Western Cape Government

Health

BETTER TOGETHER.

THE EFFECTIVE COORDINATION AND ALIGNMENT OF NATIONAL AND PROVINCIAL SPHERES OF GOVERNMENT IN THE DELIVERY OF HEALTH SERVICES

Western Cape input to Standing Committee on Appropriations and Portfolio Committee on Health, Wednesday 22nd March

Parliament

Dr Beth Engelbrecht, HOD: WCGH

Context

1. The Portfolio Committee for Appropriations has identified the need for **improved co-ordination and alignment** between the National DoH and Provincial DoHs to ensure **value for money** and **efficient planning** and **resource allocation.**

2. The committee in collaboration with the Portfolio Committee on Health are convening this meeting to address this need.

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Alignment between the strategic goals of the National government, the National Department of Health and the Western Cape Department of Health

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National Development Plan

The National Development Plan (NDP) sets out nine (9) long-term health goals for South Africa:

Goals related to improving the health and well-being of the population

- By 2030, South Africa should have:
  1. Raised the life expectancy of South Africans to at least 70 years;
  2. Progressively improved TB prevention and cure
  3. Reduced maternal, infant and child mortality
  4. Significantly reduced the prevalence of non-communicable diseases
  5. Reduced injury, accidents and violence by 50 percent from 2010 levels

Goals related to aspects of health systems strengthening.

- By 2030, South Africa should have:
  6. Complete Health system reforms
  7. Primary healthcare teams provide care to families and communities
  8. Universal health care coverage
  9. Fill posts with skilled, committed and competent individuals

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Source: NDOH APP 2015/16 to 2016/17

Strategic goals of the National Health Department

1. Prevent disease and reduce its burden, and promote health;

2. Make progress towards universal health coverage through the development of the National Health Insurance scheme, and improve the readiness of health facilities for its implementation;

3. Re-engineer primary healthcare by: increasing the number of ward based outreach teams, contracting general practitioners, and district specialist teams; and expanding school health services;

4. Improve health facility planning by implementing norms and standards;

5. Improve financial management by improving capacity, contract management, revenue collection and supply chain management reforms;

6. Develop an efficient health management information system for improved decision making

7. Improve the quality of care by setting and monitoring national norms and standards, improving system for user feedback, increasing safety in health care, and by improving clinical governance

8. Improve human resources for health by ensuring appropriate appointments, adequate training and accountability measures.

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Source: NDOH APP 2015/16 to 2016/17

Western Cape DoH "Service transformation strategy"

"5 Whats"

1. **Patient-centred care**
2. **Service Pressure mitigation**
3. **HIV & TB outcomes [90-90-90 strategy]**
4. **Maternal, Neonatal and Child outcomes [1st 1000 days strategy]**
5. **Non-communicable disease outcomes [Integrated Chronic Condition Management]**

"3 Hows"

1. **Population-based approach**
   - Geographic, population based approach
   - PHC platform strengthening
2. **Service Design**
   - Streamline patient flow
   - Integrated Care
3. **Enabling & Responsive critical support services**

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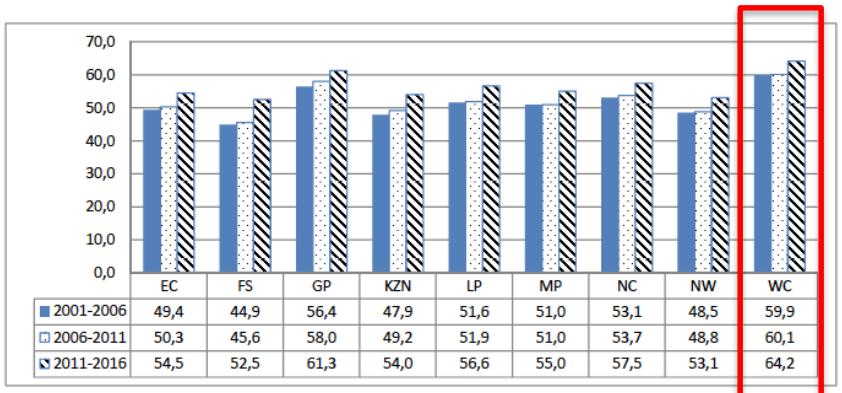
Effective alignment between National and Provincial health priorities is evidenced by the fact that many of WCGH's outcomes for National priority conditions, as shown in the following slides, are amongst the best in SA.

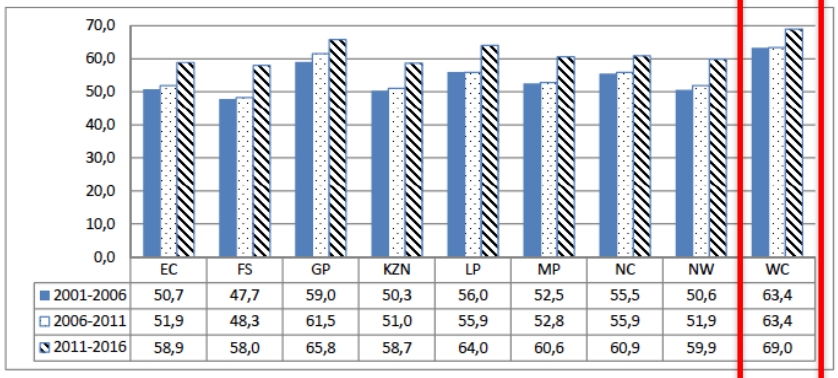
Outcome 1: Raising life expectancy

Figure 2: Provincial average life expectancy at birth (males)



	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2001-2006	49,4	44,9	56,4	47,9	51,6	51,0	53,1	48,5	59,9
2006-2011	50,3	45,6	58,0	49,2	51,9	51,0	53,7	48,8	60,1
2011-2016	54,5	52,5	61,3	54,0	56,6	55,0	57,5	53,1	64,2

Figure 3: Provincial average life expectancy at birth (females)



	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2001-2006	50,7	47,7	59,0	50,3	56,0	52,5	55,5	50,6	63,4
2006-2011	51,9	48,3	61,5	51,0	55,9	52,8	55,9	51,9	63,4
2011-2016	58,9	58,0	65,8	58,7	64,0	60,6	60,9	59,9	69,0

Life expectancy in the Western Cape is the highest in the country for both males and females and is rising with each 5 year period.

Source: StatsSA, mid year population estimates 2016

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Outcome 2: improving TB prevention and cure

The percentage of deaths due to HIV/AIDS and TB is decreasing year on year in the WC.

