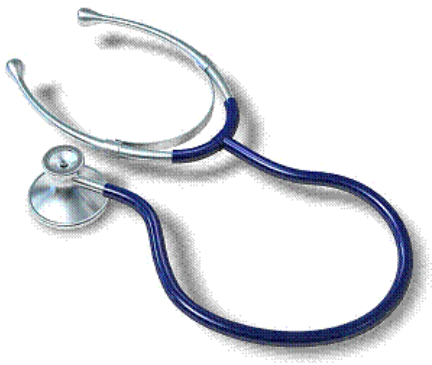
North West Department of Health

Report
of the Integrated Support Team



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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 North West 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
BEE	Black Economic Empowerment
CEO	Chief Executive Officer
CFO	Chief Financial Officer
DDG	Deputy Director-General
DFID	UK Government's Department for International Development
DHIS	District Health Information System
DHS	District Health System
DMT	District Management Team
DOH	Department of Health
DPSA	Department of Public Service and Administration
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HR	Human Resources
HRD	Human Resource Development
HSS	Health Systems Strengthening
ICT	Information and Communication Technology
IST	Integrated Support Teams
IT	Information Technology
IYM	In Year Monitoring
KT	Klerksorp/Tshepong
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
NHLS	National Health Laboratory Service
NIDS	National Indicator Data Set
NTSG	National Tertiary Services Grant
NW	North West Province
NWDOH	North West Department of Health
OSD	Occupational Specific Dispensation
PDE	Patient Day Equivalent
PERSAL	Personnel and Salary Administration System
PFMA	Public Finance Management Act
PHC	Primary Health Care
PMDS	Performance Management and Development System
PMTCT	Prevention of Mother-To-Child-Transmission
RRHF	Rapid Response Health Fund
SCOPA	Standing Committee on Public Accounts
SPS	Strategic Position Statement
STI	Sexually Transmitted Infection
STP	Service Transformation Plan
TB	Tuberculosis
TOP	Termination of Pregnancy
TR	Team Representative
WHO	World Health Organization

Foreword

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

The report contains the findings and recommendations of the Institutional Support Team (IST), set up at by the Minister of Health. At the time of writing this report the North West Department of Health (NWDOH) has experienced a relatively stable period with no real high risk or adverse events. Although the over expenditure of the last financial year has resulted in a significant budget and centralisation of most human resources and financial functions, there was a continuous effort to fill key clinical posts and ensure that service delivery continues. There were no service cuts. It is evident that while staff are aware and burdened by the financial constraints, there is generally a spirit of optimism and cooperation.

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

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

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

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

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

The review has highlighted a number of key challenges and recommendations, which are contained in the body of the report. The overall approach to the review is based on the World Health Organization (WHO) classification of health systems building blocks viz:

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

The priority findings of the review are:

1. 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.

2. The provincial budget allocation to the NWDOH is around 25% instead of the recommended 26% guideline from NDOH (1% equated to nearly R200 million in 2009/10, which is equal to the accruals for 2008/09). This trend is the same when conditional grants are excluded. This is reflected in the 2009/10 per capita allocation to the North West province of R1 ,607 compared to the national average per capita of R1 ,974.

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

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

5. There is a dearth of national guidelines, norms, standards and targets. This perceived lack of national stewardship and leadership impacts on every aspect of the health system and its performance.

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

7. The NWDOH organogram has not been updated to incorporate new posts. This has resulted in confusion around responsibilities and lines of reporting as well as overlap of functions. The head office component of the organogram has too many assistant directors.

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

9. 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 isare 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.

10. It is widely acknowledged throughout the province that strategic, operational and budget planning is not comprehensively linked, nor does the existing information system provide accurate data to influence the planning processes. At present the APPs focus on mainly on input, process and output indicators with less emphasis on outcomes.

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

12. Managers, especially directors and deputy directors have insufficient authority, responsibility and accountability to manage their budgets in accordance with the specific needs of their respective districts, sub-districts and facilities.

13. Drug budgets have not been prioritised or ring fenced and districts are overspending their own budgets. The budgeting practices applicable to pharmaceutical products hamper service delivery.

14. There are problems with the supply chain management and compliance and asset management which undermine service delivery, efficiency and BEE goals.

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

UNFUNDED MANDATES

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

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

3. The NWDOH budget must be aligned with national trends as well as the trends in other provinces.

LACK OF COHESION BETWEEN POLICY AND BUDGETS

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

2. All operational units (cost centres) need to have 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

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

NATIONAL GUIDELINES, NORMS AND STANDARDS

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

HUMAN RESOURCES

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

2. There should be a comprehensive and detailed review of the provincial, district and sub-district organisational structures. This review should include job evaluation at all levels and take into account the need to align similar institutions in terms of structure, level of posts and funding.

GOVERNANCE

1. There should be increased delegations with decentralisation of responsibilities and accountability. This must be balanced by effective performance management and a steering away from the current approach where one transgression leads to the restriction of all without the relevant manager being held accountable.

M&E

1. M&E needs to become a central component of all managerial activity with the use of objective information being the basis for decision making. This applies to all aspects of management, including financial and HR, and not only service related data. There needs to be an iterative link between planning, implementation and monitoring.

2. Regular formal monitoring of key indicators needs to take place with analysis and questioning of variances (in much the same way as financial management variance analysis should take place).

INFORMATION MANAGEMENT SYSTEM

1. The current management information systems need to be restructured so as to facilitate appropriate planning, implementation, M&E and fiscal control.

PLANNING

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

2. All planning processes in the NWDOH should be simplified and aligned with each other and well communicated. There should be a limited number of key targets for each area of operation for which managers are responsible and accountable.

SERVICE DELIVERY FOCUS

1. Senior management meetings need to focus more on strategic issues, and service delivery needs to be one of the priority strategic issues.

2. Performance agreements should be clearly linked to clear delegations, organisational priorities and key indicators that drive organisational performance.

Introduction

1. BACKGROUND

1.1. During the course of the 2008/09 financial year it became apparent that there was a negative difference between what was budgeted for in the health system and what was required to implement agreed upon policies. This was associated with overspending in most of the provinces undermining the capacity of the Health Ministry and the National and Provincial Department's of Health to revitalise and re-orientate South Africa's response to the HIV pandemic and to support health systems strengthening to improve health outcomes. In response to this threat to the overall functioning of the health system, the honourable Minister of Health, Ms Barbara Hogan, requested an in-depth review of the underlying factors behind the overspending. This led to the establishment of the Integrated Support Teams (ISTs) in February 2009. The ISTs comprise consultants who are financial, public health, and management and organisational development specialists.

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

2. AIMS OF THE ISTs

2.1. The aims of the ISTs are to:

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

2.1.2. Integrate the recommended actions into a health systems approach that includes perspectives on governance, leadership, finances, human resources, information,

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

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

3. SPECIFIC OBJECTIVES

3.1. The specific objectives of the ISTs were to:

3.1.1. Assess the current and projected expenditure trends at the National Department of Health (NDOH) and the 9 Provincial Departments of Health.

3.1.2. Examine the alignment between:

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

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

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

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

4. METHODOLOGY

4.1. The review was a broad-based, rapid appraisal that focused on the health system as a whole, but with an emphasis on the over-expenditure. The work of the finance, health systems and management experts was integrated into a holistic framework, adapted from the World Health Organization (WHO). This WHO framework suggests that the key building blocks of a heath system are: Service Delivery, Leadership and Governance; Human Resources (Health work force); Finances; Information

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

4.2. This rapid review consisted of two main parts: a desk top review and in-depth interviews with key informants at provincial and district levels. The desktop review comprised an analysis of available public documents plus selected documents obtained from the North West Province and other sources. This desktop review was carried out by a group of experts in the fields of public health, finance and management and organisational development. A list of these documents is shown in Appendix 2.

4.3. In-depth interviews were conducted with the majority of senior managers at the provincial level and at one purposefully selected district and sub-district viz Moretele in the Bojanala district. The interviews were conducted by a team of experts (three at provincial level and two at district and sub-district level) who visited the North West province between the 14th and 23rd of April 2009. The list of people interviewed is shown in Appendix 3. The interviews were complemented by a further analysis of the documentation provided.

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

5. OUTLINE OF THE REPORT

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

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

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

Financial Review

1. INTRODUCTION

1.1. The financial review derives from an in-depth assessment of the NWDOH budget and expenditure reports, National Treasury reports and interviews with NWDOH 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 NWDOH 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. For 2009/10 the NWDOH has been allocated 25% of the total NW provincial revenue, which is a significant improvement from the allocation of 22% for 2005/06, but is still below the average provincial allocation of around 26%.
3. This has resulted in the per capita budget for health in the NW being lower than the average national per capita for health in the provinces. The national average per capita for health in 2009/10 is R 1,974 compared to the North West per capita of R1,607.
4. The contention of underfunding of the NWDOH 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.
5. For 2009/10 the NWDOH has been allocated 25% of the total NW provincial revenue, which is a significant improvement from the allocation of 22% for 2005/06, but is still below the average provincial allocation of around 26%.
6. This has resulted in the per capita budget for health in the NW being lower than the average national per capita for health in the provinces. The national average per capita for health in 2009/10 is R 1 974 compared to the North West per capita of R1 607.
7. The relative proportion of the national conditional grant for HIV/AIDS allocated to the NWDOH has remained constant at between 7,8 and 8,8% over the past four years.
8. Although under-expenditure is reflected in the years 2005/06 to 2006/07, in the

Box 1: Key findings from the financial review

2007/08 financial year there is over-expenditure of R36 million due to underfunding of the OSD and higher numbers of patients on anti-retroviral therapy (ART) than original forecasted numbers. These are unfunded mandates.

9. Most of the financial and HR delegations have been withdrawn in order to curb overspending.
10. There is lack of alignment between annual plans and the adjusted or allocated budget.
11. Budgeting and financial management processes (including cost allocations and proper cost centre accounting; financial monitoring and evaluation) are sub-optimal.
12. Management accountability for finances needs improvement.
13. The financial system is not integrated with the quarterly performance reporting system and the follow up, feedback or accountability is sub-optimal.
14. The DHIS information is used when compiling budget requests but in the allocation process this information seems to be discarded.
15. The full budgetary impact of the cost of treatment for patients on ART needs to be better quantified.

2. UNDERFUNDING OF THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA

2.1. The IST team has consistently been confronted by the assertion that the main cause of the difficulties being experienced by the public health system in the North West 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.

3. PROVINCIAL BUDGET ALLOCATION

3.1. The allocation of the North West Province’s budget to the NWDOH is shown in Table 1. The allocation includes the equitable share, conditional grants and provincial revenue. The allocated amount is less than the national average but over the period 2005/06 to 2008/09 there has been an increase of 3 percentage points from 22.1% to 25%.

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

	R m Provincial Budget	Year on year increase	R m Health Budget	Year on year increase	% Allocation to Health	R m Adjustment Provincial Budget	R m Adjustment Health Budget	% Allocation to Health
2005/06	12 843	N/A	2 894	N/A	22.5%	13 529	2 987	22.1%
2006/07	14 400	12.12%	3 428	18.45%	23.8%	15 532	3 616	23.3%
2007/08	14 412	0.08%	3 755	9.54%	26.1%	15 558	3 917	25.2%
2008/09	16 938	17.53%	4 223	12.46%	24.9%	17 776	4 445	25.0%
2009/10	19 866	17.29%	4 919	16.48%	24.8%	N/A	N/A	N/A
2010/11	22 195	11.72%	5 579	13.42%	25.1%	N/A	N/A	N/A
2011/12	24 331	9.62%	6 055	8.53%	24.9%	N/A	N/A	N/A

When conditional grants are excluded, the provincial equitable share allocation to health fluctuated quite considerably (between 21.6% and 26%) over the period 2005/06 to 2008/09. (Table 2).

