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, etc., and in some of the statutory funds, such as the road accident fund.
Key messages and recommendations

South Africa plans to spend 216 billion rand (R) on national and provincial health programmes in FY2019. Combined health spending will grow by less than 1 per cent above inflation on average over the next three years. Overall, the country aims to spend 11.8 per cent of its public resources on national and provincial health programmes in FY2019 and this combined spending represents 4 per cent of the gross domestic product (GDP).

While combined health spending made impressive gains in the post-2008 period, health spending has been lacklustre since 2012. Both the combined national health spending (0.9 per cent) and province-specific public health spending (0.7 per cent) are projected to grow by less than 1 per cent on average over the 2019 Medium Term Expenditure Framework (MTEF). The government is encouraged to:

1. 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, HIV/AIDS, etc.
2. While reductions in infrastructure spending have been 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.
3. Publish performance frameworks that concretely show how adequacy (in budgets), and efficiency, effectiveness and equity in health expenditure and performance will be measured.

Despite a substantial slowdown in real spending over the 2019 MTEF, the health sector has managed to produce an array of impressive outcomes. Life expectancy has been raised, infant and under-five mortality rates have declined, and reductions in mother-to-child transmission of HIV have been achieved. The government is encouraged to:

1. Continue its innovations in the health sector, such as its new medicine dispensing model and centralised procurement of vital medicines such as antiretroviral therapies
2. 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
3. Adopt performance-based health budgeting systems that project the cost of producing additional output (marginal cost)
4. Invest in in-year or real-time monitoring of health service delivery to shorten the feedback loop to decision-making, i.e. the subsequent planning and budgeting stages.

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 non-profit organisations that are non-compliant. Underspending invariably impacts ultimately on the delivery of health services. Provincial governments are encouraged to:

1. Devise a plan to increase budget utilisation by improving planning and execution functions
2. Publish the outcome of attempts at reducing spending arrears as agreed with the National Treasury
3. 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
4. Gradually adopt performance-based health budgeting systems that contribute to transparency in the performance effects of health sector underspending, thereby holding provincial health managers accountable for good governance in their departments.

**Provincial district health services budgets, which fund most PHC services, have seen considerable variations in terms of per capita and by headcount expenditure, both within provinces and across all provinces.** District-level PHC expenditure in some provinces is persistently low in relative terms, especially in districts serving poor, rural and marginalised communities. Much needs to be done to improve equitable access by all to essential health services. The government is encouraged to:

1. Refine distribution models at the district level to reflect relative needs as the central variable in the allocation of resources
2. Provide regular in-year or real-time reports on the non-financial performance (equity, quality, effectiveness) of PHC expenditure
3. Invest in studies that probe the relative (in)efficiencies, (in)effectiveness and (in)equities in the provision of health services at the district level, to arrive at appropriate benchmark levels of spending on PHC services.
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 provide 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 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 and ensure the creation of mechanisms for the equitable, effective and efficient utilisation of the resources of the fund
- 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 provides 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 6 years.

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, 2014–2019). 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. The National Development Plan 2030 of the government’s 2014–2019 Medium Term Strategic Framework (MTSF) (RSA Government, MTSF, 2014–2019) provides high-level targets for the health sector, which 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
- Achieve an infant mortality rate of less than 20 deaths per 1,000 live births, and an under-five 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 clients that were successfully treated and a slow, yet consistent decline in the mother-to-child transmission of HIV rates (from 1.5 per cent in FY2014 to 0.9 per cent in FY2017). The HIV prevalence rate for young people (15–24 years) has slowly decreased from 5.8 per cent in FY2014 to 5.6 per cent in FY2017. Considering that the human papilloma virus (HPV) coverage for Grade 4 girls appears to dip in FY2016 (from 85.3 per cent in FY2015 to 79.3 per cent in FY2016), there is concern that the NDoH may not reach the target of 90 per cent coverage rate for young girls in Grade 4 by March 2021.

Key fiscal indicators on the health system

PHC constitutes approximately one-third of the budgets of the combined health sector, while spending on personnel consumes 61 per cent of combined provincial health resources.

