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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 Western Cape Department of Health.

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### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AFS</td>
<td>Annual Financial Statements</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>APH</td>
<td>Associated Psychiatric Hospitals</td>
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<td>APP</td>
<td>Annual Performance Plan</td>
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<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
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<td>ARV</td>
<td>Anti-retroviral</td>
</tr>
<tr>
<td>ASSA</td>
<td>Actuarial Society of South Africa</td>
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<tr>
<td>BAS</td>
<td>Basic Accounting System</td>
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<tr>
<td>BUR</td>
<td>Bed Utilisation Rate</td>
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<tr>
<td>CBS</td>
<td>Community Based Services</td>
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<tr>
<td>CD</td>
<td>Chief Director</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CFO</td>
<td>Chief Financial Officer</td>
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<td>CHC</td>
<td>Community Health Centre</td>
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<td>CSP</td>
<td>Comprehensive Service Plan</td>
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<tr>
<td>DDG</td>
<td>Deputy Director-General</td>
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<tr>
<td>DEXCO</td>
<td>District Executive Committee</td>
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<tr>
<td>DFID</td>
<td>UK Government’s Department for International Development</td>
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<tr>
<td>DHIS</td>
<td>District Health Information System</td>
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<td>DHS</td>
<td>District Health System</td>
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<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DORA</td>
<td>Division of Revenue Act</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Shortcourse</td>
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<tr>
<td>DPSA</td>
<td>Department of Public Service and Administration</td>
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<tr>
<td>DR TB</td>
<td>Drug Resistant Tuberculosis</td>
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<tr>
<td>EDL</td>
<td>Essential Drug List</td>
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<td>EMS</td>
<td>Emergency Medical Services</td>
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<tr>
<td>FBU</td>
<td>Financial Business Unit</td>
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<tr>
<td>FMC</td>
<td>Financial Monitoring Committee</td>
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<td>GMT</td>
<td>Government Motor Tariffs</td>
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</table>
GSH  Groote Schuur Hospital
HIV  Human Immunodeficiency Virus
HOD  Head of Department
HPC  Health Platform Committee
HPTD(G)  Health professionals Training and Development Grant
HR  Human Resources
HRP  Hospital Revitalisation Programme
HRP  Human Resource Plan
HSS  Health Systems Strengthening
IMCI  Integrated Management of Childhood Illnesses
IST  Integrated Support Teams
IYM  In Year Monitoring
JSAC  Joint Standing Committee
KZN  KwaZulu-Natal
M&E  Monitoring and Evaluation
M&OD  Management & Organisational Development
MACH  Ministerial Advisory Committee on Health
MCH  Maternal and Child Health
MCWH  Maternal, Child and Women’s Health
MDGs  Millennium Development Goals
MDHS  Metro District Health Services
MDR TB  Multiple Drug Resistant Tuberculosis
MEC  Member of the Executive Council
M&EC  Monitoring and Evaluation Committee
MHS  Metro Health Service
MMM  Minister’s Management Meeting
MTEF  Medium Term Expenditure Framework
N/A  Not available/ not applicable
NDOH  National Department of Health
NGO  Non-Governmental Organisation
NHLS  National Health Laboratory Services
NIDS  National Indicator Data Set
NPO  Non-Profit Organisation
NSP  National Strategic Plan
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>NTSG</td>
<td>National Tertiary Services Grant</td>
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<tr>
<td>OMT</td>
<td>Operational Management Team</td>
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<tr>
<td>OPD</td>
<td>Outpatients Department</td>
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<tr>
<td>OSD</td>
<td>Occupational Specific Dispensation</td>
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<tr>
<td>PAC</td>
<td>Provincial Aid Council</td>
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<tr>
<td>PDE</td>
<td>Patient Day Equivalent</td>
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<tr>
<td>PERSAL</td>
<td>Personnel and Salary Administration System</td>
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<td>PFMA</td>
<td>Public Finance Management Act</td>
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<tr>
<td>PGDP</td>
<td>Provincial Growth and Development Plan</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PHCIS</td>
<td>Primary Health Care Information System</td>
</tr>
<tr>
<td>PIDAC</td>
<td>Provincial Inter-Departmental AIDS Council</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-To-Child-Transmission</td>
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<tr>
<td>SANBS</td>
<td>South African National Blood Service</td>
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<tr>
<td>SITA</td>
<td>State Information Technology Agency</td>
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<td>SLA</td>
<td>Service Level Agreement</td>
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<td>SMT</td>
<td>Senior Management Team</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>STP</td>
<td>Service Transformation Plan</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TMM</td>
<td>Top Management Meeting</td>
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<tr>
<td>TR</td>
<td>Team Representative</td>
</tr>
<tr>
<td>UCT</td>
<td>University of Cape Town</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<tr>
<td>WC</td>
<td>Western Cape Province</td>
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<tr>
<td>WCDOH</td>
<td>Western Cape Department of Health</td>
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<tr>
<td>WCHIS</td>
<td>Western Cape Health Information System</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>XDR TB</td>
<td>Extreme Drug Resistant Tuberculosis</td>
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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, former Minister of Health, honourable 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 review was a broad-based, rapid appraisal that focused on the health system as a whole. The review was conducted by a team of financial, public health, and management and organisational development specialists. 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 health system are: Service Delivery, Leadership and Governance; Human Resources (Health workforce); Finances; Information management; Medical products; and Technology and Infrastructure.

The IST team found a number of features that suggest that in general, the Western Cape Department of Health (WCDOH) is a well-functioning provincial health department.

- Firstly there is good capacity evident in the planning tools used and the management structures, processes and systems established.

- Secondly, underlying this capacity has been the retention of competent managers with the ability to manage change and draw from external expertise when necessary.

- Thirdly, there are a number of good practices that have contributed towards better management of the limited funding available in the WCDOH. These include:
• the implementation of fiscal discipline to limit over-expenditure across service platforms;
• the use of robust methods to plan and manage health service delivery based on a well-developed and well-communicated strategic vision and direction;
• promoting accountability of managers through implementing performance agreements and; developing innovative programmes that increase efficiency and quality of care;
• focusing on a number of priority areas for monitoring and evaluation of the system.

Priority findings of the review

1. **Finance:** The WCDOH has had unqualified audit reports for the period under review. Except for 2007/08, spending by the WCDOH has been within budget. The WCDOH has monitoring structures in place to flag potential over expenditure and to prevent budget overruns. All plans have associated costs and the expenditure is reviewed monthly and quarterly.

2. **Leadership:** The WCDOH has a strong, competent and motivated corps of senior and middle managers in the provincial head office, in the central hospitals and in the five districts; there are delegations of authority and responsibility to these managers, accompanied by performance management measures.

3. **Alignment of Plans:** Respondents indicated that there is a dearth of national guidelines, norms, standards and targets and lack of national stewardship affecting the health system’s planning and performance. This is exacerbated by insufficient resources to implement a range of national policies such as the OSD, ARV rollout and implementation of new vaccines. The WCDOH has a well-formulated vision and direction, outlined in the Healthcare 2010 statement and the CSP that guide the thinking, both strategic and operational, and the activities of all the senior and middle managers interviewed. The plans have not be fully funded and thus preventing the plan being fully implanted. The WCDOH has developed a dashboard system to track 15 key indicators that measure core service delivery targets.

4. **Governance:** Some of the governance structures envisaged in the National Health Act have been formally put in place e.g. Provincial Health Councils. However, at
district level some of the relevant legislation has not yet been passed. There are parallel systems of PHC provision by both local and provincial government in the City of Cape Town/Metro District, while the rural health system has been provincialised. The functions, roles, value and management of central hospitals and universities needs clarification.

5. **Service Delivery:** The lack of adequate funding has resulted in rationing of many health services and the WCDOH has been accused by some of "putting cash before care". Notwithstanding this perception, the WCDOH has developed an enhanced TB Response and accelerated HIV prevention strategies with the overall aim of addressing the high burden of TB and HIV and AIDS and improving the TB and HIV programme performance and treatment outcomes. The TB treatment success rate in the province has increased to 81.9% and the defaulter rate decreased from 11.1% to 9.1% but the WCDOH has limited resources to implement improved TB drug protocols, conduct intensive TB case findings, follow up defaulters and provide counselling services. The WCDOH has achieved reduction of mother to child HIV transmission to 4%, responding to the recommendations of the Saving Mothers Report III.

6. **Human Resource Management:** Compensation of employees accounts for the largest expenditure within the WCDOH and is a major cost driver. The WCDOH has put in place controls around recruitment of staff, which has enabled them to limit staff costs to stay within budget. The HR Plan will enable the WCDOH to align staff qualifications, skills and experience with the required level of patient care at an institutional level as defined in the Comprehensive Service Plan (CSP). However, there is a significant funding gap between what is available and what is needed to fund the HR Plan.

7. **Monitoring and evaluation (M&E):** The WCDOH has made significant progress in utilising data for decision-making purposes and in strengthening the provincial leadership's use of health information. As part of the HR plan, the WCDOH will be conducting a skills competency assessment of all staff and M&E competencies will be integrated into managerial performance agreements and assessments. It was reported that the NDOH has not provided direction towards a simplified health
information system. Consequently, this has increased expenditure on M&E as the 
WCDOH has had to establish its own system.

8. **Laboratory and medical products**: Laboratory services, blood products and drugs are 
key cost drivers in WCDOH and TB drugs are second to ARVs as one of the cost 
drivers in strategic programmes. Fiscal discipline is promoted to limit over-
expenditure and control wastage. There was a streptomycin drug stock-out in the 
province and the supply problem was exacerbated by the centralised drug clearing 
house. The overall gate keeping and monitoring of the laboratory service requests 
and drugs expenditure per facility and the chronic dispensing unit are best practices, 
which could be replicated in other provinces.

9. **Technology and Infrastructure**: There is an infrastructure plan for the period 2008/09 
to 2010/11. This plan provides buildings, equipment and maintenance aligned to 
service requirements. The plan is funded by the provincial infrastructure grant and the 
hospital revitalisation programme (HRP). The HRP budget allocation fluctuates, 
making it hard to plan and budget for capital projects requiring funding beyond a one 
year cycle. There are also concerns that WCDOH is accountable for the money spent 
on infrastructure and yet it has little control on the infrastructure funding process (e.g. 
Department of Public Works). The cost on construction is reportedly 25% higher per 
square meter than the cost of construction per square metre in the private sector.

**Key recommendations** are shown below. The complete recommendations are found in the 
body of the report.

**FINANCE**

1. Addressing equity between districts in the province is a key priority as there are 
   significant inequities at present.

2. Given the tension between limited resources and unlimited need, the NDOH should 
   prescribe realistic policies and fund them adequately. Policies that cannot be 
   implemented due to resource constraints should be revised.
LEADERSHIP & GOVERNANCE

1. Strong advocacy, communication and lobbying for an increased health budget to the National Treasury by the Minister of Health and the national Director-General is needed for the implementation of the District Health System (DHS) and for the realisation of the Millennium Development Goals (MDGs).

2. The NDOH needs to review the structure of the national health system, cost and amend national policies to fit the realities in provinces. They should develop clear national guidelines, norms and standards that are affordable within the available resource envelope.

3. A review of the functions, roles, values and management of central hospitals, NHLS, and the South African National Blood Service (SANBS) is necessary.

4. The impact of rationing of support services (e.g. maintenance) as a result of budgetary constraints requires regular monitoring to avoid long term consequences.

SERVICE DELIVERY FOCUS

1. The WCDOH needs to strengthen the integration of strategic programmes (e.g. HIV and TB) within the DHS to ensure their sustainability. The NDOH needs to review, cost and amend national policies to fit the realities in provinces.

2. The impact of various initiatives that are currently piloted needs to be documented and shared.

HUMAN RESOURCES

1. The HR Plan needs to be aligned to the budget constraints and a phased staff training and recruitment strategy developed by the WCDOH.

2. The issue of joint staff (university and WCDOH) needs to be addressed at a national level to find a resolution to the current impasse.
3. A suitable plan to address the shortage of nurses needs to be agreed and funded by the WCDOH.

4. Absenteeism and leave management is a major problem in the WCDOH and needs to be addressed.

**M&E**

1. The NDOH must focus on developing a unified M&E framework that interfaces with all M&E systems (DHIS, BAS, supply chain management) which are easy to monitor to ensure accountability.

2. Improving IT infrastructure, provided by SITA, is not part of the WCDOH budget and is therefore perceived to be an unfunded mandate. The NDOH must permit provinces to develop service level agreements (SLAs) directly with SITA to promote accountability and efficiency.

**LABORATORY AND MEDICAL PRODUCTS:**

1. There should be a review of the legislation and regulation of the NHLS and SANBS.

2. The laboratory gate-keeping system and chronic dispensing unit are best practices, which should be documented, shared and replicated in other provinces, with the assistance of the NDOH.

**INFRASTRUCTURE**

1. The Hospital Revitalisation Programme (HRP) should commit to funding the full lifecycle of the projects.
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, thus 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 for improved health outcomes. In response to this threat to the overall functioning of the health system, the former Minister of Health, honourable 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 was 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 WERE 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 nine 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 health system are: Service Delivery, Leadership and Governance; Human Resources (Health workforce); Finances; Information
management; Medical products; and Technology and Infrastructure.\(^1\) Due to time constraints, the HIV & AIDS, tuberculosis (TB) and maternal and child health (MCH) programmes were used as tracer programmes, both to add depth and to complement the health system building block reviews. The rationale for selecting these programmes include: contribution to the disease burden; ministerial priorities; important Millennium Development Goals (MDGs) indicators; facilitates analysis of conditional grant and the equitable share expenditure; and because of their relative contribution to component expenditure (e.g. pharmaceuticals).

4.2. This rapid review consisted of two main parts: a desktop review and in-depth interviews with key informants at provincial and district levels. The desktop review comprised an analysis of available public documents plus selected documents obtained from the Western Cape Province and other sources. A list of these documents is shown in Appendix 2.

4.3. In-depth interviews were conducted with the majority of senior managers at the provincial level and at one purposefully selected sub-district structure, the Eastern and Khayelitsha Sub-District. The interviews were conducted by a team of three experts who visited the Western Cape Province between the 27\(^{th}\) of March and 9\(^{th}\) of April 2009. The list of people interviewed is shown in Appendix 3. The interviews were complemented by a further analysis of the documentation provided.

4.4. The report is based on interviews and information obtained from the WCDOH visit and does not include the viewpoints of NDOH and national and provincial Treasuries.

5. OUTLINE OF THE REPORT

5.1. This document reports on the IST review done in the Western Cape Department of Health (WCDOH). Financial Review focuses firstly on the key findings and recommendations of the financial assessment, because the over-spending was the catalyst for the IST review. As overspending is an indicator of broader systemic challenges, the remainder of the sections focuses on the assessment of other key

building blocks of the health system. Leadership, Governance and Service Delivery focuses on an assessment of leadership, governance and service delivery. Human Resources sets out the results of the human resource assessment, while Information Management focuses on information management. Medical Products, Laboratory and Technology and Infrastructure contain the assessment on medical products and laboratory, and infrastructure and technology, respectively. Taking forward the Recommendations gives an overview of the recommendations and suggests the assignment of responsibility for the implementation of these.
Financial Review

1. INTRODUCTION

1.1. The financial review derives from an assessment of the WCDOH budget and expenditure reports, National Treasury reports and interviews with WCDOH management. The key findings from the review are summarised below.

Box 1: Key findings from the financial review

1. Just over one third of the total Western Cape provincial revenue is allocated to health and this has been constant over the past four years.
2. Per capita health spending in the Western Cape has been above the national average.
3. WCDOH has had unqualified audit reports for the period under review.
4. Except for 2007/08, the WCDOH has been within budget (on the cash accounting basis), but has overspent in the 2005/06 and 2007/08 financial years when the cash basis is adjusted for movements in accruals. The WCDOH would have overspent the 2008/09 budget with R152 million when adjusted for movements in accruals and the underspending on capital projects.
5. With the exception of the unfunded mandates (see Financial Review, paragraph 7), services are planned based on available funding.
6. The full budgetary impact of the cost of treatment required by patients on ARTs needs to be better quantified and sufficient funding allocated to the WCDOH. The HIV & AIDS conditional grant will be overspent by over R30 million.
7. The WCDOH is of the view that they are under resourced as some hospitals run at 105% occupancy and because of inter-provincial movement of patients, notably from the Eastern Cape.
8. Agency staffing costs make up to 20% of staff costs in some cases and this is among the main cost drivers and needs to be closely monitored.
9. The WCDOH has monitoring structures in place to flag potential over expenditure and to prevent budget overruns. Budgeting and financial management processes are at acceptable levels. All plans have associated costs and the expenditure is reviewed monthly and quarterly and there is a good
Box 1: Key findings from the financial review

understanding of the relationship between planning and budgeting.
10. Addressing equity between districts in the province is a key priority as there are significant inequities at present (see table 8).

2. UNDERFUNDING OF THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA

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

2.2. A separate component of the IST review is focusing on the adequacy of public health funding and the findings of the rapid investigation will be included in the consolidated IST report.

3. PROVINCIAL BUDGET ALLOCATION

3.1. The allocation of the Western Cape Province’s budget to the WCDOH is shown in Table 1. The allocation includes the equitable share, conditional grants and provincial revenue. Just over one third (34%) of the Provincial budget between 2005/06 and 2008/09 was allocated to Health and this allocation will increase slightly to just over 35% over the MTEF period. Thus, in relation to the other provinces, the WCDOH is relatively well resourced.

3.2. The 2008/09 health budget experienced a sharp increase of 21.8% compared to 2006/07 and 2007/08 which had budget increases of 10.1% and 12.2%, respectively. This was as a result of the OSD being funded in 2008/09.
Table 1: Allocation of Provincial budget to Health (including conditional grants)

<table>
<thead>
<tr>
<th></th>
<th>R m Provincial Budget</th>
<th>Year on year increase</th>
<th>R m Health Budget</th>
<th>Year on year increase</th>
<th>% Allocation to Health</th>
<th>R m Adjustment Provincial Budget</th>
<th>R m Adjustment Health Budget</th>
<th>% Allocation to Health</th>
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<tr>
<td>2005/06</td>
<td>16 374</td>
<td>N/A</td>
<td>5 743</td>
<td>N/A</td>
<td>35.07%</td>
<td>16 957</td>
<td>5 777</td>
<td>34.07%</td>
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<td>2006/07</td>
<td>18 360</td>
<td>12.13%</td>
<td>6 323</td>
<td>10.10%</td>
<td>34.44%</td>
<td>19 443</td>
<td>6 476</td>
<td>33.31%</td>
</tr>
<tr>
<td>2007/08</td>
<td>20 702</td>
<td>12.76%</td>
<td>7 095</td>
<td>12.21%</td>
<td>34.27%</td>
<td>21 667</td>
<td>7 427</td>
<td>34.28%</td>
</tr>
<tr>
<td>2008/09</td>
<td>24 889</td>
<td>20.23%</td>
<td>8 642</td>
<td>21.80%</td>
<td>34.72%</td>
<td>26 202</td>
<td>8 871</td>
<td>33.86%</td>
</tr>
<tr>
<td>2009/10</td>
<td>29 009</td>
<td>16.55%</td>
<td>9 893</td>
<td>14.48%</td>
<td>34.10%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2010/11</td>
<td>30 999</td>
<td>6.86%</td>
<td>10 925</td>
<td>10.43%</td>
<td>35.24%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2011/12</td>
<td>33 453</td>
<td>7.92%</td>
<td>11 764</td>
<td>7.68%</td>
<td>35.17%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

3.3. When conditional grants are excluded, the provincial equitable share allocation to health remains around 30% and will slightly increase to around 31% over the MTEF (Table 2).

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

<table>
<thead>
<tr>
<th>Financial year</th>
<th>R m Adjustment Provincial Budget (incl. Grants)</th>
<th>R m Adjustment Conditional Grants</th>
<th>R m Adjustment Provincial Budget (excl. Grants)</th>
<th>R m Adjustment Health Budget (incl. Grants)</th>
<th>R m Health Grants</th>
<th>% Year on year increase in Health Grants</th>
<th>R m Adjustment Health Budget (excl. Grants)</th>
<th>% Allocation to Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>16 957</td>
<td>2 819</td>
<td>14 138</td>
<td>5 777</td>
<td>1 861</td>
<td>N/A</td>
<td>3 916</td>
<td>27.70%</td>
</tr>
<tr>
<td>2006/07</td>
<td>19 443</td>
<td>3 630</td>
<td>15 813</td>
<td>6 476</td>
<td>2 055</td>
<td>10.42%</td>
<td>4 421</td>
<td>27.96%</td>
</tr>
<tr>
<td>2007/08</td>
<td>21 667</td>
<td>4 075</td>
<td>17 592</td>
<td>7 427</td>
<td>2 263</td>
<td>10.12%</td>
<td>5 165</td>
<td>29.35%</td>
</tr>
<tr>
<td>2008/09</td>
<td>26 202</td>
<td>5 289</td>
<td>20 913</td>
<td>8 871</td>
<td>2 683</td>
<td>18.56%</td>
<td>6 188</td>
<td>29.59%</td>
</tr>
<tr>
<td>2009/10 (Main budget)</td>
<td>29 009</td>
<td>5 978</td>
<td>23 031</td>
<td>9 893</td>
<td>2 819</td>
<td>5.07%</td>
<td>7 074</td>
<td>30.72%</td>
</tr>
<tr>
<td>2010/11 (Main budget)</td>
<td>30 999</td>
<td>6 312</td>
<td>24 687</td>
<td>10 925</td>
<td>3 232</td>
<td>14.65%</td>
<td>7 693</td>
<td>31.16%</td>
</tr>
</tbody>
</table>
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 WCDOH (Table 3).

