

# Analyzing funding for HIV and TB in South Africa to assess allocative efficiency (2011/12–2013/14)

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RESULTS FOR  
DEVELOPMENT

# Outline of this presentation

## Purpose and methodology

### Key Findings:

- National analysis
- Provincial breakdown
- District breakdown

### Key Messages

## Purpose of this analysis

The national, provincial, and district-level analysis of spending on HIV and TB in South Africa was intended to supplement the cost estimates undertaken for the Investment Case, and attempted to answer the following questions:

1. How much money was spent on HIV and TB by the South African Government (SAG), PEPFAR, and the Global Fund in the years 2011/12 to 2013/14 – are there issues affecting sustainability?
2. How was this money spent across interventions and geographies, and by funding source – were these the ‘optimal’ mix/ balance?
3. What financial and epidemiological data challenges limit our understanding – what needs to be improved to ensure that geographical targeting (hotspots) has the impact we hope for?

# Basic Methodology

1

## Collect Inputs

- Collected HIV and TB spending from PEPFAR EA, Global Fund EFRs, and SAG BAS & NT reports
- SAG = DOH, DOE, DSD, DCS, SAPS, DOD and other ES (if labelled HIV (BAS records & NT records))
- TB out-patient estimated spending was calculated based on provincial patient # and unit costs

2

## Crosswalk

- 3 datasets consolidated into one (common structure based on BAS – country suitability)
- 6 sets of spending categories were “crosswalked” or reconciled

3

## Analysis

- Analysis of Excel consolidated database
- Matrices and graphs generated
- Draft figures were approved by NDOH, NT, PEPFAR and GF

## Six sets of spending categories were “crosswalked” (or reconciled) to the public BAS ‘common codes’

	Spending Category	Example
1	South Africa IC Categories	“Treatment & Care”
2	NASA Categories	“ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment”
3	SHA Categories	“HC.1.3.1 General outpatient curative care”
4	Global Fund SDA Categories *	“Care and support for the chronically ill”
5	PEPFAR EA Program Areas **	“FBTCS”
6	BAS – 300 different names for 35 core programs - consolidated	“ART”

**BAS  
Common  
Codes**

\* Global Fund EFR data were not split by district. Estimates were used based on indicative split

\*\* PEPFAR data not split by district

# Outline

## Purpose and methodology

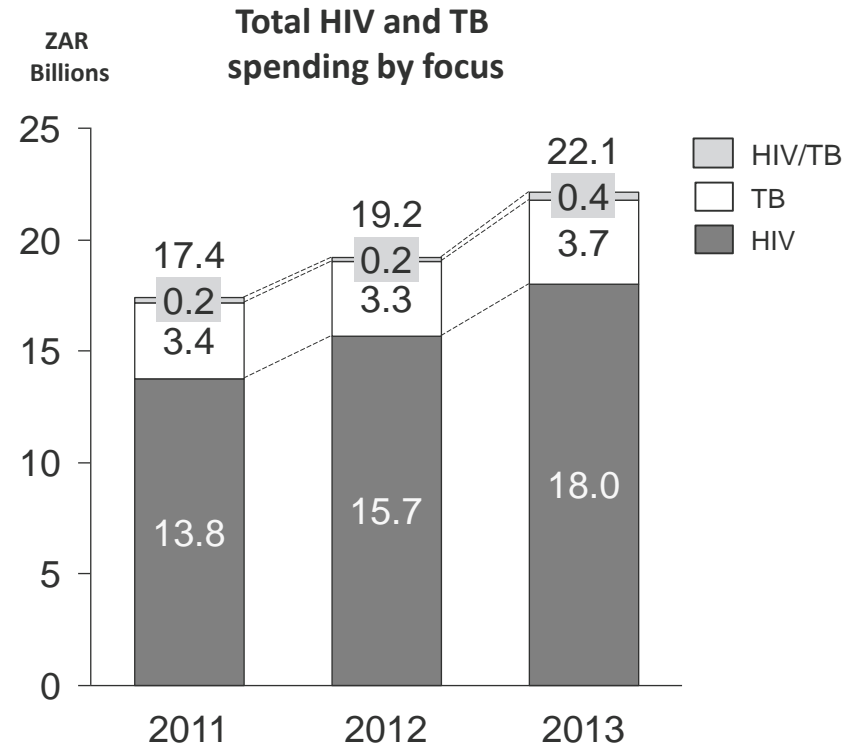
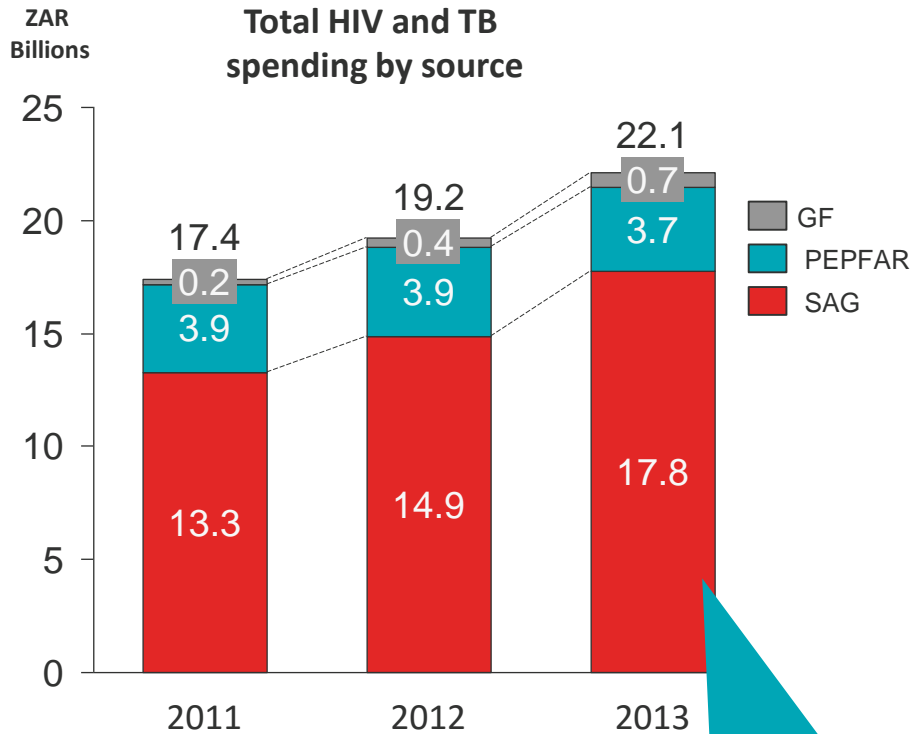
### Key Findings:

- National analysis
- Provincial breakdown
- District breakdown

## Key Messages

## National Analysis – SAG, GF, PEPFAR

# The SAG contributes the majority of funding, which mainly goes to HIV



**US\$ 2.3 billion in 2013/14**  
**SAG = 80% (16% inc ann.av)**  
**PEPFAR = 17% (5% dec)**  
**GF = 3% (77% increase)**

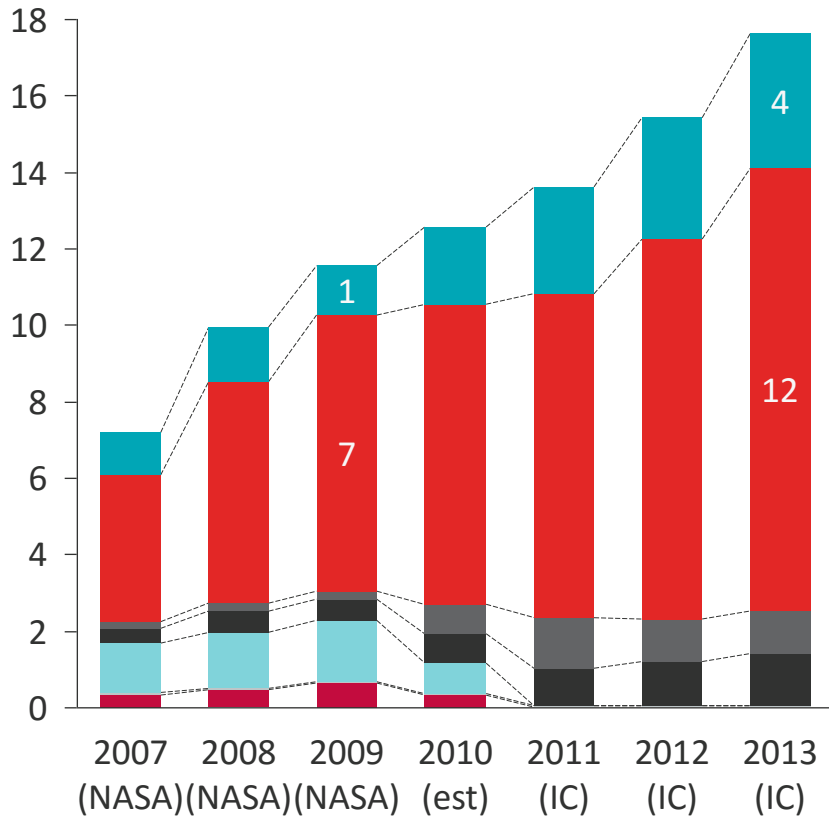
**NB. GF TB expenditure could not be separated within the SDAs. Excludes USAID additional contributions to TB (not reported in the EA data): USG FY11: \$13,972,000, USG FY12: \$12,000,000, USG FY13: \$12,008,901.**