Although official development assistance constitutes a small share of the budget of the NDoH (roughly R1.4 billion in FY2018), it finances vital spending on priority diseases such as HIV/AIDS and tuberculosis.
Takeaways

• The NDoH continues to focus on diseases such as HIV/AIDS and tuberculosis 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 coverage of 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 tuberculosis are continued, to safeguard important gains.

• In the context of an aging population that is generally reliant on public health services, and population growth pressures at various cohorts, provincial health expenditure levels may be inadequate.
2. Health spending trends

Size of spending

The NDoH and the nine provincial health departments are projected to spend R216 billion in FY2019, which represents 5 per cent nominal growth from the FY2018 revised estimated figure. This amount (henceforth referred to as ‘total health expenditure’) is the sum of (i) the NDoH’s total budget net of transfers to provincial health departments and (ii) the total health budgets of all nine provinces for FY2019. The NDoH plans to spend R6.5 billion (or 3 per cent) of this estimated R216 billion, while provinces collectively plan to spend roughly R210 billion (97 per cent). Roughly 87 per cent of the budget (or R45 billion) of the NDoH are transfers in the form of conditional grants to provincial health departments.

The total health expenditure budget (UNICEF calculation) constitutes 11.8 per cent of total consolidated national and provincial public expenditures in FY2019 and roughly 4 per cent of the country’s GDP. As mentioned above, this compares favourably with the spending target of 15 per cent of total government expenditure contained in the Abuja Declaration. Combined national and provincial spending of about R261.8 billion on health in FY2019 would have ensured South Africa’s compliance with the Abuja Declaration (considering UNICEF’s calculation method).

Table 1: Summary of nominal national and provincial health budgets, FY2019 (R billion)

<table>
<thead>
<tr>
<th></th>
<th>National</th>
<th>Provincial</th>
<th>Percentage of total</th>
<th>Provincal population (million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Department of Health</td>
<td>51.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Of which transfers to provincial health departments</td>
<td>-45.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net NDoH spending</td>
<td>6.5</td>
<td></td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>Combined provincial health budgets</td>
<td>209.5</td>
<td>97.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>25.2</td>
<td>12</td>
<td>6.7</td>
<td></td>
</tr>
<tr>
<td>Free State</td>
<td>11.1</td>
<td>5</td>
<td>2.8</td>
<td></td>
</tr>
<tr>
<td>Gauteng</td>
<td>50.8</td>
<td>24</td>
<td>15.5</td>
<td></td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>45.0</td>
<td>21</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td>Limpopo</td>
<td>20.8</td>
<td>10</td>
<td>5.7</td>
<td></td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>14.4</td>
<td>7</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Northern Cape</td>
<td>5.2</td>
<td>2</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td>12.3</td>
<td>6</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Western Cape</td>
<td>24.8</td>
<td>11</td>
<td>6.4</td>
<td></td>
</tr>
</tbody>
</table>

Consolidated health budget FY2019 216

*Source: Estimates of National Expenditure 2019, Estimates of Provincial Revenue and Expenditure 2019 (own calculations)*
Spending changes

Inflation-adjusted (real) growth on total health expenditure (NDoH and provincial health departments) prior to FY2019 was robust and positive, averaging 3.8 per cent real growth per year. Despite substantial cost containment measures that were introduced during this period, total health spending outpaced inflation. However, projected trends over the new MTEF period are bleak and consolidated health spending is projected to grow by 0.9 per cent on average, while over the entire six-year period represented below, health budgets grew on average by 2.3 per cent after inflation has been accounted for. By barely keeping up with inflation, this expenditure outlook places even greater pressure on health programmes to cut costs and improve efficacy (efficiency and effectiveness).

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’. Social sector spending that benefits children, including health budgets, has been consistently adjusted upwards, even during this period of fiscal adjustment. At 11.8 per cent of the total consolidated government budget (as per the
UNICEF definition) in the current fiscal year (FY2019), the health sector is the second-largest recipient of resources, trailing only the basic education sector (14.4 per cent) and leading the social development sector (11.3 per cent).

When combined, the three largest social service sector votes account for nearly 38 per cent of consolidated government expenditure, a ratio that has remained quite stable since FY2014, albeit with some noticeable decreases since FY2018.

