

## Chapter 6: Sustainability

The gains made by the Government, noted in the previous chapters, need to be sustained over time. While there was undoubtedly significant progress made toward equity and allocative efficiency in the first few years of democratic government, the battles are far from won. There are still large inequities across provinces, serious inefficiency in some hospitals and a slow-down in the injection of resources into the health sector. In this chapter, we look forward to assessing the sustainability of early gains while examining the feasibility of addressing some of the remaining challenges and bottlenecks of the South African health care system.

The analysis is, nevertheless, restricted to the issue of *financial* sustainability. There are two common definitions. The first discusses the financing of the health sector in relation to its dependency on *external* resources. By this measure, South Africa is doing well: the flow of foreign donor funds into the health system is minimal, as noted in Chapter 3. Yet, perhaps a more pertinent issue for South Africa is the stability of funding sources. A second definition is concerned with the sufficiency and regularity of sources of finances into the health sector (McPake and Kutzin, 1997). While there are never enough resources in the health sector to meet all the demands and needs of the population, a good foundation for meeting stated objectives is real growth in funding. Further, predictability of financing allows proper planning to meet objectives and it is hoped that this chapter will contribute to the understanding of this issue. Hence, we explore the likely potential availability of public sector health funds in the future and the extent to which they can be forecasted. We also explore major or unexpected items of expenditure which absorb these funds. This is important as it may indicate future needs for funds or even potential areas for savings. Consideration is also given to potential bottlenecks in processing finances and decentralisation. Capacity to plan, budget, spend and monitor finances is an important prerequisite to financial sustainability and this issue will be addressed further in a subsequent NHA report.

### *Economic Outlook*

Projections of the macroeconomic environment over the medium term allow us to assess the viability of future health plans and expenditure trends. Table 6.1 contains data outlining the expected growth in the economy according to the Department of Finance (1999). Real GDP growth is expected to reach 3%, up from current levels by 2000/01. Nevertheless, public expenditure growth will be lower than GDP growth. (As noted earlier this appears to be a stipulation of the GEAR policy.) Further, for three of the four years shown, public expenditure will decline in real *per capita* terms.

A notable feature of GEAR is that it integrates the South African economy into the global market. The forecasts, in Table 6.1, assume relative stability in the international markets. However, as recent events have shown, there is always the risk of crises in other emerging markets, or in the Southern African region and these can have substantial knock-on effects for South Africa. While no-one can predict such events they do mean that exchange rates are susceptible to increasing volatility, because of the movement of speculative funds. If this feeds through into higher interest rates, then GDP growth and public expenditure trends may well be adversely affected. The forecasts in Table 6.1 could be seen, in such a light, as being optimistic. Alternatively, others argue that any depreciation in the Rand can only boost export levels, especially given the prospects of improved access to European

and North American markets. Export-led growth could then push up available resources for budget expenditure. Thus while the MTEF is designed to improve the predictability of sectoral financing through forward budgeting, South Africa's integration into the global market does not.

**Table 6.1: Economic Forecasts for Growth and Budget Expenditure,**

**1999/00 – 2002/03**

	1999/00	2000/01	2001/02	2002/03
GDP nominal (R billion, 99/00 prices)	810.55	881.95	958.525	1042.35
Inflation	5.4%	5.2%	5.0%	4.8%
GDP real (R billion, 99/00 prices)	810.55	836.31	863.25	893.34
Real GDP growth	1.5%	3.2%	3.2%	3.5%
Real GDP growth per capita	-0.6%	1.2%	1.2%	1.6%
Public Expenditure, nominal (R billion, 99/00 prices)	215.3	232.7	249.2	265.2
Public Expenditure, real (R billion, 99/00 prices)	215.3	220.7	224.4	227.3
Real Public Expenditure growth	-0.8%	2.5%	1.7%	1.3%
Real Public Expenditure growth per capita	-2.9%	0.4%	-0.4%	-0.8%

Sources: DoF (1999), SSA (1998)

Note: Figures for 2002/03 for GDP and inflation are NHA team extrapolations

### ***Future Budgets for Health***

It appears that the difficult economic environment for public expenditure plans, reviewed in Chapter 1, will continue into the medium term. How do these economic forecasts translate into health sector funding? Table 6.2 derives real health expenditure trends for the medium term. Here, available funds for public expenditure (equivalent to budget projections) are drawn from Table 6.1. Funds to be used for financing debt are removed. Of the remaining funds, health takes a set proportion, identified by the MTEF. The health budget figures are, therefore, derived from the MTEF health shares and remain approximately constant over the period (between 14.6-14.8%), implying very small growth in available health resources for budgetary expenditure. The year-on-year growth only climbs above 1% in 2002/03. When translated into per capita figures this equates into a decline every year (see Diagram 6.1).

It might be contested that the figures in the MTEF may not be the actual figures that are budgeted or spent in future years. Nevertheless, the aim of the MTEF is to provide us with as near a guide as possible to future budgets. They are, therefore, the best indication of future budget trends and Government financing (Abedian *et al*, 1998).

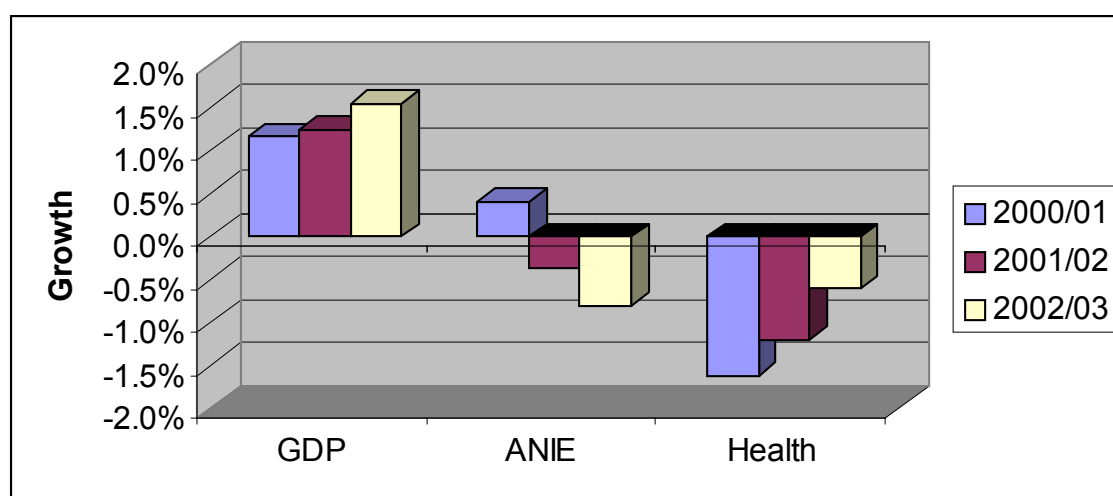
**Table 6.2: Implied Public Health Expenditure from the MTEF,  
1999/00-2002/03 (R billion 99/00 prices)**

	1999/00	2000/01	2001/02	2002/03	Average Annual Growth
Public expenditure, nominal	215.3	232.7	249.2	265.2	7%
Available non-interest expenditure (ANIE), nominal	170.7	183.2	194.4	204.2	6%
ANIE, real	170.7	173.7	175.1	175.0	1%
<i>Health shares in MTEF</i>	<i>14.8%</i>	<i>14.6%</i>	<i>14.6%</i>	<i>14.8%</i>	
Implied real health budget	25.26	25.36	25.56	25.90	1%
Implied real growth		0.4%	0.8%	1.3%	N/a
Implied health budget per capita	581	572	565	562	-1%
Implied real growth per capita		-1.6%	-1.2%	-0.6%	N/a

Source: DoF (1999), SSA (1998), NHA Team

Note: These figures are not the comprehensive picture of health financing in South Africa, and so do not match the figures earlier in the report. Instead such funds only include National and Provincial Departments of Health, which is a narrow definition of the public health sector

**Diagram 6.1: Projections of year-on-year increases in GDP per capita, ANIE per capita and health sector budget expenditure per capita (2000/01-2002/03)**



Key: GDP – Gross Domestic Product, ANIE – Available non-interest expenditure (through Public Sector Budgets), Health – Combined National and Provincial DoH Budgets.

