Budget Analysis: Health

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Introduction

The South African Constitution commits government departments to the progressive realisation of various socio-economic rights within available resources. These rights include the right to education, healthcare, housing and social welfare.[1] The PSAM defines social accountability as the obligation of public officials and private service providers to justify their performance in progressively addressing the above rights via the provision of effective public services.[2] In order to realise these rights effectively through the delivery of public services, state departments and private service providers responsible for the management of public resources must implement effective accountability and service delivery systems.[3] These include; planning and resource allocation systems; expenditure management systems; performance monitoring systems; integrity systems; and oversight systems.[4] The effectiveness of these systems can be established by monitoring their information outputs. To evaluate these systems, the PSAM has developed a set of evidence-based tools for monitoring the information produced annually by each system.

This budget analysis aims to assess the alignment between policy priorities and budget allocations within the Eastern Cape Department of Health (ECDoH) in relation to Programme 2: District Health Services and specifically the policy priorities and budget allocation around Maternal, Child and Women's Health and Nutrition. The analysis outlines the international and national contexts in which the programme exists and details the policy and budgetary challenges of the Eastern Cape Department of Health, which, are characterised by, *inter alia*, human resources issues, the rurality of the Eastern Cape's landscape and the Province's diverse socio-economic conditions. These challenges can be addressed through effective and efficient strategic planning, along with oversight mechanisms, which ensure corrective action and proper consequence management.

[1] Constitution of the Republic of South Africa. Act 108 of 1996, Chapter 2, Sections 26, 27 and 29.
[2] Public Service Accountability Monitor, *Knowledge Management Systems*. P. 12.
[3] Public Service Accountability Monitor, *Knowledge Management Systems*. P. 12.
[4] Public Service Accountability Monitor, *Knowledge Management Systems*. P. 13.

Findings and Recommendations

Finding I:

Despite clear policy prioritisation towards a National Health Insurance system for the benefit of all South Africans, it is disappointing that the National Health Insurance Conditional Grant was underspent by almost of R2.1 million in the 2015/16 financial year.[5] Under-expenditure is linked to poor strategic planning and resource allocation.

Recommendation I:

The Eastern Cape Department of Health should appoint a financial advisor to improve the spending within the Department in addition to a co-ordinator for the NHI to ensure the effective and efficient use of the NHI Conditional Grant in line with policy priorities.

The Portfolio Committees are encouraged to play a more vigorous oversight role over the Eastern Cape Department of Health's spending and should require more frequent financial and performance reporting.

Finding II:

The Eastern Cape Department of Health is faced with medico-legal claims in the amount of R17 billion for the 2016/17 financial year.[6] In the 2015/16 financial year, the Department spent R260 million in medico-legal settlements and R59 million in legal fees to the State Attorney.[7] The implication of this on the budget and the delivery of services is obviously extremely negative, says the MEC for Health in the Eastern Cape, Dr Dyantyi.[8]

Recommendation II:

The Eastern Cape Department of Health must conduct an audit of negligence cases in order to determine from which services and facilities, and from a lack of which supplies or equipment the majority of the negligence claims arise. The Department must then target the problem areas and ensure that the causes of these medico-legal cases are resolved.

Where a patient is left in a worse position as a result of obtaining medical help from a public healthcare provider, the South African Human Rights Commission needs to conduct an extensive and thorough investigation into the factors contributing to this.

Finding III:

Vacancy rates in the Eastern Cape Province public health sector are high. There are a number of posts where the "temporary category"[9] has a higher level of employment compared with the "permanent category"[10] in the same post. This has the potential to impact negatively on the morale and motivation of healthcare professionals.

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[5] Eastern Cape Department of Health, *Annual Report 2015/16.* P. 173.
[6] E Ellis "East Cape to Outsource Medical Case Defence" (accessed 5 August 2017) http://www.heraldlive.co.za/news/top-news/2017/07/12/east-cape-outsource-medical-case-defence/.
[7] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 14.
[8] E Ellis "East Cape to Outsource Medical Case Defence" (accessed 5 August 2017) http://www.heraldlive.co.za/news/top-news/2017/07/12/east-cape-outsource-medical-case-defence/.
[9] According to section 8(3)(b) of the Public Service Act 103 of 1994, a temporary employee is any employee who is not a permanent employee to whom the retirement age of 65 years applies.
[10] According to S8(3)(a) of the Public Service Act 103 of 1994, a permanent employee "means an employee to whom a retirement age of" 65.

Recommendation III:

The Eastern Cape Department of Health must undertake an audit of critical posts and investigate how temporary employees can be allocated to permanent posts to effectively meet sectoral needs and promote stability.

Finding IV:

Poor quality healthcare, employee and patient dissatisfaction are all too common throughout the Province. It is imperative that the Eastern Cape Department of Health improve the quality of health services and that the Health Professions Training and Development Conditional Grant is put to better use.

Recommendation IV:

There needs to be a bigger focus on the quality of the training and development support provided to healthcare workers that are currently in the employ of the Eastern Cape Department of Health and of those who will be entering the public healthcare system in the future.

The Department should appoint a co-ordinator who will be responsible for ensuring that the Health Professions Training and Development Conditional Grant is used to prioritise the training of practitioners over the medium to long term.

The Global Health Context

In many respects, South Africa mirrors the global health challenges. Of the top 10 causes of death in the world, 6 causes are the same as those faced by the African region as a whole, and 4 of the global causes are the same as the causes of death in the Eastern Cape.[11] Tuberculosis (TB), HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) are diseases that plague Africa and the Eastern Cape on a greater scale compared to the rest of the world.[12]

On a global scale, the United Nations (UN) member states created a number of targets in order to ensure that Goal 3 (ensuring healthy lives and promoting well-being for all at all ages) of the Sustainable Development Goals (SDGs) is achieved by 2030. The SDGs provide indicators related to each of the goals that allow countries to compare the success of interventions in the years going forward.

In relation to children and infant mortality; more than 6 million children die before they reach the age of 5 years old; measles vaccines have prevented almost 15.5 million deaths, and 80 percent of the deaths of children below the age of 5 occur in sub-Saharan Africa and Southern Asia.[13]

In terms of maternal health, in 2012, antenatal care increased from 65 percent in 1980 to 83 percent in developing countries, however, only half of women in developing countries

[11] The World Health Organisation “Top 10 Causes of Death” (accessed on 10 August 2017) http://www.who.int/gho/mortality_burden_disease/causes_death/top_10/en/.
[12] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 41 and The World Health Organisation “Top 10 Causes of Death” (accessed on 10 August 2017) http://www.who.int/gho/mortality_burden_disease/causes_death/top_10/en/.
[13] The United Nations “Sustainable Development Goals" (accessed 4 August 2017) http://www.un.org/sustainabledevelopment/health/.

receive the recommended *amount* of healthcare they need; and progress has slowed in respect of the number of teens giving birth in developing regions.[14]

HIV/AIDS, and malaria have a prevalence in Africa; the figures illustrate the severity of these diseases. While the rate of new infections in 2013 was 38 percent lower than it was in 2001, there are still 36.7 million people infected with HIV.[15] In June 2017, of the 36.7 million people infected with HIV 20.9 million people had access to anti-retroviral treatment.[16] Again, while the new HIV infection rate of children decreased by almost 60 percent as compared to the rate in 2001, at the end of 2013, there were still 240 000 children newly infected by the virus.[17] Most concerning is the fact that HIV is the leading cause of death for women of reproductive age worldwide, the leading cause of death among adolescents (aged 10-19) in Africa, and the second most common cause of death among adolescents globally.[18]

In terms of the targets set in order to achieve Goal 3, member states committed to a number of health targets, such as reducing the maternal, infant and child (under 5 years of age) mortality through ending preventable deaths.[19] In addition, member states committed to, *inter alia*, eradicating AIDS, TB and malaria, promoting well-being in order to reduce deaths from non-communicable diseases, increasing access to reproductive and sexual health and to advocating for a cleaner environment.[20]

To achieve the abovementioned goals, the World Health Organisation (WHO) has published a number of documents that describe ideal approaches to healthcare delivery. In 2016, the WHO published the "WHO Recommendations on antenatal care for a positive pregnancy experience", which, as the title suggests, sets out 37 recommendations on how to ensure that pregnant women experience a healthy pregnancy.[21] Similarly, in 2017, the WHO published "Guidelines on the public health response to pre-treatment HIV drug resistance", which provides support to countries such as South Africa that face issues relating to the emergence of drug resistant HIV.[22]

Global Legislation

There are a number of international treaties and covenants, which set the tone for the right to health in general and women's health in particular. For example, Article 25 of the United Nations Declaration of Human Rights promotes "the right to a standard of living adequate for

[14] The United Nations "Sustainable Development Goals" (accessed 4 August 2017) http://www.un.org/sustainabledevelopment/health/.
[15] UNAIDS "Fact Sheet – World AIDS Day 2017" (accessed 1 December 2017) http://www.unaids.org/en/resources/fact-sheet.
[16] UNAIDS "Fact Sheet – World AIDS Day 2017" (accessed 1 December 2017) http://www.unaids.org/en/resources/fact-sheet.
[17] The United Nations "Sustainable Development Goals" (accessed 4 August 2017) http://www.un.org/sustainabledevelopment/health/.
[18] The United Nations "Sustainable Development Goals" (accessed 4 August 2017) http://www.un.org/sustainabledevelopment/health/.
[19] The United Nations "Sustainable Development Goals" (accessed 4 August 2017) http://www.un.org/sustainabledevelopment/health/.
[20] The United Nations "Sustainable Development Goals" (accessed 4 August 2017) http://www.un.org/sustainabledevelopment/health/.
[21] The World Health Organisation "WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience" (2016).
[22] The World Health Organisation "WHO Guidelines on the Public Health Response to Pretreatment HIV Drug Resistance" (2017).

