REPUBLIC OF SOUTH AFRICA

Institutional Arrangements

Final Lab Report

21 November 2014

Abbreviations

- CoGTA : Cooperative Government and Traditional Affairs

- IGRFA : Intergovernmental Relations Framework Act

- MEC : Member of the Executive Council

- NCOP : National Council of Provinces

- NHA : National Health Act

- NHC : National Health Council

- NSDA : Negotiated Service Delivery Agreement

- PHC : Primary Health Care

- SALGA : South African Local Government Association

- UHC : Universal Health Coverage

- WP-NHI: White Paper on National Health Insurance

Contents: Institutional Arrangements

- **Context & Case for Change**

- Aspiration

- Issues & Root Causes

- Initiatives

- Costing

Context and case for change

Context

- The **Minister** is held publicly accountable for the quality of **service delivery** at clinics, but does **not have direct executive authority** over the **provincial** health departments to ensure this quality, because Health service delivery is a **concurrent function** between National and Provincial government: *Schedule 4 of the Constitution*

- While provinces must manage the health function within national legal and policy frameworks, experience has shown that there **is uneven implementation** of these frameworks and agreed-to decisions are not always implemented at provincial level

- **Inter-sectoral collaboration** is required to address the social determinants of health – but this is not currently taking place sufficiently

Case for change

- We will **explore mechanisms for improving cooperation and implementation** of policy directives for the Ideal Clinic Initiative

- **As constitutional amendment is not practical**, **we will work within current legislation** to strengthen accountability and governance

- **We will work to further articulate prescripts of the National Health Act (NHA)**
  - in Provincial Health Acts
  - In concluding the Provincialisation of Primary Health Services

- **A unified Public Service** (inclusive of Local Government) will speed up change and realization of the ideal clinic

The *Institutional Arrangements* Lab has sought to find answers to key questions and will deliver a memorandum to the Minister

Key questions

- How can intergovernmental relations between the three spheres of government be strengthened to ensure successful delivery and scaling up of the Ideal Clinic Initiative?
- What legal instruments and policy frameworks can be used to foster this collaboration?
- What roles need to be played by each sphere of government (and statutory bodies) to run an effective primary health system?
- How should the roles of the various levels of government be to ensure successful implementation of the Ideal Clinic Initiative?
- What cross- departmental roles are required for a successful Ideal Clinic roll-out?
- What governance model/legislative changes are needed to implement and sustain the system?
- What are the targets, action steps and timetables for execution of the required institutional change at each level of government?

Resources

- The Constitution of the Republic of South Africa 108 of 1996
- National Health Act 61 of 2003
- Intergovernmental Relations Framework Act 13 of 2005
- The Aid Effectiveness Framework for Health in South Africa- 21 January 2011
- Extending Participation: Challenges of Health Committees as Meaningful Structures for Community Participation – January 2011
- Public Administration Management Bill
- Public Service Charter
- Public Service Act
- Health in All Policies
- Municipal Systems Act of 2000

Key deliverable

- Memorandum outlining
  - Key issues and analysis of their impact
  - Literature review of alternative solutions and case studies
  - Final recommendation
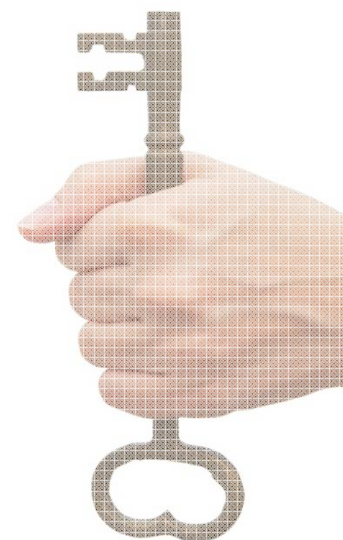
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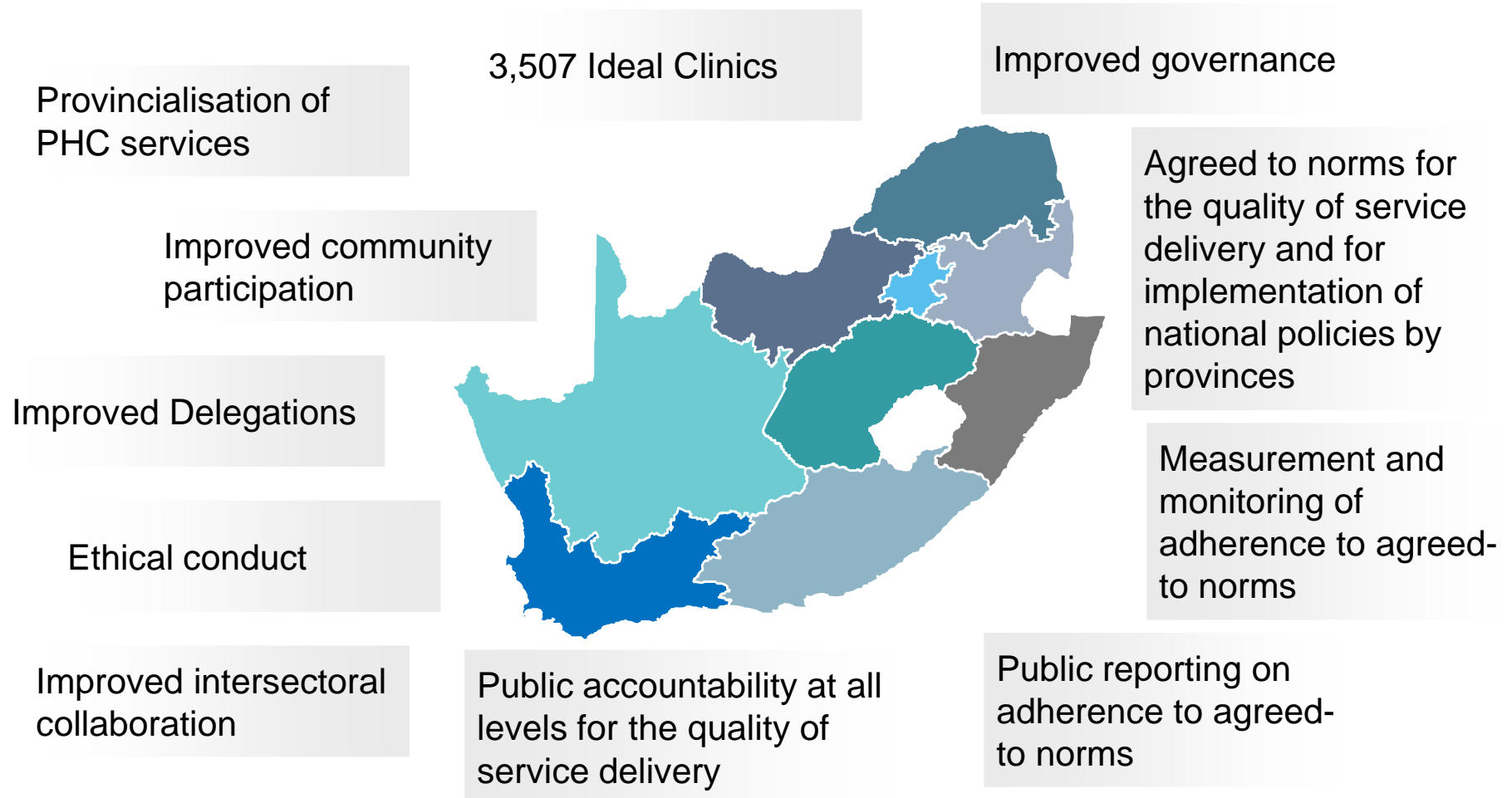
- Context & Case for Change

