.8%.

In 2006/07 the budgets of Northern Cape (12.8%), North West (11.2%), Limpopo (9.2%) and Eastern Cape (8%) rise strongly in real terms, whereas those of Gauteng (0.1%) and Free State (0.6%) hardly increase compared to final 2005/06 expenditure.

Table 3 shows provincial expenditure expressed in terms of spending per capita uninsured person over the period from 2002/03 to 2008/09. Figure 3 shows the same data but over a longer time-span since 1995/96. Conditional grant spending is included and analysis excluding grants is presented in a later section. The data show that Western Cape is the best funded province at R1 827 per capita for public sector health services and has grown at an annual real rate of 5.1% over the period. All provinces will exceed R1 000 per capita by the end of the MTEF period, with the lowest being North West at R1 151 per capita in 2008/09, despite annual real growth of 6% of a six year period. The highest growth has been in Mpumalanga (7.3% annually) which is recovering strongly and boosting personnel numbers under the leadership of a new management team.

Previously advantaged provinces have been the slowest to recover, with Gauteng, Western Cape and Free State only now recovering to past peaks whereas several previously disadvantaged provinces have seen real funding growth exceeding population growth. Gauteng's health budget declined rapidly in real per capita terms in the late 1990s from levels which it has not yet achieved again despite a significant budget boost in 2005/06. Its growth is the lowest of all provinces over the period (2.4%). This is a result both of prioritisation

TABLE 2:

Provincial health expenditure and budget trends (Rand million)

Rand million	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Real change 02/03-08/09	% annual Real growth 02/03-08/09
Eastern Cape	4 493	5 242	5 173	6 122	6 893	7 658	8 412	2 043	6.2
Free State	2 194	2 563	2 797	3 099	3 250	3 470	3 736	698	4.5
Gauteng	7 688	8 190	8 597	9 973	10 404	11 011	11 900	1 484	2.8
KwaZulu-Natal	7 535	8 243	8 950	10 517	11 737	12 796	13 841	3 210	5.8
Limpopo	3 166	3 724	4 196	4 790	5 448	5 912	6 543	1 936	7.9
Mpumalanga	1 688	2 007	2 263	2 664	2 912	3 194	3 520	1 057	8.1
Northern Cape	609	833	832	1 098	1 291	1 401	1 373	465	9.5
North West	2 012	2 263	2 595	2 957	3 428	3 778	3 988	1 093	7.2
Western Cape	3 984	4 597	5 172	5 707	6 323	6 774	7 333	1 710	5.9
Total	33 370	37 662	40 575	46 928	51 686	55 993	60 647	13 696	5.6

Source: National Treasury provincial data-base 2006.

processes within each province, national changes to conditional grants and the equitable share formula and rapid urbanisation stagnating medical scheme coverage has contributed to a larger population being dependant on the public sector, particularly for hospital care.

TABLE 3:

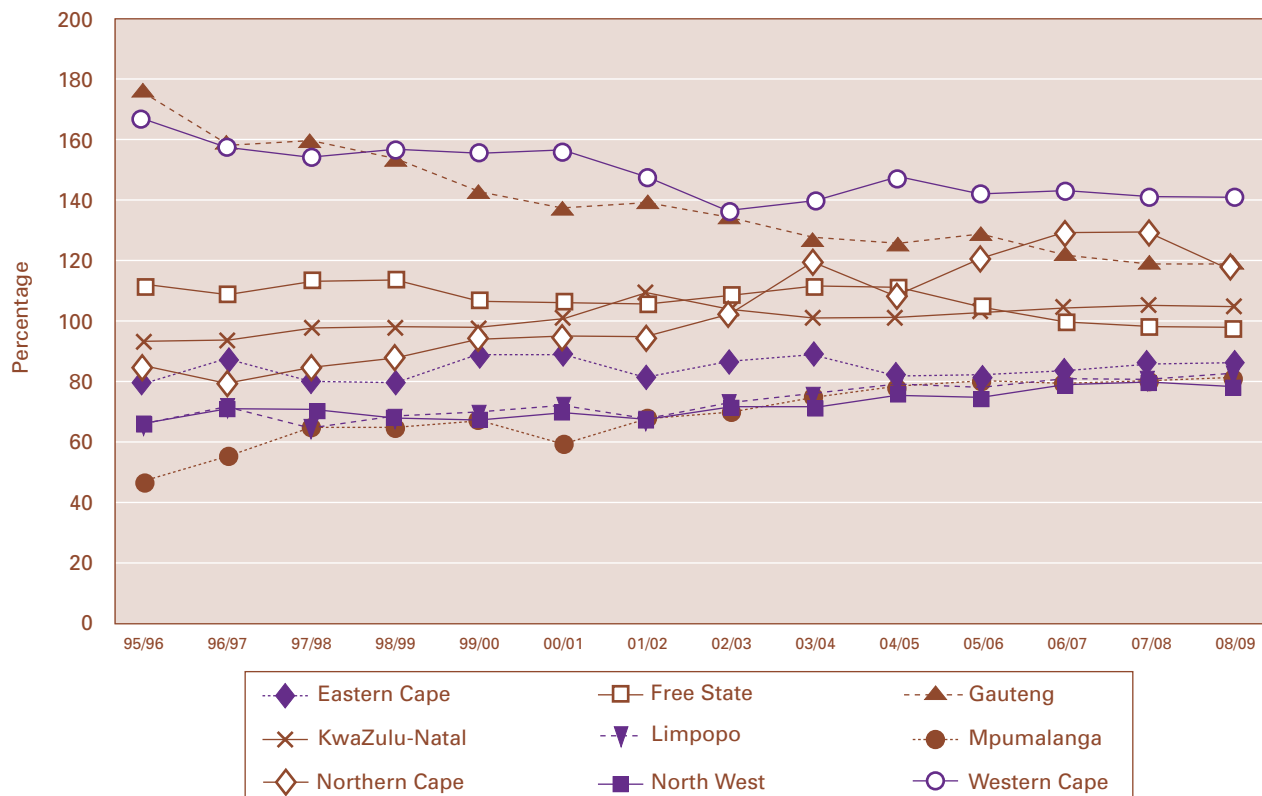
Per capita health funding trends (Rand per capita)

Rand million	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Real annual growth 02/03-08/09 %
Eastern Cape	748	851	827	955	1 066	1 175	1 280	4.6
Free State	938	1 069	1 133	1 229	1 276	1 354	1 446	2.8
Gauteng	1 161	1 218	1 287	1 508	1 561	1 638	1 756	2.4
KwaZulu-Natal	898	967	1 029	1 206	1 335	1 444	1 549	4.7
Limpopo	629	720	808	914	1 031	1 110	1 218	6.8
Mpumalanga	603	715	798	935	1 014	1 103	1 206	7.3
Northern Cape	885	1 144	1 103	1 417	1 652	1 778	1 728	6.9
North West	619	686	772	875	1 006	1 099	1 151	6.0
Western Cape	1 183	1 340	1 506	1 666	1 831	1 946	2 089	5.1
Total	867	960	1 023	1 175	1 284	1 379	1 482	4.5

Source: National Treasury.



FIGURE 7:
Per capita funding as a percentage of the national average by province (05/06 prices)



Source: National Treasury.

Figure 7 shows convergence of per capita funding levels across provinces, a sign of improving equity. These changes result both from more equitable national allocation formulae for the provincial equitable share formula and conditional grants and from increasing prioritisation of health care in previously disadvantaged provinces such as Limpopo and Mpumalanga.

Table 4 examines the reported concern that budget growth has largely been in the area of conditional grants and that unconditional expenditure is being squeezed out. It shows that provincial health budgets excluding conditional grants are in the main growing reasonably strongly.

TABLE 4:
Provincial health funding excluding conditional grants (R million)

Rand million	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Real change 02/03-08/09	% annual Real change
Eastern Cape	4 097	4 650	4 545	5 234	5 988	6 693	7 404	1 782	5.5
Free State	1 739	1 996	2 177	2 371	2 470	2 661	2 890	535	4.0
Gauteng	5 186	5 638	5 988	7 334	7 327	7 693	8 225	1 254	3.2
KwaZulu-Natal	5 906	7 115	7 741	9 134	10 136	10 998	11 835	3 586	7.3
Limpopo	2 754	3 353	3 877	4 403	5 041	5 471	6 104	2 184	9.2
Mpumalanga	1 498	1 763	2 036	2 388	2 612	2 853	3 188	1 072	8.4
Northern Cape	509	671	653	825	752	822	903	206	5.2
North West	1 808	2 013	2 327	2 611	2 933	3 278	3 475	969	6.6
Western Cape	2 517	3 048	3 576	4 081	4 394	4 803	5 280	1 734	8.2
Total	26 015	30 248	32 920	38 383	41 653	45 272	49 304	13 323	6.4

Source: National Treasury.

Table 5 examines equity in interprovincial funding excluding conditional grants by presenting trends in per capita funding as a proportion of the national average. This shows considerable improvement in the position of Mpumalanga, Limpopo and North West, with only North West falling below 90% of the average by the end of this MTEF period.

TABLE 5:
Per capita funding excluding conditional grants as a proportion of the national average

	2001/02 %	2005/06 %	2008/09 %
Eastern Cape	95.3	84.9	93.5
Free State	104.9	97.8	92.8
Gauteng	114.2	115.4	100.7
KwaZulu-Natal	115.5	109.0	110.0
Limpopo	76.4	87.4	94.3
Mpumalanga	77.2	87.2	90.6
Northern Cape	100.5	110.8	94.4
North West	78.4	80.4	83.3
Western Cape	116.0	124.0	124.9
Total	100.0	100.0	100.0

Source: National Treasury.

