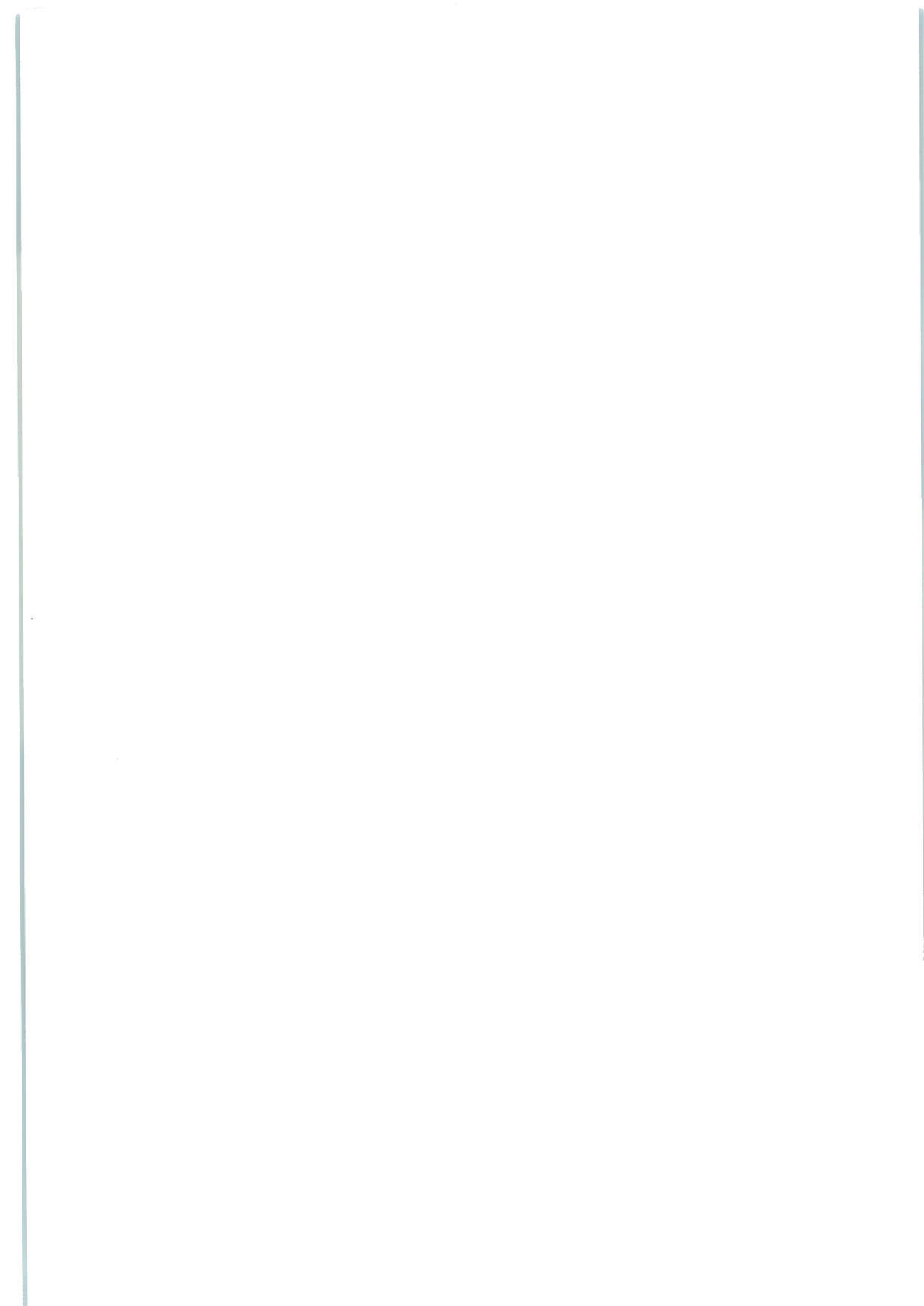


Development Bank
of Southern Africa



Strategic health policy for the
Reconstruction and Development
Programme

Max Price &
Alex van den Heever



Strategic health policy issues for the Reconstruction and Development Programme

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Preface

Restructuring South Africa's health system is essential for improving the well-being and ensuring the full and equal participation of all the people in the economy and society. DBSA is committed to enhancing the opportunity of all people to participate fully and equitably in the economy. Unequal access to health services and unequal quality of care make it necessary that health policy issues receive urgent attention.

The broad goals for health programmes enunciated in the Reconstruction and Development Programme are widely shared. Translating goals into policies, priorities and programmes, however, is the key to development. The integration of the health services of homeland authorities and the reallocation of responsibility among the different levels of government are essential to this process. The allocation of resources

between health and other claimants on national revenue, and within the health services themselves, requires analysis which goes beyond identifying and costing particular desired health programmes and stating target expenditures derived from international comparisons. Expenditure on health can be made more efficient by, among other things, integrating separate programmes and analysing comparative experience to identify how productivity can be enhanced and costs contained.

This occasional paper was commissioned in order to inform Bank policy on health issues and was prepared by Max Price and Alex van den Heever of the University of the Witwatersrand Centre for Health Policy. The advisory panel of the health policy programme recommended its publication as a contribution to policy dialogue.

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1. Introduction

This paper focuses on the African National Congress's National Health Plan (ANC, 1994a) and its priority programmes, which are reproduced as part of the Reconstruction and Development Programme (ANC, 1994b). By way of shorthand, both the plan and the programmes will be referred to as the 'RDP health plan'.¹

There are, of course, other health programmes that have been developed by other political parties and health forums. Those of the Inkatha Freedom Party and the National Party that appear in party documents are very brief and vague, although some additional detail was found in speeches and responses to questions which we reviewed (Arbuckle, 1994; Venter, 1994; Fortuin, 1994). While the National Party and Inkatha may take issue with the details of the RDP health plan, our reading of their policies suggests that they would support its broad goals. However, these parties have not provided details of their health plans, and there is no point in guessing at how they would differ with the ANC on that level. Furthermore, since the ANC holds all ten Ministries of Health, ANC policies will in all likelihood form the basis of policy debates.

The National Health Forum, a body representing the authorities that render health services, and the 'Patriotic Health Front' began producing its own national health plan but never completed the process. The main products were a proposal on structures and mechanisms for formulating policy and a position paper on the structure and functions of different levels of government with respect

to health services. The latter will be summarised in Section 6 below.

Section 2 reviews very briefly those aspects of the RDP health plan which do not require significant resources. Section 3 reviews, from a more theoretical perspective, the dilemmas faced by economists in the health sector in deciding how to allocate national expenditure appropriately to health as opposed to other sectors. The strategy for identifying priority programmes set out in the RDP health plan is discussed. However, the RDP health plan did not attempt to cost these programmes, and so the costs did not influence either the selection of programmes or their scope.

Section 4 describes the resource-intensive priority programmes briefly, with some estimates of their costs. The methodology used in the costing of these programmes is presented in Appendix 1. Section 5 presents a critique of this programmatic approach to planning and budgeting.

Section 6 examines some of the institutional factors that will affect the implementation of the RDP health plan, including aspects of the new constitution which have relevance to health care funding (also discussed in detail in Appendix 2).

Section 7 analyses the sources of funding contemplated by the RDP health plan with specific reference to removing the tax concession on medical aid contributions, and tobacco and alcohol taxes. Other fiscal issues covered in this section include the potential for and constraints on reallocating resources within the health sector – particularly from hospital care to primary care; the question of revenue retention at facility level; and a brief overview of National Health Insurance and its effect on the public sector.

Finally, the Conclusion points to the major problems with the plan, assesses its chances of being accepted by the Government of

¹ The health and nutrition chapters of the RDP, published in March 1994, were based on the second draft of the National Health Plan, distributed by the ANC Health Department in December 1993. However, the plan underwent some further substantial modification before the final draft was released in May 1994. This analysis is therefore based on the RDP but updated to reflect the final ANC health plan.

National Unity and other stakeholders, and the prospects of implementation.

