

Eastern Cape Department of Health

Report of the Integrated Support Team



**Strictly Private & Confidential
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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 Eastern Cape Department of Health.

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Abbreviations

AFS	Annual Financial Statements
AIDS	Acquired Immunodeficiency Syndrome
AIP	Audit Improvement Programme
ANC	Ante-Natal Care
AOP	Annual Operational Plan
APP	Annual Performance Plan
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BAS	Basic Accounting System
CEO	Chief Executive Officer
CD	Chief Director
CFO	Chief Financial Officer
CG	Conditional Grant
CHC	Community Health Centre
COE	Compensation of Employee
COO	Chief Operating Officer
CPIX	Consumer Price Index
CSC	Corporate Service Centre
DDG	Deputy Director General
DFID	UK Government's Department for International Development
DHIS	District Health Information System
DMT	District Management Team
DM	District Manager
DOH	Department of Health
DPSA	Department of Public Service and Administration
EMS	Emergency Medical Services
ECDOH	Eastern Cape Department of Health
EXCO	Executive Council
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HR	Human Resources
HRD	Human Resource Development
HRM	Human Resource Management



HSS	Health Systems Strengthening
IST	Integrated Support Teams
IYM	In Year Monitoring
M&E	Monitoring and Evaluation
M&OD	Management & Organisational Development
MACH	Ministerial Advisory Committee on Health
MCH	Maternal and Child Health
MCWH	Maternal, Child and Women's Health
MEC	Member of the Executive Council
MTEF	Medium Term Expenditure Framework
N/A	Not applicable/Not available
NDOH	National Department of Health
NHLS	National Health Laboratory Service
NIDS	National Indicator Data Set
NTSG	National Tertiary Services Grant
OSD	Occupational Specific Dispensation
PDE	Patient Day Equivalent
PEAR	Performance and Expenditure Analysis and Review
PERSAL	Personnel and Salary Administration System
PFMA	Public Finance Management Act
PHC	Primary Health Care
PMTCT	Prevention of Mother-To-Child-Transmission
PPP	Public Private Partnership
SCM	Supply Chain Management
SG	Superintendent General
SLA	Service Level Agreement
STP	Service Transformation Plan
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Foreword

This final report comes at a time when South Africa is entering its 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 we serve.

This report contains the findings and recommendations of the Institutional Support Team (IST), set up at by the Minister of Health. We found many committed senior managers, much of the foundation for a well-performing health system is in place, a comprehensive and wide range of services are available to the people in the Eastern Cape and there is a lot of goodwill to contribute to change and implement ongoing health system transformation policies. The report also identified many shortcomings, ranging from strategic planning and leadership, through to financial management and monitoring and evaluation. We recognise that the health sector is complex, and many of the solutions to the problems and issues raised are to be found in other government departments such as the National Treasury, Provincial Treasury, Department of Public Service and Administration and the National Department of Health. Hence, the entire Public Health system, and its component parts, needs to function as an integrated whole to achieve improved health system performance. At the same time, many solutions fall within the ambit of the Eastern Cape Department of Health, and we urge senior managers to become champions for the changes proposed in the report. The concluding section contains a detailed set of recommendations for health system improvement, including the responsibility of key stakeholders, many who are outside the ECDOH.

We conclude with a quote from the 2008 World Health Report:¹

“In order to bring about such reforms in the extraordinarily complex environment of the health sector, it will be necessary to reinvest in public leadership in a way that pursues collaborative models of policy dialogue with multiple stakeholders – because this is what people expect, and because this is what works best”.

Executive Summary

During the course of the 2008/09 financial year it became apparent that there was a negative difference between what was budgeted for in the health system and what was required to

¹ World Health Organization (2008). *World Health Report 2008: Primary health care: now more than ever*. Geneva, Switzerland: WHO, 2009



implement agreed upon policies. This was associated with overspending in most of the provinces undermining 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 to improve health outcomes. In response to this threat to the overall functioning of the health system, the 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.

The IST undertook a rapid review of the Eastern Cape Department of Health in April 2009. 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*. It consisted of a desk top review and in-depth interviews with key informants at provincial and district levels. The review has highlighted a number of key challenges and recommendations, which are contained in the body of the report. The overall approach to the review is based on the World Health Organization (WHO) classification of health systems building blocks viz:

- Finances
- Leadership, Governance and Service Delivery
- Human Resources
- Information Management
- Medical Products and Laboratory
- Technology and Infrastructure

The priority findings of the review are:

1. *Limited focus on service delivery by the ECDOH.* There is an increasing emphasis on ensuring a clean audit often at the expense of effective, efficient and equitable service delivery.
2. *The lack of clear roles and responsibilities* between different levels of management within the ECDOH and between the political and administrative role-players. This has led to an increased lack of responsibility and accountability.
3. *Centralisation* as a means of problem solving. When administrative problems are clearly identified, the response is to *create additional structures and systems to*



address the problem, which further complicates the issue. There is also an ongoing tendency to centralise functions within the ECDOH.

4. Reluctance of politicians to accept the need to *realign services to fit the available resources*.
5. *Meetings* in the department appear to *consume a large portion of executive time*. More effective communication methods and decision-making methodologies could significantly improve management and reduce costs.
6. There are *material unfunded* mandates at provincial level contributing to overspending. This in turn results in stringency measures with associated negative consequences for service delivery, managerial performance and staff morale. Financial management practices, including budgeting at national and provincial level, need improvement. As a result of the manner in which the cash based system is applied (increases in accrual levels not included in reported underspending), the *reported underspending is overstated* in the ECDOH and if no radical measures are taken to remedy the situation there is likely to again be forced cuts in service delivery in the 2009/10 financial year. The ECDOH did not report overspending over the last few years. However, this was only achieved by limiting service delivery and withholding payments to employees and providers of goods and services. This trend of limiting services and delaying payments is likely to continue and even increase in the 2009/10 and subsequent financial years.
7. There is a *lack of cohesion* between policy formulation, budgets and resources to implement the policies and planning. This has led many managers to assert that the public health sector is under-funded.
8. The district health system has become fragmented and lacking in energy.
9. The *current model for the scale up of anti-retroviral therapy (ART) for people with AIDS* is unsustainable from a health systems perspective and unaffordable from a budgeting perspective.



10. *There is a dearth of national guidelines, norms, standards and targets. This perceived lack of national stewardship and leadership impacts on every aspect of the health system and its performance.*
11. Although HR policies and procedures exist execution appears to be problematic. Recruitment processes, as one very important example, need to be overhauled to make them fit-for-purpose. The organisational structure and staff establishment are not synchronised with the budgets or planning processes to optimally meet service delivery requirements. The information contained in, and the manner in which HR information systems are used, require urgent attention. For example, the PERSAL establishment data is irrelevant for management purposes.
12. Monitoring and evaluation (M&E) is inadequate. Although much time and resources are invested in data collection these data are not analysed, interpreted or used for decision making and there is little or no feedback of information from one level to the next. There is little link between the financial reviews and service related data. An appropriate climate of mutual responsibility (rather than blame) is required for successful implementation of an effective M&E programme.
13. Much time and effort goes into planning, but the process is formulaic and based on compliance rather than being utilised as an effective management tool. Additionally, there is a *disjuncture and lack of integration between planning, budgeting and implementation*. There is a plethora of plans at different levels, which do not support each other and there is confusion around the terminology and status of various plans.
14. *Senior management appear to be pre-occupied with bureaucratic functions, especially financial*, and are not focussed on service delivery which is the core responsibility of the ECDOH. This is partially due to the withdrawal of delegations which causes management to be involved in mundane day to day paperwork.
15. There is a *general lack of prioritisation of drug budgets* and the ECDOH has experienced intermittent shortages of medicines both in the hospitals and the clinics, affecting many aspects of service delivery. The logistical and budgeting practices applicable to pharmaceutical products hamper service delivery.



In line with these *priority findings*, find the *key recommendations* below. Additional recommendations are found in the body of the report.

UNFUNDED MANDATES

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

LACK OF COHESION BETWEEN POLICY AND BUDGETS

1. The budgeting process needs to be seen and used as an extension of the annual performance plan, and needs to follow an iterative process.
2. All operational units (cost centres) need to have realistic budgets that can be used as guideline for the financial year's activities. Operational plans need to be aligned with available funding to deliver the services.

ART MODEL

1. The current model of monitoring and delivering ARVs needs review to ensure that it is sustainable, affordable and equitable and addresses issues of access.



NATIONAL GUIDELINES, NORMS AND STANDARDS

1. Clear national guidelines, norms and standards should be produced by the NDOH to cover all areas of functioning within the available resources.

HUMAN RESOURCES

1. Restructuring, with a view to establishing minimum staffing levels, should be undertaken based on a number of factors including objectively agreed benchmarks, the provincial disease burden profile, geographic constraints, optimal application of scarce skills and service delivery priorities as well as on available resources.
2. The restructuring process needs to include the elimination of duplicate structures that essentially perform the same support services.

M&E

1. M&E needs to become a central component of all managerial activity with the use of objective information being the basis for decision making. This applies to all aspects of management, including financial and HR, and not only service related data. There needs to be an iterative link between planning, implementation and monitoring.
2. Regular formal monitoring of key indicators needs to take place with analysis and questioning of variances (in much the same way as financial management variance analysis should take place). All identified variances need to be followed up with corrective actions, and the success of the corrective actions monitored.

PLANNING

1. The STP should be reviewed, revised, costed, endorsed politically, communicated to all relevant stakeholders and then used as the basis to guide all strategic decision making in the ECDOH.



2. All planning processes in the ECDOH should be simplified and 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.

SERVICE DELIVERY FOCUS

1. Senior management meetings need to focus more on strategic issues and service delivery needs to be one of the priority strategic issues.
2. Performance agreements should be clearly linked to relevant delegations, organisational priorities and key indicators that drive organisational performance.



Introduction

1. BACKGROUND

- 1.1. During the course of the 2008/09 financial year it became apparent that there was a negative difference between what was budgeted for in the health system and what was required to implement agreed-upon policies. This was associated with overspending in most of the provinces, undermining 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 to improve health outcomes. In response to this threat to the overall functioning of the health system, the 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 is 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 ARE 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 9 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 work of the finance, health systems and management experts was integrated into a holistic framework, adapted from the World Health Organization (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.² 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 block reviews. The rationale for selecting these programmes include: contribution to the disease burden; ministerial priorities; important Millennium Development Goals' indicators; facilitates analysis of conditional grant and the equitable share expenditure; and their relative contribution to component expenditure (e.g. pharmaceuticals).

- 4.2. This rapid review consisted of two main parts: a desk top review and in-depth interviews with key informants at provincial and district levels. The desktop review comprised an analysis of available public documents plus selected documents obtained from the Eastern Cape Province and other sources. This desktop review was carried out by a group of experts in the fields of public health, finance and management and organisational development. A list of these documents is shown in Appendix 2.
- 4.3. In-depth interviews were conducted with the majority of senior managers at the provincial level and at one purposefully selected district (Amathole) and sub-district (Mbashe). The interviews were conducted by a team of three experts who visited the Eastern Cape Province between the 31st of March 2009 and the 17th of April 2009. The interviews were complemented by a further analysis of the documentation provided. The list of interviewees is contained in Appendix 3.
- 4.4. The report is based on information and interview inputs obtained from the ECDOH visit and does not include the viewpoints of the National Department of Health, Provincial Government or the National or Provincial Treasuries.

5. OUTLINE OF THE REPORT

- 5.1. This document reports on the IST review done in the Eastern Cape Department of Health (ECDOH). Financial Review focuses firstly on the key findings and recommendations of the financial assessment, because the over-spending was the

² WHO. *Everybody's Business. Strengthening health systems to improve health outcomes*. World Health Organization, Geneva, 2007.



catalyst for the IST review. As over-spending is an indicator of broader systemic challenges, the remainder of the sections focus on the assessment of other key building blocks of the health system. Leadership, Governance and Service Delivery focuses on an assessment of leadership, governance and service delivery. Human Resources sets out the results of the human resource assessment, while Information Management focuses on information management. Medical Products, Laboratory and Technology and Infrastructure contain the assessment on medical products and laboratory, and infrastructure and technology respectively. Taking Forward the Recommendations integrates the recommendations from the various sections, and indicates the hierarchy of responsibilities for implementation.



Financial Review

1. INTRODUCTION

- 1.1. The financial review derives from an in-depth assessment of the ECDOH budget and expenditure reports, National Treasury reports and interviews with ECDOH management. The key findings from the review are summarised in Box 1, and elaborated on below.

Box 1: Key findings from the financial review

1. The contention of under-funding of the ECDOH and the South African public health system as a whole is being investigated at a national level and will be commented on in the overall IST national report.
2. About one quarter of the total Eastern Cape provincial revenue is allocated to health and this has been constant over the past four years.
3. The relative proportion of the national conditional grant for HIV/AIDS allocated to the ECDOH has significantly decreased over the past four years.
4. The growth rate in the uninsured per capita budget for the ECDOH for the period 2005/06 to 2010/11 is erratic with significant changes in the year on year increases.
5. The funding pressures result from OSD, higher than budgeted salary increases, medical inflation and higher numbers of patients on anti-retroviral therapy (ART) than original forecast numbers.
6. Increases in 'abnormal' appointments and the growth in corporate service structures had a material impact on compensation of employees expenditure.
7. As a result of the manner in which the cash based system is applied, the true extent of the reported underspending is significantly overstated (increases in accrual levels not included in reported underspending). The relatively small underspending reported for 2007/08 financial year would have resulted in a material overspend had an accrual accounting system been in place.
8. The contention of under-funding of the ECDOH and the South African public health system as a whole is being investigated at a national level and will be commented on in the overall IST national report.
9. About one quarter of the total Eastern Cape provincial revenue is allocated to



Box 1: Key findings from the financial review

- health and this has been constant over the past four years.
10. The relative proportion of the national conditional grant for HIV/AIDS allocated to the ECDOH has significantly decreased over the past four years.
 11. The growth rate in the per capita budget for the ECDOH for the period 2005/06 to 2010/11 is higher than the growth in the national per capita budget for the same period.
 12. The funding pressures result from OSD, higher than budgeted salary increases, medical inflation and higher numbers of patients on anti-retroviral therapy (ART) than original forecast numbers.
 13. Increases in 'abnormal' appointments and the growth in corporate service structures had a material impact on compensation of employees expenditure.
 14. As a result of the manner in which the cash based system is applied, the true extent of the reported under-spending is significantly overstated (increases in accrual levels not included in reported under-spending). The relatively small under-spending reported for 2007/08 financial year would have resulted in a material overspend had an accrual accounting system been in place.
 15. There has been a marked shift in the nature of the items in which over-expenditure has taken place during the past three years (changed from machinery and equipment to employee compensation and goods and services).
 16. There is lack of alignment between annual plans and the budget.
 17. Budgeting and financial management processes (including proper cost centre accounting and financial monitoring and evaluation) are sub-optimal.
 18. From the ECDOH perspective, conditional grants are not allocated according to grant specific indicators.
 19. Unfunded mandates (e.g. occupational specific dispensation) exacerbate spending pressures.
 20. Management accountability for finances needs improvement.
 21. The current systems of financial and quarterly performance reporting make it difficult to link finances to performance.
 22. The lack of an integrated health information system results in a deficient budgeting process.
 23. The full budgetary impact of the cost of treatment required by patients on ART needs to be better quantified.



2. UNDER-FUNDING OF THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA

- 2.1. 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 Eastern Cape and nationally is due to the under-funding of the system with consequent “unfunded mandates”.
- 2.2. The IST team is in the process of investigating this assertion on a national basis, and a conclusion will be reached upon completion. This assessment will also include a conclusion regarding the conditional grants awarded to the ECDOH in respect of the two tracer programmes identified (see paragraph 4 below).

3. PROVINCIAL BUDGET ALLOCATION

- 3.1. The allocation of the Eastern Cape Province’s budget to the ECDOH is shown in Table 1. The allocation includes the equitable share, conditional grants and provincial revenue. Slightly more than one quarter of the total provincial revenue is allocated to health and this figure has remained fairly constant over the last four years.



Table 1: Allocation of Provincial budget to Health (including conditional grants)

Financial year	R m Provincial Budget	Year on year increase	R m Health Budget	Year on year increase	% Allocation to Health	R m Adjustment Provincial Budget	R m Adjustment Health Budget	% Allocation to Health
2005/06	23 392	N/A	6 088	N/A	26.03%	23 904	6 213	25.99%
2006/07	26 827	14.68%	6 893	13.22%	25.69%	27 530	7 337	26.65%
2007/08	31 009	15.59%	8 143	18.13%	26.26%	30 609	8 069	26.36%
2008/09	38 085	22.82%	9 746	19.69%	25.59%	39 660	10 639	26.83%
2009/10	42 635	11.95%	11 328	16.23%	26.57%	N/A	N/A	N/A
2010/11	45 931	7.73%	12 108	6.89%	26.36%	N/A	N/A	N/A
2011/12	49 650	8.10%	13 146	8.57%	26.48%	N/A	N/A	N/A

3.2. When conditional grants are excluded, the provincial equitable share allocation to health shows an increasing trend over the last 4 years (Table 2).



Table 2: Allocation of Provincial budget to Health (excluding conditional grants)

Financial year	R m Adjustment Provincial Budget (excl Grants)	R m Adjustment Health Budget (incl. Grants)	R m Health Grants	% Year on year increase in Health Grants	R m Adjustment Health Budget (excl. Grants)	% Allocation to Health
2005/06	21 205	6 213	888		5 325	25.11%
2006/07	24 628	7 337	954	7%	6 383	25.92%
2007/08	26 831	8 069 ³	1 261 ⁴	32%	6 808	25.37%
2008/09	34 919	10 639	1 295	3%	9 344	26.76%
2009/10 (main budget)	35 235	11 328	1 362	5%	9 966	28.28%
2010/11 (main budget)	39 468	12 108	1 645	21%	10 463	26.51%

³ Eastern Cape Province Budget Estimate 2008/09, page 75

⁴ Eastern Cape Province Budget Estimate 2008/09, page 72



4. NATIONAL CONDITIONAL GRANT ALLOCATION

4.1. The comprehensive HIV & AIDS and national tertiary services grants (NTSG) were used as two tracers to assess trends in the allocation of conditional grants to the ECDOH (Table 3). There has been a steady decline in the proportion of the HIV and AIDS grant allocated to the ECDOH from 2005/06 through to 2008/09. Initially in 2005/06 the grant was in line with the provincial population (viz 13.5-14% of total SA population).

Table 3: National Conditional Grants to Provinces

Grant	Financial year	R 000 Total Conditional Grant to Provinces	R 000 Eastern Cape Provincial Allocation	% Allocation of National Grant
Comprehensive HIV & AIDS Grant	2005/06	1 150 108	159 005	13.83%
	2006/07	1 616 214	218 021	13.49%
	2007/08	2 006 223	233 204	11.62%
	2008/09	2 885 400	300 522	10.42%
	2009/10	3 476 200	401 727	11.56%
	2010/11	4 311 800	497 599	11.54%
National Tertiary Services Grant	2005/06	4 709 386	384 071	8.16%
	2006/07	4 981 149	374 203	7.51%
	2007/08	5 321 206	428 912	8.06%
	2008/09	6 134 100	472 542	7.70%
	2009/10	6 614 400	509 429	7.70%
	2010/11	7 398 000	557 137	7.53%
Total Conditional Grants to Provinces	2005/06	8 907 346	888 087	9.97%
	2006/07	10 206 542	953 967	9.35%
	2007/08	11 736 678	1 110 945	9.47%
	2008/09	14 362 800	1 294 956	9.02%
	2009/10	15 578 400	1 362 343	8.75%
	2010/11	18 012 800	1 645 185	9.13%

Source: Population numbers per STATS SA mid-year estimates (P0302).



