Strictly Private and Confidential

# Limpopo Department of Health:

## *Report of the Integrated Support Team*

**11 May 2009**

**Final Draft**

DRAFT

## Contents

ACKNOWLEDGEMENTS....4
ABBREVIATIONS....5
22. FOREWORD ....8
EXECUTIVE SUMMARY
....9
1 INTRODUCTION....14
2. FINANCIAL REVIEW....16
4 HUMAN RESOURCES....44
4.1 Introduction....44
5. INFORMATION MANAGEMENT....55
5.1 Introduction....55
6. MEDICAL PRODUCTS, LABORATORY ....62
62
7. TECHNOLOGY AND INFRASTRUCTURE....64
APPENDIXES....79
Appendix 1: Terms of Reference....79
Appendix 2: List of Documents Reviewed....90
Appendix 3: Schedule of Interviews....92

DRAFT

DRAFT

## ACKNOWLEDGEMENTS

We wish to thank the Senior General Manager, Health Branch, Dr Nkadimeng, the then Acting Head of Department Mr Tshikovhi and the chief financial officer, Mr FP Mushwana for facilitating the review and for the information provided. Special thanks also to all the other managers of the different Branches of the Limpopo Provincial Department of Health at Polokwane offices, Mopani District office and Nkhensani Hospital for the time spent in interviews and the valuable insights they provided.

We appreciate the oversight of the project from Mr Bertie Loots, Dr Nicholas Crisp, Mr Kevin Bellis, Dr Letitia Rispel and Dr Peter Barron

We thank Gitesh Mistry, Frank Groenewald and Ruqayya Dawood for project management and administrative assistance and Pontsho Makgabo for travel and accommodation arrangements.

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

This review has been conducted with funding from the UK Government's Department for International Development Rapid Response Health Fund.

## ABBREVIATIONS

| | |
|---|---|
| AFS | Annual Financial Statements |
| AIDS | Acquired Immunodeficiency Syndrome |
| APP | Annual Performance Plan |
| ART | Anti-retroviral Therapy |
| ARV | Anti-retroviral |
| BAS | Basic Accounting System |
| CEO | Chief Executive Officer |
| CFO | Chief Financial Officer |
| CHC | Community Health Centre |
| COGNOS | IBM business intelligence (BI) and performance management solution |
| DFID | UK Government's Department for International Development |
| DHIS | District Health Information System |
| DHS | District Health System |
| DMT | District Management Team |
| DM | District Manager |
| DOH | Department of Health |
| DoRA | Division of Revenue Act |
| DPSA | Department of Public Service and Administration |
| EHS | Environmental Health Services |
| EMRS | Emergency Medical Rescue Services |
| GITO | Government Information Technology Office |
| GM | General Manager |
| HIV | Human Immunodeficiency Virus |
| HOD | Head of Department |
| HR | Human Resources |
| HRD | Human Resource Development |
| HRM | Human Resource Management |
| HSS | Health Systems Strengthening |
| ICT | Information and Communication Technology |
| IST | Integrated Support Teams |
| IYM | In Year Monitoring |
| LP | Limpopo Province |
| LDHSD | Limpopo Department of Health and Social Development |
| M&E | Monitoring and Evaluation |
| M&OD | Management & Organisational Development |
| MACH | Ministerial Advisory Committee on Health |
| MCH | Maternal and Child Health |
| MEC | Member of the Executive Council |
| MTEF | Medium Term Expenditure Framework |
| N/A | Not available/ not applicable |
| NDOH | National Department of Health |
| NIDS | National Indicator Data Set |
| NTSG | National Tertiary Services Grant |
| OSD | Occupational Specific Dispensation |



DRAFT

| | |
|---|---|
| PDE | Patient Day Equivalent |
| PERSAL | Personnel and Salary Administration System |
| PFMA | Public Finance Management Act |
| PHC | Primary Health Care |
| PMTCT | Prevention of Mother-To-Child-Transmission |
| RACI | Responsible, Accountable, Consulted, Informed |
| RRHF | Rapid Response Health Fund |
| SCM | Supply Chain Management |
| SGM | Senior General Manager |
| STI | Sexually Transmitted Infection |
| STP | Service Transformation Plan |
| TB | Tuberculosis |
| TOP | Termination of Pregnancy |
| TR | Team Representative |
| WHO | World Health Organisation |

DRAFT

DRAFT

# 22. FOREWORD

This final report comes at a time when South Africa is entering its fourth period of democratic government. This provides an exciting opportunity to reflect on past performance and identify or revise strategies that will improve health system performance in order to achieve better health outcomes of the people we serve.

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

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

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

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



DRAFT

# 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 Department's of Health to revitalise and reorient South Africa's response to the HIV pandemic and to support health systems strengthening to improve health outcomes. In response to this threat to the overall functioning of the health system, the honourable Minister of Health, Ms Barbara Hogan, requested an in-depth review of the underlying factors behind the overspending. This led to the establishment of the Integrated Support Teams (ISTs) in February 2009. The ISTs comprise consultants who are financial, public health, and management and organisational development specialists.

The IST team undertook its review of the Health Branch of the Limpopo Department of Health and Social Development during March and April 2009. The review was a broad-based, rapid appraisal that focused on the health system as a whole, but with *an emphasis on the over-expenditure*. It consisted of a desk top review of documents and in-depth interviews with key informants at provincial and district levels.
The review has highlighted a number of key challenges and recommendations, which are contained in the body of the report. The overall approach to the review is based on the World Health Organisation (WHO) classification of health systems building blocks viz:

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

The priority findings of the review are:

1. There has been a degree of longstanding inadequate funding for the health branch of the LDHSD that has resulted in the development of an overdraft.

DRAFT

2. There are material unfunded mandates at provincial level contributing to overspending. This in turn results in stringency measures with associated negative consequences for service delivery, managerial performance and staff morale.

3. The narrowing of the gap between the amounts budgeted for and the amount allocated by the Limpopo Provincial Government coupled with settlement of the current existing overdraft and financial discipline will enable the LDHSD to get a fresh start

4. The *current model for the scale up of anti-retroviral therapy (ART) for people with AIDS* is unsustainable from a health systems perspective and unaffordable from a budgeting perspective.

5. The*re is a dearth of national guidelines, norms, standards and targets. This perceived l*ack of national stewardship and leadership impacts on every aspect of the health system and its performance.

6. Decision making on issues of strategic importance like the organisational structure are not finalized even after years that work on these have been concluded. The organizational structure foster inefficient functioning in silos, an issue which inevitably gets replicated at all levels from the provincial Head Office through to the district health services.

7. Monitoring and evaluation (M&E) systems are inadequate and are undertaken to comply with requirements of the Provincial Legislature or the National Department, rather than to provide information to the different levels in the LDHSD, for managing the health service. The M&E component of the service is under-resourced, fragmented and data collected are not analysed, interpreted or used for decision making. In addition there is little or no feedback of information from one level to the next.

8. There is inadequate attention paid to the support of effective Primary Health Care and a greater preoccupation with and pursuit of tertiary hospital care and a medical school. .

9. *Senior management appear to be pre-occupied with operational functions* and do not appear to be focussed on service delivery particularly at the PHC level. This is partially due to the withdrawal of delegations which causes management to be involved in mundane day to day paperwork.

10. There are developmental factors external to the LDHSD that impinge on service delivery and on the cost of healthcare in the province (e.g. population dispersion over a vast geographic expanse, poor road infrastructure) Many of these cannot be quantified with any degree of accuracy for accurate budget estimates.

11. Opportunities exist for reducing costs and improving the quality of care by investing in newer technologies e.g. tele-medicine (for improving access to better quality of care) and voice over internet protocol – VOIP – (for facilitating communication and cutting costs of telephony).

Based on these priority findings, key recommendations are made below. Additional recommendations are found in the body of the report.

***Unfunded mandates***

- *The existing overdraft which occurred in part as a result of the unfunded mandates needs to be settled to enable the LDHSD to start with a clean slate.*
- *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.*
- *There should be alignment between political decisions and operational implementation and agreement reached for any proposals on increases of service levels prior to their announcement. The availability of funding should also be confirmed.*

***Lack of cohesion between policy and budgets***

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



DRAFT

***ART Model***

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

***National guidelines, norms and standards***

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

***Human resources***

- *Restructuring, with a view to establishing minimum staffing levels, should be undertaken based on a number of factors including objectively agreed benchmarks, the provincial disease burden profile, optimal application of scarce skills and service delivery priorities as well as on available resources.*

***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.*
- *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).*

***Planning***

- *The STP should be reviewed, finalised, costed, endorsed politically, communicated to all relevant stakeholders and then used as the basis to guide all strategic decision making in the LDHSD*
- *All planning processes in the LDHSD should be simplified and aligned with each other and well communicated. There should be a limited number of key targets for each area of operation for which managers are responsible and accountable.*

***Service delivery focus***

- *The organisational structure should be reviewed with a view to create optimal co-ordination viz incorporate district hospitals and district health structures into the same Directorates*

DRAFT

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

DRAFT

# 1 INTRODUCTION

## 1.1 Background

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 Department's of Health to revitalise and reorient South Africa's response to the HIV pandemic and to support health systems strengthening to improve health outcomes. In response to this threat to the overall functioning of the health system, the honourable Minister of Health, Ms Barbara Hogan, requested an in-depth review of the underlying factors behind the overspending. This led to the establishment of the Integrated Support Teams (ISTs) in February 2009. The ISTs comprise consultants who are financial, public health, and management and organisational development specialists.

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

## 1.2 Aims of the ISTs

The aims of the ISTs are to:

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



DRAFT

## 1.3 Specific objectives

The specific objectives of the ISTs were to:

1. Assess the current and projected expenditure trends at the National Department of Health (NDOH) and the 9 Provincial Departments of Health.
2. Examine the alignment between:
   - Stated objectives in the Strategic Plans and the Budget Statements.
   - Budget Statements, the resources used/available and the actual results achieved.
3. Identify the key cost drivers underpinning expenditure and to establish the extent of overspending.
4. Review the management and financial processes in operation with a view to suggesting possible improvements.

## 1.4 Methodology

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 Organisation (WHO). This WHO framework suggests that the key building blocks of a heath system are: Service Delivery, Leadership and Governance; Human Resources (Health work force); Finances; Information management; Medical products; and Technology and Infrastructure.[2] Due to time constraints, the HIV & AIDS, tuberculosis (TB) and maternal and child health (MCH) programmes were used as tracer programmes, both to add depth and to complement the health system building block reviews. The rationale for selecting these programmes include: contribution to the disease burden; ministerial priorities; important Millennium Development Goals (MDGs) indicators; facilitates analysis of conditional grant and the equitable share expenditure; and their relative contribution to component expenditure (e.g. pharmaceuticals).

This rapid review consisted of two main parts: a desk top review and in-depth interviews with key informants at provincial and district levels. The desktop review comprised and analysis

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



DRAFT

of available public documents plus selected documents obtained from the LDHSD and other sources. This desktop review was carried out by a group of experts in the fields of public health, finance and management and organisational development. A list of these documents is shown in Appendix 2.

In-depth interviews were conducted with the majority of senior managers at the provincial level and at one purposefully selected district, viz Mopani its sub-district Giyani and its district hospital, Nkhensani Hospital. The interviews were conducted by a team of three experts who visited the Limpopo province between the 30th of March and the 8th of April 2009. The list of people interviewed is shown in Appendix 3. The interviews were complemented by a further analysis of the documentation provided.

The report is based on information and interview inputs obtained from the LDHSD visit and do not include the viewpoints of NDOH and Treasuries.

### 1.5 Outline of the report

This document reports on the IST review done in the Limpopo Department of Health ad Social Development (LDHSD). Section 2 focuses firstly on the key findings and recommendations of the financial assessment, because the over-spending was the catalyst for the IST review. As over-spending is an indicator of broader systemic challenges, the remainder of the sections focuses on the assessment of other key building blocks of the health system. Section 3 focuses on an assessment of leadership, governance and service delivery. Section 4 sets out the results of the human resource assessment, while section 5 focuses on information management. Sections 6 and 7 contain the assessment on medical products and laboratory, and infrastructure and technology respectively. Section 8 integrates the recommendations from the various sections, and indicates the hierarchy of responsibilities for implementation.

DRAFT

## 2. FINANCIAL REVIEW

### 2.1 Introduction

The financial review derives from an in-depth assessment of the Limpopo DOH budget and expenditure reports, National Treasury reports and interviews with Limpopo DOH management at the Head Office, Mopani District and the Giyani subdistrict. The key findings from the review are summarised in Box 1, and elaborated on below.

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

1. The contention of under-funding of the Limpopo DOH and the South African public health system as a whole is being investigated at a national level and will be commented on in the overall IST national report.
2. The result from the perceived under-funding is perceived under-staffing. The LDHSD is already spending 65,9% of its total budget on compensation of employees.
3. For the 2009/10 financial year, 26% of the total Limpopo provincial revenue is allocated to Health bringing the allocated percentage in line with the National Treasury guidelines. Previous years the allocation to health was 23 – 24%.
4. The relative proportion of the national conditional grant for HIV/AIDS allocated to the Limpopo DOH has decreased over the past four years from 10.95% in 2005/06 to 8,12% in 2008/09.
5. During the period 2005/06 to 2010/11 initially the per capita allocation was lower than the national budget per capita but a 27,66% increase in 2008/09 has brought the province closer to the national average although still slightly below.
6. Although over-expenditure only commenced in the 2006/7 financial year, it was exacerbated by OSD and higher numbers of patients on anti-retroviral therapy (ART) than original forecast numbers.
7. There has been a marked shift in the nature of the items in which over-expenditure has taken place during the past three years (changed from goods and services to employee compensation).
8. There is lack of alignment between annual plans and the adjusted or allocated budget.
9. Budgeting and financial management processes (including cost allocations and proper cost centre accounting; financial monitoring and evaluation) are sub-optimal.
10. Unfunded mandates (e.g. policy decisions such as function shifts, occupational specific dispensation) exacerbate spending pressures.
11. Management accountability for finances needs improvement.
12. The financial system is integrated with the quarterly performance reporting system but the follow up, feedback or accountability is sub-optimal.
13. The integrated health information system information is used when compiling



DRAFT

budget requests but in the allocation process this information seems to be disregarded.

