Challenges and constraints at district management level

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This chapter explores the constraints and challenges faced by District Health Management Teams (DMTs) as they strive to ensure the delivery of quality public health care in a rapidly changing environment characterised by major national reform initiatives, such as the re-engineering of primary health care (PHC) and the introduction of National Health Insurance (NHI).

The main difficulties faced by this group of public health managers were identified through surveys and interviews conducted with a cross-section of managers from urban and rural districts. Data were collected using three methods. Firstly, individual semi-structured interviews were conducted with nine district managers regarding the district planning process. Secondly, quantitative data using a structured questionnaire were collected from 233 operational and district managers within these nine districts regarding their qualifications and their length of service within the health department. Thirdly, this information was supplemented by interviews with representatives of the United States President's Emergency Plan for AIDS Relief who provide technical assistance to DMTs.

Most of the problems identified relate to obstacles preventing the effective implementation of various steps in the management model. These originate from within and beyond the DMT, and include issues such inadequate delegation of authority to DMTs, defective budgeting processes, staffing issues, lack of managerial skills and vacancies in key managerial positions, and ineffective use or absence of quality management information systems to support decision-making. Despite these constraints, DMTs take on ambitious national programmes with a positive attitude, and there are promising indications that the hindrances identified are being successfully addressed through policy reforms.

> Inadequate delegation of authority, defective budgeting processes, staffing issues, lack of managerial skills, vacancies in key managerial positions, and ineffective use or absence of quality management information systems to support decision-making were identified as challenges facing District Management Teams.

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Introduction

The District Health System (DHS) is the organisational entity around and through which the provision of healthcare delivery should be organised as mandated by the National Health Act (61 of 2003).[1] A DHS approach entails a geographic and population-based approach to the planning and management of health services, and South Africa's DHS has been a core component of the post-1994 strategy to create a decentralised and unified healthcare system. The role of the DHS was first articulated in the White Paper for the Transformation of the Health Sector in South Africa published in April 1997.[2] It is based on a DHS Policy that was drafted in 1995 by an inter-provincial National District Health Systems Committee, established in August 1994.[3] In essence, these documents address the need to reorganise the inherited, highly fragmented healthcare delivery system into a unified system managed by District Management Teams (DMTs) with a focus on primary health care (PHC) and in line with an overarching government policy of decentralising government services.

The World Health Organization (WHO) defines a DHS based on PHC as:

> a more or less self-contained segment of the National Health System. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional. A District Health System therefore consists of a large variety of inter-related elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self-care and all health-care workers and facilities, up to and including the hospital at the first referral level, and the appropriate laboratory, other diagnostic, and logistic support services.[4]

As originally envisaged in 1995, the DHS would be a highly autonomous system, functioning not in isolation but as an integral part of the National Health System, and comprising three major levels:

➢ National Department of Health (NDoH), responsible for the overall co-ordination and determination of policy for the country's health system, and for monitoring and support of the provinces;

➢ Provincial Departments of Health (PDoH), responsible for the co-ordination of the health system within each province, for the provision of specialist health services, and for monitoring and support of the districts; and

➢ District Health Authorities, responsible for the provision of non-specialist health services within each district.[3]

The National Health Act of 2003 largely preserved this three-tier system while accommodating the role of municipalities in providing certain health services, with co-ordination taking place at the district level through a District Health Council, to which the respective district and municipal managers would report.[1]

The commitment to establishing a well-functioning DHS must be viewed as one of the key reform initiatives of the democratically elected government, which identified a DHS as a priority in 1994 with a policy rapidly following in 1995. However, implementation has lagged behind intention.[5] A 2008 Development Bank of South Africa (DBSA) report entitled *A roadmap for the reform of the South African health system*, suggests that the reason for South Africa's deteriorating health outcomes lies in flawed institutional design, and stresses the need for institutional design to be a central theme for health system reform.[6] It recommends that "restructuring health districts to improve performance is an essential prerequisite for achieving any improvement to the public health goals."[6] The report further cites problems around governance frameworks, specifically the lack of decentralisation of authority to district or hospital management level that lack the mandate to carry out their functions effectively.[6] The report concludes that "a dysfunctional district system will never be able to effectively carry out programmes assigned to it, and consequently represents an obstacle to improvements in the achievement of key health goals".[6] Similar obstacles to implementing the DHS were identified by McCoy and Engelbrecht in 1999, such as the different understandings of the managerial roles and relationships between the three tiers of the healthcare system.[7]

The National Health Act was promulgated in 2004, and 2009 heralded the beginning of an increased focus on health systems strengthening. Barbara Hogan, during her brief term as Health Minister, appointed a series of Ministerial Advisory Committees tasked with finding solutions to various health system weaknesses.[8] This systems-strengthening approach has continued under the current Minister of Health, Aaron Motsoaledi, who has driven a specific focus on improving the managerial competence of public sector health managers. In 2012 he launched the Academy for Leadership and Management in Health Care, which is tasked with developing a managerial competency framework and an inventory of available training courses, accrediting and commissioning providers, and conducting competency assessments of key post-holders.[9]

Lack of managerial skills within the public health sector attracted media attention in 2011 when an assessment of managerial competency among hospital Chief Executive Officers (CEOs) and District Managers (DMs) was conducted. Subsequently the Minister of Health initiated a process whereby a large number of hospital CEOs had to reapply for their posts. As at February 2013, 86% (102) of the 118 new CEO positions were filled.[10] The institutional design reforms recommended by the DBSA to ensure that competent managers have the decentralised authority to implement policies and programmes are, however, still lagging.[11]