- 4.2. The NTSG grant to the Eastern Cape has been fairly constant at around eight percent of the total NTSG. The ECOH's proportion of the total conditional grants was markedly reduced from 2005/06 to 2009/10.
- 4.3. The ECDOH received a portion of the Provincial Infrastructure Grant during the 2007/08 financial year. During the 2005/06 and 2006/07 financial years, the grant was fully allocated to the Eastern Cape Department of Transport.
- 4.4. The criteria for the allocation at national level of all the conditional grants were neither transparent nor clear.

5. TOTAL BUDGET PER CAPITA

- 5.1. The budget per capita for the ECDOH was calculated using Statistics South Africa mid-year estimates adjusted with the insured population from the general household survey (Table 4). The nominal budget per capita has increased, and is expected to increase at a rate in excess of inflation according to the MTEF.



Table 4: Comparing national and Eastern Cape provincial trends in per capita health budget

Financial year	National Population	R m National Health Budget	R National Health Budget per capita	% Increase year on year	Eastern Cape Population	R m Eastern Cape Health Budget	R Eastern Cape Health Budget per capita	% Increase year on year
2005/06	46 888 200	48 067	1 025		7 039 300	6 088	865	
2006/07	47 390 900	54 533	1 151	12.3%	6 894 300	6 893	1 000	15.6%
2007/08	47 850 700	62 633	1 309	13.7%	6 906 200	8 143	1 179	17.9%
2008/09	48 687 300	75 492	1 551	18.5%	6 579 300	9 746	1 481	25.6%
2009/10	48 687 300	86 945	1 786	15.2%	6 579 300	11 328	1 722	16.3%
2010/11	48 687 300	97 632	2 005	12.3%	6 579 300	12 108	1 840	6.9%

Source: Population numbers per STATS SA mid-year estimates (P0302).



5.2. The per capita budget for health in the Eastern Cape (based on the uninsured population) is lower than the national per capita budget for South Africa, with the exception of the 2008/09 financial year. There has been an increase in the Eastern Cape compounded annual growth rate per capita over the period reviewed of 16,1% per annum, this is higher than the 13.5% per annum increase nationally. The per capita budget for 2010/11 is however still 6.3% lower than the national per capita budget.

6. TRENDS IN HEALTH EXPENDITURE

6.1. The ECDOH has overspent its budget since the 2007/08 financial year (Table 5). The surplus/(deficit) per the Appropriation Statements has been adjusted by the IST team to take into account the increase in the accruals outstanding at year-end (i.e. accounts payable). This has been done to better align the operational activity with actual payments of expenses made (e.g. medication utilised prior to year end and only paid after year end). It should be noted that the numbers for the 2008/09 financial year have been prepared on a different basis than those for the other years (i.e. the numbers for 2008/09 are unaudited). Comparable figures will only be available once the 2008/09 annual financial statements have been audited. Any conclusion on trends up to 2008/09 should therefore be reserved until the financial statements have been finalised.

Table 5: Trends in ECHOD expenditure

	R 000 2005/06 (AFS)	R 000 2006/07 (AFS)	R 000 2007/08 (AFS)	R 000 2008/09 (estimate)
Surplus/(deficit) per Appropriation Statement	105 940	79 881	55 689	94 637 ⁵
(Increase)/decrease in accruals payable	173 990	170 288	(561 918)	(472 061)
Surplus (deficit) adjusted for movement in accruals	279 930	250 169	(506 229)	(377 424)
<i>Balance of accruals at year end</i>	<i>333 309</i>	<i>163 021</i>	<i>724 939</i>	<i>1 197 000</i>

6.2. The surpluses/(deficits) per the Appropriation statements/Financial statements are balanced on a cash basis by not paying accruals when it is possible that the payment

⁵ Estimate per IYM report (February 2009)



of these creditors will result in reported over-expenditure. The result is that the financial reporting (both Annual financial statements and IYM reports) loses effectiveness as a management tool and report in terms of desired, not actual results. This may also result in the Provincial Treasury not reporting possible over-expenditure to the National Treasury.

- 6.3. A concern was raised by several respondents that additional funding without fundamental improvements in the health delivery system (focus, effectiveness and efficiency) will only result in more usage and spending. Additional funding alone, without these improvements, may therefore only resolve the current overspending, but the pattern of overspending will continue as soon as the additional funding is exhausted.
- 6.4. Provincial Treasury allocated an additional R415 million to the ECDOH in the 2009/10 financial year for the payment of the goods and services component of the outstanding accruals and R177 million for Compensation of Employees as at 31 March 2009.
- 6.5. The main contributors to the overspending in the 2007/08 financial year are:
 - 6.5.1. Compensation of employees, in particular the effect of implementation of the OSD for nurses and higher salary increases than budgeted for and the increase in the number of personnel.
 - 6.5.2. Medical inflation being higher than budgeted inflation increases.
 - 6.5.3. Increase in operational service levels e.g. higher numbers of patients on anti-retrovirals (ARVs) than the forecast numbers.
 - 6.5.4. Increases in abnormal appointments and the growth in corporate service structures had a material impact on compensation of employees expenditure. Total compensation of employees increased by 18.2% year on year while the total expenditure increased by 10.4%.
- 6.6. As can be seen from Table 6 below, the trend of overspending (on the cash basis of accounting) has shifted from machinery and equipment to mainly compensation of



employees (OSD, material salary increases and increases in the number of employees). The number of employees increased from 34 802⁶ at the beginning to 39 106 at the end of the 2007/08 financial year. That is an increase of 12.4%⁷ in the total number of employees. In the 2007/08 financial year, the training expenditure increased by only 2.9% from the 2006/07 financial year, which might have a long term negative impact on service delivery. This aspect is further dealt with under Human Resources, paragraph 10.

- 6.7. The material changes in the goods and services expenditure from year to year is the result of managing cash flow by increasing and decreasing the level of outstanding accruals (see Table 5 above).

⁶ Annual Report 2006/07, pg 288

⁷ Annual Report 2007/08, pg 323



Table 6: Trends in health programme budget and expenditure, 2005-08

Programme	2005/06			2006/07			2007/08		
	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000
	Final Appropriation	Actual Expenditure	Variance	Final Appropriation	Actual Expenditure	Variance	Final Appropriation	Actual Expenditure	Variance
Administration	250 256	248 398	1 858	407 203	331 643	75 560	374 856	374 549	307
District Health Services	2 820 680	2 812 011	8 669	3 296 391	3 237 762	58 629	3 672 358	3 712 566	(40 208)
Emergency Medical Services	219 079	219 052	27	275 269	321 856	(46 317)	318 765	318 793	(28)
Provincial Hospital Services	2 030 962	2 043 109	(12 147)	2 290 597	2 287 337	3 260	2 731 075	2 637 418	93 657
Central Hospital Services									
Health Sciences and Training	333 514	327 406	6 108	369 382	364 582	4 800	358 346	375 126	(16 780)
Health Care Support	36 150	36 049	101	21 711	20 930	781	24 125	24 126	(1)
Health Facilities Management	535 596	434 159	101 437	675 727	692 427	(16 700)	588 409	569 421	18 988
Special functions									
Internal charges	673	786	(113)	719	851	(132)	763	1 009	(246)
Total	6 226 910	6 120 970	105 940	7 336 999	7 257 118	79 881	8 068 697	8 013 008	55 689
Economic classification									
Compensation of employees	3 453 865	3 445 574	8 291	3 879 362	3 860 060	19 302	4 525 338	4 562 518	(37 180)
Goods and services	1 592 933	1 583 864	9 069	2 510 799	2 546 080	(35 281)	2 196 439	2 225 674	(29 235)
Financial transactions in assets and liabilities									
Transfers and subsidies	725 605	733 308	(7 703)	359 950	288 747	71 203	423 422	422 420	1 002



Table 6: Trends in health programme budget and expenditure, 2005-08

Programme	2005/06			2006/07			2007/08		
	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000
	Final Appropriation	Actual Expenditure	Variance	Final Appropriation	Actual Expenditure	Variance	Final Appropriation	Actual Expenditure	Variance
Buildings and other fixed structures	433 242	266 609	166 633	469 909	444 483	25 426	747 047	694 793	52 254
Machinery and equipment	21 265	91 615	(70 350)	116 979	117 783	(769)	176 451	107 603	68 848
Total	6 226 910	6 120 970	105 940	7 336 999	7 257 748	79 881	8 068 697	8 013 008	55 689

Source: Annual reports of various financial years



7. UNFUNDED MANDATES DURING 2008/09

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

7.2. Examples of unfunded mandates in the case of the ECDOH include:

7.2.1. *Occupational Specific Dispensation (OSD)* – the implementation and costing 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. The underfunding for this OSD amounted to R170 - 200 million.

7.2.2. *Nationally negotiated salary increase* for 2008/09 was 10.5%, although the budgeted increase provided for by the ECDOH was only 7.1%.

7.2.3. *The activity levels increased.* For example, the numbers of patients registered for ARTs increased from a projected 60 000 (funded by the HIV conditional grant) by the end of 2008/09 to 73 882. At an average cost of around R500 per patient per month this is equivalent to an underfunding of R6.9 million per month.

7.2.4. *New facilities.* The opening of clinics during the 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. For example, nursing staff in the Mbashe sub-district had to be diverted from other, already thinly staffed facilities to allow for the opening of these clinics.

7.2.5. *Higher medical inflation than budgeted inflation increases.* The exact effect of this cannot be accurately quantified with the summarised information available.

7.2.6. *EMS (Fleet Africa contract).* Transport in the province falls under a PPP, negotiated by the Department of Transport. The contract was not negotiated in a



competitive environment, and has been inadequately managed. This has resulted in material penalties and unbudgeted expenditure, e.g. excess kilometres travelled by ambulances. The contract is evidently suitable for transport in general, but not at all suitable for EMS. Either a set of different requirements should be defined for EMS or EMS should be excluded from the contract. Disputes and operational issues currently need to be communicated through the DDG Clinical, to the COO and then to the senior management of the Department of Transport. The involvement of various senior management results in delayed corrective actions.

8. BUDGETING PROCESS

- 8.1. The budgeting process was identified as a major contributor to the current funding challenges in the ECDOH. Currently, the budgeting process is a top down process. Although basic inputs are compiled from operational levels, an indicative figure is obtained from the national budgetary process. This indicative amount is then allocated to the operational budgets (various institutions/levels) taking into consideration material known changes in operations, but to a large extent not aligned to operational plans and budgets.
- 8.2. It was indicated that there is a projected deficit of R710 million for the 2009/10 financial year, consisting of R300 million for goods and services and R410 million for compensation of employees. The expected deficit stems from the misalignment between the budget request of the ECDOH based on past (and future expected) activity and the top-down amount allocated by the Provincial Treasury. The ECDOH's solution to managing the expected deficit is to effectively budget the allocated funding up to the adjustment budget, and hope for additional funding for the remainder of the financial year. Operational levels are therefore not aligned with available funding. An example of the disjointed budget process is a hospital, which received about half of the budget amount requested for goods and services. The actual amount spent on goods and services for the 2008/09 financial year was R6.9 million, but the allocated budget for the 2009/10 financial year amounts to only R3.6 million.
- 8.3. There is also no clear alignment between the annual performance plans and the financial budgets. Even though it was indicated that the annual performance plans



are updated to reflect the available funding received, it is clear, based on the discussion in the previous paragraph, that the process of updating the annual performance plans and aligning it to the budget is not effectively done.

8.4. Levels of available funding do not seem to have a material impact on day-to-day management of service delivery. Hospitals and districts evaluate the overspending trend and implement limited cost saving strategies, but this is not sufficient to eliminate the shortfall.

8.5. With the relatively fixed levels of compensation expenditure linked to the number of personnel, it is only possible to effect cost saving strategies in goods and services and infrastructure expenditure. Managers indicated that with insufficient funding available, they have the following options to reduce a funding shortage:

8.5.1. Implement limited cost saving strategies (e.g. telephones, laboratory expenditure)

8.5.2. Cut staff (but this is not usually possible, given the permanence of public servants)

8.5.3. Cut services or limit access to more expensive services. Managers are reluctant to implement any service limitations without specific instructions to do so. It is also not usually politically acceptable.

9. FINANCIAL MANAGEMENT PROCESSES

9.1. Cost centre accounting, electronically, is only done down to a sub-district level (clusters of clinics), and not down to clinic level. This high level of cost centre accounting also applies to hospitals with few hospitals having cost centres (e.g. wards within the hospital). A notable exception is a pilot project at Frere hospital using cost centres within the hospital. Efficiency and effectiveness indicators needed for good financial management are therefore not available. Even though the current indicators are for larger groupings (hospitals, CHCs or clusters of clinics), they could still be useful measures of efficiency and effectiveness such as cost per PDE, food cost per PDE, bed occupancy rates, number of patients per nurse. These indicators should be monitored on a regular basis, and corrective actions taken if required.



- 9.2. Variance analysis of differences between actual and budgeted expenditure can be a very useful management tool. Currently, whenever variances are identified, the 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, very little follow-up is done to identify any possible or necessary operational corrective actions flowing from variances.
- 9.3. Management responsibility and accountability are limited at all levels of the hierarchy, making it more difficult to maintain effectiveness and efficiency standards. Supporting evidence for this contention is provided under Human Resources, paragraph 2.

10. COST ALLOCATION

- 10.1. In some cases, costs for doctors and dentists are allocated to district hospitals, but the personnel in question are deployed at primary health care level. The cost per patient day equivalent (PDE) indicator loses some of its relevance and usefulness as a result. Hence, there is a need to improve the personnel cost allocation. There is currently a process in place for person-to-post matching.
- 10.2. Distribution of medication is not always done through the medical depot. Some personnel have developed a manual system to redistribute medication and medical supplies to the different facilities themselves. Not all clinics have depot demander codes for the ordering of medicines, meaning that the costs are allocated to the CHCs ordering the medicines for the clinics. This also applies when doctors use medicines from hospitals when visiting clinics. As a result of the non-integrated, manual system, accurate cost allocation of medication to institutions/cost centres is not done. Again, the cost per PDE indicator loses some of its effectiveness and cannot be used to identify areas that require investigation and possible corrective action.



11. CONDITIONAL GRANTS

- 11.1. The national budgetary processes, referred to in paragraph 8 above, apply equally to conditional grants. Although annual performance plans are compiled at national and provincial levels, there are mismatches between the provincial business plans and the level of national grant funding. For example, the criteria for HIV grant allocations are not clear but appear to be somehow based on the equitable share, and not the business plans of the province which reflect the number of HIV positive individuals in need of care.

12. QUARTERLY PERFORMANCE REPORTS

- 12.1. Quarterly performance reports on service related indicators are compiled and submitted to the Provincial Treasury. The current systems of financial and quarterly performance reporting make it difficult to link finances to performance. In addition, as a result of national prescribed indicators, there are too many non-financial indicators, with doubtful value and usefulness. Currently, variances are identified, but there is no follow-up of these variances. This matter is also commented on in Information Management, paragraph 2.

13. FINANCIAL REPORTING

- 13.1. The principal financial reporting mechanisms are the Annual Financial Statements and the monthly In Year Monitoring (IYM) reports.
- 13.2. Although the *IYM report* can be an effective tool to identify possible budget over-runs, these are compiled on a cash basis and not on an accrual basis. The result is that 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 over-spending is also limited by the withholding of invoices for payment. The effect of this deficiency where unpaid amounts show an abnormal increasing trend is highlighted in Table 5. (The PFMA implications of this practice have not been considered for purposes of this report).



- 13.3. The annual financial statements (AFS) are drafted on a *cash basis*. Expenditure not paid (accruals) is not matched with the operational activities of the ECDOH. Material amounts payable are accumulated, but the reporting does not take this into consideration.
- 13.4. Resulting from the practice of withholding payments and increasing accruals, material under-spending will be reported in certain programmes/economic classifications and over-spending in others. The compensation to employees will, for example, be reported as overspent (a priority payment) and goods and services or infrastructure underspent. However, a material amount will still be outstanding/payable at the end of the financial year.

14. SUPPLY CHAIN MANAGEMENT

- 14.1. Multiple systems are used for supply chain management:
- 14.1.1. LOGUS (not fully implemented)
 - 14.1.2. Proquote (for purchases less than R30 000)
 - 14.1.3. Procure (for purchases more than R30 000)
 - 14.1.4. Manual systems
 - 14.1.5. New system in process of implementation
- 14.2. There are various problems with these procurement systems. The suppliers' database is not always up to date and results in suppliers that may not be in business any more being selected for procurement. Suppliers selected by the systems are not always in the area of the purchasing institution or clinic, or may not be delivering the required goods or services. This results in long delays in procurement because the process has to be abandoned half way and restarted, hoping for a further successful selection of suppliers for quotations.



- 14.3. The first limit for procurement authorisations is R30 000. An order for very limited maintenance totalling R30 000 was noticed. This seems in line with concerns raised in Head Office that goods and services are procured, not based on the value of the goods or service, but rather the limit for procurement authorisations.

15. CORPORATE SERVICE CENTRES AND ABNORMAL APPOINTMENTS

- 15.1. There are currently duplicate or even triplicate structures in place for the same deliverables. Corporate Service Centres (CSCs) were established in response to the difficulty to attract and retain skilled staff in rural areas. The idea was that support staff (human resources, finance and supply chain management (SCM)) would move to CSCs. But only a small number of staff actually moved, with support staff remaining in the institutions. There are currently support staff (HR, Finance and SCM) in both structures - the CSCs and the institutions/sub-districts. The introduction of the CSCs added approximately 1 300 staff members to the work force.
- 15.2. The Audit Intervention and the Bundy-Park projects were introduced to deal with issues raised by the Auditor-General during previous audits. The Audit Intervention project focuses on financial audit issues and the Bundy-Park project with documentation management. These projects added around 1 063 abnormal appointments to the work force. The projects are scheduled to finish during the next year (2009/10), but it was mentioned that the personnel may be integrated into the full time work force.
- 15.3. The number of abnormal appointments increased from 2 135 at the end of 2006/07⁸ to 4 448⁹ at the end of 2007/08.

⁸ Annual report 2006/07 page 288

⁹ Annual report 2007/08 page 323



16. MONITORING STRUCTURES

- 16.1. The effectiveness of essential monitoring structures requires improvement. Issues reported by the Auditor-General in the 2007/08 annual report include:
- 16.1.1. Audit committee – the ECDOH did not have an effective audit committee in operation during the financial year. The IST was informed that this is now in place, but was not able to confirm this due to time constraints.
 - 16.1.2. Internal audit – the internal audit function did not fulfil its responsibilities for the year, as set out in Treasury Regulation 3.2/27.2.
 - 16.1.3. External audit – prior year’s external audit recommendations have substantially not been implemented.

17. RECOMMENDATIONS

17.1. PROVINCIAL HEALTH BUDGET ALLOCATION

- 17.1.1. The Provincial Treasury should allocate an amount to the ECDOH, which is substantially in line with the equitable share indicated by the National Treasury in the national budget.
- 17.1.2. Allocations of conditional grants by the NDOH should be based on clear, objective criteria that are linked to grant specific indicators and not on the equitable share formula.

