HIV Financing Integration in South Africa: Policy Scenarios and Feasibility Analysis

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RESULTS FOR DEVELOPMENT

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Foreword

At the June United Nations General Assembly High-Level Meeting on Ending AIDS, Member States committed to implementing a bold agenda to end the AIDS epidemic by 2030 through the adoption of a progressive, new and actionable Political Declaration. Together with the UNAIDS Strategy 2016-2021, these important documents bring hope for the 37 million people living with HIV around the world, two-thirds of whom still lack access to treatment. Only by rapidly scaling up their HIV programmes will countries reach this target. Large increases in investment are imperative, particularly in the near term, which is why many high-burden countries have embraced UNAIDS' "Fast-Track" 90-90-90 HIV treatment targets for 2020.

South Africa has been a pioneer in these efforts, expanding access to HIV services over the last 15 years. Slowly but surely, the country is overcoming the world's largest HIV burden. Development partners have played an important role in the epidemic response. However with donor support plateauing and expected to decline, the success of South Africa's HIV programme will rest on its ability to mobilize and manage a sustainable flow of domestic resources.

Ending the AIDS epidemic is one of the targets of the Sustainable Development Goals, which also codify countries' aspirations to achieve universal health coverage (UHC). At long last more countries are investing seriously in the realization of health as a human right, by enhancing their health infrastructure, training new cadres of health workers, and creating more equitable systems to protect all citizens from the risks of poor health.

Here, too, South Africa is a leader. The government has laid out a bold vision for a new National Health Insurance (NHI) scheme, which will guarantee access to a wide range of essential services, including those for HIV prevention, care, and treatment. This reform is a massive undertaking, requiring new thinking about how to finance and deliver health services for a large and diverse citizenry.

Ensuring the compatibility of South Africa's HIV and UHC objectives is of paramount concern.

In this study, UNAIDS takes the first steps toward exploring whether integrating financing for HIV services into the broader NHI system is advisable and, if so, how it might be done. It offers four alternatives to the status quo and reviews their respective virtues and shortcomings. It also charts a detailed path forward for the government to further evaluate its options and, eventually, to implement one.

UNAIDS is fortunate to partner with Dr David de Ferranti, President of Results for Development Institute, whose team has broadened the HIV community's understanding of integration's promise and potential pitfalls.

We offer this analysis to South Africa as it deliberates over NHI financing policy design and the role therein of the health programme. We also hope our work and the discourse it stimulates will offer useful lessons for other countries, who often look to South Africa's large and highly successful HIV response for inspiration.

Jose Antonio Izazola Licea
Division Chief, Evaluation and Economics
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Preface

I recall the last International AIDS Conference in South Africa, a dramatic and memorable event that took place in Durban in 2000 at a troubled moment in the history of the country's HIV response. At that time the virus was spreading rapidly, prevention measures were inadequate, and HIV treatment was virtually non-existent. South Africa's first National Strategic Plan for HIV/AIDS called for merely 400 million rand (about 60 million US dollars in 1999/2000) to fight the epidemic.

What a remarkable change has occurred over the past decade and a half—Mr. Mandela would be proud. With strong political leadership, South Africa has mounted a formidable response to HIV. The country and its development partners, including PEPFAR and the Global Fund, are annually investing more than 20 billion rand (2 billion US dollars in 2014/15) in the battle against the virus. More than 3 million South Africans are now on treatment, and every day new patients access services paid in full by the government. Rates of infection may be falling, but far too many people are still being infected. At the same time, the government has published its White Paper on National Health Insurance and is starting to put in place the building blocks of a universal system.

In this dramatically changed context, this study can play an important role in tying together two daunting challenges: the long-term financial sustainability of South Africa's HIV response, and the development of the NHI system.

Drafted in close consultation with key country stakeholders, the report lays out a series of options for the integration of HIV funding and other health financing over the next three to five years. It describes these scenarios in detail, including how they would reconfigure funding flows and distribute important responsibilities—target-setting, budget planning, and performance monitoring for HIV and other services—across the national, provincial, and local spheres. It then assesses the pros and cons of each option, offering insights into their political, legal, and technical feasibility, as well as estimating their impact on the HIV response, other primary health care services, and health system efficiency. Along the way the study flags key risks and knowledge gaps for each option and highlights which integrative approaches are most compatible with the NHI White Paper.

This effort is closely linked to Results for Development Institute (R4D)'s other health policy work in South Africa and elsewhere. For nearly a decade, and against the backdrop of the drive toward Universal Health Coverage, R4D has helped countries and their partners better estimate resource needs and track expenditure for HIV and other health programs; plan, manage, and evaluate the phase-out of donor support and transition to national self-reliance; assess options for integrating "vertical" and "horizontal" health funding streams; and design, implement, and strengthen national health insurance systems.

It is an honour for R4D to have been invited to conduct this study in consultation with the National Treasury, Department of Health, and other talented individuals and institutions in South Africa.

We hope that our work will make a meaningful contribution to the debate on HIV financing in South Africa, and to the search for the most efficient, equitable, and sustainable health financing solutions for the country and its 54 million people.

Robert Hecht
Results for Development Institute

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UNAIDS gratefully acknowledges all of the colleagues and partners who helped this project to succeed. We thank the numerous government officials in South Africa who patiently assisted the study team to understand the country's health financing system and the potential consequences of altering it. UNAIDS is particularly indebted to Mark Blecher, Jeanette Hunter, Anban Pillay, Yogan Pillay, and Edgar Sishi, as well as their respective teams in the National Treasury and National Department of Health, for providing critical guidance, insights, and data.

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Abbreviations

ART	Antiretroviral therapy
CG	Conditional grant
CMS	Council for Medical Schemes
DHMO	District Health Management Office
DOH	Department of Health
DORA	Division of Revenue Act
DRG	Diagnosis-related group
FY	Financial year
Global Fund	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HAST	HIV & AIDS, STI, and TB
HIV CG	Comprehensive HIV and AIDS conditional grant
HMIS	Health management information system
MMC	Medical male circumcision
MTEF	Medium Term Expenditure Framework
NDOH	National Department of Health
NHI	National Health Insurance
NHIF or NHI Fund	National Health Insurance Fund
NT	National Treasury
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	Preventing mother-to-child transmission
PDOHs	Provincial Departments of Health
PTs	Provincial Treasuries
R	South African Rand
SANAC	South African National AIDS Council
SBCC	Social and behaviour change campaign
TB	Tuberculosis
UHC	Universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

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Executive Summary

Background and motivation

South Africa's government has committed itself to achieving universal health coverage for its population. A proposed national health insurance (NHI) system would consolidate resources in a centrally managed Fund that purchases services from both government-run and private health care providers. In preparation, the government is already reengineering primary health care to ensure all public clinics are adequately staffed, equipped, and managed to efficiently deliver high-quality services.

At the same time, South Africa has embraced ambitious goals for its burdensome HIV epidemic. In accordance with UNAIDS's 90-90-90 framework, by 2020 in South Africa:

- 90 percent of people living with HIV will know their status,
- 90 percent of those diagnosed with HIV infection will receive antiretroviral therapy, and
- 90 percent of those receiving treatment will have viral suppression.

Today more than 3.4 million South Africans living with HIV receive life-sustaining therapy, reflecting the country's (and its development partners') rapid scale-up of investment in treatment and other interventions. Unless a cure emerges, they and 3.5 million additional people living with HIV will need treatment for the rest of their lives. Meeting their health needs, and thereby achieving the 90-90-90 targets, will require even greater investment in HIV services, which already consume more than a tenth of the government's health budget.

Currently the financing and delivery of health services is largely in the purview of the provincial sphere of government; each province is free to distribute its share of national revenue, determined by an equitable share formula, between sectors and specific activities therein. In complement, through conditional grants from national line ministries to their provincial counterparts, the national sphere ring-fences funding for priority government investments, including the national HIV response. For more than a decade the Comprehensive HIV and AIDS conditional grant has provided the vast majority of government financing for HIV activities. This could all change under an NHI system, raising important questions about the future of South Africa's health financing and service delivery systems.

This feasibility study seeks to help the South African government to answer one such question: **over the next three to five years, as the government continues preparing the design and implementation of a new NHI system, how might HIV and other health services be financed in a more integrated fashion?** Toward that end, the study characterizes in detail the government's current health financing system, describes the status quo and four additional scenarios for reconfiguring HIV financing, and evaluates these options for their feasibility and potential impact on the health system. It serves as a discussion document for government officials and other health sector stakeholders and, consequently, does not explicitly endorse or recommend any of the scenarios. Instead, the study strives simply to highlight the opportunities and risks posed by each option and the similarities and trade-offs between them.

Methodology

This study required a combination of desk research and stakeholder and expert consultation. In addition to reviewing publicly available literature, we consulted with officials from the National Treasury and National Department of Health to gain access to documents and data pertaining to health sector policy and expenditure. In

parallel, we interviewed numerous government officials at the national and provincial levels, as well as consulted with South African and international experts on HIV financing and health system reform. These processes enabled us to unpack the incumbent health financing system and develop four alternative HIV financing scenarios.

Five HIV financing scenarios

The study features five scenarios indicative of the government's options in the next three to five years:

1. **Sustained HIV conditionality** (status quo) would maintain the ring-fencing of HIV funds in a large conditional grant and the financing of most other health services through the equitable share.

2. A **National HIV Fund** would pool the majority of financing currently flowing to provinces through the HIV grant. The Fund would purchase a package of personal HIV services, while a small grant would continue to finance non-personal HIV services.

3. **Unconditional integration** would eliminate the HIV grant and fold all HIV funding into the equitable share, whose allocation formula would be modified to account for HIV burden.

4. **Ring-fenced PHC integration** would create a large conditional grant covering all primary health care services, including for HIV. Funds could be shifted from the equitable share to the grant, or new resources could be added to the grant over time by the national sphere.

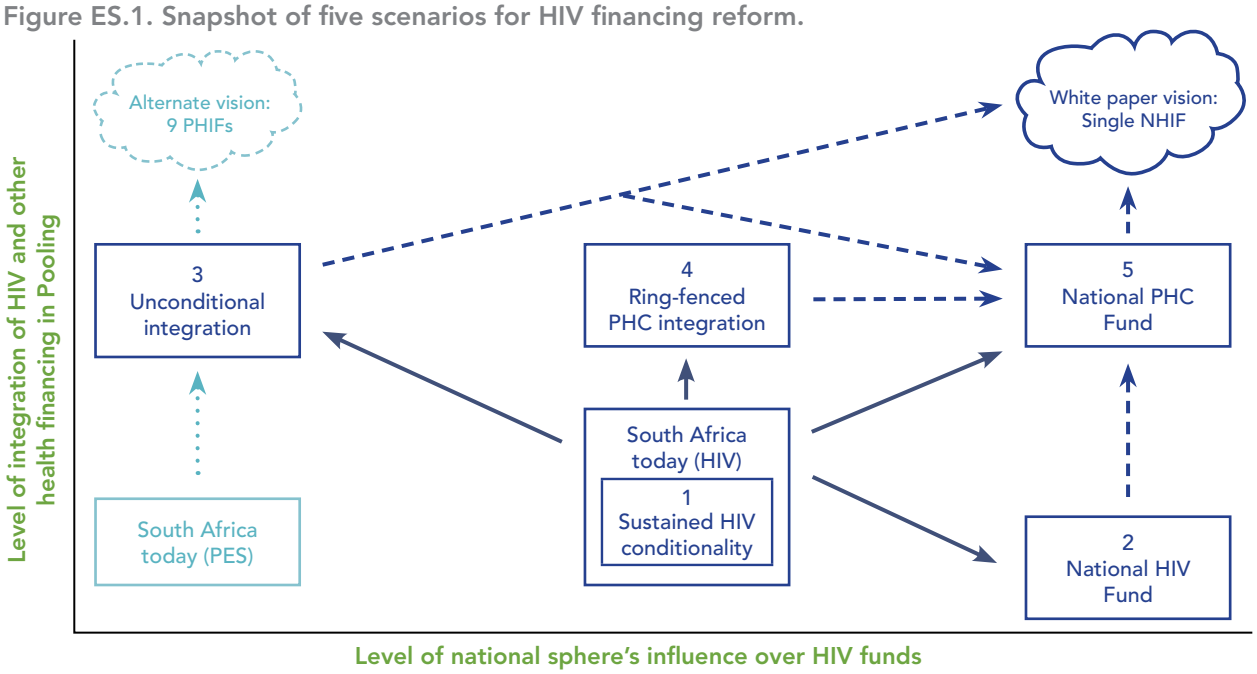
5. A **National PHC Fund** would pool financing currently flowing through the HIV grant with additional resources for other primary health care services. Additional funds could be shifted from the equitable share to the Fund, or new resources could be added to the Fund over time. The Fund would purchase all personal primary health care services, while provinces would remain responsible for non-personal services.

As Figure ES.1 depicts, these scenarios vary along two key dimensions. First, they differ in terms of how integrated financing for HIV and other health services would be (vertical axis). Given the study's time horizon of three to five years, we did not consider scenarios that would fully integrate all health financing. Instead, our options range from further isolating HIV financing (i.e., *decreasing* the extent of integration) to pooling together all funds for primary health care services, including those for HIV.

Second, if the government were to revisit the configuration of HIV financing, it would be important to understand to what degree the national sphere would continue to exercise influence over the use of funds intended for HIV activities (horizontal axis). Accountability at the national level may be crucial to further scaling up the HIV response. Therefore, some of our scenarios for HIV financing would strengthen the national sphere's authority over HIV funds, while some would retain or even dilute the current level of influence.

The five scenarios are not intended as potential end points of health financing reform. Some of them could be sequenced in a series of incremental changes toward the eventual creation of an NHI Fund, or features of multiple scenarios could be combined into a single alternative. The

Figure ES.1. Snapshot of five scenarios for HIV financing reform.



Source: Authors.
Notes: Solid lines indicate movement from the current HIV financing approach (Scenario 1) to the other four scenarios presented in this study. Dashed lines (dark blue) depict potential pathways from those scenarios to the NHI system proposed in the White paper (2015). Dotted lines (light blue), in contrast, show the potential pathway from the current system to a more devolved NHI scheme in which each province manages its own insurance fund.
Abbreviations: NHIF = National Health Insurance Fund, PES = provincial equitable share, PHC = primary health care, PHIFs = Provincial Health Insurance Funds.

solid and dashed arrows in Figure ES.1 indicate several possible pathways from the status quo through one or more of this study's scenarios, ultimately arriving at a single NHI Fund as proposed in the 2015 NHI White Paper. The dotted arrows plot a course toward a more devolved NHI system with nine provincial Funds.

Comparing the scenarios

Integration or other reconfigurations of HIV financing would entail considerable alterations to the size, nature, and governance of public-sector pools of health funds. Figure ES.2 presents illustrative allocations of the health sector budget for financial year 2016/17, with a new NHI Fund appearing in Scenarios 2 and 5. Notably, only a minority of funds would be implicated by the financing arrangements addressed in this study. Across all five scenarios, funds for all non–primary health care activities would continue to flow through the provincial equitable share, but the government could also explore changes to the pooling of hospital funds, for instance.

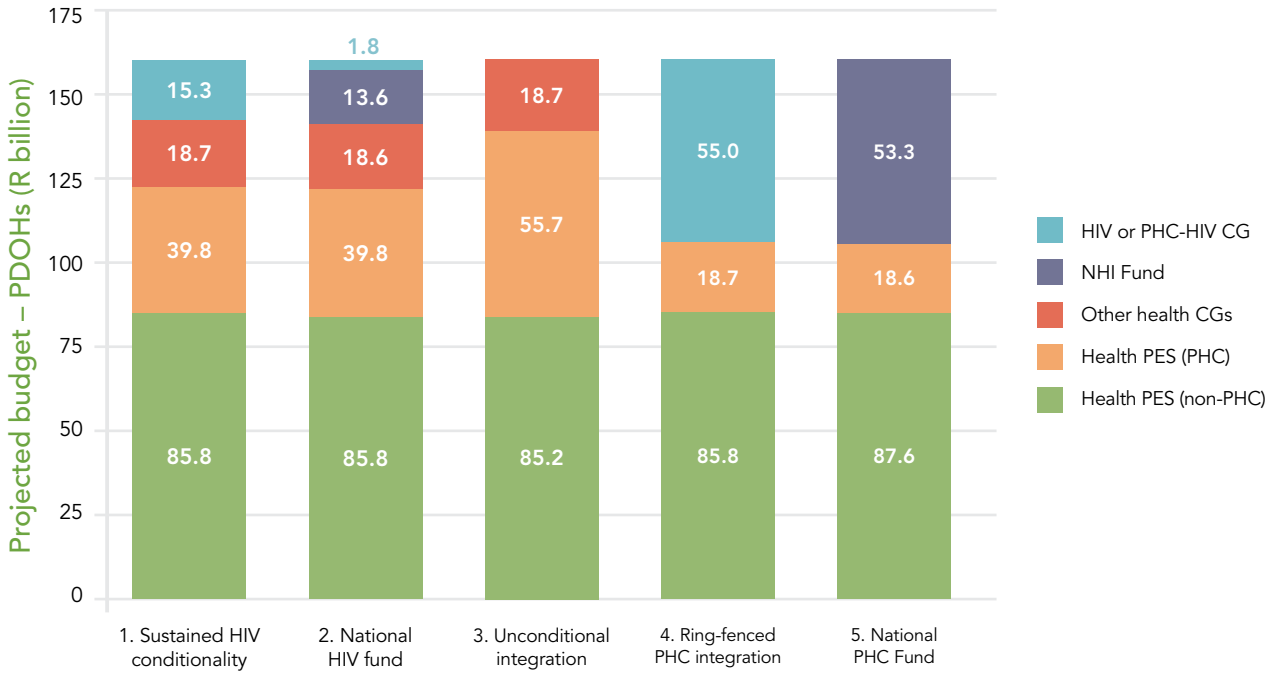
In addition to altering how health funds are pooled, the scenarios would also affect how HIV and others funds are governed. Only Scenario 3 would shift predominance over how HIV funds are spent to the provincial sphere, where Departments of Health and Treasuries would exercise full control over resource allocation across sectors and within the health sector. The other scenarios differ in terms of whether the national sphere would continue to ring-fence HIV (and other) funds before transferring them to provinces (Scenarios 1 and 4), or if a new nationally managed Fund would hold money centrally and dispense it directly to providers (Scenarios 2 and 5).

The reallocation of funds and revised governance of HIV spending would help to determine the scenarios' impact and feasibility. Based on additional desk research and informant interviews, and drawing on our own reasoning and experience, we evaluated each option for its likely effect on South Africa's HIV response, on primary health care services more generally, and on health system efficiency, as well as for its feasibility along legal, political, and technical dimensions. Our assessments are qualitative and merely indicative of the direction and relative magnitude of effect; quantifying any scenario's impact would require a more resource-intensive modelling effort. Nonetheless, our evaluative scorecard (Table ES.1) can serve as useful input to government deliberations.

There are several key takeaways from the evaluation of the scenarios' likely impact:

- If 'do no harm' is a guiding principle for HIV financing reform, unconditional integration (Scenario 3) stands out for the widespread view that it could severely undermine the HIV programme.
- There is some appeal in using the HIV programme to pilot an NHI system (Scenario 2), but given how integrated certain aspects of financing and service delivery already are, such an approach could do more harm than good.

Figure ES.2. Illustrative allocations for Scenarios 1–5 for FY 2016/17 (R billion)



Sources: National Treasury (2015b, 2016).
Abbreviations: CGs = conditional grants, PES = provincial equitable share, PDOHs = Provincial Departments of Health, PHC = primary health care.

Table ES.1. Summary scorecard of impact and feasibility, Scenarios 1–5.

Scenario	IMPACT			FEASIBILITY		
	HIV response	PHC services	Health system efficiency	Legal	Political	Technical
1. Sustained HIV conditionality	*Reference scenario*			High	High	High
2. National HIV Fund	? / -	Ø	? / -	Low–medium	Low–medium	Low–medium
3. Unconditional integration	- - -	? / +	Ø / -	High	Low	High
4. Ring-fenced PHC integration	Ø	++	? / +	Medium–high	Medium–high	Medium
5. National PHC Fund	? / -	+	?	Low–medium	Medium	Low

Source: Authors' assessment.
Key: + = favourable, Ø = minimal, - = unfavourable, ? = uncertain. Dual ratings (e.g., ? / -) indicate a primary estimate and possible but less certain alternative. Number of symbols indicates relative magnitude of effect (e.g., ++ is more favourable than + and less favourable than +++).

- There is little basis for expecting pooling reforms alone to improve the HIV response or to increase health system efficiency. More strategic approaches to purchasing, which would be possible under any scenario, are a more promising way to promote efficiency through financing.

- Primary health care could benefit most from more integrated financing, particularly with considerable national influence (Scenarios 4 and 5), if management and service delivery were imbued with similar business planning, resource tracking, and evaluation to what exists for HIV.

- Integrating primary health care financing under national influence or control (Scenarios 4 and 5) may offer the best balance between the government's twin objectives of moving toward universal health coverage and achieving 90-90-90 coverage targets for HIV; however, of the scenarios analysed in this study, the status quo (Scenario 1) would pose the fewest risks to the HIV response.

Assessing feasibility also yields important conclusions:

- Only the status quo (Scenario 1) would be highly feasible in legal, political, and technical terms.

- Creating a new Fund (Scenarios 2 and 5) would be technically challenging and could invite legal or even constitutional challenges from provinces.

- Ring-fencing or nationalizing an integrated pool of primary health care funds (Scenarios 4 and 5) would require better tools and data for planning and monitoring primary health care services; such investments would benefit a future NHI system.

- Smooth implementation of a scenario, particularly if it is a clear interim step toward the proposed NHI system, could help to galvanize support for more ambitious reforms; conversely, mismanagement could undermine the broader NHI agenda.

- Ease of implementation may not be sufficient reason to pursue an option (e.g., Scenario 3), nor should anticipated challenges alone preclude a particular course (e.g., Scenarios 4 and 5).

Looking ahead

This study provides useful input to government debate and decision making about the future of HIV financing and how its integration relates to the broader NHI agenda. In addition to assessing the feasibility and desirability of various integration scenarios, the study raises numerous considerations that require additional analysis and debate, and align well with the NHI work streams. These include:

- How to best integrate financing and delivery of primary health care and monitor performance;

- How to implement a purchaser-provider split and design payment mechanisms for HIV and other primary health care services;

- How to mobilize sufficient political support for integration and other challenging NHI reforms;

- How to concurrently address other important health financing issues, including the anticipated decrease in donor funding and the management of funding for hospital services; and

- How to manage the immediate integration of tuberculosis into the HIV grant.

In this formative time for South Africa's health system, the government's HIV response will factor critically into any major reforms. Integration could position HIV as the 'tip of the spear' of NHI design.

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Section 1: Introduction

South Africa has the world's largest HIV burden, with an estimated 6.8 million people living with the virus (UNAIDS, 2014b). The country has rapidly scaled up HIV treatment and care over the last decade—the government's HIV response guarantees free access to antiretroviral therapy (ART), and by the end of 2015 it was treating more than 3 million people living with HIV. If South Africa is to meet its ambitious HIV 90-90-90 targets by 2020,[1] 5.7 million patients will need to be on ART by financial year (FY) 2018/19. This will require accelerating the expansion of treatment coverage and adding between 670,000 and 900,000 new patients to the ART programme annually until 2019 (Department of Health, South Africa & South African National AIDS Council, 2016). Continued rapid scale-up raises concerns about the financial sustainability of the country's HIV response, compounded by the expectation that donor funding from the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Malaria, and Tuberculosis (Global Fund), will scale down in next five to 10 years. Over the last decade, there has been a sharp increase in public financing for HIV, which is now approaching almost a third of government spending on primary health care (PHC) and about 10 percent of all government health expenditure (National Treasury, 2014).

Meanwhile, South Africa has embarked on an ambitious plan to develop national health insurance (NHI) that will provide universal and equitable access to health care, including HIV services, for the whole population. Planners in the National Department of Health (NDOH) and National Treasury (NT) may need to consider alternative models for organizing the HIV programme that address the sustainability concerns for its financing, respond to disparities between its governance and that of the wider public health financing system, and integrate or at least coordinate it with the country's larger vision for NHI. This study responds to this need by presenting and evaluating various scenarios for changes to the management of funding for the government's HIV response over the next three to five years. Any proposed changes must be carefully scrutinized to ensure, first and foremost, that they do not undermine current efforts.

The public sector dominates South Africa's HIV response: about three-quarters of all HIV financing in South Africa is raised from domestic revenue sources, the bulk of which is then managed through direct transfer from the national government to Provincial Departments of Health (PDOHs) using the Comprehensive HIV and AIDS conditional grant (HIV CG). This grant—determined for each province on the basis of HIV prevalence and need—is a means of ring-fencing financing for the government's HIV response via PDOHs under conditions of careful business planning; tight budgeting, spending, and tracking of funds; and detailed reporting of outputs against programmatic targets. In contrast, government spending on most other health care services is primarily discretionary at the provincial level. The bulk of provincial health budgets is sourced from national revenue transferred to provinces under South Africa's provincial equitable share (PES) allocation system. PES transfers to provinces by NT account for approximately 81 percent of public health financing. Provinces have autonomous control over the budgeting and service delivery functions for all health programmes funded through this mechanism. PES spending is guided by provinces' Annual Performance Plans and monitored through annual financial reporting to the national government, but these processes are minimal compared to those in place for the conditional grants.

The HIV and non-HIV health budgets have also been following contrasting trajectories. The annual HIV conditional grant has grown dramatically from R1 billion

[1] The 90-90-90 targets are that 90 percent of people living with HIV will know their HIV status, 90 percent of people diagnosed with HIV will receive sustained antiretroviral treatment, and 90 percent of those on treatment will have durable viral suppression (UNAIDS, 2014a).

since its introduction in FY 2003/04 to R13.7 billion over a decade later in FY2015/16, and it will reach R20 billion by FY 2018/19 (Guthrie, Ryckman, Soe-Lin, & Hecht, 2015; Janari, 2015). Given this government commitment under the 2016 Medium Term Expenditure Framework (MTEF), the grant will continue to grow by over 10 percent annually in nominal terms—double the rate of growth in the overall health budget (National Treasury, 2014). Government health expenditure, on the other hand, has declined as a share of the overall government budget in recent years. With donor funding for HIV expected to recede over the next ten years, the government will likely have to channel an even greater share of funds to sustain and expand its large HIV programme, particularly to increase the number of people on ART.

