

Fiscal Space for Health: Assessing Policy Options in South Africa

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Abstract: South Africa's health care system is at a crossroads. Health care reform is necessary and long overdue. If, within the next 14 years, the country wishes to strive towards universal coverage, public resources for health care will have to be freed up and used more efficiently. What budgetary room does South Africa have to sustain and expand its health services in the short to medium term? This paper outlines the results of a fiscal space analysis conducted for the South African health sector. It highlights the fact that a number of options are available to policy makers, as long as the political will exists to increase public resources for health. Since no such analysis has been conducted to date, such exercises fill a key research gap and contribute to current health care reform debates at a critical juncture in South Africa's history.

JEL Classifications: H21, H32, H50, I10

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1. Introduction

South Africa is at a crossroads (Kleinert et al., 2011) and so is its health care system. The government has committed to the introduction of a National Health Insurance (NHI) within the next 14 years. This pledge is set against a background of delivery, administrative and management challenges, as well as rapidly escalating costs, which have put into question the feasibility and sustainability of the health system (Minister of Health, 2011). The currently over-stretched and poorly performing public health sector threatens quality standards and reinforces existing social inequalities, in a country where 83 percent of the population is not covered by health insurance and therefore relies predominantly on inadequate public health services (Blecher et al., 2011). Moreover, as the country's epidemiological transition advances, South Africa faces a so-called "quadruple burden" of disease - communicable, non-communicable, maternal and injury-related - which simultaneously strain the system (Mayosi et al., 2009). The combination of these challenges, among many others, signals that health care reform is necessary and long overdue.

Public resources for health care will have to increase significantly in order to feasibly enact many of the reforms planned by the government. A ruling party discussion document on a future NHI (ANC, 2010) states that the health sector's share of the overall government budget will need to reach 14 to 14.5 percent – from the current 9.3 percent (WHO, Global Health Observatory) - in order to finance this new system. Costing estimates provided in the 2011 Green Paper on National Health Insurance suggest that spending on publicly funded health services will have to increase from 4.2 percent to 6.2 percent of GDP (Minister of Health, 2011). In addition, the exceptional burden of HIV/AIDS in South Africa, both from a health systems and financial perspective cannot be overlooked. Within the next 20 years, the total HIV/AIDS-related costs to the health system are estimated to range between R598 and R765 billion, equivalent to US\$79-102 billion (aids2031 Project, 2010). In light of these considerations, the government has committed to allocating an additional R12.3 billion between 2012 and 2015 to the health sector (Minister of Health, 2011).

Herein lies the challenge of ensuring that the health system can gain sufficient fiscal space to ensure the sustainability of such manoeuvres. What scope and budgetary room does South Africa have to sustain or expand its health services in the short to medium term? What options are available to the government to expand its resource envelope for health, from a broad policy perspective? Since no such analysis has been conducted in South Africa to date, this exercise fills a key policy gap and contributes to current health care reform debates.

1. Methodological Approach and Conceptual Framework

We conducted a fiscal space analysis to determine South Africa’s prospects for sustainably increasing public spending for health. Fiscal space for health refers to “the ability of governments to increase spending for the sector without jeopardising the government’s long-term solvency or crowding out expenditure in other sectors” (Tandon and Cashin, 2010). Fiscal space analysis is a useful means of assessing, monitoring, or predicting the sources and level of available public resources for a given purpose.

This paper focuses on the latest spending and budget trends in the South African health sector, drawing on the most recent national and international databases, figures and reports. As a conceptual framework, it adopts the five dimensions of fiscal space first conceptualised by Heller (2006) and tailored to the health sector by Tandon and Cashin (2010). This framework provides the key areas where extra revenues for health could feasibly be raised, as outlined in Table 1.

Table 1 Conceptual framework for fiscal space analysis for health

<i>Dimension 1</i>	Conducive macroeconomic conditions, such as economic growth and increases in total government revenue
<i>Dimension 2</i>	A re-prioritisation of health within the government budget
<i>Dimension 3</i>	An increase in health sector-specific resources, such as earmarked taxation
<i>Dimension 4</i>	Health sector-specific grants and foreign aid
<i>Dimension 5</i>	An increase in the efficiency of existing government health outlays

In the allocation of fiscal space, just as in any reform process, consideration for the political mechanisms involved is paramount. What is commonly referred to as policy space (Van der Gaag et al., 2009), acts as an enabler or hindrance in any attempt to alter the status quo. It is clear that issues of feasibility and political buy-in must be given sufficient attention by policy-makers. Although such issues will be touched on in this paper, they largely fall beyond the scope of this analysis and should constitute the subjects of future research.

2. Fiscal Space Analysis

2.1 Conducive Macroeconomic Conditions

One of the strongest predictors of fiscal space and rising government expenditure is national income. Conducive macroeconomic conditions (e.g. sustained economic growth), low levels of fiscal deficits and debt, and improvements in revenue generation are key elements of fiscal space considerations for the health sector (Tandon and Cashin, 2010). It must be noted that economic growth can lead to the creation of fiscal space for health in real terms even without an accompanying increase in the government’s health spending share of GDP. In South Africa’s case, such increases are plausible, given its current economic context, as detailed below.