- **Aspiration**

- Issues & Root Causes

- Initiatives

- Costing

Our aspiration is to build effective institutional arrangements and mechanisms for the Ideal Clinic Realisation and Maintenance
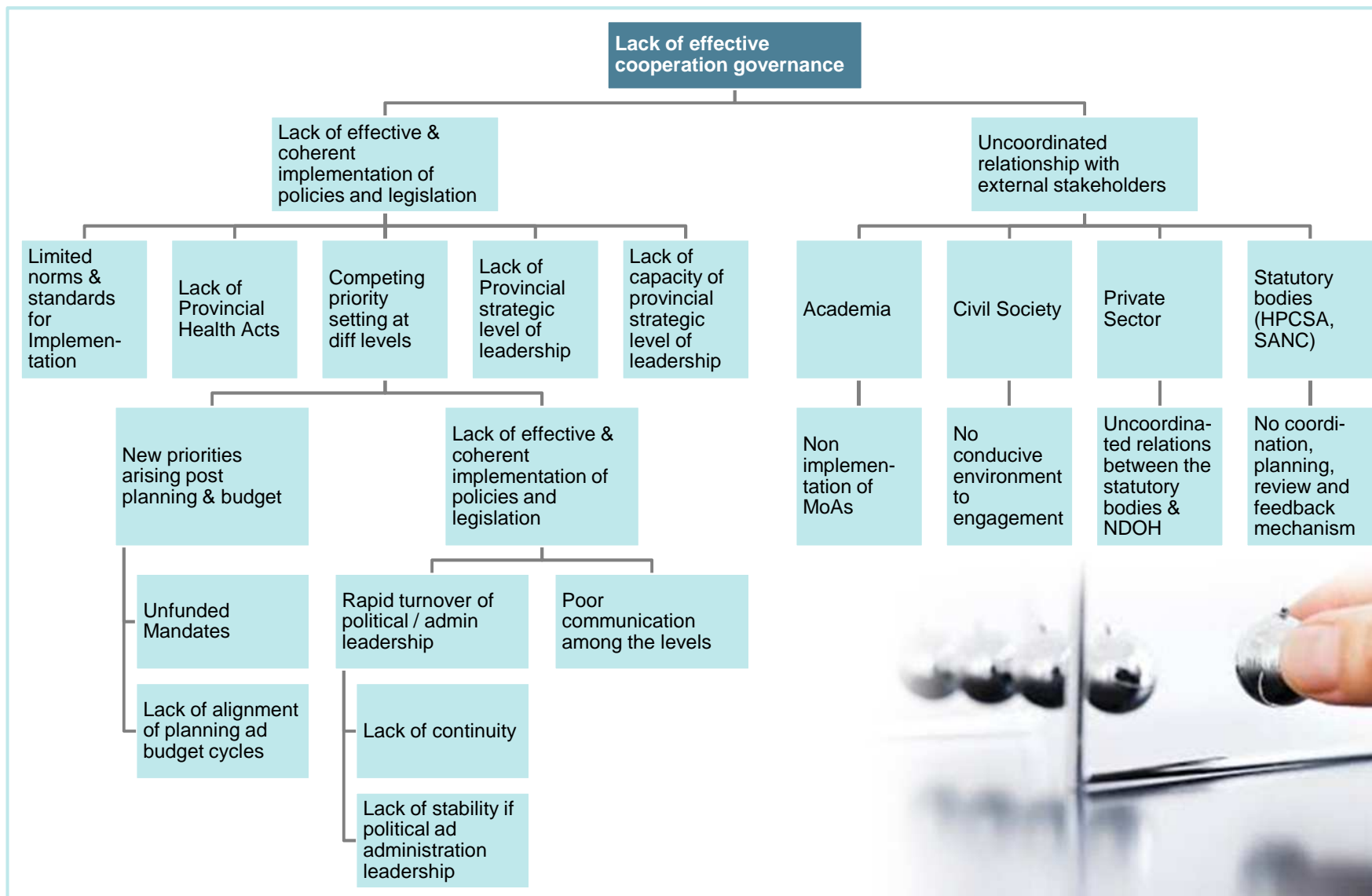
3,507 Ideal Clinics

Improved governance

Provincialisation of PHC services

Agreed to norms for the quality of service delivery and for implementation of national policies by provinces

