FACT SHEET: FUNDING THE RIGHT TO HEALTH

2019 election brief - #Vote4Health

Section 27 of the Constitution of South Africa states that access to healthcare is a basic human right which must be enjoyed by everyone.

The Current State of Healthcare

South Africa has two healthcare systems. One is private, serving a minority of the population who can afford to pay increasingly exorbitant monthly as well as out of pocket fees. The other is public, funded mainly by tax revenues and serving the vast majority of citizens. Although only 17 in 100 people have private medical insurance (StatsSA 2017), private sector healthcare* spend is 4.2% of Gross Domestic Product(GDP), versus 4.4% for the public sector (DPME 2017). This unequal resourcing leads to unequal health outcomes that mirror the fault lines of race and geography inherited from apartheid.

Despite these inequities, public health spending has increased significantly since 1994 and the government has made progress in improving access to healthcare. Overall outcomes in areas such as infant and maternal mortality have improved and after a disastrous period of delay and denialism by government, the HIV/AIDS programme has expanded exponentially. The percentage of deaths in South Africa due to AIDS fell by 12.6% between 2001 and 2016. (SPII, 2018).

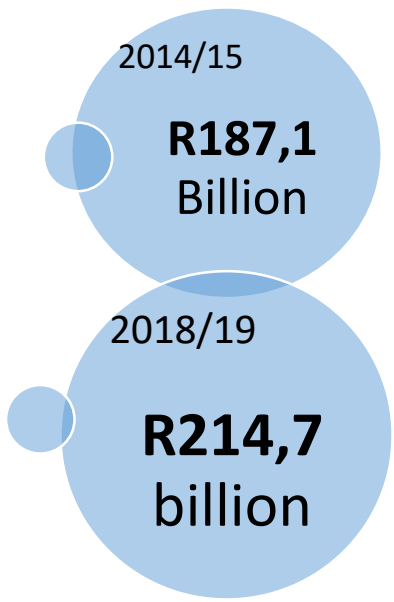
However, the public healthcare system remains severely overstretched and underfunded. Recent years have seen the implementation of austerity budget policies (social spending cuts to finance debt). This has led to vacant posts and declining standards in many parts of the public health system. In May 2018, the Treatment Action Campaign (TAC) reported that 38 217 posts were not filled. Despite being central to the implementation of primary health care, an estimated 60 000 community healthcare workers remain informally employed and reliant on a paltry stipend with poor equipment and training (SAMRC 2018).

Implementation of Universal Health Coverage through a single payer system where every citizen has access to comprehensive, quality services regardless of their ability to pay is long overdue. Yet the NHI Bill tabled by the Department of Health in 2018 was rushed, not subjected to proper consultation processes, and needs work in a number of areas, including on governance and financing.

This Fact Sheet examines key funding trends in health in South Africa over the past five years and sets out what SECTION27 and the IEJ would like to see from the next government in this crucial sector.

Expenditure on health in real terms

In 2019/20 Rands



Source: National Treasury, 2019; Own Calculations

Annual average real healthcare spend per person

	Public Healthcare	Private Healthcare
2014/15	R4 225	R16 224
2018/19	R4 480	R17 225

Source: National Treasury, 2019; CMS 2019; Own Calculations

*Includes medical schemes, out of pocket payments, medical insurance and employer private.

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Overall spending trends

Spending on public health has been constrained during the 5th democratic administration, despite the NHI White Paper recognising that expenditure will have to double if quality healthcare is to be provided to all. Consolidated spending still falls below the government's 2001 commitment in the Abuja Declaration of 15 percent (WHO 2011). Shortfalls in funding have delayed the implementation of the NHI as well as the completion of the Health Market Inquiry.