2. Policies requiring limited resources within the health budget

Much of the RDP health plan is concerned with restructuring the inherited health system to make it more effective and efficient. This includes the integration of the homeland health services and a new division of responsibility for health between the different levels of government. In the new system substantial responsibility and authority will devolve to district health authorities via local authorities, and preventive and curative health care will be integrated at all levels. The system will also be reoriented towards primary health care. This will not only require a shift in the allocation of resources so that everyone receives basic services (see below), but also the development of institutions which emphasise community participation, the relationship between health and other sectors, and appropriate health management information systems. The RDP health plan pays considerable attention to the personnel problems of the health sector in respect of their training, distribution, the paucity of management skills and the absence of a primary health care orientation, and proposes reorienting and retraining large numbers of personnel in the shortest possible time. Such restructuring and training would obviously incur costs, and a number of studies are under way to determine just how expensive it will be.² The sums could be so large as to absorb any increases in the health sector's budget.

A variety of other policies in the RDP health plan relate primarily to legislative and regulatory changes, and have limited financial implications. Examples of such policies are those concerning the rights of women to abortion; the decriminalisation of traditional healing and cooperation with healers; research and technology; the implementation of occupational health legislation; gun control; the promotion of NGO and CBO activities; and the regulation of private-sector providers. Some new policies are intended to improve efficiency and reduce costs, particularly in the public sector. Examples are policies on essential drug lists and national procurement and pricing of pharmaceuticals.

The policies identified above tend to receive less attention in public debates precisely because they are not competing for scarce resources. Yet this is going to render them more feasible in the short term, particularly if the government is struggling to keep its other promises in the health sector.

The intersectoral approach adopted by the RDP health plan is reflected not only in the proposal for intersectoral development committees, but also in the identification of programmes in other sectors which will promote health. These are mentioned in this section because, although they will require massive resources, these resources will fall outside the health budget, and so have not been costed or included in the additional R2 billion (recurrent) that is being requested for the health sector. For example, most of the interventions proposed as part of the nutrition component of promoting food security would fall outside the health sector's area of direct responsibility and therefore its budget. These interventions include increasing employment levels and incomes, reducing VAT on a wider range of basic foodstuffs and targeted income transfers. Only feeding programmes and nutritional surveillance would be part of the health budget. Similarly, increasing female literacy is recognised as probably the most cost-effective way of improving child health

² The Health Economics Unit at the University of Cape Town is doing such a study in the Western Cape. The different authorities in a single area – local and regional authorities, the Regional Services Councils, the National Department of Health – all have different salary scales. It is likely that all employees of the newly integrated health authority will be brought onto the highest scales.

outcomes (World Bank, 1993). Other development initiatives such as providing household electricity and clean water, not only improve health directly but also have indirect benefits because they reduce the time and energy burdens on women. Housing and sanitation are also mentioned in the plan, as is health education and promotion, much of which would happen in the schools and would therefore be funded through the education budget.

The welfare department is most closely related to health, and could end up carrying the costs of many of the programmes in the RDP health plan. The plan argues for the need for: shelters for victims of violence; counselling and rehabilitation services for people who have been raped or psychologically scarred by violence; support for people with HIV; community services for people with AIDS, the mentally ill and the elderly; and much more. All these services would traditionally fall under the welfare department and have therefore not been costed as part of the proposed increase in health spending.

3. Determining expenditure targets in the health sector

Assuming for the moment that the government only has control over public expenditure, the first dilemma faced by health policy-makers is whether to allocate new resources to the health sector or to other sectors that benefit health, that is, what proportion of public spending, or of GDP, should be allocated to the health sector? There is little doubt that for many people in South Africa improvement in water supplies, food security and agriculture, better housing in a family environment and better education would have a far greater effect on their health than investment in health services. With few exceptions (such as obstetric care and child immunisation) investment in health services only becomes justifiable as a cost-effective

measure for improving health, once communities have crossed a certain threshold of 'development'. It is therefore difficult to make a case for increasing expenditure in the health sector on the basis of rational resource allocation to maximise the health of society.

The argument for spending anything above the barest minimum turns rather on two other issues. First, there is the principle of equity. Many communities do indeed receive reasonable, publicly funded, basic health services. It would be politically impossible to remove funding from these services, since the communities concerned have come to expect at least this level of health care and would not be able to fund such care themselves. Moreover, in these communities, which already enjoy healthier environments, better income, reasonable nutrition and some education, health care makes a substantial contribution to an improved quality of life and is a cost-effective use of resources to improve health further. It would obviously be unacceptable in view of equity to provide health services only to the better-off, largely urban communities, while refusing to fund similar services in poor rural communities.

Secondly, there is the fact that health is regarded as a merit good. As a society we believe that people are entitled to have their suffering minimised and their quality of life maximised should they become ill. For better or worse, our society has chosen to rescue people from motor accidents even though this is amongst the least cost-effective uses of health resources.

It seems that there is no economically rational answer to the health economist's first question: 'How much should South Africa spend on health care relative to other sectors?' But can we at least calculate how much should be spent to meet all legitimate needs for health care, that is, to provide care which has been shown to improve quality of life?

Unfortunately we cannot do this either. The legitimate needs for health care exceed what any industrialised country can afford, let alone a developing one. Clearly, limited resources make it necessary for the society, and especially the public sector, to ration health care, in relation to the scope of the health problems the public sector will take on and the choice of who receives services. (Most rationing at present occurs through queuing and clinicians decide who should be treated and what resources expended.) However, a more rational, planned approach would spell out what services should be available through the public sector and the criteria for individual eligibility where services are rationed.³ Once the basic services have been specified, equity would again require that they be provided to all communities equally.

The approach usually adopted, more or less consciously, is to make a judgement about what type of health service would be acceptable and slightly above average for a country, and then to set that as a target for the whole country. This implies a more realistic incremental approach to health service development, rather than an idealistic, if rational 'blueprint' approach. It also sets as targets models which are already available in the country and argues on the basis of equity for raising the average to those targets. The cost of closing the gap represents the additional resources required by the health sector, and in turn determines the proportion of GDP that should be spent on health.

The RDP health plan has attempted to define this rationed range of services by listing the types of service everyone should receive. These include, for example, certain services provided through community health centres;

³ For example, neonatal intensive care for premature babies may be included in the range of services, but only for babies weighing more than 1.5kg (although the technology can save babies from 750g). The cost per baby saved increases rapidly as the birth weight of the baby decreases, and the smaller babies tie up the scarce intensive care cots for much longer, preventing other premature babies from receiving care.

at least one 24-hour emergency service per health district; and maternity services that enable women to have their babies delivered by a professionally trained attendant with access to a facility which can undertake Caesarean sections. The plan advocates the provision of mental health services, rehabilitation care, health promotion, and the prevention, early detection and treatment of specific diseases including TB, sexually transmitted diseases, cervical cancer, hypertension and diabetes. The selection of these priority services is not based on a rational cost-benefit analysis, but rather on an historically informed sense of what everyone should be entitled to in a country of South Africa's level of development.

The list of services is much longer and vaguely stated for the most part. The plan in fact fails to specify the basic services that everyone should receive and so the total additional costs cannot be calculated. They might be just a little more than we currently spend on health – or two or three times as much!

Could the RDP health plan have done otherwise? It would obviously have been necessary to start costing the proposals before more detail was added. This has not been done, and we do not have the data that would allow us to do it. In fact, for many of the targets, not only are unit costs unknown, but so is the coverage provided by health services at present. We cannot even determine the gap between existing services and targets, let alone absolute costs. For example, the target for attended deliveries is 50 per cent by the end of 1995, by which time over 60 per cent of pregnant women should also be attending antenatal care at least once. Yet there is no national data on the current situation and so we cannot say what would be required to meet these targets. Ironically, for this set of indicators, the country is probably already far better off than the targets set for 1995. Isolated studies from rural areas show that about 60 per cent of women have attended

deliveries and 90 per cent attend antenatal care at least once (Schneider *et al*, 1991). The national averages are probably far better.

We are left with the problem of having no indication of what the total allocation to health should be. At this point, most planners resort to international practices and norms. These can be derived by locating South Africa in the international development league tables and comparing our health spending with countries close to us on the ladder. In addition, the WHO guideline of 5 per cent of GDP by the year 2000 is often hauled out as the basis for determining our spending targets. There is, of course, no reason why we should be spending what other countries spend, given the unique development of our services and the specific cost structure of our economy, for instance, the relative cost of professional staff (salaries constitute 70 per cent of spending in the health sector).

