

**Consolidated Report  
of the Integrated Support Team**

**Review of health overspending and  
macro-assessment of the public health  
system in South Africa**



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The views presented in this report are those of the authors and based on inputs received during the interview process and documentation analysed and do not necessarily represent the decisions, policy or views of the National Ministry of Health or the Provincial Departments of Health.

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## Abbreviations and Acronyms

AFS	Annual Financial Statements
AIDS	Acquired Immunodeficiency Syndrome
ANHP	Annual National Health Plan
APP	Annual Performance Plan
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BAS	Basic Accounting System
BUR	Bed Utilisation Rate
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHC	Community Health Centre
DFID	UK Government's Department for International Development
DG	Director-General
DHIS	District Health Information System
DHS	District Health System
DMT	District Management Team
DOH	Department of Health
DPSA	Department of Public Service and Administration
ECDOH	Eastern Cape Department of Health
EDL	Essential Drug List
EMS	Emergency Medical Services
FSDOH	Free State Department of Health
GDOH	Gauteng Department of Health
GDP	Gross Domestic Product
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HR	Human Resources
HSS	Health Systems Strengthening
ICT	Information and Communication Technology
IMCI	Integrated Management of Childhood Illnesses
IST	Integrated Support Teams



IYM	In Year Monitoring
KZDOH	KwaZulu-Natal Department of Education
LDHSD	Limpopo Department of Health and Social Development
M&E	Monitoring and Evaluation
M&OD	Management & Organisational Development
MACH	Ministerial Advisory Committee on Health
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MDOH	Mpumalanga Department of Health
MEC	Member of Executive Council
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
N/A	Not available/ not applicable
NCDOH	Northern Cape Department of Health
NDOH	National Department of Health
NHA	National Health Act
NHISSA	National Health Information System of South Africa
NHLS	National Health Laboratory Service
NIDS	National Indicator Data Set
NSP	National Strategic Plan (on HIV&AIDS and STIs)
NTSG	National Tertiary Services Grant
OSD	Occupational Specific Dispensation
PDE	Patient Day Equivalent
PERSAL	Personnel and Salary Administration System
PFMA	Public Finance Management Act
PHC	Primary Health Care
PMTCT	Prevention of Mother-To-Child-Transmission
RACI	Responsible, Accountable, Consulted, Informed
RRHF	Rapid Response Health Fund
STI	Sexually Transmitted Infection
STP	Service Transformation Plan
TB	Tuberculosis
TR	Team Representative
WCDOH	Western Cape Department of Health
WHO	World Health Organization



## Executive Summary

*“Things fall apart; the centre cannot hold; Mere anarchy is loosed upon the world”<sup>1</sup>*

The accompanying consolidated report contains the background, methods, results and recommendations of the reviews conducted by the Integrated Support Team (IST). The IST was established in February 2009 at the initiative of the then honourable Minister of Health, Ms Barbara Hogan. The review was prompted by the projected overspending in some of the provinces during the 2008/09 financial year, because overspending has the potential to undermine the capacity of the national health system to improve health outcomes, in particular the health sector’s response to the HIV epidemic.

This summary reflects only the critical strategic issues and associated recommendations that should be prioritised for intervention. It does not purport to be a full summary of all the issues and recommendations. These are to be found in the detailed provincial health and national IST reports, which should be read in conjunction with this consolidated report.

This consolidated report comes at a time when South Africa has started her fourth period of democratic government. This provides an exciting opportunity to reflect on past performance and identify or revise strategies that will improve health system performance in order to achieve better health outcomes of the people served. We found many committed, hard-working managers and health professionals, who are willing to contribute to change and implement ongoing health system transformation policies. The foundation for a well-performing health system is largely in place and a comprehensive and wide range of public health services are available to South Africans. In addition, there were many examples of good practice and a few of these have been highlighted in the individual reports.

The review, however, found many shortcomings, ranging from strategic planning and leadership, through to financial management and monitoring and evaluation. Although we recognise the complexity of the health sector, and the time required to observe measurable

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<sup>1</sup> William Butler Yeats. The Second Coming



change, there is urgency to address the weaknesses identified and take forward the priority recommendations contained in the report.

It is clear, in our view, that if the issues raised in our reports are not addressed fundamentally, the system will increasingly come under more pressure with mounting negative consequences.

## **1. FINANCE**

### **1.1. FINDINGS FROM THE FINANCIAL REVIEW**

1.1.1. The exact amount of overspending is significantly understated. The public health system had at 1 April 2009 a significant deficit which needs to be settled in order to allow space to improve overall health system performance and effectiveness of service delivery. The magnitude of this deficit is estimated to be least R7.5 billion and was due to:

1.1.1.1. Bank overdrafts at 31 March 2009 as a result of 2007/08 overdrafts carried forward and over-expenditure in 2008/09.

1.1.1.2. Abnormally high accruals at 31 March 2009 not yet paid.

1.1.2. The current model for the scale up of anti-retroviral therapy (ART) for people with AIDS is unsustainable from a health system perspective and unaffordable from a budgetary perspective.

1.1.3. There are a variety of “unfunded mandates” causing pressures on the allocated health budget which are beyond the control of the accounting officers (HODs). Examples of these include the costs of occupational specific dispensation (OSD) that are not fully budgeted for, or funded; new policies introduced by the Ministry of Health (MOH) such as dual therapy for PMTCT; and new vaccines that are not sufficiently funded; unfunded legislative requirements (e.g. the creation of the district health system and takeover of local government functions and staff); and promises made by MECs (e.g. new clinics) for which funds have not been budgeted.



1.1.4. NDOH criteria for the determination and allocation of conditional grants are not sufficiently objective, quantifiable or transparent and the related administration, monitoring, evaluation and accountability arrangements require improvement. There is a lack of adequate financial management, reporting and accountability processes, as envisaged in the PFMA, and overspending occurs, often with minimal or no consequences. The budgeting bid process, lead by the NDOH, must be substantially improved. These shortcomings lead to an inability to manage overall public health sector performance.

1.1.5. A financial management improvement plan should be launched with the NDOH taking the lead and overall responsibility.

## **1.2. FINANCE RECOMMENDATIONS**

1.2.1. The exact amount of the financial backlogs in each province should be accurately determined with the NDOH CFO taking the lead, and a consistent plan of action to deal with this must be implemented. While a certain element of “bailout” is considered inevitable, the action plan should include preventive measures, clear accountability mechanisms and explicit consequences, and should be designed to prevent a recurrence and setting a negative precedence.

1.2.2. The financing of an appropriate country response to HIV&AIDS and epidemic impact on the public health system in South Africa must be ring fenced and should flow from the result of a fundamental review and adjustment of the current delivery model of providing ART for people with AIDS.

1.2.3. All changes in service delivery, from a properly determined baseline budget and activity level, need accurate costing and guaranteed funding before public policy announcements on implementation are made.

1.2.4. As part of an overall financing review, conditional grants need to be linked to specific, defined activity. The mechanism for allocation of these grants needs to be open, transparent and based on objective criteria. Financial management at all levels, starting with the budget bid process, must be fundamentally improved.



- 1.2.5. Once the financial “backlogs” have been settled and HIV country response funding is ring fenced, all operational (annual) plans should be tightly linked to the available budget and there should be full, ongoing and effective accountability to ensure that there is no over-spending. The effect of ongoing operational improvements should be properly tracked and reported on.

## **2. LEADERSHIP, GOVERNANCE AND SERVICE DELIVERY**

### **2.1. FINDINGS**

- 2.1.1. There are de facto ten health departments in operation in South Africa and there is not a single national health vision and strategy for the achievement of population health outcomes and ongoing health system transformation in South Africa.
- 2.1.2. The NDOH has provided insufficient leadership and stewardship to solve the fundamental problem of ensuring that the health resources available are sufficient for the levels of service and targets envisaged by a range of national policies.
- 2.1.3. Planning processes are fragmented both within NDOH and between NDOH and the provinces.
- 2.1.4. There is no national Service Transformation Plan (STP) which provides overall guidance on how to reshape and reconfigure the public health system over a five to ten year period. In most of the provinces the STP has neither been accurately costed nor politically approved.
- 2.1.5. National affordable, costed norms, standards and guidelines are not available in many areas, and where these are available, implementation is sub-optimal and varies considerably across the nine provinces.
- 2.1.6. There are inadequate linkages, coordination and integration among clusters within national health and sometimes between directorates within the same cluster.



2.1.7. There are inadequate structural linkages as well as a lack of coordination and communication between national and the provinces.

2.1.8. The core business of the public sector i.e. actual service delivery and the quality of such service delivery, receives insufficient attention from senior managers at national and provincial levels. There is no synergy between key programme clusters in HIV, TB & MCH. Managers have not integrated their work plans, resulting in missed opportunities to improve health outcomes at reduced costs.

## **2.2. LEADERSHIP, GOVERNANCE AND SERVICE DELIVERY RECOMMENDATIONS**

2.2.1. The Minister of Health should drive the development of one national health vision and strategy. This should be done with the involvement and participation of the provincial health MECs and health departments and other stakeholders.

2.2.2. There should be alignment between the national vision and strategy, programme strategic plans and annual national health plan, as well as between targets and interventions within the NDOH. All plans should pay more attention to implementation, should be aligned with each other and should contain a clear M&E framework with performance targets. Implementation of the plans should be monitored regularly, deviations from targets picked up and remedial action taken if necessary. The annual national health plan should guide and determine provincial priorities and plans, and should be completed before the beginning of each financial year, and be in line with the annual government budget cycle.

2.2.3. A national, affordable STP should be developed, as a complementary, but linked activity to the national vision and strategy. The criteria for developing the STP should be transparent, and should also cover district level services and primary health care, in addition to secondary and tertiary services.

2.2.4. The Office of Standards Compliance should be capacitated and resourced to: develop a national repository of norms, standards and guidelines; oversee and guide the development of more effective and affordable service, quality and clinical care guidelines.



- 2.2.5. A simple, but effective governance and accountability framework should be developed to better align roles and responsibilities across the various clusters within national and between national and provincial health departments.
- 2.2.6. In line with the governance and accountability framework, the role and required expertise of strategic health programme managers at national, provincial and district levels need to be reviewed with the aim to develop a clear outline of their key result areas and performance measures. There need to be clear vertical and horizontal communication mechanisms between these programme managers and line service delivery managers.
- 2.2.7. The various meetings of senior managers should be reviewed, restructured and their functioning improved. Senior management meetings need to focus on strategic issues, such as achieving health outcomes, quality service delivery and improving overall health system performance.

### **3. HUMAN RESOURCES**

#### **3.1. FINDINGS**

- 3.1.1. Organisational structuring in the provinces is not done according to agreed benchmarks or aligned with existing plans or resources. Of serious concern is the considerable and continued growth in management and administrative positions across the various provinces, especially in provincial head offices, relative to the growth in health care professional positions. There is insufficient guidance from the NDOH on this matter. As a result, alignment of affordable human resources planning and budgeting, to fulfil the public health sector's strategic plans, was not evident.
- 3.1.2. Despite written policies on delegations, in most provinces delegations have been withdrawn by the Provincial Treasury or by the HODs, with resultant day to day management by head office, widespread feelings of disempowerment and lack of accountability. In the NDOH - although delegations exist and are followed - clear



accountability mechanisms, with clearly defined roles and responsibilities among various branches and clusters, were not evident.

- 3.1.3. Besides inadequate linkages there was a lack of coordination and integration as well as “silo” functioning within the various provincial departments. Simple, but integrated departmental performance dashboards are absent for most provincial health departments as well as for the NDOH.
- 3.1.4. The shortage and retention of health professionals in rural areas remains a major challenge while lengthy recruitment processes compound this problem.
- 3.1.5. Recruitment turnaround times across the various national and provincial health departments range from six to nine months.
- 3.1.6. With the exception of NDOH and WCDOH, performance management is not functioning as envisaged. In addition, performance management criteria rarely have a link to service delivery performance or rewards.
- 3.1.7. OSD implementation has led to numerous problems in the various provinces, including over-expenditure and the recent and threatened doctors’ industrial action. Provincial health departments view this as a result of inadequate planning by NDOH. The NDOH holds the opinion that this is as a result of National Treasury and provincial treasuries not providing sufficient funding for OSD, insufficient skills and capacity to implement the roll-out, wrongful application of guidelines by provinces, incorrect staffing numbers provided and inconsistent job titles and grades in provinces.
- 3.1.8. Training of current staff is not receiving sufficient attention and training budgets, with the exception of NDOH, are decreased as a cost containment measure, which will have long term negative consequences.
- 3.1.9. PERSAL is not fully used as a management and planning tool. Limited, inconsistent HR indicators are found in different official documents. PERSAL consistently reflects large numbers of outdated and unfunded positions.



## 3.2. HUMAN RESOURCE RECOMMENDATIONS

- 3.2.1. National and provincial organisational structures should be reviewed and aligned, once the national vision and strategy has been finalized. The technical capacity should be strengthened at national level to provide stewardship and leadership to provinces for the achievement of health outcome goals.
- 3.2.2. Proposed new structures should be carefully reviewed and restructuring, with a view to establishing minimum staffing levels and optimal management and administrative positions, should be undertaken based on objectively agreed benchmarks, optimal application of scarce skills, the public health sector's strategic and service delivery priorities and resource availability. A moratorium on the establishment of additional provincial head office positions should be considered until the review is concluded.
- 3.2.3. Appropriate delegations should be re-instituted to improve service delivery and efficiency, accompanied by a clear matrix of delegation of authorities and decision making at various levels. This should be in line with a RACI matrix where different people are responsible, accountable, consulted or informed. The responsibility level of CEOs of institutions and district managers and their district management teams (DMTs) should be reviewed and addressed. This should include a review of financial management responsibilities aligned with capabilities.
- 3.2.4. Communication and coordination mechanisms need to be established across clusters to prevent "silo" operational functioning. One integrated national health system performance dashboard, linking to departmental performance dashboards, should be developed and implemented to provide an integrated view of performance across various provinces, programmes and branches.
- 3.2.5. A review and improvement of recruitment procedures and processes should be urgently conducted in consultation with the DPSA with a goal to shorten appointment times.



- 3.2.6. A review of the performance management system and its application should be undertaken to ensure the performance management system encompasses employee performance which is linked to organisational performance, employee development, team based performance where appropriate and rewards based on clear performance goals.
- 3.2.7. A review of the national health professional and scarce skills retention strategy should be undertaken.
- 3.2.8. A total reward strategy (monetary and non-monetary) review should be undertaken at national level to address issues of employee compensation overspend, skills scarcity and staff retention. This must include:
  - 3.2.8.1. A thorough costing of any change in the reward system which must be done in collaboration with the affected parties and include an assessment of affordability at various levels.
  - 3.2.8.2. Rewards linkages to organisational, employee and team performance.
  - 3.2.8.3. Lessons learned from the current OSD implementation review for nurses should be captured to inform future implementation of other improvement initiatives.
- 3.2.9. Training and development programmes should be clearly defined and aligned to the service delivery priorities of the provinces. Well considered and prioritised commitments to relevant training should be maintained even during times of cost containment.
- 3.2.10. An assessment should be undertaken to establish reasons for under utilisation of systems and improved measures should be implemented including the full use of PERSAL as an HR management tool. PERSAL should be corrected to accurately reflect funded personnel positions and staffing numbers.



## **4. INFORMATION MANAGEMENT**

### **4.1. FINDINGS**

- 4.1.1. There is a lack of a properly functioning M&E system for the health sector. Contributing to this is a lack of national guidelines, norms and standards as well as a lack of alignment between planning, implementation and monitoring and evaluation.
- 4.1.2. There is a lack of managerial accountability for the attainment of service related targets and M&E does not appear to be part of managerial performance assessment.
- 4.1.3. The above problems are exacerbated by the lack of an approved policy and overarching framework, and lack of clarity regarding roles and responsibilities (e.g. between M&E, strategic planning and programme divisions (e.g. HIV, TB, MCH)). This is exemplified by the lack of coordinated M&E around the HIV ART programme with each province having its own, but generally inadequate, information system.
- 4.1.4. Although the NHISSA committee liaises with provinces and despite the critical nature of the M&E cluster as a whole, there are no structural mechanisms and/or formal linkages with the provincial health departments.
- 4.1.5. A significant amount of time and resources is spent on data collection, capture and collation at all levels. However, these data are characterised by poor quality control; inadequate analysis, interpretation; and little utilisation of information for decision-making. Hence poor quality indicators derived from the data find their way to NDOH and National Treasury, where there is also little interrogation and feedback.



## **4.2. INFORMATION MANAGEMENT RECOMMENDATIONS**

- 4.2.1. Monitoring and evaluation must be prioritized as a matter of urgency; a national M&E system must be developed, with commensurate financial and human resources and technical expertise to ensure successful implementation.
- 4.2.2. M&E needs to become a central component of all managerial activity with the use of objective information being the basis for decision making. The number of indicators should be reduced and rationalised.
- 4.2.3. Regular formal monitoring, analysis, interpretation and feedback of key indicators needs to take place at every level of the system with analysis and questioning of variances (in much the same way as financial management variance analysis should take place).
- 4.2.4. To achieve this, an urgent plan to achieve an integrated and affordable National Health Information System (NHIS) should be developed. As part of this process, the NHISSA membership and its effectiveness should be assessed. NHISSA should be appropriately mandated and resourced to fulfil its functions.
- 4.2.5. The District Health Information System (DHIS), and associated National Indicator Data Set (NIDS), needs to be reviewed by the NDOH, and aligned with the overall M&E framework and a workable, practical, easy-to-use system of monitoring the ARV programme needs to be put in place, but not outside the framework of the M&E system and the NHIS.
- 4.2.6. An immediate moratorium should be placed on provincial health departments acquisition of costly electronic health information systems - the resources should be pooled and contribute to the NHIS development.



## **5. MEDICAL PRODUCTS**

### **5.1. KEY FINDINGS**

- 5.1.1. Pharmaceuticals are not treated as a major strategic issue, despite its critical nature to overall health care delivery, and despite it being a major cost driver.
- 5.1.2. Some provinces have experienced a shortage of medicines as a result of over-expenditure, affecting many aspects of service delivery, from the vaccination of infants through to the continuation of patients on ARVs.
- 5.1.3. There appears to be a general lack of prioritisation of drug budgets.
- 5.1.4. There is inadequate communication and linkages between the provincial medical depots, pharmacists and programme managers are lacking.
- 5.1.5. Capacity constraints are experienced both at national and provincial departments of health. The national pharmaceutical cluster manager's post has been vacant for six months and it was reported that responsible staff members at provincial levels have insufficient and inappropriate skills to manage pharmaceutical budgets of millions of rand.
- 5.1.6. Monitoring and control of pharmaceutical products is inadequate.

### **5.2. MEDICAL PRODUCTS RECOMMENDATIONS**

- 5.2.1. Pharmaceutical issues should form part of the agenda of HOD, CFO and provincial departmental strategic meetings and linkages between the pharmaceutical cluster and programme clusters should be established and/or improved.
- 5.2.2. Drug budgets should be prioritised and should form an integral part of health service planning, budgeting and monitoring activities.



- 5.2.3. The national pharmaceutical cluster manager should be appointed as a matter of urgency and the unit resourced appropriately so as to guide provinces and to ensure provincial compliance with norms and standards.
- 5.2.4. A review of all aspects of the management, operations and skills requirements of provincial medical depots should be carried out.
- 5.2.5. Strategic pharmaceutical issues should form an integral part of the overall STP and other key initiatives outlined above.

## **6. LABORATORY**

### **6.1. KEY FINDINGS**

- 6.1.1. Laboratory costs are a major cost driver and many provinces reported that the NHLS costs are extremely high compared with the private sector costs.
- 6.1.2. There is no national essential laboratory test list and clinicians and managers have not developed methods of prioritising laboratory tests or of working within a fixed budget for laboratory services.
- 6.1.3. Although the Public Entities, governance and management and special programmes branch at NDOH has been established to manage governance of the NHLS, the roles and functions of the branch are not clear and neither are its linkages with provinces.
- 6.1.4. Monitoring and control of laboratory services is inadequate.

### **6.2. LABORATORY RECOMMENDATIONS**

- 6.2.1. The NDOH should establish a national working group of clinicians, managers and the NHLS staff to develop essential laboratory test lists for different levels of health care and to work out how limits can be placed on laboratory usage, drawing on some good practices that exist within provincial health departments.



6.2.2. The role and responsibilities of the Public Entities, governance and management and special programmes branch should be reviewed and clarified, as well as its linkages to other NDOH clusters and to provinces.

6.2.3. A review should be done to benchmark laboratory costs of the NHLS and to develop appropriate national guidelines.

## **7. TECHNOLOGY AND INFRASTRUCTURE**

### **7.1. KEY FINDINGS**

7.1.1. Generally, the current Information Technology and Telecommunication infrastructure is inadequate to support planning, monitoring and evaluation as well as service delivery.

7.1.2. Facility and equipment maintenance is insufficient and impacts negatively on service delivery and retention of staff.

7.1.3. It was reported that basic diagnostic and medical equipment, especially at lower level hospitals and clinics, is lacking across the country.

7.1.4. The poor roads, water and electricity infrastructure in rural areas creates numerous problems for service delivery.

7.1.5. Capital and operational infrastructure budgets are not aligned.

7.1.6. Inefficient fleet and transport management systems at provincial and district levels lead to poor access, duplication of effort and the delayed response time of emergency response vehicles.

