

## 5 Financial Framework of the Public Health System

### 5.1 Introduction

Although a proportion of revenue raised for government as a whole is not based on general taxes, no consistent set of principles has been established in South Africa as to how these funds should be raised, managed, and related to general tax revenue. There is furthermore no consistent set of principles underlying the manner in which funds are subject to provincial discretion.

The principles underlying the allocation of the budget arising from general tax revenue as well as that arising from alternative sources is consequently reviewed to determine appropriate principles to guide policy with respect to existing and potential health system environments.

### 5.2 Allocation of Funds arising from General Taxes

Roughly 80 percent of the health budget is allocated by provincial governments from an unconditional grant allocated from central government. The other 20 percent is a conditional allocation from central government to cater for the “spill-over” problem resulting from the concentration of secondary, tertiary and teaching services within only a few provinces.

The size of the spill-over effect is a significant proportion of the entire budget. It would be expected that a spill-over problem should be a fairly small percentage of the total budget. The larger the spill-over the more consideration needs to be given to a consolidation of the jurisdictional reach of the health budget.

Gildenhuys (1993, pp.194-196) comments as follows:

- There are few government services, such as defence, which can be rendered at one government level. Because of their nature most services can be rendered at any government level. The question is what factor determines the most suitable government level for the rendering of any service, and how should its financing be arranged?
- The primary and most important factor to be considered with the allocation of functions is the extent of the benefits and costs created by the spill-over effect. Because the sole reason of government is the supply of collective and particular public services, as far as possible it is logical to match the extent of the spill-over with the jurisdictional scope of the government

making the decisions about that service. This structural idea is called the *correspondence principle*.

- Matching the jurisdictional area with the effective distance of the spill-over excludes the need for a complicated intergovernmental financial relations policy. A mismatch of the spill-over with the jurisdictional area of the government may result in serious misallocations of financial resources.
- There are virtually no collective services without any externalities. Neither is there a tax system which can ensure that its impact is limited to the jurisdictional area of the taxing authority. Therefore, a measure of fiscal inequality will always exist. The ideal remains, however, the elimination as far as possible of any fiscal inequalities with a policy of intergovernmental fiscal relations.
- Vertical fiscal equality means that all governments at whatever level have sufficient flexible revenue resources at their disposal to pay for the full costs of their services. This inequality is usually the result of an unscientific allocation of functions and revenue sources as provided for in the constitutional legislation of a country. Such an unequal allocation is usually the result of political expedience rather than the result of scientific rationality.

Despite the allocation of an equitable share of the unconditional grant to all provinces equity has not been achieved in the provision of health services. Provincial allocations also fail to keep pace with population increases. The budget allocations to health departments show no consistent correlation with underlying population and equity considerations both of which are central to health policy.

Consistent with theoretical arguments, in most countries the budget for redistributive public services are more centralized than for all public services. There has been a trend since the 1930s for central governments to take additional responsibility for redistributive programmes and to expand their scope and magnitude, with Australia, Canada, Denmark, England, and Sweden all joining the United States as illustrations. (Fisher, 1996, p.591).

Responsibility for social security, welfare, and housing is quite centralized, with federal expenditures accounting for at least two thirds of the total in the four major federal systems (Australia, Canada, Germany, and the United States). In all cases, federal expenditures are a greater share of the total for the broad category of social security, welfare and housing than they are for government purchases in general. Education expenditures are the least centralized of the

group, although it is much more centralized in Australia than for the other three countries (Fisher, 1996,p.592).

The ability provincial governments have to undermine allocations to health services arising either from conditional grants or user fees has been identified by the national Department of Health as a problem. Additional revenue from these sources, which should result in a net increase in revenue over budget, are offset through reductions in the general budget allocations at a provincial level.

To the extent that these reductions are consistent with national health policy no problem arises. However, in reaching these allocational decisions provinces are not required to defer to national health policy. This results in a misallocation of resources from what would occur if national policy were to prevail.

