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Health Care Financing and Expenditure

Abstract

This chapter provides an overview of health care financing and expenditure in South Africa. It reviews total health care expenditure in 2005, as well as recent trends in spending in the public and private health sectors. While public sector health care expenditure has been relatively stagnant in real per capita terms over the last decade, expenditure in the private sector has continued increasing at rates far exceeding the rate of inflation despite medical schemes covering a declining share of the population. Differentials in the public-private health sector, in terms of the financial and human resources available in each sector relative to the population served, have increased dramatically. It is critical that these diverging trends be urgently addressed, both through increased tax funding of public sector services and efforts to promote improved efficiency within the private health sector.

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Introduction

This chapter presents a brief overview of health care financing and expenditure in South Africa. It considers the funding flow in the overall health system, reviews key issues in relation to the public and private health sectors and explores the public-private health care mix. By considering financial resources in the overall health system, this chapter provides an important context for the discussion of issues relating to the private health sector covered in the other chapters.

Overview of health care financing and expenditure

Health care expenditure in South Africa was slightly more than R100 billion in 2005. This was equivalent to 7.7% of the Gross Domestic Product (GDP) in that year. This has declined from a level of 8 to 8.5% of GDP throughout the 1990s and early 2000s, largely due to the rapid growth in GDP in recent years. Despite this decline in health care expenditure relative to GDP, South Africa's level of spending is relatively high by international standards; it exceeds that in the majority of countries of a similar level of economic development and is similar to that in some high income countries (see Table 1). However, health status indicators (such as infant mortality) in South Africa are far worse than that in other upper-middle income countries. There is, therefore, a strong basis for arguing that the key challenge facing the South African health sector is not one of a lack of resources, but rather a great need to use the existing resources more efficiently and equitably.

Figure 1 provides an overview of the flow of funds between key financing intermediaries (i.e. organisations that receive funding and purchase health services) and health care providers. Approximately 40% of total health care funds in South Africa flow via public sector financing intermediaries (primarily the national, provincial and local departments of health), while 60% flow via private intermediaries.

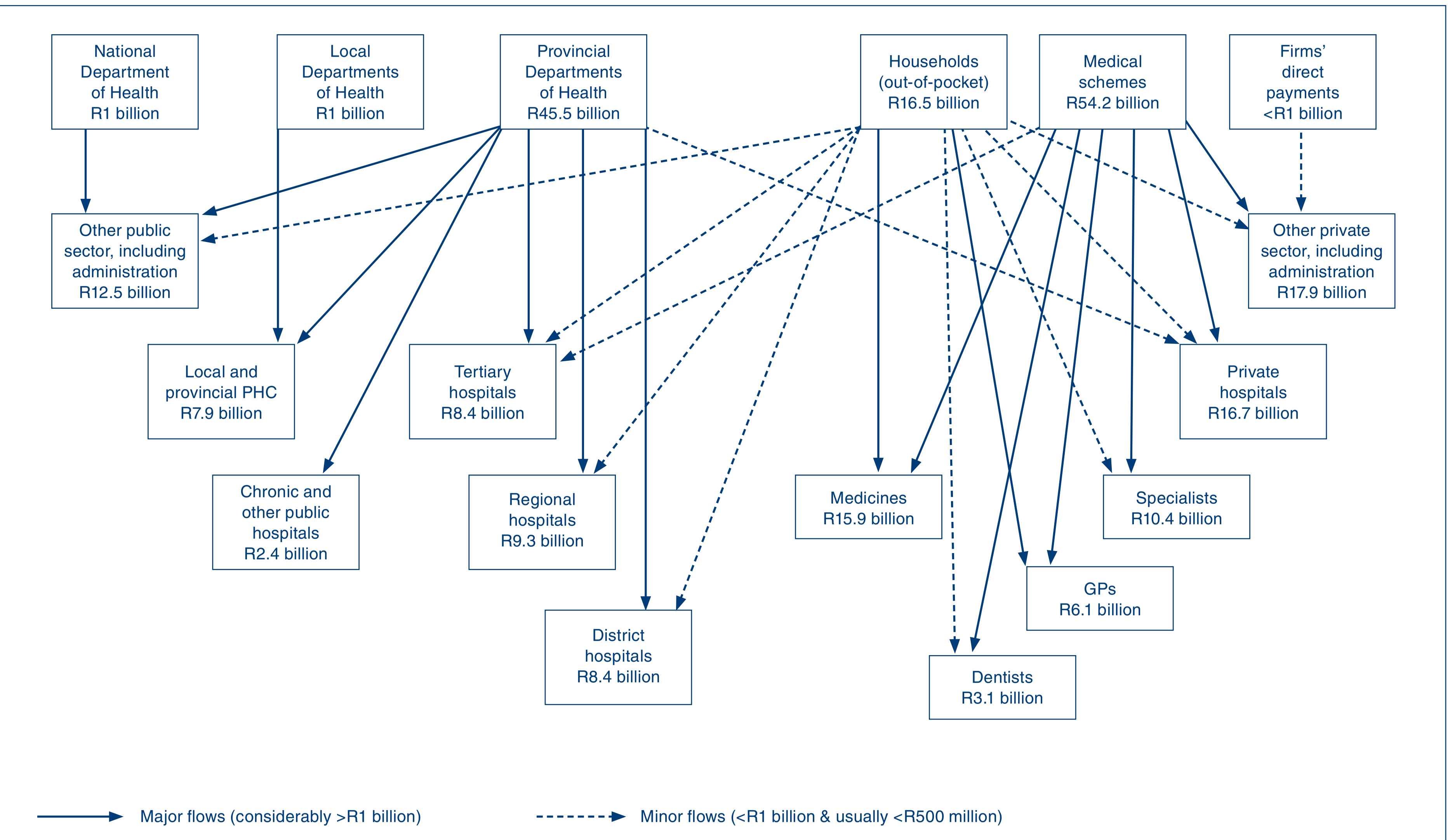
Table 1: Comparison of health care expenditure and health status indicators in selected high and middle income countries