7.1.7. Security measures across various provinces require attention.



## **7.2. TECHNOLOGY AND INFRASTRUCTURE RECOMMENDATIONS**

- 7.2.1. ICT infrastructure architecture should form part of a plan to achieve an integrated and affordable National Health Information System.
- 7.2.2. Capital programmes should incorporate planning for operational requirements and expenditure and include quality and service guidelines for contractors.
- 7.2.3. Facility management, maintenance and security plans should form part of STPs and budgeting processes.
- 7.2.4. External infrastructure issues which impact on service delivery, such as telephone coverage, water and electricity supply as well as roads, should be raised and addressed at a higher political level as well as at municipal planning levels such as the Integrated Development Plan.
- 7.2.5. A medical equipment review should be undertaken as matter of urgency, with special focus on rural areas.
- 7.2.6. The emergency medical services operating model needs to be reviewed to ensure that coverage, availability, cost efficiency and service quality are optimal.
- 7.2.7. The EMS review should form part of the overall STP.



## Introduction

### 1. BACKGROUND

- 1.1. During the course of the 2008/09 financial year it became apparent that there was a negative difference between the public health sector budget and the actual funding required to implement agreed upon policies. Most of the provinces projected an over-spending, which had the potential to undermine the capacity of the Health Ministry and the National and Provincial Departments of Health to revitalise and reorient South Africa's response to the HIV pandemic and to support health systems strengthening in improving health outcomes. In response to this threat to the overall functioning of the health system, the then honourable Minister of Health, Ms Barbara Hogan, requested an in-depth review of the underlying factors behind the overspending. This led to the establishment of the Integrated Support Teams (ISTs) in February 2009. The ISTs comprise consultants who are financial, public health, and management and organisational development specialists.
- 1.2. The purpose of this specific IST consultancy was to provide the Ministerial Advisory Committee on Health (MACH) with a thorough and holistic understanding of the underlying factors behind the overspending trends, to review health service delivery priorities and programmes and to make recommendations on where and how cost savings can be made into the future through improved cost management. The full terms of reference are attached as Appendix 1.

### 2. AIMS OF THE ISTS

- 2.1. The aims of the ISTs were to:
- 2.1.1. Recommend prioritised and practical actions (flowing from reviews at national, provincial and district levels) by which the functioning of the public health care system in South Africa can be improved on a sustainable basis.
- 2.1.2. Integrate the recommended actions into a health systems approach that includes perspectives on governance, leadership, finances, human resources, information,



infrastructure and technology that result in improved service delivery that is effective and equitable.

- 2.1.3. Achieve maximum possible consensus on the recommended actions with the existing public health delivery structures in South Africa.

### **3. SPECIFIC OBJECTIVES**

- 3.1. The specific objectives of the ISTs were to:

- 3.1.1. Assess the current and projected expenditure trends at the National Department of Health (NDOH) and the nine Provincial Departments of Health.

- 3.1.2. Examine the alignment between:

- 3.1.2.1. Stated objectives in the Strategic Plans and the Budget Statements.

- 3.1.2.2. Budget Statements, the resources used/available and the actual results achieved.

- 3.1.3. Identify the key cost drivers underpinning expenditure and to establish the extent of overspending.

- 3.1.4. Review the management and financial processes in operation with a view to suggesting possible improvements.

### **4. METHODOLOGY**

- 4.1. The review was a broad-based, rapid appraisal that focused on the health system as a whole, but with an emphasis on the over-expenditure. The reviews were carried out by a group of experts in the fields of public health, finance and management and organisational development.

- 4.2. The work of the finance, health systems and management experts was integrated into a holistic framework, adapted from the World Health Organisation (WHO). This WHO framework suggests that the key building blocks of a health system are: Service Delivery, Leadership and Governance; Human Resources (Health work



force); Finances; Information management; Medical products; and Technology and Infrastructure.<sup>2</sup> Due to time constraints, the HIV & AIDS, tuberculosis (TB) and maternal and child health (MCH) programmes were used as tracer programmes, both to add depth and to complement the health system building blocks review. The rationale for selecting these programmes include: contribution to the disease burden; ministerial priorities; important Millennium Development Goals (MDGs) indicators; facilitating analysis of conditional grant and the equitable share expenditure; and their relative contribution to component expenditure (e.g. pharmaceuticals).

- 4.3. This rapid review consisted of two main parts: a desk top review, including detailed financial analyses, and in-depth interviews with key informants at national, provincial and district levels. A pilot review was conducted in the Free State Department of Health (FSDOH). The Free State was chosen as the pilot province because of ease of access and state of readiness; availability of information, and it provided a balanced view between rural and urban areas and a spread of health services across the various levels. Thereafter simultaneous reviews of the other eight provinces and the National Department of Health (NDOH) were conducted.
- 4.4. The desktop reviews comprised an analysis of available public documents plus selected documents obtained from the NDOH, the provinces and other sources.
- 4.5. In-depth interviews were conducted with the majority of senior managers at the provincial level and at the NDOH. This consolidated report is largely based on the NDOH and nine provincial reviews but also on additional other documents obtained. A cumulative total of about 150 interviews were completed (see IST reports 2 to 11). This report should be read in conjunction with these other more detailed reports to get a full perspective of the IST findings and recommendations.

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<sup>2</sup> WHO. *Everybody's Business. Strengthening health systems to improve health outcomes*. World Health Organisation, Geneva, 2007.



# Finances

## 1. INTRODUCTION

### Box 1: Key review findings on finance

1. The exact amount of overspending is significantly understated. The public health system requires possible emergency funding as a result of extraordinary over-spending and the resultant cash shortfall. It is estimated that the minimum amount required at 31 March 2009 to fund the provincial departments of health deficit is R7.5 billion. Over 80% of this is attributable to KwaZulu-Natal, Gauteng and Eastern Cape provinces. There is also an expected shortfall for the 2009/10 financial year that is not included in the number stated above and this matter should receive urgent attention to prevent rationing of services in the second half of the 2009/10 financial year.
2. There is a widespread perception that the public health sector is underfunded. This is an extremely complex issue, which must be considered from a variety of perspectives. Based on macro-economic trends there is insufficient evidence to support this perception. Over the past 14 years health sector funding has been between 13% and 14% of available government funds, with per capita expenditure increases at a level which exceeds inflation.
3. South Africa has been faced with an unprecedented HIV epidemic which has placed an enormous burden on the public health sector and with significant mortality and morbidity retrogression to which a funding response is required commensurate with the scale of the epidemic. The current model for the scale up of ART for people with AIDS is unsustainable from a health system perspective and unaffordable from a budgetary perspective.
4. There are material “unfunded mandates” arising from pressures on the allocated budget beyond the control of the accounting officers (HODs). Examples of these include OSD not fully budgeted for, new policies introduced by the MOH (e.g. dual therapy for PMTCT and new vaccines) that are not sufficiently funded, legislative requirements not funded (e.g. creation of district health system and takeover of local government functions and staff) and promises made by MECs (e.g. new clinics).
5. NDOH criteria for the determination and allocation of conditional grants are

**Box 1: Key review findings on finance**

not sufficiently objective and quantifiable; nor has the process been open and transparent.

6. The administration, monitoring, evaluation and accountability arrangements with regard to conditional grants require improvement.
7. There is lack of alignment between annual MTEF budgets of health strategic and other plans, policies and targets. Costing of health sector activities and interventions is deficient.
8. There is a lack of adequate financial management, reporting and accountability processes, as envisaged in the PFMA. Overspending has occurred with minimal or no consequences. These inadequacies lead to an inability to manage overall public health sector performance.

**2. ESTIMATED EXTRAORDINARY FUNDING REQUIRED BY PROVINCIAL DEPARTMENTS OF HEALTH**

- 2.1. The previous Minister of Health was insightful in calling for a full review of the challenge of overspending, within the context of overall health system functioning. It has become abundantly clear, that there is a major problem with over-expenditure in the provinces, with a serious resultant cash shortfall.
- 2.2. The magnitude of the immediate funding crisis facing the health system as a whole is shown in this section. A very high level estimate of the potential extraordinary funding required by Provincial Departments of Health as at 31 March 2009, is set out in Table 1 below.
- 2.3. It is estimated that a minimum of R7.5 billion will be required to get the system back on a sound financial footing, with around 80% of this attributable to the KwaZulu-Natal, Gauteng and Eastern Cape provinces.



**Table 1 High level computation of the estimated extraordinary funding required by Provincial Departments of Health**

	<b>Notes</b>	<b>Total</b>	<b>Eastern Cape</b>	<b>Free State</b>	<b>Gauteng</b>	<b>KwaZulu-Natal</b>	<b>Limpopo</b>	<b>Mpumalanga</b>	<b>Northern Cape</b>	<b>North West</b>	<b>Western Cape</b>
		<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	<b>R'000</b>
Bank overdrafts as at 31 March 2009	<b>1</b>	5 353 507	-	178 204	1 527 396	3 118 211	291 000	-	238 696	-	-
Estimated Accruals as at 31 March 2009	<b>2</b>	3 576 760	1 197 000	270 000	700 000	365 681	109 000	280 000	130 079	200 000	325 000
<b>Estimated cash shortfall</b>		<b>8 930 267</b>	<b>1 197 000</b>	<b>448 204</b>	<b>2 227 396</b>	<b>3 483 892</b>	<b>400 000</b>	<b>280 000</b>	<b>368 775</b>	<b>200 000</b>	<b>325 000</b>
Cash shortfall as % of adjustment budget			11%	10%	15%	22%	5%	6%	20%	4%	4%
Adjustment for normal accruals	<b>3</b>	<u>1 379 644</u>									
Potential minimum extraordinary funding required		<u><u>7 550 623</u></u>									
<b>Notes</b>											
1 Amounts obtained from the provincial health departments											
2 Accruals are estimates provided by the provincial health finance departments											
3 Based on ½ month of provincial budgeted expenditure excluding compensation of employees as per the 2008/09 adjustment budget of R 33,1 bn.											



- 2.4. The computation is based on the various overdraft balances as at 31 March 2009, plus the estimated accruals at the same date, that were obtained as indications of the unpaid bills from the various provincial health finance divisions.
- 2.5. The accruals reflected above are unaudited indicative estimates. The IST team is of the opinion that the accruals presented are in all likelihood understated as many of the departments could not provide detailed substantiation. In addition, doubt exists as to whether there are adequate systems in place to ensure that material unrecorded liabilities are in fact accurately recorded.
- 2.6. The estimated accruals have been adjusted for normal year-end accruals, by calculating half a month's expenditure, excluding compensation of employees, of the 2008/09 adjustment budget, as a "normal" accrual amount outstanding.
- 2.7. The minimum extraordinary figure of R7.5 billion excludes the net aggregate unauthorised expenditure (i.e. after deducting the bank overdrafts) of R943 million as reflected on the financial statements of the provincial health departments as at 31 March 2008, arising from previous financial years. These items have not been through the appropriate legislative approval processes and could add further to the funding pressures. In addition, there is significant anticipated pressure (shortfall) on the 2009/10 allocated budget to provide the presently configured package of health services.

### **3. UNDERFUNDING OF THE HEALTH SECTOR**

- 3.1. The IST team has consistently been confronted by the assertion that the main cause of the difficulties being experienced by the public health system in the provinces and nationally is due to the underfunding of the health system.
- 3.2. It is important that the merits of this assertion be dealt with as thoroughly as possible so that the future plan of action to deal with the challenges facing the public health system in South Africa can be focussed. Indeed, if this matter is not addressed properly, unnecessary time and effort will continue to be spent on attributing blame and detracting from the need to develop and implement well thought through responses to the very complex challenges facing the system.



3.3. The answer to the assertion was sought from a variety of perspectives.

### **3.3.1. The impact of HIV & AIDS on the public health system**

3.3.1.1. The current model for the scale up of ART for people with AIDS is reliant on centrally located hospitals and medical doctors, with stringent criteria for the accreditation of health facilities. The IST team has concluded that the current model is unsustainable from a health system perspective and unaffordable from a budgetary perspective.

3.3.1.2. Well publicised incidents in the past months provide ample support for this contention, and information clearly points to the fact that the difficulties experienced with rolling out the existing model are likely to get progressively worse as more people are enrolled. Further roll out of the current model will also increase the pressure on the overall funding of the public health system.

### **3.3.2. Share of government expenditure spent on public health**

3.3.2.1. The share of available (non-interest) government expenditure directed towards health has displayed an increasing tendency for some time and presently constitutes about 13.4%<sup>3</sup>.

3.3.2.2. From a macro economic perspective, other than during the 5 year period ending during the 2002/03 financial year, there have been no sharp reductions in the amount of money that has been made available for public health purposes.

3.3.2.3. It is clear that without compelling arguments to motivate an increased share of public spending (for example to deal with the effect of HIV&AIDS), especially in these worsening economic times, that a valid perspective is that the public health system in South Africa is receiving the appropriate proportion relative to the total fiscus and that reasons for its underperformance must be sought elsewhere. This

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<sup>3</sup> Budget Review 2009, Table 7.1 on page 101, Table 7.2 on page 102 and Table 8.1 on page 115



conclusion should, however, be qualified in that there is a need for additional funding to mitigate the effect of the HIV&AIDS pandemic.

### **3.3.3. International Comparisons**

3.3.3.1. Comparative analysis of public health expenditure of middle economic countries by the WHO shows that South Africa spends about equal to the median when government expenditure on health is compared to Gross Domestic Products (GDP)<sup>4</sup>. Also, the proportion of the expenditure on public health, compared to total non interest government expenditure, of about 13.4 %, compares well with the resolution of the African Union for countries to spend 15 % of their total budgets on health <sup>5</sup>. Thus, the conclusion here is that the public health system is not inadequately resourced using these benchmarks.

3.3.3.2. But, this conclusion should again be qualified with the effect of dealing with, and the funding of, the HIV/AIDS pandemic which renders attempts at general international benchmarking of South Africa's public health funding situation largely meaningless.

### **3.3.4. Per capita expenditure on health**

3.3.4.1. When using the 1995/96 financial year as a base year and projecting it forward to the 2009/10 financial year, the nominal per capita expenditure on health increases at a compounded annual growth rate of 9.3%<sup>6</sup>. If this analysis is done by province, the compounded annual growth rate over the period varies from a low of 6%<sup>7</sup> (Gauteng) to a high of 14.3%<sup>8</sup> (Mpumalanga). The compounded annual growth rate in inflation for the period 1995 to 2008 is 6.2%<sup>9</sup>.

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<sup>4</sup> World Health Organization, 2006

<sup>5</sup> ABUJA DECLARATION on HIV/AIDS, Tuberculosis and other related infectious diseases. Abuja, Federal Republic of Nigeria. 27 April 2001.

<sup>6</sup> National Treasury, August 2007

<sup>7</sup> National Treasury, August 2007

<sup>8</sup> National Treasury, August 2007

<sup>9</sup> Stats SA, P0141



3.3.4.2. The conclusion from this perspective again is that there does not appear to be a general retrograde trend in health funding. However, in certain provinces the level of funding has decreased (or increased) relative to the average, as there has been a trend in improving equity between provinces. Undoubtedly this trend has caused stress in those provinces where a relative decrease has been experienced. It is, however, important to note that in reaching this conclusion, the clear increase in the burden of disease which has occurred over the period has not been taken into account <sup>10</sup>.

### **3.3.5. Public Health expenditure taking into account the burden of disease**

3.3.5.1. Assuming that sufficient funds were available, and further assuming that the base-line level of funding was appropriate, in an ideal world the level of funding of public health services would be sufficient to meet the need. In such a situation, changes in the funding requirement from year to year would be a function of the change of the value of money related to the basket of items to be procured to render the services required, as well as a change in the health needs.

3.3.5.2. The IST team was not able to find evidence that objective criteria, which include disease burden and population growth, are used to determine the health budget.

3.3.5.3. As a consequence, a rapid study<sup>11</sup> was commissioned by the IST team to attempt to assess, at a rudimentary and indicative level, what the trend in real public expenditure in the provinces on health, relative to the need, has been. One of the key findings of the study was that, over the 10 year period commencing in 2000/01, and using changes in morbidity as a proxy for changes in needs, overall budget allocations expressed in real money, have not been sufficient to keep pace with need.

3.3.5.4. It is clear that the reason for the situation is largely the effect of the HIV&AIDS pandemic as reflected by the increased morbidity and mortality rate. A further important conclusion reached by the study revealed that, due to the substantial restructuring that occurred in the package of health services being provided, it was

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<sup>10</sup> Evaluation of funding levels in the public health system, Alex van den Heever, April 2009

<sup>11</sup> Evaluation of Funding Levels in The Public Health System, April 2009



likely that some areas were under severe stress (for example central and district hospitals) while others were increasingly becoming relatively well resourced (for example clinic services).

### **3.3.6. The influence of financial “backlogs”**

- 3.3.6.1. During the work done by the IST team in the field, three main categories of “backlogs” were identified which would support the reality experienced by senior health managers that underfunding was indeed a significant constraining factor.
- 3.3.6.2. The first of these relate to the actual overspending of prior years which had been funded by the provincial treasuries by way of overdraft and now needs to be made good out of the current budgeting allocation. The extent of this liability varies and differs by province and estimates of this have been shown in the previous section in Table 1.
- 3.3.6.3. A second category of “backlog” relates to the abnormally high (and apparently increasing) amount of unpaid accounts and commitments (accruals) which actually relate to services rendered and goods consumed in previous years, but of which the settlement must be met out of the current budgetary allocation (Table 1).
- 3.3.6.4. The third category of “backlog” relates to the known shortage in the current (i.e. the 2009/10) budgetary allocation to deliver the currently configured package of services, excluding the HIV package. This third category also includes the so-called “unfunded mandates”, which includes the roll over effect of OSD and other unfunded salary increases, as well as the introduction of new vaccines and take-over of local government services.
- 3.3.6.5. The effect of these three “backlogs” does mean that the current public health service package is indeed underfunded by at least the total of these (excluding the additional amounts required for the necessary response to HIV).



### 3.3.7. Other Factors

- 3.3.7.1. There are also a number of other factors which have an important effect on the funding adequacy question. Two of these are addressed for this purpose.
- 3.3.7.2. One of these factors is the change in the relative number of people who are dependent on the public sector. Over a twelve year period commencing in 1995, the coverage of the population covered by the private sector (as measured by medical aid membership) decreased from 18.1% to 14.3%<sup>12</sup>. Clearly, this development would increase the need for public health services relative to the base line situation, and place increased pressure on the funds allocated to public health. In addition, the cross-border flow of people from other countries was mentioned by some respondents, but the exact number of foreigners in need of care has not been quantified.
- 3.3.7.3. A further factor which has had an important potential effect on the overall functioning and funding position of the public health system, is the significant but sustained decline in the number of employees in the sector from the 1995/96 financial year to the 2002/03 financial year. This was only restored to the original situation in terms of numbers during the 2006/07 financial year. The specific question that arises in this regard is whether the damage sustained by the public health system during this period could have been properly restored without a very focussed and extraordinary programme which was fully funded.

### 3.3.8. Final Perspective

- 3.3.8.1. A final and very important perspective, which the IST team supports, is that provided by a well respected operational leader in the health system. This person indicated that substantial additional funding, without fundamental improvements in the health delivery system, starting with a common vision and focus, strong central leadership and appropriate measures to enhance effectiveness and efficiency, will only result in more usage and spending. Additional funding alone, which is not

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<sup>12</sup> StatsSA, General household survey July 2007, Statistical Release P0318



focussed with laser-like precision, may temporarily resolve the pattern of overspending which has recently become pronounced in the system, but such overspending is then likely to continue once the additional funding is exhausted.

#### **4. HIV/AIDS - ART FUNDING**

4.1. Various learned teams and individuals are working on costing models for the provision of ART. There are numerous hypotheses and models developed on various assumptions with no level of finality at present. It is, however, extremely urgent that a model be accepted and implemented to address the financial implications of the pandemic for the public health system. As indicated earlier, the questions around the service delivery models and funding for the ART rollout are unsustainable from a health system perspective and unaffordable from a budgetary perspective.

4.2. While all models indicate that significant funding will be required to address the future treatment, it should also be pointed out that this does not address the other costs that need to be borne by the public health system, including staff and laboratory costs, which also have to be funded.

#### **5. UNFUNDED MANDATES**

5.1. Unfunded mandates are changes in policies or operational requirements resulting in additional expenditure for which provision has not been made in the approved budgets.

5.2. Examples of unfunded mandates at the provincial level include:

5.2.1. **Occupational Specific Dispensation (OSD)**. The implementation of this policy resulted in higher expenditure than the amount provided for in the budget. The additional amount allocated for OSD by the National Treasury was based on an equitable share calculation, and not on actual human resource (HR) figures from the PERSAL system.

5.2.2. **Nationally negotiated salary increases** for 2008/09 were 10.5%, although the budgeted increases provided for by the provinces were between 5 and 8%.



- 5.2.3. **Function shifts.** The budget did not cater for the movement of operations, e.g. in respect of Emergency Medical Services.
- 5.2.4. **The activity levels increased.** For example, in the case of the FSDOH, the numbers of patients registered for ARTs increased from a projected 27 000 (funded by the HIV conditional grant) by the end of 2008/09 to 34 000.
- 5.2.5. **New facilities.** The opening of clinics during a financial year without funding being provided in the budget. The opening of these clinics was based on political promises being made without ascertainment of whether running costs were available.
- 5.2.6. **New policies** introduced by MOH (e.g. dual therapy for PMTCT and new vaccines) that are not sufficiently funded.
- 5.2.7. **Legislative requirements.** For example, the creation of the district health system and the takeover of local government functions and staff.

