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Free State Department of Health:

Report of the Integrated Support Team

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Contents

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

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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
FS	Free State Province
FSDOH	Free State Department of Health
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
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
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
Snr	Senior
STI	Sexually Transmitted Infection
STP	Service Transformation Plan
TB	Tuberculosis
TOP	Termination of Pregnancy
TR	Team Representative
WHO	World Health Organisation

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 undertook a rapid review of the Free State Department of Health in March 2009. The review was a broad-based, rapid appraisal that focused on the health system as a whole, but with *an emphasis on the over-expenditure*. It consisted of a desk top review and in-depth interviews with key informants at provincial and district levels.

The review has highlighted a number of key challenges and recommendations, which are contained in the body of the report. The overall approach to the review is based on the World Health 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 are *material unfunded* mandates at provincial level contributing to overspending. This in turn results in stringency measures with associated negative consequences for service delivery, managerial performance and staff morale.

Financial management practices, including budgeting at national and provincial level, need improvement. *Because of the current cash-based reporting system,* the *reported overspending is understated* in the FSDOH and if no radical measures are taken to remedy the situation there is likely to again be forced cuts in service delivery in the 2009/10 financial year.

2. There is a *lack of cohesion* between policy formulation, budgets and resources to implement the policies and planning. This has led many managers to assert that the public health sector is under-funded.

3. 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.

4. 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.

5. Although HR policies and procedures exist execution appears to be problematic. Recruitment processes, as one very important example, need to overhauled to make them fit for purpose. The organisational structure and staff establishment are not synchronised with the budgets or planning processes to optimally meet service delivery requirements. The information contained in, and the manner in which HR information systems are used, require urgent attention. For example the PERSAL establishment data is irrelevant for management purposes

6. *Monitoring and evaluation (M&E) is inadequate and* managers at all levels pay lip service to M&E. Although much time and resources is invested in data collection these data are not analysed, interpreted or used for decision making and there is little or no feedback of information from one level to the next.

7. Much time and effort goes into planning, but the process is formulaic and based on compliance rather than being utilised as an effective management tool. Additionally, there is a *disjuncture and lack of integration between planning, budgeting and implementation.* There are a plethora of plans at different levels,

which do not support each other and there is confusion around the terminology and status of various plans.

8. *Senior management are pre-occupied with bureaucratic functions, especially financial,* and are not focussed on service delivery which is the core responsibility of the FSDOH. This is partially due to the withdrawal of delegations which causes management to be involved in mundane day to day paperwork.

9. Drug budgets have not been prioritised and the FSDOH has had a shortage of medicines from November 2008 through to March 2009, affecting many aspects of service delivery. The budgeting practices applicable to pharmaceutical products hamper service delivery. A best practice relating to the overall monitoring of the laboratory services was noted and should be considered for replication in other Provinces.

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

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.*
- *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.*

ART Model

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

Service delivery focus

- *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.*

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.

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.[1] Due to time constraints, the HIV & AIDS, tuberculosis (TB) and maternal and child health (MCH) programmes were used as tracer programmes, both to add depth and to complement the health system building block reviews. The rationale for selecting these programmes 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).

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

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 Free State Department of Health (FSDOH) was chosen as the pilot province because of ease of access and state of readiness; availability of information, and it provided a balanced view between rural and urban areas and a spread of health services across the various levels.

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

In-depth interviews were conducted with the majority of senior managers at the provincial level and at one purposefully selected district and sub-district viz Maluti-A-Phofong in the Thabo Mofutsanyana district. The interviews were conducted by a team of three experts who visited the Free State province between the 2nd and 13th of March 2009 and again on the 28th April 2009. The list of people interviewed is shown in Appendix 3. The interviews were complemented by a further analysis of the documentation provided.

Because of time constraints, the initial review did not, and the report does not yet, include comments or findings related to the tertiary health operations in the Free State. This will be attended to during April 2009 and the findings will be incorporated into this report.

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

1.5 Outline of the report

This document reports on the IST review done in the Free State Department of Health (FSDOH). Section 2 gives an overview of the recommendations and assigns responsibility for the implementation of these. Section 3 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 4 focuses on an assessment of leadership,

governance and service delivery. Section 5 sets out the results of the human resource assessment, while section 6 focuses on information management. Sections 7 and 8 contain the assessment on medical products and laboratory, and infrastructure and technology respectively.

2 PREAMBLE

At the time of writing this report the Free State Department of Health (FSDOH) had suffered adverse media publicity regarding the lack of anti-retroviral drugs since November 2008. These lack of drugs, which was not limited to ARVs, is a consequence of inadequate funds in relation to the cost associated with the health services being provided in the Free State as well as a tightening of the financial belt by the Free State Treasury.

Many of the issues highlighted in this report need to be viewed against this disjuncture between funds available versus the cost of services to be delivered.

A second major theme related to the findings was that 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, and not only the FSDOH The Public Health system, and all its component parts, as a whole, needs to made to work better, and not just the FSDOH.

Thirdly, although the IST process was not designed to primarily focus on and detect mismanagement or corruption, the reviewers did not gain the impression that mismanagement or corruption on the part of the management of the FSDOH needed to be highlighted or deserved special further attention. To the contrary, there was a strong indication that they were collectively working hard to try and solve some intractable problems.

However, despite certain of the problems and their solutions lying outside the control of the FSDOH, there are still many things that could and should be improved and this report highlights some of these. Recommendations are made concerning areas of improvement in relation to the FSDOH as well as structures outside of the FSDOH to illustrate where relevant decisions and corrective action need to be taken.

The Table 1 is a summary of all the recommendations in Sections 3 to 8. These are linked with the institution(s) that have responsibility for the implementation of these recommendations.

Table 1: Recommendations contained in Free State Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input

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

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State Treasury	Department of Public Service and Administration	External stakeholders
FINANCE RECOMMENDATIONS								
Provincial health budget allocation								
The Provincial Treasury should allocate an amount to the FSDOH, which is substantially in line with the equitable share indicated by the National Treasury in the national budget.				2	2	1		
Allocations of conditional grants by the NDOH should be based on clear, objective criteria that are linked to grant specific indicators and not on the equitable share formula.		1		2	2	2		
Unfunded Mandates								
The operational impact of national policy decisions (e.g. OSD, new vaccine programme) should be determined and must be agreed with the provincial health department prior to implementation.		1		2	2	2		
There should be alignment between political decisions and operational implementation and agreement reached for any proposals on increases of service levels prior to their announcement. The availability of funding should also be confirmed.	1		1	2	2	2		
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		

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State Treasury	Department of Public Service and Administration	External stakeholders
All operational units (cost centres) need to have a realistic budget that can be used as a guideline for the financial year's activities. Operational plans need to be aligned with available funding to deliver the services.				1		2		
Budget virements needs to be linked to changes in operational activity, not merely to balance the number of over- and under-expenditure items.				1		2		
The practice of continuous budget reallocations 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		
Financial management								
Cost centre accounting needs to be done at the lowest possible practical level (i.e. facility/clinic level). This is needed to properly identify areas of operations that require attention.				1	2	1		
Allocation of expenses needs to be accurate 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	Free State Health MEC	Free State Department of Health	National Treasury	Free State 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		
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		

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State 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				
Diaries of all managers need to be respected by politicians to ensure better time management throughout the department.			1	2				
Management of over-expenditure is a core senior management function together with its effects on service delivery and needs to be explicitly on the agenda of senior management.				1		2		
Short term rationing of important areas (e.g. maintenance of facilities) can influence long term strategies (e.g. run down of facilities) and should be guarded against with ring-fencing these critical components of the budget.				1	2	2		
Planning								
The STP should be reviewed, revised, costed, endorsed politically, communicated to all relevant stakeholders and then used as the basis to guide all strategic decision making in the FSDOH.		2	1	1	2	2		
All planning processes in the department should be simplified and aligned with each other and well communicated. There should be a limited number of key targets for each area of operation for which managers are responsible and accountable.		1		1				

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State Treasury	Department of Public Service and Administration	External stakeholders
Plans should be given the status for which they are intended and should be a roadmap for all health workers in the province. There should be a clear M&E process which ensures that the implementation of the plans are regularly monitored with remedial action taken if necessary to ensure that targets are attained.		1		1				
Targets should be set based on guidelines from NDOH and the provincial realities. These targets need inputs from programme and line managers to ensure that there is buy-in.		1		2				
Targets need to be based on realistic forecasts of what the need is and what is achievable as well as linked to budgets. This is particularly important in relation to ARVs. This is a national and provincial issue.		1		1		2		
External support for the planning processes should be sought from other institutions where this is thought to be relevant (e.g. NDOH, Universities, private sector).		2		1				2
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								
There should be clear written guidelines delineating the areas of responsibility the MEC and the HOD.			1	1			2	
All senior management appointments should take merit and ability into strong consideration.			1	2				
The NDOH should provide provinces with clear written guidelines regarding the delegation of authority, responsibility and accountability to facility and district managers. Provinces should implement these delegations whilst ensuring that there is sufficient and adequate oversight and monitoring.		1		2				

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State Treasury	Department of Public Service and Administration	External stakeholders
Service delivery (HIV TB and MCH)								
The NDOH should produce comprehensive, integrated guidelines covering all aspects of service delivery in relation to HIV, TB and MCH. These guidelines should contain norms and standards (including addressing data gathering, monitoring and evaluation, human resources).		1		2				
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				
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				
Quality of care and solving of problems at the local level needs to be given greater emphasis and the provincial facility supervision programme needs to be strengthened through regular supportive supervision from competent supervisors.				1				
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								
It should be assessed if withdrawing delegations adds value in terms of cost containment and service delivery. If not, then delegations should be re-instituted. A clear matrix in terms of delegation of authorities and decision making at various levels should be completed (This should be in line with a RACI matrix where different people are responsible, accountable, consulted or informed)			2	1				

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State Treasury	Department of Public Service and Administration	External stakeholders
The responsibility level of CEOs of institutions and district managers and their district management teams (DMTs) should be reviewed and addressed. This should include a review of financial management responsibilities.			2	1		2		
Integration and co-ordination								
Communication mechanisms need to be established across clusters and DHIS to prevent "silo" operational functioning.				1				
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	