the health and wellbeing of [a person and his/her] family."[23] Women and children get special mention in Article 25(2) of the Declaration, in which it is stated "motherhood and childhood are entitled to special care and assistance."[24]

The International Covenant on Economic, Social and Cultural Rights, further entrenches the right to health by pronouncing in Article 12 that "the States Party (of which South Africa is) to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[25] The Article goes on to say that, "the steps taken by the States… to achieve the full realisation of this right shall include those necessary for… the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child."[26]

In addition to the above legislative framework, countries around the word undertook to work toward achieving the SDGs by 2030. As mentioned previously, the SDGs are a set of goals that countries, civil society organisations, businesses and the United Nations have agreed to work towards collectively. Goal 3 contains the commitment of all governments to work towards achieving the good health and well-being of its citizens.[27]

South Africa's Health Context: Equity vs Equality

The public health system in South Africa is in a poor state.[28] One of the major problems facing our health system is the fact that our public sector needs to cater for 83 percent of the population while the private sector only caters for 17 percent.[29] This has implications for service delivery and the cost of healthcare.[30]

Because decent education and healthcare were exclusively afforded to white people during Apartheid, these systems failed black people miserably.[31] In addition, while legislated and policy driven apartheid has officially ended, the social consequences of its institutionalisation such as high unemployment rates, sub-standard levels of education and spatial apartheid, continue to exist and leave the right to health unattainable for the majority of South Africans.[32] It is for this reason that health *equity* is of such importance in the new constitutional dispensation.

Importantly, there is evidence that one of the programmes, which has suffered the most because of failing health systems and the unequal distribution of public resources, is the Maternal and Child Health and HIV/ AIDS programme.[33] The root cause of these failures in the aforementioned programme are the failures in the "primary healthcare and the district

[23] "The Universal Declaration of Human Rights", Article 25(1) (accessed on 5 July 2017) http://www.un.org/en/universal-declaration-human-rights/.
[24] "The Universal Declaration of Human Rights", Article 25(2). (accessed on 5 July 2017) http://www.un.org/en/universal-declaration-human-rights/.
[25] International Covenant on Economic, Social and Cultural Rights, Article 12 (accessed on 5 July 2017) http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx.
[26] International Covenant on Economic, Social and Cultural Rights, Article 12 (accessed on 5 July 2017) http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx.
[27] The United Nations "Sustainable Development Goals" (accessed 4 August 2017) http://www.un.org/sustainabledevelopment/health/.
[28] C Keeton "Bridging the Gap in South Africa" (accessed 5 August 2017). http://www.who.int/bulletin/volumes/88/11/10-021110/en/.
[29] C Keeton "Bridging the Gap in South Africa" (accessed 5 August 2017). http://www.who.int/bulletin/volumes/88/11/10-021110/en/.
[30] C Keeton "Bridging the Gap in South Africa" (accessed 5 August 2017). http://www.who.int/bulletin/volumes/88/11/10-021110/en/.
[31] The National Planning Commission "Our Future – Make it Work" 2030. P. 354.
[32] The National Planning Commission "Our Future – Make it Work" 2030. P. 24.
[33] The National Planning Commission "The National Development Plan, 2030" 301.

health system".[34] Another reason that health systems seem to be failing has to do with the top-down rather than bottom-up approaches to healthcare in South Africa in that focus has arguably shifted away from Batho Pele[35] principles and community participation.[36]

While the right to adequate health is protected in terms of Section 27 of the Constitution, because of South Africa's inequitable past, there are many challenges that create barriers to the realisation of this right for the majority of South Africans. Some of these challenges include the demographics of South Africa, the challenges of the health system, and social determinants.[37]

The demographic challenges that have plagued South Africa since 1990 include maternal and under-five child mortality.[38] Deaths in infants (0-4 years old) and women (30-34 years old) trebled between 1998 and 2008, due for the most part to HIV infection.[39] South Africa has one of the highest percentages of people living with HIV even though it contains less than one percent of the world's population.[40] Having said this, it appears that the prevalence of HIV has and will likely continue to decline due to the decrease in unsafe sex and increase in access to antiretroviral treatment.[41]

Social determinants and ecology further aggravate the challenges in the health system.[42] The social determinants of health include "income inequalities, poverty, unemployment, racial and gender discrimination, the migrant labour systems, and the destruction of family life and extreme violence" which have contributed to the current wave of communicable and non-communicable diseases.[43] These issues influence maternal, child and women's health through income inequality.[44] In addition, unemployment affects women hugely in that they often are left with offspring to feed and clothe.

It is not only important to ensure increased access to quality healthcare, but governments must also prioritise improving the social contexts in which people exist.[45] For example, history has shown that improved social circumstances such as "better nutrition and living conditions, lead to an increase in health and longevity" and also that a number of non-medicine related aspects, affect the health of individuals, for example, "adequate nutrition, clean water, sanitation, and housing."[46] These social circumstances "begin with the physical, mental and nutritional states of women during pregnancy."[47]

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[34] The National Planning Commission "The National Development Plan, 2030" 301.
[35] The Batho Pele principles relate to the way in which people in public administration should conduct themselves and inform how they should do their work. These principles are important in discourse related to the delivery of healthcare because they ensure that the correct procedures and processes are used in providing services and demand that these services be delivered in a particular way.
[36] The National Planning Commission "The National Development Plan, 2030". P. 301.
[37] The National Planning Commission "The National Development Plan, 2030". P. 299.
[38] The National Planning Commission "The National Development Plan, 2030". P. 300.
[39] The National Planning Commission "The National Development Plan, 2030". P. 300.
[40] The National Planning Commission "The National Development Plan, 2030". P. 299.
[41] The National Planning Commission "The National Development Plan, 2030". P. 300.
[42] The National Planning Commission "The National Development Plan, 2030". P. 302.
[43] The National Planning Commission "The National Development Plan, 2030". P. 302.
[44] The National Planning Commission "The National Development Plan, 2030". P. 302.
[45] S Benatar, "The Challenges of Health Disparity in South Africa", *The South African Medical Journal* Vol 103, No. 3 2013.
[46] S Benatar, "The Challenges of Health Disparity in South Africa", *The South African Medical Journal* Vol 103, No. 3 2013 para 5.
[47] S Benatar, "The Challenges of Health Disparity in South Africa", *The South African Medical Journal* Vol 103, No. 3 2013 para 4.

While understanding what the *right* to health entails in the South African context, it is important to take cognisance of the difference between health equality and healthy equity. This distinction is vital to any government attempting to make sure that the right to health is realisable. In short, health equality means that everyone has the right to healthcare, while health equity means that there are no avoidable differences between different classes or groups of people, which render some people unable to access healthcare.[48] South Africa is riddled with social circumstances, which prevent citizens from being equitable, and this paper is set within that context.

While providing free healthcare is vital, perhaps just as much focus should be on improving social factors so that less people get sick and therefore the burden on the public health system is greatly reduced.[49]

In realising the right to healthcare and in order to fully achieve health equity; government needs to address social factors and the circumstances of different economic groups that tend to act as barriers to quality healthcare.[50] Some of these social factors are a lack of primary healthcare clinics in rural areas, a lack of antenatal education, adequate electricity, water and sanitation and sufficiently trained healthcare professionals in rural areas throughout South Africa.

The National Health Insurance (NHI)

Because of the context in which South Africa finds its healthcare system and in the interests of providing free, quality healthcare to all, the South African government is in the process of implementing universal healthcare in the form of the NHI. This concept was introduced in South Africa at the start of the new Constitutional dispensation. However, progress has been slow and the implementation process only started in 2011 with the publishing of the Green Paper.

The objectives of the NHI are to improve "*access to quality healthcare services that are delivered equitably, affordably, efficiently, effectively and appropriately*".[51]

The main difference between the NHI and medical aid schemes is that the NHI will ensure the provision of healthcare to all South Africans whether they are employed or not and whether they can afford it or not and the type of healthcare provided to a user will be dependent on his/her need rather than a user's socio-economic status.[52] While medical aid is a form of healthcare provisioning between a private organisation and an individual (for which you pay a monthly fee), the NHI will facilitate the provision of quality healthcare for all citizens of South Africa and is provided for by the government through public funding.[53]

Currently medical schemes are offered to "those that can afford it and are employed" on the basis of voluntary pre-payments while the NHI will provide healthcare to all South Africans

[48] World Health Organisations: "Health Systems: Equity" (accessed on 10 August) http://www.who.int/healthsystems/topics/equity/en/.
[49] S Benatar, "The Challenges of Health Disparity in South Africa", *The South African Medical Journal* Vol 103, No. 3 2013.
[50] S Benatar, "The Challenges of Health Disparity in South Africa", *The South African Medical Journal* Vol 103, No. 3 2013.
[51] South Africa, (2017) Department of Health. White Paper on National Insurance Policy: Towards Universal Health Coverage. *Government gazette* 40955, June 17. P. 1.
[52] South Africa, (2017) Department of Health. White Paper on National Insurance Policy: Towards Universal Health Coverage. *Government gazette* 40955, June 17. P. 2.
[53] BDO South Africa "National Health Insurance of South Africa (NHISA) & Medical Aids: What you need to know".

through compulsory pre-payments.[54] Medical schemes often do not provide comprehensive cover to their members, they offer certain services depending on which scheme is purchased which means that in addition to paying monthly contributions, members need to make out-of-pocket payments for healthcare services.[55] Contrastingly, the NHI promises to deliver a "comprehensive set of personal health services".[56] This service "will include a continuum of care from community outreach, primary healthcare… health promotion and prevention to other levels of curative, specialised, rehabilitative, palliative care, and acute emergency as well as access to pharmacies and Emergency Medical Services."[57]

Medical schemes and the different benefits offered by them are available to people according to "occupational categorisation and the ability of individuals to afford the contributions."[58] This will not be the case once the NHI has been successfully implemented.