The 5 per cent target itself is unclear and subject to different interpretations in South Africa because of the large private sector. Total spending on health in South Africa is about 6.4 per cent of GDP, but half of this is private spending benefiting only 20 per cent of the population. Thus, while the WHO figure should translate into average spending per head of 5 per cent of per capita GDP, in South Africa the 3.2 per cent of GDP being spent in the public sector on 80 per cent of the population is equivalent to about 4 per cent of per capita GDP. To raise this to 5 per cent of per capita GDP therefore requires that public health spending be increased to 4 per cent of GDP. This is an increase of about R2 billion.

This may still not be enough to provide the basic services universally. So the next problem is to prioritise health sector improvements and programmes, and then to assess how these benefits would compare with alternative uses of that R2 billion – either in the health sector or in other sectors.

In summary, then, the approach apparently adopted in the RDP health plan was not to cost the priority programmes and work out how much was needed, but to combine two separate parallel processes. First, to identify a target expenditure based largely on international patterns for an overall increased budget allocation; and secondly, to identify priority health programmes that would be uncontroversial since almost everyone would agree that they propose absolute minima and ought to be provided in a country with South Africa's level of development and health service sophistication. Few would disagree that South Africa should be able to halve the levels of severe malnutrition, for example, or ensure that every woman can deliver her baby without fear of dying for lack of an operating theatre. The cost of achieving these minimum standards, though unrelated to the budget being requested, so far exceeds that budget that it can safely be used within the Cabinet to justify at least the increased budget allocation.

4. Priority programmes and their costs

The following programmes, projects and extensions to services have been identified as the most likely to have capital and recurrent cost implications. As noted above, in many cases services already exist and the proposed targets do not take account of present levels of service. Where possible we have indicated the total costs of a programme as well as our estimate of the costs of closing the gap between the present level and the 1999 target. All figures are 1993 prices unless otherwise specified. The methods used to calculate the costs are explained in Appendix 1, which also gives additional rough estimates of the distribution of the costs across the nine provinces.

4.1 Child health care

All children under the age of six should be treated for free at all public sector facilities, provided the child is not covered by medical

aid. The revenue losses resulting from declaring these services free at the point of service are not significant since most children using the public sector do not pay for services at present. Therefore the main costs are those of extending the services to children who do not yet receive them.

TABLE 1: Total and additional annual costs of extended child health services

	Total R million	Gap R million
Cost of immunisation	84	30
Cost of curative care	499	175
Total	583	205

4.2 Maternity health care

Prenatal and postnatal care and delivery should be provided free of charge by 1997 and coverage extended to 80 per cent by 1999. The total recurrent costs at target levels of 80 per cent, 90 per cent and 100 per cent, and the gap between these targets and estimated coverage at present are shown in Table 2.

TABLE 2: Total and additional annual costs of extending maternal care

Target coverage	Total R million	Gap R million
80%	347	38
90%	391	82
100%	434	125

4.3 Nutritional supplementation

Nutritional supplementation should be provided to vulnerable groups. Based on 1989 data, the number of people most in need was estimated at 2.5 million in 1993 (Committee for the Development of a Food and Nutrition Strategy for Southern Africa, 1990). The cost of providing a nutrition programme to these people, based on an average cost of R2 per person per day, is R1.83 billion annually. This is the most expensive component of the RDP health plan, and is unlikely to be affordable. There is also debate about the value of giving

nutrition supplementation to children once they are already at school, since most stunting has already occurred by then. (There are other benefits, such as improving school attendance and concentration, but this is not particularly effective for reducing malnutrition.) If the supplementation programme were to concentrate on children under six, the costs would be R683 million per year.

4.4 Clinic expansion

In order to improve basic clinic services, at least another 150 clinics must be built in the medium term.⁴ The capital and recurrent costs for 50 large and 100 small clinics would be R176 million and R73 million respectively. The capital costs of other programmes, such as the expansion of 24-hour maternity and emergency services, have been annualised. For consistency, therefore, the annual costs of the clinic programme are approximately R85 million.⁵

4.5 Emergency services

According to the ANC's National Health Plan, all health districts should have at least one 24-hour facility by the end of 1995. The costs are fairly difficult to estimate as they include the provision of trauma facilities, communication infrastructure and ambulance services. We estimate an additional annual recurrent expenditure of around R206 million.

4.6 Immunisation against hepatitis B

The ANC health department estimates that this will cost R25 million annually. Note that the extension of the other routine childhood immunisations is covered in the child health programme (4.1 above).

⁴ This estimate was provided by the Department of National Health and Population Development (personal communication), and is in addition to 310 clinics planned or under construction by the Independent Development Trust. The former provinces also indicated a need for additional clinics, but this has not been assessed or included.

⁵ R176 million annualised over 30 years at a real discount rate of 5 per cent.

4.7 NACOSA AIDS programme

The National Aids Congress of South Africa, chaired by the head of the ANC health department, has developed and costed a comprehensive AIDS strategy. Although this programme is not spelt out in the RDP health plan, we assume that it will be incorporated into the RDP. This programme will cost approximately R100 million in the 1994/95 financial year and will involve the budgets of both the health and the education departments. The health department would be responsible for funding around R50 to R60 million of the programme, part of which would be a reallocation of the department's existing budget for AIDS prevention of around R45 million. The gap is therefore R15 million in the health sector.

4.8 A mental health programme for the victims of violence

A mental health programme for the victims of violence has been proposed. This programme would train, supervise and support primary care workers, teachers and volunteers in identifying and treating psychological problems, especially those related to exposure to violence. Although much of the programme could be run through NGOs, full-time professionals are needed to set up and coordinate the provision of training and support. The initial set-up costs for the first year are estimated at R10 million. (This figure was supplied by Mel Freeman of the ANC's mental health working group, the main proponent of the programme.)

4.9 Rural salary allowance

Health services in rural areas should be improved. It is not possible to cost a rural extension programme accurately because of the many factors involved. Some of the costs are already included in the expansion of clinics, maternal and child health services, and emergency services. Others must be reckoned separately, for example, the proposal to increase salaries of professional staff in rural areas as an incentive to attract staff into these underserved communities. A

very crude estimate of the additional costs, assuming a 15 per cent increase on the salary bill of the former homelands, is R256 million.⁶ If the increase applied only to doctors and senior staff the costs would probably be 10 per cent of the initial estimate, that is, R26 million. Improving staff housing and other conditions of service, such as housing subsidies, sabbaticals and schooling allowances, would obviously cost much more than the initial estimate.

4.10 Existing health services

Improving and strengthening the existing health services would involve a general increase in maintenance expenditure and improvements in the conditions of service. This could absorb as much money as was available and therefore cannot be costed definitively. The process should probably be managed through a planned, real increase in health expenditure derived largely from efficiency improvements by managers, who should then be allowed to retain the savings to improve facilities and services.

The total additional cost of the above priority programmes is between R563 and R1 071 million excluding the nutrition programme, and between R1.31 and R3.08 billion including the nutrition programme. Neither estimate includes any allocation for item 4.10. Low and high estimates are presented in Table 3 and explained further in Appendix 1.

5. Critique of the programmatic approach adopted in the RDP health plan

One can criticise the nine priority programmes in the RDP health plan on the grounds that other areas, such as population, mental health and rehabilitation of the

⁶ Up until 1 May 1994 there was a 15 per cent salary increment allocated to white doctors who worked in the homelands. Part of this money could be used for a rural salary increment.

physically disabled, are of greater urgency. The ANC National Health Plan, on the other hand, is far more comprehensive than the health and nutrition components of the RDP. It can be criticised for setting goals which resemble something of a naive wish-list, a list that is far more extensive and obviously also less affordable than the priority programmes described here.