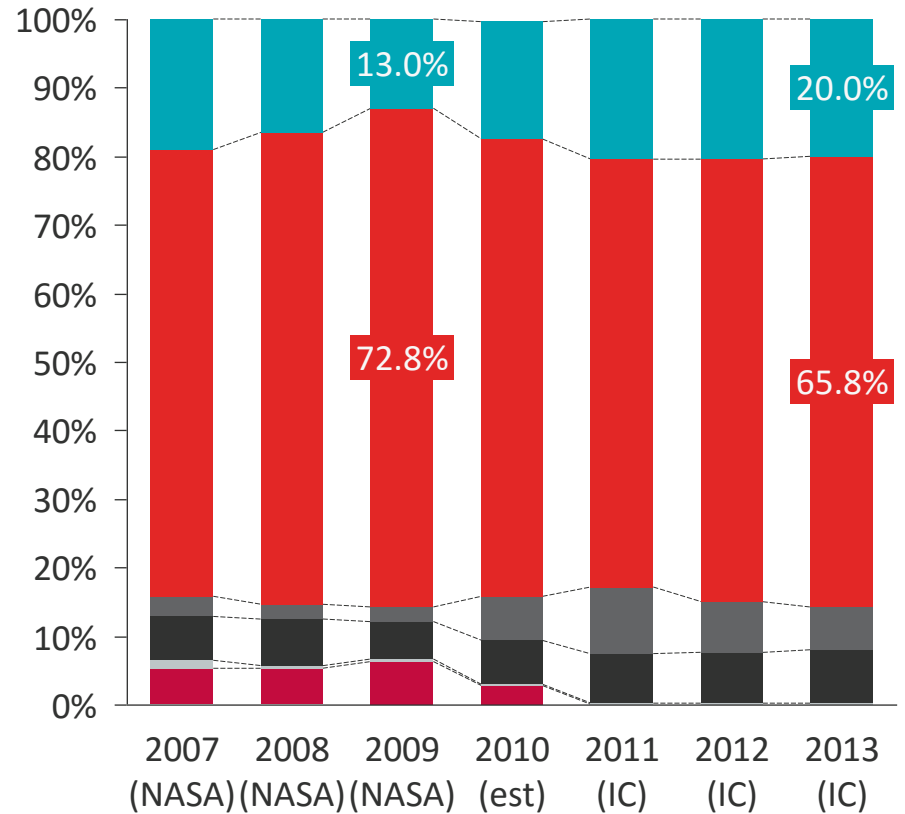
# Spending by thematic split for HIV has changed over time, but what should be the optimal mix?