4.2. The relative proportion of the national conditional grant for HIV/AIDS (Table 3) allocated to the WCDOH has been around 8% over the past four years and will increase to 10% over the MTEF period. The National Tertiary Services Grant has been around 25% but is expected to decrease to around 24% over the MTEF. There is a forecasted decline in the total conditional grant from nearly 21% in 2005/06 to 17% in the WCDOH at the end of the MTEF period.

Table 3: National Conditional Grants to Provinces Adjustment Budgets

<table>
<thead>
<tr>
<th></th>
<th>R 000 Total Conditional Grant to Provinces</th>
<th>R 000 Western Cape Provincial Allocation</th>
<th>% Allocation of National Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive HIV &amp; AIDS Grant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005/06</td>
<td>1 150 108</td>
<td>82 451</td>
<td>7.17%</td>
</tr>
<tr>
<td>2006/07</td>
<td>1 616 214</td>
<td>133 170</td>
<td>8.24%</td>
</tr>
<tr>
<td>2007/08</td>
<td>2 006 223</td>
<td>200 559</td>
<td>10.00%</td>
</tr>
<tr>
<td>2008/09</td>
<td>2 885 400</td>
<td>241 467</td>
<td>8.37%</td>
</tr>
<tr>
<td>2009/10</td>
<td>3 476 200</td>
<td>309 913</td>
<td>8.92%</td>
</tr>
<tr>
<td>2010/11</td>
<td>4 311 800</td>
<td>448 834</td>
<td>10.41%</td>
</tr>
<tr>
<td>2011/12</td>
<td>4 633 000</td>
<td>480 994</td>
<td>10.38%</td>
</tr>
<tr>
<td>National Tertiary Services Grant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005/06</td>
<td>4 709 386</td>
<td>1 214 684</td>
<td>25.79%</td>
</tr>
<tr>
<td>2006/07</td>
<td>4 981 149</td>
<td>1 272 640</td>
<td>25.55%</td>
</tr>
<tr>
<td>2007/08</td>
<td>5 321 206</td>
<td>1 335 544</td>
<td>25.10%</td>
</tr>
<tr>
<td>2008/09</td>
<td>6 134 100</td>
<td>1 503 749</td>
<td>24.51%</td>
</tr>
<tr>
<td>2009/10</td>
<td>6 614 400</td>
<td>1 583 991</td>
<td>23.95%</td>
</tr>
<tr>
<td>2010/11</td>
<td>7 398 000</td>
<td>1 763 234</td>
<td>23.83%</td>
</tr>
<tr>
<td>2011/12</td>
<td>7 798 900</td>
<td>1 848 976</td>
<td>23.71%</td>
</tr>
<tr>
<td>Total Conditional Grants to Provinces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005/06</td>
<td>8 907 346</td>
<td>1 805 930</td>
<td>20.27%</td>
</tr>
<tr>
<td>2006/07</td>
<td>10 206 542</td>
<td>1 993 078</td>
<td>19.53%</td>
</tr>
<tr>
<td>2007/08</td>
<td>11 736 678</td>
<td>2 182 606</td>
<td>18.60%</td>
</tr>
</tbody>
</table>
Table 3: National Conditional Grants to Provinces Adjustment Budgets

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Conditional Grant to Provinces</th>
<th>Western Cape Provincial Allocation</th>
<th>Allocation of National Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>14 362 800</td>
<td>2 588 035</td>
<td>18.02%</td>
</tr>
<tr>
<td>2009/10</td>
<td>15 578 400</td>
<td>2 704 168</td>
<td>17.36%</td>
</tr>
<tr>
<td>2010/11</td>
<td>18 012 800</td>
<td>3 103 584</td>
<td>17.23%</td>
</tr>
<tr>
<td>2011/12</td>
<td>19 171 800</td>
<td>3 293 491</td>
<td>17.18%</td>
</tr>
</tbody>
</table>

5. **TOTAL BUDGET PER CAPITA**

5.1. The budget per capita for the WCDOH was calculated using Statistics South Africa mid-year estimates adjusted with the insured population obtained from the general household survey (Table 4). 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: Western Cape provincial trends in per capita health budget

<table>
<thead>
<tr>
<th>Year</th>
<th>Uninsured national population</th>
<th>Rm Total of provincial health budgets</th>
<th>R Uninsured total provincial health budget per capita</th>
<th>Year on year increase</th>
<th>Uninsured provincial population</th>
<th>Rm Western Cape health budget</th>
<th>R Uninsured per capita</th>
<th>Year on year increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>40 323 852</td>
<td>47 147</td>
<td>1 169</td>
<td>N/A</td>
<td>3 604 986</td>
<td>5 777</td>
<td>1 603</td>
<td>N/A</td>
</tr>
<tr>
<td>2006/07</td>
<td>40 898 347</td>
<td>53 175</td>
<td>1 300</td>
<td>11.2%</td>
<td>3 853 346</td>
<td>6 476</td>
<td>1 681</td>
<td>4.9%</td>
</tr>
<tr>
<td>2007/08</td>
<td>41 007 279</td>
<td>60 812</td>
<td>1 483</td>
<td>14.1%</td>
<td>3 750 845</td>
<td>7 427</td>
<td>1 980</td>
<td>17.8%</td>
</tr>
<tr>
<td>2008/09</td>
<td>41 725 016</td>
<td>73 581</td>
<td>1 763</td>
<td>18.9%</td>
<td>4 078 050</td>
<td>8 871</td>
<td>2 175</td>
<td>9.8%</td>
</tr>
<tr>
<td>2009/10</td>
<td>41 725 016</td>
<td>82 359</td>
<td>1 974</td>
<td>11.9%</td>
<td>4 078 050</td>
<td>9 893</td>
<td>2 426</td>
<td>11.5%</td>
</tr>
<tr>
<td>2010/11</td>
<td>41 725 016</td>
<td>91 999</td>
<td>2 205</td>
<td>11.7%</td>
<td>4 078 050</td>
<td>10 925</td>
<td>2 679</td>
<td>10.4%</td>
</tr>
</tbody>
</table>

Source: Population numbers per STATS SA mid-year estimates (P0302).
5.2. The per capita budget for health in the Western Cape (based on the total uninsured population) is higher than the national per capita budget for South Africa. However, this per capita budget excludes the reportedly large numbers of people from the Eastern Cape who make use of health services in the province. Despite this, the figures show that the WCDOH is resourced better than average in terms of health funding.

6. **TRENDS IN HEALTH EXPENDITURE**

6.1. Management prides itself on its ability to limit over expenditure of divisions and programmes and makes concerted efforts to operate within the budget allocated as reflected below (Table 5). Consequently, it has had a trend of unqualified audit reports for the period under review (2005/06 to 2007/08). Control measures to prevent over expenditure include recruitment and procurement limits.

6.2. Fiscal discipline is promoted and pushed very hard by the WCDOH and at times it has been accused of “putting cash before care”. The projected operational over-spending is approximately R152 million in 2008/09 when adjusted for the increase in accruals and the underspending in capital projects are excluded. It is however concerning that the budget is balanced by increasing accruals payable (more than doubled since the previous financial year), thus not matching expenditure with operational activity.

6.3. The surplus/(deficit) per the Appropriation Statements has been adjusted by the IST team to take into account the increase or decrease in the accruals outstanding at year-end (i.e. accounts payable). This has been done to better align the operational activity with actual payments of expenses made (e.g. medication utilised prior to year end and only paid after year end). 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.
6.4. The WCDOH underspent its budget (based on the cash basis of accounting) in the 2005/06 and 2006/07 financial years and it is also expects to be within budget in 2008/09 (Table 5). However, the 2007/08 budget was overspent due to:

6.4.1. Implementation of the Occupational Specific Dispensation (OSD) for nurses which was not fully funded. It was pointed out that the total over expenditure would have been substantially higher if measures to curtail all expenditure, to fund the deficit to a certain extent, were not introduced.

6.4.2. Higher than expected inflation on Goods and Services (estimated at 17%).

6.5. 2008/09 (ESTIMATE)

6.5.1. The February 2009 IYM estimates an underspend of R185 million. When adjusted for the movement in the level of accruals, the estimated underspend is R18 million. The WCDOH would have overspent its budget by R152 million if the underspend in the Hospital Revitalisation Grant of R170 million is taken into consideration: successful implementation of the project would have resulted in a net overspend by the WCDOH.

6.5.2. Specific items of over and underspending for the financial year are listed below:
6.5.2.1. HIV & Aids conditional grant will be overspent by more than R30 million due to higher numbers of patients on anti-retroviral therapy (ART) than the original forecast.

6.5.2.2. Forensic Pathology Services conditional grant shows a saving of R20 million due to two contractors going bankrupt (from the IYM report).

6.5.2.3. Global Fund transfer is anticipated to have a R20 million underspend due to non-completion of ARV pharmacy projects.

6.5.2.4. Programme 3, Emergency Medical Services will overspend by R14.5 million due to the increase in Government Motor Tariffs (GMT) and the appointment of Emergency Care Practitioners.

6.5.2.5. Hospital revitalisation grant will save R170.3 million due to non completion of some projects (from the IYM report).

6.5.2.6. Infrastructure grant to provinces saving of R18.7 million.

6.5.2.7. Compensation of employees will overspend by R29 million due to filling of vacancies not budgeted for, carry forward effect of OSD and also higher than budgeted salary increases.

6.5.3. As can be seen from Table 6 below, under economic classification, overspending has in 2007/08 become accentuated in compensation of employees (OSD and higher than budgeted salary increases).
### Table 6: Trends in health programme budget and expenditure, 2005-

<table>
<thead>
<tr>
<th>Programme</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Final Appropriation</td>
<td>Actual Expenditure</td>
<td>Variance</td>
</tr>
<tr>
<td>Administration</td>
<td>168 872</td>
<td>167 291</td>
<td>1 581</td>
</tr>
<tr>
<td>District Health Services</td>
<td>1 640 479</td>
<td>1 629 951</td>
<td>10 528</td>
</tr>
<tr>
<td>Emergency Medical Services</td>
<td>256 112</td>
<td>255 851</td>
<td>261</td>
</tr>
<tr>
<td>Provincial Hospital Services</td>
<td>1 297 321</td>
<td>1 295 905</td>
<td>1 416</td>
</tr>
<tr>
<td>Central Hospital Services</td>
<td>1 974 576</td>
<td>1 980 705</td>
<td>(6 129)</td>
</tr>
<tr>
<td>Health Sciences and Training</td>
<td>79 987</td>
<td>79 009</td>
<td>978</td>
</tr>
<tr>
<td>Health Care Support</td>
<td>93 672</td>
<td>93 075</td>
<td>597</td>
</tr>
<tr>
<td>Health Facilities Management</td>
<td>265 803</td>
<td>217 025</td>
<td>48 778</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5 776 822</strong></td>
<td><strong>5 718 812</strong></td>
<td><strong>58 010</strong></td>
</tr>
</tbody>
</table>

Economic classification

<table>
<thead>
<tr>
<th></th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Final Appropriation</td>
<td>Actual Expenditure</td>
<td>Variance</td>
</tr>
<tr>
<td>Compensation of employees</td>
<td>3 001 387</td>
<td>2 976 610</td>
<td>24 777</td>
</tr>
<tr>
<td>Goods and services</td>
<td>1 870 875</td>
<td>1 892 503</td>
<td>(21 628)</td>
</tr>
<tr>
<td>Financial transactions in assets and liabilities</td>
<td>1 900</td>
<td>1 900</td>
<td>-</td>
</tr>
<tr>
<td>Transfers and subsidies</td>
<td>509 043</td>
<td>502 598</td>
<td>6 445</td>
</tr>
<tr>
<td>Buildings and other fixed structures</td>
<td>203 478</td>
<td>163 879</td>
<td>39 599</td>
</tr>
<tr>
<td>Machinery and equipment</td>
<td>189 956</td>
<td>181 127</td>
<td>8 829</td>
</tr>
<tr>
<td>Software and other intangible assets</td>
<td>183</td>
<td>195</td>
<td>(12)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5 776 822</strong></td>
<td><strong>5 718 812</strong></td>
<td><strong>58 010</strong></td>
</tr>
</tbody>
</table>

7. **UNFUNDED MANDATES DURING 2008/09**

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

7.1.1. The AIDS programme will have an over expenditure of R30 million in 2008/09. Management indicated that funds were approved by NDOH but never reached the WCDOH. Nevertheless, the WCDOH went ahead and incurred the expenditure.

7.1.2. Similarly, the Metropolitan District Health Services in 2008/09 will overspend on HIV and AIDS by R9 million.

7.1.3. The eye clinic in Eerste River Hospital continues to incur expenditure of R3 million annually.

7.1.4. **Occupational Specific Dispensation (OSD)**

7.2. Respondents were of the opinion that the policies (and associated targets) set by the National Department of Health (NDOH), although often considered to be excellent policies and in line with international best practice, are not linked to the necessary funding. For example, the NDOH has introduced two new childhood vaccines to be implemented by the 1st of April 2009. However, there was no additional funding provided for this by the National Treasury.

7.3. The WCDOH manages unfunded mandates by conducting costing studies on new policies prescribed by national, assesses their affordability and human resource requirements, and the available budget before it supports the proposed activities. Only activities that have a budget are implemented. Other activities are rolled-over to the new financial year or until funding becomes available.
8. **BUDGETING PROCESS**

8.1. WCDOH has an inclusive budgeting system. A planning summit is held where the divisional priorities are discussed, a few are selected as key priorities for a particular year, are aligned to NDOH priorities and the budget is allocated accordingly.

8.2. The WCDOH has a budget advisory committee that provides regular feedback to line managers and other divisions about over-expenditure and variances on line budgets. The responsibility for implementing corrective action is left to the line manager and a finance counterpart, both of whom are responsible for developing a budget control and savings plan.

8.3. The expenditure trends of each division within WCDOH inform future budget allocation and are aligned to the CSP. All plans include costing of activities and are analysed based on the population served, HR and case mix of the facility.

8.4. When the total indicative budget from the Provincial Treasury is received, the CFO meets with the HOD, 2 DDGs and CDs to decide on the process of budget allocation based on the 8 programme areas of the WCDOH. Further division into sub-programmes may occur either at this level or lower down.

8.5. For example, the Community Based Services’ (CBS) budget allocation is decided upon and allocations are also made for sub-programmes within CBS. In the same way, the MDHS is allocated a budget that the MDHS finance manager can allocate to sub-district structures.

9. **FINANCIAL MANAGEMENT PROCESSES**

9.1. The IST review found that there is good alignment between the plans and the budget in the WCDOH. To aid this, a cost centre accounting system that allows for accountability and planning is in place. Cost centre accounting is understood by designated managers being allocated reasonable budgets and thereafter they are responsible for controlling their expenditure. For example, within a central hospital,
the budget is broken down into units or cost centres. Similarly, at district level (including the MDHS) each facility is a cost centre.

9.2. Variance analysis forms an integral part of the WCDOH expenditure management processes and in particular the Financial Monitoring and Control committee (FMC – see Human Resources, paragraph 3). The FMC is involved in expenditure reviews, which include remedial action to address areas of over and under expenditure. Three colours (green, orange and red) are used to represent the result of comparing actual expenditure against budget. Each colour then requires a particular action to be taken to address the variance.

9.3. At district level there are monthly reports that show the status of the budget down to cost centre level. Monthly reports are presented by each facility manager at the monthly meetings. On a monthly basis the WCDOH also generates reports that assist with: budget projections; expenditure reviews; identifying high cost items (not within the norm); identifying areas that could possibly go over-budget and comparing expenditure across sub-districts.

10. COST ALLOCATION

10.1. Proper cost allocation is a priority in the WCDOH in order to get meaningful indicators and is done reasonably well.

11. CONDITIONAL GRANTS

11.1. WCDOH has good estimates of the numbers of individuals that will be on ARTs in 2009/10. Business plans are based on these numbers and already a shortfall of R60 million between the provincial business plans and the level of national grant funding is expected. Since the funding of ART is from Conditional Grants, any shortfall needs to be funded from the equitable share allocation, putting added pressure on the remainder of the budget. The Global Fund has relieved some of the pressures associated with providing care for HIV-AIDS patients.
11.2. To avoid turning people away, the WCDOH will limit expansion of ART sites, which will cut down on infrastructure costs.

11.3. Under spending of the Hospital Revitalisation and Forensic Pathology grants are due to:

11.3.1. Delays in the approval of business plans.

11.3.2. Slow performance of contractors.

11.3.3. Late delivery of equipment, hence late submission of accounts for equipment, ordered during 2008/09.

11.3.4. Delays in the Department of Public Works providing claims for construction.

11.4. The WCDOH indicated that the brief from health to public works could be improved. Thus, WCDOH has developed a prototype for doing designs which although very detailed, provides a blueprint for the architects. It is expected that this will improve the design and building processes.

12. QUARTERLY PERFORMANCE REPORTS

12.1. All plans have associated costs and the expenditure is reviewed monthly and quarterly. Alignment of plans with budgets is clearly demonstrated in the quarterly reports where the in-year quarterly performance is evaluated against the APP.

12.2. The quarterly reports also show the implementation of the CSP against targets as set out in the key events schedule and also form the basis from which the annual report is compiled.

12.3. This is discussed in the quarterly Monitoring and Evaluation Committee (M&EC) meeting chaired by the HOD (see Human Resources, paragraph 3).
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. The purpose of the IYM is to highlight expenditure, actual and forecasts. However, it does not take into account accruals. This means that the expenditure reflected may be understated as invoices are withheld for payment and only paid in the next financial year. The IYM needs to be used as an effective management tool to prevent over expenditure and accurately reflect expenditure incurred. Table 5 shows clearly the effect on year end surplus/(deficit) when accruals are included.

13.3. The effectiveness of the IYM as a management tool could be improved:

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

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

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

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

14.1. The WCDOH has effective monitoring structures in place, as reported by the Auditor-General in the 2007/08 annual report:

14.1.1. Audit Committee - operational throughout the year

14.1.2. Internal audit - operational throughout the year

14.1.3. External audit - prior year's external audit recommendations are considered of prime importance and implemented.

15. RECOMMENDATIONS

15.1. PROVINCIAL HEALTH BUDGET ALLOCATION

15.1.1. The Provincial Treasury should allocate a budget that reflects the operational activity of the WCDOH. For example, the budget increase in 2007/08 was 12.2% while medical inflation was estimated at 17% for the same period. The result is less funds to deliver the same service.

15.1.2. The approved CSP needs to be funded adequately by the Provincial Treasury. For example, the MDHS is expected to delegate HR and finance functions to lower levels but inadequate funds were provided for the personnel required. As a consequence, some of the HR and finance functions require central management until capacity at lower levels is strengthened.

15.1.3. Conditional grant allocation should be based on clear criteria and should reflect the burden of disease, services and training provided e.g. HIV&AIDS, Tertiary and HPTD grants should be sufficient for the related requirements. Conditional grant money allocated by NDOH should not be withheld thereby causing over expenditure as was the case in 2008/09 for HIV/AIDS.
15.2. UNFUNDED MANDATES

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

15.3. FINANCIAL MANAGEMENT

15.3.1. Financial management should be expanded to manage expenditure on the accrual basis.

15.4. FINANCIAL REPORTING IYM (IN YEAR MONITORING) AND ANNUAL FINANCIAL STATEMENTS

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

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

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

1. INTRODUCTION

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

1. The NDOH has provided insufficient leadership and stewardship to solve the fundamental problem of ensuring that there are sufficient resources for health for the levels of service and targets envisaged by a range of national policies.
2. The NDOH has also not given sufficient direction with regard to setting of affordable norms, standards and guidelines.
3. Some of the governance structures envisaged in the National Health Act have been formally put in place e.g. Provincial Health Councils. However, at district level the situation is different as the relevant legislation has not yet been passed.
4. The role of metropolitan council health as “stand-alone” and their interaction with provincial management is not clearly defined. Similarly, the functions, roles, value and management of central hospitals and university institutions need clarification.
5. There is strong alignment among the various plans (WC Provincial Growth and Development Plan, strategic plans, Healthcare 2010, CSP, and APP), articulating clearly the overall vision, mission, and values for the public health system in the province. These plans are aligned to the NDOH Strategic Plans and are implemented through the district health services.
6. The WCDOH has developed an enhanced TB Response and accelerated HIV prevention strategies with the overall aim of addressing the high burden of TB and HIV and AIDS and improving the TB and HIV programme performance and treatment outcomes. HIV and AIDS and TB are designated as strategic focus areas in the APP. The department is strengthening the integration between the programmes.
7. The WCDOH has achieved a reduction of mother to child HIV transmission to 4%. The WC is the only province that has reduced the transmission rate below
### Box 2: Key findings from the leadership, governance and service delivery review

- There are about 54,000 patients accessing ARVs in 66 sites.
- The province has benefited from donor funding that has assisted in strengthening the provincial HIV and AIDS programme. Linked to this, the current funding model of ARV provision is viewed to be unsustainable.
- The Provincial Inter-Departmental AIDS Council (PIDAC) developed a PIDAC plan to monitor the implementation of the National Strategic Plan (NSP) at provincial level.
- The WCDOH has developed a dashboard system to track 15 key indicators that measure core service delivery targets.

