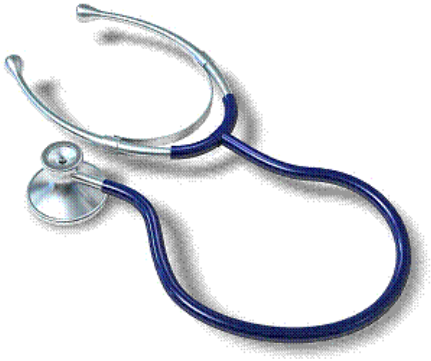
# Gauteng Department of Health

# 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 Gauteng Department of Health.

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# Abbreviations

| | |
|---|---|
| AFS | Annual Financial Statements |
| AIDS | Acquired Immunodeficiency Syndrome |
| APP | Annual Performance Plan |
| ART | Anti-retroviral Therapy |
| ARV | Anti-retroviral |
| BAS | Basic Accounting System |
| BBBEE | Broad-Based Black Economic Empowerment |
| BEE | Black Economic Empowerment |
| CEO | Chief Executive Officer |
| CFO | Chief Financial Officer |
| CHC | Community Health Centre |
| COE | Compensation of employees |
| DDG | Deputy Director-General |
| DFID | UK Government's Department for International Development |
| DHIS | District Health Information System |
| DHS | District Health System |
| DMT | District Management Team |
| DOH | Department of Health |
| DPSA | Department of Public Service and Administration |
| EMS | Emergency Medical Service |
| EWP | Employee Wellness Programme |
| GDOH | Gauteng Department of Health |
| GP | Gauteng Province |
| GSSC | Gauteng Shared Services Centre |
| HAST | HIV, Aids, STI's, TB |
| HIS | Health Information System |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System |
| HOD | Head of Department |
| HR | Human Resources |
| HRD | Human Resource Development |
| HRH | Human Resource for Health (management tool) |

| | |
|---|---|
| HSS | Health Systems Strengthening |
| IDP | Integrated Development Plan |
| IST | Integrated Support Teams |
| IT | Information Technology |
| IYM | In Year Monitoring |
| LG | Local Government |
| M&E | Monitoring and Evaluation |
| M&OD | Management & Organisational Development |
| MACH | Ministerial Advisory Committee on Health |
| MCH | Maternal and Child Health |
| MEC | Member of the Executive Council |
| METRO | Metropolitan (Local Government) |
| MSAU | Multi Sectoral Aids Unit |
| MSD | Medical Supply Depot |
| MTEF | Medium Term Expenditure Framework |
| N/A | Not available/ not applicable |
| NDOH | National Department of Health |
| NGO | Non-Governmental Organisation |
| NHA | National Health Act |
| NHLS | National Health Laboratory Services |
| NIDS | National Indicator Data Set |
| NSP | National Strategic Plan |
| NTSG | National Tertiary Services Grant |
| OD | Organisational Development |
| OSD | Occupational Specific Dispensation |
| PCM | Personnel Circular Minutes |
| PDE | Patient Day Equivalent |
| PERSAL | Personnel and Salary Administration System |
| PFMA | Public Finance Management Act |
| PHC | Primary Health Care |
| PHRU | Perinatal HIV Research Unit |
| PMO | Project Management Office (internal) |
| PMTCT | Prevention of Mother-To-Child-Transmission |
| PMU | Project Management Unit (external service provider) |
| RACI | Responsible, Accountable, Consulted, Informed |

| | |
|---|---|
| RHRU | Reproduction Health Research Unit |
| RRHF | Rapid Response Health Fund |
| RWOPS | Routine Work Outside of Public Service |
| SANBS | South African National Blood Service |
| SCOA | Standard Chart of Accounts |
| SIP | Service Improvement Plan |
| SLA | Service Level Agreement |
| STI | Sexually Transmitted Infection |
| STP | Service Transformation Plan |
| TB | Tuberculosis |
| TPA | Transvaal Provincial Administration |
| TR | Team Representative |
| TSG | Tertiary Services Grant |
| WHO | World Health Organization |

# Foreword

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

At the time of writing this report the Gauteng Department of Health (GDOH) had suffered adverse media publicity regarding the perceived lack of independence of implementing a Project Management Unit (via an external service provider), the non-payment of suppliers (since approximately January 2009) and the doctors' strike (due to the non-implementation of OSD for doctors, which was due to be implemented in July 2008, but to date has not been implemented). The non-payment of suppliers and non-implementation of OSD for doctors is a consequence of inadequate funds in relation to the cost associated with the health services being provided in Gauteng as well as a tightening of the financial belt by the Gauteng Treasury.

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

This report contains the findings and recommendations of the Integrated Support Team (IST), set up by the Minister of Health. We found many committed senior managers (who provided examples of working hard at attempting to achieve targets despite an inadequacy of the human resources required to achieve these targets and limited funding), much of the foundation for a well-performing health system is in place, a comprehensive and wide range of services are available to the people in Gauteng and there is a lot of goodwill to contribute to change and implement ongoing health system transformation policies. The report also identified many shortcomings, ranging from strategic planning and leadership, through to financial management and monitoring and evaluation. We recognise that the health sector is complex, and many of the solutions to the problems and issues raised are to be found in other government departments such as the National Treasury, Provincial Treasury, Department of Public Service and Administration and the National Department of Health. Hence, the entire Public Health system, and its component parts, needs to function as an integrated whole to achieve improved health system performance. At the same time, many solutions fall within the ambit of the Gauteng Department of Health, and we urge senior managers to become champions for the

changes proposed in the report. The concluding section contains a detailed set of recommendations for health system improvement, including the responsibility of key stakeholders, many who are outside the GDOH.

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 GDOH 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, district and hospital level.

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; and
- ❒ Technology and Infrastructure

The priority findings of the review are:

1. Budgeting and financial management processes (including cost allocations and proper cost centre accounting; financial monitoring and evaluation) are sub-optimal;

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

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

4. Primary Health Care. The core provision of health services is supposed to be realised through accessible, effective, efficient and quality primary health care (PHC) services, delivered through the District Health System (DHS). Many strategic plans indicate that the "strengthening of primary healthcare" is a key focus area. However, there are a number of issues that undermine this:

4.1. Clinics and CHC's may be inappropriately located (in that taxi services there are limited or they are not close to any main highways).

4.2. The operating hours of clinics and CHC's are limited, which results in some patients having to access services from hospitals;

4.3. The DHS, in terms of the National Health Act, has not been implemented and the delivery of PHC is split between Local Government and GDOH. As a result different clinics offer different "packages of primary health services", with some confusion for the patients.

4.4. The existing nurses at clinics and CHC's are expected to implement new programmes without an increase in human resource numbers despite an increase in the workload and the targets.

4.5. There appears to be more of a focus on hospital services.

5. Although HR policies and procedures exist, execution and full implementation and adequate monitoring appears to be problematic. The organisational structure and staff establishment are not aligned with the budgets or planning processes to optimally meet service delivery requirements. The information contained in, and the manner in which HR information systems are used, require improvement.

6. There is a lack of accountability at various levels of the system. For example, there is no consequence if there is overspending. Even directorates that have under spent or spend according to their budget allocation are being punished, as their accounts / service providers are not being paid due to the over-expenditure by other directorates, and hence they have to face the wrath of their service providers. Similarly, where targets are not met, there appear to be no consequences. If individuals do not submit performance management agreements on time (or at all), there are no adverse consequences.

7. There are many frustrations faced in dealing with the Gauteng Shared Services Centre (GSSC). There are many inefficiencies and time delays at GSSC, which if better managed could lead to cost savings and better service delivery. Currently GSSC has not paid GDOH service providers since January 2009, resulting in many service providers not wanting to deal with the GDOH. The process for the advertising of posts for the GDOH, for which GSSC is responsible, is so long that prospective employees are lost.

8. Political statements - It was mentioned that statements are made by politicians (eg “we will roll this out” or “we will build a clinic here”), without an exercise being undertaken to determine the costs and human resource implications of such a statement. Managers are then expected to turn the politician’s statement into a reality and to implement. However, this comes as a sacrifice to other budgeted activities.

9. Monitoring and evaluation (M&E) is inadequate. Although in some directorates, much time and resources are invested in data collection, these data are not always analysed, interpreted or used for decision making and there is little or no feedback of information from one level to the next. The PERSAL data is hardly used for management purposes yet HR costs account for 50% of the total expenditure.

10. Much time and effort goes into planning, but the process is formulaic and based on compliance rather than being utilised as an effective management tool. Additionally, there is a disjuncture and lack of integration between planning, budgeting and implementation. There is a plethora of plans at different levels, leading to confusion around the status of various plans and which is the “lead” plan.

11. Senior management appear to be pre-occupied with bureaucratic functions and as a result may lose focus on service delivery which is the core responsibility of the GDOH. This is partially due to the withdrawal of delegations which causes management to be involved in mundane day to day operations.

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

**UNFUNDED MANDATES**

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

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

**LACK OF COHESION BETWEEN POLICY AND BUDGETS**

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

2. All operational units (cost centres) need to have a realistic budget that can be used as a guideline for the financial year's activities. Operational plans need to be aligned with available funding and available human resources to deliver the services.

**ART MODEL**

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

## STRENGTHENING OF PRIMARY HEALTH CARE

1. A decision on the implementation of the National Health Act, through the provincialisation of clinics and CHC's, is required. The lack of decision making in this regard impacts on efficiency and budgets.

2. A comprehensive plan to improve and strengthen primary health care and access to primary health care needs to be developed. The financial implications (and sustainability) and human resource and infrastructure and all associated implications needs to be taken into account in this plan.

## NATIONAL GUIDELINES, NORMS AND STANDARDS

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

## ACCOUNTABILITY

1. Application of the provisions of the PFMA regarding accountability need to be enforced, and accountability needs to be entrenched from the top and downwards to all staff throughout the system.

## GAUTENG SHARED SERVICE CENTRE

1. The formal Service Level Agreements (SLA's) in place between the GSSC and the GDOH should be modified to clearly define responsibilities and detail expected standards of delivery (e.g. turn-around times). This SLA may then be used by the GDOH to adequately monitor the performance of the GSSC, and hold parties accountable for non-performance.

## POLITICAL STATEMENTS

1. Any political statement made by the MEC / Premier with service delivery and budgetary implications should undergo some kind of approval process, in consultation with the HOD and CFO, before it is made public.

## HUMAN RESOURCES

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

## MONITORING & EVALUATION

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

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

## PLANNING

1. The STP should be costed, revised in terms of the available budget and then implemented.

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

## SERVICE DELIVERY FOCUS

1. Senior management need to focus on strategic as well as operational issues and service delivery needs to be one of the priority strategic issues.
2. Performance agreements should be clearly linked to clear delegations, organisational priorities and key indicators that drive organisational performance.

# Introduction

## 1. BACKGROUND

1.1. During the course of the 2008/09 financial year it became apparent that there was a negative difference between what was budgeted for in the health system and what was required to implement agreed upon policies. This was associated with overspending in most of the provinces undermining the capacity of the Health Ministry and the National and Provincial 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, district and hospital level.

4.3. The desktop review comprised an analysis of available public documents plus selected documents obtained from the GDOH 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 the majority of senior managers at the provincial level and at the purposefully selected district of Metsweding and the Chris Hani Baragwanath hospital. The interviews were conducted by a team of three experts who visited the GDOH between the 2nd and 17th of April 2009. The list of people interviewed is shown in Appendix 3. The interviews were complemented further by an analysis of documentation provided.

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

## 5. OUTLINE OF THE REPORT

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

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

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

# Financial Review

## 1. INTRODUCTION

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

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

1. The contention of under-funding of the GDOH and the South African public health system as a whole is being investigated at a national level and will be commented on in the overall IST National Department of Health report.
2. Since 2006/07, approximately 30% of the total Gauteng provincial revenue has been allocated to health and this has been constant over the past three years. The allocation came down from a level of 35% in 2005/06.
3. The relative proportion of the national conditional grant for HIV/AIDS allocated to the GDOH has marginally increased over the past four years, whilst for the national tertiary services grant (NTSG) it reduced. The overall HIV/AIDS grant increased substantially over the past three years whilst the NTSG grew by an average of 8% during the same period.
4. The GDOH per capita budget based on the uninsured population is consistently higher than the national per capita budget for South Africa.
5. The GDOH, received real growth in terms of budget allocation during the past three years, but compared to other provinces their allocation was reduced.
6. Although over-expenditure commenced in the 2005/6 financial year, it was exacerbated in subsequent financial years by an increase in staff numbers, higher than budgeted medical inflation and higher numbers of patients than original forecast numbers.
7. There is lack of alignment between annual plans and the budget.
8. Budgeting and financial management processes (including cost allocations and proper cost centre accounting; financial monitoring and evaluation) are sub-optimal.
9. Management accountability for finances needs improvement.

| Box 1: Key findings from the financial review |
|---|
| 10. The financial system is not integrated with the quarterly performance reporting system. |
| 11. The lack of an integrated health information system results in a deficient budgeting process. |

## 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 GDOH 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 Gauteng Province’s budget to the GDOH is shown in Table 1. The allocation includes the equitable share, conditional grants and provincial revenue. Approximately 30% of the total provincial revenue is allocated to health and this figure has remained fairly constant over the last three years (2005/06 to 2008/09). The material reduction in the provincial budget allocation from 35% to 30% between the 2005/06 and 2006/07 years was due to the increased allocation to the Department of Public Transport, Roads and Works in respect of the Gautrain. Table 1 also illustrates that year-on-year growth including grants for the years 2006/07, 2007/08 and 2008/09 was 12.4%, 15.8% and 15.2% respectively, which is above inflation. The MTEF forecast indicates that the growth in the budget allocation from 2009/10 to 2010/11 reduces to 1%, this being well below the target inflation and may impact on overspending in the future.

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 | 26 604 | N/A | 9 258 | N/A | 34.80% | 27 579 | 9 841 | 35.68% |
| 2006/07 | 34 460 | 29.53% | 10 404 | 12.38% | 30.19% | 35 278 | 10 654 | 30.20% |
| 2007/08 | 40 312 | 16.98% | 12 052 | 15.84% | 29.90% | 41 194 | 12 446 | 30.21% |
| 2008/09 | 46 672 | 15.78% | 13 889 | 15.24% | 29.76% | 48 605 | 14 908 | 30.67% |
| 2009/10 | 55 259 | 18.40% | 16 590 | 19.45% | 30.02% | N/A | N/A | N/A |
| 2010/11 | 55 915 | 1.19% | 18 351 | 10.61% | 32.82% | N/A | N/A | N/A |

3.2. Table 2 indicates that when conditional grants are excluded, the provincial equitable share allocation to GDOH, remains relatively constant around 28% with a slight increase in 2008/09. The year on year growth of the GDOH's health budget during the 2007/08 and 2008/09 period is 20%. The GDOH's allocation reflects a growing trend during the past three years, however, a recurring theme during the interview process, highlighted the fact that this may not be adequate to cover the increase in patient numbers (i.e. from across provincial and national borders).

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 Adjustment Health Grants | % Year on year increase in Health Grants | R m Adjustment Health Budget (excl. Grants) | % Allocation to Health |
|---|---|---|---|---|---|---|---|---|
| 2005/06 | 27 579 | 4 537 | 23 043 | 9 841 | 2 709 | N/A | 7 131 | 30.95% |
| 2006/07 | 35 278 | 8 855 | 26 423 | 10 654 | 3 269 | 20.67% | 7 385 | 27.95% |
| 2007/08 | 41 194 | 9 699 | 31 494 | 12 446 | 3 682 | 12.63% | 8 764 | 27.83% |
| 2008/09 | 48 605 | 11 484 | 37 122 | 14 908 | 4 353 | 18.22% | 10 555 | 28.43% |
| 2009/10 (Main Budget) | 55 259 | 13 351 | 41 908 | 16 590 | 4 638 | 6.55% | 11 952 | 28.52% |
| 2010/11 (Main Budget) | 55 915 | 10 801 | 45 114 | 18 351 | 5 081 | 9.55% | 13 270 | 29.41% |

# 4. NATIONAL CONDITIONAL GRANT ALLOCATION

4.1. The comprehensive HIV & AIDS and national tertiary service grants (NTSG) were used as two tracers to assess trends in the allocation of conditional grants to the GDOH (Table 3). There has been a steady decline in the proportion of the NTSG allocated to the GDOH from 2006/07 through to 2009/10. On the other hand the HIV grant allocation has steadily increased and appears to mirror the provincial population as a percentage of the total population (around 21%).[3] The growth in the expected number of ARV treatment patients is approximately 285% during the period 2005/06 to 2008/09[4]. Cognisance should be taken of the fact that the ART programme is currently to a large extent dependent on donor support. Should donor funding reduce in future, the sustainability of the programme would be compromised and place pressure on the Treasury to increase HIV/AIDS funding. There is a perception in the GDOH that the current ART coverage is only at around 20%, highlighting both the magnitude of the HIV pandemic and raising doubt as to whether the NSP target to reach 80% of patients requiring ARV by 2011 can be attained.

Table 3: National Conditional Grants to Provinces

| | | R 000 Total Conditional Grant to Provinces | R 000 Gauteng Provincial Allocation | % Allocation of National Grant |
|---|---|---|---|---|
| Comprehensive HIV & AIDS Grant | 2005/06 | 1 150 108 | 185 048 | 16.09% |
| | 2006/07 | 1 616 214 | 270 195 | 16.72% |
| | 2007/08 | 2 006 223 | 399 604 | 19.92% |
| | 2008/09 | 2 885 400 | 649 631 | 22.51% |
| | 2009/10 | 3 476 200 | 760 879 | 21.89% |
| | 2010/11 | 4 311 800 | 866 452 | 20.09% |
| | | | | |
| National Tertiary Services Grant | 2005/06 | 4 709 386 | 1 760 465 | 37.38% |
| | 2006/07 | 4 981 149 | 1 866 094 | 37.46% |
| | 2007/08 | 5 321 206 | 1 959 399 | 36.82% |
| | 2008/09 | 6 134 100 | 2 207 424 | 35.99% |
| | 2009/10 | 6 614 400 | 2 328 301 | 35.20% |
| | 2010/11 | 7 398 000 | 2 561 154 | 34.62% |
| | | | | |

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

[4] Clinton foundation estimates

Table 3: National Conditional Grants to Provinces

| | | R 000 Total Conditional Grant to Provinces | R 000 Gauteng Provincial Allocation | % Allocation of National Grant |
|---|---|---|---|---|
| Total Conditional Grants to Provinces | 2005/06 | 8 907 346 | 2 635 294 | 29.59% |
| | 2006/07 | 10 206 542 | 3 187 549 | 31.23% |
| | 2007/08 | 11 736 678 | 3 600 224 | 30.67% |
| | 2008/09 | 14 362 800 | 4 266 167 | 29.70% |
| | 2009/10 | 15 578 400 | 4 540 766 | 29.15% |
| | 2010/11 | 18 012 800 | 4 970 337 | 27.59% |

4.2. The NTSG grant allocated to GDOH in proportion to the total NTSG reduced from around 37% in 2005/06 to 36% in 2008/09 The GDOH's proportion of the total conditional grants was marginally reduced from 2006/07 to 2008/09. The criteria for the allocation of all the conditional grants were not clear. The split between the NTSG and equitable share to institutions was not clearly communicated, adding to administrative and reporting burden.

## 5. TOTAL BUDGET PER CAPITA

5.1. The budget per capita for the GDOH was calculated using Statistics South Africa mid-year estimates (Table 4) adjusted with the insured population from the general household survey. The nominal budget per capita has increased, and is expected to increase at a rate in excess of inflation according to the MTEF.

