Free State Provincial AIDS Spending Assessment Brief (2007/08-2009/10)

April 2013

SANAC and UNAIDS commissioned the national and provincial HIV/AIDS and TB spending assessments (NASA and PASAs).The overall goal of NASA was to contribute to the strengthening of comprehensive tracking of actual spending from all sources that comprises the national response to HIV/AIDS and TB in South Africa, to leverage both technical and financial support for the development, implementation, management, monitoring and evaluation of the national HIV/AIDS and TB response. The overall aim of the assessment was, in its initial phase, to implement an AIDS Spending Assessment in the Free State (FS), for the years 2007/08 to 2009/10.

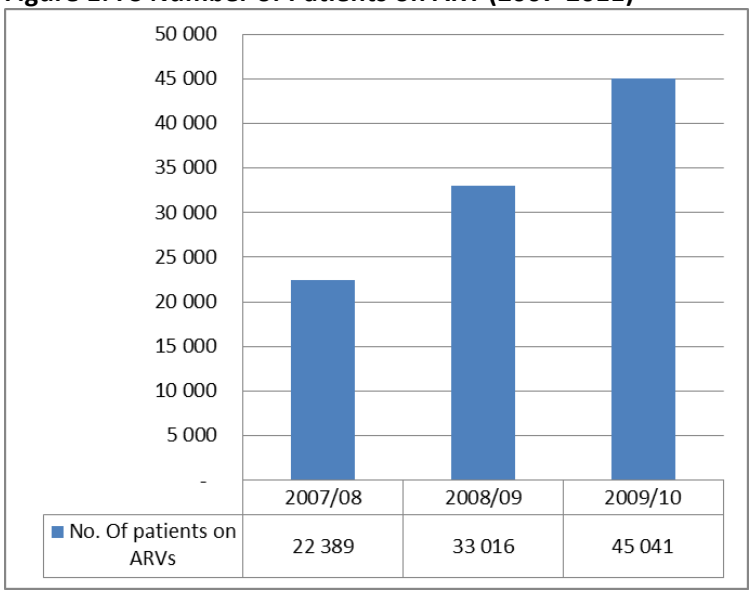
Total HIV/AIDS and TB spending in Free State

In addition to the burden placed on the population by poverty, the Province faces a high mortality rate of 299 per 100,000 live births. The mortality rate for children under five years of age is 68.2 per 1000 and the infant mortality rate is 48.1 per 1000. The high prevalence of chronic infectious diseases such as Tuberculosis and HIV/AIDS has contributed significantly to the increasing burden of disease[1]. The FS DOH reports that the top four specific causes of death in the FS are either HIV or diseases directly related to HIV. They are: Pneumonia; other ill-defined and unspecified causes of mortality; Tuberculosis; and HIV[2].

The recent ANC survey (2011) found that FS's HIV prevalence amongst the general population as 30.6% in 2010 and 32.5% in 2011. FS is now just under KZN's prevalence rate of 37.4% and Mpumalanga (36.7%).[3] According to the ASSA provincial modelling, there were 351,745 people living with HIV in FS in 2011. **Figure 1** shows the number of patients on antiretroviral treatment (ART) for the years 2007-2011. The ASSA Provincial modelling estimated 97,947 people on ART in FS in 2011. The DORA targets estimated the number of ART patients in care for FS to be 142,243 in 2012/13, 174,296 in 2013/14 and 199,373 in 2014/15.

[1] Free State Province Estimates of Provincial Revenue and Expenditure 2011/12.
[2] Free State Department of Health. Annual Performance Plan 2011/12 to 2013/14.
[3] The National Antenatal Sentinel HIV and Syphilis Prevalence Survey, South Africa, 2011, National Department of Health

Figure 1: FS Number of Patients on ART (2007-2011)



Source: Information provided by FS DOH

Reportedly, the HIV prevalence rate among women aged 15-49 attending public antenatal clinics dropped from 30.3 per cent in 2005 to 30.1 per cent in 2009 (a small 0.2 per cent drop), but a notable improvement from a high of 32.9 per cent in 2008.[4] The 2011 ANC survey noted FS HIV prevalence among antenatal women increased from 30.1% in 2009 to 30.6% in 2010 and 32.5% in 2011.[5]

According to the Stats SA General Household Survey (GHS) of 2009, 24.3% of South African households had a member who belonged to a medical aid scheme. In the FS, the coverage was lower, at 18.0%[6]. Given the health indicators of the FS population and the Province's poverty rates, the FS DOH faces an increasing patient load.

