Inter-provincial equity document produced by Health financial Planning & Economics directorate

Report on Inter-Provincial Inequity

Purpose

This brief document which outlines the provincial inequities will assist not necessarily the department of health but even the provinces with respect to the status of inequities in public healthcare spending. The primary objective of the document is to develop a common understanding of definition as far as equity and create a robust discussion amongst the stakeholders in the public health care system the extent of the inequities within provinces and further interrogate whether the current resources allocation mechanism assists the department of health in addressing the inequities existing in health care in South Africa.

Introduction

In 1994/1995, the Dept of Health introduced a resource allocation formula, aimed specifically at addressing the massive inequities that existed between provinces in terms of public health care spending. The formula was introduced through the FUNCTIONS COMMITTEE process of determining provincial allocations. In this approach each function, e.g. Health was given a National budget, and the Function Committee was then responsible for determining the split between provinces and the NDoH allocation.

A five-year plan was put forward to address inequity, with a top-heavy phasing strategy, i.e. the major shifts were to occur in the early years of phasing.

This formula was implemented in 1995/1996 and continued until 1996/1997. Due to the adoption of the new constitution for South Africa, significant autonomy was afforded to provinces in many respects, including the responsibility of Provincial

Legislatures to determine functional/sectoral budgets for their respective provinces. This was called FISCAL FEDERALISM. The implication of the

introduction of Fiscal federalism was that the function committees were abolished. A new budgeting system was introduced, whereby National Treasury determined the divisions of revenue between different spheres of Government.

The formula worked (and continues to work) as follows:

- The Vertical Split – the division between national functions and provincial functions. The vertical split includes conditional grants, which flow from National departments to provinces. It is the responsibility of the respective national department to determine the division of conditional grant revenue between provinces.

- The horizontal split – division of revenue for provincial functions between provinces. This is also commonly referred to as the equitable share, and is an unconditional allocation of revenue to each province to cover all provincial functions.

It is then the responsibility of each Provincial Legislature (through the Provincial treasury) to determine the division of revenue between functions, e.g. Health education, social development.

Depending on provincial priorities and pressures, the provincial legislature determines how much goes to each function. The allocation is also dependant on the capacity of each provincial department to motivate for funding. Hence, there is no longer a national health budget; rather the national figure of spending is the sum of the nine provinces plus the National Dept of Health. There is also no ability for a national department to influence directly a provincial function allocation, except for conditional grants.

Fiscal Federalism was introduced with the budget of 1997/1998, and has been functioning ever since. The formula used by National Treasury was based on a five-year phasing strategy, which implies that it should be revised at the end of the 2002/2003 financial years. The most important implication and unintended

consequence of fiscal federalism was the fact that it actually resulted in the expansion of inequities for some provinces.

This report will look at inequities in health and attempt to address some of these consequences in detail.

Approach to assessing inequity

Equity or rather inequity is measured as the percentage deviation of weighted per capita public healthcare spending from the national average.

This is derived as follows:

- Population weighting per province – as per the national Treasury Formula, the population is split between medical scheme beneficiaries and non-medical scheme beneficiaries (those dependant on public health care services). The medical scheme beneficiaries are divided by a factor of four and added back to the population who are not medical scheme beneficiaries. This approach is debatable, but to ensure consistency with Treasury calculations, the NDoH has decided to follow this approach.
- The respective population of that province, giving a per capita expenditure figure, as well as a national average, then divides total public health expenditure for each province.

