GTAC Analyse Assess Activate
Strategic & Technical Advisory
National Treasury
REPUBLIC OF SOUTH AFRICA

2019

Why are the Medical Legal Claims against the state on the rise?

Medical Equipment Costs in FS Health District Hospitals as a possible contributor from 2015/16-2021/22

STUDENT NAME: MOKOATJA MOLEFE

CLUSTER: HEALTH

PROVINCE: FREE STATE

SAVINGS@WORK
GOVERNMENT SPENDING REVIEWS

Summary

The Free State Department of Health is currently faced with over R1.3 billion worth of unpaid registered medical legal claims, calculated from 2015/16 to 2018/19.

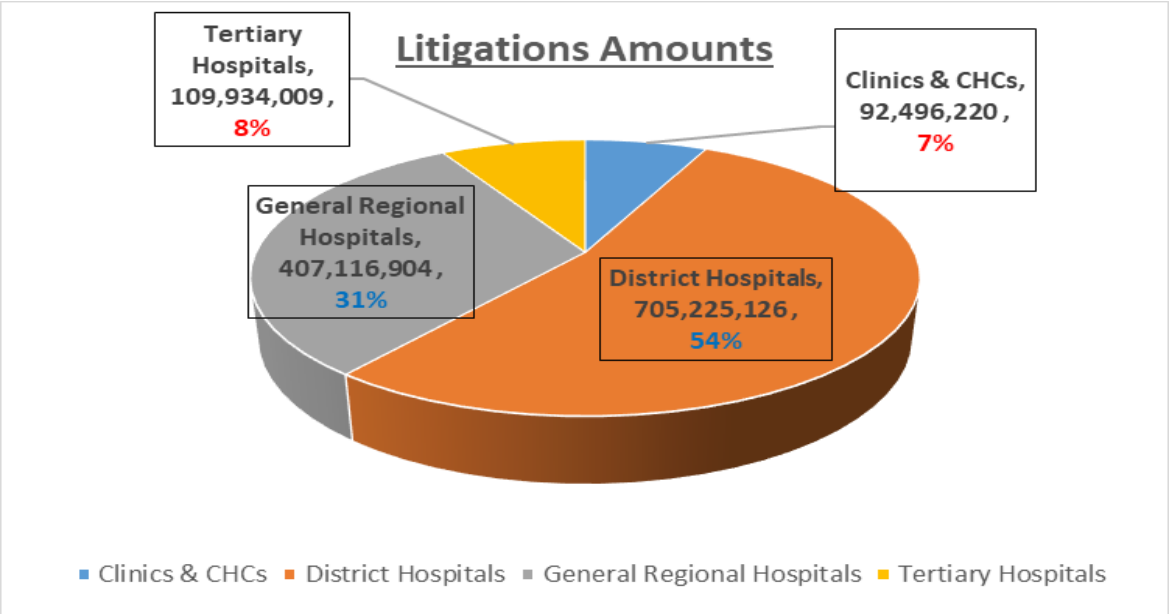
From 2015/16 to 2018/19 the department has already spent or lost R133.9 million on medical legal claims excluding legal advice fees, as seen on the following expenditure report table extracted from Vulindlela (National Treasury's website):

Department - FS Health	2015/2016	2016/2017	2017/2018	2018/2019	Grand Total
Paid Legal Claims - Amounts	32,073,627	45,377,443	16,194,905	40,300,110	133,946,085

Compound Annual Growth Rate (CAGR)				8%
Projected Legal Claims	2019/2020	2020/2021	2021/2022	Grand Total
	43,486,951	46,925,800	50,636,585	141,049,335

At the current annual rate of 8% with which the payments made are increasing, the department is projected to pay a further R141 million from 2019/20 to 2021/22 for legal claims. Let alone the other R1.3 billion worth of claims cited above. This will impact negatively on the service delivery as the department will have to fund the payment of claims by cutting the budget and reducing the service delivery targets of other items. As shown in this Performance and Expenditure Review(PER), the department has apparently slacked on the performance, budgeting and expenditure of the District Hospitals. The problem is much deeper and broader than inadequate medical equipment found at district hospitals. Unfortunately, this has contributed to an alarming increasing number of expensive medical legal claims which the department is faced with, which mainly emanate from the District Hospitals.

From 2015/16 to 2018/19 the District Hospitals were the biggest contributors or alleged culprits to the R1.3 billion registered medical litigations.



Medical Litigations Register						
Facility Category	**2015/2016**	**2016/2017**	**2017/2018**	**2018/2019**	**Grand Total**	**% Share**
Clinics & CHCs	1,902,720	68,693,500	21,900,000	-	92,496,220	7.0%
District Hospitals	217,871,970	69,470,000	290,792,256	127,090,900	705,225,126	53.6%
General Regionals Hospital	82,298,207	195,035,697	95,953,000	33,830,000	407,116,904	31.0%
Tertiary Hospitals	21,998,259	20,704,550	44,060,000	23,171,200	109,934,009	8.4%
Grand Total	**324,071,156**	**353,903,747**	**452,705,256**	**184,092,100**	**1,314,772,259**	**100.0%**

The District Hospitals are accountable to 53.6% or over R705 million of all the registered medical legal claims from 2015/16 to 2018/19 financial year. Clearly, the department has to give more attention to the District Hospital's performance, budget and expenditure.

Increasing the budget of district hospitals' budget by approximately R170 million as seen in section 4 and 8 of this report, would reduce the medical litigations. This, will require reprioritising funds from other areas whose performance and expenditure should be evaluated. Critical vacant posts should be allocated the budget, as well as other item buckets at District Hospitals. In the long run, the department will achieve a better outcome, as opposed to a current R705 million worth of litigations. Which is a potential loss that emanated from the District Hospitals.

Contents

1. Introduction

This PER of the District Hospitals from 2015/16 to 2018/19 focuses on why the medical legal claims against the Free State Department of Health are increasing? There are several answers. But, the focus is mainly on answers to questions such as, whether the medical equipment and other items at district hospitals are budget adequately or not? Is there adequate number of appointed health professionals at District Hospitals, in order to improve service delivery at the District Hospital level of care?

The review revealed that there are a number of contributing factors to the worsening litigations/medical legal claims problem. Which include:

- Shrinking equitable share allocation to the department, from Treasury.
- Increasing compensation of employees costs, which crowd out other items.
- Failure to generally budget equitably within the department.
- Failure to fill critical health professionals 'posts.
- Failure to allocate budget for the essential equipment and slow or non-procurement of medical equipment.

The results end up being unintended poor performance at District Hospitals. But, the situation can be improved, and the wastage of funds in that area could be prevented.

I used the data from:

- District Health Information System(DHIS) as provided by Information Management Office, information published in the Annual Performance Plan and the District Hospitals' gazette.
- Legal Services' Litigation register. The information on the register is not easy to modify into a management report. It is provided in the pdf format and the data could be better categorised and captured on the register.