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

	R m Adjustment Provincial Budget (incl Grants)	R m Adjustment Conditional Grants	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	13 529	1 335	12 194	2 987	355	N/A	2 631	21.6%
2006/07	15 532	1 809	13 723	3 616	496	39.7%	3 120	22.7%
2007/08	15 558	2 411	13 148	3 917	523	5.4%	3 393	25.8%
2008/09	17 776	2 875	14 901	4 445	762	45.7%	3 683	24.7%

4. NATIONAL CONDITIONAL GRANT ALLOCATION

4.1. 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 NWDOH (Table 3). The proportion of both the HIV and AIDS and NTSG grants allocated to the NWDOH from 2005/06 through to 2008/09 has been fairly steady. The criteria for the allocation of all the conditional grants were neither clear nor transparent.

Table 3: National Conditional Grants to Provinces Adjustment Budgets

		R 000 Total Conditional Grant to Provinces	R 000 North West Provincial Allocation	% Allocation of National Grant
Comprehensive HIV & AIDS Grant	2005/06	1 150 108	100 921	8.8%
	2006/07	1 616 214	142 316	8.8%
	2007/08	2 006 223	156 429	7.8%
	2008/09	2 885 400	247 930	8.6%
National Tertiary Services Grant	2005/06	4 709 386	67 889	1.4%
	2006/07	4 981 149	69 380	1.4%
	2007/08	5 321 206	81 409	1.5%
	2008/09	6 134 100	118 433	1.9%
Total Conditional Grants to Provinces	2005/06	8 907 346	324 169	3.6%
	2006/07	10 206 542	496 364	4.9%
	2007/08	11 736 678	503 331	4.3%
	2008/09	14 362 800	721 901	5.0%

5. TOTAL BUDGET PER CAPITA

5.1. The budget per capita for the NWDOH was calculated using Statistics South Africa mid-year estimates adjusted with the insured population from the general household survey (Table 4).

Table 4: Comparing national and North West Province provincial trends in per capita health budget

	National uninsured population	Rm Total of provincial budgets	R National uninsured per capita	Year on year increase	Uninsured North West provincial population	Rm North West provincial budget	R North West uninsured per capita	Year on year increase
2005/06	40 323 852	47 147	1 169	N/A	3 399 447	2 897	879	N/A
2006/07	40 898 347	53 175	1 300	11.2%	2 918 683	3 616	1 239	41.0%
2007/08	41 007 279	60 812	1 483	14.1%	3 034 415	3 917	1 291	4.2%
2008/09	41 725 016	73 581	1 763	18.9%	3 061 950	4 445	1 452	12.5%
2009/10	41 725 016	82 359	1 974	11.9%	3 061 950	4 919	1 607	10.7%
2010/11	41 725 016	91 999	2 205	11.7%	3 061 950	5 579	1 822	13.4%

5.2. The table clearly illustrates that the budget per capita in the North West was well below the national budget per capita. In the current financial year the North West budget per capita of R1 607 is 18.6% below the total provincial budget per capita of R1 974.

6. TRENDS IN HEALTH EXPENDITURE

6.1. The NWDOH has under spent its budget for the three years 2005/06 to 2007/08. But the current 2008/09 estimate indicates over spending of R36,467 million. (Table 5). The surplus/ (deficit) per the Appropriation Statements has been adjusted by the IST team to take into account the increase in the accruals outstanding at year-end (i.e. accounts payable). This has been done to better align the operational activity with actual payments of expenses made (e.g. medication utilised prior to year end and only paid after year end). It should be noted that the numbers for the 2008/09 financial year are unaudited. Comparable figures will only be available once the 2008/09 annual financial statements have been audited. Any conclusion on trends up to 2008/09 should therefore be reserved until the financial statements have been finalised.

Table 5: Trends in NWDOH 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	18,552	136,599	69,327	(36,467)
(Increase)/decrease in accruals payable	(82,613)	47,954	41,866	(108,978)
Surplus/(deficit) adjusted for movement in accruals	**(64,061)**	**184,553**	**111,193**	**(145,445)**
Balance of accruals at year end	*180,842*	*132,888*	*91,022*	*200,000*

6.2. The main contributors to the overspending in the financial statements in 2008/09 are shown in Financial Review, paragraph 7.

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

6.4. It is difficult to accurately determine the trend of overspending due to virements. There is an impression of under spending in certain programs. However, most of these programs had to implement severe cost cutting measures in order to fund compensation for employees.

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

	2005/06			2006/07			2007/08		
	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000
Programme	**Final Appro-priation**	**Actual Expenditure**	**Variance**	**Final Appro-priation**	**Actual Expenditure**	**Variance**	**Final Appro-priation**	**Actual Expenditure**	**Variance**
Administration	128 849	135 173	(6 324)	144 767	138 038	6 729	168 103	174 375	(6 272)
District Health Services	1 566 149	1 585 270	(19 121)	1 894 386	1 793 451	100 935	1 897 098	1 880 116	16 982
Emergency Medical Services	98 491	92 245	6 246	112 573	106 084	6 489	133 535	131 805	1 730
Provincial Hospital Services	706 447	743 845	(37 398)	830 666	839 267	(8 601)	1 024 337	978 457	45 880
Central Hospital Services	71 283	71 283	0	69 380	69 602	(222)	81 409	80 119	1 290
Health Sciences and Training	86 163	83 651	2 512	107 337	99 628	7 709	92 486	124 818	(32 332)
Health Care Support	92 337	77 304	15 033	104 299	93 809	10 490	119 438	93 915	25 523
Health Facilities Management	236 993	179 389	57 604	352 498	339 428	13 070	400 222	383 699	16 523
Total	**2 986 712**	**2 968 160**	**18 552**	**3 615 906**	**3 479 307**	**136 599**	**3 916 628**	**3 847 304**	**69 324**
Economic classification									
Compensation of employees	1 705 342	1 764 998	(59 656)	1 972 888	1 913 612	59 276	1 996 435	1 983 390	13 045
Goods and services	553 839	568 959	(15 120)	653 771	634 080	19 691	780 241	782 694	(2 453)
Administrative Expenditure	121 121	118 499	2 622	131 162	127 228	3 934	139 959	158 268	(18 309)
Professional and Special Services	234 668	215 830	18 838	336 995	314 419	22 576	361 283	329 647	31 636
Transfers and subsidies	164 652	107 816	56 836	111 901	170 660	(58 759)	126 757	121 388	5 369
Buildings and other fixed	115 509	137 599	(22 090)	284 814	216 548	68 266	340 663	317 291	23 372

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

	2005/06			2006/07			2007/08		
	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000	R 000
Programme	**Final Appro-priation**	**Actual Expenditure**	**Variance**	**Final Appro-priation**	**Actual Expenditure**	**Variance**	**Final Appro-priation**	**Actual Expenditure**	**Variance**
structures									
Machinery and equipment	91 581	54 459	37 122	124 375	102 760	21 615	171 290	154 626	16 664
Total	**2 986 712**	**2 968 160**	**18 552**	**3 615 906**	**3 479 307**	**136 599**	**3 916 628**	**3 847 304**	**69 324**

Source: North West Province Budget Statement 2006/07, North West Province Budget Statement 2007/08, North West Province Budget Statement 2008/09, North West Province Budget Statement 2009/10

6.5. Compensation of employees as a percentage of the total budget reduced over the period as follows; 59,5% in 2005/06; 55% in 2006/07 and 51,6% in 2007/08. Goods and services remained fairly constant over the same period (19,2% in 2005/06; 18,2% in 2006/07 and 20,3% in 2007/08) as well as administrative expenditure (4.0% in 2005/06; 3,7% in 2006/07 and 4,1% in 2007/08).

7. UNFUNDED MANDATES DURING 2008/2009

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

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

7.2.1. Occupational Specific Dispensation (OSD) – the implementation and costing of this policy resulted in higher expenditure than the amount provided for in the budget. The additional amount allocated for OSD by the National Treasury was based on an equitable share calculation, and not on actual human resource (HR) figures from the PERSAL system. The underfunding for this OSD amounted to R64,047 million for the 2008/09 financial year.

7.2.2. The activity levels increased. For example, the numbers of patients registered for ARVs increased from a targeted 56,000 (funded by the HIV conditional grant) by the end of 2008/09 to actual enrolled of 66,243. At an average cost of around R500 per patient per month just for the medicine, this equates to an underfunding of R5,122 million per month.

8. BUDGETING PROCESS

8.1. The budgeting process was identified as a major contributor to the current funding challenges in the NWDOH. 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. It must be stated that the

CFO is working to improve the process by starting the budgeting process earlier using the MTEF figures as a baseline.

8.2. In the NWDOH it is not required to submit the annual performance plans together with the financial budgets. This leads not only to non-alignment between annual performance plans (APP) and budgets but the APP's 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.

9. FINANCIAL MANAGEMENT PROCESSES

9.1. The new CFO has only recently started reviewing the cost centre accounting. The number of cost centres has been reduced, so that each of the four districts has only one cost centre and only one cost centre per hospital. Currently efficiency and effectiveness indicators needed for good financial management are therefore not available.

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

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

10. CONDITIONAL GRANTS

10.1. The budgetary processes referred to in Financial Review, paragraph 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.

11. QUARTERLY PERFORMANCE REPORTS

11.1. Quarterly performance reports on service related indicators are compiled and submitted to the Provincial Treasury. The alignment between the quarterly performance reports and financial performance is not clear. In addition, there are too many non-financial indicators, with doubtful value and usefulness. Currently, variances are identified, but there is no follow-up of these variances.

12. FINANCIAL REPORTING

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

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

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

13. MONITORING STRUCTURES

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

13.1.1. Basis for qualified opinion:

13.1.1.1. Tangible capital assets – No proper asset register

13.1.1.2. Commitments – No proper commitment register and project files

13.1.1.3. Internal audit – deficiencies exist in more than one internal control component.

13.1.1.4. Non-compliance with certain treasury regulations (E.g. all payments not within 30 days)

13.1.1.5. Prior year's external audit recommendations as well as SCOPA resolutions not substantially implemented.

14. KEY RECOMMENDATIONS

14.1. PROVINCIAL HEALTH BUDGET ALLOCATION

14.1.1. The Provincial Treasury should allocate an amount to the NWDOH, which is in line with the equitable share indicated by the National Treasury in the national budget.

14.1.2. Allocations of conditional grants by the NDOH should be based on clear, objective criteria that are linked to grant specific indicators and not on the equitable share formula.

14.2. UNFUNDED MANDATES

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

14.2.2. 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.

14.3. BUDGETING PROCESS

14.3.1. The budgeting process needs to be seen and used as an extension of the annual performance plan, and needs to follow an iterative process, especially after finalallocation of funds.

14.3.2. All operational units (cost centres) need to have a realistic budget that can be used as a guideline for the financial year's activities. Operational plans need to be aligned with available funding to deliver the services and should be based on hard data such as number of beds; volume of services.