The same is true for the age-standardised death rates for all persons and for premature mortality due to HIV/AIDS and to tuberculosis

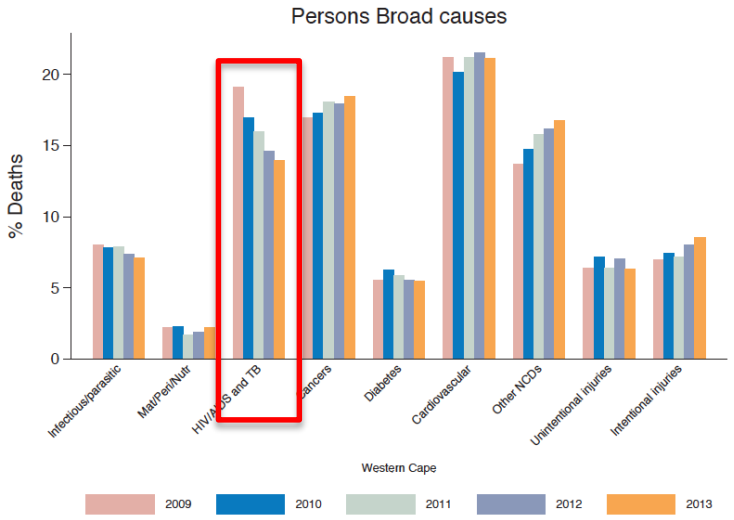


Figure 2.3: Trends in the percentage of deaths by broad cause disease category for all persons, Western Cape 2009-2013

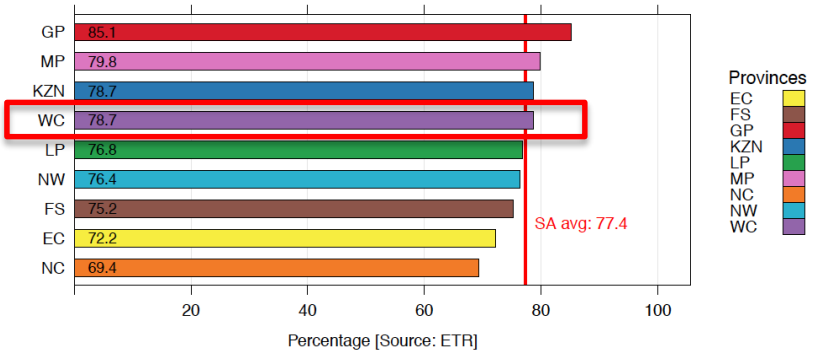
Source: Morden E, et al. Western Cape Mortality Trends, 2009-2013

Outcome 2: improving TB prevention and cure

The TB cure rate in 2014 was 78.7%, which was the 4th highest in the country; the treatment success rate was 81.8% (3rd highest)

The TB death rate in 2014 was 3.6% in the WC, which was the lowest in the country

Figure 16: TB cure rate (new smear-positive) by province, 2014



Source: Massyn N, et al. 2016. District Health Barometer 2015/16. Health Systems Trust.

Outcome 3: Reducing maternal, infant and child mortality

The under 5 mortality rate is dropping in all WC districts

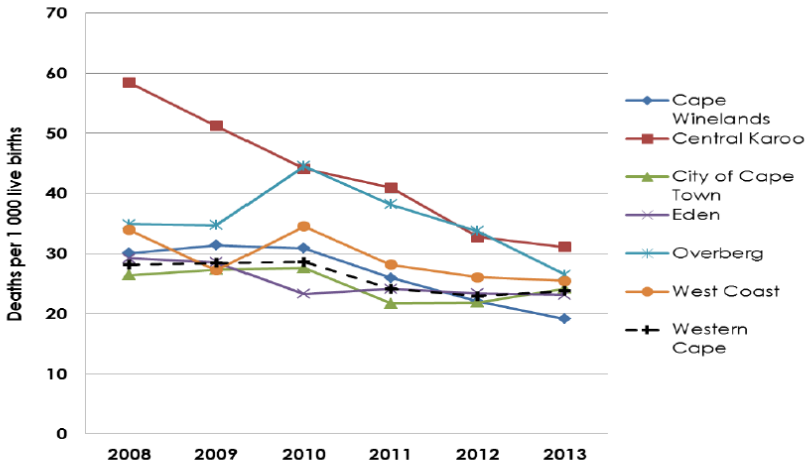


Figure 2.2: Trends in under 5 mortality rate by district, Western Cape 2008-2013

The infant mortality rate is dropping in all WC districts

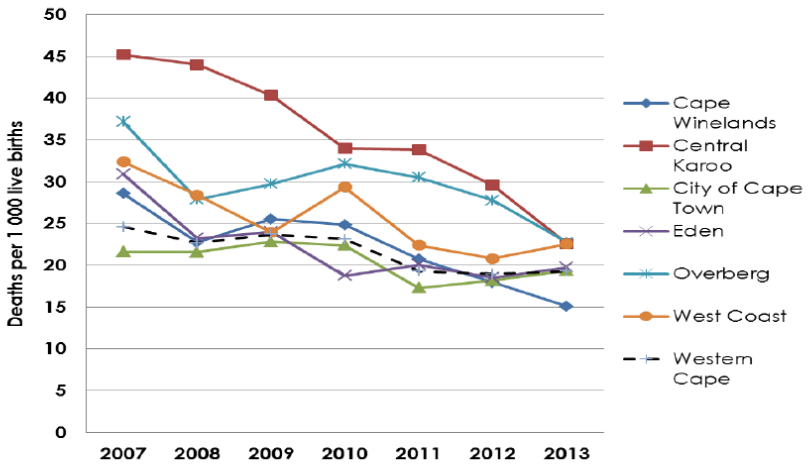


Figure 2.1: Trends in infant mortality rate by district, Western Cape 2008-2013

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Source: Morden E, et al. Western Cape Mortality Trends, 2009-2013

Outcome 3: Reducing maternal, infant and child mortality

The iMMR (institutional maternal mortality ratio) was the lowest in the Western Cape in 2014/15.

Provinces ranked highest to lowest	2014-5 iMMR
North West 2014-5	176.66
Free State 2014-5	176.66
Limpopo 2014-5	163.75
Eastern Cape 2014-5	152.60
South Africa 2014-5	133.79
KwaZulu-Natal 2014-5	129.33
Gauteng 2014-5	126.22
Mpumalanga 2014-5	125.83
Northern Cape 2014-5	119.97
Western Cape 2014-5	62.35

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Source: Pattinson R, et al. Saving Mothers Report, 2015

Outcome 4: reducing the prevalence of non-communicable diseases

The WC has the fifth-highest ASDR for non-communicable diseases out of the 9 provinces but the lowest ASDR for overall deaths across all causes

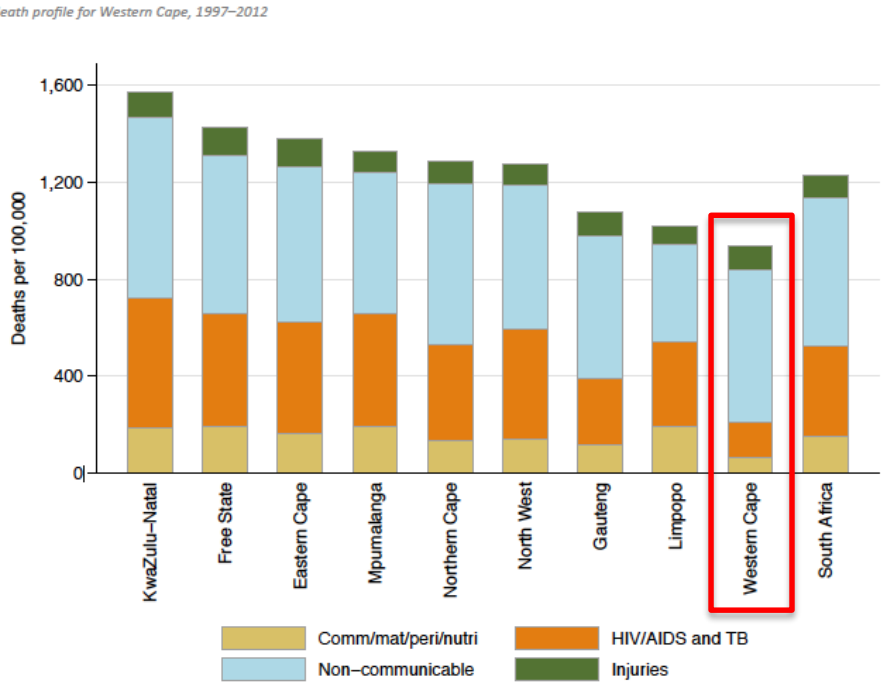

Figure 19: Provincial broad-cause ASDR, 2012

Source: Msemburi, W. et al. 2016. Second National Burden of Disease Study: Cause of death profile for Western Cape 1997-2012.

