Budgeting for HIV/AIDS in South Africa:

Report on intergovernmental funding flows for an integrated response in the social sector

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AIDS Budget Unit—*Idasa*

Acronyms

AE	Adjusted Estimates
ANC	African National Congress
ARV	Anti-retrovirals
ASSA	Actuarial Society of South Africa
BS	Budget Statements
CBO	Community-based organisation
CFO	Chief Financial Officer
CG	Conditional Grant
CHBCS	Community and Home Based Care Services
CHS	Community Health Service
CHW	Community Health Worker
DDG	Deputy Director-General
DG	Director-General
DHS	District Health Services
DOE	Department of Education
DOH	Department of Health
DOR	Division of Revenue
DORA	Division of Revenue Act
DSD	Department of Social Development
EC	Eastern Cape
ECD	Early Childhood Development
ES	Equitable Share
FBO	Faith-based organisation
FFC	Financial and Fiscal Commission
FS	Free State
GAAP	Government AIDS Action Programme
GP	Gauteng Province
HBC	Home-based care
HOD	Head of Department
IEC	Information, Education and Communication
IGFR	Intergovernmental Fiscal Riview
INP	Integrated Nutrition Plan
KZN	KwaZulu-Natal
LP	Limpopo Province
MP	Mpumalanga Province
MT	Master Trainer
MTEF	Medium Term Expenditure Framework
NACCA	National Action Committee for Children Affected by HIV/AIDS
NACOSA	National AIDS Coordinating Committee of South Africa
Nat.	National
NC	Northern Cape
NDOE	National Department of Education
NDOH	National Department of Health
NDSD	National Department of Social Development
NGO	Non-governmental organisation
NIP	National Integrated Plan for HIV/AIDS

NT	National Treasury
NW	North West
OI	Opportunistic Infection
PEP	Post Exposure Prophylaxis
PFMA	Public Finance Management Act
PHC	Primary Health Care
PL(W)A	People Living with AIDS
PMTCT	Prevention of Mother to Child Transmission
Prov	Provincial
SANAC	South African National AIDS Council
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
TI	Targeted Increase
VCT	Voluntary Counselling and Testing
WC	Western Cape

Executive Summary

What is the best way to deliver funds to the provinces for HIV/AIDS interventions? This report analyses provincial capacity and spending procedures currently impacting on conditional grant (CG) effectiveness and assesses the success of the new funding approach which channels HIV/AIDS funds to the provinces via the equitable share grant. Analysis is based on official budget documents and interviews with national and provincial officials in social service departments and treasuries. The report concludes with recommendations on effective funding mechanisms for transferring funds to the provinces for HIV/AIDS interventions.

The research shows that on the whole provinces are improving their spending on the HIV/AIDS CGs and that provinces are also beginning to allocate substantial funds for HIV/AIDS from their own provincial budgets. Although this report provides evidence that spending records on HIV/AIDS earmarked allocations are improving and both provinces and national government are boosting their budgeted allocations for HIV/AIDS, it is important to emphasise that the report does not speak to the sufficiency of these allocations. Nor does this research speak to whether the additional amounts spent and allocated are translating into the needed changes on the ground.

On the whole the HIV/AIDS CGs are functioning well and should be continued with some changes in expenditure conditions and resource allocation criteria. There is evidence of great improvement: on aggregate provinces spent 36.5% of the total HIV/AIDS CG allocations in 2000/1 and 85.0% in 2002/3.[1] These improved track records occurred despite massive increases in allocations year to year. *Including expenditure on rollovers*, provincial HIV/AIDS managers succeeded in spending R109 million in 2001/2 - this is six times the amount spent in the previous year. Moreover, in 2002/3 actual spending increased again by over 250%, to R385 million.

Part of this success can be attributed to the decision to loosen restrictions on the HIV/AIDS CG so that provincial health departments have discretion to allocate funds between HIV/AIDS interventions. In the case of the Lifeskills education programme, provincial interviews suggest spending is blocked more by staff capacity and absorption than by the amount of funds available. Adding funds to support provincial management to the Lifeskills grant could ease this bottleneck.

The primary advantage of CGs or earmarked funds is that the administering national department is able to change how funds are divided between provinces from year to year, as well as change the items and objectives of the CG. Dedicated funding (e.g. CGs) is an adjustable funding tool that works well to drive programmes, and to catalyse interventions which provinces would not otherwise undertake.
However the greatest impact of HIV/AIDS in the health sector is to increase the overall demand for routine health care services (e.g. hospital beds, medicines for opportunistic infections, demands on medical care professionals). Thus the report argues that to address the indirect or "hidden" costs of HIV/AIDS it is necessary to also have some form of unconditional transfer or general budget support to provinces. National Treasury is therefore correct in pursuing a financing strategy that relies on multiple funding channels.

The targeted increment to the equitable share introduced in 2002/3 may be a suitable tool to send funds to the provinces to cover HIV/AIDS treatment and care expenditure. But this indirect funding channel has serious liabilities, the largest of which is the difficulty of tracking whether provinces are using the funds for HIV/AIDS allocations and/or support to health services.

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[1] These figures do not include expenditure of unspent funds rolled-over from the previous year's budget.

We are beginning to see provinces making special allocations for HIV/AIDS from their own budgets - in addition to the CG funds for HIV/AIDS received from national government. On aggregate, Idasa calculates that actually provinces have allocated R356.5 million from their own budgets for HIV/AIDS health expenditure in 2003/4. This is a 96% increase from the previous year. However it is still a few provinces taking the lead. KwaZulu-Natal and Gauteng together account for 73% of the aggregate discretionary provincial HIV/AIDS health expenditure in 2003/4. The strongest evidence to suggest provinces are dedicating more of their discretionary funds to HIV/AIDS is that in 2002/3 provinces on aggregate allocated 0.61% of their discretionary provincial health budget specifically to HIV/AIDS. In 2003/4, this percentage rose to 1.22%.

Thus although the targeted increment for HIV/AIDS does appear to have been associated with increased funding for provincial health services, it is still very difficult to learn from official budget documents whether these funds were allocated for HIV/AIDS. Improved accuracy, detail and disaggregation in official provincial budget statements would facilitate our understanding of government expenditure on HIV/AIDS; enable civil society to better monitor HIV/AIDS resource allocation; and provide the public with a more accurate picture of the degree to which provinces *are* financially committing themselves to fighting the epidemic.

The report argues against the formal incorporation of HIV/AIDS into the equitable share formula. Instead the main concluding recommendation is the introduction of a new recurrent grant to support provincial integrated strategies for HIV/AIDS. Instead of being administered by the Department of Health and thus limited to the health sector, the grant should be a lump sum transfer (similar to the equitable share) which provinces would allocate across departments according to a provincial integrated HIV/AIDS strategy. Provinces would have the discretion to allocate the HIV/AIDS funds between interventions at their discretion, thus favouring programmes experiencing greater need or which are ready for expansion. This new grant would assist in supporting provinces to fold HIV/AIDS into their regular budget priorities so that provinces' HIV/AIDS response can be scaled-up, sustainable and effective.

CHAPTER 1.

INTRODUCTION

The aim of this research report is to produce recommendations on effective funding mechanisms for transferring funds to the provinces for HIV/AIDS interventions. We will achieve this by analysing the provincial capacity and spending processes currently impacting on conditional grant (CG) effectiveness and assessing the success of the new funding approach which channels HIV/AIDS funds to the provinces via the equitable share grant.

1.1 THE PROBLEM AND THE BASIC RESEARCH QUESTION

The severity and size of the epidemic make the fight against HIV/AIDS an unparalleled challenge. But this public policy problem is all the more difficult to approach because it requires the co-operation and active participation of local, provincial and national government, as well as non-health departments. Government's response to HIV/AIDS must span sectors and levels of government. This creates momentous challenges in terms of management, intergovernmental relations, strategic planning and service delivery. From a budgeting and financing perspective, a multi-sectoral intergovernmental response raises unique problems for budgeting and spending.

More recently, the upcoming launch of a national programme to provide anti-retroviral drug treatment in the public sector raises the immediate question of how to finance such a large-scale programme.

Clearly unique and innovative funding mechanisms and budgeting approaches are called for. The Department of Health and the National Treasury have encountered difficulties with funding mechanisms used thus far and therefore are currently experimenting with new funding mechanisms and considering other approaches.

1.1.1 Track record of conditional grants

First, the conditional grant funds channelled to provinces via the Departments of Health, Education and Social Development have poor spending records in their first year. This was partially due to slow disbursement of the funds to provinces, set-up of management structures and development, and approval of business plans. (The spending record has improved since the first year.) However there is some evidence that another reason for the underspending on CGs is the bureaucratic requirements inherent in all CGs. Also, there may be less provincial buy-in on national programmes funded via the grants (as opposed to projects/funding streams drawing from the provinces' own budgets). Although alternate funding mechanisms are perhaps more appropriate for other components of the national HIV/AIDS strategy, CGs should not be eliminated entirely as they are the national departments' means of ensuring that funds are spent by provinces on national priorities. Therefore identification of the strengths and weaknesses of the HIV/AIDS CGs are critical for the success of the national response to HIV/AIDS. This is the objective of Chapter 4.

1.1.2 Increased reliance on provinces

Second, as the epidemic spreads and government's response matures, the provincial level is increasingly central to the success of government's strategy. Constitutionally the provinces are responsible for social service delivery and thus are obviously key agents in combating the disease. National government's heightened reliance on the provinces is evidenced by the increased portion of HIV/AIDS-designated funds that are being sent directly to the provinces. The national Department of Health estimates that, of the R4.4 billion incurred by the public health system for HIV/AIDS in this financial year, all but some R219 million is accounted for by provincial health departments (DOH 2001). In future budgets, the provinces' role expands further. Of the total dedicated funds going to HIV/AIDS in 2002/03, nearly 75% will be passed along to the provinces (approximately half those funds are ring-fenced). In 2003/4 the provinces will spend all but 17% of funds targeted for HIV/AIDS in the national budget.

If provinces are at the front-line in delivering government services for treatment and prevention, we need to know more about what is blocking or facilitating provincial spending of both CG funds and funds allocated for HIV/AIDS direct from the provincial budget. "Poor provincial capacity" is frequently cited as the reason for underspending but what this means exactly and what concretely can be done – in terms of budget allocations and better-designed funding mechanisms – is still unclear. Sections 4.4 and 4.5 look at this issue directly.

1.1.3 Introduction of new funding mechanism in Budget 2002/3

Third, in response to both these developments described above, the Department of Health and National Treasury implemented a new funding mechanism in Budget 2002/03. National government gave R400 million to the provinces – via the equitable share funding channel – to be used for treatment and care for HIV/AIDS. By sending the money to provinces via the equitable share, national government relies upon and trusts provinces to allocate those funds for HIV/AIDS but does not have legal mechanisms to guarantee that happens (as with CG funds). The advantage of the "targeted increase to the equitable share" is that provinces will have more independence to spend funds on treatment and care programmes which they identify as effective. Provinces can also use the funds to broadly strengthen health care services so that they can better respond to increased demand as the result of HIV/AIDS. As an analysis by the Health Financing & Economics Directorate in the Department of Health states: "The success of this component now lies entirely in the hands of provinces, who must ensure that this increment does indeed feed through into health care budgets" (DOH 2002a: 3).

By 2004/05, these "targeted increase" funds will represent 50% of the total national funds dedicated to HIV/AIDS and will be over 60% of the total funds sent to the provinces by national. For these reasons, assessing the success of this funding mechanism after its first year is very important for planning the HIV/AIDS financing strategy for Budget 2003/04 and on. If the new funding mechanism is unsuccessful, changes must be made by either improving the current system, replacing the "targeted increase" with a type of grant or supplementing an existing CG.

The following section from the Department of Health's 2002/03 budget request to National Treasury summarises the issue related to funding mechanisms:

> *…Different options for the specific routing of the funds proposed are possible, and considerable thought will need to be given to achieving the most effective routing of funds. Four main channels are available: direct expenditure/procurement by the National Department of Health; expansion of the current HIV//AIDS conditional grant; creation of a new recurrent conditional grant for HIV//AIDS and TB funding for provinces; and expansion of the health component of the equitable share revenue pool…Direct national-level*

expenditure will remain desirable for the broad range of activities currently undertaken in this manner (e.g. condom procurement, campaigns, research funding, etc.), and can be expanded relatively safely. Clearly, though, the vast majority of HIV/AIDS and TB funding must be channeled to provinces, where service delivery actually takes place….

Creation (or conversion) of a new HIV/AIDS and TB recurrent grant, which is much more "permissive" in that funds are released prospectively on a recurrent basis subject only to broad output/outcome targets, would allow earmarking of funds, but may cause artificial divisions between "AIDS" and "non-AIDS" services. Expanding equitable share funding to address HIV//AIDS and TB would require explicit guidance to provinces on desirable areas of spending, but would allow a better fit with existing services. Either of the two latter options would require the development of some form of resource allocation formula for provinces, which should be more or less directly based on AIDS-related service needs. (DOH 2001: 11)

In subsequent budgets, the Department of Health and National Treasury will be making a decision whether to continue delivering funds to the provinces via the equitable share (either with the regular formula or a new HIV-related formula) or to create a new type of recurrent HIV/AIDS and TB grant. Furthermore, this issue will be pivotal to the effective financing of national ARV programme.

1.1.4 Research Question

The ultimate aim is to formulate ideas on the best combination or adaptation of these funding mechanisms for effectively transferring funds to the provinces for HIV/AIDS interventions, including an ARV programme. Therefore given the context and recent developments described above, this report focuses on the provinces with the following two research objectives:

1. To conduct a detailed investigation of the obstacles to spending on CGs at the provincial level. Is the actual expenditure record by provinces of these CG improving? We analyse actual expenditure of HIV/AIDS CGs by province and sector. What changes can still be made to improve the effectiveness of the CGs (i.e. administrative processes, formula/criteria used to split funds between the provinces)? *(Chapter 4.)*

2. To assess the success of the "targeted increase" mechanism in its first two years. We will evaluate the success of the targeted increase by measuring the extent to which provincially sourced HIV/AIDS allocations, and provincial health budgets as a whole, have increased in 2002/03 and 2003/4 budgets. Further, we consider the feasibility and desirability of including HIV/AIDS in the horizontal split formula for the equitable share. *(Chapters 4 and 5.)*

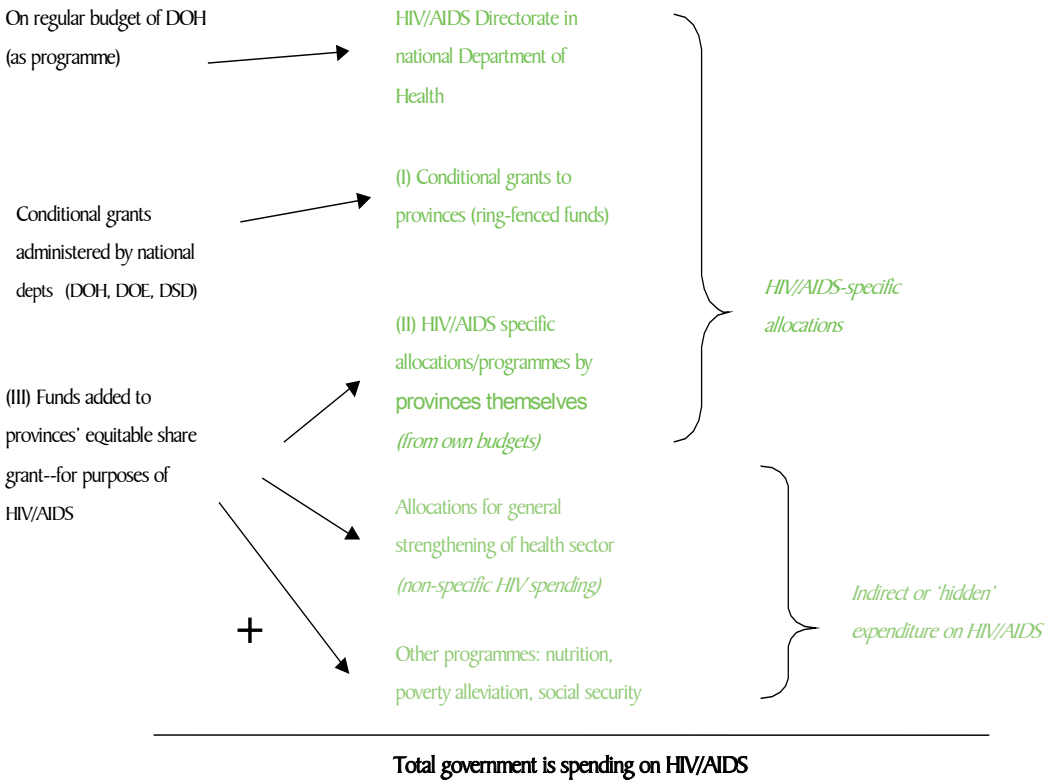
1.2 Framework for Analysis

Tracking government expenditure on HIV/AIDS and following financial flows is complicated by the fact that budgets generally do not disaggregate HIV/AIDS monies. Such efforts in South Africa are facilitated by the readability and level of detail of the national budget documents, compared to other African states. Identifying and quantifying HIV/AIDS line items in provincial and national budgets is easier here than elsewhere in southern Africa. However we can only get so far before running into problems. This is because when we attempt to summarise what government is spending on HIV/AIDS, the allocations specifically targeted and named for HIV/AIDS can be readily identified, but the bulk of the expenditure needed to respond to the epidemic is indirect.

In our framework for analysis for this report, we distinguish between these two categories: HIV/AIDS-specific allocations, and indirect expenditure on HIV/AIDS.

Figure 1.1 shows these different categories and provides an overall map of government spending on HIV/AIDS in South Africa. The HIV/AIDS-specific (or direct) and indirect or "hidden" categories are further defined and described below.

Figure 1.1: What is government spending on HIV/AIDS ?



1.2.1 HIV/AIDS-specific allocations

When we refer to HIV/AIDS-specific allocations, we are referring to direct expenditure on HIV/AIDS interventions. These are programmes whose chief purpose is to combat HIV/AIDS in the areas of prevention, treatment and care, research, legal issues, public awareness, or impact mitigation. These are *proactive* efforts by government to spend public resources to prevent the spread of the disease, conduct research, provide treatment for those who are HIV-positive, or to provide support to those who are infected and affected by the disease.

In South Africa, examples of such direct expenditure would be: the Lifeskills prevention programme in schools; condom distribution; funds to NGOs for HIV/AIDS activities (disbursed by the NGO Funding Unit in the HIV/AIDS Directorate in the Department of Health); and community and home-based care and support programmes. These programmes are identifiable in government budgets; they have particular line items which contain funds solely for these purposes.

The funding channel or mechanism used to finance these interventions can help us track the HIV/AIDS-specific funds. For example, the fact that there are CGs specifically for HIV/AIDS means that we can track these funds; they are disaggregated in both national and provincial budgets. Furthermore, a good number of interventions run by the national Department of Health's HIV/AIDS Directorate are identified as separate line-items on the Directorate's budget e.g. funds transferred to NGOs.

To summarise, the three main categories of *HIV//AIDS-specific* allocations are: the budget of the HIV/AIDS Directorate in the national Department of Health; three CGs for HIV/AIDS; and HIV/AIDS-specific funds in provincial budgets. Chapter 4 of this report deals with the CGs – which are the funding channel or mechanism for most of government's direct expenditure on HIV/AIDS. (In Figure 1.1, they are marked "I".) Chapter 5 excludes the CGs and looks at any *other* HIV/AIDS-specific expenditure in provincial health budgets. (This is the category marked "II" in Figure 1.1.)

1.2.2 Indirect or "hidden" expenditure as a result of HIV/AIDS

However even if government did not take initiative and proactively put programmes in place to combat HIV/AIDS, the public budget would still include funds which are being spent as a result of the epidemic. For instance, hospitals have more admissions, the length of hospital stays increase, HIV-positive people (regardless of whether they or their doctors are aware of their status) need treatment and medicines for opportunistic infections, etc. We refer to expenditure which routinely occurs as a result of HIV/AIDS as indirect or "hidden" expenditure on the epidemic.

Up to this point, we have spoken only of the health sector. However there is also indirect expenditure in sectors outside of health, which is occurring as a result of HIV/AIDS. For example, take-up rates on social security grants increase as HIV/AIDS throws more households into poverty, schools must hire relief teachers, etc.

Furthermore, other government programmes which generally support development and poverty alleviation are critical to a holistic government response to the HIV/AIDS epidemic but are neither allocations specifically targeted for HIV/AIDS interventions nor funds which go to support health service delivery generally. To the extent that these developments are pro-poor, they are also favourable from an HIV/AIDS perspective. For example, the Integrated Nutrition Programme (INP) receives a large boost in 2003/4 to R808.66 million. The INP will expand to improve frequency of feeding, expanding the number of schools involved, including Grade R learners in the programme, and standardising menus across schools. An increase in the amount of the old age pension (from R640 to R700 per month) impacts on families affected by HIV/AIDS, particularly given that the pension often supports numerous family members, including children (IDASA 2003: 3). Furthermore, the Child Support Grant – which is targeted at poor children – has been increased from R140 to R160 per month.[2] Even a new CG to provide food relief to the poor – R388 million each year over the medium term – is a part of government's total HIV/AIDS response.

The first point of note is that such indirect expenditure on HIV/AIDS is tremendously difficult to quantify. In Chapter 6 we explain some of the reasons why this is so.

The second point follows. In the health sector, it is tremendously difficult to identify which expenditure is on HIV-positive people. Therefore we cannot use earmarked funds or CGs to cover these expenses. "Hidden" expenditure in the health sector requires a different type of funding channel, namely general budget support. Chapter 6 deals directly with this question. It examines the funding tool developed by National Treasury – the "targeted increment to the Equitable Share" – which is intended to deal with the indirect impact of HIV/AIDS on the public health sector. (Chapter 6 deals with the category marked "III" in Figure 1.1.)

[2] More importantly, the age of eligibility for the grant will be progressively extended over the next few years. Up to now, only children up to age seven have qualified for the grant. However government will now extend the grant so that by 2005/6 children up to age 14 will be able to receive the grant.

1.3 RESEARCH METHODOLOGY

The starting point for our analysis is the official budget documents – both the national budget and nine provincial budget statements – and monthly expenditure figures published by National Treasury.[3] We supplement this source with in-person interviews with provincial HIV/AIDS managers in six provinces (Gauteng, Eastern Cape, Western Cape, Free State, Limpopo and KwaZulu-Natal). We met with officials from provincial treasuries, health departments, social development or welfare departments, and education departments. At national level, we met with officials in National Treasury and the Departments of Health, Education and Social Development.

We have published a companion document to this report called *Where is HIV/AIDS in the budget?: 2003 survey of provincial social sector budgets.* The Survey compiles findings from the desk study of budget documents and department strategic plans, as well as all provincial interviews.

1.4 LIMITATIONS AND SCOPE OF THIS STUDY

In this report, we have concentrated on public expenditure on HIV/AIDS in both national and provincial budgets and tried to capture the HIV/AIDS-specific and indirect expenditure in the government budget. The study does not extend to private sector expenditure on HIV/AIDS, nor does it look at donor financing for fighting the epidemic. Due to resource constraints, our in-depth analysis (including provincial visits and interviews) covers only six provinces. Our analysis of the remaining three provinces is limited to desk study i.e. primarily official budget statements and departmental strategic plans.

This report does not extend to the sphere of local government – again due to resource and time constraints. Analysis of local governments is tremendously complex. Municipal budgets are not standardised, are often not readily available or accurate, and often lack the text and explanation to understand the figures. There has been no comprehensive attempt to assess what local governments in South Africa are allocating for HIV/AIDS, or what transfers and funding flows are available to local governments and municipalities for spending on HIV/AIDS. Given the resource constraints of most municipalities and the lack of detail and dissagregation in municipal budget formats, it is unlikely that such a study would uncover considerable contributions targeted for HIV/AIDS. However this is a very important area for future research.

Furthermore, this study focuses on the health, education and social development sectors exclusively. Given our limited resources, we focused on these three sectors firstly because they are the three departments that receive resources via the National Integrated Plan (NIP), which is the main policy and funding framework for government's response to HIV/AIDS. Second, although other national and provincial departments have allocations for HIV/AIDS, they are workplace programmes for internal staff and/or very limited allocations (compared to NIP funds). Nor does this report, as mentioned above, speak to government expenditure on development and poverty alleviation programmes which indirectly work to combat the spread and impact of HIV/AIDS. Analysis of these programmes is beyond the scope of this report, but is worth mentioning because these developments are part of the broader context of indirect expenditure that supports an effective HIV/AIDS response on the part of government.

Another limitation of this study relates to the availability and accuracy of budget data (see Chapter 4, Box 2). National Treasury publishes monthly Statements of Revenue and Expenditure which provide figures on

3 These Statements on the National Revenue, Expenditure and Borrowing are readily available on the website of the National Treasury www.treasury.gov.za

actual funds transferred and spent on each CG, by each province. However, because South Africa operates on a cash-accounting basis, these Statements do not capture funds that are committed but not yet spent. Particularly in cases where provinces transfer grants to NGOs or CBOs, outsource services or put large projects out to tender, actual expenditure figures in these Statements will create a picture of less activity and accomplishment at the provincial level than is actually occurring within the department.

Furthermore, tracking CG expenditure can be difficult in situations where provinces do not separate out funds sourced from CGs compared to the provincial department line budget. In some cases, when reporting to national, provinces lump the funds together, and later in the financial year rectify their accounting.

Finally budget analysis is complicated and messy in that provincial budget statements, the Division of Revenue Act and information received directly from provincial treasuries and provincial departments can be contradictory. In these situations, we have made informed judgement calls on the best figures to use in our analysis, and have provided explanations in footnotes.

Most importantly, this report is just one step in a entire chain of analysis which should commence with policy analysis, and then move through the steps of programme planning, resource allocation and budgeting, and service delivery to conclude with impact assessment of government's HIV/AIDS response. Our budget analysis focuses on budget *inputs* and does not include impact assessment, as this is beyond the scope of this project. We leave it to other research efforts to take these findings and link them with other studies being conducted on the impact of government HIV/AIDS programmes and service delivery. This is necessary in order to reach our ultimate objective of understanding how well government HIV/AIDS spending is improving the lives of those infected and affected by the disease.

1.5 Relevance for a national ARV programme

As a final point, the issues explored in the report and the resultant recommendations have immediate relevance to government's plans to launch a national programme to provide free anti-retroviral drug treatment in the public sector.

Responding to increasing public pressure for the provision of free ARVs to AIDS-sick South Africans, in July 2002 a joint health and treasury technical task team was established to look at the financing and feasibility of the large scale roll-out of an ARV programme in the public sector. The Joint Health and Treasury Treatment Costing Task Team delivered their report to the Minister of Health in August 2003, and subsequently the government announced its decision to roll-out the provision of ARVs (CGIS, 2003). According to the costing exercise conducted by the task team, the total cost of providing the drugs to everybody needing them will be between R7.9 billion and R8.3 billion by 2005 (South African Joint Treasury and Health Task Team, 2003: 56). However the task team also states: "By 2004/5, the technical team modelling indicates that – given estimates of current provincial expenditure on HIV/AIDS – existing funding commitments will be adequate to fund comprehensive access to the current treatment package (the "No ARV" option)" (2003:79). Thus the total *additional* funding requirements for 2005/6 for the 100% ARV option would only be between R1.7 and R2.1 billion.

Although the Task Team report contains costing information and some analysis of financial management systems, it stops short of a full analysis of funding requirements and does not explore the budgeting implications of a full-scale ARV programme. Indeed the report acknowledges "that detailed discussion of the routing and mechanisms for funds under all scenarios will be required, in order to best meet the implementation requirements of the option chosen" (2003:79).

Such a detailed discussion *is* our objective, in that this report speaks to the routing of and mechanisms for sending funds to the provinces for HIV/AIDS interventions. Given that provinces are responsible for health care service delivery, an ARV programme would require sizeable transfers to provincial governments specifically for this purpose. The most appropriate and efficient means for allocating resources for ARV programmes between geographic regions, and between urban and rural areas, must be considered, as well as determining the most efficient funding mechanism or channel for transferring funds to provincial health departments. CGs – the topic of Chapter 3 – were the primary vehicle used to finance other recently-expanded, vital interventions – primarily Prevention of Mother To Child Transmission programmes – and should play a key role in financing an ARV programme in the public sector. The report's concluding recommendations also speak to the mix of funding streams needed to effectively finance the different components of an ARV programme.

CHAPTER 2.

BACKGROUND OVERVIEW OF SOUTH AFRICA'S HIV/AIDS POLICY AND PROGRAMMES

2.1 HIV/AIDS EPIDEMIC IN SOUTH AFRICA

Dorrington, Bradshaw and Budlender (2002: 3) cite that Statistics South Africa estimated 45.4 million people were living in South Africa by July 2002. Of these 51.1% are female. Of the total population, 6.5 million people were living with HIV/AIDS in July 2002. Altogether, 95.1% of HIV-positive people are in the age group 18-64 years.

Of these, 49.5% are women of childbearing age (15-49 years). There are more women infected than men; for age group 15-24 years, there are four infected women for every infected man – a 4:1 ratio. The Human Sciences Research Council (2002) reported a prevalence rate of 11.4% for the total population by July 2002. There are an estimated 69,000 babies infected at birth (5.9%). More than 20,000 babies will become infected through mothers' breast milk. As a result, 73% of maternal orphans are due to AIDS.

Dorrington *et al* (2002: 6) further reported that 55% of HIV-positive people were in stage one in July 2002, 20% were in stage two, 18% in stage three and 7% with full-blown AIDS (stage four). However 75% of all these people are asymptomatic.

From the standpoint of research and analysis on HIV/AIDS public expenditure in South Africa, the key point to note is that demographic and statistical analysis indicates that South Africa has yet to see the full impact of the HIV/AIDS epidemic. According to Dorrington *et al*, the total number of AIDS sick people is set to increase from 591,088 in 2003 to 1.049 million in just three years time. Meanwhile the number of AIDS deaths is projected to jump from 987,061 in 2003 to 2.387 million in 2006, the outer year of this medium term budget cycle. The Joint Health And Treasury Task Team confirms this point:

> *"…we must still expect the AIDS epidemic to continue to grow for several years. The AIDS epidemic typically lags behind the HIV epidemic by eight or nine years, due to the long period during which most HIV-infected people remain largely free of symptoms. Given the very fast growth of HIV prevalence through the mid- and early 1990's, we could expect now to see rapid growth in the number of AIDS cases and AIDS deaths, as the initial HIV epidemic matures into an epidemic of AIDS" (South African Joint Treasury and Health Task Team, 2003: 8).*

It is therefore imperative that government's HIV/AIDS policy and programmes adjust and expand to accommodate these figures, by scaling-up interventions for treatment and care. Furthermore, government budgets must move in step with the increased demand for services implied by these HIV/AIDS projections.

This chapter provides an overview of government's HIV/AIDS response in order to provide background information on the component programmes to be found in the government budget.

2.2 Early development of the South African government's HIV/AIDS policy

The beginnings of a co-ordinated public policy response to HIV/AIDS date back to 1992, with the formation of the National AIDS Coordinating Committee of South Africa (NACOSA). During the early years after the democratic elections, NACOSA developed the *National AIDS Plan for South Africa* (1994) - a "seemingly well-considered national strategy…(that) remained largely DOH-centred and, moreover, fell short of implementation" (Van Rensberg, *et al*, 2002: 58).

The new Government of National Unity adopted the *AIDS Plan* and renamed it the HIV/AIDS & STDs Programme 1995-1996 (DOH, 1995). The Programme proposed the establishment of the HIV/AIDS and STD Advisory Group, the Committee on NGO Funding, and the Committee on HIV/AIDS and STD Research. However, these structures took some time to be set-up. Van Rensberg *et al* (2002: 63) commented that the Programme secured a high level of commitment from the Department of Health, initiated collaboration between departments and intersectorally, and improved access to treatment for STDs. However, Whiteside and Sunter (2000) criticised the Programme for the following reasons:

- Sluggishness on the part of government in implementing the programme;
- The failure to mobilise civil society;
- The lack the financial and human resources (necessary) to achieve its goals;
- An insufficient institutional framework for implementation;
- Continued centralisation within the Department of Health;
- Inadequate support for NGO & CBO activities, and;
- Lack of provincial policies, guidelines or management protocols for comprehensive care and counselling.

Progress in implementing the NACOSA plan was assessed in 1997 by the South African National STD/HIV/AIDS Review. This Review identified major strengths in the response to date, but also highlighted areas for substantial improvement. Building on this Review and an extensive consultation process, government launched its five-year Strategic Plan for HIV/AIDS/STD in 2000.

Two other important developments took place during the period prior to the launch of the Strategic Plan. The Partnership Against AIDS - between government and civil society - was formalised in October 1998 by then Deputy President Thabo Mbeki. Furthermore, the South African National AIDS Council (SANAC) was formed in 2000.

2.3 HIV/AIDS/STD Strategic Plan for South Africa 2000-2005

"The Strategic Plan is a milestone in policy development to the extent that it reflects, in a conspicuous way, a break with policies that on the whole saw HIV/AIDS as the primary responsibility of the national DoH," explain Van Rensberg *et al* (2002: 65). It incorporates national, provincial and local levels of government, as well as other sectors and stakeholders. The Strategic Plan corresponds substantially with two key international instruments to which South Africa is a party (South African Joint Treasury and Health Task Team, 2003: 11):

- The Abuja Declaration on HIV, AIDS, Tuberculosis and Other Related Infectious Diseases, adopted by African Heads of State in April 2001;
- The UNGASS Declaration of Commitment on HIV/AIDS which was endorsed by the UN Special General Assembly Session in June 2001.

The primary goals of the Strategic Plan are to reduce the number of new HIV infections (especially among youth) and to reduce the impact of HIV/AIDS on individuals, families and communities. The Plan is structured according to four key areas: Prevention; treatment, care and support; human and legal rights; and monitoring, research and surveillance. It emphasises the following strategies:

- Effective and culturally appropriate information, education and counselling;
- Increasing access and acceptability of voluntary counselling and testing (VCT);
- Improving the management of STDs and promoting the use of condoms; and
- Improving the care and treatment of people living with HIV/AIDS and promoting a better quality of life.

With regard to children and youth specifically, the HIV/AIDS & STD Strategic Plan for South Africa takes a two-pronged approach: transforming the care for children infected and affected by HIV/AIDS, and identifying and building up the strength of families and communities to enhance their effectiveness as caregivers (DSD, 2001). The strategy centres on families and communities as key assets or partners in the mammoth effort required to care for the expanding number of children orphaned due to AIDS. Supporting communities to care and support these children in turn requires financial and human resources, as well as improved access to social security grants. The strategy prioritises life skills and education programmes, as well as VCT and community and home based care (CHBC). In addition, it seeks to pilot alternative models of care for children infected and affected by HIV/AIDS.

In a cabinet statement on 17 April 2002, the government noted progress in the implementation of the Strategic Plan. The statement included the following points:

- Government will continue research on the use of Nevirapine in preventing mother-to-child transmission (PMTCT) while simultaneously implementing the temporary ruling of the Constitutional Court. The Department of Health will develop a plan for the universal roll-out of PMTCT in preparation for the post-December 2002 period;
- Cabinet reinforces government's commitment to the treatment and management of opportunistic infections and reiterates that no South African will be turned away without appropriate treatment and management of any infection or illness, irrespective of HIV status;
- Cabinet notes that ARVs can help to improve the conditions and health of people living with AIDS if administered at certain stages in the progression of HIV/AIDS, in accordance with international standards;
- "Alongside poverty alleviation and nutritional interventions, government will encourage investigation into alternative treatments, particularly on supplements and medication for boosting the immune system" (GCIS, 2003: 1).

In April 2002, cabinet also resolved to make antiretroviral post-exposure prophylaxis available in the public health system for survivors of sexual assault and a National Medium Term Tuberculosis Development Plan was finalised (DOH, 2002).

However, despite all these commitments, the strategy has been criticised for lacking a clear commitment to treatment options, such as the provision of ARV therapy, as well as lacking clear and measurable plans, timeframes and a dedicated budget for implementation. There is also criticism that the government response does not pay adequate attention to the greater vulnerability of women to infection (Grimwood, Crew and Betterridge, 2000).

2.4 National Integrated Plan for HIV/AIDS

The relevant policy document for the national Department of Health is the National Integrated Plan (NIP), although not all Department of Health programmes and units fall under the NIP. Theoretically provincial HIV/AIDS responses are guided by the NIP, as well as by strategies and business plans they develop for their specific province (Hickey and Whelan, 2001: 4).

In brief, the NIP is an intersectoral national government plan for responding to HIV/AIDS which was developed by the Departments of Health, Education, Agriculture and Social Development in 1999. Jointly delivered by the health, education and social development sectors, the NIP originally comprised three programmes:

- the Life Skills programme in primary and secondary schools;
- the voluntary counselling and testing programme (VCT); and
- the community and home based care and support (CHBC) programme.

Separate from the regular budget process, NIP funds are a special allocation that has a different funding source, separate funding mechanisms and a unique intersectoral implementation plan.

The source of funds for the NIP is a top-slice from the National Revenue Fund (prior to the vertical split), meaning that cabinet has set aside these funds as a national priority. In its decision to establish the fund, cabinet acknowledged the serious need for care, support and treatment, but also emphasised prevention and the need for government to respond to HIV/AIDS intersectorally.

Initially the bulk of the resources supported Life Skills and HIV/AIDS training in primary and secondary schools. As the NIP moves into its fourth year in 2003/04 and the disease and its impact spreads, the policy emphasis has begun to shift towards treatment and strengthening the CHBC component of the programme. Section 4.1 provides an overview of the HIV/AIDS activities of the NIP that are funded via the conditional grants (CGs).

2.5 Enhanced Response for HIV/AIDS

In September 2001, the national Department of Health then developed "An Enhanced Response to HIV/AIDS and Tuberculosis in the Public Health Sector" (DOH, 2002), essentially as a follow-on or enhancement of the NIP. This document sets out a proposed funding framework to strengthen the capability of the South Africa public health system to deal with the unfolding HIV/AIDS and TB epidemics. Sections 4.1.2 and 6.2 describe the programmes and funding streams introduced as part of the Enhanced Response.

2.6 Provincial policies

Instead of possessing a comprehensive strategy, most of the provincial health departments studied by Hickey and Whelan (2001) have a set of plans for a collection of interventions. Hickey and Whelan (ibid.) explained that provincial "strategies" are essentially health-centred or interdepartmental:

- *Health-centred strategies* include activities that are not strictly health interventions, but are clustered around health because historically HIV/AIDS was considered a health issue;
- *Interdepartmental strategies* give more emphasis to the role of the health department in facilitating other government departments to develop HIV/AIDS responses. They usually include health-centred

strategies. Through interdepartmental strategies, support and resources are made available to other departments for policy development and planning and service delivery.

In their evaluation of the national and provincial policies and strategies, Van Rensberg *et al* (2002: xviii-xix) concluded that:

- Generally there has been a disparity between policy ideals and policy implementation;
- The provinces have tended to be primarily responsible for the implementation of policy. There has been growing commitment towards HIV/AIDS and interdepartmental collaboration;
- Provincial programmes lack an independent evaluation system; and
- There appears to have been little interprovincial collaboration or communication.