Improved community participation

Improved Delegations

Measurement and monitoring of adherence to agreed-to norms

Ethical conduct

Improved intersectoral collaboration

Public accountability at all levels for the quality of service delivery

Public reporting on adherence to agreed-to norms

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- Context & Case for Change

- Aspiration
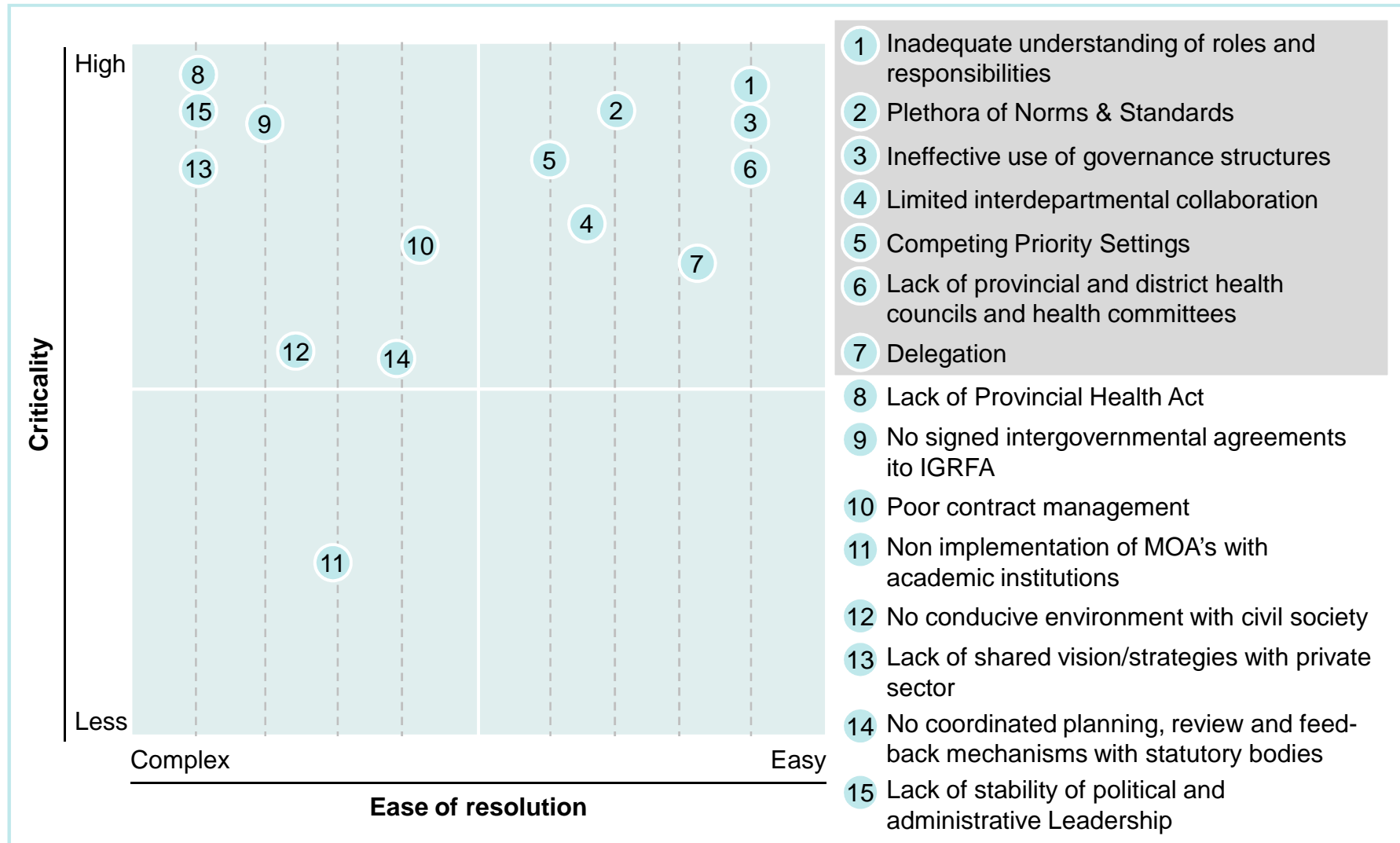
- **Issues & Root Causes**

- Initiatives

- Costing

Institutional Arrangements are limited by key issues

Lack of effective cooperation governance

Lack of effective & coherent implementation of policies and legislation

- Limited norms & standards for Implementation
- Lack of Provincial Health Acts
- Competing priority setting at diff levels
- Lack of Provincial strategic level of leadership
- Lack of capacity of provincial strategic level of leadership

New priorities arising post planning & budget
- Unfunded Mandates
- Lack of alignment of planning ad budget cycles

Lack of effective & coherent implementation of policies and legislation
- Rapid turnover of political / admin leadership
  - Lack of continuity
  - Lack of stability if political ad administration leadership
- Poor communication among the levels

Uncoordinated relationship with external stakeholders

- Academia
  - Non implementation of MoAs
- Civil Society
  - No conducive environment to engagement
- Private Sector
  - Uncoordinated relations between the statutory bodies & NDOH
- Statutory bodies (HPCSA, SANC)
  - No coordination, planning, review and feedback mechanism

The key issues were prioritised to focus the lab on the most important issues to find solutions to

Prioritised

1	Inadequate understanding of roles and responsibilities
2	Plethora of Norms & Standards
3	Ineffective use of governance structures
4	Limited interdepartmental collaboration
5	Competing Priority Settings
6	Lack of provincial and district health councils and health committees
7	Delegation
8	Lack of Provincial Health Act
9	No signed intergovernmental agreements ito IGRFA
10	Poor contract management
11	Non implementation of MOA's with academic institutions
12	No conducive environment with civil society
13	Lack of shared vision/strategies with private sector
14	No coordinated planning, review and feed-back mechanisms with statutory bodies
15	Lack of stability of political and administrative Leadership

This workstream's focus is under-pinned by a determination to find solutions for key prioritised issues

	Description	**Impact of the issue**
Issue 1	▪ The different governance structures are not clear on their roles and responsibilities	▪ Functional Paralysis ▪ Poor Job Performance ▪ Poor service delivery, poor health outcomes, poor efficiency and effectiveness, inequitable outcomes and limited coverage of services

Issue 2	▪ A plethora of norms and standards exist. However: There are none that address accountability, ethics and governance
	  – Limited guidelines for the implementation of Norms & Standards
	  – Some prescripts of the National and Provincial Health Acts have not been translated further into regulations and guidelines to facilitate implementation
		▪ Limits standardisation
		▪ Disparity in service standards
		▪ Failure to realise the required standard of performance for ICRM

Issue 3	▪ Governance structures are used ineffectively and there is a lack of district and provincial councils	▪ Poor planning and allocation of resources ▪ Poor accountability ▪ Limits the quality of support to MEC ▪ Limits Public Participation leading to lack of ownership by community ▪ Lack of bottom-up feedback ▪ Poor health outcomes
Issue 4	▪ Limited intergovernmental, and intra- and interdepartmental collaboration	▪ Weak vertical accountability between provincial and local government spheres could be detrimental to the roll-out of ICRM. ▪ Weak horizontal accountability between departments which lead to Inefficiency in dealing with social determinants of Health)
Issue 5	▪ Competing Priority Setting at different levels	▪ Conflict in matching emerging priorities to approved planning and budget ▪ Variance in the implementation of strategy ▪ Inability to conclude the Provincialisation of PHC services leading to fragmentation and duplication of services
Issue 6	▪ Inadequate delegation of authority to the lowest possible levels of Management	▪ Limited local accountability and responsiveness ▪ Delays in decision-making

1 The different governance structures are not clear on their roles and responsibilities

Evidence

- As quoted in the section 5 of *The Status of Clinic Committees* report*, "There appears to be a lack of clarity on the range and types of activities that clinic committees are expected to perform…"*
- The National Health Act offers clear roles & responsibilities for the national provincial and district councils but hospital board roles & responsibilities are meant to be outlined by the Provincial Health Act, which is in place for only KZN, Eastern Cape Free State and Western Cape .

Root Causes

- The absence of any national guidelines
- Facility managers and clinic committees are not trained jointly (if trained)
- Some prescripts of the National and Provincial Health Acts have not been translated further into regulations and guidelines to facilitate implementation
- Weak vertical accountability between provincial and local government spheres could be detrimental to the roll-out of ICRM
- Non implementation of existing legislation

Challenges Hampering Resolution

- Absence of guidelines
- Lack of an established method to collect relevant community views
- Inadequate or lack of implementation of legislation (spirit and letter)
- Lack of financial and technical support for the governance structures at clinic level
- Lack of training of the governance structures

2 **There is a plethora of norms and standards**

Evidence

- There is no cohesion between the many different guiding policies on Norms & Standards, a sample illustration:
  - National Core Standards
  - WHO – 6 building blocks for a Health System
  - Norms & Standards for Primary Health Care Facilities

Root Causes

- Limited guidance existed on the minimum acceptable levels of service and quality in hospitals and clinics

Challenges Hampering Resolution

- While many norms and standards can be found, not all of them have been constructed as criteria for measuring and tracking performance
- Decisions around the quality of health services are left largely up to the health establishment, which has little incentive to improve its performance
- It is not uncommon for patients to have to wait in long queues, be treated in unclean wards and often dealt with by impolite staff

3 **Governance structures are used ineffectively and there is a lack of district and provincial councils**

Evidence	Root Causes	Challenges Hampering Resolution
▪ The PCC (President's Coordinating Council) is a powerful structure that is not effectively used. This powerful structure has not been adequately used to advance the health agenda ▪ Community participation has been formalized in The National Health Act 61 of 2003 (Department of Health, 2004) with provisions for the establishment of health committees, hospital boards and district health councils ▪ Health committees in South Africa are not functioning optimally ▪ The 2003 Facilities Survey found that while 59% of clinics reported having clinic committees, only 35% were functional and had met recently	▪ Lack of clear guidelines ▪ Lack of corporate and financial support ▪ Although The National Health Act is clear on the establishment of Provincial and District Health Councils, it is silent on outlining a mandate for health commit-tees, leaving it to provincial governments to provide legislation that stipulates the role and function of health committees ▪ Legislation that stipulates the functioning of health committees is not yet deve-loped by some provinces or is yet to be implemented ▪ Lack of clarity of man-date, role and function ▪ Limited skills and capacity ▪ Lack of institutional support	▪ Explicit political support ▪ Lack of allocation of resources to support the operational and logistical needs of governance structures ▪ Research suggests that training for governance structures mostly does not take place and if it does, it is not executed in a consistent or coordinated manner. ▪ Lack of a set of national guidelines be developed ▪ Lack of capacity building programmes ▪ Lack of stipends ▪ Slow Implementation of legislation for community participation

