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New allocations for ARV treatment: An analysis of 2004/5 national budget from an HIV/AIDS perspective

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Executive Summary

From an HIV/AIDS perspective, the 2004/5 national budget shows serious commitment to making financial resources available for the new anti-retroviral (ARV) treatment programmes to be rolled out this year. National Treasury has specifically allocated R1.439 billion in the national budget for HIV/AIDS programmes and services in 2004/5.

To put these increases in context, the amount designated for HIV/AIDS in this year's budget is nearly 7 times what was set aside to fight HIV/AIDS in the 2000/1 national budget three years ago. However funds earmarked for HIV/AIDS in the national budget still constitute less than 1% of the total consolidated budget, and health expenditure remains a steady 11% of consolidated national and provincial spending.

A total of R373 million is designated for ARV treatment programmes in the national budget for 2004/5, the first year of roll-out. If we assume a R6000 annual average cost per person on treatment, the ARV conditional grant allocations will only pay for 49,614 persons on treatment in the first year of implementation, which is slightly short of the 53,000 target set in the Operational Plan. Given the current conditional grant allocations to provinces for ARV treatment, only 7% of the estimated number of AIDS sick persons nationally will be able to enter treatment in the first year. However indications are that government's intention was to provide a level of funding in Budget 2004/5 which could be absorbed by the provinces, and then to ratchet up and add additional resources as and where needed partway through the financial year.

Of the total new conditional grant funds for ARV treatment, KZN receives the largest slice (22%), followed by Gauteng (16%) and Eastern Cape (14%). KZN, Gauteng and Mpumalanga's shares of the total ARV CG funds are disproportionate to their heavy HIV/AIDS burden.

However, provincial shares of the total estimated AIDS sick persons were not the only factor used to allocate the funds. The resource allocation approach used was a reasonable one. Other important factors were included: the varying abilities of provinces to absorb the added funds, the need to cover basic infrastructure costs in low-population provinces, and the need to build the capacity of under-resourced or underspending provinces.

The critical issue is the ability and commitment of national and provincial health departments to speedily get ARV treatment programmes up and running. Funds being transferred by national government to provincial health departments for HIV/AIDS programmes jump by 134% in this budget, which means that provinces will experience sharp spending pressures. Provinces have significantly improved their spending on HIV/AIDS funds but some provinces still remain problematic and may struggle to spend the additional ARV funds—especially Eastern Cape and Mpumalanga. For those provinces with weaker financial and project management skills, absorption capacity could very well be the primary obstacle to roll-out. A new clause inserted in the 2004 Division of Revenue Bill will allow unspent HIV/AIDS health conditional grant funds to be reallocated to better-performing provinces.

The success of the roll-out of the national ARV treatment programme will be dependant upon strong support and guidance from national Department of Health and the demonstrated performance of provinces in absorbing the added funds.

Contents

I. Introduction[1]

From an HIV/AIDS perspective, the 2004/5 national budget shows serious commitment to making financial resources available for the new anti-retroviral (ARV) treatment programmes to be rolled out this year. Following on Cabinet's announcement of an Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa on 19 November 2003, National Treasury has specifically allocated R1.439 billion of the national budget for HIV/AIDS programmes and services in 2004/5. A total of R373 million is designated for ARV treatment programmes in the national budget for 2004/5, the first year of roll-out. Given that the funds being transferred by national government to provincial health departments for HIV/AIDS programmes jump by 134% in this budget, the provinces will be under sizable pressure to spend and deliver.

This Occasional Paper makes an initial assessment of how well Budget 2004/5 establishes a sufficient and efficient funding framework for government's response to HIV/AIDS. It takes a closer look at these new allocations for the anti-retroviral (ARV) treatment programme as well as other regular HIV/AIDS conditional grants (CG).

It is important to note that this Paper addresses the *national* budget—including conditional grants and a top-down look at funds sent to provinces via the equitable share (ES). It does not analyse the provincial budgets to identify what funds are specifically allocated for HIV/AIDS (from the equitable share) by each province. This will be covered in an upcoming Budget Brief.

First, we provide an overview of the total allocations specifically allocated for HIV/AIDS programmes in order to provide a bird's eye view. Second, we examine HIV/AIDS allocations in the national departments, including those conditional grants sent to the provinces. Third, we look specifically at the funds for HIV/AIDS flowing to provinces via the equitable share grant.

Fourth, we take a closer look at the hot issue in this year's budget: the allocations for the new ARV treatment programme. We analyse the provincial shares of the total ARV funds, examine the criteria used, and discuss key budget issues associated with the new ARV funding stream. These issues underline a main theme of this Paper which is that roll-out of this massive ARV programme will include multiple challenges for intergovernmental fiscal relations and provincial capacity which will be profoundly critical to successful implementation. Finally, we step back to look at how these massive increases in allocations for HIV/AIDS compare to the overall national budget, and to spending in the health sector generally.

II. Overview of allocations for HIV/AIDS in 2004/5 national budget

In order to provide a context, Table 1 details the total HIV/AIDS-designated funds in the national budget for 2004/5. In essence, there are five major funding streams or categories of HIV/AIDS allocations appearing in the national budget:

1. **Health sector**. First, the Chief Directorate: HIV/AIDS and TB in the national Department of Health (DOH) receives a budget of R1.212 billion in 2004/5. The role of the Chief Directorate is to develop policy, support research and surveillance, and

[1] The author would like to thank the following persons for their inputs and comments on this paper: Mark Blecher, Anita Marshall, Alan Whiteside, and Celicia Serenata.

essentially to drive and administer the national HIV/AIDS programme.[2] The large HIV/AIDS health conditional grant also sits in the budget of the Chief Directorate; the funds are transferred by DOH to provincial health departments specifically to finance a variety of HIV/AIDS health interventions, including voluntary counseling and testing (VCT), prevention of mother-to-child transmission programmes (PMTCT), and the new ARV programme. (Row A in Table 1).

2. **Social Development**. Second, the HIV and AIDS programme in the National Department of Social Development runs programmes targeting orphans, vulnerable children, women and youth. The bulk of its budget is transferred to the provinces as a conditional grant earmarked for community-and-home-based care and support programmes run by provincial departments of welfare/social development. (Row B in Table 1).

3. **Education**. In addition to some funds spent directly by the national department, the majority of HIV/AIDS spending in the education sector is in the conditional grants transferred from the national DOE to provincial departments of education and used to finance lifeskills HIV/AIDS education in schools. (Row C in Table 1).

4. **Other national departments**. While the services and programmes of many departments indirectly support an HIV/AIDS response or help to alleviate the impact of HIV/AIDS on households, only two other national departments have disaggregated allocations identifiable as HIV/AIDS-related. They are the Department of Public Service and Administration and the Department of Science and Technology. (Row D in Table 1).

5. Fifth, beginning in 2002/3, the national government has added funds to the provincial equitable share pool for HIV/AIDS treatment and care. This is an indirect channel for making funds available to provinces which they may then allocate to their health departments and to HIV/AIDS sub-programmes, if they choose to do so.[3] This funding stream is discussed in Section IV below.

Figures for the first four of these categories are shown in Table 1. In Budget 2004/5, a total of R1.439 billion is specifically allocated for HIV/AIDS. Over the medium term (2004/5 to 2006/7), a total of R5.505 billion is specifically dedicated for HIV/AIDS spending in the budgets of the national departments—including ARV funds and grants transferred to the provinces for HIV/AIDS programmes.

[2] The HIV/AIDS Programme contains five programmes: the Office of the Chief Director; Directorate: HIV/AIDS and STIs; Directorate: Government AIDS Action Plan; Directorate: Tuberculosis; and Directorate: NGO Coordination. The Office of the Chief Director contains: the National Integrated Plan; Interdepartmental Support Programme and the SANAC Secretariat. The Directorate: HIV/AIDS and STIs includes sub-directorates for: Youth Programme; Prevention (STI and HIV/AIDS); Research and PMTCT; Treatment, Care and Support; and VCT. The Directorate: Government AIDS Action Plan contains the Partnership Support section. (Source: Personal correspondence with Celicia Serenata, Project Manager: HIV/AIDS, Department of Health. 20 May 2004)

[3] These monies would be transferred to the provinces in their Equitable Share grant and then be allocated by each province—at their discretion—to a particular provincial department. They would therefore be found on provincial budgets. We discuss this funding channel in this Occasional Paper on the national budget because these funds make up a huge portion of the R12 billion which the Budget Review claims will be spent on HIV/AIDS (pg. 124). A subsequent Budget Brief will track these Equitable Share funds for HIV more closely and trace what provinces actually allocate for HIV/AIDS in their respective budgets.

Table 1. Summary of HIV/AIDS-specific allocations in the 2004/5 national budget

R million	2001/2	2002/3	2003/4	2004/5	2005/6	2006/7	Total over MTEF
(A) Chief Directorate: HIV/AIDS and TB in national Dept. of Health (including conditional grants to provinces, ARV funds)	265.84	459.95	766.29	1,212.17	1,545.34	2,008.37	**4,765.88**
(B) HIV and AIDS Programme in national Dept. of Social Development (including conditional grant to provinces)	14.954	51.153	70.388	78.290	85.153	89.402	**252.85**
(C) HIV and AIDS conditional grant from national Department of Education	62.896	133.458	131.621	128.579	136.293	144.471	**409.34**
(D) Dept. of Public Service and Administration and Dept. of Science and Technology		2.160	5.218	19.958	30.384	26.380	**76.72**
Total	**343.69**	**646.72**	**973.52**	**1,439.00**	**1,797.17**	**2,268.62**	**5,504.79**
Real terms	395.83	677.12	973.52	1,365.27	1,616.21	1,939.34	**4,920.82**
Real growth rate	49%	71%	44%	40%	18%	20%	**26%**

Source: 2004 Division of Revenue Bill. 2003 Estimates of National Expenditure, pgs. 246, 390, 426, 479, 518. Real terms calculated based on GDP inflation, with 2003/4 as the base year.

Graph 1 shows the upward sweep visually. To put these increases in recent historical context, the R1.439 billion amount set aside in this year's budget is nearly 7 times what was set aside to fight HIV/AIDS in the 2000/1 budget three years ago (R213.7 million). And, largely as a result of the injection of funds to finance the new ARV roll-out, the dedicated HIV/AIDS budget jumps 40% in real terms compared to last year's allocation.[4]

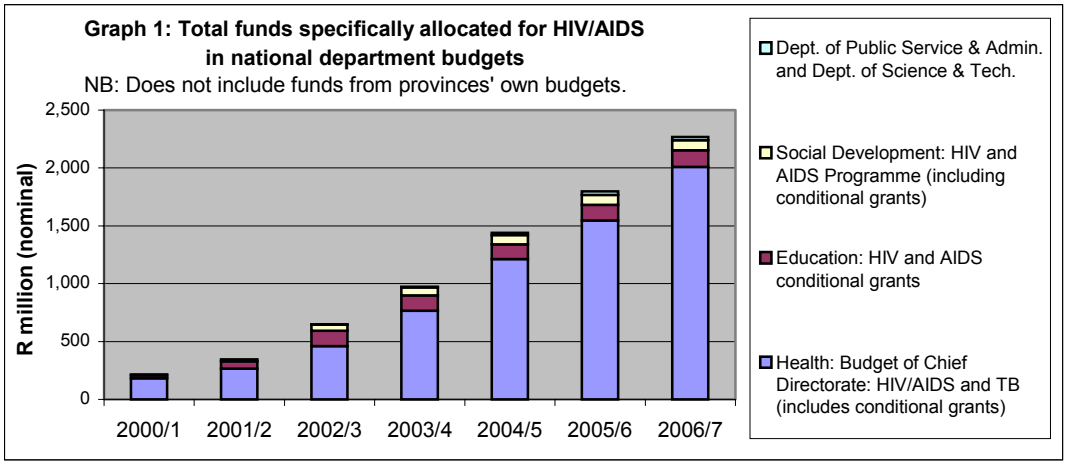
A key characteristic of this overall financing framework for government's HIV/AIDS response is that a small share of the funds designated for HIV/AIDS in the national budget are actually spent by national departments. Given that provinces in South Africa are responsible for health care and social service delivery, the bulk of funds are transferred to the provinces (either directly via conditional grants, or indirectly via the equitable share).

The total HIV/AIDS budget for South Africa can be organised in terms of spending by sector. Section II examines spending in the sectors, by examining the budgets of the national departments in turn, primarily health, social development and education. We include analysis of both the funds spent directly by the national departments as well as the conditional grants which those departments are responsible for transferring to their provincial counterparts. In Section IV

[4] Real calculations throughout this paper are based on GDP inflation and utilise 2003/4 as the base year. Deflators are as follows:

2000/1	2001/2002	2002/003	2003/04	2004/5	2005/6	2006/7
0.805456	0.868282	0.95511	1	1.054	1.11197	1.169792

we then look at the fifth category described above: the funds for HIV/AIDS sent to the provinces via the equitable share.



Source: 2004 Division of Revenue Bill. 2004 Estimates of National Expenditure, pgs. 246, 390, 426, 479, 518.

III. HIV/AIDS allocations on national department budgets

A. Budget of the Chief Directorate: HIV/AIDS and TB in the national Department of Health

The large injection of funds for the roll-out of ARV treatment programmes is located here on the budget of the Chief Directorate: HIV/AIDS and TB in the national Department of Health. The budget of the Chief Directorate totals R1.212 billion in 2004/5, which is almost a 60% increase from the budget controlled by the Chief Directorate last year. Those funds fall roughly into three categories: 1) funds transferred to NGOs, 2) funds spent directly by the national department, and 3) funds transferred to the provincial health departments as HIV/AIDS conditional grants.