In summary, at this stage, healthcare services are predominantly available to those who can afford it rather than to those who are in need; the NHI intends to address this inequity.[59]

A significant implication of this policy on programmes such as maternal and child health programmes is that everyone will be able to afford quality healthcare and the quality of healthcare will not depend on whether a patient has access to a particular medical aid or not.

National Policy Priorities and the Budget:

Over the past twenty years, there has been some progress made in narrowing resource equity gaps in the provisioning of healthcare in South Africa. Despite this, however, significant structural inequities continue to present obstacles to universal access to quality healthcare.

The National Development Plan (NDP) outlines the following relevant targets for 2030:

1. The infant mortality is less than 20 deaths per 1000 live births;
2. The under 5 mortality rate is less than 30 deaths per 1000;
3. The maternal mortality is less than 100 per 100 000 births.[60]

The critical actions which the government intends to take in terms of the NDP, include the following;-

1. "addressing the social determinants" of health such as; social and emotional development in young children[61];
2. improving health and health information systems[62];
3. promoting health and focussing on eradicating disease burdens through decreasing the prevalence of HIV/AIDS[63],

[54] South Africa, (2017) Department of Health. White Paper on National Insurance Policy: Towards Universal Health Coverage. *Government gazette* 40955, June 17. P. 58.
[55] Department of Health. White Paper on National Insurance Policy: Towards Universal Health Coverage.
[56] South Africa, (2017) Department of Health. White Paper on National Insurance Policy: Towards Universal Health Coverage. *Government gazette* 40955, June 17. P. 8.
[57] South Africa, (2017) Department of Health. White Paper on National Insurance Policy: Towards Universal Health Coverage. *Government gazette* 40955, June 17. P. 22.
[58] South Africa, (2017) Department of Health. White Paper on National Insurance Policy: Towards Universal Health Coverage. *Government gazette* 40955, June 17. P. 22.
[59] South Africa, (2017) Department of Health. White Paper on National Insurance Policy: Towards Universal Health Coverage. *Government gazette* 40955, June 17. P. 22.
[60] The National Planning Commission "The National Development Plan, 2030". P. 298.
[61] The National Planning Commission "The National Development Plan, 2030". P. 302.
[62] The National Planning Commission "The National Development Plan, 2030". P. 302.

4. reducing transmission of HIV between mothers and their children[64];
5. providing "quality pre-birth and postnatal services through a primary healthcare approach;"[65] and
6. moving towards a universal financing system for healthcare.[66]

In light of the context illuminated by the NDP and considering the targets it has set for the government, it is necessary to have a look at the legislative and regulatory framework relevant to the maternal, child and women's health and nutrition challenges in South Africa.

Other than Section 27(1)(a) of the Constitution of South Africa which enshrines the right to healthcare services, including reproductive healthcare, the primary piece of legislation regulating the South African healthcare system is the *National Health Act*, 61 of 2003 (the Health Act).

Section 4(3)(a) of the Health Act states that "the State and clinics and community health centres funded by the State must provide pregnant and lactating women and children below the age of 6 years, who are not members or beneficiaries of medical aid schemes, with free health services."[67] This provision illustrates the commitment of government to women and children in South Africa.

In terms of the regulatory framework, the former Minister of Finance, Pravin Gordhan, stated in his 2017 Budget Speech that one of the key features for the 2017/18 financial year is the government's aim to redistribute health services, which will mean that those living in areas that are more rural should have easier access to health facilities.[68] This will go a long way towards reducing maternal and child mortality as the rural areas of South Africa have the highest rate of maternal and infant mortality.

The 2017 Budget Speech gave specific mention to the fact that the NHI Fund (still to be established) will focus on "maternal health and ante-natal services" and that "an additional R885 million has been added to support the implementation of the universal test-and-treat policy for HIV."[69] This affirms National Treasury's commitment to maternal and child health.

Within Vote 16 (health at the national level), R18.3 billion was allocated to the "HIV/AIDS, TB and Maternal and Child Health" Programme for the 2017/18 financial year.[70]

For 2017, a total of R42.6 billion was allocated to health at the national level.[71] This represents 5.55 percent of the overall national budget.[72] The Eastern Cape Province was allocated R74.65 billion,[73] of which R21.7 billion is allocated to the ECDoH.[74] The ECDoH

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[63] The National Planning Commission "The National Development Plan, 2030". P. 302.
[64] The National Planning Commission "The National Development Plan, 2030". P. 322.
[65] The National Planning Commission "The National Development Plan, 2030". P. 323.
[66] The National Planning Commission "The National Development Plan, 2030". P. 323.
[67] Act 61 of 2003.
[68] Gordhan, P. 2017. *South Africa 2017 Budget Speech: 22 February 2017*. P. 5.
[69] Gordhan, P. 2017. *South Africa 2017 Budget Speech: 22 February 2017*. P. 21.
[70] South Africa National Treasury. 2017. *Estimates of National Expenditure* 2017/18. Vote 16: National Treasury. P. 291.
[71] South Africa National Treasury. 2017. *Estimates of National Expenditure* 2017/18. Vote 16: National Treasury. P. 291.
[72] South Africa National Treasury. 2017. *Estimates of National Expenditure* 2017/18. Vote 16: National Treasury. P. xxi.
[73] Somyo, S. 2017. *Eastern Cape 2017 Provincial Budget Speech: 2 March 2017*. Bhisho: Eastern Cape Legislature. P. 11.
[74] Somyo, S. 2017. *Eastern Cape 2017 Provincial Budget Speech: 2 March 2017*. Bhisho: Eastern Cape Legislature. P. 21.

has allocated R10.9 billion to the District Health Services Programme (Programme 2) of which R48.5 million has been allocated to sub-programme 2.7: Maternal, Child and Women's Health and Nutrition.[75]

Figures 1 and 2 below illustrate current and projected allocations to the **HIV/AIDS, Maternal and Child Mortality Programme** (Programme 3) within the **National Department of Health**. An important indication of whether and how a programme is prioritised relates to the proportion of the overall budget allocated to it. Additionally the change in allocation over time in related service delivery targets is important to consider.

Figure 1: National allocations (nominal vs real) to Programme 3 for 2017/18 MTEF[76]

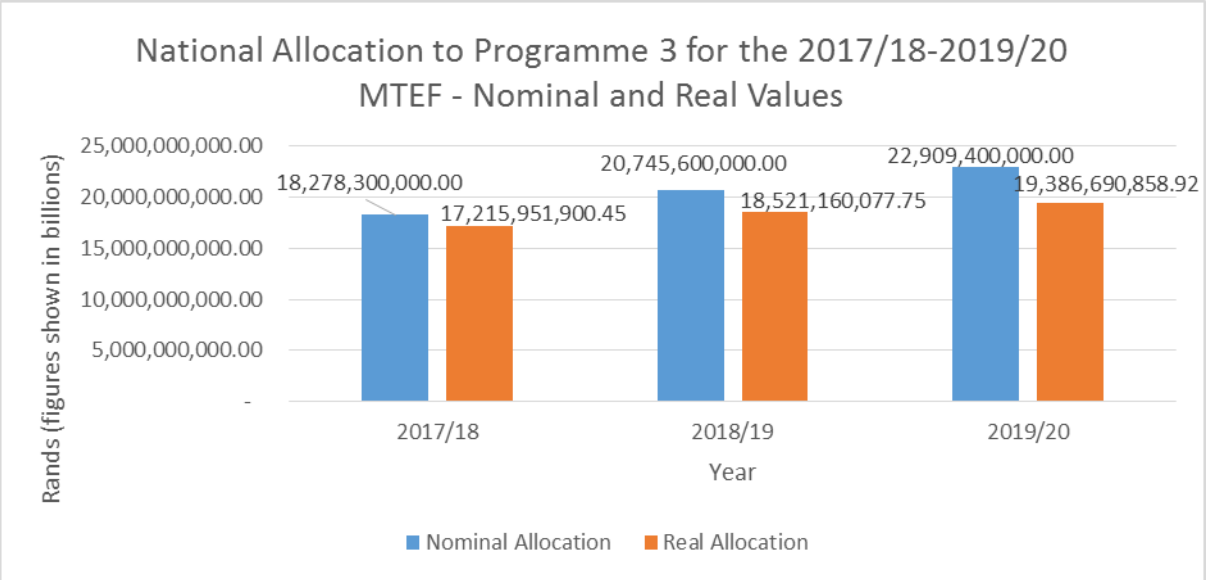

Figure 1 illustrates the difference in the nominal and real allocation to the HIV/AIDS, Maternal and Child Mortality Programme in the National Department of Health from the 2017/18 financial year to the 2019/20 financial year.[77] The graph shows that between 2017/18 and 2018/19 the allocation to Programme 3 is projected to grow by 13.5 percent in nominal terms and by 7.5 percent in real terms. Between 2018/19 and 2019/20 the allocation is projected to grow by 10.4 percent in nominal terms and by 4.7 percent in real terms. Over the medium term, this programme is set to grow by 25.3 percent in nominal terms but only 12.6 percent in real terms. While the increase in the allocation to this particular programme is significant in nominal terms, the real allocation is in fact growing by a small amount. It is indicative of the constrained fiscal resources and the fact that South Africa is experiencing extremely slow economic growth.