4 **Intergovernmental, Intra- and Inter-Departmental Collaboration is not adequate**

Evidence

- The delay in the finalisation of provinicialisation is as a result of poor inter-governmental collaboration
- Failure to implement resolutions of the NHC, e.g. refusal to implement the PHC reengineering stream of NHI piloting in Western Cape
- Agreements with Department of Community Safety and Security Liaison (DCSSL) in Mpumalanga, and Public Works poorly managed and ineffective in not delivering key infrastructure

Root Causes

- Intergovernmental
  - Lack of political will
- Intradepartmental
  - Health is a concurrent function of National and Provinces
  - Decisions are on a consensus basis but are not always enforceable
- Interdepartmental
  - Lack of systems to enforce interdepartmental agreements

Challenges Hampering Resolution

- Intergovernmental
  - Autonomy of the spheres of government
- Intradepartmental
  - Constitutional mandate giving autonomy to Provinces
- Interdepartmental
  - Organisational culture with lack of mutual accountability
  - Vested interests in the SCM process

5 Priorities set at different spheres of government often compete

Evidence

- There are instances where plans from the National level are not aligned to service transformation plans at the provincial and local government level

Root Causes

- Poor coordination mechanism
- Different needs and agenda per spheres of Governments
- Different budgeting cycles

Challenges Hampering Resolution

- Failure to implement the IGRFA requirements
- Poor alignment to NDP vision and IHPF
- Different financial management Acts

6 Authority is not adequately delegated to the lowest implementation levels

Evidence/Data to quantify the issue

- The threshold for delegations varies from province to province but does not adequately delegate appropriate authority to the lowest levels of service.
- By way of example, in two of the provinces the powers are vested with HODs by the Executive Authority (i.e. MECs). The delegations are further delegated by the HOD down to the level of the District office and District hospitals. The delegation does not filter further down to clinics.

Root Causes

- No decentralization of the authority to the clinics. It ends at District level
- No capacity at clinic level
- No cost centres

Challenges Hampering Resolution

- Absence of administration support (finance, scm and HR) staff
- Cost containment issues
- Staff turnover
- Centralization of corporate services
- Risks of corruption and fraud

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Options for Addressing the Problem

|		
1	Make Health a **National Competency**	■ Give the Minister authority to accompany the political responsibility ■ This would involve making Health a national function, i.e. remove it from Schedule 4 ■ This will be politically controversial and could take a long time. ■ There are pro's and con's to this option, and a political decision would need to be taken to pursue it
2	Optimise **existing Constitution and Legislation**	■ There is room to make better use of the existing legislation for intergovernmental cooperation ■ This requires the utilisation of intergovernmental cooperation structures more effectively, so as to ensure more consistent implementation of national, legal and policy frameworks

1 Constitutional change would give the National government primary responsibility for health, and the provinces an oversight function …

The proposal

- Table a proposal to Parliament/NCOP to:
  - Remove health from schedule 4
  - Remove ambulance services from schedule 5

New role of the Provinces
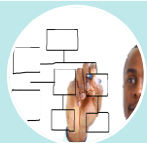
- Change from executive and accountability to oversight and advocacy

Intended benefits of the proposed change (the Pros)

- Centralisation of authority and responsibility for health
- Elimination of competing priorities across all spheres
- One consolidated budget bid for health:
  - Single pool of funding for health
  - More equitable allocation of resource

Cons

- Would generate strong political resistance
- May take a long time to conclude
- Potential disadvantages of centralisation: a possible weak future national department could result in the deterioration of the health system across all provinces
- Argument that health is best managed on a decentralised basis

A political decision would need to be taken to pursue this option

Options for Addressing the Problem

1 Make Health a **National Competency**

- Give the Minister authority to accompany the political responsibility
- This would involve making Health a national function, i.e. remove it from Schedule 4
- This will be politically controversial and could take a long time.
- There are pro's and con's to this option, and a political decision would need to be taken to pursue it

2 Optimise **existing Constitution and Legislation**

- There is room to make better use of the existing legislation for intergovernmental cooperation
- This requires the utilisation of intergovernmental cooperation structures more effectively, so as to ensure more consistent implementation of national, legal and policy frameworks

2 **To Optimise existing Constitution and Legislation, 4 initiatives to build an enabling environment for Ideal Clinic Realisation and Maintenance are proposed**

Initiatives	Description
A **Consistently implement National Policies**	▪ Develop comprehensive and agreed upon **Norms & Standards** ▪ **Intergovernmental agreements** on the basis of the norms signed by Premiers and MECs ▪ Reporting and adherence to the norms to be **monitored** and held to **public accountability**
B **Bring Provinciali-sation process to completion**	▪ Bringing the **PHC** services **under one authority**, the province ▪ Implement as per NHC Resolution of 2005
C **Improved public accountability and transparency**	▪ Establishment of provincial and district health **councils and committees**, where they don't currently exist ▪ Enhancing effectiveness of health committees where they do currently exist ▪ District Health Committee as a **coordinating mechanism** to ensure greater cooperation at grassroots level
D **Increase responsive-ness at the point of service delivery**	▪ Implementation of **standardised delegations** to the **lowest** possible level of management ▪ Norms for delegations and monitor and report on adherence to these

2 In order to resolve these prioritised issues, we have identified 4 key initiatives

		Description	Rationale – why this initiative is needed
A	**Consistently implement National Policies**	▪ Make health a National competency ▪ Establish vertical and horizontal accountability between national, provincial and local governments through intergovernmental and interdepartmental agreements guided by IGRFA. – Develop and implement norms and standards for accountability, ethics and governance.	▪ Enhances horizontal accountability between departments leading to efficient dealing with the social determinants of Health ▪ Improves planning and allocation of resources ▪ Improves accountability ▪ Improve service delivery, health outcomes, efficiency and effectiveness, equitable outcomes and increase coverage of services
B	**Provinciali-sation**	▪ 2005 the National Health Council took the decision to provincialize all PHC services, but progress was impeded by a variety of reasons leading to the resolution not being concluded	▪ Prevention of conflict in matching emerging priorities to approved planning and budget ▪ Standardisation in the implementation of strategy
C	**Health Councils & Committees**	▪ Health Councils and Committees do not currently exist in all provinces. Where they do exist, they are not effective , thus there is a need to put a coordinating mechanism in place to ensure improved accountability and responsiveness to communities	▪ Provides for a clearer picture of the Health Service ▪ Increases ownership by community via Public Participation ▪ Improves planning and allocation of resources ▪ Improves accountability
D	**Enhance delegations**	▪ Improve effectiveness and efficiency of clinics by delegating authority to the lowest possible level of management ▪ Inability of lower levels of managers to initiate interventions timeously and take accountability. ▪ Non-standardization of delegations across provinces, districts, sub-districts and health establishments. ▪ Inadequate implementation and monitoring of delegations, where these exist.	▪ Enhanced local accountability and responsiveness to improve patients experience of health service delivery with improved health outcomes

