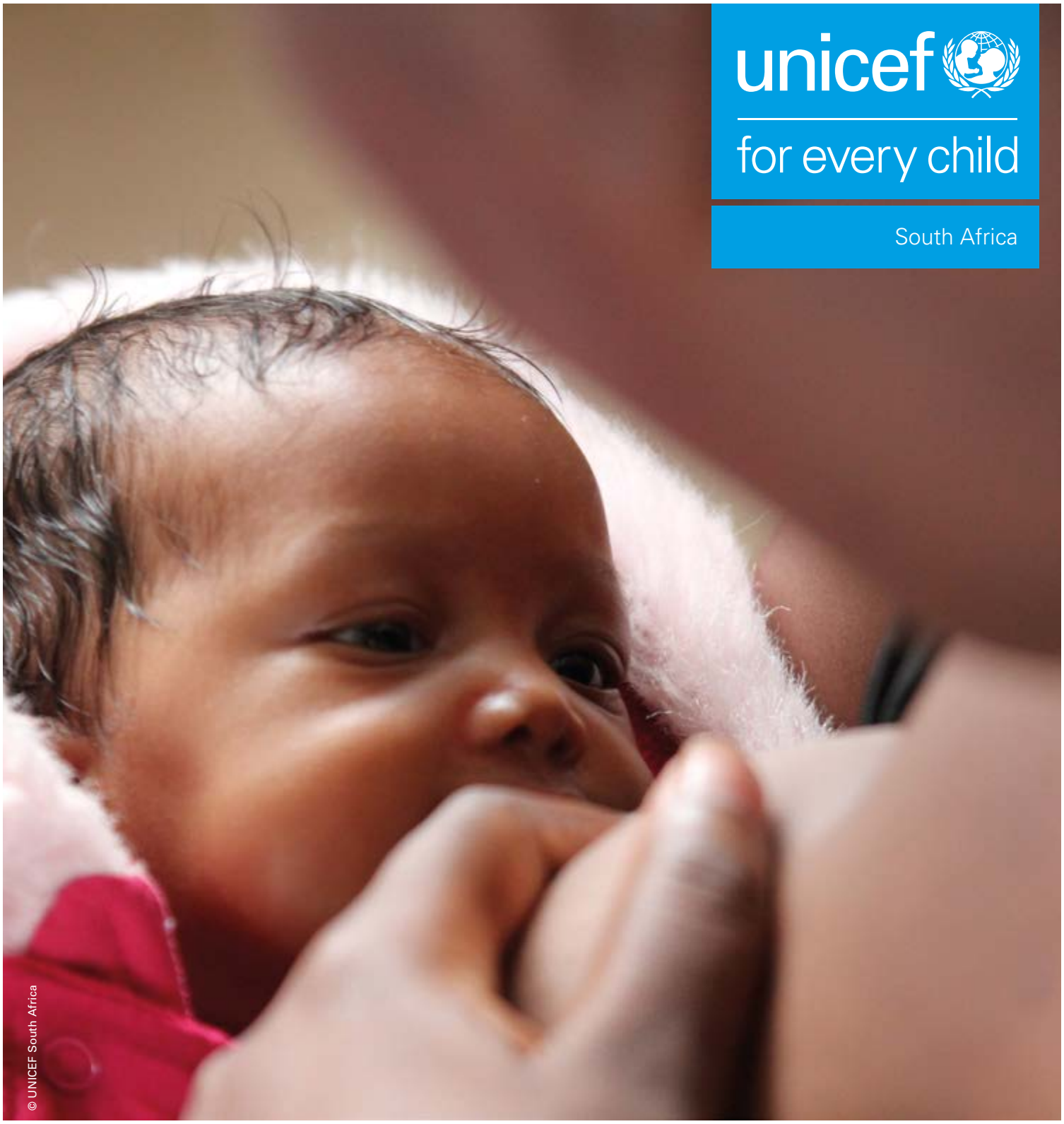

HEALTH BUDGET
SOUTH AFRICA
2017/2018

13.5%

Expenditure on health programmes as a share of total government expenditure

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Preface

This budget brief is one of four that explore the extent to which the national budget and social services sector budgets address the needs of children under 18 years in South Africa. The briefs analyse the size and composition of budget allocations for the fiscal year 2017/18 as well as offer insights into the efficiency, effectiveness, equity and adequacy of past spending. Their main objectives are to synthesise complex budget information so that it is easily understood by stakeholders and to present key messages to inform financial decision-making processes.

Key Messages and Recommendations

Overall spending trends: Expenditure on health programmes as a share of total government expenditure appears stable and averages around 13.5 per cent. However, allocations to provincial health programmes over the Medium-Term Expenditure Framework (MTEF) show no signs of positive growth, which is concerning. The government is encouraged to:

1. Protect priority programmes and services that benefit children;
2. Expedite its work on the National Health Insurance programme; and
3. Increase its investment in programmes that are successfully improving the mortality rates of young children.

Composition of spending: Provincial health spending is heavily dependent on transfers from the national government. The national government's transfer framework has benefited provinces as evidenced by the large investments in the HIV/AIDS conditional grant. The government is encouraged to:

1. Protect its investment in primary health care; and
2. Accelerate spending on health infrastructure in the rural provinces, given the large inequities in access to health facilities.

Decentralisation and the equity of spending: Provincial Departments of Health budgets are projected to grow at a real average annual rate of less than 0.1 per cent over the MTEF, which presents considerable challenges to meeting the increasing demands for children's services. The government is encouraged to:

1. Improve the targeting of health services that serve poor and vulnerable children;
2. Strengthen its coordination and collaboration with Education and Social Development so as to multiply the effects of existing health programmes for children; and
3. Prioritise rural areas in the rollout and maintenance of existing health infrastructure.

Financing: The government finances the bulk of health expenditures at the national and provincial levels from its own coffers. However, donors have continued to make strong contributions to fighting the HIV/AIDS pandemic. Given this situation, the government is encouraged to:

1. Continue funding HIV/AIDS programmes, especially where donors have scaled down their monetary contributions;
2. Protect the real value of spending on both HIV/AIDS and primary health care programmes in the provinces; and
3. Encourage the National Treasury to pursue constructive cost-cutting and revenue measures that would increase the fiscal space programmes and services that benefit children.

Section 1.

Introduction

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In South Africa, the National Department of Health (NDoH) is responsible for policymaking, coordination and oversight of health services in the country, while the nine provincial departments bear the main responsibility for service delivery. The Department of Health derives its mandate from the National Health Act (2003), which requires that the department provide a framework for a structured and uniform health system for South Africa. The act sets out the responsibilities of the national, provincial and local government spheres in the provision of health services. In addition to the National Health Act, other legislation that guides the work of the health sector include:

- The Mental Health Care Act (No. 17 of 2002), which provides for the care, treatment and rehabilitation of people who are mentally ill;
- The Medical Schemes Act (No. 131 of 1998), which provides for the registration and control of activities of medical schemes, protects the interests of members of medical aid schemes and establishes the Council for Medical Schemes;
- The Traditional Health Practitioners Act (No. 35 of 2004), which establishes a framework to ensure the efficacy, safety and quality of traditional health care services and to provide management and control over the registration, conduct and training of practitioners and students;
- The South African Medical Research Council Act (No. 58 of 1999), which provides for the continued existence of the South African Medical Research Council and its management by an appointed Board;
- The Nursing Act (No. 33 of 2005), which promotes the provision of nursing services to inhabitants and ensures that professional and ethical standards are maintained and upheld in all matters pertaining to nursing.

In terms of the government's Outcomes Framework, the health department contributes directly to the realisation of Outcome 2 (a long and healthy life for all South Africans) of the government's 2014–2019 Medium-Term Strategic Framework (RSA Government, MTSF, 2014–19). The high-level targets for the health sector are articulated in the country's National Development Plan 2030[1] and confirmed in the sector's MTSF. These include:

- Raise life expectancy to at least 70 years;
- Ensure that the generation of under-20s is largely free of HIV;
- Significantly reduce the burden of disease;
- Achieve an infant mortality rate of less than 20 deaths per 1,000 live births, and an under-five mortality rate of less than 30 per 1,000.

