ASSESSING FINANCIAL MANAGEMENT CAPACITY FOR DISTRICT HEALTH SYSTEM DEVELOPMENT A CASE STUDY OF THE MOUNT FRERE DISTRICT

A COLLABORATIVE RESEARCH PROJECT BETWEEN THE
HEALTH ECONOMICS UNIT (HEU)
AND THE
INITIATIVE FOR SUB-DISTRICT SUPPORT (ISDS) PROJECT

MORAR RL, DEPARTMENT OF COMMUNITY HEALTH

MMED (COMMUNITY HEALTH) THESIS

TABLE OF CONTENTS

TABLE OF CONTENTS 2
LIST OF BOXES, FIGURES AND TABLES 3
DECLARATION 5
ACKNOWLEDGEMENTS 6
CHAPTER 1. BACKGROUND TO THE COLLABORATIVE PROJECT 7
CHAPTER 2. AIMS AND OBJECTIVES OF THE OVERALL PROJECT 10
2.1 AIMS 10
2.2 OBJECTIVES 10
CHAPTER 3. METHODS 12
3.1 Mount Frere study 12
3.2 "District Financing in Support of Equity" Project 14
3.2.1 CHP/HEU project: Methods of data collection 17
3.3 Analysing financial management capacity: the Mount Frere study 18
CHAPTER 4. DEFINING AND DESCRIBING THE TASKS OF FINANCIAL MANAGEMENT WITHIN THE EC PROVINCIAL DEPARTMENT OF HEALTH AND THE MOUNT FRERE DISTRICT 19
4.1 Resource Mobilisation/Allocation 19
4.2 Planning and budgeting 22
4.2.1 Budget structure and provincial process 22
4.2.2 The district budgeting process 24
4.2.2.1 Region and District Office Budgeting Process 25
4.2.3 The district planning process 29
4.2.4 Subsiding local authorities and other service providers 30
4.2.5 General Procurement 30
4.2.6 Drug procurement and management 31
4.2.7 Claims processing 32
4.2.8 Expenditure monitoring 33
4.2.9 Virement 34
CHAPTER 5. DEFINING AND DESCRIBING THE CURRENT CAPACITY PROBLEMS IN THE MOUNT FRERE DISTRICT 35
5.1 Human Resources: Are enough appropriately trained people available? 35
5.1.1 New staff structures and staff availability 35
5.1.2 Staff experience, knowledge and behaviour 36
5.1.3 Current training strategies 36
5.2 Planning and budgeting weaknesses 37
5.3 Procurement and related expenditure monitoring problems 40
5.3.1 Procurement: the case of drugs 40
5.3.2 Expenditure monitoring 43
5.3.3 Information and Systems for Financial Management (information availability) 43
5.4 Support and supervision 44
5.5 Authority: Do districts have adequate authority? 45
5.5.1 Centralisation within the province and public sector 45
5.5.2 Authority delegations 46
5.6 Are districts accountable? 47
5.7 Are task networks functioning effectively? 47
CHAPTER 6. DHS IMPLEMENTATION STRATEGIES 50
CHAPTER 7. RECOMMENDATIONS FOR THE MOUNT FRERE DISTRICT AND REGIONAL OFFICE IN KOKSTAD 54
CONCLUSION 61
CHAPTER 8. BIBLIOGRAPHY 62

LIST OF BOXES, FIGURES AND TABLES

Title	Page
Box 1: Critical Questions for District Financing in South Africa	8
Table 1: The regions and districts in the EC province	12
Box 2: Critical Dimensions of Financial Management Capacity	15
Figure 1: The dimensions of capacity	16
Box 3: Key financial management tasks and activities Required for Health Services	19
Table 2: EC PDoH 1996/97 Health Budget and Programme Allocations	23
Table 3: Reflection of the District Health Services by Sub-programmes (1996/97)	23
Table 4: Reflection of the EC PDoH Budget for District Health Services by Standard Item (1996/97)	24
Box 4: Budgetary Steps	25
Figure 2: The district budgeting process	27
Figure 3: Operational Plan Estimates	29
Box 5: Expenditure monitoring functions	34
Box 6: Planning And Budgeting Weaknesses At Hospital And Clinic Level	38
Box 7: Planning And Budgeting Weaknesses At the District Office	39
Box 8: Planning And Budgeting Weaknesses At the Regional Office	39
Box 9: Consequences Of A "Top Down" Planning And Budgeting Process	40
Box 10: Consequences Of Budgets Not Being Linked To Outputs For Hospitals	40
Box 11: Problems Which Affect The Distribution Of Essential Pharmaceuticals From The Umtata Depot To Hospitals	42
Box 12: Problems Which Affect The Distribution Of Essential Pharmaceuticals From Hospitals and Clinics	42
Box 13: Factors relating to the implementation strategies with reference to DHS Development in EC PDoH	51
Box 14: Priority Recommendations for Implementation to Facilitate DHS Development	61

LIST OF ABBREVIATIONS

CHP	Centre for Health Policy
CPA	Cape Provincial Administration
CSS	Central Statistical Services
DHS	District Health Systems
DoH	Department of Health
EC	Eastern Cape
EDL	Essential Drugs List
FFC	Fiscal and Finance Commission
FMS	Financial Management System
HEU	Health Economics Unit
HSP	Hospital Strategy Project
HST	Health Systems Trust
ISDS	Initiative for Sub-district Support
IDHWMT	Interim District Health and Welfare Management Team
LA	Local Authority
NDoH	National Department of Health
NGO	Non-governmental organisation
NITER	National increase for teaching, education and research
PAS	Provisioning Administration System
PDoH	Provincial Department of Health
PERSAL	Personnel salary (and pension) management system
PHC	Primary Health Care
PSC	Public Service Commission
PSNP	Primary School Nutrition Programme
RDP	Reconstruction and Development Programme
ZBB	Zero-based Budgeting

DECLARATION

I, Reno Lance Morar, hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise), and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

I empower the University of Cape Town to reproduce for purposes of research either the whole or any portion of the contents in any manner whatsoever.

Signed by candidate

29/April 1998

Signature Date

ACKNOWLEDGEMENTS

This study forms part of an ongoing collaborative project undertaken by the Health Economics Unit, University of Cape Town, and the Initiative for Sub-District Support Project, funded by a grant from the Health Systems Trust.

This case study of the Mount Frere district in the Eastern Cape province benefited tremendously from the collaboration and interaction with research partners from the "District Financing in Support of Equity" project, undertaken by the Health Economics Unit and the Centre for Health Policy (CHP), University of Witswatersrand. I would like to acknowledge the inputs provided by the CHP members (Lucy Gilson and Vishal Brijlal).

Without the involvement of the Eastern Cape Provincial Department of Health (EC PDoH) this project would not have been possible. I am particularly grateful to all of those at the district and regional level who gave up their time to provide us with valuable information and insights. I would like to thank all interviewees at the Kokstad regional office and particularly Mr. Chuake Tyekele, Regional Director. In addition, special thanks and mention needs to be made of the Mount Frere Interim District Health and Welfare Management Team under the leadership of Mr. Hansen Maqaqa (District Manager) and all the interviewees at the district level.

My personal acknowledgement to my co-researchers, Mr. Bupendra Makan and Dr. David McCoy, for their professional assistance, advice and patience as well as the invaluable guidance of Dr. Di McIntyre, my supervisor. Lastly, I would gratefully acknowledge the HST for the financial contribution and support.

CHAPTER 1. BACKGROUND TO THE COLLABORATIVE PROJECT

The development of the District Health System (DHS) represents a core strand of health sector decentralisation in South Africa. The DHS is seen as the foundation for effective development of Primary Health Care (PHC) within the country and the main vehicle through which PHC services will be delivered. The objectives underlying the development of the DHS include overcoming fragmentation in service delivery, delivering comprehensive services, community participation and local accountability as well the pursuit of equity, efficiency, effectiveness and quality.

A critical lesson that can be drawn from the international experience with health systems change and decentralisation is the importance of establishing a financial management structure that supports, rather than constrains the district level (Brijlal and Gilson, 1997). Furthermore, the financial management structure must ensure that districts work within a common framework of promoting equity and efficiency.

The National Department of Health's formative document "A policy for the development of a district health system for South Africa" (1995) states:

"It is vital that sufficient powers are devolved to the managers of the districts and their facilities, especially with respect to personnel and financial controls. This will increase both accountability and efficiency but is also important as a means of boosting staff morale and encouraging local initiative and flexibility".

The critical issues in district financing are outlined in Box 1 below. These questions have been assessed within the ***"District Financing in Support of Equity"*** project undertaken by the Centre for Health Policy (CHP) at the University of Witswatersrand, and the Health Economics Unit (HEU) at the University of Cape Town. It was done in conjunction with provincial officials in the Health Ministries of the Eastern Cape and North- West province.

Box 1: Critical Questions for District Financing in South Africa

Critical Questions for District Financing in South Africa

- how will districts be financed in ways that promote equity and efficiency?
- how will financial allocation decisions be related to district planning and budgeting processes?
- what "capacity" is required to allow effective resource-related decision making and financial control and responsibility to be devolved to district level?
- what strategy can most effectively develop financing mechanisms and procedures in support of DHS development?
- how will district budgets and resources be allocated to optimise the impact of health care delivery on specific target groups and towards achieving the health priorities identified within the district?

Source: HEU/ISDS 1997

The CHP/HEU research team produced two literature reviews which considered the following:

- an assessment of what capacity is required to enable and support financial management at the district level of the public health system, and how most effectively to develop that capacity (Brijlal and Gilson 1997); and
- an evaluation of how resources can be allocated to districts in a manner that promotes equity and which ensures that allocations made are linked to district planning and budgeting processes (Reagon, Makan, and McIntyre 1997)

The HEU/CHP study focused on an assessment of intra-provincial resource allocation to districts and the financial management capacity at the regional and district level. Seven of the twenty one districts in the Eastern Cape (EC) that were selected for district level interviews, one of which was the Mount Frere district, in Region E.

The Mount Frere Health and Welfare district is also part of the Health Systems Trust's (HST) Initiative for Sub-district Support (ISDS). This Initiative is aimed at providing support to selected districts and sub-districts to bring about improvements in health care delivery. The exact nature of the support will vary from district to district and will be defined at the local level of the participating district. The support provided by the ISDS is built around the principle of providing sustainable and replicable interventions.

In identifying the importance of decentralised planning and budgeting, key tasks mandated by the Mount Frere district to the ISDS team were:

- to provide an overview and analysis of the current financial management system;
- to assess financial management capacity and to determine what capacity is required to allow effective and appropriate resource-related decision making and control to be devolved to district level; and
- to support a move towards the district taking responsibility for its own planning and budgeting; and
- to provide training for the development of the required financial management skills and capacity.

In a series of meetings between the two research project teams (HEU and ISDS), it was agreed that the collaboration between the two projects would foster the:

- sharing of contacts, expertise and planning for the collection of data to meet the objectives of both projects;
- sharing of documentation and ideas collected during the research process pertaining to financial management assessment at the district level;
- development and consolidation of research methods at the district and sub-district level; and
- the enhancement of support to the province generally, and to a former homeland area specifically, for district health systems.

CHAPTER 2. AIMS AND OBJECTIVES OF THE OVERALL PROJECT

2.1 AIMS

2.1.1 To conduct an in-depth and detailed case study in the Mount Frere district of:
- the pattern of resource allocation *within* the health district; and
- the financial management capacity within the health district level;

2.1.2 To develop and strengthen financial management capacity and resource allocation analysis and decision making in a sustainable manner that can be replicated in other districts in the region.

2.1.3 To assist the Mount Frere Interim District Health and Welfare Management Team (IDHWMT) and the Regional Office with developing the district budget for the 1998/99 financial year.

2.1.4 To develop appropriate resource material on financial management and budgeting for district level health workers.

2.2 OBJECTIVES

2.2.1 To provide an overview of the current financial management system in Region E and the Mount Frere district.

2.2.2 To conduct an analysis of the expenditure and resource allocation patterns within the Mount Frere district for the financial years 1995/96 and 1996/97.

2.2.3 To strengthen the financial management capacity of the Mount Frere district managers in a manner that is sustainable and replicable in other districts in the region.
- assess the current financial management capacity at the district level;
- assess provincial/regional plans to increase financial management capacity and for decentralising expenditure control;
- identify specific training needs amongst the IDHWMT with regard to the functions of resource mobilisation and allocation, budgeting and planning, procurement, claims processing and expenditure monitoring and control, information collection and management;
- formulate a training programme to address the needs identified;

- identify specific issues requiring intervention with regard to financial management capacity in terms of the following: human resource development; organisation issues such as authority, communication, recruitment and management systems; the public sector rules and regulations; and the external environment.

2.2.4 To support the Mount Frere IDHWMT to develop its budget for the 1998/99 financial year

- document the current formal and informal budgeting and planning procedures;
- expose members of the IDHWMT and Regional Office to the different budgeting approaches that could be used in the Mount Frere district;
- record the budgeting option considered to be most appropriate to the needs of the district;
- identify information requirements and develop service indicators (e.g. establishing a sustainable minimum data set) which would be required for the development of the district budget for 1998/99; and
- investigate the feasibility, appropriateness and time frames of the transition to decentralised budgeting within the district.