[75] Eastern Cape Provincial Treasury. 2017. *Estimates of Provincial Revenue and Expenditure* 2017/18. Vote 3: Health. P. 137.
[76] Calculations completed using the 2016 inflation index obtained from the International Monetary Fund website as the base year.
[77] South Africa National Treasury. 2017. *Estimates of National Expenditure* 2017/18. Vote 16: National Treasury. P. 291.

Figure 2: Proportion of Total National Health Budget Allocated to Programme 3 2016/17-2019/20[78]

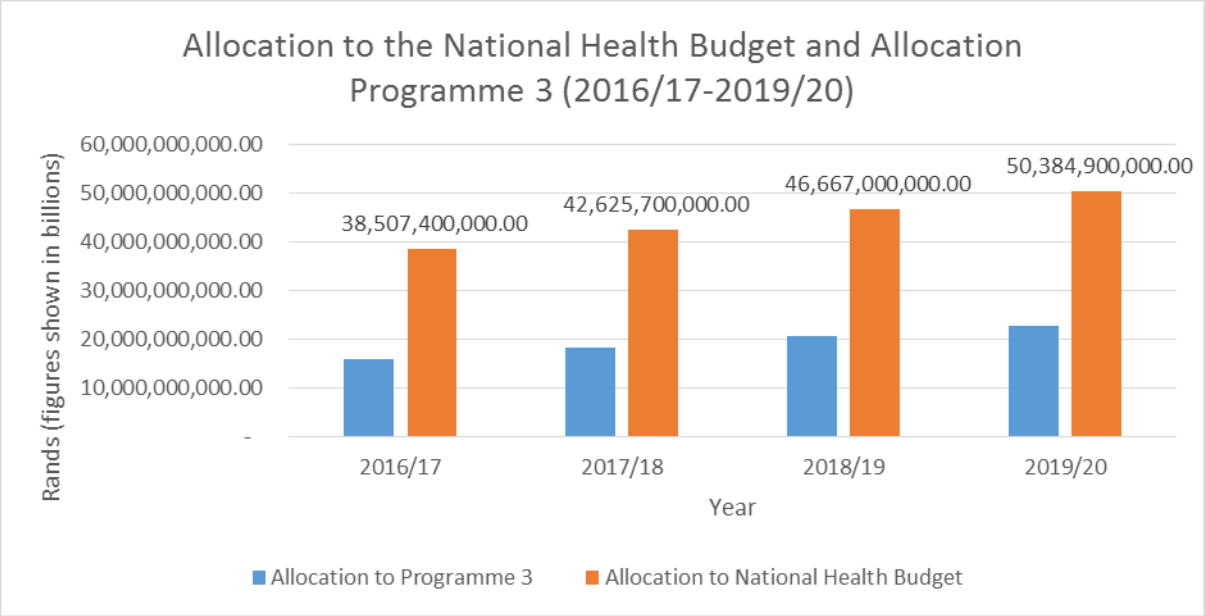

Figure 2 indicates that a large proportion of the total National Health Budget between 2016 and 2020 will be allocated to the national HIV/AIDS, Maternal and Child Health Programme. In the 2016/17 financial year in nominal terms 41.5 percent of the National Health Budget was allocated to Programme 3, in 2017/18; 42.8 percent, 2018/19; 44.5 percent and 2019/20; 45.5 percent.[79] While these large allocations are encouraging to see, it is important to remember that this specific programme is very labour, equipment and service intensive, it therefore makes sense that a large portion of the health budget is allocated to this programme and these allocations do not necessarily imply that this programme is adequately prioritised.[80]

Provincial Policy Priorities and the Budget

From the 2017/18 Eastern Cape Policy and Budget Speech, one can determine that maternal and infant health is one of the Department's priorities. The Eastern Cape Health MEC noted the reduction in the maternal mortality rate, as well as the reduction in the prevalence of HIV/AIDS in the 15–49 years of age category "from 10.4 percent in 2014 to 7.7 percent by 2016."[81]

The ECDoH has committed and continues to commit to offering pregnancy tests to women who fall within a particular age bracket attending healthcare facilities.[82] As a result of these tests, there has been an increase from 59.7 percent in 2015/16 to 64 percent in 2017/18 of women who visited a healthcare facility within the first 20 weeks of their pregnancy which

[78] South Africa National Treasury. 2017. *Estimates of National Expenditure* 2017/18. Vote 16: National Treasury. P. 294-295.
[79] South Africa National Treasury. 2017. *Estimates of National Expenditure* 2017/18. Vote 16: National Treasury. P. 294-295.
[80] South Africa National Treasury. 2017. *Estimates of National Expenditure* 2017/18. Vote 16: National Treasury. P. 294-295.
[81] Dyantyi, P. 2017. *Eastern Cape 2017 Health Budget and Policy Speech: 14 March 2017*. Bhisho: Eastern Cape Legislature. P. 4.
[82] Dyantyi, P. 2017. *Eastern Cape 2017 Health Budget and Policy Speech: 14 March 2017*. Bhisho: Eastern Cape Legislature. P. 2.

allows midwives and doctors to identify potential risks to the pregnancy, detect HIV infections and therefore to treat mother and child accordingly.[83]

In order to reduce infant and child mortality, the government has taken steps to ensure the provision of certain vaccines, namely those for "measles, TB, pneumonia, diarrhoea, measles, whooping cough and rubella."[84] The ECDoH reported in February that toward the end of 2016, 86 percent of children within the Eastern Cape had been vaccinated.[85] The prevalence of deaths related to diarrhoea and pneumonia in children under five has decreased from 3.6 percent and 3.7 percent in 2015/16 to 3.4 percent and 2.7 percent in 2016/17 respectively.[86]

Going forward, the ECDoH intends to decrease maternal and infant mortality further through investing in more staff, equipment and technology, which will be used to identify potential risks during pregnancy.[87] While the MEC for Health has not specifically stated the amount of the investment, or for which programmes these investments will be made, if one looks at sub-programmes related to maternal health one might find it difficult to find proof that this statement is genuine. For example, resources allocated to Community Health Centres only increase by 9.6 percent between 2016 and 2017, 9.3 percent between 2017 and 2018 and 7.5 percent between 2018 and 2019 in nominal terms.[88] Significantly, these increases translate into only 3.2 percent between 2016 and 2017, 3.6 percent between 2017 and 2018, and 1.9 percent between 2018 and 2019 in real terms.[89] Allocations to the Provincial Hospital Services sub-programme within Programme 8, steadily decrease from 2016 to 2020, this is concerning because it is the sub-programme responsible for upgrading provincial hospitals.[90] In addition, the allocation to Community Health Facilities also decreases between 2016/17 and 2017/18 by 34 percent in real terms, however, it does increase by 44 percent between 2018/19 and 2019/20 in real terms.[91] Allocations to the Nursing Training Colleges programme increases by 7.9 percent between 2016 and 2017, 5.2 percent between 2017 and 2018 and 7.7 percent between 2018 and 2019.[92]

Considering the above, the "investment into reducing maternal and infant mortality" which the MEC for Health promised in her 2017 Budget Speech does not appear to be mirrored in the budget allocations over the medium term.

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[83] Dyantyi, P. 2017. *Eastern Cape 2017 Health Budget and Policy Speech: 14 March 2017*. Bhisho: Eastern Cape Legislature. P. 2.
[84] Dyantyi, P. 2017. *Eastern Cape 2017 Health Budget and Policy Speech: 14 March 2017*. Bhisho: Eastern Cape Legislature. P. 2.
[85] Dyantyi, P. 2017. *Eastern Cape 2017 Health Budget and Policy Speech: 14 March 2017*. Bhisho: Eastern Cape Legislature. P. 2.
[86] Dyantyi, P. 2017. *Eastern Cape 2017 Health Budget and Policy Speech: 14 March 2017*. Bhisho: Eastern Cape Legislature. P. 3.
[87] Dyantyi, P. 2017. *Eastern Cape 2017 Health Budget and Policy Speech: 14 March 2017*. Bhisho: Eastern Cape Legislature. P. 8.
[88] Eastern Cape Provincial Treasury. 2017. *Eastern Cape Estimates of Provincial Revenue and Expenditure 2017/18*. Vote 3: Health. P. 137.
[89] These calculations were done using the 2015 consumer price index obtained from the International Monetary Fund as a base year and using allocations on page 137 of the Eastern Cape Estimates of Provincial Revenue and Expenditure 2017/18 publication.
[90] Eastern Cape Provincial Treasury. 2017. *Eastern Cape Estimates of Provincial Revenue and Expenditure 2017/18*. Vote 3: Health. P. 145.
[91] Eastern Cape Provincial Treasury. 2017. *Eastern Cape Estimates of Provincial Revenue and Expenditure 2017/18*. Vote 3: Health. P. 146.
[92] Eastern Cape Provincial Treasury. 2017. *Eastern Cape Estimates of Provincial Revenue and Expenditure 2017/18*. Vote 3: Health. P. 143.

Challenges

Since 1998, the number of maternal deaths per 100 000 live births in South Africa increased from 150 in 1998 to 270 in 2010.[93] In 2013, maternal mortality was estimated at 141 maternal deaths for every 100 000.[94] Research shows that "HIV infection in pregnancy is the major contributing factor to maternal deaths, accounting for more than 30 percent of all these deaths."[95]

The South Africa Demographic and Health Survey 2016 indicated that in 2014, 85.6 percent of births took place in a public healthcare facility and 92.9 percent of expectant mothers were able to achieve at least one visit to a healthcare facility.[96] Increasing the number of expectant mothers visiting healthcare facilities and increasing the number of births at healthcare facilities is in line with government policy and is indicative of the fact that their policy priorities are slowly being met. However, it is concerning that even with these figures; the maternal and infant mortality rates are so high.

