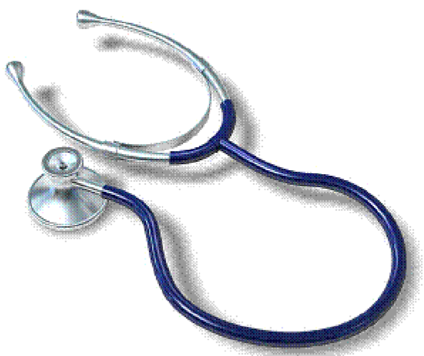
# KwaZulu-Natal Department of Health

# Report
# of the Integrated Support Team



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# Contributors and Editorial Support

Hanno Gouws

Bertie Loots

Alfred Mikosi

Gugu Ngubane

Laetitia Rispel

Annie Snyman

Ayesha Swalah

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The views presented in this report are those of the authors and are 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 KwaZulu-Natal Department of Health.

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# Abbreviations

| | |
|---|---|
| ABET | Adult Basic Education and Training |
| AFS | Annual Financial Statements |
| AIDS | Acquired Immunodeficiency Syndrome |
| ANC | Antenatal Care |
| APP | Annual Performance Plan |
| ART | Anti-retroviral Therapy |
| ARV | Anti-retroviral |
| BAS | Basic Accounting System |
| BBBEE | Broad Based Black Economic Empowerment |
| BEE | Black Economic Empowerment |
| CEO | Chief Executive Officer |
| CFO | Chief Financial Officer |
| CHC | Community Health Centre |
| COO | Chief Operating Officer |
| CPS | Central Provincial Store |
| DFID | UK Government's Department for International Development |
| DHIS | District Health Information System |
| DHP | District Health Plan |
| DHS | District Health System |
| DOH | Department of Health |
| DoRA | Division of Revenue Act |
| DPSA | Department of Public Service and Administration |
| EMS | Emergency Medical Services |
| EU | European Union |
| EXCO | Executive Committee |
| FINCOM | Financial Committee |
| FIO | Facility Information Officer |
| GM | General Manager |
| HAST | HIV, AIDS, STI and TB |
| HIS | Health Information System |
| HIV | Human Immunodeficiency Virus |
| HOD | Head of Department |
| HR | Human Resources |
| HRD | Human Resource Development |
| HRM | Human Resource Management |

| | |
|---|---|
| HSS | Health Systems Strengthening |
| IALCH | Inkosi Albert Luthuli Central Hospital |
| IST | Integrated Support Teams |
| IT | Information Technology |
| IYM | In Year Monitoring |
| KZN | KwaZulu-Natal Province |
| KZNDOH | KwaZulu-Natal Department of Health |
| M&E | Monitoring and Evaluation |
| M&OD | Management & Organisational Development |
| MACH | Ministerial Advisory Committee on Health |
| MANCO | Management Committee |
| MCC | Medicines Control Council |
| MCH | Maternal and Child Health |
| MDG | Millennium Development Goal |
| MDR | Multi-Drug Resistant |
| MEC | Member of the Executive Council |
| MEDSAS | Medical Supply Administration System |
| MTEF | Medium Term Expenditure Framework |
| N/A | Not available/ not applicable |
| NDOH | National Department of Health |
| NGO | Non-Governmental Organisation |
| NHLS | National Health Laboratory Service |
| NTSG | National Tertiary Services Grant |
| OSD | Occupational Specific Dispensation |
| PC | Personal Computer |
| PDE | Patient Day Equivalent |
| PERSAL | Personnel and Salary Administration System |
| PFMA | Public Finance Management Act |
| PHC | Primary Health Care |
| PMTCT | Prevention of Mother-To-Child-Transmission |
| PPSD | Provincial Pharmaceutical Supply Depot |
| RACI | Responsible, Accountable, Consulted, Informed |
| RRHF | Rapid Response Health Fund |
| SCM | Supply Chain Management |
| SITA | State Information Technology Agency |
| SMME | Small, Medium and Micro Enterprise |

| | |
|---|---|
| STI | Sexually Transmitted Infection |
| STP | Service Transformation Plan |
| TB | Tuberculosis |
| TED | Targeted Enterprise Development |
| TR | Team Representative |
| UKZN | University of KwaZulu-Natal |
| VCT | Voluntary Counselling Testing |
| WHO | World Health Organization |

# Foreword

The KwaZulu-Natal Department of Health (KZNDOH) has been under considerable stress over the last few years and particularly within the last two financial periods. The significant over expenditure noted for two consecutive years (2007/8 and 2008/9), coupled with allegations of fraud and corruption against both political and administrative authorities has resulted in a perceived sense of despair and despondency within the KZNDOH.

Despite the onerous challenges facing the KZNDOH, many managers interviewed during our review were optimistic and passionate about improving health care within the province of KwaZulu-Natal. This was evidenced by the best practices, including decentralised community-based initiatives to improve accessibility to services, innovative retention strategy for community pharmacists, etc. These best practices are contained within the various sections of this report.

Although the IST process was not designed to focus on and detect mismanagement or corruption, the information obtained from the interviews conducted suggests that these aspects require further investigation. This concern is further accentuated by the lack of integration between the finance and the service delivery components resulting in a top down approach to budget preparation and financial management.

There is urgency to address the issues highlighted in the report. We urge the new political authority and managers in the system to take forward the recommendations contained in the report.

# 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 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 former Minister of Health, honourable 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 Kwazulu-Natal Department of Health (KZNDOH) in April and May 2009. The IST review was a broad-based, rapid appraisal that focused on the health system as a whole. 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 workforce); Finances; Information management; Medical products; and Technology and Infrastructure.

The priority findings of the review are:

**FINANCE**

1. The inefficiencies within financial management and a lack of consistent and transparent leadership within the KZNDOH have contributed to the over-expenditure of the past two financial years in particular. This is evidenced by the poor expenditure control, and the occasional blatant disregard of approved and functional policies, procedures and processes. Material unfunded mandates at provincial level further contribute to the overspending.

2. There is lack of proper costing of priority programmes such as HIV & ART, TB and MCH, leading to lack of understanding of the real costs of each programme. The ART programme consistently exceeds the performance target set for each financial year

(e.g. the actual number of patients on ART in 2007/08 was 146 537 against an estimate of 81 614), resulting in significant over-expenditure of the ART drug budget.

3. The alleged contravention of supply chain management (SCM) regulations results in potential wasteful and fruitless expenditure being incurred.

4. There appears to be significant focus and funding of non-core functions such as the provision of food parcels (more aligned to the activities of the Department of Social Development) and targeted enterprise development (aligned to the activities of the Department of Economic Development).

**LEADERSHIP, GOVERNANCE AND SERVICE DELIVERY**

1. Pivotal to most challenges that surfaced during this review is the lack of decisive, focused, consultative and strategic senior leadership that take transparent decisions and respond promptly to urgent matters within the KZNDOH.

2. There is lack of clear and affordable national norms and standards to guide service delivery at provincial level.

3. There is inadequate coordination and integration of plans, lack of integrated planning between finance and service delivery clusters and dysfunctional systems to monitor implementation of plans and adherence to set targets.

4. The STP is still in draft form and has not been shared with external stakeholders for their inputs into the plan.

5. Service delivery is currently facing many challenges with staff shortages, inadequate medical supplies, lack of critical training and reduced budgets as a result of the cost containment strategy that was allegedly imposed on managers by the finance component without consultation.

## HUMAN RESOURCES

1. The structure at head office is bloated. It is also unclear which organisational structure is being used, adding to the confusion and disorganisation in the KZNDOH.

2. The undermining of the HR structure contributes towards non alignment of its plans to the broader provincial DOH strategic plan.

3. There is a lack of effective Performance Management and Development processes in the KZNDOH, exacerbating the challenges with service delivery.

## INFORMATION MANAGEMENT

1. Monitoring and evaluation is the weakest link in the overall management of the health services, exacerbated by the lack of an enabling environment to use information for management and for decision-making.

2. There are disintegrated multiple information systems used for different programmes, which do not link to the DHIS.

## MEDICAL PRODUCTS, LABORATORY

1. The provincial pharmaceutical services has been reporting an urgent problem of limited drug storage space at the provincial drug depot which has resulted in the Medicines Control Council (MCC) and the Pharmacy Council not issuing KZNDOH a licence for the current depot to store medical drugs safely in terms of the Pharmacy Act regulations. This matter has been prioritised in all annual plans but with no plan of action or prompt decisions taken for the past 5 years.

2. There is overspending on the ART drug budget, with almost 80% more patients receiving drugs than estimated in 2007/08.

**TECHNOLOGY AND INFRASTRUCTURE**

1. There are reportedly a number of concurrent IT systems that are implemented and procured outside the Master Systems Plan, normal SCM procedures and outside budget allocations for this function.

2. Annually, the Provincial Infrastructure Plan reports significant backlogs totalling billions of rand as a result of the insufficient capacity of the Department of Works to meet demand. This negatively affects the ability of the KZNDOH to respond to health service needs.

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

**FINANCE**

1. *Clear, transparent, sound and consistent leadership from KZNDOH executive management should be provided to address the issues of underfunding raised and to mitigate and/or manage its impact on service delivery.*

2. *The budget process should be enhanced to promote a more consultative approach. All priority programmes and services rendered at institutions should be accurately costed utilising the expertise of both the relevant service delivery and finance components.*

3. *A comprehensive early warning process should be established to allow programme and responsibility managers to manage their budgets in an effective and proactive manner.*

4. *Unfunded mandates from national or provincial levels should be discussed with the implementers before they are implemented.*

5. *A comprehensive and independent review of the SCM process within the KZNDOH should be undertaken to identify all SCM contraventions, potential political interference and potential conflict of interests for the last 3 years.*

6. *Given the current economic climate and the 2009/10 reduction in the goods and services budget, there should be a determined effort to focus on the core business of the KZNDOH i.e. health service delivery.*

**LEADERSHIP, GOVERNANCE AND SERVICE DELIVERY**

1. *There should be a determined effort to stabilise the top management structure of the KZNDOH, and to re-build morale, motivation and a common vision for public health service provision in the province.*

2. *An immediate revision and approval of the STP, by leadership of the highest level, is required.*

3. *Planning should be co-ordinated between the various components of both the national and provincial health departments. It is also imperative that the budget component of the finance section is intimately involved in the planning process.*

4. *NDOH should be more visible and interact more frequently with the provincial structures in terms of disseminating national guidelines, norms and standards regarding all areas of function. These documents should be informed by realities on the ground in order for them to remain relevant and appropriate.*

5. *The ever increasing demand for HIV treatment means that there is a need to develop a more sustainable HIV prevention and treatment model that takes into consideration issues of prevention, current need, affordability, equity and accessibility.*

**HUMAN RESOURCES**

1. *An urgent review and consolidation of all three current organisational structures of the KZNDOH is required in order to address the question of service delivery in terms of the province's disease burden profile. The review and restructuring should be guided by the strategic plan; approved STP; agreed benchmarks; optimal application of scarce skills and the available resources.*

2. *Individual performance should be aligned to organisational performance. Performance agreements should be based on clearly defined key performance areas with specific*

*targets. Performance assessments should be conducted quarterly and responsibility managers should enforce team integration to dispel the silo mentality.*

3. *The HR component should play a more central role in all planning processes and help to align individual plans to the overall provincial strategic plans.*

**INFORMATION MANAGEMENT**

1. *There is a need for a shift in mindset, also from the senior leadership of the KZNDOH, to promote the use of performance information as a management tool. Management needs to acknowledge that M&E is a core function for every manager in the system. It is also important to streamline all the data collection and analysis processes so that the information provided is consistent and valid at all times.*

2. *M&E units should be vigilant in terms of monitoring key indicators and also keep all the stakeholders regularly informed. The improvement of the DHIS and the development of an organisational culture for M&E and information management should be prioritised.*

**MEDICAL PRODUCTS**

1. *The provincial pharmaceutical supply depot should be moved to an appropriate structure as a matter of urgency and ensure that it complies with the MCC and Pharmacy Act requirements in order for it to obtain a license to operate.*

**TECHNOLOGY AND INFRASTRUCTURE**

1. *IT systems should be standardised and centralised so that the quality of data collected is consistent and reliable for effective planning and operational processes.*

# Introduction

## 1. BACKGROUND

1.1. The projected overspending in most of the provinces during the 2008/09 financial year led to the request by the then honourable Minister of Health, Ms Barbara Hogan, for an in-depth review of the underlying factors behind the overspending. This is because overspending has the potential to undermine the capacity of the national health system to improve health outcomes, in particular the health sector's response to the HIV pandemic. Consequently, the Integrated Support Teams (ISTs), comprising financial, public health, and management and organisational development specialists, were established in February 2009.

1.2. The purpose of this specific IST consultancy was to provide the Ministerial Advisory Committee on Health (MACH) with a thorough and holistic understanding of the underlying factors behind the overspending trends, to review health service delivery priorities and programmes and to make recommendations on where and how cost savings can be made into the future through improved cost management. The full terms of reference are attached as Appendix 1.

## 2. AIMS OF THE ISTs

### 2.1. THE AIMS OF THE ISTs WERE TO:

2.1.1. Recommend prioritised and practical actions (flowing from reviews at national, provincial and district levels) by which the functioning of the public health care system in South Africa can be improved on a sustainable basis.

2.1.2. Integrate the recommended actions into a health systems approach that includes perspectives on governance, leadership, finances, human resources, information, infrastructure and technology that result in improved service delivery that is effective and equitable.

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

# 3. SPECIFIC OBJECTIVES

## 3.1. THE SPECIFIC OBJECTIVES OF THE ISTs WERE TO:

3.1.1. Assess the current and projected expenditure trends at the National Department of Health (NDOH) and the 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.[1] 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 included: contribution to the disease burden; ministerial priorities;

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

important Millennium Development Goals (MDGs) 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, including detailed financial analysis and in-depth interviews with available key informants at provincial and district levels.

4.3. The desktop review comprised an analysis of documents obtained from the KwaZulu-Natal Department of Health (KZNDOH) and relevant documents in the public domain. A list of these documents is included in Appendix 3.

4.4. The IST planned to conduct in-depth interviews with all senior managers at provincial level, including the Acting Head of Department, CFO, Chief Operations Officer (COO), all the General Managers and programme and responsibility managers. The IST faced challenges of access to key decision-makers and, despite several attempts, were unable to secure interviews with the Acting Head of Department, COO and some of the relevant General Managers. Due to the limited time allocated to conduct the interviews (originally planned for three weeks) the departmental senior management was prioritised as key informants and further interviews. Although desired, interviews could not be arranged with the CEO of a tertiary/academic hospital, e.g. Inkosi Albert Luthuli Hospital, and with the dean of the University of KwaZulu-Natal Health Science faculty.

4.5. In addition, the district management team of the ILembe district, one of the 18 priority districts in the country was interviewed. In order to obtain an understanding of the challenges facing institutions, the hospital management team of Stanger Hospital in Ilembe was also interviewed with the intention of understanding some of the underlying reasons of over-expenditure at institutional level.

4.6. The interviews were conducted by a team of three experts between the 3rd and 17th of April 2009 followed by interview write-ups and analysis of information collected. At the request of the CFO on 29 April 2009, an additional week of interviews (primarily for the finance and HR teams) was scheduled from the 4th to the 7th of May 2009, thereby enabling the review team to obtain a more holistic understanding. The list of people interviewed is reflected in Appendix 4. The interviews were complemented by a further analysis of the documentation provided.

4.7. The report is based on information and interview inputs obtained from the KZNDOH visits and it 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. The Financial Review focuses on the key findings and recommendations of the financial assessment, because the overspending was the catalyst for the IST review. As overspending is an indicator of broader systemic challenges, the remainder of the document focuses on the assessment of other key building blocks of the health system. Other sections included in the report are Leadership, Governance and Service Delivery, Human Resources, Information Management, Medical Products, Laboratory, and Technology and Infrastructure. The final section, Taking Forward the Recommendations, integrates the recommendations from the various sections, and indicates the proposed allocation of responsibilities for implementation.

# Financial Review

## 1. INTRODUCTION

1.1. The financial review derives from an assessment of the KZNDOH budget, expenditure and annual reports, and interviews with KZNDOH 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. Just under one third of the total KwaZulu-Natal provincial revenue is allocated to health and this figure has shown a marginal decrease over the period under review.
2. There is a perception of underfunding of the KZNDOH in particular, and the South African public health system in general. Assuming current levels of service delivery, a study by the KZNDOH estimated the underfunding in the provincial health department to be between R2.5 and R3 billion.
3. The over-expenditure, which commenced in the 2005/06 financial year, is largely due to increases in staff numbers (head office), staff costs (OSD), operational activity increases (HIV and TB) and unfunded mandates.
4. As a result of the cash based accounting and reporting system, the true extent of the reported overspending is significantly understated as accruals, which have increased abnormally, are not included in the reported overspending.
5. Over-expenditure during the past three years has changed from goods and services to be centred on employee compensation, largely due to the expanded head office staff establishment.
6. Unfunded mandates and poor management decisions (e.g. focus on targeted enterprise development) exacerbate spending pressures and over-expenditure.
7. There is a distinct divide between the finance and service delivery components of the KZNDOH, with the former reportedly operating in isolation.
8. There is lack of alignment between annual performance plans and the budget. The operational plans are also not updated to take into consideration possible changes in the final budget allocations. The lack of an integrated health information system further exacerbates a deficient budgeting process.
9. Budgeting and financial management processes (e.g. financial monitoring and evaluation) are sub-optimal. The current system of financial and quarterly

**Box 1: Key findings from the financial review**

performance reporting makes it difficult to link finances to performance.

10. The full budgetary impact of the cost of treatment required by patients for various services is not comprehensively and accurately assessed.
11. There is inadequate compliance with supply chain management (SCM) policies and processes.

# 2. UNDERFUNDING 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 KwaZulu-Natal and nationally is due to the underfunding of the system, exacerbated by numerous "unfunded mandates". Assuming the current level of service delivery, a zero based budget projection compiled by an independent consultant, appointed by the KZNDOH's CFO during June 2008, indicated that the KZNDOH is underfunded by approximately R2.5 - R3 billion.

2.2. A separate component of the IST review is focusing on the adequacy of public health funding in South Africa and the findings of the rapid investigation will be included in the consolidated IST report.

# 3. PROVINCIAL BUDGET ALLOCATION

3.1. The allocation of the KwaZulu-Natal provincial budget to the KZNDOH is shown in Table 1. The allocation includes the equitable share, conditional grants and provincial own revenue. Slightly less than one third of the total provincial budget is allocated to health and this figure has shown a marginal decrease over the period under review.

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 |
|---|---|---|---|---|---|---|---|---|
| 2005/2006 | 32 802 | N/A | 10 379 | N/A | 31.6% | 33 779 | 10 425 | 30.9% |
| 2006/2007 | 37 192 | 13.4% | 11 737 | 13.1% | 31.6% | 37 429 | 11 819 | 31.6% |
| 2007/2008 | 43 515 | 17.0% | 13 413 | 14.3% | 30.8% | 44 538 | 13 925 | 31.3% |
| 2008/2009 | 51 101 | 17.4% | 15 043 | 12.2% | 29.4% | 53 201 | 15 678 | 29.5% |
| 2009/2010 | 60 463 | 18.3% | 17 449 | 16.0% | 28.9% | N/A | N/A | N/A |
| 2010/2011 | 66 245 | 9.6% | 20 668 | 18.4% | 31.20% | N/A | N/A | N/A |

3.2. The 2009/10 provincial health budget reflected above, has already been adjusted for the 7.5% reduction (which equates to R321.430 million) in goods and services, from the equitable share as requested by Provincial Treasury.