South Africa is home to 49.3 million people and has a GDP per capita of US\$ 7,275 (World Bank, WDI). Although considered an upper middle income country, it has widespread inequalities (represented by a Gini coefficient of 0.631 in 2009) and 23 percent of the population (2006) falling below the national poverty line (World Bank, WDI). Since the end of apartheid in 1994, South Africa has maintained a solid record on macroeconomic management. It has succeeded in reducing the high budget deficits of the 1980s and for the most part managed to maintain inflation control (IMF, 2010a). Although its economic growth record has been sound - with GDP growth rate averaging 4 percent from 2000 to 2008 – the global financial crisis has had a profound impact on the country (Figure 1).

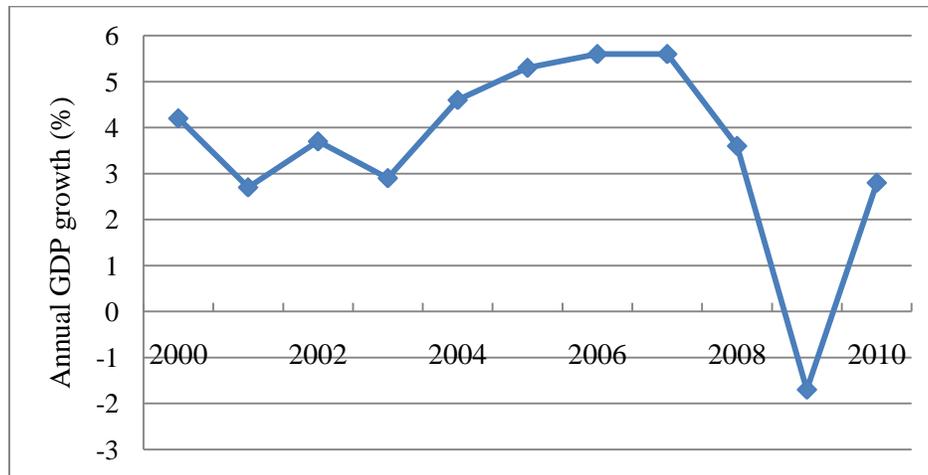


Figure 1 South Africa's annual GDP growth (Source: World Bank, WDI)

The contraction in economic activity in 2009 lasted for three consecutive quarters beginning in the last quarter of 2008 and has led to the loss of 1 million jobs, before GDP picked up again (IMF, 2010a). The elasticity of South Africa's main exports – including primary commodities such as platinum and diamonds - to the economic performance of the Euro area has rendered it particularly vulnerable to the squeezed credit conditions of many advanced countries (IMF, 2010a).

South Africa suffers from an overvalued currency, which leads to a marked deterioration in export market performance and competitiveness; according to IMF estimates, the exchange rate could be between 5 and 15 percent overvalued (IMF, 2010a). South Africa's finances have also recently suffered from a decrease in tax revenue, including VAT, fuel levy, customs and transfer duties and personal income tax (South African Revenue Service, 2010). In fact, the net revenue fell from R615.9 billion in 2008/09 to R594 billion in 2009/10 (South African Revenue Service, 2010).

The picture painted above is, however, mitigated by a number of key factors. First, South Africa was not as strongly hit by the crisis as other upper middle income countries, like Turkey and Mexico (Figure 2). Secondly, there are clear signs that the economy is recovering and that growth will be sustained at around 4 percent of GDP (IMF, 2010b; IMF, 2011). The broad-based recovery seems to be driven by higher consumer spending, resulting from low interest rates and strong real wage growth for those employed (Economist Intelligent Unit, 2011). If this growth persists, it could potentially create some fiscal space for health.

In relation to the link between declining government revenues and fiscal space, three considerations must be made. With tax revenue at 25.5 percent of GDP in 2009, South Africa already exceeds the average of 15.8 percent for upper middle income countries (World Bank, WDI). Given the impressive record of the national revenue service and its efficiency in collecting taxes,

this is unsurprising. Secondly, after a significant dip, net revenue did pick up in 2010/2011, reaching R686.3 billion (South African Revenue Service, 2011). Moreover, South African authorities have stated that should revenue collections continue to rise in the near future, they would spend some of these additional resources to fund urgent development priorities (IMF, 2010a). Health care will hopefully be one such priority.