2.2.5 To develop appropriate resource and training materials, emanating out of the workshops, around issues of financial management and resource allocation

- for district management teams; and
- for managers at the institutional level within the district.

The specific objective of this report is the assessment and analysis of the current financial management capacity at the district level in Mount Frere (referred to in objective 2.2.3 of the overall project). It will specifically address the assessment and analysis of financial management capacity in the Mount Frere district, Region E in the EC Province, Department of Health.

CHAPTER 3. METHODS

3.1 Mount Frere study

The Mount Frere district is one of four districts in Region E (part of the former Transkei) of the EC province (see Table 1 below). The EC province has had one of the most difficult tasks of reconstruction as this province faced the worst consequences of the apartheid era (HST 1996). In addition, this province contained within its boundaries two underdeveloped and populated so-called "independent states" of the Ciskei and Transkei. The former Transkei, where Mount Frere district is situated, is less adequately resourced compared to districts in Region A for example. It has a lack of resources including human, financial and physical resources and poor maintenance and inadequate capital funds have resulted in deteriorating and inadequate services (HST 1996).

Table 1: The regions and districts in the EC province

REGION[1]	REGIONAL OFFICE LOCATION	TOTAL NUMBER OF DISTRICTS WITHIN EACH REGION	FORMER ADMINISTRATIVE AREA
A	Port Elizabeth	4	Cape Provincial Administration (CPA)
B	Queenstown	4	CPA, Ciskei, and Transkei
C	East London	5	CPA, Ciskei, and Transkei
D	Umtata	4	Transkei
E	Kokstad	4	Transkei

Source: Makan, Morar, McIntyre 1997.

The Mount Frere district office is situated in the town of Mount Frere, while the regional office in Kokstad is approximately 100 km from Mount Frere. The Mount Frere district comprises of two magisterial districts (Kwabhaca and Tabankulu). The district is extremely rural and has poor infrastructure. Currently there

[1] In this report, for reasons of simplicity and easy reference, the regions are referred to as the following: Region A (Western), Region B (Northern), Region C (Central), Region D (Eastern) and Region E (North Eastern)

are two hospitals in the district, namely Mary Teresa and Sipetu hospitals. Mary Teresa supports ten clinics (Kwabhaca magisterial district) and Sipetu hospital seven districts (Tabankulu magisterial district).

The methods for assessing the current financial management capacity within the Mount Frere district included:

- a review of interviews conducted within the CHP/HEU project (as mentioned above);
- additional interviews of key informants (e.g. with relevant district, regional and provincial managers);

As part of the CHP/HEU project, interviews were conducted with the District Manager and members of the Mount Frere IDHWMT. In these interviews, examining issues such as the present budgeting, planning and resource allocation processes formed part of the assessment of financial management capacity in the district. A review of the CHP/HEU interviews was done, and further interviews were conducted with the District Manager for the purposes of this study.

In addition, interviews were conducted with the following personnel at the regional level: Regional Stores Officer, Regional Finance Officer, Deputy Director for Primary Health Care programmes, Deputy Director for Administration and Regional Personnel Officer. For the hospitals within the Mount Frere district, interviews were conducted with the following:

- Mary Theresa Hospital Administrator;
- Mary Theresa Accounts Officer;
- District Pharmaceutical Officer;
- Sipetu Hospital Administrator; and
- Sipetu Accounts Officer and Sipetu Hospital Dispensary Assistant

In addition interviews with the Mntwana and Tshungwane Clinic Sister were conducted to reflect the differences between the clinics in terms of physical infrastructure as well as the relationship that the clinics have with respective hospitals.

A record review was conducted of relevant national, provincial, regional and district policy and procedure manuals, delegations, memoranda and budget commentaries with a specific emphasis on intra-district issues. In addition, the province's future plans and policies for decentralising financial control and the implications of this for the Mount Frere district examined.

3.2 "District Financing in Support of Equity" Project

The assessment and analysis of financial management capacity within this project utilised the framework of assessment developed within the CHP/HEU ***"District Financing in Support of Equity"*** project. The CHP/HEU analysis sought to determine the financial management capacity required to allow effective implementation of the district health system, and to make recommendations concerning appropriate capacity building activities.

Although the development of "capacity" is known to be a critical pre-requisite for any form of decentralisation, there has so far been only limited international research within the health sector addressing the issue in any detail. The research process within the CHP/HEU project included an initial examination of evolving frameworks for analysing management capacity[2] and decentralised systems.[3] The frameworks were then adapted to the specific contextual features of their study within the North-West and EC province: namely financial management; DHS development; poorer South African provinces.

Many managers and health workers in general tend to refer to the issues of "capacity" in terms of the availability of people with the appropriate training and with a specific mix of skills. This mix of skills therefore enables an individual to perform and fulfil certain tasks associated with their job grading or classification. In summary, it's about "bones and skills."

However, the international literature[4] supports the philosophy that in order to achieve public sector goals, its takes more than appropriately trained people. The broad conceptual framework used for the CHP/HEU study as well as this study is summarised in Box 2 below.

---

[2] In particular, Bennett and Russell 1995 *op cit.*
[3] WHO, *Decentralization and Health Systems Change: a framework for analysis,* WHO/SHS/NHP/95.2, March 1995
[4] Brijlal V, Gilson L. Understanding capacity: financial management within the district health system. A literature review. Paper No. 48. Centre for Health Policy, Johannesburg, 1997.

Box 2: Critical Dimensions of Financial Management Capacity

Critical Dimensions of Financial Management Capacity

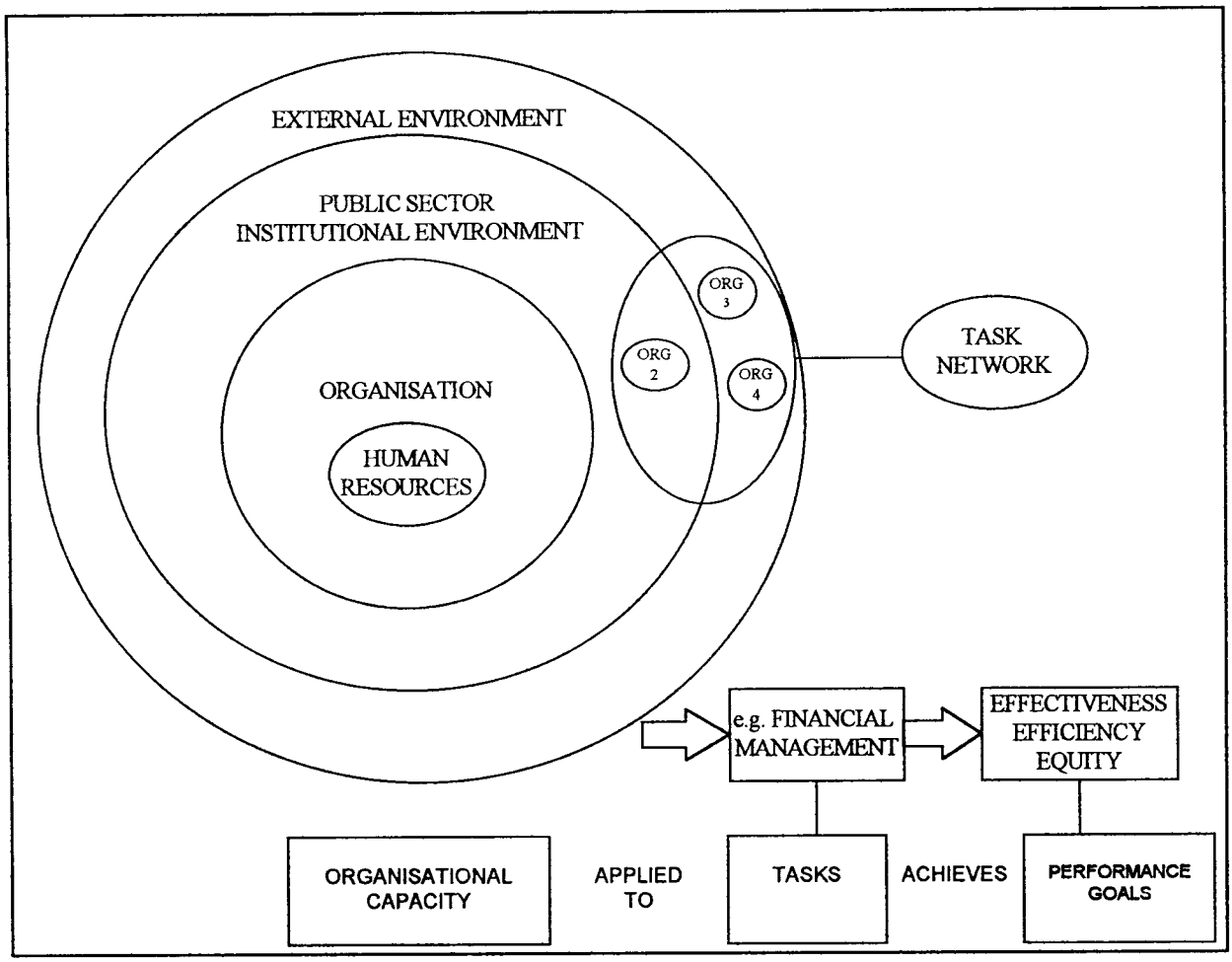
- Tasks and their respective components which need to be undertaken;
- The organisations involved in undertaking the task (the "task network");
- Critical aspects influencing the availability and quality of human resources required to undertake tasks (within the various organisations of the "task network");
- Critical elements of the organisation which will undertake the task which influence its ability to undertake the task (e.g. the procurement methods etc.);
- Critical aspects of the public sector institutional context which affect the organisation's ability to undertake the task; and
- The external environment which is broadly considered as an influence on the public sector, organisation and human resources who are involved in undertaking the tasks.

Source: Brijlal and Gilson, 1997

The critical dimensions interact with one another and it may be difficult to disentangle them from each other (Figure 1 below). To have the necessary organisational capacity for financial management, it requires that each individual dimension referred to in Box 2 above, supports the performance of tasks required in financial management. In addition, the interaction and inter-relationship between all these dimensions need to be supportive of this performance.[5]

[5] Gilson L, van den Heever A, Brijlal V. District Financing/North West Province Briefing document. Centre for Health Policy, Johannesburg, September 1997.

Figure 1: The dimensions of capacity [6]



Source: Brijlal and Gilson, 1997

The CHP/HEU analysis therefore involved the following:

- Establishing what adaptations to the institutional conditions of districts are required in order to develop effective budget-holding authorities, considering: financial and economic conditions; factors associated with civil society-public sector interaction; private sector development; political structures and practices; legal and administrative frameworks; and provincial policy especially with respect to the Provincial Department's of Health (PDoH);
- Determining the capacity required at district level to enable effective decentralisation of financial authority, responsibility and accountability, considering: organisational and administrative structures (such as information and budgeting systems), personnel skills, and the incentive systems governing personnel behaviour.
- Assessing the appropriate roles and responsibilities of provincial and regional levels in support of effective district financial management, and the associated management capacity requirements.

[6] *Adapted from: Hilderbrand and Grindle 1994 in* Brijlal and Gilson (1997) *op cit.*

- Determining the additional management capacity required to enable the tasks associated with the health care purchasing function to be undertaken effectively i.e. the contracting with Local Authorities (LA) to provide services and the monitoring of this through performance contracts.

In considering these above-mentioned issues, the CHP/HEU researchers through their resource allocation analysis considered particularly the "capacity" (such as skills, budgeting and information systems) required to implement the proposed resource allocation procedures. This study does not address the resource allocation analysis of the Mount Frere district.

3.2.1 CHP/HEU project: Methods of data collection

Policy interviews

A range of interviews within provinces were undertaken as part of the analysis of policy context. The groups that were interviewed in the CHP/HEU project included:

- local government managers;
- Public Service Commission (PSC) officials;
- officials in the provincial finance department;
- regional and other programme directors within the provincial health department;
- public health service managers and providers at district level;
- private health care providers.

The literature reviews mentioned in section 1 formed part of the research method of the CHP/HEU project[7]. A checklist of key questions to explore with interviewees was developed on the basis of the literature review and analysis of policy context, but it also addressed the range of issues identified above. Interviewees were selected on the basis of the 'snow-ball' sampling approach, where important respondents are identified through previous interviews. The interviews were undertaken on a one-to-one basis as well as involving group discussions with similar groups of respondents, depending on what was most appropriate and feasible.

[7] Brijlal V, Gilson L. Understanding capacity: financial management within the district health system: a literature review (CHP 1997) and Reagon *et al.* District financing in support of equity: resource allocation mechanisms within the district health system (HEU 1997).

Document review

Interviewees identified key documents, such as existing legislation and management manuals, which were reviewed in order to understand current systems and procedures, and detailed plans for the future. These were analysed using the same guiding questions incorporated into interviews.