TABLE 3: Total cost of 9 RDP health programmes (in 1994 prices)⁷

Programme	Low R million	High R million
Child health care	97	225
Maternity health care	42	138
Nutritional supplement.	751	2 013
Clinic expansion	36	90
Emergency services	227	227
Hepatitis B immunisation	25	25
AIDS/STD prevention	100	100
Mental health/violence	10	10
Rural salary allowance	26	256
Total	1 314	3 084

The priority programmes are described and costed almost as independent activities and this is largely a result of the RDP's principal role as an instrument for advocacy – aimed both at the public to garner support, and at the other members of the cabinet, where success in the competition for resources will depend on the government's ability to describe its plans in terms of concrete activities. Simply demanding R2 billion for a general expansion of the primary health care system will not be persuasive. Yet in reality, expanding the child health services will necessitate expanding the services for adults, the treatment of sexually transmitted diseases, the detection of TB, the reduction of deafness through treatment of ear infections and the whole gamut of health care provision. This in turn will generate referrals to hospitals for higher-level care, since clearly one cannot send home abused or disabled children presenting to newly established

clinics just because the programme focuses on basic clinic services. Thus the programmatic definition of the RDP health plan confounds its practical implementation, and to a large extent also makes a mockery of the attempts to cost it.

In some senses the programmatic approach is actually dangerous, because if some programmes do get funded they will develop vertical bureaucratic systems with their own budgets, line accountability, targets and indicators of success, and this could undermine the rest of the routine health service. This 'selective primary health care approach' has been encouraged by some donor agencies in poor countries; it has also been severely criticised as antithetical to the primary health care approach. Even in South Africa, where we have had experience of these vertical programmes in family planning, AIDS, TB and other areas, the duplication and fragmentation that resulted have finally forced us to move towards more integrated, comprehensive primary health care. The latter cannot be funded or managed in a programmatic way.

There is another fundamental critique of the programmatic approach. It assumes that current services are acceptable and simply need to be intensified or extended to more people. The effectiveness and efficiency of the health services are never challenged. The approach also clearly presumes that more money can always be made available. If not a cent more were available, we would be forced to do things differently. This may mean looking at the major expenditure items, for example, salaries, and finding alternatives, such as the use of fewer or cheaper staff.

A few strategies are available to planners and managers. All are slower than a desk study on programme costing! One strategy would be to do comparative analyses of facilities and services to compare their 'productivity' and identify outliers where savings could be made or where too few resources are available.

⁷ 1993 figures inflated by 10% to obtain approximate 1994 prices.

Another would be to develop standards based on a few model services which are running well and tuned to maximum efficiency, and then adjust facility and service budgets according to those guidelines. Substantial savings could also be made by changing the basis of funding (for instance, linking budgets to activities or output rather than simply providing global, historically based budgets) and giving managers more incentives to make savings (such as allowing them to retain year-end surpluses and to transfer between line items).

6. Institutional frameworks for implementation

6.1 The implications of the Interim Constitution for the decentralisation of financial control in the health service

The institutional framework for financial control in the health sector as envisaged in the Interim Constitution is described in Appendix 2. The major issues raised by the Interim Constitution with regard to decentralisation would seem to be:

— The degree to which the health system will correspond to the levels and boundaries of political and administrative structures, particularly within the provinces, is a key issue which is not explicitly addressed in legislation and will need to be clarified to allow the development of mechanisms of accountability and coordination between health services, elected government and other sectors. This issue is likely to be affected as much by decisions of the demarcation authorities, and pragmatic solutions to problems of service coordination and lack of capacity in certain areas, as by the constitution *per se*.

— There is considerable devolution and deconcentration of control of legislative and executive power to the provinces. However, the extent of effective decentralisation of control within the provinces will probably

vary considerably, depending on political and bureaucratic will, and technical capacity. It is unclear what role the national government will play in ensuring that effective decentralisation of control in the health services occurs in the provinces.

— The powers of provincial government in health matters, coupled with capacity constraints at local level and the fact that provincial government will be the conduit of most finance to local level, make it a powerful tier which is potentially removed from and relatively insensitive to the reality of districts. This could lead to a powerful centralising tendency within each province.

— Central government probably retains considerable power to set national health priorities and minimum standards and to pressure provinces to pursue them, as well as to monitor the overall performance of the health sector. A major power at its disposal is control of the bulk of financial resources and the ability to make conditional allocations to provinces. Central government will have uncertain but probably significant limits on its ability to exercise direct authority within the provinces over detailed management and planning decisions such as the hiring and dismissal of staff, and health budget allocations at sub-provincial levels.

— The constitution seems to accommodate a strong role for local government in primary health service provision, and this could allow for a district health system accountable to local government.

— Local government's entitlement to equitable allocations of funds could promote equity in health care for rural areas.

— The establishment of Provincial Service Commissions and the ability of central government to make direct allocations to local authorities may contribute to the decentralisation of functions within the provinces.

— The form and functions of a possible fourth tier of government or service provision, between local and provincial level, are unclear.

In general, although the potential for increased decentralisation of elements of financial control for health services is created by the interim legislation, there seems to be a danger of strong centralising tendencies at the provincial level which could compromise potentially beneficial aspects of decentralisation. This will be particularly important in view of the strong role the provinces will have to play in managing a process of phased decentralisation. It is during this process that, if overly centralised systems are not to become entrenched, particular attention will have to be paid to issues like the creation of management and administrative capacity in district health services, local government and other sectors, as well as communities' ability to participate in services and hold the providers accountable.

6.2 Institutional capacity to implement RDP programmes

In our view, there are no significant institutional constraints to implementing the suggested RDP programmes. The following is a short, somewhat patchy list of the kinds of institutions that exist in the health sector and the ways in which spending could be absorbed – though we are not suggesting that these programmes should be adopted.

Non-governmental organisations: The health sector, like welfare, has many NGO-based services and activities, including hospitals, clinics and mobile services; programmes oriented towards specific diseases like leprosy, TB, AIDS, heart disease and cancer; and organisations which focus on health education, health and development, community health workers, care groups, and the mentally ill and disabled. It is worth recalling that the health services originated with the missions. Most rural hospitals were owned and run by missions until the mid-1960s, and there is still a strong church-based and philanthropic voluntary health sector. Most of these organisations spend a lot of time raising funds – time which could perhaps be better spent delivering services if funding

were available from government. Government funding could probably be profitably used to leverage private funds through matching fund-raising efforts.

Nutritional projects: There are many organisations involved in nutrition projects which could assist in the nutrition programme of the RDP. However, these organisations and the previous government's R440 million nutrition programme should be subjected to a thorough critical review before a new programme is implemented.

Schools of public health: Various schools of public health and university departments of community health have been proposed, but they have been unable to raise the funds they need to get off the ground. Yet such schools are critical for providing reorientation and retraining courses to the thousands of health service staff who will need to develop management skills to implement a decentralised district health system and to develop and adopt new policies. The development of at least three schools of public health and the initiation of regular, ongoing management training programmes could absorb tens of millions of rands almost immediately.

Demonstration district services: The implementation of decentralised primary health care requires systems, personnel and skills which do not exist widely and will take years to develop nationally. However, there is an urgent need for models which can be developed in quasi-experimental ways beginning immediately. Consultants should help to plan and evaluate the programmes. The district services could be developed primarily through NGOs or through existing service providers and local authorities (who could be asked to tender for the pilot projects).

The upgrading of services to 24-hour services: This would require an additional two or three nurses per facility. Many facilities

would be able to expand services without further building or capital investment. In the longer term, other facilities would need on-site accommodation for night staff and space for a few patient beds.

The improvement of salaries and conditions of employment: The improvement of salaries and conditions of employment, especially in rural areas, could absorb large increases very quickly. These conditions include housing, schooling subsidies, location allowances (a suggested 15 per cent increase) and the creation of more posts to enable sabbatical leave (an approximate 10 per cent increase in selected posts). We must be very cautious about following these strategies, as they increase costs substantially without actually increasing coverage of services or improving equity.

7. Sources of finance for health and other fiscal issues

It is not, strictly speaking, the concern of the health sector how the additional R2 billion is generated. Taxation policy should be designed to maximise the collection of government revenue in a way that is efficient and does not distort the economy. Only the expenditure side of the budget should be used to achieve policy goals, which are set by political authorities. Health should be treated as merely one of the expenditure items, to be financed out of general revenue. Generally, policies should not link certain revenue to specific expenditure items, since this creates budgetary rigidities. However, there are four sets of health policies in the RDP health plan which have been motivated primarily for their health and health-service management consequences, and these have revenue implications which might be useful in providing funding for the sector too.

