



**STAYING AFLOAT:
SOUTH AFRICA KEEPS A FOCUS ON HEALTH PRIORITIES
DURING A FINANCIAL STORM, 2009–2017**

SYNOPSIS

In 2009, South Africa's health-funding system teetered on the verge of collapse. Despite the adoption of a transparent and credible budget framework in 1994, large parts of the public health system suffered from chronic overspending and poor financial control. As wage hikes and supply costs ate into the health budget and as government revenues plummeted in the wake of the 2008 global financial crisis, the national health department had to find ways to preserve priorities, linking them more effectively to the budget. The department won agreement on a list of non-negotiable expenditure items to protect in provincial budgets, used earmarked conditional grants to channel funds to key programs, cut medicine costs by improving central procurement, rolled out a new information technology system, and improved its monitoring of provincial finances. Although the country's nine provincial health departments had important roles to play, most of them struggled. However, the Western Cape was able to set a model by controlling personnel costs, improving monitoring, and creating incentives for health facilities to collect fees. Nationally, total per-capita government revenues dropped by 5% in the immediate aftermath of the financial crisis and grew only slowly thereafter, but the health sector's strategy helped ensure progress on its key priorities even as resources fluctuated.

Leon Schreiber drafted this case study on the basis of interviews conducted in Pretoria and Cape Town, South Africa, in August 2018. Case published in October 2018.

INTRODUCTION

In November 2008, the health department in the Free State—one of South Africa's nine provinces—announced that it would not enroll any new HIV patients on antiretroviral medication for the following three months.¹ The decision sparked a public outcry because previous government denials of a link between HIV and AIDS had contributed to one of the highest rates of infection in the world (10.6% of the population, or 5.2 million people who were HIV-positive).² Although, by 2008, the Free State health department had reversed its policy and agreed to

provide free antiretroviral treatment at public health facilities, it faced a new problem: it had run out of money.

The crisis in the Free State, as well as similar budget shortfalls in other provinces, had resulted from years of overspending—and despite South Africa's complete overhaul of its approach to public financial management in the late 1990s.

The national government had tried to devise effective budget procedures, partly impelled by a requirement in the 1996 constitution to provide universal access to health services within the government's available resources. But the new, fit-

for-purpose financial management system that the National Treasury created—including a three-year rolling expenditure framework, a redesigned budget calendar, and a variety of practices to improve coordination and monitoring—failed to stem the problem.³ In 2008, an investigation commissioned by then health minister Barbara Hogan found that the sector faced a crippling deficit of at least 7.5 billion rand (US\$1.05 billion).⁴ It was clear that the earlier reforms had not been sufficient. The health sector urgently had to find ways of improving its budget planning, execution, and monitoring.

The onset of the 2008 global financial crisis and the resultant threat of government-wide budget cuts further raised the stakes. From 2001 to 2007, government revenues had increased 2.7-fold in nominal terms on the back of strong economic growth⁵—to the point that the country achieved a budget surplus in 2007. But in 2009, in the midst of the global financial crisis, total government revenue fell by 5% compared with the previous year.⁶ Michael Sachs, a longtime National Treasury official who headed the budget office from 2013 to 2017, said that in the aftermath of the 2008 crisis, “the conversation changed from how to allocate an annual budget surplus to one about reallocating within the existing budget during a period of constraint.”

In May 2009, newly elected President Jacob Zuma appointed medical doctor Aaron Motsoaledi as his health minister to run the national health department. Motsoaledi assembled a new team under the department’s director general, Malebona Matsoso. To the post of chief financial officer he appointed Ian van der Merwe, who had headed finance departments in several provincial ministries. And he named Anban Pillay, a pharmacist, as deputy director general of regulation and compliance. Working together with Dr. Mark Blecher, a physician and experienced head of health and social development at the National Treasury, Motsoaledi’s new team would

have to guide South Africa’s health system through the gathering storm.

THE CHALLENGE

Motsoaledi’s national team could not go it alone. The country’s highly decentralized health-care system vested primary responsibility for implementation in its provincial health departments. Under the 2003 National Health Act, whereas the national department had to “identify national health goals and priorities and monitor the progress of their implementation,” it was up to each of the nine provincial health departments to “ensure the implementation of national health policy, norms and standards.”⁷

Because of decentralization, the national health department directed spending on only 20.5% of the health budget through a set of earmarks called *conditional grants*. (An additional 3.5% went to the funding of the national department’s administrative and other operations.)⁸ Although the *provinces* implemented the conditional grants, the *national* department designed and monitored them, and the grants served as the primary mechanism for incorporating national priorities into provincial programs.

The balance of the department’s allocation—76%⁹ of the country’s total health budget—went directly to provincial treasuries, which in turn directed those funds to provincial health departments. A complex, constitutionally enshrined formula known as the *equitable share* divided central government funding across the provinces based on demographic features, such as population size. Sachs said that “aside from conditional grants, the national government has no legal authority to instruct provincial treasuries in how much to budget for health—or any other sector—from their equitable shares.” Provincial health departments had broad leeway to determine and manage their own budgets.

Fortunately, some procedures were already in place to help align priorities. The country’s

Medium Term Expenditure Framework (MTEF), a three-year rolling budget system adopted in 1998, established both technical and political mechanisms for intergovernmental coordination. Special MTEF forums, which convened annually, provided opportunities to work with the provinces in protecting national priorities when it came to funds exclusively under provincial control. The national health department could also influence the way the provincial departments spent their resources by setting norms and standards and taking additional steps to coordinate support for priorities.

The second obstacle was the weakness of the priority-setting process itself. During the controversial, 10-year tenure of Motsoaledi's predecessor, who had supported the AIDS denialism of then President Thabo Mbeki, there was no national health strategy.¹⁰ Hogan's 2008 investigation had found that "The [national department] has provided insufficient leadership and stewardship. . . . There is no national [plan] which provides overall guidance on how to reshape and reconfigure the public health system over a five to ten-year period."¹¹ To rally the components of the health-funding system behind a common set of goals, the national department urgently needed to begin providing strategic leadership. Rebuilding credibility and forming a national vision were essential.

But even with better intergovernmental coordination, stronger leadership, and a clear strategy, rapidly escalating wage and supply costs threatened the sector's ability to improve its financial management in the context of looming budget cuts. In 2007, on the back of strong economic growth and signs that the civil service was losing skilled personnel to better-paying jobs in the private sector, the government adopted a new framework for compensating civil servants. Rather than granting increases across the board, the new policy, called Occupation Specific Dispensation (OSD), permitted a onetime bigger wage adjustment for civil servants who had skills

in high demand in the labor market. Adoption of the adjustment led to substantial pay increases for professionals such as doctors and nurses.

Although "the logic of OSD was sound," Sachs said, once the salaries for skilled workers had been brought in line with the private sector, "the public sector continued to increase salaries far in excess of inflation and productivity gains." After Mbeki stepped down as president in 2008, new presidential administration, led first by interim President Kgalema Motlanthe and then by Jacob Zuma from 2009, was more closely aligned with labor unions and continued to grant additional above-inflation pay increases. Ian Stuart, who succeeded Sachs as acting head of the National Treasury's budget office in 2017, said, "From a budgeting perspective, just as the economy was turning in the wrong direction, health professionals were being paid a lot more."

Rising costs of medicines further eroded budgets. South Africa imported most of its medicines, and the prices it paid rose as the value of the South African rand fell in the aftermath of the 2008 global financial crisis, declining about 17% against the US dollar by 2009. An ineffective procurement system also contributed to escalating costs.