Country	Health care expenditure as % GDP, 2002	Life expectancy at birth, 2003	Infant mortality rate per 1 000 live births, 2003
South Africa	8.3	48	53
High income countries			
Australia	9.5	80	6
Canada	9.6	80	5
United Kingdom	7.7	78	5
Middle income countries			
Brazil	7.9	71	33
Chile	5.8	78	8
China	5.8	72	30
Costa Rica	9.3	78	8
Cuba	7.5	77	6
Egypt	4.9	70	33
Estonia	5.1	71	8
Malaysia	3.8	73	7
Thailand	4.4	70	23

Source: UNDP, 2005;[3] WHO National Health Accounts database.[a]

a World Health Organization estimates for country National Health Accounts (1996-2005). Available at: http://www.who.int/nha/country/ZAF.pdf

Figure 1: Health care expenditure in South Africa, 2005 (Rand billion)



Source: McIntyre, 2007;[1] National Treasury, 2006;[2] National Treasury, 2007;[4] CMS, 2006;[5] Cornell, 2001.[6]

Medical schemes are the largest financing intermediaries, accounting for nearly 46% of health care expenditure. Provincial health departments follow as the next largest intermediary, with 38% of all health care funds flowing via them. Households' out-of-pocket payments directly to health care providers also account for a sizeable contribution of nearly 14% of all health care expenditure. Given that all expenditure data used in this analysis are based on recent audited reports (for public sector expenditure and for medical schemes), with the exception of estimated out-of-pocket payments, which relies on extrapolating from the somewhat dated (late 1990s) National Health Accounts, it is likely that out-of-pocket payments are underestimated.

In relation to the original sources of finance, the vast majority of funds flowing through public sector financing intermediaries are funded through nationally collected general tax and other revenues. About R1 billion accrues from local government rates, taxes and other local revenues, while provincial revenues are insignificant. Most of the funds flowing through private intermediaries are attributable to households. In addition to their direct out-of-pocket payments, households contribute significant amounts to medical schemes. From the provider perspective, about 41% of all health care expenditure is attributable to public sector health services and administration and 59% on private sector services and administration.

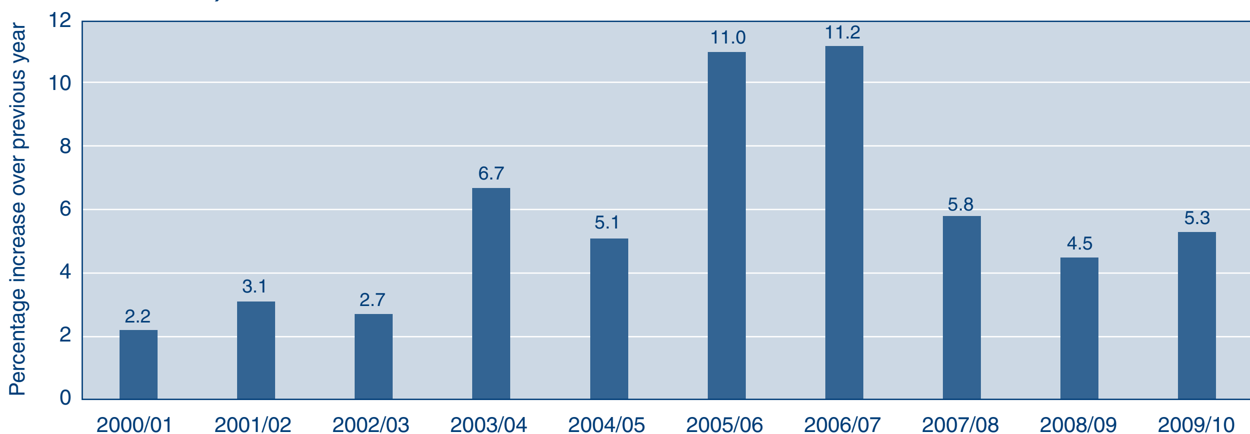
Key issues in the public health sector

There was very limited real growth in public health sector expenditure in the decade after the first democratic elections in South Africa. Government health budgets were particularly constrained in the late 1990s, largely as a result of the Growth Employment and Redistribution (GEAR) macroeconomic policy of reducing government debt through constraints on government expenditure. Figure 2 illustrates that by early 2000, health care expenditure was increasing in real terms (after taking inflation into account), but it should be noted that these increases did not keep pace with population growth and as a result there was a small decline in real per capita expenditure.

Increases in expenditure have been greater since 2002/03, and considerable in 2005/06 and 2006/07. This has resulted in a small real per capita increase in recent years. Although real annual increases of approximately 5% are promised, based on the Medium Term Expenditure Framework (MTEF) budget projections, these increases are barely keeping pace with population growth in South Africa. The bottom line is that public sector health care expenditure has been stagnant in real per capita terms for a considerable period of time, despite the fact that the demands on public sector services have increased dramatically due to the AIDS epidemic.