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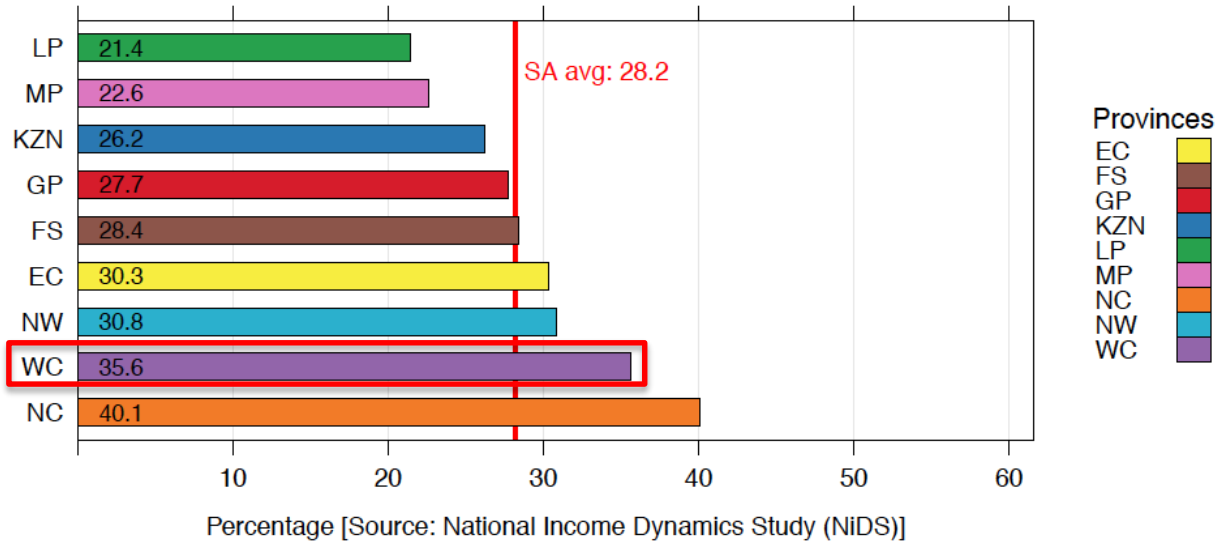
Outcome 4: reducing the prevalence of non-communicable diseases

The WC has the second-highest prevalence of hypertension out of the 9 provinces.

Figure 1: Hypertension prevalence (crude) in people 15 years and older, by province, 2015



Source: Massyn N, et al. 2016. District Health Barometer 2015_16. Health Systems Trust.

Outcome 5: Reducing injury, accidents and violence

In 2014, WC had the highest homicide rate in the country

Reducing injuries, accidents and violence lies only partly with Health: it requires intersectoral, whole-society, whole-government collaboration.

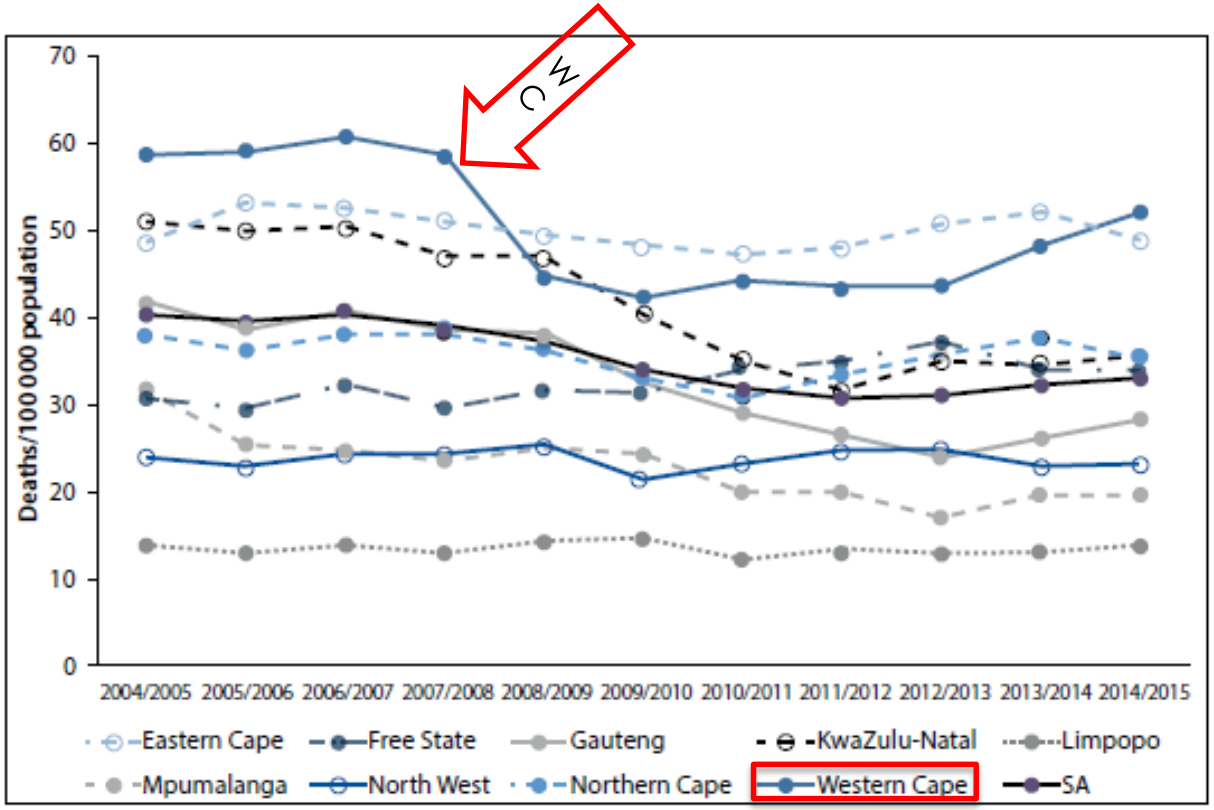


Fig. 1. SAPS crude homicide rates by province, 2004/2005 - 2014/2015. (Source: South African Police Service, 2004 - 2014,[4] and 2014/2015 rates from the Institute for Security Studies.[5])

Source: Prinsloo, 2016, as quoted in Bradshaw D, Injury Data in South Africa, 2017

Outcome 5: Reducing injury, accidents and violence

Interpersonal violence was the leading cause of premature mortality in the Western Cape for the period 2009-2013 and it is getting worse.

Road injuries are also a substantial cause of premature mortality, but are contributing less YLL's each year.