With regard to the first category, the HIV/AIDS Programme contains an NGO Coordination Unit which coordinates and provides grants to NGOs for HIV/AIDS and TB activities. A total of R43.05 million (or 3.6% of the Chief Directorate budget) is to be disbursed via the NGO Funding Unit in 2004/5, which is a drop from last year. However the Unit has experienced stumbling blocks including lack of monitoring and support systems for NGOs and weak financial and reporting systems of NGOs. [5] This resulted in R10.567 million in unspent funds from 2002/3 being rolled over into the 2003/4 allocation. [6]

In addition to small grants to national and provincial NGOs, the Chief Directorate budget also contains allocations for large transfers to other key institutions. The South Africa AIDS Vaccine Initiative will receive R10 million this year and each year over the medium term, as it did in the previous budget. The NGO Lifeline receives a total of R42.9 million over the medium term. Love Life is usually given R25 million, however this year this amount drops just slightly to R23 million in 2004/5. The R25 million in annual support is set to resume in next year's budget. In

[5] For more information on the NGO Funding Unit in the Chief Directorate: HIV/AIDS and TB, refer to Ndlovu, N. 2003. "Understanding expenditure and procedures of the National NGO Coordination Unit for HIV/AIDS and Tuberculosis." Budget Brief No. 133. Available online at www.idasa.org.za/bis
[6] Adjusted Estimates 2003, pg. 66.

summary, the share of the total Chief Directorate budget transferred to these three institutions in 2004/5 is 3.7%.[7]

Moving onto the second category of spending, the Chief Directorate: HIV/AIDS and TB also runs a number of national programmes directly. These are primarily public awareness and prevention programmes, and include: Trucking Against AIDS, Commuters Aids Project, Traditional Leaders Project, and Men in Partnership Against AIDS. Although the 2004/5 Budget does not provide details on the amount allocated for condoms this financial year, the Department's target is to distribute 400 million male and 2.9 million female condoms in this financial year. In 2002/3 R18.5 million was spent for the purchase and distribution of 2.5 million female condoms, and 358 million male condoms were bought and distributed at a cost of R104 million.[8]

Thirdly, the Chief Directorate: HIV/AIDS and TB administers the HIV/AIDS conditional grants, in operation since 2000/1. Approximately 55% of the Chief Directorate budget is transferred to the provinces via these conditional grants. As in last year's budget, the conditional grant is transferred to provincial health departments to finance a range of HIV/AIDS interventions:[9]

1. Voluntary counseling and testing (VCT)
2. Mother to child transmission prevention (PMTCT) programmes
3. Strengthening of provincial management
4. Establishment of Regional Training Centres (in conjunction with academic institutions)
5. Post exposure prophylaxis (PEP) for rape survivors
6. Home-based care
7. Step-down care
8. Sex Worker Programmes

What changes in Budget 2004/5 is that this conditional grant will be expanded to include new funds to support implementation of the National Operational Plan for Comprehensive HIV and AIDS Treatment and Care (19 November 2003). We discuss the new funds it contains for ARV treatment programmes in greater detail in Section V below. In this section we just focus on the overall trends in the conditional grant.

On aggregate, the health HIV/AIDS conditional grant (including the ARV allocations) increase massively from R334 million in 2003/04 to R782 million in 2004/05. The amount is set to continue to climb over the medium term: R1.1 billion in 2005/06 and R1.6 billion in 2006/07. The majority of these increases are due directly to the new ARV allocations. Table 2 shows the HIV/AIDS health conditional grant, which is referred to as the Comprehensive HIV and AIDS grant beginning in Budget 2004/5. It gives the provincial allocations and also shows the increases in the total envelope from year to year. (Appendix A gives the provincial allocations and shares for the two previous budgets as well.) From 2002/3 to 2003/4 the total amount increased by 52% in real terms. This year the total amount jumps by 122% in real terms due to the injection of ARV funds.

In the period prior between the start of the HIV/AIDS conditional grant and the introduction of the ARV funds, provincial shares of health HIV/AIDS CG funds have been fairly stable (from

[7] In previous budgets, the South African National AIDS Council (SANAC) has received a R10 million transfer from the Chief Directorate budget. However during 2003/4, that amount was shifted back into the core department budget (to Professional and Special Services) for, among others, the administrative support which the department provides to SANAC. SANAC has received R30 million into its trust fund account, and does not require the R10 million. (Source: Adjusted Estimates 2003, pg. 73.)
[8] 2004 Estimates of National Expenditure, pg. 409.
[9] 2004 Division of Revenue Bill, pg. 96.

2001/2 to 2003/4) (See Appendix A). One exception is Northern Cape which was allocated 10% of total HIV/AIDS health CG funds in 2001/2 and then dropped to 3% in 2003/4. The second exception is Gauteng, which was allocated 10% in 2001/2 but then benefited from an increased share of 17% in 2003/4.

Budget 2004/5 continues this trend. Over the medium term, the shares going to each province remain essentially unchanged. KZN receives the bulk of the grant (22%), with large shares also allocated to Gauteng (16%) and Eastern Cape (14%). Northern Cape (4%) receives the smallest slice and Western Cape is given 7%. According to the Division of Revenue Bill (DOR), the funds are split between the provinces based on: 2001 Antenatal HIV Prevalence Survey; estimated share of HIV+ births; share of reported rapes; and estimated share of AIDS cases.[10] Section V below discusses further how the additional funds for ARV treatment were divided between the provinces.[11]

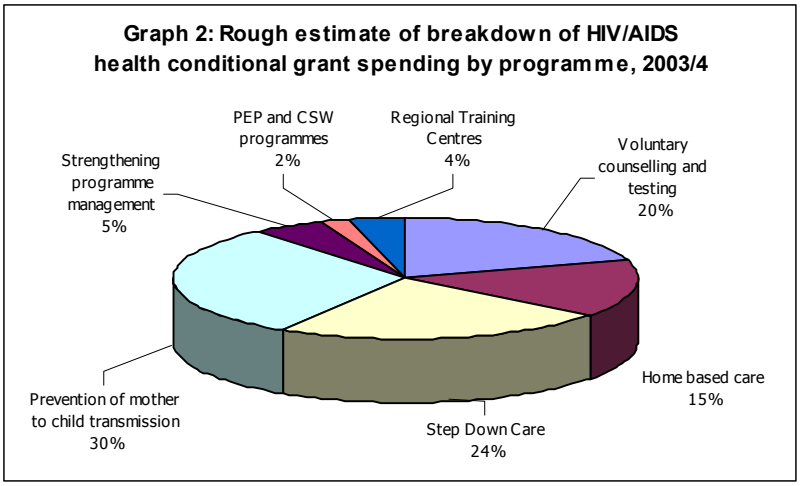
Table 2: Comprehensive HIV and AIDS conditional grant allocations by province

R million	2003/4	2004/5	2005/6	2006/7	Total MTEF (2004/5-2006/7)	Provincial shares over MTEF
Eastern Cape	38.934	98.97	159.005	218.021	475.996	14%
Free State	30.144	69.969	100.874	142.265	313.108	9%
Gauteng	55.275	134.231	185.048	252.695	571.974	16%
KwaZulu-Natal	85.591	186.348	251.468	344.304	782.12	22%
Limpopo	28.962	77.43	125.899	175.861	379.19	11%
Mpumalanga	26.287	53.84	81.392	107.479	242.711	7%
Northern Cape	11.268	31.881	48.05	68.603	148.534	4%
North West	32.891	70.981	100.921	142.316	314.218	9%
Western Cape	24.204	57.962	82.451	115.67	256.083	7%
Total	**333.556**	**781.612**	**1,135.108**	**1,567.214**	**3,483.934**	**100%**
Nominal growth rate	59%	134%	45%	38%		
Real growth rate	52%	122%	38%	31%		

Source: 2002 Division of Revenue Bill, 2003 Division of Revenue Bill, 2004 Division of Revenue Bill. Idasa calculations. Real calculations based on GDP inflation figures; 2003/4 base year.

Provinces were told the amount which has been added to their HIV/AIDS conditional grant for the ARV treatment plan. In their business plans which they submit to the national department for approval, they are permitted discretion to allocate the conditional grant funds between the nine interventions as they see fit. Graph 2 shows how provinces, on aggregate, split their conditional grant funds between the 8 interventions in 2003/4 *prior to the new ARV funds*, and suggests that roughly 50% went to prevention programmes. Generally speaking, 30% went to PMTCT and 20% to voluntary counseling and testing programmes, while nearly 40% was spent on step-down and home-based care.[12]

[10] Ibid.
[11] For a comprehensive analysis of how HIV/AIDS conditional grant funds are split between the provinces, see Chapter 4 of Hickey, Ndlovu, and Guthrie. 2003. *Budgeting for HIV/AIDS in South Africa*. Available at www.idasa.org.za/bis.
[12] NB: Estimates are based on figures from DOH on expenditure on conditional grant programmes as per provincial reports for December 2003. They should only be regarded as rough estimates of the breakdown.



Source: National Department of Health. Shares based on figures from DOH on expenditure on conditional grant programmes as per provincial reports for Dec 2003.

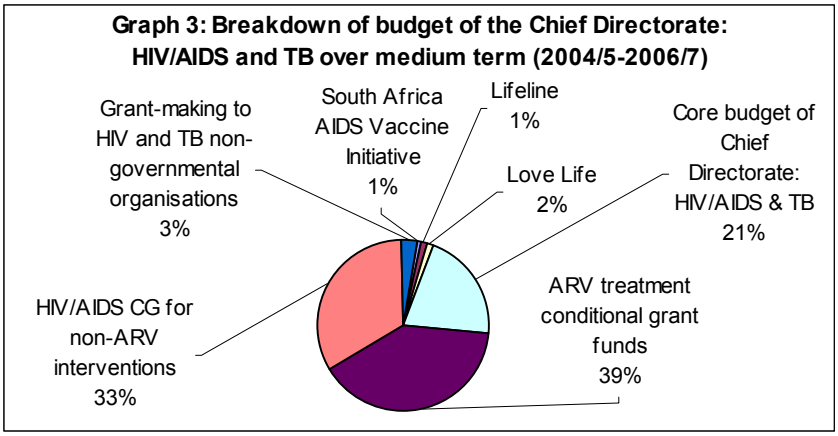
To summarise, Table 3 shows the overall budget of the Chief Directorate: HIV/AIDS and TB and outlines the three categories of expenditure described above: transfers to NGOs, funds spent directly by the department, and conditional grants to the provinces. Graphs 3 and 4 show the breakdown of the Chief Directorate budget visually.

Table 3: Budget of the Chief Directorate: HIV/AIDS and TB in national Department of Health

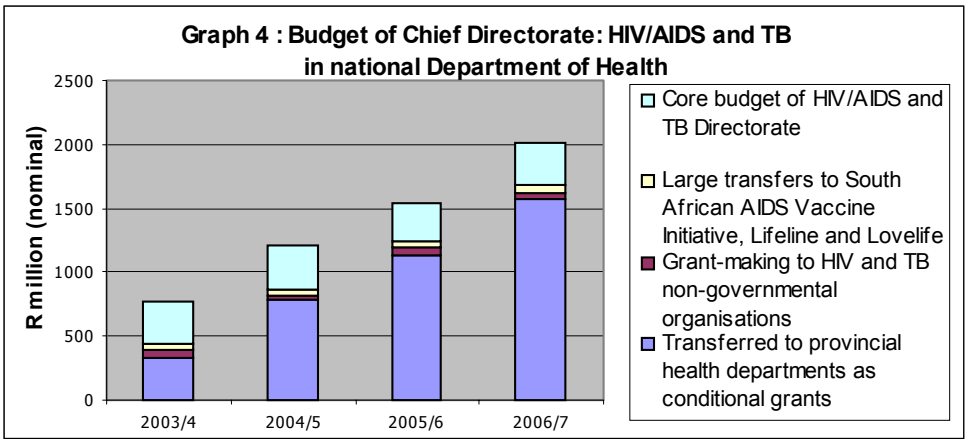
R million	2003/4	2004/5	2005/6	2006/7	Total over MTEF
HIV/AIDS NGOs	53.817	40.25	49.745	52.73	142.725
Tuberculosis NGOs	2.6	2.8	2.968	3.146	8.914
South Africa AIDS Vaccine Initiative	10	10	10	10.6	30.6
Lifeline	11	12	15	15.9	42.9
Love Life	25	23	25	25	73
HIV/AIDS health conditional grant to provinces	333.56	781.61	1,135.11	1,567.21	3,483.93
Core budget of Chief Directorate: HIV/AIDS and TB	330.32	342.51	307.52	333.78	983.81
Total budget of the Chief Directorate: HIV/AIDS and TB in national DOH	**766.29**	**1,212.17**	**1,545.34**	**2,008.37**	**4,765.88**
Real terms	766.29	1,150.06	1,389.74	1,716.86	4,256.66
Real growth rate	59%	50%	21%	24%	31%[13]

Source: 2004 Estimates of National Expenditure, pgs. 406-408. Idasa calculations. Real calculations based on GDP inflation figures; 2003/4 base year.

[13] This refers to annual average real growth rate over the medium term period (2004/5-2006/7).



Source: 2004 Estimates of National Expenditure, pgs. 406-408.



Source: 2004 Estimates of National Expenditure, pgs. 406-408.

B. HIV and AIDS Programme in national Department of Social Development

Apart from appearance of the ARV funds on the DOH budget, from an HIV/AIDS perspective there are also positive new changes in other areas of the 2004/5 national budget. In a welcome development, HIV/AIDS receive increased profile and additional financial resources in the budget of the national Department of Social Development (DSD). Funds specifically allocated for HIV/AIDS in DSD's budget total R78.29 million. Approximately 90% of that amount is transferred to provinces as conditional grants to finance community and home-based care (CHBC) programmes.

Our examination of the HIV/AIDS earmarked funds in DSD's budget should be framed in the context of overall trends in the social development budget. According to Budget 2004/5, the total budget of the national Department of Social Development is projected to increase nearly fivefold from 2003/4 to 2006/7, from R2.1 billion to a projected R10.3 billion.[14] This sizable boost in expenditure is due to the following main factors:

- The extension of the Child Support Grant to children aged 7 to 13 is being supported by a special conditional grant to the provinces. This began with a R1.2 billion allocation in its first year, 2003/4, and is set to grow to R9.3 billion by 2006/7.[15]

[14] 2004 Estimates of National Expenditure, pg. 497.
[15] 2004 Estimates of National Expenditure, pg. 498.

- In 2002/3, a new effort was launched to provide food parcels to poor families, to assist with the impact of high food prices. This was financed by a R230 million allocation in 2002/3, but will be continued with a R400 million allocation over the period 2003/4 to 2005/6. The majority of that money will be transferred to the provinces to support food relief programmes.[16]

- Apart from the conditional grants, the budget of the national department itself has also been boosted in order to pay for institutional reform of the social security grant system—including the establishment of the Social Security Agency and Inspectorate for Social Security. Over the next 3-5 years, the national department will be responsible for establishing the new agency. The plan is for national government to take over responsibility for grant administration and financing from the provinces. Administrative functions, including registration and payment of beneficiaries, will become the task of the national agency.[17]

These developments will indirectly impact positively on government's response to HIV/AIDS. Research has proven a critical link between HIV/AIDS and poverty and demonstrated that children left orphaned as a result of the epidemic are uniquely vulnerable. Thus food relief, the extension of the Child Support Grant, and overall improvements to the social security net should be understood as critical components of an overall strategy for fighting poverty in hand with fighting HIV/AIDS.

Apart from these less direct ways of mitigating the impact of HIV/AIDS on vulnerable children and families, DSD has increased the profile and attention accorded to targeted strategies to address HIV/AIDS. This is apparent in the establishment of a separate Programme (and line-item) for HIV/AIDS in 2004/5,[18] the new appointment of a Chief Director for the HIV and AIDS cluster at DSD, and more dimensions and complexity to the department's HIV/AIDS programmes.