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State Treasury	Department of Public Service and Administration	External stakeholders
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	
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				
Consistency in grades for similar positions across various areas should be analysed in more depth. This should include the standardisation of nomenclature of job titles between provinces so that comparisons can be easily made.		2		1				
DPSA should assist NDOH and provinces to support changes to structures in a more efficient manner		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	
Recruitment of more staff nurses should be considered to fill the gap between assistant nurses and professional nurses.		1		1			2	
The pilot scheme in Motheo District where private doctors have been contracted to provide medical services should be evaluated to assess whether it addresses the problem of staff shortages at a similar or lower cost than the appointment of foreign doctors.		2		1			2	
Performance Management								
Performance contracts at job level 13 and above should be clearly linked to organisational priorities and key indicators that drive organisational performance.				1				
The performance management system should be utilised as intended and incorporate, Organisational performance; Employee development; Reward based on clear performance goals.				1			2	

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State Treasury	Department of Public Service and Administration	External stakeholders
Team performance should form part of performance standards and evaluation and should be escalated to DPSA.		2		2			1	
Retention								
A national health professional and scarce skills retention strategy should be developed by the NDOH.		1		2			2	
The FSDOH retention strategy should be analysed in terms of impact and cost to test possible success and affordability.				1			2	
Rewards								
A total reward strategy (monetary and non-monetary) review should be undertaken at national level to address issues of employee compensation overspend, skills scarcity and staff retention – including highlighting the importance of:		1		2	1	2	1	
A thorough costing of any change in the reward system which must be done in collaboration with the affected parties and include an assessment of affordability at various levels.		1		2	1	2	2	
Rewards should be linked to organisational, employee and team performance.		2		2	2	2	1	
Lessons learned from the current OSD implementation review for nurses should be captured to inform future implementation of other improvement initiatives.		1		2	1	2		
Learning and Development								
Training needs should be properly and objectively determined.		2		1				
Well considered and prioritised commitments to relevant training should be maintained even during times of cost containment. Training and development programmes should be clearly defined and aligned to the service delivery priorities of the province.		2		1				

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State Treasury	Department of Public Service and Administration	External stakeholders
HR information systems								
An assessment should be undertaken to establish reasons for under utilisation of systems and improved measures should be implemented including the use of PERSAL to its full capacity as a HR management tool.		2		1				
INFORMATION MANAGEMENT RECOMMENDATIONS								
Overall M&E								
M&E needs to become a central component of all managerial activity with the use of objective information being the basis for decision making. This applies to all aspects of management, including financial and HR, and not only service related data. There needs to be an iterative link between planning, implementation and monitoring.		1		1	2	2	2	
Regular formal monitoring of key indicators needs to take place with analysis and questioning of variances (in much the same way as financial management variance analysis should take place).		2		1		2		
Use of information for decision making								
M&E, based on a limited number of key indicators, needs to be built into every senior manager's job description and performance appraisal.		2		1			2	
Where applicable, in-service training around understanding of and the importance of key indicators for managers needs to take place.		2		1				
There should be regular analysis, comparison, interpretation and feedback around indicators to lower levels of the system.		2		1				
District Health Information System (DHIS)								
The DHIS, and associated NIDS, needs a thorough review by the NDOH.		1		2				
The numbers of indicators need to be decreased		1		2				
There should be unambiguous, easy to understand, standardised definitions.		1		2				

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State Treasury	Department of Public Service and Administration	External stakeholders
There also needs to be clear written guidelines, norms and standards for each component of the DHIS, including data collections tools (forms and registers); relevant human resources, hardware, software, data flow policies and linkages between the DHIS and other data collection systems such as the TB (ETR-net), PERSAL and BAS.		1		2	2	2	2	
An appropriate training regime also needs to be introduced at the correct time.		1		1				
ARV Monitoring and Evaluation								
A workable, practical, easy-to-use system of monitoring the ARV programme needs to be put in place.		1		2				
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.		1		2				
Given the urgency of the situation this should be done immediately and the Meditech system should be reviewed and replaced where it is not working.		1		1				
Other M&E issues								
There needs to be one official repository of information for the FSDOH. 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				
Parallel systems of information (e.g. direct flow of information from facilities to programme managers – whether at provincial or national level-, and the by-passing of district management structures) should be discontinued.		2		1				
Basic record keeping needs to be maintained at facility level.		2		1				

RECOMMENDATIONS	National Minister of Health	National Department of Health	Free State Health MEC	Free State Department of Health	National Treasury	Free State Treasury	Department of Public Service and Administration	External stakeholders
MEDICAL PRODUCTS, LABORATORY RECOMMENDATIONS								
A review of all aspects of the management and operations of the medical depot should be carried out. As part of this review the communication between the depot and the pharmaco-vigilance unit should be clarified.				1				
Drug budgets should reside at the lowest level of activity as part of the cost centre hierarchy and drug costs should be accurately allocated to particular clinics.				1	2	2		
The laboratory monitoring system is a best practice, which should be shared and replicated in other provinces, with the assistance of the NDOH		2		1				
TECHNOLOGY AND INFRASTRUCTURE RECOMMENDATIONS								
A plan of action should be prepared to deal with the logistical issues identified in the review, some of which should be coordinated by the NDOH.		2		1				

3 FINANCIAL REVIEW

3.1 Introduction

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

Box 1: Key findings from the financial review

1. The contention of under-funding of the FSDOH and the South African public health system as a whole is being investigated at a national level and will be commented on in the overall IST national report.
2. About one quarter of the total Free State provincial revenue is allocated to health and this has been constant over the past four years.
3. The relative proportion of the national conditional grant for HIV/AIDS allocated to the FSDOH has significantly decreased over the past four years.
4. The growth rate in the per capita budget for the FSDOH for the period 2005/06 to 2010/11 is consistently lower than national per capita budget for the same period.
5. Although over-expenditure commenced in the 2005/6 financial year, it was exacerbated in subsequent financial years by OSD, higher than budgeted salary increases, medical inflation and higher numbers of patients on anti-retroviral therapy (ART) than original forecast numbers.
6. As a result of the manner in which the cash based system is applied, the true extent of the reported overspending is significantly understated (increases in accrual levels not included in reported overspending).
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 budget.
9. Budgeting and financial management processes (including cost allocations and proper cost centre accounting; financial monitoring and evaluation) are sub-optimal.
10. From the FSDOH perspective, conditional grants are not allocated according to grant specific indicators.
11. Unfunded mandates (e.g. policy decisions such as function shifts, occupational

specific dispensation) exacerbate spending pressures.

12. Management accountability for finances needs improvement.
13. The current systems of financial and quarterly performance reporting make it difficult to link finances to performance.
14. The lack of an integrated health information system results in a deficient budgeting process.
15. The full budgetary impact of the cost of treatment required by patients on ART needs to be better quantified.

3.2 Underfunding 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 the Free State and nationally is due to the under-funding of the system with consequent “unfunded mandates”.

The IST team is in the process of investigating this assertion on a national basis, and a conclusion will be reached upon completion. This assessment will also include a conclusion regarding the conditional grants awarded to the FSDOH in respect of the two tracer programmes identified (see 3.4).

3.3 Provincial budget allocation

The allocation of the Free State Province’s budget to the FSDOH is shown in Table 2. The allocation includes the equitable share, conditional grants and provincial revenue. Slightly more than one quarter of the total provincial revenue is allocated to health and this figure has remained fairly constant over the last three years. The percentage allocation for Health 2005/6 is not comparable in this trend due to inclusion of the Social Security function in the South African Social Security Agency (SASSA) from 2006/07 onwards resulting in an overall decrease in the Free State’s total budget.

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

Financial year	R m Provincial Budget	Year on year increase	R m Health Budget	Year on year increase	% Allocation to Health	R m Adjustment Provincial Budget	R m Adjustment Health Budget	% Allocation to Health
2005/06	14 542[2]	N/A	3 076[3]	N/A	21.15%	15 062[4]	3 118[5]	20.70%
2006/07	11 626[6]	-20.05%	3 250[7]	5.66%	27.95%	11 883[8]	3 369[9]	28.35%
2007/08	13 309[10]	14.48%	3 643[11]	12.09%	27.37%	13 528[12]	3 744[13]	27.68%
2008/09	15 685[14]	17.85%	4 288[15]	17.70%	27.34%	16 178[16]	4 469[17]	27.62%
2009/10	18 374[18]	17.14%	5 198[19]	21.22%	28.29%	N/A	N/A	N/A
2010/11	20 290[20]	10.43%	5 883[21]	13.19%	29.00%	N/A	N/A	N/A

The percentage allocation to the FSDOH is calculated on the total amount allocated to the different Free State departments and not the total provincial budgeted receipts, which would have resulted in a lower percentage allocation to the FSDOH. This was done to ensure consistency and comparability between the different provinces.

When conditional grants are excluded, the provincial equitable share allocation to health remains relatively constant around 25%, with a projected increase over the MTEF (Table 3).