Figure 4: Social service sectors as a percentage of consolidated government expenditure, FY2015–2021


Takeaways

- The government’s commitment to maintain inflation-adjusted growth in health budgets over the medium term remains under pressure, because of intense pressure emanating from its fiscal consolidation project.
- Combined health spending is slowing down in relative terms: in FY2019 combined spending was 11.8 per cent of total health expenditure, down from 12.4 per cent in FY2018.
- Combined public national and provincial health spending consumes 4 per cent of the country’s GDP – considerably less than the emerging benchmarks.⁶
- Collectively, spending on the social sectors essential to children (basic education, health and social development) consumes roughly 40 per cent of total government resources. This may be considered evidence of the government’s continued commitment to the country’s ‘social wage’.
- However, the relative weights of the social sectors’ budgets have been declining relative to other sectors since FY2018.
3.

Composition of health spending

Composition of spending by department

Provincial health budgets are projected to decline in real terms in the current financial year (FY2019) (-0.8 per cent), barely grow in FY2020 (1.0 per cent) and marginally recover at the end of the MTEF (2.0 per cent). 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 5: Inflation-adjusted spending trends in health departments,2 FY2016–2021 (FY2015=100)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consolidated provincial health</td>
<td>1.4%</td>
<td>4.0%</td>
<td>6.2%</td>
<td>-0.8%</td>
<td>1.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>National health (inc. provincial transfers)</td>
<td>0.6%</td>
<td>5.2%</td>
<td>5.8%</td>
<td>4.1%</td>
<td>4.4%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Consolidated health (net of transfers)</td>
<td>1.5%</td>
<td>4.0%</td>
<td>6.3%</td>
<td>-0.8%</td>
<td>1.2%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>


Composition of spending by programme: National health budget

Spending and allocations in the NDoH’s budget are expected to grow from R36 billion in FY2015 to close to R62 billion in FY2021. In the present financial year, NDoH’s allocation is planned to grow by 4 per cent above inflation and average roughly the same magnitude over the MTEF. However, because the bulk of the department’s budget is transfers to provincial health departments, it is more important to assess whether this part of the allocation outpaces inflation.
Table 2: Programme expenditure in the national health budget, FY2015–2021 (R billion): FY2015=100

<table>
<thead>
<tr>
<th>Programme</th>
<th>FY2015</th>
<th>FY2016</th>
<th>FY2017</th>
<th>FY2018</th>
<th>FY2019</th>
<th>FY2020</th>
<th>FY2020 (%)</th>
<th>Real average annual change over MTEF (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>0.5</td>
<td>0.5</td>
<td>0.5</td>
<td>0.6</td>
<td>0.7</td>
<td>0.7</td>
<td>3.8</td>
<td>1.8</td>
</tr>
<tr>
<td>National health insurance</td>
<td>0.4</td>
<td>0.5</td>
<td>0.6</td>
<td>1.2</td>
<td>2.1</td>
<td>2.8</td>
<td>3.0</td>
<td>69.1</td>
</tr>
<tr>
<td>Communicable and non-communicable diseases</td>
<td>14.4</td>
<td>16.0</td>
<td>18.4</td>
<td>20.9</td>
<td>23.0</td>
<td>25.5</td>
<td>29.0</td>
<td>5.9</td>
</tr>
<tr>
<td>Primary health care</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.3</td>
<td>64.0</td>
</tr>
<tr>
<td>Hospital systems</td>
<td>16.5</td>
<td>16.8</td>
<td>18.0</td>
<td>19.3</td>
<td>20.4</td>
<td>22.1</td>
<td>23.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Health system governance and human resources</td>
<td>4.0</td>
<td>4.4</td>
<td>4.7</td>
<td>4.8</td>
<td>5.1</td>
<td>5.3</td>
<td>5.6</td>
<td>-0.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>36.0</td>
<td>38.5</td>
<td>42.4</td>
<td>47.0</td>
<td>51.5</td>
<td>56.7</td>
<td>61.9</td>
<td>4.1</td>
</tr>
</tbody>
</table>

Source: Estimates of National Expenditure 2018 and 2019 (own calculations)

Composition of spending by the type of expenditure: National health budget

**Transfers to provinces and municipalities to deliver health services constitutes between 86 and 90 per cent of total national health funding (Figure 6).** 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 3.8 per cent above inflation on average over the next three years. Due to the aggressive cost containment measures undertaken, ‘spending on goods and services’ (inclusive of medicines) has grown steadily from 3.1 per cent of total spending in FY2014 to 4.9 per cent in FY2021.

