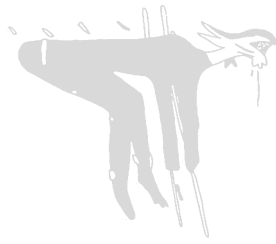




# Equity in Public Sector Health Care Financing and Expenditure in South Africa: An Analysis of Trends between 1995/96 to 2000/01

Technical Report to Chapter 4 of the  
South African Health Review 1998



# Equity in Public Sector Health Care Financing and Expenditure in South Africa: An Analysis of Trends between 1995/96 to 2000/01

Technical Report to Chapter 4 of the 1998 South African Health Review

Prepared by:

Di McIntyre

Luvuto Baba

Bupendra Makan

Health Economics Unit, University of Cape Town



Published by the Health Systems Trust

401 Maritime House  
Salmon Grove, Victoria Embankment  
Durban 4001, South Africa

Tel: +27-31-3072954

Fax: +27-31-3040775

Email: [hst@healthlink.org.za](mailto:hst@healthlink.org.za)

Internet: <http://www.hst.org.za>

ISBN No. 1-919743-31-6

Also available on the Internet:

<http://www.hst.org.za/sahr>

HST is funded by the Department of Health (South Africa), the Department for International Development (UK) and the Henry J. Kaiser Family Foundation (USA)

Designed and Printed by the Press Gang, Durban • Tel: (031) 3073240

# Table of Contents

	Page No
List of Boxes, Figures and Tables	i
List of Abbreviations	ii
Executive Summary	iii
<b>1. Introduction</b>	
1.1 Public sector health care financing and expenditure challenges	1
1.2 Key policies impacting on public health care financing and expenditure	2
1.3 Aim	2
1.4 Data sources	2
1.5 Conceptual framework for equity analysis	3
1.6 Structure of paper	3
<b>2. Overview of the South African Budget Process</b>	
2.1 The budget process prior to the new Constitution	5
2.2 The budget process after the introduction of the Constitution	6
<b>3. Total Government Financing and Expenditure</b>	
3.1 Financing	11
3.2 Expenditure	11
3.2.1 Actual and budgeted expenditure trends	11
3.2.2 Inter-provincial distribution of government expenditure and budgets	12
<b>4. Public Sector Health Care Financing and Expenditure</b>	
4.1 Financing	16
4.2 Expenditure	17
4.2.1 Total expenditure on public sector health care	17
4.2.2 Inter-provincial distribution of health expenditure and budgets	17
4.2.3 Intra-provincial distribution of health expenditure and budgets	22
4.2.4 Distribution of expenditure and budgets between levels of care	25
<b>5. Conclusions and Recommendations</b>	31
Appendix A: The Financial and Fiscal Commission (FFC) and Department of Finance (DoF) Recommendations for the Vertical and Horizontal Divisions	34
<b>References</b>	41

# List of Boxes, Figures and Tables

	Page No
<b>Box 1:</b> Major challenges to equity in public health sector financing and expenditure	1
<b>Box 2:</b> Key policy developments influencing financing and expenditure within the public health sector since 1994	2
<b>Figure 1:</b> Nature and timing of key changes in the South African budget process	5
<b>Figure 2:</b> Budget cycle after introduction of new Constitution and MTEF	7
<b>Figure 3:</b> Percentage difference between real per capita provincial expenditure/ budgets and national average	14
<b>Figure 4:</b> Percentage difference between real per capita provincial health budgets (total health budget) and the national average	20
<b>Figure 5:</b> Percentage difference between real per capita provincial health expenditure/ budgets (excluding academic hospitals) and the national average	22
<b>Figure 6:</b> Inequities in the distribution of district health service expenditure in the Eastern Cape (1996/97)	24
<b>Figure 7:</b> Inequities in the distribution of district health service budgets in the North West province (1997/98)	25
<b>Figure 8:</b> Trends in inequities in the distribution of district health service resources in Mpumalanga (1996/97 and 1997/98)	26
<b>Figure 9:</b> Trends in real per capita district health services expenditure/budgets in case study provinces	30
<b>Table 1:</b> Trends in real per capita provincial and total government budgets	14
<b>Table 2:</b> Relative annual changes in provincial and national expenditure/budgets	16
<b>Table 3:</b> Trends in real per capita provincial (and total) health expenditure/budgets	19
<b>Table 4:</b> Provincial health expenditure/budgets as a percentage of total provincial expenditure/budgets	21
<b>Table 5:</b> Trends in real per capita provincial (and total) health expenditure/ budgets, excluding academic hospitals	21
<b>Table 6:</b> Provincial health expenditure/budgets (excluding academic hospitals) as a percentage of total provincial expenditure/budgets	22
<b>Table 7:</b> Trends in the distribution of health budgets between programmes in case study provinces	29
<b>Table 8:</b> Comparison of the MTEF submissions and actual budget for 1998/99 in terms of the relative distribution between programmes	30

# List of Abbreviations

<b>CEAS:</b>	Central Economic Advisory Service (conducted research and provided overall policy advice on macro-economic matters to the pre-1994 government)
<b>CPI:</b>	Consumer Price Index
<b>DoH:</b>	Department of Health
<b>DNHPD:</b>	Department of National Health and Population Development (now the national Department of Health)
<b>DoF:</b>	Department of Finance
<b>DSE:</b>	Department of State Expenditure
<b>EXCO:</b>	Executive Council (provincial 'cabinet')
<b>FFC:</b>	Financial and Fiscal Commission
<b>GDP:</b>	Gross Domestic Product
<b>GEAR:</b>	Growth, Employment and Redistribution (macro-economic policy of current government)
<b>GST:</b>	General Sales Tax
<b>MTEF:</b>	Medium-Term Expenditure Framework
<b>MinComBud:</b>	Ministers Committee on the Budget
<b>NCOP:</b>	National Council of Provinces
<b>SGTs:</b>	Self-governing territories (the 6 former 'homelands' which were considered 'self-governing' but not 'fully independent')
<b>SHI:</b>	Social Health Insurance
<b>RDP:</b>	Reconstruction and Development Programme
<b>VAT:</b>	Value Added Tax
<b>VSP:</b>	Voluntary Severance Package

# Executive Summary

At the time of the 1994 elections, the South African public health sector faced considerable challenges in relation to health care financing and expenditure. In particular, there were large disparities in the allocation of health care resources *between* and *within* provinces. Improved access to primary care services was also an important challenge, given that the major burden of ill-health and premature death in South Africa is attributable to potentially preventable diseases.

Since the elections, a wide range of health sector and broader macro-economic policies have been introduced that have impacted on health care financing and expenditure patterns. Of particular importance is the government's macro-economic policy, termed 'Growth, Employment and Redistribution' or GEAR, which sets ambitious targets for reducing the budget deficit while at the same time not increasing the overall tax burden. This has translated into a decline in real per capita government budgets from R3,960 in 1995/96 to a projected R3,720 in 2000/01 (based on the Medium-Term Expenditure Framework or MTEF projections). The health sector has been relatively protected as the overall government budget is declining more rapidly than the health sector budget (in real per capita terms).

Health sector policies developed since the elections provide a good basis for addressing the challenges faced by this sector. Considerable progress was made in reallocating health budgets between provinces during the first two years after the election, when provincial budgets were determined by the Health Function Committee. However, with the introduction of the new constitution in early 1997, provinces were allocated global budgets and could themselves determine the allocation between different sectors or functions. Since this occurred, there has been somewhat less progress in addressing inter-provincial inequities in *health* budgets. Some provinces (notably Gauteng) are moving away from their equity target health budget allocations.

Based on the extremely limited data available, it appears that there is some progress towards equity in the distribution of health care budgets *within* provinces (i.e. between districts). However, the extent to which human resources, and hence *expenditure*, is being redistributed is unclear due to the lack of expenditure data.

There also appears to be a relative redistribution of health budgets between levels of care, with a higher *proportion* of provincial health budgets being devoted to district health services. However, the extent of these changes have been insufficient to achieve real per capita increases in district health service budgets in some provinces. Improved resourcing for district health services is particularly constrained in provinces which are faced with declining real health budgets (such as the Western Cape).

While the available data suggest that there has been progress in addressing the challenges facing the public health sector since the 1994 elections, it is difficult to draw any firm conclusions due to the lack of expenditure data. Currently, there are no mechanisms for the routine monitoring of equity in health financing and expenditure patterns. Of particular note is the evident lack of concern for equity issues displayed in the MTEF Health Sector Task Team report. This Task Team focussed almost exclusively on efficiency issues, despite the fact that the health sector's White Paper has equity as a key policy objective. If health sector equity in South Africa is to be achieved in the foreseeable future, it is critical that a mechanism for routine monitoring of health care financing and expenditure patterns from an *equity perspective* be established.



# Chapter 1: Introduction

## 1.1 Public sector health care financing and expenditure challenges

The apartheid era has left a legacy of inequality in South Africa, both in relation to income distribution and in access to social services. A range of documents have highlighted the substantial inequities within the health sector at the time of the democratic elections in 1994 (e.g. see McIntyre et al 1995; Doherty and van den Heever 1997). There is growing consensus about the major equity challenges facing the public health sector (McIntyre 1995; South Africa 1995; Makan et al 1996; Department of Health 1997a; McIntyre 1997a). The challenges relating to public health care financing and expenditure are summarised in Box 1.

### **BOX 1: MAJOR CHALLENGES TO EQUITY IN PUBLIC HEALTH SECTOR FINANCING AND EXPENDITURE**

- Improving the geographic distribution of public sector health care resources *between* and *within* provinces.
- Increasing primary care utilisation levels, particularly for currently disadvantaged groups, including:
  - \* Redistributing resources between levels of care to improve resourcing of primary care services, while still maintaining adequate referral services; and
  - \* Reducing barriers to primary care access.
- Seeking alternative sources of finance for public health services to reduce the reliance on general tax revenue.

The geographic distribution of public sector health care resources has been the major focus of debates about addressing health sector inequities in South Africa. Less attention has been paid to the equity implications of level of care resource distribution. Level of care issues, particularly the extent to which primary care services are prioritised, are of importance from an equity perspective as much of the morbidity and mortality in South Africa is attributable to potentially preventable diseases (McIntyre et al 1995; McIntyre 1997a). Although access to health services is not the only determinant of health status, it has been shown that excess suffering and premature death could be reduced at relatively low cost through primary care interventions, such as increased coverage by preventive programmes and improved access to basic medical care (World Bank 1993; World Bank 1994). The extent to which, and the speed with which, the public health sector can redress these geographic and level of care inequities is constrained by its heavy dependence on general tax funding (McIntyre 1995; Makan et al 1996; McIntyre 1997b). Hence, the need to explore alternative financing mechanisms (such as increased user fees at public hospitals for insured patients and a social health insurance scheme) is a matter of some urgency. All of these issues are considered in greater detail in later sections.

## 1.2 Key policies impacting on public health care financing and expenditure

Since the 1994 elections, various government policies have been developed which impact on the financing and expenditure challenges faced by the health sector. These are summarised in Box 2.

### **BOX 2: KEY POLICY DEVELOPMENTS INFLUENCING FINANCING AND EXPENDITURE WITHIN THE PUBLIC HEALTH SECTOR SINCE 1994**

- White Paper for the Transformation of the Health System in South Africa: This document outlines the official government health policy (Department of Health 1997a). Its main goals are to unify fragmented health services at all levels into a comprehensive and integrated National Health System, to reduce disparities and inequities in health service delivery and increase access to improved and integrated services based on primary health care principles.
- Growth, Employment and Redistribution (GEAR) which is the government's macro-economic policy (Department of Finance 1996a): The component which has been the most vigorously implemented to date is the fiscal policy, which has the following goals:
  - \* To cut the budget deficit (i.e. to reduce the amount by which government expenditure exceeds its revenue);
  - \* To avoid permanent increases in the overall tax burden; and
  - \* To reduce consumption expenditure by general government relative to Gross Domestic Product (GDP).

Although these fiscal goals have been part of government policy for some time, the importance of GEAR is that it sets explicit, stringent targets for reducing the budget deficit.

- Policies relating to the distribution of revenue between spheres of government and between provinces: The main proposals in this regard have been made by the Financial and Fiscal Commission (FFC 1996; FFC 1998). They proposed a largely 'population-based' formula for determining the equitable allocation of resources between individual provinces. The Department of Finance (1997a) put forward a different (also 'population-based') formula, which was accepted by the Budget Council as the basis for determining the 1998/9 budgets.
- Medium-Term Expenditure Framework (MTEF) (Department of Finance 1997): This policy has introduced three-year rolling budgets for all national and provincial departments. The MTEF is intended to encourage departments to evaluate their objectives within realistic budget projections and to enable government to make strategic policy choices between expenditure priorities.

## 1.3 Aim

The aim of this paper is to evaluate the extent to which post-election policies have impacted on equity in health care financing and expenditure in South Africa. The approach adopted was to collate financing and expenditure trend data, and to critically evaluate the policies in the light of these financing and expenditure patterns.

## 1.4 Data sources

The majority of the data has been derived from the Department of Finance's MTEF database. This contains expenditure data for the 1995/96 and 1996/97 financial years and budgets for the 1997/98 to 2000/01 financial years. The budget data for 1998/99 to 2000/01 financial years are based on the MTEF projections. While the actual budgets for these years will differ somewhat from the MTEF projections, these data provide insights into likely future budget trends. Data on the health budgets for the 1995/96 and 1996/97 financial years were derived from other sources (Makan et al 1996; Doherty and van den Heever 1997). Case studies were also conducted in certain provinces and data for these studies were derived directly from the provincial health departments (provincial budget estimates and expenditure data from their financial management systems and/or audited statements).

Population data are based on the recently released final 1996 census estimates. Population estimates for other years were estimated using the provincial population growth rates calculated by the Demographic Information Bureau (Quoted in: Doherty and van den Heever 1997). Total government expenditure and budgets are compared with the total population, whereas public sector health care expenditure and budgets are compared with the population dependent on public sector services (assumed to be the total population less medical scheme members).

The official Consumer Price Index (CPI) was used to deflate nominal expenditure (using 1995 as the base year). It was assumed that inflation would remain at the 1997 level (of approximately 8.5 percent) in 1998 to 2000. This is likely to be a conservative estimate.

## 1.5 Conceptual framework for equity analysis

Equity is difficult to define, not least of all because equity is interpreted differently in each society depending on the dominant ideology within that society. However, it is commonly understood that equity implies justice and fairness. In pursuing equity, existing differences are taken into account explicitly, and measures adopted which will address these differences. The goal is to achieve a more just (i.e. equitable) distribution of health care resources.

It is important in a study such as this to establish a conceptual framework. The purpose of such a framework is to explicitly define the concepts of equity used for evaluating various aspects of the health sector.

Evaluating inequities in health care expenditure (and hence the delivery of health services) serves to answer the question “Who benefits (and who does not benefit) from health services?” Where there are substantial differences in health status, and in access to health services, efforts should be made to prioritise the use of scarce health sector resources for those in greatest need (Mooney 1996). What this means is that society gives preference to health gains in those groups which have the worst health status, and hence the greatest capacity to benefit from health services, and the least ability to pay for health services.

As indicated above, a key challenge within the South African context is that of addressing historic inequities in the geographic distribution of resources. The fundamental issue in relation to geographic equity is that people with an equal capacity to benefit from health care (i.e. an equal need for health services) should not receive unequal treatment purely on the basis of their place of residence. To assess geographic equity, differences in the distribution of health care resources between provinces (and to a more limited extent, within provinces) are documented in this paper. Although there are a range of indicators of differential need between geographic areas (e.g. differential morbidity and mortality rates), the size of the population dependent on public sector services within each province is used as the only indicator of health service ‘need’ in this paper (i.e. trends in per capita expenditure or budgets are evaluated). This is largely due to constraints in obtaining accurate data for other indicators of ‘need’ for all provinces.