[2] Free State Budget Statement 2006/07, page 21
[3] Free State Budget Statement 2006/07, page 21
[4] Free State Budget Statement 2006/07, page 21
[5] Free State Budget Statement 2006/07, page 21
[6] Free State Budget Statement 2007/08, page 46
[7] Free State Budget Statement 2007/08, page 46
[8] Free State Budget Statement 2007/08, page 46
[9] Free State Budget Statement 2007/08, page 46
[10] Free State Budget Estimate 2008/09, page 24
[11] Free State Budget Estimate 2008/09, page 24
[12] Free State Budget Estimate 2008/09, page 24
[13] Free State Budget Estimate 2008/09, page 24
[14] Free State Budget Estimate 2008/09, page 24
[15] Free State Budget Estimate 2008/09, page 24
[16] Free State Adjustment Estimates 08/09, page 6
[17] Free State Adjustment Estimates 08/09, page 35;IYM, January 2009
[18] Free State Budget Estimate 2009/10, page 28
[19] Free State Budget Estimate 2009/10, page 28
[20] Free State Budget Estimate 2009/10, page 28
[21] Free State Budget Estimate 2009/10, page 28

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

Financial year	R m Adjustment Provincial Budget (excl Grants)	R m Adjustment Health Budget (incl. Grants)	R m Health Grants	% Year on year increase in Health Grants	R m Adjustment Health Budget (excl. Grants)	% Allocation to Health
2005/06	9 359	3 118[22]	801[23]		2 317	24.75%
2006/07	10 076	3 369[24]	933[25]	16.42%	2 436	24.18%
2007/08	11 281	3 744[26]	980[27]	5.07%	2 764	24.50%
2008/09	13 313	4 469[28]	1 137[29]	15.94%	3 332	25.03%
2009/10 (main budget)	14 822	5 198[30]	1 341[31]	17.99%	3 857	26.02%
2010/11 (main budget)	16 059	5 883[32]	1 609$[33]	19.99%	4 274	26.62%

3.4 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 FSDOH (Table 4). There has been a steady decline in the proportion of the HIV and AIDS grant allocated to the FSDOH from 2005/06 through to 2008/09 with increases over the MTEF. Although the proportion of the HIV grant has been larger than the Free State's proportion of the total population (around 6%)[34] the Free State had the second highest antenatal HIV sero-prevalence in 2007 of 33%. Also the Free State has been the only province to show a rising sero-prevalence from 2005 when the rate was 30.3%.[35]

[22] Free State Budget Statement 2006/07, page 21
[23] Free State Budget Statement 2006/07, page 163
[24] Free State Budget Statement 2007/08, page 46
[25] Free State Budget Statement 2007/08, page 193
[26] Free State Budget Estimate 2008/09, page 24
[27] Free State Budget Estimate 2008/09, page 157
[28] IYM, January 2009
[29] Free State Budget Estimate 2009/10, page 155
[30] Free State Budget Estimate 2008/09, page 24
[31] Free State Budget Estimate 2009/10, page 155
[32] Free State Budget Estimate 2008/09, page 24
[33] Free State Budget Estimate 2009/10, page 155
[34] STATS-SA mid-year population estimates.
[35] The National HIV and Syphilis Prevalence Survey South Africa, 2007.

Table 4: National Conditional Grants to Provinces

Grant	Financial year	R 000 Total Conditional Grant to Provinces	R 000 Free State Provincial Allocation	% Allocation of National Grant
Comprehensive HIV & AIDS Grant	2005/06	1 150 108[3637]	100 874[38]	8.77%
	2006/07	1 616 214[3940]	142 265[41]	8.80%
	2007/08	2 006 223[42]	153 646[43]	7.66%
	2008/09	2 885 400[44]	189 630[45]	6.57%
	2009/10	3 476 200[46]	235 792[47]	6.78%
	2010/11	4 311 800[48]	326 658[49]	7.58%
National Tertiary Services Grant	2005/06	4 709 386[5051]	432 116[52]	9.18%
	2006/07	4 981 149[53]	458 043[54]	9.20%
	2007/08	5 321 206[55]	480 945[56]	9.04%
	2008/09	6 134 100[57]	545 350[58]	8.89%
	2009/10	6 614 400[59]	642 835[60]	9.72%
	2010/11	7 398 000[61]	659 469[62]	8.91%
Total Conditional Grants to Provinces	2005/06	8 907 346[6364]	754 644[65]	8.47%
	2006/07	10 206 542[6667]	799 306[68]	7.83%

[36] Actual amounts
[37] Estimates of National Expenditure 2008, page 279
[38] Free State Budget Statement 2006/07, page 18
[39] Actual amounts
[40] Estimates of National Expenditure 2008, page 279
[41] Free State Budget Statement 2007/08, page 44
[42] Estimates of National Expenditure 2008, page 279
[43] Free State Budget Statement 2008/09, page 22
[44] Estimates of National Expenditure 2009, page 298
[45] Free State Budget Statement 2008/09, page 22
[46] Estimates of National Expenditure 2009, page 298
[47] Free State Budget Statement 2008/09, page 22
[48] Estimates of National Expenditure 2009, page 298
[49] Free State Budget Statement 2008/09, page 22
[50] Actual amounts
[51] Estimates of National Expenditure 2008, page 279
[52] Free State Budget Statement 2006/07, page 18
[53] Estimates of National Expenditure 2008, page 279
[54] Free State Budget Statement 2007/08, page 44
[55] Estimates of National Expenditure 2008, page 279
[56] Free State Budget Statement 2008/09, page 22
[57] Estimates of National Expenditure 2009, page 298
[58] Free State Budget Statement 2008/09, page 22
[59] Estimates of National Expenditure 2009, page 298
[60] Free State Budget Statement 2008/09, page 22
[61] Estimates of National Expenditure 2009, page 298
[62] Free State Budget Statement 2008/09, page 22
[63] Amount is actual
[64] Estimates of National Expenditure 2008, page 279
[65] Free State Budget Statement 2006/07, page 18
[66] Amount is actual

Grant	Financial year	R 000 Total Conditional Grant to Provinces	R 000 Free State Provincial Allocation	% Allocation of National Grant
	2007/08	11 736 678[69]	863 866[70]	7.36%
	2008/09	14 362 800[71]	1 070 931[72]	7.46%
	2009/10	15 578 400[73]	1 270 123[74]	8.15%
	2010/11	18 012 800[75]	1 519 171[76]	8.43%

The NTSG grant to the Free State has been fairly constant at around nine percent of the total NTSG. The FDOH's proportion of the total conditional grants was markedly reduced from 2005/06 to 2008/09 but increases again in 2009/10. The criteria for the allocation of all the conditional grants at National level were not clear or transparent.

3.5 Total budget per capita

The budget per capita for the FSDOH was calculated using Statistics South Africa mid-year estimates (Table 5). The nominal budget per capita has increased, and is expected to increase at a rate in excess of inflation according to the MTEF.

[67] Estimates of National Expenditure 2008, page 279
[68] Free State Budget Statement 2007/08, page 44
[69] Estimates of National Expenditure 2008, page 279
[70] Free State Budget Statement 2008/09, page 22
[71] Estimates of National Expenditure 2009, page 298
[72] Free State Budget Statement 2008/09, page 22
[73] Estimates of National Expenditure 2009, page 298
[74] Free State Budget Statement 2008/09, page 22
[75] Estimates of National Expenditure 2009, page 298
[76] Free State Budget Statement 2008/09, page 22

Table 5: Comparing national and Free State provincial trends in per capita health budget

Financial year	National Population	R m National Health Budget	R National Health Budget per capita	% Increase year on year	Free State Population	R m Free State Health Budget	R Free State Health Budget per capita	% Increase year on year	R Free State Health Budget per capita (excl Capital assets)	% Increase year on year
2005/06	46 888 200	48 067	1 025		2 953 100	3 076	1 042		964	
2006/07	47 390 900	54 533	1 151	12.3%	2 958 800	3 250	1 098	5.4%	1 043	8.20%
2007/08	47 850 700	62 633	1 309	13.7%	2 965 600	3 643	1 228	11.8%	1 159	11.12%
2008/09	48 687 300	75 492	1 551	18.5%	2 877 700	4 288	1 490	21.3%	1 351	16.57%
2009/10	48 687 300	86 945	1 786	15.2%	2 877 700	5 198	1 806	21.2%	1 653	22.35%
2010/11	48 687 300	97 632	2 005	12.3%	2 877 700	5 883	2 044	13.2%	1 832	10.83%

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

With the exception of 2005/06 the per capita budget for health in the Free State (based on the total population) is lower than the national per capita budget for South Africa. This population excludes the large numbers of people from Lesotho and the Eastern Cape who reportedly make use of health services in the Free State. Although there has been an increase in the Free State compounded annual growth rate per capita over the period reviewed of 13,0% per annum this is lower than the 14.4% per annum increase nationally. Over time, this is a substantial difference.

3.6 Trends in health expenditure

The FSDOH has overspent its budget for three years running following the 2004/05 financial year (Table 6). 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 6: Trends in FSDOH 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	(2 947)	(91 927)	(89 597)	6 409[77]
(Increase)/decrease in accruals payable	21 618	(15 753)	(115 502)	(93 890)
Surplus (deficit) adjusted for movement in accruals	**18 671**	**(107 680)**	**(205 099)**	**(87 481)**
Balance of accruals at year end	*44 855*	*60 608*	*176 110*	*270 000*[78]

Although the overspending commenced in 2005/06, the main contributors to the overspending in financial years 2006/07 and 2007/08 are:

- 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-retrovirals (ARVs) than the forecast numbers.

The estimated decrease in the actual overspending (to a projected underspending) for the 2008/09 financial year appears to be due to the change in the cash supply policy from the Provincial Treasury. During the previous financial years, projected overspending was funded with additional cash flow from the Provincial Treasury. During the 2008/09 financial year, no additional cash was provided. This resulted in a large increase in the level of outstanding accruals, a reduction in the overspending trend, as well as the rationing of services (e.g. the supply of ARVs and other essential drugs) during the course of the year.

A concern was raised by the CFO 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.

[77] Estimate per IYM report (January 2009)

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

As can be seen from the table 7 below, the trend of overspending has shifted from goods and services to compensation of employees (OSD and material salary increases). In the 2006/07 financial year, the training budget was reduced, which might have a long term negative impact on service delivery. The annual growth rate in actual expenditure on training over the two years only amounted to 1.5% per annum. This aspect is further dealt with under paragraph 5.10.