- Acquisition Plans. The acquisition plans do not specifically show if the medical equipment was planned for acquisition. Unfortunately, it was also discovered that some District Hospitals do not submit their acquisition plans as required by law.

Expenditure reports from the Vulindlela system,

- Persal report #3.3.20.

The following were my research Questions:

1. How much has the department paid on medical claims from 2015/16 to 2018/19?
2. How much will the department probably pay on medical claims over the MTEF period?
3. Which area of the department causes more claims?
4. How much do district hospitals contribute on the medical legal cases problem? Are they disadvantaged by the current budget allocation? Should the department reprioritise funds from other areas to fund district hospitals more?
5. Which district hospital causes more medical claims?

2. Policy and Institutional Information

At the Parliament level, the Bill of Rights in Section 27 of the **Constitution of the Republic of South Africa of 1996** states unequivocally that access to healthcare is a basic human right. The state is obligated to provide health care services to all the people that need medical care within the country.

And then, the **National health act (2003)** provides 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 has further developed the **Norms and Standards for the District hospitals (2002)**, which indicates the type of health professionals required, what kind of equipment is needed and the service which should be rendered at district hospitals.

Provincially, the **Free State Provincial Health Act (1999)** aims to help establish appropriate and effective district and provincial Health Authorities within the Free State and to spell out the rights and duties of health care service providers and health care users. Some of the principles upon which the Act is based:

- The constitutional right for everyone to have access to health care services;
- The requirement for provincial health services to be part of an integrated National Health System;
- The Free State Provincial Government's commitment to providing acceptable, affordable, effective, integrated and comprehensive health care to the people the Free State;
- The organisation of health services according to the District Health System (DHS) model, which includes the participation of communities and inter-sectoral collaboration;
- The constitutional principle of co-operative governance.

The Act also makes clear that the population of the Free State will be provided access to Primary Health Care that is accessible, acceptable, affordable and efficient, and preventative, curative and rehabilitative services being provided in an integrated manner. The act further directs the Department to endeavour to avoid and remove any duplication and fragmentation of health services; improve and maintain the quality of health services within the available resources; and remove all barriers to access to health services where possible.

The medical professionals play a key role in the delivery of health care. That is why the

Health Professions act (1974) sets standards on the conduct of health professionals in performing their functions. It also provides for control over the education, training and registration for and practising of health professions.

The **Chiropractors, Homeopaths and Allied Health Service Professions Act (2000**) serves to provide for the control of the practice of allied health professions, and for that purpose to establish an Allied Health Professions Council of South Africa and to determine its functions; and to provide for matters connected therewith.

The items use in the health care are regulated by the **South African Health Products Regulatory Authority, or SAHPRA Medicines and Related Substances Act (1965),** which serves to provide for the registration of medicines and related substances intended for human and for animal use; to provide for the establishment of a Medicines Control Council.

The health care services cost a lot of money. So, the **Public Finance Management Act (1999)** regulates the financial management in the national government and provincial government, to ensure that all revenue, expenditure, assets and liabilities of those governments are managed efficiently and effectively, to provide for the responsibilities of persons entrusted with financial management in those governments and to provide matters connected therewith.

3. Programme Chain of Delivery

1. Medical legal claims mainly arise from hospitals which do not budget adequately for medical professionals, equipment and consumables. Below, we map the steps in the budgeting process. The process starts in June and July of each year at the cost centre level at the district hospitals where cost centre mangers identify their cost centres' priorities and medical equipment needs for the medium term period (Next 3

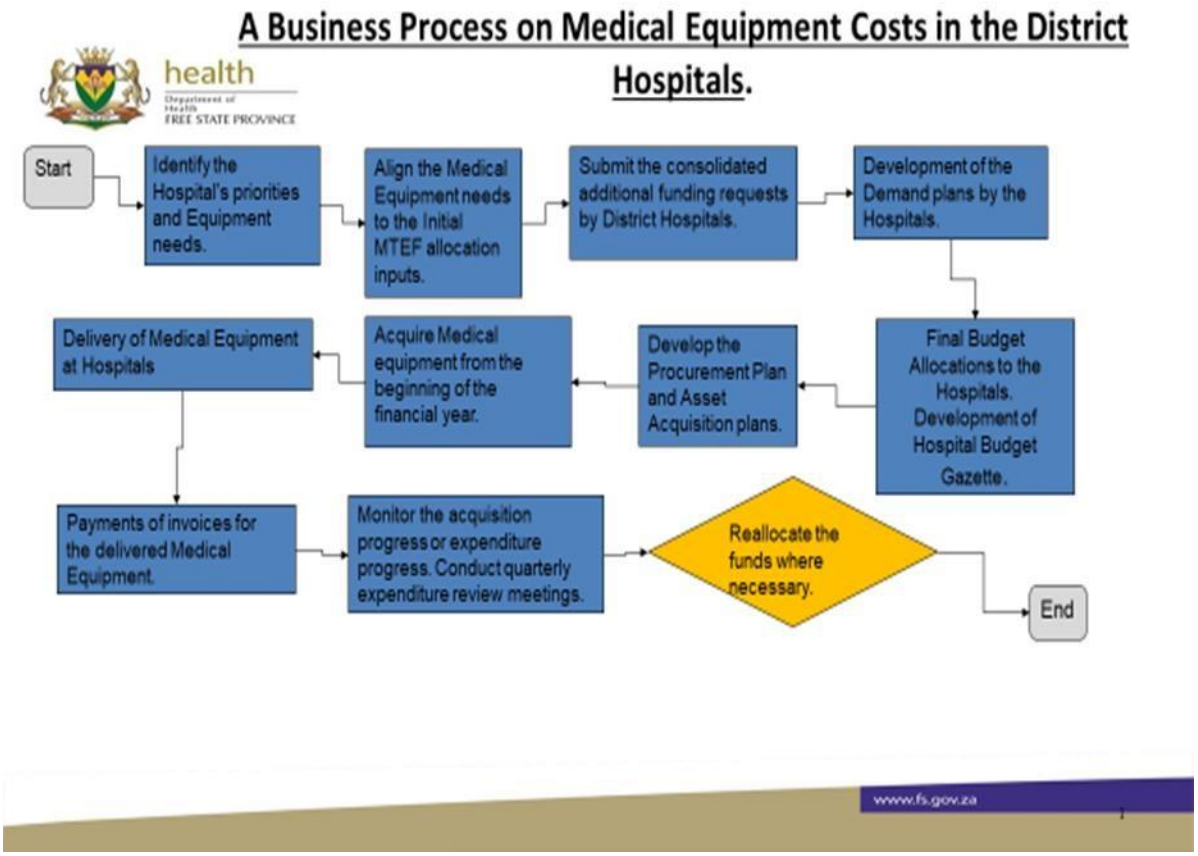
financial years), and then the hospital CEO consolidates the hospital needs from the different cost centres within his/her hospital.