## 2. GENERAL LEADERSHIP

### 2.1. OVERALL LEADERSHIP

#### 2.1.1. The Western Cape Department of Health has many features suggestive of a well-functioning provincial health department, highlighted below:

- **2.1.1.1.** A well-formulated vision and direction, outlined in the Healthcare 2010 statement and Comprehensive Service Plan (CSP), that guides strategic and operational activities, and the actions of all the senior and middle managers interviewed.

- **2.1.1.2.** Integrated annual evaluation, planning and budgeting processes that establish priorities for senior managers and which form the basis for periodic monitoring of performance during the year.

- **2.1.1.3.** An ability to implement efficiencies and identify new revenue sources in order to shift/increase spending towards service goals and priority interventions, such as the District Health System/Primary Health Care, whilst staying within budget.

- **2.1.1.4.** A focus on quality of care and health outcomes, and investment in priority health programmes, such as HIV and TB.
2.1.1.5. A strong, competent and motivated corps of senior and middle managers in the provincial head office, in the central hospitals and in the six districts; and clear delegations of authority and responsibility to these managers, accompanied by performance management measures.

2.1.1.6. An ability to produce timely information of reasonable quality, that integrates financial, human resource and health system/programme performance measures; and that feeds into individual and programme performance management systems.

2.1.1.7. Organisational structures and processes that support coherent and integrated action.

2.1.1.8. Placing the management of health programmes within the District Health Services division.

2.1.1.9. Regular divisional and senior management team meetings that bring together support and line functions; and that are structured to focus on strategic rather than operational decision-making. Additionally, perusal of the minutes of senior management meetings shows an emphasis on strategic issues including CSP, financial, resource management and performance towards achieving the APP objectives. The meetings are attended by senior managers from different programme areas and other representatives are also invited to share their expertise on specific issues under discussion e.g. district ANC surveys and costing studies. In addition, the meetings are scheduled well in advance, are well attended, have an agenda, and the minutes include action or tasks that are linked to individuals to follow up. The tasks are reviewed and progress reported in the next meeting. Ad hoc calling of meetings happens only on urgent unexpected matters or events affecting the WCDOH. For a review of the different meetings see Human Resources, paragraph 3.

2.1.1.10. The alignment of planning, budgeting, monitoring and evaluation, infrastructure development, and organisational and accountability processes around the core direction and goals of the WCDOH.
2.2. **KEY SUCCESS FACTORS:**

2.2.1. The presence of stable and competent senior leadership in the WCDOH for some years. The HOD has been in place since 2004, and came to the province with experience of being the HOD in another provincial department.

2.2.2. An incremental but committed approach to the management of change over time.

2.2.3. Recognition of the need for active stakeholder management: “upwards” in the political sphere, and “downwards” amongst key middle level managers and clinicians and “outwards” in drawing in available external expertise.

2.2.4. Well resourced service platform and above average per capita health spending

2.3. **CHALLENGES FACED BY THE WCDOH INCLUDE:**

2.3.1. Ongoing significant shortfalls in funding, with an estimated overspend of R152 million (including accruals and underspend on the Hospital Revitalisation Grant) for the 2008/09 financial year.

2.3.2. Parallel systems of PHC provision by both local and provincial government in the City of Cape Town/Metro District, and little apparent progress in the provincialisation of local government services.

2.3.3. Failure to finalise memoranda of understanding with the universities on the governance of academic complexes, in particular to reach agreement on the management of joint appointees; and the ongoing expression of considerable dissatisfaction and frustration by both parties to the relationship.

2.3.4. The need to institutionalise management systems and cultures at lower levels of the health system, especially at facility level, where ultimately quality of care is expressed.
2.4. RELATIONSHIP BETWEEN THE WCDOH AND THE NDOH

2.4.1. Poor communication between national and provincial senior managers on important decisions was identified as a barrier to building strong working relationships. The response to a request submitted by the province on ARV shortfall was not communicated appropriately, as one of the key informants reported: “In the past national had provided funding, but last year NDOH gave the province R28 million to cover the shortfall for ARVs which was later withdrawn without any explanation.”

2.4.2. In addition, the NDOH has also not given sufficient direction with regard to setting of norms, standards and guidelines. Areas where national norms, standards and guidelines were required included:

2.4.2.1. Facilities planning;

2.4.2.2. Allocation of conditional grants, especially the National Tertiary Services Grant (NTSG) and the Health Professional Training and Development Grant (HPTDG);

2.4.2.3. Framework for relationship between provinces and NDOH;

2.4.2.4. Definitions of tertiary services;

2.4.2.5. Packages of services by level: PHC, district, regional, tertiary; and

2.4.2.6. Processes of rationing, especially tertiary services.

2.4.3. The NDOH has provided insufficient leadership and stewardship to solve the fundamental problem of ensuring that resources available for health are sufficient for the levels of service and targets envisaged by a range of national policies. As expressed by one key informant: “Is the health policy funded? The answer is not really”. 
2.4.4. It was generally felt that there is minimum support and guidance from national senior managers. As a result, this has limited opportunities for national involvement in identification, planning and budgeting processes for provincial health priorities. In addition, national is unable to lead in the budget process and fiscal discipline measures that provinces can follow; and has expectations that policies will be implemented by provinces without considering the current provincial budgets and commitments.

3. PLANNING

3.1. There are three key plans that have informed the restructuring of WCDOH service platforms within an overarching provincial growth and development plan (PGDP). These are Healthcare 2010, the comprehensive service plan (CSP) and annual performance plans.

3.2. HEALTHCARE 2010

3.2.1. The healthcare 2010 plan is a foundational document developed to ensure equal access to quality health care that is affordable and sustainable through a focus on PHC and the District Health System. It was initiated in response to provincial over-expenditure and prior to the Integrated Health Planning Frameworks of the NDOH. The principles underpinning this plan include: quality care at all levels, efficiency, accessibility of care, cost-effectiveness, PHC approach, collaboration between levels of care and de-institutionalisation of chronic care.

3.3. COMPREHENSIVE SERVICE PLAN

3.3.1. The comprehensive service plan (CSP) was begun in 2003 and finalised in May 2007 after approval by the Provincial Cabinet in July 2006. This CSP is the equivalent of a Service Transformation Plan (STP) that facilitates the restructuring of health services in line with the Healthcare 2010 plan, by defining and quantifying service provision at all levels. The CSP focuses on building a strong Primary Health Care (PHC) service platform, which is integrated with acute hospital services (Level 2 & 3) at all levels of care in the Western Cape Province. The plans are linked to the infrastructure, financial and human resource plans.
3.3.2. The criteria used in the development of the CSP plan includes: geographic accessibility and equity of resource allocation; NDOH core PHC package; well-balanced health teams; effective and efficient services; district management structures; effective referral systems; and clear links to service implementation.

3.3.3. It describes urban and rural facility based service models and provides a summary of the full package of PHC services in clinics and community health centres. The plan defines and differentiates district, regional and central hospital services and community based services. It recommends, for example, that the number of beds in district (level 1) hospitals be increased, and the number of beds in central hospitals be reduced over time.

3.3.4. The plan and funding thereof, was included in the medium term budget policy statement: 2009-2012 of the WC Minister of Finance, Economic Development in November 2008. Hence, there is high level political endorsement of the plan and clear linkages between what politicians say and the plan developed by the WCDOH.

3.4. **ANNUAL PERFORMANCE PLAN**

3.4.1. An annual performance plan (APP) for the 2009/10 financial year outlines initiatives that will be implemented efficiently to achieve the objectives of the CSP during this financial year, considering available resources and the population size of the WC. There are two clinical service divisions viz DHS and Programmes, and Central, Regional and Associated Psychiatric Hospitals and EMS. The four inter-divisional key performance areas included to integrate the service delivery across levels are: acute services (including emergency medical services and acute hospitals); ambulatory care (outreach and support); infectious disease management; and de-hospitalised care. The deliverables within each area will be linked to support services, namely infrastructure, maintenance, training and administration services.

3.4.2. The principles for each service platform, the approach, and only four key deliverables are clearly articulated for each key performance area. The projected achievements for the 2008/09 financial year are listed and are building blocks of the new key deliverables for the following year. For example, by March 2009, the Tygerberg
Hospital should have provided level 2 services to clients in Khayelitsha District hospital wards, and in 2009/10 deliverables are: Consolidation of the level 2 services at Tygerberg Hospital with improved linkages with the level 2 service at Karl Bremner Hospital.

3.4.3. The APP appears to play a meaningful role in addressing key strategic priorities, such as equity, and ensuring that health care services are accessible at lower levels of care to reduce costs. HIV and AIDS and TB are designated as strategic focus areas in the APP; targets for interventions are linked and matched per district to the burden of disease across the service platform. The targets are monitored and discussed regularly at District Health Executive Committee meetings (DEXCO), chaired by the Deputy Director-General (DDG) - District Health Services (DHS), and other management meetings including the Strategic Management Team (SMT) and the eight operational management teams (OMTs) representing the DHS divisional priorities.

3.4.4. The plan appears to be designed to guide and streamline the activities of CSP to manageable initiatives that are easily implemented by managers and staff at all levels. In this way, the managers and staff are not overwhelmed by the CSP and can pace their initiatives and performance based on a limited number of key deliverables.

3.4.5. The APP highlights WCDOH’s contribution towards achieving the NDOH priorities and WC provincial growth and development strategy’ social transformation projects in the 27 priority areas, of which the Khayelitsha sub-district is included.

3.4.6. Hence, the APP outlines situational analyses with demographic, socio-economic, health, poverty and financial indicators. Issues of inequities within and between districts are considered and there are efforts to reduce these, for example as shown in Table 7, the infant mortality rate that is a marker for access to maternal care before, during and after birth; and HIV and AIDS. To monitor and reduce inequities, the priorities are linked to measurable objectives and performance indicators, e.g. PMTCT and HIV prevalence rates and ANC coverage between districts.
Table 7: Infant Mortality Rate (per 1,000 live births) in WC over 3 years (2005-2007).

<table>
<thead>
<tr>
<th>Year</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>-</td>
<td>26</td>
<td></td>
<td>South African Health Review 2006:386</td>
</tr>
<tr>
<td>Cape Town Metro district</td>
<td>22.28</td>
<td>21.40</td>
<td>20.28</td>
<td>City of Cape Town</td>
</tr>
<tr>
<td>Cape Town Metro Sub-districts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastern</td>
<td>27.51</td>
<td>32.00</td>
<td>28.38</td>
<td></td>
</tr>
<tr>
<td>Khayelitsha</td>
<td>34.72</td>
<td>31.33</td>
<td>30.16</td>
<td></td>
</tr>
<tr>
<td>Klipfontein</td>
<td>27.41</td>
<td>24.65</td>
<td>24.74</td>
<td></td>
</tr>
<tr>
<td>Mitchell’s Plain</td>
<td>22.85</td>
<td>22.08</td>
<td>21.27</td>
<td></td>
</tr>
<tr>
<td>Northern</td>
<td>22.88</td>
<td>20.62</td>
<td>21.08</td>
<td></td>
</tr>
<tr>
<td>Southern</td>
<td>15.23</td>
<td>11.88</td>
<td>11.98</td>
<td></td>
</tr>
<tr>
<td>Tygerberg</td>
<td>16.20</td>
<td>17.61</td>
<td>14.91</td>
<td></td>
</tr>
<tr>
<td>Western</td>
<td>15.22</td>
<td>14.21</td>
<td>20.28</td>
<td></td>
</tr>
<tr>
<td>Cape Winelands East Sub-districts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breede River winelands</td>
<td>28</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breede Valley</td>
<td>21</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witzenberg</td>
<td>42</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overberg</td>
<td>35</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overberg sub-districts</td>
<td>29</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cape Agulhas</td>
<td>35</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overstrand</td>
<td>31</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swellendam</td>
<td>11</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thewaterskloof</td>
<td>31i</td>
<td>26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Cape Winelands East Drakenstein and Stellenbosch data are not included in the infant mortality rates. Source WCDOH-APP-2009/10 page 10.
Table 8: Resource allocation and utilisation of primary health services relative to uninsured population in 6 districts of the Western Cape Province

<table>
<thead>
<tr>
<th>District Name</th>
<th>WC Uninsured Population</th>
<th>Provincial PHC expenditure per uninsured person</th>
<th>Total PHC headcount per annum</th>
<th>PHC utilisation per uninsured person</th>
<th>Clinic service points 2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropole</td>
<td>2,503,086</td>
<td>R 306</td>
<td>7,787,777</td>
<td>3.05</td>
<td>102</td>
</tr>
<tr>
<td>West Coast</td>
<td>234,152</td>
<td>R 639</td>
<td>911,470</td>
<td>3.91</td>
<td>70</td>
</tr>
<tr>
<td>Cape Winelands</td>
<td>574,555</td>
<td>R 142</td>
<td>1,799,879</td>
<td>3.1</td>
<td>75</td>
</tr>
<tr>
<td>Overberg</td>
<td>178,047</td>
<td>R36</td>
<td>648,500</td>
<td>3.65</td>
<td>38</td>
</tr>
<tr>
<td>Central Karoo</td>
<td>50,450</td>
<td>R475</td>
<td>239,099</td>
<td>4.84</td>
<td>18</td>
</tr>
<tr>
<td>Eden</td>
<td>419,153</td>
<td>R 361</td>
<td>1,642,274</td>
<td>3.88</td>
<td>73</td>
</tr>
</tbody>
</table>

Source: WCDOH-APP: 2009/10

3.4.7. Table 8 above shows the resource allocation process that is based on access and utilisation of PHC services, past expenditure trends, reconciliation of the MTEF projections and the burden of disease within and across districts. This data is explicit and well-communicated to all managers. The uninsured population size is factored into targets. However, as can be seen from Table 8, there are huge inequities with provincial PHC expenditure ranging from a very low R36 in the Overberg to a high of R639 on the West Coast.

3.4.8. When comparing the cost per patient day equivalent in selected district hospitals over 3 years, wide variations are observed that have not narrowed over time (Table 9). However, between central hospitals, there are minor differences, as shown in Table 10. Hence, it will be important to monitor the impact of the approach used to allocate resources to ensure that the variations in district hospitals narrow over time.
### Table 9: Comparisons of Costs per Patient Day Equivalents in Selected District Hospitals

<table>
<thead>
<tr>
<th>Province</th>
<th>Hospital</th>
<th>2005/06 (Rands)</th>
<th>2006/07 (Rands)</th>
<th>2007/08 (Rands)</th>
<th>No of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>Vredenburg</td>
<td>1 363.2</td>
<td>1 603.5</td>
<td>1 797.1</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Clanwilliam</td>
<td>487.3</td>
<td>535.8</td>
<td>652.0</td>
<td>48</td>
</tr>
</tbody>
</table>

Source: NDOH-DHIS

### Table 10: Bed utilisation rate and cost per patient day equivalent in selected central hospitals

<table>
<thead>
<tr>
<th>Province</th>
<th>Hospitals</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BUR % PDE cost</td>
<td>BUR %</td>
<td>PDE cost</td>
<td>BUR %</td>
<td>PDE cost</td>
</tr>
<tr>
<td>Western Cape</td>
<td>Groote Schuur</td>
<td>82.7</td>
<td>n/a</td>
<td>82.3</td>
<td>2 195.0</td>
</tr>
<tr>
<td></td>
<td>Red Cross Children’s War Memorial</td>
<td>81.1</td>
<td>n/a</td>
<td>84.0</td>
<td>2 136.5</td>
</tr>
<tr>
<td></td>
<td>Tygerberg</td>
<td>80.4</td>
<td>n/a</td>
<td>81.2</td>
<td>2 101.5</td>
</tr>
</tbody>
</table>

Source: NDOH-DHIS

3.4.9. The Annual Performance Plans appear to reflect the strategic priorities of the WCDOH. For example, TB is one of the key priorities under the infectious disease management performance area. The WCDOH objective is to reduce the morbidity and mortality due to TB through expansion and enhancement of high quality DOTS in high TB burden sub-districts and health facilities.

3.4.10. Each service platform has developed visuals to communicate the focus priority areas and targets and is provided with a template to report on the progress made towards achieving the targets. This method conveys a sense of urgency and assists staff at lower levels to understand the “big picture” across the service platform within the WCDOH. In addition, managers are accountable for programme performance through performance agreements.

3.4.11. Accountability mechanisms arising from the APP are very strong and explicit. The performance indicators hold the WCDOH accountable across service platforms and these have been included in the performance agreements of all managers per level and service platform.
3.5. ALIGNMENT OF PLANS

“All plans are costed and the expenditure is reviewed monthly and quarterly. The WCDOH understands the relationship between the plans and budget well. Lower levels of the financial department are requested to submit monthly financial statements. Budget expenditure planning is based on the population size, HR and the burden of disease”. (WCDOH senior manager)

3.5.1. Provincial managers at different levels were of the view that the role of the NDOH in assisting the WCDOH in developing plans and budgets could be improved. The WCDOH plans are aligned to the National Health Act, NDOH priorities and policies as well as the PGDP.

3.5.2. There are good channels of communication within the WCDOH around planning. A bottom-up approach is used to ensure that there is buy-in, support and cooperation from lower levels. Plans are designed to improve and strengthen the quality of the programmes and services in the WCDOH and to ensure financial sustainability. The plans explicitly enforce compliance and accountability at all levels. The APP is reviewed monthly and quarterly at various meetings held at all levels within the WCDOH. The senior managers are tasked with developing action plans for controlling expenditure and identifying areas for savings. Follow-up and feedback is expected at the financial committee meetings held at all levels (provincial head office to sub-district level). It was also reported and verified that the communication channels and interaction within and between divisions and service platforms is adequate to promote coherence of a vision, cooperation and compliance to the WCDOH service delivery and budget approaches as well as set targets. Reference to Healthcare 2010, CSP and APP were made by all key informants interviewed across service platforms.

3.5.3. The programme plans and the district plans correlate with each other. This is reflected by the same information for the same intervention written in different plans. The preparation of district plans are integrated and aligned with the APP using the
same templates. All key informants were very familiar with all plans and how each plan relates to the other. Similar terminology was used to describe each plan and differences.

3.5.4. From the discussions held with key informants, it was evident that there is sufficient and sophisticated planning capacity at provincial level to ensure that the planning process is appropriate, cost-effective, efficient and relevant to districts. However, it was felt that capacity at facility level may need to be strengthened.

3.5.5. The methodology used for setting targets is informed by the situational analysis, allocated budget per cost centre, and socio-economic indicators. Inputs were drawn from a budget advisory committee, epidemiologists, an actuarial scientist as well as health economists. A process of consultation with both internal and external stakeholders was held over a year, during which the CSP was developed, to ensure that the plan addressed issues appropriately, feedback was obtained and it was endorsed by all stakeholders. Some of the targets thus developed differ from the NDOH targets.

3.5.6. Overall, key planning documents of the WCDOH clearly articulate an overall vision, mission, and values for the public health system in the province. There is strong alignment among the various plans (WC Provincial Growth and Development Plan, CSP, strategic plan and APP). The plans are based on actuarial models (ASSA 2003), population estimate data, poverty deprivation indices and the burden of disease. These are costed, aligned and supported by HR, financial and infrastructure plans. The plans ensure that services are responsive to the needs of the population and are adjusted to population growth.

4. GOVERNANCE

4.1. Nearly all senior executives positions in the WCDOH are filled (refer to organogram - appendix 8). The relationship between the accounting officer/Head of Department (HOD) and the Member of the Executive Council (MEC) for Health was regarded as a "cordial working relationship". A high turnover of HODs, across provinces was
regarded as a challenge for the Minister of Health to address and it was pointed out that the lines of responsibilities must be clear and reviewed regularly.

4.2. Governance structures envisaged in the National Health Act have been formally put in place e.g. Provincial Health Councils. The Western Cape Province has not promulgated the District Health Council Bill. Thus, District Health Council and related structures are not yet formalised and do not have official terms of reference to guide their functions.

4.3. Respondents identified gaps in the National Health Act, which require revision including:

4.3.1. the provincialising of health was reported to be ambiguous and needs revision;

4.3.2. clarity on the role of metros as “stand-alone structures” and their relationship with provincial management is required;

4.3.3. the certificate of need has never been implemented;

4.3.4. community accountability has also not been implemented.

4.4. At a provincial level a number of governance issues concerning universities and tertiary level services were raised.

4.4.1. Firstly, relationships and responsibilities between universities and chief executive officers (CEOs) of central hospitals need to be reviewed and reinforced.

4.4.2. Secondly, the relationship between WCDOH and universities appears to be strained, in particular around the decision taken on the allocated number of level 2 and 3 beds in hospitals.

4.4.3. Thirdly, conditional grants are perceived to be inadequate for the delivery of tertiary services and health professional training and development.
4.4.4. Fourthly, views were expressed that funding does not match the needs of tertiary institutions and central hospitals. Limited participation in the provincial health planning processes was stated as a reason, as expressed by an informant “The DORA states that business plans must be compiled in conjunction with the universities but none of this happens. The funding from the WCDOH is in conflict with the needs of universities”. Furthermore, it was reported that, over the years the funding has decreased significantly in real terms.

5. SERVICE DELIVERY (HIV, TB AND MCWH)

5.1. LEADERSHIP FOR IMPROVED SERVICES

5.1.1. The WCDOH has made a decision to prioritise components within the HIV and AIDS programme, as stated: “We fund prevention, care and support HIV programme components first before ARVs”. This would ensure a balanced approach to the delivery and sustainability of services and ensure that services are delivered within budget allocations.