The rate of increase of health expenditure envisaged in the MTEF is not impressive. How does health compare with other sectors? After all, available non-interest expenditure (for sectoral spending) is only growing itself at very low levels, by an annual average of 1% between 1999/00 and 2002/03. It may be that health is far from being exceptional in only receiving marginally more funds each year. Table 6.3 compares the sectoral shares in the MTEF. The largest increase is allocated to *Protection services*. More specifically the share of the budget allocated to *Defence and Intelligence* will increase from 6.6% in 1999/00 to reach 8.5% by 2002/03. The additional expansion in Defence expenditure is due to the Strategic Procurement

package and is worth R 3.3 billion in 2002/03. This is not without its opportunity cost. In health terms it is equivalent to the funding of all the health services in the Eastern Cape, for one year, or 70% of annual non-hospital PHC expenditure.

**Table 6.3: Share of Future Budgets by Different Sectors, excluding debt payments and the contingency reserve, 1999/00-2001/03**

	1999/00	2000/01	2001/02	2002/03
<i>Social Services</i>	53.8%	53.7%	53.6%	54.0%
Education	27.5%	27.7%	27.6%	27.8%
<b>Health</b>	<b>14.8%</b>	<b>14.6%</b>	<b>14.6%</b>	<b>14.8%</b>
Welfare	11.5%	11.4%	11.4%	11.4%
<i>Protection Services</i>	19.6%	21.3%	21.5%	21.7%
<b>Defence and Intelligence</b>	<b>6.6%</b>	<b>8.0%</b>	<b>8.3%</b>	<b>8.5%</b>
Integrated Justice System	13.0%	13.3%	13.2%	13.2%
<i>Economic Services</i>	6.6%	6.5%	6.7%	6.8%
<i>Infrastructure</i>	12.3%	11.1%	11.1%	11.0%
<i>Administration</i>	6.3%	6.6%	6.4%	6.4%

Note: 1999/00 figures are revised estimates, 2000/01-2002/03 are MTEF estimates

Source: DoF, 1999

### ***Other Sources of Health Sector Funds***

The expenditure flowing through the national and provincial Departments of Health does not reflect all of the health sector sources as defined by the NHA project. To construct a more accurate picture of future resource availability we need to consider all the sources outlined in Chapter 3. In particular, it is necessary to consider public sector funds from donors, households and local authorities.

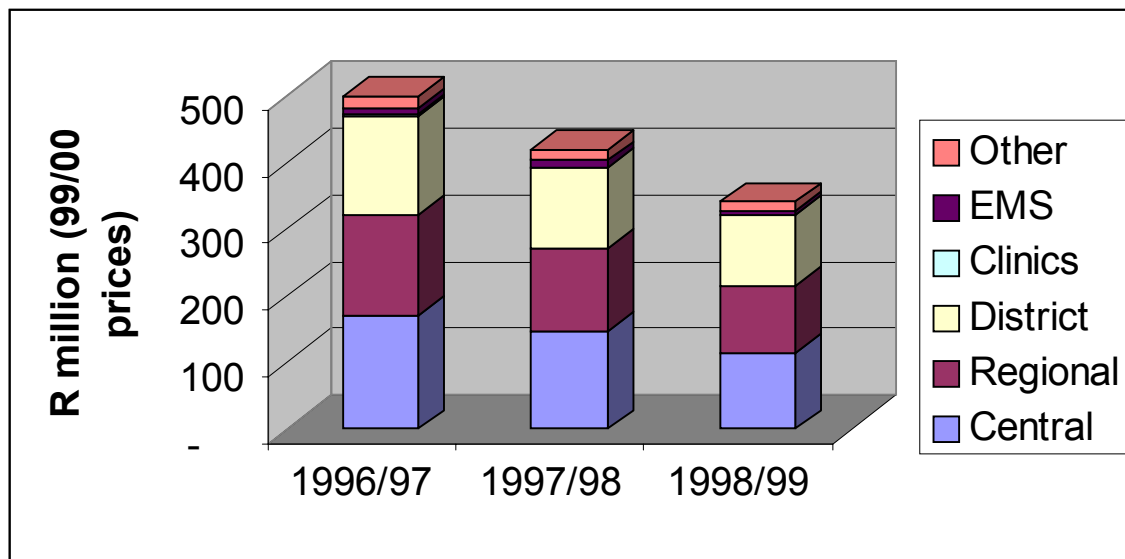
### Donors

The increase in donor funds in recent years to the public sector has been extremely strong. Nevertheless, this was from such a small base that donor funds are still only a tiny proportion of overall funding. The huge increase can be attributed to the end of apartheid; where previously donors had funded NGOs, they are now switching to finance partnership activities with government (Schneider and Gilson, 1997). Further, the administrative requirements of processing such funds and limited experience of donor coordination meant that donor expenditure in the health sector did not increase immediately after the democratic elections. Nevertheless, as collaboration improves between donors and government and systems are ironed out, such problems will ease. For the financial projections, the average annual increase between 1992/93 and 1998/99 could be extrapolated (see Table 6.6), but this may be overly optimistic. Instead, we assume funds from donors will grow at a steady 5% per annum. Such an assumption can be altered without significantly affecting our overall results.

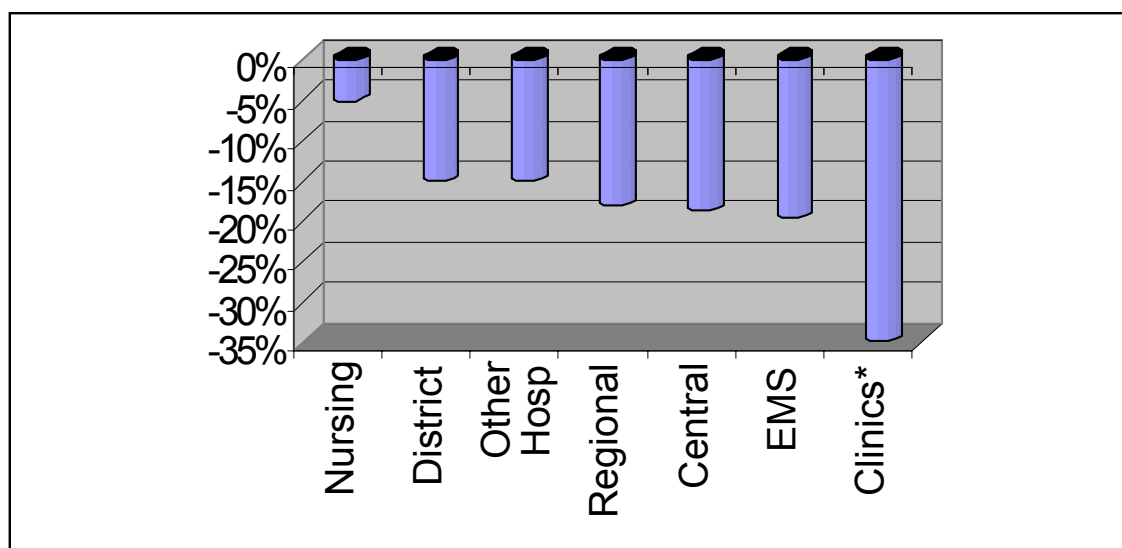
### User Fees

The declining trend in public sector user fees is troubling to those who see this source as a critical complement to general taxation. The decline in fees is noted again in Diagram 6.2, which also outlines the breakdown in fees by type of facility or service. There appears to be no level of care which has retained its level of fee collection. The average annual decline in user fee collection is shown in Diagram 6.3 for each provider type or activity. (It must be noted that fee revenue from OP care centres should be zero given the Government's policy of free PHC.)

