Rural Health Advocacy Project

Protecting Rural Healthcare in Times of Economic Crisis
There is Another Way
An Overview

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Acronyms

CHW	Community health workers
CMBS	Constitutionally Mandated Basic Services
ICESCR	International Covenant on Economic, Social and Cultural Rights
IGFR	Intergovernmental Fiscal Relations
NDoH	National Department of Health
NHA	National Health Act
OHCHR	Office of the United Nations High Commissioner for Human Rights
PAYE	Pay as you earn
PHC	Public healthcare
RHAP	Rural Health Advocacy Project
UHC	Universal health coverage
UNHRC	United Nations Human Rights Council

Protecting Healthcare in Times of Economic Crisis

An Overview

Introduction

South Africa, unlike many other countries, was able to weather the initial impact of the 2008 global financial crisis. However, as the country's economy faltered, health expenditure started flat lining from 2012.

Despite modest annual increases averaging around 2,5 % per year, the actual budget for healthcare per person is shrinking. Higher-than-inflation cost increases in human resources and medical products, as well as growing health needs in a context of declining government revenue has led to the implementation of austerity measures in the health sector.

The Rural Health Advocacy Project's (RHAP) 2015 report on the causes and implications of the moratoria on the filling of vacant posts in the public health sector we found that the practice was largely informed by budgetary constraints. After a long period of denial, findings of that report have since been confirmed by the National Department of Health (NDoH) as well as by a ministerial task team investigating service delivery in public health facilities across the nine provinces.

The introduction of a National Health Insurance (NHI) is set to reorganise the manner in which healthcare is delivered, but the extent of this reorganisation requires significant amendment of current legislation. It is likely to take at least another five years to implement the institutional arrangements needed to fully implement NHI. Until then, the primary challenge will be about balancing a shrinking fiscus as a result poor economic growth on the one hand, with lower tax revenue projected with the attainment of universal health coverage on the other hand.

Understanding how to respond to austerity in a manner that protects health gains and the worst-off and which makes best use of available resources is critical. With this in mind, RHAP has published a report titled: *Protecting Healthcare in Times of Economic Crisis.* The report presents a blueprint which demonstrates that resilient government systems and structures are key to protecting the most vulnerable in society and how this can be achieved. It explores various remedial interventions implemented in countries with a similar demographic and economic profile to ours. It highlights how some governments successfully managed to navigate the difficult journey of cutting expenditure while protecting critical areas of service delivery, and asks what South Africa can learn?

Causes and Effects of Austerity

The global financial crisis of 2008 posed the most significant challenge to financial markets and state economies since the Great Depression of 1929.

Such downturns have a knock-on effect on the health and wellbeing of populations – as economies come under pressure, incomes decline together with government revenue from various direct (PAYE) or indirect (VAT/fuel levies) taxes and surcharges.

Businesses get caught in this downward spiral too. As the number of customers declines, businesses generate less income, employ fewer people, and ultimately pay less tax. While this is an oversimplification, the point is that an economic crisis inevitably results in less money for governments to spend on social services, while unemployment forces them to provide more services with diminishing resources.

The extent and effects of austerity are further worsened by internal inefficiencies within the country; caused by corruption, wasteful expenditure and irrational decision-making on the efficient use of available funds to achieve equitable and improved health outcomes for the population.

A Complex Relationship

The relationship between economic crisis and poor health outcomes is complex. A review of health spending trends in 128 developing nations after the 2008 economic crisis found that spending declined by an average of 3% of GDP in these countries between 2008 and 2010 (Ortiz, Chai and Cumming (2011). These cuts in health and associated expenditure consequently meant greater rationing of essential care.

In many developing countries, declines in government revenue from domestic sources is further compounded by diminishing foreign financial assistance for health programmes. As revenue in these donor countries comes under increasing pressure, their willingness to contribute to development aid diminishes.
The effects of economic crisis on the social determinants of health (income, education, social status, poverty, etc) are more immediate. Rising unemployment and declining incomes have consistently been shown to reduce access to basic nutrition, increase abuse of alcohol, escalating incidents of violence and worsen mental health outcomes. The incidence of non-communicable disease also rises.

In the developing world, children seem particularly vulnerable to both long and short-term negative health outcomes associated with the financial crisis (Hossain and McGregor, 2011). Research from sub-Saharan Africa suggests that there were between 25,000-50,000 additional infant deaths in 2009 that were directly attributable to the financial crisis (Friedman and Schady, 2013).

Recent evidence suggests that one of the primary contributing factors to ill health in children during times of financial crisis is a substantial reduction in the intake of food and vegetables (Hall and Perry, 2011). Not only does a shortage of fresh fruit and vegetables affect the immediate wellbeing of children, but it also has long-term consequences for physical and cognitive development.

Global Healthcare Spending Before and After 2008

Over the past 20 years, global health spending has tended to outpace inflation with real per capita spending increasing by on average 3% per year between 1995 and 2014 (OECD, 2015a). Even though the rate of this increase slowed from an average annual growth rate of 5% before 2008 to an average of approximately 1% between 2009 and 2014, it remained positive (World Bank, 2017).

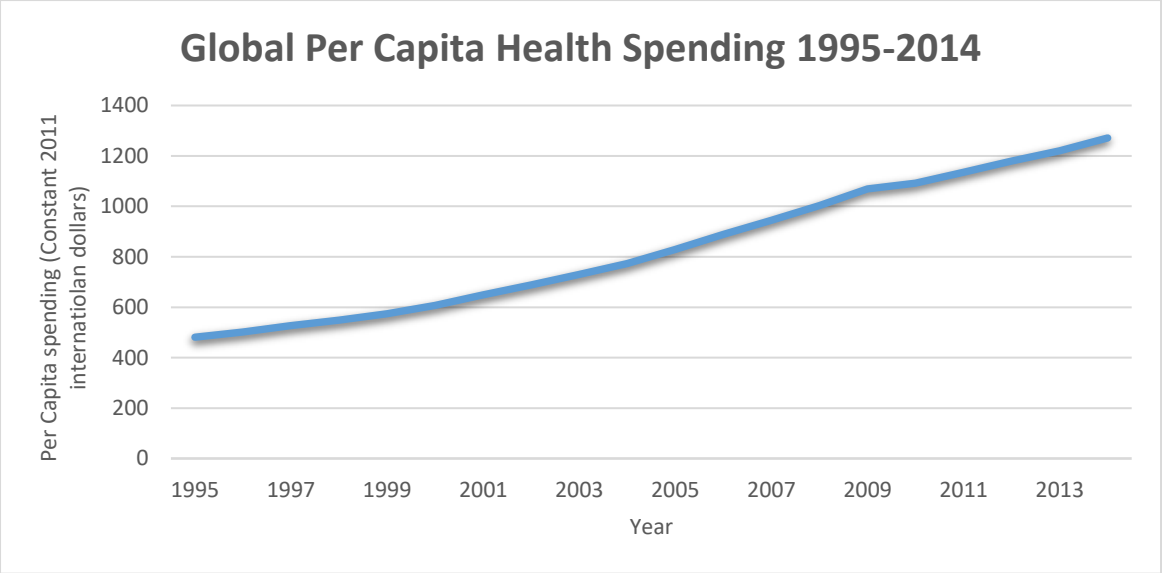


Figure 1: Per Capita Global Health Spending (Source World Bank, 2017)[1]

Despite population increases, per capita growth from global health spending has continued to increase in real terms since 2009, but growth in spending as a proportion of GDP stagnated (Figure 2). This trend is particularly pronounced, says the Organisation for Economic Cooperation and Development (OECD), where health spending as a proportion of GDP had been climbing significantly before the crisis (Figure 2), indicating that growth in health spending now tracks economic growth more closely than it did before the crisis (OECD, 2015). As a result of this low growth scenario, we see that health spending focuses on maintaining existing services and infrastructure, without expanding service delivery to address unmet needs.

[1]Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.

