Capital flows in the health sector in South Africa: Implications for equity and access to health care

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In the Regional Network for Equity in Health in east and southern Africa (EQUINET)

EQUINET DISCUSSION PAPER 76

July 2009

With the support of Southern African Trust

Table of contents

Cite as: Dambisya YM, Modipa SI and Health Systems Research Group, Department of Pharmacy, University of Limpopo (2008) 'Capital flows in the health sector in South Africa: Implications for equity and access to health care,' *EQUINET Discussion Paper Series 76.* Rhodes University. York University, TARSC, SEATINI; EQUINET: Harare.

Executive summary

This paper was commissioned under the umbrella of the Regional Network for Equity in Health in east and southern Africa (EQUINET), led by the Institute of Social and Economic Research, Rhodes University (ISER) as part of a research effort exploring how private capital flows are impacting on the health sector in east and southern African, and the effect of such flows on national health systems and equitable access to health care. Our main task was to conduct a mapping and review of documented (secondary) evidence on capital flows in the health sector and their implications for equitable access to health care services between 1995 and 2007 in South Africa.

For the review of evidence, we adapted the Kutzin (2001) framework on health system financing, as modified by McLeod (2007), for gathering information in areas such as:

- the composition of the health system;
- sources of health financing, pooling of health finances and financial intermediaries;
- service providers and access to health services;
- utilisation of health services;
- the public/private mix; and
- policy and legislative reforms with impact on health service delivery.

We reviewed published and grey literature on capital flows in the South African health sector from sources including the National Department of Health (NDoH), Council for Medical Schemes (CMS), Health Systems Trust (HST), the Hospital Association of Southern Africa (HASA), Board of Health Care Funders (BHF), South African Pharmacy Council (SAPC), Health Professions Council of South Africa (HPCSA), South African Nursing Council (SANC), World Health Organisation (WHO)/World Health organisation Africa Regional Office WHO/WHO AFRO, the World Bank and United Nations Development Programme (UNDP), and scientific literature using Pubmed/Medline, EBCOhost and Google Scholar search engines. The search was further broadened by snowballing based on obtained documents, which were searched for references as primary sources of information.

The South African health system has a public sector that caters for about 80% of the population, and a private sector that caters for less than 20% of the population but uses the most of the financial and human resources devoted to health. The main sources of funding for health care in South Africa are general taxation for the public sector, and individuals, government departments and companies for the private sector. The main financial intermediaries are provincial departments of health for the public sector and medical aid schemes for the private sector. Overall, private intermediaries channel more funds than the public ones. Nevertheless, a significant proportion of the population meets health service costs through out-of-pocket payments, and for many this is catastrophic expenditure. There have been successful pro-equity measures to increase access to both public and private health care services e.g. through removal of barriers, such as user fees at primary health care (PHC) facilities, increased coverage of medical aid, e.g. through the Government Employee Medical Scheme (GEMS), and through regulation of the private sector using various laws and policies, such as the Government White Paper on Health Transformation (1997) and the National Health Act (2003).

Health services have become more accessible and affordable overall, with fewer people in need of health care finding the cost of health care prohibitive. However, geographical accessibility remains a problem, with slightly more people not seeking health care because the services are “too far” in 2006 (8.6%) than in 2002 (6.8%). There have been consistent efforts to redistribute resources between and within provinces to increase access to health services. Inter-province differences in per capita expenditure in health have decreased over the years under review with more significant allocations to health in provinces with low

allocations for health. For instance, per capita expenditure on PHC was lowest in Mpumalanga at R72 and highest in the Western Cape at R317 in 2001 (national average R168); while in 2006 Mpumalanga spent R187 and the Western Cape R371 (national average R256) per capita on PHC. Per capita expenditure on health, however, still shows wide disparities between private sector and public sector, with the private sector spending four to seven times as much as the public sector per capita. The population with access to medical aid, and therefore regular access to private services has also remained constant, at about seven million in the period under review. The number of medical aid beneficiaries is, however, expected to increase with the implementation of the GEMS.

There has been an increase in funding in both sectors of the health system during the period under review. Public health sector expenditure rose from R32.9 billion in 1998/99 to R38.9 billion in 2005/06, while provincial health expenditure was on average consistently at least 23% of total provincial budgets; and per capita public sector expenditure on health rose from R670 in 1998 to R1232 in 2006, the respective figures for the private sector were R3099 and R6767. Additional public sector facilities were constructed, while existing ones have been upgraded or expanded (present strength of public sector facilities is about 4000), and there has been a net increase in utilisation of public sector health services (61.2% of all users in 2006). There has also been an increase in use of all forms of private services, associated with real growth and expansion of the private sector, with a relative stagnation of public sector funding for health during some of the years under review. The private hospital industry is the largest investor in health in the country, and contributes to the largest capital flows in the health sector. Some of the funds are from hospital operations (operational revenue/profit), while some are generated through private capital raised through the stock market. For example, the Netcare group underwent phenomenal growth after listing on the Johannesburg Stock Exchange, which reported a 9,7% increase in profit to R1,5 billion in September 2007 (Netcare, 2007). Further evidence of such expansion is the increase in private hospital sector beds to more than 27,000 (end of 2006) from below 6,000 beds (1996). This increase has been associated with concentration of private capital in the health sector, with a larger ownership share to fewer companies. Further work needs to be done on the extent to which this is associated with cost escalation, given its impact on equity.

Racial inequalities in access to and utilisation of health care services persist, with people classified as ‘White’ and ‘Indian‘ more likely to have medical aid cover and utilise private health services than those classified as ‘African’ and ‘Coloured’. Fewer of the latter are covered by medical aid, so they mainly use public health services, while in contrast the percentage of people classified as ‘White’ using public services fell from 30.8% in 1995 to 15.4% in 2003 (Statistics South Africa, 2003a). Reported satisfaction with service received is higher among users of private healthcare services than among users of public services.

The public-private mix is characterised by many public-private interactions (PPIs), including private financing initiatives (PFIs) and public-private partnerships (PPPs) in various forms, and in various provinces. Examples of successful PPIs include the PPP for the construction of Inkosi Albert Luthuli Hospital in KZN, co-location agreements between private sector players and public hospitals in the Free State and Limpopo provinces, outsourcing of laundry services in Limpopo Province and of transport services in the Eastern Cape. The impact of these investments on availability, equity and access is yet to be effectively evaluated.

The period reviewed is thus one where expansion of both public and private sectors has taken place. The challenge remains to translate this into equitable use of available resources, or increased access to health services, especially for those with higher health need. Improved monitoring and data collection on the health systems impact of the trends described in this paper is important, given the significant share of private sector services in the public-private mix in health in South Africa.

1. Introduction

This paper was commissioned under the umbrella of the Regional Network for Equity in Health in east and southern Africa (EQUINET), led by the Institute of Social and Economic Research, Rhodes University (ISER), in co-operation with York University; Southern and Eastern African Trade Information and Negotiation Institute and Training and Research Support Centre. It was part of a research effort exploring the manner in which private capital flows are impacting on the health sector within the east and southern African region, and the effect of such flows on national health systems and equitable access to health care. Our main task was to conduct a mapping and review of documented (secondary) evidence on capital flows in the health sector and their implications for equitable access to health care services between 1995 and 2007 in South Africa.

South Africa is a middle-income developing country, divided into nine administrative provinces: Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga Northern Cape, North-West and Western Cape. Due to its apartheid past, South Africa has both first-world (well-developed) and third-world (under-developed) characteristics in many areas including health service delivery, with inequalities along racial lines (Wadee et al, 2003b). The overall health of the population has declined over the last 10 years, as seen from a decreasing life expectancy, mainly because of the impact of the HIV/AIDS epidemic (Badri et al, 2006). Life expectancy at birth now stands at 50 years – 48.4 years for males and 51.6 years for females (Statistics SA, 2007). South Africa has a quadruple burden of disease, consisting of HIV/AIDS, injury, diseases of poverty and emerging chronic diseases (Bradshaw et al, 2003). Females live longer than the males because more males die of injuries, including those due to firearms and those incurred in road traffic crashes (ibid).

Prior to 1994, when South Africans elected their first non-racial government, the old apartheid health system was centralised and undemocratic, highly fragmented, inefficient and inequitably biased towards curative services, preferential treatment for 'whites' and development of the private sector. In 1994, a large private sector already existed, taking up to 60% of health spending, covering 23% of the population, which had regular access to private health care (mainly through medical aid membership), and employing highly skilled medical and nursing professionals trained in the public sector at public expense (HST, 1995). There were fourteen different health authorities overseeing services which were predominantly private, specialist and curative (McIntyre et al, 1995; van Rensburg et al, 1992; HST, 1995). South Africa's first democratically elected government set out to restructure the system and now there is only one national Department of Health (DoH) which takes charge of the public services throughout the nine provinces and 53 health districts (Tshabalala-Msimang, 2004). In addition, the DoH regulates the private sector through legislative and other policy measures. The focus of the DoH is primary health care (PHC) through the district health system, and increased provision of health care that is affordable and accessible to all, especially the rural and historically under-served areas. Despite health system restructuring, there are still wide intra-provincial inequities in per capita spending on health (Ntuli and Day, 2004; Thomas et al, 2004).

The foundation of any health system is the right to health care, a basic human right enshrined in section 27 of the current South African Constitution, and in the International Covenant on Economic, Social and Cultural Rights of 1966 (article 12) issued by the United Nations which was ratified by South Africa. That right has been a guiding principles for the initiatives undertaken by the government to redress the inequality of the pre-1994 apartheid health system, characterised by extremely unfair distribution of health care resources and services, and the lack of a national health system (Hirschowitz and Orkin, 1995).

The health care system in South Africa is made up of public and private sectors. The public sector is composed of the Ministry of Health (national and provincial), other government

departments/ministries (such as defence and local government) and other government statutory bodies which offer health services (Blecher and Harrison, 2006; McLeod, 2007). The private sector includes non-government organisations (NGOs), philanthropic organisations, faith-based hospitals, voluntary/support organisations and a for-profit sector (McLeod, 2007). The private hospital industry is the largest group in the for-profit sector, with three dominant players – Medi-Clinic, Life Health Care and Netcare. Together they own more than 80% of all private hospital facilities in the country (HASA, 2007; Shevel, 2007).

South Africa's health care financing is characterised by a public sector financed through general tax revenue, and a private system dominated by medical schemes and covering 15% of the population (Blecher and Harrison, 2006). The flow of health sector financing moves from financing sources (households, employers, national budget), to financing intermediaries (medical schemes, provincial departments of health), and then to expenditure areas (e.g. doctors, clinics, hospitals and pharmacies).

The public sector includes government departments, organs of state and institutions exercising a public power or performing a public function in terms of legislation, while the private health sector includes 'all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease' (Mills et al, 2002; Bennet et al, 2005). There is some overlap between the public and private sectors in South Africa; for instance, some staff employed in the public sector work in the private sector (and vice versa), some public hospitals operate private wards and public facilities rely on the private sector for some of their services (Mills et al, 2002). The same is true of medical aid contributions from government employees, which lead to the flow of capital from the public sector to the private sector (HST, 2004a).