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

14.4. FINANCIAL MANAGEMENT

14.4.1. Financial delegations should be re-instated with the required accountability.

14.4.2. Cost centre accounting needs to be improved and done at the lowest possible practical level (i.e. facility/clinic level). This is needed to properly identify areas of operations that require attention. Coding and data entry should be done by support staff.

14.4.3. 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.

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

14.4.5. The required monitoring structures need to be put in place.

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

14.5. QUARTERLY PERFORMANCE REPORTS

14.5.1. 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.

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

14.6. FINANCIAL REPORTING IYM (IN YEAR MONITORING)

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

14.6.2. The IYM report needs to serve as an accurate forecast of expected expenditure and cost. It has limited use as a monitoring tool when it only reflects actual and expected cash flow, which is not linked to operational activity (expenditure).

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

14.7. ANNUAL FINANCIAL STATEMENTS

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

14.8. SUPPLY CHAIN MANAGEMENT

14.8.1. Although not currently allowed, as per directive from the National Treasury, benchmarking should be allowed to address the exorbitant pricing of some of the tenders.

14.8.2. A Supply Chain Compliance unit for the NWDOH should be activated in order to better manage existing tenders and speed up service delivery, especially tenders awarded via the provincial database of approved suppliers.

14.9. ADDITIONAL FUNDING

14.9.1. In order for the NWDOH to start the year without a backlog it would require R200 million to pay for the accruals.

Leadership, Governance and Service Delivery

1. INTRODUCTION

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

1. The NDOH has provided insufficient leadership and stewardship to solve the fundamental problem of ensuring that the resources available for health are sufficient for the levels of service and targets envisaged by a range of national policies.
2. The NDOH is perceived to be a reactive rather than a proactive entity which is characterised by slow responses to provincial priorities with lengthy turnaround times; failure to provide adequate information within a timeframe which allows proper perusal and analysis by the NWDOH; and a tendency to shift the blame for inability to address key issues to other departments such as the DPSA and Treasury.
3. The NDOH has provided limited and insufficient direction with regard to setting of norms, standards and guidelines. This is further compromised by a lack of consultation with the NWDOH, a process that would have greatly assisted the NDOH.
4. The Health Consultative Forum is perceived to be merely addressing compliance requirements, rather than focusing on key strategic issues and promoting synergy.
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. This is complicated by the inability of line managers to exercise executive corrective measures, due to the continuous centralisation of financial responsibilities.
6. 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.
7. The NDOH is perceived to be a reactive rather than a proactive entity which is characterised by slow responses to provincial priorities with lengthy turnaround

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

times; failure to provide adequate information within a timeframe which allows proper perusal and analysis by the NWDOH; and a tendency to shift the blame for inability to address key issues to other departments such as the DPSA and Treasury.

8. The NDOH has provided limited and insufficient direction with regard to setting of norms, standards and guidelines. This is further compromised by a lack of consultation with the NWDOH, a process that would have greatly assisted the NDOH.
9. The Health Consultative Forum is perceived to be merely addressing compliance requirements, rather than focusing on key strategic issues and promoting synergy.
10. 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. This is complicated by the inability of line managers to exercise executive corrective measures, due to the continuous centralisation of financial responsibilities.
11. As a result of the STP (and a number of key feeding documents, such as the provincial HR Plan) still being in a draft format, key planning documents lack an overall vision and cohesion for the public health system in the province. There is a lack of alignment among the various plans.
12. There is a lack of planning skills in the NWDOH to complete and guide the STP and supportive documents.
13. As a result of the projected over expenditure most of the financial and human resource delegations have been centralised, resulting in increasing bureaucracy with consequent delays in appointments (or simply non-appointments), general inefficiencies, additional costs and insufficient accountability.
14. 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.
15. Proper service delivery planning is severely lacking as a result of inadequate M&E and associated feedback.
16. 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.

Box 2: Key review findings on service delivery, leadership and governance
17. There is insufficient supervision of health facilities and an inadequacy of the monitoring systems (e.g. number of patients on ARVs), making it extremely difficult to forecast both demand and supply.
18. 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.

2. GENERAL LEADERSHIP

2.1. The NWDOH has a strong leadership team in the HOD (appointed in 2006) and the CFO (appointed 9 months ago). It is evident that both managers have a firm grasp on the challenges that the NWDOH is facing and have been jointly working towards addressing these challenges.

2.2. However, it appears that there are several senior managers who have insufficient capacity to optimally function in their positions. While these shortcomings are acknowledged by the executive it is extremely difficult in the public sector to dismiss on the basis of incompetence. The Performance Management and Development System (PMDS) is regarded as a good tool, yet its implementation is ineffective and it is used incorrectly at various levels within the NWDOH. As a result the executive has reverted to centralised control.

2.3. Concerns about politically motivated appointments were expressed on a regular basis on all levels of the NWDOH.

2.4. The NWDOH and NDOH do not have an optimally functioning relationship. The NDOH is perceived to be a reactive rather than a proactive entity which is characterised by slow responses to provincial priorities with lengthy turnaround times; failure to provide adequate information within a timeframe which allows proper perusal and analysis by the NWDOH; and a tendency to shift the blame for inability to address key issues to other departments such as the DPSA and Treasury.

2.5. In response to the over -expenditure, mainly due to the OSD, a decision was taken at the end of 2008 to centralise certain human resource and financial aspects. Included amongst these is the approval for filling of all posts at HOD level. It must be noted that this decision was not purely driven by the projected over - expenditure, but also by the perceived inability of managers to appropriately manage.

2.6. It is important to note that the cost cutting measures implemented did not result in any bed or service cuts. In this regard 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.

2.7. 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 followed up or supported during implementation at provincial level. The policies contain the core strategies, but lack clear guidelines on comprehensive implementation and do not take cognisance of province specific challenges such as the burden of disease, available resources and infrastructure. The NDOH has provided limited and insufficient direction with regard to setting of norms, standards and guidelines. This is further compromised by a lack of consultation with the NWDOH, a process that would have assisted the NDOH.

3. PLANNING

3.1. SERVICE TRANSFORMATION PLAN

3.1.1. The NWDOH developed and adopted a Strategic Position Statement (SPS) in 2001, which served as a position paper for future service configuration with a focus on affordability and sustainability. The SPS estimated healthcare service requirements up to 2010. In 2003 the assumptions of the SPS model were further developed in the “Blue Sky Option Appraisal Project”, which provided a firm basis from which to prepare the business cases for the revitalisation of hospitals and ensure that patients are treated at the right level of care.

3.1.2. This was followed by the start of the Service Transformation Plan (STP). Each district was analysed according to demography, geography, infrastructure of current facilities and utilisation of facilities. An optimal distribution of hospital facilities is suggested based on national and provincial norms, with the consideration that provincial population numbers per facility are lower than national norms due to the rural nature of the province. This first component of the STP is followed by a human resource plan, considerations on the size and shape of the supporting PHC network as well as the required transport and ICT infrastructure and support by the private sector. The STP has been in draft format for a number of years now and resulted in a recent decision by the HOD to appoint external consultants to complete the STP.

3.1.3. 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 NWDOH should look like in the future. The lack of guidance of an overarching framework is leading to a disjuncture between facilities, districts and sub-districts. For example, some facilities with strong leadership have developed service packages to meet the requirements of the population served.

3.2. ANNUAL PERFORMANCE PLAN

3.2.1. An annual performance plan (APP) for a three year period is prepared to a standardised format. There is very little difference in the APP from one year to the next and many of the tables used are identical. The APP does not appear to play a meaningful role in addressing key strategic priorities, such as equity, and appears formulaic in terms of its layout and content. It appears designed to satisfy compliance, as a result of national National Ttreasury guidelines, rather than to be a guiding document for the public health sector in the NWDOH to improve the health of the people.

3.2.2. The APP follows a prescribed, standardised format. However, most of the numerous indicators are input, process and output related with limited outcome and impact indicators. This APP format is not conducive to allowing the NWDOH to comprehensively plan how to address the burden of disease in the province.

3.2.3. The resource allocation process within the NWDOH is neither explicit nor is it well-communicated as many managers are not clear as to the processes used. While the new CFO is attempting to involve managers in the budgeting process, there is no uniform budgeting process at facility, sub-district or even district level. Budget planning varies greatly but is largely based on historical usage.

3.3. ALIGNMENT OF PLANS

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

3.3.2. It was also clear that there was a lack of communication between the various levels of the NWDOH and that planning was done in organisational boxes. For example, the APP and the operational plans are written without explicit correlation. The APP is also not linked to the budget planning process. This is reflected in different information and different targets for the same intervention occurring in different plans. A number of interviewees 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.

3.3.3. There is no clear methodology in the setting of targets and budgets and financial resources are not linked to enhanced performance targets. 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. GOVERNANCE

4.1. The NWDOH has a strong leadership team in the HOD and the CFO. The HOD is further supported by a DDG: Health Services. Posts in this branch have received preference during recent budget cuts and the branch is reasonably well staffed. A specific concern is the inability (due to financial constraints) to fill the position of

DDG: Corporate Services, resulting in a number of Chief Directors and Directors in the branch reporting directly to the HOD.

4.2. As a result of the projected over -expenditure, 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 (CEOs) 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.

5. SERVICE DELIVERY (HIV, TB AND MCH)

5.1. Inequity in the resourcing of service delivery in the various districts is of concern. Table 7 shows non hospital PHC expenditure.

Table 7: Provincial PHC expenditure per uninsured person (Rand)

District	2004/2005	2005/2006	2006/2007	2007/2008
North West	216	* 151	259	* 209
Bojanala	150	165	161	232
Dr Ruth S Mompati	171	249	338	350
Ngaka Modiri Molema	287	319	334	* 198
Dr Kenneth Kaunda	256	212	201	* 56

Source: NWDOH Annual Report 2007/08

5.2. It would appear that the allocation to the Bojanala District is below the rest of the Districts. It is also clear that this data is unreliable as the figures marked with a (*) are unlikely to be accurate. As these are official figures it is clear that inadequate attention is being paid to the M&E of the data.

Table 8.2: Expenditure per Patient Day Equivalent (Rand)

District	2004/2005	2005/2006	2006/2007	2007/2008
North West	1092	969	* 1345	1100
Bojanala	487	716	* 1221	814
Dr Ruth S Mompati	850	883	806	850
Ngaka Modiri Molema	1007	* 1308	1104	1537
Dr Kenneth Kaunda	2025	Not provided	2249	* 1200

Source: NWDOH Annual Report 2007/08

5.3. It is evident from Table 8 that there are marked fluctuations in data relating to the districts' expenditure per Patient Day Equivalent (PDE). See the figures marked with (*) for examples. Despite these unreliable data it does appear as if the Bojanala and Dr Ruth S Mompati districts are consistently below that of the province as a whole and the Dr Kenneth Kaunda district consistently much higher. More attention needs to be paid to the M&E of this important indicator as well as to the overall equity in resource allocations among the hospitals in the NWDOH.

5.4. The financial stringency measures implemented in the NWDOH are over time likely to have a negative impact on service delivery at all levels. Up to now the NWDOH has managed to continue with no bed or service cuts. However, the NWDOH is faced with extremely stringent measures on staff appointments, while budget increases are largely taken up by the increase in salaries.

5.5. HIV and TB are both designated as high priority areas in the APP. However, the targets for intervention are modest and do not seem to convey a sense of urgency or act as a galvanising force for the DOH. Of specific concern is the very low number of accredited ART sites, currently at an estimated 25 and targeted to increase to a mere 40 by 2011/12. This does not make the service easily accessible.

