

SOUTH AFRICA



2018/19

2018/19
Health
Budget Brief
South Africa

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Acronyms

AIDS | Acquired Immunodeficiency Syndrome
ARV | Antiretroviral (drug)
DHS | District Health Services
DHS | District Health System
DHIS | District Health Information System
GDP | Gross Domestic Product
GHS | General Household Survey
GP | General Practitioner
HIV | Human Immunodeficiency Virus
HPV | Human Papilloma Virus
HST | The Health Systems Trust
MTEF | Medium-Term Expenditure Framework

MTSF | Medium-Term Strategic Framework
NDoH | National Department of Health
NDP | National Development Plan
NHI | National Health Insurance
NHIF | National Health Insurance Fund
NHLS | National Health Laboratory Service
NPOs | Non-Profit Organisations
ODA | Official Development Assistance
PHC | Primary Health Care
RAF | Road Accident Fund
RSA | Republic of South Africa
SLAs | Service Level Agreements
TB | Tuberculosis
WHO | World Health Organization

Preface

This budget brief is one of five that explores the extent to which the national budget and social services sector budgets address the needs of children under 18 years in South Africa. *This budget brief analyses trends in health expenditure and allocations at the national and provincial levels. Our analyses are restricted to Departments of Health, even though additional health spending happens in the Departments of Correctional Services, Defence and other departments and in some of the statutory funds, such as the Road Accident Fund (RAF). In addition to examining broader spending and allocation trends, this budget brief focuses on spending equity at the District level to quantify the degree of spatial inequality in the distribution of health spending.*

Key Messages and Recommendations

South Africa plans to spend R200 billion on national and provincial health programmes in 2018/19. Combined health spending will grow by 0.5 per cent above inflation on average annually over the next three years. Overall, the country spends more than 13 per cent of its public resources on national and provincial health programmes and its combined spending is 4 per cent of the Gross Domestic Product (GDP).

Combined health spending made impressive gains in the post-2008 period, but health spending has been reined in since 2012, and the true extent of the declines is felt over the 2018 Medium-Term Expenditure Framework (MTEF). Provincial Government health budgets are projected to grow by a mere 0.2 per cent above inflation on average for the next three years. The Government is encouraged to:

- I. Continue to protect the spending items that have been designated as non-negotiable by the Minister of Health, which include medicines, medical supplies, laboratory and food services and HIV/AIDS;
- II. Build on Provincial Government successes in sustaining the non-negotiable spending items over the MTEF by finding a good balance between front-line personnel spending and non-negotiable spending items; and
- III. While reductions in infrastructure spending were driven by poor spending performance, 'savings' in health budgets should not depend solely on reductions to infrastructure, because health infrastructure in poor rural areas remains critical for service delivery.

Despite a substantial slowdown in real spending over the 2018 MTEF, the health sector has managed to produce an array of impressive outcomes. Life expectancy has been raised, infant and under-5 mortality rates have declined, and reductions in mother-to-child transmission of HIV have been achieved. The Government is encouraged to:

- I. Continue its innovations in the health sector such as its new medicine dispensing model and its centralised procurement of vital medicines such as antiretrovirals (ARVs);
- II. Encourage these innovations to create additional fiscal space to invest in the country's Primary Health Care (PHC) systems as a key strategy to ensure universal health coverage, and;
- III. While it is reasonable to assume that specific combinations of personnel and non-personnel spending would have made the production of improved outcomes possible, the health sector needs to define baseline personnel spending that should not be subject to expenditure cuts over the 2018 MTEF.

Underspending continues to plague provincial budgets. Underspending in health budgets is driven mainly by supply chain management problems (procurement), pressures associated with cash flow challenges, and NPOs that are non-compliant. Provincial Governments are encouraged to:

- I. Devise a plan to increase budget utilisation by improving planning and execution functions;
- II. Put in place a plan to address and gradually eliminate the large spending arrears in health departments to improve planning and budget execution;
- III. Intensify its focus on Non-Profit Organisations' (NPOs) financing and governance arrangements because NPOs are often implicated in underspending in both national and provincial health departments; and
- IV. Reduce delays in procurement for infrastructure and capital items more generally, because delays in procuring emergency vehicles for example create service delivery backlogs that could have life-changing consequences for individuals and communities that need it most.

The distribution of public health resources at the District level does not yet reflect the vision of equitable access to health services, especially for poor and marginalised communities. The Government is encouraged to:

- I. Refine distribution models at the District level to reflect relative need as the central variable in the allocation of resources; and
- II. Invest in studies that probe both the efficiencies and the inefficiencies in the provision of health services at the District level to arrive at appropriate benchmark levels of spending on PHC services.

SECTION 1.

Introduction

Governance and National Policy

In South Africa, the National Department of Health (NDoH) is responsible for policy making, coordination and oversight of health services in the country, while the nine provincial departments bear the main responsibility for service delivery. The Department of Health derives its mandate from the National Health Act (2003), which requires that the department provides a framework for a structured and uniform health system for South Africa. The Act sets out the responsibilities of the National, Provincial and Local Government spheres in the provision of health services. In addition to the National Health Act, other legislation and emerging policy that guide the work of the health sector include:

- The Mental Health Care Act (No. 17 of 2002), which provides for the care, treatment and rehabilitation of people who are mentally ill;
- The Medical Schemes Act (No. 131 of 1998), which provides for the registration and control of activities of medical schemes, protects the interests of members of medical aid schemes and establishes the Council for Medical Schemes;
- The Traditional Health Practitioners Act (No. 35 of 2004), which establishes a framework to ensure the efficacy, safety and quality of traditional health care services and to provide management and control over the registration, conduct and training of practitioners and students;
- The South African Medical Research Council Act (No. 58 of 1999), which provides for the continued existence of the South African Medical Research Council and its management by an appointed board;
- The Nursing Act (No. 33 of 2005), which promotes the provision of nursing services to inhabitants and ensures that professional and ethical standards are maintained and upheld in all matters pertaining to nursing;
- Free health care for pregnant women and children under the age of six years; and
- The National Health Insurance Bill, which aims to provide mandatory prepayment health services in terms of Section 27 of the Constitution, establish a National Health Insurance Fund (NHIF), and ensures the creation of mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund.

In terms of the Government's Outcomes Framework, the health department contributes directly to the realisation of Outcome 2 ('a long and healthy life for all South Africans') of the Government's 2014–2019 Medium-Term Strategic Framework, MTSF (RSA Government, MTSF, 2014–19). The MTSF allows the National Government to embed electoral

campaign promises in national policy and ensures the alignment of policy goals with the country's long-term vision, the National Development Plan (NDP). The *National Development Plan 2030*ⁱ provides the high-level targets for the health sector and these include:

- Raise life expectancy to at least 70 years;
- Ensure that the generation of under-20s is largely free of HIV;
- Significantly reduce the burden of disease, and;
- Achieve an infant mortality rate of less than 20 deaths per 1 000 live births, and an under-5 mortality rate of less than 30 per 1 000.

Indicators on the Performance of the Health System

Figure 1 depicts a steady rise in the percentage of new tuberculosis (TB) clients that were successfully treated and a slow, but consistent decline in the mother-to-child transmission HIV rates (from 1.5% in 2014/15 to 1.3% in 2016/17). The HIV prevalence rate for young people (15-24) has remained constant at around 5.8 per cent over the last three years, and although the Human Papilloma Virus (HPV) coverage for Grade 4 girls appears to dip in 2016/17 (from 85.3% in 2015/16 to 79.3% in 2016/17), the National Department of Health aims to achieve a 90 per cent coverage rate for young girls in Grade 4 by March 2021.

FIGURE 1:
Health sector performance,
2014 to 2016 (%)ⁱⁱ | Source:

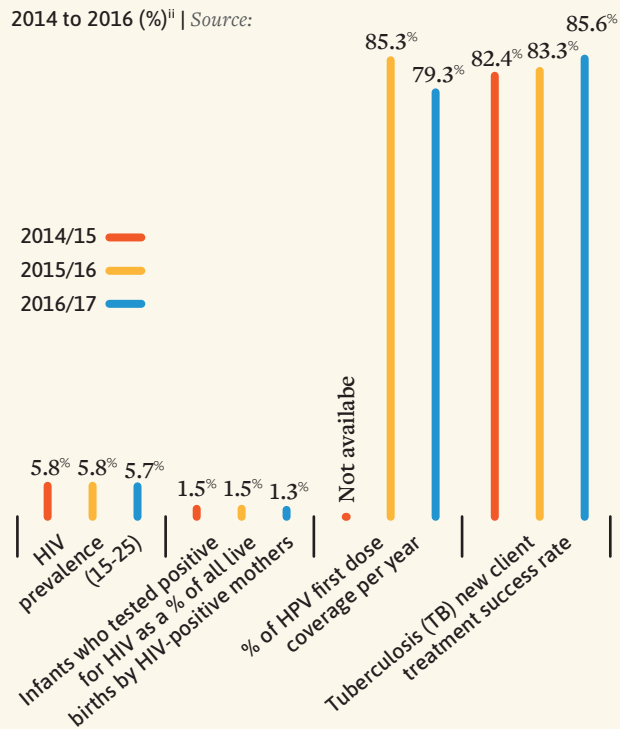


Figure 2 documents the progress made in reducing the under-5 mortality rate between 2000 and 2017 (53% reduction), while approximately one-third (29%) of neonatal deaths per 1,000 live births occurred in 2017 versus a corresponding mortality figure of one-fifth (23%) neonatal deaths in 2000. The mortality rate for children and young adolescents (5-14) was reduced from 9,000 deaths in 1990 to 8,000 deaths in 2017.