## 1.6 Structure of paper

The structure of the rest of this paper is as follows:

- Chapter 2 provides a brief overview of the budget process, and highlights important changes in the budget process over the past few years.
- Chapter 3 briefly considers recent trends in total government financing and expenditure. It provides important background information for the health sector analysis.
- Chapter 4 reviews recent trends in public health sector financing and expenditure and considers the influence of various policies on these trends. Particular emphasis is placed on the three challenges outlined in Box 1, i.e. to what extent have alternative financing sources been identified, and to what extent have resources been redistributed between geographic areas and between levels of care.
- The final chapter summarises the findings of this research and makes recommendations on further steps that can be taken to promote health sector equity in South Africa.

# Chapter 2:

## Overview of the South African Budget Process



The budget process has changed dramatically since the 1994 elections, particularly since the introduction of the new constitution in February 1997. This chapter provides an overview of the budget process before and after the implementation of the new Constitution. The focus is on this process as it relates to determining health budgets. To guide the reader through the various changes in aspects of the budget process, Figure 1 summarises the nature and timing of these changes. It particularly highlights changes in:

- the department responsible for determining the global government budget limits and for establishing guideline allocations;
- the broad mechanism for determining health budgets;
- the use of an equity-promoting resource allocation formula; and
- key actors or stakeholders in the budget process.

**FIGURE 1: NATURE AND TIMING OF KEY CHANGES IN THE SOUTH AFRICAN BUDGET PROCESS**

<b>Financial year (for which budget was being prepared)</b>	<b>Setting spending limits/guideline allocations</b>	<b>Mechanism for determining health budgets</b>	<b>Resource allocation formula</b>	<b>Key Factors</b>
Until 1994/95 (before 1994 election)	Set by DSE with inputs from CEAS & DoF	Function committee process	None	Overall: DSE, DoF, CEAS, cabinet Health function committee: Health depts. (DNHPD, 4 provinces, SGTs), DSE, DoF, CEAS
Preparation of budget for 1995/96 (first post-election budget)	Set by DSE with inputs from DoF	Function committee process	Formula for health sector	Overall: DSE, DoF, cabinet Health function committee: Health depts. (national and 9 provinces), DSE, DoF, RDP office, FFC
Preparation of budget for 1996/97	Set by DSE with inputs from DoF and Budget Council	Function committee process	Revised formula for health sector	Overall: DSE, DoF, Budget Council, cabinet Health function committee: Health depts. (national and 9 provinces), DSE, DoF, RDP office, FFC
Preparation of budget for 1997/98 (first budget after GEAR and taking account of new constitution)	DoF sets spending limits (i.t.o. GEAR model) and Budget Council recommends vertical and horizontal division to cabinet	Global provincial budgets; negotiation with provincial treasuries	Aspects of FFC formula used	Overall: DoF, Budget Council & cabinet assume key role in global budgets Health: Individual depts. negotiating with relevant provincial (or national) DoF & DSE; provincial EXCOs
Preparation of budget for 1998/99 (first budget using MTEF)	DoF sets spending limits and Budget Council recommends vertical and horizontal division to cabinet	Global provincial budgets & MTEF process	DoF formula used	Overall: DoF, Budget Council & cabinet Health: Health MTEF Task Team; negotiations at provincial (or national) level; provincial (or national) level; provincial EXCOs

Abbreviations: CEAS = Central Economic Advisory Service; DNHPD = Department of National Health and Population Development; DoF = Department of Finance; DSE = Department of State Expenditure; EXCOs = Executive Council (provincial 'cabinet'); FFC = Financial and Fiscal Commission; RDP = Reconstruction and Development Programme; SGTs = 'Self-governing territories'.

## 2.1 The budget process prior to the new Constitution

Until 1997, the budget process was highly centralised with the national Department of State Expenditure (DSE) playing a key role. The DSE negotiated budgets with various 'agencies', including:

- Function committees (which existed for specific sectors, such as health and education, where a number of departments at national, provincial and 'homeland' level had a service delivery role); and
- Individual departments where their functions largely related to the national level.

Within the health sector, the Health Function Committee was the body responsible for drafting the health budget submission to the DSE. The Health Function Committee was chaired by the Department of National Health and Population Development (DNHPD) and included representatives of the 4 provincial and 6 'self-governing territory' health departments<sup>1</sup>, as well as representatives of DSE, Department of Finance (DoF) and the Central Economic Advisory Service (CEAS) before the 1994 elections. After the elections, the Function Committee was chaired by the national Department of Health and had representatives from the 9 provincial health departments, DSE, DoF, the RDP office and the Financial and Fiscal Commission (FFC). In addition, the Parliamentary Portfolio Committee on Health was invited to participate in the Health Function Committee after the 1994 elections.

Prior to the elections, the Health Function Committee used a historical budgeting process to determine allocations to national, provincial and 'self-governing territory' health departments (i.e. the previous year's budget with a small adjustment). After the 1994 election, a 'needs-based' formula was used to determine the budget allocations between provincial health departments. This formula consisted of the provincial population size, which was weighted by an indicator of disparities in per capita income between provinces (i.e. provinces with lower per capita incomes would receive a higher weighting as they were likely to have a higher proportion of their population dependent on public sector health services). There was also an allowance for the training, research and specialised referral services provided by Academic Health Centres in certain provinces.

Thus, an important feature of the budget process prior to the introduction of the new constitution was that the Health Function Committee determined how the overall health budget would be allocated between national, provincial and 'self-governing territory' health departments. Provinces had very limited flexibility in adjusting their health budget once it had been determined by the Function Committee.

While the introduction of the new constitution has brought the most radical change in the budget process (in that it introduced provincial level decision-making about allocations between different sectors or functions - see section 2.2), certain budgeting changes began to be implemented immediately after the 1994 elections. These include the following changes:

- The DoF began to assume a more important role in the budget process. In particular, it became more involved in projecting macro-economic trends and in setting spending limits based on its government revenue estimates and the desired budget deficit level.
- The Budget Council was established and began playing an increasingly central role in the budget process, particularly from 1996 onwards. This forum includes the Minister and Deputy Minister of Finance, the MECs of Finance, the Heads of the provincial finance departments/treasuries and the Director-Generals of the national DoF and DSE. The FFC has observer status on the Budget Council. The introduction of the Budget Council further enhanced the status of the DoF as an important role-player in the budget process.

---

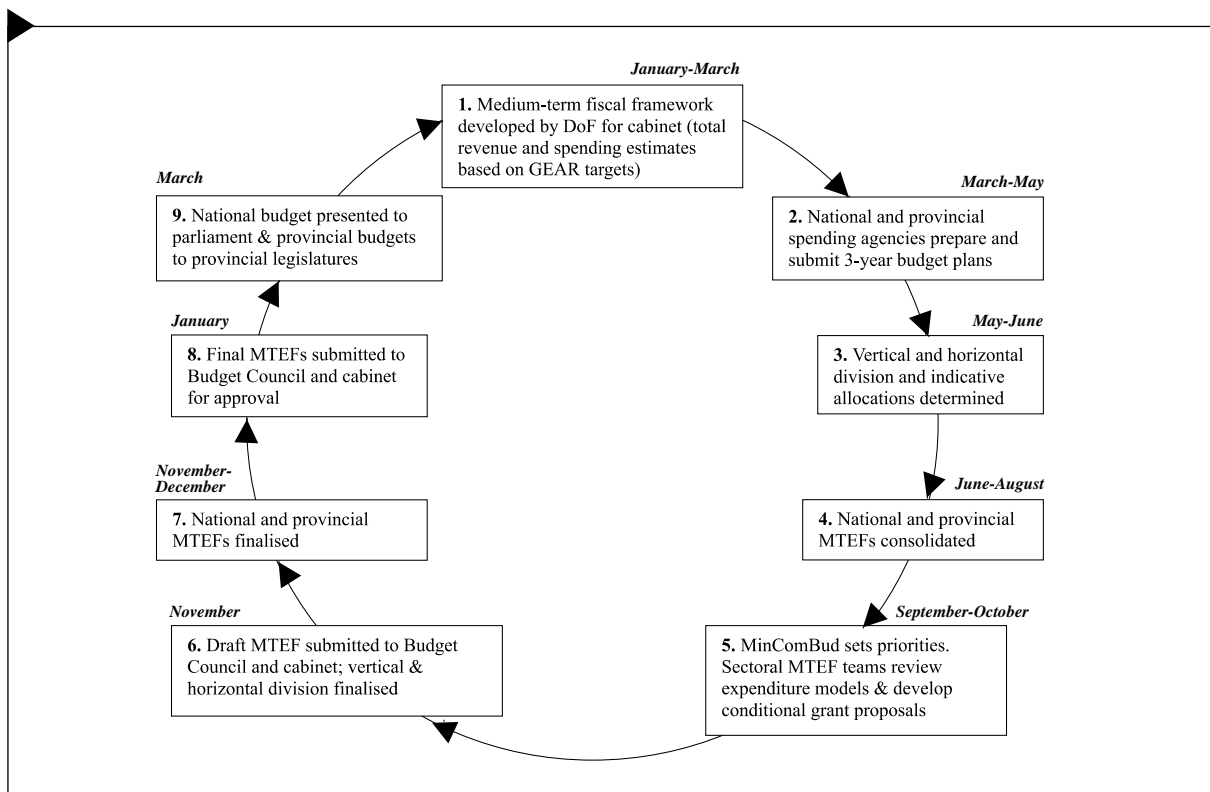
<sup>1</sup> The so-called 'independent' or 'TBVC' homelands were allocated a global budget by the Department of Foreign Affairs and were not involved in the Health Function Committee

- The FFC was established. Its function is to advise parliament and provincial legislatures on issues such as the mechanism for allocating resources between the spheres of government in an equitable manner, the taxing powers of provinces and government borrowing. As the FFC is an advisory body, its recommendations are not legally binding.

## 2.2 The budget process after the introduction of the Constitution

The major change in the budget process arising from the introduction of the new constitution was the move to the allocation of global provincial budgets and the decentralisation of decision-making about the allocation of those budgets between functions or sectors to the provincial level (called fiscal federalism). However, certain other events occurred around the same time which also impacted on the budget process. In particular, the DoF drafted a macro-economic policy, called 'Growth, Employment and Redistribution' (GEAR), in 1996. While the fiscal policy in GEAR was similar to that spelt out in the RDP (i.e. reduce the budget deficit primarily through constraining government expenditure), GEAR added a new dimension by setting explicit, and very ambitious, deficit reduction targets. As the custodian for the implementation of this policy, the DoF has now assumed a central role in the budget process. In particular, the DoF is responsible for setting the parameters for budgeting through its medium-term fiscal framework. This framework contains DoF estimates of GDP growth, anticipated tax revenue (based on the target tax:GDP ratio) and government spending limits (based on estimated revenue and the desired budget deficit level). This information is critical as it sets the upper limit on the total government budget. This framework is submitted to cabinet for approval and forms the basis for the rest of the budget process (see box 1 in Figure 2). The cabinet also sets broad government priorities (against which the detailed budgets will be evaluated) at the same time as it considers the medium-term fiscal framework.

FIGURE 2: BUDGET CYCLE AFTER INTRODUCTION OF NEW CONSTITUTION AND MTEF



Source (of background information): Presidential Review Commission (1998)

The next stage (box 2 in Figure 2) is the preparation of initial budget estimates by spending agencies (i.e. a government department or other government unit that incurs expenditure) at both the provincial and national level. The budgets of individual agencies are combined to form consolidated provincial and national budgets at a later stage. These initial estimates took the form of a one-year projection in the case of the budget for the 1997/98 financial year. Spending agencies were required to prepare 3-year budget plans (in line with the government's new Medium-Term Expenditure Framework or MTEF) when preparing budgets for the 1998/99 financial year. The advantages of budgeting over a longer time horizon (3 years, in the case of the South African MTEF), rather than the traditional annual budget, were summarised by the Presidential Review Commission as follows:

- “Permits policy development to be linked with resources over time
- Creates a predictable medium term planning environment
- Provides a framework for assessing priorities
- Promotes the credibility of the fiscal strategy by, inter alia, making explicit the assumptions on which projections and prioritisation is based” (Presidential Review Commission 1998: 26).

Thus, the MTEF was seen as a mechanism for ensuring that spending agencies explicitly consider how to match planned spending with their policy priorities, and for promoting integration of the planning and budgeting processes. Under the MTEF, spending agencies are required to prepare 3-year budgets under 2 scenarios:

- A ‘no-growth’ scenario - which requires agencies to consider how they would stay within the previous year’s budget allocation (i.e. if new programmes are to be introduced, they have to consider what existing programmes will be downscaled and/or where efficiency gains could be achieved); and
- A ‘needs-based’ or ‘zero-based’ budget - which requires agencies to cost current activities which they wish to maintain, the expansion of existing programmes and new programmes which they wish to implement.

These preliminary budget estimates are submitted to the provincial treasuries (in the case of provincial spending agencies) and to the national DoF and DSE (in the case of national spending agencies) for consideration.

The third stage of the budget process is determining the guideline or indicative allocations to the different spheres of government (i.e. national, provincial and local government) and within each sphere (e.g. the allocation to individual provinces from the total amount set aside for provincial budgets). These allocations are respectively called the ‘vertical’ and ‘horizontal’ divisions. One of the functions of the FFC was to develop recommendations on the basis for determining the vertical and horizontal divisions. The FFC published its recommendations in May 1996 (see Appendix A for details). However, these are merely recommendations, and the responsibility for determining the vertical and horizontal divisions rests with the Budget Council. The extent to which the FFC’s recommendations were (or were not) taken into consideration during the budget cycle for the 1997/98 year is unclear. As noted by the Presidential Review Commission (1998: 24) “In the 1997/98 fiscal year, this whole process was completely non-transparent, since Budget Council deliberations are secret”. It was, however, clear that the Budget Council was not entirely satisfied with the FFC recommendations as the DoF submitted counter proposals for the vertical and horizontal divisions to the Budget Council in May 1997. Although discussions within the Budget Council cannot be publicly disclosed, the Intergovernmental Fiscal Relations Bill requires that the Minister of Finance introduces a ‘Revenue Sharing Bill’ in the National Assembly at the same time as the annual budget. This Bill must document the vertical and horizontal division, and must be accompanied by a memorandum indicating exactly how this division was determined and how FFC

recommendations were taken into account. This occurred for the first time when the 1998/99 budget was presented to parliament; at this time, it was indicated that the DoF proposals had been accepted by the Budget Council (see Appendix A for details of the DoF proposals).

The vertical and horizontal divisions translate into guideline allocations for the overall national level budget and the global budgets for each province (local governments are not dealt with here as the mechanism for allocating resources to local governments is still under review (see Appendix A for FFC proposals on local government allocations). Once these allocations have been determined, the consolidated national and nine provincial MTEFs (or 3-year budget plans) are developed (see box 4 in Figure 2). This requires negotiation between the provincial treasuries and individual spending agencies at the provincial level, and between national spending agencies and the relevant Programme Officer in the DSE at the national level. The role of the provincial treasuries and the DSE is to try to reconcile the budget requests of the various spending agencies with the guideline allocation for their province or the national government level respectively.

While the provincial treasuries have the final responsibility for the MTEF submission to their respective Executive Councils (EXCOs), the MTEF Committee makes the final MTEF recommendations to cabinet at the national level. The MTEF Committee consists of the Minister and Deputy Minister of Finance, the Director-Generals of Finance and State Expenditure and other officials of the DoF and DSE. Officials of the various national departments make submissions to the MTEF Committee defending their budget requests while the DSE programme officer responsible for each department then defends his/her recommendations. The MTEF Committee adjudicates and recommends budget allocations for each national department (as part of the national MTEF) to cabinet.