The purpose of this new dedicated HIV and AIDS Programme in the budget of the national Department of Social Development is to develop policies, strategies and programmes aimed at mitigating the social impact of HIV/AIDS.[19] The broader focus on mitigating impact represents an expanded policy mandate for the Department, compared to an earlier, more limited focus on the CHBC conditional grants.[20] The new separate programme for HIV/AIDS contains three subprogrammes (plus an Administration subprogramme):

1. Community and home based care programmes: This subprogramme contains the conditional grant and therefore takes up 97% of the programme budget. Implementation has been accelerated, in partnership with provinces and NGOs. According to the Department, only 6 home-based care programmes were in operation in 2001, increasing to 400 by 2003.[21] The Department has the following medium term aims for the CHBC Programme:
   - To establish 500 drop-in centres for children infected and affected by HIV/AIDS by April 2007;
   - To develop a capacity-building programme for CHBC service providers by Dec 2004;

[16] Ibid.
[17] 2004 Estimates of National Expenditure, pg. 495.
[18] Previously the HIV/AIDS conditional grant for community-and-home-based care programmes was located in the budget under Programme 5: Development and Implementation Support.
[19] 2004 Estimates of National Expenditure, pg. 494.
[20] 2004 Estimates of National Expenditure, pg. 498.
[21] 2004 Estimates of National Expenditure, pg. 520.

- To continue to monitor and evaluate CHBC projects via quarterly reports, and;
- To set up a database of all funded organisations (by end of March 2005).

2. Coordinated Action for Orphans and Vulnerable Children: The goal of this subprogramme is to establish functioning coordinated structures at all levels of service delivery. Building on a June 2003 national conference which established a plan of action, the aim is to set up a database for orphans and vulnerable children (by March 2006), and produce a manual on psychosocial counseling and support services for orphans and vulnerable children (to be developed and implemented by December 2004).[22]

3. Women and Youth: This subprogramme has an ambitious goal of reaching 75% of the vulnerable population with prevention and awareness-raising strategies by March 2005. Working with the Lovelife partnership, 40 groundBreakers have already been trained and placed in CHBC sites, with the aim of expanding that number to 340 by March 2006. Furthermore, guidelines to reduce the risk of HIV/AIDS among women and youth are being put together, with a proposed deadline of October 2004.[23]

Table 4 shows the amounts allocated to each of these subprogrammes, beginning with their creation in this Budget 2004/5. Although direct expenditure by the national department represents only 12% of the total HIV and AIDS Programme over the medium term, the establishment of the separate HIV and AIDS Programme 8 as well as the additional three subprogrammes targeting women, youth and vulnerable children are very welcome as they greatly facilitate expenditure tracking on these priorities and also indicate increased attention to HIV/AIDS within the Department. It is hoped that, with the creation of this programme infrastructure, more funds will be allocated in Budget 2005/6 at the national level as well as the conditional grants. It is a cause for concern that, according to Budget 2004/5, funding for the entire programme plateaus and then fails to increase at all in 2006/7.

Table 4: Programme 8: HIV and AIDS in Department of Social Development

R million	2004/5	2005/6	2006/7	Total over MTEF
Subprogrammes:				
1. Community and home-based care programmes	76.265	83.009	87.129	**246.403**
2. Coordinated action for orphans and vulnerable children	0.645	0.684	0.725	**2.054**
3. Women and youth	0.688	0.729	0.773	**2.19**
4. Administration	0.692	0.731	0.775	**2.198**
Total Programme 8: HIV and AIDS	**78.29**	**85.153**	**89.402**	**252.845**
Real growth rate of Programme 8: HIV and AIDS	**5%**	**3%**	**0%**	**3%**
Funds spent directly by the national DSD	8.110	10.762	10.548	**29.420**
As percent of total budget for Programme 8: HIV and AIDS	10%	13%	12%	**12%**
Conditional grants to provinces for community and home-based care	70.180	74.391	78.854	**223.425**
As percent of total budget for Programme 8: HIV and AIDS	90%	87%	88%	**88%**

Source: 2004 Estimates of National Expenditure, pg. 518 & 534. Idasa calculations. Real calculations based on GDP inflation figures; 2003/4 base year.

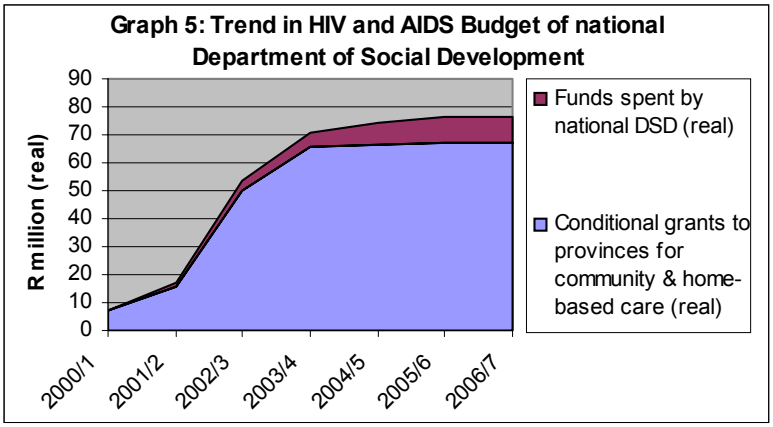
[22] Ibid.
[23] Ibid.

Turning to the conditional grants specifically, the funding of community-based care projects for people infected and affected by HIV/AIDS was introduced in 2000/1 at an amount of R5.6 million.[24] By 2006/7, it will be R78.9 million, or 14 times its original size. The allocation leapt from R13.4 million in 2001/2 to R47.5 million in 2002/3, and the following year it grew again to R65.9 million. However, as Table 5 and Graph 5 show, after its initial growth spurt, the allocation has now begun to level off. Beginning in 2004/5, the CHBC CG plateaus at R70.18 million, only shifting up 1% or less in real terms each year.[25]

Table 5: Community and home-based care conditional grant

R million	2000/1	2001/2	2002/3	2003/4	2004/5	2005/6	2006/7	Total over MTEF
Nominal terms	5.620	13.400	47.500	65.917	70.180	74.391	78.854	**223.425**
Nom growth rate		138%	255%	39%	6.47%	6.0%	6.0%	**6.16%**
Real terms	6.977	15.433	49.733	65.917	66.584	66.900	67.409	**200.893**
Real growth rate		121%	222%	33%	1.01%	0.47%	0.76%	**0.75%**

Source: 2004 Estimates of National Expenditure, pg. 534. Idasa calculations. Real calculations based on GDP inflation figures; 2003/4 base year.



Source: 2004 Estimates of National Expenditure, pg. 518 & 534. Idasa calculations.
Real calculations based on GDP inflation figures; 2003/4 base year.

The national department divides the funds between the provinces using a formula based on the antenatal HIV and AIDS prevalence survey and the poverty index.[26] Table 6 provides the provincial shares of the total CHBC funds available. Provincial splits do not vary at all year to year over the medium term; KZN, Mpumalanga, Gauteng and Free State (respectively) receive the largest shares, with the Western Cape receiving the smallest share at 4%.

[24] 2001 Budget Review, pg. 276.
[25] The actual allocation made in Budget 2004/5 is only R1.995 million more than the projection for 2004/5 which was published back in Budget 2002/3 (2002 DOR, pg. 88). In other words, in the annual budget process, the CHBC conditional grant did not receive significant increases from the baseline estimates.
[26] 2004 Division of Revenue Bill, pg. 108.

Table 6: Provincial allocations for community and home-based care conditional grant

R million	2002/3	2003/4	2004/5	2005/6	2006/7	Total over MTEF	Provincial shares over MTEF
Eastern Cape	4.798	6.658	7.089	7.514	7.965	22.568	10%
Free State	6.65	9.228	9.825	10.415	11.040	31.28	14%
Gauteng	6.983	9.69	10.315	10.934	11.590	32.839	15%
KwaZulu-Natal	8.644	11.996	12.773	13.540	14.352	40.665	18%
Limpopo	3.135	4.353	4.634	4.912	5.207	14.753	7%
Mpumalanga	7.077	9.821	10.456	11.084	11.749	33.289	15%
Northern Cape	2.66	3.691	3.930	4.165	4.415	12.51	6%
North West	5.463	7.58	8.070	8.554	9.067	25.691	11%
Western Cape	2.09	2.9	3.088	3.273	3.469	9.83	4%
Total	**47.5**	**65.917**	**70.180**	**74.391**	**78.854**	**223.425**	**100%**

Source: 2003 Division of Revenue Bill, pg. 97. 2004 Division of Revenue Bill, pg. 33. Idasa calculations.

C. HIV/AIDS allocations in national Department of Education

The HIV/AIDS Lifeskills Conditional Grant administered by the national Department of Education is allocated R129 million in 2004/05.[27] Over the medium term, the Lifeskills grant increases from to R136 million in 2005/6 and then to R144 million by 2006/7. Table 7 shows the path of the allocation.

Table 7: HIV/AIDS conditional grant to provincial departments of education

R million	2000/1	2001/2	2002/3	2003/4	2004/5	2005/6	2006/7	Total over MTEF
Nominal	26.93	62.89	133.458	131.621	128.579	136.293	144.471	409.343
Nom growth rate		133.5%	112.2%	-1.4%	-2.3%	6.0%	6.0%	3.2%
Real terms	33.43	72.43	139.73	131.62	121.99	122.57	123.50	368.06
Real growth rate		116.6%	92.9%	-5.8%	-7.3%	0.47%	0.76%	-2.0%

Source: 2004 Estimates of National Expenditure, pg. 364. Idasa calculations. Real calculations based on GDP inflation figures; 2003/4 base year.

The drop in 2004/5 is explained by the fact that the original allocation for 2003/4 was R120.474 million.[28] Then in the Adjusted Estimates 2003, R11.147 million was rolled over from the 2002/3 budget into Budget 2003/4. These were conditional grant funds for Limpopo which went unspent in 2002/3 and therefore were rolled over into 2003/4.[29]

However over the medium term, the conditional grant allocation only increases 6% nominally in 2005/6 and again in 2006/7. This is identical to the forward planning for the CHBCS conditional grant administered by DSD. When inflation is taken into account, this means that the conditional grant is set to *drop* an average of 2% in real terms each year.

[27] 2004 Budget Review, pg 154.
[28] 2003 Division of Revenue Bill, pg. 82.
[29] 2003 Adjusted Estimates, pg. 68.

Since the inception of the grant, the education component of the equitable share formula has been used to allocate this grant amongst the provinces.[30] Table 8 shows how the total Lifeskills conditional grant funds are to be split between the provinces over the medium term. KZN receives the bulk of the funds (23%), followed by Eastern Cape (17%) and Limpopo (15%). Given their small populations, Northern Cape and Free State receive the smallest portions.

Previously in Budget 2003/4, the conditional grant was located in Programme 3: General Education, under Sub-programme 1: Curriculum and Assessment Development and Learner Achievement. HIV/AIDS also appeared in Programme 2: Planning and Monitoring, under Sub-programme 3: HIV/AIDS and Human resources Planning and Development Support. However this sub-programme was not disaggregated enough to permit any quantification of how much of this sub-programme was directed to activities addressing HIV/AIDS. Thus although its quite likely that additional funds were spent on HIV/AIDS activities by the national department in 2003/4 and earlier, the budget did not allow for identification of amounts besides the conditional grant.

Table 8: Provincial allocations of Lifeskills conditional grant funds

R million	2004/5	2005/6	2006/7	Total MTEF	Provincial splits over MTEF
Eastern Cape	22.244	23.579	24.993	70.816	17%
Free State	7.715	8.178	8.668	24.561	6%
Gauteng	17.487	18.536	19.648	55.671	14%
KwaZulu-Natal	29.188	30.938	32.795	92.921	23%
Limpopo	19.415	20.580	21.815	61.810	15%
Mpumalanga	9.772	10.358	10.980	31.110	8%
Northern Cape	2.186	2.317	2.456	6.959	2%
North West	10.029	10.631	11.269	31.929	8%
Western Cape	10.543	11.176	11.847	33.566	8%
Total	**128.579**	**136.293**	**144.471**	**409.343**	**100%**

Source: Division of Revenue Bill 2004, pg. 30. Idasa calculations.

However the national DOE budget has been reorganised somewhat this year.[31] The conditional grant for Lifeskills education is still located in Programme 3: General Education under Sub-programme 1: Curriculum Development and Assessment (as in Budget 2003/4). The amounts for the conditional grants have remained essentially unchanged compared to the planned amounts announced in the last two years' Budgets. However new in Budget 2004/5, Programme 5: Quality Promotion and Development has a Subprogramme 2 called HIV and AIDS and School Nutrition.[32] The activities of this subprogramme include the development and implementation of policies on HIV/AIDS as well as managing and monitoring the implementation of the Primary School Nutrition Programme.[33]

[30] 2004 Division of Revenue Bill, pg. 92.
[31] For further information see Wildeman, R. 2004. "The National Education Budget 2004." Budget Brief No. 140. Available at www.idasa.org.za/bis
[32] This is one of the new programmes resulting from the reorganisation of the national DOE budget. Programme 5: Quality Promotion and Development provides leadership for policy development and special education programmes in support of quality education across the system.
[33] Budget 2004/5 saw the shift of the conditional grant for the Primary School Nutrition Programme from DOH to DOE. Beginning 1 April 2004, DOE will take over management and monitoring of the programme.

Unfortunately, the same problem of disaggregation remains. The combination of the HIV and AIDS and Nutrition programmes in one Sub-programme line item in the budget still does not allow sufficient disaggregation to indicate what share is spent on HIV/AIDS activities. When the conditional grant funds for the Primary School Nutrition Programme are deducted from the line item, the following amounts are left to be spent at the national level for both HIV/AIDS *and* School Nutrition: R13.75 million for 2004/5; R12.33 million for 2005/6, and; R11.95 million for 2006/7.[34]

D. Other national departments

Apart from the three social service departments examined in the previous sections, two other national departments have HIV/AIDS specific line items appearing on their budgets.

First, notably the South Africa AIDS Vaccine Initiative (SAAVI) receives funding from both the Department of Health *and* the **Department of Science and Technology** (DST). Although R10 million is provided to SAAVI from the DOH budget, as mentioned above, the bulk of government funding to SAAVI comes off the Department of Science and Technology's budget, totaling R50 million over the medium term. The transfer to the SAAVI from DST equals R15 million in 2004/5, R20 million in 2005/6 and R15 million in 2006/7.[35] Formed in 1999 as a lead programme of the Medical Research Council of South Africa, the SAAVI coordinates the research, development and testing of HIV/AIDS vaccines in South Africa.[36] Combining both funding sources, SAAVI is set to receive R80.6 million in government support over the medium term.

