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Review of the Military Health Support Programme within the Department of Defence

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NATIONAL TREASURY

SAVINGS@WORK
GOVERNMENT SPENDING REVIEWS

1. Executive summary

In order for the Department of Defence (DoD) to meet its obligations highlighted in section 200 of the Constitution, Defence Act (2002), Defence Amendment Act (2010), White Paper on Defence (1996), and the Defence Review (2015), it needs a healthy military force. The South African Military Health Services (SAMHS) programme enables the other arms of service to function optimally and effectively. This in turn results in the Defence Force being able to meet its constitutional mandate.

The South African Military Health Services (SAMHS) programme has a budget of R5.3 billion and health related personnel of 7 109. On the face of it, the size of the budget seems large when compared with provincial departments of health and their target populations. The department has a target population of 300 000. The SAMHS delivers health services to the target population through a combination of military hospitals, area military health units and to some extent the private medical facilities and provincial hospitals.

Over the past 5 years, the actual number of patients served by SAMHS ranges between 174 000 and 179 000. So the case load is about 40% below the target, but the budget has been growing by about 5.4 % over the past 5 years. What is even more puzzling is the fact that the department spends about 10% of its COE budget on overtime despite being 40% below the target population. These numbers require explanations and will also be benchmarked against provincial departments of health. Therefore, the aim of this spending review is to investigate some of these apparent inefficiencies that may be inherent in the current service delivery model of SAMHS.

The key findings from the study are as follows:

1. SAMHS spends about 15% of its budget on Admin related functions and this is higher than the benchmark of 10%.
2. SAMHS spends more than 10% of its CoE budget on overtime and this spending is high when compared to provincial departments of health and there seem to be an abuse of the overtime system within SAMHS.
3. SAMHS spends significant amount of its budget on outsourcing of healthcare services to private healthcare facilities. The outsourcing has not prevented SAMHS spending higher amounts on overtime which on the face of it is contradictory especially at 1 Mil Hospital.

4. The ratio of health care professionals to other personnel for SAMHS at frontline hospitals and sickbays is lower than that of the provincial departments of health. This suggests that there may be too many administration and management posts at these frontline facilities.
5. The SAMHS Policy seems too broad in terms of its healthcare benefits coverage and does not have sufficient stringent conditions. Currently, the policy provides comprehensive health care to DoD members and their dependents, which becomes a main cost driver for outsourced services.

Taking consideration of these findings and the SAHMS context, the following recommendations are made:

- SAMHS must put in place more stringent controls on overtime payments (specific monitoring and control measures should be in place). Defence's policy on overtime for medical personnel should be strictly aligned to the National Policy on Commuted Overtime for Medical & Dental Personnel. The department could save about R60 million rand per year by aligning their overtime policies to the provincial department of health and putting in place for stringent controls. The analysis shows that they are spending more on overtime that the best performing provincial departments of health.
- In terms of outsourcing, SAMHS should only outsource tertiary services that are not cost efficient to insource and must make greater use of provincial tertiary hospitals by minimising transfers to private medical health facilities.
- The department should reduce the share of spending directed to administrative functions. Management and administration related functions should be kept at a minimum within SAMHS. In our view, the department could save about R88.6 million per year from reviewing the structure.
- Defence must look into gradually changing the structure of its healthcare facilities so that over time the ratio of healthcare practitioners to non-healthcare practitioners is significantly more than what we are observing at the moment.
- Defence must relook at its benefit structure contained in its Healthcare Delivery Model Policy. As it stands, the policy is broad, especially in terms of the benefits provided to the target population. Most medical aids put a cap on what you can qualify for and also specify how much you must pay to qualify for certain benefits.

By implementing these recommendations, the DoD can realise a total saving of R148.6 million per year. These savings can be reprioritised towards other emerging spending

pressures within the department such as funding for border safeguarding to deal with porous borders and transnational crimes.

2. Summary

The aim of this spending review is to investigate if there are inefficiencies inherent in the current service delivery model of the SAMHS. The spending review will analyse the overtime and outsourcing models to determine whether there are inefficiencies within these models. Analysis will also include a comparison of the relative allocation of resources across frontline services and management and administration. The SAMHS model will also be benchmarked against the provincial departments of health in order to determine if resources allocated to SAMHS are being used optimally. Lastly, the spending review will analyse the efficiency of the SAMHS health care policy.

Currently, the SAMHS Programme has a budget of R5.3 billion and health related personnel of 7 109. On the face of it, the size of the budget seems large when compared with provincial departments of health and their target populations. The department has a target population of 300 000. The SAMHS delivers health services to the target population through a combination of military hospitals, area military health units, and to some extent the private medical facilities and provincial hospitals.

Over the past 5 years, the actual number of patients served by SAMHS ranges between 174 000 and 179 000. So the case load is about 40% below the target, but the budget has been growing by about 5.4 % over the past 5 years. What is even more puzzling is the fact that the department spends about 10% of its COE budget on overtime despite being 40% below the target population. These numbers require explanations and are benchmarked against provincial departments of health. Therefore, the aim of this spending review is to investigate some of these apparent inefficiencies that may be inherent in the current service delivery model of SAMHS.

The key findings from the study are as follows:

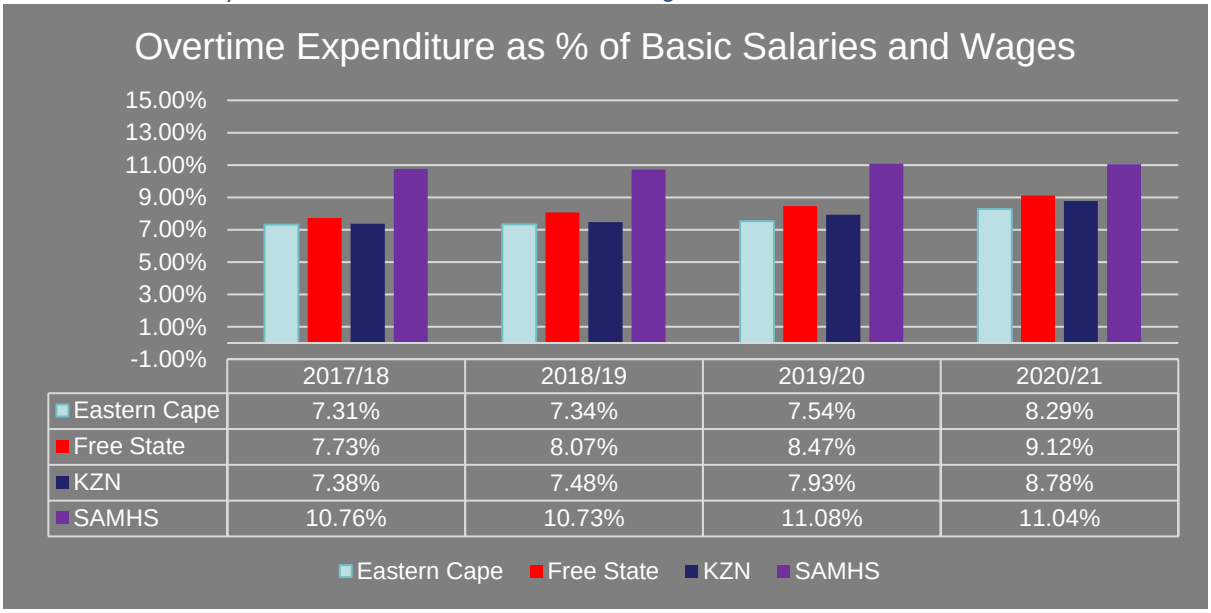
1. SAMHS spends about 15% of its budget on admin related functions and this is higher than the benchmark of 10%.
2. SAMHS spends more than 10% of its CoE budget on overtime and this spending is higher when compared to provincial departments of health. From data analysis, there seem to be an abuse of the overtime system within SAMHS.

3. SAMHS spends significant amount of its budget on outsourcing of healthcare services to private healthcare facilities. The outsourcing has not prevented SAMHS spending higher amounts on overtime which on the face of it is contradictory (Especially at 1 Mil Hospital).
4. The ratio of health care professionals to other personnel for SAMHS at frontline hospitals and sickbays is lower than that of the provincial departments of health. This suggests that there may be too many administration and management posts at these frontline facilities.
5. The SAMHS Policy seems too broad with respect to healthcare benefits coverage, and does not have sufficient stringent conditions. Currently, the policy provides comprehensive health care to DoD members and dependents, which becomes a main cost driver for outsourced services.

Taking consideration of these findings and the SAHMS context, the following recommendations are made:

1. SAMHS must put in place more stringent controls on overtime payments (specific monitoring and control measures should be in place). When compared with the best performing provincial department of health department, we see that there is room for SAMHS to improve efficiency in terms of overtime. SAMHS is consistently higher than the selected provincial department of health departments (Table 1 below). Defence's policy on overtime for medical personnel should be strictly aligned to the National Policy on Commuted Overtime for Medical & Dental Personnel. The department could save about R60 million rand per year by aligning their overtime policies to the provincial department of health, and putting in place for stringent controls. The analysis shows that they are spending more on overtime that the best performing provincial departments of health.

Table 1: Overtime Expenditure as % of Basic Salaries and Wages



	2017/18	2018/19	2019/20	2020/21
Eastern Cape	7.31%	7.34%	7.54%	8.29%
Free State	7.73%	8.07%	8.47%	9.12%
KZN	7.38%	7.48%	7.93%	8.78%
SAMHS	10.76%	10.73%	11.08%	11.04%

Source: BAS

2. In terms of outsourcing, SAMHS should only outsource tertiary services that are not cost efficient to insource and must make greater use of provincial tertiary hospitals by minimising transfers to private medical health facilities. Table 2 below shows that the department spends about 10% on outsourced medical services. When one considers SAMHS is 40% below their target case load, and spends a significant amount on outsourcing, one wonders what exactly do the health care professionals do on a daily basis? It might indicate that health care professionals and not being used optimally and effectively.

Table 2: Outsourcing Expenditure

	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Basic Salaries and wages		2 309 716 241	2 496 672 653	2 611 851 303	2 633 829 634
Other components of salaries and wages	3 091 687 043	965 458 398	1 019 190 773	1 088 270 622	1 141 604 195
Outsourced medical services	408 221 914	539 514 210	470 568 692	521 342 823	518 289 193
Other goods and services	431 154 567	367 713 521	381 111 045	401 488 326	413 845 857
Overtime	237 096 165	248 510 741	267 817 643	289 315 494	290 901 075
Medicines	197 208 967	243 193 214	246 639 331	237 066 347	273 830 602
medical supplies	8 591 828	63 566 537	84 676 326	80 126 118	116 584 357
Other	74 784 110	115 233 912	123 914 206	133 447 017	102 508 792
Grand Total	**4 448 744 594**	**4 852 906 774**	**5 090 590 668**	**5 362 908 051**	**5 491 393 703**

Source: BAS

3. The department should look to reduce the share of spending directed to administrative functions. Management and administration related functions should be kept at a minimum within SAMHS. In our view, the department could save about R88.6 million per year from reviewing the structure. Defence must look into gradually changing the structure of its healthcare facilities so that over time the ratio of healthcare practitioners to non-healthcare practitioners is significantly more than what we are observing at the moment. Table 3 below shows a summary of spend on Administration and Management for 2020/21 for the SAMHS. The department spends significantly more than the recommended 10% benchmark.

Table 3: Administration and Management- Actual vs Target

Actual (17%)	951 709 598
Target (10%)	549 139 370
Potential Savings	402 570 228
22% of Potential Savings	88 565 450

Source: BAS

4. We recommend that Defence must relook at its benefit structure contained in its Healthcare Delivery Model Policy. As it stands, the policy is broad, especially in terms of the benefits provided to the target population. Most medical aids put a cap on what you can qualify for and also specify how much you must pay to qualify for certain benefits.

Therefore, DoD can realise a total saving of R148.6 million per year. We recommend that the identified savings be reprioritised towards other emerging spending pressures within the department such as funding for border safeguarding to deal with porous borders and transnational crimes

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This document is not for quoting or circulation. It was done as part of the NT training exercise on the spending review methodology and is intended for discussion purposes. Furthermore, there were some data limitations and both the appropriate level of information, and its correctness could not be independently verified.

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3. Introduction

The importance of having military personnel that are fit and healthy cannot be taken lightly. James F Dunnigan in his seminal How to Make War notes that *"combat does not destroy armies; it merely hastens the process. The real killer is day-to-day wear and tear."* Turning to military health he notes: *"Annually, disease and non-combat injuries often cause far more loss than the dangers of combat. … As long as the troops are living in primitive field conditions, they are more prone to disease and injury."*

In order for the Department of Defence (DoD) to meet its obligations highlighted in section 200 of the Constitution, Defence Act (2002), Defence Amendment Act (2010), White Paper on Defence (1996), and the Defence Review (2015), it needs a healthy military force. The South African Military Health Services (SAMHS) plays a supporting role to the other arms of service. This means that the structure and plans of the other arms of service have a direct impact on the SAMHS.