7.1 Tobacco tax

The first set of policies deals with increased taxes (either excise, or higher VAT rates) on tobacco products and possibly on alcohol. There is plenty of research to show that increasing the price of tobacco products is the most effective way of reducing consumption. The negative health effects of smoking are well established and the consequent costs to the health services are substantial. Thus the argument for increased tobacco taxes is primarily a public health argument to improve health. In addition, it reduces costs to the health services, but only in the longer term (after 20 years or more – since this is the average time between starting smoking and the manifestation of smoking-related diseases). The possibility of using this revenue for the health sector is therefore not the motivation for the tax, but can be defended on the principle that those who generate additional costs to the health services, particularly through consumption choices, should foot the bill for those services. Since the health service is today burdened with the ill health caused by past smoking habits, it is appropriate to use taxes collected from smokers to offset these costs. This does not necessarily require that the revenue be earmarked for health, but simply that the health budget be increased to match the increase in revenue from these taxes.

7.2 Removal of tax concessions for medical aids⁸

It has been argued that the tax concession on employers' contributions to medical-aid schemes constitutes a substantial loss of revenue to the public health sector and therefore a form of subsidy to the private health sector. (Note that employees' contributions are not tax-deductible unless they exceed 5 per cent of income.) The size of this lost tax revenue is probably around R1.8 billion. The ANC health plan says that this concession should be reviewed.

⁸ The analysis in this section is based on research in the Centre for Health Policy which will be completed and published in 1994.

First, it is important to realise the practical effect of removing the concession. As a real cost to a firm, and part of its labour bill, it cannot simply be ignored when calculating pre-tax profit and then deducted from after-tax profit. This would shift many firms from a net after-tax profit to a net after-tax loss, and the problem of reclaiming tax would be enormous. It is far more likely that the employer's contribution on behalf of the employee will come to be treated like any other fringe benefit, that is, it will become taxable in the hands of the employee as if the employee had earned it as part of his or her wage. This will have the effect of reducing the employee's after-tax income. Although this system could be phased in over a few years, and the employee would probably negotiate an arrangement in which the employer carries some of this tax, the effect would be tantamount to raising the average personal income-tax rate by 2 per cent. This would clearly be extremely unpopular, and would encounter strong resistance from the trade unions in particular. It would have substantial macroeconomic effects which have to be considered as part of the broader taxation policy.

Secondly, and perhaps more importantly from the perspective of health planners, there is no reason to think that the revenue thus generated would come to the health sector. For the same reasons that economists would be strongly opposed to earmarking particular sources of tax revenue for particular functions (the argument already mentioned with respect to tobacco taxes), revenue generated from the one-off removal of the medical-aid concessions would not be earmarked for health.

Thirdly, even if the Department of Finance allocated part of this recovered tax to health, it would be impossible to ensure that the money thus earmarked did not substitute for money from general revenue sources, leaving the total health allocation unchanged in the long run.

Thus the relative increase in the cost of private health care may benefit the public sector indirectly by reducing competition for professional staff, but not directly by generating money for the health sector. In fact, it is most likely that total spending on health (public and private) would decline if the tax concession were removed.

In view of these arguments, and particularly the political resistance from low-paid workers, the tax concession should be retained in some form, but restructured so that it is more equitable and can be used as an instrument to serve the goals of national health policy. The employer's contribution should still be made taxable in the hands of the employee, but a fixed rand amount should be allowed as a deduction by the employee. This would favour low-income workers who may find that nearly the whole of their medical-aid contribution is tax-deductible, while high earners, with much more expensive medical aids, would find that only a portion is tax-deductible. The deduction would apply equally to employees and self-employed people (which is not the case at present), and the deduction could be conditional upon membership of a medical-aid scheme which participates in the National Health Insurance System (see below).

7.3 Retention of revenue

The third cluster of policies relates to the need to change management incentives within the public sector by allowing facilities to retain a portion of the revenue they generate from paying (that is, insured) patients. At present, all revenue generated from fees is returned to the Central Revenue Fund. This creates incentives for hospital managers to turn away any patient who can afford to go elsewhere, since these patients generate costs which are not recovered from their fees. The hospital simply goes further over budget. Moreover, if paying patients do come, there is no incentive to collect their bills since this also costs the health service money which it does not recover. Hence the revenue to the Central

Revenue Fund is also reduced. Instead, facilities should be allowed to retain the revenue generated, and managers should be given the autonomy to adjust staffing levels according to need and to spend the revenue they generate in improving the facilities, the quality of care and perhaps even the conditions of employment of their staff. They would then have an incentive to attract paying patients.

It is mainly hospitals and in particular tertiary hospitals that would be able to attract insured patients. This revenue could cross-subsidise the non-paying patients, thus allowing the health authorities to divert some of the funding from hospital services, and especially tertiary services to primary care. This change would also reduce budget overspending, something which is routine in many big hospitals since they know that politically it is almost impossible to shut down hospitals when they run out of money. The revenue generated could first be written off against the overspent budget before the local facility and staff received any benefit. This would create a powerful incentive not to overspend and allow the health authorities more flexibility in allocating resources according to planned priorities.

7.4 National health insurance

The fourth set of policies relates to the development of a national health insurance system (NHIS). The proposal is explained in some detail in the ANC National Health Plan. Of relevance here is the principle that anyone able to afford his or her own health care should have to pay for it. Accordingly, membership of a medical aid that is part of the NHIS would become mandatory. Thus the public sector would reduce the number of people for whom it is responsible, perhaps by several million, and the per capita expenditure would increase proportionately even if public spending on those services remained fixed.

There are four important variations on the NHIS model. They are not mutually exclusive

but each is better suited to different circumstances and one may in fact form a stepping-stone to another. The four variations are illustrated in Table 4, which also gives examples of countries which fall into each type. The table is a simplification of the multiple permutations that are found in reality, but serves to illustrate the main distinguishing features which will influence the choice in South Africa.

TABLE 4: Variations on the NHIS model

	One government-based fund (or, in a federation, one in each state government)	Multiple funds makeup NHIS. May be industry-based, union-based, or geographical
Total population covered through NHIS. Government contributes on behalf of unemployed	Canada, Australia	Germany, Netherlands
Only contributors covered by NHIS. Government may contribute as well, but unemployed receive care from separate public health service	Thailand, Vietnam (proposed), proposed for some developing countries	Most of Latin America eg Mexico, Argentina, Brazil

7.4.1 General features of universal-cover models

All people in formal employment earning above a certain minimum are obliged to make monthly payments into a central health fund. These funds are combined with the allocation to health care from the public budget (generally raised from taxes) and used to buy health care for all, from a mixture of providers in both the public and the private sectors.

The chief virtue of the universal-cover NHIS is its ability to achieve equality of access for the care it covers. However, the universal-cover NHIS depends for its financial viability on the ratio of employed to dependent population (the latter including the unemployed and those in the informal sector). A narrow employment base not only limits the tax base out of which the government can contribute on behalf of the unemployed, but also increases the proportion of the contributors' premium that is needed to cross-

subsidise the non-contributors. It seems unlikely that South Africa would be able to afford this in the short term.

7.4.2 Partial cover: the likely model for South Africa

The most likely model for the introduction of an NHIS in South Africa is one in which only contributors are covered by the system and non-contributors continue to use the services provided by the state. Since the NHIS services are likely to be more attractive than state services, there will also be an incentive for self-employed and informal-sector workers to contribute to the NHIS. The system should probably be introduced in phases, starting with firms above a certain size, then extending to small firms, agricultural and domestic workers, and finally being made mandatory for everyone in the formal sector. The informal sector would also be encouraged to join.

7.4.3 Single versus multiple funds

There is certainly still serious debate on whether the NHIS should function through a central fund, controlled and administered by government, or whether multiple independent funds should be used. The single-fund model places enormous power in the hands of the central authorities thus allowing for substantial control of the private sector through control of the purse-strings, ensuring far greater cost-effectiveness in private care and making it a valuable participant in a coherent national health system.

