

**2020**

**HIV/AIDS COMPONENT OF THE HIV, TB,  
MALARIA AND COMMUNITY OUTREACH GRANT**  
*- an analysis of expenditure per output and  
options for future reform*

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## 1. Executive Summary

South Africa has the largest number of people living with HIV in the world and also has the world's largest antiretroviral treatment (ART) programme. The ART programme, as well as to a somewhat lesser extent prevention programmes are largely domestically funded and the vast majority of government HIV funding is channelled through a ringfenced conditional grant from national to provincial governments. This grant has now become very large and has more than doubled in nominal terms in less than a decade, reaching R24bn in 2020/21.

For some time, consideration has been given to reforming the grant, including various ways to integrate HIV funds into a broader primary healthcare (PHC) funding pool. Concerns have also been raised regarding the efficiency of spending in the grant and that spending patterns differs considerably between provinces. This spending review has two broad objectives:

1. To quantify and analyse differences in cross-provincial expenditure patterns in HIV programmes, such as differences in expenditure per beneficiary and/or service rendered.
2. To identify, quantify and consider options for reforming the grant, including options for greater integration of HIV/AIDS and general PHC funding streams

The table below summarises the findings for the first objective. For each of the programmatic areas of HIV spending shown, the average expenditure per unit was estimated by dividing the expenditure on each area (drawn from BAS) by the number respective outputs produced. Indicative potential savings were estimated by calculating how much the provinces with high expenditure per output would save by bringing their expenditure per output down to the national average. The table below shows the average across 2017/18, 2018/19 and 2019/20, whereas the main body of the spending review presents this for each year individually. Based on this methodology, an estimated average of R732.6 million per year could have been saved in the ART programme (R328 million if looking at ARV drugs only), R32.7 million in the condoms programme and R203.8 million in the HIV testing programme. This brings the total indicative savings to R969.1 million. It is, however, important to emphasise that these estimates should not be taken as recommendations for direct budget cuts, as the analysis was done at a relatively high level, without consideration to local context-specific factors. The findings should therefore be seen as indicative and more detailed analysis would be required to make firm budget recommendations in this regard.

**Table A. Summary of indicative savings from bringing higher spending provinces down to the national average spending per beneficiary/service**

| Province                                | ART                       |                           | ARV                       |                           | Condoms                   |                           | Testing                   |                           | Total indicative savings - ART, condoms and |
|-----------------------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------------------------|
|                                         | Variance from average (%) | Indicative annual savings | Variance from average (%) | Indicative annual savings | Variance from average (%) | Indicative annual savings | Variance from average (%) | Indicative annual savings |                                             |
| Eastern Cape                            | 15%                       | 229,152                   | 5%                        | 54,116                    | -5%                       | 2,847                     | -71%                      | -                         | 231,999                                     |
| Free State                              | -1%                       | 4,362                     | 0%                        | 8,104                     | -31%                      | -                         | 45%                       | 15,443                    | 19,805                                      |
| Gauteng                                 | -2%                       | 24,806                    | 6%                        | 94,137                    | -3%                       | 789                       | -22%                      | -                         | 25,595                                      |
| KwaZulu-Natal                           | -8%                       | -                         | -6%                       | 0                         | 34%                       | 20,840                    | 89%                       | 183,298                   | 204,139                                     |
| Limpopo                                 | -7%                       | 484                       | -5%                       | 13,983                    | 13%                       | 4,948                     | -36%                      | -                         | 5,432                                       |
| Mpumalanga                              | -15%                      | -                         | 18%                       | 133,544                   | -13%                      | -                         | -24%                      | -                         | -                                           |
| North West                              | 15%                       | 115,254                   | -17%                      | 0                         | -17%                      | -                         | -6%                       | 2,031                     | 117,286                                     |
| Northern Cape                           | 48%                       | 92,106                    | 27%                       | 24,904                    | 3%                        | 993                       | 1%                        | 3,005                     | 96,105                                      |
| Western Cape                            | 31%                       | 266,412                   | -17%                      | 0                         | -2%                       | 2,291                     | -21%                      | -                         | 268,703                                     |
| <b>Total</b>                            |                           | <b>732,577</b>            |                           | <b>328,789</b>            |                           | <b>32,708</b>             |                           | <b>203,778</b>            | <b>969,062</b>                              |
| <b>Savings as a % total expenditure</b> |                           | <b>5.1%</b>               |                           | <b>4.7%</b>               |                           | <b>8.3%</b>               |                           | <b>22.8%</b>              | <b>6.2%</b>                                 |

With regards to the second objective, four scenarios (some with sub-scenarios) were considered and quantified:

1. Maintaining status quo
2. Shifting the entire grant component to the provincial equitable share
3. Creating a primary healthcare funding stream (e.g. a PHC conditional grant)
4. Shifting expenditure on CoE from the grant to PES and thereby maintaining a grant focusing mainly on HIV/AIDS commodities

Each of the scenarios are described, the financial implications (overall and per province) are quantified, and potential pros and cons are discussed. From the above scenarios, number 4 seems to be a useful middle-ground option and it is recommended that this is considered, possibly for implementation from 2022/23.

## 2. Problem statement

The HIV/Aids death and infection rate in South Africa has decreased over the years, but is still high. There were approximately 7.5 million people in South Africa living with HIV/Aids in 2019. The comprehensive HIV/Aids conditional grant was established in order to enable the public health sector to develop and implement an effective response to HIV/Aids and for the prevention and protection of health workers of exposure to hazards in the work place. Since implementation, the programmes set out in the conditional grant have reached millions of South Africans, through management, prevention, and treatment of HIV/Aids.

While the dedicated ringfenced funding stream for HIV/AIDS has had many benefits and has ensured adequate funding to significantly expand antiretroviral treatment (ART) coverage over the past decade, there are also potential concerns, including:

- The grant has now become very large. R24bn was allocated to in in 2020/21, which is more than a doubling in nominal terms in less than a decade. The grant is larger than the clinics subprogramme of provincial budgets.
- Ringfenced funding causes fragmentation, rigidity and possibly some inefficiencies in the health financing system. World Health Organization and others often argue that the most efficient health systems avoid parallel or duplicative financing systems.
- Health systems need to be responsive to the wholistic health needs of the population. The burden of disease in South Africa is gradually shifting from communicable diseases, such as HIV and TB, to non-communicable diseases, such as diabetes, hypertension, cancer etc., and the HIV “exclusivity” in health financing and health systems generally is increasingly being questioned. Calls for similar ringfenced allocations for other diseases would risk further fragmenting health financing.

This spending review seeks to:

3. Analyse the HIV/AIDS conditional grant in light of the above concerns, and make recommendations for possible reforms to the grant. It focuses mainly on the HIV/AIDS component which makes up the bulk of the total grant allocation.
4. Investigate the differences in cross-provincial expenditure patterns in HIV programmes, such as differences in unit costs and expenditure per beneficiary. The aim is to analyse trends in HIV/AIDS expenditure by the provinces and compare expenditure per beneficiary and/or service rendered in order to analyse different levels of resourcing and efficiency across provinces.

### 3. Institutional analysis

#### Programme beneficiaries

The beneficiaries of the HIV/AIDS grant are all people accessing HIV treatment and prevention services rendered by provincial departments of health. These services target particularly people living with HIV (PLHIV) or at high risk of contracting HIV, including health workers. In a broader sense, the programme benefits all residents of South Africa, as successful prevention and management of HIV reduces risks of infection for the whole population.

#### Key Policies

##### The Constitution

Chapter 2, Section 27 of the bill of rights states that, (1) Everyone has the right to have access to— (a) **health care services, including reproductive health care;** (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

##### National Health Act 61 of 2003

##### Chapter 3 states the general functions of the National Department of Health:

21. (1) The Director General must (a) ensure the implementation of the national health policy and (b) issue guidelines for the implementation of the national health policy.  
  
(2) The director general must in accordance with the national health policy [...] (k) facilitate and promote the provision of health care services for the management, prevention and control of communicable and non-communicable diseases; and (l) co-ordinate health services rendered by the national department of health with health services rendered by the provinces and provide such additional health services as may be necessary to establish comprehensive national health system.
22. (1) National health council, MOH and HODs/MECs etc. The National Health Council must advise the Minister on- (a) policy concerning any matter that will protect, promote, improve and maintain the health of the population,

##### Chapter 4 states the responsibilities of the provincial department of health:

- 25 (1) The relevant member of the executive council must ensure the implementation of the national health policy, norms, standards in the provinces.  
  
(2) The head of the provincial department must, in accordance with national health policy and the relevant provincial health policy in respect of or within the relevant province [...] (f) plan, co-ordinate and monitor health services and must evaluate the rendering of health services (O) provide health services contemplated by specific provincial health service programmes.

##### Division of Revenue Act

The Division of Revenue Act allocates the nationally raised revenue across the spheres of Government each year. It determines the allocations to each province, both of the provincial equitable share and the conditional grants. The Act provides the rules for how conditional grants are managed and spent. There is a specific grant framework for the HIV, TB, Malaria and Community Outreach Grant. The framework states that the following priority areas must be supported through the grant:

- ART related interventions
- care and support

- condom distribution and high transmission area interventions
- post exposure prophylaxis
- prevention of mother to child transmission
- programme management strengthening (PMS)
- regional training centres
- HIV counselling and testing
- medical male circumcision

### National Strategic Plan (NSP)

The National Strategic Plan for HIV, TB and STIs, 2017-2022 serves as a roadmap for South Africa's HIV/AIDS response. It sets out goals and approaches to realise these goals. The eight goals are the following (with selected relevant objectives in sub-bullets):

1. Accelerate prevention to reduce new HIV and TB infections and STIs
  - Reduce new HIV infections to less than 100 000 by 2022 through combination prevention interventions
2. Reduce morbidity and mortality by providing HIV, TB and STI treatment, care and adherence support for all
  - Implement the 90-90-90 strategy for HIV<sup>1</sup>
3. Reach all key and vulnerable populations with customised and targeted interventions
4. Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP
5. Ground the response to HIV, TB and STIs in human rights principles and approaches
6. Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs
7. Mobilise resources to support the achievement of NSP goals and ensure a sustainable response
  - Improve efficiency and mobilise sufficient resources to achieve the goals, objectives and targets of the NSP
8. Strengthen strategic information to drive progress towards achievement of the NSP goals.

Goals 1, 2 and 7 are the goals that are most relevant to this spending review, as they speak directly to aspects of the HIV response funded by the HIV/AIDS conditional grant.