Second, the budget of the **Department of Public Service and Administration** shows evidence that the Department is taking the impact of HIV/AIDS on the public service seriously. Implementation of its strategy to manage HIV/AIDS and its impact on the public service is cited as one of the department's main focuses for the next three years. "The main thrust is prevention, with significant attention being paid to other health and wellness issues for public servants and their families."[37] Programme 2: Integrated Human Resources contains a Subprogramme: HIV/AIDS which first appeared in Budget 2002/3. Table 9 shows the growth of the subprogramme's allocation since then.

Table 9: Department of Public Service and Administration, Programme 2: Integrated Human Resources, Subprogramme 5: HIV/AIDS

R million	2002/3	2003/4	2004/5	2005/6	2006/7	Total over MTEF
Nominal	2.160	5.218	4.958	10.384	11.380	**26.722**
Nominal growth rate		142%	-5%	109%	10%	**38%**
Real terms	2.262	5.218	4.704	9.338	9.728	**23.771**
Real growth rate		131%	-10%	99%	4%	**31%**

Source: 2004 Estimates of National Expenditure, pg. 246. Real calculations based on GDP inflation figures; 2003/4 base year.

The Department attributes the growth in Programme 2: Integrated Human Resources to the additional funding for combating and preventing HIV/AIDS in the public service. However the

[34] 2003 Estimates of National Expenditure, pg. 370.
[35] 2004 Estimates of National Expenditure, pg. 479.
[36] South Africa AIDS Vaccine Initiative website http://www.saavi.org.za/
[37] 2004 Estimates of National Expenditure, pg. 241.

allocation drops slightly in this budget 2004/5 and then nearly doubles in real terms in 2005/6. No specific explanation is given for this substantial jump in next year's budget 2005/6.[38] However it is noted that in the last two years, the communication strategy developed in 2003/4 has begun implementation, and workshops have been held with departments to impart knowledge and skills needed to develop and implement workplace policies and programmes.[39]

Other departments may have activities targeted to combating HIV/AIDS but the budget is not sufficiently disaggregated to permit identification of the financial resources committed to those efforts by these departments. For example, the following departments identify HIV/AIDS-related activities but do not attach budget numbers to those activities in the official budget documents:

- As part of their efforts to combat HIV/AIDS in the workplace, in 2003 the **Department of Labour** published technical guidelines for employers and their employees regarding HIV/AIDS and disability in terms of the Employment Equity Act.[40] However, no budgetary information is available to understand the department's commitment to HIV/AIDS.

- The **Department of Correctional Services** developed an HIV and AIDS Policy which was approved by the Minister in October 2002. Although Budget 2004 does not indicate how much the department will allocate for HIV/AIDS activities, it reports that "the increases in spending can be ascribed to the department's commitment to the treatment of HIV and AIDS, the financing of health services previously provided free by provincial health departments, and the introduction of three meals per day."[41] In addition, with the roll-out of free ARV treatment in the public service commencing in 2004, "DCS will be involved in the roll-out of the government's anti-retroviral implementation plan to HIV-positive prisoners during the medium term."[42]

- Programme 5: Military Health Support of the **Department of Defense** has extended its medical services to the extended families of their personnel from 2003/04 onwards. However the Department notes up front that these services have been extended despite an insufficient programme budget and further states that increasing patient load (including patients engaged in commitments in the DRC and Burundi, and those with opportunistic illnesses related to HIV/AIDS) is placing a heavy burden on already limited budgetary resources.[43]

- **The South African Management Development Institute (SAMDI**) (Vote 12 of the national budget) has a specific HIV and AIDS Programme with the purpose of sensitising managers to appropriate attrition management and awareness raising strategies in the workplace.[44] SAMDI also aims to implement HIV/AIDS related guidelines developed by the Department of Public Service and Administration (DPSA). However it is difficult to monitor this department's commitment to HIV/AIDS because there is no specific budgetary information available.

[38] 2004 Estimates of National Expenditure, pg. 247.
[39] 2004 Estimates of National Expenditure, pg. 248.
[40] 2004 Estimates of National Expenditure, pg. 445.
[41] 2004 Estimates of National Expenditure, pg. 564.
[42] 2004 Estimates of National Expenditure, pg. 565.
[43] 2004 Estimates of National Expenditure, pg. 596-7.
[44] 2004 Estimates of National Expenditure, pg. 284.

Finally, it should be noted that analysis of the government budget from an HIV/AIDS perspective should not be limited to an accounting exercise which seeks only to add up HIV/AIDS specific-line items in national department budgets. Developments in other national departments' budgets can indirectly reinforce government's response to HIV/AIDS by contributing to poverty alleviation and thus making households less vulnerable and susceptible to infection and/or the impacts of the epidemic. Thus it is important to acknowledge budget allocations which support development-oriented programmes and thereby offer indirect support and assistance to persons infected and affected by HIV/AIDS. From a pro-poor perspective, the following programmes stand to impact positively on broad efforts to mitigate the impact of the epidemic on households and families:

- The Urban Renewal Programme, the Integrated Sustainable Rural Development Programme and the Anchor Projects within the Provincial and Local Government Vote.

- The Poverty Alleviation Programme, incorporating Community Development and Emergency Food Relief, in the Social Development Vote.

- The Integrated Food Security and Nutrition Programme, incorporated in the Farmer Support and Development Programme in the Department of Agriculture. Also importantly the budget for the Farmer Resettlement sub-programme grows by an average annual increase of 107% between 2000/1 and 2006/7.[45]

- The Poverty Alleviation projects under the Auxiliary and Associated Services Programme in the Department of Environmental Affairs and Tourism.

- The Housing department aims to provide adequate housing to all South Africans. Its budget sees steady average annual growth of 8.7% between 2000/1 and 2006/7.

- Department of Land Affairs undertakes important development activities, such as land reform and capital works projects (in conjunction with the Department of Public Works).[46]

- The Department of Water Affairs and Forestry aims to ensure that all South Africans have access to adequate, safe and affordable water.

- Continuing a move first introduced in Budget 2003/4, more funds are made available for rural allowances and increased remuneration for scarce health professional skills. [47]

- The Expanded Public Works Programme will be "creating work opportunities in public social programmes (e.g. community-based care in health and social welfare and early childhood development) under the leadership of the DSD."[48] Between 2004/5 and 2008/9, at least R600 million is to be allocated to national departments, provinces and municipalities for spending in the social sector, via the normal budgeting process.

As part of the government's poverty reduction and development strategies, these activities and programmes have the potential to contribute to breaking the vicious cycle between poverty and

[45] 2004 Estimates of National Expenditure, pg. 702.
[46] 2004 Estimates of National Expenditure, pg. 844.
[47] 2004 Estimates of National Expenditure, pg. 402.
[48] 2004 Budget Review, pg. 123.

HIV/AIDS, while also directly enhancing the well-being of persons infected and affected by HIV/AIDS, assuming their access to such benefits and services.

IV. Funds added to the provincial equitable share for HIV/AIDS

As mentioned above, beginning in 2002/3, the national government has used a second funding mechanism—in addition to the conditional grants—to make funds available to provinces to respond to HIV/AIDS.[49] In Budget 2002/3 National Treasury announced that R400 million, R600 million and R900 million would be added to the entire provincial equitable share pool for HIV/AIDS in 2002/3, 2003/4 and 2004/5 respectively. Then in Budget 2003/4 National Treasury decided to add *more* funds to the ES pool for HIV/AIDS—over and above the previously announced amounts. In Budget 2004/5, government instituted the new ARV funds but did not make any announcement of additional funds to the equitable share for HIV/AIDS. Table 10 shows the end result of the total amounts flowing through the ES for HIV/AIDS.

Table 10: Amounts added to provincial equitable share for HIV/AIDS

R million	2002/3	2003/4	2004/5	2005/6	2006/7	Total over MTEF
Equitable share allocation announced in Budget 2002/3	400	600	900	954[50]	1,011	**2,865**
Equitable share allocation announced in Budget 2003/4		500	1,000	1,500	1,590[51]	**4,090**
Total channeled via equitable share	**400**	**1,100**	**1,900**	**2,454**	**2,601**	**6,955**
Total HIV/AIDS specific allocations on natl department budgets, including CGs[52]	**647**	**974**	**1,439**	**1,797**	**2,269**	**5,505**
Total HIV/AIDS related spending amounts (including funds via ES)	1,047	2,074	3,339	4,251	4,870	**12,460**
ES funding channel as share of total HIV/AIDS amounts in national budget	38%	53%	57%	58%	53%	**56%**

Source: 2004 Estimates of National Expenditure, pgs. 247, 364, 406, 479, 518. 2002 Budget Review, pg. 141. Personal correspondence with Dr. Mark Blecher, National Treasury.

In his MTBPS speech to Parliament in November 2003, Minister of Finance Trevor Manuel announced that an estimated amount of R12 billion was to be allocated to HIV/AIDS activities over the MTEF[53] and the recent 2004/5 budget states that "total HIV and AIDS related spending amount to R12.3 billion over the MTEF period."[54] However, it must be stressed that these figures include those funds which are to be sent via the equitable share (ES) to provinces. In other words, the total R12.46 billion (see Table 10) includes two broad categories:

1. HIV/AIDS-specific allocations on national department budgets, totaling R1.439 billion in Budget 2004/5 and R5.505 billion over the MTEF. This includes funds directly spent by

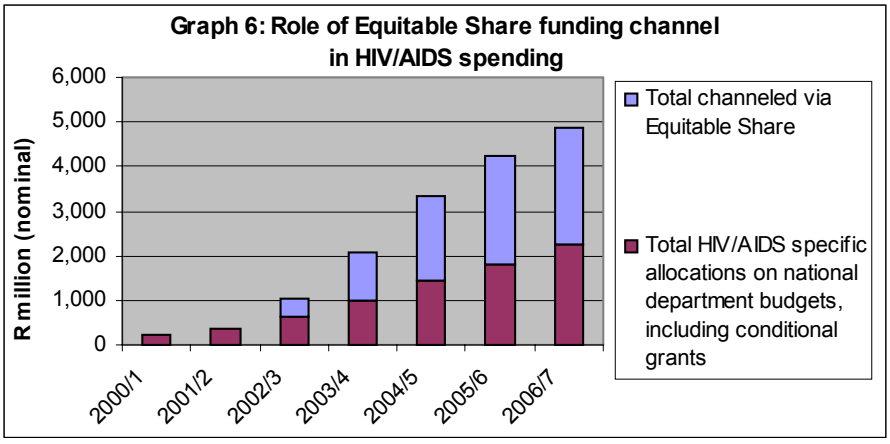
[49] The equitable share grant which each province receives from national government is an unconditional transfer which provinces may allocate at their discretion between various sectors and departments. The size of each province's ES grant is determined by a technical formula which utilises poverty and demographic data.
[50] The figures for 2005/6 and 2006/7 were not listed in Budget 2002/3 but have been provided by National Treasury. They are 6% nominal increases from the previous year's allocation.
[51] The figure for 2006/7 was not given in Budget 2003/4 but has been provided by National Treasury. It is a 6% nominal increase on the previous year's allocation.
[52] See Table 1 above.
[53] 2003 Medium Term Budget Policy Statement Speech, pg. 14.
[54] 2004 Budget Review, pg. 124.

the national departments of education, health, social development, science & technology, and public service & administration, as well as the conditional grants those national departments transfer to their provincial counterparts for HIV/AIDS programmes.

2. The funds for HIV/AIDS which are made available to provinces for HIV/AIDS spending via the equitable share, which amount to R1.9 billion for 2004/5, and R6.955 billion over the medium term.

National government is not intending or assuming that all these funds will appear on provincial budgets in HIV/AIDS specific line-items. The funds are intended to help provinces to generally strengthen health care services and to cope with the impact of HIV/AIDS e.g. treatment of opportunistic infections, increased hospital admissions. These are costs which are difficult (and undesirable) to isolate as HIV/AIDS-specific and thus are better financed via the regular provincial health department as opposed to via conditional grants.[55] If the equitable share funding mechanism is functioning as intended, the funds will partially be allocated to HIV/AIDS specific line-items in provincial health budgets, and the balance will be allocated to provincial health departments generally to reinforce their capacity to respond to the impact of HIV/AIDS on service delivery.

This is why it is important to monitor what provinces allocate from the ES funds to their health departments for HIV/AIDS and the ARV roll-out. Empirically, our research found that the provinces had only allocated R356 million from their own health budgets in 2003/4 specifically for HIV/AIDS.[56] In other words, only 32% of the R1.1 billion added to the ES for HIV/AIDS that year was directed specifically to HIV/AIDS line items in provincial health budgets. The remaining funds were difficult to track because provinces allocated them according to their own priorities. In addition, the funds were intended for more indirect support to health services and infrastructure, which cannot be traced in specific line-items. However there is evidence that these funds are resulting in increased provincial health budgets: for example, R3.432 billion was added to provincial health budgets in 2003/4, compared to forward estimates for 2003/4 published in 2002/3.[57]



Source: 2004 Estimates of National Expenditure, pgs. 246, 364, 406, 479, 518. 2002 Budget Review, pg. 141. Personal correspondence with Dr. Mark Blecher, National Treasury.

[55] For a full discussion of the equitable share funding channel for sending funds to the provinces for HIV/AIDS, see Chapter 6 of Hickey, Ndlovu, and Guthrie. 2003. *Budgeting for HIV/AIDS in South Africa*. Idasa-ABU. Available at www.idasa.org.za/bis

[56] Hickey, Ndlovu, and Guthrie. 2003. *Budgeting for HIV/AIDS in South Africa*. Idasa-ABU. Pg. 80.

[57] Intergovernmental Fiscal Review 2003, pg. 76.

Table 10 above also shows that government is increasing its reliance upon this indirect funding channel. When the initial R400 million was added to the ES for HIV/AIDS in 2002/3, the amount constituted 38% of national government's overall budget for HIV/AIDS. In Budget 2004/5, government will be sending 57% of the overall budget for HIV/AIDS to the provinces via the equitable share. Graph 6 shows the role of the equitable share funding channel in the overall budget framework for HIV/AIDS. Given that the roll-out of the new ARV treatment programme will place substantial demands on the regular health care service delivery system, the indirect funding channel for HIV/AIDS will become more critical as a funding source for provincial health departments.

V. New allocations for ARV treatment programmes

From an HIV/AIDS perspective, the newsworthy development in Budget 2004/5 is undoubtedly the new allocations for ARV treatment programmes. Additional allocations for the HIV and AIDS Treatment Plan total R2.072 billion over the medium term.[58] This includes R1.9 billion in conditional grants to provincial health departments, as well as R172 million of the Chief Directorate: HIV/AIDS and TB budget "to provide adequate oversight of the treatment programme for the next three years."[59] Conditional grants amount to R300 million for 2004/05, R600 million for 2005/06 and R1 billion for 2006/07.[60] Table 11 shows the total new allocations to fund the implementation of the Comprehensive HIV and AIDS Care, Management and Treatment Operational Plan.