All arguments for and against cannot be presented here. However, it is our view that South Africa needs multiple funds, which are independent but strictly regulated. There are several reasons. First, the infrastructure already exists in the form of the not-for-profit medical scheme system, with its well-developed administrative systems, technology, and management experience (all of which are lacking in the public sector).

Secondly, the present crisis within the medical scheme system has made it ripe for fundamental restructuring; this was investigated by the Melamet Commission of Enquiry, but in our view the conclusions the commission reached are seriously flawed. Thirdly, the competition between schemes will encourage efficient, high-quality care.

The dangers of competing insurance funds and the problems of market failure peculiar to the health sector are well known. For an NHIS to succeed while being administered through multiple independent funds, and in particular to avoid risk skimming and the consequent loss of cross-subsidisation, the following kinds of regulation would have to be implemented:

- All schemes should be obliged to cover at least a minimum range of basic services. The range of care that could be purchased needs to be defined precisely. Certainly, it would include all care at the level of the general practitioner and also preventive care, and so could draw the approximately 8 000 general practitioners into the national health system while they remained in private or independent practice.
- Schemes should be prohibited from excluding any member.
- There should be no individual risk rating. Contribution rates as a proportion of income could be fixed centrally.
- The compulsory, income-dependent premiums (designed to cover the basic range of care) should be pooled in a central fund. Every medical scheme would then be assessed to determine its overall risk profile and the money would be redistributed between schemes through a risk-adjusted capitation fee.
- Both health insurance companies and medical schemes would be free to offer 'top-up' cover or any other cover at all, provided that a member could prove that he or she already had the basic statutory cover.

8. Conclusion

What chance does the RDP health plan have of being funded at the levels described above, given competing demands from other sectors, many of which also improve health outcome? In our view the priority programmes concern such basic needs, needs which many would almost consider rights fundamental to a society that respects human dignity, that they are uncontroversial. Moreover, from a politician's perspective, they are highly visible, generally achievable within a five-year period and have long-term benefits. They will probably never have a better chance of being funded, though the increases required are in the region of 10 to 20 per cent of current government spending on health. It is unlikely that such increases will be available, though the health sector should stake a claim to as much as possible and perhaps increases could be linked to increases in tobacco taxes.

It is more likely that the major reallocation of resources from tertiary and secondary hospital care to primary care will be made by encouraging hospitals to recover a greater proportion of their costs from paying patients at a rate that allows the cross-subsidisation of non-paying patients. This requires changes to the regulations of the Commission for Administration, and particularly those governing the ability of facilities to retain the revenue they generate. These changes could be implemented immediately and would produce results in a very short time – probably within a year. No other intervention will have as rapid and dramatic an impact on the health sector, nor is so feasible, having no direct costs.

Cost recovery would probably also be improved (or else patient load reduced) if more lower-income patients were insured. This could happen if medical scheme cover were extended under an NHIS.

The development of managerial capacity in the public health sector is the major constraint

to identifying inefficiency and to managing change and the reallocation of resources. Donor funds could be appropriately used for this 'capital' investment in the short term to bring about a massive increase in health management training in the country.

There is a danger that the marketing appeal of the programmatic approach of the RDP will translate into programmatic interventions with separate programme targets, indicators, budgets and bureaucracies. This will be a serious set-back to the recent moves away from selective and vertical primary health care. Rather, the health plan should be developed over the next year with much more innovative thinking about how to do things differently and how to make the system more efficient. Comparative economic analyses of regions, districts, hospitals, facilities and programmes should be used to identify outliers where productivity can be improved. Experiments with various models of health service delivery should be encouraged, funded, and intensively evaluated rather than imposing uniform models immediately. And an information system should be set up immediately to analyse the availability of health services at the local level and so identify the most urgent need.

9. Appendices

Appendix 1: The costing of aspects of the Reconstruction and Development Programme for health⁹

Not all of the programmes identified in the RDP health plan can be costed directly or will have financial implications. This analysis has picked out those aspects that can be costed directly in one way or another. It should be noted that in many cases services do exist. While it may be possible to identify the total

⁹ These costs are based on work currently being done in the Centre for Health Policy funded by the Department of Economic Planning of the ANC.

allocation, it is not always possible to identify the net impact of a policy proposal because of a lack of data. Where an estimate is possible it has been provided.

1. The treatment of all children under the age of six

The proposal in the RDP health plan is to 'provide free health care to children under six years of age'. This refers only to children who are not covered by a medical aid. At present the government revenue collected from the utilisation of these services is minimal. Consequently, we do not have to concern ourselves with the revenue lost by rendering the service free, but rather with the recurrent cost of extending services to those who qualify for free health care but do not receive it at present.

In order to ascertain the extent of the existing backlog it was necessary to determine both the existing coverage and the desired coverage for children under the age of six. To make these estimates we had first to identify the number of children under the age of six who would most likely be dependent on public health facilities. This was estimated by adjusting the total population under the age of six by the percentage of people covered by registered medical aids. The resulting total population under the age of six who would be most likely to use public medical facilities comes to around six million.

The number of consultations that each child is likely to have annually in the first six years of life has been estimated as follows:

— Seven consultations for immunisation: against tuberculosis, BCG (one visit); diphtheria, typhoid and paratyphoid (three visits); measles (two visits); DT (one visit). It is assumed that these seven visits will suffice as a minimum for growth monitoring as well, although current practice is to bring infants back almost monthly for this. Although these immunisations all occur within the first two years, we can average them over six years (ie 1.17 per year) and apply the figure to the

population under six who use public medical facilities.

— Acute minor ailment consultations are assumed to take place at a rate of three per year.

The costs associated with these figures are as follows. The cost per immunisation in 1993 prices is estimated at R11.98 based upon information obtained from the evaluation of the clinic services in KaNgwane, while the cost of a curative care visit was assessed at R19.83 (Price, 1992). This information was also compared with information from the Diepkloof Community Health Centre costing study by Broomberg and Rees (1993) and found reasonably consistent. If the cost information is combined with the population in need and the required quantity of consultations it is possible to suggest what the total cost of full coverage might be. This information is presented in Table 5 on a regional basis.

The estimates of existing coverage were determined using data on the percentage of the population, excluding the TBVC states, already immunised (Department of National Health and Population Development, 1993) and then assuming that approximately the same percentage applied to the coverage for normal diagnostic consultations. It should be noted that there is a significant difference between the immunisation rates in rural as opposed to urban areas. The rural/urban division is indicated in Table 6.

These figures excluded the coverage of the DT vaccination in the second year of life. A figure of 30 per cent was assumed, because coverage is normally very poor with this final vaccination. Using these figures, existing coverage was estimated at 63.78 per cent of total desired coverage, as indicated in Table 6 below. The additional expenditures required to achieve 80, 90 and 100 per cent coverage are R88 million, R146 million and R204 million respectively (Table 7).

