5

Health

Introduction

South Africa has a large health sector

South Africa's public and private health care system contributes approximately 8 per cent of South Africa's GDP. Two of the largest components are medical aid scheme contributions of about R41 billion, and expenditure by provincial health departments of around R33,2 billion in 2002/03. Close to 7 million South Africans are covered by medical aid schemes. The majority are predominantly covered by public health services, which comprise 13,3 per cent of consolidated national and provincial non-interest expenditure. Private medical aid scheme contributions were approximately R5 900 per beneficiary in 2002 (R490 per month), approximately six times provincial health expenditure of R911 per uninsured person.

All three spheres perform aspects of the health function

Each of the three spheres of Government plays a role in the delivery of health services. The national Department of Health focuses mainly on policy, legislation, national programmes and international liaison. The major delivery responsibility rests with provinces with combined budgeted health expenditure amounting to R36,9 billion in 2003/04, including conditional grants. Of this, about R6,0 billion is budgeted for out-of-hospital primary health care. Local Government also plays a role in relation to environmental health and clinic based primary health care services. Combined budgeted spending of the six largest municipalities, or metros, amounts to R1,1 billion in 2002-03[1].

Significant growth in health budgets

Provincial health budgets rise significantly in 2003/04, in keeping with the expansionary fiscal stance of the 2003 Budget. This is also in order to strengthen the health sector in particular and to intensify a range of specific programmes.

[1] Throughout this review, "2002-03" is used to cover the municipal financial year from 1 July 2002 to 30 June 2003. In contrast "2002/03" is used to cover the national and provincial financial year, from 1 April 2002 to 31 March 2003. Similarly for other financial years.

Key features of the provincial health budgets are:

- Substantial funding increases especially for health services in previously disadvantaged provinces
- Large increases in the Hospital Revitalisation Programme
- Increases for the Integrated Nutrition Programme
- Further strengthening of the Enhanced Response to HIV/Aids Strategy
- R500 million rising to R1 billion additional funding annually for a new system of rural incentives and a scarce-skills strategy for the health sector.

Significant reforms introduced in this year's budgets include a new standardised budget programme structure for health and, improved uniform formats for the nine provincial strategic plans. The new framework for tertiary health services funding is now operational and is being strengthened by the Modernisation of Tertiary Services project.

Overall budget and expenditure trends

Provincial health spending continues to show strong growth over the MTEF period

Table 5.1 shows that provincial health expenditure is budgeted to increase from about R33,2 billion in 2002/03 to R36,9 billion in 2003/04, and further rise to R42,9 billion by 2005/06. This reinforces the acceleration in health expenditure, which started in 2000/01. This year, provincial expenditure on health is budgeted to grow by 10,9 per cent. This follows significant growth rates of 9,5 per cent in 2000/01, 12,7 per cent in 2001/02 and 11,7 per cent in 2002/03. The step-up in expenditure in 2001/02 is associated mainly with the turnaround in capital expenditure, including increases in the funding for the Hospital Revitalisation Programme.

Strongest growth in most disadvantaged provinces

Strong growth going forward applies specifically to some of the most disadvantaged provinces. Against an average growth rate of 10,9 per cent for all provinces in 2003/04, health budgets grow by 22,7 per cent in Mpumalanga, 22,1 per cent in Northern Cape, 20,9 per cent in North West and 16,9 per cent in Eastern Cape. These increases create the basis for substantial improvements in health services. Rapid growth in health budgets of historically disadvantaged provinces continues over the medium term.

Health expenditure will constitute 21,6 per cent of provincial expenditure in 2005/06, down from 24,1 per cent in 1999/00. This is mainly due to faster growth in social security grants and non-social services expenditure.

Table 5.1 Health expenditure by province

R million	1999/00 Actual	2000/01 Actual	2001/02 Actual	2002/03 Estimated actual	2003/04 Medium-term estimates	2004/05	2005/06
Eastern Cape	3 496	3 790	3 892	4 377	5 118	5 711	6 314
Free State	1 589	1 777	1 954	2 242	2 475	2 720	2 935
Gauteng	5 605	5 942	6 838	7 675	8 112	8 681	9 121
KwaZulu-Natal	5 110	5 772	7 030	7 534	8 056	8 677	9 208
Limpopo	2 221	2 524	2 664	3 180	3 466	3 845	4 167
Mpumalanga	1 147	1 117	1 457	1 712	2 102	2 315	2 503
Northern Cape	433	468	517	604	737	810	890
North West	1 384	1 561	1 699	1 949	2 357	2 604	2 963
Western Cape	3 125	3 451	3 706	3 964	4 430	4 653	4 841
Total	**24 110**	**26 403**	**29 757**	**33 238**	**36 852**	**40 014**	**42 942**
Percentage growth							
Eastern Cape		8,4%	2,7%	12,4%	16,9%	11,6%	10,6%
Free State		11,8%	9,9%	14,8%	10,4%	9,9%	7,9%
Gauteng		6,0%	15,1%	12,2%	5,7%	7,0%	5,1%
KwaZulu-Natal		12,9%	21,8%	7,2%	6,9%	7,7%	6,1%
Limpopo		13,7%	5,5%	19,4%	9,0%	10,9%	8,4%
Mpumalanga		-2,6%	30,4%	17,6%	22,7%	10,1%	8,1%
Northern Cape		8,1%	10,6%	16,7%	22,1%	9,8%	9,9%
North West		12,8%	8,8%	14,7%	20,9%	10,5%	13,8%
Western Cape		10,4%	7,4%	7,0%	11,7%	5,0%	4,0%
Total		**9,5%**	**12,7%**	**11,7%**	**10,9%**	**8,6%**	**7,3%**

Western Cape includes capital works i.r.o Health on voted on Public Works.

Health departments receive substantial additions to their baselines

The 2002 health budgets set out forward estimates for 2003/04 and 2004/05. These have been revised upwards substantially in the 2003 MTEF. Table 5.2 shows additions to baseline health budgets for the two years by provinces. The 2003 provincial budgets add R3,4 billion to provincial health baselines for 2003/04 and R4,6 billion in 2004/05. With these revisions to baselines, provincial health budgets grow by 10,9 per cent in 2003/04 or 4,5 per cent in real terms. Growth moderates somewhat over the medium term but real average annual growth still averages 3,3 per cent between 2002/03 and 2005/06, following an average annual real increase of about 2,6 per cent between 1999/00 and 2002/03.

Table 5.2 Additional funds added to baseline health budgets

R million	2003/04	2004/05
Eastern Cape	689	1 136
Free State	299	384
Gauteng	373	551
KwaZulu-Natal	703	822
Limpopo	356	450
Mpumalanga	214	278
Northern Cape	113	135
North West	300	400
Western Cape	385	400
Total	**3 432**	**4 558**

Comparing to 2003/04 and 2004/05 allocations stated in 2002 budget statements.