Given the rapid growth in South Africa's HIV budget both in absolute terms and as a share of government health spending, the differences between HIV and other health care financing raises important and immediate questions for policymakers. The government must consider if it can sustain the growth rate in the HIV CG, particularly as donor funding recedes. Similarly, while separate planning, tracking, and performance monitoring systems for the HIV response have helped to strengthen it, it is important to weigh the benefits of continued ring-fencing against any inefficiency it creates in the government's health financing and service delivery systems.

These questions regarding integrated management of HIV and non-HIV health financing are both pressing and timely: the government of South Africa has proposed the establishment of an NHI system by 2025 in pursuit of universal health coverage (UHC). The recently published White Paper (National Department of Health, 2015d; hereafter White Paper, 2015) envisages an NHI Fund that acts as "a single-payer and single-purchaser" with centralized purchasing of health care services, including those for HIV, local management of delivery through District Health Management Offices (DHMOs), and mechanisms for direct payments to providers. Hence, the government and other stakeholders are interested in considering how public financing for HIV may be more fully integrated with that for other health services ahead of broader NHI implementation, as well as how financing integration might affect delivery of HIV and other services. These concerns relate closely to ongoing debates about how to enhance South Africa's public financial management system, how to design an NHI benefits package, and how to modify intergovernmental functional and fiscal arrangements in preparation for a purchaser-provider split.

This study explores the nature of these problems by describing and evaluating five distinct scenarios for the pooling and management of public funds for HIV. In particular, our analysis is crafted to help policymakers grapple with the following questions:

- Should the current structure of public HIV financing be altered in the next three to five years?
- If so, what are some policy options or scenarios for HIV financing, and particularly its integration with financing for other health services, that could be explored over this period?
- How would the scenarios affect the HIV response and other primary health care services?
- Would the scenarios increase health system efficiency?
- How feasible are the scenarios?
- How would the scenarios facilitate or impede the realization of the government's NHI vision?

To address these questions, we undertook extensive desk research utilizing published literature, data, and policy documents related to South Africa's health financing system, HIV response, and NHI proposals. Officials from NT and NDOH provided supplementary documents and data. To build on and complement the desk research, we consulted government officials, experts, and other stakeholders to collect suggestions for how HIV financing could be restructured. Consultations included individual interviews, group discussions, and presentations during which the potential strengths and weaknesses of different financing changes were discussed. Appendix 1 contains a full list of government participants, while other experts and stakeholders are acknowledged above. The majority of consultations were with representatives of three divisions in NDOH (HIV/AIDS, TB and Maternal and Child Health; Primary Health Care; and Regulation and Compliance) and two in NT (Public Finance and Intergovernmental Relations).

Due to the preliminary and sensitive nature of this work, we do not directly attribute opinions expressed by individuals during the consultations. However, at times we include informants' institutional affiliations to lend additional context to their views. We conducted most of our consultations in Pretoria in October 2015, and some conversations took place by phone in the preceding and subsequent months. We presented our preliminary analysis to selected government officials in January and February 2016; their feedback is reflected throughout the study.

Although we consulted widely with senior national officials in both NT and NDOH, numerous other stakeholders are not well represented in our analysis. They include provincial officials, patients, private health care providers, and civil society organizations. As we note later, more extensive consultation and political analysis should inform the government's policy design and implementation decisions. Additionally, we did not quantitatively model the impact of the five scenarios. We focused instead on the governance implications of reconfiguring HIV financing and qualitatively assessing whether the scenarios would have a favourable or unfavourable impact on the health system.

To set the stage for that analysis, we first provide an overview of the current situation in South Africa (Section 2). We begin with a brief description of the country's health financing system and government expenditure on HIV.

We then explain in greater detail what we mean by HIV financing integration and the extent to which there is already such integration in South Africa. Underlying this analysis is a recognition that as they pursue a range of important policy goals, decision makers must take care not to harm South Africa's largely successful HIV programme. For this reason, the current financing arrangement remains a compelling option, while the other four scenarios represent potential opportunities to build upon gains made in the HIV programme and, in some cases, extend them to other parts of the government-financed health system.

With the status quo in mind, we present five possible scenarios for reorganizing HIV financing and detail our methods for developing and evaluating them (Section 3). We then offer a comparative analysis of the scenarios and highlight key takeaways for policymakers (Section 4). Finally, we reflect on how this study can be used to facilitate decision making and shape additional analysis and policy design (Section 5).

Photo: ©UNAIDS

Section 2: Health financing and HIV integration in South Africa

To characterize South Africa's current health financing system, we conducted desk research relying on publicly available data and documents about the health system's structure and flow of funds. We organized our search and analysis around the three principal health financing functions of revenue collection, pooling, and purchasing (Kutzin, 2001). We then assessed the extent of integration of HIV with non-HIV health funds to determine a status quo scenario to which proposed alternatives could be compared. This analysis builds on a recently developed framework for evaluating integration across the three financing functions (see Box 2.1), though our emphasis here is more on the specific mechanisms by which HIV and other health funds are mobilized, managed, and deployed to purchase services.

Box 2.1. What is health financing integration?

This study is part of a growing body of work that responds to mounting interest, in South Africa and globally, in the desirability, feasibility, and mechanics of integrating 'vertically' financed health programmes, such as those for HIV, with broader, 'horizontal' health systems. In particular, it builds on a recent Results for Development Institute (R4D) report for the UNAIDS-World Bank Economic Reference Group's Technical Working Group on Sustainable Financing. R4D defines HIV financing integration as "the process of moving toward national health financing systems where funds for HIV & AIDS are collected, pooled, and used to pay for health services together with funds for other health services rather than through separate financing and payment structures."

The report goes on to assess the level of integration—high, medium, or low—across the three health financing functions of revenue collection, pooling of funds and risk, and purchasing of services. For collection, the level of integration depends on what share of HIV funds are drawn from the same revenue sources as other health funds. The extent of pooling integration, in turn, depends on whether HIV funds are pooled and managed together with or separately from other health funds.

Finally, the degree of purchasing integration reflects whether the flow of HIV and other health funds from purchasers to providers relies on the same channels and mechanisms. Critically, to date there is insufficient evidence about whether integration is inherently good or bad for a national health system. For now, it remains a useful concept to help describe certain aspects of a country's health financing system. Nonetheless, policymakers and other stakeholders profess a number of hypotheses about the potential benefits of integration, including efficiency and service quality.

Analysis of 13 countries, including South Africa, revealed considerable variation in the level of HIV financing integration between countries and within countries across financing functions. Additionally, integration in one function does not necessarily require or enable integrating other functions. In fact, integrative policies can be quite targeted at one or more functions depending on the country context, available sources of funds, and policymakers' health system goals. Finally, the report highlighted the need for country-specific research and consultation to better understand integration and inform relevant policies.

Source: Blanchet et al. (2014).

We focus exclusively on public financing for HIV services channelled through the national and provincial health departments, which accounts for roughly three-quarters of all HIV spending in South Africa. The government also finances HIV programmes through the Departments of Basic Education, Correctional Services, Defence, and Social Development, as well as the South African Police Force, but collectively these account for only 6 percent of public HIV spending (Guthrie et al., 2015). Additionally, although external funds from PEPFAR and the Global Fund are important to the country's HIV response, they represent a decreasing share of financing and are likely to recede in the next decade. Consequently, the future sustainability and impact of HIV spending will depend principally on how the government manages and spends its own resources. At the same time, South Africa and its partners will need to manage the donor transition carefully. In Section 5 we note a number of important questions related to the plateauing and expected decline in donor funding for HIV, which go beyond the scope of this study.

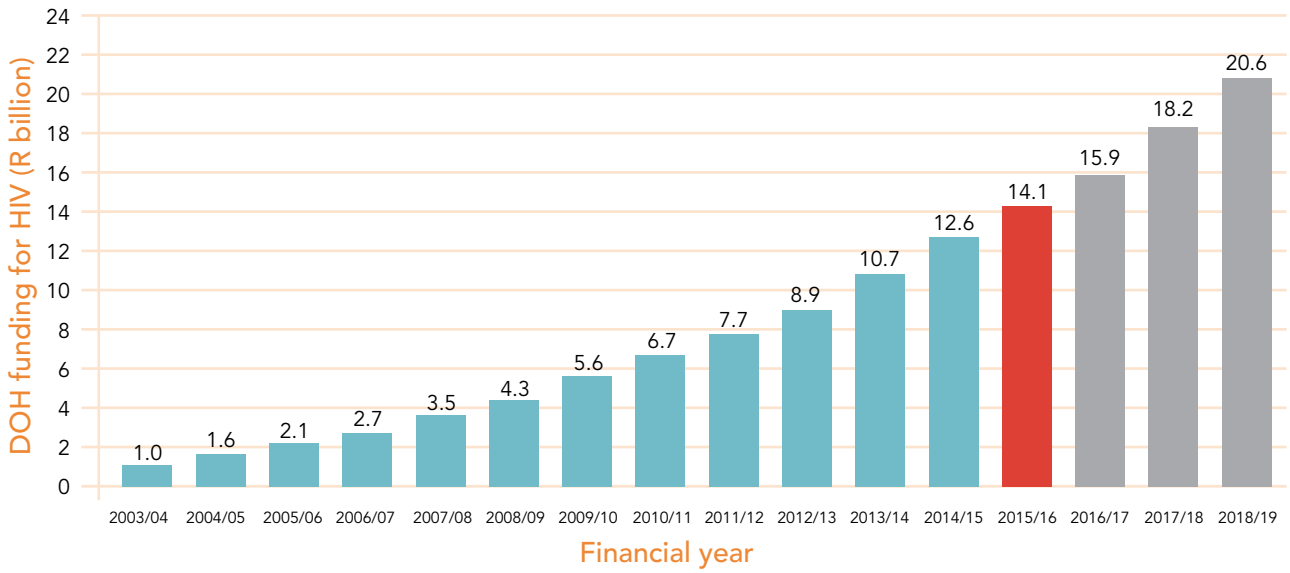
In the rest of this section we quantify government spending on HIV and describe how public HIV funds are collected, pooled, and used to purchase services in relation to the rest of the publicly financed health system. We also highlight the need for careful thinking about integrated service delivery and incorporation of tuberculosis (TB) financing into the HIV CG.

DOH expenditure on HIV

South Africa's National and Provincial Departments of Health spent more than R14 billion on HIV in FY 2015/16 (National Treasury, 2016) and will spend R20–30 billion in FY 2018/19.[2] After more than a decade of expansion, the HIV programme now accounts for more than 10 percent of all government health sector expenditure and is growing faster than the overall budget for health (National Treasury, 2014). Figure 2.1 depicts the growth in HIV funding from FY 2003/04 to FY 2018/19.

South Africa's lacklustre economic performance complicates efforts to sustain this growth in domestic HIV spending. Depressed global commodity prices and persistent drought have contributed to sluggish economic growth, which is forecasted to be only 0.9 percent in 2016 (Gordhan, 2016). Slow growth will constrain fiscal space for all government investments, underscoring the continual need for finding more efficient means of financing and delivering HIV and other health services (Blecher et al., 2016). Addressing this structural challenge is beyond our scope, but fiscal space constraints should be borne in mind when evaluating the current HIV financing structure and any alternatives, such as the scenarios we describe in Section 3.

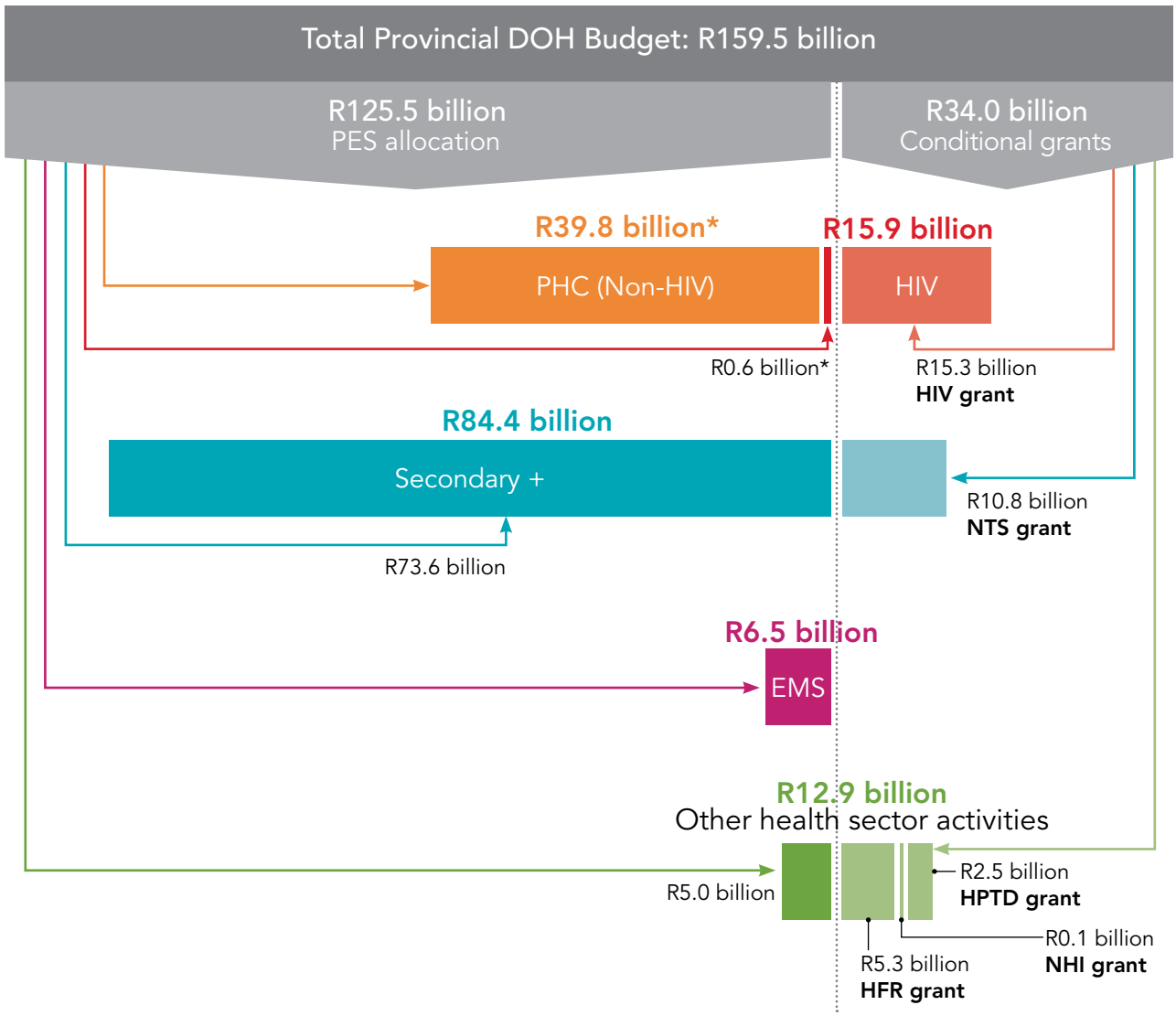
Figure 2.1. Historical and projected DOH HIV funding (nominal R billion), FY 2003/04–2018/19.



Source: Update to Figure 4 in Ndlovu & Meyer-Rath (2014) using National Treasury (2016).
Notes: Data reflect audited outcomes for FYs 2003/04–2014/15 (blue), adjusted appropriation for FY 2015/16 (red), and projections for FYs 2016/17–2018/19 (grey). Figures include funds for HIV-TB integration and other TB interventions channelled through the Comprehensive HIV and AIDS grant until FY 2015/16 and then through the Comprehensive HIV, AIDS and TB grant from FY 2016/17 on.
Abbreviations: DOH = Department of Health, R = South African Rand.

[2] R20 billion has already been allocated to the Comprehensive HIV, AIDS and TB conditional grant for FY 2018/19 (Janari, 2015), but how much additional money will be spent by PDOHs out of equitable share funds is uncertain. The upper bound of R30 billion assumes a similar ratio of PES-to-CG spending as is reported in Guthrie et al. (2015) for FYs 2011/12–2013/14. Due to the difficulty of identifying HIV-related spending within South Africa's Basic Accounting System, these estimates may overstate the amount of non–conditional grant spending on HIV. Guthrie et al. (2015) estimates that the grant accounts for 76 percent of the DOH's HIV spending. Our own estimate, extracted from National Treasury (2015b), suggests the grant accounts for upwards of 90 percent of all DOH spending on HIV at the provincial level. In reality the overall share is probably between the two.

Figure 2.2. Expected allocation of Provincial DOH budgets in FY 2016/17.



Sources: Authors' analysis using National Treasury (2015b, 2016).
* Estimates vary on the total budgets for HIV and other PHC activities. The amounts depicted here are based on the sources noted above, while the total HIV budget may be closer to R20 billion.
Notes: Other health sector activities include administration, training and professional development, facilities revitalization, research, and preparation for NHI implementation.
Abbreviations: DOH = Department of Health, PES = provincial equitable share, PHC = primary health care, Secondary + = secondary, tertiary, and quaternary services, NTS = National Tertiary Services, EMS = Emergency Medical Services, HFR = Health Facilities Revitalisation, HPTD = Health Professional Training and Development.

Collecting HIV funds

The collection of public funds for HIV services is straightforward and identical to revenue mobilization for all government-financed health services. General tax revenue collected at the national level funds the overwhelming majority of government health spending. The national tax base principally comprises individual taxes (35 percent), the value-added tax (26 percent), and the company tax (21 percent), as well as includes small shares from a fuel levy, customs duties, and excise taxes (National Treasury, 2015c). Provinces also directly collect modest revenue that funds 1.5 percent of South Africa's total health expenditure (Blecher et al., 2011). Virtually all government health spending, including on HIV services, relies on this general revenue. Therefore, public HIV financing is highly integrated in collection with financing for other health services.

This public HIV financing accounts for about three-quarters of all HIV spending in South Africa. Similarly, integrated financing is collected by Medical Aid schemes and other private insurers, but only 8 percent of HIV spending occurs in the private sector. More substantial are donor-funded HIV programmes, which collect funds exclusively for HIV (or occasionally for HIV and TB together). These external sources of HIV funds—the largest of which are PEPFAR and the Global Fund—account for 16 percent of HIV spending and are not integrated with other health funds (South African National AIDS Council, 2013).

The plateauing and foreseen decline in donor financing compounds South Africa's already daunting challenge to raise sufficient revenue to finance the growing HIV programme and roll out a new NHI system. However, broad questions about fiscal space go beyond the scope of this study. To date there have been no proposals from the government or others to introduce HIV-specific revenue streams into the government's financing system, and none is considered among our scenarios.

Pooling and managing HIV funds

After collecting general revenue, NT distributes funds between the spheres of government and across national departments in accordance with the national budget process. Although they serve as the financing agent for all government health services, PDOHs receive funds for general health services and for HIV differently (Figure 2.2). Most health funds flow to provinces through the PES allocation system, which applies a legislatively defined formula to divide a large portion of national revenue among South Africa's nine provinces. PES (or voted) funds are intended for education, health, and other social-sector programmes that are concurrent responsibilities of the national and provincial spheres of government ("Constitution of the Republic of South Africa," 1996). Provinces exercise near-complete discretion over the use of PES funds, which is tracked annually at the national level against provincial budgets and Annual Performance Plan targets. NT also reviews provincial budgets through a benchmarking exercise to ensure provinces will meet contractual obligations, such as those to public employees and suppliers.

In contrast, the bulk of the PDOHs' HIV financing is channelled to provinces via the HIV CG, which will include more than R15 billion in FY 2016/17 and more than R20 billion in FY 2018/19 (Janari, 2015). Conditional grants are typically created to enable a national department to support, with dedicated funds, the rapid implementation and scale-up of priority initiatives. Currently, the HIV CG is the second largest across all sectors and accounts for 43 percent of all conditional grant funding to DOH (National Treasury, 2014).[3]

For each conditional grant the transferring (national) department, in consultation with NT, develops a legally binding mechanism that governs the grant's administration and the responsibilities of both the transferring and receiving (provincial) departments. For the HIV CG, these include specific services and priority activities to be funded by the grant, requirements that provincial business plans specify their measurable output and outcome indicators, and a schedule for quarterly reports by PDOHs to NDOH (National Department of Health, 2015a).[4] Box 2.2 provides examples of conditions and output measures for the HIV CG in FY 2015/16.

The binding nature of the conditional grant mechanism, NDOH's ability to withhold payments from provinces failing to comply, and the elaborate business planning and monitoring systems required to implement the grant all distinguish the CG from the PES health financing mechanism. In fact, these conditions allow HIV funds to be effectively ring-fenced from the rest of provincial health budgets without actually pooling them in separate accounts or even separate financing agents. Therefore, the current level of integration in pooling HIV and non-HIV

Box 2.2. Conditions and output measures for the Comprehensive HIV and AIDS conditional grant (FY 2015/16).

The HIV CG mechanism, a legally binding agreement between the national and provincial spheres of government, requires funds to be spent on specific activities with measureable outputs. They can be summarized as follows:

Priority activities to be supported by the grant

- ART-related interventions
- Home- and community-based care
- Condom distribution
- Interventions for high-transmission areas
- Post-exposure prophylaxis
- Prevention of mother-to-child transmission
- Programme management strengthening
- HIV counselling and testing services
- Medical male circumcision
- TB screening and prevention for HIV patients

Outputs for grant-funded activities

- Number of new patients initiated on ART
- Number of ART patients remaining in care
- Number of male condoms distributed
- Number of female condoms distributed
- Number of exposed infants tested at 6 weeks with polymerase chain reaction test
- Number of clients tested for HIV (including antenatal)
- Number of medical circumcisions performed

Source: National Treasury (2015a).

[3] In fact, DOH is the greatest beneficiary of direct CG financing, receiving 37 percent of all funds channelled in this manner. Other health CGs include those for Health facility revitalization, Health professions training and development, National tertiary services, and National health insurance.
[4] In Scenario 1 below, we assume that the same or similar conditions as those currently governing the HIV CG will remain in place in the next three to five years.

health funds is quite low, so scenarios for HIV financing integration will naturally feature reconfigurations of financing pools.

Purchasing HIV services

There is currently no purchaser-provider split in South Africa's publicly financed health care system, though NDOH and PDOHs do mimic some aspects of the purchaser-provider relationship through the business planning and accountability mechanisms in place for the HIV CG. Nonetheless, individual clinics neither receive nor manage their own budgets. Provinces make global budget allocations to hospitals, which in some cases include funds for clinics in the hospitals' service areas. Elsewhere, district health offices manage clinic budgets. Either way, some health care inputs are paid for directly by PDOHs, including health care worker salaries and some drugs and laboratory services. Due to the conditional grant reporting requirements, provinces must tag their HIV spending as such and specify the programme or intervention, as well as the line items on which funds are spent. However, some of their HIV inputs are shared with other service areas, including labour (nurses, community health workers), facility maintenance, overheads, some supplies, and more. These tend not to be labelled as HIV related in CG reporting and therefore are subsidized with PES funds.

Most of these inputs are purchased in an integrated fashion. Health care workers, for example, receive their salary in the same way regardless of whether their position is officially designated as HIV related (let alone whether they are actually delivering HIV care). Moreover, provinces purchase HIV and other drugs often through nationally coordinated tenders and transfer them to facilities. Despite the ring-fencing of HIV funds in pooling, there is actually little to distinguish purchasing of HIV services from that of other types of care, except for the additional monitoring and reporting that is required under the CG rules. Some provinces are also explicitly attempting to more fully integrate service delivery, further blurring the line between HIV and non-HIV financing at the facility level. Even in a few cases where a province contracts private providers to deliver HIV services, it demands that they provide a wide range of other (typically PHC) services as well.

Because purchasing is fairly integrated between HIV and other health services, particularly PHC, most of our scenarios for HIV financing integration do not include specific changes to the purchasing arrangements. This is not to say that such reforms should not be considered in South Africa. In fact, transitioning to strategic purchasing arrangements may be one of the most promising ways to incentivize greater efficiency and quality in health care. As a purely illustrative example, a future NHI Fund might decide to pay for a basket of PHC services through capitated payments, but retain a separate pay-for-performance or fee-for-service payment mechanism for certain key HIV services. For this reason we highlight in Section 3 the types of purchasing arrangements that could be explored under each scenario, though we also note that the government could experiment with many new approaches without significantly altering its pooling structure. As most of these possibilities do not relate to a change in how *integrated* purchasing would be, a more thorough exploration of them goes beyond the scope of this study.

Delivering HIV services

South Africans can typically seek HIV and other services while visiting a single government facility, which may promote increased access to services and could generate economies of scale if coverage expands to patients who previously have not sought care for lack of availability or convenience. In fact, integrating HIV services into the general health system has led to considerable increases in utilization of inpatient and outpatient care in Rwanda (Piot et al., 2015a). Integrating service delivery can also generate economies of scope if HIV and other service areas share the fixed factors of production, including clinic space, equipment, financial and information management systems, and health workers (Sweeney et al., 2012; Topp et al., 2013). Facility-level integration may also strengthen programmes and generate wider health benefits (Piot et al., 2015b).

However, the extent to which HIV and other services are delivered in an integrated fashion has not been well documented in South Africa. A general measure of Integrated Clinical Services Management indicates considerable variation. On this component of the Ideal Clinic Programme, which includes not only service provision but also several other aspects of performance, districts score between 43 percent and 75 percent, with provincial averages ranging from 52 percent (Mpumalanga) to 63 percent (KwaZulu-Natal) (Steinhobel, Massyn, & Peer, 2015). When asked about HIV services integration, informants also described variation. In some settings facilities dedicate space and workers exclusively to HIV service delivery (perhaps including a handful of related services, such as TB screening). In others, facilities incorporate HIV patients into a single flow for all health services, which are delivered by generalist clinicians.

Optimizing the facility-level choreography of service delivery will depend on local conditions, including a clinic's staffing model, the disease burden of the local population, the volume of patients seeking HIV services relative to others, and more. Facilities with high volumes of HIV patients, for instance, may be able to more efficiently serve them in a separate ward with dedicated clinicians. In contrast, low-volume facilities might struggle to efficiently deliver unintegrated services. There are numerous empirical questions about whether integrating service delivery is desirable in terms of efficiency, quality, and morale. In fact, we encountered anecdotal evidence that paper-based information systems in South African clinics may render integrated service delivery less efficient and unpleasant for both health care workers and patients.

Additionally, even if there are efficiency grounds for integration, there may be compelling reasons to retain unintegrated services in certain settings. For example, key

populations' utilization of services can be deterred by the prospect of stigmatization by providers or other patients (Druce et al., 2006). In South Africa as elsewhere, more research is required to understand the optimal approaches to service delivery integration in different settings and for different patient populations (Piot et al., 2015b). Desirable service delivery modalities could then be linked to purchasing mechanisms and other policies meant to shape provider behaviour.