Spending and allocations on provincial health budgets

**Provincial health spending is projected to increase in nominal terms from R210 billion in FY2019 to R240 billion at the end of MTEF at a real average annual rate of 0.7 per cent**

Source: Estimates of National Expenditure 2018 and 2019 (own calculations)
In the present financial year, provincial health allocations are projected to decline in real terms by 0.8 per cent, with a 12 per cent decline in the administration programme, pointing to a firm commitment to cost-cutting and achieving greater efficiencies. Over the MTEF, provincial health care support services programmes contributed the most (at 4.7 per cent) to the 0.7 per cent aggregate real growth. Allocations to the central hospital services programme are merely maintained over the MTEF. The provincial district health services programme is barely maintained in real terms over the 2019 MTEF (1.2 per cent average growth). This programme contains allocations for PHC and provides a good indication of the relative prioritisation of PHC programmes over the medium term. The administration and health facilities management programmes are subject to large real decreases over the medium term.

| Table 3: Spending trends in provincial health programme budgets, FY2015–2021 (R billion): FY2015=100 |
|--------------------------------------------------|------------------|-------------------|
| R billion                                        | FY2015           | FY2016            | FY2017            | FY2018            | FY2019            | FY2020            | FY2021            | Real change between FY2018 and FY2019 (%) | Real average annual change over MTEF (%) |
| Administration                                    | 4               | 4                | 5                | 5                | 5                | 5                | 6                | –11.8                          | –3.8                         |
| District health services                          | 70              | 77               | 84               | 94               | 98               | 105              | 113              | –0.4                          | 1.2                          |
| Emergency medical services                        | 6               | 6                | 7                | 8                | 8                | 9                | 9                | 2.6                           | 0.5                          |
| Provincial hospital services                      | 29              | 29               | 32               | 35               | 37               | 39               | 43               | 0.5                           | 1.4                          |
| Central hospital services                         | 30              | 34               | 37               | 42               | 43               | 46               | 49               | 2.1                           | 0.1                          |
| Health sciences and training                      | 5               | 5                | 5                | 6                | 6                | 7                | 7                | 3.6                           | 3.2                          |
| Health care support services                      | 1               | 2                | 2                | 2                | 2                | 3                | 3                | 3.4                           | 4.7                          |
| Health facilities management                      | 9               | 8                | 9                | 10               | 10               | 10               | 10               | –6.1                          | –3.8                         |
| Total                                            | 154             | 166              | 181              | 201              | 210              | 223              | 240              | –0.9                          | 0.7                          |
| Plus unauthorised spending                        | (0)             | (0)              | (0)              | (0)              | –                | –                | –                | –100.0                         | –100.0                       |
| South Africa                                     | 154             | 166              | 181              | 201              | 210              | 223              | 240              | –0.8                          | 0.7                          |

Source: Estimates of Provincial Revenue and Expenditure 2018 and 2019 (own calculations)
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. The average real spending growth in all provinces over the period FY2016–2021 is close to 4 per cent, with a real average annual growth of 1.8 per cent projected specifically for the new MTEF. Real declines in the PHC budgets of provinces are a deviation from the norm and only Limpopo Province (5.0 per cent in FY2019) and Mpumalanga (2.4 per cent in FY2019) recorded unusually big declines in their PHC programme activities. Any decline is worrisome at this stage, due to the pronounced role of PHC in the implementation of the much-discussed national health insurance.

Source: Estimates of Provincial Revenue and Expenditure 2018 and 2019 (own calculations)

Note: PHC expenditure and allocations are taken from the district health programmes 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.
Per capita expenditure on PHC programme activities in provincial and local government decreased by 5.9 per cent in real terms (rand value in 2015) from a real allocation of R1,044 in FY2015 to R987 in FY2018. Gauteng achieved the highest per capita real spending in FY2018 (R1,107), whereas the lowest per capita spending was recorded in Limpopo (R830). North West achieved an average PHC spending level of R954 – the closest to the national average. 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 in Limpopo.