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

| Financial year | National Uninsured Population | R m Total of Provincial Health Budget | R Total of Provincial Health Budget per capita Uninsured | % Increase year on year | Gauteng Uninsured Population | R m Gauteng Health Budget | R Gauteng Health Budget per capita uninsured | % Increase year on year |
|---|---|---|---|---|---|---|---|---|
| 2005/06 | 40,323,852 | 47,147 | 1,169 | NA | 6,988,950 | 9,841 | 1,408 | NA |
| 2006/07 | 40,898,347 | 53,175 | 1,300 | 11.20% | 7,449,488 | 10,654 | 1,430 | 1.58% |
| 2007/08 | 41,007,279 | 60,812 | 1,483 | 14.06% | 7,663,287 | 12,446 | 1,624 | 13.55% |
| 2008/09 | 41,725,016 | 73,581 | 1,763 | 18.92% | 8,263,656 | 14,908 | 1,804 | 11.08% |
| 2009/10 | 41,725,016 | 82,359 | 1,974 | 11.93% | 8,263,656 | 16 590 | 2,008 | 11.28% |
| 2010/11 | 41,725,016 | 91,999 | 2,205 | 11.70% | 8,263,656 | 18 351 | 2,221 | 10.62% |

Source: Population numbers per STATS SA mid-year estimates (P0302) adjusted with the insured population from the STATS SA general household survey.

5.2. The GP per capita budget based on the uninsured population is consistently higher than the national per capita budget for South Africa. This population excludes the influx of large numbers of people from neighbouring provinces such as Mpumalanga, Limpopo and North West and cross border (Zimbabwe, Mozambique) who reportedly make use of health services in Gauteng. The year-on-year increases during the period 2006/07 to 2010/11 are consistently lower than that of the national per capita budget. During 2008/09 the national budget per capita increased much more than that of GP and the difference between the GP and national per capita budget reduces over time to be almost on par in 2010/11.

# 6. TRENDS IN HEALTH EXPENDITURE

6.1. The GDOH has overspent its budget for all the years under review (being 2005/06 to 2008/09) (Table 5). The surplus/(deficit) per the Appropriation Statements has been adjusted by the IST team to take into account the increase in the accruals outstanding at year-end (i.e. accounts payable). This has been done to better align the operational activity with actual payments of expenses made (e.g. Pharmaceutical products utilised prior to year end and only paid after year end). It should be noted that the numbers for the 2008/09 financial year have been prepared on a different basis than those for the other years (i.e. the numbers for 2008/09 are unaudited). Comparable figures will only be available once the 2008/09 annual financial statements have been audited. Any conclusion on trends up to 2008/09 should therefore be reserved until the financial statements have been finalised.

Table 5: Trends in GDOH 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 | (133,543) | (366,480) | (639,507) | (771 147) |
| (Increase)/decrease in accruals payable | (158,899) | (62,989) | (228,127) | (126 035) |
| Surplus (deficit) adjusted for movement in accruals | **(292,442)** | **(429,469)** | **(867,634)** | **(897 182)** |
| *Balance of accruals at year end* | *282,849* | *345,838* | *573,965* | *700,000*[5] |

Source: Annual financial statements of various years.

[5] The balance of accruals as per the GDOH

6.2. Table 5 above indicates the estimated overspend for the 2008/09 financial year to be R771 million. There has been a substantial increase in the balance of accruals over the past four years with the result that the carry through effect of unpaid bills accumulates and adds pressure to the following years' budgets. Any further comment on the 2008/09 figures should be reserved until audited results are available.

## 6.3. ANALYSIS OF EXPENDITURE IN THE GDOH

6.3.1. Evident from Table 6 below, the trend in overspending has substantially increased from a level of R133 million in 2005/06 to R640 million in 2007/08 and an estimated overspend of R771 million in 2008/09. The trend reflects an alarming growth in overspending over the period under review, particularly under economic classifications compensation of employees and goods and services. In the 2008/09 financial year, capital expenses were also overspent partly due to the roll out of new information systems. It should be noted that the reported actual and budgeted figures per the 2006/07 financial statements differ materially from the reported actual and budgeted figures in the 2006/07 provincial budget statements.

### 6.3.2. Explanations and general perceptions

6.3.2.1. There is a perception from National Treasury that GDOH spends excessive amounts on non-core business whilst core business is neglected.

6.3.2.2. In reviewing internal management information for the 2007/08 and 2008/09 financial years, as well as feedback given in various interviews, underlying reasons and contributing factors to the overspend are discussed below:

- ❒ Compensation of employees

  - *The history of human resources* – Historically, all staff fell under the Transvaal Provincial Administration (TPA), with all staff accounted for in a central human resource system. Since then a process was embarked on, the Service Improvement Plan (SIP), to develop staff establishments per district / facility. This process resulted in certain employees being on the payroll, yet not allocated to a specific establishment (these are referred to as "floating"

bodies). The implication of this is an under budgeting of staff costs, as these are based on staff establishments. A number of interviewees indicated that there was insufficient budget to cover the current staff employed. Prior to 2006, the GDOH under spent on COE due to staff losses balancing out on a potential over spend in terms of COE (due to the "floating bodies"). The budget was then moved from COE to goods and services. Subsequent to 2006, GDOH budgeted inappropriately for additional staff. Since then, staff recruitment and retention policies were more effective and thus the staff numbers increased, leading to massive overspending on COE.

- Carry through effect from previous year's unfunded mandates.
- Appointment of additional staff without having adequate budget.
- Commuted and normal overtime by doctors. Commuted overtime is not managed properly and becomes open to abuse. It remains a difficult item to monitor.
- Higher than budgeted salary increases
- Progression payments ("notch increases")
- Year on year increases in staffing numbers
- It is evident that the change in salaries due to the OSD has made a major contribution to the increase in personnel expenditure. In addition salary increases, additional fringe benefit contributions, overtime and other allowances coupled with higher staff numbers compounded the overspend problem.

❒ Goods and Services

- GDOH faces major challenges with regards to spending on Goods and Services. The main reasons are set out below:

  → Higher than inflation (CPIX) increases on some of the top ten items:

    - Nursing services
    - NHLS
    - Blood
    - Telephones and cell phones
    - Medicines
    - Surgical and medical supplies

- Consultants

→ BEE suppliers add to costs due to their pricing structures but also have limited capacity to deliver on time and to the standard and quality required. Feedback in interviews confirmed that at times contracts initially awarded to a BEE supplier resulted in poor quality and insufficient skills required to perform the service, and that other contractors were required to correct or complete the service. A direct result is buying on short notice at considerably higher prices and possible litigation costs relating to faulty maintenance. An example of where this occurred related to the repair of specialised medical equipment. BEE supplier contracts management and quality control is lacking in this regard.

→ Inefficiencies relating to diagnostic services and accompanying records management. It was noted that in some cases, patient information was lost in the system (between facilities or even within the facility itself), resulting in duplication of tests performed and resources wasted.

→ Lack of controls and inefficiencies relating to transport, telephone and cell phone usage.

→ The new Saurion IT system was piloted in a number of hospitals and clinics in 2008/09 resulting in overspend. A general anomaly is that IT expenditure is budgeted for under operational budgets and not capital expenses, hence there is never enough budget to properly roll out systems and equipment where needed. The system is further discussed under Technology and Infrastructure below.

→ Additional operational costs are not considered when medical equipment is purchased (such as the expertise to operate and maintain the equipment).

→ The Gauteng Shared Service Centre has been in operation since 2001. A SLA is in place between GDOH and GSSC. The GSSC provides on behalf of the GDOH general procurement, staff appointments, accounting functions and administrative functions relating to tender processes. There is a general perception from management that the GSSC is inefficient and contributes to overspend.

→ Some of the main inefficiencies and cost implications reported are:

- Inflated prices are charged e.g. IT equipment

- Recruitment costs are as high as three times the normal cost (as GDOH pays GSSC for this service and GSSC outsources this and then charges GDOH again for the outsourcing)
- Recruitment of staff is time consuming and the process is dragged out for more than six months. This has a direct impact on service delivery where key clinical staff appointments are lost due to potential employees finding employment elsewhere due to the long timeframes
- Incorrect data and journal capturing and unacceptable long periods elapsing before corrections are captured
- Delayed payments to suppliers that results in interest charges for the GDOH, as well as suppliers unwilling to do business with the GDOH
- It does not prioritise health in relation to other provincial functions
- Adds to bureaucracy in the system.

→ It was noted during the interviews that some service providers have not been paid since January 2009, resulting in service providers stopping to render services or supplying goods to the GDOH. The late payment of the NHLS account for example has the following consequences. It limits their ability to evaluate new technologies, to develop own technologies and to expand and train staff to maintain a high standard. [6]

- The PMO/PMU(3P) impact.
- The GDOH has established a PMO, being an internal project management office and a PMU, being an external project management unit.
- The PMU was created to capacitate the PMO by providing the necessary skills in performing project management functions.
- Feedback given by certain managers indicated concerns with the PMU, with comments stating the following:
- Due to lack of proper and informed role distinction, the PMU is regarded as a duplication of services, hence increasing costs;
- Managers feel disempowered in that the PMU is “stealing” projects;

[6] Noted at the NDOH ART workshop, 24/25 March 2009

- The PMU has attributed to the low staff morale, in that the PMU has been given authority to perform some of the normal functions of the GDOH;
- The impression given by the PMU is that there is a lack of decision making /leadership and ownership at senior management level, in that it can be said "the consultants said so" (i.e the PMU) (i.e decisions made at a senior level are justified by a consultants report);
- There is currently a moratorium on the filling of posts / employment of staff, yet the PMU is still able to sub-contract staff as the costs of the PMU are reflected under goods and services;
- The value for money provided by the PMU in terms of effective, efficient and economical principles as envisaged by the PFMA was perceived to be questionable. The PMU staff is said to have very good financial skills, but very limited health expertise;
- Due to lack of proper and informed role distinction, duplication of functions is experienced and may result in fruitless and wasteful expenses;
- The PMU is also perceived to contribute to the shift in focus of the GDOH from a service department to a more corporate or business like activity.

❒ General

- Changes made to the standard chart of accounts (SCOA) in April 2008 created problems for GDOH during the transition process from the old SCOA to the new SCOA. (e.g changes in the coding of line items resulted in incorrect capturing against the revised codes).
- Patients enter into the health system at inappropriate levels, i.e. Level 1 and 2 patients are treated at tertiary hospitals instead of PHC. This has a massive impact on all resources, e.g. staff, infrastructure and impacts negatively on the GDOH financially. Transporting these patients back to clinics is costly and time consuming. Contributing to this issue: some clinics are inappropriately located; have limitations to access from a transport perspective; have fixed operating hours (open 08h00 – 16h00); have inadequate infrastructure (e.g. insufficient consulting rooms); some clinics apply a quota system to reduce the workload.

Table 6: Trends in health programme budget and expenditure, 2005/06-2008/09

| | 2005/06 | | | 2006/07 | | | 2007/08 | | |
|---|---|---|---|---|---|---|---|---|---|
| | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 |
| **Programme** | **Final Appro-priation** | **Actual Expenditure** | **Variance** | **Final Appro-priation** | **Actual Expenditure** | **Variance** | **Final Appropriation** | **Actual Expenditure** | **Variance** |
| Administration | 250,325 | 239 996 | 10,329 | 310,861 | 310 861 | - | 346,765 | 346 765 | - |
| District Health Services | 2,154,358 | 2 152 883 | 1,475 | 2,503,497 | 2 479 485 | 24,012 | 3,205,199 | 3 293 189 | (87,990) |
| Emergency Medical Services | 329,451 | 329 451 | - | 331,016 | 295 818 | 35,198 | 414,465 | 363 053 | 51,412 |
| Provincial Hospital Services | 2,645,825 | 2 645 825 | - | 2,852,391 | 2 940 538 | (88,147) | 3,146,071 | 3 343 530 | (197,459) |
| Central Hospital Services | 3,502,390 | 3 656 071 | (153,681) | 3,399,250 | 3 802 607 | (403,357) | 3,689,268 | 4 094 738 | (405,470) |
| Health Sciences and Training | 220,818 | 220 818 | - | 273,283 | 272 149 | 1,134 | 348,280 | 348 280 | - |
| Health Care Support | 119,911 | 100 818 | 19,093 | 106,714 | 105 803 | 911 | 114,237 | 114 237 | - |
| Health Facilities Management | 631,325 | 642 084 | (10,759) | 995,125 | 931 356 | 63,769 | 1,202,867 | 1 202 867 | - |
| Special functions | 13,509 | 13 509 | - | 3,125 | 3 125 | - | 1,189 | 1 188 | - |
| Internal charges | (27,272) | ( 27 272) | - | - 26,764 | ( 26 764) | - | (22,710) | ( 22 710) | - |
| **Total** | **9,840,640** | **9 974 183** | **( 133 543)** | **10,748,498** | **11 114 978** | **( 366 480)** | **12,445,631** | **13 085 138** | **( 639 507)** |
| **Economic classification** | | | | | | | | | |
| Compensation of employees | 4 870 199 | 4 688 666 | 181 533 | 5,179,398 | 5 347 243 | (167,845) | 6,187,304 | 6,519,005 | (331,701) |

Table 6: Trends in health programme budget and expenditure, 2005/06-2008/09

| | 2005/06 | | | 2006/07 | | | 2007/08 | | |
|---|---|---|---|---|---|---|---|---|---|
| | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 | R 000 |
| **Programme** | **Final Appro-priation** | **Actual Expenditure** | **Variance** | **Final Appro-priation** | **Actual Expenditure** | **Variance** | **Final Appropriation** | **Actual Expenditure** | **Variance** |
| Goods and services | 3 219 640 | 3 429 466 | ( 209 826) | 3,768,196 | 4 101 011 | (332,815) | 4,254,623 | 4,700,002 | (445,379) |
| Financial transactions in assets and liabilities | | 14 329 | ( 14 329) | 3,129 | 3 129 | - | 1,218 | 1,218 | - |
| Transfers and subsidies | 903 705 | 872 481 | 31 224 | 736,324 | 742 689 | (6,365) | 736,352 | 736,352 | - |
| Buildings and other fixed structures | 320 260 | 329 793 | ( 9 533) | 684,016 | 610 852 | 73,164 | 863,291 | 845,291 | 18,000 |
| Machinery and equipment | 526 836 | 639 448 | ( 112 612) | 377,435 | 310 054 | 67,381 | 365,385 | 239,552 | 125,833 |
| Household | | | | | | | 37,458 | 43,718 | (6,260) |
| **Total** | **9 840 640** | **9 974 183** | **( 133 543)** | **10,748,498** | **11 114 978** | **(366 480)** | **12 445 631** | **13 085 138** | **( 639 507)** |

Source: Gauteng Province Annual Report 2006/07 and Gauteng Province Annual Report 2007/08

# 7. UNFUNDED MANDATES

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

7.2. Examples given of unfunded mandates in the case of the GDOH include:

7.2.1. The impact of *demarcation changes* resulted in an increased number of facilities falling under GP. Mpumalanga facilities were transferred without budget.

7.2.2. *Occupational Specific Dispensation (OSD)* – the implementation and costing of this policy resulted in higher expenditure than the amount provided for in the 2007/08 budget. An accurate figure of the underfunding for OSD could not be determined for the 2007/08 financial year, but an estimate indicates R87 million. Another impression gained, however, was that OSD was fully funded by the Treasury in the 2008/09 financial year and thus represents a timing difference. The difference in opinion needs to be further investigated and with the time available no further comment could be made.

7.2.3. *Nationally negotiated salary increases* for 2008/09 were 10.5%, although the budgeted increases provided for by the GDOH were only 5, 3%.

7.2.4. *Pay Progression payments ("notch increases*"). The payment of pay progression payments of 1% of salaries is not allowed to be budgeted for, but is paid as part of retention initiatives. Over time this effect is substantial. The impact in the 2006/07 year was estimated at R200 million.

*7.2.5. The activity levels increased.* In general the perception in the GDOH is that the population of GP is underestimated resulting in increased numbers of patients. Estimates given by GDOH of the GP population are in excess of 15 million, being higher than the official statistics of 10,4 million, of which 80% are uninsured. Reduction in medical insurance levels, results in higher usage of public health facilities.

*7.2.6.* *Disease burden*. GP's population as stated by Statistics SA, does not reflect the spill over effect of neighbouring provinces, especially Mpumalanga and North West Provinces as well as the cross border influx from Zimbabwe and Mozambique. Furthermore, the burden is increased by the insured population making use of public health facilities, where medical aid cover is exhausted.

*7.2.7.* *New facilities and medical equipment*. Although conditional grants cover the capital costs of new facilities and medical equipment, the ongoing related operational costs are not budgeted. These costs relate mainly to employee costs and may also be a contributing factor to higher staff numbers. Other substantial related costs include information system costs, and general maintenance of the facilities and equipment. (e.g the Hospital Revitalisation grant does not take account of human resource requirements and costs).

7.2.8. *Higher medical inflation than budgeted inflation increases.* Key items affected by this include medical supplies, NHLS blood services, and nursing agencies. For example, there were annual increases of 15 -35% for NHLS and SANBS services. The exact effect of this cannot be accurately quantified with the summarised information available.

# 8. BUDGETING PROCESS

8.1. The budgeting process was identified as a major contributor to the current funding challenges in the GDOH. Although the GDOH has a budget committee at the central office, this committee does not meet regularly and its function is perceived to be functioning on paper only.

8.2. Currently, the budgeting process is a top down process. In general hospitals and directorates receive their budgets which are merely an incremental increase in the budget, and to a large extent not aligned to operational plans.

8.3. Communication regarding budgeting is currently inadequate. Budget allocations to the hospitals are done late and do not adequately address the requests put forward at the budget committee meetings. In the past there used to be a transparent and interactive meeting between districts, hospitals and sub-districts

that was chaired by the HOD. Furthermore, it appears that as though operational plans are not updated to reflect realistic activities and targets once the final budget allocation has been given.

8.4. Budget shifting takes place between some clinics in order to transfer underutilised budget to where budgets were overspent. This practice negatively impacts on general financial management principles.

8.5. Budget shifting also occurs between items that are not normally queried, such as shifting from the pharmaceutical budget to other items. A perception exists that pharmaceutical costs can exceed its budget in light of patient needs.

8.6. There is also no clear alignment between the annual performance plans and the financial budgets. Annual performance plans are also not updated subsequent to the allocation of funding. A good example of this non-alignment is the difference between the forecasted numbers of patients on ART and the budget allocated. In terms of the provincial strategic plans, there are targets, but there is a lack of alignment between the costing of and the delivery of services.

8.7. Another example of budgetary inefficiencies is IT expenditure that is paid from operational budgets and is not budgeted for separately under the capital budget.

8.8. There is an estimated opening deficit of R2, 5 billion for the 2009/10 financial year, but due to the current budgeting and reporting processes this figure is not reflected. The expected deficit stems from the misalignment between the budget request of the GDOH based on past (and future expected) activity and the top-down amount allocated from the Provincial Treasury.

## 9. FINANCIAL MANAGEMENT PROCESSES

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

9.2. Variance analysis of differences between actual and budgeted expenditure can be a very useful management tool. Several excel based spreadsheet analyses are done at the central office, but the impression gained by the IST, is that very little follow-up is done to identify any possible or necessary operational corrective actions flowing from variances.

9.3. Management responsibility and accountability are limited at all levels of the hierarchy, making it more difficult to maintain effectiveness and efficiency standards. In general, accountability issues are exacerbated by the recent restructuring in the GDOH. Many lines of accountability are broken due to acting posts, regular staff turnover and the fulfilling of multiple roles. In some instances it is the IST perception that dual roles are impossible to fulfil with due care and diligence e.g. both Chris Hani-Baragwanath and Charlotte Maxeke Johannesburg Hospitals have acting CEOs who also take care of their substantive posts. This is further discussed under Human Resources, paragraph 8. The GSSC is also believed to add to the accountability contention, where the HOD remains responsible although certain functions are performed by the GSSC over which the GDOH has no control.

## 10. COST ALLOCATION

10.1. The introduction of family medicine doctors as a measure to strengthen the district health system resulted in cost allocation anomalies. It impacts negatively on the cost per patient indicator, as doctors are more expensive than nurses and results in skew indicators.

10.2. Distribution of medication to individual facilities is not always done through the medical depot. Medical supplies may be ordered at a central point from the depot for a number of institutions and received at a central point, and redistributed to the various institutions from this central point. As a result of the non-integrated, manual system, accurate cost allocation of medication to institutions/cost centres is not done. Again, the cost per PDE indicator loses effectiveness and cannot be used to identify areas that require investigation and possible corrective action.