Perhaps the targets relating to maternal and infant mortality should be revised to be more in line with the WHO Recommendations that state "antenatal care models with a minimum of eight contacts are recommended to reduce perinatal mortality and improve women's experience of care."[97] These contact points should be at stages in the pregnancy during which problems can be identified to improve the well-being of child and mother and to improve results.[98] The WHO has started using the word "contact" instead of "visits" in relation to expectant mothers attending healthcare facilities in order to ensure that expectant mothers are actually being treated and examined when they attend these facilities or when healthcare workers provide home-based care and assessments.[99] Currently, the performance indicator for maternal mortality in the ECDoH Strategic Plan 2015/16 to 2019/20 is set at one visit before 20 weeks and therefore is a much lower target than the one recommended by the WHO.[100]

While the maternal mortality rate has decreased overall since 2009, between 2012 and 2013 it increased from 153 to 180[101] despite a real increase in expenditure for the Maternal, Infant and Child Nutrition Programme of 3.78 percent[102] in the 2012/13 financial year.[103]

Evidence shows that the highest maternal mortality rate during the 2015/16 financial year, occurred in the OR Tambo district, with 244.7 deaths per 100 000 live births.[104] The second highest maternal mortality rate was recorded in Buffalo City Metropolitan Municipality and

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[93] Statistics South Africa. "Millennium Development Goal 5: Improve Maternal Health 2015" (accessed 11 September 2017) http://www.statssa.gov.za/MDG/MDG_Goal5_report_2015_.pdf. P. v.
[94] Statistics South Africa. "Millennium Development Goal 5: Improve Maternal Health 2015" (accessed 11 September 2017) http://www.statssa.gov.za/MDG/MDG_Goal5_report_2015_.pdf. P. v.
[95] Statistics South Africa: "Millennium Development Goal 5: Improve Maternal Health 2015". P. v.
[96] Statistics South Africa: "Millennium Development Goal 5: Improve Maternal Health 2015". P. vi.
[97] The World Health Organisation "WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience" (2016). P. 101.
[98] The World Health Organisation "WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience" (2016). P. 101.
[99] The World Health Organisation "WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience" (2016). P. 101.
[100] Eastern Cape Department of Health, *Five-Year Strategic Plan 2015-2020*. Vote 3. P. 61.
[101] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 43.
[102] The 2011 inflation index from the International Monetary Fund was used as the base year to work out the real increase.
[103] Eastern Cape Provincial Treasury. *Eastern Cape Estimates of Provincial Revenue and Expenditure* 2015/16. P. 129.
[104] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 44.

the third in Nelson Mandela Metropolitan Municipality.[105] The lowest maternal mortality rates were recorded in the Amathole District and Alfred Nzo Municipalities.[106]

The primary causes of maternal mortality in the Eastern Cape are non-pregnancy-related infections, mainly because of AIDS, complications relating to hypertension, obstetric haemorrhage, and pregnancy-related sepsis and pre-existing maternal disease.[107]

The Eastern Cape Health Strategic Plan 2015/16-2019/20 shows that the leading causes of infant mortality in our country are respiratory and cardiovascular disorders,[108] and that the leading cause of child mortality is intestinal infectious diseases.[109] During the 2014/15 financial year, the OR Tambo District Municipality recorded the highest number of both infant and child mortality in comparison with the rest of the Province.[110]

In the Eastern Cape, the MEC for Finance announced in his Budget Speech at the beginning of the 2017/18 financial year that 89.1 percent of the province's total budget has been allocated to the social sector in order to address the rights of the people.[111]

Significantly, almost half of the Eastern Cape Department of Health's budget goes to Programme 2: District Health Services, as illustrated in Figure 3 below.[112] This shows alignment between the national policy and provincial expenditure because Programme 2 is tasked with ensuring "the delivery of primary healthcare services and District Hospital Services through the implementation of the District Health System."[113] Re-engineering primary healthcare is one of the focus areas of the ECDoH and is a concept in line with Goal 7 of the National Development Plan that centres on ensuring that "primary healthcare teams provide care to families and communities."[114] Programme 2 consists of 8 sub-programmes including Community Based Services, HIV/AIDS healthcare services and Nutrition, making it the biggest programme within the ECDoH.[115] The 8 sub-programmes within Programme 2 all relate to the delivery of primary healthcare services.

[105] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 44.
[106] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 44.
[107] Eastern Cape Department of Health, *Five-Year Strategic Plan 2015-2020*. Vote 3. P. 28.
[108] Eastern Cape Department of Health, *Five-Year Strategic Plan 2015-2020*. Vote 3. P. 22.
[109] Eastern Cape Department of Health, *Five-Year Strategic Plan 2015-2020*. Vote 3. P. 22.
[110] Eastern Cape Department of Health, *Five-Year Strategic Plan 2015-2020*. Vote 3. P. 26.
[111] Somyo, S. 2017. *Eastern Cape 2017 Provincial Budget Speech: 2 March 2017*. Bhisho: Eastern Cape Legislature. P. 12.
[112] Eastern Cape Provincial Treasury. 2017. *Estimates of Provincial Revenue and Expenditure* 2017/18. Vote 3: Health. P. 130.
[113] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 72.
[114] Eastern Cape Department of Health, *Five-Year Strategic Plan 2015-2020*. Vote 3. P. 34.
[115] Eastern Cape Provincial Treasury. 2017. *Estimates of Provincial Revenue and Expenditure* 2017/18. Vote 3: Health. P. 136.

Figure 3: Portion of Total Eastern Cape Health Budget Allocated to Programme 2: District Health Services (nominal figures) for the 2017/18 Financial Year[116]

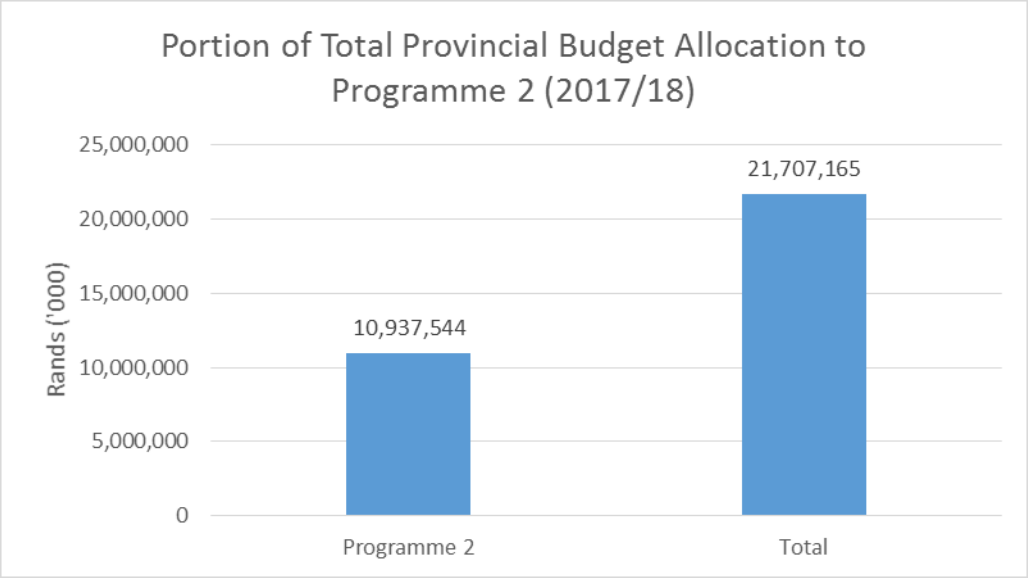

Figure 3 illustrates the prioritisation of Programme 2 in the ECDoH for the financial year beginning in April 2017.

Quality Healthcare

One of the biggest concerns around maternal mortality in South Africa is that "avoidable factors, missed opportunities, poor quality of care and the lack of training of front-line healthcare workers" are contributors to maternal deaths.[117] The ECDoH receives resources for "Health Professions Training and Development" by way of a conditional grant from national treasury in order to invest in quality care and training.[118] It is interesting to note that the average annual nominal increase in this conditional grant, between the 2013/14 financial year and the 2017/18 financial year, is only 4.7 percent.[119] This small increase could have a constraining impact on the development and training of staff. While the cost of services are increasing, the ECDoH is arguably unable to meet that increase because the rate of increase of this particular grant is moving at a slower pace to that of the cost of training services. It is clear from the above, and the general state of healthcare in the Eastern Cape, that the quality of these services is extremely low in many instances, and a Health Professions Training and Development conditional grant is a vital component of quality healthcare services. If this particular grant is increasing at a rate less than inflation, it implies that the ECDoH is not prioritising this important issue to the extent that it should.

It is discouraging that even though 100 percent of the Health Professions Training and Development Grant and Health Facilities Revitalisation Grant were spent, the Department was faced with an increase in medico-legal claims. Many medico-legal claims result from the negligence of healthcare professionals, which is preventable through better training facilitated by the Health Professions Training and Development Grant. Many other medico-legal claims are a result of procedures taking place without certain medical equipment, which

[116] Eastern Cape Provincial Treasury. 2017. *Estimates of Provincial Revenue and Expenditure* 2017/18. Vote 3: Health. P. 130.
[117] Statistics South Africa: "Millennium Development Goal 5: Improve Maternal Health 2015". P 2
[118] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 169.
[119] Eastern Cape Provincial Treasury. 2017. *Estimates of Provincial Revenue and Expenditure* 2017/18. Vote 3: Health. P. 133.

is preventable through the efficient usage of the Health Facilities Revitalisation Grant. It is clear that the ECDoH is not providing value for money to its clients and it is not getting value for money from suppliers.