HIV integration summary

In this section we have illustrated how pooling is the financing function with the greatest scope for integration of HIV and other health funds. Both collection and purchasing are integrated already, and though the latter is ripe for other forms of policy change, the evaluation of those possibilities (e.g., alternative payment mechanisms for different types of services) does not fit into the parameters of this study. Nor does more detailed analysis of the interplay between integrated financing and integrated service delivery.

In the following section we turn to the heart of our analysis: a detailed description of the five scenarios for HIV financing options that have been developed in close consultation with key stakeholders in South Africa. In light of the analysis above, the scenarios focus mainly on how the government could reconfigure the pooling arrangements for HIV and other funds.

A note on TB financing and the HIV conditional grant

Before proceeding to the scenarios, it is important to note the recently announced modifications to the HIV CG and the trend toward integrated financing for some HIV and TB activities. TB imposes a large and growing burden on South Africa, especially on people living with HIV, who account for around 60 percent of the country's TB patients (World Health Organization, 2014). Provinces use PES funds to pay for the vast majority of government-provided TB care and treatment services. However, in recognition that addressing TB is an essential part of a robust HIV response, for several years South Africa has financed some HIV-TB integration and TB control, management, and surveillance activities[5] through the HIV CG (Guthrie et al., 2015).

Moreover, the grant will now be used to scale-up financing for other TB services. The government has already committed R740 million in the current MTEF period for active TB case finding among high-risk and vulnerable populations, chemoprophylaxis for high-risk individuals (including people living with HIV), and widespread deployment of improved diagnostics (Xpert MTB/RIF). In fact, to accommodate this increased funding, and in anticipation of future expansion in the grant's TB components, starting in FY 2016/17 it is called the Comprehensive HIV, AIDS and TB conditional grant (Janari, 2015; National Department of Health, 2015c).

Greater incorporation of TB financing into the grant complicates considerations about how HIV financing might be reconfigured in the next several years. Important questions arise, including whether rearrangements in HIV financing should also be applied to TB funds and how such changes might catalyse or undermine ongoing efforts to strengthen South Africa's TB response. These issues go beyond the scope of this study, but in Section 5 we argue that they must be examined carefully before implementing any integration scenario.

[5] These include TB screening for HIV patients and some TB programme management costs, among other activities. The spending categories reflect labels in South Africa's Basic Accounting System, which does not provide additional detail on how funds are actually used.

Photo: ©UNAIDS/Eveline Simaloy

Section 3: HIV financing scenarios for the next three to five years

Developing the scenarios

While developing the scenarios, we selected two key parameters to define the realm of possible financing arrangements to consider. First, we elected to focus on options that can plausibly be implemented in the next five years (if not sooner). This stems from the interest of some government officials to redesign the HIV financing mechanisms in concert with decision making about longer-term NHI system design. Below we do discuss how each scenario might fit into NHI implementation, but we emphasize the more immediate implications of the financing options.

Second, we chose not to vary the total resource envelop for HIV or health across the scenarios. Others have worked extensively to determine the resource needs for achieving South Africa's ambitious national coverage targets, including the recent UNAIDS-supported Investment Case for HIV and TB (Department of Health, South Africa & South African National AIDS Council, 2016). This study's short time frame and focus on integration precluded any meaningful advancement on this body of work. Instead, we offer complementary analysis that highlights how, given a particular spending level, altering the organization of health financing, particularly in the pooling function, might affect health system performance.

Descriptions

From our consultations we distilled and synthesized informants' ideas into the five scenarios presented later in this section. To each we applied a descriptive template with six components meant to capture key features that vary across the scenarios and relate to policymakers' key questions. Table 3.1 summarizes the descriptive framework.

Evaluations

The consultations also revealed policymakers' main interests and concerns for evaluating the scenarios. Six criteria emerged, the first three of which relate to the scenarios' potential **impact** on health system performance.

Potential effect on the HIV response

Policymakers are keen to understand whether the alternative financing mechanisms would enhance or undermine the country's HIV response. We identify the risks and potential gains each scenario might entail for the HIV programme.

Potential effect on PHC services

It is useful to highlight potential synergies or trade-offs between HIV and other services, particularly PHC, under each scenario. For instance, if a scenario jeopardized certain aspects of the HIV programme, could policymakers at least expect improvements in PHC service quality?

Potential effect on health system efficiency

A major impetus for considering changes to HIV financing in South Africa is the potential for efficiency gains. The practical constraints on this study preclude a rigorous, quantitative modelling exercise to precisely estimate efficiency gains and losses, but we do attempt to qualitatively assess the likely direction of each scenario's effect.

For the impact criteria we use a qualitative rubric to indicate a scenario's likely effect. We argue that a scenario will have a favourable (+, ++, +++), unfavourable (-, - - , - - -), or minimal (Ø) effect on HIV, PHC, and health system efficiency. We use multiple symbols to convey differences in magnitude (e.g., ++ means more favourable than +) or borderline cases (e.g.,

Table 3.1. Descriptive framework for integration scenarios.

Component	Details
Financing mechanism	The core features of the scenario's financing mechanism and its implications for the pooling of HIV and other health funds.
Rationale	The scenario's motivation from the perspective of a proponent of the option. The rationale does not necessarily reflect what would happen if the scenario were implemented; rather, it explains why the scenario is worth considering and offers hypotheses for the scenario's potential effects.
Potential pools of funds	An estimate of the expected allocation of provincial health sector funds across the financing pools and mechanisms the scenario would require. We manipulate MTEF budget estimates (National Treasury, 2015b) for provincial health spending in FY 2016/17 to generate illustrative allocations.[6]
Governance of HIV funds	How the scenario would distribute responsibility for and authority over HIV funds between the spheres of government, which sphere(s) would be responsible for HIV budget planning, and which would establish and monitor HIV service targets.
Purchasing of HIV services	The opportunities the scenario would create for modifying how the government purchases HIV services.
Implementation and pathway to NHI	Some immediate implementation steps the scenario would require and how the scenario could fit into a new NHI system in the longer term.

Source: Authors.

Ø/+ indicates the effect is likely to be minimal or potentially favourable). In some cases we cannot estimate the effect because it depends too much on additional policy choices that go beyond the scenario (?).

The second trio of evaluation criteria addresses three aspects of scenarios' **feasibility**: legal, political, and technical.[7]

Legal feasibility

Amid South Africa's complex constitutional and legal context, in which legislative competence for the health sector is shared among the national, provincial, and local spheres of government, different scenarios would require varying degrees of policy change. For instance, national departments might be able to implement some scenarios on the basis of their executive authority alone. Others, however, might rely on major enabling legislation. In fact, there is an ongoing debate about whether some of the NHI White Paper (2015)'s proposals would require changes to the constitution. Consequently, in addition to the magnitude of policy change required for each scenario, we also consider the risk of legal challenges when relevant. We relied on our understanding of relevant statutes and on our informants' insights to assess legal feasibility. A more formal legal analysis would be useful but was outside the scope of this study.

Political feasibility

Political feasibility derives from the political economy of health reform, which is driven by interest groups' views and influence, their ability and willingness to push through or block new policies, and how these factors are mediated through existing institutions. Key interest groups include government officials and agencies, civil society organizations, providers and their professional associations, labour unions, insurers, and patients. Proposed changes to HIV financing arrangements would likely animate treasury and health officials at the national and provincial levels, public-sector health workers, and HIV advocates. Regardless of its other virtues, no scenario would succeed if it could not amass critical support from these and other important constituencies. A full political analysis, including institutional and stakeholder mapping and widespread consultations, was beyond the scope of this study. Nonetheless, we offer insights into the views of some key stakeholders and the likely attitudes of others about each scenario.

Technical feasibility

Each scenario would have practical implications for the financial and performance management of entities and individuals within the health system. Technical feasibility reflects the extent to which they would have the skills and resources to play

[6] For scenarios that include pooling HIV and other PHC funds together, we estimate the PHC budget by summing forecasts for district management, community health clinics, community-based clinics, other community services, nutrition, primary health care training, and health facility management for community health facilities, plus 25 percent of projected spending on district hospitals and associated facility management. District hospitals provide both primary and secondary health care services. There is no way to extract from public expenditure data the share of their budgets these facilities spend on PHC. The share is certainly greater than none, and intuitively half seemed the upper limit because even if the majority of district hospital services could be considered PHC, those services should be much cheaper to provide. We then simply selected the midpoint of this range. 25 percent is admittedly arbitrary, so we emphasize the "illustrative" nature of the allocations and note later in the study that much more work needs to be done anyway to better understand the cost of delivering PHC services in various settings. Some of this work is already underway under the umbrella of the NDOH-NT PHC Costing Task Team.

[7] Feasibility is a broad concept encapsulating many considerations. Policymakers and analysts might consider numerous feasibility dimensions depending on the nature of proposed scenarios, the local context, government's implementation capacity, and more. Beyond those addressed here, an important additional dimension is fiscal feasibility, which captures whether the costs associated with a scenario are reasonable given available resources. Although we assume a fixed envelop of resources for health across all five scenarios, they may vary in terms of the short-run implementation costs.

their proposed role. With scenarios focused on the pooling and management of funds, technical feasibility measures the degree of existing financial and performance management knowhow, as well as the availability and skilled use of information systems for monitoring, evaluation, and decision making. The scenarios would directly alter processes and data requirements for budget planning, negotiation and execution of contracts, and performance monitoring. All scenarios would require a high degree of capacity, so we estimate technical feasibility in terms of the gap between existing and required capacities of the relevant actors, as well as the ease with which new capacities could be developed.

For the feasibility criteria we again use a qualitative rubric to indicate how challenging a scenario will be to implement. We adopt a three-point scale—high, medium, and low—to indicate their legal, political, and technical feasibility.

Overview of the five scenarios

The characterization of South Africa's government financing system for health and HIV in Section 2 serves as a natural starting point for the development and analysis of the proposed scenarios. Here we describe five scenarios designed in close consultation with government counterparts and other stakeholders, as well as evaluate them according to the impact and feasibility criteria detailed earlier in this section.

1. **Sustained HIV conditionality:** HIV funds would remain ring-fenced in the HIV CG, and all other financing channels would remain in place, with PES funds covering most other health services.

2. **National HIV Fund:** The majority of funds from the HIV CG would be used to seed a new NHI Fund, which would purchase a package of personal HIV services.

3. **Unconditional integration:** The HIV CG would be eliminated, and all HIV funds would be folded into the PES. The PES allocation formula would be modified to account for HIV burden.

4. **Ring-fenced PHC integration:** PES funds currently paying for PHC services would be folded into the HIV CG to create a Comprehensive PHC conditional grant that would support a wide range of personal PHC services, including those for HIV.

5. **National PHC Fund:** In an amalgam of 2 and 4, PES funds currently paying for PHC services and funds from the HIV CG would be used to seed the NHIF, which would purchase a package of PHC and HIV services.

These scenarios represent a range of options, including maintenance of the current financing arrangements, that vary principally along two key dimensions of interest to senior government officials. First, the scenarios imply differing **levels of national influence over the management and use of HIV funds.** The HIV CG mechanism empowers NDOH to strictly oversee business planning and performance monitoring for provincially managed HIV service delivery, including by withholding funds from underperforming provinces. Consequently, it is important to consider how any scenario might modify NDOH's oversight authority. Moreover, the NHI White Paper (2015) proposes a single national Fund as purchaser of all health services; therefore, whether scenarios would alter the extent of health financing centralization is germane to the broader NHI policy discourse. Scenarios 2 and 5 would increase national influence over HIV funds, while Scenario 3 would dramatically curtail it. Meanwhile, Scenarios 1 and 4 would retain the current level of influence.

Second, the scenarios represent varying **degrees of integration in pooling of HIV and non-HIV health financing**. As Section 2 notes, collection and purchasing are already considerably integrated, while pooling is not.[8] It is important to reiterate that these descriptive ratings of integration are, in and of themselves, non-normative. Whether greater integration in pooling and purchasing is *better* for a health system—for example in terms of efficiency, access, quality, or equity—is empirically uncertain. There are plausible hypotheses for why integration would enhance health system performance, just as there are well-founded reasons to prefer stricter ring-fencing for ensuring spending and reporting on priority health issues. The scenario-specific analyses later in this section address these issues in greater detail.

Scenario 2 is non-integrative because, although it would reconfigure HIV financing, it would not increase the extent to which HIV funds are pooled with money for other health services. In fact, it would entail a *less* integrated approach to purchasing and perhaps even to service delivery. Scenarios 3, 4, and 5 all would represent significant increases in the degree of pooling integration. Scenario 3 would integrate pooling of HIV and all PES health funds, while 4 and 5 would integrate pooling of HIV and PHC funds. Meanwhile, the extent to which these scenarios integrated purchasing would depend on a number of additional policy choices pertaining to the potential implementation of a purchaser-provider split, selection of various payment mechanisms, and contracting of private providers alongside public ones to deliver services.

Figure 3.1 situates the five scenarios along these two dimensions, as well as illustrates a major difference between the HIV CG and PES health funds in the current financing system. The horizontal axis reflects the extent of national control over the use of HIV funds, while the vertical indicates the extent of integrated pooling for HIV and non-HIV health financing. Integrated purchasing is

[8] These characterizations of integration in South Africa are broadly consistent with those provided in Blanchet et al. (2014). However, in focusing on government financing only, this study's evaluation of the three financing functions is slightly different.

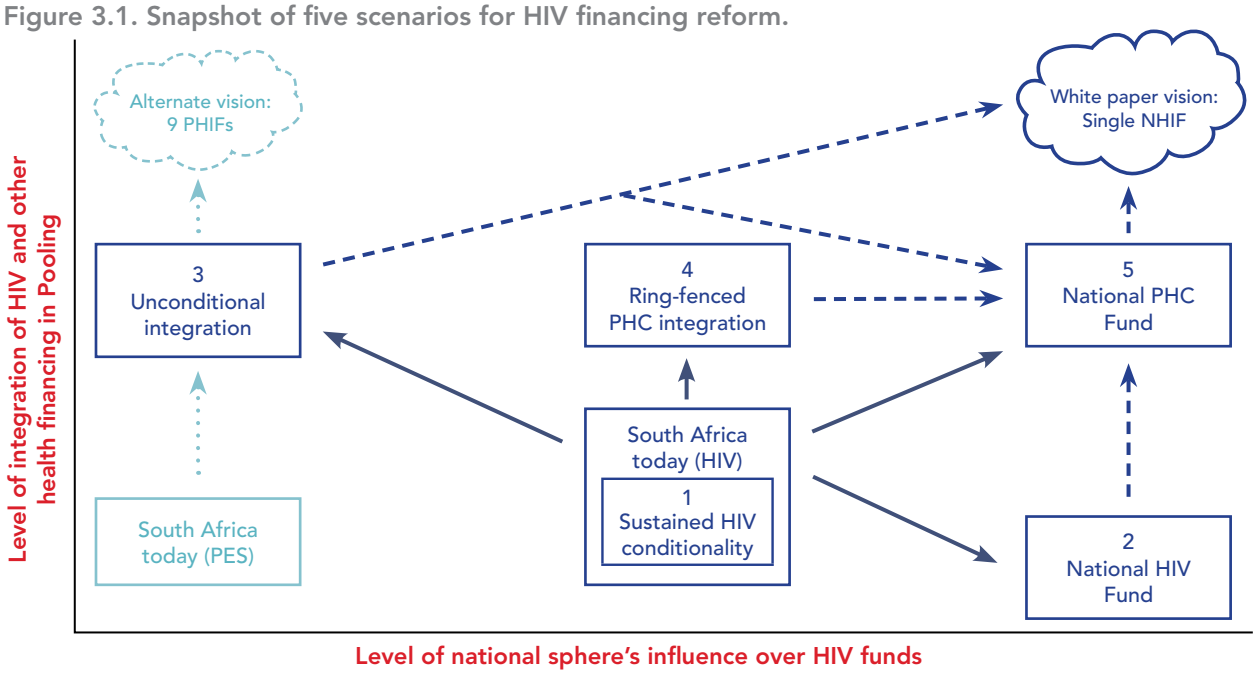
also of great policy interest, but the possible modalities of purchasing are largely unrelated to those of pooling, at least in the near term. For example, with no adjustment to pooling arrangements, the government could already introduce strategic purchasing mechanisms that tie HIV and other health financing to service delivery outputs or even outcomes. Likewise, there is no specific purchasing system inherent to the creation of an NHIF. That entity could continue to provide input-based budgets to providers or adopt a wide range of contracting processes, many of which would require a purchaser-provider split.

While not exhaustive, the scenarios capture a broad range of pooling options. Common to all is a sense, both intuitive and validated through consultation, that with sufficient political support, the scenario could be implemented in the next three to five years. At the same time, Scenarios 2–5 could not be realized over night; rather, they would require a sequence of preparatory and implementation steps. These are addressed for each scenario below and again in Section 5. This near-term timeframe also motivates a focus on integrating HIV and PHC financing. More complete financing integration across the entire continuum of care, particularly with respect to purchasing, would entail even more radical health reforms than those the White Paper (2015) proposes.[9]

In the long run, and especially in the context of South Africa's evolving NHI discourse, none of the scenarios is intended as an endpoint. Instead, each represents a possible step toward NHI—either as envisaged in the White Paper (2015) or alternative structural models—and indeed multiple scenarios could be sequenced in a multiphase reform process. The lines in Figure 3.1 indicate just some of the possible pathways from the current system to NHI, with the solid lines indicating movement from the current system to any of the other scenarios. Scenarios 2, 4, and 5 are all direct steps toward a centralized NHI system such as that proposed by the White Paper (2015) (dashed lines). In contrast, Scenario 3 may only be constructive as a step toward a more devolved NHI system, one in which each province operates its own Provincial Health Insurance Fund (dotted lines). This would diverge significantly from the White Paper (2015) vision.

The subsections that follow present short summaries of each scenario. They follow a standard format based on the descriptive and evaluative frameworks described earlier. Additional comparative analysis and discussion of the five scenarios can be found in Section 4, while the key questions and next steps for South Africa emerging from this study are presented in Section 5. More detailed analysis of each scenario can be found in Appendix 2.

Figure 3.1. Snapshot of five scenarios for HIV financing reform.



Source: Authors.
Notes: Solid lines indicate movement from the current HIV financing approach (Scenario 1) to the other four scenarios presented in this study. Dashed lines (dark blue) depict potential pathways from those scenarios to the NHI system proposed in the White paper (2015). Dotted lines (light blue), in contrast, show the potential pathway from the current system to a more devolved NHI scheme in which each province manages its own insurance fund.
Abbreviations: NHIF = National Health Insurance Fund, PES = provincial equitable share, PHC = primary health care, PHIFs = Provincial Health Insurance Funds.

[9] Such reforms might include the integrated management of district health systems in which payments are linked to patient or population outcomes regardless of the care delivery setting; this would be akin to the Accountability Care Organization (ACO) model currently being piloted in the United States.

Scenario 1: Sustained HIV conditionality

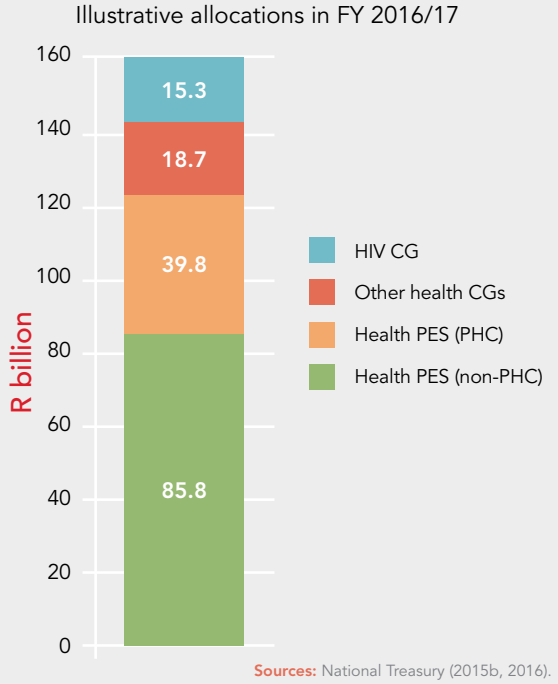
Financing mechanism

Scenario 1 would maintain the status quo. The current financing mechanisms for HIV within DOH would be retained, and the bulk of government spending on HIV would be channelled through the HIV CG. The annual Division of Revenue Act (DORA) would continue to indicate the conditions for the grant, stipulating each subprogramme's allocation and targets. NDOH, in consultation with each PDOH, would continue to determine annual allocations to provinces and targets for each HIV subprogramme, and the provinces would continue to report on these quarterly.

Rationale

The HIV response deserves independent focus and management, even at the cost of some inefficiency in the health system. Until NHI plans are finalized and critical decisions are made about how HIV services will be provided under the new scheme, it may be premature to alter a well-functioning system which has enabled unprecedented annual funding increases for the provision of essential curative and preventive HIV services. Sustaining HIV conditionality and harnessing the HIV programme's business planning and monitoring strengths will ensure that funds are used for their intended purpose and performance targets are achieved.

Pools of funds



Sources: National Treasury (2015b, 2016).

Governance of HIV funds

- NDOH would continue to oversee HIV CG spending, set targets and monitor outputs. The CG would specify priority interventions and measurable performance standards.
- Provinces would develop business and budget plans, oversee service delivery, and report on performance.
- Districts and facilities would deliver HIV and other services based on business plans and budgets determined above.

Purchasing of HIV services

- Input-based budgets for HIV would continue to be standard for providers, often with inputs shared between HIV and other services (e.g., clinicians, exam rooms).
- Surplus funds might be spent on low-priority HIV activities instead of much needed non-HIV services.
- Provinces could pilot active purchasing arrangements with high-performing Ideal Clinics or private providers.

Implementation and pathway to NHI

- The current HIV financing system could precede either further centralization of HIV (and other) funds, such as under Scenarios 2, 4, and 5, or further devolution of HIV funding, such as under Scenario 3.
- In the near future, experience with the HIV CG could be the basis for building wider capacity for contract management and performance monitoring, which will be essential for the NHI system. Facilities in the NHI pilot districts could be the natural starting point during the next phase of the Ideal Clinic Programme.

Impact

Note: Scenario 1 is the reference scenario against which we assess the potential impact of other scenarios. Therefore, we comment on the HIV response, PHC services, and health system efficiency under the status quo, but we do not offer impact ratings.

HIV response
The HIV CG would continue to ensure adequate funds are committed and spent accordingly on HIV, and therefore would protect the performance of the HIV response and achievement of national targets. The HIV and TB Investment Case (Department of Health, South Africa & South African National AIDS Council, 2016) is already guiding the budget proposal and business planning processes for the conditional grant, helping to justify additional resource allocations in pursuit of ambitious national 90-90-90 coverage targets.

PHC services
Sustaining HIV conditionality would not likely affect PHC services directly. The benefits (and costs) of the CG framework would not be expanded to PHC, nor would the financing structure necessarily promote further integration of service delivery. Lack of integrated service delivery is but one small portion of the challenges faced in PHC. There are many obstacles to improved PHC services, including stagnant PHC budgets, minimal accountability, weak management capacity, and inadequate data and models to guide budget planning.

Health system efficiency
Any inefficiency from overlapping planning and oversight systems would persist, as might inefficient spending driven by strict ring-fencing. There is anecdotal evidence that surplus HIV funds are spent on excess equipment and conferences because they cannot be reallocated to other PHC services. This has not been documented or quantified, but complementary measures to encourage more flexible use of CG funds at the provincial and provider levels, such as a waiver process to repurpose HIV funds when service targets are met, could integrate and improve service delivery and reduce inefficient spending. The ongoing process of developing and executing District Implementation Plans could also improve the efficiency of resource allocation among HIV, TB, and selected maternal and child health activities.

Feasibility

Legal: HIGH
Sustaining HIV conditionality would not require any policy reforms. The grant mechanism is well established in South African law, and it remains fully compatible with the distribution of governmental responsibilities envisaged by the National Health Act (2004) and the Constitution.

Political: HIGH
NDOH is eager to move forward with NHI implementation, but possibly not so rapidly that HIV financing should change in the next three to five years. More generally, the current system of dedicated HIV funding and programme management enjoys considerable support from NDOH, PDOHs, SANAC, and probably HIV advocates. NDOH and NT are both keen on more integrated financing, which might be pursued within the current financing structure, as is being done with TB starting in FY 2016/17.

Technical: HIGH
The core capacity required for planning, budgeting, and monitoring CG spending and HIV activities already exists. Financial and performance management systems for HIV continually evolve and improve, and integration of TB more fully into the CG mechanism will require additional capacitation at various levels of the system.

Scenario 2: National HIV Fund

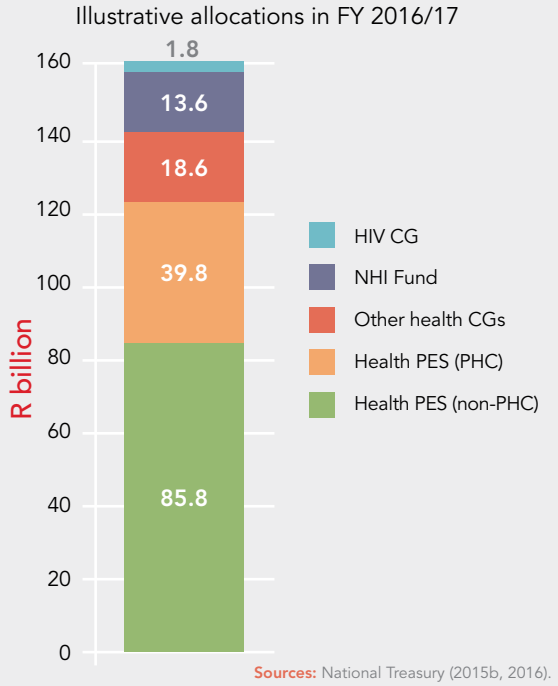
Financing mechanism

Scenario 2 would seed the NHI Fund with funds from the HIV CG and the small NHI CG.[10] The Fund would purchase a package of personal HIV services, including care, treatment, and biomedical preventive services like PMTCT and MMC. Once a purchaser-provider split is instituted, the Fund would purchase services through contracts negotiated with public and private providers. HIV-related public health activities, such as social behaviour change campaigns (SBCC), demand creation for MMC, programmes for high-transmission areas, and procurement and distribution of condoms, would be funded via a small CG. Scenario 2 would not further integrate HIV financing, and it might reduce the extent of integration, particularly in purchasing.

Rationale

Scenario 2 would protect financing for more effective and measurable administration and delivery of HIV services, but it would also involve more explicit steps than Scenario 1 toward NHI. Establishing the Fund would harness the HIV programme's business planning and monitoring strengths to catalyse development of capacity for output-based purchasing and performance management under NHI. This will be key to strategic purchasing, which in the future could drive efficiency gains across many services in the NHI system.