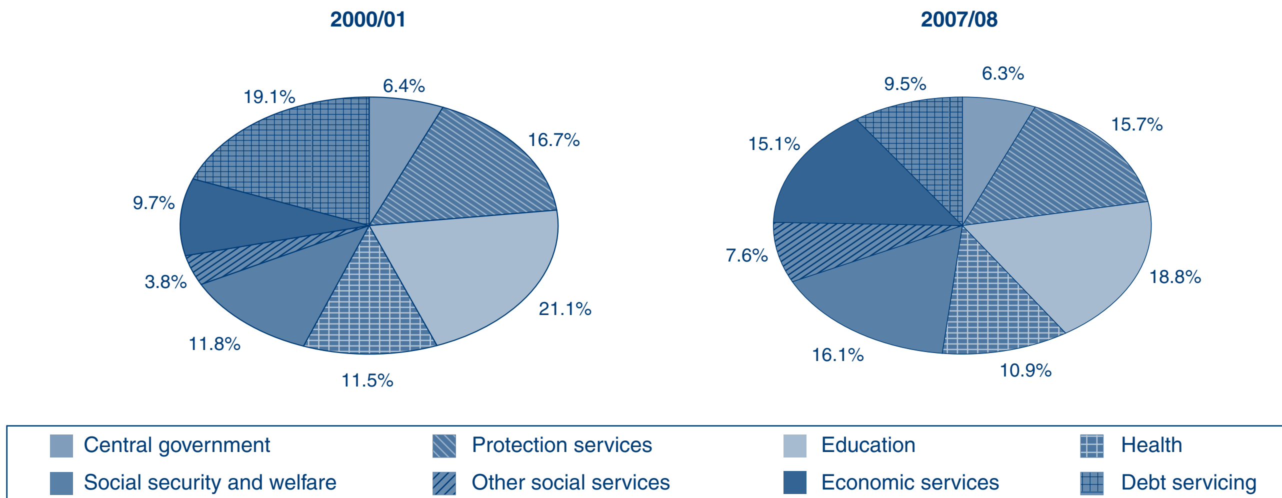
Although total government expenditure has been constrained for the past decade, the health sector has been receiving a declining share of these resources. As indicated in Figure 3, the health sector's share of total government expenditure has declined from 11.5% in 2000/01 to 10.9%

Figure 2: Annual increase in real government health care expenditure (until 2005/06) and budgets (2006/07 onwards)



Source: National Treasury;[4,7,8,9,10] StatsSA, 2007.[11]

Figure 3: Government expenditure shares, 2000/01 and 2007/08 (functional classification)



Source: McIntyre, 2007;[1] National Treasury.[4,9]

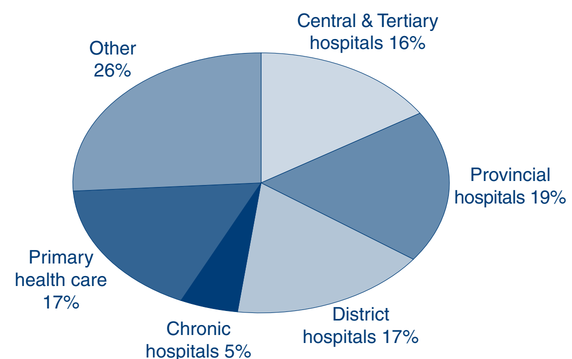
in 2007/08. Over this period, government's debt servicing commitments have declined from consuming 19.1% of total government resources in 2000/01 to 9.5% in 2007/08. The resources released from this declining debt burden have largely been allocated to social security and welfare (whose share of total government expenditure has increased from 11.8% in 2000/01 to 16.1% in 2007/08), other social services (increased from 3.8% to 7.6%) and economic services (including National Treasury and the Department of Trade and Industry, increased from 9.7% to 15.1%).

While the dramatic increase in spending on social grants is likely to contribute to improved health status, the public health sector is in desperate need of additional resources. There is the potential for funding of the public health sector to increase in the next few years; as the debt servicing requirements decline even further, resources will be released which could partially be devoted to the health sector, if sufficient pressure is placed on key policy makers.

At the time of the first democratic elections in 1994, the key challenges facing the public health sector included allocative inefficiencies and geographic inequities. In particular, there was inefficient distribution of resources between levels of care with hospitals accounting for nearly 89% of expenditure on the major categories of health services and non-hospital primary care accounting for only 11% in the early 1990s.[12] This relative distribution has shifted with hospitals accounting for 77.5% and primary care for 22.5% respectively in 2005.[2,4]

Figure 4 shows the distribution of total government health care expenditure, including 'other' spending such as administration, facility maintenance, health professional training, ambulance and other patient transport. It is encouraging that over one-third of all expenditure is devoted to district level (i.e. primary care and district hospitals), followed by the next level of provincial hospitals at almost a fifth of total expenditure and finally by the highest level of tertiary and central hospitals.

Figure 4: Distribution of total government health care expenditure, 2005



Source: National Treasury.[2,4]

There was also an inequitable distribution of public sector health care resources between provinces at the time of the first democratic elections. In 1992/93, the most well resourced province (the Western Cape) was spending approximately 3.5 times more per person residing in the province than the least resourced province (Mpumalanga).[12] If those who use the private health sector are removed from the provincial populations (estimated as those who are members of medical schemes in each province), there was a more than fivefold difference in public sector spending