"Most medicines were already centrally procured, but the National Treasury followed a very standard process regardless of whether they were procuring tables and chairs, or medicines," said Pillay, the health department's deputy director general. "However, the market for medicines is much more complicated." He added that because the treasury didn't study the market closely, South Africa by 2008 was paying double the price that other countries were paying for antiretroviral medication. Getting a grip on personnel and medicine costs would help prevent budget reductions for other priorities.

A final impediment was the weakness of the national health department's monitoring and data management system. Although provinces submitted monthly, quarterly, and annual reports

on their compliance with conditional grants, the national department did not have the right procedures in place to follow up on and correct deviations. And lack of detailed and accurate data presented an even greater obstacle.

The department had installed access to a web-based District Health Information System (DHIS) in most public health facilities around the country. The aim of the DHIS was to provide information on health activity—including numbers of patients and types of diseases or reasons for patient visits—at the district level. However, the system did not accommodate the direct input of individual patient data, so health facilities kept paper records for each patient; and every month, clinic and hospital staff used rudimentary tally sheets to count paper files opened and updated during the previous month as a way to determine the aggregate number of patient visits, disease prevalence, and types of medicines prescribed. Individual facilities submitted the data to subdistrict or district offices, where staff members uploaded the information to the DHIS. The system then generated monthly reports and submitted them to the provincial and national authorities.

Aside from not being detailed enough, the data were often incomplete, duplicated, or incorrect, reported a 2008 study published in the *South African Medical Journal*.¹² Pillay suggested that one of the reasons for such poor data quality was that there was no link between the level of use at a health-care center and the budget allocation the facility received. “Whether DHIS shows that you had 10 patients or 100 patients, the budget stays the same, and it’s seen only as a bureaucratic exercise to satisfy [officials in] Pretoria,” he said.

A final factor that contributed to poor record keeping was that most of the public health facilities did not bother to bill patients who were required to pay. Although South Africa introduced free primary health care for all patients at public facilities in 1996, secondary and tertiary services were free or subsidized only for individuals with annual incomes of less than R72,000 (US\$5,100) or households earning less than R100,000 (US\$7,100). The law required patients whose earnings exceeded those thresholds to pay for secondary and tertiary health-care services (text box 1). Most facilities had little incentive to collect fees, because the money went into the provincial government’s general fund rather than the health department’s budget.

Text Box 1: Free primary health care and user fees

In 1996, South Africa introduced at public health facilities free care for all pregnant women and for children younger than six years of age, as well as free primary health care for all citizens. For secondary- and tertiary-care services, the government introduced a means test. Any person receiving a social grant (welfare) or support from the unemployment insurance fund was exempt from paying fees, and any person earning less than R36,000 (US\$2,550) and any households earning less than R50,000 (US\$3,350) had to pay only 1 to 25% of the full price for services.¹

A second category of users—those earning R36,000 (US\$2,550) to R72,000 (US\$5,100) as individuals or R50,000 (US\$3,350) to R100,000 (US\$7,100) as households—paid 7 to 75% depending on the procedure or service; those earning more than R72,000 (US\$5,100) as individuals or more than R100,000 (US\$7,100) as households paid full user fees.² However, even for full-paying patients, all fees were determined according to a uniform schedule, with the costs of procedures and services subsidized partly by provincial departments and set at relatively affordable rates.

¹ Department of Health, *User Guide – Uniform Patient Fee Schedule 2015*, accessed September 11, 2018;

<http://www.health.gov.za/index.php/shortcodes/2015-03-29-10-42-47/2015-04-30-09-10-23/uniform-patient-fee-schedule>.

² Department of Health, *User Guide – Uniform Patient Fee Schedule 2015*.

FRAMING A RESPONSE

When health minister Motsoaledi assumed office in 2009, South Africa already had a well-established budget process in place. In a 2008 evaluation by Public Expenditure and Financial

Accountability (PEFA)—a public financial management assessment program operated by development partners—South Africa scored A ratings, which is the highest possible, in all measures of budget credibility, as well as in five of

Text box 2: South Africa's MTEF cycle

Under the MTEF system, the process for determining allocations for the following three years kicked off each year in June, when the National Treasury sent government departments updated budget workbooks in Excel format, which included the previous year's second- and third-year allocations, as well as projections for the third year. Jonatan Davén, National Treasury senior budget analyst for health, said, "Initially, the first two years broadly stay the same, and the third year is based largely on inflation and upcoming salary increases."

Next, working within the financial limits the treasury outlined, the national health department conveyed changes in funding levels or the structures of its programs it wished to make. The proposal included both a narrative report and the Excel workbook of any proposed changes. At a bilateral meeting between the treasury and health departments, officials analyzed both documents and then discussed the plan with stakeholders in subsequent meetings of the health function group, which was composed of a collection of health sector officials from the National Treasury, the national health department, all nine provincial treasuries, and provincial health chief financial officers—and the 10x10 meetings of heads and chief financial officers of the provincial health departments and treasuries. During these meetings, "We discuss various priorities, performance, and planned major reforms. In some cases, when there's a proposal for new funding, we also discuss that," Davén said.

During late July, the treasury's health unit consolidated the outcomes from the initial meetings into a report submitted to August meetings of the Ministers' Committee on the Budget Technical Committee (MTEC), which was composed of senior civil servants. MTEC made further revisions, and by late September, the treasury submitted the revised report to the Ministers' Committee on the Budget (usually referred to as MinComBud). MinComBud meetings operated similarly to those of MTEC but were political forums chaired by the finance minister and attended by the ministers of public service and administration, performance monitoring and evaluation, health, and other ministers invited by the finance minister. Davén explained that "MinComBud makes the decisions on what recommendations go to the cabinet, and they record minutes of any revisions."

After the treasury's health unit implemented the ministers' recommendations, the cabinet approved the medium-term budget policy statement, which the finance minister delivered annually during late October. Following the statement, colloquially known as the *minibudget*, the treasury sent a preliminary allocation letter to the health department. Then the function group and MTEC met again to discuss any concerns and proposals from the health department in response to the preliminary allocation. By mid-November, the treasury would issue final allocation letters.

Based on the allocation letters, the treasury sent the health department Excel-based workbooks, which included very detailed itemizations of the budget. The first two years of the spreadsheet entries contained the agreed-upon allocations, and the department populated the third year. After the treasury reviewed the submission, it incorporated the health budget into the budget documents it published annually in February, which included the budget review, the appropriation bill, the division-of-revenue bill, estimates of national expenditures, and tax proposals. (See exhibit 1)

the six measures of comprehensiveness and transparency; in six of the nine measures of predictability and control in budget execution; in two of the four measures of accounting, recording, and reporting; and in one of the three measures for external scrutiny and audit. (A follow-up PEFA

report in 2014 registered a slight regression in credibility, but otherwise largely retained the positive ratings.)

The budget process followed a strict calendar that ran from April 1 to March 31 (text box 2). Crucially, it included technical and political forums

Text Box 3: Integrated support team reports

Motsoaledi's predecessor as health minister, Barbara Hogan, commissioned Integrated Support Team (IST) reports during her brief, September 2008 to May 2009 tenure. The reports were compiled by a group of external experts and former officials.

Hogan tasked her adviser, Nicholas Crisp, with selecting the team. Crisp explained that "we found people who knew both health and finances from among the cohort who originally established the new health system in the 1990s." The IST also partnered with a financial consulting firm to further bolster its analytical capacity.

