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FINANCIAL DIRECTIONS AND BUDGET TRENDS IN GOVERNMENT HEALTHCARE

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INTRODUCTION

Following the Presidential Health Summit in October 2018, stakeholders in the sector agreed on a compact that aims "to strengthen the South African health system to ensure that it provides access to quality health service for all in an equitable, efficient and effective manner" (South African Government, 2019: 33).[1] Pillar six of the compact is concerned with public finances, but questions of health financing and financial management arise throughout the compact.

This report provides evidence and analysis that can assist in taking forward the agenda of the Presidential Health Compact. It does so by reviewing the financial performance of the government healthcare system over the last decade. After assessing the financial management performance, it looks at the "financial health" challenges facing the system, including the problems of accruals and medico-legal claims. The report then examines the budget pressures faced by provincial healthcare departments, as well as the different allocation of resources and levels of care across provinces. It ends with a conclusion and tentative reflections informed by the evidence.

After the compact was agreed upon, the healthcare sector was put on an emergency footing by the coronavirus (Covid) pandemic. The lockdowns led to temporary but deep shifts in patterns of financing and utilisation of healthcare systems. The impact of the pandemic and the nature of its permanent effects on the systems are still being assessed, and it is hoped that future work will address this directly. While unavoidably touching on the resource shocks associated with the pandemic, the report's focus is on the longer-term trends in public healthcare financing.

POOR FINANCIAL MANAGEMENT THREATENS SERVICES

Audit opinions give a high-level indicator of financial management outcomes and provide insights into the ability of government departments to fulfil their mandates. The most recent report by the Auditor-General noted, "If the health sector challenges relating to record keeping, staff shortages, and policies and legal frameworks are not addressed, they will have a **detrimental long-term effect** on the sector's ability to deliver swift, good-quality health care services" (AGSA, 2022: 54, emphasis added).

In short, financial mismanagement is widespread in the sector, which is unable to comply with many of the requirements set out in the Public Finance Management Act (1999). Year after year, most provincial health departments receive qualified audit opinions, meaning that their financial reports contain material misstatements of the facts (Figure 1). Although the Western Cape Department of Health (DoH) consistently receives unqualified audits, and Gauteng and Mpumalanga have improved their status in recent years, audit opinions have overall regressed. And in 2021, the national DoH received a qualified audit for the first time. Covid played a role in the recent negative findings across the sector, due to rising volumes of emergency procurement and substantial temporary relaxation of procurement rules during the pandemic. Nevertheless, the main reason for audit outcomes not improving was "the inadequate action plans that were developed and/or slow implementation of these audit action plans which resulted in repeat findings" (ABSA, 2022: 5)

[1] See Annexure 1 for a summary of the Presidential Health Compact's recommendations.

Figure 1: Departments of health and health entities – overall audit opinions (2010–2021)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Eastern Cape	Q	Q	Q	Q	Q	Uf	Uf	Uf	Q	Q	Q	Q
Free State	Q	Q	Q	Q	Q	Q	Uf	Uf	Q	Q	Q	Q
Gauteng	Q	Q	Q	Q	Q	Q	Q	Uf	Uf	Uf	Uf	Uf
KwaZulu-Natal	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q
Limpopo	D	D	D	Q	Uf	Q	Q	Q	Q	Uf	Q	Q
Mpumalanga	Q	Q	Q	Q	Q	Q	Q	Q	Q	Uf	Uf	Uf
Northern Cape	D	D	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q
North West	Uf	Q	Uf	Uf	Uf	Q	Q	N	Q	Q	Uf	Uf
Western Cape	Uf	Uf	Uf	Uf	Uf	Uf	Uf	Uf	Un	Un	Un	Un
National Department			Uf	Uf	Uf	Uf	Uf	Uf	Uf	Uf	Uf	Q
Council for medical schemes			Un	Uf	Uf	Uf	Un	Un	Uf	Uf	Uf	Uf
Health Professions Council of SA									Uf	Uf	Un	Un
National Health Laboratory Services			Uf	Uf	Uf	Uf	Uf	Q	Q	Uf	Uf	Uf
Office of Health Standards Compliance							Uf	Uf	Un	Un	Uf	Un
SA Health Products Regulator Authority										Q	Q	Q
SA Medical Research Council			Uf	Un	Un	Un	Un	Un	Uf	Un	Un	Un

Key

N	Audit not finalised
D	Disclaimer
Q	Qualified
Uf	Unqualified with findings
Un	Unqualified with no findings

Source: AGSA, PFMA Audit Reports, Annex 3: Auditee's Opinions over five years (2020 and 2016 reports) National Treasury

Since 2010, the Northern Cape and KwaZulu-Natal have had qualified audit outcomes. The Northern Cape's most recent adverse audit finding was the result of weak internal controls and record-management systems, and having key positions filled by acting appointments, including accounting officers. Similarly, in KwaZulu-Natal, the position of chief financial officer had been vacant for a significant period, and the 2021 audit was qualified because of excessive irregular spending, due to a failure to monitor compliance with the law.

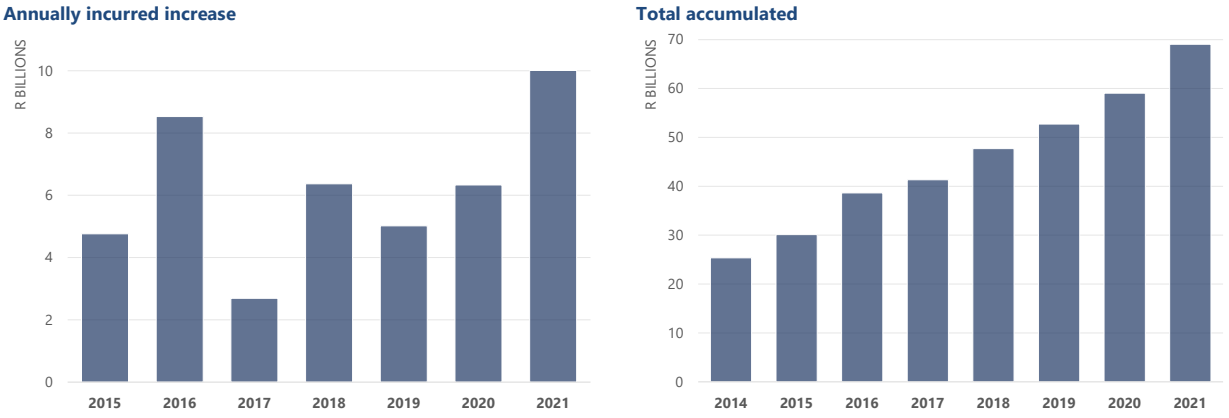
Irregular expenditure[2] is the broadest indicator of financial management capabilities. Five of the top ten contributors to unauthorised expenditure in government were health departments (Eastern Cape, Free State, Northern Cape, North West and national DoH). Figure 2 shows that provincial health departments add about R6 billion to the tally of irregular expenditure with each year that passes. Total irregular expenditure continues to accumulate, reaching nearly R60 billion in 2020. This reflects the departments' failure to get condonation,[3] hold people accountable, recover misspent funds or otherwise resolve the findings of previous years. Where the issue is technical – for instance spending on unbudgeted medico-legal claims – treasury condonation should be straightforward, and the failure of the sector to resolve these issues may reflect deeper underlying problems.

[2] **Irregular expenditure** is expenditure that was not incurred in the manner prescribed by legislation; in other words, somewhere in the process that led to the expenditure, the auditee did not comply with the applicable legislation. Such expenditure does not necessarily mean that money had been wasted or that fraud had been committed. It is an indicator of non-compliance in the process that needs to be investigated by management to determine whether it was an unintended error, negligence or done with the intention to work against the requirements of legislation. Such legislation requires, for example, that procurement should be fair, equitable, transparent, competitive and cost-effective. Through such investigation, it is also determined who is responsible for the non-compliance and what its impact was. Based on the investigation, the next steps are determined. One of the steps can be condonement if the non-compliance had no impact and negligence was not proven. Alternatively, if negligence was proven, the steps can be disciplinary action, recovery of any losses from the implicated officials or even cancelling a contract or reporting it to the police or an investigating authority. (Source: https://www.agsa.co.za/Portals/0/Reports/PFMA/201617/GR/17%20need%20to%20know.pdf)

[3] **Condonation** is the process whereby the relevant authority (usually the provincial or national treasury) acknowledges the irregular expenditure and pardons the action that has resulted in the incurrence of irregular expenditure. Then enables the department to write off the irregular expenditure from its books.