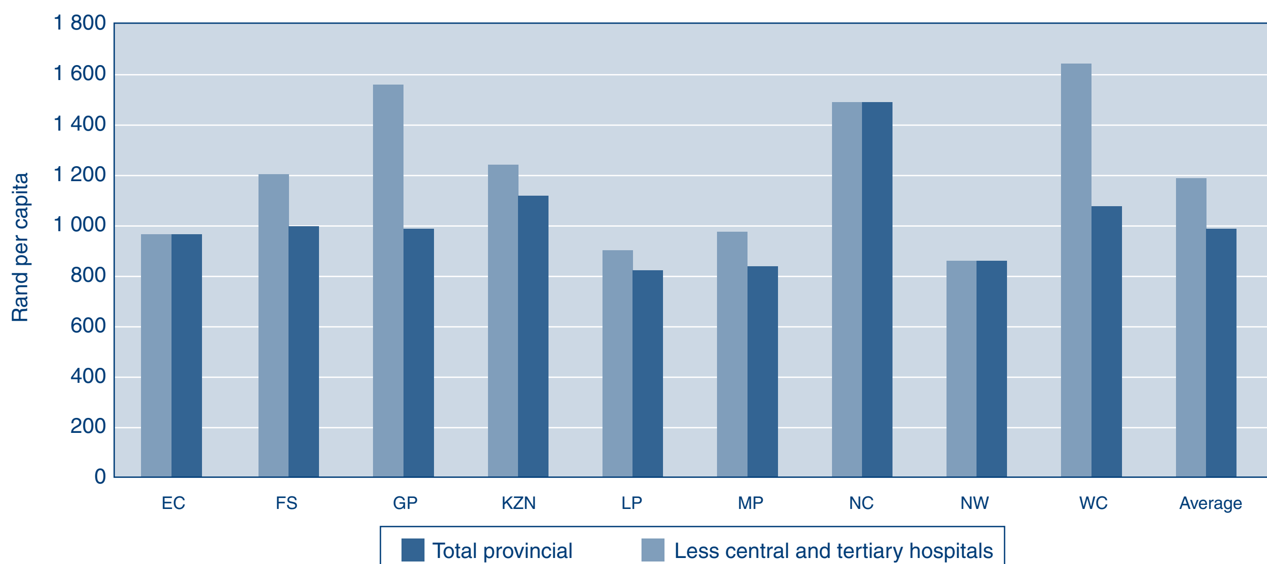
per person dependent on the public sector between the Western Cape and Mpumalanga.[13] However, certain provinces (particularly the Western Cape and Gauteng) provide what can be considered to be 'national services' (i.e. highly specialised services that are only provided in very few provinces and made available to residents of other provinces). If these services are excluded from the interprovincial comparisons, disparities were less great, but the Western Cape was nevertheless spending twice as much on non-highly specialised health services per person dependent on public sector services than Mpumalanga.[13]

A few years after the elections in 1994, public sector health care resources were actively redistributed by the national Department of Health (DoH) between provinces, based on the relative needs of individual provinces. During this period, differences in per capita spending between provinces were greatly reduced. However, with the adoption of the final Constitution in 1996, a fiscal federal system was introduced whereby significant autonomy was granted to individual provinces to determine their own budgetary allocations between sectors. Thus, from the 1997/98 financial year, disparities in health spending between provinces began increasing.[14]

In more recent years, there has been progress towards greater equity in interprovincial health care expenditure. Figure 5 indicates that by 2005/06, total public sector health care expenditure per person dependent on public sector services was approximately twice as high in the Western Cape as in North West (compared to the fivefold difference between the best and worst resourced provinces in 1992/93). If spending on highly specialised services (central and tertiary hospitals) is excluded, the gap diminishes to 1.8 times greater in the highest spending province (Northern Cape) than the lowest spending province (Limpopo), which is a small reduction in the disparities existing in 1992/93. However, the Northern Cape is regarded as a 'special case', requiring greater than average funding levels. This province is extremely sparsely populated (about 2.5 people per square kilometre) and spans a vast area (of over 360 000 square kilometres), which translates into a higher cost per person in order to deliver accessible health services. The appropriate comparison would be the province with the next highest spending levels, KwaZulu-Natal, which spent about 1.4 times more per person dependent on public sector services than Limpopo in 2005/06, which is a definite improvement on the 1992/93 level of a twofold difference.

These data indicate that there has been progress towards addressing both the allocative efficiency and geographic equity challenges that faced the public health sector at the time of the first democratic elections.

Figure 5: Provincial health care expenditure per person dependent on public sector services, 2005/06



Source: National Treasury, 2006;[2] StatsSA, 2006;[15] CMS, 2006.[5]

Key issues in the private health sector

Medical schemes

In contrast to the public sector, expenditure in the private sector has continued to increase on an annual basis since the 1980s, at rates far exceeding the inflation rate. Membership of medical schemes has become increasingly unaffordable for South Africans. Expenditure increases are associated with a concomitant increase in contribution rates or premiums that are charged by medical schemes. In the late 1980s and early 1990s, contribution rates were increasing between 25% to 30% per year in real terms.[12] The rate of annual contribution increases has reduced dramatically in recent years, but the average annual real increase in contributions of 7% between 2000 and 2005 is still of concern.