Table 7: Trends in health programme budget and expenditure, 2005-8

	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 Appro-priation**	**Actual Expen-diture**	**Variance**	**Final Appro-priation**	**Actual Expen-diture**	**Variance**	**Final Appro-priation**	**Actual Expen-diture**	**Variance**
Administration	155 676	142 866	12 180	173 066	154 665	18 401	194 410	186 449	7 961
District Health Services	1 142 549	1 137 573	4 976	1 302 317	1 290 966	11 351	1 384 519	1 408 370	-23 851
Emergency Medical Services	145 918	146 339	-421	149 678	164 704	-15 026	191 585	191 585	0
Provincial Hospital Services	836 066	856 209	-20 143	888 957	951 962	-63 005	957 472	997 366	-39 894
Central Hospital Services	526 809	543 235	-16 426	576 169	599 443	-23 274	685 935	693 694	-7 759
Health Sciences and Training	94 085	95 873	-1 788	91 658	98 150	-6 492	111 400	98 727	12 673
Health Care Support	55 049	55 050	-1	60 313	62 547	-2 234	66 955	64 001	2 954
Health Facilities Management	186 363	170 953	15 410	153 257	157 387	-4 130	180 003	210 947	-30 944
Special functions	0	3 682	-3 682	0	6 092	-6092	0	3 548	-3 548
Internal charges	-24 187	-30 505	6 318	-26 005	-24 579	-1 426	-27 879	-20 690	-7 189
Total	**3 118 328**	**3 121 275**	**-2 947**	**3 369 410**	**3 461 337**	**-91 927**	**3 744 400**	**3 833 997**	**-89 597**
Economic classification									
Compensation of employees	1 857 427	1 849 533	7 894	2 027 996	2 012 009	15 987	2 262 363	2 351 744	-89 381
Goods and services	896 190	946 677	-50 487	1 033 238	1 123 423	-90 185	1 109 570	1 103 584	5 986
Financial transactions in assets and liabilities	0	3 693	-3 693	0	6 087	-6 087	0	3 547	-3 547
Transfers and subsidies	101 483	92 533	8 950	66 192	73 837	-7 645	72 243	72 422	-179
Buildings and other fixed structures	185 447	172 299	13 148	161 731	162 175	-444	212 421	227 845	-15 424
Machinery and equipment	77 781	56 540	21 241	80 253	83 806	-3 553	87 803	74 855	12 948
Total	**3 118 328**	**3 121 275**	**-2 947**	**3 369 410**	**3 461 337**	**-91 927**	**3 744 400**	**3 833 997**	**-89 597**

Source: Budget statements of various financial years

3.7 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 FSDOH 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 underfunding for this OSD amounted to R92 million for the 2008/09 financial year.

- *Nationally negotiated salary increases* for 2008/09 was 10.5%, although the budgeted increases provided for by the FSDOH were only 7.1%. The impact of this was R64m during the 2008/09 financial year.
- *Function shifts*. The budget did not cater for the movement of operations, e.g. in respect of Emergency Medical Services and municipal clinics from local government to the FSDOH. The remuneration shortage for local authority employees amounts to R35 million per annum.
- *The activity levels increased.* For example the numbers of patients registered for ARTs increased from a projected 27000 (funded by the HIV conditional grant) by the end of 2008/09 to 34000. At an average cost of around R500 per patient per month there is an underfunding of R3.5million per month.
- *New facilities.* The opening of a clinic during a financial year without funding being provided in the budget. The opening of this clinic was based on political promises being made without ascertainment of whether running costs were available.
- *Higher medical inflation than budgeted inflation increases, calculated at an estimated 4.5 percentage points.* The exact effect of this cannot be accurately quantified with the summarised information available.

The negative financial pressure caused by unfunded mandates was in excess of R200 million, or more than 5% of the budget of the FSDOH.

3.8 Budgeting process

The budgeting process was identified as a major contributor to the current funding challenges in the FSDOH. 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.

There is also no clear alignment between the annual performance plans and the financial budgets. Annual performance plans are also not updated subsequent to the allocation of

funding. A good example of this non-alignment is the difference between the forecasted numbers of patients on ART and the budget allocated.

The CFO indicated that there is an expected deficit of R170m for the 2009/10 financial year, but due to the current budgeting and reporting processes this figure is not reflected. The expected deficit stems from the misalignment between the budget request of the FSDOH based on past (and future expected) activity and the top-down amount allocated from the Provincial Treasury, as well as national conditional grants

3.9 Financial management processes

Cost centre accounting electronically 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.

During November 2008, the Free State provincial Treasury withdrew delegations due to overspending by the health department and will remain in place for 2009/2010 financial year. This severely impacts on and limits management responsibility and accountability at all levels of the hierarchy, making it more difficult to maintain effectiveness and efficiency standards. Supporting evidence for this contention is provided under paragraph 5.2.

3.10 Cost allocation

In some limited cases, costs for doctors and dentists are allocated to district hospitals, but the personnel in question are deployed in primary health care level. The cost per

patient day equivalent (PDE) indicator loses some of its relevance and usefulness as a result. Hence, there is need to improve the personnel cost allocation.

Re-distribution of medication is not done through the medical depot. The various pharmacy personnel developed a manual system to redistribute medication and medical supplies to the different facilities themselves. As a result of the non-integrated, manual system, accurate cost allocation of medication to institutions/cost centres is not done. Again, the cost per PDE indicator loses some of its effectiveness.

3.11 Conditional grants

The national budgetary processes referred to in paragraph 3.8 apply equally to conditional grants. Although annual performance plans are compiled at national and provincial levels, there are mismatches between the provincial business plans and the level of national grant funding. For example, the criteria for HIV grant allocations are not clear but appear to be somehow based on the equitable share, and not the business plans of the province which reflect the number of HIV positive individuals in need of care.

3.12 Quarterly performance reports

Quarterly performance reports on service related indicators are compiled and submitted to the provincial Treasury. The current systems of financial and quarterly performance reporting make it difficult to link finances to performance. In addition, as a result of national prescribed indicators, there are too many non-financial indicators, with doubtful value and usefulness. Currently, variances are identified, but there is no follow-up of these variances. This matter is also commented on in paragraph 6.2.

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

The Provincial Treasury requested that the current year's IYM (from the 2008/09 financial year) only reflects the projected cash flows, and not the expected cost of operations. The result is that the IYM will not accurately indicate over-spending. The effectiveness of the IYM report as a management tool to assist with the prevention of over-runs is therefore limited. The Provincial Treasury apparently also does not report the potential problems to national Treasury and according to information supplied, the estimated R87 million deficit (due to the movement of accruals) of the FSDOH has not been reported (see Table 6).

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

Resulting from the change in policy in the provision of cash resources to fund over-spending, material under-spending will be reported in certain programmes/economic classifications and over-spending in others. The compensation to employees will, for example, be reported as overspent (a priority payment) and goods and services under-spent. However, a material amount will still be outstanding/ payable for goods and services at the end of the financial year.

3.14 Monitoring structures

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

- Audit committee – the FSDOH did not have an audit committee in operation during the financial year.
- 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 not been implemented.

3.15 Key Recommendations

3.16.1 Provincial health budget allocation

- *The Provincial Treasury should allocate an amount to the FSDOH, which is substantially in line with the equitable share indicated by the National Treasury in the national budget.*
- *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.*

3.16.2 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.*
- *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.*

3.16.3 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.*
- *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 needs 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.

3.16.4 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.*
- *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.*

3.16.5 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.*
- *Variances in specific indicators need to be followed up with actions, and not merely identified.*
- *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.*

3.16.6 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).*
- *Through the appropriate channels, the forecasting component of the IYM should be investigated to ensure best basis or reporting – cash versus accrual reporting. .*

3.16.7 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.*

4 LEADERSHIP, GOVERNANCE and SERVICE DELIVERY

4.1 Introduction

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

1. The NDOH has provided insufficient leadership and stewardship to solve the fundamental problem of ensuring that the resources available for health are sufficient for the levels of service and targets envisaged by a range of national policies.
2. The NDOH has also not given sufficient direction with regard to setting of norms, standards and guidelines.
3. Governance structures envisaged in the National Health Act have not been formally put in place e.g. hospital boards and clinic health committees.
4. Minutes of senior management meetings reveal a pre-occupation with operational processes, rather than strategic issues of service delivery. In addition, regular well planned, scheduled meetings throughout the FSDOH are compromised through ad hoc calling of meetings by .
5. Although there is feedback to line managers on over-expenditure and variances on line budgets, the manner of, and responsibility for, follow-up and action is inadequate.
6. As a result of the non-approval of the STP key planning documents of the FSDOH lack an overall vision for the public health system in the province. There is lack of alignment among the various plans and lack of communication within the FSDOH around planning. Plans are designed to satisfy compliance and accountability mechanisms are neither strong nor explicit.
7. As a result of the provincial treasury imposition most of the financial and human resource delegations have been centralised, resulting in increasing bureaucracy with consequent inefficiencies, additional costs and insufficient accountability.
8. Despite HIV&AIDS and TB being designated as high priority areas in the APP, targets for intervention are modest and do not convey a sense of urgency.
9. The large number of priority health programme managers at national and provincial level is out of sync with the capacity at district level, exacerbated by the lack of integration across the various programmes.
10. There is insufficient supervision of health facilities and an inadequacy of the

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

monitoring systems (e.g. number of patients on ARVs), making it extremely difficult to forecast both demand and supply.

11. The current model of delivery by which ARVs are supplied by a small number of centrally located facilities is not compatible with improving service access and the current funding model of ARV provision is also neither affordable nor sustainable.

4.2 General Leadership

The FSDOH 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 FSDOH has introduced increasingly more stringent expenditure constraints. These culminated in November 2008 with a moratorium of expenditure on ARVs and other essential health programmes with consequent huge negative publicity in the media.

There was a belief that health services were above the financial imperative 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 National Department of Health (NDOH), although often considered to be excellent policies and in line with international best practice, are not linked to the necessary funding. For example, the NDOH has introduced two new childhood vaccines to be implemented by the 1st of April 2009. However, although additional funding has been provided for this by the national Treasury, this has been added to the equitable share of the province. In reality this means that the Provincial Treasury will swallow these additional funds to pay for the backlog of over-expenditure and if the vaccine policy is implemented the FSDOH will pay for this out of insufficient funding and this will again result in "an unfunded mandate".

This is one of the critical issues facing the FSDOH. 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[79]), or to cut the existing services so that the service provision occurs within budget.