The NDoH has renewed its commitment to devolving greater autonomy to the district level and to ensuring that "the re-engineering process does not detract from the need to strengthen the district health system" and "in particular … District Management Teams (DMTs), Sub-DMTs and district hospital CEOs must be responsible and accountable for all the services that take place in all the facilities and communities in the districts".[12] This commitment is being translated into action through a project currently underway in Tshwane District, as part of the National Health Insurance (NHI) pilot programme that is assessing the policy and legislative changes required to achieve full decentralisation of authority to the DMT. In July 2013, the Minister of Health also announced increased autonomy for the CEOs of certain categories of government hospitals in Gauteng Province, with expansion to all provinces being planned.[13]

Figure 1:   Health Systems Strengthening Building Blocks
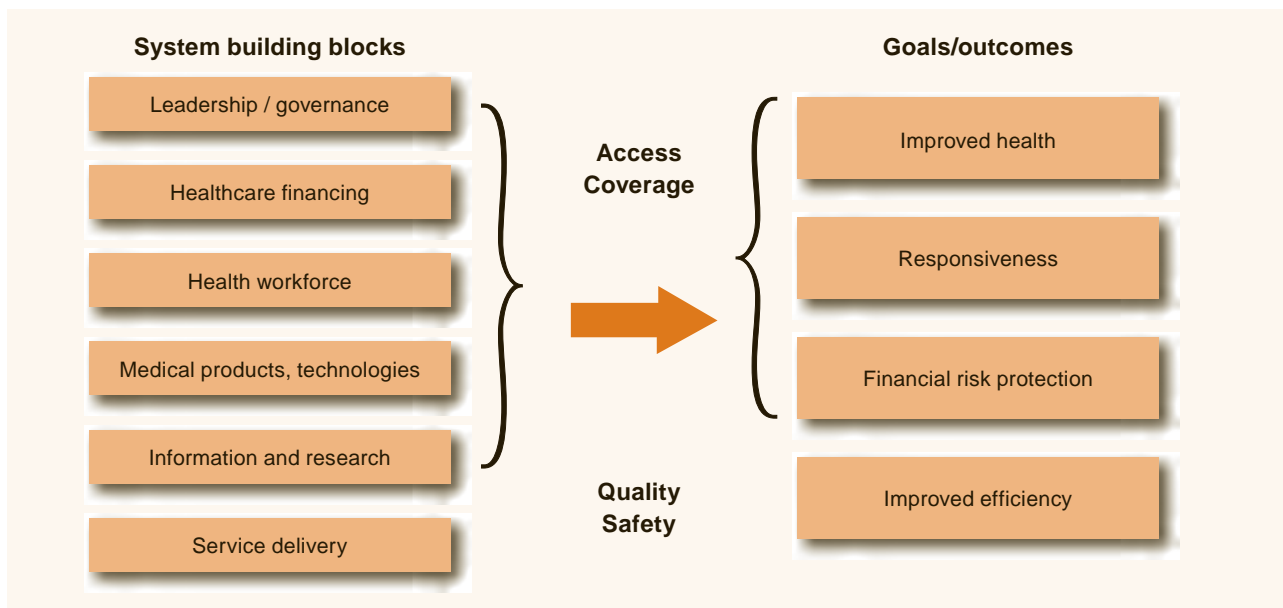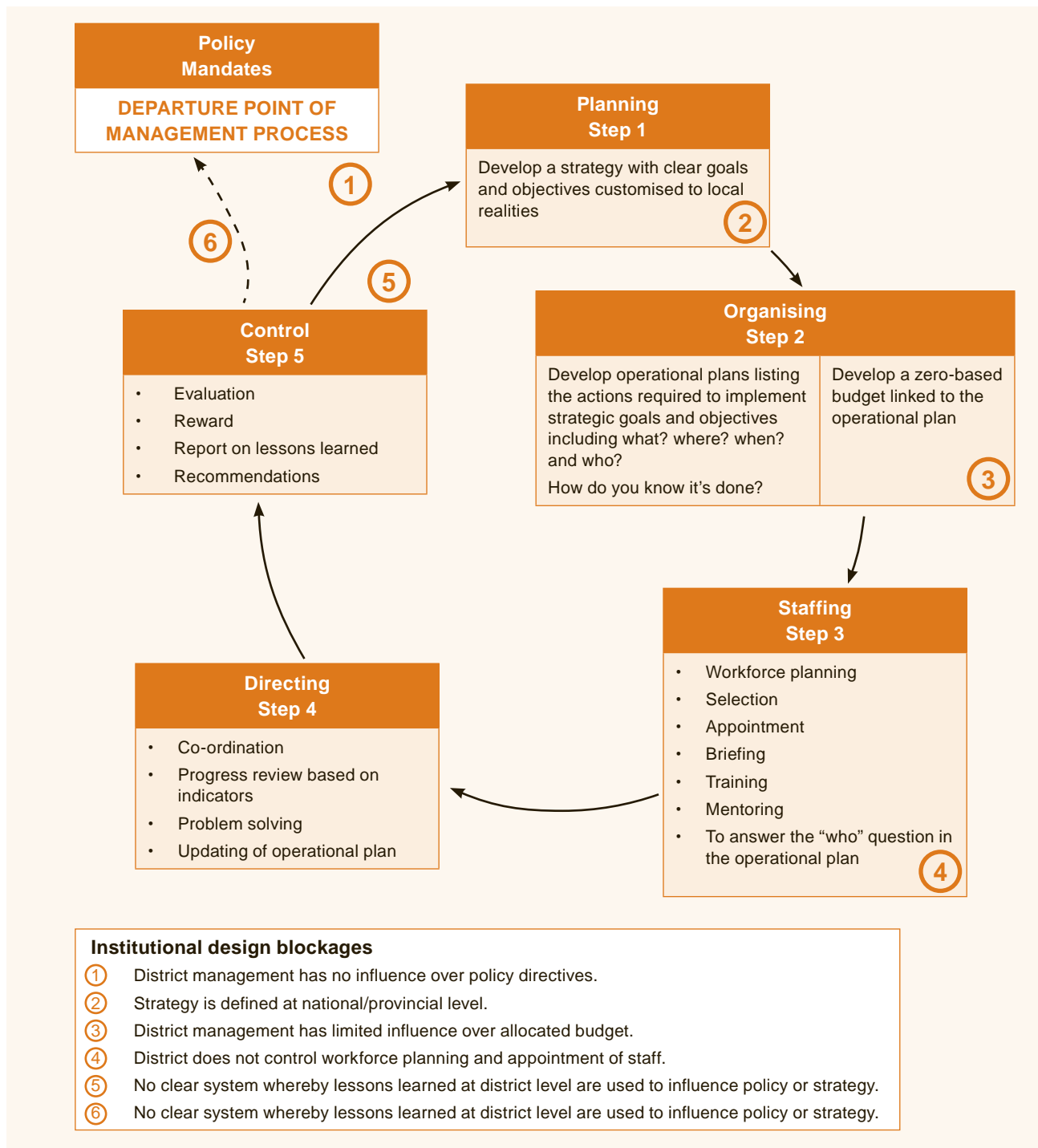