3.1 Problem Statement and Context

The SAMHS programme provides health capabilities to the other arms of service. The SAMHS enables the other arms of service to function optimally and effectively. This in turn results in the Defence Force being able to meet its constitutional mandate.

The aim of this spending review is to investigate if there are inefficiencies inherent in the current service delivery model of the SAMHS. The spending review will analyse the overtime and outsourcing models to determine whether there are inefficiencies within these models. Analysis will also include a comparison of the allocation of resources share for frontline services and management and administration. The SAMHS model will also be benchmarked against the provincial departments of health in order to determine if resources allocated to SAMHS are being used optimally. Lastly, the spending review will analyse the efficiency of the SAMHS health care policy.

Currently, the SAMHS Programme has a budget of R5.3 billion and health related personnel of about 7 109. The yearly target population for SAMHS is about 300 000.However, the SAMHS patient population for the past 5 years ranges between 174 000 and 179 000. The patient population

consists of the regular force, dependants, reserve force, military skills development and military veterans. For the 2020/21 financial year, the dependants was the biggest contributor to the total patient population (72 291), whilst the regular force was the second biggest contributor with 61 662 patients. The total patient population for the past 5 years has been included in appendix 3.

4. Policy and Institutional Information

4.1 Key policy, laws and regulations

Table 1 below summarises the key policies, laws, and regulations governing the SAMHS.

Table 4: Key Policy, laws and regulations

Policy, Law or regulation	Purpose	How it affects SAMHS?
Process and procedures on South African Military Health Services Health care delivery	This publication describes the process and procedures to be followed with respect to the health care delivery in the SAMHS.	This publication explains what medical services will be provided to the regular force members, dependants and military veterans. The publication explains the various medical services that are available to the target population
National Health Act, 2004.	To provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith.	The National Department of Health will in certain situations make use of the personnel of the SAMHS. For example, when there is a shortage of personnel, or crises situation, SAMHS will assist the National Department of Health to achieve its outcomes of providing health care to the citizens of South Africa.
Defence Review 2015	The review provides a long-term Defence Policy and Defence Strategic Trajectory to be pursued by the country over four Medium-	The Defence Review highlights that some of the standards that military personnel will need to adhere to. Moreover, The Defence Review

Policy, Law or regulation	Purpose	How it affects SAMHS?
	Term Strategic Framework periods.	explains some of the activities that will be done within Defence to promote health among defence members.
Defence Act of 2002	To provide for the defence of the Republic and for matters connected therewith.	The Act outlines the steps involved in dealing with injury or disability sustained by military personnel. Moreover, the Act outlines the medical, dental and hospital benefits that Defence must provide for its regular force and dependants. Lastly, the Act highlights the right of recourse in terms of expenditure for injuries of members.
The Constitution of the Republic of South Africa, 1996	The Constitution sets out South Africa's values, the rights of the people, how Parliament and the other legislatures work, how the national and provincial executives are chosen, and how the courts work.	According to section 27 of the constitution, everyone has the right to access health care services, including reproductive health care. Although the SAMHS provides health services the designated beneficiaries, there are also instances where the SAMHS will assist the National Department of Health whenever there is a shortage of medical personnel due to crises situations such as pandemics.
Government Immovable Asset Management Act of 2007	To provide for a uniform framework for the management of an immovable asset that is held or used by a national or provincial department; to ensure the	The Government Immovable Asset Management Act of 2007 applies to all organs of state. Any immovable asset acquired or owned by government will be subject to this Act.

Policy, Law or regulation	Purpose	How it affects SAMHS?
	coordination of the use of an immovable asset with the service delivery objectives of a national or provincial department; to provide for issuing of guidelines and minimum standards in respect of immovable asset management by a national or provincial department; and to provide for matters incidental thereto.	Therefore, Defence, and specifically the SAMHS, as the user of immovable assets owned by government are subject to this Act. Accordingly, one of the objectives of this Act is to ensure optimisation of cost of service delivery by means of the maintenance of immovable assets by the DPWI as the custodian of government's immovable assets.
Defence Review 2015	The review provides a long-term Defence Policy and Defence Strategic Trajectory to be pursued by the country over four Medium-Term Strategic Framework periods.	The Defence Review highlights that some of the standards that military personnel will need to adhere to. Moreover, The Defence Review explains some of the activities that will be done within Defence to promote health among defence members.
Defence Act of 2002	To provide for the defence of the Republic and for matters connected therewith.	The Act outlines the steps involved in dealing with injury or disability sustained by military personnel. Moreover, the Act outlines the medical, dental and hospital benefits that Defence must provide for its regular force and dependants. Lastly, the Act highlights the right of recourse in terms of expenditure for injuries of members.
PFMA	The object of this Act is to secure transparency, accountability, and	The SAMHS programme makes use of health equipment and facilities.

Policy, Law or regulation	Purpose	How it affects SAMHS?
	sound management of the revenue, expenditure, assets and liabilities of the institutions to which this Act applies.	The Accounting Officer, and specially the programme manager of the SAMHS Programme must make sure that assets are managed in accordance with the PFMA. Moreover any procurement of equipment, pharmaceuticals etc. must be done in accordance with the PFMA.
Treasury Regulations	In terms of sections 76, of the PFMA, the National Treasury may make regulations or issue instructions applicable to all institutions to which the PFMA applies to promote and enforce transparency and effective management in respect of revenue, expenditure, assets and liabilities.	The treasury regulations state the responsibilities of Accounting Officers in terms of managing the assets of the department, and making sure that assets are used economically and in an efficient manner. Moreover any procurement of equipment, pharmaceuticals etc. must be done in accordance with the PFMA.

4.2 Key Stakeholders

Within the Department of Defence, the key stakeholders are the Minister of Defence and Military Veterans, Secretary for Defence, Chief of the South African Defence Force (SANDF), Chiefs of Services, Chief of Joint Logistics, Chief of procurement and the Surgeon General.

The Minister directs and controls the performance of the Defence function through the Council on Defence. The plans developed by the council of Defence would be implemented by the various

arms of service. Any plans developed by the various arms of service would need the support from the SAMHS as a healthy and fit military personnel is required to implement any plans developed.

The Chief of procurement would provide strategic oversight to the Military Health Procurement unit in terms of procuring Military Health equipment and pharmaceuticals. The Chief of Joint Logistics would provide strategic oversight to the Military Health Logistics function in terms of the warehousing of any pharmaceuticals and equipment bought.

The SAMHS also has relationships with various external stakeholders, namely the National Department of Health, provincial departments of health , private health care providers, and the Department of Public Works and Infrastructure (DPWI).

Normally the SAMHS would make use of Area Military Health Units (AMHU) and hospitals located across the country to service its members. These AMHU's are commonly referred to as sickbays. However, if there are no AMHU's and hospitals available in a certain area, the SAMHS would make use of the services of the provincial departments of health to provide health services to the intended beneficiaries. Another key stakeholder are private health care providers. SAMHS would make use of private health care services for instances where a certain specialisation is not available within the SAMHS.

Lastly, the DPWI as the landlord of all government facilities, maintains all the facilities that the SAMHS uses. The importance of maintenance needs to be highlighted. Lack of proper maintenance of facilities can lead to the dilapidation of facilities, which in turn leads to higher refurbishment costs. Therefore, the relationship between Defence (specifically SAMHS) and the DPWI is crucial in making sure that costs are kept to a minimum. A case in point is the delay in the refurbishment of 1 Military hospital. This has resulted in SAMHS having to outsource some of its activities to the private sector because of the delay in finalising the refurbishment of 1 Military Hospital

5. Programme Chain of Delivery

5.1 Understanding how programme works

The SAMHS provides health services to the South African National Defence Force (SANDF), military veterans and their dependants. According to the SAMHS Process and Procedures Publication, the Surgeon General *"Is responsible for providing prepared and supported military medical health capabilities, services and facilities in support of the defence of South Africa that meet the requirements of Government."*

The Surgeon General would oversee Military Health Force Preparation and Military Health Force Support[1].

The Military Force Preparation Function consists of the following directorates:

Medicine, Nursing, Oral Health, Psychology, Social Work, Animal Health, Ancillary Health, Pharmacy, SSO Environmental Health, and Medical Support.

The Military Health Force Support functions consists of the following directorates:

Military Health Logistics, SSO Health informatics, Human Resource and Patient Administration.

The Surgeon General also oversees the following formations and units:

Mobile Military Health Formation (Battalion Groups); Tertiary Military Health Formation (Hospitals and Medical institutes); Area Military Health Formation (Geographical sickbays); Military Health Support Formation (Procurement and Base Depot); and Military Training Formation (Training, School and college)

The Mobile Military Health Formation; Tertiary Military Health Formation and Area Military Health Formation are the frontline services provided to the regular force members, military veterans, and their dependants. The Military Health Support Function provides "administration" by means of procurement and base support. Military Training Formation provides the training function for the SAMHS.

The Military Health Support programme is divided into 7 sub-programmes. Table 2 below is a summary of the sub-programmes within SAMHS.

Table 5: SAMHS Sub-programmes

[1]Full Organogram included as an appendix

Strategic Direction	Formulates strategy, policies and plans; and provides advice from the surgeon-general's office to prepare and provide the capabilities required by the Chief of the South African National Defence Force.
Mobile Military Health Support	Provides health support for deployed and contingency forces, and health services to provincial hospitals and the Department of Health, as and when ordered.
Area Military Health Service	Provides a comprehensive, self-supporting, multidisciplinary geographic military health service through a formation headquarters, and commanding and controlling 9 area military health units to ensure a healthy military community. The military hospitals also attend to health care activities, medical support and health activities in the specialist aviation environment.
Specialist/Tertiary Health Service	Provides a specialist health service to develop and maintain tertiary military health capabilities within the parameters of relevant legislation, as contained in the South African military health service strategy.
Military Health Product Support Capability	Provides for the warehousing of pharmaceuticals, sundries, military health mobilisation equipment and unique stock; the procurement of unique military health products, materials and services; an asset management service; military health product systems; and cooperative common military health logistics.
Military Health Maintenance Capability	provides general base support services to identified military health service units to sustain and maintain the approved force design and structure.
Military Health Training Capability	provides a military health training service to develop and maintain military health training capabilities within the parameters of relevant legislation and policies.

Source: 2021 Estimates of National Expenditure

5.2. The programme logical framework

Impact: SANDF are equipped to protect the interests of SA and its citizens

The SAMHS primary purpose is to provide health services to all the members of the military so that the Navy, Army and Air Force are equipped to meet their respective mandates, and the overall SANDF mandate. Notwithstanding this, the SAMHS services between 174,000 and 179,000 patients per annum. The dependants, and not the military personnel make up the biggest share of this patient population. Total patient population for the past 5 years has been included in section 6.1.

Outcome 1: A health support capability for deployed and contingency forces.

The first outcome that is required to achieve the above impact is a health support capability for deployed and contingency forces. It is critical that deployed and contingency forces are healthy so that they can carry out whatever task they need to carry out.

Outcome 2: A comprehensive, multidisciplinary military health services to service personnel and Military Veterans.

The second outcome required to achieved the above impact, is SAHMS' provision of health services to the military personnel and military veterans. These services are usually provided through the tertiary hospitals, and the AMHU's (geographical sickbays across the country). If the health services are not available in an area, the SAMHS will need to make use of the provincial departments of health. Moreover, if specific skills are not available within the SAMHS, the expertise of the private sector will be used.

Outcome 3: SANDF contributes to a Long and Healthy Life for all South Africans

The 3rd outcome associated with this programme not only applies to the military personnel, military veterans, and their dependents, but also applies to the citizens of the South Africa. This would apply in situations where SAMHS is required to assist the National Department of Health in situations where there is a shortage of staff.

Outcome 1 Outputs: Ability to deploy and maintain field hospitals; Field hospitals deployed and maintained; Ability to provide emergency evacuation services; Emergency evacuation services provided; and Training of Staff.

Field hospitals provide the military personnel with the opportunity to receive health services whenever they are deployed. The SANDF must be able to provide emergency evacuation services to preserve the lives of the military personnel. Staff must be trained so that they can adequately provide health services in the field hospitals and during emergency evacuation services.

Outcome 2 Outputs: Training of Staff; Inpatient health care support (Emergency and trauma/ Injury based care/illness); Outpatient health care support(rehab care, consultative care, specialised services); Functional medical facilities i.e. hospitals, sick bays in barracks; Preventative Health care programmes (e.g. Vaccination drives, mental health campaigns, HIV prevention programmes, TB prevention programmes)

Training of staff is required to ensure that the military health personnel are skilled and prepared to provide various medical services. SAMHS provides various medical services such as both inpatient and outpatient health care support to meet the health needs of the military personnel, military veterans and their dependents. In order to provide inpatient and outpatient services, SAMHS requires functional medical facilities to treat the military personnel, military veterans, and their dependents. Preventative health care programmes are also utilised to reduce the effects of diseases such as TB and HIV AIDS.