Under-spending has been a problem in provincial DoH for several years mainly in capex^d and conditional grants, but the situation improved substantially in 2005/06, with the exception of Limpopo province, which under-spent by R310 million (Table 6). Improvement in Mpumalanga and North West is especially noted. Year-on year expenditure increases have been strong across the board. Changes in spending appear related to management capacity. For example, a stronger management team in Mpumalanga has substantially turned around under-spending and filled more than 2500 posts over two years. Under-spending in Limpopo may have been related to rapid turnover and instability in senior management in 2005/06.

d Short for capital expenditure.



TABLE 6:
Under-spending 2004/05 and 2005/06

R million	2004/05	2005/06
Eastern Cape	29	106
Gauteng	357	
Limpopo	65	310
Mpumalanga	127	
Northern Cape	35	
North West	67	19
Western Cape		58
Total	680	493

Source: National Treasury.

PROVINCIAL BUDGETS 2006/07

This section briefly describes the nine provincial health budgets of Budget 2006. Overall provincial budgets grew strongly by 5.7% real in 2006/07. Examination of provincial budgets suggests allocations in some areas may be too large to absorb while other areas of the service may be at risk of under-funding.

After declining in 2004/05, the Eastern Cape health budget recovered substantially in 2005/06 (13.6% real) as overall provincial finances stabilised and continues to grow (8% real) in 2006/07. Beneficiaries include the Emergency Medical Services (ambulance) budget which grows massively, HIV, primary health care and capital programmes. Apparent reductions in district hospitals funding is an area of risk.

The Free State Health budget increases by a mere 0.6% in real terms in 2006/07 and may contain some risk. It is the only budget to have declined from previous baselines. This was partly due to poor capital spending trends which led to funding reductions in the Hospital Revitalisation and Provincial Infrastructure grants, also associated with management change. The budgets of some sub-programmes e.g. tertiary and regional hospitals are areas of risk.

Gauteng, historically the best resourced health department, has experienced declines in real per capita expenditure and personnel numbers over a decade (Figure 7). The 2005/06 year was a watershed with

funding and expenditure recovering by almost R1 billion. Although baseline funding was significantly boosted by the 2006 Budget up to the new expenditure level, forward growth is minimal (0.1%, Table 2). The budget contains increases for HIV, forensic pathology and infrastructure, but funding for large central hospitals declines and may require attention. Capacity to deliver on infrastructure has improved greatly and rapid progress on projects may necessitate in-year upward revisions.

The KwaZulu-Natal DoH has become the largest in the country whose budget will exceed R13 billion by 2008/09. However, it is the province with the largest population and its per capita funding is just above the national average. Spending grew by a massive R1 billion in 2005/06 and grows by a further 7.1% in real terms in 2006/07. Personnel numbers are increasing. Growth is spread across service programmes, with the only risk area being regional hospitals. Its community health worker programmes are the best developed of all provinces.

Expenditure by the Limpopo DoH has increased steadily over recent years (Table 3 and 4) from a low base, with real increases of 9.6% in 2005/06 and 9.2% in 2006/07. This has enabled recruitment of 4 000 additional health workers and development of the health service. Of concern was under-spending of R310 million in 2005/06 associated with management instability. Growth is found throughout the budget programmes, with the exception of regional hospitals.

Mpumalanga's health service is improving significantly under a stronger management team with expenditure increasing by 13% in real terms in 2005/06. Numbers of health workers have been boosted by almost 3 000 over the past two years.

The Northern Cape health service has grown substantially over recent years and is the second best funded province per capita in 2006/07 (Table 3). The improving quality of health service delivery is noticeable. Spending growth was a hefty real 26.7% increase in 2005/06 and continues with 12.8% growth in 2006/07. Over-spending of R60 million occurred in 2005/06 and financial controls probably need to be strengthened. The province has been a major beneficiary of revisions to conditional grants especially

for National Tertiary Services which now constitute a significant proportion of budget. It has managed its capital programmes well, which has led to further national investments in revitalisation projects.

The North West's health budget and service has also strengthened significantly over the past three years, with real growth averaging 8.7% annually over that period and the 2006/07 budget allows for a further 11.2% real increase. Although currently the lowest per capita of all nine provinces, steady growth over recent years has enabled service improvements.

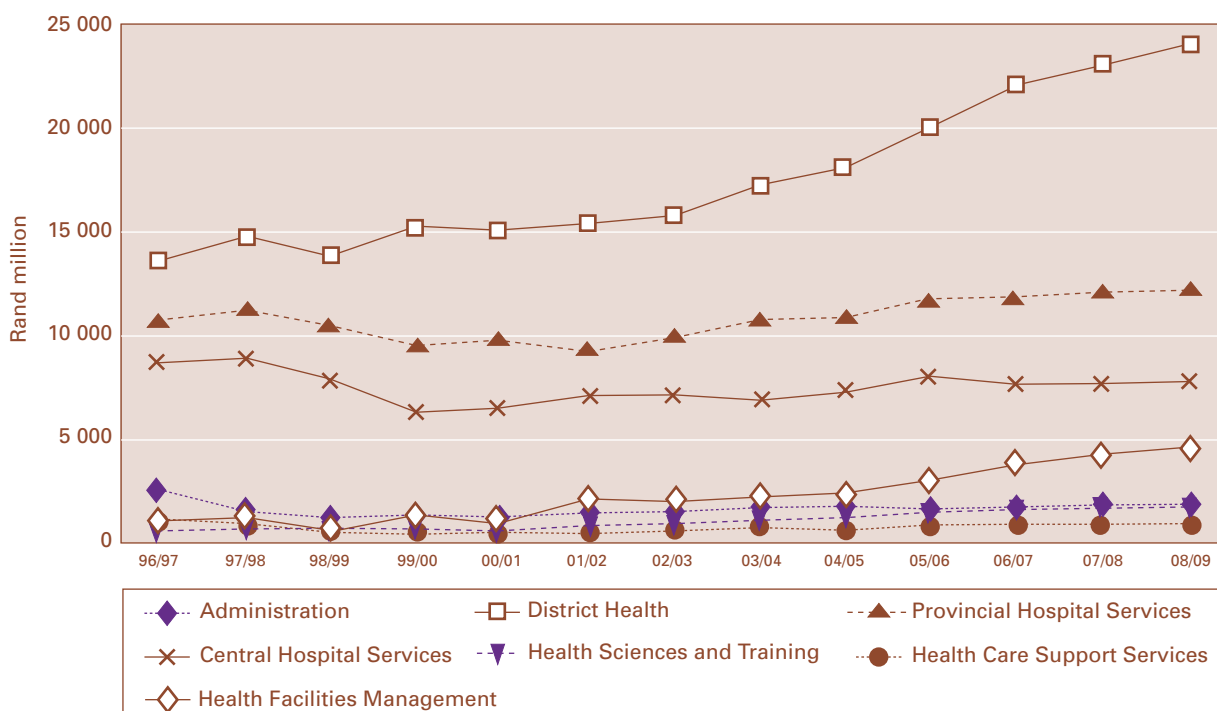
The Western Cape is the best funded health department with funding reaching R2 000 per uninsured person by 2008/09 and provides something of a benchmark. It has the highest doctor density, relatively good performance on a range of indicators and a strong management team. The province downsized by over 8000 health workers in the late 1990s, but funding has stabilised considerably in recent years.

SPENDING BY PROGRAMME

Spending by programme area is shown in Figure 8. Most notable is the location of the large majority of funding growth in the District Health Services and on Health Facilities Management programmes. The first reflects prioritisation of PHC, HIV programmes and Emergency Medical Services, where-as the second reflects increasing attention to upgrading health infrastructure. Notable also is low growth in the hospital programmes over a decade.

Table 7 groups the budget sub-programmes in a somewhat different way to present expenditure by functional area. This shows strong expenditure growth in the areas of health facilities, HIV, PHC and Coroner Services. However expenditure growth on hospitals is low suggesting that provinces have given little attention to the Modernisation of Tertiary Services programme in the 2006 budget.

FIGURE 8:
Expenditure by budget programme (real 2005/06 prices)



Source: National Treasury.



TABLE 7:

Expenditure by functional area

R million	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	Real annual growth 2002/03-2008/09 %
		Outcome		Preliminary outcome	Medium-term estimates			
Hospitals	21 565	23 104	24 976	28 102	28 580	30 343	32 421	2.3
Primary Health Care	5 626	6 478	7 149	8 233	9 468	10 471	11 714	8.1
HIV and AIDS	330	618	1 147	1 692	2 441	2 734	2 960	37.8
Health facilities (Infrastructure)	1 755	2 076	2 243	3 103	3 910	4 593	5 153	14.4
Administration	1 267	1 614	1 706	1 652	1 852	1 991	2 130	4.3
Emergency medical services	913	1 283	1 341	1 758	2 210	2 414	2 643	14.2
Health sciences and training	800	987	1 187	1 495	1 732	1 897	2 051	11.9
Health care support	467	631	608	791	844	883	934	7.3
Coroner services	66	73	82	117	483	490	454	31.9
Nutrition	72	122	159	172	167	177	186	12.1
Total	32 860	36 987	40 599	47 116	51 686	55 993	60 647	5.9

Source: National Treasury provincial data-base 2006.

PRIMARY HEALTH CARE

Primary health care expenditure continues to grow strongly reflecting the national emphasis on meeting basic needs and the centrality of PHC in the national health system. Growth in clinic and community health expenditure is particularly strong. Table 8 shows the basic sub-programmes and demonstrates real growth of R3.7 billion over the period or 8.5% annually. Over the period from 2000/01 to 2005/06 primary care visits have increased from 81 million to 101 million visits per annum or 2.5 visits per capita uninsured with a range from 2.1 in Gauteng to 3.9 in Western Cape – the national target is 3.5. Spending rises to R248 per capita uninsured person by 2008/09 and this excludes local government and district hospitals. Recently a funding target of R300 per capita has been proposed (2003/04 prices).⁹ See Table 8.