*Based on the information reviewed strong consideration needs to be given to a greater degree of centralisation of the health budget. No evidence or rationale appears to exist suggesting the budgets be programmed at a central level. However, the ring-fencing of a significant portion of the provincial allocations after determination at a national level appears consistent with both international practice and the current and future needs of the health system.*

### **5.3 Allocation of Funds arising from User Fees**

User fees raised by public hospitals are currently not differentiated from general tax revenue. This is inconsistent with the normal treatment of user charges. Typically where user fees have a strong cost-recovery purpose, they are recovered and utilised at source and are not regarded as part of the redistributable income of government. The non-redistributable nature of user charges relates to fact that general taxes have not made financial provision for the service being sold. As such, fee recovery must cover the costs.

The following are recommendations regarding the principles that should be applied to user charges:

- (a) In all instances where user charges, consumer tariffs, or levies are charged, separate operational accounts should be maintained by the relevant institution or authority.
- (b) Financial accountability should be delegated to the lowest appropriate level where separate operational budgets exist.
- (c) Surpluses on all charges should not occur or be accumulated for redistributive purposes. Appropriate mechanisms should be put in place to ensure that surpluses and deficits even out over time.

- (d) As far as possible, specific redistributive goals should be achieved through *general tax and budget allocations* and not via the revenue obtained from dedicated taxes. It would not be inconsistent, however, for certain redistributive goals to be achieved amongst contributors (as opposed to that between contributors and non-contributors). Keeping to these guidelines should ensure that redistributive goals and objectives are transparent and based on clear and rational policy objectives.

#### **5.4 Allocation of Funds arising from Earmarked Taxes**

Earmarked taxes are important with respect to proposals for a mandatory contributory environment based on a specific contribution to be made to a public fund for the reimbursement of benefits obtained from public hospitals. Although such a proposal clearly does not take the form of general tax it nevertheless has many of the characteristics of a tax. This is related to two key features:

- (a) It is mandatory; and
- (b) There is a redistribution of income involved.

The justification for an earmarked tax often lies in the application of the exclusion and benefit principles. In exchange for payment, contributors gain access to the services so funded. Non-contributors would be excluded. The application of the exclusion and benefit principles in conjunction with an earmarked tax enhances the willingness-to-pay and improves tax compliance. However, where a new tax is introduced which replaces the funding from a general tax, an offset from general revenues could be considered. Any net improvement in financing would in all circumstances be an explicit policy decision of national Government.

Principles that should be applied with respect to earmarked taxes are:

- (a) Earmarked taxes should not be considered as an alternative to the general budget but rather be used only in specific instances where the quasi-public nature of the good or service requires a direct relationship to be established between the contributor and the good or service to be provided. Insurance of one form or another and retirement contributions, where compelled by the state, would fall into this category.
- (b) Where earmarked taxes are considered, separate operational budgets are required to ensure consistency between the funds raised and the entitlements to be funded.

#### **5.5 Alternative Options for Reform and their Implications**

Various alternative directions for reform of the public sector financing framework are possible. For simplicity they are broken down into four types that broadly reflect directions that can be taken.

### **5.5.1 Option 1 - Budget programmed at the national level**

If programmed at national level the health budget will be more easily protected from inappropriate cuts and there will be more influence over provincial administrations. However, the over-centralised approach to programming would diminish some of the effective control over policy implementation and resource allocation. This option is generally weak in respect of decentralised service delivery, although it is possible that this could be overcome. On the whole this option is compatible with both the reforms to the medical schemes environment and any potential future social health insurance option: the centralised allocation of health funds allow a single administrative system for allocating the budget; protect the base-line allocations the health system from being undermined by provincial treasuries; and compatibility between the allocation of funds in respect of the contributory and non-contributory environment can be achieved.

### **5.5.2 Option 2 - Budget ring-fenced but not programmed at the national level**

With the budget ring-fenced but not programmed a high degree of provincial discretion is permitted within any nationally determined policy framework. Operational decisions, including the programming of budgets are fully dependant on provincial, regional and local governments. This approach is compatible with decentralised models of service delivery and greater autonomy at facility level. It is also compatible with the medical schemes reforms and any potential social health insurance approach directed at public hospitals. As with option 1 the development of a single administrative framework for allocating general budget and social health insurance. It also protects the base-line budgets from being undermined by provincial treasuries when increased revenue occurs from medical schemes.

