Centre for Economic Governance and AIDS in Africa
Accountable, efficient use of resources for wellbeing

A review of the health and AIDS spending patterns in light of slow economic growth in South Africa

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1. Introduction

South Africa has not been spared from the impact of the recent recession and slow economic growth at the global level. The South African economic growth has also slowed, although still positive, from 3 per cent growth in 2011/12 to an estimate rate of 2.5 per cent in 2012/13. This will affect trends in resource allocation for social services meant to benefit South Africans who depend on the public sector for essential services. Constitutionally, the government should do its optimal best within its power and available resources to provide acceptable and quality public services such as health, education and social development. As expected, the government should develop sound policies and budgets, and put in place proper systems and processes for the delivery of the right to health to the citizens. Similarly already allocated funds need to be spent wisely, to ensure that the state achieves its goals with restricted resources. Spending efficiency is of optimal importance, coupled with effectiveness in achieving government's promises to the people.

This brief provides a snapshot analysis of the 2012 Medium Term Budget Policy Statement (MTBPS), the Mid-Year Health Spending Update, and trends in the provincial allocations for health and HIV and AIDS, thus providing a snapshot of what can be expected in the 2013/14 - 2015/16 medium term budgets.

2. Economic growth and public expenditure

The 2012 MTBPS provided a clear picture of the compromised international and domestic financial situation due to the recent recession, with the South African government's plans to navigate through this era of uncertain economic recovery. The government still sees some opportunities for progressive growth in its economic and social affairs, despite the weak economic growth. This is depicted in the estimated real growth of GDP from 2.5 per cent in 2012/13 to the promising 3 per cent and 3.8 per cent real growth estimates in 2013/14 and 2015/15 respectively (MTBPS 2012; page 5). On the public finance side, whilst there have been increases in a few priority spending areas identified in Budget 2012, such as in infrastructural investments and HIV and AIDS interventions, the 2012 MTBPS and Adjusted Estimates of National Expenditure (AENE) warned of strict financial controls to save money and to use savings on new or insufficiently funded priorities. This indicates that the public revenue cannot accommodate new expenditures due to the slow economic growth rated at 2.5 per cent in 2012/13, as compared to 3 per cent in 2011/12.

South Africa's tightening of its expenditure does not come as a surprise. Internationally, economic growth has been slowed down in both public and private sectors. The Finance Minister Mr Pravin Gordhan stated in his 2012 MTBPS speech that 'economic growth in developed countries will remain below 1.5 per cent this year and next, while developing countries will grow between 5 and 6 per cent' (MTBPS, 2012: 9), with South Africa fairing at 2.5 per cent.

Consequently the new proposed budget for the next budget term (2013/14 – 2015/16) estimates a limited growth in expenditure of 2.9% in real terms a year over the medium term. Gordhan assured the National Parliament that additional resources to support the economy will be generated from efficiency gains, savings and reprioritisation (MTBPS, 2012: 11). This indicates that the government wants to intensify its financial control measures for more efficient use of resources, and for improved control of overspending. Financial controls are important to guard against wastage of funds, but may also discourage optimistic strategic planning and budgets which would require more money for key priorities, or expanded interventions. Thus, planning will still remain constrained by tight budget ceilings, requiring departments to cut costs in some areas to make money for other under-funded areas.

As a result of the financial controls and 'saving process', there has already been R40 billion in spending reprioritized over the current MTEF period (2012/13 – 2014/15) (MTBPS 2012; page 6). A total appropriation of R969.4 billion was initially provided for total government spending for the 2012/13 financial year at the beginning of the period, however, this has been adjusted down to R967.5 billion in the 2012 Adjustments Appropriation Bill, of which 48 per cent has already been spent in the first half of 2012/13. The bill indicates that national departments have declared savings totalling R3 billion for 2012/13, for monies that will not be

spent this year. This is in line with Gordhan's call for '*greater expenditure discipline*' which has been ensured by Cabinet and their provincial executives (MTBPS Speech, 2012: 15).