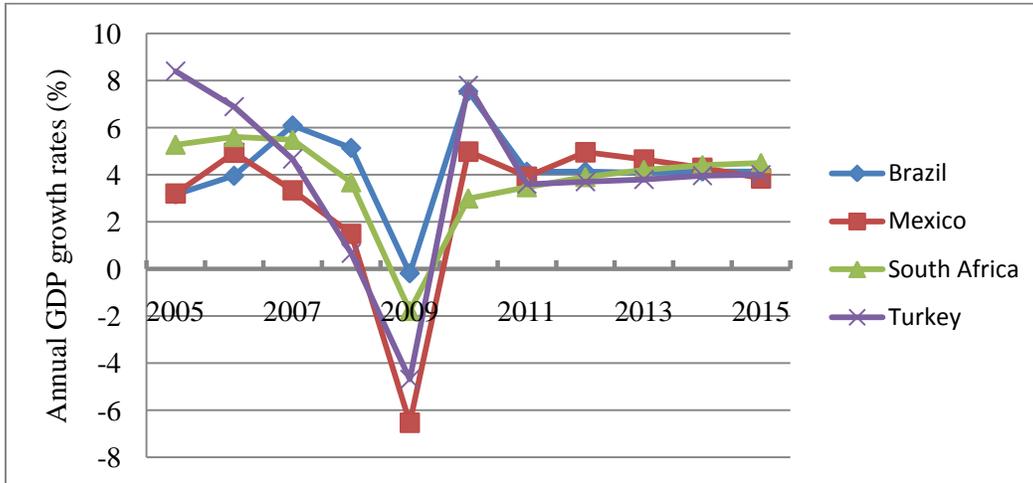
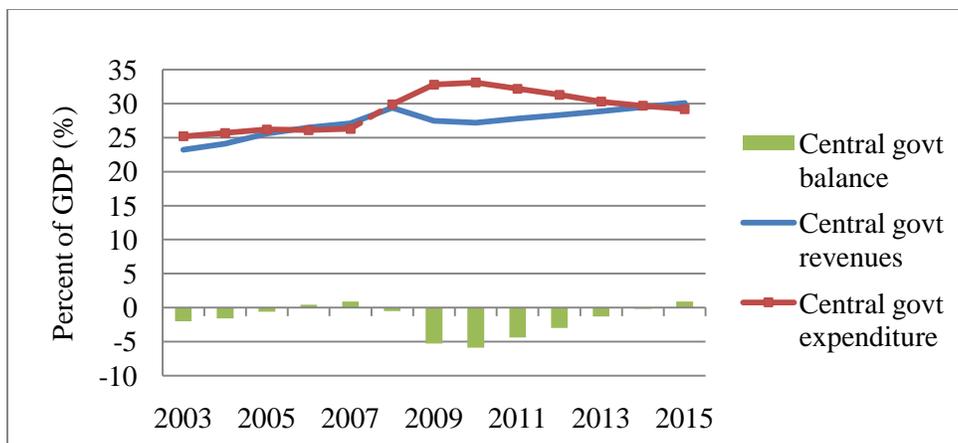


Figure 2 GDP growth rates, S. Africa and comparator countries
Actual: 2005-2009; Projected: 2010-2015 (Source: IMF 2010b)

Finally, in 2010, the current account deficit narrowed from 4 percent in 2009 to 2¾ percent of GDP (IMF 2011), and while public debt is expected to peak just under 40 percent in 2012 (Figure 3), this is low by global standards and is expected to decline steadily in the coming years (Economist Intelligent Unit, 2011). The burden of debt repayment in South Africa is relatively low and does not occupy a disproportionate amount of fiscal space. In addition, the South African government plans to reduce the fiscal deficit through lower spending growth (IMF, 2010a). South Africa’s high levels of domestic investment capital, significant foreign currency reserves and natural resources decrease its overall dependence on global economic markets, placing it in good stead to weather future crises. In sum, the prospects that South Africa’s macroeconomic climate - especially once recovery is completed – could lead to the creation of fiscal space for health are positive.



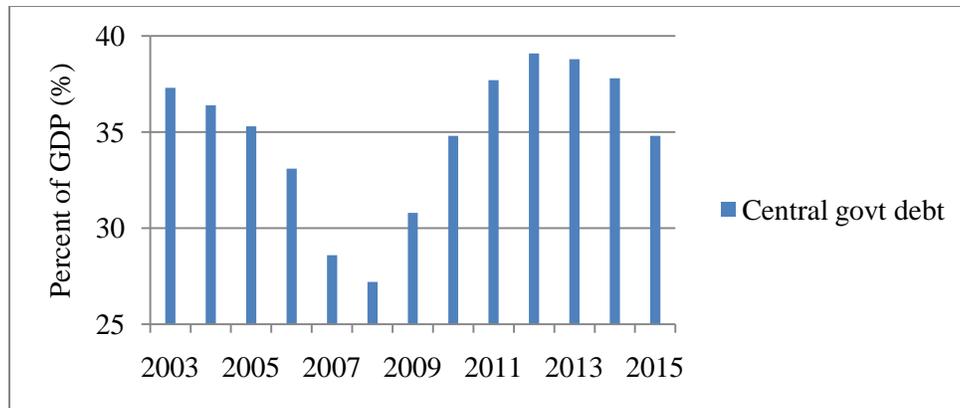


Figure 3 Key fiscal indicators for South Africa
(Central government revenues, expenditure, balance and debts)
Actual: 2003-2011; Projected: 2012-2015 (Source: IMF Article IV, various years)

3.2 A re-prioritisation of Health within the Government Budget

In 2009, the South African government allocated 8.5 percent of its budget to health (World Bank, WDI). South Africa spends more on health than any other African country (Kleinert et al., 2009), in line with other upper middle income countries and just below advanced economies like Norway, Sweden and Finland. Therefore, on the one hand, given that health is already a key priority in South Africa, it may be difficult to argue that the sector deserves extra funds as a result of previous neglect. However, two key arguments can be used to increase fiscal space within this remit.

The first is by arguing that the implementation of the NHI demands extra resources. In its Green Paper, the Minister Health clearly stated that this is imperative and outlined a few measures he plans to use to raise such funds (Minister of Health, 2011). Secondly, the percentage of the budget currently allocated to the health sector continues to be far from South Africa's commitment to the 2001 Abuja summit target of 15 percent. In theory, one argument for the Ministry of Health to gain fiscal space for the sector could be to honour the nation's pledge to reach this objective. Endowed with a relatively high tax-to-GDP ratio (25.5 percent in 2009; World Bank, WDI) and low debt-servicing, this goal should be within the country's reach.