14. The full budgetary impact of the cost of treatment required by patients on ART needs to be better quantified.

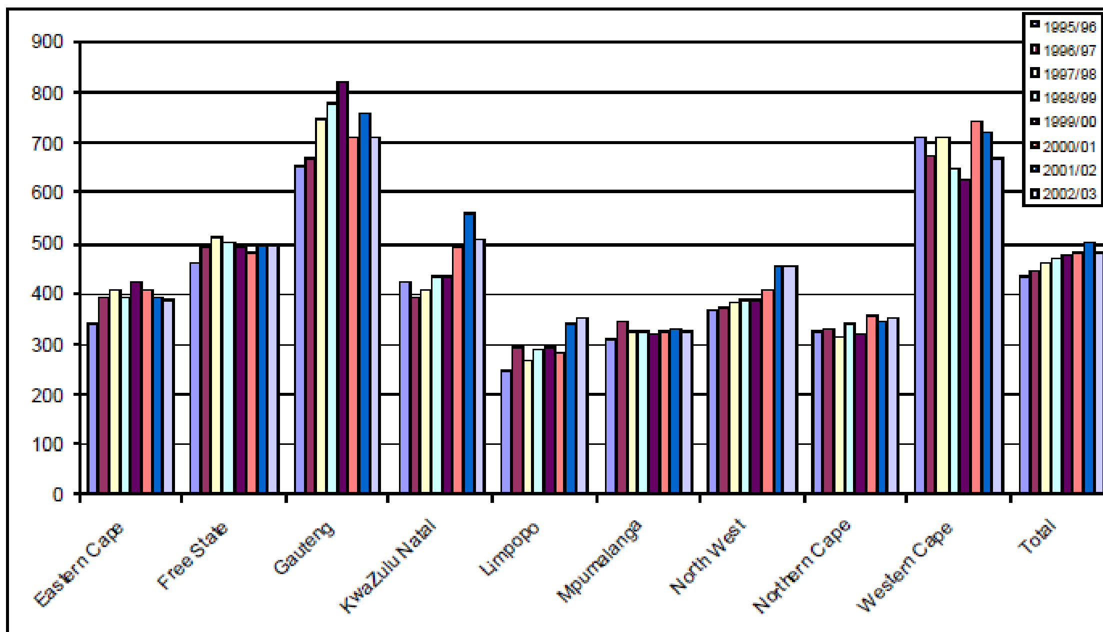
## 2.2 Under-funding of the Public Health System in South Africa

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 Limpopo and nationally is due to the under-funding of the system with consequent “unfunded mandates” resulting again in under-staffing.

Historically the LDHSD like other predominantly rural provinces has been affected by inequity in public health funding as shown in Figure 1 below. Though annual funding of the LDHSD improved somewhat since 2002, fiscal federalism allowed the inter-provincial inequity to continue.

DRAFT

Trends in real per capita Public Health spending: 1995 - 2002




Real per capita trends- Distance from National average: 1995 - 2002

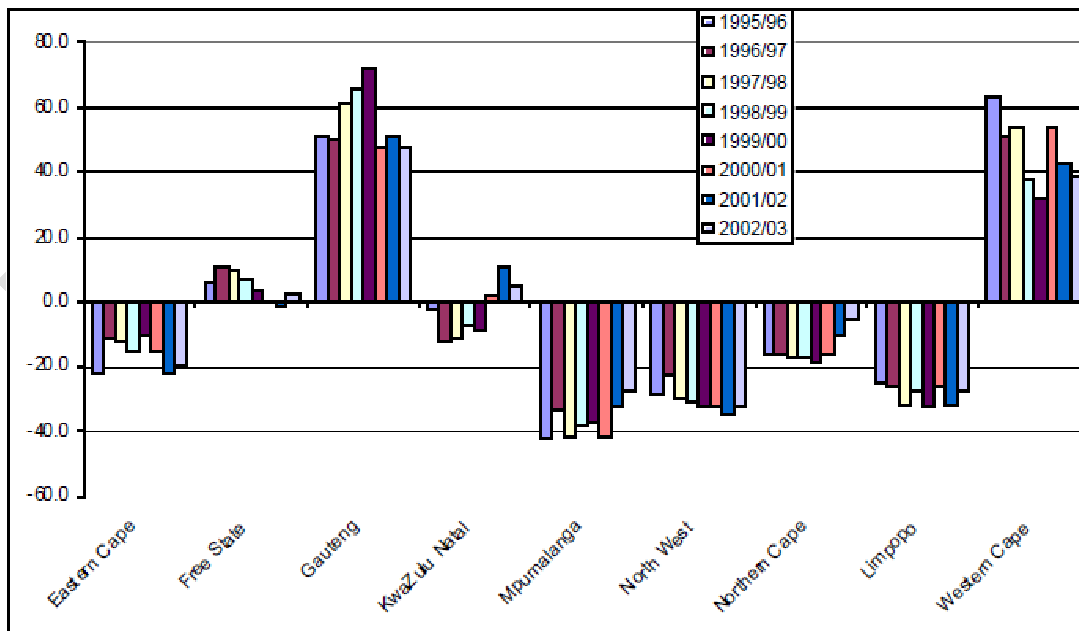



**Figure 1: History of inter-provincial equity in health spending**

Source: Report on Interprovincial inequity. Health Financial Planning and Economics Directorate.::
Available on www.doh.gov.za/documentssearch/index.htm/

### 2.3 Provincial budget allocation

The allocation of the Limpopo Province's budget to the Limpopo DOH is shown in Table 1. The allocation includes the equitable share, conditional grants and provincial revenue. Although initially the LDHSD received less than the national guideline of 26% (2005/06 – 23,86%; 2006/07 – 23,41%; 2007/08 – 23,99%), this was corrected in 2008/09 with a

26,02% allocation to Health. There was a large increase in the last financial year 2008/09 from 24% to 26%

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

| | R m Provincial Budget | Year on year increase | R m Health Budget | Year on year increase | % Allocation to Health | R m Adjustment Provincial Budget | R m Adjustment Health Budget | % Allocation to Health |
|---|---|---|---|---|---|---|---|---|
| 2005/06 | 20 643[3] | N/A | 5 046[4] | N/A | 24.44% | 21 367[5] | 5 098[6] | 23.86% |
| 2006/07 | 22 899[7] | 10.9% | 5 448[8] | 8.0% | 23.79% | 23 722[9] | 5 554[10] | 23.41% |
| 2007/08 | 25 312[11] | 10.5% | 6 096[12] | 11.9% | 24.08% | 24 961[13] | 5 987 [14] | 23.99% |
| 2008/09 | 29 633[15] | 17.1% | 7 594[16] | 24.6% | 25.63% | 30 562[17] | 7 952[18] | 26.02% |
| 2009/10 | 34 476[19] | 16.3% | 9 018[20] | 18.8% | 26.16% | N/A | N/A | N/A |
| 2010/11 | 38 111[21] | 10.5% | 10 076[22] | 11.7% | 26.44% | N/A | N/A | N/A |
| 2011/12 | 41 157[23] | 8.0% | 10 786[24] | 7.0% | 26.21% | N/A | N/A | N/A |

When conditional grants are excluded, the provincial equitable share allocation to health was relatively constant around 23% for from 2005/06 to 2007/08 with a large increase to nearly 26 % in 2008/09 (Table 2).

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

[3] Limpopo Province Budget Statement 2006/07, page 10
[4] Limpopo Province Budget Statement 2006/07, page 10
[5] Limpopo Province Budget Statement 2006/07, page 10
[6] Limpopo Province Budget Statement 2006/07, page 10
[7] Limpopo Province Budget Statement 2007/08, page 19
[8] Limpopo Province Budget Statement 2007/08, page 19
[9] Limpopo Province Budget Statement 2007/08, page 19
[10] Limpopo Province Budget Statement 2007/08, page 19
[11] Limpopo Province Budget Statement 2008/09, page 56
[12] Limpopo Province Budget Statement 2008/09, page 56
[13] Limpopo Province Budget Statement 2008/09, page 56
[14] Limpopo Province Budget Statement 2008/09, page 56
[15] Limpopo Province Budget Statement 2008/09, page 56
[16] Limpopo Province Budget Statement 2008/09, page 56
[17] Limpopo Province Adjustment Estimates 08/09, page provisional budget for 2009/10
[18] Limpopo Province Adjustment Estimates 08/09, page 56 of Budget Statement 2008/09;IYM, January 2009
[19] MEC Budget Speech, 2009, page 9
[20] MEC Budget Speech, 2009, page 11
[21] MEC Budget Speech, 2009, page 9
[22] MEC Budget Speech, 2009, page 11
[23] MEC Budget Speech, 2009, page 9
[24] MEC Budget Speech, 2009, page 11



DRAFT

| | R m<br><br>Adjustment Provincial Budget (incl Grants) | R m<br><br>Adjustment Provincial Conditional Grants | R m<br><br>Adjustment Provincial Budget (excl Grants) | R m<br><br>Adjustment Health Budget (incl. Grants) | R m<br><br>Health Grants | % Year on year increase in Health Grants | R m<br><br>Adjustment Health Budget (excl. Grants) | % Allocation to Health |
|---|---|---|---|---|---|---|---|---|
| 2005/06 | 21 367[25] | 1 935[26] | 19 432 | 5 098[27] | 612[28] | N/A | 4 486 | 23.09% |
| 2006/07 | 23 722[29] | 1 997[30] | 21 725 | 5 554[31] | 509[32] | -16.83% | 5 045 | 23.22% |
| 2007/08 | 24 961[33] | 2 578[34] | 22 383 | 5 987[35] | 654[36] | 28.49% | 5 333 | 23.83% |
| 2008/09 | 30 562[37] | 3 368[38] | 27 196 | 7 952[39] | 904[40] | 38.23% | 7 048 | 25.92% |

## 2.4 National conditional grant allocation

The comprehensive HIV & AIDS and national tertiary service grants (NTSG) were used as two tracers to assess trends in the allocation of conditional grants to the Limpopo DOH (Table 3). There has been a steady decline in the proportion of the HIV and AIDS grant allocated to the Limpopo DOH from 2005/06 through to 2008/09. The National Tertiary Services Grant remained fairly constant at around 1,5% with an increase to 2,48% in 2008/09. The criteria for the allocation of all the conditional grants were not clear.

### Table 3: National Conditional Grants to Provinces

| | | R 000 Total Conditional Grant to Provinces | R 000 Limpopo Provincial Allocation | % Allocation of National Grant |
|---|---|---|---|---|
| Comprehensive HIV & AIDS Grant | 2005/06 | 1 150 108[41] | 125 899[42] | 10.95% |
| | 2006/07 | 1 616 214[43] | 175 861[44] | 10.88% |
| | 2007/08 | 2 006 223[45] | 200 578[46] | 10.00% |
| | 2008/09 | 2 885 400[47] | 234 410[48] | 8.12% |

[25] Limpopo Province Budget Statement 2006/07, page 10
[26] Limpopo Province Budget Statement 2006/07, page 7
[27] Limpopo Province Budget Statement 2006/07, page 10
[28] Limpopo Province Budget Statement 2006/07, page 7
[29] Limpopo Province Budget Statement 2007/08, page 19
[30] Limpopo Province Budget Statement 2006/07, page 16
[31] Limpopo Province Budget Statement 2007/08, page 19
[32] Limpopo Province Budget Statement 2007/08, page 16
[33] Limpopo Province Budget Estimate 2008/09, page 56
[34] Limpopo Province Budget Statement 2006/07, page 41
[35] Limpopo Province Budget Statement 2008/09, page 56
[36] Limpopo Province Budget Statement 2008/09, page 41
[37] Limpopo Province Adjustment Estimates 08/09, page 9 of MEC Budget Speech, 2009
[38] Limpopo Province Budget Statement 2006/07, page
[39] IYM, January 2009 page 56 of Budget statement 2008/09
[40] Limpopo Province Budget Estimate 2008/09, page 1 of 21 of 2009/10 provisional budget statement
[41] Estimates of National Expenditure 2008, page 279
[42] Limpopo Province Budget Statement 2006/07, page 7
[43] Estimates of National Expenditure 2008, page 279
[44] Limpopo Province Budget Statement 2007/08, page 16
[45] Estimates of National Expenditure 2008, page 279
[46] Limpopo Province Budget Statement 2008/09, page 41
[47] Estimates of National Expenditure 2009, page 298

| | | R 000 Total Conditional Grant to Provinces | R 000 Limpopo Provincial Allocation | % Allocation of National Grant |
|---|---|---|---|---|
| National Tertiary Services Grant | 2005/06 | 4 709 386[49] | 71 182[50] | 1.51% |
| | 2006/07 | 4 981 149[51] | 71 579[52] | 1.44% |
| | 2007/08 | 5 321 206[53] | 79 649[54] | 1.50% |
| | 2008/09 | 6 134 100[55] | 152 239[56] | 2.48% |
| | | | | |
| Total Conditional Grants to Provinces | 2005/06 | 8 907 346[57] | 519 069[58] | 5.83% |
| | 2006/07 | 10 206 542[59] | 406 683[60] | 3.98% |
| | 2007/08 | 11 736 678[61] | 547 174[62] | 4.66% |
| | 2008/09 | 14 362 800[63] | 769 892[64] | 5.36% |

## 2.5 Total budget per capita

The budget per capita for the Limpopo DOH was calculated using Statistics South Africa mid-year estimates (Table 4).

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

| | Uninsured national population | Rm Total of provincial budgets | R Uninsured per capita | Year on year increase | Uninsured Limpopo provincial population | Rm Limpopo Provincial budget | R Limpopo Uninsured per capita | Year on year increase |
|---|---|---|---|---|---|---|---|---|
| 2005/06 | 40,323,852 | 48 067 | 970 | N/A | 5 257 455 | 5 046 | 895 | N/A |
| 2006/07 | 40,898,347 | 54 533 | 1 110 | 14.43% | 5 005 918 | 5 448 | 1 015 | 13.41% |
| 2007/08 | 41,007,279 | 62 633 | 1 193 | 7.48% | 5 019 294 | 6 096 | 1 128 | 11.13% |
| 2008/09 | 41,725,016 | 75 492 | 1 623 | 36.04% | 4 900 289 | 7 594 | 1 440 | 27.66% |
| 2009/10 | 41,725,016 | 86 945 | 1 840 | 13.37% | 4 900 289 | 9 018 | 1 710 | 18.75% |
| 2010/11 | 41,725,016 | 97 632 | 2 056 | 11.74% | 4 900 289 | 10 076 | 1 910 | 11.70% |

[48] Limpopo Province Budget Statement 2008/09, page
[49] Estimates of National Expenditure 2008, page 279
[50] Limpopo Province Budget Statement 2006/07, page 7
[51] Estimates of National Expenditure 2008, page 279
[52] Limpopo Province Budget Statement 2007/08, page 16
[53] Estimates of National Expenditure 2008, page 279
[54] Limpopo Province Budget Statement 2008/09, page 41
[55] Estimates of National Expenditure 2009, page 298
[56] Limpopo Province Budget Statement 2008/09, page
[57] Estimates of National Expenditure 2008, page 279
[58] Limpopo Province Budget Statement 2006/07, page 7
[59] Estimates of National Expenditure 2008, page 279
[60] Limpopo Province Budget Statement 2007/08, page 16
[61] Estimates of National Expenditure 2008, page 279
[62] Limpopo Province Budget Statement 2008/09, page 41
[63] Estimates of National Expenditure 2009, page 298
[64] Limpopo Province Budget Statement 2008/09, page

The per capita budget for health in the Limpopo (based on the total uninsured population) is lower than the national per capita budget for South Africa. The nominal budget per capita has increased with the major "correction" coming in 2008/09 at 27.66% to bring it closer to the national average. The MTEF shows a slightly lower than national average for 2008/9 to 20010/11.

This population excludes the large numbers of people from Zimbabwe, Mozambique and Botswana who reportedly make use of health services in the Limpopo. There has been an increase in the Limpopo compounded annual growth rate of the health per capita budget over the period reviewed of 16,53% per annum compared to the 16.61% per annum increase nationally.