2. He/she then submits the inputs to the programme manager, who will then consolidate all the district hospitals' needs translated into the Medium Term Expenditure Framework (MTEF) budget inputs, and align them to the MTEF budget allocations as received from the Provincial Treasury. The needs which could not be accommodated within the MTEF budget inputs should be included into the additional funding requests, which are submitted at the Provincial Treasury. The Budget Management Office acts as an intermediary between the hospitals and the Provincial Treasury during this MTEF process.

3. After that, the hospitals develop and discuss the comprehensive Demand plans with the Supply Chain Management and the Budget Management Office in the head office. The budgets are then finalised in December, thereafter, the Demand plans are fine-tuned, and the acquisition plans are also compiled in line with the finalised budget and submitted to the Supply Chain Management. In summary, the Supply Chain Management will compile the departmental procurement plan which includes the District Hospital's inputs.

4. From the beginning of the financial year in April, the district hospitals are then given a go ahead to start the process of purchasing the medical equipment as planned. At this stage, the process of filling the critical vacant posts should also begin with the submission of inputs to the Human Resources department. And then, after the medical equipment is delivered to the hospitals, the hospitals are required to pay for the invoices within thirty days.

5. And then, after every quarter the expenditure review meetings are held, where the Programme managers will account on any deviations from the planned purchasing of the medical equipment, goods and services and the filling of vacant posts. Finally, the remedial steps are then adopted and where there is a saving, the funds are reallocated to other areas within the department.



6. The following failures to comply to the above process have contributed to the problems:

    - Non submission of MTEF inputs or submission of poor quality inputs.
    - Additional funding requests are not submitted or they are not adequately costed and motivated.
    - Non submission of demand plans.
    - Non-compliance to supply chain management processes like, compilation of asset acquisition plans and procurement process etc.

- Rising compensation of employees costs, which crowd out the purchasing of other items.
- Lack of proper functioning Financial Control Committees at district hospitals.

4. Expenditure Observations

Expenditure Per Patient Day Equivalent (PDE)

According to the South African Health Review of 2011(SAHR 2011) the average Expenditure Per Patient Day Equivalent(PDE) “measures the average cost per patient per day as seen at a particular level of hospital. PDEs combine the number of inpatients, plus half($\frac{1}{2}$) the number of day patients plus a third($\frac{1}{3}$) of emergency room or outpatient visits.” So, the following table provides an idea of how much on average it costs the District Hospital to service each patient per day, per financial year.

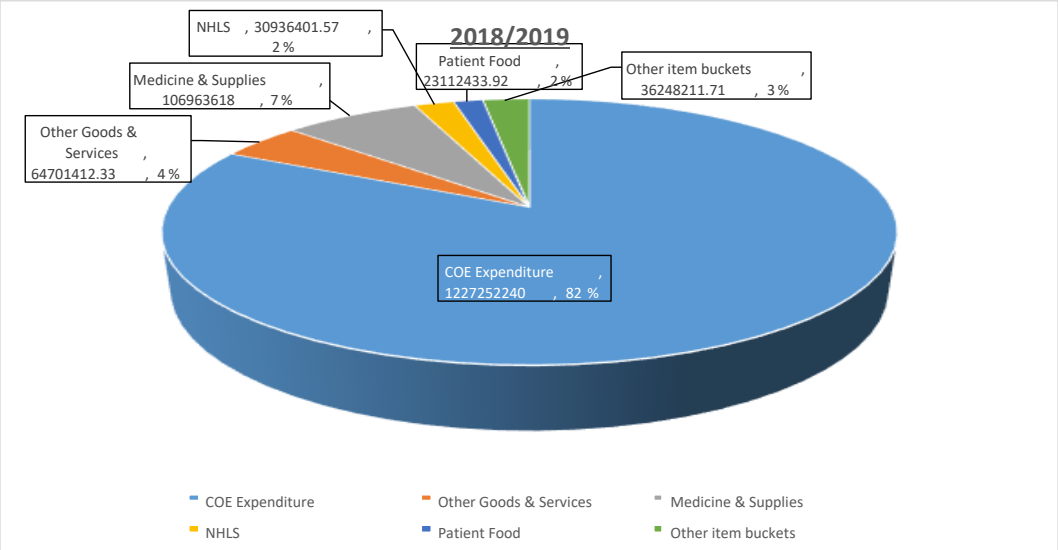
Annual Performance Report (APP) targets versus Projected Expenditure By comparing the APP projections and expenditure projections calculated on the compound annual growth rate(CAGR) of 15.02% between 2015/16 and 2018/19, it is clear that the district hospitals will have a shortfall of R366 million. This supports the observation that the department is not budgeting realistically for the district hospitals ‘expenditure:

Expenditure Per Patient Day	**%**						
Compound Annual Growth Rate (CAGR)	**15.02%**						
	Actual Average PDE from APP				**Growth Projections**		
	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Average Expenditure Per Patient Day Equivalent(PDE) - Per District Hospital.	**R1,643**	**R2,495**	**R2,522**	**R2,500**	**R2,875**	**R3,307**	**R3,804**

Annual Performance Plan PDE Projections	**R3,000**	**R3,200**	**R3,200**
Difference (Projected Over Expenditure Per Patient)	**R125**	**-R107**	**-R604**
Projected Number Of Patient to be Serviced	**618,760**	**620,834**	**623,472**
Total Projected Over Expenditure Amount	**R77,059,707**	**-R66,622,064**	**-R376,587,550**
Total Projected cost over the MTEF			**-R366,149,906**

District Hospitals' actual expenditure

The departmental expenditure report and an expenditure summary table on Annexure 2, show that in 2018/19 the compensation of employee's expenditure item bucket accounted for 82.4% of the total expenditure of district hospitals. This means that, only 17.6% of the expenditure went to other expenditure item buckets. If the department continues to increase the number of health professionals, those officials will have less and less goods and equipment to work with. If there are no additional funds for the new appointments, the cost of living adjustment on compensation of employees will also lead to the crowding out of other items.



A total of 10.8% was spent on Medicine & Medical Supplies, NHLS, and Patient Food. When one adds 82.4% of compensation of employee's expenditure item bucket to that, the total spent was 93.2%. Other goods and services item buckets shared 4.3%. Which means that,

other non-goods and services items such as Medical Equipment were left to share 2.4%.

Which is not enough in improving conditions at district hospitals.

This option of reducing the expenditure on all other Item buckets except compensation of employees, leads to a declining capacity of District Hospitals to service over 600 000 patients which seek cure at District Hospitals.