2.7 Recent developments in South Africa's HIV/AIDS response

Van Rensberg *et al* (2002) acknowledge the damage and delay done by "government officials explaining and defending untenable positions on policy (rather) than actually doing HIV/AIDS work" and that South Africa's international image has been undermined by government's association with the views of "AIDS dissidents". However, they hope that "the new government policy should go a long way towards restoring public confidence in government's handling of HIV/AIDS. More importantly, it should also heal the rift between government and civil society" (Van Rensberg *et al*, 2002: 71). In this respect, two of the key issues that have attracted public attention and pressure are the PMTCT programmes and the provision of anti-retroviral drugs in the public sector.

A High Court decision in 2001 held that the government was taking too long in delivering its PMTCT programme, and ordered government to accelerate delivery and to provide comprehensive access to Nevirapine to HIV-positive pregnant mothers and their babies. At that time full implementation was not achieved and national government funds only provided for pilot sites in each province. In 2002, the Constitutional Court confirmed the requirement that PMTCT services be expanded to achieve national implementation (DOH, 2002). Since then, additional CG funds were allocated for strengthening the infrastructure and expanding roll-out of the PMTCT programme. Furthermore, some provinces are also allocating funds from their own budgets for PMTCT (see Sections 4.1 and 5.3).

More recently public pressure has been increasing for the provision of free ARVs to AIDS-sick South Africans. In July 2002, the Joint Health and Treasury Technical Task Team was established to look at the financing and feasibility of the large scale roll-out of an ARV programme in the public sector. The Joint Health and Treasury Treatment Costing Task Team delivered its report to the Minister of Health in August 2003, and subsequently the government announced its decision to roll-out the provision of ARVS (Ministry of Health, 2003).

The Task Team estimated that 1.7 million lives could be saved by 2010 if ARV drugs were given to everyone needing them (2003: 56). Up to 1.8 million more children would be orphaned by 2010 if ARVs were not provided (2003: 54). This number would be reduced by 860,000 if there was 100% drug coverage, and by 350,000 if there was 50% coverage, the report found. According to the costing exercise conducted by the Task Team, the total cost of providing the drugs to everybody needing them will be between R7.9 billion and R8.3 billion by 2005 (South African Joint Treasury and Health Task Team, 2003: 56).[4]

[4] However the Task Team also states: "By 2004/5, the technical team modelling indicates that - given estimates of current provincial expenditure on HIV/AIDS - existing funding commitments will be adequate to fund comprehensive

An ARV rollout on the scale envisaged for South Africa has implications in terms of both the expectations of HIV-positive people, and the impact on the health care system and health professionals who will administer the programme (UN Office for the Coordination of Humanitarian Affairs, 2003). Importantly, "universal provision of ARVs is not a simple step for government to take. It will require that the Department of Health and National Treasury develop a systematic framework to allocate resources and deliver funds to the government body tasked with implementation of such a programme" (Ndlovu and Hickey, 2003: 4). CGs were the primary vehicle used to finance other recently expanded, vital interventions - primarily PMTCT programmes - and should play a key role in financing an ARV programme in the public sector. The strengths and weaknesses of such CGs are the topic of Chapter 3.

Box 2.1
Chronological overview of policy developments (DoH, 2003: 3)

1995-6
- HIV/AIDS and STD Programme developed by Department of Health.

1997
- Review of the HIV/AIDS strategy and programme.

1998
- Establishment of the national Interdepartmental Committee on HIV/AIDS (IDC) to co-ordinate and support the response to HIV/AIDS of national government departments. By 2002 IDCs were established in all provinces.
- Partnership Against AIDS launched to provide for greater multi-sectoral collaboration.

2000
- HIV/AIDS/STD Strategic Plan for South Africa 2000-2005. This document provides the framework for a co-ordinated response to HIV/Aids, STDs and other opportunistic infections. The strategy addressed four key areas: prevention; treatment, care and support; legal and human rights; and research, monitoring and surveillance.
- South Africa National AIDS Council established to formalise multi-sectoral collaboration.
- Launch of the Impact and Action Project to assist the public sector to mitigate the impact of HIV/AIDS.
- Launch of the nine HIV/AIDS related guidelines in the management of HIV/AIDS.
- Formal partnership between the government and the South Africa AIDS Vaccine Initiative.

2001
- Development of the Integrated Plan for Children and Youth Infected and Affected by HIV/AIDS.

Aug 2003
- Government announces the agreement to roll out ARV treatment to all South Africans.

access to the current treatment package (the 'No ARV' option)" (2003: 79). Thus the total *additional* funding requirements for 2005/6 for the 100% ARV option would only be between R1.7 and R2.1 billion.

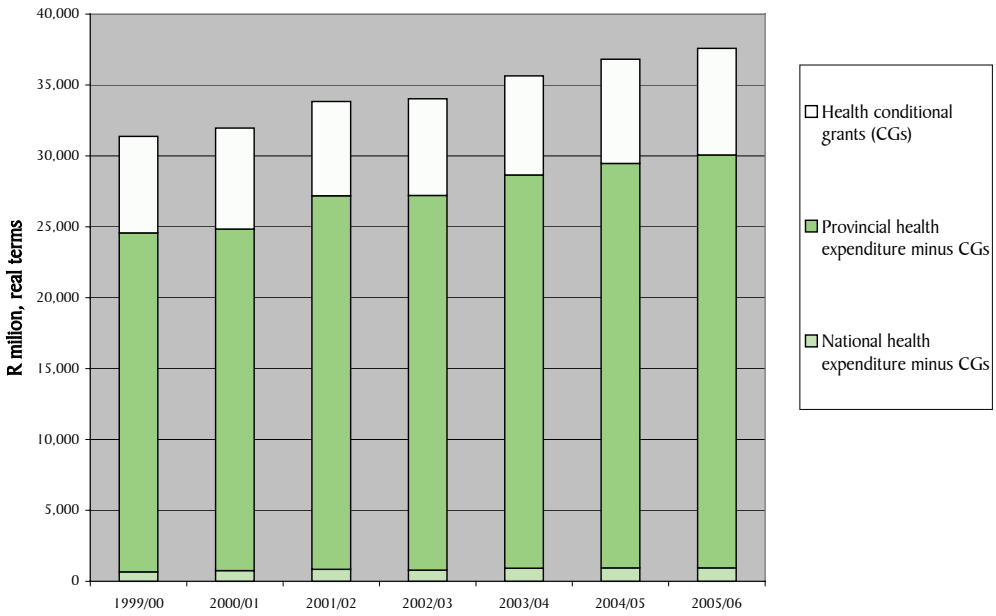
CHAPTER 3.

OVERVIEW OF SOUTH AFRICAN BUDGET AND HEALTH SPENDING

An effective HIV/AIDS response - and certainly South Africa's multi-sectoral response to the epidemic - extends well beyond the health sector. However the health sector is the primary arena for combating the disease, and the sector which experiences the greatest impact. It is reported that close to seven million South Africans are covered by medical aid schemes, while the majority is reliant upon public health services. The public and private health care systems together account for an estimated 8% of South Africa's GDP.[5]

In South Africa, provinces are primarily responsible for social service delivery, while the role of national departments is limited to policy formulation, legislation, development of norms and standards, provision of support to provinces, and monitoring and evaluation. As a result, the majority of public health expenditure is found on provincial budgets. The budget of the national Department of Health - totalling R973 million in 2003/4 - accounts for only 2.6% of consolidated national and provincial health expenditure in South Africa. Provinces account for the largest share because they are responsible for the actual implementation and delivery of public health services - for example, the sizable medical personnel expenditure will appear on provincial, not national, budgets. Provincial health expenditure (excluding conditional grants) totals R29,4 billion in 2003/04 and accounts for 77.8% of the total.

Graph 3.1: Consolidated national and provincial health expenditure



Source: 2003 Budget Review, pg. 59. 2003 IGFR, pg. 75. 2003 Estimates of National Expenditure, pgs. 330 and 351.

[5] SA National Treasury 2003 Intergovernmental Fiscal Review. 2003: 73.

The health conditional grants (CGs) (R7.4 billion) account for the remaining 19.6%. These proportions have remained similar over the years. (The role of local government in health care delivery has related to environmental health and clinic-based primary health care services.[6])

Overall real allocations to health have been steadily increasing over the years.[7] Graph 3.1 and Table 3.1 give a broad overview of public health expenditure in South Africa and show the percent contributed from the national health department budget, provincial health department budgets and CGs.[8]

Table 3.1: Real consolidated national and provincial health expenditure and shares

	Audited 1999/00	Audited 2000/01	Prelim Outcome 2001/02	Revised Estimate 2002/03	Voted 2003/04	MTEF 2004/05	MTEF 2005/06
National health expenditure minus CGs (R million real)	658	753	834	788	917	939	939
Provincial health expenditure minus CGs (R million real)	23,918	24,084	26,364	26,417	27,746	28,536	29,128
Health CGs (R million real)	6,808	7,129	6,637	6,821	6,988	7,347	7,512
Consolidated national and provincial health expenditure (R million real)	31,384	31,966	33,835	34,026	35,650	36,823	37,580
Provincial health expenditure (including CGS) as a share of consolidated national and provincial health expenditure	97.90%	97.64%	97.53%	97.68%	97.43%	97.45%	97.50%
Health conditional grants as share of consolidated national and provincial health expenditure	21.69%	22.30%	19.61%	20.05%	19.60%	19.95%	19.99%
Consolidated national and provincial health expenditure as a share of GDP	3.01%	2.96%	3.03%	3.04%	3.06%	3.05%	3.00%
Consolidated national and provincial health expenditure as share of total expenditure	11.47%	11.56%	11.60%	11.66%	11.33%	11.30%	11.13%

Source: 2003 Budget Review, pg. 59. 2003 IGFR, pg. 75. 2003 Estimates of National Expenditure, pgs. 330 and 351.

As noted in Table 3.1, overall public health expenditure has stayed at approximately 11.5% of consolidated national and provincial expenditure for the last few years.[9] South Africa thus falls short of the the target set out in the Abuja Declaration, adopted at the Organisation of African Unity's special summit on AIDS in 2001. At the Abuja summit, African states pledged that 15% of national budgets would be allocated to health spending.

[6] 2003 IGFR. 2003: 73.

[7] Deflators used in this analysis to calculate real growth (growth adjusted for inflation) are based on inflation figures provided by the National Treasury, base year 2002/03:

Year	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
Deflator	0.78468	0.84588	0.90171	1.00000	1.06100	1.11511	1.17198

[8] The national Department of Health transfers the CGs to provinces, who actually spend the funds, but in these graphs CGs are separated out from the regular provincial health budgets.

[9] Public health spending comprises 13.3% of consolidated national and provincial *non-interest* expenditure, according to the 2003 IGFR, pg. 73. Table 3.1 includes state debt cost in total expenditure.

Given that provinces are the main vehicle for health care service delivery, provincial budgets are the focus of this chapter. As a backdrop to our HIV/AIDS analysis, we describe the trends in provincial health budgets, before we proceed in Chapter Four to focus on HIV/AIDS-designated allocations.[10]

3.1 General trends in total provincial health expenditure

Table 3.2 shows considerable growth in overall budgets for health service delivery in the provinces in 2003/04 and over the medium term. The aggregate resource envelope for health in the provinces is projected to grow from R33.1 billion in 2002/03 to R36.9 billion in 2003/04.[11] By 2005/6, provincial health expenditure is projected to be R43 billion.

This increase outpaces inflation. Real growth from 2002/3 to 2003/4 is 5.14%. On average, provincial health expenditure will increase in real terms by 3.49% each year over the medium term.

Table 3.2: Nominal provincial health department budgets and real growth

R million (nominal)	Revised Est. 2002/03	MTEF 2003/04	MTEF 2004/05	MTEF 2005/06	Real growth 2002/03-2003/04	Real annual average growth 2002/03-2005/06
Eastern Cape	4352	5118	5711	6314	10.83%	7.40%
Free State	2258	2475	2720	2935	3.32%	3.52%
Gauteng	7645	8112	8681	9121	0.00%	0.60%
KwaZulu-Natal	7419	8055	8676	9207	2.33%	1.93%
Limpopo	3146	3466	3845	4167	3.83%	4.17%
Mpumalanga	1702	2102	2315	2503	16.41%	8.03%
Northern Cape	614	737	809	889	13.19%	7.39%
North West	1974	2357	2604	2963	12.56%	8.64%
Western Cape	3997	4510	4712	4901	6.36%	1.58%
Aggregate	33107	36932	40073	43000	5.14%	3.49%

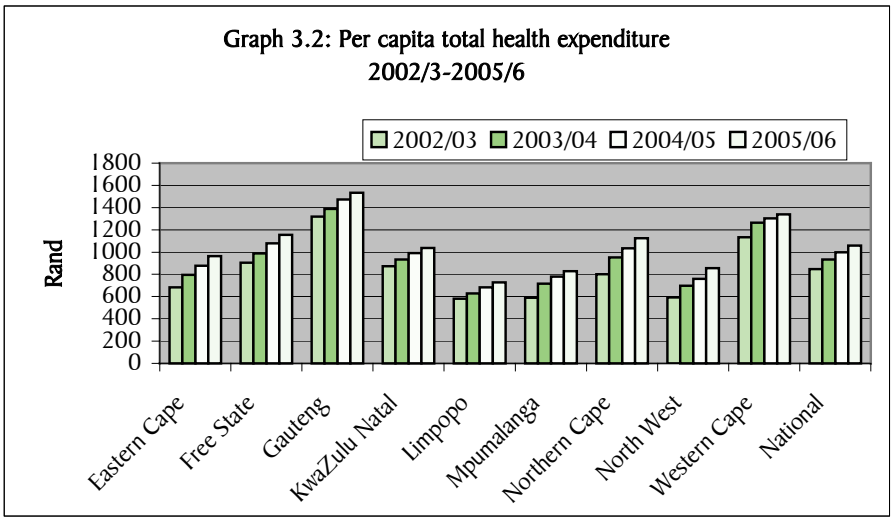
Source: Provincial Budget Statements 2003; Idasa calculations.

With regard to individual provincial health budgets, Gauteng and KwaZulu-Natal clearly outpace the other provinces, given their larger populations. Graph 3.2 compares per capita health expenditure across provinces.[12] In 2002/3 average per capita provincial health expenditure was R847 - rising to R933 in 2003/4. However, in real terms the increase from 2002/3 to 2003/4 is only R32. Over the medium term, average per capita provincial health expenditure continues to increase - in nominal and real terms - but by less each year.

[10] This chapter draws heavily on a Budget Brief by Alex Vennekens-Poane (2003) which compiles provincial health expenditure figures *using provincial budget statements*. Those figures (from provincial budget statements) for total health department budgets and conditional grant amounts actually differ slightly from the amounts listed by National Treasury in the Intergovernmental Fiscal Review 2003. Table 3.1 utilises figures from National Treasury sources. Table 3.2 uses figures taken directly from provincial budget statements.

[11] This includes CGs from the national department.

[12] Per capita calculations are based on the population utilising public health care facilities - meaning that the portion of the population without medical aid is given four times greater weighting than the population with medical aid.



Source: DBS, Provincial Population Projections, 1996 to 2021; Medical aid figures: 1995 October Household Survey; Provincial Budget Statements 2003; Idasa calculations.

3.2 Provincial health expenditure as share of total provincial budget

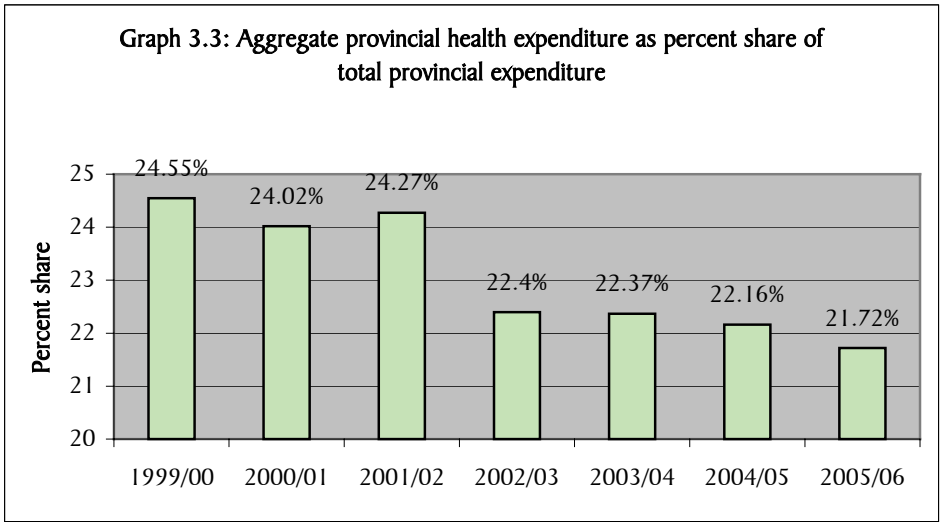
Total provincial health expenditure may be increasing over the medium term, but as a share of total provincial budgets, health expenditure is declining. Table 3.3 shows how provinces on aggregate have decreased health expenditure as a share of their total budget - from 24.55% in 1999/00 to 22.40% in 2002/03. By 2005/6 the health vote is just 21.7% of total provincial expenditure.

Table 3.3: Health budget as percent share of total provincial budget

	Outcome 1999/00	Outcome 2000/01	Outcome 2001/02	Revised Est. 2002/03	Voted 2003/04	MTEF 2004/05	MTEF 2005/06
Eastern Cape	21.60	20.87	19.87	17.39	18.32	19.06	19.10
Free State	23.76	23.92	23.74	21.65	22.39	22.21	21.97
Gauteng	33.41	33.23	33.66	31.33	30.01	29.23	27.64
KwaZulu-Natal	27.02	26.48	28.05	25.60	24.48	23.81	23.13
Limpopo	17.65	17.42	17.01	16.43	16.21	16.38	16.20
Mpumalanga	18.09	16.27	17.23	17.45	18.50	18.49	18.31
Northern Cape	17.22	17.54	17.44	16.41	19.30	19.35	20.72
North West	17.29	16.94	17.15	17.13	17.86	17.73	18.44
Western Cape	30.44	30.17	29.83	27.00	27.50	26.76	25.85
Aggregate	24.55	24.02	24.27	22.40	22.37	22.16	21.72

Source: Provincial Budget Statements 2003. Idasa calculations.

Graph 3.3 clearly indicates the decreasing proportion being allocated to health out of the total provincial budgets. This may imply that provinces are de-prioritising health, or it could be attributable to the increasing allocations to the social development vote for the extension of the social security system. However, the total share of provincial budgets allocated to the health, education and social development votes is also set to decrease - from 81.63% in 2002/03 to 80.96% in 2003/04. In order to draw definitive conclusions, analysis is required of the other votes receiving the increasing allocations, which is beyond the scope of this report.

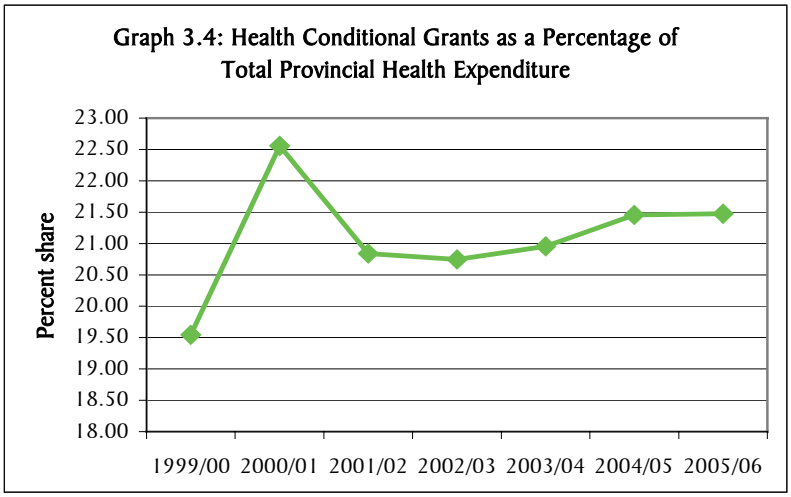


Source: Provincial Budget Statements 2003. Idasa calculations.

3.3 HEALTH CONDITIONAL GRANTS

The national Department of Health ensures that certain issues are prioritised by provincial departments by allocating funds through CGs. In addition to a CG for HIV/AIDS interventions (see Chapter 4), there are seven other CGs in the health sector - mainly for the purposes of strengthening hospitals, financing the integrated nutrition programme, and training and development of health professionals. On aggregate, there has been positive growth in the health CG allocations to the provinces: 4.7% in real terms between 2002/03 and 2005/06.

Of importance is whether provinces are tending to rely less on CGs by allocating proportionally more of their own revenue to health. Over the medium term a slightly increasing share of provincial health budgets are sourced from CGs. In 2003/4, 20.96% of aggregate provincial health expenditure comes from CGs, compared to 20.6% in 2002/3. Graph 3.4 shows the degree to which provinces are relying on the equitable share formula and own revenue as funding sources for their health budgets.



Source: Provincial Budget Statements 2003; Idasa calculations.

3.4 PROVINCIAL DISCRETIONARY HEALTH EXPENDITURE

The "discretionary budget" refers to provincial expenditure excluding the CGs. This would include resources from the equitable share allocation and from provincial own revenue, which are allocated via the province's regular budget process. As mentioned earlier, it is important to understand if provinces are relying more on their discretionary allocations, and less on the CG, which might also indicate a province's prioritisation of health issues. Analysis of discretionary budgets helps us to understand what provinces are doing with the funds they have control over themselves.

Table 3.4 shows aggregate provincial discretionary health expenditure as a share of total provincial discretionary expenditure. Because national CGs are omitted from these calculations, the percent shares give an indication of the priority attached to health services in provincial strategies.

Discretionary provincial health expenditure increases by R2.954 billion (in nominal terms) in Budget 2003/4 - a 4.86% real increase compared to 2002/3. Despite real increases in discretionary health budgets for all provinces, provinces on aggregate allocate a slightly decreasing proportion of their discretionary provincial budgets to health services over the medium term (19.95% in 2003/4, down from 20.03% in 2002/03).

Table 3.4: Aggregate provincial discretionary health expenditure

	Revised Est. 2002/03	Voted 2003/04	MTEF 2004/05	MTEF 2005/06
Real aggregate provincial discretionary health expenditure	R26.24 billion	R27.51 billion	R28.22 billion	R28.81 billion
Real growth rate	0.35%	4.86%	2.58%	2.08%
Provincial discretionary health expenditure as a percent share of total discretionary provincial expenditure	20.03%	19.95%	19.72%	19.62%
Average per capita discretionary provincial health expenditure	R668	R734	R781	R828

Source: Provincial Budget Statements 2003; Idasa calculations.

Similar to per capita provincial health expenditure, per capita discretionary provincial health expenditure is also set to increase over the medium term, although more modestly.

3.5 DISTRICT HEALTH SERVICE PROGRAMME EXPENDITURE

The District Health Services Programme in provincial budgets covers clinics, community health centres and community-based services; nutrition; HIV/AIDS; and district hospitals.[13] The HIV/AIDS health CGs are situated within Programme 2: District Health Services in provincial health department budgets. It is therefore useful to examine general trends in this programme.

Table 3.5 shows how on aggregate the provinces have increased their 2003/04 allocations to District Health Services, both in nominal and real terms. The MTEF sees further accelerated aggregate growth; annual average real growth over the medium term is 2.79%. For this programme (DHS), positive real

[13] District Health Services, Provincial Hospitals and Central Hospitals are the three largest programmes in provincial health budgets. The District Health Services Programme accounts for 39.5% of provincial health budgets in 2003/4 (2003 IGFR, pg. 83.)

growth is envisaged for most provinces, with the exception of Eastern Cape, KwaZulu-Natal and North West. Particularly strong growth is projected for District Health Services in Northern Cape and Gauteng.

Table 3.5 Aggregate provincial District Health Services Programme expenditure

	Revised Est. 2002/03	MTEF 2003/04	MTEF 2004/05	MTEF 2005/06
Aggregate DHS programme expenditure (nominal)	R13.515 billion	R14.560 billion	R15.947 billion	R17.200 billion
Real growth in aggregate District Health Services programme budget	0.69%	1.53%	4.21%	2.63%
DHS at percent share of total provincial health expenditure	40.8%	39.4%	39.8%	40.0%

Source: Provincial Budget Statements 2003; Idasa calculations.

3.6 Other developments in provincial health budgets

Provinces on aggregate show funding support over the 2003/04 MTEF to national priorities of HIV/AIDS, nutrition, primary health care and emergency transport, as well as tuberculosis, and psychiatric, chronic and other specialised care in provincial specialised hospitals. To complete an overview of South African public health budgets, we also note the following relevent developments:

- *Recurrent expenditure.* Despite a decline in the proportion of the provincial health budget allocated to recurrent expenditure, aggregate growth in recurrent expenditure is still positive (4.45%).
- *Personnel.* In line with the national strategy objectives to strengthen health personnel recruitment and retention, aggregate personnel expenditure grows by 5.39% in real terms in 2003/4, and particularly in those provinces that have staffing levels very far below the average. However, as a proportion of the total health expenditure, aggregate provincial personnel expenditure is generally declining.
- *Primary Health Care.* With respect to service delivery more generally, all provinces except Eastern Cape (-9.9%) have planned for real increases in expenditure on clinics, community health centres and community health services in 2003/4. This is consistant with the national strategic objective to increase the average number of primary health care visits per person per annum, and to improve the quality of services at this level. Ostensibly this will enable improved care to HIV-infected people in the earlier less symptomatic stages of the disease.
- *District hospitals.* All provinces except Limpopo and Western Cape have projected real budget declines (10.4% on aggregate) for district hospitals in 2003/04. This could be related to a shift of activity from district hospitals to PHC clinics and centres (in line with national strategies). However, the decline in district hospital funding may negatively affect the national strategic objective to strengthen hospital care at district level and to shift hospital patients presently treated at provincial hospitals to district hospitals. Sub-optimal standards of care at district hospital level would also particularly affect poorer people in the rural and relatively under-serviced areas.

CHAPTER 4.

HIV/AIDS CONDITIONAL GRANTS

4.1 OVERVIEW

The South African National Integrated Plan for Children Infected and Affected by HIV/AIDS (NIP) sets up a complex lattice of funding flows between three national departments and two spheres of government. Three conditional grants (CGs) to provinces for HIV/AIDS serve as the financial backbone to the NIP. CGs are funds transferred to provincial departments by an administering national department conditional on the delivery of certain services or interventions as defined by national. Strict conditions, reporting and monitoring requirements are usually attached to the funds. In the NIP, the role of the national departments is to provide technical assistance, co-ordination and programme support to the provincial social service departments; the provinces actually implement the programmes, using the CG funds.

4.1.1 General funding flow between national and provinces

Driven jointly by the departments of health, education and social development, the NIP began in 2000/1 with three primary programmes: voluntary counselling and testing (VCT), Lifeskills education, and community and home-based care and support (CHBCS). The total pool of funds set aside for the NIP was initially split between these three primary programmes. Three CGs were set up to finance implementation of the three programmes. The three programmes' shares were then subsequently split between those funds to be spent directly by the national department and those funds which would be disbursed to provincial departments as CGs. The Department of Education took on the Lifeskills programme and the VCT programme rested with the Department of Health. However the implementation of the CHBCS programme was split between Health and Social Development. The Department of Health's mandate was to implement home/community-based care for chronically ill patients, while the Department of Social Development's mandate was to implement a coherent response for orphans and vulnerable children.[14]

4.1.2 Purpose and programmes associated with each conditional grant

Therefore at present there are three CGs for HIV/AIDS interventions.

The Lifeskills conditional grant - totalling R120.47 million in 2003/4 - is administered by the national Department of Education and divided among the provinces using the education component of the equitable share formula. The broad objective of the Department of Education's HIV/AIDS strategy is to ensure access to an appropriate and effective integrated system of prevention, care and support for children infected and affected by HIV/AIDS; and to deliver curriculum-based life skills and HIV/AIDS education in primary and secondary schools.

The HIV/AIDS conditional grant from the Department of Social Development finances the aspects of the CHBCS programme that support orphans and vulnerable children. The smallest of the three, this CG totals R62 million in 2003/4. As noted above, funding for CHBCS is particularly complex: provincial

[14] Personal correspondence with Anita Marshall, National Co-ordinator - National Integrated Plan, Department of Health.

welfare departments receive CHBCS CG funds from the Department of Social Development while simultaneously the health HIV/AIDS CG also makes funds available to provincial health departments for the health-related aspects of the CHBCS programme.

The health HIV/AIDS conditional grant is the giant, totalling R314 million in Budget 2003/4. The health HIV/AIDS CG has changed considerably since its inception - in scope and purpose. Originally the health CG for HIV/AIDS entailed strict conditions and only covered the VCT programmes and the medical/health aspects of the CHBCS programmes.

Then in 2002/3, the Department of Health loosened the restrictions on how provincial health departments could spend the funds, increased the allocation and expanded the interventions for which it could be used. The "Enhanced Response to HIV/AIDS" (government's follow-on to the NIP) added funds to the health HIV/AIDS CG in Budget 2002/3 for step-down care,[15] strengthening provincial management, PMTCT and the provision of post-exposure prophylactics. Under the looser restrictions on the health HIV/AIDS CG, provinces were now simply given a list of activities for which they could use the funds; resource allocations between those activities would be left to the provinces' discretion.
A set of broad output indicators would be used to monitor expenditure and act as the primary condition for the grant.[16]

In the 2003/4 Budget the total allocation for the health HIV/AIDS CG jumped again - by 50% in real terms. In addition to providing for a rapid roll-out of the PMTCT programmes and continuation of programmes previously covered by the CG, the expanded allocation is intended to finance at least two new components:

1. Provincial programmes to provide post-exposure prophylactic (PEP) drug treatment to women who may have been exposed to the virus due to rape. Limited funding for this purpose was added in 2002/3 during the year, with increased funding voted in 2003/4. National protocols were due to be distributed to provinces in June 2002. Provincial services for rape survivors vary by province - they may be located in multi-disciplinary crisis centres or victim empowerment centres, or in emergency rooms at general hospitals.[17]

2.Centres of Excellence in AIDS care. This is a new initiative by the national Department of Health in recognition of the need to improve and standardise the quality of HIV/AIDS treatment and care in medical facilities. The plan is for a Centre of Excellence to be established in each province - attached either to a medical school in the province or in a neighbouring province. The Minister of Health has announced:

Box 1. PMTCT funds

Dedicated funds for PMTCT first appeared in the national budget in 2001/2 - R20.298 million was added in the Adjusted Estimates for two pilot sites in each province (Adjusted Estimates 2001, pg. 81). Then in 2002/3 Treasury added a dedicated sum of R25 million to the health HIV/AIDS conditional grant for the "progressive roll-out" of PMTCT programmes; at that time projected allocations for 2003/4 and 2004/5 were given as R79.125 million and R155.693 million respectively. However the following year the national Department of Health changed the process for the health conditional grant, which meant that amounts spent by provinces for PMTCT were no longer centrally determined. Instead it was left to provinces to determine what share of their health conditional grant would be used for PMTCT. As a result, precise figures on the aggregate amount allocated for PMTCT for 2003/4 are not readily available. As an additional note, R100 million was also provided by the US government in February 2002 to expand the PMTCT programme (African National Congress (ANC). "Update on the National HIV and AIDS Programme." 19 March 2003. Pg. 9.)

[15] Step-down care is the term used to described treatment and care services for individuals who do not require acute medical care in a hospital setting, but are still too ill to be cared for at home.
[16] Department of Health, September 2002. Pg. 8.
[17] ANC, "Update on the National HIV and AIDS Programme." 19 March 2003. Pg. 4.

"Discussions are underway with the deans of health science faculties on the establishment of Co-ordination and Training Centres for Management of HIV
and AIDS."[18]

Each Centre would serve as a base for a core team of medical and nursing professionals who would be responsible for province-wide training on clinical HIV/AIDS prevention and management, and ensure updated guidelines are disseminated and used in all clinics and hospitals.[19] The plan is a very important step towards the massive training and infrastructure required to implement a national treatment plan to provide anti-retroviral drug treatment (South African Joint Treasury and Health Task Team, 2003: 31). The Centres' main function would be to "develop curricula on HIV, AIDS and TB care and to align the skills of health workers with the requirements of national treatment guidelines". [20] The Department of Health proposed an annual budget of R5 million per province to set up a Centre in each province.[21]

Section 4.2 describes the criteria for allocating CG funds between the provinces. Section 4.3 examines the spending record on the CGs. Section 4.4 then lays out the procedures and systems set up by each national department for financial accountability between transferring and receiving agents (i.e. national and provincial departments). We conclude in Section 4.5 with some analysis and recommendations regarding what is working and what needs improvement.

4.2 Criteria and decision-making structures for determining provincial split

To simplify, there are two basic allocations/budgeting decisions associated with each CG. First: how is the global amount determined? (e.g. How was the figure of R120 million for the Lifeskills prevention programme for 2003/4 reached?) Essentially, the initial budget split between the three NIP programmes for 2001/2 to 2003/4 was made by the National Steering Committee of the NIP, which consists of Dr Simelela, Chief Director HIV and AIDS; Mr Edcent Williams, Chief Director: Curriculum, Department of Education and Dr Maria Mabetoa, Director: HIV, Department of Social Development. The 2004/5 and 2005/6 budget splits were decided upon by National Treasury.[22]

Second, how does the national department administering the CG decide to split up that sum between the nine provinces? This section asks this question for each of the three grants - both in terms of the criteria/rationale for the decision and also with respect to who is making the decision.

This inquiry is important for two reasons. First, resource allocation decisions in the public sector need to balance ability to spend with need. At first glance, it might appear that prioritising those provinces with the highest prevalence rates is appropriate. However it is necessary to be more discerning and to consider costing of programmes and norms and standards, and target populations for particular interventions. For example, the target population for HIV/AIDS prevention programmes is all people, not simply those already infected. Therefore it is more appropriate to use a formula that includes a number of school age children in each province (the education component of the equitable share formula) as the Department of Education has done.

[18] "Parliamentary Media Briefing by the Social Sector Cluster." 19 February 2003, by Ministers of Health, Social Development, Water Affair and Forestry, and Home Affairs. Available at www.doh.gov.za/docs/sp/2003
[19]Department of Health, "Revising the Enhanced Response to HIV/AIDS and Tuberculosis in the Public Health Sector - Funding Requirements, 2003/4-2005/6." September 2002.
[20] ANC, "Update on the National HIV and AIDS Programme." 19 March 2003. Pg. 7.
[21] Department of Health. "Revising the Enhanced Response." September 2002. Pg. 8.
[22] Personal correspondence with Anita Marshall, National Co-ordinator - National Integrated Plan, Department of Health.

Second, we are concerned with the degree to which the process for determining the size of the HIV/AIDS CG for each province is a top-down as opposed to a bottom-up affair. Are the intergovernmental mechanisms and forums intended to facilitate budget planning and negotiations working properly? Are provinces able to feed information up to national departments regarding their anticipated programme costs?

One of the areas of improvement in the NIP has been the evolution and refinement of the allocation criteria for each CG. Table 4.1 shows the available information on the allocation criteria for each grant since the first year, 2000/1.

Table 4.1 Allocation criteria for three HIV/AIDS conditional grants

	2001/2 allocation criteria	2002/3 allocation criteria	2003/4 allocation criteria
Education	Education component of equitable share formula	Education component of equitable share formula	Education component of equitable share formula
Health	Based on the national survey conducted in 1999 on the status and availability of VCT in all provinces and the business plans submitted by the provinces. Also 1999 audit on health and NGO sectors used in the Department of Social Development's allocation process; provinces of highest prevalence; priority areas identified by cabinet (Eastern Cape, KwaZulu-Natal, Limpopo, North West); areas with poverty alleviation programmes in place; areas implementing the Integrated Nutrition Programme	Based on national survey conducted in 1999 on the status and availability of VCT in all provinces which also informed the decision to prioritise Eastern Cape, KwaZulu-Natal, Northern Province, and North West Province	2001 Antenatal HIV Prevalence Survey, estimated share of HIV-positive births, share of reported rapes, estimated share of AIDS cases
Social Development	Allocation made on the basis of the results of 1999 audit on the readiness of the health and NGO sectors to deliver CHBCS (R1.5 m to all provinces)	Guiding principles in developing the NIP: -- Provinces which studies have shown have highest HIV/AIDS prevalence, which are also identified as priority - Eastern Cape, KwaZulu-Natal, Limpopo and North West Province --Resources available in the provinces and linkages with the following programmes and strategies: Urban renewal and rural development strategy; Poverty alleviation programme; Integrated Nutrition Programme	--HIV/AIDS prevalence --Resources available in the provinces and linkages with the following programmes and strategies: Urban renewal and rural development strategy; Poverty alleviation programme; Integrated Nutrition Programme
Source	*National Treasury 2001a: 265, 268, 276.*	*National Treasury 2002f: 75, 79, 88.*	*National Treasury 2003c: 82, 87, 97.*

4.2.1 Lifeskills education conditional grant

As noted above, the National NIP Steering Committee meets regularly and decides upon the global amount for each CG, including the Lifeskills programme. The national Lifeskills co-ordinator and provincial Lifeskills co-ordinators do not have input into the size of the grant allocations.[23]

The Lifeskills programme has consistently used the education component of the equitable share formula to determine the size of the slice for each province. The education component of the equitable share formula targets primary and secondary schools and uses both school-age population figures and enrolment numbers to reflect the demand for education services. "The school-age cohort, ages 6-17, is double-weighted, reflecting government's desire to reduce out-of-age enrolment." (National Treasury 2003c: 62). This is a rational allocation tool for the CG and its consistent use has the further benefit of allowing provincial co-ordinators to plan ahead with certainty.

4.2.2 CHBCS conditional grant from the Department of Social Development

The global amount of the CHBCS CG through the Department of Social Development is determined by National Treasury. According to the CHBCS Co-ordinator in the Department of Social Development, at first the Department of Social Development experienced some difficulties identifying evidence of achievements due to the slow nature of a community-based approach and the Department of Social Development's inability at first to provide hard numbers.[24] While National Treasury's orientation is with figures and quantitative results, the Department of Social Development operates with a community-oriented, social work approach. Although the global allocation was very small in the first year 2000/1 (R5.6 million), the Department of Social Development was able to show results and essentially put itself "on the map" with regard to government's HIV/AIDS response - reinforcing the notion that HIV/AIDS is not simply a health issue.

The second question is how the global amount for the Department of Social Development HIV/AIDS CG is split between the provinces. According to the CHBCS co-ordinator in the Department of Social Development, National Treasury essentially decides how the total pool of CHBCS funds will be split between the provinces - through meetings between itself, the Department of Health and the Department of Social Development.[25] That provincial split will not be revisited unless more funds become available. As Table 4.1 shows, in 2001/2 the Department of Social Development simply transferred the same lump sum to all provinces, but the following year the Department refined its method and began to consider the relative severity of the epidemic. The Department also sensibly recognised the value of piggy-backing on ongoing government development and poverty relief programmes to make inroads into communities. Also, prior to 2002/3, the Department of Social Development was using different allocation criteria than those used by the Department of Health to determine the health HIV/AIDS funds each provincial health department received for the medical aspects of the CHBCS programme.[26] In 2002/3 the two national departments aligned their allocation criteria for the two sides of the CHBCS programme.