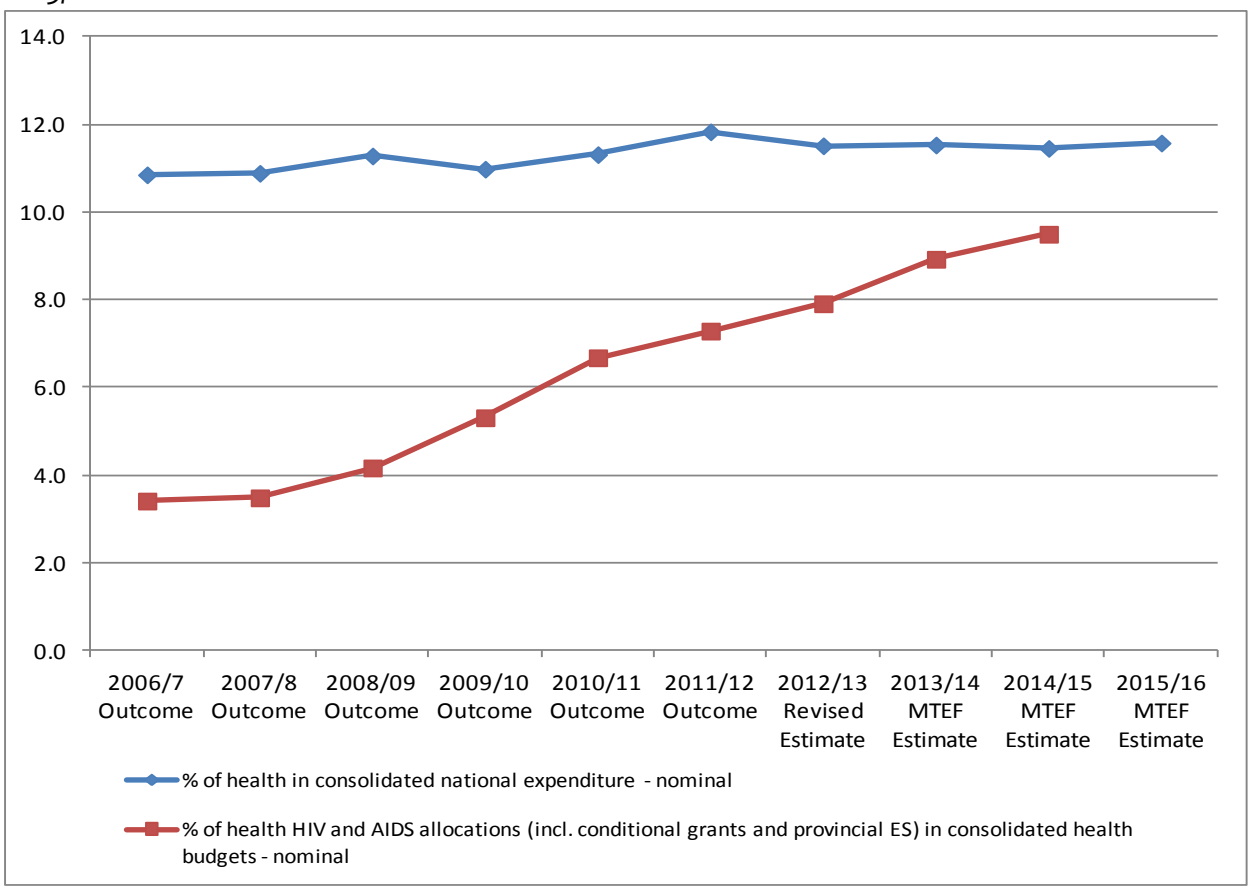
3. Health allocations and expenditure trends

The consolidated health expenditure estimates (national, provincial and local government health allocations) have grown nominally in 2012/13 by 6.7 per cent, from an actual health expenditure of R114 billion in 2011/12. The 2012/13 consolidated revised budget is estimated at R122 billion, growing further nominally by 8.7 per cent in 2013/14 to R132 billion (MTBPS 2012, page 41). However the influence of inflation on health spending cannot be ignored given the amounts that are lost to inflationary price increases involved in purchasing goods and services. Thus, in real terms, the consolidated health expenditure estimates only grew by 0.7 per cent in 2012/13 and are estimated to grow by 3.2 per cent in 2013/14.

Year-on-year, for the 2012/13 – 2014/14 medium term, the consolidated health budget receives as a share of total consolidated government budget an annual average of 11.5 per cent. This is below the Abuja Declaration recommendation that governments should spent 15 per cent of their national budgets on health. Interestingly the consolidated national and provincial health HIV and AIDS allocations grow from year to year as part of the consolidated health expenditure, despite the slow growth of the health share in the total national expenditure. See Figure 1 below.

In the medium term, the health budget prioritises improved diagnostic testing for TB, additional allocations for HIV and AIDS, and continued funding for hospitals and health infrastructure. It is commended that the health HIV and AIDS interventions will receive increased budget allocations for the medium term, but this needs to be viewed more carefully against the backdrop of capped health spending due to scarce financial resources in the public sector.

