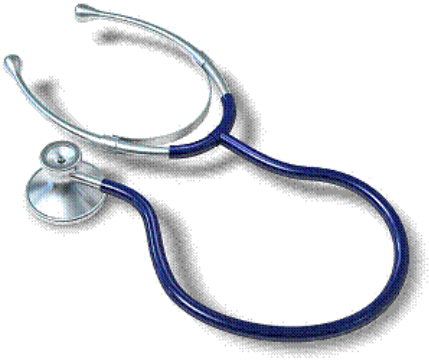
Northern Cape Department of Health

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 Northern Cape Department of Health.

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Abbreviations

AFS	Annual Financial Statements
AIDS	Acquired Immunodeficiency Syndrome
AMS	Air Mercy Services
APP	Annual Performance Plan
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BAS	Basic Accounting System
CCMT	Comprehensive Care Management and Treatment
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHC	Community Health Centre
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
DoRA	Division of Revenue Act
DPSA	Department of Public Service and Administration
EMS	Emergency Medical Services
HIS	Health Information System
HISP	Health Information System Project
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HOPS	Head of Pharmaceutical Services
HPTD	Health Professional Training and Development
HR	Human Resources
HRD	Human Resource Development
HRP	Hospital Revitalisation Programme
HSS	Health Systems Strengthening
HST	Health Systems Trust
ICU	Intensive Care Unite
IDIP	Infrastructure Deliver Improvement Programme

IHPF	Integrated Health Planning Framework
IST	Integrated Support Teams
IT	Information Technology
IYM	In Year Monitoring
KZN	KwaZulu-Natal
M&E	Monitoring and Evaluation
M&OD	Management & Organisational Development
MACH	Ministerial Advisory Committee on Health
MCH	Maternal and Child Health
MCWH	Maternal, Chield, Women's Health
MDG	Millenium Development Goals
MEC	Member of the Executive Council
MoH	Minister of Health
MPH	Masters in Public Health
MSH	Management Sciences Health
MTEF	Medium Term Expenditure Framework
N/A	Not available/ not applicable
NCDOH	Northern Cape Department of Health
NDOH	National Department of Health
NGO	Non-Governmental Organisation
NHLS	National Health Laboratory Services
NTSG	National Tertiary Services Grant
OD	Organisational Development
OSD	Occupational Specific Dispensation
PCR	Polymerase Chain Reaction
PERSAL	Personnel and Salary Administration System
PFMA	Public Finance Management Act
PHC	Primary Health Care
PMTCT	Prevention of Mother-To-Child-Transmission
RACI	Responsible, Accountable, Consulted, Informed
RRHF	Rapid Response Health Fund
SCM	Supply Chain Management
SCOPA	Stancing Committee on Public Accounts
STI	Sexually Transmitted Infection
STP	Service Transformation Plan

TB	Tuberculosis
TR	Team Representative
UWC	University of Western Cape
WHO	World Health Organization

Foreword

This 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 Northern Cape has several unique features which pose specific challenges for the delivery of services. It has the smallest population of the nine provinces - 1.1 million in 2008 or 2.3% of total population - but has the largest surface area - 360 000 square kilometres or 29.7% of the country's surface area. The capital, Kimberley has a population of approximately 300,000, with the remaining population scattered in small towns and settlements across a vast geographical area. The distance between a primary health care facility and the next level of care can be up to 200km. The size of the province and low population density make the task of ensuring equitable access to services complex and costly, and services may seem less efficient than in other provinces where economies of scale are more possible. This is compounded by the fact that because of its small population and relatively low budget, the size and seniority of management structures in the provincial health department have historically not been sufficient to enable it to discharge its responsibilities. Repeated poor Auditor-General reports can be ascribed to a severe lack of capacity (costs and skills) in the finance divisions of the department. Solutions to the problems and issues raised in the Northern Cape have to recognise these specific features and challenges.

Responsibility for implementation of recommendations outlined in this report lie at a number of levels: within the NCDOH, in other provincial departments and at national level. They include political/ministerial interventions as well as actions in other government departments such as the National Treasury, Provincial Treasury, Department of Public Service and Administration and the National Department of Health.

This report contains the findings and recommendations of the Integrated Support Team (IST), set up by the Minister of Health. We found many committed managers, with much of the foundation for a well-performing health system in place. A comprehensive and wide range of services are available to the people in the Northern Cape and there is a lot of goodwill to contribute to change and implement ongoing health system transformation policies. The report also identified shortcomings, ranging from strategic and operational planning, through to

financial management and monitoring and evaluation. Certain solutions fall within the ambit of the Northern Cape Department of Health. It should also be noted that the concluding section contains a detailed set of recommendations for health system improvement, including the responsibility of key stakeholders, many who are outside the NCDOH.

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

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

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

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

1. Expenditure by the NCDOH remained within its budget of R1.8 billion for the 2008/09 financial year. However, this was achieved by implementation of stringency measures towards the end of the financial year that involved severely curtailing non-essential expenditure (while protecting essential items such as drug supplies), withdrawal of already limited financial delegations, delays in the payment of suppliers, and a large

carry-over of accruals into the 2009/10 financial year – not reflected in the current cash-based reporting system.

2. Budgeting, supply chain management and financial management processes including monitoring and evaluation are sub-optimal.

3. There is a need for improved efficiency throughout the NCDOH and inefficiencies within the NCDOH must be addressed before the true extent of underfunding of the NCDOH can be identified.

4. The 2014 Health Vision, developed in 2006, is no longer adequate as a strategic guiding document. A Service Transformation Plan provides the best articulation of strategic direction but still requires approval and popularisation. Annual Performance Plans are developed and monitored in quarterly review meetings, but are still not linked to budgeting or district planning. In general, capacity for needs identification, priority setting and planning is low.

5. Because of its small population size and budget, the NCDOH provincial health department has historically been underdeveloped and is battling a legacy of blurred reporting lines, inadequate managerial systems and poor accountability.

6. There is excessive centralisation of human resource, financing, planning and budgeting functions, widely viewed as constraining potential efficiency gains and impacting negatively on service delivery.

7. The current HOD has been in position for 18 months. He is credited by managers with bringing new leadership and direction in the NCDOH – with respect to both service delivery and managerial systems.

8. Ensuring equitable access to primary health care and hospital services is a challenge in the Northern Cape. Vast distances and small catchment populations make economies of scale difficult to achieve. District hospitals in the province are generally small and have the highest costs per patient day equivalent in the country. The STP makes proposals for the rationalisation of this sector. Greater attention is also required to improving the governance and management of district hospitals.

9. The functioning of the district health system varies considerably across the province; support to districts and the primary health care system from the provincial level is inadequate.

10. The Northern Cape has a smaller burden of HIV, in relative and absolute terms, than other provinces. ART coverage rates, relative to need appear to be high, although existing sites are saturated and further growth in the programme will require decentralised and nurse-based models of care. National accreditation requirements are still not aligned to new models and urgently require revision.

11. Following targeted action, TB cure rates showed impressive improvements, then a decline again over the last year. The province has had a high number of maternal deaths, a problem that is of serious concern. However, with respect to both TB and maternal health, the identification of a problem is not followed by clear analysis of causes or rapid remedial action.

12. Of the 9,267 posts in the PERSAL staff establishment, 5,551 are filled. However, the PERSAL dataset is outdated and needs to be cleaned to reflect funded posts. Based on the Integrated Health Planning Framework (IHPF) norms, the STP proposed a staff establishment of 6,924 for the NCDOH.

13. The implementation of the OSD was viewed as highly problematic in the province. R16.6 million in extra funds were received but the cost of implementation was R40 million in 2007/08.

14. Recruitment and retention of staff are key challenges in the Northern Cape given its rural nature.

15. Information systems and monitoring and evaluation need urgent improvement. Health information systems capacity is low, data collection systems are poorly designed and fragmented and there is a poor culture of information use.

16. The maintenance function is severely under funded relative to the funding of revitalisation (new infrastructure), and is a source of major frustration at service delivery level.

In line with these priority findings, the key recommendations for the Province are as follows:

1. Finalise the approval of provincial and district organograms, and ensure minimum human capacity, especially for financial management.

2. Decentralise authority and responsibility, in particular for human resource, finance and supply chain management, to the five districts, Kimberley Hospital, and provincial programmes, by allocating budgets, finalising policy on delegations, and instituting budget and performance monitoring systems.

3. Improve the accountability of middle and senior managers by implementing more rigorous performance management and monitoring systems.

4. Align planning and budgeting processes:

   - ❒ Link budgets to Annual Performance Plans (APP) and quarterly monitoring
   - ❒ Link district planning to APPs
   - ❒ Recommendations made in the Service Transformation Plan should be incrementally included in APPs
   - ❒ Finalise 5-year Strategic Plans

5. Implement strategies to improve the quality and use of health information.

6. Establish clinical quality assurance mechanisms in level 1 hospitals, and improve doctor support to PHC in rural areas.

7. Finalise departmental administrative and service delivery policies and procedures and strengthen internal control functions.

8. Increase budgeting for facility maintenance to acceptable norms.

Additional detailed recommendations are provided in individual sections of the report.

Introduction

1. BACKGROUND

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

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

2. AIMS OF THE ISTs

2.1. THE AIMS OF THE ISTs ARE TO:

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

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

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

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

3. SPECIFIC OBJECTIVES

3.1. THE SPECIFIC OBJECTIVES OF THE ISTS WERE TO:

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

3.1.2. Examine the alignment between:

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

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

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

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

4. METHODOLOGY

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

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

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.

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

4.4. In-depth interviews were conducted with 14 senior managers at the provincial level and six managers in the John Taolo Gaetsewe District. This district was formed in 2007 from the amalgamation of the former Kgalagadi District and Moshaweng Sub-District of the North-West Province. It was chosen because it is a presidential priority node. The interviews were conducted by a team of three consultants who visited the Northern Cape Province between the 14th and the 24th of April 2009. The list of people interviewed is shown in Appendix 3. The report combines the findings from these interviews and the documentation provided. It does not include any viewpoints of the NDOH, or other provincial players such as the minister or Treasury.

5. OUTLINE OF THE REPORT

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

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

the catalyst for the IST review. As over-spending is an indicator of broader systemic challenges, the remainder of the sections focus on the assessment of other key building blocks of the health system, i.e. Leadership, Governance and Service Delivery, Human Resources, Information Management, Medical Projects, Laboratory and Technology and Infrastructure. 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 NCDOH budget and expenditure reports, National Treasury reports and interviews with NCDOH 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. When conditional grants are excluded, the allocation of provincial budget to health was 22% in 2008/09 but is expected to increase to 23.5% in 2011/12.
2. The per capita budget on health in the NCDOH is set to increase considerably over the MTEF.
3. Although the NCDOH has had a history of over spending, it stayed within budget in 2007/08 and is projected to stay within budget in 2008/09, mostly due to under spending on infrastructure development.
4. The NCDOH is expecting an under spend of R24 million for the 2008/09 financial year, should accruals be taken into account.
5. Inefficiencies within the NCDOH must be addressed before the true extent of underfunding of the NCDOH can be identified.
6. During the course of 2008/09 the department temporarily centralized finances in order to prevent an over expenditure and to obtain an accurate picture of accruals at district and facility levels.
7. The department continues to receive disclaimers of opinion from the Auditor-General, due to, amongst others, weaknesses in internal controls, governance and legislative compliance.
8. The budgeting process is centralised and top down and not linked to other forms of planning.
9. Financial management processes are negatively affected by a lack of appropriate staff, skills and policies and procedures in the finance division.
10. Monitoring mechanisms in the NCDOH are insufficient and ineffective in controlling

Box 1: Key findings from the financial review

and monitoring expenditure.

11. Quarterly Performance Monitoring processes do not link budgets and expenditure to Annual Performance Plans.

2. UNDERFUNDING OF THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA

2.1. The IST has consistently been confronted by the assertion that the main cause of the difficulties being experienced by the public health system nationally is due to under-funding of the system with consequent “unfunded mandates”.

2.2. The IST is in the process of investigating this assertion on a national basis. This will also include an assessment regarding the conditional grants awarded to the NCDOH in respect of the two tracer programmes identified, being the HIV/ Aids conditional grant and the NTSG.

3. PROVINCIAL BUDGET ALLOCATION

3.1. The allocation of the Northern Cape Province’s budget to the NCDOH is shown in Table 1. The allocation includes the equitable share, conditional grants and provincial revenue. One quarter (25.78%) of the total provincial revenue was allocated to health in the 2007/08 financial year and is projected to increase to 28.22% over the MTEF period up to 2011/12.

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	5 048		941		18.64%	5 320	1 037	19.49%
2006/07	4 395	-12.94%	1 291	37.19%	29.37%	4 510	1 316	29.18%
2007/08	5 663	28.85%	1 460	13.09%	25.78%	5 899	1 580	26.78%
2008/09	6 689	18.12%	1 774	21.51%	26.52%	7 062	1 857	26.30%
2009/10	7 941	18.72%	2 214	24.80%	27.88%	N/A	N/A	N/A
2010/11	8 788	10.67%	2 533	14.41%	28.82%	N/A	N/A	N/A
2011/12	9 516	8.28%	2 685	6.00%	28.22%	N/A	N/A	N/A

3.2. In interpreting these figures it is important to note the following:

3.2.1. The percentage allocation for Health 2005/06 is not comparable in this trend due to transfer of the Social Security function from provinces to the South African Social Security Agency (SASSA) from 2006/07 onwards, resulting in a decrease in the Northern Cape's total budget, and changes in the ratios of allocations to sectors.

3.2.2. When conditional grants are excluded, the provincial equitable share allocation to health remains relatively constant around 22%, with a projected increase to 23.5% over the MTEF (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	5 320	2 018	3 302	1 037	318	N/A	719	21.77%
2006/07	4 510	952	3 557	1 316	561	76.42%	755	21.23%
2007/08	5 899	1 161	4 738	1 580	553	-1.43%	1 027	21.68%
2008/09	7 062	1 398	5 664	1 857	600	8.50%	1 257	22.19%
2009/10	7 941	1 778	6 163	2 214	788	31.33%	1 426	23.14%
2010/11	8 788	2 056	6 732	2 533	954	21.07%	1 579	23.45%
2011/12	9 516	2 261	7 255	2 685	979	2.62%	1,706	23.51%

4. NATIONAL CONDITIONAL GRANT ALLOCATION

4.1. The comprehensive HIV/AIDS and National Tertiary Services Grants (NTSG) were used as tracers to assess trends in the allocation of conditional grants to the NCDOH (Table 3). The relative proportion of the national conditional grant for HIV/AIDS allocated to the NCDOH has been decreasing, from 4.58% in 2005/06 to 3.17% in 2008/09 but is expected to increase marginally over the MTEF to 3.64% in 2011/12. However, the proportion of the HIV /AIDS grant is still slightly higher than the Northern Cape proportion of the total population (around 2.3%)[3].