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A **Increase the consistency of implementation of national policies**

Norms & Standards	▪ Develop comprehensive and detailed **agreed**-upon minimum **norms and standards** for the **quality** of service at clinics, as well as **process** norms where necessary ▪ **Publicly** report on implementation of the norms to **increase public accountability** ▪ Put in place **monitoring capacity** and monitoring **systems** at various levels of government to measure and monitor the **implementation** of the norms
Negotiated inter-governmental agreements	▪ Enter into **inter-governmental agreements** on the basis of the norms, to be signed by **Premiers** as well as **MECs** ▪ Intergovernmental agreements to include commitment to **monitoring** the norms, reporting on **adherence** to them **publicly**, and **participation** in intergovernmental structures ▪ **Optimise** the use of intergovernmental structures to reach agreement on the norms, to monitor their implementation, and to address problems with implementation of the norms, including making use of the **President's Coordinating Council with Premiers**
Overall	▪ Use **Operation Phakisa** as an opportunity to implement the above
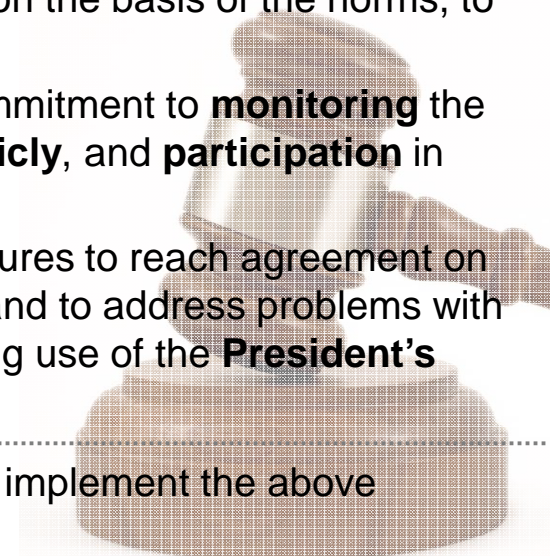
A Norms and Standards

Process norms

Quality norms

Current situation	Description of intervention	1000 foot actions	Impact
No specific standards exist for effective leadership, corporate governance and ethical standards within the health sector although numerous guidance documents are in place which provide general standards for governance. These include general documents such as King III and Auditor General compliance requirements with the PFMA, and the Department for Public Service Administration, Senior Management Service Handbook	Review and streamline the norms and standards Develop norms and standards for accountability, ethics and governance Consequences/penalties for non-compliance	Develop a standardised guide on norms and standards for accountability, ethics and good governance (interdepartmental and intradepartmental). Implement new guide M&E the impact of the implementation of the new guide	Use of norms and standards as a monitoring mechanism for improved accountability, ethics and good governance (Interdepartmental [Social Determinants] and Intradepartmental [Performance determinants])

A **Intergovernmental agreements would be on a fully negotiated basis to create both political and administrative accountability across all 3 spheres of government**

> **The different parties would develop, agree on and sign Performance Agreements at all levels, with clear KPIs**

Key terms

- ✓ Packages of services to be delivered

- ✓ Implementation of package of services

- ✓ Performance indicators

- ✓ Accounting framework internally and to the Public

- ✓ Incentive/Consequence management

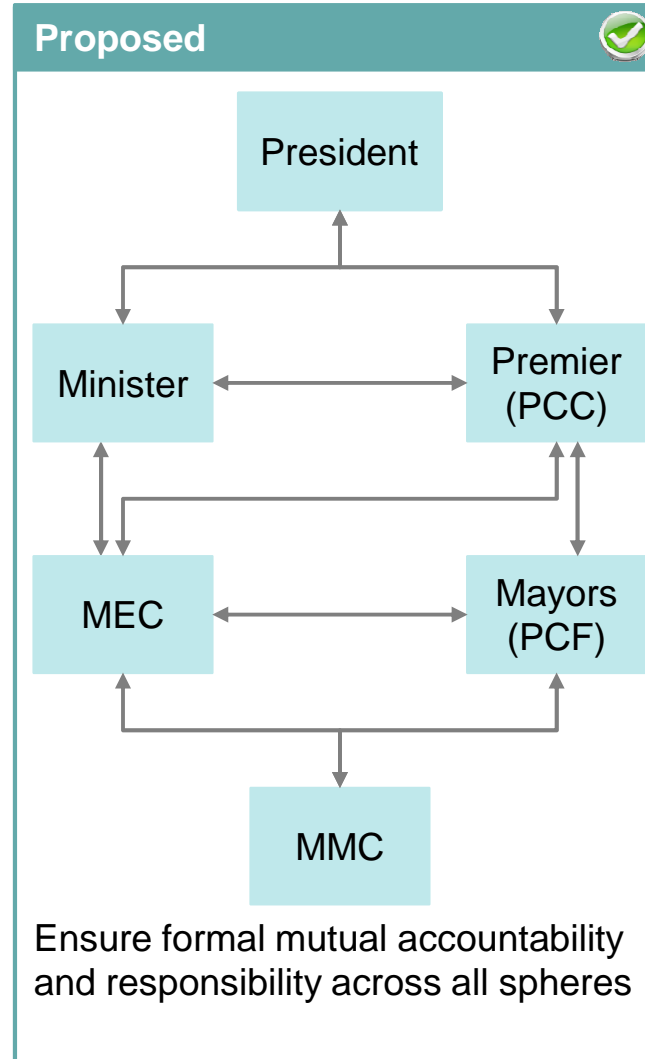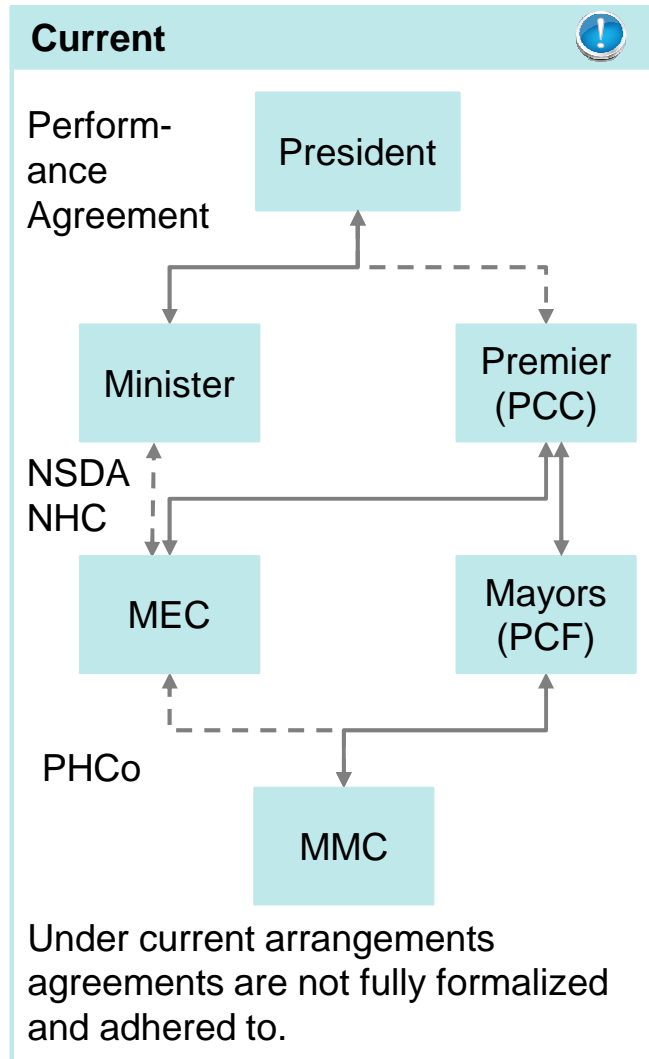- ✓ Oversight over health service delivery

Existing ⟷   Currently adhoc ⇠---⇢

Current ⓘ

Performance Agreement

President

Minister

Premier (PCC)

NSDA
NHC

MEC

Mayors (PCF)

PHCo

MMC

Under current arrangements agreements are not fully formalized and adhered to.