[23] Interview with Brennand Smith, National Life Skills Co-ordinator, National Department of Education.
[24] Interview with Ms. Johanna De Beer, Deputy Director: HIV/AIDS, Department of Social Development.
[25] Ibid.
[26] As explained above, provincial health departments receive funds in the health HIV/AIDS CG for the medical aspects of the home-based care (for chronically ill patients), while each provincial welfare/social development department receives a CG from the Department of Social Development for interventions to support orphans and vulnerable children (food parcels, social workers, stipends for volunteers etc.). Theoretically the two work together through the integrated strategy.

4.2.3 Health HIV/AIDS conditional grant

The HIV/AIDS CG from the Department of Health is particularly complex. There are three resource allocation decisions related to:

- The global amount of the health HIV/AIDS CG;
- The split between the provinces, i.e. the size of the CG to be transferred to each province;
- Each province's separate process for determining how those funds will be split between the various component HIV/AIDS interventions funded by the CG (e.g. PMTCT, VCT).

Determining the global amount of the HIV/AIDS health conditional grant. To understand how the global amount for the health HIV/AIDS CG is derived, its helpful to understand three points. First, the HIV/AIDS CG in the health sector has become a catch-all funding vehicle for sending funds to the provincial health departments for nationally-determined HIV/AIDS priority interventions; it channels funds for seven different types of activities.

When the NIP was launched, the total NIP amount was split between the three programmes (VCT, CHBCS and Lifeskills), and the amounts intended for the VCT and health-related CHBCS were channelled via the health HIV/AIDS CG. However, in subsequent years, national government has identified and initiated other priority HIV/AIDS interventions besides the original three programmes. Government capitalised on the health HIV/AIDS CG funding channel already in place and added allocations for the new programmes to this existing funding stream. The global amount for the HIV/AIDS health CG then became a sum of the original NIP allocations for CHBCS and VCT, plus new funds for PMTCT, step down care etc.

Appendix 1 attempts to summarise this evolution. It shows how the number of component programmes covered by the health HIV/AIDS CG has increased over time, and, where information is available, it also shows the criteria or rationale the Department of Health uses to determine how the funds for each component will be split between the provinces.

The second point is that the global allocation is the result of a negotiation between National Treasury and the Department of Health. As our understanding of the epidemic and effective government responses developed, government realised the need to launch new targeted interventions in addition to the original NIP. As the Department of Health carefully costed these new interventions and submitted budgetary requests to National Treasury as part of the regular budget process, National Treasury would elect to partially fund some components of the health HIV/AIDS CG. The Department of Health then had to take the global amount actually approved by National Treasury and break it down between the provinces. For example, for 2002/3 the Department of Health requested a total of R205.7 million for the health HIV/AIDS CG. This figure was derived by carefully estimating the cost of implementing each component (at the planned scope and quality) and then adding up the figures. Table 4.2 shows the assumptions and rationale the Department of Health used for costing each component of the health CG in its Budget 2002/3 request.

Table 4.2 Department of Health Budget submission for HIV/AIDS, 2002/3

	BASIS FOR CALCULATION/COSTING	DOH request	Actually approved by NT
VCT	DOH's cost estimate for 2002/3 for the national roll-out of VCT was based on "5000 health facilities having trained staff, using rapid HIV tests, as per VCT plan presented to Health Minmec."[27]	R49 m	R49 m
CHBCS	The cost estimate for the CHBCS component was based on "joint Health & Social Development policy on CHBC, rolling out 200 CHBC teams in 2002/3, 600 in 2003/4, 1000 in 2004/5". Also assumes a R500 stipend for volunteers.[28]	R120 m	R46.5m
Provincial management	The cost estimate for the provincial management component of the health CG is based on the following for each province: one director; two senior administrative officers; and two administrative assistants. Also calculates costs at 80% in the first year, to allow time for recruitment of personnel.[29]	R6.7 m	R6.7m
Step-down care	The cost estimate for the step-down care component was based on "Integrated Health Planning Framework estimates of Step-down care recurrent and capital costs."	R30 m	R30 m
	Total	R205.7 m	R132.2 m

Source: Directorate: Health Financing and Economics, Department of Health.

R132.2 million was actually approved by National Treasury for 2002/3. (This excludes the R25 million later allocated for PMTCT.) The entire shortfall was taken from the CHBCS line item, where the Department of Health motivated for R120 million but only R46.5 million was approved.

The reason put forward for blocking the CHBCS funding request was the ability to spend. Concerned that the provinces were not delivering, National Treasury "requires National and Provincial Health Departments to demonstrate improved spending and management of current allocations before major increases for Home Based Care can be entertained".[30] Confirming National Treasury's concerns, in April 2002 the Department of Health reported to parliament that spending on the CHBCS portion of the health CG was 57% for 2001/2, while spending on the overall health HIV/AIDS CG was 68%.[31] (Our calculations are actually higher and put aggregate spending of the health HIV CG at 83% in 2001/2 - a considerable improvement from 59.5% in 2000/1.[32]) However it is important to note that the community-based care and support funds flowing through the Department of Social Development for HIV/AIDS were experiencing the same difficulties - their record was 81.3% in 2001/2 (See Table 4.3).
The Department of Health's response to National Treasury's denial of their request concerning CHBCS was as follows: "The National Department of Health accepts these concerns as valid, but is still committed to accelerating the expansion of Community & Home Based Care, in partnership with the Department of

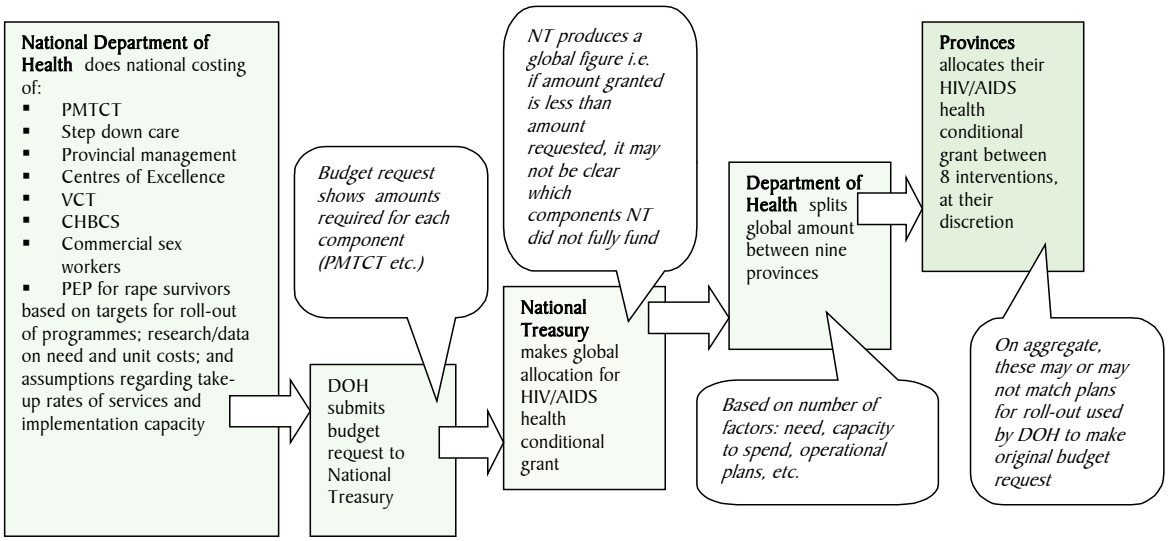
[27]Department of Health, "An Enhanced Response to HIV/AIDS and Tuberculosis in the Public Health Sector - Key Components and Funding Requirements, 2002/3—2004/5." September 2001. Pg. 15.
[28] Ibid.
[29] Ibid.
[30] Department of Health, "HIV/AIDS Funding for the Health Sector in Budget 2002: Comparison of funds allocated and funds requested in the Department of Health's 'Enhanced Response' Budget Submission." 26 March 2002. Directorate: Health Financing and Economics.
[31] Department of Health. Presentation to Parliamentary Portfolio Committee on Health. 29 April 2002. "HIV/AIDS CGs 2001/2."
[32] See Table 4.3. These calculations reflect percent spent of the CG allocation for the current financial year and do *not* include expenditure of unspent funds that were rolled-over from the previous year.

Social Development. The primary focus during 2002/3 will therefore be upon improving the effectiveness of CG expenditure; once improved performance has been demonstrated, the issue of funding for CHBC will be reopened with Treasury for future years." [33]

This interaction over the CHBCS budget allocation for 2002/3 is evidence of how the varying perceptions and priorities of the two national departments influence the global allocation for the health HIV CG. It is also an example of National Treasury taking provincial actual expenditure records into account in determining *global* amounts. The danger here is that poor performance of particular provinces influences the global allocation instead of being incorporated into resource allocation decisions at a lower level (i.e. in determining how much goes to each province).[34]

Third, as discussed above, the Department of Health has moved towards a looser, more flexible CG for HIV/AIDS. Provinces are now allowed to allocate the CG funds between a list of eight activities. However this new system makes the separate cost estimates for each component irrelevant from the provinces' perspective. Cost estimates of each component done by the Department of Health are now a theoretical exercise. They are calculated by the Department of Health for its budget submission to National Treasury, but once National Treasury responds with the global amount for the health HIV/AIDS CGs and those funds are split between provinces, provinces need take no note of the relative costs and weightings given to each component by the Department. In other words, because provinces can use the funds for different combinations of these eight activities, the Department of Health cannot base its global cost estimate for the health HIV/AIDS CG on what provinces plan to spend or even which programmes they plan to implement. Figure 4.1 shows this process graphically.

Figure 4.1: Resource allocation decisions for health HIV/AIDS conditional grant



Essentially the global amount for the health HIV/AIDS CG is now the sum of top-down cost estimates of its component national programmes (as generated by the Directorate: Health Financing and Economics in the Department of Health), which may or may not be fully approved/funded by National Treasury. It is *not*

[33] Department of Health, "HIV/AIDS Funding for the Health Sector in Budget 2002: Comparison of funds allocated and funds requested in the Department of Health's 'Enhanced Response' Budget Submission." Directorate: Health Financing and Economics. 26 March 2002.

[34] In September 2002, the Department of Health submitted a request for R428.471 million for the HIV/AIDS CG for 2003/4. The amount granted in Budget 2003/4 was only R333.556 million (or 78% of that requested). Information on which line items National Treasury declined to fully or partially fund was not available to us.

the sum of cost estimates generated in each province for those interventions they plan and choose to implement.

How funds are split between the provinces. Once the global amount of the HIV/AIDS CG for health is set, the allocation of those funds between provinces is decided upon within the HIV/AIDS Directorate in the Department of Health.[35] The National Steering Committee of the NIP determines how those funds will be split between the provinces. Table 4.1 details the criteria the Department has used each year to make that decision. It appears that indicators of need have become a more prominent determinant in 2003/4, compared to the province's relative ability or readiness to spend. Where initially business plans were a key factor, according to the 2001 and 2002 Division of Revenue Bills, the provincial split now depends more largely on demographic indicators of the supposed cost drivers for the key programmes. However the 2003 DOR also indicates that, given that four provinces have significantly under-spent, "additional funds have been targeted towards provinces with stronger spending performance" (National Treasury 2003c, pg. 87).

The balance between ability to spend and need will always be an issue in allocating resources for the HIV/AIDS CGs. However the key point to note is that the amount each province receives for the HIV/AIDS CG from the Department of Health is *not* based on costing of the programmes the province plans to implement in that given financial year. This is a consequence of the decision to permit provinces to allocate their HIV/AIDS CG funds between interventions at their discretion.

Division of provincial HIV/AIDS health conditional grant between various interventions. With this new approach, upon receiving its HIV/AIDS CG from the Department of Health, each provincial health department allocates those funds between the eight component interventions as it sees fit, according to the operational plans of their HIV/AIDS unit. Provincial business plans inform the Department of Health on how the CG will be split between the programmes.[36]

According to the Department of Health, this decision was made to increase efficiency; one province may be particularly good at delivering one type of service but not another. Provincial discretion allows that province to capitalise on this success, and to go ahead and proceed with roll-out where systems are functioning well.[37] The new approach was also intended "to address under-spending on CGs as some programmes were spending better than others and indicated that the budget split between programmes needed to be established at a provincial level".[38]

In 2003/4, the first year of this system, the Department of Health sent a memo to provinces in which they suggested guidelines for allocating resources between the various activities.[39] The ratios or relative weightings were put forward in meetings between provincial HIV/AIDS managers and the Department of Health, however ostensibly the Department of Health input remained advisory. One notable consequence of this approach is that figures on the aggregate budget allocations and expenditure by provinces for each intervention (e.g. PEP for rape survivors, or programmes for commercial sex workers) are not readily available.[40]

[35] Interview with Gerritt Muller, Chief Financial Officer, Department of Health.
[36] Personal correspondence with Anita Marshall, National Co-ordinator - National Integrated Plan, Department of Health.
[37] Interview with Gerritt Muller, Chief Financial Officer, Department of Health.
[38] Personal correspondence with Anita Marshall, National Co-ordinator - National Integrated Plan, Department of Health.
[39] Interview with Gerritt Muller, Chief Financial Officer, Department of Health.
[40] National Treasury statements posted on the Treasury website do not disaggregate for the various interventions covered by the health HIV/AIDS CG. (Instead there is one figure for provincial spending against the total health

4.3 Spending record on HIV/AIDS conditional grants

CGs make up approximately 10% of provincial revenue, with the bulk of provincial budgets sourced from the equitable share (86.5%) and provincial own revenue (3.5%).[41] CGs have pros and cons. By ring-fencing the funds, central government ensures that national priorities will be sufficiently resourced in provincial budgets and that provinces will implement these programmes. However the financial and programme regulations attached to CG funds - detailed in Section 4.4 - also create bureaucratic hurdles and delays in transferring and spending funds. For these reasons, spending on CGs in South Africa is typically quite low: between 70.1% (our calculation) and 84.6% (Treasury).[42]

How does conditional grant spending compare to spending against the regular provincial department budgets? On aggregate, provinces were 0.4% under expenditure on their health budgets for 2001/2. (Actual health expenditure was R29.634 billion compared to R29.765 billion adjusted budget - or 99.56%.)[43] [44] With respect to total provincial expenditure, under-spending was 3.6% for 2001/2.[45] This suggests further support for the idea that provinces find it easier to spend funds from their regular budgets than to spend CGs from national.

4.3.1 Improvements since 2000/1

Thus the CG funding mechanism - while guaranteeing provinces run these HIV/AIDS interventions and do not apply the funds for other purposes - also carries the downside of potential under-spending. In the first year of the NIP, spending on HIV/AIDS CGs was quite low, confirming this pattern. (Part of the reason for the initial low spending figures is that accounting structures of government initially did not allow for spending on CGs to be adequately captured separately.) The massive improvements in spending over the next two years suggest that the problem initially was not the CG mechanism itself, but the mammoth administration and financial management challenges to be expected in the first year of a national programme. Getting the NIP programmes up and running required setting up management structures and employing co-ordinators in the provinces, developing financial transfer and monitoring systems, and establishing programme standards, plans and materials. This implies that HIV/AIDS provincial managers have succeeded in overcoming the bureaucratic hurdles inherent in the CG mechanism itself - which line managers regularly confront when spending other CGs (for nutrition programmes, hospitals, etc.)

HIV/AIDS CG.) In order to compile aggregate spending across provinces for PMTCT, for example, would require direct correspondence with the provinces and/or the Department of Health.

[41] 2003 Budget Review, pg. 159.

[42] National Treasury ("Provincial Budgets: 2001 Outcome and 2002 Budgets". 31 July 2002. pg. 16) reports that the overall spending record for CGs for 2001/2 was 84.6%. This calculation assumes that spending on four large CGs (Central Hospitals, Professional Training and Research, Provincial Infrastructure and Supplementary Allocation) was 100% because these grants are "treated as general revenue by provinces, so actual spent against them cannot be measured." Our own calculations are compiled from provincial spending figures reported in National Treasury's *Revenue and Expenditure Statement for the 4th Quarter ended 31 March 2002.* Figures in this source exclude three of these four grants (Central Hospitals, Training and Research, and Supplementary Grant) because spending of these grants is "subsumed in the spending of a range of programmes across provincial departments and therefore no reporting is required on these grants". Therefore the National Treasury figure will be inflated upward compared to our calculation.

[43] National Treasury, "Provincial Budgets: 2001 Outcome and 2002 MTEF Budgets." 31 July 2002. Pg. 8.

[44] According to our calculations, on aggregate provinces spent 99.3% of their provincial health department budgets in 2001/2. (Based on data from National Treasury, *Revenue and Expenditure Statement for the 4th Quarter ended 31 March 2002.)*

[45] National Treasury. "Provincial Budgets." 31 July 2002. Pg. 7.

Table 4.3: Overview of actual spending on HIV/AIDS conditional grants
(not including spending on rolled-over funds)

R million	2000/1			2001/2			2002/3		
	Allocated	Spent	**Percent spent**	Total available	Actual spending	**Percent spent**	Total available	Actual spending	**Percent spent**
Lifeskills CG	26.93	6	**22.3%**	63.5	41.956	**66.1%**	144.605	125.041	**86.5%**
Health CG	16.819	10	**59.5%**	54.398	45.095	**82.9%**	210.209	172.879	**82.2%**
CHBCS CG from Department of Social Development	5.62	2	**35.6%**	12.5	10.156	**81.3%**	47.5	44.019	**92.7%**
Total HIV/AIDS CGs	49.369	18	36.5%	130.398	97.207	74.5%	402.314	341.939	85.0%

Sources:
2000/1 figures are taken from 2001 Intergovernmental Fiscal Review and 2001 Budget Review.
2001/2 and 2002/3 figures are primarily taken from Statement of the National and Provincial Governments' Revenue and Expenditure and National Borrowing as at 31 March 2002, and as at 31 March 2003, with some corrections made based on direct information from the provinces. 2001/2 social development figures are corrected against information obtained from Ms J. De Beer, Deputy Director: HIV/AIDS at the Department of Social Development, and only include expenditure against the 2001/2 allocation. (In other words, in the cases where provinces rolled-over funds from the previous year - Mpumalanga, Northern Cape, North West and Limpopo - we do not include their 100% expenditure of the rolled-over funds here.)
***NB:** In a number of cases provinces reported spending to National Treasury which exceeded their CG allocation. (This occurs when provinces report expenditure of departmental funds in addition to CG funds, or when provinces report on expenditure of funds rolled-over from the previous year.) In these cases, we have adjusted the figures here to instead show 100% expenditure - so as to ensure that total percentages are not skewed. See Appendix 3 for full references for all figures and explanations of corrections.*

Table 4.3 and Graph 4.1 show the aggregate provincial spending records on the three HIV/AIDS CGs and give evidence of massive improvement. It is important to note that our figures do not include spending on funds rolled-over from previous years, and thus only reflect provincial expenditure on the current year's CG allocation.[46] Appendix 3 contains a spreadsheet with budgeted, and actual expenditure figures for each province for each HIV/AIDS CG (2001/2 and 2002/3) *excluding roll-overs.*

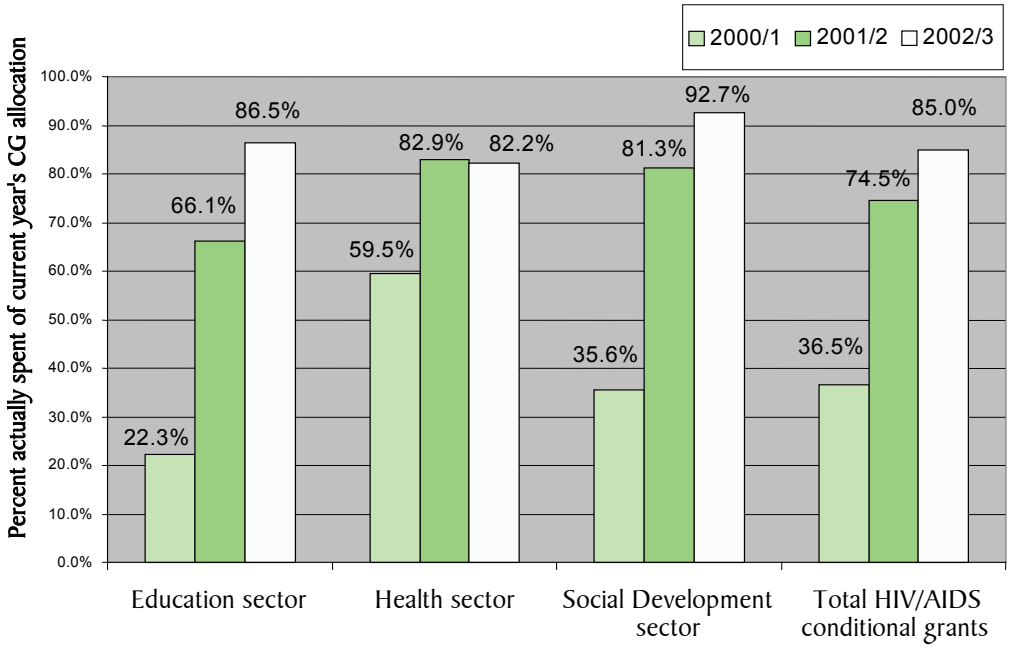
- Overall 85% of HIV/AIDS CG funds were spent in 2002/3, compared to a low 36.5% spent in 2000/1.

- Beginning in 2001/2 aggregate spending on HIV/AIDS CGs matched or exceeded average spending on CGs generally, which tells us that the usual difficulties experienced with CG spending have been surmounted by quick improvement in HIV/AIDS programme structures and spending procedures.

- Capacity (e.g. financial and project management) remain stumbling blocks, but primarily in the Department of Social Development and the Department of Education, because provincial health departments have been able to use provincial management funds for staffing.

[46] Rollovers are funds that are unspent in one budget year and then reallocated in the following financial year.

Graph 4.1: Improved spending records of HIV/AIDS conditional grants, by sector

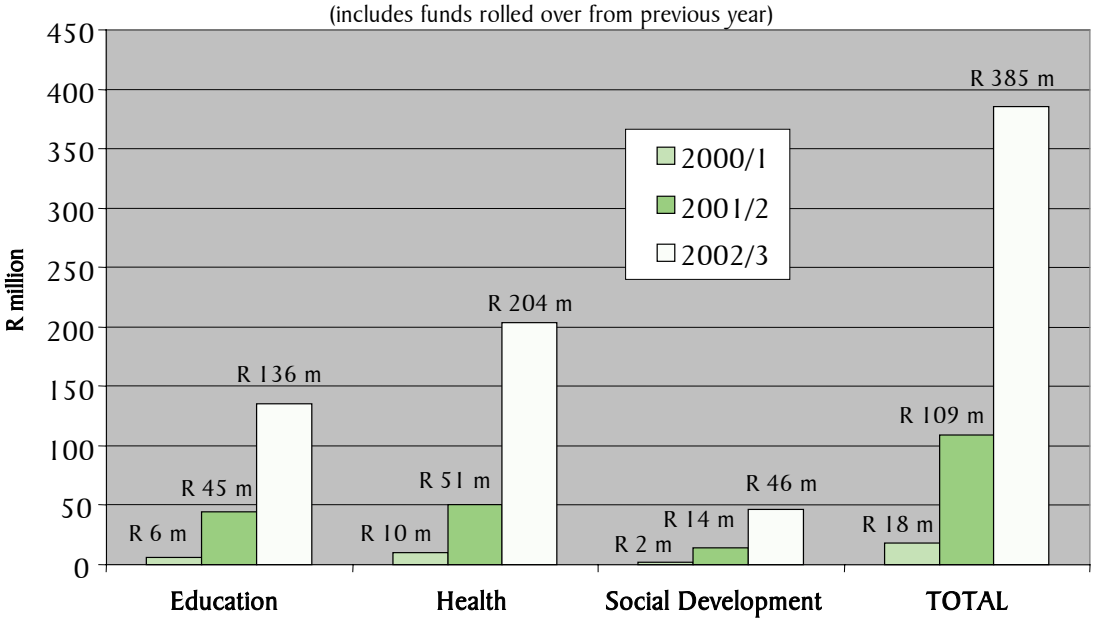


Source: 2001 Intergovernmental Fiscal Review. 2001 Budget Review. Statement of the National and Provincial Governments' Revenue and Expenditure and National Borrowing as at 31 March 2002, and as at 31 March 2003. Information obtained from interviews with: Deputy Director: HIV/AIDS, Department of Social Development; and HIV/AIDS managers in provincial education, health and social development/welfare departments.

It is also vital to understand that these improved track records occurred despite massive increases in allocations year to year. What is happening here is that national government is responding to the epidemic by rapidly increasing allocated funds, as it should. But realistically, it must be understood that this places extraordinary expectations on line managers to spend doubled or tripled allocations from one year to the next. From 2000/1 to 2001/2 national boosted the earmarked funds for HIV/AIDS sent to provinces by over 160%. From 2001/2 to 2002/3, the amount national expected provinces to spend tripled from one year to the next. In 2003/4 the global health HIV/AIDS CG grows by 59%. (Table 4.3 shows the growth in budgeted amounts year to year.)

Provinces responded to the challenge. In the first year, total provincial spending of the HIV/AIDS CG funds was R18 million. Some unspent funds were rolled-over into 2001/2, meaning that provinces were then faced with the additional pressure of spending the roll-overs *plus* the current year's allocation. *Including expenditure on roll-overs*, provincial HIV/AIDS managers succeeded in spending R109 million in 2001/2 - this is six times the amount spent in the previous year. Moreover, in 2002/3 actual spending increased again by over 250%, to R385 million (see Graph 4.2). Appendix 2 contains a full spreadsheet with budgeted and actual expenditure figures for each province for each HIV/AIDS CG (2001/2 and 2002/3) *including roll-overs.*

Graph 4.2: Aggregate actual expenditure of HIV/AIDS conditional grant funds, by sector
(includes funds rolled over from previous year)



Source: Statement of the National and Provincial Governments' Revenue and Expenditure and National Borrowing as at 31 March 2002, and as at 31 March 2003. 2001 Intergovernmental Fiscal Review. Information obtained from interviews with: Deputy Director: HIV/AIDS, Department of Social Development; and HIV/AIDS managers in provincial education, health and social development/welfare departments.

What enabled this rapid improvement in spending and absorption capacity? As mentioned previously, with the NIP now past its first painful start-up year, national co-ordination structures in the Department of Health are running more smoothly, provincial HIV/AIDS NIP programme co-ordinators posts are mostly filled, and wrinkles in the CG business plan approval and financial reporting processes are being worked out. The following section examines the track record of each CG in an effort to identify other specific contributors to this improvement.

4.3.2 By sector

4.3.2.1 Health

According to the 2002 Division of Revenue Bill, all budgeted funds were transferred to the provinces in 2000/1. Yet reported under-spending was 30%, due to provinces receiving funds very late and weak capacity at provincial level.[47] However according to our calculations, provinces spent 59.5% of the R16.8 million in health HIV/AIDS CGs in 2000/1. At that point near the end of 2001, National Treasury predicted that all funds for 2001/2 would be spent, and asserted that the Department of Health has taken the problem of under-spending seriously and worked to research problems and to develop counter measures.[48]

At this point we encounter a serious problem because of the lack of available information on whether unspent funds were rolled-over from one year to the next (See Box 2). If one uses National Treasury's

[47] DOR, Appendix E1: Frameworks for CGs to Provinces, 2002, pg. 75.
[48] DOR, 2002, pg. 75.

figure of R46 million actual expenditure for 2001/2, then unspent health CG funds for HIV/AIDS in 2001/2 amounted to R8 million.[49] However according to the 2002 Adjusted Estimates, none of these funds were rolled-over into the next budget year. [50] However its very likely funds were indeed rolled-over because CG expenditure - as reported in National Treasury statements - far exceeds 100% in a number of cases. For example, the Eastern Cape reported R11.395 million actual expenditure for 2001/2 to National Treasury but its total allocation for that year was only R6.281 million.

Table 4.4 shows how much each province spent each year - it is likely to include expenditure of funds rolled-over from the previous year, and thus shows how much total expenditure increased year on year.

Box 2. Problems with data

Our research is complicated by numerous instances of conflicting data. National Treasury Statements of Expenditure, compiled based on information obtained by the provinces and published monthly on their website, provide actual expenditure figures for each conditional grant by province. However these figures have frequently conflicted with information received directly from the provinces - in interviews and personal correspondence with HIV/AIDS managers and chief financial officers in the provincial social service departments. There are three main reasons this might occur:

- Government operates on a cash accounting system - not an accrual basis - so that expenditure is only recorded when payment is actually made. Therefore funds committed in contracts will not show up in the books until cheques are actually paid out.

- Provinces often will not rectify their books until the end of the financial year, at which point expenditures will be corrected and assigned to the correct cost centres and codes. For example, provinces might incorrectly include expenditure from the department's regular budget in the conditional grant financial reports, and only later reassign the expenditure.

- There is a lack of available information on roll-overs of unspent funds. The Adjusted Estimates published in October/November of each financial year ostensibly includes information on unspent funds rolled-over from the previous budget. However it is likely not all conditional grant roll-overs are identified in the Adjusted Estimates. This confuses calculations and can lead to inflated actual expenditure records. For example, if provincial actual expenditure figures for 2001/2 include expenditure of funds rolled-over from 2000/1, the comparison with the 2001/2 budget allocation could easily result in a figure over 100%.

As a result, figures can vary significantly, which means that budget analysis is limited and its conclusions must be qualified. For example, National Treasury statements give a figure of R11.395 million actual expenditure for 2001/2 for the Eastern Cape for their HIV/AIDS health conditional grant. However personal correspondence with Mrs Nonzwakazi Madonsela, Deputy Director of the HIV/AIDS and STDs, at the provincial health department provided a different figure of R2.899 million. The lower figure probably underreports expenditure, as systems were not yet in place to capture all conditional grant spending.

In this report, we use the National Treasury statements and budget documents as a starting point, and then are forced to make judgement calls. In all situations where there are contradictions or adjustments made, we have stated our assumptions and reasons in notes.

[49] National Treasury. " Provincial Budgets." 31 July 2002. Pg. 16.
[49] *Adjusted Estimates of National Expenditure 2002*. Pg. 97.
[50] *Adjusted Estimates 2002*. Pg. Viii. The Department of Health did roll-over R23.839 million from 2001/2 into 2002/3 but these were funds for pharmaceutical services, capital works, the Integrated Nutrition Programme and mortuaries - not HIV/AIDS interventions.

Graph 4.3, in contrast, tries to disentangle expenditure of roll-over funds from the previous year so that instead we can compare how well provinces are able to spend their present year's CG allocation. (For example, Table 4.4 compares expenditure in 2001/2 to 2002/3, while Graph 4.3 compares expenditure in 2001/2 to the budgeted allocation for 2001/2.)

In 2001/2, national more than doubled the amount the provinces were asked to spend to R54.4 million, yet provinces managed that year to *increase* their aggregate spending record to 82.9%.[51] [52]

When we include roll-over funds, we see that in 2001/2 provinces spent over four times the amount they did the first year. By our calculations, aggregate actual expenditure on the HIV/AIDS health CG in 2001/2 was R50.525 million, compared to R10 million spent the previous year.[53] (See Table 4.4).

Table 4.4: Actual expenditure on health HIV/AIDS conditional grants, by province (2001/2 and 2002/3) ~ includes expenditure of funds rolled-over from previous year

R million	Unaudited provincial actual spending 2001/2	Provincial actual spending 2002/3	Percent increase in actual expenditure
Eastern Cape	11.395	24.758	117%
Free State	3.767	16.884	348%
Gauteng	4.409	16.113	265%
KwaZulu-Natal	14.240	80.857	468%
Mpumalanga	1.528	7.946	420%
North West	2.254	21.245	843%
Northern Cape	4.665	5.727	23%
Limpopo	4.701	18.517	294%
Western Cape	3.566	11.519	223%
National Total	50.525	203.566	303%

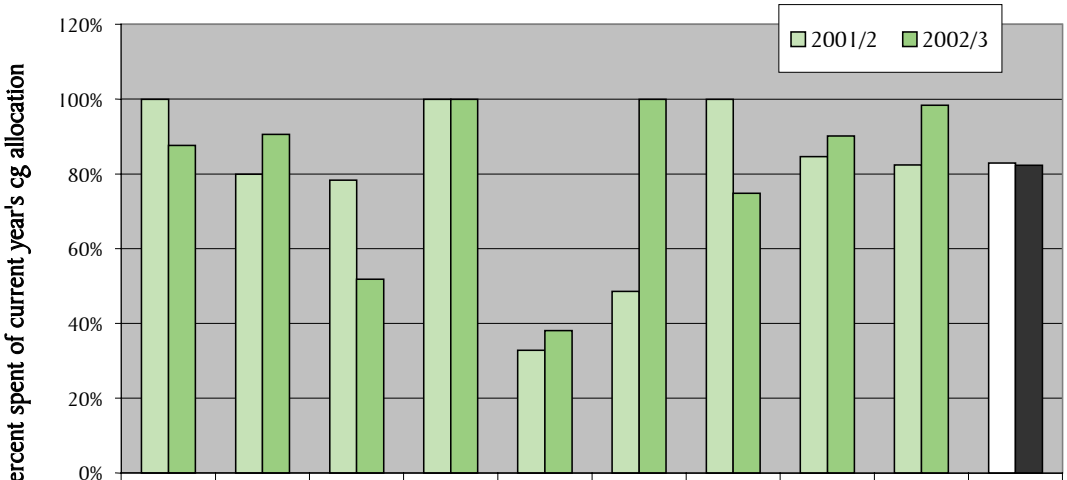
Source: Figures are taken from Statement of the National and Provincial Governments' Revenue, Expenditure and National Borrowing as at 31 March 2003 Issued by the Director-General: National Treasury except in the following cases:

Free State: *Correspondence with Mr. ONV Fundakubi, Manager: Financial Planning & Control, indicates that the 2002/3 figure of R16.884m listed in BS, pg. 205 is estimated expenditure. National Treasury Statements instead list R18.657m.*
Northern Cape: *NC 2003 Budget Statement, pg. 226 lists R5.727 million estimated actual expenditure for 2002/3 (Subprogramme 2.6 only contains CG). National Treasury statements instead indicate R7.657m.*
KZN: *There is contradictory information. National Treasury statements give a figure of R80.857 million for 2002/3. In a presentation to the Parliamentary Health Committee (14/3/03), KwaZulu-Natal reported that they overspent on their CG allocation by R57.612m which then had to be paid back from the department budget.*
North West*: NT Statements give actual expenditure for 2002/3 as R23.567m. Presentation to Parliamentary Health Committee 16 April 2003 gives figures of R21.245m.*

[51] This figure does not included expenditure of any funds rolled-over from the previous year—it is the percent spent of the current year's CG allocation. See Graph 4.3.
[52] Government admitted that actually in 2001/2 "underspending was a problem in some provinces, but procedures were simplified for 2002/3". Government claims that 43.1% of the health HIV/AIDS CG funds were spent by end of December 2002: "Four provinces remain significantly underspent; additional funds have been targeted forwards provinces with stronger spending performance". (Division of Revenue Bill 2003, pg. 87.)
[53] The 2003 IGFR and Provincial Budgets: 2001 Outcome and 2002 MTEF Budgets (31 July 2002) give aggregate percentages for HIV CG spending for 2001/2 which are slightly different for health than ours (which were reached by adding up individual provincial spent). For the health HIV/AIDS CG, they reported that only R46 million was spent (pg. 16), when our calculations put it higher (R50.5 million).

Graph 4.3: Percent spent of 2001/2 and 2002/3 health HIV/AIDS conditional grant allocation, by province

~ not including expenditure on rolled over funds



	Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Mpuma-langa	North West Province	Northern Cape	Limpopo	Western Cape	National
2001/2	100%	80%	78%	100%	33%	49%	100%	85%	82%	83%
2002/3	88%	91%	52%	100%	38%	100%	75%	90%	98%	82%

Source: Figures are taken from Statement of the National and Provincial Governments' Revenue, Expenditure and National Borrowing as at 31 March 2002, and as at 31 March 2003 except in the cases of Free State, Northern Cape and KZN (see source note in Table 4.4). Also, in a number of cases provinces reported spending to National Treasury which exceeded their CG allocation. (This occurs when provinces report expenditure of departmental funds in addition to CG funds, or when provinces report on expenditure of funds rolled-over from the previous year). In these cases, we have adjusted the figures here to instead show 100% expenditure--so as to ensure that aggregate spending records are not biased upwards. This adjustment was made in the following cases:

***2001/2* Eastern Cape:** *National Treasury statements give a figure of R11.395m. (Personal correspondence with provincial health dept gives figure of R2.899m, although this probably underreports expenditure as systems were not yet in place to capture all CG spending.)*

***2002/3* KwaZulu-Natal:** *R80.857m; North West R23.567m.*

Beginning in Budget 2002/3 the Department of Health has substantially loosened restrictions on provincial CG spending on HIV/AIDS. Instead of requiring a detailed breakdown from provinces, the Department of Health has identified a list of interventions and left provinces with the flexibility to allocate resources to activities that they prioritise.

By our calculations, aggregate actual expenditure for the health HIV/AIDS CG has increased from 59.5% in the first year to 82.2% in 2002/3 (see Table 4.3).

Pressure on provincial HIV/AIDS managers to spend increased CG amounts continues in Budget 2003/4. In 2003/4 the total health HIV/AIDS CG allocation is R333.556 million. This can be compared to R210.209 allocated the previous year. To achieve full expenditure, provinces will need to spend over 60% more than they did in 2002/3, or a further R130 million compared to last year.

4.3.2.2 Education

According to official budget documents, achievements on this grant are:

- 2000/1: Spending was 23% of allocated funds. Eleven HIV/AIDS provincial co-ordinators were appointed and computers obtained.[54] Also nine financial administrators were appointed;[55]
- 2001/2: Contracts of provincial Lifeskills co-ordinators were extended; [56] HIV/AIDS booklets printed & distributed in each province; [57]
- 2002/3: 46.5% spent up to end of December 2002. "HIV/AIDS provincial co-ordinators have been re appointed and vacancies filled as they arise. National co-ordinator has been appointed and this has enhanced project management capacity, effectiveness and efficiency." [58]

Table 4.5 and Graph 4.4 show actual expenditure of Lifeskills CG funds, including expenditure of funds rolled-over from the previous year. Details on roll-over amounts were not available, but likely account for the massive increases in spending from one to the next in Mpumalanga, North West, Free State and Western Cape particularly.

It must be noted that these figures in Table 4.5 are taken from National Treasury statements and may differ from actual expenditure figures from the national department and provinces. The prime case is Gauteng, which spent zero in 2001/2, according to the National Treasury statements as at 31 March 2002. However the national Lifeskills co-ordinator in the Department of Education reports that Gauteng's expenditure was actually 81.06% that year.[59] The inaccuracy of the National Treasury figures, and the contradiction with the Department of Education and provincial figures, is worrying and an important finding of this report.