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 |
|---|---|---|---|---|---|---|
| 2005/2006 | 30 345 | 10 425 | 1 576 | N/A | 8 849 | 29.2% |
| 2006/2007 | 33 449 | 11 819 | 1 786 | 13.3% | 10 033 | 30.0% |
| 2007/2008 | 39 285 | 13 925 | 2 326 | 30.2% | 11 600 | 29.5% |
| 2008/2009 | 45 934 | 15 678 | 2 634 | 13.2% | 13 044 | 28.4% |
| 2009/2010 (main budget) | 51635 | 17 449 | 3 031 | 15.1% | 14 418 | 27.9% |
| 2010/2011 (main budget) | 56 661 | 20 668 | 3 406 | 12.4% | 17 262 | 30.5% |

3.3. When conditional grants are excluded, the provincial equitable share allocation to the KZNDOH shows a similar marginally declining trend, towards just under 28% for 2009/10, but with a projected increase over the MTEF (Table 2).

## 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 KZNDOH (Table 3). There has been a steady increase in the proportion of the HIV and AIDS grant allocated to the KZNDOH from 2005/06 through to 2008/09 with a marginal decrease in allocation projected for 2009/10 and 2010/11. The anticipated trend in the reduction of the KZN provincial allocation is cause for concern as the number of patients on ART in KZN has constantly exceeded targets over the last few years (2007/08 exceeded target by 79.5%). Although the proportion of the HIV grant has been larger than the KZN proportion of the total population (around 21%)[2] KZN has had the highest antenatal HIV sero-prevalence in 2007 of 37.4% against a country prevalence rate of 28%[3]. However, the criteria for the allocation of conditional grants by the NDOH are not clear.

[2] STATS-SA mid-year population estimates.

[3] ANC HIV Sero-prevalence surveillance report 2007

Table 3: National Conditional Grants to Provinces

| Grant | Financial year | R 000 Total Conditional Grant to Provinces | R 000 KwaZulu Natal Provincial Allocation | % Allocation of National Grant |
|---|---|---|---|---|
| Comprehensive HIV & AIDS Grant | 2005/2006 | 1 150 108 | 251 468 | 21.86% |
| | 2006/2007 | 1 616 214 | 344 304 | 21.30% |
| | 2007/2008 | 2 006 223 | 466 922 | 23.27% |
| | 2008/2009 | 2 885 400 | 757 213 | 26.24% |
| | 2009/2010 | 3 476 200 | 880 659 | 25.33% |
| | 2010/2011 | 4 311 800 | 1 013 082 | 23.50% |
| | | | | |
| National Tertiary Services Grant | 2005/2006 | 4 709 386 | 691 451 | 14.68% |
| | 2006/2007 | 4 981 149 | 732 167 | 14.70% |
| | 2007/2008 | 5 321 206 | 789 578 | 14.84% |
| | 2008/2009 | 6 134 100 | 911 892 | 14.87% |
| | 2009/2010 | 6 614 400 | 983 948 | 14.88% |
| | 2010/2011 | 7 398 000 | 1 102 585 | 14.90% |
| | | | | |
| Total Conditional Grants to Provinces | 2005/2006 | 8 907 346 | 1 417 977 | 15.92% |
| | 2006/2007 | 10 206 542 | 1 612 023 | 15.79% |
| | 2007/2008 | 11 736 678 | 2 065 971 | 17.60% |
| | 2008/2009 | 14 362 800 | 2 339 358 | 16.29% |
| | 2009/2010 | 15 578 400 | 2 671 128 | 17.15% |
| | 2010/2011 | 18 012 800 | 3 004 659 | 16.68% |

4.2. The NTSG grant to KZN has been fairly constant at approximately fifteen percent of the total NTSG. KZN's proportion of the total conditional grants is steadily increasing over the period under review.

## 5. TOTAL BUDGET PER CAPITA

5.1. The per capita budget for the uninsured KZN population was calculated using Statistics South Africa mid-year estimates, which was adjusted for the insured population based on the general household survey (Table 4). The nominal per capita budget has increased, and is expected to increase at a rate in excess of inflation according to the MTEF. The budget per capita budget compares well to the national budget per capital, but may be insufficient based on the relatively high burden of disease in the province.

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

| Financial year | Uninsured National population | R m Total of Provincial Health Budgets | R Uninsured Health Budget per Capita | % Increase year on year | Uninsured KZN Population | R m KZN Health Budget | R m Uninsured KZN Health Budget per Capita | % Increase year on year |
|---|---|---|---|---|---|---|---|---|
| 2005/2006 | 40 323 852 | 47 147 | 1 169 | N/A | 8 550 875 | 10 425 | 1 219 | N/A |
| 2006/2007 | 40 898 347 | 53 175 | 1 300 | 11.2% | 8 852 208 | 11 819 | 1 335 | 9.5% |
| 2007/2008 | 41 007 279 | 60 812 | 1 483 | 14.1% | 8 832 789 | 13 925 | 1 577 | 18.1% |
| 2008/2009 | 41 725 016 | 73 581 | 1 763 | 18.9% | 8 913 051 | 15 678 | 1 759 | 11.5% |
| 2009/2010 | 41 725 016 | 82 359 | 1 974 | 11.9% | 8 913 051 | 17 449 | 1 958 | 11.3% |
| 2010/2011 | 41 725 016 | 91 999 | 2 205 | 11.7% | 8 913 051 | 20 668 | 2 319 | 18.4% |

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

5.2. It should, however, be pointed out that the population estimates exclude the large number of people from Swaziland, Mozambique, Lesotho and the Eastern Cape who reportedly make use of KZN health services.

# 6. TRENDS IN HEALTH EXPENDITURE

6.1. The trend of overspending has shifted from goods and services to compensation of employees (OSD, material salary increases and significant increase in the number of managers within the KZNDOH). Compensation of employees has increased annually with 13%, 30% and 17% from the 2005/06 to the 2008/09 financial years. This is, obviously, far in excess of normal inflationary increases.

6.2. The cost containment strategy embarked upon in December 2008 has limited the overspending in 2008/09. Key aspects of the cost containment strategy are listed below:

6.2.1. Overtime must only be approved in the case of absolute necessity and no overtime to be paid to administrative and support staff.

6.2.2. All services sourced from nursing agencies were suspended with immediate effect.

6.2.3. No events allowed until further notice and if a specific meeting/workshop is approved by the HOD, no catering, promotional gift packs or external venues allowed.

6.2.4. No free teas and meals to any staff.

6.2.5. Attendance at all non-core workshops and seminars prohibited.

6.2.6. All travel has to be pre-planned, pre-approved and limited to 1,500km per month per employee.

6.2.7. The purchase of new office and domestic furniture and equipment is strictly prohibited.

6.2.8. Avoiding stockpiling of pharmaceuticals and consumables at institutional level.

6.2.9. Moratorium on the filling of posts (with the exception of critical posts).

6.3. The service delivery impact of this strategy has not been costed and this might have a long term negative impact on both service delivery and expenditure for the MTEF period.

Table 5: Trends in health programme budget and expenditure, 2005-2008 and 2009 estimated actual expenditure

| | 2005/2006 | | | 2006/2007 | | | 2007/2008 | | | 2008/2009 |
|---|---|---|---|---|---|---|---|---|---|---|
| | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 |
| **Programme** | Final Appropriation | Actual Expenditure | Variance | Final Appropriation | Actual Expenditure | Variance | Final Appropriation | Actual Expenditure | Variance | Actual Expenditure |
| Administration | 192,917 | 192,917 | 0 | 219,856 | 224,900 | -5,044 | 280,763 | 279,689 | 1,074 | 281,280 |
| Disrict Health Services | 4,736,757 | 4,924,947 | -188,190 | 5,422,598 | 5,370,301 | 52,297 | 6,375,856 | 7,209,609 | -833,753 | 8,080,189 |
| Emergency Medical Services | 420,604 | 420,604 | 0 | 472,380 | 474,023 | -1,643 | 554,863 | 548,796 | 6,067 | 672,377 |
| Provincial Hospital Services | 2,808,367 | 2,796,081 | 12,286 | 3,143,329 | 3,138,945 | 4,384 | 3,614,550 | 3,883,814 | -269,264 | 4,459,392 |
| Central Hospital Services | 1,024,735 | 1,068,606 | -43,871 | 1,168,164 | 1,191,810 | -23,646 | 1,285,717 | 1,407,703 | -121,986 | 1,805,303 |
| Health Science and Training | 411,589 | 408,227 | 3,362 | 423,219 | 421,069 | 2,150 | 522,634 | 524,333 | -1,699 | 675,328 |
| Health Care Support Services | 7,600 | 7,600 | 0 | 29,560 | 29,560 | 0 | 12,649 | 12,649 | 0 | 34,130 |
| Health Facilities Management | 821,947 | 736,770 | 85,177 | 940,145 | 813,208 | 126,937 | 1,278,396 | 1,092,807 | 185,589 | 1,099,039 |
| Special Functions | | | 0 | | 135 | -135 | | 41 | -41 | |
| **Total Expenditure** | **10,424,516** | **10,555,752** | **-131,236** | **11,819,251** | **11,663,951** | **155,300** | **13,925,428** | **14,959,441** | **-1,034,013** | **17,107,038** |
| | | | | | | | | | | |
| **Econonic Classification** | | | | | | | | | | |
| **Current payments** | **8,990,362** | **9,228,051** | **-237,689** | **10,318,971** | **10,359,501** | **-40,530** | **12,174,929** | **13,542,527** | **-1,367,598** | **15,469,323** |
| Compensation of employees | 5,866,998 | 5,866,764 | 234 | 6,660,756 | 6,628,829 | 31,927 | 7,913,564 | 8,643,767 | -730,203 | 10,079,549 |
| Goods and Services | 3,123,364 | 3,361,287 | -237,923 | 3,658,215 | 3,730,540 | -72,325 | 4,261,365 | 4,898,719 | -637,354 | 5,389,677 |
| Financial transactions in assets & liabilities | | | | | 132 | | | 41 | -41 | 97 |
| | | | | | | | | | | |
| **Current transter & subsidies** | **399,739** | **384568** | **15,171** | **384,578** | **366242** | **18,336** | **361,636** | **345,978** | **15,658** | **449,572** |
| | | | | | | | | | | |
| **Payments for capital assets** | **1,034,415** | **943,133** | **91,282** | **1,115,702** | **938,208** | **177,494** | **1,388,863** | **1,070,936** | **317,927** | **1,188,143** |
| Building and other fixed structures | 427,689 | 421,838 | 5,851 | 675,327 | 549,366 | 125,961 | 841,123 | 623,762 | 217,361 | 635,569 |
| Machinery & equipment | 605,061 | 519,625 | 85,436 | 440,257 | 388,460 | 51,797 | 547,624 | 429,978 | 117,646 | 552,574 |
| Software and other intangilable assets | 745 | 750 | -5 | 118 | 382 | -264 | 116 | 17,196 | -17,080 | |
| Land and Subsoil assets | 920 | 920 | 0 | | | 0 | | | 0 | |
| **Total** | **10,424,516** | **10,555,752** | **-131,236** | **11,819,251** | **11,663,951** | **155,300** | **13,925,428** | **14,959,441** | **-1,034,013** | **17,107,038** |

Source: Annual Reports of various financial years, March 2009 Preliminary IYM.

6.4. The surplus/(deficit) in 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) (Table 6). A review of the expenditure trends within the KZNDOH reflects an increasing trend in over-expenditure from 0.7% of the budget in 2005/06 up to an estimated 9% of the budget in 2008/09. A significant portion of the over-expenditure relates to compensation of employees.

Table 6: Trends in KZNDOH expenditure adjusted for accruals

| | 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 | -113 236 | 155 300 | -1 016 013 | -1 320 116 |
| (Increase)/decrease in accruals payable | 38 856 | -160 549 | -82 780 | -88 815 |
| Surplus/(deficit) adjusted for movement in accruals | -74 380 | -5 249 | -1 098 793 | -1 408 931 |
| Balance of accruals at year end | 33 537 | 194 086 | 276 866 | 365 681 |

6.5. The table 7 below highlights some of the main reasons/overspent items for the 2007/08 financial year:

Table 7: Overview of main reasons for over-expenditure – 2007/08

| Category | Details | R m Amount |
|---|---|---|
| Compensation of employees | Nurses strike between January and April 2008. Additional nurses were employed and 959 of the original nurses were reinstated with backpay | 55.9 |
| | Fees: Task Team at Labour Tribunal | 3.4 |
| | National strike – June 2007 (funding to the value of R220 million was received) | 78.0 |
| | Increase in the number of staff employees and commensurate increase in salary related payments (e.g. medical aid; overtime; service bonus; etc) | 322.8 |
| | Underfunding of OSD | 204.0 |
| Goods and services | ART (targets significantly exceeded budget) | 154.0 |
| | Opportunistic infections | 154.5 |
| | Medical and surgical sundries | 42.6 |
| | Blood products | 17.9 |
| | Intravenous feeds | 4.0 |
| | Nutritional support (ART and TB patients) | 54.2 |
| | Increase in patient catering (inflation and number of patients) | 8.0 |
| | Strike related expenditure (security, agencies, | 95.9 |

| Category | Details | R m Amount |
|---|---|---|
| | etc) | |
| | Increase in operational costs (transporting patients and corpses) | 12.9 |
| | Maintenance and information systems | 61.9 |
| | Accommodation and leases (additional offices not initially budgeted for) | 15.6 |

6.6. The most significant over-expenditure items that affect the last two financial years can be summarised as:

6.6.1. Compensation of employees, in particular the significant increase in senior management (General Manager on level 14 increased from 4 to 14); implementation of the OSD for nurses and higher salary increases than budgeted for.

6.6.2. Medical inflation (on specific items such as blood products, medical and surgical sundries, etc) being higher than budgeted inflation increases.

6.6.3. Unbudgeted increase in operational service levels e.g. higher numbers of patients on anti-retrovirals (ARVs) than the forecast numbers; increase in the number of victims of trauma.

6.6.4. Provision of non-core functions such as the procurement and distribution of food parcels and nutritional supplements, as well as targeted enterprise development which allocates funds to developing co-operatives and SMMEs.

# 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. Examples of unfunded mandates in the case of the KZNDOH include:

7.1.1. **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 of R237 million allocated for OSD by the National Treasury was based on an arbitrary calculation, and not on actual human resource (HR) figures from

the PERSAL system. The OSD for nurses in KZN was calculated at approximately R441 million.

7.1.2. **Nationally negotiated salary increases** for 2008/09 were significantly higher than those provided for in the budget.

7.1.3. **New vaccine.** The new vaccine introduced for children under 5 years of age has been grossly underfunded. NDOH has embarked on an extensive advertising campaign in this regard which will increase the number of children presented at PHC clinics for vaccination. To date there has been no strategy or action plan adopted for the roll-out of the limited vaccines according to the available budget.

7.1.4. **Function shifts**. The budget did not make provision for the movement of operations, e.g. in respect of municipal clinics, moved from local government to the KZNDOH. In this regard some hospitals have already incurred significant expenditure in respect of these clinics, without receiving appropriate funding.

7.1.5. **The activity levels increased.** For example, the numbers of patients registered for ARTs increased from 146 537 in 2007/08 (against a projection of 81 614 for that year) to 205 120 for 2008/09.

7.1.6. **New facilities**. Approximately 10 new clinics and 1 HAART unit was completed in 2008. In addition, major upgrades (generally attracting more patients) were completed at 19 clinics. Unfortunately, not all of the operating costs relating to these new additions were adequately funded.

# 8. IMPACT OF POOR MANAGEMENT DECISIONS - 2008/09

8.1. In addition to the unfunded mandates described above, some of the management decisions taken over the last few years, coupled with inadequate processes on specific activities (e.g. supply of blood products), have directly contributed to the over-expenditure in 2008/09. Examples of these include:

8.1.1. **Focus on non-core functions.** The core mandate of the KZNDOH is to deliver health services to the people of the province. Some of the activities that are questionable are the Targeted Enterprise Development (TED) and the supply of food parcels (not

referring to vitamin supplements) to HIV and AIDS and TB patients. These activities utilise the much needed scarce resources of the Department.

8.1.2. **Central Provincial Stores (CPS) "buy-outs".** The non-availability of stock at CPS has caused institutions to "buy-out" products at higher prices thereby impacting on the over-expenditure of the institutions.

8.1.3. **Blood products**. Based on the over-expenditure in blood related products during 2007/08 (about R17.9 million), a similar projection is anticipated for 2008/09 given the fact that a uniform process has not been established for the ordering and control of blood and blood products.

8.1.4. **Potential duplicate payments**. Some doctors and nurses, appointed by the KZNDOH, are performing overtime work through agencies without obtaining the necessary approval. As a result of the agency work performed, the individual could end up being remunerated twice for the same services rendered. Unfortunately, to date, the impact of this has not been quantified.

## 9. INTEGRATION AND FINANCIAL MANAGEMENT SUPPORT TO ALL COMPONENTS

9.1. It was reported that the finance component of the KZNDOH tends to operate in isolation. Most of the programme and responsibility managers interviewed do not have a sound understanding of the financial situation of their programmes. As an example, the development of the cost containment strategy (described in paragraph 6.2 above) was a top down approach and led by finance without consultation with managers at service delivery level who have to implement the plan. Consequently, the impact of the cost containment exercise on service delivery, managerial performance and staff morale is not being measured or monitored and therefore has not been quantified nor mitigated against. The reported non-consultative leadership style of the Finance component further exacerbates the existing critical situation.

## 10. BUDGETING PROCESS

10.1. The budgeting process was identified as a major contributor to the current funding challenges in the KZNDOH. Currently, the budgeting process is a top down process.

Although basic inputs are compiled from operational levels, an indicative figure is obtained from the provincial budget allocation. 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.

10.2. There is also no clear alignment between the annual performance plans and the financial budgets as the strategic planning component (within M&E) and the budget control component (within Finance) operate in isolation. Annual performance plans are also not updated subsequent to the allocation of funding. A good example of this non-alignment is the difference between the forecasted numbers of patients on ART and the budget allocated.

10.3. It was noted that most programme and responsibility managers do not have ownership and accountability for their budgets and expenditure. As budgets are allocated on a top down basis, the effect on service delivery is often ignored. In some instances, items are procured by the Executive Committee (EXCO) without the knowledge of the relevant programme or responsibility manager, e.g. office automation equipment. Budget virements are often used to match expenditure to the available funding instead of adopting stringency measures to address issues of over-expenditure.

## 11. FINANCIAL MANAGEMENT PROCESSES AT INSTITUTIONS

11.1. A correlation between packages of service offered, to the budget allocated per institution could not be performed as most institutions do not accurately capture and allocate the financial transactions relating to services rendered. Consequently, certain services (e.g. TB and HIV) may be understated as the costs associated with these services have been incorrectly allocated (e.g. to “general medical conditions” which is a standard item on the chart of accounts, often used to record various types of expenditure incurred at institutional level).

## 12. COST ALLOCATION

12.1. In some limited 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.

## 13. QUARTERLY PERFORMANCE REPORTS

13.1. 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.

