There’s another way to make health more equitable in SA’s districts

A submission to the NCOP Select Committee on Finance
on the Division of Revenue Bill 2026

Russell Rensburg

March 2025

RHAP
Rural Health
Advocacy Project

What is the problem?

South Africa's district health system is funded through three streams that were never designed to work together:

1. Provincial equitable share -- this funds most primary health care services and all district hospitals. It is unconditional, flows to provinces through a formula that accounts for population size, service utilisation and developmental need, and provinces determine all allocations relative to their own priorities and cost pressures.

2. The District Health Programme Grant – this focuses on HIV, TB, community outreach, and some PHC enablers. It is a conditional grant with its own rules, reporting requirements, and performance framework.

3. A patchwork of smaller conditional grants – these cover training, infrastructure, oncology, and digital health systems — each with its own framework, reporting cycle, and accountability structure.

RHAP
Rural Health Advocacy Project

How does this manifest

District managers are asked to produce coherent, integrated population health outcomes from a budget that is split across three incompatible funding streams.

None of these streams was designed to account for the full district health mandate.

None of them together constitutes a financing instrument for the district health system as a system.

This architecture made a kind of sense in 2003. But the case for maintaining this architecture in 2026 is much weaker. The architecture has outlived its rationale.

What does the data show

Real per capita district health financing is declining: PHC expenditure per capita fell from R1 556 to R1 448 over the same period. All nine provinces experienced this decline simultaneously — which means the problem is structural and national, not a matter of individual provincial management.

Inter-provincial inequity is extreme and uncorrected: DHS spending per capita for the uninsured population ranged from R1 834 in Gauteng to R2 788 in Limpopo in 2023/24 — a 52% disparity that does not track population health need.

The DHPG adjustment confirms the fragility: The system is absorbing the PEPFAR gap with less real resource per person than the year before.

The provincial equitable share has flatlined: The PES showed no medium-term real growth in the 2025 MTEF. Provinces must still absorb wage drift, overtime, medicines inflation, and demographic demand — creating year-on-year pressure with no new fiscal space

What does the data show

The population health data confirms the system is not reaching those who need it most: District Health Barometer data on essential health services coverage shows persistent gaps in RMNCH outcomes, TB treatment success rates, and PHC utilisation in the districts with the highest burden — Alfred Nzo, OR Tambo, Pixley ka Seme, Sekhukhune, Vhembe. These are not management failures. They are financing architecture failures. The system cannot produce equitable population health outcomes from an inequitable and incoherent financing base.

A potential solution?

Engage National Treasury on the consolidation of the district health conditional grant architecture into a single, expanded District Health Programme Grant with the following design features:

Scope consolidation. It incorporates the existing District Health Programme Grant, the relevant components of the NHI indirect grant, the community health worker programme funding, and the operational components of smaller grants currently funding district-level functions.

Outcomes-linked accountability. The grant framework should be restructured around population health outcomes rather than input compliance. Performance metrics should be drawn from the District Health Barometer's essential health services coverage indicators —antenatal care coverage, TB treatment success rate, ART coverage, under-5 mortality, facility delivery rate — measured at district level and reported against a declared district health package standard. This shifts accountability from financial compliance to health impact.

A potential solution?

Equity-adjusted allocation. The grant allocation formula should incorporate a burden of disease weighting that directs proportionally greater resources to districts with the highest preventable mortality and the lowest essential services coverage. This requires no additional money just the reallocation of existing grant resources toward the districts where the constitutional obligation of progressive realisation is most unmet.

District manager decision-space. The consolidated grant should provide district managers with genuine budget flexibility within the outcomes framework — the ability to allocate resources responsively to population health priorities rather than being constrained by the rules of incompatible funding streams. This is not a weakening of accountability. It is the precondition for accountability that is meaningful rather than merely procedural.

Relationship to the provincial equitable share. The expanded DHPG does not replace the PES health component. It creates a clearly defined conditional grant layer that funds the district health system's population health mandate separately from the broader provincial health budget, making the district health investment visible, accountable, and protected from provincial budget pressures.

The bigger picture: SA's National Health Act

Is this even possible?

The National Health Act of 2003 provides the governance and organisational framework for

the district health system — including the provision for a district health package that would

define the standard of services every South African is entitled to receive at district level.

The NHI Act of 2023 provides a financing mechanism for universal access to health care. It is currently subject to constitutional challenge. The resolution of that challenge will take time.

The expanded District Health Programme Grant proposal does not depend on either the NHI

Act's implementation or its constitutional validation. It operates within the existing

Next steps

RHAP recommends that the NCOP Select Committee on Finance:

Request National Treasury to provide a province-by-province analysis of real per capita district health services expenditure against burden of disease indicators, and an assessment of whether the current equitable share formula and conditional grant architecture is producing or correcting for inter-provincial health inequity.

Engage the Department of Health on the timeline and content of the district health package promulgation under the National Health Act — the foundational governance instrument without which no grant accountability framework can be outcomes-based.

Signal to National Treasury that the NCOP expects the 2027 Division of Revenue process to include a proposal for consolidating the district health conditional grant architecture, with equity-adjusted allocation and outcomes-linked accountability, as a precondition for the district health system to fulfil its constitutional mandate.

In conclusion

The Division of Revenue Bill 2026 reflects a fiscally responsible effort to distribute nationally raised revenue equitably across three spheres of government. RHAP does not dispute the fiscal framework within which it operates.

The expanded District Health Programme Grant is the practical, fiscally neutral, constitutionally grounded reform available to government now. It does not require new money. It does not require the NHI Act. It requires the political will to reorganise existing resources in the interest of the communities that the Constitution was written to protect.

The NCOP is the chamber where that argument belongs. The Committee need to use its constitutional mandate to insist on it.

THANK YOU