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Figure 1: Health sector performance, 2013 to 2015 (%)[2]

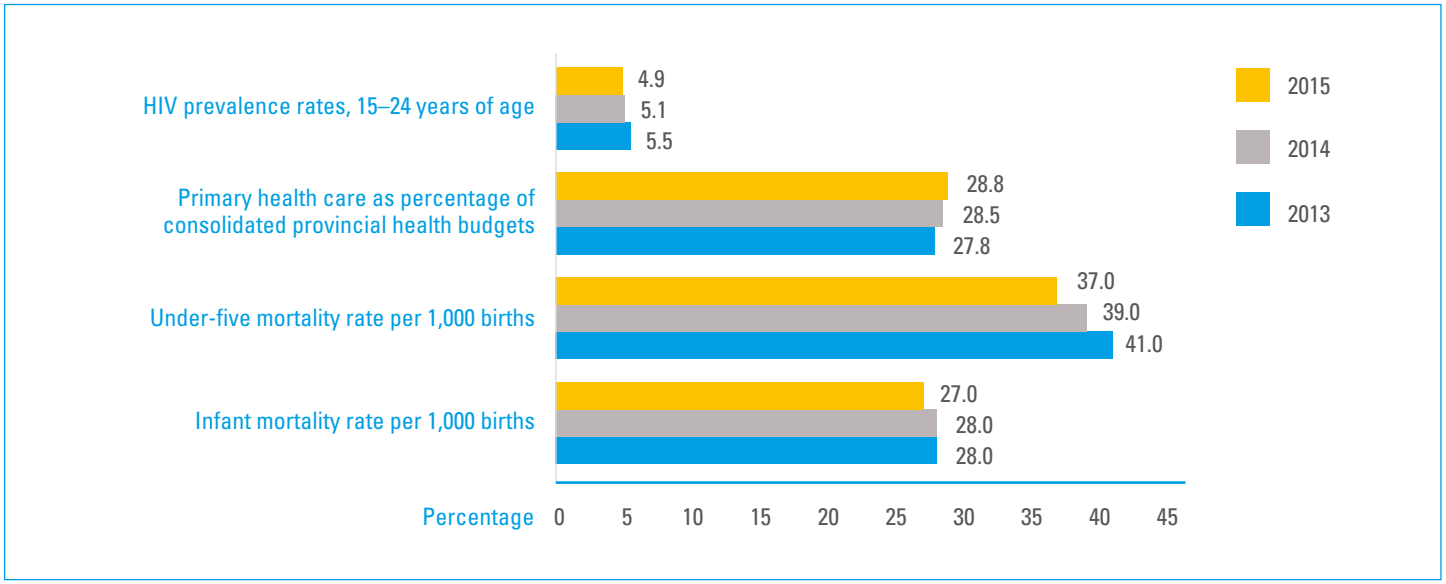

Figure 1 depicts a declining trend in infant and under-five mortality rates, while the HIV prevalence rates among young people (15–24 years old) show a slow, but consistent decline between 2013 and 2015. The share of primary health care programmes grew consistently over the three-year period and consumed almost 29 per cent of consolidated provincial health spending in 2015/16.

Table 1: Key fiscal indicators of the health system, 2015–2017[3]

Per capita spending on consolidated national and provincial health, 2016	ZAR3,155
Health as percentage of consolidated government budget, 2017/18	13.8%
Primary health care as percentage of consolidated health budget, 2017/18	30.0%
Personnel as percentage of consolidated health budget, 2017/18	61.5%
Official development assistance as percentage of national health budget, 2017/18	1.3%

TAKEAWAYS:

- **The NDoH develops and coordinates health policy, while provinces deliver on this policy mandate.**
- **Provincial departments of health are guided by a very strong health policy framework with ambitious goals that are heavily focused on improving child health.**
- **Progress is being made in reducing mortality rates for young children and the government appears to be on course to meet the goals of the NDP.**
- **HIV prevalence rates for young people (15-24 years old) show a slow, but consistent decline between 2013 and 2015. This trend is confirmed in recently-released prevalence estimates for 15-24 year olds, which show that in 2016, the rate was estimated at 4.8 per cent, while in the first half of 2017, it is estimated at 4.6 per cent.**

Section 2.

Health Spending Trends

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Size of Spending

Table 2 shows that the NDoH and the nine provincial health departments are projected to spend R183 billion in 2017/18. Provincial health departments spend the largest percentage of combined health funding (97.2%), while the NDoH is allocated 2.8 per cent of the combined health budget once the grant transfers to provinces are netted out.

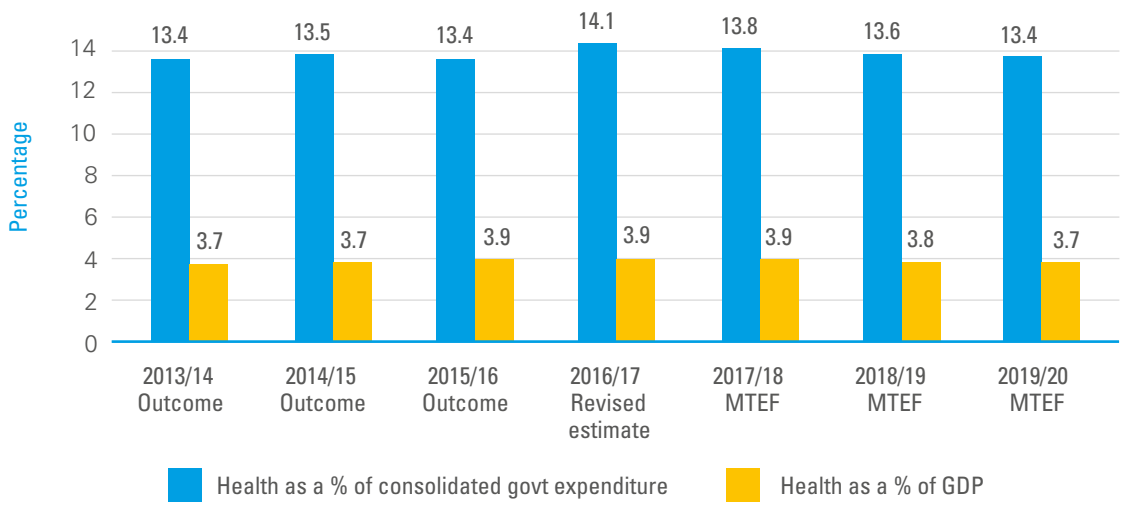
Table 2: Summary of nominal national and provincial health budgets, 2017/18 (ZAR'000)

Department	National	Provincial	% of total
National Department of Health	42,625,700		23.3%
...of which transferred to provinces	-37,520,392		-20.5%
Combined provincial health		177,767,845	97.2%
Eastern Cape		21,707,165	11.9%
Free State		9,774,916	5.3%
Gauteng		40,207,046	22.0%
KwaZulu-Natal		39,440,865	21.6%
Limpopo		18,042,777	9.9%
Mpumalanga		12,020,037	6.6%
Northern Cape		4,433,893	2.4%
North West		10,461,340	5.7%
Western Cape		21,679,806	11.9%
Total health budget	**182,873,153**		**100.0%**

Source: *Estimates of National Expenditure 2017 and Estimates of Provincial Revenue and Expenditure 2017*

Health spending continues to be very stable in South Africa, both as a percentage of total government spending and as a share of the economy. Consolidated health spending and allocations as a share of consolidated government expenditure range between 13.4 and 14.1 per cent over the 2013/14 to 2019/20 period (Figure 2). At the same time, consolidated health expenditure varies between 3.7 and 3.9 per cent of gross domestic product (GDP). Despite the stability, the government has yet to reach its commitment to the Abuja Declaration spending target of 15 per cent of the national budget for health.