Outcome 3 Outputs: Research Facilities; Deployment of staff to the public health care facilities; and Sharing of Facilities

The SAMHS are sometimes required to deploy medical personnel and share medical facilities with the Department of Health to provide health services to the citizens of the country. The research facilities provide the SAMHS with the opportunity to solve health problems and to grow in health care knowledge.

5.3 Resources and process key to the programme

The SAMHS provides health care support services to the various beneficiaries mentioned in its policy document. SAMHS provides 3 levels of health care services namely, primary, secondary, and tertiary health services. According to the SAMHS policy, the 3 levels operate as follows:

Primary Health Care: Primary health care is not only the foundation of the care continuum, but it is also the entry point into the system where equity must be ensured through maximising accessibility during normal working hours, except under operational circumstances.

Secondary Health Care: Secondary health care is the environment where small surgical interventions and short admissions into a health care facility is needed to determine initial patient response or to finalise a diagnosis, before transferring the patient to the tertiary level. Secondary military health care and support has the minimum s Health Care Practitioners (HCP's) after normal working hours.

Tertiary Health Care: Tertiary health care is the environment where specialist services, including rehabilitation, are rendered around the clock. The tertiary health care services also include the following specialist functions.

- Aviation medicine (Institute for Aviation Medicine - IAM),
- Maritime medicine (Institute for Maritime Medicine - IMM),
- Psychology (Military Psychological Institute - MPI), and
- Animal health (Military Veterinary Institute – MVI).

The SAMHS makes use of 4 major resources to provide health services to the various beneficiaries:

1. The first major resource is human resources which can be divided into health care professionals and other personnel. Health care professionals includes doctors and nurses, whilst other personnel refer to the personnel who would assist with the administration and running of the SAMHS programme.
2. The second major element is the medicine and medical supplies that are given to the patients.
3. The third major resource is property. The properties include the three military hospitals in Tshwane, Cape Town, and Bloemfontein, the nine AMHU's across the country and the four specialist health care institutions.

4. The last major resource is the machinery and equipment. The machinery and equipment allow the health care professionals to provide health services to the targeted group.

5.4 Impact of savings on service delivery and quality of outputs

Due to the current constrained economic condition of the country, it is imperative that departments find efficient and effective ways to meet their mandate. Since the 2012 MTEF, the baseline of the DoD has been reduced by R48.6 billion due to Cabinet approved budget cuts as a result of constrained fiscal environment. This has led to decline in some defence capabilities. According to the department, these budget cuts have hindered the department's ability to rejuvenate the SANDF and increase the capacity for border safeguarding to protect the country's territorial integrity. This means that the Department has to focus on realising efficiency savings in order to fund emerging priorities and critical defence capabilities given the constrained fiscal environment.

For the SAMHS, a failure to adjust to these budget cuts, could lead to the SAMHS not being able to upgrade their facilities, which could result in further outsourcing of activities (meaning higher costs). It could also mean that the military hospitals would be unable to procure the medicines, medical supplies and the machinery and equipment required to function optimally.

Therefore, the Department of Defence, specifically the SAMHS, has to ensure that measures are put in place to induce savings through efficiency measures to compensate for the cuts that have taken place over the last couple of years. If the department were to induce savings, these savings could be used for other pressing matters within the department. Although there is a need to achieve savings, it is imperative that the actions taken to achieve savings do not affect the quality of service delivery and outputs.

As already mentioned, SAMHS is a support service, and if for example certain equipment is not available to treat the military personnel, this will have a direct impact on the other arms of service, and ultimately could affect combat readiness.

The lack of proper equipment will also mean that SAMHS will not be able to provide certain health services. This will mean that these health services will need to be outsourced to the private sector

at a steep cost. Therefore, it is imperative that proper diligence and care is taken when analysis is done in terms of availability of savings within the SAMHS.

6. Performance Analysis

6.1 Performance Indicators

Table 3 below shows some of the performance indicators for the SAMHS programme. Unfortunately, most of the information is classified because the information is related to national security. The only indicator that is available is the percentage compliance with the military health service training target indicator. It is also important to point out that the this indicator had been meeting its target before covid-19 but has seen a decline due to the covid-19 pandemic.

Table 6: Selected Performance Indicators

	2017/18		2018/19		2019/20		2020/21	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Percentage compliance with Military Health Service training targets	80% (648)	98% (790)	80% (648)	80% (649)	80% (648)	79% (640)	80% (648)	29.14% (236)
Percentage compliance with Joint Force Employment requirements as resourced	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified
Percentage combat-ready capabilities available for the SANDF	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified
Percentage compliance with capabilities required to support national efforts in mitigating and combating the spread of COVID-19	-	-	-	-	-	-	100%	100%
Percentage availability of medical stock	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified	Information Classified

Source:2020/21 Preliminary Annual Report

In order mitigate for the lack of performance information, we will use the expenditure information of SAMHS, and compare that with the with the Provincial departments of health to see exactly where funds are being used and whether there is scope to induce savings as highlighted in the previous section. This will be further discussed in the expenditure observations section. Secondly,

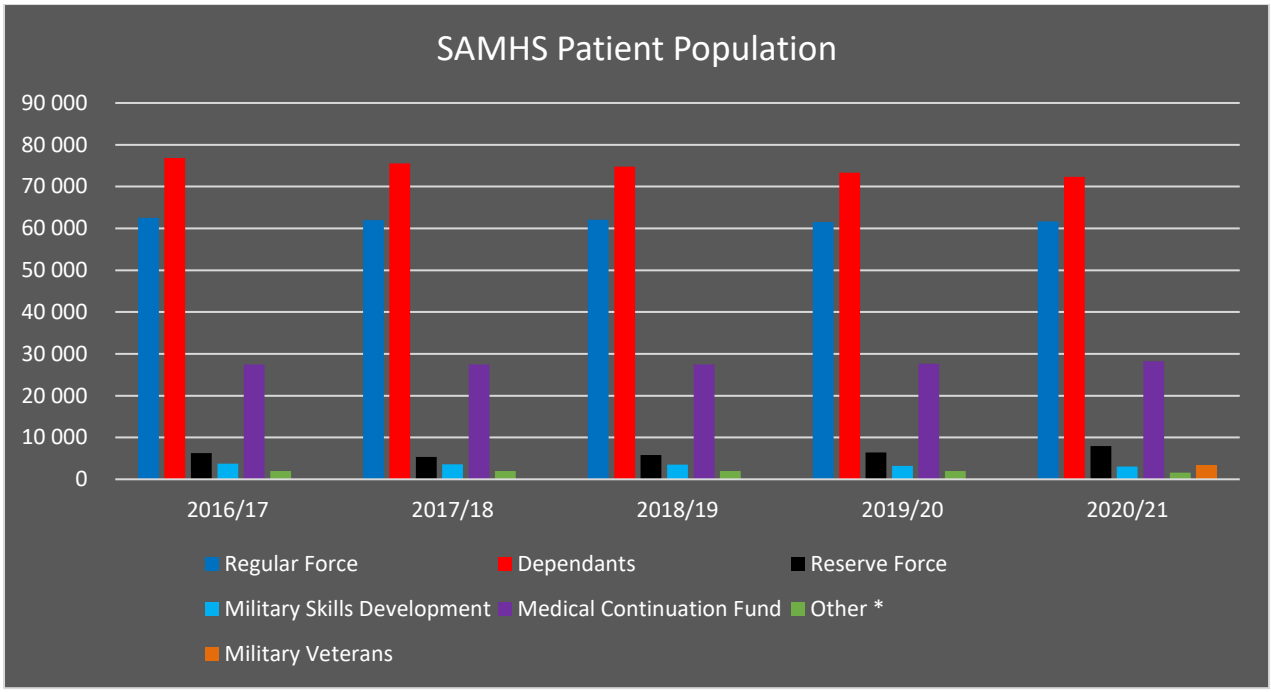
we will look at the amount of patients that SAMHS provides with health care services on an annual basis. Table 4 and Figure 1 below show the SAMHS patient population. What is surprising is the number of dependents that receive health care benefits, as compared with the regular force. This might require more stringent requirements been put in place to cap the amount of benefits the dependants receive as dependants are the main cost driver.

Table 7: SAMHS Patient Population

	2016/17	2017/18	2018/19	2019/20	2020/21
Regular Force	62 555	61 990	62 070	61 508	61 662
Dependents	76 804	75 534	74 752	73 300	72 291
Reserve Force	6 266	5 349	5 816	6 409	7 925
Military Skills Development	3 736	3 593	3 526	3 207	3 064
Medical Continuation Fund	27 473	27 484	27 444	27 606	28 257
Other *	1 971	1 965	1 978	1 989	1 624
Military Veterans	0	0	0	0	3 292
TOTAL	**178 804**	**175 915**	**175 587**	**174 018**	**178 115**

Source: Department of Defence

Figure 1: SAMHS Patient Population



Source: SAMHS

6.2 SAMHS Health Care Process and Procedures Publication

The SAMHS provides health services to its members, their dependants and other clientele in accordance with the SAMHS publication. The SAMHS publication explains that the health status of DoD member is a strategic issue.

According to the SAMHS publication, section 1-10.59 states that comprehensive health care is delivered to members of the DoD and approved clientele through an infrastructure within the SAMHS that makes provision for a complete continuum of care.

According to section 1-3.13 the approved clientele includes registered Regular Force members and their registered dependants (spouses and children), pensioners and their dependants registered with the Regular Force Medical Continuation Fund (RFMCF)as well as any person with approved authority to be treated by the SAMHS e.g., the President, former Presidents, members of parliament, members of the Military Skills Development System and Reserve Force members during call-up. Approved clientele also includes former Regular Force members who, through compelled demilitarisation, become a DOD employee and choose to be a member of the RFMCF (CS suffix added to their Force No).

Section 1-4.20 of the SAMHS policy stipulates who qualifies as a dependant for both spouse and child. However, what might require some rethinking is how much health care benefits the approved clientele gets. For example, the Government Employment Scheme (GEMS) works on the premise the more you contribute towards to scheme, the greater your benefits. Moreover, there are caps as to how much you can qualify for. If for example you need a certain procedure done, it is capped at certain level. The benefits for the approved clientele of SAMHS regardless of how much you contributed are the same for all the approved clientele. You will receive comprehensive healthcare, and no expenditure limits are specified in the publication.

7. Expenditure Observations

The expenditure analysis focused on 3 analytical threads:

1. A comparison of the historical expenditure on the SAHMS to the expenditure on other Defence programmes as well as to the total expenditure on the defence.
2. An exploration of the allocative inefficiencies within SAHMS by comparing how much is spent on frontline / core resources vs. non-frontline resources / non-core services . This was complemented by looking at how much of the SAMHS expenditure goes towards Health care personnel and how much goes towards other personnel.
3. An exploration of the outsourcing and overtime models used within the SAMHS.

7.1 Comparison of SAHMS Expenditure to Other Defence Programme

With reference to the table below, over the 5-year period, FY 2016/17 to FY 2020/21, the Department's of Defence's annual expenditure has grown at an average rate of 3.2% per annum. In contrast, expenditure on the SAHMS has grown at average annual rate of 5.4% per annum. This suggests that the SAHMS has largely been unaffected by cuts to the overall defence budget. Over the same period SAHMS has accounted for an average of 10.1% of the defence department's expenditure.

Table 8: 5-year expenditure for Defence

Programme	2016/17	2017/18	2018/19	2019/20	2020/21	Average: Expenditure/Total (2016/17 - 2020/21) %	Average growth rate(%) 2016/17 - 2020/21
Administration	5 740 558 797	5 505 180 224	5 692 748 103	5 993 160 406	5 325 012 186	11.3%	-1.9%

Force Employment	3 431 011 073	3 208 000 513	3 168 677 804	3 491 507 783	4 544 595 106	7.2%	7.3%
Landward Defence	15 557 821 818	16 673 536 122	16 427 498 834	16 763 706 486	17 186 568 750	33.2%	2.5%
Air Defence	6 782 585 576	6 753 390 576	6 257 442 916	6 701 150 101	7 684 711 310	13.7%	3.2%
Maritime Defence	4 298 384 710	4 631 876 741	4 503 929 931	4 709 410 806	4 607 953 219	9.1%	1.8%
Military Health Support	**4 448 744 594**	**4 852 906 774**	**5 090 590 668**	**5 362 908 051**	**5 491 393 703**	**10.1%**	**5.4%**
Defence Intelligence	881 289 044	887 995 892	938 173 407	1 002 361 669	1 130 930 729	1.9%	6.4%
General Support	6 056 698 474	6 456 378 903	6 413 011 455	6 858 054 000	7 656 692 448	13.4%	6.0%
Grand Total	**47 197 094 085**	**48 969 265 746**	**48 492 073 118**	**50 882 259 302**	**53 627 857 450**	**100.0%**	**3.2%**

Source BAS

7.2 Allocative Efficiencies within SAHMS

To assess if there are any allocative inefficiencies within the SAHMS, the share of the total expenditure allocated to frontline / core resources was compared to the share of expenditure allocated to non-frontline resources / non-core services. This was complemented by looking at how much of the SAMHS expenditure goes towards Health care personnel and how much goes towards other personnel.