## 14. FINANCIAL REPORTING

14.1. The principal financial reporting mechanisms are the monthly In Year Monitoring (IYM) reports and the Annual Financial Statements.

14.2. 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 overspending is also limited by the withholding of invoices for payment. The effect of this deficiency where unpaid amounts show an increasing trend is highlighted in Table 6. (The PFMA implications of this practice have not been considered for purposes of this report).

14.3. The annual financial statements (AFS) are drafted on a cash basis. Expenditure not paid (accruals) is not matched with the operational activities of the department. Material amounts payable are accumulated, but the reporting does not take this into consideration.

# 15. SUPPLY CHAIN MANAGEMENT (SCM)

15.1. It was reported that SCM regulations are contravened resulting in potential wasteful and fruitless expenditure being incurred. The possibility of conflict of interest in contracts has also arisen.

15.2. Recently new office automation equipment, in the form of new copiers/printers, has been installed at various components within the head office of the KZNDOH, despite current existing contracts being in place with various service providers and SITA. The cost of this contract (which did not follow due SCM processes) has not yet been established but preliminary indications from some responsibility managers indicate that costs may have trebled as colour copiers are being used instead of black and white copiers.

15.3. Respondents indicated that in some cases, the SCM division has awarded bids to suppliers without obtaining the required inputs from the institution requesting the service. Details such as availability of funds and the tender specifications are not always confirmed prior to the award of the bid and this results in bids being awarded to suppliers that end up being up to two or three times more expensive than the amount originally budgeted for by the institution.

15.4. It was noted that some BEE companies (especially those servicing the rural areas of the province) charge significantly higher prices for basic commodities (e.g. A PC memory stick costing approximately R95.00 is charged at R350.00; or 750g of Coffee at R47.00 is charged at R190.00). In some cases this represents 40% to 70% more than the original price budgeted for.

15.5. There is a serious lack of long term or “period contracts” (e.g. monthly security contract). This contributes to the over-expenditure and create an administrative burden, as the time and effort required to finalise a number of monthly contracts is significantly more than the time and effort required to finalise one contract for a longer period (e.g. for six or twelve months). Based on the information received, monthly contracts are significantly more expensive than period contracts.

# 16. MONITORING STRUCTURES

16.1. The internal audit and risk management component in particular, has been successful in identifying potential wasteful expenditure and more importantly identifying fraudulent activities having a significant impact on the KZNDOH and contributing to the over-expenditure. To date, this unit has been highly effective (e.g. effective co-ordination of the audit, resulting in an unqualified audit opinion for more than the last 5 years; significant charges of fraud and corruption executed against employees, etc.) and the adequate resourcing of this division is likely to yield much required improvements within the KZNDOH. However, there are 10-15 vacant posts within this component. Given the importance of this unit, there is a dire need to increase the resources allocated to enable proper execution of their core mandate.

# 17. KEY RECOMMENDATIONS

## 17.1. CONDITIONAL GRANTS

17.1.1. Allocations of conditional grants by the NDOH should be based on clear, objective criteria that are linked to grant specific indicators.

## 17.2. UNFUNDED MANDATES AND INEFFICIENT PROCESSES COUPLED WITH POOR DECISION MAKING

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. Appropriate measures should be introduced to control all overtime worked as well as the time worked for agencies. There should be a clear distinction between overtime worked for the KZNDOH and time worked for agencies.

## 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 needs to be linked to changes in operational activity, not merely to balance the number of over and under-expenditure items.

17.3.4. A comprehensive financial management procedure guide (detailing the approach and key parameters to be used in creating a budget as well as detailed guidance on monitoring of actual expenditure against the budget) should be developed, implemented and adherence monitored on a periodic basis.

17.3.5. All Programme Managers and other relevant implementers at various levels of the chain of service delivery need to take full responsibility for developing realistic (in accordance with available funds) and properly costed budgets that are fully aligned to all operational plans.

## 17.4. INTEGRATION AND FINANCIAL MANAGEMENT SUPPORT TO OTHER UNITS

17.4.1. The impact of the cost containment exercise (currently being implemented by the finance component) on service delivery, staff performance and staff morale should be assessed. All cost containment measures should be developed in conjunction with service delivery components of the Department and CEOs of institutions.

17.4.2. An early warning dashboard should be developed by finance in conjunction with the relevant programme and responsibility managers to identify significant over and under-spending.

17.4.3. Programme and responsibility managers should be given monthly financial information highlighting budget variances.

17.4.4. Dedicated teams within finance should be allocated to various programmes and sub-programmes to allow the finance component an opportunity to understand challenges affecting service delivery and afford the programme and responsibility managers the opportunity to understand and appreciate the limited funding available.

17.4.5. The working relationship between finance and the service delivery components of the KZNDOH should be enhanced by facilitating a close working relationship between the components. This should be facilitated by the COO and the CFO and championed by the HOD.

## 17.5. FINANCIAL MANAGEMENT

17.5.1. The chart of accounts used by institutions should be reviewed to ensure that all services offered are adequately accounted for.

17.5.2. A comprehensive financial management session with individual programme and responsibility managers should be held on a quarterly basis to enable programme and responsibility managers to understand the variances between the actual expenditure and the available funding.

17.5.3. Programme and responsibility managers should be held accountable for their budgets and all items of expenditure should be approved by the relevant manager (based on the delegations of authority).

17.5.4. Managers should be held accountable for the performance of their operating units and this must be built into the performance management system.

17.5.5. The recording of financial transactions should be improved to ensure that costs per service offered are accurately captured. This should be reviewed periodically by the financial manager, FIO (facility information officer) and the institutions' management committee to ensure that costs are correctly allocated to the correct objective codes.

17.5.6. An internal programme and responsibility manager training session should be held to capacitate managers in financial management.

17.5.7. Financial managers at institutions and districts should be trained appropriately to improve the current skill level on issues of financial management including accurate recording of transactions, cost allocations, preparation of management accounts, etc.

17.5.8. 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.

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

## 17.6. QUARTERLY PERFORMANCE REPORTS

17.6.1. The accuracy and use of essential performance indicators needs to be improved. The necessary steps must be taken in conjunction with the NDOH to improve the quality of information available in this regard.

17.6.2. Variances in specific indicators need to be followed up with appropriate actions, once identified.

17.6.3. 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.

## 17.7. FINANCIAL REPORTING IYM (IN YEAR MONITORING)

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

17.7.2. 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).

17.7.3. Through the appropriate channels, the forecasting component of the IYM should be investigated to ensure best basis of reporting – cash versus accrual reporting.

### 17.8. ANNUAL FINANCIAL STATEMENTS

17.8.1. 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.

### 17.9. SCM

17.9.1. A forensic audit of SCM management and processes within the KZNDOH should be undertaken to identify all SCM contraventions and potential conflict of interest during the last 3 years and to recommend prevention and management strategies.

17.9.2. Adequate controls and processes should be implemented to ensure that henceforth the SCM policies and processes for tenders and contracts are adhered to by all employees of the KZNDOH, irrespective of their positions in the departmental hierarchy.

17.9.3. A cost benefit analysis should be done to estimate the potential cost saving derived by the KZNDOH when buying inventory in bulk, using the CPS.

17.9.4. Short-term contracts should be reduced in order to cut down on unnecessary expenses and “period contracts” should be considered instead.

### 17.10. MONITORING STRUCTURES

17.10.1. The internal audit and risk component of the KZNDOH should be adequately resourced to enable it to execute its mandate.

# Leadership, Governance and Service Delivery

## 1. INTRODUCTION

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

1. The NDOH has not provided guidelines, norms and standards to guide resource allocation at different levels of care. Respondents indicated that NDOH has not provided visible leadership and stewardship to provinces with regard to proper costing of plans and resource requirements for the implementation of policies. It was indicated that national plans usually impose targets and service packages that are not costed and do not consider resource limitations.
2. The integrity of provincial leadership has been dented by fraud allegations against the previous political and administrative heads, and the SCM manager, resulting in poor morale and distrust.
3. Respondents' perception of provincial health leadership is of indecision, lack of insight and lack of focus on core health functions and inefficiency in their response to urgent health matters.
4. Management, described as EXCO and MANCO, is reportedly not transparent in their decision making processes and does not consult or communicate well with lower levels as per the provincial core values stated in the strategic plans. MANCO meetings dwell too much on operational issues rather than focusing on giving the department a strategic direction.
5. A significant level of political interference, that has a negative impact on service delivery, has been reported at different levels.
6. The STP is still in draft form and there has not been a consultation on the document with external stakeholders to finalize it. There is an urgent need to have a final approved STP to guide planning and rationalization of resources in the department.
7. Most districts have not established District Health Councils in accordance with the National Health Act.
8. There is a disjuncture between service delivery targets and financial management and budget processes, which are reportedly not consultative and transparent.
9. Respondents indicated that the cost containment strategy to curb overspending in the department was imposed in a top down manner with little consultation of service delivery managers to provide their feasible inputs into the plan. The

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

strategy has no concurrent plan to monitor and measure the direct and indirect impact of the cost cutting measures on service delivery.

## 2. GENERAL LEADERSHIP

2.1. Respondents were of the opinion that, despite the existing resource limitations, in-roads have been made in KZN to improve health care in the province and there are many examples of best practices in operation. However, currently the KZNDOH is faced with many challenges at both political and administrative leadership levels, thus exacerbating the factors that have led to over-expenditure. There is a general perception that the leadership since 2005/06 had poor insight into the service delivery needs and priorities of the province and had failed to put good governance structures in place that could have led to early identification of problems and appropriate remedial strategies. The pending fraud and corruption charges against the previous political leader and SCM manager have dented perceptions of leadership integrity and resulted in many demotivated departmental managers.

2.2. Respondents were of opinion that the current executive committee (EXCO) lacks the necessary health background to make informed decisions on critical and strategic aspects of public health and has no sense of urgency to act on these issues. There is a perception that the financial cluster is the final decision maker on service delivery issues, based on financial indicators. Others believe that decisions are largely driven and influenced by perceptions from the Provincial Treasury and consequently the moral high ground has been taken away from current health leadership, rendering it largely ineffective.

2.3. Managers at institutions, districts and even within the head office expressed an urgent need for decisive and visible leadership that has insight into the strategic needs of the department, is service delivery focused and is able to put systems in place to deliver on the priorities and core mandates of the department.

2.4. Frequent reference was made to the need for systems that used to be functional to ensure good governance, namely the Financial Committee (FINCOM) that had scheduled meetings and respected the service delivery needs; MANCO that had met frequently and discussed strategic issues decisively more than operational issues and

lastly the budget process that was consultative, transparent and considered inputs from each programme manager. None of the respondents are happy with the new head office structure and feel that it is bloated and has become too bureaucratic and is another service delivery bottleneck. Some systems could have been sustained, but have been discontinued.

2.5. The poor leadership is considered to be a setback to past provincial health achievements in KZN. Should the current leadership vacuum continue, the danger is the reversal of gains made in the past decade which will put more pressure on the already fragile health system.

2.6. The National Department of Health (NDOH) has not been able to provide adequate leadership and stewardship with regard to the development of national plans that are implementable and are accompanied with the necessary resources. Although NDOH provides good policies for provinces to follow, there is a lack in providing consistent supportive leadership. An example was made of the new immunization campaign where national has gone on massive marketing of the campaign without determining the readiness of provinces to implement. Other examples of this include ILembe district that did not commence the implementation of the new vaccines on the 1st of April 2009, despite the additional funding provided by national to kick-start the programme. The dual therapy PMTCT protocol implementation was delayed in some districts and was not rolled out from the 1 April 2008 start date. This is exacerbated by national targets that are not necessarily informed by resource availability and the realistic ability of provinces to achieve them. It was suggested that national plans should be costed and have an indication of resource requirements for implementation with clear norms, standards and guidelines for the provision of specific services.

2.7. Financial delegations, albeit limited, seem to be clear and all managers are reported to adhere to and perform within their delegations.

# 3. PLANNING

## 3.1. SERVICE TRANSFORMATION PLAN

3.1.1. Although KZNDOH started developing the Provincial Health Service Transformation Plan (STP) during 2006/07, the province does not have an approved STP and the

current draft document has only been circulated internally within the KZNDOH for inputs. The public, and external stakeholders, have not been consulted. The STP is reportedly aligned with the Provincial Spatial Economic Development strategy, the Provincial Growth and Development Strategy and the key legislative imperatives that include the National and Provincial Health Act, Mental Health Act and the White Paper on Transformation of Health Services. The final draft of the STP was signed by the MEC for Health in June 2007, and submitted to the NDOH. The norms and standards provided in this draft document are said to be Province and District specific and were informed by data collected using the Integrated Health Planning Framework review tool that was provided by the NDOH and from consultations with Health District Management Teams and the Local Government Representatives.

3.1.2. The ultimate aim of the provincial STP is to reshape the health service delivery system in order to provide accessible and quality health care services to all, using a plan that will enable the province to deliver on all priorities through the implementation of the primary health care approach. The plan will therefore see the KZNDOH gradually moving away from a fragmented and hospital based system to that of a decentralised, less hospi-centric and more cost effective health service model.

3.1.3. The STP seeks to be a comprehensive document that takes the diverse characteristics of the province into consideration. The main priorities of the plan are to provide an easily accessible, cost effective, efficient and quality health care service that adheres to the Patients' Charter and observes the Batho Pele principles.

3.1.4. In line with the aim to strengthen the Primary Health Care system over the next 10 years, the STP recommends increasing the number of Community Health Centres (CHCs) from the current 17 to 90 CHCs by 2016 and recommends increasing the accessibility to and utilisation of PHC services.

3.1.5. There are huge cost implications for a successful implementation of the STP that are mainly driven by infrastructure development and human resources allocation. The STP is currently costed at almost R10 billion to implement over the next 10 years. The plan reads well and addresses strategic issues to strengthen the PHC and the DHS systems, but still needs to be circulated to the public and other external stakeholders so that departmental plans may address public interests and recommendations. The affordability of the STP needs to be assessed.

3.1.6. Some programme managers are already utilizing the draft document during planning and have found it useful in determining norms and standards to guide the allocation of resources for specific services, e.g. step down beds, maternal and child health services and this illustrates the urgent need for finalisation of the STP to guide planning and rationalization of resources.

## 3.2. ANNUAL PERFORMANCE PLAN

3.2.1. The annual plans of the province are comprehensive and outline very clearly the priorities of government from the MDGs, national priorities, social cluster of cabinet priorities and the departmental 12 point plan. Alignment of plans to each other is emphasised. Each plan presents a situational analysis that gives an overview of what has been achieved and current constraints to service delivery. The achievements and challenges of the past financial year are used as the point of departure from which the priorities are developed for the subsequent year's annual plan.

3.2.2. Although the plans are well written and highlight relevant strategic issues that are prioritised in all strategic plans and align with the priorities of the five year strategic plan, respondents indicated that their inputs into the plan were ignored and misrepresented. Other criticisms included that it was a desktop exercise and that implementation does not necessarily adhere to the plans nor is it properly monitored to manage inevitable deviations that have cost implications. Targets in the operational plans are not always aligned with the annual plans because of the flawed consultation process. There is also a lack of urgency regarding implementation of certain critical aspects. For example, the Provincial Drug Depot was reported to have limited space to store the increased drug demand and has been operating illegally for the past 5 years. Although the issue has been included in the 2005-2009/10 strategic plan and all the APPs including the new 2009/10 APP, it has never been resolved. There are allegations that the delay has been largely caused by political interference and lack of decisiveness with poor insight into the cost and litigation implications for storing drugs under unsuitable conditions. This issue could have easily been prioritised over other matters of equivalent expense - such as office space.

3.2.3. The plans highlight challenges that require urgent attention, ranging from management of HIV and AIDS, TB/HIV co-infections through to the health sector readiness for the 2010 World Cup Soccer event in terms of EMS and related services. However, although the service delivery managers reported that they set realistic

targets based on their current resources, the finance component indicated that service delivery sections develop plans beyond available resources and allocated budget and cites this as the main cause for overspending. Again, the ART programme was quoted as an example. The IST review, however, found that poor management and poor team work have contributed to the overspending.

## 3.3. ALIGNMENT OF PLANS

3.3.1. The Provincial APPs seem to align well with National and International Plans and declarations. Analysis of the 2008/09 and 2009/10 APPs revealed increasing alignment with previous plans, provincial priorities, past achievements and challenges and highlights the relevance of the strategic objectives. The 2009/10 APP includes new national priorities such as the dual therapy for PMTCT and the new pneumococcal vaccine for children.

3.3.2. Although the plans show evidence of intensive desktop review and critical analysis, interviews revealed conflicting reports from the strategic planning unit and service managers. The latter group pointed to a deficient consultative process to develop the plans whereas the planning unit indicated that they conduct a thorough consultation to request inputs from the mangers using a specific template and even using the MANCO as a platform to get these inputs. It seems that the major issue is communication within components, between General Managers and their staff and even with each other. Respondents also pointed to instances of ‘bypassing lines of communication’ where some managers reportedly communicate directly with the executive authority or with either the CFO or HOD without notification or involvement of the General Manager.

3.3.3. The district level planning is not aligned to the provincial plans. Some respondents in ILembe even admitted that the provincial APP was not used as a reference document to inform their plans, although the district manager acknowledged reference to the provincial plans.

3.3.4. Of note is that the format of the provincial APP does not seem to be cascaded down to the District Health Plans (DHP). In the case of the ILembe district, the DHP loses the detail and comprehensiveness that informs the reader on the district health structure; the vision and the mission of that district; the legislative frameworks, policies and strategies that inform its functioning; nor does it give an overview that informs the

reader of the priorities of the district as informed by the National and Provincial priorities. Achievements and challenges of the previous APP are not referred to either. The IST review found that that the DHPs do not comply with the national framework. Important information is missing, like the strategic vision and mission of the district endorsed by a foreword from the district manager, the district structure or organogram drawn into the plan as an annexure for ease of reference and to give a better understanding of what the district is as well as a brief description of the demographical characteristics of the district. The 2007/08 annual plan and report states that DHPs are signed off by the MEC and the role of the HOD is not mentioned at all in approving the plans as the Accounting Officer.

3.3.5. Although the IST review found a consistent attempt to describe the distribution of health services in the province, including illustrative tables on trends for public health expenditure, service utilisation, Patient Daily Equivalents, etc, these seem to be added in the reports more as a matter of compliance and are not accompanied by a critical analysis on whether resource distribution is sufficient for service delivery needs. The methodology is also not clear on how the targets are set and how the calculations are made by each facility on the PDEs. Respondents raised these challenges in the interviews, but they are not reflected in the plans, thus showing the disjuncture between plans and targets and management buy-in and commitment.

# 4. GOVERNANCE

4.1. This review had to be done in the absence of critical inputs from the acting HOD and the Chief Operations Officer of KZNDOH. There seems to be a lot of dissatisfaction with current leadership, as highlighted above. The appointment of an HOD has not been finalised and the acting HOD has been seconded from the Office of the Premier.