Billions ZAR

## Historical Thematic Spending

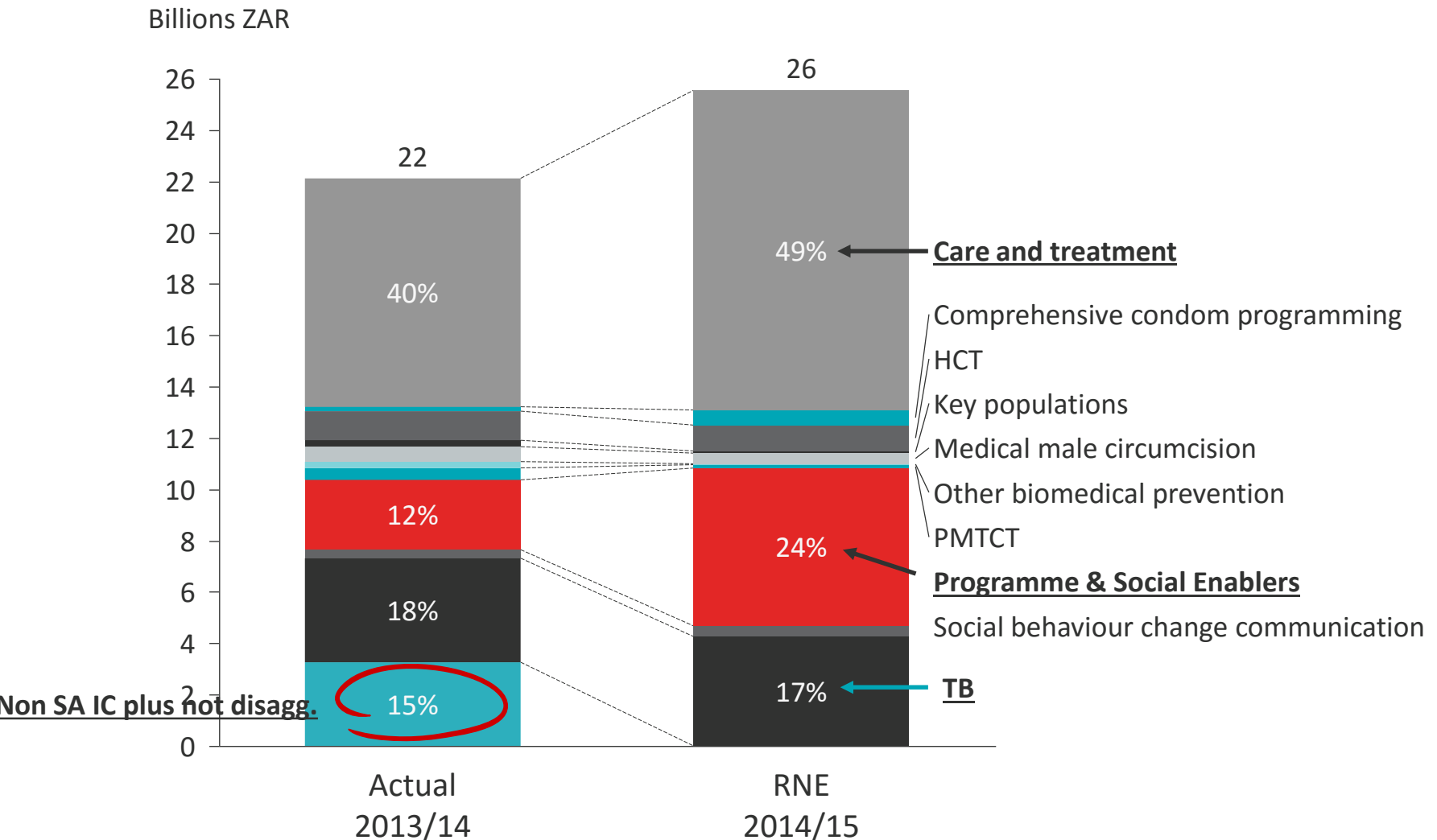


## Historical Thematic Spending (%)



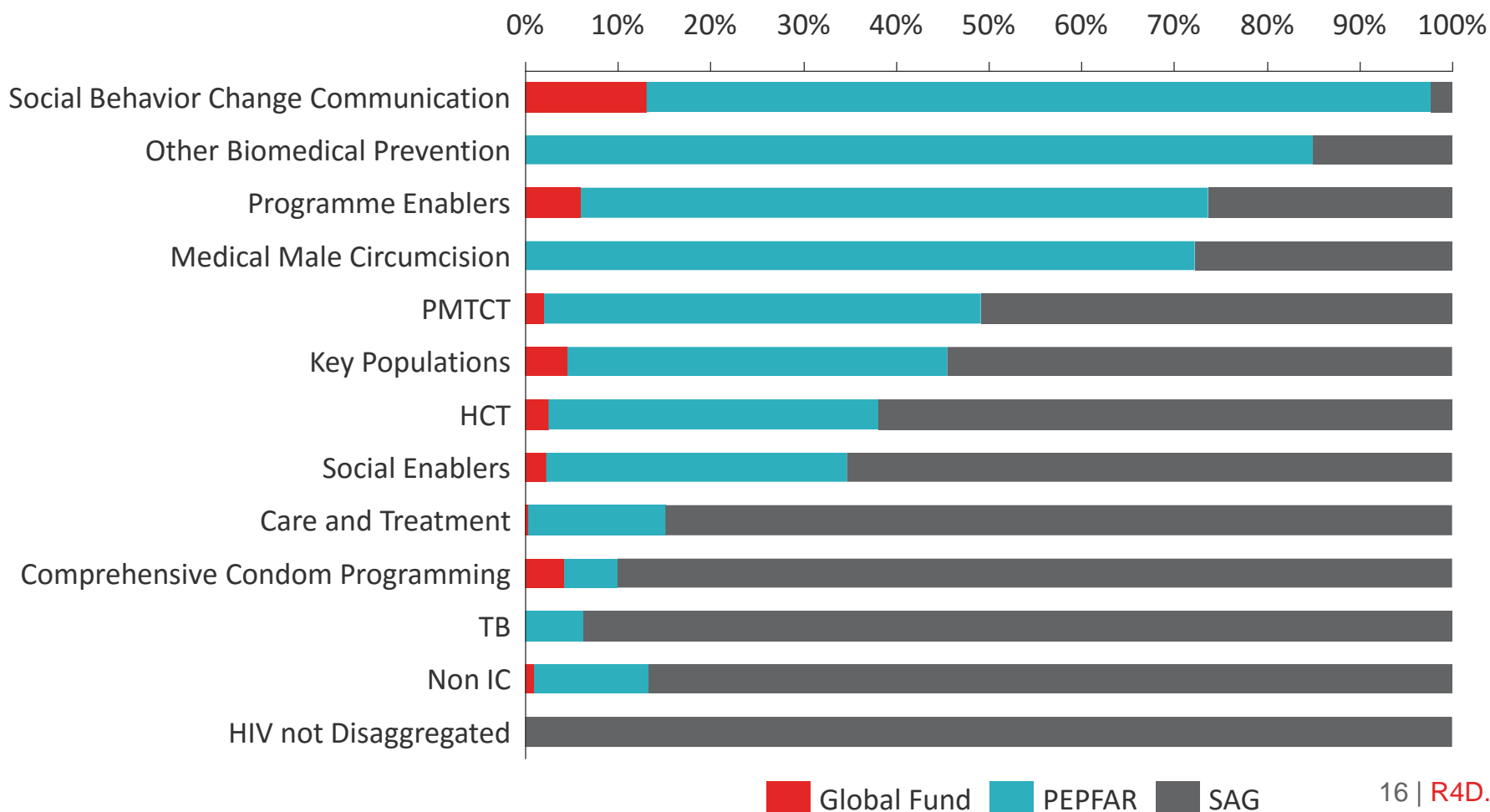
# Comparing 2013/14 spending with 2014/15 Resource Needs