Expenditure per capita

There is a wide gap in per capita spending across provinces

The estimates of per capita spending set out in Table 5.3 are calculated on total provincial expenditure and include conditional grants. They show that, based on budgeted spending for 2003/04, health spending per uninsured person ranges from R627 in Limpopo to R1 668 in Gauteng. Although there are inequities in the health system across provinces, this is largely due to the historical distribution of tertiary hospitals and the training of health professionals. These components are mainly funded through conditional grants and are concentrated in the large urban centres.

Phased reconfiguration of conditional grants will improve equity in future

The reconfiguration of conditional grants, which started in 2001/02, will result in a more equitable distribution of resources among provinces. It will see the share of conditional grant funding going to Western Cape declining from 23,9 per cent to 18,5 per cent, while Gauteng's share will drop from 38,4 per cent to 31,3 per cent. These will be coupled with increases in the shares of other provinces that previously received little or no funding through these grants. However, phased redistribution and strong growth in overall expenditure will minimise the impact on services of the change in the distribution of resources.

Narrowing of gap between provinces

Table 5.3 shows that because of the above average growth in allocations to health in Eastern Cape, North West and Mpumalanga, the gap between provinces reduces over the medium term. However, despite the redistribution, the gap remains constant in the case of Limpopo throughout the MTEF period.

Table 5.3 Expenditure per capita (public sector users)

Rand	1999/00 Actual	2000/01 Actual	2001/02 Actual	2002/03 Estimated actual	2003/04 Medium-term estimates	2004/05	2005/06
Expenditure per capita including conditional grants							
Eastern Cape	572	606	610	668	769	841	906
Free State	711	782	849	969	1 049	1 138	1 201
Gauteng	1 203	1 279	1 450	1 580	1 668	1 758	1 800
KwaZulu-Natal	660	751	902	939	1 006	1 069	1 105
Limpopo	451	498	511	586	627	676	709
Mpumalanga	445	433	554	635	770	832	873
Northern Cape	624	680	745	876	1 042	1 135	1 231
North West	449	511	548	628	740	806	898
Western Cape	1 043	1 128	1 183	1 261	1 377	1 425	1 457
Average	**689**	**749**	**830**	**911**	**992**	**1 058**	**1 107**
Expenditure excluding conditional grants per capita as a % difference from the national average							
Eastern Cape	-0,9%	-7,6%	-13,6%	-13,9%	-14,2%	-13,5%	-12,4%
Free State	-0,8%	2,7%	2,2%	8,2%	2,0%	3,4%	4,3%
Gauteng	41,5%	39,8%	44,0%	52,3%	44,3%	45,4%	43,2%
KwaZulu-Natal	-0,2%	8,6%	15,3%	5,4%	9,2%	7,6%	6,4%
Limpopo	-21,2%	-24,0%	-29,6%	-27,3%	-29,4%	-28,8%	-29,3%
Mpumalanga	-22,8%	-35,0%	-23,9%	-19,9%	-14,1%	-12,8%	-12,6%
Northern Cape	1,3%	0,3%	-3,9%	1,6%	2,7%	3,7%	6,6%
North West	-21,4%	-20,2%	-23,2%	-21,7%	-16,5%	-15,7%	-9,8%
Western Cape	14,5%	21,3%	15,6%	14,7%	16,7%	14,4%	12,8%

Expenditure by economic classification

Strengthening of capital and other non-personnel inputs

The medium term sees a continuation of the trend of the past three years towards a further small reduction in the share of personnel in overall health expenditure from 64,2 per cent in 1999/00 to 56,4 per cent in 2005/06, within the context of growing overall resources going to the sector. Excluding transfers, this allows for further strengthening of capital inputs (8 per cent) and spending on non-personnel non-capital inputs (28,4 per cent), which should both accelerate and improve service delivery.

Table 5.4 Expenditure by economic classification

R million	1999/00 Actual	2000/01 Actual	2001/02 Actual	2002/03 Estimated actual	2003/04 Medium-term estimates	2004/05	2005/06
Current	23 103	25 088	27 505	30 807	33 823	36 894	39 523
Personnel expenditure	*15 472*	*16 408*	*17 773*	*19 320*	*21 226*	*22 699*	*24 206*
Transfer payments	*1 932*	*2 193*	*2 046*	*2 315*	*2 680*	*2 910*	*3 120*
Other current expenditure	*5 699*	*6 487*	*7 686*	*9 172*	*9 918*	*11 286*	*12 197*
Capital	1 007	1 315	2 251	2 431	3 029	3 120	3 419
Total	**24 110**	**26 403**	**29 757**	**33 238**	**36 852**	**40 014**	**42 942**
Percentage of total							
Current	95,8%	95,0%	92,4%	92,7%	91,8%	92,2%	92,0%
Personnel expenditure	64,2%	62,1%	59,7%	58,1%	57,6%	56,7%	56,4%
Transfer payments	8,0%	8,3%	6,9%	7,0%	7,3%	7,3%	7,3%
Other current expenditure	23,6%	24,6%	25,8%	27,6%	26,9%	28,2%	28,4%
Capital	4,2%	5,0%	7,6%	7,3%	8,2%	7,8%	8,0%
Total	**100,0%**	**100,0%**	**100,0%**	**100,0%**	**100,0%**	**100,0%**	**100,0%**

Personnel expenditure

Personnel cost pressure and declining numbers

After the 1996 wage agreement, personnel expenditure absorbed increasing proportions of health budgets and crowded out other health expenditure. In the context of these personnel cost pressures and the need to remain within budgets, health sector personnel numbers declined substantially in the late 1990s, as departments strove to remain within budget. As Table 5.5 shows, personnel numbers in health fell by 11 486 people in 2000/01 but have stabilised somewhat since then. The decrease in personnel numbers by 1 460 people during 2002/03 is mainly due to the transfer of staff from provincial departments to the National Health Laboratory Service. This is a public entity, which is the preferred provider for laboratory services to provinces, and therefore does not represent a loss of staff to the sector.

Declining personnel share but strong growth over medium term

Due to the declining trend in personnel numbers and the containment of growth in remuneration in recent years, personnel expenditure has declined in real terms over the period 1999/00 to 2002/03. Table 5.4 shows that this has led to the personnel share of expenditure declining from 64,2 per cent in 1999/00 to 58,1 per cent in 2002/03. Over the medium term, personnel budgets are projected to grow in real terms but will continue to decline as a proportion of health spending.