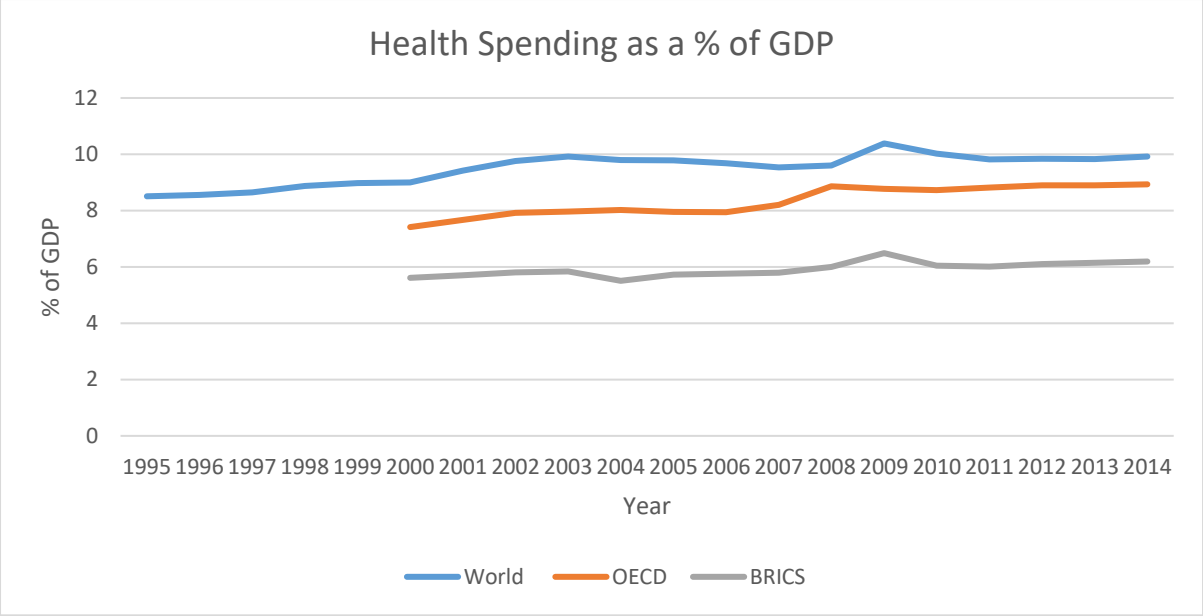


Figure 2: Global Health Spending as % of GDP 1995-2014

The problem with aggregate data is that it fails to communicate the diversity in individual government responses to the financial crisis and the impact these responses have had on health spending at the national level. The OECD is particularly instructive in this regard; per capita spending increased but when assessed at a country level approximately one-third of countries experienced a real average decline in per capita spending (Figure 3).

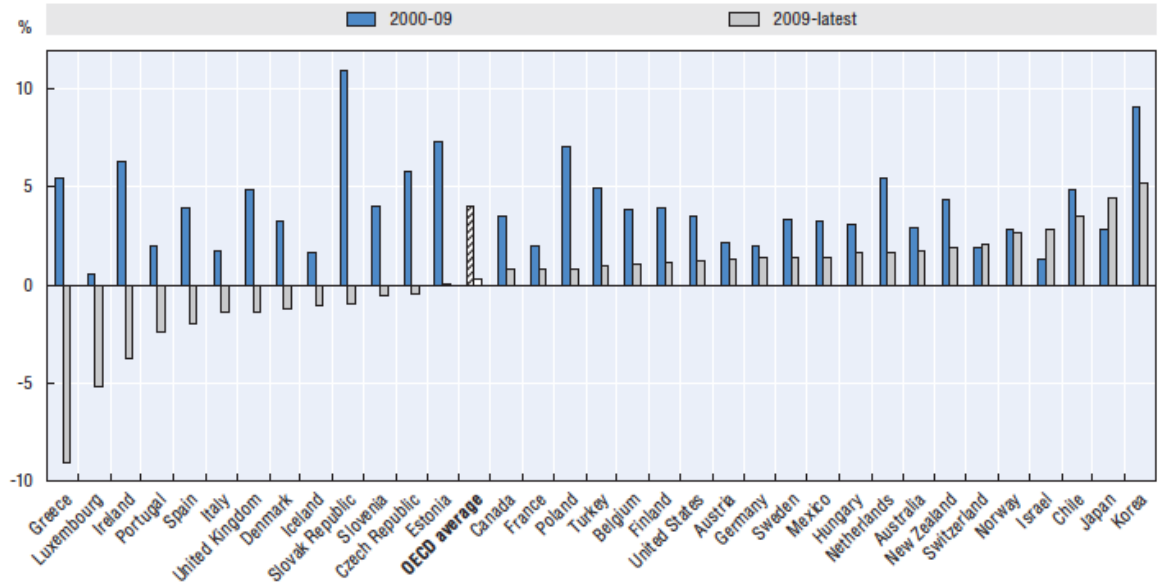


Figure 3: Average Annual Growth Rates in Real Health Spending Per Capita (Source: OECD, 2015)

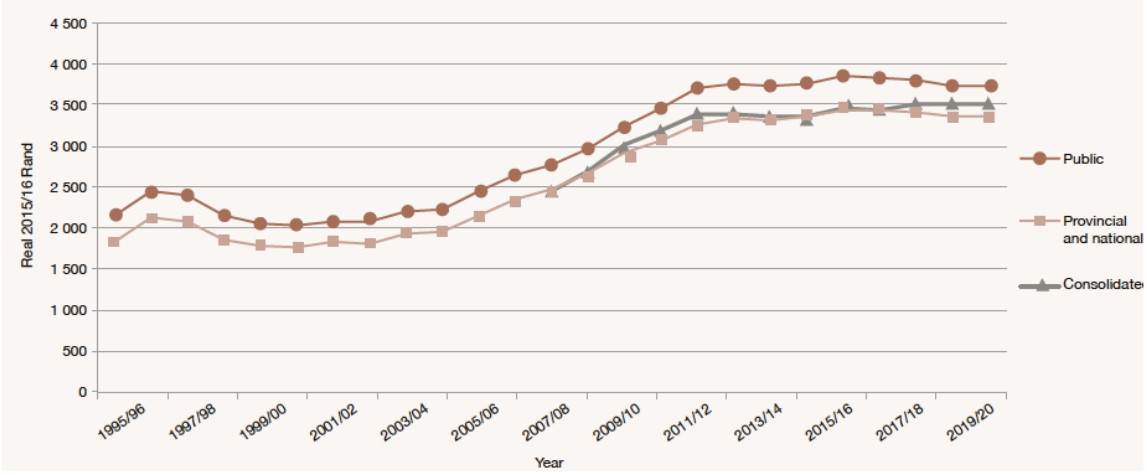
If we compare Greece to Japan for instance, we note particularly divergent approaches to health spending during an economic crisis. Greece turned a more than 5% annual growth rate in per capita spending between 2000 and 2009 into an almost 10% annual decline following the crisis – a 10 percentage point turnaround (Thomson et al., 2014). Japan, on the other hand, managed to increase its annual average growth rate in public health spending by two percentage points following the crisis (OECD, 2015a).

Where are we now? Fiscal Sustainability in South African Healthcare

Since 2011, the South African government has committed to far-reaching reforms on how healthcare is organised, financed and provided. These reforms, through the envisaged NHI are meant to radically restructure the country's healthcare network over the next decade to deliver universal access to health for all.

Healthcare Spending in South Africa Before and After 2008

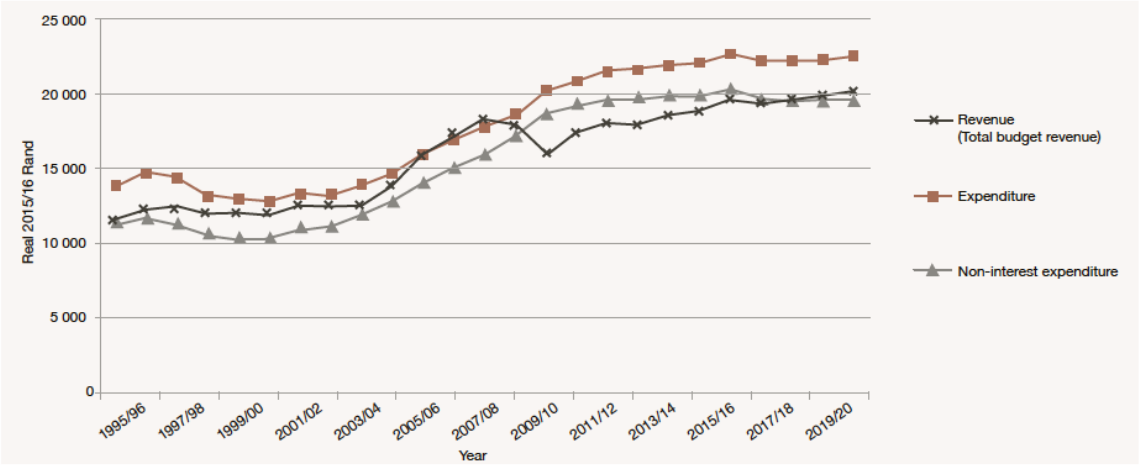
There has been substantial and sustained real growth in healthcare expenditure in South Africa between 2000 and 2012. In 2001/02 South Africa spent approximately R33 billion on health in the public sector. By 2015/16 this had increased to more than R171 billion (Blecher et al., 2017), which in real terms means that spending more than doubled. On a real per capita (uninsured) basis, spending in the public sector increased from approximately R2000 per capita to approximately R3800 per capita (Figure 4).