Pools of funds



Sources: National Treasury (2015b, 2016).

Governance of HIV funds

- The new NHI Fund would control HIV spending while NDOH would accredit providers for payment eligibility.
- Provinces would play a minor role, controlling prevention funds from a small HIV CG for public health activities (e.g., SBCC) and perhaps helping to build district-level financial management capacity.
- District Health Management Offices (DHMOs) would plan budgets and potentially manage service provision.

Purchasing of HIV services

- The NHI Fund could implement strategic purchasing mechanisms to incentivize efficiency and quality improvement in the delivery of HIV services.
- It is not clear how an HIV-focused NHI Fund would purchase an integrated package of PHC services.

Implementation and pathway to NHI

- The Fund would start developing capacity for strategic, contract-based purchasing of HIV services. In the future, non-HIV services could be added to the benefits package.
- The Fund, DHMOs, and providers would all develop financial and information management capacity that will be essential for a well-functioning NHI system.
- This scenario could be a precursor to Scenario 5 and the full NHI White Paper (2015) vision.

[10] This is distinct from the National Health Grant, which as of FY 2016/2017 is called the National Health Insurance Indirect Grant.

Impact

HIV response: ? / - (uncertain/unfavourable)
Strategic purchasing could drive quality improvement and efficiency with well-designed payment mechanisms. However, problems with enrolment and cost-sharing policies could negatively affect access, particularly for poor and stigmatized patients. Moreover, dividing responsibility for personal (NHI Fund) and non-personal (PDOHs) interventions could erode coordination of the overall response.

PHC services: Ø (minimal)
PHC services would continue to be financed via the PES and thus not integrated with HIV financing. Removing HIV financing from provincial budgets would preclude using CG funds for re-journalization, which could lead to non-HIV service delivery disruptions. NT, NDOH, and provinces are already exploring other solutions to cash flow problems.

Health system efficiency: ? / - (uncertain/unfavourable)
Further separating HIV and other health financing could reduce allocative efficiency, at least in the short run. In contrast, priority setting and health technology assessment could improve allocative efficiency within the HIV response, and strategic purchasing could incentivize more technically efficient HIV services. However, an HIV-focused Fund could complicate management and purchasing of shared inputs, particularly labour, as well as hinder integration of service delivery in the short run. These challenges would recede as additional PHC services were incorporated into purchasing contracts (i.e., movement toward Scenario 5).

Feasibility

Legal: LOW–MEDIUM
Major enabling legislation would be required to establish the Fund as a standalone legal entity. Strategically purchasing all health inputs, including labour, may require changes to employment laws as well. If provinces were bypassed entirely in contractual arrangements, the risk of legal challenge could be considerable.

Political: LOW–MEDIUM
National officials might see this scenario as a valuable step toward NHI, but its lack of integration may put off NHI supporters. HIV programme managers and advocates might be wary without assurances on enrolment policies and access to services. Provinces might resist losing such a large share of their health budget to a nationally controlled Fund, though their options for recourse may be limited.

Technical: LOW–MEDIUM
South Africa already has considerable planning, costing, and tracking capacity for its HIV response, a purchasing-based HIV response would require improved financial management, contracting, and monitoring capacity, particularly at the district and facility levels. The Fund itself would also need to be capacitated; there is little precedent for such a large, government-administered purchasing agency in the country.

Scenario 3: Unconditional integration

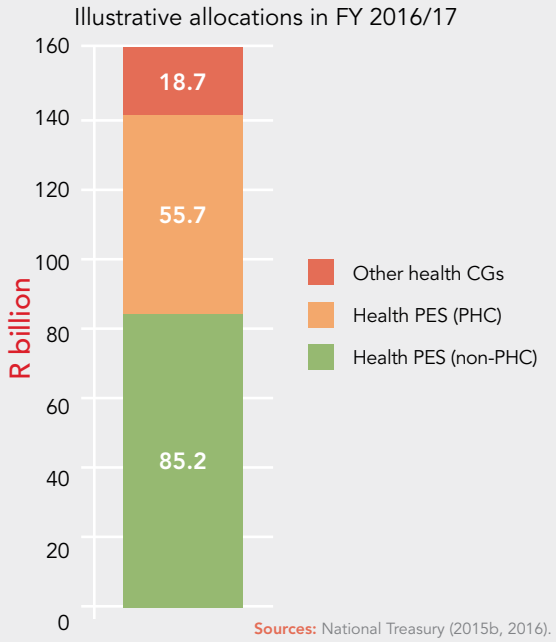
Financing mechanism

Scenario 3 would entail complete HIV financing integration via abolition of the HIV CG. All provincially managed health sector HIV funding—for both personal and non-personal services—would be channelled through the PES, for which the allocation formula would be adjusted to account for provincial HIV burden. There would be no ring-fencing of HIV funds, and the strict conditions of the CG would be removed. Like for most other health services, the funding and delivery of HIV services would fall fully under provincial authority in accordance with the National Health Act of 2004. Provinces would have full discretion over the allocation of resources across sectors and within the health sector, including for HIV and other programmes, subject only to the financial requirements outlined in the Public Finance Management Act (PFMA).

Rationale

Given HIV's increasing share of the overall health budget, it may be increasingly difficult to justify a large CG focused on a single disease. Giving provinces full control over their HIV budgets might reduce inefficiency by fully integrating HIV and other health financing. The business planning, budget tracking, and performance monitoring systems developed for HIV are already ingrained in PDOHs and could be the basis for improved management practices across all health services. An integrated pool of funds could reduce the need for parallel administrative, management, and oversight capacity across programme areas, and some programme management resources (e.g., personnel, data systems) could be redeployed where needed.

Pools of funds



Sources: National Treasury (2015b, 2016).

Governance of HIV funds

- Control of HIV spending would shift to provinces, which would determine funding allocations to HIV and its distribution across HIV interventions.
- NDOH could set national targets or benchmarks but would lose its ability to enforce planning, reporting, or performance standards requirements.

Purchasing of HIV services

- Purchasing would likely remain input based, but provinces could on their own experiment with more strategic purchasing or contracting with private providers.

Implementation and pathway to NHI

- Placing the already centralized HIV funds within the PES would run counter to creating a single, nationally controlled NHI Fund and could make it more politically challenging to subsequently incorporate money into such a Fund in the future.
- Scenario 3 could lead to a devolved NHI system with nine provincially managed health insurance funds. This would mimic Canada's social health insurance system but would diverge from current proposals.

Impact

HIV response: - - - (extremely unfavourable)
Loosening the conditionality of the CG might be detrimental to the HIV response because the funds would no longer be ring-fenced and thus would be easily reallocated to other provincial priorities, possibly outside the health sector altogether. Provinces' legislative prerogative and financial management challenges could drive decreases in HIV spending, undermining access to ART, lab tests, and other critical services. This scenario illustrates how financing integration for integration's sake might not be desirable.

PHC services: ? / + (uncertain/favourable)
Placing the HIV funds into the PES might make more resources available for PHC and allow for more efficient spending and improvement of PHC services. However, to the extent that they reallocated HIV funds to other uses, there is no guarantee that provinces would retain those resources in the health sector.

Health system efficiency: Ø / - (minimal/unfavourable)
Eliminating dual management and reporting systems could generate modest savings. However, there would be minimal assurance that funds would be deployed to allocatively efficient interventions; instead, provinces might channel more money to hospitals and non-health priorities.

Feasibility

Legal: HIGH
Unconditional integration could be achieved without any major legislative reforms. Channelling funds via the PES allocation system is already the core mechanism for intergovernmental transfers in South Africa, and there is no law or constitutional provision requiring a conditional grant for HIV in perpetuity. Adjusting the PES allocation formula to account for HIV burden would pose a modest policy design challenge, but the existing distribution of CG resources across provinces would provide a useful starting point.

Political: LOW
Among informants there was clear opposition to this scenario and minimal direct support. NDOH would strongly oppose this option, as likely would provincial HAST Directors and HIV advocates. Other provincial authorities might support it if it could mean more money for non-health priorities. NT officials expressed interest in alternatives to an ever-growing HIV CG, but they would not likely risk harm to the HIV response.

Technical: HIGH
This scenario has the fewest technical requirements. No new capacity would be required beyond existing systems for financial and performance management for PES spending. No special capacity would be needed for provinces to apply the same management systems in place for PES funds to a larger pool of money. Moreover, provinces already oversee HIV service delivery; in this scenario they would be liberated from the financial management processes demanded by the CG mechanism.

Note: PDOHs' capacity to protect and manage their health budgets for specific programmes is generally weak and subject to other provincial priorities, political agendas, and misuse. Protecting HIV funds within the PES, and hence the achievements made in the HIV response, would require capacity building within PDOHs and improvement of the PES reporting and control mechanisms. It is uncertain whether the capacity that has been built to cost and budget for the HIV CG would be retained and continued if the funds were channelled through the PES. Potentially these skills could remain and perhaps be applied to other PHC services.

Scenario 4: Ring-fenced PHC integration

Financing mechanism

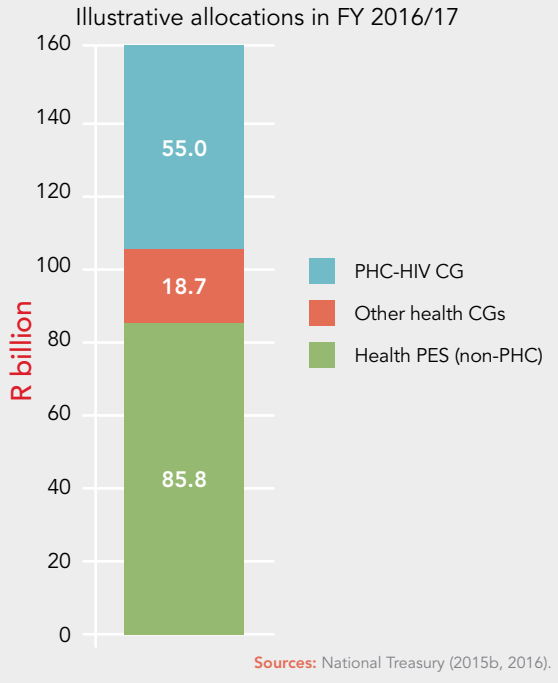
Under Scenario 4, the scope of the HIV CG would be expanded to include all of PHC, fully integrating financing for HIV and other PHC services. The resulting Comprehensive PHC CG would be modelled on the existing HIV CG, with funds managed by provinces in accordance with a revised CG framework for all PHC services. There would be at least two possible approaches:

1. PES funds currently spent on PHC could be shifted to the HIV CG. The share of national revenue distributed via the PES would be reduced, as would be the share of PES funds allocated to health.
2. More incrementally, new funds could be added to the CG over several years to cover PHC services. This is already happening on a small scale with the fuller integration of TB into the CG framework in FY 2016/17 and addition of new funds for TB starting in FY 2017/18. In future years other PHC service areas could be integrated as well, perhaps starting with maternal and child health.

Rationale

Since its inception, the HIV CG has been instrumental to the scale and quality of the world's largest HIV programme. Meanwhile PHC service delivery in government facilities has reportedly struggled. Extending ring-fencing around PHC funds could potentially imbue PHC services with the same rigorous planning, monitoring, and evaluation that underpin the HIV programme's success. It would also require improving capacity for PHC resource needs estimation, budgeting, and reporting. Finally, it might reduce financing barriers to integrated service delivery, thereby promoting better and more efficient use of resources.

Pools of funds



Sources: National Treasury (2015b, 2016).

Governance of HIV funds

- NDOH would oversee HIV spending, set service targets, approve business plans, and track performance.
- NDOH influence would extent to the rest of PHC services, for which similar planning and monitoring processes would be developed.
- Provinces would continue to oversee service delivery.

Purchasing of HIV services

- Over time PHC budgets would be linked to output and outcome targets, as is the case currently for HIV.
- Provinces could also experiment with strategic purchasing of an integrated package of HIV and other PHC services.

Implementation and pathway to NHI

- An integrated pool of PHC funds could be the first step toward the Transition Fund proposed in the White Paper (2015), which is similar to the National PHC Fund we describe in Scenario 5.
- In the short run this scenario would vest financial management capacity at the provincial level, whereas the NHI White Paper (2015) proposes shifting management to the district and facility levels.

Impact

HIV response: Ø / - (minimal/unfavourable)
Current HIV planning and monitoring systems would persist and be combined with analogous processes for other PHC services. There could be trade-offs between allocative efficiency and total HIV spending; full integration might lead provinces to shift funds between HIV and other PHC services, while retaining separate sub-pools within the PHC CG could temper any gains from integration.

PHC services: ++ (very favourable)
Integrating and ring-fencing HIV and other PHC financing should improve the planning, tracking, and monitoring of PHC spending and service delivery. Integrated financing may also lead to more spending on non-HIV services, both from shifting funds from HIV activities and the likelihood that the CG will grow faster than the general health budget drawn from PES funds. If new funds were added to the CG, there would be some risk that provinces would substitute away PES spending on PHC, which would dampen gains.

Health system efficiency: ? / + (uncertain/favourable)
Integrated financing could promote allocative efficiency across HIV and other PHC interventions. It may also yield economies of scope in programme management. Technical efficiency may depend on more strategic approaches to purchasing by provinces.

Feasibility

Legal: MEDIUM–HIGH
Retaining PHC's share of the PES funds at the national level would represent a significant change in intergovernmental fiscal relations and could invite legal challenges from provinces. Incrementally adding new PHC funds to the CG would be more feasible, particularly in the next three to five years. The CG mechanism would need to change gradually to accommodate an increasing share of PHC services and funds.

Political: MEDIUM–HIGH
NDOH might find appealing this incremental step toward greater national control over all PHC spending, especially if it were coupled with additional preparatory steps for NHI. NT might be wary of creating a massive PHC CG, particularly if it required clawing back to the national sphere a large share of PES funds. However, if integrated ring-fencing facilitated more strategic purchasing of PHC services, NT might consider this scenario a useful step toward the creation of an NHI Fund. Provincial officials would likely object to losing a large portion of their PES budget, while adding new funds to a PHC CG could appeal to provinces, whose overall social sector budgets would increase.

Technical: MEDIUM
Ring-fenced integration would require expansive scale-up of costing, budgeting, tracking, and monitoring competencies for PHC services. Resource needs for PHC are currently not well understood or researched, though the NT-NDOH PHC Costing Task Team has begun to fill key knowledge gaps. Similarly, considerable effort would be required to develop appropriate PHC indicators and expand the systems for provinces to routinely collect and report them. Incumbent systems for HIV would provide a useful foundation, but both research and capacitation would be required to extend those systems to all of PHC.

Scenario 5: National PHC Fund

Financing mechanism

Under Scenario 5, the NHI Fund would be established first as a PHC Fund with a large pool of resources to purchase an integrated PHC benefits package that includes personal HIV prevention, care, and treatment services. Similar to Scenario 4, there would be two possible approaches for creating a National PHC Fund:

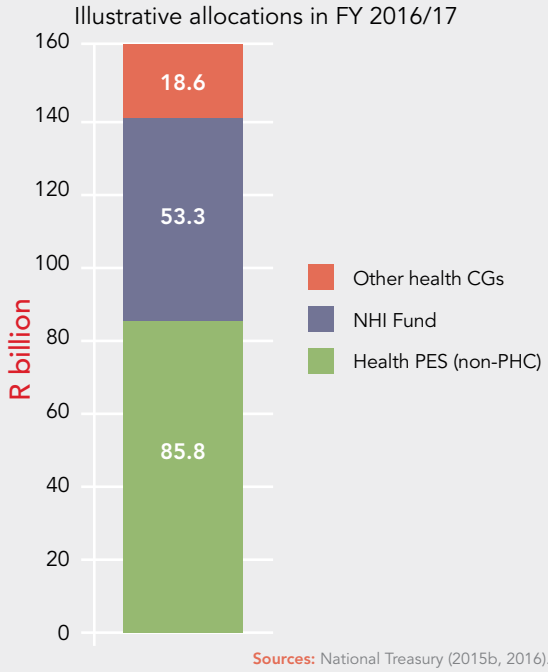
1. The Fund could consolidate most of the HIV CG, the entire NHI CG[11], and the portion of PES funds corresponding to anticipated PHC spending.
2. Most of the HIV CG and the NHI CG could seed the Fund, with new resources added incrementally.

In either case, the fate of financing for non-personal HIV services might be different from that of financing for personal services. We analyse the implication of integrating these funds into the PES, from which provinces draw resources for other non-personal health activities.

Rationale

Scenario 4 is a step in the right direction but insufficiently ambitious to achieve the government's health reform objectives. Integrated financing may promise some efficiency gains, but the creation of a national Fund capable of strategically purchasing all services could lead to substantial improvements in access to high quality, efficiently delivered services for the entire population. Health reform is politically challenging, so each step should be as ambitious as possible.

Pools of funds



Sources: National Treasury (2015b, 2016).

Governance of HIV funds

- The Fund would assume the purchasing function for PHC services, with DHMOs managing service delivery.
- NDOH would consult with the Fund, DHMOs, and providers to set policies, accreditation criteria, and performance standards.

Purchasing of HIV services

- The NHIF would enable a shift from input- to output-based budgeting and an eventual purchaser-provider split.
- Any payment mechanism(s) could be instituted to incentivize quality and efficiency, including capitation for PHC as proposed in the NHI White Paper (2015).
- In the near term, payment for HIV and other PHC services might need to remain separate until risk-adjustment mechanisms were in place.

Implementation and pathway to NHI

- This scenario may align with the Transitional Fund for PHC proposed in the NHI White Paper (2015). Beyond PHC, the NHIF could eventually collect all health funds and purchase all personal services.
- NHI pilot districts would be a natural starting point for strategic purchasing.

[11] As in Scenario 2, the NHI Indirect Grant (previously the National Health Grant) would not be implicated in this scenario.

Impact

HIV response: ? / - (uncertain/unfavourable)
Similar to Scenario 2, strategic purchasing could drive quality improvement and efficiency with well-designed payment mechanisms. However, clumsy enrolment and cost-sharing policies could negatively affect access, particularly for poor and stigmatized patients. Moreover, dividing responsibility for personal (NHI Fund) and non-personal (PDOHs) interventions could erode coordination of the overall response. At the national level, oversight and funding for HIV activities could be diluted due to integration with financing for the rest of PHC.

PHC services: + (favourable)
Strategic purchasing and improved performance management could strengthen PHC services, especially if the Fund effectively linked financing to clinical behaviours. Integrated financing could bring more resources for non-HIV services and capitalize on the planning and performance monitoring strengths of the HIV response. Enrolment and cost-sharing policies would demand careful design to ensure equitable access.

Health system efficiency: ? (uncertain)
Integrated purchasing could improve allocative efficiency across PHC services, especially if the benefits package prioritized preventive and cost-effective services. Well-designed payment mechanisms could also incentivize quality improvement and efficiency at the facility level. Simply merging all PHC financing in the Fund, however, would achieve little on its own.

Feasibility

Legal: LOW–MEDIUM
Establishing a National PHC Fund would require legislation amending the National Health Act of 2004 to create the Fund, its governance structure, and the process by which the benefits package would be defined and modified over time. The policy design process would likely be protracted: the 2004 law was based on a White Paper from 1997. Nationalizing much of the health budget could also invite constitutional challenges, particularly if PES funds were implicated.

Political: MEDIUM
NHI proponents might champion this scenario as a decisive step toward the White Paper (2015)'s vision. The pace of implementation might dictate the level of NDOH support; some officials may be wary of complicating or undermining the pursuit of ambitious HIV targets, especially if non-personal services were not well handled. Provinces may strongly resist nationalization of funds, but their options for recourse may be limited. An incremental approach that respects current PES allocation levels may be more feasible.

Technical: LOW
Implementing a National PHC Fund would require considerable new financial management and performance monitoring systems, not to mention the capacitation of a new, complex government institution. Some of this capacity could be built atop existing planning and data collection processes in place for HIV and other services, and there would be a few straightforward implementation steps, such as setting up provider bank accounts. Others would require considerably more time and effort, including training a large cadre of financial managers at the facility and district levels. It would be quite ambitious to build all the requisite capacity in only three to five years.

Scenarios wrap-up

This concludes our summaries of the five scenarios. Appendix 2 contains more detailed analysis of each one. Next, in Section 4 we discuss key points of variation and highlight major issues policymakers will want to consider as they determine the path forward for South Africa's publicly financed HIV response and health system more generally. In Section 5 we conclude with recommendations for additional analysis that can contribute to the implementation of a selected scenario or some variant thereof.

Photo: ©UNAIDS

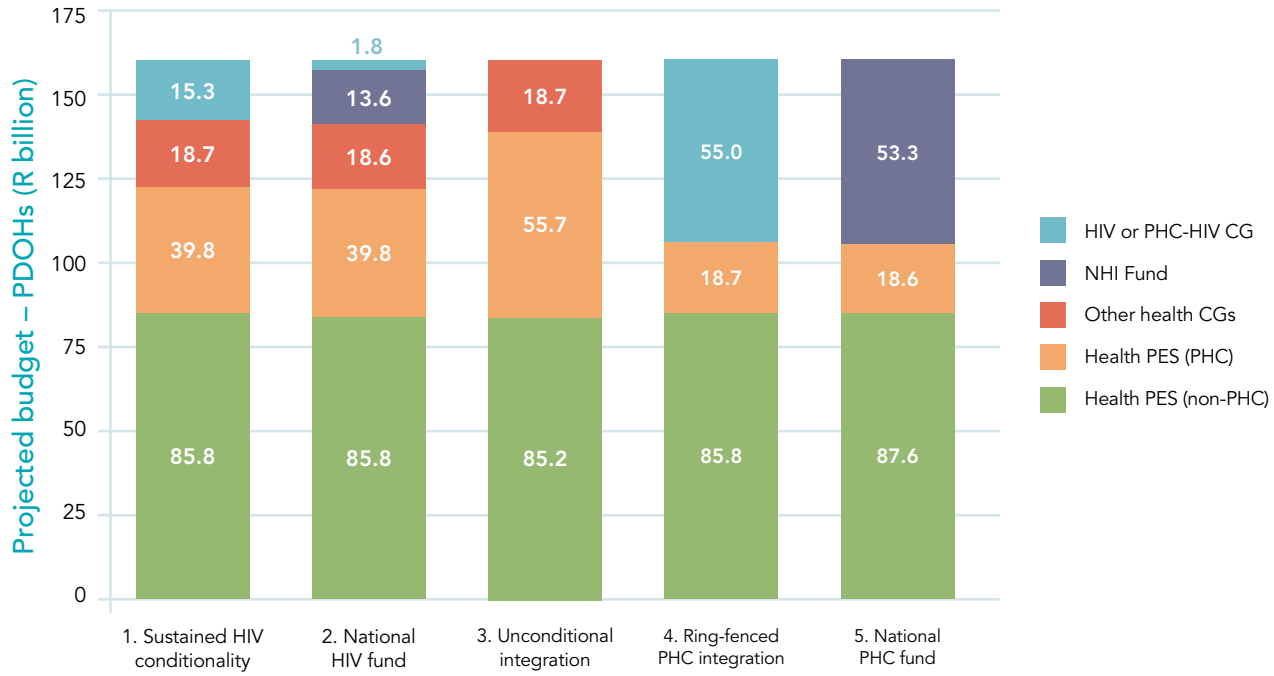
Section 4: Discussion

Drawing on our analysis in Section 3, we now compare the scenarios along their several descriptive and evaluative dimensions. These include the allocation of funds across financing pools and the distribution of responsibilities for governing HIV funds across spheres of government and actors therein. They also include the scenarios' potential impact on health system performance and feasibility.

Allocation of funds across financing pools

The scenarios would imply different allocations of health funds to various pools. Figure 4.1 consolidates the data from Section 3 to illustrate how HIV and other health financing pools would be structured and resourced based on budget forecasts for FY 2016/17.[12]

Figure 4.1. Illustrative allocations for Scenarios 1–5 for FY 2016/17 (R billion)



Sources: National Treasury (2015b, 2016).
Abbreviations: CGs = conditional grants, PES = provincial equitable share, PDOHs = Provincial Departments of Health, PHC = primary health care.

[12] These figures are aggregate across all nine provinces but may not include all DOH funds retained at the national level.

Side-by-side examination of the pooling configurations reveals several important observations. First, in all cases the majority of revenue for health spending will not be implicated by the financing mechanisms proposed in the five scenarios. We retained all non-PHC funds in the PES, but the government could also explore changes to the management of hospital funds, for instance. Second, two pairings of similar scenarios are evident: 1-2 and 4-5. Within each pairing the size of the HIV- or PHC-dedicated pool of funds would be nearly the same, while only the financing mechanism would differ between a conditional grant and a nascent NHI Fund. With respect to Scenarios 4 and 5, this reinforces the notion that the former could be a natural precursor to the latter. Third, the figure shows how only Scenario 3 would eliminate all ring-fencing around HIV funds, underpinning the concerns about unconditional integration expressed by health officials at both the national and provincial levels.

Governance of HIV funds

Next, Table 4.1 summarizes the key governance features of each scenario.

In Scenarios 1, 2, 4, and 5, the national government would retain a high level of control over how HIV funds were spent (column 2 of Table 4.1). NDOH would play a prominent role in each, while the Fund-oriented scenarios (2 and 5) would naturally also imply a major role for the new NHIF. Under these two scenarios, important questions would arise about the division of oversight responsibilities between NDOH and the NHIF, including which entity would be empowered to suspend payments to providers or districts that failed to meet performance standards. Additionally, Scenarios 2 and 5 would entail greater responsibility for districts than under the current system. This aligns with the NHI White Paper (2015), which proposes a prominent (albeit undefined) role for DHMOs in overseeing facilities on the provider side of the purchaser-provider split.

Scenario 3 would be quite distinct, placing near-total control over HIV funds with the provinces, much like with the majority of other health financing through the PES. Unconditional integration would liberate provinces from the CG's stringent planning and reporting requirements. NDOH's attempts to promote accountability outside the CG mechanism, such as more closely monitoring spending on the so-called 'non-negotiables,' are not yet viewed as adequate protections for priority programmes. However, there may be opportunities for enhancing such normative measures in the future.

Responsibility for HIV target-setting (column 3) would correspond to the spheres of government with greater control over the use of funds. A high level of control over funds use would correspond to a leading role in target-setting, while a medium level of control over funds use would typically imply a consultative role in target-setting.