Expenditure per Facility

	Facility Name	Grand Total	Grand Total
	DISTRICT HOSPITALS	Actual Expenditure 2018/19	2018/19 Share Analysis
1	NATIONAL HOSPITAL	R194,350,425	13.1%
2	BOTSHABELO HOSPITAL	R142,003,117	9.5%
3	METSIMAHOLO HOSPITAL	R122,570,493	8.2%
4	MOROKA HOSPITAL	R115,458,564	7.8%
5	ELIZABETH ROSS HOSPITAL	R97,892,986	6.6%
6	PHEKOLONG HOSPITAL	R77,664,035	5.2%
7	KATLEHO HOSPITAL	R69,040,174	4.6%
9	THUSANONG HOSPITAL	R66,016,279	4.4%
8	THEBE HOSP	R65,962,590	4.4%
20	ALBERT NZULA HOSPITAL	R53,234,485	3.6%
10	TOKOLLO HOSPITAL	R53,135,569	3.6%
11	PARYS HOSPITAL	R50,175,911	3.4%
12	MANTSOPA HOSPITAL	R50,093,469	3.4%
13	MAFUBE HOSP	R36,938,741	2.5%
14	ITEMOHENG HOSPITAL	R36,576,508	2.5%
15	PHUTHULOHA HOSPITAL	R34,416,807	2.3%
16	DIAMANT HOSPITAL	R32,925,700	2.2%
18	NKETOANA HOSPITAL	R29,052,085	2.0%
17	NALA HOSPITAL	R28,290,344	1.9%
19	EMBEKWENI HOSPITAL	R23,921,793	1.6%
22	MOHAU HOSPITAL	R22,454,063	1.5%
24	STOFFEL COETZEE HOSP	R21,530,744	1.4%
21	PHUMELELA HOSPITAL	R21,128,258	1.4%
23	JD NEWSBERRY HOSP	R20,428,696	1.4%
25	WINBURG HOSPITAL	R19,654,698	1.3%
26	OTHER(*Misclassifications*)	R4,297,781	0.3%
	Grand Total	**R1,489,214,317**	**100.0%**

The bulk of the medical claims' expenditure from 2015/16 to 2018/19 was reported and accounted for under Administration – Management programme, instead of district hospitals. Even though it was generated at a facility level. The reason provided is, the expenditure would have crippled the budget of the district hospitals. Currently, the department does not budget for medical legal claims. However, when there is a clear budget saving at the end of the financial year, the available budget is then reprioritised to settle those claims.

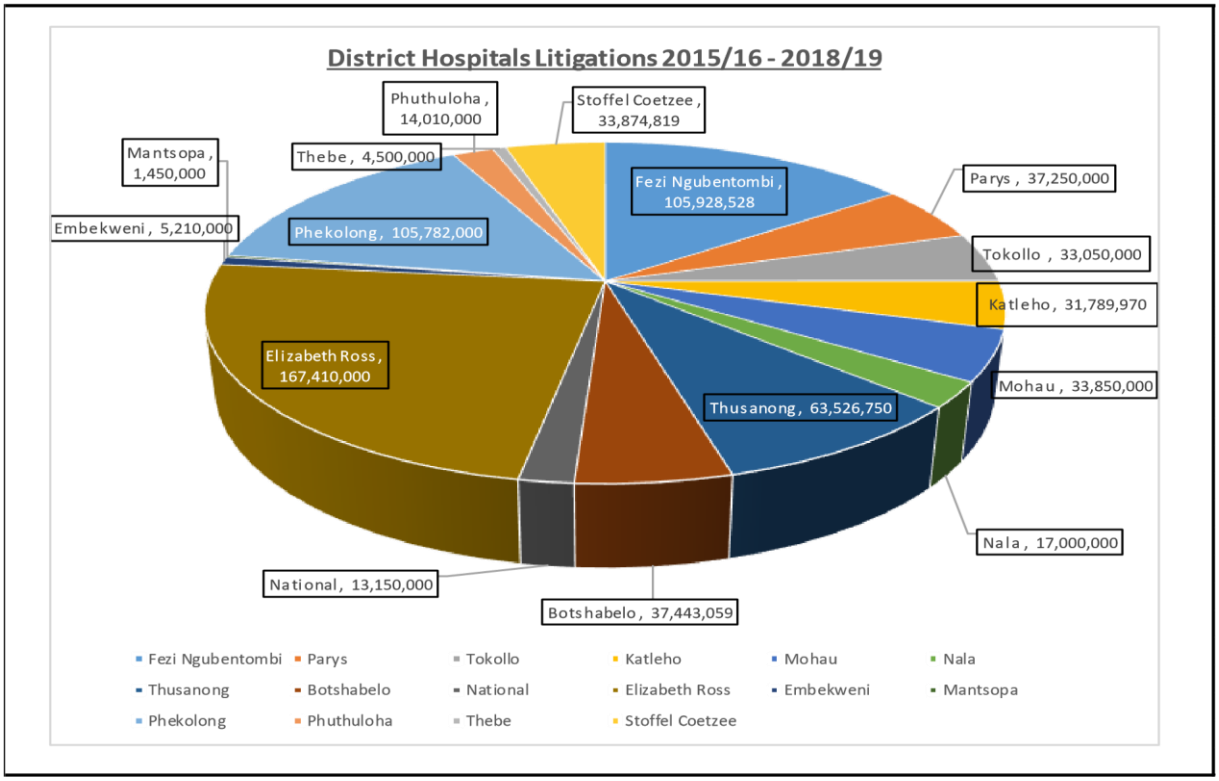
District Hospitals' Maintenance and PDE

The District Hospitals are increasingly spending the equitable share fund on the maintenance of buildings. The Maintenance of biding expenditure amounted to about R6 million from 2015/16 to 2018/19. The use of the Health Facilities Revitalisation Grant to fund the maintenance of District Hospitals more should be explored. The published Estimates of Provincial Revenue and Expenditure of 2019/20 indicates that the allocation for maintenance or revitalisation of District Hospitals' facilities from Health Facilities Revitalisation Grant has been reduced to be lower than in 2016/17, each year from 2019/20 to 2021/22.

The recently built Albert Nzula District Hospital has contributed to the growing number of admitted patients and increasing PDE from 2017/18. As a result, the expenditure projected to increase more over the MTEF.

Litigations per District Hospital

At which facilities were the most litigations registered from 2015/16 to 2018/19? The Litigation register provides an indication on which facilities should be given more attention.