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

One of the essential means of communication and decision making is through regular well planned, scheduled meetings. It appears that the predictability of these meetings has been compromised through the calling of meetings irregularly by the premiers' office and other politicians. This has a spin-off effect throughout the FSDOH and one of the consequences at district level is that managers are called very regularly to Bloemfontein at short notice, and this impact on service delivery.

Additionally, perusal of the minutes of senior management meetings shows that more time is spent on bureaucratic processes such as budgetary issues, rather than on service delivery. There is little discussion of the performance of the system. It is likely that this pre-occupation is due to the on-going financial "crises" over the past three years.

*There was a **perception** by some managers that if there was more of a focus on the real issues of improving service delivery rather than a focus on politics and bureaucracy that significant improvements could be made in a relatively short period of time.*

Although the finance cluster provided regular feedback to line managers and other clusters about over-expenditure and variances on line budgets the responsibility for the dealing with these was left by the finance cluster to these other managers. It is not clear whether or how these variances were dealt with by the non-financial managers.

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

4.3 Planning

4.3.1 Service Transformation Plan

A draft service transformation plan (STP) was completed in 2007. This STP is an attempt to reshape and reconfigure the public health system in the FSDOH mainly through a norms-based approach linked to the number of hospital beds and appropriately situated and functioning hospitals. It recommends, for example that the number of district (level 1) hospitals be reduced from 24 to 7 and that the number of regional hospitals be reduced from 5 to 3. This plan has not been approved yet reportedly due to the fact that its implementation would be politically unacceptable.
There is a gap between what politicians accept as the levels of service delivery versus the objective determination of services (e.g. the numbers of hospital beds per population).

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

4.3.2 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. The APP does not appear to play a meaningful role in addressing key strategic priorities, such as equity, and appears formulaic in terms of its layout and content. It appears designed to satisfy compliance, as a result of national

treasury guidelines, rather than to be a guiding document for the public health sector in the FSDOH to improve the health of the people.

For example, in terms of equity the APP clearly shows that inequities among districts have widened rather than reduced. As is shown in the table below the proportion of the funding for programme 2 (primary level care and district hospitals) is increasing in Motheo. Thabo Mofutsanyana with a similar proportion of the population as Motheo is receiving a constant share and the gap between the two districts is increasing. This is actually increasing the inequities between the two districts as Motheo, centred around Bloemfontein, has much greater access to all resources including health professionals, whilst Thabo Mofutsanyana is much more under-resourced in terms of infrastructure and other resources.

Table 1: Comparison of district budgets relative to population proportion

District	% Free State Population	% District Budget 2004/05	% District Budget 2006/07	% District Budget 2008/09
Xhariep	5.1	6.3	7.8	6.9
Motheo	27.2	30.9	30.5	31.3
Lejweleputswa	23.6	20.2	17.1	19.3
Fezile Dabi	16.9	15.1	17.2	15.1
Thabo Mofutsanyana	27.1	27.4	27.4	27.5

The resource allocation process within the FSDOH is neither explicit nor is it well-communicated as many managers are not clear as to the processes used. It appears that the financial resource allocation is based on historical usage.

The plans do not appear to reflect the strategic priorities of the province. For example prevention of HIV was identified by the FSDOH as one of the critical areas for intervention yet the targets for distribution of male condoms is static at 11 condoms per male per year from 2007/08 through to 2010/11.

4.3.3 Alignment of Plans

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

It was also clear that there was a lack of communication between the various levels of the department and that planning was done in organisational boxes. For example the APP, the programme managers' plans and the district plans are all written without explicit correlation. This is reflected in different information and different targets for the same intervention occurring in different plans. Also the preparation of district plans are not integrated and aligned with the APP. They use very different formats. Many people interviewed were not sure of the status of the various plans and were not sure of the relationship between the plans. Also terminology usage was loose with terms "business plans", "annual plans" and "strategic plans" being used interchangeably. Terminology originated from national Treasury and requires consistency and clear definitions

One respondent mentioned that there is insufficient planning capacity to ensure that the planning process is appropriate and relevant.

There is no clear methodology in the setting of targets and budgets and financial resources are not linked to enhanced performance targets. In this regard the role of NDOH in assisting the provinces in the setting of targets is unclear. In many cases the targets used (as supplied by the NDOH) are out of date (e.g. 2005/06 targets used in 2008/09) or else the same target is supplied year after year without adjustment based on realities.

4.4 Governance

The FSDOH was hampered during the period 2005-2008 by the lack of appointment of senior executives, including the Head of Department (HOD), with many managers in acting positions. During this time many of the functions of the accounting officer (HOD) were centralised and assumed by the Member of the Executive Council (MEC) for Health. There were significant delays in the appointment of senior management.

As a result of provincial treasury imposition, currently most of the delegations relating to financial and human resources that were previously decentralised have been centralised. This has resulted in senior managers, hospital chief executive officers (CEO's) and district managers not being able to take key management decisions, appropriate for the level of service delivery. It has also increased the bureaucracy with consequent inefficiencies and additional transactional costs. Furthermore, this centralisation has undermined accountability and levels of responsibility, and as a result most managers do not see themselves as accountable for overspending.

The Free State Province has not passed legislation in line with the National Health Act to formalise the district health system. It has also not passed legislation and regulations around the formation of hospital boards and clinic health committees. As a result these structures do not have formal, clear terms of reference to guide them, where they are in place. The NDOH has not provided the province with clear guidelines around these issues to assist.

4.5 Service delivery (HIV, TB and MCH)

The financial stringency measures implemented in the FSDOH are likely to have a negative impact on service delivery at all levels but particularly affect achievement of targets of priority programmes at primary care level. Districts are faced with increased interventions both in the range of services (e.g. ARVs, PMTCT, additional vaccines for MCH) and in the volume of services (e.g. many more patients with TB; ever-increased numbers on ARVs). At the same time they are faced with a moratorium on staff

appointments and budget increases that are largely taken up by improvements in conditions of service.

HIV (especially prevention) and TB are both designated as high priority areas in the APP. However, the targets for intervention are extremely modest and do not convey a sense of urgency or act as galvanising force for the DOH. For example male condom distribution, one of the main areas of prevention is pegged at a constant low rate throughout the MTEF period.. The outcome targets for TB are also not inspirational with an extremely low target of 0.2% per year set as the improvement in the indicator measuring the successful TB treatment rate.

The work of the national and provincial programme managers is not integrated with each other and one of the key problems is that at sub-district and facility level all the various programmatic inputs need to be integrated. Each programme manager is pushing for his/her area of responsibility to be prioritised and there is a lack of understanding of how each bit contributes to the big picture i.e. what the department is trying to achieve as a whole. For example, each programme manager wants staff trained in her area of functioning. This can result in on-going training demands placed on district level staff in an uncoordinated manner.

Another example which exemplifies the lack of communication around the strategic priorities of the FSDOH and setting appropriate targets and goals is around the termination of pregnancy which is a national high profile priority programme. In the current APP it shows that in 2003/04 16.6% of hospitals offered this service. This figure stayed constant through to 2006/07. In the 2007 calendar year this figure however jumped to 30% and then in 2007/08 reverted back to 16.6%. From years 2008/09 through to 2010/11 the target has been set at 26.6% (the national target is 100%).

There is by-passing of the regular lines of authority by programme managers from national and provincial level who interact directly with facility level staff. This is especially significant in the case of ARVs. It appears that NDOH programmatic staff are too hands on with implementation and not spending enough time on setting norms, standards, guidelines and targets and monitoring the implementation of these.

There is insufficient supervision of facilities, with a target of 80% set for the 2008/09 year but only 50% being reached. This is at the level of one supervisory visit per month to facilities. Stringency measures have played a role in hampering supervision with inadequate resources for transport.

One of the problems facing the ARV programme is the inadequacy of the monitoring systems, including those of waiting lists. This makes it extremely difficult to forecast both demand and supply. One respondent stated that the targets of individual facilities for numbers of patients to be put on ARVs was determined at national level.

The current model of delivery by which ARVs are supplied by a small number of centrally located facilities (currently 28) is not compatible with making this service accessible to the large numbers of people who are currently infected. Similarly the current funding model of ARV provision is also neither affordable nor sustainable.

4.6 Recommendations

4.6.1 *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.*
- *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.*
- *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.*
- *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.*
- *Senior management meetings need to focus more on the core business of service delivery.*
- *Diaries of all managers need to be respected by politicians to ensure better time management throughout the department.*
- *Management of over-expenditure is a core senior management function together with its effects on service delivery and needs to be explicitly on the agenda of senior management.*

- *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.*

4.6.2 Planning

- *The STP should be reviewed, revised, costed, endorsed politically, communicated to all relevant stakeholders and then used as the basis to guide all strategic decision making in the FSDOH.*
- *All planning processes in the department should be simplified and aligned with each other and well communicated. There should be a limited number of key targets for each area of operation for which managers are responsible and accountable.*
- *Plans should be given the status for which they are intended and should be a roadmap for all health workers in the province. There should be a clear M&E process which ensures that the implementation of the plans are regularly monitored with remedial action taken if necessary to ensure that targets are attained.*
- *Targets should be set based on guidelines from NDOH and the provincial realities. These targets need inputs from programme and line managers to ensure that there is buy-in.*
- *Targets need to be based on realistic forecasts of what the need is and what is achievable as well as linked to budgets. This is particularly important in relation to ARVs. This is a national and provincial issue.*
- *External support for the planning processes should be sought from other institutions where this is thought to be relevant (e.g. NDOH, Universities, private sector).*
- *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.*

3.6.3 Governance

- *There should be clear written guidelines delineating the areas of responsibility the MEC and the HOD.*
- *All senior management appointments should take merit and ability into strong consideration.*

- *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.*
- Provincial legislation should be passed to ensure that the provisions of the National Health Act in relation to the district health system, hospital boards and clinic committees are formalised and effected.