At the time of the NASA assessment , the FS provincial health system composed of facilities for first contact from patients (including mobile clinics, fixed clinics and community health centres) as well as district, regional, academic, psychiatric and military hospitals. There were 310 primary health care facilities (first contact), of which 27% were mobile clinics and nearly 70% were fixed clinics. The FS DOH ran 24 district hospitals and five regional hospitals. The hospitals include primary, secondary and tertiary facilities, and provide in-patient and out-patient care, supported by a referral system[7].

The AIDS Spending Assessment in the Free State sought to capture all public, external (donor) and business sector contributions to the HIV/AIDS and TB response in the province, in 2007/08, 2008/09 and 2009/10. The Assessment excluded household and individual contributions (out-of-pocket expenditure), including payments made to traditional healers. This may be a large component of the total spending on HIV/AIDS and TB in the province, and should be included in future spending assessments.

[4] Free State Province. Estimates of Provincial Revenue and Expenditure 2011/12. Pg. 17.
[5] The National Antenatal Sentinel HIV and Syphilis Prevalence Survey, South Africa, 2011, National Department of Health
[6] Free State Province Estimates of Provincial Revenue and Expenditure 2011/12.
[7] Free State Department of Health. Annual Performance Plan 2011/12 to 2013/14.

In 2007/08, FS spent R360.5 million on HIV/AIDS and TB, increasing by 34% to R481.5 million in 2008/09. In 2009/10, the amount increased again by 30% to reach R626.2 million. Bearing in mind that not all the external funds could be captured at the provincial level, and that the business sector was reluctant to share their expenditure, these may be underestimations to some degree. Although a proportion of the PEPFAR funds is missing from the total figures, it was estimated that approximately 85% of the total provincial spending has been captured.

When adjusting for total population size (2.8 million), FS spent approximately R224 per person on HIV/AIDS and TB in 2009/10, making it the fourth highest spending province *per capita*, after KwaZulu-Natal (KZN), North West (NW) and Northern Cape (NC) provinces.

Sources for HIV/AIDS and TB in the Free State

In 2009/10, public sources contributed 90% of total HIV/AIDS and TB funds, while external and private sources contributed 8% and 2% respectively. The contribution from public funds averages 83% throughout the three-year period.

While the contribution from private funds has remained steady at about 9% of total HIV/AIDS and TB expenditure over the study period, the contribution from external funds jumped from R7 million in 2007/08 to R57.4 million in 2008/09, due to a large injection of bilateral aid. As a result, external sources as a share of total expenditure rose to 12% in 2008/09, from just 2% in the previous year.

Bilateral organisations were responsible for the largest portion of externally sourced HIV/AIDS and TB funding, totaling R289 million or nearly 70% of total external funds over the three-year period. Nearly 90% of total bilateral aid over this three-year period was sourced from the USA. The second-largest bilateral aid contributor was the United Kingdom (UK), followed by Ireland. The primary multilateral donor was the European Union (EU), which contributed a total of R20 million in 2008/09 and 2009/10. The World Bank was the second-largest multilateral contributor, giving an average of R1.85 million each year. UNAIDS and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) made smaller contributions of less than R1 million each.

Private sources – which include For-Profit businesses, Not-For-Profit NGOs and out-of-pocket expenditure (OOPE) –increased substantially, rising from R29.5 million in 2007/08 to R54.3 million in 2009/10. The majority of the spending came via medical aid schemes. Together, employee and employer contributions make up 8% of the total HIV/AIDS and TB spending in 2009/10, and 90% of total private HIV/AIDS and TB spending. However, many other businesses could not provide province-specific data, and thus For-Profit funds are likely to be under-represented here.

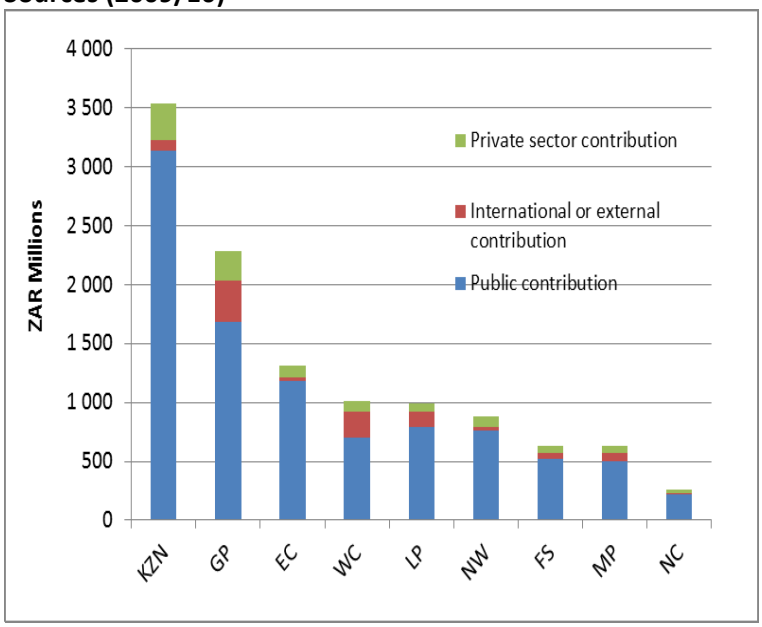
Table 1: Sources of all HIV/AIDS and TB Spending in the Free State (ZAR, 2007/08 - 2009/10)