3.3 Analysing financial management capacity: the Mount Frere study

Using information collected from interviews and documents (section 3.1 and 3.2), and drawing on the available frameworks for analysing capacity and decentralisation (CHP/HEU project and Figure 2 below), it was possible to:

- determine the critical financial management tasks that will be necessary, given existing plans for DHS development (including proposals generated by this study for future resource allocation procedures);
- determine the support that must be provided to districts in the short-, medium- and long-term;
- assess the existing financial management capacity at all levels and its ability to perform these tasks;
- identify key constraining and facilitating factors, within and outside provinces, influencing the development of the necessary capacity; and
- generate recommendations on the key steps to be taken within provinces and at national level in developing the required elements of capacity, and tackling the key constraining factors.

This study in the Mount Frere district thus draws from the CHP/HEU assessment of **inter-provincial,** as well as **inter-district** analysis within the EC province. **The Mount Frere study is however an in-depth and detailed case study of financial management capacity within the health district.** It is also done in conjunction with other ISDS activities assessing generic management capacity and health systems development. Recommendations made are thus part of a broader process of DHS development.

The analysis of financial management capacity was presented to the key regional personnel and the members of the Mount Frere IDHWMT at a workshop held in October 1997. Participants at the workshop assimilated and discussed the information in order to identify and prioritise issues for strengthening financial management capacity in the Mount Frere district.

CHAPTER 4. DEFINING AND DESCRIBING THE TASKS OF FINANCIAL MANAGEMENT WITHIN THE EC PROVINCIAL DEPARTMENT OF HEALTH AND THE MOUNT FRERE DISTRICT

This section will review the key tasks and related problems within the function of financial management that are presently being performed or should be performed within the EC Provincial Department of Health and the Mount Frere district. The tasks that are considered to be most important are indicated in Box 3 below.

Box 3: Key financial management tasks and activities required for health services

- resource mobilisation/allocation
- planning and budgeting
- LA subsidisation
- general procurement
- drugs procurement and management
- claims processing
- expenditure monitoring
- virement

Source: Brijlal and Gilson, 1997.

Each of the above tasks outlined in Box 5 are explored in relation to the activities and experiences of the key informants that were interviewed at district, regional and provincial levels within the EC PDoH.

4.1 Resource Mobilisation/Allocation

Resource mobilisation involves the raising and maintaining of a regular flow of financial resources (Brijlal and Gilson, 1997). In the context of Mount Frere, the resources for the district health system will primarily be mobilised through the allocation of resources from higher levels of government. Resource allocation occurs from national to provincial level, and provincial to district level through the regional office in Kokstad.

There are sequential steps in the current process of resource allocation which determines district level budgets. These steps include the following:

1. The government determines a national budget based on macro-economic issues. The national budget is sliced into four:

- national top slice including the Reconstruction and Development Programme (RDP) funds, debt servicing, etc.
- provincial top slice: for health this includes national training of health professionals (NITER), "unique" level 3 health services, Local Government functions, etc.
- national functions
- provincial functions

2. For provincial functions, after the resources have been allocated from national level, the province then distributes the resources between department and sectors e.g. health, education, housing
3. Provincial health departments then distribute resources between levels of care and geographical areas e.g. hospitals, district health services, local authorities.

This is effectively a top-down process and as such provides the context in which much of the planning and budgeting must occur at district level.

According to the Financial and Fiscal Commission's (FFC) document "The Financial and Fiscal Commission's recommendations for the allocation of financial resources to the national and provincial governments for the 1997/97 financial year" (May 1996), an alternative approach to the budgetary process was stipulated. The primary constitutional role of the FFC is to advise the legislatures on the allocation of financial resources between the three spheres of government (Section 199 of the Interim Constitution and section 195 of the working draft of the Final Constitution). Accordingly, the national government budgetary allocations to provinces are in the form of global grants. Provincial legislatures have the necessary constitutional authority to allocate the resources between the various ministries, based on provincial priorities and considering national guidelines.

The Mount Frere district is dependent on PDoH allocations. The regional office in Kokstad is currently serving as gatekeeper to the four districts in Region E[8]. The issue of "capacity" is commonly cited as a reason for this gatekeeping function. One of the major reasons for this gate keeping role, as expressed by the regional and provincial levels, is that districts do not at present have the capacity to be fully functional with regard to financial management. This issue will be explored further later.

Only districts in Regions A, B and C benefit from the financial allocations of programmes from local authorities or the district councils for health services. Regions like D and E, are thus significantly disadvantaged given their limited scope to mobilise resources. The reasons for this difference has its

[8] The EC province is divided into five administrative regions and twenty one districts. The provincial capital and centre of administration is Bisho. The five regional headquarters are: Region A (predominantly former CPA) in Port Elizabeth, Region B in Queenstown, Region C in East London, Region D (former Transkei and Ciskei) in Umtata and Region E (former Transkei) in Kokstad.

roots in the historical development of local government structures being more prominent in the former CPA (of the former Republic of South Africa) than that of the former homeland and independent states.

There are two areas which require further investigation given the lack of clarity at present within the EC PDoH. These are:

- the process whereby regional office will allocate monies to districts; and
- dis-aggregating the budget at the district level by facility (e.g. hospital versus clinic versus community health centres) and by type of service.

Presently the dis-aggregation of hospital curative services and curative community services is being initiated but this is occurring in a random manner without any consistent policy and financial directive. Interviewees expressed the need to dis-aggregate from the hospital budget all community services including school health, geriatric, community psychiatry.

There has been limited involvement of the district office regarding the 1996/97 and 1997/98 financial resource allocation process. The district office at this stage is not required to perform the task of resource allocation from the district office to the facilities (hospitals and clinics). Criteria still need to be developed by the province, regional and the district office about how the resource allocations are to be made in the future. Many of the district offices and district managers were in the process of establishing a planning and budgeting committee which would be responsible for the process.

The Mount Frere district, at the time of the interviews had not yet established a permanent planning and budgeting committee. Key personnel at the facility level in the districts who have traditionally been involved in the budgetary and resource allocation activities (hospital to clinic) have expressed support for the establishment of a district planning and budgeting committee with the district manager as convenor. This committee will perform the key tasks of collating the data and information from the facilities in the district for the budget, as well as making decisions about budget estimates and projections. In addition, this committee will decide on the allocations once the budget has been submitted and approved at the regional and/or provincial level.

Without these planning and budgeting committees, district and regional offices may adopt less formal mechanisms for allocation. An example was cited where one of the sub-directorates at regional level participated in drawing up criteria for resource allocation using the population size of the district, the number of health facilities available as well as some of the activity and utilisation data from these facilities. This was however undone by a verbal request or instruction at the regional office to simply split the resources into 25% for each district without a thorough explanation of the process of allocation.

4.2 Planning and budgeting

4.2.1 Budget structure and provincial process

This sub-section provides an overview of the Budget Structure and Process at the district, regional and provincial level. The Provincial Minister for Health and Welfare, Dr. T. Thomas, presented the 1996/97 budget for health and welfare in the provincial legislature (22 May 1996). The 1996/97 EC PDoH (Health - Vote 3 and Welfare - Vote 4), like other provincial ministries, receives their budget estimate from the provincial government legislature. This overall provincial budgetary system is a standard for all provinces within the new South Africa.

The overall Provincial Budget is divided among different Provincial Departments according to Votes. In the EC province the PDoH is allocated to Vote 3. Each Provincial Dept. (e.g. Health, Education, Transport, etc.) submits estimates of expenditures and puts forward a case for justifying the levels of estimated expenditure (capital and recurrent). The Provincial Dept. of Health undergoes a similar process of assimilating estimated expenditures for each of the programmes that fall under Health. Decisions are taken at the provincial legislature and budgetary allocations are determined by Provincial Department of Finance. Once the Provincial Dept. of Heath receives its allocation, this allocation is broken down (divided) into the various programmes that constitute Health.

For the 1996/97 budget allocation for health, vote 3, was divided according to seven programmes. According to the PDoH Annual Report, the budget allocation was cited at R2,509,536,000. Table 2 below outlines the 1996/97 budget and programme allocations (note total R2,654,356,971: computation error):

- Programme 1: Health Administration;
- Programme 2: District Health Services;
- Programme 3: Provincial Hospital Services;
- Programme 4: Academic Health Services
- Programme 5: Health Sciences;
- Programme 6: Health Care Support Services; and
- Programme 7: Health Facilities Development and Maintenance.

The Table 2 below illustrates the financial allocations to programmes.

Table 2: EC PDoH 1996/97 Health Budget and Programme Allocations

Programme	Budget Allocation (Rands)	% Allocations
1. Health Administration	87,604,000	3
2. District Health Services[9]	1,054,853,000	40
3. Hospital Services	1,131,235,000	43
4. Academic Health Services	144,822,971	5
5. Health Sciences	36,969,000	1
6. Health Care Support Services	14,873,000	1
7. Health Facilities Development and Maintenance	184,000,000	7
TOTAL BUDGET:	**R2,654,356,971**	***100***

Source: EC PDoH Annual Report, 1996/97

Each of the above programmes receives a capital and a recurrent budget allocation. These budget allocations are further divided to reflect capital and recurrent transfer payments. Programme 1: Health Administration comprises of the budget for only the administration at Provincial and Regional level (e.g. the Minister of Health's Office, Provincial Management and Regional Management). Each programme's budget is further sub-divided into sub-programmes or cost centres. Table 3 below reflects the sub-programmes or cost centres for Programme 2: District Health Services.

Table 3: Reflection of the District Health Services by Sub-programmes (1996/97)

Programme 2: District Health Services
District Management
Community Health Services
Emergency Medical Services
Community Hospitals

Source: EC PDoH Annual Report, 1996/97

[9] District hospital expenditure is included within the programme of District Health Services.

However, the entire budget for a particular programme (e.g. Programme 2: District Health Services) is only reflected by **standard items** (Table 4) **and not by sub-programmes or cost centres** (Table 3 above). The Programme 2: District Health Services budget by standard item is illustrated in Table 4 below.

Table 4: Reflection of the EC PDoH Budget for District Health Services by Standard Item (1996/97)

Standard Item	1996/97 Allocation	%
Personnel	319,244,000	56,1
Administration	19,900,000	3,5
Stores and Livestock	87,690,000	15,3
Equipment	39,398,000	6,9
Land and Buildings	0	0
Professional and Special Services	27,113,000	4,8
Transfer Payments		
• current	68,640,000	12,1
• capital	0	0
Miscellaneous	7,135,000	1,3
Total Estimated Expenditure	**569,120,000**	**100**

Source: EC PDoH Annual Report, 1996/97

The main problem with the budget drawn up in this manner (Table 4) is that information contained within it is not directly related to the sub-programmes or cost centres in Table 3. While none of the sub-programmes in Table 3 can be directly related to the standard items in Table 4, the only common figure from the two tables will therefore be the total estimated expenditure.

4.2.2 The district budgeting process

For all planning and budgeting occurring within the province, there are recommended steps for the compiling of budgets and planning submissions from the district and regional level. According to the provincial guidelines to regions, various steps are stipulated for the budget/planning submission process. The Department of State Expenditure requires these allocations to be based on the steps outlined in the Box 4 below.

Box 4: Budgetary Steps:

- identifying activities;
- defining goals of government and formulating missions;
- examining rationale for all activities;
- discarding existing activities and establishing new activities;
- costing activities on most economic, efficient and effective way of providing services;
- prioritising activities;
- determining alternative planning options for vote as a whole and the implications thereof; and
- compiling a budget planning submission based on the above processes.

Source: Provincial Memorandum, 1997

A provincial budgetary forum was initiated in 1997 by the Permanent Secretary and the Chief Directorates for Health Systems and Finance. The objective of these forums are for the province and regions to examine budgetary allocations and the linkages to policy priorities. The region/district budgeting process and subsequent allocations are influenced by the provincial budget allocation to Health received from the provincial legislature. The budget for districts is assigned to Programme 2 (District Health Services).

The budget of the EC PDoH is allocated to the five regions according to the submissions received from the regional (including districts and facilities) level. Within the Eastern Cape province, the actual district budgeting process is not clear and relatively unknown. There are however processes within the province which allow for regions and established districts to attend the annual budgetary forum meetings.

The district budgeting process comprises broadly of two activities. These include the submission of initial estimates of expected expenditures (which are submitted to the Province via the region); and the receiving of budget allocations for expected expenditure. These activities are tied together, however, certain key linkages have collapsed. The links between the two activities need to be strengthened and consolidated.

4.2.2.1 Region and District Office Budgeting Process

For the 1996/97 period the allocations were based on the Zero Based Budgeting (ZBB) process initiated by the EC PDoH although facilities actually performed an incremental adjustment of 1995/96 budgets. The financial year for the Province runs from the 1st of April to the 31st of March. Regions are requested

to compile and prepare their budgets for the forthcoming year around September/October (of the immediate preceding financial year) by the Provincial Finance Directorate.

At present the regions assume primary responsibility for the districts within it's boundaries. For the compilation of the budget estimate, regional offices co-ordinate and aggregate the total regional budget. This would include consideration of all district-based facilities, regional hospitals, and regional and district offices. In many instances within the EC province, where there are acting or appointed district managers, they are expected to contribute to the regional budgeting process but were only responsible for the district office budgets for the 1996/97 period.