4.2. Institutions and districts feel that the head office is not well coordinated and submissions that go to head office are often not responded to promptly. This delays implementation and service delivery. Head office is reportedly trying to control most spending such that managers divorce themselves from the responsibility of current overspending and refer blame to EXCO. The Management Committee (MANCO) comprising General Managers, Senior General Managers including the CFO and the HOD apparently does not meet frequently and fails to discuss strategic issues. The EXCO members show very little commitment to the MANCO meetings with

inconsistent attendance and the tendency to leave meetings before they are concluded. The Finance Committee meetings had allegedly been phased out for most of 2006 to 2008 according to some senior managers interviewed until the financial crisis in late 2008 and only resumed again this year. It largely consists of MANCO members. The SCM and other financial managers for budget control and expenditure control get invited ad hoc, but are not permanent members because their General Managers and the CFO sit in the meetings. Finance has monthly meetings for its component. This was one of the inconsistent findings from the interviews with managers within finance and the interview with the head of finance. Minutes, however, could not be obtained to verify or dispute these allegations. The interviews revealed various inconsistencies, poor coordination, lack of transparency and poor communication by senior management with the rest of the department. This creates concern around the senior leadership and some decision making processes.

4.3. KZN has a Provincial Health Act but none of the managers were aware of it or made reference to its existence. A Provincial Health Council was established in December 2005 in accordance with the National Health Act. It is chaired by the MEC and meets quarterly. The District Health Councils have not yet been established and this was confirmed at ILembe district during the review. Hospitals, Community Health Centres and Primary Health Clinics have boards or committees that represent the interest of communities and oversee governance. The quality of discussions in these structures is, however, not known. Other governance structures include four Mental Health Review Boards at Durban, Empangeni, Newcastle and Pietermaritzburg.

4.4. There is a chief directorate for corporate governance whose functions could not be confirmed because there was no interview with the acting HOD or the General Manager heading the component. The department also has an internal audit and risk management component that works closely with the Auditor-General and the Internal Audit Unit of the Provincial Treasury in the execution of its duties. It deals with all audit matters affecting health institutions and ensures that risks are identified and mitigated through the implementation of internal control measures. Inclusive to its function has been the development of the fraud and corruption strategy. As a result of the internal risk assessment and audits done by the unit, the department has put certain key controls and systems in place. The audit reports have thus been unqualified because the systems are in place.

# 5. SERVICE DELIVERY (HIV, TB AND MCH)

5.1. Respondents pointed out that KZNDOH is, despite internal and external challenges, in the process of transforming services and responding to service delivery needs. Cognisance is taken of the diverse characteristics of the province where 54% of the total population live in rural areas and with high mobility of communities to urban areas to seek health care, for example. eThekwini has experienced a significant increase in the number of health service users.

5.2. Utilisation of services has increased over the years and is attributed by the KZNDOH to the improved district health system and primary health care, as is demonstrated by the increased rate of primary health care headcounts in the province from 17,353,569 in 2005/06 to 22,941,828 in 2008/09. There is a high burden of disease, including TB and HIV infections, and a range of other chronic illnesses. The department has commissioned a study that is in progress of determining the extent of the burden of disease that will assist with future plans and budgeting.

5.3. Common challenges noted in all interviews included the lack of guidelines to cost services and lack of capacity at institutions to properly cost their packages of services resulting in under allocations of budget. ILembe district management cited that there are two district hospitals, Maphumulo and Untunjambili, that are in close proximity to each other and are providing similar competing services, and also pointed out that resources are not being rationalised. Managers indicated that they are unable to have pro-active, preventive plans, but tend to focus on reacting to problems. This is because of limited financial resources and the lack of good working cooperation with the finance component. Respondents also noted that the District Health Care System is experiencing undue high service loads that are mainly due to poor rationalization of services and the continued preference by patients to utilise hospitals compared to clinics.

## 5.4. HIV AND AIDS

5.4.1. The 2009 provincial budget speech indicated that the budget allocation for HIV and AIDS in KwaZulu-Natal has been rising in the past four years, and continues to do so over the MTEF.

5.4.2. The HIV programme is considered a priority by the executive authority and HIV treatment figures have grown from 11 499 patients on ART in 2004/05 to 205 120 patients in 2008/09. The province has had problems with long waiting lists to initiate patients on treatment in the past. Although these could not be quantified, the programme developed strategies to respond to the need, including the accreditation of NGOs as sites to initiate treatment and the PHC clinic model of roving doctors to initiate patients. These innovations will be expanded to include pregnant women being initiated at antenatal clinics.

5.4.3. The province seems to have adopted a strategic approach in the utilisation of support from several international financial and technical donors. The Global Fund grant has been mainly used to improve the health system and health service programmes through different activities and making sure that there was no duplication of services. Funded programmes had more emphasis on health system strengthening, infrastructure improvement, prevention, research and care and support.

5.4.4. The ART programme experienced high attrition rates of nurses associated with the introduction of OSD as HIV qualifications did not qualify for OSD. The programme lost nurses to PHC clinics while it is also experiencing difficulties in recruiting pharmacists because the entry levels are too low and unattractive. Staffing norms stated in the ART accreditation guidelines are outdated and no longer practical to adhere to due to increased numbers of patients on treatment.

5.4.5. The main concern with this programme is the sustainability of ART drug management of the high numbers of patients requiring treatment in KZN. There is a need for a more reliable baseline of estimated number of people requiring treatment in KZN annually so that the province is able to plan targets that are based on the need which will then inform budget allocation for ART drugs and avoid the 2007/08 incidence where patients on ART increased by 75% from the original target in the business plan.

**5.5. TB**

5.5.1. The major cost drivers for TB are drugs, laboratory diagnostics and human resources. The programme manager believes that the reason for over-expenditure patterns within the department is mainly due to undercosting of services. He believes that facilities and district financial managers are not skilled in proper costing of health services. Consequently, TB is always perceived to underspend annually and this does not tally

with the performance activities and targets. True spending is hidden in the General Medical Condition objective code which is consequently always overspent. Unfortunately, TB is therefore allocated a reduced budget based on previous spending history which is always inaccurate. NDOH provides plans and targets but the department sets its own realistic targets based on available resources so that they are achievable. There seems to be little leadership from the current acting HOD with regard to the TB programme, but good support is received from the General Manager for strategic health programmes.

5.5.2. The programme is striving to find cost effective innovative methods to implement the TB crisis plan and is also assisting facilities with a method they could use to cost TB services and allocate a proper budget to facility TB services. One of these methods is the community based model to treat MDR patients. This was stimulated by the insufficient bed capacity at MDR hospitals, especially King George V hospital, which is a MDR TB dedicated hospital in the province. The model is discussed in detail as a best practice model (Appendix 5) that illustrates effective use of information for management and to guide development of cost effective innovative approaches to improving services.

5.5.3. The province has improved the tuberculosis cure rate from 35 per cent in 2005/06 to 85 per cent in 2007/08 which is attributed to TB being declared a national emergency. This resulted in accelerated efforts that prioritised the implementation of the TB crisis plan and made TB a separate directorate from the communicable diseases unit. The greatest achievement has been the decentralisation of MDR TB management to make services more patient friendly and to bring services closer to patient homes and families. This has relieved bed occupancy making more beds available at hospitals because patients are followed up and maintained in communities. It also contributed to the decline in the defaulter rate that the province is starting to see. The decentralised community based treatment model for MDR TB is being investigated for its cost effectiveness compared to hospital based treatment before it is rolled out.

## 5.6. MATERNAL AND CHILD HEALTH SERVICES

5.6.1. The main reported challenges in the maternal and child health service include the lack of a strategic plan to guide accelerated activities towards achieving the MDGs; lack of necessary resources to function effectively, e.g. the director for MCH was only appointed in October 2008 and the programme has always been paired with other

programmes like nutrition and HAST under one director which made it lose the necessary strategic focus.

5.6.2. It was also indicated that services for maternal health are not properly costed at institutions and the general budget allocation for MCH services are not adequate to meet the priority targets and MDG targets. Integration of services and especially PMTCT which has been migrated from HAST is still a huge challenge at planning, M&E and implementation level. Community and prevention based programmes are weak and the immunization coverage is below target.

5.6.3. Respondents also noted that Monitoring and Evaluation is poor and does not inform surveillance and research to evaluate the impact of current programmes in addressing the determinants for maternal and child morbidity and mortality rates.

# 6. RECOMMENDATIONS

## 6.1. GENERAL LEADERSHIP

6.1.1. The KZNDOH needs to appoint an HOD as a matter of urgency and stabilise the top management level.

6.1.2. The National and Provincial departments of Health need to play a more visible and supportive leadership role regarding prioritisation and rationalization of resources to achieve cost containment.

6.1.3. There should be a tool developed that guides the methodology for managers to develop their own cost containment plans that critically analyse core from non core activities without a negative impact on service delivery. Such plans should be developed using a consultative process, should facilitate adherence and utilise regular M&E.

6.1.4. National policies need to take into context the resource restrictions that are experienced by provinces, especially to ensure that new programmes and the set targets are achievable and sustainable.

6.1.5. NDOH should provide a more visible leadership and stewardship role and consult with provinces before imposing plans in a top down manner.

6.1.6. National plans should be costed to provide an indication of required resources with norms and standards for implementation of services to ensure a continuous standardized service throughout provinces and to enable provinces to budget accordingly for the sustainability of introduced plans.

6.1.7. The HOD's first priority should be to create an enabling environment for coordination of structures and functions in the head office, through a head office structure review, role clarifications and better communication with the rest of the Department.

6.1.8. Governance structures like MANCO and FINCOM need to be put back in place, meet more frequently, have the authoritative mandate of making strategic decisions for the KZNDOH that are transparent, adhered to and monitored for compliance.

6.1.9. Management of over-expenditure is a core senior management function together with its effects on service delivery. This needs to be explicitly on the agenda of senior management.

## 6.2. PLANNING

6.2.1. The finalisation of the STP should be prioritised for the 2009/10 financial year and proper processes embarked on to ensure that relevant external stakeholders provide their inputs into the plan.

6.2.2. There should be better coordination, integration and monitoring of plans in the department. The resources of the strategic planning unit should be used optimally for maximum benefit to address some of the planning challenges.

6.2.3. The targets that are set in the provincial plans need to be realistic, agreed upon by the line and programme managers and set based on affordable national guidelines.

6.2.4. There is an urgent need for the NDOH to develop norms and standards regarding resource allocation at all levels of the healthcare system.

6.2.5. Line and programme managers, especially at institutions, need to be trained and given guidelines on how to cost different services and packages of care as this affects planning and budgeting.

## 6.3. GOVERNANCE

6.3.1. There should be clear written guidelines delineating the areas of responsibility between the MEC, the HOD and the CFO.

6.3.2. Senior Managers should be made accountable for their own budgets and monitored for adherence and compliance to the PFMA.

6.3.3. 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.

## 6.4. SERVICE DELIVERY (HIV, TB AND MCH)

6.4.1. 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).

6.4.2. There should be improved coordination and collaboration between various provincial departments to ensure that Health focuses on its core functions, e.g. the Targeted Enterprises Development should be a function of the Department of Economic Development and not Health.

6.4.3. The Department should focus more decisively on strengthening the Primary Health Care system in all the districts and allocate resources accordingly.

6.4.4. Budget allocations (at institutional level) should be aligned to the priorities of the institutions and these institutions should not be allowed to create competing service offerings to the same/similar community in one district or in neighbouring districts.

6.4.5. There should be a focus on developing refined funding guidelines for the HIV strategy. The ever increasing demand for ARV drugs means that there is a need to develop a more sustainable model that will take into consideration issues of affordability, equity and accessibility.

# Human Resources

## 1. INTRODUCTION

**Box 3: Key findings from the Human Resources review**

1. Restructuring of the KZNDOH has resulted in a bloated and bureaucratic structure at Head Office, where the number of general managers (GMs) has increased from 4 to 14 within a two and a half year period. In addition, there are three different concurrent "approved" structures; which have neither been costed nor budgeted for, and it is unclear which structure is being implemented or has been adopted.
2. There are confusing lines of reporting, exacerbated by the lack of a comprehensive change management strategy to accompany the restructuring process.
3. There is limited interaction between the HIV&AIDS, STIs & TB programmes at head office and it is only at the district level that these seem to be better integrated.
4. KZN Provincial Treasury has given clear instructions on cost containment and this in turn has resulted in the finance function encroaching in some of the core activities of the other functions and in the process disregarding service plans that are in place. The ongoing moratorium on staff recruitment within the Department is creating a situation where existing HR policies and procedures are being ignored and impacting negatively on service delivery.
5. Leadership commitment to performance management is limited and the performance management process is inadequate.
6. HR does not seem to play a crucial role in managing and coordinating the performance management system and staff development, with the finance function usurping some of the HR functions. There is largely crisis management which hampers proper alignment of programmes to strategic priorities and HR management requirements.
7. It was reported that PERSAL is not effectively maintained, ghost workers appear on the system and there are insufficient controls around salary administration.
8. The implementation of occupational specific dispensation (OSD) has been consistently identified as one of the major contributors to overspending. It has also created a lot of confusion and unhappiness amongst nurses and other health

**Box 3: Key findings from the Human Resources review**

professionals as there is no clear way forward regarding this matter. There has not been sufficient communication in terms on how the outstanding issues around OSD will be addressed and the long term strategies to address this matter.

9. A moratorium on staff recruitment is severely affecting the capacity of the various components at provincial and district levels to provide quality service delivery. Training of staff in critical areas linked to service delivery has not occurred for some time due to financial constraints. HR Managers seem to be in a state of paralysis as they cannot fully implement the stipulated policies but have to operate on the basis of instructions from the Finance component (relating to a moratorium on recruitment and severe curtailment of training activities).

## 2. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

2.1. The KZNDOH has a proposed Human Resource Management Structure aligned to the DPSA generic HRM Structure (March 2009) as well as Performance Management and Development System for Salary Levels 1 to 12 and Employee Performance Management and Development System (April 2007) documents which outline various delegated powers, ranging from employment relations, leave arrangements through to service terminations.

2.2. HR planning and policy development functions were moved by the former HOD to the “Strategic Planning” component within M&E. This resulted in confusion with regard to the general human resource management where some recruitment within the head office was done outside HR. The cost containment strategy implemented by finance has severely hampered service delivery within HR as travel is limited; training has been reduced and there is a moratorium on recruitment of new staff.

2.3. KZN Provincial Treasury has given clear instructions on cost containment and this in turn has resulted in the finance component interfering in some processes e.g. unnecessary delays in the procurement processes. Most managers at head office, district and institution level feel marginalised and powerless. They were left with no control over their budget and they are forced to operate with drastically reduced budgets. This has also led to the interference of senior management in the day to day running of programmes. The most frustrating issue for the Programme Managers is

lack of clear communication and consultation from senior management in dealing with the current financial crisis.

2.4. Limited "functional delegations" have resulted in confusion of roles and responsibilities as well as:

2.4.1. Interference in the day to day running of programmes at head office and district level which leads to duplication and confusion as well as unnecessary waste of scarce resources.

2.4.2. The Ilembe District Manager, the District Programme Managers and Stanger Hospital Manager indicated their frustrations of being unable to make decisions on certain aspects of the management of their programmes. Communication and decision making processes from head office were very slow and hampering service delivery.

2.4.3. Appointment of staff at higher, middle and lower levels has almost come to a standstill due to a moratorium on staff recruitment that is currently in place.

# 3. INTEGRATION AND CO-ORDINATION

3.1. Many respondents pointed out that the bloated structure at head office is not adding value to service delivery. The structure was driven and recommended by an external consultant and it is highly questionable whether most of the positions that have been created from this restructuring process are really effective. One manager noted:

> *"You could remove half of the managers at Head Office and nobody will notice that they are gone".*

3.2. The KZNDOH Strategic Plan 2005-2009/10 states that the Department has adopted the comprehensive approach to the management of HIV&AIDS, STIs and TB. However, there is very little interaction between the two programmes at Head Office; it is only at the district level that they seem to be integrated. Although the province acknowledges the shortcoming of having the HIV&AIDS and TB programmes running as vertical programmes, this creates serious challenges in terms of reporting and management of data that is generated at institutions and PHC levels.

3.3. Integration and coordination does not seem to exist in the planning and budgeting phases of the programmes at both national and provincial levels, while it is expected to be implemented at service delivery level. The M&E component has highlighted some of the critical challenges that are facing the KZNDOH in terms of information coordination among staff and programmes at various levels. Information management systems are currently managed by the various M&E components internally and externally by the State Information Technology Agency (SITA) which impacts the safety and quality of the gathered information.

3.4. It appears that the reporting structure at HOD level contributes to the general insufficient integration and coordination within KZNDOH. The current span of control of the HOD is too wide with too many sections reporting directly to the HOD and these divisions appear to work in isolation from the rest of the structure. These sections include: Risk Management and Internal Audit; Communications; Office of the Health Ombudsperson; Special Projects; Strategic Health Programmes; Legal Services; Corporate Services and M&E.

# 4. HUMAN RESOURCE PLANNING

4.1. Human Resources Management Service is located within the Institutional Integrity and Corporate Governance Cluster and its role is to ensure the provision of effective Human Resource Management Policy Framework and Systems, enabling effective and efficient decentralised management, development and accountable administration of human resources by institutions. As this post is currently vacant, the GM (level 14) reports directly to the HOD.

4.2. Although good HR policy and employee performance management and development documents exist within KZNDOH, these are not fully implemented and there are several challenges, listed below:

4.2.1. There is virtually no coordination and alignment between planning, budgeting and service delivery. Most of the programme managers do not have full control of their budget and most of their plans are not necessarily informed or aligned to the STP.

4.2.2. HR seems fragmented at head office and as a result there seem to be different interpretations of key indicators that are outlined in their plans. Already there are signs

that some of the institutions are operating on the basis of limited credible information that is leading to huge financial losses for the Department.

4.2.3. The existing HR plans are not fully implemented due to the moratorium on recruitment as one of the cost containment activities driven by the Provincial Treasury. Given this situation, little effort and commitment exist to align HR plans to the existing STP.

4.2.4. The HR unit is isolated within the Department, to a degree that it does not play a meaningful role in planning processes to address the ever increasing disease burden and enable staff capacity related to service delivery. Some of the district offices have one Programme Manager responsible for over 30 PHC facilities. There are Programme Managers at all levels responsible for as many as four portfolios. This leads to frustration and low morale amongst staff at all levels and there seem to be no clear strategies to address this situation by senior management.

# 5. ORGANISATIONAL DESIGN AND ESTABLISHMENT

5.1. KZNDOH has for a number of years been using the services of an external consultant (who later became the HOD in 2006) to restructure its head office structure. The number of GM's (level 14) has increased from 4 to 14 within a two and a half year period. The effects of the restructuring during the reign of the former HOD are being seriously felt now. The restructuring ended up with a costly, bloated structure at head office which is the major reason for the existing confusion and ineffectiveness within the Department. In addition, there are three different concurrent "approved" structures; which have neither been costed nor budgeted for, and it is unclear which structure is being implemented.

5.2. More than one structure has been proposed and various units are using different structures as the basis for their operations. There is an absence of clear strategic direction, which impacts on establishing a structure which is aligned with strategic priorities and service delivery requirements. The HR unit is currently developing organisational design norms and standards in the absence of guidance from NDOH.

5.3. In the midst of the disorganised state of the head office, there are significant discrepancies and general disregard of existing job descriptions. The fact that a number of staff are responsible for more than one portfolio at a time, results in

inconsistencies across job titles. Some of the district positions are not necessarily aligned to the head office structure and one such example is the creation of an Area Manager position that is supposed to coordinate and support the activities of more than one district, but seems to be completely ineffective and irrelevant. There seems to be very little contact between the Area Managers and the various district Programme Managers and most of the communication seems to be directly between district offices and the provincial head office.