4.2. The NCDOH share of the National Tertiary Services Grant increased from 1% in 2005/06 to 2.5% in 2008/09 and the increase is expected to continue over the MTEF reaching 3% in 2011/12. The proportion of the total conditional grant received by the NCDOH was well above the provinces' relative population proportion.

Table 3: National Conditional Grants to Provinces and NCDOH share

		R 000 Total Conditional Grant to Provinces	R 000 NCDOH Provincial Allocation	% Allocation of National Grant
Comprehensive HIV & AIDS Grant	2005/06	1 150 108	52 638	4.58%
	2006/07	1 616 214	72 682	4.50%
	2007/08	2 006 223	74 091	3.69%
	2008/09	2 885 400	91 444	3.17%
	2009/10	3 476 200	113 703	3.27%
	2010/11	4 311 800	157 150	3.64%
	2011/12	4 633 000	168 559	3.64%
National Tertiary Services Grant	2005/06	4 709 386	76 353	1.62%
	2006/07	4 981 149	92 286	1.85%
	2007/08	5 321 206	110 775	2.08%
	2008/09	6 134 100	153 567	2.50%
	2009/10	6 614 400	173 241	2.62%
	2010/11	7 398 000	225 948	3.05%
	2011/12	7 799 000	238 964	3.06%
Total Conditional Grants to	2005/06	8 907 346	295 065	3.57%

[3] STATS SA Mid Year Estimates 2008

Table 3: National Conditional Grants to Provinces and NCDOH share

		R 000 Total Conditional Grant to Provinces	R 000 NCDOH Provincial Allocation	% Allocation of National Grant
Provinces	2006/07	10 206 542	548 887	5.50%
	2007/08	11 736 678	515 955	4.40%
	2008/09	14 362 800	566 029	3.94%
	2009/10	15 578 400	705 632	4.53%
	2010/11	18 012 800	887 986	4.93%
	2011/12	19 172 000	908 165	4.74%

5. TOTAL BUDGET PER CAPITA

5.1. The budget per capita for the NCDOH was calculated using Statistics South Africa mid-year estimates and reduced with the insured population according to the STATS SA General Household Survey (Table 4). The nominal budget per capita has increased, and is expected to increase at a rate in excess of inflation over the MTEF. This per capita budget is well above the national average.

Table 4: Northern Cape provincial vs national trends in per capita health budget

	Uninsured national population	R m Total of provincial budgets	R Uninsured per capita	Year on year increase	Uninsured provincial population	R m Provincial budget	R Uninsured per capita	Year on year increase
2005/06	40,323,852	47,147	1,169		761,541	1,037	1,362	
2006/07	40,898,347	53,175	1,300	11.20%	946,743	1,316	1,390	2.10%
2007/08	41,007,279	60,812	1,483	14.06%	937,972	1,580	1,684	21.15%
2008/09	41,725,016	73,581	1,763	18.92%	958,141	1,857	1,939	15.09%
2009/10	41,725,016	82,359	1,974	11.93%	958,141	2,214	2,310	19.18%
2010/11	41,725,016	91,999	2,205	11.70%	958,141	2,533	2,644	14.44%

6. TRENDS IN HEALTH EXPENDITURE

6.1. The NCDOH overspent its budget in 2005/06 and 2006/07, but stayed within budget in 2007/08 and is projected to do so again in 2008/09. The preliminary March 2009 IYM report reflects an anticipated under spending of R109.350 million for 2008/09 (Table 5). The programmes that are expected to significantly contribute to the under-spend are Health Facilities Management (R77.4 million) and District Health Services (R38 million) while Emergency Medical Services will overspend by R8.5 million.

6.2. In terms of economic classification the underspend occured in payments for capital assets (R105.4 million), particularly in buildings and other fixed structures (R92.5 million), due to non-completion of the building programme, and compensation of employees (R57 million), due to staff vacancies. Goods and services are expected to be overspent by R52.3 million.

6.3. The NCDOH underspent its budget by R109 million in the 2008/09 financial year (based on the preliminary March 2009 IYM report). However, this was partly accounted for by the fact that a sum of R96 million (representing the “surrender” of the underspend on the revitalisation grant in 2007/08) was erroneously categorised as an expenditure by the Provincial Treasury, thereby reducing the available funds during 2008/09. This situation was detected late in the financial year and up until March 2009 Treasury’s cash flow projections (IYM report) were indicating an overspend in the health department.

6.4. Due to the continuous reported overspend, the NCDOH introduced stringency measures from October 2008 that included curtailing non-essential expenditure (while protecting essential items such as drug supplies), withdrawal of financial delegations, delays in the payment of suppliers, and a carry-over of expenditure into the 2009/10 financial year.

6.5. During the preparation process of the financial reports of March 2009 the erroneous deduction of R96 million, referred to above was identified. The late detection of the error was a major contributor to the underspend in the captal and infrastructure expenditure. A further consequence of this error is that the balance of accruals could have been processed in 2008/09. This error should have been picked up much earlier,

and again highlights the problem of poor financial monitoring and controls in the NCDOH. Monthly cash flow reconciliations are not done as it is considered a year-end activity.

6.6. The surplus/(deficit) per the Appropriation Statements has been adjusted by the IST team to take into account the increase in the accruals outstanding at year-end (i.e. accounts payable). This has been done to better align the operational activity with actual payments of expenses made (e.g. medication utilised prior to year-end and only paid after year- end).

6.7. The year-end accruals figure is estimated to be around R130 million, although the list is still incomplete. During the course of 2008, a restructured finance division made a concerted effort to receive all outstanding invoices from districts, programmes and facilities. Some of the outstanding invoices received date back as far as 2007.

6.8. Trends in accruals are shown in Table 5 below. However, any conclusion on trends up to 2008/09 should, be reserved until the financial statements have been finalised.

Table 5: Trends in NCDOH 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	-58,762	-90,866	23,399	109,350
(Increase)/decrease in accruals payable	-18,952	8,870	-11,100	-85,026
Surplus/(deficit) adjusted for movement in accruals	-77,714	-81,996	12,299	24,324
Balance of accruals at year-end	42,823	33,953	45,053	130,079

6.9. The NCDOH has had qualified audit reports since 2003/4. This is a source of major concern in the department and indicates a situation of ineffective management and poor financial controls. The main areas highlighted by the Auditor-General are indicated in Table 6 below. Sources of over (unauthorised) expenditure are most frequently in goods and services (see also Table 7), such as drugs, laboratory services, medical gasses, transport, and security. The “emphases of matter” leading to successive “audit disclaimers” include weaknesses in internal controls, governance and legislative compliance.

6.10. According to the NCDOH finance department unauthorised expenditure in 2008/09 is expected to drop to R12 million, from a high of R92 million in 2007/08. Poorly designed and managed external contracts were seen as the most obvious source of fruitless or wasteful expenditure in the NCDOH. Specific ones mentioned were:

6.10.1. Oxygen manufacturing plant

6.10.2. Photocopy contract

6.10.3. Imperial (fleet) contract

6.10.4. Security contract.

Table 6: Summary of audit outcomes of Northern Cape Department of Health: 2003/04- 2007/08

	2003/04	2004/05	2005/06	2006/07	2007/08
AUDIT OPINION	❒ Disclaimer	❒ Disclaimer	❒ Disclaimer	Disclaimer	Disclaimer
UNAUTHORISED EXPENDITURE	❒ (141,599)	❒ (16,360)	❒ (76,295)	(181,818)	(92,073)
AREAS OF OVER-EXP & REASONS	❒ Telephone cost ❒ Pharmaceutical Stock ❒ Motor fleet services	❒ Pharmaceutical Stock	❒ Pharmaceutical Stock ❒ Machinery & equipment	Performance bonuses Laboratory services Outreach services Security services Government motor transport	Pharmaceuticals Medical gasses Administration Transport Patient Food Laboratory services
EMPHASIS OF MATTER	❒ Suspense Accounts ❒ PERSAL interface into BAS ❒ Unauthorised Expenditure ❒ Weakness in internal control ❒ Disclosure (Contingent liabilities, Leases) ❒ Unauthorized expenditure ❒ Weakness in internal control ❒ Cash management ❒ Patient fee management ❒ Expenditure management ❒ Assets management ❒ Stock management ❒ Personnel	❒ Unauthorised Expenditure ❒ Weakness in internal control	❒ Patient fee management ❒ Income and receipting ❒ Compensation of employees ❒ Payment for goods and services ❒ Subsistence and travelling ❒ Assets ❒ Inventory ❒ Journals ❒ Budget ❒ Transfer payments ❒ Rental income ❒ Oxygen unit procured ❒ Division of Revenue Act ❒ Non- compliance with laws and regulations ❒ Internal audit function ❒ Performance information	Internal control (revenue system) Non compliance with Income tax Act, 1997, Treasury regulation and PFMA Other audit investigations (Premiers commission, Infrastructure and conflict of interest Internal control and subsequence event. Value for money (HIV AIDS Grant, Hospital Revitalization, Forensic services and Delays in the Finalization of the audit	Unauthorised and irregular expenditure Material underspending of the budget Restatement of irregular expenditure Non-compliance with PFMA and Treasury regulation

Table 6: Summary of audit outcomes of Northern Cape Department of Health: 2003/04- 2007/08

	2003/04	2004/05	2005/06	2006/07	2007/08
	management ❒ Information system audit ❒ No approved policies and SCOPA ❒ Donor fund ❒ Non-compliance with laws and regulations ❒ Internal control audit function				

6.11. In response to the Auditor-General's reports, Provincial Treasury began implementing a turn-round strategy in 2007 that has effected an increase in the staffing of financial divisions within the NCDOH, stricter control over cash flow, and the appointment of short-term contract workers to process outstanding invoices.

6.12. With the exception of 2006/07, expenditure on compensation of employees has remained within budget (Table 7). Expenditure on personnel (compensation of employees) has remained at 50% or lower of total expenditure from 2005/06 to 2007/08. This appears relatively low for a service organisation and could be due to unfilled posts. However, filling these posts without additional funding, will add pressure on the NCDOH's budget going forward.

Table 7: 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 Expen-diture**	**Variance**	**Final Appro-priation**	**Actual Expen-diture**	**Variance**	**Final Appro-priation**	**Actual Expen-diture**	**Variance**
Administration	57 584	56 491	1 093	60 915	67 446	(6 531)	66 803	66 733	70
District Health Services	432 234	421 305	10 929	510 966	526 246	(15 280)	722 108	763 508	(41 400)
Emergency Medical Services	69 178	72 688	(3 510)	74 214	105 816	(31 602)	92 459	87 487	4 972
Provincial Hospital Services	292 933	295 230	(2 297)	308 030	336 294	(28 264)	379 067	401 171	(22 104)
Central Hospital Services									
Health Sciences and Training	26 694	26 749	(55)	30 581	30 584	(3)	23 241	23 146	95
Health Care Support	18 598	87 809	(69 211)	7 290	99 641	(92 351)	8 170	13 905	(5 735)
Health Facilities Management	140 592	136 303	4 289	324 374	241 209	83 165	288 145	200 644	87 501
Special functions									
Internal charges									
Total	**1 037 813**	**1 096 575**	**(58 762)**	**1 316 370**	**1 407 236**	**(90 866)**	**1 579 993**	**1 556 594**	**23 399**
Economic classification									
Compensation of employees	528 014	522 587	5 427	590 828	620 972	(30 144)	793 238	786 437	6 801
Goods and services	309 547	383 090	(73 543)	415 040	458 858	(43 818)	428 560	518 118	(89 558)
Financial transactions in assets and liabilities		984	(984)		200	(200)			
Transfers and subsidies	24 682	20 071	4 611	28 641	28 891	(250)	27 967	24 592	3 375
Buildings and other fixed structures	135 998	126 696	9 302	234 880	215 373	19 507	287 943	212 913	75 030
Machinery and equipment	39 572	43 147	(3 575)	46 981	82 942	(35 961)	42 285	14 534	27 751
Total	**1 037 813**	**1 096 575**	**(58 762)**	**1 316 370**	**1 407 236**	**(90 866)**	**1 579 993**	**1 556 594**	**23 399**

Source: Applicable Province Budget Statement 2006/07, Applicable Province Budget Statement 2007/08, Applicable Province Budget Statement 2008/09, Annual reports of various financial years.

7. UNFUNDED MANDATES DURING 2008/09

7.1. Unfunded mandates are changes in policies or operational requirements resulting in additional expenditure for which provision has not been made in the approved provincial budget. Those in the NCDOH identified by informants during the review included:

7.1.1. Occupation specific dispensation (OSD): The NCDOH received R16 million for OSD in 2007/08, whilst the implementation thereof amounted to R40 million.

7.1.2. Top down directives from NDOH. For example, the NDOH provided money for the introduction of the new vaccines as an adjustment budget, but additional costs such as fridges and generators for clinics with no electricity were not considered.

7.2. When interviewees were asked about “unfunded mandates”, they were more likely to refer to inefficient or wasteful expenditure on external contracts entered into by the NCDOH, than to nationally imposed mandates. It was believed that inefficiencies within the NCDOH should be addressed before the true extent of underfunding could be determined.

8. BUDGETING PROCESS

8.1. The current budgeting process is top-down in which divisions are allocated amounts based on historical patterns. At the time of review (three weeks into the new financial year), programme, hospital and district managers had not yet received notice of their budgets for 2009/10, let alone provided input into these budgets.

8.2. The consequence of this is that middle and senior managers do not prioritise or manage spending.

8.3. Issues pertaining to the budget process raised by managers highlighted the following:

8.3.1. Programme managers are not seen as budget holders and do not see finance related matters as their responsibility.

8.3.2. Divisions do not actively manage their expenditure and some are not even aware of their allocated budgets.

8.4. The APP has never been linked to the budget and there are no specific budget monitoring tools and processes, apart from the IYM system to monitor budgets.

8.5. In future, it is envisaged that the budget process will be bottom-up starting with programme managers. A budget manager is being appointed to support the process and training will be provided.

8.6. One senior manager expressed the following views regading the budget process and related funding as follows:

> *"In the Northern Cape we don't know how to use our budgets - my feeling is that we may in fact not be under-funded – but just not be spending our money wisely and effectively. The problem is that the provincial health head office does not consult with us - the end users – we know what we need, what the costs are and where we can save perhaps. Would prefer it if we could control expenditure ourselves – we are also capable to answer to treasury and to manage aspects of the audit."*

8.7. Several interviewees, including the HOD were of the opinion that there was scope for greater efficiencies in management of the current budget, and in the light of this it was hard to argue for more resources from the equitable share.

8.8. On the other hand, another manager felt that the absence of financial or health economic expertise had prevented the NCDOH from ascertaining its true needs. The STP provided the "scientific information" to make a case for more funding to the Provincial Treasury.