# 11. CONDITIONAL GRANTS

11.1. The budgetary processes referred to in Financial Review, paragraph 8, apply equally to conditional grants. Although annual performance plans are compiled at national and provincial levels, there are mismatches between the provincial business plans and the level of national grant funding. For example, the criteria for HIV grant allocations are not clear but appear to be somehow based on the equitable share, and not the business plans of the province which reflect the number of HIV positive individuals in need of care.

11.2. Regarding the NTSG, there are no systems to manage and report on this grant. It is also noted that not all expenses related to tertiary services offered by tertiary hospitals to neighbouring provinces are covered by the conditional grant. The result of this is that GDOH is providing tertiary services to other provinces without being compensated financially by these provinces, and without being compensated for these services through grants either. The financial loss to the GDOH is substantial over time. Allocations to a tertiary hospital also did not split its budget between conditional grants and equitable share, making it difficult to manage.

11.3. Due to the importance of an integrated, robust and efficient IT system in the health sector, both in respect of financial and performance related data, there is a case to be made for a conditional grant aimed at improving information systems. The GDOH requires substantial funding to achieve its integration of all facilities.

# 12. QUARTERLY PERFORMANCE REPORTS

12.1. Quarterly performance reports on service related indicators are compiled and submitted to the Provincial Treasury. In addition, there are too many non-financial indicators, with doubtful value and usefulness. There is currently a project to change the indicators to more outcome based rather than input and output based. The number of indicators to be reported on is also to be reduced. The current systems of financial and quarterly performance reporting make it difficult to link

finances to performance. Currently, variances are identified, but there is no follow-up of these variances.

# 13. FINANCIAL REPORTING

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

13.2. Although the *IYM report* can be an effective tool to identify possible budget over-runs, the effectiveness thereof is compromised by non-adherence of submission deadlines, inappropriate projections, incorrect historical figures and incomplete sheets submitted.

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

# 14. MONITORING STRUCTURES

14.1. No material issues were reported by the Auditor-General dealing with the effectiveness of monitoring structures.

# 15. RECOMMENDATIONS

## 15.1. PROVINCIAL HEALTH BUDGET ALLOCATION

15.1.1. The equitable share for GDOH should be re-visited to take cognisance of the real population of the province.

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

## 15.2. UNFUNDED MANDATES

15.2.1. GDOH to determine the number of “floating bodies” and to correct the staff establishments. A consultative process should then be launched between Provincial Treasury, GDOH and NDOH to address the funding thereof.

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

15.2.3. Nationally negotiated salary increases should be done in consultation with Provincial Treasury to confirm the availability of funding to cover shortfalls.

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

15.2.5. A plan to improve and strengthen primary health care and access thereto should be developed. The financial implications, human resource, infrastructure and all associated implications need to be taken into account in this plan.

## 15.3. BUDGETING PROCESS

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

15.3.2. All operational units (cost centres) need to have a realistic budget that can be used as a guideline for the financial year’s activities. Operational plans need to be aligned with available funding to deliver the services. Operational plans need to be changed to realistically reflect the operations given the allocated budget.

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

## 15.4. FINANCIAL MANAGEMENT

15.4.1. Cost centre accounting needs to be done at the lowest possible practical level (i.e. facility/clinic level). This is needed to properly identify areas of operations that require attention.

15.4.2. Allocation of expenses needs to be accurate and up to date to assist with effective management. Actual expenditure is an important indicator and inaccurate information impacts on effective monitoring and evaluation at all levels. Effective management is not possible without accurate and timely information.

15.4.3. Variance analysis needs to be used as a management tool to identify areas that require attention and not merely a paper exercise.

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

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

15.4.6. Review the SLA between the GDOH and the GSSC to improve efficiency clauses, performance management as well as accountability issues. Include penalty clauses for non-performance.

15.4.7. Improved BEE SLA management, incorporating BEE supplier training with proper management of work done and enforcing of quality assurance.

15.4.8. The PMU's projects should be evaluated in terms of value added and all the non critical projects should be abandoned until funding for those projects are available.

## 15.5. QUARTERLY PERFORMANCE REPORTS

15.5.1. The accuracy and use of essential performance indicators needs to be improved e.g. the number of patients on ARVs. The necessary steps must be taken in

conjunction with the NDOH to improve the quality of information available in this regard.

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

15.5.3. There needs to be a link between performance and financial reports. A financial report reflecting actual expenditure compared to budget should also be provided where performance indicators reflect a deviation in operational performance.

15.5.4. The GDOH implemented various initiatives (such as piloted integrated systems, monitoring and evaluation mechanisms) to address the above. These need to be evaluated for their effectiveness.

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

15.6.1. Through the appropriate channels, the forecasting component of the IYM should be investigated to ensure that accurate accrual reporting is done in the IYM process.

## 15.7. ANNUAL FINANCIAL STATEMENTS

15.7.1. 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

1.1. The key findings from the review are summarised in Box 2, and elaborated on below:

**Box 2: Leadership, Governance and Service Delivery- Key Findings**

1. The NDOH has provided insufficient leadership and stewardship to solve the problem of either increasing the resources or providing guidelines for service provision to occur within budget.
2. Budgets have been decentralized and feedback to line managers happens at management meetings, but accountability for staying within budget is lacking.
3. The overall vision is well articulated in key planning documents within the GDOH. The vision is well defined and there is alignment with national health and Gauteng provincial priorities.
4. There is over-reliance on hospital services in Gauteng; DHS require strengthening if this trend is to be reversed.
5. The establishment of the PMO/PMU, whilst initiating a number of important projects, has caused dissatisfaction in the GDOH by duplicating services & increasing expenses. Some hold the opinion that these initiatives e.g. costing of services, HMIS should be driven from a national level.
6. The TB and HIV programmes are performing well in Gauteng at present; however, they draw strength from the PEPFAR-funded NGOs and academic & research institutions in the province. It is important to plan for the long term sustainability of the programmes when external assistance is no longer available.
7. The linkages between health, HR and financial management systems are not optimal. This is being addressed by the new HIS which is being rolled out in the province.
8. Governance structures e.g. District Health Councils, Hospital Boards and Clinic Committees as mandated in the NHA have been established.

# 2. GENERAL LEADERSHIP

2.1. The senior leadership - Member of the Executive Council (MEC) and Head of Department (HOD) - of the GDOH changed in 2006, midway through the 2004 to 2009 term of office. The constant restructuring of the GDOH and reorientation of vision each time there is a change of political head and his or her senior management, is experienced by staff as disruptive and leads to uncertainty and lack of focus. There is a perception amongst some managers that the GDOH should have a health professional leading the GDOH and the fact that neither the political head (MEC) nor the HOD is a health professional presents a problem in terms of lack of decisiveness and inappropriate decisions regarding health-related matters. In addition, the feeling of some staff is that since 2006 the emphasis in GDOH has shifted from health service delivery to developing the corporate image ('corporatization') of the GDOH.

2.2. Gauteng province has had good leadership with regards to HIV and AIDS. The previous Premier was very involved with the programme, spoke out about AIDS and formed the Multi-Sectoral AIDS Unit (MSAU) – funded from the Premier's Special Projects Fund. MSAU monitors and exercises oversight over the HIV programmes in all provincial government departments and is responsible for liaison with civil society. On the other hand, the ex-Premier made health-related commitments without proper planning and consultation with the GDOH as to their impact on service delivery activities or budget and without extra funding provision. An example of this – in February 2008 the Premier announced the immediate implementation of dual PMTCT therapy in Gauteng. Whilst the HAST programme agreed with this on a policy level, programme staff had no time to adequately prepare the logistics for smooth implementation.

2.3. Provincial and district level managers are constantly called to meetings, training sessions and workshops which impacts on the time available to spend on carrying out their core business. Provincial programme managers admit that there is little time to conduct supervisory and support visits to the district facilities. There also appears to be role confusion in terms of the responsibilities of district managers versus programme managers at central office i.e. programme managers often get

called upon to sort out operational issues in the district which they feel should be the responsibility of the district management.

2.4. It is a priority of the GDOH strategic plan to strengthen district health services (DHS); however, Gauteng does not have proper leadership at sub-district level and district and sub-district management structures need to be strengthened.

2.5. There is little innovation, support or leadership from the NDOH. This has resulted in the GDOH forging ahead with projects such as costing of service packages, HMIS and e-Health which some managers feel should be driven from a national level. NDOH tends to monitor progress using quarterly written reports only and NDOH counterparts seldom visit the province to get a first hand understanding of constraints on the ground and assist with solutions.

2.6. The implementation of occupational specific dispensation (OSD) has had an unintended negative effect at programme management level because many nurse managers have since opted to go back to clinical work leaving a vacuum at programme leadership level.

2.7. A high level review of the Executive Committee minutes indicated that although meetings were held monthly and regularly, the minutes reviewed did not indicate who the responsible person was for execution of certain tasks with assigned timeframes associated to the responsible person. Feedback given was that action lists with responsibilities and timeframes are generally followed up outside of the Exco forum. Input during the interview process provided an opinion that many decisions and resolutions are not performed timeously by the Exco and that at times matters may be delayed for months. These delays on strategic decisions have a negative impact on National and Provincial mandates. The review of the Exco minutes indicated a number of items that had been adjourned to the next meeting, and then the next meeting, which may cause delays in the resolution of certain matters.

# 3. PLANNING

3.1. Although the HOD is very supportive of health information systems, there is not a general culture of using information for management, especially at the lower levels of service delivery.

3.2. There is the strong feeling that health is under-funded. It is a demand-driven service and patients cannot be turned away. Furthermore, there is not a culture of cost saving in the health sector, especially amongst clinicians who believe that their patients must get the best care regardless of cost. That being said, there is also the strong perception that regardless of how efficient the systems that were to be put in place may be, there will not be significant cost saving because of the quadruple burden of disease and particularly the impact of HIV and AIDS.

3.3. The sentiment was expressed that NDOH is out of touch with the realities on the ground in that policies are established and programme benchmarks are set according to international best practice, but without a clear understanding of either the resources, skills and capacity requirements for implementation or the resource gaps and constraints (e.g. budget, staff and skills shortages) experienced at service delivery level.

3.4. Business planning at a district level has been identified as a gap e.g. the process for allocation of conditional grants and earmarked funds such as that for MDR TB requires provinces to submit business plans in a prescribed format to NDOH. Each district in Gauteng compiles a business plan which is integrated into the GDOH submission. Despite repeated training sessions, district submissions require extensive revision to meet the required standard and once funds are disbursed to the districts they are sometimes spent on items not covered by the conditional grant. This could be attributed to capacity limitations at districts with respect to staff numbers, skills and competence.

3.5. There is also pressure on the GDOH because of political imperatives e.g. the Premier promised the immediate rollout of dual therapy for PMTCT in his speech last year and it was not budgeted for. Although this will not be a recurring cost, this

year (2008/09), prior to the elections several expensive launches and events had to be organised.

## 3.6. STRATEGIC TRANSFORMATION PLAN

3.6.1. The STP was approved in 2006 and updated in 2008, but has not been fully implemented. The main aim of the STP is to improve PHC as it is only when PHC services are fully functional that the demand on hospital services will decrease. Caution has been raised, that full scale implementation of the STP would increase GDOH over-expenditure dramatically and the current STP is therefore unaffordable.

## 3.7. STRATEGIC PLAN

3.7.1. GDOH still operates according to the strategic plan developed for the 2004-2009 five-year term. A mid-term review in 2006 revealed that the GDOH was only achieving 60% of targets in the annual performance plan (APP) and was unlikely to achieve any better by the end of the term. Hence the Turnaround Strategy was embarked upon.

## 3.8. TURN-AROUND STRATEGY

3.8.1. The Turn-around Strategy is structured around three (3) focus areas which are further broken down into four (4) sub-areas:

3.8.1.1. Refocus on all four levels of health interventions i.e. promotion of health, prevention of disease, curative care and rehabilitation instead of the extreme bias towards curative care.

3.8.1.2. Focus on satisfaction of four key stakeholder groups i.e. clients, employees, stakeholders (Unions, Universities, Professional Bodies, Suppliers, NGOs) and shareholders/funders (National Treasury, NDOH, Provincial Treasury).

3.8.1.3. There are four pillars to the turn-around strategy:

- ❒ Strengthen healthy lifestyles approach to decrease the burden of chronic diseases. This includes the *Know your status* project.
- ❒ Strengthen existing programmes/projects e.g. activity based costing, revenue collection.
- ❒ Quality healthcare programme which is facilitated through the Project Management Office (PMO) – to set the standard for project management and drive the implementation of all projects undertaken throughout the organization and Project Management Unit (PMU) – a consultancy that provides expertise and skills of a project management environment to implement projects and transfer skills to the GDOH.
- ❒ Management and leadership e.g. training of clinician managers, information systems, M&E.

## 3.9. THE PROJECT MANAGEMENT OFFICE AND PROJECT MANAGEMENT UNIT

3.9.1. It is the opinion of some interviewees that consultants compete with senior managers for projects; that the consultants are poorly managed resulting in projects which are expensive and of poor quality and that the consultants have good financial, but poor health and community intervention expertise. There is also duplication of programmes which are currently being done in the GDOH e.g. the PMO manages the Healthy Lifestyles programme when there is a Health Promotion Unit in the GDOH. The Healthy Lifestyles programme spends a lot of money on beach volleyball which is not a core competency of the GDOH and interviewees thought that this should be left to the Department of Sports & Recreation. Some managers highlighted that the Provincial Treasury also raised the contention that GDOH spends money on non-core business and should focus more on core business.

## 3.10. ALIGNMENT OF PLANS

3.10.1. There has been no linkage of plans and budgets up to date. Although policies and programmes are good, these are never costed. The province does adjust national targets downwards so that they are more realistic for the province (e.g. PHC attendance 2.8 instead of 3.5 visits per annum), but this is still not realistic for the budget allocated.

3.10.2. Despite attempts at realistic target setting, there are instances where annual provincial targets are escalated without a concomitant increase in the programme budget allocation. Examples cited include the priority TB and cervical cancer screening programmes. In Gauteng most TB cases (up to 70%) are diagnosed in hospital meaning that diagnosis is made late. In an effort to improve earlier diagnosis, a programme of active case finding in the community was embarked upon instead of waiting for patients to present at the clinics before having their sputum tested. This lead to significantly higher numbers of TB microscopy smears being tested. A similar scenario exists for the PAP smears in the drive for cervical cancer screening. Both campaigns resulted in higher than anticipated laboratory costs.

3.10.3. At the level of the metro districts, planning and budgeting is aligned to the processes of local government (LG) i.e. plans take account of the municipal integrated development plan (IDP) which in turn is aligned to the provincial growth and development plan and follow a July – June financial year.

# 4. GOVERNANCE

4.1. The Gauteng District Health Services Act was passed in 2000 to facilitate devolution of services to LG in line with the thinking at that time. It has not been updated subsequent to the promulgation of the NHA.

4.2. Governance structures such as the Provincial Health Council, District Health Councils, Clinic Committees and Hospital Boards have been established in line with the NHA, 2003.

4.3. The decision to provincialise PHC and EMS was adopted at the Provincial Exco in August 2005 and confirmed at a special Provincial Health Council Meeting on the 15th January 2007. Services in the 3 district municipalities (West Rand, Sedibeng and Metsweding) have been provincialised and it is planned to transfer the services (88 LG clinics) in the three Metros by 2013. The funding gap to provincialise PHC in the District Councils and to strengthen PHC over the MTEF (2008-2011) is as follows[7]:

[7] Gauteng Department of Health APP 2009-2010

4.3.1. 2008/09: R111 million

4.3.2. 2009/10: R388 million

4.3.3. 2010/11: R803 million.

4.3.4. An additional R120 million will be required in 2010/11 if the services in the City of Tshwane are provincialised.

# 5. SERVICE DELIVERY

## 5.1. ACCESS

5.1.1. GDOH has done a great deal in providing geographic access to PHC services. Several clinics have been established in underserved areas and have been planned for in all new settlements. ARV rollout services have also been established in even the remotest areas of the province with the help of the NGOs.

5.1.2. However, other aspects of access have been compromised. Not all the facilities provide the full package of services. For example, community health centres (CHC) are often not open 24 hours and even if they are, only maternity services operate 24 hours forcing patients to come to the hospital for other conditions. The budget, however, does not support the opening of CHCs for 24 hours and the GDOH is seriously understaffed making it impractical to do so at present. Health workers are expected to be ‘super-doctors’ and ‘super-nurses’ which leads to overwork, burnout, mistakes and litigation and rudeness which puts patients off. Adding to the complication is the fact that some clinics are allegedly operating on a quota system and their operating hours are between 8:00 and 16:00, resulting in patients making use of hospital services instead.

## 5.2. EFFICIENCY

5.2.1. “Development of DHS would have been much easier if we were working with a green-fields scenario. However, the history of the health service in Gauteng in

particular was very hospicentric. It takes a long time to change people's mindset. When they are ill they want to be seen by a doctor and not a nurse"[8]. Gauteng has tried to address this by introducing Family Health Physicians into the district to oversee a number of clinics. There needs to be a PHC Revitalisation Plan similar to the Hospital Revitalisation Plan and this will require a significant injection of funding – one cannot siphon off from hospital services to build PHC.

5.2.2. There are several programme managers at national and provincial level each dealing with a separate aspect of the programme. However, at facility level all these must be integrated and implemented by one nurse. Competing priorities for programme training and meetings often arranged at short notice place a huge pressure on health workers in the field and take them away from their service duties.

5.2.3. A common observation was that patients access the GDOH health system at inappropriate levels i.e. they by-pass the PHC clinic structure, attend hospitals for their initial contact visits and often receive primary level care at expensive tertiary institutions. This practice is probably a legacy from the hospi-centric health service provision of the past and will require extensive patient education. In Gauteng the situation is aggravated by the fact that there are four (4) Central Hospitals and the number of District hospitals is sub-optimal so that even hospital patients are treated at a higher level of care at a higher cost. Currently there are ten (10) district hospitals in GP with plans to increase the number to eighteen (18) by 2014 according to the STP. A suggestion is that until the process of provincialisation of PHC is completed (planned for 2013) GDOH should consider paying the metros to provide PHC services effectively i.e. extended hours, standardized basket of services at all facilities, set standards in consultation with the metros and then monitor the standards on a regular basis. During this period the provincial DHS should focus on strengthening the district hospital services.

5.2.4. Patient transport - The Chris Hani Baragwanath Hospital pays a private service provider R1000 per trip to transport patients within the grounds of the hospital from the wards to theatre, for example.

[8] Quote obtained from a GDOH manager in interview process.

5.2.5. Although a few interviewees mentioned that LG is better at providing prevention and promotion services whereas the forte of provincial health is provision of curative services, there is a strong feeling that PHC should be provided in an integrated manner to be efficient and to avoid the missed opportunities that arise when the service is fragmented e.g. improved uptake of HIV and TB treatment when these services were integrated.

5.2.6. The occupational specific dispensation (OSD) that was rolled out for nurses last year was supposed to be rolled out for doctors in July 2008 and has not been done, leading to considerable dissatisfaction amongst medical practitioners in the public service. Recent media attention regarding the strikes by doctors in the province highlights the poor morale amongst clinicians at present.

## 5.3. EQUITY

5.3.1. According to the GDOH APP (2007-2010) efforts have been made since 2003 to redistribute resources to areas of greatest need. Table 7 shows the non-hospital PHC expenditure per capita over a 7 year period in each of the Gauteng health districts. The metros continue to have a higher PHC per capita expenditure than the district municipalities although the difference between the highest and lowest narrowed from R336 (between Ekurhuleni and Metsweding) in 2001 to R138 (between City of Johannesburg and Sedibeng) in 2007.