## 2.6 Trends in health expenditure

The Limpopo DOH has overspent its budget for the last three years running including the 2008/09 estimate. (Table 5). The surplus/ (deficit) per the Appropriation Statements has been adjusted by the IST team to take into account the increase in the accruals outstanding at year-end (i.e. accounts payable). This has been done to better align the operational activity with actual payments of expenses made (e.g. medication utilised prior to year end and only paid after year end). It should be noted that the numbers for the 2008/09 financial year have been prepared on a different basis than those for the other years (i.e. the numbers for 2008/2009 are unaudited and have been affected by a change in the funding policy from the Provincial Treasury-see below). Comparable figures will only be available once the 2008/09 annual financial statements have been audited. Any conclusion on trends up to 2008/09 should therefore be reserved until the financial statements have been finalised.

**Table 5: Trends in Limpopo DOH expenditure**

| | R 000 **2005/06** (AFS) | R 000 **2006/07** (AFS) | R 000 **2007/08** (AFS) | R 000 **2008/09** (estimate) |
|---|---|---|---|---|
| Surplus/(deficit) per Appropriation Statement | 309 612 | (277 636) | 39 630 | (35 000)[65] |
| (Increase)/decrease in accruals payable | | | (342 367) | 4 839 |
| Surplus/(deficit) adjusted for movement in accruals | | | **(302 737)** | **(30 161)** |
| *Balance of accruals at year end* | | *62 472* | *404 839* | *109 000*[66] |

[65] Estimate obtained from the CFO (the estimate is based on judgement and can only be confirmed after the end of the financial year)

[66] Estimate obtained from the CFO (the estimate is based on judgement and can only be confirmed after the end of the financial year)

The overspending commenced in 2006/07 with the main contributors to the overspending in financial years 2006/07 and 2007/08 being:

- Compensation of employees, in particular the effect of implementation of the OSD for nurses and higher salary increases than budgeted for.
- Medical inflation being higher than budgeted inflation increases.
- Increase in operational service levels e.g. higher numbers of patients on anti-retroviral (ARV's) than the forecast numbers.

The IST team believes that additional funding without fundamental improvements in the health delivery system (focus, effectiveness and efficiency) will only result in more usage and spending. Additional funding alone, without these improvements, may therefore only resolve the current overspending, but the pattern of overspending will continue as soon as the additional funding is exhausted.

It is difficult to determine the trend of overspending due to virements. However, it seems as if the spending has shifted from goods and services to compensation of employees (OSD and material salary increases).

DRAFT

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

| | 2005/06 | | | 2006/07 | | | 2007/08 | | |
|---|---|---|---|---|---|---|---|---|---|
| | 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** |
| Administration | 320 173 | 305 337 | 14 836 | 291 214 | 345 804 | (54 590) | 162 381 | 160 618 | 1 763 |
| District Health Services | 2 416 612 | 2 366 331 | 50 281 | 2 800 173 | 2 900 126 | (99 953) | 3 312 851 | 3 303 974 | 8 877 |
| Emergency Medical Services | 115 587 | 115 586 | 1 | 181 642 | 204 106 | (22 464) | 201 525 | 196 746 | 4 779 |
| Provincial Hospital Services | 620 141 | 620 139 | 2 | 722 984 | 722 432 | 552 | 884 439 | 884 923 | (484) |
| Central Hospital Services | 475 348 | 431 189 | 44 159 | 480 238 | 496 655 | (16 417) | 560 379 | 559 264 | 1 115 |
| Health Sciences and Training | 195 153 | 182 571 | 12 582 | 235 997 | 242 695 | (6 698) | 230 684 | 210 397 | 20 287 |
| Health Care Support | 479 003 | 365 630 | 113 373 | 363 935 | 365 332 | (1 397) | 393 365 | 391 677 | 1 688 |
| Health Facilities Management | 475 232 | 400 889 | 74 343 | 477 357 | 554 026 | (76 669) | 424927 | 423 322 | 1 605 |
| Internal charges | 620 | 585 | 35 | 719 | 719 | 0 | | | |
| **Total** | **5 097 869** | **4 788 257** | **309 612** | **5 554 259** | **5 831 895** | **(277 636)** | **6 170 551** | **6 130 921** | **39 630** |
| **Economic classification** | | | | | | | | | |
| Compensation of employees | 2 861 859 | 2 854 190 | 7 669 | 3 216 281 | 3 309 914 | (93 633) | 4 043 635 | 4 043 635 | 0 |
| Goods and services | 1 581 445 | 1 445 038 | 136 407 | 1 531 872 | 1 647 474 | (115 602) | 1 459 728 | 1 452 891 | 6 837 |
| Financial transactions in assets and liabilities | 620 | 585 | 35 | 719 | 719 | 0 | 0 | 0 | 0 |
| Transfers and subsidies | 120 074 | 97 100 | 22 974 | 123 976 | 132 136 | (8 160) | 145 025 | 118 404 | 26 621 |
| Buildings and other fixed structures | 287 626 | 226 414 | 61 212 | 391 604 | 403 103 | (11 499) | 384 498 | 379 371 | 5 127 |
| Machinery and equipment | 246 245 | 164 930 | 81 315 | 289 807 | 338 547 | (48 740) | 137 665 | 136 620 | 1 045 |
| **Total** | **5 097 869** | **4 788 257** | **309 612** | **5 554 259** | **5 831 893** | **(277 634)** | **6 170 551** | **6 130 921** | **39 630** |

DRAFT

## 2.7 Unfunded mandates during 2008/2009

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 Limpopo DOH include:

- ***Occupational Specific Dispensation*** *(OSD)* – the implementation and costing of this policy resulted in higher expenditure than the amount provided for in the budget. The additional amount allocated for OSD by the National Treasury was based on an equitable share calculation, and not on actual human resource (HR) figures from the PERSAL system. The under-funding for this OSD amounted to R66 million for the 2008/09 financial year.
- ***The activity levels increased****.* For example the numbers of patients registered for ARV's increased from a targeted 20,000 (funded by the HIV conditional grant) by the end of 2008/09 to 39,000. At an average cost of around R500 per patient per month just for the medicine, this equates to an underfunding of R9.5million per month.

## 2.8 Budgeting process

The budgeting process was identified as a major contributor to the current funding challenges in the Limpopo DOH. Currently, the budgeting process is a top down process. Although basic inputs are compiled from operational levels, an indicative figure is obtained from the national budgetary process. This indicative amount is then allocated to the operational budgets (various institutions/levels) taking into consideration material known changes in operations, but to a large extent not aligned to operational plans and budgets.

In Limpopo it is required to submit the annual performance plans (APPs) together with the financial budgets. This leads to a much improved alignment between and budgets but we do not believe the APP's. However these APPs are 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.


DRAFT

### 2.9 Financial management processes

Cost centre accounting is only done down to a sub-district level, and not down to clinic level. Efficiency and effectiveness indicators needed for good financial management are therefore not available.

Variance analysis of differences between actual and budgeted expenditure can be a very useful management tool. Currently, whenever variances are identified, the practice appears to be to reallocate budgeted amounts in order to reduce the variance amounts for the different over- and under-expenditure items. On the evidence available to the IST, very little follow-up is done to identify any possible or necessary operational corrective actions flowing from variances.

Management responsibility and accountability are limited at all levels of the hierarchy, making it more difficult to maintain effectiveness and efficiency standards.

### 2.10 Cost allocation

The basis for derivation of the current formula recommended by the NDOH for use in calculating the PDEs across the country for hospitals at the different levels is not clear. It does not seem to take account of the variations in institution-specific costs, for example level of services rendered, etc.

### 2.11 Conditional grants

The budgetary processes referred to in paragraph 2.8 applies equally to conditional grants. Although annual performance plans are compiled at national and provincial levels, there are mismatches between the provincial business plans and the level of national grant funding. For example, the criteria for HIV grant allocations are not clear but appear to be somehow based on the equitable share, and not the business plans of the province which reflect the number of HIV positive individuals in need of care.



DRAFT

### 2.12 Quarterly performance reports

Quarterly performance reports on service related indicators are compiled and submitted to the provincial Treasury. The alignment between the quarterly performance reports and financial performance is not clear. In addition, 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.

### 2.13 Financial reporting

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

Although the *IYM report* can be an effective tool to identify possible budget over-runs, these are compiled on a cash basis and not on an accrual basis. The result is that any unpaid expenditure is carried forward to future financial periods and the reported results do not accurately reflect the actual operational cost of the current year's operations. Reported over-spending can also be limited by the withholding of invoices for payment. (The PFMA implications of this practice have not been considered for purposes of this report).

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

### 2.14 Monitoring structures

The effectiveness of essential monitoring structures requires improvement. Issues reported by the Auditor-General in the 2007/08 annual report include:

- Internal audit – the internal audit function did not operate in terms of an approved internal audit plan, and did not substantially fulfil its responsibilities, as set out in Treasury Regulation 3.2.
- External audit – prior year's external audit recommendations have substantially been attended to with only the Asset Register as qualified opinion issue left.



DRAFT

## 2.15 Key Recommendations

### *2.15.1 Provincial health budget allocation*

- *The current existing debt of R400m (of which R291m is an overdraft and the balance accruals) that the LDHSD which has developed in part as a result of the unfunded mandates, needs to be funded to allow the LDHSD to start on a new slate. .*
- *The Provincial Treasury should continue to allocate an amount to the LPDHSD which is in line with the equitable share indicated by the National Treasury in the national budget. (26%).*
- *Allocations of conditional grants by the NDOH should be based on clear, objective criteria that are linked to grant specific indicators and not on the equitable share formula.*

### *2.15.2 Unfunded Mandates*

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

### *2.15.3 Budgeting Process*

- *The budgeting process needs to be seen and used as an extension of the annual performance plan, and needs to follow an iterative process, especially after final allocation of funds.*
- *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.*
- *Budget virements need to be linked to changes in operational activity, not merely to balance the number of over- and under-expenditure items.*
- *The practice of continuous budget reallocations needs to be discontinued. Virement movements which are effected to minimise unauthorised expenditure (over-spending) should not hinder the application of the principles of proper financial management and variance analysis during the course of a financial year.*



DRAFT

***2.15.4 Financial management***

- *Cost centre accounting needs to be done at the lowest possible practical level (i.e. facility/clinic level). This is needed to properly identify areas of operations that require attention. This function should be performed by support staff and not clinicians.*

- *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.*

- *Variance analysis needs to be used as a management tool to identify areas that require attention.*
- *The required monitoring structures need to be put in place.*
- *Managers should be held accountable for the performance of their operating units and this must be built into the performance management system.*

***2.15.5 Quarterly Performance Reports***

- *The accuracy and use of essential performance indicators needs to be improved e.g. the number of patients on ARV's. 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 actions, and not merely identified.*
- *Better alignment in reporting is required with one unit made responsible. This would help to resolve the differences and inaccuracies in the current reporting.*
- *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.*

***2.15.6 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.*

- *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).*
- *The Auditor General, through the appropriate channels, should be requested to audit and comment on the accuracy of the IYM reports.*

- *Through the appropriate channels, the forecasting component of the IYM should be investigated to ensure best basis or reporting – cash versus accrual reporting.*
  *2.15.7Annual Financial Statements*

### *2.15.7Annual 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.*

### *2.15.8 Supply Chain Management*

- *Although not currently allowed as per directive from National Treasury, benchmarking should be allowed to address the exorbitant pricing of some of the tenders.*
- *A supply chain compliance unit should be activated in order to better manage existing tenders and speed up service delivery. With such a unit in place periodic tenders could be used instead of the expensive and misused three quotation system. BEE tender allocations should then also be better managed and the purpose of BEE better attained.*

### *2.15.9 Additional Funding*

- *Except for the funding issues mentioned under 2.7 the LDHSD have illegally managed to acquire an overdraft during the past couple of financial years. Provincial Treasury have now stopped this facility and instructed the LDHSD to refund the overdraft within the next financial year with the allocated funding. The LDHSD will not be able to manage this. The overdraft currently stands at R291 million. In order for the LDHSD to start the year without any backlogs it would require R400 million which is made up of the R291 million overdraft and the rest being accruals.*

DRAFT

# 3. LEADERSHIP, GOVERNANCE and SERVICE DELIVERY

## 3.1 Introduction

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

1. The NDOH has provided insufficient leadership and stewardship to solve the fundamental problem of ensuring that the resources available for health are sufficient for the levels of service and targets envisaged by a range of national policies.
2. The NDOH has also not given sufficient direction with regard to setting of norms for transversal issues, standards, guidelines and oversight.
3. The organizational structure of the LDHSD has remained in a state of flux for years. In addition, neither the existing nor the proposed structure is designed for integrated and efficient public health system of service delivery.
4. Minutes of senior management meetings reveal a pre-occupation with operational issues, rather than strategic issues of or critical issues affecting service delivery. In addition, there is persistent failure by senior management to make follow-ups of and provide feedback on the issues raised in the management meetings.
5. Monitoring and evaluation reports are generated to satisfy compliance requirements and accountability mechanisms rather than to provide information used for the management of the health service.
6. Most of the financial and human resource delegations have been centralised, resulting in increasing bureaucracy with consequent delays, inefficiencies, additional costs and insufficient accountability.
7. Lack of appreciation of the importance of appropriate resource mix as shown by undersupply of some critical resources necessary for service delivery, results in inefficiencies and redundancy of even the available human resources.

## 3.2 General Leadership

It is felt that the NDOH has not provided sufficient leadership and stewardship to solve the fundamental problem of ensuring that the resources allocated to the LDHSD are adequate for the provision of the levels of health service and targets envisaged. It is felt that although NDOH had for some years been aware of the below average annual equitable share allocation for the health component of the LDHSD, it has done little to assist the LDHSD in addressing the situation. Furthermore it was felt that the NDOH has not

DRAFT

provided sufficient direction on the norms and standards for hospital services and for other transversal issues

The LDHSD has had a number of years of over-expenditure (also known widely throughout the province as under-budgeting or "unfunded mandates"). In response to this the LDHSD has introduced increasingly more stringent expenditure constraints.

The effects of these has been drastic cuts which affected predominantly the for support services.

There was a belief that the delivery of health services had to be maintained even in the face of budget constraints as in previous years there had been a relaxation of over-expenditure rules by the Provincial Treasury. In the 2008/09 financial year these rules have been rigidly enforced by the Treasury resulting in negative service delivery consequences.

It is generally felt that the policies (and associated targets) set by the NDOH, although often considered to be excellent and in line with international best practice, are not linked to the necessary funding. For example, an amount of R144million was allocated by the NDOH to the LDHSD in the 2008/09 financial year for the nurses' OSD, an allocation made before the NDOH had concluded negotiations with the trade unions. After conclusion of negotiations with the trade unions an additional allocation of R130million was made. However, LDHSD's maintains the actual payment made by the LDHSD to the nurses for OSD exceeded the sum of these two amounts by R66million. It is reported that these payments were based on the guidelines provided by the Department of Public Service Administration. Similarly the LDHSD was compelled to obey the instruction of the MEC to increase the number of accredited ARV sites from 10 to 15 in the 2008/09 financial year, an additional service which was not budgeted for and for which no resources were allocated to accompany the instruction. Furthermore two additional childhood vaccines have recently been introduced by the NDOH for implementation with effect from the 1st of April 2009. However, although additional funding has been provided for these by the national Treasury, this funding has been added to the equitable share of the province. In reality this means that the Provincial Treasury will incorporate these additional funds into the existing LDHSD budget which had not factored the additional cost of these new vaccines when it was submitted to Provincial Treasury in 2008. The result will again be insufficient funding in the current financial year which will again result in "an unfunded mandate".