Sources		2007/08	Share of total	2008/09	Share of total	2009/10	Share of total
Public							
Private	Medical Aids	13 811 291	3.8%	18 793 627	3.9%	25 094 641	4.0%
	Medical Aids	12 568 577	3.5%	17 654 694	3.7%	23 795 658	3.8%
External							
Totals		**360 550 234**	**100%**	**481 551 103**	**100%**	**626 137 902**	**100%**

Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

Figure 2 provides a comparison to HIV/AIDS and TB spending in other provinces.[8] It shows that HIV/AIDS and TB spending in 2009/10 in Gauteng exceeded spending in all the other provinces, excepting KZN.

Figure 2: HIV/AIDS and TB Spending in South African Provinces – Public, Private and External Sources (2009/10)



Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

According to Treasury, the government spending on HIV/AIDS in FS had increased significantly again to reach R655 million in 2012/13, excluding other discretionary and hidden spending (provincial

[8] **Figure 2** excludes PEPFAR spending which was not confirmed by recipient partners.

voted funds and in-patient costs). The recent Annual Planning Tool should be able to indicate the total provincial spending, including the development partners' contributions.

Agents of the HIV/AIDS and TB funds in the Free State

As the entities which receive and send on funds to the service providers, funding agents have power in determining the spending priorities in the province. Not surprisingly, the main funding agent for HIV/AIDS and TB expenditure in the Free State is government. In 2009/10, 85% of funds were managed by government entities (including the South African Social Security Agency - SASSA), 10% by private funding agents and only 5% by external funding agents.

Looking only at publicly sourced HIV/AIDS and TB expenditure in the FS in 2009/10, national government[9] acted as funding agent for 66% of the funds, provincial government for 12%, with the balance (21%) being managed by SASSA and other public funding agents. The public funds managed by provincial funding agents include Voted Funds from the DOH, as well as some other workplace programmes in other provincial departments. The public funds managed by national government are the Conditional Grant funds for HIV/AIDS and the funds channeled to SASSA for social security grants.

Externally sourced HIV/AIDS and TB funds in FS were primarily managed by bilateral organisations (58% in 2009/10) and provincial government (26% in 2009/10). Essentially, donor aid from foreign governments was mostly being controlled and allocated to various activities by those bilateral aid agencies themselves or transferred to the province for their management.

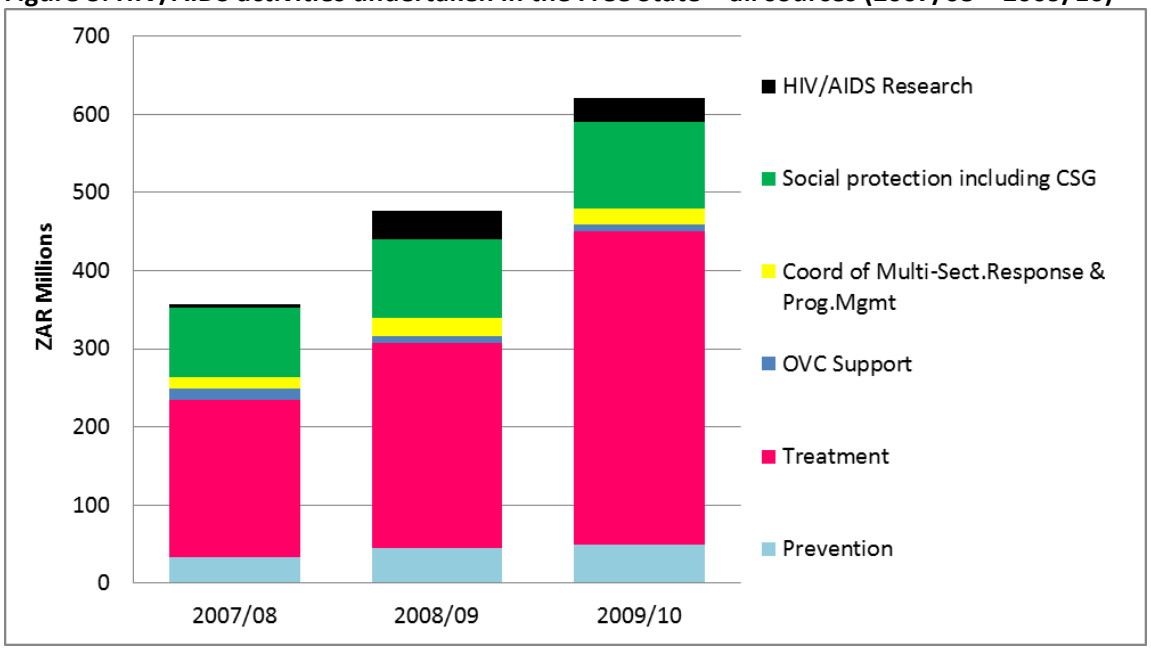
Turning to HIV/AIDS and TB funds sourced from the private sector, which were primarily the estimated contribution from the medical aid schemes, nearly all the privately sourced funds (88% in 2009/10) were managed by private medical aid schemes.