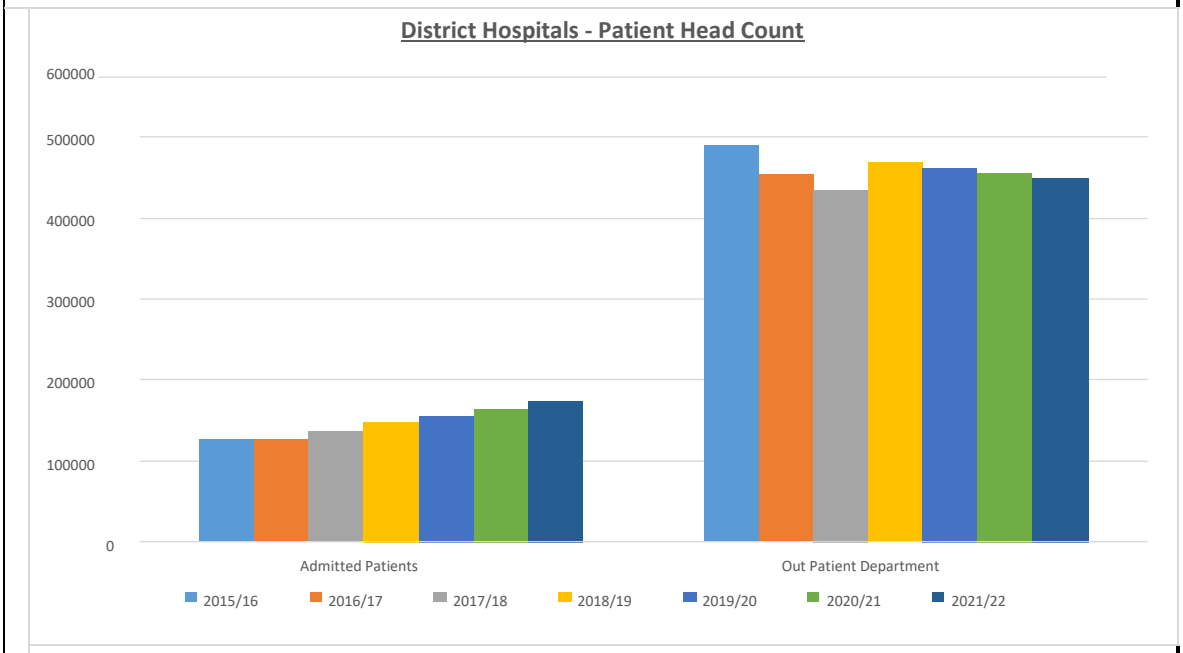
Certain facilities within each district need more assistance than others.

Litigations per District Hospital	2015/16	2016/17	2017/18	Grand Total
Fezile Dabi District	**62,250,000**	**900,128**	**113,078,400**	**176,228,528**
Fezi Ngubentombi District Hospital	25,000,000	900,128	80,028,400	105,928,528
Parys District Hospital	37,250,000			37,250,000
Tokollo District Hospital			33,050,000	33,050,000
Lejweleputswa District	**71,439,970**	**1,200,000**	**73,526,750**	**146,166,720**
Katleho District Hospital	31,789,970			31,789,970
Mohau District Hospital	32,650,000	1,200,000		33,850,000
Nala District Hospital	7,000,000		10,000,000	17,000,000
Thusanong District Hospital			63,526,750	63,526,750
Motheo District	**2,000,000**	**150,000**	**48,443,059**	**50,593,059**
Botshabelo District Hospital			37,443,059	37,443,059
National District Hospital	2,000,000	150,000	11,000,000	13,150,000
Thabo Mofutsanyana District	**127,582,000**	**45,670,000**	**125,110,000**	**298,362,000**
Elizabeth Ross District Hospital	32,250,000	29,270,000	105,890,000	167,410,000
Embekweni District Hospital			5,210,000	5,210,000

Mantsopa District Hospital		1,450,000		1,450,000
Phekolong District Hospital	95,332,000	10,450,000		105,782,000
Phuthuloha District Hospital			14,010,000	14,010,000
Thebe District Hospital		4,500,000	-	4,500,000
Xhariep District			**33,874,819**	**33,874,819**
Stoffel Coetzee District Hospital			33,874,819	33,874,819
Grand Total	**263,271,970**	**47,920,128**	**394,033,028**	**705,225,126**

5. Performance

The total number of patients treated at District Hospitals declines between 2015/16 and 2017/18 but starts increasing from 2018/19. Caused by the declining number of Out Patients at a rate of 1.41% per year, and perhaps due to a better performance by the clinics and community health centres. The decline is projected to continue over the MTEF. However, the number of Admitted Patients is increasing at a rate of 5.5% per year. The average number of days spent by admitted patients at the District Hospital has increased from 2.9 days in 2016/17 to 3.5 days in 2018/19, according to the published 2019/20 APP.



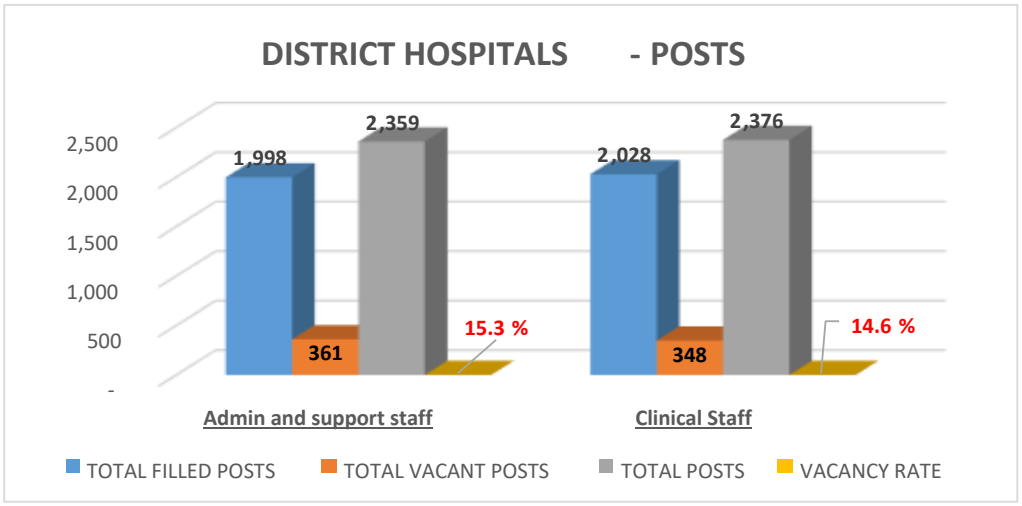
	Actual Patient Head Count				Growth Projections		
Patient Head Count	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Admitted Patients	125,964	125,665	135,950	147,899	156,029	164,606	173,654
Out Patient Department	489,680	454,582	434,378	469,326	462,731	456,229	449,818
Total	**615,644**	**580,247**	**570,328**	**617,225**	**618,760**	**620,834**	**623,472**

Growth Rate (CAGR)	**%**

Admitted Patients	5.50%
Out Patient Department	-1.41%

Moreover, the increase on the number of admitted patients, increases the burden on the current staff. Thus, it warrants the department to appoint more staff.

There is currently a total vacancy rate of 15% or 709 vacant posts at the District Hospitals. 348 vacant posts are for clinical staff, which translates to a vacancy rate of 14.6%. When looking at the department's Litigation Register, one will notice that the lack of adequate staff and supervision has also contributed to some of the increasing number of medical negligence cases.