Table 5.5 Number of personnel in provincial health departments

	1998/99	2000/01	2001/02	2002/03	2003/04	Employees per 1000 public user population
Eastern Cape	36 744	31 951	31 077	29 433	28 498	4,4
Free State	14 483	15 246	15 049	14 463	14 459	6,2
Gauteng	45 005	43 097	42 817	43 285	42 578	8,9
KwaZulu-Natal	50 039	48 191	48 811	49 543	49 373	6,2
Limpopo	23 993	23 607	23 843	23 569	23 550	4,4
Mpumalanga	11 367	11 188	11 335	11 242	11 038	4,1
Northern Cape	3 356	3 952	4 043	4 166	4 178	6,0
North West	16 881	16 068	15 438	15 623	15 332	4,9
Western Cape	26 576	23 658	25 139	24 768	23 977	7,8
Total	**228 444**	**216 958**	**217 552**	**216 092**	**212 983**	**5,8**

Initiatives to improve distribution and retention of personnel

The increase in personnel budgets of 9,9 per cent in 2003/04 and continued real growth over the medium term provide for two key initiatives to ensure appropriate levels and geographical distribution of health professionals in the public sector. The first strategy is to increase the existing rural allowance and to broaden its scope to a wider range of health professions. This is aimed at facilitating the deployment of large numbers of health professionals to rural areas. Table 5.6 shows the population served by a single health worker of each category by province. For example one dentist in Eastern Cape must serve a public sector population of 190 117 people. This analysis demonstrates both inequities in personnel distribution and gives some sense of scarcity of particular professional groups.

Table 5.6 Population served per public sector health worker: February 2003

	Doctor (non-specialist)	Medical specialist	Profes-sional nurse	Dentist	Pharma-cist	Physio-therapist	Occupa-tional therapist	Speech therapist	Dietician	Radio-grapher
Eastern Cape	8 825	47 529	1 278	190 117	53 662	237 646	554 507	950 583	475 292	26 616
Free State	422	11 342	786	71 491	31 881	45 369	3 932	157 279	65 533	14 212
Gauteng	273	3 398	606	25 458	18 994	29 117	31 575	79 714	54 635	8 104
KwaZulu-Natal	4 362	15 641	901	145 607	27 239	43 289	79 291	170 391	148 304	21 528
Limpopo	8 544	92 129	1 001	141 736	48 067	106 302	76 774	197 418	110 554	60 084
Mpumalanga	5 772	143 698	1 124	54 605	35 003	75 841	65 006	151 681	60 672	5 056
Northern Cape	823	6 635	1 079	74 066	47 535	86 076	99 526	244 986	109 821	49 763
North West	3 352	39 296	776	64 303	32 151	5 441	101 047	235 777	70 733	24 391
Western Cape	2 979	2 746	796	28 074	13 789	32 126	33 152	135 489	61 103	691
Total	**4 829**	**10 403**	**910**	**65 406**	**29 578**	**55 698**	**64 722**	**172 793**	**98 282**	**17 878**
Ratio of highest to lowest	3,2	52,3	2,1	7,5	3,9	8,2	16,7	7,0	8,7	8,7

Scarce-skills strategy to recruit and retain a range of health professionals

The second is a scarce-skills strategy, which is being devised to improve recruitment and retention of a range of health professional categories in the public service. This strategy addresses the fact that over 90 per cent of pharmacists, dentists and psychologists practise in the private sector, and the loss suffered from the high level of emigration of skilled professionals. Table 5.7 shows the number of health professionals in selected categories in the public service. Employee numbers in several professions have increased in 2003, following the initiation of compulsory community service for seven additional professions. As the rural and scarce-skills strategies are progressively implemented it is expected that these numbers will increase even more in future.

Table 5.7 Trends in number of health professionals in provincial health departments

	Dec 2001	Feb 2003	Change[1]	Community service posts filled 2003	Ratio of filled posts to community service posts
Professional nurse	41 063	40 846	-217	–	–
Medical practitioners	7 363	7 694	331	1 072	7,2
Medical specialists and registrars	3 807	3 571	-236	–	–
Radiographer	2 058	2 078	20	214	9,7
Pharmacists	1 239	1 256	17	344	3,7
Dental practitioners	625	568	-57	164	3,5
Dental specialists	44	63	19	–	–
Physiotherapists	455	667	212	290	2,3
Occupational therapist	399	574	175	192	3,0
Psychologists	259		-259	116	–
Dieticians	250	378	128	147	2,6
Speech therapist	118	215	97	123	1,7

1. Some of the decreases are due to establishment of NHLS (111 specialists and 47 medical practitioners).

Table 5.7 also shows the number of community service posts by professional group, which provides a useful indication of the size of the annual cohort going from undergraduate training into services. The ratio of filled posts to community service posts provides a useful indication of average duration of retention in the public sector.

Non-personnel non-capital expenditure

Strong recovery in non-personnel non-capital expenditure

Non-personnel non-capital expenditure in health includes medicines, laboratory services, surgical consumables and other supplies. These are critical for the delivery of quality health services. During the late 1990s, as personnel expenditure grew rapidly, this component came under substantial pressure. From 2000/01, non-personnel non-capital expenditure has recovered and grew substantially in 2001/02 by 18,5 per cent, and in 2002/03 by 19,3 per cent. Strong growth is maintained over the medium term.

As a percentage of total expenditure, non-personnel non-capital expenditure (excluding transfers) increased from 23,6 per cent in 1999/00 to 27,6 per cent in 2002/03, and is projected to increase to 28,4 per cent in 2005/06.

Monitoring health input costs necessary to contain price increases

While health budgets have grown substantially in nominal terms, the generally higher price increases for critical health inputs such as blood products and pharmaceuticals tend to absorb a substantial proportion of the growth. More work is required to explore a range of options for containing price increases in the health sector, including stimulating domestic production; improved relations with suppliers; longer-term contracts; collective purchasing; and improved supply chain management. Given the recent strengthening of the Rand, the sector needs to focus on its supply chains to ensure that price reductions are passed on to public sector providers.

Provincial gap in per capita expenditure is narrowing

As Table 5.8 shows, non-personnel expenditure in Eastern Cape, Limpopo and North West is lower than the average. The gap between the low and high per capita spending by province has been closing between 1999/00 and 2002/03 as a result of increases in historically disadvantaged provinces. Significant increases in per capita spending are evident in Mpumalanga, Limpopo (albeit off a very low base) and North West.