9. FINANCIAL MANAGEMENT PROCESSES

9.1. Poor financial management in the NCDOH resulted in the centralisation of finances and supply chain management to the Provincial DOH. A process of evaluating the finance management capacity of districts and facilities is now underway, and facilities that are “managing well” will have decentralised responsibilities in the next financial year. In addition, finance managers are to be appointed in key facilities such as Kimberley Hospital.

9.2. The policy division has developed drafts of missing policies as highlighted in the Auditor- General’s report. A policy management committee has been set up and members meet regularly to identify gaps. However, the approval of policies has proved difficult and most still remain in draft form.

9.3. Variance analysis is poorly and irregularly done. Divisions are not routinely provided with reports, although districts and the larger hospitals (e.g. Kimberley) reportedly do request financial reports monthly from the province, thereby allowing them to track expenditure against budget. However, variances are only reported at the item (e.g. goods and services) rather than programme (districts and hospitals) level. As a result, individual programmes are unable to manage expenditure according to anticipated activities during the course of the year. This has particular implications for programmes with ring-fenced funding such as HIV/AIDS, who are unable to incur expenditure for an item, if the rest of the NCDOH has overspent in this category.

9.4. It was noted as an example that contracts with external suppliers such as oxygen manufacturing plant contract, INTAKA, entered into by previous NCDOH management resulted in expenditure pressures. The management of such contracts is therefore a financial management concern.

10. CONDITIONAL GRANTS

10.1. Reporting as envisaged by the Division of Revenue Act (DORA) in respect of conditional grants is not up to date and sub-optimal. Due to the lack of proper reporting on conditional grants during the financial year, it may lead to an underspend

on conditional grants as the financial reports incorrectly reflect overspending during the year, whilst in fact the NCDOH is underspending thereon.

10.2. Apart from the Henrietta Stockdale Nursing College, the NCDOH does not run health training institutions. The conditional grant for Health Professional Training and Development Grant (HPTDG) is used to fund bursaries for undergraduate and post graduate training.

11. QUARTERLY PERFORMANCE REPORTS

11.1. NCDOH has a team that reviews performance by having quarterly meetings. It is comprised of the department's management team, the hospital CEOs, middle managers with strategic functions and district managers. Performance reports are submitted and interrogated. However, financial information is not incorporated into these quarterly review processes, or directly linked to the performance data.

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. The purpose of the IYM is to highlight expenditure, actual and forecasts. However, it does not take into account accruals, which means the expenditure reflected may be understated. The IYM is therefore not an effective management tool to prevent over expenditure and accurately reflect expenditure incurred. Table 5 above shows clearly the effect on the year-end surplus/ (deficit) when accruals are included.

12.3. The annual financial statements, while meeting Constitutional and Government accounting requirements, do not go beyond a cash basis of reporting, to include accruals as part of reported, aggregated expenditure numbers.

13. MONITORING STRUCTURES

13.1. The Auditor-General has raised a number of matters relating to finance monitoring structures in the NCDOH. The internal audit function, which is a Shared Internal Audit

Service: Social Cluster has not substantially fulfilled its responsibilities and the prior year's external audit recommendations and SCOPA resolutions are often not implemented. Furthermore, there is no budget committee in the province, although plans are being made to institute same in the 2009/10 financial year.

14. RECOMMENDATIONS

14.1. PROVINCIAL HEALTH BUDGET ALLOCATION

14.1.1. Treasury should allocate an amount to the NCDOH which is substantially in line with the equitable share indicated by the National Treasury in the national budget.

14.2. UNFUNDED MANDATES

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

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.

14.3.2. Operational units should prepare zero-based budgets. Therefore when funds are allocated, the extent to which service delivery may be impacted will be known and shortfalls highlighted.

14.3.3. The STP should be re-evaluated taking cognisance of the available budget. The evaluation should include the quantification of all inefficiencies, and measures taken to address these.

14.3.4. Virements should reflect operational activity and not a process of balancing over and under expenditure. The current system of December/January virements to shift the money to cover other areas should be abolished.

14.4. FINANCIAL MANAGEMENT

14.4.1. All service contracts (such as water purification and oxygen supply) need to be reviewed and managed so as to remove sources of wasteful and fruitless expenditure.

14.4.2. Finance skills must be improved and finance and supply chain management functions decentralised.

14.4.3. Outstanding policies and procedures must be drafted and approved, in line with audit recommendations.

14.4.4. Variance analysis must be improved to assist with the following:

14.4.4.1. produce budget projections;

14.4.4.2. review expenditure;

14.4.4.3. identify high cost items (not within the norm);

14.4.4.4. identify areas that could possibly exceed the budget; and

14.4.4.5. compare expenditure across sub-districts.

14.4.5. Contracts management should be improved in order not to inappropriately bind the department in inefficient and wasteful expenditure over long periods of time.

14.5. QUARTERLY PERFORMANCE REPORTS

14.5.1. The accuracy of performance information needs to be improved in line with the recommendations of the Auditor-General.

14.5.2. There needs to be a link between performance and financial reports.

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).

14.7. 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.

Leadership, Governance and Service Delivery

1. INTRODUCTION

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

1. The management structures of the provincial health department have historically been underdeveloped at all levels; the NCDOH lacks the minimum capacity to function adequately as a provincial health department. A new, expanded and upgraded organisational structure is being implemented in stages.
2. There is consensus in the NCDOH of the need for better alignment of planning, monitoring and budgeting frameworks and systems.
3. Human resource and financial management functions are excessively centralised and hamper effective and efficient service delivery.
4. The Service Transformation Plan and the Annual Performance Plans are the main strategic and operational plans guiding the department.
5. Capacity for planning and monitoring amongst managers is generally low as a consequence of which inequitable patterns of resource allocation and service provision remain unchanged.
6. Governance and management structures in district hospitals are weak, impacting on quality of care.
7. Doctor support for PHC is non-existent in remote, rural areas.
8. HIV treatment services are achieving good coverage but existing national models are not appropriate to the needs of the province.
9. HIV prevention, including condom distribution and PMTCT is poorly implemented.
10. TB cure rates have improved although improvements are not being sustained.
11. There is a concern with the high number of maternal deaths occurring in the province, which appears to be predominantly a problem of avoidable mortality in Level 1 facilities.

2. GENERAL LEADERSHIP

2.1. Because of its small population size and budget, the NCDOH has historically been underdeveloped. Departmental structures and systems have been partly linked to Kimberley Hospital, which in the past assumed certain provincial managerial functions (such as management of other hospitals and the IT infrastructure). While the two institutions are now clearly separated organisationally, the NCDOH is battling a legacy of undeveloped structures, blurred reporting lines, inadequate managerial systems and poor accountability persist.

2.2. The NCDOH has had two ministers (the most recent change in December 2008) and three Heads of Department (HOD) in the last 5 years. The present HOD was appointed 18 months ago. He was seen by most provincial interviewees as bringing a new direction to the department, combining a commitment to national health policy goals with a greater focus on managerial structures, systems and processes. He has prioritised action around the following:

2.2.1. Addressing a serious gap in the senior management layer within the department, created on the one hand, by the historical absence of key portfolios within the provincial health department (e.g. hospital management), and on the other hand, by a culture of “inappropriate appointments” in existing senior posts. A new CFO has been appointed and Chief Director posts have been advertised for Hospital and Corporate Services as the first steps in the implementation of a new provincial organogram. Arrangements have also been made with the Western Cape Department of Health for the mentoring of new senior managers.

2.2.2. Better implementation and alignment of planning, monitoring and budgeting frameworks/systems to enhance strategic thinking and accountability amongst senior managers. Quarterly review meetings involving senior managers up to district manager level have been instituted.

2.2.3. Greater decentralisation of financial and human resource functions and building financial management capacity at district and hospital level, with the view to improving efficiency in the use of resources. Financial delegations have been defined and the next step is an implementation strategy. As for the HR delegations, the MEC has not

given these to the HOD, who would then delegate them to the rest of the mangers in the department.

2.2.4. More effective revenue generation through existing mechanisms such as Workmen's Compensation and the Road Accident Fund.

2.2.5. A focus on primary health care and the district health system, and developing systems of community participation and accountability.

2.3. While the impact of these measures is yet to emerge, there was at least consensus amongst most of those interviewed on the challenges facing the NCDOH and what needed to be done. This consensus is partly a sign of the new direction and leadership within the department (which appeared to be further enabled by a change at the MEC level), but also of the long standing and somewhat intractable nature of the challenges. These feature repeatedly, for example, in the Annual Reports and Performance Plans.

2.4. While there are signs of incremental change towards a proactive and organised style of functioning and the recruitment of skilled new talent in middle level positions, a crisis management organisational style is also still very evident. Experienced staff members in the NCDOH are regularly re-deployed from assigned roles to sort out crises in other areas; and the provincial health department has yet to achieve a decisive "turn around". Although not stated as such, the impression gained in the review was that political dynamics had also had a negative stranglehold on departmental functioning in the past. There was a hope that a new term of government would bring a change in this regard.

2.5. Top of everyone's list of problems to be addressed was the excessive centralisation of human resource, finance and procurement functions, in particular the need for the MEC's approval of all appointments, down to the cleaner level. The latter was seen by the HOD as stemming from a structural problem - the Public Service Act vests final accountability for appointments in the minister (the Executive Authority), in contrast to the PFMA, where the HOD assumes the function of accounting officer for finances, and therefore has power to delegate.

2.6. Contrary to other provinces, there was little mention of inappropriate expectations, unfunded mandates, or inadequate support from the national government. The national sphere was portrayed in a largely neutral manner, for example, as the author of guiding frameworks and tools such as the Integrated Health Planning Framework for the development of the STP, APPs and the Quarterly Review System. When pressed managers did, however, indicate:

2.6.1. Confusion on current policy on models of ART delivery, and the imposition of national blue-prints that do not necessarily match provincial realities;

2.6.2. "Roll-overs" created by national directives /adjustments such as the OSD and the two new vaccines, and the absence of specific provincial processes to deal with these situations; and

2.6.3. That national forums, such as the HOPS (Head of Pharmaceutical Services) meetings, did not address the relevant issues faced by provincial managers and tended to be "operational rather than strategic".

2.7. The NCDOH has both monthly and quarterly review meetings where presentations are made on data from the District Health Information System (DHIS) and the IYM system. However, due to financial constraints, the last quarterly meeting of the 2008/09 year was cancelled which also prevented the finalisation of the APP for 2009/10.

2.8. With respect to the functioning of meetings, interviewees also felt that "action was missing", and one commented that "they tended to stray to logistical issues and not deal with strategic issues and the implementation of our objectives." As the IST did not have access to senior/top management minutes, they were unable to independently review their content.

2.9. At district level, leadership and support from provincial players was portrayed as largely absent. For example, when Moshaweng Sub-District was incorporated into the Northern Cape in 2007, "the minister came over with her management to welcome us to the Northern Cape, we gave them a document of our operational plans and that was the end of it."

3. PLANNING

3.1. THE FOLLOWING PLANS WERE IDENTIFIED DURING THE COURSE OF THE NCDOH REVIEW:

3.1.1. A document entitled **Vision 2014**, published in 2006, and developed as part of the broader Provincial Growth and Development Strategy. However, Vision 2014 appears to have lost its status as a statement of vision for the NCDOH. Although the service delivery recommendations in this document formed the basis for the initial scenarios developed in the STP (see below), these were "shelved" when their costs turned out to be prohibitive. Vision 2014 comes across as a document never finalised (it lacks, for example, prefaces by the minister and the HOD), and serves more as a wish list rather than evidence-based planning. Further, its elements are a mix of operational and strategic objectives and past achievements, organised in ways that are not easy to follow.

3.1.2. A **Strategic Plan** (for the period 2006-09). Apart from the HOD, interviewees were unaware of the existence of this document (or any 5 year strategic plans) and it therefore does not provide a meaningful template for the departments' activities. The HOD indicated that the next 5 year Strategic Plan would be developed once the new political leadership had been installed in the province. The current vision for the NCDOH, as outlined by the HOD above, is an implicit one and remains to be decisively stated and adopted in writing. This vision is aligned to the national one of building access and quality through primary health care and a district health system, and is also specifically oriented to meeting the unique service challenges of the Northern Cape through innovative means. It is evident in the **Service Transformation Plan** (see below), currently in its third iteration, which is still to be approved and communicated, but which is seen by key players as the central guiding document of the department. The STP links to the **Hospital Revitalisation Plans**. Also frequently referred to were the new departmental organogram, and the **Annual Performance Plans** (see below).

3.1.3. **District operational plans**. All five districts had operational plans for the 2008/09 period. However, district planning cycles are not yet aligned to core planning in the APP. District plans are completed in September – yet budgets are only allocated in

December. These plans therefore also became “a wish list - not a plan based on real needs”. As a consequence, “district plans are not given credibility, they are not seen as essential - yet they are mandated by the National Health Act.” This was confirmed in the review team’s visit to John Taolo Gaetsewe District, where the absence of a district plan for 2009/10 was identified as an issue, yet no concrete steps were in evidence to rectify this.

3.1.4. The problem of inadequate capacity for planning in the Northern Cape was raised in both the documents reviewed and interviews conducted. The planning process is managed from the Directorate of Policy and Planning in conjunction with the health information division. Directors are provided with the formats and minimum data sets but are often unable to translate this into meaningful strategies and plans. As stated above, a key issue is the lack of synergy between strategy/vision, planning and budgeting, and planning is therefore often an abstract exercise lacking in realism.

3.1.5. The Policy and Planning director saw the key tasks of his division over the next five years as aligning budget to planning and improving information management for planning purposes. In the parts of the John Taolo District that were formerly part of the North-West Province there was evidence of a functional process of planning, budgeting and monitoring/evaluation that had extended to the health service area (i.e. one level below the sub-district). This does suggest that capacity can be generated far down into the health system, if appropriate structures and systems are put into place and aligned.

3.2. SERVICE TRANSFORMATION PLAN

3.2.1. The Service Transformation Plan (STP) is based on the National Department of Health’s ‘Integrated Health Planning Framework’, which “attempts to model the entire health system and the interactions between different levels of service.” (Northern Cape STP, V3c 2009, page 1). The first version of the STP was developed in 2006; the most recent version (Version 3c) is dated 27 February 2009.

3.2.2. The Northern Cape STP makes proposals for the following:

3.2.2.1. The re-configuration of all health facilities, from Primary Heath Care to Level 3 care;

3.2.2.2. Human resources requirements for implementation of the STP;

3.2.2.3. Expansion of Emergency Medical Services, Planned Patient Transport, Telemedicine and Outreach Services as interventions to address the problem of geographical distances;

3.2.2.4. Financial resources (capital and recurrent), including capital investments required to upgrade facilities.

3.2.3. In the preferred scenario of the STP (Scenario F), hospital services are rationalised down in favour of an expansion in the number of twenty-four hour community health centres and clinics, reflecting an overall vision of broadening access through the primary health care system.