Table 7: Non-Hospital PHC Expenditure per Capita per District in Gauteng 2001-2007

| | 2001/02 | 2005/06 | 2006/07 | 2007/08 |
|---|---|---|---|---|
| Sedibeng | 269 | 212 | 210 | 233 |
| Metsweding | 214 | 223 | 161 | 287 |
| West Rand | 231 | 272 | 237 | 236 |
| Ekurhuleni | 550 | 274 | 307 | 273 |
| City of Johannesburg | 484 | 324 | 336 | 371 |
| City of Tshwane | 239 | 276 | 334 | 335 |

*Source: District Health Barometer, 2008*

5.3.2. A funding formula for the allocation of the provincial health subsidy to metros has been established in order to promote more equitable resource distribution amongst

the districts in Gauteng. As a benchmark, the subsidy was based on 30% of costs and has been allocated according to the formula since the 2007/8 financial year. The transfer payments to the metros are now based on actual services and the normative cost of these services instead of historical allocations.

5.3.3. District Health Expenditure Reviews (DHER) were conducted in each district taking into account the combined resources of province and Local Government in each district. It is cautioned to review comparative results carefully as nurse patient workloads tend to be lower in facilities that provide maternity services and PDEs are high in some facilities which stock expensive medicines in an effort to relieve the patient load off big hospitals e.g. Chris Hani Baragwanath.

5.3.4. The GDOH pays a high price for the large number of patients affected by trauma and violence in the province. According to one key informant, 70% of the theatre time at Charlotte Maxeke Johannesburg Hospital is taken up with trauma cases requiring a large amount of blood products. The costs of blood products escalate 15-35% per annum whereas the budget increment in the hospital budget is in the order of 5% placing a considerable burden on the goods & services line item each year. The use of SANBS is mandated by the National Health Act (NHA) and the respective annual increases in SANBS, NHLS and Comed fees and the health budget is approved by the National Treasury.

**5.4. HIV**

5.4.1. The ARV rollout programme has performed well in Gauteng in terms of patient enrolment largely because of the excellent working relationships with what were described as the PEPFAR-funded NGOs. These include the Reproductive Health Research Unit (RHRU), Perinatal HIV Research Unit (PHRU) and Aurum Health Research Institute. Large numbers of patients have been put on ARV (currently 180 000 of the 250 000 targeted for 2009) and as there is no waiting list (not required, as patients are enrolled on the programme immediately) for ARV in Gauteng there is much cross-border spill-over from neighbouring provinces which have long waiting lists. These NGOs assist with training and facilitate employment of professionals with scarce skills e.g. pharmacists and nurses who are employed at higher salaries than the province. Whilst this works well for now, it raises

concerns regarding the sustainability of the programme when donor funding comes to an end. In addition, the HIV programme is still seen as a vertical programme in the district and is not well integrated into the routine clinic services.

5.4.2. A particular concern was raised regarding the PMTCT programme which is working very well in Gauteng. It has been implemented in 100% of maternity units and transmission rates have been reduced to 5%. However, the full benefit of the programme is not achieved as post delivery mothers are often lost to follow-up and the babies and children who are HIV+ are referred to HIV programme for treatment instead of being handled within the routine MCH programme. Concern has been expressed regarding the sustainability of the HIV programme because of the huge dependence on PEPFAR-funded and other NGOs for counselling, treatment and home-based care. Managing NGO grants adds a significant administrative burden to the HAST unit and a suggestion is that this aspect of the programme should be transferred to MSAU.

5.4.3. Metsweding was chosen as a priority district based on poor health programme performance indicators in 2006. However, since then all indicators have improved e.g. immunization coverage has increased from 60% in 2006 to 100% now and TB cure rate increased from 60% to 76% in the same time period. This has been accomplished through the provincial priority programmes and through the initiatives that the district itself has instituted e.g. Saving the Child.

# 6. RECOMMENDATIONS

## 6.1. GENERAL LEADERSHIP

6.1.1. There should be explicit and open discussion around the budget and the level of services that can be rendered for this budget. The areas of rationing and prioritization should be made clear and communicated effectively to all concerned. All sources of funding should be evaluated, and should rationing be required, the process followed should be constitutionally sound.

6.1.2. There should be an iterative process to national policies where provincial realities and feedback is given so that policies can be amended to fit the realities or additional resources made available.

6.1.3. Service delivery and budgets should be aligned so that managers are not faced with ad hoc budget cuts.

6.1.4. Better day-to-day planning is required so as to avoid unplanned meetings and better time management by managers. This can also include cutting back on unnecessary meetings and streamlining programme training and workshops through better coordination amongst national and provincial programme managers.

6.1.5. Executive Committee meetings should assign a person responsible for specific tasks, and assign a deadline date for the completion of the task. The Exco minutes should capture these decisions. In this way, at subsequent Exco meetings, persons may be held responsible and accountable for reporting back on the completion of their responsibilities.

**6.2. PLANNING**

6.2.1. The STP should be costed, revised in terms of the available budget and then implemented.

6.2.2. Strengthen primary health care (PHC) through:

6.2.2.1. defining and costing the package of services to be delivered at each facility level

6.2.2.2. extending hours of service and cost it properly

6.2.2.3. deliver minimum package of service from each designated facility

6.2.2.4. provide appropriate (numbers, training, qualifications) staffing levels

6.2.2.5. integration of all health services

6.2.3. Implement DHS model effectively:

6.2.3.1. evaluate and establish a proper funding model for PHC package

6.2.3.2. increase District Hospital services.

6.2.4. Ensure that patients access the health system at the appropriate level of care by implementing

6.2.4.1. bypass fees at hospitals

6.2.4.2. improved screening at hospitals

6.2.4.3. effective referral system

6.2.4.4. patient transport system

6.2.4.5. patient education

6.2.5. Strengthen relationships between universities and GDOH with regards to health systems research.

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

6.2.7. There should be linkages between health programme, HR and financial management and reporting systems.

6.2.8. Ring-fence the budget of each priority programme in order to set and monitor targets effectively. Plans should be a roadmap for all health services in the province. There should be a clear M&E process which ensures implementation of plans are regularly monitored with remedial action to ensure that targets are me.

6.2.9. Targets should be based on NDOH guidelines and provincial realities.

6.2.10. Measures to ensure sustainability must be built into programme planning for programmes e.g. HIV which currently have a high reliance on external resources.

## 6.3. GOVERNANCE

6.3.1. All senior management appointments should take merit and ability into strong consideration.

6.3.2. Changes at senior management level each time the MEC changes should be avoided to ensure stability and continuity.

6.3.3. The NDOH should provide provinces with clear written guidelines regarding the delegation of authority, responsibility and accountability to facility and district managers. Provinces should implement with due regard to adequate oversight.

## 6.4. SERVICE DELIVERY

6.4.1. Role and expertise of managers at provincial and district levels must be defined with clear guidelines of performance expectations.

6.4.2. Improved communication (vertical) between programme managers and (horizontal) between programme and service delivery managers.

6.4.3. Quality of care & problem solving at local level must be encouraged.

6.4.4. Revitalisation of PHC services. Gauteng should consider an action plan between the present and the provincialisation of metros in 2013.

# Human Resources

## 1. INTRODUCTION

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

1. Compensation of employees is currently the largest component of expenditure, at 53% of the GDOH's total expenditure (2007/08) and in 2007/08 COE made up 52% of the over expenditure in that year.
2. Lengthy recruitment processes (through GSSC) compounds the problem of filling of posts and often leads to desperately needed medically skilled personnel finding employment elsewhere outside of the public health sector. This includes bursars whose academic studies the GDOH has funded.
3. Many managers believe that the new organogram is "top heavy" with insufficient focus on health service delivery. The view is that the focus of GDOH is on "Corporate", with the result that health services are suffering due to thinning operational numbers.
4. A large number of key posts are filled by personnel in an "Acting" capacity, and many of these personnel share these "Acting" positions with their other permanent management positions, contributing to a large work load, and raising concerns about the ability to effectively perform all tasks required.
5. The process of recruitment is a lengthy process (through the GSSC), and may at times take up to 6 to 8 months to fill a position.
6. Although well-defined human resource (HR) policies and procedures exist, implementation is impaired by cost containment and "crisis" management.
7. Organisational structuring and staff establishments are not done according to agreed benchmarks or aligned with existing plans or required and available resources and there is insufficient guidance from the NDOH on this matter.
8. Despite a written policy on delegations, delegations have been withdrawn, with resultant day to day operational management by the provincial head office, resulting in widespread feelings of disempowerment and lack of accountability.
9. There is currently a moratorium on filling of posts, resulting in management needing to submit a formal request for the approval of filling of critical posts. This is a lengthy process.
10. Programmes tend to operate in silos with their own monitoring systems,

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

training and reporting procedures.

11. Neither PERSAL nor Vulindlela nor BAS are fully used as management and planning tools. GDOH has developed its own HRH tool. Inconsistent HR indicators are found in different official GDOH documents.
12. Human resource development is not properly addressed through the performance management and development system.
13. Rewards are not linked to performance; the performance management system is not functioning as envisaged and linkages to strategic priorities and staff development are absent.
14. The implementation of the occupational specific dispensation (OSD) for nurses resulted in numerous operational problems, including over-expenditure, negative impact on appointment of other professionals, discrepancies in nurses' salaries within the same levels, and many managers leaving management positions to go back to the health service leaving a gap at management levels, and general unhappiness among health professionals.

## 2. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

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

2.1.1. Employment Relations (advertising, short listing and selection);

2.1.2. Upgrade of officials;

2.1.3. Payment of overtime;

2.1.4. Filing of vacant posts;

2.1.5. Transfer of Officials between institutions, provincial and National Departments;

2.1.6. Extension of employment beyond age 65;

2.1.7. Labour management (including precautionary suspension, pronouncing of misconduct up to dismissal);

2.1.8. Planning and work organisation (including remunerative work outside the public service and overtime management);

2.1.9. Service Terminations;

2.1.10. Allowances;

2.1.11. Leave ; and

2.1.12. General.

2.2. Despite the existence of these clear policies they are not adhered to or implemented effectively and managers are not held accountable or sanctioned for this.

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

2.4. As a result of the current financial crises in the GDOH (and possible lack of certain financial management skills), delegations have been withdrawn and centralized at the head office. There is currently a moratorium of the filling of posts at GDOH, whereby submissions need to be made for the approval of filling of critical posts. This has several consequences. It has led to managers feeling disempowered with little responsibility and associated lack of accountability. It has led to senior managers at the head office being involved in the day to day running of the various institutions and performing mundane administrative tasks (e.g. having to approve the appointment of all staff).

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

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

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

2.5.3. Delays in appointment of staff at all levels.

2.6. A recurring theme throughout the interview process is that there is a lack of accountability, and that no one is really held responsible and accountable for the non-achievement of certain plans. The process also makes accountability difficult, in that it is difficult for HR to be held accountable for not effectively recruiting more key staff, when the responsibility for this process lies with the GSSC.

## 3. INTEGRATION AND CO-ORDINATION

3.1. A number of examples illustrate the lack of integration and co-ordination of efforts within the GDOH:

3.1.1. Programmes tend to operate in silos with their own systems for data collection, own monitoring and evaluation systems, own training schedules and suppliers and their own reporting procedures which are not always aligned to those of managers of health facilities.

3.1.2. Many managers feel that the NDOH representatives should attend their Provincial quarterly review meetings, to assist and provide guidance of integration and co-ordination. It was mentioned that NDOH is invited to these meetings, however, they seldom attend.

3.1.3. There is a lack of coordination between the PHC services delivered by the provincial and local government health departments in the metros. These services each have a different conceptualisation of PHC and the basket of services to be

delivered. This does not make for a district health system with an aim of improving the health of the population.

# 4. LABOUR PLANNING

4.1. It was stated that there are good HR policy documents and frameworks. However, the implementation of these policies is sub-optimal with a number of factors contributing to this. These include:

4.1.1. The alignment between the HR planning and feedback loops appears to be generally problematic.

4.1.2. Key HR statistics and indicators were not consistent in the various document sets. This has potentially serious consequences for labour planning if the wrong base data is used for planning and reporting. The HR cluster developed its own Human Resources for Health (HRH) Tool, which they stated was required due to the weaknesses and lack of "detailed drill down" functions within Persal, BAS and Vulindlela. This HRH Tool was manually developed by officials physically going to each institution and compiling the HR / staff compliment. This process was also used as a "clean-up" of Persal, where it was established that staff may have been allocated against the incorrect post (eg pharmacist placed against the post of a nurse), and staff (as per Persal) were allocated against the incorrect institutions. These factors made planning for HR difficult, and information contained within Persal was not necessarily correct.

4.1.3. A number of HR plans exist (eg DPSA generic HR plan and the NDOH HR plan tailored for GDOH). It was stated that the DPSA HR plan is used mainly for compliance, and that the NDOH HR plan is used to inform HR Health plans. Although these HR plans exist they are not fully used due to cost containment requirements (i.e the budget constraints restrict the achievement of the planned staffing targets), and planning does not necessarily take into account the budgetary constraints. At the time of compiling this report, the HR plan had not been received for review.

4.1.4. It could not be determined whether there was alignment between the draft STP (July 2008) and the National HR Plan.

4.1.5. HR planning was not directly related to disease burden and policy decisions (e.g. additional services have to be rendered, but structures are not adjusted to address service delivery requirements. It was reported that when clinics had to start delivering dual therapy or new programmes introduced, no new specific posts were created. This results in staff already overworked having to do more). This non-aligned HR planning and associated lack of increase in resource numbers can lead to staff having low morale, feeling exhausted and overwhelmed and going into a state of "despair" with always having to do more with less.

# 5. ORGANISATIONAL DESIGN AND STAFF ESTABLISHMENT

5.1. The organisational structure is not planned on a realistic model of service requirements and available financial resources. It is not altogether clear what the basis of the current staff establishment is. Many units feel that the staff establishment is insufficient for the unit to realistically fulfil its mandate and to reach targets. This result in an understated staff establishment, with the resultant workload becoming the responsibility of the persons already employed.

5.2. Discussions with various units indicated that the NDOH does apparently provide limited norms and standards regarding organisational structures and staffing numbers required. These NDOH norms and standards appear to be specific to a particular service / department / unit, as opposed to the organisation as a whole.

5.3. The GDOH is in the process of restructuring (from Chief Director upwards only) but there is the concern of creating an inappropriate organisational structure that is "top heavy", and that it may be too expensive to implement (feedback indicated that there would be between 6-7 DDG posts created in the new structure). Directorates are concerned about this restructuring, as few new posts are being created for positions that affect health service delivery or assist in strengthening the staff establishment at district level. There was major uncertainty as to which organogram was approved, and whether it has in fact been approved. Concern was raised that there was the risk that the correct processes had not been

followed for the approval of the organogram in terms of the Public Service Act / DPSA. It was felt that the new structure supported incompetence with certain senior positions obtaining the support of too many other managers. A common theme in the interview process was an urgent plea to consider revising the new organogram.

5.4. Structure normally follows strategy and if the staffing is not aligned to the strategy due to inefficient planning, the organisational structure will also be deficient in dealing with service delivery and priority challenges. Views are that the new organogram will support monitoring and evaluation, and afford managers the time to plan for the implementation of policies. The aim of having a strong head office is to give support and capacitate lower levels. This will mean higher management costs when the new organogram is implemented. It has been reported that there is confusion as to what has, and what has not been approved in terms of the "new" organogram, and there has been insufficient communication around this. It is felt by managers that this new organogram does not necessarily support the plan of strengthening District Health Services. It could be better justified if it was at health service delivery level, rather than at Central Office.

5.5. Opinions were expressed that restructuring should be based on the imperatives to deal with the burden of disease and within available financial resources. Alternatively, lower cost options for organisational design should be considered through the use of "task shifting", where scarce professional skills are used to their optimum and use of non-professional health workers is encouraged (e.g. sufficiently trained data capturers used to collate and capture data and information, as opposed to nurses having to perform this function in addition to dealing with patients) and with proper reallocation and re-shifting of duties to lower paid staff or volunteers, the workload on health professionals could be reduced (e.g. current use of matriculants as data capturers could be more effectively and efficiently organised).

5.6. There are currently (31 March 2009) **51,475** filled posts. (Note that during the interview process, approximately **50,535**[9] were believed to be the filled positions).

[9] As per GDOH HR Department interview

Table 8 below as obtained from the GDOH indicates the approved, filled and vacant posts as at 31 March 2009. It was noted that there is a difference in approved, filled and vacant staffing numbers depending on the source of the information. The figures below in Table 8 were obtained from the SIP (Service Improvement Plan). This is compared to staffing levels at 31 March 2008 of **46,354** filled positions, and 31 March 2007 when there were **45,680** filled positions.

Table 8: Approved, filled and vacant posts

| Year | 31 March 2009 | | | |
|---|---|---|---|---|
| **Category** | **Approved** | **Filled** | **Vacant** | **Vacancy rate** |
| Admin | 9 017 | 6 243 | 2 774 | 30.76% |
| Allied Prof | 6 998 | 3 233 | 3 765 | 53.80% |
| Allied Support | 2 187 | 1 764 | 423 | 19.34% |
| Clinical Prof | 5 258 | 4 787 | 471 | 8.96% |
| Management | 144 | 146 | -2 | -1.39% |
| Nursing | 30 795 | 23 216 | 7 579 | 24.61% |
| Support | 15 678 | 12 086 | 3 592 | 22.91% |
| **Grand Total** | **70 077** | **51 475** | **18 602** | **26.55%** |

5.7. As may be determined from the table below which indicates filled posts, the GDOH has gradually, year on year increased its staffing numbers. The build up of staff numbers was also done without having an adequate HR budget.

5.8. Table 9 below also indicates some of the discrepancies of HR information between various data sets / documentation.

5.9. Filled posts for the periods 2004/05 to 2008/09 are indicated in the table below.

Table 9: Filled posts / staffing numbers 2004/05 to 2008/09

| GAUTENG | | | | | |
|---|---|---|---|---|---|
| **Personnel Numbers** | **2004/05** | **2005/06** | **2006/07** | **2007/08** | **2009/09** |
| Programme 1: Administration | 882 | 541 | 586 | 709 | 747 |
| Programme 2: District Health Services | 10 592 | 10 919 | 9 679 | 12 849 | 14 257 |
| Programme 3: Emergency Medical Services | 28 | 75 | 414 | 273 | 330 |
| Programme 4: Provincial Health Services | 13 623 | 13 677 | 15 144 | 15 145 | 16 945 |
| Programme 5: Central Hospital Services | 13 931 | 13 676 | 14 499 | 14 228 | 16 898 |
| Programme 6: Health Training and Science | 2 393 | 2 501 | 3 798 | 3 831 | 3 887 |
| Programme 7: Health Support Services | 1 018 | 1 054 | 1 093 | 1 184 | 1 283 |
| Programme 8: Health Facilities Management | 8 | 17 | 26 | 27 | 32 |
| **Total** | **42 475[1]** | **42 460[1]** | **45 239[1]** | **48 246[2]** | **54 379[2]** |
| **Total** | **42 475[3]** | **44 919[3]** | **45 680[3]** | **46 354[3]** | **50 535[4]** |

[1]Source: 2008/09 Gauteng Budget Statement – Page 169

[2]Source 2008/09 Gauteng Budget Statement – Page 169 (note 2007/08 and 2008/09 are estimates

[3]As per Annual Report 2004/05, 2005/06, 2006/07 and 2007/08 respectively

[4]As indicated in interviews with senior management (approximate filled posts as at 31 March 2009)

5.10. Staffing levels increased by 8,060 from March 2005 to March 2009. This increase in staffing levels, associated with an increased burden of disease and additional functions, is likely to have a negative impact on the budget, but should positively impact on service delivery.

5.11. The correction of the establishment requires attention. In reviewing various document sets, it became clear that establishment figures and actual filled positions over a number of years showed differences of between 7,300 and 21,000 positions. Refer to the 2007/09 staff establishment and filled posts table below (which indicate a gap in staffing of 21,043). This situation is not conducive to proper planning and reporting on and managing real vacancies. Information was not available to determine the vacancies of critical health posts, and for the various health professions.

5.12. Information was not available for the 2008/09 year that indicated where the largest gaps are when comparing the filled posts against the staff establishment. The 2007/08 information was available, and is presented in the table below.

5.13. The table below indicates that there were large HR gaps as at 31 March 2008 in EMS (at 88%), all health facility services (District Health, Provincial Health and Central Hospitals), ranging between 25% - 37%).