As a further example of this, the actual expenditure figures reported to National Treasury for 2002/3 (Table 4.5) exceed the CG allocation for that year in six provinces.[60] Since spending over 100% of CG funds is not possible, the only explanation is that either provinces are reporting expenditure on funds rolled-over from the previous year, or they are erroneously including expenditure of departmental funds in their CG reporting to National Treasury. (In the second scenario, it is essentially an administrative issue related to accounting codes; provinces spend from their line budgets, causing an overspend to show up on CG reports. Later provinces correct records by debits. See Box 2.)

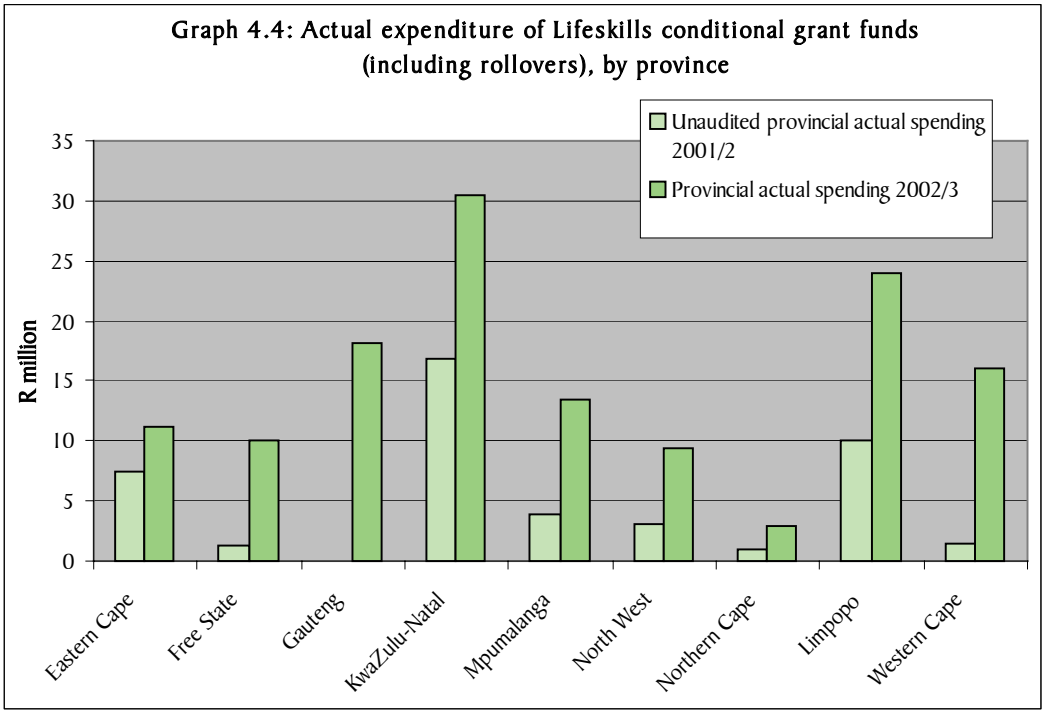
[54] DOR Appendix E1: Frameworks for CGs to Provinces, 2002, pg. 79.
[55] Interview with Brennand Smith, National Life Skills Co-ordinator, National Department of Education.
[56] Ibid.
[57] Division of Revenue Bill 2003, pg. 82.
[58] Ibid.
[59] Personal correspondence with Brennand Smith, National Life Skills Co-ordinator, National Department of Education.
[60] Free State, Mpumalanga, Northern Cape, Limpopo, Western Cape, and Gauteng. See Appendix 2.

Table 4.5: Actual expenditure on Lifeskills education HIV/AIDS conditional grants, by province
(includes expenditure on rolled-over funds)

R million	Unaudited provincial actual spending 2001/2	Provincial actual spending 2002/3	Percent increase in actual expenditure
Eastern Cape	7.377	11.163	51%
Free State	1.232	10.083	718%
Gauteng	0	18.154	-
KwaZulu-Natal	16.8	30.403	81%
Mpumalanga	3.895	13.449	245%
North West	3.115	9.452	203%
Northern Cape	0.944	2.859	203%
Limpopo	9.969	23.906	140%
Western Cape	1.391	16.005	1051%
National Total	44.723	135.474	203%

Source: Statement of the National and Provincial Governments' Revenue and Expenditure and National Borrowing as at 31 March 2002, and as at 31 March 2003.

Graph 4.4: Actual expenditure of Lifeskills conditional grant funds (including rollovers), by province



Source: Statement of the National and Provincial Governments' Revenue and Expenditure and National Borrowing as at 31 March 2002, and as at 31 March 2003.

Table 4.6 shows actual expenditure as a percent of the current year's allocation (based on National Treasury expenditure statements and adjustments to exclude roll-over expenditure). It shows that despite rapid increases in allocations *plus* added pressures from unspent funds rolled-over, provinces still managed to improve their spending records from 66% in 2001/2 to 87% in 2002/3.

Table 4.6: Percent spent of 2001/2 and 2002/3 Lifeskills conditional grant allocation, by province ~ not including expenditure on rolled-over funds

	2001/2	2002/3
Eastern Cape	63%	41%
Free State	31%	100%
Gauteng	0%	100%
KwaZulu-Natal	100%	96%
Mpumalanga	84%	100%
North West Province	61%	82%
Northern Cape	78%	100%
Limpopo	100%	106%
Western Cape	28%	100%
National	66%	87%

Source: Own calculations. Figures are taken from Statement of the National and Provincial Governments' Revenue, Expenditure and National Borrowing as at 31 March 2002, and as at 31 March 2003. Also, in a number of cases provinces reported spending to National Treasury which exceeded their CG allocation. (This occurs when provinces report expenditure of departmental funds in addition to CG funds, or when provinces report on expenditure of funds rolled-over from the previous year). In these cases, we have adjusted the figures here to instead show 100% expenditure - so as to ensure that aggregate spending records are not biased upwards. This adjustment was made in the following cases:
2001/2: *KZN (R16.8m)*
2002/3: *KZN (R80.857m), Mpumalanga (R13.449m), Northern Cape (R2.859m), Western Cape (R16.005m), Gauteng (R18.154m)*
Note: Limpopo Department of Education indicated that actual expenditure in 2001/2 was R1.434m, not R9.969m as reported to National Treasury.

As with the health CG, sufficient information on roll-over funds is unavailable for the Lifeskills CG, and raises concern that not all unspent funds are being rolled-over into the next financial year. According to National Treasury, unspent funds in 2001/2 were R19 million.[61] However according to the Adjustments Estimate published by National Treasury which theoretically lists all roll-overs, in Budget 2002/3 the Department of Education rolled-over only R605 thousand in Lifeskills CG money which went unspent in 2001/2 due to "outstanding claims for the printing of HIV/AIDS materials".[62] This would indicate that only 3.2% of the unspent HIV/AIDS Lifeskills CG funds from 2001/2 were rolled-over into 2002/3. This suggests that either the National Treasury figures are inaccurate or the Adjustments Estimate is not capturing all roll-over funds.

4.3.2.3 Social Development

According to National Treasury and the Department of Social Development, accomplishments on this CG are as follows: [63]

- 49 sites established, bringing the total number of sites to 55. (When sites funded via the Poverty Relief Programme are included, the total number of sites increases to 185);
- Approximately 50 000 children reached;
- Rapid appraisal of home/community based care identified 466 projects of which 136 received government funding;

[61] National Treasury. "Provincial Budgets." 31 July 2002. Pg. 16.
[62] *Adjusted Estimates 2002*. Pg. 78.
[63] Division of Revenue Bill 2003, pg. 97.

- "Practice guidelines were developed and made available to NGOs, CBOs, and government officials to assist them in providing services to children within the basic parameters of children's rights and childcare legislation." [64]

National Treasury reported that aggregate spending on this grant for 2000/1 was only R2 million of the R5.62 million allocated.[65] Free State managed to spend 100% of its allocation and Limpopo spent 87% of its budget. [66] However the rest of the provinces had a very difficult time in that first year. North West spent none of its allocation and rolled-over the entire R1 million budget into 2001/2. Northern Cape reported only R68,000 expenditure and required that the balance of its R1 million budget be rolled-over. It is unclear whether Eastern Cape and Mpumalanga were able to spend any of their allocations.

However provinces rapidly picked up the pace in 2001/2. Not only did provinces do much better at spending their CG budgets in 2001/2, some provinces also managed to spend the entire unspent funds from 2000/1 which were rolled-over into 2001/2. For example, Northern Cape, North West and Limpopo managed to spend all their unspent funds from the previous year *in addition* to large shares of their current 2001/2 CG budget.

If instead we only look at provinces' expenditure record on the current year's CG budget (i.e. expenditure of funds rolled-over from the previous year are not included), we see that expenditure in 2000/1 was only 35.6% but that on aggregate provinces spent 81.3% of the total CG budget for 2001/2. That percentage rises to 92.7% in 2002/3 (see Table 4.3 and Appendix 3).

Table 4.7 and Graph 4.5 show actual expenditure of both current budget *and* rolled-over funds. It compares across years to show the rapid increase in spending. The figures tell a success story of how provincial HIV/AIDS managers were able to rapidly increase their absorption capacity from one year to the next.

[64] Division of Revenue Bill 2003, pg. 97.
[65] 2002 Division of Revenue Bill, pg. 88.
[66] Information on 2000/1 expenditure obtained from personal correspondence with Ms. J. De Beer, Deputy Director: HIV/AIDS in Department of Social Development.

Table 4.7: Actual expenditure of social development/welfare HIV/AIDS conditional funds, by province (includes expenditure of funds which were rolled-over from previous year)

R million	2001/2	2002/3	Percent increase in actual expenditure
Eastern Cape	1.921	4.798	150%
Free State	1.500	8.858	491%
Gauteng	1.000	6.983	598%
KwaZulu-Natal	1.285	5.144	300%
Mpumalanga	2.272	7.102	213%
North West	1.135	5.463	381%
Northern Cape	2.432	2.706	11%
Limpopo	1.601	3.135	96%
Western Cape	0.983	2.084	112%
National Total	14.129	46.273	227%

Source: Statement of the National and Provincial Governments' Revenue and Expenditure and National Borrowing as at 31 March 2002, and as at 31 March 2003. Figures are corrected against information obtained from Ms J. De Beer, Deputy Director: HIV/AIDS at the Department of Social Development.

Eastern Cape: *According to J. De Beer, expenditure was only R750,000 with R761,000 under-spent and requested as roll-over. National Treasury statements give R1.921m figure as actual spent. We assume that the entire R950,000 of unspent funds from 2000/1 were rolled-over and became part of the 2001/2 expenditure.*

KZN: *National Treasury statements give figure of R1.499m. According to J. De Beer, expenditure is R1.285m.*

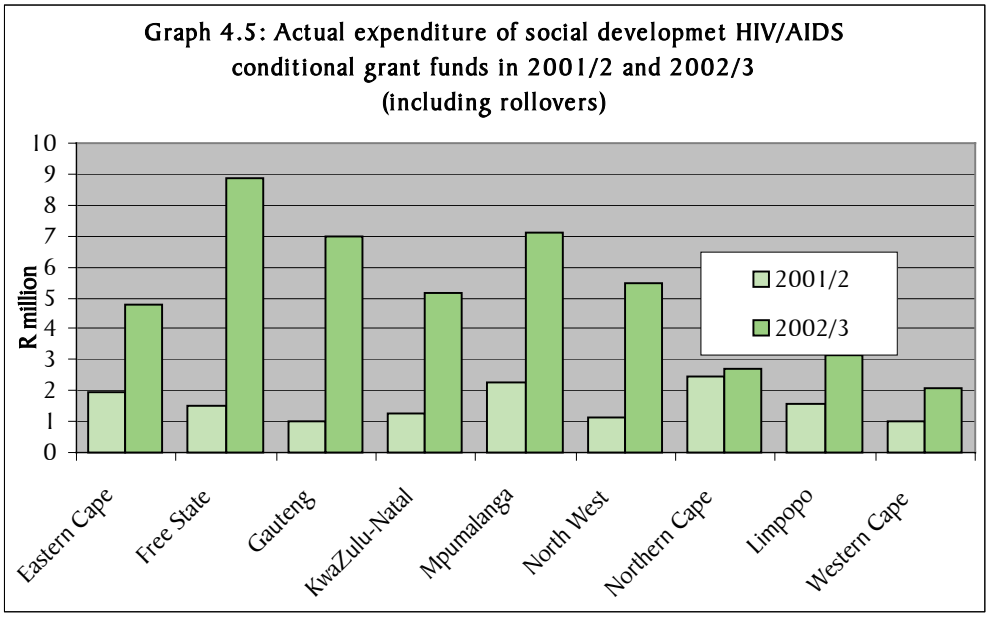
Mpumalanga: *Most likely the entire unspent amount from 2000/1 of R960,000 was rolled-over into 2001/2. Total spent during 2001/2 (according to J. De Beer) was R2.446m. National Treasury statements give figure of R2.272m.*

North West: *Total expenditure during 2001/2 was R1.135486m (according to J. De Beer) This includes expenditure of R1 million rolled-over from the previous year. National Treasury statement give a figure of R1.151m actual spent for 2001/2.*

Northern Cape: *R932,000 was rolled-over from 2000/1, according to J. De Beer. Total expenditure reported in National Treasury of R2.432m is complete spending of 2000/1 and 2001/2 allocations.*

Limpopo: *Total expenditure listed in National Treasury of R1.601m is complete spending of both 2001/2 allocation and R101,000 rolled-over from 2000/1, according to J. De Beer.*

Graph 4.5: Actual expenditure of social developmet HIV/AIDS conditional grant funds in 2001/2 and 2002/3 (including rollovers)



Source: Statement of the National and Provincial Governments' Revenue and Expenditure and National Borrowing as at 31 March 2002, and as at 31 March 2003. Personal correspondence with J. De Beer, Deputy Director: HIV/AIDS at National Department of Social Development. See source notes for Table 4.7.

4.4 Processes, structures and obstacles for spending

As administering agents for the CGs, the responsible national department also sets out the conditions, reporting requirements, monitoring procedures and payment schedules. Thus the three HIV/AIDS CGs each have different structures and procedures for spending. This section describes the procedures set out by national and also describes the experiences of provinces - based on interviews conducted with provincial managers in the three sectors.

4.4.1 Lifeskills education conditional grant

Staffing and management. Overall co-ordination of the Lifeskills programme is shared by a Lifeskills co-ordinator in the national Department of Education and a Lifeskills co-ordinator located in the HIV/AIDS Directorate at the Department of Health. At the inception of the NIP, the Department of Health facilitated the introduction of the Lifeskills programme by hiring two consultants as Lifeskills co-ordinators - one for primary schools and one for secondary schools. Upon the employment of a national Lifeskills co-ordinator in the Department of Education, the Department of Education took over full responsibility for Lifeskills implementation in schools.[67] Later, one of the Department of Health Lifeskills consultants resigned, the post was dissolved, and the remaining consultant's new focus became the development of Lifeskills material for out-of-school youth. The national Lifeskills co-ordinator in the Department of Education is located in the Chief Directorate: Curriculum and Assessment Development and Learner Achievement. [68] [69]

To support this management structure, a portion of the global Lifeskills budget is retained by the Department of Education (R6 million) and the Department of Health (R2 million) for management. Nearly 60% of this amount funds the salaries of provincial co-ordinators.[70] In each provincial education department, the national Department of Education funds a Lifeskills co-ordinator post (one-year renewable contracts) as well as an administrative/financial person. These provincial posts are on the national payroll; technically speaking, provincial departments pay salaries and then claim reimbursement from the national Department of Education. However since the original appointments in 2000, some people have left and a number of posts are vacant. In a few provinces (e.g. Eastern Cape, Limpopo and KwaZulu-Natal), there are a total of three nationally funded posts (two co-ordinators plus one administrative post) instead of the usual two. This is due to the size of these provinces and the larger number of learners.

Importantly, at least two provinces have not simply relied upon national to finance their Lifeskills staff but have created additional Lifeskills posts in their provincial education departments which are funded from the regular provincial education budget. For example, the Northern Cape has three of its own posts in addition to the two nationally funded positions; Gauteng has four provincially funded staff in addition to the two posts paid by the national Department of Education.[71] From the perspective of sustainability, this development in two provinces is important as it shows provincial budgetary commitment to the programme.

[67] Personal correspondence with Anita Marshall, National Co-ordinator - National Integrated Plan, Department of Health.
[68] Interview with Brennand Smith, National Life Skills Co-ordinator, National Department of Education.
[69] Division of Revenue Bill 2003, pg. 82.
[70] Information in this section obtained from interview with Brennand Smith, National Life Skills Co-ordinator, National Department of Education.
[71] Interview with Brennand Smith, National Life Skills Co-ordinator, National Department of Education.

Despite these developments, in Idasa interviews with provincial Lifeskills co-ordinators, it was reported that shortage of personnel who staff the HIV/AIDS Lifeskills programme at provincial and district levels impacts negatively on the roll-out and implementation of the programme. In some provinces, district offices have HIV/AIDS co-ordinators who are not full-time but have had this component added to their job description. In response to this staffing shortage, some provinces have included additional staff at provincial or district level in their 2003/4 business plans - although those posts are short-term contracts. However the net result is considerable disparity between provinces in terms of capacity and number of staff managing the Lifeskills programme - at both provincial and district level. KwaZulu-Natal is one example where there is plenty of staff: one director, one programme manager, two provincial co-ordinators and eight regional/district co-ordinators.[72] This can be compared to Eastern Cape where one provincial co-ordinator/manager handles the entire programme due to a vacancy at provincial level and no current posts at district level.[73]

In summary, the variation in size and structure of management of Lifeskills programmes among provinces is largely due to a) varying commitments by provinces to the Lifeskills programme in terms of establishing dedicated posts in addition to those funded by the Department of Education, and b) varying degrees of programme maturity in terms of devolving management and establishing posts at district level.

Business plans. Provinces submit business plans for approval by the Department of Education, prior to the transfer of any CG funds. Those plans are written with a two-year horizon and address the eight programme objectives jointly decided upon in 2001/2 by provincial and national Lifeskills co-ordinators. Those objectives are: advocacy; peer education; teacher development and training; school-based activities; care and support; monitoring and evaluation; administration; and learner and teacher support materials. In the 2002/3 and 2003/4 budget cycles, the Department of Education organised workshops for provincial co-ordinators to provide technical training on business plan preparation. For 2004/5, business plans will be submitted in October/November 2003 with an approval letter from national sent out in February 2004.

Payments and reporting. Upon approval of the business plans, payments are now made in four instalments, with the first on 15 April. This is a change from the previous budget cycle when there were two tranches. The increased number of payments allows the Department of Education more control and closer monitoring over provincial expenditure. Actual expenditure reports from provinces are due on the 15th of each month, with financial and activity reports due every six weeks. These regulations are in line with the Division of Revenue Act and the Public Finance Management Act, which permit the Director-General to withhold payments to provinces if necessary. However these reporting requirements and increased number of payments are an example of the bureaucratic obstacles which have the potential to slow spending and complicate implementation, from the provinces' perspective. In Idasa's interviews with provincial Lifeskills co-ordinators, some provinces reported a lack of skills with regard to financial and project management. There is also an indication that inefficient finance systems result in delayed transfers of payments to NGOs, consequently delaying service delivery. However it is precisely these weaknesses which necessitate close support and monitoring from the national Department of Education.

Devolving budgets to district level. Expenditure of Lifeskills CG funds is further complicated by the fact that provinces frequently devolve large portions of their funds to district level, and districts may in turn transfer funds to schools. The national Lifeskills co-ordinator estimates that most provinces send approximately 40-50% of their budgets to districts; about one quarter of that money is further devolved

[72] Interviews with Dr. Gumede (Director of Psychological Guidance and Special Education Services) and Mr. Khumalo (Manager of the HIV/AIDS Life Skills Programme), KZN Department of Education.
[73] Interview with Mrs Gwarube, HIV/AIDS Lifeskills Manager/Provincial Co-ordinator, Eastern Cape Department of Education.

to schools for school-based activities. For example, Gauteng, KwaZulu-Natal and Free State currently devolve portions of their Lifeskills funds to districts; most provinces are planning to do the same in the next financial year. In the case of Gauteng, funds are further devolved to schools. The common procedure is that schools write a business plan or proposal for a particular HIV/AIDS-related activity and districts then transfer the required budget. (The situation is different for non-Section 21 schools where districts essentially spend the funds directly on behalf of the school.) Such funding flows require strong financial systems at the provincial and district level and also depend upon business-plan writing skills on the part of schools. Ultimately the Department of Education is looking to support the establishment of self-managing districts and schools, so that in the next round of provincial business plans, the devolution of funds to district and school level will be encouraged.

Issues related to outsourcing and tendering. Provincial Lifeskills programmes rely heavily on outsourcing for particular aspects of their implementation, particularly publication of learner support materials, teacher training (largely by NGOs or higher education institutions) and monitoring and evaluation functions. The national Lifeskills co-ordinator estimates that approximately 50-60% of the total provincial Lifeskills budget is tendered amounts. Outsourcing can increase effectiveness (by capitalising on the skills and experience of NGOS, for example) and reduce costs (by using service providers or suppliers who can produce the learner support materials more cheaply, for example).

However outsourcing can also have adverse affects, not the least of which is the time-consuming tender process triggered when costs of services or supplies exceed the province's tender limit. Provinces have reported that procurement procedures are very rigid and characterised by highly protective yet essential rules. Tendering or outsourcing is unrealistically difficult and has been described as being "messy".[74] For example, some provinces can spend up to R750,000[75] without going out to tender, while other provinces have a tender limit of only R2,000.[76]On top of this disparity is the impasse of tender board meetings and their timeliness for responding to service delivery demands. It is reported that tender board members are very busy individuals who are hard-pressed to find time to read tender documents and discuss and review tender requests.

Provincial co-ordinators also identified other problems associated with outsourcing, which are not necessarily unique to the Lifeskills programme but may be experienced by other government departments:

- As a result of reported delays and inefficiency with regard to invoicing, payouts, reporting and accountability, official financial reports on programmes are released incomplete. The reality is that by the end of a financial year some invoices are still pending – waiting to be processed and paid. Typically, the story from departments goes: "Alright, that's what's indicated there (on the financial report), but the reality is a little bit different."[77] For example, in addition to the 30 days required for payment, delay may result from invoices being submitted late, or service-providers or suppliers not paying on time.

- Secondly, in some instances outsourcing/tendering is more expensive compared to using the government's internal expertise. Necessary skills may be available within the government system itself. For instance, Peter Fenton of the Western Cape Lifeskills programme stated that there are experts from partner departments - Health and Social Development - capable of providing the services the Department of Education currently obtains from external agents through tendering. Further, the Western Cape Lifeskills programme mainly runs its own training programme and "spends R300 per

[74] Mrs. Speckmeier, Free State Department of Education, Lifeskills Programme.
[75] Northern Cape.
[76] Western Cape.
[77] Ibid.

person/educator on Lifeskills training whereas other provinces are spending around R1500 a head because they outsource it." [78] According to the national Lifeskills co-ordinator, this occurs where there is insufficient capacity within the department - perhaps due to restructuring in the department, vacant posts, and/or insufficient personnel.[79]

- Thirdly, outsourcing may impede skills development in the public sector. NGOs and experts from outside the government system provide training and services and then leave with their skills. It is left to the provinces to ensure there is added capacity within the government system to foster self-sufficiency and interdependency of government departments.

- Fourthly, according to the Public Finance Management Act (PFMA), accounting officers in departments retain accountability for activities and expenditure that are outsourced. However outsourcing training has the potential to distance the department from responsibility and accountability so that "the problem is then given to somebody else to deal with it". [80] As a result, departments may report budgets spent and objectives achieved when in fact the funds are only "committed" to NGOs and other service providers.

Other issues related to spending. Restrictions attached to CG spending also create problems. Provinces have reported lack of sufficient resources, such as staff, computers, transport, etc. However stipulations attached to CG funds bar their expenditure on particular items. For example, KwaZulu-Natal noted that although computers were essential to proper functioning, these were non-allowable costs.[81]

Although some provinces do finance Lifeskills posts, the issue of whether provincial departments provide necessary support to the Lifeskills programme remains. In Idasa's interviews with provincial Lifeskills co-ordinators, the concern was expressed that the national Department of Education assumes that provincial education departments will supply the necessary infrastructure for implementation and expenditure of the CG funds, when this is not always the case. Yet, for example, on the issue of computers, national notes that the Department of Education has assisted with the purchase of computers for all provinces. [82]

Finally, although some provinces (as noted above) finance Lifeskills manager positions at provincial and/or district level and provincial education departments contribute in-kind support to the Lifeskills programme, it appears from budget documents and interviews that no provinces contribute themselves to the budget of the Lifeskills programme. Provincial contributions to the Lifeskills budget (in addition to CG funds from national government) would not only ease budgetary pressures but may well increase expenditure - due to the fact that funds sourced from provincial department allocations are more flexible and do not carry the same strict spending requirements attached to CG funds. However, with regard to the question of whether the CG amounts were adequate, some co-ordinators say it is difficult to comment on sufficiency of funding due to shortage of staff to spend funds already available. This suggests the most urgent issue remains securing fully staffed and skilled management at provincial and district levels.

[78] Interview with Peter Fenton, Western Cape Department of Education, Lifeskills programme.
[79] Interview with Brennand Smith, National Life Skills Co-ordinator, National Department of Education.
[80] Peter Fenton, Western Cape Department of Education, Lifeskills programme.
[81] Interview with Dr Gumede (Director of Psychological Guidance and Special Education Services) and Mr Khumalo (Manager of the HIV/AIDS Life Skills Programme), KwaZulu-Natal Department of Education.
[82] Personal correspondence with Anita Marshall, National Co-ordinator - National Integrated Plan, Department of Health.

Table 4.8 Lifeskills conditional grant transfer procedures and conditions, 2003/4

MEASURABLE OBJECTIVES	○ Additional 200 trained master trainers. ○ Additional 15,000 trained primary and secondary school teachers. ○ Verified implementation of Lifeskills programme in additional 35% of primary and secondary schools. ○ Peer education framework conceptualised and piloted in six secondary schools per province. ○ Course for Lifeskills programme for teachers designed and related support material developed. ○ "Ongoing training of life orientation educators, and other educators in sex ed and care, support of infected and affected learners and educators, which they have to teach to learners as part of a compulsory curriculum in schools." ○ "Training of all educators in the system in Lifeskills to deal with their own sexuality and risk of HIV/AIDS infection."
CONDITIONS	Provincial business plans must be approved by the accounting officer in the Department of Education before release of first instalment. Also business plans must address outputs/measurable objectives.
PAYMENT SCHEDULE	Payment schedule is four instalments (15 April 2003; 15 July; 15 October; 15 Jan 2004).
MONITORING	Monitoring is done via interdepartmental and interprovincial meetings arranged by three departments. Evaluations are conducted by the Department of Education.

Source: National Treasury, 2003 Division of Revenue Bill, pg. 82.

4.4.2 CHBCS from the Department of Social Development

For the Department of Social Development, the primary challenge concerns the slow and pain-staking processes required when working with and in communities. Building relationships and making inroads can take six months before programmes can be up and running.

Business plans. This financial year, the Department of Social Development kept R1.6 million of the CHBCS CG funds at national level (for printing manuals on home-based care and child care forums; contract workers, etc.) and sent the rest to the provinces in three tranches. Business plans outlining how provinces anticipate using the funds are due to the Department of Social Development by January. Those business plans include activity budgets with specific information on what funds will be spent on, anticipated cash flow and performance indicators.

The plans are adjusted and refined via a back-and-forth process between national and provinces. Ultimately the provincial head of department must sign off on business plans, then signatures of the chief finance officer and director general at the Department of Social Development are required. The Department of Social Development uses a matrix to evaluate provincial business plans and convenes a panel within the department annually to evaluate and approve the plans. The Department of Social Development considers the following aspects or components of the provincial business plans when making its evaluation:

- 3 year business plan
- Operational plan
- Cash flow
- Budget breakdown
- Indicators
- Children
- Youth
- Women
- Older people
- Disabled people
- Capacity building
- Child care forums
- Food parcels
- Funding NGOS (criteria and agreement)
- Monitoring and evaluation activities
- Contract workers appointed

Grant-making to NGOS. The bulk of CHBCS CG funds are disbursed to NGOS and CBOS. The national department funds a limited number of NGOS directly but the majority receive funds through a grant application process set up by each province. In essence, the NGOS and CBOs do the work, with national and provinces disbursing funds and monitoring expenditures and outcomes.

Each province has its own procedure for selecting grant recipients, although the application processes are largely similar. In Mpumalanga, the provincial department has set up a panel and prospective grant recipients are invited to present their proposals. KwaZulu-Natal has a very different system whereby the department essentially retains the funds and NGOS apply to the department for each expenditure. This system helps control expenditure but creates a slower process.

One problem with the current situation is timing. Earlier submission of business plans by provinces (e.g. October instead of May) would ensure that when the financial year begins and the Department of Social Development receives its budget allocation, the first tranche can immediately be paid to provinces, who then can move the funds to NGOs more quickly. Currently most spending is lumped in October-November, due to planning back-ups.

From the provinces' perspective, tendering and transfers to NGOs are indeed problems. The tendering process takes an enormous amount of time, delaying money transfers to NGOs and leading to delayed and somewhat late implementation of projects. Connected to the issue of NGOs is a lack of monitoring mechanisms designed for the NGO sector – it is important to develop a monitoring system for NGOs to measure impact and achievement of outcomes and objectives, as agreed upon in contracts between NGOs and the department.

Reporting. With respect to reporting, provinces send monthly expenditure reports to their provincial treasuries who then pass them to the Director of Budget Planning in the Department of Social Development. The CHBCS co-ordinator in the Department of Social Development then receives and checks them before they are sent to National Treasury. Provinces also complete monthly written reports showing project outputs and indicators. For this purpose, the CHBCS co-ordinator has developed a monitoring tool for provinces to use which allows provinces to insert data on progress towards key indicators. These monthly written reports require the following information from provinces:

- Type of services rendered to families and number of families reached.
- Services provided to children (provinces are asked to give breakdown for number of children orphaned by HIV/AIDS; HIV-positive children; children whose primary caregiver is HIV-positive; child-headed households; and children whose primary caregiver is AIDS-sick).
- Food parcels provided (number, cost, contents).
- Income-generation activities.
- Involvement of schools.
- Intersectoral collaboration amongst NGOs, CBOs and faith-based organisations.
- Child care forums (number in operation, activities).
- Volunteers (number, stipend provided, training).
- Services for youth.
- Total expenditure for the month, and breakdown by activity.

The CHBCS co-ordinator is then able to compile this data from provinces monthly and keep an ongoing tally. The net result is an ongoing database - maintained by national - with information on the beneficiaries, activities and scope of provincial CHBCS programmes. That database contains information, broken down by province, on the number of:

- ✓ Identified orphans and vulnerable children
- ✓ Child-headed households
- ✓ Placements of children in foster care
- ✓ Families assisted
- ✓ Food parcels disbursed
- ✓ Contract workers/co-ordinators employed by provinces
- ✓ Volunteers
- ✓ Volunteers trained
- ✓ Caregivers receiving stipends
- ✓ Women involved
- ✓ Provision of protein products and name of service providers
- ✓ Child care forums
- ✓ Funded initiatives (grants to NGOS and FBOS)
- ✓ Older people involved
- ✓ Youth trained and involved
- ✓ Support groups operating
- ✓ Bereavement support and burials
- ✓ Income generation projects

These numbers can then be compared to estimates of eligible beneficiaries to determine progress towards coverage targets. However provinces have noted that a system of identifying orphans may differ from province to province. According to provincial managers, national government expects reports but they do not look at the systems used and the validity and accuracy of information feeding into those reports. This means the national government should play an active role in what is happening at a provincial level.

Co-ordination with the Department of Health. The home-based care co-ordinator in the Department of Health originally spearheaded the support to NGOs and pro-actively ensured that the Department of Social Development participated.[83] In the present situation where the Department of Health and the Department of Social Development jointly implement the CHBCS programme (with separate but associated mandates), there is a real need for co-ordination between the Department of Social Development and the Department of Health on this programme, both at national level and within each province. The CHBCS co-ordinator in the Department of Social Development meets regularly with the CHBCS co-ordinator in the Department of Health, however co-ordination at the provincial level has been uneven. Originally the national CHBCS co-ordinators in the Department of Social Development and the Department of Health would travel to the provinces and convene full meetings of HIV/AIDS managers from the three departments. However this did not work as well as having each sector convene its own meeting and invite one or two representatives from the other departments.[84]

Interviews with provincial CHBCS managers echoed the need for co-ordination and clear channels of communication: "HIV/AIDS is a catastrophe that needs a powerful collaborative force to be attacked effectively."[85] Managers and co-ordinators are engaged in many activities that prevent them from having sufficient time to engage with other departments in the integrated strategy. Inadequate communication between departments creates confusion regarding who should be doing what - especially with the community and home-based care activities that run across health and social development sectors. Tension between the two departments may develop as a result of their activities landing on each other's territory without the knowledge of the other department.

[83] Personal correspondence with Anita Marshall, National Co-ordinator - National Integrated Plan, Department of Health.
[84] Interview with Ms. Johanna De Beer, Deputy Director: HIV/AIDS in Department of Social Development.
[85] Interview with Mrs. Nombembe, Eastern Cape Department of Social Development, CHBCS programme.

Staffing. DOR 2002 reports that the national department has set up a dedicated HIV/AIDS Directorate - consisting of the national co-ordinator, an associate, financial person and two contract people.[86] Provincial Departments of Social Development have appointed dedicated programme co-ordinators at provincial and district levels.[87] At this point, each provincial welfare department has an HIV/AIDS co-ordinator working primarily on CHBCS, and in a number of provinces district co-ordinators have also been employed as contract workers (North West and KwaZulu-Natal as two key examples). From the perspective of sustainability, the key issue is whether these posts are funded via regular provincial budgets or still covered by CG funds. The national CHBCS co-ordinator reports that provincial HIV/AIDS co-ordinators are now permanent officials paid by the provinces.

From the provinces' perspective, some CHBCS managers reported a need for further training because of lack of essential financial management expertise within the programme. Also the issue of working solo at the provincial office means that the HIV/AIDS manager/ co-ordinator has to take time to ensure all districts are catered for - in terms of allocations, monitoring, support, reporting and evaluations. This impacts negatively on the provincial HIV/AIDS integrated strategy because HIV/AIDS managers end up not having time to meet the cluster and actively participate in realising the strategy.

Table 4.9 Social development HIV/AIDS conditional grant transfer procedures and conditions, 2003/4

MEASURABLE OBJECTIVES	○ Increase in number of orphans receiving appropriate care. ○ Increase in number of identified children infected and affected. ○ Provision of essential material assistance to identified children and families. ○ Provision of alternative care to vulnerable children. ○ 50% of caregivers identified from communities, CBOs, NGOs, FBOs, families and volunteers to be capacitated through training and support. ○ provision of counselling and support services to children and families. ○ Increase in number of co-ordinating structures and partnerships for management and maintenance of social welfare services to children infected and affected.
CONDITIONS	Provinces must have their business plans - with measurable outputs - approved by the national co-ordinator. Also provinces must secure legal contracts signed between provincial departments and implementing agencies. (Previous DOR 2002 went further to state that business plans must be in place by 12 April.)
REPORTING	Provinces submit monthly and quarterly reports to national.
PAYMENT SCHEDULE	Payments are made in three instalments. Funds are sent to the provinces in three tranches: first is 30% of the total due to the province and is delivered about May. The second is 60% in September, with the final 10% disbursed in January.
MONITORING	Provinces are evaluated by national/provincial co-ordinators. There are also structured site visits twice a year by a team consisting of both the Department of Social Development and Department of Health on national and provincial levels.

Source: National Treasury, 2003 Division of Revenue Bill, pg. 97. 2002 Division of Revenue Bill, pg. 88.

[86] DOR, Appendix E1: Frameworks for CGs to Provinces, 2002, pg. 88. And interview with Ms. Johanna De Beer, Deputy Director: HIV/AIDS in Department of Social Development.
[87] Division of Revenue Bill 2003 Appendix E1: Frameworks for CGs to Provinces, pg. 97.

4.4.3 Health HIV/AIDS conditional grant

Provincial departments of health are a step ahead of other social cluster departments in that they have HIV/AIDS (sub)directorates that are equipped and staffed with full-time personnel to implement HIV/AIDS activities in the health sector. In some provinces, provincial co-ordinators are employed on a permanent basis by provincial departments. In addition to provincial co-ordinators, HIV/AIDS co-ordinators are placed at a district level to facilitate and roll out the programme.

Similar to the CGs from the Department of Social Development and the Department of Education, provincial health departments must submit a business plan to the Department of Health prior to the transfer of CG funds. Despite the expansion of the CG to include funds for eight different types of activities (see Appendix 1), the funds are transferred as one payment to the province each quarter. A narrative report (covering all activities) is due to the NIP co-ordinator at the Department of Health each quarter, and expenditure reports (noting expenditure per programme) are submitted monthly.[88] Provinces report that the introduction of the more flexible CG for health in 2003/4 is welcomed and facilitates their spending. Flexibility has helped them do things not previously allowable. For example, incentives for volunteers can now be paid out of the HIV/AIDS CGs under the home-based care sub-component. In addition, it is up to provincial departments to decide how they want to shift the CG funds around and across programmes.[89] Even so, provinces report that the procurement procedures are extremely slow, hindering efficient spending of funds.

The issue of financial and project management skills still impacts on spending. It is reported that portfolio managers are not always experts in all areas of management. Lack of skills does affect spending and the overall running of provincial HIV/AIDS programmes. Fortunately the health CG includes funds to strengthen provincial management, build capacity and improve skills among officials. In cases where there was shortage of staff (for example, Limpopo and Free State), HIV/AIDS managers could motivate for more staff to be appointed on this grant to fulfil HIV/AIDS objectives. Currently the grant seems to be helpful in employing more people and providing essential support for personnel development and management. This is the primary reason that provincial health departments do not emphasise shortage of staff as their key implementation problem - as is the case with the provincial education departments.