Source: Authors' calculations using National Treasury data.[f]

Figure 4: Per Capita Healthcare Spending (Public Sector) South Africa 1995/96-2019/20 (Blecher et al., 2017)

Although the economy was hard hit by the financial crisis, government honoured its commitment to increase health spending and between 2009/10 and 2012/13 allocations grew by between 8.5% and 10.5% in nominal terms.



Source: Compiled by authors based on Budget Review series for 2006/07–2017/18[6] and the MTBPS 2016.[5]

Figure 5: Government Revenue vs Spending 1995/96-2019/20 (Blecher et al., 2017)

However as Figure 5 shows, growth has declined after 2012/13 to near stagnation.

The South African economy has continued to struggle due to several structural and political issues, resulting in a slow and continuously faltering return to economic growth. Government has therefore had to increase its borrowings to sustain investment in key areas of the economy and essential basic services. Increases in non-interest spending have slowed significantly as the budget deficit has grown (Figure 5).
While healthcare spending has remained a priority, growing by an average of 2.3% in real terms since 2012/13, this has been insufficient to meet service delivery costs that continue to outstrip inflation. Above inflationary increases in human resources costs (without concurrent increases in personnel numbers) and the rapid increase in investment in the country's HIV/Aids programme has been the main budgetary pressure (Figure 6).

Government has consequently implemented a range of austerity measures in the public health system to contain costs. Since human resources are, by some margin, the most significant and fastest growing component of the health budget, this area of spending has been subject to numerous cost-saving exercises and over the last years posts in the public healthcare system have been frozen or cut at facility level[2].

[2] http://rhap.org.za/rhap-response-ministerial-task-team-committee-report-investigation-service-delivery-select-hospitals/

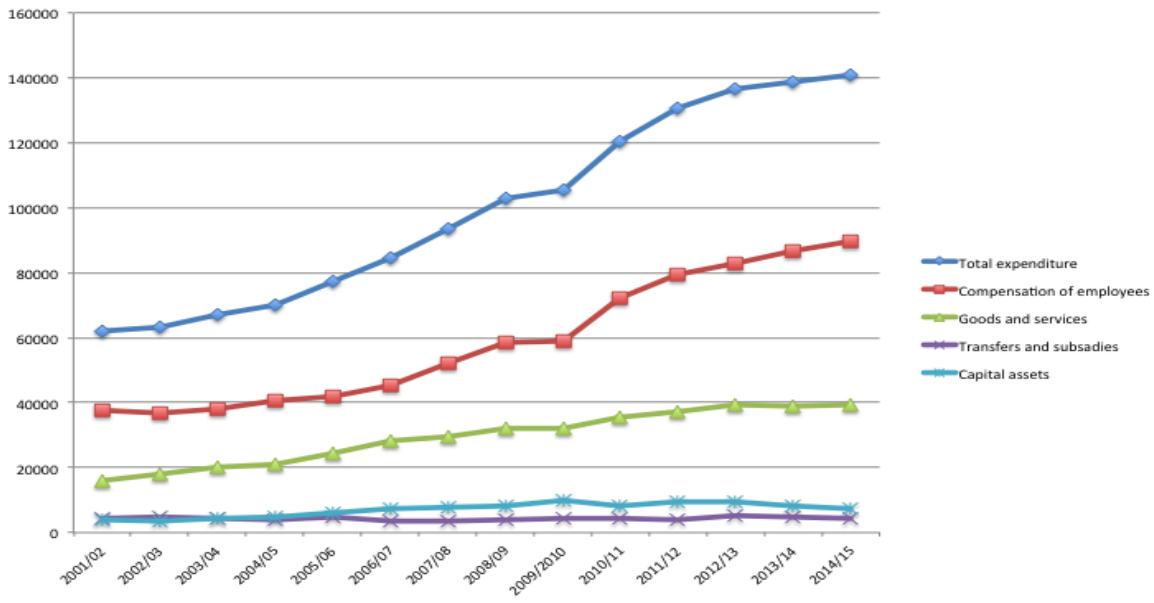


Figure 6: Consolidated Provincial Health Spending by Economic Classification South Africa 2001/02-2014/15 (RHAP, 2016)

Best Practice Options for Health System Reform

Balancing health system priorities such as promoting access, efficiency and equity with issues of fiscal sustainability and the pressure to cut costs is complex. It is therefore important to understand both what has worked and what has not in trying to achieve fiscal sustainability while broadening access to services and promoting equity.

Three cases studies are highlighted in this overview. Additional case studies are available on request.

Case Study: From Progress Towards Universal Health Care to Two Decades of Austerity – How Two Years of Political Turmoil in Brazil Can Undo Three Decades of Progress

Brazil is viewed by many, including the South African government, as the most appropriate comparison with South Africa in terms of its present socio-demographics and its membership of the Brazil, Russia, India, China and South Africa (Brics) trading block. Unfortunately, both countries also have an unflattering similarity when viewed against the gini co-efficient – indicating the widest gaps between wealthy and poor.

Brazil's health system also has a complex history of development and reform that has closely followed broader political, social, and economic change, very much like South Africa.

The Dictatorship Years: 1960s and 1970s

Reforms focused heavily on the privatisation and fragmentation of health care in Brazil. Between 1970 and 1974, for example, public funds were used to recapitalise and develop new private hospitals. At the same time, the government removed health insurance subsidies, replacing them with tax credits with the aim of promoting a move to private insurance schemes.

While some provision was made for subsidised primary health care for the indigent population, most care at this time was provided on a fee-for-service basis. By the late 1970s Brazil's health system was largely market-based with little protection for those with no access to private healthcare insurance.

Brazil's economic crisis of the early 1980s and a growing push towards democratisation drew health care reform aimed at broadening access to care to the forefront of the political agenda. By the mid-1980s plans were well underway to creating a state-funded unified health system. The *Sistema Único de Saúde* (SUS) was launched in 1988 with an express commitment to the realisation of the right to health care and the responsibility of the state to fund and provide that care.

One of the key features of SUS was the decentralisation and democratisation of health systems. Reforms gradually shifted the responsibility of administering and delivering care to municipalities with the central government taking responsibility for funding and oversight. Notable improvements have been:

- Vastly improved access to primary and emergency care;
- Universal access to vaccination and prenatal care;
- The expansion of human resources and technology; and
- Domestic production of essential pharmaceuticals.

The expansion of access to services, particularly PHC and outreach services, dramatically improved access to healthcare services and outcomes for all Brazilians (Table 1).

	Before 1985	1986[14]	1996[13]	2006–07[12]
Any contraceptive use in women living with their partner (%)	..	65·8%	76·7%	80·6%
Modern contraceptive use in women living with their partner (%)	..	57·0%	72·0%	78·5%
Pregnancy and delivery care (5 years before survey)				
Any antenatal care (% of all women)	74·7% (1981)[79]	74·0%	85·7%	98·7%
Antenatal care (>six visits; % of all women)	40·5% (1981)[79]	..	75·9%	80·9%
Started antenatal care during first trimester of pregnancy (% of all women)	..	..	66·0%	83·6%
Received ≥one dose of tetanus toxoid vaccine during pregnancy (% of all women)	..	..	58·5%	76·9%
Institutional delivery (%)	79·6% (1981)[79]	80·5%	91·5%	98·4%
Caesarean section delivery (%)	24·6% (1981)[79]	25·4%	36·4%	43·8%*
Vaccine coverage for children aged 12–23 months (informed plus confirmed doses)				
Measles vaccine (%)	16% (1975);[53] 56% (1980)[53]	79·4%	87·2%	100%
Diphtheria, tetanus, and pertussis vaccine (%)	20% (1975);[53] 37% (1980)[53]	68·9%	80·8%	98·2%
Other health-related indicators (all children younger than 5 years)				
Oral rehydration solution or recommended home fluids (%)	0% (not yet implemented)	10·9%	53·6%	52·1%
Received care for cough or fever (%)	..	..	18·2%	52·0%
Public water supply (%)	32·8%[82] (1975)	..	78·7%	81·8%

For the first column (Before 1985), the year in which data is from is given in parentheses. ..=data not available. *The survey-based estimate of caesarean sections is slightly lower than that reported by the Live Births Information System.

Table: **Coverage of indicators for reproductive, maternal, and child health from national surveys**

Table 1: Key Maternal and Child Health Indicators for Brazil 1970s-2006/07 (Cesar G. Victora et al., 2011)

Post-Dictatorship Years: 1990 to 2008

Despite remarkable progress towards a unified health system, significant fragmentation still exists. Driven partly by a sustained commitment to economic liberalisation, a large private sector continued to develop throughout the 1990s and into the 21st century. By 2008 more than a quarter of Brazilians (26%) had some form of private health insurance and accessed services in a comparatively well-funded private system, which is still being subsidised by the state.