Source: World Health Organization, 2007.[4]

An important step to support the strengthening of district health management was initiated in 2012 with the transition of bilateral health co-operation between South Africa and the United States of America away from support for direct AIDS and TB service provision through the US President's Emergency Plan for AIDS Relief (PEPFAR) and towards supporting health systems strengthening (HSS).[14] Under this new five-year strategy, a number of civil society organisations have been contracted to provide technical assistance (TA) to health districts. Through this process, each district has been allocated a TA partner who supports district and facility management through providing consultant support, training and mentoring. The specific focus of TA support is customised on a district-by-district basis to respond to targets contained in the Minister of Health's Negotiated Service Delivery Agreement and annual performance plans. Deficiencies identified through national benchmarking exercises, such as the District Health Barometer and the 2012 National Health Care Facilities Baseline Audit, are also addressed.[15,16]

To better understand the current challenges faced by district managers, face-to-face interviews were held with a convenience sample of nine DMs representing a cross-section of urban and rural districts. An additional structured survey was carried out with 233 operational and district managers within these districts regarding their qualifications and their length of service within the health department. PEPFAR TA partners were also surveyed on their impressions relating to the constraints and challenges faced by DMTs. Although not exclusive, this approach provided a snapshot of 25 districts (both urban and rural) covering all provinces. Through this approach, the most common hindrances that impact on the ability of the DMT to deliver high-quality healthcare services in a number of selected districts were explored.

Constraints and challenges

The most common constraints identified are those that hamper the ability of DMTs to effectively translate national policy into district-specific strategies. These strategies need to be supported by detailed work plans specifying the actions required with related roles, responsibilities and deadlines, and linked to reliable management information systems that provide regular overview of progress. These plans should also be supported by well-constructed budgets and sufficient dedicated human resources for implementation. In essence, the cycle of management activities that underpins any project management model involving such basic steps as planning, organising, staffing, directing and controlling is currently ineffective in the public health sector due to a multiplicity of factors originating from national, provincial and district-specific levels. An overview of the limitations on the autonomy and authority of the DMT that results in constrained managerial capacity is provided in Figure 2.

Policy Mandates

DEPARTURE POINT OF MANAGEMENT PROCESS

Planning
Step 1

Develop a strategy with clear goals and objectives customised to local realities

Organising
Step 2

Develop operational plans listing the actions required to implement strategic goals and objectives including what? where? when? and who?

How do you know it's done?

Develop a zero-based budget linked to the operational plan

Control
Step 5

- Evaluation
- Reward
- Report on lessons learned
- Recommendations

Staffing
Step 3

- Workforce planning
- Selection
- Appointment
- Briefing
- Training
- Mentoring
- To answer the "who" question in the operational plan

Directing
Step 4

- Co-ordination
- Progress review based on indicators
- Problem solving
- Updating of operational plan

Institutional design blockages
1. District management has no influence over policy directives.
2. Strategy is defined at national/provincial level.
3. District management has limited influence over allocated budget.
4. District does not control workforce planning and appointment of staff.
5. No clear system whereby lessons learned at district level are used to influence policy or strategy.
6. No clear system whereby lessons learned at district level are used to influence policy or strategy.

In essence, the institutional design flaw identified in the DBSA report still hinders the ability of districts to deliver the healthcare services they are mandated to provide.[6] District managers are deeply aware of these constraints and express a sense of frustration regarding their inability to overcome them, but despite these challenges, they remain largely positive about and committed to improving healthcare delivery.

In the section below the constraints and challenges faced by DMTs are discussed from a health systems strengthening perspective using the health systems strengthening (HSS) building blocks framework as defined by the WHO.[4]

Service delivery

Service delivery is directly influenced by the other HSS building blocks, but the primary issue that undermines health service delivery is the inability of the DMT to translate national policies into district-specific strategies, work plans and budgets. Findings yielded in interviews with district managers show that the process of developing annual district health plans (DHPs) is well-defined and districts receive good guidance from the NDoH on the required format. However, institutional design flaws around budget and human resources weaken the implementation of these plans.[6] Interviewees were mostly satisfied with the district planning process and expressed a strong conviction that planning was important, as was reviewing the implementation of plans. Specific benefits of planning at district level that were cited included:

➢ improved ownership by managers of plans they had contributed to developing;

➢ better understanding of timelines and higher probability of services being delivered on time;

➢ improved compliance; and

➢ ensuring stability from year to year, especially in an environment where there are often changes in senior district management.

The DMs interviewed were divided on the ideal length of the planning cycle. While some managers believed that the current cycle of developing annual plans is effective, others expressed a preference for longer planning cycles. An innovative approach advocated by one of the DMs involves district planning taking place in a two-tier system of developing a three- to five-year strategic plan supported by annual operational plans.