5.1.2. The Western Cape Department of Health has many features of a well-functioning health service delivery model. The capacity of the WCDOH is evident in the following:

5.1.2.1. A clear picture of the provincial epidemiological profile provided by a detailed situational analysis with demographic, socio-economic, poverty and health indicators, including the burden of disease, HIV high transmission areas and causes of death.

5.1.2.2. An ability to commission relevant studies (e.g. HIV antenatal district prevalence survey) and pilot interventions that are capable of being scaled up throughout the province.

5.1.2.3. The target setting for interventions are high and demonstrate a sense of urgency and the commitment of the WCDOH to manage the infectious diseases at lower levels of care by using a comprehensive approach e.g. HIV testing within PMTCT has achieved 100% targets.
5.1.2.4. Ability to identify provincial flagship programmes, implement according to best practices and allocate appropriate resources. For example, PMTCT is one of the provincial flagship programmes. Since 2004, the WCDOH has used dual therapy.

5.1.2.5. A well-structured planning process that assists the WCDOH to be proactive. For example, when a shortfall is identified in the HIV and AIDS conditional grant, it is presented to senior managers, and top management structures. Alternatives are explored and costed accordingly, and the CFO submits appropriate requests.

5.1.2.6. The alignment of planning tools (budgeting, monitoring and evaluation, infrastructure development, and HR) with health outcomes and appropriate achievable targets.

5.1.2.7. An ability to align facility APPs to the provincial APP. For example, at Groote Schuur Hospital, the APP includes internal shifting of hospital beds by reducing the number of level 3 and increasing level 2 beds. It also includes external shifting of services such as orthopaedic, obstetric services and outpatients (OPD) to regional hospitals and paediatric care to the Red Cross Hospital.

5.1.2.8. The development of relevant and appropriate policies accompanied by adequate resource allocation to complement CSP and APP priorities (e.g. EMS acute case load management policy with normative response times that outlines diversion of patients to hospitals. This is backed by a Health-Net transport system, a public-private partnership, for non-emergency cases of local and inter-city outpatient support. APP has a target of 15 minutes and 40 minutes EMS response time for urban and rural districts, respectively).

5.1.2.9. Competent senior and middle managers that have capacity to develop and submit successful bids and proposals to external sources. The WCDOH is one of the two health departments in South Africa that is a recipient of the Global Fund.

5.1.2.10. Leadership and management structures that are responsive; hold M&E and service delivery review meetings regularly; and are committed to implement recommendations using an integrated approach.
5.1.2.11. Commitment to implement health service related recommendations emanating from health service research or enquiries e.g. Saving The Mothers Report III.

5.1.2.12. Linking acute PHC and CBS services to emergency medical services (EMS) in order to facilitate appropriate drainage with an up and down referral system (see Appendix 6).

5.2. FEATURES THAT STRENGTHEN THE DHS

5.2.1. An ability to place the management of priority health programmes within the District Health Services division, in particular, community based services, primary health care services, and acute services (district hospitals with level 1 beds). As one of the senior managers stated: “This ensures that patients are treated at the right level of healthcare”.

5.2.2. The DHS focuses on the most important causes of burden of disease in the province namely HIV, unnatural deaths due to homicide or road accidents; TB, maternal and women’s health and child health.

5.2.3. The APP that explicitly outlines the 8 divisional priorities (see Appendix 7) within DHS and allows flexibility of districts management structures to expand on these, based on the variations of the burden of disease between districts.

5.2.4. Managers at sub-district levels have a clear understanding of what their priorities and targets are and are enforcing these during meetings held with facility managers, to ensure that all staff understand the objectives and are clear on activities that need to be implemented to achieve the targets.

5.2.5. There are regular lines of authority by programme managers from provincial to facility level that are understood and followed.

5.2.6. At sub-district level, the priorities are customised to meet the burden of disease of that particular sub-district. For example, in Khayelitsha, due to the high cervical cancer rate, cervical screening is a priority.
5.2.7. A standardised clinic supervisory checklist, called the Red Flag (see Appendix 4), has been developed and is used across all clinics in the province during monthly clinic visits.

5.3. PRIORITY PROGRAMMES

5.3.1. Findings from some of the priority programme initiatives that have positively contributed to achieving targets are:

5.3.1.1. TB

- The WCDOH developed an Enhanced TB Response strategy in 2006/07 with the overall aim of addressing the high burden of TB in the Western Cape and improving the TB programme performance and treatment outcomes in the province.
- The WCDOH promotes and supports integration and synergy of TB and HIV and AIDS care interventions.
- Additional resources (administrative, nurses and funding to NGOs) have been allocated to the five sub-districts identified to have high burden of TB and HIV and AIDS. The selected five sub-districts were Khayelitsha, Cape Town Eastern, Klipfontein, Breede Valley and Drakenstein.
- The WC MDR and XDR TB review committee, chaired by CEOs of facilities, advises on clinical management of TB patients with poor prognosis and those defaulting treatment.

5.3.1.2. HIV/AIDS

- The HIV and AIDS programme has an accelerated HIV Prevention Strategy that was developed in 2006 by the Provincial Inter-Departmental AIDS Committee (PIDAC) and informed by the district ANC survey and surveillance reports. The objectives were to reduce HIV prevalence in young people and the transmission of HIV from mother to baby, provide anti-retroviral treatment; protect and support orphans and vulnerable children and provide access to home community based care to over 80% of those in need.
The Provincial Aid Council (PAC) was established in 2002/03, is chaired by the MEC and has representations from social clusters (social development, health and education) and other sectors (it is multi-sectoral).

The PIDAC developed a PIDAC plan to monitor the implementation of the National Strategic Plan (NSP) at provincial level.

5.4. ACHIEVEMENTS

5.4.1. As a result, the following achievements have been reported:

5.4.1.1. **Ability to attract additional funding:** The WCDOH has benefited from donor funding and the funding has strengthened HIV and AIDS programme in terms of treatment, care and support.

5.4.1.2. **EMS:** In 2007/08, the WCDOH has been actively trying to improve their response rate of 30% response time of less than 15 minutes in urban areas and from 75% response time of less than 40 minutes in rural areas.

5.4.1.3. **TB:** The TB treatment success rate increased to 81.9% and the defaulter rate decreased from 11.1% to 9.1% in the WC. A number of clinics have achieved 85% TB cure rates and have received awards for achieving this target.

5.4.1.4. **HIV and AIDS:** The WCDOH has achieved reduction of mother to child HIV transmission to 4%, the first in the country. The WCDOH expects to increase the number of patients enrolled to receive ARVs from 54,000 during 2008/09 financial year to 68,000 patients in 2009/10. To date, it is reported that the WCDOH enrols between 1,500 and 2,000 patients on ARV per month. Approximately 2-3% of the population is tested for HIV through primary health care. There are 66 sites; 16 step-down facilities with 184 beds; and 145 schools are implementing a peer education programme.

5.4.1.5. **MCWH:** By prioritising resource allocation to the sub-districts with the highest burden, implementing interventions to strengthening PHC and PMTCT and creating linkages between ANC, PMTCT and IMCI services, the WCDOH has adequately responded to recommendations from the Saving Mothers Report III.
5.4.1.6. **Capacity of M&E:** Adequacy of monitoring systems (ARV Business plans are based on ASSA 2003 model-scenario planning, staff capacity and available finances) which makes it easy to forecast both demand and supply.

5.4.1.7. **Supervision:** The supervision rate of facilities has been reported to be gradually improving from the rate of 43.5% in the 2007/08 financial year. It is anticipated that it will increase to 74% in the metropolitan district. The target for 2009/10 is 100%.

5.5. **CHALLENGES**

5.5.1. Challenges faced by WCDOH include:

5.5.1.1. Limited resources to implement improved TB drug protocols, conduct intensive TB case findings, follow up defaulters and provide counselling services.

5.5.1.2. The fiscal discipline and budget saving mechanisms that draw from infrastructure and maintenance, in the long-term, may likely affect the expansion of ARV sites and cause service pressures on the existing sites.

5.5.1.3. With regard to HIV and AIDS, there are concerns that the WCDOH may reach its highest level of capacity to enrol all patients in need of ARVs sooner than expected with the current budget allocation. In addition, the target for ART enrolment for 2009/10 has increased significantly as compared to the 2007/08 financial year, yet the conditional grant allocated has only increased marginally (refer to Table 3). Therefore, the current funding model of ARV provision is viewed to be unsustainable.

5.5.1.4. In addition, considering the past ART enrolment trends it is presumed that the WCDOH will exceed its targets. If the infrastructure remains unchanged, issues concerning quality assurance across sites will need to be addressed.

5.5.1.5. In the recent past, the WCDOH have experienced shortages of male condoms, following the implementation of their strategy to reduce sexually transmitted infections (STIs) and new HIV infections in high transmission areas.
5.5.1.6. Gaps in monitoring of programmes by national were identified. It was reported that the DORA reviews that are supposed to be conducted annually, by NDOH and Treasury managers, were only conducted five years ago and the WCDOH did not receive feedback.

5.5.1.7. Pertaining to other programmes, the view is that the interaction between national and provincial level is minimal and focused on the reports and directives.

5.5.1.8. Furthermore, the interaction between the two levels does not necessarily ensure that lessons learnt from provinces are documented and rolled out to other provinces, with national driving this process. As expressed by one key informant, with regard to PMTCT: “At national level, we read shocking statistics about 66,000 babies born HIV positive last year - this is 30% transmission rather than the 4% in the WC”.

6. RECOMMENDATIONS

6.1. GENERAL LEADERSHIP

6.1.1. The NDOH needs to review the structure of the national health system, cost and amend national policies to fit the realities in provinces.

6.1.2. There should be a review of the National Health Act in terms of provincial roles and responsibilities, its interaction with metropolitan municipalities and a review of items that have not been implemented to date.

6.1.3. The impact of rationing of support services (e.g. maintenance) as a result of budgetary constraints requires regular monitoring to avoid long term consequences (e.g. run down facilities).

6.1.4. Leadership and management strengthening should be part of the national health sector strategy and be linked to human resource development plans with appropriate M&E indicators to monitor progress in national and provincial health departments.
6.2. **PLANNING**

6.2.1. Promote structured planning and provide technical assistance at PHC level to ensure that targets are attained.

6.2.2. Explore the causes of variations in the PDE, and monitor the impact of budget allocations between district hospitals to ensure that inequities in resource allocations are identified early and addressed.

6.2.3. There should be a concerted effort to address the inequity in per capita PHC expenditure between districts.

6.3. **GOVERNANCE**

6.3.1. **National**

6.3.1.1. In relation to the NTSG and HPTDG, the NDOH should conduct grant evaluations, review their requirements and allocate appropriate funding to costed training and service plans, using objectively defined criteria.

6.3.1.2. Decisions (on the governance, management, funding, boundaries and roles and functions, economies of scale and potential costs to nearby communities and provinces) with regard to central hospitals need to be taken by the Ministry of Health and thereafter be integrated into the national health strategy, planning and budgeting processes.

6.3.1.3. National and provincial competencies need to be reviewed, clarified and guidelines delineating these developed through a national consultation process.

6.3.2. **Province**

6.3.2.1. There should be clear written guidelines delineating the areas of responsibility of the MEC and the HOD.
6.3.2.2. The WCDOH must consider decentralising decision-making to central hospitals on budgetary issues and appointment of staff; and involve both tertiary institutions and central hospitals in provincial planning processes.

6.3.2.3. Once the District Health Council Bill has been finalised and promulgated, the district health councils, hospital boards and clinic committees can be formalised and put into effective operation.

6.4. SERVICE DELIVERY (HIV, TB AND MCH)

6.4.1. National

6.4.1.1. The NDOH must ensure that donor funding is coordinated, aligned and harmonised across the service delivery platform and explore health sector or earmarked budget support with its development partners.

6.4.1.2. The current model, as suggested by the national comprehensive plan, of monitoring, accessing and delivering ARVs needs review to ensure that it is sustainable, affordable, equitable and addresses issues of access.

6.4.2. Province

6.4.2.1. Introduce affordable incentives for optimising clinical performance to encourage sustained cost savings practices and efficiency across service platforms.

6.4.2.2. Identify, document and exploit positive spill-over from global initiatives (funded by donors) to strengthen the WC DHS.

6.4.2.3. Strengthen integration of TB and HIV and AIDS programmes.

6.4.2.4. Explore inclusion of ARV dispensing for stable patients in the chronic dispensing unit network and work towards integrating the ARV procurement into the existing provincial supply chain management system.
6.4.2.5. The impact of various initiatives that are currently piloted needs to be documented and shared in the country.

6.4.2.6. Hospitals (L1-3) must strengthen the DHS by exploring hospital-based resources that can be capitalised to achieve integration, efficiency and quality of care.
Human Resources

1. INTRODUCTION

1.1. The WCDOH has developed a comprehensive HR Plan in compliance with the requirements of the Human Resource Plan as defined in Part III/D of Chapter 1 of the Public Service Regulations, 2001. The plan was signed off by the HOD in November 2008.

1.2. The plan will act as a blueprint for institutional management to develop institutional HR plans. The plan will also assist heads of institutions and line managers to successfully implement the CSP. For details of the HR plan see Appendix 4.

Box 3: Key findings from the Human Resource review

1. Compensation of employees accounts for the largest expenditure within the WCDOH at 55.98% (excluding agency costs which are included in goods and services) and is a major cost driver.

2. There is no guidance from national regarding norms and standards for staffing at different levels of care and the WCDOH have developed their own standards.

3. The HR plan has put the WCDOH on a strategic course that will align staff qualifications, skills and experience with the required patient level of care at an institutional level as defined in the CSP. However, the budget is insufficient to implement the HR Plan.

4. Respondents were of the opinion that the WCDOH is understaffed and will continue to be understaffed in the future due to budget constraints.

5. The controls around recruitment of staff has enabled the WCDOH to limit staff costs to stay within budget but it has resulted in institutional and line managers being frustrated at their inability to fill posts that they consider critical. The fact that all unfunded posts have been deleted from PERSAL and only funded posts can be filled has led to a perception that the delegation to recruit staff has been centralised.

6. Agency staff is a major cost driver and it is difficult to recruit permanent staff to replace agency staff as staff prefer to earn the higher salaries of agencies with
Box 3: Key findings from the Human Resource review

- There is a shortage of nurses due to the fact that supply is lower than demand. Although the WCDOH has developed a plan to train more nurses and provide further training to existing nurses to alleviate the skills shortage, the plan is unfunded.
- Job grading between the provinces varies greatly and needs to be standardised at a national level.
- There are parallel systems of PHC provision by local and provincial government in the City of Cape Town Metropolitan District. The issue around the provincialisation of local government services in the metros is unresolved.
- A national policy needs to be implemented to resolve the issue of joint staff.
- The abuse of absenteeism and the management of leave is a major problem in the WCDOH and needs to be addressed as it is potentially costing the WCDOH millions of rand.

2. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

2.1. The WCDOH has a comprehensive policy delegating human resource management down to the institutions and line managers. The delegations have not been withdrawn due to the financial constraints as has occurred in some provinces, but have been restricted. In fact, the WCDOH is one of the few provinces which handle HR issues at a district level. WCDOH has put in place tighter controls to ensure staff expenditure remains within budget.

2.2. Due to the financial constraints all unfunded and vacant posts have been deleted from PERSAL. To employ additional staff, managers have to first provide proof that the post is fully funded or motivate for the post to be funded before it can be advertised. Advertisement of new posts is done centrally by HR as is all the paperwork around the appointment and PERSAL loading. This seems to have led to the feeling of some institutional and line managers that recruitment has been centralised and that HR delegations have been reduced.
2.3. The tighter controls have limited the filling of needed posts. Managers who manage to save costs on Goods and Services can motivate for these savings to be put to staff salaries though it was stated that it is not guaranteed that a department that saves on Goods and Services will be granted the staff post. Rather the post will be allocated where it is needed most.

2.4. The controls around recruitment of staff have resulted in the following:

2.4.1. It has enabled the WCDOH to manage staff costs to stay within budget.

2.4.2. It has resulted in some staff shortages and institutional and line managers being frustrated at their inability to fill posts that they consider critical.

3. INTEGRATION AND CO-ORDINATION

“The Comprehensive Service Plan 2010 transformation plan is based on a robust model that is costed, aligned and supported by HR, financial and infrastructure plans. The plan ensures that services are responsive to the needs of the population and are adjusted to population growth.

There is a good multi-skilled management team managing the WCDOH. The organisation has been split into two service divisions (i) Tertiary, Regional Hospitals, Associated Psychiatric Hospitals and Emergency Services, (ii) District Health Services, and two support divisions (iii) Professional Support Services and (iv) Administration and Finance. The divisional executives run their sectors and they have accountability and authority to manage their divisions. The big central hospitals have also had authority devolved to them to hire and fire and manage services.”

3.1. There is integration and coordination across the WCDOH. The WCDOH has a lean organisational structure with 3 DDGs and 2 CDs reporting to the HOD. These are the
DDG: Tertiary, Regional Hospitals, APH & EMS; DDG: District Health Services; DDG: CFO; CD HR; CD Professional Support Services.

3.2. An effective meeting structure that is well planned has been developed to enable the integration and coordination of strategies and activities across the WCDOH. There is no defined meeting structure with the NDOH. The meeting structure is as follows:

3.2.1. **Minister’s Management Meeting (MMM)** - attended by all managers from the CD level upwards together with directors of Red Cross Hospital and Communications - meets as indicated by the Minister. This meeting handles issues tabled by the Minister.

3.2.2. **TRIO meeting** - Head of Department and the three DDGs meets bi-weekly. This is an informal meeting that handles issues related to the overall management of the WCDOH and strategy, tactical and management initiatives.

3.2.3. **Department Executive Meeting** - constituted by the HOD, three DDGs and CD (HR) with additional members co-opted as per the agenda, meets bi-weekly. This meeting handles strategic and transversal issues related to human resource management and finance, strategic issues related to the CSP and operational issues of transversal urgent and/or strategic nature.

3.2.4. **Top Management Meeting (TMM)** - This is attended by the HOD, DDGs, Chief Directors (DHS, Health Programs, HR, Finance, Professional Support, Tygerberg and Groote Schuur Hospitals, Regional hospital services, APH and EMS), and Directors (Red Cross Hospital, Communications and Nursing). Additional members are co-opted to the TMM according to the agenda. The committee meets monthly. Appropriate matters are raised at this forum once they have been dealt with at their respective Divisional Executive or interdepartmental meetings prior to being tabled at the TMM. The TMM deals with matters of a strategic transversal policy nature including budget issues, transversal departmental policy decisions, reports from the Financial Monitoring Committee (FMC) and Monitoring and Evaluation Committee (M&EC) and reports from the divisional and inter divisional meeting, where relevant and of a transversal nature.
3.2.5. **Interdivisional Management Meeting** - constituted by representatives from the top management of both the divisions, chaired by HOD and meets bi-monthly. The committee handles operational matters of a transversal nature as outlined in the APP and prioritized by the CSP.

3.2.6. **Divisional Executives** - Meets monthly and is chaired by the line DDGs and attended by senior managers within each division and appropriate “central” support functions, as arranged by the respective senior management. This committee handles operational matters within the area of responsibility of the divisions as outlined in the APP and prioritized in the CSP. The HOD attends these meetings for discussion of specific operational issues in support of the respective line DDGs and on an intermittent basis to be informed of key issues both within the respective divisions and in support functions such as HR, infrastructure and finance.

3.2.7. **Financial Monitoring Committee (FMC)** - chaired by the HOD; constituted by the three DDGs together with the CFO, programme managers (according to the programme) and support staff; meets quarterly or according to need. This meeting handles projections of expenditure on personnel, goods and services. It also reviews projections on revenue generation and collection, remedial steps to address areas of over expenditure, reports from the CD: Finance regarding financial control and the Auditor-General and consequential remedial actions.

3.2.8. **Monitoring and Evaluation Committee (M&EC)** - chaired by the HOD; constituted by the HOD, the DDGs from the line divisions, Directors: Information Management, Policy and Planning and support staff, and attended by the programme and support staff; meets quarterly. The meeting handles quarterly performance reports and evaluation against APP, the implementation of the CSP against targets as set out in the key events schedule and the Annual Report.

3.2.9. **SMS strategic meetings** - include all SMS members and others deemed necessary. These meetings deal with strategic planning, evaluation of performance as per the annual report and any other matters deemed necessary by top management. The universities are engaged in these matters through the Joint Standing Committee (JSAC) and the Health Platform Committee (HPC) structures.
3.3. There is evidence from the minutes of these meetings that issues are carried through from one meeting structure to another and then dealt with in a decisive manner.

4. **HUMAN RESOURCE PLANNING**

4.1. The WCDOH has developed an extensive macro labour plan with key HR indicators as part of the HR Plan 2008 to 2010. The following key points illustrate its linkages within the WCDOH:

4.1.1. There has been considerable consultation and involvement of stakeholders at all levels of the organisation in developing the HR Plan and there is a good alignment between HR requirements, planning, implementation and control. Throughout the design process the bottom up and top down consultative approach was followed.

4.1.2. This plan still needs to be translated to District HR Plans and the Metro District Health Systems HR section (MDHS-HR) is responsible to ensure that the sub-district structures are informed, oriented and develop their plans in line with the provincial plan.

4.1.3. The WCDOH is currently embarking on an exercise to update the skills, experience and qualifications profile as required by the CSP and auditing the gap between the plan and the current staff profile. This exercise will only be completed in the next financial year.

4.1.4. The HR plan has been costed and there is a funding gap at a macro level to cater for the increase in staff numbers by 7,141 in the proposed new structure:

4.1.4.1. There would be an estimated additional cost of R1 166 334 631 to fill the current posts and the new posts required for the CSP structure based on the current staff salary structure.