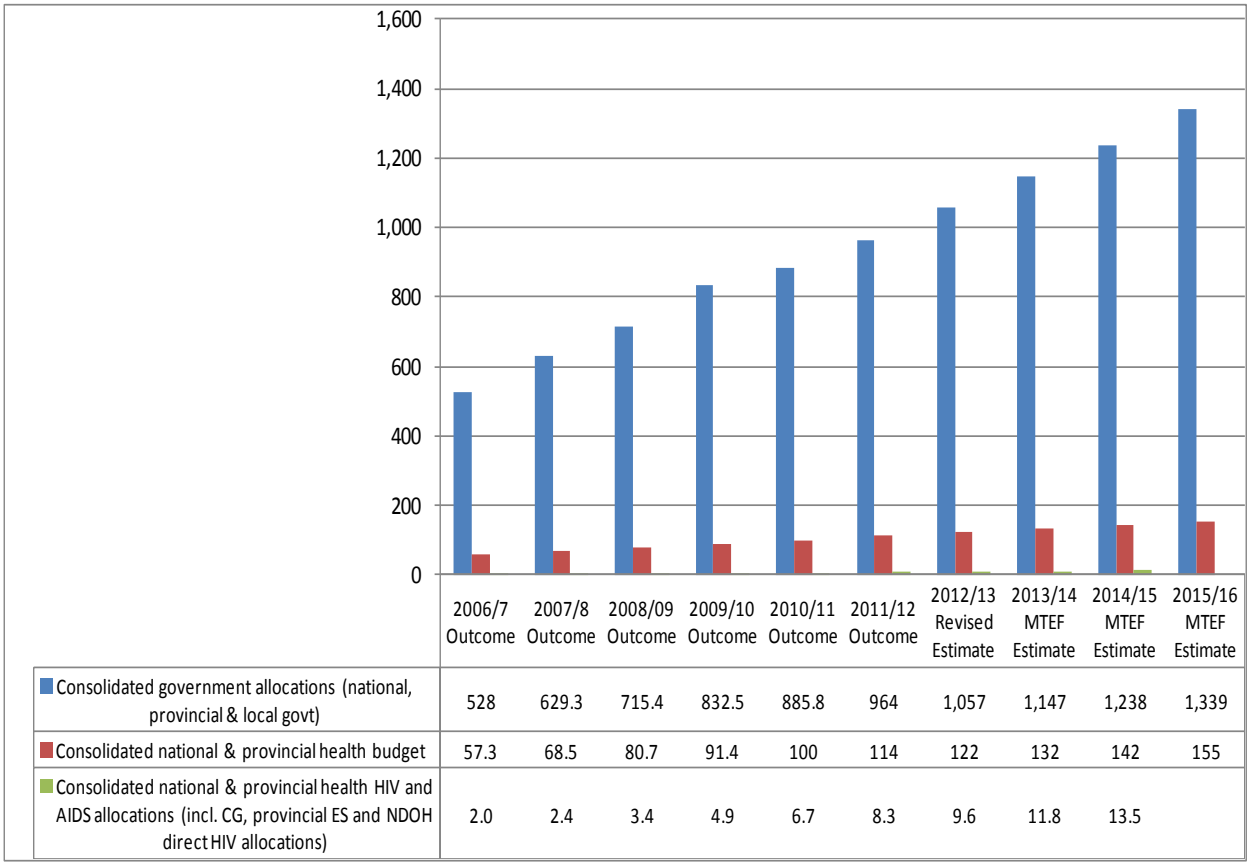
Figure 1: Per cent shares of health and HIV and AIDS in consolidated allocations (%), 2006/7 – 2015/16



Sources:
Health allocations: National Treasury 2007/8 – 2012/13 Medium Term Budget Policy Statements.
HIV and AIDS allocations: National Treasury Estimates of National Expenditure (ENE) 2009/10 – 2012/13 and Estimates of Provincial Expenditure 2009/10 – 2012/13.
Note: National Treasury has not publicised the health HIV and AIDS budget estimate for 2015/16 as yet. The 2006/7 – 2009/10 provincial figures exclude provincial discretionary allocations.

As shown below, the national health allocations grow slightly from year to year, by an annual average real growth of 2 per cent for the medium term (equating to an annual average nominal growth rate of 7.5 per cent). However, of concern is the decline in real provincial health allocations for 2012/13, where five (5) out of nine (9) provinces face a negative trend in real growth, with the Eastern Cape facing a real decline in health allocation of 8 per cent in this financial year, followed by Northern Cape and Limpopo dropping at 4 per cent and 3 per cent respectively. Mpumalanga and Gauteng also face a downward trend in real growth at 2 per cent and 1 per cent respectively.