17.2. UNFUNDED MANDATES

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



17.2.2. 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.

17.2.3. For medical inflation, the National Department of Health could determine a basket of items, based on volume and price, which could be tracked annually as a medical inflation rate, much as the CPIX is measured.

17.3. BUDGETING PROCESS

17.3.1. The budgeting process needs to be seen and used as an extension of the annual performance plan, and needs to follow an iterative process.

17.3.2. All operational units (cost centres) need to have a realistic budget that can be used as a guideline for the financial year's activities. Operational plans need to be aligned with available funding to deliver the services.

17.3.3. Budget virements need to be linked to changes in operational activity, not merely to balance the number of over and under expenditure items.

17.3.4. The practice of continuous budget reallocations needs to be discontinued. Virement movements which are effected to minimise unauthorised expenditure (over-spending) should not hinder the application of the principles of proper financial management and variance analysis during the course of a financial year.

17.4. FINANCIAL MANAGEMENT

17.4.1. Cost centre accounting needs to be done at the lowest possible practical level (i.e. facility/clinic level). This is needed to properly identify areas of operations that require attention.

17.4.2. Allocation of expenses needs to be accurate and up to date to assist with effective management. Actual expenditure is an important indicator and inaccurate



information impacts on effective monitoring and evaluation at all levels. Effective management is not possible without accurate and timely information.

- 17.4.3. Provincial organograms must be finalised.
- 17.4.4. Variance analysis needs to be used as a management tool to identify areas that require attention.
- 17.4.5. The required monitoring structures need to be put in place.
- 17.4.6. Managers should be held accountable for the performance of their operating units and this must be built into the performance management system.
- 17.4.7. Although current cost per PDE indicators are not effective, they should be monitored and identified outliers need to be followed up with corrective actions. If the cost per PDE is incorrect due to misallocation, a process should be started to correct allocations.
- 17.4.8. Selection of suppliers by the procurement systems needs to be improved to reduce the time delays of acquisitions.
- 17.4.9. All orders just below the authorisation limits need to be inspected for value for money purchases. Disciplinary action needs to be instigated against personnel procuring or authorising goods and services for more than market related prices.

17.5. QUARTERLY PERFORMANCE REPORTS

- 17.5.1. The accuracy and use of essential performance indicators needs to be improved e.g. the number of patients on ARVs. The necessary steps must be taken in conjunction with the NDOH to improve the quality of information available in this regard.
- 17.5.2. Variances in specific indicators need to be followed up with actions, and not merely identified.



- 17.5.3. There needs to be a link between performance and financial reports. A financial report reflecting actual expenditure compared to budget should also be provided where performance indicators reflect a deviation in operational performance.

17.6. FINANCIAL REPORTING IYM (IN YEAR MONITORING) AND BAS

- 17.6.1. 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.
- 17.6.2. The IYM report needs to serve as an accurate forecast of expected expenditure and cost. It has limited use as a monitoring tool when it only reflects actual and expected cash flow, which is not linked to operational activity (expenditure).
- 17.6.3. Personnel need to be trained on BAS, including the accounting structures, process flow (what will be populated when and where in the database) and methods for extracting data.
- 17.6.4. Reporting from BAS needs to be made more user friendly with only relevant information included in reports.

17.7. ANNUAL FINANCIAL STATEMENTS

- 17.7.1. 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.



Leadership, Governance and Service Delivery

1. INTRODUCTION

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

1. The NDOH has provided insufficient leadership and stewardship to solve the fundamental problem of ensuring that the resources available for health are sufficient for the levels of service and targets envisaged by a range of national policies.
2. The NDOH has also not given sufficient direction with regard to setting of norms, standards and guidelines.
3. Because of the lack of an approved and accepted STP, key planning documents of the ECDOH lack an overall vision for the public health system in the province. There is lack of alignment among the various plans and lack of communication within the ECDOH around planning. Plans are designed to satisfy compliance. Accountability mechanisms are neither strong nor explicit.
4. Key political support for difficult decisions on rationing services is not forthcoming and has paralysed planning.
5. Key problems identified that have systems and capacity challenges as core problems are addressed by creating parallel systems and structures which complicate rather than resolve the problems.
6. Roles and responsibilities at different levels and between politicians and administrators are not clearly defined.
7. Senior management meetings reveal a pre-occupation with operational processes, rather than strategic issues of service delivery. In addition, regular well-planned, scheduled meetings throughout the ECDOH are compromised through ad hoc calling of meetings at high level.
8. Although there is feedback to line managers on over-expenditure and variances on line budgets, the manner of, and responsibility for, follow-up and action is inadequate.
9. Most of the financial and human resource delegations have been centralised, resulting in increasing bureaucracy with consequent inefficiencies, additional costs and insufficient accountability.
10. The large number of programme managers at national and provincial level is



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

out of sync with capacity at district level. This is exacerbated by the lack of integration across the various programmes.

11. Key services are under budgeted (e.g. ART) and services will suffer unless this is addressed.
12. Targets for specific diseases need to be disaggregated so that districts, sub-districts and facilities are aware of their targets and can be held to account.
13. The HIV/AIDS programme needs to be integrated and not run as a separate vertical programme.

2. GENERAL LEADERSHIP AND GOVERNANCE

“Overspending is quite predictable. Planning is done, costs are predictable, but money is expected to run out. The problem is that the budget is inadequate for the demands, particularly in the light of the TB/HIV epidemic”.

Senior manager, ECDOH.

- 2.1. This is part of the truth.
- 2.2. The ECDOH has for the last few years a history of over-expenditure (also known widely throughout the province as under-budgeting or “unfunded mandates”). The reasons for this seem multiple and include:
 - 2.2.1. Unfunded or underfunded mandates from national level (e.g. OSD, new vaccines)
 - 2.2.2. Discrepancies between budgeted and actual increases for annual salary increases
 - 2.2.3. The proliferation of corporate service and management structures at all levels
 - 2.2.4. Increasing service demands (e.g. ARV therapy)
 - 2.2.5. The failure to implement the recommendations of the STP
 - 2.2.6. Poor controls over pharmaceuticals, laboratories and infrastructure



2.2.7. Little focus on efficiencies

2.3. It is generally felt that the policies (and associated targets) set by the NDOH, although often considered to be excellent policies and in line with international best practice, are not linked to the necessary funding. For example, the NDOH has introduced two new childhood vaccines to be implemented by the 1st of April 2009. However, although additional funding has been provided for this by the National Treasury, this has been added to the equitable share of the province. In reality this means that the Provincial Treasury will swallow these additional funds to pay for the backlog of over-expenditure and if the vaccine policy is implemented the ECDOH will pay for this despite insufficient funding. This will again result in “an unfunded mandate”.

2.4. Similarly, the tools used for administration (especially PERSAL, BAS and PROQUOTE) are not commensurate with the capacity within the province. It was reported by several respondents that few people had the capacity to utilise these systems effectively. It was observed that the types of reports drawn from BAS were very basic and that not all relevant staff could interpret even these reports. Several respondents highlighted the fact that few of the administrative people could capture data on PERSAL. PROQUOTE seemed to have no process to verify the claims of private contractors and thus service providers had to choose from private contractors who were unable to supply what was needed. Rather than assessing capacity and introducing structured training and mentoring systems, the tendency has been to allow corporate services staff to struggle on or to use consultants to temporarily plug gaps or rectify matters.

2.5. The key governance and leadership issues in the Eastern Cape are four:

2.5.1. Limited focus on service provision, the key function of the ECDOH.

2.5.2. The lack of clear roles and responsibilities between the different levels of management within the ECDOH and between the political and administrative role-players. This has led to an increased lack of responsibility and accountability.



2.5.3. Centralisation as a means of problem solving. When administrative problems are often clearly identified, the response has been to create additional structures and systems to address the problem which then further complicates the issue. There is also an ongoing tendency to centralise functions within the ECDOH.

2.5.4. Reluctance of politicians to accept the need to realign services to fit the available resources.

2.6. LIMITED FOCUS ON THE KEY BUSINESS

2.6.1. The key business is providing public health services to nearly 7 million people in the Eastern Cape. However, the emphasis is on ensuring a clean audit. Several respondents alluded to the fear that permeates the ECDOH and the efforts that have ensued to ensure a clean audit bill. This has included the creation of a duplicate financial structure (the Audit Intervention Programme – discussed below and in Financial Review, paragraph 15), and the general beefing up of managerial and corporate service structures often at the expense of clinical services. For example, it was reported that although the ECDOH has identified 5,000 critical health service posts for filling between the 2007 and 2009 financial years and has budgeted R120 million per annum for this, this has not happened as the funds have been used elsewhere. Similarly, it was reported that although the overall personnel budget at the East London complex is the same for 2009/10 as for 2008/09, the clinical component of the compensation of employees has been reduced by R24 million.

2.6.2. Linked to this is the limited resources spent on maintenance. In 2008/09, the East London complex spent around R2 million on maintenance. The accepted figure for maintenance expenditure is annually around 5% of the building cost. This would estimate Frere and Cecilia Makiwane Hospital buildings at R40 million – clearly a gross underestimate.



2.7. LACK OF CLEAR ROLES AND RESPONSIBILITIES

2.7.1. Two key issues warrant discussion.

2.7.1.1. Firstly, there is a lack of understanding of roles and responsibilities at all managerial levels. This is compounded by multiple vertical reporting channels which fragment the health system. For example, the district CSC manager reports to the corporate services cluster in Bhishe while the district manager reports to the health cluster and the complexes report to the corporate strategy and organisational performance cluster. There are also moves to restructure the CSC to have separate finance and HR components with the finance/supply chain management components of the CSC reporting to the financial management cluster. Thus, relationships at district level depend on goodwill and the concept of unitary managerial relationships at each level is affected.

Then the district hospitals report directly to the district manager while the clinics, CHCs and community services report first to the sub-district manager. Effective management requires the re-establishment of an integrated district health service where district hospitals and their concomitant PHC services function as a unit and a team (with links to the tertiary facilities for outreach, backup and supervision). This is now also dependent on goodwill. Similarly, clinical and administrative functions are subject to fragmentation with HR and finance managers at sub-district level having dual reporting lines to the sub-district manager and the district CSC structures and this being repeated at district level.

Health programme managers (e.g. TB, MCH) at provincial level are nominally responsible for targets in their functional areas. However, similar programme managers at district and sub-district levels are accountable to district managers and sub-district managers, respectively. Although programme managers at all levels have regular meetings, programmatic activities are determined by management at the different levels.

While all these structures and systems might be appropriate, they contribute to role confusion and impact on responsibility and accountability. For example, the



chief financial officer was reported as saying that her cluster could only be responsible for finance if the finance people at all levels reported directly to her. The comment relates to whether or not finance should be a line programme or a staff one. Under the current situation with the emphasis on finance it would appear that the CFO is being held accountable for budget compliance – which is impossible. However, there should be close collaboration between finance and operations to develop appropriate ways of managing the budget.

- 2.7.1.2. Secondly, there is a lack of clarity on the roles and responsibilities of the political and administrative arms of the ECDOH. This seems to be dependent on the actual people in the positions as the situation has fluctuated over time. While the political head is responsible for policy and overseeing whether the policy has been implemented, the administrative head is responsible for the implementation of programmes and projects within the budget envelope of the ECDOH and the policies of the day. It is clear from several respondents that the political mandate has encroached on the administrative mandate. For example, all level 13 and above appointments are interviewed by a panel that then sends the results to the MEC for the MEC to make the final selection (without the MEC taking part in interviews or even meeting the candidates). This is unwarranted interference. Infrastructure projects have changed with incoming MECs. Similarly, it was reported that the national Minister during a visit in 2008 issued a 'directive' to employ an additional 1,600 junior health care workers.

2.8. CREATING ADDITIONAL STRUCTURES/SYSTEMS TO ADDRESS FUNDAMENTAL ADMINISTRATIVE PROBLEMS

- 2.8.1. The Eastern Cape is an amalgamation of three former health systems that had different cultures, capacities and ways of working. Some of the key administrative challenges identified by ECDOH management over the last 15 years have included:

2.8.1.1. The inability to get a clean audit

2.8.1.2. The capacity of managers/corporate services personnel at all levels within the province



- 2.8.1.3. The problems that exist with the personnel files
- 2.8.1.4. Lack of clarity of the ECDOH organogram.
- 2.8.2. Rather than deal with the issues directly and simply the tendency has been to adopt methods which have complicated the processes and involved substantial additional expenditure.
- 2.8.3. In pursuit of a clean audit, the head office has created an additional structure of around 800 people¹⁰ to shadow the financial and supply chain management structures. This three year project is headed by the equivalent of a DDG/CFO (level 15), has 24 personnel at director level and around 800 people (interns and contract workers) who are scattered across the province - at head office and CSC level predominantly. While this audit intervention programme has undoubtedly had an impact in resolving many finance and supply chain problems, the fundamental problems of skills, capacity and corruption have not been addressed and once the programme has ended¹¹ it appears as if things will return to business as usual.
- 2.8.4. Similarly, past inheritance has affected the management of personnel files. Two of the three pre 1994 systems were characterised by personnel files and issues largely being dealt with at head office level. The other, decentralised many of these functions to the hospitals. The different approaches have never been debated and an agreed mechanism developed. However, there have been several attempts to update the personnel files – usually using the centralist approach. As there are around 40,000 employees in the ECDOH, this has resulted in generally unsatisfactory outcomes. The current attempt (the so-called Bundy Park project) has 250 additional personnel to resolve these HR file issues.
- 2.8.5. Linked to this is the lack of clarity around the organogram. Currently the PERSAL system has around 82,000 posts of which around 40,000 are filled (including

¹⁰ Note that the head office currently has around 950 people

¹¹ There is already a strong lobby to remove the AIP directors and only to incorporate the interns and contract workers into the full-time work force



around 4,000 'abnormal' or additional to establishment appointments¹²). There have been several attempts to address the organogram confusion. These include the 'Rodion Krause' project which was rejected by the IMT in 2003 (at the point of capturing these structures onto PERSAL¹³), and several workstudy projects. What appears to have happened is that there has been an *ad hoc* capturing of organogram structures on PERSAL which has led to duplicate structures with all the attendant problems. The current initiative is to load the existing filled posts (excluding the 'abnormals' as it is hoped that their situation will be resolved by June 2009) plus the vacant funded posts (those vacated in the last financial year, 2008/09) and the Project 5,000 additional critical posts – largely clinical posts. This will lead to a staff establishment which is much closer to 40,000. This will obviously bring down the vacancy rate but is not necessarily related to equity, workload of the different facilities or the needs and changes as encapsulated by the STP.

- 2.8.6. An important reason for the overspend and the increasing bureaucracy has been the increase in management and corporate service staff and structures. The reasons for this expansion have neither been clear nor understood by many. The expansion has occurred across the board and the following examples illustrate this:
- 2.8.6.1. At hospital level, the former triad of superintendent, matron and hospital secretary has been replaced by a quartet of hospital manager, clinical manager, nursing service manager and middle manager (administration). In addition, some hospitals have been clustered into hospital clusters and a new structure, that of cluster CEO, has been created.
- 2.8.6.2. The three hospital complexes are headed by a chief director and the complex CSCs are managed by a director with six deputy directors. Previously the hospital secretary at complex level was the only deputy director.
- 2.8.6.3. Where there once were regions and districts there are now districts and sub-districts. However, the corporate services (largely HR, finance and SCM) have

¹² Besides the AIP and the Bundy Park project these include additional health care givers that were employed apparently following a Ministerial visit and 'directive'

¹³ It appears that some had already been captured



been split off and consolidated into 11 CSCs that service the 7 districts, the three hospital complexes and the head office. Excluding Mthatha and East London CSCs, the other 8¹⁴ employ approximately 1,400 people. While the purpose of the CSCs was to amalgamate scarce skills and support the facilities from these CSCs, what has happened is that many of the posts have remained at hospital and sub-district level and much of the work seems to occur there resulting in a duplicated and over bureaucratized system.

- 2.8.6.4. There has been a large increase in the senior managers at head office. In 1995 there was one DDG, 3 CDs and about 15 directors. Currently there is now one SG, 3 DDGs, 19 CDs and many more directors¹⁵. For example, where there was a director for infrastructure there are now a chief director and three directors.
- 2.8.6.5. At sub-district level, there are programme managers for many of the PHC programmes and also clinical supervisors (one per 7 clinics).
- 2.8.7. While many of these posts might be necessary, they have substantially increased costs. In addition, many managers reported that they were not sure which of the other managers to approach if they were experiencing a problem.
- 2.8.8. Linked to the increase in the bureaucracy is the ongoing centralisation of administrative functions. For example, the sub-district finance personnel have to travel twice to the district CSC to get authorisation – once for pre-audit and again for payment authorisation – in order to purchase an item. This occurs despite the fact that responsibility has been delegated and the bulk of the work gets completed at the lower level. To appoint most staff requires the advert to be placed through a central unit in Bhisho, for multiple managerial signatures to be obtained and for the final authorisation to pay to emanate from Bhisho. Thus, the process is decentralised in name only.
- 2.8.9. This has resulted in senior managers, hospital, district and sub-district managers not being able to take key management decisions, appropriate for the level of

¹⁴ PE complex and district CSC have merged and employ 434 people

¹⁵ For example, where there was once a regional director, both the district managers and the CSC managers are at director level



service delivery. It has also increased the bureaucracy with consequent inefficiencies and additional transactional costs. Furthermore, this centralisation has undermined accountability and levels of responsibility, and as a result most managers do not see themselves as accountable for overspending.

2.9. RELUCTANCE OF POLITICIANS TO ACCEPT THE NEED TO REALIGN SERVICES TO FIT THE AVAILABLE RESOURCES

- 2.9.1. Although an attempt has been made to plan rationally for an improved distribution of services and facilities within the available resources through the STP, this process has stalled after being tied up in political and union wrangling. Politicians at national and provincial level have not given clear direction regarding the fitting of available resources with the level of services to be provided.
- 2.9.2. The ARV programme is a clear example. In 2008/09, around 90% of the conditional grant for HIV/AIDS was spent on ARV, which exceeded the recommended amount. In addition to the original conditional grant budget of around R300 million a further R112 million was added through the budget adjustment process and an increase allocated by the new Premier for the turnaround strategy. The conditional grant budget has increased to R400 million for 2009/10, but the target for ARV therapy has also increased from around 70 000 to 100 000. The drug costs alone will exceed the conditional grant. Resources are needed for prevention and care and support. Clearly the HIV/AIDS programme will be overspent and resources will be diverted from elsewhere.
- 2.9.3. As a result of a lack of strategic direction regarding the package of services and associated norms, standards and costs, rationing occurs often in an ad hoc manner at facility level (e.g. restrictions on renal dialysis).
- 2.9.4. This is one of the critical issues facing the ECDOH. It either has to ensure a greater source of funding to continue with existing services and the new ones required in terms of policy (e.g. expansion of ART, TB, PMTCT and MCH services), or to cut the existing services so that the service provision occurs within budget.



- 2.9.5. It is felt in the province that the NDOH has provided insufficient leadership and stewardship with regards to helping solve this fundamental problem.