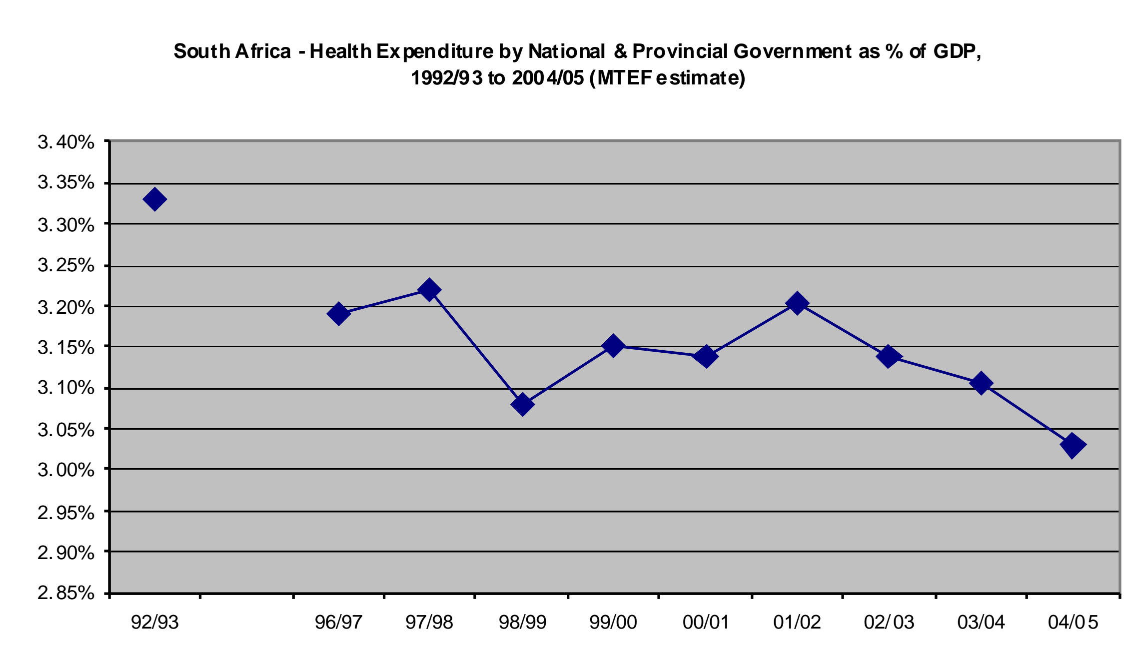
- The extent by which a province exceeds or is below the national average, determines the level of inequity.
- This figure is then represented as a percentage.

Trends in Inequities in Public Health Spending

Overall, over past five to six years, in nominal terms health care spending has improved significantly. However, a closer examination, taking into account the effects of general inflation and population growth, indicates that health care spending has remain static since 1995/96, with slight real decreases between financial years.

Measured against the growth in Gross Domestic Product (GDP), we see from the figure below that public health care spending has not kept pace with growth in GDP, in fact public health care spending has been slowly but steadily declining as a percentage of GDP. The outlook for the future, based on current MTEF projections of National Treasury indicates that the downward trend is expected to continue. This despite South Africa experiencing positive growth in GDP. In fact the great inequities are between the public and private sector, but the focus now is on the inequities in the public sector.

Figure 1: Public Health spending as a percentage of GDP



South Africa spends 8.7% of the Gross Domestic Product on health. This is higher than countries like United Kingdom and others. However, private sector share is 5.2% and public sector share is 3.5%. it is these inequities that needs to be addressed between these two sectors.