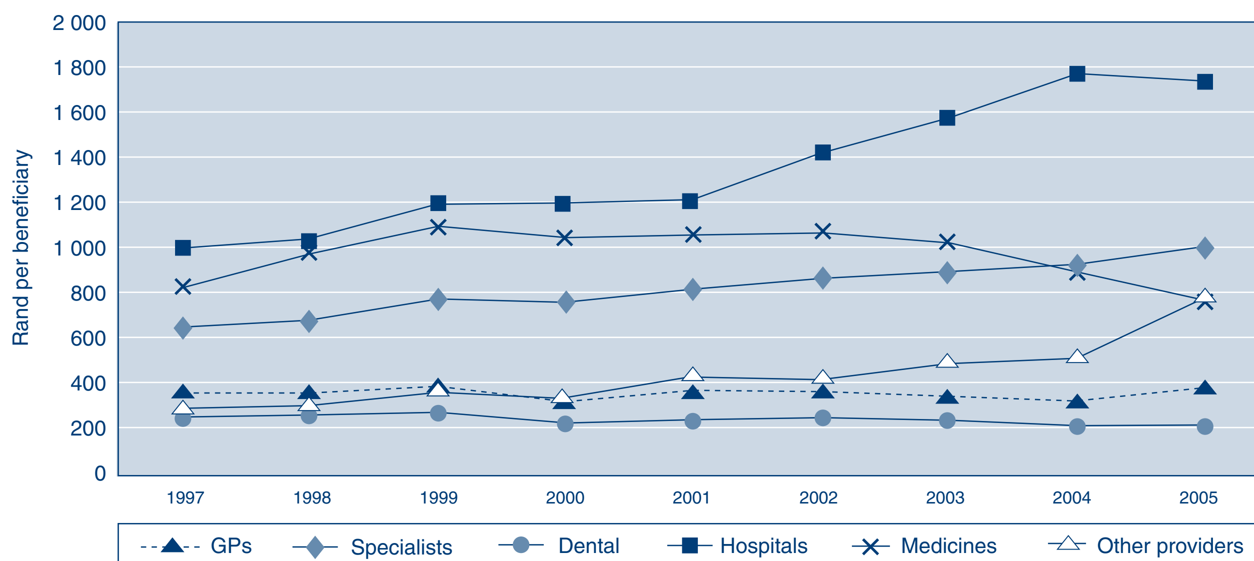
Although medical scheme membership increased from about 6.5 million in the early 1990s to 6.9 million by 1997, the absolute total number of beneficiaries decreased thereafter and had only again reached 6.9 million by 2005. Medical scheme membership has declined considerably as a percentage of the population, from 17% of the population being members of medical schemes in 1992 to only 14.8% in 2005.[12,5]

The main cost drivers of medical schemes expenditure have been private hospitals, specialists and medicines.[6,14,16] While in the 1980s and early 1990s, expenditure on medicines increased rapidly, expenditure on private hospitals registered the most rapid increases in the latter part of the 1990s and the 2000s.[14]

Figure 6 demonstrates the pace of change in medical scheme expenditure on different service providers, expressed as per beneficiary and real terms (i.e. after accounting for inflation). General practitioners and dentists have not registered much change in expenditure on their services since 1997. There has been a considerable increase in expenditure on 'other providers', which includes a wide range of service providers such as physiotherapists, psychologists, chiropractors, homeopaths, acupuncture therapists, traditional healers and many others. This partly reflects changes in benefit package design, particularly that many medical scheme members have a 'savings account' component for their day-to-day health care needs, which can be used for a wider range of providers than previously permitted.

While real per beneficiary expenditure on specialists increased by 53% between 1997 and 2005, expenditure on hospitals increased by 74% over this period. Spending on private hospitals accounted for 98.5% of all medical scheme expenditure on hospitals in 2005.[5] The increasing expenditure on private hospitals is of particular concern. While the average expenditure on a medical scheme beneficiary for hospital care was R995 in 1997, it increased to R1 729 by 2005 (expressed in real terms, 2000 base). Expressed differently, medical scheme expenditure on hospitals per beneficiary increased three times more rapidly (189% in nominal terms) than inflation (66%) between 1997 and 2005.

Figure 6: Medical scheme expenditure per beneficiary on different services (real, 2000 base)



Source: McIntyre, 2007;[1] CMS, 2006;[5] StatsSA, 2007.[11]

An increase in hospital expenditure can be attributed to increases in unit costs and / or utilisation levels. Key issues in relation to utilisation patterns of relevance to private hospitals can be identified by comparing data for 2004 and 2005. While the private hospital admission rate did not increase dramatically, there were increases in high cost services such as caesarean section, magnetic resonance image (MRI), CT scans, and angiograms.[5] The price of various private hospital services have also increased considerably in the past few years. There has been considerable concentration of private hospital beds under the control of the three major hospital groups, which now stands at 84% of all private hospital beds. As demonstrated in a recent submission to the Competition Commission, there are clear indications that these major groups are using their oligopoly power to charge excessively high prices and not to engage in price competition with each other.[17]

The fee-for-service method of reimbursing private hospitals and private practitioners is likely to have contributed to the rise in utilisation, since earnings are directly related to the volume of work.[13] The reported increase in utilisation of high-tech diagnostic procedures in recent years illustrates the incentives contained in a fee-for-service reimbursement system. When expensive high-technology equipment is purchased by owners of private hospitals, substantial pressure is applied on clinicians to use this equipment to earn revenue for the hospital. It is not surprising that there were substantial increases in expenditure on both medical specialists and private hospitals since the late 1990s, given that many private specialists had a stake in the financial performance of private hospitals through share ownership or other forms of financially beneficial relationships, such as rent-free or subsidised consulting rooms within hospitals.[13,17] Specialists are only entitled to these financial benefits if they meet targets for use of hospital facilities, which is likely to have contributed to higher levels of hospitalisation, longer periods of admission and / or increased use of diagnostic procedures than would have occurred without these financial interrelationships.

One of the most dramatic trends in medical scheme expenditure, shown in Figure 6, is the overall decrease in spending on medicines per beneficiary, by nearly 6% in real terms between 1997 and 2005, although this trend levelled off in 2006. As indicated, expenditure on medicines by medical schemes was increasing more rapidly than any other category in the 1980s and early 1990s. Although private hospitals were the main cost driver from the mid-1990s, expenditure on medicine continued to increase rapidly throughout most of the 1990s. It levelled off in the early 2000s, largely in line with the pace of inflation. Although expenditure began to decrease in 2003, the largest decreases occurred in 2004 and 2005.