3.2.4. The adoption and implementation of the STP, as in other provinces, is political. It requires arguing for additional funds from Treasury on the one hand, as well as managing the down-grading or even closing of health facilities, on the other hand. While the plan was reported as having the support of the minister, it has yet to be translated into additional resource allocations or communicated and accepted by providers and managers within the NCDOH. Its implementation was therefore put on hold until after the elections, although in the meantime it is informing other processes such as the Hospital Revitalisation Programme.

3.3. ANNUAL PERFORMANCE PLAN

3.3.1. The NCDOH is meeting its requirement to produce Annual Performance Plans (APPs). Perusal of APPs over recent years suggests attempts to improve the quality and usefulness of APPs and to link them with long term plans such as the STP. Quarterly meetings are held to review performance on APP, and the Planning Directorate believed there had been some improvement in people's understanding of the importance of planning and the planning cycle. However, the ability of programmes (in the PFMA sense) to identify meaningful activities and targets and define resource needs appears to vary considerably. In some areas, such as the DHS (programme area 2), the APPs simply reproduce the same list of indicators and targets over the years without any indication of how these are to be reached, or specific objectives/activities for the year. Although costs are allocated to different activities in

sections of the APP, according to the finance division these are thumb sucks not based on proper costing exercises.

3.3.2. As already raised, the 2009/10 APP was still not finalised at the time of the review. In addition, because of lack of clarity as to the department's financial situation at the end of 2008/09, programme managers, hospitals and districts had not been informed of their budget allocations for the new financial year (normally communicated in January). This combination of circumstances resulted in considerable uncertainty at district and hospital level, where in the words of one manager "we are swimming in a sea of uncertainty." Managers therefore no longer prioritised activities or spending and sent through requests for payment as they occurred, with the expectation that approvals would stop at some point in the financial year when the budget ran out. Some still continued to develop their plans based on historical budgets but felt that these processes lacked weight or meaning. When asked what guided their day-to-day work, one manager replied: "our current activities are based on general things and crisis."

3.3.3. While the APP process in the NCDOH appears to be more than a minimalist exercise to satisfy PFMA obligations, it has yet to develop into a core managerial tool guiding progress towards achievement of strategy. The conditions for this - clear goals, a good assessment/knowledge of the current situation and an incremental but systematic approach to the implementation of activities – are not as yet present across the board, although there is evidence of capacity in specific divisions and facilities. As pointed out by one senior manager, "in health most expenditure is just not optional… so the question is how to manoeuvre within the small margins we have available, as well as shift resources between parts of the system." While many of the problems and the ultimate vision of the NCDOH are well understood, the planning system at present does not enable actors at all levels to shift towards new goals.

3.3.4. One of the effects of this are that large provincial inequities in resource allocation and service provision continue unchanged, as demonstrated in Table 8 below, which shows the distribution of per capita spending and utilisation of PHC in the five districts of the province, over three years. Although poor data quality hampers comparisons, major differences exist between districts that cannot be accounted for by factors such as geography. Service provision and budgeting follow historical patterns and have not

been “reworked” to reflect the distribution of need. This may shift as the STP becomes incorporated into APPs in future years.

Table 8: Per capita spending on PHC and utilisation rates, Northern Cape 2005 to 2008

District	Per capita spending on PHC (2007/08 prices)			PHC utilisation rate		
	2005/06	2006/07	2007/08	2005/06	2006/07	2007/08
Namakwa	468	535	633	3.3	3.2	3.3
Pixley ka Seme	266	315	376	3.3	3.7	3.7
Siyanda	134	161	206	2.6	2.7	2.8
Frances Baard	227	281	314	2.5	2.8	2.8

Source: District Health Barometer 2007/08

3.3.5. In contrast to the STP process, the NDOH does not appear to have provided much support to the NCDOH for annual performance planning and the methodologies of priority setting, defining activities, setting targets and budgeting.

3.4. ALIGNMENT OF PLANS

3.4.1. Many interviewees recognised the need for better alignment and integration of planning and other managerial processes – both horizontally across functions (e.g. HR and finances), as well as vertically between levels of the system. Efforts are clearly being made to align all planning processes with the APP cycles, including district plans. The visit of the review team to the province interrupted a senior manager process to discuss decentralised budgeting and links to the future cycles of APPs. There are plans to appoint a budget manager to assist programme managers and an excel-based model has been developed for directors to cost out their activities. However, a key problem remains the lack of synchrony in time frames and deadlines for the two governmental processes.

3.4.2. Discussions have also been initiated with the human resources department to link individual staff performance plans to the indicators/targets of their division. There is an expectation that future Auditor-General reports will include an assessment of APP targets and this is also driving the need to improve planning and alignment.

3.4.3. A number of managers interviewed, at provincial, district and hospital levels were keen to assume greater responsibility for planning and budgeting, and appeared to have the

necessary insight or experience. For others it will require a culture shift and considerable support.

4. GOVERNANCE

4.1. Governance of the health sector in the Northern Cape has been severely hampered by a legacy of inadequate and poorly developed structures. As already mentioned, there is a gap in the senior managerial layer (Chief Director level) and key posts, such as district and hospital managers are not graded at an appropriate level to match responsibilities. In the provincial health department, the clustering of functions, spans of control and reporting lines are also problematic.

4.2. These problems are mirrored at district level: some two years after incorporating the Moshaweng sub-district from the North West Province, the John Taolo Gaetsewe District still does not have an amalgamated organisational structure. A district manager was appointed without a fair or transparent process and weak leadership and confused reporting lines have all but rendered this district dysfunctional.

4.3. We were not able to obtain official organograms for this district or the provincial office. There are, however, proposals for a complete overhaul of organisational structures at all levels, a process being managed in conjunction with the Department of Provincial Service and Administration. Senior posts have been advertised and key posts within districts are being prioritised.

4.4. We were not able to establish to what extent funding for these and other posts have been secured; they appear to be incorporated in the recommendations of the Service Transformation Plan that provides for an expanded administrative and managerial layer.

4.5. A provincial health act for the Northern Cape is in the preliminary stages of drafting, following the establishment of a legal unit in the NCDOH. District Health Councils were reportedly launched in 2008. Community accountability structures were described as inconsistently present and generally weak. There was difficulty establishing clinic committees and hospital boards and responses to advertisements were poor – “people want to know what’s in it for them”. In John Taolo Gaetsewe District only 6 of the 35 clinics/CHCs have functional clinic committees; Kimberley Hospital has a hospital

board but it is “not represented by leaders in community who can represent them or speak up for the needs of the hospital, and to help with fund raising for special needs.”

5. SERVICE DELIVERY (HIV, TB AND MCH)

5.1. HOSPITAL AND PHC SERVICES

5.1.1. The Northern Cape has 14 hospitals - 12 district hospitals, 1 regional hospital (in Upington) and 1 tertiary hospital (in Kimberley). It also has 26 community health centres and 118 clinics. The STP proposes a rationalisation of hospital services to 11 facilities - 8 district, two regional (Upington and de Aar) and one tertiary facility (Kimberley Hospital). Kimberley Hospital complex which currently consumes 24% of the provincial budget, incorporates a 558 bed tertiary hospital, a specialised TB/mental health facility and a day hospital in Kimberley. Kimberley Hospital’s CEO was previously responsible for all hospital services in the province although district hospitals now fall under the district health system. The Kimberley Hospital Complex is itself undergoing a process of “unbundling” into separate institutions, and a new CEO was recently appointed to manage Kimberley Hospital as a stand alone tertiary institution. There is a provincial director for “medical services and EMS” who is responsible for medical doctors employed in the hospitals of the province.

5.1.2. The legacy of Kimberley Hospital’s role in the province is evident at a number of levels. On the positive side, specialists in the hospital provide a regular outreach service to district hospitals. The province has a well established air ambulance and transport service contracted out to the South African Red Cross Society that transports specialists, patient referrals, emergency cases and at times medical supplies between Kimberley and the more remote areas of the province. Evaluations have shown this to be a cost effective use of resources for a province the size of Northern Cape, with fuel and capital costs compensated for by savings on staff time and greater safety. Although not directly evaluated, Kimberley Hospital also appears to have a good reputation for the quality of its clinical services, which it has maintained despite a lull in leadership for a few years (when it “ran on auto-pilot”), and is a potential resource for improving clinical governance in the province as a whole. The present hospital management team is experienced, skilled and goal directed, and is both able and willing to manage the hospital as a more decentralised and autonomous institution. It has identified key areas for improvements in efficiency and quality but can not

implement these without greater financial and human resource delegations and unfreezing of administrative posts. The long turn around times to appoint staff, up to six months, poses huge challenges, especially for attracting and recruiting scarce skills, where speed is often of the essence.

5.1.3. Although there is a shared view of Kimberley Hospital's role as limited to providing secondary and tertiary referral and clinical outreach/support to the rest of the province, in practice it also still fulfils administrative functions for the province. This includes information technology support and engineering services, and staffing of the supply chain management unit in the NCDOH. As a consequence, reporting and accountability lines are blurred. The absence of a clear focal point for hospital services in the provincial office (now being corrected) has also had a detrimental effect on peripheral district hospitals, which currently exist in a governance and managerial vacuum. This was highlighted in interviews with actors in John Taolo Gaetsewe District who did not know to whom they could turn for support in addressing the duplication of services in two adjacent district hospitals (brought about by the amalgamation of sub-districts) and the problem of maternal and perinatal deaths (see below) in these hospitals.

5.1.4. Certain district hospitals have benefited from the quality assurance/organisational development interventions of the hospital revitalisation programme. Tshwarangano Hospital which was formerly in the North-West Province had participated in COHSASA's (Council on Health Service Accreditation of South Africa) hospital accreditation programme, which provided valued on-site mentoring. Apart from these interventions there are currently no provincial processes building managerial capacity and safe-guarding the quality of hospital services. The new provincial organogram does include a Directorate for Standards, Compliance and Quality Assurance.

5.1.5. Ensuring equitable access to hospital services is a challenge in the Northern Cape. Vast distances and small catchment populations make economies of scale difficult to achieve. District hospitals in the province are small, varying in size from 30 (Postmasburg) to 180 (Tshwaragano) beds. It is unclear whether this is the reason for the Northern Cape having the highest costs per patient day equivalent in the country (see Figure 1), or whether this is an indicator of other inefficiencies. The rationalisation of district hospital services proposed in the STP will see an increase in the number of

district hospital beds but a reduction in the number of hospitals, with improved provision of emergency medical transport substituting for fewer facilities.

5.1.6. Attracting and retaining skilled professionals to remote areas of the province was considered a major challenge by all interviewees. Figures provided in the STP show that in mid 2008, 33 medical officers worked in the 11 district hospitals (average of 3 per facility); whereas the proposed staffing establishment is 53 doctors for 8 facilities (average of 6.6 per facility). Significantly, only 33 doctors service the 144 facilities (clinics/CHC) of the primary health care system. Inequities in the distribution of medical personnel were particularly evident in John Taolo Gaetsewe District where:

5.1.6.1. a 60 bed hospital had three full-time and four sessional doctors;

5.1.6.2. a 180 bed hospital had three full-time doctors;

5.1.6.3. 30 CHCs/PHC clinics had no doctor visits or support for the last two years.

5.1.7. Attempts by the district management team to establish a common pool of doctors for the two district hospitals failed. The HOD acknowledged this as a difficulty when he said: “There are problems of how doctors are managed and what level of care and support they are giving to the PHC facilities. There are district management teams in place but they seem to be afraid of doctors.”

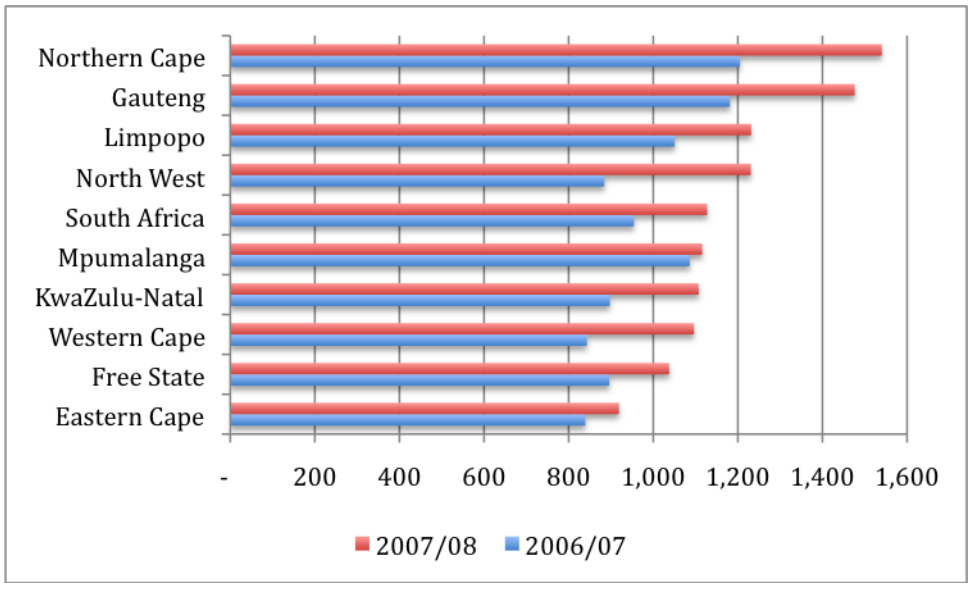

Figure 1: District hospital costs per patient day equivalent (in rand) by province, 2006/07 and 2007/08 Source: DHS Barometer 2007/08.

5.1.8. Interestingly, with respect to support for the primary health care system, interviewees were of the view that implementation of the occupation specific dispensation (OSD) had resulted in an exodus of nurses into the primary health care system. PERSAL data extracted at the end of March 2009, indicate that 97% of clinical nurse practitioner (specialist PHC nurse) posts were filled, compared to 58% of all other professional nurse (generalist and specialist) posts.

5.2. HIV/AIDS

5.2.1. Antenatal HIV sero-prevalence in the Northern Cape was 16% in 2007, less than two-thirds the national prevalence rate of 28%. In both absolute and proportional terms, the Northern Cape has a smaller burden of HIV than other provinces.

5.2.2. According to information in the 2009/10 APP, by November 2008, more than 12,000 people had been initiated onto antiretroviral therapy (ART) in the province in 15 Comprehensive Care Management and Treatment (CCMT) sites, of which nearly 5,000 were initiated during the course of 2008. In that year, the ASSA2003 actuarial model estimated that 5608 people entered the AIDS phase ("new AIDS sick") and were therefore in need of ART.[4] If these estimates are correct, ART coverage rates, defined as the percentage of those entering the AIDS phase enrolled into treatment each year, are high in the province.