Table 10: Approved versus filled posts for 2007/08

| GAUTENG | 2007/08 | | | |
|---|---|---|---|---|
| **Programmes** | **Post Establish-ment** | **Posts Filled** | **Posts Vacant** | **Vacancy Rate** |
| Programme 1: Administration | 784 | 651 | 133 | 17% |
| Programme 2: District Health Services | 16 586 | 12 385 | 4 201 | 25% |
| Programme 3: Emergency Medical Services | 3 298 | 397 | 2 901 | 88% |
| Programme 4: Provincial Health Services | 20 488 | 14 680 | 5 808 | 28% |
| Programme 5: Central Hospital Services | 20 933 | 13 286 | 7 647 | 37% |
| Programme 6: Health Training and Science | 3 900 | 3 845 | 55 | 1% |
| Programme 7: Health Support Services | 1 382 | 1 098 | 284 | 21% |
| Programme 8: Health Facilities Management | 26 | 12 | 14 | 54% |
| **Total post numbers** | **67 397** | **46 354** | **21 043** | **31%** |

5.14. No in-depth analysis could be undertaken of management levels, ratios and correct grading due to a lack of information. However, comments were made that there is a possible understaffing at programme management levels.

5.15. Feedback from hospital management indicated that the staff establishment is not aligned to the services to be delivered and is also not aligned to the budget. It was stated that Head Office determines the staff establishment of hospitals. At times the budget does not even adequately cover the number of staff employed (i.e the budget does not cover “warm bodies”), which results in the situation that there will definitely be an over spend with regard to compensation of employees.

5.16. A reported disruption in GDOH that occurs from time to time is that that whenever a new HOD is appointed, there is a restructuring. Personnel find this extremely disruptive and it results in an uncertainty of the changes, as well as a resistance to working as officials are uncertain if they will be moved or shifted to another unit.

5.17. As supported by many interviewees, there is a lack of linking the staff establishment with the targets. For example, there is no link in assessing “these are the targets that need to be reached”, and then determining the resources and budget required to reach those targets. In reality what takes place is that targets are set, yet the budget, human resources and organogram are not aligned to these targets.

5.18. Many directorates /units reported having too few posts on the establishment (and hence unable to advertise for the required staff) for their function eg. IT requires 30 additional staff for the unit in order to implement the plans of the IT unit, to assist with full roll out and support across district and facility level.

# 6. RECRUITMENT

6.1. The single most important challenge with regard to human resources is the recruitment and retention of key personnel. GDOH appears to be doing reasonably well with regards to recruitment and retention of personnel (even given the challenges faced in the recruitment process), as their filled posts have increased year on year as shown in Table 9, with 42,475 in 2005 to 44,919 staff in 2006 (increase of 2,444), an increase of 716 in 2007 to 45,680, an increase of 674 in 2008 to 46,354, and an increase of filled posts of 4,181 to 50,535 in 2009. The last year (2008 to 2009) has shown a significant increase in staffing numbers. Certain of these increases in staff numbers relate to the provisionalisation of EMS and the new clinics obtained in demarcation changes.

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

based on service packages to be delivered, estimated population needs and affordability.

6.3. Gauteng is not as adversely affected as other provinces when it comes to the problems of recruitment in rural areas. The problems facing recruitment and retention in the rural areas is a societal one as socio-economic factors such as lack of proper housing, schools, recreation and facilities are important factors that discourage medical personnel to go to rural areas. As a result, the rural area, where the need is greatest, recruiting skilled staff is one of the most significant constraints to improving access to health care. Possibly the most rural district in Gauteng is Metsweding. The IST met with the management team at the Metsweding District office. Overall the Metsweding team painted a very positive picture and feedback from the interactions with the Metsweding team included:

6.3.1. The Metsweding district team had provided input on the organogram, and appeared reasonably satisfied with it;

6.3.2. The district has adequate and appropriate staffing levels for the population they are required to serve, when comparing these to staffing norms;

6.3.3. The district manager is in an acting position;

6.3.4. Recruitment of staff is performed via the GSSC and the DMT did not appear to have the concerns and issues of the GSSC that others who were interviewed indicated;

6.3.5. In 2007, the District placed a block advert for nursing staff. Many nurses resigned from local government and applied for provincial posts because of the OSD.

6.4. Gauteng is the only province that has a Shared Service Centre (GSSC), which performs the recruitment process (from advertising of the posts, to interviews, to selection and employment). The overly bureaucratic recruitment procedures at GSSC (e.g. extended periods of advertisements for professional posts), and the fact that GSSC does not prioritise the advertising of health related posts (e.g. the

GDOH must wait in line, along with all other departments for the advertising of posts) has a number of negative effects including:

6.4.1. Potentially interested candidates going elsewhere;

6.4.2. Delays in recruitment and overly long appointment timelines;

6.4.3. Resultant excessive overtime of existing staff and contracting of agency nurses or private doctors which has an additional impact on costs.

6.5. Another concern identified by managers is the secondment of key management personnel from a specific unit to the Project Management Office. This has resulted in the gap in management positions within the unit, and the Chief Director not being able to fill that posts as the “secondee” is still being held against that post, and the budget for the “secondee” still being applied to the specific unit. As a result, the manager of the specific unit (in addition to his/her own tasks) now has to “Act” in the “secondee’s” position, creating an even higher workload for the manager.

6.6. GDOH is extremely dependant on NGO’s. NGO’s have increased potential to acquire the scarce skills that the GDOH lacks, due to less bureaucratic processes, and the ability of NGO’s to offer better salary packages. Qualified staff may leave the GDOH to work at NGO’s due to these reasons.

## *7.* PERFORMANCE MANAGEMENT

7.1. A well defined performance and development policy framework exists. However, it was stated by many managers that the process is not working as envisaged. Each person develops his or her performance agreement without taking cognisance of the overall plan of the GDOH. At times individuals do not even develop performance agreements up front, but may only develop the performance agreement when it is time for review (i.e performance agreements developed after the fact and this is not being properly monitored). It appears as though the development of performance agreements up front with individuals is specific to the type of management style and focus that the managers give to the performance

management process. There is no clear linkage between agreed performance measures and organisational strategic priorities. Performance management is also currently aimed at individuals rather than teams, which is how the health sector delivers services.

7.2. The linkages between performance and rewards were unclear. One manager stated that because as managers they know that their staff are over worked and exhausted, and also believe that they are underpaid in the first place, they wish to have their staff rewarded financially in any possible way. Hence staff members are given good ratings which are linked to sympathy and empathy as opposed to performance.

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

7.4. Feedback given was that, with regard to performance management, use of the generic DPSA model is made. The system requires improvement, especially as it relates to the performance management of clinical staff. The link to pay progression is not working, and not being used properly, and the process is cumbersome. There are no sanctions for persons not doing performance agreements properly. There are timeframes and deadlines given as to when performance evaluations must be submitted but nothing happens to anyone if these are not adhered to. This is a HR function, which is not managed effectively. HR is also uncertain as to what measures they may take where there is non-compliance. Overall the culture of performance management is poor, and needs improvement.

## 8. ACTING POSTS

8.1. Due to staff shortages, there are many “Acting” posts within the GDOH. For example, the CEO of Chris Hani Baragwanth Hospital is “Acting” and still has other management responsibilities with the GDOH. The same situation applies to the CEO of Charlotte Maxeke Johannesburg Hospital. The CFO of GDOH is in an

"Acting" position (during the performance of this assignment it was mentioned by an interviewee that the CFO may since have been appointed). Many other examples exist where currently employed managers of one directorate are given "Acting" positions in other directorates. This has the effect that:

8.1.1. Managers are over worked and feel that they are not coping and are not supported;

8.1.2. Managers' time available for managing all these various tasks are extremely limited and they are unable to apply the necessary time and management to all their functions, resulting in "crisis management";

8.1.3. Managers are not compensated for this increase in responsibilities;

8.1.4. Staff feel that managers are not available for support.

8.2. There are insufficient succession plans for key staff, such as CEOs at hospitals.

8.3. One manager described this acceptance of "Acting" positions in GDOH as the "yes paralysis", whereby managers say yes to these "Acting" positions, but are then paralysed as the workload is too large to make proper impacts in various areas.

## 9. RETENTION

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

9.2. The OSD has also resulted in nurses who had management positions, returning to the service, and hence leaving a gap in certain management positions.

9.3. In addition to this, OSD for doctors should have been implemented in July 2008, however, this did not transpire. This has led to doctors getting frustrated and

angry, and results in the risk of these critical skills leaving the public service out of severe frustration. Currently (April 2009) there is a doctors' strike, as doctors are wanting their concerns addressed urgently.

9.4. It was stated that a GDOH retention strategy exists and scarce skills are defined. However, the implementation of this strategy is difficult due to financial constraints. A list of factors that impact on retention includes:

9.4.1. Poor competitive remuneration packages;

9.4.2. Emigration of highly trained professionals (although it was mentioned that with the current global recession, the influx of persons back to South Africa may increase, and the return of people back in to public service may increase);

9.4.3. Competing with other provincial departments (and even the metros within Gauteng) to attract and retain scarce skills;

9.4.4. The impact of HIV/AIDS on the health workforce;

9.4.5. Excessive work demands and an unpleasant workplace environment;

9.4.6. Insufficient developmental opportunities;

9.4.7. Inadequate career progression opportunities;

9.4.8. Poor job satisfaction;

9.4.9. Safety aspects at institutions.

9.5. The review of PCM's (Personnel Circular Minutes) indicated that the introduction of an exit interview to capture and address recurring trends has been proposed. Discussions with others indicated that this process is not working as well as envisaged, as personnel do not want to partake in this exit interview process. In addition to this, there is a lack of monitoring of personnel leaving, and it is a fact that staff may leave the employ of the GDOH with laptops and other departmental

assets including data, as there is no check-list or sign off procedure to ensure staff return departmental assets prior to leaving.

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

## 10. REWARDS

10.1. The February 2009 IYM estimates an overspend on COE of R639 468 000. It should, however, be noted that items that relate to COE such as nursing services, temporary staff (not on Persal) and uniform allowances totalling R289 640 000[10] were paid from Goods and Services during the 2008/09 year, that results in COE being the largest contributor to the overspend.

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

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

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

10.4.1. The OSD was not costed properly and implemented by NDOH without getting input from GDOH;

[10] Information from management account reports.

10.4.2. The personnel over-expenditure from OSD has impacted negatively on other staff appointments (e.g. a moratorium on filling of posts);

10.4.3. A concern is that with the introduction of OSD, nurses involved in management roles were excluded from OSD and have now returned to clinical functions, in order to receive OSD, which may create a gap in management personnel;

10.4.4. Nurses in the clinical field (after the implementation of OSD) earn higher salaries than program coordinators and supervisors. It appears as though certain program coordinators and supervisors may have returned to clinical services in order to obtain the OSD.

## 11. LEARNING AND DEVELOPMENT

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

11.2. The HRD (Human Resource Development) team is responsible for the following scope of work:

11.2.1. Development of employees to align with service delivery objectives;

11.2.2. Generic skills development;

11.2.3. Nursing education – there are currently 4 nursing colleges situated on 6 campuses and catering for 5,300 nursing students;

11.2.4. Professional Development – Health Sciences Development, Professional Services Support, Health Professionals Training Grant;

11.2.5. Lebone College –Emergency Medical Services training;

11.2.6. HAST training & strengthening PHC and District Health Services;

11.2.7. Employee Wellness Programme – including Human Rights & Justice, Occupational Health & Safety (it was stated that the EWP is poorly staffed and that it is poorly supported by National);

11.2.8. Knowledge Management – this is a new sub-directorate.

11.3. It was found that good HR development policies exist, and the HRD has identified that the rapid staff turnover increases the need for training and orientation, and it is believed that Gauteng is still under resourced in terms of health resources due to rapid urbanisation. Although HRD in GDOH is beginning to feature as a highly prioritized objective in the strategic plan of the GDOH, the GDOH had done a thorough analysis of the human resource development (HRD) strategy and listed the following challenges impacting on learning and development in the province:

11.3.1. The performance management and development system is not used to address HRD;

11.3.2. HRD faces difficulties in being properly aligned and coordinated with other directorates;

11.3.3. Resources are generally insufficient and not all critical positions that are essential for the performance of the GDOH are filled (although HRD is one of the better staffed units / directorates, and in addition to this Programme 6 – in which HRD falls, did not overspend in 2008/09);

11.3.4. Line managers do not engage in pre and post training interventions (e.g. managers select staff for training; however, if these staff do not show up, the budget comes out of HRD);

11.3.5. Training provided is not based on skills audits or training needs from performance development plans;

11.3.6. The content of training programmes is not generally related to the actual requirement of the job (e.g. managers of other directorates are responsible for

selecting which staff are to attend which training courses, and these may not always be appropriate);

11.3.7. Other directorates by-pass HRD, and may send staff on training courses offered by external service providers;

11.3.8. Procurement processes impede or disrupt the training process;

11.3.9. Late payment of service providers (by the GSSC) results in qualified service providers' hesitance in dealing with the GDOH;

11.3.10. Principals of nursing colleges are only at Level 12, with the majority of these personnel having Masters and PHD qualifications. It is felt that these skills are not appropriately recognised;

11.3.11. Another key issue which was indicated is that from 2011, a national policy makes the nursing qualification a degree. The concern is that currently the colleges do not have a higher education status or accreditation. The fear is that changing the nursing diploma to a degree will discourage candidates to apply, and there will be a significant drop in the output of nurses. It could not be determined whether enough discussion has taken place and whether the implications of this policy had been thoroughly investigated.

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

11.5. Mention was made of the fact that a large number of nurses are not computer literate. With a lot of the clinics gradually being upgraded to include IT and computers, it was suggested that computer skills should be part of the nursing curriculum.

11.6. Certain directorates / units feel that HRD is not contributing to the training and development of their staff. It was stated that many staff who are required to work

with IT systems lack basic computer literacy (this was an inherited problem). In an attempt to train these officials, the policy states that training is to go through HRD; however, managers feel that in certain areas HRD is not pro-active, and hence HRD is by-passed and training of these officials is done by the directorate concerned (by sending officials on training through an external service provider), and hence this training expenditure may contribute to an over expenditure of this directorate.

## 12. HR INFORMATION SYSTEMS

12.1. PERSAL and Vulindlela appear to be used at the various levels, including hospitals and districts, for basic functions although it is reported that these systems have limited functionality. It was due to these reported limited functionalities that the HRH (Human Resources for Health) tool was developed. This attempts to give the user more detailed analyses of the HR component. This HRH tool was also used as a “clean up” of PERSAL where it was reported that PERSAL has undergone two “clean ups” over the past year and a half, in an attempt to identify and correct “ghost workers”, correct staffing assigned to the incorrect institution in PERSAL and to correct staffing allocated incorrectly against the incorrect post in PERSAL.

12.2. Basic functions, such as the leave function, are performed centrally at the GSSC.

12.3. As stated above, and re-iterated here, PERSAL is not used as an HR planning tool. PERSAL is merely used as an input of relevant HR information. The GSSC is responsible for updating PERSAL (eg leave applications are performed manually at institutional level and sent to the GSSC to update on PERSAL). The monitoring of this becomes a concern, as there are so many processes which by-pass HR at Central office, which make monitoring difficult and tedious to perform.

12.4. Currently, within the GDOH, there are a number of projects relating to PERSAL taking place, for example:

12.4.1. Staff establishment clean up (eg where a post does not exist on the establishment, that post may be placed against another post that is vacant, such as where a

pharmacist is required but this does not exist on the establishment, the pharmacist is placed against a nurse post

12.4.2. Correct coding of staff for alignment with BAS;

12.4.3. GSSC, BAS and PERSAL reconciliations;

12.4.4. Qualification audit;

12.4.5. Personal information update and audit.

12.5. Institutions may maintain records of specialities and the related HR implications, to be used as a “make shift” HR planning tool. It has been reported that there is little guidance from the NDOH with regards to norms and standards for staffing (although it was mentioned that norms were received from the Eastern Cape Department of Health; however, these were found to apply mostly to rural facilities, and were not appropriate for Gauteng).

12.6. The Metsweding interview did confirm that the allocation of staff to specific clinics in PERSAL was not correct in terms of a nurse working at clinic x, may be allocated to clinic y on the PERSAL system.

## 13. OTHER GENERAL HR

13.1. Other general Human Resource challenges identified in the interview process are:

13.1.1. A query raised by one of the interviewee’s was that this process (of the IST review) should be an internal process that is supported by leadership in the department, whereby there is skills transfer from the reviewers to the GDOH;

13.1.2. A Service Improvement Plan was initiated to review staff establishments. The result of this initiative indicated that there were “floating bodies” (ie staff who are employed, but are not on the establishment). Prior to 2006, staff losses balanced out the overspend, which resulted in an underspend on Compensation of Employees. In 2006, GDOH did not budget sufficiently for additional staff, and

since then staff have been retained and increased, and the lack of budgeting for these additional resources has caught up with GDOH in the form of overspending currently.

13.1.3. Certain directorates report being understaffed. For example the post for a TB Director does not exist, yet it was stated that this is desperately required (despite these challenges it was mentioned that the TB cure rate has increased from 67% to 76%);

13.1.4. There is a lack of change management and communication during transitional arrangements, resulting in personnel feeling uncertain and confused;

13.1.5. Issues relating to Personnel working in the health sector are :

13.1.5.1. Burn out of staff is a reality;

13.1.5.2. There is major stress around work place management;

13.1.5.3. The workload, and type of work is extremely stressful;

13.1.5.4. If a staff member is HIV positive, these people may require additional support, which is not always possible.

13.1.6. Clinicians are allowed to do limited private practice. This may be a concern (especially anaesthetists and surgeons), as patient care in the public sector may be compromised;

13.1.7. The appointment of staff where there is insufficient budget is a problem;

13.1.8. HR policies that have been difficult to implement and monitor are :

13.1.8.1. Commuted overtime – which in some managers opinions, has become a money making scheme; and

13.1.8.2. Routine Work Outside of Public Service (RWOPs) – which states that doctors must be present for 8 core hours in the public service; however, it was mentioned that this is difficult to manage. This policy was given by DPSA.

13.1.9. The process of how certain policies are to be managed or approved or implemented is not clearly defined (e.g. consultation with DPSA for organograms);

13.1.10. Skills, leadership and competency – views expressed indicated that key management and leadership roles lack knowledge in health, which severely impacts the decisions made relating to health related focus and strengthening;

13.1.11. Commuted overtime for doctors has increased substantially, and the system is open to abuse (an example was given whereby some doctors may earn up to R700 000 per annum in overtime). Currently the process is that overtime schedules at hospitals are submitted by hospital HR to the GSSC. Only after payment of overtime is made by GSSC, are "exception" reports produced by GSSC for HR management to review (and these exception reports are only produced on request). There is no approval process by HR prior to overtime payments being made;

13.1.12. GDOH generally has a decentralised hospital system, whereby under normal conditions hospitals can employ and dismiss staff. However, currently there is a moratorium on the appointment of staff (this is due to budget constraints);

13.1.13. Skills at hospitals (especially accounting staff) are insufficient, however, it is too costly to appoint higher skilled personnel (a statement by a manager was "penny wise, pound foolish");

13.1.14. Levels are a problem (eg a doctor is Level 12, with a registrar being a Level 10. Should a doctor decide to study a speciality, the requirement is that the doctor would be required to go down to Level 10. This discourages studying specialities, and there is little or no flexibility in the system to handle this adequately. The suggestion made is that there is a "pool" of staff establishments (not on the specific hospital establishment) that can be flexibly used to remunerate staff that are needed. The budget impact of this suggestion was not indicated.

13.1.15. Mention was made of the fact that there is a lack of career pathing (an example was indicated, whereby senior specialists get stuck.)

13.1.16. Feedback indicated that currently there is no standardisation of posts across facilities, and across provinces, which resulted in facilities competing with each other as well as provinces competing for staff.

13.1.17. There have been problems with salaries not being paid in time (GSSC performs the salary payments);

13.1.18. HR at all levels are exhausted (due to workload and responsibilities). A management representative at one of the hospitals that were engaged, was not coping;

13.1.19. It was indicated that there are concerns with the RWOPS (Routine Work Outside the Public Service) process, in that the belief is that RWOPS is not being managed properly, and those health professionals who were involved in both public and private sector work were providing more attention to private sector to the detriment of public service.