2. Conceptual framework, methods and limitations of the study

2.1 Conceptual framework

Bennet et al (2005) have suggested various ways in which the public and private sectors interact, including:

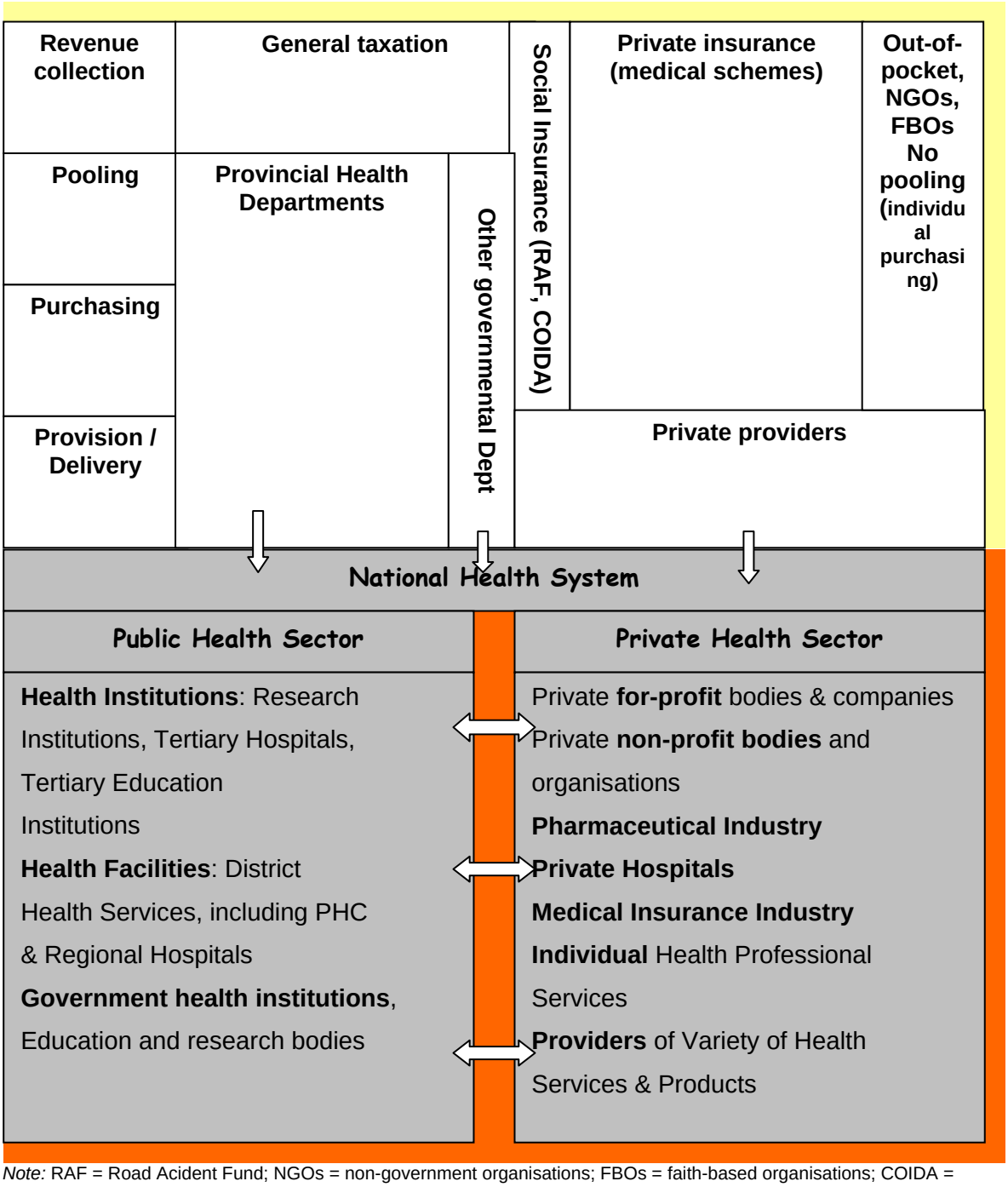
- the provision of preventive and psycho-social support by people living with HIV/AIDS (PLWHA) support groups;
- the provision of auxiliary (non-clinical) support services like laundry, transport, cleaning services etc.;
- financing health care, e.g. through medical benefit schemes, private health insurance and community-based insurance;
- pharmaceutical production, importation and distribution; and
- health professional training, e.g. through privately established medical and nursing colleges (Bennet et al, 2005).

Most of these interactions within the South African health system are discussed *Section 3.3*.

Many frameworks have been developed for understanding the composition and dynamics of the health system and of health sector financing flows. For the purposes of this study, we combined health system structure with health financing flows, as shown in *Figure 1*, based on the four major functions in health care financing: collection of revenue, pooling of collected revenue, purchasing of health services, and provision or delivery of health services (Kutzin, 2001). Kutzin (2001) described a health care financing framework with four domains: revenue collection, pooling of funds, purchasing of services and provision of health care services. Collection of funds covers sources of financing such as individuals, firms, corporate entities, NGOs, charities and taxes, and financing mechanisms such as direct payment, indirect payments, wage-related contributions shared between employers and employees (medical schemes) and health insurance. Pooling of funds includes collecting

and pooling to a central level, e.g. for tax-financed system – treasury collection and then health allocation (pooling), and South Africa's decentralisation with provincial authorities getting the autonomy to allocate and spend funds for the health sector. Purchasing health care services and remunerating providers cover mechanisms such as transfer of pooled resources to service providers. Remuneration is the mechanism used to allocate the resources and could take place through use of financial intermediaries. In South Africa, remuneration of providers depends on the sector: the private sector uses a service-based (fee-for-service) system; while the public sector uses mainly time-based approaches through annual/monthly pay and benefits or payment for sessions. Provision of services occurs through the national health system, which has both public and private sectors (Kutzin, 2001).

Figure 1: The South African health system and health care financing



Note: RAF = Road Acident Fund; NGOs = non-government organisations; FBOs = faith-based organisations; COIDA = Compensation for Occupational Injuries and Diseases Act

Adapted from: Kutzin, 2001; Wadee et al, 2003b and McLeod, 2007

McLeod (2007) adopted the Kutzin framework (collection, pooling, purchasing and delivery) to the South Africa context, as shown in *Figure 1*. The major revenue collection in the public sector is from general taxation. The funds are then pooled by the provincial departments which are also responsible for purchasing and delivery of health services. For the private sector, funds are collected and pooled largely through private insurance (medical schemes), with a significant contribution from social insurance such as the Road Accident Fund (RAF) and Compensation for Occupational Injuries Act (COIDA) funds, and some individuals pay out-of-pocket to private providers. The money collected is then channelled into the public or private sectors of the national health system.

As can be seen from *Figure 1*, there are always interactions between the public and private sectors, as indicated by the double-headed arrows between the two sectors in the figure. For instance, about 9.4% of the total public hospital budget in 1999 went towards private sector contracts for the provision of both clinical and non-clinical services to public sector hospitals (Wadee et al, 2003b) – this represents a capital outflow from the public to the private sector. The McLeod (2007) adaptation of Kutzin's (2001) framework to the South African system (*Figure 1*), emphasises the relative contribution of the various role players. In the public sector, the pooling, purchasing and service provision functions are largely carried out by the provincial departments of health. In the private sector, the medical schemes collect the funds from members, pool them and purchase care from private providers. The relatively smaller contribution of other role players is indicated by the smaller boxes in *Figure 1*, as proposed by McLeod (2007). Analysis of health care financing systems using this framework highlights the interactions of various policies and the need for a coherent consideration of all stakeholders, rather than looking at each part of the system separately (Kutzin, 2001).

That framework (*Figure 1*) was used to guide the collection of evidence on trends of capital flows in the South African health system between 1995 and 2007, with respect to sources of finance, pooling of funds, purchasing of health services and provision of services. We looked at areas of overlap between the public and private sector as well, for public-private initiatives (PPIs) and, for the context of the developments in the health sector, we also reviewed the policy and legislative reforms.

2.2 Methods

We conducted a desk review of published and grey literature on capital flows in the health sector in South Africa between 1995 and 2007, focussing on:

- the current composition of the health sector, particularly the public-private mix and the nature of the for-profit sector;
- the current private capital flows situation and trends since 1995;
- key entry points for capital, including within the public sector and geographical distribution;
- the impact of these flows on the health sector;
- arguments in support of private flows; and
- issues related to data availability and bias, and methods of analysis.

The overarching issues of equity, efficiency, effectiveness and quality of the health system and their contributions to health outcomes were also considered, within the limits of what information was available.

We conducted a document search on websites for the National Department of Health, the Council for Medical Schemes, Health Systems Trust, the Hospital Association of Southern Africa, Board of Health Care Funders, South African Pharmacy Council, Health Professions Council of South Africa, and South African Nursing Council, and also from WHO/WHO AFRO, the World Bank and UNDP. We also searched the scientific literature through

Pubmed/Medline, EBCOhost and Google Scholar search engines with a document search strategy using terms such as South Africa health care services, health care delivery, health care financing, access to health care, out of pocket payment, medical insurance, medical schemes, private hospitals, private health care, private health services and customer satisfaction. The search was further broadened through the obtained documents which were used to snowball the search by looking at the references therein for primary sources of information.

The report is structured to give an overview of the state of health in South Africa, the structure and composition of the health systems, the main areas of progress – in policy and legislative reform, access to health care and equity – and the role of the private sector in health care delivery. The main capital flows in the health sector are presented, using the framework outlined in *Figure 1*.

2.3 Limitations of the study

There were varied sources of data, and in many cases the information was obtained using different parameters/ denominators, so it was sometimes difficult to establish trends for the period under review, especially where different groups looked at the same problem in different years. The presentation of the data is often confusing with some reports referring to rand values in a certain year (e.g. Belcher and Thomas, 2004; Belcher and Harrison, 2006), and not in the year of expenditure, while others consider the data in the year it was spent without correcting for inflation and rand depreciation (e.g. HST, 2004b). Some of the comparisons may have been flawed, or at the very least skewed by such inconsistencies in the primary data. This was evident in calculations of the ratio of private-to-public per capita expenditure on health, which varies according to the assumptions used in the sources of data (Blecher and Thomas, 2004; HST, 2004b).

Many data sources used estimates (including population estimates), assumptions and projections, and not actual expenditure figures (e.g. Statistics SA, 2004, 2007) and yet subsequently such estimates may have been cited as factual figures by others. Not all parameters were reported upon every time, hence consistent trends were difficult to establish across all the years – a difficulty experienced was in getting trends in racial inequalities, for instance (GHS, 2003, 2006). Much of the data on the private sector was based on self-reporting of earnings by private providers, which may not be a true reflection of the situation.

Much of the information presented was obtained from medical scheme operations, and yet until the coming into effect of the Medical Scheme Act 1998, in 2000, not all medical schemes were obliged to report to a central body; it is thus possible that figures for periods prior to that understated the numbers of the people with access to medical aid, and the financial flows through those schemes. Many inferences about use of private sector are based on medical aid coverage, for instance the seven million medical aid beneficiaries are taken as the ones that have access to private health services; in reality however, as shown in section 3.2.1, more than half the people who used private health services were without medical aid cover (GHS, 2003) and paid out-of-pocket. The most reliable data based on those with access to medical aid would be for those who use private hospital services (most of their patients have medical aid) but the same may not be true of those who use private facilities such as GP consultations, and purchase of drugs at pharmacies. Even with all the regulations in place, it is not possible to know which private practitioners are engaged in which type of service – a case in point are private medical practitioners (GPs) for whom the HPCSA does not keep a separate register. Consequently hardly any data on their operations exists, except for what the medical aid pays out to GPs. Anecdotal evidence would suggest that about half the people who visit GPs pay out-of-pocket, and in practices based in rural areas this figure may be even higher, and yet there are apparently no reports on such

financial flows. The figure of seven million (based on beneficiaries of the various medical aid schemes) and the amounts spent on private health services, as inferred from medical aid expenditure (CMS, 2006; BHF, 2004, 2007), may therefore be an underestimation.

Whereas it is a widely held perception that much of the population uses traditional and alternative health practitioners (Republic of South Africa, 2004) there are apparently no studies on financial flows to traditional/ alternative practitioners, who are a recognised part of the private sector. Thus the figures for expenditure on health may be an underestimate. Similarly, the expenditure pattern of out-of-pocket payments is problematic due to under-reporting; for instance, it may be possible that more retail pharmaceutical services are paid for out-of-pocket than was reported.