Improving the training and development of healthcare workers will not only improve the quality of care they are able to provide patients; it will also motivate professionals to stay within the ECDoH. This has the potential of reducing the number of medico-legal cases emanating from the ECDoH as well as the potential to retain more health professionals.

The fact that the District Health Services programme overspent by R14.35 million in the 2015/16 financial year is indicative of the fact that there may be an inefficient use of public resources and efforts must be made to curb this inefficiency.[120] One of the reasons provided for this over-expenditure is that the ECDoH was over burdened with medico-legal claims during the year.[121]

The mounting medico-legal claims in the amount of approximately R17 billion, is a great cause of concern as it means that resources that could and should be allocated to service delivery are used to settle cases and pay for legal services.[122]

Medico-Legal Cases

As mentioned above, the ECDoH is faced with medico-legal claims in the amount of R17 billion for the 2016/17 financial year.[123] In the 2015/16 financial year, the ECDoH spent R260 million in medico-legal settlements and R59 million in legal fees to the State Attorney.[124] The implication of this on the budget and the delivery of services is obviously extremely negative, says the MEC for Health in the Eastern Cape, Dr Dyantyi.[125]

Since 2014, the ECDoH has won only 4 out of 155 medico-legal claims, the rest were settled.[126] The ECDoH has spent R204 million in legal fees since 2014.[127]

Dr Dyantyi stated that the ECDoH was paying for these claims and legal fees out of the "goods and services" budget in order to protect health workers' posts.[128] She also warned that "if the remainder of the R17 billion in medico-legal claims goes undefended, the cost will collapse the ECDoH and it will either have to reduce or consolidate its facilities or reduce its services to the public."[129]

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[120] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 18.
[121] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 19.
[122] Medical Brief. "Eastern Cape Health to Outsource Lawyers". https://www.medicalbrief.co.za/archives/eastern-cape-health-outsource-lawyers/.
[123] E Ellis "East Cape to Outsource Medical Case Defence" (accessed 5 August 2017) http://www.heraldlive.co.za/news/top-news/2017/07/12/east-cape-outsource-medical-case-defence/.
[124] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 14.
[125] E Ellis "East Cape to Outsource Medical Case Defence" (accessed 5 August 2017) http://www.heraldlive.co.za/news/top-news/2017/07/12/east-cape-outsource-medical-case-defence/.
[126] E Ellis "East Cape to Outsource Medical Case Defence" (accessed 5 August 2017) http://www.heraldlive.co.za/news/top-news/2017/07/12/east-cape-outsource-medical-case-defence/.
[127] E Ellis "East Cape to Outsource Medical Case Defence" (accessed 5 August 2017) http://www.heraldlive.co.za/news/top-news/2017/07/12/east-cape-outsource-medical-case-defence/.
[128] E Ellis "East Cape to Outsource Medical Case Defence" (accessed 5 August 2017) http://www.heraldlive.co.za/news/top-news/2017/07/12/east-cape-outsource-medical-case-defence/.
[129] E Ellis "East Cape to Outsource Medical Case Defence" (accessed 5 August 2017) http://www.heraldlive.co.za/news/top-news/2017/07/12/east-cape-outsource-medical-case-defence/.

As noted by the MEC, it is the public who suffers as a result of the ECDoH settling medico-legal claims.[130] However, the MEC fails to recognise that the public suffers regardless because they are at the mercy of poor quality healthcare whenever they seek treatment at a facility with poor infrastructure or insufficient equipment, medicine and/or staff.

In the 2015/16 Annual Report, the Accounting Officer for the ECDoH notes that the following interventions are being made in order to mitigate the financial pressure caused by medico-legal cases:

- A Health Ombudsperson was being appointed and should be effective as of 1 February 2016;
- The ECDoH was evaluating a bid "for a panel of medico-legal experts" and it was expected that appointments would be made "before the end of the first quarter of 2016";
- Provision was made for "targeted interventions at the 4 priority hospitals through a package of healthcare interventions to prevent Cerebral Palsy";
- "implementation of an Electronic Patient Records Management System; as well as promotion of early intervention strategies"; and
- "Undertaking a feasibility study to create regional centres or partnerships with available service providers to deal with Cerebral Palsy patients in a bid to reduce future medical costs."[131]

The South African Human Rights Commission should play a more significant advocacy role in medico-legal cases involving negligence as these cases directly infringe upon the right to health.

Vacancy Rates

High vacancy rates within the ECDoH are another cause for concern. Within the "permanent" category of healthcare staff employed by the ECDoH, there is a 10.9 percent vacancy rate.[132] While there is a high vacancy rate of permanently employed healthcare workers, many critical occupations have an excess of staff employed in the temporary category of healthcare workers.[133] This seems highly irrational and the ECDoH should undertake to assess which "temporary" employees could become permanent.

Figure 4: The Number of Staff Permanently Employed by the ECDoH in Programme 2: District Health Services as at 31 March 2016[134]

Number of posts	26 429
Number of posts filled	23 616
Vacancy rate	10.8 percent

[130] E Ellis "East Cape to Outsource Medical Case Defence" (accessed 5 August 2017) http://www.heraldlive.co.za/news/top-news/2017/07/12/east-cape-outsource-medical-case-defence/.
[131] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 14-15.
[132] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 213.
[133] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 215-220.
[134] Eastern Cape Department of Health, *Annual Report 2015/16.* P. 213.

Number of posts filled additional to the Establishment[135]	491

As at March 2016, there was a 10.8 percent vacancy rate of permanent staff within the District Health Services Programme.[136] While the vacancy rate in this one programme is sitting at 10,8 percent, the number of posts "filled additional to the establishment" is 491 out of a total number of 571 posts "filled additional to the establishment" for the entire ECDoH.[137] It is unclear why this figure is so high, however, the fact that this number is so high implies that employees who have filled posts *of* the establishment are unable to perform certain tasks or it could imply that obstacles have arisen which the ECDoH did not foresee and therefore did not plan for. It would be useful for stakeholders and civil society to be provided with records of how long the contracts are of those filling posts "in addition to the establishment" and, the reason that these additional posts are needed. Providing such records would also prevent unscrupulous officials from making irregular appointments.

Figure 5 illustrates the vacancy challenges within some of the critical occupations in the ECDoH which impacts negatively on the District Health Services Programme generally and maternal and child health specifically.[138]

[135] According to the Public Service Act 103 of 1994 ; "'establishment' means the posts which have been created for the normal and regular requirements of a department". Posts "filled in addition to the establishment therefore means that posts have been created and filled in order to meet a specific requirement which is not ordinarily considered a normal and regular requirement for the running of a department. Where these numbers are high, one must enquire about the reason such posts need to be created and a determination must be made on why the employees in the normal and regular posts cannot deal with the issues for which irregular and abnormal posts are filled.
[136] Eastern Cape Department of Health, *Annual Report 2015/16.* P. 213.
[137] Eastern Cape Department of Health, *Annual Report 2015/16.* P. 213.
[138] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 215-220.

Critical occupations	**Vacancy Rate (%)**	**Number of Posts filled in addition to the Establishment**	**Issue/Impact on maternal and child health**
Ambulance and related workers, permanent	15,2	0	Ambulance drivers are needed when women go into labour in remote areas. High vacancy rates mean that less women will receive / have access to emergency medical services.
Cleaners in offices, workshops, hospitals etc., permanent	7,9	108	It seems irrational to have a high number of "posts filled in addition to the establishment" when there are also vacancies. This occupation category is important for ensuring hygiene.
Dieticians and nutritionists, permanent	23,2	3	Nutrition is vital for pregnant/ breastfeeding women and young children and the high vacancy rate is concerning given the priority of maternal, child and infant nutrition.
Household and laundry workers, permanent	8,5	16	It seems irrational to have a high number of "posts filled in addition to the establishment" when there are also vacancies.
Human resources & organisational development and related professionals, permanent	15,2	0	High vacancy rate means that there are fewer people to conduct interviews/ hire healthcare workers and ensure the smooth running of the Department.
Human resources clerks, permanent	11	3	High vacancy rate means that there are fewer people to conduct interviews/ hire healthcare workers and ensure the smooth running of the Department.
Inspectors of apprentices, works and vehicles, permanent	25	0	High vacancy of inspectors means that people might not be safe in vehicles etc.
Medical practitioners, permanent	18,6	26	It seems irrational to have a high number of "posts filled in addition to the establishment" when there are also vacancies.
Medical practitioners, temporary	-36,9	7	It is concerning that the ECDoH employed so many more temporary medical practitioners than they planned to employ. Employees in this category might be susceptible to bringing labour lawsuits against the ECDoH if they hold these "temporary" positions for too long.
Medical specialists,	27,9	0	High vacancy rates in this category are concerning.

permanent			
Medical specialists, temporary	-75	0	It is concerning that the ECDoH employed so many more temporary medical practitioners than they planned. Employees in this category might be susceptible to bringing labour lawsuits against the ECDoH if they hold these "temporary" positions for too long.
Nursing assistants, permanent	6,5	25	It seems irrational to have a high number of "posts filled in addition to the establishment" when there are also vacancies.
Optometrists and opticians, permanent	41,7	0	High vacancy rate - a lack of optometrists will lead to children in need of their services not receiving the attention that they need and this will affect their ability to learn in school, which will perpetuate the poverty cycle.
Pharmacists, permanent	23,9	25	High number of "posts filled in addition to the establishment" and a high vacancy rate.
Professional nurses, permanent	11,1	138	High number of "posts filled in addition to the establishment".
Psychologists and vocational counsellors, permanent	10	2	This category of health worker is important for pregnant women and new mothers.
Radiography, permanent	14,6	9	This type of health worker is important to identify difficult / dangerous pregnancies.
Safety, health and quality inspectors, permanent	21,7	0	High vacancy rate, which puts the health and safety of users in jeopardy.
Speech therapy and audiology, permanent	26,7	4	High vacancy rate, a lack of speech therapists and audiologists will lead to children in need of their services not receiving the attention that they need and this will affect their ability to learn in school, which will perpetuate the poverty cycle.
Staff nurses (qualified nurses), permanent	6,5	38	The high number of "posts filled in addition to the establishment" is of great concern.
Student nurse (nurses completing their practical training), permanent	95,9	0	This high vacancy rate is hugely worrying; it means that there are very few nurses being trained for future years.