3.6.4 Service delivery (HIV TB and MCH)

- *The NDOH should produce comprehensive, integrated guidelines covering all aspects of service delivery in relation to HIV, TB and MCH. These guidelines should contain norms and standards (including addressing data gathering, monitoring and evaluation, human resources).*
- *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.*
- *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.*
- *Quality of care and solving of problems at the local level needs to be given greater emphasis and the provincial facility supervision programme needs to be strengthened through regular supportive supervision from competent supervisors.*
- *The current model of monitoring and delivering ARVs needs review to ensure that it is sustainable, affordable, equitable and addresses issues of access.*

5 HUMAN RESOURCES

5.1 Introduction

Box 3: Human resource review key findings

1. Compensation of employees is currently the largest contributing factor to overspending.
2. The shortage and retention of health professionals in rural areas remains a major challenge while lengthy recruitment processes compounds this problem.
3. Although well-defined human resource (HR) policies and procedures exist, implementation is impaired by cost containment and "crisis" management.
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.
5. Despite a written policy on delegations, delegations have been withdrawn by provincial Treasury, with resultant day to day management by head office, widespread feelings of disempowerment and lack of accountability.
6. Some strategic health programmes (e.g. HIV) tend to operate in silos with their own systems, training and reporting procedures.
7. Neither PERSAL nor FSDOH's own personnel planning system called COGNOS is fully used as a management and planning tool and inconsistent HR indicators are found in different official FSDOH documents.
8. Human resource development is not properly aligned with the performance management and development system; it does not feature as a strategic priority and is not aligned or coordinated with HR management.
9. 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.
10. The implementation of the occupational specific dispensation (OSD) for nurses resulted in numerous operational problems, including over-expenditure, negative impact on appointment of other professionals, discrepancies in nurses' salaries within the same levels and general unhappiness among health professionals.

5.2 Delegations, Accountability and Responsibility

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

- Employment Relations
- Upgrade of officials
- Payment of overtime
- Filing of vacant posts
- Transfer of Officials
- Service Terminations
- Allowances
- Leave
- General.

Despite a written policy on delegations, there seems to be no real decentralization of HR functions and sometimes the HR functions are performed at head office with no clear distinction between the roles of mangers at the head office, hospitals and district.

As a result of the current financial crises (and possible lack of certain management skills), all delegations have been withdrawn and centralized at the head office. This has several consequences. It has led to managers feeling disempowered with little responsibility and associated lack of accountability. It has led to senior managers at the head office being involved in the day to day running of the various institutions (e.g. having to approve the appointment of all staff, including that of general assistants).

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

- Senior managers get involved in lower level decision making which leads to inefficient utilisation of resources.
- Managers at district and hospital level cannot make routine and necessary day-to-day decisions timeously impacting on service delivery due to the long chain of command.
- Delays in appointment of lower level staff.

5.3 Integration and co-ordination

> "*The current organogram was driven by the MEC's office and it is inappropriate for the department to fulfil its mandate and for optimum service delivery. The separation between health programmes and districts is problematic and results in lack of accountability and ownership of service delivery performance*".
> Senior manager: FSDOH

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

- Health programmes (e.g. HIV) tend to operate in silos with their own systems, training and reporting procedures which are not always aligned to those of managers of health facilities.
- The medical depot and pharmaco-vigilance staff who are responsible for overall drug management in the province, are in different clusters and the the way in which integration and coordination of functions is executed, is not optimal.
- There is inadequate communication and co-ordination between staff in priority health programmes and staff working on the DHIS to ensure that there is a single system of data flow.

5.4 Labour Planning

There are good HR policy documents and frameworks. 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.
- Key HR indicators were not interpreted in the same manner in different documents. This has potentially serious consequences for labour planning if the wrong base data is used for planning and reporting.
- Although a HR plan exists it is not fully used due to cost containment requirements. The HR plan and the draft STP are not aligned and the latter was not costed in terms of HR requirements.
- HR planning was not directly related to disease burden and policy decisions (e.g. additional services have to be rendered, but structures are not adjusted to address service delivery requirements. It was reported that when hospitals had to start delivering TOP and forensic services, no new specific posts were created). 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.

5.5 Organisational Design and Establishment

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. In one example a modelling exercise based on an “ideal” situation, created many posts at Universitas Hospital which reportedly resulted in 2000 vacant, unfunded posts.

The NDOH has not provided norms and standards regarding organisational structures. The FSDOH is in the process of restructuring but there is the risk of creating an inappropriate organisational structure if no or wrong norms and standards are used when creating or abolishing positions. Structure normally follows strategy and if the strategy is inappropriate due to inefficient planning, the organisational structure will also be deficient in dealing with service delivery and priority challenges.

DPSA requirements are extremely bureaucratic and therefore make changes within current staff structures difficult.

Opinions were expressed that restructuring should be based on the imperatives to deal with the burden of disease changes and within available financial resources. Alternative, lower cost options for organisational design should be considered through the use of “task shifting”

Although job descriptions are in place, discrepancies exist in terms of grading and non-uniformity of district structures e.g. there are inconsistent job titles across similar positions in the FSDOH and currently district management team structures are in a state of transition with no prospects of uniformity without additional resources..

There are currently **15 865** filled positions compared to staffing levels of 2005, when there were **15 281** filled positions. Staffing levels decreased by 433 from March 2008 to March 2009. 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.

The correction of the establishment requires attention. In reviewing various document sets, it became clear that establishment figures and actual filled positions over a number of years showed differences of between 9 000 and 11 300 positions. This situation is not conducive to proper planning and reporting on and managing real vacancies. In budget terms there is no vacancy rate.

No in-depth analysis could be undertaken of management levels, ratios and correct grading due to a lack of time to access and analyse the information. However, comments were made that there is not consistency in grades across various areas and there is a possible overstaffing at programme management levels.

5.6 Recruitment

The single most important challenge with regard to human resources is the recruitment and retention of key personnel. The problems facing recruitment and retention in the rural areas is a societal one as socio-economic factors such as lack of proper housing, schools, recreation and facilities are important factors that discourage medical personnel 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. It was reported that in Thabo Mofutsanyana district there is a shortage of staff in all sections, health professionals and other skilled staff.

Overly bureaucratic recruitment procedures from DPSA (extended periods of advertisements for professional posts) and head office has a number of negative effects including:

- Potentially interested candidates going elsewhere
- Delays in recruitment and overly long appointment timelines.

5.7 Performance Management

A well defined performance and development policy framework exists. However it was stated that the process is not working as envisaged. Each person develops his or her performance agreement without taking cognisance of the overall plan of the Department. There is also no discussion concerning the proposed performance goals and no clear linkage between agreed performance measures and organisational strategic priorities. Performance management is also currently aimed at individuals rather than teams, which is how the health sector delivers services.

As a result of DPSA guidelines, the linkages between performance and rewards are unclear. An example was given of the assessment of the performance of a number of clinicians who were doing similar work. The reward system forced the manager to reward only one individual when all those in the team were doing well.

One of the aims of a performance management system is also to assist in the development and training of employees. It was stated that there is little or no correlation between performance management, individual developmental plans and training programmes.

5.8 Retention

The OSD has been one attempt to retain staff, but it appears to have had limited success. Firstly, It has brought cost pressures to bear on the FSDOH. Secondly the response of the private sector was to increase their pay scales to achieve parity with the FSDOH, thus neutralising the impact.

Vacancy rates are academic if the PERSAL based establishment is used as a basis. When vacancy rates are looked at in budgetary terms there is no real vacancy rate, as any unfunded post is not considered to be “vacant”. However, given the fact that rural areas are struggling to fill certain positions, this could present a skewed picture. Ideally staff norms are required based on service packages to be delivered, estimated population needs and affordability.

A FSDOH retention strategy exists and scarce skills are defined. However the implementation of this strategy is difficult due to financial constraints. A list of factors that impact on retention includes:

- Poor competitive remuneration packages.
- Over-concentration of health personnel in urban areas and under-provision of health personnel in rural areas.
- Emigration of highly trained professionals.
- Competing with other provincial departments to attract and retain scarce skills.
- The impact of HIV/AIDS on the health workforce.
- Excessive work demands and an unpleasant workplace environment.
- Insufficient developmental opportunities.
- Inadequate career progression opportunities.
- Selective sabbatical leave.
- Lack of recognition of performance.
- Poor job satisfaction.
- Lack of accommodation in rural areas.

The retention strategy also describes actions to be implemented to improve retention of scarce skills. The strategy focuses on effective recruitment and selection, effective job evaluation, training opportunities, priority bursary allocation, promotion of research and development, employee mobility, improved performance management, increased authority over own work, flexible working arrangements and service benefits. The introduction of an exit interview to capture and address recurring trends was also proposed.

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

5.9 Rewards

The largest contributing factor to the current overspend is attributable to compensation of employees. In the 2007/08 financial year, 99% (R 89 381 000) of the budget variance was due to compensation of employees.

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.

It is important to note is that if thorough costing of any change in the reward system is not done in collaboration with the affected parties, accountability is blurred, money is wasted and there are unintended effects. In addition, if only a certain category of staff are seen to benefit, the perceived disparities and inequalities in the reward system could lead to dissatisfaction, people leaving and possible manipulation within the reward system.

There is a perception that rewards are not linked to performance. A suggestion received was that this could be corrected by linking performance reviews to clearly defined objective indicators and to reduce the general eligibility to salary increases to a lower number than is presently applied.

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

- The OSD was not costed properly and implemented by NDOH. The personnel over-expenditure from OSD has impacted negatively on other staff appointments (e.g. five chief specialists, with equity credentials, cannot be appointed at Universitas Hospital due to insufficient funds being available and a moratorium on filling of posts).
- A concern is that since the introduction of OSD nurses who are clinic managers, earn higher salaries than program coordinators although both are on the same salary level 8. There are also discrepancies between staff at the same level between different districts e.g. between Xhariep and Thabo Mofutsanyana.
- In certain cases the OSD did correct previous salary disparities where HIV/AIDS section staff were paid more than other staff on the same grade.

5.10 Learning and Development

The success of health service delivery depends on a sufficient number of skilled people to address service delivery requirements. If training is not receiving sufficient attention, service delivery and cost effectiveness will suffer as a result.

