

2023



ANNUAL RETURNS RECOMMENDATIONS REPORT

NATIONAL

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Abbreviations and Acronyms

AR	Annual Returns
IBUR	Inpatient Bed Utilisation Rate
CEO	Chief Executive Officer
DHIS	District Health Information System
EC	Eastern Cape Province
FS	Free State Province
GP	Gauteng Province
KZN	KwaZulu-Natal Province
LP	Limpopo Province
MP	Mpumalanga Province
NHA	National Health Act
NC	Northern Cape Province
NW	North West Province
OHSC	Office of Health Standards Compliance
WC	Western Cape Province
WHO	World Health Organisation

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1.Introduction and overview

1.1 Background

The 2023 Annual Returns (AR) recommendations report provides an overview of the profiles of the hospitals that submitted their annual returns (AR) information during the period from 1 April to 19 June 2023. The AR overview in this report is based on the information submitted by South African hospitals from the public and private sector. The focus of this report is to provide a contextual and integrated analysis of the information and profile of hospitals using the different variables and indicators for the various categories of hospitals in both health sectors.

South Africa currently has a two-tier health system, with the public health sector governed concurrently by the national and provincial departments of health and the private health sector governed and managed by private entities. The public hospitals are funded through the national fiscus (National Treasury allocations) whilst private hospitals are funded mainly through private medical insurance and to a lesser extent throughout- of- pocket payments.

Due to the inherent differences in the nature of the business and funding models as well as operational characteristics of the two hospital sectors, the report is presented in two sections in order to understand and account for the two sectors within their unique contexts.

According to the Procedural regulations pertaining to the functioning of the OHSC and handling of complaints by the Ombud, the AR information must be submitted by hospitals each year by the 31st of March. However, in 2023 the submission process was opened in April, thus the closing date for submission was 30 April 2023. The deadline was further extended as and when hospitals requested; no further extensions were granted after 19 June 2023. During verification of the data collected through AR process, it was discovered that there were missing variables (i.e., clinical staff; number of deliveries and water disruptions).

The AR variables and indicators cover a wide spectrum of information in relation to the operational characteristics and available health systems' resources. The AR information also contributes to the capacity of the OHSC to provide appropriate health systems recommendations aimed at improving quality of care in the hospitals through better health planning and decision making to relevant authorities in accordance with section 79(1)(e) of the National Health Amendment Act 12 of 2013.

The AR information provides a critical health systems' context within which the hospitals operate given the various health system's inputs and their impact on quality of healthcare services and health system performance. Furthermore, the analysis attempts to identify factors that could either enable or hamper compliance with norms and standards regulations and ultimately the delivery of quality healthcare services. In addition, the AR information allows the Office of Health Standards Compliance (OHSC) to provide relevant feedback to and recommendations to the national department of health, provincial departments of health, private healthcare groups, and hospitals to identify critical characteristics required for the provision of quality of healthcare as well as to emphasise the importance of Annual Returns as a key regulatory requirement in the governance of the health system in South Africa.

1.2. Introduction

According to section 79(1)(e) of the National Health Amendment Act 12 of 2013, the OHSC is mandated to identify areas and make recommendations for intervention by the relevant authority to ensure compliance with prescribed norms and standards. The information provided through the AR is key in profiling hospitals including identifying trends and inconsistencies in resource allocation as well as hindrances and enablers for compliance with promulgated norms and standards. Furthermore, the information is critical for the purpose of planning for routine inspections as part of assessing health establishments for compliance with the promulgated norms and standards regulations and the maintenance of a national health establishments' register.

1.3 Methodology and Process

The collection of AR information is currently focussed on the hospitals with the intention of extending the AR process to the primary healthcare level in the future in line with progressive and phased implementation of OHSC's regulatory mandate and functions.

In preparation of the annual returns submission process, the OHSC sent out communication to the provincial departments of health and the private healthcare groups' authorities a month prior to the opening of the AR online system informing them of the 2023 AR submission process. The communication included the information on the opening and closing dates and a copy of the form that outlined the information to be captured on the system. In addition, all the hospitals were provided with guidance documents to help in the submission process and were granted access to the dedicated OHSC's Annual Returns online system from 1 April 2023 to 30 April 2023 to enable the submission of profiles.

The hospital profile variables collected from the public and private hospitals were different in some respects because of key differences in the nature of the business operating models between the two sectors. The information collected from the public sector hospitals is shown in Table 1 whilst the information collected from the private sector hospitals is shown in Table 2 below.

Table 1: Annual Returns information requested from public sector hospitals

Section	Variables
Facility overview	Facility classification, number of approved beds, number of usable beds, common spoken (local) languages, catchment population number of feeder PHC facilities and hospitals where applicable
Contact information:	Name of the person in charge, designation, nature of appointment i.e., whether appointed or acting, facility address and contact details
Infrastructure	Year in which the facility was built, size of building, number storey, type of back-up power, running water, availability of information system, security system, lifts
Human Resources	Number of staff available on full-time and part time basis and available vacancies (funded) in different staff categories i.e., administration, medical, nursing, clinical support and general support.
Package of service	Inpatient services Clinical support services Outpatient services
Governance/Budget/Expenditure/Quality	Current budget allocation, previous expenditure including expenditure on medicine, laboratory, human resources. Patients experience of care survey score/outcome, staff satisfaction survey score/outcome and self -assessment score, including dates on which the surveys were conducted.