Figure 2: Irregular expenditure

All provincial health departments | R billions | (2014–2020)

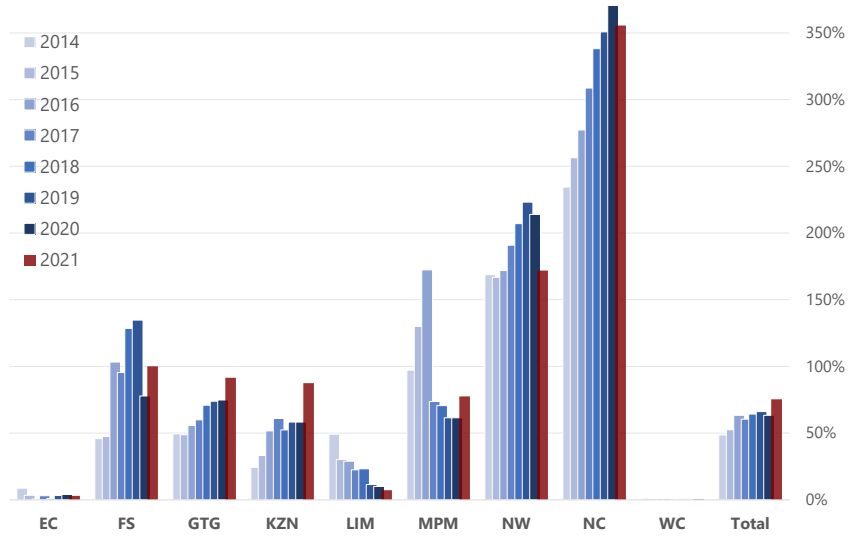


Source: National Treasury

Figure 3 shows the cumulative total of irregular expenditure relative to each department's operational spending.[4] Although Gauteng has the largest irregular expenditure in rand terms, it also has the largest health budget in the country, and other provinces fare worse in relative terms. Performance in the North West and the Northern Cape is particularly concerning, as irregular expenditure appears to both be very high and rising rapidly.

Figure 3: Irregular expenditure

% of non-compensation spending | Total accumulated



Source: National Treasury Data, Public Economy Project Calculations

Where health departments waste resources, this is identified as fruitless and wasteful expenditures.[5] In 2020, the Gauteng DoH was responsible for the second largest amount of fruitless and wasteful expenditure in the country due to service providers overcharging for personal protective equipment. Figure 4 shows that (relative to the size of their health budgets) Gauteng, Free State, Northern Cape and North West continue to waste scarce resources.

An example of fruitless and wasteful expenditure is the construction of the Dr Pixley Ka Isaka Seme Memorial Hospital in KwaZulu-Natal, where poor project management led to "irregular

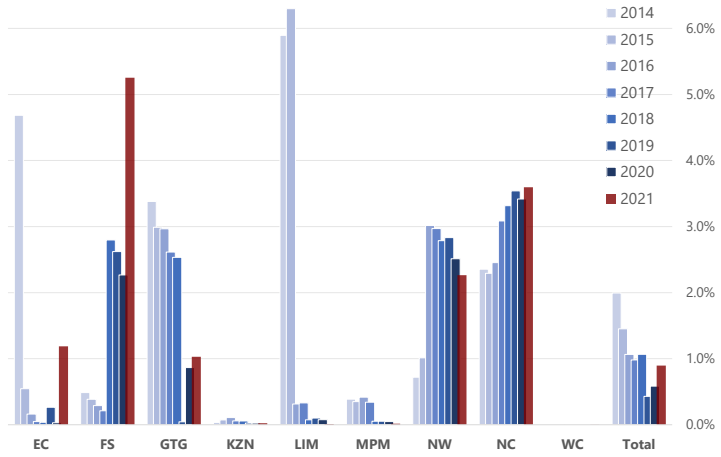
[4] Defined here as total spending excluding compensation of employees.

[5] **Fruitless and wasteful expenditure** refers to expenditure that was made in vain and could have been avoided had reasonable care been taken. Such expenditure includes interest, the payment of inflated prices, and the cost of litigation that could have been avoided.

expenditure of R304,5 million for acceleration costs", missed project deadlines "and adjustment to the professional fees budget". Delayed payments to the contractor resulted in avoidable interest payments of R2 million. In the end, the hospital cost R2,3 billion compared to the R1,9 billion original contract value (AGSA, 2022: 41). This undoubtedly puts further pressure on the fiscus at a time when reductions in health-facility budgets place the quality of health infrastructure at risk.

Figure 4: Fruitless and wasteful expenditure

Provincial health departments | % of non-compensation spending



Source: National Treasury Data, Public Economy Project Calculations

Examples of **material irregularities** are instructive for understanding the impact of financial mismanagement, since by definition they reflect cases of severe loss or harm to the public.[6] Material irregularities reported by the AGSA (2022) include:

- Construction of the Sekhing Community Health Centre in the North West province started in October 2012, with completion initially planned for August 2014. When the AGSA visited the site in May 2022, the project had still not been completed. The delay negatively affected the community, as they must travel from their local area at great cost to access healthcare services at other public healthcare facilities.
- In November 2013, the Northern Cape DoH entered into a radiology services contract that was extended multiple times. The contract contained a mathematical error that resulted in overpayments estimated at more than R4 million.

  In March 2015, the Gauteng DoH awarded a contract for information technology infrastructure without inviting competitive bids. This resulted in a financial loss of R148,9 million, as cheaper alternatives were available. Following a departmental investigation, in July 2019, the matter was referred to the National Prosecuting Authority for possible criminal charges and to the State Attorney for civil claims against the implicated officials.

In short, despite the commitment made in the compact to improve financial management in the sector, the situation remains dire, leading to very high levels of tainted spending, as identified by the AGSA. The failures in financial management have a direct impact on services and add to the financial strains experienced by the sector.

[6] **Material irregularity** means any non-compliance with, or contravention of, legislation, fraud, theft or a breach of a fiduciary duty identified during an audit performed under the Public Audit Act that resulted in or is likely to result in a material financial loss, the misuse or loss of material public resources or substantial harm to a public sector institution or the general public.

FINANCIAL HEALTH AND HEALTHCARE SERVICES

As the previous section shows, weak financial management capabilities in the public healthcare sector are having a direct impact on service delivery. One element of irregular expenditure is **unauthorised expenditure**,[7] or overspending and other deviations from the approved budget, due to pressures often arising from compensation of employees and medico-legal claims.

For compensation of employees, the national government agrees on annual wage settlements in collective bargaining. However, the budgets allocated to provinces for compensation are frequently less than that implied by the wage settlement. In the case of medico-legal claims, budget conventions and regulations mean that no funds are authorised, effectively making all payouts irregular by definition. A recent paper by the South African Law Reform Commission counsels that this is not strictly required in terms of the law (SALRC, 2021).

Unauthorised spending takes place in a context of binding budget constraints and intense fiscal pressure. This may be the result of poor budgeting or financial management practices, but may also reflect a situation in which allocated budgets are insufficient to meet service delivery obligations set out in policy. In the latter case, fiscal constraints result in adverse financial outcomes because, in order to maintain services, health departments are obliged to make payments in support of policy mandates despite the inadequate budget envelope. The AGSA highlights some of the main concerns (AGSA, 2021:107–8, emphasis added):

> The sector's financial health situation is also concerning, given its critical role in ensuring that South Africans have access to quality healthcare, and this threatens its ability to achieve overall targets by 2030. **The covid-19 pandemic aggravated the pressure of the situation**, as the sector had to use its limited budget to expand its current activities to include measures to deal with the pandemic. Some activities had to be reprioritised because the already strained budget was not geared for any unplanned activities.
>
> **The situation is further exacerbated by the significant increase in medico-legal claims,** with claims paid by the sector in the 2020/21 financial year amounting to R1 756 million, while total claims against the sector amounted to R124 145 million. If these claims are unsuccessfully defended and need to be paid out, it will further erode an already stretched budget and have a negative impact on service delivery.
>
> **This financial strain also led to an increase in unpaid invoices (accruals)** amounting to R15 364 million, which represents 17% of the sector's 2021-22 appropriation (excluding compensation of employees and transfer payments). When the sector settles these invoices, only 83% of its budget for the 2021-22 financial year will be available for service delivery. As the sector requires 100% of its budget to deliver an effective and efficient service, it may have to suspend some activities, which will further disadvantage citizens.

Staff shortages are affecting medico-legal claims. In 2015, the AGSA's audit of the Health Minister's strategy to address the increasing medico-legal claims found the following (AGSA, 2022: 107–8):

> In 67% of healthcare facilities audited, administrative staff shortages affected medical record keeping because vacant posts could not be filled due to financial constraint. A shortage of medico-legal officers in six provinces (Eastern Cape, Free State, Gauteng, Limpopo, Mpumalanga and Northern Cape) and a

[7] **Unauthorised expenditure** is spending that goes over budget or was not used for the purpose intended.

lack of medical expertise in two provinces (Free State and Mpumalanga) contributed to delays in finalising medico-legal claims.

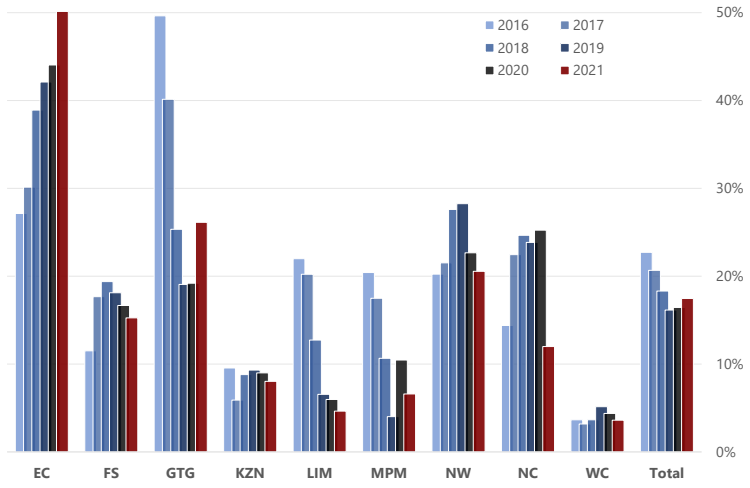
It is evident that the continuous state of poor financial health has a negative impact on health services in many provinces. "These financial challenges directly resulted in the poor state of the primary healthcare system, as there were inadequate funds for building and maintaining healthcare facilities and providing adequate staff and medical supplies" (AGSA, 2022: 81). For example, the Eastern Cape reported that only 178 of its 775 clinics (23%) met the ideal clinic standard.