For the purpose of this analysis, the SAHMS cost (responsibilities) centres and their associated budget programmes in BAS were firstly grouped into 10 services as listed below:

- hospital services
- sickbays within the geographical areas
- military health training
- strategic direction
- auxiliary services
- conventional military health support
- specialised services
- Financial Management Services.

Further based on the cost centres and associated budget programmes, the expenditure under each service was allocated to one of 3 service types based on the assumed proximity to the end user.

- Frontline/core services refers to cost centres and associated budget programmes whose outputs are directly enjoyed / used by the SAHMS ultimate beneficiaries
- Shared service refers to cost centres and associated budget programmes whose outputs are used by the cost centres/budget programmes that directly serve the SAHMS ultimately

beneficiaries. As results, these are outputs are said to be indirectly enjoyed by the ultimately beneficiaries.

- Management and administrative services refer to cost centres and associated budget programmes whose outputs are neither directly or indirectly enjoyed by the SAHMS ultimately beneficiaries. Though necessary for the running of the SAHMS, they take away resources from activities that either directly or indirectly benefit the ultimate beneficiaries

Therefore, efficient organisations seek to allocate the bulk of their expenditure on frontline or shared services, with as little as possible going to management and administrative services.

As shown in Table 6 below, in terms of services, over the reviewed 5-year period, 77% of the total expenditure over the 5-year period was on Hospital services and Sickbays within Geographical areas. Within these services, the majority of their expenditure (91% and 85% respectively) was on frontline facility/services. 1% was spent for management and admin for hospital services, and 13.85% for management and admin for sickbays within geographical areas. The share of management and admin within the Sickbays within the Geographical areas is particularly concerning when one considers that the Sickbays are set up to service the intended beneficiaries, and not to do admin related activities.

Based on the above, the numbers indicate that there is an allocative inefficiency in terms of spending at the frontline facilities of the SAMHS. What is also concerning about Table 6 is the management and administration taking place across the various service types (Hospital Services, Sickbays, Military Health Training etc). This seems to indicate that there are duplicated administration functions within the SAMHS.

The third largest service in terms of expenditure is Strategic Direction which accounts for about 5% of the total budget. However as shown in table 6, there is also management and administration services under each of the services. When one adds the Management and Administration expenditure under the various service to that the expenditure on management and administration incurred under strategic direction, the spend for 2020/21 was about R951.7 million, which is about 17% of the budget. Over a 5-year period, the total spent for management and admin is about 15% The rule of thumb in terms of spending for management and administration is that a department should not spend more than 10% of its budget (whether at a vote or programme level) on administration functions.

The department argues that there has been centralisation of some frontline services' expenditure within Admin over the same period (e.g., military health training budgets). However, the SAMHS will need to look into ways to improve the efficiency of this programme.

Table 9: Service Type and Expenditure Type Expenditure

Service Type and Facility Type	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	5 year Total	Total %
Hospital Services	**1 612 841 929**	**1 814 134 473**	**1 940 363 798**	**2 100 225 732**	**2 208 893 194**	**9 676 459 126**	
Frontline Facility/Services	1 504 389 639	1 680 935 160	1 778 734 060	1 938 077 704	1 862 542 976	8 764 679 539	90.58%
Management and Admin	17 614 588	19 657 676	22 674 484	21 998 966	53 742 799	135 688 514	1.40%
Shared Services	90 837 702	113 541 636	138 955 253	140 149 062	292 607 419	776 091 073	8.02%
Sickbays within Geographical areas	**1 754 105 346**	**1 900 124 655**	**2 011 974 314**	**2 127 011 000**	**2 094 390 240**	**9 887 605 556**	
Frontline Facility/Services	1 552 256 797	1 639 700 287	1 715 417 518	1 776 986 147	1 731 688 628	8 416 049 376	85.12%
Management and Admin	146 353 392	189 798 708	209 170 734	305 356 905	315 249 967	1 165 929 706	11.79%
Shared Services	55 495 157	70 625 661	87 386 062	44 667 949	47 451 645	305 626 474	3.09%
Military Health Training	**335 060 390**	**341 224 395**	**352 080 506**	**358 165 421**	**372 141 378**	**1 758 672 090**	
Frontline Facility/Services	118 380 296	112 745 914	100 022 480	100 902 242	104 062 211	536 113 144	30.48%
Management and Admin	216 680 093	228 478 481	252 058 025	257 263 179	268 079 167	1 222 558 946	69.52%
Conventional Military Health Support	**121 515 071**	**140 285 120**	**163 384 392**	**225 519 067**	**191 026 837**	**841 730 486**	
Frontline Facility/Services	121 483 341	129 212 787	163 375 093	184 686 870	178 325 101	777 083 193	92.32%
Management and Admin	0		0	40 827 000	12 700 123	53 527 123	6.36%
Shared Services	31 730	11 072 333	9 298	5 196	1 613	11 120 170	1.32%
Specialised Services	**149 690 763**	**170 055 159**	**182 318 262**	**195 739 745**	**189 407 064**	**887 210 992**	
Frontline Facility/Services	149 690 763	170 055 159	182 318 262	195 739 745	189 407 064	887 210 992	100.00%
Strategic Direction	**189 455 897**	**180 537 274**	**221 245 338**	**252 245 199**	**301 134 738**	**1 144 618 446**	
Management and Admin	189 455 897	180 537 274	221 245 338	252 245 199	301 134 738	1 144 618 446	100.00%
Auxiliary Services	**364 472 143**	**379 374 849**	**263 512 823**	**224 481 254**	**200 804 984**	**1 432 646 053**	
Shared Services	364 472 143	379 374 849	263 512 823	224 481 254	200 804 984	1 432 646 053	100.00%
Financial Management Services	**(78 396 944)**	**(72 829 151)**	**(44 288 764)**	**(120 479 368)**	**(66 404 733)**	**(382 398 960)**	
Management and Admin	(78 396 944)	(72 829 151)	(44 288 764)	(120 479 368)	(66 404 733)	(382 398 960)	100.00%
Grand Total	**4 448 744 594**	**4 852 906 774**	**5 090 590 668**	**5 362 908 051**	**5 491 393 703**	**25 246 543 790**	**100.00%**

Source: BAS

SAMHS must look to prioritise the frontline service facilities, namely the Hospital Services and Sickbays within Geographical areas as, as these facilities are for the benefit of the intended target population. If SAMHs were to review their structure, consolidate some of these functions, and remove some of the duplications so that administration is spending is decreased, the department could derive some savings. Table 7 below shows the spending of the department by economic

classification level. The department should look to decrease the expenditure for goods and services as this could be a quick win. As mentioned, the departments spend for management and admin is about 17%, which is 7% above the norm. However, it would be impossible for the department to reduce management and administration to a 10% level as the 7% contains various elements of compensation of employees, goods and services, transfers and subsidies and so forth. We are only interested in the goods and services portion of this 7%, which as we know from the below table is about 22%.

Table 10: 5-year Expenditure for the Department of Defence

R'000	2016/17	2017/18	2018/19	2019/20	2020/21	Total	%(5-yar period)
Compensation of Employees	27 059 700	28 040 854	30 011 960	31 803 026	32 759 882	149 675 422	60%
Goods and Services	11 720 961	10 785 524	10 370 806	10 960 184	11 681 649	55 519 124	22%
Transfers and Subsidies	7 466 820	8 507 422	6 655 205	6 674 370	8 168 995	37 472 812	15%
Payments of Capital Assets	947 294	1 633 786	1 442 941	1 417 666	1 466 700	6 908 387	3%
Payment for Financial Assets	2 319	9 646	11 358	27 011	8 964	59 298	0%
Total	**47 197 094**	**48 977 232**	**48 492 270**	**50 882 257**	**54 086 190**	**249 635 043**	**100%**

Source: BAS

In order to see how much savings could be available to the department, we will need to quantify the 7% that we spoke about in the previous paragraph. Remember, this 7% is how much the department is "overspending" on management and administration.

Table 8 below shows a summary of the current spending for management and administration and the target spending for management and administration. Just to reiterate, we are only looking at the goods and services portion of potential savings amount, which is 22% of the amount. The potential yearly savings is approximately R88.6 million. This is the amount of money that the department could save by optimising and consolidating the management and administration function within the SAMHS programme.

Table 11: Potential Savings

Actual (17%)	951 709 598
Target (10%)	549 139 370
Potential Savings	402 570 228
22% of Potential Savings	88 565 450

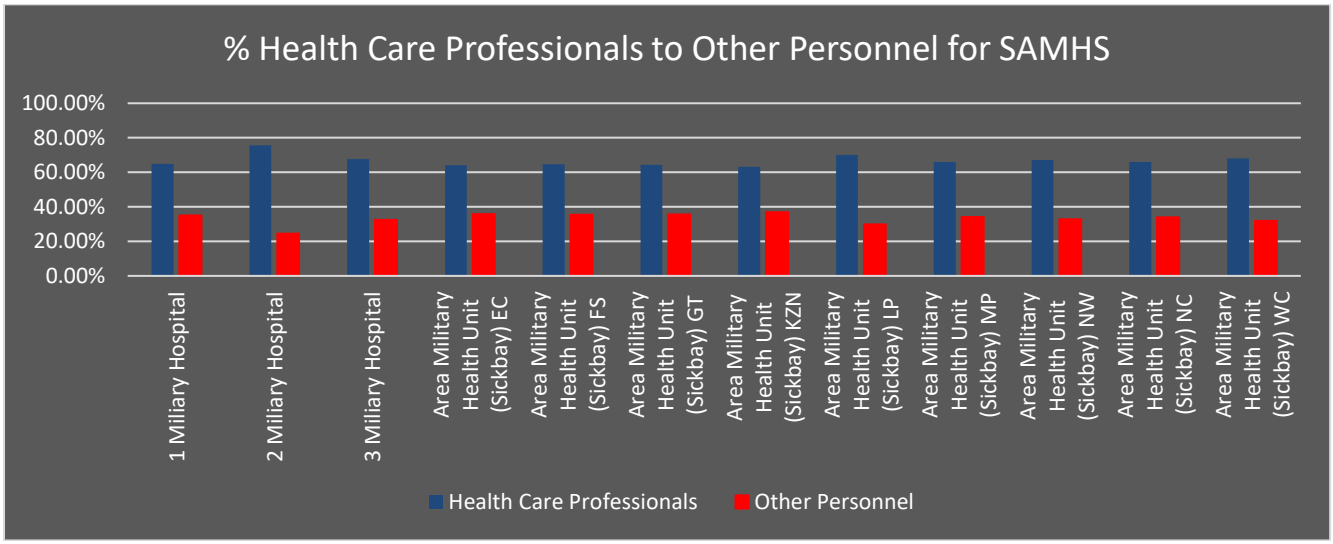
Source: BAS

To validate the analysis above, the share of health care professionals to other personnel was also investigated. Ideally, in terms of efficiency, a large percentage of the budget should be spent on

health care professionals as the health care professionals are the ones who provide frontline services.

For the purpose of this analysis, the analysis focused on the ratio of health care professionals to other personnel for the big three hospitals (1, 2 and 3 Military Hospitals) and the nine sickbays within the specified geographical areas across the country. The reason for this was that as shown in Table 6 above, amount spent for on management and administration for the past 5 years was about 15% of the total SAMHS budget. Further, it was assumed that the majority of non-health care staff will not be working at these facilities.