This is one of the critical issues facing the LDHSD. It either has to ensure a greater source of funding to continue with existing services and the new ones required in terms of policy (e.g. expansion of ART, TB, PMTCT and MCH services[67]), or to cut the existing services so that the service provision occurs within budget.

Minutes of senior management meetings shows that there is a pre-occupation with operational issues rather than with strategic issues of the core business of the LDHSD which is service delivery and its oversight. There is little discussion of the performance of the system. Primary health care in particular gets very little attention compared to other capital intensive services.

The LDHSD has had a number of changes in top management positions in the past 5 years. Although some stability in the LDHSD is now evident, the factors that led to the changes and the effects the changes have had in such a large and geographically widely dispersed province have left a mark on the different aspects of functioning of the LDHSD. The major effect of these challenges is inadequacy of close supervision that is compounded by staff shortages, particularly of the support services. Another consequence is the organizational structure that has not been finalised since its development in 2006.

Some hospitals do not have appointed CEOs and are run by acting CEOs. Many of the appointed hospital CEOs do not have health background and therefore are not able to comprehend the consequences on health service delivery, of a cut in some of the essential support services. Competent CEOs who understand well the health issues and who have a full complement of competent management support staff (e.g. Financial Manager, Clinical Manager) are essential for effective governance of the institutions. This is not the case for a large number of these institutions.

## 3.3 Planning

### 3.3.1 Service Transformation Plan, 5 year strategic plan and the 3 year Medium Term Expenditure Frame Work

Although discussion on the LDHSD's service transformation plan (STP) started in 2007 the STP has as yet not been approved. This STP consists of selected and identified long term strategic priority areas that the LDHSD intends to focus its attention on. These priority areas are drawn from a wide range of the national politically determined priorities.

[67] Antiretroviral therapy (ART), tuberculosis (TB), prevention of mother to child transmission (PMTCT), maternal and child health (MCH)



DRAFT

The LDHSD has developed a five year strategic plan and the three year Medium Term Expenditure Frame Work (MTEF). The hospital revitalization plans and the development of tertiary hospitals are among these five year strategic plans and the MTEFs.

### 3.3.2 Annual Performance Plan

An annual performance plan (APP) for a three year period is prepared to a standardised format. There is very little difference in the APP from one year to the next and many of the tables used are identical and even the foreword by the MEC is similar. The use of health information for planning purposes is minimal as analysis of data and interrogation of results from these seldom takes place. Thus the plans tend to focus more on the development and establishment of the facilities and very little on the improvement of the health outcomes of services provided. It appears designed to satisfy compliance rather than to be a guiding document for the public health sector in the LDHSD to improve the health of the people.

For example, regular mention is made of the rising maternal mortality in the district hospitals of the LDHSD with no supportive information nor any indication in the APP of the operational actions to contain and reduce this rise in maternal mortality in the affected health care facilities.

### 3.3.3. Alignment of Plans

There is no consistent alignment between the strategic and operational plans as well as between the operational plans of different branches of the LDHSD. For example, the process of developing operational plans is done in silos: Development of plans of the corporate services branch is not co-ordinated with that of developing plans for health branch of the LDHSD. Among the consequences of this silo mode of functioning are the lack of convergence of priorities of the branches and the delay in staff appointments. Part of the disjuncture in the alignment of plans arises from structural organization of the LDHSD. The location of the strategic planning unit is under corporate services while that of the information management unit overseen by the Communications Manager, is located in a separate branch - the Government Information Technology Office (GITO). Further more according to the current organizational structure the strategic planning unit reports to corporate services but will report to the HOD according to the “new” organizational structure developed in 2006 but has as yet not been approved. The planning process is a formality undertaken for compliance with.

### 3.4 Governance

The boundaries of responsibility between the MEC and the HOD are not clearly defined as shown by the MECs order for the opening of additional 5 new ARV sites that were not budgeted for by the LDHSD in the 2008/09 financial year.

The hospitals' management structure follows the NDOH guidelines in terms of which the Hospital Board, (which includes members of the community), is an important role player. Community participation in the governance of hospitals is suboptimal, largely as there are no financial rewards associated with serving in hospital boards. Only 73% of District Hospitals and 60% of Regional Hospitals had functional Hospital Boards in the 2008/09 financial year.

### 3.5 Service Delivery HIV & AIDS, TB and MCWH sub-programmes

The province serves 10.8%[68] of the South African population (about 5.2 million people) which has a high dependency ratio (39.4% of the population is below the age of 15 years and 7.7% above the age of 60) - the highest in South Africa and higher than the national average of 32.1%. Service delivery is affected by staff shortages lack of functioning equipment and inadequate drug supplies.

#### 3.5.1 Staffing, facilities and equipment:

There is an average vacancy rate of 35% (range from 30-46%). Professional staff appointments have not been restricted by the budget cuts as has been the case with the non-professional categories of posts. Vacancy rates are high even among the professional categories partly due to the delays in appointments brought about by centralized process of advertising posts in the province. It often takes 8 months or more to fill a medical post. The freezing of non-professional posts to reduce expenditure has resulted in acute shortages of technicians for maintenance of facilities and equipment, drivers for patient transportation and other categories of support staff, with the resultant consequences on service delivery. Shortage of managers and appointment of persons with no sound health background in top managerial positions (e.g. as hospital CEOs) affect the quality of service provision.

[68] Stats-SA 2008 mid-year population estimates

Budget cuts have also affected the maintenance of facilities as well as the purchase and maintenance of equipment essential for patient care. In some cases primary health care patients that should be handled at the clinics are referred to hospital for follow-up examinations and treatment as there is no functioning basic blood pressure measuring equipment at the clinics. There is a strong feeling at the district level that the increased patient burden that hospitals are experiencing are in part due to failure of the LDHSD to provide the needed support for the PHC services in the clinics.

There is a mismatch of resource availability, a factor which leads to inefficiencies and poor or lack of service delivery. For example:

- professional clinic staff appointed at the clinics do not have the basic tools to render diagnosis of PHC conditions or to monitor chronic patients,
- insufficient support staff at the hospitals, health centres and clinics to process patient-care-related activities like patient transport.
- stock-outs of medicines and vaccines and
- lack of maintenance staff to maintain facilities in operational condition.

Malaria control programmes and cholera outbreak affecting particularly the non-resident migrant population in the north and eastern parts of the province, were additional unique factors that added to the cost of health care.

### 3.5.2 Drug supply

Drug supply has been another factor that has negatively affected service delivery in the province. The drug supply problem, which arose mainly from failure of the national tender process managed by the NDOH to ensure continuity of drug supply, resulted in shortages of medicine in health care facilities. The supply of tuberculosis medicines was particularly affected.

**Table 5: Impact of budget cuts on service delivery in the District and Regional health care facilities**

| 1. District Health Services | Performance against selected 2007/08-2010 APP |
|---|---|



DRAFT

| | Performance indicator | 2007/08 Target | 2007/08 Actual | 2006/07 Actual |
|---|---|---|---|---|
| | Percentage of clinics visited by clinical support once a month | 75% | 56% | 60% |
| | Percentage of PHC facilities providing 24 hour services | 90 % | 78% | 76.5% |
| | Percentage of District Hospitals with full complement of CEO support staff (clinical, finance % corporate) | 100% | 10% | 20% |
| | | | | |
| **2. Regional Hospitals** | **Performance against selected 2007/08-2010 APP** | | | |
| | Regional hospitals with appointed (not acting) CEOs in posts | 100% | 80% | 60% |
| | Expenditure on drugs for hospitals as % of regional hospital expenditure | 11% | 8.75% | 7.75 |
| | Bed utilization rate (based on usable beds) in regional hospitals | 75% | 64% | 69.1% |

Source: *Annual Report 2007/08, Health Vote 7: Limpopo Provincial Government, Department of Health and Social Development*[3]

### 3.5.3 Communication

Some clinics (e.g. in Giyani sub-district) do not have telephone communication. Transfer of patients relies on the nurses' use of their private cell phones to contact EMS. Pregnant women who attend antenatal services at the Mopani clinics thus prefer to go direct to the local district hospital (Nkhensani hospital) when in labour for delivery rather than to their nearby clinics. This results in overloading the hospital maternity ward with normal deliveries that aught to take place in the clinics.

Giyani sub-district in Mopani District has not had a printer for more than three months even though part of its major functions is to communicate in writing with the 22 PHC facilities under its care, produce patient documents and provide other documents essential for supporting primary health care.

### 3.5.4 Resource Utilization:

There are inefficiencies in resource utilization as well. An amount of R22m was used to prepare temporary nurse's teaching facilities at Sekhukhune and Waterberg which were not utilized further after construction. The organization of services tend to encourage

functioning in silos e.g. district hospitals separate from district offices which is another source of inefficiency in the health service. The proposed addition of another layer of management above that of district manager and district hospital CEO for the purpose of co-ordinating these will only add to the inefficiencies by bloating the bureaucracy further.

### 3.5.5 HIV & AIDS and STI, TB and Maternal Women and Child Health programs

#### 3.5.5.1 HIV & AIDS program

Prevalence of HIV in Limpopo in 2007 was estimated to be 18.5%[69] (CI 16.7-20.4)*. The comprehensive programme and APP for the sub-program are structured in line with the National Strategic Plan 2007-2011 with the relevant indicators for monitoring performance. HIV and AIDS related conditions are the leading causes of hospital deaths among adults in the province. Of the R230 million allocated for the programme in 2008/09, R93m was for ARV therapy alone. The major cost drivers in this sub-programme are the ARV drugs and the associated laboratory investigations. The LDHSD exceeded both the 2007/08 and the 2008/09 output targets for new admissions to the ARV therapy partly due to the high demand for services and partly in compliance with an unfunded mandate on the orders of the MEC to increase the newly accredited ARV treatment sites in 2008/09 from the 10 planned for in the budget to 15. As a result of this there was at the end of the 2008/09 financial year, an over-expenditure of R66 million in this vote.

Among the challenges related to HIV and AIDS program in 2008/09 was the nationwide lack of male condoms experienced last year and the delay in the implementation of the dual therapy for PMTCT since its introduction in February 2008. Some patients on ART default intentionally when their condition improves appreciably to the point where they should be taken from the receiving temporary financial grant for seriously ill HIV and ADS patients.

#### 3.5.5.2 TB program

Although Limpopo has historically had the lowest incidence of tuberculosis among all the provinces in South Africa, the incidence has been rising gradually, probably in line with the rise in HIV prevalence. The outcome indicator for reducing TB mortality (TB treatment

[69] The National Hiv And Syphilis Prevalence Survey South Africa 2007



DRAFT

cure rate for new smear positive TB cases) is low. Although this may be due to a number of reasons which include high defaulter rate among the TB patients, high prevalence of HIV and TB co-infection (HIV prevalence among the TB patients is 52% compared to 20% in the general population), or change-over to the new cheaper TB medication introduced by the NDOH, it may also be the outcome of inability to implement Ineffective DOTS program associated with financial constraints

**Table 6: Deterioration in the performance indicators for TB programs 2005/06 to 2008/09**

| | | 2005/06 | 2006/07 | 2007/08 | 2008/09 |
|---|---|---|---|---|---|
| 1 | Cure rate among New smear positive PTB | 69% | 60% | 56.5% | n/a |
| 2 | TB Treatment interruption rate | 4% | 7% | 8% | n/a |

n/a = Not available

*Annual Report 2007/08. Health (Vote 7): Limpopo Provincial Government Department of Health and Social Development[3].*

**Table 7: Incidence of Tuberculosis per 100 000 population in Limpopo and South Africa: 2004-2007**

| | Limpopo Incidence of TB per 100 000 population | | RSA TB incidence per 100 000 population | |
|---|---|---|---|---|
| **Year** | **New smear + PTB** | **All forms of TB** | **New smear +PTB** | **All forms of TB** |
| **2004** | 113.4 | 214.7 | 235.5 | 550.9 |
| **2005** | 121.6 | 237.2 | 267.5 | 645.0 |
| **2006** | 133.6 | 305.2 | 277.8 | 722.4 |
| **2007** | na | na | 358.0[70] | 948.0[71] |

*Source: Global TB database and Millennium Development Goals. Country profile South Africa. accessible on: www.who.int/global.int/globalatlas/predefinedreports/tb/PDF*

### 3.5.5.3 Maternal Child and Women's Health

Access to MCWH is primarily through PHC facilities. There was an increase in hospital maternal mortality over the two year period 2006/07 and 2007/08 from 110/100 000 to 130/100 000. Percentage of fully immunized children under the age of 1 year has declined over the 3 year period 2005/06, 2006/07 and 2007/08 from 93.5%, to 83.9% and 79.5% respectively. The current measles immunization coverage for children under 1 year is 81%. Further decline in measles coverage rate will increase the risk of measles

70 *Global TB database and Millennium Development Goals. Country profile South Africa. accessible on: www.who.int/global.int/globalatlas/predefinedreports/tb/PDF*



DRAFT

outbreak in the affected population. Vitamin A supplementation for children under the age of 5 is also low. Only one fifth of the women targeted for cervical cancer screening were tested in the 2007/08 financial year. In general the MCWH sub-programme has shown some degree of deterioration over the past three years as suggested above figures. However some of the reported indicators have either remained unchanged or have shown minimal deterioration. Examples of these are the input and outcome indicators on improved women's health (percentage of hospitals implementing 80% of recommendations of the Saving Mothers Report – increased from 88% in 2005/06 to 100% in 2006/07 while percentage of hospitals implementing 80% of recommendations of Saving Babies Report declined over the same period from 92% to 86%),

## 3.6 Recommendations:

### 3.6.1 Leadership

*3.6.1.1 Political principals should exercise leadership and responsibility by establishing and confirming funding for new or additional services before pronouncing these to the general population.*

*3.6.1.2 South Africa is a developing country with limited resources Rationing of health care is inevitable. Smart choices will have to be made for optimal affordable improvement of the health of the population. There should be an explicit and open discussion around the budget and the level of services that can be rendered for that budget. The areas of rationing and prioritisation should be made clear and communicated effectively to all relevant stakeholders*

*3.6.1.3 The NDOH needs to play a far greater and structured role in ensuring stewardship and assistance to the province which faces intractable problems linked to finances.*

*3.6.1.4 Senior management meetings need to focus more on the core business of service delivery - making and monitoring strategic plans and actions for cost effective interventions, rather than on operational issues.*

*3.6.1.5 There should be an iterative process to national policies where provincial realities and feedback are given so that either policies get amended to fit the realities or else additional resources are made available so that the level of service delivery can be elevated, consistent with policies.*

*3.6.1.6 Service delivery and budgets need to be linked to each other so that managers are not faced on a regular basis with the making of ad hoc financial cuts.*

*3.6.1.7 Short term rationing of important support services (e.g. maintenance of facilities) can influence long term strategies (e.g. run down of facilities) and should be guarded against with ring-fencing these critical components of the budget.*

### 3.6.2 Planning

*3.6.2.1 Health Information system should be consolidated and well resourced so as to enable the LDHSD to collect and process valid and reliable data and generate information that is essential for for planning and rational decision making.*

*3.6.2.3 There should be alignment between the building of facilities (new or expansion of existing facilities - like nursing colleges, hospitals and clinics) and the available financial and human resources to ensure the efficient use of these facilities.*