At the same time as the national cabinet and provincial EXCOs are considering the draft consolidated MTEFs, the Minister's Committee on the Budget (MinComBud) meets to set broad priorities, which are submitted to cabinet via the Minister of Finance (see box 5 in Figure 2). MinComBud comprises of the Minister and Deputy Minister of Finance, and the Ministers of Trade and Industry, Arts and Culture, Science and Technology, Health and Education. At the same time, sectoral teams for the 'big five' (i.e. education, health, social welfare, justice and defence) also consider all the MTEF submissions relating to their sector. These sectoral teams contain representatives of the relevant national and provincial departments (Departments of Health in the case of the health sector), the national DoF and DSE, and the provincial treasuries. The function of these teams is to develop expenditure models for the sector, consider policy choices, develop norms and standards and make recommendations on conditional grants.

Once the cabinet, the EXCOs and the sectoral MTEF teams have undertaken their reviews of, and made recommendations on, the national and provincial MTEFs, the draft overall MTEF is compiled and submitted to the Budget Council and then to cabinet (see box 6 in Figure 2). This document describes the broad policy framework, within the context of the budget constraint (which was set at the beginning of the cycle - see box 1 in Figure 2), suggests allocations for the 3-year period, provides an analysis of the implications of these allocations and suggests alternative expenditure options. Once Budget Council and cabinet have approved the MTEF, the vertical and horizontal division is finalised (i.e. allocations to national government and each province are adjusted to match the budget requirements arising from the draft MTEF which has been approved by cabinet).

National spending agencies and provincial treasuries are informed of their final allocations and must then finalise their MTEFs in line with this allocation and taking into consideration the recommendations of the various stakeholders (e.g. EXCOs, sectoral MTEF teams, Budget Council and cabinet) (see box 7 of Figure 2). The final MTEFs are once again submitted to cabinet, via the Budget Council, for approval (see box 8 of Figure 2). Relevant budget

documentation is compiled (particularly the 'white books') and is then ready to be tabled in parliament during the annual budget speech by the Minister of Finance (see box 9 of Figure 2).

In summary, the introduction of the new constitution fundamentally changed the budgeting process in South Africa. Previously, budgets were centrally allocated to each sector or function and the allocation of the overall health budget between the national, provincial and 'self-governing territory' health departments was determined by the Health Function Committee. Since the introduction of the new constitution, budgets are allocated to the national, provincial and local spheres of government and each province has the authority to determine their own budget allocations to different functions or sectors. In addition to these constitutional changes, there have also been changes in the key 'actors' within the budgeting process. These include the following shifts in power:

- The Ministry and Department of Finance have assumed the dominant role in the budgeting process. Together with the provincial treasuries, they hold considerable power.
- The increasing role of the DoF (and the Budget Council) has been matched by a relatively decreasing role for the DSE.
- The cabinet, and to a lesser extent the provincial EXCOs, also have considerable power in the budget process. The EXCOs approve provincial budgets and MTEF submissions, while cabinet sets priorities, approves the vertical and horizontal division of government revenue and evaluates and approves the overall MTEF. The extent to which cabinet makes substantive changes to Budget Council recommendations is unknown.
- National and provincial parliaments have a relatively limited role in the budget process at present (although there are likely to be some changes in the future). Some of the ways in which parliament does or can play a role include:
  - Parliament plays an indirect role in setting some of the budgeting parameters, as it is involved in deciding on government priorities (through debating and passing policy documents and legislation relating to various sectors). These parliamentary decisions should form the basis for the government priorities determined by cabinet.
  - In terms of the budget itself, parliament could previously only accept or reject a budget. However, the Money Bills Amendment Procedure Bill (still to be passed) will enable parliament to make limited changes to budgets. While parliament will not be allowed to change tax rates or to change allocations across votes, they will be allowed to suggest changes to allocations within a particular vote. This Bill is a result of a constitutional requirement: The constitution (section 77(2)) specifies that there must be an act of parliament which will allow for the amendment of money bills (which includes budgets). There is a similar requirement for the provincial level (section 120(2) of the constitution). The actual process by which parliament engages with the budget is as follows:
    - The budget is presented to parliament during the annual budget speech (and since 1998, is accompanied by the Division of Revenue Bill - see below).
    - Following the first reading of the budget, the Appropriation Bill (which gives spending agencies the legal authority to spend funds allocated to them) and proposed tax legislation are submitted to the National Assembly Portfolio Committee on Finance. They are given seven working days to hear submissions (mainly from government departments and the South African Reserve Bank) and are then required to table a report on their hearings in parliament.

- The Appropriation Bill and associated bills are then voted on in the National Assembly.
- As the Appropriation Bill is regarded as a ‘national money bill’ (under section 77 of the constitution), it is deemed not to affect provinces. As a result, the Appropriation Bill is only sent to the National Council of Provinces (NCOP) *after* the National Assembly vote. The NCOP may hold public hearings on the Bill (through its Select Standing Committee on Finance). Once enabling legislation (Money Bills Amendment Procedure Bill) has been passed, the NCOP could recommend that the Bill be passed, amended or rejected. If either amendment or rejection is recommended, the National Assembly will have to reconsider the Bill. However, as this is considered a section 77 bill, the National Assembly does not have to adhere to the NCOP recommendations.
- Although there will be greater scope for parliamentary involvement in amending budgets (once enabling legislation has been passed), the extent to which there can be meaningful involvement is dependent on the timing of the process. In particular, it has been argued that an allowance of 7 working days for consideration by the Portfolio Committee on Finance is inadequate. There is some discussion about moving the budget speech and tabling of the Appropriation and other related Bills forward (to February) to allow for more meaningful parliamentary debate.
- An area where there could potentially be significant parliamentary input (particularly from the NCOP) relates to the Division of Revenue Bill. As indicated previously, this documents the vertical and horizontal division of government revenue. It is considered a ‘section 76’ bill which is deemed to affect both the national and provincial levels. At present, this bill is tabled at the same time as the Appropriation Bill and is considered by the National Assembly and the NCOP in the same way as described above for the Appropriation Bill. However, as a ‘section 76’ bill, if the NCOP rejects or amends the Division of Revenue Bill, the National Assembly must give serious consideration to the NCOP recommendations. The National Assembly may either pass the NCOP amended Bill, or make other amendments that will be acceptable to the NCOP. If they reject the NCOP amendments, the Bill will be submitted to a mediation committee. Once again, the extent to which there can be meaningful engagement with the Division of Revenue Bill is dependent on the timing of the parliamentary review process. Given that the vertical and horizontal division of government revenue is critical for the entire budget process (as it defines the budget limits for national departments and each province), it has been proposed that the Division of Revenue Bill is tabled at an earlier stage.
- In relation to provincial legislatures, the implementation of the new constitution has increased their potential role in the budget process. Under the previous budget process (see section 2.1), provincial budgets were merely a combination of the sectoral budgets determined by the various Function Committees and provincial legislators had no power to amend these budgets. However, provinces now have greater freedom in determining their own budgets. The provincial treasuries and EXCOs take the lead in the provincial budget process, but the provincial legislatures will also have the power to amend money bills (in terms of section 120(2) of the constitution).



# Chapter 3: Total Government Financing and Expenditure

Before analysing the health sector in detail, it is important to look at recent changes in total government financing and expenditure. The total amount of resources available to the South African government has a major impact on health care financing, not least of all because the public health sector is almost entirely dependent on general tax revenue at present.

## 3.1 Financing

Largely due to low economic growth rates, government revenue has been increasing relatively slowly since the mid-1980s. Government expenditure, however, has increased at a faster rate, resulting in a budget deficit (i.e. expenditure exceeded revenue). With higher economic growth rates since 1993, tax revenue has increased, but still falls short of government expenditure levels. The current fiscal policy (as expressed in GEAR) of reducing the budget deficit while not increasing the levels of tax relative to GDP, translates into severe constraints on government spending.

Over 80 percent of government revenue is collected at the national level. The remainder is collected at provincial level (from sources such as vehicle registration fees and user fees at health facilities) or at local government level (such as property rates revenue, minor payroll levies on local industries, and surpluses on the sale of utilities such as water and electricity supplies).

In the 1996/97 financial year, approximately 56 percent of general tax revenue was generated from income tax (mainly individual and company tax receipts), 25 percent from Value Added Tax (VAT), 12 percent from excise duties and 7 percent from other sources (Department of Finance 1996b). The relative contribution of direct income taxes has fallen from approximately 70 percent in the early 1980s. In contrast, there has been an increase in the contribution of indirect taxes (initially General Sales Tax (GST) and more recently VAT). GST contributed less than 20 percent of total tax revenue in the early 1980s, whereas VAT is now contributing over a quarter of tax receipts (Department of Finance 1996b). There is some concern about this changing mix of tax revenue, as VAT is a more regressive financing source (i.e. poor people tend to pay a higher percentage of their income in VAT than rich people do).

## 3.2 Expenditure

### 3.2.1 Actual and budgeted expenditure trends

According to the Department of Finance's MTEF database, total government expenditure increased from R158 billion in 1995/96 to R174 billion in 1996/97. It is projected to increase to R240 billion in 2000/01. However, in real terms (i.e. allowing for the effects of inflation) the 2000/01 budget will have marginally increased to R160.9 billion (expressed in 1995/96 terms). In real per capita terms, this represents a 0.8 percent increase between 1995/96 and 1996/97 and a constant decline thereafter (as the population size is increasing more rapidly than the budget). The annual rate of decrease in real per capita government budgets is as follows:

1996/97-1997/98	=	-0.87%
1997/98-1998/99	=	-2.14%
1998/99-1999/2000	=	-2.82%
1999/2000-2000/01	=	-1.13%

Overall, it is anticipated that real per capita government expenditure will decline from R3,960 in 1995/96 to R3,720 in 2000/01.

These data highlight the impact of the government's fiscal policy contained in GEAR. They demonstrate the government's commitment to reducing the government deficit through placing constraints on government consumption expenditure. Despite the fact that the Department of Finance recently adjusted its economic growth estimates (to reflect lower growth rates than those used in the GEAR model), it has not deviated from its goal of reducing the budget deficit from 5.4 percent of GDP in 1996 (de Bruyn et al 1998) to 3 percent of GDP by 2000/01 (Department of Finance 1997a). Thus, while the Department of Finance acknowledges that tax revenue will be lower than initially projected in GEAR (as it intends reducing the tax to GDP ratio and recognises that GDP is growing more slowly than anticipated), it remains committed to meeting budget deficit reduction targets. This means that even greater pressure will be placed on government spending than originally anticipated in the GEAR fiscal policy. This has serious implications for all government departments, particularly the two largest sectors (in terms of their share of the budget), namely education (which accounted for over 21 percent of the government budget in 1997/98) and health (accounting for nearly 11 percent of the budget).

While the fiscal policy is driving these budgetary changes, the MTEF provides an instrument for enforcing greater discipline in government spending. It is intended that the MTEF will encourage all government departments to use more realistic budget projections when developing their plans. It will also assist the Departments of Finance and State Expenditure to prioritise between competing claims on increasingly constrained resources.

### 3.2.2 Inter-provincial distribution of government expenditure and budgets

As indicated in section 2.2, the new Constitution requires that provinces are awarded global budgets, i.e. a lump sum from which each province can decide on allocations to individual provincial departments. Thus, it is important to evaluate trends in real per capita provincial budgets (see Table 1), as changes in total provincial budgets in turn have implications for changes in provincial health budgets.

**TABLE 1: TRENDS IN REAL PER CAPITA PROVINCIAL AND TOTAL GOVERNMENT BUDGETS (RANDS)**

	1995/96	1996/97	1997/98	1998/99	1999/2000	2000/01
Eastern Cape	2,149	2,500	2,183	1,879	1,734	1,651
Free State	2,047	2,229	2,081	1,857	1,700	1,608
Gauteng	1,672	1,745	1,679	1,536	1,473	1,433
KwaZulu-Natal	1,856	1,982	1,968	1,602	1,457	1,428
Mpumalanga	1,549	1,787	1,717	1,520	1,470	1,471
North West	1,959	2,127	1,873	1,710	1,567	1,486
Northern Cape	2,205	2,245	2,446	2,003	1,865	1,785
Northern Province	1,530	2,066	1,991	1,730	1,594	1,505
Western Cape	2,257	2,415	2,281	1,958	1,744	1,642
Average for provincial budgets	1,875	2,092	1,974	1,711	1,581	1,520
<b>Total</b> (including national budgets)	<b>3,960</b>	<b>3,991</b>	<b>3,957</b>	<b>3,872</b>	<b>3,763</b>	<b>3,720</b>

Figure 3 shows the extent to which each province's per capita budget is above or below the national average and how this has changed over time. It provides insights into government's efforts to address historical disparities in the geographic distribution of resources.

**FIGURE 3: PERCENTAGE DIFFERENCE BETWEEN REAL PER CAPITA PROVINCIAL EXPENDITURE/ BUDGETS AND NATIONAL AVERAGE**

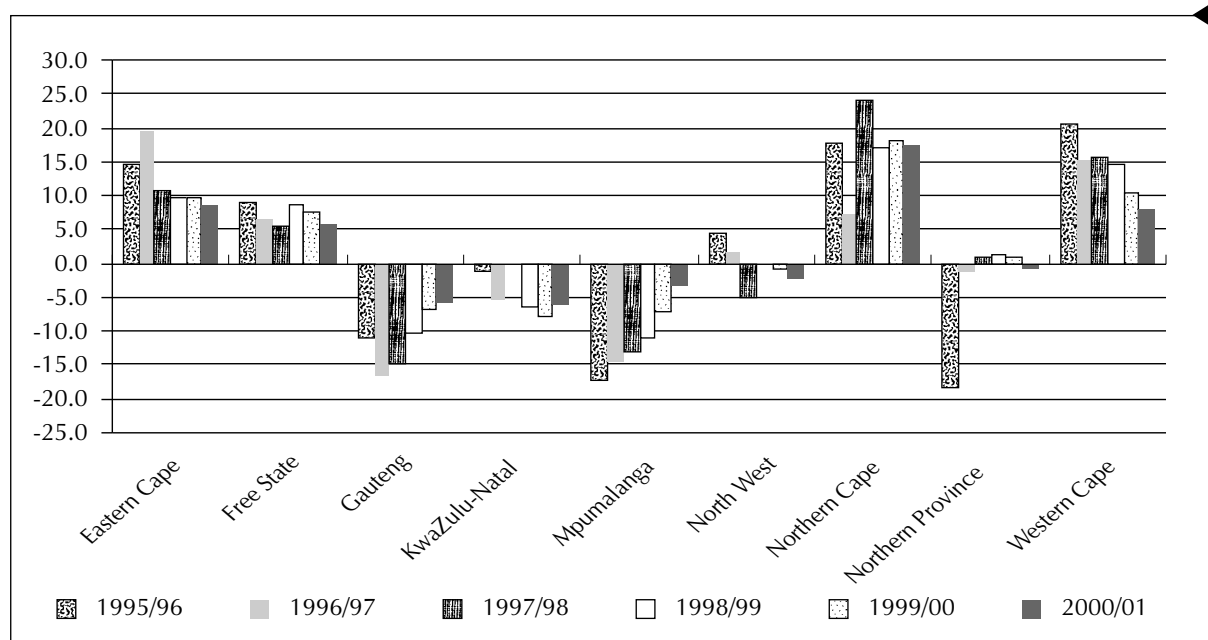


Figure 3 shows that in general, per capita provincial budgets are coming closer to the national average. This would be considered equitable if one assumes that provinces should receive the same amount of money from the national budget per person living within that province. It is of concern however that the North West has declined from being above the national average to potentially being below the national average by 2000/01 (if the MTEF projections are to be applied). In addition, KwaZulu-Natal has moved further below the national average than in 1995/96.

Two points should be made about the above data. Firstly, the population data on which inter-provincial budget redistribution decisions were based have been shown to be incorrect by the 1996 census estimates. In particular, the census indicates that highly urbanised provinces such as Gauteng and the Western Cape contain a higher proportion of the population than previously thought. Thus, it is critical that accurate population data are obtained, as the relative population size of provinces will profoundly affect their budget allocations (given that the redistribution formula is population-based). Secondly, the above figure is purely based on population size. The various proposed budget redistribution formulae (see Box 2 and Appendix A) attempt to take other factors into account. Of particular importance is the additional weighting given to rural residents within a province, as a proxy for socio-economic deprivation. Thus, while the above figure indicates that Gauteng receives budgets which are below the national average (in per capita terms), once relative socio-economic status is taken into account, Gauteng may in fact be above the national average. Conversely, due to the high poverty levels in the Eastern Cape, its budget may not be as far above the national average as Figure 3 suggests. Unfortunately, as the precise data used by the Department of Finance in their formula calculations are not available to the research team, the weighted allocations could not be reconstructed.