By 2008, only 41% of healthcare in Brazil had been through public sources (lower even than the US at 45%) with the remaining funding provided through private health insurance contributions (28%) and out-of-pocket spending (31%) (World Bank, 2017).

Post-Recession Years: 2008 to Present

The global economic recession of 2008 seems to have had a somewhat positive impact on healthcare spending in Brazil. Between 2008 and 2012 per capita healthcare spending in Brazil increased, by on average 6% year-on-year (OECD, 2015b). While the public, private and out-of-pocket spilt remained largely unchanged, spending as a proportion of GDP increased from 8.03% in 2006 to more than 9% by 2013. Overall access to services also appears to have improved during this time (Mullachery, Silver, & Macinko, 2016).

Health care coverage				
Enrolled in the Family Health	48.79	[47.78,50.10]	54.61**	[53.18,56.03]
Enrolled in private plan	26.16	[25.64,26.69]	26.40	[25.47,27.34]
Health care utilization				
Doctor visit	69.81	[69.44,70.18]	74.20**	[73.43,74.96]
Dentist visit	38.97	[38.53,39.43]	44.43**	[43.58,45.29]
Hospitalization[c]	6.66	[6.51,6.81]	5.73**	[5.39,6.08]
Usual Source of Care	72.89	[72.19,73.58]	77.07**	[76.21,77.91]
Sample size (unweighted)	271,677		60,202	

Note: Percentages adjusted for survey design. *p-value < 0.05 **p-value < 0.001 for change between 2008 and 2013
[a]Measured by a five-point Likert scale going from excellent to very poor and recoded into a dummy variable with 1" representing excellent or good and 0" representing fair, poor and very poor
[b]Chronic diseases included arthritis, cancer, diabetes, bronchitis/asthma, hypertension, heart disease, kidney failure, and depression
[c]Hospitalization rate excluded hospitalization due to birth of a child and adjusted for age structure using standard population from 2010

Table 2: Change in Healthcare Coverage and Utilisation in Brazil 2008-2013 (Mullachery et al., 2016)

The resilience of Brazil's health system during the global financial crisis appears to be driven by the resilience of the country's economy at the time. While its economy did flatline in 2009, it quickly returned to growth of 7.5% in 2009 and, despite a slowdown between 2010 and 2013, it remained positive, and the government managed a moderate budget deficit of 2.8%. At this point, austerity remained unnecessary (Watts, 2016).

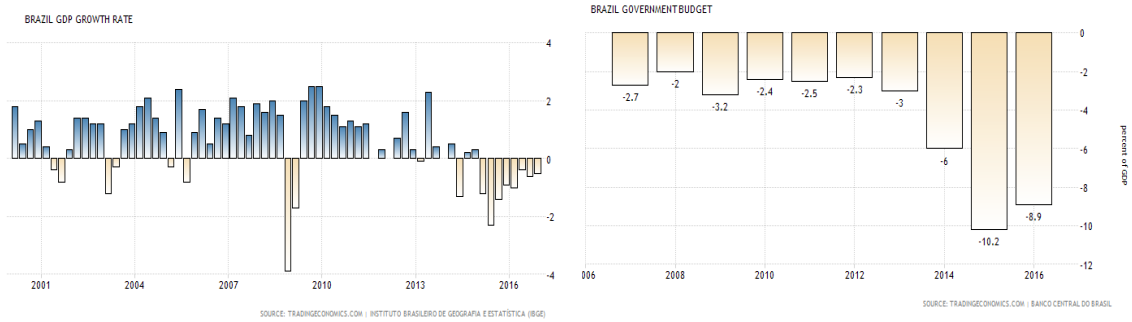


Figure 7: Key Economic Indicators Brazil 2000-2016

In 2014, however, global economic pressure and political turmoil forced Brazil into a recession. By 2016 GDP had declined by more than 3.5% a year, while the budget deficit had grown to more than 10% of GDP (World Bank, 2017).

In 2015 the Brazilian government began implementing austerity measures across social sector departments and cut the health budget by over 2%. While this seems a small amount, in the context of an already underfunded health system, the consequences were quickly felt. It is too early to quantify the full impact of austerity on access to care in Brazil but early signs suggest that they involve human resource cuts, slowed investment in infrastructure, and curtailed funding for PHC services and programmes (Watts, 2016)

In December 2016 Brazil' s central government voted to amend the country's constitution and introduced a provision, referred to as PEC55, which freezes social spending for the next 20 years and ties it to inflation (de Souza, 2017). Even if the economy returns to growth, health budgets will not increase in real terms for the next two decades, and an already overstretched system will be unable to keep pace with an increased need and demand for health services

Sustained improvement in access to healthcare requires ongoing investment. Given the similarity in levels of inequality between South Africa and Brazil we can infer that the government's spending on public health is likely to deepen inequality of access, while those who enjoy private cover will continue to benefit.

Case study: Reducing Fragmentation and Reforming Risk Pooling in Colombia – A Success Story

Colombia is arguably the best example of a middle-income country that has implemented legislative reforms aimed at addressing fragmentation in the financing of healthcare. In 1993, the Colombian legislature introduced far-reaching social sector reforms when they amended the Constitution and passed Law 100. While the law included a wide range of social service and social security reforms, those aimed at healthcare were the most revolutionary.

The primary objective of these reforms was to separate financing from provision within the health sector. The law then unified both public and private provision into a single provider sector. The second significant reform was to make membership of a health insurance scheme mandatory for the entire population. As part of reforms, universal insurance coverage would be made possible by restructuring how the health insurance sector functioned (Vargas-Zea, Castro, Rodríguez-Páez, Téllez, & Salazar-Arias, 2012).

Before 1993 only one-third of Colombia's population was covered by some form of insurance. While there was some government subsidised care for the poor, more than 50% of all healthcare spending before 1993 was out-of-pocket.

Under the reforms, there were two primary mechanisms to ensure everyone would be covered by insurance. The first was the introduction of a mandatory payroll-tax contribution from every employed person that would go to one of a range of private and often sector-specific insurers as part of the Contributive Mandatory Health Plan (*Plan Obligatorio de Salud—POS*). The second was the formation of a government subsidised scheme for low-income and unemployed people called the Subsidized Mandatory Health Plan (*Plan Obligatorio Subsidiado de Salud—POS-S*). In addition to mandatory membership schemes that cover a set package of care, the reforms allowed for individuals to purchase add-on medical insurance not covered by their insurer (Gottret & Schieber, 2006).

While there are multiple insurers who administer the financing of services for their members, the reforms have addressed fragmentation through the formation of a redistribution fund. This fund, which is a risk equalisation fund, collects all insurance contributions (payroll taxes and government subsidies) and allocates funds to insurers based on a risk-adjusted capitation formula. So, while there are multiple insurers, they compete on the package of care they offer and administrative efficiency, rather than based on adverse risk selection (Gottret & Schieber, 2006).

For the first decade of implementation, the financial sustainability of the financing reforms came into question due to declining contributions through payroll taxes and an increase in demand for subsidised insurance. The decrease in payroll-tax contributions was both a function of economic instability as well as poor administration of contribution collection (OECD, 2016). Many of these weaknesses are being resolved by combining small insurers into larger single schemes, improving the administration of the funds, and bringing down healthcare costs through the introduction of a Health Technology Assessment Centre within the Ministry of Health (MoH) (Vargas-Zea et al., 2012).

According to OECD (2016) statistics, by 2015 Colombia was close to achieving universal coverage with more than 96% of the population covered by some form of insurance (Graph 1). Colombia now also has amongst the lowest levels of OOP health spending in the OECD and South America. OOP spending now only accounts for 15% of total healthcare spending.

Case Study: Community Healthcare Workers and Broadening Access to Services in Low-Resource Settings

In 1978 the Alma Ata Declaration identified community health workers (CHWs) as a key component in improving access to primary healthcare services and, over the long-term, improving health outcomes in low resource settings. CHWs are lay healthcare workers who are trained in providing basic promotive, preventative and in some instances curative healthcare within community settings (Witmer, Seifer, Finocchio, Leslie, & O'neil, 1995).

Working alongside other healthcare providers such as nurses and doctors, they are a cost-effective option in supporting programmes aimed at broadening access to priority PHC interventions. Globally they have been particularly effective in supporting maternal and child health (Lewin et al., 2010).

Rwanda – despite having to recover from the most horrific ethnic genocide since Pol Pot in Cambodia in the mid-90s - is a good example of where CHWs have been highly effective in improving access and long-term outcomes to healthcare. Over the past decade, the Rwandan government embarked on a programme of health system

reform and strengthening aimed at improving outcomes in high impact areas such as maternal health, child health and HIV&AIDS (Mwai et al., 2013).