Figure 2: Consolidated health expenditure as a percentage of consolidated government expenditure[4] and the GDP, 2013/14 to 2019/20

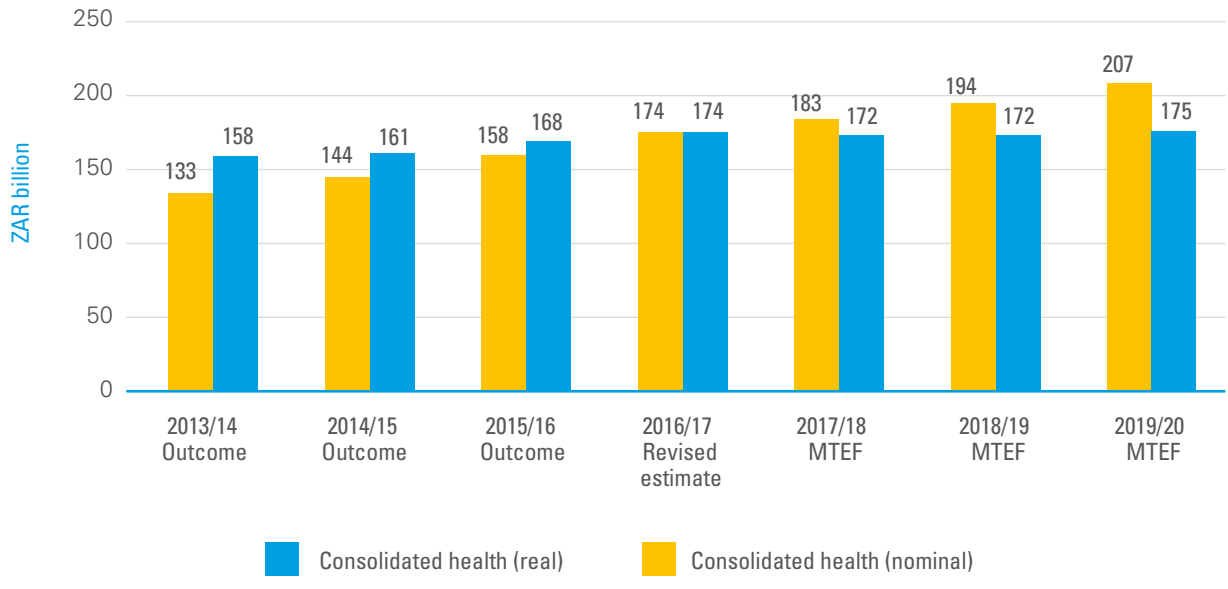


Source: *Estimates of National Expenditure 2017, Estimates of Provincial Revenue and Expenditure 2017 and Budget Review 2017*
Note: *Health expenditure is strictly limited to expenditure in the national Department of Health and provincial departments of health budgets. It excludes relevant health expenditure in other departments such as Defence Correctional Services, Basic Education etc.*

Spending Changes

The government has attempted to moderate spending growth in the health sector over the medium term, with virtually no real growth projected through 2019/20. Once adjusting for expected changes in price levels, spending and allocations on the combined health budgets are projected to decrease slightly in 2017/18 and 2018/19, relative to 2016/17, and experience a small uptick at in 2019/20 (Figure 3). The aggregate trends thus indicate that there is a squeeze on health spending.

Figure 3: Nominal and inflation-adjusted consolidated health spending and allocation trends, 2013/14 to 2019/20 (ZAR billion): 2016/17=100

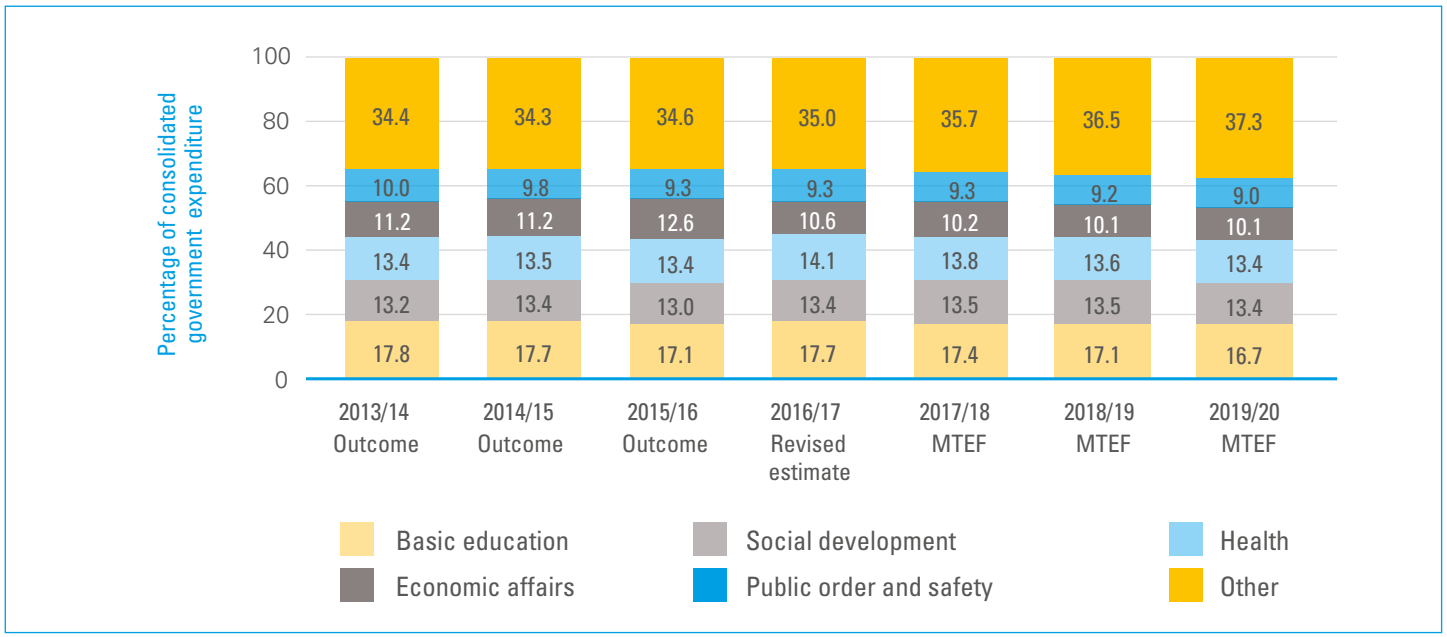


Source: *Estimates of National Expenditure 2017 and Estimates of Provincial Revenue and Expenditure 2017*

The Priority of Health in the Budget

Along with the broad social sectors, the health sector is a key budget priority in South Africa. At 13.8 per cent of the total budget in the current fiscal year, the health sector is the second largest recipient of resources, trailing only basic education (17.4 per cent) and receiving slightly more than social development (13.5 per cent) (Figure 4). When combined, the three largest social service sector votes account for nearly 45 per cent of consolidated government expenditure, a balance which has remained quite stable since 2013/14. However, by the end of the MTEF period, the social sectors are projected to receive a smaller proportion of the budget, with the health budget falling from 13.8 to 13.4 per cent of total spending between 2017/18 and 2019/20.

Figure 4: Social service sectors as a percentage of consolidated government expenditure, 2013/14 to 2019/20



Source: *Estimates of National Expenditure 2017 and Estimates of Provincial Revenue and Expenditure 2017*

When compared to other countries in Africa, South Africa's spending on health compares favourably. As a percentage of GDP, South Africa is among the highest investors in health on the continent, spending more than some of its neighbours, such as Botswana, Mozambique and Rwanda, but spending less than Lesotho and Malawi (Figure 5). However, Malawi and Lesotho's health expenditures are largely donor-funded, which places the South African investment in an even more positive light.

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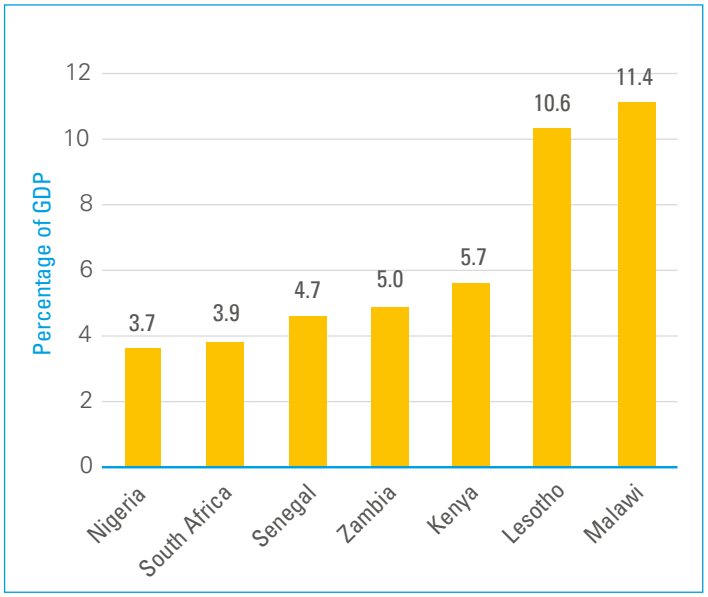
Figure 5: Public and private health expenditure as a percentage of GDP (2014 values)



Source: *WHO Global Health Expenditure Database*[5]
Note: *The WHO estimates refer to total health expenditure (public and private) as a percentage of countries' GDP.*

TAKEAWAYS:

- **Consolidated health spending consumes between 13.4 per cent and 14.1 per cent of total government resources, which falls below the government's commitment to the Abuja Declaration of 15 per cent.**
- **In spite of falling short of the Abuja Declaration, South Africa's health expenditure as a percentage of total government expenditure is the fifth highest on the continent;**
- **The real rate of growth of allocations on health programmes over the MTEF period is near zero, which highlights the need to better understand how well health departments are managing their resources, both in terms of execution, value for money and equity.**
- **Compared to South Africa's immediate neighbours, official government expenditure as a percentage of the country's GDP ranges from 3.9% in 2017/18 (for official health departments' spending only) to 4.3% (inclusive of all government health expenditures), which identifies South Africa as a high-spending country in the region.**

Section 3.