3. Results

The South African health system has a public sector that caters for about 80% of the population, and a private sector that caters for less than 20% of the population but uses the majority of resources, financial and human.

The main sources of funding for health care in South Africa are general taxation for the public sector, and individuals, government departments and companies for the private sector. The main financial intermediaries are the provincial departments of health for the public sector and the medical aid schemes for the private sector, but a significant proportion of the population meets health service costs through out-of-pocket payments, and for some this is a catastrophic expenditure. The private intermediaries channel more funds than the public ones. Pro-equity initiatives to increase access to both public and private health care services have included the removal of barriers such as user fees at primary health care facilities, increased coverage of medical aid, e.g. through the Government Employees Medical Scheme (GEMS), and regulation of the private sector through laws and policies, e.g. the 1997 Government White Paper on Health Transformation and the National Health Act of 2003. In the public sector, measures have been taken to redistribute resources between and within the provinces in order to increase access to health services. Consequently, the differences in per capita expenditure in health between the various provinces have decreased over the years. Per capita expenditure on health, however, shows wide disparities between private sector and public sector, with the private sector spending five to seven times as much as the public sector, and yet the proportion of the population with access to medical aid, and therefore regular access to private services, has declined from about 20% in the early 1990s to 13.2% in 2006. The number of medical aid beneficiaries may increase with the implementation of GEMS.

There has been an increase in health sector funding, especially in the private sector, but also in the public, associated with expansion in facilities and utilisation of services. Health services in general have become more accessible and affordable, with fewer people in need of health care services finding the cost of health care prohibitive (possibly due to the removal of user fees in the public sector). Yet racial inequalities in access to health care services still persist, with people classified as ‘white’ and ‘Indian’ more likely to have medical aid cover and utilise private health services than those classified as ‘African’ and ‘coloured’, fewer of whom are covered by medical aid and utilise public health services. (These racial categories are as defined by Statistics South Africa, not EQUINET.) Satisfaction with quality of service received was higher among users of private healthcare services than public service users.

There has been an increase in use of all forms of private services, real growth and expansion of the private sector, with a relative stagnation of public sector funding for health during some of the years covered by the review. The private hospital industry is the largest investor in health in the country, and contributes to the largest capital flows in the health

sector. Some of the funds are operational revenues, while some are raised through private capital, e.g. from shares on stock markets. The private sector, through civil society organisations, has spearheaded efforts towards public sector access to essential medicines for patients living with HIV and AIDS, despite constraints arising from international trade agreements and obligations.

The public-private mix is characterised by many public-private initiatives (PPIs), successful examples of which include the PPI for the construction of Inkosi Albert Luthuli Hospital in KwaZulu-Natal, co-location agreements between private sector players and hospitals in the Free State and Limpopo Province, and outsourcing of transport services in the Eastern Cape Province.

3.1 The impact of policy and legislative reform on capital flows in the health sector

How have policy and legislative reforms in South African impacted on the flow of capital in the health sector? First, the health system has undergone major restructuring since 1994, with the formation of a single national public health system under the National Department of Health (NDoH) and nine provincial departments of health. The NDoH is responsible for policy and coordination, while the provincial departments provide the most services, through 53 health districts (Dambisya, 2005). Second, there have been a number of policy and legislative initiatives aimed at regulating the private sector, such as the 1994 moratorium on building private hospitals (which has since been lifted and has resulted in the proliferation of private hospitals), control and regulation of private practice (e.g. dispensing doctors regulation, pharmacy fees), regulation of medical schemes towards more equitable spread of benefits, better governance and promoting more sound financial health of medical schemes (through the Medical Schemes Act 1998) and the National Health Act (2003).

Third, there have been deliberate policies aimed at increasing access to primary health care (PHC) services in the public sector. Government abolished user fees for children and pregnant women, followed by abolition of fees at all primary health care facilities. Removal of user fees led to an increase in health care utilisation (Gilson and McIntyre, 2005). The removal of price barriers has been accompanied by a gradual shifting of resources – financial, human and physical resources – to PHC services; e.g. expenditure on PHC services (clinics and health centres, public health programmes and out-patient departments at district hospitals) increased at an annual average rate of 5.3% between the fiscal years 1996/97 and 1998/99 (Doherty et al, 2002). An important aspect of increasing access to health services has been the procurement of affordable essential medicines for all, as regulated by the National Drug Policy. *Table 1* summarises the various policies and legislative measures that have been instrumental in reshaping the medical sector and its capital flows in an attempt to provide more equitable health services.

The White Paper for the Transformation of the Health System (1997) envisaged co-operation between public and private health sectors in a number of areas, including the delivery and management of services, provision of information to the national health information and audit system, development of standardised clinical management protocols, co-ordination of expensive equipment in geographic areas, service provision to district health authorities by accredited providers, sessional work by private providers in public facilities and referral contracts with private practitioners. Other areas for possible co-operation were leasing spare health care capacity in one sector to the other rather than allowing it to stand idle, a programme to attract private patients to public sector hospitals and allow revenue to be retained, and the utilisation of private sector facilities for the training of medical and administrative staff (Republic of South Africa, 1997c).

Table 1: Policies and legislative measures taken to reshape capital flows in the health sector, 1994–2003

Policy/Legislation	Key objectives	Main outcomes
ANC National Health Plan (1994)	• Ensure health equity and the right to health for all South Africans • Implement a PHC approach for service delivery • Create a national health system based on decentralisation with central coordination	• One public health system with a national department of health, nine provincial departments and a functional district health system
Reconstruction and Development Programme (RDP) and Growth, Employment and Redistribution (GEAR) policies	• Provide the policy framework for equitable distribution of resources preferentially to vulnerable groups, e.g. women and children.	• Pro-equity measures such as the abolition of user fees for children and pregnant women • Expansion of health infrastructure with emphasis on primary care facilities • Shift in funding from tertiary to primary care levels
Nursing Amendment Act (1995) Pharmacy Amendment Act (1995) Medical, Dental and Supplementary Health Service Professions Amendment Act (1995) Chiropractors, Homeopaths and Allied Health Service Professions Amendment Act (1995)	• Streamline the statutory governance of health professions • Unify the fragmented health services and to promote equity and accessibility to health services	• All medical professions unified under their South African professional bodies • Contributed to the unification of fragmented health services, together with other measures, such as the expanded PHC system through the district health system
National Drug Policy (1996)	• Ensure availability and accessibility of essential drugs to all citizens • Lower the cost of drugs in both the public and private sectors • Promote cost-effective and rational use of drugs • Establish a complementary partnership between government bodies and private providers in the pharmaceutical sector • Optimise the use of resources through cooperation with international and regional agencies	• Acts of Parliament that regulate all aspects of medicines • Reduction in drug prices • Free drugs at PHC facilities
White Paper on Transformation of the	• Integrate activities of the public and private health	• National Health Act (2003) to give effect to

Policy/Legislation	Key objectives	Main outcomes
Health Sector (1997)	sectors in a way which maximises the effectiveness and efficiency of all available health care resources • Establish health care financing policies to promote greater equity between people living in rural and urban areas and between people served by the public and private health sectors • Equitably distribute health personnel throughout the country • Develop human resources for health	the contents of the White Paper • Strategic plan for human resources in the health sector
Medicines and Related Substances Amendment Act (2002)	• Provide for the parallel importation of medicines • Establish a medicines pricing committee • Introduce a transparent, non-discriminatory pricing system	• Lower drug prices
Medical Schemes Act (1998)	• Consolidate the laws relating to registered medical schemes • Establish the Council for Medical Schemes • Register and control the activities of medical schemes • Protect the interests of members of medical schemes • Coordinate medical schemes	• More equitable operation of medical schemes through prescribed minimum benefits, open enrolment and community rating • Reduced dumping of medical aid patients on the public sector • Consolidation of medical aid schemes, with better financial stability
National Health Act (2003)	• Provide a framework for a structured, uniform health system within South Africa • Ensure the equitable distribution and rationalisation of health services, e.g. more equitable distribution of services between public and private sectors and between rural and urban areas	• No data is available to evaluate the impact of the Act – some of the provisions have not yet come into effect due to court challenges

The NDoH has successfully tabled various acts aimed at improving equity in health care (*Table 1*). A case in point is the Pharmacy Amendment Act 1997, which provides that a pharmacy can be owned by people other than pharmacists, thus expanding access to pharmaceutical services in underserved areas. The Medical, Dental and Supplementary Health Services Amendment Act 1997 introduced community service for doctors, a move designed to increase the number of doctors in underserved areas. In 2000, community service was extended to pharmacists and, in 2002, to other health practitioners, including physiotherapists and dieticians (Reid, 2002). Nurses were included in 2006. The Medical Aid Schemes Act of 1998 removed discriminatory clauses and brought the schemes' operations in line with the Constitution by making medical scheme provisions more equitable.

Legislative changes have been introduced in the area of drug policy through the Pharmacy Amendment Act (1997), including generic substitution, no dispensing by doctors (except when registered to do so), corporate ownership of pharmacies and parallel importation of drugs. Some of these provisions have been challenged in court, and the issue of the pharmacist's dispensing fee has been sent back for review by the minister of health. It is plausible that the decline in percentage of private sector funding going to medicines (pharmacies) is related to those changes – as shown in *Table 9*, in 1995 the biggest single expenditure item for medical schemes was medicines, which has now been over taken by hospitals and medical specialists (CMS, 2006).

The National Health Act (2003) also sets out regulations to ensure equitable distribution and rationalisation of health, with special regard to vulnerable groups such as women, older persons, children and people with disabilities. One of these is the Certificate of Need requirement which aims to contribute to a more equitable distribution of health services between public and private sectors, and to regulate the distribution of health professionals between urban and rural areas by ensuring that new facilities are opened only in areas of great need. On human resources for health, the Act calls on the government to ensure adequate resources for education and training of health care personnel, to identify shortages of key skills, expertise and competencies within the national health system, to prescribe strategies for the recruitment of health care personnel from other countries to make up for the skills and expertise that may be lacking, to prescribe recruitment and retention strategies for human resources for health, and to ensure adequate human resources planning (National Health Act, 2003).

The Medical Schemes Act No 131 of 1998, which only became operational in 2000, had several policy objectives: to promote non-discriminatory access to privately funded health care, to reduce the burden on the public sector, to improve governance of medical schemes in the interest of members, to promote greater financial stability in the industry (by the 25% solvency requirement) and to improve consumer protection through enhanced government oversight through the appointment of a Council and Registrar:

> *[The aims are] to consolidate the laws relating to registered medical schemes; to provide for the establishment of the Council for Medical Schemes as a juristic person; to provide for the appointment of the Registrar of Medical Schemes; to make provision for the registration and control of certain activities of medical schemes; to protect the interests of members of medical schemes; to provide for measures for the co-ordination of medical schemes; and to provide for incidental matters"* (Preamble to the Medical Schemes Act, 1998).

The Act sought to promote non-discriminatory access to privately funded health care through open enrolment, community rating and protecting a core set of benefits from arbitrary attrition (Rakoloti, 2007). A long-term goal was to enable the development of managed care in South Africa, which it was hoped would contribute to more efficient and less costly private health care. The basic 'minimum package of benefits' provision means that more South Africans who can afford medical aid are adequately covered, with less pressure on the public

system. Prior to the Act, many patients on medical aid would revert to the public sector once the funds in their accounts were exhausted, a practice referred to as ‘dumping’; the minimum benefits requirements removed the limits on the list of diseases in the package. The intent of the Act included the channelling of private health care funds into public health care system, with medical aid patients paying user fees at public facilities (Medical Schemes Act, 1998). We, however, did not find any evidence to that effect.