3. OTHER GOVERNANCE AND LEADERSHIP ISSUES

3.1. DECISION-MAKING PROCESSES

- 3.1.1. One of the essential means of communication and decision making is through regular well-planned, scheduled meetings. It appears that the predictability of these meetings has been compromised through the calling of 'crisis' meetings irregularly by both politicians and the head office administration. This has a spin-off effect throughout the ECDOH and one of the consequences at district level is that managers and senior clinicians are called very regularly to Bhisheo at short notice. This has an impact on service delivery.
- 3.1.2. This is exacerbated by informal channels of communication often involving politicians that tend to undermine and negate the work of the civil servants.
- 3.1.3. Additionally, many respondents commented that management meetings are pre-occupied with operational processes, rather than on service delivery. There is little discussion of the performance of the system.
- 3.1.4. Managers are seldom held to account with little focus on actions that have occurred between the meetings. The process adopted in the ECDOH has been one of "*consensus management*". However, this in effect means "*veto management*" because unless all are on board, the decision will be shelved. This could be seen as an abdication of individual managerial responsibility in order to ensure the protection of the group in the event of decisions being unpopular or deemed to have been politically incorrect.
- 3.1.5. There was a perception by some managers that if there was more of a focus on the real issues of improving service delivery rather than a focus on the clean audit bill and bureaucratic issues, that significant improvements could be made in a relatively short period of time.



3.1.6. Although the finance cluster provided regular feedback to line managers and other clusters about over-expenditure and variances on line budgets the responsibility for dealing with these matters was left by the finance cluster to these other managers. In addition, the focus tends to be on compliance rather than efficiencies and effectiveness. Very seldom are financial and performance-related data discussed at any meeting.

3.2. PLANNING

3.2.1. STP

3.2.1.1. A draft strategic transformation plan (STP) was completed in 2006 and amended subsequently. This STP is an attempt to reshape and reconfigure the public health system in the ECDOH mainly through a norms-based approach linked to the number of hospital beds; appropriately situated and functioning hospitals; de-complexing of tertiary hospital services; realigning the numbers of CHCs and clinics; and building a functional district health system. It recommends, for example that the number of district (level 1) hospitals be reduced from 64 to 25, CHCs will increase to around 100 and clinics will reduce slightly in number. This plan was approved by the MEC and EXCO but not implemented due to the fact that its implementation would be politically unacceptable.

3.2.1.2. As discussed earlier there is a gap between what politicians accept as the levels of service delivery versus the objective determination of services (e.g. the numbers of hospital beds per population) given the financial resources available.

3.2.1.3. One of the consequences of the lack of an STP is that all other strategic planning is compromised by not having an overall vision of what the ECDOH should look like in the future. For example, many hospitals are functioning at sub-optimal levels of efficiency and effectiveness and are hospitals by name only (e.g. many district hospitals do not perform even the most basic of operations such as Caesarean sections). As a result of the STP not being approved, the ECDOH is not able to make the necessary changes to convert some of these hospitals to community health centres, and by so doing improve both effectiveness and efficiency through financial savings.



3.2.1.4. It must be expected that a transformation plan will encounter objections and obstacles as it moves towards implementation. Thus it is essential that the STP be approved and a plan developed for communication, implementation and dealing with challenges as it unfolds. Several respondents felt that the NDOH could play a role in this process.

3.2.2. Annual Performance Plan

3.2.2.1. An annual performance plan (APP) for a three year period is prepared to a standardised format. 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. It appears designed to satisfy compliance rather than to be a guiding document for the public health sector in the ECDOH to improve the health of the people. The documents are too long with little alignment between goals, objectives, and strategies. Indicators are numerous and are focussed on input or process indicators and many would be difficult to measure. Monitoring and accountability processes are weak.

3.2.2.2. The resource allocation process within the ECDOH is neither explicit nor is it well-communicated as many managers are not clear as to the processes used. It appears that there is a centralised approach to planning of financial resource allocation based on historical usage.

3.2.3. Alignment of Plans

3.2.3.1. The role of the NDOH in assisting the province through more explicit written guidelines, norms and standards and key targets could be improved.

3.2.3.2. It was also clear that there was a lack of communication between the various levels of the ECDOH and that planning was done in organisational boxes. For example, the APP, the programme managers' plans and the district plans are all written without explicit correlation and have different timelines for finalisation. This is reflected in different information and different targets for the same intervention



occurring in different plans. Also, the preparation of district plans are not integrated and aligned with the APP. They use very different formats. Many people interviewed were not sure of the status of the various plans and were not sure of the relationship between the plans. Also, terminology usage was loose with terms “business plans”, “annual plans” and “strategic plans” being used interchangeably. Terminology originated from National Treasury and requires consistency and clear definitions.

3.2.3.3. Examples of alignment problems include:

- ❑ The 2007/08 annual report¹⁶ has a figure of 49 889 patients receiving ART from a baseline at the end of the previous year of 28 382 patients. However, in the operational plan for 2008/09 the baseline at the end of 2007/08 is 42 280¹⁷.
- ❑ In the 2007/08 annual report¹⁸ the number of ANC clients tested is 123 436 while the target in the 2008/09 annual operational plan is 99 500.

3.2.3.4. It was mentioned that there is insufficient planning capacity to ensure that the planning process is appropriate and relevant.

3.2.3.5. There is no clear methodology in the setting of targets and it does not appear as if budgets and financial resources are linked to enhanced performance targets. It also appears as if plans are written annually and not looked at again until the next planning cycle starts. Plans and targets are not reviewed once the final budget allocation is known.

3.3. USE OF REPORTS AND PROCESSES

3.3.1. There are many examples of previous work that was commissioned by the ECDOH that could be extremely useful but was shelved. This includes:

3.3.1.1. The Hospital Strategy Project work started in the late 1990s which realigned facilities and organograms in relation to need and workload.

¹⁶ Page 140

¹⁷ Page 214

¹⁸ Page 43



- 3.3.1.2. The STP mentioned earlier.
- 3.3.1.3. The Pytron process which ran for a couple of years from 2005. The purpose was to develop the business processes for the CSCs and the organograms.
- 3.3.1.4. The Benguela report of July 2008 which reviewed PHC services across the province and made significant proposals re improvement.
- 3.3.1.5. The PEAR process which ran in the early 2000s and reviewed on a regular basis hospital performance and expenditure across the province.
- 3.3.2. The reasons for inaction are different but include changes in personnel, lack of political and administrative leadership and union pressure.

4. SERVICE DELIVERY (HIV, TB AND MCH)

- 4.1. The financial stringency measures implemented in the ECDOH are likely to have a negative impact on service delivery at all levels but particularly affect achievement of targets of priority programmes at primary care level. Districts are faced with increased interventions both in the range of services (e.g. ARVs, PMTCT, additional vaccines for MCH) and in the volume of services (e.g. many more patients with TB; ever-increased numbers on ARVs). At the same time they are faced with difficulties in appointing new or replacement staff and budget increases that are largely taken up by improvements in conditions of service. However, the impression is that budget shortages are not currently leading to restrictions on activities – rather accruals are building up. But it is likely that activity restrictions will become more prominent in either 2009/10 or 2010/11 financial years.
- 4.2. One worrying concern was that several respondents reported that not all district hospitals were doing caesarean sections but rather just referring complicated deliveries to tertiary centres. The data from the DHIS reflects that in 2007/08 18 of the around 60 district hospitals had a caesarean section rate of 0.



- 4.3. One of the observations made is that there are a large number of programme managers managing the three diseases at national and provincial level. For example, for HIV/AIDS there are one director, 3 deputy directors (treatment, care and support, and prevention) and approximately 12 assistant directors. However, at district level there is one programme manager for HIV/AIDS and at sub-district level there are two assistant directors. There is a similar situation in MCWH – at provincial level there are one director, six deputy directors and several assistant directors. At district and at sub-district level there is one person only. Several respondents in the district complained that there were insufficient numbers to match their provincial counterparts. The perception is that at district and sub-district levels there should be equal numbers of programme managers to the provincial complement. However, the number of managers should be commensurate with the level and range of services provided.
- 4.4. It is a problem that the health programme managers at provincial level are responsible for drawing up the targets and are held accountable for the targets being met while they have little control over what is done at district, hospital and sub-district level. The simplest mechanism would be for the targets to be disaggregated down to the lower levels (from the respondents and the plans reviewed this does not seem to be the case at this stage) and for the programme managers to then provide support for activities at these levels.
- 4.5. The work of these national and provincial programme managers is not integrated and one of the key problems is that at sub-district and facility level all the various programmatic inputs need to be integrated. Each programme manager is pushing for his/her area of responsibility to be prioritised and there is a lack of understanding of the big picture i.e. what the ECDOH is trying to achieve as a whole. For example, each programme manager calls meetings in his/her area of functioning. This can result in uncoordinated meetings and demands placed on district level managers.
- 4.6. There is by-passing of the regular lines of authority by programme managers from national and provincial level who interact directly with facility level staff and with mid level managers at levels below them without informing their senior managers. It appears that NDOH programmatic staff are too hands on with implementation



and not spending enough time on setting norms, standards, guidelines and targets and monitoring the implementation of these.

- 4.7. The HIV/AIDS programme is partly run as a separate vertical programme with its own funding rather than as part of integrated PHC service delivery. For example, the 'regular' nurse will often not deal with VCT and refer to the VCT nurse (even if she/he is not there on the day); while blood is drawn for syphilis testing (which is compulsory) at the ANC clinic, this is not the case for HIV – separate blood will be drawn after counselling by the lay counsellor; often the HIV programme is in a separate space (e.g. a park home). Thus the client is not seen and treated in a holistic manner but compartmentalised by the health service.
- 4.8. Another concern is the integration across departments. For example, the PMTCT needs to align with MCWH but falls under different programmes.
- 4.9. A key issue for the social needs cluster is the disability grant for HIV. This grant is available if the CD₄ count falls below 200 but is withdrawn when the CD₄ count rises above 200. This has obvious implications for compliance and patient care; in a sense it is a perverse incentive as you pay people not to be well!
- 4.10. The roles and responsibilities of clinic supervisors and health programme managers at sub-district level are overlapping and are not clearly defined.

5. RECOMMENDATIONS

5.1. LEADERSHIP AND GOVERNANCE

- 5.1.1. There should be explicit and open discussion around the budget and the level of services that can be rendered for that budget. The areas of rationing and prioritisation should be made clear and communicated effectively to all relevant stakeholders. This discussion needs to occur from National Treasury level down.
- 5.1.2. There should be an iterative process to national policies where provincial realities and feedback is given so that either policies can be amended to fit the realities or else additional resources made available so that the level of service delivery can



be elevated, consistent with policies. In addition, the financial resources among the provinces should be equitable as far as possible.

- 5.1.3. Service delivery and budgets need to be linked to each other so that managers are not faced on a regular basis with the making of ad hoc financial cuts.
- 5.1.4. There needs to be a thorough review of the current head office structure (including the 'abnormals') and the structures created at district and sub-district level. As far as possible a unitary line of accountability needs to be created and the services need to be integrated at district level. Once decisions are reached then an implementation plan needs to be developed, implemented and monitored.
- 5.1.5. The issues of capacity need to be faced head-on and a system of competency testing, training and mentoring introduced to ensure that sufficient capacity is built both within management and in corporate services in general. Performance standards need to be developed and monitored.
- 5.1.6. Where possible, review and simplify systems, processes and tools.
- 5.1.7. Senior management meetings need to focus on service delivery which is one of the priority strategic issues.
- 5.1.8. Diaries of all managers need to be respected through better time management and discipline.
- 5.1.9. Management of over-expenditure is a core senior management function together with its effects on service delivery and needs to be explicitly on the agenda of senior management. However, the discussions also need to broaden to include performance-related data so that efficiencies and effectiveness can be measured and discussed. This needs to occur at all levels.
- 5.1.10. Short term rationing of important areas (e.g. maintenance of facilities) can influence long term strategies (e.g. run down of facilities) and should be guarded against with ring-fencing these critical components of the budget.



- 5.1.11. There should be clear written guidelines delineating the areas of responsibility between the MEC and the HOD.
- 5.1.12. All senior management appointments should take merit and ability into strong consideration. The MEC should only be involved in the appointment of the HOD.
- 5.1.13. The NDOH should provide provinces with clear written guidelines regarding the delegation of authority, responsibility and accountability to facility and district managers. Provinces should implement these delegations whilst ensuring that there is sufficient and adequate oversight and monitoring.

5.2. PLANNING

- 5.2.1. There needs to be one overall National Health Plan that incorporates the plans of all nine provinces.
- 5.2.2. The STP needs to be implemented through a careful change management process with possible support from national level. If necessary, the STP needs to be broken down and the easier bits implemented first. But there needs to be an overall strategic time-bound framework for implementation with buy-in from politicians at all levels and unions. The implications of the STP need to influence the current work on the organograms that are being captured on PERSAL.
- 5.2.3. All planning processes in the ECDOH should be simplified and 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.
- 5.2.4. Plans should be given the status for which they are intended and should be a roadmap for all health workers in the province. There should be a clear M&E process which ensures that the implementation of the plans are regularly monitored with remedial action taken if necessary to ensure that targets are attained.



5.2.5. Targets should be set based on guidelines from NDOH and the provincial realities. These targets need inputs from programme and line managers to ensure that there is buy-in.

5.2.6. Targets need to be based on realistic forecasts of what the need is and what is achievable as well as linked to budgets. This is particularly important in relation to ARVs.

5.3. SERVICE DELIVERY (HIV, TB AND MCH)

5.3.1. The NDOH should produce comprehensive, integrated guidelines covering all aspects of service delivery in relation to HIV, TB and MCH. These guidelines should contain norms and standards (including addressing data gathering, monitoring and evaluation, human resources).

5.3.2. The role and expertise of programme managers at national, provincial, district and sub-district levels needs review with clear guidelines of performance expectations. There needs to be clear communication (vertical) between programme managers at these four levels on the one hand and also between programme managers and line service delivery managers (horizontal) on the other hand. In addition, the roles of sub-district programme managers and clinic supervisors need clarification, communication and monitoring.

5.3.3. 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. Disaggregating provincial targets to district, hospital and sub-district levels would assist this process.

5.3.4. Although budgets might come from different 'pots' (e.g. HIV), services need to be integrated on the ground.

5.3.5. Quality of care and solving of problems at the local level needs to be given greater emphasis and the facility supervision programme needs to be strengthened.



- 5.3.6. The current model of delivering ARVs needs review to ensure that it is sustainable, affordable, equitable and addresses issues of access.
- 5.3.7. The Madwaleni Hospital programme needs to be seen as a model that could be replicated across the province.
- 5.3.8. The issue of nurse initiation and nurse management of ART needs review within an integrated HIV/AIDS programme.
- 5.3.9. National DOH should review the disability grant criteria for HIV/AIDS.



Human Resources

1. INTRODUCTION

Box 3: Human resource review key findings

1. Compensation of employees is currently the largest contributing factor to overspending. This includes the OSD, the gap between the budgeted and actual annual salary increase and the appointment of 'abnormals' to perform specific functions on a stipend (rather than salary) basis.
2. Health professional staff vacancies and retention of health professionals in rural areas remains a major challenge while lengthy recruitment processes compound these problems.
3. Retention of nursing staff in rural areas depends largely on the provision of accommodation. Where this is not available, it is not possible to retain the services of professional nurses. Infrastructure planning is not integrated with clinical planning.
4. As identified in the previous section, the organograms on PERSAL have changed over the years as different structures have been captured, but is still not based on reasonable staffing needs.
5. Vacancy rates are difficult to interpret because of the fluctuating numbers on PERSAL as the organograms have changed. For example, it was reported that vacancy rates for nurses have significantly increased due to an increased number of nursing posts on PERSAL whereas the actual number of nurses in the ECDOH has increased by 400 in the last year or by 2.5% (in a total of around 16 000 nurses).
6. Gateway clinics work well, but need to be staffed independently from hospitals.
7. Organisational structuring is not done according to agreed benchmarks or aligned with existing plans or resources and there is insufficient guidance from the NDOH on this matter.
8. Delegations are instituted, but these tend to be withdrawn for budgetary control reasons, with resultant day to day management being done by head office, and producing widespread feelings of disempowerment and lack of accountability.
9. Programmes tend to operate in silos with their own systems, training and reporting procedures.



Box 3: Human resource review key findings

10. PERSAL is not fully used as a management and planning tool.
11. HR indicators are not monitored appropriately.
12. Human resource development is not properly aligned with the performance management and development system; it does not feature as a strategic priority and is not aligned or coordinated with HR management.
13. Rewards are not linked to performance, the performance management system is not functioning as envisaged and linkages to strategic priorities, staff development and rewards are either absent or tenuous.
14. The implementation of the occupational specific dispensation (OSD) for nurses resulted in numerous operational problems, including over-expenditure, negative impact on appointment of other professionals, discrepancies in nurses' salaries within the same levels and general unhappiness among health professionals.

2. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

- 2.1. A senior manager alleged that a serious problem in the ECDOH is a “*culture of lack of accountability and commitment*”. The lack of accountability, in particular, was raised in a number of interviews. The ECDOH needs to develop systems based on the strategic and operational plans which clearly specify roles and responsibilities, targets and M&E systems. This must be linked to the performance management system which itself needs to be re-established.
- 2.2. A culture of ‘blame’ exists in the ECDOH and it was reported by several respondents that managers who default could be humiliated in meetings. This type of approach is not supportive of a culture of ‘monitoring and evaluation (M&E)’ and the ‘blame culture’ needs to be changed right from top management and throughout the organisation. Unless this takes place, it is unlikely that an effective M&E system can be established.
- 2.3. The ECDOH has developed a system of management centres where *inter alia* HR functions will be managed. These centres, known as Corporate Services Centres (CSCs) will be responsible for the following HR functions:



2.3.1. Appointments up to level 12

2.3.1.1. Preparation of advertisements for posts

2.3.1.2. Appointment of selection committees

2.3.1.3. Short-listing of applicants

2.3.1.4. Interviews

2.3.1.5. Recommendations

2.3.1.6. Capturing of information onto PERSAL

2.3.2. The CSC will also handle all other personnel functions, including leave and promotions.

2.4. Delegations were found to be contradictory. While authority to make appointments has been delegated to CSCs, approvals appear to be required from Head Office. Furthermore, budget constraints regularly lead to the withdrawal of delegations. The effect of this is that structures are set up to perform certain functions, but these functions are not permitted for the full financial year. This has introduced an element of inefficient resource utilisation. It also negatively affects planning and recruitment processes as well as service delivery.

2.5. The appointment process is not under local control. Consequently appointments, even though managed at the CSC level, can take up to two years to finalise. HR practitioners are supposed to be under the control of the CSC, but tend in reality to work directly with Head Office.

2.6. Unclear roles and responsibilities and withdrawing delegations result in the following:

2.6.1. Senior managers get involved in lower level decision making which leads to inefficient utilisation of resources.



- 2.6.2. Managers at district and hospital level cannot make routine and necessary day-to-day decisions timeously, impacting on service delivery due to the long chain of command.
- 2.6.3. Delays in appointment of staff.
- 2.6.4. Lack of accountability which is reflected in
 - 2.6.4.1. Unnecessary delays
 - 2.6.4.2. Duplication of activities
 - 2.6.4.3. Difficulty with the implementation of a performance management system.

3. INTEGRATION AND CO-ORDINATION

“The organogram distribution between clinical, administration and support is not proportional. There are a lot of (new) high level posts without changing things at the ground level”.