### **5.5.3 Option 3 - Provincial discretion limited through use of national norms and standards**

Where an attempt to ring-fence provincial allocations occurs through the use of national norms and standards a weak form of option 2 results. It does become possible for a national policy framework to be implemented, but its potential effectiveness as a lever is subject to certain difficulties. These relate to changes in norms over time (which now become budget decisions) and enforcement. The risk of unfunded mandates is a potential but avoidable possibility. Compatibility with a policy framework incorporating the contributory system the only key objective achieved is the protection of the base-line allocation to the health system. Options for a unified allocation mechanism for both general tax revenue and social health insurance contributions are not possible.

#### 5.5.4 Option 4 - Provincial allocations with full discretion

This option largely reflects the status quo. A key defect of this option relates to the need for ten health departments to separately motivate for budget allocations. The resulting consolidated allocation is less a result of national policy than it is of the adding up of ten individual bargaining processes tenuously linked to any national framework.

When provinces have full discretion over the allocation of budget they have virtually full discretion over health policy in their region. Links to all areas relating to a national policy framework are weak as there are no associated financial flows. This budget framework shows little compatibility with either existing or future policy environments.

**Table 5.1: Evaluation of Alternative Options for Allocating the Health Budget**

	<b>Budget programmed at national level</b>	<b>Budget ring-fenced (but not programmed) at national level</b>	<b>Provincial allocations subject to national norms and standards</b>	<b>Provincial allocations with full discretion</b>
<b>Ability to prioritise national resources toward health care</b>	High	High	Medium	Weak
<b>National influence over provincial health policy</b>	Medium/High	High	Medium	Weak
<b>Inter-provincial resource allocation</b>	Medium/High	High	Medium	Weak
<b>Consistency with decentralised service delivery options</b>	Weak	High	High	High
<b>Compatibility with reforms to the voluntary contributory environment (medical schemes)</b>	High	High	Medium/Weak	Weak
<b>Compatibility with the introduction of social health insurance directed at public hospitals</b>	High	High	Medium/Weak	Weak

Overall the *option 2* is most consistent with both current and future policy directions of the health system. It is the least disruptive to the current organisational structure and can be introduced in a phased manner. Although there is a need for improved capacity at the national Department of Health, the focus is on strategic allocations linked to policy rather than interference in operational matters. As such the short-term need does not place an onerous burden on the national

department. In the medium- to long-term the national Department of Health would have to develop a more coherent institutional framework around provincial financing linked to strategic policy objectives and any conditional allocations linked to public sector social health insurance options.

*Option 4* reflects the status quo and is incompatible with both current and future policy directions. It is the weakest of the four approaches. Without significant changes to the current framework linking provincial policy to national policy in key areas the public health system will probably diminish in importance over time. Although certain social insurance options will be possible despite these arrangements, i.e. mandating medical scheme cover, low cost private sector facilities will probably develop instead of public sector options. Where public sector services are sold into the contributory environment, differential amenities will inevitably become differential services, as private sector funding will be stable while public sector funding will vary.

#### **5.5.5 Recommendation 1**

It is recommended that *option 2*, or some variation thereof, be considered in the short- to medium-term. Such an option could be phased over time with the development of other reforms dependant on the restructuring. Although the implementation of this option is an important prerequisite for social health insurance and related options incorporating the public hospital system, it is just as important for optimising existing policy objectives.

#### **5.5.6 Recommendation 2 (alternative to recommendation 1)**

An alternative approach to the full adoption of *option 2* is the use of a mix of *options 2* and *3*. This would involve a reasonable increase in the value of the existing conditional grant going to public hospitals to a level sufficient to achieve base-line budget protection for public hospital services. This would include the use of *variable matching conditional grants*.

The matching could vary by province depending upon service needs and national policy. Here the Province is required to match a grant allocation with an allocation of their own. Funds would be allocated only if the matching occurred. This approach would prove important when any central allocation occurred from any social health insurance or related fund. Such an approach would allow a single mechanism to be used to allocate both public sector budgets and social health insurance budgets for public hospitals.

The conditional grant system should be combined with the development of a coherent approach to setting minimum norms and standards for provincial health services. Although in these instances no direct control over the budget allocations will exist, provinces will be required to

adhere to minimum levels of service delivery. Provinces would nevertheless be free to offer services in excess of the minimum.

Together these approaches should achieve the objectives of recommendation 1 without full ring-fencing at a national level.