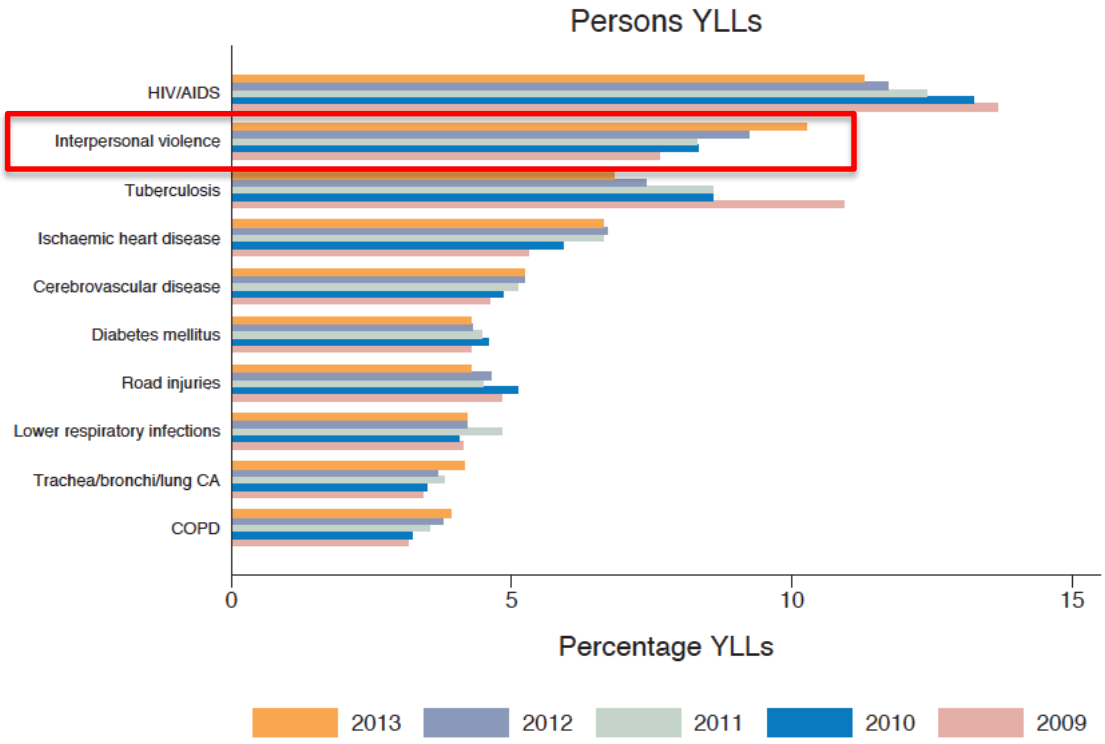


Figure 2.9: Leading causes of premature mortality (YLL) for all persons, Western Cape 2009-2013

Source: Morden E, et al. Western Cape Mortality Trends, 2009-2013

National and Provincial Budget process alignment

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Key NT Processes That Guide Provincial Budget Process

1. **PT Budget Circular 1 of any given financial year references National Treasury Budget Formats Guide (EPRE) and NT MTEF guidelines.**
   - These guidelines are the technical guidance provided by NT in preparation of the Estimates of Provincial Revenue and Expenditure (EPRE) and contain the templates for publishing or gazetting hospital and school budgets.
2. **Guideline for budget programmes with departmental budget and programme structures is communicated for implementation by Provinces.**
   - This is to attain a better alignment between the current budget and programme structures and the functional categories.
   - Compliance to these collectively agreed upon structures is vital: provincial departments are urged to comply strictly to the agreed programme structures
3. **Bilateral engagements: Benchmark exercises take place in early December (after submission of first draft budgets by provinces) at NT.**
4. **Overall objective of benchmark meetings is to assess the extent to which provincial budgets give expression to budget priorities as agreed (in Budget Council, Cabinet, etc.)**
5. **The Province is issued with allocation letters from NT detailing equitable share, conditional grant and new (if any) priority allocations for the Province.**

Acknowledgement: S Nieftagodien, WC Provincial Treasury

Budget coordination efforts

BUDGET COORDINATION EFFORTS

1. Provincial Health Departments annually participate in the National 10x10 meetings.

2. Provincial Health Departments were requested in January 2017 to attend a feedback session with National DoH. This was the first occurrence, and was at a high level.

3. The Province's trend in budget allocations is consistent with National priorities, particularly the shift of spending to PHC & DHS – see graphs in following 2 slides

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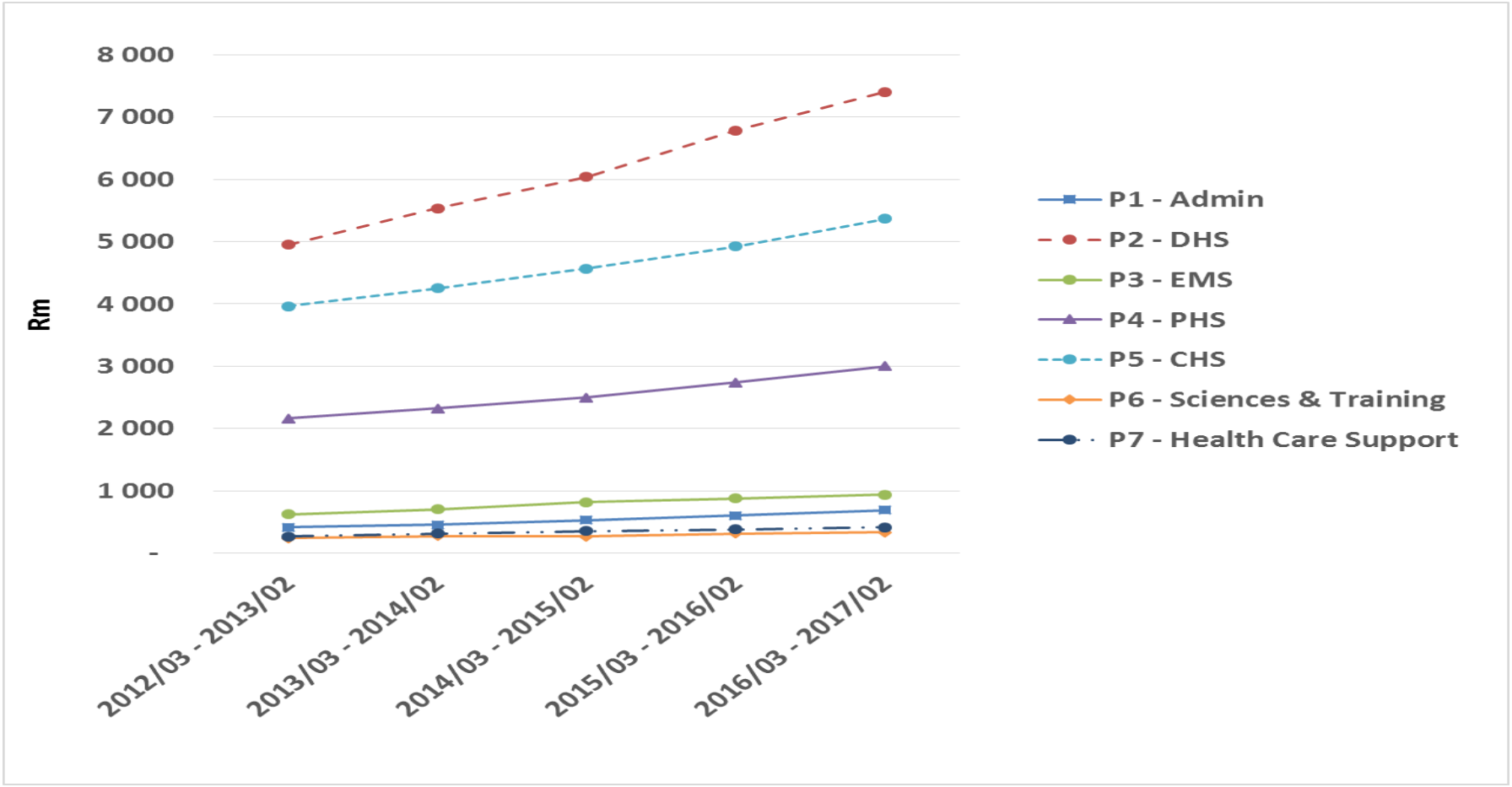
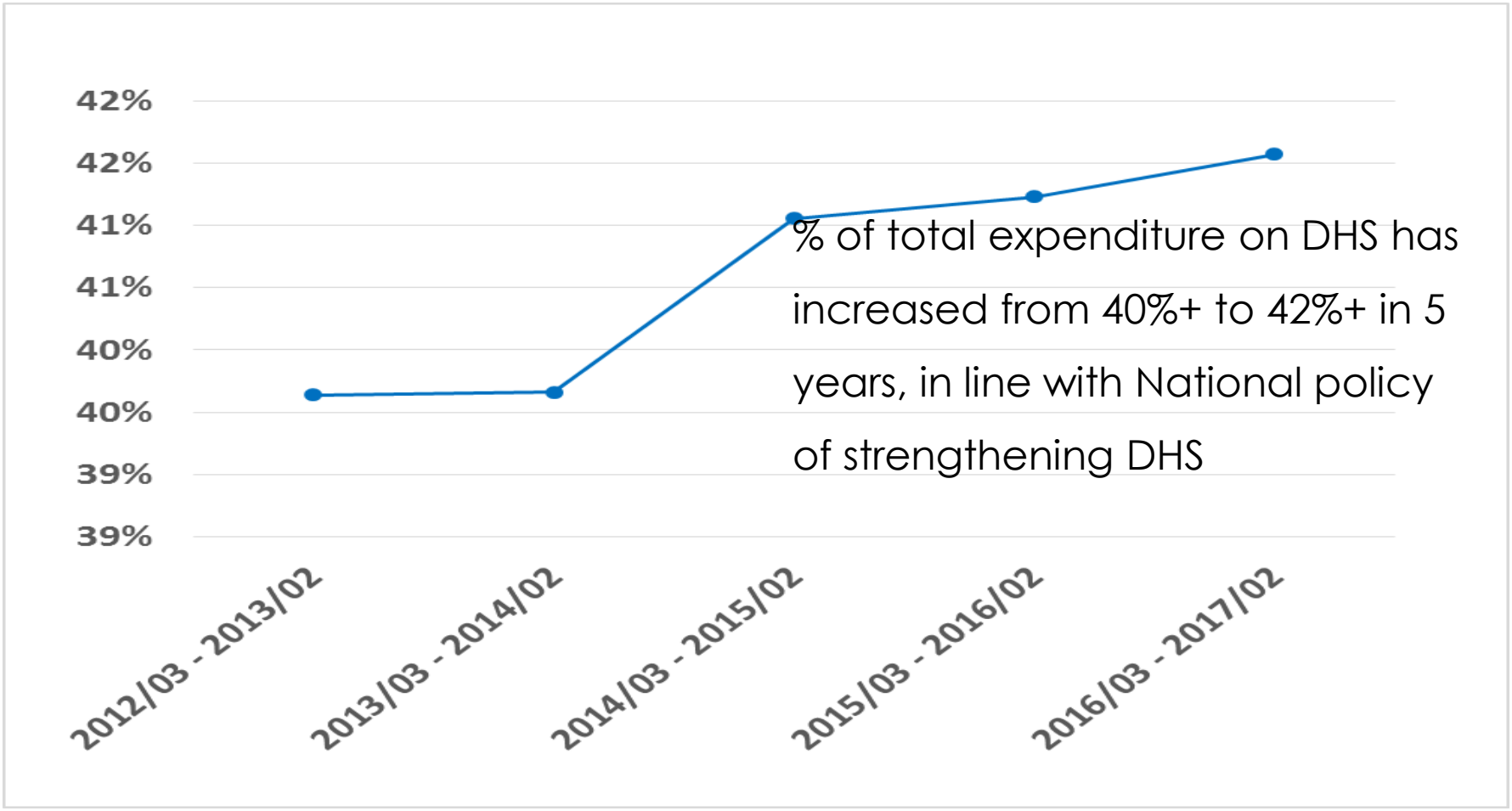
BUDGET ALLOCATION PER PROGRAM