### Clinical guidelines

A range of clinical guidelines exist for the HIV response, such as:

- 2019 Guideline for the Prevention of Mother to Child Transmission of Communicable Infections
- 2019 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates
- 2019 Adherence Guidelines for HIV, TB and NCDs
- National Consolidated Guidelines for the Management of HIV in Adults, Adolescents, Children and Infants and Prevention of Mother-to-Child Transmission (updated February 2020)

### Current grant arrangement and key programmes funded in the HIV/AIDS component

The HIV, TB, Malaria and Community Outreach Grant (originally named Comprehensive HIV/AIDS Grant) has existed for more than a decade and has changed shape over time. It is a schedule 5A conditional grant, meaning that it is a specific-purpose allocation which funds the bulk of provincial HIV expenditure (as opposed to a Schedule 4 grant which supplements existing budgets). While

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<sup>1</sup> 90% of all people living with HIV know their HIV status; 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy; 90% of all people receiving antiretroviral therapy are virally suppressed

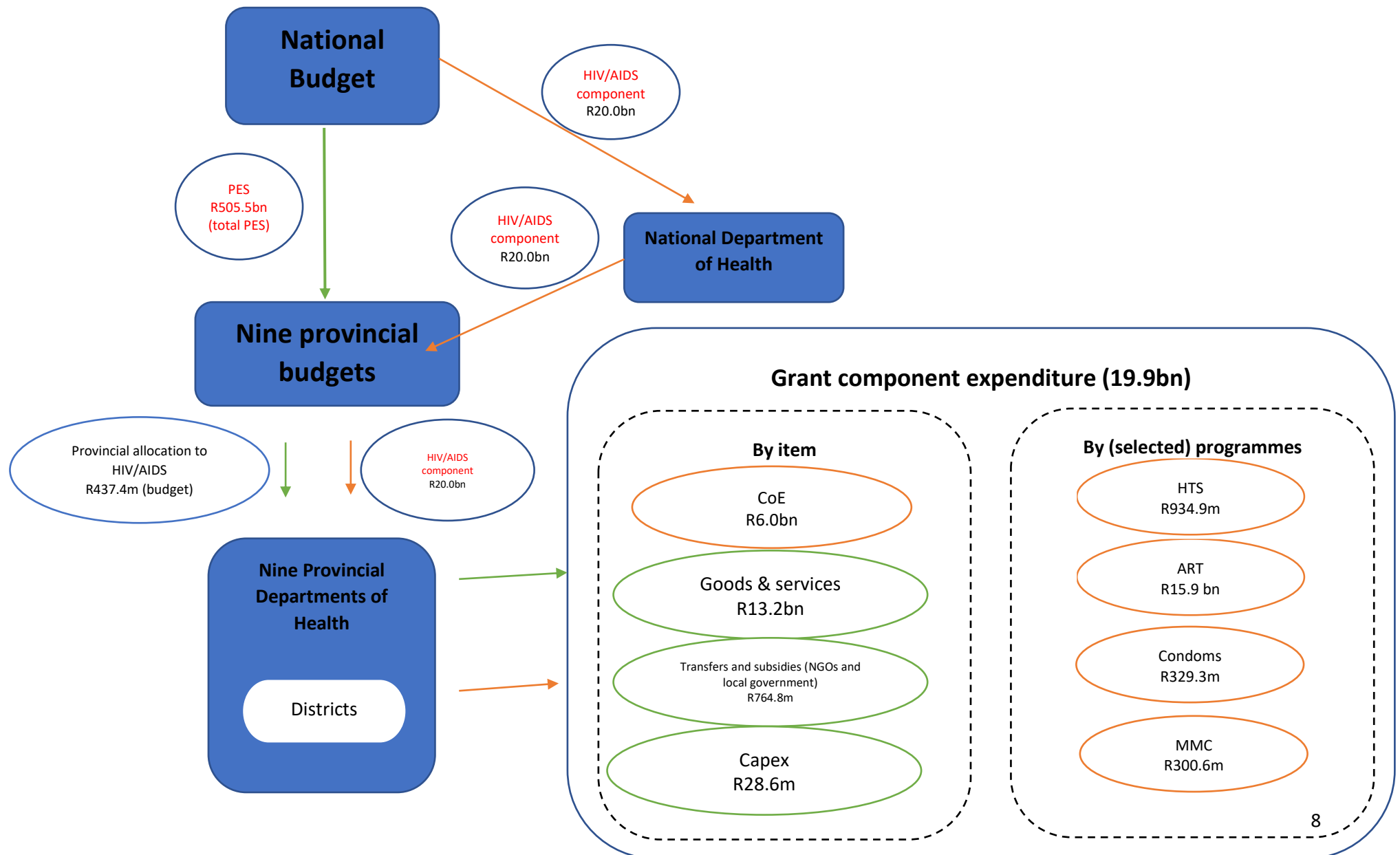
initially focusing exclusively on HIV/AIDS, its scope has broadened, and in 2020/21 it has components for several health programmes. The HIV/AIDS component, on which this spending review predominantly focuses, makes up the bulk of the grant, but there are also components for TB, malaria, the community health worker programme and the HPV vaccine programme.

The HIV component funds several different programmatic areas. The largest ones, which the expenditure analysis looks closer at are:

- *Antiretroviral treatment (ART)*: This is the largest spending area, accounting for R15.9 billion of expenditure in 2019/20. The ART programme provides life-saving treatment for over 5 million people. In addition to providing the antiretroviral (ARV) drugs to patients, it involves regular check-ups, including viral-load testing to assess the degree to which the virus is suppressed in the body.
- *HIV testing services (HTS)*: This programme area had R935 million in 2019/20 and funds screening, consultation and testing for HIV.
- *Medical male circumcision (MMC)*: MMC reduces the risk of males contracting HIV during unprotected sex. Government and development partners therefore offer free MMC as a prevention measure. MMCs are to a large extent funded by donors, mainly PEPFAR.
- *Condom distribution*: Government procured condoms are distributed free of charge both at health facilities and other outlets. Most condoms are procured by provincial departments of health using the HIV/AIDS component of the grant, but NDOH also procures a significant number of condoms and uses it as a buffers stock that can be distributed to provinces that experience shortages.

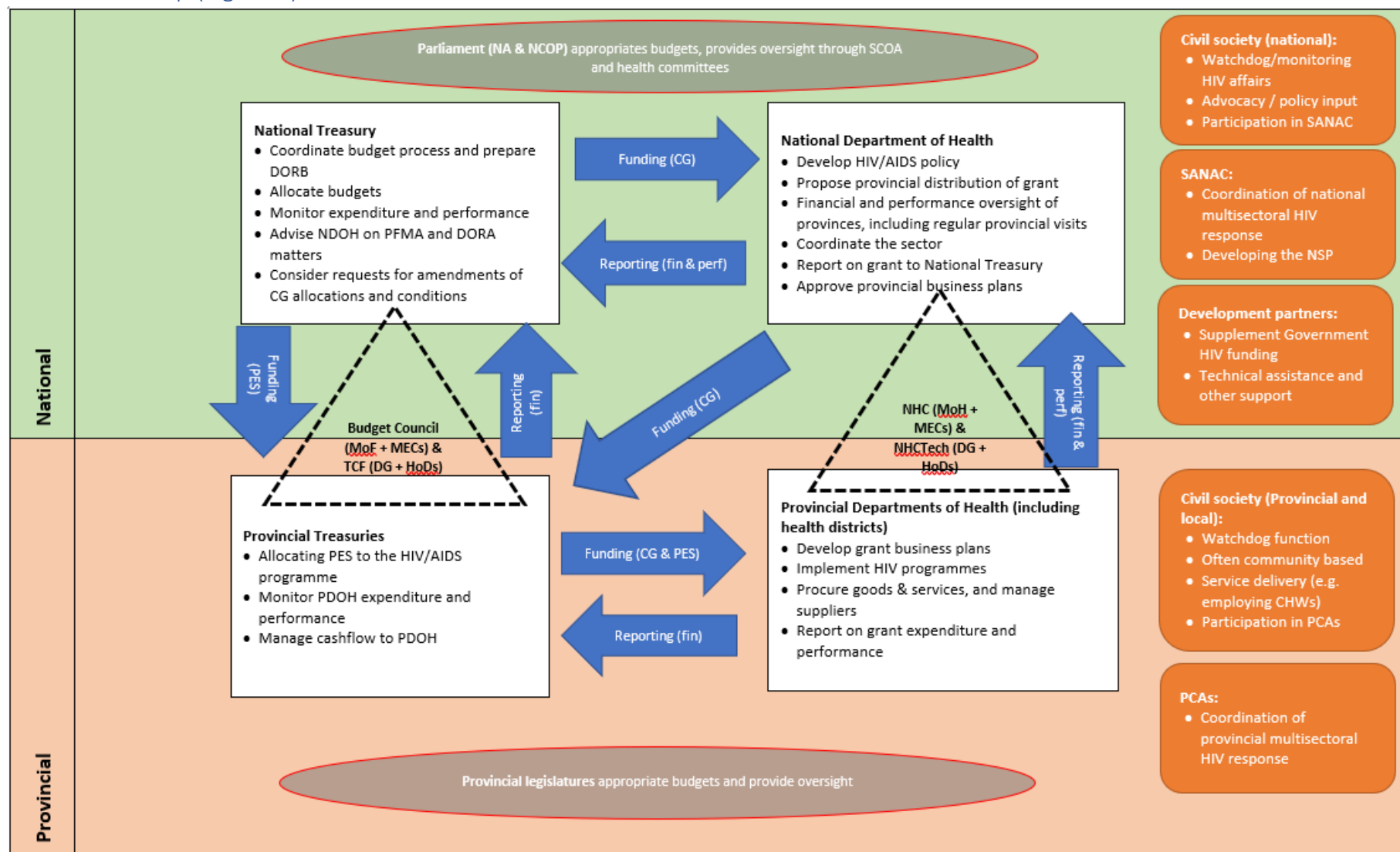
Other programmatic areas funded through the grant, but not discussed in detail here are programme management; high-transmission areas; post-exposure prophylaxis; prevention of mother-to-child transmission; regional training centres; HIV/TB collaboration; and sexually transmitted infections.

Flow of funds for provincial HIV/AIDS programmes (PES and HIV/AIDS component with 2019/20 amounts) (Figure 1)





Institutional map (Figure 2)



## 4. Expenditure analysis

### Introduction

The HIV grant has grown considerably in size for the past a decade from R6 billion in 2010/11 to R23.5 billion in 2020/21 and is projected to reach R28.2 billion in 2022/23. It remains the fastest growing expenditure item in provincial health budgets.