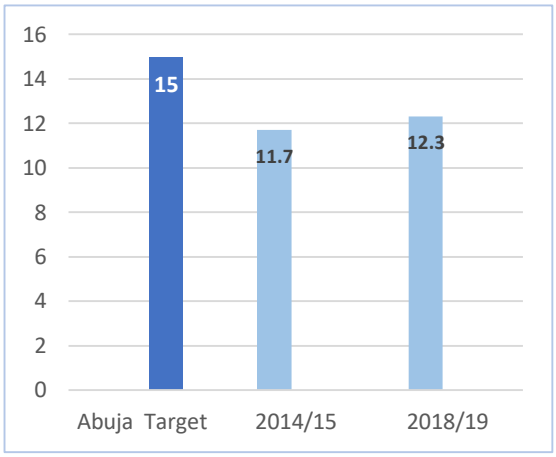
Austerity measures have also contributed to a rapid growth of unfunded commitments and accruals (costs incurred, but in the absence of sufficient funding, rolled over to the following financial year). To meet those financial obligations which are hardest to avoid, such as wages, operational health budgets are cut or invoices simply unpaid. In 2017/18 health departments accounted for 57% of unpaid bills by government. Budget constraints are exacerbated by fruitless, wasteful and irregular expenditure (National Treasury, 2019). In 2017/18, departments of health had some of the poorest audit results (AGSA, 2018).

Spending per capita

Figure 3 shows that, over the last five years, growth of health expenditure per uninsured person has slowed and in 2016/17, was actually reduced. When average inflation of around 5% (National Treasury, 2019) and population growth of 1.6% (Stats SA, 2019) are accounted for, per capita healthcare spending has essentially stalled. However, this overall picture masks cuts in many areas of the health budget. This is occurring despite a rising burden of disease and higher than average medical price inflation. The inconsistency in expenditure has ramifications for the state's capacity to maintain, as well as to improve, care.

There is also variance between provinces in how resources are equitably allocated and the standard of health care delivered (Stats SA 2016). Health outcomes diverge along the rural versus urban geographies. For example, life expectancy in largely urban Gauteng province is 64 years whereas, it is 59 in mostly rural Limpopo (Stats SA 2018).

Figure 1: Health expenditure as a percentage of total government expenditure



Source: National Treasury, 2019

Figure 2: Real growth rate of the Health Facilities Revitalisation Grant

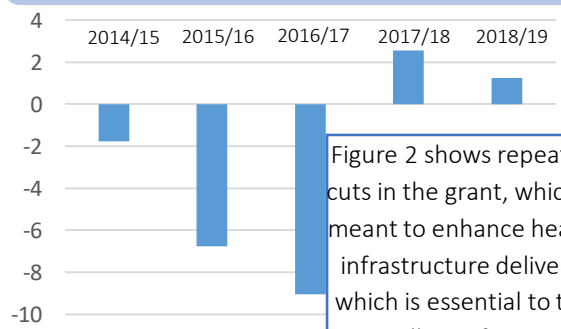
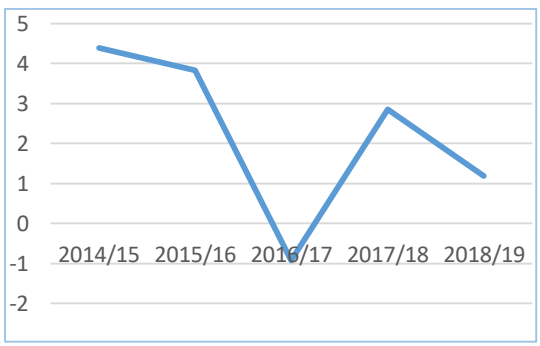


Figure 2 shows repeated cuts in the grant, which is meant to enhance health infrastructure delivery, which is essential to the rollout of NHI.

Source: National Treasury, 2019

Figure 3: Real growth rate of expenditure per uninsured person 2014/15 – 2018/19



Source: National Treasury 2019, Own calculations

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Health Human Resources

Reducing the public sector wage bill is a central tenet of austerity. Since 2016, the South African Medical Association and other organisations have raised concerns over the freezing of health worker posts, which have caused widespread staff shortages in the public health system. After the new public-service wage agreement negotiated in 2018, provincial governments were required by the National Treasury to absorb the increases within their current compensation ceilings. Provincial departments of health already spend approximately 65% of their expenditure on wages and therefore had an impossible choice: cut non-personnel budgets or reduce headcount.