Table 5.8 Non-personnel current expenditure excluding transfers (Rand per capita)

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	Average annual growth	
R/capita	Actual	Actual	Actual	Estimated actual	Medium-term estimates			1999/00 - 2002/03	2002/03 - 2005/06
Eastern Cape	103	123	138	140	132	184	207	10,8%	13,9%
Free State	168	201	241	305	332	361	386	22,0%	8,2%
Gauteng	354	378	458	516	522	580	588	13,4%	4,5%
KwaZulu-Natal	147	194	219	240	254	269	279	17,8%	5,1%
Limpopo	78	114	117	167	171	192	205	28,9%	7,1%
Mpumalanga	136	50	208	245	292	320	342	21,7%	11,8%
Northern Cape	180	204	205	257	282	336	399	12,6%	15,8%
North West	105	111	125	183	200	236	288	20,3%	16,3%
Western Cape	243	272	291	347	381	387	398	12,6%	4,7%
Total	**163**	**184**	**219**	**257**	**269**	**301**	**319**	**16,4%**	**7,5%**

Capital expenditure

Turnaround in capital expenditure

Health capital expenditure allocations have tripled between 1999/00 and 2003/04, as reflected in Table 5.9. A substantial turnaround in health capital expenditure started in 2001/02, with expenditure in that year virtually doubling to R2,3 billion.

Successes in hospital revitalisation

A key factor in the turnaround in capital expenditure has been the improvement in expenditure on the Hospital Revitalisation Grant. From expenditure of R85 million in its inception year (1998/99), expenditure grew to a projected R694 million in 2002/03. From 2002/03 the Grant targets the funding of large strategic revitalisation projects, such as major upgrading, replacement and transformation of hospitals. Management of the Grant has been improved and planning strengthened by building on provincial

strategic position statements and the national Integrated Health Planning Framework. This ensures that sustainability is a key component of planning. A long-term plan for revitalising all public hospitals in the country has also been developed.

Further additions to Hospital Revitalisation Grant over the medium term

To further strengthen capital financing and address backlogs, a substantial step-up in the Hospital Revitalisation Grant is made in the 2003 Budget. This is intended to fund upgrading or replacement of additional 18 hospitals. Nine large revitalisation projects were initiated in 2002/03 and 492 small rehabilitation projects have been completed. The Hospital Revitalisation Grant increases to over R1 billion by 2005/06. Detailed business plans have been prepared for the planned projects. Growth in overall provincial health capital expenditure slows down over the medium term from the average annual growth of 34,1 per cent between 1999/00 to 2002/03, but substantial real growth is maintained. Capital expenditure grows particularly fast in Mpumalanga, Northern Cape, North West and Western Cape.

Two large hospitals have been completed

In addition to real progress made in revitalising a range of hospitals, some key projects have been finalised or are nearing completion. Construction of the Nkosi Albert Luthuli Hospital near Durban was completed in 2001/02 and the hospital is now in operation. The KwaZulu-Natal health department in partnership with private sector companies manages the hospital in terms of a groundbreaking public-private partnership arrangement. The Nelson Mandela Hospital in Umtata has also been completed, and so has the first phase of work at the Pretoria Academic Hospital. National Government funded about 50 per cent of the construction costs.

Table 5.9 Capital expenditure trends

R million	1999/00 Actual	2000/01 Actual	2001/02 Actual	2002/03 Estimated actual	2003/04 Medium-term estimates	2004/05	2005/06
Eastern Cape	72	158	232	382	500	462	538
Free State	32	53	98	116	128	136	144
Gauteng	231	254	530	470	624	539	583
KwaZulu-Natal	343	383	784	819	816	924	967
Limpopo	218	226	225	297	285	309	336
Mpumalanga	30	25	48	86	171	195	233
Northern Cape	13	10	34	32	80	82	87
North West	17	76	112	107	187	210	265
Western Cape	50	130	189	121	238	262	266
Total	**1 007**	**1 315**	**2 251**	**2 431**	**3 029**	**3 120**	**3 419**
Expenditure on Hospital Revitilisation grant	140	323	550	695	718	912	1 027

Western Cape includes capital works i.r.o Health on voted on Public Works.

Health expenditure and service delivery by programme

New budget programme structure

Table 5.10 sets out the new structure for provincial health budgets, which has been introduced in 2003/04. The aim of the new budget

structure is to enhance planning and monitoring of service delivery. One of the advantages of the new structure is the separation of different components of primary health care services, hospital services and emergency services. Primary health care services include clinics, community health services, community-based services, HIV/Aids and nutrition. Hospital services include district, provincial, psychiatric and tuberculosis hospitals; and Emergency Medical Services is separated out as a programme.

New format for strategic plans will enhance planning and monitoring of performance

The Department of Health in collaboration with National Treasury has developed a uniform strategic plan format, which all provinces could use to enhance the strategic planning process. The new formats have been used for the first time for the nine provincial plans, which accompany the 2003 provincial budgets. These contain measurable objectives and a substantial set of sectoral indicators against which forward progress can be monitored. The nine strategic plans provide important route maps for the period ahead. While substantial progress has been made in the first year of implementation, further improvements are anticipated, particularly in achieving greater alignment between budgets and strategic plans.

Table 5.10 New provincial budget structure from 2003/04

1. Administration	**5. Central hospital services**
1.1.Office of MEC	5.1. Central hospital 1
1.2. Management (Head Office)	5.2. Central hospital 2 etc.
2. District Health Services	**6. Health Sciences Training**
2.1. District management	6.1. Nursing Training Colleges
2.2. Clinics	6.2. Ambulance Training Colleges
2.3. Community Health Centres	6.3. Bursaries
2.4. Community based services	6.4. Primary health care training
2.5. Other Community health services	6.5. Training Other
2.6. HIV/Aids	**7. Health Care Support Services (Only where centralised)**
2.7. Nutrition	7.1 Laundries
2.8. Coroner services	7.2. Engineering
2.9. District hospitals	7.3. Orthotic & Prosthetic services
3. Emergency health services	7.4. Medicine Trading account
3.1. Emergency transport	**8. Health facilties**
3.2. Planned patient transport	8.1. Administration
4. Provincial Hospital Services	8.2. District health services
4.1. General hospitals	8.3 Emergency medical
4.2. T.B Hospitals	8.4 Provincial hospitals
4.3. Psychiatric/mental hospitals	8.5. Central hospitals
4.4. Chronic and sub-acute medical hospitals	8.6. Health science training
4.5. Dental training hospitals	8.7. Support services
4.6 Other specialised Hospitals	

Composition of expenditure by programme

Table 5.11 sets out health spending by programme and shows that the three programmes – District Health Services, Provincial Hospitals and Central Hospitals – account for the bulk of provincial health expenditure. In 2003/04 District Health Services receives 39,5 per cent, Provincial Hospitals receives 26,7 per cent and Central Hospitals receives 15,5 per cent of budgeted health

spending. A key trend over the period 1999/00 to 2002/03 was the decline in the proportion of spending on Central Hospitals from 17,7 per cent in 1999/00 to 14,8 per cent in 2005/06. Smaller programmes, which have gained over the past three years and continue to gain over the medium term, are Emergency Health Services, Health Facilities and Administration.

Spending growth by programme

Over the period 1999/00 to 2002/03, spending in all programmes grew considerably, except for Central Hospitals and Other. Over the medium term, growth is fairly strong in most programmes, averaging 8,9 per cent. The lowest growth is in Central Hospitals at an average annual rate of 6,5 per cent. Health Facilities budget growth is 9,2 per cent a year after rapid growth over the past three years.