Figure 1.1 : Public sector health expenditure per capita

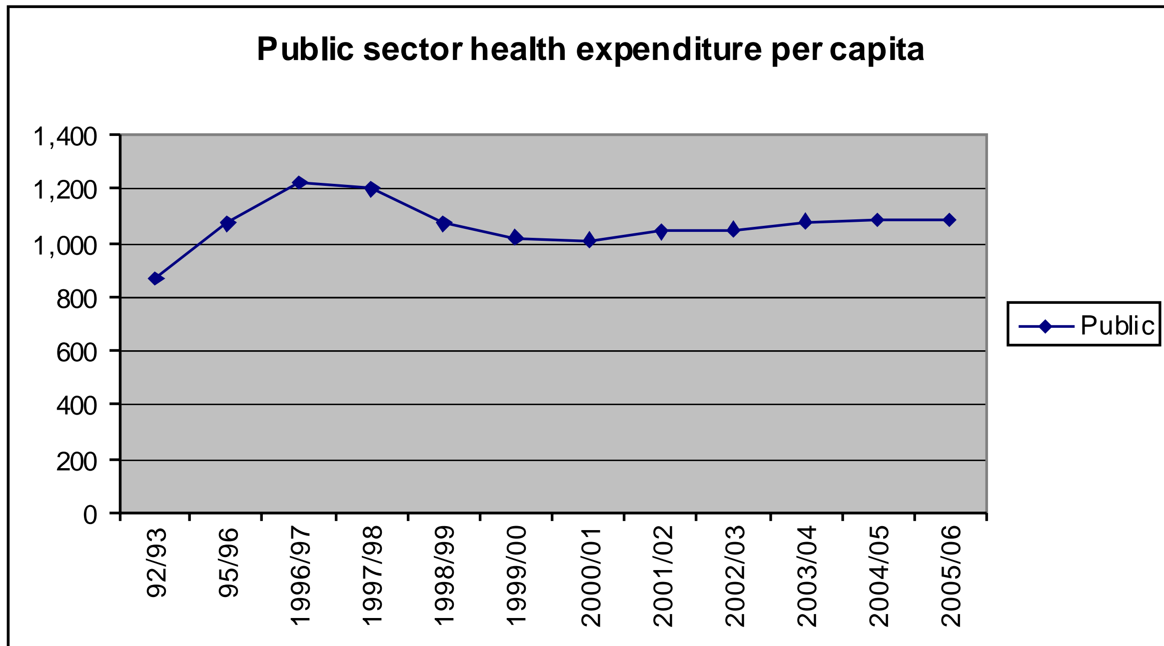


Figure 2 and Figure 2(a) show the trends in Public Health spending from 1995/96 to 2002/03. The data represented in Figure 2 is in nominal values, i.e. not adjusted for inflation), whilst the data in figure 2(a) has been adjusted for inflation, with 1995 being the base year.

A quick comparison between Figure 2 and Figure 2(a) shows that in nominal terms, the health budget has been adjusting upwards, however, in real terms this has actually not been the case for all provinces, with the previously disadvantaged provinces spending static allocations in real terms.

Something that is common between Figure 2 and Figure 2(a) is that the proportion of increases between provinces is disproportionate, with Gauteng, KwaZulu-Natal and Western Cape receiving the greatest annual increases.

Figure 2: Trends in Public Health Spending (Nominal Value)

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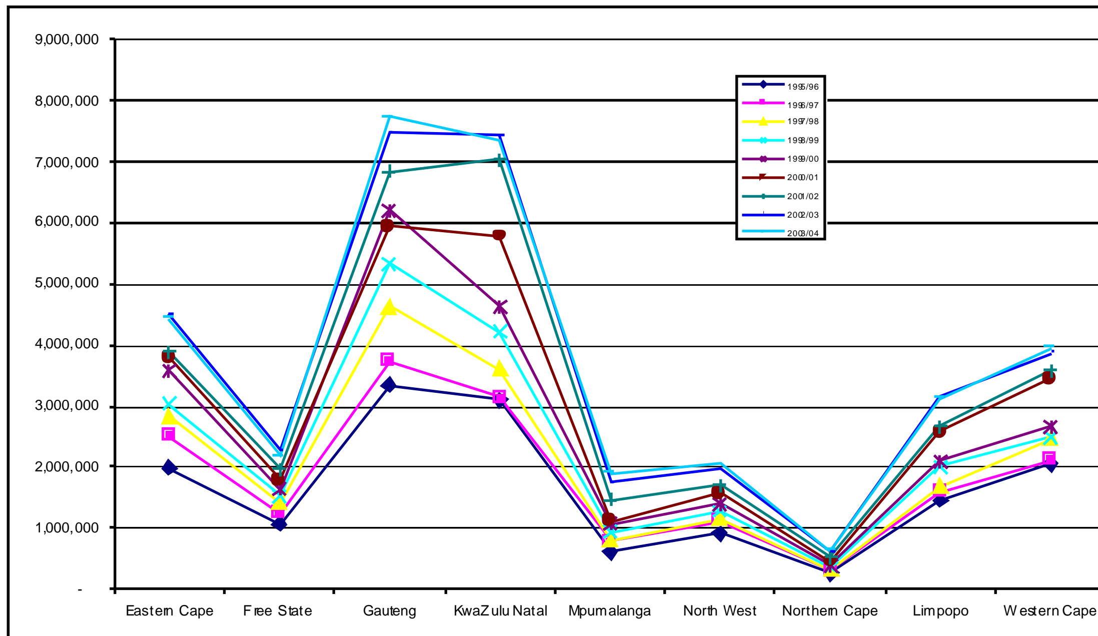


Figure 2(a): Trends in Public Health Spending (Real Value)