The majority of the DMs interviewed believed that their management team members did not have the required skills to undertake effective planning. As expressed by one of the DMs: "You can't do this thing with junior people."

There was a strong sentiment that management teams would benefit from additional management training and mentoring. This finding correlates with those of a survey of public and private sector hospital managers showing that public sector hospital managers were more likely to indicate the need for further development and training.[17] In this context, the DMs commented favourably on the technical assistance support they receive from the PEPFAR-funded TA partners.

Other process difficulties cited were:

➢ securing commitment from all managers to commit to the plan and poor implementation of the plan. As one DMs put it: "What gets planned for does not necessarily get done";

➢ vacant posts at managerial level were seen as constituting an impediment to effective planning; and

➢ national and provincial plans were considered unworkable because national strategic plans do not take into account realities on the ground, and generic plans were unsuitable for the specific needs of each district.

It was also clear from these discussions that planning for service delivery at district level is focused only on service delivery by the public sector, which does not take into account the WHO definition of a health district that "includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional".[4] The exclusion of other stakeholders within a health district results in a serious lack of co-ordination of resources and initiatives falling within the ambit of a unified structured district plan. Notably, this omission is not caused by limitations in the policy environment, as the 1995 DHS Policy specifically acknowledges the importance of leveraging all possible resources from all sectors by stating that it is only possible to make maximal use of the relatively limited resources available for health care in South Africa if the combined resources of the public and private sectors are efficiently utilised and co-ordinated.[3]

Lack of guidance from provincial government regarding the prioritisation of service improvement surfaced as a challenge during this study. One of the TA partners describes their experience of supporting the planning process in a number of districts thus:

> Probably the biggest challenge is determining priority. Each health interest assumes its niche to be the most important and the DM has to respond to the broad noisy crowd with a harmonised approach, e.g. HIV, TB, NCDs (non-communicable diseases), MCH (maternal and child health), PHC, NHLS (National Health Laboratory Service), PHC re-engineering, NHI, CQI (Continuous Quality Improvement), emergency services, NGO agendas, audits, arbitrary political promises – how do you plan to meet all these competing agendas without imploding?

Health workforce

DMs identified health workforce issues as one of the major constraints hampering service delivery. The challenges faced by DMTs in this regard predominantly revolve around the key issues of workforce planning, recruitment and retention, and were articulated as follows.

➢ Where do health workers with a specific skill-set need to be deployed in order to have maximum impact (workforce planning)?

➢ How does one bring new health workers into the system (recruitment)?

➢ How does one retain health workers in those positions for as long as possible (retention)?

The shortage of skilled health workers and managers was one of the most cited constraints. However, workforce planning is an area over which district management feel they have little control; as a result, district human resources plans seldom exist and human resources management is seen as an administrative rather than a proactive managerial function. Although DMs reported that they were participating in a national initiative to determine facility staffing norms, their interpretation was that planning to meet this staffing requirement would be a provincial and not a district responsibility. DMs often referred to what they perceive as a standard cost-control intervention by the province of freezing posts when there are resignations, irrespective of the impact this has on service delivery. Consequently, key clinical positions remain unfilled and management positions are sustained by an acting manager. One district reported that 50% of hospital managers were in "acting" positions. Ratios of managers to service-level staff can also be a challenge, in that budget allocations for management positions exceed the related operational budget. A major problem described by DMTs was the lack of responsive human resources information systems at district level to support planning.

Recruitment is another area in which districts have very little autonomy. Although DMs reported district-level participation in the interviewing of potential candidates, the actual appointment processes are usually centralised at provincial level. This approach is protracted and subject to postponement if the province is under budgetary pressure. A common effect is the collapse of clinical teams especially in rural hospitals. When clinical staff numbers fall below a certain critical level, the workload overwhelms the remaining team members, often resulting in all or many of them resigning in rapid succession. The effort to re-establish a clinical team will be disproportionately onerous.

In 2013, Africa Health Placements, a non-governmental organisation working on issues of HR in health, conducted a survey of health workers and managers in nine rural districts and one urban sub-district in six of South Africa's nine provinces. Retention factors were examined from the health worker's perspective, where retention is dependent on the value they experience in their role, this factor being defined as the Employee Value Proposition (EVP). EVP is articulated as "a set of associations and offerings provided by an organisation in return for the skills, capabilities and experiences an employee brings to the organisation".[18] These associations and offerings can be described as leaders, organisation, people, workplace, communication, people processes (including work, opportunity and reward), and culture (central to all of these attributes).

Information relating to each of the EVP attributes was collected. The purpose of the survey was to enable district management teams to select their priority focus areas for HR capacity-building initiatives. Figure 3 presents the aggregated results.

EVP attributes, such as workplace and resources, financial recognition, co-workers and the organisation itself, create dissatisfaction in health workers if not addressed. EVP attributes, such as culture, recognition, advancement, meaningful work, communication and leadership, are those that drive engagement. It is important to note that satisfied employees do not equate to engaged employees. Engaged employees are those who are so enthusiastic about their work that they will behave in a way that acts to advance the goals of the institution, e.g. a doctor who works through lunch-breaks.