After an initial phase of piloting, the CHW programme, which had quickly shown success, was expanded into a national programme. Currently, 40 000 CHWs are working across all 30 of Rwanda's health districts. CHWs are organised into co-operatives of approximately 120 CHWs, which are linked to and supported by healthcare professionals from the closest PHC facility (Haver, Brieger, Zoungrana, Ansari, & Kagoma, 2015).

CHWs in Rwanda receive two weeks of initial training and then six days for each intervention. They are then expected to undertake refresher training every six months. CHWs in Rwanda are not salaried though. CHW cooperatives are paid based on their performance across 26 key indicators (e.g. women accompanied to a health facility, HIV tests undertaken, children immunised). Their cooperatives also undertake subsistence (e.g. farming and food sale in markets) activities to raise additional income and in support of community projects (Haver et al., 2015).

While CHWs were initially hired to undertake health promotion activities, task shifting has become an increasingly important part of the programme and CHWs are now given responsibility for the treatment of conditions such as diarrhoea, malaria and pneumonia. CHWs also undertake to test for HIV and support the treatment of Tuberculosis (TB) within a community setting. The most prominent role CHWs play, however, is in support of the country's maternal health programmes. Here CHWs provide a range of services, from supplying pregnant women with information to promoting healthy pregnancies through to assisting women to attend antenatal care at clinics, and even assisting with home births. Since the start of the programme in the early 2000s, CHWs have helped to ensure that the number of women giving birth in a health facility has increased by more than 50% (Haver et al., 2015).

Reprioritising Government Budgets: Allocating Proportionately More Towards Health

Investments in health go beyond just healthcare, interventions such as investing in good nutrition, adolescent sexual reproductive health and eye health when available, can drastically alter the prospects of the population. However, health is but one of many priorities in a developing country such as ours. There are a number of opportunities to increase the available funding for healthcare delivery. The question that emerges then is how do we optimise investments in health to address the decline as a result of ill-considered cost-cutting measures as well as improve the quality of services given that we aspire to achieve universal health access by 2030?

While there is a need for greater funding for health, it is concerning that the percentage of health spending in South Africa, in relation to overall budget spending, has dropped in recent years. In 2001, 26 African nations, including South Africa, signed the Abuja Declaration, committed to allocating a minimum 15% of government spending to health. At the time, South Africa was already spending approximately 13.5% of government revenue on health, and by 2011 this had increased to 14.5%. Because of persistently slow economic growth, however, the proportion of government spending allocated to health has now declined to 13.5%. So, while South Africa has come close to meeting this commitment it has moved backwards over the last few years.

Another, or an additional option for re-prioritisation would be to look beyond existing government spending and include all health spending in the assessment of resource availability. Total health spending in South Africa accounts for 8.8% of GDP, yet less than half of that spending takes place in the public sector. More than 4.6% of GDP is spent on healthcare within the private sector. So, when considering how to account for the predicted shortfall in NHI resource needs, re-directing money from private to public spending is an obvious area to look at as part of urgent reform.

How this re-prioritisation occurs is a complex process though. Private sector spending consists of out of pocket spending and spending by private medical schemes, and careful consideration would need to be given to how that spending is redirected to a universal healthcare system. Current proposals include the creation of a single national insurance fund financed through additional taxes such as a payroll tax. The fund that would then act as a single purchaser of health care services using its market power to reduce pricing. The lack of trust in government after years of fiscal abuse will be a major obstacle to this in the near term.

Re-prioritisation in the current context of fiscal constraint in South Africa should therefore not necessarily be thought of regarding re-prioritisation of existing government spending. It should rather be thought of as improving efficiencies (without compromising on equity) and the re-prioritisation of health spending more generally.

Human Rights Obligations and Ethical Priority Setting in Budget Allocations

There are clear human rights obligations placed on the government concerning the allocation of additional resources to health. In terms of Section 27 of the Constitution, the South African government has an obligation to sufficiently resource healthcare towards the progressive realisation of the right to healthcare and to justify any limitations in allocating additional resources towards fulfilling this obligation. It is not sufficient for government to simply say resources are limited and that it cannot allocate more resources to healthcare. It is also not enough to say that 'we cannot allocate additional resources to healthcare because doing so would compromise other areas of spending'.

Budgeting using a human rights framework demands that any trade-offs in the allocation of additional resources between spending priorities be explicitly articulated. This articulation should demonstrate how the allocation of additional resources to one priority over another better serves the progressive realisation of basic rights and entitlements. So, the decision not to allocate more money to healthcare is only justifiable if the government can demonstrate that additional money available will result in more important gains in access to basic or core rights in other areas such as education, housing and social security. Any spending that does not demonstrably contribute to the realisation of basic rights and entitlements should automatically be of secondary concern.

While this may seem simple enough—especially in South Africa - which has an unambiguous set of core rights—there are inevitable trade-offs between core rights in a resource-constrained environment. Here, for instance, questions arise around what should receive more attention: health or economic development? The two are not necessarily mutually exclusive and the current health crisis provides an opportunity to frame investments in health care as part of a broader social stimulus that supports economic growth.

WHO Model and RHAP's Approach to Fiscal Sustainability

RHAP's approach to fiscal sustainability in healthcare during times of austerity (and beyond) is based on the World Health Organization's (WHO) six health system building blocks (Figure 8).

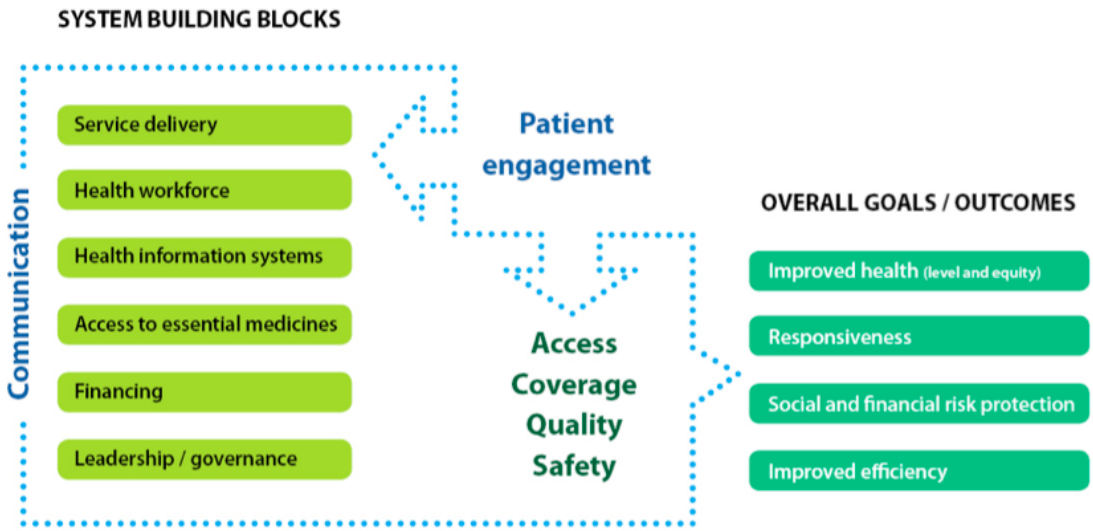


Figure 8: Proposed modified system building blocks. Lazarus and France. A new era for the WHO health system building blocks?

1. **Service Delivery**: health systems should deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources. The WHO maintains that effective service delivery has the following characteristics:
    - Comprehensiveness: services provided should include curative, preventative, palliative, rehabilitative, preventative and promotive care.
    - Accessible: cost, geographic, language, cultural and other potential barriers to care should be minimised.
    - Coverage: all people should be covered regardless of risk or income.
    - Continuity: there should be continuity for patients across different service types and all levels of care.
    - Quality: services should be effective, safe, patient centred and delivered promptly.

2. **Health workforce**: well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances. I.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive.

3. **Essential medicines and health technology**: A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.

4. **Health information systems**: A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.

5. **Financing**: health system financing involves the mobilisation, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system. the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care. This includes two related objectives: (i) to raise sufficient funds and (ii) to provide financial risk protection to the population. Achieving these objectives then involves the effective implementation of three functions: (i) revenue collection, (ii) fund pooling, and (iii) purchasing/provision of services.

6. **Leadership and governance**: Leadership and governance involve ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system-design, and accountability.

The WHO framework provides a guide to understanding the structural factors necessary to improve fiscal sustainability during times of austerity. It offers a practical framework on how to implement policy and health system reforms to improve efficiency, reduce wastage, and ensure maximum benefit from available resources.

A Human Rights Perspective on Austerity and Healthcare Spending

Austerity measures can (and often do) compromise basic rights and entitlements of a country's population if due consideration is not given to a state's fundamental obligations regarding the progressive realisation of these rights (OHCHR, 2013). Austerity also threatens foundational rights of equity and social justice. It is therefore critical that austerity, and austerity in healthcare specifically, is approached through a human rights framework.