5.4. There should be an urgent and serious commitment from senior leadership to address the bloated structure at head office. This would mean that all the positions at senior level should be properly analysed and appropriate strategies designed to address this situation. This will include addressing the fact that the previous restructuring processes remain incomplete and have created a lot of confusion.

5.5. The Accounting Services and Technical General Manager indicated that KZNDOH has a staff complement of 67 246 and there are serious challenges in doing a proper audit of the actual filled positions, especially at institution level.

5.6. It was reported that there are many 'ghost' employees and double payments happen within the system due to inefficient controls and system alerts, including when employees exit KZNDOH. This situation is preventing the effective management of over-expenditure related to compensation of employees and requires urgent attention.

## 6. RECRUITMENT

6.1. The current moratorium on recruitment means that a number of critical positions cannot be filled despite a serious lack of capacity. This in turn has a negative impact on service delivery at various levels of the Department.

6.2. The overly bureaucratic recruitment procedures from DPSA and the moratorium imposed by head office on staff recruitment have 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.

6.2.3. Existing staff being overwhelmed with the workload.

6.2.4. Confusion in terms of roles and responsibilities.

6.3. A number of managers expressed extreme frustration with the current moratorium placed on staff recruitment as it does not take cognisance of the increased demand for service delivery. The moratorium has also resulted in key staff leaving the Department to other available opportunities within other sections of government and the private sector. It was reported that there is a need to engage all stakeholders in developing comprehensive and innovative alternative cost containment measures and organisational design strategies.

6.4. Staff recruitment seems to be one of the biggest challenges facing the Department. For example, there is currently a shortage of about 78% of Pharmacists in the whole KZN province and this shortage is acutely felt in rural areas. In addition, KZNDOH is only able to produce 60 to 70 pharmacists per annum which are far below the required numbers, although a new strategy of developing community based Pharmacists seems to be bearing fruit.

6.5. It is difficult for the KZNDOH to recruit key personnel because the private sector offers more attractive salary packages. Key personnel are also reluctant to work in rural areas because of an absence of attractive incentives, suitable accommodation and recreational facilities, amongst others.

# 7. PERFORMANCE MANAGEMENT

7.1. A comprehensive Employee Performance Management and Development System document exists, as developed by HR in April 2003. However, the current reality is that limited performance management is undertaken within KZNDOH and the actual implementation of these policies and guidelines remains a major challenge.

7.2. The limited commitment to performance management, even at senior management levels, results in the arbitrary awarding of rewards and without linking these to the performance management system. The less effective role of the HR unit has further aggravated this situation.

7.3. Added to this challenge is the fact that some staff members are responsible for more than one portfolio making it difficult to align performance management with job functions. Programme Managers' plans are generally not linked and aligned to the overall plan of the Department which result in a discord between the various elements within this process. Poor communication from senior management also impacts negatively on the implementation of the performance management system.

## 8. RETENTION

8.1. Despite staff losses, no evidence was found of the existence of a clearly defined retention strategy in KZDOH. The proposed Human Resource Management Structure developed by HR also does not touch on the issue of retention.

8.2. OSD has tried to address retention of staff, but the implementation of OSD was not completed within KZNDOH and there are unexplained issues. It was reported that the pharmaceutical staff category is one of the worst affected and the Pharmacy has lost a number of pharmacists to the private sector.

8.3. The limited utilisation of the PERSAL system regarding critical staff data, limits the understanding of the dynamics around vacancy rates within various units. Whilst it might be slightly easier to understand the situation at head office, it becomes much more complicated at district and institution levels.

8.4. The biggest retention challenge is in rural areas where it is extremely difficult to attract skilled people.

8.5. Factors that impact on retention in general include:

8.5.1. Poor competitive remuneration packages especially in comparison with what is offered in the private sector.

8.5.2. Despite the fact that the province has a large rural population, there is an over-concentration of health personnel in urban areas and an underprovision of health personnel in rural areas.

8.5.3. Emigration of highly trained professionals - largely amongst nurses and doctors.

8.5.4. Competing with other provincial departments to attract and retain scarce skills, particularly Gauteng, which is seen as a province with more opportunities than KZN.

8.5.5. The impact of HIV&AIDS on the health workforce drains the resources and programme managers are overwhelmed with the workload.

8.5.6. Excessive work demands and an unpleasant workplace environment around hospitals and some of the clinics in poor areas.

8.5.7. Insufficient developmental opportunities with a moratorium on both staff recruitment and training.

8.5.8. Inadequate career progression opportunities.

8.5.9. Lack of recognition of performance.

8.5.10. Poor communication and lack of effective leadership skills has led to poor job satisfaction for most of the employees within the department.

8.5.11. Lack of accommodation, transportation systems, schooling and recreational facilities in rural areas.

8.6. In the absence of a clearly defined strategy from the KZNDOH, it is difficult to see how retention will be addressed and NDOH should provide guidance on this matter, because many of the problems noted are not unique to KZN.

# 9. REWARDS

9.1. The Department has approximately 67 246 employees, and their compensation is by far one of major cost drivers. The allocation of compensation of employee costs as a percentage of total expenditure has steadily increased from 56% (in 2005/06) to 59% (in 2008/09). Poor management of information systems results in unnecessary expenditure that further escalates the costs related to HR.

9.2. There appear to be insufficient controls around salary administration. Examples quoted during the interviews included:

9.2.1. Potential ghost employees.

9.2.2. Full time employees receiving two salary payments for occupying two posts.

9.2.3. No control measures to identify potential duplicate payments made via employment agencies.

9.2.4. Limited alert mechanisms when an employee exits employment.

9.3. KZNDOH has a financial performance incentive scheme for salary levels 1 to 12. This scheme includes the awarding of performance bonuses, subject to the measures as set out in the Performance Bonuses guidelines.

9.4. There are serious challenges to ensure effective measures are in place to manage rewards processes within the KZNDOH. Problems such as astronomical overtime claims, “ghost employees” drawing salaries from KZNDOH and the OSD implementation were reported.

9.5. The arbitrary promotion and incremental increase of salaries of certain administration staff (from level 6 to12 in some cases) has strengthened the perception that awarding of rewards is not necessarily linked to performance. It appears that there is not much commitment from staff to properly align their activities and plans to the overall departmental strategies.

9.6. The KZN IST Team did not discuss OSD related issues in detail because of the current OSD implementation investigation at national level. However, various issues in the KZNDOH were raised regarding the implementation of OSD:

9.6.1. The OSD was not costed properly. The personnel over-expenditure from OSD has impacted negatively on other staff appointments and has most likely contributed to the current moratorium on staff recruitment.

9.6.2. Some of the nurses were overpaid and there was an attempt to recover some of these funds.

9.6.3. Respondents felt that the OSD process was not properly planned and implemented and resulted in unhappiness and confusion.

9.7. There is need to go back to the drawing board around OSD and urgently address the outstanding issues, including the disparities in payment of staff at the same level - including staff at lower levels being paid more than those at a higher level.

## 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. A moratorium on training and development of staff currently exists in KZNDOH due to cost pressures.

10.2. It was found that HR development policies exist, but apart from the current moratorium, execution is generally problematic. The KZNDOH 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. The HR component is not playing a central role in the performance management and development processes.

10.2.2. The HR component is not properly aligned and coordinated and is also not prioritised within the Department.

10.2.3. Ongoing training needs assessment and impact evaluation are not done.

10.2.4. Not all occupational categories have access to training, e.g. doctors and training budgets are not fully managed by HR.

10.2.5. The HR functions are not generally responsive to the changing job requirements of staff.

10.2.6. The current cost containment initiatives impede or disrupt the training process as special authorisation is required from head office.

10.2.7. Lack of mentors and coaches for junior staff impacts negatively on their morale and the quality of service.

10.2.8. ABET and other related programmes are not available to all staff levels for advancing personal and professional growth and development.

10.2.9. No competency framework is used in planning the training programmes.

10.2.10. No action is taken to ensure that all talent in the department is effectively groomed and utilized.

10.3. It is clear that training should be appropriately funded, focused and aligned to priorities. Inappropriate reductions in the training spend or insufficient training programmes can seriously impair service delivery and increase cost in the long run.

## 11. HR INFORMATION SYSTEMS

11.1. There is an effort to standardise and have one common system in place. This can, however, only be realised in the distant future as the current information system is still too fragmented because even at a provincial level various systems are being used. There are various IT systems that are currently being used by the department and there is a need for standardisation and centralisation of these systems. A centralised standardised information system at provincial and national levels will contribute

towards more reliable information being collected and being available for planning purposes.

11.2. PERSAL seems to be used largely at head office and some district offices and institutions. Some of the clinics have received the necessary equipment, however, the biggest drawback is lack of training due to severe budgetary constraints. The situation is more critical at PHC level and this in turn seriously compromises the quality of data that is used for planning.

11.3. KZNDOH HR unit uses PERSAL largely as a planning system for its 67 246 staff complement but this is hampered by cases of incorrect data, insufficient capacity and poor controls. KZNDOH is looking at aligning this into one common system. The main challenge is the limited skills amongst staff at PHC level to fully utilise the system and the lack of financial resources to put relevant training programmes in place.

# 12. RECOMMENDATIONS

## 12.1. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

12.1.1. The current centralised model should be reviewed to determine whether withdrawing delegations adds value in terms of cost containment and service delivery.

12.1.2. A clear matrix in terms of delegation of authorities and decision making at various levels should be completed. This should be in line with a RACI matrix where different people are responsible, accountable, consulted or informed.

12.1.3. The roles and responsibilities of district and institution managers should be clearly defined, especially regarding their interaction with the PHC clinics and to eliminate overlaps. Area Managers' (responsible for 'managing' a cluster of districts) roles and responsibilities should also be revisited in this regard.

## 12.2. INTEGRATION AND CO-ORDINATION

12.2.1. Integration, coordination and collaboration between and amongst programmes should be improved and actively endorsed by the Department's leadership as a matter of urgency.

## 12.3. HUMAN RESOURCE PLANNING

12.3.1. 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.

12.3.2. Clear and consistent key HR statistics and indicators should be developed and reported to relevant stakeholders.

12.3.3. Clear decisions and direction at various levels of the Department regarding service delivery should be communicated to all the stakeholders.

## 12.4. STAFF ESTABLISHMENT

12.4.1. There is an urgent need for restructuring aimed at establishing minimum staffing levels, based on the following factors: objectively agreed benchmarks, provincial disease burden profile, optional application of scarce skills and service delivery priorities and taking into consideration available resources. Special attention should be paid to:

12.4.1.1. Restructuring should allow for the optimal use of scarce skills (e.g. service hubs at district level, such as information technology skills and artisan's skills which are made available to all the institutions that are linked to the hub).

12.4.1.2. Restructuring should also allow for re-allocation of lower level duties to lower graded staff.

12.4.1.3. Appropriate management ratios and levels should be reviewed to address the current confusion at head office.

12.4.1.4. Job titles and job grades should be consistent across various components and levels.

12.4.2. PERSAL should be corrected to accurately reflect personnel positions and staffing numbers as reported in the KZNDOH Budget Estimate and Annual Report statements.

12.4.3. Norms and standards from NDOH should guide provinces to determine correct structures and establishments. This should include guidance on management levels, ratios and grading of positions.

12.4.4. Consistency in grades for similar positions across various areas should be analysed more closely and systematically. This should include the standardisation of nomenclature of job titles within the Department so that comparisons can be easily made.

12.4.5. DPSA should assist NDOH and provinces to implement changes relating to structures in a more efficient manner.

## 12.5. RECRUITMENT

12.5.1. There should be a thorough review and improvement of recruitment procedures and processes with a view to shorten appointment times.

12.5.2. There is a need to drastically increase capacity at PHC level to improve and make a positive impact on service delivery.

12.5.3. The community service pharmacist programme being implemented in some of the institutions in the province should be closely monitored and evaluated as to whether it could be used as a model to address the challenges of staff shortages in other areas.

## 12.6. PERFORMANCE MANAGEMENT

12.6.1. All performance contracts should be clearly linked to organisational priorities and key indicators that drive organisational performance. Senior management should in turn make sure that their respective subordinates' performances add value to their set targets.

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

12.6.2.1. Organisational performance;

12.6.2.2. Employee development;

12.6.2.3. Reward based on clear performance goals.

12.6.3. Team performance should form part of performance standards and evaluation and should be escalated to DPSA.

## 12.7. RETENTION

12.7.1. There is need for clear strategies and guidelines from NDOH regarding the retention and recruitment of scarce skills. KZNDOH has been battling to recruit and retain Pharmacists and many other critical skills within the Department.

## 12.8. REWARDS

12.8.1. A long-term comprehensive reward strategy at national level should be developed to address issues relating to: Employee compensation; skills scarcity, staff retention and affordability.

12.8.2. A thorough costing process of the reward system should be done in collaboration with the affected parties and should include an assessment of affordability at various levels.

12.8.3. Rewards should be linked to organisational, employee and team performance as outlined in the plans that are aligned to the STP.

12.8.4. Lessons learned from the current OSD implementation review for nurses should be used to inform and plan future implementation of improvement related initiatives.

## 12.9. LEARNING AND DEVELOPMENT

12.9.1. The impact of the current moratorium on training should be fully assessed and priorities need to be set in terms of training needs and then addressed urgently and accordingly.

12.9.2. The Department needs to seriously consider addressing the priority training needs as it is closely linked to quality service delivery.

## 12.10. HR INFORMATION SYSTEMS

12.10.1. An assessment should be undertaken to establish reasons for underutilisation of the existing information systems and improved measures should be implemented - including the full use of PERSAL as a HR management tool.

# Information Management

## 1. INTRODUCTION

**Box 4: Key findings from the Information Management review**

1. Monitoring and evaluation is one of the weakest links in the overall management of health services in the KZNDOH. 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. There are different Health Information Systems (HIS) that function in isolation of one another.
3. Separate uncoordinated M&E sections at various components and programmes exist and are not linked to the central M&E chief directorate within head office.
4. The use of information for management and planning is sub-optimal.
5. The main focus of the M&E system is on inputs and outputs.
6. The DHIS is not reliable and it is not real time and cannot be used promptly for early warning signs in service delivery. The same weaknesses are evident with the ARV monitoring system. These include problems around data quality; the large number, standardisation and interpretation of indicators; and the lack of national norms and standards. There is also a lack of coordination of all M&E activities within the department, between finance and operational performance indicators because of the silo structure between finance and service delivery.
7. There is no integrated Health Information System that compares financial and performance indicators.
8. Indicators are not well defined and therefore sometimes inaccurately captured, resulting in unreliable reporting.

1.1. The KZNDOH has a central M&E unit falling under a chief directorate. There are several other M&E sections within specific components like finance, HR, HIV and TB, which should be linked to the central M&E unit, but coordination with and integration of these separate sections into the central unit are very weak. Silo operations were evident.

1.2. M&E in the province is weak and is a contributing cause for poor management of services and failure to promptly respond to signs of deterioration of services. The main

challenge within M&E is that the KZNDOH does not have an integrated M&E framework and an integrated Health Information System to support and implement the framework. The central M&E unit has consequently developed a provincial M&E framework that is results based with a focus on inputs, outputs, outcomes and impact indicators. The draft framework has, however, overlooked the importance of integrating financial indicators within the framework.

1.3. The framework reveals an array of gaps and challenges due to the absence of a recognised M&E Framework that guides M&E in the Department and these are stated as:

1.3.1. Inaccuracy in the indicator system.

1.3.2. Different Health Information Systems (HIS) that function separately.

1.3.3. Lack of capacity and verification systems leading to poor information culture, reporting system and data usage.

1.3.4. Data quality was also described as unreliable to properly inform policy directives, programme planning and decision-making.

1.3.5. One of the crucial gaps related to the M&E system itself is that it still adopts a traditional approach where the focus is mainly on inputs and outputs and does not link to outcomes and performance indicators.

## 2. USE OF INFORMATION FOR DECISION MAKING

2.1. The central head office planning and M&E unit expressed a concern that the culture of using information, performance indicators and following up on planned targets is not established in the department. Some managers apparently do not seem to understand their performance indicators and how to interpret them for management and decision making or how to act on them. The financial indicators are worst understood and are often not matched to service delivery targets for the comprehensive management of programmes.

2.2. It was mentioned in several interviews that one of the major reasons for over-expenditure is the failure of managers to use service delivery indicators to inform service delivery needs and for costing of services provided. Therefore the allocations are often under the required budget and result in overspending which could be avoided through proper costing of services and adequate planning.

2.3. The districts and province expressed concern regarding the large number of reporting data elements from national. The data is hardly used by the managers at the level of service delivery (the facilities). There is more focus on compliance to ensure that statistics are submitted on time with little verification, validation and interrogation of the presented data. Indicators are not well defined and distributed to all facilities to ensure a common understanding of what the numerator and the denominator of each indicator is.

# 3. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

3.1. The DHIS is reportedly unreliable in KZNDOH as a system for M&E, although it has been improving over the years. The department is now using the DHIS 1.4 version which, at least, includes the data elements for the ARV programme and PMTCT programmes. The system is also not easily accessible and does not provide real time data that can be used timeously for decision making and the detection of early warning signs in service delivery as the information is always at least a month in arrears.

3.2. The biggest challenge is the lack of an integrated HIS and related skills to fully utilise the systems that are in place. The systems are fragmented and there is no Master Systems Plan to guide future development of systems.

# 4. ARV MONITORING AND EVALUATION

4.1. There is a dedicated ARV monitoring and evaluation manager and the ARV roll out manager and they both report to the HIV&AIDS, STIs and Tuberculosis (HAST) director. When the programme started it came with its own M&E data collecting tools and system which was not integrated into the existing HIV system and is not linked with the other HIV programmes. The system remains a standalone paper based system fed into the DHIS. ART data elements can now be captured in the 1.4 version.

Each programme has its own separate, specific data collecting tools. TB has an electronic register that is populated at district level. At facility level it is paper based. There is a huge challenge in the utilisation of these tools because the nurses need to be trained before they are familiar with them and have to, preferably, be trained on site. Turnover of staff demands continuous training which is not possible under the current budget limits.

4.2. There are allegations that some patients are shopping around for services and have registered themselves in more than one facility and accessing the same services and drugs more than once to sell ARV drugs fraudulently in the community. The department has no system to detect or trace patients throughout the service or to investigate these allegations.

## 5. OTHER M&E ISSUES

5.1. There are a number of parallel information systems - (e.g. HIV 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 and reports, e.g. DHIS may have different statistics to what the programme managers have.

5.3. There is a lack of communication between those responsible for data management in the strategic planning unit and those responsible for programme management.

5.4. Quarterly reports are regularly prepared for NDOH and the National Treasury. These reports are not scrutinized throughout the department and there is little or no feedback on these reports by senior management.

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 ART employees are doing work elsewhere distorting PDEs and the costs of providing an ART service for that institution).

# 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).

## 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.

## 6.3. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

6.3.1. The number of indicators needs to be decreased.

6.3.2. There should be unambiguous, easy to understand, standardised definitions.

6.3.3. 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.

6.3.4. DHIS access should be allowed to all managers.

6.3.5. An appropriate training regime also needs to be introduced at the correct time for managers and information managers to maximize utilisation of health information systems.

## 6.4. ARV MONITORING AND EVALUATION

6.4.1. A workable, practical, easy-to-use system of monitoring the ARV programme needs to be put in place.

6.4.2. A patient Information System is needed for proper monitoring of patients on ART.

## 6.5. OTHER M&E ISSUES

6.5.1. There needs to be one official repository of information for the KZNDOH. 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. Master systems plan should be aligned to the STP and integrate all health information systems.