The problems arising from accruals and medico-legal claims are discussed below, while the question of budget pressures arising from compensation is dealt with in the next section.

Accruals (unpaid invoices): Budget shortfall or financial management failure?

Figure 5 shows the evolution of the accruals' problem in recent years. Prior to the Covid pandemic, the national level of accrued liabilities appeared to have stabilised at around 17% of non-compensation spending but has since been increasing. The picture varies by province, with Limpopo and Mpumalanga able to contain the situation, while matters seem to be getting worse in the North West and Northern Cape. The Eastern Cape's situation must surely represent an acute budget crisis, as nearly 45% of operational funds are used to pay invoices from the previous year, leaving only 55% of the annual budget to address the current year's needs. This means that the sector is constantly borrowing from future allocations to fund current year expenses, which forces "management to continuously make choices of which activities/service to prioritise and which to suspend, further disadvantaging citizens" (AGSA, 2021: 47).

Figure 5: Accruals (unpaid invoices), % of non-compensation spending



Source: National Treasury Data, Public Economy Project Calculations

The Presidential Health Compact recognises two aspects of the problem. It says that "specific funds must be allocated to cover the accumulated shortfalls", suggesting that the problem reflects budget shortfalls (South African Government, 2019: 61). It also calls on provincial health departments to "ensure that management processes are in place to prevent a recurrence" and to "eradicate backlogs", suggesting that the problem is effective budgeting, financial management and control (ibid).

To the extent that accruals reflect the underfunding of service delivery obligations, the solution would *not* be a once-off allocation, as suggested by the compact, but a permanent increase in annual budgets to enable departments to execute their mandates. However, if the problem is

mainly one of financial control and budgeting, a feasible solution is a once-off eradication of backlogs backed by improved management capabilities.

While both aspects of the problem are likely to play a role, it is hard to reach conclusions about which factors predominate in provinces based on the high-level analysis presented here. The low level of accruals in the Western Cape suggests that the problem is mainly one of financial control (and the data in the previous section shows the Western Cape has exceptional audit scores in all respects). On the other hand, as noted below, the Western Cape spends more per capita on healthcare and allocates a larger share of its total provincial budget to healthcare than other provinces, which may be a factor behind the low level of accruals. The marked improvement in Gauteng (at least until 2021) could be the result of better financial management practices and a concentrated effort on the part of the provincial department to resolve the issue. Alternatively, it may be the result of increased resources, as Gauteng's allocation to healthcare grew considerably over this period, overtaking basic education as the largest item on the provincial budget (see below).

The fiscal imbalances reflected in unpaid invoices may indicate strains that emanate from compensation budgets. Overpayment on compensation is a leading cause of unauthorised expenditure in the health sector. Nevertheless, to avoid an immediate breakdown in services, employees must be paid, and paid on time. If the increased remuneration of healthcare workers is not backed by budget allocations from national revenue, one result will be pressure to shift resources from other line items to compensation, as a first call on cash resources. In the meantime, service providers are held at bay or asked to act as creditors until the next fiscal year.

Hidden fiscal imbalances can also emerge in intergovernmental payments and transfers – i.e. in transactions within the public sector. A case in point is the National Health Laboratory Services (NHLS), which was owed large amounts by many provinces for laboratory tests performed in public hospitals. The matter was resolved by a national agreement to prioritise payments to the NHLS in the goods and services budget. However, it is notable that once this agreement was reached, the problem of accruals on other line items began to escalate. This is an example of pushing one service provider to the front of the queue when cash payments are rationed, as cash resources are unable to cover all commitments. Another example is local government, which has to carry part of the fiscal pressure on the health sector in the form of non-payment of rates and utilities by provincial health departments. Given that transactions between public institutions can be mediated through political negotiations, there is a very high danger that shortfalls in one part of the public finances will have an impact on other elements of the system.

Medico-legal claims

As mentioned earlier, provincial health departments may not have budgeted for medico-legal claims, which therefore have to be settled out of current funds, imposing pressure on other line items. Figure 6 shows *payments* made to claimants over the last nine years.[8] The burden is felt unevenly across provinces. For the Eastern Cape, payments of medico-legal claims are absorbing a percentage of non-compensation spending, which probably explains much of the province's accrual problem. For example, the provincial health department's balance for medico-legal claims escalated to R38,608 million, reducing the its total budget for service delivery (AGSA, 2020:108). In 2023, Gauteng settled medio-legal claims amounting to R369,7 million but had to shift funds from goods and services to do so (AGSA, 2023: 12). In KwaZulu-Natal, the province had "2360 active medico-legal claims to the value of R16 062 920 316. This puts the department

[8] Payments reflect the conclusion of legal processes and the real impact on resource allocations. Claims reflect a possible future contingent liability, but this liability is (in an accounting sense) notional until it is realised in the form of actual payments.

under immense pressure, as payments for these claims were **not budgeted** for and are paid from the department's voted funds" (ibid, emphasis added).

Nevertheless, despite all these pressures, the data suggests that payments for medical legal claims have stabilised and, at the least, are not growing at the rate observed in recent years (Figure 6). This reflects actions by provinces to better administer and respond to claims lodged.

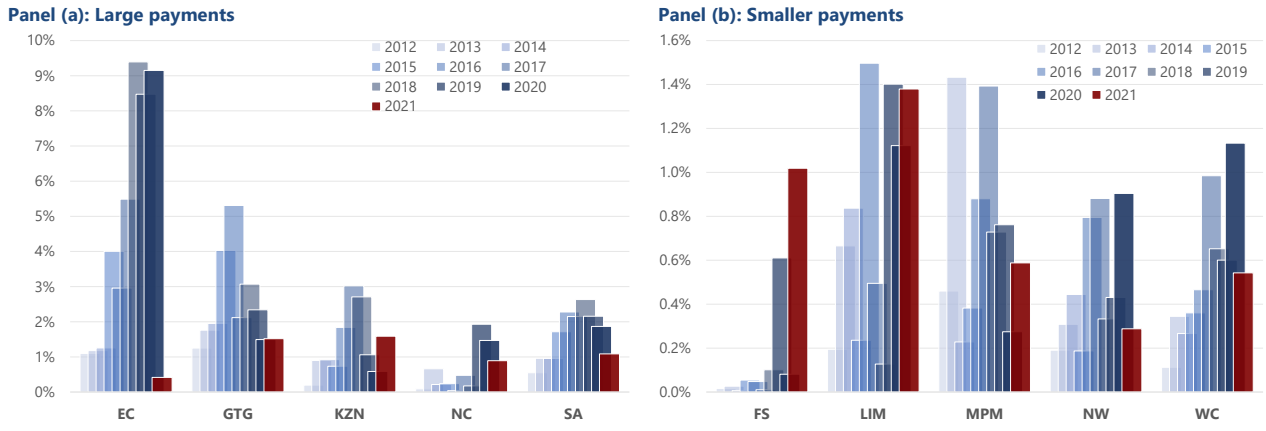
Staff shortages are affecting medico-legal claims. In 2015, the AGSA's audit of the Health Minister's strategy to address the increasing medico-legal claims found the following (AGSA 2022: 107–8):

> In 67% of healthcare facilities audited, administrative staff shortages affected medical record keeping because vacant posts could not be filled due to financial constraint. A shortage of medico-legal officers in six provinces (Eastern Cape, Free State, Gauteng, Limpopo, Mpumalanga and Northern Cape) and a lack of medical expertise in two provinces (Free State and Mpumalanga) contributed to delays in finalising medico-legal claims.

It is evident that the continuous state of poor financial health has a negative impact on health services in many provinces. "These financial challenges directly resulted in the poor state of the primary healthcare system, as there were inadequate funds for building and maintaining healthcare facilities and providing adequate staff and medical supplies" (AGSA, 2022: 81). For example, the Eastern Cape reported that only 178 of its 775 clinics (23%) met the ideal clinic standard.

Figure 6: Payments for medico-legal claims

% of non-compensation spending; Note that scales differ on panel (a) and (b)



Source: National Treasury Data, Public Economy Project Calculations

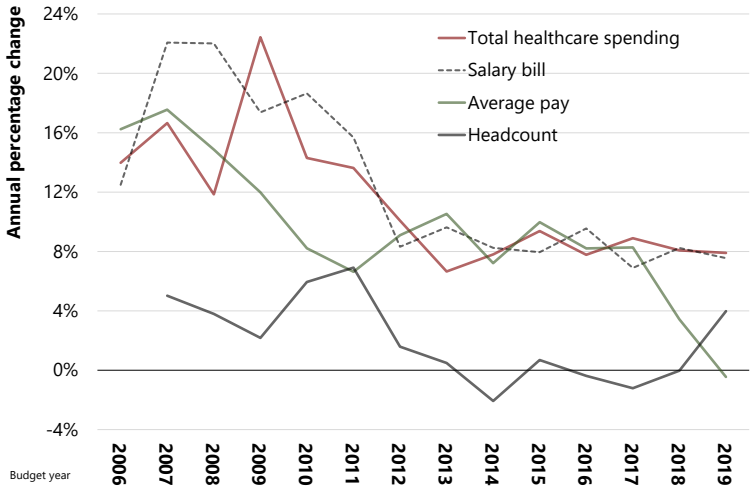
SPENDING TRENDS AND BUDGET PRESSURES OVER THE LAST 15 YEARS[9]

In recent years, provincial health departments have struggled to pay salaries out of their compensation budgets, sometimes incurring unauthorised expenditure. Figure 7 illustrates the pay and headcount dynamics in provincial health spending since 2006. Improved remuneration for health workers dates to the implementation of occupation specific dispensations (OSD) after

[9] This section and the next draws on work previously published in Sachs et al. (2023).