DISTRICT HEALTH SERVICES (P2)
% of Total Expenditure (excl P8)



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Budget coordination efforts

DEFICIENCIES IN COORDINATION

1. In the view of the Department, National DoH does not consult the provinces sufficiently when compiling the budget bid.

2. There is a measure of discontinuity between the interests of the National and Provincial Departments with respect to budget planning. The emphasis at National level is on conditional and earmarked funding, such as AIDS & TB, while the concern at Provincial level is to ensure adequate funding for basic services. This leads to the undesirable situation that additional conditional and earmarked funds are allocated to Provinces, while the budgets of the bulk of the services decline in real terms.

3. This Department's budget has been shrinking slightly in the current and next financial years, while patient numbers continue to increase by between 1% and 2% per annum.

4. The Department's budget in years two and three of MTEF reduces sharply in real terms. The same probably applies to all Provinces.

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Irregular, Unauthorised Expenditure

1. The Department has received an unqualified audit report for more than a decade and a clean audit report for the latest audited financial year (2015/16).

2. The Department's Expenditure Deviation from budget is very small:
   - Deviation % of budget – past 5 years – excluding P8 – see slide 26

3. The Department in recent years over-collected substantially on its Revenue budget.

4. The WC Treasury generally returns to the Department any amounts unspent and/or over-collected.

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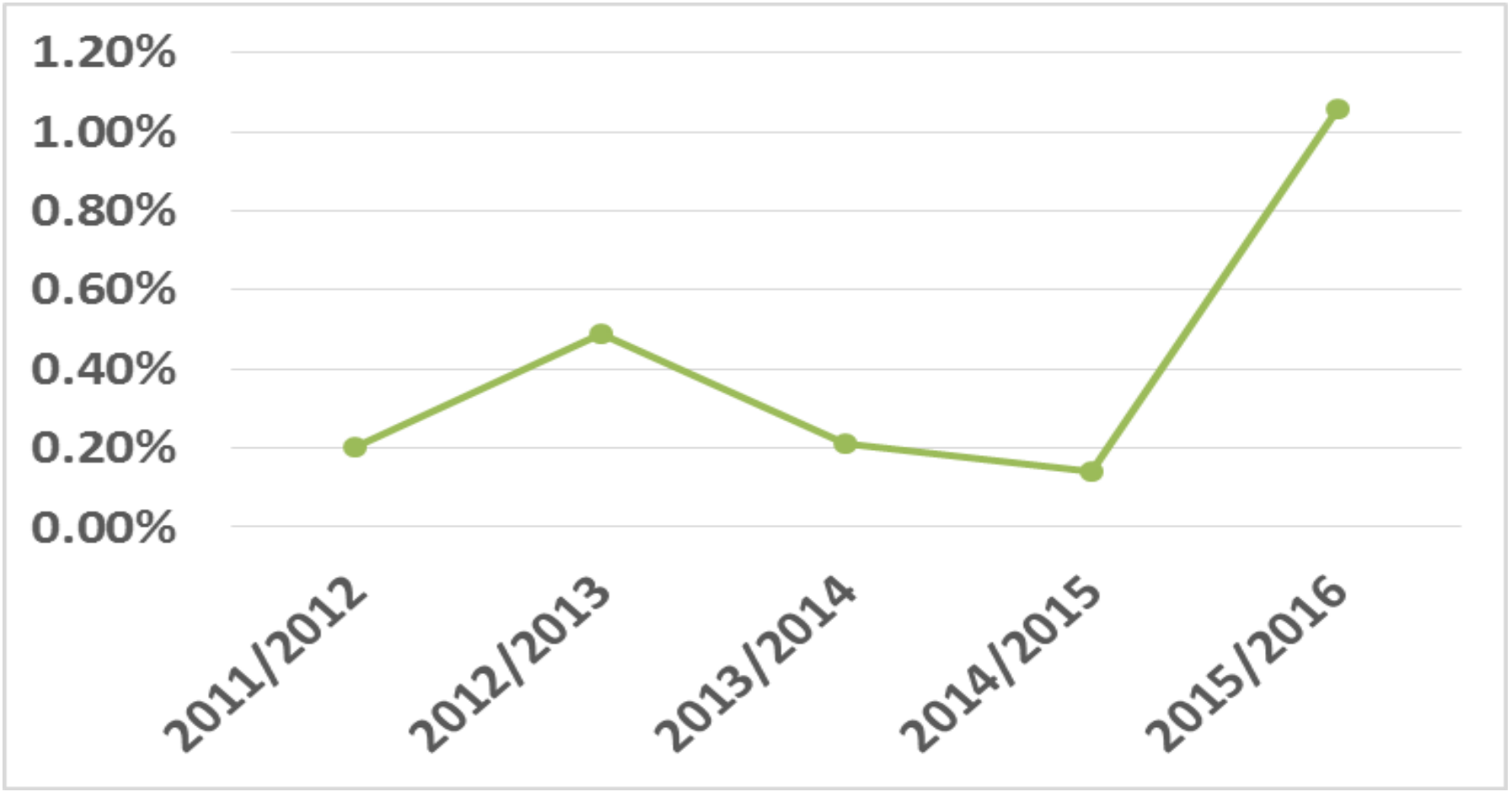
DEPARTMENTAL EXPENDITURE WITHIN BUDGET (excl P8)