Key Fiscal Indicators on the Health System

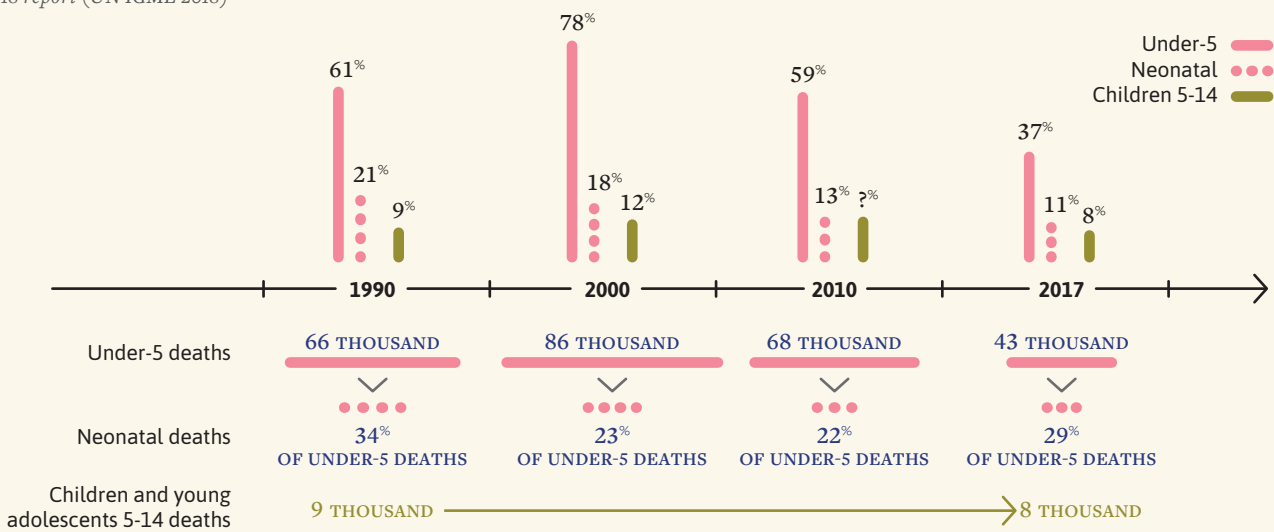
Primary health care constitutes approximately one-third of the budgets of the combined health sector, while spending on personnel consumes 61 per cent of combined health resources. Although official development assistance constitutes a small share of the budget of the national Department of Health (roughly ZAR 1.4 billion in 2018/19), it finances vital spending on priority diseases such as HIV/AIDS and tuberculosis (TB).

TAKEAWAYS

- » The NDoH continues to focus on diseases such as HIV/AIDS and TB that place tremendous pressure on the financing and physical health infrastructure of the country.
- » Successes are being achieved on key disease targets such as the reduction in the mother-to-child transmission of HIV and the extension of HPV to young girls in primary schools.
- » In the country’s overall climate of fiscal austerity, it is vital that donors’ contributions in fighting HIV/AIDS and TB are continued, to safeguard important gains.
- » Primary health care commands a healthy slice of combined health budgets, but in the context of the implementation of the National Health Insurance (NHI), significant increases in its share of health spending will be required.

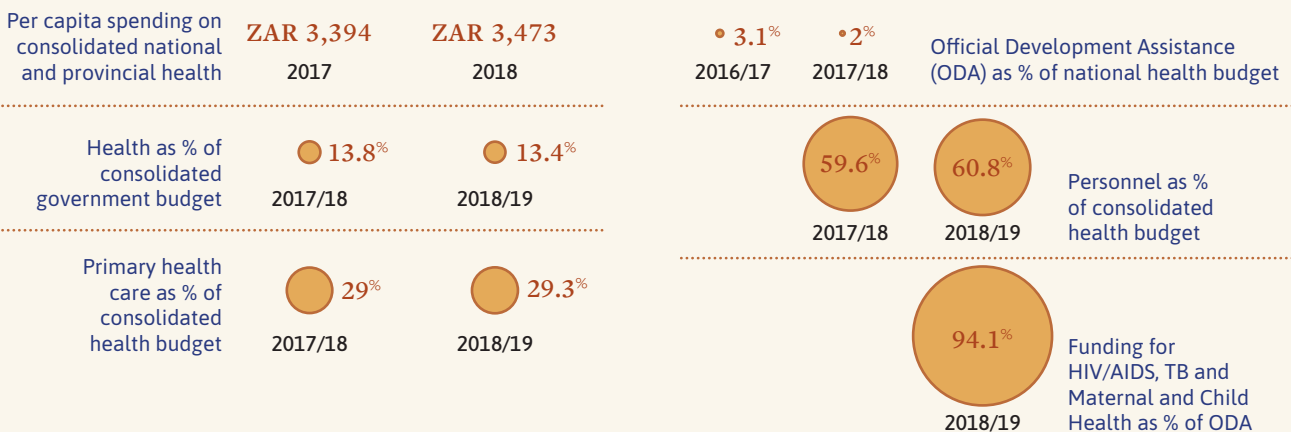
FIGURE 2:

Mortality rates and deaths by age (deaths per 1,000 live births), 1990 to 2017 | Source: UN Inter-agency Group for Child Mortality Estimation 2018 report (UN IGME 2018)



BOX 1:

Key fiscal indicators of the health system, 2016–2018ⁱⁱⁱ | Source: Estimates of National Expenditure 2018 and Provincial Revenue and Expenditure Estimates 2018



SECTION 2. Health Spending Trends

Size of Spending

The NDoH and the nine provincial health departments are projected to spend ZAR 200 billion in 2018/19.

The NDoH plans to spend ZAR 6 billion (3%), while the lion's share of the allocation goes to provincial departments of health (97%). Roughly 87 per cent of the budget (or ZAR 41 billion) of the NDoH are transfers in the form of conditional grants to provincial health departments.

Allocations to health departments constitute 13.4 per cent of total government resources in 2018/19 and roughly 4 per cent of the country's Gross Domestic Product (GDP). Given the restricted definition of health spending and allocations in the country adopted in the budget brief, South Africa might be much closer to the spending target of 15 per cent contained in the Abuja Declaration.^{iv} A spending tally of ZAR 223 billion in 2018/19 would have ensured South Africa's compliance with the Abuja Declaration.

TABLE 1:

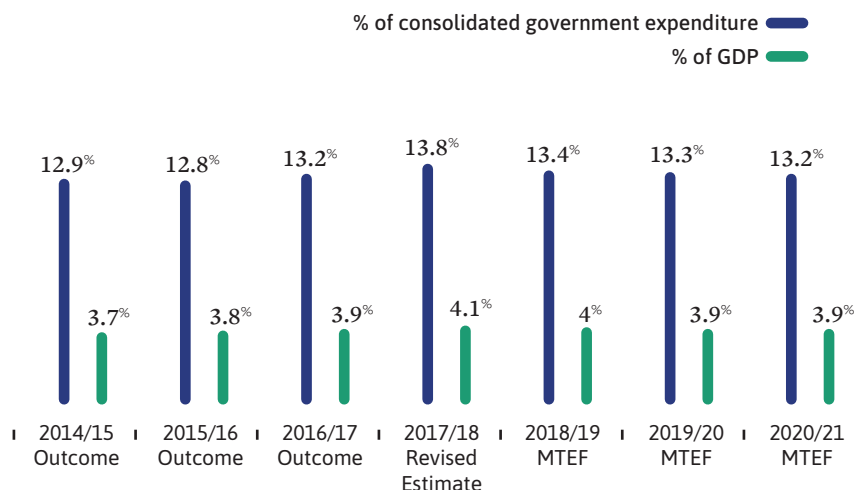
Summary of nominal national and provincial health budgets, 2018/19 (ZAR billion) | Source: Estimates of National Expenditure 2018 and Estimates of Provincial Revenue and Expenditure 2018

	National	Provincial	% of total	Provincial population (million)
National Department of Health	47.1			
Of which transfer to provinces	-41.1			
Net National Department of Health spending	6.0		3.0%	
Combined provincial health budgets		194.4	97.0%	
Eastern Cape	23.7		12.2%	6.7
Free State	10.4		5.4%	2.8
Gauteng	46.4		23.9%	13.5
KwaZulu-Natal	42.3		21.8%	10.8
Limpopo	19.3		9.9%	5.7
Mpumalanga	13.3		6.8%	4.3
Northern Cape	4.7		2.4%	1.2
North West	11.2		5.7%	3.8
Western Cape	23.1		11.9%	6.4
CONSOLIDATED HEALTH BUDGET	200.4			

FIGURE 3:

Consolidated health expenditure as a percentage of consolidated government expenditure^v and the GDP, 2014/15 to 2020/21 | Source: Estimates of National Expenditure 2018, Estimates of Provincial Revenue and Expenditure 2018 and Budget Review 2018

Note: Health expenditure is strictly limited to expenditures in the National Department of Health and Provincial Departments of Health budgets. It excludes relevant health expenditure in other departments such as Defence, Correctional Services and in statutory funds such as the RAF or the Workmen's Compensation Fund.



Spending Changes

Inflation-adjusted growth on the combined health budget between 2014/15 and 2017/18 was robust and positive.

Despite substantial cost containment measures that were introduced during this period, combined health spending outpaced inflation. However, over the new Medium-Term Expenditure Framework (MTEF), combined health spending is severely limited and suffers a real decline in 2018/19. Allocations to health departments are projected to recover to its 2017/18 levels at the end of the MTEF (2020/21).

FIGURE 4:
Nominal and inflation-adjusted consolidated health spending and allocation trends, 2014/15 to 2020/21 (ZAR billion): 2014/15=100 |
Source: Estimates of National Expenditure 2018 and Estimates of Provincial Revenue and Expenditure 2018 (own calculations)

The Priority of Health in the Budget

One of the defining features of the country's management of its public finances in the aftermath of the 2008 global economic crisis has been its consistent commitment to maintain what it calls the 'social wage'.^{vi} Social sector spending that benefit children, including health budgets, was consistently adjusted upwards, even during this period of fiscal adjustment. At 13.4 per cent of the total budget in the current fiscal year, the health sector is the second largest recipient of resources, trailing only basic education (16.5 per cent) and receiving slightly more than social development (12.9 per cent) (Figure 5). When combined, the three largest social service sector votes account for nearly 45 per cent of consolidated government expenditure, a ratio that has remained quite stable since 2013/14.