Table 9: ART enrolment, need and coverage 2006-08

Year	ART initiated*	New AIDS Sick**	Coverage (%)	Cumulative total initiated*	Total number on treatment at year end***	Cumulative retention (%)
2006	3120	4699	66	4,876	4,876	100
2007	2858	5195	55	7,734	7,158	93
Jan-Nov 2008	4792	5608	85	12,526 (Nov)	10,521 (Nov)	84

Source: NCDOH: APP 2009/10 **ASSA2003 ***NDOH: CCMT statistics, Jan '09

5.2.3. These figures do not take into account loss to follow-up through death, transfer and drop out, which the programme director indicated was a "major problem". Drawing on

[4] Note: Figures of new AIDS sick are now regarded as an under-estimate of need (people with CD4 <200 are not necessarily "AIDS sick", and conversely, some with CD4>200 may present with AIDS defining illnesses) and probably demand for services.

both provincial and national data[5] cumulative retention in care appears to be 84% for the province (Table 9). However, as with ART data in most other provinces, these figures should be treated with caution. The province does not have an established cohort ART monitoring system (such as that of the TB programme), and is unable to track individuals and outcomes with certainty over time. The NGO, Right to Care, is currently assisting the province to introduce its ART monitoring programme, Therapy Edge.

5.2.4. The official model of ART provision, through dedicated and accredited CCMT sites is not serving the province adequately. As the initial sites became saturated the province was able to get accreditation for an outreach programme from core CCMT sites into satellite facilities. The outreach programme is now itself reaching saturation and the province is keen to implement new programme strategies such as decentralised, nurse-initiated care. However, despite the provisions of the HIV/AIDS National Strategic Plan, provincial actors were still being required to follow the original 2004 CCMT operational plan for doctor-centred accreditation requirements. The obligation to place scarce skills such as doctors, pharmacists and dieticians in CCMT sites demanded "a huge amount of energy" to "manoeuvre within national requirements", and created unnecessary competition with other divisions in the department. This also prevented the rational use of existing resources, fostered a dependency on external NGO resources, and raised the per capita costs of the programme. The 2008/09 HIV/AIDS conditional grant (of R91 million) was short of R9 million for the ARV programme, which was covered by virements from other sub-programmes in the grant, as well as the provincial equitable share.

5.2.5. The Director of HIV, TB and Communicable Diseases indicated that the ART programme was the most time consuming aspect of her work, leaving little space for HIV prevention or other diseases. The male condom distribution rate in the Northern Cape is the lowest of all provinces (5.6 vs. 40.5 condoms per adult male per year in the Western Cape). Prevention of mother-to-child-transmission (PMTCT) is managed within the MCWH sub-directorate where it is one of several major issues being addressed. Although uptake of HIV testing in pregnancy and provision of nevirapine appears high in the Northern Cape (DHB 2008), facility staff have not yet been trained in the new dual therapy protocols and PCR screening of infants, and there are no

[5] NCDOH: APP 2009/10; NDOH: CCMT statistics, Jan '09

systems to collect and report rapidly on CD4 counts in pregnant women for remote areas.

5.2.6. At the time of the review, the TB/Communicable Disease components were being split off from HIV into a separate directorate. The review team was left with the impression of an increasingly vertical, ART-focused HIV programme that was achieving good coverage, but is unable, because of constraints imposed upon it by the national level, to develop tailored, sustainable and cost effective provincial models. It is also insulated from broader provincial departmental problems and does not participate in helping to solve these problems.

5.3. TB

5.3.1. In contrast to HIV/AIDS, the Northern Cape is a high TB burden province – in 2007 the province had approximately 9,500 new TB cases, representing an incidence rate of 840/100,000 population (DHB 2008).

5.3.2. The TB programme has received specific attention over the last years. Between 2004 and 2006, TB cure rates improved dramatically, from 42.3% to 69%. This was attributed to an EU-funded TB-tracer programme in two “crisis” districts – Frances Baard and Siyanda. However, cure rates underwent successive declines over the first three quarters of 2007 to 61% by quarter 3. This problem was identified and discussed in departmental quarterly review meetings, and reported in the APP 2009/10. The cause of the problem has not been fully identified – the APP cites increasing defaulter rates in crisis districts but also the problem of patients not being evaluated (follow-up sputum) because of shortened treatment periods. It was also not clear whether specific actions had been instituted to address the problem.

5.4. MATERNAL, CHILD, WOMEN’S HEALTH

5.4.1. Provincial actors at both provincial and district level made frequent mention of the problem of high maternal deaths - 58 in both 2007 and 2008 (giving a minimum annual maternal mortality ratio of around 300/100,000 live births). However, in contrast to TB and HIV/AIDS, there are few provincial resources devoted to MCWH. The sub-directorate forms part of a broad ranging cluster of service and support related “priority programmes” that includes mental and oral health services, environmental health and

health promotion, chronic disease and rehabilitation, quality assurance and health information. In this context, proactive processes of identifying and managing priorities is almost impossible, and activities are oriented to managing national requests as they arise (e.g. new vaccines) or dealing with crises. At the time of the review, the MCWH deputy-director, a skilled and experienced programme manager, had been deployed to John Taolo Gaetsewe District to assist with the rationalisation of the district hospitals, an issue outside of her area of expertise. Lower level staff, mostly at chief professional nurse level, were left to manage the provincial programme.

5.4.2. During her time in John Taolo Gaetsewe District, the MCWH manager had been able to conduct a formal analysis, based on national audit methodologies, of the perinatal and thirteen maternal deaths that occurred in the district in 2008. The audit concluded that poor quality delivery and emergency obstetric services, particularly within district hospitals, were the most important factors in the deaths, and prompted the introduction of an outreach and training programme from Kimberley Hospital. It emphasizes the urgent need for a programme of support and quality assurance targeted at rural district hospitals, and the necessity of creating a minimum programmatic support infrastructure at provincial level.

6. RECOMMENDATIONS

6.1. GENERAL LEADERSHIP

6.1.1. Ensure approval of the new departmental organogram and develop a clear, transparent and consulted plan for its implementation over the next five years.

6.1.2. Revise and finalise policy on the decentralisation of human resource and financial management and ensure appropriate capacity – numbers, skills and systems.

6.2. PLANNING

6.2.1. Incrementally address all the components of an aligned system: five year strategic planning, service transformation plan, budgeting, annual performance and district planning, improved quality of monitoring and individual performance management systems. Ensure a simultaneous bottom-up process in districts and hospitals that feeds into provincial level planning.

6.2.2. Build capacity and on-site mentoring in all aspects of planning – identifying needs, priority setting, developing activities, costing and monitoring.

6.2.3. Obtain approval for and communicate the findings of the Service Transformation Plan.

6.3. GOVERNANCE

6.3.1. Build governance and management capacity in district hospitals, and institute measures to improve quality.

6.3.2. Support the development of community accountability mechanisms such as clinic committees, hospital boards and district councils.

6.4. SERVICE DELIVERY (HIV, TB AND MCH)

6.4.1. Institute decentralised service planning to ensure equitable allocation of resources.

6.4.2. Monitor the efficiency of district hospitals and develop doctor support for rural areas.

6.4.3. Develop revised models of ART delivery nationally (a new version of the CCMT Plan) and provincially.

6.4.4. Institute patient registers and cohort monitoring systems.

6.4.5. Investigate the causes of declining TB cure rates and institute corrective action.

6.4.6. Institute maternal and perinatal audit and problem identification processes for all facilities doing deliveries, develop and circulate guidelines.

Human Resources

1. INTRODUCTION

Box 3: Human resource review key findings

1. A new organogram has been developed and is being implemented in the province, but has only been costed to level 9.
2. Centralising HR delegations is a major cause for general inefficiency and long recruitment turn around times resulting in potential appointments being lost.
3. There are signs that the HIV and TB programmes increasingly operate as vertical silos, separated from the rest of the department and other programmes. The recruitment and retention of health professionals in rural areas remains a major challenge while lengthy recruitment procedures compound this problem.
4. PERSAL is not being used for strategic decision making or for management planning purposes.
5. Human resource development of current staff 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 or a skills audit.
6. The performance management system has not been rigorously implemented.
7. The poor implementation of the occupational specific dispensation (OSD) for nurses resulted in numerous operational problems including; a mass exodus of staff away from certain areas of clinical service delivery, salary discrepancies, and high levels of unhappiness.

2. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

2.1. The management of human resources is centralized, which effectively means that the provincial HR Department is responsible for all HR related matters at all levels of the health department, including the Kimberley hospital complex, district offices, district hospitals and PHC facilities.

2.2. The Public Service Act determines that the minister – and/or his/her designate - must approve all new appointments. Final authority is vested with the minister as Executive Authority. This is clearly stipulated in the departmental HR policy document "Delegations of Human Resource Authority" as follows:

2.3. "No appointment should be made without prior written approval of the minister or her/his delegate

2.4. No employee has any right to promotion to a vacant post until the minister or his/her delegate has approved the promotion in writing."

2.5. The previous minister chose not to delegate this authority, although negotiations are underway for certain HR delegations to be decentralised to the district level. Decision-making on financial delegations lie in the hands of the HOD, who is the accounting officer in terms of the PFMA. There is a strong drive to ensure that financial responsibilities are delegated down to the district and hospital levels and emphasis will be placed on building adequate capacity at all levels.

3. INTEGRATION AND CO-ORDINATION

3.1. As a relatively small organisation, the NCDOH does not experience the same coordination difficulties as a larger provincial department. Informal networks can compensate for inadequate structures and processes. However, as raised elsewhere in this report, integration and co-ordination issues to note include;

3.1.1. there is awareness of (and efforts are being made to address) poor coordination between finance, human resource, planning and information system divisions within the provincial department;

3.1.2. these support functions, in turn, do not coordinate their activities with the programmatic and service delivery functions within the NCDOH;

3.1.3. there is the danger that the HIV and TB programmes increasingly operate as vertical silos, separated from the rest of the department and other programmes;

3.1.4. the vast distances between the centre and the periphery make communication and integration across different levels of government (province, district, facility) complex. Interviewees at lower levels of the system were often not aware of thinking and plans at provincial level;

3.1.5. although district hospitals fall under the district health system, they are still inadequately integrated with PHC. For example, hospital doctors in the John Taolo Gaetsewe District do not routinely provide outreach/support to the clinics in the area.

4. LABOUR PLANNING

4.1. A draft Human Resources Plan is still in early stages of development. Although this plan is being developed, it was reported that the required skills audit has not yet been carried out for the province. At present the Premier's office is involved in determining whether people in existing posts have been correctly placed.

4.2. Most HR related policies are still in draft form. The process of ratifying policies has been recognized as a priority and will be fast-tracked. Key HR indicators for planning purposes are available, but not updated on a continous basis to support planning.

4.3. Although it was reported that the STP is aligned with human resource needs and a modelling exercise was undertaken to determine staffing needs, it was found that planning for human resource requirements does not take cognisance of afforbability issues. Weaknesses were identified with the process such as the increase in the staffing of managerial and administrative layers (from 39% to 42% of total staff) and the proposed structure will add another 1 373 staff to the establishment.

4.4. An oversight of existing planning frameworks such as the IHPF is that they do not include community health workers, who perform a vital function, particularly in HIV/AIDS and TB services, but who are employed through contracts with non-profit organisations. There are 1,300 such workers in the province who receive monthly stipends of R1 000. Failure to include them more centrally in human resource development initiatives underplays the increasing reliance on these workers and the eventual need for integration into primary health care teams.

4.5. Some districts make use of agencies to cover facilities when staff are away on leave or when recruitment is not possible. As payment for these services fall under goods and services this distorts staff compensation figures.

5. ORGANISATIONAL DESIGN AND ESTABLISHMENT

5.1. A new provincial organogram has been developed and was presented to NCDOH staff in early 2008. The new organogram will be adopted at the end of April 2009 by the minister who will sign it off and send it to the Public Service Commission.

5.2. This new organogram was based on modelling of human resource needs as part of the STP process. According to IHPF norms, the NCDOH needs an increase in the effective staff establishment from a current of 5,551 filled posts to 6,924. This proposed staff establishment is considerably lower than the official PERSAL staff establishment of 9,267, which clearly over inflates needs.

5.3. A phased approach to implementation is being adopted. The new organogram proposes five new chief director posts, two of which (Hospital Management and Corporate Services) have been approved by the minister and Treasury and have been advertised. In addition, a new CFO has been appointed and funding has been set aside in the budget to address critical administration posts in districts. Posts to level 9 have been costed but not yet at the lower levels.

5.4. The lack of sufficient skilled staff, particularly in finance was seen as a key factor contributing to repeated poor Auditor-General reports. This had been compounded by inappropriate appointments at senior level that placed people into posts for which they were not qualified. Although a new CFO has been appointed, interviewees believed that to avoid further qualified audits the capacity of the finance department as a whole needed to be substantially expanded, both in the provincial and district offices. Currently the finance staff employed at some of the district offices are only at Grade 4, which is not senior enough. Administrative staff requirements for the districts include an HR and finance manager at the level of Deputy Director, state accountants for the hospitals, and a labour relations officer at the level of Assistant Director. Appointments for district managers should be at the Director level.

5.5. Specific gaps/problems identified include:

5.5.1. District managers have a big portfolio to manage almost single-handedly. They must provide oversight for finance, HR, SCM, transport including EMS and the AMS and service delivery. Yet these posts have up to now been graded at Deputy Director (DD) level.

5.5.2. There is no Nursing Services Manager for the province. There are instances when the interests of professional nurses are not fully taken into account by the provincial HRD (such as determining OSD).

5.5.3. Currently no doctors have been appointed to provide sessional services at PHC facilities in the districts.

5.5.4. To ensure that the Health Information System (HIS) is functioning optimally and that information is used for informed decision making, it was suggested that a HIS manager and two skilled data capturers should be appointed in each district.

5.5.5. Inadequate staffing of programmes exists, in particular MCWH.

5.6. Since its amalgamation from two sub-districts two years ago, John Taolo Gaetsewe District has not as yet developed a formal organogram or put in place a functional managerial structure. For example, the manager for HIV/TB & MCWH reports to the district manager and not the manager for PHC services and the HR manager whose work is related to administration reports to the PHC Manager. These weaknesses reflect a serious gap in provincial support to districts.

5.7. District and hospital managers do not have the delegated authority to ensure that doctors are performing optimally – yet by the same token they are held accountable for results in their facilities. The provincial Medical Director did not believe it was his function to play this role.

5.8. PERSAL data shows that there are 9 267 positions of which 5 551 are filled. In budget terms as per the IYM report, there is an approximate 8% vacancy rate. Some vacancies reflected on PERSAL date as far back as 2001 and these posts have never

been filled. The HR department has acknowledged that the system needs to be "cleaned up" and that some of the posts need to be re-allocated; they are currently busy with an analysis. HR reports indicated that nursing vacancy rates for 2008 were at 20%, but vacancy rates are academic of nature, if the current PERSAL system is used as basis.