Nevertheless, growth in medical scheme membership has been slow with absolute numbers remaining around seven million per year prior to the introduction of GEMS, an idea based on equity considerations. Within 18 months of operation, GEMS had extended medical aid cover to 400,000 beneficiaries, most of whom were previously uninsured (Rakoloti, 2007; Medical Schemes Act, 1998; GEMS, 2007). One of the intentions of the Medical Schemes Act 1998 was to curb health care costs, but health sector inflation has consistently stayed higher than general consumer price index inflation (CMS, 2006; Still, 2007; Twine, 2007).

The prescribed minimum benefits under the Medical Schemes Act are a list of 270 conditions/ groups of acute conditions, 25 chronic diseases and all emergency conditions. According to the Act, medical schemes have to provide full costs of treatment, diagnosis and care for all the specified conditions with no limit, no co-payment and no deductibles, and without using medical savings account. The schemes may choose designated service providers, including public sector facilities (BHF, 2007).

A number of ideas that have been in development for a while are a (proposed) Medical Schemes Amendment Bill, which will provide for the introduction of a Risk Equalisation Fund (REF), restructuring of the benefit design (based on experience over the last few years of the operation of the Medical Schemes Act 1998), strengthening of the governance framework and introduction of the general framework for low-income products (Rakoloti, 2007). The REF is intended to create fairness between private medical schemes, between income and risk levels, and to achieve a community rating and greater equity and solidarity across medical schemes. This should enable competition on the basis of efficiency, rather than merely profit making. It is also seen as a mechanism to facilitate spread of financial risk between medical schemes and to reduce any unfair financial advantages of schemes. When it comes into being, it will be administered by the Council for Medical Schemes (ibid).

The possibility of introducing social health insurance (SHI) has been under discussion over the past twelve years. Two options have been considered: a risk-based cross subsidy between medical schemes and an income-based cross subsidy, where the more affluent contribute relatively more than the less affluent. One of the main selling points for the establishment of social health insurance is that of a low-income medical scheme (ibid).

As announced in 2007’s budget speech, there a number of guiding principles have been proposed towards realising the goal of social health insurance:

- **Equity:** There must be fair and uniform rates of contribution and benefits for all.
- **Pooling of risk:** Collective funding arrangements and non-discriminatory rules and entitlement must apply.
- **Mandatory participation:** There will be compulsory participation of employees and inclusion of self-employed individuals on reasonable terms.
- **Administrative efficiency:** The streamlined use of pay-roll-based contributions, modern information systems and efficient payment arrangements are essential.
- **Solidarity:** Minimum benefits will be assured through continued social assistance grants programmes financed by the budget (Minister of Finance, 2007).

3.2. Equity and health services: Access, supply and utilisation

In this section, our analysis of current trends and capital flows provides some baseline statistics for the public and private health care sectors in South Africa. We compare the public and private health sectors, with an equity-based approach, since our aim in the next section (3.3) is to analyse the capital flows between these two sectors.

3.2.1 Equity in access to health care services: Public vs. private sectors

Since 1994, there has been increased access to public health sector services through the expansion of facilities and an emphasis on primary health care (PHC):

> *More than 1,300 clinics have been built or upgraded, 2,300 have seen new equipment installed, childhood immunisation programmes have been extended, and our health services receive 101 million patient visits a year – about eight or nine visits per family. HIV treatment programmes are in place at 192 health facilities. Over the MTEF [medium-term expenditure framework] period ahead, 46 hospitals will undergo physical rehabilitation and administrative overhaul as part of the nationally coordinated Hospital Revitalisation Programme (Minister of Finance, 2006:5).*

Public health services were also mentioned as a core priority, with more funding allocated to home-based community care, early childhood development and social development partnerships with NGOs, strengthening of HIV/AIDS programmes, and for the revitalisation of hospitals and forensic pathology services:

> *The health sector receives a further R5.3 billion to spend on increased remuneration for health workers and an increase in staffing levels. We are budgeting to increase the number of health workers by about 30,000 over the next five years. Our previous budget framework made provision for the treatment and care of about 250,000 people who are ill with AIDS. We are likely to reach that figure in the next few months. Health receives a further R1.7 billion for this programme, presently being delivered through 272 sites, allowing for a doubling of the uptake over three years. Spending on dedicated HIV and AIDS programmes by health, education and social development departments will exceed R5 billion by 2009/10. The hospital revitalisation programme, one of our more successful infrastructure programmes, receives a further R1 billion taking total spending on this programme to R6,8 billion over the next three years. In addition, the sector receives R1 billion for the modernisation of tertiary services, with particular emphasis on diagnostic equipment (Minister of Finance, 2007:14).*

The effects of the expansion of facilities and emphasis on primary health care and abolition of user fees are evident in the reduction in the number of people who, although they required health services, did not seek care in 2006 largely due to cost barriers (*Table 2*). The trend suggests that health services are more affordable than they were in 2002 (GHS, 2006).

Table 2: Cost barriers preventing patients from accessing health services (percentage of patients), 2006

Reason for not seeking health services	Percentage of patients per year				
	2002	2003	2004	2005	2006
Too expensive	31.3	29.7	21.0	19.2	19.4
Clinic is too far from home	6.8	7.9	7.3	7.6	8.6

Source: Statistics South Africa, 2006

According to the General Household Survey (GHS) of 2003, a mere 3.3% of those who accessed public services were covered by medical aid, while 96.6% were not covered by medical aid. Of those who accessed private sector services, 43.5% were covered by medical

aid and 56.6% were not (GHS, 2003). In the same survey, of the 'Africans' who consulted health practitioners, 43.8% consulted a nurse and 60.2% a doctor (GP or specialists), compared to 84.8% of others who consulted a doctor and 11.9% of others who consulted a nurse (ibid). So, access to health services still shows some racial and income inequalities. Access to private health services is largely dependent on medical scheme membership or ability to pay out-of-pocket. Because growth in medical scheme membership has been slow, at about seven million beneficiaries per year, the proportion of the population with medical aid cover has declined in the past decade, with latest figure at 13.2% of population (HST, 2007). Moreover, there remain wide racial inequalities in access to medical aid cover, with the number of 'Africans' on medical aid declining from 10% in 1996 to 8% in 2003, while 'whites' remained well covered at over 60% (*Table 3*).

Table 3: Racial inequalities in medical aid coverage (% population), 1996–2003

Racial group	1996	1998	1999	2002	2003
'African'	10	6.3	8.4	8	8
'Coloured'	21.7	19.7	21.3	18.8	19.3
'Indian'	29.7	24	28.9	29	35
'White'	68.8	63.3	67.8	68.2	65.2
Total	18.1	16.6	16.3	15.3	14.8

Sources: Hirschowitz et al, 1999; Statistics South Africa, 2003a

A number of role players in the private sector have undertaken to make their services more accessible. For instance, the Netcare Group claims to have developed a strategy to promote equity of access to quality healthcare through four broad approaches: increasing access to private healthcare for a larger portion of the population by developing affordable services, helping to improve the quality of healthcare delivered by the public sector, developing skills to the benefit of the public and private sectors, and developing public-private partnerships (PPPs) (Netcare, 2007).

3.2.2 Equity and the supply of health services: Public vs private sectors

The South African public health sector has more than 4,000 facilities and employs about 235,000 personnel (Blecher and Harrison, 2006). Private health services are well developed and vibrant, with some of the best-equipped facilities in the world. The private sector offers expensive, high-quality care, but the cost is prohibitive so the sector caters for a small minority of the population. About 55.5% of funds spent on health services are in the private sector, and more skilled health professionals work for the private sector (ibid).

The movement of skills is largely in favour of the private sector, which employs most registered health professionals, though there has been a steady increase in the number of health professionals in the public sector over the years. The total number of health professionals in the public sector was 114,395 in 2001, 116,547 in 2003, 123,268 in 2005 and 131,145 in 2007, with corresponding vacancy rates of 57.3%, 31.1%, 27.2% and 33.3% (HST, 2008). As can be seen from the above, whereas the absolute numbers are rising, the vacancy rates in the public sector remain fairly high. The numbers for public sector medical practitioners were 7,591 in 2000, rising to 8,747 in 2005 and 9,959 in 2007; those for pharmacists were 1,085 in 2000, 1,617 in 2005 and 1,830 in 2007; and for professional nurses they were 41,734 in 2000, 43,660 in 2005 and 45,102 in 2007. Though the proportion of professional nurses employed in the public sector is the highest among all health professionals, this has remained around 44% over the last eight years (ibid).

The private hospital sector is one of the main suppliers of health services, and the single biggest investor in health care in South Africa. There are more than 200 private hospitals with more than 76,000 beds, directly employing 60,000 health workers plus 6,000 supporting medical practitioners and specialists, and treating more than 2 million patients a year (HASA,

2007). The Hospital Association of South Africa (HASA) brings together most of the private hospitals, which belong to groups like Netcare, Life Healthcare, Joint Medical Holdings, Medi-Clinic, Community Health Care and Melomed Hospital Holdings (ibid). HASA ideals include promotion of the development of an economic and social system based on equal opportunity, justice, free market economy and individual entrepreneurship. In other words, they are pursuing a neoliberal agenda. *Table 4* shows the provincial distribution of public and private hospitals, while *Box 1* illustrates the growth of the private hospital sector using the Netcare group as an example.

Table 4: Numbers of public and private hospitals, 2007

Provinces	Private hospitals	Public hospitals
Eastern Cape	40	72
Free State	19	35
Gauteng	112	28
KwaZulu-Natal	44	64
Limpopo	2	44
Mpumalanga	13	28
Northern Cape	20	26
North West	19	33
Western Cape	16	47

Source: HST, 2007

3.2.3 Equity and the utilisation of services: Public vs. private sectors

The 1995 October Household Survey (OHS, 1995) found that 60.1% of the people used public sector health services, 36.3% used private health services and 3.6% consulted spiritual/ traditional healers. Most 'Africans' and 'coloureds' used public sector services, while most 'whites' and 'Indians' used private services. 'Africans' were the most likely to use traditional/ spiritual healers (OHS, 1995). Similar patterns occurred in 2003, with public sector facilities used by 63.4% of 'Africans' and 57.8% of 'coloureds', while 84.5% of 'whites' and 53.7% of 'Indians' utilised private health services (GHS, 2003). Utilisation of health services is closely related to medical aid cover. In 1997 the proportion of people on medical aid who used health services was 68% higher than for those not on a medical aid. In the 2003 GHS, 65.2% 'whites', 35% 'Indians', 19.3% 'coloured' and 8.0% 'Africans' had medical cover, and this pattern was apparently responsible for the type of health services utilised (ibid).The perceived quality or responsiveness of health services is apparently different between the two sectors, with satisfaction levels consistently higher among private sector health service users than public sector users (GHS, 2006; *Table 5*). The converse was also true, with more users of public services feeling dissatisfied than users of private services – about 13% and 4% respectively (ibid). Even government ministers (including the Minister of Health) use private services. For instance, when a cabinet minister suffered a heart attack, he was rushed first to a government facility, then transferred to a private one where 'he was treated by a heart specialist. […] the hospital had been fitted with the most modern cardiac equipment' (du Plessis and Gibson, 2005).