**Table 1. Overview of public HIV/AIDS financing in South Africa**

| Rand million                   | 2010/11       | 2016/17       | 2017/18       | 2018/19       | 2019/20       | 2020/21       | 2021/22       | 2022/23       | Average growth (2016/17 - 2022/23) |
|--------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|------------------------------------|
| National DoH (excl. CG)        | 352           | 422           | 436           | 415           | 482           | 881           | 1,128         | 1,182         | 19%                                |
| DoH conditional grant          | 6,052         | 15,291        | 17,578        | 19,922        | 21,949        | 24,047        | 27,364        | 28,812        | 11%                                |
| Provincial total, of which:    | 6,333         | 15,945        | 18,166        | 20,116        | 22,483        | 24,956        | 28,288        | 29,749        | 11%                                |
| Provincial own dedicated (PES) | 281           | 654           | 588           | 194           | 534           | 909           | 924           | 936           | 6%                                 |
| Other sectors                  | 813           | 1,298         | 1,425         | 1,573         | 1,742         | 1,664         | 1,720         | 1,781         | 5%                                 |
| <b>Total public</b>            | <b>7,498</b>  | <b>17,664</b> | <b>20,027</b> | <b>22,105</b> | <b>24,706</b> | <b>28,409</b> | <b>32,060</b> | <b>33,648</b> | <b>11%</b>                         |
| Donor                          | 3,921         | 7,327         | 8,184         | 9,763         | 11,388        | 11,136        | 9,865         | 10,775        | 7%                                 |
| <b>Total</b>                   | <b>11,419</b> | <b>24,992</b> | <b>28,211</b> | <b>31,867</b> | <b>36,094</b> | <b>39,546</b> | <b>41,925</b> | <b>44,423</b> | <b>10%</b>                         |

*NB conditional grant row includes HIV/AIDS component, Community Outreach Services component and TB component. Expenditure excludes cost of treatment of opportunistic infections.*

This growth has enabled a considerable expansion of Government's ART programme, which now has more than 5 million people remaining in care ("total remaining on ART"- TROA) . In 2019/20, R16 billion, was spent on the ART programme, comprising 73% of the overall grant and 84% of the HIV/AIDS component.<sup>2</sup>

The grant has also expanded in scope over time, with new components added for:

- **Community outreach services**, funding remuneration and training of community health workers
- **Tuberculosis**, funding the implementation of the recommendations of the TB investment case
- **Malaria**, funding prevention, screening and treatment of malaria in response to the Malaria elimination investment case
- **Human Papillomavirus (HPV)**, funding the HPV vaccination of girls in Grade 4 and 5
- **Mental health and oncology**, which are new components to be introduced from 2021/22.

The HIV/AIDS component remains the main component of the grant, with by far the largest allocation.

**Table 2. Components of the HIV, TB, Malaria and Community Outreach Grant**

| R million                                         | 2020/21       | 2021/22       | 2022/23       |
|---------------------------------------------------|---------------|---------------|---------------|
| HIV, TB, malaria and community outreach grant     | 24,387.20     | 27,931        | 29,405        |
| <i>HIV&amp;AIDS component</i>                     | <i>21,151</i> | <i>24,241</i> | <i>25,521</i> |
| <i>Community outreach services component</i>      | <i>2,384</i>  | <i>2,583</i>  | <i>2,723</i>  |
| <i>Malaria elimination component</i>              | <i>117</i>    | <i>111</i>    | <i>117</i>    |
| <i>Tuberculosis component</i>                     | <i>512</i>    | <i>540</i>    | <i>569</i>    |
| <i>Mental health services component</i>           | -             | <i>110</i>    | <i>116</i>    |
| <i>Oncology services component</i>                | -             | <i>110</i>    | <i>116</i>    |
| <i>Human Papillomavirus vaccination component</i> | <i>223</i>    | <i>235</i>    | <i>244</i>    |

<sup>2</sup> 2019/20 Conditional Grant Annual Evaluation Report.

## Overall grant

Expenditure on the overall Comprehensive HIV, TB, Malaria and Community Outreach Grant increased by 12% per year from R17.5 billion in 2017/18 to R21.9 billion in 2019/20. Growth was particularly high in Mpumalanga due to a change in the proportional allocations in 2018/19. As seen in subsequent tables, the expenditure growth has mainly been driven by the ART programme. The HIV/AIDS component which this spending review focuses on, was only created in 2019/20, so it is not possible to analyse expenditure over time for the component specifically.

**Table 3. Expenditure on the Comprehensive HIV, TB, Malaria and Community Outreach Grant**

|                 | Total grant       |                   |                   |                   | HIV/AIDS component |                        |                        |                                |
|-----------------|-------------------|-------------------|-------------------|-------------------|--------------------|------------------------|------------------------|--------------------------------|
|                 | 2017/18           | 2018/19           | 2019/20           | Total             | 2019/20            | Growth 2017/18-2018/19 | Growth 2018/19-2019/20 | Average Growth 2017/19-2019/20 |
| Province        |                   |                   |                   |                   |                    |                        |                        |                                |
| EC              | 2,042,316         | 2,103,650         | 2,398,113         | 6,544,080         | 2,240,841          | 3%                     | 14%                    | 8%                             |
| FS              | 1,148,408         | 1,199,425         | 1,244,516         | 3,592,349         | 1,174,431          | 4%                     | 4%                     | 4%                             |
| GP              | 3,744,381         | 3,965,836         | 4,662,826         | 12,373,043        | 4,315,326          | 6%                     | 18%                    | 12%                            |
| KZN             | 4,852,495         | 5,677,225         | 5,840,575         | 16,370,295        | 5,206,664          | 17%                    | 3%                     | 10%                            |
| LIM             | 1,366,911         | 1,574,262         | 1,970,493         | 4,911,665         | 1,459,025          | 15%                    | 25%                    | 20%                            |
| MPU             | 1,196,069         | 1,744,102         | 1,998,197         | 4,938,368         | 1,659,640          | 46%                    | 15%                    | 29%                            |
| NW              | 1,269,229         | 1,337,461         | 1,475,402         | 4,082,092         | 1,475,547          | 5%                     | 10%                    | 8%                             |
| NC              | 468,761           | 524,749           | 596,279           | 1,589,788         | 562,941            | 12%                    | 14%                    | 13%                            |
| WC              | 1,454,773         | 1,531,535         | 1,685,517         | 4,671,824         | 1,485,031          | 5%                     | 10%                    | 8%                             |
| <b>National</b> | <b>17,543,343</b> | <b>19,658,245</b> | <b>21,871,917</b> | <b>59,073,505</b> | <b>19,579,447</b>  | <b>12%</b>             | <b>11%</b>             | <b>12%</b>                     |

## Expenditure per programme area

Expenditure data drawn from BAS for 2017/18, 2018/19 and 2019/20 were analysed for the HIV grant. The lowest level objective segment was used to disaggregate HIV spending by programmatic spending areas. These include ART, HIV testing services (HTS), medical male circumcision (MMC) and condoms distribution, amongst others. The disaggregation through the objective segment was available for all provinces except Free State, however we were able to extract the same data from the responsibility segment in that province.

Expenditure per key output was calculated for these four programmatic areas. The four areas were selected, based on their importance to the overall HIV response and because they each have distinct outputs which are reported on in the conditional grant reports for the 3 years covered in this spending review. These four areas together made up 81.3% of the total grant expenditure over these three years and 91% of the HIV/AIDS component in 2019/20.

**Table 4. Summary of expenditure on key programmatic areas**

|                          | 2017/18           | 2018/19           | 2019/20           | Total             | Growth 2017/18-2018/19 | Growth 2018/19-2019/20 | Average growth 2017/19-2019/20 |
|--------------------------|-------------------|-------------------|-------------------|-------------------|------------------------|------------------------|--------------------------------|
| <b>Total expenditure</b> | <b>17,543,343</b> | <b>19,658,245</b> | <b>21,871,917</b> | <b>59,073,505</b> | <b>12.1%</b>           | <b>11.3%</b>           | <b>11.7%</b>                   |
| <i>Of which:</i>         |                   |                   |                   |                   |                        |                        |                                |
| ART                      | 12,959,055        | 14,284,972        | 15,932,109        | 43,176,136        | 10.2%                  | 11.5%                  | 10.9%                          |
| MMC                      | 284,412           | 329,308           | 300,607           | 914,327           | 15.8%                  | -8.7%                  | 2.8%                           |
| HTS                      | 858,797           | 890,150           | 934,892           | 2,683,839         | 3.7%                   | 5.0%                   | 4.3%                           |
| CONDOMS                  | 427,580           | 427,776           | 329,305           | 1,184,661         | 0.0%                   | -23.0%                 | -12.2%                         |
| PMTCT                    | 353,681           | 373,646           | 413,806           | 1,141,133         | 5.6%                   | 10.7%                  | 8.2%                           |

## Analysis of expenditure per output

This section compares and analyses expenditure per output for the ART, MMC, HTS and condoms programmes. For each of these programmes, expenditure per output was calculated by dividing total expenditure drawn from BAS by the annual outputs presented in the NDOH conditional grant annual evaluation reports.

This is done for each of the provinces and for the country as a whole, and the provincial amounts are compared to the national weighted average. Estimates are also made of how much would have been saved if the higher spending provinces would have been brought down to the national average expenditure per output. For illustrative purposes, the first section dealing with ART describes this approach in greater detail, while the subsequent sections present the results in a more condensed format.

It is important to note that the approach has some notable limitations, mainly related to differences in how expenditures are classified across programmes and that some programmes are significantly co-funded from other sources, while outputs cannot be disaggregated by funding source. Specific examples of these will be mentioned in the relevant sections below.

### Antiretroviral treatment (ART)

ART is by far the largest spending area in the grant. This spending area does not only include expenditure on ARV drugs but also other inputs required to deliver the service, such as compensation of employees, laboratory services and other goods and services etc.. Expenditure on ART as captured on BAS, increased by 11% per year from R13.0 billion in 2017/18 to R15.9 billion in 2019/20. In some provinces, expenditure fluctuated considerably from year to year, notably NW where expenditure declined by 8% from 2017/18 to 2018/19 but increased by 15% the year thereafter. The largest increase in absolute terms was in GP, which spent R803 million more on ART in 2019/20 in comparison to 2017/18, followed by KZN at R616 million.