Encouragingly, and perhaps unsurprisingly, "meaningful work" received the highest rating. Health workers in the public sector clearly feel that their work adds value and makes a difference. This is a key engagement driver and a much more intractable attribute to institute when absent. Of the satisfaction drivers, workplace and resources were rated the most poorly, due to lack of hospital equipment and accommodation. However, more concerning was that three of the four most poorly rated attributes were those related to engagement and, thus, retention of health workers. The most foundational of all EVP attributes – culture – received the lowest rating. Perceptions regarding "disrespect", "favouritism", "management do not listen" and "lack of clear goals and vision" emerged as significant issues which were borne out by discussions with individual managers, all of whom expressed the desire to achieve high-quality health delivery. The core problem, then, seems to be one of a schism between intended purpose and visible behaviour. Of concern is a perception among some managers that if their district is in a popular city, and therefore an attractive destination for healthcare professionals, a focus on retention is not required. Overall, the impression is that management is distant from clinical staff in particular, and that a

Figure 3:   Aggregated survey results measuring health worker satisfaction
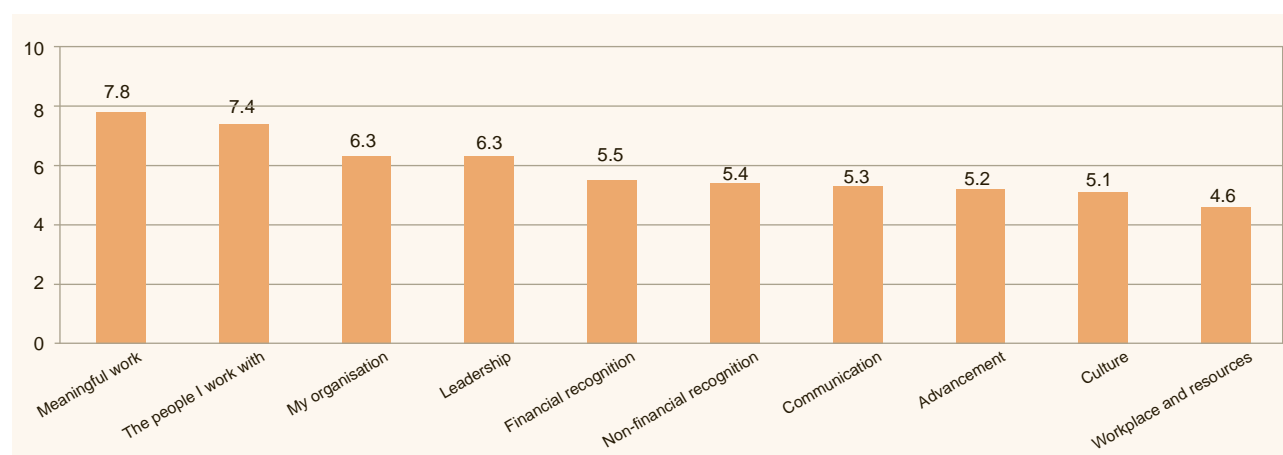
Note: Employee Value Proposition attributes in nine rural districts and one urban sub-district in the South African public healthcare system (1 = least satisfied; 10 = most satisfied)

focus on creating an environment that is conducive to staff retention is not a priority.

Professional development of staff is a priority for districts, and resources are channelled via regional training centres for this purpose. Training is an area in which partnership with civil society organisations leverages substantial additional training resources. DMTs feel that staff have adequate access to professional development opportunities, although these tend to favour HIV-related clinical subjects due to the availability of donor funding. Fewer opportunities exist for other clinical subjects and management training, which were key gaps identified by DMs.

Management of staff around absenteeism and productivity was raised as an overarching problem, and addressing such issues is regarded as being dependent on facility managers' competency in human resource management, which is generally perceived as poor.

Information and research

South Africa's District Health Management Information System (DHMIS) encompasses the people, policies, procedures, hardware, networks and datasets, in addition to software solutions, to capture, process and manage required health information.[19] Despite widespread consensus regarding the importance of good monitoring and evaluation (M&E) and the "use of data to improve health systems performance, to respond to emergent threats and to improve health",[20] many DMTs concede that managers do not consistently and effectively use data for evidence-based decision-making, particularly with regard to planning and performance management. Although there are routine reports and datasets to promote information use (e.g. the annual District Health Barometer, National Health Laboratory Services laboratory results reports, 3-tier HIV cohort reports, and data extracts from DHIS), continued poor performance against key health service delivery indicators and gaps in adequate resource allocation highlight more systemic problems within the information building block for health systems strengthening. Reasons for sub-optimal use commonly cited by DMs include the lack of data availability and timeliness, poor data integrity and data validity, as well as the sheer quantity of data and their presentation format. Some managers also concede uncertainty relating to how data are and should be presented, as well as principles for correct interpretation and use in decision-making. Data quality is undermined by a multiplicity of data collection tools and a large number of data elements, inadequately trained data staff, poor data verification and validation exercises from facility to district level, changes in policy and reporting which do not necessarily coincide with updated data collection tools, and off-line data flow resulting in poor version control. In what can be likened to a vicious cycle, poor data quality contributes to sub-optimal use of data, and in turn, sub-optimal use of data perpetuates poor data quality.

Having recognised gaps in the implementation and interpretation of the DHMIS, the NDoH has clarified the vision of the DHMIS in the DHMIS Policy with its associated processes and standard operating procedures (SOPs).[19] These strategic documents provide clearer and more comprehensive guidance and standardisation in terms of the co-ordination and leadership of health information, indicator sets, data management, data security, data analysis and information products, data dissemination and use, as well as the DHMIS resource requirements (including human resources, hardware and interfaces between other information systems). In line with the standardisation

of the DHMIS, the NDoH has taken a stance to streamline, harmonise and align the various tools and systems that contribute to the DHMIS. Most notably, the NDoH has clearly signalled that the only health information system tools to be used in public sector facilities will be the South African government's HIS tools, in particular DHIS, TIER.Net and ETR.Net and the affiliated stationery, registers and tick sheets. Parallel systems – the legacy of PEPFAR partners' roles in supporting public sector HIV clinics – are no longer permitted for use. The DHIMS policy establishes the framework for a strong and robust information system in South Africa.

However, there are three significant threats to successful implementation of the DHIMS policy: inadequate data ownership by all levels of management; insufficient planning and resourcing for information systems (human and information technology); and cumbersome data sets that inhibit easy use and dialogue around the meaning and implications of the data.