5.9. In John Taolo Gaetsewe District there are 122 approved professional nursing posts with 35 (29%) vacancies. Tshwaragano hospital has 12 posts for medical doctors, but only three filled (75% vacancy). The HR manager for the John Taolo Gaetsewe District reported that no new appointments have been made since 2007, other than for medical personnel.

5.10. Other general hr problems raised include:

5.10.1. Lack of uniformity of salary packages and different grading of posts across provinces, encouraging poaching.

5.10.2. The same posts e.g. Director having differing levels of responsibility in different government departments also leading to movement.

5.10.3. Greater difficulty in retaining nurses over the years; those with families increasingly express the need to be near tertiary education facilities.

5.10.4. Inadequate Employee Assistance Programme facilities for staff.

6. RECRUITMENT

6.1. The HR department is reportedly not functioning effectively or efficiently when it comes to the recruitment and placement of staff and the recruitment processes that can take up to 6 months. This often results in prospective candidates taking up a position elsewhere. Posts are also lost if not filled within six months. An example cited was the radiologist post at Kimberley Hospital.

6.2. It is generally difficult to recruit specific and scarce skills, especially some categories such as scarce, specialist skills including doctors, advanced midwives and radiologists. The need for rural placements and vast distances make this particularly

challenging in the Northern Cape. National strategies are not tailored to the peculiarities of the province and interventions such as rural allowances have reportedly not had the desired effect; more effective incentives were suggested such as good staff housing and access to a reliable vehicle.

7. PERFORMANCE MANAGEMENT

7.1. National performance management frameworks and policies have been in place since 2003. The minister established a performance moderating committee whose task it is to ensure that performance monitoring is fair and objectively done.

7.2. However, the evidence suggests that the policy is inconsistently implemented and as yet insufficiently institutionalised. While the provincial HR department reported that 85% of all staff are taken through performance management assessments, several interviewees at senior and middle manager level indicated never having received performance contracts, job descriptions or having undergone performance reviews, despite being employed for a number of years. Others reported having performance review meeting “always cancelled at the last moment.” The implications of this is that staff have little recourse to mentoring, support or grievance channels and/or procedures - which lead to feelings of not being heard which in turn leads to a generally demoralized atmosphere amongst staff .

7.3. A manager in the John Taolo Gaetsewe District reported that quarterly performance reviews were not being carried out in the district and that there have been delays this year with issuing performance contracts. He believed managers did not have the required skills to carry out performance assessments.

7.4. The HOD confirmed that the performance management system is not rigorously applied, and that in certain key portfolios (e.g. DHS) managers were unclear about their roles and responsibilities.

8. RETENTION

8.1. Although there are no official retention policies and guidelines in place, the de facto retention strategies employed in the province include:

8.1.1. Skills development - funding the studies for required categories of staff who on completion of their studies will be expected to work in the province.

8.1.2. Supporting staff to enrol in part-time courses (such as Hospital Management), which ensures retention for at least 3-4 years.

8.1.3. Taking over specific student loans.

8.1.4. Providing learnerships.

8.2. The province has also administered an Employee Satisfaction questionnaire to establish retention strategies for the province.

9. REWARDS

9.1. The implementation of the Occupation Specific Dispensation in the province experienced the following problems:

9.1.1. The province was given R16.6 million in extra funds but spent R40 million on OSD in 2007/08.

9.1.2. The process of allocation/translation was centralised without appropriate consultation with nursing managers who understood the nature and dynamics of the nursing establishment in the province. The interpretation of the OSD framework, especially the grandfather clause was particularly problematic, and key specialist nurses such as advanced midwives were overlooked. The OSD at Kimberley Hospital, for example, only applied to the speciality posts of theatre and ICU.

9.1.3. Professional nurses with PHC qualifications who were working in hospitals received directives that in order for them to be able to benefit from the OSD they would have to join the PHC services. This resulted in many professional nurses leaving hospitals which had a major impact on Kimberley Hospital. PERSAL data extracted at the end of March 2009, indicate that 97% of clinical nurse practitioner (specialist PHC nurse) posts were filled, compared to 58% of all other professional nurse (generalist and specialist) posts.

9.1.4. Provincial managers who are mostly nurses were excluded because they were not "operational". This has resulted in nurses resigning from management and administrative posts.

9.1.5. An exacerbating factor was the belief that some staff members had been overpaid. A directive was issued to collect money back, which resulted in union action, and the process was put on hold.

10. LEARNING AND DEVELOPMENT

10.1. The province receives a conditional grant for Health Professional Training and Development (HPTD) which is seen as a key vehicle for recruitment and retention of staff. The province is currently funding 100 medical student doctors outside of the province, including in Cuba; it also provides bursaries for post graduate training (such as the MPH in Hospital Management).

10.2. The Nursing Council withdrew its accreditation of Henrietta Stockdale Nursing College and it has therefore not taken in new enrolments for the past 3 years. A key problem is providing sufficient practical exposure for midwifery students.

10.3. With respect to on-site mentoring and development:

10.3.1. Kimberley Hospital sent specialists in obstetrics, gynaecology and paediatrics to assist Kuruman Hospital to implement improvements in their clinical care and ward management.

10.3.2. The Western Cape DOH has agreed to provide training and mentoring for new managers from the NCDOH.

10.3.3. On-site support is provided to the Health Information Unit by the Health Information Support Project of UWC; Right to Care, a PEPFAR-funded NGO is supporting HIV treatment services; and Management Sciences of Health (MSH) will be supporting the pharmaceutical services. Hospital facilities in the former North-West Province reported favourably on on-site support provided by the Council on Health Service Accreditation of South Africa (COHSASA).

11. HR INFORMATION SYSTEMS

11.1. PERSAL is not used as a management tool. There are still vacant posts reflected on PERSAL dating back from 2001 and which have never been filled. The HR department acknowledged the need to clean up the system and to re-allocate posts.

11.2. There is a lack of capacity in the administration of PERSAL. During the course of 2008, codes related to allocation of staff to cost centres were inadvertently changed such that massive overspends were wrongly reflected in certain programme areas. Attempts to correct the problem resulted in two further rounds of errors in allocation over two successive months. This prevented correct assignment of spending to programme areas and hampered the financial monitoring for some months.

12. RECOMMENDATIONS

12.1. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

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

12.1.1.1. The specific roles and responsibilities of the minister and the HOD.

12.1.1.2. The reporting lines within the district offices.

12.1.2. Financial and human resource delegations for the districts and in hospitals should be reviewed and implemented, including reporting structures and guidelines for delegations.

12.1.3. Policies and procedures for effective clinical governance should be clarified.

12.1.4. 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 areas such as the Kimberley Hospital which carried out dual roles and responsibilities in the past.

12.2. INTEGRATION AND COORDINATION

12.2.1. An overarching strategic plan needs to provide a clear framework that coordinates and integrates the activities of all NCDOH players. This should include co-ordination and communication mechanisms across clusters and DHIS to prevent “silo” operational functioning and emphasize the integration of services/programmes.

12.2.2. Support functions (HR, finance, information etc.) need to be represented at all senior management meetings.

12.2.3. Special attention must be paid to ensuring that the HIV/TB programmes (and associated NGO-based community care givers) are integrated into the planning, budgeting and management of the district health system, hospitals and clinics.

12.3. LABOUR PLANNING

12.3.1. The HR plan and HR policies should be finalised and ratified, in line with the STP.

12.4. ORGANISATIONAL DESIGN AND DEVELOPMENT

12.4.1. The new staff structure (organogram) should be reviewed, costed and a plan developed for its incremental implementation based on affordability. Special consideration should be given to:

12.4.1.1. Structuring to allow for the optimal use of scarce resources;

12.4.1.2. The review of appropriate management ratios;

12.4.1.3. Consistent job titles and job grades across various areas.

12.4.2. 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.

12.4.3. PERSAL should be corrected to accurately reflect personnel positions and staffing numbers as reported in the NCDOH Budget Estimate, Annual Report statements and aligned with the approved structures.

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

12.4.5. A review of current staff placements should be undertaken to determine their appropriateness, more especially at the provincial and district management levels. This should include the assurance that appropriately skilled HR, labour relations, finance, SCM, IT, HIS and programme managers exist at the district level.

12.4.6. Consideration should be given to the establishment of a provincial Organisational Development (OD) unit to implement national OD directives to ensure:

12.4.6.1. OD is seen as an integral and important aspect of all provincial activities and not confined to the revitalisation programme as is the case at present.

12.4.6.2. OD, planning and monitoring is integrally and continuously linked.

12.4.6.3. Decentralisation is underpinned by the establishment of effective organisational systems.

12.4.7. Informed and active organizational change and culture change management processes should be put in place and driven from the leadership level. These should emphasize issues of diversity to ensure inclusion.

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.

12.6. PERFORMANCE MANAGEMENT

12.6.1. Rigorous implementation of the national performance management policy should be ensured which must include the monitoring of the effective implementation of staff performance reviews including issuing of performance contracts linked to programme indicators, individual development plans, and unbiased reward mechanisms.

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.

12.7. RETENTION

12.7.1. Staff retention strategies need to be reviewed and strengthened including consideration to improved staff housing and use of personal vehicles given the vast distances between service points.

12.7.2. A national health professional and scarce skills retention strategy should be updated by the NDOH to assist provinces.

12.8. REWARDS

12.8.1. NDOH should review and if necessary amend the criteria used to determine implementation of the OSD for the various nursing categories.

12.8.2. 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. A comprehensive and fair staff development and training plan should be developed which is based on the specific HR needs of the province and the results of a skills audit.

12.9.2. Managers should be provided with training in the effective implementation of an integrated approach to programme management.

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 full use of PERSAL as a HR management tool.

Information Management

1. INTRODUCTION

Box 4: Information management review key findings
1. Most senior managers identified the need for better information, monitoring and evaluation as a core challenge facing the NCDOH. 2. There is insufficient health information systems capacity in the province, both human and infrastructural (e.g. IT). 3. Data collection systems are poorly designed and fragmented. 4. There is a poor culture of information use. 5. There is no cohort monitoring of ART. 6. These problems were identified in audits published by the Health Systems Trust in 2005 and 2006.

2. USE OF INFORMATION FOR DECISION MAKING

2.1. Managers receive monthly and quarterly summaries of the District Health Information System (DHIS) data. Although managers are not supplied with routine financial reports, expenditure data can be requested at any time and provides information to facility level. At Kimberley Hospital systems are being introduced to provide financial information to cost centres within the facility.

2.2. DHIS data are presented to monthly and quarterly management meetings, but on the whole, the view was that managerial decisions were not data driven. There was “no time to interrogate these reports, to understand the issues and to make recommendations and/or find solutions” and “action is missing”. Managers do request financial statements to monitor expenditure, but requests for DHIS were usually made when meeting demands for reports from the national level. PERSAL does not appear to be used as managerial tool at all.

2.3. A number of factors mitigate against better use of information:

2.3.1. Poor quality of data collected within facilities and the belief that much of the information lacks credibility. Based on facility audits, the provincial information manager estimated that 65% of facilities provide data of adequate quality. Poor quality is evident in widely differing findings for certain data elements between geographical areas and over time. It arises from poorly designed data collection processes at facility level where there are many different forms and registers scattered across the facility, from which over-stretched or demotivated nurses have to extract data.

2.3.2. Lack of capacity at district and provincial level – both in terms of numbers of posts and skills – to adequately manage data flow and quality; and limited access to information technology.

2.3.3. In the absence of decentralised planning and management, a sense of futility in obtaining and interrogating information. For example, managers reported difficulty querying items of expenditure allocated to their budgets that they did not believe was appropriate.

2.3.4. A defensive attitude to findings of poor performance or which challenged commonly held assumptions. Managers tended to reject data which showed that workloads were lower than assumed or which highlighted inefficiencies.

2.4. Apart from the institution of quarterly review meetings, steps being taken to improve quality and use of data include making information management a Key Result Area (KPA) in the performance contracts of managers and the placement of 40 data capturers through learnerships in health facilities across the province.

3. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

3.1. The DHIS is in operation in all clinics of the province. The data are collected manually and entered into the DHIS database at district level. The hospital information system is not based on the DHIS; the province leases a hospital information system (“EPR software”) which includes modules for patient registration, procurement and pharmaceuticals.

3.2. Activity data from hospitals and clinics are collated in the provincial HIS unit, using the national APP indicators as a template, and reported at monthly and quarterly meetings. The unit reportedly works closely with the Policy and Planning Directorate in implementing the NCDOH planning and monitoring system. It is currently staffed by a manager at deputy director level and an administrative officer, and recently lost two staff members, who could not be replaced because of budget constraints. The unit manager had received training and support from HISP (Health Information System Project) based at University of Western Cape, was well versed in the principles of managing a health information system, and had been in the post since 2003. He expressed the wish to work on the better integration of all sources of information – financial, human resource, programmatic and district/hospital.

3.3. In John Taolo Gaetsewe District, the information office was staffed by one information officer (who also doubled as the unofficial IT support for the district office) and two assistants. This is in contrast to only one district information system post at the time of an HST inventory in 2006. At the time of our visit, the office appeared reasonably well supplied with computers and other IT equipment, email and intranet/internet services were functioning and anti-virus software was up to date. Despite the apparent expansion in capacity and infrastructure, managers interviewed in the district were of the view that the health information system in the district was not functioning well: in particular, there were backlogs and problems with quality of data, and the district had not as yet migrated to DHIS version 1.4, creating incompatibilities with data collected from former North-West facilities. This possibly points to the need for better on-site mentoring and support to districts, as well the more general problem of leadership and accountability in this particular district.

4. ARV MONITORING AND EVALUATION

4.1. The province does not have an established cohort ART monitoring system (such as that of the TB programme), and is unable to track individuals and outcomes over time. The programme has based its monitoring on national tools, indicators and the DORA framework. There are data capturers at each ART site who enter data electronically at facility level and produce cross-sectional reports. The PEPFAR-funded NGO, Right to Care, is currently assisting the province to introduce its ART monitoring programme, Therapy Edge.

4.2. The HIV programme recently appointed a Deputy Director for the M&E of both HIV and the TB programmes. Prior to this data from the electronic TB register was compiled in the HIS unit.

5. OTHER M&E ISSUES

5.1. In an audit of information systems conducted by Naomi Massyn for the Health Systems Trust in 2005, the following weaknesses in data management were identified:

5.1.1. Quality of data collected is poor.

5.1.2. No feedback to programmes and irregular meetings are conducted to evaluate information.

5.1.3. Problem areas were identified, sometimes they were translated into action plans but most of the time these were not implemented.