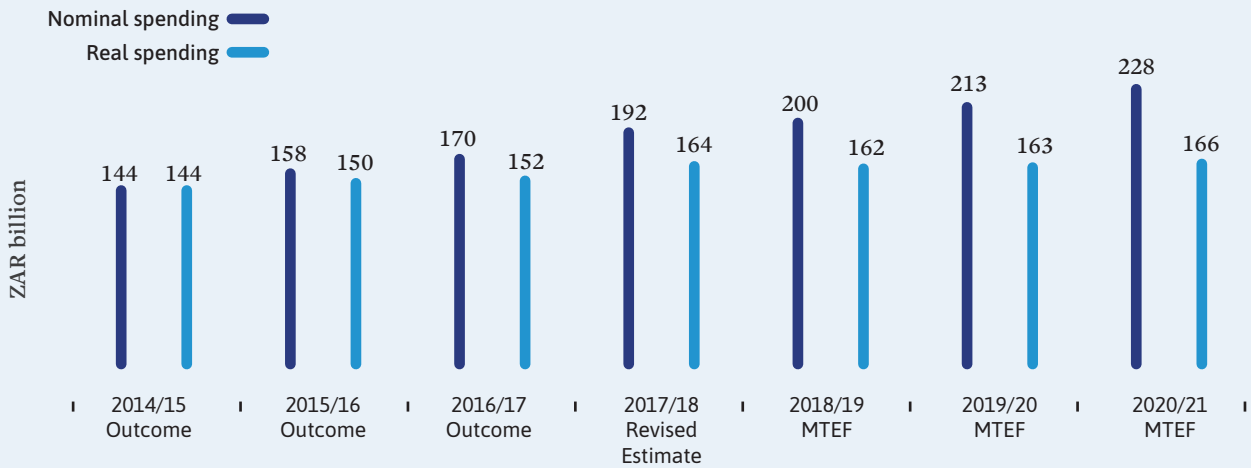
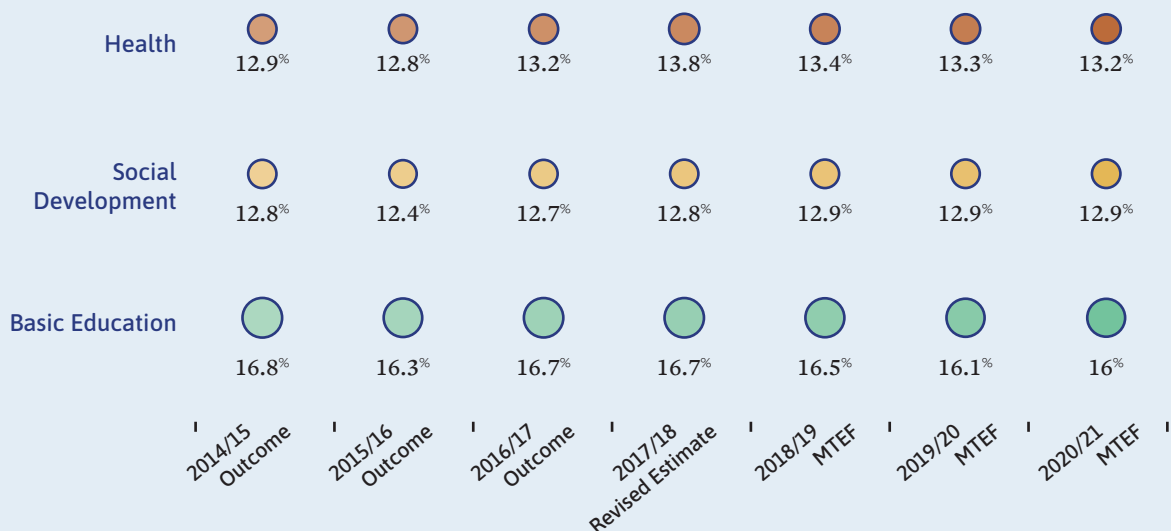


FIGURE 5:
Social service sectors as a percentage of consolidated government expenditure, 2014/15 to 2020/21 | Source: Estimates of National Expenditure 2018 and Estimates of Provincial Revenue and Expenditure 2018



TAKEAWAYS

- » The Government’s commitment to maintain inflation-adjusted growth in health budgets is under pressure because of intense demands emanating from its fiscal consolidation project.
- » Combined health spending is slowed down considerably over the country’s 2018 MTEF, which is cause for concern, given the country’s ambitious plans to implement the NHI.
- » Despite these challenges, the combined health budget (using our restricted definition) comes close to meeting the 15 per cent spending target contained in the Abuja Declaration of 2000, and consumes more than 13 per cent of national government resources and 4 per cent of the country’s GDP.
- » Collectively, spending on the social sectors (basic education, health and social development) consumes almost half of total government resources, which is evidence of the Government’s continued commitment to the country’s ‘social wage.’



SECTION 3. Composition of Health Spending

Composition of Spending by Department

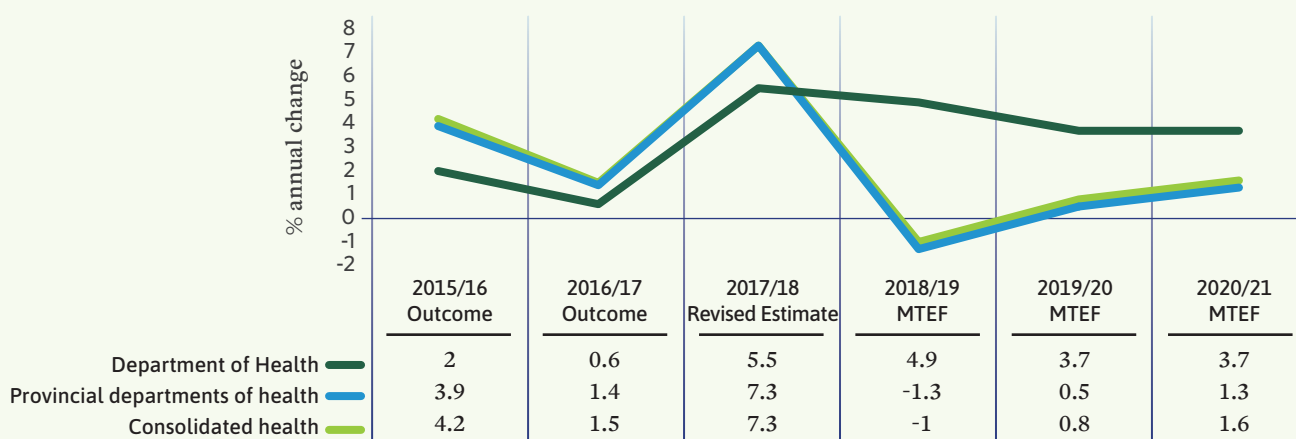
Provincial health budgets are projected to decline in real terms in 2018/19 (-1.3%), barely grow in 2019/20 (+0.5), and marginally

recover at the end of the MTEF (+1.3%). In the context of the challenges we discuss in Section 4 (spending arrears, medico-legal claims, and a shrinking resource base), these numbers are cause for concern. Efficiency gains and a focus on high impact interventions

are vital to compensate for the slow growth in resources to the sector. Overall growth in the health sector mirrors that of spending trends in provincial health departments because the largest share of spending on health is channelled to these departments.

FIGURE 6: Inflation-adjusted spending trends in health departments^{vii}, 2014/15 to 2020/21 (2014/15=100) | Source: Estimates of National Expenditure 2018 and Estimates of Provincial Revenue and Expenditure 2018

Note: Total consolidated health expenditure nets out the transfers to provincial health departments.



Composition of Spending by Programme: National Health Budget

Spending and allocations in the NDoH's budget are expected to grow from R34 billion in 2014/15 to more than R56 billion in 2020/21. Over the MTEF, the NDoH allocations are projected to grow by 4 per cent above inflation on average, while in 2018/19, its allocation is planned to grow by 5 per cent above inflation. However, because the bulk of the department's budget are transfers to provincial health departments, it is more important to assess whether this part of the allocation outpaces inflation.

Composition of Spending by the Type of Expenditure: National Health Budget

Transfers to provinces and municipalities to deliver health services constitutes between 88 and 90 per cent of total national health funding (Figure 7). This expenditure item reflects all the conditional grants that are paid over to provincial health departments. Although the budget brief does not show the growth of this allocation over the MTEF, transfers to provinces are projected to grow by 3.1 per cent

above inflation on average over the next three years. Due to the aggressive cost containment measures undertaken, spending and allocations on Goods and Services (inclusive of medicines) have been reduced from 6.8 per cent of total spending in 2014/15 to 3.6 per cent in 2018/19. Further reductions are on the cards over the MTEF and by the end of 2020/21, this expenditure item is projected to make up just 3 per cent of national health spending.

Spending and Allocations on Provincial Health Budgets

Provincial health spending is projected to increase its spending from R194 billion in 2018/19 to R220 billion at the end of MTEF at a real average annual rate of 0.2 per cent. (Table 3). In 2018/19, provincial health allocations are projected to decline in real terms by 1.3 per cent, and it is only the Provincial Hospital Service programme that manages to achieve inflation-adjusted gains. Over the MTEF, only the District Health Services and the Provincial Hospital Services programmes manage to achieve positive real growth rates (1.1% and 1.1% respectively). Allocations to the Central Hospital Services programme are merely maintained over the MTEF.

TABLE 2:

Programme expenditure in the national health budget, 2014/15 to 2020/21 (ZAR billion):

2014/15=100 | Source: Estimates of National Expenditure 2018

Note: To promote readability, the financial numbers have been rounded up.