Provincial HIV/AIDS managers/co-ordinators also report that employment of district co-ordinators by the Department of Health has significantly improved HIV/AIDS CG spending. However, decentralised authority and funds should accompany appointment of district co-ordinators. Western Cape is a good example of where this has occurred, and yielded significant success.[90] KwaZulu-Natal has also elected to transfer approximately R10 million to 11 regions to implement programmes in 2002/3. Human resource capacity and infrastructure development at national and provincial levels remain the primary challenges, according to the NIP co-ordinator in the Department of Health.[91]

The more flexible HIV/AIDS health CG moves an important step closer to mainstreamed HIV/AIDS financing. The CGs require separate reporting requirements to national, which run parallel to spending against the regular provincial health budget. Provincial HIV/AIDS managers are then faced with the difficult task of disaggregating HIV/AIDS spending from regular expenditure. For example, step-down

[88] Personal correspondence with Anita Marshall, National Co-ordinator - National Integrated Plan, Department of Health. 2003
[89] Interview with Dr S. Buthelezi, KwaZulu-Natal Department of Health.
[90] Interview notes, Dr F. Abdullah. Western Cape Department of Health, HIV/AIDS programme. 2002.
[91] Personal correspondence with Anita Marshall, National Co-ordinator - National Integrated Plan, Department of Health.

care funds arguably should flow directly to hospital programme budgets and PMTCT funds should be a regular part of the budget for Maternal, Child and Women's Health programme. For this reason, some HIV/AIDS provincial managers transfer portions of their CG funds to hospital budgets, and then collect reports from these other programmes on their expenditure against HIV/AIDS funds for submission in a summary report to the national Department of Health. For example, KwaZulu-Natal elected to transfer CG funds to district hospitals for step-down care. If this is what occurs in practice, it suggests the HIV/AIDS CG funds for interventions such as PMTCT ought to be directly transferred to hospital budgets - cutting out the middle layer of reporting and transfer via the HIV/AIDS provincial manager. If this is the advisable future direction for HIV/AIDS funding flows to provinces, then we are looking at a possible scenario of provincial HIV/AIDS managers merely playing a co-ordination role (collating reports and facilitating integrated planning) without controlling budget flows. In which case, provincial HIV/AIDS managers would likely encounter difficulty coercing co-ordination without the leverage accorded by budget control.

Table 4.10 Health HIV/AIDS conditional grant transfer procedures and conditions, 2003/4

MEASURABLE OBJECTIVES	○ Increased access to VCT by 12.5% of adult population aged 15-49 within three years, with specific targets for youth and rural communities. ○ Number of health districts that have VCT. ○ Number of mothers receiving VCT and number of mother/baby pairs receiving PMTCT prophylaxis. ○ Number of home-based care teams operating, caseload and number of patient contacts. ○ Number of step-down facilities in operation, number of admissions and bed days. ○ Number of adults and children receiving PEP after assault. ○ Number of projects targeting commercial sex workers and number of commercial sex workers reached.
CONDITIONS	Approval of business plans before first instalment.
REPORTING	Quarterly progress reports are required. The 2002 DOR also says that provinces should be detailing their programme achievements and evaluation in annual reports.
PAYMENT SCHEDULE	Payments are made in equal quarterly instalments. This is a change from previous 2002 DOR where it said payment schedule was three instalments (18 April, 15 August, and 12 December).
MONITORING	Members of the Department of Health make provincial liaison and technical support visits and the national steering committee meets regularly to monitor progress. An Output Monitoring Framework is to be finalised by 30 April 2003. 2002. DOR also says that provinces must establish expenditure codes on their financial systems to monitor expenditure.

Source: National Treasury, 2003 Division of Revenue Bill, pg. 87. 2002 Division of Revenue Bill, pg. 75.

4.5 DISCUSSION OF PROVINCIAL EXPERIENCE WITH HIV/AIDS CONDITIONAL GRANTS

Interviews with HIV/AIDS programme managers in provincial education, health and social development raised some additional general issues related to their experiences with the CGs, which are not necessarily captured in the discussion above.

As described in this chapter, CGs are governed by strict rules and stipulations, which consequently shape the way business plans are designed. Departments must indicate how they intend to spend the funds, in alignment with CG conditions. As a result, items not funded by CGs can only be funded from the provincial equitable share.[92] On the whole, provincial managers reported that it is much easier to spend

[92] Examples are Free State, KwaZulu-Natal and the Eastern Cape (provincial interviews, 2003).

HIV/AIDS monies from provincial budgets because there is less structure and more flexibility for spending compared to CG spending.

With respect to interdepartmental co-ordination, theoretically the NIP is echoed at the provincial level with health, education and social development/welfare departments in each province co-operating on HIV/AIDS activities. Provinces are adopting the NIP for HIV/AIDS and adapting it to provincial needs and situations by way of a provincial AIDS executive plan and/or provincial HIV/AIDS integrated strategy. However there remains a tendency for departments to focus on their own core agendas and priorities, and not prioritise integrated planning. This makes it hard to reach agreements and common understanding of the integrated HIV/AIDS strategy. A problem of staff shortages in other departments and lack of time for meetings among members can lead to insufficient interaction.

Regardless of issues associated with the integrated nature of the plan, commitment from top management such as members of executive councils, heads of departments, directors general, etc, is pivotal to effective implementation. This view supports the idea that the AIDS problem will not be solved by national government transfers, but by political will, good policy and contributions from provincial budgets. For example, provinces report that top management support in the KwaZulu-Natal Department of Health and Free State Department of Education is making processes a bit easier and more manageable for HIV/AIDS offices to carry out tasks. Along a similar theme, there is also a call for signatories to familiarise themselves with business plans and the whole HIV/AIDS strategy to avoid delayed approval and implementation of the business plans. In cases where leadership is well-informed of HIV/AIDS and is willing to drive the process, implementation moves at a quicker pace and problems can easily be dealt with.[93]

With the Lifeskills CG in particular, our provincial interviews indicated that staff and capacity appear to be the prominent issues. Reportedly, shortage of staff and time undermines the integrated strategic process. In addition, lack of dedicated HIV/AIDS staff at district levels makes work more difficult.

From the perspective of the national department, the key issue at present is whether provinces have integrated Lifeskills into their departmental organograms, and subsequently integrated the programme into regular line budgets.[94] According to official budget documents and our interviews, no provincial education departments were specifically allocating additional funds to the Lifeskills programme from their regular education department budgets. However provincial departments of education do contribute to the HIV/AIDS programme from their resources by providing support in the form of support staff, computers, telephones and infrastructure already available to all staff in provincial education departments.

Given that there are no financial contributions from provincial budgets specifically for the Lifeskills programme, the CGs are vital. As the Free State Lifeskills manager said: "HIV/AIDS CGs are imperative. Without them nothing will happen."[95] At present, if national government increased the CG allocation, it is unlikely to be absorbed given that staffing is insufficient and capacity to spend is minimal. However improvement and strengthening of provincial Lifeskills programmes would require increased allocation from provincial department budgets because, as pointed out by the Western Cape Lifeskills manager, where capacity is starting to improve, such as in the Western Cape, the CG budget is going down (-21% real growth rate in 2003/4) and there is no financial contribution from province.[96]

[93] Mrs. Speckmeier, Free State Department of Education, Lifeskills Programme.
[94] Interview with Brennand Smith, National Life Skills Co-ordinator, National Department of Education.
[95] Mrs. Speckmeier, Free State Department of Education, Lifeskills Programme.
[96] Peter Fenton, Western Cape Department of Education, Lifeskills programme.

One recommendation raised to address these problems was to loosen the conditions on the Lifeskills CG - similar to what has been done with the health HIV/AIDS CG. Specifically, it was suggested that restrictions be amended to permit CG funds to be used to cater for staffing and purchase of essential equipment such as computers. This would enhance service delivery options and facilitate development of sufficient infrastructure for HIV/AIDS work in the provincial education departments.

With respect to the CHBCS programme in provincial welfare departments, interviews reflected a general feeling that policy is good but the problems centre on funding and implementation.

For the most part, provinces depend entirely on the CG to finance the CHBCS programmes. The exception is Gauteng, which contributes 42% (R6.979 million) of the CHBCS budget from its own provincial budget for 2003/4. In 2004/5 and 2005/6 the province contributes 37% (R6.071 million) and 38% (R6.680 million) respectively.[97] [98] Apart from Gauteng, no other provinces specifically allocate additional funds for CHBCS from their own provincial budgets (over and above the CG funds received from national). Consequently, provincial CHBCS managers/co-ordinators reported that the CHBCS allocation is insufficient due to many demands brought about by HIV/AIDS on the social welfare sector. For example, community demands - such as training for CBOs, NGOs, and volunteers - impose a large burden on the CG allocation for HIV/AIDS. The CHBCS programme must also be supplemented by other efficiently delivered social security grants that address the needs of children and families infected and affected by HIV/AIDS. As a result of these budgetary pressures, some provinces must cover overspending on CGs with funds from the department.

Given that the bulk of CHBCS funds are transferred to NGOs, a major issue is smooth grant-making procedures and timely flow of funds from national to provinces to NGOs. To this end, it was recommended that the communication system is improved to enhance communication between provincial and national departments of finance to ensure that chief financial officers talk with one another to avoid delayed payments and to encourage timely business plan approval.

From the perspective of the national Department of Social Development, the advantage of the CG is that it pushes provinces to act and to have programmes and initiatives in place. The challenge now is to up the ante and to roll-out more broadly. At first the Department of Social Development used a site-based approach, but now the work must be extended to more areas to truly become a national, universal programme.

At provincial level, concern was also expressed that provinces have not moved a step further to analyse the impact of the CHBCS spending. One provincial manager asked: "Is implementation really reaching the needy? Are grants reaching the right beneficiaries?"[99] The second rapid appraisal of the CHBCS programme - recently completed but not publicly available at the time of writing - will help the department and provinces to understand how far they have moved in that direction.

[97] Gauteng Budget Statement 2003. 2003: 224-226. Own calculations.
[98] Gauteng Budget Statement 2003. 2003: 226. Own calculations. From these provincial allocations, NGOs receive a share of 66% (R4.591 million) in 2003/4; 57% (R3.484 million) in 2004/5; and 58% (R3.877 million) in 2005/6.
[99] Interview with Mrs Nombembe, Eastern Cape Department of Social Development, CHBCS programme. 2003.

Box 3. Auditor-General assessments and financial management

Outcomes of the Auditor-General's assessment can be used as an indicator of the quality of financial management. An "unqualified" audit opinion is the best outcome. Audit opinions range from unqualified to qualified, adverse and disclaimer (in increasing degrees of severity) so that "disclaimer" is the worst. The number of provincial departments that passed the audit (receiving unqualified status) was only two in 1999/00 and dropped to just one in 2000/1. Eastern Cape, Limpopo and the Northern Cape had zero provincial departments that passed the audit with unqualified status in 2001/2.

Looking specifically at the health sector, in 2001/2 four provincial health departments passed the audit and earned unqualified status. Of those provincial health departments which did not, Northern Cape and Eastern Cape received the worst outcome - disclaimer. Meanwhile the national department of health passed the audit with unqualified status in 1999/00 and 2000/1, but dropped to an adverse opinion in 2001/2. (In 2001/2, health was one of eight national departments that failed to achieve qualified status (out of a total of 35 national departments).

To the extent that audit outcomes indicate the quality of financial management, this information helps us understand the context for expenditure and financial reporting on HIV/AIDS conditional grants, and clearly demonstrates that the issue is not specific to HIV/AIDS - pertaining not simply to other provincial departments but to national departments as well (National Treasury. Intergovernmental Fiscal Review 2003. April 2003. Annexure F).

Provincial treasuries provide an additional important perspective, which cannot be omitted from our understanding of CG spending and effectiveness. According to interviews with provincial treasuries, all problems identified by departments on HIV/AIDS spending come from a common source of poor financial and project management (see Box 3). Provincial treasuries also argue that under-spending on CGs is not rooted in rigid CG procedures and rules, but is simply a management issue. Similarly, the issues associated with the tender process - such as failure to transfer money to NGOs on time, inability to spend, etc. - all lie in the hands of managers.

Provincial treasuries argue that CGs do not impose new operational challenges for departments because systems are already in place for non-HIV/AIDS programmes. This view disputes the departments' assertion that national government does not provide sufficient support systems to provinces for HIV/AIDS programmes. Furthermore, according to the provincial treasuries, problems of staffing could be easily resolved - provincial departments can write to national departments and make requests to use a certain amount of money for staffing, together with a motivation for employing more people. In addition, departments can also request national departments to deploy other provincial staff to HIV/AIDS programmes.

Provincial treasuries concurred with line departments that poor communication channels between and within departments result from strict bureaucracy, resulting in late transfers to departments and the recipient NGOs. Further, provincial treasuries agree that systems for monitoring transfers to local government and NGOS must be strengthened. In these respects, bureaucracy can hinder HIV/AIDS expenditure, financial management and reporting.

Despite these obstacles, the expenditure records, particularly given the massive increases year on year in budgeted allocations, demonstrate that the HIV/AIDS CGs are functioning effectively. Certainly improvements are needed, particularly with financial management and staffing needs, so that absorption capacity and efficiency can be improved. Without also conducting impact analysis, it is not possible

to comment on the outcomes of expenditure. But from a budgeting perspective, the CGs are largely successful as funding channels for delivering funds to provincial departments for HIV/AIDS interventions identified as priority items by national government.

The time horizon for the CGs continues to shift outward and it is not clear if national and provincial governments have a clear strategy on their lifespan. For example, in 2002 it was stated that for the Lifeskills programme, "It is envisaged that, given the nature of the epidemic, the need for such a grant will be necessary as long as the epidemic of HIV/AIDS." [100] However by the following year, this has been modified: "Given the nature of the epidemic, the need for such a grant will persist for another six to nine years at least."[101] The Lifeskills co-ordinator in the Department of Education speculates that the CG will be needed for at least the next three to four years, however the objectives of the CG should and will shift as the focus becomes treatment and support for learners infected and affected by HIV/AIDS. Up to now, 55,000 educators have been trained and one million copies of learner support materials distributed, meaning that the programme is past its start-up phase and expenditure should steady out. [102] More training will be needed to integrate the material into the curriculum.

The Lifeskills programme example demonstrates how, as these programmes mature and objectives shift, expenditure may "flatten out" or the types of expenditure required may change (e.g. printing materials vs. training). As HIV/AIDS programmes become integrated into provincial department organograms, ideally provincial departments also budget for those salaries. Such changes should trigger a reassessment to determine if a CG is still the most appropriate funding mechanism.

The challenge will be to encourage provincial budgetary commitment to the three HIV/AIDS programmes currently funded by the CGs, while still ensuring a minimum level of national financial support to allow for a degree of control; ensure a minimum level of service delivery; and to monitor equity. The following chapter therefore focuses on the priority accorded to HIV/AIDS by provinces as demonstrated by allocations from their own budgets. Chapter 6 goes further to argue that ultimately South Africa's HIV/AIDS financing strategy must rely on both provincial own allocations for HIV/AIDS as well as a continuation of the CGs examined in this chapter.

[100] 2002 DOR, pg. 79.
[101] DOR 2003, pg. 82.
[102] Information in this section obtained from interview with Brennand Smith, National Life Skills Co-ordinator, National Department of Education.

CHAPTER 5.

PROVINCIAL OWN ALLOCATIONS FOR HIV/AIDS

Chapter 4 has covered the conditional grants (CGs) provinces receive from national for HIV/AIDS. In addition to the CG funding stream, resources at a provincial level come either from the provincial health department budget or a combination of provincial health budgets and a "top slice" of the province's equitable share. "In most provinces these resources are not quantified on the basis of an intervention or spending strategies" (Whelan, 2001: 137). This chapter attempts to isolate those funds specifically designated for HIV/AIDS in provincial health department budgets that are *not* sourced from CGs.

5.1 TOTAL HIV/AIDS SUBPROGRAMME ALLOCATIONS IN PROVINCIAL HEALTH BUDGETS

Recent standardisation of provincial budget formats assists our analysis considerably. Beginning in 2003/4, each provincial budget now has a Subprogramme 6: HIV/AIDS, under Programme 2: District Health Services. This designated sub-programme in District Health Services is generally aimed at providing primary health care services and preventative projects in respect of HIV/AIDS; it contains the health HIV/AIDS CGs each province receives from the national Department of Health. Table 5.1 shows the HIV/AIDS subprogramme allocations by province and their growth in real terms. KwaZulu-Natal, Gauteng and Eastern Cape have the most noticeable jumps in budgeted amounts.

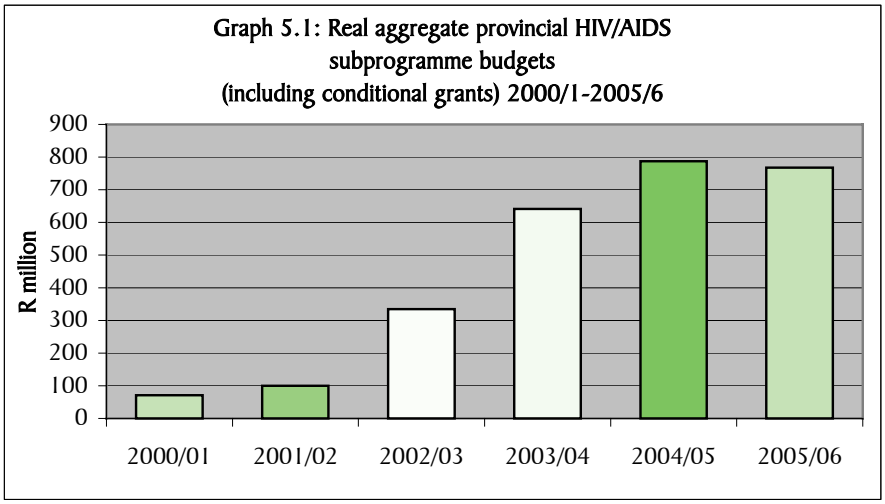
The aggregate amount of HIV/AIDS subprogramme allocations (across provinces) is increasing significantly. In 2002/3 the aggregate total is R334.894 million, increasing by 91.39% in real terms to R680 million in 2003/4. Over the Medium Term Expenditure Framework (MTEF), the aggregate total for the HIV/AIDS subprogramme will increase by 37.23% in real terms each year (Vennekens-Poane 2003: 53).

Table 5.1: Allocations for Subprogramme 2.6 HIV/AIDS in provincial health budgets

R million	Revised Est. 2002/03	MTEF 2003/04	MTEF 2004/05	MTEF 2005/06
Eastern Cape	N/a	70.947	92.988	114.111
Free State	16.884	34.832	21.169	22.923
Gauteng	90,.616	155.275	287.540	241.844
KwaZulu-Natal	143.313	246.523	289.843	300.869
Limpopo	3.862	37.783	43.095	55.679
Mpumalanga	8.439	26.287	27.864	29.397
Northern Cape	5.727	11.268	17.318	18.924
North West	30.419	42.891	40.479	56.024
Western Cape	35.634	54.254	57.175	59.566
Aggregate	334.894	680.060	877.471	899.337

Source: Provincial Budget Statements 2003; Idasa calculations.

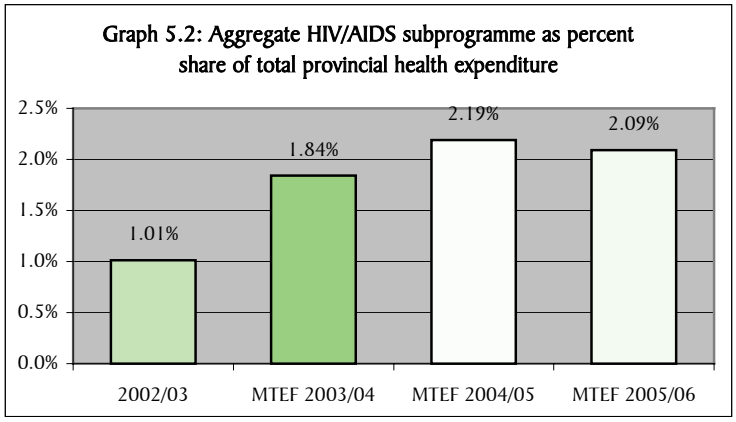
It must be kept in mind that these HIV/AIDS subprogramme allocations include the HIV/AIDS conditional grant funds received from the Department of Health. The net effect is that, on aggregate, provincial expenditure on the HIV/AIDS subprogramme in health is steadily increasing in real terms.



Source: Provincial Budget Statements 2003; Idasa calculations.

5.2 HIV/AIDS SUBPROGRAMME (DISTRICT HEALTH SERVICES) AS SHARE OF PROVINCIAL HEALTH BUDGETS

When we consider the HIV/AIDS subprogramme allocation (including the CGs) as a share of the entire provincial health budget, we see a gradually increasing percentage over the medium term. Graph 5.2 demonstrates this. In 2002/3, the HIV/AIDS subprogramme was 1.01% of aggregate provincial health budgets, increasing to 1.84% in Budget 2003/4. By 2005/6 it takes up 2.09% of aggregate provincial health expenditure.



Source: Provincial Budget Statements 2003. Idasa calculations.

5.3 PROVINCIAL DISCRETIONARY ALLOCATIONS FOR HIV/AIDS IN HEALTH BUDGETS

Graph 5.1 displays the increasing share of provincial health budgets taken up by the HIV/AIDS subprogrammes. However, because those subprogramme amounts contain the CG from the Department of Health, this analysis is not an accurate means to assess the extent to which provinces are prioritising HIV/AIDS in their own budget processes. As in Chapter 3 we refer to provincial expenditure which excludes CGs as "discretionary" provincial expenditure.[103]

[103] Discretionary provincial expenditure is sourced either from the provincial equitable share or provincial own revenue.

5.3.1 According to official provincial budget statements

The first step in isolating provincial discretionary HIV/AIDS expenditure is to subtract the health HIV/AIDS CGs from the total HIV/AIDS subprogramme amounts. Table 5.2 below takes figures directly from the official budget documents and shows the HIV/AIDS subprogramme allocations *minus the CGs*.

Table 5.2: Discretionary funding for the HIV/AIDS sub-programme, according to official provincial budget documents (HIV/AIDS subprogramme amounts minus CGs)

R million	Revised Est. 2002/03	MTEF 2003/04	MTEF 2004/05	MTEF 2005/06
Eastern Cape	n/a	32.013	34.795	36.660
Free State	-1.773	4.688	-19.674	-19.698
Gauteng	59.523	100	199.911	150
KwaZulu-Natal	90.817	160.932	167.573	177.556
Limpopo	-16.692	8.821	616	317
Mpumalanga	-12.428	0	-8.5	-17.044
Northern Cape	-1.930	0	0	0
North West	1.5	10	-1.376	13.355
Western Cape	23.921	30.050	22.514	23.717
Aggregate	124.685	346.504	395.859	364.229
Discretionary amount as percent share of the total HIV/AIDS sub-programme	37.23%	50.95%	45.11%	40.50%

Source: Provincial Budget Statements 2003; Division of Revenue 2003; Idasa calculations.

Gauteng and KwaZulu-Natal stand out in Table 5.2 as the two provinces that have allocated substantial amounts from their equitable share to their HIV/AIDS subprogramme budgets in 2002/03 and 2003/04. The negative figures in the table are likely to indicate that those provinces have not allocated any additional funds to the HIV/AIDS subprogramme beyond the CG, or that some of the HIV/AIDS CGs funds were actually allocated to another subprogramme other than HIV/AIDS. (As noted in Section 4.2.1, some provinces actually transfer the CGs funds to other programmes e.g. prevention of mother to child transmission [PMTCT] funds being transferred to the Maternal, Child and Women's Health [MCWH] programme.) However, based on information from the official budget documents, it is impossible to know which, or if both, occurred.

5.3.2 According to provincial interviews

The section above only uses the data from provincial budget documents, but this gives a limited and inaccurate understanding of provincial discretionary HIV/AIDS allocations in their health budgets. For this reason, Idasa conducted interviews at the provincial level to get a more detailed picture beyond the budget documents. Unfortunately Idasa obtained validated information from only six of the nine provinces.

Interviews uncovered the fact that in addition to some provinces adding funds to the HIV/AIDS subprogramme budgets from their own provincial health department budgets, some provincial cabinets and treasuries had also made special allocations for HIV/AIDS which were essentially top-sliced off the global provincial budget.

In the case of KwaZulu-Natal, a cabinet decision was made to allocate additional funds to the health department for the roll-out of PMTCT. The amounts were: R126.5 million in this year's budget; R134.7 million in 2004/5; and R143.5 million in 2005/6.[104] In 2003/4, R34.4 million was allocated to the HIV/AIDS subprogramme as part of the regular health department budget process, so that the total amount in the HIV/AIDS subprogramme in 2003/4 includes the PMTCT funds from cabinet, the CG from national and funds from the regular provincial health department budget.

In the previous year, 2002/3, the original budget of the Provincial AIDS Action Unit in the KwaZulu-Natal health department came from three sources: R52.5 million CG; R21.36 million special allocation for HIV/AIDS from cabinet; and a R15.966 million allocation for HIV/AIDS from the regular provincial health department budget. Reportedly the Unit overspent by R58.802 million in 2002/3 and so a further allocation of that amount had to be made from the health department budget, to "pay back" treasury. (It is unclear whether this amount was deducted from another line item in the health budget.) Interestingly, R3.7 million (or 23%) of the funds originally sourced from the provincial health department budget were transferred by the Unit to local authorities and NGOs. The Unit took advantage of the flexibility of the monies sourced from the cabinet allocation to transfer 47% (or approximately R10 million) to the regions for expenditure on HIV/AIDS interventions.

A second example is the Eastern Cape, where treasury made an additional allocation of R33 million to its health department for HIV/AIDS in 2002/3 and again in 2003/4 - to be allocated within the department at the department's discretion.

Gauteng is the principal case of dedicated contributions to HIV/AIDS from the province's own budget. Cabinet allocated R100 million to the HIV/AIDS subprogramme in 2003/4, rising to R200 million in 2004/5 and then R250 million in 2005/6. The increase was clearly the result of recognition of the growing impact of the epidemic generally; the resulting increased demand for HIV/AIDS treatment and care interventions; and the heightened need for prevention programmes. However the global amount was not arrived at via scientific formula or bottom-up costing of component programmes. Resources available, and ability to absorb the increased funds, were also reportedly taken into account in determining the R100 million figure.

On aggregate, Idasa calculates that actually provinces have allocated R356.5 million from their own budgets for HIV/AIDS health expenditure in 2003/4, compared to only R346.5 million calculated by subtracting the CG amount from the aggregate provincial HIV/AIDS subprogramme (as given in the official provincial budget documents). According to our figures, in 2004/5 and 2005/6 the aggregate totals for provincially sourced HIV/AIDS health expenditure are R433.4 million and R501.3 million respectively.

[104] 2003 KZN Budget Statement, pg. 16.

Table 5.3: Provincial discretionary HIV/AIDS health expenditure

R million	2002/3	2003/4	2004/5	2005/6
According to official provincial budget statements only:				
Health HIV/AIDS conditional grants	210.209	333.556	481.612	535.108
Aggregate HIV/AIDS Subprogramme 2.6 allocations (including CGs)	334.894	680.060	877.471	899.337
Provincial discretionary HIV/AIDS health expenditure	124.685	346.504	395.859	364.229
According to official provincial budget statements and financial information obtained directly from provinces in interviews:				
Total HIV/AIDS allocations in provincial health budgets (including CGs)	392.151	690.014	915.018	1036.396
Provincial discretionary HIV/AIDS health expenditure	181.942	356.458	433.406	501.288
As a percentage of total	*46.40%*	*51.66%*	*47.37%*	*48.37%*

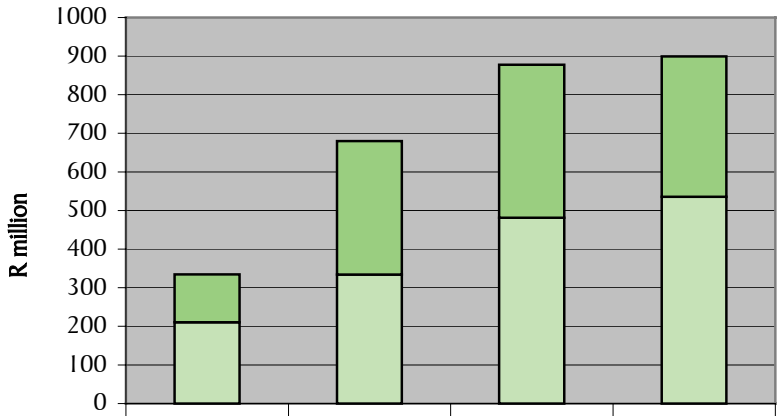
Source: Provincial Budget Statements 200;. Division of Revenue 2003; Idasa interviews with provincial HIV/AIDS managers and provincial treasuries.

Table 5.3 shows the difference between financial information reported in the official provincial budget statements and financial information obtained from provinces through interviews.[105] The key point to note is that calculations based solely on official budget statements **under-report** the amount provinces are dedicating to HIV/AIDS in their health budgets (by the order of R185 million over the MTEF). Improved accuracy, detail and disaggregation in official provincial budget statements would facilitate our understanding of government expenditure on HIV/AIDS; enable civil society to better monitor HIV/AIDS resource allocation; and provide the public with a more fair picture of the degree to which provinces are designating funds for HIV/AIDS.

The figures tell some good news: on aggregate provincial discretionary allocations have increased - as a share of the total HIV/AIDS subprogramme expenditure - from 46.4% in 2002/3 to 51.7% in 2003/4. Given that aggregate HIV/AIDS subprogramme expenditure is also increasing in absolute terms, this is evidence that at least some provinces are relying less on national funding to finance their HIV/AIDS subprogramme budgets. See Graph 5.3 below.

[105] Appendix 4 gives the actual discretionary HIV/AIDS health expenditure figures Idasa obtained via provincial interviews, and details the source of each figure.

Graph 5.3: Sources of HIV/AIDS allocations in provincial health budgets



	Revised Estimate 2002/03	MTEF 2003/04	MTEF 2004/05	MTEF 2005/06
Provincial discretionary	124.685	346.504	395.859	364.229
HIV/AIDS conditional grant from natl	210.209	333.556	481.612	535.108

Source: Provincial Budget Statements 2003; Division of Revenue 2003; Idasa interviews with provincial HIV/AIDS managers and provincial treasuries.

The decrease in the percent share (to 47.4% in 2004/5 and 48.4% in 2005/6) does not necessarily mean that provincial contributions to the HIV/AIDS subprogramme budgets are declining. It is more likely a reflection of the fact that CG allocations are published by national through the MTEF, while provincial budget allocations may not be planned or known two years in advance. Since HIV/AIDS was not instituted as a separate subprogramme on provincial budgets prior to 2003/4, it is possible that provinces have not seriously planned for provincially sourced HIV/AIDS allocations. We would expect this to improve in the next financial year because provinces would have familiarised themselves with the new budget format.

5.4 Crowding out of non-HIV/AIDS-related expenditure

Concern has emerged that HIV/AIDS expenditure has been prioritised at the expense of other components of the health care system, and that the on-the-ground reality is that medical personnel are being forced to ration access to services and supplies due to the increased demand due to HIV/AIDS.[106] There is a danger that people needing non-HIV/AIDS related services will be denied full care due to the priority being given to HIV/AIDS while, simultaneously, concern has also arisen that HIV-positive people might be turned away at health care facilities due to those clinics and hospitals being overburdened with HIV/AIDS cases.

Although there is anecdotal evidence of this occuring, limited research studies provide clear evidence. A study conducted in Hlabisa, KwaZulu-Natal, which spanned seven years, found that hospitals experienced a shift in the ranking of causes of admission, so that AIDS became a more prominent cause of admission (Floyd, Wilkinson and Gilks, 1997). According to the Department of Health: "Evidence from systematic,

[106] The Joint Task Team Report (2003: 31) refers to estimated baseline expenditure of R4.4 billion for HIV/AIDS in 2001/2. The report then notes that: "prior to 2002, 'baseline' spending on HIV/AIDS has, to a considerable degree, displaced other health service delivery. The 'baseline' estimate thus reflects a degree of 'crowding out' of other health care services by HIV/AIDS, rather than deliberate targeting of resources."

longitudinal tracking of hospitalisation in Nairobi over a ten-year period indicates that, as increasing numbers of HIV positive people become sick with opportunistic infections and late-stage AIDS related illneses, these individuals have represented an ever greater proportion of admission to hospital, with significant 'crowding out' of other workload" (DOH 2001: 4).

Can budget analysis contribute to our understanding on this issue? Crowding out or rationing is very difficult to isolate or test for using budget figures, and a full analysis is beyond the scope of this report. However we do note the following:

- The HIV/AIDS Subprogramme 2.6 consumes an increasing proportion of the District Health Services programme budget. However, our analysis of the sub-programme indicates that most of the provinces are increasingly allocating additional amounts from their equitable share to this subprogramme in 2003/04, with the exception of Mpumalanga and Northern Cape.

- On aggregate the HIV/AIDS subprogramme consumes an increasing share of the provincial health budget (including CGs). As discussed above, on aggregate, provinces plan to double the proportion of the total provincial health budget spent on the HIV/AIDS subprogramme from 1.01% in 2002/03 to 2.19% in 2004/05 (see Graph 5.2).

Table 5.4: Aggregate HIV/AIDS subprogramme expenditure within provincial health budgets

	Outcome 2001/02	Revised Est. 2002/03	MTEF 2003/04	MTEF 2004/05	MTEF 2005/06
Provincial HIV/AIDS subprogramme as proportion of District Health Services programme	0.74%	2.48%	4.67%	5.50%	5.23%
Provincial HIV/AIDS subprogramme as percent share of total provincial health budgets	0.30%	1.01%	1.84%	2.19%	2.09%
Real growth rate of HIV/AIDS subprogramme		235.96%	91.39%	22.77%	-2.48%
Real growth rate of District Health Services programme	2.78%	0.69%	1.53%	4.21%	2.63%
Real growth rate of provincial health budget	5.67%	0.23%	5.14%	3.24%	2.10%
Real growth rate of District Health Services programme allocation *excluding HIV/AIDS subprogramme*	2.58%	-1.07%	-0.76%	3.30%	2.93%

Source: Provincial Budget Statements 2003; Idasa calculations.

As Table 5.4 shows, in real terms, aggregate provincial health expenditure, aggregate District Health Services programme expenditure and aggregate HIV/AIDS subprogramme expenditure all increase this year and next. However over the next two years, the HIV/AIDS subprogramme is increasing year-to-year much faster than the District Health Service programme and provincial health expenditure overall.

Since non-HIV/AIDS District Health Service expenditure decreases somewhat in real terms, we know that the overall District Health Service programme is only able to maintain its growth over the medium term because of the jump in HIV/AIDS subprogramme expenditure. (The average annual growth of 1.82% over the MTEF for non-HIV/AIDS District Health Service expenditure is insignificant when compared to the 37% increase in the HIV/AIDS subprogramme allocation specifically. It is also less than the health budget average annual increase over the same period, of 3.5%.)

A consequence of this is that the HIV/AIDS subprogramme more quickly takes up a larger portion of the District Health Service programme. This suggests that HIV/AIDS may be supplanting other District Health Service expenditure.

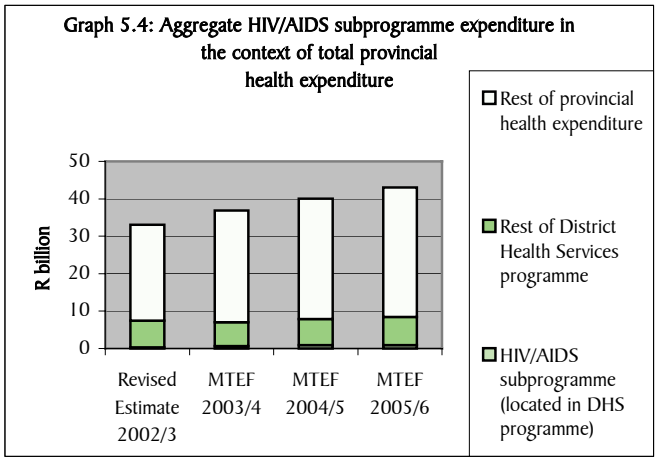
However, the overall provincial health expenditure envelope is increasing steadily and HIV/AIDS is not rapidly increasing as a share of total provincial health budgets. Therefore it is not possible to make definitive conclusions about "crowding out" of expenditure. Graphs 5.4 and 5.5 show what is happening.

5.5 Per capita HIV/AIDS spending in provincial health budgets

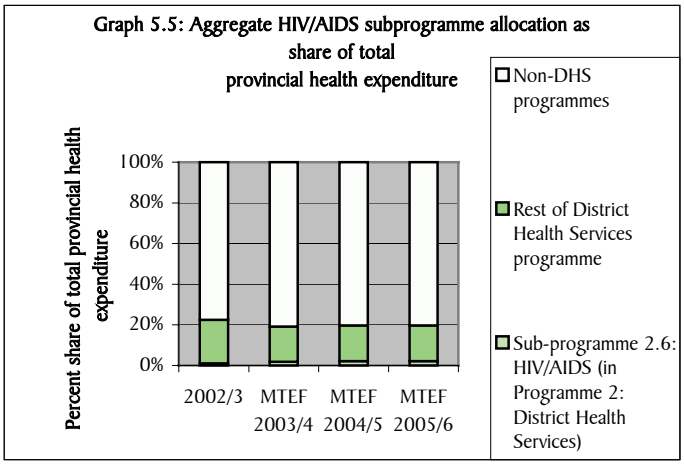
Section 4.2 discussed the criteria the Department of Health uses for splitting available HIV/AIDS CG funds between the provinces. As noted above, provinces are also dedicating funds from their own provincial budgets to the HIV/AIDS subprogramme - and these amounts vary widely between provinces. The net effect is that provincial HIV/AIDS subprogramme budgets (including the CGs) differ considerably between provinces. Per capita analysis is a means to analyse provincial equity with respect to dedicated HIV/AIDS health expenditure. In May 2000, the HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 recommended an "agreed resource standard for all provinces" set at R10 per person per year (in 1999/00 prices) (DOH 2000: 27). The Strategic Plan also suggests provincial equity should be monitored by comparing resources on per capita and per HIV-infected person.

To this end, Table 5.5 shows per capita HIV/AIDS health expenditure by province.[107] In 2003/4, five provinces are still below the target figure identified in the Strategic Plan - R10 in 1999/00 is equivalent to approximately R13.6 in 2003. With respect to per capita HIV/AIDS provincial health expenditure (based on public population), Limpopo and Eastern Cape trail behind, while KwaZulu-Natal and Gauteng are at the top end.

Graph 5.4: Aggregate HIV/AIDS subprogramme expenditure in the context of total provincial health expenditure



Graph 5.5: Aggregate HIV/AIDS subprogramme allocation as share of total provincial health expenditure



[107] In this section we are using the Idasa figures for provincial HIV/AIDS health allocations - which were calculated based on provincial budget documents and interviews with provincial HIV/AIDS managers and provincial treasuries (see Table 5.3 and Appendix 4). The population and AIDS figures are taken from Dorrington, Bradshaw and Budlender (2002) and are projections utilising the AIDS and demographic model from the Actuarial Society of South Africa (ASSA). For calculations based on "public population", the population without medical aid is given four times greater weight than the population with medical aid. Figures of percent on medical aid (by province) are taken from the 1995 October Household Survey.

The high per capita spending in KwaZulu-Natal and Gauteng is due to the extra funds contributed from the provincial budget to supplement the CG funds.