**Table 5. Expenditure on ART by province (R'000')**

| Province        | 2017/18           | 2018/19           | 2019/20           | Growth<br>2017/18-<br>2018/19 | Growth<br>2018/19-<br>2019/20 | Average<br>Growth<br>2017/18-<br>2019/20 |
|-----------------|-------------------|-------------------|-------------------|-------------------------------|-------------------------------|------------------------------------------|
| EC              | 1,574,071         | 1,727,467         | 2,001,199         | 10%                           | 16%                           | 13%                                      |
| FS              | 774,285           | 833,193           | 898,520           | 8%                            | 8%                            | 8%                                       |
| GP              | 2,835,048         | 2,938,441         | 3,638,719         | 4%                            | 24%                           | 13%                                      |
| KZN             | 3,590,023         | 4,116,948         | 4,206,397         | 15%                           | 2%                            | 8%                                       |
| LIM             | 852,690           | 1,060,841         | 1,216,813         | 24%                           | 15%                           | 19%                                      |
| MPU             | 1,023,204         | 1,308,060         | 1,383,465         | 28%                           | 6%                            | 16%                                      |
| NW              | 985,667           | 910,739           | 1,045,417         | -8%                           | 15%                           | 3%                                       |
| NC              | 249,252           | 266,232           | 330,438           | 7%                            | 24%                           | 15%                                      |
| WC              | 1,074,816         | 1,123,051         | 1,211,139         | 4%                            | 8%                            | 6%                                       |
| <b>National</b> | <b>12,959,055</b> | <b>14,284,972</b> | <b>15,932,109</b> | <b>10%</b>                    | <b>12%</b>                    | <b>11%</b>                               |

This spending review uses patients remaining on ART at the end of each financial year as the output for the ART programme. Although it might have been preferable to use mid-year estimates, the year-end conditional grant reports are generally more accurate as they have undergone more data verification than the quarterly reports.. The number of patients on ART at the end of the year also increased considerably, from 4.2 million in 2017/18 to 5.0 million in 2019/20, an average increase of 9% per year. The largest percentage increase was seen in NW at 15% per year. The largest absolute

increase was in KZN, which increased by 210,566 patients from 2017/18 to 2019/20, followed by GP at 192,856 patients. These two provinces also had the largest absolute increases in expenditure as reflected in the table above.

**Table 6. Total number of patients remaining on ART (TROA)**

| Province        | 2017/18          | 2018/19          | 2019/20          | Growth 2017/18-2018/19 | Growth 2018/19-2019/20 | Average Growth 2017/19-2019/20 |
|-----------------|------------------|------------------|------------------|------------------------|------------------------|--------------------------------|
| EC              | 452,072          | 493,810          | 531,804          | 9%                     | 8%                     | 8%                             |
| FS              | 246,002          | 273,392          | 294,188          | 11%                    | 8%                     | 9%                             |
| GP              | 926,829          | 1,037,212        | 1,119,685        | 12%                    | 8%                     | 10%                            |
| KZN             | 1,271,116        | 1,387,688        | 1,481,682        | 9%                     | 7%                     | 8%                             |
| LIM             | 329,044          | 356,915          | 381,792          | 8%                     | 7%                     | 8%                             |
| MPU             | 411,905          | 464,562          | 514,605          | 13%                    | 11%                    | 12%                            |
| NW              | 236,856          | 278,802          | 315,074          | 18%                    | 13%                    | 15%                            |
| NC              | 57,429           | 59,347           | 65,592           | 3%                     | 11%                    | 7%                             |
| WC              | 256,821          | 278,290          | 300,470          | 8%                     | 8%                     | 8%                             |
| <b>National</b> | <b>4,188,074</b> | <b>4,630,018</b> | <b>5,004,892</b> | <b>11%</b>             | <b>8%</b>              | <b>9%</b>                      |

Expenditure on the ART programme was divided by the number of persons on ART to arrive at expenditure per person on ART. The average for the three-year period is shown in Table 7. In total, expenditure per patient on ART increase from R3,094 in 2017/18 to R3,183 in 2019/20, with an average of R3,121. This is an average increase in expenditure per person was 1.4%, which is considerably below inflation, and thus a real negative decline. The estimate in ranged from a low of R2,663 in MPU to a high of R4,621 in NC (the latter 73.5% higher than the former). The second last column of the table shows the difference between each province and the national average. As can be seen, four provinces (NC, WC, NW and EC) exceeded the national average considerably, whereas Mpumalanga was considerably below the national average.

**Table 7. Average ART expenditure per person remaining on ART (ZAR), annual growth, variance from national average and number of persons on ART (2017/18 -2019/20)**

| Province        | Averages - 2017/18 -2019/20   |                     |                                |                          |
|-----------------|-------------------------------|---------------------|--------------------------------|--------------------------|
|                 | Expenditure per person on ART | Percentage increase | Variance from national average | Number of persons on ART |
| NC              | 4,621                         | 7.7%                | 1,500                          | 60,789                   |
| WC              | 4,084                         | -1.9%               | 963                            | 278,527                  |
| NW              | 3,582                         | -10.7%              | 461                            | 276,911                  |
| EC              | 3,581                         | 4.0%                | 460                            | 492,562                  |
| FS              | 3,083                         | -1.5%               | -38                            | 271,194                  |
| GP              | 3,047                         | 3.1%                | -74                            | 1,027,909                |
| LIM             | 2,917                         | 10.9%               | -204                           | 355,917                  |
| KZN             | 2,877                         | 0.3%                | -244                           | 1,380,162                |
| MPU             | 2,663                         | 4.0%                | -458                           | 463,691                  |
| <b>National</b> | <b>3,121</b>                  | <b>1.4%</b>         | <b>0</b>                       | <b>4,607,661</b>         |

Table 8 uses this approach to estimate the potential savings if the expenditure per person in the higher spending provinces would have been brought down to the national average. This was done by multiplying the national average spending per person with the number of persons on ART in these provinces, which is shown in the first set of columns. In the second set of columns, these estimates

are subtracted by the actual historical spending on the ART programme to arrive at the indicative savings. The last column shows these savings as a percentage of the expenditure.

This approach indicates that savings of R792.8 million in 2017/18, R602.0 million in 2018/19 and R802.9 million in 2019/20, could have been realised, with the largest savings in WC and EC provinces. In percentage terms, the largest savings would have been in NC, given that this was the province with the highest ART expenditure per person on ART. In aggregate, this represents indicative savings of 5.1% of total expenditure on ART over the three-year period.

**Table 8. Calculation of indicative savings in ART programme**

| R'000'          | Calculated cost at national average unit cost |                   |                   | Indicative savings by aligning unit costs to national average |                |                | Average % savings |
|-----------------|-----------------------------------------------|-------------------|-------------------|---------------------------------------------------------------|----------------|----------------|-------------------|
| Province        | 2017/18                                       | 2018/19           | 2019/20           | 2017/18                                                       | 2018/19        | 2019/20        | 2017/18 - 2019/20 |
| EC              | 1,398,835                                     | 1,523,550         | 1,692,895         | 175,235                                                       | 203,918        | 308,303        | 13.0%             |
| FS              | 761,198                                       | 843,495           | 936,491           | 13,087                                                        | -              | -              | 0.5%              |
| GP              | 2,867,864                                     | 3,200,105         | 3,564,301         | -                                                             | -              | 74,418         | 0.8%              |
| KZN             | 3,933,183                                     | 4,281,427         | 4,716,649         | -                                                             | -              | -              | 0.0%              |
| LIM             | 1,018,153                                     | 1,101,188         | 1,215,361         | -                                                             | -              | 1,452          | 0.0%              |
| MPU             | 1,274,548                                     | 1,433,311         | 1,638,146         | -                                                             | -              | -              | 0.0%              |
| NW              | 732,898                                       | 860,186           | 1,002,977         | 252,770                                                       | 50,553         | 42,440         | 11.8%             |
| NC              | 177,701                                       | 183,103           | 208,799           | 71,551                                                        | 83,129         | 121,639        | 32.7%             |
| WC              | 794,675                                       | 858,607           | 956,488           | 280,141                                                       | 264,444        | 254,651        | 23.4%             |
| <b>National</b> | <b>12,959,055</b>                             | <b>14,284,972</b> | <b>15,932,109</b> | <b>792,783</b>                                                | <b>602,044</b> | <b>802,902</b> | <b>5.1%</b>       |

There are multiple reasons for the differences across provinces, so they should be interpreted with a degree of caution, and may not directly translate to potential budget cuts. For example, further analysis shows that the degree to which compensation of employees are funded through the grant differs considerably across the provinces, with WC, NC and NW allocating considerable amounts to CoE under the ART objective whereas other provinces might primarily fund CoE under other objectives or through PES. A nurse funded under the ART objective would likely also conduct HIV testing and vice versa.

The same approach outlined in detail above is, in the next subsections, applied to ARV drugs, condoms, HIV testing services and medical male circumcisions.

#### *Antiretroviral drugs*

Whereas there can be different reasons for variations in overall ART expenditure per person on ART, such as different approaches to classifying CoE etc, one would expect greater similarity across provinces on spending on antiretroviral drugs per person treated.

Unit expenditure was indeed more aligned across provinces, with average ARV expenditure per person in 2017/18 - 2019/20 ranging from R1,269 in NW to R1,941 in Northern Cape. This is a 52.9% difference, compared to 73.5% difference for ART expenditures shown above.

**Table 9. Average ARV drug expenditure per person remaining on ART (ZAR), annual growth, variance from national average and number of persons on ART (2017/18 -2019/20)**

| Province        | Averages - 2017/18 - 2019/20  |                     |                                |                          |
|-----------------|-------------------------------|---------------------|--------------------------------|--------------------------|
|                 | Expenditure per person on ART | Percentage increase | Variance from national average | Number of persons on ART |
| NC              | 1,941                         | -2.4%               | 414                            | 60,789                   |
| MPU             | 1,807                         | -1.0%               | 280                            | 463,691                  |
| GP              | 1,615                         | -1.5%               | 88                             | 1,027,909                |
| EC              | 1,614                         | -7.1%               | 86                             | 492,562                  |
| FS              | 1,526                         | -4.5%               | -2                             | 271,194                  |
| LIM             | 1,451                         | -5.2%               | -77                            | 355,917                  |
| KZN             | 1,441                         | -3.4%               | -86                            | 1,380,162                |
| WC              | 1,276                         | -6.7%               | -251                           | 278,527                  |
| NW              | 1,269                         | -0.9%               | -258                           | 276,911                  |
| <b>National</b> | <b>1,527</b>                  | <b>-3.3%</b>        | <b>0</b>                       | <b>4,607,661</b>         |

Table 10 shows that if the high spending provinces had been brought down to the national average, this would have reduced national spending on ARVs by R247 million in 2017/18, R382 million in 2018/19 and R357 million in 2019/20 (R986 million in total over the three years), in aggregate 4.7 % of total expenditure on ARVs.