These decreases were attributable to two key regulatory interventions. Firstly, legislation was introduced that required pharmacists to offer patients a generic substitute for any medicine prescribed, unless the prescribing doctor explicitly stated that the medicine should not be substituted. The use of generic medicines increased by 14% between 2003 and 2004, which contributed to the decline in medicine expenditure during this period. For example, while the price at which a medicine was sold to a private hospital, pharmacy or dispensing doctor for the branded antibiotic 'Augmentin' was R133.10, a generic equivalent 'Adco-Amoclav' was R89.42 (the price of the generic was 33% lower than the branded originator product). While there was a wide variation in the price difference between generics and the originator product (e.g. from less than 10% to over 80%), generic substitution contributed to reducing medicine expenditure.

Secondly, in 2004, Regulations were introduced to control the price of medicines. In particular, discounting was outlawed and manufacturers were required to sell at a Single Exit Price (SEP). Previously, purchasers such as private hospitals and dispensing doctors were granted enormous discounts (sometimes up to 80% of the stated price) in order to ensure that their product was included on the hospital formulary or dispensed by doctors. Small retail pharmacies, particularly in rural areas, paid the highest price for medicines. A key problem was that discounts were not offered to consumers. The introduction of a SEP, which had to be set at the level of the previous list price less the value of the previous discounts, translated into an average price decrease of approximately 22%.

These diverging changes in expenditure over the past decade or more have translated into dramatic changes in the distribution of medical scheme expenditure between different categories of health services (see Table 2). While medicines were the single largest category of medical scheme expenditure (nearly 32%) shortly before the first democratic elections, private hospitals (in terms of ward and theatre fees, consumables and medicines used during hospitalisation) had taken over this place by the mid-1990s.

Private hospitals now account for over 35% of medical schemes expenditure, medical specialists account for nearly 21% of expenditure, and medicines account for a mere 16% of expenditure. These expenditure patterns reflect differen-

tial changes in prices and utilisation patterns, with private hospital fees increasing dramatically and medicine prices decreasing equally dramatically. Whereas medical schemes initially provided a comprehensive benefit package, in recent years the emphasis has been on high cost inpatient care and the treatment of chronic diseases, which is linked to the Prescribed Minimum Benefit (PMB) package that is now stipulated in Regulations. This has particularly impacted on general practitioners and dentists, whose services are no longer covered under the core benefit package.

Table 2: Distribution of medical scheme expenditure between providers

Service	1992/93 (%)	1997 (%)	2005 (%)
General Practitioners	11.5	10.6	8.0
Specialists	17.8	19.5	20.5
Dental	9.7	7.7	4.6
Hospitals	21.8	29.4	35.3
Medicines	31.8	24.2	15.8
Other services	7.3	8.6	15.9

Source: CMS, 2006;[5] McIntyre, 1995;[12] CMS, 1997.[18]

Although not reflected in the data presented in Table 2, another area of rapid increase in expenditure is on 'non-health care' items (which accounted for a total of R7.8 billion in 2005), such as administration (R5.4 billion in 2005), managed care initiatives and brokers' fees. More is spent on these activities than is spent on general practitioners and dentists combined, or on medicines.

Clearly, controlling the rapid spiral of medical scheme contributions and expenditure is one of the greatest challenges facing the private sector. This is largely because medical scheme beneficiary levels are stagnant (and has declined in some years), as a growing number of South Africans find that they can no longer bear the costs of this contribution and expenditure spiral. Although the quantity of financial and human resources available to medical scheme members continues to increase, the proportion of the population served by these schemes is rapidly declining.

The medical schemes environment is rapidly becoming unsustainable. Controlling the cost spiral cannot be achieved merely through ongoing regulatory efforts in relation to the financing intermediaries. It is also necessary to address the rapid growth in supply of private sector health care provision in the context of stagnating demand for such services (declining medical scheme coverage as a percentage of the population and inability to extend coverage through low cost schemes).

Out-of-pocket spending

It is also of concern that direct out-of-pocket payments, which are the most regressive form of health care financing, account for almost a quarter of private health care financing. Although no accurate and current data on the magnitude and distribution of out-of-pocket payments exist, the most recent National Health Accounts, which provide data for the late 1990s, indicates that the majority of such expenditure (two-thirds) is incurred by medical scheme members (e.g. for co-payments, and services not covered by the scheme).[6]

For medical scheme members, 55% of their out-of-pocket payments were for medicines; some for over-the-counter medicines not covered by schemes, but mostly for prescription medicines. This is related to the considerable co-payments on prescription medicine required by some medical schemes as well as the fact that benefit limits for both acute and chronic medicines are frequently reached months before the end of the year. This situation may have changed with the dramatic decline in medicine prices in recent years, but it is known that pharmacists were charging patients an extra 'administration fee', not covered by medical schemes, in order to maintain their income levels.

The next largest category of out-of-pocket payments by medical scheme members (28%) is that of payments to medical and dental practitioners. This usually occurs where the practitioner charges a higher fee than the scheme is willing to reimburse (most often in the case of specialists, which alone account for 12% of all out-of-pocket payments by medical scheme members) or where the practitioner's services are not included in the benefit package (e.g. some schemes do not cover dental services). The remaining out-of-pocket payments by scheme members are co-payments for hospital care (8% of payments by medical scheme members) and payments to other providers (e.g. homeopaths, if not covered in the scheme's benefit package).