Table 5.5 2003/4 per capita provincial HIV/AIDS health expenditure (including conditional grants)

	Provincial population 2003 (ASSA)	Total 2003/4 provincial HIV/AIDS health expenditure (Idasa calculations) **R million**	R per capita HIV/AIDS provincial health expenditure 2003/4					Provincial prevalence rate (total population) at July 2002
			Based on public population	Based on HIV+ population	Based on HIV+ public population	Based on AIDS sick population	Based on public AIDS sick population	
Eastern Cape	7,244,554	70.9	10.4	78.8	83.9	1,137.3	1,210.9	11.3%
Free State	2,931,662	34.8	13.7	67.3	77.6	803.6	926.6	16.7%
Gauteng	9,142,158	155.3	24.3	100.9	144.7	1,204.9	1,726.8	16.0%
KwaZulu Natal	9,556,833	246.5	28.6	136.0	150.8	1,357.6	1,505.6	18.4%
Limpopo	5,535,670	41.7	8.0	63.3	67.1	860.8	912.8	11.0%
Mpumalanga	3,160,127	32.3	11.4	59.4	66.3	603.0	673.8	16.5%
Northern Cape	1,011,774	11.3	13.2	128.2	152.0	1,992.6	2,363.0	7.9%
North West	3,906,592	42.9	12.2	69.0	76.8	851.5	948.2	15.1%
Western Cape	4,615,965	54.3	14.9	248.3	315.9	3,983.4	5,066.3	4.2%
	47,105,335	690.0	17.1	100.0	116.6	1,173.8	1,368.5	14.2%

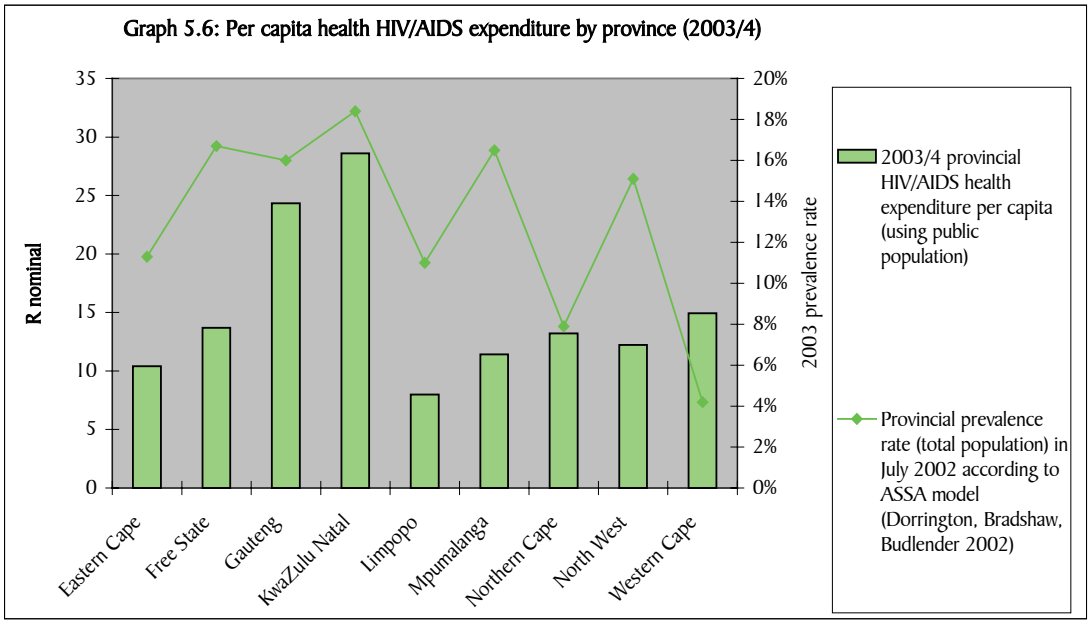
Source: Total HIV/AIDS health expenditure figures are Idasa given figures given in Table 5.3 and Appendix 4 Population figures are from the ASSA model (Dorrington, Bradshaw and Budlender, 2002. For calculations based on 'public population', the population without medical aid is given 4 times greater weight than population with medical aid. Figures of percent on medical aid (by province) are taken from 1995 October Household Survey.

However it is more telling to look at per capita spending based on the HIV-positive population and AIDS-sick population in each province. In per capita calculations based on the HIV-positive public population, Western Cape immediately outpaces the other provinces at R316, compared to a low of approximately R67 in Mpumalanga and Limpopo. When we consider provincial health HIV/AIDS expenditure per AIDS-sick person (based on public population), we find that Northern Cape ranks high at R2,363. This is due to the CG funds from national, combined with the relatively low AIDS sick population of 5,655 people. However the highest per capita spending based on public AIDS-sick population is Western Cape at R5,066. The lowest is Mpumalanga, despite being the province with the third highest overall prevalence rate (see Table 5.5).

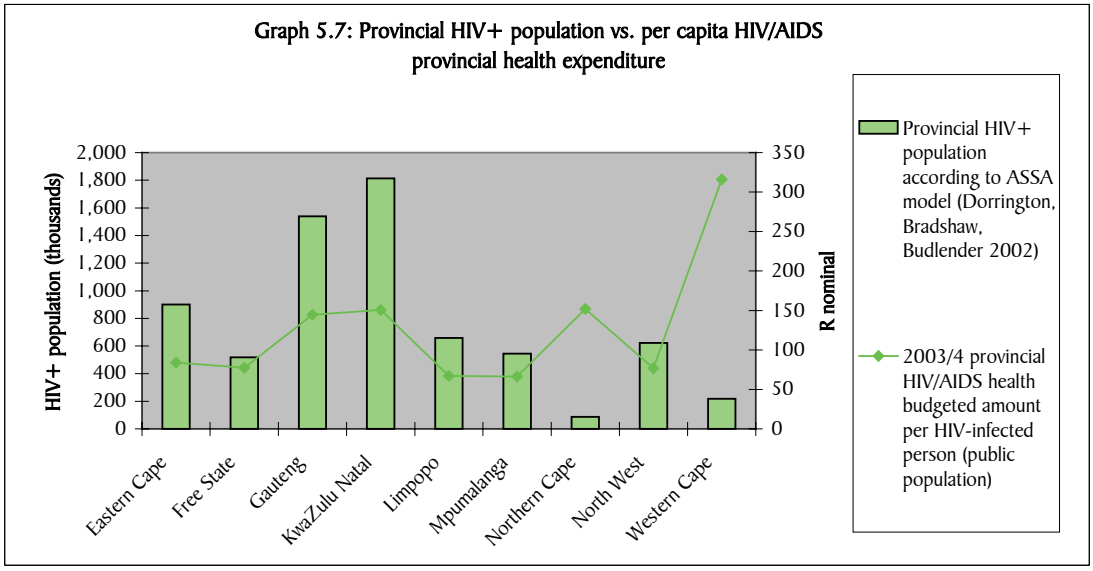
In this vein, we might expect provinces with more severe HIV prevalence rates to budget more per capita - thus Graph 5.6 puts provincial prevalence rates alongside the per capita spending figures from Table 5.5.

Graph 5.7 compares the provincial expenditure per HIV-positive person to the total HIV-positive population estimated in each province, according to ASSA model projections (Dorrington *et al* 2002). Although Western Cape has the second smallest number of HIV-positive people, its health department budgets the highest amount per HIV-infected person.

Although this per capita analysis gives us some insight into sufficiency and equity considerations in resource allocation across provinces, it should be treated with caution because they do not take into account HIV/AIDS spending in sectors outside health, nor does it include the indirect or "hidden" HIV/AIDS-related expenditure in regular health care services.



Source: Total HIV/AIDS health expenditure figures are Idasa figures given in Table 5.3 and Appendix 4. Population and AIDS figures are from the ASSA model (Dorrington, Bradshaw and Budlender, 2002). For calculations based on 'public population', the population without medical aid is given 4 times greater weight than population with medical aid. Figures of percent on medical aid (by province) are taken from 1995 October Household Survey.



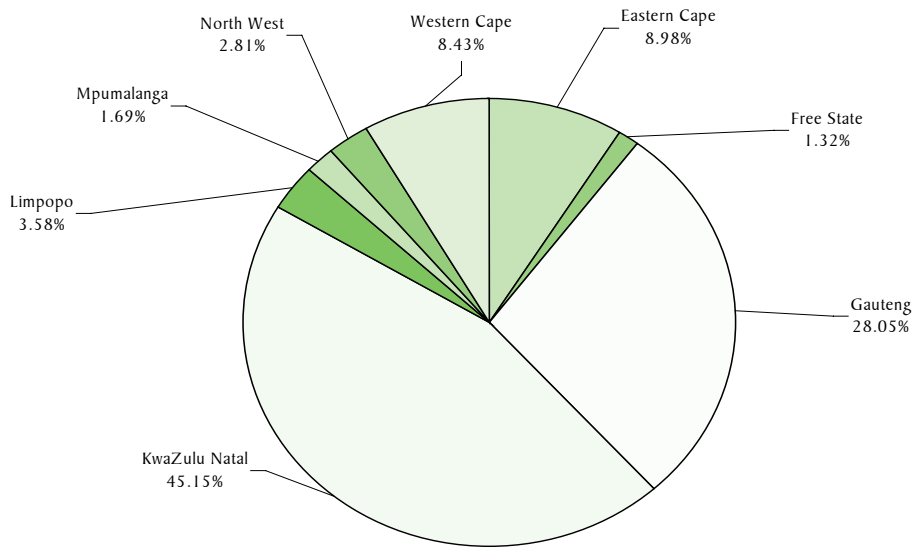
Source: Total HIV/AIDS health expenditure figures are Idasa figures given in Table 5.3 and Appendix 4. Population and AIDS figures are from the ASSA model (Dorrington, Bradshaw and Budlender, 2002). For calculations based on 'public population', the population without medical aid is given 4 times greater weight than population with medical aid. Figures of percent on medical aid (by province) are taken from 1995 October Household Survey.

5.6 Discussion

Our deeper inquiry beyond the budget books tells us provincial discretionary allocations specifically targeted for HIV/AIDS *is* increasing. Our research indicated that provincial discretionary HIV/AIDS health allocations total R356.5 million in 2003/4, a 96% nominal increase compared to last year. Next year it is set to increase by 22%, and by a further 16% the following year. Clearly provinces are making an effort to set aside funds specifically for HIV/AIDS health interventions - in addition to what they receive from central government. Such provincial buy-in is critical for a sustainable HIV/AIDS response in the health sector, which is of the scope required by the epidemic in this country.

The absolute amounts dedicated to HIV/AIDS in provincial health department budgets *are* increasing, but two points are worth noting. First, the aggregate figures hide the fact that two provinces account for most of that increase. Two provinces are clearly taking the lead in dedicating funds from their own budgets for HIV/AIDS health interventions: KwaZulu-Natal and Gauteng together account for 73% of the aggregate discretionary provincial HIV/AIDS health expenditure in 2003/4 (see Graph 5.8).[108] It remains for other provinces to step up their commitment by allocating further funds from their own budgets, in addition to the HIV/AIDS CG transferred from national.

Graph 5.8: Provincial shares of total provincial discretionary HIV/AIDS health allocations Total R356.458 million in 2003/4



Source: Provincial Budget Statements 2003; Division of Revenue 2003; Idasa interviews with provincial HIV/AIDS managers and provincial treasuries.

[108] Northern Cape is excluded from the graph because information on any funds allocated for health HIV/AIDS interventions from their provincial budget was unavailable for 2003/4. See Appendix 4.

The second point is that evidence regarding whether provinces are coming to rely more or less on CGs is ambiguous. It appears that between 2002/3 and 2003/4, provinces *reduced* their reliance on CGs to finance their health HIV/AIDS programmes (see Table 5.3). However in 2003/4 provinces are contributing 51.7% of the total HIV/AIDS-dedicated funds in their health department budgets. This share decreases to 47.4% in 2004/5 and 48.4% in 2005/6. This could indicate that provinces will be relying more - not less - on CGs from national to finance their HIV/AIDS health interventions in the future. Or the decreased percentage could be a result of provinces not yet having planned own allocations for HIV/AIDS for the next two years. The evidence from budgets is insufficient to draw good conclusions.

With the recent standardisation of an HIV/AIDS subprogramme in every provincial health budget, analysis of this category of HIV/AIDS-specific spending will be easier in future years. However the main lesson from Idasa interviews with provincial HIV/AIDS managers is that all HIV/AIDS-designated expenditure by provincial health departments is not captured in this line item.

Those provinces where cabinet *has* set aside special funds for HIV/AIDS or where the provincial health department is targeting amounts for HIV/AIDS in addition to the CGs, would do well to clearly reflect that in their official budget documents. There is a need for greater transparency, comprehensiveness and accuracy related to HIV/AIDS-targeted funds in provincial health department budgets.

A final point to note is that even those provinces that did not have HIV/AIDS-dedicated allocations made by cabinet, provincial treasuries or their health departments are not necessarily dropping the ball.

Provincial treasury officials express that it is not realistic to say some departments do not contribute money from their provincial budgets for HIV/AIDS. The reason for this is that there are always *indirect costs* that are covered from the HIV/AIDS CG but are resulting from HIV/AIDS. For instance, hospitalisation costs for many illnesses may be linked to HIV/AIDS, but because there is no notification criteria it is difficult to track them down. These indirect or "hidden" costs are the topic of Chapter 6.

CHAPTER 6.

ROLE OF EQUITABLE SHARE GRANT IN CHANNELLING HIV/AIDS FUNDS TO PROVINCES

Chapter One distinguished between the direct and indirect expenditure by government on HIV/AIDS. This chapter addresses the indirect impact HIV/AIDS is having on the health sector budget, in terms of increasing demand for services and also undermining supply.

> *People with AIDS tend to come from the age group (people in early and middle adulthood), which, prior to the advent of HIV/AIDS, traditionally made the least demand upon health care services. AIDS demand therefore tends to be additional demand for health care, on top of a largely unchanged demand profile from children and older people. As more individuals develop AIDS-related illnesses each year, clearly total demand for health care will tend also to rise on an annual basis. (DOH 2001: 2)*

The greatest impact of HIV/AIDS in the health sector is to increase the overall demand for routine health care services (e.g. hospital beds, medicines for opportunistic infections, demands on medical care professionals). The issue is how to increase the budget for the overall health sector so that the sector may: a) continue to deliver regular services to the population, and b) deliver the additional services and treatment required as a result of HIV/AIDS.

The most basic problem with budgeting for the indirect impact of HIV/AIDS on the public health sector is that it is tremendously difficult to quantify. This chapter first lays out the little information we do have on what HIV/AIDS indirectly costs the health sector. Given these difficulties in costing and planning for the indirect impact, we then ask what are the possible funding or budgeting mechanisms for meeting this financial need. Sections 6.2 and 6.3 analyse the funding strategy South Africa has adopted - the targeted increment to the equitable share - and try to assess its success. We conclude in Section 6.4 by looking at other funding options besides those currently used.

6.1 AVAILABLE EVIDENCE ON THE "INDIRECT" COSTS INCURRED BY THE HEALTH SECTOR IN AFRICA DUE TO HIV/AIDS

The HIV/AIDS pandemic has become the greatest challenge not only to health in Southern Africa, but to development in general. The broader socio-economic impact of the disease has been recognised and described (Haacker 2002, Bollinger and Stover 1999, UNAIDS 2000a, UNAIDS 2002). In addition, "some attention has been given to the direct economic impact of the HIV/Aids epidemic, the costs of prevention, the treatment, care of those infected and the management of death practices. The costs have been analysed in terms of public, private and personal costs" (Mhone 2002).

However, with regard to actual "indirect costs" or increased general expenditure of health programmes from the increased demand due to HIV/AIDS, very little information is available in Africa (Hansen *et al* 2000:433). Gilks (2000) concurs: "current knowledge of the impact of HIV/Aids on hospital services in Africa is sparse". Costing the impact is further complicated by the fact that only in the later stages of the illness will the demand for health care increase, while in the earlier stages management of minor

symptoms and infections will be required but the demand is difficult to differentiate from other presenting illnesses. Current surveillance only counts AIDS cases in hospitals and misses about 50% of all HIV-related disease. Thus very little data is available on the cost of care to HIV-positive people in the earlier, less symptomatic stages of the illness (Gilks, 2000).

However, understanding and costing these indirect costs on the health care system in general is imperative to inform budgetary allocations and choices of funding flow mechanisms. As Franklin *et al* (2001:19) stress: "the costs of undefined 'outpatient' and 'inpatient' care are useful in estimating macro-level impact and budget planning".

This section attempts to provide evidence of what health facilities are actually spending due to the extra demand by HIV-infected people versus projected costs of specific HIV/AIDS programmes, such as anti-retrovirals (ARVs), voluntary counselling and testing (VCT), etc.

6.1.1 Overview of the available literature

It was found that information on the burden and cost of HIV/AIDS on health facilities and families in Africa was generally very scarce, with only a few useful studies from countries like Kenya, Rwanda, South Africa, Tanzania, Zimbabwe and Malawi (Guthrie, 2003). With regard to the South African literature, it was found (Franklin *et al* 2001) that most studies used a cost-effectiveness analysis, which estimates the total cost of a programme, intervention or other activity and divides it by an appropriate effectiveness measure. Most studies tended to be limited to financial costs (direct costs to the service provider) while economic costs (including indirect costs to all role-players) were less available. In addition, most were once-off as opposed to longitudinal studies, and thus failed to capture the frequency and aggregate cost of hospital visits over a period of time since they focus only on the costs per single hospital visit using post-hoc clinical notes and laboratory results. It is also important to measure the costs of non-HIV/AIDS specific care, such as TB, STDs and other opportunistic infections, because HIV has increased the prevalence of these diseases.

6.1.2 Summary of available data on indirect costs of health care due to HIV/AIDS in developing countries

Table 6.1 Studies of indirect costs of HIV/AIDS in the health sector

Type of service	Cost (US$)	Place, study date
Specialist in-patient care	No data published	N.A.
Integrated in-patient services (some including costs to family for health care)	$326 per AIDS patient	Rwanda, 1988-90
	$90 per admission for a child AIDS patient	Zaire, 1988
	$132 for an HIV+ TB patient, 4/day	Zambia, 1991
	$86 for an admission for Kaposi's sarcoma	As above
	$7 for drugs per admission	WHO, 1989
	$13 per day for an HIV/AIDS patient	Zimbabwe, 1995
	$5.4 per day ($4.7 for HIV- patients)	Zaire, 1988
	$41 for drugs for HIV+ TB patients ($16.6 to $32.9 for HIV- TB patients)	Kenya, 1993
	AIDS care approximately 23% health care budget	Tanzania, 1991
	AIDS care approximately 11% health care budget	Malawi, 1991

	AIDS care approximately 4% health care budget	Kenya, 1991
	$43% adult hospital bed-days	Zambia, 1991
	$21% hospital bed-days	Ivory Coast, 1995
	Average cost to families of $70 for terminal patients	Tanzania, 2002
	HIV/AIDS patient costs & length of stay almost double that of non-HIV/AIDS patients. Detailed costs for different levels of health services, ranging from US$87 to US$312/day per stay.	Zimbabwe, 2000
	Health care costs to family: $70 for HIV patients, vs. $41 for non-HIV patients	Tanzania, 2002
	Health care costs to family = 29% due to HIV/AIDS of total family health spending = 93.5% of total funds to treatment (govt & donors). Bed occupancy of 67% due to HIV stage ¾	Rwanda , 2001
	Bed occupancy doubled from 100% (1988) to 187% (1997). $159 per patient with AIDS per stay, vs. $148 per patient without AIDS.	Kenya, 1988, 1992, 1997
	Increased admissions for TB & LRTI in young people, reduction in admissions for chronic conditions.	Hlabisa, South Africa, 1991-1998
Out-Patient Care	Annual per capita use rate by HIV+ patients = 10.92 vs. 0.28 by HIV- patients. Urban patients 10 times more visits than rural patients. Annual expenditure $63 (vs. $12.7 average per capita health spending).	Rwanda, 2001
	80% of out-patient contacts could have been seen at primary care site. Largest costs due to lab investigations, drugs for infections, and staff.	Soweto, South Africa. 1989-1992
Home-based care	Between $16 and $42 per visit	Zimbabwe, 1995
	Between $66 and $100 for care provided by families over a three-month period.	Same as above
	Between $14 and $38 per visit for hospital-initiated home-based care programmes; 52 to sustain a client for a year in one community-initiated programme.	Zambia, 1994
	$49 per visit	Botswana, 1994
Hospice care	As low as $0.23 per patient per annum, but only drug cost, excluded care costs. Outdated.	World Bank, 1997

Table 6.1 is adapted from Gilks (2000:110) and includes mostly direct costs. What is lacking is the more indirect, general studies.

6.1.3 Gaps in the available information

> *"The sad fact is that 20 years into the HIV/Aids epidemic there really are so few data about the impact on African health-care systems"* (Gilks 2000).

Franklin *et al* (2001) could not find any studies in South Africa that considered the costs of primary health care to HIV-positive persons. Such information is vital, firstly, to understand the impact of HIV-related needs on those facilities that act as the first contact for many patients and, secondly, to ascertain the cost saving to outpatient and hospital services through the provision of adequate services at the primary level. There is also very little analysis of the costs of outpatient care that might be attributed to HIV/AIDS. In particular, there appears to be a shortage of updated costs of managing opportunistic infections. Very few studies examine the costs incurred by family members, such as medication, transport and time costs incurred in caring for HIV-positive people.

While some cost analyses of home-based care (HBC) programmes are available, most do not compare the HBC costs with the costs of hospitalisation in the absence of HBC. Nor do they consider how the provision of HBC would affect the use of hospital services. "Ideally, researchers should attempt to estimate the total cost of HBC to the health system broadly defined, including direct costs as well as indirect savings in other programmes or facets of care" (Franklin *et al* 2001: 21).

While there is little research on the indirect impact of HIV/AIDS on health care services in general, and the increased costs due to caring for infected people, it is nevertheless apparent that HIV/AIDS has increased bed occupancy in hospitals and placed a strain on the supply of medication, staff and other resources. Since it is often impossible to identify HIV-positive patients in the early stage of the illness, when they can be asymptomatic and/or due to the non-notifiable status of the illness, the costs incurred by such patients cannot be distinguished from non-infected patients. Therefore the real impact and increased demand for services cannot be efficiently measured.

6.2 Introduction and debate on the equitable share funding flow for HIV/AIDS

When it comes to the indirect impact of HIV/AIDS on the public health budget, earmarked funds (including conditional grants [CGs]) are not the right mechanisms for transferring funds to the provinces, for two primary reasons. First, these costs are too intertwined with regular health care service delivery to use CGs to finance them. As described above, in a regular hospital or clinic setting, it is nearly impossible to make a distinction between HIV/AIDS-related services and non-HIV/AIDS related services.[109] Second, even if this were possible, it is not desirable. Experience and literature from health care service delivery tells us that vertical programmes do not work. Ultimately dedicated funding (e.g. CGs) works to drive programmes and to catalyse interventions which provinces would not otherwise undertake. However when it comes to scaling up, budgets must be integrated in order to be sustainable, effective, efficient and of a wide scope.

Therefore Budget 2002/3 introduced a new funding channel for making funds available to the provinces for HIV/AIDS spending. In addition to the CGs, the national Department of Health and National Treasury agreed to create a "targeted increment" or an additional funding infusion to the total provincial equitable share pool (DOH 2002d: 2). When National Treasury first embarked on this new approach in 2002/3, it said that the extra R400 million added to the equitable share was to be targeted for HIV/AIDS. According to the *Budget Review*, these funds were intended to cover "a range of interventions including improved

[109] See discussion in Section 4.4.3

care of sexually transmitted infections and TB, medication for prevention of TB and pneumonia in infected persons, and costs arising from hospitalization and treatment of opportunistic infections".[110]

In the most recent 2003/4 budget, the amount channelled via the equitable share shot up to R1.1 billion. This was a great leap in comparison to the previous budget, but also in comparison to the R600 million originally allocated for 2003/4 when the medium term estimates were laid out in 2002, the first year of the Enhanced Response. National Treasury gave the following purpose and rationale for the R1.1 billion in HIV/AIDS funds channelled through the equitable share:

- to ensure "that health services generally can cope with increased demand as a result of the disease" [111] and;
- to allow for provinces to "finance medically appropriate treatment for HIV/AIDS"[112]
  - including ARVs - once policy is finalised/approved.[113]

Table 6.2: Summary of HIV/AIDS allocations in national Budget 2003/4

R million	2002/3	2003/4	2004/5	2005/6
Dept. of Health HIV/AIDS Directorate (includes HIV/AIDS conditional grant)	458.63	665.72	850.97	903.34
Conditional grant for CHBCS from Department of Social Development	47.50	65.92	70.13	74.39
Lifeskills conditional grant from Department of Education	144.61	120.47	128.58	136.29
To provinces via equitable share	400	1,100	1,900	2,454
Total	**1,051**	**1,952**	**2,950**	**3,568**
Real growth rate of total		***75%***	***44%***	***15%***
Total over 3 year period (MTEF) in nominal terms				8,469.82

Source: 2002 Estimates of National Expenditure. Idasa calculations.

Table 6.2 shows the amounts National Treasury is sending to the provinces via the equitable share. In 2003/4, this funding mechanism represents over 55% of the total amount dedicated to HIV/AIDS in the national budget. Over the medium term (2003/4 to 2005/6), R5.45 billion will flow to the provinces via this channel.

The first months of 2002 continued to unroll multiple policy developments for HIV/AIDS. These included the decision to provide ARV post-exposure prophylactics (PEP) in the public sector for rape survivors, the expansion of prevention of mother-to-child-transmission (PMTCT) services nationally (as required by the Constitutional Court) and heightened public pressure to provide highly active anti-retroviral therapy (HAART) in the public sector. In July 2002, the national Department of Health and National Treasury agreed to set up a joint technical committee to investigate the funding framework for HIV/AIDS in the public sector. The task team was not solely concerned with costing a national programme for providing ARV therapy to HIV-positive people. Its mandate was wider (DOH 2002d: 2):

- To explore the longer-term macroeconomic and fiscal implications of HIV/AIDS;
- To develop a long-term funding framework for HIV/AIDS in the public sector;

[110] SA National Treasury *Budget Review 2002*, 2002: 141.
[111] SA National Treasury 2003 Estimates of National Expenditure, 2003: 329.
[112] SA National Treasury 2003 Budget Speech, 2003: 19.
[113] 2003 Estimates of National Expenditure, 2003: 329.

- To review current mechanisms for funding HIV/AIDS in the public health sector;
- To review and revise the Enhanced Response to reflect recent developments.

As a result of these developments, the current funding framework for HIV/AIDS is organised into three streams: nationally funded and implemented programmes (funded primarily in the HIV/AIDS Directorate budget in the Department of Health); CGs to provinces for specific interventions; and the targeted increment. National government is of the opinion that earmarked funding for HIV/AIDS is only appropriate for limited aspects of HIV/AIDS-related spending, such as public awareness campaigns, condom distribution and PMTCT programmes.[114] Other aspects of HIV/AIDS-related expenditure which are difficult to isolate (such as medicines and treatment of opportunistic infections) are better funded via the equitable share.

In weighing up this matter, the Financial and Fiscal Commission (FFC) has stressed that disaggregating HIV/AIDS expenditure from regular health spending is nearly impossible and has the potential to set up artificial divisions between HIV/AIDS and non-HIV/AIDS related services. Tracking and monitoring any HIV/AIDS funds channelled via the equitable share will be problematic (FFC 2003b: 61). While supporting the FFC's view that the HIV/AIDS CG allocations should grow, National Treasury responded to the FFC in Budget 2003/4 by stating that unconditional funding to provinces should also expand to reinforce key HIV/AIDS interventions that provinces are operating from equitable share and own revenue funding sources.[115]

6.3 Assessing the success of the targeted increment to the equitable share for HIV/AIDS

For now, the debate between CGs and some form of unconditional budget support to provinces for HIV/AIDS is not an either/or issue. By its introduction of indirect HIV/AIDS funding (in the form of the equitable share increment) national government is adopting a dual strategy to finance a holistic response to the epidemic - using CG funds for targeted programmes while simultaneously channelling additional funds (through the equitable share) to deal with the larger indirect impact of HIV/AIDS on the public health sector budget. The joint task team - in its work of reviewing this framework - produced the following general recommendations for the 2003/4 budget cycle, although its work is ongoing:

- National funding via the Chief Directorate: HIV/AIDS, targeted increment and TB remains as is, i.e. limited to programmes needing central management and implementation;
- CGs should be simplified, beyond the procedural improvements instituted in 2002/3.
- The targeted increment to the equitable share is all right as it is. "The Committee agreed that, fundamentally, this mechanism had proved successful in 2002/3, and that there were not currently compelling grounds to propose an alternative route"(DOH 2002d: 8).

6.3.1 The problem of how we measure or monitor effectiveness of the new approach

Given the impossibility and undesirability of tracking all HIV/AIDS-related expenditure in hospitals and clinics, clearly some form of general budget support to provincial health departments is necessary. However the danger is that funds intended for HIV/AIDS, which are sent via the equitable share, will instead be diverted by provinces to other departments and priorities. Therefore the issue is

[114] SA National Treasury 2003 *Budget Review*, 2003: 245.
[115] 2003 Division of Revenue Bill, Explanatory Memorandum to the Division of Revenue, 2003: 50.

whether the targeted increment is the appropriate vehicle, or whether it could be refined and adjusted so that it more efficiently fulfils its purpose.

In this regard, the third conclusion of the task team (above) is worrying because it is premature and unsubstantiated. The Department of Health and National Treasury have not identified indicators of success for the targeted increment. Given that the targeted increment is an indirect funding channel intended to generally support the health sector, it is - by definition - very difficult to assess. The indirect method is used precisely because we cannot and should not be detailing which expenditure is for HIV/AIDS and which is not. However, there are rough proxies or measures that can shed better light on whether the targeted increment system is working, and with refinement we can achieve greater understanding of whether the funds *are* indeed trickling down to provincial health budgets. The following section suggests starting points for assessing the success of the targeted increment.

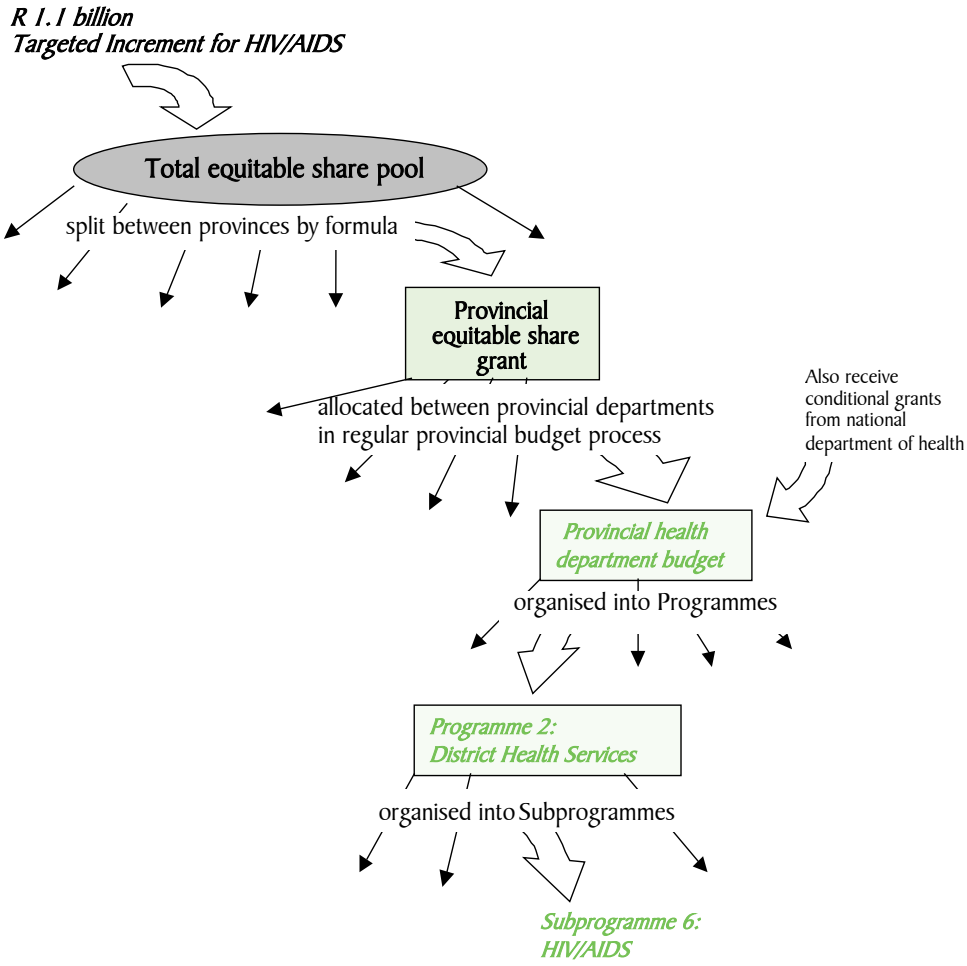
6.3.2 Proposed indicators of success of equity share funding mechanism for HIV/AIDS

The ultimate *impact* of the HIV/AIDS funds channelled through the equitable share should be improved treatment and care for HIV/AIDS patients. The associated budget *inputs* would be:

- An increase in funds specifically allocated for HIV/AIDS treatment and care interventions in the provincial budget; and
- An increase in funds used to generally strengthen the health sector (due to increased impact of HIV/AIDS).

Once the equitable share grant arrives in provincial coffers, it is up to the provinces to allocate these resources - along with provincial own revenue - through the regular provincial budget process, which sees provincial treasuries and departments in iterative formulation, consultation and approval of departmental budget submissions. The onus is on provinces to reinforce HIV/AIDS as a policy priority in their own budgets by passing those funds through to HIV/AIDS subprogramme line-items specifically, or to provincial health department budgets more broadly. The liability associated with this funding approach is that provinces will divert the funds to other programmes or policy priorities. The FFC expressed concern that the HIV/AIDS increment to the equitable share may not be used by provinces to support HIV/AIDS activities (FFC 2003b: 61). Figure 6.1 shows the theoretical flow of the targeted increment funds through the budgeting process.

Figure 6.1: Flow of Targeted Increment funds for HIV/AIDS in budget process



Have provinces used these extra equitable share funds to increase their health budgets? To trace whether the HIV/AIDS funds channelled through the equitable share are indeed resulting in these increased budget inputs, Box 4 lists the rough indicators we can use as a starting point for analysis.

Box 4.
Approximate budget indicators to assess the "success" of the equitable share funding channel for HIV/AIDS:

- ✓ Size of discretionary provincial health budget (i.e. provincial health department budget minus CGs received from national government).
- ✓ Share of provincial health department budget sourced from equitable share or provincial own revenue (i.e. discretionary provincial health spending).
- ✓ Provincial discretionary health expenditure as a share of total provincial discretionary expenditure.
- ✓ Size of HIV/AIDS subprogramme allocations (in provincial health department budget) *excluding* HIV/AIDS CG received from the Department of Health.
- ✓ Share of HIV/AIDS subprogramme allocation that is sourced from provincial budget (not CGs).
- ✓ HIV/AIDS subprogramme as a share of provincial health budget.
- ✓ HIV/AIDS subprogramme (minus CG) as a share of discretionary provincial health budget.

6.3.3 Evidence in budget allocations

Using these indicators, our analysis of Budget 2002/3 and preliminary analysis of 2003/4 allocations indicates that the new equitable share funding channel does appear to have been associated with increased funding for provincial health services. However, using budget analysis, it is very difficult to establish that these funds were used for HIV/AIDS. The strongest evidence produced in our research is that HIV/AIDS discretionary health expenditure by provinces is increasing as a share of the total provincial discretionary budget - meaning that provinces are allocating more of their discretionary funds to HIV/AIDS health interventions.

To trace whether the HIV/AIDS funds channelled through the equitable share are indeed resulting in these increased budget inputs, we pursued three lines of questioning:

First: Are provinces receiving more funds in their equitable share grants as a result of the targeted increment?

The total equitable share pool increased by R16 billion from 2001/2 to 2002/3. From 2002/3 to 2003/4 it increased by R19 billion. How does R400 million and R1.1 billion compare to these increases? In other words, how much of the increase in the total equitable share pool is attributable to the decision to add funds to the equitable share for HIV/AIDS treatment and care? The R400 million was 2.5% of the total increase to the equitable share pool from 2001/2 to 2002/3. The R1.1 billion added to the equitable share pool for HIV/AIDS in this year's budget is about 8% of the total R13.9 billion which was added to the equitable share for provinces (in Budget 2003/4) compared to the baseline (given in Budget 2002/3).

Second: Are provinces allocating more of their equitable share funds to their health departments?

Aggregate provincial health expenditure *is* increasing. The aggregate resource envelope for provincial health departments grows from R33.105 billion in 2002/3 to R36.931 billion in this year's budget - this is real growth of 5.14%. Over the Medium Term Expenditure Framework (MTEF), in real terms aggregate provincial health expenditure is set to increase an average of 3.49% annually (Vennekens-Poane 2003: 9). Furthermore, average per capita provincial health expenditure continues to increase over the medium term, but by less each year. In 2002/3 average per capita provincial health expenditure was R843. It increased to R928 (a 3.8% real increase) in 2003/4.

Discretionary provincial health expenditure also increases by R2.954 billion in this year's budget (representing a 4.86% real increase compared to 2002/3). In 2002/3 it is R26.237 billion, and in 2003/4 it is R29.192 billion. Over the MTEF it will increase, in real terms, by an average of 3.18% annually (Vennekens-Poane 2003: 47).

However provincial health budgets are failing to increase as a **share of total provincial expenditure**. Despite aggregate positive growth in the health budgets in real terms, health declines as a share of the total provincial budget in 2003/4 and over the MTEF. Provincial health budgets actually *decreased* as a share of total provincial budget from 24.27% in 2001/2 to R22.4% in 2002/3. By 2005/6 health it is only 21.72% of the total provincial budget (Vennekens-Poane 2003: 10). This does not necessarily indicate provincial deprioritisation of health, as the lower health share is largely attributable to an increase in social development budgets to accommodate the extension of the child support grant.[116] However its important to note that despite this push in social development budgets, social services as a whole does

[116] Social development's share of total provincial spending increases from 21.6% in 2002/3 to 25.8% in 2005/6. 2003 Intergovernmental Fiscal Review, pg. 16.

not increase significantly as a share of total provincial spending over that period. The total proportion of provincial budgets allocated to health, education and social development actually decreases slightly from 81.2% in 2002/3 to 80.8% in 2003/4.

Furthermore, despite a real increase in discretionary health budgets, provinces on aggregate allocated a slightly smaller share of their discretionary provincial budgets to health over the medium term. Discretionary health expenditure as a percent of discretionary provincial expenditure is 20.03% in 2002/3 and drops to 19.95% in 2003/4 (Vennekens-Poane 2003: 14).

There is also evidence that provinces are not reducing their reliance upon CGs to finance their provincial health budgets. In 2002/3, 79.3% of provincial health budgets was discretionary. In 2003/4, it was 79.0%. It drops very slightly to 78.5% by 2005/6.

For our analysis of the targeted increment in 2003/4, the critical question is: How do the increases in each province's discretionary health budget compare to that province's slice of the R1.1 billion (distributed according to the provincial shares of the total equitable share)? *Theoretically, if the R1.1 billion was successfully flowing through the equitable share grant to provincial health budgets (with zero leakage), then provincial discretionary health expenditure for each province should increase by at least the province's share of the R1.1 billion.* As Table 6.3 shows, this held true for each province. On aggregate, in 2003/4, the total equitable share pool increased by R22.9 billion compared to the previous year, and R4.7 billion of that money flowed through to provincial health budgets (or 20%).