Activities the money was spent on in the Free State

The majority of HIV/AIDS and TB funds in FS were spent on treatment in all three years (See **Figure 3**). In 2009/10, the funds went to treatment (64%), followed by social protection including the Child Support Grant (18%), and prevention (8%). Five per cent of funds were spent on research activities in 2009/10.

[9] Categorised as "central public" in the graphs.

Figure 3: HIV/AIDS activities undertaken in the Free State – all sources (2007/08 – 2009/10)



Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

Notably, spending on prevention in the Free State has grown at a slower rate than increases to the overall HIV/AIDS and TB budget. However, expenditure on treatment doubled between 2007/08 and 2009/10, reaching R400 million in 2009/10. Although expenditure on social protection (including the Child Support Grant) grew from R88 million to R110 million over the period, spending on OVC support activities was cut nearly in half, from R15 million to R9 million.

Public funds and private funds were being used primarily to fund treatment, while the bulk of funds from external sources went towards research activities. Public funds also served to finance social protection and social services, to which private and external sources did not contribute. The spending within the categories is broken down below.

- **Prevention:** Overall, funds spent on prevention activities rose from R33.3 million in 2007/08 to R49.3 million in 2009/10, largely driven by increases in spending for male condoms and "prevention activities not disaggregated". Compared to R6.3 million spent on male condoms in 2009/10, only R1.9 million was spent on female condoms. Of concern is the rather low spending on most-at-risk populations, such as youth out-of-school and interventions for vulnerable and accessible population interventions (less than 1% of total prevention).

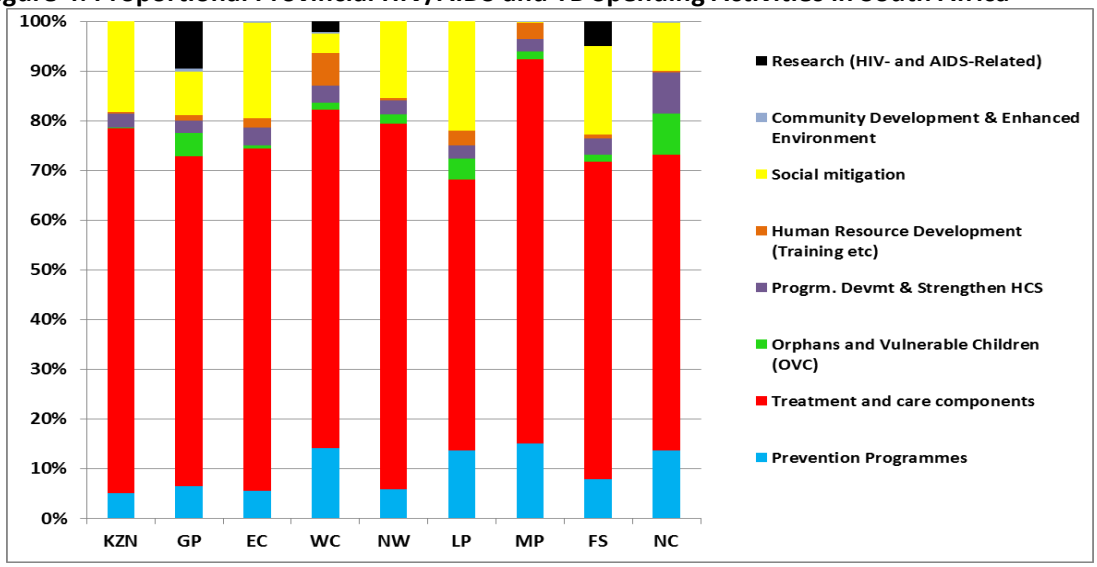
- **Treatment**: Overall, spending on treatment and care has climbed steadily, growing by 30% in 2008/09 and by 53% in 2009/10. Antiretroviral therapy (ART) consumed over half of the total treatment funds every year, amounting to R239 million in 2009/10. In-patient TB treatment took an increasing share of treatment funds, with none labeled as TB-specific in 2007/08 to R17.5 million (or 4% of treatment) in 2009/10. This was largely due to the increasing number of cases of Multi-Drug Resistant (MDR) TB. Note that the out-patient TB treatment spending could not be measured, as it is embedded in the clinics' primary health care spending and could not be disaggregated. The other key treatment activity was home-based care (HBC). However, expenditure on HBC declined from 23% of total treatment spending in 2007/08, to 10% in 2009/10.