In the case of those who are not covered by a medical scheme, the majority of out-of-pocket payments in the late 1990s were devoted to medicines, 78% of which was spent on over-the-counter medicines and 22% on prescription medicines. This indicates that most of the population who are not beneficiaries of a medical scheme, but who use a

private pharmacy do so for self-treatment purposes. Very few are able to afford to purchase prescription medicines on an out-of-pocket basis. Some also use private practitioners, particularly general practitioners and occasionally a dentist, which account for 26% of total out-of-pocket payments by non-scheme members. Finally, 18% is spent on hospital care, which relates particularly to the payment of user fees at public sector hospitals, and 8% on a wide range of 'other' private practitioners (including traditional healers, psychologists, homeopaths, etc.).

The public-private health sector mix

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 care sectors relative to the population served by each. To illustrate the extent of the disparities, approximately R9 500 per person was spent on less than 15% of the population covered by medical schemes in 2005. The average spending per person was R1 500 for those who use private sector primary health care on an out-of-pocket basis and public sector hospitals for specialist and inpatient care (21% of the population) and only R1 300 for those entirely dependent on the public sector (64% of the population).[1]

These disparities are even greater in relation to health professionals; each pharmacist in the public sector serves 12 times, and each generalist doctor in the public sector serves 7 times more people than those in the private sector (assuming that up to 36% of the population use private pharmacists and private general practitioners including both medical scheme members and those paying out-of-pocket for these services). There is a sixfold difference in the number of people served per nurse, and a 23 times difference in the number of people served per specialist doctor, working in the public and private sectors in South Africa.[1] Expressed differently, 75% of generalist doctors and 84% of pharmacists work in the private sector, serving a maximum of 36% of the population using the most generous assumptions possible. However, most of their clients come from the 15% of the population covered by medical schemes. Eighty per cent of specialist doctors reportedly now work in the private sector and they serve almost exclusively medical scheme members (i.e. less than 15% of the population).

A vicious cycle exacerbating the inequities in the public-private mix was set in motion in the 1980s, which has spiralled out of control in recent years. This can be summarised as follows:

- There has been an exodus of doctors and other health professionals from the public to the private sector, especially from the 1980s onwards. About 40% of doctors worked in the private sector by the early 1980s, which had increased to over 60% by 1990 and over 70% by the late 1990s. There have been similar trends for other health workers. There was also a rapid increase in the number of private for-profit hospital beds over this period, which increased from approximately 8 000 in the early 1980s to over 11 000 by the late 1980s, with a very rapid increase thereafter to 16 415 by 1994 and 23 706 by 1999. A less rapid increase was observed since 1999 to nearly 25 000 at present.[6,17] Importantly, there is a heavy concentration of private providers in urban areas. For example, 54% of private for-profit hospital beds are located in the four largest metropolitan areas alone.[17]
- Although the supply of private sector health care providers has been increasing very rapidly, the population able to afford private services, particularly medical scheme beneficiaries, has not been increasing as rapidly and has declined over the last decade or so as a percentage of the population. While there were about 4.8 million medical scheme beneficiaries in the early 1980s, this increased rapidly to 6.3 million by the early 1990s.[12] However, growth was much slower during the 1990s and reached a high of 6.9 million by 1997 and has since fluctuated around this level. Medical scheme membership has increased in 2006 largely due to the rapid growth of the Government Employees Medical Scheme (GEMS), but the pool being served by private providers remains limited.
- The result is that the supply of private sector providers has increased dramatically since the early 1980s, but the population that they serve has not. Although medical scheme membership increased during the 1980s, this was at a slower rate than the increase in providers. In addition, there has been growing unemployment since the 1980s and limited economic growth over much of this time, suggesting that the number of people using private providers on an out-of-pocket basis has significantly increased. The data presented clearly indicate that there is an over-supply of private providers relative to the population that can access and use their services.

- How is it that this growing group of private providers were able to generate what they considered as an acceptable level of income? In the 1980s, there was relatively 'tight control' on provider fees, with most private providers adhering closely to the Representative Association of Medical Schemes' (RAMS) tariff schedule in order to secure direct and full payment from medical schemes. Although it has been difficult to document due to data deficiencies, there has been an increase in utilisation (e.g. higher number of doctor visits and hospitalisations per medical scheme beneficiary). A clear trend that was documented was the number of doctors registered to dispense medicines, which nearly doubled between 1988 and 1993.[12] This coincided with a dramatic increase in spending on medicine within medical schemes, strongly suggesting that many doctors had begun selling medicines as a mechanism to ensure that they were able to reach their income goals given that they were not able to do so purely from consultations. In relation to hospitals, there are considerable perverse financial relationships between specialists and private hospitals.[17] Private hospitals have invested in technology to attract specialists, and then place specialists under pressure to utilise this technology in order to recoup the expenses incurred in the purchase of technology. Thus, in the initial phase of the growth of private sector providers, the key response to a relative over-supply was to promote increased utilisation (supplier-induced demand).
- Over time, the balance of power in relation to influencing prices has shifted away from medical schemes and in favour of private providers, particularly in relation to hospitals. This has been fostered through the increased concentration of private hospital beds within three major groups and concerted action by doctor and other professional groupings to act in unison in charging higher prices. The Competition Commission's decision that each scheme should negotiate prices with each provider has also contributed to this shift in the balance of power.

These factors have contributed to the unconstrained cost spiral in the private sector, which has resulted in a rapidly widening gap in the public-private sectors. While per capita expenditure in medical schemes was five times greater than public sector expenditure in 1998, this had increased to 6.6 times greater in 2005.