4.1.4.2. The cost of implementing Job Evaluation and Occupational Dispensation (JE) Benchmark salaries for the filled non-health professionals posts would be R16 437 761.
5. ORGANISATIONAL DESIGN AND ESTABLISHMENT

5.1. The new organisational structure and design has been well thought out and is based on sound planning and is a realistic model of service requirements within available funds. A new macro organisational structure for the WCDOH was approved in 2007 and a customised exercise at a micro level is currently underway. The new organisational structure aligned to the CSP increases staff numbers by 7,141 (26,535 staff to 33,676 staff). This is not reflected in the PERSAL system or staff vacancies as all unfunded positions have been deleted from PERSAL. Only priority posts are being filled. Medical posts have preference when posts are being filled and there needs to be more of a balance in the filling of posts as both line and medical posts are important.

5.2. When one reviews the HR plan it is evident that many lower level jobs are being replaced by fewer higher level skilled jobs. Existing staff are being trained and re-skilled. In the long term fewer people at a higher skills level will do this job and this will save money. The WCDOH’s aim is to reduce the salary plus agency costs from 65% to 63% of the total budget.

5.3. Although job descriptions are currently in place, the next phase of the HR plan will focus on developing job competencies including identifying skills, qualifications and experience and aligning this to training plans and performance agreements.

5.4. According to the planning department, currently about 70% of the beds and staff have been redeployed on the basis of the CSP. There have not been major problems with the reallocation of staff. An example was given of a laundry that was closed and 200 staff needed to be reallocated. The exercise was done successfully with no disputes arising.

5.5. The district management structure has recently been put in place. The Metro district has been divided into 4 sub-district structures managed by directors who are responsible for all health issues in the sub-district (excluding training and support services), Metro Health (MHS) and emergency services. They are also in charge of
community health care centres, clinics, district hospitals and NPOs for community centres.

5.6. No in-depth analysis was undertaken of management levels, ratios and grading. However, no information was received that this was a problem.

5.7. There is a parallel system of PHC provision by both local and provincial government in the City of Cape Town Metro District, and the issue around the provincialisation of local government services is unresolved.

5.8. Another ongoing structural problematic area is joint staff. There is a problem between the WCDOH and the universities regarding the accountability of joint staff. Both the WCDOH and the universities want joint staff to report to them. The WCDOH pays a portion of the joint staff salaries yet joint staff has reportedly no accountability to WCDOH. There are significant differences in management practices between the universities and the WCDOH and this appears to be at the root of the problem.

“The tension between UCT and WCDOH is due to unclear direction from national health. The key issue is who employs the professors. Both University and Province want to be the employers. On a personal basis there is a good relationship with the deans and good cooperation at an operational level. The problem is at a political level.”

5.9. There is a need for a national policy to resolve the issue. It was recommended that the Minister drives the development of a position statement on the major issues around academic complexes and that these be resolved at a national level.

6. **RECRUITMENT**

6.1. A statement was made that the Western Cape is a desirable location to work and recruitment of staff is not a problem. There is the perception that the WCDOH is underfunded and that this limits the ability to recruit new staff. The WCDOH has
identified the posts that they can afford and deleted the balance of the posts from PERSAL. This has meant that the current vacancy rate is about 2.5% while the real vacancy rate is considerably higher. For example, the PERSAL vacancies for nurses are 2-3% but the real vacancies for nurses based on the HR plan of staff requirements are between 16-25%. This varies depending on the category of nurse’s posts.

6.2. It was reported that the DPSA recruitment process is bureaucratic, and that recruitment takes on average between 3 to 6 months. The advert stage is 30 days, then a selection committee needs to be set up and this all takes time. This results in lengthy recruitment periods. There is a debate on whether recruitment is a line function or HR function. HR maintains that it is a line function that they provide support on. Both sides blame the other for the length of time to recruit.

6.3. There is a shortage of nurses in South Africa because the supply of nurses is less than the demand. WCDOH challenges include:

6.3.1. The OSD has helped the situation in the short term by increasing salary levels. But it has also resulted in problems. There were 1,300 grievances in the WCDOH around OSD.

6.3.2. Another problem is that the economy is making nurses resign to take their pension to pay off debt and they then return as agency nurses.

6.3.3. The overseas market is attracting people away.

6.4. It was reported that the output of nurse training is inadequate. A statement was made that “nursing is no longer a career of choice as it was in earlier times and the public image of nursing has declined”. An example was given stating that more than 1,000 nurses in WC left in 2008 while only 273 new trained nurses entered the system. What is interesting to note is that there is not a short supply of applicants for nursing, as there are over 3,000 applications each year of which only a few are selected (+/- 500) due to the quality of applications and the number of training facilities available.
6.5. The WCDOH has developed a plan to train more nurses and retrain existing nurses and to attract other nurses to alleviate the skills shortage, but the plan is unfunded.

6.6. The WCDOH has implemented a bursary system for nurses. This means that the nurses are students rather than employees and do not have access to all the benefits. This has saved the WCDOH considerable funds.

6.7. A large cost driver for staffing is agency costs. The WCDOH has a large number of agency staff on their payroll. In the tertiary, regional and EMS division about 20% of the nursing staff are reported to be sourced from agencies. There is a focus on replacing agency staff with permanent staff but this is complicated by the fact that:

6.7.1. Many staff members prefer to be contract staff;

6.7.2. There is a preference by staff to be employed temporarily with an additional income of approximately 37% rather than be employed permanently with benefits.

6.7.3. Staff members have had to resign and cash in their benefits due to financial pressure and then return the next day as agency staff.

6.7.4. Recruiting and replacing staff who resign is a length process and agency staff are used to fill the staff gap.

6.8. The recruitment of agency staff is centrally driven and procured. Head office is not always aware of the specifications and functions or skills required to work. An example was given in Khayelitsha where agency staff could not perform certain functions needed yet they had to be paid for a full service. For example, if they send a doctor who cannot do what they need (e.g. insert a chest drain), then the doctor is of no use. This has been resolved by sub-districts providing specifications for Head Office to use.
7. PERFORMANCE MANAGEMENT

7.1. There is a well developed performance agreement policy framework in place. There are performance agreements in place for all employees and HR indicated that the process has been entrenched.

7.2. The linking of performance agreements to the strategic targets of the WCDOH down to district level is currently being put in place. The following statement was made: “Right now there are performance agreements in place for all employees but the link to strategic objectives stops at sub-district level i.e. if the sub-district plan is to do X number of pap smears then the performance agreement of the facility manager must be a % of the target pap smears. This is currently not in place. But it is going to be in place in the new financial year”.

7.3. There are criticisms though that the performance agreement system is not working as effectively as is hoped. The majority of facility managers are not complying with the policy. In addition, problems were experienced in the evaluation being seen primarily for reward purposes. It was suggested that the solution was to promote compliance by enforcing disciplinary measures; re-training in the use of the performance appraisal tool; or implementing the new approval system that has been piloted at the WC-Premier’s Office.

8. RETENTION

8.1. The OSD has been an attempt to retain staff. It was successful in the short term but it brought financial pressure to bear on the WCDOH. In addition, the private sector responded by increasing their pay scales to achieve parity with the WCDOH thus neutralising the OSD impact.

8.2. It was noted that there is a challenge to recruit staff in rural areas and this is affecting service delivery. It was suggested that one of the reasons was that training needed to be provided in the rural areas to encourage people to stay in these areas once
training was complete. This concept has been incorporated into the training plan to address the nurse shortage.

8.3. The WCDOH is actively developing strategies to address the challenges of retaining staff but funding problems limit the implementation of these plans. The current HR Plan that focuses on training and retraining of staff should impact on the retention of staff as it:

8.3.1. Recognises skills, qualifications and training and provides training opportunities to staff.

8.3.2. Focuses on competency based selection and recruitment.

8.3.3. Provides progression and career planning for staff.

8.4. The WCDOH is aware that there is a succession problem because more than 40% of the staff is younger than 40 years of age while half of the employees are over 40 years of age and just under 10% are over 50 years of age. They have implemented a mentorship programme to assist with succession planning.

8.5. The decision to do away with “rank promotion” due to length of service has left a gap in HR’s ability to retain good technical skilled staff. It limited the WCDOH’s ability to promote staff based on technical skills. Rather the only promotion option left was promotion into management positions.

9. REWARDS

A senior manager commented that the OSD has had a big impact at GSH. Salaries were adjusted and the majority of people were happy, leaving the unhappy few making news in the media. OSD has improved morale.

9.1. The WCDOH knew that there were going to be problems before the OSD was implemented and tried to manage these in advance through the following:
9.1.1. The WCDOH identified that the budget was insufficient and notified national and provincial treasuries.

9.1.2. WCDOH developed 25 instructional circulars to assist the department implementing the guidelines and a multi-sectoral team was set up to implement the policy.

9.1.3. WCDOH feel that the upgrades were done fairly and well.

9.1.4. There might have been some problems in their own audit and they dealt with these. They do not accept the finding of the national audit of the OSD and feel that “the report is not worth the paper it was written on”. The major concern centres on the lack of health knowledge of the national audit team. It is felt that the national audit reports were not an accurate reflection of the process.

9.2. Job grading between the provinces varies greatly. An example was made of the same job function that is graded as a 12 in the WC and a 14 in KZN. It was suggested that there was a need for national standards on job grading.

9.3. In the audit reports a problem has been identified with the payment of overtime:

9.3.1. The policy is very clear but not the interpretation thereof. There was a perception by doctors that the overtime was to compensate them for poor salaries. Therefore, they did not want to apply the guidelines which said that (a) there must be a need for the overtime, (b) there must be a contract in place and (c) that it was a payment in advance for overtime that must be done; therefore, they should not be paid overtime while on leave. There has been a great deal of resistance to the implementation of the policy. The doctors do not want to be monitored, especially the joint staff.

9.3.2. In the case of normal overtime - certain job functions like EMS exceed the overtime limit of 30% of their salary due to the nature of their job and skill shortages. As this can be justified, there is an authorisation process in place.

9.4. The WCDOH compensation policy makes allowance for increases in salary to retain good staff and also to match a salary offer.
9.5. A major area of concern is the cost of absenteeism and employee leave and this has been identified in the HR Plan as a priority area for attention. An analysis of the WCDOH showed that there is poor management of leave and an abuse of sick leave that is potentially costing the WCDOH millions.

10. LEARNING AND DEVELOPMENT

10.1. The CSP outlines the changes needed in the health system structure, and the HR strategy links to these structures. The CSP spells out the staffing numbers and staff-mix. Shifts are required in the current establishments to bridge gaps in numbers, as well as retraining. An example was given with regards to nursing assistants. “There is an oversupply of nursing assistants and an under supply of enrolled nurses and professional nurses. The WCDOH is developing a nursing training strategy to deal with this.”

10.2. The WCDOH is currently undertaking a skills, qualifications and experience audit at all levels of the WCDOH. Once this has been completed a plan will be developed to bridge the gap through redeployment and retraining.

10.3. The current skills plan is not aligned to the HR strategy but that will change in the next financial year. Constraints to implementing the skills plan will include financial and time constraints. The WCDOH is currently short staffed and staff have indicated that they do not have time to go on training. Another problem is that medical training is given preference and it is difficult for non medical personnel to access the training that they need to perform their job function. While the plan is sound and comprehensive, it will take time to develop and implement at all levels. But, the WCDOH has the depth of management needed to develop and implement the HR Plan.

11. HR INFORMATION SYSTEMS

11.1. It was reported that the PERSAL system does not include ghost workers but the information on skills and qualifications of staff is not up to date. The PERSAL system allows staff to be entered without filling in all the information and this is a problem as
it allows information gaps to occur. There is currently a manual auditing process underway to update the PERSAL system. Once this is complete PERSAL can be used for the implementation of the HR Plan. In addition, due to the financial constraints, all unfunded and vacant posts have been deleted from PERSAL. Advertisement of new posts is done centrally by HR as is all the paperwork around the appointment and PERSAL loading.

11.2. Poor filing of leave forms and lack of timeliness in submission of these forms causes delays in approvals. Currently all HR data such as leave, absenteeism, salary and overtime is captured centrally. There is a problem with the currency of the information in the system due to a backlog of capturing. The CSP attempts to alleviate this pressure through appointing an HR officer in each district office.

12. RECOMMENDATIONS

12.1. DELEGATIONS, ACCOUNTABILITY AND RESPONSIBILITY

12.1.1. Institutional and line managers need more direct input in the funding of posts to enable them to apply the delegation of authority to recruit staff. A balance needs to be achieved between budget controls and delegation of authority.

12.2. INTEGRATION AND CO-ORDINATION

12.2.1. There needs to be better coordination and alignment with NDOH which should play a more active role in developing norms and standards for all aspects of HR.

12.2.2. NDOH should consult with provinces before implementing new policies and ensure that there is sufficient funding.

12.3. HUMAN RESOURCE PLANNING

12.3.1. The HR Plan needs to be aligned to the budget constraints and a phased staff training and recruitment strategy developed.
12.4. STAFF ESTABLISHMENT AND ORGANISATIONAL DESIGN

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

12.4.2. The issue of joint staff needs at WCDOH and universities needs to be addressed at a national level to find a resolution to the impasse.

12.5. RECRUITMENT

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

12.5.2. The plan developed to address the shortage of nurses needs to be agreed and funded.

12.6. PERFORMANCE MANAGEMENT

12.6.1. The performance management system needs to be reviewed and reassessed.

12.7. RETENTION

12.7.1. A succession plan should be developed to ensure the ongoing sustainability of the strong leadership within the WCDOH.

12.7.2. A retention strategy is needed to reduce staff turnover and retain skilled staff

12.8. REWARDS

12.8.1. A plan needs to be developed to address the problem of employees leaving the WCDOH and becoming temporary employees to access the benefit portion of their salary in cash rather than medical aid and pension benefits.
12.8.2. The abuse of absenteeism and poor management of leave is a major problem in the WCDOH and a strategy needs to be developed to resolve this problem.

12.8.3. 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:

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

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

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

12.9. LEARNING AND DEVELOPMENT

12.9.1. A learning and development plan needs to be completed and aligned to the HR Plan and CSP at district and institutional level.

12.10. HR INFORMATION SYSTEMS

12.10.1. The PERSAL system audit needs to be completed to provide the information needed to support the implementation of the HR Plan and CSP.
Information Management

1. INTRODUCTION

**Box 4: Key findings from the Information Management review**

1. In the absence of national norms and standards, the WCDOH has made significant progress in the implementation of a new health information system, albeit at high costs.

2. The WCDOH is concentrating on efforts to strengthen the provincial leadership’s use of health information.

3. The health information system has provincial guidelines and standards (developed in consultation with the City of Cape Town) to ensure coherence and alignment between planning, implementation and monitoring and evaluation tools.

4. The WCDOH received a silver medal at the Premier’s Annual Excellence Award ceremony for the implementation of the Primary Health Care Information System at community health centres, but lack of feedback on reports submitted to NDOH is a challenge.

5. Implementing the HR plan, the WCDOH will soon conduct a skills competency assessment of all staff and M&E competencies will be integrated into managerial performance agreements and assessments.

6. The integration of M&E with the Red Flag system (a facility-based supervisory tool) has promoted better follow-up and feedback on data submitted by facilities.

7. The data audit review meetings assist with analyses of data and motivate officers to use data from their facilities for planning and decision making.

8. The WCDOH conducts district ANC surveys to identify the HIV prevalence and assist with plans for the burden of disease within districts.

9. The dual systems (the district health information system and the ARV monitoring system) have exacerbated workload and increased reporting requirements to various divisions at national level.

1.1. M&E is one of the thriving components in the overall management of health services in the WCDOH. The WCDOH has made significant progress in monitoring provincial health status and health service indicators.
1.2. Contributing towards strengthening the health information system is the development of provincial guidelines and standards (in consultation with the City of Cape Town) and ensuring coherence and alignment between planning, implementation and monitoring and evaluation tools. Facility and sub-district and district managers are delegated to interrogate data before submitting to higher levels. This ensures that data is verified at the point of collection and wide variations are addressed and corrected. Each programme captures performance indicators to monitor its implementation towards meeting the objectives of the CSP.

1.3. NDOH has not provided direction towards a simplified health information system. There is no minimum data set that produces one integrated report. There is also a lack of alignment between planning, implementation and monitoring and evaluation. The WCDOH submits quarterly reports to NDOH and Treasury. These reports are reviewed by managers at all levels and are approved by senior managers and the HOD before they are submitted. There is little communication or feedback from NDOH to WCDOH programme and line managers around M&E.

1.4. A significant amount of time and resources, in the last 18 months, was spent on developing and establishing a health information structure; procuring hardware and other equipment; and improving data quality through tracking data, mentoring and coordination at all levels. Through this there has been a significant improvement in data quality, data flow and staff understanding of their roles and responsibilities in data management. The WCDOH is reviewing its M&E indicator set, with a goal to reduce the number of indicators and align indicators to CSP and APP.

1.5. The WCDOH has previously implemented a top-down approach while setting up health information structures. This ensured top and senior management accountability and involvement to develop information infrastructure that was suitable and aligned to the CSP and APP. This enabled managers to monitor progress towards attainment of service targets.

1.6. Following the HR plan, the WCDOH will soon implement a skills competency assessment of all staff and M&E competencies will be integrated into managerial performance agreements and assessments.
2. USE OF INFORMATION FOR DECISION MAKING

2.1. Monitoring and evaluation (M&E) appears to be gaining momentum towards meeting its objectives as envisioned by the WCDOH. At provincial level, there is a functional M&E Committee, chaired by the HOD that meets every quarter with all programme managers to discuss programme performance against the APP and CSP. This demonstrates senior management’s commitment towards improving both programmes and health information systems. The WCDOH strives to enhance the health information systems as a whole rather than focus only upon specific diseases. Thus, the WCDOH concentrates on efforts to strengthen the provincial leadership for both health information production and utilisation.

2.2. Because of the vast amounts of service information being generated at various levels in the system daily and to use the information optimally for management purposes, the WCDOH has developed a dashboard to monitor the performance of the eight budget programme plans. With the limited number of indicators, this dashboard will generate current data for decision-making.

2.3. Currently there is inadequate analysis, interpretation and utilisation of information for decision-making at lower levels. Thus in the new financial year, the focus will be on data analysis and interpretation for decision-making at all levels. The WCDOH will implement a bottom-up M&E management approach to ensure that data quality and management is controlled at lower levels. It is expected that this should improve the quality of reports sent to the top managers at provincial and national levels.

2.4. Although the financial, supply chain management and service data M&E systems remain vertical, there are attempts to integrate programme reviews drawing from these three data sources. The performance of each programme including strategic programmes is reviewed at the quarterly M&E committee meetings at each health care level.

2.5. The integration of M&E with the Red Flag system (a facility-based supervisory tool) has promoted better follow-up and feedback on data submitted by facilities. This process also promotes the development of action plans to address gaps identified by an audit and ongoing monitoring of performance until all data gaps are addressed.
The WCDOH conducts district ANC surveys to identify the HIV prevalence and develop plans for the burden of disease within districts.

2.6. Currently, there are a number of issues that need to be addressed to improve the quality of data and the utilisation of the information generated. These include:

2.6.1. Limited skills of recruited staff to analyse data for decision-making: “We have a lot of information but not enough resources to interrogate the information for decision making”.

2.6.2. At facility and district levels, it was reported that there are information officers who can capture, collate data and submit data but are not able to analyse and interpret data. The posts of health information managers have remained vacant for longer than 6 months, as these positions are budgeted for on a Level 9 salary scale.

2.6.3. Minimal focus on M&E during facility supervisory visits. The WCDOH has now integrated the M&E data audit into the facility supervisory manual to address this gap and to facilitate interpretation of data, timely feedback on data submitted and implementation of corrective action at facility level.

2.6.4. Limited funding for M&E: “There is no specific budget for M&E and the manager has to compete for funds in the general pool. There are too many indicators resulting in a mass of data.” There are insufficient data capturers and information officers. Service provisions are perceived to outweigh the needs of support services, in terms of recruitment of staff and procurement of equipment. Medical posts and equipment were reported as a priority.

2.6.5. Data submitted by Non-Profit organisations (NPOs) through CBS needs to be accurate, yet, there is lack of staff to adequately provide technical assistance to funded NPOs to ensure the validity of the data. The NPOs are funded per carer and each carer is given targets. Some of the carers lack numeracy and literacy skills and are not able to understand the data collection tools. Where data could be verified through patient clinic files, this has been done, in particular, for step-down-care services; however, this area remains a challenge.
2.6.6. There is minimal security to access the database.

3. **DISTRICT HEALTH INFORMATION SYSTEM (DHIS)**

3.1. The DHIS software is limited and is reportedly inadequate to meet the needs in the WC Province. Hence, the WCDOH has developed its own health information system, called Sinjani that responds to the prescribed national data elements but is more responsive to provincial M&E needs. The Sinjani system produces the required ‘DHIS’ reports to the NDOH. The Sinjani system is operational in all six districts. In the metro districts, the City of Cape Town uses the DHIS system. However, based on a mutual agreement from May 2009 the City of Cape Town will use the Sinjani system, thus moving away from parallel information systems.

3.2. At the source, data collection is performed manually using paper-based data collection tools such as tick-sheets and registers. Thereafter, the data is aggregated and entered into the electronic database at sub-district levels in the metro district and district level in rural areas. The data is exported through the various levels of the system i.e. sub-district, district, province and national. The routine data monitoring is complemented by six-monthly and annual audits. In addition, there are multiple data sources on the state of service delivery, including surveys, censuses and special studies conducted in the province.