Figure 2: % Health care Professionals to Other Personnel for SAMHS

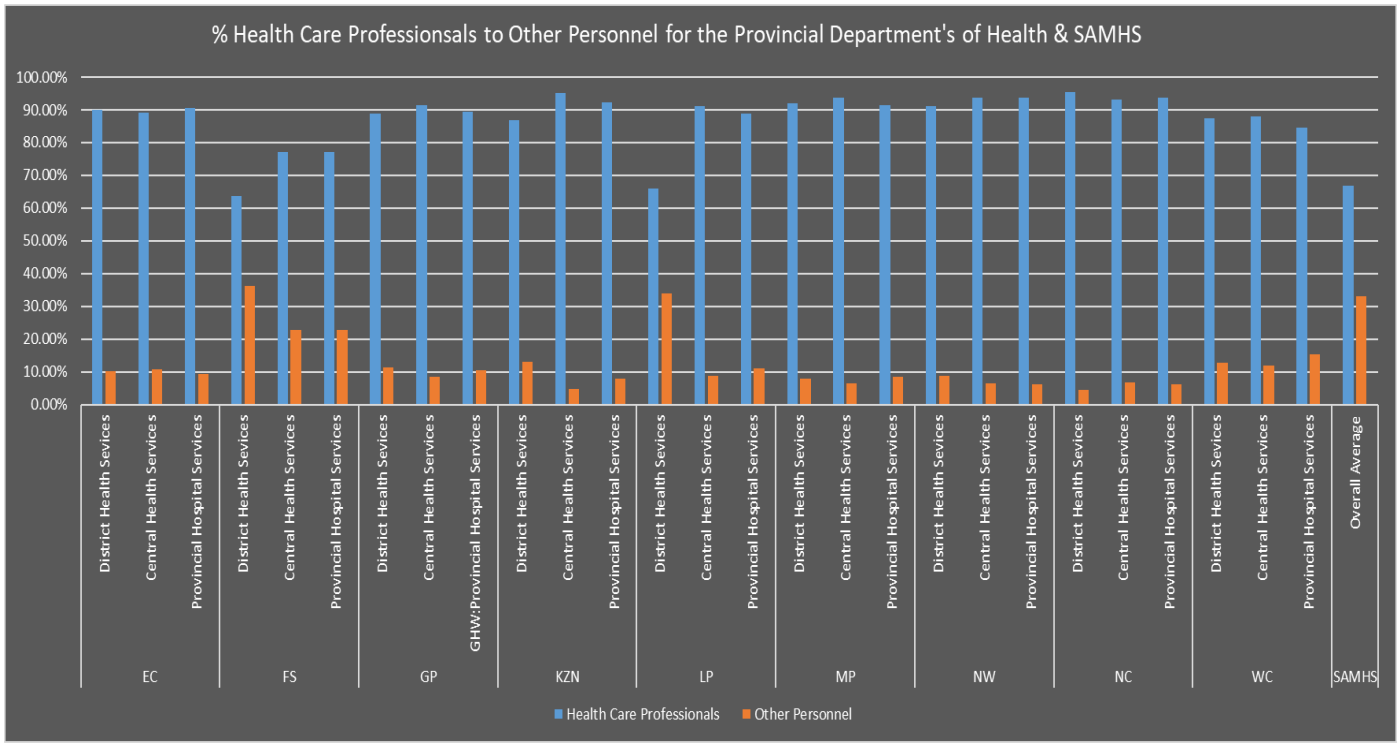


Source: Persol

Figure 3 above shows the percentage of health care professionals to other personnel for the SAMHS. The percentage of health care professionals for each of the facilities ranges from 64 per cent to 76 per cent. 2 Military hospital has the highest percentage of health care professionals. The share of other personnel to health care professionals is above 20% for all facilities supporting the suggestion SAMHS has higher share of Admin spending. The average number of health care professionals is 66.82%, whilst the average number of other personnel is to 33.18%. The ratio of health care professionals for SAMHS was compared with the ratio for the provincial departments of health.

Figure 2 below shows the percentage of health care professionals for district, central and provincial hospital services for the provincial departments of health. Immediately what is evident is that the ratio of health care professionals to other personnel for these facilities is higher than 80 percent for most of these facilities, with some of the facilities even having a ratio of 90 per cent to 10 per cent in terms of health care professionals to other personnel. The only exceptions are found in Free State and Limpopo, however even in some of the facilities located in those provinces, the ratio is close to 80 per cent, and even higher for Limpopo.

Figure 3: Comparison of SAHMS ratio of health care to non-healthcare professionals to Provincial Departments of Health.



Source: PERSAL/Persol

Figure 4 shows that SAMHS might not be making the most efficient use of resources allocated to them as compared with the provincial departments of health. A large portion of the funds should be allocated towards health care professionals who provide frontline services.

Therefore, based on the analysis of expenditure on frontline services vs. non-frontline services and the allocation of expenditure on healthcare professionals vs non-healthcare professionals it is concluded that there are allocative inefficiencies within the SAHMS as evident by:

1. An allocation of up to 17% of the programme's expenditure to management and administrative services compared to a target of 10% for the public sector. This high aggregated share is due to the relative high allocation of expenditure to management and administrative services within the different SAHMS services in addition to what the programme already spends on its strategic direction sub-programme.
2. A ratio 67:33 in terms of spend on healthcare professionals compared to other personnel. This is significantly less than the best-in-class ratio of 90:10 across the Provincial Government Health sector.

7.3 SAHMS outsourcing and overtime models

Table 6 below shows that SAMHS spent R518.3 million for outsourced services[2], whilst R290 million was spent on overtime for 2020/21 financial year. This spending pattern seems contradictory since higher spending on outsourcing should reflect low patient caseload within SAMHS. In other words, it seems most cases are dealt with in private health care facilities which should reduce the need for overtime. This seems to indicate that there might be some inefficiencies within SAMHS in terms of overtime.

Table 12: Key Expenditure Items for SAMHS

Key Expenditure Items	2017/2018	2018/2019	2019/2020	2020/2021	Average Growth Rate(%)
Basic Salaries and wages	2 309 716 241	2 496 672 653	2 611 851 303	2 633 829 634	4.47%
Other components of salaries and wages	965 458 398	1 019 190 773	1 088 270 622	1 141 604 195	5.75%
Outsourced medical services	539 514 210	470 568 692	521 342 823	518 289 193	-1.33%
Other goods and services	367 713 521	381 111 045	401 488 326	413 845 857	4.02%
Overtime	248 510 741	267 817 643	289 315 494	290 901 075	5.39%
Medicines	243 193 214	246 639 331	237 066 347	273 830 602	4.03%
medical supplies	63 566 537	84 676 326	80 126 118	116 584 357	22.41%
Other	115 233 912	123 914 206	133 447 017	102 508 792	-3.83%
Grand Total	**4 852 906 774**	**5 090 590 668**	**5 362 908 051**	**5 491 393 703**	**4.21%**

[2] Outsourced services include medical services such as optometric services; blood and plasma; laboratory test; assistive devices and diagnostic procedures.

Source: BAS

SAMHS spent about 9.5% of its 2020/21 budget on outsourcing medical services. Excluding expenditure on COE (compensation of employees) related payment, this spending 36% of SAHMS non-COE spend. As shown in the table above, spending on outsourced medical services was 1.8x more than the spend on medicines and 4.4x higher the spend on medical supplies.

Despite this high amount of outsourcing, SAMHS spent a significant amount on overtime (11% of CoE budget in 2020/21). This expenditure has grown at an average of 5.4% over the 5 year period.

Table 7 below shows the amounts spent on outsourcing and overtime at the various facilities. The locations where the majority of outsourcing and overtime takes place are highlighted below. SAMHS would need to look into ways to eradicate any overtime and outsourcing inefficiencies for these facilities that have been highlighted. For example, 1 Military hospital had the highest spent for outsourcing and overtime.

Table 13: Expenditure and Outsourcing for various facilities

Outsourcing		
Facility		Expenditure /non-CoE Expenditure (%)
1 MILITARY HOSPITAL	179 681 258	10.47%
PRIVATE MED PAYMENTS CODE 4&7	69 117 247	4.03%
AREA MIL HEALTH FORMATION	45 387 202	2.65%
AMHU KZN	42 133 859	2.46%
2 MILITARY HOSPITAL	39 039 551	2.28%
AMHU EASTERN PROVINCE	37 886 799	2.21%
3 MILITARY HOSPITAL	27 327 446	1.59%
AMHU GAUTENG	22 380 071	1.30%
AMHU FAR NORTH	19 489 027	1.14%
AMHU MPUMALANGA	17 107 527	1.00%
AMHU NORTHERN CAPE	11 328 057	0.66%
AMHU WESTERN PROVINCE	8 904 026	0.52%
AMHU NORTH WEST	5 790 371	0.34%
AMHU FREE STATE	4 038 623	0.24%
INSTITUTE FOR MARITIME MEDCINE	2 083 102	0.12%
D MED	722 954	0.04%

Overtime		
Facility		Expenditure/non-CoE Expenditure (%)
1 MILITARY HOSPITAL	114 844 642	6.69%
2 MILITARY HOSPITAL	55 420 521	3.23%
3 MILITARY HOSPITAL	26 555 450	1.55%
AMHU GAUTENG	17 939 652	1.05%
AMHU WESTERN PROVINCE	11 010 474	0.64%
AREA MIL HEALTH FORMATION	7 515 822	0.44%
AMHU FAR NORTH	7 420 789	0.43%
AMHU KZN	4 988 223	0.29%
SURGEON GENERAL & STAFF	4 631 799	0.27%
INSTITUTE FOR AVIATION MEDCINE	4 541 135	0.26%
TRAINING FORMATION	4 470 500	0.26%
AMHU NORTH WEST	4 238 805	0.25%
INSTITUTE FOR MARITIME MEDCINE	4 091 394	0.24%
7 MEDICAL BN	3 916 807	0.23%
AMHU MPUMALANGA	3 424 226	0.20%
AMHU FREE STATE	3 231 295	0.19%

PM UNIT	86 923	0.01%
TERTIARY HEALTH FORMATION	-6 710 445	-0.39%
SURGEON GENERAL & STAFF	-7 504 406	-0.44%

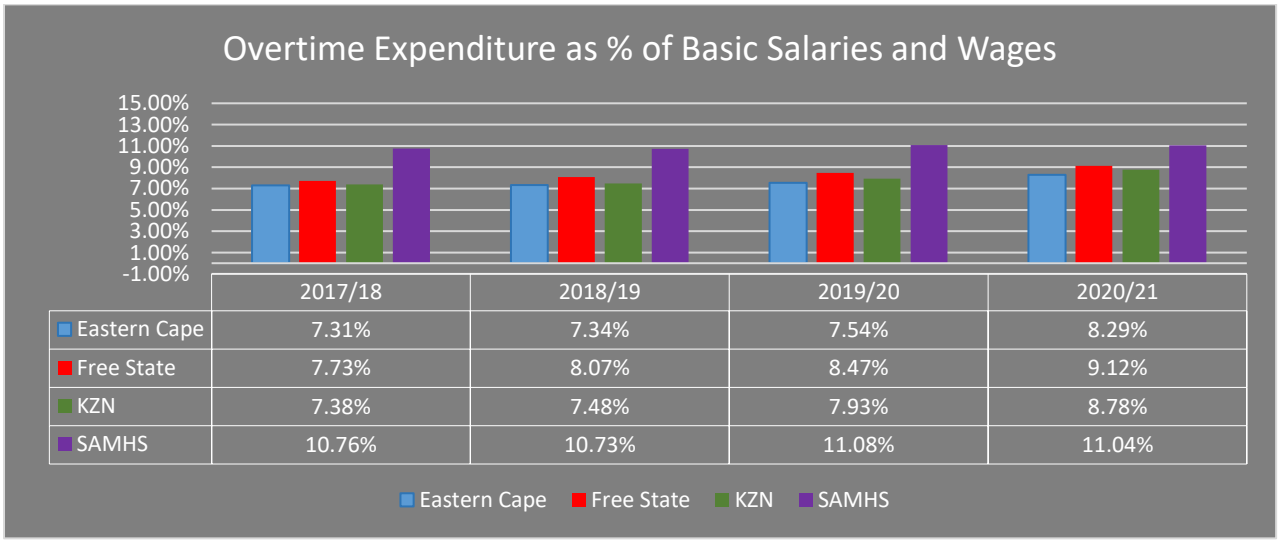
Source: BAS

AMHU NORTHERN CAPE	3 162 605	0.18%
AMHU EASTERN PROVINCE	2 582 110	0.15%
SAMHS HEALTH TRAINING	1 452 479	0.08%

Source: BAS

Figure 5 below summarises the benchmarking of overtime expenditure as a percentage of basic salaries and wages for SAMHS against various provincial departments of health.. The expenditure on overtime as a percentage of basic salaries ratio for SAMHS has been constantly higher than that of the best performing provincial health departments. On average, SAMHS's share is 2.5% higher than these selected provincial health departments. On average the 3 selected provincial departments of health spend about 8% of the basic salaries and wages budget on overtime. If the SAMHS were to put in place measures to get in line with these provincial department of health, SAMHS could save more than R60 million per financial year.

Figure 4: Comparison of SAHMS Overtime Expenditure to select Provincial Departments of Health



	2017/18	2018/19	2019/20	2020/21
Eastern Cape	7.31%	7.34%	7.54%	8.29%
Free State	7.73%	8.07%	8.47%	9.12%
KZN	7.38%	7.48%	7.93%	8.78%
SAMHS	10.76%	10.73%	11.08%	11.04%

Source: Persal and BAS

8. Options

Based on the analysis, consideration should be given to capping the benefit that the dependents of defence force members and veterans get from the programme.

The analysis has also shown that as compared with the National Department of Health, the SAMHS can do more with the resources allocated to them. What we are seeing for the three major military hospitals and the nine sickbays across the country is that the spend for the support personnel as compared with the provincial departments of health is more than that of the provincial department of health.