**Table 10. Calculated savings from bringing high spending provinces to national average ARV expenditure**

| Province        | Cost at national average (R'000') |                  |                  | Calculated savings at national average (R'000') |                |                | Average % savings |
|-----------------|-----------------------------------|------------------|------------------|-------------------------------------------------|----------------|----------------|-------------------|
|                 | 2017/18                           | 2018/19          | 2019/20          | 2017/18                                         | 2018/19        | 2019/20        | 2017/18 - 2019/20 |
| EC              | 709,361                           | 782,298          | 759,948          | -                                               | 162,349        | -              | 6.8%              |
| FS              | 386,010                           | 433,110          | 420,395          | 24,312                                          | -              | -              | 2.0%              |
| GP              | 1,454,319                         | 1,643,160        | 1,600,031        | 128,749                                         | -              | 153,663        | 5.7%              |
| KZN             | 1,994,551                         | 2,198,387        | 2,117,325        | -                                               | -              | -              | 0.0%              |
| LIM             | 516,314                           | 565,428          | 545,581          | -                                               | 41,949         | -              | 2.7%              |
| MPU             | 646,334                           | 735,963          | 735,371          | 47,441                                          | 177,342        | 175,848        | 15.9%             |
| NW              | 371,659                           | 441,680          | 450,241          | -                                               | -              | -              | 0.0%              |
| NC              | 90,114                            | 94,018           | 93,731           | 46,679                                          | 362            | 27,671         | 21.2%             |
| WC              | 402,987                           | 440,869          | 429,372          | -                                               | -              | -              | 0.0%              |
| <b>National</b> | <b>6,571,649</b>                  | <b>7,334,913</b> | <b>7,151,996</b> | <b>247,182</b>                                  | <b>382,002</b> | <b>357,182</b> | <b>4.7%</b>       |

## Condoms

Total spending on the condoms programme has declined significantly over the past 3 years from R428 million in 2017/18 to R327 million in 2019/20. Also spending by the National DOH on its condoms programme declined from R95 million in 2017/18 to R53 million in 2019/20. The number of condoms (total of male and female) distributed has also declined somewhat from 706 million (686 million male and 20 million female) in 2017/18 to 660 million (643 million male and 17 million female) in 2019/20. Provincial expenditure per condom distributed declined by 9.2% per year between 2017/18 and 2019/20. There was considerable variation across provinces in condoms programme spending per

condom distributed, with averages over the three-year period ranging from 39 cents in FS in to 75 cents in KZN.

**Table 11. Average expenditure per condom distributed (ZAR), annual growth, variance from national average and number of condoms distributed**

| Province        | Averages - 2017/18 - 2019/20       |               |                                  |                                       |
|-----------------|------------------------------------|---------------|----------------------------------|---------------------------------------|
|                 | Expenditure per condom distributed | Annual change | Difference from national average | No of condoms distributed (thousands) |
| KZN             | 0.75                               | -9.4%         | 0.19                             | 105,244                               |
| LIM             | 0.63                               | 1.9%          | 0.07                             | 82,837                                |
| NC              | 0.56                               | 26.4%         | 0.00                             | 13,189                                |
| EC              | 0.54                               | -22.6%        | -0.02                            | 72,857                                |
| WC              | 0.54                               | 7.6%          | -0.02                            | 101,213                               |
| GP              | 0.54                               | -10.6%        | -0.02                            | 166,734                               |
| MPU             | 0.48                               | -3.5%         | -0.08                            | 60,099                                |
| NW              | 0.47                               | -26.5%        | -0.09                            | 51,373                                |
| FS              | 0.39                               | -33.7%        | -0.17                            | 49,806                                |
| <b>National</b> | <b>0.56</b>                        | <b>-9.2%</b>  | <b>0.00</b>                      | <b>703,353</b>                        |

Using the approach of bringing higher spending provinces down to national average unit expenditure, estimated savings could have been R98 million over the three-year period, equivalent to 8.3% of total condoms spending. The majority of these savings would have been in KZN.

**Table 12. Calculated savings from bringing high spending provinces to national average condom expenditure**

|                 | Calculated cost at national average unit cost |                |                | Indicative savings by aligning unit costs to national average |               |               | Average % savings |
|-----------------|-----------------------------------------------|----------------|----------------|---------------------------------------------------------------|---------------|---------------|-------------------|
| Province        | 2017/18                                       | 2018/19        | 2019/20        | 2017/18                                                       | 2018/19       | 2019/20       | 2017/18-2019/20   |
| EC              | 37,384                                        | 43,851         | 40,200         | 8,541                                                         | -             | -             | 7.6%              |
| FS              | 25,739                                        | 29,889         | 27,406         | -                                                             | -             | -             | 0.0%              |
| GP              | 110,637                                       | 101,624        | 70,235         | 2,366                                                         | -             | -             | 0.7%              |
| KZN             | 54,504                                        | 65,804         | 55,522         | 10,967                                                        | 40,556        | 10,998        | 33.9%             |
| LIM             | 57,187                                        | 48,479         | 34,809         | 2,149                                                         | 1,952         | 10,743        | 12.9%             |
| MPU             | 37,195                                        | 39,739         | 24,830         | -                                                             | -             | -             | 0.0%              |
| NW              | 28,036                                        | 29,676         | 28,045         | -                                                             | -             | -             | 0.0%              |
| NC              | 7,323                                         | 8,205          | 6,588          | -                                                             | -             | 2,979         | 15.1%             |
| WC              | 69,576                                        | 60,509         | 41,669         | -                                                             | -             | 6,874         | 5.5%              |
| <b>National</b> | <b>427,580</b>                                | <b>427,776</b> | <b>329,305</b> | <b>24,023</b>                                                 | <b>42,508</b> | <b>31,593</b> | <b>8.3%</b>       |

There are two important limitations to these findings. The first is that the national DOH also procures condoms and distributes them to provinces. This expenditure is reflected in NDOH books and is not disaggregated by provinces. These condoms would therefore be included in the output figures for the relevant provinces but not in the expenditure figures. So, if a province received and distributed a large consignment of condoms from NDOH, this would have brought down their expenditure per condom distributed.

The second limitation is that the year in which condoms are procured (which determines the bulk of expenditure) may not entirely coincide with the year they were distributed, which might also in some instances distort the estimates of expenditure per condom distributed presented here.



## HIV testing services

Conditional grant expenditure on HTS increased from R859.5 million in 2017/18 to R934.7 million in 2019/20. The number of tests performed (including antenatal tests) also increased considerably from 13.9 million in 2017/18 to 19.0 million in 2019/20, causing conditional grant expenditure per test performed to decrease from R62 to R49. The increase in tests may thus have been partly funded by international donors (in 2016/17 roughly half of HTS expenditure was financed by PEPFAR<sup>3</sup>). These donor funds do not flow through government systems and are not accounted for in this expenditure analysis. Differences in geographical distribution of donor funding is likely to have contributed to differences in expenditure per test, ranging from R17 in EC in to R107 in KZN in 2017/18. Nevertheless, the high spending across all years in KZN, could be worth investigating further for potential inefficiencies.

**Table 13. Average expenditure per HIV test (ZAR), annual growth, variance from national average and number of HIV tests conducted**

| Province        | Averages - 2017/18 - 2019/20 |               |                                  |                                   |
|-----------------|------------------------------|---------------|----------------------------------|-----------------------------------|
|                 | Expenditure per test         | Annual change | Difference from national average | No of tests performed (thousands) |
| KZN             | 107                          | 5.2%          | 50                               | 3,712                             |
| FS              | 83                           | 5.0%          | 26                               | 620                               |
| NC              | 59                           | 52.2%         | 3                                | 290                               |
| NW              | 53                           | 0.0%          | -3                               | 989                               |
| WC              | 45                           | 1.4%          | -12                              | 1,678                             |
| GP              | 44                           | 7.1%          | -12                              | 3,808                             |
| MPU             | 42                           | 3.5%          | -14                              | 1,351                             |
| LIM             | 36                           | 1.4%          | -21                              | 1,630                             |
| EC              | 17                           | 32.5%         | -40                              | 1,889                             |
| <b>National</b> | <b>57</b>                    | <b>4.1%</b>   | <b>0</b>                         | <b>15,966</b>                     |

If expenditure per test in KZN would have been brought down to the national average, between R193 million and R210 million per year could potentially have been saved, equivalent to 22.8% of total provincial expenditure on HIV tests.

<sup>3</sup> Guthrie T, Chaitkin M, Khoza N, Zulu N, Madisha V, Ndlovu N, Shezi S, Karume J, Motsoeneng P, Simelane S, Meyer-Rath G, Masuku S, Jamieson L, and Ghai K. 2018. Consolidated Spending on HIV and TB in South Africa (2014/15–2016/17). Pretoria: National Department of Health; Washington, DC: Health Finance & Governance Project, Results for Development Institute.

**Table 14. Calculated savings from bringing high spending provinces to national average HIV test expenditure**

| Province        | Cost at national average (R'000') |                |                | Calculated savings at national average (R'000') |                |                | Average % savings |
|-----------------|-----------------------------------|----------------|----------------|-------------------------------------------------|----------------|----------------|-------------------|
|                 | 2017/18                           | 2018/19        | 2019/20        | 2017/18                                         | 2018/19        | 2019/20        | 2017/18-2019/20   |
| EC              | 106,525                           | 109,990        | 102,740        | -                                               | -              | -              | 0.0%              |
| FS              | 35,767                            | 30,316         | 37,892         | 14,886                                          | 17,058         | 14,384         | 44.6%             |
| GP              | 186,466                           | 193,330        | 253,318        | -                                               | -              | -              | 0.0%              |
| KZN             | 189,632                           | 219,854        | 214,595        | 184,527                                         | 169,767        | 195,601        | 88.1%             |
| LIM             | 106,211                           | 93,063         | 78,774         | -                                               | -              | -              | 0.0%              |
| MPU             | 80,328                            | 66,085         | 80,638         | -                                               | -              | -              | 0.0%              |
| NW              | 48,093                            | 51,068         | 65,323         | -                                               | 6,094          | -              | 3.7%              |
| NC              | 17,889                            | 16,988         | 14,413         | 8,963                                           | 54             | -              | 18.3%             |
| WC              | 88,590                            | 108,658        | 86,991         | -                                               | -              | -              | 0.0%              |
| <b>National</b> | <b>859,501</b>                    | <b>889,353</b> | <b>934,685</b> | <b>208,376</b>                                  | <b>192,973</b> | <b>209,985</b> | <b>22.8%</b>      |

Given the large degree to which the HIV testing programme is co-funded by donors, the results here should be seen as indicative and treated with considerable caution. A more complete expenditure analysis of this programmatic area would need include donor funding in the calculations.

#### Medical male circumcisions

Expenditure on MMCs increased from R284 million in 2017/18 to R301 million in 2019/20. However, the number of MMC performed declined from 581,172 in 2017/18 to 462,494 in 2019/20, suggesting that expenditure per MMC increased considerably.

Conditional grant expenditure per MMC performed also varied hugely across provinces, which again is due to MMCs being an area which is substantially co-funded by international donors, such as PEPFAR. In fact, previous studies have shown that as much as 71% of MMC expenditure in the 2016/17 was financed by PEPFAR.<sup>4</sup> A clear example of how this distorts the results presented here is that MP in 2018/19 showed no expenditure on BAS for MMC, but nevertheless reported that 80,516 MMCs had been performed. This makes it difficult to draw any firm conclusions based on the results presented here.