	2014/15 Outcome	2015/16 Outcome	2016/17 Outcome	2017/18 Revised Estimate	2018/19 MTEF	2019/20 MTEF	2020/21 MTEF	Real change between 2017/18 and 2018/19 (%)	Real average annual change over MTEF (%)
Administration	0.4	0.4	0.4	0.5	0.6	0.6	0.6	1.4	1.3
National Health Insurance, Health Planning and Systems Enablement	0.3	0.6	0.7	0.9	1.7	2.4	3.1	73.2	43.7
HIV/AIDS, TB, and Maternal and Child Health	12.8	14.2	16	18.3	20.7	22.9	25.3	7.5	5.8
Primary Health Care Services	0.2	0.2	0.2	0.3	0.3	0.4	0.4	8.4	11.8
Hospitals, Tertiary Health Services and Human Resources Development	18.4	19	19.5	20.9	22.1	23.4	24.8	0.3	0.4
Health Regulation and Compliance Management	1.3	1.6	1.7	1.7	1.8	1.9	2	-2.5	-0.7
Total	33.5	36	38.5	42.6	47.1	51.5	56.3	4.9	4.1

FIGURE 7:

Expenditure by type in national health budget, 2014/15 to 2020/21 | Source: Estimates of National Expenditure 2018

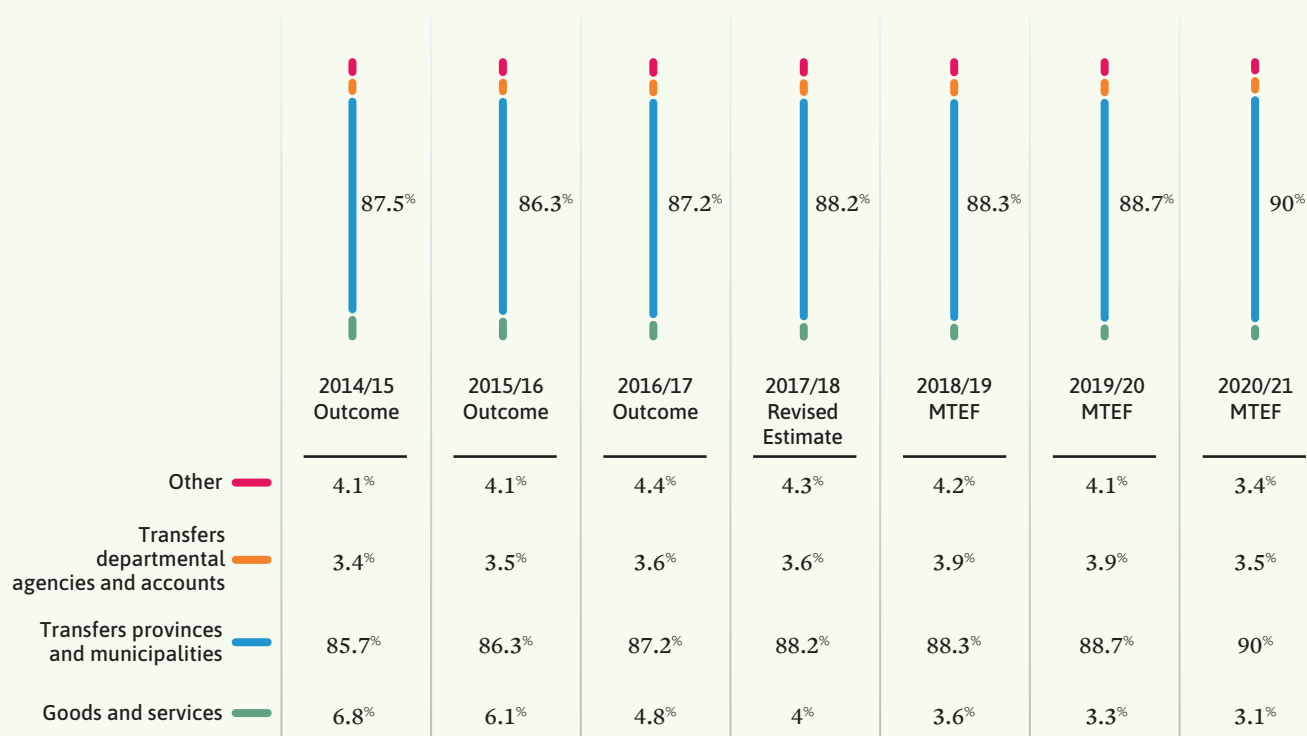


TABLE 3:

Spending trends in provincial health programme budgets, 2014/15 to 2020/21 (ZAR billion) | Source: Estimates of Provincial Revenue and Expenditure 2018

	2014/15 Outcome	2015/16 Outcome	2016/17 Outcome	2017/18 Revised Estimate	2018/19 MTEF	2019/20 MTEF	2020/21 MTEF	Real change between 2017/18 and 2018/19 (%)	Real average annual change over MTEF (%)
Administration	3.6	4.3	4.5	4.9	4.7	4.8	5	-9	-4.1
District Health Services	63.8	70.1	76.5	86.2	90.3	97.1	104.4	-0.6	1.1
Emergency Medical Services	5.6	6	6.4	7.8	7.7	8.2	8.8	-6.3	-1.2
Provincial Hospital Services	26.7	29.6	29.7	32.5	35	36.9	39.5	2	1.1
Central Hospital Services	28.2	29.5	33.7	38.4	39.8	42.8	45.6	-1.9	0.4
Health Sciences and Training	4.2	4.5	5.1	5.2	5.4	5.7	6	-1.7	-0.9
Health Care Support Services	1.3	1.5	1.8	2.1	2.2	2.2	2.4	-4.5	-1.6
Health Facilities Management	7.5	8.5	8.3	9.7	9.5	8.1	8.4	-7.3	-9.4
Total	140.9	154.1	166.1	186.9	194.6	205.8	220	-1.3	0.2
Plus unauthorised spending	0	-0.11	-0.11	-0.11	-0.20	0	0	73.1	0
Grand Total	140.9	154	166	186.8	194.4	205.8	220	-1.3	0.2

FIGURE 8:

Inflation-adjusted annual growth in expenditure and allocations for a select number of programmes by provincial health department, 2015/16 to 2020/21 (%) | Source: Estimates of Provincial Revenue and Expenditure 2018 (own calculations)

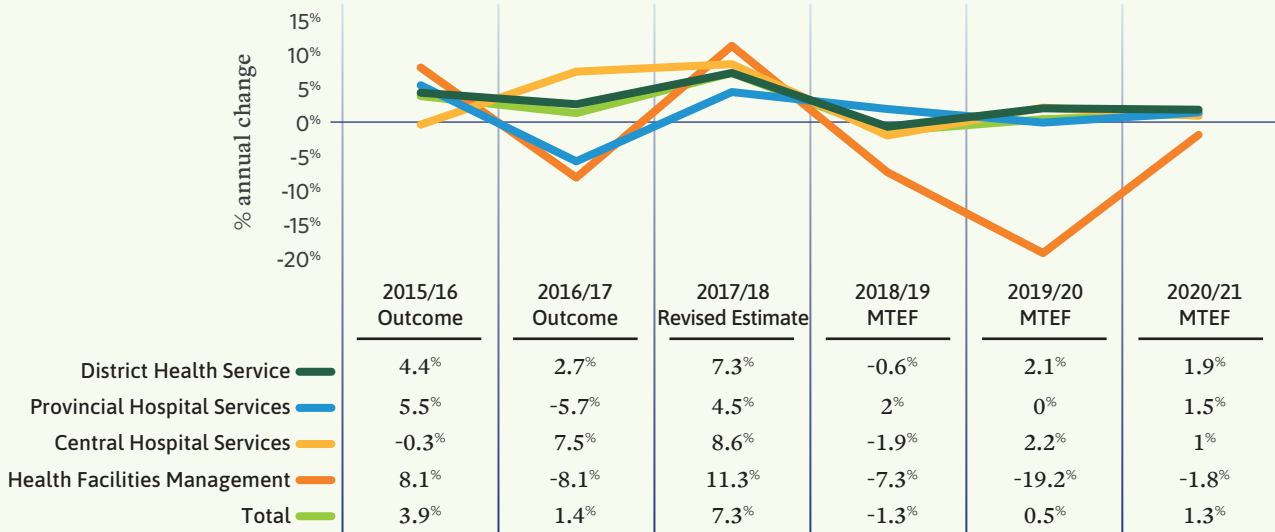
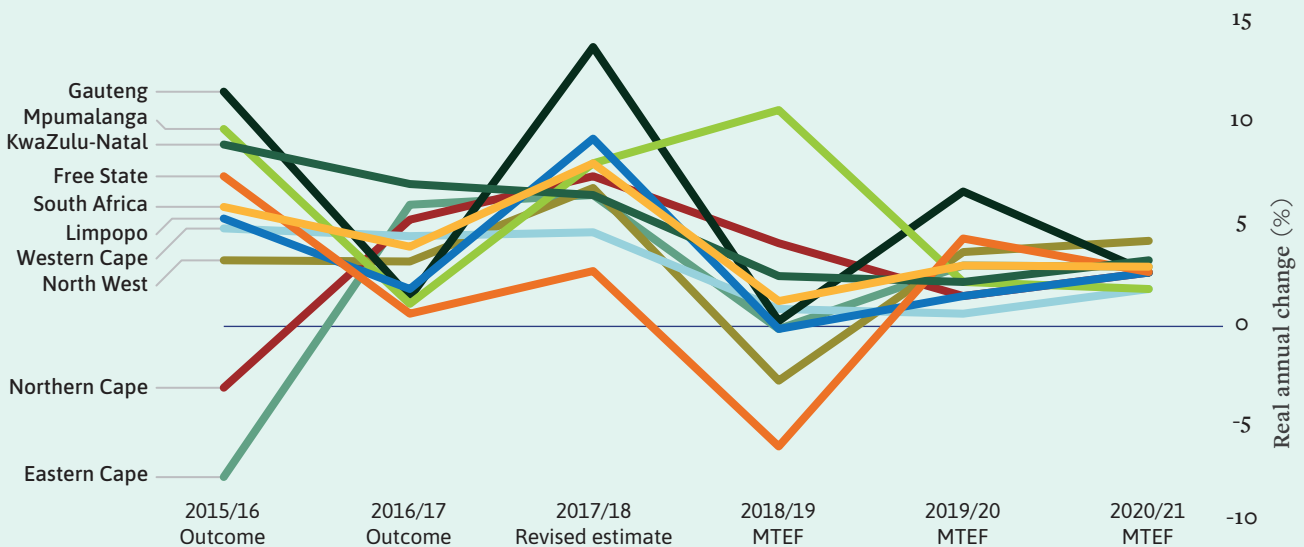


FIGURE 9:

Inflation-adjusted annual growth in expenditure and allocations on the Primary Health Care programme activities in provincial health departments, 2014/15 to 2020/21 | Estimates of Provincial Revenue and Expenditure 2018 (own calculations)

Note: Primary health care expenditure and allocations are taken from the District Health Programme and include Community Health Clinics, Community Health Centres, HIV/AIDS, Nutrition, Community-Based Services, and other community services. It excludes District Management, District Hospitals and Coroner Services.



The District Health Services (DHS) programme maintains for the most, positive real annual growth rates over the 2018 MTEF, except in 2018/19, where this programme declines by 1 per cent below inflation. It is also notable that this programme manages to achieve real annual growth rates above that of total provincial spending and allocations. This programme contains allocations for Primary Health Care (PHC) and provides a good indication about the relative prioritisation of PHC programmes over the medium term. The Health Facilities Management programme is subject to large real decreases over the medium-term, in part, to achieve spending targets and in recognition of the poor rate of spending on health infrastructure via the conditional Health Facility Revitalisation grant.