13.1.20. One health facility manager indicated that a hindrance in obtaining the “right people for the right job” is the HR policy that deals with “Internal recruitment”, whereby positions first needed to be advertised internally. Because the criteria are low, the internal staff member who is not necessarily adequately suited to the position may get the job (an example was given of the internal advertisement for a state accountant, whereby nurses apply, and because the criteria is lacking, it may happen that a nurse is employed in that position).

13.1.21. Process for HR and OD is that it should be bottom up and feed into strategic planning, where it is important that structure must follow strategy.

13.1.22. The salary packages are not necessarily supportive of attempting to attract the required skills into health facilities (an example was given of the accounting and

financial function as health facilities, whereby one of the problems is the over expenditure, yet insufficiently skilled persons are employed in financial functions);

13.1.23. The sector is highly unionised, and it is difficult to change attitudes and mindsets (e.g. cleaners sweep the floor once a day, opposed to when it is necessary);

13.1.24. Some nurses moonlight in the private sector in addition to working in the public sector. They are tired when they come on duty leading to poor service and potential staff burn out as the health service is understaffed and extremely busy and stressful;

13.1.25. The HRD directorate is in the process of investigating the roll out of a GDOH Employee Wellness Programme (EWP), which will assess the establishing of Wellness Centres. The EWP has been citied as a good practice model and may deserve the funding for strengthening. A large factor influencing the EWP, besides the workload of treating HIV patients, is that the health workers themselves may be HIV positive and require support.

# 14. RECOMMENDATIONS

## 14.1. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

14.1.1. Application of the provisions of the PFMA regarding accountability to be enforced, and for accountability to be entrenched from the top to all staff and downwards through the system.

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

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

14.1.4. The RACI matrix may then be used to hold individuals accountable for actions.

## 14.2. INTEGRATION AND CO-ORDINATION

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

14.2.2. The organisational structure should be reviewed with a view to create optimal clusters and co-ordination e.g. incorporate the medical depot and pharmacists into the same cluster or Multi-sectoral Aids Unit to be incorporated under the Premier’s Office.

14.2.3. Communication mechanisms need to be enhanced between NDOH and GDOH.

## 14.3. LABOUR PLANNING

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

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

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

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

## 14.4. ORGANISATIONAL DESIGN AND STAFF ESTABLISHMENT

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

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

14.4.1.2. Structuring should also allow for re-allocation of lower level duties to lower graded staff.

14.4.1.3. Appropriate management ratios and levels should be reviewed and current proposals to inflate the provincial head office structure should receive serious attention with a view to limit additional top level positions

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

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

14.4.3. Norms and standards from NDOH should exist to guide provinces to determine correct structures and establishments. This should include guidance on management levels, staffing numbers to manage programmes, staffing ratios and grading of positions.

14.4.4. Consistency in grades for similar positions across various areas should be analysed in more depth. This should include the standardisation of job titles between provinces so that comparisons can be easily made.

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

## 14.5. RECRUITMENT

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

14.5.2. Proper Service Level Agreements (SLA's) should be in place between the GSSC and the GDOH, which details turn-around times and clearly defines responsibilities. This SLA may then be used by the GDOH to adequately monitor and manage the GSSC, and hold parties accountable for non-performance.

## 14.6. PERFORMANCE MANAGEMENT

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

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

14.6.2.1. Organisational performance;

14.6.2.2. Employee development;

14.6.2.3. Reward based on clear performance goals.

14.6.3. Team performance should form part of performance standards and evaluation.

## 14.7. ACTING POSTS

14.7.1. The effect of Acting positions and the increase in workload should be carefully considered, and managers should not feel compelled and obliged to accept acting positions to the detriment of their own documented responsibilities. Senior

management, such as the CFO, should also ideally not be an acting post and should rather be filled in-house than be outsourced.

## 14.8. RETENTION

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

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

## 14.9. REWARDS

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

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

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

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

## 14.10. LEARNING AND DEVELOPMENT

14.10.1. Training needs should be properly and objectively determined.

14.10.2. The costs and implications of training nurses in computer skills could be investigated further and incorporated into planning processes;

14.10.3. Well considered and prioritised commitments to relevant training should be maintained even during times of cost containment. Training and development

programmes should be clearly defined and aligned to the service delivery priorities of the province.

## 14.11. HR INFORMATION SYSTEMS

14.11.1. 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;

14.11.2. The NDOH should liaise with provincial DOHs on the HR tools that they are investigating.

## 14.12. OTHER GENERAL HR

14.12.1. Core hours required of clinicians working in both public and private sector should be adequately monitored in order to ensure that clinicians are working their core hours as indicated in Personnel Minute Circulars;

14.12.2. Financial management of budgets (and the resultant employing of staff where there is no budget) should be managed more rigorously;

14.12.3. Commuted overtime should be appropriately monitored (and submitted with supporting documentation) and approved by HR managers prior to being paid by the GSSC. “Top earners” and exceptions should be investigated.

# Information Management

## 1. INTRODUCTION

**Box 4: Information Management review key findings**

1. The GDOH has recognized monitoring and evaluation (M&E) as a significant weakness and have embarked on a drive to instil a culture of programme management in the GDOH. A M&E project is in progress to rationalize the indicators and align these with performance management systems.
2. The District Health Information System (DHIS) is well established in Gauteng; hospital information systems, however, are weak. A number of stand alone systems which do not talk to each other have been developed by various departments making collation of information cumbersome and prone to inaccuracies. In response, the GDOH has piloted and is in the process of rolling out a Health Management Information System (HMIS) which will integrate all the health and management information systems currently in use.
3. The GDOH has a strong Health Information Systems Directorate with good senior management support for the use of information for planning. This needs to be cascaded down to district and facility level so that managers are seen to be using information for management and action.
4. At present there is no system which integrates, or central repository for, health programme, human resources (HR) and budget information. These have to be accessed from various sources in order to compile composite reports.
5. There is no records retention policy in the GDOH. As a result institutional memory is lost when people leave and there is a strong possibility for duplication of work that has previously been done.

## 2. OVERALL MONITORING AND EVALUATION

2.1. The GDOH has recognized that the GDOH's M&E strategy requires strengthening. They are working with six (6) strategic goals, more than 162 strategic objectives and in excess of 1000 indicators which measure mainly inputs and outputs with little attention to outcome and impact. There is little outcomes based evaluation. A M&E project is currently underway to rationalize the number of indicators, refocus on outcome and impact measures as well as aligning these with the performance management and reporting system. Although it appears as managers in the GDOH place a strong focus on M&E, it was stated that some managers are "really just paying lip service to M&E".

2.2. There is a perception amongst some managers, however, that certain core management functions such as quality assurance and monitoring and evaluation (M&E) have been relegated to the project management unit (PMU) instead of being institutionalized within the GDOH. This undermines managers and fosters competition between managers and the PMU.

## 3. USE OF INFORMATION FOR DECISION MAKING

3.1. The Head of Department (HOD) is *"very big"* on information for management and is therefore very supportive of the development of health information systems.

3.2. The HIS unit has produced a publication entitled *Health in Gauteng* which is a status report 2006/7 compiled from the DHIS and other information sources. It is useful in providing baseline health and demographic information for the province and informed prioritization of projects in the GDOH. It also highlighted gaps in the accuracy and completeness of available health information and made the importance of information for planning and action relevant for managers who were actively involved in developing the report.

3.3. Managers are required to produce management reports and monitor key performance indicators in their respective directorates, but have not had the IT tools to do this. As a result, many managers, especially the clinical heads of units,

have implemented their own makeshift systems (often Excel spreadsheets). There are twenty eight (28) standalone systems in use in the GDOH. This makes compilation of reports cumbersome and copying and pasting data from a variety of sources makes the information vulnerable to inaccuracies with the added risk inherent with human intervention. A HMIS has been piloted at Sebokeng Hospital and surrounding clinics and is being rolled out to other facilities. The Saurian system will integrate all health and management information systems currently in use and data collection at all facilities will be automated and connected. The Saurion system is currently being piloted, and the effectiveness can not be commented on by the IST.

3.4. District managers often send junior staff to provincial M&E meetings. These staff members often do not have the background to the strategic objectives of the meetings and discussions and cannot provide adequate feedback when they get back. District managers are therefore not as informed as they should be and the information management culture is not well communicated down to facility level.

## 4. HEALTH INFORMATION SYSTEMS

4.1. The GDOH has a Directorate: Health Information Systems – a well functioning information unit - which is responsible for data quality and has an excellent geographic information system (GIS). Despite the well established HIS unit, data quality can still be a problem sometimes. This is mainly because CEOs of hospitals (especially those who are new) seem unaware that reliable information is available on the DHIS. When facility information is requested, they ask their staff to recollect and collate statistics manually leading to discrepancies in the data from various sources.

4.2. Although some units at the NDOH e.g. Policy, Planning and M&E, are extremely supportive, in general, there is little leadership and guidance from national. This has resulted in GDOH taking the lead in developing HMIS and e-Health Smartcard projects.

4.3. A number of different systems are currently being operated in various institutions e.g some institutions run PAAB and some Medicom. GDOH has spent a huge

amount on Saurian – a proprietary system which will require the payment of licensing fees, but any customizations of the system will belong to the GDOH. The costs of the Saurian project were underestimated as infrastructure (cabling, phone-lines etc) were not budgeted for. Part of the project has been done using wireless technology. Managers compare this with the DHIS on the other hand which is open source and therefore free and has evolved with a lot of input from the users ensuring that the system is user-friendly and well accepted.

4.4. The hospital information system is weak. International Classification of Diseases (ICD 10) coding is done, but there is no standardised procedure coding. Poor/incorrect procedure coding means poor quality data, making it difficult for the GDOH to implement preventive or take corrective measures. Incorrect coding has also cost the GDOH in cases of litigation, where GDOH is unable to provide patient records which substantiate that patients have been managed appropriately.

4.5. In addition, the weak hospital information system affects the ability of hospitals negatively in terms of revenue collection as claims from medical aids are disputed because of incorrect coding. The uniform patient fee system is applied, but this is too high level to be useful.

4.6. There is no system for managing and reporting on the tertiary services grant (TSG). The TSG is reported within the general pool of funds unlike the HIV conditional grant which has good monthly reporting systems that work well.

4.7. The lack of a pharmaceutical management system was highlighted as a major issue since medicines are a major cost driver in the health system. There is also no prescriber-level interaction between pharmaceutical and clinical services – "*clinicians spend and pharmacy accounts"*.

4.8. There is no IT system for reporting on emergency medical services (EMS) information.

# 5. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

5.1. The HIS Directorate boasts 95% accuracy of the numeric indicators on the DHIS. Data is validated by the HIS and quarterly feedback meetings held with district level staff. There is excellent cooperation with the metros in Gauteng. Reports are received timeously and there is full participation by local government staff in feedback meetings ensuring that district level information is complete.

5.2. Data is collected manually at facility level using registers and tally sheets for the various programmes. The collated facility level data is forwarded to sub-district or district level where it is captured electronically and sent on to province where it is validated before being reported to national. Although the quality of information received from the districts is improving, the HIS still reports finding 'obvious' mistakes in the district reports, pointing to a need for more training of district and facility level staff who deal with data collection.

5.3. Staff working in HIS may not have the required training, qualifications and experience – some staff members who are required to work with IT lack basic computer literacy skills. This means that managers need to spend more time on training and staff supervision as well as monitoring data outputs.

5.4. The provincial HIS directorate has produced guidelines on the numbers, job descriptions and qualifications of staff required for effective information management. However, it is up to the discretion of district managers how or whether these are implemented. At present health information staff is employed at too low a salary scale to attract the required level of skills or to retain them as once they have received training they move on to other better paying jobs. This coupled with a moratorium on staff appointments other than critical skills - information officers are not regarded as such – results in high vacancy rates and a constant cycle of retraining at significant cost, when staff are appointed.

5.5. Data must be collated manually from several sources before reaching the provincial HIS Directorate leading to data inaccuracies. Central HIS managers

spend a large amount of time validating information and correcting mistakes with the result that information only becomes available 30 days later.

5.6. Although NDOH utilises the DHIS as main source of data, personnel within GDOH do not make sufficient use of the system, due to a lack of IT infrastructure, skills and competency. There is only 16% connectivity amongst the health institutions in the GDOH.

5.7. The lack of IT resources has also delayed the implementation of e-learning programmes which had been planned by human resource development (HRD).

## 6. ARV MONITORING AND EVALUATION

6.1. The Gauteng HIV programme is extremely well funded (GDOH received 1/3 of the adjustment budget of the national HIV conditional grant in 2008/9) because the planning, M&E and reporting systems work very well, business plans are realistic, targets met and reports submitted on time. The DHIS is used to monitor the ARV programme. Outcome data such as cohorts of patients still on treatment or cohort mortality rates is not available. However, the GDOH is investigating the acquisition of a system which provides this information and interfaces with the DHIS.

6.2. There is a lack of systems to use evidence based outcomes. Prestigious well renowned research institutions with overseas funding (e.g. RHRU, PHRU) work with and support the programme in initiating sites at district level. This is provided in the form of infrastructure upgrades, provision of specialist skills e.g. pharmacists, doctors, nurses and paediatric HIV care and training.

## 7. OTHER INFORMATION MANAGEMENT ISSUES

7.1. The GDOH has no policy for records retention or data backup. When staff members leave the GDOH, they often leave without adequate handover and work they have done whilst in the employment of GDOH is lost.

7.2. At present there is no system for the integration of health programme management, HR and financial management information.

7.3. There is no single repository of information in the GDOH. Managers need to source data from a variety of sources, including the GSSC, in order to compile reports.

# 8. RECOMMENDATIONS

## 8.1. OVERALL MONITORING AND EVALUATION AND USE OF INFORMATION FOR MANAGEMENT

8.1.1. Integrate health programme and management information systems and ensure that this system is institutionalized within all levels of the GDOH. M&E based on a number of key indicators needs to be built into every senior manager's job description and performance appraisal. (This process is currently underway).

8.1.2. In-service training around understanding of the importance of key indicators for management needs to take place where applicable and with a particular focus on district and facility level.

8.1.3. There should be regular analysis, comparison, interpretation and feedback around indicators to lower levels of the system and support from provincial managers to take preventive or remedial action as necessary.

## 8.2. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

8.2.1. The GDOH needs to ensure that their 'new' HIS interfaces with the DHIS. (This is also work in progress).

8.2.2. Training needs to be developed and conducted for district and facility level staff and facilitation of the use of information for action.

8.2.3. The DHIS and associated NIDS, needs a thorough review by NDOH. The numbers of indicators need to be decreased and there should be unambiguous, easy to understand, standardized definitions. There also need to be clear written guidelines, norms and standards for each component of DHIS, including data

collection tools, relevant human resources, hardware, software, data flow policies and linkages between the DHIS and other data collection systems e.g. PERSAL, BAS, ETR-net.

8.2.4. Training and development courses for information officers should be developed. The levels at which they are appointed should be reviewed and other ways to encourage retention of staff should be explored.

## 8.3. OTHER INFORMATION MANAGEMENT ISSUES

8.3.1. A records retention and information backup policy should be developed and implemented at facility, district and central provincial levels.

8.3.2. There needs to be one official repository of information for the GDOH. All reports and documents using information should be drawn form this warehouse to eliminate duplicate sources of information. All relevant role-players need to ensure that information in the repository is up to date and of good quality.

8.3.3. Parallel and standalone data collection systems should be integrated or enabled to talk to each other to improve the reliability of collated data and minimise inaccuracies in report compilation.

# Medical Products, Laboratory

## 1. INTRODUCTION

| Box 5: Medical products and Laboratory: Key findings |
|---|
| 1. Pilferage of medicines may be a concern, due to ineffective internal control processes.<br>2. Duplication of laboratory tests and x-rays due to lack of integrated systems for monitoring and control.<br>3. Staff inappropriately skilled to manage pharmaceutical budgets of millions of Rand. |

## 2. MEDICAL PRODUCTS

2.1. Medical and other medical related consumables are procured by the Medical Supply Depot (MSD).

2.2. A respondent indicated that pilferage of medicines, food and equipment is rife, as there is little control and monitoring of this. Feedback given is that another cost driver is the wastage of medicines, due to lavish prescribing (eg patient receives 8 days of intravenous antibiotics instead of standard practice of 5 days of oral antibiotics, with intravenous treatment being more expensive than oral).

2.3. Feedback indicated that the staffing levels at hospitals are inappropriate to manage a pharmaceutical budget of millions. The comment made was that the state accountants are poorly qualified and unable to perform proper financial analyses.

## 3. LABORATORY

3.1. NHLS is paid a fee for service. The main concern relating to laboratory costs, was reported to be at central hospitals which use a manual system (and no capturing of information onto an integrated system), which leads to duplication of tests when a

patient may be referred down to another level of care, and the same tests were repeated, as they had been lost in the process.

3.2. It was also believed that Gauteng subsidises other Provinces due to patients from other Provinces making use of Gauteng facilities, which increases the costs across the board.

3.3. At district level a clinic may request a certain laboratory test to be performed. The account is received by the district to pay. There appears to be a weakness in the process whereby the district may not always have complete, accurate and valid figures from the clinics to confirm that the services were in fact requested by the clinic. The risk arises that the district may be paying for services which the clinics did not request. (An example was given of a doctor who used to work at one of the clinics, has now left but who was still purporting to be linked to the clinic and having the accounts sent to the district office).

## 4. BLOOD SERVICE

4.1. Blood shortages are problematic, due to fewer donors (due to HIV prevalence). It was stated that clinicians tend to use $O^+$ blood, instead of cross-matching, which increased costs.

4.2. Blood services are charged as a fee for service model. It was stated that this is an expensive service, where costs have increased significantly. A suggestion was made that other models such as capitation may need to be explored to curb costs.

## 5. RECOMMENDATIONS

5.1. A review of the processes to ensure that payments are only made for valid services provided should be performed and enhanced if necessary.

5.2. Proper controls for monitoring and controlling pharmaceuticals should be implemented.

5.3. Investigate the possibility (and resultant cost implications) of increasing staffing levels to adequately manage the pharmaceutical budget.

# Technology and Infrastructure

## 1. INTRODUCTION

| Box 6: Technology and Infrastructure - Key findings |
|---|
| 1. There is a general misalignment of capital and operational plans. |
| 2. Some clinics are too small and their infrastructure is not conducive for proper service delivery. |
| 3. Health care waste management is a concern and may lead to reputation risk. |
| 4. There are no formal plans for maintenance of medical equipment. |
| 5. Capital and IT related operational budgets are not always aligned. |

## 2. INFRASTRUCTURE

2.1. The tertiary hospitals in the province are equipped with world class equipment.

2.2. There is a general misalignment of capital and operational plans. When new medical equipment is installed, little or no planning was done on the operational impact, such as the additional staff required to operate the equipment as well as ongoing maintenance thereof. Inefficiencies pertaining to BEE contractors' equipment maintenance were raised. These inefficiencies resulted in equipment being out of order for long periods and additional costs to have them fixed by a series of consultants. A further implication of unreliable maintenance is litigation, which cannot be budgeted for (e.g. faulty theatre equipment resulting in death or disability, for which GDOH is subsequently sued). The GDOH is in the process to develop a terms of reference to identify and create a pool of reliable medical equipment maintenance contractors.

2.3. Clinics often have a shortage of space as a result of increased patient volumes and the infrastructure is not conducive for proper service delivery.

2.4. There is a lack of computers in the clinics with a lack of connectivity. The new Saurion roll out will also include installation of computers and connectivity at the

clinics. Issues regarding connectivity were addressed by way of satellite where required. As it is at an early stage, the IST cannot comment on the effectiveness and efficiency thereof.

2.5. Pharmacy infrastructure is poor, even in the new facilities.

2.6. Following a PMU safety and security risk analysis, security was improved at the tertiary hospitals and the plan is to be rolled out to the district hospitals. Clinics are not part of the roll out phase at present. Security is now provided by a third party including third party liability. This may explain the sharp increase in security costs during the past two years.