Estimates could help answer adequacy and allocative efficiency questions



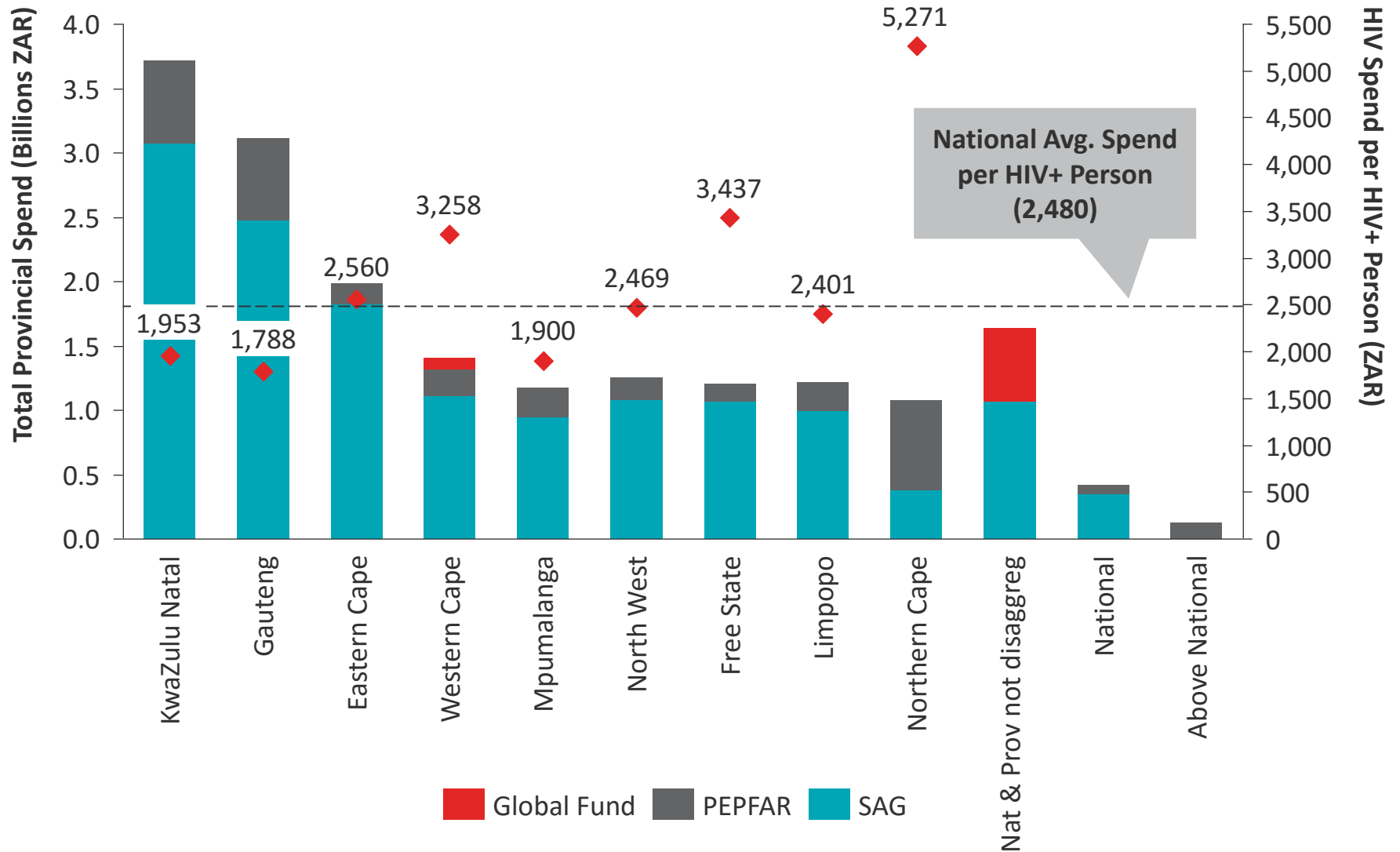
## Proportional contribution by funding source shows potential program vulnerabilities (2013/14)

- *What is the optimal balance from funding sources for each program?*
- *At what point would a program be considered vulnerable?*