Environmental health services (EHS) are a local government function. Progress was made in funding this function in the 2006/07 budget, when for the first time funding for this function has been specifically included as a sub-component in the local government equitable share formula.

Although the National Health Act¹⁰ has provided a legal framework for the responsibilities of provincial and local government respectively in the district health system, in many cases, lack of finality around the local decision as to which will constitute the District Health Authority has impeded progress around service integration and district development.

TABLE 8:
Primary health care expenditure

Rand million	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Real growth 02/03-08/09	Real growth annual %
District Management	910	906	1 024	997	1 029	1 089	1 213	20	5.1
Clinics	3 055	3 009	3 358	3 920	4 589	5 106	5 872	1 640	7.8
Community Health Centres	783	1 681	1 796	2 141	2 313	2 610	2 812	1 563	15.5
Community-based Services	625	592	579	836	948	1 023	1 110	255	7.1
Other Community Services	241	286	424	436	507	546	603	252	10.5
Total	5 614	6 474	7 181	8 330	9 384	10 374	11 611	3 731	8.5

Source: National Treasury provincial data-base 2006.

HIV AND AIDS

Expenditure on dedicated programmes for HIV in Health Departments has grown strongly over the period shown in Table 9 and will amount to R3.5 billion in 2008/09. The conditional grant levels off in 2006/07 and is likely to require review in budget 2007 as treatment and prevention programmes roll-out. Provinces are allocating increasing amounts from their own budgets (besides the grant) for this purpose.^e

While prevention programmes are rolling out widely there is much to be done to improve effectiveness and quality. Access to HIV testing and counselling is becoming widespread, condom usage is increasing and there is some emerging evidence of delayed sexual debut.¹¹ However, various indicators suggest sub-optimal effectiveness of the PMTCT programme and incidence rates of HIV and sexually transmitted infection (STI) are still too high.

The treatment component of Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa (CCMT) has been expanded to 192 sites in all 53 health districts and in more than 170 local municipalities, compared to 139 accredited facilities in 2004/05.¹² From the beginning of the programme in April 2004 to June 2006, over 178 000 patients had started antiretroviral therapy versus estimated need exceeding 400 000.⁷ Deficiencies in existing information systems do not allow for monitoring on adherence to treatment and retention in the treatment programme.

TABLE 9:
HIV dedicated programme expenditure in Health Departments

Rand million	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Real change 02/03-08/09	Real change annual %
HIV and AIDS conditional grant	210	334	782	1 135	1 567	1 646	1 735	1 278	40.2
Provincial other	98	335	419	568	958	1 185	1 327	1 048	47.5
National other	245	343	326	431	410	437	453	116	5.9
Total	553	1 011	1 527	2 135	2 935	3 268	3 516	2 442	30.1

Source: National Treasury provincial data-base and Estimates of National Expenditure, 2006.

e As seen from the row in Table 12 'provincial other'



CORONER SERVICES SUB-PROGRAMME AND FORENSIC PATHOLOGY

On 1 April 2006 the responsibility for forensic pathology services was officially shifted from the South African Police Service to provincial DoH. A new conditional grant has been established for a period of five years to build up these services to an acceptable level. Amounts of R525 million, R551 million and R466 million have been allocated in the new conditional grant over the MTEF for this purpose.

EMERGENCY MEDICAL SERVICES

Funding for emergency ambulance services is growing remarkably strongly and the programme will exceed R2.6 billion by 2008/09. Almost R500 million was added to the 2006/07 budget. There are a number of factors driving this growth including strengthening of services being provincialised (many provinces previously delegated these services to local government), institution of two person ambulance crews, strengthening communication systems and control centres, purchase of new vehicles and information systems. A new national ambulance model was prioritised in the 2006/07 budget and aims at reducing response times to under 15 minutes in urban areas and under 45 minutes in rural areas. Air ambulance services are also being extended in several provinces. Further strengthening is anticipated in preparation for 2010 soccer World Cup to be hosted in SA and to implement the improved national ambulance model.¹³

HOSPITAL FUNDING

Hospital funding growth has been unimpressive in the period under review with 2.4% annual real growth over the period and no real growth in 2006/07 (Table 11 and Figure 9). However, as discussed above, capital expenditure on upgrading hospitals has increased significantly.

Regional hospitals receive the area of greatest expenditure but in many cases still appear to be under-resourced with reference to funding and staffing norms.¹⁴

Two large national conditional grants assist in the funding of hospitals. The National Tertiary Services grant was formed in 2002/03 and funds tertiary hospital services in 27 hospitals. The Modernisation of Tertiary Services report,^{15,16} released in 2004, presented a far reaching set of proposals for specialised hospital services, but is lagging behind in implementation. The Health Professions Training and Development grant supports academic medicine by compensating provinces for expenditure incurred in teaching. The later grant is currently the subject of a review in order to strengthen its support for academic medicine. However, as the table and Figure 8 show, these grants have had limited effect in protecting central hospital funding during a period of prioritisation of primary health care. The lack of growth in central hospitals funding in provincial budgets despite initiation of the Modernisation of Tertiary Service project suggests that routing funding through the equitable share has proved ineffective and that this issue will need to be considered again for conditional grant funding in budget 2007. Overall hospital funding has been constrained over a decade and this issue requires attention in future budgets.

TABLE 10:
Emergency medical services funding

Rand million	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Real change 02/03-08/09	% Real change annual
Emergency transport	899	1 231	1 311	1 645	2 053	2 239	2 449	1 550	13.0
Planned patient transport	8	52	30	94	156	176	195	186	61.2
Total	907	1 283	1 341	1 739	2 210	2 414	2 643	1 736	14.3

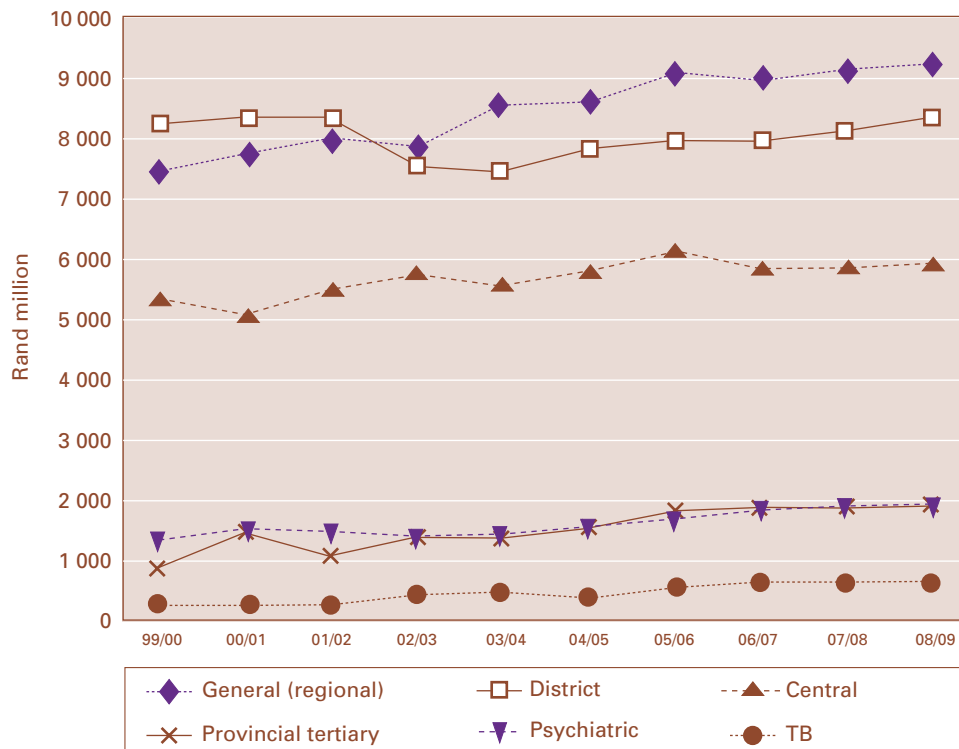
Source: National Treasury provincial data-base.

TABLE 11:
Hospital funding (nominal prices)

Rand million	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Real change 02/03-08/09	Real change annual %	Real growth 06/07 %
District	6 558	6 837	7 489	7 930	8 272	8 814	9 534	835	18	0.1
General (regional)	6 846	7 878	8 252	9 082	9 334	9 951	10 564	1 405	28	-1.4
TB	332	400	341	513	621	656	697	230	8.2	16.2
Psychiatric	1 217	1 310	1 482	1 679	1 903	2 043	2 169	504	53	8.8
Chronic / subacute	182	107	131	190	173	190	202	-31	-2.7	-12.7
Dental	154	169	180	202	211	223	235	30	2.6	0.2
Other specialised	30	36	37	36	58	66	69	26	9.6	52.9
Central	5 024	5 121	5 545	6 098	6 061	6 362	6 761	164	0.5	-4.6
Provincial tertiary	1 211	1 238	1 448	1 825	1 947	2 039	2 190	529	5.5	2.4
Total	21 555	23 095	24 903	27 555	28 580	30 343	32 421	3 690	2.4	-0.5

Source: National Treasury provincial data-base, 2006.