South Africa's public health expenditure amounted to 3.4 percent of GDP in 2009 (World Bank, WDI). Given the high proportion of the population reliant on public services, this percentage is small, although it is in line with the average for other upper middle income countries. What is striking, however, is that this figure has been relatively stable over time (Figure 4). This is surprising because the elasticity of government health spending to GDP generally tends to be greater than one (Tandon and Cashin, 2010; Poullier et al., 2002). That is, government spending on health, on average, tends to rise at a faster rate than the rate of GDP growth. With the exception of the latest recession, GDP in South Africa has grown steadily since 1994; so while the public share of GDP devoted to health would be expected to experience a proportionally greater increase, this has not been the case. In fact, using data from 1999-2009, the elasticity of nominal government health spending in South Africa was calculated by the authors of this paper to be 1.1. The relatively low nature of this figure could offer some room for negotiating extra fiscal space for the health sector within the government budget.

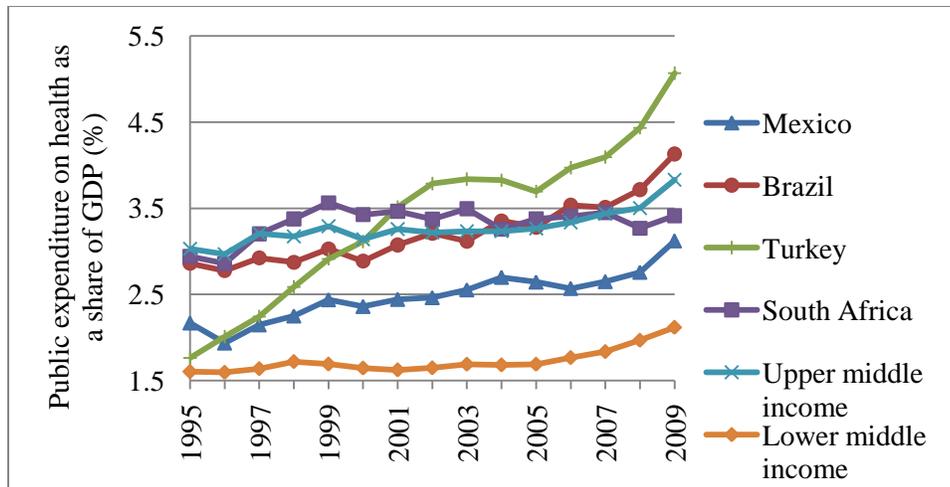


Figure 4 Public expenditure on health as a share of GDP
(Source: World Bank, WDI)

Alternatively, given the political will to do so, the percentage allocation for health given to each province by the central government in South Africa could be modified. The provincial equitable formula gives a 51 percent weight to education but only a 26 percent weight to health (Alm and Martinez-Vazquez, 2009). Perhaps an argument could be made for increasing the funds devoted to health at the provincial level. However, once provinces are allocated their shares, they are free to spend them as they wish, so there are no guarantees that such funding increases would actually be spent on health care. In addition, given that the allocation of the budget is a highly politicised process and there are many competing needs, the scope for increasing fiscal space in this particular respect may be limited. However, as suggested above, a number of arguments can be made to support the idea of increasing the budget share for health in order to bring South Africa in line with international standards.

3.3 An Increase in Health Sector-specific Resources

There are a number of ways in which fiscal space can be generated for use exclusively by the health sector. Earmarked taxes are a popular means of raising revenues for health. Such cordoning-off of resources is not entirely unfamiliar in South Africa, which created a Road Accident Fund to compensate third party victims of road accidents using a hypothecated levy on fuel.

Taxes on tobacco and alcohol (often referred to as ‘sin taxes’) are among the most common types of earmarked taxes around the world. While South Africa already has a strong programme of tobacco control, more revenues could potentially be raised through tobacco price increases. Van Walbeek (2003) suggests that between 1994 and 2001, for every 10 per cent increase in real excise tax on tobacco, real excise revenues increased by approximately 6 per cent. This means that despite reduced consumption - given the high price elasticity of tobacco - government revenue still increased significantly, and could continue to do so. However, one would have to consider how flexible the budget is to accommodate such hikes, whether such earmarking would indeed be acceptable as a fiscal tool, and what impact further price increases would have on illicit sales of tobacco.

Perhaps more feasibly, earmarked revenues from an increase in alcohol prices could be considered. A 2009 *Lancet* article on the state of South Africa’s health suggests that authorities have failed to tackle the negative effects of alcohol consumption (Kleinert and Horton, 2009). The

latest World Health Organisation (WHO) report on alcohol and health (2011) estimates that South Africa's annual adult (recorded and unrecorded) pure alcohol consumption amounts to 9.5 litres per capita. This figure represents the second highest figure in southern Africa after Namibia. Given the wide variation in excise tax (as a percentage of the retail sale price) for different beverages in South Africa, scope exists to increase the price of certain products to increase revenues. For example, Parry et al. (2003) propose that the price of malt and sorghum beer be increased; although politically very sensitive, this measure would produce extra resources for public health, which would in part help compensate for the regressive nature of such a tax. Part of the reason for the feasibility of such taxes (both tobacco and alcohol) is that they have regularly been used in South Africa, with Finance Minister Gordhan announcing further increases in such taxes during his March 2012 budget speech (Gordhan, 2012).