## 6. **CONDITIONAL GRANTS**

- 6.1. Although annual performance plans are compiled at national and provincial levels, there are mismatches between the provincial business plans for grants and the level of national grant funding allocated. For example, the criteria for HIV grant allocations are not clear but appear to be somehow based on the equitable share, and not the number of HIV positive individuals in need of care in each province. The process is not transparent and there are fluctuations from year to year. Additionally, the equity of the process may be questioned as, for example, the Northern Cape with the lowest prevalence of HIV receives significantly more than the population proportion whilst Mpumalanga conversely receives significantly less. Figure 1 illustrates these points.

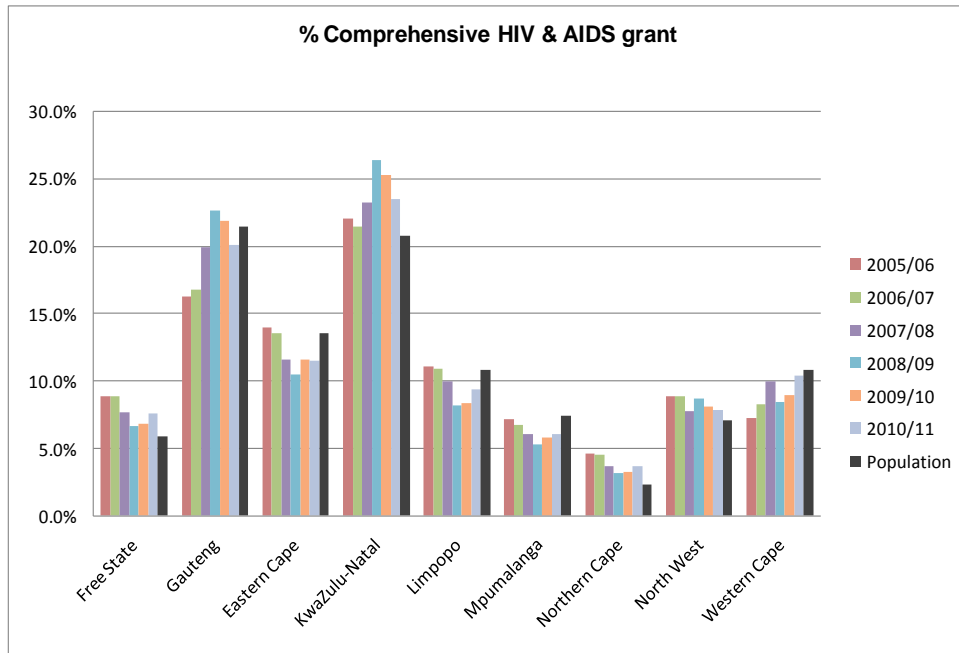


Figure 1: Trends in annual provincial HIV Conditional Grants 2005 to 2011.

6.2. These observations apply to the other grant, viz the national tertiary services grant (NTSG) that we analysed as well as to the total conditional grants. For example, the Northern Cape with around 2.3% of the total population on average received more of the total conditional grants than did Mpumalanga with more than three times as many people (7.4% of the total population).

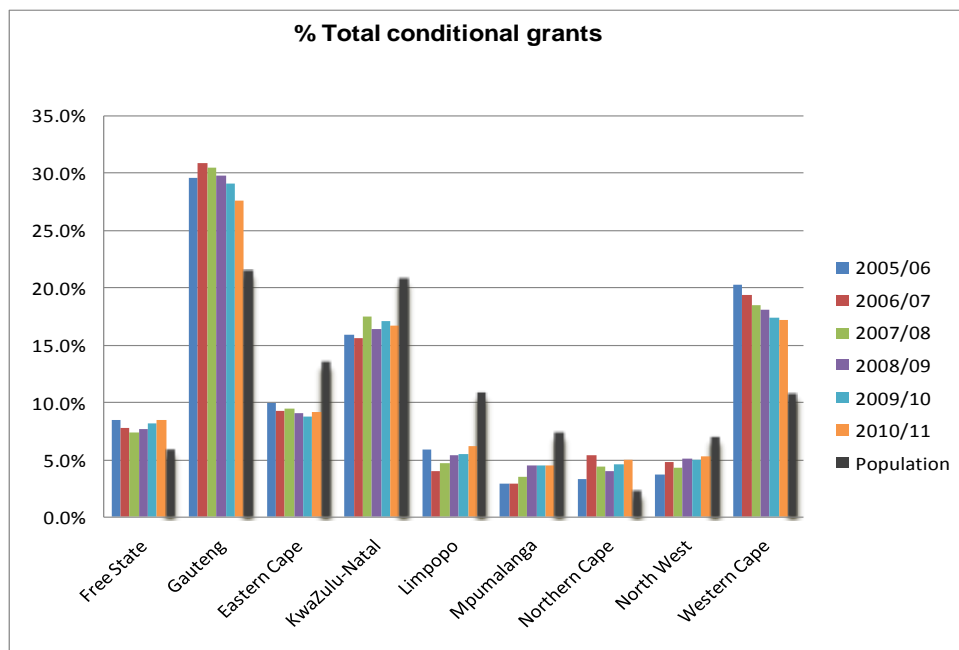


Figure 2: Total Conditional Grant proportion, by province by year.



- 6.3. Accountability processes in relation to conditional grants are inadequate, as the national DG is reliant on provincial HODs for performance of the conditional grants against budget and targets. As some conditional grants are used for funding current expenditure (personnel, goods and services), the national departmental officials cannot guarantee that such spending relates to the funds allocated for the conditional grants or that the personnel and the goods are utilised for the specific grant purpose. At a high level, the CFO's office in the NDOH assists with the financial issues and payment of transfers and monitors the spending on an overall basis e.g. that at least 25% is spent per quarter. The CFO also has discussions around the conditional grants with the relevant programme and cluster managers in the NDOH on a quarterly basis.
- 6.4. The conditional grants are managed by the provinces and monitored by the national department's cluster managers during meetings and visits. There is insufficient coordination between the NDOH cluster managers and some respondents were of the opinion that duplication might take place in the funding from the various conditional grants. This could not be confirmed, but is a matter of concern.
- 6.5. It was reported that the NDOH is adding to grant conditions, creating enormous administrative burdens both on itself and on the provincial departments of health. In some instances, there is blurring of the monitoring role of NDOH, with a more operational role e.g. the involvement of NDOH in the approval of tenders.



## 7. OVER-EXPENDITURE TREND

7.1. Set out in the table below are the over-expenditure trends for the 3 years up to the 2008/09 financial year as computed by the summation of the appropriation statements as included in the provincial annual financial statements.

Table 2: Trends in health programme budget and expenditure

Programme	2005/06			2006/07			2007/08		
	Final Appropriation	Actual Expenditure	Variance	Final Appropriation	Actual Expenditure	Variance	Final Appropriation	Actual Expenditure	Variance
Administration	1 658 299	1 621 432	36 867	1 948 751	1 914 338	34 413	1 987 869	1 980 585	7 284
District Health Services	18 233 314	18 389 068	( 155 754)	21 278 062	21 075 911	202 151	25 177 747	26 295 325	(1 117 578)
Emergency Medical Services	1 760 409	1 757 599	2 810	1 984 070	2 059 388	( 75 318)	2 398 193	2 316 737	81 456
Provincial Hospital Services	11 637 568	11 695 793	( 58 225)	12 861 907	13 055 201	( 193 294)	14 549 455	14 966 158	( 416 703)
Central Hospital Services	7 958 679	8 133 813	( 175 134)	8 259 349	8 726 185	( 466 836)	9 072 254	9 630 061	( 557 807)
Health Sciences and Training	1 519 245	1 495 411	23 834	1 720 564	1 709 940	10 624	1 921 545	1 937 902	( 16 357)
Health Care Support	928 081	848 968	79 113	822 471	895 396	( 72 925)	926 924	863 239	63 685
Health Facilities Management	3 501 382	3 103 280	398 102	4 440 664	4 251 128	189 536	5 010 169	4 628 464	381 705
Special functions	13 509	17 191	( 3 682)	3 125	9 352	( 6 227)	1 189	4 778	( 3 589)
Internal charges	( 49 416)	( 55 635)	6 219	( 50 581)	( 49 012)	( 1 569)	( 48 357)	( 41 061)	( 7 296)
<b>Total</b>	<b>47 161 070</b>	<b>47 006 920</b>	<b>154 150</b>	<b>53 268 382</b>	<b>53 647 827</b>	<b>( 379 445)</b>	<b>60 996 988</b>	<b>62 582 188</b>	<b>(1 585 200)</b>
<b>Economic Classification</b>									
Compensation of employees	25 342 138	25 418 382	( 76 244)	28 647 311	28 739 450	( 92 139)	33 799 665	35 069 898	(1 270 233)
Goods and services	14 323 305	14 598 527	( 275 222)	16 903 047	17 637 895	( 734 848)	18 279 755	19 599 044	(1 319 289)
Professional and Special Services	250 897	236 736	14 161	341 539	325 333	16 206	365 602	337 564	28 038
Transfers and subsidies	2 995 290	2 899 281	96 009	2 285 237	2 259 733	25 504	2 443 086	2 401 556	41 530
Buildings and other fixed structures	2 259 493	2 001 391	258 102	3 297 619	2 992 129	305 490	4 228 885	3 742 679	486 206
Machinery and equipment	1 989 947	1 852 603	137 344	1 793 629	1 693 287	100 342	1 879 995	1 431 447	448 548
<b>Total</b>	<b>47 161 070</b>	<b>47 006 920</b>	<b>154 150</b>	<b>53 268 382</b>	<b>53 647 827</b>	<b>( 379 445)</b>	<b>60 996 988</b>	<b>62 582 188</b>	<b>(1 585 200)</b>



- 7.2. Table 2 shows the analysis of over-expenditure for the 2007/08 financial year. From this high level analysis it is difficult to pinpoint the exact areas of overspend of R1,585 billion due to the widespread financial practice of virements at a lower level between different expense accounts that are overspent and those that are underspent.
- 7.3. Indications from the provincial reports are that the over-expenditure for the 2008/09 financial year is attributable to OSD for nurses, additional staff appointments, salary increases and medical inflation in excess of budget. However, it is alarming that the public health sector moved from a surplus of R154 million in 2005/06 to a deficit of R1.6 billion within a space of 3 years (on the cash basis). This situation is exacerbated when taking into account the aggregate estimated level of accruals of R3.5 billion at the end of the 2008/09 financial year.

## **8. BUDGETING PROCESS**

- 8.1. The budgeting process was identified as a major contributor to the current funding challenges in the public health sector. Currently, the budgeting process is a top down process instead of an interactive top down, and bottom up, process. Although inputs are compiled from operational levels and provinces, and an indicative figure is obtained, the extent to which these are utilised by National Treasury in their allocation process is uncertain. National Treasury determines the health allocation, and this indicative amount is then allocated to the provinces (mainly via the provincial equitable share). The ultimate allocation to the provincial departments of health is determined by the provincial treasuries, but is to a large extent not aligned to provincial health departments' operational plans and budgets originally submitted.
- 8.2. In most cases the objectives set during the planning phases are not realistic and affordable. Budget inputs are not based on actual costs or activities, but it is an incremental process based on previous allocations and expenditure. It is also difficult to link programme objectives to budget allocations and there is no clear alignment between the annual performance plans and the budgets. Annual performance plans are also not updated once the final funding allocations have been made.
- 8.3. The need for an improved budgeting process is evidenced by the increasing trend of overspending, as well as the numerous virements in each financial year to reduce the number of over and underspent items.



## 9. FINANCIAL MANAGEMENT PROCESSES

- 9.1. Management responsibility and accountability are limited at all levels of the hierarchy, making it more difficult to maintain effectiveness and efficiency standards. There are limited, and in some instances neither formalised nor clearly defined, financial management reporting structures, formats and timeframes. Lines of accountability are broken due to posts being filled in an acting capacity, high staff turnover and the fulfilling of multiple roles.
- 9.2. Line managers reportedly see all aspects of finances as the responsibility of the various CFOs' offices and are therefore not sufficiently committed to essential financial management aspects such as budgeting, expenditure control, and financial accountability.
- 9.3. Variance analysis of differences between actual and budgeted expenditure can be a very useful management tool. Currently, whenever variance reports are produced and variances identified, a general practice appears to be to reallocate budgeted amounts in order to reduce the variance amounts for the different over and under-expenditure items. On the evidence available to the IST team, very little follow-up is done to identify any possible or necessary operational corrective actions flowing from variances.

## 10. FINANCIAL REPORTING

- 10.1. The principal financial reporting mechanisms are the monthly In Year Monitoring (IYM) reports and the Annual Financial Statements.
- 10.2. Although the *IYM report* can be an effective tool to identify possible budget over-runs, these are not consistently compiled on either the cash or accrual basis. Accordingly, on the cash basis, any unpaid expenditure is carried forward to future financial periods and the reported results do not accurately reflect the actual operational cost of the current year's operations. Reported overspending is also limited by the withholding of invoices for payment. (The PFMA implications of this practice have not been considered for purposes of this report).



10.3. It was reported that some of the provincial treasuries requested that the 2008/09 IYM only reflect the projected actual cash flows (after the effect of an abnormal increase in unpaid invoices and expenses), and not the expected cost of operations. The result is that the IYM will not accurately indicate overspending. The effectiveness of the IYM report, as currently prepared, as a management tool to assist with the prevention of over-runs is therefore limited.

10.4. The annual financial statements (AFS) are drafted on a *cash basis*. Expenditure not paid (accruals) is not matched with the operational activities of the department. Material amounts payable are accumulated, but the reporting does not take this into consideration, leading to the amount of overspending being materially understated.

## **11. INEFFICIENCY AND COST SAVING**

11.1. Table 3 shows selected indicators in selected tertiary hospitals. Focussing on the cost per patient day equivalent (an indicator showing on average how much it costs for one patient to spend one day in the hospital) it is clear that this important indicator is not being well monitored and on face value indicates that there is a wide range of inefficiencies in the system. The data indicates that the central, academic hospitals in KwaZulu-Natal and Free State are much more expensive than those in the Western Cape and Gauteng. Clearly the causes of these differences need more investigation and corrective actions should follow.



Table 3: **Bed Utilisation Rate and Cost per Patient Day Equivalent in Selected Tertiary Hospitals**

Province	Hospitals	2005/06		2006/07		2007/08	
		BUR %	R PDE cost	BUR%	R PDE cost	BUR%	R PDE cost
Eastern Cape	Nelson Mandela	81	n/a	76	n/a	69	n/a
	Port Elizabeth Provincial Hospital	60	n/a	69	n/a	68	n/a
Free State	Universitas	61	n/a	68	2 735	71	3 089
Gauteng	Chris Hani Baragwanath	85	n/a	74	1 577	75	1 843
	Charlotte Maxeke Johannesburg Academic	86	n/a	85	2 043	81	2 366
	Steve Biko Academic (Pretoria)	77		76	2 206	74	2 100
KwaZulu-Natal	Grey's Hospital	67		73	1 585	74	2 107
	Inkosi Albert Luthuli Central Hospital	42	n/a	46	4 259	41	5 299
Limpopo	Pietersburg Hospital (Polokwane)	71	n/a	75	1 545	64	2 147
Mpumalanga	Witbank	71	n/a	70	1 857	69	2 094
Western Cape	Groote Schuur	83	n/a	82	2 195	81	2 513
	Red Cross Children's War Memorial	81	n/a	84	2 137	81	2 487
	Tygerberg	80	n/a	81	2 102	79	2 395

n/a - Not available

11.2. The IST review also suggests that there is insufficient strategic guidance and attention paid to high cost tertiary services. The ten central hospitals are national assets, and they play a significant role in the training of medical specialists, research and medical innovation.



11.3. Table 4 shows costs per patient day equivalents in selected district hospitals of comparable size. This shows material differences within provinces and between provinces, again illustrating possible inefficiencies and potential for cost savings.

Table 4: Comparisons of Cost per Patient Day Equivalents in Selected District Hospitals

Province	Hospital	R 2005/06	R 2006/07	R 2007/08	No of beds
Eastern Cape	Sundays Valley (Kirkwood)	4 659	4 507	3 092	37
	Dordrecht	530	569	693	35
Free State	Nala Hospital (Bothaville)	555	623	797	38
	Phumelela Hospital (Vrede)	2 781	2 268	1 571	27
Gauteng	Heidelberg Hospital	831	975	1 433	126
	Tswane District	n/a	2 036	2 801	125
KwaZulu-Natal	Manguzi	768	837	973	264
	Emmaus	997	1 177	1 625	156
Limpopo	Ellisras	1 321	1 575	1 799	82
	Dilokong	777	819	948	144
Mpumalanga	Piet Retief	784	901	804	176
	Barberton	2 091	1 713	1 414	151
Northern Cape	Calvinia (Abraham Esau)	1 211	7 950	2 144	50
	Barkley West	2 692	5 379	5 769	30
North West	Swartruggens	n/a	1 285	2 917	32
	Ventersdorp	n/a	1 142	5 209	40
Western Cape	Vredenburg	1 363	1 604	1797	52
	Clanwilliam	487	536	652	48

n/a - Not available



## **12. KEY RECOMMENDATIONS**

### **12.1. EXTRAORDINARY FUNDING REQUIRED**

12.1.1. The exact quantum of the financial “backlogs” in each province should be properly determined, and a consistent plan of action to deal with this must be implemented. While a certain element of “bailout” is inevitable, the action plan should include preventive measures, clear accountability mechanisms and explicit consequences, and should be designed to prevent a recurrence and setting of a negative precedence.

### **12.2. HEALTH SECTOR FUNDING (INCLUDING HIV/AIDS – ART FUNDING)**

12.2.1. The current model of business as usual and tinkering on the margins is inappropriate. An emergency response is required to deal with the HIV epidemic and its effects on the health sector, and on all aspects of society.

12.2.2. The financing of the appropriate response to HIV/AIDS and its impact on the public health system in South Africa must be ring fenced and flow from the result of a fundamental review and adjustment of the current delivery model of providing ART for people with AIDS. The financial effect of this pandemic, if grouped together with the normal funding needs (even in the form of the current conditional grants) makes meaningful comparisons and monitoring almost impossible.

12.2.3. The implementation of these recommendations will require a team effort, will take time, and will require careful ongoing project management until the various aspects are embedded.

### **12.3. UNFUNDED MANDATES**

12.3.1. The operational impact of national policy decisions (e.g. OSD, new vaccine programme) should be determined and must be agreed with the provincial health departments prior to implementation.



12.3.2. There should be alignment between political decisions and operational implementation and agreement reached for any proposals on increases of service levels prior to their announcement. The availability of funding should also be confirmed.

#### **12.4. CONDITIONAL GRANTS**

12.4.1. The NDOH, in consultation with the National Treasury and provincial departments of health, should review all the conditional grants against their original purpose to decide whether these should continue. The review process should take into account: objective and transparent criteria for the determination and allocation of such grants; mechanisms to improve accountability, administrative efficiency, service delivery performance; and measures that facilitate regular monitoring and evaluation.

12.4.2. A coordination forum should be established within the NDOH to ensure that, inter alia, there is no duplication in funding to provinces from the different grants.

12.4.3. Appropriate accountability mechanisms with regard to conditional grants, including independent auditing, should be put in place by the NDOH.

12.4.4. There needs to be separation between the monitoring role of the NDOH and the implementation role of the provinces and NDOH should not be involved in operational issues.

#### **12.5. BUDGETING PROCESS**

12.5.1. Measures should be put in place to strengthen the role of the NDOH in the process of determining the overall public sector health allocation, with concomitant accountability.

12.5.2. The capacity of the NDOH should be strengthened to enable it to undertake better financial analysis of the existing health financial situation, improve the annual bidding processes, costing methods, decisions on additional funding and early warning expenditure (IYM) reports.



- 12.5.3. A proper base-line must be established and changes in needs from period to period should be properly quantified and motivated.
- 12.5.4. In order to inform this base-line and movements from it, a national STP should be drawn up and aligned with all the provincial STPs in order to ensure that there is one transformation plan that informs service delivery and which is in line with budgetary constraints.
- 12.5.5. The funding and management of tertiary hospitals and academic training should be the focus of discussions between the Ministries of Health and Education so that there is a clear, joint policy framework to guide the development of services and to strengthen health science education and tertiary services that are national assets. Such a framework should provide guidance on:
  - 12.5.5.1. Joint appointments of staff;
  - 12.5.5.2. The funding of health science education, training and research;
  - 12.5.5.3. The services linked to education and training;
  - 12.5.5.4. The funding and management and accountability of the institutions.
- 12.5.6. Proper reprioritisation processes must be introduced to deal practically with the consequences of the unavoidable budget shortfalls in relation to the bids developed, from the political level down to the lowest relevant level in the system.

## **12.6. FINANCIAL MANAGEMENT PROCESSES**

- 12.6.1. Formalised and clearly defined financial management reporting structures, formats and timeframes should be developed, effectively communicated and diligently followed.
- 12.6.2. Managers should be held accountable for the performance of their operating units and this must be built into the performance management system.



12.6.3. Variance analysis needs to be used as a management tool to identify areas that require attention.

## **12.7. FINANCIAL REPORTING**

12.7.1. The IYM report needs to be expanded to include accruals. The report needs to be compiled on an accrual basis and not only on a cash basis to create a link between operational activity and costs.

12.7.2. The annual financial statements, while meeting Constitutional and Government Accounting requirements, should be expanded beyond the cash basis of reporting and include accruals as part of reported, aggregated expenditure numbers.