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

5.7. 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 programme 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.

5.8. Transport is a major problem. The NWDOH has not approved subsidised vehicles for the last 2 years with provincial staff having to rely on a limited number of pool cars, some of which have not been replaced as per schedule and are now unreliable. This is further complicated by the condition of many of the rural roads in the province.

6. RECOMMENDATIONS

6.1. GENERAL LEADERSHIP

6.1.1. There should be explicit and open discussion around the budget and the level of services that can be rendered for that budget. The areas of rationing and prioritisation should be made clear and communicated effectively to all relevant stakeholders.

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

6.1.3. Personnel should be employed on the basis of skills and capacity without political interference in this process.

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

6.1.5. 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.

6.1.6. 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.

6.1.7. 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.

6.2. PLANNING

6.2.1. The STP should be completed, costed, endorsed politically, communicated to all relevant stakeholders and then used as the basis to guide all strategic decision making in the NWDOH.

6.2.2. All planning processes in the NWDOH 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.

6.2.3. 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.

6.2.4. 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.

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

6.2.6. 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).

6.2.7. 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.

6.3. GOVERNANCE

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

6.3.2. 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.

6.3.3. 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.

6.4. SERVICE DELIVERY (HIV, TB AND MCH)

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

6.4.2. 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.

6.4.3. There should be clear communication between all these role players in ensuring that their planning is based on the current realities. However, targets should be set

that continuously ensure significant improvement in health outcomes in agreed upon priority areas.

6.4.4. 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.

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

6.4.6. Support services (such as transport) to the programmes require a comprehensive review.

Human Resources

1. INTRODUCTION

Box 3: Human resource review key findings

1. The NWDOH organogram has not been updated to incorporate new posts. This has resulted in confusion around responsibilities and lines of reporting as well as overlap of functions. The head office component of the organogram has too many assistant directors.
2. Managers, especially directors and deputy directors have insufficient authority, responsibility and accountability to manage their budgets in accordance with the specific needs of their respective districts, sub-districts and facilities. Such decentralisation must be balanced by accountability and effective performance management, thus steering away from the current approach that one transgression leads to the restriction of all without the relevant manager being held accountable.
3. Human resource planning is dealt with differently across the NWDOH and clear planning principles and norms and standards are required.
4. The shortage and retention of health professionals, especially nurses, in rural areas remains a major challenge. Most institutions seem to have filled their doctor establishment and good retention practices keeps staff turnover for doctors relatively low. Lengthy recruitment processes compounds the problem related to nurses.
5. Although well-defined human resource (HR) policies and procedures exist, implementation is impaired by cost containment and “crisis” management.
6. 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.
7. Despite a written policy on delegations, delegations have been withdrawn by NWDOH, with resultant day to day management by head office, with resulting feelings of disempowerment and lack of accountability.
8. Some strategic health programmes (e.g. HIV) tend to operate in silos with their own systems, training and reporting procedures.

Box 3: Human resource review key findings

9. PERSAL is not fully used as a management and planning tool and inconsistent HR indicators are found in different official NWDOH documents.
10. The Klerksdorp/Tshepong Complex has developed and implemented excellent strategies on the retention of health professionals, a best practice exercise which should be elevated to a provincial and national level.
11. 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.
12. Rewards are not clearly 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.
13. The implementation of the occupational specific dispensation (OSD) for nurses resulted in numerous operational problems, including over -expenditure, negative impact on appointment of other professionals, discrepancies in nurses' salaries within the same levels and general unhappiness among health professionals.

2. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

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

2.2. 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 filling of all levels of staff, including that of general assistants).

2.3. Unclear roles and responsibilities and withdrawing delegations resulted in the following:

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

2.3.2. Managers at district and hospital level cannot make routine and necessary day-to-day decisions timeously, impacting on service delivery due to the long chain of command.

2.3.3. Delays in appointment of lower staff grades.

3. INTEGRATION AND CO-ORDINATION

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

3.1.1. Health programmes (e.g. HIV) tend to operate in silos with their own systems, training and reporting procedures which are not aligned to those of managers of health facilities.

3.1.2. There is inadequate communication and co-ordination between staff in priority health programmes and staff working on the DHS to ensure that there is a single system of data flow.

3.1.3. It is further not clear how the priority health programmes are integrated into the functioning of the hospitals.

4. LABOUR PLANNING

4.1. 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:

4.1.1. The alignment between the HR planning, budgeting and service delivery seems to be generally problematic.

4.1.2. Key HR indicators are 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.

4.1.3. The HR plan is currently being drafted by consultants and a first draft is expected in June 2009.

4.1.4. HR planning is 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 going into a state of "despair" with always having to do more with less.

5. ORGANISATIONAL DESIGN AND ESTABLISHMENT

5.1. The organisational structure is not planned on a realistic model of service requirements and available financial resources. The planning basis for the organisational structure should be the STP, considering service requirements and applied limited national and provincial norms and standards.

5.2. The NDOH has not provided detailed norms and standards regarding organisational structures. The NWDOH is in the process of developing a HR plan, but this is not accompanied by a comprehensive organisational review and job evaluation. There is the risk of creating an inappropriate organisational structure if no or wrong norms and standards are used when creating or abolishing positions.

5.3. In the absence of a comprehensive strategic approach and lack of clear guidance from a national and provincial level, proactive managers have initiated organisational changes, e.g. restructuring of management structures at hospital level resulting in discrepancies between neighbouring hospitals.

5.4. DPSA requirements are extremely bureaucratic and therefore make changes within current staff structures very difficult. Numerous facility managers have indicated delays in obtaining approval for organisational changes.

5.5. Although job descriptions are in place, discrepancies exist in terms of grading and non-uniformity of district structures and there are inconsistent job titles and levels of appointment across similar positions in the NWDOH. For example, the CEO of the largest hospital complex, the Klerksdorp/Tshepong Complex is appointed at Level 12 while the CEO of the Rustenburg Hospital is appointed at Level 13. This is a demoralising and unfair practice.

5.6. According to the 2007/08 Annual Report there were 18 185 posts on the NWDOH staff establishment, compared to 22 138 in 2006/07 and 22 822 in 2005/06, demonstrating a decrease in the number of posts on the establishment. Table 9 clearly demonstrates a decrease in vacancy rate while the actual number of filled posts has decreased from 17 123 in 2005/06 to 15 685 in 2007/08. Of specific concern is the decrease in posts in District Health Services during the same period. 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. On the positive side, Emergency Medical Services and Provincial Hospital Services have showed a slight increase.

Table 9: Employment and Vacancies by Professional Grouping, 2006 – 2008

Programme	2006			2007			2008		
	Posts	Filled	Vac %	Posts	Filled	Vac %	Posts	Filled	Vac %
Administration	505	394	22	511	359	29.7	542	410	24.4
District Health Services	14240	10057	29.4	13396	9256	30.9	10066	8404	16.5
Emergency Medical Services	891	664	25.5	891	638	28.4	827	696	15.8
Provincial Hospital Services	6048	5003	17.3	6157	4925	20	5431	4956	8.7
Heath Sciences & Training	895	795	11.2	940	932	0.9	1081	1018	5.8
Health Care Support Services	243	210	13.6	243	200	17.7	229	196	14.4
Health Facilities Management	N/A	N/A	N/A	N/A	N/A	N/A	9	5	44.4
Total	22822	17123	25	22138	16310	26.3	18185	15685	13.7

Source: NWDOH Annual Reports: 2005/06, 2006/07 and 2007/08

5.7. Table 10 demonstrates the movement in critical occupation categories. Numerous discrepancies are highlighted including major increases and decreases in total numbers within one year and the way in which the vacancy rate is altered due to changes in the official establishment. For example, the number of Professional Nurses filled posts decreases over the three years, so also does the vacancy rate as a result of changing the number of posts. This makes interpretation difficult.

Table 10: Employment and Vacancies by Critical Occupations, 2005/06 – 2007/08

Occupations	2005/06			2006/07			2007/08		
	Posts	Filled	Vac %	Posts	Filled	Vac %	Posts	Filled	Vac %
Ambulance & Related	870	652	25.1	967	630	34.9	795	676	15
Dental Practitioners	71	48	32.4	73	50	31.5	41	38	7.3
Dental Therapy	66	27	59.1	66	22	66.7	19	16	15.8
Dieticians &	84	45	46.4	102	48	52.9	68	50	26.5
Environmental Health	123	76	38.2	123	60	51.2	56	43	23.2
Health Sciences Related	134	98	26.9	206	97	52.9	123	90	26.8
Medical Practitioners	719	399	44.5	924	435	52.9	625	388	37.9
Medical Specialists	133	38	71.4	153	42	72.5	114	37	67.5
Medical Technicians &	16	9	43.8	16	8	50	8	8	0
Nursing Assistants	3555	2912	18.1	4590	2756	40	2921	2693	7.8
Occupational Therapy	100	55	45	120	53	55.8	69	52	24.6
Oral Hygiene	25	9	64	25	10	60	5	5	0
Pharmacists &	161	108	32.9	203	115	43.3	143	102	28.7
Physiotherapy	71	34	52.1	83	45	45.8	58	39	32.8
Professional Nurse	4087	3176	22.3	5130	3025	41	3325	2868	13.7
Psychologists &	50	28	44	59	21	64.4	26	16	38.5
Radiography	119	80	32.8	150	67	55.3	78	59	24.4
Senior Managers	42	29	31	60	35	41.7	55	44	20
Social Work & Related	67	29	56.7	70	22	68.6	33	27	18.3
Speech Therapy &	23	13	43.5	27	14	48.1	12	8	33.3
Staff Nurses & Pupil	1597	1090	31.7	1860	973	47.7	882	777	11.9
Student Nurse	666	608	8.7	1113	742	33.4	857	819	4.4
Total	12847	9606	25.2	16277	9349	42.6	10412	8932	14.2

Source: NWDOH Annual Reports: 2005/06, 2006/07 and 2007/08

5.8. The correction of the establishment requires urgent attention. In reviewing various document sets, it became clear that establishment figures and actual filled positions are different in a number of official documents. This situation is not conducive to proper planning and reporting on and managing real vacancies. In budget terms there is no vacancy rate.

5.9. The provincial structures are loaded with senior posts with limited and reasonably defined responsibilities, while there is very little programmatic support at district and sub-district level. This is adding to the problem of centralised coordination and exacerbated by not involving districts in the planning processes.

5.10. Overall, the executive structure appears to be streamlined but there are numerous concerns about lower level organisational structures. There is an imbalance between provincial (policy making) structures versus district (implementation) structures. For example, at provincial level the HIV Prevention sub-programme, one of four sub-programmes in the HIV Programme, has a deputy director and 5 assistant directors. Compared to this none of the districts have any dedicated HIV managers for the overall HIV programme.

6. RECRUITMENT

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

6.2. Overly bureaucratic recruitment procedures from DPSA (extended periods of advertisements for professional posts) and head office (centralisation of the approval to fill posts) has a number of negative effects including:

6.2.1. Potentially interested candidates going elsewhere.

6.2.2. Delays in recruitment and overly long appointment timelines.

7. PERFORMANCE MANAGEMENT

7.1. A well defined performance and development policy framework exists. However, the process is not working as envisaged. Performance agreements do take cognisance of existing plans and strategies, but areis constrained by the lack of an overall plan (STP and HR plan) in the NWDOH. Performance goals are linked to the APP, but require improvement as the APP does not comprehensively address outputs and impact. Performance management is aimed at individuals and teams and there is a strong drive to ensure performance management appraisals on a quarterly basis.