Composition of Health Spending

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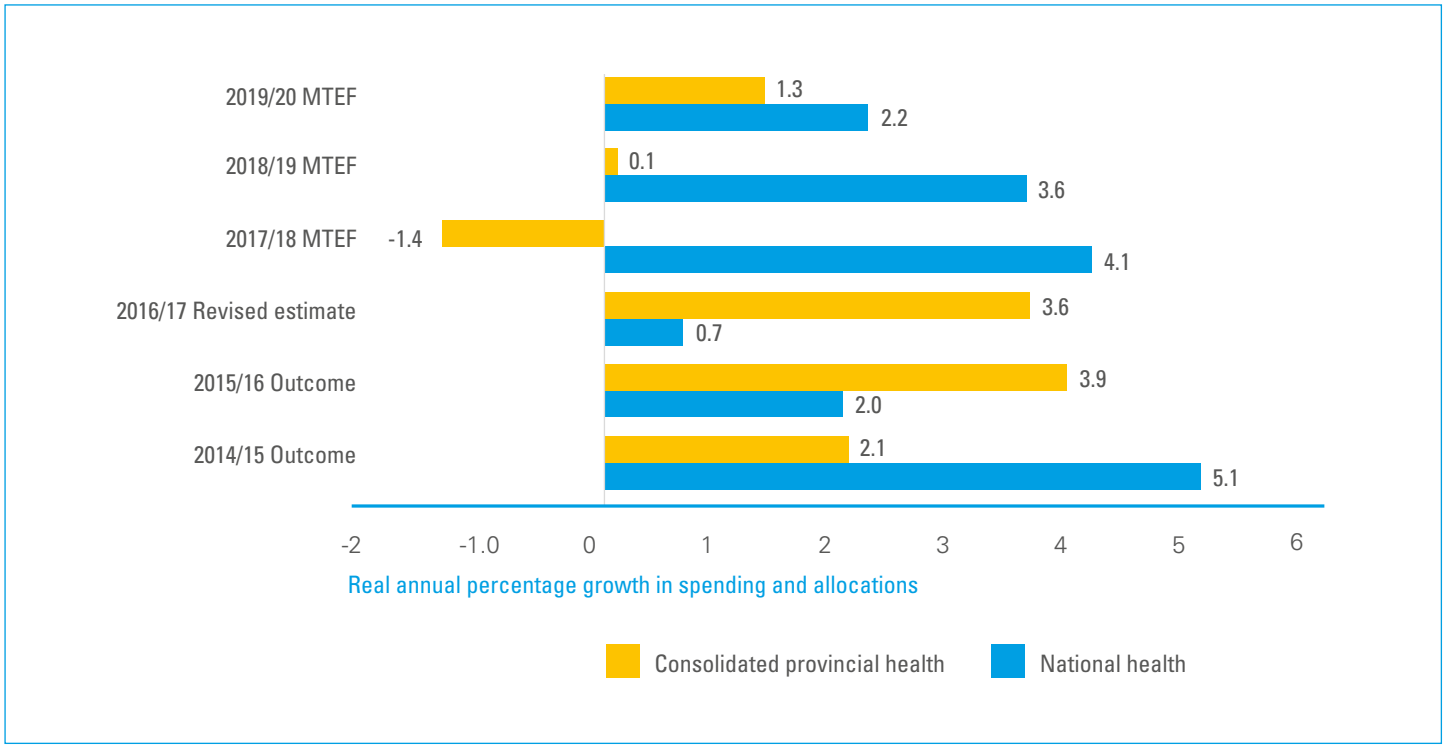
Composition of Spending by Department

Apart from a sharp decline in allocations to provincial health budgets in 2017/18, both the NDoH and its provincial counterparts have sustained real annual positive changes over the 2013/14 to 2019/20 period. Spending and allocations on consolidated health programmes is a better barometer of the relative prioritisation of the health function (Figure 6). Since the start of the 2017/18 financial year, allocations on provincial health programmes are predicted to have small growth margins in absolute terms.

Figure 6: Inflation-adjusted spending trends in health departments,[6] 2013/14 to 2019/20 (2016/17=100)



Source: *Estimates of National Expenditure 2017 and Estimates of Provincial Revenue and Expenditure 2017*

Composition of Spending by Programme: National Health Budget

Spending and allocations in the NDoH's budget are expected to grow from R39 billion in 2013/14 to more than R50 billion in 2019/20, which amounts to a real average annual rate of 3.3 per cent. The largest programme, namely Hospitals, Tertiary Health Services and Human Resources Development, is projected to grow by 0.7 per cent, while the HIV and AIDS, Tuberculosis and Maternal and Child Health programme achieves a much more robust rate of 6.5 per cent. The bulk of funding for this programme is devoted to the HIV/AIDS conditional grant, which is paid over to provincial health departments. In contrast, the primary health care programme, which is very important for providing basic services to children and families, is projected to grow at a real average annual rate of only 1.2 per cent.

Table 2: Programme expenditure in the national health budget, 2013/14 to 2019/20 (ZAR'000)

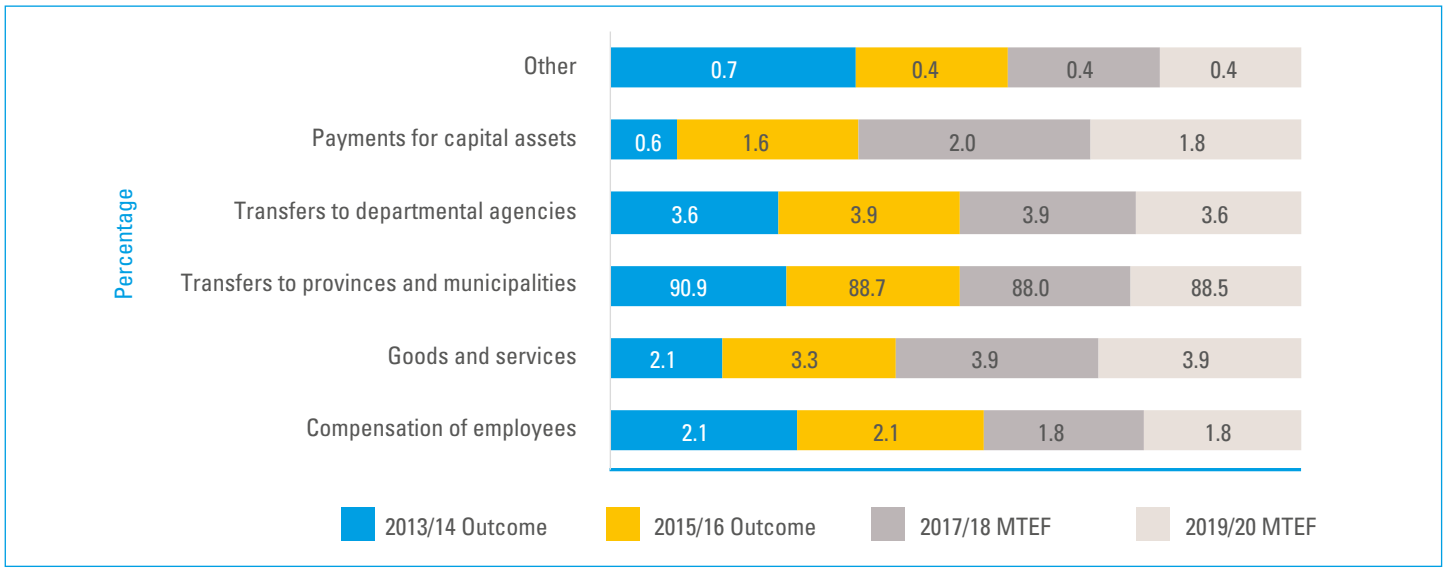
R million	2016/17 Revised estimate	2017/18 MTEF	2018/19 MTEF	2019/20 MTEF	Real change between 2016/17 and 2017/18 (%)	Real average annual change over MTEF (%)
Administration	462	513	548	583	4.4	2.1
National Health Insurance, Health Planning and Systems Enablement	589	735	993	1,047	17.5	15.1
HIV and AIDS, Tuberculosis and Maternal and Child Health	15,980	18,278	20,746	22,909	7.6	6.5
Primary Health Care Services	257	264	293	315	-3.1	1.2
Hospitals, Tertiary Health Services and Human Resource Development	19,514	21,108	22,301	23,641	1.8	0.7
Health Regulation and Compliance Management	1,707	1,727	1,787	1,890	-4.8	-2.3
Total	**38,507**	**42,626**	**46,667**	**50,385**	**4.1**	**3.3**