Table 5: Patient levels of satisfaction with health services, 2002–2006

Patients/respondents	2002	2003	2004	2005	2006
% satisfied with public sector services	81.6	82.3	82.4	82.1	84.2
% satisfied with private sector services	95.3	94.7	96.9	96.0	95.6

Source: Statistics South Africa, 2006

Although public sector consistently rated lower than the private sector in terms of patient satisfaction, more than 80% of users reported being satisfied with public services. The

survey (GHS, 2006) did not include explanations for the responses obtained, but a possible explanation could be the public sector client profile. These clients are mostly poor and without medical aid, most probably unemployed or employed in low paying jobs, all which may make their expectations low, and therefore easy to satisfy. The poor image of the public sector may, paradoxically, contribute to the relatively high levels of satisfaction: because very little is expected of them, the service rendered may appear to 'exceed expectations', hence the high percentage of those who are satisfied. Investment in public facilities and increased expenditure by the provinces at primary health care level may have led to levels of service with which the target population are satisfied. Further observations from the GHS 2006 are summarised in *Box 1* below.

Box 1: Utilisation trends in health services, 2006

Some other interesting utilisation trends emerged from the General Household Survey of 2006:

- Regarding health, 2006 experienced a decline in the percentage of persons covered by a medical aid scheme – 13.7% in 2006, compared with 15.2% in 2002.
- Among persons who were injured or ill, proportionately more consultations took place in the public sector than in the private sector – the percentage of public sector consultations was 57.8% in 2002, compared with 61.2% in 2006, showing a slight increase in utilisation.
- Among persons who were injured or ill and consulted a health worker, most of those who consulted in both the public and private sector were satisfied with the service they received, namely 84.2% and 95.6% respectively.
- The percentage of persons who consulted a health worker in the month prior to the survey interview and reported that the cost of doing so was too high declined from 31.3% in 2002 to 19.4% in 2006.

Source: GHS, 2006

Race remains one axis of inequality; choice and utilisation of health services consistently shows racial trends, with 'whites' and 'Indians' using private services more than 'Africans' and 'coloureds' (*Table 6*). The percentage of 'whites' who use the public sector has declined with time, but the shifts for the other groups have not been consistent, though there was a relative increase in utilisation of private sector services by all groups (Wadee et al, 2003a).

Table 6: Racial trends in utilisation of health services, 1995–2000

Race	1995		1999		2003	
	Public	**Private**	**Public**	**Private**	**Public**	**Private**
'Africans'	67.7	27.5	59.7	38.1	63.4	36.5
'Coloureds'	62.7	36.7	58.2	41.8	57.8	42.2
'Indians'	42.2	54.9	37	63	48.3	53.7
'Whites'	30.8	68.4	17.3	82.4	15.4	84.6
Total	60.1	36.3	51.5	46.9	57.5	42.4

Sources: Statistics South Africa, 2003a and b

Three main trends in health service utilisation emerged between 1994 and 2002:

- an increase in use of all forms of private sector services;
- real growth and expansion of the private sector, with more investment and human resources; and
- relative stagnation of government funding for publicly funded health care (Wadee et al, 2003b).

Such developments may account for the relative increase in the proportion of people using private sector services over that period.

3.3 Health care expenditure

The proportion of GDP devoted to health care was 8.8% in 1998/99, with stagnation in government health spending (1997–1999) by about 2.5% and an increase in household and employer burden on health care expenses (NHA, 2002). In 1998/99, 59% of available health resources were through private intermediaries, which covered less than 20% of population, namely those with access to medical aid benefits (Wadee et al, 2003b).

Health care expenditure in South Africa was approximately R107 billion in 2003/4, equivalent to 8.7% of GDP (Blecher and Harrison, 2006). Private sector contribution as a share of GDP was 5.2%, catering for a population of seven million people, while the public sector share was 3.5%, providing for 35 million people. Just over 38% of total health care funds in South Africa flow via public sector financing intermediaries (primarily the national, provincial and local departments of health), while 62% flows via private intermediaries. In relation to the sources of finance, most funds flowing through public sector financing intermediaries were funded through nationally collected general tax and other revenues such as licences and levies. Most funds flowing through private intermediaries were attributable to households; in addition to their direct out-of-pocket payments, households contributed significant amounts to medical schemes. From the perspective of providers, about 39% of all health care expenditure went to public sector providers and 61% to private sector providers (ibid).

In 2006, health expenditure was R137 billion, of which R55 billion was through contributions to medical schemes and R25 billion was out-of-pocket expenditure (Still, 2007; Twine, 2007). The private hospital sector alone contributes about 0.8 % to South African GDP and about R 2.5 billion to provincial and central government tax coffers (HASA, 2007). Per capita health expenditure varied greatly between the public and private sectors (*Table 7*). For instance, in 1998, it was R670 per person in the public sector, compared to R3,099 in the private sector, and, in 2003, the respective figures were R969 and R5,724. The ratio of private sector to public sector per capita health expenditure grew from 4.1:1 in 1999 to 5.8:1 in 2005 (HST, 2007).

Table 7: Per capita health expenditure: Public vs private sectors, 1998–2006

Year	Public sector	Private sector	Ratio of public to private
1998	670	3,099	4.6:1
1999	901	3,726	4.1:1
2000	897	3,868	4.3:1
2001	929	4,396	4.7:1
2002	931	5,098	5.5:1
2003	969	5,724	5.9:1
2004	1,063	6,012	5.7:1
2005	1,175	6,767	5.8:1
2006	1,232	N/A	N/A

Source: HST, 2007

3.4 Mapping capital flows in the health system: From financial source to service provider

In the rest of *Section 3*, we will map the flow of capital from its source, via intermediaries, to the health service provider that receives the payment. Capital flows in the South African health system are from three main sources: households, employers and the national government/treasury (McLeod, 2007). The money is then channelled through intermediaries, namely medical aid schemes, provincial departments of health and provincial departments of works. Public sector intermediaries spend about 44% of all health expenditure (R59 billion in 2006/7), while private sector intermediaries spend 56% of all health expenditure (R75 billion

in 2006/7) (NHA Team, 2002). In addition to money through intermediaries, about 30% of health expenditure is either paid out-of-pocket or used to pay private health service providers (NHA, 2002). (Hospitals and pharmaceutical companies are the main service providers considered here.) Out-of-pocket expenditure for hospital services is poorly quantified and under-researched, however. Money from various sources is used in several expenditure areas such as doctors, clinics, private hospitals and pharmacies (Blecher and Harrison, 2006; Twine, 2007).

3.4.1 Sources of capital in the health system: Users, employers and the government

As mentioned above, capital flows in the health system are from three main sources: households, employers and the national government/treasury (McLeod, 2007).

The main funding flows are block grants given from the national treasury to provincial treasuries, which then allocate funds to the provincial departments of health, under the fiscal federalist policy adopted by the government (NHA Team, 2002). In addition, funds allocated to the national department of health are channelled through provincial departments of health (ibid). The main expenditure by provincial departments is on hospitals, though there have been recent trends to increase funding for non-hospital PHC activities (*Table 8*). The public financial intermediaries are: provincial departments of health – 73% of finance; others, e.g. national departments of defence and education and provincial departments of works – 20% (Doherty et al, 2002).

Table 8: Per capita expenditure on primary health care, 2001–2006

Provinces	Years		
	2001	**2005**	**2006**
Eastern Cape	107	213	230
Free State	99	220	234
Gauteng	285	257	288
KwaZulu-Natal	165	231	252
Limpopo	102	181	198
Mpumalanga	72	154	187
Northern Cape	126	227	277
North West	204	270	300
Western Cape	317	339	371
National average	168	232	256

Source: HST, 2007

In 1992/93, total expenditure on health was R30 billion, which was 8.5% of GDP. Of that amount, 38.7% was from general tax revenue and local taxes, and 60.8% was from private sources, such as medical schemes, health insurance policies, employers providing health services at the workplace, out-of-pocket expenditure on health services and non-members of medical schemes, 'scheme gap' co-payments, drug purchases, user fees at public hospitals and purchasing of over-the-counter medicines (HST, 1995). Sources of public health sector funding are the national treasury through general taxation (94%), local authority revenue (3%) and some contribution from donors (less than 1%) (NHA Team, 2001). Expenditure on health services is the third-largest government expenditure area (Minister of Finance, 2006).

Lamirudin et al (2005) showed that about 41.6% of households had incurred out-of-pocket expenditure in the past one month. Out-of-pocket expenditure is a regressive form of payment, taking up to 50% of the poorest households' ability to pay, compared to 10% of the ability of wealthy ones to pay (Chetty, 2007). Equity implications of out-of-pocket payments, such as catastrophic health costs (for an accident, for example), are a cause for concern. Up to 10.5% of households were faced by catastrophic expenditure in the last one month of a survey conducted in 2003 (ibid), compared to 0.3% in 1995 (Xu et al, 2003). *Box 2*

summarises some of the main public health sector financial trends identified by the National Health Accounts project for the financial year 1998/99.

Box 2: Financial flows in the public health sector, 1998/99

A summary of financial flows in the public health sector:

- Full public funding of the health sector was around R 32.7 billion in 1998/99, amounting to R767 per capita for the whole population or R942 per person without medical aid.
- The financing of the public health sector is highly dependent on general taxation (for around 94% of funds).
- Financing of the public health sector increased by 9% per year, on average, between 1992/93 and 1998/99, with a decline in 1998/99.
- The main financial intermediaries for the public health sector were provincial departments of health, which channelled 73% of all public health sector funds in 1998/99.
- Financial intermediaries other than the national and provincial departments of health accounted for around 20% of all public health sector funds. Such channels include the national Departments of Defence and Education and the Provincial Department of works.
- Substantial progress was made in redistributing funds to lower levels of care from 1992/93 to 1997/98. In 1992/93, 85% of public health sector expenditure was on hospitals compared to 77% by 1997/98. Moreover, per capita non-hospital PHC expenditure almost doubled from R61 (1992/93) to R117 (1997/98). (Refer to *Table 7* for details of PHC expenditure per province.)
- Increased expenditure on PHC activities (including clinic upgrade/renovation and construction), removal of user fees and redeployment of staff to PHC facilities led to an increase in access to PHC services over the years between 1992/93 and 1998/99.
- There was significant redistribution of health sector funds across the provinces.
- The medical aid costs of civil servants required a significant amount of public funding. For instance, about R2.5 billion was paid to the private sector between 1996/97 and 1998/99.

Source: NHA Team, 2002

3.3.2 Financial intermediaries (medical aid schemes)

The General Household Survey (GHS) of 2006 reported that up to 42% of the population visited the private sector (estimated to mean that more than one million patients visit the private sector per month), which, compared to 15% population with medical insurance cover, suggesting that more patients without medical scheme benefits access the private sector than those with medical aid, and therefore, up to R16.7 billion of health expenditure, by about three million patients, could be through out-of-pocket payments per year (GHS, 2006).