TABLE 5: Estimated total costs of providing health care to all children under the age of six who are dependent on the public sector (1993 values and prices)

	Children under the age of six	Potential immunisation consultations	Potential diagnostic consultations	Total cost of full cover (Rands)
Western Cape	301 388	351 619	904 164	29 115 107
Northern Cape	76 819	89 622	230 457	7 420 971
Orange Free State	352 589	411 354	1 057 768	34 061 319
Eastern Cape	1 322 955	1 543 448	3 968 866	127 801 967
KwaZulu/ Natal	1 301 940	1 518 930	3 905 821	125 771 860
Eastern Transvaal	441 480	515 060	1 324 440	42 648 465
Northern Transvaal	1 059 858	1 236 501	3 179 573	102 385 852
PWV Area	570 064	665 074	1 710 191	55 070 082
North West	611 310	713 195	1 833 929	59 054 594
Total	6 038 403	7 044 803	18 115 209	563 330 217

TABLE 6: Urban/rural vaccination coverage (children aged 12-13 months) Republic of South Africa 1990 (Percentage)

	BCG	DPT3	Polio3	Measles
Urban	91	77	79	71
Rural	82	60	69	57
Overall	85	67	69	63

Source: Department of National Health and Population Development.
*Health Trends in South Africa, 1992, 34.*¹⁰

TABLE 7: Additional expenditure required to achieve targeted levels of child care coverage (1993 prices)

	80%	90%	100%
Western Cape	4 408 859	7 320 370	10 231 880
Northern Cape	1 123 747	1 865 844	2 607 941
Orange Free State	5 157 857	8 563 989	11 970 121
Eastern Cape	19 352 869	32 133 066	44 913 263
KwaZulu/ Natal	19 045 453	31 622 639	44 199 825
Eastern Transvaal	6 458 196	10 723 043	14 987 889
Northern Transvaal	15 504 143	25 742 728	35 981 314
PWV Area	8 339 184	13 846 192	19 353 200
North West	8 942 553	14 848 012	20 753 472
Total	88 332 861	146 665 883	204 998 905
Total level of expenditure	466 664 174	524 997 195	583 330 217

¹⁰ *Health Trends in South Africa, 1993* was published by the Department of National Health and Population Development while this report was being prepared. The immunisation coverage figures in that report for 1991 are much higher – 78 to 85 per cent nationally, and in some cases exceeding 100 per cent (in Natal and Western Cape). We have chosen to use the figures reported for 1990 because they seem more consistent with other published studies; the latest figures also appear to be calculated from health service statistics on the number of vaccines given, rather than on data from household surveys, and are therefore less reliable.

2. Maternal health care

The proposal in the ANC National Health Plan is to 'improve antenatal care, delivery, and postnatal care, which will be free of charge in the public sector'. The targets are:

- 50 per cent of deliveries supervised and carried out under hygienic conditions by the end of 1995;
- 80 per cent coverage by the end of 1999;
- over 60 per cent of pregnant women attending clinics at least once by the end of 1995;
- free services by the end of 1997.

This plan is very difficult to cost, as it is not clear how much of the population is already accommodated within the existing budget. Consequently, an estimate of existing coverage has been produced in order to assess the additional funds required to achieve the various targets. A rudimentary figure has been worked out based on total births expected and using 1993 population data on those people who would be dependent on the public sector.¹¹ This figure is estimated at around 1 006 400.

Basic maternal care is assumed to consist of four antenatal visits, one postnatal visit, and the delivery. Figures obtained from studies providing data on the costs of these services in 1989 were used, and adjusted to 1993 values using the consumer price index. The costs are as follows:

Cost per antenatal/postnatal visit	R23.47
(Broomberg & Rees, 1993)	
Cost per delivery	R314.19
(Valli <i>et al</i> , 1991)	

The number of urban consultations is assumed to be at or close to the target levels: actual

¹¹ This is obtained by reducing the total number of births expected by the estimated number of people covered by medical schemes. Although 1991 data was used it should not make a material difference to the totals obtained. However, the figures are rough and should be treated only as indicators rather than as hard information.

consultations as a percentage of the required number is around 80 per cent. Rural areas have therefore been separated out and examined first, as this is where most of the inadequate coverage occurs with respect to the 80 per cent target. Based on surveys in KaNgwane, which was taken as representative of rural areas in the rest of the country, 56 per cent of required antenatal and postnatal visits are made, and 69 per cent of deliveries take place in a medical facility (Schneider *et al*, 1991). The population under five years of age and its distribution across provinces and between urban and rural areas is used as the basis for calculating total expected births in one year (Development Bank of Southern Africa, 1994).

Since the targets set are low relative to the actual present national averages, the additional costs of meeting higher targets (applied to both urban and rural populations) are also presented (Table 9).

3. Nutrition programme

In 1989 it was estimated that around 2.3 million people were in need of nutritional assistance in South Africa, including the TBVC countries (Committee for the Development of a Food and Nutrition Strategy for Southern Africa, 1990). If the population growth rate for blacks in South Africa is used to update this figure to 3.1 per cent,¹² then the crude estimate of the amount of people in need of nutritional assistance in South Africa would have been around 2.6 million in 1993. Given a cost of around R2 per person daily, the estimates in Table 10 are produced for the various high-risk categories.

¹² This growth is used as a proxy for the expected growth rate of the poorest sections of the population. In rural areas one would expect this growth rate to be higher. Consequently, this figure may underestimate the actual growth rate of the population most in need of assistance.

The total cost of the programme would be around R1.9 billion, of which R1.7 billion was directed at children. These amounts are very large, and so the programme would need

to be extensive and efficient. If it was necessary to prioritise certain groups, it would make sense to target children under 6. This would cost R683 million.

TABLE 8: Estimates of expected additional current expenditure needed to achieve a rural target of 80% of required antenatal and postnatal visits and 80% of deliveries performed within a medical facility

	Rural births	Present coverage antenatal/postnatal (visits)	Present coverage deliveries	Gap to 80% coverage antenatal/postnatal (visits)	Gap to 80% coverage deliveries	Cost of closing gap to 80% coverage (Rands)
Western Cape	6 799	18 913	4 691	8 283	748	429 857
Northern Cape	3 447	9 588	2 378	4 199	379	217 906
Orange Free State	26 813	74 585	18 501	32 665	2 949	1 695 155
Eastern Cape	143 766	399 917	99 199	175 147	15 814	9 089 204
KwaZulu/ Natal	135 449	376 781	93 460	165 015	14 899	8 563 390
Eastern Transvaal	50 128	139 441	34 588	61 070	5 514	3 169 186
Northern Transvaal	160 868	447 490	110 999	195 983	17 695	10 170 434
PWV Area	3 842	10 688	2 651	4 681	423	242 920
North West	73 199	203 620	50 507	89 177	8 052	4 627 813
Total	604 311	1 681 023	416 974	736 220	66 473	38 205 863

TABLE 9: Estimates of the expected additional current expenditure required to fund the gap in the existing provision of maternal care (urban and rural)

	Maternal care at 80% of desired coverage	Maternal care at 90% of desired coverage	Maternal care at 100% of desired coverage
Western Cape	429 857	2 600 785	4 771 714
Northern Cape	217 906	771 240	1 324 575
Orange Free State	1 695 155	4 234 891	6 774 628
Eastern Cape	9 089 204	18 618 585	28 147 966
KwaZulu/Natal	8 563 390	17 941 399	27 319 408
Eastern Transvaal	3 169 186	6 349 211	9 529 236
Northern Transvaal	10 170 434	17 804 697	25 438 959
PWV Area	242 920	4 349 146	8 455 372
North West	4 627 813	9 031 139	13 434 465
Total	38 205 865	81 701 093	125 196 323

TABLE 10: The cost of a comprehensive nutrition programme targeting all those people in need

People in need	Number of people	Cost of programme	Percentage of total
Children aged 0 – 5	935 546	682 948 347	36
Children aged 6 – 12	1 455 293	1 062 364 095	56
Lactating women	207 899	151 766 299	8
Total	2 598 738	1 897 078 741	100

4. Medium-term requirements for clinics

At present the need for clinics has not been adequately defined due to inadequate data. A comprehensive national study, coordinated by the Medunsa Community Health Department, should be completed during 1994. This study will give the location of every health facility in the country, together with estimates of their staffing, expenditure, and the population served by each. The Department of National Health and Population Development has previously identified a medium-term need for 150 clinics. It is not clear what kind of clinic is being referred to, however, and so we have calculated high and low estimates.

4.1 High-cost clinics

According to information received from the provincial administrations a fairly large clinic would cost in the region of R3 million and there would be recurrent costs of around R1 million. This means that 150 clinics would cost around R450 million and result in recurrent costs of R150 million.

4.2 Low-cost clinics

These clinics are equivalent to those built using money raised from the sale of strategic oil stocks or to those built by the Independent Development Trust (IDT). At present the IDT is constructing 310 clinics at a total cost of R80 million (this figure was supplied to us by the Trust). This works out at a capital cost of R258 000 per clinic. The recurrent costs are estimated at R228 000 per annum. If these amounts are applied to the 150 clinics, the total capital cost would be around R39 million and annual recurrent costs around R34 million. Most of the more urgently needed clinics are probably of the low-cost type.