6.5.3. The draft M&E framework that the province has developed needs to be finalised, costed, approved and implemented as one of the priorities for 2009/10.

6.5.4. There should be an integration of finance indicators and service delivery performance indicators for comprehensive management of the health information system where service delivery is monitored for alignment with resource availability and utilisation.

6.5.5. The M&E function within the Department should be co-ordinated so that programme M&E functions supply relevant information to the departmental M&E unit.

6.5.6. The M&E component should be responsible for providing meaningful performance information which includes an analysis of costs and service delivery to programme and responsibility managers.

6.5.7. The M&E information system and the new draft M&E framework should also include financial information and indicators.

# Medical Products, Laboratory

## 1. INTRODUCTION

**Box 5: Key findings from the Medical Products and Laboratory review**

1. The KZNDOH has been able to reduce drug shortages from 8% to 2% by putting systems in place for drug monitoring and increasing the pharmacy assistants at the pharmacies and PHC clinics who are assisting with the correct ordering of drugs.
2. The ART programme consistently exceeds set targets of patients on ART in each financial year, resulting in significant over-expenditure in the provincial drug budget. 81 614 patients were budgeted for 2007/08 but KZN had 146 537 patients on treatment at the end of the financial year. This is a significant threat to the sustainability of the ART programme.
3. The drug budget is prioritised and monitored well, especially the ART drugs, to the extent that the KZNDOH wants to open a separate Stock Account for ART drugs.
4. There is concern regarding the sustainability of the new vaccines in the immunization schedule as they are expensive.
5. The department feels that NDOH does not prepare provinces well in advance before implementation of new protocols and is concerned that there might not be enough in the budget to satisfy expectations.
6. Since 2005 the drug depot, although functioning well, has had no operating license because of the infrastructural limitations that have compromised the conditions for drug storage and that do not comply with the MCC and Pharmacy Act. Leadership has delayed decisions on the matter.
7. The delay in the finalisation of the terms of reference for the tender to deliver and distribute drugs from the depot to the clinics has resulted in the department resorting to contract freight services on a month to month renewal system which is not cost effective compared to a period contract.
8. KZNDOH has a 78% vacancy rate for pharmacists due to the unattractive entry level salaries and the general shortage of qualified pharmacists in the country.
9. NHLS has challenges that affect service delivery. They are short staffed, cannot cope with the load, have a delayed time frame for the return of results and there is a general perception of poor customer service.
10. There is no senior manager who is responsible for managing and monitoring performance of the NHLS according to the SLA.

**Box 5: Key findings from the Medical Products and Laboratory review**

11. NHLS is expensive and is one of the major cost drivers of the department. The CFO has even been taking funds from other responsibilities to pay for the laboratory services.

# 2. MEDICAL PRODUCTS

## 2.1. DRUG STORAGE AND DELIVERY

2.1.1. The KZNDOH prides itself with the well functioning and efficient Provincial Pharmaceutical Supply Depot (PPSD) and the drug management system has improved the ordering and delivery time of drugs, called PlankMed. PPSD was previously called PMSC, which is the Provincial Medical Supply Centre, and is responsible for the bulk procurement, storage and distribution of medicines to public health facilities, including municipal clinics and approved NGOs, and does pre-packing of patient ready medication packs.

2.1.2. Medicine stock outs are reported to have been significantly reduced in the province from 10% in 2002/03 to 5% in 2006/07 and 2% in 2007/08. This is because of the electronic ordering system called the Remote Demander's Module. The system increases productivity and decreases down time. Procurement, payment and distribution processes are controlled and managed through a MEDSAS stores system and it is a Windows based bar-coding system.

2.1.3. Political influence has negatively affected service delivery and tender processes, e.g. securing freight tender to deliver drugs to clinics from PPSD has been pending since 2004 when the 2005 -2009/10 five year strategic plan was drafted and it has not been finalised. The delay is as a result of the recommendations from political principals that the tender should be district to district and observe the BBBEE policy while the capacity in current interested BBBEE freight services does not meet courier storage specifications for safe delivery of drugs. Pharmaceutical management prefers a provincial tender because it is logistically easier to manage and keep providers accountable.

2.1.4. Political influence has also been cited as the sole reason for the department to have failed to comply with the drug storage requirements in the Pharmacy Act despite the

fact that the department has been prioritising this problem since as far back as 2004. The PPSD has reached full capacity in the current premises and relocation has been a priority of DOH in every APP since the 2005 – 2009/10 five year strategic plan. The Pharmacy Council and the MCC have not issued a licence for this structure to operate and it is functioning illegally. This is still acknowledged in the 2009/10 APP, but without a decisive plan of action. Management feels that the department lacks insight into the seriousness of this situation and the full financial and legal implications. There is concern, for example, of why the relocation of PPSD to previously identified premises was not prioritised rather than the moving of certain head office staff to a new building at the equivalent cost to what would have been paid for a pharmacy depot complying with all legal requirements.

## 2.2. DRUG MANAGEMENT SYSTEM

2.2.1. Drug procurement, availability and budgets are managed at hospitals and CHCs. The PHC clinics order directly from PPSD and their budgets are managed at their referring hospitals or CHCs. Districts have district pharmacy managers who provide support and monitor governance at institutions. Despite the high vacancy rate of pharmacists at above 78% and mentioned in all the APPs, the province has managed to appoint a pharmacy manager for each institutional pharmacy. Community service pharmacists are appointed as pharmacy managers at places of greatest need, which is usually the rural areas and this is used as a retention strategy for this cadre of workers. The major challenge with recruitment and retention of pharmacists is primarily the low production of qualified pharmacists annually at about 60 -70 in KZN and 500 nationally and the severe competition from the private sector which makes the entry levels in the public sector highly unattractive.

2.2.2. ART drugs in KZN account for 46% of drug budget and are one of the major cost drivers for pharmaceutical services that have led to departmental overspending. The ART programme has been consistently exceeding its budgeted targets for financial years resulting in over-expenditure, e.g. 81 614 patients were budgeted for ART drugs by end of March 2008, however, 146 537 patients were actually on ART at that date, causing an over-expenditure of R154,5 million in ARTs. This stimulated the department to motivate for a separate Standard Stock Account for ARV drugs which is awaiting approval from the Provincial Treasury. A separate account will facilitate strict monitoring and accurate predictions of ARV drug budget needs and will ensure that ARV drugs are not paid for from the budget of other drugs.

2.2.3. The new immunization schedule has come with an initiation budget from NDOH for provinces to buy added vaccines, which are expensive and estimated at R800 per child. Dissatisfaction was reported with NDOH launching a full marketing strategy with this immunization schedule without ascertaining the readiness of provinces or providing budget estimates to sustain the programme at provinces. This put the facilities at risk of turning patients back. ILembe district, for an example, reported that they had not implemented the new schedule yet.

2.2.4. Of positive note is the use of pharmacy assistants by the district and facilities in shortening pharmacy queues, reducing over-ordering of drugs by clinic sisters and improving stock control at PHCs. This has reduced fruitless expenditure as a result of unnecessary stockpiling.

2.2.5. The ILembe district is proud of its roll out of the ART programme to PHC clinics where doctors initiate patients on ARV treatment at the clinics. ARV drugs are also dispensed to clinics pre-packed and patient name labelled from the hospitals so that patients only revisit the hospital for blood tests and doctor consultation. This has significantly decreased the long queues at hospital pharmacies. The only reservation is the insufficient training of nursing sisters on the side effects of ARV drugs.

# 3. LABORATORY

3.1. Laboratory services were taken over by NHLS as part of a NDOH process. It is not clear, however, if there is a dedicated senior manager that oversees and monitors the performance of NHLS as per the SLA in the province. Some of the funds to pay the NHLS bills have been taken from the Global Fund round 1, phase 2 grant for the HIV management laboratory tests - such as Viral Load and CD4 cell count - at about R5 million per month. The pharmacy manager has also reported that some of his ‘supposedly’ ring-fenced drug budget was used by the CFO to pay for the NHLS debt.

3.2. It is therefore the impression of this review that NHLS seems to have added significantly to the cost drivers of the KZNDOH. A comparison is needed of the expenditure patterns for laboratory services from the time when the service was provided internally to the time when it was taken over by NHLS.

3.3. Quarterly reports from the health services unit, the institutions and district reports indicate that NHLS does not seem to be coping with the load of work and that this adds to service delivery delays. In this regard, the following is experienced: loss of specimens, poor turnover of results, shortage of staff; ill discipline with poor customer care, poor response at some laboratories, no laboratory porters and no look up stations.

# 4. RECOMMENDATIONS

## 4.1. DRUG STORAGE AND DELIVERY

4.1.1. The drug delivery tender needs to be finalised urgently for cost saving purposes.

## 4.2. DRUG MANAGEMENT SYSTEM

4.2.1. The Provincial Pharmaceutical Supply Depot should be moved to an appropriate structure as a matter of urgency to ensure that it complies with the MCC and Pharmacy Act as well as standard operating procedures and that it receives a license to operate.

4.2.2. A separate Standard Stock Account for ART is a good idea and should be considered by the Provincial Treasury as KZN has the highest prevalence and the largest number of people on treatment.

4.2.3. The revenue generated by the PPSD should be utilized cost effectively to ensure sustainability of the depot.

## 4.3. LABORATORY

4.3.1. KZNDOH must allocate a manager to oversee the service quality and efficiency of NHLS and monitor the pricing and claims that are submitted for payment to ensure that double charging does not occur.

4.3.2. Service delivery delays as a result of staff shortages at NHLS need to be brought to the service provider’s attention.

4.3.3. KZNDOH needs to address the issue of efficiency with the service provider to ensure it receives best value for money.

4.3.4. KZNDOH should report challenges regarding NHLS service provision deficiencies to NDOH if they become significant.

# Technology and Infrastructure

## 1. OVERVIEW

1.1. This section of the Health System could not be reviewed in full due to the inability to secure interviews with two critical senior managers in the KZNDOH, namely, the Chief Operating Officer (COO) who could have provided an overview on this aspect and the General Manager for Infrastructure Development and Clinical Support which includes Medical Technology Services. According to the current head office structure, the General Manager for this component reports directly to the COO. The component is responsible for the following functions:

1.1.1. The implementation of the hospital revitalization programme.

1.1.2. Development of a policy framework for the procurement and maintenance of medical equipment and medical technologies.

1.1.3. Oversee policy frameworks on the provision of Health Laboratory Services, fleet management services and central laundry services for the department.

1.2. The inputs contained in this report are based on the annual performance plans and the annual reports that could be accessed within the available time frame of the review.

## 2. FACILITIES MANAGEMENT

2.1. Improvement of health facilities has been receiving considerable attention from the department to expedite service delivery and seems to be taken as a priority in all the APPs and is aligned to the past 5 year strategic plan.

2.2. The infrastructure Development Improvement Plan has integrated the infrastructure needs of facilities that were taken over by the department, such as the TB SANTA hospitals now used for MDR treatment and the local municipal clinics.

2.3. The department plans to use the improvement plan to facilitate sourcing of additional funds.

2.4. The shortage of space as a result of increasing patient volumes and the introduction of HIV programmes, especially VCT/counselling services, has been the driving force behind the numerous support donations that KZNDOH have enjoyed around 2005/06 from donors like the DBSA, ZAC, Anglo American Chairman's fund/Mondi, Richard's Bay Minerals and Italian Government, to name a few. The projects achieved from these sponsors ranged from procurement of park homes, upgrading of facilities to accommodate new services and the building of new clinics, donation of mobile units and electrification of some clinics by ESKOM.

2.5. The Global Fund round 1 grant has been utilised to build more clinics to expand the HIV/TB management.

2.6. There are, however, constant service delivery challenges, thus increasing the infrastructure backlogs. In 2006/07 there was a backlog of R2.4 billion and at the end of 2008/09 the backlog was estimated at R6.42 billion.

2.7. Rural areas have an unreliable supply of electricity.

2.8. At the district level, some managers said that rural clinics may have telephones and faxes but these may not be working due to electricity problems.

2.9. The department has been experiencing a significant shortage of artisans and other maintenance staff for hospital workshops. If it was able to address this, the extent of outsourced work would decrease and thus also reduce cost of repairs on the budget.

2.10. 2009/10 APP estimates that 33% of equipment has been rendered obsolete because the spares can no longer be obtained.

2.11. Some programmes have cited a concern regarding the poor quality of buildings that are constructed through the Expanded Public Works Programme, resulting in projects being stopped half way and even changing the contractor. This leads to delays in the hand over of sites, with potential fruitless expenditure and delayed delivery of services.

# 3. TECHNOLOGY

3.1. The IT department reports that every clinic has a computer while information managers at districts report that some clinics do not have PCs. Clinics have a challenge with poor capacity in using the computers, training is slow due to budget cuts and sometimes there is no electricity. There are 37 telemedicine sites that have been established through the Global Fund grant in provincial health facilities with one in UKZN. 3 Virtual Private Networks exist at IALCH, UKZN and NHLS and are maintained by SITA.

3.2. The following challenges are faced by the technology and infrastructure sector:

3.2.1. The capacity of KZN Department of Public Works to adequately undertake infrastructure projects and deliver efficiently for all departments has proven to be severely deficient.

3.2.2. The provincial procurement policy is lengthy and not effective to enable service delivery needs.

3.2.3. Consequently, the Hospital Revitalisation grant has been consistently underspent, resulting in roll-overs to subsequent financial years and a reduced budget provided for 2008/09. The current projects are projected to be complete by the end of 2009/10 and thus the MTEF allocation for 2010/11 increases again.

3.2.4. The equipment budget has also been experiencing underspending due to delays in delivery of equipment, resulting in roll-overs.

3.2.5. The manager for IT technology reported that he is annually allocated a significantly reduced budget that does not take cognisance of the costs of rolled over contracts and this consistently leads to considerable overspending from this section.

3.2.6. The other problem is the perception that EXCO sometimes procures systems without consultation with the responsible manager. Such consultation would ensure better coordination of integrated health information technology systems that feed into each other.

3.2.7. IT experiences a high attrition rate and is currently significantly understaffed, such that the new Telemedicine directorate has no manager or maintenance staff to maintain the existing 37 telemedicine sites that were established using the Global Fund grant.

# 4. RECOMMENDATIONS

4.1. The NDOH should assist or review the policy that limits the coordination of infrastructure to the Department of Public Works. The backlogs are proving expensive and have a negative impact on improving access to services and in the provision of quality health care.

4.2. There should be strict quality assurance and quality control measures with regular inspections of buildings that are being constructed by small contractors under the EPWP to ensure compliance with quality standards.

4.3. Coordination of IT systems should be prioritised and ensure that it facilitates integration.

4.4. There should be a review of the telemedicine sites that have been donated by the Global Fund grant, and how best to operationalise these within available resources.

# Taking Forward the Recommendations

This section brings together the recommendations from the various sections, and indicates the main role-players responsible for implementation; it also highlights the inter-dependence of the activities.

Table 8: Recommendations contained in KwaZulu-Natal 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

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|---|---|---|---|---|---|---|---|---|
| **FINANCE RECOMMENDATIONS** | | | | | | | | |
| **Conditional grants** | | | | | | | | |
| Allocations of conditional grants by the NDOH should be based on clear, objective criteria that are linked to grant specific indicators. | | 1 | | 2 | 2 | 2 | | |
| **Unfunded Mandates, inefficient processes and poor decision making** | | | | | | | | |
| 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 | | |
| Appropriate measures should be introduced to control all overtime worked as well as the time worked for agencies. There should be a clear distinction between overtime worked for the KZNDOH and time worked for agencies. | 2 | 2 | 2 | 1 | | | 1 | 1 |
| **Budgeting Process** | | | | | | | | |

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| 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 | | |
| A comprehensive financial management procedure guide (detailing the approach and key parameters to be used in creating a budget as well as detailed guidance on monitoring of actual expenditure against the budget) should be developed, implemented and adherence monitored on a periodic basis. | | | | 1 | | 2 | | |
| All Programme Managers and other relevant implementers at various levels of the chain of service delivery need to take full responsibility for developing realistic (in accordance with available funds) and properly costed budgets that are fully aligned to all operational plans. | | | | 1 | | 2 | | |
| **Integration and financial management** | | | | | | | | |

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| **support to other units** | | | | | | | | |
| The impact of the cost containment exercise (currently being implemented by the finance component) on service delivery, staff performance and staff morale should be assessed. All cost containment measures should be developed in conjunction with service delivery components of the Department and CEOs of institutions. | | | | 1 | | 2 | | |
| An early warning dashboard should be developed by finance in conjunction with the relevant programme and responsibility managers to identify significant over and underspending. | | | | 1 | 2 | 2 | | |
| Programme and responsibility managers should be given monthly financial information highlighting budget variances. | | | | 1 | | | | |
| Dedicated teams within finance should be allocated to various programmes and sub-programmes to allow the finance component an opportunity to understand challenges affecting service delivery and afford the programme and responsibility managers the opportunity to understand and appreciate the limited funding available. | | | | 1 | | | | |
| The working relationship between finance and the service delivery components of the KZNDOH should be enhanced by | | | | 1 | | | | |

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| facilitating a close working relationship between the components. This should be facilitated by the COO and the CFO and championed by the HOD. | | | | | | | | |
| **Financial management** | | | | | | | | |
| The chart of accounts used by institutions should be reviewed to ensure that all services offered are adequately accounted for. | | | | 1 | | 2 | | |
| A comprehensive financial management session with individual programme and responsibility managers should be held on a quarterly basis to enable programme and responsibility managers to understand the variances between the actual expenditure and the available funding. | | 2 | | 1 | | 2 | | |
| Programme and responsibility managers should be held accountable for their budgets and all items of expenditure should be approved by the relevant manager (based on the delegations of authority). | | 2 | | 1 | | 2 | 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 | 2 | |
| The recording of financial transactions should be improved to ensure that costs per service offered are accurately captured. This should be reviewed periodically by the | | | | 1 | | 2 | | |

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| financial manager, FIO (facility information officer) and the institutions' management committee to ensure that costs are correctly allocated to the correct objective codes. | | | | | | | | |
| An internal programme and responsibility manager training session should be held to capacitate managers in financial management. | | | | | | | | |
| Financial managers at institutions and districts should be trained appropriately to improve the current skill level on issues of financial management including accurate recording of transactions, cost allocations, preparation of management accounts, etc. | | | | 1 | | 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. | | | | 1 | 2 | 1 | | |
| Variance analysis needs to be used as a management tool to identify areas that require attention. | | | | 1 | 2 | 2 | | |
| **Quarterly Performance Reports** | | | | | | | | |
| The accuracy and use of essential performance indicators needs to be | | 1 | | 1 | 2 | 2 | | |

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| improved. The necessary steps must be taken in conjunction with the NDOH to improve the quality of information available in this regard. | | | | | | | | |
| Variances in specific indicators need to be followed up with appropriate actions, once 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 only reflects actual and expected cash flow, which is not linked to operational activity (expenditure). | | | | 2 | 1 | 2 | | |
| Through the appropriate channels, the forecasting component of the IYM should | | 2 | | 2 | 1 | 2 | | |