Source: *Estimates of National Expenditure 2017*

Composition of Spending by the Type of Expenditure: National Health Budget

Transfers to provinces and municipalities to deliver health services constitutes between 88 and 91 per cent of total national health funding (Figure 7). This expenditure item reflects all the conditional grants that are paid over to provincial health departments. The second largest expenditure items in the budget of the NDoH are transfers to departmental agencies (such as the South African Medical Research Council), while spending on employees amounts to around 2.0 per cent of overall national health resources. Goods and services consume between 2.1 per cent and 4 per cent of national health budgetary resources over the time period.

Figure 7: Expenditure by type in national health budget, 2013/14 to 2019/20

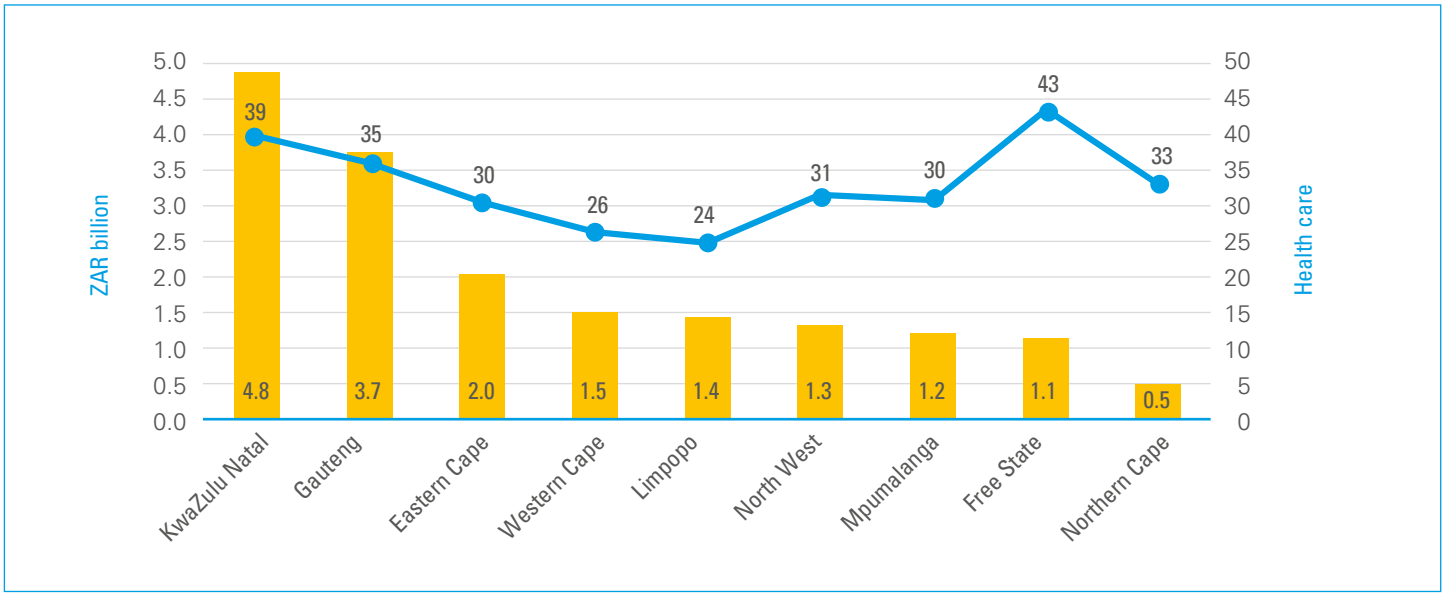


Source: *Estimates of National Expenditure 2017*

Spending on HIV/AIDS in the Consolidated Provincial Health Budget

There is a wide variance in allocations to provinces through the HIV/AIDS conditional grant. In the current fiscal year, this ranges from R500 million in the Northern Cape to nearly R5 billion in KwaZulu-Natal (Figure 8). The allocation provided to the KwaZulu-Natal Department of Health is almost four times the size of the allocation provided to Mpumalanga. The grant constitutes nearly half of all primary health care allocations in the Free State, while this amounts to one third of primary health care spending in the Northern Cape, Gauteng, Eastern Cape, Mpumalanga and North West. Moreover, the ZAR1.4 billion HIV/AIDS grant in Limpopo constitutes only a quarter of total primary health care spending in that province.

Figure 8: Allocations on the HIV/AIDS conditional grant by province and the grant as a percentage of primary health care allocations, 2017/18



Source: *Estimates of Provincial Revenue and Expenditure 2017*

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TAKEAWAYS:

- **Allocations to provincial health programmes over the present MTEF are under pressure and the growth margins are small.**
- **The government continues to robustly support HIV/AIDS programmes at the provincial level.**
- **The conditional grant allocations constitute between 30 and 45 per cent of provincial total spending on primary health care services; this funding source is absolutely critical to the delivery of basic health services for poor families and children and requires close monitoring.**

Section 4.

Decentralisation and Equity in Health Spending

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Spending and Allocations on Provincial Health Budgets

Provincial health spending is projected to grow from R170 billion in 2016/17 to R201 billion at the end of the present MTEF (Table 4). When inflation is factored in, provincial health programmes, on average, are not expected to grow in real terms. However, there are substantial differences across provinces: Mpumalanga health programmes are boosted by a real average annual gain of 2.5 per cent, while the Northern Cape registers negative growth (3.6 per cent) over the corresponding period. Moreover, the strong gain observed in Mpumalanga is not spread evenly across the MTEF, which demonstrates the general budgetary pressures facing provincial health services.

Table 4: Spending and allocation trends in provincial health budgets, 2016/17 to 2018/19 (ZAR'000)