*3.6.2.4 Operational plans of the different branches of the LDHSD should not be done in silos but should be co-ordinated to form a seamless joint matrix*

*3.6.2.5 Targets need to be based on realistic forecasts of what the need is and what is achievable as well as linked to budgets. This is particularly important in relation to the number of enrolled patients for ARVs.*

*3.6.2.5. 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*

### 3.6.3 Governance

*3.6.3.1 There should be clear written guidelines delineating the areas of responsibility for the MEC and the HOD.*

### 3.6.4 Service delivery, HIV & AIDS, TB and MCWH

#### 3.6.4.1 Service delivery

- *Clinics must be provided with basic equipment to enable them to deliver the service. Containment of costs by restricting the purchase and maintenance of essential equipment is counter productive.*

DRAFT

- *CEO must be appointed on the basis of their knowledge of the health care system. Current CEOs need to have a competency test and those with skills deficits need to undergo training*
- *Knowledge and understanding among managers, of the optimal efficiency of relevant skills and resource mix is essential. Managers at all levels need training in the health care system.*
- *The moratorium on the appointment of technicians must be lifted to empower the hospitals to employ essential maintenance staff (electricians, plumbers and medical technicians for repair of equipment)*
- *An effective health system requires co-ordination of district hospital and district health services that both follow a common strategic plan. Co-ordination of these services in each district of the LDHSD, especially the general manager for district hospital and the one for district health services and programs should be reflected as one position in the organizational structure at the provincial head office. The differentiation of related programmes under many managers at the LDHSD Head office inevitably leads to replication of similar organisational structure at the peripheral levels.*
- *Telecommunication link for all clinics is a necessity. Interim supply of cell phones for clinics should be supported.*

#### 3.6.4.2 HIV & AIDS and TB

- *Co-ordination of HIV and TB programmes is essential in all health care facilities.*
- *NDOH must act speedily in the processing of tenders to avoid drug supply interruptions as well as ensuring the quality of new drug supplies for TB*

#### 3.6.4.3 MCWH programme

- *The gains made in improving the coverage and quality of maternal and child health programmes over the past decade must be maintained and PHC must be given absolute priority.*
- *Attention should be given to ensuring the capacity of Clinics to render delivery services for maternity clients and for ensuring the communities' confidence in the quality of maternity service and of the hospital referral system*



DRAFT

# 4 HUMAN RESOURCES

## 4.1 Introduction

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

1. At 65.5% of spending in 2007/2008, compensation of employees continues to make up the largest contributing factor to overspending.
2. *The shortage and retention of health professionals in rural areas rem*ains a major challenge while lengthy recruitment processes compounds this problem and is detrimental to employment practices.
3. Although well-defined human resource (HR) Plans and policies exist, implementation is impaired by budgetary constraints.
4. Organisational structuring is not done according to agreed benchmarks or aligned with existing plans or resources and there is insufficient guidance from the NDOH on this matter. The approved organogram, which still has to be implemented will need to be reviewed.
5. The process to approve the reviewed delegations policy should be expedited and be implemented. The current delegations policy is outdated.
6. Human resource development is not effectively being implemented due to shortage of funds although it features as a strategic priority in the plans.
7. Although resources have been made available to train health professionals, there is a need to tighten measures and controls to ensure that bursary recipients are fulfilling their obligations.
8. Rewards are not linked to performance, the performance management system is not functioning as envisaged and linkages to strategic priorities, staff development and rewards are either absent or tenuous.
9. The implementation of the occupational specific dispensation (OSD) for nurses resulted in numerous operational problems, including over-expenditure, negative impact on appointment of other professionals such as nursing tutors, discrepancies in nurses' salaries between those working at the clinics and those at the district hospitals and general unhappiness among health professionals.

## 4.2 Delegations, Accountability and Responsibility

DRAFT

The LDHSD has a policy on delegations of power, which spells out delegated powers in terms of the following:

- Planning, work organisation and reporting
- Job Evaluation
- Compensation of employees
- Working environment
- Procedures for appointment, promotions and termination of services
- Performance Management and Development
- Training and Education
- Labour Relations
- Code of Conduct.

The biggest challenge is the fact that the policy has been in operation since 2003 and it is not dealing with changes that occurred in the Public Service Co-ordinating Bargaining Council (e.g. Resolution 1 of 2007-Approval of overtime compensation) and is not in line with the existing organisational structures of the LDHSD. At the time when the policy was developed, there was no directorate of Provincial Health Services, GITO and District Health Services and they are not delegated any powers in the policy.

It is important to state that the LDHSD has, however reviewed the policy but it has not yet been approved. The reviewed delegation policy appears to be an improvement of the current policy.

The advertisements of posts within the hospitals have been delegated to CEO as per the policy but in practice this function has been centralised. The centralisation of advertisement has had negative consequences. It has led to unnecessary delays in the appointment of personnel because HR has to wait until there are enough vacancies to advertise to save cost. It has been said that it takes 8 months to finalise an appointment.

At the district and hospital levels, people interviewed highlighted the difficulties associated with the centralisation of decision making authority. For example, at NKhensani Hospital there was sub-standard quality of work done by the contractor who built the new hospital who was appointed by the Provincial Office without any input by the Hospital. The result is poor electrical cabling that must be redone and infiltration of the floors by termites.

As a result of centralisation of decision making, especially human resources and finances, managers feel disempowered to take decisions and solve problems.

### 4.3. Integration and co-ordination

A number of examples illustrate the lack of co-ordination of effort within the LDHSD.:

- The Strategic Planning Directorate reports to the Legislature in terms of provincial performance indicators while the Information and Communication Directorate reports in terms of national performance figures. There seems to be no alignment between these directorates. The IST could not get quarterly reports to determine whether the figures reported are the same.
- `There appears to be inadequate communication and co-ordination between staff in the district hospitals and the district health structures. This is aggravated by the fact that they fall under different directorates, despite the fact that district hospitals are part of the district health system.
- Planning is being done in silos with the different directorates not working as a unit and not being supportive of the core function. For instance,The Health Branch felt that their posts are critical and HR is not supportive. Forexample, it takes 8 months to fill in a post in the LDHSD. As a result, potential candidates are lost
- Bursaries have been awarded to student nurses but HR is unable to trace them to ensure that they fulfil their obligations of working for the LDHSD. It was estimated that only few bursary holders do fulfil their obligations.

### 4.4 Labour Planning

The STP has not been approved and this has created a situation where labour planning is done in a vacuum without the overall document setting out the vision and plan for the LDHSD in the long term.

The HR Plan which was developed and implemented in March 2007 but without approval at the time. It was finally approved on the 23rd July, 2007 but there have been challenges with regard to implementation such as retention of personnel and lack of human resource information system This is mainly due to budgetary constraints that the LDHSD faces (the budget for 2008/2009 for training was R40 million but the allocation was a mere R9 million) and shortage of human resource practitioners at the hospitals, e.g. there are only 14 HR practitioners out of 41 hospitals.



DRAFT

HR policy documents and frameworks exists. However, the execution of these policies is sub-optimal with a number of factors contributing to this. These include:

- The alignment between the HR planning, budgeting and service delivery seems to be generally problematic.
- HR plan is not fully used due to cost containment requirements..
- HR planning was not directly related to disease burden, budget and policy decisions e.g clinics have to operate 24hours but in some clinics there are not enough nurses) This non-aligned HR planning and associated resourcing can lead to staff having lowered morale and in a state of "despair" with always having to do more with less.

## 4.5 Organisational Design and Establishment

The challenge that originally confronted the LDHSD in 1994 was the unique situation of establishing a single LDHSD from three homeland administrations (Gazankulu, Venda and Lebowa) plus parts of former "white" South Africa. A new organisational structure was developed and approved in 2006 and subsequently revised and approved in November 2007. The organisational structure was supposed to have been implemented in phases starting in January 2008 and completed in April 2008. It has, however not been implemented due to budgetary constraints. PERSAL has also not been aligned with the structure, does not indicate some of the newly established positions and still carries numerous unfunded positions.

The organisational structure is not planned on a realistic model of service requirements and available financial resources. It is not altogether clear what the basis of the current staff establishment is, but it was probably due to modelling and creation of posts without regard to financial constraints. The new structure would result in more divisions and more managers being employed. (Examples include: in the supply chain, a new division of Public Private Partnership will be established that will require a manager; information management will have three new divisions of social development, government information and technological services with 3 managers).

The organisational structure is not appropriately designed to fulfil the mandate of the LDHSD As one senior manager from LPDHSD commented "the *new organogram that still*



DRAFT

*has to be implemented, was designed to accommodate individuals, rather than serve the mandate of the LDHSD"* . The NDOH has not provided norms and standards regarding organisational structures.

There are currently 30 029 filled positions and 15612 vacant posts which is 34%. The establishment figures are at 45 641. Compared to 2005/2006, there was 26 816 out of 38 907(Vacancy rate was 31.07%). In 2006/2007 filled positions was 30 548 out of 38 907(Vacancy rate was 27.8%).

This drop in staffing levels, associated with an increased burden of disease and additional functions, is likely to have negative consequences for service delivery and also staff retention.

For the past three years, the LDHSD has not been able to fill vacant posts although the IST was not able to determine whether it is a result of lack of qualified applicants or due to financial constraints. They are now forced to focus on filling health practitioner posts and not support staff.

One of the national initiatives to address staff shortages is through awarding bursaries. For 2008/2009, over R121 million from both conditional grant and equitable share was made available for bursaries. This, however has had its fair share of implementation problems, e.g. unable to recruit sufficient numbers due to low numbers qualifying with Grade 12 maths and science subjects, shortage of nursing tutors (there are currently 62 tutors and vacancy for 38 tutors), and inability to trace graduates to fulfil their bursary obligations.

The shortage of health personnel contributes to inadequate health care. The high vacancy rates and the burden of disease that has been growing particularly due to HIV/AIDS, T.B and other chronic diseases have resulted in increased workload for staff.

### 4.6 Recruitment

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



DRAFT

The LDHSD has developed a policy on recruitment and selection but there are challenges with regard to implementation.

- Advertising for posts is centralised and as such can only be done by the provincial office.
- Fourteen of the 41 Hospitals are also without HR practitioners.
- Hospitals usually wait for more than one post to be advertised in order to save on the advertising cost. This causes serious time delays. There are serious staff shortages especially health professionals. For example, NKhensani, a 300 bed hospital in the Mopani District has 16 Medical officers (12 fulltime and 4 who work $^{5}/_{8}$) out of a total of 32 available posts; four pharmacy staff out of 10 posts; and only one professional nurse available for theatre at night; and technical support staff operating without a qualified electrician.
- The LDHSD has just advertised 49 chief medical officer’s post but are not even sure if they would be able to attract that many applicants. The province has 850 doctors of whom 150 are interns and community doctors and 250 foreign contract doctors.

- There has been political interference in the recruitment of staff with negative consequences:

    - Officials interviewed expressed a feeling that most of the CEO’s of the hospitals are comrades and ex-teachers without the necessary management experience to run these institutions. As a result, most of the hospitals are not functioning optimally.
    - There was political interference in the criteria for selection of student nurses by demanding the lowering the qualifying criteria, with the result that there was a high failure rate amongst second year students.
    - Furthermore, politicians have insisted that more colleges should be opened in Sekhukhune and Waterberg. This has resulted in the LDHSD spending R22 million in the two areas which only covered the clearing of the sites and erecting of temporary accommodation. No further funding was provided and as such these two “new” colleges are not functional.

DRAFT

### 4.7 Performance Management

The LDHSD has a performance management and development policy which provides overall direction and the processes to be followed. But performance management is not working as intended. Initially, it was complicated by the fact that the Premier's office introduced a provincial wide system, which differed with the one from DPSA and this did not work. It was reported that only 46% of managers have submitted their performance reviews, which indicates that it is not taken seriously within the LDHSD.

The linkages between performance and rewards were unclear and complicated by political interference and the delay in payment of staff bonuses (refer to paragraph 4.9). Officials interviewed also indicated that the system is open to abuse due to subjectivity and the fear of reprisal and even death threats that supervisors may have in recording poor performance even though it exists.

One of the aims of a performance management system is also to assist in the development and training of employees, which is not the case in LDHSD. Whilst there is workplace skills plan in place, it is underfunded and therefore not implemented fully. For example in 2008/09 instead of R40 million was requested; the allocation was R16m which was further reduced to R9m.

### 4.8 Retention

Given the staff shortages, the retention of staff becomes even more critical in terms of managing human resources. LPDHSD does not have a retention strategy of their own but rely on initiatives taken by NDOH such as OSD, rural and scarce allowances to retain staff.

The responses indicated that rural and scarce allowances have made some positive impact in retaining staff In Limpopo, with the exception of Polokwane all other areas are considered rural and therefore eligible for the allowances.

There are some negative issues related to the working environment at the PHC levels which impact on staff retention e.g.:

- Health personnel do not have basic equipment such as BP machines, autoclaves, telephones, faxes and computers.
- Staff shortages which create high workloads.

Stressful working conditions.



DRAFT

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

### 4.9 Rewards

It is evident that the change in salaries due to the OSD has made a major contribution to the increase in personnel expenditure. In addition salary increases, additional fringe benefits contributions, overtime and other allowances compounded the overspend problem.

Although the overall OSD implementation is being investigated at national level, various issues in Limpopo were raised regarding the implementation of OSD:

- The OSD was not costed properly. OSD cost the LDHSD R340m while only R144m was additionally allocated from provincial treasury for this process
- Differential payment of OSD. At district level, OSD was paid to PHC nurses while district nurses and programme coordinators were excluded from OSD with resultant resentment.
- The OSD has impacted on relationships between hospital staff and clinic staff. These were strained during the introduction of OSD when hospital staff felt that the PHC nurses got paid higher amounts for OSD. This resulted in the sending back by the hospital nurses, of the patients referred by the clinics. to be treated at the clinics indicating that nurses at the clinics earn more than them
- A lot of nursing tutors who did not get OSD are returning back to clinical nursing and leaving the nursing colleges without tutors.

A major concern with reward within LDHSD is that the linkages between performance and rewards were unclear and complicated by political interference. Performance bonuses are being paid but with a delay (e.g. 2005/06 only paid during 2008/09 year and the 2007/08 bonuses are not yet paid due to lack of funds). These bonuses were initially calculated on a performance score with some scoring high and others low scores. However, the MEC gave a directive that the bonuses be changed to 6% for everyone. After it was picked up by SCOPA it was corrected and some staff have had to pay back bonuses.



DRAFT

## 4.10 Learning and Development

Limpopo Health and Social Development have developed a comprehensive HRD implementation plan for 2009-2010 but its implementation will be seriously challenged due to under-funding. According to the Skills Development Act employers must allocate 1% of the salary budget to skills training. In 2008/09 instead of R40m budgeted for training and development, they were allocated R16m which were further reduced to R9m. In 2009/10 instead of a budget of R50m they were allocated R20m.

Other challenges that are listed in the HRD Plan include the following:

- High staff turn over.
- Fewer accredited service providers.
- No evaluation of the impact of training.
- Resistance and lack of buy in from other directorates
- The impact of HIV and AIDS on the personnel.

It is clear that training gets sacrificed to contain overexpenditure and this will have dire consequences for staff morale and service delivery in the long run.