Table 11: Total new allocations for Comprehensive HIV and AIDS Care, Management and Treatment Operational Plan

R million	2003/4	2004/5	2005/6	2006/7	Total over MTEF
Conditional grants to provinces	-	300	600	1,000	1,900
National component	90	73	48	51	172
Total	**90**	**373**	**648**	**1,051**	**2,072**
Real growth rate		293%	65%	54%	137%
National component as share of total	100%	20%	7%	5%	8%

Source: 2004 Estimates of National Expenditure, pg. 403-404. 2002 Budget Review, pg. 121. Adjusted Estimates 2003, pg. 72. Real calculations based on GDP inflation figures; 2003/4 base year.

This amount of R300 million for the first year allows for 5,476 new persons starting on ARVs each month and a basic yearly treatment cost of R8428 per person.[61] (A R8428 annual average unit cost is reached by taking the total budget set out in the Operational Plan for 2004/5 (R1.590 billion) and dividing it by the Operational Plan's target number of 188,665 persons on treatment for 2004/5).[62] The amount of R600 million for the second year allows for: 1) an annual average unit cost of R7000 per person, with 3076 new persons starting on ARVs each month in year two, and 2) the 65 718 persons who began ARV treatment in 2004/5 continuing treatment in 2005/6 (now at a unit cost of R7000). The R1 billion amount for 2006/7 will cover a total of 118 214 new

[58] Budget Review 2004, pg. 121.
[59] Budget Review 2004 (pgs. 124 and 138) states R161 million is allocated for national component of the treatment plan, however, 2004 Estimates of National Expenditure (pg. 404) states that total for the national department is R172 million.
[60] 2004 Estimates of National Expenditure, pg. 403.
[61] Personal correspondence with Dr. Mark Blecher, Director of Social Services, National Treasury. 6 February 2004. Annual cost per patient is adjusted depending upon the month of the year which they enter treatment i.e. annual cost for someone entering treatment in month one would be the full R8428.
[62] Operational Plan, pgs. 248 and 256.

persons entering treatment in 2006/7, assuming an annual average unit cost of R6000 per person.[63]

It should be noted that funds for ARV treatment first appeared at the end of 2003.[64] An amount of R90 million was allocated to the national DOH in the 2003 Adjusted Estimates, "for kick-starting the ARV treatment process, beyond which the budgets for continuation are in the conditional grants for provinces."[65] According to DOH, this R90 million allocation was [to be] spent from the end of November 2003 to the end of March 2004. National DOH planned to use the allocation for national procurement and for purchase of laboratory test equipment for National Health Laboratory Service (NHLS).[66] Furthermore, research under the ARV programme will primarily be funded from the national budget.[67]

Table 11 also indicates that in the first year 2004/5, 20% of the new ARV funds will be spent by national DOH, while the remaining funds will be sent to provincial health departments as an add-on to the existing health conditional grant for HIV/AIDS. As the provincial ARV programmes get up and running, the national share of the total ARV funds is projected to drop, until it reaches 5% in 2006/7.

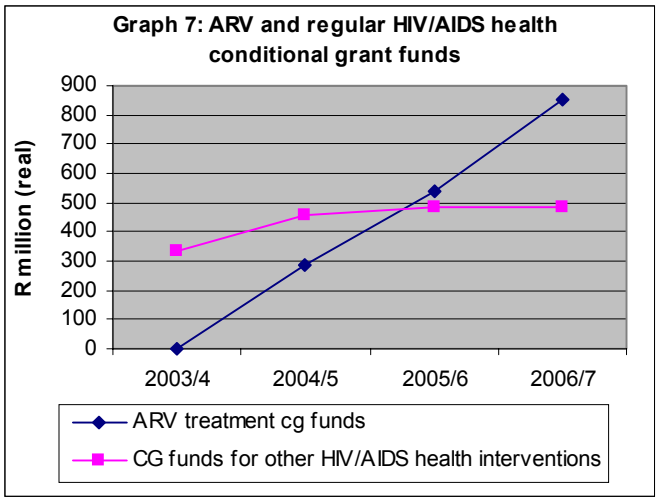
This section first looks at how the ARV funds compare to the existing HIV/AIDS conditional grant funds flowing to the provinces and shows how the ARV funds will quickly come to dominate the budget controlled by the national Chief Directorate: HIV/AIDS and TB. We then proceed to examine how much each province will receive, and what might be achieved with these amounts. We then examine how the ARV funds were split between the nine provinces. The last sections look at other specific issues related to financing for the roll-out, including drug procurement.

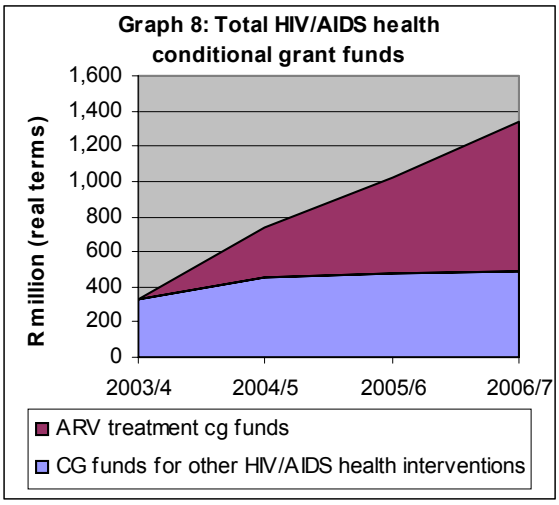
A. How do the ARV funds compare to the regular HIV/AIDS conditional grant funds?

As noted in Section III, essentially the ARV funds flow to the provinces via an existing funding channel; the regular health HIV/AIDS conditional grant allocations still stand, but will be supplemented considerably with the new funds for ARV treatment. Graphs 7 and 8 show the upward climb of the total Comprehensive HIV and AIDS conditional grant in real terms, and the degree to which the ARV funds are responsible for that increase.

The graphs illustrate how ARV conditional grant funds will come to dominate the HIV/AIDS conditional grant funding stream from the national Department of Health to provincial health departments. In the first year of ARV roll-out (2004/5), the total regular health HIV/AIDS CG (R482 million excluding ARV funds) exceeds the total ARV CG (R300 million). In that first year, 38% of the funds transferred as conditional grants to the provinces by DOH will be designated specifically for ARV treatment programmes. However beginning in 2005/6 national government will be sending more earmarked funds to provinces for ARV programmes specifically, than for all other HIV/AIDS interventions in the health sector. By 2006/7, 64% of the HIV/AIDS conditional grant funds are targeted for ARV treatment.

[63] Personal correspondence with Dr. Mark Blecher, Director of Social Services, National Treasury. 6 February 2004.
[64] Adjusted Estimates 2003, pg. 72.
[65] Bodibe, Khopotso. "Where is the ARV roll-out? Interview with Dr. Nono Simelela." 9 February 2004. Health E-news.
[66] Personal correspondence with Dr. Mark Blecher, Director of Social Services, National Treasury. 6 February 2004.
[67] Personal correspondence with Celicia Serenata, Project Manager: HIV/AIDS, Department of Health. 8 May 2004.





Source: 2004 Estimates of National Expenditure, pg. 407. 2003 Medium Term Budget Policy Statement, pg. 82. Idasa calculations. Real calculations based on GDP inflation figures; 2003/4 base year.

Table 12 displays the figures which put the ARV funds in context. It indicates the following key trends:

- **Non-ARV conditional grant funds plateau.** If we remove the layer of new ARV funding, we can see what is happening to the CG financing for regular HIV/AIDS interventions, including PMTCT, VCT, and HBC. As Table 12 shows, the regular HIV conditional grant funds increase by 37% in real terms this budget and again by 5% next year. However they are set to increase by only 1% in real terms in 2006/7, unless additions are made to the baseline in subsequent budgets.

- **ARV CG funds rise rapidly.** However, while non-ARV conditional grant funds are plateauing, ARV funds will be growing significantly and steadily. In real terms, ARV funds are set to increase dramatically by 90% in 2005/6 and then by 58% in 2006/7.

- **ARV funds take a larger share of Chief Directorate budget.** ARV treatment funds (including conditional grants to provinces as well as funds spent directly by national DOH to oversee the roll-out) take up 31% of the Chief Directorate budget in 2004/5. Over the medium term, 43% of the Chief Directorate budget is dedicated to ARV treatment programmes.

Table 12: ARV treatment funds in the context of the Chief Directorate Budget and HIV/AIDS conditional grants

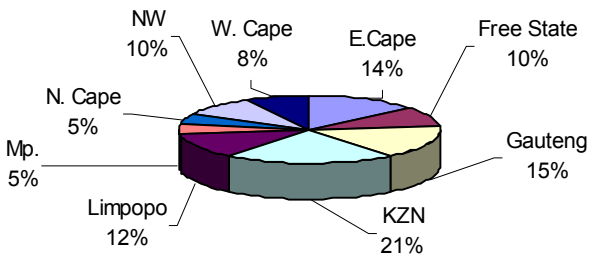
R million	2000/1	2001/2	2002/3	2003/4	2004/5	2005/6	2006/7	Total over MTEF
Nominal terms								
ARV treatment conditional grant funds		0	0	0	300	600	1,000	**1,900.0**
Conditional grant funds for other HIV/AIDS health interventions	16.82	54.40	210.21	333.56	481.61	535.11	567.21	**1,583.9**
Total health HIV/AIDS conditional grant funds	**16.82**	**54.40**	**210.21**	**333.56**	**781.61**	**1,135.11**	**1,567.21**	**3,483.93**
Real terms								
ARV treatment conditional grant funds		0	0	0	284.63	539.58	854.85	**1,679.1**
Conditional grant funds for other HIV/AIDS health interventions	20.88	62.65	220.09	333.56	456.94	481.23	484.88	**1,423.0**
Total health HIV/AIDS conditional grant funds	**20.88**	**62.65**	**220.09**	**333.56**	**741.57**	**1,020.81**	**1,339.74**	**3,102.11**
Real growth rates								
ARV treatment conditional grant funds						90%	58%	
Conditional grant funds for other HIV/AIDS health interventions		200%	251%	52%	37%	5%	1%	
Total health HIV/AIDS CG funds		**200%**	**251%**	**52%**	**122%**	**38%**	**31%**	
Total HIV/AIDS CGs as a share of total budget of the Chief Directorate:HIV/AIDS and TB	9%	20%	46%	44%	64%	73%	78%	**73%**
ARV treatment CG funds as a share of total HIV/AIDS health CG					38%	53%	64%	**55%**
ARV treatment funds (CGs and national) as share of total budget of Chief Directorate: HIV/AIDS and TB					31%	42%	52%	**43%**

Source: 2004 Estimates of National Expenditure, pgs. 406-407. 2004 Budget Review, pgs. 121-124. Idasa calculations. Real calculations based on GDP inflation figures; 2003/4 base year.

B. How much is each province allocated for ARV treatment programmes?

Which provinces are receiving the bulk of the additional conditional grant funds for ARV treatment? Table 13 shows how much each province is set to receive for ARV treatment in the first year of the roll-out. Graph 9 provides a picture of how the funds are spread across provinces. KZN, Gauteng and Eastern Cape are the clear beneficiaries in the provincial distribution.

Graph 9: Provincial shares of total ARV funds 2004/5 ~ R300 million



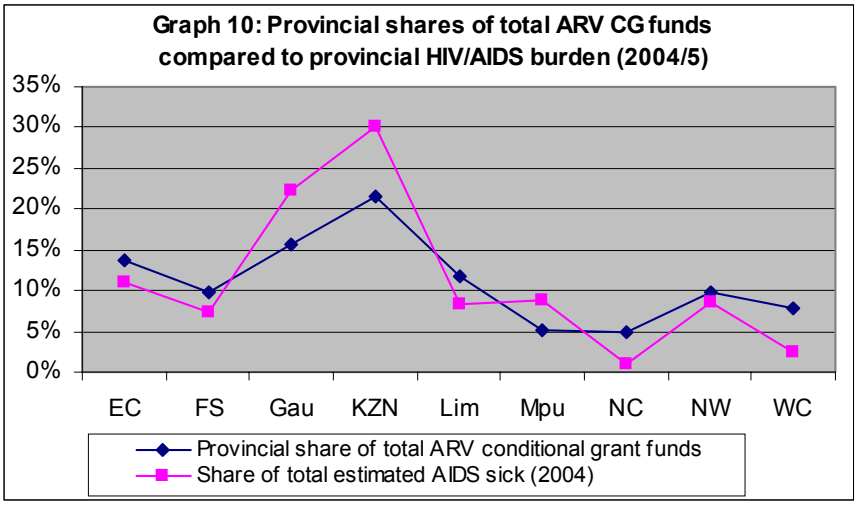
Source: 2004 Division of Revenue Bill, pg. 31. Idasa calculations.

Table 13: 2004/5 Provincial ARV treatment conditional grant allocations

R million	ARV conditional grant funds	Provincial shares of total ARV conditional grant funds	Provincial shares of total AIDS sick persons 2004 (ASSA provincial model)
Eastern Cape	40.777	14%	11%
Free State	29.126	10%	7%
Gauteng	46.602	16%	22%
KwaZulu-Natal	64.079	22%	30%
Limpopo	34.951	12%	8%
Mpumalanga	15.479	5%	9%
Northern Cape	14.463	5%	1%
North West	29.126	10%	9%
Western Cape	23.081	8%	2%
Total	**297.684**	**100%**	**100%**

Source: 2004 Division of Revenue Bill, pg. 31. Dorrington, R., Bradshaw, D. and Budlender, D.(2002). Idasa calculations.

How does the provincial distribution of ARV conditional grant funds compare to the relative HIV/AIDS burden carried by each province? Graph 10 maps the provincial share of the total ARV conditional grant funds onto the province's share of the total estimated AIDS sick persons in 2004, according to the ASSA 2000 provincial model. It shows that the distributions are only roughly aligned. KZN, Gauteng and Mpumalanga's shares of the total ARV CG funds are less than their share of the estimated number of AIDS sick people. Meanwhile Western Cape has an estimated 2% of the total estimated number of AIDS sick persons in South Africa, yet receives 8% of the ARV conditional grant funds. However, additional considerations besides the province's relative AIDS burden were rightly taken into account when the allocations were made. Section C below explains how the relative HIV/AIDS burden in each province was one of multiple factors used to allocate the funds.



Source: 2004 Division of Revenue Bill, pg. 31. Dorrington, R., Bradshaw, D. and Budlender, D.(2002). Idasa calculations.

Considering only the conditional grant funds for ARV treatment being transferred to the provinces, what can be achieved with this amount? The Operational Plan sets out a goal of establishing a minimum of one service point in every health district (District Council or

Metropolitan Council) in South Africa by the end of the first year of implementation.[68] According to rough calculations, if one assumes 1 site per district, 1000 persons treated per site,[69] then this R300 million global amount only allows provinces to spend an annual average of R5825 per person treated (with a total of 51,500 persons on treatment).