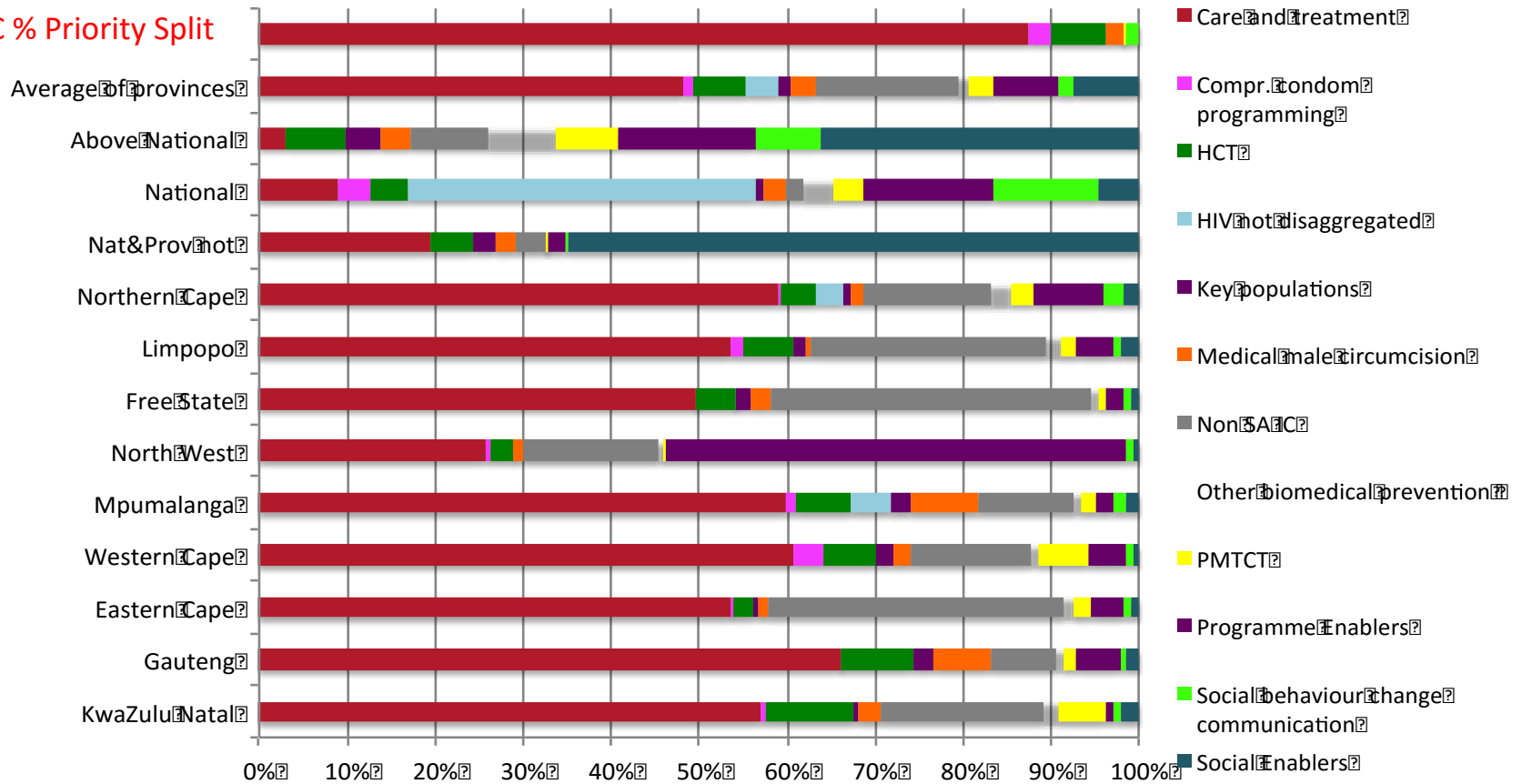
## Provincial Analysis – SAG, GF, PEPFAR

# Does variance in spending per HIV+ person imply technical and/or allocative efficiency? (2012/13, ZAR)



# Provincial proportional HIV spending by intervention – by all 3 sources (2013/14). What is the best mix?

## IC % Priority Split



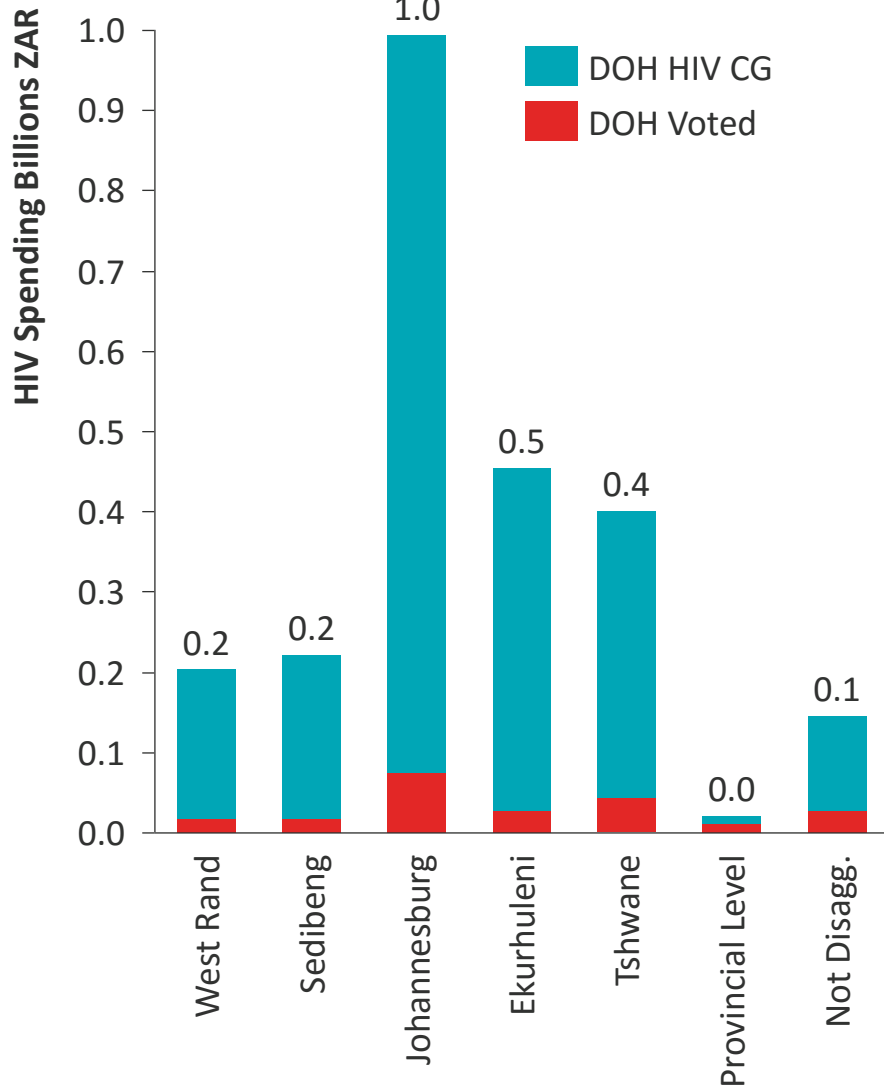
- **Treatment & Care = on average 48% [26% in NW – 66% in GP]**
- **HCT = average 6% [2% NW – 10% KZN]**
- **MMC = average 3% [1% in EC, NW, LP, NC – 8% in MP]**
- **PMTCT = average 3% [0% in NW – 6% in WC]**
- **Prog. Enablers = average 7% [1% in KZN – 52% in NW]**
- **National level = 40% not disagg., 15% prog.enablers, 12% SBCC, 9% treatment**