## 4.11 HR Information Systems

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

## 4.12 Recommendations

### *4.12.1 Delegations, Accountability and Responsibility*

- *The reviewed delegation policy should be approved and implemented and its applicability be assessed after a year.*
- *The delegation policy should spell out the powers and responsibilities of the political head i.e. MEC*
- *The advertisement of posts within hospitals should be delegated to the CEO's.*



DRAFT

### *4.12.2 Integration and co-ordination*

*.*

- *The organisational structure should be reviewed with a view to create optimal directorates and co-ordination e.g. incorporate district hospitals and district health structures into the same directorates.*
- *Communication mechanisms need to be established across clusters and DHS to prevent "silo" operational functioning.*
- *A clear policy on the relationship between the programmes and hospitals are required, i.e. vertical and horizontal integration is critical.*

### *4.12.3 Labour Planning*

- *Labour 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.*
- *Clear and consistent key HR statistics and indicators should be developed and reported on.*
- *Feedback loops should be established to update plans and define cost and service delivery impacts should new priorities arise.*
- *Clear decisions and direction at various levels (national, provincial and district levels) in terms of service delivery should be communicated – if fewer HR resources and decreased funds are available, priorities need to be adjusted and communicated accordingly.*

### *4.12.4 Staff Establishment*

- *Restructuring, with a view to establishing minimum staffing levels, should be undertaken based on a number of factors including objectively agreed benchmarks, the provincial disease burden profile, optimal application of scarce skills and service delivery priorities as well as on available resources. Special consideration should be given to appropriate management ratios and levels should be reviewed.*

- *PERSAL should be corrected to accurately reflect personnel positions and staffing numbers as reported in the LDHSD Budget Estimate and Annual Reports statements*

DRAFT

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

- *There is a need to review measures and tighten controls to ensure that bursary recipients fulfil their bursary obligations.*

### *4.12.5 Recruitment*

- *A thorough review and improvement of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times.*
- *Money should be made available for the recruitment of the prioritised lists that have been submitted to the Provincial Treasury.*

### *4.12.6 Performance Management*

.

- *The performance management system should be utilised as intended and incorporate:*
  - *Organisational performance;*
  - *Employee development;*
  - *Reward based on clear performance goals.*
- *Team performance for clinical staff should form part of performance standards and evaluation.*

### *4.12.7 Retention*

- *A national health professional and scarce skills retention strategy should be developed by the NDOH. The focus should not only be on monetary issues but include other aspects such as training, improving working conditions, safety and security.*

### *4.12.8 Rewards*

- *A total reward strategy (monetary and non-monetary) review should be undertaken at national level to address issues of employee compensation overspend, skills scarcity and staff retention – including highlighting the importance of:*
  - *A thorough costing of any change in the reward system which must be done in collaboration with the affected parties and include an assessment of affordability at various levels.*
  - *Rewards should be linked to organisational, employee and team performance.*



DRAFT

  - *Lessons learned from the current OSD implementation review for nurses should be captured to inform future implementation of other improvement initiatives.*
- *The delay in paying bonuses and the manner which these are paid should be investigated.*

#### *4.12.9 Learning and Development*

- *Training needs should be properly and objectively determined.*
- *The LPDHSD should comply with the skills development levy and set aside 1% of its total salary bill towards skills development.*
- *Training should be prioritised and not be compromised during the budget cutting process.*

#### *4.12.10 HR information systems*

- *An assessment should be undertaken to establish reasons for under utilisation of systems and improved measures should be implemented including the use of PERSAL to its full capacity as a HR management tool.*

## 5. INFORMATION MANAGEMENT

## 5.1 Introduction

| Box 4: Information management review key findings |
|---|
| 1. Monitoring and evaluation is one of the weakest links in the overall management of health services in the LDHSD. 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.<br>2. A significant amount of time and effort are spent on data collection, capture and transmission to the interested higher level in government. However little is done to ensure the quality, accuracy, timeliness and completeness of the data. Hence poor quality indicators derived from the data find their way to NDOH and Treasury, where there is also little interrogation and feedback.<br>3. There is a lack of managerial accountability for the attainment of service related targets. M&E does not appear to be part of managerial performance assessment but rather an activity undertaken to fulfil the requirements. |

| Box 4: Information management review key findings |
|---|
| 4. There are numerous weaknesses with the district health information system and the ARV monitoring system. These include problems around data quality; the large number, standardisation and interpretation of indicators; and the lack of national norms and standards.<br>5. Parallel information systems and the lack of a single repository of data result in conflicting official information. |

The LDHSD has annual operational plans for sub-programmes with stated objectives and performance targets based on data-driven indicators. There is scepticism about the quality of data which is adversely affected by staff shortages, lack of training and lack of staff motivation. The reliability of these reported indicators for annual performance is questionable

There are no adequate measurers to assure the quality of data so needed for decision making –There is little communication from NDOH and the province to programme and line managers around M&E. There are few norms and standards related to any aspect of M&E.

There is a lack of linkage between planning, implementation and M&E. Senior managers are not reviewing key indicators of efficiency (e.g. PDEs) nor indicators of effectiveness (e.g. drop-out rates of patients on ARVs) with any regularity. Wide variations among similar type of facilities (and between the same facilities over time – e.g. PDE) pass by without question or attempts to effect corrective action. Prescribed quarterly reports are submitted routinely to Provincial Treasury while those of the DHIS are submitted to the NDOH for the purpose of compliance, with no analysis and interrogation of these at the LDHSD.

### 5.2 Use of Information for decision making

There is much service information being generated at various levels in the system. Significant time and resources is going into the collection, data capture and collation of this information. However, the information is not being used optimally for management purposes and there are a number of issues that need to be addressed. These include:



DRAFT

- Managers generally do not focus on M&E and it does not appear to be part of their job descriptions and formal performance appraisals. Management meetings at provincial and district level do not appear to focus on indicators and their relevance for action.
- There are too many indicators resulting in a mass of data.
- Managers are not focussed on, and sometimes do not understand, the significance of key indicators in their sphere of management. Examples include understanding of PDEs, numbers of staff in the section/division, ARV numbers on treatment and on waiting lists for treatment.
- Data is fed up the line but there is little analysis, interpretation and feed-back of data back to the lower levels. As a result poor quality data finds a way through the system all the way through to NDOH and the National Treasury.

### 5.3 District Health Information System (DHIS)

The DHIS is a well-established system of collection of a wide range of data on different aspects of the health system in all facilities. It has a good infrastructure through which routine data can be collected. At the point of data collection in most facilities this is done through manual, paper-based data collection tools such as tick-sheets and registers. Thereafter aggregated data is entered into the electronic database and exported through the various levels of the system viz. local area (sub-district), district, province and national. Although the DHIS is a comprehensive system of routine data collection with most facilities capturing data on a regular monthly basis there are a range of problems associated that affect ensuring *the* quality of data. These include:

- There are inadequate guidelines, norms and standards from national and provincial level on data collection tools and consequently processes of data collection are not standardised.
- The indicator list in the national indicator data set (NIDS) has not been updated since 2005 and is out of date (e.g. dual therapy PMTCT indicators not included).
- Some of the indicators are confusing, not standardised and are without unambiguous and clear definitions (e.g. for the nurse workload indicator it is not clear which category of nurse is included and it is also not clear how many days to include in cases of sick leave and study leave).
- There are insufficient data capturers and information officers. This work is done by people with other designations (e.g. nurses, clerks). This results in the information

function not being given the priority that is required and is one of the reasons for sub-optimal data quality.

- Data capturers are sourced at provincial level, fall under the provincial budget and control and are then posted to various facilities without input from the district management team. This results in a disjuncture between those in control of service delivery and responsible for the day to day running of the service and those responsible for the data capturer's work performance.

### 5.4 ARV Monitoring and Evaluation

As the provision of ARVs is an important component of the overall strategy against HIV, it is essential for a good M&E programme to be in place to assess the effectiveness of the programme and to measure the cost-efficiency. This is one of the key cost drivers of expenditure in the LDHSW amounting to R244 million per annum direct costs only.

The ARV M&E system has a number of significant weaknesses including:

- There are no clear guidelines, norms and standards from NDOH guiding the LDHSD around an information system for ARV.
- The reports are centralised so that individual ARV treatment sites have no indication of what is going on in the management of their programme.
- Different managers at different places in the LDHSD quote different figures as to how many people are on ARV treatment.

### 5.5 TB data

Tuberculosis treatment outcomes is full of missing data, partly as a result of poor data capture, absconding of patients and the inability of the of the health care system to make follow–up for these patients ..

### 5.6 Other M&E Issues

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



DRAFT

- There is no single repository of information and as a result there are conflicting sources of official information.
- There is a lack of communication between those responsible for data management in the strategic planning unit and those responsible for programme management.
- Quarterly reports are regularly prepared for NDOH and the national Treasury. These reports are not scrutinised throughout the department and there is little or no feedback on these reports by senior management.
- There are parallel systems of data collection that are not linked, are not aligned with service delivery data and each of these systems reports to a stake holder external to the LDHSD. There is lack of integration of information derived from the BAS and PERSAL systems. (For example people paid from a hospital budget and designated as hospital employees are doing work at the community level distorting PDEs and other important indicators).
- Resources are lacking at the frontline facility levels (clinics and CHCs) to ensure accuracy of record keeping and completeness of data. Often there are no facility-based records kept of interactions with patients. Even basic registers are not kept. This makes it difficult to verify whether there has been adequate data collection.

DRAFT

## 5.7 Recommendations

### *5.7.1 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.*
- *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).*

### *5.7.2 Use of information for decision making*

- *M&E, based on a limited number of standardised and nationally defined key indicators, needs to be built into every senior manager's job description and performance appraisal.*
- *Systems, policies and procedures must be put in place for the improvement of data quality.*
- *In-service training for managers to improve the knowledge and skills around the key indicators relevant to their work and on the quality of data needs to take place.*

- *There must be regular analysis, comparison, interpretation and feedback of results on key indicators to the lower levels of the health care system.*

### 5.7.3 District Health Information System (DHIS)

- *The DHIS, and associated NIDS, needs a thorough review by the NDOH.*
- *The number of indicators need to be decreased*
- *There should be unambiguous, easy to understand, standardised definitions.*
- *There also needs to be clear written guidelines, uniform data collection tools, norms and standards for each component of the DHIS.*
- *Information is essential for rational decision making at all levels. Essential resources need to be provided to enable this critical function - relevant human resources, hardware and software.*
- *Data flow policies and linkages between the DHIS and other data collection systems such as the TB (ETR-net), PERSAL and BAS need to be established to ensure efficiency.*
- *An appropriate training regime also needs to be introduced at the correct time.*

### *5.7.4 ARV Monitoring and Evaluation*

- *A workable, practical, easy-to-use system of monitoring the ARV programme needs to be put in place.*
- *Monitoring of ARV treatment outcomes and survival rate in patients on ARVs should be introduced*
- *Ideally this should be developed (with detailed guidelines, norms and standards for every aspect of the system) by the NDOH and communicated to service delivery points via the province.*

### *5.7.5 Other M&E issues*

- *There needs to be one official repository of information for the LDHSD. 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.*
- *Parallel systems of information (e.g. direct flow of information from facilities to programme managers – whether at provincial or national level-, and the by-passing of district management structures) should be discontinued.*
- *Basic record keeping needs to be maintained at facility level.*



DRAFT

DRAFT

# 6. MEDICAL PRODUCTS, LABORATORY

## 6.1 Introduction

| Box 5: Key findings |
| --- |
| 1. The LDHSD has had a sporadic shortage of medicines in 2008 and vaccines in 2007 affecting many aspects of service delivery, from the vaccination of infants through to the continuation of patients on TB treatment |

## 6.2 Medical products

The shortages of drugs that have occurred in the LDHSD have largely been due to national failure to supply vaccines and the delays in NDOH clearance of tenders for new TB drug suppliers. The effect of these have been the lower than expected immunization coverage and interruption of TB treatment for some of the patients.

- Overspending on drugs, particularly on the ARVs has occurred in the 2008/09 year. However funds have had to be drawn from other programmes to maintain continuity of drug supply.
- The condition of the medical depot which is situated in Polokwane is reported to be substandard and not compliant with the medicines control regulations.
- Clinic drug budgets are held at the local area (sub-district) level. In practice this means that it is extremely difficult to compare drug usage and drug cost per patient at individual clinic or CHC level.

## 6.3 Laboratory

The laboratory services are among the major cost drivers in the LDHSD. Some of the costs charged to the LDHSD by the NHLS are for services rendered to patients in the North West and Gauteng hospitals. A detailed audit of the NHLS accounts needs to be conducted to establish the extent of this practice by the NHLS and corrective action must be taken.

DRAFT

### 6.4 Recommendations

- *A review of the state of the medical depot and the drug storage management practices within the depot should be carried out to assure the quality of medicines supplied. As part of this review the communication between the depot and the pharmaco-vigilance unit should be clarified.*
- *The drug budget should be reviewed and prioritised in line with departmental priorities.*
- *Tthe NHLS account served on the LDHSD should be audited and corrective action taken to avoid repetition of such "errors".*

DRAFT

# 7. TECHNOLOGY AND INFRASTRUCTURE

## 7.1 Introduction:

**Box 6: Key findings**

Basic diagnostic equipment is lacking in the some clinics. This compromises diagnostic and clinical management capabilities of the rendering the C clinical staff. One of the serious consequences is the rendering of these staff members ineffective, so making health care inaccessible within a health facility. This erodes the confidence of the patients in the PHC service.

Theatre equipment is lacking in hospitals, even the recently revitalized Nkhensani hospital

Telecommunication service at the PHC level (both telephony and printed communication) is disabled impaired due to a lack of telephones and/or failure of maintenance of printers at sub-district level. Hospital experiences similar frustrations with lack or delay in repairs of essential basic equipment.

## 7.2 Overview

This aspect was not reviewed in depth. However some points arose in the various interviews:

- Clinics lack some of the basic equipment (sphygmomanometers for measuring blood pressure and diagnostic sets) identified by the NDOH as being Core Standards for Primary Health Care[71] There are no technicians to repair this non-functional or damaged equipment..
- Some clinics lack telephone links, an essential and lifesaving communication tool particularly for facilities that are expected to conduct deliveries and to refer critical and emergency cases timeously to hospital. Communication with the hospital for emergency patient transfer has to rely on the use of staff members' use of their private cell phones. The result is that patients prefer to go direct to hospital when in labour rather than to take a chance of delivering at the clinic.

[71] National Department of Health. The Primary Health Care Package for South Africa. A set of Norms and Standards. March 2002



DRAFT

- In some areas affected by the drought (Mopani District) the lack of continuous water supply by local municipal tankers creates a problem that seriously affect service delivery.
- Clinics often have a shortage of space as a result of increased patient volumes and because of the need for increased privacy with HIV counselling.
- Lack of functional printers at the sub-district level mean that essential written communication with and teaching materials for the clinics are not possible.
- There is a lack of computers and in some local areas (sub-districts) managers do not have access to PERSAL because of the lack of connectivity. Thus mundane activities – e.g. the filling of leave data – have to be done at district level.
- Poor road infrastructure. A large number of communities in the province that is geographically so widely dispersed can only get access to primary health care through a network of mobile clinic services. The high cost of transport and vehicle maintenance as well as a shortening of the quality of medication and vaccines (associated with daily transportation) affect both the cost and quality of health care.