## **12.8. OVER-EXPENDITURE, INEFFICIENCY AND COST SAVINGS**

12.8.1. Although HIV/AIDS has a negative impact on over-expenditure, there are inefficiencies in the system that need to be addressed, through:

12.8.1.1. Assessing the number and usefulness of the performance indicators;

12.8.1.2. An improved M&E system;

12.8.1.3. Improved employee performance management system.

12.8.2. There needs to be follow-up of variances and appropriate corrective action with regard to identified indicators, e.g. the bed utilisation rate and cost per PDE across various levels and geographical areas.



# Leadership, Governance and Service Delivery

## 1. INTRODUCTION

### Box 2: Key review findings on leadership, governance and service delivery

1. There is not a *single national health vision and strategy* for the achievement of population health outcomes and ongoing health system transformation in South Africa.
2. The NDOH has provided insufficient stewardship and leadership to solve the fundamental problem of ensuring that the available health resources are sufficient for the levels of service and targets envisaged by a range of national policies.
3. Planning processes are *fragmented* both within NDOH and between NDOH and the provinces
4. There is no national STP which provides overall guidance on how to reshape and reconfigure the public health system over a five to ten year period. In most of the provinces the STP has neither been accurately costed nor politically approved.
5. National *affordable, costed norms, standards and guidelines are not available* in many areas, and where these are available, implementation is sub-optimal and varies considerably across the nine provinces.
6. There are *inadequate linkages and a lack of coordination and integration* among clusters within national health and sometimes between directorates within the same cluster.
7. There are *inadequate structural linkages and a lack of coordination and communication* with the provinces.
8. *Accountability mechanisms* between national and provincial health departments are deficient. In practice, the *NDOH is totally at the behest of the nine provinces* for the achievement of national health goals and policies.
9. Actual service delivery and the quality of such service delivery at provincial level receive insufficient attention at national level. There is no synergy between key programme clusters as *HIV, TB & MCH managers have not integrated their work plans, resulting in missed opportunities* to improve health outcomes at reduced costs.
10. The current HIV treatment model of delivery by which ARVs are supplied

**Box 2: Key review findings on leadership, governance and service delivery**

primarily by centrally located hospitals is not compatible with improving service access and the current funding model of ARV provision is neither affordable nor sustainable.

## **2. STEWARDSHIP AND LEADERSHIP**

### **2.1. NATIONAL LEVEL**

- 2.1.1. The NDOH assists the provinces with their Annual Performance Plans (APPs) through the provision of a standardised planning framework and some capacity building. The NDOH also prepares the national health strategic plan and manages a quarterly performance reporting system, the preparation of annual reports, and the monitoring of the provincial APPs.
- 2.1.2. The Annual National Health Plan (ANHP), as stipulated by the National Health Act (NHA), is prepared annually based on the APPs of the provinces and the NDOH's strategic plan, but is only available at the end of May of the actual financial year. Thus the ANHP takes its cue from the nine provincial APPs, rather than providing direction for the entire health system.
- 2.1.3. In practice, there are ten health departments in operation in South Africa, and there is no single national health vision and strategy for the country. This lack of a single health vision and strategy is exacerbated by the splitting of 'planning' responsibilities across three divisions at NDOH: Strategic Planning; Finance; and Planning and Monitoring, as well as inadequate coordination between these three clusters and with other clusters within NDOH.
- 2.1.4. The 2009/10 to 2011/12 NDOH strategic plan has several weaknesses, some of which are highlighted below.
- 2.1.4.1. The document is internally focused and it is a plan for the NDOH, rather than a national health strategic plan, as if NDOH functioned in isolation from the provincial health departments.



- 2.1.4.2. Both the burden of disease and specific health system challenges manifesting in the provinces (e.g. vacancy rates) do not feature prominently in the objectives, targets or indicators.
- 2.1.4.3. There is lack of alignment between this NDOH 2009-12 strategic plan and other major national strategic documents, such as the National Strategic Plan (NSP) on HIV&AIDS and STIs (2007 and 2011) and the five year Tuberculosis (TB) strategic plan. For example, a measurable objective under strategic health programmes states: 'reduce HIV prevalence amongst antenatal attendees by 50%, from 29% in 2008 to 15% in 2011'. This is not only in contradiction to the NSP goal of reducing the number of new HIV infections by 50%, but also indicates little understanding of the difference between the new infections (incidence) and existing infections (prevalence).
- 2.1.4.4. There is a disjuncture between targets set in the plan and budgets allocated, and there is no indication of the total health sector budget needed to meet the targets.

## **2.2. PROVINCIAL LEVEL**

- 2.2.1. Concerns about politically motivated appointments at various levels were expressed during interviews.
- 2.2.2. There are examples of good programme leadership in provinces, described in more detail in the provincial reports. In general provincial respondents felt that the NDOH has provided insufficient stewardship and leadership to solve the critical issue of ensuring that the available health resources are sufficient for the levels of service and targets envisaged by a range of national policies.
- 2.2.3. Provincial respondents also indicated that policies (and associated targets) set by the NDOH, are excellent and in line with international best practice, but without a clear understanding of either the resources, skills and capacity requirements for implementation or the resource gaps and constraints (e.g. budget, staff and skills shortages) experienced at service delivery level. It was also felt that national policies are not followed up or supported during implementation at provincial level. Although national policies contain the core strategies, these lack clear guidelines on implementation. In general, unclear roles and responsibilities between different levels



of management were also identified. Leadership at district and sub-district levels is generally weak and support from provincial offices is lacking.

### **3. PLANNING**

#### **3.1. AFFORDABILITY THROUGH SERVICE TRANSFORMATION PLANS (STPS)**

3.1.1. There is no national STP which provides overall guidance on how to reshape and reconfigure the public health system over a five to ten year period. This compromises other strategic planning efforts as there is no overarching vision of what the South African health system should look like in the future.

3.1.2. The Western Cape is the only province with an approved STP, while the other provincial STPs are in draft form, with varying quality and level of political support.

#### **3.2. ANNUAL PERFORMANCE PLAN (APP)**

3.2.1. It was found that at provincial level there is very little difference in the APP from one year to the next and many of the tables used are identical. The APP does not appear to play a meaningful role in addressing key strategic priorities, such as equity, and appears formulaic in terms of its layout and content.

#### **3.3. ALIGNMENT OF PLANS**

3.3.1. At the NDOH, set targets are mostly an estimate that is based on actual delivery for the previous financial year, the capacity of health care facilities (human resource and finance) and the trends of patient enrolment.

3.3.2. At provincial level, it was also clear that there was a lack of communication between the various levels and that planning was done in organisational boxes. The APP is also not linked to the budget planning process.

3.3.3. There is no clear methodology in the setting of targets and budgets and financial resources are not linked to enhanced performance targets. The role of NDOH in assisting the provinces in the setting of targets is unclear.



## 4. NORMS, STANDARDS AND GUIDELINES

- 4.1. The Office of Standards Compliance was established in terms of the National Health Act (NHA) just over one year ago. Achievements include the assessment of 27 hospitals and four community health centres and the production of a set of core standards for health facilities. However, the standards are not linked to strategic plans, monitoring and evaluation or programme indicators. The Office does not have a dedicated budget and lacks capacity to execute its mandate. Provinces are expected to incorporate the core standards into their strategic plans and are responsible for monitoring their own compliance with core standards. There is currently no system to verify compliance or to track or assist with implementation.
- 4.2. Many clusters or programmes have produced guidelines, ranging from the essential drug list for different levels of care, through to guidelines on specific disease conditions e.g. integrated management of childhood illnesses (IMCI) or the Prevention of Mother-to-Child-Transmission programme (PMTCT), and so on.
- 4.3. At provincial level, the general perception was that the NDOH has provided limited and insufficient direction with regard to setting of norms, standards and guidelines to provinces, exacerbated at times by a lack in consultation between NDOH and provinces.
- 4.4. There are several challenges regarding the setting of national norms, standards and guidelines, shown below:
  - 4.4.1. Absence of guidelines in critical areas, such as service packages for different levels of care, human resource production and highly specialised tertiary services. It is also unclear who is responsible for the production of clinical guidelines on highly specialised tertiary services, which are high cost services.
  - 4.4.2. There is lack of coordination across different divisions, and at times different programme guidelines produce contradictory facility requirements.
  - 4.4.3. Affordability of guidelines as costs are unknown or have not been carefully considered.



- 4.4.4. Implementation of and/or compliance with these guidelines. We were informed that there are nine different permutations of the implementation of the district health system.
- 4.4.5. An inadequate monitoring and evaluation system makes it difficult to determine compliance with existing guidelines, as NDOH is mostly dependent on information supplied by provinces.
- 4.4.6. Community input into quality standards is largely absent and there are limited human and financial resources to engage in a more consultative process.

## **5. GOVERNANCE AND ACCOUNTABILITY**

- 5.1. At provincial level, an analysis of the agenda and minutes of various meetings reveal that there is inadequate action and follow up and management tended to be focused more on operational and bureaucratic issues than on strategic matters of service delivery.
- 5.2. Meetings are often arranged at short notice or rescheduled and attended by inappropriate staff members.
- 5.3. Although the various clusters in the NDOH have quarterly review meetings with all the provinces to review specific programmes, portfolio or conditional grants, several shortcomings in the current process were identified:
  - 5.3.1. Plethora of meetings requiring provincial attendance. Currently every programme and/or cluster attempts to liaise with a counterpart in the nine provinces.
  - 5.3.2. Lack of clarity regarding budgets or payment for national/provincial meetings.
  - 5.3.3. Lack of structural arrangements for certain key portfolios. There are no formal structured meetings between the M&E cluster and the provinces, except through the National Health Information System of South Africa (NHISSA).
  - 5.3.4. Level of attendance at these national/provincial meetings.



- 5.3.5. Lack of a structured feedback mechanism on matters of concern.
- 5.4. There are serious challenges with the current accountability mechanisms between the provincial health departments and the NDOH. The concurrency of health functions enunciated in the Constitution was raised as the main cause of the challenges of accountability. The NDOH respondents indicated that provincial health departments do not see their primary accountability to the NDOH and have their own priorities, have their own accountability structures and act largely as independent institutions.
- 5.5. Within the national/provincial dynamic, existing processes and relationships contribute significantly to, and detrimentally affect, 'deficient' legal and structural accountability mechanisms. Accountability reportedly depends on the relationships with provinces and the attitudes of provincial programme managers, but more importantly the attitudes of provincial HODs. There are considerable variations across the nine provinces, ranging from welcoming, collegial relationships to outright antagonism, refusing national assistance or guidance.
- 5.6. Accountability was hampered at provincial level due to the lack of appointment of senior executives, with many managers in acting positions.

## **6. SERVICE DELIVERY**

- 6.1. Although NDOH is not responsible for direct service delivery, its mandate and much of its work impacts on service delivery. There appears to be little recognition of the inter-connectedness of different components of the health system, and links between high level policies and implementation, so that health outcome goals are achieved.
- 6.2. There is no or little synergy between key programme clusters as managers in HIV, TB & MCH have not integrated their work plans. The implementation of the National Tuberculosis Programme is fragmented, with considerable variation across provinces and a lack of integration between the TB programme and other programmes, notably HIV, and lack of buy-in from senior provincial managers for the TB programme. The HIV cluster indicated that HIV prevention and treatment are not well integrated, that prevention is not on target and that little is known of the current performance of HIV prevention programmes.



- 6.3. HIV (especially prevention) and TB are both designated as high priority areas in the provincial APPs. However, the targets for intervention are modest and do not convey a sense of urgency.
- 6.4. One of the problems facing the ARV programme is the inadequacy of the monitoring systems, including those of waiting lists. This makes it extremely difficult to forecast both demand and supply.
- 6.5. The current model of HIV treatment delivery by which ARVs are supplied primarily by centrally located hospitals is not compatible with making this service accessible to the large numbers of people who are in need of care. Similarly, the current funding model of ARV provision is neither affordable nor sustainable.
- 6.6. In general patients access the health system at inappropriate levels and by-pass the PHC clinic structure. They attend hospitals for their initial contact visits and often receive primary level care at expensive tertiary institutions.

## **7. RECOMMENDATIONS**

### **7.1. NATIONAL STEWARDSHIP AND LEADERSHIP**

- 7.1.1. The Minister of Health should drive the development of one national health vision and strategy. This should be done with the involvement and participation of the provincial health MECs and health departments, frontline health care providers, communities who depend on the public sector and civil society broadly. The national health strategy should include inter alia: statement of shared values and principles; key targets for improving population health outcomes; affordable service packages for different levels of care; strategies to improve the performance of the South African health system (including its building blocks); resource requirements and it should contain a prioritized set of performance indicators.
- 7.1.2. Good stewardship also requires a combination of strategies to build coalitions of support from different groups, influence stakeholders' behaviour and information for decision-making.



- 7.1.3. There should be explicit and open discussion around the budget and the level of services that can be rendered for this budget. The areas of rationing and prioritization at clinics and hospitals should be made clear and communicated effectively to all concerned. All sources of funding should be evaluated, and should rationing be required, the process followed should be constitutionally sound and involve key stakeholders.
- 7.1.4. There should be an iterative process to development of national policies where provincial realities and feedback is given so that policies can be amended to fit the realities or additional resources made available.
- 7.1.5. Service delivery and budgets should be aligned so that managers are not faced with ad hoc budget cuts.
- 7.1.6. Better day-to-day planning is required so as to avoid unplanned meetings and facilitate better time management by managers. This can also include cutting back on unnecessary meetings and streamlining programme training and workshops through better coordination amongst national and provincial programme managers.
- 7.1.7. Executive Committee meetings should assign a person responsible for specific tasks, and assign a deadline date for the completion of the task.

## **7.2. PLANNING**

- 7.2.1. The annual national health plan should guide and determine provincial priorities and plans and should be completed annually by June to form a basis for compiling the budget requests to Treasury for the following financial year.
- 7.2.2. A national STP should be developed, as a complementary, but linked activity to the national vision and strategy. The criteria for developing the STP should be transparent, and should also cover district level services and primary health care, in addition to secondary and tertiary services. The STP should contain accurate costs and other resource requirements and should be broadly consultative and participatory. It should be endorsed politically, widely communicated to all relevant stakeholders and it should inform strategic decision-making in the provinces.



Particular attention should be paid to the process of implementation of the STP and to stakeholder buy-in.

- 7.2.3. There should be alignment between the national vision and strategy, programme strategic plans and ANHP, as well as between targets and interventions within the NDOH. All plans should pay more attention to implementation, and should contain a clear M&E framework with performance targets. Implementation of the plans should be monitored regularly, deviations from targets picked up and remedial action taken if necessary.
- 7.2.4. National targets should be based on realistic forecasts of actual need, and take account of provincial dynamics, intended outcomes and should be achievable and affordable.
- 7.2.5. External support for the planning processes should be sought if necessary, but accountability must be with the NDOH, rather than with the potential consultants.
  - 7.2.5.1. The relationships between universities and provincial health departments should be strengthened with regard to service delivery, training and research.
  - 7.2.5.2. All planning processes at provincial level should be aligned with each other and well communicated. There should be a limited number of key targets for each area of operation for which managers are responsible and accountable.
  - 7.2.5.3. There should be linkages between health programme, HR and financial management and reporting systems.

### **7.3. NORMS, STANDARDS AND GUIDELINES**

- 7.3.1. The Office of Standards Compliance should be capacitated and resourced to: develop a national repository of norms, standards and guidelines; oversee and guide the development of more effective and affordable services, quality and clinical care guidelines, linked to resource requirements and performance measures and indicators; and enforce compliance with such norms, standards and guidelines.



7.3.2. The different roles and responsibilities of the Office of Standards Compliance, Priority Programmes, Strategic Planning and Monitoring and Evaluation clusters should be clarified and streamlined.

7.3.3. The development of norms and standards for highly specialised tertiary services should be prioritised, given the cost of these services and links to the training of future medical specialists.

#### **7.4. GOVERNANCE AND ACCOUNTABILITY**

7.4.1. The role and required expertise of strategic health programme managers at national, provincial and district levels need review with a clear outline of their key result areas and performance measures. There need to be clear vertical and horizontal communication mechanisms between these programme managers and line service delivery managers (see also Human Resources).

7.4.2. Within the public health sector, the various meetings should be reviewed and restructured (if necessary), and their functioning improved. Senior management meetings need to focus on strategic issues, such as achieving health outcomes, quality service delivery and improving overall health system performance. Decisions of meetings need to result in clearly defined actions with associated responsibilities and timeframes.

7.4.3. The NDOH should provide provinces with clear written guidelines regarding the delegation of authority, responsibility and accountability to facility and district managers.

#### **7.5. SERVICE DELIVERY**

7.5.1. The NDOH should adopt a broader public health approach to service delivery and produce comprehensive, integrated guidelines covering all aspects of service delivery in relation to HIV, TB and MCH. These guidelines should be linked to the overall national vision and plan, be affordable and contain norms and standards (including addressing data gathering, monitoring and evaluation, human resources, funding).



- 7.5.2. Quality of care should be prioritised and an enabling environment to achieve quality (e.g. supportive supervision, resources, delegations and accountability) should be fostered.
- 7.5.3. The current service delivery models to address the country's disease burden, and manage new and emerging health problems need review. Much more attention needs to be paid to prevention and health promotion, and making it work in practice.
- 7.5.4. The role and expertise of strategic health programme managers at national, provincial and district levels need review with clear guidelines of performance expectations. There needs to be clear communication (vertical) between these programme managers at these three levels on the one hand and also between these programme managers and line service delivery managers (horizontal) on the other hand.
- 7.5.5. There should be clear communication between all these role players in ensuring that their planning is based on the current realities. However, targets should be set that continuously ensure significant improvement in health outcomes in agreed upon priority areas.



# Human Resources

## 1. INTRODUCTION

### Box 3: Human resource review key findings

1. Organisational structuring in the provinces is not done according to agreed benchmarks or aligned with existing plans or resources. A trend raising serious concern is the continued growth in management and administrative positions across the various provinces, especially in provincial head offices. There is insufficient guidance from the NDOH on this matter as NDOH view this as a DPISA responsibility. Consequently, evidence of alignment of affordable human resources planning and budgeting, to fulfil the NDOH and the various provinces' strategic plans, could not be found.
2. Despite written policies on delegations, in most provinces delegations have been withdrawn by the Provincial Treasury or by the HODs, with resultant day to day management by head office and widespread feelings of disempowerment and lack of accountability at facility levels. In the NDOH, although delegations exist and are followed, clear accountability mechanisms, with clearly defined roles and responsibilities among various branches and clusters are largely absent.
3. Inadequate linkages, lack of coordination and integration as well as "silo" functioning within the various departments are evident. Integrated, yet simple departmental performance dashboards are absent from provincial departments as well as the NDOH.
4. The shortage and retention of health professionals in rural areas remains a major challenge while lengthy recruitment processes compound this problem.
5. Recruitment turnaround times across the various departments range from six to nine months.
6. With the exception of NDOH and WCDOH, performance management is not functioning as envisaged. In addition, performance management criteria rarely have a link to service delivery performance, strategic priorities or rewards.
7. OSD implementation has led to numerous problems in the various provinces, including over-expenditure and the recent and threatened doctors' industrial action. Provincial health departments view this as a result of inadequate planning by NDOH, whereas the NDOH holds the opinion that this is as a result

**Box 3: Human resource review key findings**

of National Treasury and provincial treasuries not providing sufficient funding for OSD, insufficient skills and capacity to implement the roll-out, wrongful application of guidelines by provinces, incorrect staffing numbers provided and inconsistent job titles and grades in provinces.

8. Training of current staff is not receiving sufficient attention and training budgets, with the exception of NDOH, are reduced as a cost reduction measure, which will have long term negative consequences.
9. PERSAL is not fully used as a management and planning tool and, inconsistent HR indicators are found in different official documents. PERSAL consistently reflects large numbers of outdated and unfunded positions.