Figure 2: Consolidated government, health and HIV and AIDS allocations (R' billion), 2011/12 – 2014/15

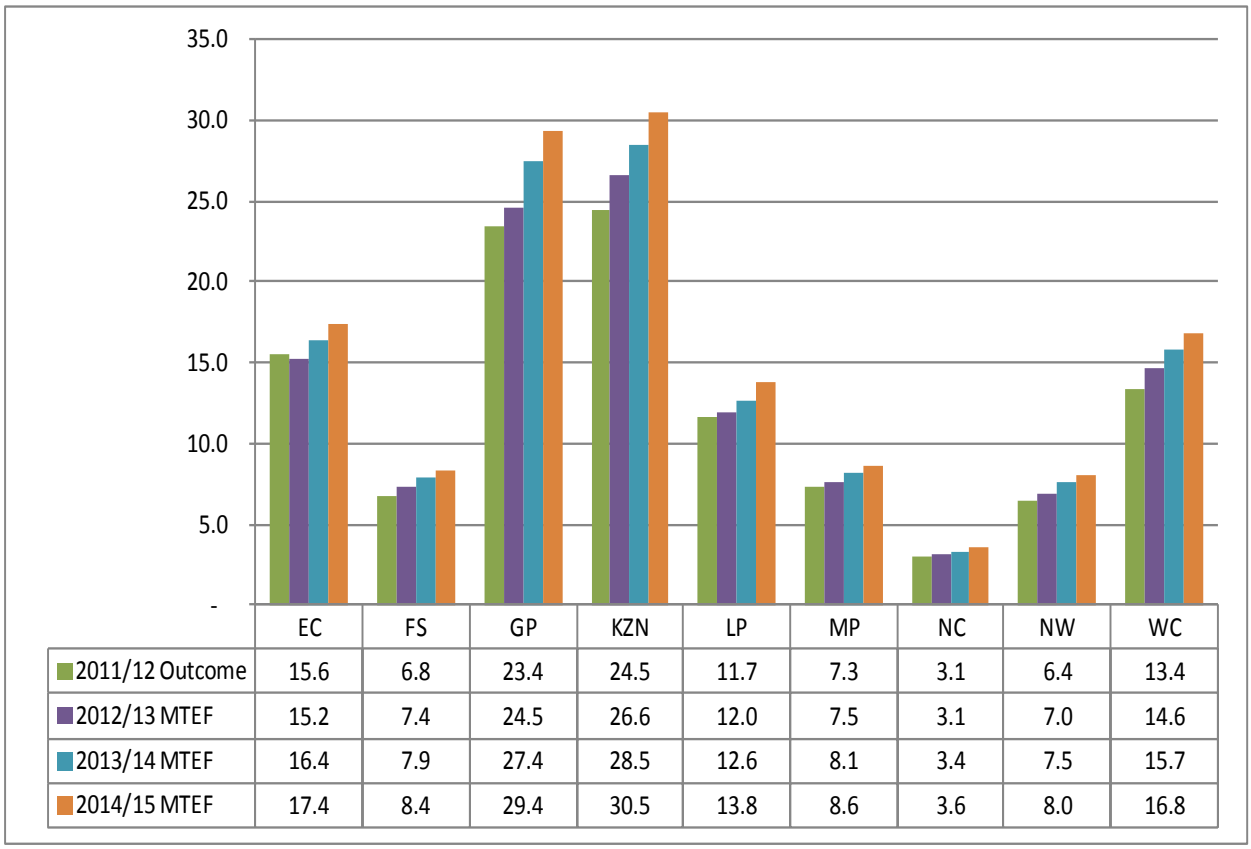


	2006/7 Outcome	2007/8 Outcome	2008/09 Outcome	2009/10 Outcome	2010/11 Outcome	2011/12 Outcome	2012/13 Revised Estimate	2013/14 MTEF Estimate	2014/15 MTEF Estimate	2015/16 MTEF Estimate
Consolidated government allocations (national, provincial & local govt)	528	629.3	715.4	832.5	885.8	964	1,057	1,147	1,238	1,339
Consolidated national & provincial health budget	57.3	68.5	80.7	91.4	100	114	122	132	142	155
Consolidated national & provincial health HIV and AIDS allocations (incl. CG, provincial ES and NDOH direct HIV allocations)	2.0	2.4	3.4	4.9	6.7	8.3	9.6	11.8	13.5	

Source: National Treasury. Medium Term Budget Policy Statement 2012; page 41; National Treasury, Estimates of National Expenditure 2012; page 332. Author's calculations.
Note: National Treasury has not publicised the health HIV and AIDS budget estimate for 2015/16 as yet. The 2006/7 – 2009/10 provincial figures exclude provincial discretionary allocations.

Overall the total consolidated provincial health budget drops by 1 per cent in real terms in 2012/13. Generally, the real decline in allocations due to inflation poses a threat of overspending on budgets by the end of the financial year, despite the existence of strict financial measures to control spending.