FIGURE 9:
Funding by hospital type



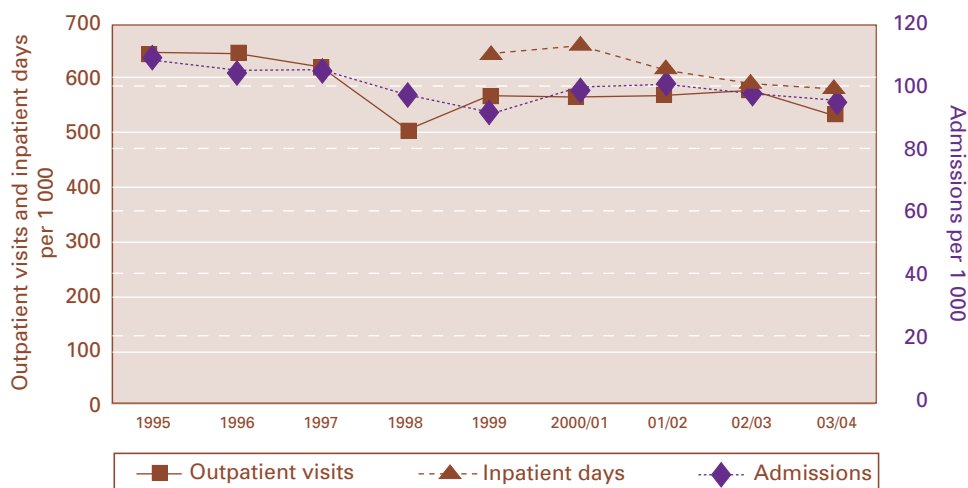


While hospital funding has shown little growth, more surprisingly hospital workloads according to national health information systems, in terms of admissions (3.6-4 million per year) and outpatient visits (20 million per year) have also not risen substantially over a decade. It is possible that funding limitations for hospitals have limited staffing and service delivery. Given the increasing proportion of admissions due to HIV it appears likely that non HIV-related admissions are being squeezed out.

Unfortunately the quality of hospital data are in too many cases not credible and this makes it more difficult to make firm conclusions on hospital funding requirements. In addition, provinces use a variety of inconsistent approaches to fund hospitals resulting in wide discrepancies in workloads and unit costs between facilities performing similar functions. It is recommended that wider use be made of performance based budgeting to better match resources to workloads.

FIGURE 10:

Hospital workloads per 1 000 uninsured



HEALTH SCIENCES AND TRAINING

Programme 6 in the standardised budget structure covers health sciences and training. Although this programme shows strong growth this appears to be partly due to reclassification with increasing location of Health Professions Training and Development grant expenditure in this programme. However, spending on nursing colleges (R971 million in 2006/07) and bursaries R223 million does appear to be increasing (Table 12).

TABLE 12:
Health sciences and training programme

Rand million	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Real growth 02/03-08/09	Real growth annual %
Nursing colleges	515	622	772	836	971	1 058	1 136	405	9.1
Emergency training colleges	16	14	15	29	32	33	35	12	8.7
Bursaries	84	139	133	200	223	237	253	125	14.9
Primary care training	41	83	65	93	93	100	108	47	12.4
Other training	118	128	201	381	412	468	520	319	22.4
Total	774	987	1 186	1 539	1 732	1 897	2 051	908	12.5

Source: National Treasury provincial data-base, 2006.

The Departments of Health, Education and Treasury are negotiating reform of the R1.5 billion Health Professions Training and Development (HPTD) grant as part of restructuring the funding of health sciences education. Numbers of health science students are shown in Table 13.

TABLE 13:
Health science students 2003

Student	Total
Medical	8 585
Medical postgraduate Registrar	2 477
Dental	1 492
Dental specialist	131
Physiotherapy	1 540
Occupational therapy	1 156
Speech therapy	241
Dietician	380

Student	Total
Registered nurse	11 070
Enrolled nurse	2 876
Nursing auxiliary	624
Pharmacy	1 347
Radiography	127
Optometry	193
Clinical psychologist	43
Total	32 282

Source: Department of Education, 2003.



The next section discusses line item expenditure, focusing particularly on personnel and infrastructure.

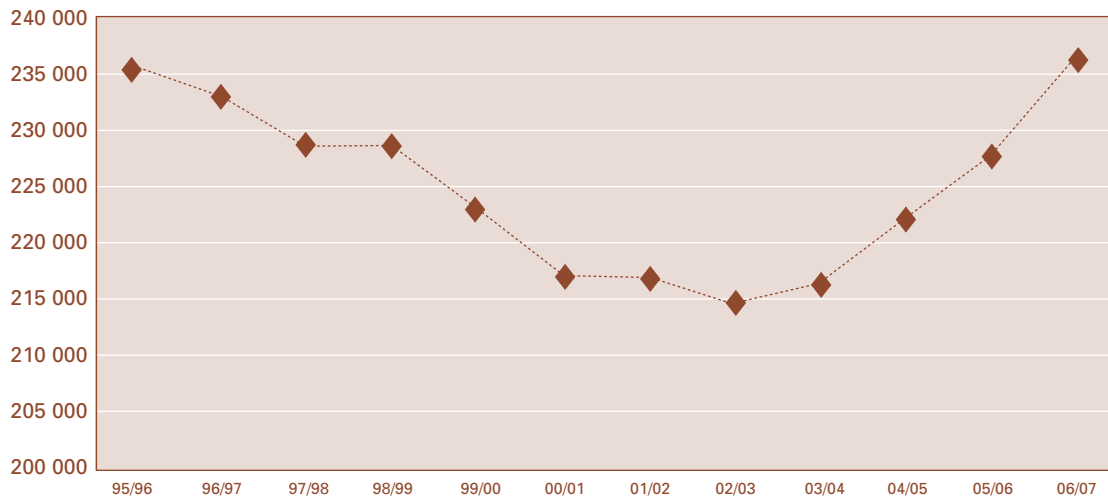
PERSONNEL

Health sector personnel numbers declined substantially in the late 1990s after an unsustainable wage agreement in 1996 in the context of the fiscal constraints and pressures on health sector budgets. Over the past two years health personnel numbers have recovered by 20 000 as the effects of a more expansionary fiscal policy are finally showing themselves in personnel numbers, but are only now approaching past peaks (Figure 11). Of these, health professional personnel have increased by approximately 10 000 over the past two years (Table 15). Spending on health personnel is shown in Table 14 expressed in nominal prices. Spending on personnel has increased by over R5 billion in real terms in the four years to 2006/07, of which about R1 billion comprised the scarce skills and rural allowances. The National Human Resources Plan recommends that personnel numbers in the health sector be expanded by 30 000 over a period of five years.⁸

TABLE 14:
Provincial health compensation of employees' expenditure, 2002/03-2008/09

R million	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	Real change 2002/03-08/09 annual %
	Outcome			Preliminary outcome	Medium-term estimates			
Eastern Cape	2 494	2 816	3 230	3 446	3 732	3 912	4 088	3.8
Free State	1 375	1 496	1 681	1 850	2 014	2 131	2 248	3.8
Gauteng	3 907	4 219	4 453	4 689	5 082	5 364	5 670	1.7
KwaZulu-Natal	4 488	4 735	5 414	5 867	6 961	7 588	8 060	5.4
Limpopo	1 950	2 377	2 614	2 855	3 181	3 498	3 803	6.9
Mpumalanga	895	1 064	1 148	1 450	1 572	1 739	1 914	8.5
Northern Cape	367	426	471	523	586	612	636	4.8
North West	1 274	1 406	1 586	1 765	1 902	2 075	2 201	4.7
Western Cape	2 370	2 445	2 799	2 977	3 598	3 842	4 183	5.1
Total	19 120	20 983	23 397	25 419	28 628	30 762	32 804	4.6

FIGURE 11:
Trends in health sector employees



Source: National Treasury, Vulindlela, 2006.

TABLE 15:
Trends in health professional numbers (head counts)

Rand million	01/02	02/03	03/04	04/05	05/06	06/07	Change	Change %
Medical officers	7 261	7 399	7 665	8 342	8 709	9 588	2 327	32.0
Medical specialists	3 619	3 626	3 431	3 553	3 559	3 765	146	4.0
Total Doctors	10 884	11 029	11 101	11 901	12 278	13 411	2 527	23.2
Nursing assistants	28 556	28 547	29 206	30 486	31 431	32 562	4 006	14.0
Professional nurse	40 804	40 646	41 815	42 848	43 839	44 641	3 837	9.4
Staff nurse and pupil nurse	20 632	20 466	20 675	20 679	20 730	21 281	649	3.1
Student nurse	7 119	7 314	7 746	8 145	8 458	9 314	2 195	30.8
Total nursing	97 111	96 972	99 441	102 157	104 458	107 798	10 687	11.0
Dentists	625	587	596	635	663	725	100	16.0
Total dental	839	790	788	845	884	951	112	13.3
Emergency service personnel	3 958	4 504	5 348	6 142	7 193	8 030	4 072	102.9
Pharmacists	1 325	1 250	1 247	1 438	1 598	1 711	386	29.1
Radiography	2 083	2 027	2 035	2 045	2 006	2 251	168	8.1
Dieticians	261	293	380	415	435	517	256	98.1
Environmental health	545	600	790	829	865	871	326	59.8
Occupational therapy	427	458	565	588	591	664	237	55.5
Physiotherapy	473	510	562	713	720	762	289	61.1
Psychologists	267	270	320	385	406	409	142	53.2
Total professional personnel	121 908	122 061	125 902	131 251	135 615	139 418	17 510	14.4

Source: National Treasury, Vulindlela, 2006.



Table 16 shows trends in public sector medical doctors per 1 000 population. Over the period from 2001/02 to 2005/06 there has been an encouraging increase in Eastern Cape, Limpopo, Mpumalanga and Northern Cape. The recently published World Health Report 2006 provides a wealth of comparative data on health personnel. This shows that the public sector total of 0.31 doctors per 1 000 population is substantially less than the country total of 0.77 or the international median of 1.37 per 1 000 for middle income countries, with doctor availability in the public sector being considerably lower.