National Treasury plans further cuts to the public sector wage bill over the 2019 Medium Term Expenditure Framework (MTEF) by offering early retirement packages. This will only make it harder for health departments to retain specialists and other experiences staff.

Life Esidimeni

The 2016 Life Esidimeni tragedy resulted in 143 mentally ill patients losing their lives after being transferred out of a private facility the government had contracted with for decades to a group of under-resourced NGOs. The arbitration process that followed found the need to cut costs was a red-herring excuse used by departmental officials attempting to avoid accountability for their poor decision-making. However, there can be no doubt that such disasters are more likely to occur in an under-resourced health system where budgets are constantly strained than in one where departments have sufficient resources to fulfil their mandates.

The government has been ordered to pay R1.2m to the families of each victim. This is one example of the exponentially rising burden of **medico-legal claims** faced by departments of health. Claims have increased from R28.6 billion in 2015 to R80.4 billion in 2018. Chronic underfunding and staffing shortages contribute to the service failures which lead to medico-legal claims.

Figure 4: Unequal human resourcing for health

1 government-employed **doctor** for every **2,457 people** not covered by medical aid

Source: Africa Check, 2018

1 doctor for **429 to 571** patients in private healthcare

Source: Africa Check, 2018

In 2016, only **35%** of registered nurses and midwives were working in the public sector

Source: **AIHD 2017**

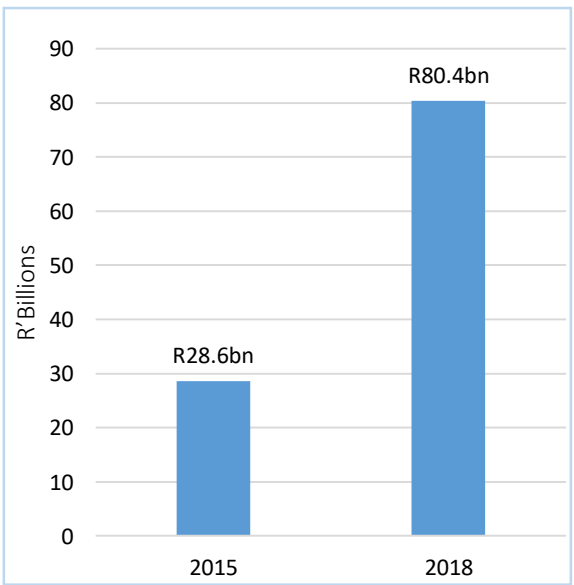
48% of registered nurses are **over 50** years old. Only **5%** are **under 30.**

Source: SANC, 2018

10 000 vacant posts in Limpopo in 2017, constituting **25%** of the health care work force.

Source: TAC, 2018

Figure 5: Medico-Legal Claims



Source: National Treasury, 2019

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What do we want?

- ❑ Undertake tax and private medical aid reform to enable the doubling of public health expenditure by 2025 to meet the funding requirements of the transition to universal health care.
- ❑ A health financing strategy which defines changes to revenue raising (particularly tax reform), governance, accountability mechanisms as well as the overall architecture of the system.
- ❑ Take all necessary measures, including budgetary, to ensure that all vacant posts in provincial health departments are filled without delay.
- ❑ Replace arbitrary wage expenditure ceilings with budgeting based on the implementation of an updated human resources for health strategy, ensuring that funds are available to train the additional health personnel that are necessary.
- ❑ Reverse cuts to the health facilities management and maintenance grant, which is expected to shrink by a further -2.6% over the MTEF.
- ❑ Greater attention on anti-retroviral treatment adherence in the HIV/AIDS programme
- ❑ Support for provincial departments of health to combat corruption, implement financial controls and ensure that all payments due for goods and services providers are paid on time (within 30 days).
- ❑ The completion and implementation of the recommendations of the Health Market Inquiry, which include taking steps to end collusion and excessive profiteering by private health providers and enhanced cooperation between the private and public health systems so that resources are shared and utilized more effectively.
- ❑ The establishment of an inquiry into the exponential rise of medico-legal claims against provincial health departments.
- ❑ Implementation of the recommendations of the Health Ombud on the Life Esidimeni tragedy, including those relating to wider mental health care reform.

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