Senior manager: ECDOH

- 3.1. As mentioned above, the ECDOH has embarked on a project to develop Corporate Service Centres which will handle HR, Finance, SCM, etc on behalf of institutions. The thinking behind this was that it was very difficult to find competent personnel to appoint in institutions and clinics to manage finance, HR and SCM. A centralised service could be better resourced. As highlighted earlier there were problems with the migration process and significant duplication has ensued.
- 3.2. A number of other examples illustrate the lack of co-ordination of effort within the ECDOH:
 - 3.2.1. There is a lack of integration between HR planning and budgeting. ‘Project 5000’ is an attempt to obtain critically needed health personnel, but has not been fully



integrated with a financial plan. Thus the budget for the last two years for Project 5,000 (R120 million per annum) has been used for other purposes.

- 3.2.2. There appears to be a disjuncture between facility development, HR and financial planning, such that a clinic can be constructed, but no budget for personnel or equipment is provided (e.g. gateway clinics are staffed with hospital personnel).
- 3.2.3. There is inadequate communication and co-ordination between staff in health programmes and staff working on the DHIS to ensure a single system of data flow.

4. LABOUR PLANNING

- 4.1. There is an appreciation of which posts are in short supply (e.g. pharmacists) but there appears to be no specific strategy to attract and retain these health professionals. Furthermore, even when a willing appointee is discovered, there may be an inability to secure his/her appointment due to budget constraints or the lengthy appointment process. This is also the case with nurses. Community service nurses are appointed but at the end of the service period there are insufficient funds to offer them posts, in spite of the general nursing shortage. *“At the beginning of the year a budget is given for new nurses, but this budget is often withdrawn”*. This makes recruitment difficult. The resultant pressure on remaining staff makes retention more difficult.
- 4.2. The HR plan and the STP and operational plans are not aligned. One comment received was as follows: *“We open a new clinic but then don’t have water, staff or medicines. The whole function must be considered. Recruitment policies need to be linked to such projects.”*
- 4.3. The attrition rates of various groups are given in the Annual Report (2007/08) as follows:
 - 4.3.1. Professional nurses: 53%
 - 4.3.2. Clinical professionals: 75%



4.3.3. Pharmacists: 108%

4.3.4. Other Allied Health professionals: 31%

4.4. These attrition rates have not been calculated in the standard manner, which would be the total number of separations (resignations + retirements + deaths) for the period divided by the average number of staff. Using this method of calculation, the attrition rates would be considerably lower than those reported.

4.5. Although the ECDOH is aware of the areas of greatest staff need, there are no specific recruitment and retention plans for these groups of staff.

4.6. A further issue of note was that the MEC has the final say in appointments of senior personnel (level 13 and above). Interviews are held and candidates are scored. This information is submitted to the MEC who makes a personal selection. Such involvement of the MEC in the functioning of the ECDOH undermines procedures.

5. ORGANISATIONAL DESIGN AND ESTABLISHMENT

5.1. Prior to the establishment of the Eastern Cape Province, the area was managed by three different jurisdictions (Transkei, Ciskei and the Cape Provincial Administration). Each of these had its own methods and culture. In order to develop a single, unified, appropriate organogram, several attempts have been made to develop the required post structures. This has largely been done by adding new posts onto PERSAL without removal of existing posts. The result is a provincial staff organogram which has over 80 000 posts. This gives an overall 'vacancy' rate of about 50%, which is not the reality.

5.2. Currently another process is in place to create a new organogram based on currently filled posts. This would give a post vacancy rate of close to 0%. But, the previously approved STP with its accompanying staff establishment has not formed the basis of the present process. Rather, a small team is in the process of ensuring that currently filled posts, current vacant funded posts (i.e. those vacated in the last year) and the Project 5,000 posts will be included in the final



organogram and is checking all personnel data and also matching person-to-post. The ECDOH has recently undertaken an 'employee verification' exercise to identify and eliminate any 'ghost' employees. These are all necessary steps towards ensuring that the data on PERSAL are accurate.

5.3. In addition, a parallel structure of 'abnormal' appointments has been established. This structure largely supplies the staff for the CSCs. Unemployed graduates have been utilised for this project and are paid a monthly stipend of R5 000.

5.3.1. Because of the audit problems of past few years, an 'Audit Intervention Programme' was initiated. Appointing people for each institution would further impact on the budget and a combined audit intervention programme was agreed on. This programme involved both Treasury and the Premier's office. An amount of R20 million was made available to kick-start the process – supply chain, financial, budgeting and asset management experts were appointed. There are 24 of these specialists (mostly accountants) who have been appointed at director level. Additional staff has been added through the use of unemployed graduates, 813 in all.

5.3.2. A further initiative to deal with the management of personnel files and documentation was established and an additional 250 personnel were appointed to this function. This was later extended to include financial documentation.

5.4. However, it is of concern that this parallel structure which is becoming of significant operational importance, is being built essentially on 'temporary staff'. In the event that these staff members are no longer available, the whole structure will collapse but no residual skills will have been left within the system. Alternatively, the formal employment of these people could result in a very large increase in the Compensation of Employees.

5.5. It would be useful if the National Department of Health could provide staffing norms against which the departmental organogram could be compared. Without such norms, it is difficult to assess what is meant by the vacancy rate in the province, or to compare vacancy rates to other provincial health departments.



6. RECRUITMENT

- 6.1. The single most important challenge with regard to human resources is the recruitment and retention of key personnel. 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 from going to rural areas. As a result, in the rural areas, where the need is greatest, recruiting skilled staff is one of the most significant constraints to improving access to health care. However, Madwaleni Hospital has managed to attract 9 doctors for the current financial year after having lost several in the previous year. This is attributable to good clinical management and supervision, coupled with integration into academic and community programmes.
- 6.2. Overly bureaucratic recruitment procedures from DPSA (extended periods of advertisements for professional posts) and head office has a number of negative effects including:
- 6.2.1. Potentially interested candidates going elsewhere
 - 6.2.2. Delays in recruitment and overly long appointment timelines.
- 6.3. Although the number of staff has increased by several thousand over the past year, the new appointments have largely been within the administrative and management components. Health professional staff vacancies still remain high. Based on norms for health professionals per population, the need for health professional staff remains high. However, most vacant posts are unfunded.
- 6.4. The total employment in the 2007/08 financial year was **39 106**¹⁹ filled positions compared to staffing levels of 2006/07, when there were **34 802** filled positions²⁰. Both include abnormals.

¹⁹ Annual report 2007/08 page 323

²⁰ Eastern Cape Department of Health Annual Report 2006/07 page 288



- 6.5. There is a general lack of personnel who are skilled in the use of the PERSAL system, either for the generation of relevant reports or for the entry of employee information. This contributes to the overall delays in finalising appointments.

7. PERFORMANCE MANAGEMENT

“People generally score 4s or 5s and this is used for bonus purposes. No sticks, only carrots. No mentoring, no skills assessment, no discipline”.

- 7.1. A well defined performance and development policy framework exists. However, it was widely agreed that the process is not working as envisaged. Each person develops his or her performance agreement without taking cognisance of the overall plan of the ECDOH. There is also no discussion concerning the proposed performance goals and no clear linkage between agreed performance measures and organisational strategic priorities. Performance management is also currently aimed at individuals rather than teams, which is how the health sector delivers services. The linkages between performance and rewards were unclear.
- 7.2. One of the aims of a performance management system is also to assist in the development and training of employees. It was stated that there is little or no correlation between performance management, individual developmental plans and training programmes.
- 7.3. It should be noted that a performance management system should also result in the provision of support to those who are struggling and of discipline for those who fail to do what they are appointed to do. A number of managers noted that *“no disciplinary action has ever resulted from the current system”*. Several managers spoke of fears of being victimised. This situation confirms that the performance management process needs to be re-introduced in an effective manner.
- 7.4. Clinicians were noted to be generally resistant to the performance management process, possibly because of the difficulties in assessing the performance of clinical staff. Guidelines for the performance management of clinicians should be established by the NDOH to ensure uniformity as far as possible.



- 7.5. It was, however, also noted that managers and supervisors are under pressure to score employees on the high side and that there could be physical risks to managers who do not do so. It may thus be necessary to develop the performance management system with some external support to bring in a component of objectivity and to protect managers and supervisors.

8. RETENTION

- 8.1. The OSD has been one attempt to retain staff, but it appears to have had only limited success. The system has also generated widespread dissatisfaction amongst staff who are performing similar tasks or who are in supervisory positions, but do not qualify for the allowance. For example, programme managers in the sub-districts do not qualify for OSD whilst the clinical staff responsible for implementation of the programme do. Programme managers feel that there is little incentive for them to remain in their current positions and are considering a return to the clinical group. In addition, the system has encouraged movement of nurses from local authority clinics and provincially aided hospitals to provincial clinics causing additional service loads to be borne by the provincial department with resultant staff shortages in the municipal clinics and provincially aided hospitals. The response of the private sector was to increase their pay scales to remain competitive with the public sector thus diminishing the impact of OSD. Although the overall OSD implementation is being investigated at national level, various issues in the ECDOH were raised regarding the implementation of OSD:
- 8.1.1. The OSD was not costed properly and implemented by NDOH.
 - 8.1.2. The personnel over-expenditure from OSD has impacted negatively on other staff appointments.
 - 8.1.3. In certain cases the OSD did correct previous salary disparities where HIV/AIDS section staff were paid more than others on the same grade.
- 8.2. It is evident that the change in salaries due to the OSD has made a major contribution to the increase in personnel expenditure (18.2%). In addition to salary



increases, additional fringe benefit contributions, overtime and other allowances compounded the Compensation of Employees (CoE).

8.3. Staff retention is linked to employee satisfaction. Some staff satisfaction surveys have been done in the province. Over half (52%) of staff dissatisfaction was attributed to poor management of staff at institutional level due to slow appointment processes, salaries not paid on time and lack of basic equipment. Other causes of dissatisfaction were:

8.3.1. Poor infrastructure management (if something breaks it is not fixed).

8.3.2. Inadequate infection control.

8.4. The ECDOH's retention strategy describes actions to be implemented to improve retention of scarce skills. The strategy focuses on effective recruitment and selection, effective job evaluation, training opportunities, priority bursary allocation, promotion of research and development, employee mobility, improved performance management, increased authority over own work, flexible working arrangements and service benefits. The introduction of an exit interview to capture and address recurring trends was also proposed. However, these strategies have generally not been implemented.

8.5. Retention of health professionals and other scarce skills is not just ECDOH specific and coordinated, national initiatives are required to address retention of staff in general.

9. REWARDS

9.1. The reward system itself is problematic. There is resistance to assuming personal accountability in the ECDOH, partly resulting from the present culture in the ECDOH, but partly due to the lack of delegated authority which should go hand-in-hand with responsibility. Without such delegated authority it is not reasonable to hold individuals responsible. This could be partially resolved by modifying the performance management system to take into account 'team objectives'. If this is



done, teams will require the opportunity to make recommendations on employment or transfer of other staff into the team as this could affect their own incomes.

- 9.2. There is a perception that rewards are not linked to performance. Those who are able to divert a significant amount of their working time towards developing and managing their performance contracts get rewarded. Those who are under greater pressure or who are more focussed on providing better service may fail to benefit from the system.
- 9.3. A suggestion received was that this could be corrected by linking performance reviews to clearly defined objective indicators and to reduce the general eligibility to salary increases to a lower number than is presently applied.
- 9.4. It is important to note that if a thorough costing of any change in the reward system is not done in collaboration with the affected parties, accountability is blurred, money is wasted and there are unintended effects. In addition, if only a certain category of staff are seen to benefit, the perceived disparities and inequalities in the reward system could lead to dissatisfaction, people leaving and possible manipulation within the reward system.

10. LEARNING AND DEVELOPMENT

- 10.1. The success of health service delivery depends on a sufficient number of skilled people to address service delivery requirements. If training is not receiving sufficient attention, service delivery and cost effectiveness will suffer as a result.
- 10.2. It was found that HR development policies exist, but execution is problematic. The ECDOH had done a thorough analysis of the human resource development (HRD) strategy and listed the following challenges impacting on learning and development in the province:
 - 10.2.1. HRD is not properly aligned with the performance management and development system.



- 10.2.2. HRD does not feature as a highly prioritized objective in the strategic plan of the ECDOH.
- 10.2.3. HRD is not properly aligned and coordinated with HR management.
- 10.2.4. Resources are generally insufficient and not all critical positions that are essential for the performance of the ECDOH are filled.
- 10.2.5. Line managers do not engage in pre- and post training interventions.
- 10.2.6. Training provided is not based on skills audits or training needs from performance development plans.
- 10.2.7. No post training assessment is made to evaluate the impact of training on the performance.
- 10.2.8. No competency framework is used in planning the training programmes.
- 10.3. The ECDOH has within the resources allocated developed a reasonable HRD plan. It is clear that training should be appropriately funded and focused and aligned to priorities. Inappropriate reductions in the training spend or insufficient training programmes can result in seriously impaired service delivery and cost more in the long run than providing adequate funds for training in the short term.

11. HR INFORMATION SYSTEMS

- 11.1. PERSAL is used at the various levels, including hospitals in the districts, for basic functions although its full potential as a management tool does not appear to have been utilised.



12. RECOMMENDATIONS

12.1. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

12.1.1. The withdrawal of delegations as a cost containment strategy should be evaluated. In effect, responsibilities shift back to Head Office during the course of a financial year. This has the following negative consequences:

12.1.1.1. Responsibility for expenditure is not clear

12.1.1.2. Central decision-makers are not necessarily aware of local pressures

12.1.1.3. Attempts to fast track appointments before delegations are withdrawn may result in sub-optimal appointees being selected

12.1.2. 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.

12.1.3. Suitable training and coaching should be provided to ensure capacity to implement delegated functions.

12.2. INTEGRATION AND CO-ORDINATION

12.2.1. Communication mechanisms need to be established across clusters and with the DHIS to prevent “silo” operational functioning.

12.2.2. The organisational structure should be reviewed with a view to create optimal clusters and co-ordination.

12.2.3. Planning should be aligned more clearly with strategic priorities, service transformation and HR staffing needs (short, medium and long term) at the various service delivery levels.



- 12.2.4. Clear and consistent key HR statistics and indicators should be developed and reported on.
- 12.2.5. Clear decisions and direction at various levels (national, provincial and district levels) in terms of service delivery should be communicated – if fewer HR resources and decreased funds are available, priorities need to be adjusted and communicated accordingly.
- 12.2.6. The ECDOH should make more use of modern communication technologies, in particular, the use of e-mail. Communication strategies should be more designed around the use of this form of communication rather than resorting to meetings which are expensive and not always productive. Furthermore, in using electronic communications, input from quiet individuals is more likely and a wider range of options or comments could be generated.
- 12.2.7. ECDOH HR plans must take into account the historical situation where the Western part of the province has more staff than the Eastern part. The plans need to show how this situation will be corrected over time.

12.3. STAFF ESTABLISHMENT

- 12.3.1. Restructuring, with a view to establishing minimum staffing levels, should be undertaken based on a number of factors including objectively agreed benchmarks, the provincial disease burden profile, optimal application of scarce skills and service delivery priorities as well as on available resources. Special consideration should be given to the following:
 - 12.3.1.1. Structuring to allow for the optimal use of scarce resources and also allow for decentralised management where decisions are taken at the lowest possible level.
 - 12.3.1.2. A review to ensure appropriate management ratios and levels.
- 12.3.2. PERSAL should be corrected to accurately reflect personnel positions and staffing numbers.



12.3.3. Norms and standards from NDOH should exist to guide provinces to determine correct structures and establishments. This should include guidance on management levels, ratios and grading of positions. Deviations from the norm would require justification.

12.3.4. DPISA should assist NDOH and provinces to support changes to structures in a more efficient manner.

12.4. RECRUITMENT

12.4.1. A thorough review and improvement of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times. National benchmarks should be developed and monitored.

12.4.2. Nursing college intake, medical student intakes and bursaries should be clearly linked to staffing needs. Tracking of bursary beneficiaries should be done to assess the effectiveness of the system.

12.5. PERFORMANCE MANAGEMENT

12.5.1. Performance contracts at job level 13 and above should be clearly linked to organisational priorities and key indicators that drive organisational performance.

12.5.2. Clear understanding of what is required to achieve a performance bonus must be communicated to employees. This must be consistently applied across all similar posts.

12.5.3. The performance management system should be utilised as intended and incorporate:

12.5.3.1. Organisational performance;

12.5.3.2. Employee development;

12.5.3.3. Reward based on clear performance goals.



12.5.4. Team performance should form part of performance standards and evaluation.

12.5.5. External support may be required to ensure objectivity in the implementation of the performance management system.

12.6. RETENTION

12.6.1. A national health professional and scarce skills retention strategy should be developed by the NDOH.

12.6.2. The ECDOH retention strategy should be analysed in terms of impact and cost to test possible success and affordability.

12.6.3. Clinical staff need to feel part of the academic and referral system. Internet connectivity, SKYPE functions and formal communication channels should be set up between rural clinicians and regional/tertiary hospitals.

12.7. REWARDS

12.7.1. 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 the following :

12.7.1.1. 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.

12.7.1.2. Rewards should be linked to organisational, employee and team performance.

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



12.8. LEARNING AND DEVELOPMENT

- 12.8.1. Training needs should be properly and objectively determined.
- 12.8.2. Well considered and prioritised commitments to relevant training should be maintained even during times of cost containment.
- 12.8.3. Training and development programmes should be clearly defined and aligned to the service delivery priorities of the province.
- 12.8.4. A learning environment should be developed in which ongoing training is part of the employment package.

12.9. HR INFORMATION SYSTEMS

- 12.9.1. 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 a HR management tool.



Information Management

1. INTRODUCTION

Box 4: Information management review key findings

1. Monitoring and evaluation is one of the weakest links in the overall management of health services in the ECDOH. 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. 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, poor interpretation and little utilisation of information for decision-making.
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.
4. There are severe capacity problems especially in relation to the BAS and PERSAL systems.
5. Most of the departmental reviews relate to BAS reports and are focussed on over and under expenditure. Little time is spent on reviewing finance, personnel and service delivery data together.
6. There are too many indicators and no process to review the indicator set or to extract a smaller set of key performance indicators for managers at the different levels.
7. The data as captured in the DHIS is different from what is presented in the annual reports.

1.1. Monitoring and evaluation (M&E) appears to be one of the weakest links in the overall management of services in the ECDOH. There is little communication from NDOH and the province to programme and line managers around M&E. There are few norms and standards related to any aspect of 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) pass by without question or attempts to effect corrective action. There is little time allocated to compare efficiencies and effectiveness across similar facilities and thus promote peer learning.

2. USE OF INFORMATION FOR DECISION MAKING

- 2.1. There is much service information being generated at various levels in the system. Significant time and 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:
- 2.1.1. 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.
 - 2.1.2. Targets as contained in annual reports and AOPs don't always agree with each other, are not easily achievable in some cases and have no bearing on performance assessment in many cases.
 - 2.1.3. There are too many indicators resulting in a mass of data.
 - 2.1.4. There is little attempt to link the data of the three major systems viz PERSAL, BAS and DHIS. Thus reviews of financial data will not take into account efficiency and effectiveness data that is largely captured through the DHIS. It should be noted that until a few years ago, the Eastern Cape had a well developed process (the PEAR process) to do exactly this. For some reason this has fallen away.
 - 2.1.5. The BAS reports are predominantly used for reviewing whether there is overspend or underspend. However, it was reported and observed that very simplistic reports are extracted from the BAS. It was also 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.

- 2.1.6. At the sub-district it was encouraging to note that the DHIS report was used to identify problems in the district. These included low coverage rates for specific immunisations and low nevirapine uptake rates. Based on this, programme managers and clinic supervisors were tasked to follow up and address these problems.

3. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

- 3.1. The DHIS is a well-established system consisting of collection of a wide range of data on different aspects of the health system in all facilities. It has a good infrastructure through which routine data can be collected. At the point of data collection in most facilities, this is done through manual, paper-based data collection tools such as tick-sheets and registers. Thereafter aggregated data is entered into the electronic database and exported through the various levels of the system viz. local area (sub-district), district, province and national. Although the DHIS is a comprehensive system of routine data collection with most facilities capturing data on a regular monthly basis, there are a range of problems associated with ensuring *good data quality*. These include:
 - 3.1.1. 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.
 - 3.1.2. The indicator list in the national indicator data set (NIDS) is extensive and should be regularly reviewed.
 - 3.1.3. 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). There is no clear process on how new indicators should be added.



- 3.1.4. There are insufficient data capturers and information officers. This work is done by people with other designations (e.g. nurses, clerks). Consequently the information function is not being given the priority that is required and this is one of the reasons for sub-optimal data quality.
- 3.1.5. 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.
- 3.1.6. The data in the DHIS is different from that captured in the annual.

4. ARV MONITORING AND EVALUATION

- 4.1. 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. This is one of the key cost drivers of expenditure in the ECDOH and approximate figures of R6 000 per patient per year for 70 000 patients show that the costs are in the region of R420 million for direct costs only.
- 4.2. Each of the 77 sites should have a data-capturer. The ECDOH uses the DHIS to capture ARV data. Each site is meant to have a data-capturer. This is not the case in all sites and nurses are then used. However, managers on the ground are not aware of how many patients are on ART.
- 4.3. At Madwaleni, because of the low capacity of the information manager (recently promoted from a clerk position), the HIV/AIDS programme was using their own database to track and monitor the 3,500 HIV+ clients on their programme.

5. OTHER M&E ISSUES

- 5.1. There are a number of parallel information systems - especially programmatic information - in addition to that supplied by the DHIS.



- 5.2. There is no single repository of information and as a result there are conflicting sources of official information.
- 5.3. There is a lack of communication between those responsible for data management and those responsible for programme management. Programme managers struggled to get appropriate information on a timely basis.
- 5.4. Quarterly reports are regularly prepared for NDOH and the National Treasury. These reports are scrutinised by management and inconsistencies queried.
- 5.5. There is a general lack of integration of information and BAS and PERSAL data are not aligned with service delivery data. For example, people paid from a hospital budget and designated as hospital employees are doing work at the community level distorting PDEs and other important indicators. Similarly, because drugs are not always available, facilities might source drugs from other facilities or from other sub-districts also distorting the picture. Senior managers in finance feel that the quality of data in BAS is poor due to this and also that people are capturing data in the wrong places.
- 5.6. Several respondents reported major capacity problems with personnel dealing with the PERSAL and BAS systems. This included problems both in capturing data and in drawing reports.

6. RECOMMENDATIONS

6.1. OVERALL M&E

- 6.1.1. M&E needs to become a central component of all managerial activity with the use of objective information being the basis for decision making. This applies to all aspects of management, including financial and HR, and not only service related data. There needs to be an iterative link between planning, implementation and monitoring.
- 6.1.2. Regular formal monitoring of key indicators needs to take place with analysis and questioning of variances (in much the same way as financial management



variance analysis should take place). The PEAR process (or something similar) needs to be resuscitated.

- 6.1.3. A smaller set of key indicators for managers needs to be agreed upon.
- 6.1.4. Capacity of staff (especially on BAS and PERSAL) needs to be reviewed and corrective measures agreed upon and implemented.
- 6.1.5. 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. cell phone technology. NDOH could help with leadership in these areas.
- 6.1.6. 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.

6.2. USE OF INFORMATION FOR DECISION MAKING

- 6.2.1. M&E, based on a limited number of key indicators, needs to be built into every senior manager's job description and performance appraisal.
- 6.2.2. Where applicable, in-service training around understanding of and the importance of key indicators for managers needs to take place.
- 6.2.3. There should be regular analysis, comparison, interpretation and feedback around indicators to lower levels of the system. In addition, this process needs to be replicated at all levels.

6.3. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

- 6.3.1. The DHIS, and associated NIDS, needs a thorough review by the NDOH.
- 6.3.2. The number of indicators needs to be decreased.



- 6.3.3. There should be unambiguous, easy to understand, standardised definitions.
- 6.3.4. There also need to be clear written guidelines, norms and standards for each component of the DHIS, including data collections 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 (ETR-net), PERSAL and BAS.
- 6.3.5. An appropriate training regime also needs to be introduced at the correct time.
- 6.3.6. Ongoing training should become an integral part of the functioning of the ECDOH at all levels.

6.4. ARV MONITORING AND EVALUATION

- 6.4.1. The ARV system using the DHIS needs to be strengthened to ensure that all data is captured on a timely basis and is available for managers.

6.5. OTHER M&E ISSUES

- 6.5.1. There needs to be one official repository of information for the ECDOH. 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.
- 6.5.2. A standard set of reports needs to be established and fed to programme managers at all levels on a timely basis.
- 6.5.3. 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.
- 6.5.4. Basic record keeping needs to be maintained at facility level.



6.5.5. Follow-up and corrective actions on identified indicators with variances need to form part of all M&E activities.



Medical Products, Laboratory

1. INTRODUCTION

Box 5: Key findings

1. The ECDOH has had a shortage of medicines affecting many aspects of service delivery, from the vaccination of infants through to the continuation of treatment of patients on ARVs.
2. There is a 92% availability level of sentinel drugs in 2008/09, but this still implies that one in ten prescriptions cannot be filled. However, in the 2007/08 report, 60% availability was recorded, thus there has been significant improvement.
3. There appears to be a general lack of prioritisation of drug budgets. Medication is the end point of the examination and investigation process. Absence of drugs for treatment negates the whole process up to that point and introduces individual and organisational problems. The drug distribution system seems to be working reasonably well. However, many hospitals are without certain drugs as a result of suppliers not being able to supply. This appears to be a national problem in most instances.

2. MEDICAL PRODUCTS

- 2.1. The 2007/08 annual report records 53 of the 56 hospital pharmacies operated by either a qualified pharmacist or a community service pharmacist. However, the operation of a hospital pharmacy requires more than just the overall control by a pharmacist and a team of pharmacists is generally required, particularly in the larger hospitals. There is a significant lack of qualified pharmacists at sub-district level. The 2007/08 annual report records that 12 of the 24 sub-districts had a pharmacist. That was a problem that was confirmed by the visit of the team to the Mbashe sub-district.
- 2.2. The province lost approximately 8 pharmacists once Pick 'n Pay and Clicks were able to sell medicines. Given the general shortage of pharmacists, this was a



significant loss. It is believed that once the OSD applicable to pharmacists is introduced, they will be able to attract some pharmacists back into the ECDOH.

- 2.3. Several respondents informed the team that the province will again overspend their goods and services budget and hold back on payment to the depot (part of the accrual problem). This progressive roll-over system (accruals) will eventually make the ECDOH unmanageable, resulting in non-availability of drugs when suppliers cease or limit deliveries while amounts due are still outstanding.
- 2.4. Many institutions are, at times, without medicines, largely related to suppliers not supplying. This is a national problem and needs to be addressed by the NDOH. Some blockages arise from depot to hospital/clinic. Information from senior management suggests that a turnaround in this situation has started. This assertion was substantiated in the Mthatha depot, which is a sub depot of Port Elizabeth, which has reported an improvement in the system.
- 2.5. Other issues include:
 - 2.5.1. Drug supplies are largely based on RT (National) contracts.
 - 2.5.2. MEDSAS captures drug information. A new system is in the process of being developed.
 - 2.5.3. Each sub-district has a procurement plan. Each CHC has its own budget for medicine. However, the sub-district visited had requested R319 000 and was allocated a budget of R95 000. However, services would continue in spite of budget amounts being overspent.
 - 2.5.4. It was reported that since clinics are sometimes out of stock of medicines, patients tend to by-pass clinics and go directly to hospitals with negative financial consequences. The reasons for the local 'stock-outs' have not been defined, but could well be related to a general shortage of pharmacists at the sub-district level.
 - 2.5.5. In practice drugs are manually further redistributed by managers on an ad hoc basis. This practice, far from ideal, is done to prevent unnecessary expiry of drugs.



As a result of this manual system, cost allocations of medicines are erroneously charged to the cost centre of the original recipient thereby over-estimating the drug budget in this facility and under-estimating the cost of drugs in the facility to which the drugs were transferred.

2.5.6. There was a shortage of 20cc syringes, drip sets and monitoring sets.

2.5.7. The funding deficit for pharmaceutical products last year was about R250 million.

3. LABORATORY

3.1. Laboratory services are provided by the National Health Laboratory Services (NHLS) on the basis of a service level agreement (SLA). Recently a mechanism has been instituted which provides the ECDOH with a detailed account of tests for each institution. This is intended to eliminate duplication of charges. However, there has been no method developed of how to detect such potential overpayments.

3.2. Clinicians and managers have not developed any methods of prioritising laboratory tests or of working within a fixed budget for laboratory services. Clinicians generally work as if there are no restrictions on laboratory usage.

3.3. The laboratory service is seen as a 'soft target' as far as payment is concerned. When budgets become exhausted, the payments to NHLS are suspended.

3.4. In the last financial year, 2008/09, the cost of the NHLS was R302 million of which R190 million was paid and R112 million rolled over as accruals.

4. BLOOD SERVICES

4.1. Blood services are an expensive component of the health system. The service is provided by the SA Blood Transfusion Service on an SLA basis.

4.2. There are blood depots at all large hospitals and emergency blood is now available at 33 smaller hospitals.



- 4.3. In the last financial year, 2008/09, the cost of the of blood products was R62 million of which R44 million was paid and R18 million rolled over as accruals.

5. EQUIPMENT AND EQUIPMENT MAINTENANCE

- 5.1. It was reported that limited new equipment was purchased in 2008/09. The ECDOH had previously recorded considerable expenditure on new equipment and the reason for the 'slow-down' in equipment purchasing was not elucidated.
- 5.2. 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.

6. EMERGENCY MEDICAL SERVICES

- 6.1. There are serious problems with the emergency medical services (EMS) in the province. The distances to be covered are large. The population density is low in some areas. The roads are poor. In addition, the ambulance services were included as part of a transport service contract entered into by the Department of Transport on behalf of the ECDOH. This contract has been a seriously detrimental factor in the provision of the EMS:
- 6.1.1. For example, the contract requires that vehicle availability should be 80%. This does not occur for ambulances but the service provider can show that this particular contractual requirement is met if all transport services provided in terms of the contract are considered.
- 6.1.2. The cost of the system for the EMS is very high, costing between R14 million and R18 million per month.
- 6.1.3. The service has not been able to build up a fleet of standby vehicles for use in disasters or major incidents.



- 6.2. In spite of these difficulties, the contract has been twice extended.
- 6.3. On the basis of the norm of one ambulance per 10 000 population, the province should have a fleet of 700 vehicles. In fact there are only 180 available. The service has a staff of 1946 people. The ECDOH has 5 decentralised control centres and these are in the process of being integrated into a single centre.
- 6.4. In addition to the EMS, the ECDOH needs to establish a patient transport service, which is only rudimentary at present.

7. RECOMMENDATIONS

- 7.1. The current review of all aspects of the management and operations of the medical depot needs to be finalised and the emergent recommendations implemented. Discussions should be held with suppliers to determine what factors inhibit their performance. Where possible, this should be corrected. For example, longer term contracts may be required for suppliers to ship in adequate quantities of medications.
- 7.2. The drug budget should be reviewed and prioritised in line with departmental priorities. Drug budgets should reside at the lowest level of activity as part of the cost centre hierarchy and drug costs should be accurately allocated to individual institutions and clinics.
- 7.3. Because of the high costs of laboratory services, the overall monitoring and control of the laboratory services and blood product usage needs to be given attention by a combined management/clinical team.
- 7.4. Clinicians and financial managers need to be involved jointly in working out how limits can be placed on laboratory usage. Since this is a national problem, the NDOH could be of assistance in establishing a national workgroup on this issue.
- 7.5. An agreed set of drugs, clinical supplies and equipment should be determined and guaranteed for each particular type of institution.



- 7.6. Clinical engineering services should be treated as a high priority, not only for functional purposes but for the exercise of due diligence in managing public resources.

- 7.7. A suitable PPP should be developed for the rendering of the emergency medical service.



Technology and Infrastructure

1. OVERVIEW

- 1.1. This aspect was not reviewed in depth. However, some points arose in the various interviews:
 - 1.1.1. Clinics often have a shortage of space as a result of increased patient volumes and because of the need for increased privacy with HIV counselling.
 - 1.1.2. There is a lack of computers and in some local areas (sub-districts) managers do not have access to PERSAL because of the lack of connectivity. Thus mundane activities – e.g. the filling of leave data – have to be done at district level.
 - 1.1.3. The provincial infrastructure grant was only used for health related infrastructure from 2007/08 onwards after intervention from the NDOH.
 - 1.1.4. Concern was expressed about suitable accommodation for professionals in rural areas and that this was a key factor in retention of health professionals.
 - 1.1.5. The Eastern Cape has suffered historically from infrastructure backlogs and the current estimated needs are around R3, 6 billion. The current budget allocations are inadequate to address these needs.
 - 1.1.6. For political reasons some facilities are renovated/built that are not in line with the STP guidelines.
 - 1.1.7. While there had been general recognition at both provincial and national levels (including National Treasury) for the need to revitalise Frere and Cecilia Makiwane Hospitals, there is currently confusion regarding the process. Some respondents said that the business plans were stuck at national level while others referred to a verbal go ahead from politicians before the administrative processes had been concluded.



- 1.1.8. The province has developed substantial experience with PPPs around infrastructure projects viz Port Elizabeth, Port Alfred, and Grahamstown. Several respondents stated that his experience should be shared with other provinces.
- 1.1.9. Some projects have an unreasonably extended life span. For example, the projects at St Elizabeth's and Queenstown have been going on for many years. Several respondents commented that a fewer number of projects should be embarked on at any one time and completed more quickly.
- 1.1.10. Currently, there are three tertiary hospital complexes in the Province – Port Elizabeth (with three hospitals), East London (with two hospitals) and Mthatha (with two hospitals). The province is currently in the process of de-complexing. One of the problems identified in the STP and in the interviews is the feasibility of all these hospitals remaining tertiary care centres. Clearly this is a political issue.
- 1.1.11. A problem was also expressed regarding the lack of level 1 hospitals in the major centres and thus tertiary hospitals are used for level 1 patients.
- 1.1.12. In some areas the electricity supply from ESKOM was problematic.

2. RECOMMENDATIONS

- 2.1. All infrastructure developments need to be in line with the approved STP.
- 2.2. The exact status of the revitalisation of Frere and Cecilia Makiwane Hospitals needs to be determined between the ECDOH, the NDOH and the National Treasury and a plan developed to finalise implementation. If necessary, a dedicated senior manager needs to be allocated to this task.
- 2.3. The rural accommodation needs and detailed suggested solutions should be packaged and presented to the NDOH/National Treasury as a matter for prioritisation.



- 2.4. Clear decisions need to be taken regarding the number of tertiary institutions in the province and this decision needs adequate consultation and communication before implementation is started. The NDOH should take the lead and politicians at both provincial and national levels should play a role in this process.

- 2.5. In the interim before the decision regarding tertiary services are implemented, tertiary hospitals should consider allocating some wards as either level 1 or step down facilities and running these at those levels.

- 2.6. NDOH could assist provinces in reviewing building estimates and costs.



Taking Forward the Recommendations

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



Table 7: Recommendations contained in Eastern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input

Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Eastern Cape Health MEC	Eastern Cape Department of Health	National Treasury	Eastern Cape Treasury	Department of Public Service and Administration	External stakeholders
FINANCE RECOMMENDATIONS								
Provincial health budget allocation								
The Provincial Treasury should allocate an amount to the ECDOH, which is substantially in line with the equitable share indicated by the National Treasury in the national budget.				2	2	1		
Allocations of conditional grants by the NDOH should be based on clear, objective criteria that are linked to grant specific indicators and not on the equitable share formula.		1		2	2	2		
Unfunded Mandates								
The operational impact of national policy decisions (e.g. OSD, new vaccine programme) should be determined and must be agreed with the provincial health department prior to implementation.		1		2	2	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.	1		1	2	2	2		
For medical inflation, the National Department of Health could determine a basket of items, based on volume and price, which could be tracked annually as a medical inflation rate, much as the CPIX is measured.		1		2	2	2		



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Budgeting Process								
The budgeting process needs to be seen and used as an extension of the annual performance plan, and needs to follow an iterative process.				1	2	2		
All operational units (cost centres) need to have a realistic budget that can be used as a guideline for the financial year's activities. Operational plans need to be aligned with available funding to deliver the services.				1		2		
Budget virements needs to be linked to changes in operational activity, not merely to balance the number of over and under expenditure items.				1		2		
The practice of continuous budget reallocations need to be discontinued. Virement movements which are effected to minimise unauthorised expenditure (over-spending) should not hinder the application of the principles of proper financial management and variance analysis during the course of a financial year.				1		2		
Financial management								
Cost centre accounting needs to be done at the lowest possible practical level (i.e. facility/clinic level). This is needed to properly identify areas of operations that require attention.				1	2	1		
Allocation of expenses needs to be accurate				1	2	1		



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and up to date to assist with effective management. Actual expenditure is an important indicator and inaccurate information impacts on effective monitoring and evaluation at all levels. Effective management is not possible without accurate and timely information.								
Provincial organograms must be finalised.				1			2	
Variance analysis needs to be used as a management tool to identify areas that require attention.				1	2	2		
The required monitoring structures need to be put in place.		2		1		2		
Managers should be held accountable for the performance of their operating units and this must be built into the performance management system.				1			2	
Although current cost per PDE indicators are not effective, they should be monitored and identified outliers need to be followed up with corrective actions. If the cost per PDE is incorrect due to misallocation, a process should be started to correct allocations.				1		2		
Selection of suppliers by the procurement systems needs to be improved to reduce the time delays of acquisitions.				1				
All orders just below the authorisation limits need to be inspected for value for money purchases. Disciplinary action needs to be				1				



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instigated against personnel procuring or authorising goods and services for more than market related prices.								
Quarterly Performance Reports								
The accuracy and use of essential performance indicators needs to be improved e.g. the number of patients on ARVs. The necessary steps must be taken in conjunction with the NDOH to improve the quality of information available in this regard.		1		1	2	2		
Variations in specific indicators need to be followed up with actions, and not merely identified.				1				
There needs to be a link between performance and financial reports. A financial report reflecting actual expenditure compared to budget should also be provided where performance indicators reflect a deviation in operational performance.		2		1	2	2		
Financial reporting IYM (in year monitoring)								
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	1	2		
The IYM report needs to serve as an accurate forecast of expected expenditure and cost. It has limited use as a monitoring tool when it				2	1	2		



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only reflects actual and expected cash flow, which is not linked to operational activity (expenditure).								
Personnel need to be trained on BAS, including the accounting structures, process flow (what will be populated when and where in the database) and methods for extracting data.				1		2		
Reporting from BAS needs to be made more user friendly with only relevant information included in reports.		2		2	1	1		
Annual Financial Statements								
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	1	2		
LEADERSHIP, GOVERNANCE and SERVICE DELIVERY RECOMMENDATIONS								
Leadership and Governance								
There should be explicit and open discussion around the budget and the level of services that can be rendered for that budget. The areas of rationing and prioritisation should be made clear and communicated effectively to all relevant stakeholders. This discussion needs to occur from National Treasury level down.	1	1	1	1	2	2		2
There should be an iterative process to national policies where provincial realities and feedback is given so that either policies can		1		2		2		