- **Activities for Orphans and Vulnerable Children (OVC)**: R15.1 million was spent on activities for OVC in 2007/08, declining to R8.8 million in 2009/10. Almost the entire amount was

spent on community/home-based support programmes (82% over the period). It is important to note that some NGOs which receive funding for their HBC programmes also included OVC in those programmes. Therefore, the amounts here may be an underestimation. In addition, the Child Support Grant, a proportion of which was captured under the Mitigation component, also benefits many OVC, although it was not possible to obtain exact details from SASSA.

Figure 4 shows the proportional spending of all provinces. Treatment was a major consumer in all provinces. Research was a dominant activity in Gauteng Province, Western Cape and Free State with no investment recorded in Limpopo. Social mitigation was well-funded Limpopo in KwaZulu-Natal, Free State, Eastern Cape and Gauteng Province. However, Limpopo proportional spent a huge amount on prevention compared to Eastern Cape, North West, KwaZulu-Natal, Free State and Gauteng.

Figure 4: Proportional Provincial HIV/AIDS and TB Spending Activities in South Africa



Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

The beneficiaries of HIV/AIDS and TB spending in the Free State

People living with HIV/AIDS (PLWHA) were the beneficiaries of the majority of the HIV/AIDS and TB expenditure in the Province, due to the large spending on ARVs. In 2009/10, R545 billion (87% of total spending) was on programmes targeted to PLWHA, increasing from R295 billion in 2007/08.

In 2009/10, a small portion (3%) was targeted to key vulnerable groups including OVC, truck drivers, prisoners and children born (or to be born) of women living with HIV, and just 0.2% went to most-at-risk populations (MARPS) such as commercial sex workers (CSW), men who have sex with men (MSM) and intravenous drug users (IDUs). A total of R744 500 was spent on prisoners over the three-year period.

Only 2% of total spending in 2009/10 went to accessible populations, such as learners in school or college (though the Department of Education's Lifeskills programme), and health care workers (through post-exposure prophylaxis services).

Most of the spending targeted to vulnerable groups and MARPs was for prevention activities. For OVC and other key vulnerable groups, 54% of total expenditure in 2009/10 was spent on OVC support activities, and 44% was spent on prevention. Approximately 73% of spending on PLWHA in 2009/10 was for treatment and care, 20% was used for impact mitigation (including the Child

Support Grant), and the remaining 6% funded research activities. In essence, PLWHA mainly benefited from treatment and care activities, while the general population, MARPS, OVC, other vulnerable populations and accessible groups benefited mainly from prevention activities.

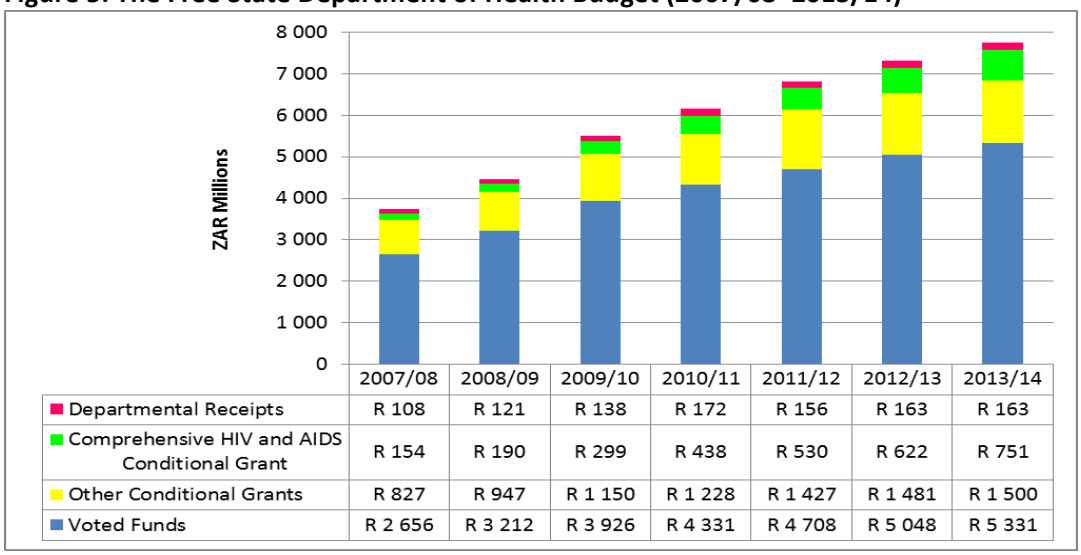
Service Providers of HIV/AIDS and TB in the Free State