**Diagram 6.2: User fees collected by Provider Type, 1996/97-1998/99**



**Diagram 6.3: Change in User Fees by Provider Type, 1996/97-1998/99**



Note: The diagram labels refer to types of hospitals, except for *Nursing*, *EMS* and *Clinics*. *Nursing* refers to nursing care facilities. *Clinics* also includes *Community Health Centres*. The decline in fees for *Clinics* may be seen as positive given the Government's commitment to PHC and legislation on free PHC.

A standard measure of financial sustainability is the proportion of costs recovered by user fees (McPake and Kutzin, 1997). The results are shown in Table 6.4 and summarised in Diagram 6.4. (Annex 8 contains the revenue raised from user fees at

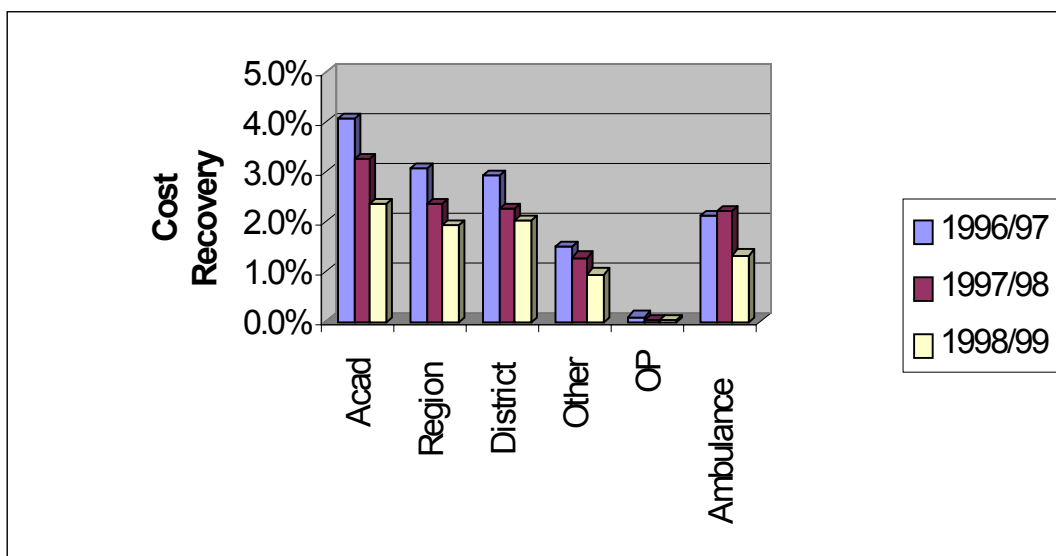
different levels of care.) In all facility types or health activities the cost recovery rate is low and decreasing. For instance, the decrease in cost recovery rates at academic, regional and district hospitals was 40%, 37% and 30% respectively, between 1996/97 and 1998/99. Were this rate of decrease to continue the revenue from user fees in 2002/03 would shrink by approximately two thirds from 1996/97. A longer term perspective reveals a less spectacular fall but comparisons with 1992/93 are problematic because of the different provider classifications in use then. Nevertheless, user fees as a share of hospital recurrent expenditure in 1992/93 were 9.2%, compared to approximately 3.3% in 1996/97 and 2.1% in 1998/99. It appears that the opportunity to raise and utilise user fee revenues in public sector hospitals is being squandered. This must be of major concern to policy makers.

**Table 6.4: User Fees as a share of costs, 1996/97-1998/99**

	1996/97	1997/98	1998/99
Academic Hospitals	4.1%	3.3%	2.4%
Regional Hospitals	3.1%	2.4%	1.9%
District Hospitals	2.9%	2.3%	2.0%
Specialist (Psychiatric/mental health) Hospitals	1.7%	1.5%	1.2%
Other specialist hospitals	0.9%	0.6%	0.4%
PDoH Nursing care Facilities	1.3%	0.0%	0.0%
PDoH clinics/health centres	0.2%	0.1%	0.1%
LA clinics/health centres	0.0%	0.0%	0.0%
Medical and diagnostic laboratories	0.7%	0.0%	0.0%
Ambulance services	2.1%	2.2%	1.3%

Note: The proportions shown are given out of total rather than recurrent expenditure. The latter is not available for individual provider types. The difference between the two measures is quite small for SA, as capital expenditure absorbs a small proportion of overall costs. If we assume that capital expenditure is distributed across levels of care in line with recurrent expenditure, then user fees at academic hospitals would be equivalent to 4.1% of recurrent expenditure in 1996/97, compared to 4.0% of total expenditure.

**Diagram 6.4: Cost recovery levels in public sector facilities (1996/97-1998/99)**



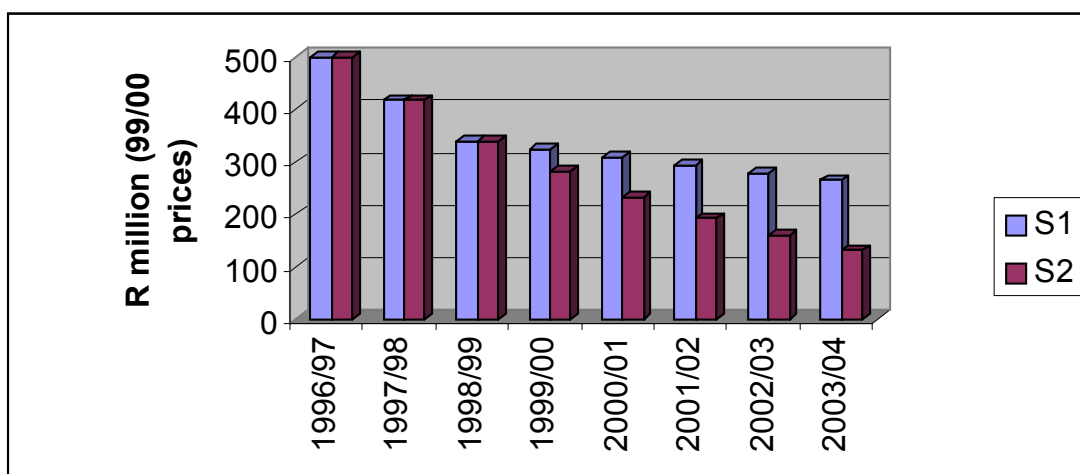
Such low and declining cost recovery rates reinforce earlier findings. The causes of the decline have been suggested by Monitor Company *et al* (1996) and Gilson *et al* (1999):

- *a lack of incentives for collection* – without revenue retention at the facility level health care providers, as in many other countries, have little motivation to enforce fee collection (Gilson, 1997).
- *a poor structure of pricing* – private patients do not pay the full costs associated with their treatment. This means that private patients are being subsidised by the public sector. Further, fees are rarely fully adjusted for inflation.
- *inadequate collection systems* – many facilities have allowed large debts to build up from patients which have had to be written off.
- *patient dissatisfaction with the quality of public sector hospitals* – the growth of the private hospital sector has drained a large number of skilled staff from the public sector. This, in turn, has exacerbated problems within the public sector and led to patients moving to the private sector.