3.3. Although the WCHIS is a comprehensive system of routine data collection with facilities capturing data on a regular monthly basis there are a range of problems associated with M&E data elements prescribed by national and with ensuring good data quality. For national prescribed data elements, the problems include:

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

3.3.2. The indicator list in the national indicator data set (NIDS) has not been updated since 2005. Managers have proposed additional indicators instead of reducing them. For example, the WCDOH has implemented dual therapy for PMTCT programme since the year 2000 and had added this indicator in their provincial data element list.
3.3.3. Some of the indicators are confusing, not standardised and are without unambiguous and clear definitions (e.g. for the nurse workload indicator it is not clear which category of nurse is included and it is also not clear how many days to include in cases of sick leave and study leave).

3.3.4. Indicators are occasionally changed, or added to, by programme managers at national level without consultation with provinces and clear written guidelines.

4. **ARV MONITORING AND EVALUATION**

“There is a DHIS report and DORA report and programmes have their reports for national and province. This means that each of the district managers had to prepare multiple reports that predominantly report on the same information. All go to National – in their own format. If they just looked at the DHIS they would find all the information”.

4.1. The ARV and TB M&E system has a number of significant weaknesses including:

4.1.1. There are no clear guidelines, norms and standards from NDOH regarding the ARV information system.

4.1.2. As a result the WCDOH, similar to other provinces, has developed its own indicators that are included in the Sinjani system. However, the province continues to use registers (e.g. VCT, PMTCT) as prescribed by NDOH. The province has included all reporting requirements into monthly and quarterly reporting structures to comply with DORA and national requirements. Each facility reports to the sub-district office, the sub-district to the district office and the district to the province.

4.1.3. The challenge of poor quality of data and slowness in compiling and submission of data remains at facility level.

4.1.4. The data is quantitative, and qualitative information to support the data is lacking.
4.1.5. There are electronic TB registers; however, the data capturing remains poor. At sub-district level data is captured manually on paper-based TB registers and submitted to the district where electronic data is compiled.

4.1.6. With the decentralising of M(X) DR TB services, the province had initially maintained two registers for two main centres. However, facility based MDR registers have now been introduced.

4.1.7. The TB cure rate’s data quality has improved because of verification measures that are in place. The coordinators compare three sets of documents (blue card, paper register and electronic register) against each other to identify differences.

4.1.8. The dual systems (the district health information system (Sinjani) and the ARV monitoring system) have exacerbated workload and increased the reporting requirements required by various divisions at national level.

4.1.9. The lack of national norms and standards has resulted in large numbers of indicators developed without standardisation and created difficulty in their calculation and interpretation.

5. OTHER M&E ISSUES

5.1. The WCDOH has a Health Information Management Unit, headed by a chief director that manages health information infrastructure and is responsible for conducting health impact assessments for the province.

5.2. Within the Metro district, the Metro District Health Services (MDHS) M&E unit personnel and their counterparts from the City of Cape Town hold monthly and quarterly meetings to discuss data flow and service targets.

5.3. The province is moving towards streamlining the data flow and has developed data flow processes that promote greater communication between those responsible for data collection with those responsible for programme implementation and data management. The data flow was outlined as follows (example from a MDHS):
“The data is captured by data clerks at facility level, sent to the facility manager that verifies and submits to information officers at sub-district level that verifies and submits to a sub-district director who verifies and approves and is thereafter captured through HIS and is submitted to the MDHS-M&E Manager. The manager verifies and submits to a senior manager at DHS before it is submitted to M&E unit at provincial level”.

5.4. CENTRAL HOSPITALS MONITORING AND EVALUATION

5.4.1. Central hospitals have their own health information systems. For example, Groote Schuur Hospital (GSH) uses CLINICOM for service related data. The hospital has departmental morbidity and mortality committees that hold meetings monthly to interrogate indicators. From CLINICOM, the business status reports are compiled and submitted to the Hospital Board and the WCDOH.

5.4.2. Over the past two years, GSH has focused on standardising M&E indicators. Discrepancies between electronic data and paper-based records have been reconciled. Each department has its own M & E indicators that are not integrated between departments and linked to budgets. The service, supply chain and financial data for each unit are all captured and analysed separately. The inability to obtain information in real time affects negatively on planning and decision-making with regard to efficiency in service delivery. Problems with clinical data quality at ward level still persist.

5.4.3. GSH plans to develop a Financial Business Unit (FBU) model that will facilitate integration and joint analysis of clinical, financial and supply chain indicators.

5.5. COMMUNITY HEALTH CENTRES

5.5.1. During the 2007/08 financial year, the WCDOH introduced and implemented the primary health care information system (PHCIS) at community health centres in the
metro district that allows a unique identification number for each patient accessing the service. This is linked to hospitals within the province. There are plans to rollout this system to rural districts. The WCDOH received a silver medal at the Premiers’ Annual Excellence Award ceremony for implementing this system. It has been found that the waiting times have been significantly reduced and there are more than 1 million patients currently registered on the system.

6. RECOMMENDATIONS

6.1. OVERALL M&E

6.1.1. Establish accountability at NDOH for M&E by clarifying roles and responsibilities of national and provincial DOH.

6.1.2. Develop an integrated framework (e.g. service data, BAS) at NDOH for implementation of M&E across all health service platforms which are easy to monitor to ensure accountability.

6.2. USE OF INFORMATION FOR DECISION MAKING

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

6.2.2. Complement quantitative data with appropriate qualitative data to inform decision making.

6.2.3. Promote, support and reward analysis and interpretation and use of data for decision making at facilities.

6.2.4. Develop a data dissemination and feedback plan that integrates human, financial, and supplies data with facility service output data.
6.3. DISTRICT HEALTH INFORMATION SYSTEM (DHIS)

6.3.1. There need to be a policy on a strategic information system that guides provinces to streamline data flow and outlines a minimum data set and system (inclusive of HR, finances, hardware, software, tools, guidelines and manuals) which will produce one report to serve various stakeholders.

6.3.2. The DHIS needs a thorough review by the NDOH and linkages between PERSAL, supply chain management systems, BAS should be established.

6.3.3. Strengthen data validation processes.

6.4. ARV MONITORING AND EVALUATION

6.4.1. NDOH should review the business plan template, reduce the number of indicators, streamline reporting requirements and remove repetitions.

6.4.2. Develop guidelines on integrating the paper-based registers into an electronic system.

6.4.3. Define coordinating mechanisms for the horizontal use of data generated from vertical programmes.

6.5. OTHER M&E ISSUES

6.5.1. Review the requirement to have a central SLA with SITA and determine whether provincial/SITA service level agreements would improve accountability and efficiency.
Medical Products, Laboratory

1. INTRODUCTION

Box 5: Key findings from the Medical Products and Laboratory review

1. Laboratory services, blood products and drugs are key cost drivers in WCDOH and TB drugs are second to ARVs as one of the cost drivers in strategic programmes.
2. Fiscal discipline is promoted to limit over-expenditure and control wastage. The drug and laboratory financial statements are reviewed monthly at all levels as key priorities in the WCDOH by review committees at provincial and sub-district or district levels including the central hospitals.
3. There was a streptomycin drug stock-out in the province and the supply problem was exacerbated by the centralised drug clearing house.
4. Budget allocation to the WCDOH from NDOH and National and Provincial Treasuries does not consider medical inflation, in particular for drugs and laboratory services.
5. The overall gate keeping and monitoring of the laboratory service requests and drugs expenditures per facility and the chronic dispensing unit are best practices, which could be replicated in other provinces.

2. MEDICAL PRODUCTS

2.1. Laboratory services, blood products and drugs are key cost drivers in WCDOH. At provincial level, there is a resource committee in place that reviews the cost-effectiveness of drugs, and there has been a reduction of expenditure on drugs from 10% to 8.5% over the past financial year.

2.2. Fiscal discipline is promoted to limit over-expenditure. There are review committees at sub-district or district levels and central hospitals, established to monitor expenditure of drugs and laboratory services and control wastage. The drug and laboratory financial statements are reviewed monthly at all levels as key priorities in the WCDOH.
2.3. TB drugs are second only to ARVs as one of the cost drivers in strategic programmes. During 2008/09 there was a streptomycin drug stock-out in the province and the supply problem was exacerbated by the centralised drug clearing house.

2.4. Budget allocation to the WCDOH from NDOH and National and Provincial treasuries does not consider medical inflation, in particular, drugs and laboratory services.

2.5. The overall gate keeping and monitoring of the laboratory service requests and drugs expenditures per facility and the chronic dispensing unit are best practices, which could be replicated in other provinces (see Appendix 4 for an overview of the chronic dispensing unit).

2.6. The essential drug list (EDL), prescribed by national is reviewed and revised to correspond with the case mix per facility serviced. The EDL is reviewed every 2 years with the latest review conducted in 2008.

3. CENTRAL HOSPITALS

3.1. The central hospitals have their own supply chain management system additional to the central medical depot used by the WCDOH. In central hospitals, there are active drugs and therapeutic committees that hold monthly meetings. The drugs utilised are closely monitored and additional drug requests (outside the norm) in central hospitals and the four mental health hospitals require motivations that are submitted to the chief operations officers for approval. There is an early warning system in place for monitoring drug stock. Stocks are obtained directly from different suppliers because of the large quantities involved.

4. ARV DRUGS

4.1. The ARVs are funded through the conditional grant. Although most ARVs have had a reduction in cost, these remain as one of the three main cost drivers in the HIV and AIDS programme. Nonetheless, drug prices were reported as not affecting the ARV budget. The programme has its own depot for better management of drug supply,
ordering and distribution. The province has not experienced any losses or shrinkages. “There has never been a stock out of drugs. The HIV unit has a very good pharmacist who is good at forecasting costs”.

4.2. The 1st line drug cost per patient per month is R466 and the 2nd line ARVs cost R660 per patient per month and annually it costs R5 600 and R7 920 to maintain a patient on 1st line or 2nd line ARV drugs, respectively. All other medication required to treat opportunistic infections are funded through the equitable share and are ordered through using the EDL at facility level.

5. **TB DRUGS**

5.1. The WCDOH has experienced streptomycin stock-outs for MDR TB and an alternative protocol for MDR TB has been developed until there are adequate supplies. Overall, TB drug supply was identified as a problem as there are a limited number of companies selected to supply TB drugs. Obtaining supplies from a centralised drug clearing house was reported to have worsened streptomycin drug availability.

5.2. It was reported that the current regimens used to treat M(X) DR TB are not regarded as best practice. There are new MDR TB regimens that have been proposed for use by the province. The drug provision draft document has been developed but not costed. However, it is estimated that the provision of the new regimen will cost approximately R10 to R12 million with R2 million for laboratory costs associated with TB treatment. A new TB Management policy document including M(X) DR TB has been developed but not yet approved and adopted by the province.

6. **LABORATORY**

6.1. The WCDOH procures laboratory services from laboratories managed by the NHLS and for these services the province pays according to the national price list. In addition to these laboratories, there are laboratories, located at central hospitals, that are jointly managed and supported by tertiary institutions and the central hospitals.
6.2. The goal of the WCDOH is to reduce the turnaround time of blood test results at all health care levels in the province and reduce wastage by 10% of the total budget allocation for laboratory services. Currently, the budget is R400 million annually.

6.3. Laboratory and drug costs are allocated to facilities based on past expenditure trends and case mix of that particular facility. Drug and laboratory budgets reside at the lowest level of activity and are part of the cost centre hierarchy. To reduce expenditure, the NHLS offers discounts for early payments.

6.4. The funding of future district laboratories as a result of decentralisation will be through signing of service level agreements (SLAs). Each district laboratory will have its own account with NHLS. These laboratory services will be paid for by money allocated based on district operational plans.

6.5. The WCDOH provides quarterly financial statements of laboratory services by facilities to assist managers identify areas needing control to reduce inappropriate laboratory requests. The key informants also reported that the courier services for laboratory test results have improved over the past year across districts allowing doctors to access results within one day to support their clinical care decision-making.

6.6. The challenges affecting efficiency are:

6.6.1. The laboratory costs are very high, in particular, TB tests that are attributable for R30 million of the R400 million laboratory budget for the province.

6.6.2. The tariffs of laboratories have increased by 6% over the past year while the volume mix has also increased by 14%, resulting in the overall increase of laboratory services.

6.6.3. Facilities are unable to save or cut laboratory tests because of reportedly unrealistic facility budget allocations that do not match the case mix and volume of test requests from the facilities.
6.6.4. Health service needs supersede support needs within the province in terms of receiving urgent attention and funding.

6.6.5. High expenditure at health facilities because of inappropriate laboratory requests. For example, the Khayelitsha sub-district laboratory costs are reported to be twice as much as those of Mitchell’s Plain sub-district. The reasons given were that of inexperienced health care providers, as stated by one informant: “Therefore the cause is inexperience of junior doctors that work in Khayelitsha. Solving the problem is not about developing the policies but rather training the doctors on appropriate tests for different conditions.”

6.6.6. It has been found that in some sub-districts, only 70% of test results are recorded and filed in correct patient folders. These lost results inflate the costs by 30%.

6.6.7. The medical doctors ordering tests do not always include their identification on the requests forms making it hard to trace the source of laboratory requests. As of January 2009, the laboratories were advised not to process requests without doctors' identification information.

6.7. It is reported that in Khayelitsha sub-district, 85% of test results have a turnaround time within 48 hours. Nevertheless, approaches that are currently implemented to decrease turnaround time and reduce wastage are:

6.7.1. The development of a web-based results support system that makes results accessible to clinics immediately when results are recorded by staff at the laboratory. The effectiveness and responsiveness depends on functional IT infrastructure and good communication lines (in particular in rural areas).

6.7.2. The WCDOH plans to decentralise the laboratories, as part of the hospital revitalisation programme, to increase access and reduce turnaround time by shortening distances to laboratory services. Decentralisation is included in the APP, however, there is uncertainty whether this will be realised because of limited funding.

6.7.3. To reduce the number of laboratory test requests, the province is implementing a gate-keeping service where administrators and clerks are placed at facilities to review
the laboratory requests submitted by clinicians for appropriateness and cost-effectiveness. This initiative has been successful in reducing duplication of laboratory requests, bottlenecks and the laboratory costs. This service is performed manually and will soon become electronic.

7. RECOMMENDATIONS

7.1. There should be a review of the legislation and regulation of the NHLS and SANBS.

7.2. The laboratory gate-keeping system and chronic dispensing unit are best practices, which should be documented, shared and replicated in other provinces, with the assistance of the NDOH.

7.3. The current laboratory waste control system should be augmented by cultivating a cost-reduction culture across service platforms and targeting clinicians to save on drug and laboratory costs.

7.4. Donor funding could be obtained to procure a software module that tracks the blood products in all facilities to reduce wastage, establish control from incorrect ordering and increase identification and tracking of unused blood products.
Technology and Infrastructure

1. OVERVIEW

1.1. This aspect was not reviewed in depth. However, some points arose during various interviews with regard to infrastructure:

1.1.1. There is an infrastructure plan for 2008/09 to 2010/11. This plan provides for buildings, equipment and maintenance aligned to service requirements as outlined by a five year strategic plan, annual performance plan, CSP and integrated development plans of the Local Authorities. The plan attempts to increase the value of fixed assets by ensuring full utilisation of existing buildings and generating of revenue from under-utilised assets. The plan is funded by the provincial infrastructure grant and the hospital revitalisation programme (HRP).

1.1.2. Capital equipment acquisition is overseen by two committees. One focuses on the 3 central hospitals. The second one focuses on sub-district structures. A list of prioritised equipment is reviewed through a reiterative process, and based on this a few items from the list are selected, dependent on the budget allocated.

1.1.3. The HRP budget allocation fluctuates, making it hard to plan and budget for capital projects requiring funding beyond a one year cycle.

1.1.4. Infrastructure grant to the province realised a saving of R18.7 million due to delays in transfers. In addition, there was an under-expenditure on the forensic pathology services conditional grant because two construction companies filed for bankruptcy.

1.1.5. The WCDOH has developed a 3 year internal audit strategic plan that outlines areas with high risks requiring corrective actions as recommended by the Auditor-General.

1.1.6. There are concerns that WCDOH is accountable for the money spent on infrastructure and yet it has little control on the infrastructure funding process (e.g. Department of Public Works).
1.1.7. Dire state of current infrastructure in some facilities (including security) impacts on the morale of staff and safety of both staff and patients.

1.1.8. In the WCDOH, the HRP funding was reported to be overfunded in 2008/09 by R 160 million, underfunded in 2009/10 and overfunded in 2010/11. As a result, the Khayelitsha Hospital construction has inadequate funding. The Mitchells Plain Hospital plan is also not yet approved due to limited funding. The WCDOH plans to re-direct the budget allocation for Mitchells Plain Hospital to complete the Khayelitsha Hospital.

1.1.9. The WCDOH has provincialised assets in 5 districts, the government vehicles as well as maintenance of buildings. This transfer has caused service pressures due to high demand for maintenance.

1.1.10. The BAS system makes it difficult to establish accurate costs for maintenance by hospital workshops.

1.1.11. The WCDOH cost on construction is 25% higher per square metre than the cost of construction per square metre in the private sector.

1.1.12. Clinics often have a shortage of space as a result of increased patient volumes. Because of the need for privacy with HIV counselling, more space is needed. However, due to limited funding, the WCDOH will not expand the number of ART sites.

1.1.13. Upgrading of George, Worcester and Paarl general hospitals is underway and funded by the HRP.

1.1.14. Groote Schuur Hospital (GSH) is strengthening the capacity of the newly developed Namibian Cardiac Unit at the Windhoek Central Hospital. This project requires R12 million and will be supported by the NTSG budget. However, it was reported that inflation has increased expenditure and the NTSG allocation has not increased. Hence, the money to support this project will be drawn from funds already committed elsewhere.
1.2. With regard to technology, points arose from the various interviews include:

1.2.1. A strategic plan for the digitisation of health technology was developed and an audit on technology was conducted by the WCDOH. The technology gaps were valued at approximately R300 million for the three central hospitals.

1.2.2. An integrated nuclear medicine system, with connectivity across three central hospitals, was procured through the Modernisation of Tertiary Services grant. This system supports medical staff to read, report, train and mentor others on investigations performed.

1.2.3. The implication of introducing the new technologies in central hospitals is likely to effect change in terms of staff requirements, competencies and professional demarcations. The extended scope brought about by new technologies affects central, regional and district hospitals. Moreover, it appears that, the WCDOH has taken into cognisance that, effective health technologies are not the only answer to meeting the health needs of its population. Greater focus on district hospitals, PHC and CBS can advance the WCDOH towards addressing inequities in health and developing comprehensive and sustainable health care systems. The CSP, APP and budget allocation demonstrates this commitment and vision.

1.2.4. The purchasing of technology equipment is based on national and provincial priorities. These priorities informed the development of a technology plan that was costed and reviewed through a reiterative process after wide consultation with all departments where service needs within each central hospital were discussed.

1.2.5. The asset registers are updated periodically but funding for tagging is required.

1.2.6. Restructuring and consolidation of central hospital services is ongoing and change management remains a challenge.

1.2.7. The joint agreements with the universities have had a significant influence on the decisions taken and priorities identified for the technology procurement plan.

1.2.8. There is lack of funding to replace depreciating equipment.
2. **RECOMMENDATIONS**

2.1. It is recommended that HRP commits to fund the full lifecycle of the projects and allocate the money to the province rather than the current annual funding system.

