

South Africa faces treatment funding shortfall

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South Africa will face tough choices in the years ahead as its government strives to extend treatment to all who need it through the public health system, a leading health economist told the Fourth South African AIDS Conference earlier this month.

Dr Susan Cleary, the director of the Health Economics Unit at the University of Cape Town's School of Public Health and Family Medicine, outlined the financial dilemma that South Africa will face in the coming decade as the number on HIV treatment grows.

The long-term sustainability of South Africa's antiretroviral treatment programme is a major concern, given the fact that 17% of people living with HIV worldwide are estimated to reside in South Africa, and an estimated half million individuals need to start treatment each year.

How will this volume of treatment remain sustainable, and how can equity of access be ensured in a country with one of the highest levels of income inequality in the world?

One of the starkest indicators of inequity in South Africa is the level of health spending. Overall South Africa spends more on health than almost any other developing country (7.7% of GDP in 2005), and its expenditure is comparable to many rich nations.

However there is a huge gap in resourcing. Fifteen per cent of the population receive health care through the private system, where per capita spending is approximately R9,500 a year.

The remainder of the population receive health care through the public system, where per capita spending is no more than R1500 a year.

That translates into one general practitioner to every 590 patients in the private sector, compared to 4200 patients to each general practitioner in the public sector.

Specialist physicians are even thinner on the ground in the public sector: one per 11,000 patients in the public sector compared to one per 500 patients in the private sector.

Given the huge reliance on the public health sector for health care, it's inevitable that South Africa will have to simultaneously build the capacity of the public health system while tailoring its treatment programme to fit the very constrained resources available.

South Africa is doing well at meeting the targets set out in the National Strategic Plan for numbers on treatment, although many argue that the national targets could be more ambitious.

But over the next 15 years treatment and prevention costs are projected to grow tenfold from R2.4 billion in 2008 to R25 billion in 2022, potentially consuming more than half of the public health budget at 2008 expenditures.

How will South Africa cope? Using the cut-off of one-third of health expenditure devoted to HIV care delivered through the current model, **Susan Cleary** projects that in ten years time it would be

possible to achieve 62% antiretroviral coverage. Task-shifting and reducing unit costs of care would increase coverage by 10% - another 400,000 people treated.

Restricting treatment to the provision of first-line therapy only would increase coverage by 16% - an additional 700,000 people treated.

If the resources of the private sector could be engaged, Cleary suggests that treatment could be delivered to all who need it, taking up 21% of the country's total health budget. In these circumstances earlier treatment and better tolerated first-line drugs could be offered to all.

However, Cleary says that in reality, treatment in South Africa is already rationed, and will continue to be rationed in the future. The challenge facing the country, she said, will be in deciding how to use scarce resources in the future. In particular, South African society will have to decide whether it is better to reach fewer people with a higher standard of care, or whether less effective but more cost-effective treatment should be provided to a wider population?

But Mark Heywood of the AIDS Law Project highlighted the finance gap already facing South Africa. "If we take the existing numbers of patients who are on treatment, which is estimated to be just over 600,000 people, and if you add to that another 200,000 who will require to be initiated onto treatment this year, then the shortfall between what has been budgeted for and what it would actually cost just to meet the treatment needs is over one billion rand [110 million dollars]."

"The NSP is budgeted to cost R48 billion over the five year period. In the next three years up until 2011, the total HIV/AIDS allocation is only 11.4 billion," said Nonkosi Khumalo, Chairperson of the Treatment Action Campaign. "How are we to reach the NSP targets if we do not have the budget for it? We have seen moratoriums in some provinces this year, but that is just the tip of the iceberg."

The worst example of the effects of the funding shortfall have been seen in the Free State, where the provincial government suspended the enrollment of new patients on antiretroviral treatment in November 2008 due to over-spending. The AIDS Law Project has estimated that 15,000 people need to start treatment, and drug supplies have been interrupted for many patients on treatment.

Advocates have criticized bad planning and poor budgetary controls for the shortfall in funding.

"It's not that South Africa does not have enough funds, but about where the funds are allocated," said Mark Heywood.

"We need to recognise the importance of health in this country, and ensure that adequate finances are available to scale up healthcare, in accordance to the Constitution," said Mark Heywood. "A major problem is that health budgeting is not needs-based. We are given a figure and then we determine how many people we can reach, instead of assessing how much it would cost to meet the health and treatment needs. We call on government to provide budget allocations based on need and that all funds are spent effectively and efficiently to save as many lives of people waiting for treatment as possible."

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