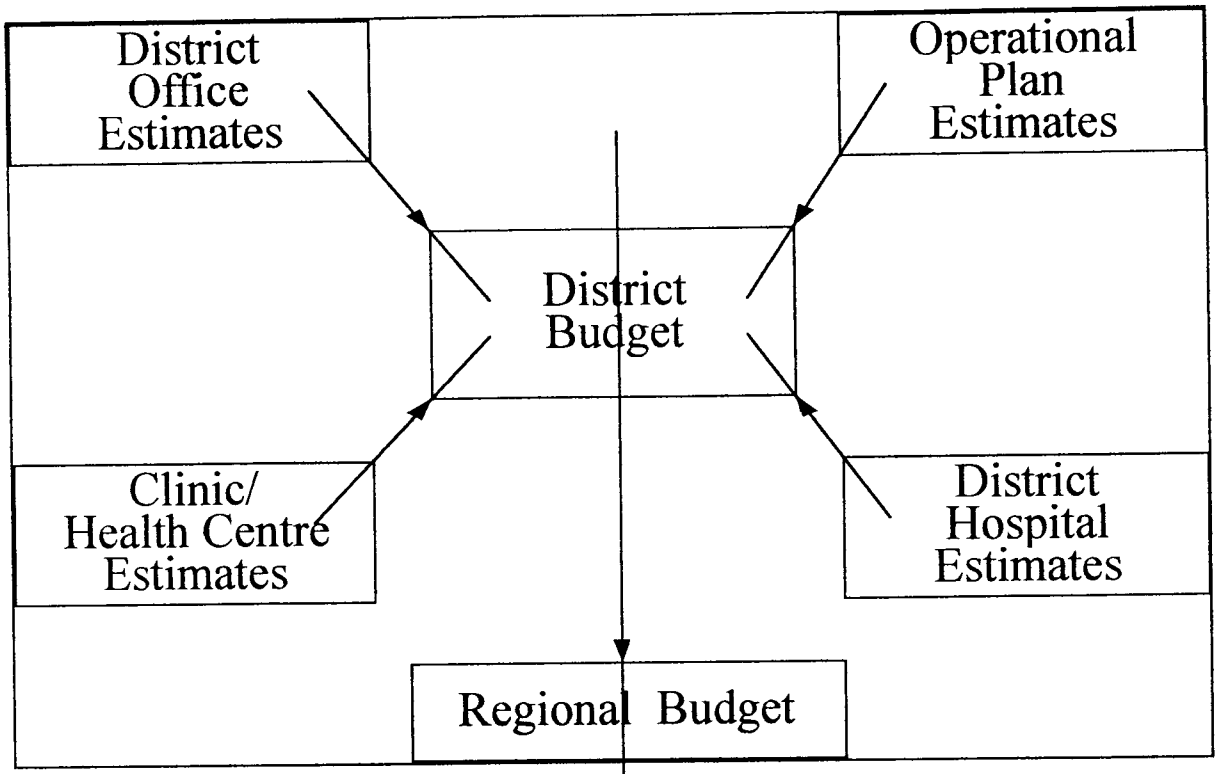
Within the EC province the provincial expectation is that all districts and regions budget according to the ZBB process. The ZBB process has been implemented in training programmes as the recognised system. The district office and all facilities within the district are expected to utilise the ZBB documentation (e.g. ZBB forms) as provided by the provincial office. The associated documentation needed to complete the ZBB form are:

- codes for votes, responsibility and objectives;
- catalogue of stationary;
- equipment inventory; and
- records of minor and major accounts.

The district manager in Mount Frere, together with his limited support staff, are currently undertaking the budgeting activities for the district office only. In some districts in the province, where there are capacity problems at the regional office level, the district office is performing the function of the regional office. For example, in Region C, the budgeting for and allocation of capital item expenditure, such as furniture, is being performed by the Queenstown district office. In others, where there is the support staff, the budgeting and allocations are undertaken at the district level with the regional office merely approving it.

Figure 2 below, illustrates how the district budgeting process should be with emphasis on the key components and estimate functions.

Figure 2: The district budgeting process



Source: Brijlal and Gilson, 1997

In theory once the regional and district offices receive budgetary allocations, they are then responsible for the dis-aggregation of these allocation to districts and facilities. However, in light of delays and problems at the level of the provincial department, this district budget process is weakened by the budgetary process in the province. This in turn will affect the ability of managers to efficiently and effectively manage service delivery. The situation will be even more problematic if the budgetary allocation to regional and district offices as well as institutions is less than their estimates / or more than their estimates, since a strategic planning process of prioritisation and down-sizing / up-sizing will be required.

In reviewing the activities between the regional office in Kokstad and the district office in Mount Frere, there were a range of interesting experiences. For the district, there is variable support and collaboration, including the extent to which the following are provided by the regional office:

- advice on training programmes for staff at the district office level;
- actual provision of training;
- advice on budgeting for clinic personnel (e.g. nurses) incorporating the minimum inputs required for budgeting and developing estimates;

In the Mount Frere district, where the hospital budgets are submitted to the district office, the district manager's role is very much reduced to the function of forwarding the documentation through to the regional authority. Hospital administrators have indicated that "emergency" budgetary requests have been submitted directly to the provincial office, and therefore both the district and the regional offices' and managers are by-passed. ***In essence, the district office does not play a significant role in the budgetary process related to the facilities within their district.***

Presently the hospital facilities' administrators develop budget estimates and projections which are submitted directly to the regional office. The hospital administrators use ledger responsibilities of the clinics to process orders. The clinics don't have their own finance section, thus the hospital administrators administer the requisitions for the clinics. Normally the budgets of the clinics are administered by the hospitals.

In the district, clinics are attached to the hospitals in the area. The personnel budget for the clinics is kept at the hospital, given that the staff are rotated via the hospital through to the clinics. There is a single personnel budget which covers both the clinics and the hospital and is not divided into hospital and clinics (community health services). As a result of this lack of separation in the personnel budget, clinics are not identified as cost centres with individual establishments within the computerised management information system presently in operation in the EC PDoH. The computerised systems in use at present include the following:

- Financial Management System (FMS) detailing expenditure; and
- PERSAL, the personnel salary (and pension) management system.

Within these two systems, and predominantly with PERSAL, each hospital or cost centre would have an allocated personnel establishment with different staffing categories, post numbers and the relevant salary detail. If clinics had staff dedicated to it's functions as opposed to the staff being allocated through the hospital, then this would be reflected through the PERSAL system as a separate establishment.

"The hospital basically has one organogram for the whole operation and then some of the clinics have of late been given establishments but the posts are not filled by an individual. Its just for the sake of having the professional personnel distributed amongst the facilities. The posts at the clinics are just a shell with a post number, but people aren't dedicated to that particular post meaning that they stay at that clinic."

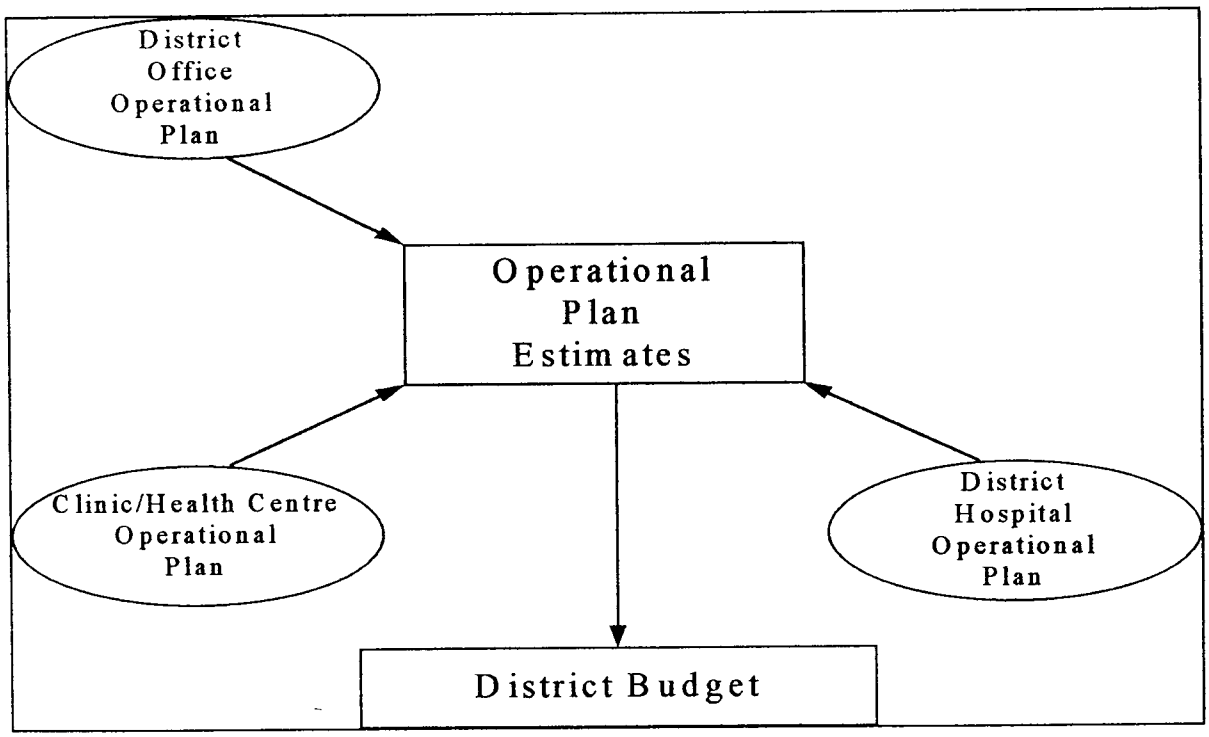
In reviewing the nature of hospital budgeting it is apparent that the key factor related to this process is the establishment of cost centres within the hospital. Within a facility and district (e.g. at the hospital level), there is a need to have a range of cost centres which separate the activities of the hospital. In the current

process of budgeting the hospitals serve as a single cost centre, which treats the hospital as a whole entity. Ideally, for example, wards, out-patients, casualty, theatre should be considered as cost centres, in order to know how much of the budget is used in each area.

4.2.3 The district planning process

In the process advised for every district in terms of the budgeting process, there is a related planning process for which the Mount Frere district is required to develop annual plans for all it's activities. The plans need to be drawn up according to the ZBB form and process. This plan is to be forwarded to the regional and provincial office. Figure 3 illustrates the advised process.

Figure 3: Operational Plan Estimates



Source: Brijlal and Gilson, 1997

The Mount Frere district has developed operational plans through a series of workshops as a result of the ISDS pilot project process. These are still to be evaluated against the budget estimates for the 1996/97 and 1997/98 financial years.

4.2.4 Subsiding local authorities and other service providers

In the Mount Frere district and in Region E specifically, there are no Local Authorities (LA) rendering services for which subsidies (transfer payments) have to be made. In general, LA receive transfer payments from the EC PDoH for preventative and environmental health services and the province allocates an annual subsidy to LA.

In addition, there is limited knowledge at both the regional office in Kokstad and the district office in Mount Frere of the detail of some of the provincially administered vertical programmes such as the Primary School Nutrition Programme (PSNP). This directly affects the ability of the Mount Frere district office to intervene in terms developing co-operative relationships with, and ensuring adequate financial management of, the Non Governmental Organisations (NGO) who have been provincially contracted to deliver services as part of these vertical programmes.

4.2.5 General Procurement

This key task is needed in order to establish and provide effective support services with the Health Department at all levels: Head Office, Regional, District and Institutional level. Within the provincial organogram, the Directorate: Auxiliary Services has, as its main function, to provide office support services and to administer, control and manage the procurement of services and goods. This section of the PDoH is sub-divided into two sub-sections with:

- one sub-section dealing with such issues as registry, photocopying, fax services, typing, security, drivers, messenger and janitorial services; and
- the other sub-section divided up into purchasing, stores and equipment, and transport (EC PDoH Annual Report 1996/97).

In terms of the Provisioning Administration System (PAS), a simplified system has been implemented temporarily until such time as the new system is in place. The directives as laid down by the Head Office in Bisho applies to all institutions as well as provincial, regional and district offices in the provinces. While the PAS regulations are the same, there may be differences between how institutions and district office personnel apply these procedures.

A tender section at Bisho Head Office was set up in the financial year of 1996/97 where with all the work of the tenders relating to the acquisition of all types of equipment, stores, provisions and consultant services was done. Tenders to the value of R 60 million have been processed through the tender unit,

Departmental Tender Committee and Provincial Tender Board for 1996/97 (EC PDoH Annual Report 1996/97). At present a revised PAS has still to be accepted by the Bisho Head Office.

The district office in Mount Frere, as well Mary Theresa and Sipetu hospitals, follow the system as recommended. General procurement within the public sector is regulated by a specific set of procedures[10] as mentioned above. However, not all the tasks related to general procurement for the efficient and effective functioning for health services is located within the Department of Health (see section 4.3)

4.2.6 Drug procurement and management

In the PDoH's budgetary structure, the pharmaceutical component is allocated to Programme 6: Health Care Support Services. Pharmaceutical services and procurement are co-ordinated through the two depots in the province with functional depots in Umtata and Port Elizabeth. All drugs utilised by the services offering PHC (clinics and district hospitals and Local Authorities) are order and delivered from these two depots. The depots are moving towards the pre-packaging of medicines destined to PHC facilities and tablet counters have already arrived at the depots.