## 2. BACKGROUND

- 2.1. As health service delivery is people driven, the largest part of the various provincial departments' operational budgets is the compensation of employees. During the financial year 2007/08 compensation of employees ranged between 51% and 65% of the operational budget, with a 56% provincial average. It is therefore of utmost importance that the complete value chain in organisational design, human resource management and development is run optimally to ensure a high standard of health service delivery and staffing cost efficiencies.
- 2.2. The IST review focussed on the following aspects impacting on the optimal utilisation of human resources:
  - 2.2.1. Delegations, accountability and responsibility
  - 2.2.2. Organisational integration and co-ordination
  - 2.2.3. Human resource planning
  - 2.2.4. Organisational design and establishment
  - 2.2.5. Recruitment
  - 2.2.6. Performance management



2.2.7. Retention

2.2.8. Rewards

2.2.9. Learning and development

2.2.10. HR information systems.

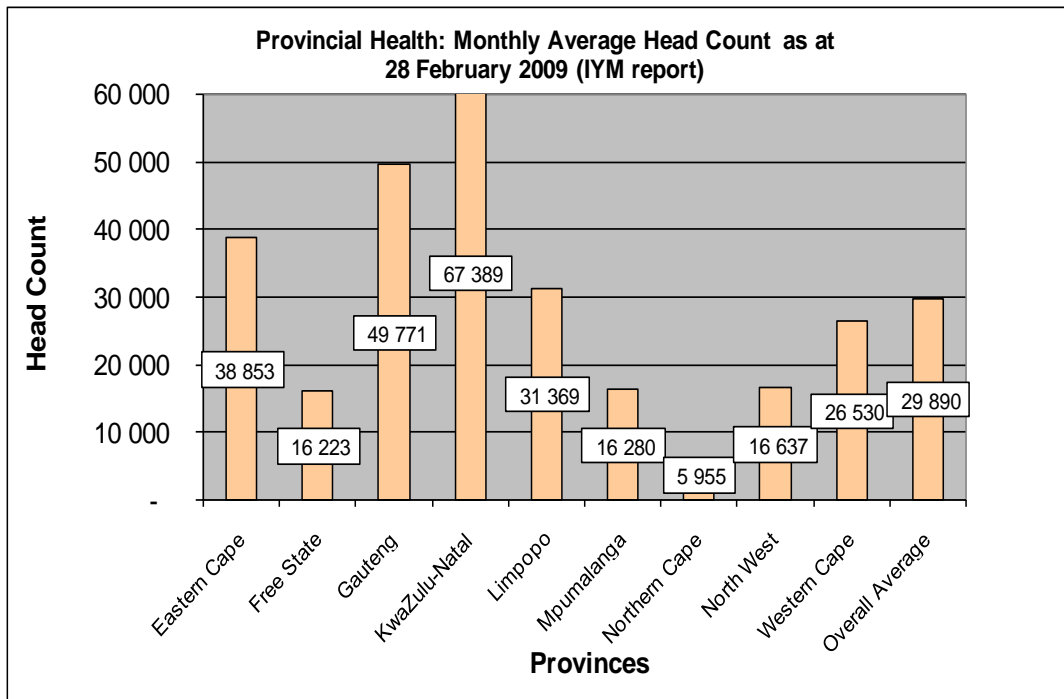
2.3. The rest of the section provides a brief overview of the overall current staffing situation, consolidated findings of the topics listed above and key recommendations.

### 3. OVERALL PROVINCIAL STAFFING PICTURE

3.1. On 28 February 2009, as per the IYM report, the head count across the provincial health departments was 269 007, with KwaZulu-Natal staffing numbers the highest at 67 389 and Northern Cape the lowest at 5 955.

3.2. The current staffing picture across the various provinces is reflected in Figure 3:

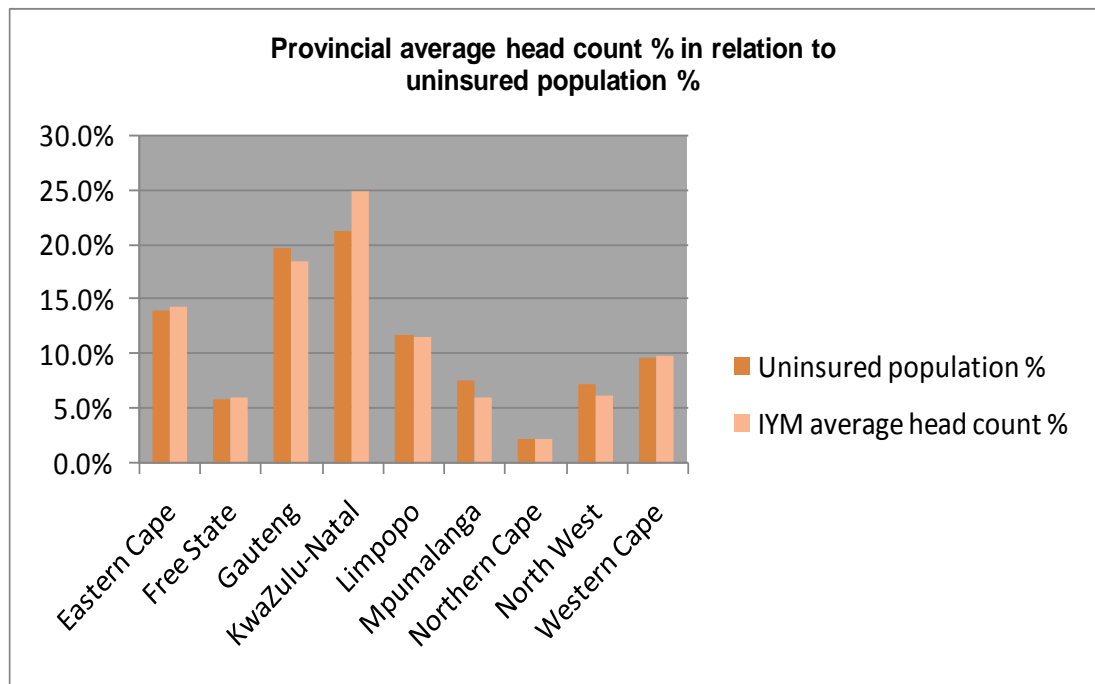
Figure 3: Provincial health monthly average head count as at 28 February 2009





3.3. Staffing numbers should be viewed among other factors, in relation to the uninsured population that is served as well as the disease burden provinces have to deal with. Figure 4 shows the relational comparisons across the provinces and indicates where attention for correction of staffing numbers, either down or up, should be focussed.

Figure 4: Provincial health monthly average head count as at 28 February 2009



3.4. In figure 4 it is evident that staff numbers in KwaZulu-Natal and to a lesser degree, Eastern Cape are high when compared to other provinces, whilst Mpumalanga, Gauteng and North West staffing numbers are slightly below the ratio relative to uninsured population. Western Cape, Free State and Limpopo appear to be in sync with the population served.

3.5. However, various factors need to be considered when assessing if a province’s staffing is sufficient to serve its needs. Factors such as disease burden, scarce skills, management ratios, administrative positions relative to professionals, the required size of head offices, rural and urban mix, the number of foreigners using the health system and general provincial infrastructure such as water, sanitation, transportation, all play a role in the workload assessment.



3.6. A trend raising serious concern is the continued growth in management and administrative positions across the various provinces, especially in provincial head offices. This needs to be addressed as a matter of urgency.

#### 4. CONSOLIDATED VIEW OF IST ASSESSMENT OF HR ASPECTS

4.1. A consolidated view of the aspects reviewed by IST across the various provinces and NDOH, which impact on cost efficiencies and service delivery review is summarised in Table 5:

Table 5 Consolidated view of HR aspects reviewed across 10 health departments  
 Legend: 1 = Acceptable, 2 = Require attention, 3 = Impacting negatively on efficiencies and service delivery

Topic	EC DOH	FS DOH	GDOH	KZN DOH	LDOH	MDOH	NC DOH	NW DOH	WC DOH	NDOH
Delegations, Accountability and Responsibility	3	3	3	3	3	3	3	3	1	1
Integration and co-ordination	3	3	2	3	3	3	3	3	2	3
Labour Planning	3	3	2	3	3	3	2	3	1	3
Organisational Design and Staff Establishment	3	3	3	3	3	3	2	3	1	3
Recruitment	3	3	3	3	3	3	3	3	2	2
Performance Management	3	2	2	3	3	3	3	3	1	2
Retention	3	3	2	3	3	3	3	3	2	2
Rewards	3	3	3	3	3	3	3	3	2	2
Learning and Development	3	3	2	3	3	3	3	2	2	1
HR Information Systems	3	2	2	3	3	3	3	3	2	2

4.2. Organisational and operational aspects that impact most severely on service delivery, working relationships and efficiencies in the various health departments include:

4.2.1. Delegations, accountability and responsibility.

4.2.2. Organisational integration and co-ordination.



- 4.3. The top five HR topics impacting most on service delivery and staffing costs identified across the various provincial health departments were:
- 4.3.1. Organisational structuring and establishments.
  - 4.3.2. Rewards, including OSD.
  - 4.3.3. Performance management.
  - 4.3.4. Retention.
  - 4.3.5. Training and development.
- 4.4. Additional aspects that impact on HR process efficiencies include recruitment and HR information systems.
- 4.5. The analysis and findings across provinces and NDOH are briefly described below.

## **5. OPERATIONAL AND ORGANISATIONAL ASPECTS**

- 5.1. Despite written policies on delegations, in most provinces delegations have been withdrawn by the Provincial Treasury or by the HODs, with resultant day to day management done by head office, and widespread feelings of disempowerment and lack of accountability at facility levels.
- 5.2. In the NDOH, although delegations exist and are followed, clear accountability mechanisms, with clearly defined roles and responsibilities among various branches and clusters, are largely absent.
- 5.3. Inadequate linkages, lack of coordination and integration as well as “silo” functioning within the various departments were evident and integrated departmental performance dashboards are absent from provincial health departments as well as the NDOH.



## 6. ORGANISATIONAL STRUCTURING AND ESTABLISHMENT

- 6.1. There are various regulations and acts describing the compliance requirements in organisational design and the HR value chain. The NDOH does not see it as its responsibility to provide norms and standards to provinces on key organisational aspects such as organisational structuring guidelines, organograms and required staffing levels based on service delivery requirements.
- 6.2. The main reason for this viewpoint is the current roles of the various role-players:
- 6.2.1. NDOH focuses on the overall planning and provision of trained health professionals and provides strategies, plans and guidelines of national concern, such as the Nursing strategy, National Human Resources for Health Planning Framework, Rural retention strategy, Foreign doctors policy and interaction with and ensuring capacity of tertiary and academic training institutions - in collaboration with the Department of Education.
- 6.2.2. The DPSA provides requirements and guidelines on organisational design, post establishment, job evaluation, performance management, compensation of employees.
- 6.2.3. Provinces are largely autonomous and have the right to implement the various acts, regulations and guidelines according to their own situation and requirements.
- 6.3. However, during the review of the various provincial health departments numerous problems were found in this process and recommendations were made that require greater guidance, collaboration and inputs by the national departments of Health and Education, the DPSA and National Treasury.
- 6.4. The organograms and establishments are of the biggest concerns with regard to the provinces. This has a direct service delivery and cost impact on the various provinces. Over a period of 10 years from 1997 to 2006 the staffing figures first declined and then returned to original levels. However, the relative number of management and administration staffing figures are totally out of line with growth in medical and nursing staff as illustrated in Table 6:

Table 6: *RSA public health staffing changes from 1997 to 2006*

RSA public health staffing	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	% change (1997 to 2006)
Administration	28 676	27 435	27 188	25 884	27 629	27 253	22 662	28 953	32 052	37 419	30.5
AHP <sup>13</sup>	13 786	13 779	13 598	13 524	13 824	16 955	18 307	19 363	22 470	23 349	69.4
HSS <sup>14</sup>	81 097	77 603	72 839	67 172	67 209	65 614	62 330	60 397	60 388	60 030	-26
Management	420	381	379	342	555	620	700	800	1 314	1 091	159.8
Medical	15 554	15 593	14 875	14 256	14 759	14 980	13 572	14 219	14 659	16 006	2.9
Nursing	111 102	105 757	101 982	99 473	99 618	100 079	101 090	103 387	107 762	113 153	1.8
<b>Total</b>	<b>250 635</b>	<b>240 548</b>	<b>230 861</b>	<b>220 651</b>	<b>223 594</b>	<b>225 501</b>	<b>218 661</b>	<b>227 119</b>	<b>238 645</b>	<b>251 048</b>	<b>0.2</b>

Source: *National and provincial public health resource expenditure, training and production costs, 2008, page 75.*

<sup>13</sup> AHP = Associated health professionals including community development, environmental health, HIV workers, malaria program, oral health, clinical psychology positions

<sup>14</sup> HSS = Hospital and health support including cleaning, food, housekeeping, laundry services, maintenance and building, security, stores, transport and unskilled labour positions.



- 6.5. This table illustrates the following:
- 6.5.1. Medical and nursing staff numbers showed little growth, even with an increase in national population and disease burden over the timeframe.
  - 6.5.2. Management staff grew by almost 160% or 671 people.
  - 6.5.3. Administrative staff grew by 30.5% or 8 743 people.
  - 6.5.4. Hospital and health services staff declined by 26% or 21 067 people.
  - 6.5.5. Together, management and administrative staff grew with 32,3 % or 9 414 people.
  - 6.5.6. This raises the question whether management structures are appropriately prioritised relative to frontline service providers.
- 6.6. It was found in all provinces that PERSAL showed major differences (in some cases more than 10 000 positions) in the number of positions when compared to budgeted positions. Many provinces indicated that new organisational structures with consequent huge cost impacts, are being considered, but with limited linkages to STPs, outcomes or disease profiles.
- 6.7. Provincial respondents identified a need for national norms and standards to guide provincial organisational structuring and staffing establishments.

## **7. RECRUITMENT**

- 7.1. The single most important challenge with regard to human resources is the recruitment and retention of health professionals.
- 7.2. The problems facing recruitment and retention in the rural areas is a societal one as socio-economic factors such as lack of proper housing, schools, recreation and facilities are important factors that discourage medical personnel to go to rural areas. As a result, in rural areas, where the need is greatest, recruiting skilled staff is one of the most significant constraints to improving access to health care.



7.3. However, recruitment of staff is a general problem, especially in the scarce skills and critical skills categories. Generally recruitment turnaround times across the various departments range from six to nine months.

## **8. REWARDS, INCLUDING OSD**

8.1. The introduction of Occupational Specific Dispensation (OSD) was based on a remuneration policy developed by NDOH and DPSA for health professionals employed in the public health sector to:

8.1.1. Enhance recruitment and retention of those skills and competencies required in the health service delivery.

8.1.2. Provide clear salary and career progression measures based on competence and performance.

8.1.3. Recognise outstanding performance through remuneration.

8.1.4. Reward skills and professional competencies.

8.1.5. Support personal development.

8.1.6. Create transparency in salary determination.

8.2. However, it is known that OSD implementation has led to numerous problems in the various provinces including over-expenditure and the recent and threatened doctors' industrial action. It was stated by NDOH that these were mainly as a result of:

8.2.1. National Treasury and provincial treasuries not providing sufficient funding for OSD.

8.2.2. Insufficient skills to implement the roll-out.

8.2.3. Wrongful application of guidelines by provinces.



- 8.2.4. Incorrect staffing numbers provided, including inconsistent job titles and grades in provinces.
- 8.3. In turn, the various provincial departments blamed OSD as a major reason for over-expenditure. Analysis by the IST showed that the implementation of OSD is not the only reason for the continued growth and overspending in the compensation of employees across the operational budgets. Growth in establishments, overtime, additional allowances and salary increases were all factors contributing to this problem. In provinces where OSD was implemented in a coordinated and planned manner, problems of over-expenditure were not as severe as in other provinces e.g. Western Cape Department of Health (WCDOH), where it was identified in advance that the budget was going to be insufficient and WCDOH notified national and provincial treasuries. In this particular case the over-expenditure was funded and a multi-sector team was established to implement the policy.

## **9. PERFORMANCE MANAGEMENT**

- 9.1. In many of the provinces it was found that performance management was sub-optimal. The worst case scenario indicated political interference in performance management procedures and withholding resultant bonuses e.g. the Limpopo Department of Health and Social Development where performance scores were pulled back to an “average” for all staff as opposed to a best case scenario e.g. WCDOH, where there are performance agreements in place for all employees and the process has been entrenched according to HR guidelines with initiatives that link performance targets to service delivery.

## **10. RETENTION**

- 10.1. OSD has assisted to some degree in retaining nursing staff. However, in provinces with rural areas, retention of health and non-health professionals remains a challenge. NDOH indicated that the rural staff retention policy is under review and the planned roll-out of OSD for doctors will assist in retention, whilst provinces are responsible to define their own initiatives in terms of attraction of staff and bursary schemes.



- 10.2. However, it was found in the various provincial reviews that retention of staff in rural areas goes beyond health professionals' rewards. It is very clearly linked to other factors including:
- 10.2.1. Career development factors such as limited career development opportunities, training and career mobility; as well as
  - 10.2.2. Socio-economic factors such as the availability of housing, schooling, entertainment, transport and adequate security measures.
- 10.3. A national, overall retention strategy addressing these various factors and covering aspects such as a "talent pool" to ensure mobility and career development, as well as regional bursary schemes, to attract regional staff for later deployment, should be considered.

## **11. LEARNING AND DEVELOPMENT**

- 11.1. NDOH has undertaken various studies and implemented various actions at a national level to address the training and development of health professionals.
- 11.2. Recent core documents include:
- 11.2.1. A National Human Resources for Health Planning Framework
  - 11.2.2. Training and production costs of national and provincial public health resource expenditure
  - 11.2.3. Nursing strategy for South Africa.
- 11.3. However, at provincial level, it has been found that learning and development for current staff is receiving insufficient attention; the training focus does not impact on or improve health service delivery; and budgeted training expenditure is cut back to save costs. As a result, longer term health service delivery and cost effectiveness will suffer and this needs a coordinated, national view to address the situation.



- 11.4. The approach to the production of health care professionals and relationships with health science faculties require more focussed national attention, as there is considerable variation in provinces.

## **12. HR INFORMATION SYSTEMS**

- 12.1. PERSAL is not fully used as a management and planning tool and limited, inconsistent HR indicators are found in different official documents. This is mainly because the system is not maintained as required, the functionality is not fully used or understood and lack of capacity and skills across the various provinces.
- 12.2. PERSAL consistently reflects large numbers of outdated and unfunded positions and hence planning and reporting using PERSAL is largely academic e.g. vacancy rates.
- 12.3. At national level an HR information system is being developed and is reportedly 90% complete. This will provide sufficient information for planning and management of the health workforce nationally. It was mentioned that this is required because PERSAL does not generate all the data sets required for planning and reporting purposes, including qualifications, gender, age and location of health professionals, external to the public health sector.
- 12.4. It is envisaged that this system will be able to pull information from other data sets and will require update from health professionals through the health and nursing professional councils and provinces. However, the total cost of the new system is unknown and it is unclear whether the maintenance and long term sustainability have been taken into account.

## **13. RECOMMENDATIONS**

### **13.1. ORGANISATIONAL STRUCTURING AND ESTABLISHMENTS**

- 13.1.1. National and provincial organisational structures should be reviewed and aligned, once the national vision and strategy has been finalised. The technical capacity should be strengthened at national level to provide stewardship and leadership to provinces for the achievement of health outcome goals.



13.1.2. Proposed new structures should be carefully reviewed and restructuring, with a view to establishing minimum staffing levels and optimal management and administrative positions, should be undertaken based on a number of factors, including objectively agreed benchmarks, optimal application of scarce skills, the departments' strategic and service delivery priorities and availability of resources. A moratorium on the establishment of additional provincial head office positions should be considered until the review is concluded.

### **13.2. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY**

13.2.1. Delegations should be re-instituted and a clear matrix in terms of delegation of authorities and decision making at various levels should be completed (This should be in line with a RACI matrix where different people are responsible, accountable, consulted or informed). The responsibility level of CEOs of institutions and district managers and their district management teams (DMTs) should be reviewed and addressed. This should include a review of financial management responsibilities.

13.2.2. Communication and coordination mechanisms need to be established across clusters to prevent "silo" operational functioning. One integrated national health system performance dashboard linking to departmental performance dashboards should be developed and implemented to provide an integrated view of performance across various provinces, programmes and branches and ensure integration and aligned cooperation.

### **13.3. RECRUITMENT**

13.3.1. A review and improvement of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times. DPSA needs to be involved in this process.

### **13.4. PERFORMANCE MANAGEMENT**

13.4.1. A review of the performance management system and its application should be undertaken to ensure the performance management system encompasses employee performance which is linked to organisational performance, employee development,



team based performance where appropriate and rewards based on clear performance goals

### **13.5. RETENTION**

13.5.1. A review of the national health professional and scarce skills retention strategy should be undertaken.

### **13.6. REWARDS**

13.6.1. A total reward strategy (monetary and non-monetary) review should be undertaken at national level to address issues of employee compensation overspend, skills scarcity and staff retention – including highlighting the importance of:

13.6.1.1. A thorough costing of any change in the reward system which must be done in collaboration with the affected parties and include an assessment of affordability at various levels.

13.6.1.2. Rewards linkages to organisational, employee and team performance.

13.6.1.3. Lessons learned from the current OSD implementation review for nurses should be captured to inform future implementation of other improvement initiatives.

### **13.7. LEARNING AND DEVELOPMENT**

13.7.1. Training and development programmes should be clearly defined and aligned to the service delivery priorities of the provinces. Well considered and prioritised commitments to relevant training should be maintained even during times of cost containment.

13.7.2. Long term production of health professionals require dedicated national focus and liaison with relevant stakeholders such as Department of Education, DPSA and universities.



### **13.8. HR INFORMATION SYSTEMS**

- 13.8.1. An assessment should be undertaken to establish reasons for under utilisation of HR systems and improved measures should be implemented including the full use of PERSAL as a HR management tool. PERSAL should also be corrected to accurately reflect funded personnel positions and staffing numbers accurately.
  
- 13.8.2. Long term maintenance and sustainability of the intended HR information system should be considered in the development and implementation thereof.



# Information Management

## 1. INTRODUCTION

### Box 4: Information management review key findings

1. There is a lack of a properly functioning M&E system for the health sector. Contributing to this is a lack of national guidelines, norms and standards as well as a lack of alignment between planning, implementation and monitoring and evaluation.
2. M&E problems are exacerbated by lack of an approved policy and overarching framework, and lack of clarity of roles and responsibilities (e.g. between M&E, strategic planning and programme divisions such as HIV, TB, MCH).
3. A significant amount of time and resources is spent on data collection, capture and collation at all levels. However, the data are characterised by poor quality control; inadequate analysis, interpretation; and little utilisation of information for decision-making. Hence poor quality indicators derived from the data find their way to NDOH and National Treasury, where there is also little interrogation and feedback.
4. There are numerous weaknesses in the district health information system and the ARV monitoring system. These include problems around data quality; the large number, standardisation and interpretation of indicators; and the lack of national norms and standards.
5. There is a lack of managerial accountability for the attainment of service related targets and M&E does not appear to be part of managerial performance assessment.
6. Although the NHISSA committee liaises with provinces, there are no structural mechanisms and/or formal linkages with the provincial health departments on M&E.
7. Parallel information systems are in operation and the lack of a single repository of information results in conflicting official information.
8. There is inadequate feedback to users, and decisions and actions are largely taken without accurate and up-to-date information.
9. The lack of technical expertise poses a risk to the already fragile M&E system, particularly the DHIS, BAS and PERSAL systems.
10. There is no dedicated budget to drive much needed M&E reforms.