2.2. Documentation of the impact and outcomes of introducing new technology is necessary; in particular the use, interface and management of technology across service platforms.
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. 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: Recommendations contained in Western Cape Department of Health IST Report May 2009 and proposals for allocation of main responsibility for implementation and provision of input

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

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<td>Conditional grant allocation should be based on clear criteria and should reflect the burden of disease, services and training provided e.g. HIV&amp;AIDS, Tertiary and HPTD grants should be sufficient for the related requirements. Conditional grant money allocated by NDOH should not be withheld thereby causing over expenditure as was the case in 2008/09 for HIV/AIDS.</td>
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<td>The operational impact of national policy decisions (e.g. OSD, new vaccine programme) should be determined and must be agreed with the provincial health department prior to implementation.</td>
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<td>Financial management should be expanded to manage expenditure on the accrual basis.</td>
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<td>The IYM report needs to be expanded to include accruals. The report needs to be compiled on an accrual basis and not only on a cash basis to create a link between operational activity and costs.</td>
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<td>The IYM report needs to serve as an accurate forecast of expected expenditure and cost. It has limited use as a monitoring tool when it only reflects actual and expected cash flow, which is not linked to operational activity (expenditure).</td>
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<td>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.</td>
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<td>The NDOH needs to review the structure of the national health system, cost and amend national policies to fit the realities in provinces.</td>
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<td>There should be a review of the National Health Act in terms of provincial roles and responsibilities, its interaction with metropolitan municipalities and a review of items that have not been implemented to date.</td>
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<td>The impact of rationing of support services (e.g. maintenance) as a result of budgetary constraints requires regular monitoring to avoid long term consequences (e.g. run down facilities).</td>
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<td>Leadership and management strengthening should be part of the national health sector strategy and be linked to human resource development plans with appropriate M&amp;E indicators to monitor progress</td>
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<td>Promote structured planning and provide technical assistance at PHC level to ensure that targets are attained.</td>
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<td>Explore the causes of variations in the PDE, and monitor the impact of budget allocations between district hospitals to ensure that inequities in resource allocations are identified early and addressed.</td>
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<td>There should be a concerted effort to address the inequity in per capita PHC expenditure between districts.</td>
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<td>In relation to the NTSG and HPTDG, the NDOH should conduct grant evaluations, review their requirements and allocate appropriate funding to costed training and service plans, using objectively defined criteria.</td>
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<td>The WCDOH must consider decentralising decision-making to central hospitals</td>
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<td>boards and clinic committees can be formalised and put into effective operation.</td>
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<td>The NDOH must ensure that donor funding is coordinated, aligned and harmonised across the service delivery platform and explore health sector or earmarked budget support with its development partners.</td>
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<td>The current model, as suggested by the national comprehensive plan, of monitoring, accessing and delivering ARVs needs review to ensure that it is sustainable, affordable, equitable and addresses issues of access.</td>
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<td>Introduce affordable incentives for optimising clinical performance to encourage sustained cost savings practices and efficiency across service platforms.</td>
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<td>Identify, document and exploit positive-spill-over from global initiatives (funded by donors) to strengthen the WCDHS.</td>
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<tr>
<td>Explore inclusion of ARV dispensing for stable patients in the chronic dispensing unit network and work towards integrating the ARV procurement into the existing provincial supply chain management system.</td>
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<td>The impact of various initiatives that are currently piloted needs to be documented and shared in the country.</td>
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<td>Hospitals (L1-3) must strengthen the DHS by exploring hospital-based resources that can be capitalised to achieve integration, efficiency and quality of care.</td>
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**HUMAN RESOURCES**

**Delegations, accountability and responsibility**

Institutional and line managers need more direct input in the funding of posts to enable them to apply the delegation of authority to recruit staff. A balance needs to be achieved between budget controls and delegation of authority. | 1                           | 2                       | 2 

|
### Table 11: Recommendations contained in Western Cape Department of Health IST Report May 2009 and proposals for allocation of main responsibility for implementation and provision of input

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

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<tr>
<td>Integration and coordination</td>
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<tr>
<td>There needs to be better coordination and alignment with NDOH which should play a more active role in developing norms and standards for all aspects of HR.</td>
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<td>NDOH should consult with provinces before implementing new policies and ensure that there is sufficient funding.</td>
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<td>Human Resource Planning</td>
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<tr>
<td>The HR Plan needs to be aligned to the budget constraints and a phased staff training and recruitment strategy developed.</td>
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<td>Staff Establishment and Organisational Design</td>
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<td>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.</td>
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<td>The issue of joint staff needs to be</td>
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<tr>
<td>addressed at a national level to find a resolution to the impasse.</td>
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<td><strong>Recruitment</strong></td>
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<td>A thorough review and improvement of recruitment procedures and processes should be urgently conducted with a goal to shorten appointment times.</td>
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<td>The plan developed to address the shortage of nurses needs to be agreed and funded.</td>
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<td>The performance management system needs to be reviewed and reassessed.</td>
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<td><strong>Retention</strong></td>
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<td>A succession plan to be developed to ensure the ongoing sustainability of the strong leadership within the WCDOH.</td>
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<td>A retention strategy is needed to reduce staff turnover and retain skilled staff.</td>
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<td><strong>Rewards</strong></td>
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<tbody>
<tr>
<td>address the problem of employees leaving the WCDOH and becoming temporary employees to access the benefit portion of their salary in cash rather than medical and pension benefits.</td>
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<tr>
<td>The abuse of absenteeism and poor management of leave is a major problem in the WCDOH and a strategy needs to be developed to resolve this problem.</td>
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<tr>
<td>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.</td>
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<td>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.</td>
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<td>Rewards should be linked to organisational, employee and team performance.</td>
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<tbody>
<tr>
<td>Lessons learned from the current OSD implementation review for nurses should be captured to inform future implementation of other improvement initiatives.</td>
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<td><strong>Learning and Development</strong></td>
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<td>A learning and development plan needs to be completed and aligned to the HR Plan and CSP at district and institutional level.</td>
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<td><strong>HR Information Systems</strong></td>
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<td>The PERSAL system audit needs to be completed to provide the information needed to support the implementation of the HR Plan and CSP.</td>
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<tr>
<td><strong>INFORMATION MANAGEMENT RECOMMENDATIONS</strong></td>
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<td><strong>Overall M&amp;E</strong></td>
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<td>Establish accountability at NDOH for M&amp;E by clarifying roles and responsibilities of national and provincial DOHs.</td>
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<td>Develop an integrated framework (e.g. service data, BAS) at NDOH for implementation of M&amp;E across all</td>
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<tr>
<td>health service platforms which are easy to monitor to ensure accountability.</td>
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<td><strong>Use of Information for Decision Making</strong></td>
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<td>M&amp;E, based on a limited number of key indicators, needs to be built into every senior manager’s job description and performance appraisal across all levels.</td>
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<td>Complement quantitative data with appropriate qualitative data to inform decision making.</td>
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<td>Promote, support and reward analysis and interpretation and use of data for decision making at facilities.</td>
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<tr>
<td>Develop a data dissemination and feedback plan that integrates human, financial, and supplies data with facility service output data.</td>
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<td><strong>District Health Information System</strong></td>
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<td>There needs to be a policy on a strategic information system that guides provinces to streamline data flow and outlines a minimum data set and system (inclusive of HR,</td>
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<th>Department of Public Service and Administration</th>
<th>External stakeholders</th>
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<tr>
<td>finances, hardware, software, tools, guidelines and manuals) which will produce one report to serve various stakeholders.</td>
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<td>The DHIS needs a thorough review by the NDOH and linkages between PERSAL, supply chain management systems, BAS should be established.</td>
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<td>Strengthen data validation processes.</td>
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<td>ARV Monitoring and Evaluation</td>
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<td>NDOH should review the business plan template, reduce the number of indicators, streamline reporting requirements and remove repetitions</td>
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<td>Develop guidelines on integrating the paper-based registers into an electronic system.</td>
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<td>Define coordinating mechanisms for the horizontal use of data generated from vertical programmes.</td>
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<td>Other M&amp;E issues</td>
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<td>Review the requirement to have a central SLA with SITA and determine whether provincial/ SITA service level agreements would improve</td>
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<td>accountability and efficiency.</td>
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<td>MEDICAL PRODUCTS, LABORATORY RECOMMENDATIONS</td>
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<td>There should be a review of the legislation and regulation of the NHLS and SANBS.</td>
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<td>The laboratory gate-keeping system and chronic dispensing unit are best</td>
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<td>practices, which should be documented, shared and replicated in other provinces,</td>
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<td>with the assistance of the NDOH.</td>
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<td>The current laboratory waste control system should be augmented by cultivating</td>
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<td>a cost-reduction culture across service platforms and targeting clinicians to</td>
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<td>save on drug and laboratory costs.</td>
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<td>Donor Funding could be obtained to</td>
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<td>procure a software module that tracks the blood products in all</td>
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<td>facilitates to reduce wastage, establish control from incorrect ordering</td>
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<td>and increase identification and tracking of unused blood products.</td>
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TECHNOLOGY AND INFRASTRUCTURE RECOMMENDATIONS
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<tr>
<td>It is recommended that HRP commits to fund the full lifecycle of the projects and allocate the money to the province rather than the current annual finding system.</td>
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<td>Documentation of the impact and outcomes of introducing new technology is necessary; in particular the use, interface and management of technology across service platforms.</td>
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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 2009/10 financial year. The IST teams, in partnership with national and provincial departments of health, will identify causes of over expenditure within the health system at both national and provincial levels. The IST will identify common or unique causes of over expenditure and the effect of these on service delivery. The IST team will identify a national and collective response for service delivery improvement despite these funding constraints.

Although the technical focus of the three different streams will be different, the integration and synthesis of these focus areas into practical recommendations which will improve the overall functioning of the departments is of pivotal importance.
1.2.5.2. **Review Scope of Work for Finance Consultants**

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

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

- Undertake a desktop review of strategic and operational plans and health service delivery data of national and provincial DOHs and compile a fact file
- Identify key health programme and systems focus areas and key districts for field visits from the desktop review, informed by the fact files, including financial data from the finance consultancy
- Participate in the development of a provincial review template and attend orientation to the project and training on the use of the provincial review template prior to deployment to provinces
- Conduct a national or provincial review, submit and present a report of national and or provincial findings including planning, policy implications and financial
controls required to strengthen financial systems and budget management to the MACH

- Work with financial consultants to formulate joint recommendations on cost management strategies and budget realignment across key service delivery components
- Attend IST related meetings and produce minutes and reports of meetings and their outcomes

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

- Undertake a desktop review of management and organisational structures and policies at national and provincial 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.

1.2.5.5. 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. **Phase 2- Provincial Teams**

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

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

1.2.6.3. **Phase 3- All Teams**

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

1.3. IST PROJECT MANAGEMENT

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

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

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

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

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

1.4. ROLES AND RESPONSIBILITIES

1.4.1. Role of NDOH and Provincial DOH

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

1.4.2. Role of Consultants

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

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

1.5.1. This refers to both national and provincial ISTs.

1.5.1.1. Standardised provincial and national review templates

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

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

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

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

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

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

1.6. **COMPETENCY AND EXPERTISE REQUIREMENTS**

1.6.1. The following skills will be expected of the Finance component of Consultancy:
1.6.1.1. Leadership experience and people and technical management skills

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

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

1.6.1.4. Computer literacy, good communication and writing skills

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

1.6.1.6. Operational and financial management of large projects and programmes

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

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

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

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

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

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

1.6.2.5. Operational and financial management of health projects and programmes

1.6.2.6. Good team management and team work (interpersonal) skills.
1.7. REPORTING REQUIREMENTS

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

1.8. TIMING AND SCHEDULING

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

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

1.9. CONTRACTING AND INVOICES

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

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

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

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

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

1.10. **GENERAL INFORMATION**

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

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

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

1.10.1.3. Experience in writing review or evaluation report

1.10.1.4. Availability within the review time frames

1.10.1.5. Short listed consultants may be interviewed by the project partner or HLSP.
2. **APPENDIX 2: LIST OF DOCUMENTS REVIEWED**

2.1. **GENERAL**

2.1.1. 5-year strategic plan 2005

2.1.2. Best practice documents TB programme

2.1.3. Cause of death report, Cape Town

2.1.4. CCMT data DOH

2.1.5. Comprehensive Service Plan for the implementation of Health Care 2010 (2007)

2.1.6. District Management Study – national summary report

2.1.7. District management study – Western Cape

2.1.8. Health Care 2010

2.1.9. Health information audit report, Western Cape 2006

2.1.10. Hospital revitalisation report template

2.1.11. Hospital revitalisation: project implementation manual 2009/10

2.1.12. Hospital revitalisation: project implementation plans for individual facilities/hospitals

2.1.13. Infrastructure Plan 2008/09 and other years

2.1.14. Input by UCT to SA HRC hearings on restructuring of health services, Western Cape

2.1.15. Internal strategic plan 2009/10-2011/12
2.1.16. M&E reports, minutes, frameworks

2.1.17. Minutes of Divisional Executive Committee, DHS and programmes (DEXCO) 2006-2009

2.1.18. Modernisation of tertiary services framework 2003

2.1.19. Mortality Report

2.1.20. National Health Act

2.1.21. PFMA

2.1.22. Service Level Agreement: Department of Transport and Public Works

2.1.23. Statistical data 2005/06

2.1.24. Top management meetings Jan 06-Jan 09

2.1.25. District Health information System Data

2.1.26. Divisional Goals

2.2. FINANCE

2.2.1. Accounting officer: Annual Financial Statements 2006

2.2.2. Accounting Officer’s Systems (AOS) for procurement, supply chain and asset management 2006

2.2.3. Adjustment estimates 2008/09

2.2.4. Annual Reports 2006/07 and 2007/08

2.2.5. Audit Committee minutes 2006/07, 2008/09
2.2.6. Audit Committee report FY ending Mar 07

2.2.7. Audit committee reports, quarterly reports Sep, Dec 2008

2.2.8. Auditor General Report FY ending Mar 07


2.2.10. Capital projects funding 2007-2011

2.2.11. Capital projects funding 2007-2011

2.2.12. Conditional grant: business plans, monthly and quarterly reporting – DORA 2008/09

2.2.13. Conditional grant: evaluation report forensic services grant

2.2.14. Conditional grants: hospital budget and expenditure for each hospitals

2.2.15. Delegations

2.2.16. Division of Revenue Act

2.2.17. Draft and final management report on regularity audit and audit of performance information FY ending Mar ‘07 and Mar ‘08

2.2.18. Final management letter: regularity audit FY 2005/06

2.2.19. Finance instructions 2004/08; list of finance instructions 2006-08

2.2.20. Financial management performance indicators to Dec 2008

2.2.21. Financial Monitoring Committee minutes, Nov 06-Oct 08
2.2.22. Internal audit report: Metro DHS services, transfer payments March 2008

2.2.23. Internal audit reports for provincial facilities, procurements, pharmacy and supply chain management

2.2.24. Internal audit reports of health facilities, general 2008/09

2.2.25. Internal strategic plan 2009/10-2011/12

2.2.26. IYM statements April 2008-Jan2009

2.2.27. National evaluation HIV/AIDS conditional grants

2.2.28. Programme areas: HIV/AIDS conditional grants

2.2.29. Public hearings on national conditional grants 2007/08

2.2.30. Summary of conditional grant 2008/09

2.2.31. W Cape Treasury provincial treasury instructions April 2008

2.3. HR

2.3.1. Annual Performance Plans 2007/08 and 2008/09

2.3.2. HR plan 2008/10

2.3.3. Internal audit report fictitious employees

2.3.4. Department of Health 2009 Top Management Structure

2.4. OTHER


2.4.5. District Health Plan 2009 – 2010 Western Cape Province. Thabo Motfutsanyana District.

2.4.6. Thabo Motfutsanyana. DHS Monthly report. February 2009

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

2.4.8. Western Cape Health Drug Supply Management (DSM) Assessment report. Dr. V. Pienaar. August 2005

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

3. **APPENDIX 3: SCHEDULE OF INTERVIEWS**

### Provincial Department Level

<table>
<thead>
<tr>
<th>Department/Area</th>
<th>Person(s) Interviewed</th>
<th>Position</th>
<th>Date of Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top Management</td>
<td>Prof C Househam</td>
<td>HOD</td>
<td>7 April 2009</td>
</tr>
<tr>
<td>Finance</td>
<td>Mr A Van Niekerk</td>
<td>CFO</td>
<td>3 April 2009</td>
</tr>
<tr>
<td>Human Resources</td>
<td>Mrs B Arries</td>
<td>Human Resource Director</td>
<td>31 March 2009</td>
</tr>
<tr>
<td>Tertiary Regional Hospital, Mental Health and Emergency Services</td>
<td>Dr E Engelbrecht</td>
<td>DDG</td>
<td>31 March 2009</td>
</tr>
<tr>
<td>Grootte Schuur Hospital</td>
<td>Dr MS Kariem</td>
<td>CD (CEO)</td>
<td>31 March 2009</td>
</tr>
<tr>
<td>Professional Support Services and Administration</td>
<td>Mr A Cunningham</td>
<td>CD</td>
<td>30 March 2009</td>
</tr>
<tr>
<td></td>
<td>Mr KB Lowenheiz</td>
<td>Director</td>
<td>2 April 2009</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>Mrs TB Mabuda</td>
<td>Director Nursing</td>
<td>30 March 2009</td>
</tr>
<tr>
<td>Health Programmes</td>
<td>Mrs M Poolman</td>
<td>Director TB Programme</td>
<td>30 March 2009</td>
</tr>
<tr>
<td></td>
<td>Mr B Smuts</td>
<td>Director HIV/AIDS</td>
<td>8 April 2009</td>
</tr>
<tr>
<td>District Health Services</td>
<td>Dr K Cloete</td>
<td>Metro DHF</td>
<td>9 April 2009</td>
</tr>
<tr>
<td></td>
<td>Dr J Cupido</td>
<td>DDG District Health System</td>
<td>3 April 2009</td>
</tr>
</tbody>
</table>

### District Level: Khayelitsha Sub-Structure

<table>
<thead>
<tr>
<th>Department/Area</th>
<th>Person(s) Interviewed</th>
<th>Position</th>
<th>Date of Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Structure Director</td>
<td>Dr GM Perez</td>
<td>Khayelitsha Sub-Structure Director</td>
<td>3 April 2009</td>
</tr>
<tr>
<td>Finance Manager</td>
<td>Mr Joseph</td>
<td>Finance Manager</td>
<td>8 April 2009</td>
</tr>
<tr>
<td>HR Manager</td>
<td>Mr Oor</td>
<td>HR Director</td>
<td>8 April 2009</td>
</tr>
<tr>
<td>District Information Systems</td>
<td>Junita Arendse, Kaaren Hermanus</td>
<td>District Information Officer</td>
<td>8 April 2009</td>
</tr>
</tbody>
</table>
4. **APPENDIX 4: BEST PRACTICES**

1. **Comprehensive Service Plan (CSP)**

1.1. The CS Plan developed in compliance with the Service Transformation Plan serves as the blueprint for the development and strengthening of the district health services including community-based services. The plan includes the following sections:

- District Health Services
- Acute Hospital Services
- Specialist Services
- Emergency Medical Services
- Forensic Pathology Services; and
- Conclusion

1.2. The plan identified the following challenges facing the WCDOH:

- Accommodating the new sub-district boundaries agreed upon by the province and the City of Cape Town
- The challenge of making service available for both insured and non-insured population
- Addressing issues of equity between sub-districts
- Undercount of certain sub-districts and suburbs of the Cape Town Metro in Census 2001
- Lack of relevant information on full package of comprehensive PHC and related indicators
- Although the principles of the Modernisation of Tertiary Services (MTS) were considered, the process had not been finalised
- Oral Health Services in particular, the Dental Hospital Services were not yet developed
- Western Cape rehabilitation centre is the only centre in the province that render services in districts and neighbouring provinces.
1.3. Some of the next steps in the CS plan will be to extend clinic service times of nine 24 hour trauma and emergency units to 21h30 at 25 CHCs. All trauma and emergency cases will be transferred to the trauma and emergency units within acute hospitals in the Cape Town Metro districts. There will be appointments of Family Medicine Practitioners located at CHC and district hospitals to improve the quality of care. The district, regional and tertiary hospitals will undergo rationalisation of acute beds (Level 2 &3). Preventative and promotive health programmes will be rendered by community-based services. Provision has been made for teaching and training of medical professionals.

1.4. The WCDOH will allocate appropriate resources aligned to the DHS restructuring. Due to the magnitude of the task in the WCDOH, a phased-in approach will be adopted.

1.5. In summary the CS plan provides an important milestone on the road toward the delivery of appropriate and effective DHS. It will be important to ensure that the plan is fully funded; however, the planning tools used are flexible to accommodate any readjustments needed in future in case of financial constraints.

2. HR Plan

2.1. The HR Plan developed in compliance with the Public Service Regulations will serve as the blueprint for the development of institutional plans in line with the CSP. The plan includes the following sections:

- Environmental Scan
- A future business and staffing outlook (demand)
- A current staffing outlook exercise (supply)
- Analysis of the human resource gap
- Integrated human resource strategies and action plans
- Monitoring and evaluation
2.2. The plan identified the following human resource challenges facing the WCDOH:

- The challenge of reshaping institutions and facilities i.e. clinics, community health centres, district hospitals, secondary hospitals as well as central hospitals.
- The development of a new organisational and post structure for the institutions within the WCDOH and consequent relocation of staff to different places of work in accordance with the shift in service to other levels of service rendering.
- Recruiting and retention of sufficient capacity and competencies in order to sufficiently staff the new organisational structures.
- Sufficient budgetary provisions to employ the required staff.
- Setting of a long-term HR vision that is linked to the long term vision of the WCDOH rather than focusing on more immediate issues.

2.3. Competencies required for the job

- The next step in the HR plan will be to do job profiling, including an analysis to ensure that the posts on the new organisational structure are described correctly in terms of defined job purpose and key result areas.
- The second step will be to define the minimum qualifications, skills and experience required from the incumbent of the post on the new post structure to be able to undertake the specific job. Due to the magnitude of the task, the WCDOH will outsource this task. In addition, a phased-in approach will be adopted.
- A database will be developed to provide the heads of institutions and line managers guidance on minimum qualifications, skills and experience per occupation. It is envisaged that this exercise will take 2 to 3 years.
2.4. **Current staff outlook**

- The current job titles of the occupational groups used in the CSP do not correlate with the job titles available on PERSAL. According to senior managers PERSAL accurately reflects the correct number of staff but does not correctly reflect the skills and qualifications of staff. An exercise will be undertaken to conduct a departmental skills profiling of current staff and update PERSAL accordingly. This exercise will be outsourced with nursing staff being focused on first in 2008/09. Thereafter other health professional and administrative groups will be addressed. This exercise will only be completed in the 2009/10 year. It will be a manual exercise on PERSAL and will involve the institutions, district offices and head office.

2.5. **Current training and development**

- The WCDOH currently has only basic information on training and development of employees. The WCDOH is going to conduct a detailed analysis of current training and capacity of training institutions to obtain accurate information that can be used in future planning to meet the CSP requirements.

2.6. In summary the HR plan provides an important milestone on the road toward the delivery of the CSP. Work needs to be done to align the plan at a more detailed institutional level. Once the qualifications, skills and experience profiling has been completed, a training and recruitment plan needs to be developed to transform the current organisational profile to the designed organisational profile. The HR plan will have to be tailored to the current financial constraints.