Table 14 shows the number of people who can go on ARV treatment in each province, given varying annual average costs, and compares this to the estimated number of Stage 4 AIDS cases in each province. (See Appendix B for the full table.) **It shows that when we assume a R6000 annual average cost per person on treatment, the ARV conditional grant allocations will only pay for 49,614 persons on treatment in the first year of implementation, which is slightly short of the 53,000 target set out in the Operational Plan.** Given the current conditional grant allocations to provinces for ARV treatment, only 7% of the estimated number of AIDS sick persons nationally will be able to enter treatment in the first year.

As noted above, the Operational Plan estimated an annual average unit cost of R8428 per person on treatment for 2004/5. Table 15 shows the annual average unit costs arrived at using the estimated total budget and target number of ARV cases for each year as given in the Operational Plan. If we use this R8428 unit cost taken from the Operational Plan and apply it to the actual amount budgeted in conditional grants in 2004/5, Table 14 showed that only 35,321 persons could be covered (or 5% of the estimated number of Stage 4 AIDS cases nationally).

Table 14: Numbers able to be treated per province at varying annual average costs (2004/5)

	Number on treatment @ R6000 unit cost	Percent share of Stage 4 AIDS cases treated @ R6000	Number on treatment @ R7000 unit cost	Percent share of Stage 4 AIDS cases treated @ R7000	Number on treatment @ R8428 unit cost	Percent share of Stage 4 AIDS cases treated @ R8428
EC	6,796	8%	5,825	7%	4,838	6%
FS	4,854	9%	4,161	8%	3,456	6%
Gau	7,767	5%	6,657	4%	5,529	3%
KZN	10,680	5%	9,154	4%	7,603	3%
Lim	5,825	9%	4,993	8%	4,147	7%
Mpu	2,580	4%	2,211	3%	1,837	3%
NC	2,411	32%	2,066	28%	1,716	23%
NW	4,854	8%	4,161	7%	3,456	5%
WC	3,847	22%	3,297	19%	2,739	15%
Total	**49,614**	**7%**	**42,526**	**6%**	**35,321**	**5%**

Source: 2004 Division of Revenue Bill, pg. 31. 2003 Division of Revenue Bill, pg. 87. Personal correspondence with Dr. Mark Blecher, Director of Social Services, National Treasury. Dorrington, R., Bradshaw, D. and Budlender, D.(2002). Idasa calculations.

[68] Operational Plan, pg. 24.
[69] With one exception of 500 persons per site in Northern Cape.

Table 15: Operational Plan estimates

	New cases starting ARVs	Total persons on ARVs	Total estimated budget (R million)	Annual average unit cost (R)
2003/4	53,000	53,000	296	5,585
2004/5	138,315	188,665	1,590	8,428
2005/6	215,689	381,177	2,358	6,186
2006/7	299,516	645,740	3,268	5,061
2007/8	411,889	1,001,534	4,474	4,467

Source: Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, pg. 52 and 256. Idasa calculations of annual average costs per person.

These figures suggest that the 2004/5 ARV treatment conditional grant allocations fall slightly short of the estimated resources called for in the Operational Plan. However indications are that government's intention was to provide a level of funding in Budget 2004/5 which could be absorbed by the provinces, and then to ratchet up and add additional resources as and where needed in the Adjusted Estimates, which will be published in November 2004. Furthermore, the ARV conditional grant funds are not the only source of funding for the ARV treatment roll-out. Provinces are expected to allocate funds from their own budgets (sourced via the equitable share—see discussion in Section IV) and donor funds are available, including those expected in KZN and the Western Cape from the Global Fund to Fight HIV/AIDS, TB and Malaria. If no further allocations are forthcoming from national government, the amounts allocated may very well be insufficient to reach the goals set out in the Operational Plan, however indications from National Treasury are that this will not be the case.

C. What process and criteria were used to split the ARV conditional grant funds between provinces?

The provincial distribution of the additional conditional grant funds for ARV treatment was the result of a compromise between National Treasury and national Department of Health, after consideration of different options generated by both departments.

In a memo to provincial departments in December 2003, the Chief Directorate: HIV/AIDS and TB in DOH indicated that the ARV funds were split between the provinces on the following basis:[70]

- *Calculations of the number of cases that can be treated within the available budget (noting that funds allocated in the MTBPS for this programme constitute less than 30% of the total funds actually required by the operational plan for the same period.)*
- *These costs include drugs and laboratory testing and an allowance for provincial management function based on caseload.*
- *Allocation of these funds across provinces based upon the projected share of AIDS cases by province. (Source: ASSA 2000 Provincial Outputs).*
- *Proportional allocation of funds earmarked for service staffing in the operational plan.*
- *Proportional allocation of funds earmarked for nutritional support in the operational plan.*

Cutting up the pie with respect to the ARV conditional grant funds was influenced by the negotiations customary to government budget processes. Although the DOH memo dated 8 December 2003 (quoted above) communicated one set of numbers, those figures were then

[70] Memo from Dr. Nono Simelela, Chief Director: HIV/AIDS and TB. 8 Dec 2003. Subject: HIV conditional grant business plan 2004/5. Page 2.

shifted and revised between December 2003 and February 2004 when the final allocations were published in the 2004 Division of Revenue Bill. Between the 8 December 2003 Memo and the final figures in the 2004 DOR, R24 million was deducted from KZN and R15 million deducted from Mpumalanga's allocation (also R3 million each deducted from Eastern Cape and North West's allocations). When that R45 million was reallocated, the main winners were as follows: adding R16 million to Western Cape, R11 million to Northern Cape, R8 million to Free State, R7 million to Limpopo. [71] Essentially the shares were 'evened out' so that disparities were less wide, particularly in the case of KZN (which received a sizable 29% of the pie according to the first draft) and the Western Cape and Northern Cape which managed to move up from 2% and 1% shares, to 5% and 8% shares respectively.

From the perspective of National Treasury, in considering various options, it became apparent that if only projected caseload was considered,[72] the resulting distribution favoured KZN heavily, with Western Cape and Northern Cape, for instance, receiving very small shares which were insufficient to set up basic infrastructure for the programme (only between R3 and R7 million).

Thus a different approach was tried based on one site per health district for the first year.[73] This basic amount was continued through for years 2 and 3, with additional amounts for the outer years distributed according to projected case load (i.e. provincial shares of total Stage 4 AIDS cases).[74] However again the provincial allocations generated using this approach are different than the final figures: the final allocations provide for approximately R12 million less for the Western Cape and approximately R12 million more for Gauteng.[75]

Resource allocation decisions between provinces thus involve negotiations and adjustments due to a number of factors. In the case of the ARV funds, it appears a technical allocation based on unit costs and provincial shares of total AIDS cases was the starting point, but other considerations were then layered on top. Those considerations include the varying abilities of provinces to absorb the added funds, the need to cover basic infrastructure costs in low-population provinces, and the need to build the capacity of under-resourced or underspending provinces.

D. How do the provincial ARV allocations relate to provinces' absorption capacity?

In considering provinces' relative ability to spend or absorb funds, there are three approaches for measuring or understanding 'ability to spend':

- Past spending record (budgeted vs. actual expenditure)
- Capacity to spend (survey of infrastructure and management/staffing currently available)
- Existence of a clear business plan/proposal for ARV treatment programme

With respect to past spending records, Idasa has conducted extensive analysis on provincial spending records for the HIV/AIDS conditional grants (i.e. actual expenditure as a percentage of amount allocated) from 2000/1 to 2002/3. That research suggests that if ARV provincial

[71] Ibid. Also Memo from Chief Director: HIV, AIDS & TB, Dr. Nono Simelela. Date 25 February 2004. Subject: HIV Conditional Grant Budget and Business Plan 2004/5.
[72] Utilising figures from the ASSA provincial model to distribute funds according to provincial shares of total estimated Stage 4 AIDS cases.
[73] Assuming R5825 annual average cost per person on treatment and 1000 persons on treatment per site (except in the case of Northern Cape where 500 persons were estimated on treatment per site).
[74] Personal correspondence with Dr. M. Blecher, Director: Social Sector, National Treasury.
[75] Ibid. 2004 Division of Revenue Bill, pg. 31.

allocations were going to include positive consideration of those provinces with the stronger spending records, KZN, NorthWest, and Western Cape would be prioritized.[76]

However calculations restricted to actual expenditure as a percentage of amount allocated shortchange some provinces because they fail to represent how allocations are also increasing rapidly year to year. The increased conditional grant allocations being channeled to the provinces put tremendous pressure upon provincial health departments to absorb the added funds. From 2001/2 to 2002/3, the provinces on aggregate increased their actual expenditure by 303%.[77] In particular Northwest, KZN and Mpumalanga (respectively) were able to substantially multiply their spend from one year to the next. Without considering impact of expenditure, the large percent increases suggest these provinces were able to rapidly expand their programmes.

Such spending pressures only intensify with the introduction of the new ARV funds. Budget 2004/5 demands that some provincial health departments spend up to 183% more in HIV/AIDS conditional grant funds than they were allocated last year. Table 16 compares this year's budget increases to how well each province is doing in spending the amount it was allocated last year.

Table 16: 2004/5 increases in Comprehensive HIV and AIDS health conditional grant allocations and 2003/4 spend as at 31 December 2003

R million	Amount allocated 2003/4	Amount spent as at 31 Dec 2003	Percent spent as at 31 Dec 2003	Amount allocated 2004/5	**Percent increase in amount allocated 2003/4-2004/5**
Eastern Cape	38.9	28.1	72%	99.0	154%
Free State	30.1	20.8	69%	79.0	132%
Gauteng	55.3	23.4	42%	134.2	143%
KwaZulu-Natal	85.6	97.2	114%[78]	186.3	118%
Limpopo	29.0	11.6	40%	77.4	167%
Mpumalanga	26.3	3.2	12%	53.8	105%
Northern Cape	11.3	4.3	38%	31.9	183%
North West	32.9	13.7	42%	71.	116%
Western Cape	24.2	12.1	50%	58.0	139%
Total	**333.6**	**214.5**	**64%**	**781.6**	**134%**

Source: 2003 Divison of Revenue Bill, pg. 87. 2004 Divison of Revenue Bill, pg. 31. National Treasury: Statement of the National and Provincial Governments' Revenue, Expenditure and National Borrowing as at 31 December 2003. Corrected with information from National Department of Health in cases of Free State, Mpumalanga and Northwest.

Thus Idasa's findings on spending track records are consistent with DOH's decision to give the largest share of ARV funds to KZN. Further cases of note include:

- Gauteng, which receives the second largest share of ARV funds, exhibits a weaker spending record according to this data. Yet as one of the provinces with a stronger, well-coordinated HIV/AIDS response, it has been quicker off the mark in planning, preparing and launching its ARV treatment programme, and will likely be able to spend the expanded conditional grant in addition to the R50 million contribution from the province's own budget.[79]

[76] See detailed analysis of spending records on health conditional grant in Hickey, Ndlovu and Guthrie; 2003. *Budgeting for HIV/AIDS in South Africa*, pgs. 35-37.
[77] Ibid.
[78] The greater-than-100% figure can likely be explained by the province reporting on expenditure on funds sourced from the regular department budget, in addition to conditional grant funds received from national government.

- Eastern Cape may experience difficulties absorbing the funds. Given that it receives 14% of the total ARV funds, its total HIV/AIDS conditional grant budget will be over 150% larger than last year.

- Limpopo will also be under pressure. It has been slow to spend its 2003/4 allocation, yet will be faced with a 167% larger CG budget in 2004/5.

- Mpumalanga remains a serious concern. Spending rates were very low in 2001/2 and 2002/3 and are still very low for 2003/4 as at 31 December. Mpumalanga is allocated R54 million in 2004/5 but has reportedly only spent R3 million of its R26 million allocation for 2003/4 by the end of the third quarter.[80]

E. Can unspent ARV conditional grant funds be reallocated between provinces?

How well provinces manage to absorb the new ARV conditional grant amounts could have direct implications for the level of funding available to them. The 2004 Division of Revenue Bill[81] contains a new clause that specifically relates to the Comprehensive HIV and Aids conditional grant administered by DOH. This clause is not present in the 2002 or 2003 Division of Revenue Bills, nor is it applicable to any other provincial conditional grant.

> *Section 23 (2). A transferring national officer may, with the written consent of the National Treasury and after consent of the National Treasury and after consultation with the affected provinces, reallocate the grant for the Comprehensive HIV and Aids grant, or a portion of such an allocation, from one province to another province, if the reallocation is necessary to shift funds from provinces spending less per month than as agreed with the transferring national officer at the beginning of the financial year.*[82]

The **authority of DOH to reallocate ARV funds between provinces** is reinforced and repeated in two other places:

- The Bill reiterates that the flow of installments will be dependant on adequate performance on expenditure and outputs. "In particular, continued poor performance in implementing Comprehensive Treatment and Care Programme may result in reallocation of funds to other provinces."[83]
- DOH is obligated to constantly monitor outputs and spending trends in order "to allow for revision of grant amounts and allocations as required to support implementation."[84]

First, its important to note that the regular clauses of the DOR Bill already provide national government with tools to suspend or stop conditional grant payments to provinces in the event that they underspend or do not meet the specific conditions of the grant. Therefore, if national government is concerned solely about underspending related to the HIV health CG, they already have the authority to delay or stop payments to under-performing provinces. Why then is it

[79] Gauteng Department of Health. "The Expanded HIV and AIDS Treatment Programme in Gauteng Issued by: Department of Health, Gauteng Provincial Government." 15 March 2004. Available at http://www.gpg.gov.za/docs/pr/2004/pr0315a.html

[80] National Treasury: Statement of the National and Provincial Governments' Revenue, Expenditure and National Borrowing as at 31 December 2003. Available at www.treasury.gov.za

[81] The Division of Revenue Bill is presented to Parliament with the Budget every financial year; it contains information on the division of nationally-raised revenue between the spheres of government as well as details on the conditional grants to provinces and transfers to local government.

[82] Division of Revenue Bill 2004, Section 23 (2).

[83] Division of Revenue Bill 2004, Appendix E1, pg. 96.

[84] Division of Revenue Bill 2004, Appendix E1, pg. 97.

necessary to insert this new clause specifically for the HIV/AIDS health grant? The following are possible reasons:

- **Added flexibility.** The clause provides DOH with more flexibility to adjust the funding stream for ARV treatment programmes. Financing to provinces which are slow to perform can be reduced, and provinces which are absorbing well can receive more resources. The Operational Plan specifically noted the need for a flexible financing tool, given the magnitude of the undertaking and newness of the programme.[85] In actuality, the Operational Plan suggested that the needed flexibility could be achieved by a) allowing rollovers of unspent funds, and b) holding significant funds in reserve centrally which would be reallocated as needed. If the Section 23(2) is invoked and funds are reallocated, the penalised province would not be able to rollover those funds to the following financial year; they would, in effect, be 'lost' to that province. Furthermore, there is no indication that DOH has been able to set aside such a central 'contingency reserve.' However Section 23(2) acts as a compromise in that the net effect is to provide some of the flexibility called for in the Operational Plan.