As the IST traveled around the country in late 2008, "it uncovered some really eye-opening information," Crisp said. "Departments declared only about half of their debts, and the rest was all undeclared accrued commitment that constituted irregular expenditures not approved by parliament. . . . Officials had simply started hiding things. The team found checks and order forms stuffed into drawers. All of it was unbudgeted overexpenditure." In its report to the minister, the IST concluded that although "the exact amount of overspending is significantly understated . . . the magnitude of this deficit is estimated to be at least R7.5 billion [about US\$1.05 billion at the time]."¹ That amount was equal to 9.1% of the entire 2008–09 public health budget of R82 billion (\$US9.6 billion).

Aside from describing the scale of financial mismanagement, the IST reports outlined how lack of strategic leadership had led to fragmentation between the national and provincial departments and how it undermined the quality of service delivery. The reports further pointed out that the Occupation Specific Dispensation system adopted in 2007, which resulted in substantial pay increases for government professionals such as doctors and nurses, "has led to numerous problems in the various provinces, including over-expenditure," and that the department's human resources database was "not fully used as a management and planning tool."² In addition, the team determined that "pharmaceuticals are not treated as a major strategic issue, despite [their] critical nature to overall health care delivery, and despite being a major cost driver," whereas weak IT infrastructure contributed to poor planning, monitoring, and evaluation.³

The reports offered recommendations to address the problems, including that (1) the minister of health should develop one national health vision and strategy; (2) the national department's chief financial officer should draw up a plan to deal with financial backlogs, HIV funding, and conditional grants; (3) departments should overhaul human resources processes to improve control over personnel costs; (4) drug budgets and the reduction of pharmaceutical costs should be prioritized; and (5) monitoring and evaluation must be improved, including by means of the development of an integrated health information system.⁴

¹ *Consolidated Report of the Integrated Support Team: Review of health overspending and macro-assessment of the public health system in South Africa.*

² *ibid.*

³ *ibid.*

⁴ *ibid.*

to coordinate funding priorities. Under the auspices of developing and maintaining the Medium Term Expenditure Framework, the treasury introduced a health-focused function group that brought together senior officials from the national and provincial health departments. The health department also convened a 10x10 forum composed of the heads and chief financial officers of the country's nine provincial departments and the director general of the national department. And the treasury formed a technical committee headed by the directors general of the National Treasury and other ministries. On the political side, the national and provincial ministers of finance also met as members of a budget council and a budget forum. Both the technical and the political groups sent recommendations to the ministers' committee on the budget, led by the finance minister and including other cabinet members. The ministers' committee made final recommendations to the full cabinet, which had to sign off on the MTEF and the annual budget before the finance minister presented the budget in parliament.

When Motsoaledi assumed office as the new minister of health in May 2009, his team moved quickly to develop priorities and begin to move them into that budget-planning process. The team had inherited Hogan's set of 10 investigative reports that had been compiled by an integrated support team of health experts and that detailed the problems of financial mismanagement across all nine provinces as well as at the national department (text box 3). Motsoaledi personally responded to the reports' call for stronger strategic leadership and negotiated a set of new goals while also taking steps to rebuild the credibility of the national health department.

In July 2009, the cabinet adopted a new governing agenda for 2009–14. Called the medium-term *strategic* framework, it sought to guide the political priorities reflected in the three-year MTEF cycle. The framework used as its

political basis the election manifesto of the governing African National Congress, which won reelection in 2009 with 65.9% of the national vote. Compared with previous election manifestos, the party's 2009 document placed greater emphasis on providing HIV treatment and for the first time included a call for the introduction of a national health insurance system that would be designed to fundamentally reengineer health-service provision.¹³

With the strategic framework as a reference point, Motsoaledi worked with provincial health ministers to draw up a negotiated service delivery agreement for the health sector. In October 2010, as part of that service delivery agreement, Motsoaledi signed a performance agreement with President Zuma, committing to achieve improved outcomes in four priority areas. The health minister was not alone in signing a performance agreement. The presidency had introduced an outcomes approach that required each department to meet a set of well-defined outcome targets rather than increasing spending to achieve loosely defined goals, as revenues declined and dissatisfaction with results intensified.¹⁴

The new agreement by the health sector aimed to increase life expectancy, decrease maternal and child mortality, combat HIV and tuberculosis (TB), and strengthen the effectiveness of the health system overall. Each indicator comprised specific targets, such as reducing child mortality to 40 per 100,000 births in 2014 from 56 per 100,000 births in 2009 and improving the TB cure rate to 85% from 71.1% during the same period.¹⁵ Blecher, the National Treasury's health and social development head and a member of Motsoaledi's core team, said this "unusual step gave more prominence to health priorities."

To translate the new strategic goals into practice and help achieve the four priority outcomes, however, the department would have to put the health sector on much firmer financial footing.

GETTING DOWN TO WORK

The department took several steps to improve alignment between priorities and actual expenditure. The most direct way in which the health department influenced provincial spending was through earmarked funding, known as *conditional grants*. Motsoaledi’s team adjusted the grants to reflect shifting priorities, but the team further created a new set of indirect grants, called *allocations in kind*, whereby the national department would spend money on behalf of the provinces; and it issued a list of non-negotiable budget items to help provincial departments bargain with provincial treasuries. The team also launched two projects that took a little longer to materialize: a new IT system that would improve monitoring capacity and a pilot for a new national health insurance system that would alter incentives at the local level.

Almost all of those steps required negotiation with provincial officials. Motsoaledi used the National Health Council—which had been created by the 2003 health act to foster intergovernmental policy coordination—as a forum for negotiation.

He chaired the council, which consisted of the national deputy minister, the nine provincial health ministers and their heads of department, the director general of the national health department, and others.

Repurposing earmarks

The single most powerful tool available to the national health department to ensure implementation of its priorities at the provincial level was a conditional grant. In 2017, conditional grants amounted to 20.5% of total health spending in South Africa.¹⁶ With funding under pressure, the national department had to ensure it was effectively directing and monitoring conditional grant expenditures.

The national department reviewed each conditional grant annually when the provinces submitted their business plans. The plans indicated how the provinces aimed to demonstrate their compliance with the earmarks. Once the national department was satisfied with the indicators used for measuring provincial performance, it included the grants in its budget proposals to the National

Figure 1: Conditional grant changes from 2009 to 2017

| 2009 | | 2017 | | |
|---|--------------|---|---------------|----------------------|
| Conditional Grant | Amount | Conditional Grant | Amount | % increase (nominal) |
| National tertiary services | R6.6 billion | National Tertiary Services | R10.8 billion | 63.6% |
| Hospital revitalization | R3 billion | Health Facility Revitalization | R5.3 billion | 76.6% |
| Health professionals training and development | R1.8 billion | Health Professionals Training and Development | R2.5 billion | 77.2% |
| Comprehensive HIV/AIDS | R4.3 billion | Comprehensive HIV/AIDS | R15.2 billion | 253% |
| | | National Health Insurance (new) | R94 million | — |

Source: Department of Health 2009/10 and 2016/17 annual reports

Treasury, which in turn determined the amount of each allocation and directed the money directly to provincial health departments.

The department began to alter the size and purpose of some of the conditional grants so as to align with the new priorities and targets. The first shift entailed a substantial increase in HIV funding from 2009 onward in order to respond to the epidemic the Mbeki administration had left unaddressed. (At the time, the South African government estimated that 10.9% of the population was HIV-positive.)¹⁷ Blecher said: “The crisis area of HIV drove that [decision]. We would basically add R1 billion [US\$71 million] annually” to the third years of each three-year budget, “with the result that South Africa now has by far the largest antiretroviral budget in the world.”