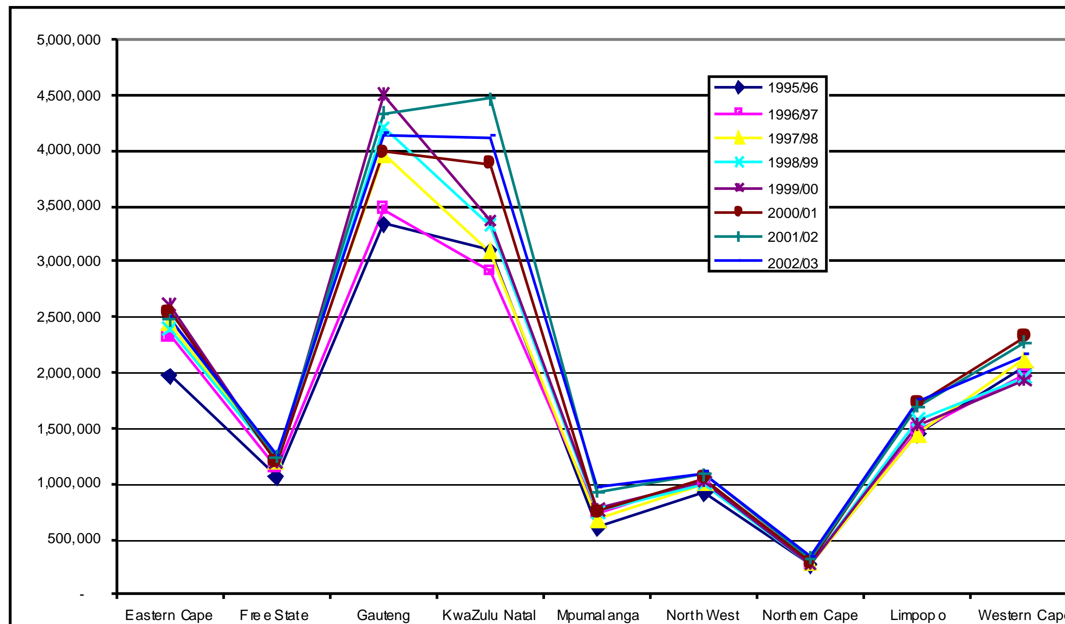


Figure three below shows the trends in real per capita spending between the nine provinces from 1995/96 to 2002/03. On the whole, the national average real per capita spend on public health care has been rising, it is very noticeable, that a comparison of this trend between provinces reveals that this has not been the case in all provinces. The Eastern Cape and Western Cape provinces show a trend since 1999/00 of a declining expenditure per capita, whilst over the years under review, the Free State, Mpumalanga and to a lesser extent the Northern Cape provinces have experienced fairly static expenditure on public health care. Although there is a trend of declining per capita spending in Gauteng, the real per capita spend in 2002

Although not directly influencing levels of inequity, but nevertheless a major concern is the fact that the real per capita expenditure in two particular provinces (Gauteng and Western Cape) jumps up and down between financial years. In 1998/99 the National treasury introduced the Medium term expenditure Framework, which was a three budgeting system with a view to giving more stability in allocations between years, but also allowed for future planning. However, the fact that there has been such massive “ups” and “downs” between financial years is of great concern around the long-term sustainability of service delivery.

Finally, in Figure 3, it is clear that the pattern, with respect to inequities in per capita public health care expenditure still exists. By 2002/03, four of the nine provinces are above the national average. Whilst the five formerly disadvantaged provinces are still well below the national average.