It was found that HR development policies exist, but execution is problematic. The FSDOH had done a thorough analysis of the human resource development (HRD) strategy and listed the following challenges impacting on learning and development in the province:

- HRD is not properly aligned with the performance management and development system.
- HRD does not feature as a highly prioritized objective in the strategic plan of the department.
- HRD is not properly aligned and coordinated with HR management.
- Resources are generally insufficient and not all critical positions that are essential for the performance of the department are filled.
- Line managers do not engage in pre- and post training interventions.
- Training provided is not based on skills audits or training needs from performance development plans.
- Training needs assessments are not conducted on an ongoing basis.
- The content of training programmes is not generally related to the actual requirement of the job.
- No post training assessment is made to evaluate the impact of training on the performance.
- Not all occupational categories have access to training.
- Not all staff members are aware of development priorities of the government.
- Some of the training budget is not managed directly by the HRD.
- The HRD functions are not generally responsive to the changing job requirements of staff.
- Procurement processes impede or disrupt the training process.
- Lack of mentors and coaches.
- The skills demands of new policy requirements are not generally assessed.
- ABET programmes are not available to all staff levels for advancing personal and professional growth and development.

- Qualified service providers are not always readily available.
- No competency framework is used in planning the training programmes.
- No action is taken to ensure that all talent in the department is effectively groomed and utilized.

It is clear that training should be appropriately funded and focused and aligned to priorities. Inappropriate reductions in the training spend or insufficient training programmes can result in seriously impaired service delivery and cost more in the long run than providing adequate funds for training in the short term

5.11 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.

The number of PERSAL users are limited due to national Treasury directives and hence local areas (sub-districts) which are also cost centres do not have PERSAL available. This results in the anomaly that basic functions (e.g. leave function) are inputted to PERSAL at district level despite more staff being employed at local areas area level.

A HR planning system using COGNOS exists, but it was mentioned that it was not utilised optimally, with little interest from managers to use data in planning and management. It was also mentioned that a similar system is being considered at national level.

5.12 Recommendations

5.12.1 Delegations, Accountability and Responsibility

- *It should be assessed if withdrawing delegations adds value in terms of cost containment and service delivery. If not, then delegations should be re-instituted. A clear matrix in terms of delegation of authorities and decision making at various levels should be completed (This should be in line with a RACI matrix where different people are responsible, accountable, consulted or informed)*

- *The responsibility level of CEOs of institutions and district managers and their district management teams (DMTs) should be reviewed and addressed. This should include a review of financial management responsibilities.*

5.12.2 Integration and co-ordination

- *Communication mechanisms need to be established across clusters and DHIS to prevent "silo" operational functioning.*

5.12.3 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.*
- *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.*

5.12.4 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:*
    - *Structuring should allow for the optimal use of scarce skills (e.g. service hubs at district level, such as information technology skills and artisans skills which are made available to all the institutions that are linked to the hub)*
    - *Structuring should also allow for 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.*
- *PERSAL should be corrected to accurately reflect personnel positions and staffing numbers as reported in the FSDOH Budget Estimate and Annual Reports statements.*

- *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.*
- *Consistency in grades for similar positions across various areas should be analysed in more depth. This should include the standardisation of nomenclature of job titles between provinces so that comparisons can be easily made.*
- *DPSA should assist NDOH and provinces to support changes to structures in a more efficient manner*

5.12.5 Recruitment

- *A thorough review and improvement of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times.*
- *Recruitment of more staff nurses should be considered to fill the gap between assistant nurses and professional nurses.*
- *The pilot scheme in Motheo District where private doctors have been contracted to provide medical services should be evaluated to assess whether it addresses the problem of staff shortages at a similar or lower cost than the appointment of foreign doctors.*

5.12.6 Performance Management

- *Performance contracts at job level 13 and above should be clearly linked to organisational priorities and key indicators that drive organisational performance.*
- *The performance management system should be utilised as intended and incorporate:*
    - *Organisational performance;*
    - *Employee development;*
    - *Reward based on clear performance goals.*
- *Team performance should form part of performance standards and evaluation and should be escalated to DPSA.*

5.12.7 *Retention*

- *A national health professional and scarce skills retention strategy should be developed by the NDOH.*
- *The FSDOH retention strategy should be analysed in terms of impact and cost to test possible success and affordability.*

5.12.8 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.*
    - *Lessons learned from the current OSD implementation review for nurses should be captured to inform future implementation of other improvement initiatives.*

5.12.9 Learning and Development

- *Training needs should be properly and objectively determined.*
- *Well considered and prioritised commitments to relevant training should be maintained even during times of cost containment. Training and development programmes should be clearly defined and aligned to the service delivery priorities of the province.*

5.12.10 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.*

6 INFORMATION MANAGEMENT

6.1 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 FSDOH. Contributing to this is a lack of national guidelines, norms and standards as well as a lack of alignment between planning, implementation and monitoring and evaluation.
2. A significant amount of time and resources is spent on data collection, capture and collation at all levels. However these data are characterised by poor quality control; inadequate analysis, interpretation; and little utilisation of information for decision-making. Hence poor quality indicators derived from the data find their way to NDOH and Treasury, where there is also little interrogation and feedback.
3. There is a lack of managerial accountability for the attainment of service related targets and M&E does not appear to be part of managerial performance assessment.
4. There are 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.
5. Parallel information systems and the lack of a single repository of information, result in conflicting official information.

Monitoring and evaluation (M&E) appears to be one of the weakest links in the overall management of services in the FSDOH. 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. The team was not provided with clear evidence that senior managers review 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

facility over time – e.g. PDE) pass by without question or attempts to effect corrective action.

6.2 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:

- 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.
- Some managers are not focussed on, and sometimes do not understand, the significance of key indicators in their sphere of management. Examples include understanding of PDEs, numbers of staff in the section/division, ARV numbers on treatment and on waiting lists for treatment.
- 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.

6.3 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 with ensuring *good data quality*. 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).
- Some of the indicators used in the FSDOH are not standardised with national indicators (e.g. for teenage pregnancy rate the FSDOH is using under 20 years as the denominator whereas NDOH is using under 18 years)
- Indicators are occasionally changed, or added to, by programme managers at national (and provincial) level without written guidelines and are sometimes based on workshop proceedings (e.g. PMTCT).
- The FSDOH is using version 1.3 of the DHIS software whereas most of rest of the country is using version 1.4. This is as a result of inadequate hardware.
- 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.
- With stringency measures, some clinics have run out of data collection tools and data is collected on pieces of paper. In particular the PMTCT programme has suffered from poor and inaccurate data collection.

6.4 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 FSDOH and approximate figures of R6000 per patient per year for 30,000 patients show that the costs are in the region of R200 million for 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 FSDOH around an information system for ARV.
- As a result the FSDOH, similar to other provinces, has developed its own systems.
- It has based its ARV patient monitoring system on software provided by Meditech. Unfortunately this software system has been beset with difficulties and is unable to provide timely, regular information on the ARV patients. As a result the FSDOH is only able to provide a rough estimate of how many people have started ARV treatment and are unable to say with any degree of certainty how many people are still on treatment, how many people have died and how many people have stopped treatment or are lost to follow-up. There is a huge backlog in the capturing of data for the Meditech system and it is obvious that this system, which has been in operation from 2001, will not solve the problems of the FSDOH in this particular regard.
- The Meditech system is down much of the time and 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 FSDOH quote different figures as to how many people are on ARV treatment.
- In one of the sites visited the clinicians were ignorant of any indicators related to ARV and were treating individual patients as they arrived at the site without any understanding of how the programme as a whole was performing.

6.5 Other M&E Issues

- There are a number of parallel information systems - (e.g. HIV programmatic information) in addition to that supplied by the DHIS.
- 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 is a general lack of integration of information and BAS and PERSAL data are not aligned with service delivery data. (For example people paid from a hospital budget and designated as hospital employees are doing work at the community level distorting PDEs and other important indicators).
- At facility level (clinics and CHCs) there are often no facility based records kept of interactions with patients. Even basic registers are not kept. This makes it difficult to verify whether there has been adequate data collection.

6.6 Recommendations

6.6.1 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).*

6.6.2 Use of information for decision making

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

6.6.3 District Health Information System (DHIS)

- *The DHIS, and associated NIDS, needs a thorough review by the NDOH.*
- *The numbers of indicators need to be decreased*
- *There should be unambiguous, easy to understand, standardised definitions.*
- *There also needs to be clear written guidelines, norms and standards for each component of the DHIS, including data collections tools (forms and registers); relevant*

human resources, hardware, software, data flow policies and linkages between the DHIS and other data collection systems such as the TB (ETR-net), PERSAL and BAS.

- *An appropriate training regime also needs to be introduced at the correct time.*

6.6.4 ARV Monitoring and Evaluation

- *A workable, practical, easy-to-use system of monitoring the ARV programme needs to be put in place.*
- *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.*
- *Given the urgency of the situation this should be done immediately and the Meditech system should be reviewed and replaced where it is not working.*

6.6.5 Other M&E issues

- *There needs to be one official repository of information for the FSDOH. 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.*

7 MEDICAL PRODUCTS, LABORATORY

7.1 Introduction

Box 5: Key findings
1. The FSDOH has had a shortage of medicines from November 2008 through to March 2009, affecting many aspects of service delivery, from the vaccination of infants through to the continuation of patients on ARVs.
2. There appears to be a general lack of prioritisation of drug budgets.
3. There is inadequate communication between the medical depot,and the chief provincial pharmacist and her team.
4. As a result of drugs shortages and occasionally misordering, drugs are manually redistributed by managers on an ad hoc basis.
5. The overall monitoring of the laboratory services, including usage checking and costs by facility is a best practice, which could be replicated in other provinces.

7.2 Medical products

As a result of over-expenditure the FSDOH has had a shortage of medicines from November 2008 through to March 2009. This has affected many aspects of service delivery, including the vaccination of infants against vaccine preventable diseases through to the continuation of patients on ARVs. This latter issue has generated massive adverse publicity for the FSDOH in the media.