The HIV and AIDS/STI/TB Unit (HAST) within the Department of Health (DOH) was the largest service provider for HIV/AIDS and TB services, delivering R255.5 million in services (or 41% of the total) in 2009/10. The Department of Social Development (DSD) and the South African Social Security Agency (SASSA) provided 19%, or R116 million, of services in 2009/10. The third-largest provider was constituted by NGOs, CSOs and CBOs, which were responsible for 17% of the 2009/10 expenditure. For-Profit providers also played an important role, delivering 8% of services in 2009/10.

The Free State Department of Health Spending on HIV/AIDS and TB

Total HIV/AIDS and TB expenditure by the DOH increased steadily over the period, rising by 34% in 2008/09 and again by 22% in 2009/10. In 2009/10, the Department spent a total of R275.7 million on HIV/AIDS and TB control.

Figure 5: The Free State Department of Health Budget (2007/08–2013/14)



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Departmental Receipts	R 108	R 121	R 138	R 172	R 156	R 163	R 163
Comprehensive HIV and AIDS Conditional Grant	R 154	R 190	R 299	R 438	R 530	R 622	R 751
Other Conditional Grants	R 827	R 947	R 1 150	R 1 228	R 1 427	R 1 481	R 1 500
Voted Funds	R 2 656	R 3 212	R 3 926	R 4 331	R 4 708	R 5 048	R 5 331

Source: The Free State Province Estimates of Provincial Revenue and Expenditure 2011/12.

Each year, approximately 90% of the funds were sourced from the CG, with the remainder coming from Voted Funds. The amount of Voted Funds rose by 64% in 2008/09, and by 10% in the following year. In contrast, the size of the CG spending increased by an average of 27% each year.

Including Conditional Grant and Voted Funds, the DOH *underspent* their total budget by 7% in 2007/08, followed by 4% overspending in 2008/09. In 2009/10, the Department underspent by 18% (R60 million). Spending rates on the Voted Funds and Conditional Grant funds varied:

- The Conditional Grant funds were 100% spent in 2007/08 and then slightly (6%) *overspent* the following year. However, in 2009/10, 17% or nearly R51 million of the CG funds were left unspent.

- In contrast, the Department consistently failed to spend all of its funds allocated for HIV/AIDS and TB from Voted Funds, although underspending was worse in the Voted Funds

used for TB than for HIV/AIDS. On average, Voted Funds were underspent by 27% each year. In total, R25 million in Voted Funds allocated for HIV/AIDS and TB activities was left unspent over the three-year period, most of which was due to funds allocated for building MDR-TB treatment centres which were unspent due to tender process delays.

In all years, the two main HIV/AIDS activities funded by FSDOH, including both the CG and Voted Funds, were antiretroviral therapy (ART) and home-based care. ART took up approximately 66% of the total DOH HIV/AIDS funds each year and amounted to over R190 million in 2009/10.

The majority of total DOH funds were spent by HAST or, more specifically, HAST was assigned as the cost centre in the public Basic Accounting System (BAS) records — approximately 61% in 2009/10. However, it is important to note that in the BAS, clinic- or hospital-level expenditure is mostly assigned to the HAST as the cost centre, rather than to the hospital or clinic itself. This may contribute to an under-reporting of expenditure at the hospital and clinic level, and an over-reporting of spending by HAST in these estimates.

NGOs were the second-largest service provider using the DOH funds, responsible for 17% of DOH spending in 2009/10. For most of the remaining amount, public hospitals, district health offices and clinics were the service providers. HAST, the hospitals and NGOs were receiving both Voted and CG funds for HIV/AIDS and TB expenditure. However, the clinics and the district health offices did not receive any Voted Funds for HIV/AIDS and TB expenditure. All of the spending by other directorates was sourced from Voted Funds.

On the whole, HAST and the hospitals were delivering ART, while NGOs were providing HBC.

The activities and service providers for the Voted Funds differed when compared to the Conditional Grant funds, as described below.

Conditional Grant Funds:

- All the CG funds were used for HIV/AIDS activities (as opposed to TB). The great majority of the CG funding was used for ART each year (76% in 2009/10). ART expenditure as a share of total CG expenditure increased from 68.5% in 2007/08 to 76% in 2009/10. The rest of the CG was primarily used for home-based care (HBC), HIV Counselling and Testing (HCT), and prevention of mother-to-child transmission (PMTCT).