According to the International Covenant on Economic, Social and Cultural Rights (ICESCR) governments have an obligation to protect existing access to healthcare and to continually expand access for the most vulnerable. Austerity measures that curtail access to basic healthcare without due consideration for these obligations are likely to be in contravention of human rights commitments (UNHROHC, 2013).

Section 27 (1)(a) of South Africa's Constitution deals with healthcare and states that "everyone has the right to healthcare services, including reproductive healthcare". The responsibility for the realisation of these rights is then clearly placed on government in Section 27 (2), which says: "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of [this right]".

The government has developed legislation, such as The National Health Act (61 of 2003) (NHA), which details its' responsibilities about the structure of our health system, how it is organised and the range of services available. The commitments and responsibilities regarding the Constitution and the NHA are then given substance in key policies such as the National Human Resources for Health Strategy, the Primary Healthcare Revitalisation Strategy, and most recently in the National Health Insurance (NHI) White Paper.

One would expect Constitutional obligations, combined with legislative and policy commitments, will provide ample guidance about protecting the right to access health care during times of austerity. While this is true for the most part, these obligations seem to be tempered by a clause in the Constitution stating that government is obliged to ensure the progressive realisation of rights "within available resources". At first glance the clause seems to imply that government's responsibilities only extend as far as is economically feasible. However, in a 2013 report the UNHRC provided a clear framework to guide the interpretation of the "within available resources" clause. It serves as a useful reference point when considering austerity measures.

1. **The existence of a compelling state interest must be demonstrated**: this means that states must demonstrate that implementing austerity measures is due to factors beyond its control and cannot be justified by the need for "fiscal discipline" or "savings" (p.16). Consequently, austerity measures should only be implemented if on balance they result in the overall protection of rights.
2. **The necessity, reasonableness, temporariness and proportionality of the austerity measures**: austerity measures are only justified if they are temporary and if any other course of action would be more detrimental to the realisation of rights.
3. **Exhaustion of alternative and less restrictive measures:** states must prove that all options have been considered and that less restrictive measures are not feasible. States must, for example, demonstrate that further tax reform aimed at generating additional revenue is not a viable solution.
4. **Non-discriminatory nature of the measures adopted:** austerity measures cannot be intentionally or unintentionally discriminatory in cause or effect.
5. **Protection of a minimum core content of the rights:** states must identify and articulate a minimum core of rights that will be protected during the implementation of austerity measures.
6. **Genuine participation of affected groups and individuals:** states must demonstrate that those who are likely to be most affected by austerity measures are consulted and play a role in identifying interventions that would minimise harm

An Approach to Ethical Priority Setting and UHC

In it's report "Making fair choices on the path to universal health coverage", the WHO (2014) argues that access to healthcare is of fundamental importance for people's health and well-being and influences people's opportunities in life, such as their ability to learn and work. However, due to scarcity, priority setting is an inevitable feature of healthcare provision and trade-offs, i.e. creating "winners and losers", are unavoidable. For a society to be considered fair and just, the WHO argues that priority setting cannot be solely based on crude assessments of cost and efficiency. If priority setting does not have fairness and justice at its core, it is likely to exacerbate inequities in access to care and will deepen inequities in society more broadly.

While every country prioritises services, many only do so implicitly. It is critical to develop explicit criteria for categorising services by priority. The WHO draws attention to three fundamental practical criteria for ethical priority setting:

1) Categorise services into priority classes:.
The WHO recommends that countries generate lists of health services, and then rank these on the basis of cost-effectiveness. The concept of cost-effectiveness depends crucially on the idea of a benefit. In quantifying the notion of a healthcare benefit, the WHO appeals to the idea of "healthy lifeyears saved", which is an outcome measure that represents both gains in lifeyears and quality of life. Here, it is important that the definition of 'quality' takes into account the rural healthcare context and adequately acknowledges the impact of relatively small interventions on vulnerable rural patients, such as access to cost-effective rehabilitation services which improve people's capabilities to participate in vital tasks and achieve reasonable lifegoals such as having an education, being able to work, and participate in community life.

2) Give priority to the worst off: In addition to cost-effectiveness over a lifetime, ethical prioritisation involves ensuring priority is given to those who are worst off in terms of health status and social determinants (e.g. income, deprivation and other associated factors such as a rural location). This leads directly to the next criteria.

3) Financial risk protection: In addition to deciding on priority services and populations, priority should be given to ensuring financial risk protection. This means removing cost barriers (out-of-pocket expenditure) associated with accessing care and the potentially catastrophic consequences of paying for access. This can be achieved through pre-payment for care and improved risk-pooling. Financial risk-protection is only ethical if it serves to protect the worse off though. So, a fundamental criterion of financial risk-protection is contribution based on ability to pay and access based on need.

The WHO outlines five trade-offs that are not acceptable in priority setting:

1. Expanding coverage for low- or medium-priority services before there is near universal coverage for high-priority services. This includes reducing out-of-pocket payments for low- or medium-priority services before eliminating out-of-pocket payments for high-priority services.
2. Prioritising very costly services whose coverage will provide substantial financial protection when the health benefits are very small compared to the alternative, less expensive services.
3. Expanding coverage for well-off groups before doing so for worse-off groups when the costs and benefits are not vastly different. This includes expanding coverage for those with already high coverage before groups with lower coverage.
4. First including only those with the ability to pay in the universal coverage scheme and not including informal workers and the poor, even if such an approach would be easier.
5. Shifting from out-of-pocket payment toward mandatory prepayment in a way that makes the financing system less progressive.

For decision-makers this may prove a long list of criteria without enough guidance for implementation. The underlying principle for distribution of healthcare resources should be that all people have adequate access to healthcare, starting off with high priority healthcare and expanding to lower priority healthcare. Principles to determine high priority healthcare need to be identified, along a hierarchy of health needs over a lifetime. Such principle would include priority for serious conditions, that are life-threatening or impair functioning with priority for the young. What follows from this is the priority to prevent and treat serious conditions early over more expensive treatment at an advanced stage of illness. Such priority healthcare services should be available to all, regardless of personal circumstances such as place of living or ability to pay. For instance, the reality of rural infants and children not accessing basic healthcare for preventable and treatable conditions is under no circumstances justifiable. In addition, while we can't guarantee rural communities 'equal' ease of access to specialised healthcare services in comparison to their urban counterparts, what we can and must guarantee is timeous detection of need and a functional, affordable and dignified referral pathway to such services concentrated in urban settings.

Leveraging National Health Insurance Reforms for Fiscal Sustainability in South Africa

The NHI, now into its second decade of planning and piloting, is a set of reforms aimed at changing the way services are delivered and financed. Both have implications for fiscal sustainability in healthcare and funding will need to increase well beyond inflation each year over the next decade. The expansion of services will undoubtedly require significant reforms to healthcare funding in a unified health system.

The extent to which more money can be allocated to health is restricted by a multitude of factors, not least of which is slow economic growth and austerity. The impact of a constrained fiscal environment in South Africa will become even more apparent as resource demands increase with the implementation of the NHI.

Regardless of whether the NHI takes off or not, there is always a need for additional money to be added to health spending each year. At a minimum, extra resources are needed to account for the effects of inflation on prices in the health sector. Realistically though, more healthcare workers are always necessary to broaden access to services and to account for ever-increasing demand.

The implementation of the NHI provides the perfect opportunity to reform healthcare financing in such a way as to integrate fiscal sustainability into systems and processes. It is therefore critical that financing take centre stage over the next decade as NHI reforms are rolled out.

RHAP believes that the WHO model is the most sensible way to cater to healthcare requirements of all strata of South African society. The *Protecting Healthcare in Times of Economic Crisis Report* makes recommendations on how healthcare system reforms under the banner of the NHI could be undertaken in such a way as to improve fiscal sustainability over the long-term, within a human rights and ethical decision-making framework.

South African Healthcare and the WHO Building Blocks Explained

1. Service Delivery

One of the most significant cost drivers in both public and private healthcare systems in South Africa is the concentration of resources and services in hospitals. Hospicentric health systems tend to rely on expensive curative services at the expense of early interventions aimed at disease prevention and health promotion. It is far more expensive than primary healthcare. Prioritising PHC is therefore an important strategy during financial crisis and austerity and can improve access and reduce the cost of care.

An important approach to broadening access is to ensure that the services are effective. There is little point in investing in services and technologies that do not achieve the desired results. This does not mean automatically investing in cheaper alternatives or not investing in 'expensive' ones. The key is to invest in interventions that ensure as many people gain access to effective care as possible with those with the least access and greatest need given first priority.

A prime example of this in South Africa has been the provision of universal access to ART. At the beginnings of the country's ART programme argument were made that it was "too expensive" or that it would "crowd out" other necessary services. Fortunately, rigorous evaluation of the effectiveness of ART and long-term economic impact made a clear case for rapidly broadening access. Not only was ART highly effective, but working towards universal access made economic sense.