Table 6.3 also displays the same analysis for the year 2002/3. In 2002/3, the targeted increment funding strategy was first used and R400 million was added to the total equitable share pool, which was subsequently divided between the provinces based on the equitable share formula. In that year, R15.3 billion was added to the equitable share (compared to the previous year), and subsequently provinces - on aggregate - added R1.9 billion to their health budgets (12% of the additional funds flowing to them via the equitable share). All provinces increased their discretionary health budgets by at least their share of the R400 million targeted increment. (The exception is Eastern Cape, which actually decreased its discretionary health expenditure in 2002/3.)

Table 6.3: Comparison of increase in ES grant to increase in provincial discretionary health budget

	Increase in ES from 2001/2 to 2002/3	Increase in provincial discretionary health expenditure from 2001/2 to 2002/3		Provincial share of R400 million (as allocated via ES formula)	Increase in ES from 2002/3 to 2003/4	Increase in provincial discretionary health expenditure 2002/3 to 2003/4		Provincial share of R1.1 billion (as allocated via ES formula)
	R million	R million	As % of increase to ES	R million	R million	R million	As % of increase to ES	R million
Eastern Cape	2532.7	-32.3	-1%	68.6	3729.9	1045.9	28%	187.2
Free State	978.0	78.5	8%	26.8	1466.7	267.7	18%	73.1
Gauteng	2376.0	408.2	17%	61.0	3651.9	744.6	20%	169.0
KwaZulu Natal	3309.1	581.0	18%	81.5	4936.2	829.7	17%	226.2
Limpopo	2135.0	205.4	10%	54.1	3207.3	456.9	14%	149.5
Mpumalanga	1223.0	188.0	15%	28.2	1791.5	382.0	21%	79.0
Northern Cape	373.6	57.6	15%	9.7	548.7	94.3	17%	26.7
North West	1231.8	189.6	15%	33.5	1828.8	355.7	19%	91.3
Western Cape	1156.9	189.4	16%	36.6	1773.1	490.9	28%	98.1
Total	**15316.1**	**1865.4**	**12%**	**400.0**	**22933.9**	**4667.8**	**20%**	**1,100.0**

Source: Division of Revenue Bill, 2001, 2002 and 2003. Provincial Budget Statements 2001/2, 2002/3 and 2003/4. Idasa calculations.

Table 6.4: Percent of additional provincial ES funds allocated to health departments

	Increase in aggregate budgeted provincial Equitable Share	Increase in aggregate provincial discretionary health budget	As percent of increase to ES
	R billion	*R billion*	
2000/1 to 2001/2	9.728	2.856	29%
2001/2 to 2002/3	15.316	1.865	12%
2002/3 to 2003/4	22.934	4.668	20%

Source: Division of Revenue Bill, 2000, 2001, 2002 and 2003. Provincial Budget Statements 2000/1, 2001/2, 2002/3, and 2003/4 Idasa calculations.

The important finding from Table 6.3 is that the percentage of new equitable share funds which "passed through" to the provincial health budgets increased from 12% to 20%. This suggests that the targeted increment is associated with additional provincial health allocations. However a historical perspective would help put this evidence in context.[117] Table 6.4 shows that there is not a regular pattern in terms of the percent of their additional equitable share funds which provinces pass along to their health departments. Based on only three years of figures, it is thus impossible to conclude if the targeted increment is resulting in a higher pass-through percentage, compared to previous years. However there is concern that the increases to provincial discretionary health expenditure are not particularly high, given the additional amounts that ought to be newly available as a result of the R1.1 billion injection to the equitable share for HIV/AIDS treatment and care.

Third: Are provinces allocating more of their equitable share funds to HIV/AIDS-specific line-items in their health department budgets?

Evidence from Chapter 5 showed us that: [118]

- Provincial discretionary allocations specifically targeted for HIV/AIDS *are* increasing. Our research indicated that provincial discretionary HIV/AIDS health allocations total R356.458 million in 2003/4, a 96% increase compared to last year. Next year it is set to increase by 22%.

- Two provinces are clearly taking the lead in dedicating funds from their own budgets for HIV/AIDS health interventions: KwaZulu-Natal and Gauteng together account for 73% of the aggregate discretionary provincial HIV/AIDS health expenditure. These funds were sourced from the equitable share grant received by the province and allocated to HIV/AIDS by a cabinet decision or the provincial treasury.

- Of the total HIV/AIDS dedicated funds in provincial health budgets (including CGs) in 2003/4, 48.3% of that amount was CGs from central government. This is a smaller percentage from last year, when 53.6% was sourced from CGs.

However the best evidence to suggest provinces are dedicating more of their discretionary funds to HIV/AIDS is displayed in Table 6.5. In 2002/3 provinces on aggregate allocated 0.61% of their discretionary provincial health budget specifically to HIV/AIDS. In 2003/4, this percentage rose to 1.22%.

[117] If the increase in provincial discretionary health expenditure had been less than the targeted increment, this would have provided strong evidence that the targeted increment is *not* working.
[118] See Section 5.3.2 and Appendix 4.

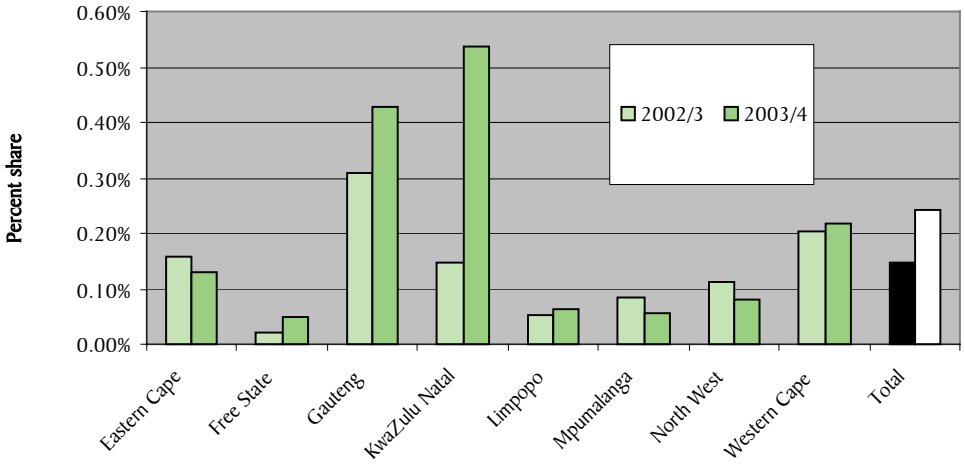
Table 6.5: Provincial discretionary HIV/AIDS health expenditure as a share of total provincial discretionary expenditure

	2002/3			2003/4		
	Discretionary provincial HIV/AIDS health expenditure	As share of discretionary health expenditure	As share of total discretionary expenditure	Discretionary provincial HIV/AIDS health expenditure	As share of discretionary health expenditure	As share of total discretionary expenditure
	R 000			*R 000*		
Eastern Cape	n/a	n/a	n/a	32,013	0.71%	0.13%
Free State	1,766	0.11%	0.02%	4,688	0.26%	0.05%
Gauteng	58,750	1.23%	0.31%	100,000	1.81%	0.43%
KwaZulu-Natal	37,326	0.62%	0.15%	160,932	2.35%	0.54%
Limpopo	8,364	0.33%	0.05%	12,745	0.42%	0.06%
Mpumalanga	7,315	0.50%	0.09%	6,030	0.33%	0.06%
Northern Cape	n/a	n/a	n/a	n/a	n/a	n/a
North West	11,500	0.67%	0.11%	10,000	0.48%	0.08%
Western Cape	23,921	0.97%	0.20%	30,050	1.01%	0.22%
Total	148,942	0.61%	0.12%	356,458	1.22%	0.24%

Source: Provincial Budget Statements 2002 and 2003. Idasa interviews with provincial HIV/AIDS managers and provincial treasuries. Idasa calculations.

More significantly: last year 0.12% of provinces' total discretionary expenditure was targeted at HIV/AIDS in the health sector. In 2003/4, this percentage climbed to 0.24%. Graph 6.1 shows the greater priority being accorded to HIV/AIDS health activities by provinces in their own budget processes.

Graph 6.1: Provincial discretionary HIV/AIDS health expenditure as share of total provincial discretionary expenditure



Source: Provincial Budget Statements 2003. Idasa interviews with provincial HIV/AIDS managers and provincial treasuries. NB: Eastern Cape and Northern Cape are omitted as information on discretionary provincial HIV/AIDS health expenditure was not available for both years.

6.3.4 The targeted increment for HIV/AIDS in the budget process

To evaluate the targeted increment funding mechanism, it is important not only to analyse the budget figures, but also to analyse the targeted increment in the context of the intergovernmental budget process. Clearly the quantitative approach to determining the success of the targeted increment funding

mechanism is very limited. Qualitative research on what actually occurred in the budget process is needed. Interviews of officials from provincial treasuries, provincial health departments, and National Treasury and the Department of Health can illuminate behind-the-scenes meetings and deliberations between departments and between spheres of government.

We are concerned with two decision points. The first decision point involves the determination of the size of the targeted increment for HIV/AIDS. Provincial treasuries participate in budget discussions in the Budget Council, but do not have a powerful say in determining allocations. Some concern exists that there is too little consultation on HIV/AIDS funding allocations. How is National Treasury determining the amount of funds that should be added to the equitable share pool for HIV/AIDS? To what degree, and by what means, do provinces feed into and influence that decision?

The second decision point in the budget process occurs when the equitable share funds reach the provincial coffers. Funds in Subprogramme 2.6: HIV/AIDS (besides the CG) come from two sources:

- The health department's regular budget process. The District Health Service programme and its HIV/AIDS subprogramme may be allocated funds as part of the regular budget process of the health department whereby the health department takes its global amount and splits it between programmes and subprogrammes. This is either achieved through negotiation between programme directors or through a more top-down process directed by health department budgeting authorities.

- Top-slice from provincial budget. The provincial cabinet elects to set aside a set amount for HIV/AIDS or the provincial treasury decides to send a special allocation to the health department for HIV/AIDS. These funds either appear entirely on the subprogramme budget, or may also be spread across other health department budget line-items (although intended for HIV/AIDS). These funds are essentially "top-sliced" from the general provincial budget (i.e. the provincial budget before it is allocated between the departments) (Whelan 2001: 27).

At this point in the budget process, the key issue is whether provincial health departments and HIV programmes in other social service departments are aware that these funds have been "added" to their province's equitable share grant. Within the provincial budget process, are they aware that they need to lobby or advocate for those funds to be allocated to the HIV/AIDS subprogramme and/or to the health department generally? There is a possibility that the targeted increment funds which national intends to be spent on HIV/AIDS will not trickle down, but instead be redirected to other priorities in the provincial budgets (tourism, child support grant, etc.).

The targeted increment funding mechanism is dependant on smooth information flows and directives from on top - which were lacking in the 2003/4 budget process. The targeted increment funding channel requires that provincial health departments motivate with their provincial treasuries for the additional HIV/AIDS funds (available via the equitable share) to be added to their budgets. However given that when the 2003/4 budget process took place last year there was no policy decision on "medically appropriate treatment", there was little impetus, context or leverage for provincial health departments to launch that motivation. Were provincial health department officials - in making their funding bids to provincial treasuries - aware of the additional funds made available via the equitable share for HIV/AIDS? Were they able to use this information as leverage to motivate for larger allocations from the provincial budget process? Were provincial treasuries aware of the funds? And, in those provinces where this knowledge directly translated into increased budget allocations for HIV/AIDS for provincial health departments, did provincial treasuries simultaneously deduct amounts from other allocations requested by provincial health departments?

The Department of Health was aware of this issue when it advised in 2001 that the equitable share funding approach for HIV/AIDS "would require explicit guidance to provinces on desirable areas of spending, but would allow a better fit with existing services" (DOH 2001: 19). With the targeted increment funding channel, national is *requesting* that provinces use equitable share funds for particular activities without having the legal authority to enforce those intentions. The targeted increment therefore relies entirely on co-operative governance principles, and thus it has become a powerful test of our intergovernmental fiscal system. The permitted mechanisms for translating national priorities into provincial budget allocations are limited to communications and agreements reached in meetings of the intergovernmental bodies established to facilitate budget planning across sectors and spheres of government - the Budget Council, joint Minmecs and 4x4s.[119] Directives to provincial treasuries from the Department of Health or National Treasury, which instruct them to allocate these funds to HIV/AIDS programmes, will be viewed as inappropriate national interventions in provincial budget processes. Thus a balance must be struck between promoting and protecting HIV/AIDS as a national priority, while simultaneously upholding the equitable share as an unconditional transfer to provinces and not undermining provincial budgeting autonomy.

6.3.5 Phasing out conditional grants

One reason the preceding analysis is important is because if the targeted increment is functioning effectively and provinces are allocating sufficient resources to HIV/AIDS the usefulness of the HIV/AIDS CGs partially falls away. CGs reinforce vertical programmes for HIV/AIDS. Their separate budgeting and reporting processes can run counter to efforts to scale up and integrate HIV/AIDS services into all aspects of health care service delivery.

From this perspective of sustainability, we need to be watching whether provinces are supplementing the CG funds with HIV/AIDS allocations from their own provincial budgets. Reduced reliance upon CGs to finance provincial HIV/AIDS interventions ought to be measurable by calculating the percentage of provincial HIV/AIDS expenditure sourced from CGs. However here we reach the limits of the official budget documentation. As Chapter 5 showed, Idasa's research based on provincial interviews has found that provinces *are* allocating additional funds for HIV/AIDS in their health budgets (over and above CGs received from national) and covering "invisible" HIV/AIDS costs from own provincial budgets (see also Appendix 4). However, most of these funds are not reflected in official budget documents, making tracking them very difficult.[120]

At what point then, in the development of government's response to HIV/AIDS, will we know the CGs are no longer appropriate? The CG for community and home-based care and support (CHBCS) is a case in point. In the 2003 DOR, National Treasury advised: "Provinces should budget for long-term recurrent funding of home based care and step down care (i.e. once projects have matured)."[121] The thinking behind this recommendation was laid out by the Department of Health as follows:

> *…funding for CHBC will in future be routed via the targeted increment to the equitable share (on the crucial assumption that this increment is adequately funded in coming years), and that the current CHBC element of the conditional grants be phased out over the MTEF, without prejudicing current plans. The*

[119] The term 4x4's refer to the joint technical committees composed of national and provincial department officials in a particular sector, as well as provincial and naitonal treasury officials. Sector 4x4s examine and research recommendations regarding key provincial spending pressures, including the administration of conditional grants.
[120] Although HIV/AIDS expenditure may not be dissaggregated in budget documentation, provincial departmental accounting structures may have specific objectives/codes for HIV/AIDS.
[121] Division of Revenue Bill 2003 Appendix E1: Frameworks for Conditional Grants to Provinces, 2003: 87.

same logic can be applied to the step down care component, which has been used for start-up funding of projects - if adequate funds are routed via the targeted increment, then recurrent funding of step down care can be taken up via this route. Clearly, this argument is rendered void if the targeted increment is not adequately funded (DOH 2002d: 6).

However, certainty that CHBCS is adequately included in the targeted increment costing is a necessary but insufficient reason for disbanding the CG. There are three additional considerations. The first holds true for all services and interventions relying on the targeted increment funds: provinces have to allocate the funds via their own provincial budget processes. Knowing that the targeted increment contains funds for these interventions does not mean that some (or all) of the required funds will necessarily trickle down to provincial health departments and be allocated for these interventions. Second, disbanding the CHBC CG funding or the step-down care CG funding would be premature if the service delivery institutions have not sufficiently established themselves and still require national's policy and technical assistance and oversight to get the proper institutions and staff in place. Third, CG funding gives the administering national department the authority to determine the split between the nine provinces, and to easily change that formula from year to year as better HIV/AIDS data becomes available, programmes mature and actual expenditure records improve.

As government continues to refine its HIV/AIDS funding strategy, it will be necessary to develop a framework for phasing out the CGs. This must include a clear understanding of the precise purpose and mandate for the three CGs and measures for calculating when their usefulness is overtaken by the targeted increment funding approach.

6.4 OTHER FUNDING OPTIONS

It is interesting to note that back in May 2000 the HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 recommended the following:[122] Funds for HIV/AIDS should be devolved to provinces from the national government only on the condition that certain standards are met. These include:

- Presence of an Inter Departmental Committee on HIV/AIDS;
- Commitment to "ring fence" funds for direct HIV/AIDS activities within provinces;
- Commitment to distribute funds according to the HIV/AIDS/STD Strategic Plan 2000-2005;
- Commitment to spend over 80% of the funds in one financial year;
- Commitment to roll funds over into the new financial year without risk of penalty;
- Commitment to prioritise the process of HIV/AIDS spending within the provinces;
- Commitment to ongoing national and provincial communication;
- Regular review of the implementation of HIV/AIDS plans;
- Establishing realistic goals and objectives that can be implemented within provinces and districts.

For the most part, these things have come to pass since the first year of the National Integrated Plan CGs in 2000/1. As examined in Chapter 4, CG spending in 2002/3 was 85% and funds are ring fenced for direct HIV/AIDS activities stipulated in the NIP. Accurate information on the successful rollover of unspent funds from one year to the next is a serious cause for concern, but will likely become less of an issue as spending improves.

[122] Department of Health, HIV/AIDS/STD Strategic Plan for South Africa 2000-2005, May 2000, Pg. 27.

In addition to the targeted increment for HIV/AIDS, two other ideas have been floated since 2000 as possible means of channelling funds to the provinces for HIV/AIDS. The first option is to formally incorporate HIV/AIDS into the equitable share formula. The second option involves variations on a more flexible CG.

6.4.1 Incorporating HIV/AIDS in the equitable share formula

As noted above, one drawback of the targeted increment for HIV/AIDS is that provinces with the most severe HIV/AIDS epidemics may not be favoured in the equitable share formula. This is because the targeted increment funds are added to the general pool of funds which is split - by formula - into equitable share grants for each province. That formula comprises seven components designed to reflect the varying demographic and economic profiles of the provinces and their relative demand for services (see Box 6.2).

Box 6.2. Equitable share formula

The equitable share formula has seven components, intended to reflect provincial circumstances. The weightings given to each are meant as indications of relative need and are not actually determinants of what provinces spend. The components are as follows:

- Education share (41%) based on the size of the school-age population (ages 6-17) and the average number of learners enrolled in ordinary public schools.
- Health share (19%) based on the proportion of the population with and without access to medical aid.
- Social security share (18%) based on the estimated number of people entitled to social security grants - the elderly, disabled and children - weighed by using the poverty index derived from the Income and Expenditure Survey.
- Basic share (7%) derived from each province's share of the total population of the country.
- Backlog component (3%) based on the distribution of capital needs as captured in the schools register of needs, the audit of hospital facilities and the distribution of the rural population.
- Economic output component (7%) based on the distribution of total remuneration in the country.
- Institutional component (5%) divided equally between all provinces.

  The equitable share is an unconditional transfer, which means that once the province receives the equitable share as a lump sum, the amount is distributed between various departments at its discretion. For example, the health component of the equitable share formula has a 19% weighting but health expenditure constituted 22.3% of provincial expenditure in 2003/4.

Source: 2003 *Budget Review*, pg. 259.

There are two possible scenarios for incorporating HIV/AIDS into the formula:

- Insert a new component for HIV/AIDS exclusively;
- Include HIV/AIDS into the health component.

In interviews with provincial HIV/AIDS managers support was expressed for the general idea, noting that it would bring more money to fight the epidemic. And in its April 2002 submission, the FFC noted that "consultations with stakeholders indicated the need for such a formula to include a variable for HIV/AIDS".[123]

However the FFC has consistently argued against formal incorporation of HIV/AIDS into the equitable share formula. In 2000 it stated: "The FFC believes that public health needs and priorities change

[123] Financial and Fiscal Commission. "Submission Division of Revenue 2003/4," 30 April 2002. Pg. 54.

continuously as new problems are identified, for example the increase in tuberculosis. Including specific disease factors in the formula tends to lock in patterns of aid distribution, making it more difficult to respond to changing needs."[124] The FFC reiterated its view in April 2002 and added additional arguments against inserting HIV/AIDS into the formula. Some of the key issues are as follows:

Data. A prime argument against inserting HIV/AIDS into the equitable share formula is technical and relates to which data is appropriate and valid. Use of government's prevalence figures from annual surveys of ante-natal clinics would be the obvious source of data. However as research improves and deepens, other studies which are arguably more comprehensive (and require fewer assumptions and less modelling to generate estimates for the overall population) might become available. For example, the Nelson Mandela/HSRC survey published in December 2002 contributed new information to our understanding of the epidemic because it used a household survey.

Related to this is the concern that - given the nature of HIV which manifests in numerous opportunistic infections - accurate data on the number of HIV-positive people using public health care services is tremendously difficult to calculate (see Section 6.1). The FFC argues that using non-credible data "could undermine the equitable share formula".[125] While HIV/AIDS data is very problematic, this is not a strong argument against inserting HIV/AIDS into the formula, given that the formula still uses the 1995 Income and Expenditure Survey and October Household Survey data, as well as 1996 Census figures.

Assurance that funds will be used for HIV/AIDS. This is a liability discussed in Section 6.3 and applies to the targeted increment as well as the incorporation of HIV/AIDS into the equitable share formula. As the FFC has also noted, there is no guarantee the funds will be used specifically for HIV/AIDS, nor is there a means to track those funds.[126]

Protecting the stability and integrity of the equitable share formula. The FFC and National Treasury assert that the stability of the formula should be protected.[127] That stability makes the formula more objective, less vulnerable to political changes and also affords provinces more certainty in predicting their revenue (Black, Calitz and Steenkamp). Given the frequent policy developments with government's response to HIV/AIDS, its not fitting to use the formula to distribute HIV/AIDS funds. Furthermore, if an entire component was to be devoted to HIV/AIDS, this raises the issue of reducing one or some components' percent share in the formula. The question would be which component should be reduced and why.

Need for greater national control over funding stream. Again, this argument applies to the targeted increment funding channel as well as the proposal to incorporate HIV/AIDS into the equitable share formula, and has been discussed earlier. As the Chief Financial Officer for the Department of Health said, the equitable share is "sluggish".[128] It is an indirect funding channel that does not allow national control over allocation of funds to HIV/AIDS generally, or to particular priority HIV/AIDS interventions.

6.4.2 Loosened conditional grant for HIV/AIDS

The best argument against incorporating HIV/AIDS into the equitable share formula is actually the argument *for* some adaptation of the present CGs. The primary advantage of CGs or earmarked funds is

[124] Financial and Fiscal Commission. "Recommendations 2001-2004 MTEF Cycle," May 2000. Pg. 46.
[125] Financial and Fiscal Commission. "Submission Division of Revenue 2003/4," 30 April 2002. Pg. 59.
[126] Financial and Fiscal Commission. "Submission Division of Revenue 2003/4," 30 April 2002. Pg. 59-60.
[127] Financial and Fiscal Commission. "Submission Division of Revenue 2003/4., 30 April 2002. Pg. 60. Also 2001 *Budget Review*. Pg. 246.
[128] Interview with Gerritt Muller, Chief Financial Officer, Department of Health.

that the administering national department is able to change resource allocation between provinces from year to year, as well as change the items and objectives of the CG. Thus it is a much more flexible and adjustable funding tool. At present, the impact of HIV/AIDS does not follow the distribution of the overall equitable share formula. Until the impact of the epidemic "evens out" across provinces, a more responsive funding tool will be needed to adjust the flow of financial resources according to relative need.

According to our interviews with provincial HIV/AIDS managers, an improved response to the epidemic would be brought about by increasing CG amounts, and reducing the conditions attached to them. Back in September 2001, the Department of Health raised the idea of a recurrent CG as a possible method of channelling funds to the provinces for the Enhanced Response to HIV/AIDS. "Creation (or conversion) of a new HIV/AIDS and TB recurrent grant, which is much more 'permissive' in that funds are released prospectively on a recurrent basis subject only to broad output/outcome targets, would allow earmarking of funds, but may cause artificial divisions between 'AIDS' and 'non-AIDS' services." (DOH 2001: 19). This has essentially been enacted in the form of the revised HIV/AIDS CG in the health sector. Given the apparent success of that approach, similarly loosening the restrictions on the Lifeskills and CHBCS CGs through the Departments of Education and Social Development might be advantageous.

As the health CG matures, it might be advantageous to standardise its allocation criteria to provide more predictability from the perspective of provinces. Indeed the Department of Health recognised that the development of "some form of resource allocation formula for provinces, which should be more or less directly based on AIDS-related service needs" would be required (DOH 2001: 19). For example, the health component of the equitable share could be used to determine the distribution of the HIV/AIDS CG - either in its present form or with the addition of health HIV/AIDS indicators. Different indicators can be given relative weightings; some indicators would need to reflect relative demand for services while others would be intended to reflect the target population of a particular intervention. For example:

Possible indicator for use in resource allocation formula	Associated HIV/AIDS interventions
Provincial share of national AIDS-sick population (using ASSA projections based on ante-natal survey data)	Treatment and care (CHBCS; step-down care; Centres of Excellence)
Provincial share of total new HIV infections in the previous year	Prevention (VCT; PEP for survivors of sexual assault; commercial sex workers)
Provincial share of HIV-positive pregnant women	PMTCT

Although more detailed indicators could be developed for each of the eight components of the health HIV/AIDS CG and relative weightings given to all eight components, it would be preferable to keep the formula simple and include the main indicators of the relative severity of the epidemic in each province. Weightings can be determined based on the general pattern of provincial allocations between these HIV/AIDS interventions. However in determining those weightings, it would be important to consider the province's entire HIV/AIDS expenditure (including provincially sourced funds as well as CG funds) so that the weightings reflect the true priority provinces assign to each intervention.

A major challenge in developing the most effective HIV/AIDS funding strategy is to balance the protection of a national priority with provincial budgetary autonomy. It will be necessary to be creative in formulating possible options besides the two main mechanisms currently used in South Africa: the equitable share and CGs. The specific expenditures, as well as hidden costs associated with HIV/AIDS, will likely demand a new and clever variation on these familiar funding channels. To this end, Chapter 7 concludes by summarising our findings and then putting forward a recommendation for a new recurrent grant to support provincial integrated strategies to address HIV/AIDS.

CHAPTER 7.

KEY FINDINGS AND RECOMMENDATIONS

We set out to analyse provincial expenditure on HIV/AIDS conditional grants (CGs) and to assess the success of the new targeted increment funding channel for HIV/AIDS. The goal was to produce recommendations on effective funding mechanisms for transferring funds to the provinces for HIV/AIDS interventions.

The research has shown that on the whole provinces are improving their spending on the HIV/AIDS CGs and that provinces are also beginning to allocate substantial funds for HIV/AIDS from their own provincial budgets. Although this report provides evidence that spending records on HIV/AIDS earmarked allocations are improving and both provinces and national government are boosting their budgeted allocations for HIV/AIDS, it is important to emphasise that this report does not speak to the sufficiency of these allocations. Nor does the report tell us whether the amounts spent and allocated are translating into improvements in the well-being of households and communities affected by HIV/AIDS. The main messages from the research are:

- On the whole the HIV/AIDS CGs are functioning well and should be continued with some changes in expenditure conditions and resource allocation criteria.

- We are beginning to see provinces making special allocations for HIV/AIDS from their own budgets - either via a decision of cabinet or the provincial treasury. However only a few provinces (primarily KwaZulu-Natal and Gauteng) are taking the lead.

- It has become clear that an effective funding strategy to address HIV/AIDS - including financing for a national ARV programme - cannot rely solely on earmarked funds, or CGs, for specific interventions. In order to address the indirect or "hidden" costs of HIV/AIDS, primarily in the health sector, it is necessary to also have some form of unconditional transfer or general budget support to provinces. National Treasury is therefore correct to adopt a dual financing strategy that relies on both funding channels.[129]

- The targeted increment introduced in 2002/3 may be the right tool to send funds to the provinces to cover HIV/AIDS treatment and care expenditure. But this indirect funding channel has serious liabilities, the largest of which is the difficulty of tracking whether provinces allocate those funds to health services and/or HIV/AIDS specifically. Therefore we need to be vigilant in reviewing this funding tool, and be willing to think creatively about ways to adjust and improve it.

[129] The Joint Task Team Report (2003: 59) recommended: "A dedicated budget for the acquisition of ARVs must be ring fenced….This budget can be centrally controlled or allocated to the provincial budgets. It can be in the format of CGs and equitable share. Whichever format is adopted, it is crucial that sustainable financing is guaranteed on an ongoing basis for this project to be successful."

7.1 KEY FINDINGS

The following are our key findings and associated recommendations.

7.1.1. Generally the HIV/AIDS conditional grants are working and should continue.

- There is evidence of great improvement: on aggregate provinces spent 36.5% of the total HIV/AIDS CG allocations in 2000/1; 74.5% in 2001/2; and 85.0% in 2002/3. (These figures do not include expenditure of unspent funds rolled-over from the previous year's budget.)

- It is also vital to understand that these improved track records occurred despite massive increases in allocations year to year. What is happening here is that national government is responding to the epidemic by rapidly increasing allocated funds, as well it should. But realistically, it must be understood that this places extraordinary expectations on line managers to spend doubled or tripled allocations from one year to the next. From 2000/1 to 2001/2 national boosted the earmarked funds for HIV/AIDS sent to provinces by over 160%. From 2001/2 to 2002/3, the amount national expected provinces to spend tripled from one year to the next.

- *Including expenditure on rollovers*, provincial HIV/AIDS managers succeeded in spending R109 million in 2001/2 - this is six times the amount spent in the previous year. Moreover, in 2002/3 actual spending increased again by over 250%, to R385 million.

- Beginning in 2001/2 aggregate spending on HIV/AIDS CGs matched or exceeded average spending on CGs generally (which is between 70.1% (our calculation) and 84.6% (National Treasury). This suggests:
    - The usual difficulties experienced with CG spending have been surmounted by quick improvement in HIV/AIDS programme structures and spending procedures;
    - The problems with spending CGs reported by HIV/AIDS provincial managers were not particular to HIV/AIDS but were largely general issues experienced by line managers.

- Capacity (e.g. financial and project management) remain stumbling blocks, but primarily in the Departments of Social Development and Education because provincial health departments have been able to use provincial management funds for staffing.

7.1.2. The more flexible conditional grant for health is welcomed by provinces and facilitates their spending.

Under the looser restrictions on the health HIV/AIDS CG, provinces were simply given an "approved list" of activities for which they could use the funds; resource allocations between those activities were left to the province's discretion.

- Aggregate spending for the health HIV/AIDS CG has increased from 60% in the first year to 99% in 2002/3.

- In 2001/2, national more than doubled the amount the provinces were asked to spend to R54.4 million, yet provinces managed that year to *increase* their aggregate spending record to 82.9%.[130] When we include rollover funds, we see that in 2001/2 provinces spent over four times the amount they did the first year. By our calculations, aggregate actual expenditure on the HIV/AIDS health CGs in 2001/2 was R50.525 million, compared to R10 million spent the previous year. In the following year - 2002/3 - provinces increased their expenditure by over 300%, to R203.6 million.

- Pressure on provincial HIV/AIDS managers to spend increased CG amounts continues in Budget 2003/4. In 2003/4 the total health HIV/AIDS CG allocation is R333.556 million. This can be compared to R210.209 allocated the previous year. To achieve full expenditure, provinces will need to spend over 60% more than they did in 2002/3, or a further R130 million compared to last year.

- The more flexible HIV/AIDS health CG does have two negative consequences:

    - One weakness of the current approach is that because provinces can use the funds for different combinations of these eight activities, the Department of Health cannot base its global cost estimate for the health HIV/AIDS CG on what provinces plan to spend or even which programmes they plan to implement. Instead the global amount for the health HIV/AIDS CG is now the sum of top-down cost estimates of its component national programmes (as generated by the Directorate: Health Financing and Economics in the Department of Health), which may or may not be fully approved/funded by National Treasury. It is *not* the sum of cost estimates generated in each province for those interventions they plan and choose to implement.

    - Another notable consequence of this approach is that figures on the aggregate budget allocations and expenditure by provinces for each intervention (e.g. PEP for rape survivors or programmes for commercial sex workers) is not readily available.

- In determining the global amount for the health HIV/AIDS CG, provincial actual expenditure records should not be taken into account. Poor performance of particular provinces should not influence the global envelope but instead be incorporated into resource allocation decisions at a lower level (i.e. the Department of Health's determination of how much goes to each province).

7.1.3. Conditional grant for CHBCS through the Department of Social Development should be increased.

For many provinces, the issue is not how to spend what they have, but how to get more.

- In the first year, aggregate spending was only R2 million of the R5.62 million allocated. Not only did provinces do much better at spending their CG budgets in 2001/2, some provinces also managed to also spend the entire unspent funds from 2000/1 which were rolled over into 2001/2. Total spending - including rollovers - was R14 million in 2001/2 and jumped to R46 million the next year. This is a remarkable increase in absorption capacity from one year to the next.

- If instead we only look at provinces' expenditure record on the current year's CG budget (i.e. expenditure of funds rolled over from the previous year are not included), we see that expenditure in

[130] This figure does not include expenditure of any funds rolled over from the previous year - it is the percent spent of the current year's CG allocation. See Table 4.3.

2000/1 was only 35.6% but that on aggregate provinces spent 81.3% of the total CG budget for 2001/2. That rises to 92.7% in 2002/3.

- According to our reading of provincial budget documents, five provinces were allocating HIV/AIDS funds in their social development budgets over and above the CG received from national.

- Given that the bulk of CHBCS funds are transferred to NGOs, a major issue is smooth grant-making procedures and timely flow of funds from national to provinces to NGOs.

- From the perspective of the national Department of Social Development, the advantage of the CG is that it pushes provinces to act and to have programmes and initiatives in place. The challenge now is to up the ante and to roll out more broadly. At first the Department of Social Development used a site-based approach, but now the work must be extended to more areas to truly become a national, universal programme.

7.1.4. Lifeskills grant spending is blocked more by limited staff capacity and absorption than by the amount of funds available. Adding a provincial management component to the Lifeskills grant (similar to the health conditional grant) could ease this bottleneck.

- In the first year provinces on aggregate only spent R6 million or just 22% of their budgeted CG allocation. However the following year actual expenditure increased to R44.7 million. And in 2002/3 provinces in total spent three times that amount: R135.5 million.[131]

- Despite rapid increases in allocations *plus* added pressures from unspent funds rolled over, provinces still managed to improve their spending records from 66% in 2001/2 to 87% in 2002/3.

- Interviews with provincial Lifeskills managers indicate that the main problem is the insufficiency of staff. In relation to need in schools, the allocation may be insufficient. But in relation to staff in place to run provincial programmes, the amount is already more than they can spend.

- The variation in size and structure of provincial management of Lifeskills programmes is largely due to a) varying commitment by provinces to the Lifeskills programme in terms of contributing dedicated posts in addition to those funds by the Department of Education, and b) varying degrees of programme maturity in terms of devolving management and establishing posts at district level.

- There is a need to devolve funds and management to district level but this requires: sufficient staffing at provincial level; funded posts at district level; strong financial management systems at provincial and district level; and financial management skills at district level.

- Although some provinces finance Lifeskills manager positions at provincial and/or district level and provincial education departments contribute in-kind support to the Lifeskills programme, it appears from budget documents and interviews that no provinces contribute themselves to the budget of the Lifeskills programme.

- Provincial contributions to the Lifeskills budget (in addition to CG funds from national government) would not only ease budgetary pressures but may well increase expenditure - due to the fact that

[131] These figures include expenditure on funds rolled over from the previous year.

funds sourced from provincial department allocations are more flexible and do not carry the same strict spending requirements attached to CG funds.

- The Lifeskills programme has consistently used the education component of the equitable share formula to determine the size of the slice for each province. Given that the target population is all learners (and not only HIV-infected people), this is a rational allocation tool for the CG and its consistent use has the further benefit of allowing provincial managers to plan ahead with certainty.

In summary, the expenditure records, particularly given the massive increases year on year in budgeted allocations, demonstrate that the HIV/AIDS CGs are functioning effectively. Certainly improvements are needed, particularly with financial management and staffing needs, so that absorption capacity and efficiency can be improved. Without also conducting impact analysis, its not possible to comment on the outcomes of expenditure, but from a budgeting perspective, the CGs are largely successful as funding channels for delivering funds to provincial departments for HIV/AIDS interventions identified as priority items by national government.

7.1.5. Provinces *are* making special allocations for HIV/AIDS from their own budgets - in addition to the conditional grant funds for HIV/AIDS received from national government.

Some provincial cabinets and provincial treasuries have made special allocations for HIV/AIDS which were essentially top-sliced off the global provincial budget.

- On aggregate, Idasa calculates that actually provinces have allocated R356.5 million from their own budgets for HIV/AIDS health expenditure in 2003/4. This is a 96% increase from the year before.

- In 2004/5 and 2005/6 the aggregate totals for provincially sourced HIV/AIDS health expenditure are R433.4 million and R501.3 million respectively.

- Two provinces are clearly taking the lead in dedicating funds from their own budgets for HIV/AIDS health interventions: KwaZulu-Natal and Gauteng together account for 73% of the aggregate discretionary provincial HIV/AIDS health expenditure in 2003/4.

    - In the case of KwaZulu-Natal, a cabinet decision was made to allocate R126 million additional funds to the health department for the roll-out of PMTCT in 2003/4. A further R34.4 million was allocated to the HIV/AIDS subprogramme as part of the regular health department budget process, so that the total amount in the HIV/AIDS subprogramme in 2003/4 includes the PMTCT funds from cabinet, the CG from national and funds from the regular provincial health department budget.

    - In Gauteng the provincial cabinet allocated R100 million to the HIV/AIDS subprogramme in 2003/4, rising to R200 million in 2004/5 and then R250 million in 2005/6.

- A key point to note is that calculations based solely on official budget statements *under-report* the amount provinces are dedicating to HIV/AIDS in their health budgets (by the order of R185 million over the Medium Term Expenditure Framework). Those provinces where cabinet *has* set aside special funds for HIV/AIDS or where the provincial health department is targeting amounts for HIV/AIDS in addition to the CGs would do well to clearly reflect those allocations in their official budget documents. There is a need for greater transparency, comprehensiveness and accuracy related to

HIV/AIDS-targeted funds in provincial health department budgets. Improved accuracy, detail and disaggregation in official provincial budget statements would facilitate our understanding of government expenditure on HIV/AIDS; enable civil society to better monitor HIV/AIDS resource allocation; and provide the public with a more accurate picture of the extent to which provinces are designating funds for HIV/AIDS.

7.1.6. We agree with National Treasury and the Department of Health that earmarked funding for HIV/AIDS is only appropriate for limited aspects of HIV/AIDS-related spending.

- The primary advantage of CGs or earmarked funds is that the administering national department is able to change resource allocation between provinces from year to year, as well as change the items and objectives of the CG. From the perspective of national departments, it is a more flexible and adjustable funding tool. Dedicated funding (e.g. CGs) works to drive programmes and to catalyse interventions which provinces would not otherwise undertake.