One respondent informed the team that the province will again run out of money for drugs around October 2009 if the business plan for the 2009/10 year is not adjusted to increase the drug budget. It has been estimated that Universitas Hospital will only have sufficient drugs for 6 months of the year at current rates of expenditure. Another senior manager responded to this predicament by saying that the drug budget will be divided into 12 equal instalments and that no institution would be able to deviate significantly from the monthly allocation without sanction. This lack of prioritisation of drug budgets is likely to affect all services equally severely.

There is inadequate communication between the medical depot, and the chief provincial pharmacist and her team.

The medical depot takes 6-8 weeks to supply orders once they are received and 3-4 years ago this same process took 2 weeks. As a comparison the private sector fulfils orders within 1-2 weeks. During the whole of March 2009 no orders are processed at all.

In practice drugs are manually further redistributed by managers on an ad hoc basis. This practice, far from ideal, is done to prevent unnecessary expiry of drugs. As a result of this manual system cost allocations of medicines are erroneously charged to the cost centre of the original recipient thereby over-estimating the drug budget in this facility and under-estimating the cost of drugs in the facility to which the drugs were transferred.

It was reported that the drug orders are cut by the depot (even where there are sufficient funds in the facility drug budget line), with inadequate feedback to the management responsible for the facility. It was not clear as to the mandate given to the depot to do this. One consequence of this practice is that it was reported that clinics are sometimes out of stock of medicines and this is one of the reasons that patients by-pass clinics and go directly to hospitals with negative financial consequences.

Clinic drug budgets are held at the local area (sub-district) level. In practice this means that it is difficult to compare drug usage and drug cost per patient at individual clinic level.

7.3 Laboratory

The laboratory services recently appointed a new manager who in a short period of time has managed to introduce a number of innovations, including overall monitoring of the lab services and checking usage costs by facility. From the perspective of the review team this was regarded as an example of best practice and this has been written up as an exemplary case study (See Appendix 4).

7.4 Recommendations

- *A review of all aspects of the management and operations of the medical depot should be carried out. As part of this review the communication between the depot and the pharmaco-vigilance unit should be clarified.*

- *Drug budgets should reside at the lowest level of activity as part of the cost centre hierarchy and drug costs should be accurately allocated to particular clinics.*
- *The laboratory monitoring system is a best practice, which should be shared and replicated in other provinces, with the assistance of the NDOH. (See Appendix 4)*

8 TECHNOLOGY AND INFRASTRUCTURE

8.1 Overview

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

- 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.
- There is a lack of computers at local areas level. (
- There is a lack of phones. In one sub-district 25% (10 out of the 40 clinics) did not have access to phones.
- Some projects have an unreasonably extended life span. For example, Elizabeth Ross has been undergoing renovations since 2001 and the theatre has not been operational for at least 3 years as a result of renovations.
- In some areas the electricity supply from ESKOM was problematic.

8.2 Recommendations

A plan of action should be prepared to deal with the logistical issues identified, some of which should be coordinated by the NDOH.

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.

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 <u>Finance Consultants</u>

- 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

- 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
- 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 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

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
- 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
7. Free State Provincial Gazette, Nr 23, 30 March 2009
8. Free State Provincial Health Act, 2009 Act No. 3, 2009

Finance:

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

HR:

14. Department of Health: Free State: Human Resource Plan, 1 April 2008 to 31 March 2011
15. Summary of Establishment as at 3 March 2009
16. IYM report - January 2009
17. Recruitment and filling of posts policy
18. Cost comparison appointment of foreign versus SA Health Professional
19. Performance and Development Policy Framework for levels 1 to 12, 1 April 2008

20. Free State Department of Health, Human Resource Development Policy, February 2008 (Draft 8)
21. Workplace Skills Plan and Annual Report, 2008
22. Retention Strategy, June 2008

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. District Health Plan 2009 – 2010 Free State Province. Thabo Motfutsanyana District.

27. Thabo Motfutsanyana. DHS Monthly report. February 2009

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

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

30. 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

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

Appendix 3: Schedule of Interviews

Provincial Department Level

Department/Area	Person(s) Interviewed	Position	Date of Interview
Top Management	Prof PL Ramela	HOD	4 March 2009
Finance	Dr Schoonwinkel	CFO	2 March 2009
	Francois de Villiers	Finance department	24 February 2009
Strategic Health Programmes	Lache Katzen	General Manager: Strategic Health Programmes	2 March 2009
	Yolisa Tsibolane	Snr Manager: TB Management	
	N.E Kgasane	Snr Manager: Health Programs	
	Mvula Tshabalala	Snr Manager: HIV/AIDS Management	
	S.N Huyo	Snr Manager: Partnerships Directorate	
Human Resources	Mzonakele Fikizolo	Executive Manager: HR and support	3 March 2009
	Magda Blom	Senior Manager: HRM	
Pharmaceutical Services	Hettie Marais	Manager: Pharmaceutical Services	4 March 2009
	Jonas Kgasang	Pharmacist: Provincial Regional Hospital	
	Zelda Loots	Pharmacist: Universitas Hospital	
	F Letolo	District Pharmacist Xhariep	
Clinical Cluster	Dr Kabane	Head of Clinical Service	3 March 2009
Lab Services	Edgar Watkins	Head of Lab Services?	4 March 2009

Department/Area	Person(s) Interviewed	Position	Date of Interview
Strategic planning	Joan Mackenzie	Manager Strategic Planning	3 March 2009
Auditor-General	Heinrich Hattingh	Audit manager	24 February 2009

District Level: Thabo Mofutsanyana

Department/Area	Person(s) Interviewed	Position	Date of Interview
District: Thabo Mofutsanyana	Mr Papi Maarohanye	District Manager: Thabo Mofutsanyana	11 March 2009
Human Resources	Mr Shabangu	District Human Resources Manager	11 March 2009
Information (M&E)	Mrs Sally Smith	Information Manager: Thabo Mofutsanyana	10 March 2009
Finance	Mr Mositoane	Finance Manager: Thabo Mofutsanyana	11 March 2009
District Program Managers	ML Ramokotjo PHC program manager	PHC program manager	11 March 2009
	PJ Ntsutle	TB coordinator	
	Bafana Msibi	MNCWH coordinator	
	AL Kilane	HBC coordinator	
	ME Bolofo	HIV/TB ART	
	TE Mpotoane	TB/HIV M&E	
	MM Somtjato	STI, HIV & AIDS coordinator	
Sub-District Managers	Mrs Tsibuli	Sub-district managers : Admin& Finance	11 March 2009
	Mr Matla	Sub-district managers: Clinical	
Elizabeth Ross Hospital	ME Radebe	CEO	12 March 2009
	Dr. RS Moeketsi	Chief Medical Officer	
	Alice Mosase	Chief Professional Nurse	

Appendix 4: Case Study Laboratory

Case study

1. Introduction

This case study looks at laboratory services and how the use of readily available information for decision making can make a difference in a short period of time.

Since 2001, the increase in costs for laboratory services was higher than the contracted percentage increase. This was as a result of an increase in the volume of tests performed. Over time this has increased the outstanding amount owed by the FSDOH to the National Laboratory Services (NHLS). Currently this amounts to R95 million (as per the February statement). For the current financial year, the original budget of R145 million will be overspent with 20%.

There are a number of information systems in use, but these are not optimally integrated and therefore impair information management and decision making. For example the THUSANO system from the NHLS records tests performed down to clinic/ward level. The Meditech system has details of test orders placed, but only 7 facilities are currently using Meditech and there is no synchronisation between THUSANO and MEDITECH. The Disa system, which is an electronic results delivery system, is used to a limited degree.

2. Intervention

A newly appointed manager instituted the following interventions:

- Processes were put into place to monitor orders placed with details per invoices received.
- Analytical reviews were undertaken e.g. lab cost per headcount for districts and lab costs per PDE for hospitals as shown below.

By ranking the expenditure at hospital and district PHC level, the laboratory manager was quickly able to identify the institutions and districts whose laboratory costs were high or which deviated from the average.

Name of District	Name of Hospital	Average PDE	Average lab Expenditure	Average Expenditure/PDE	Ranking
Motheo DM	Pelonomi	18317	2704149	148	1
Motheo DM	Universitas	18989	3716120	196	1
Thabo Mofutsanyana	Elisabeth Ross	3013	74750	25	6
Fezile Dabi	Boitumelo	8632	470 143	55	

PHC Facilities Headcount- July,2008

District	Total Headcount	Laboratory Costs	Lab Cost/headcount
Fezile Dabi	94, 386	323,960	3.43
Lejweleputswa	134, 330	500,995	3.73

Motheo	140, 204	452,065	3.22
Thabo Mofutsanyana	175,969	386,772	2.20
Xhariep	34,668	216,837	6.25
Grand Total	**579,557**	**1,880,630**	**19**

In addition to the analysis of information the manager also set about improving communication channels.

- Internally he focussed on meeting with the users of the service viz the CEOs and CMOs of hospitals and the DMTs. He also enabled the following:
- A situational analysis was conducted e.g. calculating the service load on lab.
- Externally there was institutionalization of regular meetings with the NHLS.

To understand the nature of the laboratory expenditure and audit and review of the laboratory budget and laboratory activity (i.e. the kind of tests performed)

- A situation analysis was conducted and the service load on the NHLS was calculated.
- An audit and review of budgets and lab activities were undertaken.
- An expenditure analysis was conducted

As a result of this analysis a number of concrete recommendations were made:

- Guidelines were drafted of tests to perform for particular conditions (e.g.what tests to undertake for diabetes at clinic level, district hospital, seconday and tertiary hospitals) and the next steps for subsequent lab tests.

- Instead of ordering the full battery of test initially a change was suggested to order fewer tests initially for certain conditions, and for the lab automatically to perform the remainder of the tests if and hen the results of the first tests were found to be abnormal. *(Generally the medical personnel order all the tests from the start; this is done to save time on the part of clinicians, as well as additional paper work if the remainder of the test is ordered later.)*

4.Conclusion and lessons learnt

Some of the lessons learnt from this case study are:

- Analysing and interrogating the data is crucial for the decision making process.
- Collection, management and analysis of data should be every manager's business.
- Cost could be saved if a thorough analysis is being done on a regular basis to ensure continuous improvement in processes.