8. RETENTION

8.1. 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 NWDOH. Secondly, the response of the private sector was to increase their pay scales to achieve parity with the NWDOH, thus neutralising the impact.

8.2. 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.

8.3. A NWDOH retention strategy exists and scarce skills are defined. However, the implementation of this strategy is difficult due to logistical and financial constraints. It is further restricted by the fact that managers are not allowed to implement innovative measures to retain staff and have to keep to rigid guidelines. A list of factors that impact on retention includes:

8.3.1. Poor competitive remuneration packages.

8.3.2. Over-concentration of health personnel in urban areas and under-provision of health personnel in rural areas.

8.3.3. Emigration of highly trained professionals.

8.3.4. Competing with other provincial departments to attract and retain scarce skills.

8.3.5. The impact of HIV/AIDS on the health workforce.

8.3.6. Excessive work demands and an unpleasant workplace environment.

8.3.7. Insufficient developmental opportunities.

8.3.8. Inadequate career progression opportunities.

8.3.9. Selective sabbatical leave.

8.3.10. Lack of recognition of performance.

8.3.11. Poor job satisfaction.

8.3.12. Lack of accommodation in rural areas.

8.4. The retention strategy describes actions to be implemented to improve retention of scarce skills. However, the retention strategy seems not to be working very well, with the exception of one complex, i.e. the Klerksdorp/Tshepong Complex. This Complex is managed by a strong, dedicated and involved management team, radiating a pride unequalled in other interviews. A case study illustrating the best practices in this complex is contained in Appendix 5. It would be of great benefit for NDOH and NWDOH to consider these best practice retention strategies.

9. REWARDS

9.1. 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.

9.2. 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.

9.3. 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. At present, staff does not feel motivated to perform above average because of the fact that colleagues that perform average or even below average receive the same reward.

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

9.4.1. The OSD was not costed properly and implemented by NDOH. The personnel over-expenditure from OSD has impacted negatively on other staff appointments, with the subsequent moratorium leading to key posts not being filled.

9.4.2. 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, e.g. district hospital and DHS.

10. LEARNING AND DEVELOPMENT

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

10.2. It was found that HR development policies exist, but execution is problematic. It would appear that the following challenges are impacting on learning and development:

10.2.1. HRD is not properly aligned with the performance management and development system.

10.2.2. HRD does not feature as a highly prioritized objective in the strategic plan of the NWDOH.

10.2.3. HRD is not properly aligned and coordinated with HR management.

10.2.4. Resources are generally insufficient and not all critical positions that are essential for the performance of the NWDOH are filled.

10.2.5. Training needs assessments are not conducted on an ongoing basis.

10.2.6. No post training assessment is made to evaluate the impact of training on the performance.

10.2.7. The HRD functions are not generally responsive to the changing job requirements of staff.

10.2.8. Lack of mentors and coaches.

10.2.9. The skills demands of new policy requirements are not generally assessed.

10.2.10. Qualified service providers are not always readily available.

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

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

11. HR INFORMATION SYSTEMS

11.1. PERSAL 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.

11.2. The number of PERSAL users is limited due to National Treasury directives. Hence sub-districts, which are also cost centres or cost units, 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 sub-district level.

11.3. A HR software planning system, called HR Planner, exists. This was developed by external consultants and is used to estimate staff requirements, based on norms, workload data and selected hospital indicators. It was mentioned that a comprehensive system is being developed at a national level, but no further detailed information was available.

12. RECOMMENDATIONS

12.1. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

12.1.1. It should be assessed whether 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 authority and decision making at various levels should be completed.

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

12.1.3. There should be increased delegations with a decentralisation of responsibilities and accountability. This must be balanced by effective performance management and steer away from the current approach where one transgression leads to the restriction of all without the relevant manager being held accountable.

12.2. INTEGRATION AND CO-ORDINATION

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

12.2.2. A clear policy on the relationship between the programmes and hospitals are required, i.e. vertical and horizontal integration is critical.

12.3. LABOUR PLANNING

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

12.3.2. Clear and consistent key HR statistics and indicators should be developed and reported on.

12.3.3. Feedback loops should be established to update plans and define cost and service delivery impacts should new priorities arise.

12.3.4. Clear decisions and direction at various levels (national, provincial and district levels) in terms of service delivery should be communicated – if fewer HR resources and decreased funds are available, priorities need to be adjusted and communicated accordingly.

12.4. STAFF ESTABLISHMENT

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

12.4.1.1. Structuring should allow for re-allocation of lower level duties to lower graded staff;

12.4.1.2. Appropriate management ratios and levels should be reviewed.

12.4.1.3. Job titles and job grades should be consistent across various areas.

12.4.2. District and sub-district management, implementation and supervision capabilities must be strengthened. As, the programmes are top heavy at provincial level, some of these positions could be utilised at a district and sub-district level.

12.4.3. PERSAL should be corrected to accurately reflect personnel positions and staffing numbers as reported in the NWDOH Budget Estimate and Annual Reports statements.

12.4.4. 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.

12.4.5. 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.

12.4.6. DPSA should assist NDOH and provinces to support changes to structures in a more efficient manner.

12.5. RECRUITMENT

12.5.1. A thorough review and improvement of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times.

12.5.2. Recruitment of more staff nurses should be considered to fill the gap between assistant nurses and professional nurses.

12.6. PERFORMANCE MANAGEMENT

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

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

12.6.2.1. Organisational performance;

12.6.2.2. Employee development;

12.6.2.3. Reward based on clear performance goals.

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

12.7. RETENTION

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

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

12.7.3. The KT Complex has developed a detailed retention strategy on health professionals which requires consideration by the NWDOH and NDOH. (See Appendix 5 for details).

12.8. REWARDS

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

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

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

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

12.9. LEARNING AND DEVELOPMENT

12.9.1. Training needs should be properly and objectively determined.

12.9.2. 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.

12.10. HR INFORMATION SYSTEMS

12.10.1. 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.

Information Management

1. INTRODUCTION

Box 4: Information management review key findings

1. Monitoring and evaluation is one of the weak links in the overall management of health services in the NWDOH. 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 and interpretation and little utilisation of information for decision making processes. Hence poor quality indicators derived from the data find their way to NDOH and Treasury, where there is also little interrogation and feedback.
3. Monitoring and evaluation is one of the weak links in the overall management of health services in the NWDOH. Contributing to this is a lack of national guidelines, norms and standards as well as a lack of alignment between planning, implementation and monitoring and evaluation.
4. 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 and interpretation and little utilisation of information for decision making processes. Hence poor quality indicators derived from the data find their way to the NDOH and Treasury, where there is also little interrogation and feedback.
5. There is a lack of managerial accountability for the attainment of service related targets and M&E does not appear to be part of managerial performance assessment.
6. 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.
7. Parallel information systems and the lack of a single repository of information, result in conflicting official information.

1.1. Monitoring and evaluation (M&E) appears to be one of the more challenging links in the overall management of services in the NWDOH. 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. On the positive side, a provincial M&E framework has been developed.

1.2. There is a lack of linkage between planning, implementation and M&E. There is no clear evidence that senior managers review key indicators of efficiency (e.g. PDEs) or indicators of effectiveness (e.g. drop-out rates of patients on ARVs) with any regularity. Wide variations among similar type of facilities (and between the same facilities over time, e.g. PDE) pass by without question or attempts to effect corrective action. In fact, the correctness of information contained in the Annual Report was questioned at a very senior level.

2. USE OF INFORMATION FOR DECISION MAKING

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

2.1.1. Managers generally do not focus on M&E and it does not appear to be part of their job descriptions and formal performance appraisals. Management meetings at provincial and district level do not appear to focus on indicators and their relevance for action.

2.1.2. There are too many indicators resulting in a mass of data.

2.1.3. There are few indicators that measure outcomes or impact; most are linked to inputs, processes and outputs.

2.1.4. Some managers are not focussed on, and sometimes appear not to understand the significance of key indicators in their sphere of management. Examples include

understanding of PDEs, numbers of staff in the section/division, patients on ARV treatment and on waiting lists for treatment.

2.1.5. Data is fed up the line but there is little analysis, interpretation and feedback 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.

3. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

3.1. 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:

3.1.1. There are inadequate guidelines, norms and standards from national and provincial level on data collection tools and consequently processes of data collection are not standardised.

3.1.2. The indicator list in the national indicator data set (NIDS) has not been updated since 2005 and is out of date (e.g. dual therapy PMTCT indicators not included).

3.1.3. 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).

3.1.4. 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).

3.1.5. 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.

4. ARV MONITORING AND EVALUATION

4.1. As the provision of ARVs is an important component of the overall strategy against HIV, it is essential for a good M&E programme to be in place to assess the effectiveness of the programme and to measure the cost-efficiency. This is one of the key cost drivers of expenditure in the NWDOH and approximate figures of R6 ,000 per patient per year for 66,043 patients show that the costs are in the region of R396 million for direct costs only.

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

4.2.1. There are no clear guidelines, norms and standards from NDOH guiding the NWDOH around an information system for ARV.

4.2.2. As a result the NWDOH, similar to other provinces, has developed its own systems.

4.2.3. Planning is based on population size, health facility use and known prevalence rates only. No other indicators are used.

5. OTHER M&E ISSUES

5.1. There are a number of parallel information systems - (e.g. HIV programmatic information) in addition to that supplied by the DHIS.

5.2. There is a lack of communication between those responsible for data management and those responsible for programme management, planning and implementation. The Chief Directorate Policy, Planning and Research is supposed to play a leading role in this regard, but this is not happening.

5.3. Quarterly reports are regularly prepared for NDOH and the National Treasury. These reports are scrutinised to some degree throughout the NWDOH and there is a degree of feedback on these reports by senior management. The process is supported by the HOD and CFO.

5.4. There is a general lack of integration of information and BAS and PERSAL data are not aligned with service delivery data.

6. RECOMMENDATIONS

6.1. OVERALL M&E

6.1.1. M&E needs to become a central component of all managerial activity with the use of objective information being the basis for decision making. This applies to all aspects of management, including financial and HR, and not only service related data. There needs to be an iterative link between planning, implementation and monitoring.

6.1.2. Regular formal monitoring of key indicators needs to take place with analysis and questioning of variances (in much the same way as financial management variance analysis should take place).

6.2. USE OF INFORMATION FOR DECISION MAKING

6.2.1. M&E, based on a limited number of key indicators, needs to be built into every senior manager's job description and performance appraisal.

6.2.2. Where applicable, in-service training around understanding of and the importance of key indicators for managers needs to take place.

6.2.3. There should be regular analysis, comparison, interpretation and feedback around indicators to lower levels of the system.

6.3. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

6.3.1. The DHIS, and associated NIDS, needs a thorough review by the NDOH.

6.3.2. The numbers of indicators need to be consolidated to reflect key strategic goals to enhance decision making.

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

6.3.4. 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

6.4. ARV MONITORING AND EVALUATION

6.4.1. A workable, practical, easy-to-use system of monitoring and planning 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.