The Umtata depot is located on government owned land 4 km from Umtata (Regional Office: D) and is responsible for the distribution of pharmaceuticals to institutions all of region D and E (former homeland areas of Ciskei and Transkei) as well as in parts of region C and B. The functions and tasks related to the pharmaceuticals depot in Umtata (Kintu SR 1995)[11] include acquisition, storage and distribution of all pharmaceuticals, surgical items including instruments, medical equipment, laboratory equipment/reagents, vaccines/thermolabile items and X-ray equipment. Hospitals and clinics are grouped into six distribution regions[12] with each institution supplied every six weeks on a roster or schedule system for a bulk order . Within each pharmaceutical distribution region, there are five to six hospitals.

Pharmaceuticals in the Mount Frere district are ordered through the two hospitals. The district office does not have the physical infrastructure to provide storage facilities for drugs. Clinics still receive their supply

[10] The procedures are documented in a provincial memorandum released in 1995.
[11] Kintu SR. Investigation of drug ordering and distribution practices in three hospitals in Transkei. Thesis for Diploma in Health Management, Economics and Financial planning, Health Economics Unit, University of Cape Town, 1995.
[12] The central distribution region includes the hospitals of Mary Teresa and Sipetu in the Mount Frere district (Kintu 1995)

through the hospital that it is associated with. The district office has a functioning district co-ordinator who deals with drugs but at present, the district office is not active in ordering drug supplies for the clinics as proposed by the EC PDoH in their plan for district development within the former homeland areas.

4.2.7 Claims processing

Claims processing is the activity of recording expenditure that has been incurred on the computerised FMS so that accounts can be paid. The Department of Finance controls all the entry of expenditure onto the FMS through capture points that are distributed across the province.

The Mount Frere district office is not directly linked to the FMS system nor are any of the hospitals in the district. Claims are referred to Frere hospital in East London for capturing, as well as to the Umtata Regional office. The district office as well as the hospitals tend to keep parallel systems of manual records, commitment registers as well as the copies of actual batches of forms that were sent through for capturing.

During the past administrative era of the former Transkei, capturing of accounts was done by Head Office in Umtata. In addition, in the previous system different functions related to the claims processing system were not separated from each other. For example, the purchasing, stores and the expenditure control functions were not separated from each other so that the same staff that were involved in the handling and processing of the claim performed all three functions. Financial control was thus exceedingly difficult.

With the proposed new system, the act of purchasing, stores and expenditure control functions will be separated with different personnel and/or divisions performing the different functions and tasks. If for example a facility requests an item to be purchased, the order will be processed through the ordering/purchasing office. The order is then to be forwarded to the Expenditure Control office. When the order consisting of a number of items is received, the stores office receives the goods and signs the invoice and submits this to the Expenditure Control office. Only when the Expenditure Control office is satisfied that both the invoice and the order has been delivered, will this office initiate the claim for the supplier that is to be processed. This claim, while it will be manually processes in Mount Frere, must however be forwarded/transported to an institution/hospital where there is a FMS line link to the computerised system. It is at this point that the capture of the detail takes place and it would not be unusual for the capturing to take place at Frere Hospital in East London, Region C. Frere Hospital is approximately 400 kilometres from the Mount Frere district office.

4.2.8 Expenditure monitoring

There are a range of functions and activities linked to the process of expenditure monitoring and control. These, as ascertained from regional and provincial level interviews, are outlined below in Box 5.

Box 5: Expenditure monitoring functions

- checking expenditure reports against allocations;
- analyse reports before posting them out, indicating the problems to managers and if there is a problem, following this through with the managers concerned (responsibility of regional finance persons);
- within a given budget, be able to project expenditure as part of the monitoring and controlling function;
- some interviewees felt that at the district level, their function would be mainly one of monitoring as at regional level- in the spirit of decentralisation down to institutional level; because clinics will have in the future (as hospitals in some districts have now) their own financial management systems and capacity..... the need to reduce duplication;
- provincial office needs to do inspections on a quarterly basis but in any district, regional and provincial office this needs to happen on monthly basis. sound financial control involves fulfilling this function (this is not happening according to the Provincial Finance Directorate); and
- Some interviewees clearly felt that while at all levels all the different financial management tasks need to be done, the role of the different levels need to be clear as to what extent the provincial, regional and district level fulfil their role". The heart of the financial division is your bookkeeping section "- this is where all the accounting activities take place including the reconciliation of accounts "It all is the head office function."

Source: HEU interviews and Makan, Morar and McIntyre, 1997

This is an important task of financial management. The hospitals and district office perform this function to different degrees. The regional and district office, and the hospitals in the Mount Frere districts should be receiving FMS expenditure reports on a regular basis. The delay in receiving these report often results in the manual system supplementing the computerised report.

The Directorate: Finance is required to play a significant financial monitoring and control function for all five regions. However, given the transition from the former homelands and the assuming of greater functions in the Bisho office, and noting that differing capacities of regional offices (Region A versus D and E), the directorates task has effectively been increased several fold. The directorate spends an increasing amount of time in the former homeland area regions of the province. The increasing load on the PDoH Directorate: Finance without the necessary people and skills to perform the directorate's functions effectively and efficiently, will impact directly on the ability of this directorate to support regional offices (especially Region B, D and E). This in turn impacts on regional office support to district offices in terms of district financial management capacity with regard to budgeting and planning.

The Directorate: Finance's financial control sub-division ensures that proper control over voted funds is via the maintenance of an orderly book keeping system as well as ascertaining that proper control is kept of accounts, allocations of funds and accurate records of payments. The Directorate: Finance's expenditure sub-division has the job of accurately processing the departments liabilities and the rendering of salary services.

It is pertinent to point out that the hospitals in the Mount Frere district are monitoring their expenditure despite not having received their budgetary allocation for this financial year 1997/98, already five months into the same year.

4.2.9 Virement

Virement involves the movement of funds/budgets between activities or line items within a budget, in response to either over/under-expenditure. This is not occurring within the Mount Frere district and all other districts within the province as the PDoH would require permission from the provincial Treasury to do so.

Present regulations do not permit funds to be moved between activities within the district e.g. from the district hospital budget allocations to the budget of the clinic. No funds can be moved out of a classified standard item such as personnel.

CHAPTER 5. DEFINING AND DESCRIBING THE CURRENT CAPACITY PROBLEMS IN THE MOUNT FRERE DISTRICT

5.1 Human Resources: Are enough appropriately trained people available?

5.1.1 New staff structures and staff availability

The present district organogram was approved by the Provincial PSC in 1996 with a generic district management structure. The appointment of personnel to these posts is, however, subject to the availability of funds. Mount Frere, like other districts, still only has an interim district health and welfare management team (IDHWMT). Only the district manager is officially appointed with all other personnel seconded to the district office from existing facilities within the district. Compounding the problem is the fact that the regional office in Kokstad has only five approved posts.

Key administrative personnel within the organogram of the sub-directorate District Administrative services who are expected to deal with much of the financial tasks (as described in section 4) include: Assistant Director, Personnel Officers for Personnel Services, an accountant and accounting clerks for finance administration, and Administrative Clerks and storekeepers for provisioning services.

Interviewees at the district and regional offices agreed that accountants and district pharmacists were key personnel to attract. The problem of recruiting staff to rural areas with the lower civil service salaries without appropriate incentive schemes, as well as retaining existing staff within the district and region was highlighted by interviewees. Interviewees also pointed out the following:

- concerns about the manner in which the organogram was established without clarifying and establishing the roles and job descriptions of some of the posts at district level e.g. at Mary Theresa hospital there is no superintendent and the district manager fulfils both roles which may create confusion among the staff;
- that there was no differential approach of the province in considering the needs of deep rural areas as all regional offices were instructed that the provincial level had placed a restriction on regions and districts being unable to advertise for clinic staff from outside of the province. It may have been better to allow for certain rural district to recruit staff from other provinces;
- the district office is staffed with internal appointments from the hospitals and clinics within the district and these personnel may not be the best persons to take on a new role in supporting district-wide activities; and

- their concerns about the implementation and newly defined functions that the clinics and district office will assume in separating the hospital and clinics where the new roles of the people within these structures have not yet been considered in detail.

5.1.2 Staff experience, knowledge and behaviour

It was apparent from all the interviewees at clinic, hospital, district office and regional office level that the background experience and skills of key staff varies considerably. Many of the staff appointed or seconded to the district and regional offices, particularly those from within the facilities of the region, felt that they had poor backgrounds and weak skills in financial management. The following issues were highlighted:

- at regional level, the recognition that some of the hospital administrators had limited experience of and limited training in especially budgeting and planning;
- at district level that clerical staff in the former Transkei were unfamiliar with the management systems selected to be used in the province;
- that in Mount Frere, institutional management were reshuffled from hospitals to the district office to build the best possible team (IDHWMT) for district development, with staff having limited experience in their role of supervising district-wide activities as opposed to hospital activities;
- staff within the district office need to acquire not only the knowledge of tasks but also skills in communicating and addressing issues of district importance as opposed to individual preferences; and
- the issue of the disciplinary procedures within the public sector is being inadequately addressed which constrains the process of transforming the "culture of fraud."

5.1.3 Current training strategies

Many interviewees indicated the absolute need for training within the district and the region as a whole. This need was linked to historical development of the homeland system. This was particularly so in that the interviewees often pointed out that with the previous administration of Transkei, most if not all functions were centralised to Umtata Head Office. This disadvantaged many institutions as well as individuals.

In addition to the universal indication from interviewees about the need for training, the following issues were highlighted:

- the need for staff at the district office to clearly understand their roles and functions and to be trained accordingly;
- the length of time that some of district staff are away from the office "in training" (especially the district manager) affects their ability to function optimally
- the need to "spread the training" so that the same individuals are not consistently required to go for training;
- there is a need to identify the correct target group for training - " those that are trainable and to offer the severance package to those who are not;"
- that specific consideration should be given to clerical staff involved in financial management activities for training; and
- the provincial level should give preferential attention to the more disadvantaged regions for provincial and regional training programmes.

The training formats vary from formal certificate courses at University level to the training programmes on offer by the province for specific issues such as the Tender procedures, FMS and PERSAL. A consistent theme from all those interviewed was the need for more on-the-job-training, more practically orientated, at best to be conducted at the place of work, and with sufficient follow-up, support and encouragement after the initial training.

5.2 Planning and budgeting weaknesses

Weaknesses identified at hospital and clinic level are indicated in Box 6 below

Box 6: Planning And Budgeting Weaknesses At Hospital And Clinic Level.

- the need for a formalised planning and budgeting cycle and that the process be co-ordinated through the district office;
- the lack of consistent feedback from the district office to the clinics about the "wish list" forwarded by clinics as requested from the district office;
- no specific training on drug management and budgeting skills;
- no staff on the clinic establishment (e.g. clerks, dispensary assistance) to perform these functions at present; and
- no formal planning and budgeting committee meets regularly.

Source: HEU interviews, 1997

Weaknesses identified by the IDHWMT at the district office and the regional office interviewees are included in Box 7 and 8 below.

Box 7: Planning And Budgeting Weaknesses At the District Office.

- lack of skills development throughout the district on how to plan, to budget, read reports, monitor expenditure, drug management, etc.;
- unavailability of key documents such as the tender documents, list of contracts, etc.;
- absence of a regional and district tendering committee to approve certain local tenders which may be used for purchasing items speedily;
- limited support and assistance from the regional office with regard to budget estimates for items such as X-ray equipment and materials; and
- poor, if not absent feedback from the regional office about progress of budgets and plans.

Source: HEU interviews, 1997

Box 8: Planning And Budgeting Weaknesses At the Regional Office.

- absence of a regional tender committee
- the lack of clearly defined objectives from the provincial level for planning and budgeting processes;
- the present budgetary processes are not taken seriously; and
- lack of clear lines of responsibility and functions in terms of managing finances between district and regional offices

Source: HEU interviews, 1997

In general, the planning and budgetary process is perceived to be top-down. The consequences of this top-down process are indicated in Box 9 below.

Box 9: Consequences Of A "Top Down" Planning And Budgeting Process.

- the process is seen as 'not transparent' as variances in the allocations are not explained;
- no buy-in (ownership) at hospital management level, ("It is not our budget.");
- no contracting between province and other levels within the health department i.e. no agreement on performance targets or indicators;
- the separation of the process of planning from budgeting;
- hospital managers forced to accept allocations knowing that they will overspend as they don't have operational authority to reduce expenditures significantly;
- no community or hospital representation on the allocation process;
- allocations bear no relation to prior expenditure or expected needs;
- managers are using the budgets that they prepared in order to monitor expenditure rather than the allocated budget that is entered into the FMS because the process has been delayed; and
- the current budget allocations are linked to historical allocations which are characterised by considerable inequities between similar hospitals.