In addition to creating a conditional grant for comprehensive HIV/AIDS treatment, the National Treasury in 2009 disbursed payments to provinces for three other major conditional grants focused on specialized tertiary services, the training of health professionals, and hospital revitalization. In 2012, the health department introduced a new conditional grant to fund health insurance pilot projects (figure 1).

The department also looked for new ways to earmark its priorities. In 2014, Motsoaledi’s team for the first time introduced a set of so-called indirect grants to upgrade capacity in some of the country’s poorest health districts. Allocated annually, the indirect grants formed part of the national budget. They enabled the national department to spend funds and manage projects on behalf of a province or municipality in exceptional circumstances when subnational governments lacked capacity or when the nature of a project required it.¹⁸

Van der Merwe explained that “as the national department, we can’t disburse funds directly [to projects under provincial control]. But we found some space in the law that allowed us to [use indirect grants to] procure services on behalf

of a province and then also disburse funds on the province’s behalf.” In some instances, the department piggybacked on the national health insurance conditional grant. Because the department explicitly selected some of the poorest districts in each province for the national health insurance pilots, van der Merwe’s team saw a chance to use indirect grants as a way to fund infrastructure and capacity upgrades in those districts. However, for the plan to work, the national department had to convince provinces to surrender about R40 million (US\$2.9 million) from their existing conditional grant funding, or just over 0.1% of total conditional-grant monies, to fund the indirect grants (text box 4).

The national department handled procurement and payment on behalf of the provinces for indirect grants, van der Merwe said. However, he acknowledged that there was a steep learning curve because the department was not accustomed to directly implementing projects.

Saving money through central procurement

Shortly after Motsoaledi’s appointment in 2009, national health department officials under Pillay’s leadership presented the new minister with data showing that South Africa spent twice as much as other countries on antiretroviral HIV medications (ARVs). Pillay said, “We looked at the prices of ARVs, and it was clear that the budget allocated by the treasury was nowhere close to the possible burden of the disease at the time.”

Under the existing system, the National Treasury entered into contracts with ARV manufacturers, and provincial procured these medicines for use in local facilities. However, “treasury was not efficient in getting the lowest possible price for ARVs,” Pillay said. He added that since the treasury purchased ARVs as part of its general procurement operations, it did not closely study the dynamics of the pharmaceuticals market. “The problem was the information asymmetry between the purchaser and the

Text box 4: National health insurance

At its 2007 elective conference, the African National Congress adopted a proposal calling for the creation of a national health insurance system in South Africa, and it was part of the party's election manifesto in 2009. In 2012, the health department officially launched a set of pilot projects across 11 districts in the country, followed by the 2018 publication of a draft national health insurance bill. The moves came in response to persistent inequality between the country's public and private health sectors.

In 2013, annual per-capita health-care expenditure in the public sector, which served 75 to 80% of the population, amounted to only \$150 compared with the per-capita average of \$1,500 for the 20 to 25% of the population that used private health insurance (known in South Africa as *medical schemes*).¹ In 1996, private medical scheme spending per capita was about triple that of public spending per capita. But by 2004, the gap had grown to more than seven-fold and by 2013, to 10-fold.² Plus, 79% of the country's doctors worked in the private sector.³ The depth of the inequality contributed to South Africa's failure to achieve the health-related Millennium Development Goals the United Nations had set for reducing child mortality, improving maternal health, and combating HIV and malaria.⁴

However, amid media reports of serious problems experienced during the pilot projects,⁵ critics raised serious concerns about the practicability of national health insurance during a period of rampant government corruption.⁶ It was also unclear how the country would afford universal insurance at a time when the South African economy had been stagnant or declining for nearly a decade. The national health insurance bill, published in 2018, contained no details on funding, with health minister Motsoaledi saying it was "impossible" to calculate how much the system would cost.⁷

Alex van den Heever, professor and chair of social security systems administration at the University of the Witwatersrand in Johannesburg, said that lack of detail around the policy showed that "it was only political window dressing, not a real reform. It is a tactic to kick the systemic problems down the road while pretending that you are being bold. National health insurance is never going to be implemented as currently proposed."

¹ Solomon Benatar, "The challenges of health disparities in South Africa," *South African Medical Journal* 103(3), 2013, accessed September 11, 2018; <http://www.sami.org.za/index.php/sami/article/view/6622/4918>.

² John Ataguba and James Akazili, Health care financing in South Africa: Moving towards universal coverage, *Continuing Medical Education*, 28(2), February 2010, accessed September 11, 2018; <https://pdfs.semanticscholar.org/97c3/ecb2da76faa892742b82a973f3f8eff33bb.pdf>.

³ John Ataguba and James Akazili, Health care financing in South Africa: Moving towards universal coverage.

⁴ John Ataguba and James Akazili, Health care financing in South Africa: Moving towards universal coverage.

⁵ Johan Eybers, "Só flop NGV réeds," *Rapport*, July 1, 2018, accessed September 11, 2018; <https://www.netwerk24.com/Nuus/Gesondheid/so-flop-ngv-reeds-20180701>.

⁶ Kerry Cullinan, "NHI puts R170 billion 'in the hands of one politician,'" *Health24*, June 27, 2018; accessed September 11, 2018; <https://www.health24.com/News/Public-Health/nhi-puts-r170-billion-in-the-hands-of-one-politician-20180627>.

⁷ Lameez Omarjee, "Impossible to calculate how much NHI will cost – Motsoaledi," *Fin24*, June 21, 2018, accessed September 11, 2018; <https://www.fin24.com/Economy/impossible-to-calculate-how-much-nhi-will-cost-motsoaledi-20180621>.

producer: they could raise the price because the purchaser didn't understand the costs of production."

Pillay launched an investigation to learn what drove the costs of the ARVs and whether there was any way to reduce those costs. The investigation found that in some cases, local

producers created the impression with [international] competitors that South Africa buys only locally manufactured products, so lower-cost companies based abroad chose not to compete," Pillay said. As a result, the treasury awarded contracts only to local companies, which reinforced the faulty perception. By more closely

tracking the market and getting more companies, including foreign companies, to submit bids for the contracts, the department calculated that Motsoaledi could double the number of people receiving ARV treatment by 2010 by using only the existing budget.

Motivated by the desire to improve HIV treatment, Motsoaledi backed a proposal that the health department assume responsibility for central procurement of ARVs, taking over that role from the treasury. But the move ignited a backlash from pharmaceutical companies and labor unions, who lobbied the government out of fear for job losses in the face of greater procurement from international companies.

Motsoaledi's political backing proved decisive: "The minister argued that we could have either unemployed people or dead people," Pillay recounted. "That ended the debate very quickly."

With the minister's and president's backing, the treasury in late 2009 agreed to move ARV procurement to the health department. The department first established a specifications committee, with Pillay as chair, to thoroughly investigate the market for ARVs and set price benchmarks. In addition, it required suppliers to include detailed cost breakdowns in their applications.

Next, bid proposals went to an adjudication committee, chaired by van der Merwe. With price benchmarks at their disposal, the adjudication team discarded applications that were too costly and asked for more information to ensure that very low bids met requirements. In addition, "Volume became the big thing. Because we bought on such a large scale, we were able to set the price to some extent," van der Merwe said. The selected bids then went back to the specification committee, which made a recommendation before the adjudication team made the final call.

A final feature of the system was that the national department awarded transversal contracts, which mandated that all provincial departments buy medicines from the chosen supplier at the

contracted prices. (All suppliers had to be registered with the South African Health Products Regulatory Authority.) This meant that "the national department doesn't order millions of the product up front. Instead, we negotiate the price, provinces buy when they need it, and the supplier delivers it to the depot or even to the facility," van der Merwe pointed out.