Spending and Allocations on Primary Health Care Programme Activities in Provincial and Local Government Health Budgets

Positive annual real growth is the norm for the PHC programme activities across provinces, thus reinforcing the Government's commitment to PHC. Over the six-year period represented above, the average spending growth did not dip below annual inflation, and in the pre-2018/19 period, this programme achieved impressive above-inflation growth rates of between 3.6 per cent and 8 per cent annually. Real declines in the PHC budgets of provinces are a deviation from the norm and only the Eastern Cape (7.8% in 2015/16), the Free State (6.1% in 2018/19), and the Northern Cape (3.4% in 2015/16) recorded unusually high declines in their PHC programme activities for the specific years. Any decline is worrisome at this stage, due to the pronounced role of PHC in the implementation of the much-discussed NHI.

Per capita expenditure on PHC programme activities in Provincial and Local Government decreased by 2 per cent in real terms (2014/15 Rands) from a real allocation of ZAR 970 in 2015 to ZAR 951 in 2016. KwaZulu-Natal achieved the largest per capita real spending in 2016/17 (ZAR 1,085), whereas the lowest per capita spending was recorded in Limpopo (ZAR 775). Free State achieved an average PHC spending level of ZAR 936 and Daven et al. (2016) argue that differences in per capita spending on PHC programmes are related to the expenditures per PHC visit and the fact that some PHC services are performed at District Hospitals, as is the case with Limpopo.

Actual utilisation rates of PHC facilities are regarded as a better measure of the relative efficiency of these programmes. Overall, real increases on PHC per headcount varied between 0.2 per cent and 0.9 per cent over the period represented above. Only Free State

and KwaZulu-Natal managed to achieve positive real increases over the entire period, while most provinces experience a real decline in one or more years in the period represented above. North West stands out in having two consecutive years of relatively large declines in 2014 (6.6%) and 2015 (1.6%), while Gauteng suffers a reverse in 2016/17 (3.1%).

In line with the Minister of Health's commitment^{viii} to ensure that key spending items are protected in provincial health budgets during this period of fiscal consolidation, Table 4 shows a clear pattern of prioritisation for some of the items. Medicines and HIV/AIDS have been prioritised during this entire period, while the category where most of the 'savings' have been made is the 'buildings' category. The reduction in this spending item correlates with reductions to the infrastructure conditional grants that are provided to provinces, in part, because provincial health departments traditionally spent poorly, and because there has been a deepening of expenditure cuts in provincial budgets. The overall picture, despite episodic reversals, and except for infrastructure spending, is that provinces have largely succeeded in protecting items that are vital for service delivery in the sector.^{ix}

FIGURE 10:

Provincial and Local Government primary health care expenditure per capita (uninsured population) by province, 2016/17 (2014/15 Rands) | Source: District Health System Database (obtained in personal communication with DHS in September 2018)

Note: The DHS programme is used but excludes the District Management, District Hospitals sub-programmes and Coroner services.

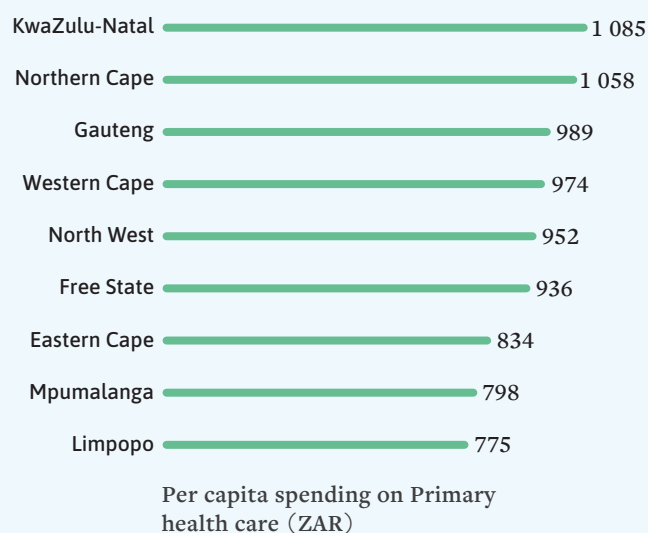
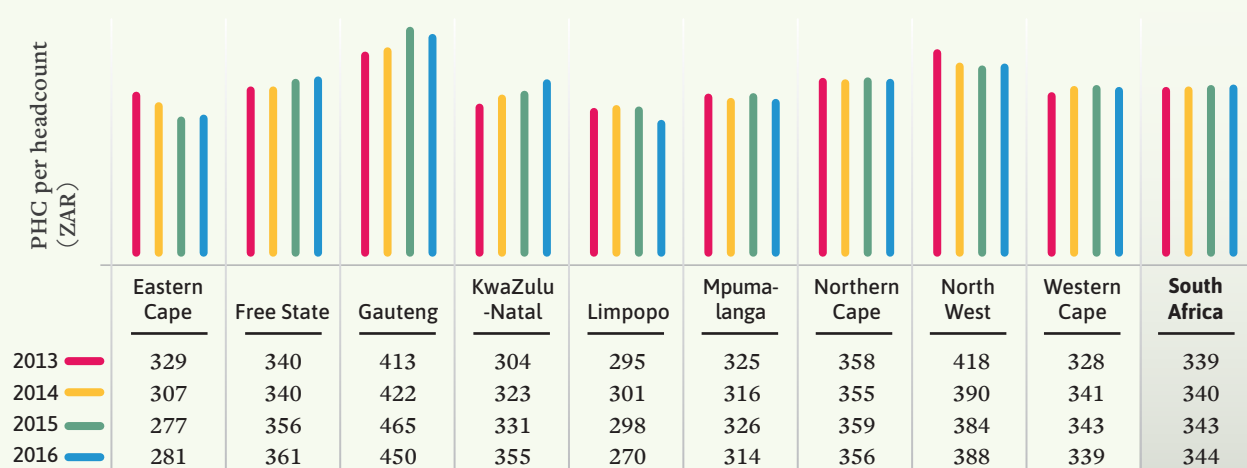


FIGURE 11:

Provincial and Local Government primary health care expenditure per headcount by province, 2013 to 2016 (2014/15 Rands) | Source: District Health System Database (obtained in personal communication with DHS in September 2018)

Note: The DHS programme is used but excludes the District management, District Hospitals, and Coroner Services sub-programmes. Actual number of PHC visits/headcount is used as the denominator.

**TABLE 4:**

Inflation-adjusted annual growth in expenditure and allocations for items that have been defined as 'non-negotiable' spending items by Ministry of Health, 2015/16 to 2020/21 (%) | Source: Estimates of Provincial Revenue and Expenditure 2018 (own calculations)

Note: Real percentage change indicated in Figure 11 (2014/15=100)

	2015/16 Outcome	2016/17 Outcome	2017/18 Revised estimate	2018/19 MTEF	2019/20 MTEF	2020/21 MTEF
Medicines	4.6	10.7	19.5	2.6	6.3	1.7
Medical supplies	-0.1	-0.9	13.3	-7.5	0.8	4.1
Laboratory services	6.1	-3.1	34.3	3.5	-3.0	2.9
Food services	1.7	-1.3	2.8	11.2	4.4	0.2
HIV/AIDS	6.4	7.5	9.8	5.8	4.6	5.0
Buildings	10.7	-14.2	11.4	-1.5	-16.9	-7.4
Overall Prov. Health budgets annual growth (%)	3.9	1.4	7.3	-1.3	0.5	1.3

TAKEAWAYS

- » Allocations to provincial health programmes over the present MTEF are under pressure and the growth margins are small.
- » Despite these challenges, provincial health departments have largely succeeded in protecting what the national Minister of Health calls non-negotiable spending (medicines, HIV/AIDS etc.) during this period of fiscal consolidation.
- » Spending on Medicines and HIV/AIDS has been strongly supported over the pre-2018 and is projected to achieve large above-inflation increases over the 2018 MTEF.
- » Provincial governments have also succeeded in continuing positive spending on the PHC programmes, especially in the pre-2018 MTEF, while growth over the 2018 MTEF is moderated.
- » Differences in spending on PHC programmes at the provincial level (per capita or actual utilisation rates) are attributed to the variable costs of PHC visits per site, the fact that some provinces do PHC work in District Hospitals, and the fact that some PHC sites are achieving more with far fewer resources.
- » Closer examination of PHC spending and utilisation rates is required to develop appropriate spending benchmarks on this important health service.



SECTION 4. Budget Execution and Credibility

Budget Execution Rates in the Health Sector^x

Budget execution figures for the NDoH have produced mixed results such that in 2013/14 and 2014/15, actual spending came in at 3 per cent under target, while for 2015/16 and 2016/17, actual spending was almost on par with what was intended after in-year adjustments. Underspending in the national departments was driven by poor spending on direct and indirect health infrastructure grants, delays in appointing general practitioners (GPs) in pilot NHI Districts^{xi}, slow spending on the District Health Information System (DHIS), and fewer transfers to NPOs due to a combination of budget

pressures, cost containment measures, and the need to prioritise annual medical intakes. Poor spending in Gauteng in 2013/14 was caused by a non-payment on its District Health Programme to the National Health Laboratory Service (NHLS) due to difference in agreement between the health department and the entity regarding a performance audit. The Northern Cape undershot its budget by 4 per cent due to delays in the procurement of emergency vehicles and medical capital equipment for its DHS programme. For the remainder of the fiscal year, underspending in provincial health departments was caused by delays in procurement across different programmes and poor spending records on health infrastructure projects.

FIGURE 12:

Budget execution in the health sector, 2013/14 to 2016/17 (%) | Source: Estimates of Provincial Revenue and Expenditure 2018 and Estimates of National Expenditure 2013/14 to 2018/19 (own calculations)

Note: Provincial health departments with large underspending ratios have been chosen.