- 1.1. Monitoring and evaluation (M&E) appears to be one of the weakest links in the overall management of health services. There is little communication from NDOH and the provinces to programme and line managers around M&E and there are few norms and standards related to M&E.
- 1.2. There is a lack of linkage between planning, implementation and M&E. Managers at all levels are not reviewing key indicators of efficiency (e.g. PDEs) or indicators of effectiveness (e.g. drop-out rates of patients on ARVs) with any regularity. Wide variations among similar type of facilities (and in the same facility over time – e.g. PDE) are neither questioned nor acted upon.
- 1.3. The NDOH reportedly has no access to BAS and financial information or to PERSAL and staff numbers in the provinces. Provincial health departments provide information to the Provincial Treasuries, from where the information goes to national Treasury. There is no central data-base within NDOH on budgets, spending or health system performance. The only provincial information that is kept is on the Conditional Grants as it is on the NDOH budget. However, *Vulindlela* is the government information system which integrates data from Persal and BAS, so it should be possible to keep and maintain a central data-base at the NDOH and to link it to other health system indicators.

## **2. LACK OF AN APPROVED POLICY AND OVERARCHING FRAMEWORK**

- 2.1. The NDOH has developed an M&E policy that has been circulated to provinces. A copy was made available to the IST team. The document aptly describes the current situation and is shown in the box below:



*“The production of health statistics is still characteristically fragmented and uncoordinated, within a “free-for-all” framework of data producers. There is lack of trust among various stakeholders. There is information collection fatigue (caused by various national reporting formats, many data elements and parallel requests for data) and poor appreciation of good information in service improvement and management of performance. Poor record management, lack of capacity, poor data quality, lack of stewardship and commitment characterize the public health sector. Policies on data flow and collection are poorly adhered to or not implemented yet these policies have been developed collectively. Private health sector collects a wealth of data, which is kept confidential and not shared. There are also data gaps in key policy areas, and a motley collection of data sets that have no common standards, are of poor quality, inconsistent, and incoherent”.*

Source: NDOH: *Policy framework for a functional, effective and sustainable health monitoring and evaluation system in South Africa*, draft document, 2009

- 2.2. Although the document is certainly a step in the right direction, it has several shortcomings in its current form, highlighted below:
- 2.2.1. Focuses on high level principles;
  - 2.2.2. Endorses the current fragmented systems of information collection;
  - 2.2.3. Does not provide a set of norms and standards to provinces;
  - 2.2.4. Is silent on resource requirements (staff, budgets, infrastructure, etc);
  - 2.2.5. Does not deal with the lack of clarity of roles and responsibilities and the lack of structural mechanisms and/or formal linkages with the provincial health departments;
  - 2.2.6. Does not deal with the difficult issues of how to move from the current reality to a results-based M&E system, and therefore misses an opportunity to achieve a lasting and sustainable M&E system.
- 2.3. These are aspects that must be addressed in any revised national policy.



### **3. USE OF INFORMATION FOR DECISION MAKING**

- 3.1. There is much service information being generated at various levels in the system. Significant time and other resources are going into the collection, data capture and collation of this information. However, the information is not being used optimally for management purposes and there are a number of issues that need to be addressed. These include:
- 3.1.1. Managers generally do not focus on M&E and it does not appear to be part of their job descriptions and formal performance appraisals. Management meetings at provincial and district level do not appear to focus on indicators and their relevance for action.
  - 3.1.2. There are too many indicators resulting in a mass of data. Only a few indicators measure outcomes or impact; most are linked to inputs and processes.
  - 3.1.3. There is little attempt to link the data of the three major systems viz PERSAL, BAS and DHIS. Thus reviews of financial data do not take into account efficiency and effectiveness data that is largely captured through the DHIS.
  - 3.1.4. The BAS reports are predominantly used for reviewing whether there are spending variances. The IST team analysis revealed that very simplistic reports are extracted from the BAS, and noted that managers had problems understanding the BAS reports. It was not clear which, if any, follow-up actions resulted from reviewing the BAS reports.
  - 3.1.5. Some managers are not focussed on, and sometimes do not understand, the significance of key indicators in their sphere of management. Examples include understanding of PDEs, numbers of staff in the section/division, ARV numbers on treatment and on waiting lists for treatment.
  - 3.1.6. There are inadequate M&E linkages and a lack of integration across divisions and with provinces and a lack of alignment with the budget.



- 3.1.7. There is also a lack of an 'early warning' health system performance measurement system, resulting in gaps in immediate action or responses.
- 3.1.8. Data is fed up the line but there is little analysis, interpretation and feed-back of data back to the lower levels. As a result poor quality data finds a way through the system all the way through to the NDOH and the National Treasury.

#### **4. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)**

- 4.1. The DHIS is a reasonably well-established system of collection of a wide range of data on different aspects of the health system throughout the country, using a combination of manual, paper-based and quasi-electronic systems. The DHIS has great potential as a comprehensive system of routine data collection, but there are several problems:
  - 4.1.1. There are inadequate guidelines, norms and standards from national and provincial level on data collection tools and consequently processes of data collection are not standardised.
  - 4.1.2. There are problems with the quality of information, and provinces do not submit the information on time.
  - 4.1.3. The indicator list in the national indicator data set (NIDS) has not been updated since 2005 and certain indicators (e.g. dual therapy PMTCT indicators) are not included.
  - 4.1.4. Some of the indicators are confusing, not standardised and are without unambiguous and clear definitions (e.g. % districts implementing primary health care; for the nurse workload indicator it is not clear which category of nurse is included and it is also not clear how many days to include in cases of sick leave and study leave; the teenage pregnancy rate in FSDOH is using under 20 years as the denominator whereas NDOH is using under 18 years).
  - 4.1.5. Indicators are occasionally changed, or added to, by programme managers at national (and provincial) level without written guidelines and are sometimes based on workshop proceedings (e.g. PMTCT).



- 4.1.6. Data is only captured into DHIS once a month. Additional manual systems are in place to track a select number of indicators on an ongoing basis to allow timely action on disease indicators.
- 4.1.7. Provincial personnel do not make sufficient use of the system, due to a lack of IT infrastructure, skills and competency. It was reported that there is only 16% connectivity amongst the health institutions in the GDOH.
- 4.1.8. Although national health owns the DHIS, there is only one person (not employed by the NDOH) who can combine the provincial files and create one 'national file'. Another person (departmental official) is being trained currently. However, this is a major risk for the health information system.
- 4.2. Indicators are also not prioritised. The national strategic planning cluster manager indicated that there are 290 performance indicators, of which 145 are reflected in the APPs and 67 of these are reported on a quarterly basis. These indicators do not necessarily include all the information collected as part of the DHIS or in some of the programmes. The team was informed that the various branches/clusters monitor performance against plans and spending against budgets is done mainly in the CFO's office. It was also reported that feedback on performance by clusters is in most cases not against targets in plans. There is little outcomes-based evaluation.
- 4.3. Data is collected manually at facility level using registers and tally sheets for the various programmes. The collated facility level data is forwarded to sub-district or district level where it is captured electronically and sent on to the provincial department where it is validated before being reported to the national department.
- 4.4. Inadequate leadership and guidance from NDOH has resulted in many provinces taking the lead in developing costly health information systems. For example, there are twenty eight (28) standalone systems in use in the Gauteng Department of Health (GDOH). This makes the compilation of reports cumbersome and copying and pasting data from a variety of sources makes the information vulnerable to inaccuracies. Similarly, the Western Cape has developed Sinjani, a parallel system to the DHIS that reportedly responds to the prescribed national data elements but is more responsive to "provincial M&E needs", whilst GDOH is planning a new HIS.



## **5. ARV MONITORING AND EVALUATION**

- 5.1. As the provision of ARVs is an important component of the overall strategy against HIV, it is essential for a good M&E programme to be in place to assess the effectiveness of the programme and to measure the cost-efficiency.
- 5.2. The ARV M&E system has a number of significant weaknesses:
  - 5.2.1. There are no clear guidelines, norms and standards from NDOH guiding the provinces around an information system for ARV, resulting in the development of individual provincial M&E systems.
  - 5.2.2. There is no single figure on the number of people on ARV treatment e.g. different managers at different places in the FSDOH quote different figures as to how many people are on ARV treatment.
  - 5.2.3. In one of the sites visited the clinicians were ignorant of any indicators related to ARV and were treating individual patients as they arrived at the site without any understanding of how the programme as a whole was performing.

## **6. OTHER M&E ISSUES**

- 6.1. There are a number of parallel information systems - (e.g. HIV programmatic information) in addition to that supplied by the DHIS.
- 6.2. There is no single repository of information and as a result there are conflicting sources of official information.
- 6.3. There is a lack of managerial accountability for the attainment of service related targets and M&E does not appear to be part of managerial performance assessment.
- 6.4. Although the NHISSA committee liaises with provinces and despite the critical nature of the M&E cluster as a whole, there are no structural mechanisms and/or formal linkages with the provincial health departments.



- 6.5. Quarterly reports are regularly prepared for NDOH and the National Treasury. These reports are not always scrutinised throughout the department and there is little or no feedback on these reports.
- 6.6. There is a general lack of integration of information and BAS and PERSAL data are not aligned with service delivery data. At facility level (clinics and CHCs) there are often no facility-based records kept of interactions with patients. Even basic registers are not kept. This makes it difficult to verify whether there has been adequate data collection.
- 6.7. Several respondents reported major skills capacity problems with personnel dealing with the PERSAL and BAS systems. This included problems both in capturing data and in drawing reports.

## **7. RECOMMENDATIONS**

### **7.1. OVERALL M&E**

- 7.1.1. Monitoring and evaluation must be prioritized as a matter of urgency; an affordable national M&E system must be developed, with commensurate financial and human resources and technical expertise to ensure successful implementation.
- 7.1.2. To achieve this, an urgent plan to achieve an integrated and affordable National Health Information System (NHIS) should be developed. Such a HIS should meet the criteria for effective and sustainable information systems; enable integration of health outcome, finance, human resource, quality and efficiency indicators and assist with the provision of data for decision-making, as well as information to measure health and service delivery improvements and the achievements of set targets.
- 7.1.3. An immediate moratorium should be placed on provincial health departments' acquisition of electronic health information systems and the resources should be pooled and contribute to the development of a NHIS.
- 7.1.4. M&E needs to become a central component of all managerial activity with the use of objective information being the basis for decision making.



- 7.1.5. Regular formal monitoring, analysis, interpretation and feedback of key indicators needs to take place at every level of the system with analysis and questioning of variances (in much the same way as financial management variance analysis should take place).
- 7.1.6. Best practices of M&E should be shared amongst the provinces.
- 7.1.7. Skills levels of staff (especially on BAS and PERSAL) need to be reviewed and corrective measures agreed upon and implemented.
- 7.1.8. To support the M&E work, basic infrastructure needs to be in place e.g. generators, ADSL lines. In addition, innovative approaches need to be explored e.g. cellular phone technology. NDOH could help with leadership in these areas.
- 7.1.9. The culture of the system must become M&E orientated. A culture of 'blame' does not support the M&E culture. Where institutional managers experience problems with decision making, they should be able to get support and backup from senior management who take collective responsibility for such decisions.

## **7.2. USE OF INFORMATION FOR DECISION MAKING**

- 7.2.1. M&E, based on a limited and reduced number of key indicators, needs to be built into every senior manager's job description and performance appraisal.
- 7.2.2. Where applicable, in-service training around understanding of, and the importance of, key indicators for managers needs to take place.
- 7.2.3. There should be regular analysis, comparison, interpretation and feedback around indicators to lower levels of the system.

## **7.3. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)**

- 7.3.1. The DHIS, and associated NIDS, needs to be reviewed by the NDOH, and aligned with the overall M&E framework.



- 7.3.2. The number of indicators need to be decreased, using international guidelines on good indicators.
- 7.3.3. There should be clear, unambiguous, easy to understand, standardised definitions.
- 7.3.4. There also need to be clear written guidelines, norms and standards for each component of the DHIS, including data collection tools (forms and registers); relevant human resources, hardware, software, data flow policies and linkages between the DHIS and other data collection systems such as the TB, PERSAL and BAS systems.

#### **7.4. ARV MONITORING AND EVALUATION**

- 7.4.1. A workable, practical, easy-to-use system of monitoring the ARV programme needs to be put in place, but not outside the framework of the M&E system and the NHIS.
- 7.4.2. Ideally this should be developed (with detailed guidelines, norms and standards for every aspect of the system) by the NDOH and communicated to the provinces. Given the importance and magnitude of the ART programme this should be done immediately.

#### **7.5. OTHER M&E ISSUES**

- 7.5.1. The NHISSA should be reviewed, both as to membership and its effectiveness. It should be appropriately mandated and resourced to fulfil its functions
- 7.5.2. There needs to be one official repository of information for health. All reports and other documents using information should be drawn from this repository to eliminate duplicate sources of information. All relevant role-players need to play their parts in ensuring that the most up to date, good quality information is passed into the repository.
- 7.5.3. Parallel systems of information (e.g. direct flow of information from facilities to programme managers – whether at provincial or national level - and the by-passing of district management structures) should be discontinued.



- 7.5.4. NDOH must support and monitor the process of implementation of the information management systems.
- 7.5.5. A records retention and information backup policy should be developed and implemented at facility, district, provincial and national levels.
- 7.5.6. Review and redesign facility data collection processes to enhance efficiency, remove duplication and simplify procedures.
- 7.5.7. Follow-up and corrective actions on identified indicators with variances need to form part of all M&E activities.



# Medical Products and Laboratory

## 1. INTRODUCTION

### Box 5: Medical products and laboratory review key findings

1. Pharmaceuticals are not treated as a major strategic issue, despite its critical nature to overall health care delivery, and despite it being a major cost driver.
2. Some provinces have experienced a shortage of medicines as a result of over-expenditure, poor planning in some instances and an inability of suppliers to fulfil contractual obligations, affecting many aspects of service delivery, from the vaccination of infants through to the continuation of treating patients on ARVs.
3. There appears to be a general lack of prioritisation of drug budgets.
4. There is inadequate communication and linkages between the provincial medical depots, pharmacists and programme managers are also lacking.
5. Supply chain processes including pro-active planning, stock control and distribution processes need to be optimised in most provinces.
6. Capacity constraints are experienced both at national and provincial departments of health. The national pharmaceutical cluster manager's post has been vacant for six months. It was reported that responsible staff members at provincial level are not appropriately skilled to manage pharmaceutical budgets of millions of rand.
7. Monitoring and control, including security measures of pharmaceutical products, is inadequate in most provinces.
8. Laboratory costs are a major cost driver and many provinces reported that the NHLS costs are extremely high compared with the private sector.
9. There is no national essential laboratory test list and clinicians and managers have not developed methods of prioritising laboratory tests or of working within a fixed budget for laboratory services.
10. The Public Entities, governance and management and special programmes branch at NDOH has been established to manage governance of the NHLS. However, the roles and functions of the branch are not clear and its linkages with provinces are not clear.
11. There is inadequate monitoring and control of laboratory services.



## **2. MEDICAL PRODUCTS**

- 2.1. Shortage of medical products was experienced in most provinces, although the extent and seriousness of the impact varied across the provinces. One of the reasons is that pharmaceuticals are not treated as a major strategic issue, despite its critical nature to overall health care delivery, and despite it being a major cost driver.
- 2.2. Apart from the impact on service delivery, patients by-pass clinics and go directly to hospitals which puts additional strain on the health system and add to the ineffective functioning of the district health system (DHS).
- 2.3. The following factors impact on the challenges experienced across provinces:
  - 2.3.1. Certain drugs e.g. streptomycin for TB could not be supplied by suppliers.
  - 2.3.2. NDOH implemented a new immunization schedule with limited prior consultation with the provinces which lead to additional over-expenditure.
  - 2.3.3. In many provinces supply chain management and distribution processes, including planning, stock control, monitoring and security are sub-optimal.
  - 2.3.4. Financial management is generally poor with the exception of WCDOH and NCDOH. In many provinces budgeting is not seen as a priority, expenditure control cannot be done due to the absence of, or outdated, systems. Manual cost allocations are mostly done.
  - 2.3.5. The turnaround times of delivering medical products in most provinces are sub-optimal.
  - 2.3.6. There is insufficient staffing due to shortage of pharmacists and skills levels at pharmaceutical depots are not appropriate.
  - 2.3.7. Ongoing monitoring and evaluation on the performance and usage of medical products is mostly inadequate.



- 2.3.8. Pharmacy infrastructure is generally poor.
- 2.3.9. The impact of HIV/AIDS and the growth of patient numbers requiring ART have had a serious impact on overspending and planning of medicines is not commensurate with service demand.
- 2.4. NDOH reported that norms and standards are provided for planning but not all provinces comply with these. In addition, the planning for ART is not done through the pharmaceutical cluster at national level.
- 2.5. NDOH also indicated that an information system has been in development for the past two years and the project, managed by SITA, is not delivering sufficient results and has not been implemented. This leads to underfunding due to incorrect data and budgeting, minimal leakage control, non-compliance with norms and standards and reported incidences of fraudulent activities. The essential drug list (EDL) data is not linked to an electronic system and NDOH has to depend on information received from provinces.

### **3. MEDICAL PRODUCTS RECOMMENDATIONS**

- 3.1. Pharmaceutical issues should form part of the agenda of HOD, CFO and provincial departmental strategic meetings and linkages between the pharmaceutical cluster and programme clusters should be established and/or improved.
- 3.2. Drug budgets should be prioritised and should form an integral part of health service planning, budgeting and monitoring activities.
- 3.3. The national pharmaceutical cluster manager in the NDOH should be appointed as a matter of urgency and the unit resourced appropriately so as to guide provinces and to ensure provincial compliance with norms and standards.
- 3.4. A review of all aspects of the management, operations and skills requirements of provincial medical depots should be carried out.
- 3.5. Strategic pharmaceutical issues should form an integral part of the overall STP and other key initiatives outlined above.



## **4. LABORATORY**

- 4.1. Laboratory services are provided to provinces by the National Health Laboratory Service (NHLS) on the basis of a service level agreement. Many provinces reported unsatisfactory service, lengthy turnaround times and double charging for costs. Laboratory costs are a major cost driver and many provinces reported that the NHLS costs are extremely high compared with the private sector.
- 4.2. Currently there is no national essential laboratory test list and clinicians and managers have generally not developed methods of prioritising laboratory tests or of working within a fixed budget for laboratory services.
- 4.3. The Public Entities, governance and management and special programmes branch at NDOH has been established to manage governance of the NHLS. However, the roles and functions of the branch are not clear and its linkages with provinces are not clear.
- 4.4. Some provinces have implemented approaches to improve the overall process and reduce costs such as:
- 4.5. The development of a web-based results support system that makes results accessible to clinics when the results are recorded by staff at the laboratory. However, the effectiveness and responsiveness depends on functional IT infrastructure and good communication lines (in particular in rural areas).
- 4.6. Some provinces have processes in place to reduce the number of laboratory test requests with improved turnaround results and cost reductions.
- 4.7. In some cases a gate-keeping service has been implemented to review the laboratory requests submitted by clinicians for appropriateness and cost-effectiveness.

## **5. LABORATORY RECOMMENDATIONS**

- 5.1. The NDOH should establish a national working group of clinicians, managers and the NHLS staff to develop essential laboratory test lists for different levels of health



care and to work out how limits can be placed on laboratory usage, drawing on some good practices that exist within provincial health departments.

- 5.2. A review should be done to benchmark laboratory costs of the NHLS and to develop appropriate national guidelines.
- 5.3. The role and responsibilities of the Public Entities, governance and management and special programmes branch should be reviewed and clarified, as well as its linkages to other NDOH clusters and to provinces.
- 5.4. An appropriate laboratory monitoring and control system should be implemented.



# Technology and Infrastructure

## 1. INTRODUCTION

- 1.1. This aspect was not reviewed in depth, but key issues were highlighted during the review and recurring issues are described below:

### Box 6: Technology and infrastructure review key findings

1. Generally, the current Information Technology and Telecommunication (ICT) infrastructure is inadequate to support planning, monitoring and evaluation as well as service delivery.
2. Facility and equipment maintenance is insufficient and impacts negatively on service delivery and retention of staff.
3. It was reported that basic diagnostic and medical equipment, especially at lower level hospitals and clinics, is lacking across the country.
4. The poor road, water and electricity infrastructure in rural areas creates numerous problems for service delivery.
5. Capital and operational infrastructure budgets are not aligned.
6. Inefficient fleet and transport management systems at provincial and district levels lead to poor access, duplication of effort and delayed response time of emergency response vehicles.
7. Security measures across various provinces differ and serious incidents of security breaches and theft were reported.