Corrective measures are now being explored in many provinces and this will be an important hurdle for improved cost-recovery in public sector facilities. Such initiatives include improved collection systems, retention of fee revenues and revised pricing schedules. Nevertheless, such initiatives address only part of the problem. Any additional user fee revenue must be channelled into quality improvements if patient dissatisfaction with the public sector is to change (see Creese, 1991). Perceptions of quality, as well as pricing, are key determinants in people's choice of health care provider (see Mwabu *et al*, 1996, amongst others). Where the public sector is not seen to provide quality services, those with the means to pay may move to the private sector. The user fee issue highlights how the sustainability of public sector funding is dependent on the relationship between the public and private sectors. This association will be explored more fully in a subsequent NHA report.

In Diagram 6.5, we present two scenarios for revenue from public sector user fees. The first assumes that revenue retention is implemented and that this will stem the fierce decline in fees seen since 1996/97. It, however, assumes no other restructuring of the hospital sector or its financing and thus brings the decline in fees back to its long-term trend. The second assumes no implementation of fee retention and a continuation of the rate of decline seen in the last two years. It is clear from Diagram 6.5 that corrective action needs to be taken.

**Diagram 6.5: Projected public sector user fee revenue under alternative scenarios, 1996/97-2003/04**



### Local Authorities

The increased role of Local Authorities in both the funding and delivery of health services has been noted in Chapter 1. Table 6.5 shows Local Authorities as an important source and financial intermediary i.e. Local Authorities both receive subsidies from PDoHs and raise their own revenue. Nevertheless, the integration of Local Authorities in the planning and management of the health sector has been difficult. There exists between some provinces and Local Authorities significant tension over finance and responsibilities (Klugman and McIntyre, 2000), caused by overlapping roles. This raises the issue of how Local Authorities can best fund and provide service within the overall health sector. The District Health System is seen as being the vehicle to provide comprehensive PHC services (DoH, 1997, African National Congress, 1994). While the precise form of the DHS is still being finalised it is clear that it must be integrated with the current boundaries and domain of Local Authorities (Gilson *et al*, 1996).

While funding from Local Authorities' own revenue appears to increase from 1996/97 to 1998/99, funding channelled through Local Authorities seems to have declined, from available data. This would be due to a lower subsidy received from respective PDoHs and may reinforce earlier qualitative findings (Klugman and McIntyre, 2000). Nevertheless, more complete data are needed on Local Authorities before firm conclusions can perhaps be drawn. Other commentators have noted that the current subsidy relationship between provinces and Local Authorities is far from satisfactory (*ibid*).

**Table 6.5: Local Authorities as Sources of Funds and Financial Intermediaries, (1999/00 prices)**

	1996/97	1997/98	1998/99
Source			
- Total (R million)	845	963	995
- Proportion	3%	3%	3%
Financial Intermediary			
- Total (R million)	1,548	1,640	1,629
- Proportion	5%	5%	5%

International experience shows that clear roles and responsibilities are key to effective decentralisation (Gilson and Travis, 1997, Brijlal *et al*, 1998). Competition between different levels of government is counterproductive. Several options are currently being considered. Many provinces and the NDoH appear to favour a contractual relationship. This may allow both parties to be clear about their roles and responsibilities. In contrast, many Local Authorities favour direct financing from the national Department of Finance. They argue that there is little point having a contract for only a fraction of their funding. This would be inefficient, create problems of dual accountability and undermine their independence. One other option considered by a couple of provinces is to remove PHC service provision from Local Authorities and return it to provincial governments. This is not a generally favoured option and would appear to be unwarranted on two grounds where nationally applied:

- It would cut off R 1 billion from the funding of essential services; and
- It would contradict the spirit of PHC, by removing planning and allocation decisions from the most decentralised level (see Green 1992).

Whichever course of action is favoured, it is hoped that it will foster effective planning. This is important for future planning of the health sector and will allow better sustainability, particularly in the delivery of PHC services. Consequently, Local Authorities may well become a more important source and financial intermediary for the delivery of PHC services and for projections of the size of the future health sector, as shown in Diagram 6.6. LA funds are assumed to increase by 10% per annum, about half their current growth path, over the medium term. While this may be optimistic, sensitivity analysis reveals little overall impact of changes in the assumption on projections of future funds.

### ***Future Public Health Sector Funding***

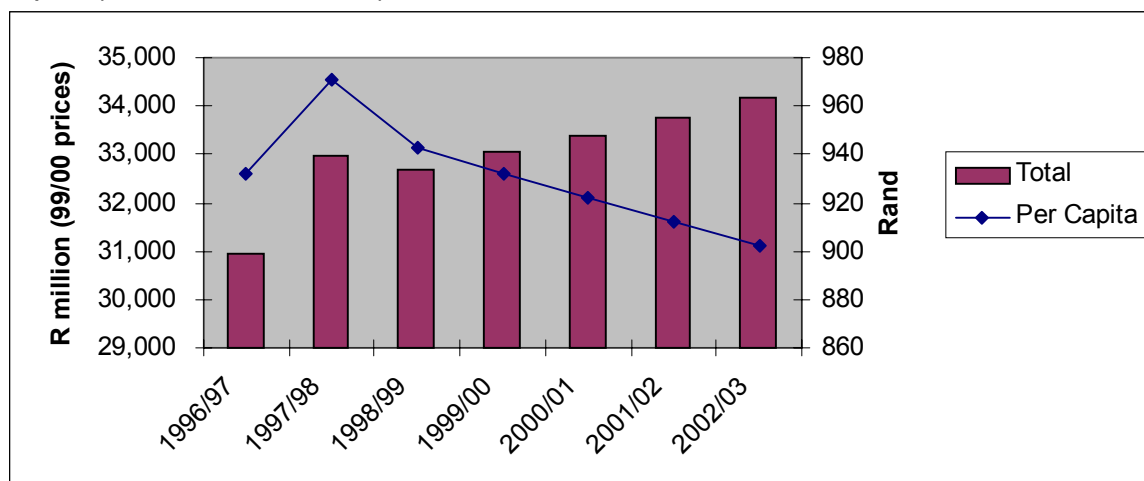
Calculation of the *resource envelope* is vital for understanding the financial sustainability of current health commitments and future plans. Simply put, the resource envelope is the *total* amount of funds available to the health sector in any one year. Again we are interested in the comprehensive financing picture for the health sector that is broader than just National and Provincial Departments of Health and includes Local Authorities and other national and provincial departments. (It is also worth restating that it is the public health sector that is of concern here, though similar projections will be done for the total, public *and* private, health sector in a future report.) The computation of likely future funds in the public health sector is done using data from previous sections up until 2002/03. Understanding the

limitations of future revenue availability allows planners to avoid being over-ambitious and lays the foundation for prioritisation of needs.