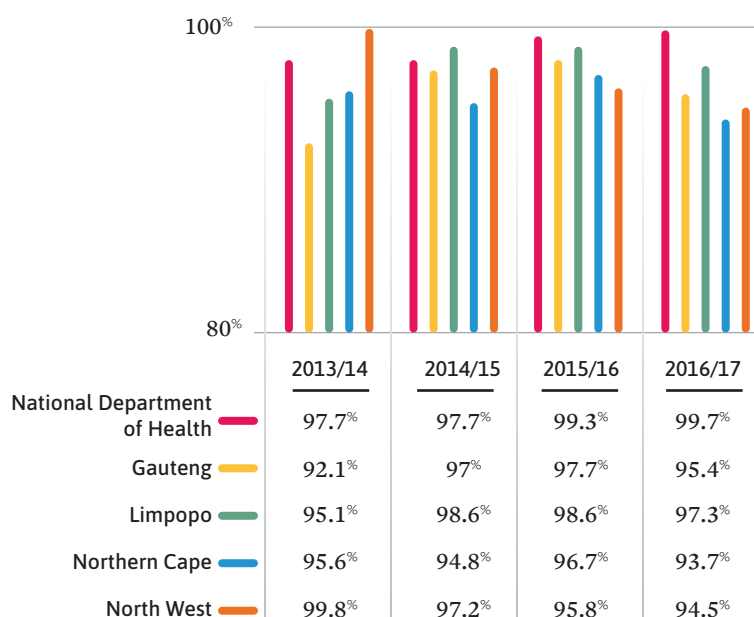


FIGURE 13:
 Comparing adjusted expenditure with final outcomes in the budget of the National Department of Health, 2013/14 to 2016/17 (%) | Source: Estimates of National Expenditure 2018 (own calculations)

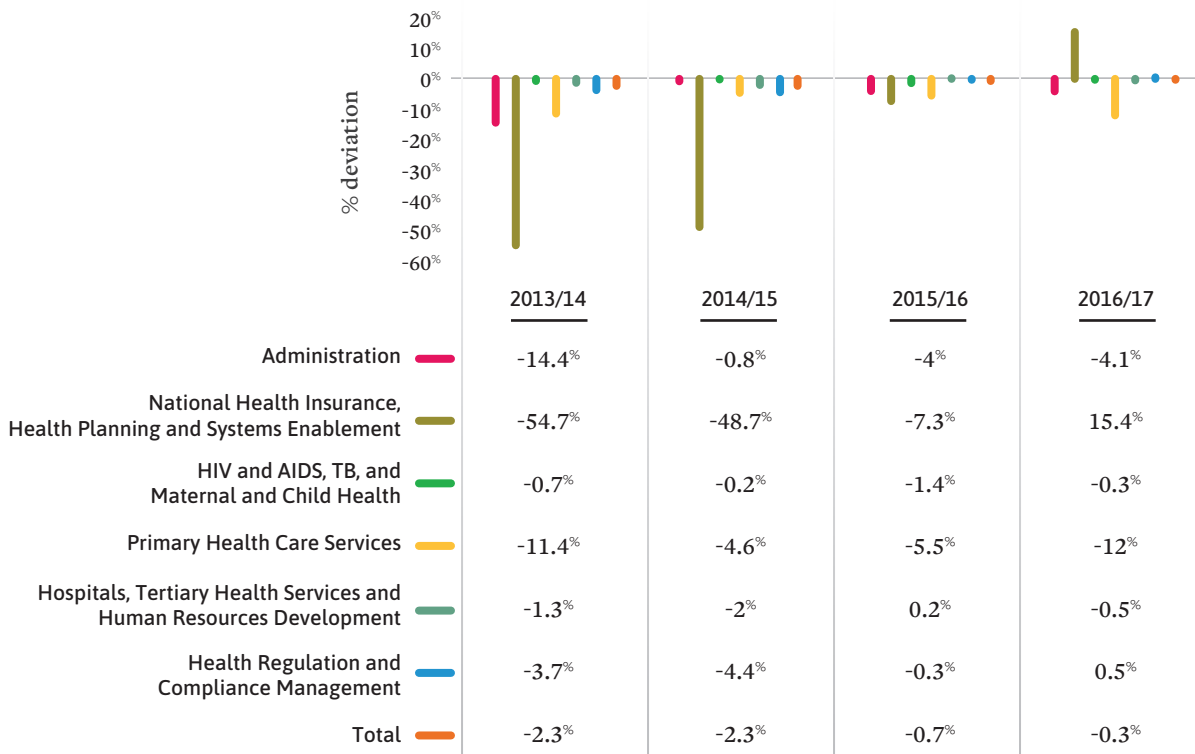
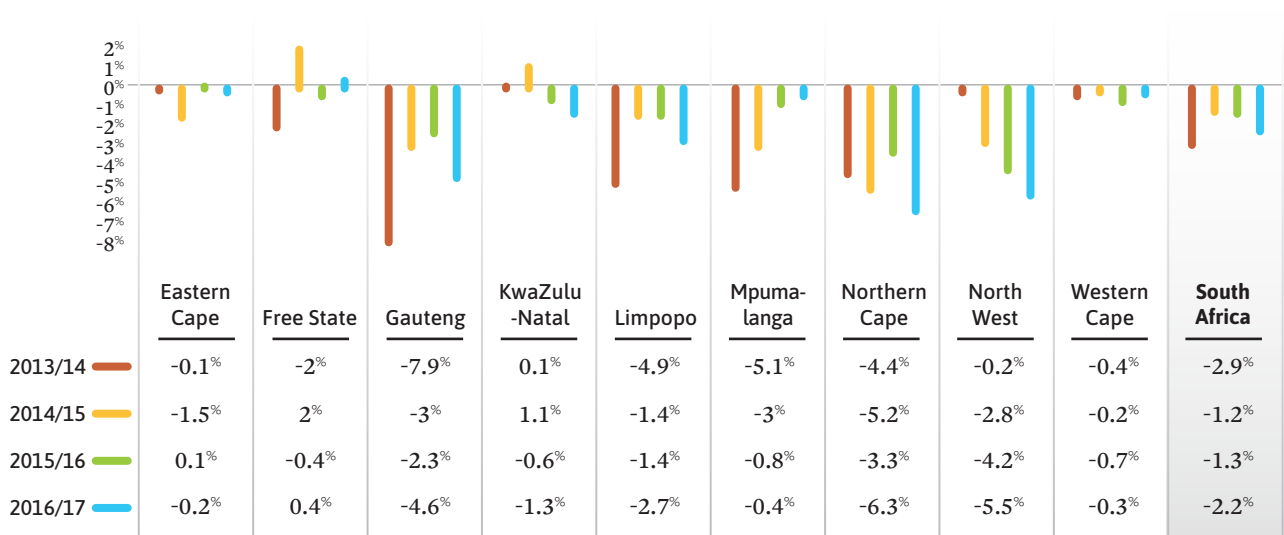


FIGURE 14:
 Comparing adjusted expenditure with final outcomes in the budget of provincial health departments, 2013/14 to 2016/17 (%) | Source: Estimates of Provincial Revenue and Expenditure 2018 (own calculations)





Budget Credibility: The National Department of Health and Provincial Health Departments

Underspending in the budget of the NDoH was caused mainly by four factors, namely poor spending on infrastructure grants (direct and indirect), the national Demographic Health Survey running over multiple years and creating planning challenges, slow uptake in NHI-related spending, and fewer transfers to NPOs due to a range of issues, including Service Level Agreements (SLAs) not being finalised on time (Figure 13). The earlier underspending on the NHI programme seems to have been overcome and much lower rates of underspending were achieved in 2015/16 and 2016/17, while continued slow spending on the Primary Health Care programme was caused by slow spending on the DHIS, payment problems with NPOs, and positions in Port Health could not be filled.

Underspending in provincial health departments was driven chiefly by supply chain challenges across different programmes. Delays in the procurement of contractors for the Health Facility Management programme, slow execution on capital contacts by implementers, and delays in procuring emergency vehicles in many provinces are some of the most prominent supply chain challenges. The Northern Cape and North West had specific challenges with delays in procurement of emergency vehicles, while Gauteng's underspending was driven by non-payment to the NHLS, which is a significant cost driver for that department's DHS programme.

Challenges

Supply chain challenges have emerged as one of the main reasons for the variable spending performance by the NDoH and provincial health departments. Both delays in the procurement of capital stocks and the slow execution rates of appointed contractors contribute to the variable state of actual spending across health departments. Both the NDoH and provincial health departments appear to have transactional problems with NPOs in that SLAs are often not finalised on time, thus preventing payment, or NPOs do not comply with government-set standards, thus leading to non-payment. In addition, the NDoH periodically undertakes

large projects such as the National Demographic Health Survey, which appears to have caused planning and spending problems. In addition, this department must take the lead in the implementation of new innovations (such as the NHI), and predictably, there have been teething problems in the roll-out of this ambitious flagship Government programme.

Spending arrears are a major problem in provincial health departments. The MTBPS 2017 recognises that if this issue is not resolved, it will contribute to what the MTBPS calls a 'hidden deficit.' The review of the annual reports (ARs) of provincial health departments suggest that medico-legal and civil claims are un-budgeted, and this transmits budget pressures to all programmes, leading to underspending in programmes that were scheduled to implement specific projects. There is a clear need to prioritise the gradual elimination of spending arrears in provincial health because of the implications this has for the stability and predictability of programme funding.

TAKEAWAYS

- » Spending performance in health departments across the country is still mainly a function of supply chain challenges.
- » The supply chain challenges are twofold, namely delays in appointing contractors to undertake large capital projects, and slow execution on approved projects.
- » The NDoH is often engaged in periodic large projects (such as the implementation of the National Demographic Health Survey) and new emerging projects such as the roll-out on the NHI, which inevitably encounter teething problems, thus leading to further underspending.
- » The evidence suggests that as the NDoH becomes more familiar with the requirements of the NHI, actual spending performance has improved and is likely to continue to improve in the near future.
- » While this section does not consider overspending, spending arrears complicate the planning and delivery of health programmes and Provincial Governments must devise measures to gradually eliminate spending arrears to enable more consistent and predictable delivery of essential health services.



SECTION 5.

Spending Equity: An Analysis of District-Level Distribution of Health Spending

Inequality in spending across Districts: Examining the Spending Benefits for the Uninsured Population^{xii}

There are substantial differences in the per capita spending on the DHS programme by District on individuals who do not have access to medical aid or insurance. The Central Karoo Municipality (Western Cape) spent three times the per capita amount as the Joe Gqabi District in the Eastern Cape (ZAR 2,899 versus 1,053). The median level spending of ZAR 1,611 was recorded for the King Cetshwayo District Municipality in the KwaZulu-Natal province. Daven et al (2016)^{xiii} note that differences in per capita spending on the DHS programme are hard to interpret because the differences are caused by the distribution of District Hospitals, which are unevenly distributed across provinces and districts.