The trend of reducing relative inequities in the distribution of global provincial budgets (as suggested in Figure 3) reflects the impact of the various inter-provincial resource allocation formulae. The 1997/98 allocations were broadly based on the Financial and Fiscal Commission's (FFC 1996) proposed formula, while the 1998/99 allocations were calculated using the Department of Finance's (1997a) formula. Both formulae have been subject to some criticism, particularly in relation to the individual formula components and weighting mechanisms, but the objective of both, namely the equitable allocation of government resources, is widely supported.

What is of concern, however, is the relative distribution of resources between the national and provincial spheres of government. Table 2 below indicates that there was a significant increase in provincial expenditure and a decline in national expenditure between the 1995/96 and 1996/97 financial years. This is partly attributable to the devolution of certain functions to provinces with the associated resources being transferred. However, it also reflects the FFC's recommendation that "... allocations to the national government [should] grow more slowly than those to the provincial governments" (FFC 1996: ii). The basis of this recommendation was that very few national departments' services are related to population increases, i.e. as the population grows, the need for nationally provided services would not increase much. Instead the need for provincially provided services will increase in line with population increases and, therefore, it was argued that the absolute priority should be to address inter-provincial inequities to "... enable the current extremely unequal provision of public services to be corrected in [a] reasonably short period" (FFC 1996: ii). The reversal of this trend, particularly under the MTEF projections for 1998/99 to 2000/01, is of great concern. In effect, while overall provincial budgets are facing dramatic real decreases, the national budget is increasing equally dramatically.

**TABLE 2: RELATIVE ANNUAL CHANGES IN PROVINCIAL AND NATIONAL EXPENDITURE/BUDGETS**

<b>Financial years</b>	<b>% change in provincial expenditure/budgets</b>	<b>% change in national expenditure/budget</b>
1995/96-1996/97	13.34	-7.41
1996/97-1997/98	-4.13	6.05
1997/98-1998/99	-11.95	10.75
1998/99-1999/2000	-6.10	2.57
1999/2000-2000/01	-2.32	2.46

An important reason for this trend is that the Department of Finance (1997a) has introduced a 'top-slice' in its resource allocation formula (which has been accepted by the Budget Council). A 'top-slice' refers to revenue that is removed before decisions on the allocations to different spheres of government (i.e. between national, provincial and local government) are made. Part of the 'top-slice' is to be used for the national debt servicing costs, while another component is set aside as a contingency reserve (for unforeseen disasters or changes in economic circumstances). However, the Department of Finance (1997a) recommended that a significant part of the 'top slice' (R3 billion) should be used for the creation of a policy reserve, which the national government will control. This reserve is to be used to "... meet specific policy priorities without compromising the proposed budgets of other services" (Department of Finance 1997a).

Based on the above data, it appears that provincial budgets are bearing most of the burden of funding the top-slice. The money in the policy reserve may be transferred back to certain provinces, but there is no guarantee that this will occur as "emerging policy priorities" could arise at the national, provincial or local government level. There is an urgent need for the Department of Finance to clarify how this reserve is to be used. The FFC (1998: 16) has noted that if "... this reserve is to be allocated on the basis of bids from departments or provinces, it may have adverse consequences on equity, where well organised provinces take up the lion's share of the reserve and little expenditure takes places where it is needed most."

In summary, while the overall trend in reducing geographic inequities in global provincial budgets is encouraging, the relative redistribution between provincial and national spheres of government is of concern. It appears that all of the additional allocations to currently under-resourced provinces must occur through budgetary cuts in other provinces, as opposed to being partially funded from the (small) real increase in the overall budget.

# Chapter 4:

## Public Sector Health Care Financing and Expenditure



### 4.1 Financing

Public sector health services are still heavily dependent on general tax revenue. The other source of finance is that of local government 'own revenue', which is sometimes used to supplement subsidies provided by provincial governments. User fees generate some income, but this revenue is returned to the provincial treasury and is thus, not strictly speaking, a source of finance for public health services (as it may be used on other services by the treasury). This reliance on a single source of finance for the majority of public sector health services constrains the ability of health authorities to restructure health services and respond to the changing (and growing) needs of the population (see Box 1). If health services are to be expanded rapidly in the context of constrained total government resources, health authorities will need either to convince budget decision-makers to award health a larger slice of the resource pie or to consider alternative funding sources. There is clearly also scope for using existing resources more efficiently and equitably, although achieving significant efficiency gains will require considerable time.

Since the implementation of the new constitution, the competition for limited government resources between different service departments occurs primarily at the provincial level. In some cases, this makes it easier for a provincial health department to obtain a larger budget, but in other cases, particularly in provinces that have inherited large bureaucracies through the re-incorporation of a number of former 'homeland' authorities, it could result in health not being adequately prioritised.

In relation to alternative financing sources, user fees and social health insurance (SHI) have received the most attention in recent years (McIntyre et al 1995; South Africa 1995; Hospital Strategy Project 1996; McIntyre 1997b; Department of Health 1997b). In particular, the potential importance of increasing revenue through charging insured patients higher fees for services received at public sector hospitals has been highlighted (McIntyre and Khosa 1996; Hospital Strategy Project 1996; McIntyre 1997b). It has been argued that at least a part of the fee revenue should be retained at the facility level as an incentive for revenue collection. In addition, it is likely to be necessary to offer improved 'hotel facilities' within public sector hospitals in order to attract medical scheme members back to the public sector. While some provinces are trying to increase fee levels for members of medical schemes and improve revenue collection methods, revenue receipts remain low. In addition, there has been little or no progress in negotiating with provincial treasuries for the retention of fee revenue within the health sector. Thus, at present user fees are still not bringing in additional revenue for the health sector.

The potential for implementing a SHI in South Africa has been the topic of debate since the late 1980s. Increasingly, the relationship between SHI and increased fee revenue at public sector hospitals has been stressed (McIntyre and Khosa 1996; Hospital Strategy Project 1996; McIntyre 1997b). Given the low proportion of the population covered by more comprehensive medical schemes (i.e. those that include cover for inpatient care) at present, it is unlikely that substantial additional fee revenue can be generated at public sector hospitals. However, if all formal sector employees and their dependants were covered by a compulsory hospital insurance scheme, the number of patients currently using public sector hospitals who could cover the costs of inpatient care (through the SHI) would increase dramatically. Despite the fact that a SHI to cover the costs of hospital care has been on the policy agenda since the Health Care Financing Committee report in 1994, there again appears to be little progress in moving towards accepting any of the proposals. The most recent policy document was issued in 1997 (Department of Health 1997b), but 6 months after the closing date for public comment there has been no indication from the Department about whether the proposals are to be implemented.

If the public health sector is to make dramatic and rapid progress towards achieving the goal of universal access to primary care services, these remaining financing issues must be addressed as a matter of urgency.

## 4.2 Expenditure

### 4.2.1 Total expenditure on public sector health care

Total government health care expenditure increased from R16.5 billion in 1995/96 to R21.1 billion in 1996/97. It is projected to increase to R26.4 billion in 2000/01, or R17.7 billion in real terms (using 1995 as the base year). Health was approximately 10 percent of total government expenditure in 1995/96. It is estimated that health will be consuming a slightly greater share (11 percent) of the total government budget by 2000/01. This will return it to the level that was encountered in the early 1990s (i.e. health as a percentage of government spending declined from 11 percent in the early 1990s to its current level of 10 percent) (Department of Finance 1996b).

The GEAR policy identifies government spending on social services as the key redistribution mechanism (Department of Finance 1996a). It is thus extremely encouraging that the MTEF indicates that health budgets are set to increase more rapidly than the overall government budget. However, it should be noted that increases in real health budgets would barely keep pace with population growth rates. Real per capita public sector health care expenditure was R516 in 1995/96 and this will decline slightly to R512 in 2000/01. Thus, unless alternative sources of finance for public sector health care services are identified, all of the resource redistribution requirements will have to be met from within the existing health sector 'resource envelope'.

### 4.2.2 Inter-provincial distribution of health expenditure and budgets

One of the key challenges facing the public health sector at the time of the first democratic elections was addressing the historical disparities in resource allocation between geographic areas. Essentially, the provinces with the greatest burden of ill-health, and thus the greatest capacity to benefit from health services, had the least access to such services.

As indicated previously, the 'Health Function Committee' determined the health budgets for each province at the time of the elections. When determining the 1995/96 health budgets (the first after the 1994 elections), the Function Committee developed a population-based formula. It was intended that weighted per capita equality in provincial health budgets should be achieved within 5 years. Given the significant disparities in per capita public sector health care expenditure that existed at this time, the five-year time frame required substantial changes in provincial budgets on an annual basis. Thus, while there was overwhelming support for the geographic redistribution of resources, there were concerns about the pace of change. In the second year of this redistribution process, the national Department of Health recognised the inability of provinces to cope with substantial budgetary changes on an annual basis. A more gradualistic approach was adopted in 1996/97, with the Minister of Health stating that it would probably take closer to ten years, than the originally anticipated five years, to achieve inter-provincial equality in per capita spending (Health Systems Trust 1996).

As from the 1997/98 financial year, the 'Function Committee' no longer had a role in determining provincial health budgets. With the implementation of the new Constitution, provinces were awarded global budgets, which were allocated using the broad parameters of the FFC's population-based formula, and more recently the formula developed by the Department of Finance (see Appendix A). Each province has the ultimate authority to determine its own health budget.

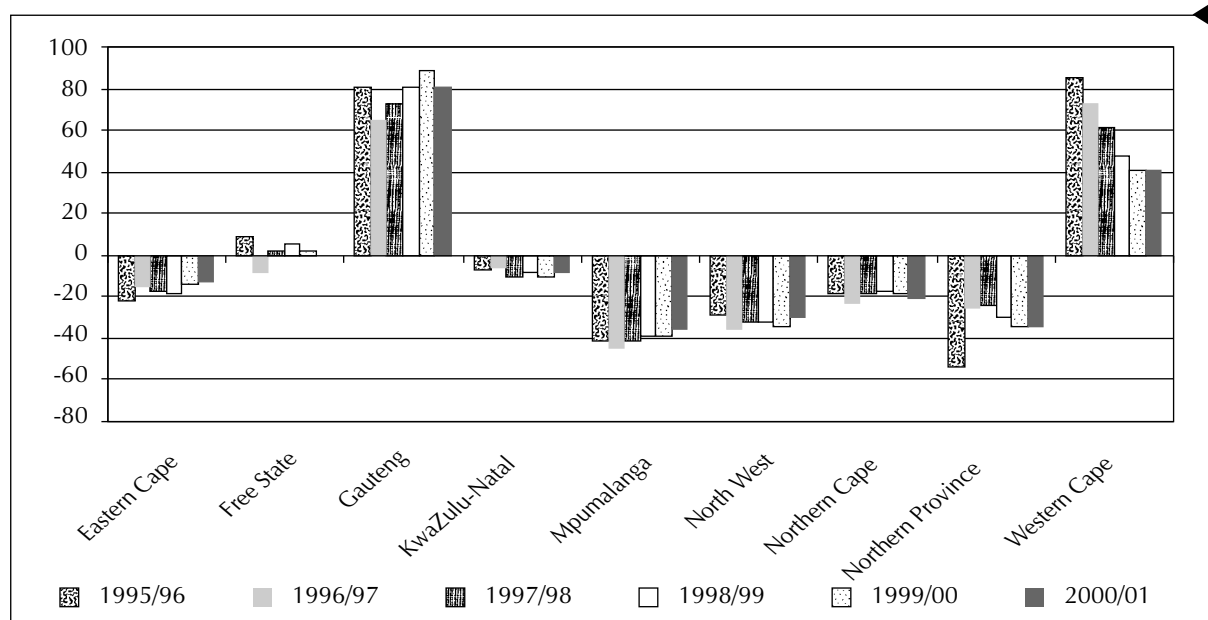
These changes in allocation mechanisms have had profound effects on the provincial health budgets. Table 3 shows how real per capita provincial health budgets have changed since 1995/96. Some provinces that have per capita health budgets above the national average, such as the Western Cape, are faced with declining real budgets. In contrast, some provinces that had per capita budgets below the national average, such as the Eastern Cape and Mpumalanga, are receiving real increases in their health budgets.

**TABLE 3: TRENDS IN REAL PER CAPITA PROVINCIAL (AND TOTAL) HEALTH EXPENDITURE/BUDGETS (RANDS)**

	1995/96	1996/97	1997/98	1998/99	1999/2000	2000/01
Eastern Cape	388	497	433	404	435	442
Free State	538	539	536	525	514	504
Gauteng	895	966	912	903	952	912
KwaZulu-Natal	460	554	470	456	455	462
Mpumalanga	290	322	308	303	310	324
North West	351	377	355	336	333	351
Northern Cape	405	452	429	412	412	398
Northern Province	229	437	398	349	332	330
Western Cape	919	1012	846	734	712	711
Average for provincial budgets	495	586	527	499	506	505
<b>Total (including national budgets)</b>	<b>516</b>	<b>606</b>	<b>536</b>	<b>509</b>	<b>515</b>	<b>512</b>

Figure 4 highlights that progress was made in redistributing budgetary resources between provinces in the 1995/96 and 1996/97 years (i.e. with most provinces coming closer to the national average per capita level). However, after this period (i.e. when global provincial budgeting was fully implemented), the pace of redistribution has slowed somewhat in some provinces. In Gauteng, the trend towards inter-provincial equity in health budgets has been reversed. Based on the MTEF projections, the Gauteng health department is set to receive substantial budgetary increases, despite being the most over-resourced province (in terms of financial health resources) in 1997/98. This indicates the impact of provincial level determination of health budgets since the introduction of the new constitution.

**FIGURE 4: PERCENTAGE DIFFERENCE BETWEEN REAL PER CAPITA PROVINCIAL HEALTH BUDGETS (TOTAL HEALTH BUDGET) AND THE NATIONAL AVERAGE**



The above data suggest that the Gauteng health department may be particularly adept at budget negotiations. In contrast, the Northern Province, North West and (to a lesser extent) Mpumalanga appear not to have been as successful in negotiating for a 'fair' share of provincial resources. One potential reason for this is that these provinces have a significant bureaucracy as they have had to combine former provincial and 'homeland' authorities. This was precisely the concern expressed at the time of the introduction of global provincial budgeting by some observers (Doherty and van den Heever 1997; McIntyre 1997b). It should also be noted that the Northern Province and North West are as a whole relatively well resourced (see Figure 3) and are thus faced with declining real per capita budgets. In these provinces, it is critical that reducing the size of provincial bureaucracies receives priority attention if health budgets are to increase to equitable levels.

The Western Cape stands out as the province that has continued its trend towards achieving equitable shares of health spending, despite the introduction of global provincial budgeting. The major contributory factor is the constrained position of the Western Cape's overall provincial budgets (see Figure 3).

The above discussion highlights that the relationship between changes in the provincial health budgets and the overall provincial budgets is a critical one. Table 4 shows the change in health expenditure and budgets as a percentage of total provincial expenditure and budgets between 1995/96 and 2000/01. The massive projected increases in the Gauteng health budget are primarily attributable to the success of the health department in increasing their share of the overall provincial budget from 33 percent in 1995/96 to an estimated 39 percent in 2000/01. In the Northern Province and Mpumalanga, although it is projected that a greater share of provincial budgets will go towards health by 2000/01, there is relatively little progress in bringing their health budgets to the national average for per capita health spending. The share of the total provincial budget going to health in the Western Cape remains roughly the same between 1995/96 and 2000/01 (although it declined to 24 percent in 1997/98). Thus, the significant reductions in the real per capita health budget in this province are largely attributable to the decline in the overall provincial budget.