As already mentioned, these military hospitals and sickbays are meant to be providing health care services to the target population. This means that administration expenditure should be kept to a minimum. SAMHS should look into becoming more efficient at each of its health facilities. If SAMHS were to gradually change the structure at each of its health care facilities, by having more health care professionals, they could do more with the funds allocated to them at each of its facilities. By doing more at each its facilities with the same or less funds, funds would be freed up for the department to use elsewhere within the vote.

The analysis has shown that there are inefficiencies in terms of the SAMHS outsourcing and overtime models. In order to derive savings, SAMHS must look at setting up more stringent criteria to qualify for overtime. Moreover, SAMHS must relook at their outsourcing model. It might be beneficial for SAMHS in certain instances to outsource to the public sector instead of the private sector, which will realise savings for SAMHS.

9. Recommendations

Based on the analysis, we recommend the following:

1. The department should reduce the share of spending directed to management and administrative functions. Management and administration related functions should be kept at a minimum within SAMHS. In our view, the department could save about R88.6 million per year from reviewing the structure. Defence must look into gradually changing the structure of its healthcare facilities so that over time the ratio of healthcare practitioners to non-healthcare practitioners is significantly more than what we are observing at the moment.
    - SAMHS must put in place more stringent controls on overtime payments (specific monitoring and control measures should be in place). Defence's policy on overtime for medical

personnel should be strictly aligned to the National Policy on Commuted Overtime for Medical & Dental Personnel. The potential savings from aligning with the best performing provincial health departments are estimated at R60 million per year

2. In terms of outsourcing, SAMHS should only outsource tertiary services that are not cost efficient to insource and must make greater use of provincial tertiary hospitals to minimising transfers to private medical health facilities.
    - Therefore, the total estimated savings per year is R148.6 million. Given significant overall baseline reductions on the Department of Defence in recent years it is also recommended that these identified savings be reprioritised towards other emerging spending pressures within the department (e.g., establishment of the Rapid Reaction Force to deal with public violence and riots in support of police and increase capacity for border safeguarding).
3. Defence must relook at its benefit structure contained in its Healthcare Delivery Model Policy. As it stands, the policy is too broad, specifically in terms of the amount of cover it provides. Comprehensive cover for the target population is a bit excessive. Generally, medical aids put a cap on medical procedures and the coverage enjoyed is also linked to the amount you contributed to the scheme.

10. Actions

The following actions should be taken to take the finding and recommendations forward.

- Findings will be presented to the SAMHS senior management to request their views on the analysis done. This presentation will include the representatives from the Departments budget team.
- Findings will be presented to the Department's senior management.
- Present to the The Justice, Crime Prevention and Security Cluster (JCPS).
- Assist the department to include the savings identified in this report in the 2023 MTEF plans.

11. References

James F Dunnigan, 2003, *How to Make War, A comprehensive guide to modern warfare in the 21st Century*, Fourth Edition, Quill, New York.

Department of Defence (DOD), 2021. *Annual Report 2020/21*, Pretoria: Department of Defence.

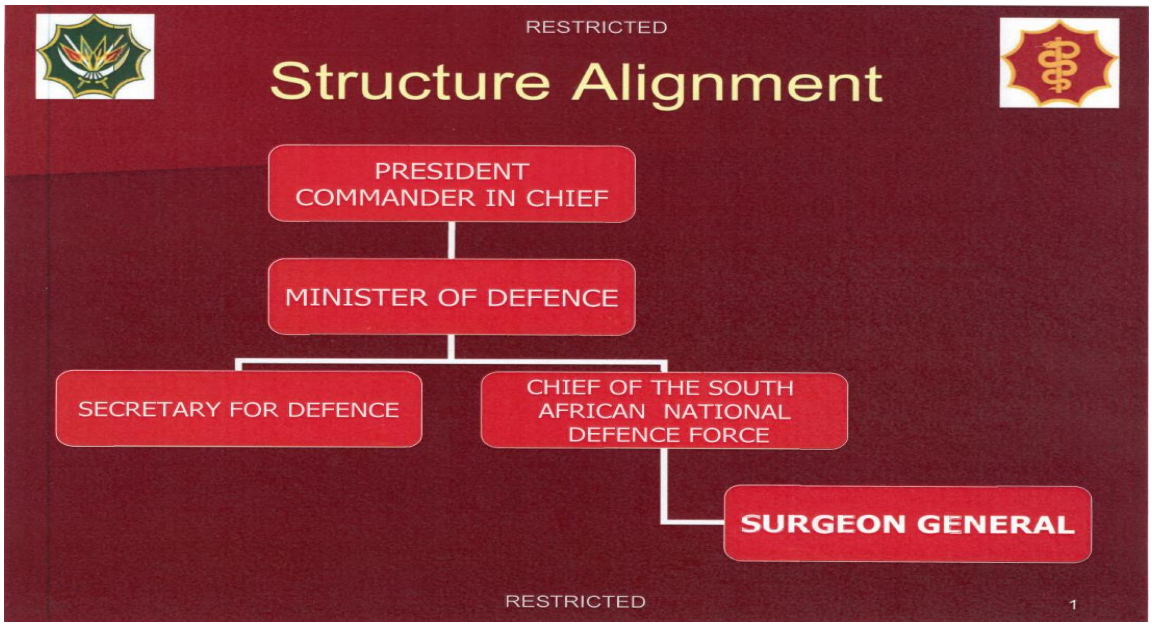
Department of Defence, 2011*, Process and Procedures on South African Military Health Service's Health Care Delivery*, First Edition, Pretoria.

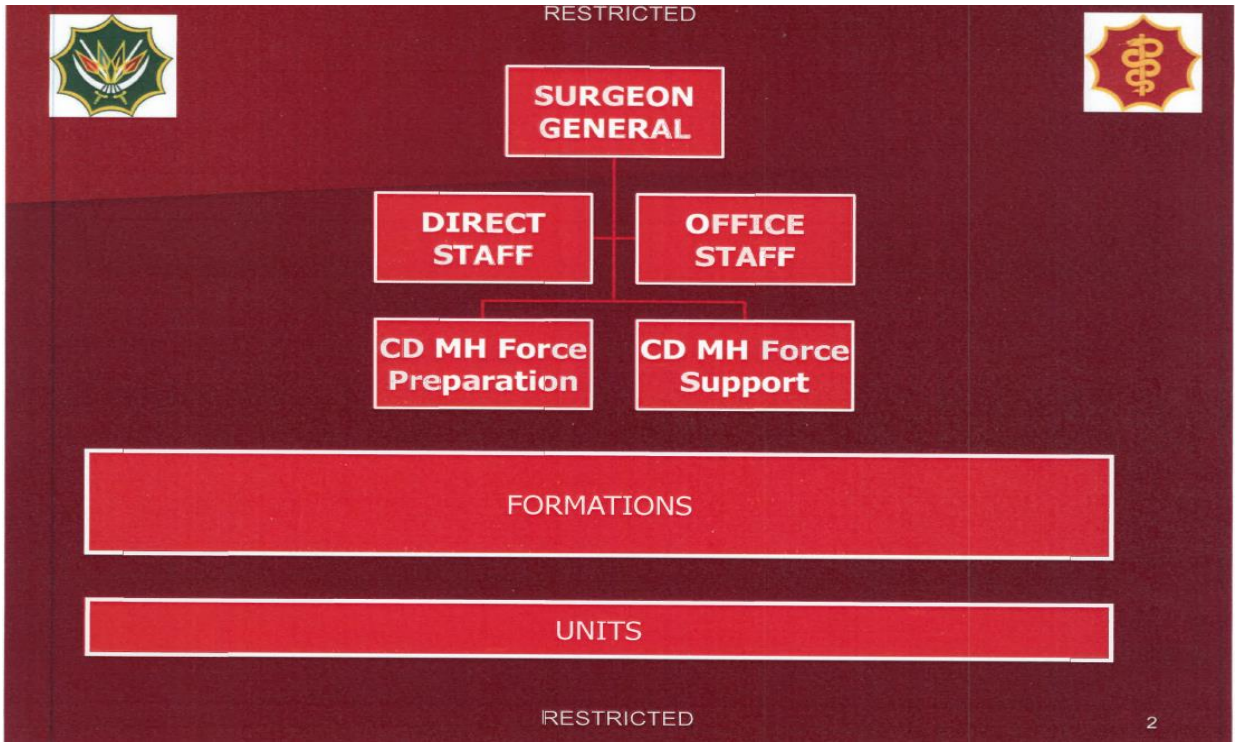
Estimates of National Expenditure, 2020. National Treasury. 2020 (Source: National Treasury).