2008.[10] Between 2008 and 2010, average pay increased by 15% per year, more than double the rate of consumer price inflation. At the same time, the health workforce grew at around 5% per year, increasing the ratio of health workers to the population served. Although health budgets expanded to accommodate the combination of these pressures, they did not cover the full cost, and the growth of the salary bill outpaced the budget for several years.

Figure 7: Growth rates of spending, average pay and personnel headcounts



Note: These figures reflect provincial governments spending and employment only

Source: National Treasury EPRE data, Persal/GTAC-PEPA[11], Public Economy Project Calculations

Then, as the economy began to stagnate and fiscal pressures mounted, spending growth (i.e., the red line in Figure 7) was brought down to an annual rate of about 8%, just sufficient to cover pay increases (the green line), but only if employment growth (the grey line) was restricted. Personnel numbers fell relative to the size of the population served, eroding the quality of services and placing an increased burden on the healthcare workforce.

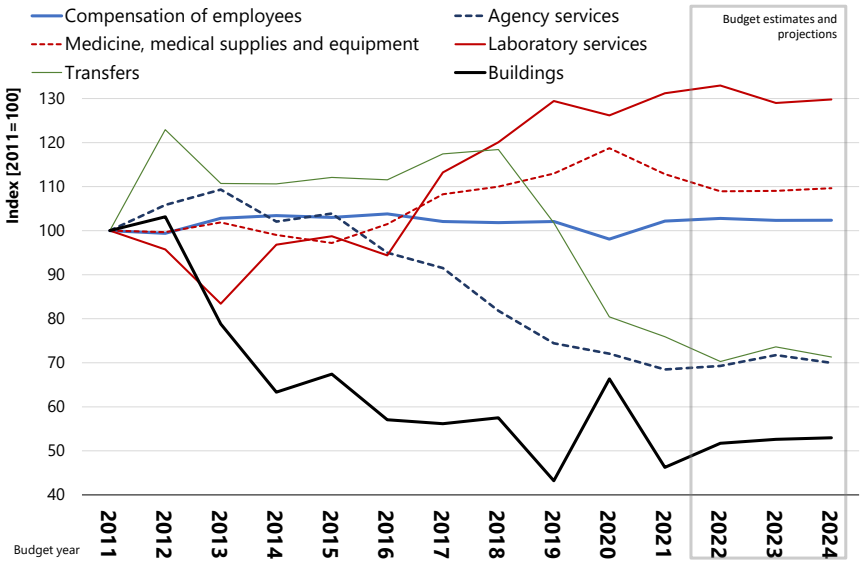
However, while the budget just kept pace with compensation pressures during this period, a growing wage bill was not the only call on the budget, as spending on support and treatment for people living with TB and HIV/AIDS expanded rapidly. As the financing for these services was ringfenced in the form of a conditional grant, the resulting budget pressure was borne by reducing spending on other items and health programmes. Figure 8 shows shifts in the composition of spending by provincial health departments over the last decade. As already noted, the wage bill remained stable as a share of spending because rising pay was offset by stagnating headcounts.

[10] OSDs were agreed in collective bargaining in 2007, creating revised salary structures that are unique to each recognised occupation in the public service.

[11] https://www.gtac.gov.za/pepa/personnel-analysis/

Figure 8: Shifts in composition of spending

Index of the share of total spending, 2011=100



Note: Based on total spending of all provincial health departments.

Source data: National Treasury (EPRE)

As treatment programmes expanded, and the national department moved to protect "non-negotiable" essential items from budget pressures, spending on items such as laboratory services, medicine, medical supplies and equipment, increased as a share of provincial health spending (see also Shezi et al., 2014). However, as the total resource envelope was growing more slowly than the needs, something had to give. The result was reduced spending on buildings and maintenance, on employing agency personnel, and transfers to municipalities and non-profit organisations. Another likely outcome was the accumulation of accrued liabilities as a means to manage budget shortfalls (see previous section).

The government health workforce

A key indicator of resource allocation in the sector is the number of workers employed by provincial health departments. During the first few years of democracy, this workforce was rationalised and then, in the decade after 2002, grew robustly, adding nearly 100 000 employees to reach 315 000 by 2013 (Figure 9). Relative to the size of the population served, between 2003 and 2012, the provincial healthcare workforce grew from a low of 534 to a peak of 724 per 100 000. After 2012, employment in the sector stagnated, falling to a low of 634 per 100 000 in 2018 – but, as discussed below, the workforce began to grow again from 2019.

Figure 9. Employees of provincial health departments

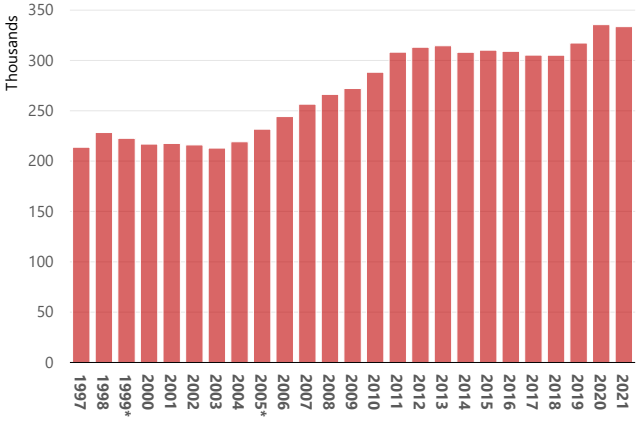
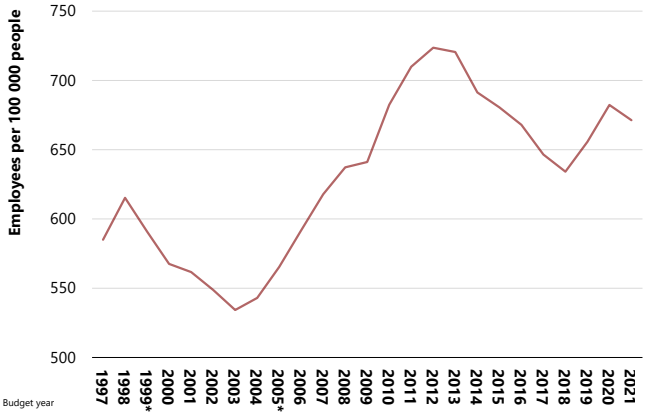


Figure. 10 Employees per 100 000 users



More than half of healthcare workers are in Gauteng, KwaZulu-Natal and the Western Cape, and a large share are employed in the Eastern Cape and Limpopo (Figure 11). Nurses account for around 45% of employees, a figure which has been stable for a decade (Figure 12). Other clinical professionals (doctors and allied healthcare workers on OSDs) account for a rising share of employment. Despite this, many critical posts have been left vacant due to budget pressures. In addition, the number of auxiliary employees, which include administration staff and essential workers, such as cleaning staff, laundry staff, porters and food service staff in hospitals, fell in absolute terms, at least until 2018.

Figure 11: Employees by province (2018)

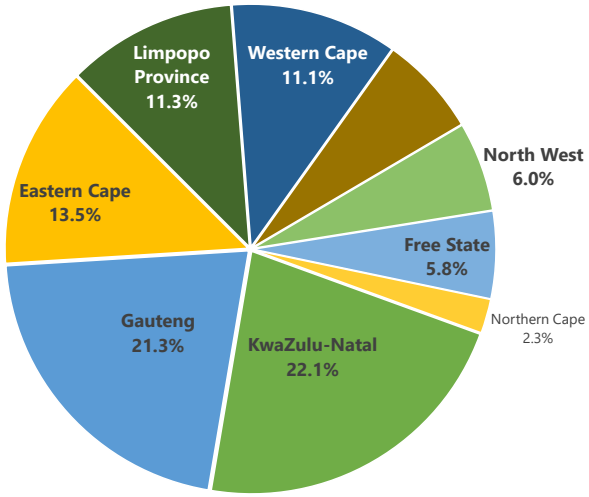
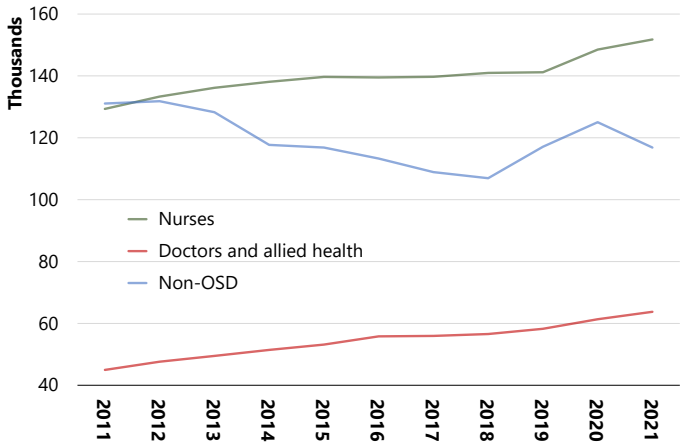


Figure 12: Employees by professional type



Source data: PERSAL, GTAC–PEPA[12]

These patterns reflect a decade-long commitment to protecting "critical posts". While this is commendable, the fall in non-OSD staff is a serious concern for the provision of quality healthcare.