Deciding on the benefits package under the NHI, therefore, is a task that requires a great deal of care and detailed assessment. It should be based on a combination of considerations that, while including a critical appraisal of cost and affordability, should not be based on these factors alone. The starting point should always be reducing inequity, ensuring greater access and improving outcomes. This demands active engagement with new technologies, alternative service delivery methods, and a willingness to place pressure on pharmaceutical companies and suppliers to supply goods and services at a fair price.

2. Health Workforce

Globally, human resources are any health system's most significant and often fastest growing expense (Kabene, Orchard, Howard, Soriano, & Leduc, 2006) and are inevitably a focus of austerity measures during times of constraint.

Balancing the need to contain costs while still improving the availability of healthcare professionals means that health systems often need to be innovative in their supply and distribution. One strategy is to increase task shifting, the "rational redistribution of tasks among health workforce teams" (WHO, 2007). In this scenario nurses

could, for example, take responsibility for prescribing routine medication. Task shifting and sharing is often supported by the introduction of new categories of mid-level workers such as physicians or pharmacists' assistants who can take on routine tasks at much lower cost (WHO, 2007). Refer also to the Rwanda case study on page 16.

South Africa's NHI Bill offers little in the way of a strategy to strengthen the health workforce and provides no insight into how this could be achieved in times of austerity. It identifies the training of additional healthcare workers as a priority but does not go into the kind of staff needed or how they would be distributed to provincial and district facilities.

A sufficiently resourced and well-trained healthcare workforce is the most important component of an effective healthcare system (WHO, 2014). It follows that cutting posts and placing freezes on the hiring of new staff is the least desirable approach to cutting costs in this area (WHO, 2014) as without enough healthcare workers and other allied health professionals with the right mix of skills, health systems cannot function. Additionally, those healthcare workers must be accessible to the most vulnerable and most in need.

Drawing on the WHO's ethical decision-making framework, RHAP argues that the distribution of the healthcare workforce should be informed by an equity principle that gives priority to the worse off in society, such as rural communities. Establishing who is worst off would necessarily be determined by both epidemiological profiles of populations, socioeconomic status and historical neglect.

3. Health Information Systems

Eliminating unnecessary and expensive technologies or procedures and finding more cost-effective alternatives can be a good way to cut costs while sustaining and even improving access to care. While getting the best value for money should always be a health system priority, financial crisis and austerity can force governments to think carefully about what services they provide and how they provide them. When times are good, and resources are readily available, authorities may be inclined to provide services and technologies that have questionable or limited benefit simply because they are in demand. Many governments have formed Health Technology Assessment (HTA) agencies to evaluate and compare the cost-effectiveness of various service delivery options, technologies and medicines (Martelli et al., 2007).

Reprioritising spending and utilising available resources more efficiently require health information systems that accurately reflect where and how money is being spent and what outcomes are achieved with this expenditure. One of the most significant challenges confronting governments trying to manage health budgets and financing during fiscal crises is the absence of timely, accurate and detailed information (OECD, 2015). Even in developed nations, where budget and health information systems are robust and well developed, the lag in information reaching decision makers results in health financing reforms which are slow to deal with growing pressure on

increasingly constrained resources. In most countries, health expenditure data can take up to six months to reach decision makers, and in some, this period can extend to well over a year.

So, while investment in health information systems may be overlooked during the financial crisis in favour of investments in sustaining service delivery, there is a case to be made for looking to improved data collection and reporting as a mechanism for improving efficiency and achieving greater population benefit for investment.

Currently, health information management in South Africa is fragmented, not only into public and private sectors, but also within each other. There are currently over 42 health management information systems used in the public sector with more than half not meeting the operational requirements of the system. In the private sector, fragmentation occurs between medical aid schemes and then between providers. In the public sector it is between national, provincial and district authorities.

Attempts have been made to develop an integrated system in the form of the District Health Information System, but this system only includes data from a district level and is largely dependent on provinces investing in appropriate infrastructure. In many instances, particularly in poorer mostly rural provinces, health information systems are still largely paper-based, with capturing taking place at a central level.

In their current state public health information systems are completely inadequate and the current crisis provides an opportunity to configure systems that support service delivery and introducing electronic patient record s will support better tracking of patient interactions with the health systems.

The NHI White Paper commits to developing an integrated electronic Health Information System. But developing and implementing such a system, particularly in areas with little or no existing IT infrastructure or expertise, will require a great deal of investment. This would demand drawing on the existing capacity of the private sector. Priority should be given to patient and financial management functions over administrative and support functions that do not contribute directly to service delivery.This would allow for more rational and equitable rationing of services.

The key feature of health information systems in contexts that have used them to manage resources as part of austerity measures is that they offer real-time monitoring of resource flows. This allows governments to rapidly adjust allocations as budget pressures arise and to re-evaluate priorities over the short- to medium-term.

One of the most significant challenges in the South African context, which has exacerbated resource constraints, has been delays associated with budget information. Health authorities have continued to spend because current information systems do not allow for immediate course correction.

The upgrade of health information systems as part of the NHI should therefore first focus on providing real-time tracking of spending in a format that is accessible to all decision-makers and managers within the health system. This would provide for early detection and response to budget pressures.

4. Essential Medicines (Central Procurement, Generic Policy, Essential Drugs Lists)

Globally, expenditure on medicines accounts for approximately a quarter of all health expenditure and are amongst the primary drivers of rising healthcare costs (Wirtz et al., 2017). During times of austerity, medicines shortages are often one of the greatest barriers to access to care (Economou et al., 2014).

The NHI White Paper commits to several reforms to improve efficiency in the supply and distribution of medicines, including central procurement and the direct supply of medicines to health facilities by suppliers. The White Paper alludes to extending pharmaceutical reforms to the critical evaluation of effectiveness and pricing towards rigorous cost-benefit analysis of medicines that should be supplied within the public system. It notes that: "The introduction of pricing and reimbursement mechanism and other regulations (such as mandated generic drugs substitution) in pharmaceutical markets internationally has proved an effective policy lever to contain health expenditures." (p. 52)

This is an important inclusion that will undoubtedly benefit the long-term fiscal sustainability and general effectiveness of the pharmaceutical aspects of the NHI. The White Paper does not detail how this commitment translates into structural pharmaceutical reform, however.

Within the public sector, pricing is controlled by volume negotiation through a national tender system. Although this does provide economies of scale, single purchaser negotiation power and consistency, it offers little opportunity to draw on international trade agreements, compulsory licensing or allowing for parallel imports. Compulsory licensing and parallel importing would allow for the purchase and production of generic medicines at a much lower cost than what is currently available in South Africa.

5. Financing

The bulk of revenue for public healthcare originates from the national revenue fund which is informed by tax revenues and sovereign debt, among others. Revenue is allocated according to the budget priorities of the government of the day, outlined in a mandate paper developed with the office of the president. Revenue allocation is then guided by the intergovernmental fiscal relations act which governs the relationship between the various spheres of government.

Total allocations for health are distributed between NDoH which receives around 47 % of the health allocation. Some 80% of this is transferred to provinces in the form of eight conditional grants, the largest of which is the

HIV/Aids and TB grant. Nationally raised revenue is allocated to the sub-national level for service delivery based on an Equitable Share Formula (ESF), which accounts for various service delivery and equity needs in how money is allocated between provinces. While provincial governments do follow national priorities, they are not bound by decisions at this level and decide how money should be divided between provincial departments and then spent within those departments.

So, although there is ostensibly a single pool of funds from which all services in the public sector are funded in practice, authority over and administration of those funds is fragmented. The fragmentation of the health budget thus creates administrative inefficiencies since structures are replicated across the nine provincial health departments. This inefficiency is further compounded by additional administrative structures within each of the 52 health districts spread across the provinces.

The National Health Insurance Bill currently under review proposes an alternative funding mechanism with the country divided into 208 sub-districts organised around contracting units for primary care. The units comprise district hospitals, community health centres, primary healthcare clinics and ward-based outreach teams. These are supported by integrated practices of general practitioners, pharmacists and allied health professionals. The units will be funded based on a risk-adjusted capitation model that is informed by population numbers, disease profile and service delivery targets that are meant to address unmet need. Higher levels of care at provincial and tertiary hospitals will be funded directly, but little detail is available on the type of cost structures to be applied.

While the proposed approach could lead to greater efficiency and equity it is a radical departure from the current system. As the system transforms, significant investments will have to be made in organisational change interventions to support what could be a difficult transition.