Figure 3: Provincial health expenditure and budget estimates (R' billion), nominal, 2011/12 – 2014/15

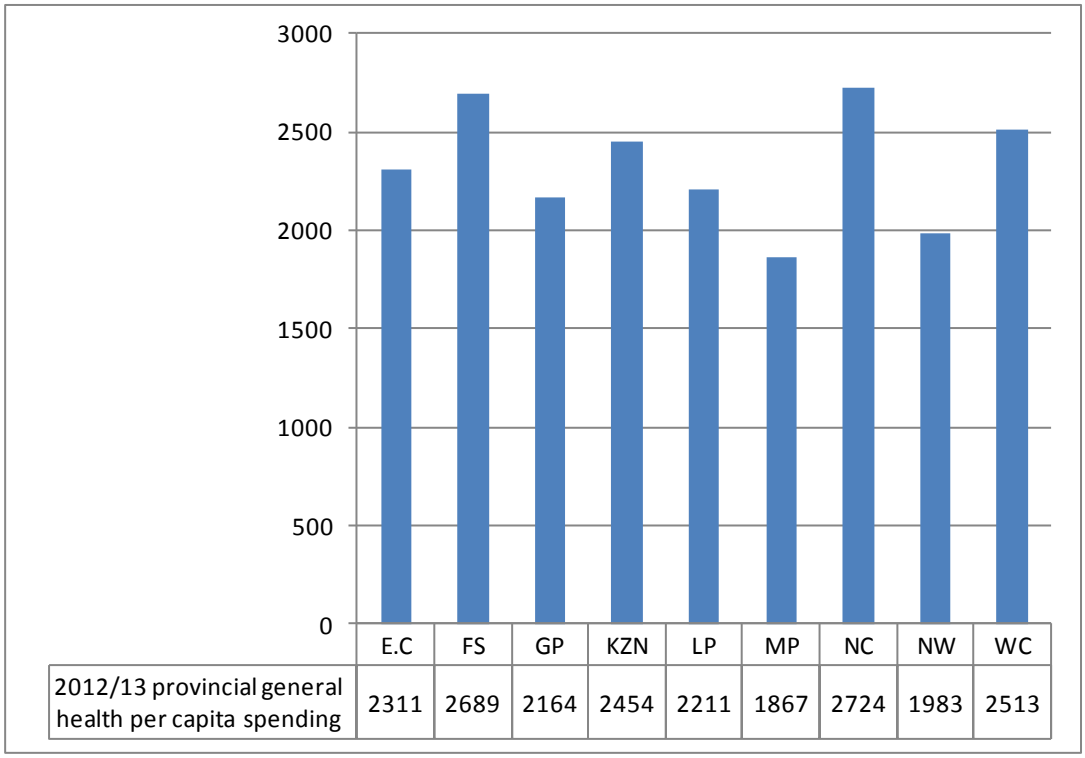


	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2011/12 Outcome	15.6	6.8	23.4	24.5	11.7	7.3	3.1	6.4	13.4
2012/13 MTEF	15.2	7.4	24.5	26.6	12.0	7.5	3.1	7.0	14.6
2013/14 MTEF	16.4	7.9	27.4	28.5	12.6	8.1	3.4	7.5	15.7
2014/15 MTEF	17.4	8.4	29.4	30.5	13.8	8.6	3.6	8.0	16.8

Source: 2012 Estimates of Provincial Expenditure. Author's calculations.

Further, provincial health per capita spending, using the 2011 Census population figures, indicates varying amounts spent per person in each province in 2012/13. Mpumalanga budgeted to spend the smallest annual amount per capita at R1,867, followed by North West at R1,983. Surprisingly Northern Cape, despite receiving the smallest share in health budgets among all provinces, spends the largest annual per capita amount on health at R2,724 followed by Free State at R2,689 per capita. Per capita spending assists us to understand what the large health budgets mean in real service delivery terms as they may imply that people receive everything they need. The picture painted by the Northern Cape per capita budget indicated that the size of the actual budget may not be of too much concern given the number of people who will be accessing it. One would have assumed that KwaZulu-Natal spends the largest amount per capita looking at the large provincial health budget, but the provincial population size determines what the province should spend, resulting in the fourth highest annual amount (R2,454) among provinces.

Figure 4: Provincial health annual per capita spending (Rand), 2012/13



	E.C	FS	GP	KZN	LP	MP	NC	NW	WC
2012/13 provincial general health per capita spending	2311	2689	2164	2454	2211	1867	2724	1983	2513

Source: 2012 Estimates of Provincial Expenditure and 2011 Census Population Statistics. Author's calculations.