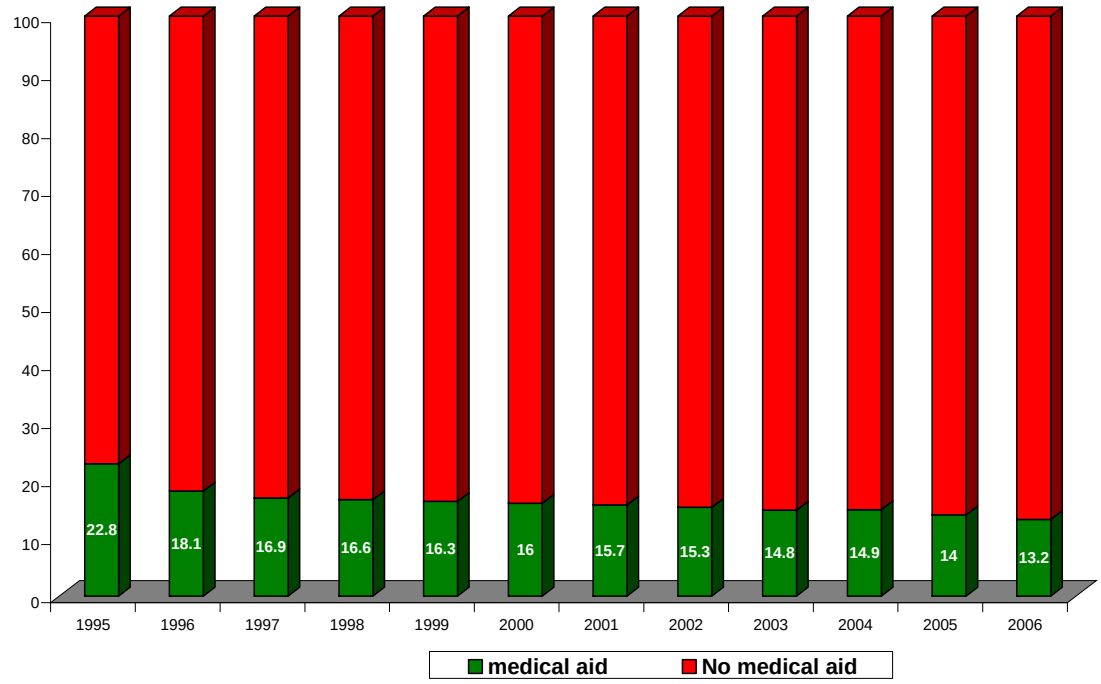
Another major source of capital flows through the private sector intermediaries is the government, which subsidises civil servants' medical aid payments. This subsidy has been increasing over time, to about 12 times more (per capita) than for the public sector-dependent population. Annual government expenditure per medical scheme beneficiary grew 10% between 1996/7 and 1998/9, compared to only 1% for public sector beneficiaries (ibid). More recently, the establishment of the Government Employees Medical Scheme (GEMS) – a medical scheme restricted to government employees – has provided additional funding for medical schemes and private sector health providers. GEMS was established largely to cater for those government employees who otherwise could not afford medical aid payments. The scheme was registered in 2005 and started operation on 1 January 2006 (CMS, 2006). By July 2007, GEMS had more than 150,000 principal members and about 400,000 beneficiaries, making it the largest restricted medical scheme in South Africa, and third-largest scheme overall (GEMS website, 2007). Restricted medical aid schemes are established for specific groups, e.g. GEMS for government employees and Polmed for the police, whereas open schemes are for anybody who can afford the monthly premiums.

GEMS was created for the benefit of government employees and was intended to provide them with quality affordable healthcare in an environment of transparency and good governance (GEMS newsletter, June 2006). It offers benefits largely similar to other less affordable schemes and has been actively promoted by the government, through the Ministry of Public Service and Administration, with a full government subsidy for those earning lower than R60,000 per annum and a 75% subsidy for the rest. This scheme has the potential to add a further one million beneficiaries (GEMS website, 2007).

Medical aid cover is intended to protect households from catastrophic health expenditure. About 12% of households without insurance coverage were faced with recent catastrophic payments, which was a significantly higher proportion that the 8% of households with at least one member belonging to insurance scheme who faced catastrophic health expenditure (Blecher and Harrison, 2006). The proportion of the population that is insured has declined over the past 12 years, as shown in *Figure 2*. Before GEMS, only those with high-paying jobs benefited from medical schemes, but the pattern will hopefully change in the wake of GEMS (though there is currently no data available to support this assumption).

By 1995, an estimated 23% of the population had regular access to private health services. Medical scheme options varied greatly from comprehensive benefit packages to only basic primary care in the private sector (HST, 1995). The regulation of the operation of medical aid schemes was complicated, with some reporting their numbers and others not required to report. It was therefore difficult to establish the number of medical aid beneficiaries. It was equally difficult to know the proportion of the population who utilised private health service providers directly, through out-of-pocket cash payments. Furthermore, there was little information on the geographical distribution of private sector facilities/resources, though they were arguably concentrated in the metropolitan areas (HST, 1995).

Figure 5: Percentage of the population with medical aid cover, 1995–2006



Source: HST, 2007

The net assets of South Africa's medical schemes have been mounting over time, standing currently at R23 billion. In 2005/6, they had an operating deficit of R356.2 billion, but an overall net surplus of R2.3 billion due to high investment income (CMS, 2006). A survey on the prescribed minimum solvency, which was set at 25% by the Medical Schemes Act 1998,

found that the average solvency ratio for the schemes was 39.1% by December 2005 (29.6% for open schemes and 63.5% for restricted schemes) (ibid; BHF, 2006).
The review did not find evidence of any flow of foreign capital into the South African health sector, though this should be expected through players such as multinational pharmaceutical companies. Since South Africa is viewed as a lucrative market for health care products, it may well be that companies investing in the country take out much more than they invest, in effect a case of capital outflows. And because both sectors of the South African health system are largely funded from internal resources (taxes and medical aid contributions), foreign direct investment, but there was some evidence of mergers and acquisitions, and thus of concentration of private capital in the health sector, such as in the growth of the ownership share of the private health sector by the Netcare Group, through acquisition of smaller hospital groups

3.3.3 Health service and drug providers: Hospitals and pharmaceutical companies

The public sector is estimated to have more than 4,000 health facilities, and of these about 10% are hospitals in various categories (tertiary, academic, regional and district). Hospitals are supported by primary health care clinics and health centres, which are the main point of entry into the public sector. Referrals take place from clinics or health centres to the district hospital, then to the regional hospital and finally to a tertiary or academic hospital. In 1998, there were 2,604 public clinics (HST, 2007). The private sector currently has 211 hospitals. It went through a period of growth, followed by consolidation through mergers, and ranged from a high of 357 private hospitals to the current 211, as shown in *Table 9* (HASA, 2007).

Table 9: Growth of hospital facilities in public and private sectors, 1998–2006

Year	Public sector	Private sector
1998	343	162
2002	399	350
2004	382	357
2006	396	211

Source: HST, 2007

Medical scheme trends in expenditure patterns over the years are shown in *Table 10*. Total expenditure for 1995 was R14.42 billion, increasing to R45.6 billion in 2005.

Table 10: Medical scheme expenditure on health, 1995–2005

Expenditure items	% health expenditure in 1995	% health expenditure in 2005
Medicines	29.4	15.7
Private hospitals	23.2	34.7
Medical specialists	19.2	20.5
General practitioners	10.2	8
Dentistry	8.2	4.6
Provincial hospitals	1.8	1.5
Others	7.6	11.3

Source: BHF, 2006

Medical aid scheme beneficiaries use various service providers, including those in managed care arrangements. GEMS, for instance, has contracts with Prime Cure managed care providers for their clients, while emergency services for GEMS members are through a national network consisting of Netcare 911, Clinix EMS and Melomed (GEMS newsletter, 2006). Those arrangements illustrate the complexity of financial flows in the South African health sector: money from government (medical aid subsidy) and government employees (membership contribution) is pooled through GEMS and moves from GEMS to the private

sector to purchase health care services from private providers that have contractual arrangements with GEMS.

Private hospitals are the main drivers of private health sector expenditure increases. The number of private hospital beds doubled between 1989 and 1998, despite a moratorium imposed on building new private hospitals in 1994; however, the proportion of the population covered by medical aid fell between 1992/3 and 1998/9 (Wadee et al, 2003b).

Another example of a private hospital group is Life Healthcare, which also has an extensive network of service providers with acute care hospitals, long-term care, occupational and rehabilitation services. There are 62 Life Healthcare acute care facilities in seven provinces in South Africa, with the support of 2,700 medical practitioners and specialists. Life Healthcare is also involved in public-private partnerships, as exemplified by Life Esidemeni – the oldest and largest public-private partnership in long-term care for chronically ill patients at 24 facilities. Life Occupational Health, which provides contracted on-site occupational and primary health care services to large employer groups, runs 186 clinics with 120,000 employees (including government departments). Life Rehabilitation offers rehabilitative services for the physical and cognitive rehabilitation of patients disabled by stroke, spinal trauma and other disabling injuries (Life Healthcare, 2007).

In terms of finances, private hospitals have an annual turnover of R17.5 billion, R5.5 billion in wages/salaries, R120 million on training, R1.5 billion in taxes and R8 billion on other purchases. The main benefits of the expansion of the private hospital sector include the availability of state-of-the-art facilities and high-quality care for the seven million South Africans on medical aid, who would otherwise depend on the public sector (HASA, 2006). There are inequalities in health expenditure between the two sectors: annual growth in expenditure per medical scheme beneficiary was as high 10% between 1996/7 and 1998/9, compared to only 1% for spending on public sector dependents. (Doherty et al, 2002). In addition, government spending *per year* per public sector dependent (1996/7 to 1998/9) was almost equal to the *monthly* subsidy it offered civil servants in medical aid contributions! Those costs are mainly due to spending on private hospital services.

The pharmaceutical industry is also a strong player in the private health sector, responsible for the supply and distribution of pharmaceutical products to both public and private sectors. One of the active pharmaceutical groupings is the Pharmaceutical Manufacturers' Association (PMA), which works to sustain a favourable environment for the continued development of the pharmaceutical industry, and ensures access to high quality medicines, with the ultimate aim of saving lives and improving quality of life. PMA also conducts research and development activities. According to the PMA promotional material, the benefits of the association to the country include:

- New medicines are registered and launched quite fast.
- Patients have early access to new medicines.
- Local investment is made in education and training.
- Investment is made in clinical research.
- Investment is made in therapeutic areas.
- The state sector has easy access to local suppliers of a wide range of drugs (PMA, 2007).

In contrast to the above claims, there have been some complaints of corruption in the pharmaceutical sector. In 2008, the South African media announced that the Competition Commission was investigating a number of pharmaceutical companies, including one of the country's biggest pharmaceutical companies and leading suppliers of hospital products, Adcock Ingram, on suspicion of colluding with its competitors and rigging government medicine supply tenders to public hospitals (SABC, 2008; Khumalo, 2008; Motsoeneng,

2008). Adcock Ingram allegedly teamed up with its competitors – Dismed Criticare, Thusanong Health Care and Fresenius Kabi, South Africa – to rig government tenders for large volume parenterals, irrigation solutions, administration sets and accessories. The allegations against Adcock Ingram came at a time when its parent company Tiger Brands, was involved in a bread price-fixing scandal. Information before the Competition Commission suggested that the companies were engaged in collusive tendering and market allocation, and that they allegedly held discussions with each other before they submitted tenders for the supply of medicines and drugs to hospitals. Beyond the public sector, Adcock Ingram Critical Care and Fresenius Kabi SA were found to be engaged in dividing markets in the supply of pharmaceutical products and services to hospitals, including Agroc Healthcare Limited (now Life Health Group Holdings), Network Healthcare Holdings, Medi-Clinic Corporation and mine hospitals (Khumalo, 2008; Motsoeneng 2008). According to the Competition Commission:

> *In these discussions and meetings they collaborated on their responses and discussed and agreed on prices. This involved the manipulation of prices for the pharmaceutical and hospital products with which the tender was concerned* […] *They would also agree that whenever tenders were not awarded as agreed or arranged between them, the winning firms would cede portions of the tender to one of their colluding partners* (SABC, 2008)*.*

These allegations may partly explain the escalating costs of health care in the country and point to a disturbing trend of pharmaceutical companies artificially inflating prices for profit:

> *This is an important case in the light of growing public concern about escalating healthcare costs. Collusive behaviour would undoubtedly be one of the contributing factors to higher prices in healthcare markets (Motsoeneng, 2008).*

To what extent such practices are widespread has not been established, but it is possible that other unethical practices, including kick-backs, are used to secure tenders. In the wake of the medicine price-fixing scandal, there was controversy around the tender for supply of anti-retrovirals (ARVs), with one stakeholder protesting that the specifications were arrived at in a 'non-transparent and non-collaborative manner, without the valuable input of experts in this area' (Low, 2008). Clearly, the high costs of health care in South Africa may be partly the result of corrupt practices that lead to artificially inflated prices, and such practices need to be watched and contained.