It is concerning to see certain critical occupations with high vacancy rates at the same time as having “posts filled in addition to the establishment”.

The ECDoH must explain the reasons behind creating “posts in addition to the establishment” and attach a timeframe to these posts so that stakeholders can ensure that posts are created out of need rather than for other unscrupulous reasons.

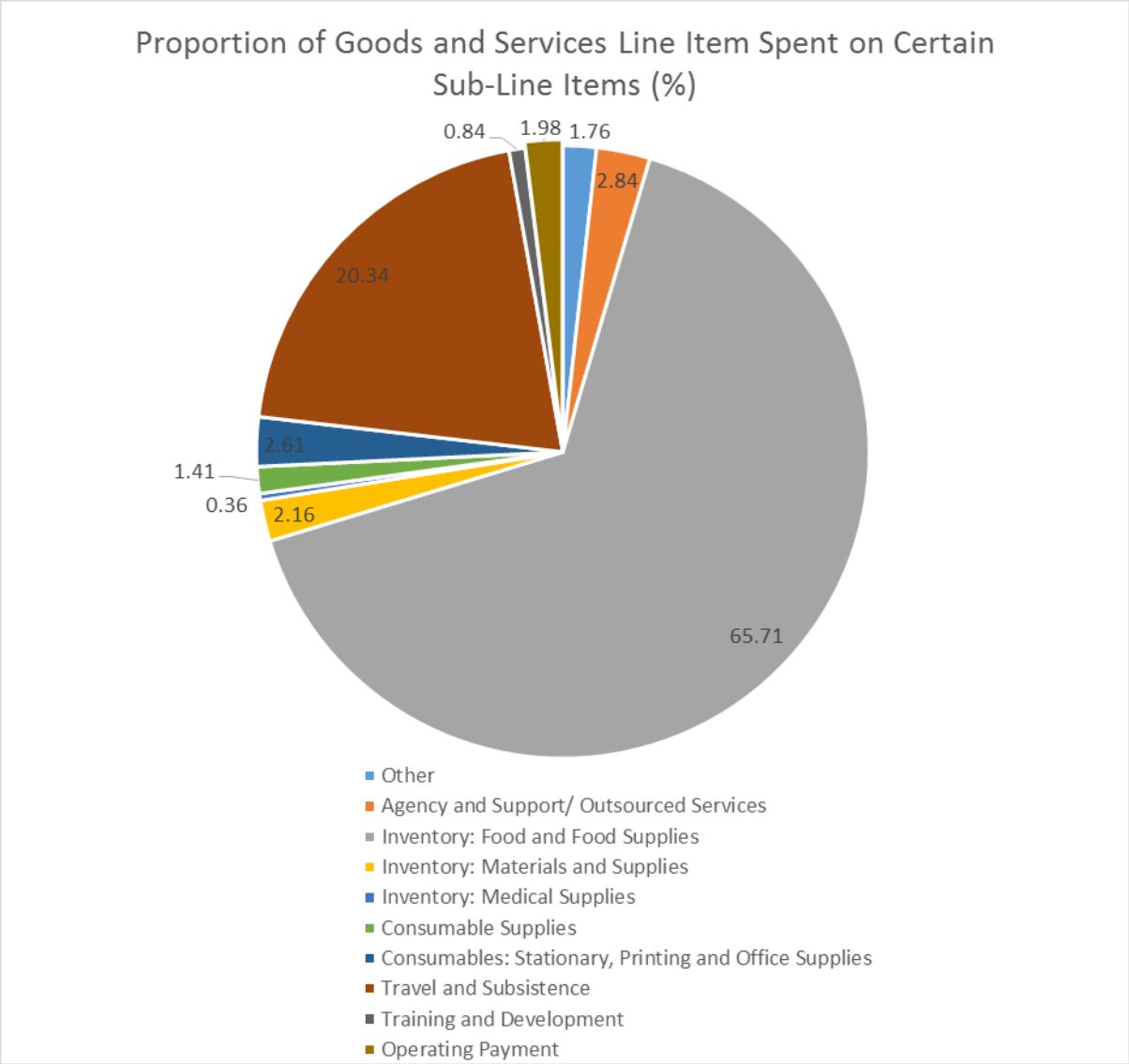
The Goods and Services Line Item

Within the goods and services line-item (of sub-programme 2,7), it is, worrying to see that the final appropriation and actual expenditure is 59 percent of the adjusted appropriation and that in real terms; the actual expenditure of this line item was only just over half of the previous year’s actual expenditure.[139]

Figure 6 below illustrates how much of the “actual expenditure” in the goods and services line item was spent on specific sub-line items.[140] It is understandable that the majority of the money spent under goods and services, was spent on food and food supplies, because the focus of this sub-programme is nutrition.[141] However, it is concerning that, the sub-line item that has the third highest expenditure is the “agency and support or outsourced services” as this implies that some the officials currently in the employ of the department are not sufficiently capacitated to deal with issues arising therein.[142]

[139] Eastern Cape Department of Health, *Annual Report 2015/16* p. 334.
[140] Eastern Cape Department of Health, *Annual Report 2015/16* p. 335.
[141] Eastern Cape Department of Health, *Annual Report 2015/16* p. 335.
[142] Eastern Cape Department of Health, *Annual Report 2015/16* p. 335.

Figure 6: Actual Expenditure of Sub-Line Items within the "Goods and Services" Line Item.[143]



[143] Eastern Cape Department of Health, *Annual Report 2015/16* p. 334-336.

It is noteworthy that the 2015/16 Annual Report shows that there were a number of sub-line items, which were under or over spent. This is indicative of poor budgeting and resource allocation. For example, the programme spent only 57 percent of its adjusted appropriation for the food and food supplies sub-line item but spent more than double its adjusted appropriation for the "travel and subsistence" sub-line item.[144] Over-expenditure on one line item could mean that money is being taken away from a different line item, which may require a bigger budget, while under-expenditure could mean that certain services are not being delivered.

It is important to look at allocation and expenditure trends in order to determine the effectiveness and efficiency of the ECDoH's resource management.

Figure 7: Allocation and Expenditure for Programme 2: District Health Services in the Eastern Cape from the year 2014/15 to 2017/18 (nominal figures).[145]

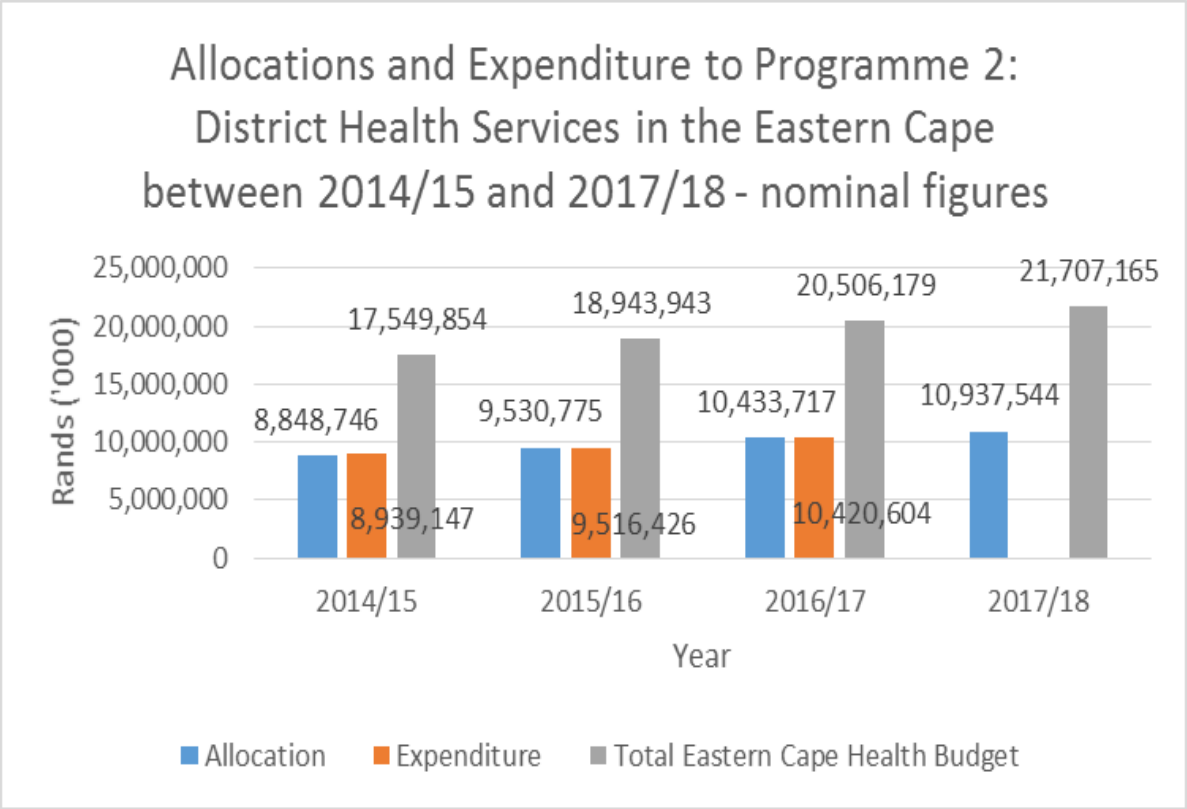


Figure 7 shows that between 2014/15 and 2016/17 there has been an average variance between allocation and expenditure of R20.9 million within Programme 2 and specifically under-expenditure by R14.3 million and R13.1 million for the 2015/16 and 2016/17 financial years respectively. The fact that the health sector in the Eastern Cape is in a negative state shows that the resource management within the ECDoH is not effective or efficient and that there is likely little value for money.