South Africa could also consider an earmarked tax on sugary drinks and foods with a high salt or fat content. Although up-to-date figures are scarce, it is estimated that more than 29 percent of men and 56 percent of women in South Africa are overweight or obese (Goedecke et al., 2006). In a country faced with high levels of both communicable and non-communicable diseases, this would have the positive effect of collecting revenue for health care and address a serious national public health threat. Other innovative ideas to raise health sector-specific funds include those adopted by Ghana, which increased VAT by 2.5 percent to finance its recently introduced national health insurance system, and Zimbabwe, which levies a 3 percent tax on top of existing personal and company income taxes to fund AIDS interventions (McIntyre, 2007).

Another way to increase health sector-specific resources would be to limit allowable deductions on tax returns for medical aid (ie. health insurance) schemes. At present, the South African government subsidizes the high cost of medical aid schemes by allowing part of the contributions to be tax-deductible. Almost five times as much is spent on each person on medical aid than on an uninsured person using the public sector (Harrison, 2009). The highest-income earners, who are taxed at the highest rates, derive the greatest benefit from this subsidy. As McIntyre (2007) suggests, the value of the subsidy to medical aid schemes in 2005 amounted to an estimated R10.1 billion, equivalent to over 20 percent of the government's health budget. The government is therefore losing more revenue through the tax deductibility of medical scheme contributions than it would spend on providing health care through public facilities to those who are currently covered by medical aid schemes (McIntyre, 2007).

Although this would be a controversial move, in the short-run South Africa could consider decreasing the existing tax exemptions, which are regressive and prevent substantive amounts of revenue from going into government coffers. The ruling party's plans for a national health insurance do envisage the removal of such subsidies already (once the NHI is in place), so one proposal could be to decrease such subsidies ahead of time and mandate that these resources be earmarked for the public health system. An important drawback of eliminating these subsidies, of course, would be a decrease in demand for medical aid schemes in the short run, which may lead to a decrease in access to care until a public health insurance system is put in place.

Current South African government plans envisage a mix of earmarked taxes to fund a future NHI, including some of the ones mentioned above (ANC, 2010). Nevertheless, as the 2010 World Health Report explains and economic theory confirms, every tax has some type of distortionary effect and will face opposition by vested interests. Governments need to implement those taxes that best suit their economies, garner political buy-in and avoid imposing an excessive tax burden, however defined. Although moves to increase taxes are welcome from a revenue generating perspective, the political feasibility of such hikes will have to be carefully considered.

3.4 Health Sector-specific Grants and Foreign Aid

Another common way to raise funds for the health sector is to seek additional, health-specific foreign aid from international and other external actors. WHO estimates that in South Africa, 1.2 percent of total health expenditure in 2008 was financed by external sources. Although this proportion has steadily increased each year from 0.5 in 2005, it does not signal a high dependence on external funding. Most overseas development assistance to South Africa, which in 2007 amounted to only 0.4 percent of GDP, is in the form of grants rather than loans and a large portion are in the form of technical cooperation (Ramkolowan and Stern, 2009). Even funding for HIV/AIDS, which is commonly viewed as an area dominated by donor funding, in South Africa comes for the most part from national coffers.

Foreign aid therefore does not seem to be a sustainable option for generating fiscal space in South Africa. First, as Cleary and McIntyre (2010) point out, South Africa is not considered a priority country for donor grants due to its relatively high level of economic development. Secondly, the current financial uncertainty in advanced economies cannot guarantee the reliability and size of such grants. Thirdly, external funding for HIV in particular looks increasingly precarious, as it competes for attention with other pressing health needs. Nevertheless, should it wish to do so, South Africa could avail itself of some external funding if it could demonstrate that resources will be used for health system strengthening, given the renewed interest in this issue by the international community. (By way of example, in 2009, the Health Systems Funding Platform was created as a joint effort between the GAVI Alliance, Global Fund, World Bank, and WHO to ensure better mobilisation and channelling of funding for health system strengthening.) In the short to medium term, kick-starting a sustainable national health insurance system could be one such opportunity.

3.5 An Increase in the Efficiency of Existing Government Health Outlays

Increasing the efficiency of government spending on health is another key means of creating fiscal space. Some countries (such as Sri Lanka) have been able to attain impressive health outcomes with a relatively low level of resources, in part because of the efficiency of their health systems. Figures suggest that South Africa's total health expenditure per capita on health amounts to US\$ 934.95 (PPP constant 2005 prices; World Bank WDI 2010). As outlined earlier, it spends 8.5 percent of GDP (2009) on health, on par with many other advanced economies, without achieving the same standards of health care as the latter. This is in large part due to the scourge of HIV/AIDS, which places an exceptional burden on South Africa. Blecher, et al. (2011) report that, spending on HIV/AIDS comprises approximately 0.7 percent of GDP, and will rise to 1 percent in the next few years. However, the epidemic cannot account for all the challenges inherent in the health system.

A review of progress towards the MDGs suggests that improvements in South Africa have been insufficient or even reversed in many cases (Chopra et al., 2009). Infant mortality, a key indicator for health outcomes in the country, is very high (43.1 per 1,000 live births in 2009), both compared to other upper middle income countries and to countries with lower income levels. In addition, South Africa's maternal mortality provides a worrying trend. In a country whose income level would suggest low and decreasing maternal mortality ratios (MMR), estimates indicate otherwise. From a rate of 230 per 100,000 live births in 1990, the MMR grew to 410 per 100,000 live births in 2008 (WHO, UNICEF, UNFPA, World Bank, 2010). South Africa's poor health outcomes relative to health expenditure suggest that improving the quality and efficiency of care is paramount.