Overall per capita expenditure on Primary Health Care (PHC) at the District level declined by 2.3 per cent in real terms between 2015 and 2016 (using 2014/15 Rands) from ZAR 1,001 to ZAR 978. The Xhariep District Municipality recorded the highest per capita spend on PHC in 2016/17 (ZAR 1,502), whereas the lowest per capita spend on PHC was achieved in the Alfred Nzo Municipality in the Eastern Cape (ZAR 552). Differences in per capita spending on PHC programmes are related to population sizes and population density, and this explains, in part, the high per capita spending for the Xhariep and Central Karoo (not shown in the graph) Districts. The low level of funding for the Alfred Nzo Municipality is cause for concern and Daven et al (2016) indicate that this might be a case of underfunding.

Overall PHC per headcount expenditure by District grew marginally by 0.4 per cent in real terms between 2015 and 2016 (from ZAR 352 in 2015 to ZAR 353 in 2016). Daven et al (2016) attribute the slow rise in real expenditure to the

Government's commitment to sustain real increases on PHC spending and reduced pressures on the use of PHC facilities because of system innovations such as the new central chronic medicine dispensing model, whereby patients can collect their medicines at alternative pick-up points instead of visiting a PHC centre. The Sedibeng Municipality (Gauteng) achieved the highest PHC per headcount spending in 2016 (ZAR 477), whereas the Alfred Nzo Municipality (Eastern Cape) achieved the lowest PHC headcount rate (229). In the absence of any detailed benchmark exercises, it is not possible to tell whether the per headcount spending figures are indicative of inefficiencies or efficiencies, and closer examination is needed to offer meaningful guidance to Districts about increases or reductions to their per headcount spending investments.

TAKEAWAYS

- » Differences in the uneven distribution of District Hospitals explain largely the different per capita spending on the DHS programme across districts.
- » While there has been a concerted drive to reduce inequalities in spending between provinces and within provinces, much work remains to ensure that the health allocation system at District level is needs-based.
- » Differences in historical allocation patterns, variable utilisation rates of PHC services across Districts, and inefficiencies all contribute to variable spending on PHC programme activities across Districts within provinces.
- » While high-spending Districts attract attention, Districts in the Eastern Cape, due to its below-national average spending on PHC services, need closer examination in future allocation models, which will be based on need rather than historical spending patterns.

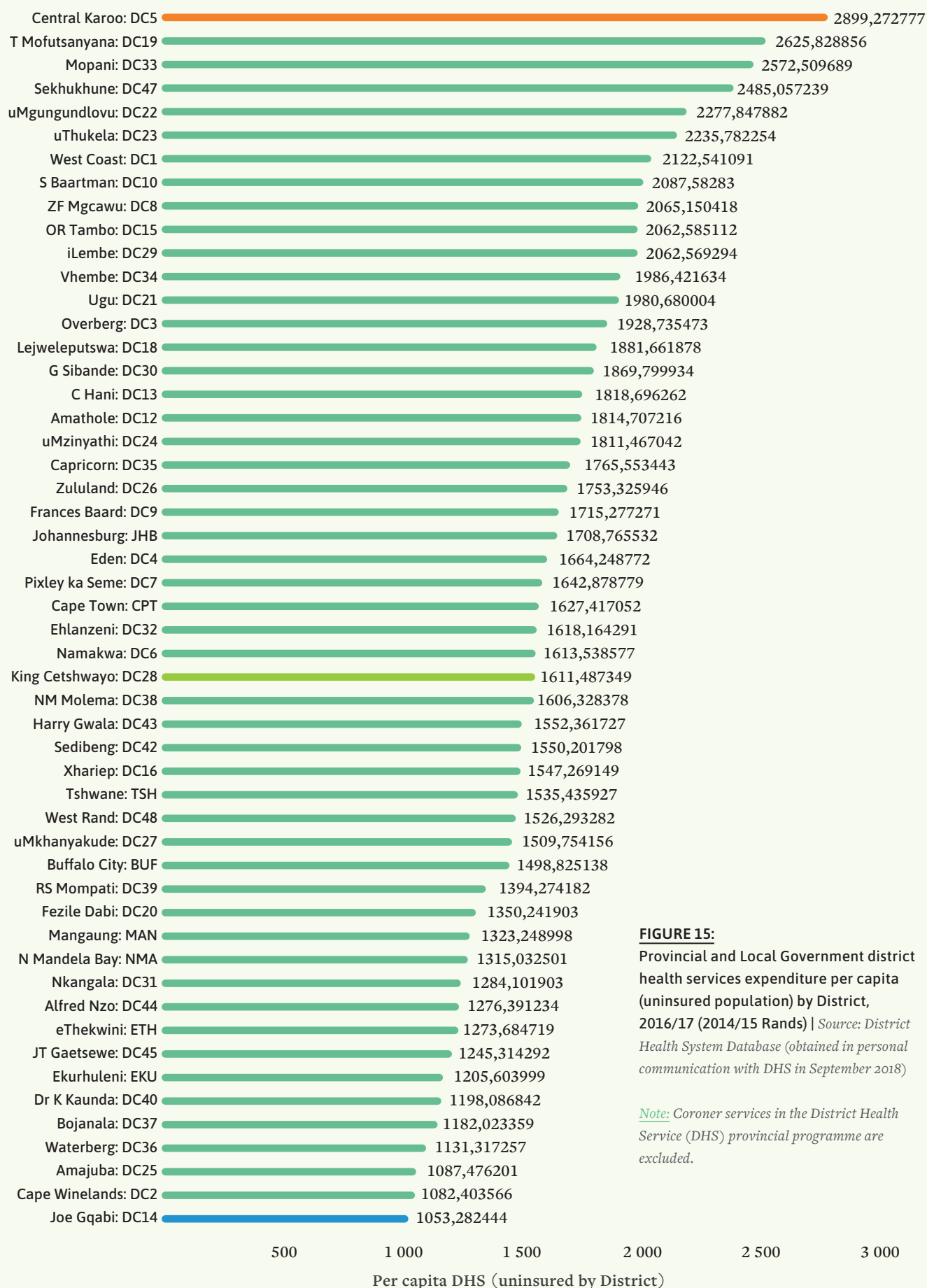


FIGURE 15:
Provincial and Local Government district health services expenditure per capita (uninsured population) by District, 2016/17 (2014/15 Rands) | Source: District Health System Database (obtained in personal communication with DHS in September 2018)

Note: Coroner services in the District Health Service (DHS) provincial programme are excluded.

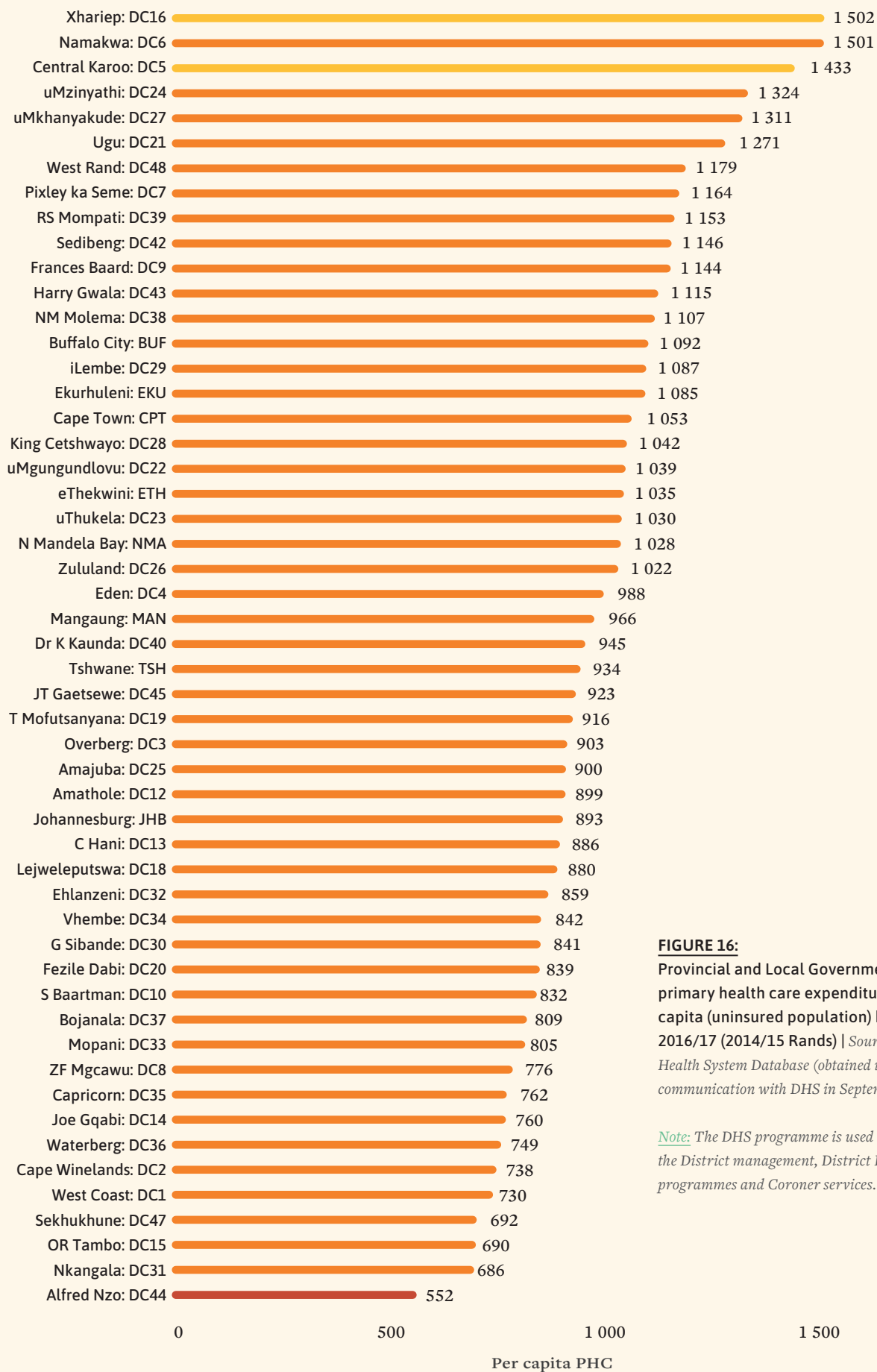


FIGURE 16: Provincial and Local Government primary health care expenditure per capita (uninsured population) by District, 2016/17 (2014/15 Rands) | Source: District Health System Database (obtained in personal communication with DHS in September 2018)

Note: The DHS programme is used but excludes the District management, District Hospitals sub-programmes and Coroner services.