Concerns about the public-private mix are compounded by the fact that limited tax resources are devoted to supporting the expensive private medical scheme system. This occurs in two ways. Firstly, the tax deductibility of medical scheme contributions significantly reduces government tax revenue. In South Africa, this was estimated to be over R8.2 billion in 2001 (which is equivalent to nearly 30% of total government spending on health in that year) and had increased to R10.1 billion by 2005.[19,20] Despite recent revisions in the regulation of tax deductions of medical scheme contributions, these benefits are inequitably distributed, with higher income earners receiving a much greater share of the tax benefits. Secondly, the largest single employer in South Africa is the government, and a substantial sum of tax resources is devoted to purchasing medical scheme cover for civil servants. For example, in early 2000 the South African government spent 12 times more for medical scheme cover per civil servant than it spent on funding public sector health services per person dependent on these services.[14] This raises serious equity concerns about the use of limited tax funds.

The existing public-private mix suggests that a key challenge within South Africa is to find a way to promote cross-subsidisation (between healthy, younger and wealthier population groups and the sick, elderly and poorer groups) in overall health care financing and expenditure. Ways of improving cross-subsidies are explored in the Chapter on Social or National Health Insurance.

Conclusion

The analyses presented in this chapter indicate that while public sector health care expenditure has been relatively stagnant in real per capita terms over the past decade, expenditure in the private sector has continued spiralling at rates far exceeding the rate of inflation. Inequities in the public-private health sector, in terms of the financial and human resources available in each sector relative to the population served have rapidly grown more severe. It is critical that these diverging trends be urgently addressed, both through increased tax funding of public sector services and efforts to promote improved efficiency within the private health sector.

References

1 McIntyre D, Thiede M, Nkosi M, Mutyambizi V, Castillo-Riquelme M, Gilson L, et al. A Critical Analysis of the Current South African Health System. Cape Town: Health Economics Unit, University of Cape Town and Centre for Health Policy, University of the Witwatersrand; 2007.
URL: http://web.uct.ac.za/depts/heu/publications/SHIELD_WP1_only_report_SA_final.pdf

2 National Treasury. Provincial Budgets and Expenditure Review: 2002/03-2008/09. Pretoria: National Treasury; 2006.

3 United Nations Development Programme. Human Development Report 2005. New York: United Nations Development Programme; 2005.
URL: http://hdr.undp.org/reports/global/2005/

4. National Treasury. 2007 Budget Review. Pretoria: National Treasury; 2007.
URL: http://www.treasury.gov.za/documents/budget/2007/review/isbn.pdf

5. Council for Medical Schemes. Annual Report, 2005-6. Pretoria: Council for Medical Schemes; 2006.
URL: http://www.sapma.co.za/assets/attachments/0334_Council_for_Medical_Schemes_Annual_Report_2005-6.pdf

6 Cornell J, Goudge J, McIntyre D, Mbatsha S. South African National Health Accounts: The Private Sector. Pretoria: National Department of Health; 2001.
URL: http://web.uct.ac.za/depts/heu/publications/dimac_9_1.pdf

7 National Treasury. 2003 Budget Review. Pretoria: National Treasury; 2003.
URL: http://www.treasury.gov.za/documents/budget/2003/review/foreword.pdf

8 National Treasury. 2004 Budget Review. Pretoria: National Treasury; 2004.
URL: http://www.treasury.gov.za/documents/budget/2004/review/ISBN%20page%20rev.pdf

9 National Treasury. 2005 Budget Review. Pretoria: National Treasury; 2005.
URL: http://www.treasury.gov.za/documents/budget/2005/review/ISBN%20page%20rev.pdf

10 National Treasury. 2006 Budget Review. Pretoria: National Treasury; 2006.
URL: http://www.treasury.gov.za/documents/budget/2006/review/ISBN%20page%20rev.pdf

11 Statistics South Africa. Annual Inflation on a Monthly Basis: Consumer Price Index, Metropolitan and other urban areas- Core Index (January 1997 - January 2007). Pretoria: Statistics South Africa; 2007.

12 McIntyre D, Bloom G, Doherty J, Brijlal P. Health Expenditure and Finance in South Africa. Durban: Health Systems Trust and the World Bank; 1995.

13 McIntyre D. Health Care Financing and Expenditure in South Africa: Towards equity and efficiency in policy making. PhD Dissertation. Cape Town: University of Cape Town; 1997.

14 McIntyre D, Doherty J. Health care financing and expenditure: Progress Since 1994 and Remaining Challenges. In: Van Rensburg H, editor. Health care in South Africa. Pretoria: Van Schaik Publishers; 2004.

15 Statistics South Africa. Mid-year Population Estimates, South Africa 2006. Pretoria: Statistics South Africa; 2006.
URL: http://www.statssa.gov.za/Publications/P0302/P03022006.pdf

16 McIntyre D, Valentine N, Cornell J. Private Sector Health Care Expenditure in South Africa. S Afr Med J 1995; 85:133-5.

17 van den Heever AM. Evaluation of the Merger Between Network Healthcare Holdings and Community Healthcare. Pretoria: Council for Medical Schemes; 2007.

18 Council for Medical Schemes. Report of the Registrar of Medical Schemes, 1996/97. Pretoria: Council for Medical Schemes; 1997.

19 McLeod H. Mutuality and Solidarity in Healthcare in South Africa. In: Sessional meetings of the Actuarial Society of South Africa: Actuarial Society of South Africa; 2005.
URL: http://www.assa.org.za/scripts/file_build.asp?id=100000419

20 McIntyre D, McLeod H, Thiede M. Comments on the National Treasury Discussion Document on the Proposed Tax Reforms Relating to Medical Scheme Contributions and Medical Expenses. Cape Town: Health Economics Unit; 2005.