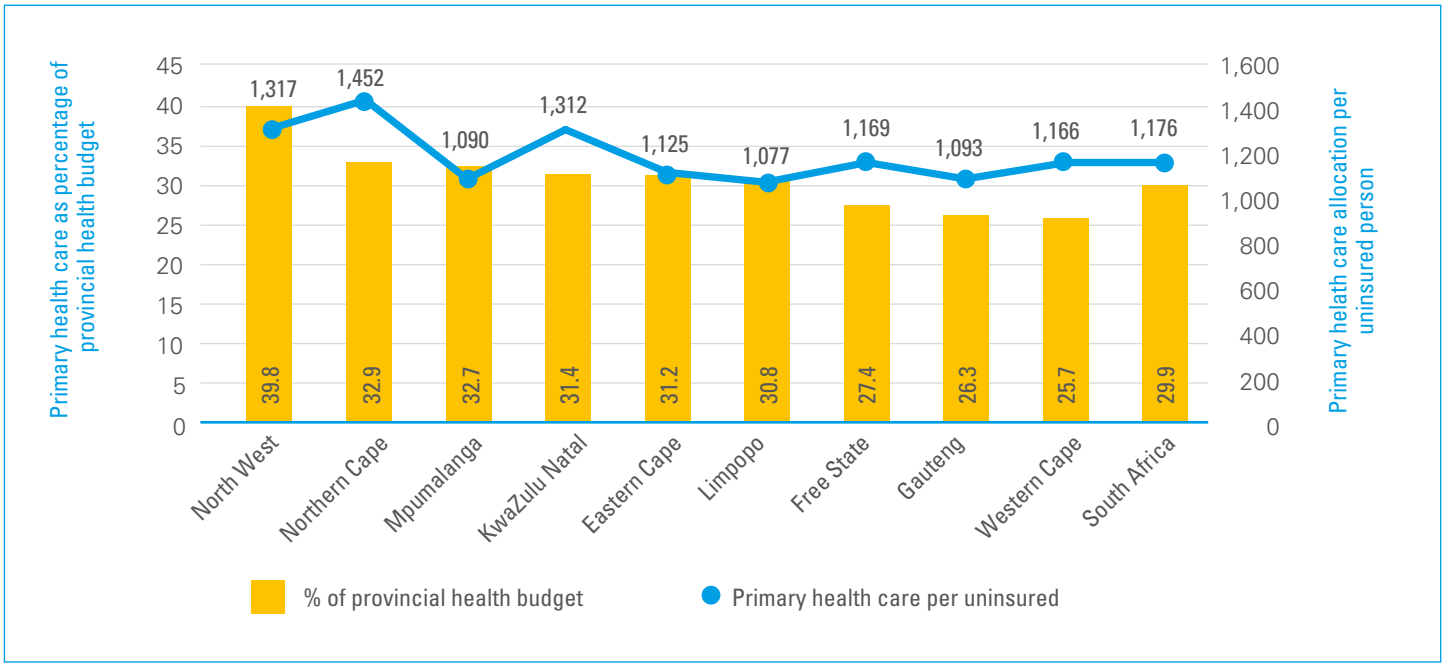
ZAR'000	2016/17 Revised estimate	2017/18 MTEF	2018/19 MTEF	2019/20 MTEF	Real change between 2016/17 and 2017/18 (%)	Real average annual change over MTEF (%)
Eastern Cape	20,543,771	21,707,165	23,364,729	25,091,146	-0.6	1.0
Free State	9,042,105	9,774,916	10,486,793	11,267,855	1.7	1.6
Gauteng	39,238,323	40,207,046	42,068,422	45,193,153	-3.6	-1.0
KwaZulu-Natal	37,284,049	39,440,865	41,959,574	44,992,728	-0.5	0.6
Limpopo	17,693,377	18,042,777	18,990,763	20,235,709	-4.1	-1.2
Mpumalanga	10,624,087	12,020,037	12,688,869	13,552,612	6.4	2.5
Northern Cape	4,663,027	4,433,893	4,614,994	4,933,205	-10.5	-3.6
North West	10,334,747	10,461,340	11,121,303	12,011,392	-4.8	-0.6
Western Cape	20,142,360	21,679,806	22,798,527	24,030,698	1.3	0.2
Total	**169,565,846**	**177,767,845**	**188,093,974**	**201,308,498**	**-1.4**	**0.0**

Source: *Estimates of Provincial Revenue and Expenditure 2017*

Provincial Differences in Health Allocations on Primary Health Care and Average Distance to Health Care Facilities

Allocations to primary health care programmes[7] constitute between 26 and 40 per cent of total provincial health budgets in the current fiscal year (Figure 9). Provinces that have a larger share of their health budgets devoted to primary health care (e.g. North West and Northern Cape) also plan to allocate the highest per person amount for those who are without medical insurance. For instance, the Northern Cape plans to spend R1,450 per uninsured person, while the North West and KwaZulu-Natal plan to spend R1,317 and R1,312 respectively. In contrast, Gauteng and the Western Cape have the lowest shares devoted to primary health care (about 26 per cent) and plan to spend much less in terms of uninsured persons (only about R1,100 per person). These provinces have a larger share of individuals with access to medical aid, thus in part explaining the differences in allocations per uninsured person.

Figure 9: Primary health care as a percentage of provincial health budget and allocation per uninsured person, 2017/18 (ZAR)



Source: *Estimates of Provincial Revenue and Expenditure 2017 and General Household Survey 2016 (own calculations)*

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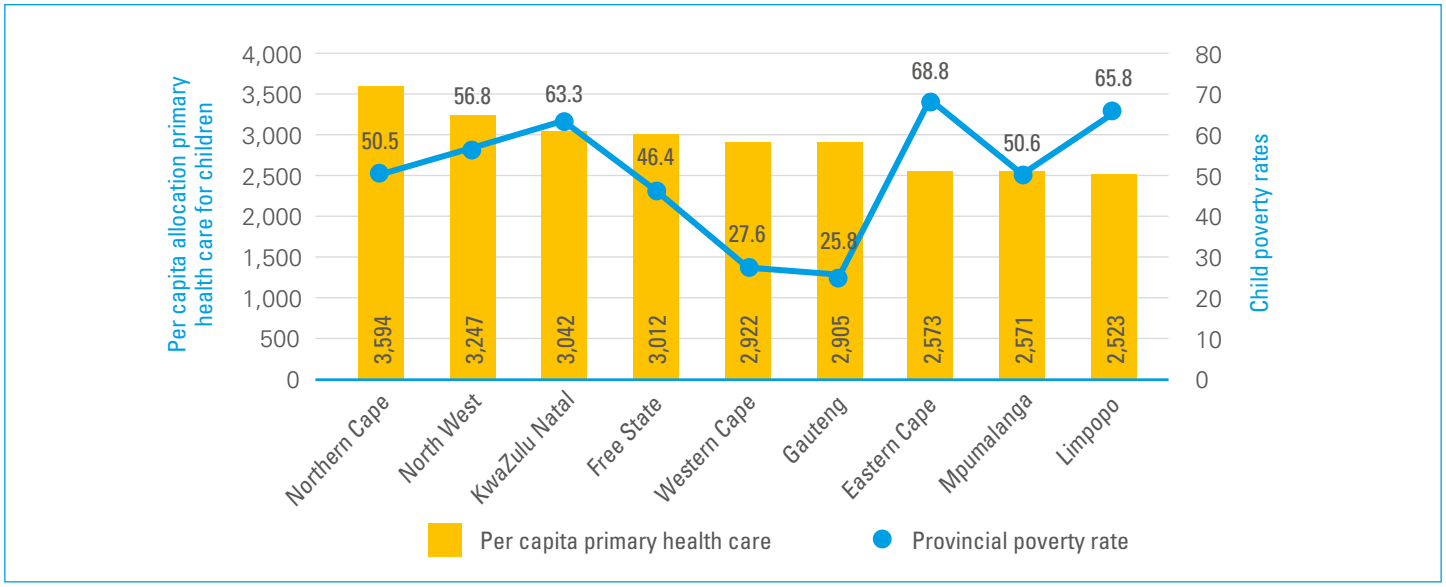
The inequity of health allocations is further evidenced when looking at child poverty rates. With child poverty rates of 26 per cent and 28 per cent respectively, Gauteng and the Western Cape are planning to spend around R2900 per child in 2017/18. The per capita allocation for children in the Eastern Cape is only R400 less per person than Gauteng and the Western Cape, but it has a poverty rate that is almost three times higher than these two urban provinces. More strikingly, Limpopo has the second highest child poverty rate (65.8% of children are poor), but it has the lowest per child spending on primary health care. (Figure 10).

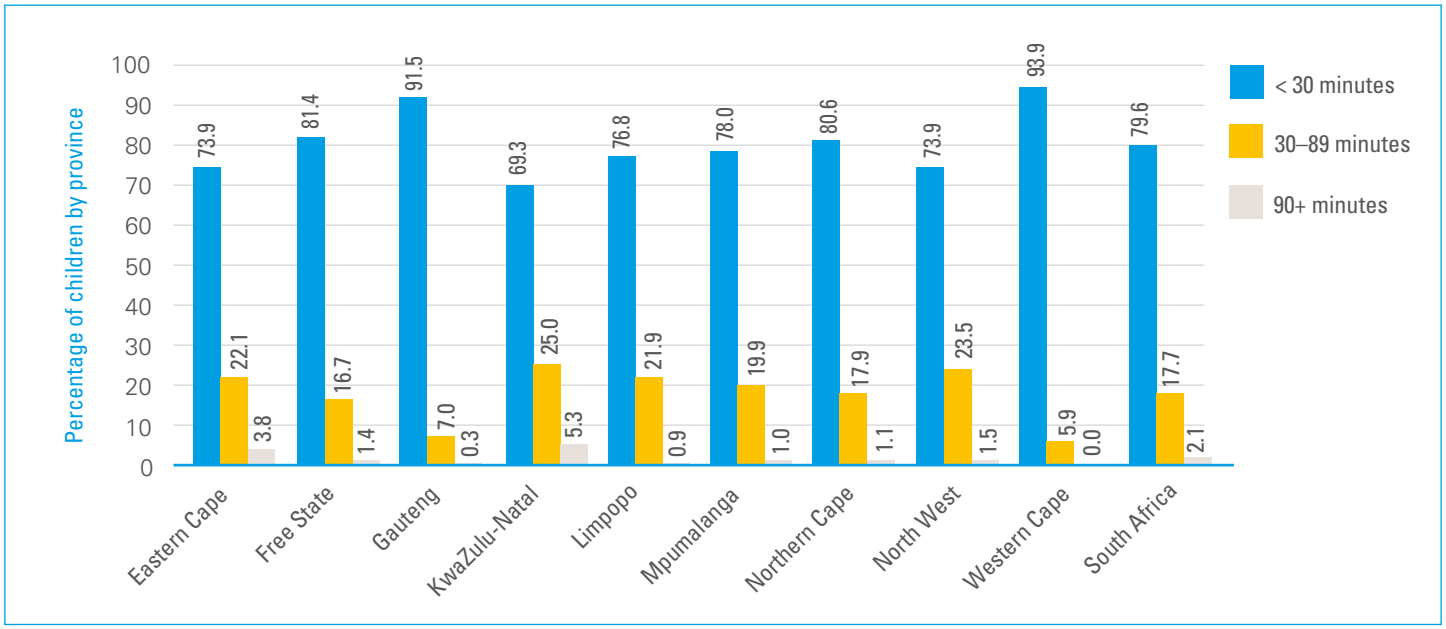
Figure 10: Examining the relationship between provinces' per capita allocation on primary health care for children in 2017/18 and child poverty rates by province in 2015