Addressing human resource deficits can undoubtedly contribute to the quality of the national health care service. The recently released national Human Resource Plan of the Department of Health⁸ proposes bold steps to increase supply of health professionals, including substantially increasing numbers of doctors in training. The plan also recommends that numbers of health personnel be increased by 30 000 over a period of five years.

TABLE 16:
Public sector doctors per 1 000 uninsured persons

Province	01/02	02/03	03/04	04/05	05/06
Eastern Cape	0.12	0.15	0.15	0.16	0.18
Free State	0.28	0.33	0.32	0.33	0.34
Gauteng	0.48	0.47	0.46	0.47	0.47
KwaZulu-Natal	0.28	0.28	0.26	0.30	0.32
Limpopo	0.10	0.12	0.14	0.16	0.16
Mpumalanga	0.17	0.16	0.18	0.21	0.23
Northern Cape	0.31	0.29	0.34	0.35	0.36
North West	0.14	0.13	0.13	0.15	0.16
Western Cape	0.69	0.65	0.63	0.63	0.67
Total	0.28	0.29	0.29	0.30	0.31

Doctor distribution in middle income countries

Country	Doctors per 1 000 population
Cuba	5.91
Russian Federation	4.25
Argentina	3.01
Poland	2.47
Mexico	1.98
Republic of Korea	1.57
Median	1.37
Turkey	1.35
Brazil	1.15
Algeria	1.13

Country	Doctors per 1 000 population
Chile	1.09
China	1.06
South Africa	0.77
Malaysia	0.70
Iran	0.45
Thailand	0.37

Source: WHO 2006 and Vulindlela 2006.

INFRASTRUCTURE

Spending on infrastructure continues to grow strongly partly driven by the Hospital Revitalisation and Provincial Infrastructure grants. Spending on the Health Facilities Programme (programme 8) will exceed R5 billion in 2008/09.

TABLE 17:
Capital expenditure

	02/03	03/04	04/05	05/06	06/07	07/08	08/09	Real change 02/03-08/09	Real change annual %
Health facilities management	1 770	2 076	2 252	3 060	3 910	4 593	5 153	3 384	14.3
Capex	1 837	2 426	2 693	3 851	4 315	4 841	5 456	3 619	14.6
Buildings	1 057	1 430	1 580	2 119	2 401	2 844	3 224	2 167	15.1
Equipment and vehicles	780	996	1 102	1 718	1 851	1 982	2206	1 426	13.7

Source: National Treasury provincial data-base 2006.

In the 2006 budget, funding for the Hospital Revitalisation programme was increased. This programme has a medium to long term focus on the capital upgrading or replacement of entire hospitals, with subcomponents for medical equipment and hospital management and quality improvement. Amounts of R100 million, R300 million and R500 million were added to the grant over the MTEF. In addition the previous Hospital Management and Quality Improvement grant is being phased into this programme over the next 1-2 years. This will bring the Hospital Revitalisation funding to R1.98 billion by 2008/09.

Thirty-two hospitals will be included in the programme over the MTEF period. These include large projects such as the upgrading of Chris Hani Baragwanath Hospital, the building of two new district hospitals in Soweto, completion of the three rural regional hospitals in the Western Cape including Paarl hospital, two new 250 bed hospitals in KwaMashu, Durban and four replacement hospitals in Limpopo. The large projects are scheduled over a multiple year period and will not be completed within this MTEF. Under-expenditure continues to be a problem in this grant and steps are being taken to progressively strengthen programme and project management and address obstacles to delivery. The massive capital upgrading programme underway presents a major challenge for government in the areas

of supervisory and project management, planning, technical skills, inter-departmental coordination and acquiring international best practice designs.

OUTCOMES

Despite improvements in social grants, education, water, housing, electrification, public health, health funding and primary care services, the numbers of deaths are increasing (Table 18) as the HIV epidemic matures. The rate of increase strongly suggests linked increasing pressure and demand for health services. Of particular concern is the rise in mortality in young adults from 30-50 years.

TABLE 18:
Mortality (deaths per year) estimates from three sources

	Population Register	Stats SA	ASSA 2003
1997	250 745	316 505	420 900
1998	299 737	365 053	460 410
1999	327 826	380 982	503 247
2000	366 121	413 736	531 291
2001	407 675	452 896	583365
2002	441 731	499 494	632 561
2003	484 332	552 825	680 585
2004	513 931	567 488 (incomplete)	720 654
% Change 1977-2003 annual	12.0	9.7	8.3

Source: Population Register, Statistics South Africa,¹⁷ Actuarial Society of South Africa.¹⁸



PRIVATE SECTOR FINANCING TRENDS

This section of the chapter, considers some of the major trends affecting medical scheme coverage in SA, and in particular, developments during 2005. Trends in the number of lives covered by medical schemes, differences in coverage between the provinces, as well as the overall number of registered medical schemes are analysed. Financial trends affecting medical schemes, including changes in solvency levels, claims ratios and health care expenditure of medical schemes are discussed. Finally, certain important policy and strategic developments are considered, notably the creation of the Government Employees Medical Scheme (GEMS), progress toward the establishment of a REF, reform of the tax subsidy framework, and a consultative process around conditions conducive to the emergence of risk pooling products for low income individuals.

These developments must be seen against the backdrop of the a broad process of reform of the private health funding system in SA, which commenced with passage of the Medical Schemes Act, No 131 of 1998.¹⁹ This Act, which became fully operational in 2000, had the following major policy objectives: to promote non-discriminatory access to privately funded health care; to reduce unnecessary financial burden on the public sector; to improve governance of medical schemes in the interests of members; to promote greater financial stability in the industry; and to improve consumer protection through enhanced governmental oversight.²⁰

The introduction of community rating, open enrolment and a package of prescribed minimum benefits were among the interventions introduced by the Medical Schemes Act, 1998. In terms of community rating, medical schemes must price contributions at the average expected cost of the group, rather than loading premiums according to the risk status of individuals. Open enrolment demands that medical schemes may not deny an applicant membership of their scheme based on an assessment of the risk status of an individual.

The prescribed minimum benefit (PMB) package is a minimum set of benefits that a medical scheme must offer to all its beneficiaries with coverage of full cost in at least one reasonably accessible setting. The challenge in defining and developing the PMB package has been the difficulty of striking a balance between protecting

the members' interest of receiving a reasonably core PHC package of essential health care, on the one hand, and maintaining affordability of medical scheme contributions, on the other. Industry stakeholder assertions that the affordability of the current package negatively impacts on their ability to introduce low cost medical scheme packages in the market has been one of the factors giving rise to the Low Income Medical Schemes (LIMS) research process, which is discussed below.

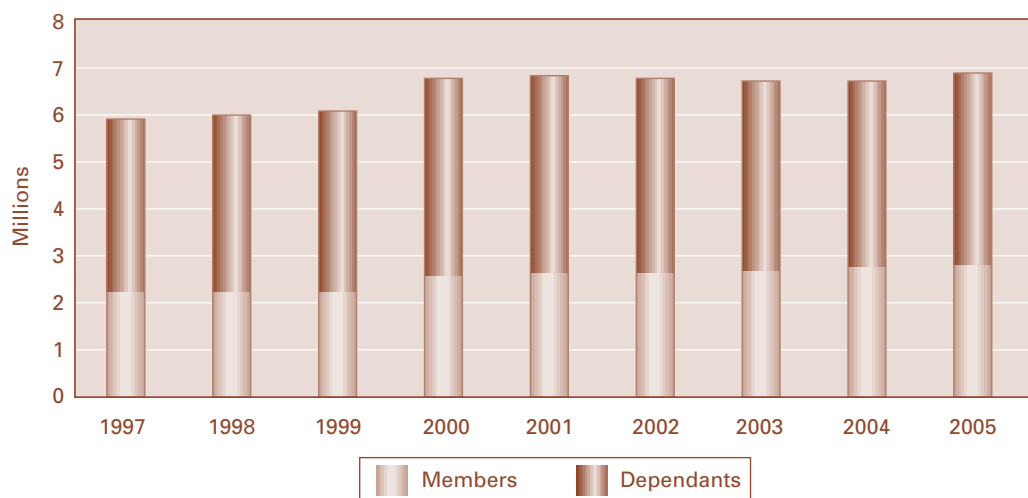
MEMBERSHIP TRENDS

In 2005, a total of 6 835 621 beneficiaries⁴ were covered by medical schemes registered in terms of the Medical Schemes Act, 1998.^f This figure represents a 2.6% increase in covered lives from 2004 (compared to an overall estimated population growth rate for 2004-2005 of 0.92%). During 2005, medical schemes covered some 14.6% of the South African population. The gross contribution income of medical schemes for these beneficiaries during 2005 amounted to R54.2 billion (or R670 per beneficiary per month).⁴ The disparities between health care expenditure in the public and private sectors has already been discussed.

The lack of significant growth of the medical scheme population over the past decade, as shown in Figure 12, is indicative of the fact that medical schemes have been unable to design packages that are affordable and attractive to the emerging market in South Africa. Low income earners may face user fees from public sector providers or otherwise may make use of private providers for out-of-hospital care in particular. If these earners are unable to afford medical scheme cover whereby their risk of medical expenditure is spread across the membership of a medical scheme, they individually face the full out-of-pocket cost, which may be financially catastrophic for them. This may negatively impact on access to health care. The lack of health risk pooling options for low income earners is providing the impetus for significant policy debate at present regarding creation of conditions conducive to low income medical schemes as well as the establishment of a social health insurance system in SA.