The results of this exercise are shown in Diagram 6.6, which displays projections of both total and per capita public health sector expenditure. Basic assumptions used in the forecasting are as follows:

- General taxation funding and provincial own revenue funding of health will increase at the same real rate as that of the health sector in the MTEF. The definition of general taxation funded health activities as defined for the NHA project is broader than just the MTEF's health sector (i.e. national and provincial Departments of Health). Nevertheless, the latter accounts for the financing of over 80% of general taxation funded health activities. It is, therefore, not inappropriate to use the MTEF growth rate.
- The rates of growth of other sources (households, donors and Local Authorities) have been extrapolated as noted in previous sections, largely from historical trends. Hence, households through user fees will decline by 5% per annum, donors will increase at 5% per annum and Local Authorities at 10% per annum. These assumptions can be altered without significantly impacting on the results.

Diagram 6.6: Projections of Public Sector Health Expenditure, Total and per capita (without medical aid), 1996/97-2002/03



Steady real growth in public health sector expenditure is forecast between 1998/99 and 2002/03, see Diagram 6.6. The dip in expenditure in 1998/99, noted in Chapter 3, is immediately reversed in 1999/00. Nevertheless, when the figures are converted into per capita estimates, the financing outlook is not at all healthy. There appears to be a marked decline in funding levels from 1997/98 of around 1.5% per year. While the first few years of government were marked by a healthy expansion in funding of the public health sector, this trend appears to have been reversed. It is to be wondered whether this is the effect of GEAR and/or fiscal federalism (see Chapter 1). Hence, it appears that the constrained financial position currently faced by the public health sector will not change over the medium term. As argued earlier this is an extremely difficult context for meeting health sector goals, not least redistribution. Consequently, the Government faces some stiff challenges:

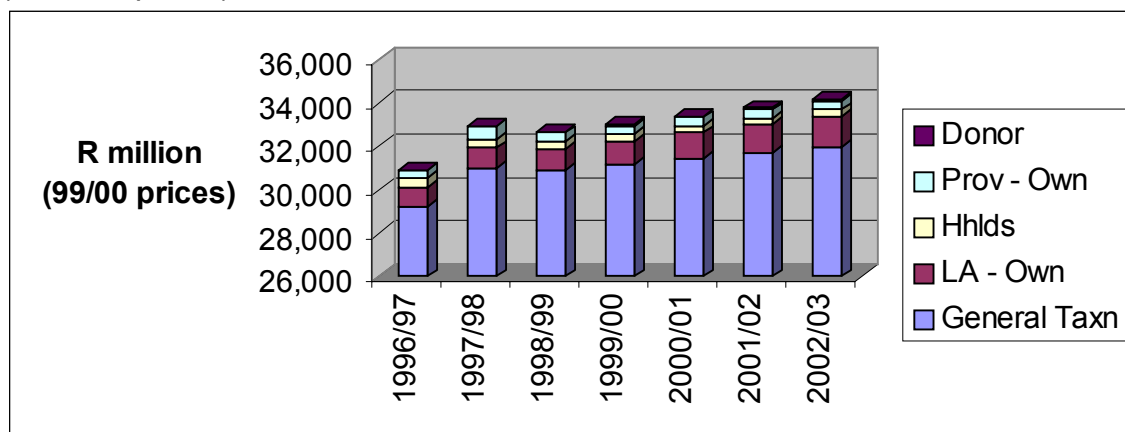
- Implement financing reforms to boost revenue
- Reprioritise public sector funds towards objectives

To gain more insight into the first option it is helpful to examine Table 6.6 and Diagram 6.7, which provide more details on the projection of available funds. The continued dominance of taxation based funding is apparent. In 2002/03, the dependency of public health sector funds on general taxation will be no different from in 1998/99, i.e. at 94%. Where taxation-based funding of the public health sector is constrained, as we have seen, the prospects for future financing are bleak. The next largest source is Local Authorities, with 4% in 2002/03, up from 3% in 1998/99. However, this might be misleading as part of LA revenue is grants from central government i.e. it is also conditional on general taxation. Other public health sector sources are of little significance. Provincial own revenue and user fees account for a meagre 1% of total funding, while donors will contribute less than 0.25%.

**Table 6.6: Projections of Sources of Funds for the Public Health Sector, 1999/00 prices**

	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	Average Annual Growth Rate (98/99-02/03)
General Taxation	29,244	30,972	30,908	31,165	31,425	31,688	31,952	0.8%
Local Authority revenue	845	963	996	1,095	1,205	1,325	1,458	10.0%
User fees from households	499	418	340	324	308	293	279	-4.9%
Provincial own revenue	334	578	384	387	390	394	397	0.8%
Donor Funding	18	33	68	71	75	78	82	5.0%
<b>Total</b>	<b>30,941</b>	<b>32,963</b>	<b>32,695</b>	<b>33,043</b>	<b>33,403</b>	<b>33,778</b>	<b>34,168</b>	<b>1.1%</b>
<b>Per Capita (total)</b>	<b>758</b>	<b>790</b>	<b>767</b>	<b>760</b>	<b>753</b>	<b>746</b>	<b>741</b>	<b>-0.9%</b>
<b>Per Capita (without medical aid)</b>	<b>932</b>	<b>971</b>	<b>942</b>	<b>932</b>	<b>922</b>	<b>912</b>	<b>903</b>	<b>-1.1%</b>

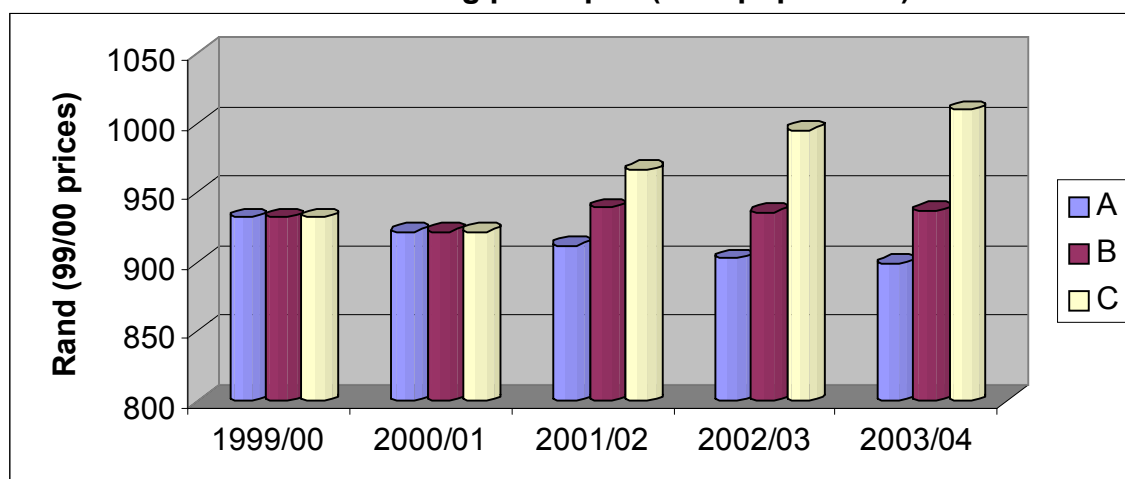
Diagram 6.7: Projected Sources of Public Health Sector Funds, R million, (1999/00 prices)



As argued earlier, both the stagnation in health funding and its reliance on general taxation point to the need to consider financing reform to boost the revenue available to the public sector. The importance of restructuring current arrangements around the setting and collecting of user fees has been discussed earlier. The other financing source, currently under consideration by Government, is a Social Health Insurance scheme. This “new” financing mechanism has been discussed in many forms since before the democratic transition but has, despite several policy initiatives, failed to be implemented. At present, the SHI scheme is being linked to the development of a social security system, as part of a broader package of welfare benefits and safety nets.