Proposed ✓

President

Minister ⟷ Premier (PCC)

MEC ⟷ Mayors (PCF)

MMC

Ensure formal mutual accountability and responsibility across all spheres

Take-aways

- There are currently no formal agreements between the levels of government and as such, no accountability
- The structure proposed will ensure agreements at all levels, encouraging accountability horizontally and vertically

A Proposed Structure for Consistent implementation of National Policies within Administrative structures

What currently exists ↕   **What is proposed** ↕   ▮ Will fall away with provincialisation
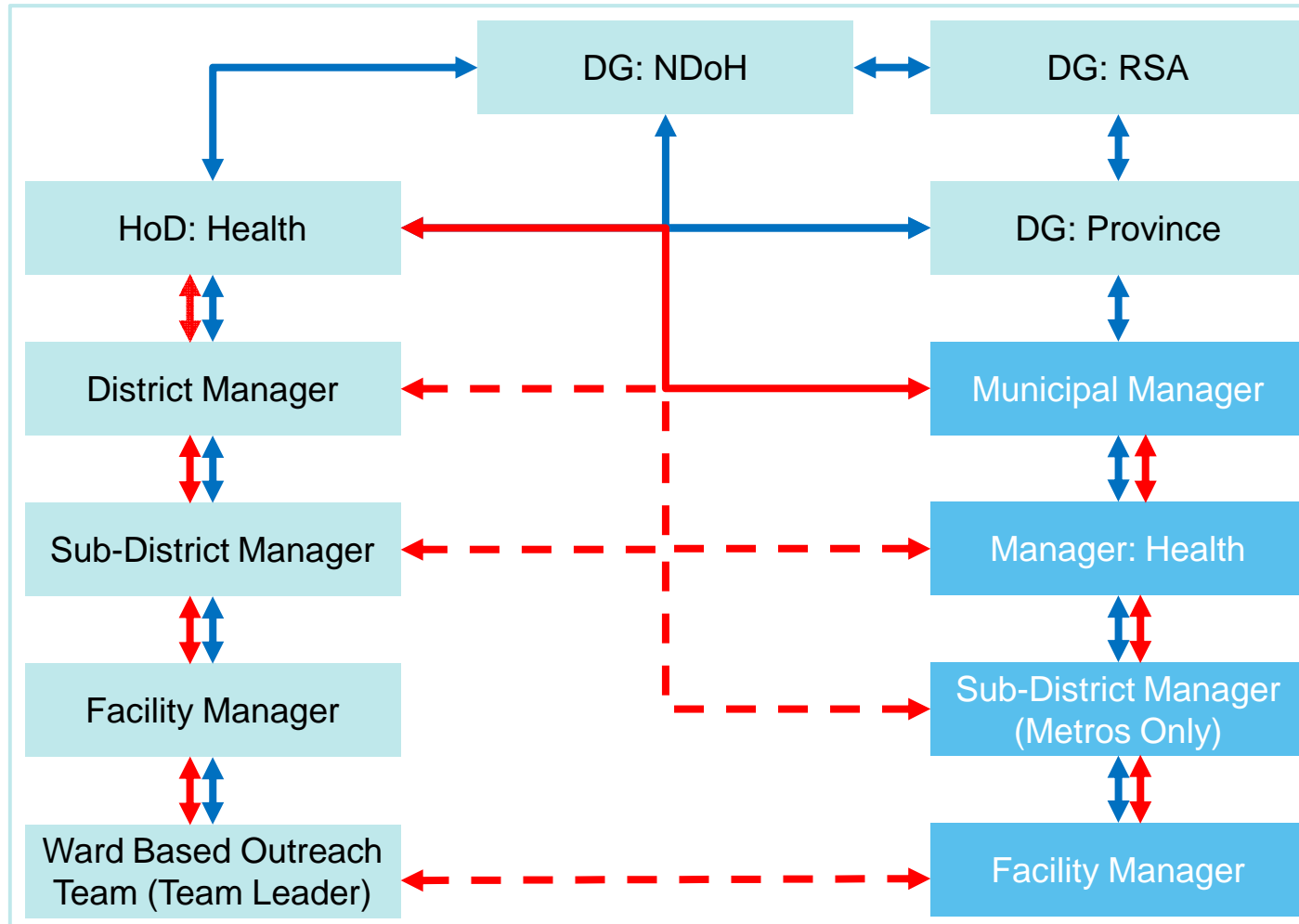

Take-aways

- There are currently no formal agreements between the levels of government and as such, no accountability
- The structure proposed will ensure agreements at all levels, encouraging accountability horizontally and vertically

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A Develop and implement an intergovernmental and interdepartmental agreement guided by IGRFA

From current consensus based arrangement, without accountability

To mutually binding agreements, with clear KPIs and consequences for non-adherence

Multi-layout system

- There is currently no direct accountability between the Minister, MECs and MMCs.
- The Minister accounts to the President and Parliament, while the MEC accounts to the Premier and Provincial legislature, and the MMC accounts to the Mayor and the Council.
- Each has its own priorities and expectations, and are not of necessity linked to each other, leading to fragmentation and duplication of services.

Key features of the proposed agreement

- Agreements based on a common understanding of a National Health Strategy
- A shared vision and policy direction
- Spirit of corporate governance, intergovernmental and interdepartmental
- Good faith and reasonableness
- Clear financial and non-financial resource contributions