- The main service provider of the DOH Conditional Grant was HAST, which spent approximately 63% of total CG funds in 2009/10. NGOs were the second largest service provider for CG funds, spending 14% of total CG purse. Some CG funds were also channelled to hospitals, District Health Offices and clinics each year.

Voted Funds:

- The Free State DOH primarily used the Voted Funds for TB control activities. An amount of R13 million (or 50% of DOH Voted Funds for HIV/AIDS) was spent on TB control in 2009/10.

- The main providers of services covered by Voted Funds were HAST and NGOs. Over the three-year period, 47% of total HIV/AIDS Voted Funds were spent by HAST, while a further 43% were spent by NGOs. Hospitals spent 9% of Voted Funds for HIV/AIDS, while a small amount was also spent by other directorates within the DOH, besides HAST. Over the three-year period, only 8% of total funds spent by HAST were sourced from Voted Funds.

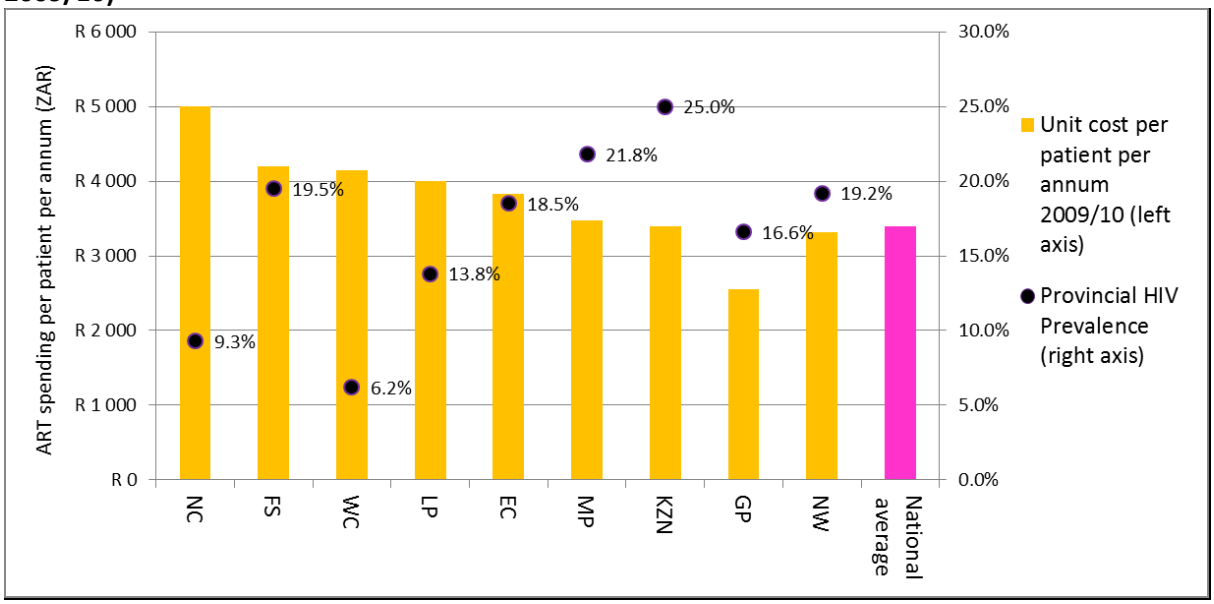
Expenditure on Antiretroviral Treatment in the Free State

Total spending on the ART programme by the DOH increased steadily from R102 million in 2007/08, to R189 million in 2009/10. Interestingly, in 2007/08, ARV drugs and Wages and Pensions each took approximately 35% of the total ART budget. However, by 2009/10, costs for ARV drugs had swelled to 63% (R118.3 million) of the total ART budget. Laboratory costs as a share of total expenditure shrank from 21% in 2007/08 to under 10% in 2009/10.

Calculated on all the costs coded as "ARV" in the Basic Accounting System (BAS) and the total number of active patients receiving ART as provided by the DOH, the rough annual per patient unit cost for ART treatment decreased from R4,578 in 2007/08 to R4,200 in 2009/10.

Figure 6 depicts the comparison between ART unit cost per patient per annum and provincial HIV prevalence rates. The Free State has the second largest ART spending per patient per annum.

Figure 6: Provincial DOH Public ART cost per patient per annum (ZAR) and HIV Prevalence (%, 2009/10)



Source: NASA (2012), UNAIDS, SANAC, CEGAA

Department of Social Development Expenditure on HIV/AIDS in the Free State

Total expenditure by the Department of Social Development (DSD) on HIV/AIDS activities amounted to R32.7 million in 2007/08, but then fell by 42% in 2008/09. In 2009/10, the amount declined very slightly to R18.2 million.