<sup>4</sup> Guthrie T, Chaitkin M, Khoza N, Zulu N, Madisha V, Ndlovu N, Shezi S, Karume J, Motsoeneng P, Simelane S, Meyer-Rath G, Masuku S, Jamieson L, and Ghai K. 2018. Consolidated Spending on HIV and TB in South Africa (2014/15–2016/17). Pretoria: National Department of Health; Washington, DC: Health Finance & Governance Project, Results for Development Institute.

**Table 15. Average expenditure per HIV test (ZAR), annual growth, variance from national average and number of HIV tests conducted**

| Province        | Averages - 2017/18 - 2019/20 |               |                                  |                      |
|-----------------|------------------------------|---------------|----------------------------------|----------------------|
|                 | Expenditure per MMC          | Annual change | Difference from national average | No of MMCs performed |
| WC              | 1,675                        | 0.5%          | 1,125                            | 16,257               |
| NC              | 1,401                        | 204.9%        | 850                              | 7,949                |
| GP              | 830                          | 146.3%        | 280                              | 95,561               |
| FS              | 806                          | 25.8%         | 255                              | 29,016               |
| LIM             | 585                          | 44.3%         | 35                               | 64,883               |
| KZN             | 578                          | 11.4%         | 28                               | 188,443              |
| EC              | 433                          | 5.5%          | -118                             | 49,770               |
| NW              | 72                           | 88.5%         | -478                             | 39,663               |
| MPU             | 27                           | 91.0%         | -523                             | 70,778               |
| <b>National</b> | <b>550</b>                   | <b>10.9%</b>  | <b>0</b>                         | <b>562,321</b>       |

**Table 16. Calculated savings from bringing high spending provinces to national average MMC expenditure**

| Province        | Cost at national average (R'000') |                |                | Calculated savings at national average (R'000') |               |               | Average % savings |
|-----------------|-----------------------------------|----------------|----------------|-------------------------------------------------|---------------|---------------|-------------------|
|                 | 2017/18                           | 2018/19        | 2019/20        | 2017/18                                         | 2018/19       | 2019/20       | 2017/18 - 2019/20 |
| EC              | 23,679                            | 24,181         | 34,858         | -                                               | -             | -             | 0.0%              |
| FS              | 17,262                            | 15,960         | 13,354         | 18,418                                          | 12,389        | -             | 41.5%             |
| GP              | 53,319                            | 52,262         | 49,059         | -                                               | 45,267        | 30,734        | 33.1%             |
| KZN             | 100,600                           | 109,937        | 94,019         | 9,405                                           | -             | 9,433         | 5.9%              |
| LIM             | 26,392                            | 50,147         | 27,674         | 2,294                                           | -             | 10,015        | 12.4%             |
| MPU             | 38,752                            | 41,123         | 34,242         | -                                               | -             | -             | 0.0%              |
| NW              | 13,742                            | 22,151         | 30,928         | -                                               | -             | -             | 0.0%              |
| NC              | 2,568                             | 5,602          | 4,965          | 1,703                                           | 9,859         | 10,134        | 62.3%             |
| WC              | 8,096                             | 7,198          | 11,797         | 16,662                                          | 19,929        | 17,276        | 66.5%             |
| <b>National</b> | <b>284,410</b>                    | <b>328,563</b> | <b>300,895</b> | <b>48,482</b>                                   | <b>87,444</b> | <b>77,593</b> | <b>23.4%</b>      |

## Conclusions

This expenditure analysis has reviewed trends in HIV/AIDS expenditure, particularly focusing on the HIV/AIDS component of the HIV, TB, Malaria and Community Outreach Grant. Expenditure has more than quadrupled in nominal terms since 2010/11, and has increased considerably also in the last three years. This expenditure increase has enabled the expansion of ART coverage which now reaches more than 5 million South Africans, making the country's ART programme the largest in the world.

The analysis has also highlighted some major discrepancies in expenditures per output. Hypothetically, significant savings would have been realised by bringing higher spending provinces closer to the national average expenditure per output, particularly in the ART programme which accounts for the majority of the HIV/AIDS component expenditure.

However, these estimates should be taken with a great degree of caution and should not be interpreted as direct recommendations for budget cuts, primarily because:

1. *Further analysis shows that a more than half of the indicative savings in the ART programme is in CoE* and classification of expenditure under the ART objective is not consistent across provinces. Some provinces, like WC, NC and NW allocate considerable amounts towards CoE under the ART objective, whereas other provinces pay mainly for this under other objectives or in PES.
2. *Differences in cost structures between provinces may sometimes be warranted.* For example, it is generally accepted that it is more expensive to render services in very sparsely populated areas, such as in NC.
3. *Donor funding is not included in the expenditure estimates.* However, the outputs can generally not be disaggregated by funding source. Donor funding play a particularly important role in HIV testing and MMCs where donors at least historically have accounted for half or more of expenditure. This means that the estimates of expenditure per output presented for these two areas are very skewed. This is less of an issue for the ART programme, which is predominantly domestically funded.
4. *Bluntly cutting budgets will not automatically address inefficiencies,* and could therefore result in less services being rendered.
5. *The budget of the grant over the 2020 MTEF was already reduced in Budget 2020.* This analysis is retrospective, looking at expenditure between 2017/18 and 2019/20. The budget reductions effected from 2020/21 and onwards are thus not factored into the analysis.

While some budget reductions might be necessary for the purposes of fiscal consolidation, this is not the only purpose of this expenditure analysis. It can also be used to point the sector as a whole, and specific provinces, towards areas where greater efficiency is needed. Provinces that have high expenditure per output in specific areas may want to look at whether there are more efficient ways to deliver services at lower cost.

## 5. HIV/AIDS grant component options for reform

The problem statement section above briefly explained some concerns with the grant in its current form and that there is arguably as strong case for greater integration of HIV funding into the broader PHC funding envelope. This section of the spending review considers four main options (with some sub-scenarios) for reforming the grant component.

### Relevant parallel processes to consider

There are a few parallel policy and other processes that are relevant in considering possible scenarios for the HIV grant.

Firstly, work is currently underway to review the health component of the provincial equitable share formula, which will likely take relative HIV/AIDS burden into account to a greater extent than it is currently. The new component will likely be introduced in the PES from the 2022/23 financial year. This might have an impact on how we want to deal with HIV grant, and it is perhaps advisable to delay reforms to HIV grant until PES work is completed and possibly implement changes to the grant in parallel with changes to the PES formula.

Secondly, major changes to South Africa's health financing landscape are envisaged as the country implements NHI. The majority of funding for and purchasing of health services will be centralised to the NHI Fund which will be a national public entity. This will likely entail changes also to how HIV services are funded, and it may not be advisable to make changes in a direction that is in considerable conflict with the longer-term vision of NHI.

Finally, NDOH has indicated that it is also reviewing the configuration of health conditional grants more broadly. It has previously presented ideas of merging several grants under new "district health grant", and although these proposals are being reconsidered, partly due to a pushback from provincial health departments against some of these ideas, it is important that NDOH is consulted and gives its concurrence to major reforms to the grant.

### Scenarios considered

Four possible scenarios are considered here for possible reforms to the HIV/AIDS conditional grant component:

1. Maintaining status quo
2. Shifting the entire grant component to the provincial equitable share
3. Creating a primary healthcare funding stream (e.g. a PHC conditional grant)
4. Shifting expenditure on CoE from the grant to PES and thereby maintaining a grant focusing mainly on HIV/AIDS commodities

Each of these scenarios are described below, together with potential pros and cons as well as quantifications of their financial implications.

#### Scenario 1: Maintain status quo

##### *Description*

This is the baseline scenario and implies maintaining the grant component as is.

##### *Pros:*

The main benefit of this scenario is that it maintains protection of HIV funding, and reduces the risk of funding shortfalls for HIV programmes resulting from provinces reprioritising funds towards other areas. Another benefit is that systems and processes are already well established and maintaining status quo would cause the least disturbance to existing processes.

#### *Cons:*

It maintains the fragmentation of the primary healthcare funding envelope, and given that HIV budgets are growing faster than general PHC funding, it will fragment it further. HIV service delivery is largely integrated in the general PHC platform, so the case for maintaining separate funding streams is getting weaker.

While the grant was very useful in building up a national response to the health crisis South Africa experienced in the 1990s and the first decade of the new millennium, the case for HIV “exclusivity” in approaches to health systems and health financing is now getting weaker. Other demands, such as non-communicable diseases are placing increasing pressure on the health system, and the precedent of the HIV grant component has led to demands for other priorities to have their own conditional grants or grant components (e.g. for mental health, oncology, cancer etc.).

#### *Financial implications:*

? Under current baseline projections, which are subject to change during the 2021 budget process, the overall grant component would grow to R25.5 billion by the end of the 2021 MTEF-period.

**Table 12. 2021 MTEF baseline under Scenario 1**

|                    | Adjusted allocation | Preliminary baseline |               |               |
|--------------------|---------------------|----------------------|---------------|---------------|
|                    | 2020/21             | 2021/22              | 2022/23       | 2023/24       |
| Eastern Cape       | 2,334               | 2,738                | 2,883         | 3,010         |
| Free State         | 1,279               | 1,496                | 1,575         | 1,644         |
| Gauteng            | 4,530               | 5,356                | 5,639         | 5,887         |
| KwaZulu Natal      | 5,660               | 6,587                | 6,935         | 7,240         |
| Limpopo Province   | 1,555               | 1,941                | 2,043         | 2,133         |
| Mpumalanga         | 1,814               | 2,133                | 2,246         | 2,344         |
| North West         | 489                 | 604                  | 636           | 664           |
| Northern Cape      | 1,322               | 1,553                | 1,635         | 1,707         |
| Western Cape       | 1,563               | 1,833                | 1,930         | 2,015         |
| <b>Grand Total</b> | <b>20,546</b>       | <b>24,241</b>        | <b>25,521</b> | <b>26,644</b> |

#### Scenario 2: Shifting the entire grant component to PES

##### *Description*

This scenario means integrating the HIV/AIDS component fully into the provincial equitable share, effectively removing any ring-fencing of HIV-specific funds in provincial departments’ budgets. This would also imply less authority of the National Department of Health and the National Treasury over HIV/AIDS budget and each province would be at liberty to allocate their budgets to HIV as they see fit.

##### *Pros*

The main benefit of this scenario is that it reduces fragmentation of primary healthcare financing. It gives provinces greater flexibility to manage their own budgets and be responsive to the wholistic health needs of the population. It may also incentivise greater efficiency in HIV programmes, as savings generated through these efficiencies would become available to fund other services and needs. A larger, less siloed health financing pool will improve risk-sharing across the whole populations served, instead of a ring-fenced risk-pool for HIV patients.