With regard to data ownership, the DHMIS policy articulates that the DM and not the information manager is responsible for mobilising the required resources to ensure the provision of strategic information, ensuring adaptation and adoption of provincial and national targets for the district, and enforcing that M&E forms part of every manager's performance agreement. Furthermore, managers' accountability for data is reinforced through the data flow process and SOPs, which stipulate that health establishment managers, sub-DMs and DMs must sign off that data submitted constitute a "true reflection of the situation".

For any information system to succeed, skilled data personnel and sufficient information technology infrastructure, including networking capability, should be in place. Unfortunately this is often not the case, as historically, data-capturer posts have not been designated as permanent and/or critical posts for recruitment. As one TA partner remarked:

> Some districts have adopted an internship approach to data capturers which would require recruiting and training and releasing a new cadre of data capturers on an annual basis. This seriously undermines quality as it takes three to six months for an adequately supported data-capturer to be fully functional in his/her role to feed quality information into the various HIS.

The transient nature of data-capturer posts also often results in contracts not being renewed in time, long-term vacancies and the added burden of training new data staff.

Concomitantly, the eHealth strategy and the DHMIS strategy are rapidly moving South African data onto electronic platforms (see Chapter 2). However, the requisite information technology (IT) support structures do not adequately follow pace. Existing IT departments at district level are often unable to respond to this strategy as they are usually understaffed, typically with only one individual responsible for IT management in a district. In addition, progress is hampered by limited operational budgets to roll out and maintain IT systems in an environment of outdated and/or non-functional computer equipment, poorly enforceable IT policies, non-existent and/or faulty networks and rampant computer viruses.

The importance of quality strategic information in managing implementation is integral to project management, as coined in the maxim: "What gets measured gets managed."[21] Unfortunately, most

DMs are compelled to manage programmes in an environment in which they do not have access to quality information; this scenario was summarised by a DM thus: "Decisions are not based on any evidence."

Medical products and technology

The availability of medical products and technology at facility level is dependent on a complex system that involves acquisition, procurement, storage, distribution, dispensing and in the case of medical technology, training and maintenance. Linked to this are the important issues of quality assurance, such as compliance with Good Pharmacy Practice and the implementation of effective and functional stock control systems to manage stock movement and prevent stock losses. Sustainability of reliable operational systems in the districts depends on continuous training of dedicated personnel, maintenance and regular upgrades.

Procurement is not a district-based function, as it takes place through national and/or provincial tender processes to procure and supply medical products to provincial pharmaceutical depots, stores or facilities. Although the benefits of central procurement, especially in reducing purchase prices, is acknowledged by DMs, the fact that district pharmaceutical management is seldom involved in item forecasting or budgeting exercises was identified as a constraint, as it creates a disconnect between procurement and actual need.

Management of medical products at the district level is envisaged to be the responsibility of district pharmacists; however, these posts do not exist in all districts despite these positions being essential for managing all pharmaceutical-related matters and supporting compliance with South African Pharmacy Council (SAPC) regulations in terms of the registration and accreditation of facilities and tutors. These incumbents are also needed to implement and monitor effective supply chain systems in collaboration with the provincial medical depots, oversee implementation of sound pharmacovigilance systems, and co-ordinate functional pharmacy and therapeutic committees and pharmacist forums.

Pharmaceutical stock control and dispensing technology at district and facility level are often outdated, poorly maintained, or do not exist. Manual stock card systems are used in all primary healthcare facilities and at some hospitals, placing strain on understaffed pharmacies, which in turn contributes to the drug stock outs frequently reported in the media. To address these problems, the NDoH has introduced a programme instituting direct delivery of identified high-volume medical and related surgical supplies from the manufacturer/distributor to hospital facilities, with the objective of relieving pressure on provincial medical depots. However, this might require additional storage space and stock control systems at hospitals to ensure that buffer stocks are available should suppliers be unable to adhere to contracted lead times. Efficient stock control systems will be required as hospitals will serve as "sub-depots" for PHC facilities.

Dispensing takes place within a highly regulated environment, as both the NDoH and the SAPC require all pharmacies (hospital and community health centres where pharmacists are deployed) to be licenced and registered with the SAPC. PHC facilities are required to be recorded by SAPC for quality purposes, although the South African government is mostly not compliant in this regard. The purpose of such registration and recording is to ensure the

standardisation of infrastructure, storage conditions, equipment, material and procedures to support quality services to the public. SAPC accreditation of pharmacies is also required for the training of pharmacist assistants. Moreover, some provincial depots and public sector pharmacies are not registered and/or accredited for training of pharmacist assistants with the SAPC, which restricts the ability of these facilities to train pharmacist assistants.

At PHC facility level, dispensing and procurement of pharmaceutical and related surgical items usually falls on the shoulders of overburdened clinical nurses, often resulting in poor supply chain management. To address this problem, most districts are in the process of training and deploying post-basic pharmacist assistants. This process is being hampered by a shortage of pharmacies accredited as pharmacist assistant training facilities, and a general shortage of pharmacists to supervise training.

Healthcare financing

While districts do go through an annual budgeting process (District Health Expenditure Reviews) linked to developing DHPs, in general most DMs felt they had minimal actual control over their budgets, as decisions regarding budget allocation are made by the Provincial Treasury. These allocations appear to be done on the basis of historical budgets rather than on the budget needs presented by the districts, these being typically developed from a zero-based budget perspective linked to their DHP. The most cited constraint by DM respondents was that the budget allocations are insufficient to implement the annually developed DHPs, especially as new strategic objectives with additional service delivery requirements are introduced by the NDoH on a regular basis. These new activities were rarely accommodated in the previous year's budget, such that Treasury's use of a historical budget allocation fails to make provision for these new activities. In addition, there appears to be no system allowing the DMT to amend DHP objectives based on the actual resources secured. Consequently, implementation of the DHP proceeds with the DMT being fully aware that the budget is insufficient, as expressed by one respondent:

> Around the third quarter (of the financial year) you are in the position where you are out of pocket and you have to bring in austerity measures and the plan grinds to a halt.