Table 5.11 Trends in expenditure on health programmes

R million	1999/00 Actual	2000/01 Actual	2001/02 Actual	2002/03 Estimated actual	2003/04 Medium-term estimates	2004/05	2005/06	Average annual growth 1999/00 - 2002/03	Average annual growth 2002/03 - 2005/06
Administration	934	960	1 187	1 351	1 593	1 621	1 747	13,1%	8,9%
District Health Services	9 896	10 994	12 051	13 073	14 560	15 947	17 200	9,7%	9,6%
Emergency medical services	684	772	812	1 290	1 471	1 563	1 672	23,6%	9,0%
Provincial hospitals	6 508	7 245	7 878	8 952	9 824	10 777	11 595	11,2%	9,0%
Central hospitals	4 278	4 821	5 022	5 243	5 706	5 992	6 334	7,0%	6,5%
Health sciences and Training	491	502	652	851	920	1 020	1 104	20,1%	9,1%
Support services	342	370	417	546	586	679	718	16,9%	9,6%
Health Facilities	899	584	1 542	1 833	2 012	2 235	2 388	26,8%	9,2%
Other	78	155	196	99	180	180	184	8,0%	23,1%
Total	**24 110**	**26 403**	**29 757**	**33 238**	**36 852**	**40 014**	**42 942**	**11,3%**	**8,9%**
Percentage of total									
Administration	3,9%	3,6%	4,0%	4,1%	4,3%	4,1%	4,1%		
District Health Services	41,0%	41,6%	40,5%	39,3%	39,5%	39,9%	40,1%		
Emergency medical services	2,8%	2,9%	2,7%	3,9%	4,0%	3,9%	3,9%		
Provincial hospitals	27,0%	27,4%	26,5%	26,9%	26,7%	26,9%	27,0%		
Central hospitals	17,7%	18,3%	16,9%	15,8%	15,5%	15,0%	14,8%		
Health sciences and Training	2,0%	1,9%	2,2%	2,6%	2,5%	2,5%	2,6%		
Support services	1,4%	1,4%	1,4%	1,6%	1,6%	1,7%	1,7%		
Health Facilities	3,7%	2,2%	5,2%	5,5%	5,5%	5,6%	5,6%		

Primary health care

Primary health care amounts to R6 billion in 2003/04 and grows sharply over the MTEF

Table 5.12 presents expenditure in selected areas of out-of-hospital, primary health care (PHC) excluding the HIV/Aids, nutrition and district hospital sub-programmes. For the first time, the new subprogramme structure disaggregates expenditure at the level of clinics, community health centres and community-based services. Budgeted primary health care expenditure is around R6 billion in 2003/04, and grows over the MTEF period.

Table 5.12 Selected primary health care expenditure and budgets

R million	1999/00 Actual	2000/01 Actual	2001/02 Actual	2002/03 Estimated actual	2003/04 Medium-term estimates	2004/05	2005/06	Average annual growth 1999/00 - 2002/03	Average annual growth 2002/03 - 2005/06
2.1 District Management	612	672	730	552	608	660	691	-3,4%	7,8%
2.2 Clinics	1 700	1 719	2 261	2 709	2 779	3 382	3 669	16,8%	10,6%
2.3 Community Health Centres	817	982	896	1 395	1 595	1 682	1 845	19,5%	9,8%
2.4 Community Based Services	283	365	296	488	685	490	532	19,9%	2,9%
2.5 Other Community Services	268	274	383	255	288	297	306	-1,6%	6,3%
Total	**3 680**	**4 012**	**4 566**	**5 399**	**5 955**	**6 511**	**7 043**	**13,6%**	**9,3%**
Total rand per capita	105	114	127	148	160	172	183		

Excludes HIV/AIDS, nutrition and district hospital subprogrammes.

Table 5.13 shows primary health care expenditure by province for 2003/04. It shows large inequalities between provinces in per capita expenditure. Limpopo, Eastern Cape and Mpumalanga have low expenditure in out-of-hospital primary health care services. This is partly due to the greater reliance by rural provinces on district hospitals to deliver primary health care. Nevertheless, more than any other health services, primary health care services are generally associated with improved health status. This means that increased focus on these areas is required.

Table 5.13 Primary health care expenditure

R million	2002/03 Estimated actual	2002/03 Rand per capita	2003/04 Budget	2003/04 Rand per capita
Eastern Cape	592	91	703	106
Free State	425	183	396	168
Gauteng	1 138	238	1 183	243
KwaZulu-Natal	1 288	163	1 392	174
Limpopo	378	70	417	75
Mpumalanga	328	122	405	148
Northern Cape	139	199	174	246
North West	456	145	548	172
Western Cape	654	213	738	237
Total	**5 398**	**148**	**5 955**	**160**

Trends in selected indicators of primary health care performance

Table 5.14 shows selected indicators of primary health care performance by province. At 2,3 visits a year, utilisation in terms of headcount is still lower than the desirable 3,5. Access is especially low in Mpumalanga (1,5 per capita), which has an under-developed primary health care infrastructure, and highest in Western Cape (3,8 per capita) which has a very well established system of community health centres, especially in the metropolitan area. Access to antenatal care is generally good, at about 79 per cent, with an average of 3,9 visits. Immunisation coverage of 70 per cent is still less than the desirable 85 per cent. At 64 per cent the tuberculosis (TB) cure rate is also lower than the desirable 85 per cent and is much lower in KwaZulu-Natal (49 per cent).

Table 5.14 Primary health care performance

	PHC visits 2001/02 (headcounts per capita)	Antenatal coverage rate (% having at least one visit) 2002	Antenatal visits per antenatal attender 2002	% children fully immunised at 1 year (ave of past 2 years)	TB cure rate 2000
Eastern Cape	2,3	77,0%	3,3	60,0%	59,0%
Free State	2,2	100,0%	4,3	82,0%	66,0%
Gauteng	2,3	78,0%	3,8	64,0%	70,0%
KwaZulu-Natal	2,0	89,0%	4,0	77,0%	49,0%
Limpopo	2,2	82,0%	3,9	67,0%	62,0%
Mpumalanga	1,5	100,0%	3,7	80,0%	65,0%
Northern Cape	2,8	63,0%	4,0	65,0%	63,0%
North West	2,7	82,0%	4,2	71,0%	66,0%
Western Cape	3,8	79,0%	4,7	65,0%	71,0%
Total	**2,3**	**79,0%**	**3,9**	**70,0%**	**64,0%**
Target	3-3,5			85,0%	85,0%
Total number	81 907 094	762 226	3 337 057	704 855	144 910

Indicators of burden of disease

Table 5.15 presents selected indicators of burden of disease. HIV/Aids prevalence is high but levelling off and will lead to substantially increasing workloads in health care facilities. Declining syphilis prevalence and sexually transmitted disease incidence suggest some successes of reproductive health programmes. TB cases associated with HIV/Aids continue to rise. After a substantial malaria epidemic in affected regions, which peaked in 2000, the incidence of malaria declined sharply in 2001, partly associated with improved control measures. The cholera outbreak peaked in 2001, showing that despite substantial progress in water supply, there remain significant underserved areas, particularly for sanitation. Measles cases have declined dramatically, suggesting improved primary care services for children.