The national sphere would not have a leading role in HIV budget planning under any scenario (column 4). As is the case in the current system, PDOHs and Provincial Treasuries would be principally responsible for developing HIV budgets under Scenarios 1, 3, and 4, subject to NDOH's adjustments and approval. Meanwhile, under Scenarios 2 and 5, districts would be responsible for HIV budget planning to reflect the contracting arrangements between local providers and the NHIF. Depending on

Table 4.1. Proposed distribution of governance responsibilities for HIV funds, Scenarios 1–5.

Scenario	Level of control over how HIV funds are spent	Responsibility for HIV target-setting	Locus of HIV budget planning
1. Sustained HIV conditionality	National – High (NDOH) Provincial – Medium District – Low	NDOH (+ PDOHs)	PDOHs + PTs
2. National HIV Fund	National – High (NDOH + NHIF) Provincial – Low District – Medium	NDOH (+ NHIF + DHMOs + PDOHs)	DHMOs (+ providers)
3. Unconditional integration	National – Low Provincial – High (PDOHs + PTs) District – Low	PDOHs (+ NDOH)	PDOHs + PTs
4. Ring-fenced PHC integration	National – High (NDOH) Provincial – Medium District – Low	NDOH (+ PDOHs)	PDOHs + PTs
5. National PHC Fund	National – High (NDOH + NHIF) Provincial – Low District – Medium	NDOH (+ NHIF + DHMOs)	DHMOs (+ providers)

Source: Authors' assessment.
Notes: In the second column, entities listed in parentheses would bear principal oversight responsibility and authority for HIV funds. In the third and fourth columns, the first entities listed would play the leading role in budget planning and target setting, while those in parentheses would have a consultative role.
Abbreviations: DHMOs = District Health Management Offices, NDOH = National Department of Health, NHIF = National Health Insurance Fund, PDOHs = Provincial Departments of Health, PTs = Provincial Treasuries.

the details of the purchaser-provider split and the role of DHMOs, providers may eventually need to undertake their own internal budgeting process as well.

Overall, only Scenario 3 would imply radical changes to the governance of HIV funds by reducing the national sphere in most critical functions. The other four scenarios would retain or even enhance the national sphere's prominent role in controlling how HIV funds were used and targets were set, though budget planning would remain driven at more local levels in all five scenarios. The more dramatic changes would relate to governance of funds for other PHC services. Scenarios 4 and 5 would entail significantly increasing the national sphere's level of control and purchasing power for PHC.

Impact on health system performance

We find considerable variation in the potential impact of the five scenarios on the HIV response, PHC services, and health system efficiency. Table 4.2 provides a concise scorecard reflecting our analysis.

This portion of the evaluative analysis sheds light on some of the key trade-offs and risks of the scenarios. First, if 'do no harm' is a guiding principle of any HIV financing reform, Scenario 3 (removing the HIV CG) clearly stands out for the widespread view that it could be detrimental to the HIV programme. Informants consistently cautioned that eliminating ring-fencing around HIV funds would lead to insufficient spending and minimal accountability for service delivery. Most of our informants represented HIV-related interests, but the state of other government health services may corroborate their views. For example, PHC services in public facilities are generally thought to be of poor quality relative both to publicly provided HIV services and privately delivered PHC. Scenario 3 also serves as an important point of caution for health reformers in other countries: financing integration is not inherently beneficial, and in fact it could be detrimental if poorly designed. Scenarios 2 and 5 also merit caution on this front. Equitable enrolment and cost-sharing policies will be crucial to ensuring any NHI-like system does not undermine access to HIV services. Additionally, financing for and effective management of non-personal HIV services will need to be assured.

Second, there is minimal basis for expecting pooling reforms alone to yield major gains to the HIV response. This is partly a reflection of the current programme's strength: the conditional grant mechanism has enabled fairly rapid, evidence-based scale-up of the government's HIV response with exceptional spending rates and service target achievement.[13] Given these virtues, the means by which financing reform might further enhance the HIV response relate principally to purchasing rather than pooling. As discussed at the outset of Section 3, potential purchasing reforms could be pursued independently of changes to pooling mechanisms, though the latter certainly helps to define the range of possibilities for the former. For instance, transitioning to a Fund (as in Scenarios 2 and 5) implies eventually adopting a more strategic approach to purchasing services—a defining feature of a purchaser-provider split—but the particulars of payment mechanisms would ultimately determine the extent to which purchasing policy effectively incentivized the efficient delivery of high-quality services. Concurrently, equitable implementation of any financing scheme would require careful management of enrolment policies so as not to disadvantage hard-to-reach populations that require HIV and other health services.

Third, primary health care could be the area of greatest gain from pooling reforms if PHC service delivery were imbued with some of the mechanisms for business planning, tracking, and evaluation currently in place for the HIV response. Benefits may not be immediate because the tools for PHC costing, resource needs estimation, and business planning are not yet as sophisticated as those in use for HIV. However, Scenarios 4 and 5 would both create more urgent demand for such capacity and catalyse research and other investments to improve South Africa's understanding of PHC financial needs and management.

Table 4.2. Summary scorecard of likely impact on health system performance, Scenarios 1–5.

Scenario	HIV response	PHC services	Health system efficiency
1. Sustained HIV conditionality	*Reference scenario*		
2. National HIV Fund	? / -	Ø	? / -
3. Unconditional integration	- - -	? / +	Ø / -
4. Ring-fenced PHC integration	Ø	++	? / +
5. National PHC Fund	? / -	+	?

Source: Authors' assessment.
Key: + = favourable, Ø = minimal, - = unfavourable, ? = uncertain. Dual ratings (e.g., ? / -) indicate a primary estimate and possible but less certain alternative.

[13] External financing, particularly from PEPFAR and the Global Fund, has also been important to these achievements. How to phase out this funding is a major question for the future of the HIV programme and should be considered alongside any integration proposals. For example, eliminating ring-fencing of the HIV budget could hinder government efforts to absorb donor programs targeting key populations. Additionally, shifting toward strategic purchasing could include specific plans for contracting with PEPFAR's implementing partners.

These investments would bear fruit for the NHI system more generally because they are necessary precursors to decisions about PHC pricing and performance evaluation that should underpin the purchasing policies of any future NHIF. In fact, our analysis suggests that Scenarios 4 and 5 (and their variants)—if carefully implemented—would be the most likely to include strides toward the system envisaged by the NHI White Paper (2015) without unduly jeopardizing the HIV response.

Fourth, we are unable to shed much light on the likely impact of the proposed financing changes on health system efficiency. Prioritization processes, health technology assessment, and other means of improving allocative efficiency are exogenous to the types of pooling reforms embedded in the five scenarios. These are often tied closely to the institutional design of national health systems, and indeed they fall within the remit of one of the government's NHI work streams. Meanwhile, improvements to technical efficiency are most likely to be driven by strategic purchasing, the details of which will be difficult to design until the government makes key decisions about a path forward for financing integration and, ideally, experiments with multiple approaches to contracting for services. Better management at all levels of the health system may also enhance performance. An additional source of uncertainty is whether private providers, if contracted, would deliver services more efficiently than the public sector. Several informants, including a senior NDOH official and others with extensive knowledge of South Africa's private health care sector, predicted that private providers could be very cost competitive if they could access national tender prices for key commodities, like antiretroviral drugs. In turn, another senior NDOH official confirmed that, in terms of laws or regulation, nothing precludes extending the economies of scale from national procurement processes to private providers. Indeed, the NHI White Paper (2015) proposes extending these benefits to all accredited providers, public and private.

Commodity prices aside, incentivizing efficiency in the private sector will require careful design of payment policies, monitoring of service quality, and measures to discourage cost escalation. Some provinces are already contracting with private providers to deliver an integrated package of PHC services (including HIV), such as Mpumalanga's service level agreement with two Right to Care–managed facilities. These experiences should be evaluated to better understand the prospect for scaling private sector delivery of publicly financed services.

This analysis is indicative and should not be the sole basis for decision making. It highlights the major opportunities and risks posed by each scenario, but it by no means predicts outcomes with a high degree of certainty. Moreover, as we note repeatedly above, many of the scenarios' consequences will depend on additional policy choices and the effectiveness of their implementation. Nonetheless, even our qualitative and interview-driven methods help to highlight some scenarios policymakers may more easily eliminate from consideration than others. For example, if Scenario 3 indeed fails the 'do no harm' test, it may not be worthy of further consideration.

Feasibility

We also find important differences among the scenarios regarding feasibility. Table 4.3 overviews our ratings of each scenario's legal, political, and technical feasibility, which we define in Section 3.

As with the impact criteria, a number of observations emerge from this scorecard. Only Scenario 1—maintenance of the status quo—would be highly feasible in legal, political, and technical terms. By definition the systems are already in place to sustain HIV conditionality, as are the requisite laws and other legal instruments for administration of the conditional grant mechanism. Political feasibility is slightly lower because some NT officials may be growing wary of indefinite growth in an HIV-dedicated conditional grant, and some in NDOH may be eager to move forward quickly with NHI implementation. However, NT will face stiff opposition from NDOH, provincial HIV managers, and HIV advocates to any financing reforms that do not preserve (and indeed expand) the country's robust, scaled, and high-quality HIV response. For this reason, despite its technical and legal ease, Scenario 3 is likely a non-starter politically. NDOH's leadership, including the Minister, are firmly committed both to the HIV programme and to implementation of NHI. Consequently, they would be very unlikely to embrace unconditional integration,

Table 4.3. Summary scorecard of feasibility, Scenarios 1–5.

Scenario	Legal feasibility	Political feasibility	Technical feasibility
1. Sustained HIV conditionality	High	High	High
2. National HIV Fund	Low to medium	Low to medium	Low to medium
3. Unconditional integration	High	Low	High
4. Ring-fenced PHC integration	Medium to high	Medium to high	Medium
5. National PHC Fund	Low to medium	Medium	Low

Source: Authors' assessment.

which would neither ring-fence HIV funds nor obviously advance NHI rollout.

Scenarios 2, 4, and 5 would present more moderate challenges. They would all pose daunting technical problems, including creating the institutional architecture for a national purchasing agency and defining a benefits package (Scenario 2), integrating PHC financing and generating valid resource needs estimates (Scenario 4), or both (Scenario 5). Recognizing these would be no small tasks, NDOH and NT have already begun to invest in relevant analysis. For example, their jointly convened PHC Costing Task Team seeks to improve understanding of PHC costs and how they differ between the public and private sectors. Concurrently, one of the NHI work streams focuses on the institutional arrangements and establishment of the NHI Fund, and another is dedicated to preparing for the purchaser-provider split.

Additionally, all three of these scenarios (2, 4, and 5) would require considerable legal effort. The Fund-based scenarios (2 and 5) would require authorizing legislation for the creation of the Fund and the development of processes to define benefits and contract for services from both public and private providers. Similarly, all three would require nationalizing control over funds that have historically been allocated via the PES. By removing some health funds entirely from provincial management, Scenarios 2 and especially 5 could provoke litigation challenging their constitutionality.

Finally, Scenarios 2, 4, and 5 would all be likely to generate both support and opposition across the national departments, at the provincial level, and among HIV advocates. For instance, HIV advocates might resist the Fund scenarios (2 and 5) unless key concerns about enrolment, cost-sharing, and service coverage were addressed. Meanwhile, provinces might oppose the integrative scenarios (4 and 5) if they stood to lose control over a large portion of their health budgets and were increasingly sidelined with respect to health service delivery. The fate of the health sector wage bill looms large. Some informants felt that provinces would more willingly accept integration if, along the way, the national sphere assumed responsibility for paying health workers.

Given that all three of these scenarios would be plausible steps toward the government's proposed NHI system, galvanizing public and institutional support for systemic reform could be key to overcoming opposition. On the other hand, mismanagement of any interim steps could undercut enthusiasm for more ambitious NHI policies. Once the government selects its preferred course, much more detailed appraisal of a policy's technical and legal requirements, as well as a thorough political analysis, will be necessary.

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Section 5: How to move forward

This study aspires to help South African policymakers (i) to better understand the range of possibilities for HIV (and PHC) financing adjustments and integration in the next three to five years, and (ii) to identify one or more promising options for further study and implementation, on the basis of comparative analysis. The five scenarios described and evaluated in Sections 3 and 4 are indicative of the government's choice set. They provide a useful foundation for debate and decision making within government and beyond with regards to the near-term future of HIV financing and how its integration fits into broader NHI implementation.

In particular, our analysis lays a foundation for several possible next steps in policy design and analysis. First, the time is ripe for the government—namely, NDOH and NT—to choose a scenario for more detailed analysis and possible piloting or implementation. The selected option could be one of the five featured in this study, a hybrid or variant of several, or an entirely different approach from those we have examined.

Selecting any new HIV financing arrangement will generate a substantial list of analytical needs for designing and implementing the new pooling and purchasing arrangements. For example, if PHC services were to be incrementally integrated into the conditional grant framework and purchased strategically—per the second option in Scenario 4—numerous questions would require attention, including:

- How much does the government currently spend to deliver various PHC services? How much should those services cost?
- What criteria or principles should guide selection and sequencing of services to be integrated?
- What performance indicators should be monitored for PHC?
- What information systems are in place, or would need to be strengthened or developed, to ensure the collection of appropriate performance indicators?
- Should the government more extensively contract with private providers to deliver PHC services, and how?

Additionally, if near-term experimentation with strategic purchasing arrangements appeals to the government, additional questions will arise, including:

- What steps are required to prepare for a purchaser-provider split?
- What information systems and human capacity are needed to negotiate and monitor contracts between the purchaser and providers?
- What are the best payment mechanisms for integrated PHC service delivery? How soon can capitation be sufficiently risk adjusted to account for variable HIV burden? What payment mechanism should be used for HIV services in the meantime?
- What are appropriate prices for PHC services? How can fair pricing be ensured between public and private providers?

Though these questions are motivated by a specific policy option, they are also germane to any future NHI scheme. It is no surprise, then, that the government and others are already working to answer many of them, including through the NHI Work Streams and the PHC Costing Task Team.

Additionally, more detailed political analysis will benefit the design and implementation of any new HIV financing policies. Building on the consultations conducted for this study, more can be done to understand the interests of various provincial officials, HIV and other advocacy organizations, labour organizations including those representing health care workers, and private providers. Related to political economy are the complex dynamics of intergovernmental relations. Financing integration could dramatically alter the distribution of responsibilities and purchasing power among the spheres of government, as would adoption of the NHI White Paper (2015)'s proposals. How to capacitate and empower districts to play their envisaged role, and how quickly, remain critical NHI implementation challenges, as does the future role of provinces in health financing and service delivery. These matters will interplay with the Presidency's ongoing examination of fiscal federalism, whose outcomes will shape the course of government financing for health and other sectors.

Critically, ongoing efforts to understand and effect HIV financing integration need not preclude, nor should they ignore, other important health financing considerations. As noted in Section 1, this study focuses on public financing because the government already accounts for three-quarters of HIV spending, and major donors have signalled their intention to scale down their programmes in the next five to 10 years. Careful management of the donor transition will be critical to the continued viability and scale-up of South Africa's HIV response. Important questions include:

- What programme areas are primarily funded by donors? How can the government ramp up spending and capacity in these areas?
- What share of donor spending will the government need to absorb, and how quickly?
- What populations do donor programmes serve that could fall through the cracks during the transition? How can the government ensure continuity of services to them?
- How can the delivery capacity of donors' implementing partners be best leveraged as financing shifts ever more to the public sector?

Moreover, as discussed at the end of Section 2, the fate of TB financing must be included in discussions about restructuring HIV financing. The government is only now beginning to integrate substantial TB activities into the HIV CG, and careful planning is required to ensure that HIV financing reforms reinforce the incipient will and capacity for TB business planning and expenditure tracking that will complement and strengthen performance monitoring for TB services. Policymakers would do well to explore the critical success factors for strengthening the national TB response, including:

- To what extent does HIV-TB integration in service delivery require integration in financing?
- What opportunities and risks will arise if HIV financing is simultaneously integrated with both TB and other PHC services, and for whom?
- What efficiency gains could the government seek through financing reforms in terms of targeting key populations, engaging private providers, and improving access to HIV and TB services?
- What surveillance and monitoring systems need to be strengthened or developed to enable the careful tracking of the impact of TB spending through the CG?
- What capacity needs to be developed within PDOHs' TB units to adequately plan, cost, and budget for their TB funds?
- How can the national government ensure new allocations for TB, via the CG, increase overall TB spending rather than prompt provinces to reduce their own contributions to TB services from PES funds?

The financing of other types and levels of care is also important to NHI design and implementation. Today PHC (including HIV) accounts for less than half of government health spending. Consequently, there may be substantial opportunities for financing policy, particularly with respect to purchasing, to increase the system's efficiency, both allocative (by prioritizing preventive and cost-effective interventions) and technical (by incentivizing and enabling facility-level operational improvements). The Ideal Clinic Programme and the ongoing process to introduce DRG payments to the 10 national hospitals are both important components of these broader reform efforts.

Taken together, this multitude of current and anticipated activities indicates how promising and formative a time this is for South Africa's health system. As its most visible—and arguably most successful—health programme, the government's HIV response will factor critically into any major reforms. In fact, many of the scenarios we present here would position HIV as the 'tip of the spear' of NHI design and implementation. By charting a course that is both feasible and broadly consistent with its vision for NHI, the government can take meaningful strides toward its conjoined goals of ending the world's largest HIV epidemic and building a vibrant, sustainable, and responsive health system for all South Africans.

Appendix 1: Participants in consultations

Name	Position and organization
Yogan Pillay	Deputy Director General for HIV/AIDS, TB, and MCH National Department of Health
Anban Pillay	Deputy Director General for Regulation and Compliance National Department of Health
Jeanette Hunter	Deputy Director General for PHC National Department of Health
Ian Van der Merwe	Chief Financial Officer National Department of Health
Nthabiseng Khoza	Director, HIV Conditional Grant National Department of Health
Aquina Thulare	Director, NHI National Department of Health
Moremi Nkosi	Director, Insurance National Department of Health
Shaidah Asmall	Senior Technical Advisor for Health System Strengthening National Department of Health
Peter Barron	Senior Advisor National Department of Health
Mark Blecher	Chief Director, Health and Social Development National Treasury
Edgar Sishi	Chief Director, Intergovernmental Relations National Treasury
Aparna Kollipara	Director, Health National Treasury
Dubemi Obugu	Director, Intergovernmental Relations National Treasury
Ogali Gaarekwe	Director, Intergovernmental Relations National Treasury
Jonatan Daven	Senior Budget Analyst, Health and Social Development National Treasury
Fareed Abdullah	Chief Executive Officer South African National AIDS Council
Nevilene Slingers	Executive Manager South African National AIDS Council
Adri Mansvelder	Finance Manager KwaZulu-Natal Department of Health
Juanita Arendse	HAST Director Western Cape Department of Health

Appendix 2: Scenarios – detailed narratives

Scenario 1: Sustained HIV conditionality – sticking with what works

Financing mechanism

Scenario 1 would maintain the status quo. The current financing mechanisms for HIV within DOH would be retained, and the bulk of government spending on HIV would be channelled through the HIV CG. The annual Division of Revenue Act (DORA) would continue to indicate the conditions for the grant, stipulating each subprogramme's allocation and targets. NDOH, in consultation with each PDOH, would continue to determine annual allocations to provinces and targets for each HIV subprogramme, and the provinces would continue to report on these quarterly.

Rationale

The HIV CG has symbolized the government's commitment to the HIV response and to the roll out of ART over the years. Despite considerable progress, HIV remains a unique public health threat to South Africa, and the population has come to expect the government not only to provide treatment to all people living with the virus, but also to undertake ambitious prevention activities. Consequently, HIV deserves independent focus and management, even if at the cost of some inefficiency in the health system.

The CG mechanism has enabled unprecedented annual funding increases—HIV accounts for 11 percent of the total health budget—to pay for essential curative and preventive HIV services (Ndlovu & Meyer-Rath, 2014). In light of the ongoing NHI policy discourse, significant changes to HIV financing may be premature. Until NHI plans are finalized, and critical decisions are made about how HIV services will be provided under the new scheme, it may not be desirable to alter a well-functioning system.

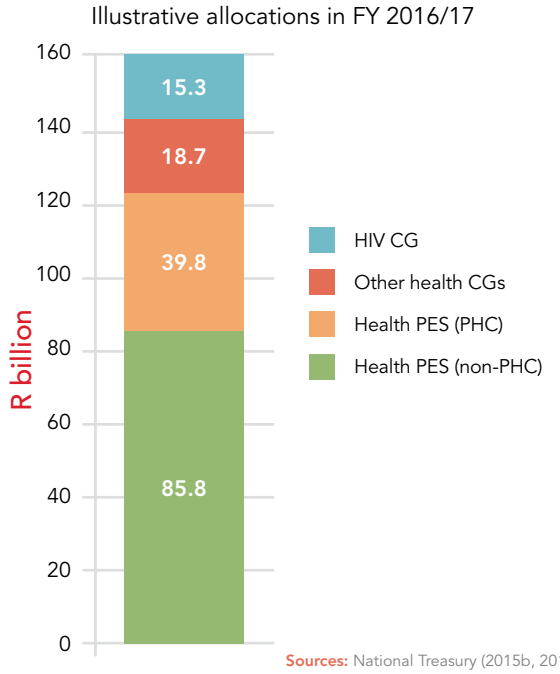
In the meantime, sustaining conditionality would leverage the HIV programme's business planning and monitoring strengths to ensure that HIV funds were used for their intended purpose and performance targets were achieved. The CG mechanism would continue to ring-fence allocations for HIV and thereby protect the HIV response from provincial discretion to allocate resources across sectors and health programmes. The national sphere would retain the ability to ensure that performance targets were achieved, while provinces would continue to oversee delivery of HIV services.

Detailed description

Pools of funds

Figure A2.1 depicts the expected pools of provincial health sector funds in FY 2016/17 under sustained HIV conditionality. Nearly 80 percent (R125.6 billion) of provincial health spending would flow from PES funds, almost a third of which would be spent on PHC. Meanwhile, the HIV CG would amount to roughly 10 percent (R15.3 billion) of provincial health spending. Other conditional grants, including those for tertiary services, training, infrastructure improvement, and the National Health Insurance conditional grant[14], would amount to around R18.7 billion.

Figure A2.1. Illustrative allocation of funds in FY 2016/17 for Scenario 1 (R billion).



Sources: National Treasury (2015b, 2016).

Governance of HIV funds

NDOH would exercise a high level of control over the use of HIV funds. The CG mechanism would continue to specify priority spending areas and measurable outputs for which provinces would be accountable. NDOH would lead the development of service delivery targets in consultation with provinces. The CG mechanism would also continue to enable resource allocation across provinces on the basis of HIV-related needs rather than the PES allocation formula, which currently does not account for high-burden diseases. The current strong systems of national oversight and

[14] The NHI conditional grant, which is a direct grant to provinces, is distinct from the National Health Insurance Indirect Grant, which before FY 2016/17 was known simply as the National Health Grant. The latter is not implicated in any of the scenarios.

accountability required by the CG mechanism would be retained. If provinces did not comply with the conditions or failed to achieve their HIV spending and output targets, NDOH would be able to intervene and even sanction them by withholding CG funds.

Provinces would continue to have moderate control over the use of HIV funds. Provincial DOHs and Treasuries would develop HIV business and budget plans, oversee service delivery, and manage tracking of expenditure and outputs. Meanwhile, districts and facilities would have minimal control over the use of funds, accepting budgets and targets from above. Facilities would, however, continue to make choices about the extent of service delivery integration, often on the basis of guidance from national, provincial, and district officials.

Purchasing of HIV services

Generally, providers would continue to be paid for HIV services according to input-based budgets, and in turn they would use HIV CG funds for their expressed purpose. However, in some provinces CG funds are already used more flexibly at the facility level, particularly with respect to resources shared between HIV and other services—most notably, facility space and health care workers. Such flexibility could be more explicitly permitted, or even encouraged, so as to lessen some of the inefficiency and disadvantages being experienced in PHC service delivery. The national or provincial health departments (or both) could also begin exploring more strategic approaches to purchasing HIV services, including introducing performance-based financing. Facility managers would require decision-making autonomy to respond to new financing policies, including the ability to translate facility-level incentives into a viable performance management system for their own personnel. High-performing Ideal Clinics in NHI pilot districts would be natural settings for introducing new purchasing arrangements. Likewise, health departments might already consider more extensive contracting with private providers to deliver HIV and other services.

Implementation and pathway to NHI

Sustained HIV conditionality would extend the incumbent HIV financing system for the next three to five years. On its own, it would be a step neither toward nor away from an NHI system, whether that envisaged by the White Paper (2015) or another. Scenario 1 could precede any of the other scenarios, including those involving further centralization of HIV and PHC funds (Scenarios 2, 4, and 5) and the one entailing fuller devolution of control to provinces (Scenario 3). In the interim, the existing CG mechanism could allow for the strengthening of systems for contract management and performance monitoring, building capacity among districts and providers that will be required for NHI implementation. NHI pilot districts may be the appropriate starting point for such capacity building, which could be incorporated into the next phase of the Ideal Clinic Programme.

Impact on health system performance

Scenario 1 serves as the reference or baseline scenario for evaluating all other scenarios' effects on the HIV programme, PHC services, and efficiency. We offer analysis of all three here but omit any ratings.

Effect on the HIV response

As indicated above, the HIV CG would ensure adequate funds are committed and spent accordingly on HIV, and therefore would protect the performance of the HIV programme and achievement of national targets. South Africa is internationally acclaimed for its successes with regards to its response to HIV. This would continue under Scenario 1, and plans are already in motion for these benefits to be expanded to the TB programme starting in FY 2016/17. Moreover, the new HIV and TB Investment Case (Department of Health, South Africa & South African National AIDS Council, 2016) is already guiding the budget proposal and business planning processes for the conditional grant, helping to justify additional resource allocations in pursuit of ambitious national coverage targets.

Effect on PHC services

Sustaining HIV conditionality would not likely affect PHC services directly. The benefits (and costs) of the CG framework would not be expanded to PHC, nor is there anything inherent to the financing structure that would promote further integration of service delivery. Consequently, the government might consider complementary measures to encourage more flexible use of CG funds at the provincial and provider levels. That said, lack of effective integration with HIV services is but one small portion of the challenges faced in PHC. Officials cited numerous obstacles to improved PHC services, including stagnant PHC budgets—the bulk of resource growth for District Health Services has been for salaries—poor accountability, minimal management capacity, and inadequate data and models to guide budget planning. As one senior official stated, "you cannot blame the CG for the poor delivery of PHC services." Likewise, it might be unlikely that merely reconfiguring the HIV CG would solve PHC's problems.