6.5. OTHER M&E ISSUES

6.5.1. There needs to be one official repository of information for the NWDOH. All reports and other documents using information should be drawn from this repository to eliminate duplicate sources of information. All relevant role-players need to play their parts in ensuring that the most up to date, good quality information is passed into the repository.

6.5.2. Parallel systems of information (e.g. direct flow of information from facilities to programme managers – whether at provincial or national level – and the bypassing of district management structures) should be discontinued.

6.5.3. Basic record keeping needs to be maintained at facility level.

Medical Products, Laboratory

1. INTRODUCTION

Box 5: Key findings on Medical Products and Laboratory
1. The outsourcing of the Central Medical Depot, together with selected functions, has resulted in numerous benefits for the province. 2. Inventory and information management systems at the facilities are outdated resulting in poor inventory control. 3. Many facilities do not have the necessary resources to ensure comprehensive inventory management and record keeping. 4. Lack of security at facility level is leading to substantial losses. In many cases these are unquantifiable due to the lack of proper inventory management systems. 5. The existing relationship between the NWDOH and the NHLS is not to the benefit of the NWDOH as costs keep increasing while the service from the NHLS service and associated feedback is deteriorating.

2. MEDICAL PRODUCTS

2.1. Management of the Central Medical Depot was outsourced, including the functions of procurement, warehousing and distribution down to district hospital level. This has resulted in a number of benefits including:

2.1.1. Improved level of service delivery.

2.1.2. Recruitment of skilled staff.

2.1.3. No procurement capacity problems.

2.1.4. No distribution (vehicles) problems.

2.1.5. No problems with security, especially during transport.

2.1.6. Maintenance of 90 – 95% EDL levels

2.2. NWDOH is continuously losing pharmacists to the private sector and other provinces (especially Gauteng) because of their more competitive salaries (or higher level of appointment). Many facilities do not even have pharmacy assistants and nurses are expected to take full responsibility for dispensing and inventory management.

2.3. As a result of the lack of sufficient support staff, stock control is inefficient and there is limited data is available to support planning. As a result, pharmaceutical requirements are based on estimates and historical consumption, without really considering burden of disease trends.

2.4. There are no M&E measures in place to assure accuracy and validity of orders placed or to pick up fraud, e.g. there is no proper way of ascertaining whether all pharmaceuticals issued reach the end-user and do not disappear somewhere along the supply chain.

2.5. Security at facility level is inadequate and no additional security provision is made for pharmacies, resulting in theft and loss of pharmaceuticals.

3. LABORATORY

3.1. Laboratory (NHLS) costs are perceived to be extremely high while the NHLS is not rendering a high quality service. One example of this is the lack on the side of the NHLS to provide constructive feedback to be used in clinical service planning, e.g. no information on disease patterns is provided.

3.2. The turnaround time of the NHLS is slow as the results on some routine tests take 2 to 3 days to arrive, resulting in increased hospital costs as a result of additional time spent in hospitals by patients waiting for results.

3.3. Laboratory budgets are insufficient. Standard treatment guidelines are in place at many facilities in the province and only the most essential investigations are done.

Yet, in spite of these cost cutting interventions, there is over expenditure on the laboratory budget.

4. RECOMMENDATIONS

4.1. 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.

4.2. Proper inventory management systems should be instituted at all levels.

4.3. Increase security, especially related to the pharmacy, at all facilities.

4.4. A review of the contract with NHLS is required. This review should include the costs of tests and feedback mechanisms.

Technology and Infrastructure

1. INTRODUCTION

Box 6: Key findings on Technology and Infrastructure

1. Hospitals are faced with a lack of, and delays in, maintenance and repairs of essential basic equipment. This is largely due to the centralisation of budgets and the inefficiency of the department of public works.
2. The centralisation of budgets are causing delays in essential or critical maintenance which again causes additional cost which defeats the reason why budgets were centralised in the first place.
3. Basic diagnostic and resuscitation equipment is lacking in some clinics. This results in the erosion of confidence of the patients and the by-passing of clinics, putting additional pressure on the hospitals.
4. Certain IT functions such as infrastructure development are the responsibility of the Provincial Treasury which limits their functionality and only focuses on financial systems.

2. OVERVIEW

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

2.1.1. Clinics often have a shortage of space as a result of increased patient volumes and because of the need for increased privacy with HIV counselling.

2.1.2. There is a lack of IT hardware and supportive infrastructure, e.g. cabling for facility networks, in a number of the sub-districts.

2.1.3. The NW Provincial central IT department is located in Treasury, resulting in Treasury related systems getting preference. Requests for IT by the NWDOH are beyond the control of the health management.

2.1.4. In some areas affected by the disputes between departments and municipalities on the payment of municipal services (e.g. Moretele Sub-district) the lack of a continuous water supply creates a problem that seriously affects service delivery.

2.1.5. There appears to be no coherent maintenance and equipment (service and replacement) schedule.

2.1.6. These were numerous requests by hospitals to use vacant land to build and provide accommodation to health professionals. This would not only save money by not having to rent expensive and limited accommodation, utilise existing vacant land but also assist with the retention of staff.

3. RECOMMENDATIONS

3.1. A plan of action should be prepared to deal with the logistical issues identified, some of which should be coordinated by the NDOH. This plan should be aligned to the Hospital Revitalisation Grant.

3.2. A detailed maintenance and equipment (asset management) plan must be developed, costed and implemented.

3.3. Political involvement is critical to ensure that disputes between departments and/or municipalities do not result in crippling essential municipal services to health facilities.

3.4. Centralise the provincial IT system in the office of the Premier so as to decrease the current emphasis on financial systems only.

Taking Forward the Recommendations

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

Table 11 is a summary of all the recommendations in Financial Review to Technology and Infrastructure. These are linked with the institution(s) that have responsibility for the implementation of these recommendations.

Table 11: Recommendations contained in North West 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	North West Health MEC	North West Department of Health	National Treasury	North West Treasury	Department of Public Service and Administration	External stakeholders
FINANCE RECOMMENDATIONS								
Provincial health budget allocation								
The Provincial Treasury should allocate an amount to the NWDOH, which is 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. The National department should provide clear and direct guidelines		1		2	2	2		

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RECOMMENDATIONS	National Minister of Health	National Department of Health	North West Health MEC	North West Department of Health	National Treasury	North West Treasury	Department of Public Service and Adminis-tration	External stakeholders
regarding these policies.								
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, especially after final allocation of funds.				1	2	2		
All operational units (cost centres) need to have a realistic budget that can be used as a guideline for the financial year's activities. Operational plans need to be aligned with available funding to deliver the services and				1		2		

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should be based on hard data such as number of beds; volumes of services.								
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		
Financial management								
Financial delegations should be re-instated with the required accountability.				1		2		
Cost centre accounting needs to be improved and done at the lowest possible practical level (i.e. facility/clinic level). This is needed to properly identify areas of operations that require attention. Coding and data entry should be done by support staff.				1	2	1		
Allocation of expenses needs to be accurate and up to date to assist with effective management. Actual expenditure is an important				1	2	1		

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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.				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								
There needs to be a link between performance and financial reports. A financial report reflecting actual expenditure compared to budget should also be		2		1	2	2		

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provided where performance indicators reflect a deviation in operational performance.								
Variances in specific indicators need to be followed up with actions, and not merely identified.				1				
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		
Annual Financial Statements								
Through the appropriate channels, the forecasting				2	1	2		

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component of the IYM should be investigated to ensure best basis or reporting – cash versus accrual reporting. .								
The annual financial statements, while meeting Constitutional and Government Accounting requirements, should be expanded beyond the cash basis of reporting and include accruals as part of reported, aggregated expenditure numbers				2	1	2		
Supply Chain Management								
Although not currently allowed as per directive from National Treasury, benchmarking should be allowed to address the exorbitant pricing of some of the tenders.		2		2	1	1		
A Supply Chain Compliance unit for the department should be activated in order to better manage existing tenders and speed up service delivery,				1	2	2		

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especially tenders awarded via the provincial database of approved suppliers.								
Additional Funding								
In order for the department to start the year without any back lock'slogs it would require R200 million to pay for the accruals.	1	2		2	1	1		
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		
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	2	1	2	1	2	2		2

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made available so that the level of service delivery can be elevated, consistent with policies.								
Personnel should be employed on the basis of skills and capacity without political interference in this process.	2	2	2	1			1	
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	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		
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		

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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 completed, costed, endorsed politically, communicated to all relevant stakeholders and then used as the basis to guide all strategic decision making in the NWDOH.		2	1	1	2	2		2
All planning processes in the department should be simplified and aligned with each other and well communicated. There should be a limited number of key targets for each area of operation for which managers are responsible and accountable.		1		1				

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Plans should be given the status for which they are intended and should be a roadmap for all health workers in the province. There should be a clear M&E process which ensures that the implementation of the plans are regularly monitored with remedial action taken if necessary to ensure that targets are attained.		1		1				
Targets should be set based on guidelines from NDOH and the provincial realities. These targets need inputs from programme and line managers to ensure that there is buy-in.		1		2				
Targets need to be based on realistic forecasts of what the need is and what is achievable as well as linked to budgets. This is particularly important in relation to ARVs. This is a national and provincial issue.		1		1	2	2		
External support for the		2		1				2

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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.		1		1	2	2		
Governance								
There should be clear written guidelines delineating the areas of responsibility of the MEC and the HOD.	1		1	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		1		2				

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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.			1	2				
Service delivery (HIV, TB and MCH)								
The NDOH should produce comprehensive, integrated guidelines covering all aspects of service delivery in relation to HIV, TB and MCH. These guidelines should contain norms and standards (including addressing data gathering, monitoring and evaluation, human resources).	2	1		2				
The role and expertise of strategic health programme managers at national, provincial and district levels needs review with clear guidelines of performance		1		1				

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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.		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				1				

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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.	1	1	2	2				
Support services (such as transport) to the programmes require a comprehensive review.				1				
HUMAN RESOURCES RECOMMENDATIONS								
Delegations, Accountability and Responsibility								
It should be assessed whether 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.			2	1				
The responsibility level of CEOs of institutions and district managers and their			2	1		2		

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district management teams (DMTs) should be reviewed and addressed. This should include a review of financial management responsibilities.								
There should be increased delegations with a decentralisation of responsibilities and accountability. This must be balanced by effective performance management and steer away from the current approach where one transgression leads to the restriction of all without the relevant manager being held accountable.			1	1				
Integration and co-ordination								
Communication mechanisms need to be established across clusters and DHS to prevent "silo" operational functioning.				1				
A clear policy on the relationship between the programmes and hospitals is required, i.e. vertical				1				
Labour Planning								

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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								

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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 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	
District and sub-district management and implementation capabilities must be strengthened, as especially the programmes are top heavy at provincial level – these positions could be utilised much better at a		2	1	1				

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district and sub-district level .								
PERSAL should be corrected to accurately reflect personnel positions and staffing numbers as reported in the NWDOH 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			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			2	
DPSA should assist NDOH		2		2			1	

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and provinces to support changes to structures in a more efficient manner.								
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.		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				1			2	

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development; Reward based on clear performance goals.								
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 NWDOH retention strategy should be analysed in terms of impact and cost to test possible success and affordability.				1			2	
The Klerksdorp/Tshepong Complex has developed a detailed retention strategy on health professionals which requires consideration by the NWDOH and NDOH.		1		1			2	
Rewards								
A total reward strategy (monetary and non-monetary) review should be undertaken at national level to address		1		2	1	2	1	