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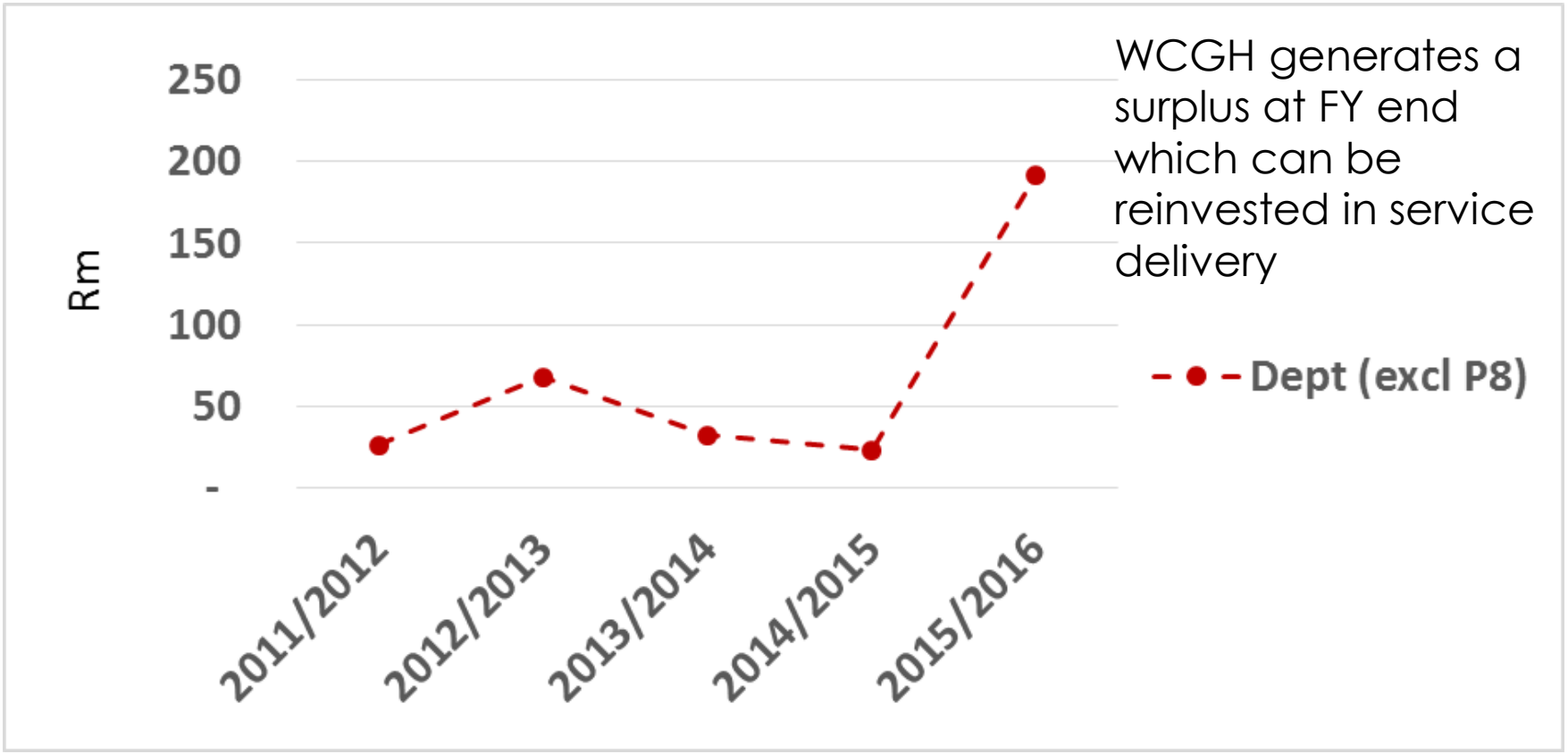
FINANCIAL YEAR END SURPLUS



WCGH generates a surplus at FY end which can be reinvested in service delivery

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Conditional Grants

1. This Department produces a third of the doctors and 77% of the dentists in this country, but the allocation of the National Department to this province for Tertiary Services and for Training & Development has reduced substantially n recent years.

3. The allocation is being shifted to other provinces, but those provinces do not have the capacity to increase the number of new doctors and dentists. Since the Western Cape has to reduce training capacity, due to the reduced budgets, the risk is that the production of doctors and dentists in the country as a whole will reduce.

4. Growth in AIDS Conditional Grant is less than the growth in the number of patients in treatment, while medicine costs increased steeply during 2016.

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- Ensuring alignment in health information systems (including revenue and billing, patient, pharmaceutical application, network infrastructure, etc) between the province and other national ICT systems for effective coordination in the health sector;

Revenue and Billing

Revenue and Billing

1. WCGH recovers in excess of R500 million per annum from patient fees.

2. Patient billing is done directly into the program "Clinicom" which is running in the vast majority of WC hospitals

3. Once a patient has been discharged from the ward or from outpatients/casualty, their diagnosis is coded (ICD10) and they are billed according to their "H status" – H0 are free; H3 receive the highest bills.

4. Clinicom interfaces with Sinjani (WCGH) and DHIS (NDOH) as far as the clinical data goes and with BAS as far as the financial data goes.