Table 5.15 Burden of disease – selected epidemiological indicators

Infectious diseases	1998	1999	2000	2001
HIV prevalence antenatal %	22,8%	22,4%	24,5%	24,8%
HIV prevalence total pop %	7,6%	9,9%	9,6%-12,9%	11,4%
Syphilis prevalence % antenatal	10,8%	7,3%	4,9%	2,8%
Terminations of pregnancy	39 912	44 238	52 172	53 967
TB - cases	90 747	59 896	89 497	108 826
STI incidence per 1000 >15yrs			62,6	56,4
Malaria - cases	26 445	51 535	61 934	26 506
Cholera- cases per 100 000			24	221
Diarrhoea incidence <5 per 1000	286,4	144,8	165,0	133,0
Viral hepatis - cases per 100 000		1,6	3,4	3,4
Measles- cases	1 148	694	646	

Local government health services

Defining local government responsibilities in health services

To ensure a coherent framework for the provision of primary health care and to avoid legislative fragmentation of the primary health care function, recent work has proposed that municipal health services be defined narrowly to encompass environmental health services only. This will give provinces the bulk of responsibility for primary health care. If this approach is legislated and implemented by the departments of Health and Provincial and Local Government, it will entail a shift of functions to provinces in cases where local governments provide substantial primary health services. This will have significant fiscal implications for provinces. Resolving the financial and fiscal implications of this issue will be critical to establishing the district health system.

Metropolitan municipalities' spending on health

Table 5.16 reflects patterns of health care contributions by the six metropolitan municipalities for 2002-03. Collectively, their budgets total over a R1,1 billion, of which 67 per cent is derived from own revenue and 33 per cent derived from provincial subsidies. Municipalities spend their resources mainly on staffing clinics, antenatal and environmental health services, and to a limited extent on medicines.

Table 5.16 Local government health budgets 2002-03: Metropolitan municipalities

R thousand	Local government health budget 2002-03	Subsidy from provincial department	Own revenue contribution
Cape Town	308 887	87 937	220 950
Ekurhuleni	258 719	105 000	153 719
Johannesburg	198 320	72 000	126 320
eThekwini (Durban)	197 791	22 518	175 273
Tshwane (Pretoria)	84 708	40 000	44 708
Nelson Mandela (P.E.)	73 783	42 594	31 189
Total	**1 122 208**	**370 049**	**752 159**

HIV/Aids funding

Enhanced Response to HIV/Aids Strategy

One of the thrusts of the 2003 Budget is a further step-up in the Enhanced Response to HIV/Aids Strategy. This is a budgetary response to reinforce the national HIV/Aids plan, which the national Department of Health has developed, working jointly with National Treasury.

As the first phase of the Enhanced Response to HIV/Aids Strategy, Government increased earmarked funding for HIV/Aids in the 2002 Budget, from R345 million in 2001/02 to over R1 billion in 2002/03, rising to R1,8 billion in 2004/05 This focused on the basic preventive interventions such as life-skills, condoms, voluntary counselling and testing, prevention of mother-to-child transmission, support for the South African Aids Vaccine Initiative, co-funding the (R100 million per year) loveLife Programme, and proper treatment of sexually transmitted

infections. It also provided funding to strengthen programme management at provincial level and began laying the foundation for the treatment and care response. The additions were effected through substantial increases to the equitable share over and above to the three conditional grants of the departments of Health, Education and Social Development.

This year's budget adds a further R3,3 billion to provincial allocations to be spent on Government's Enhanced Response to HIV/Aids Strategy over the MTEF. In addition to strengthening preventive programmes and supporting full rollout of the mother-to-child and post-exposure programmes (PEP), the 2003 Budget provides for a substantial boost to care and treatment programmes. This takes into account the additional costs arising from hospitalisation for HIV/Aids, treatment of opportunistic infections and TB, and for a progressive strengthening of medically appropriate treatment programmes over the medium term.

Increased earmarked allocations for HIV/Aids

Earmarked allocations for HIV/Aids have increased significantly, starting from 2002/03. The HIV/Aids conditional grant administered by the Department of Health will more than double from R210 million in 2002/03 to R535 million in 2005/06. Sharp growth in this grant presents a major challenge to provinces to scale up HIV/Aids programmes. Proposals have been tabled to allow more flexibility in the use of the grant for an allowable list of interventions and to improve its functioning. The new subprogramme in the revised budget structure also indicates that provincial departments add funding to the earmarked allocation from Government.

Hospitals

Hospital budgets amount to R22,6 billion in 2003/04

Trends in hospital expenditure and budgets are shown in Table 5.17. An amount of R22,6 billion is budgeted for hospitals in 2003/04. The new structure provides separate budget information for different categories of hospitals - psychiatric hospitals and tuberculosis hospitals - and introduces a category for provincial tertiary hospitals.

Table 5.17 Hospital expenditure and budgets

R million	1999/00 Actual	2000/01 Actual	2001/02 Actual	2002/03 Estimated actual	2003/04 Medium-term estimates	2004/05	2005/06	Average annual growth 1999/00 - 2002/03	Average annual growth 2002/03 - 2005/06
District	5 690	6 421	6 815	6 233	7 076	7 678	8 241	3,1%	9,8%
General (regional)	5 159	5 731	6 261	6 734	7 394	8 146	8 740	9,3%	9,1%
Provincial tertiary	591	760	685	800	879	926	993	10,6%	7,5%
Central	3 687	4 061	4 337	4 443	4 826	5 066	5 340	6,4%	6,3%
Psychiatric and mental handicap	924	1 039	1 094	1 236	1 338	1 468	1 624	10,2%	9,5%
TB	162	186	205	425	474	503	533	37,9%	7,8%
Chronic/subacute	46	50	57	189	203	218	230	60,2%	6,8%
Dental	129	139	155	175	191	203	212	10,7%	6,6%
Other specialised	87	100	101	195	224	239	256	30,9%	9,5%
Total	**16 475**	**18 487**	**19 710**	**20 430**	**22 605**	**24 447**	**26 169**	**7,4%**	**8,6%**