Beyond raising additional revenue or improving how financial resources are managed, governments and healthcare providers can maximise benefit from the resources that are available by doing things differently. Sustaining and improving access to healthcare during the financial crisis and austerity demands that service delivery platforms be designed in such a way that they maximise benefit for the greatest number of people at the lowest possible cost. These decisions should then always be grounded in equity principles that ensure that disparities in access are addressed and those with greatest need receive proportionally greater attention. This is not an easy task, but there are several approaches to doing this.

6. Leadership and Governance

One of the most important reforms in this regard is improved transparency and accountability within the governance of the health system. Key to this is developing systems and processes that allow for the timely production of both financial and performance information (Kutzin, Cashin, & Jakab, 2010). Improvements to

these systems should contribute to the more efficient and effective use of resources through more informed and accountable decision making.

One of the challenges with governance and financial management in the South African public healthcare system is multiple layers of authority, made up of a National Department of Health, nine Provincial Departments and 52 district authorities. Each level plays a role in setting priorities, allocating resources and spending. This decision making and governance structure adds layers of bureaucracy and complexity, administrative inefficiencies and contradictions.

In the NHI White Paper, the government recognises the importance of restructuring how the health system is governed, noting that: "Despite efforts by government to inculcate a culture of good leadership and governance, the knowledge and skills amongst managers is still very inadequate. Furthermore, weak accountability mechanisms are linked to inadequate, disparate measures and standards for managing performance (good or poor). Poor accountability is also exacerbated by a semi-federal public sector." These concerns remain unaddressed in the NHI Bill as the role of provinces is unclear. This is because accountability lines between the contracting units and provincial authorities has not been adequately addressed.

Relating specifically to financial management the White Paper (2018) states that: "The South African health system is underpinned by a financing method that is based on the Intergovernmental Fiscal Relations (IGFR) system. The IGFR system is faced with an institutionalised and structural form of fiscal imbalance as a result of vertical fiscal federalism and other factors that impact on intergovernmental fiscal relations. The main problem that underpins IGFR challenges relates to striking a balance between the need to provide Constitutionally Mandated Basic Services (CMBS) within macroeconomic constraints that limit the available resources and a fiscal federal structure that has its own defined priorities" (p. 16)

One option would be to remove provincial departments altogether and pass PHC provider functions to districts, while hospitals run autonomously. Another option would be to pare down provincial functions to the management of hospital and emergency services, leaving PHC services to the districts.

What is clear is that the current structures of authority and control need to change, and duplications removed.

Leadership and governance: human rights obligations and ethical decision-making

The importance of leaders working within a defined ethical framework becomes most apparent during times of austerity. As resources become increasingly constrained, decision makers are expected to balance trade-offs within an increasingly constrained resource envelope. Without guidance on how to set priorities to best protect access to healthcare for the most vulnerable, priority setting can simply become a cost-cutting exercise.

The first step in entrenching ethical decision making in the health system is to build it into policy, strategic planning, and budgeting processes. The NHI provides the perfect opportunity to do this. In addition, if the basis for decisions making is transparent, there is opportunity for public participation to provide the checks and balances needed to secure ethical decision making as an overarching framework.

Summary of Options: Improving Fiscal Sustainability as Part of NHI Reforms

WHO Building Block	Approach to fiscal sustainability	Option available under NHI	Opportunities during austerity	Risks/limitations
1. Financing	1.1 Reprioritising government budgets: giving proportionally more to health	1.1.1 No commitment to shifting existing government revenue to health from other priorities 1.1.2 Drawing on revenue used in the private sector	1.1.1 limited as competing priorities may mean little space to shift government revenue 1.1.2 Increasing size of risk pool and improving equitable access to existing resources	1.1.1 Compromise other priority areas (e.g. education) 1.1.2 Mechanisms to draw funds from private sector are ineffective
	1.2 Raising additional revenue for health	1.2.1 Additional NHI specific taxes: VAT 1.2.2 Additional NHI specific taxes: income and payroll taxes	1.2.1 Administrative efficiency and increasing size of risk pool 1.2.2 Administrative efficiency (less so than VAT) and progressive	1.2.1 Regressive tax and opportunity to generate revenue diminishes during downturn 1.2.2 Capacity to generate revenue diminishes during economic downturn
	1.3 improve efficiency in financing	1.3.1 Better pooling of resources under single NHI fund 1.3.2 Reimbursement reform: PHC risk-adjusted capitation and DRGs for hospitals	1.3.1 Reduces fragmentation and improves the benefit of risk pooling. Single purchaser may also improve pricing of services 1.3.2 Improves efficiency and cost management	1.3.1 Administratively difficult. Will need to change role of provinces (intergovernmental relations) and private sector, which may bring resistance 1.3.2 May focus too heavily on cost saving and rationing and not address equity principles sufficiently
	1.4 establish a fiscal cushion	1.4 None explicitly outlined in White Paper	1.4 Provides a safety net to maintain spending during short to medium term financial downturns	1.4 May not be sufficient to sustain spending during protracted downturns
2. Service Delivery	2.1 Benefit Package	2.1 Health Technology Assessment Agency proposed for the NHI and will include assessment of services to be offered. HTA must be applied within the parameters of a healthpackage over a lifetime.	2.1 Expanding from high to priority services to achieve greatest benefit to population, following a prudent healthcare package design over a lifetime.	2.1 Misuse of cost-effectiveness exercises at expense of equity
	2.2 Levels of care: giving priority to PHC services	2.2 PHC re-engineering and referral pathways	2.2 Giving priority to PHC (disease prevention, health	2.2 Insufficient investment in health system

			promotion and early intervention) saves costs over the long-term and reduces dependence on expensive curative and hospicentric care	strengthening and human resources will result in significant pressure being placed on the public system
3. Health workforce	3.1 Prioritising mid-level workers such as Clinical Associates (CA) and CHWs	3.1 White paper does not detail comprehensive health workforce strategy, but PHC re-engineering does include CHWs and CA's provided in general strategy	3.1 Increase access to lower per capita cost 3.1 Provide early health promotion, prevention and surveillance provides for long-term cost savings	3.1 Viewed as cost-cutting and not sufficiently resourced or supported. 3.1 Insufficient attention paid to equity principles and need for a broad strategy to promote access to all cadres of HCWs
4. Essential medicines	4.1 Thorough assessment of effectiveness of medicines and health technologies 4.2 Improve supply chain and identify opportunities for efficiency gains	4.1 Commitment in White Paper to improving assessment of pricing and effectiveness including generic substitution 4.2 Detailed commitment to improving supply chain efficiency with centralised procurement and direct distribution to health facilities and patients	4.1 Cheaper pharmaceuticals at lower price through generic substitution and better negotiation of pricing 4.2 Removal of inefficiency within the supply chain can reduce unit costs of pharmaceutical supply. Centralised procurement can improve price negotiation further lowering costs	4.1 Focus too heavily on cost saving at the expense of access and effectiveness 4.2 Poor infrastructure and system complexity may threaten access and introduce wastages
5. Health Information Systems	5.1 Introduction of unified health information to improve decision making and monitoring of expenditure, outputs and outcomes towards improving value for money, less wastage and greater efficiency	5.1 White Paper commits to unified and uniform HIS covering entire financing, supply chain, service delivery and surveillance processes	5.1 Improve decision making and setting priorities 5.1 Help identify wastage within system	5.1 Complexity of establishing unified system may result in system failure/ inefficiency
6. Leadership and governance	6.1 Streamlining lines of authority and decision-making structures (reducing bureaucracy) 6.2 Improving accountability in use and management of resources	6.1 Single NHI Fund and single purchaser. 6.1 Re-organisation of health system and intergovernmental relations (fewer layers of authority 6.2 Commitment to greater oversight and accountability through improved systems	6.1 Leverage single line of authority and decision making to negotiate lower pricing from suppliers and providers 6.1 Streamline decision-making to improve efficiency and remove duplication 6.2 Prevent loss of resources through waste and corruption	6.1 Structures to be reformed/eliminated may be resistant to change (e.g. provinces and private sector) 6.2 Endemic patronage may result in substantial resistance to accountability mechanisms

Conclusion

The Rural Health Advocacy Project (RHAP) published this research as part of its mandate to present the very real health challenges of rural communities, which make up 40% of the South African population. Rural citizens have, by and large, been discriminated against. They have not received an equitable share of public health financing as historically the emphasis has been on urban areas and hospitals as opposed to rural communities and primary healthcare.

It is about connecting policy, practice and partners, giving visibility and voice to the needs of rural dwellers and how they can access health services.

It should also be noted that the principle of “money follows infrastructure” applies. In the case of provision of healthcare, it is not only the responsibility of the Departments of Health to get healthcare to rural areas. This calls for determined participation by authorities that are responsible for road construction, building of hospitals and clinics by the Department of Public Works, etc.

Using the six WHO building block for health the report identifies how current health system reforms can be easily incorporated under the banner of the NHI, in all probability the only opportunity we have to introduce a more equitable public health system.

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