> [I]t is difficult to distinguish between critical and non-critical posts in the healthcare system because a range of skill sets is required to provide a good service. For example, cleaners play a vital role in ensuring that facilities comply with good hygiene practices which reduce the risk of hospital-acquired infections. (National Treasury 2021: 77)

Similar points could be made about porters, administrators and a range of other non-clinical staff who are essential to ensuring the effective running of a healthcare service facility.

As can be observed in both Figure 9 and Figure 12, since 2018, employment in the sector has increased, with the addition of 28 000 (mainly non-OSD) employees to the payroll. Interestingly, the increase in healthcare employment began in 2019, before the onset of the Covid-19 pandemic. We suspect that a large part of this increase (especially in non-OSD staff) reflects the transfer of community health workers (CHWs) onto the government's payroll system. CHWs numbered more than 50 000 in 2019 and are essential elements of the primary healthcare (PHC) system (National Treasury, 2021). The national DoH is working to permanently engage these contract workers, including them in collective bargaining arrangements. This approach is strongly supported by unions, and provincial departments are already acting to bring CHWs onto government's payroll.

[12] https://www.gtac.gov.za/pepa/personnel-analysis/

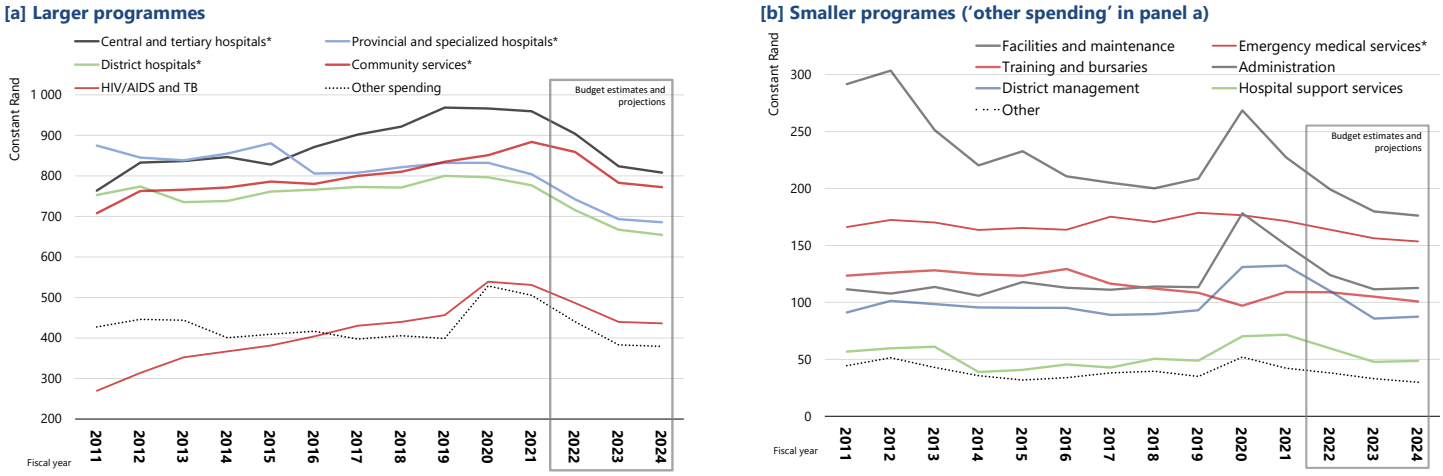
Another factor behind the growth in headcounts was the employment of temporarily contracted staff during the Covid pandemic. The most recent budget assumes that these staff – or at least a large proportion of them – will be let go. However, this assumption will be tested over the medium to long term, as provinces battle both shortages of clinical staff and a surplus of unemployed trained personnel. Moreover, national health policy supports a large expansion of employment to meet sufficient levels of clinical, professional and nursing staff. Given that the national DoH (2020: 19) has acknowledged that "the shortfall in essential health workers will worsen by 2025 if health workforce expenditure only increases in line with inflation", it is likely that some proportion of contract staff will have their contracts renewed or be absorbed into permanent establishments.

Programme spending

The previous sections looked at spending by economic input (i.e., salaries, goods and services etc.). Similar patterns are visible through the lens of **programme spending** (Figure 13). In recent times, spending on central hospitals, HIV/AIDS and community-based PHC services has improved in real terms. However, spending on facilities, maintenance and training has fallen. Allocations to district hospitals, especially provincial and specialised hospitals, **fell in real terms**, and these hospitals are most likely to carry the burden of fiscal consolidation over the next few years.

Figure 13: Health spending by programme

Real spending per uninsured person | Total spending of all provincial health departments



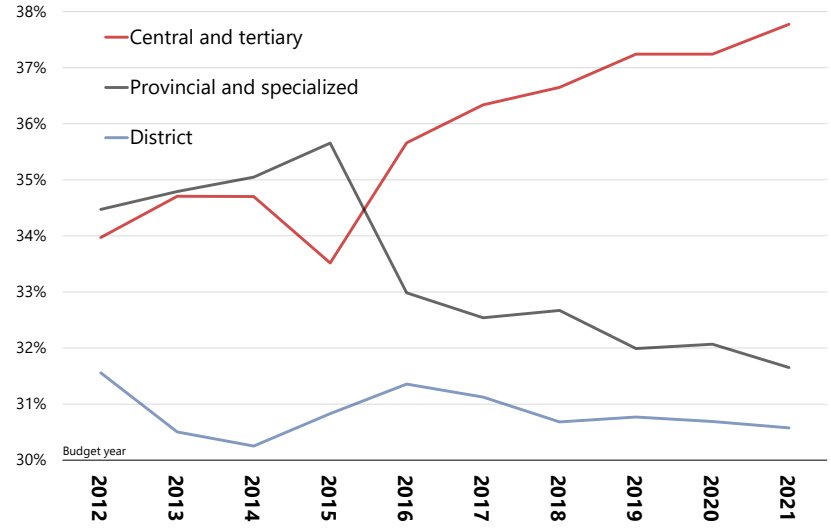
* Includes facilitates and maintenance programme spending

Source: National Treasury EPRE data, Public Economy Project Calculations

Figure 14 starkly illustrates the plight of specialised and provincial hospitals. As spending pressures in central hospitals have grown, provincial and specialised hospitals have seen a sharp decline in their share of hospital spending. District hospitals have retained about a third of hospital spending.

Figure 14: Hospital spending

[% share of provincial hospital spending spending by hospital type]



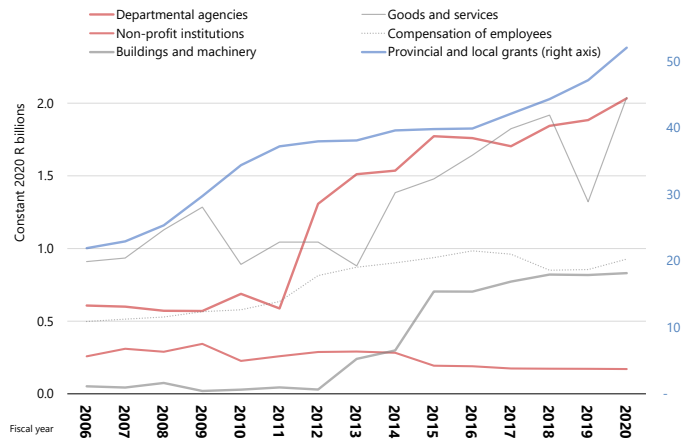
Source: National Treasury EPRE data, Public Economy Project Calculations

Note: "District hospitals" reflect hospital spending only and does not include community services and other elements of PHC.

Most of the *national* DoH's budget is allocated as conditional grants to provinces. Preparation for National Health Insurance (NHI) has meant the creation of new public agencies, and the changing emphasis of the department's budget, which is visible in Figure 15.

Figure 15: National Department of Health

[Spending in constant 2020 R billions]



The creation of the Office of Health Standards Compliance and the South African Health Products Regulatory Authority has driven the increase in transfers to agencies. While Figure 15 shows transfers to public entities from the budget, Table 1 shows total spending of the entities, which in several cases have their own sources of revenue. The NHLS is a case in point. Although far higher than those of other entities, its spending and employment levels are largely financed by payments for hospital-based laboratory tests made from provincial budgets. The forthcoming establishment of the National Public Health Institute of South Africa and the NHI Fund will create new pressures for the funding of entities.