## 2. INFORMATION AND TELECOMMUNICATION TECHNOLOGY (ICT)

- 2.1. Although pockets of excellence exist in some provinces on the application of ICT to assist service delivery, ICT infrastructure, especially in rural areas is lacking to support planning, monitoring and evaluation as well as service delivery.
- 2.2. A lack of functional telephone lines, computers and connectivity especially in rural areas, impairs service delivery and leads to lost opportunities to improve efficiencies and service delivery e.g.:



- 2.2.1. Telemedicine opportunities cannot be optimised.
- 2.2.2. Basic inputs into health data cannot be done on a real-time-on-line basis.
- 2.2.3. Administration such as leave data cannot be undertaken on-site and need to be escalated to the centre.
- 2.2.4. On-line laboratory results are not possible.
- 2.2.5. Stock control and planning of pharmaceuticals and medical products are not possible.
- 2.2.6. Essential written communication required for on-site training or administrative purposes is not possible.
- 2.2.7. Emergencies cannot be reported and personal cellular phones are often used to arrange for patient transportation.
- 2.3. In addition, essential ICT should be available to support a fully functioning M&E system and DHIS.

### **3. HEALTH FACILITIES**

- 3.1. Although a facilities and hospital revitalisation programme is underway, it is reported that some projects have an unreasonably extended lifespan and a number of provinces are underspending on capital expenditure. It was also reported that operational planning is not linked to capital expenditure and operational costs for medical equipment, staffing and medical products are often not budgeted for when planning the facility.
- 3.2. The quality and space requirements of clinics, administrative offices and staff accommodation facilities vary across provinces, but an issue of concern is the recurring trend of disrupted water and electricity supplies to health facilities, especially in rural areas. Combined with poor road infrastructure, these external influences impact on service delivery, retention of staff and utilisation of the district health system.



- 3.3. Facilities maintenance plans exist in some cases, but budgets do not allow for sufficient maintenance. Reports were received that the Department of Works' service delivery has long turnaround times and is not always of high quality. Health waste management at facilities was also reported to be problematic.
- 3.4. Security measures across various provinces differ and serious incidents of security breaches, litigation cases due to insufficient security and theft were reported. A national health security policy and standards need to be developed to guide provinces.

## 4. MEDICAL EQUIPMENT

- 4.1. It was reported that basic diagnostic and medical equipment is lacking across the country, but especially at lower level hospitals and clinics.

- 4.2. Equipment maintenance is insufficient and impacts negatively on service delivery and retention of staff. The following example illustrates a recurring theme:

*“There is a severe problem with the maintenance of equipment. There are virtually no clinical engineering services available. In one hospital, the operating theatre light was not working and a gynaecological spotlight was being used instead. For difficult cases, a privately owned mountaineering headlamp was being used.”*

- 4.3. Clinical engineering services are not sufficiently staffed in all provinces to support optimal maintenance of medical equipment. It was reported that in some provinces no tenders for the purchasing or maintenance of medical equipment has been advertised since 2006 and managers rely on national tenders to purchase equipment.
- 4.4. “Condemned equipment” is also taking up valuable space in facilities (including hospital wards) in some provinces due to lengthy and cumbersome disposal procedures.



## **5. EMERGENCY MEDICAL SERVICES**

- 5.1. Serious problems were reported with emergency medical services, again especially in rural areas. The number and availability of ambulances, large distances to be covered, poor road quality and lack of standby vehicles in cases of disasters or major incidents need to be reviewed.

## **6. RECOMMENDATIONS**

### **6.1. INFORMATION AND TELECOMMUNICATION TECHNOLOGY (ICT)**

- 6.1.1. ICT infrastructure architecture should form part of a plan to achieve an integrated and affordable National Health Information System.

### **6.2. HEALTH FACILITIES**

- 6.2.1. Capital programmes should incorporate planning for operational requirements and expenditure and include quality and service guidelines for contractors.
- 6.2.2. Facility management, maintenance and security plans should form part of STPs and budgeting processes.
- 6.2.3. External infrastructure issues which impact on service delivery, such as telephone coverage, water and electricity supply as well as roads, should be raised and addressed at a higher political level as well as municipal planning levels such as the Integrated Development Plan.

### **6.3. MEDICAL EQUIPMENT**

- 6.3.1. A medical equipment review should be undertaken as a matter of urgency, with special focus on rural areas.
- 6.3.2. An essential equipment list, together with norms and standards should be developed.



#### **6.4. EMERGENCY MEDICAL SERVICES**

6.4.1. The emergency medical services operating model needs to be reviewed to ensure that coverage, availability, cost efficiency and service quality are optimal.

6.4.2. The EMS review should form part of the overall STP.



## Taking Forward the Recommendations

This section brings together the recommendations from the various sections, and indicates the main role-players responsible for implementation. It highlights the inter-dependence of the activities, and the need for the public health system as a whole to work in unison to achieve improvement of health system performance, and ultimately the improvement of population health outcomes.

The key to the table with consolidated recommendations and implementation is summarised below. The following groups of stakeholders have been identified:

- ❑ National Ministry of Health: This includes the Minister and the Deputy Minister of Health, as well as the National Department of Health management and administration component (the DG and officials);
- ❑ Provincial Health: Includes the provincial minister or Member of the Executive Council, as well as the Provincial Department of Health management and administration component (the HOD and officials);
- ❑ National Treasury: includes relevant officials responsible for health inter-governmental relations and health financing;
- ❑ Provincial Treasuries: Relevant provincial treasury officials responsible for health coordination and financing;
- ❑ Department of Public Service and Administration: includes relevant officials responsible for health inter-governmental relations and health workforce and human resource functions;
- ❑ External/other stakeholders: This includes civil society at large, depending on the issue e.g. universities; communities; labour unions, or other departments not mentioned.
  - 1= Main responsibility: This means that the identified stakeholder is the driver or champion for implementation;
  - 2= Provide Input: Means that the champion or driver should obtain the inputs of these identified stakeholders. In general, though, we recommend an inclusive process to ensure buy-in and implementation of recommendations. However, the champion or driver should identify stakeholders up-front and ensure their inclusion.



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
<b>FINANCE RECOMMENDATIONS</b>						
<b>Extraordinary Funding Required</b>						
The exact quantum of the financial “backlogs” in each province should be properly determined, and a consistent plan of action to deal with this must be implemented. While a certain element of “bailout” is inevitable, the action plan should include preventive measures, clear accountability mechanisms and explicit consequences, and should be designed to prevent a recurrence and setting of a negative precedence.	1	2	2	2		2
<b>Health Sector Funding (including HIV/AIDS – ART funding)</b>						
The current model of business as usual and tinkering on the margins is inappropriate. An emergency response is required to deal with the HIV epidemic and its effects on the health sector, and on all aspects of society.	1	2	2	2		2
The financing of the appropriate response to HIV/AIDS and its impact on the public health system in South Africa must be ring fenced and flow from the result of a fundamental review and adjustment of the current delivery model of providing ART for people with AIDS. The financial effect of this pandemic, if grouped together with the normal funding needs (even in the form of the current conditional grants) makes meaningful comparisons and monitoring almost impossible.	1	2	2	2		2
The implementation of these recommendations will require a team effort, will take time, and will require careful ongoing project management until the various aspects are embedded.	1	1	2	2		2
<b>Unfunded Mandates</b>						
The operational impact of national policy decisions (e.g. OSD, new vaccine programme) should be determined and	1	2	2	2	2	



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
must be agreed with the provincial health departments prior to implementation.						
There should be alignment between political decisions and operational implementation and agreement reached for any proposals on increases of service levels prior to their announcement. The availability of funding should also be confirmed.	1	1	2	2		
<b>Conditional Grants</b>						
The NDOH, in consultation with the National Treasury and provincial departments of health, should review all the conditional grants against their original purpose to decide whether these should continue. The review process should take into account: objective and transparent criteria for the determination and allocation of such grants; mechanisms to improve accountability, administrative efficiency, service delivery performance; and measures that facilitate regular monitoring and evaluation.	1	2	2	2		
A coordination forum should be established within the NDOH to ensure that, inter alia, there is no duplication in funding to provinces from the different grants.	1	2	2			
Appropriate accountability mechanisms with regard to conditional grants, including independent auditing, should be put in place by the NDOH.	1	2	2			
There needs to be separation between the monitoring role of the NDOH and the implementation role of the provinces and NDOH should not be involved in operational issues.	1					
<b>Budgeting Process</b>						
Measures should be put in place to strengthen the role of the NDOH in the process of determining the overall public sector health allocation, with concomitant accountability.	1	2	2			
The capacity of the NDOH should be strengthened to enable it to undertake better financial analysis of the existing health financial situation, improve the annual	1	2	2			



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
bidding processes, costing methods, decisions on additional funding and early warning expenditure (IYM) reports.						
A proper base-line must be established and changes in needs from period to period should be properly quantified and motivated.	1	2	2	2		2
In order to inform this base-line and movements from it, a national STP should be drawn up and aligned with all the provincial STPs in order to ensure that there is one transformation plan that informs service delivery and which is in line with budgetary constraints.	1	2	2	2		2
<p>The funding and management of tertiary hospitals and academic training should be the focus of discussions between the Ministries of Health and Education so that there is a clear, joint policy framework to guide the development of services and to strengthen health science education and tertiary services that are national assets. Such a framework should provide guidance on:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Joint appointments of staff;</li> <li><input type="checkbox"/> The funding of health science education, training and research;</li> <li><input type="checkbox"/> The services linked to education and training;</li> <li><input type="checkbox"/> The funding and management and accountability of the institutions.</li> </ul>	1	2	2		2	2
Proper reprioritisation processes must be introduced to deal practically with the consequences of the unavoidable budget shortfalls in relation to the bids developed, from the political level down to the lowest relevant level in the system.	1	1	2	2		2
<b>Financial Management Processes</b>						
Formalised and clearly defined financial management reporting structures, formats and timeframes should be developed, effectively communicated and diligently	1	1	2	2		



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
followed.						
Managers should be held accountable for the performance of their operating units and this must be built into the performance management system.	1	2			2	
Variance analysis needs to be used as a management tool to identify areas that require attention.	1	1	2	2		
<b>Financial Reporting</b>						
The IYM report needs to be expanded to include accruals. The report needs to be compiled on an accrual basis and not only on a cash basis to create a link between operational activity and costs.	2	2	1	2		
The annual financial statements, while meeting Constitutional and Government Accounting requirements, should be expanded beyond the cash basis of reporting and include accruals as part of reported, aggregated expenditure numbers.	2	2	1	2		2
<b>Over-expenditure, inefficiency and cost savings</b>						
Although HIV/AIDS has a negative impact on over-expenditure, there are inefficiencies in the system that need to be addressed, through: <ul style="list-style-type: none"> <li><input type="checkbox"/> Assessing the number and usefulness of the performance indicators;</li> <li><input type="checkbox"/> an improved M&amp;E system;</li> <li><input type="checkbox"/> Improved employee performance management system.</li> </ul>	1	2			2	
There needs to be follow-up of variances and appropriate corrective action with regard to identified indicators, e.g. the bed utilisation rate and cost per PDE across various levels and geographical areas.	1	1				2
<b>LEADERSHIP, GOVERNANCE AND SERVICE DELIVERY</b>						
<b>National Stewardship and Leadership</b>						



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
The Minister of Health should drive the development of one national health vision and strategy. This should be done with the involvement and participation of the provincial health MECs and health departments, frontline health care providers, communities who depend on the public sector and civil society broadly. The national health strategy should include inter alia: statement of shared values and principles; key targets for improving population health outcomes; affordable service packages for different levels of care; strategies to improve the performance of the South African health system (including its building blocks); resource requirements and it should contain a prioritized set of performance indicators.	1	2				2
Good stewardship also requires a combination of strategies to build coalitions of support from different groups, influence stakeholders' behaviour and information for decision-making.	1	2				2
There should be explicit and open discussion around the budget and the level of services that can be rendered for this budget. The areas of rationing and prioritization at clinics and hospitals should be made clear and communicated effectively to all concerned. All sources of funding should be evaluated, and should rationing be required, the process followed should be constitutionally sound and involve key stakeholders	1	2	2	2		2
There should be an iterative process to development of national policies where provincial realities and feedback is given so that policies can be amended to fit the realities or additional resources made available.	1	2	2	2		2
Service delivery and budgets should be aligned so that managers are not faced with ad hoc budget cuts.	1	1	2	2		2
Better day-to-day planning is required so as to avoid unplanned meetings and facilitate better time management by managers. This can also include cutting back on unnecessary meetings and streamlining programme	1	1				



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
training and workshops through better coordination amongst national and provincial programme managers.						
Executive Committee meetings should assign a person responsible for specific tasks, and assign a deadline date for the completion of the task.	1	1				
<b>Planning</b>						
The annual national health plan should guide and determine provincial priorities and plans and should be completed annually by June to form a basis for compiling the budget requests to Treasury for the following financial year.	1	2	2			2
A national STP should be developed, as a complementary, but linked activity to the national vision and strategy. The criteria for developing the STP should be transparent, and should also cover district level services and primary health care, in addition to secondary and tertiary services. The STP should contain accurate costs and other resource requirements and should be broadly consultative and participatory. It should be endorsed politically, widely communicated to all relevant stakeholders and it should inform strategic decision-making in the provinces. Particular attention should be paid to the process of implementation of the STP and to stakeholder buy-in.	1	2	2	2		2
There should be alignment between the national vision and strategy, programme strategic plans and ANHP, as well as between targets and interventions within the NDOH. All plans should pay more attention to implementation, and should contain a clear M&E framework with performance targets. Implementation of the plans should be monitored regularly, deviations from targets picked up and remedial action taken if necessary.	1	2				2
National targets should be based on realistic forecasts of actual need, and take account of provincial dynamics, intended outcomes and should be achievable and	1	2	2	2		2



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
affordable.						
External support for the planning processes should be sought if necessary, but accountability must be with the NDOH, rather than with the potential consultants.	1					2
The relationships between universities and provincial health departments should be strengthened with regard to service delivery, training and research.	1	2				2
All planning processes at provincial level should be aligned with each other and well communicated. There should be a limited number of key targets for each area of operation for which managers are responsible and accountable.	2	1				
There should be linkages between health programme, HR and financial management and reporting systems.	1	1			2	
<b>Norms, Standards and Guidelines</b>						
The Office of Standards Compliance should be capacitated and resourced to: develop a national repository of norms, standards and guidelines; oversee and guide the development of more effective and affordable services, quality and clinical care guidelines, linked to resource requirements and performance measures and indicators; and enforce compliance with such norms, standards and guidelines.	1	2	2		2	
The different roles and responsibilities of the Office of Standards Compliance, Priority Programmes, Strategic Planning and Monitoring and Evaluation clusters should be clarified and streamlined.	1	2				
The development of norms and standards for highly specialised tertiary services should be prioritised, given the cost of these services and links to the training of future medical specialists.	1	2	2		2	2
<b>Governance and Accountability</b>						
The role and required expertise of strategic health programme managers at national, provincial and district	1	2				



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
levels need review with a clear outline of their key result areas and performance measures. There need to be clear vertical and horizontal communication mechanisms between these programme managers and line service delivery managers (see also section 4).						
Within the public health sector, the various meetings should be reviewed and restructured (if necessary), and their functioning improved. Senior management meetings need to focus on strategic issues, such as achieving health outcomes, quality service delivery and improving overall health system performance. Decisions of meetings need to result in clearly defined actions with associated responsibilities and timeframes.	1	1				
The NDOH should provide provinces with clear written guidelines regarding the delegation of authority, responsibility and accountability to facility and district managers.	1	2			2	
<b>Service Delivery</b>						
The NDOH should adopt a broader public health approach to service delivery and produce comprehensive, integrated guidelines covering all aspects of service delivery in relation to HIV, TB and MCH. These guidelines should be linked to the overall national vision and plan, be affordable and contain norms and standards (including addressing data gathering, monitoring and evaluation, human resources, funding).	1	2				2
Quality of care should be prioritised and an enabling environment to achieve quality (e.g. supportive supervision, resources, delegations and accountability) should be fostered.	1	1				2
The current service delivery models to address the country's disease burden, and manage new and emerging health problems need review. Much more attention needs to be paid to prevention and health promotion, and making	1	2				2



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
it work in practice.						
The role and expertise of strategic health programme managers at national, provincial and district levels need review with clear guidelines of performance expectations. There needs to be clear communication (vertical) between these programme managers at these three levels on the one hand and also between these programme managers and line service delivery managers (horizontal) on the other hand.	1	1				
There should be clear communication between all these role players in ensuring that their planning is based on the current realities. However, targets should be set that continuously ensure significant improvement in health outcomes in agreed upon priority areas.	1	1				2
<b>HUMAN RESOURCES</b>						
<b>Organisational Structuring and Establishments</b>						
National and provincial organisational structures should be reviewed and aligned, once the national vision and strategy has been finalized. The technical capacity should be strengthened at national level to provide stewardship and leadership to provinces for the achievement of health outcome goals.	1	1			2	2
Proposed new structures should be carefully reviewed and restructuring, with a view to establishing minimum staffing levels and optimal management and administrative positions, should be undertaken based on a number of factors, including objectively agreed benchmarks, optimal application of scarce skills, the departments' strategic and service delivery priorities and availability of resources. A moratorium on the establishment of additional provincial head office positions should be considered until the review is concluded.	1	2			2	2
<b>Delegations, Accountability and Responsibility</b>						
Delegations should be re-instituted and a clear matrix in	1	1				



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
terms of delegation of authorities and decision making at various levels should be completed (This should be in line with a RACI matrix where different people are responsible, accountable, consulted or informed). The responsibility level of CEOs of institutions and district managers and their district management teams (DMTs) should be reviewed and addressed. This should include a review of financial management responsibilities.						
Communication and coordination mechanisms need to be established across clusters to prevent “silo” operational functioning. One integrated national health system performance dashboard linking to departmental performance dashboards should be developed and implemented to provide an integrated view of performance across various provinces, programmes and branches and ensure integration and aligned cooperation.	1	1			2	2
<b>Recruitment</b>						
A review and improvement of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times. DPSA needs to be involved in this process.	2	2			1	
<b>Performance Management</b>						
A review of the performance management system and its application should be undertaken to ensure the performance management system encompasses employee performance which is linked to organisational performance, employee development, team based performance where appropriate and rewards based on clear performance goals	1	2			1	
<b>Retention</b>						
A review of the national health professional and scarce skills retention strategy should be undertaken.	1	2			2	2
<b>Rewards</b>						
A total reward strategy (monetary and non-monetary)	1	2	2		2	2



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
<p>review should be undertaken at national level to address issues of employee compensation overspend, skills scarcity and staff retention – including highlighting the importance of:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> A thorough costing of any change in the reward system which must be done in collaboration with the affected parties and include an assessment of affordability at various levels.</li> <li><input type="checkbox"/> Rewards linkages to organisational, employee and team performance.</li> <li><input type="checkbox"/> Lessons learned from the current OSD implementation review for nurses should be captured to inform future implementation of other improvement initiatives.</li> </ul>						
<b>Learning and Development</b>						
<p>Training and development programmes should be clearly defined and aligned to the service delivery priorities of the provinces. Well considered and prioritised commitments to relevant training should be maintained even during times of cost containment.</p>	1	1			2	2
<p>Long term production of health professionals require dedicated national focus and liaison with relevant stakeholders such as Department of Education, DPSA and universities.</p>	1	2			2	2
<b>HR Information Systems</b>						
<p>An assessment should be undertaken to establish reasons for under utilisation of HR systems and improved measures should be implemented including the full use of PERSAL as a HR management tool. PERSAL should be corrected to accurately reflect funded personnel positions and staffing numbers accurately.</p>	1	2	2		2	
<p>Long term maintenance and sustainability of the intended HR information system should be considered in the development and implementation thereof.</p>	1	2	2			



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
<b>INFORMATION MANAGEMENT</b>						
<b>Overall M&amp;E</b>						
Monitoring and evaluation must be prioritized as a matter of urgency; an affordable national M&E system must be developed, with commensurate financial and human resources and technical expertise to ensure successful implementation.	1	2	2			2
To achieve this, an urgent plan to achieve an integrated and affordable National Health Information System (NHIS) should be developed. Such a HIS should meet the criteria for effective and sustainable information systems; enable integration of health outcome, finance, human resource, quality and efficiency indicators and assist with the provision of data for decision-making, as well as information to measure health and service delivery improvements and the achievements of set targets.	1	2	2			2
An immediate moratorium should be placed on provincial health departments' acquisition of electronic health information systems and the resources should be pooled and contribute to the development of a NHIS.	1	2	2	2		
M&E needs to become a central component of all managerial activity with the use of objective information being the basis for decision making.	1	2				2
Regular formal monitoring, analysis, interpretation and feedback of key indicators needs to take place at every level of the system with analysis and questioning of variances (in much the same way as financial management variance analysis should take place).	1	1				
Best practices of M&E should be shared amongst the provinces.	1	1				
Skills levels of staff (especially on BAS and PERSAL) need to be reviewed and corrective measures agreed upon and implemented.	1	1	2	2	2	