3.3.4 The impact of trade agreements on health care: GATS and TRIPS

As a founding member of the General Agreement on Tariffs and Trade (GATT), South Africa participates in a number of preferential trade relationships and has negotiated many general trade agreements with international trading partners (SA Official Gateway, 2007). South Africa is active in the World Trade Organisation (WTO) and has signed the General Agreement on Trade in Services (GATS) and the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) (SA Official Gateway, 2007), which have sometimes worked to undermine efforts towards access to affordable health services. The TRIPS agreement, for instance, provides protection for intellectual property across a range of property rights areas (copyrights, patents and trademarks), and obliges states to grant patent owners at least 20 years of exclusive commercial rights to make and sell their inventions, such as medicines (WHO and WTO, 2002). Although the aim is to protect research and development investments, this may prohibit access to essential drugs. The impact of the TRIPS agreement in South Africa has been most evident in the cost of antiretroviral therapy drugs. In 1998, 39 pharmaceutical manufacturers sued the government of South Africa to prevent the implementation of a law designed to facilitate access to AIDS drugs at low cost. They accused South Africa of circumventing patent protection guaranteed by intellectual property rules in trade agreements, and only dropped the suit three years later due to adverse publicity in the media (Barnard, 2002).

For a number of years, antiretroviral drugs (ARVs) were much cheaper in countries where generic versions were available, yet the South Africa government was seen as reluctant to act against the patent holders of the ARVs by enforcing compulsory licensing (TAC, 2008). Civil society, through groups such as the Treatment Action Campaign (TAC) and the AIDS Law Project, led the fight for affordable ARVs through various approaches, including court challenges and importing the drugs from countries such as Brazil and India (TAC, 2008). In one of its most successful initiatives, TAC, with Medicines Sans Frontier (MSF), started a programme to deliver ARVs to communities around Cape Town, starting with a pilot project in Khayelitsha. The initial drugs were from Brazil, at a fraction of what they then cost in South Africa. Ultimately, government was forced to accept generics through enforced compulsory licensing. Civil society was also instrumental in increasing access to ARVs by HIV positive pregnant women for prevention of mother-to-child transmission through a High Court ruling that stated that it was the government's responsibility to provide such drugs (Njoroge, 2002)

In a 2007 case lodged with the Competition Commission, TAC challenged Merck and Co and its South African partner, MSD (Pty) Ltd, over exclusive rights to sell the ARV efivarenz in South Africa through their holding of patent no. 93/5727, which is supposed to expire only on 6 August 2013 (TAC, 2007). The challenge followed the perceived refusal of Merck and Co. to license other pharmaceutical manufacturers to manufacturer and/or import generic versions of efivarenz. Part of the basis for the challenge was the wide-raging nature of the patent, covering all pharmaceutical compounds containing efivarenz, its use in the treatment of HIV/AIDS, its use in combination with ARVs medicines such as AZT, didanosine (ddI) and zalcitabine (ddc) and the process of synthesising efivarenz (TAC, 2007). At the time we completed the review, the Competition Commission had not yet delivered its verdict on the case.

As shown in the cases above, the private sector (in terms of NGOs) has been an effective change agent in ensuring public sector access to and availability of essential medicines, in spite of the hurdles imposed by international trade rules and obligations. Before the provision of ARVs in the public sector, most South African patients on that treatment were those in the private sector, and about half of the estimated more than 230,000 currently receiving ARVs do so through the private sector (JCSMF, 2007).

3.4. Public-private initiatives (PPIs)

Public-private initiatives (PPI) are *'public-private Interactions in terms of which one or more persons or entities involved in health care within the public sector interact with one or more persons or entities involved in health care within the private sector or the NGO sector with the object of achieving a mutual benefit or goal and includes but is not limited to a PPP. PPIs include: public financing of health services provided by the private and/or NGO sectors; private financing of publicly provided health services; innovative healthcare delivery models and business models for health practices; delivery models aimed at skill retention and effective distribution and utilisation of skills; use of public assets for the provision of health services by the private sector; [and] use of private assets for the provision of health services by the public sector' (Charter of the Public and Private Health Sectors of the Republic of South Africa, undated:10).*

The South African health system has a long history of public-private sector interaction, such as the care of TB and psychiatric patients, which was contracted out to for-profit and non-profit organisations. While South Africa spends 8.5% of GDP on health care, its health indicators are poor, and the country scores poorly on health system efficiency (Tandon et al, 2005). That inefficiency is partly due to fragmentation between the public and private sectors, which does not allow the efficient use of available resources, pointing to the need

for public-private initiatives (PPIs, *Box 4*) to optimise use of the resources (Wadee et al, 2003b).

PPPs in health are part of the broader government national policy of public-private initiatives, under the guidance of the national treasury. Some of the provinces developed PPPs, e.g., the Northern Province (1997), Eastern Cape (1997) and Western Cape (1998), ahead of the national department guidelines which were drafted in 1999 and finalised in 2000 (Wadee et al, 2003b). The treasury first published the Public Finance Management Act (PFMA) to improve public sector efficiency, which then provided a PPP strategic framework adopted by cabinet for use by all provincial departments. According to National Treasury (2001) a PPP is a contractual agreement in which a private party delivers a service or performs a function for the public sector with the private sector assuming the risks associated with the delivery or function. The main tenets of the PPP guidelines are transfer of risk to the private sector, affordability and demonstrable value-for-money (National Treasury, 2001).

The government's purported rationale for PPPs is informed by the need to share risks with, or transfer risks to, the private sector, increase revenue for the public sector, increase efficiency for service delivery, and utilise private sector knowledge, skills and resources to improve public sector service delivery and close the gap between private sector and public sectors. Some of the legislative and policy developments that have provided a conducive environment for public-private interactions include the National Health Plan (ANC, 1994) which recognised the role of the public and private health sectors, and included a plan for a national health insurance fund (NHI) and the 1997 White Paper for Health Transformation, which expressed the need for well coordinated public-private sector interactions.

Private subsidies to the public sector may occur through out-of-pocket payments (user fees), medical scheme reimbursement for private patients treated in public facilities, and the leasing out public facility beds and wards to private providers for the care of their patients. That may lead to cross subsidy between high and low income patients (Doherty et al, 2002; Wadee et al, 2003a). In reality, however, government resources subsidise the private sector on many levels. Firstly, medical scheme contributions by private companies are tax deductible, so private sector employers are rewarded for funding private health care. Secondly, general tax revenue goes into medical schemes through government contributions (as employer) for civil servants. Thirdly, health worker training is heavily subsidised, and yet most of those workers service the private sector (Wadee et al, 2003b; GEMS website, 2007)

Partnerships on Workplace Policies in Health (WPP) is another area through which PPIs are effected. Fourie and Vogel (2005) reported on WPPs in which the German technical Cooperation (GTZ) worked with four companies to develop and implement WPPs on HIV/AIDS from 2003 to 2005. By 2005 all four companies HIV/AIDS WPPs had been successfully introduced and well established, despite great differences in organisational character and workforce profile between the companies. In all of the four companies, essential elements of the WPP concept as proposed by GTZ, were introduced, including successful anonymous HIV prevalence studies (Fourie and Vogel, 2005). The main lessons and experiences from the three-year experience by GTZ are summarised in *Box 4* below.

Wadee et al (2003b) identified five PPIs in health care: joint ventures, including leasing of space or space capacity, purchasing of clinical services, e.g. from independent practitioner associations, outsourcing non-clinical services (at reduced cost, with better quality and efficiency), private finance initiatives (PFIs) including leases and concessions, and public subsidisation of private services, e.g. through ownership transfers. They suggested a framework for PPIs in the health system which identifies formal dialogue, informal dialogue and policy formulation/implementation as falling under 'managing relationships', and purchasing services, outsourcing services, joint ventures, private finance initiatives, and PPPs as falling under 'supporting service delivery' (ibid).

Box 4: Lessons learnt from WPPs

A number of lessons have been learnt from WPPs:

- The concept of the HIV/AIDS WPP and its four components (Awareness and IEC, Integrated Health Care, Risk Management and Community Involvement) should be adapted to the company environment and workplace reality.
- Messages on prevention and communication processes should be in line with the needs of specific company profiles, and with the mentality of the workforce in order to increase effectiveness.
- The promotion of VCT to the workforce in order to determine each individual's HIV status is widely supported and appreciated.
- There is a lower than expected HIV prevalence amongst employees in the companies. The studies provided strong arguments to counter the wide-spread perception of AIDS as a "disease of 'black' workers"; even the predominantly 'white' management staff had substantial infection rates in most of the companies.
- Though community activities are an important part of the WPP, defining a close link between company and community remains difficult.
- The PPP project for WPPs substantially contributed to the national response to the HIV/AIDS challenge, through the prevention measures and increased access to treatment which have implications for economic and social survival of individuals and families.

Source: Fourie and Vogel, 2005

Public-private partnerships (PPPs) are a common form of PPIs; some of the often used one are summarised in *Box 5*. The examples of PPPs in the health sector that follow are drawn from national treasury data (Treasury Department, 2006). Limpopo Province has several PPP arrangements, including one for Phalaborwa and Maphuta Malatji Hospitals. For Phalaborwa Hospital, the private sector undertook to upgrade and operate the entire hospital, and to build and maintain a new clinic, while Maphuta Malatji Hospital was to be operated by the provincial department of health after renovation by the private sector. Both Ellisras Hospital and the Polokwane Renal Unit are in co-location agreements. Part of Ellisras Hospital is to be used by a private provider, while the Polokwane Renal Unit is to be extended and upgraded, and then operated by the private sector. Renal services will continue to be provided to public patients, alongside private patients. The department also has an agreement for laundry services at 43 health centres and all clinics in the province.

In KwaZulu Natal Province, the Inkosi Albert Luthuli Hospital was set up under a 15-year, R4.5 billion DFBOT PPP with Impilo Consortium. The province (public sector) took care of the construction while Impilo furnished the hospital with state-of-the-art equipment.

In the Free State Province, a PPP was established between the province and a consortium of Community Health and Netcare group for co-location of Universitas and Pelonomi hospitals. The agreement is worth R43 million (cash) in a DFBOT arrangement over 16.5 years plus R38 million in upgrades. Other PPP arrangements in the Free State are co-location of Trompsburg and Ladybrand hospitals.

The State Vaccine Institute, a national institution, entered a four-year PPP with Biovac Consortium, in a deal worth R15 million. That resulted in the formation of the Biovac Institute which was launched in 2003, 'with a view to restructure and upgrade the former state vaccine assets, ensuring South Africa has the required capacity to respond to its vaccination needs, as well as those of the rest of Africa' (Biovac, 2007).

Box 5: Commonly used PPPs in health

Some commonly used PPPs in health are:

- **Build Operate Transfer (BOT):** The private sector builds and operates a new facility for a given period of time and then transfers it to the public sector at the end of the concession period.
- **Build Transfer Operate (BTO):** The transfer of the facility to the government takes place as soon as the construction is completed, rather than at the end of the concession period.
- **Revitalise Operate and Transfer (ROT):** The private sector can rehabilitate the existing public health facilities at its own risk, and then operates and maintains the facility at its own risk for a given period, e.g. Pelonomi Hospital, Free State Province.
- **Design Finance Build Operate and Transfer (DFBOT):** The private sector is involved in all the stages up to operation, e.g. Inkosi Albert Luthuli Hospital, Kwa-Zulu Natal.
- **Hospital co-location** involves the leasing of space capacity to private sector providers or sharing underutilised public/private resources, e.g. private radiology services using public facilities in some hospitals in Gauteng Province, Universitas Hospital in Bloemfontein, the Renal Unit at Polokwane Hospital, and Ellisras Hospital.