[144] Eastern Cape Department of Health, *Annual Report 2015/16.* P. 335-336.
[145] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 18 and Eastern Cape Department of Health, *Annual Report 2016/17* P.18.

Conditional Grants:

The efficient and effect spending of conditional grans is an important consideration when assessing the strategic planning and resource allocation of a department.

It is disconcerting that even though the full amount of the Health Professions Training and Development Grant was spent, there are still challenges the ECDoH faces in relation to shortages of skilled staff.[146] All things being equal, spending 100 percent of this specific grant should result in an improvement in the quality of services provided, and an increase in the number of skilled staff members becoming available in the near future.

In addition, almost 100 percent of the Comprehensive HIV/AIDS Grant was spent and this should contribute to the reduction in the number of mothers dying from HIV/AIDS infections and the transmission of HIV/AIDS from mother to child.[147] The Health Infrastructure Grant, which is used to "accelerate construction, maintenance, upgrading and rehabilitation of new and existing infrastructure in health", was also spent in its entirety.[148] This grant was spent on the completing "of 17 clinics across the province, completion of an Emergency Medical Service (EMS) base in Tombo, renovations at Mthatha General Hospital and the provision of consulting rooms to 23 clinics."[149] This spending should translate into an improvement of our healthcare system as a whole because more people will gain access to clinics, the EMS base in Tombo will service patients from areas close by, Mthatha General Hospital will be better equipped to service its patients and patients attending clinics with consultation rooms will gain more privacy. However, it is important that these better-equipped facilities are filled with healthcare workers so that healthcare can actually be provided.

Disappointingly, only 71 percent of the National Health Insurance Grant was spent because of "delays due to reprioritisation and amendments that had to be made to the business plan."[150] It is unclear what these aforementioned "reprioritisations and amendments" are and it is therefore difficult to draw an accurate conclusion as to the impact of the underspending on the success of the NHI pilot. However, it is obvious that because of the underspending, a number of the expected outputs were not achieved. Some important expected outputs include the creation of a "model for contracting private providers that include innovative arrangements for harnessing private sector resources at a primary healthcare level and the provision for a rational referral system based on a re-engineering primary healthcare platform with a particular focus in rural and previously disadvantaged areas."[151]

As of December 2016, the ECDoH had not been very successful in their endeavour to harness private sector resources. Research conducted and published in the Human Sciences Research Council Review showed that while General Practitioners (GPs) in the private sector were keen to contract with the government and assist with the NHI, there was low uptake because of a lack of communication from government.[152] This lack of communication led to a lack of understanding of the role the GPs would play and led them to mistrust the system tasked with implementing the NHI.[153] In addition to the lack of communication, GPs were apprehensive about signing an NHI contract because remuneration was inadequate; there was "inadequate infrastructure and equipment in some

[146] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 170.
[147] Eastern Cape Department of Health, *Annual Report 2015/16.* P. 170.
[148] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 171.
[149] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 171.
[150] Eastern Cape Department of Health, *Annual Report 2015/16.* P. 173.
[151] Eastern Cape Department of Health, *Annual Report 2015/16*. P. 173.
[152] C Hongoro. "Why GPs don't contract for NHI in the Eastern Cape" (2017) *Human Sciences Research Council* 11 at 14 HSRC Review 14.
[153] C Hongoro. "Why GPs don't contract for NHI in the Eastern Cape" (2017) *Human Sciences Research Council* 11 at 14 HSRC Review 14.

public facilities, lack of appropriate accommodation and recreational facilities, high workload and poor referrals, and a shortage of staff."[154] The fact that issues such as poor infrastructure and equipment, accommodation and staff shortages exist, are evidence of the poor budgeting and planning around the implementation of the NHI and can be solved with dedicated efforts to plan and budget effectively and efficiently.

At the end of 2016, only 2 out of 25 clinics tested for Ideal Clinic Status in the OR Tambo District managed to achieve this status.[155] In summary, the Ideal Clinic programme was implemented in order to improve the facilities and quality of healthcare provided in the public sector.[156] Healthcare facilities need to attain a certain score on a scorecard in order to be considered an Ideal Clinic.[157] The R2 million that was not spent during the 2015/16 financial year could have been spent on healthcare facilities in order to help them attain Ideal Clinic status. However, it is difficult to make these assertions without knowing exactly what was reprioritised and amended in the NHI business plan for the OR Tambo District.

Unfortunately, the possible implication of the underspending of the National Health Insurance Conditional Grant is that National Treasury could decrease the amount of the NHI Conditional Grant awarded to the ECDoH in future years. The purpose of the National Health Insurance Conditional Grant, is to, *inter alia*; test ideas for how to implement NHI, strengthen health systems in order to ensure the delivery of services, strengthen resource management in certain central hospitals, identify ways in which universal healthcare can be achieved and to "assess the effectiveness of these interventions."[158] These are important aspects of the health system and need to be addressed urgently.

The Financial and Fiscal Commission (FFC) explains the poor spending of the direct NHI grants as a result of "poor supply chain management systems, human resource capacity and the lack of delegation powers at district level," which are issues that can be solved through better oversight and through consequence management mechanisms.[159] The FFC recommends that capacity be built amongst the health district offices through the use of the indirect conditional grant, in order that these offices are able to implement the rollout of the NHI in due course.[160] The FFC also notes that the roll-out of the introductory aspects of the NHI such as "contracting with private sector general practitioners and strengthening central hospitals patient information systems" are "un-sequenced" which is further evidence of a lack of planning in respect of how to roll-out the NHI.[161]

The ECDoH has explained that in order to improve its performance and prevent underspending in the future it hopes to strengthen the "Pilot District management team" which will contribute to improved and more frequent performance reports and better group work for the purpose of reaching target objectives.[162]

The ECDoH should ensure that the total budget is spent in respect of this grant going forward and should most certainly adhere more strictly to the "expected outputs of the grant"

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[154] C Hongoro. "Why GPs don't contract for NHI in the Eastern Cape" (2017) *Human Sciences Research Council* 11 at 14 HSRC Review 14.
[155] The National Department of Health. "Status of NHI Pilot Districts, November 2016". P. 11.
[156] The National Department of Health. "Status of NHI Pilot Districts, November 2016". P. 11.
[157] The National Department of Health. "Status of NHI Pilot Districts, November 2016". P. 11.
[158] Eastern Cape Department of Health, *Annual Report 2015/16.* P. 172.
[159] Financial and Fiscal Commission (FFC). 2017. Submission on the 2017 Division of Revenue Bill 2017/18, May 2016. P. 17.
[160] Financial and Fiscal Commission (FFC). 2017. Submission on the 2017 Division of Revenue Bill 2017/18, May 2016. P. 17.
[161] Financial and Fiscal Commission (FFC). 2017. Submission on the 2017 Division of Revenue Bill 2017/18, May 2016. P. 17.
[162] Eastern Cape Department of Health, *Annual Report 2015/16* p. 173.

because the “actual outputs achieved” do not seem to be well aligned to the “expected outputs” in the annual report.[163]

Conclusion

While expenditure looks to be in-line with National and Provincial policy priorities in most respects, the fact that the general consensus is that the public health sector provides inadequate health services (*see medico legal situation*), and the fact that quality healthcare remains largely inaccessible implies that there is little value for money in the transactions that the ECDoH enters into with service providers.

Through analysing the data above and by looking at the data obtained from the ECDoH Annual Report 2015/16, Annual Performance Plan 2017/18 and the Financial and Non-Financial Report 2016/17, one can see that many of the challenges faced by the ECDoH such as; high vacancy rates, unskilled staff members, poor infrastructure and poorly equipped facilities, are exacerbated by poor strategic planning and resource allocation, and these challenges then lead to medico-legal claims which require resources earmarked for improved service delivery, and so the cycle is perpetuated.

There needs to be stronger human resource management within the ECDoH which can be achieved through appointing the correct number of staff with the relevant qualifications who can prioritise the recruitment and retention of healthcare workers. There also needs to be stronger performance management in order to ensure that the quality of the healthcare being delivered is of a high standard. This will decrease the number of medico-legal claims which will free up a huge amount of financial resources which can then be allocated to programmatic policies within the department such as maternal, child and infant nutrition.

[163] Eastern Cape Department of Health, *Annual Report 2015/16* p. 173.

OUR ORGANISATION

The PSAM was founded in 1999 as a research project in the Rhodes University Department of Sociology. Its initial aim was to monitor incidents of corruption within the Eastern Cape government. From 2005, recognising the systemic nature of poor governance and corruption in the province, the PSAM began a concerted advocacy effort to systematically strengthen public resource management by key Eastern Cape government departments.

In 2007, PSAM introduced a training and academic component. The training component has developed to be what is known as the Regional Learning Programme and the academic component has changed to become what is known as the Advocacy Impact Programme. The various activities and interventions by PSAM over the years have emphasised the on-going need for greater and improved accountability interventions by civil society organisations across the region. Through our work we seek to achieve improved networking and advocacy to leverage impact and enhanced learning so that achievements are shared, evaluated and used to bolster social accountability interventions in sub-Saharan Africa.

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