### Cons:

The main risk of this scenario is that funding of HIV/AIDS services could become deprioritised as the ringfencing ceases and other budgetary pressures in provincial health departments require additional funding. This could lead to a funding shortfall for critical items and services, such as ARV drugs, laboratory tests, HIV test kits, condoms etc. This was raised as a major concern by several of the provincial treasuries when presenting an earlier version of this analysis to them.

This scenario could also weaken the national coordination of the HIV programme. Under the current arrangements, provinces are legally required to report on pre-defined indicators and outputs on a quarterly basis and the national department also has the power to withhold funds if provinces do not comply with the specific conditions applicable to the grant.

Another possible downside is that full decentralisation of funds to provinces, may be considered a step in the opposite direction of NHI, which envisages a national centralised financing mechanism for healthcare services. It has been argued that it would be easier to shift funds already in the national sphere, such as conditional grants, to the future NHI Fund than it would be to shift funds to the PES. On the other hand, once the NHI Bill is enacted many health functions will be legally shifted to the national sphere so this argument may become less relevant.

### Financial implications

The scenario would entail shifting R76.4 billion (R24.2bn in 2021/22, R25.5bn in 2022/23 and R26.6bn R2023/24) from the HIV/AIDS component to the provincial equitable share over the 2021 MTEF, based on the preliminary baselines. This equates to a 4.2% increase to the overall PES each year. Different approaches to the shift could be considered, which would have different implications for individual provinces. Two such approaches are presented in the tables below.

The first approach (sub-scenario 2.1) would be to simply add these allocations to the PES and distributing it via the overall PES formula. As seen in the last three columns, this approach would have quite drastic implications for individual provinces. For example, KwaZulu-Natal would lose more than R1.5 billion per year, given its relatively high weight in the HIV/AIDS grant (due to its high HIV burden) comparative to the PES formula. Eastern Cape, Limpopo and Western Cape would benefit considerably through this approach.

**Table 13. Sub-scenario 2.1: Allocating the funds to PES according to PES formula**

| R million          | Grant component reduction |               |               | PES addition  |               |               | Net effect |          |          |
|--------------------|---------------------------|---------------|---------------|---------------|---------------|---------------|------------|----------|----------|
|                    | 2021/22                   | 2022/23       | 2023/24       | 2021/22       | 2022/23       | 2023/24       | 2021/22    | 2022/23  | 2023/24  |
| Eastern Cape       | 2,738                     | 2,883         | 3,010         | 3,180         | 3,312         | 3,458         | 442        | 429      | 448      |
| Free State         | 1,496                     | 1,575         | 1,644         | 1,347         | 1,414         | 1,476         | -149       | -161     | -168     |
| Gauteng            | 5,356                     | 5,639         | 5,887         | 5,115         | 5,457         | 5,697         | -241       | -182     | -190     |
| KwaZulu Natal      | 6,587                     | 6,935         | 7,240         | 4,973         | 5,190         | 5,418         | -1,614     | -1,745   | -1,822   |
| Limpopo            | 1,941                     | 2,043         | 2,133         | 2,798         | 2,938         | 3,067         | 858        | 895      | 934      |
| Mpumalanga         | 2,133                     | 2,246         | 2,344         | 1,985         | 2,089         | 2,181         | -148       | -157     | -164     |
| North West         | 604                       | 636           | 664           | 642           | 675           | 705           | 38         | 39       | 40       |
| Northern Cape      | 1,553                     | 1,635         | 1,707         | 1,697         | 1,793         | 1,872         | 143        | 158      | 165      |
| Western Cape       | 1,833                     | 1,930         | 2,015         | 2,503         | 2,655         | 2,771         | 670        | 724      | 756      |
| <b>Grand Total</b> | <b>24,241</b>             | <b>25,521</b> | <b>26,644</b> | <b>24,241</b> | <b>25,521</b> | <b>26,644</b> | <b>0</b>   | <b>0</b> | <b>0</b> |

A second approach (sub-scenario 2.2) is to distribute the funds via the health component of the PES (possibly by increasing the weight of the health component in the overall formula). The net effect of this would be similar to sub-scenario 2.1 but benefit Western Cape even more and Eastern Cape and Limpopo slightly less. A consequence of this would be that other PES formula components, such as the basic component or education component, would decrease in weight.

**Table 14. Sub-scenario 2.2: Allocating the funds to PES according to health component of the PES formula**

| R million          | Grant component reduction |               |               | PES addition  |               |               | Net effect |          |          |
|--------------------|---------------------------|---------------|---------------|---------------|---------------|---------------|------------|----------|----------|
|                    | 2021/22                   | 2022/23       | 2023/24       | 2021/22       | 2022/23       | 2023/24       | 2021/22    | 2022/23  | 2023/24  |
| Eastern Cape       | 2,738                     | 2,883         | 3,010         | 2,982         | 3,139         | 3,277         | 244        | 256      | 268      |
| Free State         | 1,496                     | 1,575         | 1,644         | 1,285         | 1,353         | 1,412         | -211       | -222     | -232     |
| Gauteng            | 5,356                     | 5,639         | 5,887         | 5,818         | 6,125         | 6,395         | 462        | 486      | 508      |
| KwaZulu Natal      | 6,587                     | 6,935         | 7,240         | 4,969         | 5,232         | 5,462         | -1,617     | -1,703   | -1,778   |
| Limpopo            | 1,941                     | 2,043         | 2,133         | 2,473         | 2,603         | 2,718         | 532        | 560      | 585      |
| Mpumalanga         | 2,133                     | 2,246         | 2,344         | 1,818         | 1,914         | 1,998         | -315       | -332     | -346     |
| North West         | 604                       | 636           | 664           | 509           | 536           | 560           | -95        | -100     | -105     |
| Northern Cape      | 1,553                     | 1,635         | 1,707         | 1,624         | 1,710         | 1,785         | 71         | 75       | 78       |
| Western Cape       | 1,833                     | 1,930         | 2,015         | 2,763         | 2,909         | 3,037         | 930        | 979      | 1,022    |
| <b>Grand Total</b> | <b>24,241</b>             | <b>25,521</b> | <b>26,644</b> | <b>24,241</b> | <b>25,521</b> | <b>26,644</b> | <b>0</b>   | <b>0</b> | <b>0</b> |

The third approach (sub-scenario 2.3) would be to maintain the existing proportions of the HIV/AIDS component and allocate these to the PES, but outside the PES formula, which currently happens with funds for a few special programmes. This would not change the total allocations to each province, however national government would not be able to control whether the funds are allocated to HIV or not.

#### *Comments*

This scenario is likely too drastic to be implemented in the short-term, but could potentially be considered for the medium-to-long term. If implemented in the short term, sub-scenario 2.3 should be used to avoid short-term distortion to provincial budgets, which are already under pressure. Once the provincial equitable share formula review is completed and implemented (likely from 2022/23), and if it sufficiently accounts for HIV/AIDS costs, the allocations could increasingly be made based on the PES formula distribution.

The main risk of this scenario, as mentioned above, is that given general budget pressures in the sector, budgets for antiretroviral drugs and other critical supplies are not adequately protected, leading to stock-outs and lack of access to drugs for patients on ART.

#### Scenario 3: PHC conditional grant / fund

##### *Description*

This scenario could be conceptualised in a few different ways, such as a new PHC conditional grant or some other type of ring-fenced funding pool for primary healthcare more broadly. The conditional grant option would entail shifting considerable funds from the PES to the new grant. What has been quantified here is the shifting of the PHC-related budget subprogrammes<sup>5</sup> in provincial health departments to a new grant.

##### *Pros:*

HIV services are important but they are not, and should not be, implemented in isolation from other healthcare services. The most efficient healthcare systems cater for people's holistic health needs through a strong, responsive general PHC platform. HIV services are already primarily delivered in PHC facilities, such as clinics and community health centres (CHCs) and having two separate financing streams funding the same facility can be seen as duplicative and fragmented. A comprehensive, integrated PHC financing stream would ensure that PHC services are prioritised.

<sup>5</sup> Included here are the following subprogrammes: HIV/AIDS, Clinics, Community Health Centres, Community-based Services and Other Community Services.



This could also be seen as a step towards NHI, which envisages that PHC funding would be pooled in the NHI Fund, which would purchase PHC services through risk-adjusted capitation. A ringfenced, centralised PHC funding envelope, could assist in phasing in payment of PHC services through capitation and pilot the contracting units for primary care (CUPs) which will be established at the subdistrict level under NHI. This could also assist in improving geographical equity in distribution of funds for PHC.

#### *Cons:*

The National Health Act currently assigns primary healthcare services to the provincial sphere of government. It might not be considered constitutional to fund an entire function, and such a large share of provincial health budgets, through a conditional grant. The Constitution entitles provinces to receive equitable share funding for the functions assigned to them.

It may also be administratively cumbersome to have such a large conditional grant (e.g. R70bn+ per annum).

#### *Financial implications*

If a PHC conditional grant is implemented, considerable PES funding would need to be shifted to the new grant. Based on the PHC subprogramme budgets tabled in Budget 2020, the shift would be R45 billion in 2021/22, increasing to R49 billion in 2023/24. The grant allocation would be R69 billion in 2021/22 increasing to R76 billion in 2023/24.

**Table 15. Scenario 3: New PHC grant including current HIV and PHC subprogrammes**

|                    | Current HIV/AIDS grant component |               |               | Shift from PES to new PHC fund/grant |               |               | New PHC fund/grant allocations |               |               |
|--------------------|----------------------------------|---------------|---------------|--------------------------------------|---------------|---------------|--------------------------------|---------------|---------------|
|                    | 2021/22                          | 2022/23       | 2023/24       | 2021/22                              | 2022/23       | 2023/24       | 2021/22                        | 2022/23       | 2023/24       |
| Eastern Cape       | 2,738                            | 2,883         | 3,010         | 5,213                                | 5,382         | 5,618         | 7,951                          | 8,264         | 8,628         |
| Free State         | 1,496                            | 1,575         | 1,644         | 2,156                                | 2,221         | 2,319         | 3,652                          | 3,795         | 3,962         |
| Gauteng            | 5,356                            | 5,639         | 5,887         | 9,679                                | 10,000        | 10,440        | 15,035                         | 15,639        | 16,327        |
| KwaZulu Natal      | 6,587                            | 6,935         | 7,240         | 9,999                                | 10,553        | 11,018        | 16,586                         | 17,488        | 18,257        |
| Limpopo Province   | 1,941                            | 2,043         | 2,133         | 5,254                                | 5,508         | 5,751         | 7,195                          | 7,551         | 7,883         |
| Mpumalanga         | 2,133                            | 2,246         | 2,344         | 3,721                                | 3,904         | 4,076         | 5,855                          | 6,149         | 6,420         |
| North West         | 604                              | 636           | 664           | 1,232                                | 1,288         | 1,345         | 1,836                          | 1,924         | 2,009         |
| Northern Cape      | 1,553                            | 1,635         | 1,707         | 3,155                                | 3,336         | 3,483         | 4,708                          | 4,971         | 5,190         |
| Western Cape       | 1,833                            | 1,930         | 2,015         | 4,895                                | 5,127         | 5,352         | 6,728                          | 7,057         | 7,367         |
| <b>Grand Total</b> | <b>24,241</b>                    | <b>25,521</b> | <b>26,644</b> | <b>45,304</b>                        | <b>47,318</b> | <b>49,400</b> | <b>69,545</b>                  | <b>72,840</b> | <b>76,044</b> |

#### Scenario 4: Shifting CoE from the HIV/AIDS component to PES

##### *Description:*

Under this scenario, HIV/AIDS commodities, contracted services and some other items would remain ringfenced through the conditional grant, but personnel would be funded through PES. One could consider various sub-scenarios under scenario 4, with different options for how the CoE allocations would be shifted to PES.