## 7.3 Recommendations

- *Clinics must be assured of continued supply of safe water without which patient care is not possible.*
- *All clinics must be provided with a functioning telephone as a basic communication tool that is essential for patient care..*
- *Basic clinical diagnostic tools prescribed in for PHC facilities must be provided for all cllinics*
- *Action should be taken to deal with the logistical issues identified, some of which should be coordinated by the NDOH.*
- *The NDOH should revisit the Telemedicine/Telehealth pilot project initiated by in 6 of thein provinces about a decade ago, to establish whether or not the lessons learned from it would not hold benefits for reducing the cost of rendering supportive diagnostic, consultative, medical data transfer and educational services particularly in rural settings.*

DRAFT

DRAFT

## Table 8: Recommendations contained in Limpopo Department of Health and Social Development's IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input

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

| *RECOMMENDATIONS* | National Minister of Health | National Department of Health | Limpopo Health &SD MEC | Limpopo Department of Health & Social Development | National Treasury | Limpopo Provincial Treasury | Department of Public Service and Administration | External stakeholders |
|---|---|---|---|---|---|---|---|---|
| **FINANCE RECOMMENDATIONS** | | | | | | | | |
| ***Provincial health budget allocation*** | | | | | | | | |
| *The Provincial Treasury should allocate an amount to the LDHSD, which is substantially in line with the equitable share indicated by the National Treasury in the national budget.* | | 2 | | 2 | 2 | 1 | | |
| *Allocations of conditional grants by the NDOH should be based on clear, objective criteria that are linked to grant specific indicators and not on the equitable share formula.* | | 1 | | 2 | 2 | 2 | | |
| ***Unfunded Mandates*** | | | | | | | | |
| *The operational impact of national policy decisions (e.g. OSD, new vaccine programme) should be determined and must be upon 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 | | |
| ***Budgeting Process*** | | | | | | | | |
| *The budgeting process needs to be seen and used as an extension of the annual performance plan, and needs to follow an iterative process.* | | | | 1 | 2 | 2 | | |
| *All operational units (cost centres) need to have a realistic budget that can be used as a guideline for the financial year's activities. Operational plans need to be aligned with available funding to deliver the services.* | | | | 1 | | 2 | | |
| *Budget virements need to be linked to changes in operational activity, not merely to balance the* | | | | 1 | | 2 | | |

DRAFT

| *number of over- and under-expenditure items.* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ***RECOMMENDATIONS*** | **National Minister of Health** | **National Department of Health** | **Limpopo Health &SD MEC** | **Limpopo Department of Health & Social Development** | **National Treasury** | **Limpopo Provincial Treasury** | **Department of Public Service and Administration** | **External stakeholders** |
| *The practice of continuous budget reallocations needs to be discontinued. Virement movements which are effected to minimise unauthorised expenditure (over-spending) should not hinder the application of the principles of proper financial management and variance analysis during the course of a financial year.* | | | | 1 | | 2 | | |
| *Cost centre accounting needs to be done at the lowest possible practical level (i.e. facility/clinic level). This is needed to properly identify areas of operations that require attention.* | | | | 1 | 2 | 1 | | |
| **Financial management** | | | | | | | | |
| *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 | | |
| *The required monitoring structures need to be put in place.* | | 2 | | 1 | | 2 | | |
| *Managers should be held accountable for the performance of their operating units and this must be built into the performance management system.* | | | | 1 | | | 2 | |
| **Quarterly Performance Reports** | | | | | | | | |
| *The accuracy and use of essential performance indicators needs to be improved e.g. the number of patients on ARVs. The necessary steps must be taken in conjunction with the NDOH to improve the quality of information available in this regard.* | | 1 | | 1 | 2 | 2 | | |

| RECOMMENDATIONS | National Minister of Health | National Department of Health | Limpopo Health &SD MEC | Limpopo Department of Health & Social Development | National Treasury | Limpopo Provincial Treasury | Department of Public Service and Administration | External stakeholders |
|---|---|---|---|---|---|---|---|---|
| *Variances in specific indicators need to be followed up with actions, and not merely identified.* | | | | 1 | | | | |
| *There needs to be a link between performance and financial reports. A financial report reflecting actual expenditure compared to budget should also be provided where performance indicators reflect a deviation in operational performance.* | | | | 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 be investigated to ensure best basis or reporting – cash versus accrual reporting. .* | | | | 2 | 1 | 2 | | |
| **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 | | |

DRAFT

| *RECOMMENDATIONS* | National Minister of Health | National Department of Health | Limpopo Health &SD MEC | Limpopo Department of Health & Social Development | National Treasury | Limpopo Provincial Treasury | Department of Public Service and Administration | External stakeholders |
|---|---|---|---|---|---|---|---|---|
| | | | | ***LEADERSHIP, GOVERNANCE and SERVICE DELIVERY RECOMMENDATIONS*** | | | | |
| ***General Leadership*** | | | | | | | | |
| *There should be explicit and open discussion around the budget and the level of services that can be rendered for that budget. The areas of rationing and prioritisation should be made clear and communicated effectively to all relevant stakeholders.* | *1* | 1 | 1 | 1 | 2 | 2 | | |
| *Appointments of all senior managers should take merit and ability into strong consideration. CEO must be appointed on the basis of their knowledge of the health care system. Current CEOs need to have a competency test and those with skills deficits need to undergo training* | | 2 | | 1 | | | | |
| *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 | | | | |
| *Clinics must be provided with basic equipment to enable them to deliver the service.* | | | | 1 | | | | 2 |
| *The moratorium for the of appointment of technicians and maintenance staff must be lifted* | | | | 1 | | 2 | | |
| *Speedy attention to tenders for drug supplies speedily in* | | 1 | | 2 | | | | |
| *Co-ordination of District services and district hospitals within the LDHSD must be implemented* | | 2 | | 1 | | | | |
| *Review of NHLS accounts* | | 1 | | 2 | | | | |

DRAFT

| *RECOMMENDATIONS* | National Minister of Health | National Department of Health | Limpopo Health &SD MEC | Limpopo Department of Health & Social Development | National Treasury | Limpopo Provincial Treasury | Department of Public Service and Administration | External stakeholders |
|---|---|---|---|---|---|---|---|---|
| *There should be an iterative process to national policies where provincial realities and feedback is given so that either policies can be amended to fit the realities or else additional resources made available so that the level of service delivery can be elevated, consistent with policies.* | | 1 | | | 2 | | | |
| *The NDOH needs to play a far greater and structured role in ensuring stewardship and assistance to the province which faces intractable problems linked to finances.* | | 1 | | | 2 | | | |
| *Service delivery and budgets need to be linked to each other so that managers are not faced on a regular basis with the making of ad hoc financial cuts.* | | | | | 1 | | 2 | |
| *Senior management meetings need to focus more on the core business of service delivery.* | | 2 | | | 1 | | | |
| *Short term rationing of important areas (e.g. maintenance of facilities) can influence long term strategies (e.g. run down of facilities) and should be guarded against with ring-fencing these critical components of the budget.* | | | | | 1 | 2 | 2 | |
| ***Planning*** | | | | | | | | |
| *Valid and reliable data should be collected and processed for generate information that is essential for planning and monitoring of the service.* | | 2 | | | 1 | | 2 | 2 |
| *Resource utilization. Optimal matching of resources to ensure service delivery and operational efficiency must be effected* | | -2 | | | 1 | | | 2 |
| *Targets need to be based on realistic forecasts of what the need is and what is achievable as well as linked to budgets. This is particularly important in relation to the number of enrolled patients for ARVs. This is a national and provincial issue.* | | 1 | | | 1 | | | |

DRAFT

| *RECOMMENDATIONS* | National Minister of Health | National Department of Health | Limpopo Health &SD MEC | Limpopo Department of Health & Social Development | National Treasury | Limpopo Provincial Treasury | Department of Public Service and Administration | External stakeholders |
|---|---|---|---|---|---|---|---|---|
| *There should be alignment between the building of new hospitals and clinics and available financial and human resources to ensure the operational and running costs of these facilities are assessed.* | | 1 | | 1 | 2 | 2 | | |
| ***Governance*** | | 1 | | 2 | | | | |
| *Political principals should exercise leadership and responsibility by establishing and confirming funding for new or additional services before pronouncing these to the general population* | *1* | | 2 | 2 | | 2 | | |
| *There should be clear written guidelines delineating the areas of responsibility the MEC and the HOD.* | *1* | 1 | 2 | 2 | | 2 | | |
| *All senior management appointments should take merit and ability into strong consideration.* | | 2 | | 1 | | | | |
| *The NDOH should provide provinces with clear written guidelines regarding the delegation of authority, responsibility and accountability to facility and district managers.* | | 1 | | 2 | | 2 | | |
| *Provinces should implement these delegations whilst ensuring that there is sufficient and adequate oversight and monitoring.* | | | | 1 | | 2 | | |
| *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 | | | | |
| *The role and expertise of strategic health programme managers at national, provincial and district levels needs review with clear guidelines of performance expectations. There needs to be clear communication (vertical) between these programme managers at these three levels on the one hand and also between these programme managers and line service delivery managers (horizontal) on the other hand.* | | 1 | | 1 | | | | |

DRAFT

| *RECOMMENDATIONS* | **National Minister of Health** | **National Department of Health** | **Limpopo Health &SD MEC** | **Limpopo Department of Health & Social Development** | **National Treasury** | **Limpopo Provincial Treasury** | **Department of Public Service and Administration** | **External stakeholders** |
|---|---|---|---|---|---|---|---|---|
| **Service delivery (HIV TB and MCH**) | | | | | | | | |
| *There should be clear communication between all these role players in ensuring that their planning is based on the current realities. However, targets should be set that continuously ensure significant improvement in health outcomes in agreed upon priority areas.* | | 1 | | 1 | | | | |
| *Clinics must be provided with the basic equipment to enable the required service* | | | 2 | 1 | | 2 | | |
| *The current model of monitoring and delivering ARVs needs review to ensure that it is sustainable, affordable, equitable and addresses issues of access.* | *1* | 1 | 2 | 2 | | | | |
| **HUMAN RESOURCES RECOMMENDATIONS** | | | | | | | | |
| ***Delegations, Accountability and Responsibility*** | | | 2 | 1 | | | | |
| *The reviewed delegation policy should be approved and implemented and its applicability be assessed after a year.* | | | 2 | 1 | | | | |
| *The advertisement of posts within hospitals should be delegated to the CEO's.* | | | 2 | 1 | | - | | |
| ***Integration and co-ordination*** | | | | | | | | |
| *The organisational structure should be reviewed with a view to create optimal directorates and co-ordination e.g. incorporate district hospitals and district health structures into the same directorates.* | | | 2 | 1 | | | | |
| *Communication mechanisms need to be established across clusters and DHS to prevent "silo" operational functioning.* | | | | 1 | | | | |

DRAFT

| *RECOMMENDATIONS* | National Minister of Health | National Department of Health | Limpopo Health & SD MEC | Limpopo Department of Health & Social Development | National Treasury | Limpopo Treasury | Department of Public Service and Administration | External stakeholders |
|---|---|---|---|---|---|---|---|---|
| ***Labour 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 on.* | | 1 | | 1 | | | 2 | |
| *Feedback loops should be established to update plans and define cost and service delivery impacts should new priorities arise.* | | 2 | | 1 | 2 | 2 | 2 | |
| *Clear decisions and direction at various levels (national, provincial and district levels) in terms of service delivery should be communicated – if fewer HR resources and decreased funds are available, priorities need to be adjusted and communicated accordingly.* | | 1 | | 1 | | | 2 | |
| ***Staff Establishment*** | | | | | | | | |
| *Restructuring, with a view to establishing minimum staffing levels, should be undertaken based on a number of factors including objectively agreed benchmarks, the provincial disease burden profile, optimal application of scarce skills and service delivery priorities as well as on available resources. Special consideration should be given to: Structuring should allow for the optimal use of scarce skills, re-allocation of lower level duties to lower graded staff, appropriate management ratios and levels should be reviewed, job titles and job grades should be consistent across various areas.* | | 1 | | 1 | | | 2 | |
| *PERSAL should be corrected to accurately reflect personnel positions and staffing numbers as reported in the FSDOH Budget Estimate and Annual Reports statements.* | | 2 | | 1 | | | 2 | |

DRAFT

| *RECOMMENDATIONS* | National Minister of Health | National Department of Health | Limpopo Health &SD MEC | Limpopo Department of Health & Social Development | National Treasury | Limpopo Provincial Treasury | Department of Public Service and Administration | External stakeholders |
|---|---|---|---|---|---|---|---|---|
| ***Staff establishment (continued)*** | | | | | | | | |
| *Norms and standards from NDOH should exist to guide provinces to determine correct structures and establishments. This should include guidance on management levels, ratios and grading of positions.* | | 1 | | 2 | | | | |
| *There is a need to review measures and tighten controls to ensure that bursary recipients fulfil their bursary obligations.* | | 2 | | 1 | | | | |
| ***Recruitment*** | | | | | | | | |
| *A thorough review and improvement of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times.* | | 2 | | 2 | | | 1 | |
| *Money should be made available for the recruitment of the prioritised lists that have been submitted to the Provincial Treasury.* | | 1 | | 1 | | 2 | 2 | |
| ***Performance Management*** | | | | | | | | |
| *The performance management system should be utilised as intended and incorporate:*<br>○ *Organisational performance;*<br>○ *Employee development;*<br>○ *Reward based on clear performance goals.* | | | | 1 | | | | |
| *Team performance for clinical staff should form part of performance standards and evaluation* | | 2 | | 1 | | | 2 | |
| **INFORMATION MANAGEMENT** | | | | | | | | |
| ***Use of Information for decision making*** | | | | | | | | |

| *RECOMMENDATIONS* | National Minister of Health | National Department of Health | Limpopo Health &SD MEC | Limpopo Department of Health & Social Development | National Treasury | Limpopo Provinci al Treasury | Department of Public Service and Administration | External stakeholders |
|---|---|---|---|---|---|---|---|---|
| *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 | | | 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 | | | | |
| *M&E, based on a limited number of standardised and nationally defined key indicators, needs to be built into every senior manager's job description and performance appraisal.* | | 1 | | 1 | | | 2 | |
| *Systems, policies and procedures must be put in place for the improvement of data quality.* | | 1 | | 2 | | | | |
| *In-service training for managers to improve the knowledge and skills around the key indicators relevant to their work and on the quality of data needs to take place.* | | | | 1 | | | | |
| *There must be regular analysis, comparison, interpretation and feedback of results on key indicators to the lower levels of the health care system.* | | | | 1 | | | | |
| ***District Health Information System*** | | | | | | | | |
| *The DHIS, and associated NIDS, needs a thorough review.. The numbers of indicators need to be decreased* | | 1 | | 2 | | | | |
| *Clear written guidelines, standard data collections tools and norms must be produced for each component of the DHIS, with unambiguous, easy to understand, standardised definitions* | | 1 | | 2 | | | | |
| *M&E component should be adequately resourced with relevant competent human resources, hardware and software.* | | | | 1 | | 2 | | |
| *Appropriate training also needs to be introduced* | | | | | | | | |