Effect on health system efficiency

The conditional grant mechanism for funding HIV services has been efficient in terms of absorption of funds and targeting. The rigorous business planning and performance monitoring systems in place have helped to achieve an extremely high spending rate—upwards of 99 percent in recent years—alongside achievement of service delivery targets. Although the administrative burden of sustaining such a grant is additional to that required for PES funds management, there is a strong consensus among policymakers and other stakeholders that the benefits accrued in terms of service quality and accountability are worth the extra investment. There may be some duplicative spending resulting from having parallel planning and monitoring processes for the HIV programme and general health services, but the former is widely recognized as being of superior quality and a potentially useful template for the entire health system. To date these stronger financial management and monitoring systems have minimally benefitted financial management or service delivery for PHC more generally. However, more integrated planning is underway across South

Africa with the development of District Implementation Plans for addressing performance deficiencies in HIV, TB, and maternal and child health. Widespread execution of these plans will commence throughout 2016, and early signs are promising for improving performance and efficiency, including optimizing resource allocations by the government and development partners (Muzah et al., 2015).

At the provider level, there is at least anecdotal evidence that the rigidity of the CG framework has prevented fuller integration of HIV and PHC service delivery. For instance, in some settings facility space, workers, and supplies paid for with HIV funds are kept separate from other services, resulting in patient and worker dissatisfaction and suboptimal use of clinical resources. In these circumstances PHC services suffer due to insufficient resources relative to HIV. In fact, the need to tag CG spending as HIV related may even lead to overspending on excess equipment and travel to HIV conferences instead of on much needed PHC supplies. Unfortunately, the extent of this problem—a lack of what one senior NDOH official described as "common-sense integration"—remains poorly documented or quantified. NDOH could investigate further and, if warranted, devise a process by which districts would propose reallocations of surplus HIV funds if their service and outcomes targets are met.

At the same time, some provinces (e.g., KZN and WC) have achieved integrated service delivery despite the vertical funding mechanism for HIV, indicating that verticality alone does not preclude service delivery integration. Provincial officials noted varying degrees of integration of HIV and PHC service delivery, with some reporting that they were fully integrated and that they used the CG strategically to cover HIV costs as well as PHC costs to ensure the optimal quality of service delivery. Even where CG funds are managed flexibly, however, informants felt conditionality is essential to ensuring the continued scale and quality of HIV services.

Nonetheless, officials at the national and provincial levels acknowledged some non-compliant use of HIV funds despite the CG monitoring framework. One senior NDOH official estimated that 10–15 percent of CG funds are spent on non-HIV activities. Noncompliant spending generally arises for one of two reasons. First, provinces may divert CG funds to address cash-flow problems elsewhere in the health sector, such as paying vendors for non-HIV medicines and supplies. In theory there should be a subsequent transfer of funds back to the HIV programme, documented through a re-journalization process, though often this does not occur in a timely fashion (or at all). Awareness of these practices affirms that the CG mechanism is working as intended and that there are other important financial management challenges in need of remedy. In fact, NT, NDOH, and the provinces are already working on addressing cash-flow challenges, including the potential introduction of prospective payments for laboratory services.

Second, HIV funds are often used to pay for resources shared across multiple programmes, such as health care workers. For example, for accounting ease clinicians' salaries in PHC facilities are typically either allocated entirely to the HIV programme or not at all, even though nurses routinely care for HIV and non-HIV patients alike. In fact, the same NDOH official felt that the HIV programme is a net beneficiary of such shared resources; we found no additional evidence to support or contradict this claim. Either way, this form of cross-programme financing further evinces the possibility of integrated service delivery despite non-integrated pooling mechanisms.

Feasibility

Legal feasibility

Sustaining HIV conditionality would not require any policy reforms beyond those already planned for the incorporation of TB into the CG. The grant mechanism is well established in South African law, and it remains fully compatible with the distribution of governmental responsibilities envisaged by the National Health Act (2004) and the Constitution. Therefore, the legal feasibility of this scenario is high.

Political feasibility

With respect to political economy, there are many stakeholders who support any scenario that protects the gains made in the HIV programme to date. Under Scenario 1, the HIV programme and its funding would be protected from competing provincial health priorities and crises, unfunded mandates, political agendas, misuse, and more. For this reason, most HIV officials within NDOH and the PDOHs (specifically the HAST Directors), as well as SANAC, prefer sustained HIV conditionality, at least until such time that the implications of NHI policy for the HIV response are clearer. Several NT officials echoed this view, and recognition of the CG mechanism's value is implicit in NT's embrace of an integrated HIV-TB CG starting in FY 2016/17.

In contrast, NDOH officials responsible for PHC would prefer more integrated funding for PHC in hopes that it would drive quality improvements characteristic of the HIV programme. They, together with some NT officials, see the integration of the HIV-TB CG into one PHC funding mechanism as a means to reduce inefficiency, both by eliminating parallel management structures and by promoting integrated service delivery, where appropriate. In fact, to some NT officials the CG's rapid growth is concerning—the HIV CG is now the second largest government grant and accounts for an increasing share of the total health budget—so options to transition away from vertical funding channels may be desirable. Meanwhile, PHC managers at NDOH want to apply the same protections to PHC funding as exist for HIV, rather than dismantling the HIV CG. To them this would be the best option for improving PHC services and accountability. Additionally, maintaining the status quo may forestall progress toward implementing NHI, so some NDOH (and other) officials may prefer incremental changes in the next few years.

Despite these diverse views on the advantages and drawbacks of the current system, there is little evidence that the government would struggle to secure sufficient

support should it opt to sustain HIV conditionality for the next several years, particularly if longer-term planning for NHI proceeds apace. Therefore, the **political feasibility of this scenario is high.**

Technical feasibility

Capacity for management of the CG has developed over many years and is relatively well performing at the provincial and national levels. The provincial HIV programme and finance managers have skills in planning, budgeting, monitoring of CG spending, reporting, and linking outputs to outcomes. However, districts still need greater capacity for these functions. Efforts are already underway to improve districts' engagement in the planning and budgeting for the CG. These skills also need to be extended at all levels to TB planning and budgeting as an integrated HIV-TB CG takes shape in FY 2016/17. To the extent that the government wants to introduce contract-based purchasing of HIV (and TB) services using CG funds, additional capacity would be required for contract negotiation and management.

With respect to performance management, provinces already collect and report on HIV programme indicators. The monitoring system took some years to develop, and the programme has achieved good absorption and achievement of national targets. Indicators for the TB programme will similarly need to be determined and collected. As the CG amount continues to increase, there may be need to strengthen the accountability for performance and impact of the CG spending, especially increasing the capacity of NDOH to monitor outcomes, and to ensure provincial compliance and achievement of targets.

Finally, service delivery capacity may need to increase in line with demand for HIV services, particularly ART. For instance, there is growing interest in alternative modalities for dispensing medications so as to alleviate the burden on providers. These considerations are not unique to Scenario 1, however, and in the meantime sustaining the CG mechanism would ensure that facilities have adequate resources for continued scale-up of the HIV programme.

To summarize, though the CG system still requires deepening some capacity for planning and monitoring, compared to other scenarios these needs are minimal and can be met with relative ease.[15] Therefore, **technical feasibility of this scenario is high.**

[15] The needs are more substantial and will require considerably more effort for the planned integration of TB into the existing CG. We consider this a separate consideration from whether Scenario 1 is technically feasible for the purposes of sustaining HIV conditionality alone.

Scenario 2: National HIV Fund—a focused start for the NHI Fund

Financing mechanism

Under Scenario 2, the NHI Fund would be established with a moderately sized pool of funds to purchase a package of HIV care and treatment services. The Fund would consolidate most of the HIV CG with the small NHI conditional grant and would pay for personal HIV services, including care, treatment, and biomedical preventive services like PMTCT and MMC. In line with instituting a purchaser-provider split, the Fund would eventually purchase these services through contracts negotiated with both public and private providers. Such transactions would require additional public financial management capacity at the district and facility levels. Public health and non-biomedical preventive services related to HIV, such as social behaviour change campaigns (SBCC), demand creation for MMC, and procurement and distribution of condoms, would continue to be funded via a small conditional grant to provinces. Both pools of HIV funds would be managed and deployed separately from funds for other health services; therefore, Scenario 2 would not further integrate HIV financing and in fact may reduce the extent of integration, particularly in purchasing.

In practice, in the Fund's first one to two years it would retain very similar purchasing practices as those that characterize the current HIV CG. These include linking budgets to output-based resource needs estimates and monitoring performance against both financial and service standards. Over time, the Fund would explore and scale-up more strategic purchasing arrangements with providers, which would also entail phasing out provinces' role as financing intermediaries between the national sphere and facilities. In some ways Scenario 2 would mirror the process of NHI rollout proposed in the White Paper (2015) but with a benefits package focused narrowly on personal HIV services.

Rationale

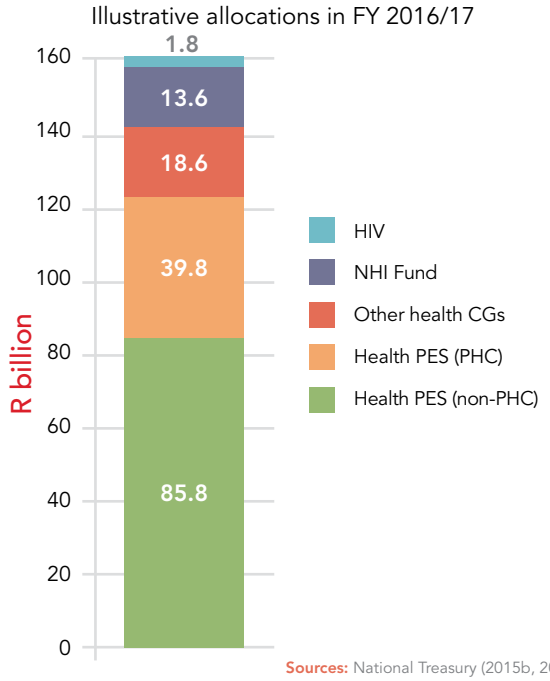
Like Scenario 1, Scenario 2 would help to protect financing for the HIV response, ensuring effective and measurable administration and delivery of government-financed HIV services. However, Scenario 2 would involve more explicit steps toward an NHI system and the creation of an NHI Fund that would eventually adopt strategic purchasing strategies to promote efficiency and quality in service delivery. Toward this end, establishing the Fund would catalyse development of capacity for output- or even outcome-based purchasing within the public sector for wider use down the line as part of NHI. In fact, HIV service delivery is the public system's best in terms of business planning and monitoring, making it the perfect programme to pioneer the purchasing and performance management systems that will be essential to NHI's success. Scenario 2 could be the best option for simultaneously protecting the HIV response and leveraging its programmatic strengths for the benefit of the health system more generally. In the future HIV services would also benefit from efficiency gains achieved through strategic purchasing. These will be essential to sustaining and expanding the HIV response, especially if new international treatment guidelines are to be implemented.[16]

Detailed description

Pools of funds

Figure A2.2 depicts the expected pools of provincial health sector funds in FY 2016/17 with the creation of a National HIV Fund. Under this scenario, existing NDOH financing for HIV care and treatment and biomedical prevention would be pooled within the Fund instead of being transferred to provincial health departments. This early version of the NHI Fund would assume responsibility for paying for these services. Nearly 90 percent of the current HIV CG would be transferred to the Fund, representing the personal preventive, care, and treatment services the grant currently covers. These funds would be combined with the current small NHI CG. The remaining HIV CG funds, which currently cover public health activities like condoms procurement and distribution, demand creation for medical male circumcision, and special programmes for key populations and high-transmission areas, would continue to be tightly ring-fenced and transferred to the

Figure A2.2. Illustrative allocation of funds in FY 2016/17 for Scenario 2 (R billion).



Sources: National Treasury (2015b, 2016).

[16] As of 2015, the World Health Organization recommends initiating on ART anyone who tests positive for HIV, regardless of CD4 count. Current clinical guidelines in South Africa specify treatment initiation at CD4 counts at or below 500 cells per microliter (National Department of Health, 2015b). However, the government may soon update these guidelines to align with the WHO's recommendations ("Nursing SA back to health," 2016).

provinces as a conditional grant. If applied to FY 2016/17, this policy would shift R13.6 billion to the Fund, while R1.8 billion would flow to provinces in the remaining CG. Other conditional grants (R18.6 billion) and PES allocations to health (R39.8 billion for PHC services and R85.8 billion for non-PHC activities) would remain unchanged.

Governance of HIV funds

Scenario 2 would entail significant changes to the distribution of financial and programmatic responsibilities across levels of government. Financial authority would primarily be elevated to the national level: not only would the NHIF—proposed to be a centrally managed organization in the White Paper (2015)—assume the HIV purchasing functions currently fulfilled by the provinces, but the government health system would eventually also include a purchaser-provider split for the first time. NDOH would set policy and quality standards by which providers would be accredited for NHIF payment eligibility, as well as establish HIV service delivery and coverage targets in consultation with the NHIF, provincial DOHs, and District Health Management Offices (DHMOs) to continue to scale up the HIV response. Provinces would continue to manage population-level prevention (i.e., public health) activities for HIV via dedicated national transfers as mentioned above. They could also assume a quality monitoring and evaluation role and oversee the building of adequate financial planning and management capacity in districts. In turn, districts would plan HIV budgets and manage the delivery of HIV care, treatment, and biomedical preventive services. Contracts between the NHIF and providers, both public and private, would be developed on the basis of adequate data collection systems to track service delivery outputs and outcomes and providers' financial performance.

The accreditation and payment systems implied by the creation of the NHIF would also enable mechanisms of oversight and accountability, albeit quite different from the current system. First, accreditation for NHIF payment eligibility would be a critical initial check on capacity and quality. Facilities would have to demonstrate readiness to deliver all services in the HIV benefits package in accordance with quality standards established by NDOH. For public providers, assessment of readiness could be incorporated into the next phase of the Ideal Clinic Programme. Second, the country's health management information system (HMIS) would be improved to enable continual monitoring of service delivery and patient outcomes. Districts excelling in meeting quality standards and coverage targets could be rewarded with additional performance-based payments on the basis of HMIS data, while poor performers could be targeted for support or ultimately sanctioned. This scenario would also open the door to demand-side checks on quality. For example, published performance data could inform patient choice of provider, at least in areas with multiple options.

Purchasing of services

At the moment, HIV financing in the public sector is budget based, although the conditional grant mechanism allows NDOH to influence behaviour at the provincial, district, and facility levels. Provinces must carefully track, monitor, and report financing and service delivery performance against goals agreed with NDOH. However, in addition to creating new public financial management competencies at the facility level, a National HIV Fund could implement more sophisticated and blended payment mechanisms to incentivize desirable provider behaviours. For example, while capitation may promote efficient delivery of care and treatment services, a separate fee-for-service payment may be useful to reward providers for large volumes of preventive activities like MMC. In general, creating a dedicated purchasing agency like the NHIF would promote a transition to more strategic purchasing for HIV services, though it may be difficult to purchase in an integrated fashion with other services, such as those central to primary health care. Such a transition would need to be carefully sequenced and implemented over time, with new resources pooled in the NHIF commensurate with additional services to be purchased.

Implementation and pathway to NHI

Under Scenario 2, policymakers would face a sequencing choice regarding the creation of the NHIF and the introduction of strategic purchasing for HIV services. For example, the government could prioritize establishing the institutional architecture for the Fund, which the NHI White Paper (2015) characterizes as an "autonomous public entity." Alternatively, NDOH's HIV directorate could incorporate strategic purchasing into the HIV CG, either by further centralizing control of funds[17] or by modifying the conditions imposed on PDOHs. This alternative could characterize a variant of Scenario 1 or serve as a preparatory step toward the HIV-focused NHIF imagined in Scenario 2.

Because our emphasis remains on changes to pooling arrangements for HIV financing, we focus on establishment of the Fund while examining, but not assuming adoption of, possible purchasing reforms.

Creating a functional NHIF capable of strategic purchasing will require several years of capacity building and preparation at all levels of the health system. Initially the Fund would likely maintain the current budget-based approach to purchasing HIV services. Steps could then be taken to design new payment mechanisms, such as costing a package of HIV services and negotiating prices with public and private providers. Concurrently, DHMOs and PHC facilities would have to prepare for new financial management responsibilities, including receiving payments and managing their own HIV budgets. This might mirror the proposed shadow budgeting process to prepare the country's 10 national hospitals for payments based on diagnosis-related groups (DRGs), though on a much larger scale.

In the long run, this scenario would be a step toward a comprehensive NHI system. A more general PHC benefits package could be incorporated into NHI coverage, after which steps could be taken to include secondary and

[17] For instance, NDOH could covert the HIV CG into an indirect grant and then distribute funds directly to providers on the basis of purchasing contracts.

tertiary services as well. This would require expanding the scope of the benefits package and consolidating additional funds in the NHIF, including the remaining conditional grants (such as the National Tertiary Services Grant) and eventually most or all of PES funds being spent on health.

Impact on health system performance

Effect on the HIV response

It is unclear what the effect of instituting a National HIV Fund would be on the public sector's HIV programme. Much would depend on the extent to which the system adopted certain proposals in the NHI White Paper (2015). In particular, policies for enrolment would need to be carefully implemented to protect and promote gains in the HIV response. For instance, even a simple enrolment process or a requirement to carry an NHI membership card could jeopardize access to services, particularly for key at-risk populations and marginalized groups. Out-of-pocket payments, which the NHI White Paper (2015) generally precludes, could also deter care seeking, particularly by the poor. While the NHI White Paper (2015) would provide a useful blueprint for establishing the Fund and the services it finances, an HIV-focused Fund would require some distinct features. The government would also need to ensure that new financing arrangements did not disrupt distribution of drugs and provision of laboratory services.

Additionally, the overall resource envelope for HIV would need to be carefully protected and grown to ensure that the programme remained solvent as the NHIF took on mandatory service delivery commitments, including increased target patient volumes, particularly if other health funds are no longer informally (and in as yet only partially quantified ways) subsidizing the HIV programme.

Finally, there is some risk that shifting personal services to the national sphere while leaving non-personal interventions in provincial hands could fragment the HIV response. Coordinating an effective and efficient blend of interventions would become more difficult, as might monitoring HIV spending and performance. Therefore, in the near term **Scenario 2's effect on the HIV response is uncertain (?) because it depends on several other policy choices requiring care not to undermine the programme; indeed, there would be real risk of inadvertent harm (-).**

In the future, strategic purchasing could shape provider behaviour in a number of ways, including promoting increased volumes, quality improvement, and technical efficiency. Access to and quality of services could also increase if private providers become eligible for NHIF payments. In theory, an accreditation regime could also improve service quality in public facilities, though according a senior NDOH official, previous attempts to accredit public providers for participation in the current HIV programme were strongly resisted and ultimately abandoned. Consequently, a new approach to accreditation and its relationship to financing would be required.

Effect on PHC services

The financing changes envisioned under Scenario 2 would not be likely to affect the financing and delivery of PHC services, at least not before they were folded into the NHI benefits package. Until then, PHC would continue to be financed from PES funds managed by provinces. While overlap in service delivery in the public facilities would continue as before, the lack of HIV and PHC financing integration will be further solidified. However, re-journalization (temporary transfer of HIV funds to cover cash flow problems in other health areas) would no longer be possible, leading to the risk of non-HIV service delivery interruptions because of cash flow problems. In fact, this risk may affect health services well beyond PHC. Avoiding these disruptions anyway requires better budget planning and cash flow management by PDOHs. NT, NDOH, and provinces are already working on solutions, including introducing a global payments regime for services provided by the National Health Laboratory System, and more such reforms will likely be necessary in the future. Overall, **Scenario 2 would not be likely to have a meaningful effect on PHC services (Ø)**, and could even be detrimental if other financial management issues were not adequately addressed.

Effect on health system efficiency

The HIV conditional grant has been increasing as a share of national funds both for PHC and for health services overall. It is not clear, however, whether instituting a National HIV Fund to pay for HIV care, treatment, and biomedical prevention services would increase the efficiency of the health system. Creating a separate, centralized Fund for purchasing HIV services would, at least temporarily, deepen the divide between HIV financing and that for the rest of the health sector. Provinces would lose their ability to cross-subsidize between the HIV programme and other service areas, which could have either positive or detrimental effects on allocative efficiency. Within the HIV programme, the government already carefully considers needs and service targets when allocating funds across provinces and HIV programme areas; an NHIF may not be inherently better at making efficient allocations. However, as the epidemic recedes in some areas, holding HIV funds in a centralized Fund might make it easier for NDOH to reallocate resources between provinces, particularly if reduced need in one province meant its HIV budget should decrease. Additionally, the NHIF would require a process for determining, over time, exactly what services to pay for. Even if the benefits package remained HIV focused for some time, there would be a continual need for priority setting and health technology assessment, both of which could increase the system's allocative efficiency.

Meanwhile, changes in technical efficiency would depend more on how the new NHIF purchased HIV services. For example, capitation for care and treatment services could promote more efficient use of resources at the facility level, assuming health care workers and facility managers faced corresponding personal incentives as well. In contrast, fee-for-service payments tend to promote overprovision of services but may be well suited to one-time preventive interventions like MMC. Moreover, HIV services may be

compatible with performance-based payment regimes because they have an easily measured outcome: viral load. Linking payments to outcomes could be a powerful means of increasing performance without spending additional money, thereby enhancing technical efficiency.

Despite these opportunities, an HIV-focused NHIF may also pose challenges to service delivery integration. For example, HIV and other PHC services currently share numerous resources, the most important of which are health care workers. Under prevailing accounting practices, workers are either tagged as HIV related or not even though most provide multiple kinds of care. One senior NDOH official estimated that the HIV programme is a net beneficiary of this imprecise accounting: the amount of "non-HIV" labour time actually spent delivering HIV services significantly outweighs the amount of "HIV" labour time spend delivering non-HIV services. More strictly separating HIV financing from the rest of the health budget could exacerbate these accounting challenges and make providers less inclined to manage and deliver HIV and other PHC services in an integrated fashion. This relates to a major design challenge for any NHI system: will South Africa's NHIF purchase the labour component of health service inputs in the public sector? Doing so would require significant changes to the contractual relationship between public-sector health workers and the government. Alternatively, or as an interim step, the NHIF could pay only for the variable costs of HIV services, much like Ghana's National Health Insurance Scheme.[18] Given labour's high share of total health care costs, excluding it from NHIF payment mechanisms would limit the extent to which strategic purchasing could drive improvements in technical efficiency. While acute, these challenges may be short lived if non-HIV services were fairly quickly added to the NHI benefits package.

Ultimately, simply creating a National HIV Fund would do little to improve efficiency. Instead, several additional policy choices, such as the design of payment mechanisms, would determine Scenario 2's effect. Moreover, introducing very new financing arrangements only for HIV services could complicate management and hinder service delivery integration at the facility level, potentially imposing additional costs in the short run. Consequently, **Scenario 2's effect on efficiency is largely uncertain (?) and potentially even unfavourable (-) in the near term.**

Feasibility

Legal feasibility

The national government could redirect conditional grant funds relatively easily if NT and NDOH agreed. However, establishing the NHIF itself would require significant enabling legislation. The National Health Act of 2004 establishes health-related policy, oversight, financing, and delivery responsibilities for each sphere of government, so the establishment of the NHIF would upend the government's current health financing, governance, and delivery mandate. At the same time, South Africa would need to pass special legislation to establish the NHIF as a "general government public entity" with specific modalities for its governance (under the PFMA) and financing (such as diverting funds from existing conditional grants). Finally, significant legal reforms and political will would be needed to enable an NHIF—representing a purchaser-provider split in the public sector—to strategically purchase health services, especially if health worker salaries are included. Depending on the changes, civil service rules and even broader labour laws may need to be amended to allow rewards and penalties (including termination of service) to incentivize improved performance. Therefore, **the extent of legislative change required for this scenario mean its legal feasibility is medium at best; the risk of legal challenges over centralization of health funds means legal feasibility may even be low.**

Political feasibility

In terms of political economy, Scenario 2 would likely appeal to some NDOH officials. A key concern of HIV programme managers at the national level has been to protect the gains South Africa has made in promoting better business planning and accountability competencies in the financing and delivery of the HIV response. The national government's control of financing and its strategic use to incentivize improved planning and tracking of financial resources and service delivery targets at the provincial level have been crucial to securing these gains. A National HIV Fund would enable NDOH to safeguard the HIV programme and to take some key steps towards the system proposed in the NHI White Paper (2015). These include instituting a purchaser-provider split in the government health financing system, generating capacity for public financial management at the district and facility levels, and experimenting with contracting and payment mechanisms with public and private providers. However, creating an HIV-only Fund may run counter to the spirit of the NHI movement, in which much of NDOH is heavily invested. NHI proponents may oppose, even on an interim basis, financing changes that entrench vertical financing for a single disease programme.

Additionally, this scenario could face opposition from provinces, which would stand to lose control of significant health sector resources and whose own health departments could no longer be able to count on HIV CG funds to iron out cash flow problems via re-journalization or as top-up financing for integrated PHC. Even directors of provincial HIV & AIDS, STI, and TB (HAST) programmes may not support the revamping of HIV financing under this scenario if the stricter separation of HIV and other health funds inadvertently deprived the HIV response of PES funds, which currently account for a meaningful share of total HIV spending.[19] On the other hand, additional protections for HIV funds and development of financial management capacity throughout the health care system might appeal to these health officials.

As for NT, because this scenario would retain dedicated transfers for the HIV response, it would not be likely to help control the (recently sharp) growth in the size of

[18] In Ghana, despite introduction of an NHI system, public-sector health care workers remain salaried and are paid through the government wage bill.

the HIV add-on to the national health budget. Hence, NT might stay concerned about finding efficiencies in the HIV response from integrated financing and delivery rather than committing to indefinitely financing a National HIV Fund, even though it would institute a purchaser-provider split in the public sector. A clear plan to expand the NHIF's benefits package might therefore be essential to reassuring NT and other fiscally minded stakeholders that this scenario would be but one step toward larger reform that would promote greater efficiency and quality throughout the health system, not just with respect to HIV services. Similarly, PHC-oriented health officials, who have expressed expectations of leveraging the planning and monitoring capacities of the HIV programme to strengthen PHC service delivery, might resist changes to HIV financing that further insulated it from the rest of PHC.

Finally, South Africa's politically vocal HIV-affected persons and advocates may need reassurance that the NHI enrolment rules under this scenario would not cause programmatic harm nor reduce access to services—such as from ill-conceived policies that risked excluding at-risk populations from coverage, restricted access to drugs, or increased the out-of-pocket costs of clinic visits for personal treatment and prevention services. At the same time, advocates might find appealing the continuation of a large pool of HIV-dedicated funds that remained ring-fenced and linked to financial reporting and service delivery targets and standards. To the extent that a National HIV Fund purchased services from both public and private providers, advocates might also embrace the potential expansion of access, efficiency, and quality that could be driven by contracts and performance incentives. To proactively support this policy, however, advocates would probably also demand assurances that as the benefits package expanded in scope beyond HIV services, financial and human resources currently dedicated to HIV service provision would not be diluted.