- **An extra big stick.** It is unlikely Section 23(2) would ever actually be utilised. The political consequences of taking allocated financial resources away from an under-performing (and likely under-resourced) province, such as the Eastern Cape, and shifting them towards a high performing province, such as the Western Cape, would be high. However the insertion of this clause provides national government with some extra leverage to lean on provinces to perform, and urgently.

- **Retaining control of the big picture.** What is new in Section 23 (2) is the authority to suspend payment to a province that underspends *and give that money to another province instead.* This is not allowed elsewhere in the DOR for any other provincial conditional grant. National government cannot directly control spending by provinces; all it can do (empowered by the general clauses of the DOR) is withhold payments, but obviously this does not actually increase actual expenditure rates. However if national can reallocate those funds to a province that *can* spend the funds, then the *aggregate* spending rate for the HIV/AIDS health CG *does* increase. Section 23 (2) thus gives national government a means to lift the global spending record on the grant, since it cannot directly control provincial spending rates.

The utilisation of Section 23 (2) creates a danger of increasing inequity in the roll-out. However National Treasury has indicated an intention to begin with the Budget 2004/5 allocations but to give more in the 2004 Adjusted Estimates and 2005/6 Budget as called for. Furthermore, inequity in budget inputs is less important than monitoring equity in outputs and outcomes. If particular provinces are not spending their allotted amounts, equity in budget allocations will not further equitable results at the clinic level. With regard to such monitoring, a final point of note is that Section 23(2) is unusual and indicates the unique pressure national government feels with respect to delivering on the ARV programme.

F. Procurement of ARV drugs: What restrictions are attached to the conditional grant funds?

The costs of the antiretroviral drugs themselves is a major slice of the budget for the programme. Therefore who is responsible for drug procurement, and whether provincial or national budgets

[85] Operational Plan, pg. 258.

are expected to cover drug costs are key questions. Is ARV drug procurement a provincial responsibility or a national competency? The Operational Plan includes an explicit recommendation that the appropriate funding mechanism for drug procurement is direct national procurement; while drug distribution ought to be financed via the conditional grants.[86] Earlier the Plan states that the National Treasury has accepted a principle that funding "would need to flow through direct NDOH transfers via a combination of conditional grants to provinces and direct national procurement of key inputs (e.g. drugs and laboratory services)."[87]

According to the new Budget 2004/5 and information provided by National Treasury officials, it appears that national government's aim is that provinces will utilise the conditional grant funds to pay for ARVs, but that provinces buy off the national tender. In other words, national government (DOH) actually puts out the tender, makes the selection and seals the deal, but the funds are sourced from the provincial conditional grants. As is the norm with conditional grants, the provinces have been requested to submit a business plan for national approval which covers the existing eight programmes *plus* the ARV component.[88] The Chief Directorate instructions (8 December 2003) to provinces indicated that the ARV portion of the conditional grant business plans should cover the following areas:[89]

1. *New health care staff*
2. *Laboratory testing*
3. *Antiretroviral drugs*
4. *Nutrition*
5. *Other health system upgrades*
6. *Programme management*
7. *Capital investment*
8. *Research*

The Chief Directorate: HIV/AIDS and TB also indicated that provincial plans should take into account:

- *Staffing requirements*
- *Upgrading facilities and pharmacies*
- *Upgrading patient information, monitoring and evaluation systems*
- *Upgrading the national laboratory services*
- *Maintaining health after HIV infection*
- *Nutritional Support Programme*
- *Diagnostic Monitoring following diagnosis of HIV infection*

Thus the expectation is that provinces will budget ARV drug procurement into their conditional grant business plans. Those business plans were due by 15 February at which point they were reviewed and approved by the transferring national officer in the national Department of Health before the first installment was paid.[90] The Department of Health was obligated to complete final approval of provincial plans by 1 April 2004.[91]

[86] Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa. 19 November 2003. pg. 257.
[87] Operational Plan, pg. 257.
[88] Memo from Dr. Nono Simelela, Chief Director: HIV/AIDS and TB. 8 Dec 2003. Subject: HIV conditional grant business plan 2004/5. Page 2.
[89] These categories could ostensibly be used as line items for a province's budget for the ARV-earmarked funds. They match the categories used in the budget of the Operational Plan.
[90] Memo from Dr. Nono Simelela, Chief Director: HIV/AIDS and TB. 8 Dec 2003. Subject: HIV conditional grant business plan 2004/5. Page 2.
[91] Division of Revenue Bill 2004, Appendix E1, pg. 97.

As mentioned above, in order to gain approval, those business plans must meet conditions, and those conditions must continue to be met throughout the financial year, or the payment schedule may be jeopardised. Generally speaking (i.e. not only in the case of the HIV/AIDS conditional grants), conditional grants can only be utilised for the purpose stipulated in the DOR and in accordance with the allocations or conditions published in the Gazette by the Minister.[92] For each conditional grant, the Division of Revenue Bill details the amounts allocated to each province and the conditions attached. The conditions on the Comprehensive HIV and Aids grant are more complex and strict than previous years and contain seven conditions specifically related to the Comprehensive HIV and AIDS Treatment and Care Programme.[93]

One of those conditions explicitly legislated in the DOR is as follows: "Procurement of pharmaceuticals and nutritional supplements/products for use in the Comprehensive Treatment and Care programme must be undertaken as agreed with the national Department of Health including through the appropriate use of national tenders."[94]

Other new conditions inserted for the first time this year include: [95]

- Must comply with data reporting requirements or funds may be withheld. Comprehensive Treatment and Care must be delivered at nationally accredited facilities only.
- All treatment and care must follow national treatment and clinical guidelines as published by the National Comprehensive Treatment and Care Programme.
- All laboratory and diagnostic monitoring under the Comprehensive Treatment and Care Programme must be procured from the National Health Laboratory Service.
- Payment of all suppliers (including NHLS) will be effected within 30 days of receipt of invoice, continuing late payment may result in withholding of funds.

In summary, the facts above indicate that the intention of the national government is that provinces utilise the national tender process to procure drugs, and source the funds from their conditional grant amounts. However, assuming that government does expect provinces to procure ARV drugs with their conditional grant budgets, those funds are plainly insufficient, according to cost estimates in the Operational Plan. Table 17 outlines the total drug costs cited in the Operational Plan and compares these estimates to the total ARV conditional grants funds flowing to provinces.

Table 17: Estimates of ARV drug costs compared to available ARV conditional grant funds

R million	2003/4	2004/5	2005/6	2006/7
Total drug costs as listed in Operational Plan	42	369	725	1118
Aggregate conditional grant funds to provinces for ARV treatment		300	600	1000
Shortfall?		69	125	118
Total HIV/AIDS health CG funds (including ARV funds) for Comprehensive HIV and AIDS programme, including VCT, PMTCT, CHBC, PEP, Step down care, Sex worker programmes		782	1135	1567

Source: 2004 Budget Review, pg. 121-124. Operational Plan, pg. 250 and 256. 2004 Estimates of National Expenditure, pg.407. Idasa calculations.

[92] Division of Revenue Bill 2004, Section 24 (2).
[93] For the sake of comparison, the HIV/AIDS health conditional grant framework in the 2003 DOR only contained three short conditions.
[94] Division of Revenue Bill 2004, Appendix E1, pg. 96.
[95] Ibid.

There appears to be a possible shortfall. However there are two points to note. First, the Operational Plan assumes the ARV treatment programme will commence in 2003/4, which in actuality did not occur. Thus 2003/4 figures in the Operational Plan perhaps ought to be understood as estimates for year one of the programme, and thus are more appropriately compared to 2004/5 government budget allocations. Second, the Plan notes there is a strong possibility of further price reductions. However even given these two considerations, Table 17 shows that even if we were to compare next years' R600 million ARV conditional grant allocation to the R369 million estimate of drug costs, provinces would need to be spending a full 61% of their ARV conditional grant funds on purchasing drugs. This would leave less than 40% of the funds to cover all the other costs of running ARV treatment programmes.

G. Other issues related to the financing of ARV treatment roll-out

A full examination of issues related to the financing of the roll-out of ARV treatment programmes is beyond the scope of this Paper, but we note a number of outstanding issues related to the national budget for 2004/5.

★ **Provincial contributions.** As noted above, national government is expecting and relying upon provincial governments to allocate funds from their own budgets for ARV treatment. Western Cape and Gauteng are two prime cases where the provincial treasury has earmarked funds to supplement those received from national government for HIV/AIDS. The degree to which provinces supplement the conditional grant funds will have implications for equity and sufficiency of ARV financing.

★ **Nutrition programmes.** Services and education surrounding nutrition and healthy lifestyles are critical for HIV-positive persons so that they may prolong the period before their CD4 count drops to the level where ARV drug treatment should commence. Research has shown that the longer a person living with HIV can delay beginning HAART, the better. Thus adequate provision for nutrition aspects of ARV treatment must be included in provincial budgeting. Are costs related to nutrition programmes to be covered by conditional grant funds or from provincial budgets? As noted above, DOH has indicated that provincial business plans should take nutritional support programmes into account.

  With respect to nutrition programmes for children, beginning in April 2004, the primary school nutrition component of the Integrated Nutrition Programme (INP) and the associated budgets has moved from DOH to the Department of Education. However, key aspects relevant to HIV/AIDS treatment will remain under the purview of DOH, including nutritional support for malnourished children in clinics and other patients (including those with TB). Those aspects will continue to be funded via conditional grants.[96] "Nutrition programmes which remain with the health departments will be funded from a smaller grant for an intermediate period, after which funding is to be channeled through the provincial equitable share."[97]

[96] 2004 Estimates of National Expenditure, pg. 401.
[97] 2004 Estimates of National Expenditure, pg. 408.

★ **Laboratory costs.** Clarity is also needed regarding whether laboratory costs and payments to NHLS will be paid by NDOH from the Chief Directorate budget, or whether provinces are to cover these costs from their conditional grants. Reportedly national DOH intended to utilise a portion of the R90 million additional allocation in November 2003 to buy lab test equipment for NHLS.[98]

VI. How is HIV/AIDS and health prioritised in Budget 2004/5?

In terms of the broader context, the 2004/5 national budget was a 'tighter' budget than its predecessor, with a reduced revenue envelope. This was primarily due to slower economic growth than anticipated at the time of the 2003 Budget (1.9%) leading to lower revenue flows than were planned for.[99] The 2004/5 main budget provides for expenditure of R368.9 billion. This is an 11.1% increase from 2003/4, compared to a larger increase of 16.2% enjoyed in 2003/4.[100] Compared with the forward estimates published last year, the 2004/5 Budget has an additional R9.7 billion, of which R3.2 billion goes to national departments and R5.5 billion was given to provinces (via the equitable share and conditional grants).[101]

How do the HIV/AIDS allocations fit into this picture of the overall budget? Table 10 above gave two figures for the total HIV/AIDS budget for 2004/5. HIV/AIDS-specific allocations on the national department budgets (including conditional grants) total R1.439 billion in 2004/5, whereas if we also include the entire amount of funds added to the equitable share for HIV/AIDS, we reach a higher figure of R3.339 billion.

Table 18: HIV/AIDS as share of total budget

R million	2000/1	2001/2	2002/3	2003/4	2004/5	2005/6	2006/7	Total over MTEF
Total specified for HIV/AIDS in national budget (including CGs)	213.7	343.7	646.7	973.5	1,439.0	1,797.2	2,268.6	**5,504.8**
As share of total consolidated expenditure (including interest costs)[102]	0.09%	0.13%	0.21%	0.28%	0.37%	0.42%	0.49%	**0.43%**
As share of GDP	0.023%	0.034%	0.056%	0.080%	0.108%	0.123%	0.142%	**0.126%**
Total HIV/AIDS budget including CGs and ES funds	213.7	343.7	1,046.7	2,073.5	3,339.0	4,251.2	4,869.6	**12,459.8**
As share of total consolidated expenditure (including interest costs)	0.09%	0.13%	0.34%	0.59%	0.86%	1.00%	1.06%	**0.98%**
As share of GDP	0.023%	0.034%	0.091%	0.170%	0.251%	0.292%	0.306%	**0.284%**

Source: 2004 Estimates of National Expenditure, pgs. ii, 246, 364, 406, 479, 518. 2002 Budget Review, pgs. 59, 141. Personal correspondence with M. Blecher, National Treasury.

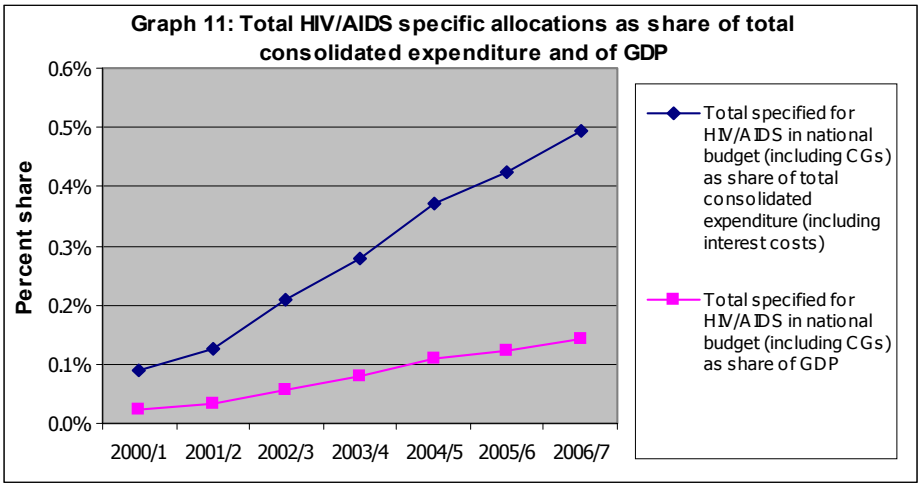
[98] Adjusted Estimates 2003, pg. 72. Personal correspondence with Dr. Mark Blecher, National Treasury. 6 Feb 2004.
[99] 2004 Budget Review, pg. 10.
[100] 2004 Budget Review, pg. 11.
[101] 2004 Budget Review, pg. 130.
[102] Total consolidated national and provincial expenditure includes main budget, plus estimates of social security spending, and provincial estimates based on preliminary data received from provincial treasuries. Budget Review 2004, pg. 144.

Table 18 shows the HIV/AIDS budget as a share of the total budget using both the strict and the expanded calculations of the HIV/AIDS budget. It shows that:

- In 2004/5, 0.37% of total consolidated expenditure is specifically earmarked for HIV/AIDS. This share has climbed steadily from only 0.09% four years ago, to a projected share of 0.49% by 2006/7.

- Even when we use the expanded definition which counts all the funds added to the ES for HIV/AIDS, less than 1% of the total budget is targeted for HIV/AIDS in 2004/5.