Figure 9: Provincial and local government PHC real expenditure per capita (uninsured population) by province, FY2017 (FY2015=100)

<table>
<thead>
<tr>
<th>Province</th>
<th>Per Capita Spending (Rand)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauteng</td>
<td>1,165</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>1,136</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>1,129</td>
</tr>
<tr>
<td>Western Cape</td>
<td>1,116</td>
</tr>
<tr>
<td>South Africa</td>
<td>1,038</td>
</tr>
<tr>
<td>North West</td>
<td>1,003</td>
</tr>
<tr>
<td>Free State</td>
<td>991</td>
</tr>
<tr>
<td>Mpumulanga</td>
<td>908</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>881</td>
</tr>
<tr>
<td>Limpopo</td>
<td>873</td>
</tr>
</tbody>
</table>

*Source: Health Systems Trust’s District Health Barometer 2017/18 (data file), January 2019 (own calculations)*

*Note: The district health service programme is used but excludes the district management, district hospitals sub-programmes and coroner services*

Actual utilisation rates of PHC facilities are regarded as a better measure of the relative efficiency of these programmes. Overall, real increases on PHC expenditure per headcount from FY2015 to FY2017 varied between -3.3 per cent (Limpopo) and 11.9 per cent (Eastern Cape) (simple straight-line method). Western Cape was the only province (other than Limpopo) that experienced real decreases in this indicator. Figure 10, on nominal PHC expenditure per headcount, shows how seemingly positive growth hides the inflation-adjusted figures, especially for Limpopo and Western Cape.
In line with the Minister of Health’s commitment\(^8\) 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.\(^9\)

Table 4: Inflation-adjusted annual growth in expenditure and allocations for items that have been defined as ‘non-negotiable’ spending items by the Ministry of Health, FY2016–2021: FY2015=100

<table>
<thead>
<tr>
<th>Outcome</th>
<th>2016/17 Revised estimate</th>
<th>2018/19 MTEF</th>
<th>2019/20 MTEF</th>
<th>2020/21 MTEF</th>
<th>2021/22 MTEF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines</td>
<td>11%</td>
<td>11%</td>
<td>9%</td>
<td>-2%</td>
<td>4%</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>-1%</td>
<td>8%</td>
<td>13%</td>
<td>-11%</td>
<td>3%</td>
</tr>
<tr>
<td>Laboratory services</td>
<td>-3%</td>
<td>25%</td>
<td>18%</td>
<td>1%</td>
<td>-2%</td>
</tr>
<tr>
<td>Food services</td>
<td>0%</td>
<td>10%</td>
<td>22%</td>
<td>-5%</td>
<td>1%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>7%</td>
<td>9%</td>
<td>9%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Buildings</td>
<td>-14%</td>
<td>2%</td>
<td>15%</td>
<td>-24%</td>
<td>1%</td>
</tr>
<tr>
<td>Overall provincial health budgets annual growth</td>
<td>1%</td>
<td>4%</td>
<td>6%</td>
<td>-1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

\(^8\) Source: Estimates of Provincial Revenue and Expenditure 2018 and 2019 (own calculations)
Takeaways

- Allocations to provincial health programmes over the present MTEF remain under pressure by not keeping up with headline inflation.

- Considering that medical inflation often exceeds headline inflation (e.g. increases in imported specialised medical equipment), the risk is that low budget growth negatively impacts the level and quality of health services.

- In the context of an aging population that is generally reliant on public health services, and population growth pressures at various cohorts, provincial health expenditure levels may be inadequate.

- 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.

- 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.
4. Budget execution and credibility

Budget execution rates in the health sector

Overall, most health departments appear to be improving their spending record across the four years represented in Figure 11. Limpopo and North West achieved the worst spending ratios in FY2017 compared to their average for the previous three years. Like FY2016, underspending in the NDoH in FY2017 was driven by poor spending on direct and indirect health infrastructure grants and slow spending on components of the PHC and the national health insurance programmes. Poor spending in Limpopo in FY2017 was driven by delays in procurement of much-needed vaccines and continued underperformance on infrastructure, while the underspending in the North West Health Department was driven by the non-payment of invoices due to severe industrial action in that province (annual reports of departments of health in Limpopo and North West, 2017/18). For the rest of the fiscal years, underspending in provincial health departments was caused by delays in procurement across different programmes, and poor spending records on health infrastructure projects.