Source: *Estimates of Provincial Revenue and Expenditure 2017 and Statistics South Africa 2017 (data obtained in personal communication with Statistics South Africa)*

Health spending disparities are further reflected when looking at access to health facilities. In the urban provinces (Gauteng and the Western Cape), more than 90 per cent of children are able to reach a public or private health facility within 30 minutes of their home (Figure 11). However, this picture changes drastically when looking at rural provinces. In KwaZulu-Natal, for example, only 69 per cent of children have relatively short commute times to health facilities, which is similar although slightly better in the Eastern Cape and Limpopo, with the remainder of children having to travel longer than 30 minutes. Moreover, in KwaZulu-Natal and Western Cape, more than 5 per cent of all children are located more than 90 minutes away from the nearest health facility. These disparities are further driven by household income: only 8 per cent of children in the richest income quintiles travel more than 30 minutes to access a health facility, whereas more than 25 per cent of those in the poorest three quintiles have to travel for longer (Figure 12).

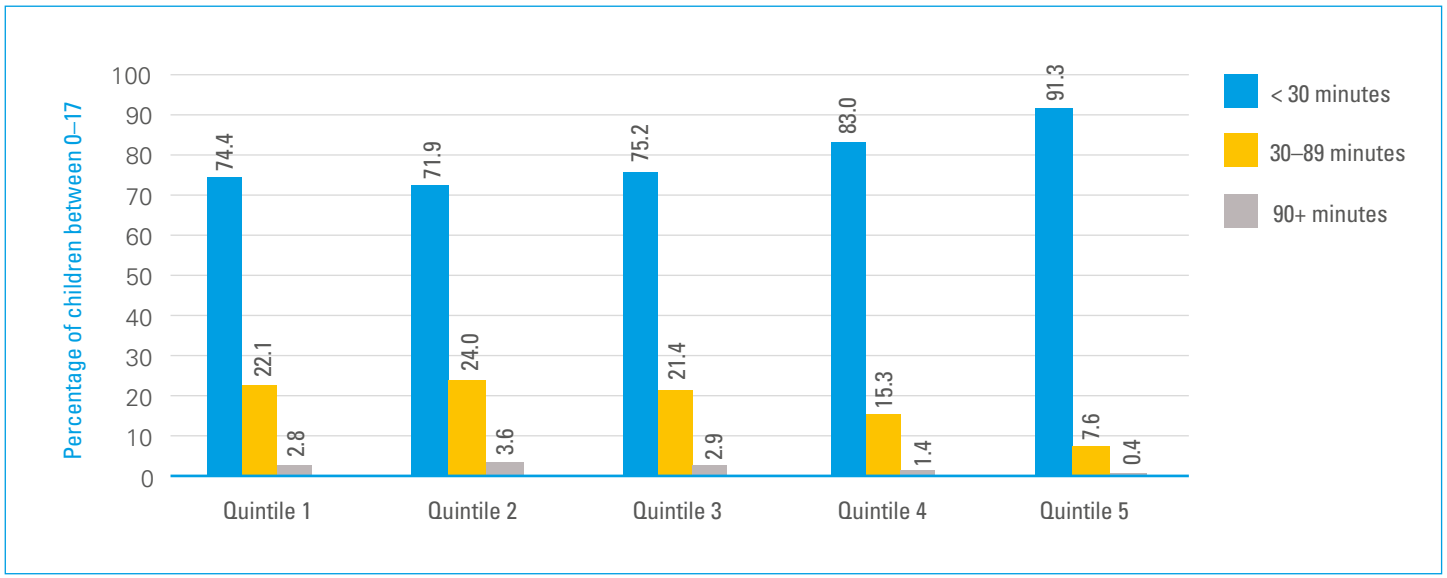
Figure 11: Differences in distance to health facility (public and private) by province, 2015



Source: *General Household Survey 2016 (own calculations)*

Figure 12 offers a breakdown of travelling times to health facilities by household income quintile. Children in the poorest quintiles are likely to travel more than 30 minutes to access a health facility. Whereas only 8 per cent of children in richer families travel more than 30 minutes to access a health facility, the corresponding numbers for the two poorest quintiles are 25 per cent and 28 per cent respectively. Given the significant transport costs that the poor incur to get to places of work, school and health facilities, this reinforces the point of accelerating infrastructure investments in the poorest rural provinces in South Africa.

Figure 12: Differences in distance to health facility (public and private) by household income quintile, 2015



Source: *General Household Survey 2016 (own calculations)*

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TAKEAWAYS:

- **Provincial health allocations are constrained and are projected to remain at zero real growth over the present MTEF.**
- **There are variations in the rate of growth of health allocations among provinces, with Mpumalanga registering a healthy 2.6 per cent real average gain, while the Northern Cape health budget shed almost 4 per cent in real terms over the same period.**
- **A weak relationship exists between the per child spending on primary health care and the percentage of children who are considered poor in each of the provinces, thus leaving further room for improved spending on children's primary health care in selected provinces.**
- **Inequities in provincial health allocations are further revealed when looking at access to health facilities, especially among the poorest children in rural provinces, which highlights the need for accelerated investment in and maintenance of provincial health infrastructure, including clinics.**

Section 5.

Financing the Health Sector

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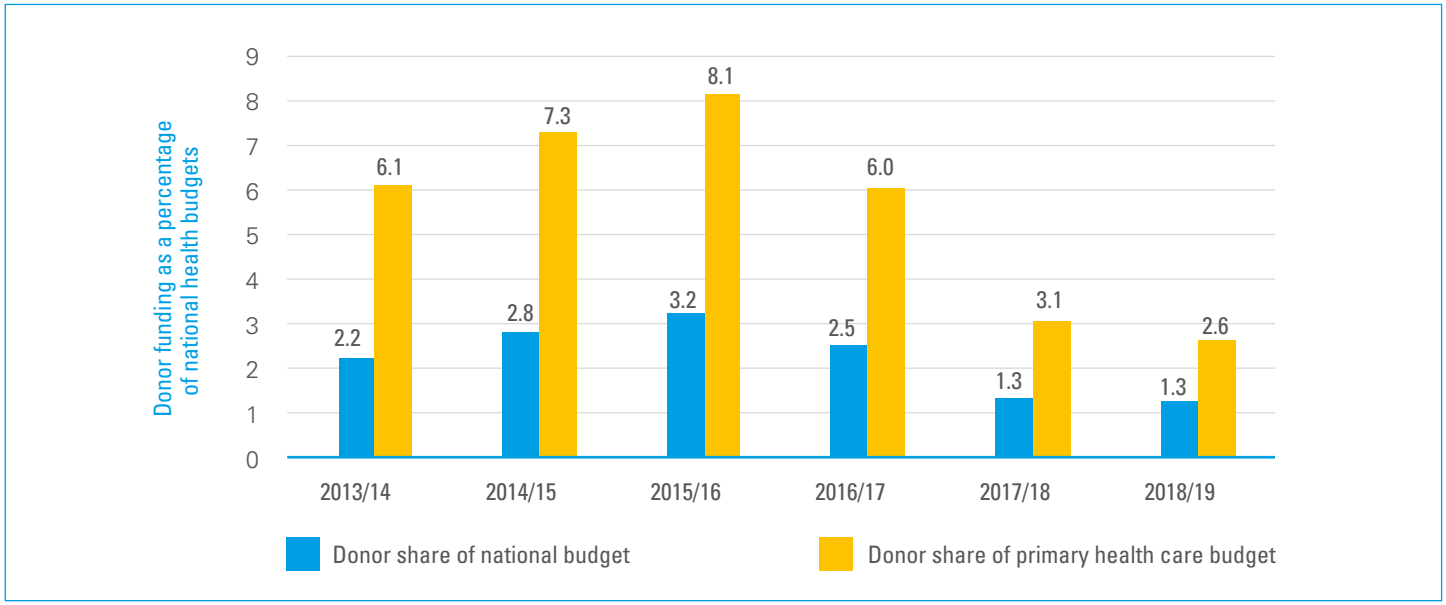
Financing Health at the National Level