Fueled possibly by corrupt intent, provinces sometimes still attempted to buy similar products at higher prices from other suppliers, and government-approved suppliers sometimes complained that provinces did not buy all of their stock. Driven largely by the improvements to procurement, however, ARV prices fell 53.1% only one year after the department assumed control of medicine price negotiations.¹⁹

In December 2010, Motsoaledi announced budget savings of R4.7 billion (US\$641 million), which he said "allows the state to treat double the number of patients."²⁰ On the back of the savings on ARVs, the health department also assumed control of central procurement for other expensive yet vital medications, including drugs for treating cancer, diabetes, and hypertension.

The department further complemented the improved procurement system by better monitoring provincial supply chain management. Even though the improvements to central procurement had made it cheaper and easier for provinces to order supplies from the central database, primary-health-care clinics in particular still faced occasional stock-outs due to weak "demand planning, order management, and the lack of an effective medicine availability system," Motsoaledi said in a prepared statement.²¹ To address those problems, the department partnered with Vodacom, one of South Africa's biggest telecommunications companies, to develop a software application called the *stock visibility system*. The application enabled clinic staff to easily record, on facility-specific smartphones, the dispensation of essential medicines such as those for HIV and TB. Once the data was uploaded, the

system automatically stored it in a cloud-based data repository, which officials in the national department could access easily.

After piloting the system at 1,100 clinics during 2014 and 2015 and finding that it reduced stock-outs 46 to 66%, the department expanded its rollout to eight of the nine provinces.²² (The project excluded the Western Cape because that province already had an effective monitoring system.) By July 2016, the system had been deployed in more than 3,000 public clinics.²³ It enabled provincial as well as national officials to track real-time information on stock levels at each clinic, and it sent early-warning alerts to clinic managers as well as to provincial and national officials when they were running low.

Alongside the savings generated by better procurement, the stock visibility system gave the national department an important new tool with which to monitor provincial facilities. Van der Merwe said: “We can now intervene quickly, which has reduced issues around medicine availability. This is the kind of big efficiency gain that we are looking for, where you can quickly save R100 million [US\$6.8 million] per year.”

Designating budget non-negotiables

While the changes were in development, the national department also began using its power to set policies, norms, and standards as tools to protect national priorities in provincial budgets.

As it became clear that escalating wage costs were crowding out other priorities, the health department began to design a set of non-negotiable expenditure items that had to be protected across all provincial budgets. The department lacked the legal authority to declare how provinces could spend their money, but the aim was to set standards and find ways to persuade the nine provincial health departments to comply. “We couldn’t simply put the list in the government gazette. At best, we could get an agreement,” said van der Merwe, who took the lead on the project.

The department introduced the proposal for the non-negotiables at the National Health Council and discussed the guidance with provincial health department heads. Then, after making a preliminary list of goods and services that each province should offer, the council commissioned experts at the Health Systems Trust, a nongovernmental organization, to conduct a benchmarking study that would determine the right levels of funding for each item in each province.

In February 2014, the trust submitted its report to the council. The report noted that “the focus on non-negotiable goods and services is led by the recognition that the share of total expenditure on goods and services is decreasing: over the past three years, compensation of employees increased by 12% whilst spending on goods and services increased by 4%.”²⁴

After quantifying each province’s average expenditure on every item during the previous three years, modeling expected future usage, and taking into account the differing levels of care at facilities, the report calculated unit costs and set benchmarks for six non-negotiables: blood supplies, childhood vaccines, HIV supplies (condoms, tests, and ARVs), laboratory services, medical supplies, and medicines.²⁵ For example, the report indicated that in Gauteng, the provincial department had to budget R31.40 (US\$3.14) for each childhood vaccine, or about R350 million (US\$35 million) annually in total.²⁶

Using the study as a baseline, the National Health Council in early 2015 agreed to a list of a 20 non-negotiable budget items for each provincial health facility, ranging from infection control supplies to cleaning services and children’s vaccines.²⁷ Motsoaledi, speaking at a National Council of Provinces Social Services Committee meeting, said these were “things that can never be negotiated—if they were not there it could not be said that there is a functioning health system in the country.”²⁸

In cases in which an item was only partially funded through a national conditional grant but the budget fell short of the benchmark, the National Health Council agreed that the “priority areas could be topped up by additional funds from the provinces’ own equitable share funds to meet the identified needs.”²⁹ The council also encouraged provinces (1) to carry out gap analyses to identify non-negotiables that were underfunded and (2) to use the findings to persuade national and provincial treasuries to bring spending in line with national benchmarks.

The council further agreed to a strict monitoring system. Provincial departments delivered progress reports on their compliance with non-negotiables during existing monthly budget and conditional grant meetings with the national department, as well as during meetings of the National Health Council.

Improving data management

Although the savings that got generated through more effective procurement and through improvements made to earmarking helped the national department protect its priorities in the immediate term, longer-term improvements to the budgeting and monitoring process would depend on better data management. The public sector had four primary data systems for managing the government’s payroll, accounting, logistics, and financial management. But the systems were outdated and fragmented, and in 2007, the state information technology agency, the Department of Public Service and Administration, and the National Treasury launched a joint project to develop and implement a modern, integrated financial management information system (IFMIS) that would combine the information from the four existing systems into one.

But the state technology agency lacked adequate capacity, and from the outset, the project suffered from poor management. It was not until March 2014, following a series of delays, that the government issued a call for bids; and another

lengthy period elapsed before it finally awarded the contract to an international software company in June 2015. The auditor general subsequently found that the project was riddled with “extremely poor financial and operating controls,”³⁰ and in 2017, parliament’s committee on public accounts accused the project team of “wasting” more than R1 billion (about US\$71 million) on the project³¹ (text box 5).

At the same time that the government-wide IFMIS project was struggling to get off the ground in the early 2010s, the national health department was turning its attention to problems with its own information system: the DHIS. In theory, once the IFMIS system was up and running, the national department could use its information on personnel, assets, and finances in combination with DHIS data, which was “intended to provide information at the district level on health activity, including how many patients there were and what types of diseases were prevalent,” Pillay said. The combination of integrated financial information with detailed health data could provide a basis for much improved budget planning.

In response to the DHIS’s shortcomings, the department in 2012 introduced a comprehensive eHealth strategy, and in partnership with the Council for Scientific and Industrial Research, South Africa’s premier research and development organization, built a new information system known as the Health Patient Registration System.

The new data management system corrected a key weakness in the health sector by using South African identity numbers, passport numbers, and other forms of legal identification to build a digital registry of individual patients.³² And in line with the eHealth strategy, the system featured strict privacy controls to prevent unauthorized access.³³ The new system also enabled officials to upload information into the database in real time, theoretically eliminating the need for paper files and reducing staffing needs. The department began rolling out the system in 50 districts during 2013 as part of the pilot project for national health

Text box 5: Introducing the IFMIS

Since the early 2000s, governments around the world have invested considerable resources in building integrated financial management information systems (IFMISs). Although the software came in different shapes, the central aims of any IFMIS were to integrate existing, often fragmented data systems and to computerize and automate key aspects of government budgeting and accounting.