## District Analysis: Gauteng, preliminary data example

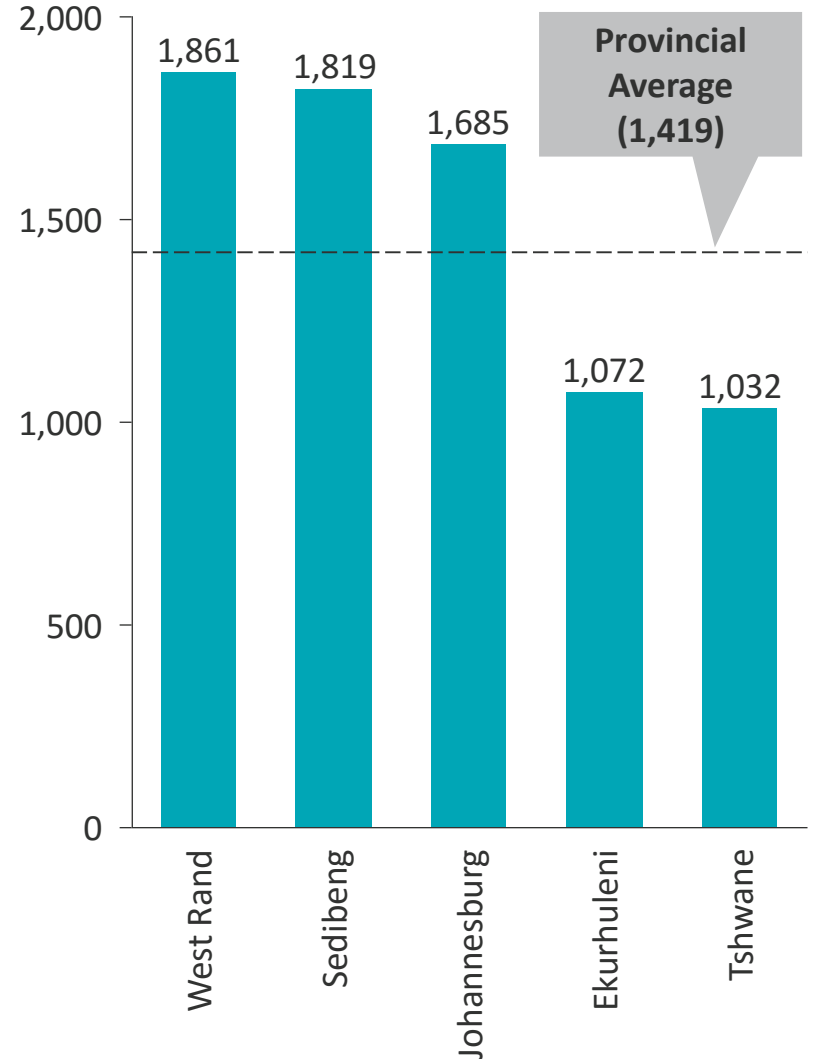
(noting a lack of district specific HIV-prevalence data limiting comparison – *pending*)