Table 1: Total expenditure and employment of public entities and national DoH (2011−2021)]

Total expenditure

R million	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
National Health Laboratory Services	3 712	5 031	5 789	5 960	6 686	9 428	7 043	8 012	8 673	11 809	10 915
Medical Research Council	581	577	728	754	902	1 029	1 174	1 193	1 195	1 240	1 505
Council for Medical Schemes	90	99	110	125	131	139	146	180	203	185	186
Compensation commissioner	148	153	145	166	172	175	195	200	293	456	288
Office of Health Standards Compliance		24	31	33	89	101	126	137	154	133	158
South Africa Health Products Regulatory Authority								200	230	292	358
National Department of Health*	1 678	2 379	2 737	3 359	4 080	4 515	4 854	5 230	4 909	6 004	12 947
Total	**4 530**	**5 885**	**6 802**	**7 038**	**7 981**	**10 872**	**8 683**	**9 923**	**10 747**	**14 115**	**13 409**

**Excluding transfers to provincial and local govt*

Total employment

Number of employees	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
National Health Laboratory Services	7 250	7 134	7 174	7 286	6 987	7 443	7 615	7 813	7 691	8 632	8 632
Medical Research Council	848	865	607	578	571	571	640	639	664	628	628
Council for Medical Schemes	92	98	98	102	109	109	109	109	120	128	129
Office of Health Standards Compliance	51	96	108	137	127	115	129	129	129	129	129
South Africa Health Products Regulatory Authority									230	276	290
National Department of Health	1 293	1 378	1 842	1 884	1 776	1 694	1 509	1 468	1 488	1 484	1 410
Total	**8 241**	**8 193**	**7 987**	**8 103**	**7 794**	**8 238**	**8 493**	**8 690**	**8 834**	**9 793**	**9 808**

Source: National Treasury ENE data, Public Economy Project Calculations

FUNDING FOR PROVINCIAL HEALTHCARE SPENDING

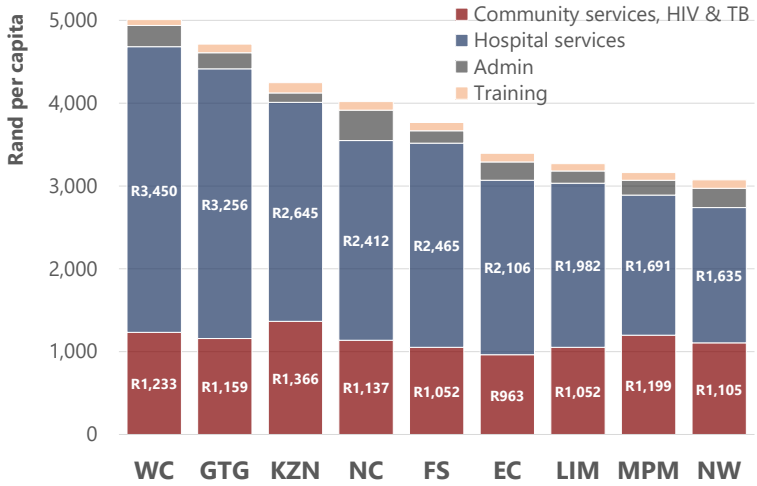
Provincial legislatures fund the vast bulk of government healthcare in South Africa from unconditional grants (i.e. the provincial equitable share) but provincial allocations to healthcare vary. Figure 12 shows healthcare spending by province in absolute terms.[13] PHC allocations are relatively even across the provinces, ranging from R956 (Eastern Cape) to R1,370 (KwaZulu-Natal) per person, for primary care, community services and combating HIV and TB. The main driver of the differences in healthcare allocations among provinces is the intensity of hospital services, which are expensive to operate and are experiencing rapidly rising costs. Most of tertiary healthcare services are found in the Western Cape, Gauteng and KwaZulu-Natal. The allocation of resources across provinces accommodates these facts.

Provinces with large academic hospitals allocate a greater share of their total budget to healthcare (Figure 16). Nevertheless, over the last decade, **healthcare has absorbed a rising share of the budget in all provinces** (Figure 17). This trend is especially pronounced in Gauteng, while in the Western Cape the share has been stable, but high.

[13] It shows the average current 2017−2019 annual spending per risk-adjusted, uninsured person.

Figure 16: Healthcare spending by province

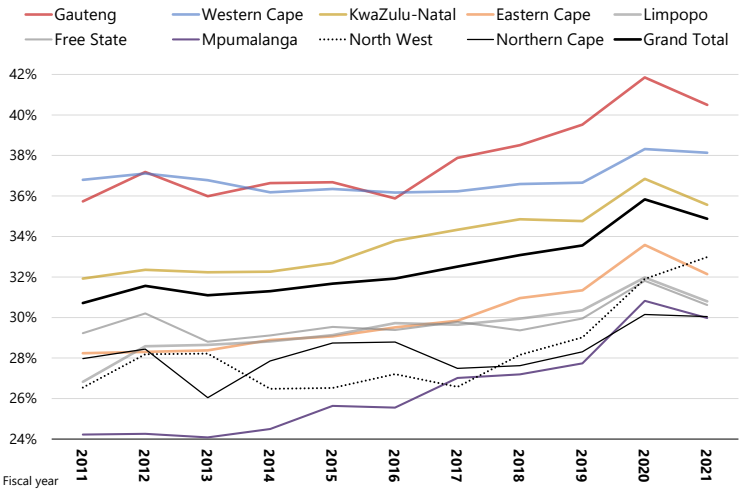
Absolute spending per capita



Source: National Treasury EPRE data, Budget Review, Public Economy Project Calculations

Note: Shows average nominal spending on healthcare between 2017–2019 per risk-adjusted, uninsured population. Risk-adjusted uninsured population is calculated by applying risk weights from the 2022 budget to estimates of uninsured population used to calculate the provincial equitable share. Admin includes district management services, Hospital services includes district, provincial, specialised and central, hospital support services (laundry, food etc.) and related facilities and maintenance spending.

Figure 17: Healthcare as a % of total provincial spending



Source: National Treasury EPRE data, Budget Review, Public Economy Project Calculations

Provincial budgets are financed from nationally collected revenue through an equitable share (which is unconditional) and several conditional grants.[14] Over the last decade, conditional grants have been stable as a share of provincial spending on healthcare, but the composition of grant funding has changed considerably. Funding for district programmes (community services and combating HIV and TB) has increased substantially, while grants for tertiary services and infrastructure have been given lower priority (Table 2).

This has meant that primary and district services (i.e., programme 2) are increasingly financed from conditional grants (Figure 13, left-hand panel). As noted earlier (Figure 9), district hospital funding has been stagnating, while spending on community services, HIV/AIDS and TB has increased. The conditional grant for district programmes (and its predecessors) ringfences the resources that are largely spent on medicines, laboratory testing and other activities closely related to the provision of drugs (including HIV testing and anti-retroviral therapy). Therefore,

[14] Conditional grants are voted on by (national) parliament, while provincial legislatures appropriate funds from the equitable share to finance healthcare and other provincial mandates.

other elements of programme 2 – particularly district hospitals – may be under pressure, as provinces' own resources (including the equitable share) are shifted to address the rising demands of operating central hospitals.

Table 2: Conditional grants to provincial health departments

												MTEF estimates		
R billions	**2010**	**2011**	**2012**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
District programmes	6.1	7.5	8.8	12.3	13.7	15.3	17.6	20.1	22.2	27.0	27.8	29.0	26.9	28.1
Tertiary services	7.4	8.0	8.9	10.2	10.4	10.8	11.7	12.4	13.2	14.0	13.7	14.3	14.0	14.7
Health infrastructure	3.6	5.9	6.1	5.5	5.4	5.3	5.7	6.1	6.3	6.3	6.4	6.8	7.1	7.4
Health human resources	1.9	2.0	2.1	2.3	2.4	2.5	2.6	2.8	3.8	4.3	4.3	5.4	5.5	5.4
National health insurance and other	0.6	0.6	0.3	0.1	0.1	0.1	0.0	0.0	0.3	0.2	0.3	0.7	0.7	0.7
Total	**19.4**	**24.0**	**26.1**	**30.4**	**31.9**	**34.0**	**37.6**	**41.4**	**45.9**	**51.8**	**52.5**	**56.3**	**54.2**	**56.2**
Share of total:														
District programmes	31.1%	31.2%	33.6%	40.5%	42.8%	45.0%	46.8%	48.6%	48.4%	52.1%	52.9%	51.6%	49.6%	50.0%
Tertiary services	38.1%	33.5%	34.1%	33.5%	32.5%	31.9%	31.1%	30.0%	28.7%	27.0%	26.1%	25.4%	25.9%	26.1%
Health infrastructure	18.4%	24.7%	23.4%	18.1%	17.0%	15.5%	15.1%	14.6%	13.8%	12.2%	12.3%	12.1%	13.1%	13.1%
Health human resources	9.6%	8.2%	8.0%	7.6%	7.4%	7.3%	7.0%	6.7%	8.4%	8.3%	8.2%	9.7%	10.1%	9.6%
National health insurance and other	2.9%	2.5%	1.0%	0.3%	0.2%	0.3%	0.0%	0.0%	0.6%	0.5%	0.5%	1.2%	1.3%	1.3%
Provincial healthcare spending	**111.3**	**122.5**	**130.7**	**140.9**	**154.1**	**166.1**	**180.8**	**195.4**	**210.9**	**231.5**	**242.8**	**238.8**	**230.9**	**240.5**
Conditional grants as a share of total	17.5%	19.6%	20.0%	21.6%	20.7%	20.5%	20.8%	21.2%	21.7%	22.4%	21.6%	23.6%	23.5%	23.4%