According to a 2008 report by the United States Agency for International Development (USAID), an IFMIS can “improve governance by providing real-time financial information that financial and other managers can use to formulate budgets, manage resources, and administer programs. Sound IFMIS systems can not only help governments gain effective control over public finances, but also enhance transparency and accountability, reducing political discretion and serving as a deterrent to corruption and fraud.”¹

Given the complexity of rolling out an integrated financial management system across entire governments, development agencies and international organizations such as the International Monetary Fund and the World Bank often play central roles in advising governments and shaping IFMISs through a combination of technical and financial assistance, training, and procurement support.² However, a common set of challenges has emerged in different countries, including the difficulties inherent in specifying precise functional requirements at the outset of a project, in adapting legal frameworks to align with new systems, in the lack of technical and procurement capacity, and in the difficulty in making decisions on whether to purchase off-the-shelf software or to design a customized system. Such challenges have resulted in regular delays to IFMIS projects, including in South Africa.³

¹ USAID, *Introducing Integrated Financial Management Information Systems*, 2008, accessed October 1, 2018; http://blog-pfm.imf.org/pfmblog/files/ifmis_bpn_web1.pdf/.

² USAID, *Introducing Integrated Financial Management Information Systems*, 2008.

³ Christoffel J. Hendricks, “Integrated Financial Management Information Systems: Guidelines for effective implementation by the public sector of South Africa,” *South African Journal of Information Management*, 14(1), December 12, 2012, accessed October 1, 2018; <https://sajim.co.za/index.php/sajim/article/view/529/600>.

insurance. According to Pillay, it was installed in all public facilities throughout the country—apart from some municipal clinics—by 2017.

The Health Patient Registration System was intended to solve a number of the problems that had crippled DHIS. “It can prevent staff from losing patient information due to improper filing because now you can store the information electronically. It can track detailed information on individual patients and allows [the national department] to see the number of patients using a facility and even their waiting times. . . . These are all big improvements,” Pillay said.

But Pillay also feared that the registration system’s greatest potential asset—the ability to use its detailed data to inform budget decisions—would go to waste. “The staff have to actually

enter the details into the database for the system to work. For that to be effective, there must be a relationship between facility budgets and data reported,” Pillay pointed out. Despite the registration system’s significant boost to the department’s ability to collect and manage health data, the National Treasury continued to doubt the accuracy of the information and was loath to base budget decisions on the system’s data. For Pillay, it was clear that “this system will suffer the same problem as DHIS if its data are not linked to financing.”

Monitoring and supporting provinces

Even though repurposed earmarks, the introduction of non-negotiables, improved central procurement, and a stronger IT system helped the

national department better monitor and coordinate with provincial departments, the team wanted to more directly support provincial budgeting and financial management. Van der Merwe subsequently appointed five people to a provincial financial management unit to undertake the initiative.

Using the national department's authority to monitor policy implementation, the provincial support team regularly traveled to each of the nine provinces to examine bookkeeping and financial management practices. The unit had overarching authority to look at provincial compliance with everything from non-negotiables to conditional grants and controlling debt accruals. When the unit flagged any issues, van der Merwe called provincial finance heads to account during regular meetings of the chief financial officers' forum. But the unit also played a proactive role. Using its access to provincial planning and budgeting information, it helped provincial departments make their budget cases to provincial treasuries. At the national level, the unit used its information on provincial performance to inform its presentations during regular meetings of the 10x10 budget committee.

In a final effort to improve monitoring, the national department in 2014 established an independent Office of Health Standards Compliance, modeled on the United Kingdom's Care Quality Commission. Staff also underwent training in the United Kingdom. The office had wide-ranging powers to inspect information, including financial data, at each public health facility in the country in order to monitor compliance with the department's national core standards for health establishments. The office's performance data complemented the annual audits conducted by the country's auditor general, thereby adding another valuable tool to the national department's tool kit for monitoring provinces, indirectly shaping provinces' activities.

OVERCOMING OBSTACLES

Despite all of those efforts, however, the national health department, in cooperation with the National Treasury, could not on its own ensure that health priorities were being protected in provincial budgets. Most provincial departments struggled to identify local needs, budget effectively, and control expenditures.

The deadly consequences of ongoing poor financial management and budget cuts by provincial health departments burst into the public consciousness in mid-2016, when media reports revealed that at least 144 mentally ill patients had died in Gauteng, the country's wealthiest province. The deaths followed what had ostensibly been a cost-cutting decision by the provincial health department to transfer 1,300 special-needs patients out of the private Life Esidimeni hospital and into the care of nongovernmental organizations, which were cheaper.

Amid allegations of widespread corruption, it soon emerged that the Gauteng department had failed to vet the organizations adequately. Many were not properly licensed and failed to provide even food or water for some of the patients who died. Although an investigation found "ulterior motives" for the patient transfers, no one was prosecuted.³⁴

While other provinces struggled, the health department in the Western Cape—South Africa's second-wealthiest province and home of the country's legislative capital, Cape Town—met the challenge head-on. From 2002 to 2015, the department head was Craig Househam, MD, a pediatrician who had earned the nickname the Axe Man for his strict enforcement of fiscal discipline at his previous post as head of the Free State health department. Househam said, "We became worried when our allocations from the National Treasury to the province started to shrink in 2009," and he recalled a meeting in early 2009 with

the head of the provincial treasury and fellow medical doctor, J. C. Stegmann, “when [Stegmann] told us that a cash crunch was about to hit. That’s when we decided we’ll have to work more effectively [to protect health funding].”

The first step was to improve the Western Cape health department’s internal process for setting priorities. Like planning processes in most other provinces, the Western Cape’s system initially operated in a top-down manner whereby the senior manager of each of the department’s eight programs drew up an annual budget proposal. That approach alienated doctors and managers of individual facilities, who said they did not have much control of—or a stake in—budget proposals. In addition, Househam said, “In the beginning, it was a mistake to give managers no boundaries because then you got shopping lists that cost billions.”

As the cash crunch set in, Househam and his longtime chief financial officer, Andries van Niekerk, modified the annual budget-planning process by giving managers clear estimates of how much overall budgets were likely to increase or decrease. The department also shifted to a bottom-up planning process. At each facility, the department created a set of so-called functional business units managed by clinicians.

That change helped the department identify local priorities and gave clinicians a say in how money got distributed. “It got them to understand the trade-offs [involved in making budget decisions],” Househam said. To secure further buy-in from managers and doctors in the face of pending budget cuts, he said: “We made a new principle that said we would never cut the top slice off maintenance and equipment. We would rather cut staff numbers, because it doesn’t make sense to have staff if they don’t have equipment to work with.” The department’s commitment to protect equipment spending rather than the wage bill was the inverse of the practice in most other provinces.

In the next step, the department held workshops on the budget proposals submitted by

each of the eight programs. The workshop meetings usually had more than a hundred people—from program managers to hospital superintendents—“so that they could talk and hear about what the other programs needed. Then we broke into smaller groups in which we partnered managers with technical planners, who would ultimately formulate the final MTEF proposal we took to treasury,” Househam said.

Once internal priorities had been set, the department began its negotiations with the provincial treasury to determine how much money it would receive from the Western Cape’s equitable share allocation. At that stage of the budgeting process, Househam said, he saw it as “my job to fight like hell for my department. I’ve used everything from facts and figures to theatrics [to argue for more funding].” In one example, Househam showed treasury officials a video of how poor conditions in one hospital led to a patient’s death. “I wanted to get them past the figures to show them the reality of what we’re dealing with,” Househam said.

While the department sought to improve its negotiating power by showing officials the life-and-death implications of funding decisions, the provincial treasury simultaneously worked to improve its understanding of the health sector. In addition to carrying out detailed financial analyses in the lead-up to negotiations with the health department, “We needed to understand the business of health care,” said Analiese Pick, director of provincial government finance at the Western Cape treasury. Marcia Korsten, the treasury’s former chief director of public policy, agreed: “We had to understand what a budget actually bought. Our teams started going out to visit the different health facilities to understand what the numbers meant in practice.” Over time, the health department and the treasury built a strong relationship that increased the depth of budget negotiations.