Graph 11 shows the steady climb in the priority given to HIV/AIDS in the budget and also shows that HIV/AIDS spending accounts for an increasing share of GDP, rising from an estimated 0.023% in 2000/1 to a projected 0.142% in 2006/7.



Source: 2004 Estimates of National Expenditure, pgs. ii, 246, 364,406,479, 518. 2002 Budget Review, pgs. 59, 141. Personal correspondence with Dr. M. Blecher, National Treasury.
NB: Provincial HIV/AIDS allocations sourced via the equitable share are *not* included here.

Turning now to the heath sector in particular, we see a steady pattern. Since 2000/1 approximately 11% of consolidated national and provincial expenditure has been consumed by the health sector. It is important to note that, with respect to provincial budgets, health consumes a larger portion of provincial budgets—22.3% in 2003/4—given that the provinces are the primary vehicles for social service delivery in South Africa's intergovernmental fiscal system.[103] Notably the 11% figure falls short of the commitment made by African heads of state (including South Africa) in Abuju, Nigeria in April 2001, to set a target of allocating at least 15% of the annual budget to the improvement of the health sector.[104]

Table 19 shows HIV/AIDS allocations in the context of health spending. It shows that:

- 2.8% of consolidated national and provincial health spending is specifically allocated for HIV/AIDS programmes in 2004/5. This percentage is set to rise to 4.0% in 2006/7.

- Again, the share has risen steadily in recent budgets, from 0.7% in 2000/1.

[103] 2003 Intergovernmental Fiscal Review, pg. 16.
[104] Section 26. "Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Abuja, Federal Republic of Nigeria." 27 April 2001. Text available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf

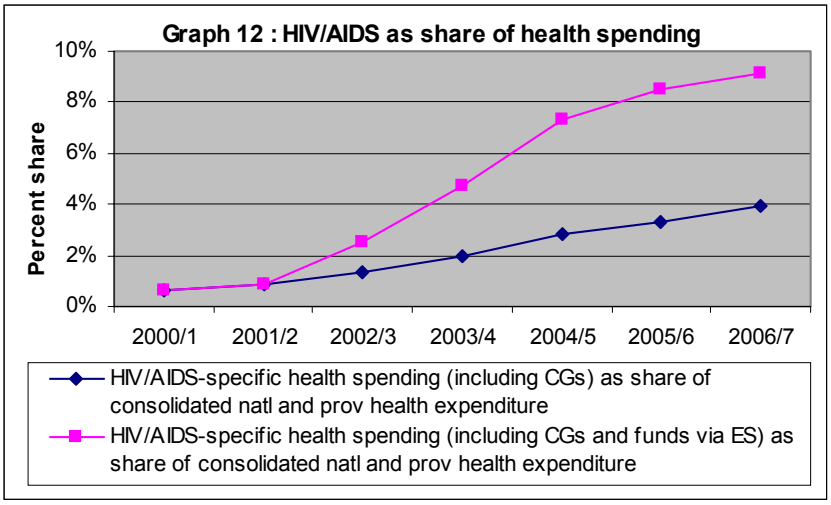
- Using the expanded estimate which includes the funds channeled via the ES, the share rises to 7.3% in 2004/5.

Table 19: HIV/AIDS-specific spending in health sector as share of total health expenditure

R million	2000/1	2001/2	2002/3	2003/4	2004/5	2005/6	2006/7	Total over MTEF
HIV/AIDS-specific health spending (including CGs; excluding funds via ES)	181.1	265.8	460.0	766.3	1,212.2	1,545.3	2,008.4	4,765.9
As share of consolidated natl and prov health expenditure	0.7%	0.9%	1.3%	1.9%	2.8%	3.3%	4.0%	3.4%
HIV/AIDS health spending (including CGs and funds via ES)	181.1	265.8	860.0	1,866.3	3,112.2	3,999.3	4,609.4	11,720.9
As share of consolidated natl and prov health expenditure	0.7%	0.9%	2.5%	4.7%	7.3%	8.5%	9.1%	8.4%
Consolidated natl and prov health expenditure, as share of total consolidated expenditure (including interest costs)	11.4%	11.3%	11.1%	11.3%	11.0%	11.1%	11.0%	11.1%

Source: 2002 Budget Review, pg. 141. 2004 Estimates of National Expenditure, pg. 406. 2004 Budget Review, pg. 144. Uses preliminary provincial MTEF budgets. 2003/4 projected outcome based on actual expenditure for 1st nine months, as at 31 December 2003.

Graph 12 shows the increasing share of the health budget targeted to HIV/AIDS, using both the stricter and more expanded categories of HIV/AIDS allocations.



Source: 2002 Budget Review, pg. 141. 2004 Estimates of National Expenditure, pg. 406. 2004 Budget Review, pg. 144. Uses preliminary provincial MTEF budgets. 2003/4 projected outcome based on actual expenditure for 1st nine months, as at 31 December 2003.

VII. Conclusion

Compared to budgets of only 3 years ago, generally speaking, we are seeing increased mention and attention given to HIV/AIDS in multiple areas—for example, acknowledgement of the effects of HIV/AIDS on the labour market and business, or identification of HIV/AIDS as a policy priority for the social cluster. As the spotlight stays on the ARV roll-out in the upcoming year, it will be important to sustain attention to government's broader efforts to combat HIV/AIDS and mitigate its impact on poor households and families. This Paper has carefully examined the allocations in the health, social development and education budgets as well as noting allocations to poverty alleviation and development programmes. With ARV treatment funding constituting 31% of the HIV/AIDS budget in the Department of Health this year, and set to consume a larger share over the medium term, it will be important to watch allocations and spending on the non-medical aspects of government's response to HIV/AIDS. After substantial increases in previous budgets, both the Lifeskills HIV/AIDS and CHBC conditional grants are now starting to plateau or decline in real terms over the medium term. This is a cause for concern. Prevention must remain a priority and community and hosme-based care and support to children infected and affected by HIV/AIDS are vital components of an holistic plan to manage the impact of the epidemic.

This Paper has analysed the national budget exclusively, but it is important to note that a full accounting of HIV/AIDS allocations in the overall government budget must also include funds which provinces will designate from their own budgets. Depending on how provinces make use of the HIV/AIDS financing made available to them via the equitable share, total funds targeted for HIV/AIDS in 2004/5 will likely comprise between R1.439 billion and R3.339 billion. (See Table 10).

The 2004/5 national budget thus indicates a readiness and commitment by National Treasury to make the needed funds available for roll-out. It becomes clear then that the critical issue is the ability and commitment of national and provincial health departments to speedily get ARV treatment programmes up and running, in keeping with the ambitious targets of the Operational Plan. This Paper has argued that the provincial health departments have a major challenge before them; the injection of ARV funds means that in this financial year provincial health departments must spend 134% more than they were given last year in HIV/AIDS conditional grant funds. Idasa research has traced a steady improvement in the aggregate spending records of provinces regarding HIV/AIDS conditional grants, but some provinces still remain problematic. For those provinces with weaker financial and project management skills, absorption capacity could very well be the primary obstacle to roll-out.

This Paper also examined the provincial distribution of the additional R300 million in conditional grant funds for ARV treatment and concluded that the approach taken is a reasonable one, given the unreliable costing data available to us when programmes are not yet operational. Instead of attempting to finance pilot sites in each province as was done with the funding for PMTCT, the approach used to allocate the ARV treatment funds does a good job of balancing infrastructure, capacity and need (as reflected by number of persons at Stage 4 AIDS sickness). Ideally provincial distribution would be based on fully developed and researched provincial roll-out plans, however given the newness of the programme and uneven provincial capacity, this was impossible in round one. The real questions will come as roll-out ensues. Partway through this financial year, does national government utilise its authority to take some funds from underperforming provinces and reallocate it to high-performing provinces? As roll-out progresses, it is absolutely imperative that accurate data on actual expenditure and numbers

treated are collected so that budget allocations can be refined to efficiently and equitably reflect the reality on the ground.

In future budgets, we would hope to see two key developments:

- provincial distribution of conditional grant funds based on improved, more accurate and timely actual expenditure data from provinces; accurate data on take-up rates; and unit costs by site (or at least by province), and;
- increased commitment by provinces to allocate funds specifically for HIV/AIDS from their own budgets, to supplement the budget of the ARV treatment programmes and to shore up health departments generally.

The financial resources are available. The success of the roll-out of the national ARV treatment programme will be dependant upon strong support and guidance from national DOH and the demonstrated performance of provinces in absorbing the added funds and getting programmes up and running.

Sources

Brijlal, V. and Segall, M. 2003. "Essential Health Care for All South Africans: An investigation into the adequacy of public health financing and the equity of provincial health resource distribution." Pretoria: National Department of Health.

Bodibe, Khopotso. "Where is the ARV roll-out? Interview with Dr. Nono Simelela." 9 February 2004. Health E-news.

Dorrington, R., Bradshaw, D. and Budlender, D. 2002. "HIV/AIDS profile in the provinces of South Africa: Indicators for 2002." MRC, ASSA, UCT Technical Report. National HIV Prevalence, Behavioural Risks and Mass Media. Household Survey 2002. Cape Town: HSRC Publishers.

Gauteng Department of Health. "The Expanded HIV and AIDS Treatment Programme in Gauteng Issued by: Department of Health, Gauteng Provincial Government." 15 March 2004. Available at http://www.gpg.gov.za/docs/pr/2004/pr0315a.html

GCIS. Statement of Cabinet on a Plan for Comprehensive Treatment and Care for HIV and AIDS in South Africa (Presented by Minister of Health, Dr. Manto Tshabalala-Msimang) 19 November 2003.

Hickey, A., Ndlovu, N., and Guthrie, T. 2003. *Budgeting for HIV/AIDS in South Africa: Report on intergovernmental funding flows for an integrated response in the social sector.* Cape Town: AIDS Budget Unit, Idasa Budget Information Service.

National Department of Health. "Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa." 19 November 2003.

National Treasury, Republic of South Africa. 2003. "2002 Division of Revenue Bill."

National Treasury, Republic of South Africa. 2003. "2003 Division of Revenue Bill."

National Treasury, Republic of South Africa. 2004. "2004 Division of Revenue Bill."

National Treasury, Republic of South Africa. *Adjusted Estimates of National Expenditure 2003*. 12 November 2003.

National Treasury, Republic of South Africa. *Budget Review 2004*. 18 February 2004.

National Treasury, Republic of South Africa. *Estimates of National Expenditure 2004*. 18 February 2004.

National Treasury, Republic of South Africa. *Intergovernmental Fiscal Review 2003*. April 2003.

National Treasury, Republic of South Africa. *Medium Term Budget Policy Statement 2003*. 12 November 2003.

Ndlovu, N. 2003. "Understanding expenditure and procedures of the National NGO Coordination Unit for HIV/AIDS and Tuberculosis" Budget Brief No. 133. Cape Town: AIDS Budget Unit, Idasa Budget Information Service. Available online at www.idasa.org.za/bis

Appendix A.

Total Comprehensive HIV and AIDS conditional grant allocations

R million	2001/2	2002/3	2003/4	2004/5	2005/6	2006/7	Total over MTEF
Eastern Cape	6.281	28.253	38.934	98.97	159.005	218.021	475.996
Free State	4.716	18.657	30.144	69.969	100.874	142.265	313.108
Gauteng	5.63	31.093	55.275	134.231	185.048	252.695	571.974
KwaZulu-Natal	13.924	52.496	85.591	186.348	251.468	344.304	782.12
Limpopo	4.659	20.554	28.962	77.43	125.899	175.861	379.19
Mpumalanga	4.665	20.867	26.287	53.84	81.392	107.479	242.711
Northern Cape	5.555	7.657	11.268	31.881	48.05	68.603	148.534
North West	4.64	18.919	32.891	70.981	100.921	142.316	314.218
Western Cape	4.328	11.713	24.204	57.962	82.451	115.67	256.083
Total (nominal)	**54.398**	**210.209**	**333.556**	**781.612**	**1,135.108**	**1,567.214**	**3,483.934**
Nominal growth rate		286%	59%	134%	45%	38%	
Total (real)	**62.65**	**220.09**	**333.56**	**741.57**	**1,020.81**	**1,339.74**	**3,102.11**
Real growth rate		251%	52%	122%	38%	31%	

Provincial shares of total Comprehensive HIV and AIDS conditional grant allocations

	2001/2	2002/3	2003/4	Provincial shares (2001/2-2003/4)	Provincial shares over MTEF (2004/5-2006/7)
Eastern Cape	12%	13%	12%	12%	**14%**
Free State	9%	9%	9%	9%	9%
Gauteng	**10%**	**15%**	**17%**	15%	**16%**
KwaZulu-Natal	26%	25%	26%	25%	**22%**
Limpopo	9%	10%	9%	9%	**11%**
Mpumalanga	9%	10%	8%	9%	**7%**
Northern Cape	**10%**	**4%**	**3%**	4%	4%
North West	9%	9%	10%	9%	9%
Western Cape	8%	6%	7%	7%	7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

NB: Provincial shares change very slightly over current MTEF, hence figures are only given for the MTEF period.

Source: 2002 Division of Revenue Bill, pg. 76. 2003 Division of Revenue Bill, pg. 87. 2004 Divison of Revenue Bill, pg. 31. Idasa calculations. Real calculations based on GDP inflation figures; 2003/4 base year.

Appendix B.

	ARV CG allocation 2004/5 (Rmill)	**Total AIDS sick (2000 ASSA provincial model)**	Share of total AIDS sick 2004	Number treated @ R6000 unit cost	Share of total AIDS sick persons treated @ R6000	Number treated @ R7000 unit cost	Share of total AIDS sick persons treated @ R7000	Number treated @ R8428 unit cost	Share of total AIDS sick persons treated @ R8428
EC	40.777	71,115	11%	6,796	8%	5,825	7%	4,838	6%
FS	29.126	53,893	7%	4,854	9%	4,161	8%	3,456	6%
Gau	46.602	167,421	22%	7,767	5%	6,657	4%	5,529	3%
KZN	64.079	211,643	30%	10,680	5%	9,154	4%	7,603	3%
Lim	34.951	54,879	8%	5,825	9%	4,993	8%	4,147	7%
Mpu	15.479	62,077	9%	2,580	4%	2,211	3%	1,837	3%
NC	14.463	7,221	1%	2,411	32%	2,066	28%	1,716	23%
NW	29.126	62,814	9%	4,854	8%	4,161	7%	3,456	5%
WC	23.081	17,680	2%	3,847	22%	3,297	19%	2,739	15%
Total	**297.684**	**708,742**	**100%**	**49,614**	**7%**	**42,526**	**6%**	**35,321**	**5%**

Source: 2004 Division of Revenue Bill, pg. 31. Dorrington, R., Bradshaw, D. and Budlender, D.(2002). Idasa calculations.