In light of expected mixed attitudes among health officials at the national and provincial levels, likely caution among NT officials, and reasons for both enthusiasm and wariness about a National HIV Fund among HIV advocates, **the political feasibility of Scenario 2 is low–medium.**

Technical Feasibility

Appropriate systems and capacities would need to be in place for organizations and individuals to play their respective roles to make a National HIV Fund technically feasible. While South Africa already has considerable planning, costing, and tracking capacity for its HIV response, the country would need to develop improved financial management, contracting, and monitoring competencies atop these existing systems at the facility level to make a new Fund a reality.

Under Scenario 2, the government would need to build substantial additional capacity for financial management of the HIV response. The HIV CG has helped to develop HIV management and reporting systems whereby the provinces engage in HIV business planning, including planning, costing, and budgeting against service delivery targets and tracking and monitoring of funds and services. However, for a central NHIF to directly contract with facilities, considerable capacity would need to be built for the Fund to manage contracts with providers, price services on the basis of routine HIV costing analysis, develop and oversee national HIV targets, monitor performance, and execute payments. Similarly, greater capacity in the form of human resources and systems would be required in districts and facilities to plan service delivery, make and control budgets, manage contracts, monitor performance, make claims, realize opportunities for efficiency, and more. These competencies are only now being developed at the district level but not yet at the facility level. A gradual process (or perhaps a 'shadow' process) of creating the necessary conditions for purchasing relevant HIV services would also need to be implemented. The types of data systems required to manage finances and track service provision would depend in part on the payment mechanism(s) selected.

The new NHIF would also require systems and capacity to monitor the performance and outputs of all contracted providers. Stewardship and quality assurance are critical functions of an NHI system, and skills and systems to ensure them would take time and resources to build and maintain. From the current conditional grant mechanism, the national sphere has experience in monitoring performance and outputs of the provinces. This useful experience provides a foundation for directly monitoring individual service providers with which the NHIF would be contracting directly. Currently, provinces rely on district-level data capturers, who collect paper-based records from individual facilities and input them into relevant computerized systems. If the NHIF contracted directly with individual providers, monitoring service delivery contracts would require timeous data entry at the facility level. Planned investment in the Integrated Patient Information System through the National Health Insurance Indirect Grant is a useful step toward developing needed capacity for Scenario 2 (and Scenario 5).

In summary, existing systems would provide a valuable foundation for the technical capacity that would be required to introduce a National HIV Fund, but substantial additional capacity would be needed, including much in levels of the health system with minimal prior experience. Therefore, **the technical feasibility of this scenario is low to medium.**

[19] The best estimates of the share of provincial DOH spending on HIV that is financed with PES funds is nearly 20 percent for FY 2013/14 (Guthrie et al., 2015). This share is almost certainly too high because it counts all spending on health workers hired to provide community and home-based care (CHBC) to HIV patients, but these workers also provide many non-HIV services. Nonetheless, the PES share of total HIV spending is clearly not negligible.

Scenario 3: Unconditional integration – moving the HIV CG into the PES

Financing mechanism

Scenario 3 would entail complete HIV financing integration via abolition of the HIV CG. All HIV funding would be allocated through the PES, whose allocation formula would be adjusted to account for the HIV burden in each province. There would be no ring-fencing of HIV funds, and the strict conditions of the CG would be removed.

Like for most other health services, the funding and delivery of HIV services would fall fully under provincial authority in accordance with the National Health Act of 2004. Provinces would have full discretion over the allocation of resources across sectors and within the health sector, including for HIV and other programmes. Although NT would provide guidance and fiscal benchmarks to ensure provinces could meet their financial obligations, the national government would not be empowered to mandate how provinces spend their health funds. As is currently the case with all PES funds, provinces would be subject to the financial requirements outlined in the Public Finance Management Act (PFMA), such as annual planning, budgeting, performance monitoring, and reporting. These requirements are less stringent than those in place for HIV and other programmes funded through conditional grants.

Rationale

Reducing inefficiency in the current financing and service-delivery systems might require full integration of HIV and non-HIV health care financing. A unified pool of funds will reduce the need for parallel administrative, management, and oversight capacity across programme areas. Redundant programme management resources (e.g., personnel, reporting processes) could be redeployed to strengthen overall financial planning and management and develop systems for enhanced, integrated service delivery. With no ring-fencing around HIV funds, provinces would be free of the artificial financing divide between HIV and the rest of PHC, which in some cases leads to inefficient spending.

The conditional grant mechanism has served well South Africa's ambition to build a high-quality, scaled-up HIV response. However, it was never intended to fund HIV services in perpetuity, separate from PHC and other health services. The business planning, budget tracking, and performance monitoring systems developed for the HIV programme are ingrained in PDOHs and could be the basis for improved management practices across all of PHC, if not the entire health sector.

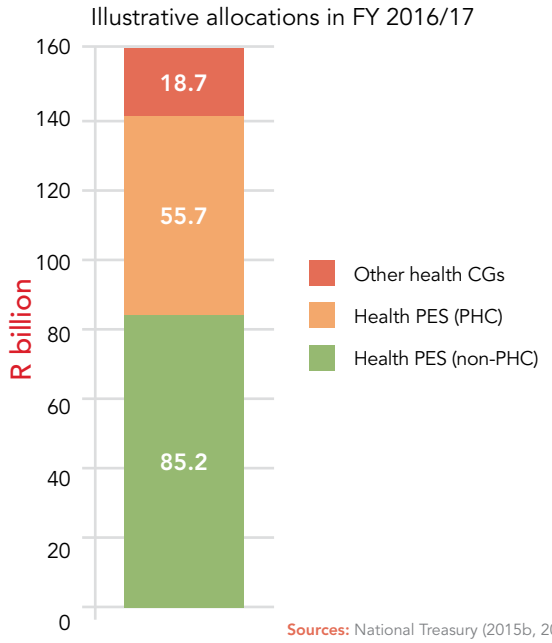
Additionally, given South Africa's multifaceted health challenges and HIV's increasing share of the total health budget, it is increasingly difficult to justify a large conditional grant focused on a single disease. The HIV CG is the second largest grant in the entire government budget—behind only the human settlements grant—and the health sector will account for more than a third of the R96 billion in conditional grant allocations projected for FY 2016/17. Consequently, and in light of the HIV programme's tremendous success, now could be an opportune time to loosen the CG's stringency and give provinces full control over their HIV budgets.

Detailed description

Pools of funds

Figure A2.3 depicts the expected pools of provincial health sector funds in FY 2016/17 under unconditional integration. Combining the allocated amounts for the current HIV CG with expected spending on other PHC services, the total PHC pool of funds would amount to 35 percent (R55.7 billion) of the provincial health budget in FY 2016/17, none of which would be ring-fenced. These PHC resources would be managed in the same pool as the R85.2 billion (53 percent of the total) in voted funds for non-PHC activities, meaning total health funds from the PES would amount to R140.9 billion. Meanwhile, the five non-HIV CGs would account for the rest of the health budget (R18.7 billion, 12 percent of the total).

Figure A2.3. Illustrative allocation of funds in FY 2016/17 for Scenario 3 (R billion).



Sources: National Treasury (2015b, 2016).

Governance of HIV funds

Scenario 3 would entail a radical change to how HIV funds are governed. The national government would no longer exercise control over the amount of funds allocated to HIV services nor their distribution across various HIV prevention, care, treatment, and support activities. Instead, the national level would play a supporting role focused on policy development and capacity building. Importantly, NDOH would still work closely with provinces in setting HIV targets, and NDOH would be able to monitor HIV spending and outputs based on their regular annual financial and performance reports, which could become

more rigorous through the non-negotiables framework, for which provinces report monthly. However, NDOH would lack any strong means of sanctioning provinces failing to meet their HIV targets.

At the same time, full control of HIV funds would be transferred to the provinces, which would be free to allocate resources as they saw fit, whether to HIV, other health programmes, or even other sectors. Responsibility for ensuring the achievement of provincial targets, through quality service delivery and timeous payment of suppliers, would fall fully to provinces. In principle they would plan, monitor, report, and evaluate PHC services in an integrated fashion, but they would no longer be bound by the stricter quarterly reporting and performance requirements of the CG mechanism.

Purchasing of HIV services

Scenario 3 would not necessarily imply changes to how HIV or PHC services were purchased. Provinces would be free, if so inclined, to experiment with alternatives to the current input-based budget system for public providers. Options could include contracting with private service providers to expand access and improve quality or introducing some form of performance incentives within the public delivery system to increase efficiency, service delivery integration, and service quality.

Implementation and pathway to NHI

Implementation of Scenario 3 would require two short-run steps. First, NT and NDOH would need to agree on a rechannelling of HIV funds through PES allocations. Second, the PES allocation formula would need to be adjusted to account for the distribution of HIV burden across provinces and to ensure additional funds flow accordingly. The burden of other diseases could also be factored in.

Unlike the other scenarios, unconditional integration would not be an obvious step toward the NHI system proposed in the White Paper (2015). Placing the already centralized HIV funds within the PES would run counter to creating a single, nationally controlled NHI Fund. As is discussed below, the deconstruction of the current CG and the adjustment of the PES formula to account for HIV burden would require considerable political effort. Such effort could be considered wasted if the funds, autonomy, and responsibility given to the provinces in the short run would were to be withdrawn again once the NHI Fund was established. In fact, it could make it more politically challenging to subsequently incorporate funds into the NHIF. However, Scenario 3 might be a natural step toward an NHI vision different from that in the White Paper (2015): the creation of nine devolved insurance funds managed at the provincial level. This option, which would resemble Canada's social health insurance scheme, has not featured in the NHI discourse; however, it could be a useful alternative if full centralization proves too politically (or constitutionally) difficult. Such a system would require extensive capacity building at the provincial level to effectively manage independent funds.

Impact on health system performance

Effect on the HIV response

Scenario 3 would pose considerable risks to the HIV response and its gains to date. All interviewed officials—including those in NDOH's PHC directorate and PDOHs—felt that loosening the conditionality of the CG will be detrimental to the HIV response because the funds would no longer be ring-fenced and thus would be easily reallocated to other provincial priorities, which might not even lie in the health sector. Without the legislative requirements on PDOHs to monitor and report quarterly on both financial and programmatic performance, there would be no way to ensure the national and provincial HIV targets were being achieved. In addition, the quality of financial management varies across provinces, with cash flow problems often delaying payments to suppliers of medicines and other clinical inputs. If the HIV programme were no longer (mostly) insulated from these issues, the consequent delays in delivery of supplies to facilities could undermine access to ART, lab tests, and other critical services. There is some chance that external pressure (advocacy) would continue to ensure that the PDOHs allocated sufficient funding to HIV. Other opportunities for improving reporting and accountability requirements for HIV and PHC within the PES, such as those being used for the non-negotiables, could also be explored. Nonetheless, the risks to the HIV response would considerable, so **this scenario would have an extremely unfavourable (- - -) effect on the HIV programme**; in fact, it illustrates how financing integration for integration's sake might not be desirable.

Effect on PHC services

As mentioned above, placing the HIV funds into the PES might make some funds available for PHC and allow for more efficient spending and improvement of PHC services. However, to the extent that they reallocate HIV funds to other uses, there is no guarantee that provinces will even retain those resources in PHC or the health sector at all. Therefore, **this scenario's effect on PHC services is uncertain (?) and potentially favourable (+) if some funds previously meant for HIV are spent on other PHC services.**

Effect on health system efficiency

The effect of unconditional integration on health system efficiency would likely depend on whether there were any concurrent changes to how provinces financed general health services. Provinces rely principally on input-based budgets for government health facilities, and no strict performance standards exist for non-HIV services. Without a robust system of oversight or reconfigured provider incentives, it is difficult to imagine how this scenario would promote efficiency gains. Nonetheless, a couple of hypotheses are worth considering.

First, the relative size of the HIV CG compared to the rest of PHC spending—it may reach 50 percent by the end of the current MTEF period—implies an opportunity for efficiency gain. One reason could be that the vertical

nature of HIV financing constrains the integration of service delivery, meaning in some cases facilities suboptimally allocate human and other resources between HIV services and other activities. However, although some provinces have kept vertical HIV service delivery, this is not true everywhere. In some settings, therefore, blending HIV funds into the PES might allow for more 'common sense' integration in facilities, but the prevailing financing system is not the only (or even main) determinant of whether service delivery is integrated.

Second, the management and monitoring systems in place for HIV may be duplicative of or parallel to those in use for the rest of government health services. PES funds have lesser planning, budgeting, monitoring and reporting requirements, so unconditional integration would require less time and effort of programme and financial managers, whose capacity could be redirected to other activities. However, this would not necessarily lead to improved spending on HIV or PHC. In fact, it could lead to reduced spending on HIV (and perhaps health more generally), or even more wastage of resources if provinces were no longer accountable to NDOH for HIV performance standards. In other words, any savings accrued from reducing the financial management burdens of the CG framework would probably be more than counterbalanced with decreases in HIV spending, reductions in business planning and monitoring, and ultimately worsened service quality.

Finally, this scenario could free provinces to more proactively address rampant cash-flow challenges by using some HIV funds to support struggling PHC services. However, this too could detract from overall spending on HIV and may not promote efficiency gains at the system level. In summary, there is little reason to expect meaningful efficiency gains from unconditional integration. Therefore, **this scenario's effect on efficiency would be minimal (Ø) or potentially unfavourable (-).**

Feasibility

Legal feasibility

Unconditional integration could be achieved without any major legislative reforms. Channelling funds via the PES allocation system is already the core mechanism for intergovernmental transfers in South Africa, and there is no law or constitutional provision requiring a conditional grant for HIV in perpetuity. Adjusting the PES allocation formula to account for HIV burden would pose a modest policy design challenge, but the existing distribution of CG resources across provinces would provide a useful starting point. **The legal feasibility of this scenario is high.**

Political feasibility

The political economy of removing the HIV CG would be simple: among our informants there was no direct support for this scenario, and there was rather clearly expressed opposition to such a proposal. According to multiple NDOH officials, the Minister of Health would probably oppose such a radical alteration to HIV financing. Moreover, although the HIV advocacy movement has been quieter in recent years, there are powerful constituencies within governmental (NDOH and PDOHs) and quasi-governmental (SANAC) agencies that, concurrent with influential organizations like the Treatment Action Campaign, Section 27, and the AIDS Law Project, could prevent the adoption of any policy that would remove the ring-fencing currently protecting HIV funding.

Some NT officials did express theoretical interest in transitioning away from having such a large conditional grant focused on a single disease, but there were no signals that they were prepared to risk harm to the HIV programme to do so. Additionally, a senior health official noted that political and financial analysis aside, and despite various competing interests, it has become a truism in South Africa that "we treat HIV-positive people in this country." Consequently, **the political economy feasibility of this scenario is low.**

Technical feasibility

Of all the scenarios, unconditional integration would have the fewest technical requirements. The PES funding channel would not require detailed budgets, business plans, monitoring of spending and outputs, or frequent and detailed reporting. Only the regular PES accounting would be required. Thus it would be much easier for provinces to simply manage HIV funds along with other health funds. No special capacity would be needed for provinces to apply the same management systems in place for PES funds to a larger pool of money. Moreover, provinces already oversee HIV service delivery; in this scenario they would be liberated from the financial management processes demanded by the CG mechanism. Therefore, **technical feasibility of this scenario is high.**

However, it is important to note that the PDOHs' current capacity to effectively protect and manage their health budgets for specific programmes is generally weak and subject to other provincial priorities, political agendas, and misuse. Protecting HIV funds within the PES, and hence the achievements made in the HIV response to date, would require capacity building within PDOHs and improvement of the PES reporting and control mechanisms. It is uncertain whether the capacity that has been built to cost and budget for the HIV CG would be retained and continued if the funds were channelled through the PES. Potentially these skills could remain and perhaps be applied to PHC services more generally. Or perhaps similar systems as for the 'non-negotiables' could be applied to PHC, HIV, and other services.

Scenario 4: Ring-fenced PHC—pushing the benefits of ring-fencing to PHC

Financing mechanism

Under Scenario 4, the scope of the HIV CG would be expanded to include all PHC services. The resulting Comprehensive PHC conditional grant would be modelled on the existing HIV CG. The implicated funds would be managed by provinces in accordance with a revised CG framework that combined business planning, expenditure tracking, and performance monitoring requirements for PHC with those already in place for HIV. There would be at least two possible approaches to creating a large ring-fenced pool of PHC funds (see Box S4.1 for additional options):

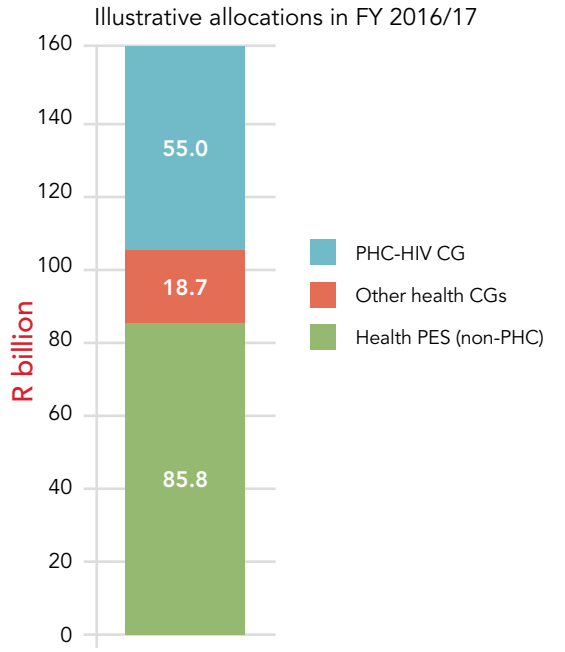
1. In order to rapidly ring-fence enough funds for all PHC services, PES funds currently spent on PHC could be added to the HIV CG. Toward this end, the share of national revenue distributed via the PES would be reduced[20], as likely would be the share PES funds allocated to health by provinces.

2. More incrementally, new funds could be added to the CG over several years to cover more and more PHC services. This is already happening on a small scale with the fuller integration of TB into the CG framework in FY 2016/17 and addition of new funds for TB starting in FY 2017/18. In future years other PHC service areas could be integrated as well, perhaps starting with maternal and child health.

Rationale

Since its inception, the HIV CG has been instrumental to the scale and quality of the world's largest HIV programme. It has also spurred the development of new competencies for costing, budgeting, tracking, reporting, and monitoring within the public sector. Meanwhile PHC service delivery in government facilities has struggled. Extending ring-fencing around PHC funds could potentially imbue PHC services with the same rigorous planning, monitoring, and evaluation that underpin the HIV programme's success. It would also require improving capacity for PHC resource needs estimation, budgeting, and reporting. Finally, it might reduce financing barriers to integrated service delivery, thereby promoting better and more efficient use of scarce resources.

Figure A2.4. Illustrative allocation of funds in FY 2016/17 for Scenario 4 (R billion).



Sources: National Treasury (2015b, 2016).

Box S4.1. Additional options for ring-fenced integration.

This scenario is rooted in financing and monitoring approaches for which there is promising precedent. However, there may be additional options. For example, one senior NDOH official proposed developing a new legal instrument that expands national oversight over PHC funds without necessarily removing them from PES allocations. In the past, NT has used 'exclusive appropriations' to designate a portion of provincial budgets for specific purposes, but this mechanism is seldom employed, and even then only for relatively small amounts of money. To expand its use for a large envelope of health resources, for instance more than R55 billion annually for HIV and other PHC services, would be unprecedented and potentially invite legal challenges.

Another option could be NDOH's more normative approach to compelling provinces to better track spending in numerous priority areas. These so-called 'non-negotiables' include an array of basic service delivery inputs, (e.g., medicines, laboratory services), service categories (e.g., children's vaccines, HIV and AIDS), and NHI-related initiatives (e.g., District Specialist Teams) (Shezi et al., 2014). Currently there is no mandatory framework for incorporating non-negotiables into business planning, resource needs estimates, or budget allocations, though the National Health Council has made recommendations along these lines. Such enhancements would mimic many of the accountability mechanisms already built into the conditional grant framework. In the meantime, the non-negotiables approach could be a positive but probably insufficiently stringent step toward ring-fenced integration.

Source: Authors.

[20] This assumes no other changes in public financing affecting the share of national revenue that is channeled through the PES allocation system.

Detailed description

Pools of funds

Figure A2.4 depicts the expected pools of provincial health sector funds in FY 2016/17 with ring-fenced PHC integration. The figure corresponds to option 1 above, in which the existing HIV CG would be combined with PES funds currently spent on PHC. About R55.0 billion could be allocated to provinces through a new Comprehensive PHC CG. The rest of health services would be financed through PES allocations (R85.8 billion) and other conditional grants (R18.7 billion).

Governance of HIV funds

Although ring-fenced integration of PHC funds within the HIV CG would entail some realignment of responsibilities across spheres of government, NDOH would continue to exercise a high level of control over HIV funds. Indeed, the scope of its control would extend to PHC funds as well. This would involve designing a process for provinces to develop PHC business plans and defining rules for the implementation and monitoring of those plans. The national government would be able to enforce compliance with its PHC performance standards by withholding funds, just as it can now within the existing CG mechanism.

Provinces would continue to bear responsibility for service delivery, only now their PHC services would also be subject to extensive oversight and monitoring by NDOH and NT. Initially PHC budgets would be based on analysis of historical spending patterns, while over time provinces would develop capacity, with support of the national government, to cost PHC services and generate more precise resource needs estimates. The detailed costing of PHC services would serve as a means of creating transparency and accountability with regards to resource needs, budgeting, utilization, and target PHC service delivery outputs and outcomes at the district and provincial levels.

Under Scenario 4, districts would not have a meaningful role in the governance of the PHC CG. Together with facilities they would accept budgets and targets from above, not only for HIV but also for the PHC services folded into the CG mechanism. Box S4.2 describes an alternate approach to ring-fenced integration in which districts would have a considerably greater role in governing HIV funds; such an approach could potentially contribute to NHI implementation, which will require bolstering district capacity.

Purchasing of HIV services

Many approaches to purchasing HIV services would be possible under a policy of ring-fenced integration. The HIV CG has already elicited strengthened approaches to budget planning linked to targets for service delivery outputs and coverage. Moreover, funds can be withheld to sanction poor programmatic performance or underutilization, improving accountability—if not quality—in the government's HIV response. In its simplest design, Scenario 4 would entail implementing a similar arrangement for other PHC services, which would benefit from more sophisticated resource needs estimation, planning, tracking, and reporting.

A more ambitious approach would involve one or more additional steps toward strategic purchasing. First, resource needs estimation for PHC could be conducted in an integrated fashion, producing budgets meant to cover a basket of services rather than allocations that simply sum separately computed PHC and HIV components. Second, steps could be taken to effect a fuller purchaser-provider split, either at the national or provincial level. In this case a defined package of PHC benefits could be purchased from both public and private providers. If a separate purchasing agency or Fund were established, this approach would approximate Scenario 5. Third, provinces could expand contractual relationships with private providers, building on the experience of Mpumalanga's service level agreement with Right to Care for the delivery of a comprehensive set of PHC services, including for HIV.

Implementation and pathway to NHI

Scenario 4 would require several key short-run steps. The National and Provincial Departments of Health would need to develop tools to estimate combined resource needs for HIV and other PHC services. The work of the PHC Costing Task Team, jointly convened by NDOH

Box S4.2. Pushing funds to the districts.

In the spirit of the NHI White Paper (2015), Scenario 4 could involve more ambitious governance reforms. In particular, the conditional grant mechanism could be modified to endow districts with more direct responsibility for business planning, budgetary oversight, and management of service delivery. In turn, provinces would assume more of a support and advisory role focused on building local capacity. Once funds were transferred to districts, the key financial relationship would then be between them and facilities. They would thereby mimic the role of District Health Management Officers (DHMOs) envisaged in the White Paper (2015) and begin developing the service delivery management capacity that will be necessary under NHI. Depending on the purchasing arrangements that accompany ring-fenced integration, the districts could also become custodians for the funds transferred to facilities in accordance with new contractual arrangements. Alternatively, they could help to facilitate the negotiation and monitoring of those contracts in coordination with the national purchasing agent, while facilities themselves would require the necessary structures (e.g., bank accounts) and legal authority to receive and manage funds directly.

Source: Authors.

and NT, could provide useful insights. Additionally, the national government would need to determine how to appropriately adjust the PES allocation formula and reflect the changes in the annual DORA. This would first require determining with reasonable accuracy how much is currently being spent on PHC. Finally, NT and NDOH would need to modify the HIV CG mechanism to govern planning, tracking, evaluation for PHC service delivery and outcomes. In turn, public financial management and health information systems would be updated to enable relevant tagging and tracking of PHC spending and outputs. Reporting could follow the same monthly and quarterly schedules as are currently in place for HIV.

Ring-fenced integration could serve as a prelude to multiple NHI structures, including the centralized system proposed by the White Paper (2015). This scenario would draw additional health funds under stringent national oversight, a small step toward an NHI Fund that consolidates spending under direct control of the national government. It would also promote decision making about what PHC and HIV services will be financed by a large, integrated conditional grant. These choices would provide a useful foundation for the eventual definition of an NHI benefits package, as would efforts to more rigorously cost PHC services. Notably, this scenario would not necessarily imply that provinces would no longer be directly responsible for service delivery and reporting. In fact, like Scenario 3, this scenario could also precede a more devolved approach to NHI in which each province manages its own Fund. It bears repeating that this would be a major departure from the NHI White Paper (2015). However, to move the health system toward the White Paper (2015)'s vision, there are additional reforms relating to the role of districts that could be pursued in conjunction with the creation of a large PHC CG. In particular, this would involve a single, centrally managed Fund whose purchasing arrangements with providers were intermediated by DHMOs rather than PDOHs.

Impact on health system performance

Effect on the HIV response

Given that strict conditionality or ring-fencing would be maintained and this scenario would not necessarily envisage relaxing the stringent HIV CG planning, tracking, and reporting requirements associated with financing and service delivery, the HIV planning and monitoring systems would be expected to persist. Integrated financing could help make the programme more efficient and help to enhance service delivery volumes for comparable total costs. The performance of HIV programmes should also not suffer because targets for all PHC services would be defined and monitored in detail. The stringency of conditionality would remain high even as the scope of services financed via conditionalised funds is expanded.