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issues of employee compensation overspend, skills scarcity and staff retention – including highlighting the importance of the following aspects.								
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		2		1				

Table 11: Recommendations contained in North West 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	North West Health MEC	North West Department of Health	National Treasury	North West Treasury	Department of Public Service and Adminis-tration	External stakeholders
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.								
HR information systems								
An assessment should be undertaken to establish reasons for under utilisation of systems and improved measures should be implemented including the full use of PERSAL 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		1		1	2	2	2	

Table 11: Recommendations contained in North West 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	North West Health MEC	North West Department of Health	National Treasury	North West Treasury	Department of Public Service and Adminis-tration	External stakeholders
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).		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				

Table 11: Recommendations contained in North West 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	North West Health MEC	North West Department of Health	National Treasury	North West Treasury	Department of Public Service and Adminis-tration	External stakeholders
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 consolidated to reflect key strategic indicators to enhance decision making.		1		2				
There should be unambiguous, easy to understand, standardised definitions.		1		2				
There also needs to be clear written guidelines, norms and standards for each component of the DHIS, including data collections tools (forms and registers); relevant human resources, hardware, software, data flow policies and linkages between the DHIS and other		1		2	2	2	2	

Table 11: Recommendations contained in North West 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	North West Health MEC	North West Department of Health	National Treasury	North West Treasury	Department of Public Service and Adminis-tration	External stakeholders
data collection systems.								
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.		1		2				
Other M&E issues								
There needs to be one official repository of information for the NWDOH. 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				

Table 11: Recommendations contained in North West 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	North West Health MEC	North West Department of Health	National Treasury	North West Treasury	Department of Public Service and Adminis-tration	External stakeholders
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				
MEDICAL PRODUCTS, LABORATORY RECOMMENDATIONS								
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		
Proper inventory management systems should be instituted at all levels.				1				
Increase security and specifically pharmacy security levels at all facilities.				1		2		
A review of the contract with NHLS is required. This review		1		1				

Table 11: Recommendations contained in North West 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	North West Health MEC	North West Department of Health	National Treasury	North West Treasury	Department of Public Service and Adminis-tration	External stakeholders
should include the costs of tests and feedback mechanisms.								
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. This plan should be aligned to the Hospital Revitalisation Grant.		2		1				
A detailed maintenance and equipment (asset management) plan must be developed, costed and implemented.		2		1		1		
Political involvement is critical to ensure that disputes between departments and/or municipalities do not result in crippling essential municipal services to health facilities.	1	2	1	2				1
Centralise the provincial IT system in the office of the Premier.			1	2	1			

Appendixes

1. APPENDIX 1: TERMS OF REFERENCE

1.1. PROJECT TITLE

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

1.2. BACKGROUND

1.2.1. The UK Government's Department for International Development (DFID) is providing technical assistance funding through a Rapid Response Health Fund (RRHF) to strengthen the office of the Ministry of Health and National Department of Health (NDOH) to achieve the objectives of the national HIV and AIDS and STIs strategic plan and strengthen its responsiveness and effectiveness in addressing key health priorities identified by the new Minister of Health, Barbara Hogan.

1.2.2. This is a 12 month programme which commenced in November 2008. HLSP (through its UK based DFID Health Resource Centre) has been contracted by DFID to manage the programme and to undertake procurement.

1.2.3. The key partner is the Ministry of Health (MOH), with selected clusters being supported at the National Department of Health (NDOH). This document provides Terms of Reference for the appointment of consultants to provide specialised technical assistance to newly proposed Integrated Support Teams (ISTs). The ISTs will comprise experts in Finance (sourced and engaged by Deloitte), Health Systems Strengthening (HSS), and Management and Organizational Development (M&OD) (these latter two consultancies sourced and engaged by HLSP). These teams will work at national and provincial levels to undertake a range of financial, managerial and health systems assessments. The selection and allocation of teams will take place collaboratively between the Ministry of Health, Deloitte, and HLSP.

1.2.4. Purpose of the IST Review

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

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

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

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

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

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

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

1.2.5. Aim and Scope of Work

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

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

1.2.5.2. Review Scope of Work for Finance Consultants

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

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

1.2.5.3. <u>Review scope of work for Health Systems Strengthening Consultants</u>

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

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

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

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

1.2.6. Project Phases

The project will be conducted in three phases:

1.2.6.1. Phase 1-National Team only

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

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

❒ Review the Conditional Grants and submit and present data analysis reports on the status of these grants by province.

❒ Review provincial IST reports and participate in the development of a consolidated IST report

❒ Based on the review, prepare a national final review report that will:

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

1.2.6.2. <u>Phase 2- Provincial Teams</u>

❒ Perform an analytical review based on the strategic and operational plans including budget (provincial-specific) and specifically comment on the following:

- Document recent trends in utilisation of services, and analyse this against costs
- Assess management and systems delivery to identify more efficient and effective options for delivery of services
- Assess systems factors that may have resulted in recent overspend, and suggest strategies for ensuring this is avoided in future.

- Consider health service implications of reductions in funding, and suggest mitigation strategies

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

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

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

1.3. IST PROJECT MANAGEMENT

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

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

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

1.3.1.3. Liaison with stakeholders – provinces and national

1.3.1.4. Management of provincial and district visits

1.3.1.5. Collating reports and finalizing the consolidated provincial reports.

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

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

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

1.4. ROLES AND RESPONSIBILITIES

1.4.1. Role of NDOH and Provincial DoH

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

1.4.2. Role of Consultants

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

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

1.5. EXPECTED OUTCOMES AND DELIVERABLES

1.5.1. This refers to both national and provincial ISTs.

1.5.1.1. Standardised provincial and national review templates

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

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

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

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

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

1.5.1.6. Oral presentations on the key findings of the review and roadmap to the MACH.

1.6. COMPETENCY AND EXPERTISE REQUIREMENTS

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

1.6.1.1. Leadership experience and people and technical management skills

1.6.1.2. Extensive experience and understanding of Finance, the effective integration and presentation of information from diverse sources, the Public Finance Management Act (PFMA) and provincial DoH with relevant qualifications and track record

1.6.1.3. Experience and understanding of South African public sector budgetary management systems

1.6.1.4. Computer literacy, good communication and writing skills

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

1.6.1.6. Operational and financial management of large projects and programmes

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

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

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

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

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

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

1.6.2.5. Operational and financial management of health projects and programmes

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

1.7. REPORTING REQUIREMENTS

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

1.8. TIMING AND SCHEDULING

1.8.1. The national review is commencing on the 26th January 2009, while the review of the pilot province is scheduled to commence on the 16th February 2009. Provincial and

consolidated final reports are expected to be submitted by the 1st May 2009. The oral presentations will be completed by the 8th May 2009.

1.8.2. All communications and queries about the terms of reference can be directed to: Kevin Bellis (Technical Manager) and Sphindile Magwaza (Technical Advisor) at HLSP: kevin.bellis@gmail.com and snkmagwaza@gmail.com respectively.

1.9. CONTRACTING AND INVOICES

1.9.1. Funding for the implementation of projects within the DFID –RRHF is secured from the UK Government Department for International Development (DFID). DFID has appointed a Procurement Service Provider, HLSP, to manage the appointment of Consultants and disbursement of consultancy and project funds.

1.9.2. HSS and M&OD consultants will be appointed on a contract issued by HLSP, the Procurement Service Provider, but will report to the IST coordinator (Deloitte) on a day to day basis. Deloitte will provide all Finance Consultants.

1.9.3. Invoices will be submitted to the HLSP for verification and authorisation in line with the HLSP Service Provider Handbook. Deloitte invoices and individual service provider invoices must be signed off by the CFO of the NDOH. The IST Coordinator is responsible for signing off on all consultant timesheets prior to submission to HLSP.

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

1.9.5. No payment will be made for extra work done out of the scope of the review or if the IST Coordinator and CFO are not satisfied with the standard of delivered outputs.

1.10. GENERAL INFORMATION

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

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

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

1.10.1.3. Experience in writing review or evaluation report

1.10.1.4. Availability within the review time frames

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

2. APPENDIX 2: LIST OF DOCUMENTS REVIEWED

2.1. Provincial Strategic Plan (2007/08)

2.2. MTEF (2008/09 – 2010/11)

2.3. Provincial Annual Reports (2005/06, 2006/07, 2007/08)

2.4. Annual Performance Plans (2006/07, 2007/08, 2008/09)

2.5. Strategic Transformation Plan (STP)

2.6. Budgets and Actual

2.7. 2006/07 (Annual report)

2.8. 2007/08 (Annual report)

2.9. 2008/09 YTD (IYM – February 2009)

2.10. Forecast, 2009/10, 2010/11, 2011/12

2.11. Annual Financial Statements 2006/07, 2007/08, 2008/09

2.12. IYM report (February 2009)

2.13. Auditor-General audit reports

2.14. North West Department of Health Human Resource Plan

2.15. Human Resource Policies

2.16. MTS Programme

2.17. NWDOH Organogram

2.18. NWDOH Departmental Instructions

2.19. Health Programme and Budget Plans

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

3. APPENDIX 3: SCHEDULE OF INTERVIEWS

Provincial Department Level

Name	Telephone	E-mail	Meeting
Human Resources Director			
Mr S Lenong	018-387 5699	Slenong@nwpg.gov.za	14 April 2009
Chief Financial Officer			
Mr A Kyereh	018-387 5749	Akyereh@nwpg.gov.za	14 April 2009
Head of Clinical Services/Health Services			
Dr A Robinson	018-387 5855	Arobinson@nwpg.gov.za	15 April 2009
Head of Security			
Mr L Mtsabe	018-387 5829	Lmtsabe@nwpg.gov.za	15 April 2009
Head of Department			
Dr L Sebego	018-387 5790	Lsebego@nwpg.gov.za	15 April 2009
Programme Director: MCWH			
Ms G Tsele	018-397 2683	Gtsele@nwpg.gov.za	15 April 2009
Programme Director: HIV			
Mr C Lebeloe	018-397 2668	Clebeloe@nwpg.gov.za	16 April 2009
Head of IT/M&E			
Mr Hendrick Metsileng	018-387 6749	Hmetsileng@nwpg.gov.za	16 April 2009
Acting CD: Pharmacy			
Mr T Mphaka	018-384 8124	Tmphaka@nwpg.gov.za	16 April 2009

District Level: Bojanala (Moretele Sub-District)

Name	Telephone	E-mail	Meeting
CEO (Rustenburg Hospital)			
Mr P Mokatsane	(014) 590 5401	pmokatsane@nwpg.gov.za	20 April 2009
Head: HR/Information Management (Bojanala District)			
Mr Mmusi	(014) 591 9700	emmusi@nwpg.gov.za	20 April 2009
Head: Finance (Bojanala District)			
Mr Laurence Gwabeni	(014) 591 9700	lgwabeni@nwpg.gov.za	20 April 2009
CEO (Klerksdorp/Tshepong Hospital)			
Ms K Wiebe-Randeree	(018) 406 4748	kranderee@nwpg.gov.za	21 April 2009
CEO (Jubilee Hospital)			
Ms D Magano	(012) 717 9301	damaria.magano@gauteng.gov.za	23 April 2009
Manager / Head: PHC (Moretele Sub-district)			
Mr D Baloyi	(012) 717 6399	dbaloyi@nwpg.gov.za	23 April 2009