Figure 3: Trends in Real Per Capita Public Health Spending

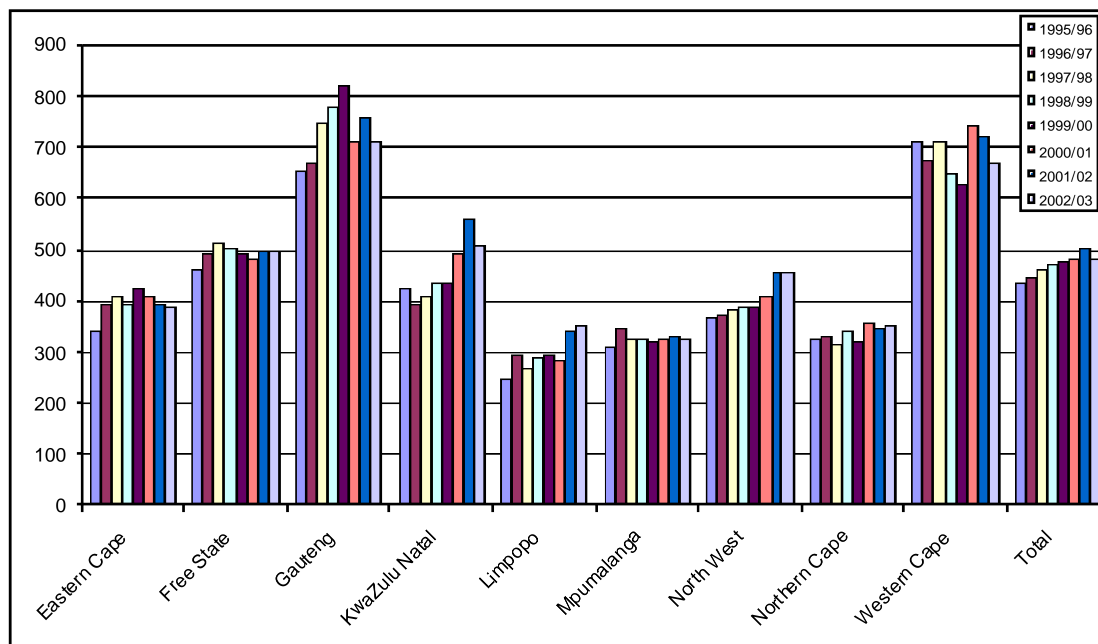
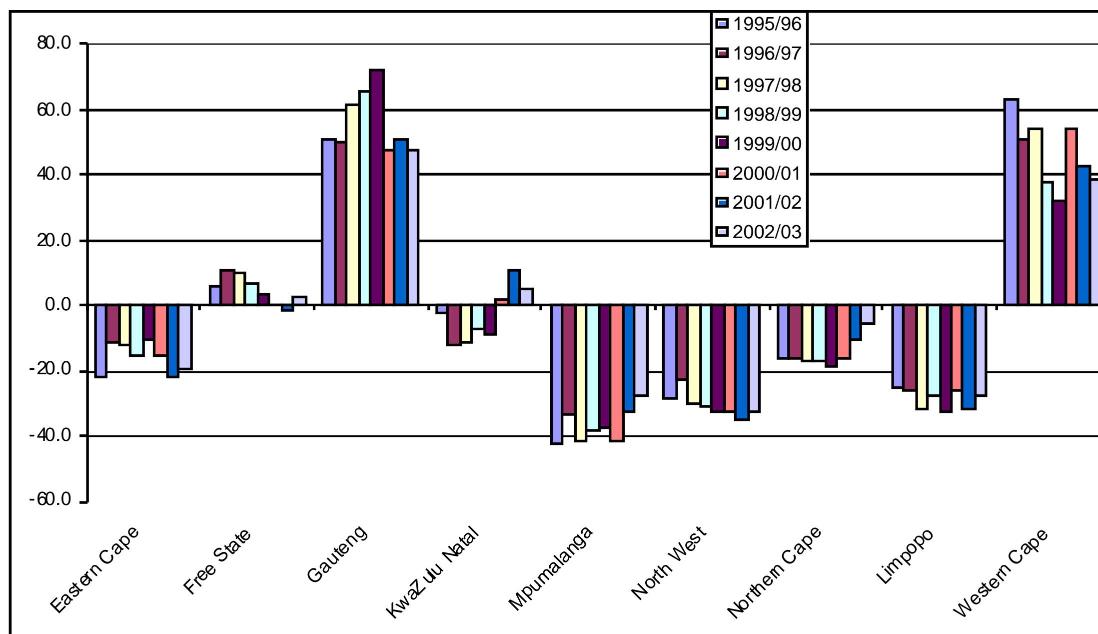


Figure 4, below, quantifies the distance from the national average, or equity. That is, the extent to which certain provinces are above or below the national average.

Gauteng and Western Cape remain by far the highest above the national average per capita expenditure on public health care. At the same time, Eastern Cape, Mpumalanga, Limpopo, North West and the Northern Cape, are significantly lower than the national average.

By 2002/2003, both the Free State and KwaZulu-Natal have move above the national average. It is possible that is not primarily due to significant increases in resources, but rather due to a trend in some provinces whereby they are moving further below the national equity level.

Figure 4: Real per capita trends - Distance from national average



It is important to note that Mpumalanga and the Northern Cape have made significant strides towards equity. The level of inequity in Mpumalanga dropped from being –43% to 27.5% between 1995/6 and 2002/03, whilst also remarkable is that of the Northern Cape, which moved from –16.5% to under –5%.

The North West and the Limpopo Province have moved significantly further away from the national average and are now further from the average than they were in 1995/96. The position of the Eastern Cape is almost unchanged.