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be amended to fit the realities or else additional resources made available so that the level of service delivery can be elevated, consistent with policies. In addition, the financial resources among the provinces should be equitable as far as possible. In addition, the financial resources among the practices should be equitable as far as possible.								
Service delivery and budgets need to be linked to each other so that managers are not faced on a regular basis with the making of ad hoc financial cuts.				1		2		
There needs to be a thorough review of the current head office structure (including the 'abnormals') and the structures created at district and sub-district level. As far as possible a unitary line of accountability needs to be created and the services need to be integrated at district level. Once decisions are reached then an implementation plan needs to be developed, implemented and monitored.				1			2	
The issues of capacity need to be faced head-on and a system of competency testing, training and mentoring introduced to ensure that sufficient capacity is built both within management and in corporate services in general. Performance standards need to be developed and monitored.				1			2	
Where possible review and simplify systems,		2		1				



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processes and tools.								
Senior management meetings need to focus on service delivery which is one of the priority strategic issues. Where possible, review and simplify systems, processes and tools.		2	2	1				
Diaries of all managers need to be respected through better time management and discipline.			1	1				
Management of over-expenditure is a core senior management function together with its effects on service delivery and needs to be explicitly on the agenda of senior management. However, the discussions also need to broaden to include performance-related data so that efficiencies and effectiveness can be measured and discussed. This needs to occur at all levels.				1		2		
Short term rationing of important areas (e.g. maintenance of facilities) can influence long term strategies (e.g. run down of facilities) and should be guarded against with ring-fencing these critical components of the budget.		2		1	2	2		
There should be clear written guidelines delineating the areas of responsibility between the MEC and the HOD.	1		1	1			2	
All senior management appointments should take merit and ability into strong consideration. The MEC should only be involved in the appointment of the HOD.			1	1				



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The NDOH should provide provinces with clear written guidelines regarding the delegation of authority, responsibility and accountability to facility and district managers. Provinces should implement these delegations whilst ensuring that there is sufficient and adequate oversight and monitoring.		1		2				
Planning								
There needs to be one overall National Health Plan that incorporates the plans of all nine provinces.		1		2				
The STP needs to be implemented through a careful change management process with possible support from national level. If necessary, the STP needs to be broken down and the easier bits implemented first. But there needs to be an overall strategic time-bound framework for implementation with buy-in from politicians at all levels and unions. The implications of the STP need to influence the current work on the organograms that are being captured on PERSAL.		2	1	1	2	2		2
All planning processes in the department should be simplified and 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.		1		1				



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Plans should be given the status for which they are intended and should be a roadmap for all health workers in the province. There should be a clear M&E process which ensures that the implementation of the plans are regularly monitored with remedial action taken if necessary to ensure that targets are attained.		1		1				
Targets should be set based on guidelines from NDOH and the provincial realities. These targets need inputs from programme and line managers to ensure that there is buy-in.		1		2				
Targets need to be based on realistic forecasts of what the need is and what is achievable as well as linked to budgets. This is particularly important in relation to ARVs.		1		1	2	2		
Service delivery (HIV TB and MCH)								
The NDOH should produce comprehensive, integrated guidelines covering all aspects of service delivery in relation to HIV, TB and MCH. These guidelines should contain norms and standards (including addressing data gathering, monitoring and evaluation, human resources).	2	1		2				
The role and expertise of programme managers at national, provincial, district and sub-district levels needs review with clear guidelines of performance expectations. There needs to be clear communication		1		1				



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(vertical) between programme managers at these four levels on the one hand and also between these programme managers and line service delivery managers (horizontal) on the other hand. In addition, the roles of sub-district programme managers and clinic supervisors need clarification, communication and monitoring.								
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. Disaggregating provincial targets to district, hospital and sub-district levels would assist this process.		1		1				
Although budgets might come from different 'pots' (e.g. HIV), services need to be integrated on the ground.		2		1				
Quality of care and solving of problems at the local level needs to be given greater emphasis and the facility supervision programme needs to be strengthened.				1				
The current model of delivering ARVs needs review to ensure that it is sustainable, affordable, equitable and addresses issues of access.	1	1	2	2				
The Madwaleni Hospital programme needs to be seen as a model that could be replicated				1				



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across the province.								
The issue of nurse initiation and nurse management of ART needs review within an integrated HIV/AIDS programme.		1		1				
National DOH should review the disability grant criteria for HIV/AIDS.	1	1			2			
HUMAN RESOURCES RECOMMENDATIONS								
Delegations, Accountability and Responsibility								
The withdrawal of delegations as a cost containment strategy should be evaluated. In effect, responsibilities shift back to Head Office during the course of a financial year. This has the following negative consequences: <input type="checkbox"/> Responsibility for expenditure is not clear <input type="checkbox"/> Central decision-makers are not necessarily aware of local pressures <input type="checkbox"/> Attempts to fast track appointments before delegations are withdrawn may result in sub-optimal appointees being selected			2	1				
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.			2	1		2		



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Suitable training and coaching should be provided to ensure capacity to implement delegated functions.				1				
Integration and co-ordination								
Communication mechanisms need to be established across clusters and with the DHIS to prevent “silo” operational functioning.				1				
The organisational structure should be reviewed with a view to create optimal clusters and co-ordination.		2		1			2	
Planning should be aligned more clearly with strategic priorities, service transformation and HR staffing needs (short, medium and long term) at the various service delivery levels.				1				
Clear and consistent key HR statistics and indicators should be developed and reported on.		1		1			2	
Clear decisions and direction at various levels (national, provincial and district levels) in terms of service delivery should be communicated – if fewer HR resources and decreased funds are available, priorities need to be adjusted and communicated accordingly.		1		1			2	



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The ECDOH should make more use of modern communication technologies, in particular, the use of e-mail. Communication strategies should be more designed around the use of this form of communication rather than resorting to meetings which are expensive and not always productive. Furthermore, in using electronic communications, input from quiet individuals is more likely and a wider range of options or comments could be generated.				1				
ECDOH HR plans must take into account the historical situation where the Western part of the province has more staff than the Eastern part. The plans need to show how this situation will be corrected over time.				1				
Staff Establishment								
Restructuring, with a view to establishing minimum staffing levels, should be undertaken based on a number of factors including objectively agreed benchmarks, the provincial disease burden profile, optimal application of scarce skills and service delivery priorities as well as on available resources. Special consideration should be given to the following: <input type="checkbox"/> Structuring to allow for the optimal use of scarce resources and also allow for decentralised management where decisions are taken at the lowest possible		1		1			2	



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level. <input type="checkbox"/> A review to ensure appropriate management ratios and levels.								
PERSAL should be corrected to accurately reflect personnel positions and staffing numbers.		2		1			2	
Norms and standards from NDOH should exist to guide provinces to determine correct structures and establishments. This should include guidance on management levels, ratios and grading of positions.		1		2			2	
DPSA should assist NDOH and provinces to support changes to structures in a more efficient manner		2		2			1	
Recruitment								
A thorough review and improvement of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times. National benchmarks should be developed and monitored.		2		2			1	
Nursing college intake, medical student intakes and bursaries should be clearly linked to staffing needs. Tracking of bursary beneficiaries should be done to assess the effectiveness of the system.		1		1				1
Performance Management								
Performance contracts at job level 13 and above should be clearly linked to organisational priorities and key indicators				1				



Table 7: Recommendations contained in Eastern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input

Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Eastern Cape Health MEC	Eastern Cape Department of Health	National Treasury	Eastern Cape Treasury	Department of Public Service and Administration	External stakeholders
that drive organisational performance.								
Clear understanding of what is required to achieve a performance bonus must be communicated to employees. This must be consistently applied across all similar posts.				1			2	
The performance management system should be utilised as intended and incorporate: <input type="checkbox"/> Organisational performance; <input type="checkbox"/> Employee development; <input type="checkbox"/> Reward based on clear performance goals.				1			2	
Team performance should form part of performance standards and evaluation.		2		2			1	
External support may be required to ensure objectivity in the implementation of the performance management system.		2		1				
Retention								
A national health professional and scarce skills retention strategy should be developed by the NDOH.		1		2			2	
The ECDOH retention strategy should be analysed in terms of impact and cost to test possible success and affordability.				1			2	
Clinical staff need to feel part of the academic and referral system. Internet connectivity, SKYPE functions and formal communication channels should be set up between rural clinicians and regional/tertiary hospitals.				1				



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RECOMMENDATIONS	National Minister of Health	National Department of Health	Eastern Cape Health MEC	Eastern Cape Department of Health	National Treasury	Eastern Cape Treasury	Department of Public Service and Administration	External stakeholders
Rewards								
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:		1		2	1	2	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.		1		2	1	2	2	
Rewards should be linked to organisational, employee and team performance.		2		2	2	2	1	
Lessons learned from the current OSD implementation review for nurses should be captured to inform future implementation of other improvement initiatives.		1		2	1	2		
Learning and Development								
Training needs should be properly and objectively determined.		2		1				
Well considered and prioritised commitments to relevant training should be maintained even during times of cost containment.		2		1				
Training and development programmes should be clearly defined and aligned to the service delivery priorities of the province.		2		1				
A learning environment should be developed		2		1				



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Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Eastern Cape Health MEC	Eastern Cape Department of Health	National Treasury	Eastern Cape Treasury	Department of Public Service and Administration	External stakeholders
in which ongoing training is part of the employment package.								
HR information systems								
An assessment should be undertaken to establish reasons for under utilisation of systems and improved measures should be implemented including the use of PERSAL to its full capacity as a HR management tool.		2		1				
INFORMATION MANAGEMENT RECOMMENDATIONS								
Overall M&E								
M&E needs to become a central component of all managerial activity with the use of objective information being the basis for decision making. This applies to all aspects of management, including financial and HR, and not only service related data. There needs to be an iterative link between planning, implementation and monitoring.		1		1	2	2	2	
Regular formal monitoring of key indicators needs to take place with analysis and questioning of variances (in much the same way as financial management variance analysis should take place). The PEAR process (or something similar) needs to be resuscitated.		2		1		2		
A smaller set of key indicators for managers needs to be agreed upon.		1		1				
Capacity of staff (especially on BAS and PERSAL) needs to be reviewed and		2		1				



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RECOMMENDATIONS	National Minister of Health	National Department of Health	Eastern Cape Health MEC	Eastern Cape Department of Health	National Treasury	Eastern Cape Treasury	Department of Public Service and Administration	External stakeholders
corrective measures agreed upon and implemented.								
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. cell phone technology. NDOH could help with leadership in these areas.				1				
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.		2		1				
Use of information for decision making								
M&E, based on a limited number of key indicators, needs to be built into every senior manager's job description and performance appraisal.		2		1			2	
Where applicable, in-service training around understanding of and the importance of key indicators for managers needs to take place.		2		1				
There should be regular analysis, comparison, interpretation and feedback around indicators to lower levels of the system. In addition, this process needs to be replicated at all levels.		2		1				



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Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Eastern Cape Health MEC	Eastern Cape Department of Health	National Treasury	Eastern Cape Treasury	Department of Public Service and Administration	External stakeholders
District Health Information System (DHIS)								
The DHIS, and associated NIDS, needs a thorough review by the NDOH.		1		2				
The numbers of indicators need to be decreased		1		2				
There should be unambiguous, easy to understand, standardised definitions.		1		2				
There also needs to be clear written guidelines, norms and standards for each component of the DHIS, including data collections 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 (ETR-net), PERSAL and BAS.		1		2	2	2	2	
An appropriate training regime also needs to be introduced at the correct time.		1		1				
Ongoing training should become an integral part of the functioning of the ECDOH at all levels.				1				
ARV Monitoring and Evaluation								
The ARV system using the DHIS needs to be strengthened to ensure that all data is captured on a timely basis and is available for managers.		1		1				
Other M&E issues								
There needs to be one official repository of		2		1				



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RECOMMENDATIONS	National Minister of Health	National Department of Health	Eastern Cape Health MEC	Eastern Cape Department of Health	National Treasury	Eastern Cape Treasury	Department of Public Service and Administration	External stakeholders
information for the ECDOH. 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.								
A standard set of reports needs to be established and fed to programme managers at all levels on a timely basis.		2		1				
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.		2		1				
Basic record keeping needs to be maintained at facility level.		2		1				
Follow-up and corrective actions on identified indicators with variances need to form part of all M&E activities.		2		1				
MEDICAL PRODUCTS, LABORATORY RECOMMENDATIONS								
The current review of all aspects of the management and operations of the medical depot needs to be finalised and the emergent recommendations implemented. Discussions should be held with suppliers to determine what factors inhibit their performance. Where				1				



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possible, this should be corrected. For example, longer term contracts may be required for suppliers to ship in adequate quantities of medications.								
The drug budget should be reviewed and prioritised in line with departmental priorities. Drug budgets should reside at the lowest level of activity as part of the cost centre hierarchy and drug costs should be accurately allocated to individual institutions and clinics.				1	2	2		
Because of the high costs of laboratory services, the overall monitoring and control of the laboratory services and blood product usage needs to be given attention by a combined management/clinical team.		2		1				
Clinicians and financial managers need to be involved jointly in working out how limits can be placed on laboratory usage. Since this is a national problem, the NDOH could be of assistance in establishing a national workgroup on this issue.		2		1				
An agreed set of drugs, clinical supplies and equipment should be determined and guaranteed for each particular type of institution.				1				
Clinical engineering services should be treated as a high priority, not only for functional purposes but for the exercise of due diligence in managing public resources.				1				



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Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Eastern Cape Health MEC	Eastern Cape Department of Health	National Treasury	Eastern Cape Treasury	Department of Public Service and Administration	External stakeholders
A suitable PPP should be developed for the rendering of the emergency medical service.		2		1				
TECHNOLOGY AND INFRASTRUCTURE RECOMMENDATIONS								
All infrastructure developments need to be in line with the approved STP.			2	1				
The exact status of the revitalisation of Frere and Cecilia Makiwane Hospitals needs to be determined between the ECDOH, the NDOH and the National Treasury and a plan developed to finalise implementation. If necessary, a dedicated senior manager needs to be allocated to this task.		1		1	2	2		
The rural accommodation needs and detailed suggested solutions should be packaged and presented to the NDOH/National Treasury as a matter for prioritisation.		2		1	2	2		
Clear decisions need to be taken regarding the number of tertiary institutions in the province and this decision needs adequate consultation and communication before implementation is started. The NDOH should take the lead and politicians at both provincial and national levels should play a role in this process.	2	1	2	1	2	2		1
In the interim before the decision regarding tertiary services are implemented, tertiary hospitals should consider allocating some wards as either level 1 or step down facilities and running these at those levels.			2	1		2		



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RECOMMENDATIONS	National Minister of Health	National Department of Health	Eastern Cape Health MEC	Eastern Cape Department of Health	National Treasury	Eastern Cape Treasury	Department of Public Service and Administration	External stakeholders
NDOH could assist provinces in reviewing building estimates and costs.		1						



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 2009/2010 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 DoH's 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 DoH 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), CFO's 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's 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 DoH

- 1.4.1.1. It is anticipated that the NDOH and provincial DoH 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

1.5.1. This refers to both national and provincial ISTs.

1.5.1.1. Standardised provincial and national review templates

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

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

1.5.1.4. Detailed review reports on conditional grants and consolidated provincial reports (National Team)

1.5.1.5. National and Provincial Reports focusing but not limited to:

- An executive summary of key findings by provinces and overall national status



- The extent to which provinces have met and complied with the objectives set out in their operational plans
- The extent to which provinces have over-expended on the budget based on their financial statements
- The impact of over-expenditure on the DoH's and implications for future operational plans and service delivery
- The quality of services and cost-effectiveness of programmes delivered
- 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

1.5.1.6. 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 26th 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.



2. APPENDIX 2: LIST OF DOCUMENTS REVIEWED

2.1. GENERAL

- 2.1.1. Provincial Strategic Plans (05/06 – 09/10)
- 2.1.2. MTEF (2008/09 – 2010/11)
- 2.1.3. Provincial Annual Reports (05/06, 06/07, 07/08)
- 2.1.4. Annual Performance Plans (07/08 – 09/10, 08/09 – 10/11)
- 2.1.5. Strategic Transformation Plan (STP) – draft 2 and earlier drafts
- 2.1.6. Operational Plan (07/08, 08/09)

2.2. FINANCE

- 2.2.1. Budgets and Actuals 2006/07 (Annual report); 2007/08 (Annual report); 2008/09 YTD (IYM – February 2009)
- 2.2.2. Forecast, 2009/10; 2010/11; 2011/12
- 2.2.3. Annual Financial Statements
- 2.2.4. IYM report (February 2009)
- 2.2.5. Auditor-General audit reports
- 2.2.6. The Departmental/Institutional Supply Chain management System (April 2005)
- 2.2.7. BAS Report: EC Health. Segment Detail Structure. 18/03/2009
- 2.2.8. Province of the Eastern Cape: Provincial Treasury. Budget Statement II 2009/10



2.3. HR

- 2.3.1. Organogram structures at different levels
- 2.3.2. Memorandum on abolishing of vacant and frozen posts – 3rd March 2009
- 2.3.3. Business Plan Health Professional Training and development 2009/2010
- 2.3.4. Draft report on human resource requirements for the Department of Health, Eastern Cape Province, Hospital Transformation project, March 2002.
- 2.3.5. Human Resources Plan, Eastern Cape Province, 2008/09 – 2014/15.
- 2.3.6. Department of Health: Nursing Strategy for South Africa 2008.

2.4. OTHER

- 2.4.1. Review of the Primary Health Care System in the Eastern Cape Province, Nic Crisp and Johan Van Heerden, July 2008 (the Benguela report)
- 2.4.2. PEAR Technical Update. Equite Project, 2002.
- 2.4.3. Amathole District 2nd Quarter Report, 2008/09.
- 2.4.4. DHIS datafile, March 2009.
- 2.4.5. World Health Organization. The World Health Report 2000, Health Systems: Improving performance. Geneva, WHO 2000.
- 2.4.6. Mbashe District Health Planning and Reporting, 2009/10.
- 2.4.7. Helen Schneider, Peter Barron, Sharon Fonn. The promise and the practice of transformation in South Africa's health system. In Buhlungu S, Daniel J, Southall R, Lutchman J. State of the Nation South Africa 2007, 289-307. HSRC Press, 2007.



