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STAYING AFLOAT: SOUTH AFRICA KEEPS A FOCUS ON HEALTH PRIORITIES DURING A FINANCIAL STORM, 2009–2017 (SHORT VERSION)

This summary draws on an ISS case study with the same title can be found on the ISS website. Leon Schreiber drafted the full case based on interviews conducted in Pretoria and Cape Town, South Africa in August 2018. Case published October 2018. Summary published in May 2019.

BACKGROUND

In 2009, South Africa's health-funding system was teetering 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.

In addition, the country's highly decentralized budget system meant that the national health department had full control over only about one-fifth of the country's health spending. The government directly allocated the remainder to provincial health departments, which—though technically obligated to ensure implementation of national health policy, norms, and standards—had broad leeway to determine and manage their own budgets.

As wage increases 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, under new director Aaron Motsoaledi, had to find ways to preserve priorities, link them more effectively to the budget, and exercise more influence over provincial spending of health funds.

KEY ISSUES

- By 2008, South Africa's health sector had a crippling deficit. It was clear that earlier reforms had not been sufficient and that costs were rising rapidly—in part because of a decision to equalize pay for government health workers with the pay of employees in the private sector.
- The onset of the 2008 global financial crisis and the resultant threat of government-wide budget cuts were further raising the stakes.
- Though the national health department was responsible for setting national health goals and priorities and monitoring implementation progress, it had long neglected those roles and had to reassert its authority.
- Further hindering the national government's influence on health policy was a system under which it controlled only about one-fifth of the country's health budget; provincial governments managed the remainder.
- The national health department's budget management and monitoring systems were weak, exacerbating what often turned into a failure by public health facilities to bill higher-income patients who were required to pay for primary health care.

REFORM STRATEGY

Motsoaledi, a medical doctor, assembled a team of veteran health administrators, who moved quickly to develop priorities and build them into the established budget-planning process. Motsoaledi worked closely with provincial health directors to win agreement on a list of nonnegotiable-expenditure items to protect in provincial budgets. His team also earmarked conditional grants that channeled funds to key programs, reduced medicine costs by improving central procurement, rolled out a new information technology system, and improved the national department's monitoring of provincial finances.

The changes in the health sector aimed to increase life expectancy, decrease maternal and child mortality, combat chronic diseases, and strengthen the effectiveness of the health system overall. In particular, the changes were expected to lower the rate of HIV infection—a goal neglected under a previous presidential administration that had denied the existence of a crisis.

ACTIONS TAKEN

The single-most-powerful tool available to the national health department to ensure the implementation of department priorities at the provincial level involved conditional grants. In 2017, such allocations amounted to 20.5% of total health spending in South Africa. 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 grant's earmarks. When the national department was satisfied with the indicators used for measuring provincial performance, it included the grants in its budget proposals to the National Treasury, which in turn determined the amount of each allocation and directed the money to provincial health departments.

As part of a service delivery agreement Motsoaledi negotiated with the provinces, the health department began to alter the sizes and purposes of some of the conditional grants so as to align with new priorities and targets. The first shift entailed a substantial increase in HIV funding from 2009 onward in order to respond to the epidemic that the administration of the prior president, Thabo Mbeki, had left largely unaddressed.

The department also looked for new ways to earmark its priorities. In 2014, Motsoaledi's team introduced for the first time 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.

To ensure progress toward national health priorities as costs rose, the health department designed a set of nonnegotiable expenditure items that had to be protected across all provincial budgets. Among them were infection control supplies and children's vaccines. In addition, the department, with support from President Jacob Zuma, took over from the provinces the responsibility for the procurement of costly drugs—especially antiretrovirals for treating HIV.

The department established a specifications committee to investigate the market and set price benchmarks. Further, it required suppliers to include detailed cost breakdowns in their applications. And it developed a software application called the *stock visibility system*, which enabled clinic staff to easily record the dispensation of essential medicines such as those for HIV and tuberculosis, thereby helping avoid issues of drug availability.

Longer-term improvements to the budgeting and monitoring process required better data management. As the national government struggled to implement a modern, integrated financial management information system and as the national health department was experiencing problems with its own web-based District Health Information System, the health department in 2012 introduced a comprehensive eHealth strategy and built a new information system known as the Health Patient Registration System. The new system corrected a significant weakness in the health sector by using South African identity data, passport numbers, and other forms of legal identification to build a digital registry of individual patients.

In a final effort to improve monitoring, the national department in 2014 established an independent Office of Health Standards Compliance, with 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.

RESULTS

During the three years following the 2008 financial crisis, the South African 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, increases in national spending on health ultimately slowed to 2.4% per year from 2013 to 2017.

Even amid the eventual funding downturn, the national health department's proactive work shielded key priorities from budget cuts. The creation of the negotiated service delivery agreement, for which 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. And it had particular success in reducing spending on drugs. The health sector, however, largely failed to control personnel costs, which limited the sector's ability to achieve the government's health goals. Only the Western Cape provincial health department, which enacted its own reforms, managed to hold down those costs and make substantial progress toward the goals.

LESSONS LEARNED

- Innovations such as the designation of nonnegotiables and earmarked conditional grants gave the national health department some leverage with the provinces, but there was no firm way to impose fiscal discipline. Michael Sachs, who headed the National Treasury's budget office from 2013 to 2017, said part of the problem was that the provinces, which received most of their funding as a share of revenue from taxes collected by the national government, "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."
- The bulk of spending on health programs took place at the provincial level, and improving fiscal capacity there would have to be an element in any substantial savings. The Western Cape alone undertook such reforms, and it was the only province to succeed in holding down cost increases. "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," said Craig Household, a medical doctor who headed the province's health department.

- Anban Pillay, 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. By channeling money from other potential priorities into HIV treatment, the sector crowded out funding for other priorities.