Table 5.18 Number of public hospital and semi-private beds

	Number of hospitals	Average beds per hospital	Number of beds by type of hospital						Beds per 1000 public users
			District	Regional	Tertiary	Central	Specialised	Total	
Eastern Cape	91	194	7 754	4 600			5 331	17 685	2,8
Free State	33	153	1 695	1 895	438	152	864	5 044	2,2
Gauteng	30	546	1 836	5 483		6 346	2 719	16 384	3,5
KwaZulu-Natal	73	373	11 239	6 356	456	2 533	6 671	27 255	3,5
Limpopo	43	251	6 282	1 879	882		1 771	10 814	2,1
Mpumalanga	29	143	2 040	1 164	326		620	4 150	1,6
Northern Cape	26	74	757	543			321	1 621	2,4
North-West	22	208	2 226	1 711			1 465	5 402	1,8
Western Cape	55	185	1 559	2 039		2 626	3 966	10 190	3,4
Total	**402**	**245**	**35 388**	**25 670**	**2 102**	**11 657**	**23 728**	**98 545**	**2,8**
Hospital admission per 1000 uninsured population: 2001/02									
Eastern Cape			35,6	18,2	–	–	16,3	70,1	
Free State			50,8	34,9	6,7	3,3	0,2	95,9	
Gauteng			22,9	68,4	–	58,3	2,2	151,8	
KwaZulu-Natal			73,2	40,2	2,7	7,0	4,6	127,7	
Limpopo			51,3	14,8	5,4	–	–	71,5	
Mpumalanga			46,9	21,8	6,2	–	0,4	75,3	
Northern Cape			107,6	85,5	–	–	1,2	194,3	
North-West			36,7	29,7	–	–	0,5	66,9	
Western Cape			47,4	49,2	–	47,3	10,8	154,7	
Average			48,7	35,3	2,3	13,4	5,2	104,9	
Total admissions			1 745 422	1 267 219	81 308	480 470	187 138	3 761 557	

In 2001 there were 402 hospitals and 98 545 beds

Table 5.18 shows that in 2001, there were 402 public and semi-private hospitals with a combined total of 98 545 beds. The wide variation in costs of hospital expenditure across provinces is largely a feature of the distribution of different bed types, each of which has very different unit costs. Western Cape, for example,

has a high proportion of beds in central and regional hospitals where care is led by medical specialists. This is substantially more expensive than Limpopo, whose hospital configuration is largely based on district beds. Table 5.18 also shows significant variability in access to hospitals by way of patient admissions. Figures range from 66/1 000 in North West to 154/1 000 in Western Cape. The table also shows variability in the type of hospital across provinces and thus the level of sophistication of care that patients receive.

Trends in admissions remain stable in spite of HIV/Aids

Trends in hospital admissions have been fairly stable over the past two years. However, the proportion of admissions by patients who have HIV/Aids is rising, pointing to some displacement of other categories of patients. It appears that supply-side constraints such as reduced personnel and more costly non-personnel items are placing a ceiling on admissions. Comparisons of tables 5.3, 5.5, 5.6 and 5.18 show a close relationship between the distribution of budgets, personnel and hospital admissions by province, reinforcing the notion that utilisation is closely linked to supply.

Signs of improvement in hospital efficiency

The average length of stay in hospitals has declined over a decade and is at relatively efficient levels. However, bed occupancy rates, notably in district hospitals, are too low, with only 57 per cent of beds occupied. Hospital information systems are currently too weak to meaningfully present unit cost trends. It is essential that provinces improve their information systems, data usage and capacity to evaluate performance.

Table 5.19 Average length of stay (days) and bed occupancy (%)

Type of hospital	District	Regional	Central
Eastern Cape	5,4	6,9	–
Free State	3,2	5,9	5,3
Gauteng	3,9	4,4	6,5
KwaZulu-Natal	4,4	5,1	8,0
Limpopo	5,2	6,0	–
Mpumalanga	3,4	4,7	–
Northern Cape	2,8	3,2	–
North-West	4,1	5,0	–
Western Cape	2,6	4,4	5,2
South Africa	**4,2**	**5,0**	**6,3**
Bed occupancy	**District**	**Regional**	**Central**
Eastern Cape	44,0%	48,0%	–
Free State	60,0%	66,0%	73,0%
Gauteng	63,0%	70,0%	78,0%
KwaZulu-Natal	61,0%	69,0%	73,0%
Limpopo	60,0%	62,0%	–
Mpumalanga	56,0%	63,0%	–
Northern Cape	77,0%	95,0%	–
North-West	57,0%	74,0%	–
Western Cape	65,0%	88,0%	78,0%
South Africa	**57,0%**	**67,0%**	**80,0%**

A range of initiatives aimed at improving hospital services

A variety of interventions for addressing deficiencies and improving the quality of care in hospitals includes: improving hospital buildings through the Hospital Revitalisation Programme;

giving greater powers to hospital managers through decentralisation and delegation; recruiting and retaining staff through the rural and scarce-skills strategies; improving medical equipment; initiating complaints procedures; and auditing against quality standards. An important emerging tool to assess and document quality is through external accreditation, by organisations such as the Council of Health Services Accreditation of South Africa (COHSASA). This is an external body that provides detailed audits of quality standards in private and public hospitals. Provincial health departments are in the process of getting accreditation for approximately 65 public sector hospitals. KwaZulu-Natal is the most advanced and Table 5.20 provides a list of public hospitals that have reached either full accreditation or pre-accreditation status in that province.

Table 5.20 Accredited or pre-accredited hospitals in KwaZulu-Natal

Fort Napier	St. Mary's	Ladysmith
Grey's	Murchison	RK Khan
Townhill	St. Andrews	Hillcrest
Umgeni Care	Niemeyer	King George
Wentworth	CJ Memorial	Ngwelazana
McCords	Eshowe	Newcastle

Support services

The National Health Laboratory Service

The National Health Laboratory Service was established as an independent public entity in 2001/02, incorporating virtually all public sector laboratories, the South African Institute of Medical Research and the National Institute of Virology. The Service is the preferred provider of laboratory services to provincial health departments.

Conditional grants

Conditional grants make up a substantial proportion of health funding

Conditional grants make up a very significant component of provincial health funding, constituting around 20 per cent of health spending. Table 5.21 shows that health conditional grants amount to R7,4 billion in 2003/04 rising to R8,8 billion in 2005/06. Allocations to individual provinces and conditions pertaining to each grant are contained in the frameworks published with the Division of Revenue Bill, 2003. Several important reforms to the conditional grant system were introduced in the Division of Revenue Act of 2002. The Integrated Nutrition Programme, Hospital Revitalisation and HIV/Aids grants are substantially augmented in the 2003 Budget.