**TABLE 4: PROVINCIAL HEALTH EXPENDITURE/BUDGETS AS A PERCENTAGE OF TOTAL PROVINCIAL EXPENDITURE/BUDGETS**

<b>Province</b>	<b>1995/96</b>	<b>1996/97</b>	<b>1997/98</b>	<b>1998/99</b>	<b>1999/2000</b>	<b>2000/01</b>
Eastern Cape	17	18	18	20	23	24
Free State	22	20	22	24	26	27
Gauteng	33	34	33	36	39	39
KwaZulu-Natal	21	24	20	24	26	27
Mpumalanga	16	15	15	17	18	19
North West	15	15	16	17	18	20
Northern Cape	15	16	14	17	18	18
Northern Province	13	19	18	18	18	19
Western Cape	27	27	24	25	27	28
<b>Provincial average</b>	<b>21</b>	<b>22</b>	<b>21</b>	<b>23</b>	<b>26</b>	<b>27</b>

Table 4 also shows that, with the exception of those provinces containing academic hospitals, approximately 20 percent of provincial budgets being assigned to health will be the norm by the 2000/01 financial year. It is also useful to consider inter-provincial health spending trends excluding resources for academic hospitals (given that some of the services they provide and their training activities have national benefits). Table 5 shows these expenditure and budgetary trends (as accurate data on academic hospital expenditure were not available for 1995/96, this year is excluded from Table 5 and Figure 5).

**TABLE 5: TRENDS IN REAL PER CAPITA PROVINCIAL (AND TOTAL) HEALTH EXPENDITURE/BUDGETS, EXCLUDING ACADEMIC HOSPITALS (RANDS)**

	<b>1996/97</b>	<b>1997/98</b>	<b>1998/99</b>	<b>1999/2000</b>	<b>2000/01</b>
Eastern Cape	497	418	384	414	419
Free State	436	426	412	402	395
Gauteng	602	484	480	516	502
KwaZulu-Natal	499	416	400	401	410
Mpumalanga	322	308	303	310	324
North West	377	355	336	333	351
Northern Cape	452	429	412	412	398
Northern Province	437	397	349	332	330
Western Cape	686	576	513	494	496
Average for provincial budgets	490	424	399	405	408
<b>Total (including national budgets)</b>	<b>511</b>	<b>433</b>	<b>409</b>	<b>414</b>	<b>415</b>

A similar pattern emerges when the academic hospitals' budgets are excluded from the analysis (see Figure 5) to that presented in Figure 4, with the exception that the Eastern Cape, Northern Cape and KwaZulu-Natal appear to be nearer their equity target allocations. Hence, the above analysis of inter-provincial health resource distribution applies irrespective of whether academic hospital budgets are included or excluded from consideration.

**FIGURE 5: PERCENTAGE DIFFERENCE BETWEEN REAL PER CAPITA PROVINCIAL HEALTH EXPENDITURE/BUDGETS (EXCLUDING ACADEMIC HOSPITALS) AND THE NATIONAL AVERAGE**

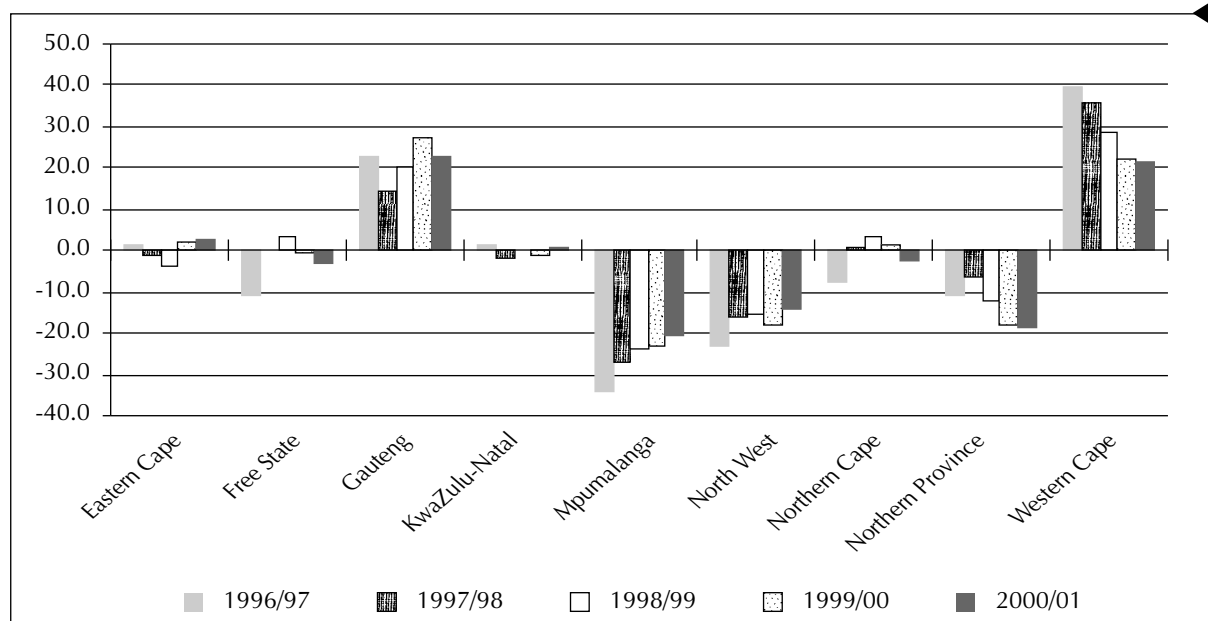


Table 6 indicates that, when academic hospital expenditure is excluded from the health expenditure estimates, approximately 20 percent of total provincial expenditure is devoted to health services in most provinces. KwaZulu-Natal and the Eastern Cape devote a higher proportion of their overall provincial budget to health services. It is also important to note that the proportion of provincial resources going to the health sector has been increasing over time.

**TABLE 6: PROVINCIAL HEALTH EXPENDITURE/BUDGETS (EXCLUDING ACADEMIC HOSPITALS) AS A PERCENTAGE OF TOTAL PROVINCIAL EXPENDITURE/BUDGETS**

	1996/97	1997/98	1998/99	1999/00	2000/01
Eastern Cape	18	18	19	22	23
Free State	17	17	19	20	21
Gauteng	21	18	19	21	21
KwaZulu-Natal	21	18	21	23	24
Mpumalanga	15	15	17	18	19
North West	15	16	17	18	20
Northern Cape	16	14	17	18	18
Northern Province	19	18	18	18	19
Western Cape	19	17	17	19	20
<b>Provincial average</b>	<b>19</b>	<b>17</b>	<b>19</b>	<b>20</b>	<b>21</b>

In summary, the data presented above indicate that, despite concerns about the pace of budgetary change implemented under the 'Function Committee' redistribution process, it was effective in initiating a move towards more equitable distribution of health resources between provinces. As feared by many observers (e.g. see Doherty and van den Heever 1997; McIntyre 1997b), the move towards global provincial budgeting has slowed the pace of relative redistribution of health budgets somewhat, and in some cases, most notably Gauteng, has dramatically reversed the redistribution process.

It is of interest that the MTEF process, which has seen the establishment of a 'Health MTEF Sectoral Team' in which all provincial health departments were invited to participate, did not explicitly evaluate provincial budget submissions in relation to the goal of promoting inter-provincial health resource allocation equity. Just about the only reference in the Sectoral Team's report to equitable resource allocation is to the formula for allocating global provincial budgets (Department of Finance 1997b). There is also a brief reference to the need to increase equity in the allocation of tertiary level services. Thus, the move to fiscal federalism, in line with the Constitution, appears to have shifted the equity focus to that of the total provincial budgets.

The apparent lack of concern about the equitable allocation of provincial health care resources within the MTEF should be urgently addressed. The MTEF is to govern budget processes in South Africa for the foreseeable future and equity should be an explicit criterion for evaluating provincial health budgets, not least of all because equity is a key policy objective in the health sector's White Paper (see Box 2). Although the need to provide output data in the MTEF provides some basis for comparing progress in meeting the health needs of the population in various provinces, there is an overwhelming emphasis on efficiency, as opposed to equity, within the MTEF documentation. To quote the Health MTEF Sectoral Team's report: "The model [MTEF] is designed to predict the implications of alternative budgets on service outputs. It also enables provincial comparison of the basic indicators and cost and policy drivers, highlighting those provinces where insufficient progress has been made in implementing health policy, or where provinces are performing less efficiently" (Department of Finance 1997b: 5). The aspect of policy that receives the greatest attention in the MTEF report is that of changing the level of care distribution.

The MTEF process provides a mechanism for placing equity in inter-provincial health budgets back on the agenda (as a single sectoral team considers all provincial health budgets). However, this opportunity has not been seized in the first round of MTEF negotiations. It is imperative that equity be reinstated on the health financing policy agenda and should be used, along with efficiency, as an explicit criterion for evaluating provincial financial and output data submissions.

#### 4.2.3 Intra-provincial distribution of health expenditure and budgets

Recent research has highlighted that disparities in the distribution of public health sector resources within provinces are even greater than the disparities between provinces (Brijlal et al 1997). This is particularly the case in provinces that include former 'homeland' areas. To a large extent, these inter-district disparities reflect the differential resourcing of facilities located in urban and rural areas.

The research by Brijlal et al (1997) evaluated the distribution of district health service resources between health districts within three provinces, namely the Eastern Cape, North West and Mpumalanga. In this study, efforts were made to include expenditure (or budgets) for district hospitals, non-hospital primary care services (both provincially-provided services and provincial subsidies to local government health services), as well as level 1 care within regional hospitals. In addition, wherever possible, adjustments were made to reflect the extent of local government contributions to district level health services from their own revenue sources. The 'equity target' allocation for each district was assumed to be the average weighted per capita district health service expenditure (or budget) for the province. The figures below indicate the extent to which each district's expenditure (or budget) is either above or below the 'equity target' allocation (which is represented in the graphs by 0).

Figure 6 presents the results for the Eastern Cape. In this province, some districts are as much as 166 percent above their target allocation whereas others are below target by 77 percent.

**FIGURE 6: INEQUITIES IN THE DISTRIBUTION OF DISTRICT HEALTH SERVICE EXPENDITURE IN THE EASTERN CAPE (1996/97)**

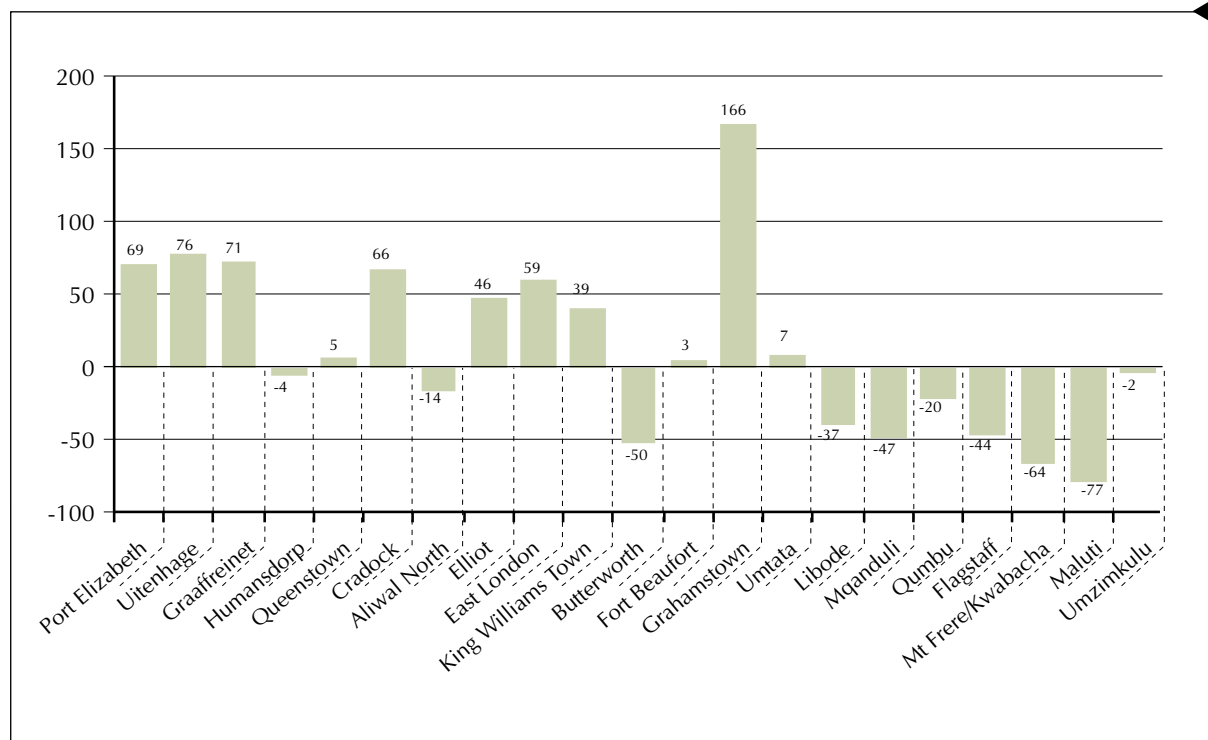
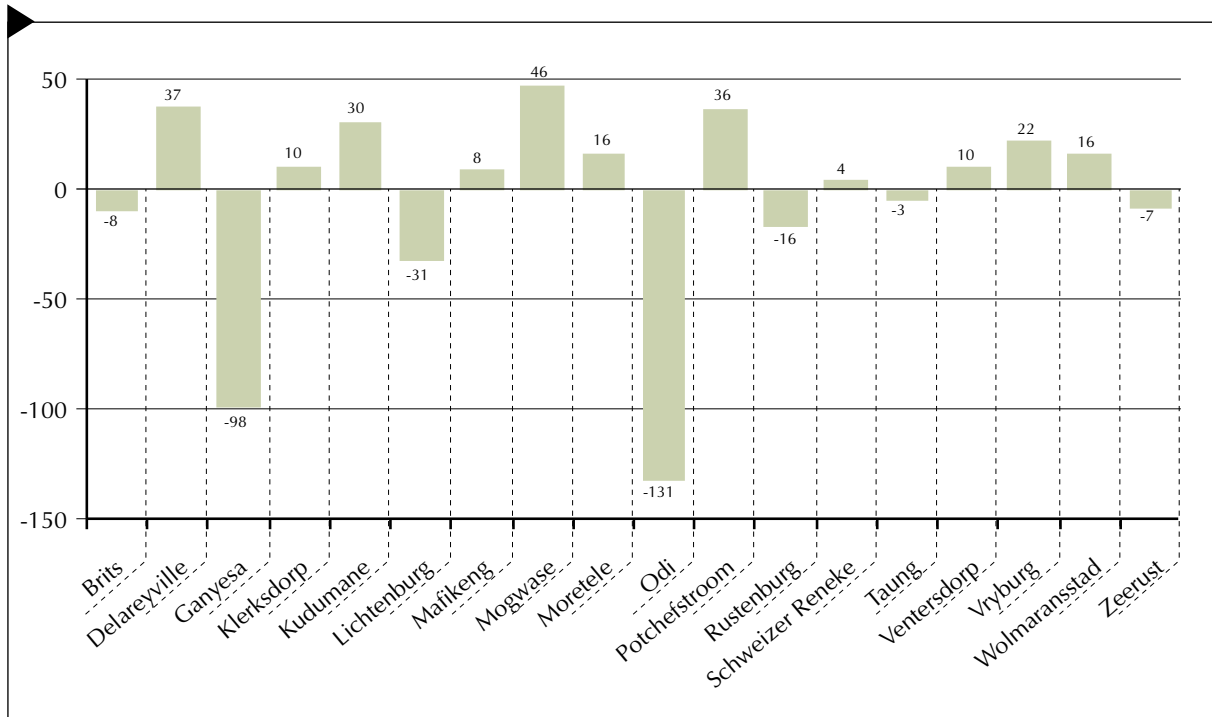