Source: HEU interviews, 1997

The provincial to hospital budgeting process results in budgets being seen as the PDoH's stated intent of inputs with no consideration to outputs or outcomes. The fact that there are no **links of budgets to outputs** has direct consequences for how the provincial hospital management view their financial management function. The consequences of this approach for the Mount Frere district as well as the EC PDoH are included in Box 10 below.

Box 10: Consequences Of Budgets Not Being Linked To Outputs For Hospitals

- some allocations that are made are lower than the prior year's expenditure without an agreement on changes in service delivery or patient profiles;
- free care has increased the number of attendance's in the last 12 months, this has not been reflected in hospital allocations;
- some hospitals that have opened new departments which have increased costs, have not had this reflected in the allocations;
- allocations made to hospitals do not reflect all expenditures incurred at the hospital, the Dept. of Transport and Works controls the budgets for some activities of the hospital; and
- EC PDoH seldom holds contingency budgets which can be used for either managing unforeseen and unavoidable events effectively or used as tools for the implementation of strategic interventions when required.

Source: HEU interviews, 1997

Given the emphasis on the budgeting problem and the introduction of the ZBB process, there is significant reason to believe that staff responsible are actually using incremental budgeting. The issue of staff "capacity" is important as may staff were exposed to the "Ciskeian process" where someone at the regional office (e.g. at Bisho) used to decide for the facilities on the compiling of budgets. Currently budgeting requests are processed in a slightly different way, with greater emphasis on involvement. However, consultation and negotiation has to date been extremely limited with changes in budgetary allocations occurring but unaccompanied by any motivation. While it may be recognised that the old processes are beginning to change, this is occurring at an extremely slow pace.

The introduction of a new financial budgeting system needs to be reviewed in terms of the objectives of implementing a new system. There is a need for a clear understanding of what the current situation is, regarding the limitations and capacity problems. The introduction of a complicated reporting system needs to be matched to the needs of users. An assessment and consultation is needed of the reporting needs, for example of the monthly report structure and link to the system (e.g. an Excel spreadsheet format). The ultimate objective should be a more user friendly reporting system than what is currently being extracted from FMS. The costs of implementing a new system as opposed to the adaptation of the existing system needs full investigation taking into account the likely benefits of the two options.

5.3 Procurement and related expenditure monitoring problems

5.3.1 Procurement: the case of drugs

Hospitals have a main medical store which receives the stock and then distributes it within the hospital and to the clinics. Direct control and monitoring is working within the hospital but the problem lies with not being able to monitor and control at the clinic level. The hospital is not in a position to supervise or to check on the clinics routinely, with "spot checks being done once in a while." For the hospital, they do stock take every six weeks before placing the main or bulk order.

Within the hospitals that the Umtata depot serves, it is clear that the dispensaries were not well planned when they were being constructed. In some hospitals, rooms were provided as dispensaries without adequate storage facilities. In considering the separation of the clinic budgets from the hospitals, hospitals have in the past not been able to meet the demand from the clinics. It is thus beneficial to the clinics to be able to order directly from the depot in Umtata. This will benefit the hospital because it "could be relieved of the burden of having to control the trucks from..[the hospital] to the consumer [at the clinic]".

This may in future need to be accompanied by the necessary support establishment at the clinic but the urgent priority for the Mount Frere district would be the appointment of a District Pharmacist.

Deliveries to the Umtata depots are done by road transport, railway and by air for the vaccines (small consignments may be sent by post). Problems which affect the distribution of essential pharmaceuticals from the depot to hospitals are included in Box 11 below.

Box 11: Problems Which Affect The Distribution Of Essential Pharmaceuticals From The Umtata Depot To Hospitals

- delay in payment of accounts (from Bisho Head Office) to supplier;
- firms do no meet their delivery requirements to the depot;
- lack of qualified Pharmacists to service the six distribution regions (3 posts available, only one filled permanently;
- lack of qualified storekeepers and officers (for drugs) as well as inadequate training for storekeepers in stock management;
- indiscipline among drivers resulting in delays in arrival of stock at the institution;
- lack of or poor maintenance of vehicles affecting reliability of transport;
- shrinkage and theft of stock from poor stock management systems;
- poor management of stock which leads to overstocking and expired stock;
- general lack of security facilities at the depot as well as at the regional and district offices;
- lack of proper stores equipment such as fork lifts and pallet lifters;
- personnel issues such as poor conditions of service, job mobility and career paths; and
- lengthy administrative procedures.

Source: HEU interviews 1997, and Kintu 1995

The problems mentioned in Box 11 above are specifically those encountered at the Umtata Depot. Box 12 below reflect the problems encountered at the service level of hospitals and clinics in Mount Frere.

Box 12: Problems Which Affect The Distribution Of Essential Pharmaceuticals From Hospitals and Clinics.

- most dispensaries served by the Umtata depot are not up to standard with lack of proper storage facilities;
- personnel issues with most dispensaries not having staff who are adequately trained in stock management;
- lack of vehicles being available and/or poor maintenance of the existing vehicles;
- the PDoH is dependent on other departments for transport requirements (Department of Transport) and for repair and maintenance of hospitals and dispensaries (Department of Public Works);
- inappropriate types of vehicles for use on poor and inaccessible roads in rural area;
- definitive lack of some core competencies of personnel as well as inadequate supervision; and
- history of indiscipline among staff and misuse of state facilities with stock missing from facility level;

Source: HEU interviews 1997.

In addition to the problems mentioned above, the EC PDoH's policy proposal for clinics to administer their own budgets and order directly from the depot will compound the existing problems. The role of the district office in co-ordinating some of the new functions which will be delegated to the clinics is important in ensuring that clinics receive a regular supply of the essential pharmaceuticals. The problem with the district offices at this stage of development is that the office does not have the financial management capacity to perform this co-ordinating function. There needs to be rapid progress towards the establishment of functional district offices, moving forward from merely the approval of the district organogram from the PSC. In expecting the clinic personnel to begin to budget and manage their stock and still continue to perform clinical duties is not practical. The clinic needs a dedicated establishment with a clerk, pharmacy assistant etc. in order to perform certain of the tasks required for sound financial management.

Stock management remains a problem in Regions D and E as well as other areas. The problems relates to not only to the number of personnel available at the district office, Mary Teresa and Sipetu hospitals, but also the ability of the personnel to perform their functions. Hospitals have been using personnel with limited formal education with "staff members...[having]..standard ten or even lower than that, who have had no training at all...we train them on the job...and ..we expect them to control our medicines, to distribute and to dispense to the public."

The depot in Umtata only plays the role of the distributor of pharmaceuticals as well as collecting expenditure information to the institutions. The depot plays no regulating, auditing or support role for institutions in the distribution region. The responsibility for control and monitoring rests at the district office and hospital level. The depot processes all orders coming to the depot. This problem needs to be addressed at regional and district level.

Most of the managers interviewed supported the proposed process/method of procurement of drugs of the provincial level which includes the following components:

- The type of drugs ordered and supplied to facilities is to be determined by the Essential Drugs List (EDL);
- The District develops a consolidated drugs budget for district needs, i.e. includes the District Hospitals, Community Hospitals, Health Centres and Clinics (including that of Local Authorities).
- The procurement of drugs for the clinics to be co-ordinated through the District Pharmacist, or should there be no District Pharmacist, then the Regional Pharmacist. The district office to have the physical space for a medical and drug store with an effective and efficient stock management system.

- District hospitals will continue to function as they have in the past with regard to hospital stock but may be required to assist clinics previously attached to the hospital until such time as the clinics have the capacity to manage the clinic budget including pharmaceuticals.

5.3.2 Expenditure monitoring

Effective expenditure monitoring is constrained by a number of factors. These include:

- hospitals and the district office use a manual system to track expenditure;
- problems related to the FMS reports which includes the following:
    - the availability of FMS reports is not timeous;
    - the reporting format is one of that which is not easily understood;
    - only claims that have been processed are recorded as expenditure rather than the processed claims as well as the commitments of expenditure already made but not yet processed for payment;
    - printouts are only available at specific locations and there is limited district level link-up; and
    - drug expenditure is recorded within the standard item "stores and livestock."
- manual records of expenditure items tend to recorded with each item done separately and that specific item is then monitored against it's specific budget (where available)- this makes more global expenditure monitoring a separate process; and
- that hospital administrators feel that there is a "need for muscle in our controlling function" and that to do this there must be proper controlling measures, computer infrastructure and accountability.

Together with the above-mentioned problems, the lack of skills is significant. Effective expenditure monitoring must be seen as part of the overall planning and budgeting process and will require appropriate development of information systems.

5.3.3 Information and Systems for Financial Management (information availability)

The PDoH makes use of the FMS I and II systems for financial management. (Reference document: Provincial DoH circular dated 3/11/96). Both FMS I and II are detailed accounting systems facilitating and monitoring expenditures. For FMS II, all budgeting and expenditure reports are available on-line.

The format of all financial information systems, reports and forms are controlled by the PSC. The PDoH has no discretionary power and authority to implement systems, forms, reports, etc. which would best

meet their needs. Many hospitals at district level are not yet computerised and are still using manual systems. Proper financial management cannot occur without the necessary information on financial and operational activities. There exists a lack of coherent national and provincial information strategies that focuses on the requirements for financial management at all levels of the EC PDoH. Without such a strategy, it is impossible to integrate information management into operational and strategic management of the health service.

Specific problems with regard to the present systems include the following:

- the system does not allow the budget to be organised according to cost centres which would integrate all expenditure around an activity;
- the system is not in line with general accounting principles, i.e. no catering for accrual accounting and balance sheet management;
- budgeting and recording of expenditures (inputs) cannot be integrated with measuring of outputs;
- lack of skilled people to interpret financial data; and
- users are not trained or skilled to gain the maximum benefit from the present system.

A key requirement for good budgeting is that costs are identified accurately. The budgeting process and compiling of estimates are inhibited by the:

- lack of information systems capable of providing costing information where the current systems are designed for expenditure controls;
- the number of skilled people at the regional and district level capable of costing activities accurately; and
- problem that many costs (e.g. capital, maintenance and repair, etc.) of the hospital are nor reflected in their budgets on a routine basis.

Many of the problems listed above are relevant to the Mount Frere district and the regional level. Specifically in Mount Frere, there are problems with the systems that are kept for drug information. Neither Sipetu nor Mary Theresa Hospital would on a routine basis keep cards for medicines which would provide costs and quantities of drugs used by the clinics. In addition, the integration of service related data and financial data remains a problem as with many other districts.

5.4 Support and supervision

Interviewees had varied responses about the support received from the regional office. The hospitals indicated that they had received limited support from the regional office in terms of assistance with the

ZBB process. There is however evidence that many of the requests and decisions that emanate from the regional office including the finance division are through verbal requests or instruction. This creates problems with issues of support and supervision as well as accountability.

Interviewees from hospitals and clinics within the Mount Frere district highlighted that in terms of their understanding and experience the development of the DHS, the district office is required to provide support and supervision to the hospitals and clinics. However, there was also recognition that the IDHWMT in the district office is clearly unable to do this because of a number of constraining factors already mentioned.

The issue of communication and discussion with the relevant staff in the facilities is therefore important in developing mutual understanding of the pace of change as well as the limitations of the IDHWMT. This issue of communication still remains a problem. The district manager is required to perform numerous functions including that of the hospital superintendent of Mary Theresa hospital. This may affect the support and supervision as one person cannot be expected to perform efficiently all these functions.

5.5 Authority: Do districts have adequate authority?

5.5.1 Centralisation within the province and public sector

While the stated policy within the EC PDoH is the development of a decentralised DHS, interviewees raised specific concerns about the current trend towards centralisation within the province. The issues include:

- the newly introduced restriction on provisioning having to take place through the regional office;
- the role of the Department of Public Works in maintaining existing and constructing new buildings; and
- the existing Tender Board procedures (where procurement occurs when an item is outside of the approved contract list of the province or it exceeds the expenditure limits that the district level personnel are permitted to authorise).

The newly introduced restriction on provisioning was introduced in August/September 1997 with district offices having to procure items through the regional office. The introduction of this centralised system was a result of the financial deficit incurred by the EC province as a whole, as well as the deficit within the PDoH. Centralisation is therefore seen as a means to control expenditure so that the EC PDoH remains within budget for the forthcoming financial year. The problem is that there is no stated intent about

whether this centralised system is to be reversed, the period that it would be operational for and how this would affect DHS development.

The authority for key functions within financial management lies outside of the Department of Health. A wide range of functions are required of the district manager as well as hospital managers within the district. The key areas of human resource management and transport functions in addition to that already mentioned is also centralised. The problems with the PSC result in long delays in the appointment of staff, very little room to make shifts in reshuffling personnel and management at hospital level and few incentives for rural areas are just some of the problem. This organisational problem pervasive within the public sector of having limited authority to reshuffle personnel is a weakness. This affects the ability of the district management teams to deploy personnel within the district in order to meet the needs of service delivery within the district.

5.5.2 Authority delegations

Delegations, within the context of the EC PDoH, involve the transfer of managerial responsibility for defined tasks and functions so that these tasks and functions are only indirectly controlled centrally by the provincial level of the DoH. Delegations represent an important step in enabling district capacity development. Importantly, delegations may also begin to define more clearly the specific responsibilities of different groups at the district and regional levels with regard to key financial management tasks.