How much additional revenue could be expected if a Social Health Insurance scheme were implemented to cover hospital costs in the public sector? This would depend significantly on the *design* of the scheme. The Department of Health (1997) estimated potential revenue generation levels of between R1,5 and R 3.0 billion for its version of SHI. Their proposal covered only formal sector employees above the income tax threshold. An alternative scheme was modelled by McIntyre (1997). This explored two scenarios, both relating to the coverage of *all* formal sector employees (in line with the recommendations of the Committee of Inquiry proposals, Republic of South Africa, 1995). The first set fees at average costs for different levels of hospitals. Under this scenario approximately an additional R 1.2 billion would be raised. In the second scenario fees were set at 50% of private hospital rates and this produced an extra R4.3 billion revenue.

**Diagram 6.7: Modelling the Impact of SHI on Future Public Health Sector Finances: Funding per capita (total population)**



Whichever version of SHI is implemented, the finances flowing from the scheme would provide a welcome boost to Government coffers at a time of constrained general resources. Diagram 6.7 models three scenarios: (A) baseline financing with no SHI; (B) current financing plus a conservative “NDoH” SHI scheme and (C) current financing plus a more bullish “McIntyre” SHI design. In both the SHI scenarios it is assumed that revenues reach their target level by 2003/04, following an introduction in 2001/02 and phased increases. While these assumptions about timing and phasing are open to question, they provide an indication of the impact of SHI on revenue sources. Diagram 6.7 shows significant per capita increases in funds which offset the constraining influence of the Government’s macro-economic policy. By 2003/04, financial sources are R 38 per capita higher under scenario B than with no SHI policy and R 110 per capita higher in scenario C. These additional resources could well ease the process of redistribution and targeting toward PHC activities and provide more funds per person in the public health sector.

Nevertheless, the acceptability of SHI models to different actors may still be a constraining factor (Gilson *et al*, 1999). Certain groups, including the Department of Finance, are concerned that a SHI scheme will effectively be taxation by another name. Any attempt to make SHI compulsory for any group may, they argue, overburden them and produce disincentives for wealth creation. Other actors, such as the former Minister of Health, are concerned that SHI might undermine social solidarity by creating a tiered health sector. Yet others, including some academics, are concerned that current SHI proposals are not focussed sufficiently on equity with little cross-subsidy. Consequently the issue of SHI design has to be handled with care. While SHI may help produce valuable resources for the health sector it may have unfortunate trade-offs, either in terms of disincentives for growth, fragmentation of society or enduring inequity.

## Major Expenditure Items

In order to review financial sustainability it is useful to examine major items of expenditure. These items determine the costs of the health sector in South Africa and their future path needs to be understood if Government is to make provision for them. It may be particularly useful to see whether such items will fit into the resource envelope, calculated above, with and without additional financing. Included are an analysis of the funding of a PHC package, an evaluation of current public health sector expenditure on personnel and an investigation of the funding of civil servants' medical aid.

### PHC Package

Delivery of health care services through the Primary Health Care approach is the top priority for Government. In this regard a PHC package of services has been endorsed and has been variously defined and costed. Indeed, Brijlal and Hensher (2000), note that there are several interpretations of the PHC package, each with their own cost estimates. These are shown in Table 6.7. The Hlanganani model focuses on qualitative targets and standards in PHC provision, provided largely through existing infrastructure. The costings developed under the Need Norms approach and the Eastern Cape model are more expensive as they set quantitative targets for availability of staff and facilities and suggest an expanded role in service provision for Community Health Centres.

**Table 6.7: PHC Package costs – Alternative Models (1999/00 prices)**

Model	Package Cost for total popn (R million)	Package Cost for uninsured popn (R million)	Per Capita (total)	Per Capita (uninsured)
Hlanganani (2.8 visits)	5,386	5,353	125	149
Hlanganani (3.5 visits)	6,141	5,473	140	152
Need / Norms	6,734	5,889	166	167
Eastern Cape	7,581	6,885	176	196

Source: Brijlal and Hensher (2000)

How affordable are such interpretations of the PHC Package? Referring back to Chapter 4, we can see that overall PHC spending was around R 6.5 million in 1998/99 (in 1999/00 prices), or R 186 per capita for the uninsured population. A cursory glance at Table 6.7 reveals that such expenditure patterns make three of the four scenarios affordable for the *uninsured* population.

Nevertheless, when considering future sustainability several points need to be noted:

- Expenditure by Local Authorities on the PHC package is vital. Current PHC expenditure estimates include spending by Local Authorities. There, therefore, needs to be agreement between provinces and Local Authorities to fund jointly the PHC package.
- PHC expenditure levels must be sustained in per capita terms. Table 6.6 shows declines in per capita health sector funding from year-to-year. Thus funding of PHC will still need prioritising.

- PHC expenditure estimates in Chapter 4 include some funds spent by non-health national departments on clinics and programmes. If removed, this has the effect of lowering PHC expenditure by R 11 per capita for the uninsured population, to R175 in 1998/99. Three of the four options are still affordable, but with a smaller margin.

Even with the above considerations and limitations, the data suggest that a PHC package is affordable within current spending patterns. More detailed analysis is, however, needed on a province by province basis to examine local, rather than overall, affordability.

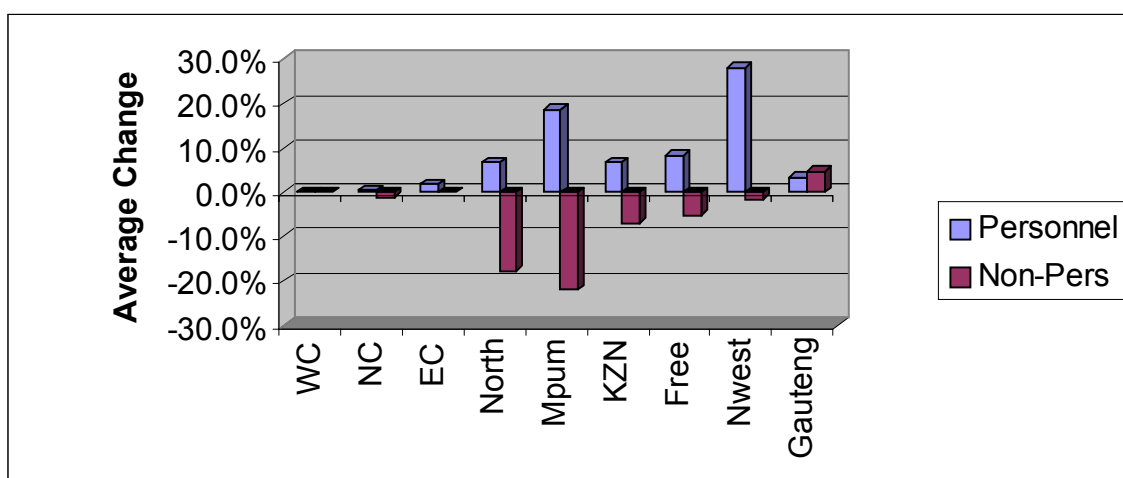
### Salaries

By far the largest line item of public sector expenditure is personnel, accounting for 71% of recurrent costs in 1998/99 (Table 6.8). Further, this proportion has been increasing, up from 67% in 1996/97. Were the trend in Table 6.8 to continue, salaries would absorb more than 80% of recurrent expenditure in 2003/04. As personnel costs absorb an ever greater proportion of total expenditure, it is possible that the funding of other activities is neglected. This makes policies around wage determination and employment fundamental to questions of sustainability.