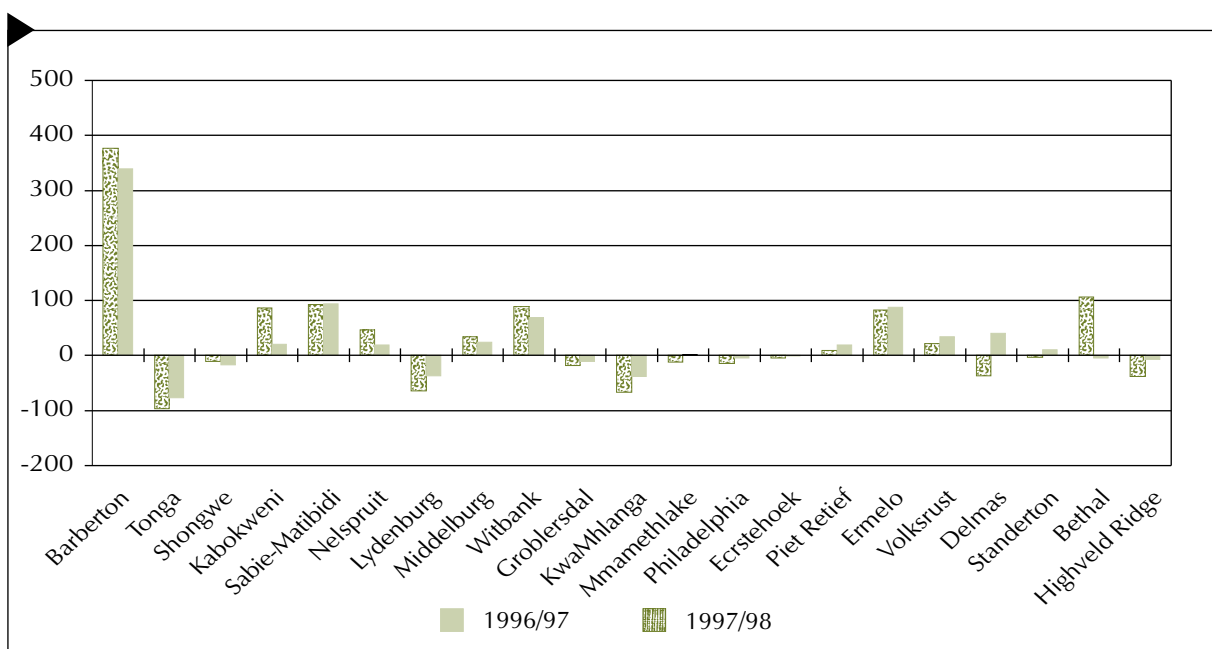
Figure 7 highlights the extent of inequities in the distribution of district health service budgets in the North West province. In this province, districts range from being 46 percent above their equity targets to 131 percent below target.

**FIGURE 7: INEQUITIES IN THE DISTRIBUTION OF DISTRICT HEALTH SERVICE BUDGETS IN THE NORTH WEST PROVINCE (1997/98)**



Mpumalanga was the only province for which trend data could be obtained. Figure 8 shows that districts in Mpumalanga had expenditure levels that ranged from being 377 percent above target to 97 percent below target in 1996/97. The 1997/98 budget allocations appear to make a concerted effort to move towards greater equity, and the range of weighted per capita budgets has been reduced to 340 percent above and 77 percent below target.

**FIGURE 8: TRENDS IN INEQUITIES IN THE DISTRIBUTION OF DISTRICT HEALTH SERVICE RESOURCES IN MPUMALANGA (EXPENDITURE FOR 1996/97 AND 1997/98 BUDGET ALLOCATIONS)**



The above data highlights the extent of resource allocation disparities between health districts within individual provinces. Brijlal et al (1997: 24) noted that “All provinces involved in this project were aware that inequities existed in the allocation of resources to districts. However, they were unaware of the extent of the inequities due to the lack of a standardised mechanism for evaluating resource allocation patterns”. In order to improve access to primary care services, it is essential that these disparities be reduced.

A ‘District Financing Task Team’, which was co-ordinated by the national Department of Health, contained representatives from the vast majority of provinces and was assisted by a research team, met during 1997 to develop a common approach for addressing intra-provincial inequities. The approach adopted was that of a needs-based resource allocation formula. Although a framework for addressing intra-provincial inequities has been agreed upon by the Task Team, the extent to which resource redistribution is occurring is unclear. The data from Mpumalanga (see Figure 8) suggest that efforts are being made to move towards an equitable allocation of district health service resources. However, intra-provincial resource allocation patterns should be monitored for all provinces.

Brijlal et al (1997: 38) stressed that the redistribution of health budgets is not sufficient. It is essential for provincial level managers “to assist individual districts faced with large budgetary changes in making the necessary service adjustments”. In particular, currently under-resourced districts, which often have inadequate financial management capacity, may need considerable support. In addition, measures to attract and retain staff in these predominantly rural districts will need to be sought. As noted by Brijlal et al (1997: 38), “Given that staff account for about two-thirds of public sector health care expenditure, expenditure will not be shifted unless human resources are redistributed”.

As argued in the previous section, equity should be an important objective of the MTEF process. The monitoring of intra-provincial equity could be facilitated by including information on changes in the distribution of financial resources between districts in the provincial health departments’ MTEF submissions.

#### 4.2.4 Distribution of expenditure and budgets between levels of care

The Department of Health’s White Paper provides important policy guidelines for level of care resource distribution in South Africa. A key policy goal is that of achieving universal access to an “...essential package of primary health care interventions” (Department of Health 1997a: 13). As indicated previously, improved access to primary care services can substantially reduce the burden of ill-health and premature death within South Africa, particularly for the poor. Primary care service improvements are thus critical from an equity perspective. The White Paper also notes that increased primary care provision requires rationalisation within the hospital sector, particularly at the tertiary and quaternary levels.

It is difficult to assess accurately changes in the distribution of health care budgets between levels of care. This is largely due to the fact that there have been considerable changes in the definition of budget ‘programmes’ over the years. In addition, there is little consistency in the interpretation of the content of programmes between each province (until the 1998/99 financial year). A common programme structure has now been agreed which will facilitate future evaluations.

Based on aggregate data provided in the health MTEF submissions, there appears to be an increase in the resources being allocated to district health services (from about 39 percent in 1996/97 to nearly 42 percent in 2000/01) (Department of Finance 1997b). According to the Health Sectoral MTEF Team, the budget for primary care services (which includes non-hospital primary care services and district hospital outpatient care) will increase from 23 percent of total provincial health budgets in 1997/98 to 26 percent in 2000/01. The budgetary share

going to academic health services remains relatively constant (declines marginally from 19.5 percent in 1996/97 to 19.3 percent in 2000/01). Administration costs also remain relatively constant at about 4 percent of the combined provincial health budgets. It appears that other hospitals (regional and specialised) hospitals bear most of the burden of level of care redistribution (in favour of district services) with their share declining from about 28.7 percent in 1996/97 to 24.5 percent in 2000/01 (Department of Finance 1997b). However, it is unclear whether this represents an actual shift of resources or whether it merely reflects a reclassification of certain regional hospitals as district hospitals.

The Health Sectoral MTEF Team noted that “Provincial budgets, overall, confirm that the commitment to primary care has been translated into planning and budgeting, although the original goal of around 8 percent annual real growth has not quite been attained” (Department of Finance 1997b: 29). The MTEF provides an important mechanism for monitoring the extent to which this commitment is being implemented on an annual basis.

The MTEF data was supplemented by case studies undertaken in three provinces (Western Cape, Eastern Cape and Northern Province). These case studies attempted to obtain more disaggregated data on the distribution of public health sector resources between levels of care. The emphasis was on the extent to which additional resources are being allocated to district health services. The three provinces were selected to reflect a range of experiences in terms of the health service infrastructure inherited when the new provinces were created and the budgetary changes since 1994 (see Table 3 and Figure 4). The profile of each province can be summarised as follows:

- The Western Cape is a historically well-resourced province, but has experienced significant cuts in its health budget in recent years;
- The Northern Province was historically one of the most under-resourced provinces, but has received major budgetary increases since the 1994 elections (particularly in 1995/96 and 1996/97); and
- The Eastern Cape is a relatively under-resourced province, which also has considerable disparities in the distribution of resources between districts within the province, and which has received more limited increases in its health budget.

The main purpose of this analysis was to assess whether provinces are giving a relatively higher priority to primary health care, through increasing the budget for district health services, in line with the policy priorities identified in the White Paper (Department of Health 1997a). Table 7 provides an overview of the changes in the relative distribution of resources between programmes since 1995/96 in the provinces under study (1996/97 in the case of the Western Cape where 1995/96 data were not available). It indicates that there has been a relative redistribution of resources in favour of district health services in all the provinces studied. The increased resourcing for district health services has been largely funded through cuts in hospital service budgets, particularly academic hospitals within the Western Cape. The most dramatic increase in district health service funding has occurred in the Eastern Cape. It is unclear whether this relative shift is partially attributable to changes in programme definitions (i.e. what services were included within the district health services category) over time. There was a relatively small redistribution in favour of district health services in the Northern Province, but it should be noted that these services were already receiving more than half of the health budget in this province in 1995/96. It is interesting to note that there is a budgetary commitment to redistributing resources towards district health services in the Western Cape, despite the fact that this province is faced with large health budget cuts. The implication of this is that hospitals in this province, particularly academic hospitals, have received considerable cuts in their budgets.

**TABLE 7: TRENDS IN THE DISTRIBUTION OF HEALTH BUDGETS BETWEEN PROGRAMMES IN CASE STUDY PROVINCES (PERCENT)**

	Western Cape		Northern Province		Eastern Cape	
	1996/97	2000/01	1995/96	2000/01	1995/96	2000/01
Administration	2.2	3.0	13.3	7.5	5.1	4.5
District health services	26.7	32.7	52.8	53.2	18.8	53.2
Hospital services	24.3	28.8	24.0	19.7	71.8	24.3
Academic health services	41.7	30.3	-	2.2	4.3	5.1
Health sciences	2.2	2.2	-	0.1	-	1.3
Health care support services	3.0	2.1	9.9	7.4	-	0.7
Health facilities & development	-	0.9	-	9.9	-	10.8

A recent study in KwaZulu-Natal found the reverse of the above trend for the three case study provinces (Palmer et al 1997). Palmer et al (1997) found that while expenditure on district health services accounted for 57 percent of provincial health care expenditure in 1995/96, only 46 percent of the 1997/98 budget was set aside for district health services. In contrast, provincial level hospitals received an increase in their budget.

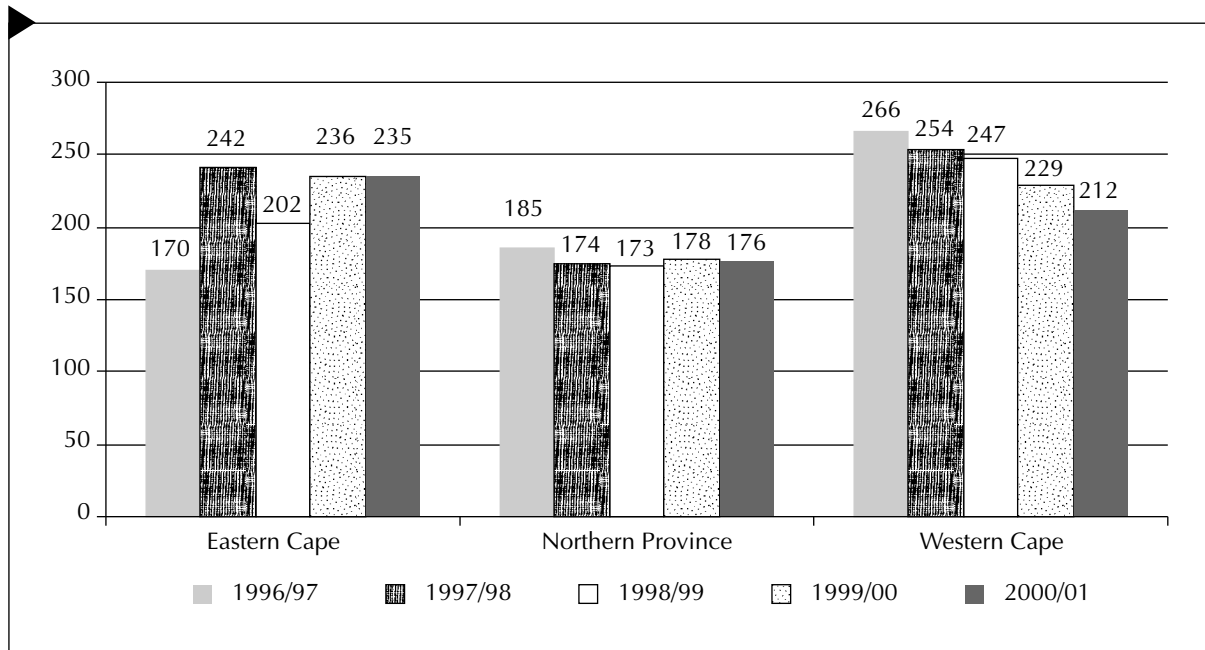
There are two important difficulties with interpreting the above data. Firstly, there have been changes in programme definitions (within each province) since 1995/96 and thus trend data may not be directly comparable. This partially explains the large increase in the percentage of the budget allocated to district health services in the Eastern Cape (i.e. it is likely to be at least partially due to changes in the definition of the programme rather than a real shift of resources in favour of district health services). Agreement has been reached on uniform programme definitions that will apply to all provinces as from 1998/99 and thus the evaluation of programme distribution trends will be more accurate in future. The second issue is that expenditure data are only available for the 1995/96 and 1996/97 financial years. Thus, the projected increase in the percentage of health budgets for district health services may not occur in practice. In this regard, it is interesting to note that there are quite marked differences between the proposed budgets submitted to the Health Sectoral MTEF Task Team and the actual budgets for 1998/99 in some provinces. Table 8 presents information for the two case study provinces (the Western and Eastern Cape) that showed the largest difference between the MTEF proposals and the actual budgets. While these differences may be a reflection of the MTEF process (e.g. if provinces were given insufficient time to prepare accurate budget estimates), it does also raise concerns about whether district health services will receive the priority suggested in the MTEF estimates. In both the Western and Eastern Cape provinces, the proportion of the actual budget going to district health services is lower than proposed in the MTEF. In the Eastern Cape, regional hospitals gain from this budgetary change while academic health services gain in the Western Cape. If provinces revise budget estimates (in terms of programme distribution) so dramatically over the period of a few months, the whole objective of the MTEF will be defeated. It also suggests that provinces may not be as successful in achieving expenditure shifts (i.e. real shifts of human and other resources) as the budgets suggest.

**TABLE 8: COMPARISON OF THE MTEF SUBMISSIONS AND ACTUAL BUDGET FOR 1998/99 IN TERMS OF THE RELATIVE DISTRIBUTION BETWEEN PROGRAMMES (PERCENT)**

	Western Cape		Eastern Cape	
	MTEF	Actual	MTEF	Actual
Administration	2.8	2.4	5.3	4.5
District health services	33.7	28.8	55.8	51.9
Hospital services	28.5	24.8	26.6	35.9
Academic health services	30.1	37.0	5.0	1.6
Health sciences	1.9	2.1	1.4	1.5
Health care support services	2.1	1.8	0.7	0.6
Health facilities & development	0.9	3.1	5.2	3.9

The above data allows consideration of trends in resource distribution between programmes within provinces. It is impossible to draw conclusions about the relative priority awarded to district health services between provinces from the above data, particularly given the substantial differences in the size of the academic health services component. Comparing the real per capita district health service expenditure and budgets (see Figure 9) can better highlight inter-provincial differences. Figure 9 also indicates that although district health services may be receiving a greater proportion of overall provincial health budgets, in some cases this relative redistribution is insufficient to achieve an increase in real per capita district health service budgets.