Simplified system of cooperative governance
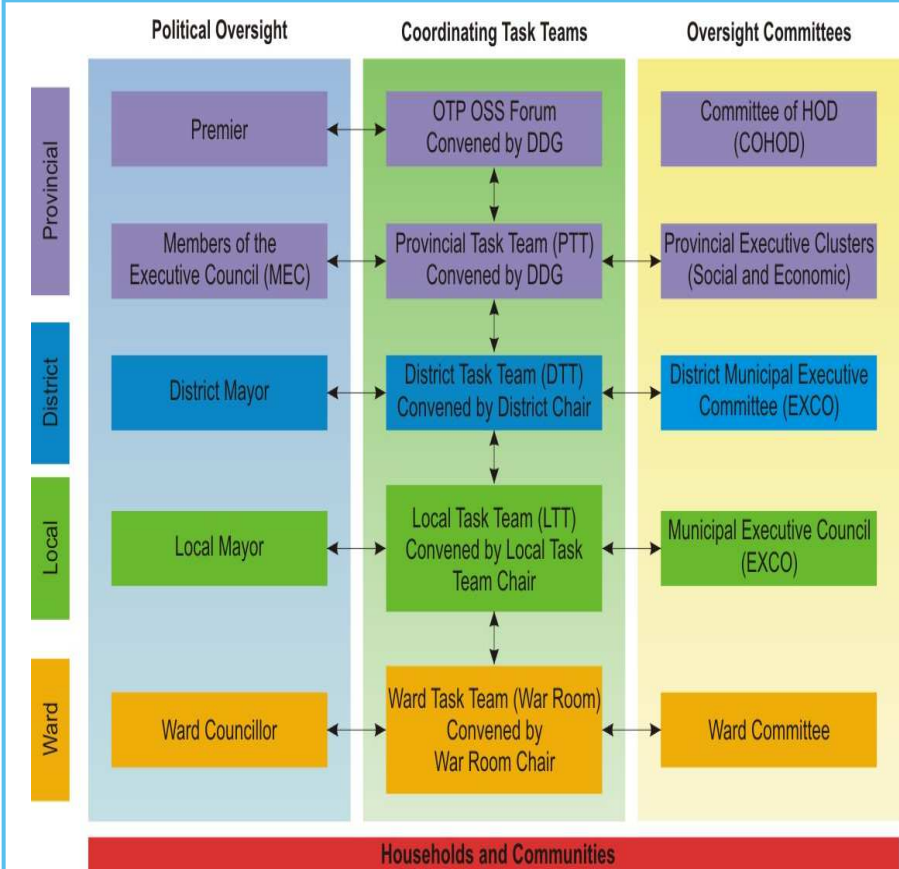
A 1000-feet plan for the consistent implementation of National policies ⭐

Objective:
development of comprehensive and agreed upon Norms & Standards; Intergovernmental agreements on the basis of the norms signed by Premiers and MECs; Reporting on and adherence to the norms to be monitored and held to public accountability

Description:
- This initiative seeks to establish institutional arrangements where leadership at all three spheres of government will be able to mutually account for the competencies constitutionally bestowed upon them. This mutual accountability will be enhanced through the development of agreed upon norms and standards which will inform agreements to be signed between all these leaders
- This same arrangement will be extended to manage the relationship within the department of health at all levels, as well as between the department of health and other sector departments, in terms of how health services are to be provided. This same arrangement will be extended to manage the relationship within the department of health at all levels, as well as between the department of health and other sector departments, in terms of how health services are to be provided

Owner:
- COO

Key stakeholders identified:
- NHC
- CoGTA

Required resources
- Non- financial:
- Financial: meetings, travelling, documentation, public consultation, and technical expertise

Implementation timeframe
- Start – February 2015:
- End – June 2015

Key milestones
- Develop draft quality Norms and Standards for health care services to address the gaps
- Develop draft process Norms and Standards for health care service delivery
- Agreement on the draft norms and standards at the technical NHC
- Agreement on the draft norms and standards at the NHC
- Printing and dissemination of the norms and standards
- M&E adherence and public accountability to the norms and standards

## B Bring Provincialisation process to Completion

Rationale

- In 2005 the National Health Council took the decision to provincialise all **personal PHC** services
- This decision was taken in the interest of bringing the services under **one authority**, the province, and **consolidating** the services until 2015 when the decision would be reviewed
- The decision was accepted and endorsed by Provincial Health Councils and other relevant bodies

Progress (Percentage)

Province	Percentage
Free State	100
Limpopo	100
Eastern Cape	100
Mpumalange	100
KZN	88
Northern Cape	88
Western Cape	78
North West	70
Gauteng	48

What to do

- Create a **blueprint** [checklist] of what needs to be done to achieve **100%**
- Deploy to provinces a **Roll-out Assist Team** with the blueprint.
- Complete provincialization in category B municipal ties ASAP- (end of 2015/16 financial year)
- Complete provincialization of category A in the next 3 years (interim SLAs)
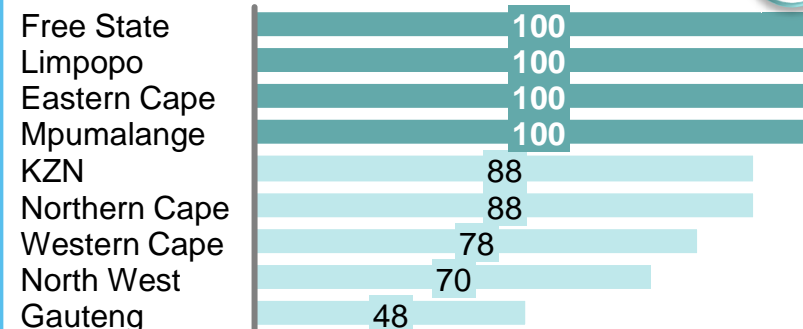
Why not 100%

- Multiparty negotiations are difficult
- Magnitude of challenges for Metro with respect to assets and staff
- Reluctance of staff to change employers fearing loss of benefits
- Assets used as surety to borrow funds
- Cost of transfers

Impact

- Completing Provincialisation will:
  - **Consolidate** PHC services
  - **Counteract** the current **lack of capacity** in many municipalities to render the services
  - **Eliminate fragmentation** by bringing PHC services under one management authority, the province

B 1000-feet plan for Provincialisation

Objective:
- Complete the provincialization process in the remaining five Provinces by 2018/2019, to overcome fragmentation and duplication and bring services under one authority.

Description:
- **2005 the National Health Council** (which had been set up in terms of the National Health Act)
  - **took the decision to provincialize** all PHC services
  - Process due for review in 2015
- Progress was impeded by the following:
  - Lack of Political Will
  - Multiparty negotiations are difficult
  - Magnitude of challenges for Metro with respect to assets and staff
  - Reluctance of staff to change employers - fearing loss of benefits
  - The assets used as surety to borrow funds, especially by Metros
  - Cost of transfers
  - Union interventions

Owner:
- NDoH

Key stakeholders identified:
- NHC; Provinces; National Treasury and SALGA

Required resources
- Non- financial: Leadership, agreements
- Financial:
  - Transfers of staff and assets, service funding gap meetings, travelling, documentation, technical expertise, legal and stakeholder consultation.

Implementation timeframe
- Start – January 2015
- End – March 2018

Key milestones
- Completed category B municipalities by March 2016
- Signed SLAs with Metros in place by March 2015
- Completed category A by March 2018

C Coordination and cooperation of committees at district and sub-district level is currently very poor