**Table: 6.8: Proportion of Line Item Expenditure absorbed by Personnel Costs, 1996/97-1998/99**

Summary Data	1996/97	1997/98	1998/99
<i>Public Health Sector</i>			
- Personnel (% Recurrent costs)	67%	68%	71%
- Personnel (% Total costs)	63%	64%	68%
<i>PDoHs only</i>			
- Personnel (% Recurrent costs)	68%	69%	72%
- Personnel (% Total costs)	65%	66%	70%

It is worth examining the issue in specific provinces to test whether and to what extent personnel costs are crowding out other recurrent expenditure. All provinces show an increase in personnel costs between 1996/97 and 1998/99 apart from the Western Cape, which has a slight decline. The largest increases are in Mpumalanga, and North West. Turning our attention to non-personnel recurrent expenditure two provinces show sharp declines between 1996/97 and 1998/99; Mpumalanga, 22% per annum and Northern Province, 18% per annum. For both provinces there is overall recurrent expenditure growth over the period but this growth is more than absorbed by personnel costs, indicating that other activities are being constrained. Further, the overall resource picture for these provinces is also highly constrained (see Chapter 5) meaning that significant increases in personnel costs must be funded through declining expenditure on non-personnel items. Hence, there is immediate evidence that in two provinces personnel costs are significantly crowding out other expenditure as a result of their overall funding position. The same phenomenon may also be occurring in KwaZulu Natal, Free State, North West Province and Eastern Cape, but to a lesser extent. Indeed, only in Gauteng, were non-personnel costs increasing at a faster rate than personnel costs (see Diagram 6.8). This is not surprising when it is considered that Gauteng is the least resource constrained of all the provinces (see Chapter 5).

**Diagram 6.8: Average annual growth in Provincial Department of Health personnel and non-personnel costs, 1996/97-1998/99**

The increasing share of personnel costs in provincial expenditure is perhaps surprising. The fact that in several provinces non-personnel expenditure is decreasing seems to be a worrying trend. It is possible that such costs are short-term in nature and reflect the costs of severance packages for staff who are retrenched. Alternatively, they could be the result of one-off promotions and/or higher than usual salary increases. It would then be expected that the increasing share for personnel would be short-lived. In addition, government plans to right-size the bureaucracy may further reduce the personnel share. Further investigation is needed.

### Medical Aid Payments

The high proportion of the public health sector devoted to paying the medical aid of civil servants is shown in Table 6.9. What may be of additional concern is that even these funds cover only about half of existing civil servants. However, a simple pro rata costing would indicate huge costs for extending this coverage, leaving medical aid absorbing R1 in every R6 spent on publicly funded health services. Further, while this money is paid by public sector sources, the funds are primarily spent in the private sector. This raises questions of the appropriate role of public and private sectors and will be examined in more detail in subsequent reports.

**Table 6.9: Medical Aid Payments by National and Provincial Governments, 1996/97-1998/99 (R million, 1999/00 prices)**

	1996/97	1997/98	1998/99
<b>TOTAL</b>	<b>2,494</b>	<b>2,544</b>	<b>2,598</b>
Total Public Sector Funding	30,941	32,963	32,695
% of Public Sector Funding	8.1%	7.7%	7.9%

### **Summary**

- According to DoF projections contained in the MTEF, there will only be limited per capita growth in real GDP over the next few years. This translates into declining public expenditure growth per capita for three of the four years between 1999/00 and 2002/03. Even though health's *share* of the budget will be protected, the per capita funding of the National and Provincial Departments of Health will decrease by about 1% each year in real terms. This is a cause for major concern.
- It is estimated that other sources for funds of the health sector will show some growth from a small base. However this will not change the dependency of the public health sector on general taxation. By 2002/03, 94% of all funds for the public sector will still come from general taxation.
- Revenue from user fees are expected to continue their long-run decline. Cost recovery rates are already low and dwindling. With no action revenue from user fees will have fallen by 75% between 1996/97 and 2003/04. Radical reform is needed to boost user fee collection in public hospitals. This should include improving pricing structures, incentives for collection, the efficiency of collection systems and patient perception of quality in public sector hospitals.

- Given the projected declines in per capita funding of the health sector, government must pursue extra funding sources or reprioritisation of existing funds. According to the Department of Health a Social Health Insurance scheme could boost revenue availability by between R1.5 billion and R3.0 billion. Other scenarios suggest even more additional funding.
- Recent costing data indicate that South Africa can still afford to finance a PHC package under two conditions: that expenditure by Local Authorities is utilised to fund such activities (in addition to provincial efforts) and that PHC per capita funding is maintained in real terms. Given declining overall health sector funding per capita this will mean continuing to prioritise the financing of PHC.
- Personnel costs are consuming an ever larger proportion of health sector funds. For PDoHs personnel accounts for 70% of expenditure. Further in some less well resourced provinces the effect of growing personnel costs is to crowd out other expenditures which are vital for providing a quality service.

## Chapter 7: Conclusions and Recommendations

The data from the National Health Accounts exercise reveal two eras of public health sector financing. The first ran from 1992/93 to 1997/98. It was characterised by substantial growth in funding (both in real and per capita terms), reallocation of resources to Primary Health Care and redistribution of health sector funds across provinces. In contrast, the second era, from 1997/98 onwards, is characterised by falling per capita public health sector funding, a reversal of redistribution across provinces and limited growth in PHC expenditure. The transition between the two periods would appear to relate to the introduction of both GEAR and fiscal federalism. As was argued earlier both these have affected the potential for increased equity in the public health sector. The current macro-economic environment translates into a highly constrained financing environment for health for the foreseeable future. Further, the current resource allocation formula for provinces and subsequent provincial budget processes have done little to encourage redistribution to where funds are most needed.

Nevertheless, there is still time for corrective action, before the features of the second era become entrenched. For South Africa to avoid a crash landing in the health sector it needs to find ways of boosting public health sector financial resources and encourage redistribution of resources. The importance of current budgeting arrangements has been noted. The formula for inter-provincial allocations needs to reflect more of an equity perspective. Further, the negotiation skills of health sectors in under-resourced provinces needs to be boosted. A complementary measure to boost public health sector resources will be to introduce a Social Health Insurance schemes as part of a social security package.

Further, expenditure on PHC activities must be protected from any overall health sector budget cuts. Exploration of use of norms and standards may be one option. In addition, the current conditional grants system needs to be reviewed so that it appropriately protects genuine national health sector assets. This will also then help increased funding of district hospitals which is so important for the development of the district health system.

Below we set out some of the main findings of the report.

### ***Overall Financing***

There has been strong growth in the public financing of the health sector since the end of apartheid. Funds for the public health sector have increased by an average of 9% per year, in real terms, between 1992/93 and 1998/99, to reach a total of just under R33 billion. Nevertheless, in per capita terms there was a drop between 1997/98 and 1998/99.

The current constrained resource environment for health means that the expansion noted above has almost certainly come to an end. While there is likely to be some real growth in health sector funding, this will not keep pace with increases in the population. While per capita public health sector funding

(for those without medical aid) was R971 in 1997/98, this is projected to fall to R903 by 2002/03.

