

Setting priorities for health spending in South Africa

After a decade of the South African public health sector being mismanaged by former minister Manto Tshabalala Msimang, our new government has committed itself to revitalising our health system. But it will have to do so within the constraints of reduced funds available from the fiscus, on account of the recession. Using appropriate interventions—those that are evidence-based—how can South Africa get better value for its spending and so improve the health of its population?

The past four years have seen an average real (i.e. inflation-adjusted) growth in state spending on health of 9% per annum. Sadly, this boon has not yet translated into better health indicators: to cite but two examples, life expectancy at birth for South Africans has declined from 63 years in 1990 to 47 today; and infant mortality almost doubled between 1997 and 2005. Government health spending amounts to 10.9% of budget, and total spending (including that in the private sector) is 8.9% of GDP. Many poorer countries spend less but have far better health outcomes. How can this be changed?

A group of civil servants, medical researchers, academics and private sector representatives met in the Magaliesberg to consider this question in August. Their aim was to set the agenda for a study on priorities for health spending in the country, which the Gates Foundation has agreed to fund to the tune of \$1.2 million. The goal of the project is to generate data that could provide the evidence for wiser policies specific to the South African context. The project—called PRICELESS SA (**P**riority **C**ost-**E**ffective **L**essons for **S**ystems **S**trengthening)—will be part of a broader network of institutions in other developing countries, and is being hosted by the SA Medical Research Council/University of the Witwatersrand (Wits) Rural Public Health and Health Transitions Unit. It is being led by Stephen Tollman together with Karen Hofman, who has been seconded from the Fogarty International Center at the US National Institutes of Health.

Lessons can be learned from other countries, but in determining priorities for health spending, South Africans need to keep local constraints in mind. If we want our population to become healthier, the first issue to understand is why it is

so unhealthy, despite our current levels of spending. There are of course several answers.

First, there is the dominant issue of HIV, which affects South Africa more severely than other countries on account of our exceptionally high prevalence. The last four years may have seen increased public health spending, but over the same period government placed 780 000 people on antiretroviral drugs—following its earlier denial of their efficacy. This intervention alone may have absorbed a good portion of the increase, not to mention the effects of associated diseases on morbidity: the incidence of tuberculosis, for example, increased threefold between 1990 and 2006.

The second big issue is that of human resources, as it is here that inefficiencies related to the public–private split are most marked: only a third of the country's doctors and half of its nurses work in the public sector, on which 86% of South Africans rely for treatment. (The remaining seven million are members of medical aid schemes). Currently, 35% of posts in the public health sector are vacant.

How could this pattern be reversed? One way would be for the state to curb the cost of medical procedures performed by private practitioners—something medical schemes themselves cap reimbursement for in any event. This should remove some of the pecuniary incentives for doctors to work in this sector. Another would be to increase the number of graduates in the system: current production of doctors by South Africa's eight medical schools is just over 1 300—an increase of 45% since the advent of democracy in 1994. In terms of nurses, the situation is worse, as the closure of many nursing colleges has led to a decline in graduates.

Human resources represent the major cost in the public sector, so are we training the right mix of professionals? Efforts to train mid-level workers are only just starting—maybe these should be expanded? There is also a need to build managerial and administrative capacity in the health sphere. Yet another sensible step would be to reverse the decision to disallow private practitioners in rural areas to work part-time for the state as district health officers, for a set number of hours per week.

But social determinants of health may also be contributing to the declining health of the nation. David Sanders of the University of the Western Cape pointed out that successive national food consumption surveys conducted in the first decade of democracy provided no evidence of improved nutritional status in children. An international study on the consumption of fast food provides some sobering data: South African consumption of burgers and chicken at branded fast-food outlets rose from 100 million purchases to 180 million in the four years between 1994 and 1998. The eating habits of our new elite were clearly displayed at the recent inauguration of President Zuma: when television cameras focused on his predecessor Kgalema Motlanthe walking down a line of police and military generals, only one of the twelve assembled did not appear overweight. Tollman reported that even adolescent girls at his unit's rural study site of Agincourt in Mpumalanga province, show indications of being increasingly overweight.

One area in which South Africans are happily becoming healthier relates to tobacco: the number of smokers has declined by a third since legislation outlawing consumption in restaurants and public places was introduced at the behest of former health minister Nkosazana Dhlamini Zuma, combined with an increase in tobacco taxes by at least one third. But smoking is still alarmingly high in affluent young women, and pregnant women in this category in particular need to be targeted in terms of behaviour change.

In terms of expenditure, differences between the private and public sectors are less marked than in terms of personnel, but still significant: annual spending in the 2008/9 financial year was R93 billion in the public sector, as opposed to R120 billion in the private sector. This basic lack of equity is the motivation behind the government's controversial proposed national health insurance (NHI) scheme. While there was consensus that our lacking a single national health strategy is hugely problematic, the implementation of a NHI scheme will have to be a long-term project on account of administrative capacity constraints.

Another complicating factor is that many preventative medicine initiatives are conducted at the local government level, with very variable levels of investment and efficacy depending on perceived priorities. This is often the case in developing countries: Jane Doherty from Wits provided an interesting example in

Mexico City, which financed increases in this sphere by cutting benefits to municipal officials!

The workshop succeeded in raising many interesting questions which the study will need to try and answer. Quite apart from the difficult issue of determining the right balance of priorities, Thulani Masilela of the National Department of Health pointed out the critical impor-

tance of putting monitoring systems into place down the line to track the effectiveness of interventions that government might adopt. Jerry Coovadia from Wits put his finger on perhaps the most crucial question facing the project when he asked how setting different priorities could change the system in practice?

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