The lack of and/or limited powers of delegation occur within a number of tasks and functions already described in the preceding sections. Problems exist in the following key areas because of the lack of or limited delegation of authority:

- human resource management (see section 5.1)
- procurement procedures and financial limits placed on procuring (see sections 4.2.5 and 5.3)
- information systems, reports and forms (see section 5.3.3)

An important issue that accompanies delegations is the "capacity" of the Mount Frere district to absorb these delegations. Managers at the district and regional level expressed concerns about financial mis-management. Thus the following must be taken into account in addressing the capacity problems:

- that delegations need to be seen as steps in empowering district management teams;
- there must be a review period and indicators used to measure how the district is performing with the new delegation;
- appropriate training and skills will accompany the delegations; and

- adequate communication and preparation at a pace that will enable district development and not constrain.

5.6 Are districts accountable?

The accountability of staff and managers is critical to any organisation. The accountability of the district office would be to the regional office, the provincial level and to the public. Performance monitoring thus requires an agreement with the district level about what is expected in terms of delivery, how frequently reports and monitoring progress will need to take place as well as what will happen if the performance targets are not met.

In defining and describing whether districts are indeed accountable, interviewees raised the following as problems of "capacity" that:

- managers have no authority over staff budgets or staffing issues;
- no penalties currently exist for not keeping within the allocated budgets;
- there are no direct mechanisms of accountability to the public and higher levels; and
- budgets are very rigid and managers have no flexibility in using financial resources to meet their goals.

5.7 Are task networks functioning effectively?

A range of groups/people/departments/organisations are involved in the tasks of financial management. The task network refers to the interaction of the organisations of people in undertaking financial management tasks. In many of the regions that were visited, problems were experienced with the different provincial departments that the regions and district works with. Regional offices have different working relationships with their counterparts in the different offices. In region E for example, some of the departments (e.g. Public Works, Transport) do not have their regional offices established. In the view of the Regional Director for Health, health department may be in a better position to perform some of these functions (e.g. the purchasing of the appropriate vehicles for the districts).

These problems arise mainly due to the fact that the regional and district offices for health do not have control over all budgets relating to their functioning, e.g. the budgets for capital is administered by the Department of Public Works (which is also responsible for maintenance functions within the region, districts and facilities). The Department of Public Works deals with the maintenance and upkeep of existing buildings and equipment and the construction of new buildings within Mount Frere district. The

Department of Transport is responsible for the procurement of new vehicles and the repairs and maintenance of existing vehicles. The tasks performed by both these departments are done on behalf of the functional service unit i.e. Department of Health.

Problems were uniformly experienced with three different Provincial Departments, the Department of Public Works, the Department of Transport and the Tender Board although the degree to which these problems affect district development varies considerably between the different regions. Within the district, there has been an indication of the increasing need to inter-link the activities of the Department of Public Works and the Department of Health. The problem however, besides the bureaucratic red tape and subsequent delays, relate to internal capacity problems existing within the Department of Public Works and also the fact that the district and regional boundaries between the two departments do not correspond.

The problem is that each department has different priorities which could conflict with the functioning of other departments especially with regard to the Department of Public Works and Transport where often communication has broken down. In the Mount Frere district, with reference to the work of Public Works there is a lack of knowledge about what is happening with the renovations/buildings occurring at the hospitals. There is no access to the contract agreement so that the IDHWMT and hospital managers would not know if a contractor has completed their work as stipulated in the contract.

The Department of Transport purchases vehicles on behalf of the Mount Frere district and it has occurred where the type of vehicle that has been recommended by the IDHWMT for purchase is not adhered to. The type of vehicle provided is then inappropriate for use on roads that are in a poor condition.

The problems within the task networks of financial management relate to the scope of the networks involved. This involves the following:

- the network of groups/organisation within the Department of Health between different levels e.g. district finance-regional finance-provincial finance directorates;
- network of groups/organisation within the DoH at provincial and regional level linking across functions at the same level e.g. in estimation for the budget at the provincial level, the finance division, PHC programmes and hospital services may all be involved; and
- networks of groups/organisation which will be across departments e.g. Department of Public Works and Health for maintenance of equipment and buildings at Sipetu hospital in the Mount Frere district.

Interviewees describe the problem of a considerable lack of or poor communication between the different departments, as well as within the health department at provincial level. This is also true for the regional

level although communication is better at regional level between different departments where these other departments exists in Kokstad. The ability of the district manager as well as the regional office in overcoming the issue of poor communication is important with regard to the perceptions of personnel at the district level.

There needs to be consistent communication through more formalised channels as well as the continuation of the present informal communication. The continuing of the informal communication as a supplement to the formal communication will contribute to the building of the IDHWMT as a team and make the task network between the Mount Frere district and the regional office in Kokstad well functioning.

CHAPTER 6. DHS IMPLEMENTATION STRATEGIES

Through the needs assessment conducted within the Eastern Cape province (Makan, Morar, McIntyre 1997), an area of concern highlighted by district managers was that the current strategy of implementation within the overall DHS development is in itself an area of weakness. As identified, these weaknesses may relate not only to the *style of implementation* (e.g. top-down orientation, lack of transparency and involvement, inappropriate deadline periods etc.) but also to the appropriateness of the strategy (see Box 13 below).

The top-down decision-making process has the potential to alienate district managers and impede DHS development. A prominent example of this was the establishment of the district office organogram which was based on a generic proposal without giving due consideration to the range of functions that were required to be performed at the district level. Appropriate job descriptions should have been developed based on the range of functions performed and then matched to the post or establishment structure. This was even reflected at the provincial level, where the finance directorate was faced with a similar problem regarding the establishment of post structures prior to establishing functions that needed to be performed.

There are a number of factors relating to the implementation strategies that need recognition. If these factors are not quickly addressed, they may exacerbate the current predicament of DHS development. Box 13 summarises these issues.

Box 13: Factors relating to the implementation strategies with reference to DHS Development in EC PDoH

- ⇒ the *linear and uniform approach* associated with the *introduction and development of policy and functional changes* occurring within the province;
- ⇒ the *pace and diversity* of the linear approach being introduced (recognising the rigid processes and time pressure);
- ⇒ limited focused *support strategies* in regions and districts that were historically disadvantaged (especially those located in the former homelands);
- ⇒ little or no *evaluation and monitoring of the effects of the changes* that were implemented; and
- ⇒ the *use of external consultants* to investigate and introduce the initial changes with problems of subsequent support and follow-up during implementation (e.g. the extension of the FMS functional network).

Source: HEU interviews, and Makan, Morar, McIntyre 1997.

The *linear and uniform approach* referred to in Box 13, is most adequately illustrated by an example cited at the regional level. In the establishment of functional finance directorates within the EC PDoH, some of

the required core and experienced staff were relocated from existing and newly established regional offices to the provincial office in Bisho. Regional offices in turn, drew core and experienced staff from existing hospital facilities and newly established district offices.

This *linear absorption process* of recruiting personnel to establish functional provincial and regional offices *"leaves the establishment of functional district offices to last"*. The nature of this implementation strategy is beginning to impeding DHS development. More importantly, a similar implementation strategy is adopted with regard to delegations. For example, the progression of delegations from provincial level to regional level, from regional level to district and facility level results in "leaving the districts for last" again.

There is a developing understanding at regional level about the *pace and diversity* of changes and the impact of the *linear and uniform* implementation strategy being effected within the province. The diversity of changes within the EC PDoH includes the amalgamation of three previous administrations, the establishment of regional and district offices, the development of a single personnel salary system, an inventory of all super-numerary staff in the province, the appointment of eleven district managers of the twenty-one districts established, etc. In recognising the rigid processes and time pressures under which some of these changes occurred, regional and district offices are constantly in a "mode of crises management."

While regional and district offices are required to assume the functions of effective and efficient financial management at a fast pace, the support and supply of appropriate personnel, physical infrastructure and systems development is occurring at a much slower pace. For example, the provincially-driven planning and budgeting processes and the resource allocation mechanisms are not accompanied by clear guidelines and realistic time frames for planning and budgeting at the regional and district level.

This is a problem particularly in those regions that contain the former homelands, where experience in planning and budgeting processes is extremely limited. In the former Transkei, the entire planning and budgeting process was performed and contained within the Head Office in Umtata. This also contributes to mis-understandings and poor communication between provincial and regional levels and district and regional levels. The communication problems between the various levels may in fact serve to limit the effectiveness of the overall implementation strategy.

Consistent with the above-mentioned problems is the absence of or limited focused *support strategies* for regions and districts that were historically disadvantaged. The provincial level needs to address the issue of providing sustained and strategic support in a co-ordinated and preferential manner according to regions and districts in greatest need. This approach would be consistent with the principles of providing

unequal treatment for unequal need. In applying this concept of vertical equity, consideration must be given to a working definition of need of regions and districts, and certain implicit value judgements about how the provincial level is to react and how to prioritise support and co-ordination for relative needs.

The evaluation and monitoring of these changes needs to be seen as part of the implementation strategies. For example, it is proposed that the district hospitals' budgets and functions be separated from those of the clinics previously attached and operating through the hospitals. However, in the Mount Frere district, the district office cannot be expected to perform the role of the hospital in terms of the provisioning and management of pharmaceuticals for clinics in the absence of the physical infrastructure and available personnel as is presently the case. **Proposed policies as illustrated will need to be monitored and evaluated if applied differentially and appropriately across regions and districts.**

As a result of the factors mentioned above, frustrations which result from the current implementation strategy are likely to either spill-over or impede future strategies of implementation. If the current strategy is part of the first stages in the process for DHS development, emanating either from the provincial and/or national level, then the Eastern Cape provincial department needs to adequately communicate the vision and associated stages of the broader implementation strategy.

There is a clear need to balance the pace and range of changes that need radical action with the need to develop preconditions for successful implementation. The process of implementation should serve as an additional mechanism for improving the understanding of district managers and involvement and participation of these managers in the overall DHS development. The process of implementing delegations and associated actions is particularly subjected to criticism by district and regional managers. The concern is that delegations are often unaccompanied by the provision of the necessary physical infrastructure, finance personnel and support staff (including procurement and stores officers, storage office space etc.).

In examining the issue of DHS implementation strategies, this project needs to build on policy related research already done at national and provincial level within health systems change and decentralisation. The Hospital Strategy Project (HSP) undertook a thorough analysis of decentralised financial management in hospitals and provided detailed understanding of the goal or vision of financial management at hospital level. It is pertinent to point out that the HSP was conducted at a time when hospitals were generally considered to be outside the domain of districts. However, the district level 1 hospital is an integral part of the DHS development strategy.

Despite this potential conflicting view on the role of hospitals in the DHS, importantly the proposed implementation strategy of the HSP recommends that a few hospitals are initially selected for "fast track" pilot sites where implementation will begin. From this "learning-by-doing" philosophy, lessons for large scale implementation will be generated. The HSP recommendations are there to "bridge the performance gap between the ideal level and the existing level of financial management in hospitals.[13]" According to the HSP project recommendations, it is stated that the existence of a vision and strategic preconditions should be accompanied by a strategic implementation plan. *"Irrespective of the option chosen a strategic implementation plan is needed. This plan must make provision for a graduated and managed approach. The plan should include standards and training"* (HSP, 1997). The HSP recommends that the "fast- track" hospitals are allocated incrementally increasing powers and associated accountability and responsibility to the chief executive officer of the selected hospital. **Implementation is a responsibility of management."** (HSP, February 1996)

In summary, corrective actions in terms of the factors considered in Box 13 are critical for the effectiveness of further implementation strategies and if not addressed, may in fact serve to impede overall DHS development.

[13] Deloitte and Touche. Decentralised Financial Management in Hospitals. Final Report. Hospital Strategy Project, February 1996.

CHAPTER 7. RECOMMENDATIONS FOR THE MOUNT FRERE DISTRICT AND REGIONAL OFFICE IN KOKSTAD

This final section draws extensively on the report from the CHP/HEU study as well as the interviews conducted in this intra-district study.

7.1 To develop the planning and budgeting system in the Mount Frere district.

7.1.1 District level

The district office, with the district manager as the co-ordinator needs to re-establish the basic building blocks of planning and budgeting in the district. This will include the following:

- Developing a vision of the district planning and budgeting process for the Mount Frere district consistent with that developed by the provincial level. The vision needs to be adequately motivated and established through the participation and communication with the staff within the district office, the hospitals and clinics as well as key stakeholders within the community.

- The establishment of a formal District Financial Management Budgeting Task Team (DFMBTT). The composition of the task team will include the district manager as overall convenor, the District Administrative Officer, the co-ordinators of the existing task teams on drugs, transport and capital works as well as a representative from the regional office. The function and role of this task team will include:
    - driving the process of preparing the annual district budget;
    - provide the information on expenditure patterns to allow the IDHWMT to develop an appropriate health plan and budget;
    - set clear and fixed timeframes for the development of the district budget;
    - review, monitor and control expenditure;
    - evaluate and review budgets;
    - co-ordinate the collecting and collation of financial information; and
    - identify issues of building financial management capacity and the related training needs.