5.1.4. Inadequate admin and/or support staff for data management.

5.1.5. Parallel data collection systems in use.

5.1.6. HIV/TB/STI data collection not optimal for programme planning.

5.1.7. Revitalization programme data not captured and disseminated.

5.1.8. Paper based data system in use up to 2005.

5.1.9. No specific formats for district weekly reports to DDG.

5.1.10. No skills audit to recommend who needs what training and huge training needs identified.

5.2. While steps are being taken to address these problems at provincial level, new national frameworks and concerted external support to build capacity are still required.

6. RECOMMENDATIONS

6.1. M&E needs to be emphasised as a central component of management, and a key performance area for all levels of management.

6.2. Key indicators for departments and programmes need to be actively monitored and appropriate action instituted.

6.3. Consider developing fewer indicators for programmes and develop systems in key areas (such as ART outcome monitoring).

6.4. Review and redesign facility data collection processes to enhance efficiency, remove duplication and simplify procedures; reduce data requirements from facilities to the core essential.

6.5. Monitor quality of data returns from facilities and set standards for improved data quality.

Medical Products, Laboratory

1. INTRODUCTION

Box 5: Key findings
1. Drug supplies in the NCDOH are protected in times of financial stringency.
2. ART is funded through the equitable share when the conditional grant is exhausted.
3. Drug procurement and distribution systems function mostly well. There are still problems in rational drug use, data collection and stock management in health facilities.
4. Potential efficiencies in laboratory use have not been exploited in the NCDOH.

2. MEDICAL PRODUCTS

2.1. During the course of the review, no problems with access to drugs were raised and the NCDOH appears to be managing its drug supply chain effectively. Since 2007, pharmaceutical services are headed by a finance manager who was reassigned from Treasury to effect a turn around in what was previously a major problem. Drug supplies in the province have been shielded from rationing processes towards the end of the financial year, although the Head of Pharmaceutical Services (HOPS) indicated that there were problems with the finance department not making payments on time. When the conditional grant for ART ran out towards the end of 2008/09, supplies were purchased with the equitable share.

2.2. The HOPS has instituted systems for the distribution and tracking of expenditure and usage of drugs, appointed district pharmacists in the 5 districts, and convenes quarterly review meetings. Where drug shortages occur, they are usually a consequence of poor stock management. Although it was possible through the existing systems to identify stock piling or shrinkage, rational drug use/over prescribing is not monitored and facility information is of poor quality. He has identified 20 candidates for pharmacy assistant training to assist with greater support to facilities.

2.3. The administration of the provincial drug depot is contracted out at a monthly cost of R37 000. According to the HOPS this is an example of a problematic contract that does not provide value for money. In particular, there is an inadequate stock management system in place - information of what has been ordered and current stocks is not easy to obtain. The NCDOH is currently in discussions with Management Sciences for Health (MSH) to assist with systems development and support.

2.4. The national Department of Health does not provide support to the province and national HOPS meetings "are only interested in discussing how to get better pay for pharmacists."

3. LABORATORY

3.1. There is currently no focal point for the oversight of laboratory services in the NCDOH. An attempt to interview the head of the National Health Laboratory Services (NHLS) was not successful as he did not believe he could comment on the service from a provincial perspective.

3.2. The CEO of Kimberley Hospital indicated that use of laboratory tests in hospitals could be managed more efficiently; conversely, in rural areas, access to essential laboratory tests and turn around times are still problematic.

4. RECOMMENDATIONS

4.1. Improve the design and management of contracts with external providers.

4.2. Identify core performance indicators for provincial pharmaceutical services and develop an agenda for national HOPs meeting that addresses strategic issues.

4.3. Conduct an audit of access, equity and efficiency of laboratory use in the province.

Technology and Infrastructure

1. INTRODUCTION

Box 6: Key findings

1. Key issues raised in the review:
2. There is a need to shift responsibility for the IT infrastructure from Kimberley Hospital to the provincial head office, decentralise support systems to district level and expand infrastructure to all health facilities.
3. Facility maintenance is woefully under funded and there is a mismatch with the resources being invested in building new facilities.
4. Inefficient and poorly managed fleet and transport management systems at both provincial and district level leading to poor access, duplication and waste.
5. Costly and poorly designed security contracts bind the province inappropriately and provide a low quality service.

1.1. The Information Technology (IT) infrastructure for the NCDOH is managed through a small unit at Kimberley Hospital, although there are plans to establish an IT sub-directorate as part of the new provincial organogram. The IT network services 18 sites – hospitals, districts and a few clinics offering ART. The unit has a help desk which logs faults and attempts to resolve them telephonically, but the distances and lack of dedicated staff in districts makes it difficult to address faults in peripheral areas.

1.2. The unit has done an audit of department and districts needs and made a submission to the province to have IT requirements included into the APP, without success.

1.3. The priorities for IT are to:

1.3.1. Establish an interlinked infrastructure in all facilities to reduce the paper trail and facilitate reporting.

1.3.2. Put support staff in place in districts and ensure they have correct skills.

1.4. The Hospital Revitalisation Programme (HRP) is managed jointly with Provincial Infrastructure in one Directorate, which has 5 sub-directorates (Organisational

Development, M&E, Infrastructure, Health Technology and Finance). The HRP is funded through a conditional grant, and infrastructure maintenance through the equitable share. As with HIV/AIDS, the HRP comes across as well resourced and staffed relative to the rest of the provincial department. In the words of the HOD the HRP is "a comprehensive intervention" that includes support for the development of management systems, OD interventions related to organisational culture, and assessment of equipment needs. The HRP has been designed to identify and respond to local needs, rather than centrally defined prestige projects. The STP has developed an infrastructure rating and priority intervention list.

1.5. While the province was underspent by R88 million on the building of new facilities in 2008/09, the maintenance budget received only R7 million for an estimated need of R100 million. The mismatch between funding of new infrastructure and maintenance is a major source of frustration for both provincial and facility level players. Examples of maintenance identified as urgent were the need for new boilers at Kimberley Hospital and maintenance of Tshwaragano Hospital while waiting for the HRP programme to build the new hospital in Kuruman. Representations have been made to Treasury to increase the funding of facility maintenance, which ideally should form 5% of the total health budget. The Directorate has been involved in developing guidelines for provincial departments on managing the maintenance function, called the "Infrastructure delivery improvement programme" (IDIP).

1.6. There is also a lack of adequate office space at the provincial offices in the facility where NCDOH is currently housed - in an old nurse's home building that is not conducive to creating open plan office spaces. A lack of space is also the case in some of the district facilities. This problem will be compounded once the new organogram is implemented.

2. RECOMMENDATIONS

2.1. Develop 5 year strategic plans for investment and expansion of the IT infrastructure.

2.2. Develop national norms, standards and guidelines for maintenance planning and budgeting, and facilitate sharing of provincial best practice.

2.3. Review transport management systems at provincial and district level, identify key indicators and implement routine monitoring systems.

2.4. Improve the design and management of contracts with external providers.

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 10 is a summary of all the recommendations in Financial Review to Medical Products, Laboratory. These are linked with the institution(s) that have responsibility for the implementation of these recommendations.

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
FINANCE RECOMMENDATIONS								
Provincial health budget allocation								
Treasury should allocate an amount to the NCDOH which is substantially in line with the equitable share indicated by the National Treasury in the national budget.				2	2	1		
Unfunded Mandates								
The operational impact of national policy decisions (e.g. OSD, new vaccines) should be determined and must be agreed with the provincial health department prior to implementation.		1		2	2	2		
Budgeting process								
The budgeting process needs to be seen and used as an extension of the annual performance plan, and needs to follow an iterative process.				1	2	2		
Operational units should prepare zero-based budgets. Therefore when funds are allocated, the extent to which service delivery may be impacted will be known and shortfalls highlighted.				1		2		
The STP should be re-evaluated			2	1				

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RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
taking cognisance of the available budget. The evaluation should include the quantification of all enefficiencies, and measures taken to address these.								
Virements should reflect operational activity and not a process of balancing over and under expenditure. The current system of December/January virements to shift the money to cover other areas, should be abolished.				1		2		
Financial management								
All service contracts (such as water purificaion and oxgyen supply) need to be reviewed and removed as sources of wasteful or fruitless expenditure.				1	2	1		
Finance skills must be improved and finance and supply chain management functions decentralised.			2	1				
Outstanding policies and procedures must be drafted in line with audit recommendations.				1		2		
Variance analysis must be improved				1		2		
Contracts management should be improved in order not to				1		2		

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
inappropriately bind the department in inefficient and wasteful expenditure over long periods of time.								
Quarterly Performance Reports								
The accuracy of performance information needs to be improved in line with the recommendations of the Auditor-General.				1		2		
There needs to be a link between performance and financial reports.				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								
The annual financial statements, while meeting Constitutional and Government Accounting requirements, should be expanded				2	1	2		

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
beyond the cash basis of reporting and include accruals as part of reported, aggregated expenditure numbers.								
LEADERSHIP, GOVERNANCE and SERVICE DELIVERY RECOMMENDATIONS								
General Leadership								
Ensure approval of the new departmental organogram and develop a clear, transparent and consulted plan for its implementation over the next five years			1	1		1	2	
Revise and finalise policy on the decentralisation of human resource and financial management and ensure appropriate capacity – numbers, skills and systems				1				
Planning								
Incrementally address all the components of an aligned system: five year strategic planning, service transformation plan, budgeting, annual performance and district planning, improved quality of monitoring and individual performance management systems. Ensure a simultaneous bottom-up process in districts and hospitals that feeds into provincial level planning.		1	2	1	2			

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
Build capacity and on-site mentoring in all aspects of planning – identifying needs, priority setting, developing activities, costing and monitoring.		2		1				
Obtain approval and communicate the findings of the Service Transformation Plan.		2	2	1				
Governance								
Build governance and management capacity in district hospitals, and institute measures to improve quality		2	2	1				
Support the development of community accountability mechanisms such as clinic committees, hospital boards and district councils		2	2	1				
Service delivery (HIV, TB and MCH)								
Institute decentralised service planning to ensure equitable allocation of resources		2		1				
Monitor the efficiency of district hospitals and develop doctor support for rural areas		1		1				
Develop revised models of ART delivery nationally (a new version of the CCMT Plan) and provincially	2	1	2	2	2	2		2
Institute patient registers and		2		1				

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
cohort monitoring systems.								
Investigate the causes of declining TB cure rates and institute corrective action								
Institute maternal and perinatal audit and problem identification processes for all facilities doing deliveries, develop and circulate guidelines.								
HUMAN RESOURCES RECOMMENDATIONS								
Delegations, Accountability and Responsibility								
A clear matrix in terms of delegation of authorities and decision making at various levels should be completed (This should be in line with a RACI matrix where different people are responsible, accountable, consulted or informed). This should address: ❒ The specific roles and responsibilities of the minister and the HOD. ❒ The reporting lines within the district offices. ❒ Financial and human resource delegations for the districts and in hospitals should be reviewed and implemented, including reporting structures and guidelines for delegations.	2	1	2	1			2	

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
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RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
Policies and procedures for effective clinical governance should be clarified.		1		1				
The responsibility level of CEOs of institutions and district managers and their district management teams (DMTs) should be reviewed and addressed. This should include a review of areas such as the Kimberley Hospital which carried out dual roles and responsibilities in the past.		2		1				
Integration and co-ordination								
An overarching strategic plan needs to provide a clear framework that coordinates and integrates the activities of all NCDOH players. This should include co-ordination and communication mechanisms across clusters and DHIS to prevent “silo” operational functioning and emphasize the integration of services/programmes.			2	1				
Support functions (HR, finance, information etc.) need to be represented at all senior management meetings.				1				
Special attention must be paid to ensuring that the HIV/TB				1				

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
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RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
programmes (and associated NGO-based community care givers) are integrated into the planning, budgeting and management of the district health system, hospitals and clinics.								
Labour Planning								
The HR plan and HR policies should be finalised and ratified, in line with an approved STP.			2	1				
Organisational design and establishment								
The new staff structure (organogram) should be reviewed, costed and a plan developed for its incremental implementation based on affordability. Special consideration should be given to: ❒ Structuring to allow for the optimal use of scarce resources; ❒ The review of appropriate management ratios, ❒ Consistent job titles and job grades across various areas.		1	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		1		2			2	

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
positions								
PERSAL should be corrected to accurately reflect personnel positions and staffing numbers as reported in the NCDOH Budget Estimate, Annual Reports statements and aligned with the approved structures.		2		1			2	
DPSA should assist NDOH and provinces to support changes to structures in a more efficient manner.		1		2			1	
Review of current staff placements should be undertaken to determine their appropriateness, more especially at the provincial and district management levels. This should include the assurance that appropriately skilled HR, labour relations, finance, SCM, IT, HIS and programme managers exist at the district level.				1			2	
Consideration should be given to the establishment of a provincial Organisational Development (OD) unit to implement national OD directives to ensure: ❒ OD is seen as an integral and important aspect of all provincial activities and not				1				

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
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RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
confined to the revitalisation programme as is the case at present. ❒ OD, planning and monitoring is integrally and continuously linked. ❒ Decentralisation is underpinned by the establishment of effective organisational systems.								
Informed and active organizational change and culture change management processes should be put in place and driven from the leadership level. These should emphasize issues of diversity to ensure inclusion.				1				
Recruitment								
A thorough review and improvement of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times.		2		1			2	
Performance Management								
Rigorous implementation of the national performance management policy should be ensured which must include the monitoring of the effective implementation of staff performance reviews including				1			2	

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
issuing of performance contracts linked to programme indicators, individual development plans, and unbiased reward mechanisms.								
The performance management system should be utilised as intended and incorporate: ❒ Organisational performance; ❒ Employee development; ❒ Reward based on clear performance goals.				1			2	
Retention								
Staff retention strategies need to be reviewed and strengthened including consideration to improved staff housing and use of personal vehicles given the vast distances between service points.				1			2	
A national health professional and scarce skills retention strategy should be updated by the NDOH to assist provinces.		1		2			2	
Rewards								
NDOH should review and if necessary amend the criteria used to determine implementation of the OSD for the various nursing categories.	2	1		2			1	
Lessons learned from the current		1		2	1	2		

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
OSD implementation review for nurses should be captured to inform future implementation of other improvement initiatives.								
Learning and Development								
A comprehensive and fair staff development and training plan should be developed which is based on the specific HR needs of the province and the results of a skills audit.		2		1				
Managers should be provided with training in the effective implementation of an integrated approach to programme management.				1				
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 as a HR management tool.		2		1				
INFORMATION MANAGEMENT RECOMMENDATIONS								
Overall M&E								
M&E needs to be emphasised as a central component of all management, and a key performance area for all levels of		1		1	2	2	2	

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
management								
Key indicators for departments and programmes need to be actively monitored and appropriate action instituted		2		1		2		
Consider developing fewer indicators for programmes and develop systems in key areas (such as ART outcome monitoring)		1		2				
Review and redesign facility data collection processes to enhance efficiency, remove duplication and simplify procedures; reduce data requirements from facilities to the core essential		2		1				
Monitor quality of data returns from facilities and set standards for improved data quality.		2		1				
MEDICAL PRODUCTS, LABORATORY RECOMMENDATIONS								
Improve the design and management of contracts with external providers		2		1	1			
Identify core performance indicators for provincial pharmaceutical services and develop an agenda for national HOPS meeting that addresses strategic issues		1		2				
Conduct an audit of access, equity and efficiency of laboratory use in				1				

Table 10: Recommendations contained in Northern Cape Department of Health IST Report April 2009 and proposals for allocation of main responsibility for implementation and provision of input
Legend: 1 = Main responsibility, 2 = To provide input

RECOMMENDATIONS	National Minister of Health	National Department of Health	Northern Cape Health MEC	Northern Cape Department of Health	National Treasury	Northern Cape Treasury	Department of Public Service and Administration	External stakeholders
the province								
TECHNOLOGY AND INFRASTRUCTURE RECOMMENDATIONS								
Develop 5 year strategic plans for investment and expansion of the IT infrastructure	2	2	2	1	2	2		2
Develop national norms, standards and guidelines for maintenance planning and budgeting, and facilitate sharing of provincial best practice		1		2	2	2		
Review transport management systems at provincial and district level, identify key indicators and implement routine monitoring systems		2		1		2		
Improve the design and management of contracts with external providers		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 STI 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 2009/10 financial year. The IST teams, in partnership with national and provincial departments of health, will identify causes of over expenditure within the health system at both national and provincial levels. The IST will identify common or unique causes of over expenditure and the effect of these on service delivery. The IST team will identify a national and collective response for service delivery improvement despite these funding constraints.