Whilst there are promising signs from Gauteng and western Cape of moving downwards towards the national average, the annual rate of change is quite mixed. Until 2000/01, Gauteng was rapidly moving further away from the national average, since then this has steadied with a slow downward movement. The western Cape on the other hand has made significant strides. In 1995/96, the Western Cape was +63percentage above the national average, but by 2002/03,

this has dropped to just under 39% above the national average. This has been slightly dampened by the fact that the trend between 1995/96 and 1999/00 was reversed in 2000/01 and the trend of moving towards the national average commenced again.

It is genuine concern that the level of inequity being reversed so dramatically as was the case in the Western Cape may have medium and long-term implications on the sustainability of the public health system in that province.

Lastly, at a glance, the picture that emerged in 1995 as to the inequities in public health spending are still there in 2002, with very little progress towards achieving improved equity.

Obstacles to achieving equity

It must be noted that the assessment of equity levels in public health expenditure in no way suggests that the public health system is adequately funded. The mere shifting of funds from certain provinces to others is insufficient if it is unclear what the desired level of spending per capita should be. This of course should be based on a robust assessment of need for public health services. Shifting of funds in itself is very difficult to achieve, given the budgeting system in place.

Hence, there are many there are many obstacles to achieving equity in public health care spending. The primary being that of fiscal federalism.

1. Fiscal Federalism

Fiscal federalism together with the current budgeting system as being implemented by National Treasury, make it extremely difficult to get a binding agreement on inequity and plotting a way forward. Some of the problems include:

- Fiscal federalism ensures that global budgets are allocated to provinces and not specifically to health. Hence the assessment of inequities and moving forward is not as simple as getting a province to agree on a target equity level, as this will impact on the funding for other sectors. Appropriate strategies need to be dealt with that addresses problems of inequity in health care spending in the light of spending in other social sector functions. Hence, if the formula that determines overall provincial revenue and thereby spending is flawed, addressing inequity in health could seriously influence service delivery on other social sector functions.

As next steps forward, two options exist that can have a positive outcome on the levels of inequity in health care spending are:

- Norms and standards; and
- Definition of a basic package of health care – broader than merely primary health care.

The constitution of South Africa makes provision that every citizen is entitled to basic health care services, linked to available resources. In the absence of such a definition, problems are experienced in determining what should be provided and what are above basic, e.g. the legal proceedings around the provision and availability of renal dialysis.

The definition of basic health care is a crucial step forward and needs to be complimented with development of minimum norms and standards for the delivery of basic health care. These need to be both qualitative and quanititave norms and standards. This has to be a living process that constantly reviews morbidity and mortality paterns and hence the list of basic health care services and the norms and standards are reflective of the need for health care in South Africa.

In 2000, the FFC proposed a mechanism of allocating resources based on a costed norms approach. However, this was flawed, as norms did not exist at that time, so the recommendations were largely based on unrealistic assumptions. As yet the health sector has not come up with proper norms and standards that can be used in a funding approach.

Thus far efforts have been made to develop packages of care for primary health care, level 1 district hospital, level II secondary hospital care and tertiary and quaternary care. Apart from the work being completed on Modernisation of Tertiary Services. These other efforts have focussed primarily on qualitative norms and standards. It tells you what services you should provide and how you should provide those services and how much they cost to provide these services. Given the fact that the Department is aware of the issues mentioned above which have been translated into definitions of basic health care and the associated norms and standards into a minimum funding requirement.

Norms and standards as a means of funding health care would need to be a binding obligation on all provinces.

The Modernisation of Tertiary Services process seeks to do exactly this, however, appropriate funding of tertiary and quaternary care in the absence of other levels of care, could possibly cause further problems in respect of equity in access to health care especially with respect to access to appropriate levels of care.

There needs to be given careful consideration as to whether fiscal federalism is appropriate for the health sector. There is a justification for considering whether moving towards a more centralised approach to budgeting in health sector, over a fixed period, is not more appropriate, given:

- The large scale inequities that exist;
- Fiscal federalism has made no impact on improving equity

- The possible introduction of SHI and the need to equitably re-distribute funds generated through SHI.

CONCLUSIONS

It is recommended that as a way forward the following steps needs to be operationalised:

- Review of the budgeting system and the use of fiscal federalism to improve inter-provincial equity. Essential steps here include:
  - o Conducting an incidence analysis of the financing and benefits health care in South Africa and National Health Accounts
  - o Review of the incorporation funding mechanisms to account for health sector specific problems, e.g. weighting for HIV/AIDS, TB, Malaria
  - o Improve the focus on equity of the approach
- Development of a definition of basic health care services
- Development of both quantitative and qualitative norms and standards
- Development of minimum funding requirements for health care provision.