**FIGURE 9: TRENDS IN REAL PER CAPITA DISTRICT HEALTH SERVICES EXPENDITURE/BUDGETS IN CASE STUDY PROVINCES (RAND)**



It should be noted that there were some differences in programme definition between provinces until 1997/98, and thus the data for the first two years may not be directly comparable. In 1996/97, the Western Cape had the highest level of per capita expenditure on district health services. On the basis of the MTEF projections, the Eastern Cape will achieve the highest per capita budget for district health service by 2000/01. This has been facilitated by the real increases in the overall health budget within the Eastern Cape (with the exception of 1998/99 when it faces a 5 percent real budget cut). The Western Cape is constrained in its efforts to sustain real per capita budget levels for district health services by the large cuts in its overall health budget.

Comparison of per capita budgets is a useful way of monitoring the relative priority awarded to district health services between provinces. However, to gain a comprehensive picture of district health service funding, local government own contributions to such services must be incorporated in the analysis. This is an area that requires further research.

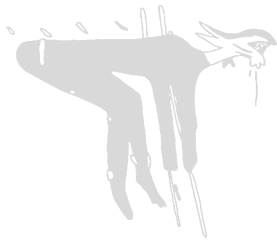
There are a number of factors constraining the ability of provinces to shift resources between levels of care at a faster pace. Firstly, the fiscal constraints imposed by GEAR limit the flexibility to shift budgets between different services. It is clearly easier to effect a relative distribution of resources when there is a real budgetary increase than when real budgets are declining, remaining stable or only increasing marginally. The second factor is the inter-provincial redistribution of global health budgets. Some of the provinces faced with the task of implementing the most dramatic level of care resource shifts (primarily those with well-established tertiary and quaternary service infrastructure) are being simultaneously confronted with substantial health budget cuts. In these provinces, the pace of redistribution is likely to be particularly slow.

Given these constraints, the Health Sectoral MTEF Team noted that "... the commitment to increased utilisation of primary health care services cannot be met from increased budgetary allocation only, and will require improved efficiency throughout the health system" (Department of Finance 1997b: 34). In an effort to improve efficiency within public sector hospitals, the Hospital Strategy Project (1996) was commissioned by the national Department of Health in 1995. It focused primarily on improving hospital management systems. While the Hospital Strategy Project reports are widely regarded as containing a useful blueprint for improving efficiency in public hospitals, it is unclear to what extent they have been implemented within the various provinces.

In summary, it appears that there is progress in reprioritising health budgets towards primary care services in that a higher proportion of provincial health budgets is being devoted to these services. However, in some provinces, the extent of this relative redistribution of resources between levels of care is insufficient to translate into increases in real per capita district health service budgets. In addition, it is impossible to determine the extent to which expenditure on primary care services has increased, due to the lack of audited expenditure statements. Expenditure shifts will only be achieved once staff are shifted to primary care facilities, as staff account for over two-thirds of total public health sector expenditure.

One policy that is constraining the redistribution of human resources within the public health sector is the offer of voluntary severance packages (VSPs). The effect of this policy has been that, instead of staff being moved from over-resourced to under-resourced provinces and shifted between levels of care, many staff are merely moving out of the public sector (either into the private sector, international markets or early retirement). There are concerns that the VSP offer, and the indiscriminate freezing and abolition of posts, are not being carried out within a strategic planning framework and will have serious short- and long-term implications for health services (Health Systems Trust 1996). Given the close relationship between human and financial resources in the health sector, improved human resource planning and the development of appropriate retrenchment and relocation tools are critical for the success of initiatives to alter the level of care (and geographic) resource distribution (de Bruyn et al 1998).

The health care financing policy that has probably had the most dramatic impact on improving access to primary care services, particularly for vulnerable groups, is the introduction of the 'Free Primary Care Policy'. In April 1996, the Minister of Health announced that primary care services would be free to all South Africans with immediate effect. While the impact of this policy is yet to be evaluated, it is likely to have improved financial access to primary care services, particularly for the poor. As such, it will support the Department of Health's policy objective of achieving universal access to primary care services. However, it is essential that *geographic* and other aspects of access to primary care services, and the *quality of care* at primary care facilities, be improved. Thus, continued efforts to implement level of care resource shifts is of critical importance.



## Chapter 5: Conclusions and Recommendations

The data presented above indicate that the policies outlined in Box 2 are impacting on government in general and the health sector. In particular, the fiscal policy outlined in GEAR has far-reaching consequences. The real per capita government budget decreased in 1997/98 and, according to the MTEF projections, will continue declining every year. The health sector has been relatively protected from these cuts as the overall government budget is declining more rapidly than the health sector budget. This is largely due to the government's policy of using social spending as the key redistribution tool. However, the real per capita budget in 2000/01 will be considerably lower than actual public sector health care expenditure in 1996/97 (see Table 3).

Initiatives to redistribute government resources between provinces, to address geographic inequities, are also having an impact. Most provinces are coming closer to their 'equity target' budget allocations (see Figure 3). However, there are two concerns about the resource allocation formula that is currently being used. Firstly, there is a need to improve the data used in the formula. In particular, there remains great uncertainty about the size and composition of the population in each province, and how this will change over time (e.g. with inter-provincial migration). As population is the major component of the resource allocation formula, inaccurate population data can adversely impact on provincial budgets. The second area of concern is the 'top-slice' that has been incorporated in the Department of Finance's resource allocation formula. This is removed before any other allocation of government resources occurs, and some is used for debt servicing and a 'contingency reserve' while the rest is set aside as a 'policy reserve'. Little information has been provided on how the money in the 'policy reserve' will be used and there are fears that it may undermine the efforts to promote equity in inter-provincial resource allocation.

While there has been progress in addressing inequities in the distribution of total provincial budgets, there has been somewhat less progress in addressing inter-provincial inequities in health budgets. There was an initial, and quite dramatic, shift of resources when health budgets were determined by the Function Committee (which was co-ordinated by the national Department of Health). However, with the move to allocating global budgets to provinces and allowing each province to decide on their health budget, the pace of redistribution of health budgets between provinces has been slower. Some provinces are in fact moving further away from their target equitable health budget allocations. It is of some concern that the MTEF Team for the health sector did not consider provincial health budget submissions in relation to the goal of achieving inter-provincial equity.

The allocation of health care resources between geographic areas (such as districts) within provinces is of concern to national and provincial health departments (Brijlal et al 1997). Unfortunately, data on recent trends could not be obtained (with the exception of Mpumalanga) to determine the extent to which this issue is being addressed. At present, there is no mechanism for monitoring intra-provincial equity in resource allocation.

Increased allocation of resources to primary care services (at the district level) was awarded a high priority in the health sector's White Paper. A relative redistribution of resources in favour of district health services is also one of the major objectives of the health sector MTEF. Provinces are making some progress in this regard with an increasing proportion of provincial health budgets being allocated to district health services in most cases. However, this relative redistribution has been insufficient to translate into real per capita district health services

budgets (see Figure 9). The extent to which district health services actually receive additional resources can only be assessed when expenditure data are compiled.

A number of recommendations arise from this research, including:

- The extent to which the fiscal policy incorporated in GEAR is impacting on the health sector must be monitored. As the government has committed itself to using social service spending as the main instrument of redistribution, the extent to which the health and other social sectors are being protected from significant budget cuts should be assessed routinely.
- There is an urgent need to improve budget and expenditure data within the health sector. There are two areas of particular concern:
  - Firstly, the case studies highlighted that provincial health departments do not have ready access to *comprehensive* financial data on their activities (e.g. RDP funded health projects are often not included in routine provincial financial records). Access to comprehensive information is essential for planning, budgeting and monitoring purposes.
  - Secondly, there are considerable delays in some provinces in compiling *expenditure* data. It is impossible to determine the extent to which the challenges facing the health sector (see Box 1) are being addressed in the absence of expenditure data. Although budgets are being reallocated in line with government policies, human and other resources (and hence expenditure) must also be reallocated.
- The national Department of Health should play an active role in monitoring progress in addressing equity challenges. Such monitoring, and determining appropriate mechanisms for moving towards equity in the health sector, should be undertaken in close consultation with the provincial health departments. This could be linked to the MTEF Team for the health sector, if the MTEF process were amended in the following ways:
  - The national Department of Health, and not the Department of Finance, should take the lead in the health sector MTEF Team. In order for the MTEF process to be successful, it is essential that there is 'ownership' of the process by the health sector.
  - Adequate time must be allowed, and appropriate guidelines provided, for the preparation of provincial health department submissions to the MTEF process. Recent research has highlighted that insufficient time was allowed for provinces to adequately prepare submissions during the 1998/99 MTEF process (Palmer et al 1997).
  - There should be a 'bottom-up' approach to the MTEF process, rather than the current 'top-down' approach. This requires that district plans and budgets feed in to the provincial submissions and hence into the health sector's MTEF submission. The issue of 'ownership' of the MTEF process at all levels of the health service is once again a major consideration in this recommendation.

If these changes are effected, the MTEF Team has a potentially important role in monitoring progress towards health sector equity. However, it is essential that the Team explicitly adopt equity as an important objective, as it is currently focusing exclusively on efficiency issues. There are three areas in which the MTEF Team, if restructured along the lines recommended above, could play a monitoring role.

- Firstly, the MTEF Team should be actively involved in monitoring the redistribution of resources between programmes. The team (in its first round of deliberations) gave priority to promoting the redistribution of resources between programmes, which is important in pursuing the policy objective of improved access to primary care services. However, as

indicated previously, some provinces have made substantial changes in the allocation of their 1998/99 budgets between programmes compared with their MTEF submissions. Sufficient time should be allowed to enable provinces to prepare realistic and accurate MTEF submissions. Thereafter, there should be adequate mechanisms for holding provinces accountable for major deviations from the budgets submitted to the MTEF Team.

- Secondly, the MTEF Team can also play a role in promoting equity in the allocation of provincial health budgets. The extent to which the health budgets submitted by each province brings them closer to their equity target allocation, should be explicitly evaluated by the Team.
- Finally, the MTEF Team can also play a role in promoting a more equitable distribution of health care resources between geographic areas within provinces. Inter-district or inter-regional budget allocations should become an explicit component of provincial health department submissions to the MTEF.

In summary, this research has indicated that government policies, both those in the health sector and broader fiscal policies, are impacting on financing and expenditure in the public health sector. It has also shown that some of the equity challenges facing the health sector at the time of the 1994 elections are being addressed through budgetary reallocations. However, in the absence of actual expenditure data, it is difficult to determine the extent to which human and other resources are in reality being reallocated in support of health sector equity objectives.

# Appendix A: The Financial and Fiscal Commission (FFC) and Department of Finance (DoF) Recommendations for the Vertical and Horizontal Divisions

## A.1 The FFC Recommendations (Financial and Fiscal Commission 1996 and 1997)

### A.1.1 Vertical division

The vertical division determines how nationally collected government revenue should be divided between the national and provincial levels of government (and to the local government level once the relevant recommendations have been finalised). This is necessary as the majority of government revenue is collected at the national level (with provincial revenue being particularly small) but the majority of government spending occurs at the provincial level. In terms of the new Constitution (section 227(1)), local government and each province “is entitled to an equitable share of revenue raised nationally to enable it to provide basic services and perform the functions allocated to it”.

Clearly, the vertical division should be in line with the respective spending responsibilities of national and provincial governments. The FFC suggested that “an appropriate intergovernmental body such as the Budget Council” should decide on this distribution on an annual basis, which should take account of national development planning priorities, provincial plans and constitutionally assigned functions. They also recommended that there should be a relative shift in favour of the provincial level of 0.5% per annum for the first 3 years.

### A.1.2 Horizontal division (provincial)

The horizontal division relates to the distribution of the provincial share of nationally collected revenues (determined in the vertical division) between individual provinces. The FFC proposed the following formula for the horizontal division:

$$P = S + m + T + I + B$$

where:

- S = a minimum national standards grant for primary and secondary education and for primary health care services. The latter was assumed to be the cost of achieving an average of 3.5 visits to a primary care clinic per person dependent on the public sector per annum and 0.5 visits per annum for members of medical schemes, as well as the costs of district hospital services. The size of the health component of this grant for each province was thus dependent on the provincial population size and medical scheme membership. The size of the education component of the grant was dependent on the size of the provincial population between the ages of 5 and 17 years.
- m = a spillover grant to compensate provinces for services provided which are of benefit to another province. This focused exclusively on the costs of medical training and ‘unique services’ at academic hospitals.
- T = a tax capacity equalisation grant. The constitution makes provision for provinces to levy their own taxes and the FFC recommended that legislation be implemented to allow for provinces to levy a surcharge on personal income taxes. This grant was intended to adjust for the different tax revenue generation potential of provinces. In

this way, provincial revenue from such a surcharge (if all provinces levied the same surcharge rate), when combined with the tax capacity equalisation grant, would translate into all provinces receiving the national average per capita revenue. In other words, the grant ensures that “the yield from the effective per capita tax base of the richer provinces is lowered to the national average and that of the poorer provinces is raised to the national average” (FFC 1996: 17).

- I = an institutional grant which covers the costs of maintaining the basic administration required by the constitution in each province (and primarily relates to the costs of the premier and provincial legislature). It was proposed that the same amount (of about R32 million in 1996/97) be allocated to each province in terms of this grant. However, the FFC did indicate that the Northern Cape may need an additional award given its small population size and low population density.
- B = a basic grant which was to include an allocation for distribution to local governments (later it was proposed that the allocation to local governments should be included in the vertical division and that there should be a separate horizontal division process for local governments) and an allocation for general provincial services not covered by other grants. This grant was based on the provincial population size which was weighted by 25% of the rural population (as a proxy of the relative wealth of the province). The resources available for the basic grant would be any revenue left over from the provincial share of the vertical division once the S, m, T and I grants had been calculated and deducted (i.e. it was determined as a ‘residual’). It was proposed that the total weighted population in the country should be calculated, and the average basic grant per weighted resident calculated. Each province’s basic grant would then equal the provincial weighted population multiplied by the average basic grant per weighted resident.

Although there were different components to the formula (to try to estimate the relative need for various types of services within each province), the formula was used to calculate a global provincial budget allocation (i.e. this was to be an unconditional grant). As is evident from the above formula, the size of the provincial population was to be an important factor in determining the equitable allocation of resources between provinces. It was recommended that the formula be used to calculate target allocations for each province, and that movement towards this target be phased in over 6 years beginning in the 1997/98 financial year.

### A.1.3 Horizontal division (local government)

The FFC has recently proposed a mechanism for allocating resources between local governments. Capital allocations are intended to be based on existing backlogs in the provision of basic infrastructure within each local government area. The recurrent budget formula proposed has two components: 1) An ‘expenditure needs’ component; and 2) A ‘tax capacity’ component.

#### ‘Expenditure needs’ component

The starting point for this component was to identify the ‘essential services’ for which local governments are responsible, namely access to potable water, sanitation services and electricity. It was proposed that central government subsidise access to these essential services for those who cannot afford to pay for them. Thus, the formula is calculated as the cost per household of the minimum amount of each ‘essential service’ needed for annual consumption, multiplied by the number of households below the poverty line in each local government area.

## ‘Tax capacity’ component

This component attempts to measure the relative ability of each local government to subsidise services for its own poor. The FFC proposed that the capacity of each local government to raise property taxes and service and staff establishment levies be estimated. The formula is calculated to be the difference between the national average per capita tax capacity and the tax capacity per capita in the local government area, multiplied by the population in that area.

## A.2 DoF Recommendations (Department of Finance 1998 and Financial and Fiscal Commission 1998)

### A.2.1 Top-slice

In terms of the DoF formula, certain amounts are ‘top-sliced’ from nationally collected revenues before the vertical division occurs. This include:

- The projected costs of national debt servicing costs - this is the largest component of the ‘top-slice’;
- ‘Standing appropriations’ which are legally binding such as the subscription to the International Monetary Fund;
- A contingency reserve which is intended for unforeseen disasters, some of which may be used to address “emerging policy priorities” or changes in economic circumstances; and
- A policy reserve, which was proposed to “meet specific policy priorities without compromising the proposed budgets of other services” (FFC 1998: 7).