4. APPENDIX 4: FINANCIAL TABLES REFERENCES

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

	R m Provincial Budget	Year on year increase	R m Health Budget	Year on year increase	% Allocation to Health	R m Adjustment Provincial Budget	R m Adjustment Health Budget	% Allocation to Health
2005/06	12 843 [3]	N/A	2 894 [4]	N/A	22.5%	13 529 [5]	2 987 [6]	22.1%
2006/07	14 400 [7]	12.12%	3 428 [8]	18.45%	23.8%	15 532 [9]	3 616 [10]	23.3%
2007/08	14 412 [11]	0.08%	3 755 [12]	9.54%	26.1%	15 558 [13]	3 917 [14]	25.2%
2008/09	16 938 [15]	17.53%	4 223 [16]	12.46%	24.9%	17 776 [17]	4 445 [18]	25.0%
2009/10	19 866 [19]	17.29%	4 919 [20]	16.48%	24.8%	N/A	N/A	N/A
2010/11	22 195 [21]	11.72%	5 579 [22]	13.42%	25.1%	N/A	N/A	N/A
2011/12	24 331 [23]	9.62%	6 055 [24]	8.53%	24.9%	N/A	N/A	N/A

[3] North West Province Budget Statement 2006/07, page 12
[4] North West Province Budget Statement 2006/07, page 12
[5] North West Province Budget Statement 2006/07, page 12
[6] North West Province Budget Statement 2006/07, page 12
[7] North West Province Budget Statement 2007/08, page 19
[8] North West Province Budget Statement 2007/08, page 19
[9] North West Province Budget Statement 2007/08, page 19
[10] North West Province Budget Statement 2007/08, page 19
[11] North West Province Budget Statement 2008/09, page 13
[12] North West Province Budget Statement 2008/09, page 13
[13] North West Province Budget Statement 2008/09, page 13
[14] North West Province Budget Statement 2008/09, page 13
[15] North West Province Budget Statement 2009/10, page xiii
[16] North West Province Budget Statement 2009/10, page 59
[17] North West Province Budget Statement 2009/10, page 59
[18] North West Province Budget Statement 2009/10, page 59
[19] North West Province Budget Statement 2009/10, page xiii
[20] North West Province Budget Statement 2009/10, page 59
[21] North West Province Budget Statement 2009/10, page xiii
[22] North West Province Budget Statement 2009/10, page 59

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

	R m Adjustment Provincial Budget (incl Grants)	R m Adjustment Conditional Grants	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	13 529 [25]	1 335 [26]	12 194	2 987 [27]	355 [28]	N/A	2 631	21.6%
2006/07	15 532 [29]	1 809 [30]	13 723	3 616 [31]	496 [32]	39.7%	3 120	22.7%
2007/08	15 558 [33]	2 411 [34]	13 148	3 917 [35]	523 [36]	5.4%	3 393	25.8%
2008/09	17 776 [37]	2 875 [38]	14 901	4 445 [39]	762 [40]	45.7%	3 683	24.7%

[23] North West Province Budget Statement 2009/10, page xiii
[24] North West Province Budget Statement 2009/10, page 59
[25] North West Province Budget Statement 2006/07, page 12
[26] North West Province Budget Statement 2006/07, page 10
[27] North West Province Budget Statement 2006/07, page 12
[28] North West Province Budget Statement 2006/07, page 10
[29] North West Province Budget Statement 2007/08, page 19
[30] North West Province Budget Statement 2007/08, page 16
[31] North West Province Budget Statement 2007/08, page 19
[32] North West Province Budget Statement 2007/08, page 16
[33] North West Province Budget Statement 2008/09, page 13
[34] North West Province Budget Statement 2008/09, page 11
[35] North West Province Budget Statement 2008/09, page 13
[36] North West Province Budget Statement 2008/09, page 76
[37] North West Province Budget Statement 2009/10, page xi
[38] North West Province Budget Statement 2009/10, page xi
[39] North West Province Budget Statement 2009/10, page xiii
[40] North West Province Budget Statement 2009/10, page 59

Table 3: National Conditional Grants to Provinces Adjustment Budgets

		R 000 Total Conditional Grant to Provinces	R 000 North West Provincial Allocation	% Allocation of National Grant
Comprehensive HIV & AIDS Grant	2005/06	1 150 108 [41]	100 921 [42]	8.8%
	2006/07	1 616 214 [43]	142 316 [44]	8.8%
	2007/08	2 006 223 [45]	156 429 [46]	7.8%
	2008/09	2 885 400 [47]	247 930 [48]	8.6%
National Tertiary Services Grant	2005/06	4 709 386 [49]	67 889 [50]	1.4%
	2006/07	4 981 149 [51]	69 380 [52]	1.4%
	2007/08	5 321 206 [53]	81 409 [54]	1.5%
	2008/09	6 134 100 [55]	118 433 [56]	1.9%
Total Conditional Grants to Provinces	2005/06	8 907 346 [57]	324 169 [58]	3.6%

[41] Estimates of National Expenditure 2008, page 279
[42] North West Province Budget Statement 2006/07, page 10
[43] Estimates of National Expenditure 2008, page 279
[44] North West Province Budget Statement 2007/08, page 16
[45] Estimates of National Expenditure 2008, page 279
[46] North West Province Budget Statement 2008/09, page 11
[47] Estimates of National Expenditure 2009, page 298
[48] North West Province Budget Statement 2009/10, page xi
[49] Estimates of National Expenditure 2008, page 279
[50] North West Province Budget Statement 2006/07, page 10
[51] Estimates of National Expenditure 2008, page 279
[52] North West Province Budget Statement 2007/08, page 16
[53] Estimates of National Expenditure 2008, page 279
[54] North West Province Budget Statement 2008/09, page 11
[55] Estimates of National Expenditure 2009, page 298
[56] North West Province Budget Statement 2009/10, page xi
[57] Estimates of National Expenditure 2008, page 279

Table 3: National Conditional Grants to Provinces Adjustment Budgets

		R 000 Total Conditional Grant to Provinces	R 000 North West Provincial Allocation	% Allocation of National Grant
	2006/07	10 206 542 [59]	496 364 [60]	4.9%
	2007/08	11 736 678 [61]	503 331 [62]	4.3%
	2008/09	14 362 800 [63]	721 901 [64]	5.0%

[58] North West Province Budget Statement 2006/07, page 10
[59] Estimates of National Expenditure 2008, page 279
[60] North West Province Budget Statement 2007/08, page 16
[61] Estimates of National Expenditure 2008, page 279
[62] North West Province Budget Statement 2008/09, page 11
[63] Estimates of National Expenditure 2009, page 298
[64] North West Province Budget Statement 2009/10, page xi

5. APPENDIX 5: CASE STUDY

5.1. KLERKSDORP/TSHEPONG COMPLEX RETENTION STRATEGY FOR HEALTH PROFESSIONALS

5.1.1. The KT Complex is managed by a strong, dedicated and involved management team, contributing their radiant pride, strong leadership and successes to the following:

5.1.1.1. Stable and strong top management team, most of whom have been in their posts for approximately 10 years.

5.1.1.2. Over time the KT Complex has developed a good work ethic and an organizational culture which places the patient at the centre of all that they do.

5.1.1.3. A culture of discipline, professionalism and continuous quality improvement has been inculcated through the leadership.

5.1.1.4. A core middle management which generally take ownership, pride, responsibility and accountability for their departments.

5.1.1.5. The complex management and staff members take pride in knowing that they are the safety net for the entire North West Province and are considered to be a centre of excellence in the North West Province.

5.1.1.6. The KT Complex has won numerous awards; has been recognized for best practice in HIV and MDR TB; has been granted full accreditation accredited by COHSASA for 3 years full accreditation. This recognition, often from organizations and bodies outside of the NWDOH, has contributed to the pride and commitment levels of the staff members.

5.2. PROJECT BACKGROUND

5.2.1. The North West Province does not have a tertiary hospital nor a medical school and is dependent on tertiary hospitals in Gauteng for tertiary services. The NWDOH wanted to change this scenario and Klerksdorp/Tshepong Hospital Complex has been identified by NDOH and NWDOH as a developing tertiary hospital.

5.2.2. Hence from 2000 efforts were put in place by Klerksdorp/Tshepong Hospital Management to develop various tertiary services. It was recognized that sustained tertiary services can only be provided by a team of health professionals led by competent medical specialists. Therefore, it was agreed that strategies needed to be put in place to attract and retain competent medical specialists. From this developed a strategy that not only focused on health professionals, but resulted in a comprehensive project that benefited the hospital and the community it serves as a whole.

5.3. MEDICAL PROFESSIONALS

5.3.1. The KT Complex began developing tertiary services from 2000 and funds were accessed through National Tertiary Services Grant (NTSG). The human resource side of the project was addressed by accessing funds through the Health Professions Training and Development Grant (HPTDG).

5.3.2. A memorandum of understanding was signed between Klerksdorp/Tshepong Complex and the University of the Witwatersrand Medical School in 2002, resulting in improved career pathing opportunities for the doctors. The relationship went from strength to strength and KT Complex achieved satellite status from the Health Professions Council of South Africa in 2007.

5.3.3. The KT Complex now has the best medical staff establishment in the province with more than one specialist in every major clinical department. These specialists are joint appointees with Wits Medical School. The complex trained more than 10 registrars in 2008, this increased to 15 in January 2009. One of the first registrars trained in the project completed her specialization and joined the complex as a senior paediatrician. Consultants from Wits visit all clinical departments on a regular basis

to assist local specialists in service delivery and training of medical staff. The complex has an excellent training programme and attracts doctors from across the province for training. Medical students from Wits also rotate through the complex. Junior doctors see this hospital now as a stepping stone to further specialist training and the hospital finds itself in an envious position of not having any difficulty to fill their internship and community service posts. The KT Complex trains 48 interns in the 2 year internship programme.

5.4. KEY RETENTION COMPONENTS

5.4.1. Benefits derived from linking to Wits

5.4.2. Dedicated accommodation arrangements and housing subsidies.

5.4.3. Facility contributes 50% to the cost of ACLS, APLS, ATLS and AMLS for health professionals who qualify.

5.4.4. In-hospital CPD programme sufficient to cover annual HPCSA requirements.

5.5. HOSPITAL WIDE APPROACH

5.5.1. Comprehensive orientation programme.

5.5.2. In hospital tutoring programme, in addition to CPD programme.

5.5.3. In hospital employee wellness programme, including dedicated staff OPD clinic and exercise programmes.

5.5.4. Initiatives to lighten the burden of staff, including the employment of caregivers through NGOs (receives training, signs a job description and works under direct supervision) and the Retired Nurses Project (retired nurse professionals, identified by way of distinctive clothing and deployed at “hotspots”, i.e. pharmacy, admissions, OPD and Radiology to assist with queue management, the elderly and disabled and policy and protocol interpretation).

5.6. FUNDING

5.6.1. The project is mainly funded from the ring fenced HPTDG and NTSG grants.

5.7. CHALLENGES

5.7.1. Unfortunately many of the benefits apply only to the medical professionals, as there is no similar funding dedicated for the recruitment, retention and training of nurses and other health professionals. Ironically the complex now has a good doctor component, but still a severe shortage of nurses, radiology and pharmacy staff to complement them.

5.7.2. Similar funding, specifically for the recruitment, retention and training of the other categories of health workers is essential. It is important to prioritise the other categories of health workers in the way that doctors have been prioritized.