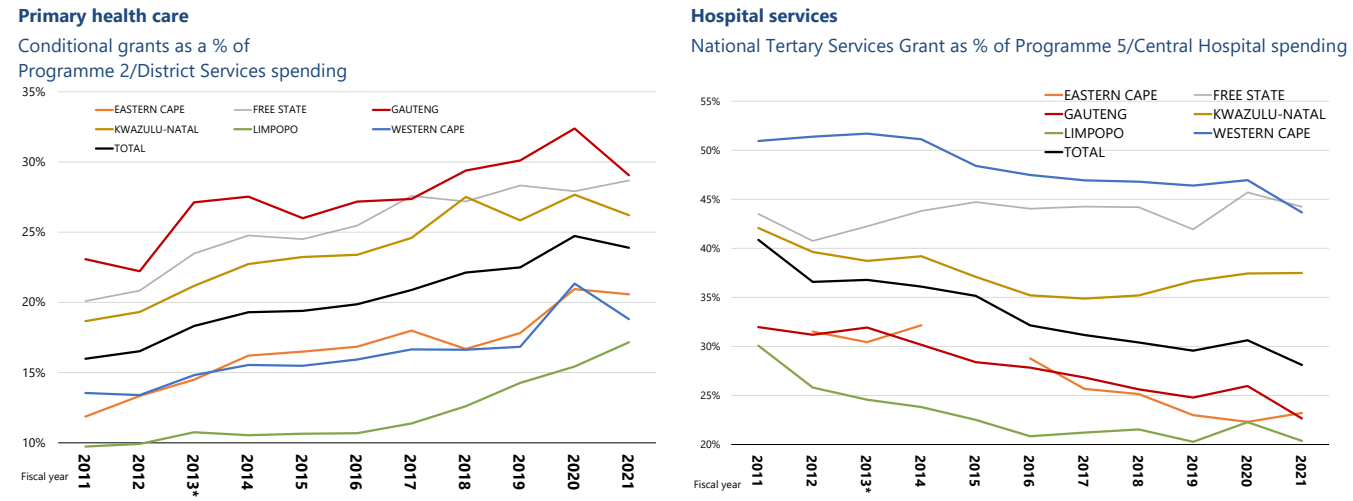
Spending on hospitals: A question of shifting priorities

Over the last decade, in contrast to district services, conditional grant funding for central hospitals has declined as a share of hospital spending (Figure 18, right-hand panel). In other words, central hospitals have increasingly relied on the equitable share to finance their expanding needs. These needs are (in absolute terms) considerably larger than the resources devoted to primary care (as illustrated in Figure 12). Moreover, patients continue to use central and provincial hospitals to access care across the spectrum, from primary to tertiary services, while the use of primary services is low in many areas (UNICEF-SA, 2022). National policy seeks to promote cost-effective PHC services delivered close to communities and households, and centred around health promotion, prevention and community involvement. This is intended to prevent unnecessary hospital-based care, which is traditionally a largely curative, high-cost care model.

Nevertheless, many cost pressures are felt most directly and acutely in hospital services. National government can negotiate centralised contracts for the medicines financed from its conditional grant allocations, and laboratory costs can be held down by absorbing some of the pressure on books of the NHLS, if required. However, hospital services require high-skilled and clinical employment, and national government has regularly agreed to above-inflation, cost-of-living adjustments (even for the highest paid specialists and consultants). This has led to a rapid cost escalation of hospital services, which national government has not fully funded, leaving provinces with little choice but to allocate additional resources out of the equitable share. Hospitals also have diverse contracts and procurements from private sector and overseas suppliers of machinery, equipment, and pharmaceuticals. Here again, cost pressures are difficult to contain, even setting aside the ample margin added for waste and corruption.

As a consequence of all these factors, provinces that are home to large central hospital-academic complexes are forced to allocate an increasing share of their budget to these hospitals or curtail services. The resulting fiscal squeeze leads to neglected maintenance and training, and the accumulation of unpaid invoices. Provinces have also been forced to squeeze spending on provincial, specialised and district services, to ensure that central flagship hospitals continue to receive the bare minimum of sufficient resources.

Figure 18: Conditional grant funding of programmes



Source: National Treasury EPRE and conditional grants data, Public Economy Project Calculations

Recent changes to the funding frameworks

The equitable share allocated to each province is determined by a formula, which takes account of spending pressures in basic education and healthcare. However, **the equitable share formula is a mechanism to divide revenue fairly, not a mandate for the composition of spending.** This is shown by the fact that 25% of the formula is unrelated to any specific policy function, being determined by the province's share of population, extent of poverty and regional gross domestic product, in addition to an institutional component that is divided equally among provinces. Therefore, it is not possible to identify a level of spending on healthcare (or any other function) that is specifically mandated or warranted by the formula. Indeed, this is the very essence of an *unconditional* grant.

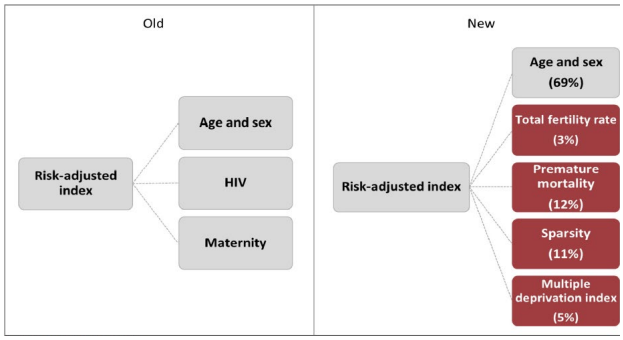
Nevertheless, the health component of the formula has a weight of 27% and is determined by:

- The number of uninsured people living in each province.
- A "risk-adjustment index" which accounts for each province's health profile, the burden of disease and the cost of delivering services.
- Indicators of workload facing the healthcare system: primary health visits and hospital patient-day equivalents.

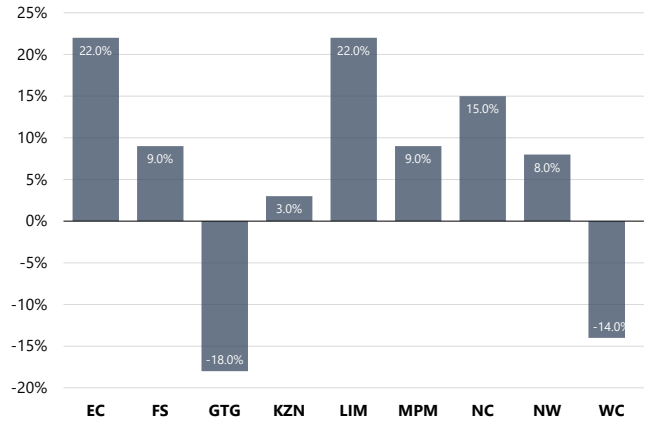
In the 2022 budget, the risk-adjustment index was amended to use five variables (Figure 18). HIV has been removed as a standalone variable because it is so strongly correlated with indicators of age, sex and premature mortality. HIV treatment and other services are also largely financed from direct conditional grants. The new approach shifts resources away from provinces with the largest concentration of tertiary services. Under the old formula, provinces such as Gauteng and the Western Cape got an upwards adjustment due to risk factors (i.e., they got more than the weight implied by their share of the uninsured population), but the new formula reverses this. Figure 19 shows how provincial weights have been adjusted in the new formula. Rural provinces with intensive primary services are given greater weight, while urban provinces have seen their allocations fall. Taken together with the rising share of hospital costs financed out of the equitable share and the fall in National Tertiary Services Grant funding (as discussed in the previous section), these developments may point to hospitals facing further resource constraints.

Figure 19: Changes to the risk-adjustment index in 2022 budget

Components of the index



Change to %-point weighting of the health share as a result of the new formula



Source: National Treasury, Explanatory Memo to the Division of Revenue, 2022

The formula also takes account of hospital workload measures, which represent 20% of the weighting. Taken together, the share of resources is shifted away from the Western Cape and Gauteng but not to the full extent of risk-adjustment reweighting alone (see Figure 19). The change is also being introduced gradually over the next three years.

Table 3: Health component of the equitable share

	Risk-adjusted uninsured population	Workload		Weighted shares		
		Primary	Hospital			
Weight:	*75.0%*	*5.0%*	*20.0%*	2021 MTEF	2022 MTEF	Change
Eastern Cape	12.4%	13.8%	13.3%	12.2%	12.7%	0.5%
Free State	5.3%	4.5%	6.6%	5.4%	5.5%	0.2%
Gauteng	23.4%	17.7%	23.2%	24.2%	23.1%	-1.1%
KwaZulu-Natal	20.1%	23.8%	21.9%	20.6%	20.7%	0.1%
Limpopo	10.4%	12.0%	9.2%	9.9%	10.3%	0.4%
Mpumalanga	8.1%	7.7%	5.8%	7.4%	7.6%	0.2%
Northern Cape	2.2%	2.3%	1.8%	2.1%	2.1%	0.0%
North West	7.3%	6.3%	5.0%	6.8%	6.8%	0.0%
Western Cape	10.7%	11.9%	13.1%	11.4%	11.2%	-0.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

The 2022 budget also made changes to the HIV, TB, Malaria and Community Outreach Grant, which was restructured and renamed the District Health Programmes Grant (DHPG). The eight individually ringfenced elements of the grant,[15] have been reduced to only two components, to reduce administration and enable more flexibility in shifting resources between constrained budgets. The two components are now:

- The comprehensive HIV/AIDS component (made up of former HIV/AIDS and TB components)
- The district health component (made up of malaria, community outreach services, HPV vaccines and Covid-19 components)

The mental health and oncology components of the old grant were shifted to the NHI Grant.