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

1.2.5.2. Review Scope of Work for Finance Consultants

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

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

1.2.5.3. Review scope of work for Health Systems Strengthening Consultants

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

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

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

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

1.2.6. Project Phases

The project will be conducted in three phases:

1.2.6.1. 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), CFOs and managers
- Conduct field visits to selected districts
- Review the outputs and outcomes against strategic and operational plans, budget and expenditure.
- Identify and quantify major cost drivers
- Assist provinces to identify financial planning and management problems
- Review management and administrative systems for monitoring, evaluation and reporting of outputs and outcomes against operational and financial plans.

1.2.6.3. Phase 3- All Teams

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

1.3. IST PROJECT MANAGEMENT

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

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

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

1.3.1.3. Liaison with stakeholders – provinces and national

1.3.1.4. Management of provincial and district visits

1.3.1.5. Collating reports and finalizing the consolidated provincial reports.

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

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

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

1.4. ROLES AND RESPONSIBILITIES

1.4.1. Role of NDOH and Provincial DoH

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

1.4.2. Role of Consultants

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

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

1.5. EXPECTED OUTCOMES AND DELIVERABLES

1.5.1. This refers to both national and provincial ISTs.

1.5.1.1. Standardised provincial and national review templates

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

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

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

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

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

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

1.6. COMPETENCY AND EXPERTISE REQUIREMENTS

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

1.6.1.1. Leadership experience and people and technical management skills

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

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

1.6.1.4. Computer literacy, good communication and writing skills

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

1.6.1.6. Operational and financial management of large projects and programmes

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

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

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

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

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

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

1.6.2.5. Operational and financial management of health projects and programmes

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

1.7. REPORTING REQUIREMENTS

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

1.8. TIMING AND SCHEDULING

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

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

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

1.9. CONTRACTING AND INVOICES

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

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

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

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

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

1.10. 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. NATIONAL DOCUMENTS

2.1.1. National Health Act, July 2004

2.1.2. Public Finance Management Act, 1999

2.1.3. Division of Revenue Act, 2008

2.1.4. National Treasury – Provincial data-base 2008, version 1.1 – for the Northern Cape

2.2. PLANNING DOCUMENTS

2.2.1. Vision 2014

2.2.2. Service Transformation Plan, 2007 (2a)

2.2.3. Service Transformation Plan, February 2009 (3c)

2.2.4. Strategic Plan 2006/2007 – 2009/2009.

2.2.5. Operational Plan 2007/2008

2.2.6. Operational Plan 2008/2009

2.2.7. Annual Performance Plan 2007/2008 – 2009/2010 – updated February 2007

2.2.8. Annual Performance Plan 2009/2010

2.2.9. Hospital Revitalization project implementation plans 2009/2010, for:

2.2.10. Upington Hospital, New Kimberley Hospital, Postmansburg Hospital, Kimberley Mental Hospital. Prof. ZK Matthews Hospital, De Aar Hospital

2.2.11. Ranking document

2.3. POLICY DOCUMENTS

2.3.1. Budget policy, February 2009

2.3.2. Supply Chain Management policy, February 2009

2.3.3. Performance management and development policy (undated)

2.3.4. Salary payment process and procedures (undated)

2.4. FINANCE DOCUMENTS

2.4.1. Auditor-General reports 2005/2006

2.4.2. Auditor-General reports 2006/2007

2.4.3. Auditor-General reports 2007/2008

2.4.4. Annual financial statements, year ended 31 March 2008 (audit adjustments)

2.4.5. Internal audit report, 2007/2008

2.4.6. Budget statement 2005/2006

2.4.7. Budget Statement 2006/2007

2.4.8. Budget Statement 2007/2008

2.4.9. Budget Statement 2008/2009

2.4.10. Integrated Business Plan 2007/2008, Comprehensive HIV/AIDS Conditional Grant.

2.4.11. Presentation, power-point: Conditional grants, February 2008

2.4.12. In year monitoring (IYM) – 2008/2009. Projected and actual expenditure.

2.4.13. Quarterly Performance Reports for:

2.4.14. 1st, 3rd & 4th quarters for 2008/2009.

2.4.15. 2nd & 3rd quarters 2007

2.4.16. Comparisons of costs per patient day equivalents in selected district hospitals.

2.4.17. Financial delegations

2.4.18. Hospital revitalization programme – 2009/10. Financial Report

2.4.19. Presentation power-point, cash flow – March 2009.

2.4.20. Presentation power-point, to the portfolio committee – August 2008 and March 2009.

2.5. HUMAN RESOURCE DOCUMENTS

2.5.1. Human Resources Plan 2008 – 2012, Financial Year 2008/09

2.5.2. Post Structure NC DOH (new organogram abridged version)

2.5.3. Human Resource policies and procedures

2.5.4. Human resource delegations

2.5.5. Staff establishment, PERSAL.

2.6. ADMINISTRATION RELATED

2.6.1. Annual Report – 2005/2006

2.6.2. Annual Report - 2006/2007

2.6.3. Annual Report - 2007/2008

2.6.4. District Management Minutes 2007/2008

2.6.5. District Management Minutes 2008/2009

2.7. OTHER

2.7.1. District Management Study, Health Systems Trust – from October 2007 to September 2008.

2.7.2. Provincial Budgets Expenditure review 2003/04 - 2009/10. Chapter 3 – Health.

2.7.3. Health System Trust: District Health Barometer Data 2008.

2.7.4. Health Systems Trust: Health Information Audit Report Northern Cape. Durban: HST, 2006.

2.7.5. Massyn, Naomi. Health Systems Trust. National contract for Support on Health Information: Report on needs assessment in Northern Cape Province with work plan, August 2005.

3. APPENDIX 3: SCHEDULE OF INTERVIEWS

Interview date	Name	Designation	Department	Work history & commencement date
Provincial Office – Kimberley				
24 April 2009	Dr T Sibeko	Head of Department	Northern Cape Provincial Health Department	October 2007
15 April 2009	Ms Z Kiti	Deputy Director	Organisation Development, Hospital Revitalization Programme	November 2008
15 April 2009	Mr M Mlatha	Director	Policy and Planning Department	
15 April 2009	Mr D Moretele	Network Controller	Information Technology Unit based at Kimberley Hospital	
15 April 2009	Mr L Mabona	Director	Hospital Revitalization and Provincial Infrastructure Department	
16 April 2009	Mr G Mentoor	Director	Pharmaceutical Services	Came to NC DOH from Treasury in 2007 – is an accountant
16 April 2009	Mr G Monthso	Chief Executive Officer	Kimberley Hospital Complex	In CEO post for 6 weeks, previously 7 years as Deputy CEO at Upington Hospital.
16 April 2009	Ms M Mdokwana	Nursing Services Manager	Kimberley Hospital Complex	
16 April 2009	Mr S Vilikazi	Director	Security and Risk Management	New in the post
16 & 17 April 2009	Mr M Dawood	Deputy Director	Budget Department	Worked at the PDOH for 12 years
17 April 2009	Ms M Thuntsi	Director	District Health Services	In 1992 was Principal of the Nursing College, in 2006 became a Director – was acting HOD for 6 months
17 April 2009	Mr G Makgopa	Manager	Health Information Unit	At PDOH since 2003

Interview date	Name	Designation	Department	Work history & commencement date
17 April 2009	Mr D Gaberone	Acting Director	Human Resource Department	At PDOH since 2000 – started as Deputy Director for Finance
17 April 2009	Ms N Mazibuko	Director	Communicable Diseases Department	
17 April 2009	Ms Mokotso	Director	Priority Programmes	At PDOH since 2000, previously Local Gov
John Taolo Gaetsewe District –Kuruman				
20 April 2009	Ms V Manong	District Manager - Health	John Taolo Gaetsewe District (Formerly Kgalagadi)	Came to NC in 1997
20 April 2009	Mr M Molejane	Assistant Director – responsible for HR	John Taolo Gaetsewe District	
20 April 2009	Ms A Thupani	Provincial Deputy Director responsible for MCWH. Seconded to district to facilitate the integration of district services and of the two hospitals	John Taolo Gaetsewe District	In department from 1976 to 2003 – ended up as the Hospital Clinical Manager. In 2003 was appointed to the sub-directorate of MCWH in the province
21 April 2009	Mr AT Sejake	Hospital General Manager	Tswaragano Hospital	Appointed hospital manager in 2003
21 April 2009	Ms M Kaotsane	Deputy Director - responsible for PHC Services	John Taolo Gaetsewe District	
21 April 2009	Ms KD Dijong	Hospital Manager	Kuruman Hospital	Started work in 2005

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	5 048[6]		941[7]		18.64%	5 320[8]	1 037[9]	19.49%
2006/07	4 395[10]	-12.94%	1 291[11]	37.19%	29.37%	4 510[12]	1 316[13]	29.18%
2007/08	5 663[14]	28.85%	1 460[15]	13.09%	25.78%	5 899[16]	1 580[17]	26.78%
2008/09	6 689[18]	18.12%	1 774[19]	21.51%	26.52%	7 062[20]	1 857[21]	26.30%
2009/10	7 941[22]	18.72%	2 214[23]	24.80%	27.88%	N/A	N/A	N/A
2010/11	8 788[24]	10.67%	2 533[25]	14.41%	28.82%	N/A	N/A	N/A
2011/12	9 516[26]	8.28%	2 685[27]	6.00%	28.22%	N/A	N/A	N/A

[6] Northern Cape Provincial Budget Statement 2006/07 Page 24
[7] Northern Cape Provincial Budget Statement 2006/07 Page 24
[8] Northern Cape Provincial Budget Statement 2006/07 Page 24
[9] Northern Cape Provincial Budget Statement 2006/07 Page24
[10] Northern Cape Provincial Budget Statement 2007/08 Page26
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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	5 320	2 018[28]	3 302	1 037	318[29]	N/A	719	21.77%
2006/07	4 510	952[30]	3 557	1 316	561[31]	76.42%	755	21.23%
2007/08	5 899	1 161[32]	4 738	1 580	553[33]	-1.43%	1 027	21.68%
2008/09	7 062	1 398[34]	5 664	1 857	600[35]	8.50%	1 257	22.19%
2009/10	7 941	1 778[36]	6 163	2 214	788[37]	31.33%	1 426	23.14%
2010/11	8 788	2 056[38]	6 732	2 533	954[39]	21.07%	1 579	23.45%
2011/12	9 516	2 261[40]	7 255	2 685	979[41]	2.62%	1,706	23.51%

Table 3: National Conditional Grants to Provinces and NCDOH share

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		R 000 Total Conditional Grant to Provinces	R 000 NCDOH Provincial Allocation	% Allocation of National Grant
Comprehensive HIV & AIDS Grant	2005/06	1 150 108	52 638[42]	4.58%
	2006/07	1 616 214	72 682[43]	4.50%
	2007/08	2 006 223	74 091[44]	3.69%
	2008/09	2 885 400	91 444[45]	3.17%
	2009/10	3 476 200	113 703[46]	3.27%
	2010/11	4 311 800	157 150[47]	3.64%
	2011/12	4 633 000	168 559[48]	3.64%
National Tertiary Services Grant	2005/06	4 709 386	76 353[49]	1.62%
	2006/07	4 981 149	92 286[50]	1.85%
	2007/08	5 321 206	110 775[51]	2.08%
	2008/09	6 134 100	153 567[52]	2.50%
	2009/10	6 614 400	173 241[53]	2.62%
	2010/11	7 398 000	225 948[54]	3.05%
	2011/12	7 799 000	238 964[55]	3.06%

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Table 3: National Conditional Grants to Provinces and NCDOH share

		R 000 Total Conditional Grant to Provinces	R 000 NCDOH Provincial Allocation	% Allocation of National Grant
Total Conditional Grants to Provinces	2005/06	8 907 346	295 065[56]	3.57%
	2006/07	10 206 542	548 887[57]	5.50%
	2007/08	11 736 678	515 955[58]	4.40%
	2008/09	14 362 800	566 029[59]	3.94%
	2009/10	15 578 400	705 632[60]	4.53%
	2010/11	18 012 800	887 986[61]	4.93%
	2011/12	19 172 000	908 165[62]	4.74%

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Table 4: Northern Cape provincial vs national trends in per capita health budget

	Uninsured national population	Rm Total of provincial budgets	R Uninsured per capita	Year on year increase	Uninsured provincial population	Rm Provincial budget	R Uninsured per capita	Year on year increase
2005/06	40,323,852[63]	47,147	1,169		761,541	1,037	1,362	
2006/07	40,898,347[64]	53,175	1,300	11.20%	946,743	1,316	1,390	2.10%
2007/08	41,007,279[65]	60,812	1,483	14.06%	937,972	1,580	1,684	21.15%
2008/09	41,725,016[66]	73,581	1,763	18.92%	958,141	1,857	1,939	15.09%
2009/10	41,725,016[67]	82,359	1,974	11.93%	958,141	2,214	2,310	19.18%
2010/11	41,725,016[68]	91,999	2,205	11.70%	958,141	2,533	2,644	14.44%

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