2.7. Impopoma was created in the GDOH to interact with Public Works. Impopoma establishes a database of service providers to perform maintenance. Previously, Public Works were responsible for maintenance. Maintenance work allocated to suppliers is done on a rotation basis which is outside the scope of the GSSC. Currently, Public Works manages Impopoma. Although the merit for Impopoma is not questioned, it is unclear why an additional structure is required, which adds to the cost of GDOH.

2.8. Health care waste management is a concern due to the lack of incinerators. The issue also has a reputation and image risk for the GDOH.

2.9. Inefficiencies were raised where Public Works built a clinic costing R180 million, which is excessive in terms of the requirements and size for a clinic.

## 3. TECHNOLOGY

3.1. The BAS accounting system and PERSAL system are not integrated.

3.2. Data collection in the GDOH is predominantly a manual process.

3.3. Approximately 15% of health facilities are connected in terms of information technology connectivity.

3.4. PAAB and Medicom are the two systems that are currently used in various facilities, but are not integrated. It is believed that the Medicom system will be phased out during the course of the year.

3.5. The IST was left with the impression that the GDOH requires in excess of R2 billion to achieve its IT goals and to have all IT improvements materialised. This will include, replacing all old equipment with new and a full business re-engineering process. This has not been budgeted for at present.

3.6. GDOH adopted a “big bang” approach regarding the implementation of the new Saurion system. Various factors added to the cost of the project, some of which are set out below:

3.6.1. The clinics had limited or no computer infrastructure at the time, which were not budgeted for and were required before implementation.

3.6.2. The GSSC was responsible for providing the wide area network (WAN) for the provincial clinics to link to one another. However, due to the slow turnaround time by the GSSC, the GDOH installed one hundred and thirty four local area networks (LAN) to cover all the clinics. The costs related thereto were paid for from the management information system budget. Additional costs flowing from computerising the clinics are higher security and maintenance.

3.7. IT is not always included in the planning process. Although the hospital revitalisation conditional grant is aimed at capital infrastructure, some of the business cases did not include IT systems as part of the project and thus IT related expenses had to be paid from the operation IT budget. Again an example of misalignment of capital and operational plans.

3.8. There are no formal plans for maintenance of medical equipment and therefore maintenance is performed when required and not on a routine basis. Inadequate systems are in place for monitoring of maintenance.

# 4. RECOMMENDATIONS

4.1. Consideration should be given to the idea of a conditional grant aimed at strengthening and creating an integrated health information system. Systems could, however, differ from province to province, provided they can feed into a national framework and be able to interface with each other.

4.2. Implement a provincial data warehouse.

4.3. A proper medical equipment maintenance plan should be developed and priced. The plan should be regularly monitored and evaluated.

4.4. National Treasury (as custodian of the policy) should consider establishing a separate fund that supports BEE suppliers by funding the incremental costs where BEE suppliers are more expensive than others and provide technical training e.g. X-ray technicians. This initiative is in line with Government's policy on job creation and supports BBBEE.

# Taking Forward the Recommendations

This section brings together the recommendations from the various sections, and indicates the main role-players responsible for implementation. It highlights the inter-dependence of the activities. As noted in the foreword to this report, the public health system as a whole needs to work in unison to achieve improvement of health system performance, and ultimately the improvement of population health outcomes. Table 11 is a summary of all the recommendations in Leadership Governance and Service Delivery to Taking Forward the Recommendations. These are linked with the institution(s) that have responsibility for the implementation of these recommendations.

**Table 11 : Recommendations contained in the Gauteng 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 Depart-ment of Health | Gauteng Health MEC | Gauteng Depart-ment of Health | National Treasury | Gauteng Treasury | Department of Public Service and Adminis-tration | External stake-holders | Gauteng Shared Service Centre |
|---|---|---|---|---|---|---|---|---|---|
| **FINANCE RECOMMENDATIONS** | | | | | | | | | |
| **Provincial health budget allocation** | | | | | | | | | |
| The Equitable Share for the GDOH should be revisited to take cognisance of the real population of the province | | | | 2 | 1 | 1 | | | |
| Allocations of conditional grants by the NDOH should be based on clear, objective criteria that are linked to grant specific indicators and not on the equitable share formula. | | 1 | | 2 | 2 | 2 | | | |
| **Unfunded Mandates** | | | | | | | | | |
| GDOH to determine the number of “floating bodies” and to correct the staff establishments. A consultative process should then be launched between Provincial Treasury, GDOH and NDOH to address the funding thereof | 2 | 2 | | 1 | | 2 | | | |
| The operational impact of national policy decisions (e.g. OSD, should be determined and must be agreed with the provincial health department prior to implementation. | | 1 | | 2 | 2 | 2 | | | |
| Nationally negotiated salaries should be done in consultation with Provincial Treasury and GDOH to confirm the availability of funding to cover shortfalls | | 1 | | 2 | | 2 | | | |
| There should be alignment between | 1 | | 1 | 2 | 2 | 2 | | | |

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| political decisions and operational implementation and agreement reached for any proposals on increases of service levels prior to their announcement. The availability of funding should also be confirmed. | | | | | | | | | |
| A plan to improve and strengthen primary health care and access thereto should be developed. The financial implications, human resource, infrastructure and all associated implications need to be taken into account in this plan | | | | 1 | | 2 | | 2 | |
| **Budgeting Process** | | | | | | | | | |
| The budgeting process needs to be seen and used as an extension of the annual performance plan, and needs to follow an iterative process. | | | | 1 | 2 | 2 | | | |
| All operational units (cost centres) need to have a realistic budget that can be used as a guideline for the financial year's activities. Operational plans need to be aligned with available funding to deliver the services. Operational plans need to be changed to realistically reflect the operations given the allocated budget. | | | | 1 | | 2 | | | |
| Budget virements need to be linked to changes in operational activity, not merely to balance the number of over- and under- | | | | 1 | | 2 | | | |

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| expenditure items. | | | | | | | | | |
| **Financial management** | | | | | | | | | |
| Cost centre accounting needs to be done at the lowest possible practical level (i.e. facility/clinic level). This is needed to properly identify areas of operations that require attention. | | | | 1 | 2 | 1 | | | |
| Allocation of expenses needs to be accurate and up to date to assist with effective management. Actual expenditure is an important indicator and inaccurate information impacts on effective monitoring and evaluation at all levels. Effective management is not possible without accurate and timely information. | | | | 1 | 2 | 1 | | | |
| Variance analysis needs to be used as a management tool to identify areas that require attention and not merely a paper exercise. | | | | 1 | 2 | 2 | | | |
| The required monitoring structures need to be put in place. | | 2 | | 1 | | 2 | | | |
| Managers should be held accountable for the performance of their operating units and this must be built into the performance management system. | | | | 1 | | | 2 | | |
| Review the SLA between the GDOH and the GSSC to improve efficiency clauses, performance management as well as | | 2 | | 1 | | | 2 | 2 | |

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| accountability issues. Include penalty clauses for non-performance. | | | | | | | | | |
| Improved BEE SLA management, incorporating BEE supplier trading with proper management of work done and enforcing quality assurance | | | | 1 | | | | | 2 |
| All the PMU's projects should be evaluated in terms of value add and all the non critical projects should be abandoned until funding for those projects are available. | | 2 | 2 | 1 | | 2 | 2 | 2 | |
| **Quarterly Performance Reports** | | | | | | | | | |
| The accuracy and use of essential performance indicators needs to be improved e.g. the number of patients on ARVs. The necessary steps must be taken in conjunction with the NDOH to improve the quality of information available in this regard. | | 1 | | 1 | 2 | 2 | | | |
| Variances in specific indicators need to be followed up with actions, and not merely identified. | | | | 1 | | | | | |
| There needs to be a link between performance and financial reports. A financial report reflecting actual expenditure compared to budget should also be provided where performance indicators reflect a deviation in operational | | 2 | | 1 | 2 | 2 | | | |

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| performance. | | | | | | | | | |
| The GDOH implemented various initiatives (such as piloted integrated systems, monitoring and evaluation mechanisms) to address the above. These need to be evaluated for their effectiveness. | | 1 | | 1 | | | | | |
| **Financial reporting IYM (in year monitoring)** | | | | | | | | | |
| Through the appropriate channels, the forecasting component of the IYM should be investigated to ensure that accurate accrual reporting is done in the IYM process. | | | | 2 | 1 | 2 | | | |
| **Annual Financial Statements** | | | | | | | | | |
| The annual financial statements, while meeting Constitutional and Government Accounting requirements, should be expanded beyond the cash basis of reporting and include accruals as part of reported, aggregated expenditure numbers. | | | | 2 | 1 | 2 | | | |
| **LEADERSHIP, GOVERNANCE and SERVICE DELIVERY RECOMMENDATIONS** | | | | | | | | | |
| **General Leadership** | | | | | | | | | |
| There should be explicit and open discussion around the budget and the level of services that can be rendered for this budget. The areas of rationing and | 1 | 1 | 1 | 1 | 2 | 2 | | 2 | |

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| prioritization should be made clear and communicated effectively to all concerned. All sources of funding should be evaluated, and should rationing be required, the process followed should be constitutionally sound. | | | | | | | | | |
| There should be an iterative process to national policies where provincial realities and feedback is given so that policies can be amended to fit the realities or additional resources made available. | 2 | 1 | 2 | 1 | 2 | 2 | | 2 | |
| Service delivery and budgets should be aligned so that managers are not faced with ad hoc budget cuts. | | 1 | | 2 | | | | | |
| Better day-to-day planning to avoid unplanned meetings and better time management by managers. This can also include cutting back on unnecessary meetings and streamlining programme training and workshops through better coordination amongst national and provincial programme managers. | | | | 1 | | 2 | | | |
| Executive Committee meetings should assign a person responsible for specific tasks, and assign a deadline date for the completion of the task. The Exco minutes should capture these decisions. In this way, at subsequent Exco meetings, persons may be held responsible and | | | 2 | 1 | | | | | |

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| accountable for reporting back on the completion of their responsibilities. | | | | | | | | | |
| **Planning** | | | | | | | | | |
| The STP should be costed, revised in terms of the available budget and then implemented | | 2 | 1 | 1 | 2 | 2 | | 2 | |
| Strengthening of Primary Health Care :<br>❒ Defining and costing the package of services to be delivered at each facility;<br>❒ Extending hours of service and cost it properly;<br>❒ Deliver minimum package of service from each designated facility;<br>❒ Provide appropriate (numbers, training, qualifications) staffing levels<br>❒ Integration of all health services | | 2 | 1 | 1 | 2 | 2 | | | |
| Ensure that patients access the health system at the appropriate level of care by implementing<br>❒ bypass fees at hospitals<br>❒ improved screening at hospitals<br>❒ effective referral system<br>❒ patient transport system<br>❒ patient education. | | | | | | | | | |
| Implement DHS model effectively :<br>❒ Evaluate and establish proper funding | | | | 1 | | 2 | | | |

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| model for PHC package of services<br>❒ Increase District hospital services | | | | | | | | | |
| Strengthen relationships between universities and GDOH for health systems research | | | | 1 | | | | 2 | |
| All planning processes in the department should be aligned with each other and well communicated. There should be a limited number of key targets for each area of operation for which managers are responsible and accountable. | | 1 | | 1 | | | | | |
| There should be linkages between health programmes, HR and financial management and reporting systems | | | 2 | 1 | | | | | |
| Ring-fence the budget of each priority programme in order to set and monitor targets effectively. Plans should be a roadmap for all health services in the province. There should be a clear M&E process which ensures implementation of plans are regularly monitored with remedial action to ensure that targets are met | | 1 | | 2 | 2 | 2 | | | |
| Targets should be based on national guidelines and provincial realities. | | 1 | | 2 | | | | | |
| Measures to ensure sustainability must be built into programme planning e.g. HIV which currently has a high reliance on | | 1 | | 1 | 2 | 2 | | | |

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| external resources | | | | | | | | | |
| **Governance** | | | | | | | | | |
| All senior management appointments should take merit and ability into strong consideration. | | | 1 | 1 | | | | | |
| Changes at senior management level each time the MEC changes should be avoided to ensure stability and continuity | | | 1 | 2 | | | | | |
| The NDOH should provide provinces with clear written guidelines regarding the delegation of authority, responsibility and accountability to facility and district managers. Provinces should implement with due regard to adequate oversight | | 1 | | 2 | | | | | |
| **Service delivery (HIV, TB and MCH)** | | | | | | | | | |
| Role and expertise of managers at provincial and district levels must be defined with clear guidelines of performance expectations; | | 1 | | 1 | | | | | |
| Improved communication (vertical) between programme managers and (horizontal) between programme and service delivery managers; | | 1 | | 2 | | | | | |
| Quality of care & problem solving at local level must be encouraged; | | | | 1 | | | | | |
| Revitalisation of PHC services. Gauteng should consider an action plan between | 2 | | 2 | 1 | | | | | |

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| the present and the provincialisation of metros in 2013. | | | | | | | | | |
| **HUMAN RESOURCE RECOMMENDATIONS** | | | | | | | | | |
| **Delegations, Accountability and Responsibility** | | | | | | | | | |
| Application of the provisions of the PFMA regarding accountability to be enforced, and for accountability to be entrenched from the top to all staff and downwards through the system. | | | | 1 | | | | | |
| It should be assessed if withdrawing delegations adds value in terms of cost containment and service delivery. If not, then delegations should be re-instituted. A clear matrix in terms of delegation of authorities and decision making at various levels should be completed (This should be in line with a RACI matrix where different people are responsible, accountable, consulted or informed) | | | 2 | 1 | | | | | |
| The responsibility level of CEOs of institutions and district managers and their district management teams (DMTs) should be reviewed and addressed. This should include a review of financial management responsibilities. | | | 2 | 1 | | 2 | | | |
| The RACI matrix may then be used to hold individuals accountable for actions. | | | | 1 | | | | | |

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| **Integration and co-ordination** | | | | | | | | | |
| Communication mechanisms need to be established across clusters and DHS to prevent "silo" operational functioning; | | | | 1 | | | | | |
| The organisational structure should be reviewed with a view to create optimal clusters and co-ordination e.g. incorporate the medical depot and pharmacists into the same cluster or Multi-sectoral Aids Unit to be incorporated under the Premier's Office; | | | | 1 | | | | | |
| Communication mechanisms need to be established between NDOH and GDOH. | | | | 1 | | | | | |
| **Labour Planning** | | | | | | | | | |
| Planning should be aligned more clearly with strategic priorities, service transformation and HR staffing needs (short, medium and long term) at the various service delivery levels; | | | | 1 | | | | | |
| Clear and consistent key HR statistics and indicators should be developed and reported on; | | 1 | | 1 | | | 2 | | |
| Feedback loops should be established to update plans and define cost and service delivery impacts should new priorities arise. | | 2 | | 1 | 2 | 2 | 2 | | |
| Clear decisions and direction at various | | 1 | | 1 | | | 2 | | |

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| levels (national, provincial and district levels) in terms of service delivery should be communicated – if fewer HR resources and decreased funds are available, priorities need to be adjusted and communicated accordingly. | | | | | | | | | |
| **Organisational design and Staff Establishment** | | | | | | | | | |
| Restructuring, with a view to establishing minimum staffing levels, should be undertaken based on a number of factors including objectively agreed benchmarks, the provincial disease burden profile, optimal application of scarce skills and service delivery priorities as well as on available resources. Special consideration should be given to:<br>❒ Structuring should allow for the optimal use of scarce skills ( e.g. service hubs at district level, such as information technology skills and artisans skills which are made available to all the institutions that are linked to the hub)<br>❒ Structuring should also allow for re-allocation of lower level duties to lower graded staff;<br>❒ Appropriate management ratios and levels should be reviewed and current | | 1 | | 1 | | | 2 | | |

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| proposals to inflate the provincial head office structure should receive serious attention with a view to limit additional top level positions.<br>❒ Job titles and job grades should be consistent across various areas. | | | | | | | | | |
| PERSAL should be corrected to accurately reflect personnel positions and staffing numbers as reported in the GDOH Budget Estimate and Annual Report statements. | | 2 | | 1 | | | 2 | | |
| Norms and standards from NDOH should exist to guide provinces to determine correct structures and establishments. This should include guidance on management levels, staffing numbers to manage programmes, staffing ratios and grading of positions. | | 1 | | 2 | | | 2 | | |
| Consistency in grades for similar positions across various areas should be analysed in more depth. This should include the standardisation of job titles between provinces so that comparisons can be easily made. | | 2 | | 1 | | | 2 | | |
| DPSA should assist NDOH and provinces to support changes to structures in a more efficient manner | | 2 | | | | | 1 | | |
| **Recruitment** | | | | | | | | | |
| A thorough review and improvement of | | 2 | | 2 | | | 1 | | |

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| implementation of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times; | | | | | | | | | |
| Proper Service Level Agreements (SLA's) should be in place between the GSSC and the GDOH, which details turn-around times and clearly defines responsibilities. This SLA may then be used by the GDOH to adequately monitor and manage the GSSC, and hold parties accountable for non-performance; | | 1 | | 1 | | | 2 | 2 | |
| **Performance Management** | | | | | | | | | |
| Performance contracts at job level 13 and above should be clearly linked to organisational priorities and key indicators that drive organisational performance. | | | | 1 | | | | | |
| The performance management system should be utilised as intended and incorporate:<br>❒ Organisational performance;<br>❒ Employee development;<br>❒ Reward based on clear performance goals | | | | 1 | | | 2 | | |
| Team performance should form part of performance standards and evaluation. | | 2 | | 2 | | | 1 | | |
| **Acting Posts** | | | | | | | | | |

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| The effect of Acting positions and the increase in workload should be carefully considered, and managers should not feel compelled and obliged to accept acting positions to the detriment of their own documented responsibilities. Senior management, such as the CFO, should also ideally not be an acting post and should rather be filled in-house than be outsourced. | | | 1 | 2 | | | | | |
| **Retention** | | | | | | | | | |
| A national health professional and scarce skills retention strategy should be developed by the NDOH. | | 1 | | 2 | | | 2 | | |
| The GDOH retention strategy should be analysed in terms of impact and cost to test possible success and affordability. | | | | 1 | | | 2 | | |
| **Rewards** | | | | | | | | | |
| A total reward strategy (monetary and non-monetary) review should be undertaken at national level to address issues of employee compensation overspend, skills scarcity and staff retention – including highlighting the importance of:<br>❒ A thorough costing of any change in the reward system which must be done in collaboration with the affected | | 1<br>1 | | 2<br>2 | 1<br>1 | 2<br>2 | 1<br>2 | | |

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| parties and include an assessment of affordability at various levels. | | | | | | | | | |
| ❒ Rewards should be linked to organisational, employee and team performance. | | 2 | | 2 | 2 | 2 | 1 | | |
| ❒ Lessons learned from the current OSD implementation review for nurses should be captured to inform future implementation of other improvement initiatives. | | 1 | | 2 | 1 | 2 | | | |
| **Learning and Development** | | | | | | | | | |
| Training needs should be properly and objectively determined. | | 2 | | 1 | | | | | |
| The costs and implications of training nurses in computer skills could be investigated further and incorporated into planning processes. | | 2 | | 1 | | | | | |
| Well considered and prioritised commitments to relevant training should be maintained even during times of cost containment. Training and development programmes should be clearly defined and aligned to the service delivery priorities of the province. | | 2 | | 1 | | | | | |
| **HR information systems** | | | | | | | | | |
| An assessment should be undertaken to establish reasons for under utilisation of systems and improved measures should | | 2 | | 1 | | | | | |

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| be implemented including the full use of PERSAL as a HR management tool; | | | | | | | | | |
| The NDOH should liaise with Provincial Departments on the HR tools that they are investigating. | | 2 | | 1 | | | | | |
| **Other general HR** | | | | | | | | | |
| Core hours required of clinicians working in both public and private sector should be adequately monitored in order to ensure that clinicians are working their core hours as indicated in Personnel Minute Circulars; | | | | 1 | | | | | |
| Financial management of budgets (and the resultant employing of staff where there is not budget) should be managed more rigorously; | | | | 1 | | | | | |
| Commuted overtime should be appropriately monitored (and submitted with supporting documentation) and approved by HR managers prior to being paid by the GSSC. “Top earners” and exceptions should be investigated. | | | | 1 | | | | 2 | |
| **INFORMATION MANAGEMENT RECOMMENDATIONS** | | | | | | | | | |
| **Overall M&E and Use of information for decision making** | | | | | | | | | |
| Integrate health programme and management information systems and ensure this system is institutionalised | | 1 | | 1 | 2 | 2 | 2 | | |