^f This figure excludes beneficiaries of bargaining council funds registered in terms of the Labour Relations Act, for which reliable figures are not easily obtained. Bargaining council funds account for something approximating an additional 120000 covered lives.

FIGURE 12:
Beneficiaries of Registered Medical Schemes⁹



Source: CMS Annual Report 2005-6.⁴

It is not surprising given the relatively high costs of medical scheme membership, that membership rates differ significantly from province to province, and are strongly correlated with rates of employment. The two

provinces with the lowest unemployment rates, Gauteng and Western Cape, have significantly higher medical scheme membership rates than other provinces, as can be seen in Table 19.

TABLE 19:
Population, Unemployment and Medical Scheme Coverage Rates per Province

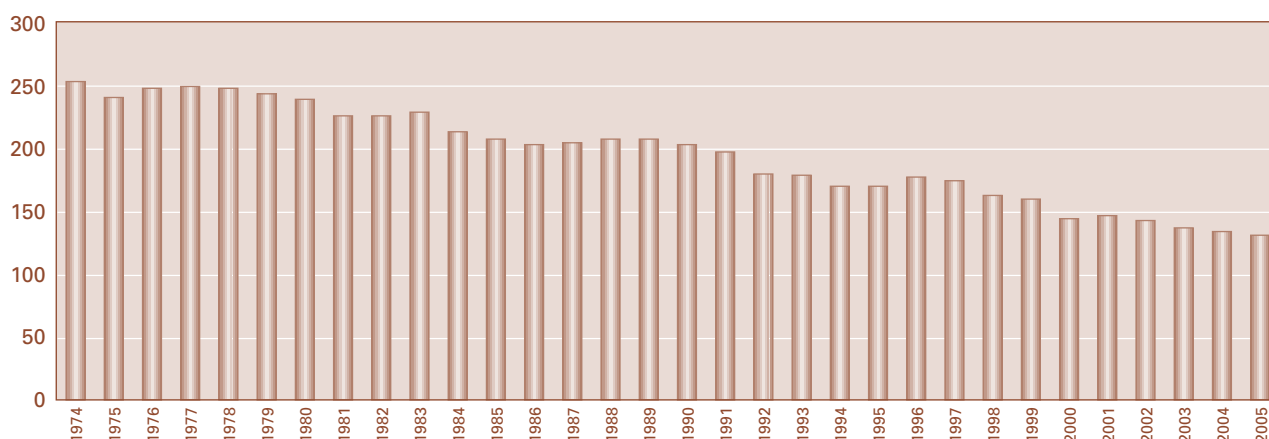
Province	Estimated Population 2005	Unemployment Rate 2005 in %	Medical Scheme Beneficiaries 2005	% Population Covered by Medical Schemes
Eastern Cape	7 039 300	29.9	601 154	8.5
Free State	2 953 100	30.2	326 151	11.0
Gauteng	9 018 000	22.8	2 535 991	28.1
KwaZulu-Natal	9 651 100	32.8	1 038 174	10.8
Limpopo	5 635 000	30.1	261 955	4.6
Mpumalanga	3 219 900	26.9	468 066	14.5
Northern Cape	902 300	24.7	143 971	16.0
North West	3 823 900	27.4	334 919	8.8
Western Cape	4 645 600	18.9	1 119 247	24.1
(Outside RSA)	5 993			
Total	46 888 200	26.7	6 835 621	14.6

Source: CMS Annual Report 2005-6;⁴ StatsSA Labour force survey, 2005;²¹ StatsSA Mid-year population estimates, 2005.²²

⁹ The apparent jump in membership from 1999 to 2000 is as a result of reclassification of a number of schemes (primarily Transmed, Medcor and Polmed) from exempted bargaining council status to schemes registered in terms of the Medical Schemes Act 1998, when this Act was implemented in 2000.



FIGURE 13:
Number of Registered Medical Schemes 1974-2005



Source: CMS Statutory Return Data-base.²³

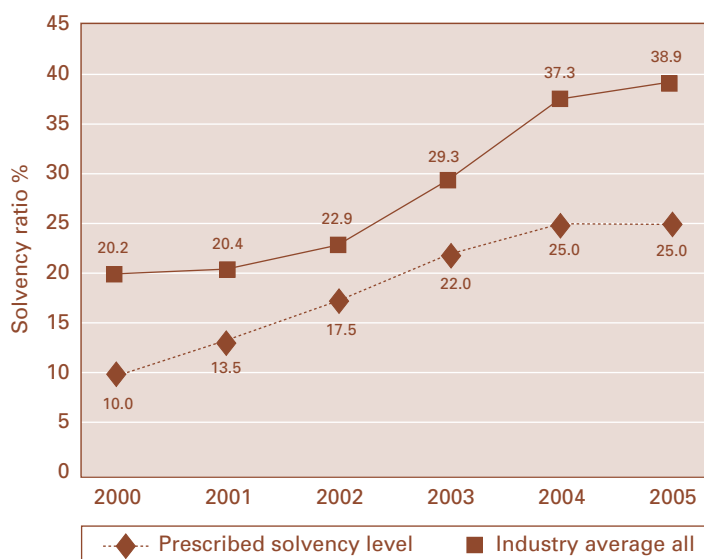
Although the number of beneficiaries of registered medical schemes has remained relatively stable over the past few decades, the number of medical schemes providing cover to those beneficiaries has declined steadily as a result of amalgamations, liquidations and mergers. This can be seen in Figure 13. From 2004 to 2005, the number of registered medical schemes again declined from 133 to 131.⁴

In principle, the reduction in the number of medical schemes is not undesirable, as it may promote the elimination of inefficient medical schemes and allow for greater financial stability in the industry through consolidation of risk pools. This principle is undermined, however, if medical schemes are able to compete on their ability to cream-skim good risk beneficiaries in the environment as opposed to the efficiency of their operations. Where playing fields are not level as a result of vastly different risk profiles of medical schemes, inefficient medical schemes may be able to remain competitive purely by manipulating the market to avoid poor risk. An evaluation of cost differences among open medical schemes in South Africa demonstrated a cost difference of 180% between two medical schemes based only upon the difference in age profiles between the two schemes.²⁴ As a consequence, to promote competition based on efficiency rather than risk selection, government is making progress toward establishment of a REF. Progress in this regard is discussed in greater detail below.

FINANCIAL TRENDS

On the whole, the medical schemes industry has achieved a fairly solid level of financial stability over the past five years. One of the major legislative interventions brought about by the Medical Schemes Act, 1998, was to require medical schemes to hold 25% of annual contributions in reserve, to provide a buffer against unforeseen variability in scheme expenditure. This 25% requirement needed to be incrementally achieved over a period of five years – with most schemes needing to have reached that level by the end of 2004. Although some medical schemes remain below that level, the industry has by and large significantly exceeded the goal with an industry average of 38.9% at the end of 2005, as can be seen in Figure 14.

FIGURE 14:
Solvency Ratios of Medical Schemes 2000-2005



Source: CMS Annual Report 2005-6.⁴

The accumulation of reserves by many schemes in excess of the statutory minimum not only provides a solid barrier against fluctuation of claims, but also provides an important opportunity to those schemes to generate a steady investment income which can contribute to the financial stability of the scheme in periods when operating results are poor. It also provides schemes with flexibility around the determination of benefits and the setting of contributions, to maintain attractiveness of benefit packages and affordability of contributions. In fact, the relative leveling off of accumulation of reserves from 2004 to 2005 must be seen in the context of a significantly greater proportion of contribution income being spent on health benefits in 2005 as compared to 2004. The risk claims ratio of medical schemes, which is the percentage of risk contributions paid out in claims, has been rapidly declining over the past decade to reach an all-time low of 78.6% in 2004.^h As can be seen in Figure 15, this trend was finally reversed in 2005, with a sharp increase in the risk claims ratio to 84.4%.

Total medical scheme expenditure on claims increased by 12.2% from 2004 to 2005 (as opposed to a 6.75% increase from 2003 to 2004).⁴ This shift would appear to be consistent with the statement in the 2004/5 Annual Report of the Council for Medical Schemes that “as reserves for most schemes are at the prescribed

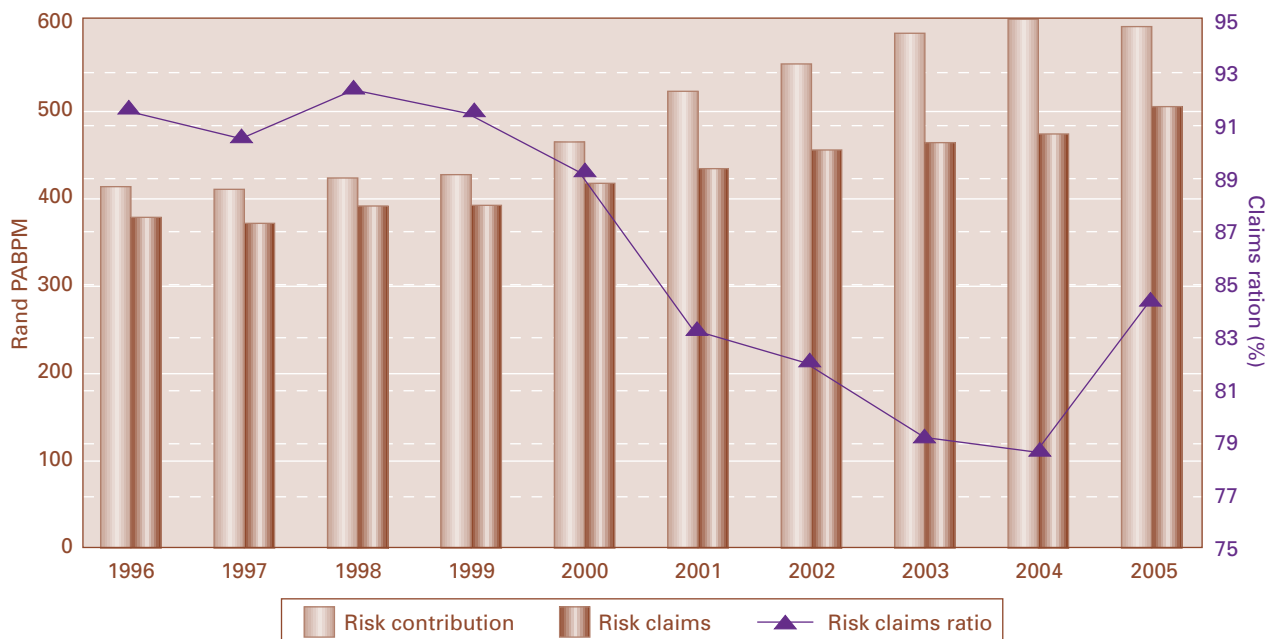
level, more of members’ contributions should in future be utilised towards benefits”.²⁵