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- Ensuring alignment in health information systems (including revenue and billing, patient, pharmaceutical application, network infrastructure, etc) between the province and other national ICT systems for effective coordination in the health sector;

"Patient"

National IT Strategy Overview

1. 2009 - NHC resolved that acquisition of software solutions not interoperable be halted until eHealth Strategy for South Africa finalized
2. 2012 - eHealth Strategy for South Africa signed off by Minister which
   - Aims to achieve integrated, well functioning national patient-based information system,
   - Aims to be based on scientific standards for interoperability
3. Strategy is critical enabling factor for implementation of NHI
4. 2014 - National Health Normative Standards Framework (HNSF) for eHealth in South Africa promulgated - foundational basis for interoperability as articulated in eHealth Strategy South Africa 2012-2016

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Initiatives that NDOH and WCG Health are working on

1. NDOH has requested development of **interface between Clinicom Patient Master Index (PMI)** used in the Western Cape and **the Health Patient Registration System (HPRS) -** would ensure that **PMI details are shared across both Clinicom and HPRS.** Demonstrates the WCG Health has **alignment to the HNSF**

2. All core systems linkable via HIS number, which is shared – i.e. the only province with a functional unique patient identifier for each patient, allowing the patient care record to be viewed irrespective of the treatment centre

3. WCG Health ensures that **SINJANI is aligned** with the National database **DHIS**, by updating and enhancing the system to align with DHIS - facility lists and codes, data collection tools

4. Currently WCG Health is **using the WebDHIS** (DHIS 2) for **NCS and HPV**. WCG Health has as its strategy to **migrate all data collection and collation to WebDHIS** in the next 2 - 3 years

5. Most of the software applications are **IHE compliant** which is in line with the HNSF

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- Ensuring alignment in health information systems (including revenue and billing, patient, pharmaceutical application, network infrastructure, etc) between the province and other national ICT systems for effective coordination in the health sector;

Pharmaceutical application

Pharmaceutical application

1. **WCGH and its partners increasingly use electronic information management systems for**
   - Pharmacy stock ordering, stock visibility, prevention of stock outs and control - JAC is in ~ 100 pharmacies.
   - CDU (Chronic Dispensing Unit) is electronic – similar to the national CCMD project
   - MEDSAS is a national procurement system which WCGH uses in the Cape Medical Depot (CMD), which interfaces with JAC through "WINRDM" and helps with stock order generation.
   - The Dept will be exploring an e-prescribing system in 2017/18.
2. **The systems interfaces with other relevant systems through the Provincial Health Data Centre, e.g.**
   - Sinjani for immunization campaigns
   - Clinicom for bed management, etc.

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- Ensuring alignment in health information systems (including revenue and billing, patient, pharmaceutical application, network infrastructure, etc) between the province and other national ICT systems for effective coordination in the health sector;

Network infrastructure

Initiatives that NDOH and WCG Health are working on

WCG Health has excellent ICT building blocks, currently maturing, to support new paradigm of using individual level patient data to support clinical care, routine reporting, and health intelligence.

- Only province in SA with a single HIS across nearly all hospitals
- Nearly all primary care clinics use either the PHCIS or PreHMIS platform
- PACS/RIS, ECM and other domains are linkable via unique patient identifier
- Electronic dispensing covers 83% of all issues, and is expanding rapidly
- All laboratory data are available electronically
- Business Intelligence demonstrated the viability & utility of an individual-patient-level health data repository, which will create true intelligence and system independence
- Complete electronic disease data for HIV, TB, and good progress being made on other chronic diseases, pregnancies and births

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WCG : Health IT vision

1. The Dept regards IT as a key enabler of service delivery with huge potential for efficiencies and service delivery improvement.

2. The IT vision has been completed and endorsed by Top Mx and will be tabled at provincial cabinet in April.

3. A roadmap for implementation is being finalised.

4. The PT and Dept has allocated additional R60m for IT priorities.

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- Ensuring critical functions such as procurement, human resources and financial management are appropriately devolved to designated levels for service delivery efficiencies and better performance;

Procurement

The Accounting Officer System (AOS)

In order to ensure that Supply Chain Management (SCM) functions are adequately devolved the Department has:

1. Compiled an Accounting Officer System
2. Handbook of SCM functions and delegations
3. Addresses the Institutionalisation of policies and procedures
4. Establishes committee structures for Formal and Informal Bidding
5. Provides Templates to assist the procurement process
   - Petty Cash
   - Integrated Procurement System (IPS) up to R500 000
   - Informal Bidding
   - Formal Bidding
   - Limited Bidding
6. The AOS is backed up by Standing Operating Procedures (SOPs)and Instructions

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Departmental Delegations

1. Delegations are aligned to the processes described in the AOS
2. Delegations are also aligned to the structure of the Department
   - Macro
   - Meso
   - Institutional or Micro level
3. Delegations must ensure that Institutions have adequate power to procure
4. Ability to procure is illustrated as follows (2015/16 financial year spend)
   - Expenditure on Goods & Services =R5,976 billion
   - Non-discretionary spend =R1,564 billion (25%)
   - National Contracts =R1,254 billion (25%)
   - Discretional spend =R3,158 billion (50%)
   - Departmental Contracts =R2,147 billion (68%)
   - Non-contract =R1,011 billion (32%)
5. R1,011 billion is procured by means of the IPS (quotation)system

- Ensuring critical functions such as procurement, human resources and financial management are appropriately devolved to designated levels for service delivery efficiencies and better performance;

Human Resources Management

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People Management Delegations (HR)

1. This Department has always had an extensive and duly authorized set of People Management (PM) delegations in place.

2. The MPSA issued a Directive on Public Administration Delegations in 2014 and the Department's PM delegation registers were amended in line with the Directive.

3. In 2016 the Department submitted its delegation registers to the DPSA and received highly favourable comment on the quality and soundness of its PM delegations.

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People Management Delegations (HR) (Continued)

1. The PM delegations were again revised and amended in line with the Public Service Regulations, 2016 that came into effect on 1 August 2016.

2. The amended delegations were duly signed by the Executive Authority and HoD on 21 January 2017.

3. Minimum levels of delegation are guided by the geographical footprint and thus decentralized service delivery model of the Department, i.e. to facilitate service delivery especially in more remote rural areas.

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- Ensuring the effective management of personnel expenditure in the health sector;

Personnel expenditure

Management of personnel expenditure

1. The lack of control over personnel expenditure is the root cause for underspending on Non-negotiables in many provinces.

2. This Department has excellent tools for the management of Personnel Expenditure. In the beginning of each year head office negotiate with each facility the posts that can be afforded from the budget. (The Approved Posts List) All other posts are deactivated on PERSAL.

3. Through a hierarchical set of regular meetings, called Financial Management Committees, management is held accountable.

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- Alignment of national and provincial health infrastructure priorities and improving infrastructure budget expenditure (challenges and opportunities for improvements; and