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| within all levels of the GDOH. M&E based on a number of key indicators needs to be built into every senior manager's job description and performance appraisal. | | | | | | | | | |
| In-service training around understanding of and the importance of key indicators for managers needs to take place where applicable and with a particular focus on district and facility level. | | 2 | | 1 | | | | | |
| There should be regular analysis, comparison, interpretation and feedback around indicators to lower levels of the system. | | 2 | | 1 | | | | | |
| **District Health Information System (DHIS)** | | | | | | | | | |
| The GDOH needs to ensure that their HIS interfaces with the DHIS. | | 2 | | 1 | | | | | |
| Training needs to be developed and conducted for district and facility level staff and facilitation of the use of information for action. | | 2 | | 1 | | | | | |
| The DHIS and associated NIDS, needs a thorough review by NDOH. The numbers of indicators need to be decreased and there should be unambiguous, easy to understand, standardized definitions. There also need to be clear written guidelines, norms and standards for each | | 1 | | 2 | 2 | 2 | 2 | | 2 |

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| component of DHIS, including data collection tools, relevant human resources, hardware, software, data flow policies and linkages between the DHIS and other data collection systems e.g. PERSAL, BAS, ETR-net. | | | | | | | | | |
| Training and development courses for information officers should be developed. The levels at which they are appointed should be reviewed and other ways to encourage retention of staff should be explored. | | 2 | | 1 | | | | 2 | |
| **Other M&E issues** | | | | | | | | | |
| A records retention and information backup policy should be developed and implemented at facility, district and central provincial levels | | 2 | | 1 | | | | | 2 |
| There needs to be one official repository of information for the GDOH. All reports and documents using information should be drawn form this warehouse to eliminate duplicate sources of information. All relevant role-players need to ensure that information in the repository is up to date and of good quality | | 2 | | 1 | | | | | 2 |
| Parallel and standalone data collection systems should be integrated or enabled to talk to each other to improve the | | 2 | | 1 | | | | | 2 |

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| reliability of collated data and minimise inaccuracies in report compilation. | | | | | | | | | |
| **MEDICAL PRODUCTS, LABORATORY RECOMMENDATIONS** | | | | | | | | | |
| A review of the processes to ensure that payments are only made for valid services provided should be performed and enhanced if necessary | | | | 1 | | 2 | | | 2 |
| Proper controls for monitoring and controlling pharmaceuticals should be implemented; | | | | 1 | | | | | |
| Investigate the possibility (and resultant cost implications) of increasing staffing levels to adequately manage the pharmaceutical budget | | | | 1 | | | | | |
| **TECHNOLOGY AND INFRASTRUCTURE RECOMMENDATIONS** | | | | | | | | | |
| Consideration should be given to the idea of a conditional grant aimed at strengthening and creating an integrated health information system. Systems could, however, differ from province to province, provided they can feed into a national framework and be able to interface with each other. | 2 | 2 | 2 | 1 | | | | | |
| Implement a provincial data warehouse. | | 2 | | 1 | | | | | 2 |
| A proper medical equipment maintenance plan should be developed and priced. The plan should be regularly monitored and | | 2 | | 1 | | | | | |

**Table 11 : Recommendations contained in the Gauteng 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 Depart-ment of Health | Gauteng Health MEC | Gauteng Depart-ment of Health | National Treasury | Gauteng Treasury | Department of Public Service and Adminis-tration | External stake-holders | Gauteng Shared Service Centre |
|---|---|---|---|---|---|---|---|---|---|
| evaluated. | | | | | | | | | |
| National Treasury (as custodian of the policy) should consider establishing a separate fund that supports BEE suppliers by funding the incremental costs where BEE suppliers are more expensive than others and provide technical training e.g. X-ray technicians. This initiative is in line with Government's policy on job creation and supports BBBEE. | | 2 | | 2 | 1 | 2 | | | |

# Appendixes

## 1. APPENDIX 1: TERMS OF REFERENCE

### 1.1. PROJECT TITLE

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

### 1.2. BACKGROUND

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

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

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

### 1.2.4. Purpose of the IST Review

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

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

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

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

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

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

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

### 1.2.5. Aim and Scope of Work

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

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

*1.2.5.2. Review Scope of Work for Finance Consultants*

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

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

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

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

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

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

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

### 1.2.6. Project Phases

The project will be conducted in three phases:

*1.2.6.1. Phase 1-National Team only*

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

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

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

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

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

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

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

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

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

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

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

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

*1.2.6.3. 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 DoH's and implications for future operational plans and service delivery
- ❒ The quality of services and cost-effectiveness of programmes delivered
- ❒ Recommendation on lessons learnt from the review, and how, if any, to address challenges in the management and implementation of the provincial operational plans to improve service delivery and reduce over-expenditure

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

## 1.6. COMPETENCY AND EXPERTISE REQUIREMENTS

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

1.6.1.1. Leadership experience and people and technical management skills

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

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

1.6.1.4. Computer literacy, good communication and writing skills

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

1.6.1.6. Operational and financial management of large projects and programmes

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

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

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

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

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

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

1.6.2.5. Operational and financial management of health projects and programmes

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

## 1.7. REPORTING REQUIREMENTS

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

## 1.8. TIMING AND SCHEDULING

1.8.1. The national review is commencing on the 26th January 2009, while the review of the pilot province is scheduled to commence on the 16th February 2009. Provincial and consolidated final reports are expected to be submitted by the 1st May 2009. The oral presentations will be completed by the 8th May 2009.

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

## 1.9. CONTRACTING AND INVOICES

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

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

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

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

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

## 1.10. GENERAL INFORMATION

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

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

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

1.10.1.3. Experience in writing review or evaluation reports

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. GENERAL

2.1.1. Provincial Strategic Plan (05/06, 06/07, 07/08)

2.1.2. MTEF (2008/09 – 2010/11)

2.1.3. Provincial Annual Reports (05/06, 06/07, 07/08)

2.1.4. Annual Performance Plans (06/07, 07/08, 09/10)

2.1.5. Strategic Transformation Plan (STP)

2.1.6. Turn-around Strategy

2.1.7. 5 Year Strategic Programme of Action 2004 - 2009

## 2.2. FINANCE

2.2.1. Budgets and Actuals 2006/07 (Annual report); 2007/08 (Annual report); 2008/09 YTD (IYM – February 2009)

2.2.2. Forecast, 2009/10; 2010/11; 2011/12

2.2.3. Annual Financial Statements

2.2.4. IYM report (February 2009)

2.2.5. Auditor-General audit reports

2.2.6. Treasury statistics

**2.3. HR**

2.3.1. Gauteng Department of Health Annual Report 2007/08, 2006/07, 2005/06 (including Addendum B – Human Resources Oversight Report);

2.3.2. Vulindlela download – 18 March 2009

2.3.3. HR delegations (unsigned) – 2006

2.3.4. Turn-around Strategy

2.3.5. Sections of the Gauteng Service Transformation Plan (STP) – December 2006

2.3.6. Departmental Personnel Circular Minutes of :

2.3.6.1. Guidelines to manage overtime;

2.3.6.2. Medical Aid subsidy;

2.3.6.3. Acting allowance;

2.3.6.4. Determination of working hours;

2.3.6.5. Commuted overtime;

2.3.6.6. Uniform allowance;

2.3.6.7. Guidelines to manage leave;

2.3.6.8. Early retirement;

2.3.6.9. Exit interview questionnaires;

2.3.6.10. Recruitment and selection policy;

2.3.7. GSSC mandate forms;

2.3.8. PERSAL procedure manual (Excel);

**2.4. OTHER**

2.4.1. Due Diligence Report on PHC and EMS Services Provided by Local Government, September 2006. Gauteng Department of Health

2.4.2. District Health Plan 2008- 2009. Johannesburg Health District

2.4.3. Service Level Agreement between Gauteng Department of Health and Municipality

2.4.4. Departmental Progress Report to City of Johannesburg Health Portfolio Committee. July – September 2008

2.4.5. Summary Report on Routine Data July 2008 – February 2009-04-29 ?

2.4.6. Health in Gauteng Status Report 2006/2007. Gauteng Health Department

2.4.7. TB Business Plans 08/09 and 09/10

2.4.8. HIV&AIDS Business Plans 08/09 and 09/10

2.4.9. Presentation – Provincialisation of PHC and EMS

# 3. APPENDIX 3: SCHEDULE OF INTERVIEWS

### Interviews

| Department/Area | Person(s) Interviewed | Position | Date of Interview |
|---|---|---|---|
| Health Information Systems (HIS) | Ms Jeanette Hunter | Director | 2nd April 2009 |
| Finance | Mr Fanuel Meso | Acting CFO | 3rd April 2009 |
| Human Resources | Ms Mary-Grace Msimango | Chief Director : HR | 7th April 2009 |
| Hospital Services | Dr Sandile Mfenyana | Chief Director | 3rd April 2009 |
| MCH | Mr Sikhonjiwe Masilela | Director : MCH | 8th April 2009 |
| Multisectoral Aids Unit | Dr Liz Floyd | Director : Multisectoral Aids Unit | 8th April 2009 |
| Chief Pharmacy | Dr Claude Mondzanga (and team) | Chief Pharmacist | 7th April 2009 |
| IT and Communications | Ms Mmakgosi Mosupi | Chief Director : IT and Communications | 6th April 2009 |
| Jhb Metro : Provincial Healthcare and District Development | Ms Jabulile Shabalala | Director : Provincial Healthcare and District Development | 6th April 2009 |
| Chris Hani Baragwanath hospital | Mrs Johanna More and management team | CEO : Chris Hani Baragwanath hospital | 9th April 2009 |
| Wits Medical School | Professor Helen Laburn | Dean : Wits Medical School | 8th April 2009 |
| District Health Services | Mr Levy Mosenogi | Chief Director : District Health Services | 8th April 2009 |
| Management accounting | Gert Kromhoud | Director : Management Accounting | 9th April 2009 |
| Metsweding District Office | Susan Kgobe and team | District Director : Metsweding District | 14th April 2009 |
| Core Health Services | Dr Patrick Maduna | DDG : Core Health Services | 14th April 2009 |
| Head of Department | Ms Sybil Ncobo | HOD | 14th April 2009 |
| Human Resources | Ms Pinkie Baloyi | DDG : Human Resources | 15th April 2009 |
| Human Resource Development | Ms Dawn Joseph and team | Chief Director : HRD | 16th April 2009 |
| ESPM (Executive Support Program Management) | Mr Hans Ramogole | Security Support services | 16th April 2009 |
| Health Programmes | Ms Thandi Chaane | Chief Director : Health Services | 17th April 2009 |

# 4. APPENDIX 4: FINANCIAL TABLES REFERENCES

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

| | R m Provincial Budget | Year on year increase% | R m Health Budget | Year on year increase % | % Allocation to Health | R m Adjustment Provincial Budget | R m Adjustment Health Budget | % Allocation to Health |
|---|---|---|---|---|---|---|---|---|
| 2005/06 | 26 604 [11] | N/A | 9 258 [12] | N/A | 34.80% | 27 579[13] | 9 841[14] | 35.68% |
| 2006/07 | 34 460[15] | 29.53% | 10 404[16] | 12.38% | 30.19% | 35 278[17] | 10 654[18] | 30.20% |
| 2007/08 | 40 312 [19] | 16.98% | 12 052[20] | 15.84% | 29.90% | 41 194[21] | 12 446[22] | 30.21% |
| 2008/09 | 46 672 [23] | 15.78% | 13 889[24] | 15.24% | 29.76% | 48 605[25] | 14 908[26] | 30.67% |
| 2009/10 | 55 259 [27] | 18.40% | 16 590[28] | 19.45% | 30.02% | N/A | N/A | N/A |
| 2010/11 | 55 915 [29] | 1.19% | 18 351 [30] | 10.61% | 32.82% | N/A | N/A | N/A |

[11] Gauteng Provincial Budget Statement, 2006/07, page 21
[12] Gauteng Provincial Budget Statement, 2006/07, page 21
[13] Gauteng Provincial Budget Statement, 2006/07, page 21
[14] Gauteng Provincial Budget Statement, 2006/07, page 21
[15] Gauteng Provincial Budget Statement, 2007/08, page 23
[16] Gauteng Provincial Budget Statement, 2007/08, page 23
[17] Gauteng Provincial Budget Statement, 2007/08, page 23
[18] Gauteng Provincial Budget Statement, 2007/08, page 23
[19] Gauteng Provincial Budget Statement, 2008/09, page 17/18
[20] Gauteng Provincial Budget Statement, 2008/09, page 17/18
[21] Gauteng Provincial Budget Statement, 2008/09, page 17/18
[22] Gauteng Provincial Budget Statement, 2008/09, page 17/18
[23] Gauteng Provincial Budget Statement, 2009/10, page 19
[24] Gauteng Provincial Budget Statement, 2009/10, page 19
[25] Gauteng Provincial Budget Statement, 2009/10, page 19
[26] Gauteng Provincial Budget Statement, 2009/10, page 19
[27] Gauteng Provincial Budget Statement, 2009/10, page 19
[28] Gauteng Provincial Budget Statement, 2009/10, page 19

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 Adjustment Health Grants | % Year on year increase in Health Grants | R m Adjustment Health Budget (excl. Grants) | % Allocation to Health |
|---|---|---|---|---|---|---|---|---|
| 2005/06 | 27 579 | 4 537[31] | 23 043 | 9 841 | 2 709[32] | N/A | 7 131 | 30.95% |
| 2006/07 | 35 278 | 8 855[33] | 26 423 | 10 654 | 3 269[34] | 20.67% | 7 385 | 27.95% |
| 2007/08 | 41 194 | 9 699[35] | 31 494 | 12 446 | 3 682[36] | 12.63% | 8 764 | 27.83% |
| 2008/09 | 48 605 | 11 484[37] | 37 122 | 14 908 | 4 353[38] | 18.22% | 10 555 | 28.43% |
| 2009/10 (Main Budget) | 55 259 | 13 351[39] | 41 908 | 16 590 | 4 638[40] | 6.55% | 11 952 | 28.52% |
| 2010/11 (Main Budget) | 55 915 | 10 801[41] | 45 114 | 18 351 | 5 081[42] | 9.55% | 13 270 | 29.41% |

[29] Gauteng Provincial Budget Statement, 2009/10, page 19
[30] Gauteng Provincial Budget Statement, 2009/10, page 19
[31] Gauteng Provincial Budget Statement, 2006/07, page 133
[32] Gauteng Provincial Budget Statement, 2006/07, page 133
[33] Gauteng Provincial Budget Statement, 2007/08, page 19/20
[34] Gauteng Provincial Budget Statement, 2007/08, page 19/20
[35] Gauteng Provincial Budget Statement, 2008/09, page 14
[36] Gauteng Provincial Budget Statement, 2008/09, page 14
[37] Gauteng Provincial Budget Statement, 2009/10, page 14/15
[38] Gauteng Provincial Budget Statement, 2009/10, page 14/15
[39] Gauteng Provincial Budget Statement, 2009/10, page 14/15
[40] Gauteng Provincial Budget Statement, 2009/10, page 14/15
[41] Gauteng Provincial Budget Statement, 2009/10, page 14/15
[42] Gauteng Provincial Budget Statement, 2009/10, page 14/15

Table 3: National Conditional Grants to Provinces

| | | R 000 Total Conditional Grant to Provinces | R 000 Gauteng Provincial Allocation | % Allocation of National Grant |
|---|---|---|---|---|
| Comprehensive HIV & AIDS Grant | 2005/06 | 1 150 108[43] | 185 048[44] | 16.09% |
| | 2006/07 | 1 616 214[45] | 270 195[46] | 16.72% |
| | 2007/08 | 2 006 223[47] | 399 604[48] | 19.92% |
| | 2008/09 | 2 885 400[49] | 649 631 [50] | 22.51% |
| | 2009/10 | 3 476 200[51] | 760 879[52] | 21.89% |
| | 2010/11 | 4 311 800[53] | 866 452[54] | 20.09% |
| | | | | |
| National Tertiary Services Grant | 2005/06 | 4 709 386[55] | 1 760 465[56] | 37.38% |
| | 2006/07 | 4 981 149[57] | 1 866 094[58] | 37.46% |

[43] Estimates of National Expenditure 2008, page 279
[44] Gauteng Provincial Budget Statement, 2006/07, page 133
[45] Estimates of National Expenditure 2008, page 279
[46] Gauteng Provincial Budget Statement, 2007/08, page 19/20
[47] Estimates of National Expenditure 2008, page 279
[48] Gauteng Provincial Budget Statement, 2008/09, page 14
[49] Estimates of National Expenditure 2009, page 298
[50] Gauteng Provincial Budget Statement, 2009/10, page 14/15
[51] Estimates of National Expenditure 2009, page 298
[52] Gauteng Provincial Budget Statement, 2009/10, page 14/15
[53] Estimates of National Expenditure 2009, page 298
[54] Gauteng Provincial Budget Statement, 2009/10, page 14/15
[55] Estimates of National Expenditure 2008, page 279
[56] Gauteng Provincial Budget Statement, 2006/07, page 133

Table 3: National Conditional Grants to Provinces

| | | R 000 Total Conditional Grant to Provinces | R 000 Gauteng Provincial Allocation | % Allocation of National Grant |
|---|---|---|---|---|
| | 2007/08 | 5 321 206[59] | 1 959 399[60] | 36.82% |
| | 2008/09 | 6 134 100[61] | 2 207 424[62] | 35.99% |
| | 2009/10 | 6 614 400[63] | 2 328 301[64] | 35.20% |
| | 2010/11 | 7 398 000[65] | 2 561 154[66] | 34.62% |
| | | | | |
| Total Conditional Grants to Provinces | 2005/06 | 8 907 346[67] | 2 635 294[68] | 29.59% |
| | 2006/07 | 10 206 542[69] | 3 187 549[70] | 31.23% |
| | 2007/08 | 11 736 678[71] | 3 600 224[72] | 30.67% |

[57] Estimates of National Expenditure 2008, page 279
[58] Gauteng Provincial Budget Statement, 2007/08, page 19/20
[59] Estimates of National Expenditure 2008, page 279
[60] Gauteng Provincial Budget Statement, 2007/08, page 19/20
[61] Estimates of National Expenditure 2009, page 298
[62] Gauteng Provincial Budget Statement, 2009/10, page 19
[63] Estimates of National Expenditure 2009, page 298
[64] Gauteng Provincial Budget Statement, 2009/10, page 19
[65] Estimates of National Expenditure 2009, page 298
[66] Gauteng Provincial Budget Statement, 2009/10, page 19
[67] Estimates of National Expenditure 2008, page 279
[68] Gauteng Provincial Budget Statement, 2006/07, page 133
[69] Estimates of National Expenditure 2008, page 279
[70] Gauteng Provincial Budget Statement, 2007/08, page 19/20
[71] Estimates of National Expenditure 2008, page 279
[72] Gauteng Provincial Budget Statement, 2008/09, page 14

Table 3: National Conditional Grants to Provinces

| | | R 000<br>Total Conditional Grant to Provinces | R 000<br>Gauteng Provincial Allocation | % Allocation of National Grant |
|---|---|---|---|---|
| | 2008/09 | 14 362 800[73] | 4 266 167[74] | 29.70% |
| | 2009/10 | 15 578 400[75] | 4 540 766[76] | 29.15% |
| | 2010/11 | 18 012 800[77] | 4 970 337[78] | 27.59% |

[73] Estimates of National Expenditure 2009, page 298

[74] Gauteng Provincial Budget Statement, 2009/10, page 14/15

[75] Estimates of National Expenditure 2009, page 298

[76] Gauteng Provincial Budget Statement, 2009/10, page 14/15

[77] Estimates of National Expenditure 2009, page 298

[78] Gauteng Provincial Budget Statement, 2009/10, page 14/15