3. APPENDIX 3: SCHEDULE OF INTERVIEWS

Provincial Department Level

Department/Area	Person(s) Interviewed	Position	Date of Interview
Top Management	Mr. L. Boya	HOD	2 April 2009
Senior Management	Mrs Vazi	CFO	1 April 2009
Senior Management	Mr. Frachet	CD Integrated Budget Planning	2 April 2009
Senior Management	Dr. Diliza	DDG Corporate Services	31 March 2009
Senior Management	Mrs Moropedi	Director, Nursing	31 March 2009
Senior Management	Dr. Wagner	CD HRD	2 April 2009
Senior Management	Dr. Matiwane	CD Hospital Management Services	3 April 2009
Senior Management	Mrs. Maseko	CD HRM	3 April 2009
Senior Management	Dr. Mjekevu	CD Strategy and Organisational Performance	3 April 2009
Senior Management	Mrs. Matabese	Director: Mother and Child Services	6 April 2009
Senior Management	Mr. Zithumane	DDG: Corporate Services (COO)	7 April 2009
Senior Management	Dr. Kotze	CD Project Support	7 April 2009
Hospital Management	Mr. Mosana	CEO: Frere Complex	7 April 2009
District Management	Dr. Noruka and team	DM: District Health Services	7 April 2009
Hospital Clinician	Dr. Boon	Head: Paediatric services (Frere Hospital)	7 April 2009
Sub-district Management	Mrs. Kati	Sub-district manager: Mbashe	8 April 2009
	Finance management team	Mbashe sub-district	8 April 2009
	Programme managers	Mbashe sub-district	8 April 2009
District Hospital Management	Mrs. Vinjwa	Hospital Manager: Madwaleni Hospital	9 April 2009
	Dr. Cook	Clinical services manager, Madwaleni Hospital	9 April 2009
Senior Management	Ms Nogaduka and team	Director: HIV/AIDS	15 April 2009
Senior Management	Mr Goduka (by email and phone)	Director: Information systems	17 April 2009
Senior management	Dr Ahern (by email and phone)	CD Clinical support	17 April 2009



4. APPENDIX 4: FINANCIAL TABLES REFERENCES

Note: Only tables with reference citations are listed below. Financial tables 1 to 6 are found in Financial Review of the report.

Table 1: Allocation of Provincial budget to Health (including conditional grants)

Financial year	R m Provincial Budget	Year on year increase	R m Health Budget	Year on year increase	% Allocation to Health	R m Adjustment Provincial Budget	R m Adjustment Health Budget	% Allocation to Health
2005/06	23 392 ²¹	N/A	6 088 ²²	N/A	26.03%	23 904 ²³	6 213 ²⁴	25.99%
2006/07	26 827 ²⁵	14.68%	6 893 ²⁶	13.22%	25.69%	27 530 ²⁷	7 337 ²⁸	26.65%
2007/08	31 009 ²⁹	15.59%	8 143 ³⁰	18.13%	26.26%	30 609 ³¹	8 069 ³²	26.36%
2008/09	38 085 ³³	22.82%	9 746 ³⁴	19.69%	25.59%	39 660 ³⁵	10 639 ³⁶	26.83%

²¹ Eastern Cape Province Budget Statement 2006/07, page 35

²² Eastern Cape Province Budget Statement 2006/07, page 35

²³ Eastern Cape Province Budget Statement 2006/07, page 35

²⁴ Eastern Cape Province Budget Statement 2006/07, page 35

²⁵ Eastern Cape Province Budget Statement 2007/08, page 62

²⁶ Eastern Cape Province Budget Statement 2007/08, page 62

²⁷ Eastern Cape Province Budget Statement 2007/08, page 62

²⁸ Eastern Cape Province Budget Statement 2007/08, page 62

²⁹ Eastern Cape Province Budget Estimate 2008/09, page 75

³⁰ Eastern Cape Province Budget Estimate 2008/09, page 75

³¹ Eastern Cape Province Budget Estimate 2008/09, page 75

³² Eastern Cape Province Budget Estimate 2008/09, page 75

³³ Eastern Cape Province Budget Statement 2009/10, page 44

³⁴ Eastern Cape Province Budget Statement 2009/10, page 44

³⁵ Eastern Cape Province Budget Statement 2009/10, page 44

³⁶ Eastern Cape Province Budget Statement 2009/10, page 44



Table 1: Allocation of Provincial budget to Health (including conditional grants)

Financial year	R m Provincial Budget	Year on year increase	R m Health Budget	Year on year increase	% Allocation to Health	R m Adjustment Provincial Budget	R m Adjustment Health Budget	% Allocation to Health
2009/10	42 635 ³⁷	11.95%	11 328 ³⁸	16.23%	26.57%	N/A	N/A	N/A
2010/11	45 931 ³⁹	7.73%	12 108 ⁴⁰	6.89%	26.36%	N/A	N/A	N/A
2011/12	49 650 ⁴¹	8.10%	13 146 ⁴²	8.57%	26.48%	N/A	N/A	N/A

Table 2: Allocation of Provincial budget to Health (excluding conditional grants)

Financial year	R m Adjustment Provincial Budget (excl Grants)	R m Adjustment Health Budget (incl. Grants)	R m Health Grants	% Year on year increase in Health Grants	R m Adjustment Health Budget (excl. Grants)	% Allocation to Health
2005/06	21 205	6 213 ⁴³	888 ⁴⁴		5 325	25.11%
2006/07	24 628	7 337 ⁴⁵	954 ⁴⁶	7%	6 383	25.92%
2007/08	26 831	8 069 ⁴⁷	1 261 ⁴⁸	32%	6 808	25.37%
2008/09	34 919	10 639 ⁴⁹	1 295 ⁵⁰	3%	9 344	26.76%

³⁷ Eastern Cape Province Budget Statement 2009/10, page 44

³⁸ Eastern Cape Province Budget Statement 2009/10, page 44

³⁹ Eastern Cape Province Budget Statement 2009/10, page 44

⁴⁰ Eastern Cape Province Budget Statement 2009/10, page 44

⁴¹ Eastern Cape Province Budget Statement 2009/10, page 44

⁴² Eastern Cape Province Budget Statement 2009/10, page 44

⁴³ Eastern Cape Province Budget Statement 2006/07, page 35

⁴⁴ Eastern Cape Province Budget Statement 2006/07, page 25, 26

⁴⁵ Eastern Cape Province Budget Statement 2007/08, page 62

⁴⁶ Eastern Cape Province Budget Statement 2007/08, page 73

⁴⁷ Eastern Cape Province Budget Estimate 2008/09, page 75

⁴⁸ Eastern Cape Province Budget Estimate 2008/09, page 72



Table 2: Allocation of Provincial budget to Health (excluding conditional grants)

Financial year	R m Adjustment Provincial Budget (excl Grants)	R m Adjustment Health Budget (incl. Grants)	R m Health Grants	% Year on year increase in Health Grants	R m Adjustment Health Budget (excl. Grants)	% Allocation to Health
2009/10 (main budget)	35 235	11 328 ⁵¹	1 362 ⁵²	5%	9 966	28.28%
2010/11 (main budget)	39 468	12 108 ⁵³	1 645 ⁵⁴	21%	10 463	26.51%

Table 3: National Conditional Grants to Provinces

Grant	Financial year	R 000		% Allocation of National Grant
		Total Grant to Provinces	Eastern Provincial Allocation Cape	
Comprehensive HIV & AIDS Grant	2005/06	1 150 108 ⁵⁵	159 005 ⁵⁶	13.83%
	2006/07	1 616 214 ⁵⁷	218 021 ⁵⁸	13.49%
	2007/08	2 006 223 ⁵⁹	233 204 ⁶⁰	11.62%
	2008/09	2 885 400 ⁶¹	300 522 ⁶²	10.42%

⁴⁹ Eastern Cape Province Budget Statement 2009/10, page 44

⁵⁰ Eastern Cape Province Budget Statement 2009/10, page 41

⁵¹ Eastern Cape Province Budget Statement 2009/10, page 44

⁵² Eastern Cape Province Budget Statement 2009/10, page 41

⁵³ Eastern Cape Province Budget Statement 2009/10, page 44

⁵⁴ Eastern Cape Province Budget Statement 2009/10, page 41

⁵⁵ Estimates of National Expenditure 2008, page 279

⁵⁶ Eastern Cape Province Budget Statement 2006/07, page 25

⁵⁷ Estimates of National Expenditure 2008, page 279

⁵⁸ Eastern Cape Province Budget Statement 2007/08, page 73

⁵⁹ Estimates of National Expenditure 2008, page 279

⁶⁰ Eastern Cape Province Budget Statement 2008/09, page 110

⁶¹ Estimates of National Expenditure 2009, page 298



Table 3: National Conditional Grants to Provinces

Grant	Financial year	R 000		% Allocation of National Grant
		Total Grant to Provinces	Eastern Cape Provincial Allocation	
	2009/10	3 476 200 ⁶³	401 727 ⁶⁴	11.56%
	2010/11	4 311 800 ⁶⁵	497 599 ⁶⁶	11.54%
National Tertiary Services Grant	2005/06	4 709 386 ⁶⁷	384 071 ⁶⁸	8.16%
	2006/07	4 981 149 ⁶⁹	374 203 ⁷⁰	7.51%
	2007/08	5 321 206 ⁷¹	428 912 ⁷²	8.06%
	2008/09	6 134 100 ⁷³	472 542 ⁷⁴	7.70%
	2009/10	6 614 400 ⁷⁵	509 429 ⁷⁶	7.70%
	2010/11	7 398 000 ⁷⁷	557 137 ⁷⁸	7.53%

⁶² Eastern Cape Province Budget Statement 2008/09, page 41

⁶³ Estimates of National Expenditure 2009, page 298

⁶⁴ Eastern Cape Budget Statement 2009/10, page 41

⁶⁵ Estimates of National Expenditure 2009, page 298

⁶⁶ Eastern Cape Budget Statement 2009/10, page 41

⁶⁷ Estimates of National Expenditure 2008, page 279

⁶⁸ Eastern Cape Province Budget Statement 2006/07, page 25

⁶⁹ Estimates of National Expenditure 2008, page 279

⁷⁰ Eastern Cape Province Budget Statement 2007/08, page 73

⁷¹ Estimates of National Expenditure 2008, page 279

⁷² Eastern Cape Province Budget Statement 2008/09, page 110

⁷³ Estimates of National Expenditure 2009, page 298

⁷⁴ Eastern Cape Province Budget Statement 2008/09, page 41

⁷⁵ Estimates of National Expenditure 2009, page 298

⁷⁶ Eastern Cape Budget Statement 2009/10, page 41

⁷⁷ Estimates of National Expenditure 2009, page 298

⁷⁸ Eastern Cape Budget Statement 2009/10, page 41



Table 3: National Conditional Grants to Provinces

Grant	Financial year	R 000 Total Conditional Grant to Provinces	R 000 Eastern Cape Provincial Allocation	% Allocation of National Grant
Total Conditional Grants to Provinces	2005/06	8 907 346 ⁷⁹	888 087 ⁸⁰	9.97%
	2006/07	10 206 542 ⁸¹	953 967 ⁸²	9.35%
	2007/08	11 736 678 ⁸³	1 110 945 ⁸⁴	9.47%
	2008/09	14 362 800 ⁸⁵	1 294 956 ⁸⁶	9.02%
	2009/10	15 578 400 ⁸⁷	1 362 343 ⁸⁸	8.75%
	2010/11	18 012 800 ⁸⁹	1 645 185 ⁹⁰	9.13%

⁷⁹ Estimates of National Expenditure 2008, page 279

⁸⁰ Eastern Cape Province Budget Statement 2006/07, page 25

⁸¹ Estimates of National Expenditure 2008, page 279

⁸² Eastern Cape Province Budget Statement 2007/08, page 73

⁸³ Estimates of National Expenditure 2008, page 279

⁸⁴ Eastern Cape Province Budget Statement 2008/09, page 110

⁸⁵ Estimates of National Expenditure 2009, page 298

⁸⁶ Eastern Cape Province Budget Statement 2009/10, page 41

⁸⁷ Estimates of National Expenditure 2009, page 298

⁸⁸ Eastern Cape Budget Statement 2009/10, page 41

⁸⁹ Estimates of National Expenditure 2009, page 298

⁹⁰ Eastern Cape Budget Statement 2009/10, page 41



Table 4: Comparing national and Eastern Cape provincial trends in per capita health budget

Financial year	National Population	R m National Health Budget	R National Health Budget per capita	% Increase year on year	Eastern Cape Population	R m Eastern Cape Health Budget	R Eastern Cape Health Budget per capita	% Increase year on year
2005/06	46 888 200	48 067	1 025		7 039 300	6 088	865	
2006/07	47 390 900	54 533	1 151	12.3%	6 894 300	6 893	1 000	15.6%
2007/08	47 850 700	62 633	1 309	13.7%	6 906 200	8 143	1 179	17.9%
2008/09	48 687 300	75 492	1 551	18.5%	6 579 300	9 746	1 481	25.6%
2009/10	48 687 300	86 945	1 786	15.2%	6 579 300	11 328	1 722	16.3%
2010/11	48 687 300	97 632	2 005	12.3%	6 579 300	12 108	1 840	6.9%

Source: Population numbers per STATS SA mid-year estimates (P0302).



Table 5: Trends in ECHOD expenditure

	R 000 2005/06 (AFS)	R 000 2006/07 (AFS)	R 000 2007/08 (AFS)	R 000 2008/09 (estimate)
Surplus/(deficit) per Appropriation Statement	105 940	79 881	55 689	94 637 ⁹¹
(Increase)/decrease in accruals payable	173 990	170 288	(561 918)	(472 061)
Surplus (deficit) adjusted for movement in accruals	279 930	250 169	(506 229)	(377 424)
<i>Balance of accruals at year end</i>	<i>333 309</i>	<i>163 021</i>	<i>724 939</i>	<i>1 197 000⁹²</i>

⁹¹ Estimate per IYM report (February 2009)

⁹² Estimate obtained from the CFO (the estimate is based on judgement and can only be confirmed after the end of the financial year) - R180m – COE, R135m – HR sundry, R204m – HROPT, R450m – Goods and services, R110m – Goods and services (Mar 09), R17m – Capital, R20m – Plant and machinery, R81m – Provincial Infrastructure Grant



Table 6: Trends in health programme budget and expenditure, 2005-08

Programme	2005/06			2006/07			2007/08		
	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000
	Final Appropriation	Actual Expenditure	Variance	Final Appropriation	Actual Expenditure	Variance	Final Appropriation	Actual Expenditure	Variance
Administration	250 256	248 398	1 858	407 203	331 643	75 560	374 856	374 549	307
District Health Services	2 820 680	2 812 011	8 669	3 296 391	3 237 762	58 629	3 672 358	3 712 566	(40 208)
Emergency Medical Services	219 079	219 052	27	275 269	321 856	(46 317)	318 765	318 793	(28)
Provincial Hospital Services	2 030 962	2 043 109	(12 147)	2 290 597	2 287 337	3 260	2 731 075	2 637 418	93 657
Central Hospital Services									
Health Sciences and Training	333 514	327 406	6 108	369 382	364 582	4 800	358 346	375 126	(16 780)
Health Care Support	36 150	36 049	101	21 711	20 930	781	24 125	24 126	(1)
Health Facilities Management	535 596	434 159	101 437	675 727	692 427	(16 700)	588 409	569 421	18 988
Special functions									
Internal charges	673	786	(113)	719	851	(132)	763	1 009	(246)
Total	6 226 910	6 120 970	105 940	7 336 999	7 257 118	79 881	8 068 697	8 013 008	55 689
Economic classification									
Compensation of employees	3 453 865	3 445 574	8 291	3 879 362	3 860 060	19 302	4 525 338	4 562 518	(37 180)
Goods and services	1 592 933	1 583 864	9 069	2 510 799	2 546 080	(35 281)	2 196 439	2 225 674	(29 235)
Financial transactions in assets and liabilities									
Transfers and subsidies	725 605	733 308	(7 703)	359 950	288 747	71 203	423 422	422 420	1 002



Table 6: Trends in health programme budget and expenditure, 2005-08

Programme	2005/06			2006/07			2007/08		
	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000
	Final Appropriation	Actual Expenditure	Variance	Final Appropriation	Actual Expenditure	Variance	Final Appropriation	Actual Expenditure	Variance
Buildings and other fixed structures	433 242	266 609	166 633	469 909	444 483	25 426	747 047	694 793	52 254
Machinery and equipment	21 265	91 615	(70 350)	116 979	117 783	(769)	176 451	107 603	68 848
Total	6 226 910	6 120 970	105 940	7 336 999	7 257 748	79 881	8 068 697	8 013 008	55 689

Source: Annual reports of various financial years



5. APPENDIX 5: MADWALENI HOSPITAL HIV/AIDS PROGRAMME

- 5.1. The HIV/AIDS programme run from Madwaleni Hospital is a model both for an effective rural HIV/AIDS programme but also a model for how an integrated district should function. Both the hospital management and the HIV/AIDS provincial directorate were interviewed.
- 5.2. Madwaleni Hospital falls into the Mbashe sub-district of the Amathole District but is approximately three hours from the district office and about 80 minutes away from the sub-district. It services a population of around 130 000 people. Besides the hospital there is one CHC (Elliotdale) and 7 clinics. Of the 130 000 people they estimate around 19 500 are HIV positive (prevalence rate of 15% estimated).
- 5.3. The hospital has formed a very strong relationship with two NGOs – the Donald Woods Foundation and the ORAM health project (using PEPFAR funds). A key principle driving the relationship is the strong linkage between the NGOs and the government. All appointments and programmes are in line with government principles and approaches. While new mechanisms might be piloted using NGO funds, if successful these are then rolled out within the health department's budget. Always the correct balance needs to be maintained between the HIV/AIDS programme and the rest of the health service work. At no stage must the HIV/AIDS work dominate or swamp other health work.
- 5.4. Madwaleni is one of those rural hospitals that has managed to attract and retain health professionals. This is often due to health professionals who commit to stay for a considerable time in one rural area and start a process of building programmes and attracting staff. This is a key component of a rural retention policy. There is a long line of such facilities in South African history (e.g. Shongwe and Tintswalo Hospitals in Mpumalanga). Currently the hospital has 10 doctors with pharmacy, radiology, nutrition and rehabilitation health professionals as well.
- 5.5. The HIV/AIDS work started 5 years ago. The focus was on developing a wellness programme of which ARVs were but one component. There are currently 3,500 HIV+ clients in support groups that are all linked to the clinics and the CHC. Because the



underlying belief is that the biggest cost-driver is not ARVs but care of sick HIV+ patients, the groups focus on a number of areas:

- 5.5.1. Providing support
- 5.5.2. Teaching clients regarding the criteria for going onto ARVs and the effects and side-effects of the ARVs. Preparing them for the optimal time to go on the drugs.
- 5.5.3. Assisting the communities with VCT services
- 5.5.4. Including other wellness issues such as INH prophylaxis, good nutrition advice, TB screening, PAP smears
- 5.5.5. Condom promotion
- 5.5.6. Supporting the OVC programme
- 5.6. Besides the groups, each clinic has been allocated to one of the doctors who visit the clinics every two weeks. The CHC is visited more frequently. The visit deals with all patients (not just HIV/AIDS) and the approach is to see the clinic and the community holistically. These clinics (and the CHC) act as down-referral sites for HIV+ clients on treatment. The visiting doctor and nurse will take prepackaged ARVs from the hospital pharmacy and leave the balance of the medications with the clinic nurses who then continue to manage the patients. There are 1,800 adults and children currently on treatment. In addition, the doctor will bring a medical box for other consultations as the clinic might be out of stock on certain items or the drugs might not be on the PHC EDL.
- 5.7. The VCT programme is also linked to the pension payout system. On these days, many people gather so it is an ideal time for running a VCT clinic. Counsellors and nurses 'work the crowd' on that day.
- 5.8. It must be remembered that the hospital reports directly to the district while the clinics and the CHC report to the sub-district manager. So while the outreach and support from the hospital is not official it is welcomed by all.



- 5.9. Recently, the hospital has started an initiative on MDR TB patients. As the referral hospital in East London is full, the hospital has been sanctioned to treat MDR patients under the guidance of the East London MDR hospital. Currently there are four patients on treatment with the drugs been couriered from East London. This is a pilot project that is being supported by the ORAM project and if successful could be rolled out.