- When it comes to indirect costs associated with HIV/AIDS, earmarked funds (including CGs) are not the most effective mechanisms for transferring funds to the provinces. These "hidden" costs are too intertwined with regular health care service delivery to use CGs to finance them. To scale up interventions, budgets must be integrated in order to be sustainable, effective, efficient and of a wide scope.

- In 2003/4 R1.1 billion was added to the total provincial equitable share intended for HIV/AIDS treatment and care. By its introduction of indirect HIV/AIDS funding (in the form of the equitable share increment) national government is wisely adopting a dual strategy to finance a holistic response to the epidemic - using CG funds for targeted programmes while simultaneously channelling additional funds (through the equitable share) to deal with the larger indirect impact of HIV/AIDS on the public health sector budget.

- Given the impossibility and undesirability of tracking all HIV/AIDS related expenditure in hospitals and clinics, clearly some form of general budget support to provincial health departments is necessary. However the danger is that funds intended for HIV/AIDS which are sent via the equitable share will not be allocated for provincial health and/or HIV/AIDS related services.

7.1.7. The targeted increment for HIV/AIDS does appear to have been associated with increased funding for provincial health services. However using budget analysis, it is very difficult to establish that these funds were used for HIV/AIDS.

Evidence supporting the conclusion that the targeted increment is resulting in increased budget allocations for provincial health services and HIV/AIDS related expenditure is as follows:

- Aggregate provincial health expenditure *is* increasing. The aggregate resource envelope for provincial health departments grows from R33.105 billion in 2002/3 to R36.931 billion in this year's budget - this is real growth of 5.14%.

- Discretionary provincial health expenditure also increases by R2.954 billion in this year's budget (representing a 4.86% real increase compared to 2002/3). In 2002/3 it is R26.237 billion, and in 2003/4 it is R29.192 billion.

- Theoretically, if the R1.1 billion was successfully flowing through the equitable share grant to provincial health budgets (with zero leakage), then provincial discretionary health expenditure for each province should increase by at least the province's share of the R1.1 billion. This holds true for each province. On aggregate, in 2003/4, the total equitable share pool increased by R22.9 billion compared to the previous year, and R4.7 billion of that money flowed through to provincial health budgets (or 20%).

- Furthermore, the percentage of new equitable share funds which "passed through" to the provincial health budgets has increased from 12% in 2001/2 to 20% in 2002/3.

- The strongest evidence to suggest provinces are dedicating more of their discretionary funds to HIV/AIDS is that in 2002/3 provinces on aggregate allocated 0.61% of their discretionary provincial health budget specifically to HIV/AIDS. In 2003/4, this percentage doubled to 1.22%.

- More significantly, last year 0.12% of provinces' total discretionary expenditure was targeted to HIV/AIDS in the health sector. In 2003/4, this percentage also doubled to 0.24%.

7.1.8. A serious drawback of the equitable share funding mechanism is reduced transparency and inability to track flow and allocation of these funds intended for HIV/AIDS treatment and care.

The key issue is whether provincial health departments and HIV programmes in other social service departments are aware that these funds have been "added" to their province's equitable share grant. The targeted increment funding channel requires that provincial health departments motivate to their provincial treasuries for the additional AIDS funds (available via the equitable share) to be added to their budgets.

7.1.9. Formal incorporation of HIV/AIDS into the equitable share formula is not advised.

The primary reasons are: the credibility of the data and questions on which data and indicators to use; the lack of assurance that funds will be used for HIV/AIDS and inability to track the funds; the need to protect the stability and integrity of the equitable share formula; and the need for greater national control over HIV/AIDS resource allocation than that afforded by the equitable share funding stream.

7.2 New recurrent grant to support integrated provincial HIV/AIDS strategies

The main problem with the targeted increment funding channel is that we cannot assure funds are allocated for provincial health services and/or HIV/AIDS programmes; the main advantage of the targeted increment is that it allows provinces discretion to allocate funds between HIV/AIDS interventions so that they can capitalise on successful programmes which are ready for roll-out. Simultaneously the main benefit of the CGs is that national government can regulate the flow of funds to each particular province and make resource allocation decisions which prioritise particular regions depending on how severely they are affected by the epidemic.

Drawing on the positives from both these current transfer mechanisms, we propose a new recurrent grant to support provincial integrated strategies for HIV/AIDS. The grant would be based on a formula and subject to broad output/outcome targets. The key characteristic of the new grant would be that instead of being administered by the Department of Health and thus limited to the health sector,

the grant should be administered by National Treasury and sent to the province as a lump sum (similar to the equitable share) so that it can be allocated via the regular budget process. Each province would allocate those funds across departments according to a provincial integrated HIV/AIDS strategy in which different social service departments participate.[132] This approach could yield the following advantages:

- Funds would be conditioned upon their expenditure according to the provincial HIV/AIDS strategy, and thus national would ensure that provinces allocate funds for HIV/AIDS. However funds would only be subject to broad output and outcome indicators. Progress towards those indicators would be taken into consideration in National Treasury's determination of the following year's grant.

- Payment schedules and funding tranches would be avoided as the funds would be transferred to the province in a lump sum at the start of the financial year.

- Provinces would have the discretion to allocate the HIV/AIDS funds between interventions at their discretion, thus favouring programmes where there is greatest need or which are ready for expansion.

- The current system of three separate HIV/AIDS CG entrenches sectoral divisions in government's HIV/AIDS response. Instead a funding strategy is needed which reinforces integrated programme planning and implementation. Funds from the new integrated HIV/AIDS grant would be allocated according to each province's integrated HIV/AIDS strategy, which does not depend on the health sector alone.

- At present not all provinces have a fully-developed integrated HIV/AIDS plan, and provincial buy-in to the National Integrated Plan and Enhanced Response is not as strong as it could be. A new grant to support provincial HIV/AIDS strategies would prompt provinces to develop interdepartmental units and planning forums to formulate a full integrated plan and to co-ordinate programmes. In some respects, provincial integrated HIV/AIDS strategies would serve as the "business plans" for accessing the grant from national government.

- Provinces can designate an interdepartmental unit, which is responsible for co-ordinating joint planning and monitoring of the HIV/AIDS funds. Some provinces already have an interdepartmental HIV/AIDS unit (e.g. Gauteng), and this would be the ideal scenario. However in the interim some provinces could elect for a HIV/AIDS unit in their health department or as a special unit in the Premier's office.

In summary, the key characteristic of this new grant for provincial integrated HIV/AIDS strategies is that it would be *conditional*, in the sense that it must be used for HIV/AIDS-related expenditure. Yet it would be *unconditional* in the sense that it would delivered as a lump sum and provinces would retain the authority to allocate it across departments and types of interventions in a manner most fitting to departmental capacity, readiness to spend and the HIV/AIDS situation in that province.

[132] Gauteng is an important model of a province that allocates funds according to a province-wide HIV/AIDS plan. Gauteng has an interdepartmental HIV/AIDS unit, separated from the health department, and an Interdepartmental AIDS Committee, which convenes an interdepartmental process for budget and programme planning. The Unit manages the interdepartmental HIV/AIDS strategy and supports departments in developing and implementing programmes (Whelan 2001: 19).

7.3 Conclusion

How do we protect HIV/AIDS as a national priority in the budget without setting up vertical programmes that are inefficient from a health care service delivery perspective, and counter-productive to an integrated national programme? Implementation of a multi-sectoral integrated HIV/AIDS response in South Africa depends upon the successful practice of co-operative governance principles - both vertically and horizontally. Horizontally, HIV/AIDS demands the involvement, investment and co-operation of national departments besides health. Vertically, government's response to HIV/AIDS is coming up against a basic tension inherent in our intergovernmental fiscal system: provinces are primarily responsible for social service delivery yet overwhelmingly reliant upon nationally sourced revenue. Thus a major issue in HIV/AIDS financing strategy is the degree of national control over provincial resource allocation and service delivery.

Ultimately the HIV/AIDS funds channelled through the equitable share raise questions of whether co-operative governance - as envisioned in the Constitution - is working in the arena of intergovernmental fiscal relations. Does the Constitutional framework of co-operative intergovernmental fiscal relations give us the tools we need to effectively mobilise resources for a government response to HIV/AIDS?

If the targeted increment funding mechanism proves successful in increasing provincial allocations to HIV/AIDS, we may see copy-cat efforts in subsequent budgets, as other "semi-earmarked" increments are infused into the equitable share for specific purposes. Taken to the extreme, this would jeopardise the equitable share as an unconditional transfer to provinces and undermine provincial budgeting autonomy. On the flip side, if the targeted increment funding mechanism is unsuccessful, it suggests national government is seriously hampered: it is unable to transmit national priorities into provincial resource allocation, yet also unwilling to further entrench HIV/AIDS vertical programmes by the continued and/or expanded use of CG financing.[133]

From a programming perspective, it is imperative that provinces take on HIV/AIDS as a priority issue and drive these programmes themselves. From a budgeting perspective, this means provinces come to decrease their reliance upon CGs for HIV/AIDS financing and truly fold HIV/AIDS into their regular budget priorities. A successful funding strategy will provide incentives for provinces to allocate funds for HIV/AIDS from their own budgets, while avoiding displacement and crowding out.

With an effective combination of funding channels, the future budgeting strategy for HIV/AIDS which includes financing for ARVs can serve as an opportunity to jack up the entire public health sector - as a tide lifts all boats - instead of strengthening one vertical programme at the expense of the rest.

[133] We are indebted to Martin Hensher, Directorate: Health Financing and Economics, Department of Health, for these points.

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NATIONAL INTERVIEWS - 2003

Ms Anita Marshall, National Coordinator - National Integrated Plan for Children and Youth Infected and Affected by HIV/AIDS, National Department of Health.

Mr Gerritt Muller, Chief Director: Financial Management, National Department of Health.

Mr Brennand Smith, National Life Skills: HIV/AIDS Co-ordinator, National Department of Education.

Ms Johanna de Beer, Deputy Director: HIV/AIDS, National Department of Social Development.

Mr Lungisa Fuzile, Chief Director: Provincial Policy and Planning, National Treasury.

Dr Mark Blecher, Director of the Social Sector, National Treasury.

Mr Martin Hensher, European Union Consultant in Health Economics, Health Financing & Economics Directorate. National Department of Health.

PROVINCIAL INTERVIEWS - 2003

Eastern Cape

Mrs Nomalanga Makwedini, Director: HIV/AIDS, TB and STDs, Department of Health.

Ms Nonzwakazi Madonsela, Deputy Director: HIV/AIDS, TB and STDs Directorate, Department of Health.

Mrs Gwarube, HIV/AIDS Life Skills Manager/Provincial Co-ordinator (Senior Education Specialist), Department of Education.

Mrs Nombembe, HIV/AIDS CHBCS Manager/Provincial Co-ordinator (Deputy Director), Department of Social Development.

Mr Qonda Kalimashe, Senior Manager: Budget Management, Provincial Treasury.

Mr Kuzi Phuthi, Senior Manager of Expenditure (Health and DSD conditional grants), Provincial Treasury.

Mr Ncedo Hoyi, Manager of Expenditure (Health conditional grant), Provincial Treasury.

Free State

Mrs Ntsiki Jolingana, Director: HIV/AIDS, TB and STI Directorate, Department of Health.

Mrs Carol Makobe, Deputy Director/ Manager: HIV/AIDS, TB and STI Directorate, Department of Health.

Mrs Speckmeier, Provincial Co-ordinator/ Manager: Lifeskills HIV/AIDS Programme, Department of Education.

Mrs D. Monare, HIV/AIDS Provincial Co-ordinator/Manager, Department of Social Development.

Mr Ntshona, Director of Social Development programme: Department of Social Development.

Gauteng

Dr Elizabeth Floyd, Director: HIV/AIDS and STD Programme, Department of Health.

Mr Hamilton Kali, Manager: HIV/AIDS Workplace Employee Support, Department of Education.

Ms Edwina MacMaster, HIV/AIDS Provincial Coordinator, Department of Social Development.

Mrs Nomfundo Tshabalala, Chief Director: Budget Management, Department of Finance and Economic Affairs.

KwaZulu-Natal

Dr Sandile Buthelezi, Director: Provincial AIDS Action Unit, Department of Health.

Mrs Cliff, Financial Manager: Provincial AIDS Action Unit, Department of Health.

Dr H. Gumede, Director: Psychological Guidance and Special Education Services, Department of Education.

Mr. Khumalo, Manager: HIV/AIDS/ Lifeskills Programme, Department of Education.

Mr. T.L. Msikinya, Deputy Director: Social Services – HIV/AIDS Programme, Department of Social Development.

Mr Siddiq B. Adam, Manager: Budget Planning, Provincial Treasury.

Limpopo

Mr Gandi Moetlo, Director: HIV/AIDS, STDs and TB Directorate, Department of Health.

Mrs Chuenyane, HIV/AIDS Manager, Department of Education.

Mr Abdul Kader Carim, Chief Financial Officer, Department of Education.

Ms Loraine Maumela, Senior Manager: Welfare Financial Management, Department of Welfare.

Mr P. Mothiba, Manager: Budget Policy and Planning, Department of Finance, Economic Affairs and Tourism.

Mr Phuti Robert Masehela, Director: Budget Policy and Planning, Department of Finance, Economic Affairs and Tourism.

Western Cape

Dr Faried Abdullah, Director: HIV/AIDS, TB and STD Directorate, Department of Health.

Mr Peter Fenton, Life Skills/HIV/AIDS Provincial Co-ordinator/Manager, Department of Education.

Mr Klaas Langehaven, Director of Expenditure, Provincial Treasury.

Appendix 1. Overview of components of health HIV/AIDS conditional grant

	Components	Allocation	Criteria for provincial split
2000/1	VCT	R8.629 m	Based on the national survey conducted in 1999 on the status and availability of VCT in all provinces and the business plans submitted by the provinces.
Budget Review 2001, pg. 265. Budget Review 2002/3, pg. 141. Errata.	Home-based care	R8.190 m	
	TOTAL	**R16.819 m**	
2001/2	VCT	R22 m	Based on the national survey conducted in 1999 on the status and availability of VCT in all provinces and the business plans submitted by the provinces. Also considered: 1999 audit on health and NGO sectors used in SD's allocation process; provinces of highest prevalence; priority areas identified by cabinet (EC, KZN, Limpopo, NW); areas with poverty alleviation programmes in place; areas implementing the Integrated Nutrition Programme.
Budget Review 2001, pg. 265. Budget Review 2002/3, pg. 141. Errata.	Home-based care	R12.1 m	
	PMTCT	R20.298 m	
	TOTAL	**R54.398 m**	
2002/3	VCT	R49 m	Health equitable share weighting
Budget Review 2002/3, pg. 141. Errata. Also "Health Share of Integrated Plan Plus Additional Grants" from National Treasury.	Home-based care	R46.5 m	2000 Antenatal Survey Prevalence
	PMTCT "progressive rollout'	R25 m	Province's estimated share of HIV+ births
	Step-down care for AIDS patients not requiring full hospital services but needing more care than can be provided at home	R30 m	Province's estimated share of stage 3 & 4 AIDS cases
	Strengthening provincial management to address "sub-optimal capacity and the need to ensure proper financial and procurement controls" (Budget Review 2002, pg. 141)	R6.709 m	Each province receives R745 000
	TOTAL	**R 157.209 m**	

Appendix 1. Overview of components of health HIV/AIDS conditional grant (cont.)

	Components	Allocation	Criteria for provincial split
2003/4	VCT	R44.58 m	"Provinces have flexibility to allocate within total - components are indicative only." (*Revising the Enhanced Response*, DOH, September 2002.) The budget request from DOH for 2003/4 totalled R428.472 million and gave requested amounts for each component. However the amount actually allocated by National Treasury in Budget 2003/4 was only R333.556m. The amounts listed here are constructed using the same proportions as the DOH request, but based on the actual R333.556 total. Annual budget of R5 million for each Centre of Excellence was put forward by DOH.
"Revising the Enhanced Response", Department of Health, September 2002. DOR 2003, pg. 87.	Home-based care	R52.23 m	
	PMTCT	R84.69 m	
	Step-down care (start-up and capacity building)	R48.81 m	
	Provincial management: HIV/AIDS and TB (programme co-ordinators, administration and monitoring staff)	R 8.15 m	
	Provincial Centres of Excellence in AIDS care.	R 29.29 m	
	Commercial sex worker programmes (condom distribution, STI treatment)	R16.27 m	
	Post-exposure prophylaxis for survivors of sexual assault	R49.54 m	
	TOTAL	**R 333.556 m**	
NOTE: Beginning in 2003/4 provinces were given flexibility to allocate conditional grant funds between the components at their discretion. Thus aggregate totals of amounts allocated by provinces for each component are no longer readily available.			

Appendix 2. HIV/AIDS conditional grant expenditure (including rollovers)

	4th Quarter ended 31 March 2002				4th Quarter ended 31 March 2003					
R '000	Govt gazettes of 15, 31May, 26 Nov 2001 and 28 March 2002	Total available 2001/02 (same as transferred from natl to prov)	Unaudited provincial actual spending	2001 spending as percent total available (or total transferred)	DOR Act 2002	Govt gazette, 29 November 2002	Total available	Transferred from national to provincial	Provincial actual spending	2002 spending as percent of total available
Eastern Cape	**2431**	**19528**	**20693**	**106.0%**	**52097**	**8192**	**60289**	**60289**	**40719**	**67.5%**
Education		11747	7377	62.8%	26270	968	27238	27238	11163	41.0%
Health	2431	6281	11395	181.4%	21130	7123	28253	28253	24758	87.6%
Social Development		1500	1921	128.1%	4697	101	4798	4798	4798	100.0%
Free State	**866**	**10217**	**6499**	**63.6%**	**29409**	**4970**	**34379**	**34379**	**35825**	**104.2%**
Education		4001	1232	30.8%	8946	126	9072	9072	10083	111.1%
Health	866	4716	3767	79.9%	13953	4704	18657	18657	16884	90.5%
Social Development		1500	1500	100.0%	6510	140	6650	6650	8858	133.2%
Gauteng	**2130**	**14440**	**5409**	**37.5%**	**47555**	**8233**	**55788**	**55788**	**41250**	**73.9%**
Education		7810	0	0.0%	17466	246	17712	17712	18154	102.5%
Health	2130	5630	4409	78.3%	23253	7840	31093	31093	16113	51.8%
Social Development		1000	1000	100.0%	6836	147	6983	6983	6983	100.0%
KwaZulu-Natal	**9424**	**29457**	**32325**	**109.7%**	**79104**	**13860**	**92964**	**92964**	**116404**	**125.2%**
Education		14033	16800	119.7%	31382	442	31824	31824	30403	95.5%
Health	9424	13924	14240	102.3%	39260	13236	52496	52496	80857	154.0%
Social Development		1500	1285	85.7%	8462	182	8644	8644	5144	59.5%
Mpumalanga	**1309**	**10795**	**7695**	**71.3%**	**32900**	**5556**	**38456**	**38456**	**28497**	**74.1%**
Education		4636	3895	84.0%	10366	146	10512	10512	13449	127.9%
Health	1309	4659	1528	32.8%	15606	5261	20867	20867	7946	38.1%
Social Development		1500	2272	151.5%	6928	149	7077	7077	7102	100.4%
North West Province	**790**	**11220**	**6504**	**58.0%**	**30857**	**5045**	**35902**	**35902**	**36160**	**100.7%**
Education		5080	3115	61.3%	11360	160	11520	11520	9452	82.0%
Health	790	4640	2254	48.6%	14149	4770	18919	18919	21245	112.3%
Social Development		1500	1135	75.7%	5348	115	5463	5463	5463	100.0%
Northern Cape	**815**	**7372**	**8041**	**109.1%**	**11029**	**2026**	**13055**	**13055**	**11292**	**86.5%**
Education		1207	944	78.2%	2698	40	2738	2738	2859	104.4%
Health	815	4665	4665	100.0%	5727	1930	7657	7657	5727	74.8%
Social Development		1500	2432	162.1%	2604	56	2660	2660	2706	101.7%
Limpopo	**1705**	**17024**	**16271**	**95.6%**	**40734**	**5568**	**46302**	**35155**	**45558**	**98.4%**
Education		9969	9969	100.0%	22294	319	22613	11466	23906	105.7%
Health	1705	5555	4701	84.6%	15371	5183	20554	20554	18517	90.1%
Social Development		1500	1601	106.7%	3069	66	3135	3135	3135	100.0%
Western Cape	**828**	**10345**	**5940**	**57.4%**	**22024**	**3155**	**25179**	**25179**	**29608**	**117.6%**
Education		5017	1391	27.7%	11218	158	11376	11376	16005	140.7%
Health	828	4328	3566	82.4%	8760	2953	11713	11713	11519	98.3%
Social Development		1000	983	98.3%	2046	44	2090	2090	2084	99.7%
TOTAL	**20298**	**130398**	**109377**	**83.9%**	**345709**	**56605**	**402314**	**391167**	**385313**	**95.8%**
Education		**63500**	**44723**	**70.4%**	**142000**	**2605**	**144605**	**133458**	**135474**	**93.7%**
Health		**54398**	**50525**	**92.9%**	**157209**	**53000**	**210209**	**210209**	**203566**	**96.8%**
Social Development		**12500**	**14129**	**113.0%**	**46500**	**1000**	**47500**	**47500**	**46273**	**97.4%**

Source notes for 2001/2:

2001/2 figures for health and education are entirely from *Statement of the National and Provincial Governments' Revenue and Expenditure and National Borrowing as at 31 March 2002.* Social development figures are corrected against information obtained from Ms J. De Beer, Deputy Director: HIV/AIDS, Department of Social Development:

Eastern Cape: According to J. De Beer, expenditure was only R750,000 with R761,000 underspent and requested as rollover. National Treasury Statements give R1.921m figure as actual spent. We assume that the entire R950,000 of unspent funds from 2000/1 were rolled over and became part of the 2001/2 expenditure.

KwaZulu-Natal: National Treasury Statements give figure of R1.499m. According to J. De Beer, expenditure is R1.285m.

Mpumalanga: Most likely the entire unspent amount from 2000/1 of R960,000 was rolled over into 2001/2. Total spent during 2001/2 (according to J. De Beer) was R2.446m. National Treasury Statements give figure of R2.272m.

Northern Cape: R932,000 was rolled over from 2000/1, according to J. De Beer. Total expenditure reported in National Treasury of R2.432m is complete spending of 2000/1 and 2001/2 allocations.

North West: Total expenditure during 2001/2 was R1.1355m (according to J. De Beer). This includes expenditure of R1 million rolled over from the previous year. National Treasury Statements give figure of R1.151m actual spent for 2001/2.

Limpopo: Total expenditure listed in NT of R1.601m is complete spending of both 2001/2 allocation and R101,000 rolled over from 2000/1, according to J. De Beer.

Source notes for 2002/3:

Figures are taken from *Statement of the National and Provincial Governments' Revenue, Expenditure and National Borrowing as at 31 March 2003* except in the following cases:

Free State health conditional grant: Correspondance with Mr. O.N.V. Fundakubi, Manager: Financial Planning & Control, indicates that the 2002/3 figure of R16.884m listed in Budget Statement, pg. 205 is estimated expenditure. National Treasury Statements instead list R18.657m.

Northern Cape health conditional grant: NC 2003 Budget Statement, pg. 226 lists R5.727 estimated actual expenditure for 2002/3 (Subprogramme 2.6 only contains conditional grant). National Treasury Statements instead indicate R7.657m.

KwaZulu-Natal health conditional grant: There is contradictory information. National Treasury Statements give a figure of R80.857m. In a presentation to the Parliamentary Health Committee (14/3/03), KwaZulu-Natal reported that they overspent on their conditional grant allocation by R57.612m which then had to be paid back from the department budget.

North West health conditional grant: National Treasury Statements give actual expenditure for 2002/3 as R23.567m. Presentation to parliamentary Health Committee 16 April 2003 gives figures of R21.245m.

North West social development conditional grant: National Treasurt Statements list R10.232m actual expenditure. According to J. De Beer, CHBC Coordinator at Department of Social Development, accurate figure is R5.463m actual expenditure.

Appendix 3. HIV/AIDS conditional grant expenditure

excluding expenditure on funds rolled over from the previous year

	4th Quarter ended 31 March 2002				4th Quarter ended 31 March 2003					
R '000	Govt gazettes of 15, 31May, 26 Nov 2001 and 28 March 2002	Total available 2001/02 (same as transferred from national to prov)	Unaudited provincial actual spending	2001 spending as percent total available (or total transferred)	DOR Act 2002	Government gazette, 29 November 2002	Total available	Transferred from national to provincial	Provincial actual spending	2002 spending as percent of total available
Eastern Cape	**2431**	**19528**	**14408**	**73.8%**	**52097**	**8192**	**60289**	**60289**	**40719**	**67.5%**
Education		11747	7377	62.8%	26270	968	27238	27238	11163	41.0%
Health	2431	6281	6281	100.0%	21130	7123	28253	28253	24758	87.6%
Social Development		1500	750	50.0%	4697	101	4798	4798	4798	100.0%
Free State	**866**	**10217**	**6499**	**63.6%**	**29409**	**4970**	**34379**	**34379**	**32606**	**94.8%**
Education		4001	1232	30.8%	8946	126	9072	9072	9072	100.0%
Health	866	4716	3767	79.9%	13953	4704	18657	18657	16884	90.5%
Social Development		1500	1500	100.0%	6510	140	6650	6650	6650	100.0%
Gauteng	**2130**	**14440**	**5409**	**37.5%**	**47555**	**8233**	**55788**	**55788**	**40808**	**73.1%**
Education		7810	0	0.0%	17466	246	17712	17712	17712	100.0%
Health	2130	5630	4409	78.3%	23253	7840	31093	31093	16113	51.8%
Social Development		1000	1000	100.0%	6836	147	6983	6983	6983	100.0%
KwaZulu-Natal	**9424**	**29457**	**29242**	**99.3%**	**79104**	**13860**	**92964**	**92964**	**88043**	**94.7%**
Education		14033	14033	100.0%	31382	442	31824	31824	30403	95.5%
Health	9424	13924	13924	100.0%	39260	13236	52496	52496	52496	100.0%
Social Development		1500	1285	85.7%	8462	182	8644	8644	5144	59.5%
Mpumalanga	**1309**	**10795**	**6909**	**64.0%**	**32900**	**5556**	**38456**	**38456**	**25560**	**66.5%**
Education		4636	3895	84.0%	10366	146	10512	10512	10512	100.0%
Health	1309	4659	1528	32.8%	15606	5261	20867	20867	7946	38.1%
Social Development		1500	1486	99.1%	6928	149	7077	7077	7102	100.4%
North West Province	**790**	**11220**	**5504**	**49.1%**	**30857**	**5045**	**35902**	**35902**	**33834**	**94.2%**
Education		5080	3115	61.3%	11360	160	11520	11520	9452	82.0%
Health	790	4640	2254	48.6%	14149	4770	18919	18919	18919	100.0%
Social Development		1500	135	9.0%	5348	115	5463	5463	5463	100.0%
Northern Cape	**815**	**7372**	**7109**	**96.4%**	**11029**	**2026**	**13055**	**13055**	**11125**	**85.2%**
Education		1207	944	78.2%	2698	40	2738	2738	2738	100.0%
Health	815	4665	4665	100.0%	5727	1930	7657	7657	5727	74.8%
Social Development		1500	1500	100.0%	2604	56	2660	2660	2660	100.0%
Limpopo	**1705**	**17024**	**16170**	**95.0%**	**40734**	**5568**	**46302**	**35155**	**44265**	**95.6%**
Education		9969	9969	100.0%	22294	319	22613	11466	22613	100.0%
Health	1705	5555	4701	84.6%	15371	5183	20554	20554	18517	90.1%
Social Development		1500	1500	100.0%	3069	66	3135	3135	3135	100.0%
Western Cape	**828**	**10345**	**5957**	**57.6%**	**22024**	**3155**	**25179**	**25179**	**24979**	**99.2%**
Education		5017	1391	27.7%	11218	158	11376	11376	11376	100.0%
Health	828	4328	3566	82.4%	8760	2953	11713	11713	11519	98.3%
Social Development		1000	1000	100.0%	2046	44	2090	2090	2084	99.7%
TOTAL	**20298**	**130398**	**97207**	**74.5%**	**345709**	**56605**	**402314**	**391167**	**341939**	**85.0%**
Education		**63500**	**41956**	**66.1%**	**142000**	**2605**	**144605**	**133458**	**125041**	**86.5%**
Health		**54398**	**45095**	**82.9%**	**157209**	**53000**	**210209**	**210209**	**172879**	**82.2%**
Social Development		**12500**	**10156**	**81.3%**	**46500**	**1000**	**47500**	**47500**	**44019**	**92.7%**

Source notes for 2001/2:

2001/2 figures for health and education are entirely from *Statement of the National and Provincial Governments' Revenue and Expenditure and National Borrowing as at 31 March 2002.*

Social development figures are corrected against information obtained from Ms J. De Beer, Deputy Director: HIV/AIDS at Department of Social Development, and only include expenditure against the 2001/2 allocation. (In other words, in the cases where provinces rolled over funds from the previous year - Mpumalanga, Northern Cape, North West, and Limpopo - we do not include their 100% expenditure of the rolled-over funds here.) Those cases were as follows:

KwaZulu-Natal social development conditional grant: National Treasury Statements give figure of R1.499m. According to J. De Beer, expenditure is R1.285m.

Northern Cape social development conditional grant: R932,000 was rolled over from 2000/1, according to J. De Beer. Total expenditure reported in National Treasury of R2.432m is complete spending of 2000/1 and 2001/2 allocations. Spending on 2001/2 allocation was therefore 100%.

North West social development conditional grant: Total expenditure during 2001/2 was R1.135486, according to J. De Beer, however R1 million was funds rolled over from the previous year. Thus R135,486 is the expenditure against the new R1.5 m allocation for 2001/2. National Treasury Statement give figure of R1.151m actual spent for 2001/2.

Limpopo social development conditional grant: Total expenditure listed in National Treasury of R1.601m is complete spending of both 2001/2 allocation and R101,000 rolled over from 2000/1, according to J. De Beer.

Source notes for 2002/3:

Figures are taken from *Statement of the National and Provincial Governments' Revenue, Expenditure and National Borrowing as at 31 March 2003* except in the following cases:

Free State health conditional grant: Correspondance with Mr. O.N.V. Fundakubi, Manager: Financial Planning & Control, indicates that the 2002/3 figure of R16.884m listed in Budegt Statment, pg. 205 is estimated expenditure. National Treasury Statements instead list R18.657m.

Northern Cape health conditional grant: Budget Statement pg. 226 lists R5.727m estimated actual expenditure for 2002/3 (Subprogramme 2.6 only contains conditional grant). National Treasury Statements instead indicate R7.657m.

KwaZulu-Natal health conditional grant: There is contradictory information. National Treasury Statements give a figure of R80.857m. In a presentation to the parliamentary Health Committee (14/3/03),KwaZulu-Natal reported that they overspent on their conditional grant allocation by R57.612m which then had to be paid back from the department budget.

North West health conditional grant: National Treasury Statements give actual expenditure for 2002/3 as R23.567m. Figure provided in a presentation to parliamentary Health Committee 16 April 2003 was instead R21.245m.

North West social development conditional grant: National Treasury Statements list R10.232m actual expenditure. According to Ms J. De Beer, Deputy Director: HIV/AIDS at Department of Social Development, the accurate figure is R5.463m actual expenditure.

Adjustments

In a number of cases, actual expenditure figures which provinces provided to National Treasury exceeded their conditional grant allocation. This occurs when provinces report expenditure of departmental funds in addition to conditional grant funds, or when provinces report on expenditure of funds rolled-over from the previous year. In these cases, we have adjusted the figures here to instead show 100% expenditure - so as to ensure that aggregate spending records are not biased upwards.

Those cases where expenditure reported exceeded the conditional grant allocation are listed below along with actual expenditures figures from National Treasury Statements.

2001/2

Eastern Cape: Health conditional grant R11.395m. Eastern Cape health department indicated in personal correspondance that 2001/2 expenditure was actually R2.988m (not R11.35 m as reported to National Treasury), although this figure likely under-reports expenditure because systems were not sufficiently developed at the time to capture all spending on conditional grant funds.

KwaZulu Natal: Education conditional grant R16.8m and Health conditional grant R14.24m

2002/3

Free State: Education conditional grant R10.083m and Social Development conditional grant R8.858m

KwaZulu Natal: Health conditional grant R80.857m

Mpumalanga: Education conditional grant R13.449m

Northern Cape: Education conditional grant R2.859m and Social Development conditional grant R2.706m

Limpopo: Education conditional grant R23.906m

Western Cape: Education conditional grant R16.005m

Gauteng: Education conditional grant R18.154m

North West: Health conditional grant R23.567m

Appendix 4

Provincially-sourced HIV/AIDS allocations in the provincial departments of health (provincial grants) R'000.					
	2002/3 Adju. Expend.	2003/4	2004/5	2005/6	Explanations on sources of financial information cited herein. Idasa calculations
EC	R33,000	R32,013	R34,795	R36,660	*For 2002/3, the HIV/AIDS programme received a R33 million provincial grant allocation from the provincial budget (Ms Madonsela, Deputy Director of HIV/AIDS, TB and STI Directorate). Figures for 2003/4 – 2005/6 are ubprogramme 2.6 allocation (EC BS: 93) minus CG allocation (DOR 2003: 87). Confirmed by Ms Makwedini, Director of HIV/AIDS and STI Directorate. Also confirmed by departmental presentation to parliamentary Health Committee 15/4/03.*
FS	R1,766	R4,688	R3,836	n/a	*Figures here were provided by Ms Jolingana, Director of HIV/AIDS, TB and STI Directorate, as the HIV/AIDS prevention allocation, sourced from the provincial budget. For 2003/4, R2.314m is transfers to NGOs and R2.373m for HIV/AIDS prevention--for a total of R4.688m for HIV/AIDS from the provincial budget, according to personal correspondence with Ms Jolingana and Mr Fundakubi, Manager: Financial Planning & Control, DOH. For 2004/5, provincial own allocation for HIV/AIDS prevention is R3.836m (Jolingana). Provincial own allocations for 2005/6 were not available from the department.*
GP	R58,750	R100,000	R200,000	R250,000	*Figures here are taken from presentation to parliamentary Health Committee by Gauteng Department of Health, 14 April 2003. According to the presentation, original allocation from province for 2002/3 was R75m but the adjusted amount was R58.75m.*
KZN	R37,326	R160,932	R167,573	R177,556	*In 2002/3 the provincial health department allocated R15.966m for HIV/AIDS and the cabinet also made a special allocation of an additional R21.36m (Dr Buthelezi, Director, Provincial AIDS Action Unit). According to a presentation to parliamentary Health Committee 14/4/03, for 2002/3 "The Department exceeded the funds provided for this CG by R57.612 m. The province has covered the difference in the funding." For 2003, cabinet approved R126.457m for PMTCT (KZN BS: 16) plus an additional R34.475m was allocated for HIV/AIDS from the provincial budget. Funds allocated from the provincial budget for 2004/5 and 2005/6 include funds approved by cabinet for roll-out of PMTCT (R134.713m in 2004/5 and R143.47m in 2005/6).*
LP	R8,364	R12,745	R4,688	n/a	*Memo from M. Moetlo (Senior Manager: HIV/AIDS,/STIs & TB) gives figure of R9.285m as actual expenditure of provincial own allocation for 2002/3 (compared to budgeted amount of R8.364m). For 2003/4, Mr Moetlo gives different figure of R6.188m for provincial own allocation from equitable share. The R12.745m figure given here for 2003/4 is taken from more detailed information provided by Mr Mabela (on behalf of Mr Moetlo) and includes funds from Office of Senior Manager: HIV/AIDS; the HIV/AIDS/STD programme; and SD: Tuberculosis Control. For 2004/5, R4.688m figure is also taken from memo from Mr Mabela. According to office of Senior Manager: HIV/AIDS in the Department of Health and Welfare, information for 2005/6 was not yet available.*
MP	R7,315	R6,030	n/a	n/a	*Figures given here for 2002/3 and 2003/4 are calculated based on information from presentation to parliamentary Health Committee 15/4/03, which indicates overall HIV/AIDS allocations was R28.182m for 2002/3 and R32.317m for 2003/4 . Figures for 2004/5 and 2005/6 are unclear/unavailable. Subprogramme 2.6 allocations (M BS: 117) are R27.864m and R29.397m for 2004/5 and 2005/6 respectively. However, CG amounts for both years are much higher: R36.4m and R46.4m respectively. Therefore its unclear if the subprogramme allocations contain some or none of the anticipated cg funds.*
NC	n/a	n/a	n/a	n/a	*For 2003/4 through 2005/6, Subprogramme 2.6 (NC BS: 226) includes no funds over and above the CG allocation.*
NW	R11,500	R10,000	n/a	R13,355	*R11.5m equals Subprogramme 2.6 allocation (NW BS: 61) minus R18.919m (DOR 2003: 87). 2003/4 figure given here is Subprogramme 2.6 allocation (R42.891m) minus cg (DOR 2003:87). 2004/5 figure is problematic because the Subprogramme 2.6 allocation of R40.479m (NW BS: 61) is smaller than the total CG amount R41.855m (DOR 2003:87). 2005/6 figure is Subprogramme 2.6 allocation of R56.024m (NW BS: 61) minus CG (DOR 2003: 87).*
WC	R23,921	R30,050	R22,514	R23,717	*Figures equal Subprogramme 2.6 allocation (WC BS: 201) minus cg allocations (DOR 2003: 87).*
Total	R181,942	R356,458	R433,406	R501,288	

National HIV/AIDS conditional grants as listed in the Division of Revenue Bill (DOR) 2003				
R'000	2002/3 Adju.Expend.	2003/4	2004/5	2005/6
EC	R28,253	R38,934	R58,193	R77,451
FS	R18,657	R30,144	R40,843	R42,621
GP	R31,093	R55,275	R87,629	R91,844
KZN	R52,496	R85,591	R122,270	R123,313
LP	R20,554	R28,962	R42,479	R55,996
MP	R20,867	R26,287	R36,364	R46,441
NC	R7,657	R11,268	R17,318	R18,924
NW	R18,919	R32,891	R41,855	R42,669
WC	R11,713	R24,204	R34,661	R35,849
Total	*R210,209*	*R333,556*	*R481,612*	*R535,108*

Total HIV/AIDS provincial health allocations (National conditional grant + provincial grant). Idasa calculations.				
R'000	2002/3 Adju. Expend.	2003/4	2004/5	2005/6
EC	R61,253	R70,947	R92,988	R114,111
FS	R20,423	R34,832	R44,679	R42,621
GP	R89,843	R155,275	R287,629	R341,844
KZN	R89,822	R246,523	R289,843	R300,869
LP	R28,918	R41,707	R47,167	R55,996
MP	R28,182	R32,317	R36,364	R46,441
NC	R7,657	R11,268	R17,318	R18,924
NW	R30,419	R42,891	R41,855	R56,024
WC	R35,634	R54,254	R57,175	R59,566
Total	*R392,151*	*R690,014*	*R915,018*	*R1,036,396*