Government is stepping up the Integrated Nutrition Programme in a bid to fight child poverty

Funding for the Integrated Nutrition Programme has been increased to over R1 billion a year by 2005/06 in order to step up the Programme as part of Government's anti-poverty strategy. The increases are intended to offset food inflation and reach out to increased numbers of children and schools, including those doing Grade R, providing meals for at least 156 days a year in all

provinces. Menus are also being standardised at nutritionally recommended levels.

The National Tertiary Services Grant funds individual tertiary care service units

In the 2002 Budget, following an intensive research and detailed costing process, the National Tertiary Services Grant was developed to replace the Central Hospitals, Redistribution of Specialised Services and part of the Health Professions Training and Research grants. As Table 5.22 shows, the new Grant is based on funding individual tertiary care service units in specific hospitals, such as the renal unit in the Johannesburg General Hospital. The Grant is thus more targeted than the previous grants. The first phase of the grant reform was based on actual expenditures in the designated units. The second reform phase, known as the Modernisation of Tertiary Services, focuses on a future desirable pattern of tertiary services and will more explicitly link service outputs to funding. Progress is being made with the support of 60 groups of specialist clinicians and preliminary reports may be accessed on website of the national Department of Health.

Table 5.21 Trends in conditional grants

R million	1999/00 Actual	2000/01 Actual	2001/02 Actual	2002/03 Estimated actual	2003/04 Medium-term estimates	2004/05	2005/06
National tertiary services	–	–	–	4 207	3 995	4 273	4 529
Central hospitals	3 075	3 112	3 270	–	–	–	–
Redistribution of specialised services	52	207	178	–	–	–	–
Health Professions Training and Development	–	–	–	1 269	1 333	1 434	1 520
Training and research	1 118	1 174	1 234	–	–	–	–
Integrated Nutrition Programme	460	534	489	642	809	950	1 042
Hospital revitilisation	140	323	550	694	718	912	1 027
HIV/AIDS	–	10	46	207	334	482	535
Hospital management and quality improvement	–	–	124	114	133	142	150
Nkosi Albert Luthuli academic hospital	189	74	298	–	–	–	–
Nelson Mandela Academic Hospital	41	95		–	–	–	–
Pretoria Academic	–	–	50	222	92	–	–
Total	**5 075**	**5 529**	**6 239**	**7 355**	**7 414**	**8 193**	**8 803**

Table 5.22 Selected tertiary service units funded by National Tertiary Services Grant

Cardiology – general	ENT – complex
Cardiology - complex and interventional	Hepatobiliary surgery
Dermatology	Intensive Care (surgical)
Endocrinology	Liver transplant
Gastroenterology	Renal transplant
Human Genetics	Neurosurgery
Hepatology	Opthalmology – general
Infectious Disease (not TB)	Opthalmology – complex
Lipidology	Orthopaedics – general
Nephrology (Renal Dialysis)	Orthopaedics – complex
Neurology	Plastic & Reconstructive Surgery
Pharmacology	Urology – complex
Respiratory Medicine	Specialised Paediatric surgery
Rheumatology	Specialised Neonatal surgery
Clinical Immunology	Neonatal ICU
Intensive Care	Tertiary Diagnostic Radiology (MRI & CT Scan)
Clinical Haematology	Nuclear Medicine
Clinical Haematology (Bone Marrow transplant)	Radiation Oncology
Burns Unit	Medical Oncology
Cardiothoracic	Oncological Surgery
Cardiothoracic Surgery (Heart transplantation)	Tertiary Psychiatry
Colorectal Surgery	Tertiary Obs & Gynae
Craniofacial Surgery	Vascular surgery
ENT – general	Spinal injury management centre

Health Professions Training and Development Grant facilitates redistribution of specialists

The Health Professions Training and Development Grant is in the first phase of its reform. A new component has been added to fund specified numbers of registrars and medical specialist trainers in provinces with the most severe shortage of specialists. Part of the grant is now contained in the National Tertiary Services Grant. This grant will need to be redesigned over the MTEF period and be better aligned with tertiary education funding.

The Hospital Management and Quality Improvement Grant

The Hospital Management and Quality Improvement Grant, which was previously part of the Finance Supplementary Grant administered by National Treasury, has now been formally established as a separate grant administered by the Department of Health. The new grant has been strengthened to support quality improvement initiatives and management reform and improvement in the sector.

Medical schemes

Amendments to legislation governing medical aid schemes under way

The Medical Schemes Amendment Bill was passed in 2001/02. Recent regulations were gazetted covering several areas, including widening the scope of prescribed minimum benefits to include chronic care benefits. The 'Committee of Inquiry Report into a Comprehensive Social Security System' was released and contains extensive recommendations for the phased establishment of a social health insurance system for South Africa.

Medical aid-related costs rise sharply

As Table 5.23 shows, medical aid schemes continue to face significant cost pressures with contributions rising by 19,9 per cent in 2001. Approximately R1,3 billion has gone to increases in accumulated funds, with schemes showing the first operating surpluses in years. However, increases in non-health expenditure amounting to 34,5 per cent are a cause for concern. They include increasing administration costs (41 per cent), re-insurance losses (61 per cent) and broker fees (26 per cent). Benefit payments increased 13,4 per cent despite some members trading down to reduced packages. Ongoing cost escalation in the industry will require interventions by a wide range of stakeholder groups.

Table 5.23 Trends in medical schemes

	2000	2001	Change	Change %
Beneficiaries	7 004 636	7 020 806	16 170	0,2%
Pensioner ratio	6,25	6,00		
Dependent ratio (Dependents/members)	1,59	1,57		
Gross contribution income (Rmil)	30 864	37 000	6 136	19,9%
Benefit payments (Rm)	27 157	30 800	3 643	13,4%
Non-health expenditure (Rm)	3 976	5 346	1 370	34,5%
Of which: Administration fees (Rm)	2 499	3 540	1 041	41,7%
Benefits+ non-health expend (Rm)	31 133	36 146	5 013	16,1%
Operating results (Rmil)	-1 041	278	1 319	
Net profit (includes investment income)	190	1 546	1 356	
Accumulated funds (Rm)	6 100	7 400	1 300	21,3%

Source: Registrar of Medical Schemes.

Medical schemes across the country are experimenting with a range of interventions in attempts to control escalating costs. It is clear that without better cost control, innovative design and more appropriate incentives, the proposed public sector medical scheme and any attempts at social health insurance may fail.

Conclusion

The 2003 provincial health budgets reflect significant growth in all components of expenditure. Critical elements in safeguarding and building service delivery in the sector are increased allocations for the Integrated Nutrition Programme, the Hospital Revitalisation Programme, the Enhanced Response to HIV/Aids Strategy and a new framework aimed at attracting and retaining health professionals with scarce skills and improving staffing in rural areas.

The new programme and subprogramme budget structure enhances the transparency of budgets and will provide strong support for improved planning and monitoring. The new strategic plan formats have been used to prepare the nine provincial health strategic plans that accompany these budgets.