Setting priorities for health spending in South Africa

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

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

A group of civil servants, medical researchers, academics and private sector representatives met in the Magaliesberg context. The project—called PRICELESS (Priority Cost-Effective Lessons for Systems Strengthening)—will be part of a broader network of institutions in other developing countries, and is being hosted by the SA Medical Research Council/University of the Witwatersrand (Wits) Rural Public Health and Health Transitions Unit. It is being led by Stephen Tollman together with Karen Hofman, who has been seconded from the Fogarty International Center at the US National Institutes of Health.

Lessons can be learned from other countries, but in determining priorities for health spending, South Africans need to keep local constraints in mind. If we want our population to become healthier, the first issue to understand is why it is so unhealthy, despite our current levels of spending. There are of course several answers.

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

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

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

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

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

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

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

Another complicating factor is that many preventative medicine initiatives are conducted at the local government level, with very variable levels of investment and efficacy depending on perceived priorities. This is often the case in developing countries: Jane Doherty from Wits provided an interesting example in
Mexico City, which financed increases in this sphere by cutting benefits to municipal officials!

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

tance of putting monitoring systems into place down the line to track the effective-

ness of interventions that government might adopt. Jerry Coovadia from Wits put his finger on perhaps the most crucial question facing the project when he asked how setting different priorities could change the system in practice?

Michael Cherry

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Not Real Funding?

Sir—I was very interested to read Dr Albert van Jaarsveld’s letter on the ‘Trac-

jectory of NRF Funding’ in your May/June issue, for a number of reasons. First, I was
erager to see what the NRF had to say regarding the correspondence that has
recently appeared in the pages of the SAJS—and especially what the official
response would be to the very serious points raised by your leader (SAJS 105, 2;
2009) and Professors Illing and Gibbons’ letter (SAJS 105, 10; 2009).

Second, I was curious to see just how the NRF could explain its apparent failure as
our premier science funding agency to actually fund science in a meaningful
way.

I was disappointed on both counts. Dr van Jaarsveld signally failed to address the ‘Blue Skies’ issue, where new applicants to the programme were not informed that projects that were considered were not subject to external review. He also
failed to give any explanation of how the NRF could allow itself to be caught in the
trap of not having any money to fund new ‘Blue Skies’ proposals, while honouring
old commitments.

Anyone familiar with the old FRDtalk discussion group on the Web will know I
have had a great deal to say on similar issues in the past: a similar paroxysmal

organizational reset in and around 2001 resulted in my funding getting cut tenfold
—despite excellent progress. I wrote at the time—although the SAJS refused to
publish it—the following:

I leapt to my trusty friend, my Netscape Messenger, and raced off indignant
letters into the ether. I phoned colleagues in Pretoria, in Stellenbosch, I talked to
people down the corridor. An interesting picture emerged, over several days, and
from all over the country. People who I consider to be leaders in their fields have
had their research awards slashed; people who I know to be good researchers
have received no money at all. Other people, on the other hand, have had no
complaints: however, the overall picture seems to be of bewildered researchers
wondering what they had done wrong, and high-up people in university facul-
ties scrambling to demand explanations of the NRF.

Plus ça change, plus c’est la même chose ...

Does no-one except us poor researchers learn from these experiences. There are
real consequences to this crisis: one of the most important is that good programmes
which train students are being terminated, with all of the knock-on effects that
this implies, such as alienation from research for students who get cut loose, and
unfunded researchers simply abandoning the NRF and basic science. As it is, I
survived the 2001 crunch by switching doing the NRF and basic science. As it is,

Sincerely,

Ed Rybicki

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As for refereeing, I was wryly amused to
read the following in Dr van Jaarsveld’s letter:

We intend to open our peer review pro-
cesses to public and stakeholder scrutiny.

As peer review and transparent and
accountable decision-making are key
principles of the NRF it is important to
ensure that our peer review processes are
benchedmarked against the best interna-
tional practices. It is intended that this
process will be completed by the end of
2009.

Right—so the peer review processes have not been either transparent, or up to
international standards in the past then? As an example, if I pool all of the referees’
comments I have received from the FRD/NRF since 1985 on all of the project
proposals and personal reviews I have been subjected to, I doubt I could fill three
A4 pages—in Arial 14 pt double-spaced. I have also had occasion to seriously doubt
—in correspondence with the FRD/NRF—both the competence and relevance to my
work of people who have reviewed my projects. I found, after repeated question-
ing of the person responsible, that very few projects were ever sent out to over-
seas reviewers, despite this supposedly being a major feature of the FRD/NRF’s
peer review process.

I note that a July 17th article in the Mail
& Guardian online (http://www.mg.co.za/
article/2009-07-17-research-put-on-hold-
to-fund-world-cup) claimed that

The [NRF] recently canned a joint project
involving researchers from South Africa
and Spain, citing a diversion of public
funds to preparations for the 2010 World
Cup and the global economic crisis as the
primary reasons for cancellation...

Let’s hope there is a long and lasting
economic benefit to SA from the 2010
World Cup—because there may well be a
long and lasting research deficit to offset.

Sincerely,

Ed Rybicki