Causes and Implications of the 2008/2009 Antiretroviral Moratorium in the Free State province of South Africa

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Photo by Anso Thom

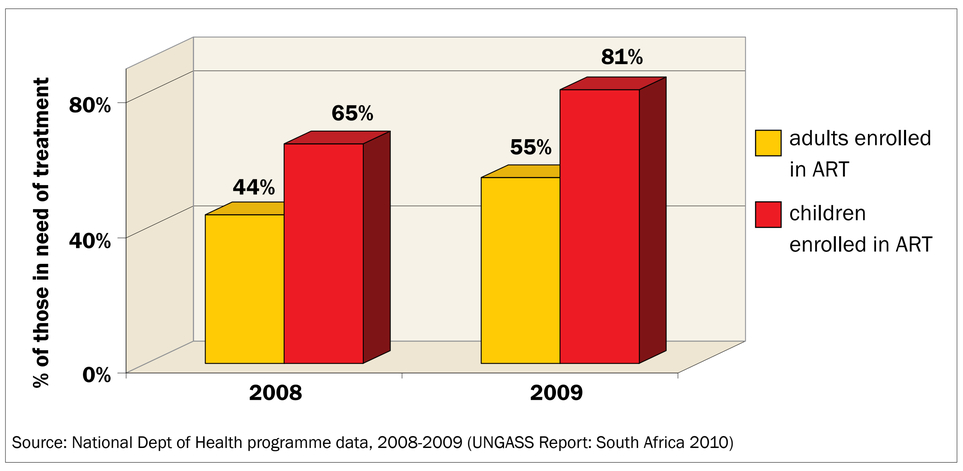
Issues:

- Between May 2004 and December 2007, one quarter of patients on the ART waiting list in the Free State died before accessing treatment (Ingle et al., 2010).
- In 2006, Free State province had lowest antiretroviral coverage in South Africa at 24.5% (ASSA2003).
- In November 2008, an antiretroviral treatment moratorium was enacted in the province.
- The moratorium lasted for four months. No new patients were initiated onto treatment during this time.
- Other cost curtailment measures reduced healthcare services available in the province.
- All outreach services terminated (except oncology).
- Clinical admissions limited to 'dire need only' (Free State Dept of Health, 2008).
- First official cessation of a provincial antiretroviral programme in South Africa.
- Valuable case study for state's response to systematic and health infrastructural problems in public roll-out of ART.

Background

- Dept of Health under Health Minister Tshabalala-Msimang obstructed access to ARVs (Nattrass, 2007).
- Ten year legacy of financial mismanagement, lack of accountability and poor oversight of provincial service delivery.
- September 2008, Barbara Hogan appointed new Minister of Health.
- Poor governance and financial mismanagement = total health overspend of approx R10 billion for the financial year 2008/2009 (ALP, 2009).
- After ARV moratorium implemented in the Free State, Hogan commissioned a national study to establish key cost drivers in health.
- HIV policy formulated at national level but implemented at provincial level.
- Rapid scale-up of ART to 55% of adults in need in 2010, according to National Dept of Health (see figure 1).
- Ambitious targets: National Strategic Plan aimed for 80% ART coverage by 2011.
- Priorities at national level not aligned with capacity at provincial and district levels.
- Provinces left to develop targets for patient initiation of ART, plan budgets and scale-up services.
- Free State province had no clear methodology to set targets and align these with budgets.
- National Dept of Health meant to play oversight role, approving provincial business plans and monitoring implementation.
- Unclear whether National Dept of Health provided any assistance in meeting ART patient targets.
- Free State struggled to initiate patients onto ART as quickly as possible.
- Model of ART provision through a small number of centrally located clinics unable to meet patients' demands.
- Legacy of obstructive accreditation process, human resources shortages and health infrastructural inadequacies.

Figure 1: Percentage of adults and children in need of receiving ART, South Africa 2008/2009



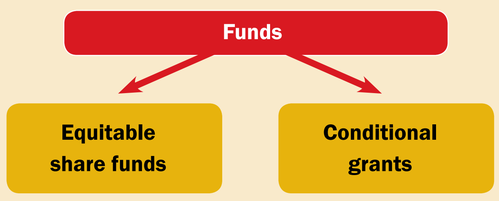
Source: National Dept of Health programme data, 2008-2009 (UNGASS Report: South Africa 2010)

Lessons learned:

Moratorium caused by financial mismanagement, bureaucratic malfunctioning, capacity constraints and lack of M&E.

Financial Causes

- Two primary forms of transfer allocated by national government to provinces to fund service delivery.
- **Equitable share funds** = unconditional. Provinces may divide these funds between departments and programmes as they see fit.
- **Conditional grants** = transferred to provincial departments to spend on specific programmes. Ensure that provinces have sufficient funds to implement programmes developed nationally. Supplement service delivery and compensate for resource provision that benefits inhabitants of more than one province.



- Free State Dept of Health officials claimed the moratorium was caused by general lack of health funding and specific lack of funding for the HIV Conditional Grant.
- Argued that 'unfunded mandates' exhausted the Free State's health budget, including increase in patient numbers; Occupational Specific Dispensation (wage increase for nurses), takeover of mortuaries from South African Police Services; global recession & increased inflation rates on medical goods and services). (Belot, 2009)

- Free State had second highest antenatal HIV sero-prevalence in 2007 of 33%, and provided healthcare to patients from the Eastern Cape and Lesotho seeking better services = increased demand for HIV and other health services in the province. (Barron et al., 2009)
- Proportion of the national conditional grant allocated to the Free State Dept of Health from 2005/06 to 2008/09 (with increases over the Medium Term Expenditure Framework) declined. (figure 2)
- Over time, substantially disadvantaged the province's health system.