# Gauteng DOH spending: total and per HIV+ person, per year (2013/14, ZAR)

## Total spending



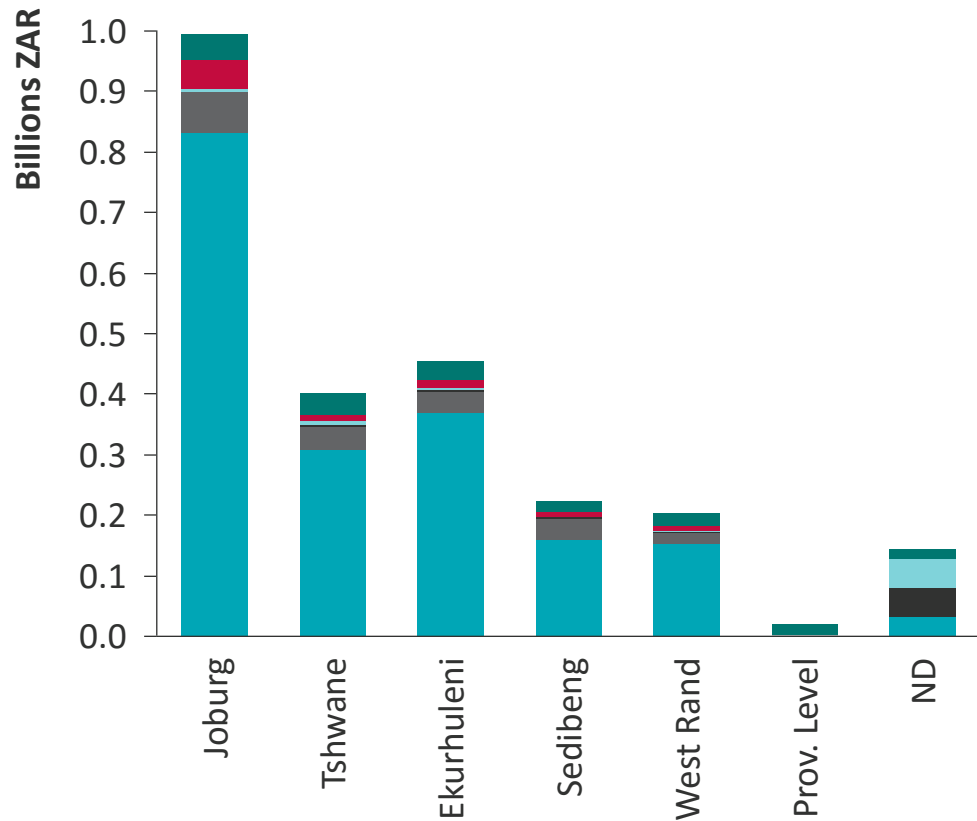
## ZAR Spending per HIV + person



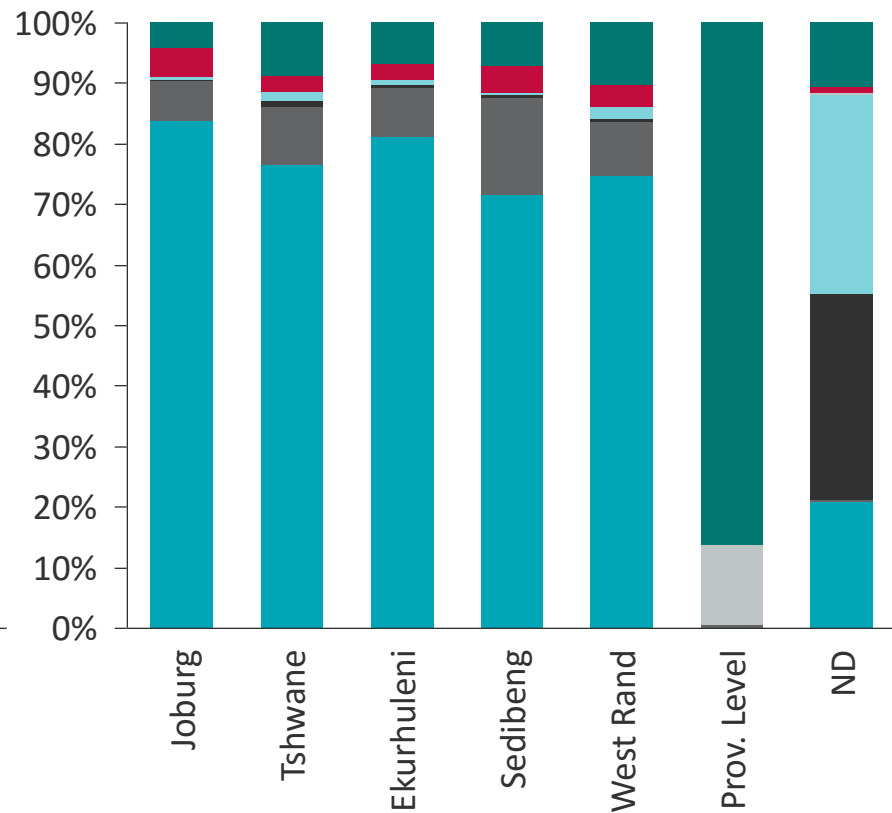


# Gauteng DOH District HIV Spending by intervention (2013/14)

Gauteng District Spending



Gauteng District Spending (%)



- District split mostly similar
- Provincial level mostly training
- MMC and key population spending was not disaggregated by district – so cannot see what was the % of total prevention spending per district – but appears to be less than 20%

## Key Messages

- South Africa appears to be achieving, or moving towards, allocative efficiency – *at national level*. Spending on mostly priority interventions with proven cost effectiveness according to Investment Case.
- The non-IC spending (15% of '13/'14 total spending) was on interventions with limited evidence of efficacy. *But are these the supportive (programme enablers) that are essential for greatest impact?*
- Sub-national analysis *shows variations warranting further examination*, mostly explained by poor financial management systems.
- Important to align and consolidate expenditure data from key funding sources – make routine in-country *(aligned to the public financial reporting structure & SHA for sustainability/ routine monitoring eg. Botswana, Zimbabwe, Kenya)*.
- Difficult to ascertain the optimal mix of services, and the most efficient allocation of resources – *without an Investment Case or Optima*.
- Lack of financial and prevalence data at the district-level hinders district comparisons. *This is critical going forward to ascertain the best targeted use of resources.*
- TB: limited cost, spending, and impact data.

# Thanks to:

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