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| be investigated to ensure best basis of reporting – cash versus accrual reporting. | | | | | | | | |
| **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 | | |
| **Supply Chain Management** | | | | | | | | |
| A forensic audit of SCM management and processes within the KZNDOH should be undertaken to identify all SCM contraventions and potential conflict of interest during the last 3 years and to recommend prevention and management strategies. | | | 2 | 1 | | 2 | | |
| Adequate controls and processes should be implemented to ensure that henceforth the SCM policies and processes for tenders and contracts are adhered to by all employees of the KZNDOH, irrespective of their positions in the departmental hierarchy. | | | 2 | 1 | | 2 | | |
| A cost benefit analysis should be done to estimate the potential cost saving derived by the KZNDOH when buying inventory in bulk, using the CPS. | | | 2 | 1 | | 2 | | |
| Short-term contracts should be reduced in | | | 2 | 1 | | 2 | | |

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| order to cut down on unnecessary expenses and "period contracts" should be considered instead. | | | | | | | | |
| **Monitoring Structures** | | | | | | | | |
| The internal audit and risk component of the KZNDOH should be adequately resourced to enable it to execute its mandate. | | | 2 | 1 | | | | |
| **LEADERSHIP, GOVERNANCE and SERVICE DELIVERY RECOMMENDATIONS** | | | | | | | | |
| **General Leadership** | | | | | | | | |
| The KZNDOH needs to appoint an HOD as a matter of urgency and stabilise the top management level. | | | 1 | 2 | | | | |
| The National and Provincial departments of Health need to play a more visible and supportive leadership role regarding prioritisation and rationalization of resources to achieve cost containment. | 1 | 1 | 1 | 1 | 2 | 2 | | |
| There should be a tool developed that guides the methodology for managers to develop their own cost containment plans that critically analyse core from non core activities without a negative impact on service delivery. Such plans should be developed using a consultative process, should facilitate adherence and utilise regular M&E. | | 2 | | 1 | | 2 | | |
| National policies need to take into context the resource restrictions that are | 2 | 1 | 2 | 2 | | 2 | | |

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| experienced by provinces, especially to ensure that new programmes and the set targets are achievable and sustainable. | | | | | | | | |
| NDOH should provide a more visible leadership and stewardship role and consult with provinces before imposing plans in a top down manner. | | 2 | | 1 | | | | |
| National plans should be costed to provide an indication of required resources with norms and standards for implementation of services to ensure a continuous standardized service throughout provinces and to enable provinces to budget accordingly for the sustainability of introduced plans. | | 1 | | 2 | | | | |
| The HOD 's first priority should be to create an enabling environment for coordination of structures and functions in the head office, through a head office structure review, role clarifications and better communication with the rest of the Department. | | | | 1 | 2 | 2 | | |
| Governance structures like MANCO and FINCOM need to be put back in place, meet more frequently, have the authoritative mandate of taking strategic decisions for the KZNDOH that are transparent, adhered to and monitored for compliance . | | | | 1 | 2 | 2 | | |
| Management of over-expenditure is a core senior management function together with | | | | 1 | | 2 | | |

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| its effects on service delivery. This needs to be explicitly on the agenda of senior management. | | | | | | | | |
| **Planning** | | | | | | | | |
| The finalisation of the STP should be prioritised for the 2009/10 financial year and proper processes embarked on to ensure that relevant external stakeholders provide their inputs into the plan. | | 2 | 1 | 1 | 2 | 2 | 2 | 2 |
| There should be better coordination, integration and monitoring of plans in the department. The resources of the strategic planning unit should be used optimally for maximum benefit to address some of the planning challenges. | | | | 1 | | | | |
| The targets that are set in the provincial plans need to be realistic, agreed upon by the line and programme managers and set based on affordable national guidelines. | | | | 1 | | | | |
| There is an urgent need for NDOH to develop norms and standards regarding resource allocation at all levels of the healthcare system. | | 1 | | 2 | | | | |
| Line and programme managers, especially at institutions, need to be trained and given guidelines on how to cost different services and packages of care as this affects planning and budgeting. | | | | 1 | | | | |
| **Governance** | | | | | | | | |

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| There should be clear written guidelines delineating the areas of responsibility between the MEC, HOD and the CFO. | | | 1 | 1 | | | 2 | |
| Senior Managers should be made accountable for their own budgets and monitored for adherence and compliance to the PFMA. | | | 1 | 2 | | | | |
| 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 | | | | |
| **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). | | 1 | | 2 | | | | |
| There should be improved coordination and collaboration between various provincial departments to ensure that Health focuses on its core functions, e.g. the Targeted Enterprises Development should be a | | 1 | | 1 | | | | |

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| function of the Department of Economic Development and not Health. | | | | | | | | |
| The Department should focus more decisively on strengthening the Primary Health Care system in all the districts and allocate resources accordingly. | | 1 | | 1 | 2 | 2 | | |
| Budget allocations (at institutional level) should be aligned to the priorities of the institutions and these institutions should not be allowed to create competing service offerings to the same/similar community in one district or in neighbouring districts. | | 1 | | 1 | | 2 | | |
| There should be a focus on developing refined funding guidelines for the HIV strategy. The ever increasing demand for ARV drugs means that there is a need to develop a more sustainable model that will take into consideration issues of affordability, equity and accessibility. | | 1 | | 1 | 2 | 2 | | 2 |
| **HUMAN RESOURCES RECOMMENDATIONS** | | | | | | | | |
| **Delegations, Accountability and Responsibility** | | | | | | | | |
| The current centralised model should be reviewed to determine whether withdrawing delegations adds value in terms of cost containment and service delivery. | | | 2 | 1 | | | | |
| A clear matrix in terms of delegation of authorities and decision making at various levels should be completed. This should be | | | | 1 | | | | |

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|---|---|---|---|---|---|---|---|---|
| in line with a RACI matrix where different people are responsible, accountable, consulted or informed. | | | | | | | | |
| The roles and responsibilities of district and institution managers should be clearly defined, especially regarding their interaction with the PHC clinics and to eliminate overlaps. Area Managers' (responsible for 'managing' a cluster of districts) roles and responsibilities should also be revisited in this regard. | | | 2 | 1 | | 2 | | |
| **Integration and co-ordination** | | | | | | | | |
| Integration, coordination and collaboration between and amongst programmes should be improved and actively endorsed by the Department's leadership as a matter of urgency. | | | | 1 | | | | |
| **Human Resource Planning** | | | | | | | | |
| 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 to relevant stakeholders. | | 1 | | 1 | | | 2 | |
| Clear decisions and direction at various levels of the Department regarding service delivery should be communicated to all the | | 1 | | 1 | | | 2 | |

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|---|---|---|---|---|---|---|---|---|
| stakeholders. | | | | | | | | |
| **Staff Establishment** | | | | | | | | |
| There is an urgent need for restructuring aimed at establishing minimum staffing levels based on the following factors: objectively agreed benchmarks, provincial disease burden profile, optimal application of scarce skills and service delivery priorities and taking into consideration available resources. Special attention should be paid to: Restructuring should allow for the optimal use of scarce skills (e.g. service hubs at district level, such as information technology skills and artisan's skills which are made available to all the institutions that are linked to the hub), restructuring should also allow for re-allocation of lower level duties to lower graded staff, appropriate management ratios and levels should be reviewed to address the current confusion at head office, job titles and job grades should be consistent across various components and levels. | | 1 | | 1 | | | 2 | |
| PERSAL should be corrected to accurately reflect personnel positions and staffing numbers as reported in the KZNDOH Budget Estimate and Annual Report statements. | | 2 | | 1 | | | 2 | |
| Norms and standards from NDOH should | | 1 | | 2 | | | 2 | |

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| guide provinces to determine correct structures and establishments. This should include guidance on management levels, ratios and grading of positions. | | | | | | | | |
| Consistency in grades for similar positions across various areas should be analysed more closely and systematically. This should include the standardisation of nomenclature of job titles within the Department so that comparisons can be easily made. | | 2 | | 1 | | | 2 | |
| DPSA should assist NDOH and provinces to implement changes relating to structures in a more efficient manner. | | 2 | | 2 | | | 1 | |
| **Recruitment** | | | | | | | | |
| There should be a thorough review and improvement of recruitment procedures and processes with a view to shorten appointment times. | | 2 | | 2 | | | 1 | |
| There is a need to drastically increase capacity at PHC level to improve and make a positive impact on service delivery. | | 2 | | 1 | | | 2 | |
| The community service pharmacist programme being implemented in some of the institutions in the province should be closely monitored and evaluated as to whether it could be used as a model to address the challenges of staff shortages in other areas. | | 2 | 2 | 1 | | | 2 | 2 |

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| **Performance Management** | | | | | | | | |
| All performance contracts should be clearly linked to organisational priorities and key indicators that drive organisational performance. Senior management should in turn make sure that their respective subordinates' performances add value to their set targets. | | | | 1 | | | | |
| The performance management system should be utilised as intended and incorporate: Organisational performance; Employee development; Reward based on clear performance goals. | | | | 1 | | | 2 | |
| Team performance should form part of performance standards and evaluation and should be escalated to DPSA. | | 2 | | 2 | | | 1 | |
| **Retention** | | | | | | | | |
| There is need of clear strategies and guidelines from NDOH regarding the retention and recruitment of scarce skills. KZNDOH has been battling to recruit and retain Pharmacists and many other critical skills within the Department. | | 1 | | 2 | | | 2 | |
| **Rewards** | | | | | | | | |
| A long-term comprehensive reward strategy at national level should be developed to address issues relating to: Employee compensation; skills scarcity; staff retention and affordability. | | 1 | | 2 | 1 | 2 | 1 | |

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| A thorough costing process of the reward system should be done in collaboration with the affected parties and should include an assessment of affordability at various levels. | | 1 | | 2 | 1 | 2 | 2 | |
| Rewards should be linked to organisational, employee and team performance as outlined in the plans that are aligned to the STP. | | 2 | | 2 | 2 | 2 | 1 | |
| Lessons learned from the current OSD implementation review for nurses should be used to inform and plan future implementation of improvement related initiatives. | | 1 | | 2 | 1 | 2 | | |
| **Learning and Development** | | | | | | | | |
| The impact of the current moratorium on training should be fully assessed and priorities need to be set in terms of training needs and then addressed urgently and accordingly. | | 2 | | 1 | | 2 | | |
| The Department needs to seriously consider addressing the priority training needs as it is closely linked to quality service delivery. | | 2 | | 1 | | 2 | | |
| **HR information systems** | | | | | | | | |
| An assessment should be undertaken to establish reasons for underutilisation of the existing information systems and improved measures should be implemented - | | 2 | | 1 | | | | |

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| including the full use of PERSAL as a HR management tool. | | | | | | | | |
| **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). | | 2 | | 1 | | 2 | | |
| **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 | | 2 | | 1 | | | | |

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| around indicators to lower levels of the system. | | | | | | | | |
| **District Health Information System (DHIS)** | | | | | | | | |
| The number of indicators needs to be decreased. | | 1 | | 2 | | | | |
| There should be unambiguous, easy to understand, standardised definitions. | | 1 | | 2 | | | | |
| There also need to be clear written guidelines, norms and standards for each component of the DHIS, including data 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 | |
| DHIS access should be allowed to all managers. | | 1 | | 1 | | | | |
| An appropriate training regime also needs to be introduced at the correct time for managers and information managers to maximize utilisation of health information systems. | | 1 | | 1 | | | | |
| **ARV Monitoring and Evaluation** | | | | | | | | |
| A workable, practical, easy-to-use system of monitoring the ARV programme needs to be put in place. | | 1 | | 2 | | | | |

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| A patient Information System is needed for proper monitoring of patients on ART. | | 1 | | 2 | | | | |
| **Other M&E issues** | | | | | | | | |
| There needs to be one official repository of information for the KZNDOH. 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. | | 2 | | 1 | | | | |
| Master systems plan should be aligned to the STP and integrate all health information systems. | | 2 | | 1 | | | | |
| The draft M&E framework that the province has developed needs to be finalised, costed, approved and implemented as one of the priorities for 2009/10. | | 2 | | 1 | | | | |
| There should be an integration of finance indicators and service delivery performance indicators for comprehensive management of the health information system where service delivery is monitored for alignment with resource availability and utilisation. | | 2 | | 1 | 2 | 2 | | |
| The M&E function within the Department should be coordinated so that programme M&E functions supply relevant information to the departmental M&E unit. | | | | 1 | | | | |

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| The M&E component should be responsible for providing meaningful performance information which includes an analysis of costs and service delivery to programme and responsibility managers. | | | | 1 | | 2 | | |
| The M&E information system and the new draft M&E framework should also include financial information and indicators. | | 2 | | 1 | | | | |
| **MEDICAL PRODUCTS, LABORATORY RECOMMENDATIONS** | | | | | | | | |
| **Drug management system** | | | | | | | | |
| The Provincial Pharmaceutical Supply Depot should be moved to an appropriate structure as a matter of urgency to ensure that it complies with the MCC and Pharmacy Act as well as standard operating procedures and that it receives a license to operate. | | | 2 | 1 | | | | |
| A separate Standard Stock Account for ART is a good idea and should be considered by the Provincial Treasury as KZN has the highest prevalence and the largest number of people on treatment. | | | | 1 | 2 | 1 | | |
| The revenue generated by the PPSD should be utilized cost effectively to ensure sustainability of the depot. | | | | 1 | 2 | 1 | | |
| **Drug storage and delivery** | | | | | | | | |
| The drug delivery tender needs to be finalised urgently for cost saving purposes. | | 2 | 2 | 1 | 2 | | | |

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| **Laboratory** | | | | | | | | |
| KZNDOH must allocate a manager to oversee the service quality and efficiency of NHLS and monitor the pricing and claims that are submitted for payment to ensure that double charging does not occur. | | 2 | | 1 | | | | |
| Service delivery delays as a result of staff shortages at NHLS need to be brought to the service provider's attention. | | 2 | | 1 | | | | 2 |
| KZNDOH needs to address the issue of efficiency with the service provider to ensure it receives best value for money. | | 2 | | 1 | | | | |
| KZNDOH should report challenges regarding NHLS service provision deficiencies to NDOH if they become significant. | | 2 | | 1 | | | | |
| **TECHNOLOGY AND INFRASTRUCTURE RECOMMENDATIONS** | | | | | | | | |
| The NDOH should assist or review the policy that limits the coordination of infrastructure to the Department of Public Works. The backlogs are proving expensive and have a negative impact on improving access to services and in the provision of quality health care. | 1 | 1 | | 1 | 2 | 2 | | |
| There should be strict quality assurance and quality control measures with regular inspections of buildings that are being constructed by small contractors under the EPWP to ensure compliance with quality | | 1 | | 1 | | 2 | | |

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|---|---|---|---|---|---|---|---|---|
| standards. | | | | | | | | |
| Coordination of IT systems should be prioritised and ensure that it facilitates integration. | | 1 | | 1 | | | | |
| There should be a review of the telemedicine sites that have been donated by the Global Fund grant, and how best to operationalise these within available resources. | | | | 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 midMay 2009.

### 1.2.5. Aim and Scope of Work

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

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

*1.2.5.2. Review Scope of Work for Finance Consultants*

- Participate in the development of a provincial review template and attend orientation to the project and training on the use of the provincial review template prior to deployment to provinces
- Participate in the development of fact files (see below)
- Determine when the cost overruns began
- Determine how they have accumulated over time
- Identify the major cost drivers
- Identify what systems were in place, if any, to flag potential over-expenditure and prevent such overruns occurring

- In collaboration with HSS and M&OD consultants, propose cost management strategies for more cost efficient and cost effective programme delivery
- Participate in the preparation of a consolidated report of national and or provincial findings required to reorient policy implications to the MACH.
- Conduct a national or provincial review, submit and present a report of national and or provincial findings including planning, policy implications and financial controls required to strengthen financial systems and budget management to the MACH
- Attend IST related meetings and produce minutes and reports of meetings and their outcomes.

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

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

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

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

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

**1.2.6. Project Phases**

The project will be conducted in three phases:

*1.2.6.1. <u>Phase 1-National Team only</u>*

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

    - Document recent trends in utilisation of services, and analyse this against costs

  - Assess management and systems delivery to identify more efficient and effective options for delivery of services
  - Assess systems factors that may have resulted in recent overspend, and suggest strategies for ensuring this is avoided in future.
  - Consider health service implications of reductions in funding, and suggest mitigation strategies.

- ❒ Review the Conditional Grants and submit and present data analysis reports on the status of these grants by province.
- ❒ Review provincial IST reports and participate in the development of a consolidated IST report
- ❒ Based on the review, prepare a national final review report that will:

  - Identify and recommend corrective actions needed in priority sequence and approaches for managing costs
  - Recommend and assist national and provincial departments of health to better align financial processes with programme implementation and reporting systems
  - Submit and present a review report with recommendations to the MACH and provide overall recommendations for improving DoH's effectiveness, efficiency and financial management.

*1.2.6.2. Phase 2- Provincial Teams*

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

- ❒ Utilise provincial templates with standardised and unique items adjusted for provinces

- Attend an orientation to the review and travel to allocated provinces
- Conduct interviews with provincial Heads of Department (HoD), CFOs and managers
- Conduct field visits to selected districts
- Review the outputs and outcomes against strategic and operational plans, budget
- and expenditure.
- Identify and quantify major cost drivers
- Assist provinces to identify financial planning and management problems
- Review management and administrative systems for monitoring, evaluation and reporting of outputs and outcomes against operational and financial plans.

*1.2.6.3. <u>Phase 3- All Teams</u>*

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

## 1.3. IST PROJECT MANAGEMENT

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

1.3.1.1. Process management and reporting, including ensuring task completion to agreed standards

1.3.1.2. Managing issues that arise – such as delays, problems, contractual matters

1.3.1.3. Liaison with stakeholders – provinces and national

1.3.1.4. Management of provincial and district visits

1.3.1.5. Collating reports and finalizing the consolidated provincial reports.

1.3.2. Only three provinces (Eastern Cape, KZN and Gauteng) will have field visits conducted up to 4-5 weeks, the remaining 6 provinces will have field visits up to 3 weeks per province concurrently.

1.3.3. The MOH, Deloitte and HLSP will jointly appoint a Team Representative (TR) for each provincial team, who will have overall responsibility for leading the team and producing reports. The TR will be responsible for communicating with the IST Coordinator on an ongoing basis and will provide weekly updates on the progress of the review to the TR, the CFO of the NDOH and HLSP. The TR will be responsible for report content and technical quality and will be required to attend project related meetings at National level. The TR will also provide project direction at provincial level, delegate tasks per the provincial template, ensure liaison with relevant stakeholders and provide progress reports to the provincial HoD as required. The TR is expected to be a senior consultant with extensive experience in leading and delivering high quality reviews in a health care environment and in possession of a relevant tertiary qualification in Finance, HSS or M&OD.

1.3.4. A Steering Committee comprising of representatives of the NDOH, Deloitte, HLSP, and the Ministerial Advisors will be established to provide support and guidance to the work of the IST.