[15] The eight components were HIV/AIDS, TB, HPV vaccine, community outreach services, malaria, mental health, oncology and Covid-19 vaccination

The budget also allocated approximately R1 billion per year to the HR and Training Grant, to augment funding for medical interns and community service doctors, where there were shortfalls due to the increasing number of medical graduates both returning from Cuba and at domestic medical schools.

DISCUSSION

The following broad conclusions emerge from this review of public finances in South Africa's healthcare system.

1. Waste and financial maladministration remain a central problem at every level of the public healthcare system, with significant and material consequences for resource availability and service delivery. Perhaps due to the size and heterogeneity of its procurement activities, the health sector appears to suffer particularly badly from these maladies. Recent revelations – for instance in relation to Covid procurement and the Tembisa Hospital – underscore that the sector has not yet implemented clear, decisive and systemic efforts to confront corruption and maladministration, despite the Presidential Health Compact's intentions and the national DoH's administrative initiatives.

2. Fiscal constraints have meant deliberate efforts to limit the increase in compensation spending, and so the wage bill has remained stable over the last decade. Between 2008 and 2012, the implementation of the OSD saw a substantial gain in pay for government healthcare workers. Since then, average pay has increased at about 2% faster than the consumer price index, in line with trends in the broader labour market (Sachs et al., 2023). In the late 2000s, the budget accommodated increased pay and a workforce that grew at a moderate pace (in line with the population serviced). However, since 2012, efforts to contain compensation spending have meant that higher pay has been accommodated at the expense of headcounts, which were flat for a decade prior to the Covid pandemic. Government employment of healthcare workers has fallen relative to the population served, increasing the burden on the existing workforce and undercutting the goals of the National Human Resources for Health policy. The employment of nurses has been stable and clinicians have increased at a moderate pace. Nevertheless, in both cases, increased employment has fallen short of demand, and there is widespread concern about the impact of unfilled clinical and nursing posts on services. The constraints on compensation spending are also reflected in falling numbers of auxiliary workers (i.e., porters, cleaners, administrators and other non-clinical staff), which also have serious consequences for the quality of services.

3. Budget limits have forced a broader set of trade-offs. The sector has protected spending on critical laboratory services, medicine, medical supplies and equipment. Community-based treatment for HIV/AIDs has been ringfenced as a conditional grant, and funding for these services expanded considerably. However, these gains have crowded-out spending on buildings and maintenance, the employment of agency personnel and transfers to municipalities and non-profit organisations. Fiscal constraints are also reflected in the squeeze on provincial and specialised hospitals (a category that includes mental health facilities).

4. Over the last decade, health spending has absorbed a rising share of provincial spending. In Gauteng, health has the largest share of the budget, having overtaken basic education. In the Western Cape, the share has been stable but high. Conditional grants have financed

a declining share of hospital spending, and so hospital services are increasingly financed from the equitable share because the rising costs associated with running hospitals must be met. The resulting fiscal squeeze has contributed to the neglect of other items financed from the equitable share, such as maintenance and training, and to the accumulation of unpaid invoices. The problem of accruals in the health system is at least in part a reflection of these fiscal limits. While financial management weaknesses exacerbate the problem, accruals are to some extent a hidden deficit in the health budget. Provinces have also been induced to squeeze spending on provincial, specialised and district services to ensure that central flagship hospitals continue to receive the bare minimum of sufficient resources.

5. The distribution of financial and human resources across provinces largely reflects the concentration of hospitals (especially tertiary hospitals) in urban areas. While resources for PHC are evenly allocated and targeted through conditional grants, tertiary healthcare services are found largely in the Western Cape, Gauteng and KwaZulu-Natal and are increasingly funded out of the equitable share. The allocation of resources to healthcare across provinces reflects this fact. However, a key element of government policy is to extend large academic hospitals to more provinces (Sachs et al., 2023b). This is highly likely to raise the overall cost base of hospital spending even more into the years ahead, straining hospital budgets further.

6. In line with the recommendations of the Presidential Health Compact, the equitable share formula for healthcare was adjusted in the 2022 budget to improve equity. This is likely to exacerbate the squeeze on urban provinces that finance hospital and tertiary services, in favour of PHC and community-based operations. Conditional grants for district services and communicable diseases have also been streamlined.

CONCLUSIONS

Healthcare involves heterogeneous and complex set of budgets and expenditures. A huge variety of institutions and professions are organised into a complex system that provides a multiplicity of goods and services to populations with diverse needs, arising from varying burdens of disease and health risks. As rising unemployment and economic stagnation have taken their toll, increasing numbers of South Africans depend on the government healthcare system.

The national DoH and National Treasury have taken important first steps to review the equitable share formula and the structure and distribution of resources through conditional grants to provinces. This has arguably led to greater equity that will be implemented gradually over the Medium Term Expenditure Framework period. Further reviews of conditional grant frameworks are under way.

The budget has not accommodated a combination of fiscal constraints and budget shortfalls, which are eroding the capabilities of the public healthcare system in South Africa, contributing directly to falling levels of service provision.

Given that the resource envelope for healthcare is likely to continue to decline further in the years ahead, it is doubtful that the plans laid out in the Presidential Health Compact to strengthen the South African health system will be adequately resourced.

In a context of widespread financial mismanagement and binding fiscal constraints, the costs of providing public healthcare are strongly concentrated in the hospital system, and these costs are putting incessant upward pressure on budgets. Additional resources would be available across the system in an expanding economy with rising national income, but in the foreseeable future South Africa will face binding fiscal constraints. Therefore, only by tackling this central question of hospitals in the health system can resources be shifted behind the PHC and community outreach, which are essential for realising health policy outcomes and almost certainly more cost effective. The solution cannot be found in allocating budgets differently. The allocation of budgets between health programmes and across provinces reflects the legacy of a hospital-based system that has not been reformed.

As South Africa moves to implement a NHI framework, government hospital services are absorbing a rising share of resources, but nevertheless appear to be under severe fiscal pressure. If central and specialised public hospitals are to be funded directly from a national centre (such as an NHI Fund), the problem of rising costs in a deteriorating service platform will be felt even more acutely. NHI funds shifted from equitable share to a central pool will still be committed against the real demands imposed by operating the health system. The rising costs of hospital spending will dominate calls on these funds, and it is not clear how these funds can be redirected towards purchasing healthcare services from both public and private providers, as envisaged in the NHI reform proposals. Shifting the equitable share into a centralised NHI fund will not create the fiscal space that NHI needs to operate, as these funds will still be overcommitted against the rising pressure of spending on public hospitals. Therefore, creating fiscal space means changing the activities and operations to which these resources are dedicated. This implies that a key pillar of executing the NHI needs to be substantial institutional reforms to the governance, management, accountability and legal standing of academic hospitals. This will require negotiation and compromise between government, public entities, medical schools, clinicians and their professional associations, organised labour and the private sector.

The Presidential Health Compact provides an opportunity to address the reforms necessary to rebuild the strength of the public sector health services – and the key is to address the financial health of the provincial health departments.

ANNEXURE 1: SUMMARY OF THE PRESIDENTIAL HEALTH COMPACT'S PUBLIC FINANCE COMMITMENTS AND RECOMMENDATIONS

The compact makes commitments to address the underfunding of the public healthcare sector. While remaining within budgetary constraints, the Presidential Health Compact makes the following recommendations:

- Public policy on funding and staffing levels should reflect the needs of the health system, and the norms and standards established by national health policy.
- The moratorium on filling posts in the public health sector should be lifted. Priority should be given to critical services and ensuring that statutory requirements for internship and community service are met and resourced. A second priority is upskilling and formalising the employment status of community health workers.
- Budget allocations for essential goods and services (medicines, medical products, medical equipment and machinery etc.) should be sufficient for the need.
- Public finance managers should prioritise medical expenditures ahead of non-medical expenditures.
- The funding and management of central hospitals need to be improved, and adequate resources allocated for the training of health professionals, including specialists.
- The resources lost to rising medical litigation need to be contained, and the flow of paying patients who are members of medical schemes to public facilities increased to augment revenue. This also requires improving the revenue collection mechanisms in public health facilities.
- Better funding is needed for health entities and institutions, particularly the health ombud.
- Infrastructure resources should be reallocated from new capital projects to the maintenance and upgrading of existing facilities. Adequate funds are also needed for the maintenance of medical equipment. In the longer term, budget allocations need to be aligned with the 10-Year Health Infrastructure plan
- There must be an equitable allocation of national revenue among provinces, and that allocations by provincial legislatures to healthcare must be sufficient, resulting in equitable access to all levels of care.
- A review of fiscal instruments (the equitable share and conditional grants) is needed, looking closely at the variations across provinces, and the need to align provincial spending choices with national health policy goals.
- The flexibility in spending choices made within health departments needs to be improved.
- Spending financed from conditional grants, unconditional transfers (i.e., the equitable share) and donor funds must be integrated and aligned behind a national programme of healthcare provision and system development.
- The public finances in the public healthcare sector must be effectively managed and corruption and wastage addressed. This includes paying suppliers on time and limiting the build-up of unpaid invoices. As financial management capabilities improve, the funding of the accumulated accruals and other backlogs in provincial health finances needs to be considered.

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