South Africa finances the bulk of its health expenditures from the country's National Revenue Fund, but has made strategic use of international aid, especially in supporting the fight against HIV/AIDS. The contribution of donor funding to the budget of the NDoH has varied from 2.2 to 3.2 per cent in recent years, but has declined in the current fiscal year to 1.3 per cent (Figure 13). However, when calculating the donor contribution as a percent of the primary health care budget, the share rises, reaching 8.1 per cent in 2015/16 before scaling down to 6.0 per cent in 2016/17 and further falling to 3.1 per cent in the current fiscal year. Nonetheless, the relatively larger contribution to primary health care reflects the importance of funding for HIV/AIDS and international development partners' strong contribution in helping the South African government fight the pandemic.

Figure 13: Donor funding as a percentage of the budget of the NDoH and as a percentage of primary health care spending and allocations at the national level, 2013/14 to 2018/19

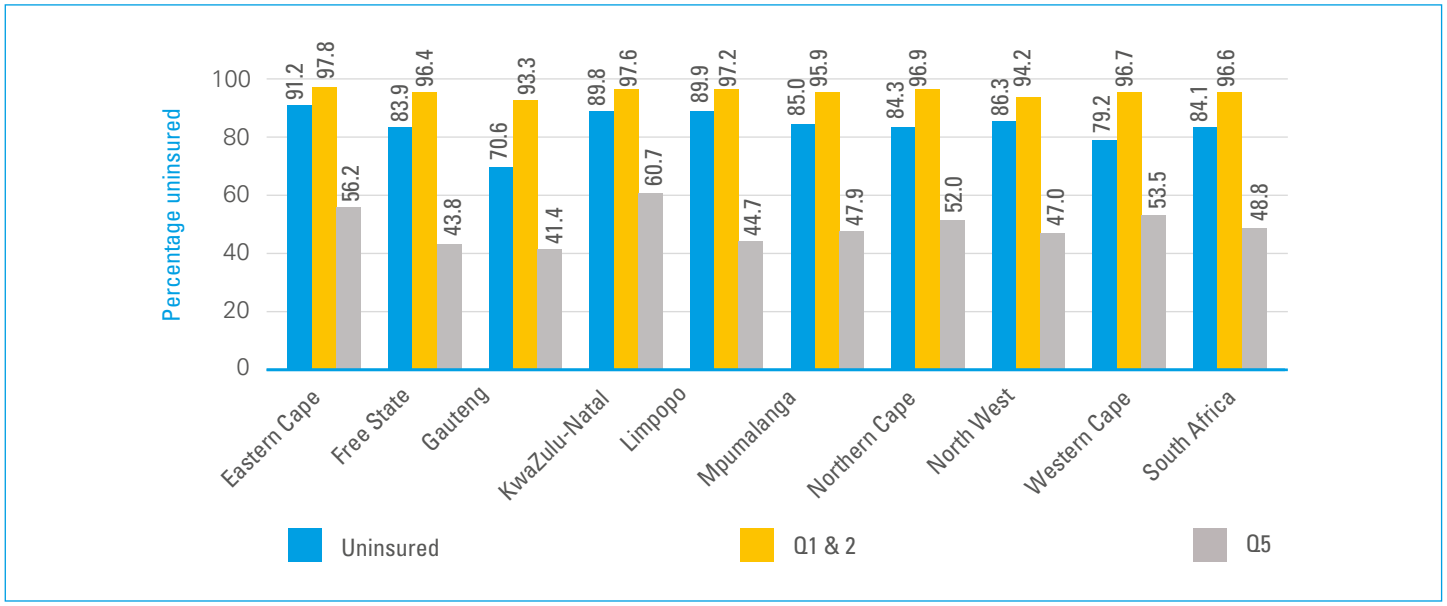


Source: *Estimates of National Expenditure (own calculations)*

Financial and Cost Barriers in Health Care Provisioning

Poverty, as reflected in the absence of access to medical insurance, remains a key challenge to improving access to health care, especially among the poor. Overall, 84 per cent of children in South Africa do not have medical insurance, which applies to nearly all children living among the poorest income quintiles (Figure 14). In contrast, fewer than half the children in the richest quintile do not have insurance, which is consistent across all provinces. Rural provinces shoulder a much heavier burden than the traditionally richer urban provinces, thus providing more evidence of the need to improve the availability and quality of health services in the rural and poorer provinces.

Figure 14: Differences in medical insurance coverage for children by province and household income quintile, 2016



Source: *General Household Survey 2016 (own calculations)*

Persistent inequities in access to quality health services point to the urgent need to scale up support to provincial health budgets. A recent UNICEF-commissioned assessment of fiscal space[8] in South Africa highlights a number of viable options that could allow the government to increase investments in the health sector. Some of the key options include: (i) levying taxes on the consumption of luxury goods; (ii) introducing the widely-debated sugar tax; (iii) achieving greater efficiency savings within existing health budgets, e.g. reducing unnecessary travel, curbing the use of external consultants, using more generic equipment and medicines, decreasing spending on activities that have a poor spending record; and/or (iv) reallocating resources from other non-priority sectors.

TAKEAWAYS:

- **Donor funding constitutes a small and shrinking percentage of overall funding in the budget of the NDoH and is expected to decline further.**
- **Poverty, as reflected in the absence of medical insurance, continues to prevent huge numbers of poor families and children from accessing basic health services.**
- **Given the deep inequities in the health care system, and a context of declining resources in the government's budget, the government should selectively invest in accelerated investment in infrastructure, especially for the poorest provinces where opportunity costs for accessing health services are high.**
- **Several financing and cost-saving options are being pursued by the South African government to increase fiscal space for programmes and services that benefit children, and it is hoped that such efforts produce an immediate boost of investments in children's health services.**

Endnotes

1 The Presidency, *The National Development Plan 2030: Our future – make it work*. Pretoria, Government Printers, 2011.

2 Mortality data were sourced from the Dorrington et al. (2016 and 2015) mortality reports. HIV prevalence rates were extracted from the Statistics South Africa's *Midyear population estimates 2017* report. Budget data were drawn from the *Provincial Revenue and Expenditure Estimates 2017/18.*

3 Budget data for this textbox were taken from *Estimates of National Expenditure 2017/18* and Provincial Estimates of Revenue and Expenditure 2017/18. Population data were drawn from the official General Household Survey 2016 report; and mortality rates were drawn from Dorrington R, Bradshaw D, Laubscher, R and Nanna, N. *Rapid Mortality Surveillance Report 2015*. Cape Town, South African Medical Research Council.

4 Our definition of consolidated government expenditure does not include provision for (interest on) public debt, excludes any public entities, but includes provision for the unallocated contingency reserve over the present MTEF. Excluding debt service costs provides a more accurate estimate of the quantity of resources available for service delivery.

5 Expenditure data were obtained from the World Health Organization's website, which is available from <http://apps.who.int/nha/database/Key_Indicators/Index/en> [accessed 02 September 2017].

6 To clearly demonstrate the two departments that are involved in health provisioning in South Africa, we have not netted out the provincial transfers from the budget of the National Department of Health. We have done that in our presentation of 'consolidated health' in Figures 2 and 3.

7 This Budget Brief replicates the definition of primary health care services that was adopted in the UNICEF Health Budget Brief in 2016. At the provincial level, primary health care services include the District Health Services Programme, but exclude the allocations for coroner services and district hospitals. Also included in the definition of primary health care services are the subprogrammes for HIV/AIDS and Nutrition, both of which are important for young children.

8 UNICEF. *National Political Economy Analysis and Fiscal Space Profiles of Countries in the Eastern and Southern African Region: Cast Study South Africa – Fiscal Space Analysis.* Pretoria, UNICEF, 2017.

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