DISTRICT HOSPITALS	TOTAL FILLED POSTS	TOTAL VACANT POSTS	TOTAL POSTS	VACANCY RATE
Admin and support staff	1,998	361	2,359	15.3 %
Clinical Staff	2,028	348	2,376	14.6 %
Grand Total	**4,026**	**709**	**4,735**	**15.0 %**

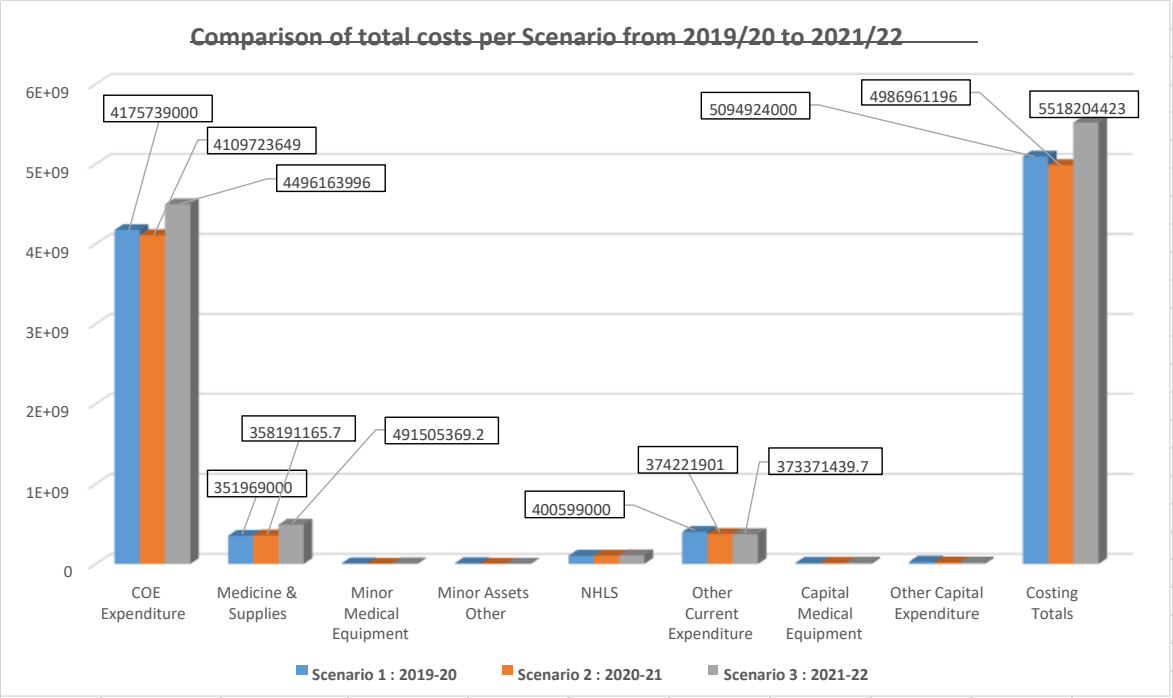
6. Options

The costing model was designed to explore three options on whether the overall funding of the District Hospital is enough to make an impact on the increasing medical legal claims, and

improve service delivery. The model compares the current 2019/20 budget allocation with the other two options, which are calculated using the 2018/19 outcome as a base.

- The first option or scenario 1 is the budget allocation of the District Hospitals, as contained in the published 2019/20 departmental budget.
- The second option or scenario 2 is calculated on the total compound annual growth rate of the District Hospitals' expenditure of 2015/16 to 2018/19, using the 2018/19 expenditure to determine the 2019/20 MTEF projected costs.
- The third option or scenario 3 is calculated based on consumer price index and additional 3 percent, to arrive at the generally accepted health sector medical inflation rate.

What will happen if the department's budget allocation to the district hospitals continues on the same trend, and the performance and expenditure of the district hospitals also continues in the same trend? Or what will happen if the District Hospitals employ more personnel within the current budget allocation, therefore increasing the compensation costs, or if the current trend of the compensation of employee's item bucket is left the same? What will happen to the goods and services and other item buckets?



Item Buckets	Actual 2018/2019	Scenario 1 2019/2020	2020/2021	2021/2022	Scenario 1 - 3yr Totals	Scenario 2 2019/2020	2020/2021	2021/2022	Scenario 2 - 3yr Totals	Scenario 3 2019/2020	2020/2021	2021/2022	Scenario 3 - 3yr Totals
COE Expenditure	1,227,252,240	1,258,589,000	1,402,476,000	1,514,674,000	4,175,739,000	1,295,978,365	1,368,553,154	1,445,192,130	4,109,723,649	1,404,952,902	1,497,679,794	1,593,531,300	4,496,163,996
Medicine & Supplies	106,963,618	115,358,000	121,472,000	115,139,000	351,969,000	112,953,581	119,278,981	125,958,604	358,191,166	150,619,562	163,572,844	177,312,963	491,505,369
Minor Medical Equipment	827,586	2,482,000	2,600,000	2,900,000	7,982,000	873,930	922,871	974,551	2,771,352	2,482,000	2,600,000	2,900,000	7,982,000
Minor Assets Other	1,312,602	3,628,000	3,834,000	3,198,000	10,660,000	1,386,108	1,463,730	1,545,698	4,395,536	1,383,482	1,460,957	1,539,849	4,384,289
NHLS	30,936,402	33,853,000	35,647,000	33,789,000	103,289,000	32,668,840	34,498,295	36,430,200	103,597,335	33,535,059	36,419,074	39,478,277	109,432,410
Other Current Expenditure	111,750,742	131,296,000	138,254,000	131,049,000	400,599,000	118,008,783	124,617,275	131,595,843	374,221,901	117,819,063	124,416,931	131,135,445	373,371,440
Capital Medical Equipment	4,371,955	5,158,000	5,200,000	5,300,000	15,658,000	4,616,784	4,875,324	5,148,342	14,640,450	5,158,000	5,200,000	5,636,800	15,994,800
Other Capital Expenditure	5,799,174	9,488,000	10,222,000	9,318,000	29,028,000	6,123,928	6,466,868	6,829,012	19,419,808	6,112,330	6,454,620	6,803,169	19,370,119
Costing Totals	**1,489,214,317**	**1,559,852,000**	**1,719,705,000**	**1,815,367,000**	**5,094,924,000** 1,572,610,319	**1,660,676,497**	**1,753,674,381**	**1,722,062,399**	**4,986,961,196**	**1,837,804,220**	**1,958,337,804**	**5,518,204,423**	