Each year, approximately R5.5 million was spent on Programme Management and Administration costs, while the remaining funds were transferred to NGOs to deliver HBC services. As the total amount budgeted for HIV/AIDS declined through the three-year period, the amount being transferred to NGOs fell sharply, but the amount spent on Programme Management and Administration costs remained fairly constant. As a result, the portion of total expenditure transferred to NGOs fell from 79% in 2007/08 to 71% in 2009/10. In 2007/08, 100% of funds budgeted for transfers to NGOs were spent, while in 2009/10, only 75% was spent.

Department of Education Expenditure on HIV/AIDS programmes in the Free State

Spending on the Life-Skills programme by the Department of Education (DOE) increased gradually over the three-year period. In 2007/08, expenditure was R9.2 million. In the following year, the amount increased by only 1%. In 2009/10, expenditure grew by 9% to R10.2 million.

Recommendations

Based on the findings of the NASA, the following recommendations are offered towards improve planning and service delivery, allocative decisions and financial management systems:

Expand the HIV/AIDS response beyond health sector: The dominance of the DOH in the response to HIV/AIDS should be balanced with increased spending on integrated HIV/AIDS services in all the other departments, particularly the DSD and DOE. Spending on OVC support, community development, enabling environment, and human and legal rights activities should be increased in the Free State and which could be best provided through NGO services.

Increase priority given to prevention: Spending on prevention in the Free State has grown at a slower rate than increases to the overall HIV/AIDS and TB budget. In order to reduce the number of persons needing treatment, it is vital that budgets are increased for those key prevention interventions that have been shown to have the greatest impact. Medical male circumcision and, potentially, the microbicides currently under development, could reduce HIV transmission rates significantly. PMTCT, condoms and post-exposure prophylaxis (PEP) remain effective interventions to be expanded.

At the same time, expanding access to ART will also reduce the levels of infectivity of HIV-positive patients, according to recent research findings.

Expand DOE's interventions: The DOE interventions are the main programmes targeting youth in school and therefore warrant expanded expenditure.

Prioritise TB prophylaxis: Spending on TB prophylaxis would contribute to a decrease in the DOH's spending on TB treatment, and greatly enhance the wellbeing of PLWHA.

Avoid crowding out by ART spending: While recognising the preventative effects of scaled-up ART access, it is equally critical that the DOH and the other departments ensure that prevention spending, and the other key activities (mitigation, research, etc.) are not crowded out. In addition, attention must be paid to other treatment requirements, such as treatment of opportunistic infections, in-hospital care, HBC and palliative care.

Increase support to NGOs and CBOs: CBOs are providing valuable HBC and other services, which offer critical support for PLWHA. Funding for NGOs and CBOs should therefore be increasing, and the DOH should be offering three-year contracts to suitable NGOs, based on performance.

Use NASA findings to inform the development of the new PSP: The findings presented here will indicate whether or not the Free State's Provincial Strategic Plan (PSP) priorities were appropriately funded. It is strongly suggested that the new PSP has clear, realistic and measureable objectives and targets that can be accurately costed to guide future allocations.

Increase transparency of funding by external sources: Development partners should be more transparent about what they are funding in the Province, as well as what they intend to commit in the longer term, in order to foster a harmonised and integrated response that is guided by the Province's priorities. This will enhance the government's ability to measure future funding requirements, and to address funding gaps in a sustained and aligned manner, so as to reduce overlap and gaps in key areas.

Improve accuracy and frequency of data collection on expenditure: The finance managers, together with programme managers, need to stipulate clear guidelines to be followed for financial data capturing and coding, so as to enable more effective budget monitoring and cost-efficient service delivery. The financial data should be linked to output indicators in a single consolidated Monitoring and Evaluation (M&E) system. There is also need for capacity-building in data management, analysis and utilisation in planning, within both the public and NGO sectors.

Centralise and institutionalise HIV/AIDS expenditure data collection: Ultimately, it is critical for improved expenditure tracking systems to be institutionalised, with detailed HIV-coding, and for these to be populated by *all actors* in the HIV/AIDS field in the Free State province. The information should be centralised and managed by SANAC and HAST, to ensure improved co-ordination and alignment of all efforts. The provincial departments should identify their capacity and skills requirements to routinely collect this data. Out-of-pocket expenditure should be included in the next expenditure tracking exercise.

Improve intergovernmental budget planning: Greater engagement of district-level public service providers is needed in managing their expenditure according to their available budgets. In order to improve programme management, there must be easy access to the BAS records.

Advocate for greater contribution from business sector: Greater commitments from the business sector, and increased provision of services for employees, would augment available funding and reduce the burden on the public health care system.