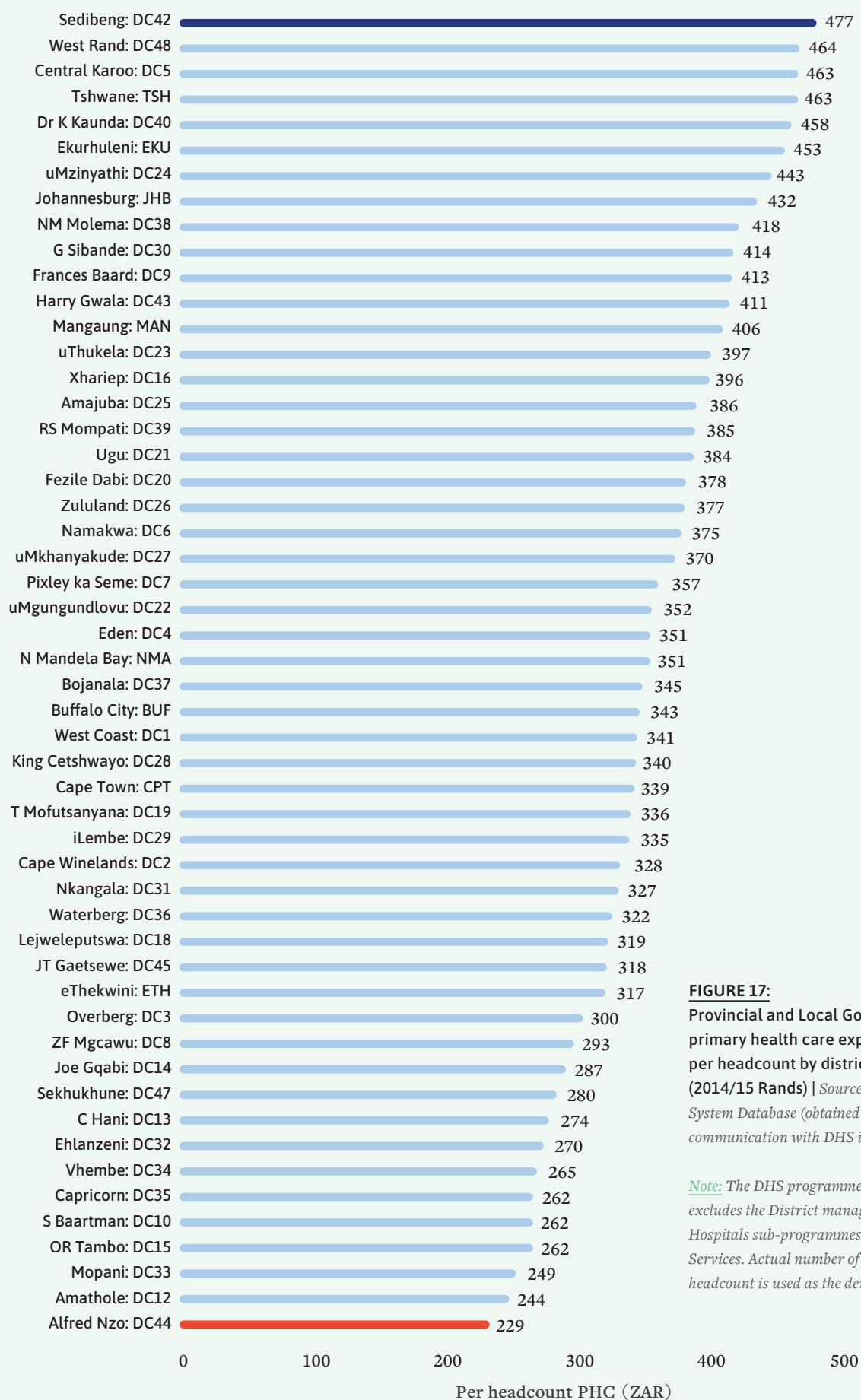


FIGURE 17:
Provincial and Local Government
primary health care expenditure
per headcount by district, 2016/17
(2014/15 Rands) | Source: District Health
System Database (obtained in personal
communication with DHS in September 2018)

Note: The DHS programme is used but
excludes the District management, District
Hospitals sub-programmes and Coroner
Services. Actual number of PHC visits/
headcount is used as the denominator.

Endnotes

i. The Presidency, The National Development Plan 2030: *Our future –make it work*. Pretoria, Government Printers, 2011.

ii. Budget data were drawn from the Health Chapter of the *Estimates of National Expenditures*, 2018. Data on HIV prevalence rates for young people (15-24) were extracted from Statistics South Africa's *Midyear Population Estimates 2018* report.

iii. Budget data for this textbox were taken from *Estimates of National Expenditure 2018/19* and *Provincial Estimates of Revenue and Expenditure 2018/19*.

iv. Please the World Health Organization (WHO) reflection on ten years after the Abuja Declaration: http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1

v. Our definition of consolidated government expenditure does not include provision for interest on public debt, but includes provision for the unallocated contingency reserve over the present MTEF. Excluding debt service costs provides a more accurate estimate of the quantity of resources available for service delivery.

vi. The National Treasury contrasts the 'economic wage' earned by workers through participation in the labour market to the 'social wage', which are in-kind transfers on key services that have a beneficial impact on the well-being and livelihoods of South Africans, and poor South Africans

in particular. This would include provision for education, health services, social development, public transport, housing, and local amenities. See the *National Treasury Budget Review 2013*.

vii. To clearly demonstrate the two departments that are involved in health provisioning in South Africa, we have not netted out the provincial transfers from the budget of the National Department of Health. We have done that in our presentation of 'consolidated health' in Figures 2 and 3.

viii. See Day C and Daviaud E (2014) *Development and application of benchmarks for budgeting of non-negotiable goods and services for provincial departments of health*. Durban: Health Systems Trust

ix. The success of this strategy is premised, in part, on the ability of provincial health departments to contain the costs associated with their wage bills. At the start of the 2018/19 fiscal year, the provincial health wage bill was projected to grow by 1.4 per cent in real terms on average over the MTEF. However, recent adjustments to the salaries of public servants will have pushed up this number and it will remain important to examine how this will affect the 'non-negotiable' spending items in future budgets.

x. This section relies on the Annual Reports of the National Department of Health and the nine provincial health departments.

Annual Reports for the 2013/14, 2014/15, 2015/16 and 2016/17 fiscal years were consulted. The budget brief also used online National Department of Health budgets that are placed on the National Treasury's website in 2018.

xi. The NHI conditional grant was used to test innovations in health service provisioning and to develop frameworks and models that can be used to roll out the NHI. A select number of Districts were chosen that would test various models and innovations and help the Government better understand the implications of implementing the NHI at a grander provincial and national scale.

xii. The Health Systems Trust (HST) used a statistical model, which is based, in part, on the number of medical insurance beneficiaries as per the General Household Survey (GHS). The model was then used to develop estimates of medical insurance beneficiaries at a small area level using census data. Cross checks of the data were done with information from the Medical Schemes Council and the GHS.

xiii. See Blecher M, Daven J, Kollipara A, Maharaj Y, Mansvelder A, and Gaarekwe O (2017) *Health spending at a time of low economic growth and fiscal constraint*. Durban: Health Systems Trust. See also the 2016 publication with the same publisher 'Indicator comparison per programme-Finance' by Daven J, Day C, Maharaj Y, Blecher M and Kollipara A.

Appendix

FIGURE A1:
Consolidated provincial health allocations by type of expenditure, percentage shares in 2018/19

| Source: *Estimates of Provincial Revenue and Expenditure 2018*

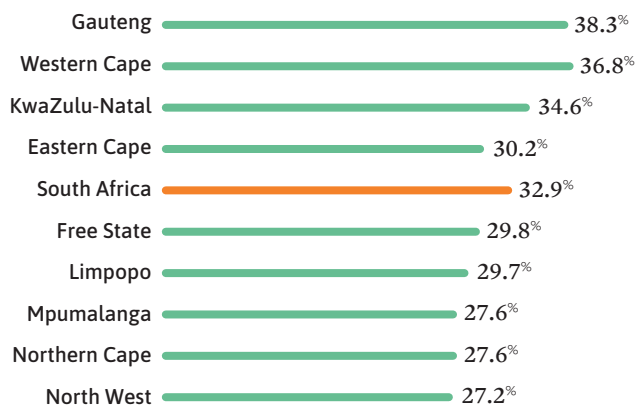


FIGURE A2:
Consolidated provincial health allocations by type of expenditure, percentage shares in 2018/19

| Source: *Estimates of Provincial Revenue and Expenditure 2018*

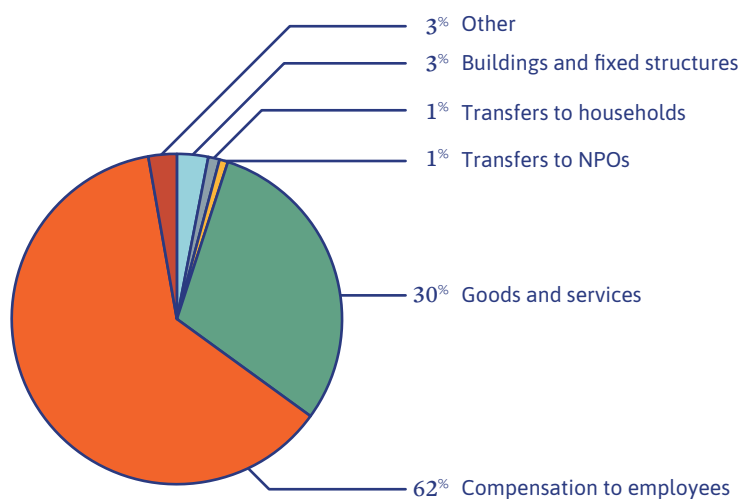


FIGURE A3:
Inflation-adjusted annual growth in expenditure and allocations by type of expenditure for provincial health departments, 2015/16 to 2020/21 (%)