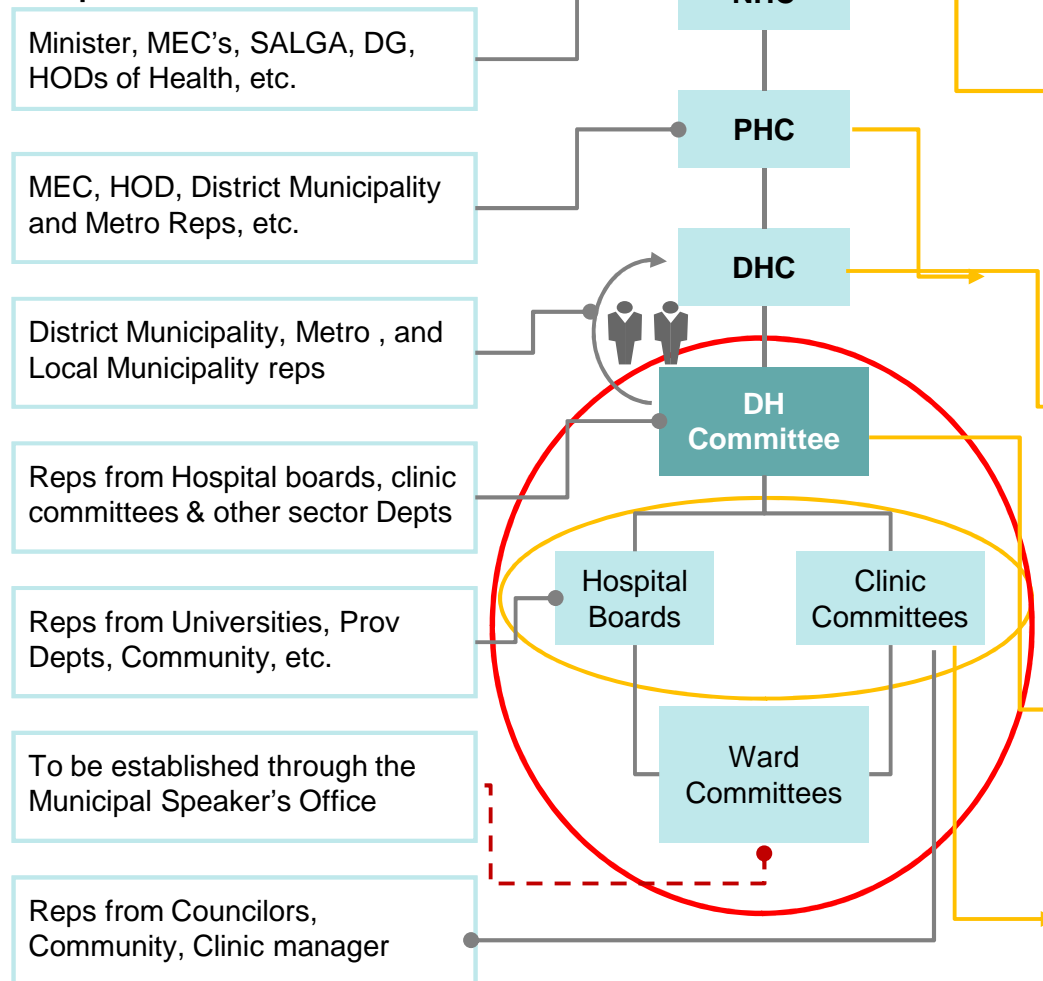|	
Current situation	▪ Health committees do not currently exist in all provinces. Where they do exist, they are not effective (e.g. they do not liaise effectively between the community and clinics and neither with the MEC and higher levels of government) ▪ There is a need to put a coordinating mechanism in place to ensure greater cooperation at grassroots level
Proposal	▪ Establish Hospital boards and Clinic Committees where they do not exist ▪ Create District Health Committee (comprising of representatives from Hospital boards and clinic committees)
Impact	Provide a platform for Hospital boards and clinic committees for: ▪ Coordination of Health issues at local level and the district ▪ ENHANCE ACCOUNTABILITY and participation of communities in governance structures ▪ Advice the District Health Council on issues of Governance

C Improved public accountability by establishing Provincial and District Health Councils and Committees

Legend:
- ☐ Existing
- ■ Proposed
- - - ● Not established through NHA
- ──● Established through NHA
- ──▶ Functions defined in NHA

Composition

- Minister, MEC's, SALGA, DG, HODs of Health, etc.
- MEC, HOD, District Municipality and Metro Reps, etc.
- District Municipality, Metro, and Local Municipality reps
- Reps from Hospital boards, clinic committees & other sector Depts
- Reps from Universities, Prov Depts, Community, etc.
- To be established through the Municipal Speaker's Office
- Reps from Councilors, Community, Clinic manager

NHC / PHC / DHC / DH Committee / Hospital Boards / Clinic Committees / Ward Committees

Function

Advices Minister on:
- Policy to promote and maintain health of the population
- Effective coordination of health services as per the NHA
- Equitable mechanisms for health care funding

Function
- Similar as above but at provincial and district level

Function
- Coordinate Health issues at district level
- Address the social determinants of health at district level
- Enhance accountability and participation of communities in governance structures

Function
- To be determined by the MEC as per PHA[1]

Take-aways
- A new committee needs to be formed eith explicit functions to allow for enhanced public accountability and participation
- This committee will be the District Health (DH) Committee

1 Need for National guidelines and training for standardisation and operationalisation.

D 1000-feet plan for the third initiative

Objective:

- To establish Functional Provincial Health Councils , District Health Councils and Health Committees in all Health Districts and health facilities in the country.

Description:

- Health Councils and Committees do not currently exist in all provinces. Where they do exist, they are not effective , thus there is a need to put a coordinating mechanism in place to ensure improved accountability and responsiveness to communities

Owner:

- NDoH

Key stakeholders identified:

- Premiers & Legislature
- MECs for Health & HODs
- SALGA / Local Govt Heads of Health
- COGTA and Traditional Authorities
- Civil society

Required resources

- Non- financial: skilled members
- Financial: stipends , meetings, training

Key milestones

- Established Health Councils using the NHA by end of May 2015
- National Framework developed for functioning of health committees by end of Sept 2015
- Provincial Health Acts enacted in all provinces by end of 2017/18 that is aligned to the NHA.

D **Increase responsiveness at the point of service delivery through review and implementation of standardised delegations to the lowest possible level of management**

Rationale	Interventions	Impact
▪ Inability of lower levels of managers to initiate interventions timeously and take accountability. ▪ Non-standardization of delegations across provinces, districts, sub-districts and health establishments. ▪ Inadequate implementation and monitoring of delegations, where these exist.	▪ Standardisation of threshold delegations – put in place norms for delegations and monitor and report on adherence to these ▪ Capacity building for all managers to implement the delegations	▪ Empowerment of provincial and district management for prompt and effective decision making and encourage innovation ▪ Improved patients'

D 1000-feet plan for the fourth initiative

Objective:
- Standardise and implement delegations to Facilitate prompt decision making thus enhancing local accountability and responsiveness
- Empower provincial and district managers for prompt and effective decision making and encourage innovation

Description:
- Inability of lower levels of managers to initiate interventions timeously and take accountability.
- Non-standardization of delegations across provinces, districts, sub-districts and health establishments.
- Inadequate implementation and monitoring of delegations, where these exist.

Owner:
- NDoH

Key stakeholders identified:
- NHC; NHC-TAC; Provinces; and National /Provincial Treasury

Required resources
- Non- financial: Leadership, Policy framework, M&E system
- Financial:
  - Training, documentation, technical expertise,

Implementation timeframe

Start – January 2015

End – March 2016

Key milestones
- Delegations framework completed by April 2015
- Training and mentoring of all levels of managers on managing the delegations by December 2015
- Delegations implemented by March 2016

Contents: Institutional Arrangements

- Context & Case for Change

- Aspiration

- Issues & Root Causes

- Initiatives

- **Costing**

Detailed initiative budget – Institutional Arrangements

Total additional budget, R million

Nr	Initiative	2015/16			2016/17			2017/18 – 2018/19			Total
		Capex	Opex	Personnel and training	Capex	Opex	Personnel and training	Capex	Opex	Personnel and training	
	Total										

Budget overview – Institutional Arrangements

Total budget
R million

Total budget
R million