The department also lived up to its promise to protect equipment and maintenance spending

by tightening its control over personnel expenditure, which accounted for 56.3% of the province's health-care spending in 2008.³⁵ Van Niekerk explained that “in the health sector, it can be difficult to control spending on goods because doctors prescribe tests and medicines as tests and medicines are needed. When you talk about financial control, it's in the first place about personnel expenses.” As a result, the provincial finance team used expenditure projections in combination with information from the government's human resources database to design an annual approved-posts list.

Van Niekerk said that any job openings “not on the approved posts list get closed down on [the human resource database], so [individual facilities] can fill only vacant posts that were on the approved posts list.” However, to preserve flexibility, health facilities had permission to close one post and open another as long as they did not increase the expenditure on the approved posts list. Van Niekerk added that because it was typical for a facility to have a job vacancy rate of about 5% at any given time, “we allowed them 5% more posts on the approved posts list than they could technically afford.” The approved-posts list gave the provincial department strong central control over personnel expenditures.

The department further boosted its budget revenues by incentivizing health facilities to collect user fees in cases in which patients earned more than the means-tested threshold for free or subsidized health services. First, it worked with the treasury to change a regulation requiring that all revenues collected by health facilities would go straight to the general provincial fund. In the late 2000s, the treasury changed the rules and permitted the provincial health department to keep all user fees collected by hospitals and clinics.

In turn, the department built a software system that enabled staff to easily enter patients' self-declared annual incomes and that then automatically calculated whether the patients were exempt from fees, qualified for subsidized fees, or

earned more than the means-test threshold for full payment of R72,000 (US\$5,100) per annum for an individual or R100,000 (US\$7,100) for a household. If patients were unable to pay up front, the facility asked for a small down payment. An automated system then sent the patient an invoice after 14 days and an SMS reminder for any outstanding payments after 45 days and placed a telephone call after 50 days. If the patient still had not paid after 120 days, the department handed the debt over to a collection agency.

The change gave the health department “a strong incentive to chase revenues, and the impact was enormous,” treasury head Stegmann said. “User fees collected shot up to about R400 million (US\$30 million) a year from about R80 million (US\$6.1 million) a year. The change closed many loopholes over the years,” he added. (It was important that it was the provincial department, rather than individual hospitals and clinics, that kept the fees, which meant that individual facilities had little incentive to overcharge patients.) The amount collected in user fees added about 2.8% to the Western Cape health department's R21.6-billion (US\$1.5-billion) budget in 2017.³⁶

Finally, van Niekerk's finance team created a sophisticated, new computerized budget-monitoring instrument to improve its oversight of individual facilities. The department hired a team of data analysts to build an algorithm that would collate information on each facility's expenditures from the human resources database and from the government's basic accounting system. The system then divided the expenses into different line items, which enabled van Niekerk to track detailed expenditure patterns over time and between facilities.

When discrepancies emerged, van Niekerk requested hospital and clinic managers to account during monthly meetings of dedicated, sector-specific financial-monitoring committees. Aside from enabling the department to continually monitor expenditures that quickly identified problems, the instrument's rich data fed into the

department's budget-planning process. "It enabled us to make data-driven budget projections per line item by using both inflation-adjusted as well as detailed historical spending trends," van Niekerk said.

ASSESSING RESULTS

Back in 2000, the head of the Southern African Institute of Government Auditors had declared South Africa "amongst the world leaders with regards to public financial management."³⁷ The system had not protected the health sector from overspending or from diversion of resources away from critical functions, however. From 2008 onward, several efforts introduced improvements, including the creation of national strategic goals and standards; indirect grants that facilitated more efficient, centralized spending on behalf of the provinces; acceptance of non-negotiable expenditures to sharpen the focus on national health priorities; a stock visibility system to ensure adequate medicine supply; a provincial financial management unit; and an Office of Health Standards Compliance.

South Africa's overall public health-care spending as a percentage of the government budget remained stable, at about 13.5%, or 3.9% of GDP, from 2008 to 2017.³⁸ Although the former figure was still short of the 15% budget target set by the continent-wide 2001 Abuja Declaration, South Africa's health-care expenditure rate was the fifth highest in Africa. It is worth noting that Lesotho and Swaziland, both of which spent more than South Africa, received most of their health funding from donors, so South Africa was third on the continent among countries that used primarily domestic resources.

During the three years following the 2008 financial crisis, the government effectively delayed the recession's full impact on the health sector. Although per-capita government revenues dropped by 5% in 2009 and recovered to pre-2008 levels only in 2013, aggregate health spending

continued to grow at an annual average of 8.5% from 2008 to 2012. But as the government surplus turned into a deficit and as economic growth failed to recover, national spending increases on health ultimately slowed to 2.4% per year from 2013 to 2017. A study coauthored by Blecher concluded that overall, "the health sector was protected for the first three years (2008/09–2011/12) but has been going through a 'lean period' (2012/13–2016/17)" ever since.³⁹

Even amid the eventual funding downturn, the national health department's proactive work shielded key priorities from budget cuts. The creation of a negotiated service delivery agreement, for which minister Motsoaledi took personal responsibility, introduced a set of national priorities and key progress indicators. In line with the new strategic goals, the department reoriented earmarks to protect its three biggest priorities: HIV funding, primary health-care services, and national health insurance.

From 2008 to 2017, the conditional grant to combat HIV increased to R15.2 billion (US\$1.08 billion) from R2.5 billion (US\$353 million)—nearly fourfold in real terms.⁴⁰ Blecher further noted that the sector managed to sustain a long-term trend toward increased spending on primary care, which grew from 35.1% of total spending in 1995–96 to 43.3% in 2012–13 and which was projected to reach 47.1% in 2019–20.⁴¹ At the same time, spending on pilot projects for national health insurance reached R346 million (US\$24.6 million) in 2017 from just R1.1 million (US\$154,290) when such spending was introduced in 2008.⁴²

The focus on HIV funding, primary health-care services, and national health insurance—in combination with the national department's emphasis on protecting its list of non-negotiable health items—meant some of the budget cuts made after 2008 involved noncore items. For example, spending on travel and subsistence, as well as catering and entertainment, fell by 11.7% after 2012.⁴³ A noteworthy exception among the

non-negotiables was infrastructure spending on buildings, which was projected to decline by 6.4% from 2012 to 2019.⁴⁴

Although the new Health Patient Registration System software significantly enhanced the department's prospects for collecting useful health data, the system could not realize its full potential until staff had incentives—such as linking database information to budget decisions—to keep the information updated. Fully data-driven health budgeting also depended on the National Treasury's completion of the chronically delayed IFMIS project.

The use of earmarks, the inclusion of non-negotiables, and efforts to improve data management produced mixed results, but the national health department managed to achieve a breakthrough with its newfound ability to control medicine costs through improved central procurement. Largely as a result of improved contracting, the cost of ARVs fell by 53.1% only one year after the health department assumed control of central procurement from the National Treasury.⁴⁵ According to Pillay, by 2017 South Africa's public sector had become able to limit spending to a much lower level than the Organisation for Economic Co-operation and Development's average spending on medicines.

