South African health care expenditure, 1975 - 1984

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Summary

South African health care expenditure is reported for the period 1975 - 1984 and analysed for the public and private sectors. Approximately 5,9% of South Africa's gross national product was devoted to health care in 1984 - 1985. This proportion appears to be increasing. Real per capita expenditure on health increased by 13% during the period under review. Trends of health care expenditure during the decade are discussed as well as some underlying causes of the increases in health care expenditure in South Africa. Precise expenditure data and outcome information are required in order to ensure appropriate resource allocation.

Public expenditure has been categorised into five sections according to the source of funding, which are: (i) Department of Health — the entire vote of the Department of National Health and Population Development (formerly the Department of Health and Welfare) less the amount spent on welfare; (ii) second tier of government, formerly Provincial Hospital Services — the costs of running the hospital services in the four provinces are accounted for under this section, as is the annual capital expenditure on hospitals; (iii) other central government departments — this includes expenditure on health by the South African Police, Prisons and Defence Force, and expenditures for the running of Ga-Rankuwa Hospital and MEDUNSA; (iv) national states — all national states (independent and self-governing) are catered for in this category, which therefore encompasses the South African Development Trust (SADT) which finances certain rural hospitals; and (v) local authorities (own contribution) — no reliable figures are available for local authority expenditure on health care, but after excluding the homeland population the expenditure for 25 - 30% of the population was obtained from Medical Officer of Health reports, central government subsidies were deducted and the remaining expenditure related to the population as a whole (excluding homelands). This is a crude estimate.

The public sector data were collated from over 150 auditor-general and other reports (the complete list of which is available from the authors).

Private sector expenditure has been categorised into two categories by the South African Reserve Bank: (i) medical and pharmaceutical products; and (ii) medical services. For the purposes of this article, these categories of expenditure will be used. The GNP as collated by the Reserve Bank is representative of the entire rand monetary area. We have adjusted the published GNP in two steps. Firstly, as the SWA/Namibian GNP is included in South Africa's GNP, a corresponding proportion was used to reduce South Africa's GNP. Secondly, as expenditure on health as collated was expressed according to financial years ending 31 March in each year, the GNP has been adjusted from calendar year to financial year.

Results

The major trends in health care expenditures for the years 1975 - 1984 are summarised in Tables I - III. The proportion of the GNP spent on health varied between 4,6% and 5,9%. The proportion of the GNP consumed by health care appears to be increasing gradually. Per capita expenditure rose from R56 in 1975/1976 to R186 in 1984/1985. However, when adjusted for inflation, this represented an increase in real terms of 13,5% per capita or 1,2% per capita per annum. Private and public sector expenditure increased by 430% and 433% respectively. The year-on-year percentage increases were similar, with a maximum increase in the public sector of 28% between 1980/1981 and 1981/1982.

The private sector accounted for about 45% of total expenditure during the period under review. It is evident that 'provincial expenditure' is the largest component of public sector expenditure, constantly absorbing between 1% and 2% of the GNP. These curative services account for 65% of public sector expenditure. Homeland expenditure increased dramatically, mainly as a result of the handing over of services during the period under review, as seen by the overall increase of 1 845% as compared with the general increase in the public sector of 433%.

Data have been collected for the period 1975 - 1985 and analysed according to public and private sector expenditure.
**Discussion**

South Africa devotes an increasing proportion of its GNP to health care and compares favourably with other African countries. At 5,8% in 1983/1984, South Africa compares with the UK in 1974\(^1\) (presently 6,8%). The increase of 13% per capita in real terms for the decade is moderate when compared with the UK where in the same decade the per capita health expenditure advanced in inflation-adjusted terms by almost 50%.\(^1\)

A marked increase in GNP was largely responsible for the low of 4,6% in 1980/1981. The percentage of GNP devoted to health care is necessary for international comparisons. However, in South Africa the GNP fluctuates widely\(^1\) and reliance on this proportion for determining policy should be avoided; the rate of increase in real terms may be a more useful measure.

Why are these estimates of the proportion of GNP spent on health care so different from those of other researchers mentioned earlier? In reviewing the methodology used by these researchers it was noted that it varied widely. In some instances provisional figures were used which changed substantially when updated. Other researchers have omitted significant areas of expenditure such as capital expenditure and local authority expenditure.

The reasons for higher health care expenditure in South Africa need to be examined. At the outset it is necessary to state that the general per capita increase in health care expenditure may be attributable to increased usage of the health care service. Although health care costs are not spiralling out of control, in real terms they are increasing gradually. This could be the result of the following factors:

1. South Africa has a demographically changing population. It is well known that the aged consume vast amounts of health care resources in developed countries.

2. Most services are purchased by 'third party' payers and price and cost cannot be regarded as inhibiting factors when health care decisions are made.

3. A large proportion of provincial expenditure is devoted to teaching hospitals. In 1984 approximately 40% of the Cape Province's hospital budget (maintenance expenditure) was spent on two teaching hospitals.\(^1\) These hospitals require medical technology of a high order which is subject to over-capitalisation and rapid obsolescence.

4. The pharmaceutical bill has increased as the result of a weakening currency, and there is a possibility of 'over-prescribing'. However, in the USA the consumer price-index has been equal to the pharmaceutical price-index.\(^1\)

5. It is a well-known fact that labour-intensive services increase in cost at a rate greater than the inflation index.\(^1\)

The intention of this article is to provide global figures of total health care expenditure and vast disparities in regional public sector expenditure have not been discussed, although they do exist and are available in an accompanying publication.\(^1\) An alternative method of calculating private sector expenditure showed that approximately 56% of this expenditure is paid by medical aid societies. Since they have an 80% white membership, it can be seen that most private sector expenditure is spent on whites.

The data presented in this article are similar to those presented at a recent conference by an entirely independent group of researchers.\(^3\) Other indicators of the reliability of these estimates are: the private sector expenditure (Reserve Bank figure) is persistently 10 - 12% higher than an estimate presented by one of the authors at a recent conference;\(^1\) the Reserve Bank figure for the private sector has a constant ratio with the public sector estimate presented. Not all capital expenditure has been included and no allowance has been made for transfer payments between various public sector departments or between the public and private sector. In view...
of the large amounts of money expended, the abovementioned deficiencies should not affect these global figures significantly.

In conclusion, the data discussed in this article were very difficult to obtain. They were derived from numerous annual reports since they are not routinely presented in a standardised format. To collect data by source of funding is clearly not ideal. The American methods of compiling data for categories such as hospital care, physician services, dental services, drugs and drug sundries, nursing home services and prepayment and administration is clearly more easy to interpret when one wants to know exactly where money is being spent. In addition, no reliable estimate exists as to the amount spent on preventive health. An urgent need exists to collate one single comprehensive database on health care expenditure. Once reliable information is available, every effort should be made to relate expenditure to outcome. Then our scarce resources could be appropriately allocated.

REFERENCES