It must be stressed that norms and standards require that the current formula be replaced with a formula explicitly based upon meeting norms and standards. These processes combined will enable us to significantly move forward towards equity in health care spending.

The inherent danger in moving down the path of norms and standards is that this tends to develop a sense of minimalist package of services. Which in the medium to long term might not influence equity? For example, should a province with available resources decide to provide above the norms and standards set, this might result in deepening inequities?

It is in this light that we need to question what are we achieving when we say equity and in the true sense of the concept what do we mean. Is it OK to get some of the under resourced provinces up to a level where they can provide a basic set of services, but at the same time other provinces still go on to provide well above the average?

This fundamental question must be answered, before any meaningful attempt towards addressing equity can be made.

REFERENCES

1. McIntyre D, Bloom G, Doherty J and Brijlal V. 1995. *Health Expenditure and Finance in South Africa.* Durban: Health Systems Trust and the World Bank.
2. Thomas S, Muirhead D. 2000. *National Health Accounts Project: the public sector report.* Pretoria: Department of Health.
3. Cornell J, Goudge J, McIntyre D, Mbatsha S. 2001. *National Health Accounts: The Private Sector Report.* Pretoria: Department of Health.
4. Thomas S, Muirhead D, Doherty J, Muheki C. 2000. Public sector financing. In: Health Systems Trust. 2000. *South African Health Review 2000.* Durban: Health Systems Trust.
5. Doherty J, Thomas S, Muirhead D. 2002. Doherty J, Thomas S, Muirhead D 2002. *Health care financing and expenditure in post-apartheid South Africa, 1996/97-1998/99*. Pretoria: Department of Health.
6. Department of Finance. 1999a. *Budget Review 1999.* Cape Town: Department of Finance.
7. South African Reserve Bank. 2001. *Annual Economic Report*. Pretoria: South African Reserve Bank.
8. Department of Finance. 2000. *Budget Review 2000*. Pretoria: Department of Finance.
9. Wagstaff A, van Doorslaaer E. 1993. Equity in the finance and delivery of health care: concepts and definitions. In: van Doorslaaer E, Wagstaff A, Rutten F. 1993. *Equity in the financing and delivery of health care: an international perspective.* Oxford: Oxford University Press.
10. World Bank. 1999. *World Bank Development Report, 1999*. Washington: World Bank.
11. Department of Finance. 1998. Budget Review 1998. Cape Town: Department of Finance.
12. Doherty J, McIntyre D, Gilson L. 2000. In: Health Systems Trust. 2000. *South African Health Review 2000.* Durban: Health Systems Trust.
13. McIntyre D, Baba L, Makan B. 1998. Equity in public sector health care financing and expenditure in South Africa: an analysis of trends between 1995/96 to 2000/01. In: Ntuli A (ed). 1998. *South African Health Review 1998*. Durban: Health Systems Trust.
14. Gilson L, Doherty J, McIntyre D, Thomas S, Brijlal V, Bowa C, Mbatsha S. 1999. *The dynamics of policy change: Health care financing in South Africa, 1994-1999.* Johannesburg: Centre for Health Policy (University of the Witwatersrand) and Health Economics Unit (University of Cape Town).
15. McIntyre D, Muirhead D, Gilson L, Govender V, Mbatsha S, Goudge J, Wadee H, Ntutela P. 2000. *Geographic patterns of deprivation and health inequities in South Africa: Informing public resource allocation strategies.* Cape Town: Health Economics Unit and Centre for Health Policy.

16. Sinanovic E. 2000. *Cost-effectiveness of highly specialised services: a review of literature. Prepared for National Department of Health.* Cape Town: Health Economics Unit, University of Cape Town.
17. Department of Health. 1999. *Review of health conditional grants for 2001/02 and beyond: discussion of key issues and proposed work plan.* Pretoria: Directorate of Health Financing and Economics, National Department of Health.
18. Department of Health. 1999. *Health Sector Strategic Framework 1999-2004*. Pretoria: Department of Health.
19. Zere E, McIntyre D, Addison T. 2001. Technical efficiency and productivity of public sector hospitals in three South African provinces. *South African Journal of Economics*: 69(2): 336-358.
20. Financial Fiscal Commission Report: 2000, Midrand.