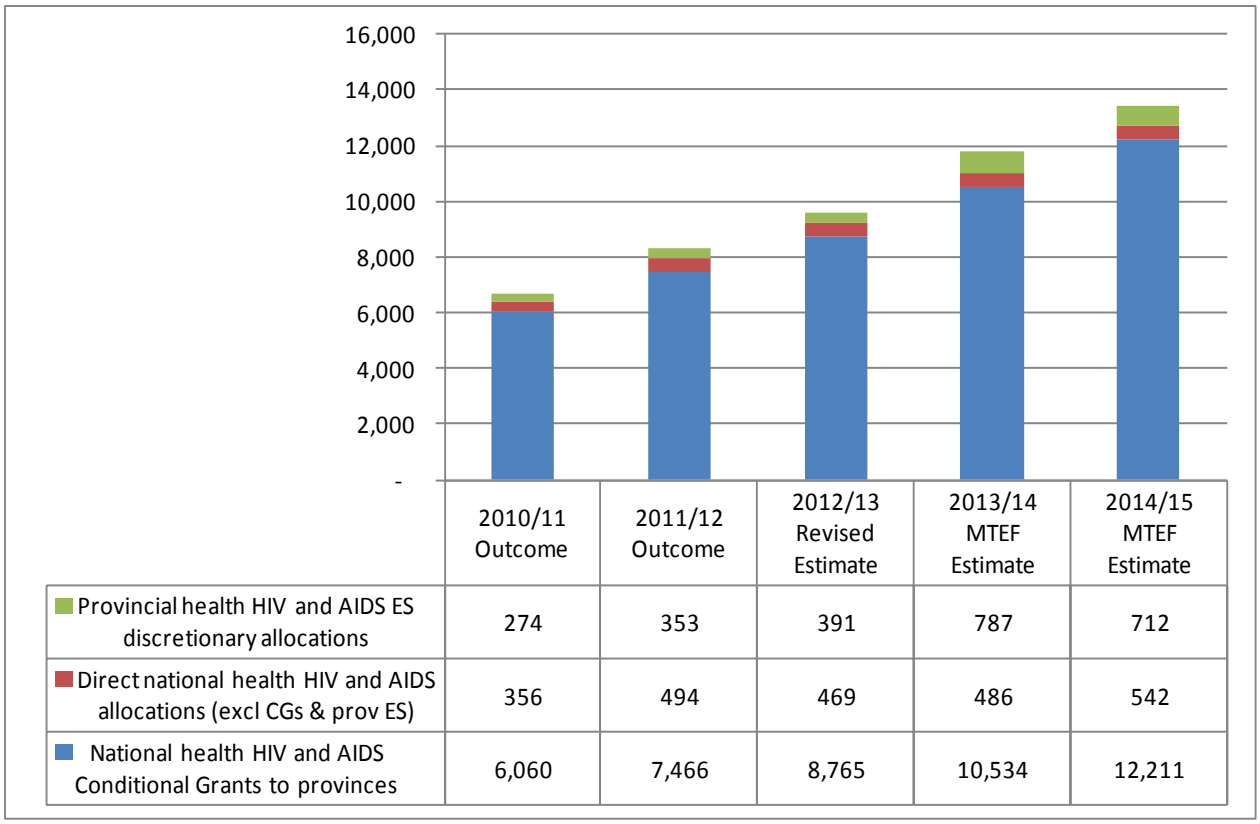
4. Update on health HIV and AIDS spending in 2012/13

The 2012 National Budget, excluding provinces' own Equitable Share discretionary allocations, saw a resource boost with R9.2 billion allocated for health-related HIV and AIDS interventions, including the conditional grants to provinces. This reflects a nominal growth in the national health HIV and AIDS budget of 15 per cent from R8 billion in 2011/12 to R9.2 billion in 2012/13. When taking inflation into account, the budget increase equates to 8.6 per cent real growth in 2012/13. The national budget is planned to increase further in the medium term (2012/13 – 2014/15), by 11.6 per cent real annual average growth rate (or 17.6 per cent nominal annual average growth rate). Provincial health discretionary Equitable Share allocations for HIV and AIDS contribute to the consolidated health HIV and AIDS budget grows an amount of R391 million in 2012/13, increasing the health spending on HIV and AIDS to R9.6 billion for the year. In 2013/14, provinces contribute R787 million for health HIV and AIDS interventions, with Gauteng and KwaZulu-Natal taking the leading in allocating additional funds from their own coffers to supplement the national health HIV and AIDS grant.

Importantly, the current adjusted budget provides increased allocations for the Comprehensive HIV and AIDS Conditional Grant (for the Department of Health) due to the

reduced US PEPFAR funding for HIV and AIDS and to allow for rising ART numbers (MTBPS 2012;page 18), and prevention and care (MTBPS 2012; page 39). Commendably the total national health HIV and AIDS allocations (including the health HIV and AIDS conditional grant to provinces, and provinces' own discretionary allocations from the Equitable Share), grew in real terms by 9.3 per cent in 2012/13 and are estimated to grow further by 16.5 per cent in 2013/14.