3. **The community based XDR and MDR - TB programme,**

3.1. Conducted, in Khayelitsha, to reduce hospital days and costs. This pilot intervention was initiated in December 2007 by Medecin Sans Frontieres
and the Khayelitsha City Health Department. This programme aims to rapidly improve Khayelitsha’s capacity to manage MDR TB as in-patients, adding up to 13 hospice beds, and outpatients, involving extensive staff training, adherence support measures, and widespread infection control at the clinic and community level. The project is based on the premise that more patients will be diagnosed and successfully treated if they are supported to follow treatment in their homes and communities, rather than being isolated in specialised hospitals. Secondly, that building capacity to manage DR TB at the primary care level will enable the scaling up of treatment provision, so that more patients can access high quality care. The programme takes advantage of existing resources and networks previously developed for the community-based antiretroviral programme for HIV.

3.2. Key aspects of the pilot model of care include:

- Increasing DR TB case detection through community awareness programmes, staff education and screening of household contacts
- Encouraging the rapid diagnosis of DR TB and decreasing the delay in initiating appropriate treatment
- Applying lessons from HIV/AIDS treatment, including a patient-centred approach to adherence, by providing counselling, education and support to patients and their families to empower them to understand the disease, observe infection control measures and take responsibility for completing their treatment
- Providing training and ongoing support to health care workers to enable them to treat and support patients
- Implementing infection control measures in clinic settings, patients’ homes, and in the community
- Improving access to treatment for complex cases through specialised outreach clinics for adult and paediatric DR TB, and inpatient facilities in Khayelitsha
- Establishing a monitoring and evaluation system to measure programme impact and assist with programme management
4. **A Red-Flag clinic supervisory checklist,**

4.1. Excel software –document with four worksheets is used by supervisors and facility managers to monitor the clinic performance. The first worksheet is completed by a supervisor, assessing the facility in following areas: infrastructure and environment; governance, safety, information, access to care, clinical care and patient experiences of care; and communication and linkages with community organisation. The second worksheet is completed by a facility manager and it lists specific activities that need to be performed, documents that are needed as evidence that an activity has been completed and outcomes (improvement noted). The third worksheet is a problem-solving chart that assists the facility manager to identify problems, causes and to list short and long-term solutions that need to be implemented. The person responsible to implement these solutions, the deadlines and a signature once completed is also required. The fourth worksheet is a questionnaire that is completed by the facility manager that captures their perceptions on the quality of supervision.

5. **The Tutu Tester's mobile clinic,**

5.1. The Tutu Tester's mobile clinic started about ten months ago, in Cape Town, visiting townships and providing quick and confidential tests for a number of chronic diseases including HIV/AIDS. More than 7,000 people have utilised its services and have been offered counselling. Of those tested for HIV, 40% percent were people testing for the first time. This is an alternative service to those not comfortable to access such services in public sector clinics for an HIV test because they are afraid of being seen by people they know. Because of its diverse testing services, people usually do not assume that those that access its services are only testing for HIV. The crew of the Tutu Tester screens an average of 40 to 60 people per day. The Tutu Tester mobile service does not provide treatment.
However, they refer patients to the clinic nearest to them for their medication. The testers do follow up with the patients within a week after the consultation. The Tutu Testers do offer professional counselling to those who need it. The Tutu Tester mobile service is planning to integrate TB testing to its services.

6. **Chronic Dispensing Unit:**

6.1. This is a unit that supplies pre-packaged chronic medication to patients with stable chronic diseases. The unit is linked to MDHS, including the district outpatient departments, CHCs and clinics in the province. This service is outsourced to a private company, with a 5 year contract that collects drug prescriptions from all facilities, then supplies and packages the drugs. Thereafter the pre-packaged medications are distributed to requested facilities 3 days prior to patient's return date for collection of medication. This system has been in operation for 3 and half years and is paid per medical script issued. There is a discount with increased volume of scripts submitted. From March 2009, this service has been extended to Eden district (East Coast). The benefits include reduced waiting times and bottlenecks, and limited wastage due to over-stocking of drugs. It has increased patient satisfaction, controlled prescribing behaviour, promoted appropriate medication prescriptions per disease profile and promoted EDL guideline review. In the near future, a savings analysis will be conducted to review savings incurred by using this system.
## 5. APPENDIX 5: FINANCIAL TABLES REFERENCES

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

<table>
<thead>
<tr>
<th>Year</th>
<th>R m Provincial Budget</th>
<th>Year on year increase</th>
<th>R m Health Budget</th>
<th>Year on year increase</th>
<th>% Allocation to Health</th>
<th>R m Adjustment Provincial Budget</th>
<th>R m Adjustment Health Budget</th>
<th>% Allocation to Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>16 374$^2$</td>
<td>N/A</td>
<td>5 743$^3$</td>
<td>N/A</td>
<td>35.07%</td>
<td>16 957$^4$</td>
<td>5 777$^5$</td>
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<tr>
<td>2006/07</td>
<td>18 360$^6$</td>
<td>12.13%</td>
<td>6 323$^7$</td>
<td>10.10%</td>
<td>34.44%</td>
<td>19 443$^8$</td>
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<td>2007/08</td>
<td>20 702$^{10}$</td>
<td>12.76%</td>
<td>7 095$^{11}$</td>
<td>12.21%</td>
<td>34.27%</td>
<td>21 667$^{12}$</td>
<td>7 427$^{13}$</td>
<td>34.28%</td>
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<td>2008/09</td>
<td>24 889$^{14}$</td>
<td>20.23%</td>
<td>8 642$^{15}$</td>
<td>21.80%</td>
<td>34.72%</td>
<td>26 202$^{16}$</td>
<td>8 871$^{17}$</td>
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<td>2009/10</td>
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<td>16.55%</td>
<td>9 893$^{19}$</td>
<td>14.48%</td>
<td>34.10%</td>
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</tr>
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2 Western Cape Budget Statement 2006/07, page 51  
3 Western Cape Budget Statement 2006/07, page 51  
4 Western Cape Budget Statement 2006/07, page 51  
5 Western Cape Budget Statement 2006/07, page 51  
6 Western Cape Budget Statement 2007/08, page 54  
7 Western Cape Budget Statement 2005/06, page 51  
8 Western Cape Budget Statement 2005/06, page 51  
9 Department of Health Annual Report 2006/07, page 158  
10 Western Cape Budget Statement 2008/09, page 68  
11 Western Cape Budget Statement 2008/09, page 68  
12 Western Cape Budget Statement 2008/09, page 68  
13 Western Cape Budget Statement 2008/09, page 68  
14 Western Cape Budget Statement 2009/10, page 68  
15 Western Cape Budget Statement 2009/10, page 68  
16 Western Cape Budget Statement 2009/10, page 68  
17 Western Cape Budget Statement 2009/10, page 68  
18 Western Cape Budget Estimates of Provincial Expenditure 2008/09, page vi  
19 Western Cape Budget Estimates of Provincial Expenditure 2008/09, page vi
Table 1: Allocation of Provincial budget to Health (including conditional grants)

<table>
<thead>
<tr>
<th>Year</th>
<th>R m Provincial Budget</th>
<th>Year on year increase</th>
<th>R m Health Budget</th>
<th>Year on year increase</th>
<th>% Allocation to Health</th>
<th>R m Adjustment Provincial Budget</th>
<th>R m Adjustment Health Budget</th>
<th>% Allocation to Health</th>
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</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>30 99920</td>
<td>6.86%</td>
<td>10 92521</td>
<td>10.43%</td>
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<td>N/A</td>
<td>N/A</td>
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<tr>
<td>2011/12</td>
<td>33 45322</td>
<td>7.92%</td>
<td>11 76423</td>
<td>7.68%</td>
<td>35.17%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</table>

20 Western Cape Budget Estimates of Provincial Expenditure 2008/09, page vi
21 Western Cape Budget Estimates of Provincial Expenditure 2008/09, page vi
22 Western Cape Budget Estimates of Provincial Expenditure 2008/09, page vi
23 Western Cape Budget Estimates of Provincial Expenditure 2008/09, page vi
Table 2: Allocation of Provincial budget to Health (excluding conditional grants)

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Adjustment Provincial Budget (incl. Grants) R m</th>
<th>Adjustment Provincial Budget (excl. Grants) R m</th>
<th>Health Budget (incl. Grants) R m</th>
<th>Health Grants R m</th>
<th>% Year on year increase in Health Grants</th>
<th>% Allocation to Health</th>
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<tbody>
<tr>
<td>2005/06</td>
<td>16 95724</td>
<td>2 81925</td>
<td>14 138</td>
<td>5 77726</td>
<td>1 86127</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>3 916</td>
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<tr>
<td>2006/07</td>
<td>19 44328</td>
<td>3 63029</td>
<td>15 813</td>
<td>6 47630</td>
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<td>2007/08</td>
<td>21 66732</td>
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<td>17 592</td>
<td>7 42734</td>
<td>2 26335</td>
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<td></td>
<td></td>
<td></td>
<td>29.35%</td>
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<tr>
<td>2008/09</td>
<td>26 20236</td>
<td>5 28937</td>
<td>20 913</td>
<td>8 87138</td>
<td>2 68339</td>
<td>18.56%</td>
</tr>
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<td></td>
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<tr>
<td>2009/10 (Main budget)</td>
<td>29 00940</td>
<td>5 97841</td>
<td>23 031</td>
<td>9 89342</td>
<td>2 81943</td>
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<td></td>
<td></td>
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<td></td>
<td>30.72%</td>
</tr>
<tr>
<td>2010/11 (Main budget)</td>
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<td>6 31245</td>
<td>24 687</td>
<td>10 92546</td>
<td>3 23247</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>31.16%</td>
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24 Western Cape Budget Statement 2006/07, page 51
25 Western Cape Budget Statement 2006/07, page 30
26 Western Cape Budget Statement 2006/07, page 51
27 Western Cape Budget Statement 2006/07, page 29
28 Western Cape Budget Statement 2007/08, page 54
29 Western Cape Budget Statement 2007/08, page 44
30 Western Cape Budget Statement 2007/08, page 54
31 Western Cape Budget Statement 2007/08, page 43
32 Western Cape Budget Statement 2008/09, page 68
33 Western Cape Budget Statement 2008/09, page 58
34 Western Cape Budget Statement 2008/09, page 68
35 Western Cape Budget Statement 2008/09, page 57
36 Western Cape Budget Statement 2008/09, page 68
37 Western Cape Budget Statement 2009/10, page 57
38 Western Cape Budget Statement 2009/10, page 68
39 Western Cape Budget Statement 2009/10, page 56
40 Budget Estimates of Provincial Expenditure 2009, page vii
41 Budget Estimates of Provincial Expenditure 2009, page v
42 Budget Estimates of Provincial Expenditure 2009, page vi
43 Budget Estimates of Provincial Expenditure 2009, page iv
Table 3: National Conditional Grants to Provinces Adjustment Budgets

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Conditional Grant to Provinces</th>
<th>Western Cape Provincial Allocation</th>
<th>% Allocation of National Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>1 150 108</td>
<td>82 451</td>
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<tr>
<td>2006/07</td>
<td>1 616 214</td>
<td>133 170</td>
<td>8.24%</td>
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<tr>
<td>2007/08</td>
<td>2 006 223</td>
<td>200 559</td>
<td>10.00%</td>
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<tr>
<td>2008/09</td>
<td>2 885 400</td>
<td>241 467</td>
<td>8.37%</td>
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<tr>
<td>2009/10</td>
<td>3 476 200</td>
<td>309 913</td>
<td>8.92%</td>
</tr>
<tr>
<td>2010/11</td>
<td>4 311 800</td>
<td>448 834</td>
<td>10.41%</td>
</tr>
</tbody>
</table>

44 Budget Estimates of Provincial Expenditure 2009, page vii
45 Budget Estimates of Provincial Expenditure 2009, page v
46 Budget Estimates of Provincial Expenditure 2009, page vi
47 Budget Estimates of Provincial Expenditure 2009, page iv
48 Actual amounts
49 Estimates of National Expenditure 2008, page 279
50 Western Cape Provincial Budget Statement 2006/07 Page 29/30
51 Actual amounts
52 Estimates of National Expenditure 2008, page 279
53 Western Cape Provincial Budget Statement 2007/08 Page iii/iv
54 Estimates of National Expenditure 2008, page 279
55 Western Cape Budget Overview 2008 Page 57/58
56 Estimates of National Expenditure 2009, page 298
57 Western Cape Provincial Budget Statement 2009/10 Page 56/57
58 Estimates of National Expenditure 2009, page 298
59 Western Cape Provincial Budget Statement 2009/10 Page 56/57
60 Estimates of National Expenditure 2009, page 298
61 Western Cape Provincial Budget Statement 2009/10 Page 56/57
Table 3: National Conditional Grants to Provinces Adjustment Budgets

<table>
<thead>
<tr>
<th></th>
<th>R 000 Total Conditional Grant to Provinces</th>
<th>R 000 Western Cape Provincial Allocation</th>
<th>% Allocation of National Grant</th>
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<tr>
<td></td>
<td>2011/12</td>
<td>4 633 000^-62</td>
<td>480 994^-63</td>
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<tr>
<td>National Tertiary Services Grant</td>
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<td></td>
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<tr>
<td></td>
<td>2005/06</td>
<td>4 709 386^-64</td>
<td>1 214 684^-66</td>
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<tr>
<td></td>
<td>2006/07</td>
<td>4 981 149^-67</td>
<td>1 272 640^-68</td>
</tr>
<tr>
<td></td>
<td>2007/08</td>
<td>5 321 206^-69</td>
<td>1 335 544^-70</td>
</tr>
<tr>
<td></td>
<td>2008/09</td>
<td>6 134 100^-71</td>
<td>1 503 749^-72</td>
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<td></td>
<td>2009/10</td>
<td>6 614 400^-73</td>
<td>1 583 991^-74</td>
</tr>
<tr>
<td></td>
<td>2010/11</td>
<td>7 398 000^-75</td>
<td>1 763 234^-76</td>
</tr>
<tr>
<td></td>
<td>2011/12</td>
<td>7 798 900^-77</td>
<td>1 848 976^-78</td>
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</tbody>
</table>

^-63 Western Cape Provincial Budget Statement 2009/10 Page 56/57
^-64 Actual amounts
^-66 Western Cape Provincial Budget Statement 2006/07 Page 29/30
^-68 Western Cape Provincial Budget Statement 2007/08 Page iii/iv
^-70 Western Cape Budget Overview 2008 Page 57/58
^-71 Estimates of National Expenditure 2009, page 298
^-72 Western Cape Provincial Budget Statement 2009/10 Page 56/57
^-73 Estimates of National Expenditure 2009, page 298
^-74 Western Cape Provincial Budget Statement 2009/10 Page 56/57
^-75 Estimates of National Expenditure 2009, page 298
^-76 Western Cape Provincial Budget Statement 2009/10 Page 56/57
^-77 Estimates of National Expenditure 2009, page 298
^-78 Western Cape Provincial Budget Statement 2009/10 Page 56/57
Table 3: National Conditional Grants to Provinces Adjustment Budgets

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Conditional Grant to Provinces</th>
<th>Western Cape Provincial Allocation</th>
<th>% Allocation of National Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>8 907 346&lt;sup&gt;79&lt;/sup&gt;</td>
<td>1 805 930&lt;sup&gt;80&lt;/sup&gt;</td>
<td>20.27%</td>
</tr>
<tr>
<td>2006/07</td>
<td>10 206 542&lt;sup&gt;81&lt;/sup&gt;</td>
<td>1 993 078&lt;sup&gt;82&lt;/sup&gt;</td>
<td>19.53%</td>
</tr>
<tr>
<td>2007/08</td>
<td>11 736 678&lt;sup&gt;83&lt;/sup&gt;</td>
<td>2 182 606&lt;sup&gt;84&lt;/sup&gt;</td>
<td>18.60%</td>
</tr>
<tr>
<td>2008/09</td>
<td>14 362 800&lt;sup&gt;85&lt;/sup&gt;</td>
<td>2 588 035&lt;sup&gt;86&lt;/sup&gt;</td>
<td>18.02%</td>
</tr>
<tr>
<td>2009/10</td>
<td>15 578 400&lt;sup&gt;87&lt;/sup&gt;</td>
<td>2 704 168&lt;sup&gt;88&lt;/sup&gt;</td>
<td>17.36%</td>
</tr>
<tr>
<td>2010/11</td>
<td>18 012 800&lt;sup&gt;89&lt;/sup&gt;</td>
<td>3 103 584&lt;sup&gt;90&lt;/sup&gt;</td>
<td>17.23%</td>
</tr>
<tr>
<td>2011/12</td>
<td>19 171 800&lt;sup&gt;91&lt;/sup&gt;</td>
<td>3 293 491&lt;sup&gt;92&lt;/sup&gt;</td>
<td>17.18%</td>
</tr>
</tbody>
</table>

<sup>79</sup> Amount is actual  
<sup>80</sup> Estimates of National Expenditure 2008, page 279  
<sup>81</sup> Western Cape Provincial Budget Statement 2006/07 Page 29/30  
<sup>82</sup> Amount is actual  
<sup>83</sup> Estimates of National Expenditure 2008, page 279  
<sup>84</sup> Western Cape Provincial Budget Statement 2007/08 Page iii/iv  
<sup>85</sup> Estimates of National Expenditure 2008, page 279  
<sup>86</sup> Western Cape Budget Overview 2008 Page 57/58  
<sup>87</sup> Estimates of National Expenditure 2009, page 298  
<sup>88</sup> Western Cape Provincial Budget Statement 2009/10 Page56/57  
<sup>89</sup> Estimates of National Expenditure 2009, page 298  
<sup>90</sup> Western Cape Provincial Budget Statement 2009/10 Page56/57  
<sup>91</sup> Estimates of National Expenditure 2009, page 298  
<sup>92</sup> Western Cape Provincial Budget Statement 2009/10 Page56/57  
<sup>93</sup> Estimates of National Expenditure 2009, page 298  
<sup>94</sup> Western Cape Provincial Budget Statement 2009/10 Page56/57
6. **APPENDIX 6: INTEGRATED SERVICE DELIVERY PLATFORM**

Source: WCDOH: APP 2009/10, page 43

The integrated clinical service delivery platform per financial sub-programme and support services per financial programme

![Diagram of integrated service delivery platform]

- **Support Services**
  - Infrastructure (8)
  - Maintenance (7)
  - Training (6)
  - Administration (1)

- **Clinical Services**
  - L3 (5.1)
  - L2 (4.1)
  - L1 (2.9)
  - PHC (2.3)
  - EM (3)
  - APH (4.3)
  - TB (4.2)
  - CBS (2.4)
### APPENDIX 7: DELIVERABLES IN KEY PERFORMANCE AREAS

**DHS: 8 Divisional Goals**

<table>
<thead>
<tr>
<th>Provincial and District 8 Divisional Goals</th>
<th>Strategies in the District Plan that require further Action</th>
</tr>
</thead>
</table>
| 1. Strengthening the DHS                 | - Provincialisation of Personal PHC services to ensure a single management.  
- Ensure that the Provincialisation process remains a constructive process that is motivating and supportive to staff as they make the transition to a single management  
- Provide a roadmap of the Provincialisation.  
- Ensure transparent and regular communication  
- Municipalisation of Environmental Health Services |
| 2. Community–based services              | - Employment of community based health workers via NGO’s.  
- Employment of Technical Advisors to co-ordinate and supervise NGO’s  
- Implement and monitor and strengthen the community–based programme |
| 3. District Hospitals                    | - Increase or maintain the number of beds  
- Increase number of surgery cases  
- Apply Human resource generic model appropriate for the district |
| 4. Chronic disease management            | - Ensure continuous drug supply via district–based pharmacy  
- Comply with the Pharmacy Act: E.g. Provide training for nurses to dispense |
| 5. TB                                    | - Improve TB cure rates by focussing on the following NDOH recommended strategies:  
  - Appointment of a District TB Co-ordinators;  
  - Improvements to Laboratory services;  
  - Improvements to the quality of the DOTS programme; and  
  - Strengthen drug supply and management. |
<p>| 6. HIV and AIDS                          | - Strengthen the detection and Syndromic management of STI’s (an HIV preventive service). |</p>
<table>
<thead>
<tr>
<th>Provincial and District 8 Divisional Goals</th>
<th>Strategies in the District Plan that require further Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>❑ Strengthen the PMTCT programme (increase Nevirapine uptake among pregnant women).</td>
</tr>
<tr>
<td></td>
<td>❑ Strengthen the VCT programme</td>
</tr>
<tr>
<td></td>
<td>❑ Increase condom distribution</td>
</tr>
<tr>
<td></td>
<td>❑ Strengthen the ARV treatment service at designated sites</td>
</tr>
<tr>
<td></td>
<td>❑ Determine whether Winelands is a high transmission area due to the national trucking route. If yes, plan special interventions to address the problem.</td>
</tr>
<tr>
<td>7. Womens’ health</td>
<td>❑ Increase the cervical screening rates</td>
</tr>
<tr>
<td>8. Child Health</td>
<td>❑ Provide IMCI services at every clinic</td>
</tr>
<tr>
<td></td>
<td>❑ Increase the rate of immunisation and maintain it above 90%</td>
</tr>
<tr>
<td></td>
<td>❑ Develop interventions that can reduce the high rate of LBW in this district</td>
</tr>
<tr>
<td></td>
<td>❑ Ensure every child has a Road to Health card</td>
</tr>
</tbody>
</table>
8. **APPENDIX 8: ORGANOGRAM**