Significantly, as may be seen in Figure 16, the dramatic increases in private hospital expenditure which were observed from 2001 to 2004 appear to have abated in 2005, while the significant real increases in health care expenditure appears to have taken place among medical specialists, general practitioners and supplementary and allied health care professionals. This is an important shift given the trend in recent years of an increasing share of the medical scheme expenditure pie going to private hospitals at the expense of professional disciplines. Also encouraging is the decreasing medical scheme expenditure on medicines, which suggests that government policy to decrease the prices of medicines through regulation of single exit prices is having the desired effect. The impact on medicine prices of proposed Regulation of the dispensing fee charged by pharmacists cannot be assessed at this point, because at the time of writing the DoH had still not published final Regulations governing this mark-up. At the end of September 2005, the Constitutional Court²⁶ set aside the dispensing fee determined by the Department of Health in regulations under the Medicines and Related Substances Act, 101 of 1965, and instructed the DoH to go back to the drawing board to determine a new fee.

^h This calculation includes only risk contributions and claims. It therefore excludes contributions to, and claims from, personal medical savings accounts.

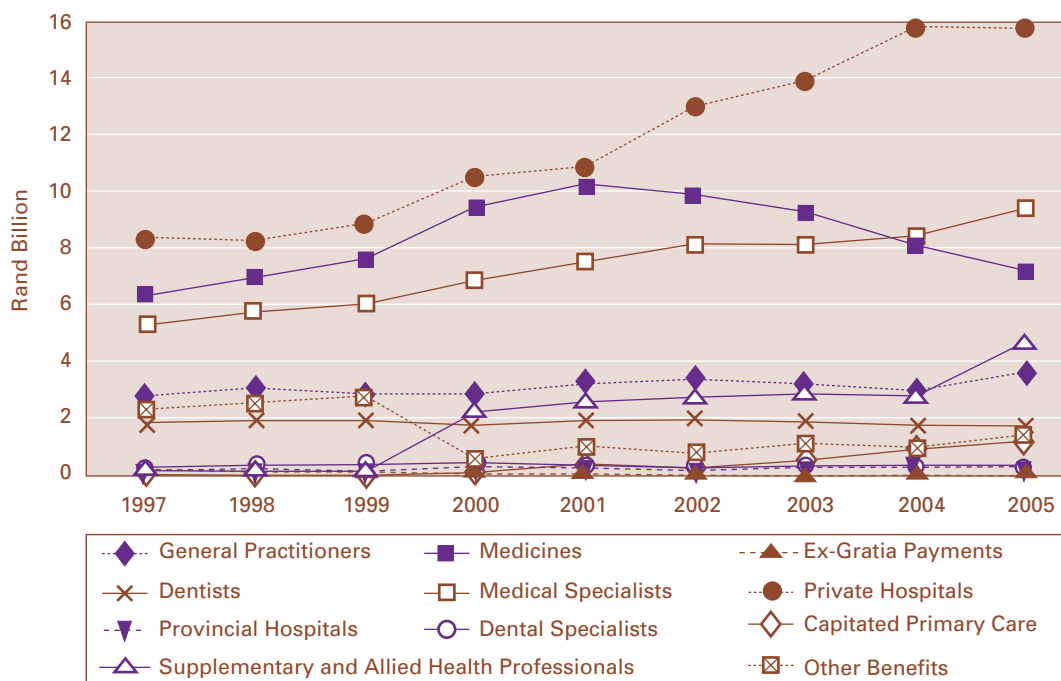


FIGURE 15:
Risk Claims Ratio 1996-2005 (2005 prices)



Source: CMS Annual Report 2005-6.⁴

FIGURE 16:
Benefit Expenditure by Medical Schemes (2005 prices)



Source: CMS Annual Report 2005-6.⁴

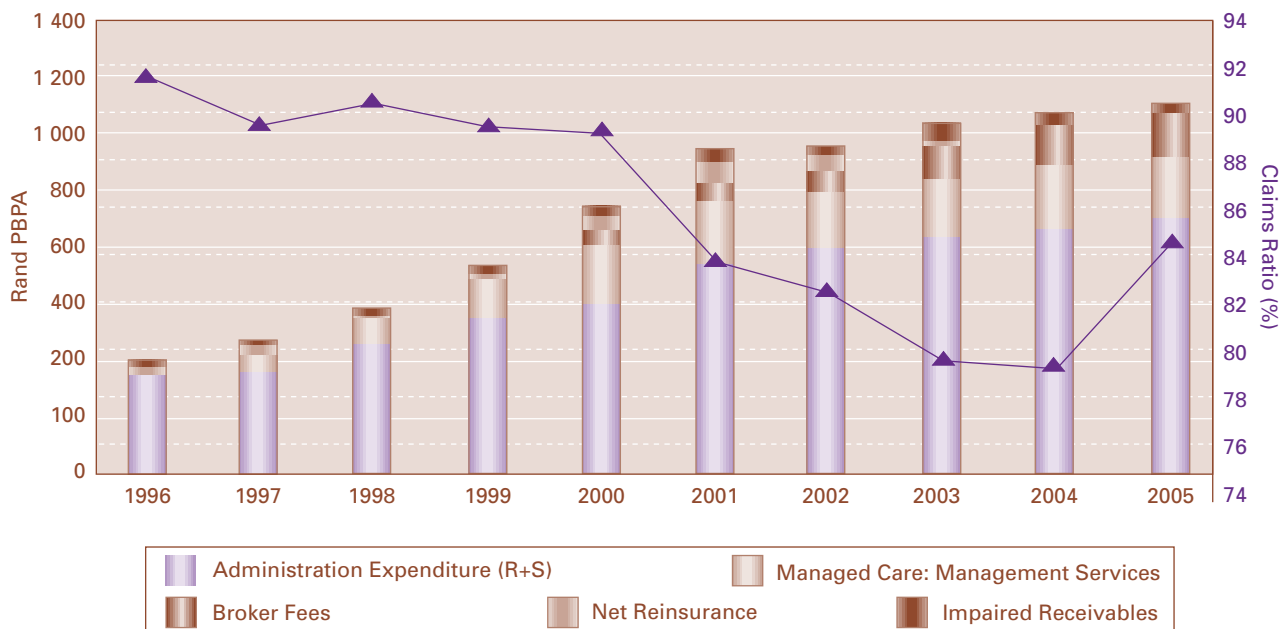
The increase in claims ratio may not be sustainable unless schemes are able to better contain levels of non-health expenditure. Total non-health expenditure again increased by 9.6% from 2004 to 2005, well in excess of inflation. The increase in non-health expenditure per average beneficiary per annum from 2004 to 2005 may be seen in Figure 17. As can be seen from this figure, the major contributors to non-health expenditure of medical schemes are: administration expenses, managed care services, and broker fees. Industry-wide, non-health expenses comprised 16.3% of contributions in 2005, the highest level in the past decade. The reason that the proportion of contributions spent on claims (claims ratio) was able to increase despite the increase in proportion of contributions spent on non-health care expenses, is that schemes drastically reduced the amount allocated to reserve building in 2005.²¹ This suggests that scheme reserve levels are at risk of rapidly diminishing if current benefit levels are maintained in the absence of curbing inflation on non-health expenditure.

KEY STRATEGIC AND POLICY ISSUES

A number of strategic and policy developments have the potential to significantly change the face of the medical schemes industry going forward. In this concluding section of the chapter, a few of the major developments are highlighted.

A particularly important development over the past year has been the establishment of the Government Employees Medical Scheme (GEMS). GEMS was registered on 1 January 2005, and commenced doing the business of a medical scheme with active member enrolment on 1 January 2006. It will, however, take some time for the medical scheme to enrol a membership base which will have significant impact on the medical schemes environment. GEMS has the potential to enrol an additional 1 million medical scheme beneficiaries, through the extension of an employer subsidy to 380 000 public servants and their families who are currently not enrolled on a medical scheme.²⁷

FIGURE 17:
Trends in Non-Health Expenditure of Medical Schemes



Source: CMS Annual Report 2005-6.⁴



Given the commitment of government for the extension of medical assistance to currently uncovered public servants, and the development of a revised medical subsidy policy aligned to GEMS, in time the scheme has the potential to capitalise on economies of scale and to achieve significant market power in negotiations with third party contractors and health care providers. Whether or not these gains will materialise will depend on the ability of the public hospital sector to establish itself as a viable contracting partner to provide hospital services to the scheme's base option, the willingness of private providers to enter into price competition amongst themselves, and the support of public service labour organisations to encourage their members to participate.