The range of health system outputs across districts and provinces suggests that there are wide discrepancies in performance, resulting from both serious historical disadvantages and differences in efficiency levels. For example, average length of stay in district hospitals varies from 2.2 to 8 days across districts (Harrison, 2009), and the usable bed utilisation rate across provinces varies from 50 to 83 percent (Fonn et al., 2010). In addition, while two provinces in the country have TB cure rates of almost 80 percent (Figure 5), for most of the districts of another province, the cure

rates are between 40 and 60 percent (Fonn et al., 2010). It should be noted that it is difficult to find a single indicator to accurately reflect the concept of efficiency; average length of stay and TB cure rates are just a few of the markers that can be used to measure efficiency. High rates of bed utilisation, for instance, are necessary but not sufficient conditions for higher efficiency, and may vary seasonally depending on the country/regional context. Nevertheless, these figures do suggest that lessons can certainly be learnt from better performing areas and that improvement on these indicators can realistically be achieved.

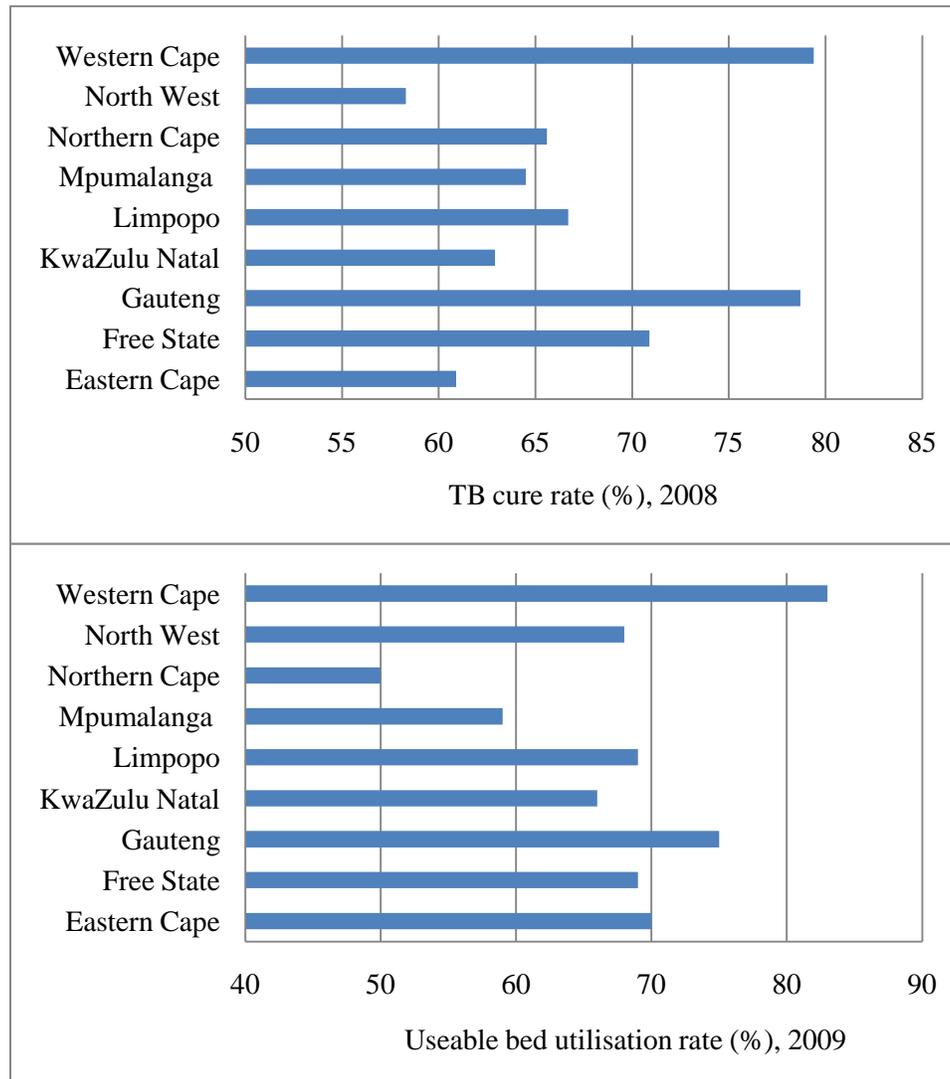


Figure 5 Provincial variation in health system outputs (Source: Fonn, et al. 2010)

One way of increasing efficiencies and thus creating health system savings could be to focus on improving the implementation of decentralisation reforms which were initiated years ago. The 2010 South African Health Review comments on the performance of the health system and highlights its highly fragmented nature. Even though decentralisation through the establishment of a district health system is at the heart of the National Health Act (2004), only one province to date has enacted the legislation to give districts the necessary authority. Weak stewardship at the central

level and a plethora of vertical health programmes overwhelm managers at the local level (Chopra et al., 2009). Harrison (2009) suggests that the success of the district-based system “has been hamstrung by the failure to fully devolve authority, and by the erosion of efficiencies through lack of leadership and low staff morale”. The clarification of responsibility at different levels of government would help improve overall efficiency by reducing duplication and ensuring greater accountability.

Reconsidering the distribution of resources between different levels of care could also lead to significant cost-savings and, most importantly, improved access to care. Although some efforts in this direction are being made, more needs to be done. Currently, 30 percent of total public health expenditure in South Africa is devoted to tertiary institutions in major cities (Chopra et al., 2009). Giving stronger emphasis to primary and community care – which is envisaged by the Green Paper on NHI - for conditions that are best treated at lower levels will decrease costs and ensure more appropriate care. This redistribution can also be aided by improved collection and analysis of data relating to inputs, processes and outputs. The lack of a human resource information system and strong central stewardship function leads to a misallocation of much-needed human resources to primary health care facilities (Chopra et al., 2009).