DRAFT

| *RECOMMENDATIONS* | National Minister of Health | National Department of Health | Limpopo Health &SD MEC | Limpopo Department of Health & Social Development | National Treasury | Limpopo Provincial Treasury | Department of Public Service and Administration | External stakeholders |
|---|---|---|---|---|---|---|---|---|
| *Data flow policies and linkages between the DHIS and other data collection systems such as the TB (ETR-net), PERSAL and BAS need to be established to ensure efficiency.* | | 1 | | 2 | | | 2 | |
| ***HIV Monitoring*** | | | | | | | | |
| *A workable, practical, easy-to-use system of monitoring the ARV programme needs to be put in place* | | 1 | | 2 | | | | 2 |
| *Monitoring of treatment outcomes and survival rates for ARVS should be introduced* | | 1 | | 2 | | | | 2 |
| ***Other M&E Issues*** | | | | | | | | |
| *There needs to be one official repository of information for the LDHSD. 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 | | 2 | 2 | |
| *Parallel systems of information (e.g. direct flow of information from facilities to programme managers – whether at provincial or national level-, and the by-passing of district management structures) should be discontinued.* | | 1 | | 2 | | | 2 | |
| *Basic record keeping needs to be maintained at facility level* | | 2 | | 1 | | | | |
| *A review of the state of the medical depot and the drug storage management practices should be carried out to assure the quality of medicines supplied. As part of this review the communication between the depot and the pharmaco-vigilance unit should be clarified.* | | 2 | | 1 | | | | |
| *The drug budget should be reviewed and prioritised in line with departmental priorities.* | | | | 1 | | | | |
| *The NHLS account served on the LDHSD should be audited and corrective action taken to avoid repetition of such "errors".* | | 1 | | 2 | | | | |

DRAFT

| *RECOMMENDATIONS* | National Minister of Health | National Department of Health | Limpopo Health &SD MEC | Limpopo Department of Health & Social Development | National Treasury | Limpopo Provincial Treasury | Department of Public Service and Administration | External stakeholders |
|---|---|---|---|---|---|---|---|---|
| **TECHNOLOGY AND INFRASTRUCTURE RECOMMENDATIONS** | | | | | | | | |
| All clinics must be provided with the basic equipment identified by the NDOH as being part of the Core Standards for Primary Health Care | | 2 | | 1 | | 2 | | |
| Technicians to must be appointed to ensure continued maintenance of hospital and clinic equipment essential for patient care | | 2 | | 1 | | | | |
| All clinics must be provided with telephone communication link as an essential and lifesaving communication tool | | 2 | | 1 | | 2 | | 2 |
| Clinics in areas affected by the drought (Mopani District) must be provided with uninterrupted water supply by local municipal tankers creates | | 2 | | 1 | | 2 | | 2 |
| Clinic building upgrades need to be speeded up to ensure effective patient care. | | 2 | | 1 | | 1 | | 2 |
| A plan of action should be instituted to deal with the logistical issues like lack of printers and computers at district and sub-district levels both for communication, health information and for administrative functions like access to PERSAL | | 2 | | 1 | | 2 | | 2 |
| The NDOH should revisit the telemedicine pilot project initiated in provinces about a decade ago | | 1 | | 2 | | | | |

DRAFT

# APPENDIXES

## Appendix 1: Terms of Reference

### 1. PROJECT TITLE

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

### 2. BACKGROUND

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.

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.

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.

## 2.1 Purpose of the IST Review

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.

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

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.

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.

DRAFT

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).

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

### 2.2 Aim and Scope of Work

**2.2.1 Aim of the ISTs:** To conduct a review of financial and strategic planning and operational plans and recommend efficient and effective cost saving strategies, that will lay the foundation for the development and implementation of a turn- around strategy that will revitalise and reorient health services for implementation by national and provincial DoHs during the 2009/2010 financial year. The IST teams, in partnership with national and provincial departments of health, will identify causes of over expenditure within the health system at both national and provincial levels. The IST will identify common or unique causes of over expenditure and the effect of these on service delivery. The IST team will identify a national and collective response for service delivery improvement despite these funding constraints.

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

#### 2.2.2 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

### 2.2.3 Review scope of work for Health Systems Strengthening Consultants

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

### 2.2.4 Review scope of work for Management and Organisational Development Consultants

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

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

## 2.3 Project Phases

The project will be conducted in three phases:

### 2.3.1 Phase 1-National Team only

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



DRAFT

- 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.

### 2.3.2 Phase 2- Provincial Teams

- Perform an analytical review based on the strategic and operational plans including budget (provincial-specific) and specifically comment on the following:
  - Document recent trends in utilisation of services, and analyse this against costs
  - Assess management and systems delivery to identify more efficient and effective options for delivery of services
  - Assess systems factors that may have resulted in recent overspend, and suggest strategies for ensuring this is avoided in future.
  - Consider health service implications of reductions in funding, and suggest mitigation strategies
- Utilise provincial templates with standardised and unique items adjusted for provinces
- Attend an orientation to the review and travel to allocated provinces
- Conduct interviews with provincial Heads of Department (HoD), CFO's and managers
- Conduct field visits to selected districts
- Review the outputs and outcomes against strategic and operational plans, budget and expenditure.
- Identify and quantify major cost drivers
- Assist provinces to identify financial planning and management problems



DRAFT

- Review management and administrative systems for monitoring, evaluation and reporting of outputs and outcomes against operational and financial plans.

### 2.3.3 Phase 3- All Teams

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

## 3. IST PROJECT MANAGEMENT

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:

- Process management and reporting, including ensuring task completion to agreed standards
- Managing issues that arise – such as delays, problems, contractual matters
- Liaison with stakeholders – provinces and national
- Management of provincial and district visits
- Collating reports and finalizing the consolidated provincial reports.

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.

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



DRAFT

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.

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

## 4. ROLES AND RESPONSIBILITIES

### 4.1 Role of NDOH and Provincial DoH

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.

### 4.2 Role of Consultants

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

## 5. EXPECTED OUTCOMES AND DELIVERABLES

DRAFT

This refers to both national and provincial ISTs.

**5.1** Standardised provincial and national review templates

**5.2** Summary Progress Reports and national and provincial DoH fact files

**5.3** Align Review Report with linkages of budgetary process and strategic and operational plans

**5.4** Detailed review reports on conditional grants and consolidated provincial reports (National Team)

**5.5** National and Provincial Reports focusing but not limited to:

- An executive summary of key findings by provinces and overall national status
- The extent to which provinces have met and complied with the objectives set out in their operational plans
- The extent to which provinces have over-expended on the budget based on their financial statements
- The impact of over-expenditure on the DoH's and implications for future operational plans and service delivery
- The quality of services and cost-effectiveness of programmes delivered
- Recommendation on lessons learnt from the review, and how, if any, to address challenges in the management and implementation of the provincial operational plans to improve service delivery and reduce over-expenditure

**5.6** Oral presentations on the key findings of the review and roadmap to the MACH

## 6. COMPETENCY AND EXPERTISE REQUIREMENTS

The following skills will be expected of the Finance component of Consultancy:

- Leadership experience and people and technical management skills
- 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
- Experience and understanding of South African public sector budgetary management systems
- Computer literacy, good communication and writing skills
- Data analysis and reporting on administrative, health management and financial issues
- Operational and financial management of large projects and programmes



DRAFT

- Good team management and team work (interpersonal) skills

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

- Extensive experience and understanding of the South African health system, PFMA and provincial DoH with relevant qualifications and track record
- Experience and understanding of South African public sector management systems
- Experience in health system strengthening and organisational development Computer literacy, good communication and writing skills
- Data analysis and reporting on administrative, health management and financial issues
- Operational and financial management of health projects and programmes
- Good team management and team work (interpersonal) skills

## 7. REPORTING REQUIREMENTS

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.

## 8. TIMING AND SCHEDULING

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 1 May 2009. The oral presentations will be completed by the 8 May 2009.
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.

## 9. CONTRACTING AND INVOICES

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.

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.

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.
Payment will be made monthly in arrears within 30 days of receipt by the consultant of an approved invoice and full supporting documents.

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.

## 10. GENERAL INFORMATION

CVs will be assessed using the following technical criteria:

- Experience in consultation with Departments of Health, finance, health systems strengthening and organisational development in developing countries, including South Africa
- Experience with review methods including primary data and secondary sources
- Experience in writing review or evaluation report
- Availability within the review time frames
- Short listed consultants may be interviewed by the project partner or HLSP.

## Appendix 2: List of Documents Reviewed

**General:**

1. Provincial Strategic Plan (05/06, 06/07, 07/08)
2. MTEF (2008/09 – 2010/11)
3. Provincial Annual Reports (05/06, 06/07, 07/08)
4. Annual Performance Plans (06/07, 07/08)
5. Strategic Transformation Plan (STP)
6. Management meetings minutes

**Finance:**

7. Budgets and Accruals 2006/07 (Annual report); 2007/08 (Annual report); 2008/09 YTD (IYM – January 2009)
8. Forecast, 2009/10; 2010/11; 2011/12
9. Annual Financial Statements
10. IYM report (January 2009)
11. Auditor-General audit reports

**HR:**

12. Summary of Establishment as at 3 March 2009
13. IYM report - January 2009
14. Recruitment and selection policy
15. Performance and Development Policy
16. Workplace Skills Plan and Annual Report, 2006/2007 and2008/2009
17. Retention Strategy,
18. Delegation Policies ( both approved and non approved)
19. Training Plan 2009-2015
20. Proposed Organisational Structure for HSD
21. Induction & Orientation Manual
22. Persal Information

DRAFT

**Other**

21. Personnel Turnover as at 4 March 2009

22. Malcolm Segall. Review of public health service delivery. *"The bottle is half full". Policy oriented overview of the main findings.* May 1999

23. World Health Organisation. The World Health Report 2000, Health Systems: Improving performance. Geneva, WHO 2000.

24. Helen Schneider, Peter Barron, Sharon Fonn. The promise and the practice of transformation in South Africa's health system. In Buhlungu S, Daniel J, Southall R, Lutchman J. State of the Nation South Africa 2007, 289-307. HSRC Press, 2007.

25. Stiaan Byleveld and Ross Haynes. District Management Study - A National Summary Report. A review of structures, competencies and training interventions to strengthen district management in the national health system of South Africa. Health Systems Trust, Durban 2009.

26. Strategic Health Programmes. Circulars 1-3 of 2009

27. Free State Health Drug Supply Management (DSM) Assessment report. Dr. V. Pienaar. August 2005

28. Christo Heunis, Michelle Engelbrecht, Gladys Kigozi, Anja Pienaar, Dingie van Rensburg. Counselling and testing for HIV/AIDS among TB patients in the Free State. Fact-finding research to inform intervention. Centre for Health Systems Research & Development 2009

29. Marian Loveday, Jackie Smith, Peter Barron, Ross Haynes. Health Information Audit Report. Free State. Health Systems Trust, 2005.

30. Public Enquiry: Access to Health Care services, Report. South African Human Rights Commission, 2007

DRAFT

## Appendix 3: Schedule of Interviews

**Provincial Department Level**

| Department/Area | Person(s) Interviewed | Position | Date of Interview |
|---|---|---|---|
| Top Management | Dr Nkadimeng | Senior Gen Manager-Health Branch | 30 March 2009 |
| Finance | Mr Mushwana | CFO | 03rd April, 2009 |
| | Mr ZP Lukhele | Acting Senior Manager Budgeting and Revenue | |
| | Mr MJ Mudau | Manager: budget | |
| Provincial Health Services | Ms Molepo M.C | Senior Manager: Nursing Education | 01 April 2009 |
| | Dr M.D Masipa | Snr Manager: Allied Health Services | |
| | Dr Rachel Chuenyane | Snr Manager: Nursing Services | |
| | Mr Phil Setsiba | Snr Manager: Pharmaceutical | |
| Corporate Services | Mr A.N Tshikovhi | General Manager: Corporate Services | 01 April 2009 |
| | MP Malwandla | Senior Manager: HRM | |
| | Ms DM Thema | Snr. Manager: HRD & Training | |
| | Mr Tshepo Maseleme | Snr. Manager: Labour | |
| | Mr HP Bamuza | Manager: Human Resources | |
| District Health Services | Elisabeth Matidze | Senior Manager : (MCWH) Maternal Child and Women's Health | 31st March 2009 |
| | Daddy Matthews | Manager: Nutrition services | |
| | Calvin Senong | Manager:CCMT | |
| Government Information and Communication officer | Stephen Nkgau | Senior Manager: Risk Management | 02 April,2009 |

| Department/Area | Person(s) Interviewed | Position | Date of Interview |
|---|---|---|---|
| | Mboneni Maumela | Snr Manager: Info & Records Management | |
| | Dipuo Dilwane | Manager: Communications | |
| | Nyiko Mutileni | Acting Snr Manager-IT/IS | |
| Supply Chain | William Kekana | General Manager: Supply Chain | 31 March 2009 |
| | CM Rapheleni | Snr. Manager: Assets | |
| | Edward Lamola | Snr. Manager: PPP | |
| | Baloyi | Snr. Manager: Transport | |
| | Antipas Matjekane | SAO: SCM | |
| | MJ Mphahlele | Manager: Demand & Acquisition | |
| District Services | Ramukumba | Snr. Manager: District Hospitals | 03 rd April |
| Strategic Planning | Ms Selina Dumela | Senior Manager: Strategic planning | 31 march,2009 |

DRAFT

**District Level: Mopani**

| Department/Area | Person(s) Interviewed | Position | Date of Interview |
|---|---|---|---|
| District Managers | Mrs Maluleke | District Manager | 06th April 2009 |
| | Mr Mantashi | Primary Health care co-ordinator | |
| | Mrs Mazibuko | HIV Programme Manager: Capacity Building | |
| | Ms Maswanganyi | TB programme Manager | |
| | Mr Baloyi | HIV and ARV programme Manager | |
| | Mr Shuvambu | Finance Manager | |
| | Mr Ntoane | Manager: Corporate services | |
| | Mr Mathebula | Manager Risk management | |
| | Mr Mathuane | Risk management | |
| Sub-District Managers | Ms M.F Maluleke | Sub-District Manager | 06th April 2009 |
| | Ms Masia | T.B Co-ordinators | |
| | Ms Mkansi | MCWHIN Coordinator | |
| | Ms Malewe | HIV/AIDS & STI Co-ordinator | |
| **Khensani Hospital** | Mr Mboweni VE | Chief Executive Officer | 07th April 2009 |
| | Selatlha JM | Clinical Manager | |
| | Chiloane ML | Acting Pharmacy Manager | |
| | Hlatshwayo MM: | Deputy Manager, Corporate Services | |
| | Maluleke NV: | Acting Deputy Nursing Service Manager | |
| | Mahungu MF | Deputy Manager, Finance | |
| | Mathonsi E | Quality co-ordinator | |
| | Risaba NM | Chief Liaison Officer, | |


DRAFT

| Department/Area | Person(s) Interviewed | Position | Date of Interview |
|---|---|---|---|
| | | Communication | |
| | Makamu R | Deputy Manager, Risk Management | |
| | Shilumani R | Deputy Manager, Clinical Support Services | |
| | Ngoveni MP | ECT. A /Support, Technical | |
| | Risenga MS | Senior Admin Officer, Logistics | |
| | Masangu NI | Human Resource Development Officer | |
| | Neluamondo TR | Senior Admin Officer, Transport | |
| | Macheke HS | Labour Relations Officer | |

DRAFT