  This committee should meet regularly, as opposed to only when budgets estimates are required, and may assist the district office to develop a strategic plan of managing the district by the priority needs of the district.

- Facilitating a population or needs-based approach to district planning and budgeting by requesting that the DFMBTT call for additional information to the financial information to assist this process.

7.1.2 Regional office in Kokstad

The regional office must nominate an individual to participate on the DFMBTT. This person will:

- Provide financial management expertise to support the process in the Mount Frere district through:
    - ensuring that FMS expenditure reports are timeously available;
    - assisting with the costing of items when budget estimates are prepared; and
    - providing the necessary information about capital items such as vehicles, maintenance contracts and equipment such as X-ray equipment.

- Serve as the key link between the regional office and the other three districts in learning from the experience of the Mount Frere district.

7.1.3 Provincial level

This level must support the region and Mount Frere district in the planning and budgeting process by:

- Ensuring access to expenditure data which can be translated into a concise and appropriate form e.g. in summary format by standard item as well as by cost centre.

- Setting clear guidelines and realistic time frames to which the provincial level is committed to and providing adequate feedback in terms of budgetary estimates and allocations.

- Developing equity-based target allocations for districts through a resource allocation process and the following:
    - developing the understanding of the regional and district level of the needs-based approach;
    - preferentially supporting districts and regions in greatest need and developing their "absorptive capacity" for these additional resources; and
    - timeous feedback on the allocations to districts especially where budgetary allocations for districts have been increased or decreased.

- Facilitate appropriate on-the-job and on-going skills development and training through the ISDS and other training institutions for planning and budgeting purposes.

- Ensure that provincial level programmes such as the Primary School Nutrition Programme link and interact with the Mount Frere district office. This is for better local co-ordination as well as providing budgetary details to the district office for planning purposes.

7.2 To complete the task of identifying key tasks, roles, responsibilities and functions of the district office, hospital and clinic staff.

The district office in Mount Frere must continue and complete the task of identifying key tasks, roles, responsibilities and functions of the district office, as well as hospital and clinic staff. The related activities in completing this will take place at the different levels.

7.2.1 At the district level, the specific areas needing attention in order to complete the task includes:

- Communicating to staff at the district facilities so that they are informed of the process the district office is embarking upon so that staff are able to meaningfully participate.

- The development of a human resource inventory for the entire district and updating this database on a regular basis in the format that will include the name and age of staff member, their post designation, the cost centre allocation (hospital, clinic, district office, community services) and salary.

- The development of simple monitoring and evaluation components that will attempt to map the progress of this process. These components could include:
    - the number of people in the district office with written job descriptions; and
    - the number of clinics who are aware of these job descriptions.

7.2.2 Regional office

The district office, in order to complete this task, will require the regional office to provide assistance with the following:

- To provide access to the job descriptions of district level personnel that are available at the regional office.

- To make available PERSAL printouts to assist the district office with developing the human resource inventory.

- To identify and provide the names and post designations of personnel who have been transferred out of the Mount Frere district but are still reflected as expenditure items of the Mount Frere district.

7.3 The developing, enabling and supporting of district facilities and the district office.

Realising this recommendation will require the various levels of DHS development to activate certain activities.

7.3.1 At the district level, the urgent priority would be the following:

- The establishment of the necessary physical infrastructure and capability of the Mount Frere district office by finding suitable and adequate office space, the presence of the administrative systems, electrification, telecommunications, computers, etc.

- Hospitals within the district need to regard the district office, and not the regional office, as their immediate level of accountability and line management for consultation and discussion. Regional advice and support should only be sought in consultation with the district manager as is necessary and not as a matter of routine.

7.3.2 At the regional and provincial levels, the following:

- The regional office must lobby with the provincial level District Financing Task Team (DFTT) to facilitate the establishment, preferentially and fast tracking, of the Mount Frere district office.

- Cognisance must be taken that pursuing realistic and appropriate time frames for district development is critical. These time frames must allow for:
    - a flexible implementation strategies adapted to different needs of district;
    - a phased approach and attempting to do things in different hospitals and clinics to be established so that new systems can be tested in piloting followed by the revision of this strategy and then implemented to the benefit of other districts in the province. (This philosophy is encompassed in "learning-by-doing").
    - the development of guidelines on how capable or possible (absorptive capacity) it is for the facilities and district office to do things (e.g. addressing new delegations of virement, tender board regulations etc.)

7.4 The appointment of key personnel to permanent posts in the district office and the allocation of personnel in the district to the district staff establishment.

7.4.1 At the district level, the IDHWMT to:

- Identify priority posts that need to be filled at the district office. The identification of the priority posts are to be based on an assessment of what the important functions of the district office will be and to so allocate permanent personnel to perform these functions.

- Facilitate the establishment of a human resource inventory by facility so that personnel may be reshuffled to meet the service needs of the district. The hospitals and clinics must be seen as the key components of the district and not as separate facilities accountable to the regional level.

- Assist facilities to utilise the human resource inventory to identify priority posts and functions at hospital and clinic level with the objective of effective and efficient service delivery.

7.4.2 Activities at the regional and provincial level to include:

- The regional office is to lobby the DFTT to allocate permanent personnel to the priority posts that are to be identified in the Mount Frere district.

- The DFTT at provincial level are to engage the PSC in securing the necessary authority for the Mount Frere district to have personnel allocated to the district establishment and not facility establishments. This will facilitate the district office being authorised to appropriately re-deploy staff to meet the service needs of the Mount Frere district as a whole.

7.5 The Establishing and transferring of authority via delegations

7.5.1 District and regional level

The district and regional office are to negotiate with the provincial level to provide the enabling environment for the district to do the following:

- Perform the functions relating to human resource management including the authority to make appointments, hire and fire, institute disciplinary procedures, reallocating and re-organising of personnel to meet service requirements, etc.

- To enable the district level managers to vire financial resources between line items.

- To ensure that the lack of availability of key documentation (e.g. updated and/or new tender documentation forms, progress reports of the status of the tender, which companies are on contract to the province, etc.) and training on procurement procedures are made available as soon as possible.

- To have the authority to decide on the purchasing of certain items (e.g. cleaning agents and chemicals, perishables, medical equipment within prescribed limits and labour saving devices such as computers etc.) which may be acquired in a more cost-effective manner than purchasing through the provincially driven system

- To make provision for flexibility in altering the present financial limit at district offices specifically if an item is not on contract and the value exceeds R7,500. The district office's are at present responsible for purchasing for the district as well as sub-district offices and clinics and the present financial limit is impracticable for this purpose.

- The establishment of the transport procedures (access, communication, monitoring, etc.) with respect to ordering and provision of type and nature of the vehicles for district level facilities. For example, in Mount Frere certain rural areas of the district, although vehicles are provided, they are not appropriate to the conditions in that area. In addition, the current moratoriums on vehicle purchases and transport claims and the processing thereof needs to be reviewed.

- To facilitate and establish clear lines of access and communication with relevant personnel in the department of public works to enable a more rapid response to problems experienced with health care facilities and buildings in the Mount Frere district (e.g. the establishment of district offices with sufficient space, and the timeous repair and provision of hospitals and clinics).

- To provide the provincial level with recommendations concerning the format of information systems, reports and forms as these need to be changed. The EC PDoH should have the authority to decide on information systems, reports and forms which would best address district level health and management information needs.

7.5.2 Provincial level

At the provincial level, the DFTT together with senior management within the EC PDoH will need to engage and effect the necessary changes through the relevant structures and on the following issues:

- The changes for human resource management and the format of information systems, reports and forms to be effected through the PSC.

- The need to review and change the Provincial Exchequer Act in order to authorise managers to vire financial resources.

- The reviewing of the Tender Board regulations for changes to the procurement procedures and the present financial limit at district offices.

- Negotiating with the Department of Transport with regard to the ordering and provision of the appropriate vehicles for district level facilities by the EC PDoH.

- The PDoH to consult and negotiate with Department of Public Works in order to facilitate a more rapid response from the Department of Public Works to problems experienced with health care facilities and buildings.

Box 14 below identifies and prioritises the five recommendations that would need to be implemented immediately in order to facilitate DHS development in the Mount Frere district.

Box 14: Priority Recommendations for Implementation to Facilitate DHS Development

⇒ The appointment of key personnel to permanent posts in the district office and the allocation of personnel in the district to the district staff establishment.

⇒ Facilitate the establishment of a human resource inventory by facility so that personnel may be reshuffled to meet the service needs of the district. The hospitals and clinics must be seen as the key components of the district and not as separate facilities accountable to the regional level.

⇒ The district office in Mount Frere must continue and complete the task of identifying key tasks, roles, responsibilities and functions of the district office, as well as hospital and clinic staff

⇒ Developing a vision of the district planning and budgeting process for the Mount Frere district consistent with that developed by the provincial level

⇒ The establishment of a formal District Financial Management Budgeting Task Team (DFMBTT).

Source: CHP/HEU study, 1997

CONCLUSION

In considering the above-mentioned recommendations, the DHS development in Mount Frere must take into account some of the recommendations of the Hospital Strategy Project. The provincial and regional office must be encouraged to adopt an approach consistent with this. **Implementation is a responsibility of management.**

An implementation strategy must include the concept of "fast-tracking" of districts so that some districts with the necessary absorptive capacity should be exempt from certain provisions of the current legislation such as the Provincial Exchequer Acts, Treasury Instructions, etc., and replace this with the accountability framework applicable to transfer payments. In summary, this is learning by doing for district health systems development.

CHAPTER 8. BIBLIOGRAPHY

Bourne DE, Pick WM, Taylor SP, McIntyre DE, Klopper JML. A methodology for resource allocation in health care for South Africa. Part III. A South African Resource Allocation formulae. South African Medical Journal 1990; 77: 456-459.

Brijlal V, Gilson L. Understanding capacity: financial management within the district health system: a literature review. Centre for Health Policy, Johannesburg. Paper No. 48 March 1997.

Brown M, van den Heever A. Report by the consultants on the existing trends and functional costs to support the function analysis and rationalisation programme in terms of the National Health Plan and the RDP. Report prepared for the Strategic Management Team 1994, Gauteng.

Cabral J, Schneider H, Gilson L, Cele M, Lauber S, Magongo B. Strengthening district health systems in South Africa: early observations from a project in two provinces. Centre for Health Policy, Johannesburg. Draft, February 1997.

Department of Health, National District Health Systems Committee. A policy for the development of a District Health System for South Africa. Health Policy Co-ordinating Unit, Pretoria, December 1995.

Department of Health and Welfare (Eastern Cape) and Health Systems Trust. Health Care in the Eastern Cape: implications for planning, 1996.

Doherty J, van den Heever A. A resource allocation formula in support of equity and primary health care. Centre for Health Policy, Johannesburg. Paper No. 47 February 1997.

Gilson L, Morar RL, Pillay Y, Rispel L, Shaw V, Tollman S, Woodward C. Decentralisation and health systems change: National Report. WHO and Health Policy Co-ordinating Unit, Pretoria, March 1996.

Gilson L, van den Heever A, Brijlal V. District Financing in Support of Equity: North-West Province Provisional Summary Report. Centre for Health Policy, Department of Community Health, University of the Witswatersrand, Johannesburg. July 1997.

Gilson L, Balfour T, Goosen V. Towards well-functioning health districts: a vision and indication for assessing progress. Centre for Health Policy, Johannesburg. Technical Report TK 47, 1997.

Hospital Strategy Project. Guidelines for Human Resource planning of hospital services: Appendix 14. Hospital Strategy Project, Johannesburg 1996.

McIntyre DE. An analysis of the geographical distribution of public sector health care expenditure in South Africa. Health Economics Unit, Cape Town. Health Economics Unit Working Paper No. 7, 1994.

Makan B, Morar RL, McIntyre DE. District Financing in support of Equity, Eastern Cape Province, Summary Report. Health Economics Unit, Cape Town. July 1997.

Makan B, Morar RL, McIntyre DE. District Health Systems Development in the Eastern Cape Province: District Financing and Financial Management Capacity. District Financing in support of Equity, Final Report. Health Economics Unit, Cape Town. December 1997.

McIntyre DE, Bloom G, Doherty J, Brijlal P. Health expenditure and finance in South Africa. Health Systems Trust and World Bank. Durban 1995.

Mills A. Health System Decentralisation: Concepts, issues and country experience. Parts 1 and 3; Botswana case study. Geneva: WHO 1990.

Price M, Broomberg J, Masobe P, Rangasamy L, Naidoo ERG. An analysis of resource allocation to community and hospital services in homelands and health wards. Centre for Health Policy, Johannesburg. National Health Expenditure Review Technical Paper No. 10, 1995.

Reagon G, Makan B, McIntyre, District Financing in Support of Equity: Resource Allocation mechanisms within the District Health System – A Literature Review, Working Paper Number 25 Health Economics Unit, 1997

Rispel L, Price M, Cabral J et al. Confronting need and affordability: guidelines for primary health care services in South Africa. Centre for Health Policy, Johannesburg. April 1996.