Budget credibility: The NDoH and provincial health departments

Underspending in the budget of the NDoH was caused by several factors, which include variable spending on infrastructure grants (technical compliance, delays in awarding contracts and contractual issues with contractors), fewer transfers to non-profit organisations due to a range of issues (including zero application for funding) and the

![Figure 11: Budget execution in the health sector, FY2014-2017 (percentage)](image)

delayed submission of invoices for planning and feedback meetings conducted in the provinces. *(Figure 12).* Underspending in FY2017 within the national health insurance programme was caused by (i) zero expenditure for the drug-related group project and (ii) difficulties in spending on the new in-kind grant for the medicine stock system (NDoH Annual Report 2017/18). Underspending in the PHC services programme was due to a delay in invoices for various projects.

Underspending in provincial health departments was driven chiefly by supply chain challenges across different programmes. Some of the most prominent supply chain challenges include delays in procuring contractors for the health facility management programme, slow execution on capital contracts by implementers and delays in procuring emergency vehicles in many provinces. Four provincial health departments received a qualified audit outcome for FY2017 (KwaZulu-Natal, Limpopo, Mpumalanga, Northern Cape and North West) because of various financial management and internal control issues, including irregular and unauthorised expenditure, contingent liabilities, weak financial reporting and inadequate performance reporting.

*Figure 12: Comparing adjusted expenditure with final outcomes in the budget of the NDoH, FY2014–2017 (percentage)*

*Source: Estimates of National Expenditure 2018 and 2019 (own calculations)  Note: The programme names provided reflect the new post-FY2019 structure*
Challenges
Supply chain challenges have emerged as one of the main reasons for the variable spending performance by the NDoH and provincial health departments in the pre-FY2018 period. Supply chain management is a function of proper financial management practices – a factor that the Auditor General probed and flagged in more than half of the provinces in FY2017 and resulting in qualified audit opinions. Highlights of the FY2017 Auditor General reports include medico-legal claims in KwaZulu-Natal, irregular expenditure in Mpumalanga, inadequate financial controls in the Northern Cape, and unauthorised and irregular expenditure in North West. Based on the above and some additional concerns, these provinces achieved qualified audit opinions in FY2017. The persistence of relatively large fiscal risks in the form of pending lawsuits against some provincial departments (KwaZulu-Natal, Limpopo and Northern Cape) is worrying. While not directly related to financial management, their potential fiscal impacts may be large and may therefore negatively impact on essential health services in the long run.
Takeaways

- The analysis confirms large variations in the absolute and relative expenditure (per capita, by headcount) on PHC across provinces.

- Differences in the uneven distribution of district hospitals largely explain the different per capita spending on the district health service programme across districts.

- 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 there has been a concerted drive to reduce inequalities in spending between provinces and within provinces, much work remains to be done to ensure that the health allocation system at district level is needs-based.

- While high-spending districts attract attention, districts in the Eastern Cape, due to their 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.

- Provincial departments are encouraged to provide regular in-year or real-time reports on the non-financial performance (equity, quality, effectiveness) of PHC expenditure. Transparency in such reporting would allow better accountability for the progressive realisation of children’s rights.
Endnotes


2. Budget data were drawn from the Health Chapter (Vote 16) of the Estimates of National Expenditures (ENE), 2018 and 2019. Data on HIV prevalence rates for young people (15–24 years) were extracted from Statistics South Africa’s Midyear Population Estimates 2018 report (Statistical Release P0302).


5. 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. National Treasury Budget Review 2013.


7. To clearly demonstrate the two sets of departments (NDoH and provincial health departments) that are involved in health provisioning in South Africa, we have not netted out the provincial transfers from the budget of the NDoH. We have done that in our presentation of ‘consolidated health’ in Figures 2 and 3.


9. 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 FY2020 fiscal year, the provincial health wage bill is projected to grow by 2.8 per cent in real terms on average over the MTEF (as per National Treasury’s Estimates of Provincial Expenditure, 2019). However, recent adjustments to the salaries of public servants will have pushed this figure up and it will remain important to examine how this will affect the ‘non-negotiable’ spending items in future budgets.

10. This section relies on the annual reports of the NDoH and the nine provincial health departments. Annual reports from FY2014 to FY2017 were consulted. The budget brief also used online NDoH budgets available on the National Treasury’s website in 2019.