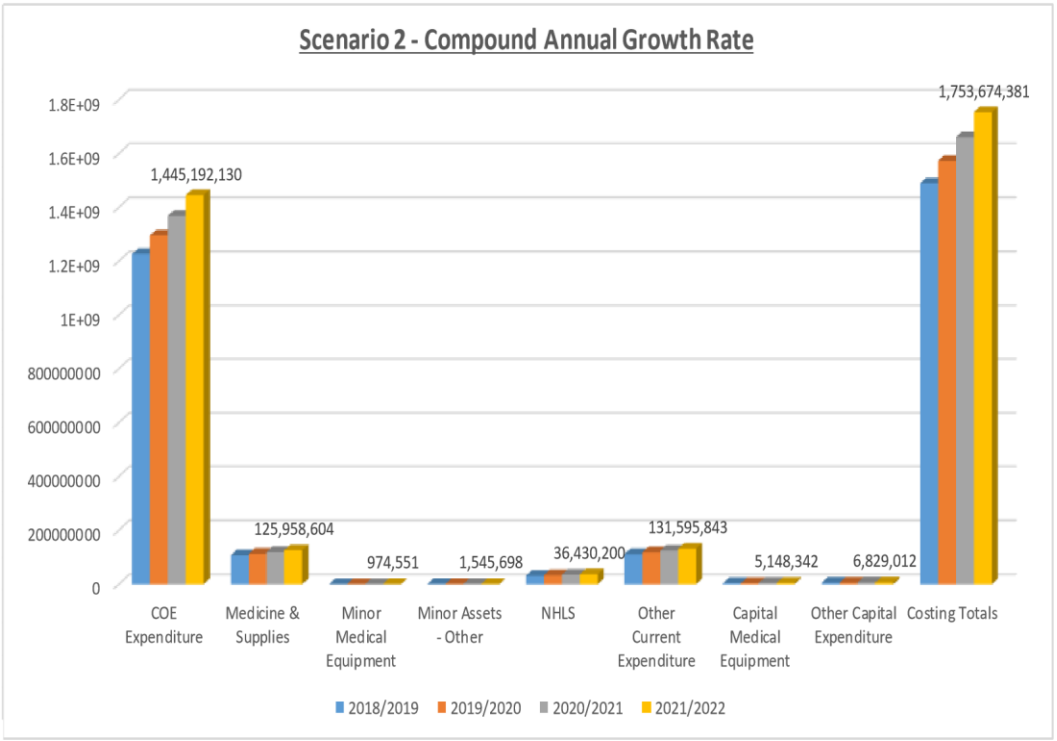
Scenario 2 – Compound Annual Growth Rate Increase

In terms of the costs, the **scenario 2** will cost the department close to R5 billion from 2019/20 to 2021/22, which is the lowest amount compared to the other two scenarios. All the item buckets were increased by the same CAGR of 5.6%.

The 5.6% increase on compensation of employees' item bucket is inadequate and lower than the 6.4% compensation of employees' expenditure increase, which was recommended by the Treasury. The department will not be able to fill any critical vacant posts, and there will be a projected over spending on compensation.

The district hospitals will still suffer with regard to the procurement of the needed medical equipment. Since, there is no significant increase on the medical equipment budget.

How much will it cost the department to run the district hospitals per item bucket in the third medium term year, of 2021/22?

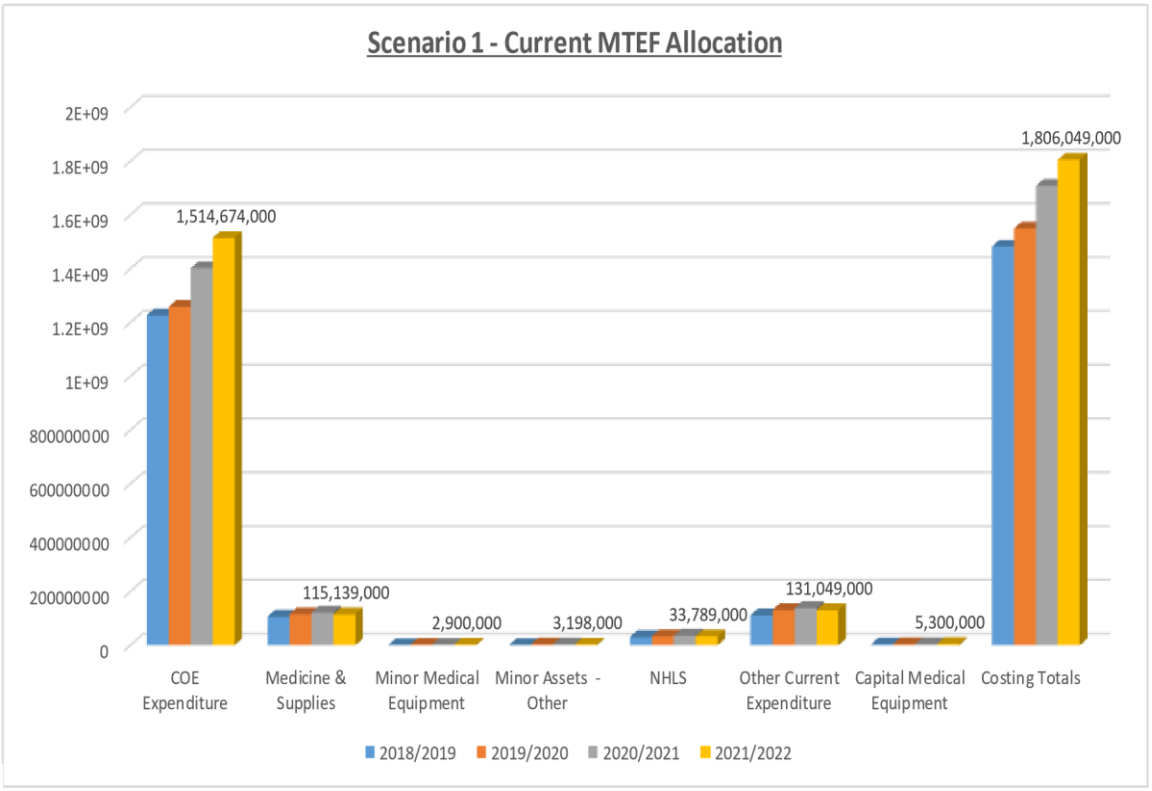


Scenario 1 – Current MTEF Allocation

The total costs of **scenario 1** over the three financial years will be just below R5.1 billion. It costs more than scenario 2 by R108 million. The deficiency of this scenario is that, the allocation of capital budget other than medical equipment increases sharply as compared to a more needed capital medical equipment and minor medical equipment items. The budget should be reprioritised to medical equipment items.

The R1,258,598,000 budget allocation on compensation of employees' item bucket of 2019/20, is an increase of 2.6% from the 2018/19 compensation of employees' expenditure, which will lead the district hospitals to over spend the 2019/20 compensation of employees' budget as the employees' salaries are projected to increase by 6.4% and therefore, the district hospitals will not be able to fill any vacant critical posts.