Figure 5: Consolidated (national and provincial) health HIV and AIDS spending in South Africa by funding mechanism (R' million), 2010/11 – 2014/15



	2010/11 Outcome	2011/12 Outcome	2012/13 Revised Estimate	2013/14 MTEF Estimate	2014/15 MTEF Estimate
Provincial health HIV and AIDS ES discretionary allocations	274	353	391	787	712
Direct national health HIV and AIDS allocations (excl CGs & prov ES)	356	494	469	486	542
National health HIV and AIDS Conditional Grants to provinces	6,060	7,466	8,765	10,534	12,211

Source: National Treasury: Medium Term Budget Policy Statement 2012/13, Estimates of National Expenditure 2012/13, and Estimates of Provincial Expenditure 2012/13. Author's calculations.

Year-on-year, the consolidated national and provincial health HIV and AIDS allocations (including the health HIV and AIDS conditional grant to provinces, and provinces' own discretionary allocations from the Equitable Share) receive as a share of consolidated health expenditure an annual average of 8.8 per cent. Specifically, the consolidated health HIV and AIDS allocations have grown as a share of the consolidated health expenditure from 6.7 per cent in 2010/11 to 7.9 per cent in 2012/13, and grows further to an estimated share of 9.5 per cent in 2014/15. Notably the growth in consolidated health expenditure as a share in consolidated government expenditure has not growth at the same speed, recording a slow growth of 0.2 per cent, from a share of 11.3 per cent in 2010/11 to 11.5 per cent in 2012/13, which remains the same until 2014/15. Figure 1 depicted this concerning trend in the

consolidated health allocations, indicating that health HIV and AIDS spending may be squeezing out other health care spending areas. Thus, consolidated health spending should grow more considerably to accommodate the increasing HIV and AIDS programme needs whilst at the same time catering for other spending areas in the health sector, such as strengthening of primary health care and boosting of human resources for health generally.

On the other side, the provincial health HIV and AIDS conditional grants combined grew in 2012/13 by 11 per cent in real terms, with the Free State budget growing by the largest 33 per cent in real terms for the year. The Free State conditional growth equates to 40 per cent growth rate in nominal terms. Despite the general provincial health budgets dropping by 1 per cent in real terms in 2012/13, the health HIV and AIDS budgets continue to grow. The question of crowding out of health spending by HIV and AIDS spending needs to be revisited, and to call for real growth in health allocations overall.

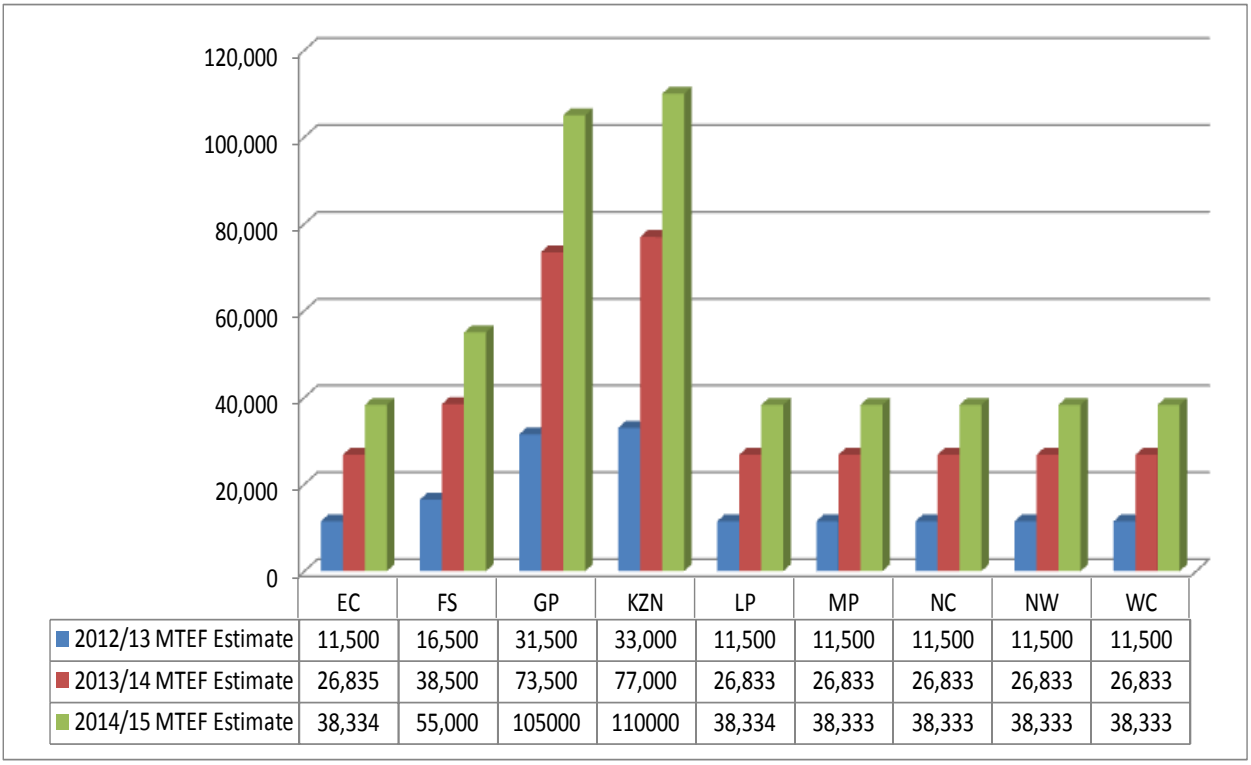
KwaZulu-Natal and Gauteng continue to receive and spend the largest and second largest HIV and AIDS funds respectively, in line with provincial needs and population size. The upward trend in HIV and AIDS allocations is commended, despite the recent call by the Minister of Finance to set strict ceilings in spending through stringent financial controls across all public sector spending. This means provinces have secured the baseline allocations as presented in the 2012/13 budgets, but there is no guarantee of massive growth in allocations beyond 2014/15, unless the economic environment improves, leading to increased public revenue.