Except for the Western Cape, however, the health sector largely failed to control personnel costs. By 2016, real unit costs for personnel had increased by 4.5% above inflation annually for more than a decade.⁴⁶ In 2008, the health sector as a whole spent 57% of its budget on staff compensation. By 2017, that figure had reached 63.2% nationally, with the Free State (64.1%), Eastern Cape (65.6%), and Limpopo (71%) nearly paralyzed by wage expenses.⁴⁷ In contrast, the Western Cape's creation of an approved-posts list meant the Western Cape's wage costs increased to only 58.9% from 56.3% over that period.⁴⁸

While other provinces were largely failing to support the national department's efforts to protect health priorities, the Western Cape—by

controlling its wage bill, improving monitoring, and creating incentives for health facilities to collect fees—sustained the highest provincial per-capita spending on health in South Africa.⁴⁹

Nationally, aside from ramping up HIV treatment, the health sector also exceeded the target—set in the 2010 negotiated service delivery agreement—to increase male life expectancy to 58 years (actual: 58.9) and female life expectancy to 60 (actual: 64.2) by 2014.⁵⁰ However, while most other indicators were also improving, the sector fell short of reducing child mortality to 20 per 100,000 births by 2014 (actual: 36.6), of reducing maternal mortality to 100 per 100,000 (actual: 130), and improving the TB cure rate to 85% from 64% (actual: 77%).⁵¹

REFLECTIONS

When medical doctor Aaron Motsoaledi became health minister in 2009, South Africa's new administration's most-pressing political priority in the health sector was to correct the damage wrought by the AIDS denialism of Thabo Mbeki's government. By 2017, South Africa had attracted wide praise for the priority and funding it assigned to combating its HIV epidemic.⁵² The country officially had the largest antiretroviral treatment program in the world,⁵³ and the national health department spent more on an HIV conditional grant than on any other national earmark.

Anban Pillay, a pharmacist and deputy director of regulation and compliance in the national health department, stressed the importance of pressure from civil society in elevating HIV funding to a national priority. "The role of civil society in the HIV fight is unique globally," Pillay said. But by 2017, South Africa's health sector was in danger of becoming a victim of its own success in overcoming systematic HIV underfunding. The country spent 8.3% of its entire health budget on the HIV conditional grant.⁵⁴ By channeling money from other potential priorities into HIV treatment, the sector crowded out

funding for combating other serious diseases and, in particular, from infrastructure and capital spending. The cutbacks to infrastructure also reflected the department's battle to keep its priorities afloat amid a nearly decade-long economic downturn.

Aside from the much-increased spending on HIV treatment and the introduction of a new national health insurance grant—a political priority—conditional grants to provincial health departments “stayed kind of stagnant during the past 10 years,” Ian van der Merwe, health department chief financial officer, said. The department did not fundamentally alter the framework it used for assessing provincial performance in using the grants, and it essentially authorized incremental annual increases to existing grants. By 2017, van der Merwe said, he thought it was high time for “all of these grants to go through some kind of review process.”

One of the reasons for delaying such review was an impending change in the insurance system. Jonatan Davén, National Treasury senior budget analyst for health, said he suspected that “one of the reasons conditional grants were not more substantially reorganized may have to do with this massive national health insurance reform that is on the way. It may not have been seen as worthwhile to make any massive changes [to conditional grants] if the whole health financing arrangement will change soon anyway.”

There were several other sticky problems to address too. For example, Pillay acknowledged that “the work around costing [budget proposals] is very rudimentary and could do with a lot of technical improvement, which is true for government in general. Decisions are not necessarily made on the best available evidence.” At the same time, “Public participation did not inform decisions as much as it ideally should,” Pillay said, adding that as a result, the department's review of conditional grants following the election of the Jacob Zuma administration was largely

“based on political decisions around key priorities.”

The effectiveness of the innovations Motsoaledi's team introduced also depended on the capacities and wills of provincial governments. The national health department did not fully overcome the limits imposed on its authority under statutes that gave provinces control over the bulk of health spending. The designation of non-negotiables was a good example, as it relied on voluntary cooperation from provinces in the face of the national department's lack of enforcement powers.

Michael Sachs, who headed the National Treasury's budget office from 2013 to 2017, pointed to an additional problem generated by what he termed “South Africa's very odd form of federalism,” saying: “In the United States, individual states are both spenders and revenue collectors because they raise their own taxes, which balances the incentives. But in South Africa, the provinces have little revenue-raising capacities and are largely spending entities. They are not active when it comes to raising taxes because their job is mainly to spend money. They lack incentives to make the tax base grow.”

In the wake of provincial health crises such as the Life Esidimeni scandal, the Western Cape health department was the only one of South Africa's nine provinces that consistently complemented the national department's efforts by way of its own steps to improve priority setting and protect its budget from cuts or cannibalization through out-of-control wage expenditure.

On one hand, the Western Cape experience proved that meltdowns like Life Esidimeni were entirely avoidable and that the country's decentralized approach to health-care funding was not inherently unworkable. On the other hand, the province's experience revealed that having on paper a transparent and credible national budget process—South Africa's highly praised Medium Term Expenditure Framework—was not on its

own enough to ensure effective prioritization and budget management.

For Craig Househam, MD, who headed the Western Cape health department from 2002 to 2015, it was clear that the province's ability to protect its budget priorities was linked to its own effective financial management. For example, alongside the national department, the Western Cape was the only province to consistently earn "unqualified" audits from the country's auditor general, indicating accurate financial statements

and compliance with financial management legislation. (In 2017, the Western Cape department received its 13th unqualified audit in a row.) For Househam, it was clear that the country's health sector would achieve firmer footing only if capacity and management improved. "You can have the best budgeting systems in the world, but financial management improves only when fraud, corruption, and incompetence become intolerable; when people get fired; and when there are consequences for mismanagement of funds," he said.

Exhibit 1: South Africa budget calendar

| Month | Task | Role Players | Forums | Outputs Required |
|-----------------------|--|---|--|--|
| June–July | Compilation of budget submissions by departments and public institutions; formulation of recommendations to technical committees | Departments; public institutions; National Treasury; Department of Public Service and Administration; Department of Planning, Monitoring and Evaluation; Department of Cooperative Governance | Bilateral and technical group interactions | Written and data budget submissions to function groups |
| End June–July | Consultation between the executive authority of parliament and the minister of finance before budget submission | Minister of finance; speaker of National Assembly; chair of National Council of Provinces; secretary of parliament | MTEC hearings | Recommendations to minister of finance |
| End July–September | Formulation of recommendations to technical and political committees | Departments; public institutions; function groups; Technical Committee on Finance; MTEC | Function group interactions; 10x10 meetings; MTEC hearings | Recommendations to political committees on information to be included in Medium Term Budget Policy Statement, which have to include: <ul style="list-style-type: none"> • Fiscal framework • Key national government spending priorities • Division of revenue • Substantial adjustments to conditional grants |
| End September–October | Formulation of recommendations to cabinet | MinComBud | MinComBud meetings; cabinet meetings | Approval of recommendations to be included in Medium Term Budget Policy Statement |
| End October | Tabling of Medium Term Budget Policy Statement | Minister of finance; parliament | | Medium Term Budget Policy Statement publication |
| End October–November | Draft allocation letters; finalize details of national government allocations to be included in next year's budget | Function groups; MTEC; MinComBud; cabinet | MTEC hearings; MinComBud meetings; cabinet meetings | Final national government allocation letters |
| December–February | Finalization of recommendations to be tabled in 2019 budget; drafting of budget documentation | MTEC; MinComBud; cabinet; national departments and public institutions | MTEC hearings; MinComBud meetings; cabinet meetings | Budget review publication; appropriation bill; division of revenue bill; estimates of national expenditure publications; people's guide to the budget; tax proposals |
| February | Submission of budget | Minister of finance; parliament | | Budget submitted to parliament |
| March–July | Adoption of budget expenditure legislation | National Assembly; National Council of Provinces | Hearings; Debates; adoption of bills | Budget adopted |

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