##### *Pros:*

This scenario would be a clear step towards integrating financing of PHC services, while still protecting critical items, such as ARV drugs and reducing the risk of stockouts. There is no clear rationale for why some health workers and other staff in health facilities should be funded separately through HIV funding, when presumably they also do general (non-HIV) consultations with patients.

This could also be partly linked to the PES formula reform, which will likely improve how HIV burden is accounted for in the PES but may not fully account for cost of ARVs etc.

This scenario may also be more palatable to HIV interest groups, HIV managers and other stakeholders who may have concerns about full integration of HIV and general PHC funding and its potentially negative impact on HIV programmes.

The scenario could be seen as a practical and easily implementable first step towards greater integration of financing streams, such as scenarios 2 or 3.

#### *Cons:*

Funding specific items under the grant may be perceived as excessive itemisation of budgets (whereas we generally want to fund services holistically). It might also be argued that some categories personnel are still, and should continue to be, dedicated specifically to HIV programmes, e.g. data-capturers for Tier.net (although eventually patient information systems should also be integrated), HIV counsellors etc.

#### *Financial implications*

Two sub-scenarios are shown in the tables below.

In sub-scenario 4.1, the amounts for each province are based on the provinces' HIV/AIDS component spending on CoE in 2019/20. In other words, the funds would be allocated outside the PES formula, and the shift would be neutral to the overall allocation to each province. It would mean shifting a total of R22.6 billion (R7.2bn, R7.6bn & R7.9bn) over the 2021 MTEF from the grant component to PES. This is approximately 30% of the total grant component, although the proportion differs significantly across provinces, ranging from 10.7% in Mpumalanga to 45% in North West.

**Table 16. Sub-scenario 4.1: Shift CoE from grant component to PES within each province.**

| R million          | Baseline grant component allocation |               |               | New grant allocation |               |               | Shift to PES |              |              |
|--------------------|-------------------------------------|---------------|---------------|----------------------|---------------|---------------|--------------|--------------|--------------|
|                    | 2021/22                             | 2022/23       | 2023/24       | 2021/22              | 2022/23       | 2023/24       | 2021/22      | 2022/23      | 2023/24      |
| Eastern Cape       | 2,738                               | 2,883         | 3,010         | 2,012                | 2,118         | 2,211         | 726          | 764          | 797          |
| Free State         | 1,496                               | 1,575         | 1,644         | 930                  | 979           | 1,022         | 564          | 594          | 620          |
| Gauteng            | 5,356                               | 5,639         | 5,887         | 4,076                | 4,291         | 4,480         | 1,278        | 1,345        | 1,405        |
| KwaZulu Natal      | 6,587                               | 6,935         | 7,240         | 4,111                | 4,328         | 4,518         | 2,468        | 2,598        | 2,713        |
| Limpopo Province   | 1,941                               | 2,043         | 2,133         | 1,562                | 1,645         | 1,717         | 376          | 396          | 414          |
| Mpumalanga         | 2,133                               | 2,246         | 2,344         | 1,905                | 2,006         | 2,094         | 228          | 240          | 250          |
| North West         | 604                                 | 636           | 664           | 331                  | 348           | 364           | 273          | 288          | 300          |
| Northern Cape      | 1,553                               | 1,635         | 1,707         | 947                  | 997           | 1,040         | 604          | 636          | 664          |
| Western Cape       | 1,833                               | 1,930         | 2,015         | 1,178                | 1,241         | 1,295         | 654          | 689          | 719          |
| <b>Grand Total</b> | <b>24,241</b>                       | <b>25,521</b> | <b>26,644</b> | <b>17,051</b>        | <b>17,951</b> | <b>18,741</b> | <b>7,171</b> | <b>7,550</b> | <b>7,882</b> |

Sub-scenario 4.2 we take 29.6%, which is the overall proportion of the grant component spent on CoE across all provinces, and shift this to PES. The total amounts to be shifted are the same as in the previous sub-scenario, but the amounts taken out of the grant component in each province is based on its proportional allocation of the grant component. The allocations to the PES are done through the PES formula. The shift is therefore not neutral for each province, as KwaZulu-Natal would lose around R500 million per year and Limpopo, Western Cape and Eastern Cape would gain significantly. The amounts shown in the net effect columns are also the differences between sub-scenarios 4.1 and 4.2.

**Table 17. Scenario 4.2: Taking 29.6% proportionally from the grant component and allocating it through the PES formula**

|                    | Amount take out of the grant component |              |              | Amount allocated through PES formula |              |              | Net effect |          |          |
|--------------------|----------------------------------------|--------------|--------------|--------------------------------------|--------------|--------------|------------|----------|----------|
|                    | 2021/22                                | 2022/23      | 2023/24      | 2021/22                              | 2022/23      | 2023/24      | 2021/22    | 2022/23  | 2023/24  |
| Eastern Cape       | 810                                    | 853          | 890          | 941                                  | 980          | 1,023        | 131        | 127      | 133      |
| Free State         | 442                                    | 466          | 486          | 398                                  | 418          | 437          | -44        | -48      | -50      |
| Gauteng            | 1,584                                  | 1,668        | 1,741        | 1,513                                | 1,614        | 1,685        | -71        | -54      | -56      |
| KwaZulu Natal      | 1,948                                  | 2,051        | 2,142        | 1,471                                | 1,535        | 1,603        | -477       | -516     | -539     |
| Limpopo Province   | 574                                    | 604          | 631          | 828                                  | 869          | 907          | 254        | 265      | 276      |
| Mpumalanga         | 631                                    | 664          | 694          | 587                                  | 618          | 645          | -44        | -46      | -48      |
| North West         | 179                                    | 188          | 196          | 190                                  | 200          | 208          | 11         | 11       | 12       |
| Northern Cape      | 459                                    | 484          | 505          | 502                                  | 530          | 554          | 42         | 47       | 49       |
| Western Cape       | 542                                    | 571          | 596          | 741                                  | 785          | 820          | 198        | 214      | 224      |
| <b>Grand Total</b> | <b>7,171</b>                           | <b>7,550</b> | <b>7,882</b> | <b>7,171</b>                         | <b>7,550</b> | <b>7,882</b> | <b>0</b>   | <b>0</b> | <b>0</b> |

#### Comments

This scenario could be a practical and easily implementable immediate step towards integration of HIV and PHC services. Maintaining existing allocations but channelling a portion of these through PES would cause minimal short-term disruption to overall provincial budgets. Whereas there may still be a need to protect key items, shifting CoE and possibly some additional budget items to PES would be a step in the right direction.

The scenario could be seen as an interim step towards scenario 2 (complete shift to PES) or scenario 3 (PHC grant/fund).

#### Discussion and conclusions

South Africa has made great strides in providing HIV/AIDS services to its citizens. The country, since many years, has the largest ART programme in the world, which is predominantly funded by government through domestic sources. At the end of 2019/20, more than 5 million South Africans accessed life-sustaining treatment through Government's ART programme. Perhaps most important consideration in deliberating on options for the future financing of HIV/AIDs programme is ensuring that these strides are not reversed and access to ART is not disrupted.

On the other hand, the ART programme is now well established. While ring-fenced funding and vertical implementation structures were likely useful in establishing and scaling up HIV programme, it is becoming increasingly difficult to argue for ringfenced funding for a single medical condition. Other diseases, particularly non-communicable diseases (NCDs) account for an increasing share of the national burden of disease, with NCDs accounting for 60% of all deaths in 2017. Health systems and health financing systems should be holistic and responsive to all health needs of the population.. Implementation of HIV/AIDS services is already now largely integrated in general PHC platforms, and the question is whether the financing should follow suit.

This document has outlined a range of scenarios for different degrees and modalities of integration for the health sector and Government's budgeting structures to consider. The scenarios range from maintained status quo to full integration into PES, and this expenditure review has tried to identify possible pros and cons of each scenario.

#### Conclusions

As illustrated above, deciding on the future of the HIV/AIDS grant is complex and each scenario has its own pros and cons. All of the options recommend maintaining existing allocations to provinces, however given the nature of fiscal transfers in South Africa provinces may benefit or lose out

differently, depending on the scenario. However, some preliminary conclusions from this review are the following:

- *Choice of scenario:* Ending the conditional grant in the short- to medium-term is likely premature. Several provincial treasuries raised concerns that if the grant is ended funds will be diverted to other priorities. Shifting CoE from the grant component to PES and thereby reforming the grant to focus on HIV/AIDS commodities seems attractive as a middle-ground option that generates some integration with PHC funding but prevents the larger risks of defunding ARV drugs and other critical commodities.
- *Changes to provincial allocations:* As shown above, shifting funds from the HIV/AIDS grant component to PES using the PES formula would result in considerable changes to overall allocations for some provinces. It is recommended that any funds shifted to PES (e.g. in Scenarios 2 or 4) be allocated outside the PES formula to maintain overall provincial baselines as is, at least in the first years. A phased shift towards allocating funds via the PES formula could be considered, preferably once the new health component of the PES formula is implemented. There is precedent to adding funds to the PES in this way.
- *Timing of potential reforms:* The timing of a reform related to the grant depends to some degree on the scenario chosen – the more drastic the change, the longer time might be required to prepare for implementation. In the authors' view, only Scenarios 1 (maintaining status quo) and 4 (HIV/AIDS commodities grant) are feasible in the short term. Timing of the phased implementation of NHI should also be considered when implementing these scenarios.
- *Impact of budget cuts:* This analysis has not considered the potential budget cuts to both conditional grants and PES that are being considered for the 2021 MTEF-period. Considerable efforts to consolidate the fiscus are on the cards for Budget 2021 and this will likely have an impact also on health budgets. Caution should be taken to ensure that any changes to the grant do not cause further disruption to health financing, and negatively impact provinces' ability to manage the implications of budget reductions.