Significant progress has also been made towards the establishment of a REF, which will provide a mechanism to facilitate financial risk transfers between medical schemes to reduce the unfair financial advantages of schemes which have benefited from disproportionately good risk membership profiles relative to other medical schemes. In July 2005, the Cabinet gave approval in principle to the establishment of the REF, to be administered by the Council for Medical Schemes. An amount of R15 million was allocated in 2006/07 to prepare the REF infrastructure and systems. During 2005, a 'shadow process' was implemented to test the formula and systems as well as looking at the implications of the Fund for both the Council for Medical Schemes, and medical schemes themselves. This was due to continue until the end of the third quarter of 2006, when a 'dry run' would commence where all systems would be up and running without actual financial transfers taking place. The date of actual commencement of financial transfers will depend on the date of passage of the enabling legislation by Parliament, as well as when the Ministers of Health and Finance are satisfied that the necessary systems and safeguards are in place to ensure that all risks to implementation are sufficiently mitigated. A particular risk to successful implementation of the REF is the collection of poor quality data by some medical schemes. Given the reliance of the REF on high quality data, mitigation of this risk is receiving significant attention from the Council for Medical Schemes at present.

The implementation of the REF is viewed as an important step in the process towards creation of a social health insurance (SHI) system in South Africa. The proposals for SHI which have been discussed in government to date contemplate introduction of both a risk-based cross-subsidy between medical schemes and an income-based cross-subsidy, whereby higher income members of medical schemes will cross-subsidise lower income members. Considerably more policy consensus has been achieved at governmental level in relation to the mechanisms for risk equalisation than the mechanisms for the income-based cross-subsidy. The nature and mechanisms for this second plank of SHI continue to be the subject of engaging policy discussion.

In the meantime, the system of tax deductibility for medical expenses by employers and employees was changed from the 2006/07 year. While deductions were previously only on 2/3 of the contribution fee, income related and unlimited, the new system allows for complete (100%) tax deductibility up to a given cap per beneficiary (amounting to R1 600 for a family of 4 per month). Because the monthly ceiling is calculated on the number of dependants registered on the medical scheme, larger families are likely to benefit from a greater tax-free portion of medical scheme contributions than was previously the case. This is intended to encourage more people to enrol their families as dependants on their medical schemes.

Furthermore, an important consultation process has been undertaken in relation to steps which may be taken to create the conditions conducive to the emergence of medical scheme products geared to the needs of low income individuals. Opportunities for risk pooling for health care expenditure among low income individuals is considered to be important to protect these people against the regressive, and potentially financially catastrophic, impact of out-of-pocket expenditure on health care. Stakeholder input and research was invited by a committee established by the Minister of Health to consider options for SHI. This gave rise to a report containing stakeholder views and research, dubbed the Low Income Medical Schemes, or "LIMS," report, which was due to be considered by policymakers in government during 2006. A key recommendation of this report was the creation of a more limited package of prescribed minimum benefits (PMB) to be mandated for LIMS products.

To the extent that the cost of the PMB package is currently an impediment to the emergence of low cost medical schemes, this will not be resolved through the risk equalisation fund. The REF will only ensure that, assuming equal efficiency in the delivery of benefits, all schemes will face the same average cost for the provision of PMBs irrespective of risk profiles of those schemes. It will not result in a lowering of the average cost of the PMB package, nor will it achieve an income-based cross-subsidy between medical schemes.

high impact of each of these processes on the coverage, affordability and equity within medical schemes, the impact of policy and regulatory developments in this environment will need to be closely monitored.

CONCLUSION

Public sector health service funding has continued to grow and stabilise under the period of review. Funding growth is occurring in real and real per capita terms and the positive funding climate has allowed the employment of 20000 additional health employees over the past two years of which 10 000 are health professionals. Funding growth is particularly strong in the areas of primary health care, HIV, infrastructure and emergency health services. Funding for hospitals remains constrained and this is an area that requires further improvement.

In the private health funding sector, membership of medical schemes has remained largely stable during the past year, with continuation of the trend of consolidation amongst medical schemes. However, significant disparities remain in membership rates between provinces, closely related to differential employment levels between provinces. Expenditure patterns showed some significant changes over the past year, including a significant increase in the proportion of contribution income spent on health care benefits. Although this in itself is a positive development, it is unlikely to be sustainable unless medical schemes manage to better control increases in both health- and non-health expenditure in the future.

Several important strategic developments affecting the private health funding sector took place during this year. These included the establishment of the Government Employees Medical Scheme, progress toward implementation of the REF, reform of the system of tax deductibility for medical scheme contributions, and a consultative process around the establishment of low income medical schemes. Given the potentially



REFERENCES

- 1 Doherty J, Thomas S, Muirhead D, McIntyre D. Health care financing and expenditure. In: Ijumba P, Ntuli A, Barron P, editors. *South African Health Review 2002*. Durban: Health Systems Trust; 2002.
URL: <http://www.hst.org.za/uploads/files/chapter2.pdf>
- 2 Department of Health. *The Charter of the Public and Private Health Sectors of the Republic of South Africa*. Pretoria: Department of Health; 2005
URL: <http://www.doh.gov.za/docs/charter-f.html>
- 3 National Treasury. *Intergovernmental fiscal review 2006*. Pretoria: National Treasury; in press.
- 4 Council for Medical Schemes. *Annual Report 2005-6*.
URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=7>
- 5 World Health Organization. *World Health Report 2006*. Geneva: World Health Organization; 2006.
- 6 National Treasury. *Budget Review 2006*. Pretoria: National Treasury; 2006.
- 7 National Treasury. *Estimates of National Expenditure*. Pretoria: National Treasury; 2006.
URL: <http://www.treasury.gov.za/documents/budget/2006/ene/Vote%2016%20Health.pdf>
- 8 Department of Health. *National Human Resource Plan for health to provide skilled human resources for healthcare to take care of all South Africans*. Pretoria: Department of Health; 2006.
URL: <http://www.polity.org.za/pdf/planforhealth.pdf>
- 9 Cleary S, Okorafor O, Chitha W, Boulle A, Jikwana S. Financing antiretroviral treatment and primary health care services. In: Ijumba P, Barron P, editors. *South African Health Review 2005*. Durban: Health Systems Trust; 2005.
URL: http://www.hst.org.za/uploads/files/sahr05_chapter5.pdf
- 10 Republic of South Africa. *National Health Act (Act 61 of 2003)*.
URL: <http://www.info.gov.za/gazette/acts/2003/a61-03.pdf>
- 11 Bradshaw D, Pettifor A, MacPhail C, Dorrington R. Trends in Youth Risk for HIV. In: Ijumba P, Day C, Ntuli A, editors. *South African Health Review 2003/04*. Durban: Health Systems Trust; 2004.
URL: http://www.hst.org.za/uploads/files/chap10_03.pdf
- 12 Mseleku T, Statement by the Director-General. *Department of Health Strategic Plan 2006/07-2008/09*. Pretoria: Department of Health; 2006.
URL: <http://www.doh.gov.za/docs/misc/stratplan/2006-2009/dg.pdf>
- 13 Fuhri P, Bennett P, Aucamp H. Project report: phase 1. Strategic planning model for provision of a national ambulance service for emergency medical services. Pretoria: Department of Health; 2002.
URL: <http://www.doh.gov.za/mts/tender/phase1.html>
- 14 Department of Health. *Modernisation of Tertiary Services National Plan for the efficient and equitable development of tertiary and regional hospital services*. Pretoria: Department of Health; 2004.
- 15 Modernisation of Tertiary Services Project Team. *Strategic Framework for the Modernisation of Tertiary Hospital Services*. Pretoria: Department of Health; 2003.
URL: <http://www.doh.gov.za/mts/docs/framework01.pdf>
- 16 Tertiary Services Project Team. *Discussion document on Strategic framework for modernisation of tertiary services*. Pretoria: Department of Health; May 2003.
URL: <http://www.doh.gov.za/mts/docs/framework03.pdf>
- 17 Statistics South Africa. *Mortality and causes of death in South Africa 2003 and 2004*. Pretoria: Statistics South Africa; 2004.
URL: www.statssa.gov.za
- 18 Actuarial Society of South Africa. *AIDS demographic model 2003 lite*. Cape Town: Actuarial Society; 2005.
URL: <http://www.assa.org.za/default.asp?id=1000000095>
- 19 Republic of South Africa. *Medical Schemes Act (Act 131 of 1998)*.
URL: <http://www.doh.gov.za/docs/legislation/acts/1998/act98-131.html>
- 20 Council for Medical Schemes. *The medical schemes industry: regulatory approach, trends, challenges & opportunities. Briefing to the Portfolio Committee of Health [powerpoint presentation]; 20 May 2003*.
URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=3>
- 21 Statistics South Africa. *Mid-year population estimates, South Africa 2005 [statistical release P0302]*. Pretoria: Statistics South Africa; 2005.
URL: <http://www.statssa.gov.za>
- 22 Statistics South Africa. *Labour force survey, September 2005 [statistical release P0210]*. Pretoria: Statistics South Africa; September 2005.
URL: <http://www.statssa.gov.za>
- 23 Council for Medical Schemes. *Statutory Return Database*.
- 24 Risk Equalisation Technical Advisory Panel. *The shadow process for the Risk Equalisation Fund. [powerpoint presentation] March 2005*.
- 25 Council for Medical Schemes. *Annual Report 2004-5*.
URL: <http://www.medicalschemes.com/publications/publications.aspx?catid=7>
- 26 Minister of Health and Another NO v New Clicks South Africa (Pty) Ltd and Others (Treatment Action Campaign and Another as Amici Curiae) 2006 (2) SA 311 (CC).
- 27 Government Employees Medical Scheme.
URL: <http://www.gems.gov.za/>