It is interesting to note that the ‘policy reserve’ was proposed in the DoF’s “Medium Term Budget Policy Statement” (released on 2 December 1997) which formed the basis of the DoF’s submission to the Budget Council on the division of revenue. The FFC commented quite extensively on this reserve in its commentary on the DoF’s recommendations (FFC 1998), but this policy reserve is not mentioned at all in the Budget Review (Department of Finance 1998). It is thus unclear if the policy reserve has been abolished, based on the critical comments received by the FFC (see below) or whether it has been incorporated with the ‘national share’ in the Budget Review.

### A.2.2 Vertical division

The DoF is not explicit about the basis on which the vertical division was determined. They do however indicate that “a similar proportion is allocated to the provinces in 1998/99” as in previous years (Department of Finance 1998: E16). However, the way in which the figures are presented in the Budget Review is not consistent with previous years, and some of the allocations to provinces (e.g. certain conditional grants) had not been finalised. Thus, it was not feasible to determine the extent to which the level of provincial allocations was in fact maintained.

## A.2.3 Horizontal division

The DoF proposed a formula for determining the provincial horizontal division (i.e. between different provinces). Unfortunately, insufficient details are provided to know precisely how various components are calculated, but whatever information was available is summarised below:

$$\text{Provincial share} = 0.39E + 0.18H + 0.16SW + 0.15B + 0.08EO + 0.04I$$

where:

- E = Education component which is based on the average of the size of the school-age population and the number of learners actually enrolled (weighted by 39%)
- H = Health component which is based on the proportion of the population without private health insurance and weighted in favour of women, children and the elderly (using estimated utilisation differentials) (weighted by 18%)
- SW = Social welfare component which is based on the estimated number of people entitled to social security grants (elderly, disabled and children - these three components were weighted to reflect the relative size of the different social security grants; old age pensions = 65%, child and family care = 10%, disability and other grants = 25%) (weighted by 16%)
- B = Basic component which is based on the total provincial population with a 50% weighting for rural residents (as a proxy for socio-economic status and the existence of backlogs) (weighted by 15%)
- EO = Economic output component which is based on the estimated provincial GGP (as a proxy for own revenue within provinces - it directs a proportion of nationally collected revenue back to the provinces where they were generated) (weighted by 8%)
- I = Institutional component, for which each province receives the same amount, is based on the cost of maintaining public administration, building essential capacity and participating in intergovernmental forums (weighted by 4%)

Each of these components was assigned a specific weight (see above). For education, health and social welfare, the weight was based on the percentage of overall provincial spending on these services. The DoF recommended moving towards equity target allocations over a 5-year period.

Table A.1 indicates the distribution of resources for each component between different provinces. The last column indicates the distribution of the total population between provinces, which serves as a comparison for the resource distribution components. This allows one to compare resources allocated on the basis of each component of the formula, and the overall weighted average formula, with the distribution of resources if merely allocated on a per capita basis. For example, Eastern Cape receives a higher proportion of the education, health, social welfare and basic revenue shares than if its unweighted population size were used to determine allocations. Conversely, Gauteng receives a relatively lower proportion. The economic output share is discussed in some detail later.

**TABLE A.1: PERCENTAGE DISTRIBUTION OF HORIZONTAL DIVISION COMPONENTS (AND TOTAL POPULATION) BETWEEN PROVINCES**

	<b>Education</b>	<b>Health</b>	<b>Social</b>	<b>Basic</b>	<b>Economic</b>	<b>Institutional</b>	<b>Weighted</b>	<b>Population</b>
<b>Weighting</b>	39	18	16	15	8	4	100	
Eastern Cape	18.5	17.3	18.7	16.6	7.6	11.1	16.9	15.5
Free State	6.3	6.7	6.6	6.1	6.2	11.1	6.6	6.5
Gauteng	13.8	15.6	13.3	15.8	37.7	11.1	16.2	18.1
KwaZulu-Natal	21.3	21.1	21.0	21.2	14.9	11.1	20.3	20.7
Mpumalanga	7.5	7.0	7.2	7.5	8.1	11.1	7.6	6.9
North West	8.0	8.3	8.8	8.7	5.6	11.1	8.2	8.3
Northern Cape	1.8	2.0	2.0	1.8	2.1	11.1	2.3	2.1
Northern Province	14.3	11.8	13.2	12.8	3.7	11.1	12.5	12.1
Western Cape	8.5	10.3	9.1	9.3	14.1	11.1	9.6	9.7
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

In addition to the 'equitable share' formula, certain conditional grants were allocated to provinces. These include:

- A health services grant which includes three components:
  - medical research and training;
  - central hospital services; and
  - redistribution of tertiary services.

The first two components intend to compensate provinces providing research training and highly specialised services for the associated costs, while the third component is intended to promote a more equitable distribution of tertiary services between provinces.

- A local government grant (this is a transitional arrangement until local government is included in the vertical division of revenue and an appropriate formula for the horizontal division of revenue between local governments is determined); and
- 'Other' conditional grants.

## A.3 Comparisons & Recommendations

### A.3.1 Top-slice

The removal of a 'top-slice' before the vertical division of revenue is one of the major differences between the FFC and DoF proposals. The FFC is opposed to the use of a 'top-slice'. It argued that debt servicing and standing appropriations were national government responsibilities and should be included in the national share of the vertical division (Financial and Fiscal Commission 1998). In terms of the 'reserves', the FFC supported the creation of a contingency reserve to ensure that there are no 'budgetary shocks' during a financial year due to unforeseen circumstances (e.g. drought, floods, sudden economic changes). However, they were strongly opposed to the creation of a policy reserve. The DoF had indicated that the policy reserve "would be allocated by national government on an annual basis depending on its own policy imperatives and priorities" (Financial and Fiscal Commission 1998: 15). The main concern was that there were no guidelines on how this money would be allocated. It appears that it can be allocated to any function within any sphere of government. This could undermine the allocation of resources based on the vertical and horizontal divisions. In particular, "If this reserve is to be allocated on the basis of bids from departments or provinces, it may have adverse consequences on equity, where well organised provinces take up the lion's share of the reserve and little expenditure takes place where it is needed most" (Financial and Fiscal Commission 1998: 16). There is also a concern that, potentially, the entire policy reserve could be used for national level activities, "leaving less for provincial governments because this amount is being top-sliced before the vertical division is made" (Financial and Fiscal Commission 1998: 16).

As indicated previously, the Budget Review does not mention this policy reserve, so it is unclear whether it has been abandoned or has been included in the national government share. The DoF's original reference to this reserve (in its 'Medium Term Budget Policy Statement, 2 December 1997) indicates that the policy reserve would be set at approximately R3 billion per annum.

### A.3.2 Vertical division

Neither the FFC nor the DoF were very explicit about the guidelines to be used in determining the vertical division, hence it is not feasible to undertake a detailed comparative analysis. However, the FFC made a firm recommendation that the provincial share of revenue should increase over time relative to the national share (by 0.5% per annum). In contrast, the DoF recommended that the relative distribution between national and provincial spheres of government should remain relatively constant.

The Presidential Review Commission (1998: 24-25) noted that "actual delivery is taking place at subnational level, substantially reducing national government expenditure responsibilities. ... It is an elementary principle of fiscal decentralisation that finance should follow function. This principle was recognised by the FFC in its recommendations. But in the 1998/99 year and the two following years, it has been proposed [by the DoF and Budget Council] that the vertical split remain constant. ... If the vertical split is not adjusted in favour of the provinces to reflect their additional spending obligations, this could not only compromise social services delivery, but could also compel provinces to overspend. ... De facto provincial deficits, driven by an inappropriate division of resources between national and provincial spheres, exacerbated by ineffective financial control systems in some provinces, could thus undermine attempts at overall public sector deficit reduction - a pivotal feature of the GEAR macro strategy." Thus, there has been sharp criticism of the DoF's recommendation that the provincial share of revenue is not to be increased over the medium-term (1998/99-2000/01; i.e. the period of the current MTEF).

### A.3.3 Horizontal division

There are quite a few similarities between the broad objectives and components of the FFC and DoF formulae. These include:

- The minimum national standards grant (FFC formula) is similar to the combination of the education and health grants (DoF formula), although the FFC used costs of providing such services while the DoF simply uses the size of the population dependent on these services, weighted by current spending levels;
- The spillover grant (FFC formula) is similar to the conditional health grant (DoF formula);
- The institutional grant is similar between the two formula; and
- The basic grant is similar, the only difference being that the FFC suggested a 25% weighting for rural dwellers while the DoF recommend a 50% weighting.

The DoF includes an additional component, in the form of an estimate of the distribution of social welfare grants. It also weights the various components of the formula. There are concerns that the social services are weighted by the current level of spending on these services. The main concern is that it is based on historical expenditure patterns rather than the perceived priority of the service. Thus, the Financial and Fiscal Commission (1998: 13) comments that “It is not clear why the 39% weighting for education should remain at that level and whether the level is appropriate in the first place”. The weighting for the other components of the formula are entirely arbitrary. Once again, the Financial and Fiscal Commission (1998: 15) notes that “Without suggesting bad faith on behalf of the DoF, the use of arbitrary weightings can be open to manipulation.”

Apart from the weighting of the components of the formula, the most important difference between the two formulae is the component relating to provincial tax revenue. The approach adopted by the FFC was to attempt to estimate what the revenue generating capacity was for each province, and to compensate for these differences through allocations from the national level (i.e. to ensure equitable shares of overall revenue when provincial taxation is implemented). The position adopted by the DoF is diametrically opposed to this in that it proposes to give money back to provinces in proportion to their contribution to the country’s economic outputs. They use what is in effect a proxy indicator for each province’s own tax revenue generating potential. The FFC criticises this as it “has a countervailing effect on all the equity based shares which then runs contrary to devising a formula that redresses the inequities amongst provinces” (Financial and Fiscal Commission 1998: 22). The DoF justifies its use of the ‘economic output’ component in the formula by stating that “This component acknowledges the link between investment and infrastructure needs and related economic services, and the level of economic output in a province” (Department of Finance 1998: E22). It is evident from Table A.1 that while the education, health, social welfare and basic components of the DoF’s formula are strongly ‘equity’ promoting (in that more resources are being directed to poorer provinces relative to their population share), the economic output component is heavily biased in favour of the ‘richer’ provinces and thus, to some extent, diminishes the strength of the equity-promoting components. However, it does not entirely offset the equitable nature of the overall formula as ‘poorer’ provinces (such as Northern Province, Eastern Cape and Mpumalanga) do receive a relatively higher weighted allocation than their population share, while ‘richer’ provinces (especially Gauteng) receive a relatively lower weighted allocation (see last two columns of Table A.1).

# References

- Brijlal V, Gilson L, Makan B, McIntyre D (1997).  
**District financing in support of equity: Tender Contract to provide technical assistance to provinces with obtaining equity in district financing.** Report submitted to the national Department of Health.  
Johannesburg: Centre for Health Policy, University of the Witwatersrand and Health Economics Unit, University of Cape Town.
- Central Statistical Service (1997). Census '96:  
**Preliminary estimates of the size of the population of South Africa.**  
Pretoria: Central Statistical Service.
- de Bruyn J, McIntyre D, Mthethwa N, Naidoo K, Ntenga L, Pillay P, Pintusewitz C (1998).  
**Public expenditure on Basic social services in South Africa.** Johannesburg: Financial and Fiscal Commission (for UNICEF and UNDP).
- Department of Finance (1996a).  
**Growth, employment and redistribution: A Macro-economic strategy.**  
Cape Town: Department of Finance.
- Department of Finance (1996b).  
**Budget review: 13 March 1996.**  
Cape Town: Department of Finance.
- Department of Finance (1997a).  
**Medium Term Budget Policy Statement.**  
Pretoria: Government Printer.
- Department of Finance (1997b).  
**The Medium Term Expenditure Framework. Report of the Health Sectoral Team.**  
Pretoria: Department of Finance.
- Department of Finance (1997c).  
**Budget review: March 1997.**  
Cape Town: Department of Finance.
- Department of Finance (1998).  
**Budget Review 1998.** Cape Town: Department of Finance.
- Department of Health (1997a).  
**White Paper for the Transformation of the Health System in South Africa.**  
Pretoria: Government Printer.
- Department of Health (1997b).  
**A social health insurance scheme for South Africa: Policy Document.**  
Pretoria: Department of Health.
- Doherty J, van den Heever A (1997).  
**A resource allocation formula in support of equity and primary health care.**  
Johannesburg: Centre for Health Policy.
- Financial and Fiscal Commission (1996).  
**The Financial and Fiscal Commission's Recommendations for the Allocation of Financial Resources to the National and Provincial Governments for the 1997/98 Financial Year.** Midrand: FFC.
- Financial and Fiscal Commission (1997).  
**Local government in a system of intergovernmental fiscal relations in South Africa: A discussion document.** Halfway House: FFC.
- Financial and Fiscal Commission (1998).  
**Recommendations and comments: The Allocation of Financial Resources to the National, Provincial and Local Governments for the 1998/99 Fiscal Year, Submitted in terms of Section 9 of the Intergovernmental Fiscal Relations Act, 1997.** Midrand: FFC.
- Health Systems Trust (1996).  
**South African Health Review, 1996.**  
Durban: Health Systems Trust and the Henry J. Kaiser Family Foundation.
- Hospital Strategy Project (1996).  
**Final report of the Hospital Strategy Project.** Johannesburg: Monitor Company, Health Partners International, Centre for Health Policy and National Labour and Economics Development Institute.

- Makan B, McIntyre D, Gwala P (1996).  
**Financing and expenditure. In: Health Systems Trust. South African Health Review, 1996.**  
 Durban: Health Systems Trust and the Henry J. Kaiser Family Foundation.
- McIntyre D (1995).  
**Health care financing and expenditure. In: Health Systems Trust.**  
**South African Health Review, 1995.**  
 Durban: Health Systems Trust and the Henry J. Kaiser Family Foundation.
- McIntyre D, Bloom G, Doherty J, Brijlal P (1995).  
**Health expenditure and finance in South Africa.**  
 Durban: Health Systems Trust and World Bank.
- McIntyre D, Khosa S (1996).  
**User fees for public sector health services: International experience and options for South Africa.**  
 Health Economics Unit Working Paper No. 23. Health Economics Unit,  
 Department of Community Health, University of Cape Town.
- McIntyre D (1997a).  
**Inequity in the South African health sector: Input paper for the Poverty and Inequality Report.**  
 Health Economics Unit, Department of Community Health, University of Cape Town.
- McIntyre D (1997b).  
**Health care financing and expenditure in South Africa:**  
**Towards equity and efficiency in policy making. PhD Dissertation,**  
 University of Cape Town.
- Mooney G (1996).  
**And now for vertical equity? Some concerns arising from Aboriginal health in Australia.**  
 Health Economics. 5: 99-103.
- Palmer N, Seritsane M, Ntutela P, Mthethwa N (1997).  
**An assessment of the planning and monitoring of provincial health expenditure.**  
 Pilot project: KwaZulu Natal. Research report submitted to Department of Health.  
 Cape Town: Health Systems Trust.
- Presidential Review Commission (1998).  
**Developing a culture of good governance. Report of the Presidential Review Commission on the reform and**  
**transformation of the public service in South Africa.**  
**Annexure 6: Finance, budgeting and procurement. Cape Town: PRC.**
- South Africa (Republic) (1995).  
**Restructuring the national health system for universal primary health care: Report of the Committee of Inquiry**  
**into a national health insurance system. Pretoria: Department of Health.**  
 (Chairpersons: Dr J. Broomberg and Dr O. Shisana).
- World Bank (1993).  
**World Development Report 1993:**  
**Investing in Health. New York: Oxford University Press for The World Bank.**
- World Bank (1994).  
**Better Health in Africa: Experience and Lessons Learned. Washington, D.C.: The World Bank.**