Another potential way of improving efficiency could be to institute some form of results-based financing (RBF), as Rwanda and several other countries have done. South African provinces receive both unconditional transfers and conditional transfers from the central government. While the Department of Health sets the conditions for how the latter should be spent and is responsible for monitoring compliance, in practice this does not always happen (Berger et al., 2007). Strengthening this conditionality could help to increase the efficiency and quality of care. Rather than ‘punishing’ poorly-performing provinces and districts - as RBF is commonly perceived to do - one could reward those that show improvement. By using a pre-defined and carefully monitored set of indicators, those provinces or districts that can demonstrate improvements from their previous performance levels could receive bonus resources. Alternatively, incentives to hospital managers or individual health care providers could be effective in both improving quality and increasing the overall efficiency of the system, which in turn could free up fiscal space. Evidently, political support for such an incentive system would have to be sought from a number of stakeholders; winning the buy-in of trade unions in South Africa would be particularly important for such an initiative to succeed. It must also be considered that RBF involves additional resources and may not be the most cost-effective way to achieve efficiency gains, but nevertheless constitutes an innovative and possible tool in the government’s arsenal.

Given the size of the burden and costs of HIV/AIDS to the South African health sector, achieving efficiencies in HIV/AIDS service delivery could also have a substantial impact. These are possible in many areas, including further reduced ARV tender prices through the procurement of generics, use of step-down and community-based approaches for delivering HIV care and rolling out nurse-initiated treatment (aids2031 Project, 2010). Integrating HIV/AIDS services into countries’ broader health systems is presumed to be cost-efficient, and research is currently being undertaken to determine the extent and amount of these cost-saving measures. In sum, if the political will to do so exists, the scope for increasing fiscal space through the creation of health sector efficiencies is ample.

4. Conclusion

Fiscal space analyses can be used as advocacy tools to demonstrate the need and potential impact of increasing the share of public resources devoted to particular sectors. They can help mobilize evidence for action, particularly when inaction is justified on the basis of lack of funds. In the context of ongoing health reforms in South Africa, such exercises become particularly important. This paper argued that sustained economic growth, a commitment to increasing the budget share for health, and guarantees that additional funds will be earmarked for the health sector, have the potential to significantly contribute to the creation of fiscal space. Even if no additional resources become available, the government could free up fiscal space by achieving much-needed efficiency gains. In sum, by systematically analyzing those areas where additional resources could be carved out, this paper offers some hope that, given political will, resources for health can be created without jeopardizing the country's impressive macroeconomic achievements.

References

- [1] Aids2031 Project, Costs and Financing Working Group (2010), *The Long-Term Costs of HIV/AIDS in South Africa*. Washington DC: Results for Development Institute.
- [2] Alm J, Martinez-Vazquez J. (2009), South Africa's Provincial Equitable Share: An Assessment of Issues and Proposals for Reform. Working Paper 09-04, Atlanta: Georgia State University.
- [3] ANC National General Council (2010), Discussion Document on National Health Insurance.
- [4] Benatar S. (2004), "Health Care Reform and the Crisis of HIV and AIDS in South Africa", *New England Journal of Medicine*, 351: 81-92.
- [5] Blecher M, Day C, Dove S and Cairns R. (2008), "Primary Health Care Financing in the Public Sector", In: Barron P. and Roma-Reardon J. (Eds), *South African Health Review*, Durban: Health Systems Trust.
- [6] Blecher M, Kollipara A, DeJager P, and Zulu N. (2011), "Health Financing", In: Padarath A, English R, (Eds). *South African Health Review*, Durban: Health Systems Trust.
- [7] Booysen F. (2004), "Social Grants as Safety Net for HIV/AIDS-affected Households in South Africa", *Journal of Social Aspects of HIV/AIDS Research Alliance*, 1(1):45-56.
- [8] Chopra M, Lawn J, Sanders D, et al. (2009), "Achieving the Health Millennium Development Goals for South Africa: Challenges and Priorities", *The Lancet*, 374(9694):1023-1031.
- [9] Cleary S and McIntyre D. (2010), "Financing Equitable Access to Antiretroviral Treatment in South Africa", *BioMed Central Health Services Research*, 10(Suppl 1): S2.
- [10] Doetinchem O, Lamontagne E and Greener R. (2010), "Health Insurance and AIDS: a Review of Experiences", Paper presented at Economics Reference Group meeting, Washington DC, 29 September, 2010.
- [11] Economist Intelligence Unit (2010), *South Africa Country Report*, London: Economist Intelligence Unit, March 2010.
- [12] Fonn S and Padarath A (Eds) (2010), *South African Health Review 2010*. Durban: Health Systems Trust.
- [13] GAVI Alliance, Global Fund, World Bank, and WHO, (2011), Health Systems Funding Platform Workplan Update, [On-line] Available at: <http://siteresources.worldbank.org/INTHSD/Resources/topics/415176-1251914777461/WorkplanUpdateJuly2011FINAL.pdf>
- [14] Goedecke J, Courtney J, and Lambert E. (2006), "Obesity in South Africa", In: Steyn K, Fourie J and Temple N (Eds). *Chronic Diseases of Lifestyle in South Africa: 1995 – 2005*. Cape Town: South African Medical Research Council.
- [15] Gordhan, P. (22 February 2012), Budget Speech 2012: Full transcript. *Times Live*.