5. Implications for the National Health Insurance (NHI)

In February 2012 the NHI pilot districts were allocated an amount of R150 million for 2012/13, R350 million for 2013/14 and R500 million for 2014/15. KwaZulu-Natal added more resources from the province's own sources, amounting to R110 million for the 2012 financial year.

The NHI pilot phase aims at achieving proper management of health facilities and health districts, quality improvement, infrastructure development, improved medical devices including equipment, strategic human resources planning, development and management, information management and systems support and more importantly the establishment of an NHI Fund to ensure that this policy decision is successful (NDoH, http://www.doh.gov.za/list.php?type=National%20Health%20Insurance).

Figure 6: NHI conditional grants (R' thousand) to pilot districts for 2012/13 – 2014/15



	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2012/13 MTEF Estimate	11,500	16,500	31,500	33,000	11,500	11,500	11,500	11,500	11,500
2013/14 MTEF Estimate	26,835	38,500	73,500	77,000	26,833	26,833	26,833	26,833	26,833
2014/15 MTEF Estimate	38,334	55,000	105000	110000	38,334	38,333	38,333	38,333	38,333

Source: National Treasury. Division of Revenue Act 2012.
Note: KZN added R110 million in 2012/13 to supplement the R33 million grant from national government, and to fund its additional pilot site added on top of the nationally selected sites.

There has been a call for more detail on what these funds would be used for, and concern as to whether the funds will be sufficient to pilot the NHI. Our budget analyses show that the NHI grant is very small as compared to the total consolidated national and provincial health spending. However this does not mean that the NHI grant spending should not be monitored closely. It is important to understand how the NHI grant would be utilised vis-à-vis all the health funds available for the general strengthening of the health sector, for better management and oversight, and for actual goods and services provided (particularly within the context of reducing health allocations in real terms).

For instance, the National Department of Health was allocated R27 billion this year for national interventions, and provincial health departments combined received R118 billion, aimed at implementing both national and provincial health priorities as defined in the government's 10 Point Plan 2009 – 2014. These include, *inter alia,* the implementation of the NHI, overhauling of the health care system, improvement of human resources for health, and accelerated implementation of the National Strategic Plan for HIV and AIDS and Sexually Transmitted Diseases. It is not clear how the funding for these objectives related to the funding allocated to the NHI pilot process. Therefore the expenditure records for the NHI pilot districts need close scrutiny vis-à-vis spending of the general budget.

6. Moving forward

It is very timely that government and its spending agencies are monitoring their spending practices closely, using treasury guidelines for strict financial controls. However caution should be taken in ensuring that financial controls do not discourage progressive programming and spending aimed at helping the government achieve its constitutional promises. The economic situation requires strengthened financial management systems and skilled human resources to ensure that public funds produce desired results. Thus, proper management systems should be put in place, and where they already exist, should be strengthened for optimal management and accounting practices. Similarly the health sector also needs to boost its human resource base, from the management capacity to service delivery capacity. It is only through this base that the tight budgets could yield desired public health outcomes. In addition, more transparency is required on the actual expenditures in the health sector, especially district-level quarterly spending and performance reports, including progress reports on the NHI pilot sites, with clear detail on how the NHI Conditional Grants have been spent.

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