To obtain a single figure we have assumed that 50 large and 100 small clinics will be built. The capital and recurrent costs would be R176 million and R73 million respectively.

5. Emergency care

In the former provincial administrations, emergency services accounted for around 4.29 per cent of the total provincial budget (this figure is based on the 1994/95 budget). If it is assumed that the other regions, including the former TBVC states, have virtually no emergency facilities,¹³ then the provincial emergency facilities accounted for 2.74 per cent of the total health budget. To raise the national average to the equivalent of the provincial average of 4.29 per cent and provide an adequate distribution of emergency services, an increase in expenditure equivalent to 1.55 per cent of the budget would be required. This would amount to an annual recurrent expenditure increase of around R206 million.

6. Immunisation against hepatitis B

The cost of this programme has been provisionally put at R25 million per annum according to Dr Tim Wilson of the ANC health department.

7. Improving health services in rural areas

A very crude estimate of the additional costs of increasing the salaries of professional staff in rural areas, assuming a 15 per cent increase on the salary bill of the former homelands, is R256 million in 1993 prices. This figure is based on a simple calculation whereby it is assumed that the expenditure on the former homelands (including the TBVC states) represented South Africa's approximate expenditure on rural areas, that is, R2 846 million. (These figures are based on budgeted rather than actual expenditure. They were supplied by the Department of National Health and Population Development and the Development Bank of Southern Africa.) Of this total expenditure around 60 per cent, that

¹³ It is not possible to distinguish this item on their budgets, but on the basis of anecdotal information provided by central government and the former provincial administrations the assumption is probably valid.

is R1 707 million, can be regarded as personnel expenditure.

8. Improving and strengthening existing health services

This would largely involve a general increase in maintenance expenditure and improvements in the conditions of service. This process need not be costed as such, as it is equivalent to a straight real percentage increase in health expenditure. Rather than treating it as an RDP programme, it would possibly be of more value to indicate the broad financial implications of potential increases along these lines. The budgeted expenditure for the 1994/95 year was used to illustrate these increases. Increases in the

conditions of service and potential increases in expenditure not related to personnel were examined and are shown in Table 11. The analysis in this section was based upon information obtained from the Central Economic Advisory Service, which coordinates the multi-year budgeting process in South Africa. The weighting of personnel as a percentage of total budgeted health expenditure was 59 per cent. These figures refer essentially to increased allocations to existing services and do not include the costs of extending facilities and personnel. For the purpose of this analysis we have not tried to determine which is the appropriate target.

TABLE 11: The costs of real increases in expenditure in the public health sector (1994 prices)

	5%	10%	15%
Salaries and wages			
% change in health budget	2.93	5.86	8.78
Actual increase (R millions)	347.37	694.73	1 042.10
% change in overall budget	0.28	0.55	0.83
Non-personnel expenditure			
% change in health budget	2.07	4.14	6.22
Actual increase (R millions)	245.88	491.77	737.65
% change in overall budget	0.20	0.39	0.59
Combined increase (R millions)	593.25	1 186.50	1 779.75

Appendix 2: The future system of government in South Africa and its implications for the decentralisation of financial control in the health service¹⁴

The Interim Constitution and the Local Government Transition Act institutionalise three tiers of government and administration (national, provincial and local). Different categories of rural local governments, with 'differentiated powers, functions and structures according to considerations of demography, economy, physical and

environmental conditions and other factors which may necessitate such categories' (Section 174(2)), may be constituted by law. This suggests that local authorities in different rural areas may have different features and incorporate elements of both centralisation and decentralisation in local government/provincial relations.

The Interim Constitution as amended classifies health services as a Schedule 6 item, over which provinces will 'be competent to make laws'. Both the national parliament and provincial legislatures will have authority to legislate on health service matters but *provincial law will prevail over national law except where it can be unequivocally argued*

¹⁴ This Appendix was prepared by Anthony Kinghorn, Centre for Health Policy.

that: a matter *cannot* be effectively regulated by provincial legislation; effective functioning *requires* that uniform norms or standards are applied throughout the country; it is *necessary* that minimum standards for services be set for the nation; a particular national law is *required* to serve national economic, environmental, commercial or security interests; a particular provincial law compromises the economic, health or security interests of another province or the nation (Section 126(3) of the Interim Constitution [our emphasis]). Provincial legislatures will therefore have considerable power over health issues, and the onus will be on national government to prove that it is necessary to legislate on a given health issue if the legislation conflicts with provincial law.

In addition to *legislative* power over Schedule 6 items, the provinces will have *executive* power over them (Section 144), implying that they will have bureaucratic and administrative structures with considerable influence over areas such as health.

In terms of Sections 174 and 175 of the Interim Constitution, local governments will be established and have their powers, functions and structures determined by law of a competent legislature (ie national and provincial legislatures, under the conditions outlined above). In terms of Section 175(3), a 'local government shall, to the extent determined in any applicable law, make provision for access by all persons residing within its area of jurisdiction to water, sanitation, transportation facilities, electricity, *primary health services* [our emphasis], education, housing and security within a safe and healthy environment, provided that such services and amenities can be rendered in a sustainable manner and are financially and physically feasible'. 'Primary health services' are not clearly defined, but there seems to be a legislative possibility of decentralising control of comprehensive health services to the local authority (although the extent of provision under its control will be determined by 'any

applicable law'), and there seems to be significant potential for intersectoral collaboration at this level.

Section 175(6) allows local government to assign specific functions to local bodies or sub-municipal entities within its jurisdiction if this will enhance or facilitate the provision or administration of services. This seems to create the possibility of further decentralisation to, for example, a district level (although not specifically named) where more than one district falls within a local government area. Local government would also appear to have the power to 'make provision for access' to primary health services through contracting or making arrangements with private or public providers from outside a local government area (eg a large health district), if it judges that they can render them most effectively, although this could be regulated by 'any applicable law' (Section 175(3)).

In some circles it has been suggested that a fourth tier of bureaucracy or government, between the local and provincial level, could be desirable in certain rural areas to facilitate coordination, improve responsiveness to local circumstances relative to provincial government and compensate for lack of capacity within local government and services. While Section 174(2) seems to allow flexibility in the form and powers of rural local government, and Section 175(3) seems to allow arrangements between local and higher levels of government, it is not clear what the exact status and powers of such a tier would be. From a functional point of view, its desirability would be determined by the extent to which it was able to perform the types of functions suggested above or, alternatively, entrench itself as an obstructive and centralising bureaucracy, preventing desirable decentralisation of certain functions and lacking accountability or responsiveness to local conditions.

The *financial power* of central, and probably provincial, government is likely to be a key determinant of power relations and control. Provinces serving large rural populations are likely to be dependent on national government for the bulk of their funding in areas like health for which limited revenue-raising capacity exists. The Interim Constitution gives national government the power to make 'conditional or unconditional allocations of national revenue' to the provinces (Section 155(2)(c)). This suggests that not only can allocations be validly earmarked for sectoral use (eg health) but that they can probably be earmarked for particular uses within that sector, for example PHC services, nationally prioritised programmes, or hospitals. However, it does create the capacity for block grants from centre to province, which could increase provincial autonomy in making decisions about spending and in setting priorities.

Section 158 (amended) states that financial allocations can be made by the national government to provincial or local government, but that allocations to local government will ordinarily be made through the provincial government. This seems to reinforce, but not make absolute, the financial power of provinces relative to local government.

Section 178 provides for revenue-raising capacity at the local government level to allow local governments to perform their functions, and entitles them to 'equitable allocation by the provincial government funds'. Recommendations regarding criteria for such allocations will be made by the Financial and Fiscal Commission. However, the Commission is purely advisory. The Commission's recommendations and the degree to which provinces act on them will have implications for both the degree of decentralisation and equity.

Another important feature of the Interim Constitution is that it gives provinces the power to create Provincial Service Commissions to oversee staffing issues and allocations within the provinces, subject to national norms and standards (Section 213). This seems to create the potential for increased provincial control over a major expenditure item through more decentralisation and more flexible staffing policy and management than was previously possible under the Commission for Administration. The actual powers which are assigned to these commissions in future and patterns of behaviour within them are likely to influence how Section 213 affects the decentralisation of management of provincial staff.

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