However, the specifics of the new CG mechanism would determine any risks to the HIV response. Some external experts raised concerns about dilution of attention to the HIV programme if all PHC services were monitored in the CG framework.[21] For example, even if all existing conditions were left in place, the addition of new reporting requirements for PHC might lessen attention focused on HIV services. Consequently, in this scenario NDOH would need to take care to sustain its current level of scrutiny of all HIV reports and outcomes. The fact that HIV and PHC oversight are currently housed in separate NDOH directorates could also help to protect against dilution of attention.

Additionally, there could be trade-offs between allocative efficiency and the HIV response. If provinces and districts began managing integrated PHC budgets, they might shift some funds previously intended for HIV to other PHC services. Even if the new allocation were more efficient, overall HIV spending—and associated outputs and outcomes—could decline. Consequently, **depending on the design and implementation of the new CG mechanism, this scenario's effect on the HIV response could be minimal (Ø) or potentially unfavourable (-).**

Effect on PHC services

Given the lack of explicit resource needs estimation, budgeting, tracking, and reporting for PHC financing, perspectives from NDOH managers and other informants indicate the public sector's PHC programme could be strengthened greatly from improved programme management. As mentioned above, the conditional grant framework has been essential to scaling up and delivering the HIV programme such that service delivery and financing targets can be adequately measured and monitored. Hence, the effect of extending similar conditionality to the PHC programme could be highly positive. **Integrating and ring-fencing HIV and PHC financing will improve the planning, tracking, and monitoring of PHC spending and service delivery, likely driving increased PHC access and quality (++).**

Effect on health system efficiency

The HIV CG has been instrumental in making South Africa's HIV response targeted, accountable, and successful at resource utilization—Scenario 4 would extend these benefits to PHC services more generally. By pooling all PHC funds in a single CG, ring-fenced integration could generate economies of scope in programme management, including business planning, expenditure tracking, and performance monitoring. Additionally, it could enable more efficient allocation of resources across all of PHC, including HIV, by giving provinces, districts, and facilities greater flexibility to deploy health care workers, facility space, and other service inputs optimally. A separate process for determining which PHC services to fold into the CG, and in what sequence, would also be important to allocative efficiency. Such a priority-setting process would go well beyond simply creating the expanded PHC CG.

Meanwhile, whether this scenario would promote technical efficiency would depend on other factors. Several informants expressed concern about the general lack of value for money in PHC. However, data collected during the development of a normative budgeting tool in

[21] These expert views were raised during the discussion period of the presentation cited as Blanchet & Chaitkin (2015).

Limpopo suggests that, to meet established PHC service standards, facilities may need to spend even more on PHC (Rockers, 2015). In fact, more rigorous costing of PHC services might produce a baseline resource needs estimate considerably greater than current expenditure. High costs may be attributable in part to the government's wage bill. Whether outcomes would improve as a result of increased PHC expenditure would depend on a number of management and other factors.

There could be opportunities to incentivize more technical efficiency and higher quality care at the facility level through well-designed purchasing policies. For example, the White Paper (2015) proposes capitation for PHC; piloting such an arrangement alongside ring-fenced integration would be a useful means of exploring potential efficiency gains. Ultimately, **much of Scenario 4's likely effect on health system efficiency is uncertain (?), though there is reason to expect at least some modest gains (+).**

Feasibility

Legal feasibility

The legal feasibility of ring-fenced integration would depend largely on whether the government sought to shift PES funds or only add new money to a PHC CG. For the former, reserving sufficient funds from the PES would require reducing the share of government revenue allocated through the PES. Such a change might invite legal challenges, even if the National Health Act of 2004 were also amended to reflect changes in national and provincial responsibilities with respect to health services.

Alternatively, if new funds for PHC were added incrementally to a PHC CG, there would be lesser risk of legal challenge, and no major legislative changes would be required. Although moving funds out of the PES allocations would be difficult, the government has far greater flexibility for channelling new money to the health sector. For example, a fraction of the resources needed for PHC could be added to the CG during each of the next several MTEF processes. Concurrently, planning, tracking, and reporting requirements for PHC would be gradually incorporated into the conditional grant framework. This way, an integrated pool for PHC and HIV services would develop without diverting funds from the PES. In practice, considerable analysis would be required to determine which PHC services, and in what sequence, should be financed through the CG. Therefore, **the legal feasibility of ring-fenced integration ranges from medium to high depending on the details of implementation.**

Political feasibility

The legal reforms or innovations pursued under Scenario 4 will also shape the political economy dynamics. First, several aspects of ring-fenced integration would likely appeal to NDOH. This scenario would give more control over health funds to NDOH by extending conditions to PHC financing. It would also preserve extensive protections and accountability for HIV funds. To the extent that integration were accompanied by additional preparatory steps for NHI, such as experimentation with purchasing arrangements, this scenario would also involve useful, incremental steps toward NHI implementation. In fact, Scenario 4 is one of only two scenarios—the other being the more ambitious Scenario 5—that are likely to appeal to the HIV-, PHC-, and NHI-focused constituencies within NDOH.

NT, on the other hand, may be wary of creating a massive PHC CG and rechannelling a significant share of PES funds. Even at our conservative estimate of R55 billion, a PHC CG would dwarf the largest current grant, which will allocate around R20 billion for human settlements in FY 2016/17. Historically conditional grants have been designed to temporarily supplement provincial budgets to enable scale-up of priority programmes. In contrast, channelling more than a third of the total health budget through a conditional grant would mark a radical repurposing of this budgetary mechanism.

These concerns aside, recently NT expressed openness to ring-fenced integration if it can facilitate piloting of strategic purchasing arrangements for HIV and other services and if it is designed as an intermediate step toward the creation of the NHI Fund. In fact, the stringency of national control over conditional grant funds makes the HIV programme a prime candidate for purchasing pilots. Moreover, given that NHI may eventually cover a comprehensive package of PHC benefits that include HIV services, piloting purchasing of a blend of HIV and other PHC benefits might be even more appealing.

While national officials might be supportive of, or at least open to, Scenario 4, provincial officials might object. First, provincial legislatures would likely oppose any reduction in PES funds, which are completely discretionary. Folding PHC financing into a conditional grant would preclude reallocations to other sectors, such as education, or other uses. Adding new funds to the CG rather than shifting PES would preclude some of these concerns. Second, this scenario would complicate the jobs of provincial health officials, who would have to assume additional responsibility for planning and monitoring financing and service delivery for PHC. This could be quite onerous given how little capacity currently exists to track PHC spending, particularly in settings where both PHC and other services are delivered (e.g., district hospitals). Additionally, conditional grant funds could be pulled back for a variety of reasons, such as when the provinces violated conditions on the use of those funds, were unable to spend them within the financial year, or if the function associated with the financing were moved elsewhere. Provinces would have to perform and report according to national standards to ensure a continuous and adequate flow of funds.

Nonetheless, some provincial health officials might welcome ring-fencing for PHC funds. HIV programme managers have indicated how valuable the conditional grant is in shielding HIV funding from competing provincial priorities and in improving their planning and management of HIV services; it is reasonable, therefore, that local PHC managers might similarly support similar protections for their budgets. In light of mounting interest in this scenario

and its potential variants at the national level, and with an expectation of divided interests at the provincial level, **the political feasibility of ring-fenced integration ranges from medium to high depending on whether funds are shifted from the PES or only new funds are added to a PHC CG.**

Technical feasibility

Scenario 4 would require expansive scale-up of costing, budgeting, tracking, and monitoring competencies related to PHC. Under the current HIV CG mechanism, these skills and capacity have been developed over almost a decade at the national and provincial levels. These activities would remain necessary under ring-fenced integration, so for HIV this scenario is highly feasible. However, this capacity would also need to be developed for PHC services because there is currently no conditionality for their management, apart from the regular PFMA requirements. PHC managers and finance officers would need to acquire the same routine skills and tools applied currently by HIV managers, such as identifying and costing PHC needs, planning service delivery scale-up, managing budgets and expenditure, and submitting detailed quarterly reports.

In addition, resource needs for PHC are currently not well understood or researched generally. Efforts are underway to cost PHC services, including both top-down and facility-based analyses by members of the NT-NDOH PHC Costing Task Team.[22] One important challenge is the lack of sufficient tracking systems to determine the extent of PHC service delivery at district hospitals. For instance, the illustrative allocations in this study somewhat arbitrarily include 25 percent of spending (see footnote 6). Therefore, investments in better information systems and public financial management practices would be required to effectively extend the conditionality of the HIV CG to all PHC services. Fortunately, these investments would also yield dividends for an eventual NHI system.

Similarly, the current HIV CG has required a strong monitoring and evaluation system and has thus developed the ability of provinces both to monitor the performance of service providers and to report these to the national sphere. These skills and systems would have to be extended to PHC services, and effort would be required to develop appropriate PHC indicators and expand the systems to collect them, as well as for provinces to report on them routinely. The general foundation provided by existing systems for HIV and nascent PHC costing efforts means that although considerable new capacity would need to be developed, the road forward is both clear and manageable. Therefore, **the technical feasibility of Scenario 4 is medium.**

[22] Participants include the University of KwaZulu-Natal, Clinton Health Access Initiative, DNA Economics, Insight Actuaries, Right to Care, and the USAID-funded Health Finance and Governance Project.

Scenario 5: National PHC Fund – an ambitious start for the NHIF

Financing mechanism

Under Scenario 5, the NHI Fund would be established first as a National PHC Fund with a large pool of resources to purchase an integrated package of PHC benefits, including for HIV prevention, care, and treatment services. The Fund would be administered at the national level as a separate legal entity from NDOH. There would be at least two possible approaches to creating such a Fund:

1. All PES funds currently spent on PHC, the small NHI CG, and the portion of the HIV CG that covers personal HIV services could be redirected to the new Fund. Like in Scenario 4, the share of national revenue distributed via the PES would be probably be reduced, as likely would be the share of PES funds allocated to health by provinces.

2. More incrementally, the NHI CG and most of the HIV CG could seed the new Fund (akin to Scenario 2), and new funds to cover other PHC services could be added over time.

In either case, the fate of financing for non-personal HIV services—roughly 12 percent of the HIV CG—might be different from that of financing for personal services. We analyse the implication of integrating these funds into the PES, from which provinces draw resources for other non-personal health activities. Instead, those resources could also be shifted to the new Fund, which would then be responsible for financing activities like SBCC and demand creation for condoms and MMC. Another alternative would be to retain those funds in a small CG, as we consider in Scenario 2.

Rationale

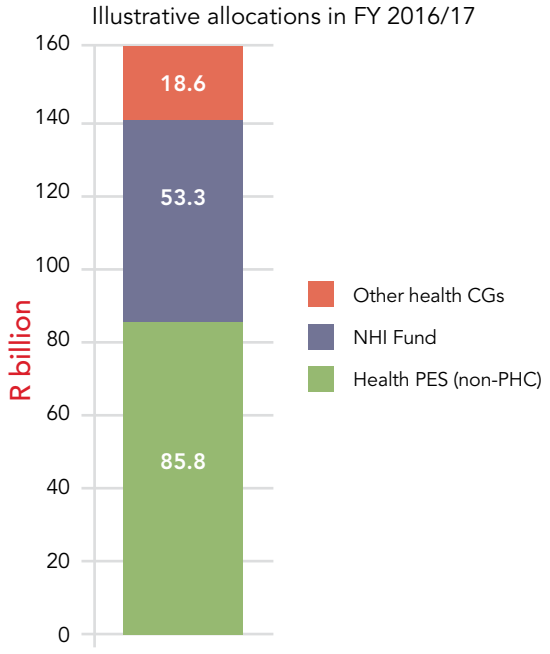
Integrating financing for HIV and other PHC services could reduce inefficiency in South Africa's current health financing and service delivery systems. Unified pooling of funds could reduce the need for duplicative administrative, management, and oversight capacity across programme areas. Redundant programme management resources (e.g., personnel, reporting processes) could be redeployed to develop new competencies in the NHIF and DHMOs. Scenario 5 could also enable strategic purchasing of a defined benefits package, as envisaged by the NHI White Paper (2015). Strategic purchasing of PHC services, for instance via capitated payments to providers, would effect greater integration of service delivery, promote optimized utilization of capacity in community clinics and health centres, and help to reducing inefficient facility-level spending currently encouraged by the ring-fencing of HIV funds. Finally, pooling funds in the NHIF would sustain, albeit in a reconfigured fashion, the protections for HIV funds afforded by the CG mechanism. This would ensure sufficient resources continued to be allocated to meet HIV-related targets, while also extending a form ring-fencing around the rest of PHC funds.

Detailed description

Pools of funds

Figure A2.5 depicts the potential pools of provincial health sector funds in FY 2016/17 with the creation of a National PHC Fund. Under this scenario, three existing pools of money could be combined to seed the NHIF. First, the small NHI CG could be transferred to the Fund. Second, nearly 90 percent of the current HIV CG could also be transferred to the NHIF, representing the personal preventive, care, and treatment services the grant currently covers. The remaining HIV CG funds, which currently cover public health activities like condoms procurement and distribution, demand creation for MMC, and special programmes for key populations and high-transmission areas, could be shifted to the PES (as in Figure A2.5) or retained in a small CG or another ring-fenced pool (e.g., a dedicated line item in the NHIF budget). Finally, money currently spent on PHC could be diverted from the PES into the NHIF. In FY 2016/17 this policy would shift one-third (R53.3 billion) of total provincial health budgets to the NHI Fund. The remaining two-thirds would continue to flow to provinces through the PES (R87.6 billion) and the remaining CGs (R18.6 billion), covering secondary and tertiary services, health worker education and training, facilities revitalization, and more.

Figure A2.5. Illustrative allocation of funds in FY 2016/17 for Scenario 5 (R billion).



Sources: National Treasury (2015b, 2016).

Governance of HIV funds

Scenario 5 would entail significant changes to the distribution of responsibilities across levels of government. Not only would the NHIF—a centrally managed organization—assume the purchasing functions for PHC, but the government-financed system would eventually also include a purchaser-provider split for the first time (as in Scenario 2). NDOH would set policy and quality standards by which providers would be accredited for NHIF payment eligibility. In turn, DHMOs would negotiate with the Fund and manage PHC service delivery contracts, including for HIV services, with providers in the both the public and private sectors. These contracts would need to be developed on the basis of adequate data collection systems to track service delivery outputs and outcomes and the financial performance of provider organizations. The role of provinces in this scenario would be less clear; the NHI White Paper (2015) suggests PDOHs may support managers and monitor and evaluate service provision.[23]

The accreditation and payment systems implied by the creation of the NHIF could enable significant oversight and accountability, albeit quite different from the current system. First, accreditation for NHIF payment eligibility would be a critical initial check on capacity and quality. PHC providers would have to demonstrate readiness to deliver all services in the benefits package in accordance with quality standards, both established at the national level. Second, the country's HMIS would be improved to enable continual monitoring of service delivery and patient outcomes. Providers excelling in meeting quality standards and coverage targets could be rewarded with performance-based payments on the basis of HMIS data, while poor performers could be targeted for support or ultimately sanctioned. Like scenario 2, this scenario would also open the door to demand-side checks on quality. For example, published performance data could inform patient choice of provider, at least in areas with multiple options.

Purchasing of services

Establishing a National PHC Fund would enable a shift from input-based to output-based payment for PHC services, as well as a purchaser-provider split. The transition would involve considerable changes to public financial management systems and capacity building in facilities and districts to negotiate service contracts and optimize service delivery inputs to fulfil those contracts. One key precondition for purchasing would be the simple mechanics of transferring money from the NHIF to providers, which itself would require all providers to have bank accounts into which the funds could flow.[24] Enabling such transactions would be but one of many important steps toward establishing a purchasing system. Others would include determining appropriate payment mechanisms, which could include capitation, case-based payments, global budgeting, fee-for-service, and others.

The NHI White Paper (2015) proposes a blend of capitation and performance-based payments for PHC services. Other mechanisms could also be desirable. For example, while capitation might promote efficient delivery of PHC services in general, a separate fee-for-service payment could be useful to reward providers for large volumes of one-off preventive activities like MMC.

Implementation and pathway to NHI

Creating a functional NHIF capable of strategic purchasing would require several years of capacity building and preparation at all levels of the health system. Legislation to establish the NHIF and its governance would need to be passed, and the annual DORA would need to alter how much revenue flowed through the PES. Concurrently, several thousand PHC facilities and their associated DHMOs would need to prepare for their new financial management responsibilities. This might mirror the proposed shadow budgeting process to prepare the country's 10 national hospitals for DRG payments, though on a much larger scale. High-performing Ideal Clinics would be a natural starting point for developing the relevant financial management capacity and practices, which could then be replicated in all other clinics. In the interim, and akin to Scenario 4, the NHIF could operate as a large PHC conditional grant with direct transfers to provinces and districts for their respective functions, as described above.

In the long run, this scenario would be a clear step toward a comprehensive NHI system, and a National PHC Fund may fit well the concept of a Transition Fund mentioned in the White Paper (2015). Once the PHC benefits package were established and the NHIF were operational, steps could be taken to incorporate secondary and tertiary services into the scheme. This would require expanding the scope of the benefits package and consolidating additional funds in the NHIF, including remaining DOH conditional grants and eventually the rest (or almost all) of health-related PES funds. For purchasing, this scenario would align with the NHI White Paper (2015)'s proposals for provider payment. Section 8.5.1 (paragraph 351) lays out a gradual process of incorporating risk adjustment into determining the PHC capitation rate, eventually "taking account of the epidemiological profile of the catchment population." Scenario 5 might require starting with separate payments for PHC and HIV services until the latter could be folded into a risk-adjustment formula for the former.

Impact on health system performance

Effect on HIV response

An NHIF focused on PHC would cover a range of services, including personal HIV preventive, care, and treatment services. The NHIF would represent a protected pool

[23] Paragraph 314 in the NHI White Paper (2015) refers only to the Department of Health without specifying whether these functions are to be fulfilled by the national or provincial sphere, or both.
[24] Providers could receive payments directly, or DHMOs could receive funds and manage or distribute them on behalf of individual facilities.

of funds dedicated to PHC but not specifically HIV; however, its contractual and performance management arrangements with districts and providers could enable extensive monitoring and accountability for HIV care. Certain payment arrangements, like capitation, could encourage underprovision of services,[25] though these incentives could also be counter-balanced with complementary performance management and oversight mechanisms. Additionally, if the Fund contracted with private providers, the available capacity for and quality of HIV services could increase. However, cost containment could become a concern in the private sector, depending on how reimbursement rates were determined and adjusted.

The vitality of non-personal HIV services might be less certain under Scenario 5. Alongside full integration of financing for personal HIV services into the Fund, this scenario proposes giving provinces full responsibility for public health–oriented activities, such as condoms distribution, programmes in high-transmission areas, demand creation for MMC, and more. The default option would be to blend the associated funds into PES allocations, removing the oversight mechanisms of the current CG framework. Such activities could still be included in the non-negotiables and subject to a form of earmarking. Alternatively, a variant of Scenario 5 could retain the non-personal services portion of the CG funds in a ring-fenced mechanism for management at the provincial level with significant oversight by NDOH. This could be a very small CG, as in Scenario 2, or a protected set of line items within the NHIF's budget.

Two additional NHI design choices could affect access to HIV services. First, coverage would depend in part on NHI enrolment processes, in particular whether HIV patients would be automatically enrolled and whether enrolment would be required to access HIV services. Second, and related, coverage could be affected by NHI cost-sharing provisions, including the need for enrolees to contribute premiums or co-payments in order to access care. Encouragingly, paragraph 146 of the NHI White Paper (2015) states that "NHI card holders will not be expected to make any out-of-pocket payments such as co-payments and user fees at the point of health care delivery." If this approach prevailed, universal enrolment of people living with HIV would be essential to ensuring equitable access to HIV services, but cost sharing should not pose any obstacles.

Scenario 5's effect on the HIV programme would depend on a number of additional policy choices. It would be reasonable to expect continued planning, resource allocation, and monitoring for essential HIV services (as under the current HIV CG), though the fate of certain population-level prevention activities might be less certain. Integrated PHC payments (e.g., capitation) may also divert funds previously intended for HIV to other PHC services. Provider contracts would require complementary mechanisms for enforcing accountability for HIV-related outputs and outcomes. Moreover, NHI design choices about enrolment procedures could affect access to HIV (and other) services, at least for certain populations. Therefore, **Scenario 5's effect on HIV services would uncertain (?) and possibly unfavourable (-)**, though there would also be some potential for improved capacity, quality, and efficiency of HIV service delivery.

Effect on PHC services

Scenario 5 has the potential to improve PHC service quality through strategic purchasing and performance management. The design and implementation of these systems would depend on how successfully the Fund can link financing to clinical behaviours, thereby incentivizing improved and more efficient practices by facilities and health care workers. A PHC benefits package would necessitate developing capacity at the district and provider levels to plan and manage budgets and monitor performance against various standards. If these mechanisms bore the benefits the existing CG framework has accrued for HIV care, access to quality PHC services could increase substantially. Contracting with the private sector could yield additional gains. The concerns about enrolment and cost sharing mentioned above for HIV would also be germane to other PHC services, and in particular care would be needed to ensure that access to services were equitable across income levels, geographies, and other important dimensions. Despite these risks, the potential gains to PHC quality through improved planning and monitoring would be compelling. Consequently, **Scenario 5 could have a favourable (+) impact on PHC services.**

Effect on health system efficiency

Creating a National PHC Fund would eliminate the need for parallel planning and monitoring systems for HIV and other PHC services, but it would also require substantial investment in building the Fund's capacity to manage contracts and issue payments, as well as the ability of districts and facilities to manage funds and service delivery. These would require additional personnel and systems. In theory, savings could be realized in a handful of ways. First, the government is already designing an evidence-based approach to defining and modifying the NHI benefits package. By focusing on preventive and cost-effective services (i.e., allocative efficiency), the government could reduce costs across the system. Second, NHI payment policies could be designed to incentivize improved technical efficiency at the facility level. Policy makers noted two main options: (1) a robust facility-level performance management system within the existing input-based budget financing arrangements; or (2) performance-based payments built into active purchasing if a purchaser-provider split is implemented. The extent to which payment policies would influence clinical behaviours would depend in large part on whether the government can tie health care worker compensation to performance. There would also be an important role for improved management structures and practices. **Due to the many additional factors that would determine how efficiently a PHC-HIV**

[25] However, the evidence on capitation's effect on service provision and quality, relative to other payment mechanisms, is both mixed and limited to high-income countries. In a systematic review, Lagarde et al. (2010) finds no evidence that American patients in capitated Medicaid schemes experience worse outcomes than those with FFS plans.

insurance scheme will operate, the relative efficiency of Scenario 5 is uncertain (?), though there certainly would be potential for efficiency gains if necessary capacity were built and payment policies were well designed.

Feasibility

Legal feasibility

Establishing a National PHC Fund would require legislation amending the National Health Act of 2004 to create the Fund, its governance structure, and the process by which the benefits package would be defined and modified over time. The policy design process would likely be protracted. The NHA 2004 was based on a White Paper published in 1997. If the NHI timeline were similar, authorizing legislation might not emerge for another 5–7 years. **Because the scenario requires major legislative changes, some of which would be difficult to achieve in the next three to five years, the legal feasibility of this scenario is low to medium.**

Political feasibility

With respect to political feasibility, Scenario 5 would likely be supported by those stakeholders keen on the realization of the government's NHI vision. Consequently, NDOH is likely to strongly support this scenario. However, the timing and pace of implementation would determine to what extent NDOH and its various internal constituencies favoured this ambitious approach over a more incremental step like Scenario 2 or 4. For instance, the HIV division might be wary of any financing integration that undermined or complicated the setting of ambitious national treatment and prevention targets to which provinces (or districts and providers) could be held accountable. Provincial HAST Directors and HIV advocates might share this view. An additional concern could be the fate of HIV-related public health activities currently funded by the CG, such as activities for high-transmission areas, demand creation for MMC, condoms distribution, and more. To be fully integrative, Scenario 5 proposes folding the relevant funds into PES resources, which could jeopardize the programmes unless NDOH included them among the non-negotiables and successfully enforced compliance. Alternatively, funds for these activities, which account for about 12 percent of the HIV CG, could be retained in a small CG or a nationally controlled pool, such as a dedicated line item on the NHIF's budget.

The extent to which provinces would resist greater centralization of the health budget is unclear. PDOHs might view such reform favourably if it entailed an increase in resources available to them, but with a fixed resource envelope for health, both Provincial DOHs and Treasuries might oppose any effort to reduce their financial autonomy.

The NHIF could imply a new approach to performance management, either within the current labour arrangement or under a refashioned system that involves performance-based financing. In either case, facility and district managers would need the training, systems, and authority to manage their personnel and make staffing decisions according to service delivery needs and efficiency objectives. Public-sector employees are likely to oppose—strongly—reforms that endanger job security or the guaranteed salary and raise schedules that have been negotiated with the government.

In summary, this scenario could enjoy fairly strong support at the national level but might invite caution from provincial authorities and HIV advocates. Labour unions might strongly oppose it. Therefore, the **political feasibility of this scenario is medium.**

Technical feasibility

Implementing a National PHC Fund would require considerable new financial management and performance monitoring capacity. As noted above, many basic reforms would be required to enable a purchaser-provider split and simple financing transactions between the NHIF and providers. In additional to creating new mechanisms for transferring funds and designing payment mechanisms, capacity in the form of trained managers and information systems would need to be built at multiple levels of the health system. Facilities would need personnel capable of managing budgets and service delivery inputs, while NDOH would need to define a PHC benefits package whose cost informed the pricing of contractual agreements between the NHIF and providers. Moreover, there is currently no standardized system for establishing or enforcing PHC service targets, so the HMIS would need to be modified to track PHC outputs and outcomes, and health care workers and data capturers would need training to document relevant clinical data.

Some of this capacity could be built atop existing systems developed primarily for HIV services. The CG framework entails extensive business planning, resource needs estimation, and performance monitoring for HIV services. These practices could be extended to the rest of PHC and ingrained at the facility level under an NHI system. The non-negotiables might also be a useful basis for more robust reporting on PHC spending. Finally, some efforts are underway to better understand the costs of PHC service delivery and integrated HIV care; this research would need to accelerate.

Despite applicable capacity in the current system, Scenario 5 would require substantial investment to capacitate a new Fund, districts, and providers for more active purchasing of PHC services. Some implementation steps would be potentially straightforward, such as setting up provider bank accounts, while others would require considerably more time and effort, such as training a large cadre of facility-based financial managers. In recognition of the magnitude of the capacity building effort that would be needed to launch the NHI system, even if just for PHC, the **technical feasibility of this scenario is low when considering a three- to five-year timeline.**

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