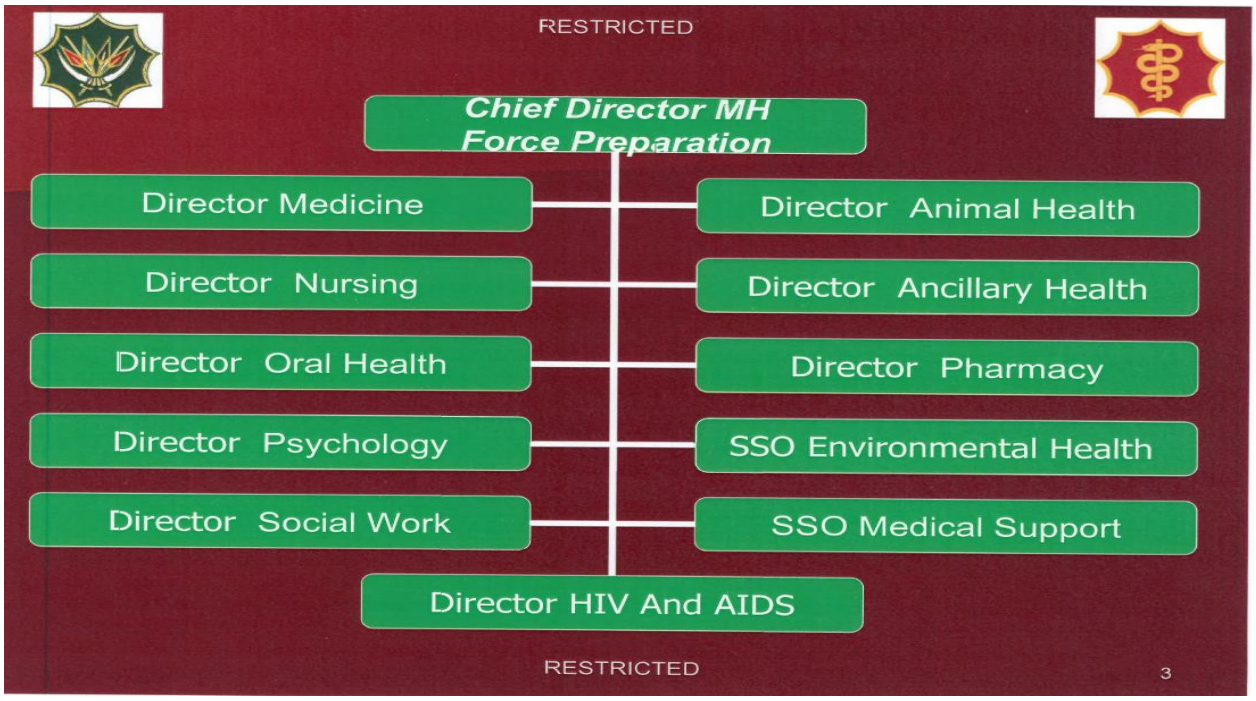
12. Appendix 1: Log-frame

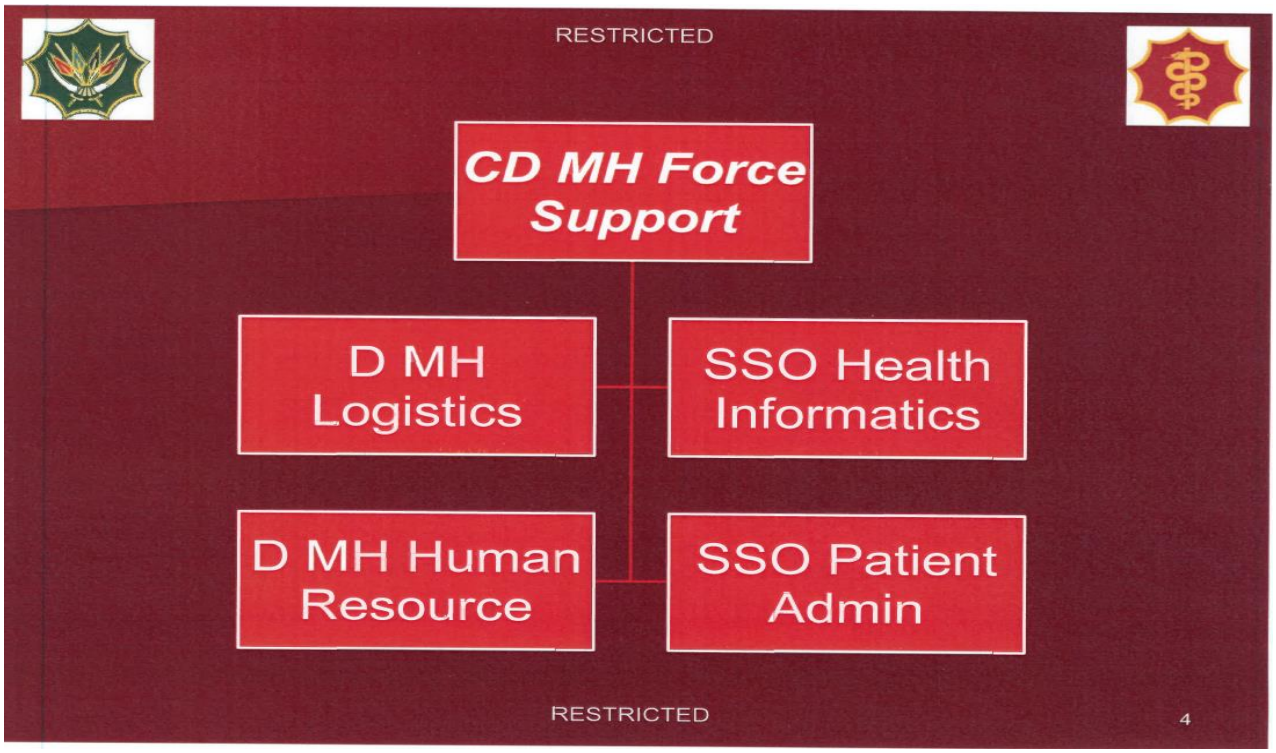
IMPACT	OUTCOME (i.e., benefit derived by beneficiaries from their receipt of	Key Performance indicators	Outputs (please put 1 output be cell)	Programme elements	Service
SANDF are equipped to protect the interests of SA and its citizens	A health support capability for deployed and contingency forces.	Number of medical general medical battalions/ Number of specialised medical battalions/ The percentage compliance with joint force requirements(Information classified)/ Percentage combat ready capabilities for the SANDF.	Ability to deploy to and maintain field hospitals.	Support to deployed forces	Conventional Military Health Support
			Field hospitals deployed and maintained.		
			Ability to provide emergency evacuation services.		
			Emergency evacuation services provided.		
			Training of Staff	Military Health Training	Military Health Training
	A comprehensive, multidisciplinary military health service to service personnel and Military Veterans.	Total Population serviced. Number of Military Veterans accessing medical support. Number of Military service people being served. Time taken to authorise to authorise access to care for military veterans. Expenditure on outsourced services (including to non-military state facilities) versus in source.	Training of Staff		
			Inpatient healthcare support (Emergency and trauma/ Injury based care/illness) .	Functional Health care facilities	Hospital Services
			Outpatient healthcare support(rehab care, consultative care, specialised services)		
			Functional medical facilities i.e. hospitals, sick bays in barracks		
			Preventative Healthcare programmes (e.g. Vaccination drives, mental health campaigns, HIV prevention programmes, TB prevention programmes)	Preventative healthcare	
	SANDF contributes to a Long and Healthy Life for all South Africans	Number of deployments per financial year.	Research Facilities	Other research facilities	Specialised Services
			Deployment of staff to the public health care facilities	General contributions to the society at large	Cost Recovery
			Sharing of Facilities		
				like accountants	Strategic Direction/ Accounting Entry

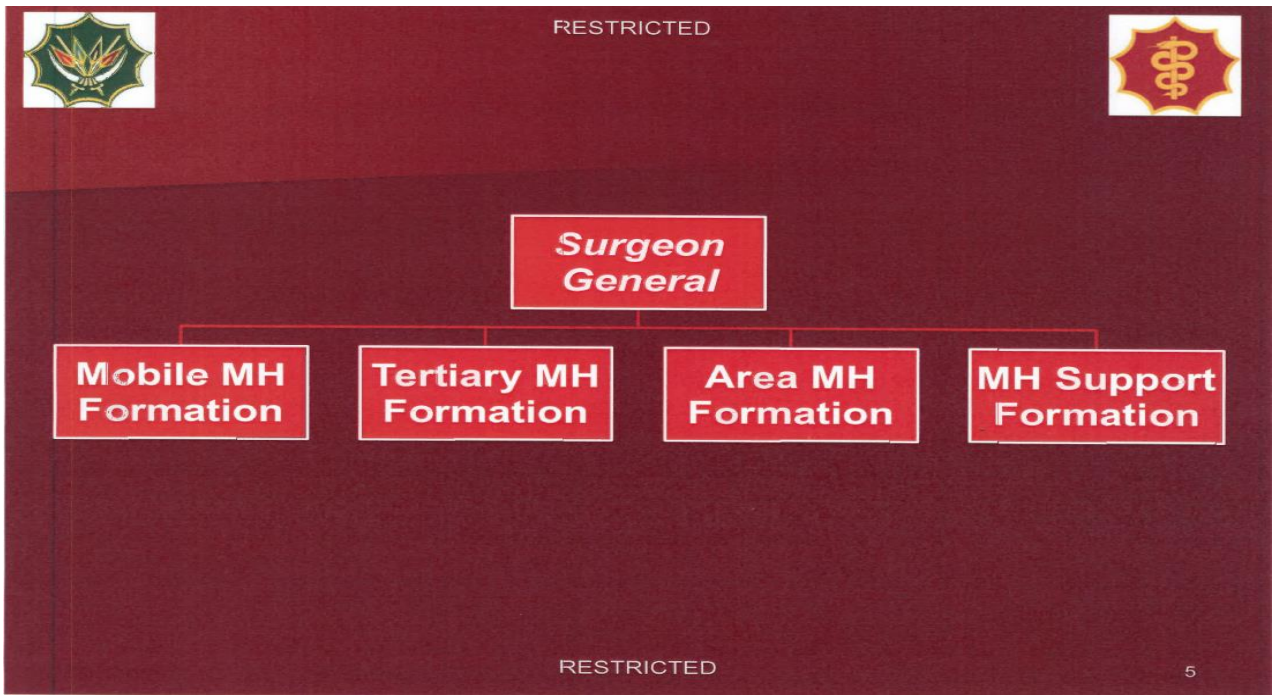
13. Appendix 2: Structure Alignment

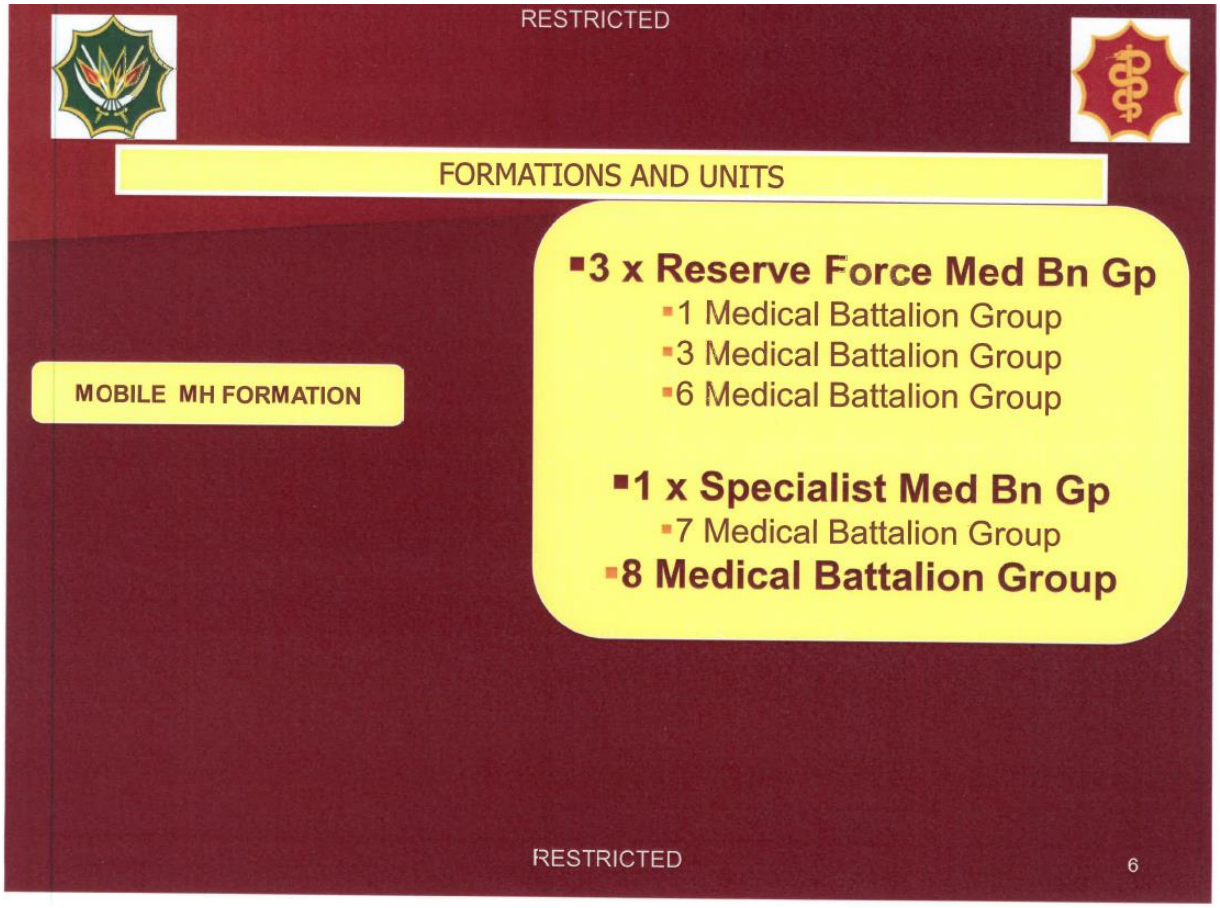


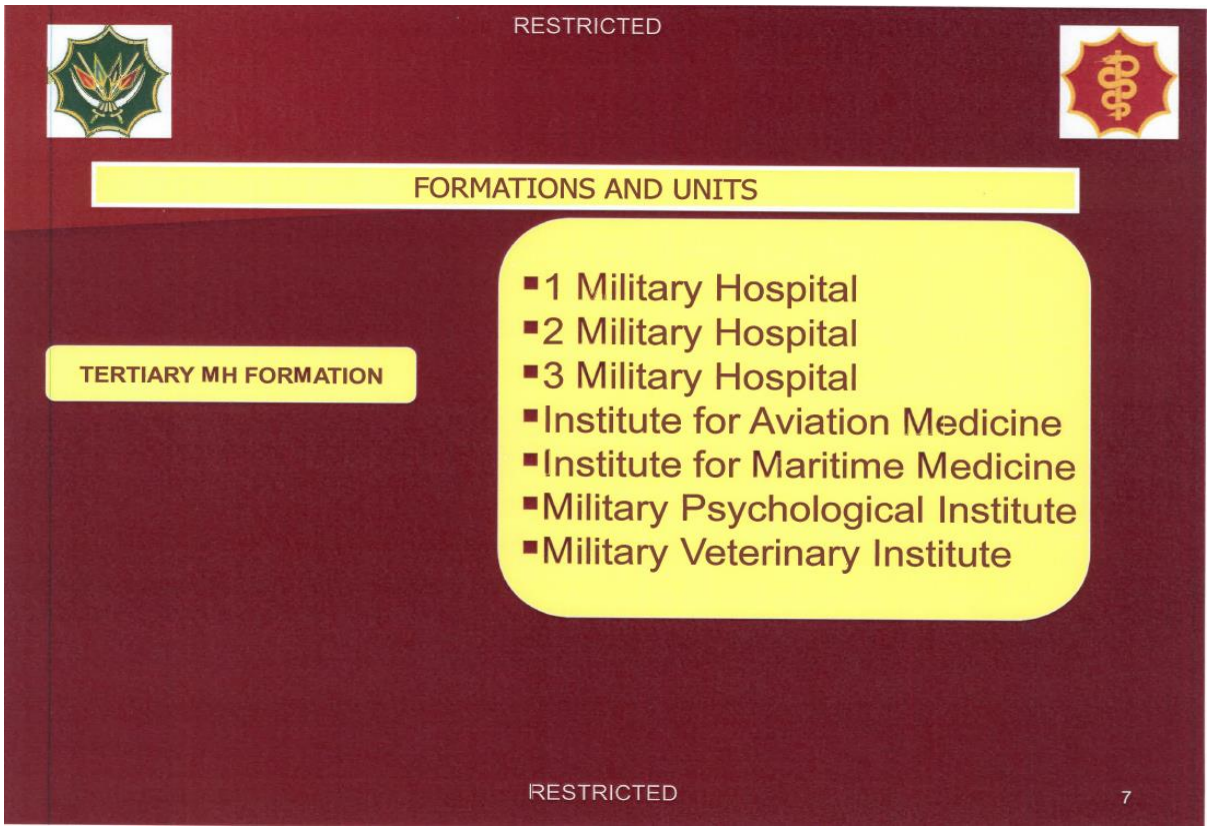

RESTRICTED
SURGEON GENERAL
DIRECT STAFF
OFFICE STAFF
CD MH Force Preparation
CD MH Force Support
FORMATIONS
UNITS
RESTRICTED
2