Sources: Wadee et al, 2003b; Thom, 2007

In the Eastern Cape Province, a PPP was established between Humansdorp District Hospital and Metrostar Hospital Ltd, in a deal valued at R18.9 million to the government, with R15 million for upgrade and a further R34 million during the course of the partnership. The province also has had a PPP for transport since 2003. A review of the transport PPP in 2006 (Hall et al, 2006) found that there was better satisfaction with the privately provided transport, though comparison of the effectiveness and efficiency of the transport system prior to and after the introduction of the PPP was not possible due to lack of baseline data (ibid). Some of the results of the transport PPP in the Eastern Cape were improved quality of the vehicles used for health sector service, shorter down time, improved responses to the needs, preference for rural and previously disadvantaged areas with more vehicles and mobile clinics, and the availability of vehicles on ad hoc basis for special programmes. Customer satisfaction rate was 91% in the second quarter of 2005 (ibid).

Remunerated work outside public service (RWOPS) is a form of joint venture, where the health workforce is shared between the two sectors. Government has a policy on RWOPS but its application is variable across the provinces. Nonetheless, it has been shown to encourage health workers to stay in the public service (Wadee et al, 2003b).

Private finance initiatives (PFIs) are used to raise capital through private money markets, which money may be used for building new facilities, or to revitalise existing ones, e.g. Chris Hani Baragwanath Hospital (Gauteng Province) and King Edward Hospital (Kwa-Zulu Natal) or may be used to buy equipment as happened in Inkosi Albert Luthuli Hospital (ibid). Wadee (2003b) interrogated various stakeholders on their motivation for involvement in PPIs – the NDoH, provincial DoH, private funders, private hospitals and trade unions. The reasons advanced by various stakeholders are summarised in *Table 11*.

The largest private hospital group in South Africa, Netcare, is involved in a number of PPPs. These include the Universitas/Pelonomi Hospitals PPP, which has been referred to above, the largest healthcare PPP in the country, with a co-location concept with the medical school, through a 16-year contract endorsed by the state treasury department. A number of Netcare tertiary facilities have academic status and are involved in the learning activities of various health professionals, including doctors and nurses training in six centres for the latter. In Bronkhorstspruit, Netcare outsources beds for State patients. Netcare also offers emergency services through various contract arrangements in many provinces. In addition, Netcare is a source of dialysis services through Renal Care (Netcare, 2007).

Table 11: Reasons given by various stakeholders for PPI involvement

Stakeholder	Reasons advanced
National Department of Health	· Strengthening the health system · Cost containment · Revenue generation · Improving equity of financing · Improving access · Improving efficiency
Provincial Department of Health	· Improve efficiency · Improve equity · Improve quality of care · Strengthening the health system · Revenue generation · Capacity building · Staff retention
Private funders	· Reduce costs · Improve access · Improve efficiency · Strengthening the health system · Profit · Enhancing trust between public and private sectors
Private hospitals	· Enhanced efficiency · Improved perception of the private sector · Profit · Enhancing trust between public and private sectors
Trade unions	· Support the public sector · Improving equity · Protecting the workers

Source: Wadee et al, 2003b

Given the wide array of PPIs in the health sector, a blanket assessment of their impact is not feasible, as these impacts may be diverse. A critical analysis of such impact is made the more difficult by the fact that most of the initiatives are fairly new and what one finds in the literature is reference to 'successful' operation of the public-private arrangement without hard data on 'how successful'. There was reportedly improved quality of transport services in the Eastern Cape, better quality of clinical services at Pelonomi, and anecdotal evidence of better services (and higher capacity) at the Polokwane Renal Unit. Evidently, there is a need to systematically document the impact of PPIs as more are being rolled out.

4. Discussion

The South African health system is made up of both a public and a private sector, with total expenditure on health at 8.7% of GDP (WHO, 2006). The public sector is funded from general tax revenue, through the national budget with provincial departments of health as the main intermediaries (Blecher and Harrison, 2006). It caters for the majority of the population, namely 61.2% of consultations (GHS, 2006), but utilises only about 40% of resources available for health. Private health sector funding is largely from voluntary contributions to medical schemes and also through out-of-pocket payments. The private health sector caters for less than 20% of the population, mainly the medical scheme beneficiaries and those who are able to pay out of pocket at point of service (ibid). Government contributes significantly to private sector funding through medical aid costs of civil servants (National Health Accounts, 2002). About 10.5% of households incurred catastrophic expenditure through out-of-pocket payments for health services in 2003 (Lamiraud et al, 2005), compared to only 0.3% who faced catastrophic expenditure in 1995

(Xu et al, 2003), which indicates that there is an increasing proportion of the population who are not benefiting from the improvements in the health sector since 1994.

Since 1994 much has been done to redress the apartheid legacy of fragmented, racially biased health service delivery (Hirschowitz and Orkin, 1995), with expansion of health facilities in both public and private sectors. Health care services have become more accessible, as shown by the 2006 GHS. In the public sector, there has been a redistribution of public sector funding from hospitals to lower levels of care (National Health Accounts, 2002). However, racial inequalities remain in access to medical aid, and therefore access to private health care services, proportionately fewer 'whites' utilise public services compared to 12 years ago.

The geographical distribution of public sector services has become more equitable with the expansion of primary health care facilities in all the provinces, but a significant proportion of people survey in the 2006 General Household Survey cited distance to health facility as a barrier to access to health services (GHS, 2006). The trend of distribution of health care funding in the public sector shows a tendency towards equity, with the disparities in per capita health expenditure narrowing between the provinces (*Table 8*). The distribution of private sector resources, however, is largely concentrated in the richer provinces, and within the poorer ones in urban centres. Private capital tends to follow the hierarchy of wealth. The Eastern Cape, for instance, has many private hospitals but most of them are within the (large) urban centres such as Port Elizabeth and East London. Limpopo Province, one of the poorest and most rural provinces, has only two private hospitals.

Equity in health care financing implies fairness. The trends in South Africa show higher per capita expenditure on health in the private than public sector. Moreover, government spends about 12 times more on civil servant per capita medical aid contributions than on the public sector dependent population (Doherty et al, 2002). That coupled with the fact that medical aid contributions are tax deductible means government is subsidising even private companies through the tax rebates. It has been shown that up to 42% of the population use private sector services, compared to 13.2% who have medical aid cover, hence a large proportion of households pay out of pocket. Whereas there have been significant gains in expanding access to health for the most vulnerable population (children, pregnant women and the elderly), the question needs to be asked whether or not it is fair for government to subsidise heavily those on medical aid when there are sections of the population who face catastrophic health expenditure. By launching GEMS where government pays the medical aid contributions into the government scheme without having to pay the private medical schemes, and covering those employees previously excluded from medical scheme membership with full subsidy, government has made a bold step towards equity. Still, something needs to be done for those who are not on GEMS and may have to face out-of-pocket payments for health services.

Government has been consistent in its determination to deliver quality health services to all, starting with the inclusion of the right to health care in the Constitution, the White Paper on Health Transformation, the Medical Schemes Act provisions and the National Health Act, all of which had equitable access to health services as a core value. Some of the laws government has in place, e.g. the National Health Act 2003, which contains a provision for a certificate of need, are not yet fully operational, while some, such as those on drug regulations, have been put in abeyance due to court challenges, so it is difficult to know how effective they will be when (eventually) they get implemented. The future of South Africa's health financing includes the possibility of national (social) health insurance to reduce reliance on tax revenues. One of the problems so far identified seems to be that countries in which social health insurance has worked are at different socio-economic development stages than South Africa, and so attempts to adapt their approaches have proved unsuccessful so far. The other issue under consideration is the Risk Equalisation Fund

(REF) (Rakoloti, 2007). REF has also been in development for some time now but is yet to be established due to uncertainties on various issues, such as whether it would be based on retrospective or prospective earnings of the medical schemes, reliance on the Council for Medical Schemes to administer it, and the fact that it will be based on calculations made ahead of expenditures (Twine, 2007).

The potential exists for synergies between the two health sectors, to maximise the strengths and resources of each sector – e.g. underused ward space in public sector being used by the private sector through co-location arrangements, and the capacity of the private sector to mobilise capital, as was the case with equipping Inkosi Albert Luthuli Hospital in KZN. The proliferation of PPIs needs to be monitored, and various partnership arrangements evaluated given the varying interests between different stakeholders in PPIs (Wadee et al, 2003b, *Table 10*) – the private partners are driven by profit while the public sector interests are largely driven by equity, efficiency and access. Due to the relatively recent introduction of the policy on PPPs by the national treasury, and also the fact that many of the initiatives are at a formative stage, careful design followed by monitoring and evaluation will be needed to realise the promise of PPIs.

5. Conclusion

The private health sector in South Africa is vibrant with more than 50% of total health funding spent on private health care. As noted by Chetty (2007), South Africa still faces major challenges in addressing inequities, but equity is high on the health and social policy agenda and a range of specific policies and programmes have been developed towards the equity goal. These include re-distributing public sector health care resources between and within provinces and improving access to primary care services. The expansion of the private health sector in South Africa poses new challenges to address the public/private mix to ensure that the resources of the private sector contribute to improved health care access and equity. The evidence in this paper suggests that there is need to improve geographic access and to address the inequities in health care financing between the public and private sectors. Further areas such as the concentration of private capital in the health sector and various dimensions of cost increase noted need to be further explored for their impact on access to health services in both public and private sectors. There has been an expansion of public-private initiatives, but the impact of these is yet to be effectively evaluated. This calls for more effective monitoring of and reporting on the public –private mix as a guide to future planning.

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Acronyms

AIDS	acquired immunodeficiency syndrome
ARV	anti-retroviral
BHF	Board of Health Care Funders
BOT	Build Operate Transfer
BTO	Build Transfer Operate
CMS	Council for Medical Schemes
COIDA	Compensation for Occupational Injuries and Diseases Act
DFBOT	Design Finance Build Operate and Transfer
DoH	Department of Health
EQUINET	Regional Network for Equity in Health in east and southern Africa
FBO	faith-based organisation
GATT	General Agreement on Tariffs and Trade
GDP	gross domestic product
GEMS	Government Employee Medical Scheme
GHS	General Household Survey
GP	General Practitioner
GTZ	German technical Cooperation
HASA	Hospital Association of Southern Africa
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HST	Health Systems Trust
ISER	Institute of Social and Economic Research, Rhodes University
NDoH	National Department of Health
NGO	non-governmental organisation
OHS	October Household Survey
PFI	private financing initiatives
PHC	primary health care
PLWHA	people living with HIV/AIDS
PPI	public-private interactions
PPP	public-private partnerships
RAF	Road Accident Fund
REF	Risk Equalisation Fund

ROT	Revitalise Operate and Transfer
SANC	South African Nursing Council
SAPC	South African Pharmacy Council
SHI	social health insurance
TRIPS	Agreement on Trade-related Aspects of Intellectual Property Rights
UNDP	United Nations Development Programme
WHO	World Health Organisation
WHO AFRO	World Health organisation Africa Regional
WPP	Workplace Policies in Health
WTO	World Trade Organisation

Acknowledgements

This paper was written with financial support from the Southern Africa Health Trust, IDRC Canada and SIDA Sweden through the ISER-EQUINET Programme of work. We are grateful to ISER for the excellent coordination, and acknowledge the guidance and support received from Katie Farrington throughout the project. We thank the reviewers, Rene Loewenson and Richard Saunders, for their valuable comments on an earlier version of this paper, participants at the workshop in Bagamoyo, Tanzania (February 2008) for the fruitful discussions, and our colleagues in the Department of Pharmacy for their cooperation and patience during the study.

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

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