Infrastructure

Infrastructure Programme – Alignment

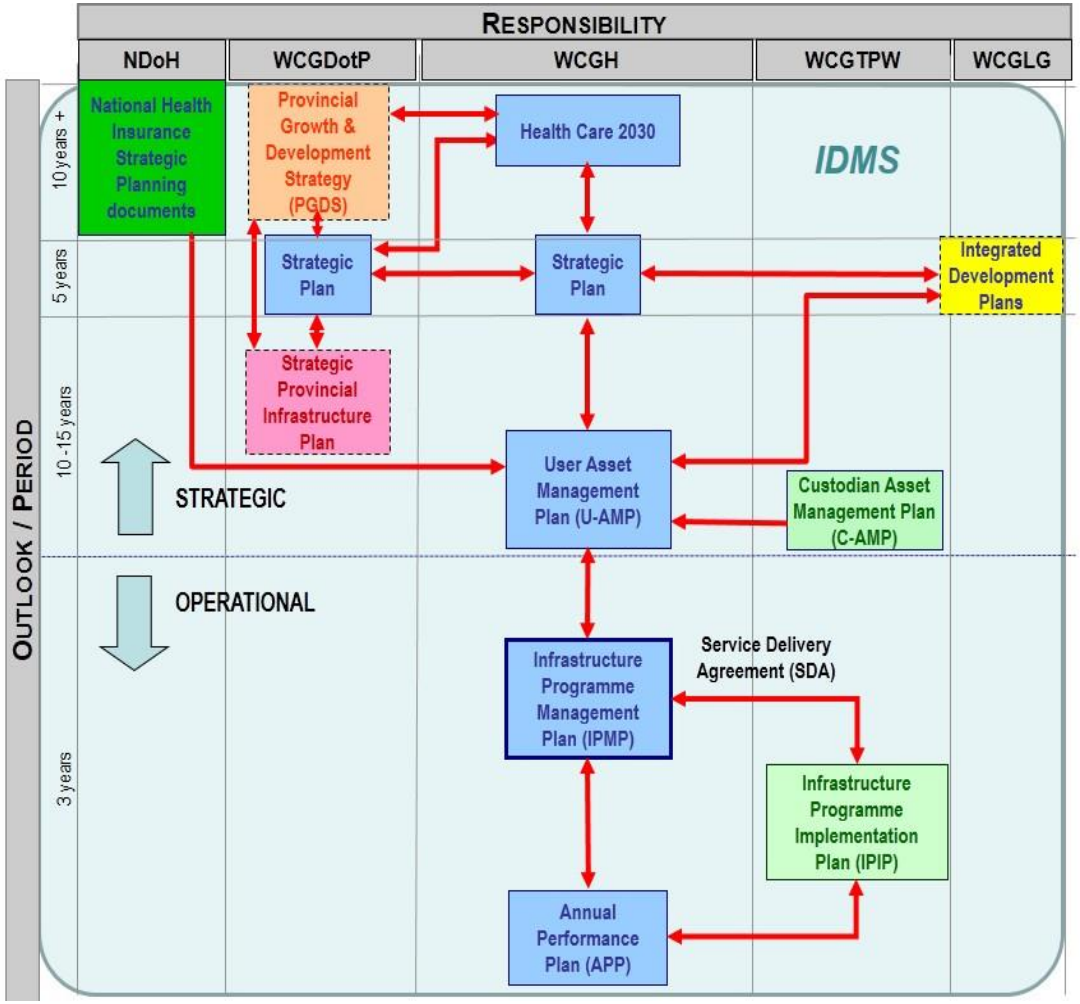
Ref. WCGH User Asset Management Plan 2017/18

Priority alignment

1. National Infrastructure Plan (2012)
   - SIP 12 Revitalisation of Public Hospital
2. Integrated Urban Development
   - Framework
   - Spatial Integration
   - Inclusion and Access
3. Ideal Clinic Initiative
4. IUSS Norms & Standards
5. PSG 1: Create opportunities for growth and jobs
6. PSG 4: Build a quality living environment resilient to climate change
7. Energy Security Game Changer
8. CoCT Built Environment Performance Plan

Strategy 5L's Agenda

1. Long Life (sustainability)
2. Loose Fit (flexibility and adaptability)
3. Low Impact (reduction of carbon foot print)
4. Luminous Healing Space (healing environment)
5. Lean Design and Construction (integrated)



Infrastructure Programme – Priorities

Ref. Infrastructure Programme Implementation Plan 2017/18

Infrastructure Delivery

1. Primary Health Care Facilities with full package of services
2. Emergency Centres at Hospitals
3. Acute Psychiatric Units at Hospitals
4. Focus on maintenance and fire compliance at health facilities
5. Rehabilitation and refurbishment of Tygerberg and Groote Schuur Hospitals (central hospitals)

Infrastructure Governance

1. Implementation of NTI No. 4 of 2015/16, including Standard for Infrastructure Procurement and Delivery Management (SIPDM) and Model SCM Policy for Infrastructure & Delivery Management
2. Service Delivery Agreement with the Implementing Agent (WC IDMS Framework 2011) – WCG Transport & Public Works

Budget Allocation

Sub-Programme	2017/18 R'000	2018/19 R'000	2019/20 R'000
8.1 Community Health Facilities	238 756	149 249	186 216
8.2 Emergency Medical Rescue Services	10 366	23 653	10 439
8.3 District Hospital Services	218 154	197 439	191 519
8.4 Provincial Hospital Services	77 924	87 631	121 326
8.5 Central Hospital Services	170 727	179 703	154 946
8.6 Other Facilties	99 536	166 475	181 936
Total	**815 463**	**804 150**	**846 382**

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Infrastructure budget expenditure

Ref. Infrastructure Programme Implementation Plan 2017/18

Estimated Backlog and Budget Requirements

1. R31,2 billion infrastructure backlog (including the replacement of Tygerberg Central Hospital)
2. R1 billion needed for replacement of health technology over next 5 years, much of this for Groote Schuur and Tygerberg Hospitals
3. R1,4 billion maintenance requirement per year

Earmarked Allocation

1. Maintenance: R329 583 000 for 2017/18
2. R60 000 000 mainly for Tygerberg and Groote Schuur Hospitals.

Grant (HFRG) allocation

1. Infrastructure
2. Capacitation
3. Health Technology
4. OD&QA

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Challenges

Capacity and Governance

1. Systems alignment – PMIS (NDoH) and IRM (NT)
2. Performance Based Incentive Grant Scoring (overall scoring for 17/18: 77%), no detailed feedback yet received
3. Recruitment and Selection of scarce skills (built environment professionals and clinical engineering technicians)
4. OSD application and staff retention

Infrastructure and Health Technology

1. Ageing infrastructure and health technology
2. Tygerberg and Groote Schuur Hospitals - condition and maintenance backlog
3. Infrastructure and HT requirements and budget allocation
4. Land availability for new developments

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Opportunities

1. Tygerberg and Groote Schuur Hospitals – special grant allocation for maintenance, refurbishment, rehabilitation, and upgrade
2. Tygerberg Central Hospital replacement: possible PPP process – feasibility study concluded - to be submitted with NDoH and NT for Treasury Approval 1
3. Institutionalisation SIPDM and Policy for SCM for Infrastructure & Delivery Management
4. Review of the maintenance implementation strategy in line with the CIDB National Immovable Asset Maintenance Management Standard and IUSS Maintenance Strategy
5. Continuing to improve collaboration with other Provincial Government departments (i.e. WCGTPW, WCGPT, WCDEADP, etc.)
6. Partnership with provincial (WCGDEDT) and national (DoH, DST, DTI, DED, NT) departments, private sector, universities, NGO's and bi-/multi-lateral organisations in areas such as health technology innovation and life-cycle management and maintenance of infrastructure and technology assets.

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- Any other matter that may assist the hearings in ensuring improved alignment and coordination in the health sector for improved delivery.

Other matters

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Other matters

1. Strong regulatory environment creates an onerous administrative responsibility of compliance which has an opportunity cost for service delivery in a highly stressed environment with escalating service demands and limited resources.

2. Excessive reporting demands nationally including a large dataset of indicators. The APP of 2016/17 had 228 indicators with the majority being national.

3. The expenditure of certain categories of medicines has far outstripped inflation. For example vaccine costs has increased by 22% and ARVs by 36 % in the last year. This has put further pressure on the budget.

4. The conditional grants in general have not kept up with inflation. This has meant for example that the Department continues to allocate a significant % of its equitable share budget to subsidize central hospitals.

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Concluding remarks

1. **The Department is strongly aligned with national policy and continues to produce amongst the best health outcomes in the country within a financially disciplined environment despite the challenges of escalating burden of disease and reducing budgets.**

2. **The Department has identified four pillars to sustain its gains and build health system resilience :**
   - Ensure patient care and service needs determine organizational priorities
   - Strengthen distributed leadership across the organization
   - Strengthen governance both within the Department as well as wit external partners.
   - Build a positive organizational culture based on the values of the Department (innovation, caring, competency, accountability, integrity, responsiveness and respect)

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Thank you

Thank you