Figure 2: National Conditional Grants to Provinces

Grant	Financial year	R000 Total Conditional Grant to Provinces	R000 Free State Provincial Allocation	% Allocation of National Grant
Comprehensive HIV & AIDS Grant	2005/06	1 150 108	100 874	8.77%
	2006/07	1 616 214	142 265	8.80%
	2007/08	2 0006 223	153 646	7.66%
	2008/09	2 885 400	189 630	6.57%

Source: Report of the Integrated Support Team: Free State Dept of Health (April 2009)

- National Treasury and National Dept of Health expect provincial Health Depts to top up funding allocated to conditional grants using their Equitable Share.
- Free State's health allocation from equitable share remained fairly constant at approximately 25%.

Photo by Anso Thom

Figure 3: Allocation of Provincial budget to Health (excluding conditional grants)

Financial year	R m Adjustment Provincial Budget (excl Grants)	R m Adjustment Health Budget (incl Grants)	% Allocation to Health
2005/06	9 359	3 118	24.75%
2006/07	10 076	3 369	24.18%
2007/08	11 281	3 744	24.50%
2008/09	13 313	4 469	25.03%

Source: Report of the Integrated Support Team: Free State Dept of Health (April 2009)

- But from 2004/05, Free State Dept of Health overspent its health budget each financial year until a change in provincial cash delegations prevented further overspending.
- Reduction of over-expenditure led to a rapid increase in outstanding accruals and rationing of health services (through cost curtailment measures including the ART moratorium). (Barron et al., 2010).

Bureaucratic Malfunctioning

- From 2005 – 2008, important positions within Free State Dept of Health were vacant or filled only by acting managers, including Head of Dept.
- Accounting functions therefore centralised within MEC's office.
- Free State Dept of Health still unable to curb overspending.
- Free State Dept of Health had no audit committee or plan to regulate internal auditing for financial year 2008/2009.
- Pharmaco-vigilance and medical depot staff responsible for drug management worked in different clusters, impeding co-ordination of drug procurement, distribution and monitoring.
- Efficiency problems with medical depot. Orders supplied within 2 weeks in 2005/2006 took 6 – 8 weeks by 2008/2009 (Barron et al., 2010).
- Free State Dept of Health did not prioritise drug budgets. Struggled to procure and distribute adequate supplies of drugs to break the moratorium and begin initiating new patients in March 2009.

M&E

- Weak information systems and poor M&E of the ARV programme meant that Free State Dept of Health could provide only rough estimates for how many people were on ARVs in 2008.
- Ineffectual monitoring and information systems across national and provincial Health Depts and Treasuries therefore resulted in poor formulation of targets and recording of patient numbers.
- Failure to integrate patient initiation with targets led to increased demand for drugs which outstripped the province's budget.

Photo by Sam Reinders

Human Resources & Equipment Problems

- Human resource shortages combined with software problems meant that health workers could not input and access accurate data about ARV programmes at their health sites.
- Between March 2008 – March 2009, 433 health workers left their posts, partly because of demoralising effects off cost curtailment measures (Barron et al., 2009.)
- Health technology and infrastructure suffering from lack of investment.
- Clinics overcrowded, lacked basic equipment from gloves and fridges to telephones and electricity (ALP, 2009).
- Situation worsened by higher medical inflation than budgeted for by the province.

Conclusion:

The ART moratorium:

- Prevented new patients from accessing treatment.
- Led to drug shortages for patients already on treatment, including children.
- Obstructed access to CD4 count tests & results.
- Further compromised accuracy of ART waiting lists.
- Undermined HIV prevention initiatives in the Free State province.
- Frustrated public confidence in the health system.
- Demoralized healthcare workers.
- By March 2009, 15,000 patients were on the waiting list for ART in the Free State (UNGASS Report: South Africa 2010).
- Protocol for addressing the backlog advised that all remaining patients be initiated onto ART within 8 weeks = unrealistic.
- In cases of unavoidable treatment interruption, realistic protocols for patient triage must be implemented.
- The financial, bureaucratic and health infrastructural problems that resulted in the moratorium remain unsolved.
- September 2009, another moratorium on ARVs was implemented in the FS.

'In this 30-bed ward, we see between three and four deaths a day. It is terrorizing us. It really feels like we are going back to the bad old days before there were ARVs'

- Nurse from Bongani Hospital (Thom and Langa, 2009)

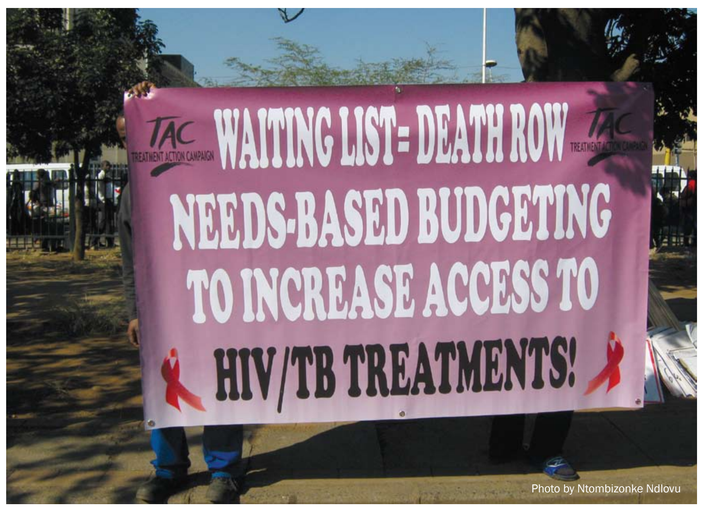


Photo by Ntombizonke Ndlovu

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Thank you

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