## 1.4. ROLES AND RESPONSIBILITIES

### 1.4.1. Role of NDOH and Provincial 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 DoHs 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. 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: REFERENCES- FINANCIAL TABLES

2.1. The references of the source information reflected in the various tables, presented in the "Financial Review" section of this report (Financial Review) are reflected below:

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 |
|---|---|---|---|---|---|---|---|---|
| 2005/2006 | 32 802[4] | N/A | 10 379[5] | N/A | 31.6% | 33 779[6] | 10 425[7] | 30.9% |
| 2006/2007 | 37 192[8] | 13.4% | 11 737[9] | 13.1% | 31.6% | 37 429[10] | 11 819[11] | 31.6% |
| 2007/2008 | 43 515[12] | 17.0% | 13 413[13] | 14.3% | 30.8% | 44 538[14] | 13 925[15] | 31.3% |

[4] KZN Budget Statement 2006/07, page 49
[5] KZN Budget Statement 2006/07, page 49
[6] KZN Budget Statement 2006/07, page 49
[7] KZN Budget Statement 2006/07, page 49
[8] KZN Budget Statement 2007/08, page 55
[9] KZN Budget Statement 2007/08, page 55
[10] KZN Budget Statement 2007/08, page 55
[11] KZN Budget Statement 2007/08, page 55
[12] KZN Budget Statement 2008/09, page 45
[13] KZN Budget Statement 2008/09, page 45
[14] KZN Budget Statement 2008/09, page 45
[15] KZN Budget Statement 2008/09, page 45

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 |
|---|---|---|---|---|---|---|---|---|
| 2008/2009 | 51 101[16] | 17.4% | 15 043[17] | 12.2% | 29.4% | 53 201[18] | 15 678[19] | 29.5% |
| 2009/2010 | 60 463[20] | 18.3% | 17 449[21] | 16.0% | 28.9% | N/A | N/A | N/A |
| 2010/2011 | 66 245[22] | 9.6% | 20 668[23] | 18.4% | 31.20% | 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 |
|---|---|---|---|---|---|---|
| 2005/2006 | 30 345 | 10 425 | 1 576[24] | N/A | 8 849 | 29.2% |
| 2006/2007 | 33 449 | 11 819 | 1 786[25] | 13.3% | 10 033 | 30.0% |
| 2007/2008 | 39 285 | 13 925 | 2 326[26] | 30.2% | 11 600 | 29.5% |
| 2008/2009 | 45 934 | 15 678 | 2 634[27] | 13.2% | 13 044 | 28.4% |

[16] KZN Budget Statement 2009/10, page 49
[17] KZN Budget Statement 2009/10, page 49
[18] KZN Budget Statement 2009/10, page 49
[19] KZN Budget Statement 2009/10, page 49
[20] KZN Budget Statement 2009/10, page 49
[21] KZN Budget Statement 2009/10, page 49
[22] KZN Budget Statement 2009/10, page 49
[23] KZN Budget Statement 2009/10, page 49
[24] KZN Budget Statement 2006/07, page 43
[25] KZN Budget Statement 2007/08, page 49
[26] KZN Budget Statement 2008/09, page 39
[27] KZN Budget Statement 2009/10, page 41

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

| | | | | | | |
|---|---|---|---|---|---|---|
| 2009/2010 (main budget) | 51635 | 17 449 | 3 031[28] | 15.1% | 14 418 | 27.9% |
| 2010/2011 (main budget) | 56 661 | 20 668 | 3 406[29] | 12.4% | 17 262 | 30.5% |

Table 3: National Conditional Grants to Provinces

| Grant | Financial year | R 000 Total Conditional Grant to Provinces | R 000 KwaZulu Natal Provincial Allocation | % Allocation of National Grant |
|---|---|---|---|---|
| Comprehensive HIV & AIDS Grant | 2005/2006 | 1 150 108 | 251 468[30] | 21.86% |
| | 2006/2007 | 1 616 214 | 344 304[31] | 21.30% |
| | 2007/2008 | 2 006 223 | 466 922[32] | 23.27% |
| | 2008/2009 | 2 885 400 | 757 213[33] | 26.24% |
| | 2009/2010 | 3 476 200 | 880 659[34] | 25.33% |
| | 2010/2011 | 4 311 800 | 1 013 082[35] | 23.50% |
| | | | | |
| National Tertiary Services Grant | 2005/2006 | 4 709 386 | 691 451[36] | 14.68% |
| | 2006/2007 | 4 981 149 | 732 167[37] | 14.70% |
| | 2007/2008 | 5 321 206 | 789 578[38] | 14.84% |

[28] KZN Budget Statement 2009/10, page 41
[29] KZN Budget Statement 2009/10, page 41
[30] KZN Budget Statement 2006/07, page 43
[31] KZN Budget Statement 2007/08, page 49
[32] KZN Budget Statement 2008/09, page 39
[33] KZN Budget Statement 2009/10, page 41
[34] KZN Budget Statement 2009/10, page 41
[35] KZN Budget Statement 2009/10, page 41
[36] KZN Budget Statement 2006/07, page 43
[37] KZN Budget Statement 2007/08, page 49
[38] KZN Budget Statement 2008/09, page 39

Table 3: National Conditional Grants to Provinces

| Grant | Financial year | R 000<br>Total Conditional Grant to Provinces | R 000<br>KwaZulu Natal Provincial Allocation | % Allocation of National Grant |
|---|---|---|---|---|
| | 2008/2009 | 6 134 100 | 911 892[39] | 14.87% |
| | 2009/2010 | 6 614 400 | 983 948[40] | 14.88% |
| | 2010/2011 | 7 398 000 | 1 102 585[41] | 14.90% |
| | | | | |
| Total Conditional Grants to Provinces | 2005/2006 | 8 907 346 | 1 417 977[42] | 15.92% |

[39] KZN Budget Statement 2009/10, page 41

[40] KZN Budget Statement 2009/10, page 41

[41] KZN Budget Statement 2009/10, page 41

[42] KZN Budget Statement 2006/07, page 43

# 3. APPENDIX 3: LIST OF DOCUMENTS REVIEWED

## 3.1. GENERAL

3.1.1. KZNDOH Strategic Plan 2005 – 2009/2010

3.1.2. KZNDOH Annual Performance Plan 2006/2007 and 2008/2009

3.1.3. Provincial Annual Reports ( 2006/2007 - 2007/2008)

3.1.4. Annual Performance Plans ( 2008/2009 - 2009/2010 -2010/2011)

3.1.5. Strategic Transformation Plan (STP)

3.1.6. KZN Provincial Health Act

3.1.7. Framework for the National Health Planning Guidelines for 5-Year Strategic Plans of Provincial Departments of Health for 2010-2014

3.1.8. State of the Province Address by Kwazulu-Natal Premier S Ndebele (18 February 2009)

3.1.9. KZNDOH Close Out Report (investing in women and children secures a healthy nation) 2004-2009

3.1.10. KZNDOH Strategic Plan 2005-2009

3.1.11. Ilembe District Health Plan 2009-2010

3.1.12. Ilembe Health District Newsletter April 2009

3.1.13. Ilembe Health District: District Manager's Quarterly Performance report (quarter 2 of 2008/2009)

3.1.14. Proposed Organisational Structure Ilembe District Office

## 3.2. FINANCE

3.2.1. KZN Zero Based Budget Proposal for the 2008/2009 Financial Year

3.2.2. KZNDOH Budget Statements from 2004/05 to 2009/10

3.2.3. Annual Financial Statements

3.2.4. Integrated Business Plan 2009/2010 Comprehensive HIV and AIDS Conditional Grant National Standard Format

3.2.5. Auditor-General audit report for year ended 31 March 2008

3.2.6. Medium Term Expenditure Framework (2005/2006 to 2007/2008)

3.2.7. National Contract for Support on Health Information (September 2005)

3.2.8. National Health Care Management Information System

3.2.9. Division of Revenue Act (DORA)

3.2.10. Stanger Hospital MTEF Budget Cycle

3.2.11. Government Budgeting Processes (the Intergovernmental Fiscal System)

3.2.12. KZN Budget Speech by Dr Zweli Mkhize (KZN MEC for Finance and Economic Development) 25 February 2009

3.2.13. National: Budget Speech (Minister of Finance Trevor A Manuel) 11 February 2009

## 3.3. HR

3.3.1. KZNDOH Proposed Human Resource Management Structure (March 2009

3.3.2. KZNDOH Performance Management & Development System for Salary Levels 1 to 12

3.3.3. KZNDOH Health Information Audit Report (October 2006)

3.3.4. KZNDOH Organisational Structure and Strategic Plan

3.3.5. KZNDOH Employee Performance Management and Development System (EPMDS) April 2007

**3.4. OTHER**

3.4.1. Presentation to MANCO: 2006 Antenatal HIV and Syphilis Seroprevalence Results (14 August 2007)

3.4.2. Office of the Premier's Annual Report Input (2006/2007)

3.4.3. World Health Oganization. The World Health Report 2000, Health Systems: Improving performance. Geneva, WHO 2000.

3.4.4. Kwazulu-Natal United Response Against HIV and AIDS (Office of the Premier: Chief Directorate for HIV and AIDS)

3.4.5. Ilembe Health District: Visit to Facilities Report (Compiled by Senior Technical Advisor HIS&MIS December 2008

3.4.6. Report for Organisation Unit 3 – Ilembe District Municipality 2009

3.4.7. Health Status in South Africa (Input paper for Health Roadmap) September 2008

3.4.8. Health Systems in Transition –Vol. 8 No. 7 2006 (Croatia Health system review)

3.4.9. Health Roadmap input report –Accelerating the Implementation Plan to Combat HIV & AIDS and TB (September 2008)

3.4.10. KZNDOH Hospital Revitalisation Programme (focussed on: Infrastructure, Health Technology, M&OD and Quality Assurance)

3.4.11. South Africa's Health Barometer (Health Systems Trust HMN meeting 29 September 2006)

3.4.12. Operational Plan HIV and AIDS Office of the Premier (Strategic objectives and outputs with time frames) 2006/07

3.4.13. KZN Office of the Premier Provincial HIV and AIDS Strategy April 2008

3.4.14. NDOH Tuberculosis Strategic Plan for South Africa, 2007-2011

3.4.15. Framework for Assessing Health Governance in Developing Countries: Gateway to Good Governance (Health System Metrics Technical Meeting September 28-29, 2006 Montreux-Glion)

# 4. APPENDIX 4: SCHEDULE OF INTERVIEWS

## Provincial Department Level

| Department/Area | Person(s) Interviewed | Position | Date of Interview |
|---|---|---|---|
| Finance | Mr Sipho Buthelezi | CFO | 4 May 2009* |
| | Mr Johan Britz | Task Team Leader: Cost Containment | 5 May 2009 |
| | Ms Ruth Kitching | Acting Manager: Budgets | |
| SCM | Ms Andile Zondo<br>Mr Mvusi Maluleka | Manager: SCM<br>Acting Manager: SCM | 6 May 2009 |
| Internal audit and risk management | Mr Roger Naidoo<br>Mr Enoch Singh | Manager: Internal Audit<br>Deputy Manager: Risk | 7 May 2009 |
| Human Resources | Mr SM Sibeko | HRMS- PERSAL | 6 May 2009 |
| | Ms J T Makhatini | KZN College of Nursing | |
| | Ms K Naidoo | EAP | |
| | Ms V G Mkhize | HRD | |
| | Ms N E Nundraj | PMDS | |
| | Ms N E Mthembu | HR Planning | |
| | Mr A H Mnguni | HR Practises | |
| | Mr A D Oelofse | Labour Relations | |
| Strategic Health Programmes | Dr Buthelezi &<br>Mr Roger Phili | GM: Strategic Health Programmes<br>Manager: HAST | 6 May 2009 |
| | Mr Bruce Margot | Chief Technical Advisor: TB Control | 14 April 2009 |
| | Dr Victoria Mubaiwa | Manager: Maternal Neonatal Child and Women's Health (MNCWH) | 14 April 2009 |
| Public Health | Ms Noeleen Phillips | GM: Public Health Service, Policy & Systems Development | 3 April 2009 |
| Pharmaceutical Services | Mr Shabalala | Chief Technical Advisor: Pharmaceutical Policy and Systems Development | 17 April 2009 |
| Donor funding | Mr Sifiso Mthembu | Provincial Programme Manager: EU Donor Fund | 3 April 2009 |
| | Ms Vuyiswa Mkhize | Provincial Global Fund Project Manager (TAM) | 9 April 2009 |
| Information Services | Mr Vuma Magaqa | Acting Chief Information Officer (CIO) | 15 April 2009 |

| Department/Area | Person(s) Interviewed | Position | Date of Interview |
|---|---|---|---|
| Monitoring & Evaluation | Ms Liza Johnson | Acting GM: M&E | 5 May 2009 |
| | Ms Ester Snyman | Acting Manager: Strategic Planning | 9 April 2009 |

*Interview terminated in mid-stream due to power outage. Could not be rescheduled due to time constraints.

**District Level: Illembe District**

| Department/Area | Person(s) Interviewed | Position | Date of Interview |
|---|---|---|---|
| District: Illembe | Ms S Dube | District Manager: Illembe | 6 April 2009 |
| Human Resources | Mr Reggie Phahla | Principal HR Practitioner (HR) | 7 April 2009 |
| Information (M&E) | Ms Dudu Mtshali | District HIS & MIS | 6 April 2009 |
| SCM | Mr Nxasane | District Procurement Manager | 7 April 2009 |
| Pharmacy | Mr Eugen Von Maltitz | District Pharmacist | 7 April 2009 |
| Finance | Ms Hlengiwe Ngcobo | Ex-district financial manager and current Principal Account (M&E) | 6 April 2009 |
| Integrated Public Health System Development | Ms N Khumalo PHC program manager | Deputy district manager | 7 April 2009 |
| | Ms L Maphalala | HAST coordinator | |
| | Ms Thandeka Mpanza | TB coordinator | |
| Stanger Hospital | Dr Adri Mansvelder | CEO | 8 April 2009 |
| | Various | Hospital Management Team | |

# 5. APPENDIX 5: MDR TB TREATMENT, MSINGA

## Case study

### 1. Introduction

Msinga is one of the internationally well known under-developed and highly impoverished places within the UMzinyathi district which is a remote and rural part of KZN. In 2006 there were widespread media reports of an outbreak of a deadly and almost incurable XDR TB at the Church of Scotland Hospital in Msinga. This posed a great threat to the public health system that was still battling with the high defaulter rates in TB and MDR TB treatment, which was at 19,2% in UMzinyathi district.

King George V Hospital (KGV) was the only referral hospital in KZN for MDR TB with 320 beds, until the decision to decentralise services to district hospitals and to create dedicated MDR TB beds in 2008. On discharge from KGV patients were transferred to home based care services in their districts to avoid generating XDR, but a system to follow up on MDR TB patients was weak. High defaulter rates were experienced with patients as they returned to their homes in Msinga and were therefore more likely to develop XDR TB.

Church of Scotland Hospital diagnosed the first two XDR TB cases in 2004. The two patients were hospitalised with HIV related illnesses and improved on ART with an evident rise in CD4 counts and undetectable viral loads. They, however, started deteriorating despite the treatment and showed signs of rapidly progressing TB. MDR TB was suspected and drug sensitivities were subsequently done for 45 TB patients where 10 were found to be resistant to almost all drugs used against TB. XDR was discovered and was a followed by a more systematic study carried out by the Yale University and the University of KZN where MDR TB was found in 221 patients (in and outpatients) and 53 had XDR TB. Most patients with XDR were HIV infected and 52 of 53 died within an average of 16 days.

## 2. Intervention

The threat of a rising, almost incurable XDR TB prevalence, stimulated an interest to evaluate and strengthen TB control in the district and find innovative ways to prevent development of new cases and reduce defaulter rates to zero in UMzinyathi district. In January 2006, a new tool was introduced to address defaulting. UMzinyathi district health received technical support from the Italian Cooperation and Istituto Superiore di Sanita and the TB programme in the district was evaluated through reviewing of data on MDR/XDR TB from households, tracing of MDR/XDR households by health teams, mapping MDR/XDR TB households in GIS maps, household visits by tracer teams and provision of systematic VCT.

Poverty profiles of MDR/XDR TB households were done and revealed that 72% of patients live in homes made out of mud, 75% are headed by women with 11.5% having formal employment while 89% depend on social grants for survival. Only 2% have electricity and 98% travel on foot to the nearest health centre, which is an average of 4.4km away.

The evaluation of the TB programme in the district was followed by household surveillance that led to the development of strategies to decrease the spread of infection and improve treatment completion which will reduce the number of new MDR cases in the district. These were:

❒ Improving Infection control

- It was acknowledged that the presence of MDR/XDR TB is a sign of inadequate infection control in facilities.
- Therefore different policies were put in place like the 'open window' policy in TB wards and waiting rooms, an extractor fan was installed in the TB ward, coughing patients are separated from the rest of the patients to well ventilated waiting areas.

- ❒ Improving the Defaulter rate.

  - Community management and Home based care management for TB has been introduced for MDR TB patients due to insufficient capacity of KGV to accommodate all MDR TB cases in the province.
  - Mobile medical teams provide home based care to patients and collect information on side effects and other issues.
  - This initiative has proven to be cost effective and amounts to approximately 10% of the cost of hospitalisation. It increases bed availability at the hospitals as patients are discharged to this programme for follow up.
  - Patients and their families are taught on the disease prevention and treatment.
  - The tracer team goes to the households of patients to gather a profile for management of the whole family which includes the type of housing, ventilation status, no. of household members, no. of under 5 year old children who have been found to be most vulnerable to transmissions.
  - When the family has been well orientated and found to be ready, the patient is discharged and followed up by the medical team.
  - This model has attracted WHO, and other international, interest and is now being considered as a pilot to properly cost it and investigate its sustainability and value in the health system, even for HIV treatment.

**3. Lessons Learnt from the Msinga Experience**

The following factors are thought to be behind the decline in defaulter rates and in MDR TB in Msinga:

- ❒ The commitment of the UMzinyathi District Health Management team ensured that TB control was placed at the top of the district's agenda and that adequate resources were allocated to tackle the disease.
- ❒ The management of TB patients was aggressively addressed by providing refresher training for nurses and introducing appointment diaries to track patients.

- ❒ An increase in the nurse-to-patient ratio also played an important role in improving treatment outcomes and in preventing defaulting.
- ❒ Tracer teams were increased and provided with GPs to map MDR/XDR TB households. Tine tests were performed and containers with sputum samples were sent to IALCH laboratory for analysis.
- ❒ TB suspects in the community were identified through strict surveillance and contact tracing.
- ❒ Measures were taken to bolster infection control at the Church of Scotland Hospital where the first cases were diagnosed, to reduce hospital transmission of MDR/XDR TB.
- ❒ Public information campaigns helped sensitise the community on the dangers and prevention of TB.
- ❒ The most important factor influencing cure rates for TB was the number of patients per nurse. It was concluded that 40 TB patients per nurse per year is likely to have a cure rate of 70% and that higher patient numbers compromise the quality of care and the quality of data collection and case recording. Higher numbers resulted in poor follow up and resultant treatment defaulters. The provincial TB manager has discovered that the best performing clinics are run by a staff nurse as the dedicated TB focal person.

## 4. Conclusion

- ❒ Active and consistent Monitoring and Evaluation needs to be one of the key activities in any programme development.
- ❒ TB programmes need disease surveillance, research and clinical support as part of the TB management team to be able to cascade this type of vigilance across service points.
- ❒ The case study highlights the critical role played by utilisation of information at the places of service delivery.
- ❒ As a result of a good monitoring system in place, innovative strategies are developed to improve service delivery.
- ❒ Community surveillance and community based management of disease contributed strongly to the decline in defaulters and MDR cases in Msinga.
- ❒ International donor support has a role in providing technical skills to support programmes that are facing challenges.