### ***Dependency on General Taxation***

Little has been done to change the dependency of public sector health financing on general taxation, which accounted for 94% of funding in 1998/99. This may well be a weakness, particularly as it leaves health sector funding hostage to the macro-economic context, which is far from benevolent.

Further, the declining trend in user fee revenue, falling by 17% per annum between 1996/97 and 1998/99 must be of major concern since it is one of the only alternative sources to general taxation. Were such trends to continue, revenue from user fees would by 2003/04 collapse to a quarter of its 1996/97 level. Key reforms are needed urgently to remedy the situation and boost revenue generation at public sector hospitals. Changes required include revenue retention, improved collection systems and pricing structures and improved quality, possibly through provision of optional hotel services.

It is critical to find alternative sources of finances to offset the expected fall in per capita funding. It is estimated that a Social Health Insurance scheme could add between R38 and R110 per capita, depending on the chosen design, to existing funding, counteracting the per capita decline in funds from general taxation. This would also boost revenue from user fees. Nevertheless, issues around the acceptability of SHI to different parties must still be tackled. Concerns around its implications for the tax burden and its impact on equity and social solidarity need to be explored further.

### ***Financial Intermediaries***

The key channel for funds in the health sector is through the PDoHs, which accounted for over 70% in 1998/99. Nevertheless, non-health government departments and bodies also channelled just under 20% of health sector funds, with the largest single non-health financial intermediary being the Department of Defence, approximately R 1 billion, in 1998/99.

Decentralisation as a result of fiscal federalism is apparent given the use of provinces as financial intermediaries. Nevertheless, provincial allocations in the health sector are also limited by conditional grants. While provinces, on average, have 20% of their health sector funding tied by such grants, conditional funding was as high as 35% and 41% for Gauteng and the Western Cape. The impact of conditional grants, as they are currently structured, may be to impede restructuring within provinces.

Local Authorities are becoming an important financial intermediary for the public health sector, channelling around 5% of public health sector funds. This is particularly the case for the delivery of PHC activities, where the funding of Local Authority clinics increased by almost one quarter between 1996/97 and 1998/99, to reach R 1.3 billion. This amounted to about 20% of total PHC expenditure in 1998/99. Nevertheless, there appear to be unclear roles and responsibilities between some provincial governments and local authorities.

This has, in some cases, led to competition for funds and mandates and a lack of trust. Such issues need to be resolved quickly to allow for effective health care delivery, particularly for PHC.

### ***Redistribution across levels of care***

There was substantial progress in redistributing funds to lower levels of care following the end of apartheid. In 1992/93 85% of public health sector expenditure was devoted to hospitals and this declined to 77% by 1997/98 (when NHA figures are adjusted to allow for comparisons with the HER). Further non-hospital PHC almost doubled over the same period from R61 to R117 per capita, total population. In particular, expenditure on public health programmes rose sharply from 1992/93 (though more recent growth has been slower, 1.7% per annum between 1996/97 and 1998/99). This is particularly encouraging given the Government's stated commitment to the Primary Health Care approach

### ***PHC***

Expenditure on PHC activities increased by more than R 0.6 billion between 1996/97 and 1998/99. In particular, there has been high growth in expenditure on clinics and community health centres (averaging 6.0% per year between 1996/97 and 1998/99). Unfortunately, expenditure on PHC activities dropped slightly in 1998/99 both in real terms and as a share of total provider expenditure. Indeed, per capita expenditure (uninsured population) fell from R 202 in 1997/98 to R 186 in 1998/99.

Increased access to PHC services has been supported by removal of user fees, redeployment of staff and renovation and construction of clinics, as well as extra finance. Nevertheless, there has been no substantive evaluation of the impact of the free PHC policy, with its supporting initiatives. This is needed for the Government to be able to develop future policies and guarantee progress toward its objectives.

One of the key aims of government is to fund a PHC package of services. The report shows that current expenditure levels are sufficient to fund several of the current costings of the package. Nevertheless, PHC per capita expenditure levels must be sustained in the face of falling per capita health sector budgets. Further, Local Authorities must be integrated into the financing and delivery of the package. In addition, the affordability of the package within each province will need to be evaluated.

### ***Allocation to Hospitals***

Perhaps surprisingly, the expenditure on hospitals increased substantially between 1996/97 and 1998/99, by 4.3% each year on average. In particular, there has been a large increase in the funding of Tertiary hospitals, up to R 5.0 billion in 1998/99. In contrast, expenditure by District Hospitals declined in

1998/99 year-on-year. This may be of concern, given the Government's commitment to the pursuit of a District Health System.

### ***Technical Efficiency***

An assessment of technical efficiency across provinces is very difficult given the lack of accurate activity data in most of the provinces. This needs to be rectified if government at national and provincial levels are to monitor the effects of policy and changes in hospital efficiency, said to be a main concern. Standard minimum data sets for collection in all provinces should be specified and used in ongoing monitoring.

Though hospitals are absorbing an increasing share of provincial health financing, the numbers of beds available for patient use have shown a decline over the past three years. Coupled with this is an increase in average costs per patient day equivalent at each level of hospital over the three year period in this analysis. This is a concern given the reducing resources available to provinces.

### **Equity**

It is of extreme concern that those provinces previously disadvantaged and currently showing the lowest per capita expenditure on health are also those showing the greatest declines in per capita expenditure on health. This is a marked move away from equity. This may well be due to the decline in overall per capita provincial budgets as a result of a reduction in government consumption expenditure generally.

Nevertheless, health's share of total provincial expenditure appears relatively unchanged, between 1996/97 and 1998/99, suggesting that there is no bias against health budgets.

Inclusion of local authorities' health spending exacerbates the already wide differential between funding of health in rural and urban provinces. The gap between public health expenditure in Gauteng and Mpumalanga was almost R700 per capita in 1998/99. This situation needs to be addressed.

### ***Line Items***

Salaries absorbed a large and increasing proportion of expenditure in the public health sector between 1996/97 to 1998/99. Over 70% of recurrent costs were personnel related in 1998/99. In several provinces it is clear that growth in personnel costs is crowding out expenditure on other items, such as drugs, maintenance and so on. This may have the effect of damaging the quality of care. Further investigation is needed of the cause into the continued growth in salary costs.

### ***Medical Aid Contributions***

The Medical Aid costs of civil servants is a significant use of public health sector funds. Between 1996/97 and 1998/99 around 8% of such public funds, or just under R 2.6 billion, were channelled to the private health sector. Further, current medical aid coverage of civil servants is only around 50%. Any attempt to extend such coverage would incur huge costs to the public sector. Indeed, the utility of current funding arrangements needs to be reviewed.

### ***Further Research and Systems Improvements***

While the NHA has been able to analyse many key financing issues in the public health sector, there are areas where only cursory inquiry was possible. In some cases this was due to issues falling outside the scope of an NHA. In particular, it is apparent that important topics for future research will be:

- A thorough evaluation of the impact of the free PHC policy, and its supporting measures.
- Detailed analysis of the affordability of the PHC package in each province.
- Exploration of projected personnel costs in the public health sector.

In other areas of research, particularly where non-financial information was needed, data were not available or alternatively were of dubious quality. Indeed, it is of great concern that the quality of non-financial data across provinces is not better. It will be important to improve non-financial information systems to allow for meaningful data for policy decisions, formulation of MTEFs and future NHA initiatives. Such issues are explored further in a subsequent report on potential strategies for institutionalising NHA in South Africa.

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