- [16] Harrison D. (2009), "An Overview of Health and Health Care in South Africa, 1994-2010: Priorities, Progress and Prospects for New Gains", Discussion document, Muldersdrift: Henry Kaiser Family Foundation.
- [17] Health in South Africa series (2009), *The Lancet*, [On-line] available at: <http://www.thelancet.com/series/health-in-south-africa>
- [18] Heller P. (2006), "The Prospects of Creating 'Fiscal Space' for the Health Sector", *Health Policy and Planning*, 21(2):75-79.
- [19] IMF (2010a), "Article IV Consultation for South Africa", *IMF Country Report* No. 10/296. Washington DC: IMF.
- [20] IMF (2010b), World Economic Outlook database, [On-line] available at: <http://www.imf.org/external/pubs/ft/weo/2010/02/weodata/index.aspx>
- [21] IMF (2011), "Article IV Consultation for South Africa", *IMF Country Report* No. 11/258. Washington DC: IMF.
- [22] Kleinert K and Horton R. (2009), "South Africa's Health: Departing for a Better Future?", *The Lancet*, 374(9692):759-760.
- [23] Mayosi B, Flisher A, Lalloo U, Sitas F, Tollman S, Bradshaw D. (2009), "The Burden of Non-Communicable Diseases in South Africa", *The Lancet*, 374(9693): 934-947.
- [24] McIntyre D. (2007), *Learning from Experience: Health Care Financing in Low- and Middle-Income Countries*. Geneva: Global Forum for Health Research.
- [25] McIntyre D, Doherty J and Gilson L. (2003), "A tale of Two Visions: the Changing Fortunes of Social Health Insurance in South Africa", *Health Policy and Planning*, 18(1):47-58.
- [26] Minister of Health (2011), *National Health Insurance in South Africa*, Policy Paper of Pretoria: Government Gazette, No.34523.
- [27] National Health Accounts Database (2012), [On-line] Available at: <http://www.who.int/nha/country/zaf/en/>
- [28] OECD (2010), African Central Government Debt, *Statistical Yearbook, 2003-2007*.
- [29] Padayachee V. (2010), *The Political Economy of Africa*. London: Routledge.
- [30] Parry C, Myers B and Thiede M. (2003), "The Case for an Increased Tax on Alcohol in South Africa", *South African Journal of Economics*, 71(2):137-145.
- [31] **Pauw K, and Mncube L. (2007), "Expanding the Social Security Net in South Africa: Opportunities, Challenges and Constraints", Brasilia: International Poverty Centre.**
- [32] Poullier J P, Hernandez P, Kawabata K and Savedoff W. (2002), "Patterns of Global Health Expenditures: Results for 191 Countries", *Discussion Paper* No. 51, Geneva: WHO.
- [33] Ramkolowan Y and Stern M. (2009), "The Developmental Effectiveness of Untied Aid: Evaluation of the Implementation of the Paris Declaration and of the 2001 DAC Recommendation on Untying ODA to the LDCs: South Africa Country Study", Pretoria: Development Network Africa.
- [34] Republic of South Africa (2010), Country Progress Report on the Declaration of Commitment on HIV/AIDS: 2010 Report. Pretoria: RSA.
- [35] South African National AIDS Council (2007), *HIV & AIDS and STI National Strategic Plan 2007-2011*.
- [36] South African Revenue Service (2010), *Annual Report: 2009-2010*.
- [37] South African Revenue Service (2011), *Annual Report: 2010-2011*.
- [38] Tandon A and Cashin C. (2010), "Assessing Public Expenditure on Health From a Fiscal Space Perspective", *Discussion Paper*, Washington DC: World Bank.

- [39] UNDP (2010), Human Development Report. New York: UNDP.
- [40] Van Der Berg S, Siebrits F and Lekezwa B. (2010), “Efficiency and Equity Effects of Social Grants in South Africa”, *Working Paper* No. 15/10. Stellenbosch: University of Stellenbosch.
- [41] Van der Gaag J, Hester V, Hect R, et al. (2009), “Fiscal Space and Political Space for Financing the Global AIDS Response to 2031”, Aids2031 Project Financing Working Group, Working Paper No. 17.
- [42] Van Walbeek C. (2003), *Tobacco Excise Taxation in South Africa*. Geneva: WHO.
- [43] WHO (2012), Global Health Observatory Database, [On-line] Available at: <http://www.who.int/gho/en/>
- [44] WHO (2012), Global Health Expenditure Database, [On-line] Available at: <http://apps.who.int/nha/database/DataExplorerRegime.aspx>
- [45] WHO (2010), *World Health Report 2010: Health Systems Financing, The Path to Universal Coverage*, Geneva: WHO.
- [46] WHO (2011), Global Status Report on Alcohol and Health.
- [47] WHO (2012), Global Information System on Alcohol and Health database, [On-line] Available at: <http://apps.who.int/globalatlas/default.asp>
- [48] WHO, UNICEF, UNFPA and World Bank (2010), *Trends in Maternal Mortality: 1990 to 2008*, Geneva: WHO.
- [49] World Bank (2012), World Development Indicators (WDI) Database, [On-line] Available at: <http://data.worldbank.org/country/south-africa>.