Another challenge faced by DMTs originates from managing year-on-year adjustments to over- or underspending. Overspending in one year is deducted from the following year's budget, making it difficult for DMs to deliver consistent service levels and perpetuating the cycle of shortfalls at the end of each financial year. Underspending is generally viewed by DMs as a poor strategy:

> You will be punished in the next budget if you do not spend your money this year.

This creates a disincentive for DMTs to be frugal. The fact that allocation of budgets to PHC facilities is inconsistent across districts is often a major reason for overspending. Hospitals generally have an allocated budget, but this does not always apply to smaller facilities such as PHC clinics, where managers authorise expenditure without any indication of their budget limits.

The opportunities to generate additional income for the fulfilment of new activities are limited. One option is to apply for conditional grants; however, some districts reported that their management team does not have the ability to generate such applications. Another

option is to form strategic partnerships with NGOs active in the district, and although the DMTs are aware of such role-players, the possibility of drawing on the resources of NGO partners to make up for shortfalls in the district budget is not robustly considered or factored into the districts' budget planning processes. Drawing on NGO resources occurs either as an ad hoc initiative or at the instigation of NGOs.

Financial management is intended to occur through a process of quarterly reviews of expenditure against budget, but districts have limited mechanisms to manage over- and under-expenditure, except for relocating funds between budget line items. Reallocation between programme budget lines sometimes takes place without consulting the affected line managers. Quarterly reviews are not always conducted and the format of meetings varies between different districts. Some managers regard the strategic information that is available to them as insufficient to manage the district's finances.

The interview findings reveal that most line managers take marginal ownership of, or are accountable for, expenditure, and that the district Chief Financial Officer is viewed as the person responsible for all financial management. One respondent said:

> Finance is received from Province, and is controlled at the district by the Senior Finance Manager and her managers.

Compounding this lack of ownership, there also appear to be limited consequences for line managers who overspend on their budgets. Vacant financial manager posts at facility level are regarded as another challenge to effective expenditure management. The quality of financial information available to management is also problematic in some districts.

Leadership and governance

Leadership is often emphasised as a key success factor in any change management situation, and district health management operates in a perpetual environment of change due to the major healthcare reforms emanating from the NDoH.[22] What is apparent from the surveys is that managers often lack the required managerial competencies to fulfil this leadership role. Healthcare managers at all levels in the district are recruited from health professional cadres, which provides appropriate context for their management functions, but seldom includes formal management training. Although managerial qualifications do not necessarily guarantee managerial competency, appropriate qualifications constitute a logical starting point. In a survey of the management qualifications of 233 district-based managers at district and sub-district level, 21% (n=49) reported having a management qualification (ranging from 5% to 43% across districts) and another 10% (n=24) were in the process of obtaining a qualification (ranging from 4% to 36% across districts).

Another constraint identified was the negative effect on programme implementation resulting from managers being in acting positions or key positions being vacant. The general impression from DMs and TA partners was that managers in acting positions often interpret their role as being a caretaker function complicated by real or perceived restrictions on their authority to implement change. Unpublished research by the University of Pretoria School of Health Systems and Public Health has shown that one of the three major predictors for a hospital not meeting the national core quality standards for healthcare delivery is that of CEOs holding acting appointments.[23]

In the survey of management qualifications, vacancy rates were low overall, with the exception of one district reporting a 30% vacancy rate. Where data were available, the average duration in the post (128 managers) was 47 months (3.9 years), suggesting a relatively low management turnover within the districts. One district was significantly low, with average time in post being 20 months (1.8 years). Overall, management turnover was relatively low with an average of 1.6 managers in a specific post over the past five years. However, those with a single manager in the post over the past five years ranged significantly between districts from 72% to 27%, suggesting that management retention and turnover differs drastically between districts.

Turnover in senior managerial and political positions at both provincial and district levels results in inconsistent leadership, as noted by one of the respondents:

> Regular change of political and executive leadership at provincial level causes paralysis.

Managing politically connected appointees who enter the management structure via "cadre deployment" was also identified as a challenge, as these managers are seen as untouchable and create major performance management challenges for their superiors, especially if they are not committed or competent.

At an operational management level, the effectiveness of monthly management meetings to monitor progress and institute remedial action varies across districts. There is no consistency around who should attend such meetings, what is reported, and how it is reported.

Holding district management accountable through governance systems that represent district-based stakeholders is envisaged in the National Health Act through a structure of committees ranging from district health committees to hospital boards and clinic committees. The interview results paint a fragmented picture of governance structures across districts. Governance does not appear to be a priority for most of the DMs; none of the districts surveyed had all the required governance committees in place and no objective evaluation of how committees were functioning existed. The composition of the various committees, despite being prescribed in the National Health Act, varied between provinces and as a rule seemed to have little representation from civil society health service providers (NGO and private providers).

Recommendations

General recommendations

➢ The institutional design problems identified in the DBSA report still exist and issues around delegation of authority and management autonomy need to be resolved.[6] Districts should be granted the authority to implement DHPs, as only under such a scenario will it be possible to hold DMTs accountable for service delivery.

Service delivery

➢ Districts should be encouraged to develop longer-term strategic plans that allow them to customise the national policies and strategies supported by one-year work plans.

- It is crucial that DMTs develop strategic planning skills and have access to all relevant national and provincial strategic documents, preferably from a single online directory that is regularly updated.

- Districts should be encouraged to take into account all possible healthcare resources in the district when developing strategies, including those available in the private for-profit and not-for-profit environment. Involving all stakeholders (NGO partners, municipalities and other functional departments) in planning initiatives could be beneficial to ensuring better co-ordination of services.