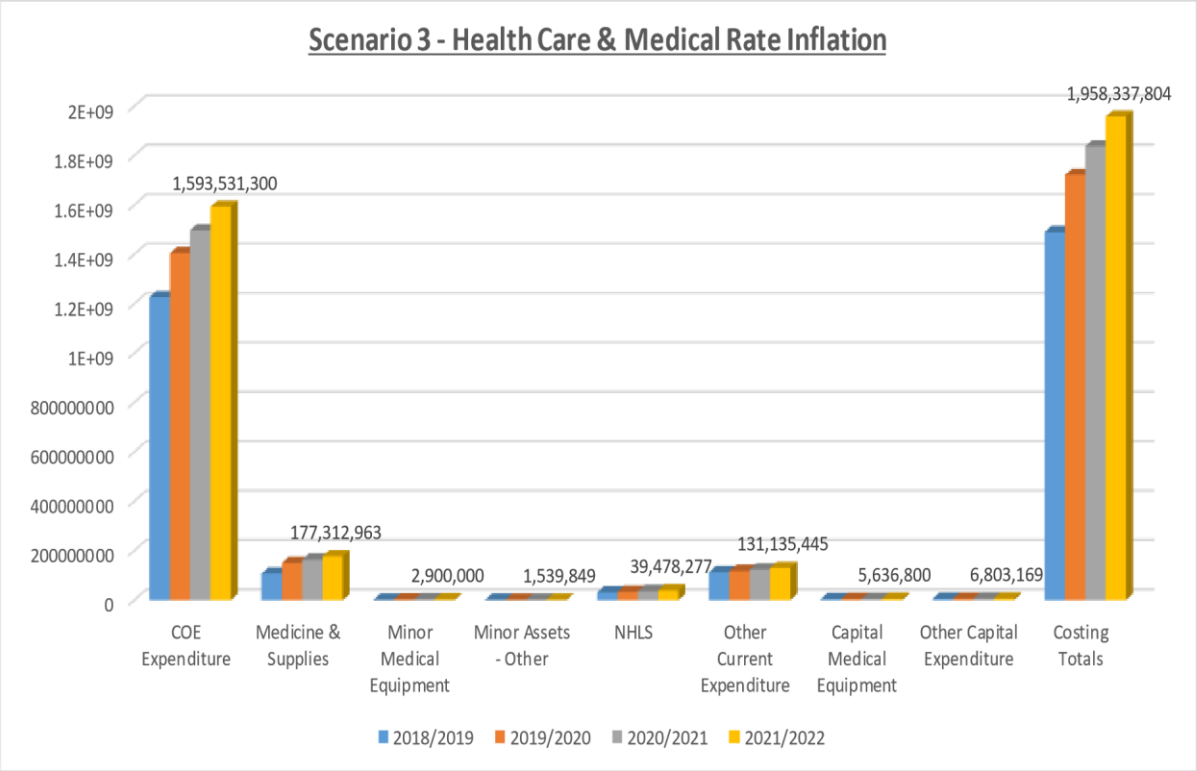
How much will it cost the department to run the District Hospitals under this scenario, per item bucket, in the third medium term year of 2021/22?



Scenario 3 – Health Care and Medical Inflation

Under the **scenario 3**, the projected budget was calculated on the following assumptions:

- The District Hospitals compensation of employees' allocation will be increased by the Treasury recommended 6.4%, and 250 critical vacant posts of staff nurses and 50 medical officers will be filled.
- R273 PDE projected shortfall was factored into the Medical items allocation, based on a number of 127 000 patients, to prevent over expenditure.
- Medical items were increased by CPI percentage plus 3% for medical inflation. Other non-medical items were increased by 5.4% CPI percentage.
- The acquisition of medical equipment as per the current published Estimates of Provincial Revenue and Expenditure and MTEF Database of District Hospitals. How much will it cost the department to run the District Hospitals under this scenario, per item bucket, in the third medium term year of 2021/22?



Even though, the total costs of running the District Hospitals over the three years will be R5.5 billion. Scenario 3 seems more likely to improve the service delivery level at the District Hospitals and address the problem of the increasing medical legal claims against the state.

7. Recommendations

The budget allocation of funds between the sub-programmes of District Health Services should be reassessed. The current allocation has indirectly led to an unintended result of over R705 million worth of litigations arising from medical legal cases at the district hospitals.

The department should look at reprioritising funds from other areas within the department, in order to avoid over expenditure and/or poor performance at district hospitals. The budget allocation of District Hospitals should be increased.

The budget should be directed at compensation of employees' item bucket for filling critical and vacant posts, and goods & services item buckets such as Medicine and Medical Supplies. The budget allocation of the compensation of employees' budget should be equitably shared among district hospitals, based on the Workload Indicators of Staffing Need (WISN). Which is a human resource planning and management tool that gives health managers at all levels a straightforward, systematic way to make staffing decisions and manage staff efficiently. The WISN approach is based on a health worker's workload, with activity {time} standards applied for each workload component.

The move to fill some critical vacant posts at District Hospitals should be done only if there are additional funds available from other areas within the department. At the current rate of expenditure as seen in Annexure 2, the compensation of employees will account for 82.4% of the total District Hospitals' budget from 2019/2020 onwards over the medium term period.

This will further shrink the goods and services share to 4.3% of the total budget, declining sharply from 12.1% share of the 2015/2016 financial year.

The amount allocated to goods and services should consider the number of patients serviced at each District Hospital. A continued effort to capacitate the clinics and community health centres should be made. So, that the number of patients seen at the district hospital level is minimised.

The allocation for the maintenance of District Hospitals' buildings should be redirected to the procurement of medical equipment. Funds for maintenance should be sought from the Hospital Revitalisation Grant.

The stabilisation of district hospitals' budgets and performance will limit the number of increasing medical litigations. The budget will be better used in the prevention of medical negligence cases and/or deficiencies.

The centralisation and reporting of medical legal claims, complicates the identification of the source of the problems. They could be still managed centrally, but reflected at the source of the problem when the process is complete. The Litigations Register could also be better compiled, by making it easier to use in monitoring liabilities and compiling reports for the executive management.

8. Action

I plan to influence the budget allocations to and within the District Hospitals:

- I will discuss my PER with the Director: Management Accounting, as soon as I have received the feedback from the National Treasury's Government Technical Advisory Centre(GTAC).
- Since the department's Budget Specialist has planned to convene budget bilateral meetings with the District Hospitals during the last week of August, I will also share

the PER with him and the Chief Financial Officer before those meetings are convened.

- I will also share and discuss the report with the District Health Services' Chief Director before the end of August, in time to influence how the budget is allocated between the District Hospitals and other sub-programmes within District Health Services.
    - I will highlight how the District Hospitals' budget could be reprioritised between and within hospitals, and how much the budget of the key item buckets could be increased.
    - I will indicate the budget shortfall of the District Hospitals.
- I will also convene a meeting with my Budget Management Office colleagues before the end of September, where I will share the key principles I learnt during the Baseline Assessment and Costing course. I anticipate that at the conclusion of this meeting, our office will select the PERs which we can conclude before the end of the financial year, with the intention of identifying wasteful areas and possible areas where we could reprioritise funds from. The Baseline assessments and costing methods will prove handy when our office visits the facilities to provide budgeting support.