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
To support the M&E work, basic infrastructure needs to be in place e.g. generators, ADSL lines. In addition, innovative approaches need to be explored e.g. cellular phone technology. NDOH could help with leadership in these areas.	1	2				2
The culture of the organisation must become M&E orientated. A culture of 'blame' does not support the M&E culture. Where institutional managers experience problems with decision making, they should be able to get support and backup from senior management who take collective responsibility for such decisions.	1	2				
<b>Use of information for decision making</b>						
M&E, based on a limited and reduced number of key indicators, needs to be built into every senior manager's job description and performance appraisal.	1	2				2
Where applicable, in-service training around understanding of, and the importance of, key indicators for managers needs to take place.	1	1			2	
There should be regular analysis, comparison, interpretation and feedback around indicators to lower levels of the system.	1	1				
<b>District Health Information System (DHIS)</b>						
The DHIS, and associated NIDS, needs to be reviewed by the NDOH, and aligned with the overall M&E framework.	1	2				2
The number of indicators need to be decreased, using international guidelines on good indicators.	1	2				2
There should be clear, unambiguous, easy to understand, standardised definitions.	1	2				
There also need to be clear written guidelines, norms and standards for each component of the DHIS, including data collection tools (forms and registers); relevant human resources, hardware, software, data flow policies and linkages between the DHIS and other data collection	1	2	2	2		



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
systems such as the TB, PERSAL and BAS.						
<b>ARV Monitoring and Evaluation</b>						
A workable, practical, easy-to-use system of monitoring the ARV programme needs to be put in place, but not outside the framework of the M&E system and the NHIS.	1	2				2
Ideally this should be developed (with detailed guidelines, norms and standards for every aspect of the system) by the NDOH and communicated to the provinces. Given the importance and magnitude of the ART programme this should be done immediately.	1	2				
<b>Other M&amp;E issues</b>						
The NHISSA should be reviewed, both as to membership and its effectiveness. It should be appropriately mandated and resourced to fulfil its functions	1	2				2
There needs to be one official repository of information for health. All reports and other documents using information should be drawn from this repository to eliminate duplicate sources of information. All relevant role-players need to play their parts in ensuring that the most up to date, good quality information is passed into the repository.	1	2				2
Parallel systems of information (e.g. direct flow of information from facilities to programme managers – whether at provincial or national level - and the by-passing of district management structures) should be discontinued.	1	1				
NDOH must support and monitor the process of implementation of the information management systems.	1	2				
A records retention and information backup policy should be developed and implemented at facility, district, provincial and national levels.	1	1				2
Review and redesign facility data collection processes to enhance efficiency, remove duplication and simplify procedures.	1	2				2
Follow-up and corrective actions on identified indicators	1	1				



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
with variances need to form part of all M&E activities.						
<b>MEDICAL PRODUCTS AND LABORATORY</b>						
<b>Medical products</b>						
Pharmaceutical issues should form part of the agenda of HOD, CFO and provincial departmental strategic meetings and linkages between the pharmaceutical cluster and programme clusters should be established and/or improved.	1	2				
Drug budgets should be prioritised and should form an integral part of health service planning, budgeting and monitoring activities.	1	1	2	2		
The national pharmaceutical cluster manager in the NDOH should be appointed as a matter of urgency and the unit resourced appropriately so as to guide provinces and to ensure provincial compliance with norms and standards;	1					
A review of all aspects of the management, operations and skills requirements of provincial medical depots should be carried out.	1	2				
Strategic pharmaceutical issues should form an integral part of the overall STP and other key initiatives outlined above.	1	2				
<b>Laboratory</b>						
The NDOH should establish a national working group of clinicians, managers and the NHLS staff to develop essential laboratory test lists for different levels of health care and to work out how limits can be placed on laboratory usage, drawing on some good practices that exist within provincial health departments.	1	2				2
A review should be done to benchmark laboratory costs of the NHLS and to develop appropriate national guidelines.	1	2				2
The role and responsibilities of the Public Entities, governance and management and special programmes branch should be reviewed and clarified, as well as its	1	2				



Recommendations	National Ministry of Health (Minister and NDOH)	Provincial Health (MEC and DOH)	National Treasury	Provincial Treasuries	DPSA	External/ Other stakeholders
linkages to other NDOH clusters and to provinces.						
An appropriate laboratory monitoring and control system should be implemented.	1	1				2
<b>TECHNOLOGY AND INFRASTRUCTURE</b>						
<b>Information and Telecommunication Technology (ICT)</b>						
ICT infrastructure architecture should form part of a plan to achieve an integrated and affordable National Health Information System	1	2	2			2
<b>Health Facilities</b>						
Capital programmes should incorporate planning for operational requirements and expenditure and include quality and service guidelines for contractors.	1	1	2	2		2
Facility management, maintenance and security plans should form part of STPs and budgeting processes.	1	2	2	2		2
External infrastructure issues which impact on service delivery, such as telephone coverage, water and electricity supply as well as roads, should be raised and addressed at a higher political level as well as municipal planning levels such as the Integrated Development Plan.	1	1				2
<b>Medical Equipment</b>						
A medical equipment review should be undertaken as a matter of urgency, with special focus on rural areas.	1	2				2
An essential equipment list, together with norms and standards should be developed.	1	2				2
<b>Emergency Medical Services</b>						
The emergency medical services operating model needs to be reviewed to ensure that coverage, availability, cost efficiency and service quality are optimal.	1	2				2
The EMS review should form part of the overall STP.	1	2				2



## Appendixes

### 1. APPENDIX 1: TERMS OF REFERENCE

#### 1.1. PROJECT TITLE

- 1.1.1. Integrated Support Teams (ISTs): Finance, Health Systems Strengthening and Management & Organisational Development (M&OD)

#### 1.2. BACKGROUND

- 1.2.1. The UK Government's Department for International Development (DFID) is providing technical assistance funding through a Rapid Response Health Fund (RRHF) to strengthen the office of the Ministry of Health and National Department of Health (NDOH) to achieve the objectives of the national HIV and AIDS and STIs strategic plan and strengthen its responsiveness and effectiveness in addressing key health priorities identified by the new Minister of Health, Barbara Hogan.
- 1.2.2. This is a 12 month programme which commenced in November 2008. HLSP (through its UK based DFID Health Resource Centre) has been contracted by DFID to manage the programme and to undertake procurement.
- 1.2.3. The key partner is the Ministry of Health (MOH), with selected clusters being supported at the National Department of Health (NDOH). This document provides Terms of Reference for the appointment of consultants to provide specialised technical assistance to newly proposed Integrated Support Teams (ISTs). The ISTs will comprise experts in Finance (sourced and engaged by Deloitte), Health Systems Strengthening (HSS), and Management and Organizational Development (M&OD) (these latter two consultancies sourced and engaged by HLSP). These teams will work at national and provincial levels to undertake a range of financial, managerial and health systems assessments. The selection and allocation of teams will take place collaboratively between the Ministry of Health, Deloitte, and HLSP.



#### **1.2.4. Purpose of the IST Review**

1.2.4.1. The Ministry and NDOH are aware of a pattern of overspending on health services in the provinces (with the exception of Western Cape) that poses a major constraint to the Ministry's and National Department of Health's ability to revitalize and reorient South Africa's response to HIV/AIDS and support health systems strengthening to achieve service delivery improvements.

1.2.4.2. The purpose of the IST consultancy is to provide the Ministerial Advisory Committee on Health (MACH) with a thorough understanding of the underlying factors behind this trend including:

- when the cost overruns began
- how they have accumulated over time
- operational challenges and constraints
- identifying the major cost drivers, and quantifying their relative importance and impact
- identifying types of data available for planning and identification of provincial health priorities and budgeting
- assessing the planning, budgetary and administrative capacity in the departments
- assessing what systems were in place, if any, to flag potential over-expenditure and prevent such overruns occurring.

1.2.4.3. In addition, the ISTs will review health service delivery priorities and programmes and will make recommendations on where and how cost savings can be made into the future through improved cost management.

1.2.4.4. The overall review will be led by the IST Coordinator (Deloitte) who will be responsible for ensuring that deliverables are of high quality and that the ISTs adhere to reporting deadlines. The IST Coordinator will have overall technical oversight and will be responsible for delivering the IST terms of reference to the Ministry of Health. It is recognised that HLSP has overall management responsibility for delivering the Rapid Response Health Fund Logical Framework, of which the IST terms of reference are a component, in accordance with HLSP's contract with DFID.



1.2.4.5. At an operational level, the IST review will be conducted by teams of six consultants working at national level and teams of three working at provincial level (nine provinces). The teams will each comprise consultants with the following expertise: 1) finance, 2) Health Systems Strengthening and 3) Management and Organisational Development. The IST Coordinator and the teams will report to the Ministerial Advisory Committee on Health (MACH).

1.2.4.6. The national level team will begin work in early February 2009. The provincial teams will commence by mid-February 2009. Overall, it is envisaged that the review process will be completed by April 24 2009 and the report findings presented in mid May 2009.

### 1.2.5. Aim and Scope of Work

1.2.5.1. Aim of the ISTs: To conduct a review of financial and strategic planning and operational plans and recommend efficient and effective cost saving strategies, that will lay the foundation for the development and implementation of a turn-around strategy that will revitalise and reorient health services for implementation by national and provincial DoHs during the 2009/10 financial year. The IST teams, in partnership with national and provincial departments of health, will identify causes of over expenditure within the health system at both national and provincial levels. The IST will identify common or unique causes of over-expenditure and the effect of these on service delivery. The IST team will identify a national and collective response for service delivery improvement despite these funding constraints.

Although the technical focus of the three different streams will be different, the integration and synthesis of these focus areas into practical recommendations which will improve the overall functioning of the departments is of pivotal importance.

#### 1.2.5.2. Review Scope of Work for Finance Consultants

- Participate in the development of a provincial review template and attend orientation to the project and training on the use of the provincial review template prior to deployment to provinces
- Participate in the development of fact files (see below)
- Determine when the cost overruns began



- Determine how they have accumulated over time
- Identify the major cost drivers
- Identify what systems were in place, if any, to flag potential over-expenditure and prevent such overruns occurring
- In collaboration with HSS and M&OD consultants, propose cost management strategies for more cost efficient and cost effective programme delivery
- Participate in the preparation of a consolidated report of national and or provincial findings required to reorient policy implications to the MACH.
- Conduct a national or provincial review, submit and present a report of national and or provincial findings including planning, policy implications and financial controls required to strengthen financial systems and budget management to the MACH
- Attend IST related meetings and produce minutes and reports of meetings and their outcomes.

#### 1.2.5.3. Review scope of work for Health Systems Strengthening Consultants

- Undertake a desktop review of strategic and operational plans and health service delivery data of national and provincial DoHs and compile a fact file
- Identify key health programme and systems focus areas and key districts for field visits from the desktop review, informed by the fact files, including financial data from the finance consultancy
- Participate in the development of a provincial review template and attend orientation to the project and training on the use of the provincial review template prior to deployment to provinces
- Conduct a national or provincial review, submit and present a report of national and or provincial findings including planning, policy implications and financial controls required to strengthen financial systems and budget management to the MACH
- Work with financial consultants to formulate joint recommendations on cost management strategies and budget realignment across key service delivery components
- Attend IST related meetings and produce minutes and reports of meetings and their outcomes



#### 1.2.5.4. Review scope of work for Management and Organisational Development Consultants

- Undertake a desktop review of management and organisational structures and policies at national and provincial DoHs and compile a fact file.
- Identify key management and organisational structures for field visits from the desktop review, informed by the fact files, noting financial data from the finance consultancy.
- Participate in the development of a provincial review template and attend orientation to the project and training on the use of the provincial review template prior to deployment to provinces.
- Conduct a national or provincial review, submit and present a report of national and or provincial findings including management and organisational systems strengthening required to reorient policy implications to the MACH.
- Work with financial consultants to formulate joint recommendations on cost management strategies and budget realignment across key service delivery components.
- Attend IST related meetings and produce minutes and reports of meetings and their outcomes.

The IST review will focus on the following key issues: relevance, appropriateness, effectiveness, outputs or results achieved, efficiency, operational plan management and coordination and sustainability of planning, delivery and management of health sector programmes and budgetary systems.

#### 1.2.6. **Project Phases**

The project will be conducted in three phases:

##### 1.2.6.1. Phase 1-National Team only

- Perform an analytical review based on budgeted and actual spending, the objectives listed in the strategic and operational plans and specifically comment on the following:



- Document recent trends in utilisation of services, and analyse this against costs
  - Assess management and systems delivery to identify more efficient and effective options for delivery of services
  - Assess systems factors that may have resulted in recent overspend, and suggest strategies for ensuring this is avoided in future.
  - Consider health service implications of reductions in funding, and suggest mitigation strategies.
- Review the Conditional Grants and submit and present data analysis reports on the status of these grants by province.
- Review provincial IST reports and participate in the development of a consolidated IST report
- Based on the review, prepare a national final review report that will:
- Identify and recommend corrective actions needed in priority sequence and approaches for managing costs
  - Recommend and assist national and provincial departments of health to better align financial processes with programme implementation and reporting systems
  - Submit and present a review report with recommendations to the MACH and provide overall recommendations for improving DoH's effectiveness, efficiency and financial management.

#### 1.2.6.2. Phase 2- Provincial Teams

- Perform an analytical review based on the strategic and operational plans including budget (provincial-specific) and specifically comment on the following:
- Document recent trends in utilisation of services, and analyse this against costs
  - Assess management and systems delivery to identify more efficient and effective options for delivery of services
  - Assess systems factors that may have resulted in recent overspend, and suggest strategies for ensuring this is avoided in future.



- Consider health service implications of reductions in funding, and suggest mitigation strategies
  
- Utilise provincial templates with standardised and unique items adjusted for provinces
- Attend an orientation to the review and travel to allocated provinces
- Conduct interviews with provincial Heads of Department (HoD), CFOs and managers
- Conduct field visits to selected districts
- Review the outputs and outcomes against strategic and operational plans, budget and expenditure.
- Identify and quantify major cost drivers
- Assist provinces to identify financial planning and management problems
- Review management and administrative systems for monitoring, evaluation and reporting of outputs and outcomes against operational and financial plans.

#### 1.2.6.3. Phase 3- All Teams

- Based on the review, field visits and interviews – prepare national or provincial review reports and a consolidated report detailing common findings and recommendations.
- Identify and recommend corrective actions needed in priority sequence and approaches for managing costs
- Recommend and assist national and provinces to better align financial processes with programme implementation and reporting systems
- Submit and present a review report with recommendations to the MACH and provide overall recommendations for improving DoH's effectiveness, efficiency and financial management.

### 1.3. **IST PROJECT MANAGEMENT**

- 1.3.1. The project will be led by and operations managed by the IST Coordinator (Deloitte) and will follow best practice, including the relevant portions of the System Development Life Cycle Management and Project Management. IST Coordinator responsibilities include:



- 1.3.1.1. Process management and reporting, including ensuring task completion to agreed standards
  - 1.3.1.2. Managing issues that arise – such as delays, problems, contractual matters
  - 1.3.1.3. Liaison with stakeholders – provinces and national
  - 1.3.1.4. Management of provincial and district visits
  - 1.3.1.5. Collating reports and finalizing the consolidated provincial reports.
- 1.3.2. Only three provinces (Eastern Cape, KZN and Gauteng) will have field visits conducted up to 4-5 weeks, the remaining 6 provinces will have field visits up to 3 weeks per province concurrently.
- 1.3.3. The MOH, Deloitte and HLSP will jointly appoint a Team Representative (TR) for each provincial team, who will have overall responsibility for leading the team and producing reports. The TR will be responsible for communicating with the IST Coordinator on an ongoing basis and will provide weekly updates on the progress of the review to the TR, the CFO of the NDOH and HLSP. The TR will be responsible for report content and technical quality and will be required to attend project related meetings at National level. The TR will also provide project direction at provincial level, delegate tasks per the provincial template, ensure liaison with relevant stakeholders and provide progress reports to the provincial HoD as required. The TR is expected to be a senior consultant with extensive experience in leading and delivering high quality reviews in a health care environment and in possession of a relevant tertiary qualification in Finance, HSS or M&OD.
- 1.3.4. A Steering Committee comprising of representatives of the NDOH, Deloitte, HLSP, and the Ministerial Advisors will be established to provide support and guidance to the work of the IST.



## **1.4. ROLES AND RESPONSIBILITIES**

### **1.4.1. Role of NDOH and Provincial DoHs**

1.4.1.1. It is anticipated that the NDOH and provincial DoHs will provide relevant documentation, facilitate meetings and consultations, select and make appointments with key informants to be interviewed. In addition, they will provide administrative support and office space to the consultants. Consultant reports and invoices must be signed off by the CFO in the National Department of Health (and the HLSP Technical Manager) prior to payment.

### **1.4.2. Role of Consultants**

1.4.2.1. Consultants will work full-time with the NDOH, Deloitte and provincial DoHs. Each consultant will report to their TR and conduct work delegated by TR according to the standard review template. It is expected that the consultant will:

- Understand and comply to the principles laid down in the Public Finance Management Act (PFMA)
- Liaise with national, provincial and selected districts
- Ensure project implementation to time and quality
- Compile weekly progress and final reports
- Work closely with provinces and national team.

## **1.5. EXPECTED OUTCOMES AND DELIVERABLES**

This refers to both national and provincial ISTs.

1.5.1. Standardised provincial and national review templates

1.5.2. Summary Progress Reports and national and provincial DoH fact files

1.5.3. Align Review Report with linkages of budgetary process and strategic and operational plans



- 1.5.4. Detailed review reports on conditional grants and consolidated provincial reports (National Team)
- 1.5.5. National and Provincial Reports focusing but not limited to:
  - 1.5.5.1. An executive summary of key findings by provinces and overall national status
  - 1.5.5.2. The extent to which provinces have met and complied with the objectives set out in their operational plans
  - 1.5.5.3. The extent to which provinces have over-expended on the budget based on their financial statements
  - 1.5.5.4. The impact of over-expenditure on the DoHs and implications for future operational plans and service delivery
  - 1.5.5.5. The quality of services and cost-effectiveness of programmes delivered
  - 1.5.5.6. Recommendation on lessons learnt from the review, and how, if any, to address challenges in the management and implementation of the provincial operational plans to improve service delivery and reduce over-expenditure
- 1.5.6. Oral presentations on the key findings of the review and roadmap to the MACH.

## **1.6. COMPETENCY AND EXPERTISE REQUIREMENTS**

- 1.6.1. The following skills will be expected of the Finance component of Consultancy:
  - 1.6.1.1. Leadership experience and people and technical management skills
  - 1.6.1.2. Extensive experience and understanding of Finance, the effective integration and presentation of information from diverse sources, the Public Finance Management Act (PFMA) and provincial DoH with relevant qualifications and track record
  - 1.6.1.3. Experience and understanding of South African public sector budgetary management systems



1.6.1.4. Computer literacy, good communication and writing skills

1.6.1.5. Data analysis and reporting on administrative, health management and financial issues

1.6.1.6. Operational and financial management of large projects and programmes

1.6.1.7. Good team management and team work (interpersonal) skills.

1.6.2. The following skills will be expected of the M&OD and HSS consultants:

1.6.2.1. Extensive experience and understanding of the South African health system, PFMA and provincial DoH with relevant qualifications and track record

1.6.2.2. Experience and understanding of South African public sector management systems

1.6.2.3. Experience in health system strengthening and organisational development, computer literacy, good communication and writing skills

1.6.2.4. Data analysis and reporting on administrative, health management and financial issues

1.6.2.5. Operational and financial management of health projects and programmes

1.6.2.6. Good team management and team work (interpersonal) skills.

## **1.7. REPORTING REQUIREMENTS**

1.7.1. It should be noted that HLSP is responsible for the quality of the outputs of the DFID Rapid Health Response Programme. This includes providing technical support to the project partner on the quality of work produced by service providers. HLSP will therefore form part of the Review Panel for the preferred consultants, will participate in the planning of work at the commencement of the contract, and will be present at progress meetings on a regular basis during the implementation of the contract.



## **1.8. TIMING AND SCHEDULING**

- 1.8.1. The national review is commencing on the 26<sup>th</sup> January 2009, while the review of the pilot province is scheduled to commence on the 16th February 2009. Provincial and consolidated final reports are expected to be submitted by the 1st May 2009. The oral presentations will be completed by the 8th May 2009.
- 1.8.2. All communications and queries about the terms of reference can be directed to: Kevin Bellis (Technical Manager) and Sphindile Magwaza (Technical Advisor) at HLSP: kevin.bellis@gmail.com and snkmagwaza@gmail.com respectively.

## **1.9. CONTRACTING AND INVOICES**

- 1.9.1. Funding for the implementation of projects within the DFID – RRHF is secured from the UK Government Department for International Development (DFID). DFID has appointed a Procurement Service Provider, HLSP, to manage the appointment of Consultants and disbursement of consultancy and project funds.
- 1.9.2. HSS and M&OD consultants will be appointed on a contract issued by HLSP, the Procurement Service Provider, but will report to the IST coordinator (Deloitte) on a day to day basis. Deloitte will provide all Finance Consultants.
- 1.9.3. Invoices will be submitted to the HLSP for verification and authorisation in line with the HLSP Service Provider Handbook. Deloitte invoices and individual service provider invoices must be signed off by the CFO of the NDOH. The IST Coordinator is responsible for signing off on all consultant timesheets prior to submission to HLSP.
- 1.9.4. Payment will be made monthly in arrears within 30 days of receipt by the consultant of an approved invoice and full supporting documents.
- 1.9.5. No payment will be made for extra work done out of the scope of the review or if the IST Coordinator and CFO are not satisfied with the standard of delivered outputs.



## **1.10. GENERAL INFORMATION**

1.10.1. CVs will be assessed using the following technical criteria:

1.10.1.1. Experience in consultation with Departments of Health, finance, health systems strengthening and organisational development in developing countries, including South Africa

1.10.1.2. Experience with review methods including primary data and secondary sources

1.10.1.3. Experience in writing review or evaluation report

1.10.1.4. Availability within the review time frames

1.10.1.5. Short listed consultants may be interviewed by the project partner or HLSP.