- Priority should be given to ensuring that key managerial and clinical positions are filled with competent and committed people whose performance is monitored with appropriate rewards and sanctions.

- All employees in the district health system should be acquainted with the contents of the DHP.

Health workforce

- Workforce planning should be a priority activity for district management, supported by reliable strategic HR information that should be made available at all levels of the healthcare system, based on indicators that are easy to update and easy to understand by facility managers.

- Ratios for the number of managerial and administrative positions in relation to service delivery positions should be established.

- Recruitment times should be shortened, and the issuing of employment contracts should take place within a reasonable time (30 days) through devolving authority for issuing such contracts.

- Line managers' HR skills should be dramatically improved and performance management systems should hold managers accountable on HR indicators such as staff satisfaction, staff turnover and productivity.

- Comprehensive induction programmes that address clinical, social, cultural and logistical orientation of newly recruited health workers should be developed.

- Professional and personal isolation of managers and clinical staff in rural areas should be addressed through Continuing Professional Development sessions that convene health workers and facilitate action learning sets for managers.

Information and research

- To ensure data ownership, three immediate interventions are recommended: orientating all levels of managers on their roles and responsibilities in accordance with the DHMIS policy; updating performance agreements to include data verification and data use; and requiring all managers (not only the information managers) to use data from the South African government's Health Information Systems for their monthly reporting against targets at programme and/or facility level.

- Districts should allocate a larger operational budget for travelling, basic equipment and networking, as well as for a solid contingent of junior IT technicians who, under the supervision of a senior technician, would respond to facility and district-based complaints.

- Districts should explore point-of-care reporting using simple phone-based applications to capture data and process information.

- The use of dashboards, barometers and other data interpretation tools should be implemented to assist managers in translating data into information for decision-making that should be analysed at monthly management meetings. Key indicators should include clinical indicators (such as those in the District Health Barometer), financial indicators, supply chain indicators (stock-out rates), HR indicators, equipment maintenance indicators and laboratory indicators (specimen adequacy rates).

- A research culture should be developed at district level to ensure that grassroots learning is captured and disseminated. Research methods such as action research that are designed to improve managers' own practice should be promoted.

Medical products and technology

- The DMT, in co-operation with the district pharmacist, should develop annual pharmaceutical budgets and item forecasts for submission to the PDoH.

- District pharmacist positions should be filled and these pharmacists should play an active role in preventing overstock and expiry of items at all facilities by re-distributing items within the district.

- The provisioning and standardisation of computerised, user-friendly stock control and dispensing systems in hospitals and community healthcare centres is essential. Training and maintenance contracts must be available to support and sustain these systems in order to secure and monitor supplies for primary healthcare facilities. These systems should interface with the NDoH database.

- The DMT should budget and plan to ensure compliance of pharmacies and PHC facilities with SAPC regulations, and should settle annual registration fees for the facilities and pharmacy staff.

- All pharmacies must be accredited for training of pharmacy staff as required by the SAPC.

- Districts should encourage the "adopt-a-clinic" concept for community service pharmacists, who should visit and support primary healthcare facilities on a regular basis to support the procurement of pharmaceutical items and monitor compliance with Good Pharmacy Practice.

- The deployment of post-basic pharmacist assistants at all PHC facilities should be prioritised.

Healthcare financing

- The financial management process should be improved vigorously across all aspects, commencing with budget processes. Zero-based budgeting should be encouraged, preferably using an indicative amount as a baseline provided by the Provincial Treasury so that DMTs have an understanding of the expected funding.

➢ Budgeting should be done according to district-specific priorities, with sufficient authority devolved to the DMTs to allow them to adjust district objectives based on actual funds received.

➢ There is a need to bail out districts caught in a revolving deduction of the previous year's overspend from the current year's budget.

➢ Accountability for expenditure and income (in the case of user fees) should be devolved to the lowest possible line manager, such that clinic managers' budget ownership, with accountability by line managers, is built into their performance plans.

➢ If national priority programmes are introduced during a budget year, such programmes should be fully costed to district level and implementation demand should be subject to additional funding being provided.

➢ Standardised financial management tools and procedures should be developed allowing line managers to review their income and expenditure on a monthly basis, with interaction between the Chief Financial Officer and line managers where under- or overspend exceeds defined criteria.

Leadership and governance

➢ Ensuring managerial competence should be a high priority for all DMTs and all senior managers should acquire a management qualification. Where required, mentorship programmes should be instigated. Competency should be ensured through effective performance management using an objective outcomes-based system such as Balanced Score Cards.[24]

➢ Acting managers should have the required authority to fulfil the requirements of the post.

➢ The composition, agenda and reporting tools of monthly district management meetings must be standardised.

➢ The private for- and not-for-profit sector should be included as representatives on governance systems in preparation for moving towards a NHI system wherein all available resources in a district will be brought in to provide services.

Conclusion

The current design of the healthcare system in South Africa creates a situation wherein the success or failure of healthcare reforms will largely revolve around the strengths and weaknesses of district management. As such, it is critical to ensure that district management has the delegated authority, competency and resources to implement national policy and strategy. If these institutional design issues are addressed, DMTs can be held fully accountable for the success or failure of service delivery at local level. With ambitious reforms such as the NHI being implemented, it has become a matter of urgency for policy-makers to commit to creating and sustaining a DHS characterised by effective decentralised decision-making and authority.

The thrust of this chapter is encapsulated in the following perspective expressed by management guru Peter Drucker:

Effective organisations take it for granted that work isn't being done by having a lovely plan. Work isn't being done by a magnificent statement of policy. Work is only done when it's done. Done by people. Done by people with a deadline. By people who are trained. By people who are monitored and evaluated. By people who hold themselves responsible for results.[25]

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