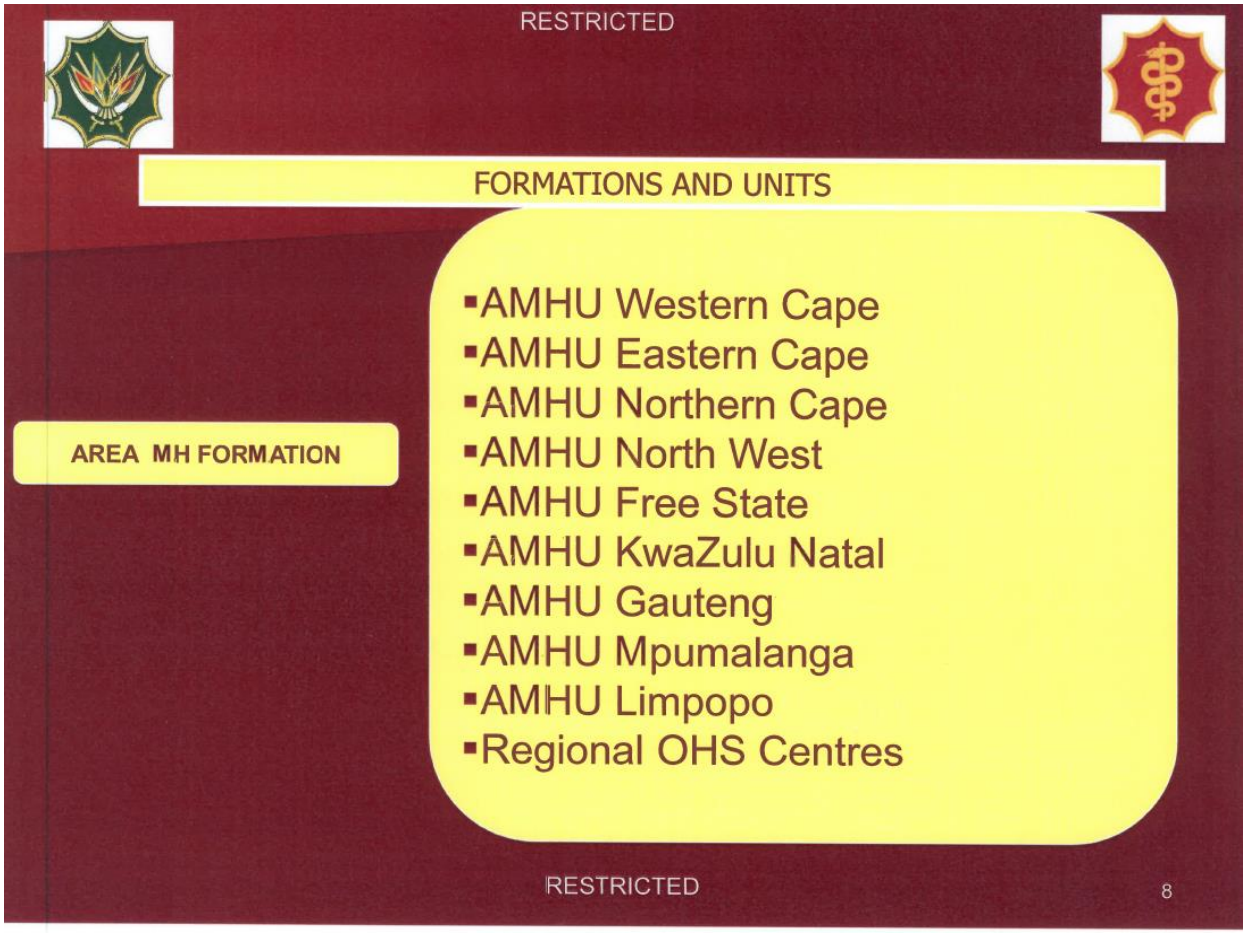

RESTRICTED
Chief Director MH Force Preparation
Director Medicine
Director Nursing
Director Oral Health
Director Psychology
Director Social Work
Director Animal Health
Director Ancillary Health
Director Pharmacy
SSO Environmental Health
SSO Medical Support
Director HIV And AIDS
RESTRICTED
3

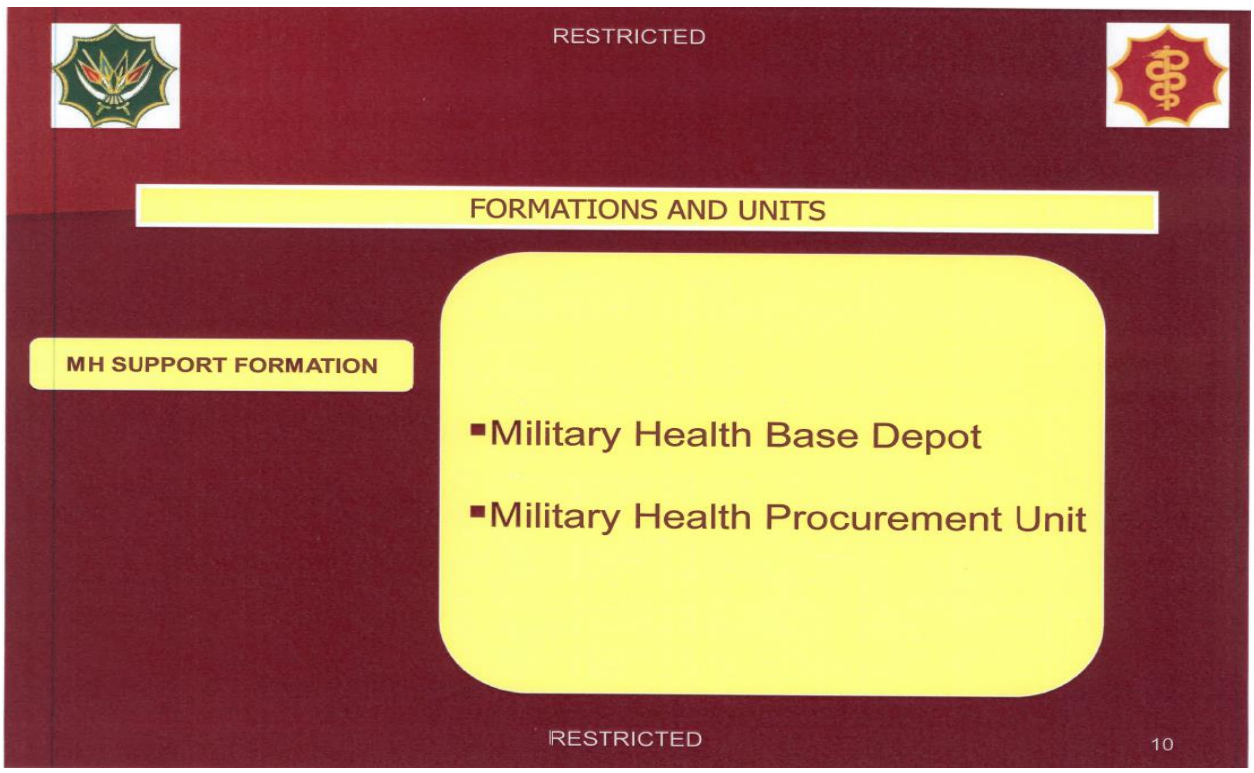

RESTRICTED
CD MH Force Support
D MH Logistics
SSO Health Informatics
D MH Human Resource
SSO Patient Admin
RESTRICTED
4

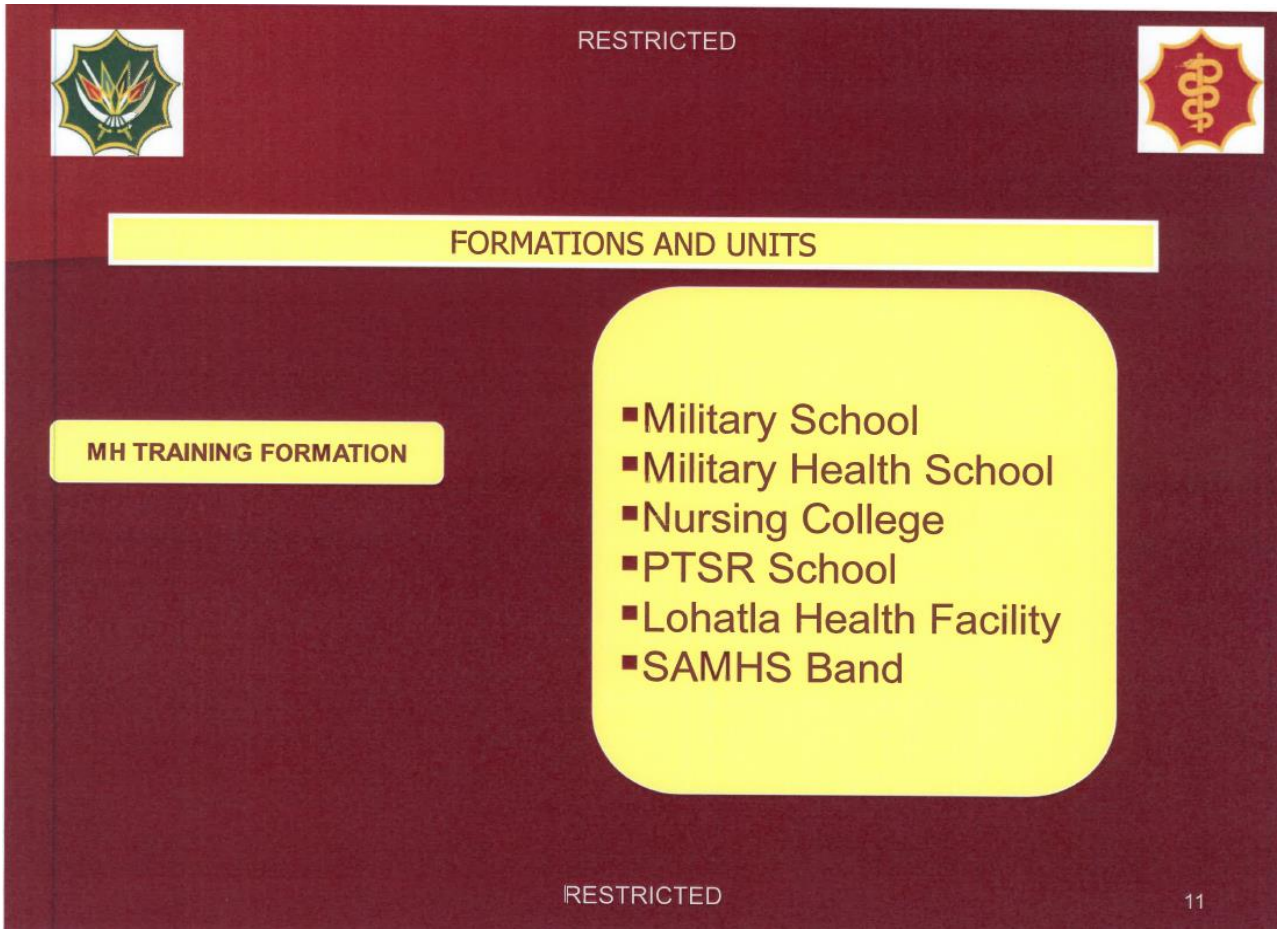

RESTRICTED
Surgeon General
Mobile MH Formation
Tertiary MH Formation
Area MH Formation
MH Support Formation
RESTRICTED
5


RESTRICTED
FORMATIONS AND UNITS
MOBILE MH FORMATION
3 x Reserve Force Med Bn Gp
1 Medical Battalion Group
3 Medical Battalion Group
6 Medical Battalion Group
1 x Specialist Med Bn Gp
7 Medical Battalion Group
8 Medical Battalion Group
RESTRICTED
6


RESTRICTED
FORMATIONS AND UNITS
TERTIARY MH FORMATION
1 Military Hospital
2 Military Hospital
3 Military Hospital
Institute for Aviation Medicine
Institute for Maritime Medicine
Military Psychological Institute
Military Veterinary Institute
RESTRICTED
7


RESTRICTED
FORMATIONS AND UNITS
AREA MH FORMATION
▪AMHU Western Cape
▪AMHU Eastern Cape
▪AMHU Northern Cape
▪AMHU North West
▪AMHU Free State
▪AMHU KwaZulu Natal
▪AMHU Gauteng
▪AMHU Mpumalanga
▪AMHU Limpopo
▪Regional OHS Centres
RESTRICTED
8


RESTRICTED
FORMATIONS AND UNITS
MH SUPPORT FORMATION
▪Military Health Base Depot
▪Military Health Procurement Unit
RESTRICTED
10



Source: Department of Defence