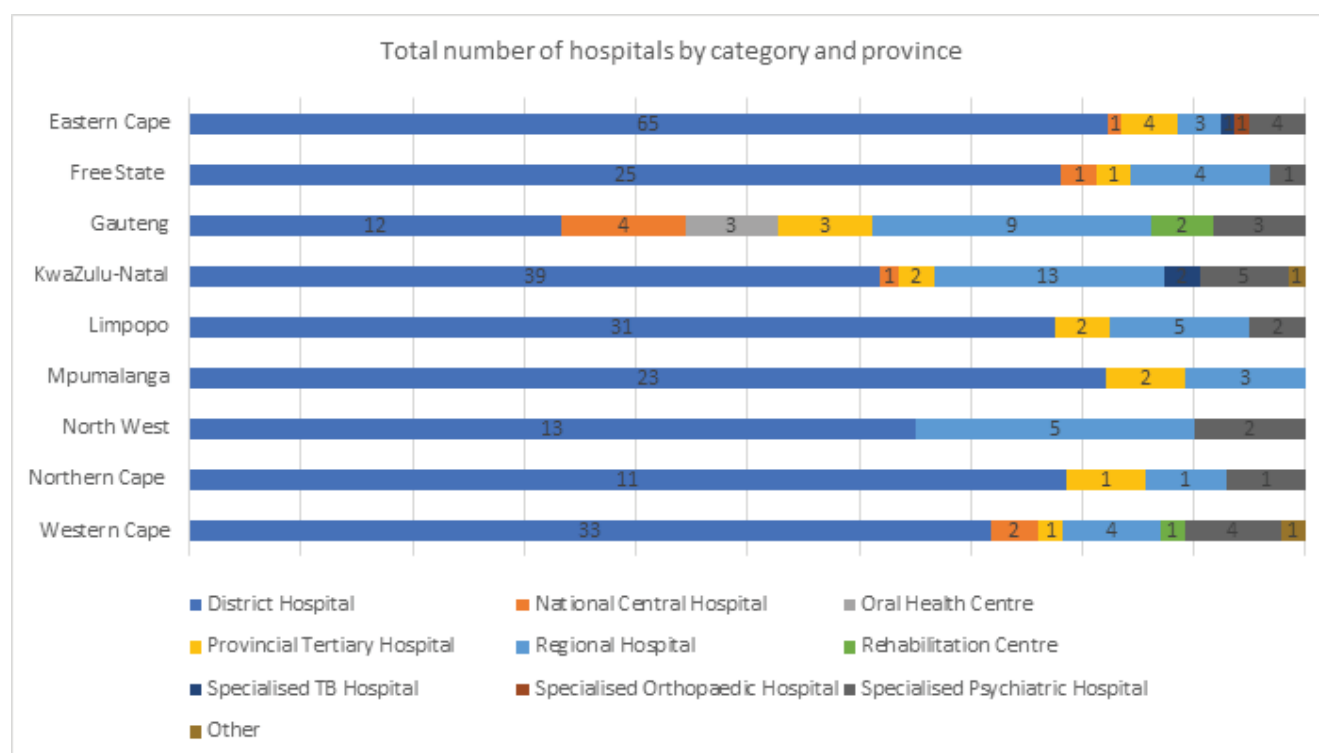
Table 2: Annual Returns information requested from private sector hospitals

Section	Variables
Facility overview	Facility licence number, network group / affiliation. Facility type, number of licenced beds, number of operational beds.
Contact information:	Name of the person in charge, designation, nature of appointment i.e., whether appointed or acting, facility address and contact details
Infrastructure	Year in which the facility was built, size of building, number of storeys, lifts, type of back-up power, running water, availability of information system, security system
Human Resources	Number of staff available on full-time and part time basis and available vacancies (funded) in different staff categories
Package of service	Inpatient services Clinical support services Outpatient services
Quality	Patients experience of care survey score/outcome, staff satisfaction survey score/outcome and inspection by OHSC

2. Public Sector

2.1. Distribution of Hospitals per category and province

Figure 1 below shows the breakdown of hospitals according to the regulations relating to categories of hospitals (R655 of 2011). Figure 1 below shows that there was a total of 386 public hospitals in the country for the financial year (FY) 2022/23. The category “other”, made up of two (2) facilities is constituted by the specialised eye and maternity hospitals in KwaZulu Natal (KZN) and Western Cape (WC) respectively.

**Figure 1: Total number of hospitals by category and province**

2.2. Submissions received per province

A total of 359 out of 386 public hospitals submitted their annual returns in 2023 compared to 365 submitted in 2022. The overall national submission rate in the period under review was at approximately 93%. It is worth noting that there was an overall decrease in the number of hospitals submitting their AR with the Eastern Cape (EC) province showing the most significant decrease from 75 in 2022 to 67 in 2023. The provincial submission rates ranged from 64% to 100% in 2023, compared to 43% - 100% in 2022. A total of seven provinces achieved a 100% submission rate in 2023 compared to six in 2022. The lowest provincial submission rate in 2023 was Northern Cape at 64%. A total of 27 hospitals from two provinces, namely Eastern Cape and Northern Cape, did not submit their Annual Returns. Figure 2 below shows submission rates per province.

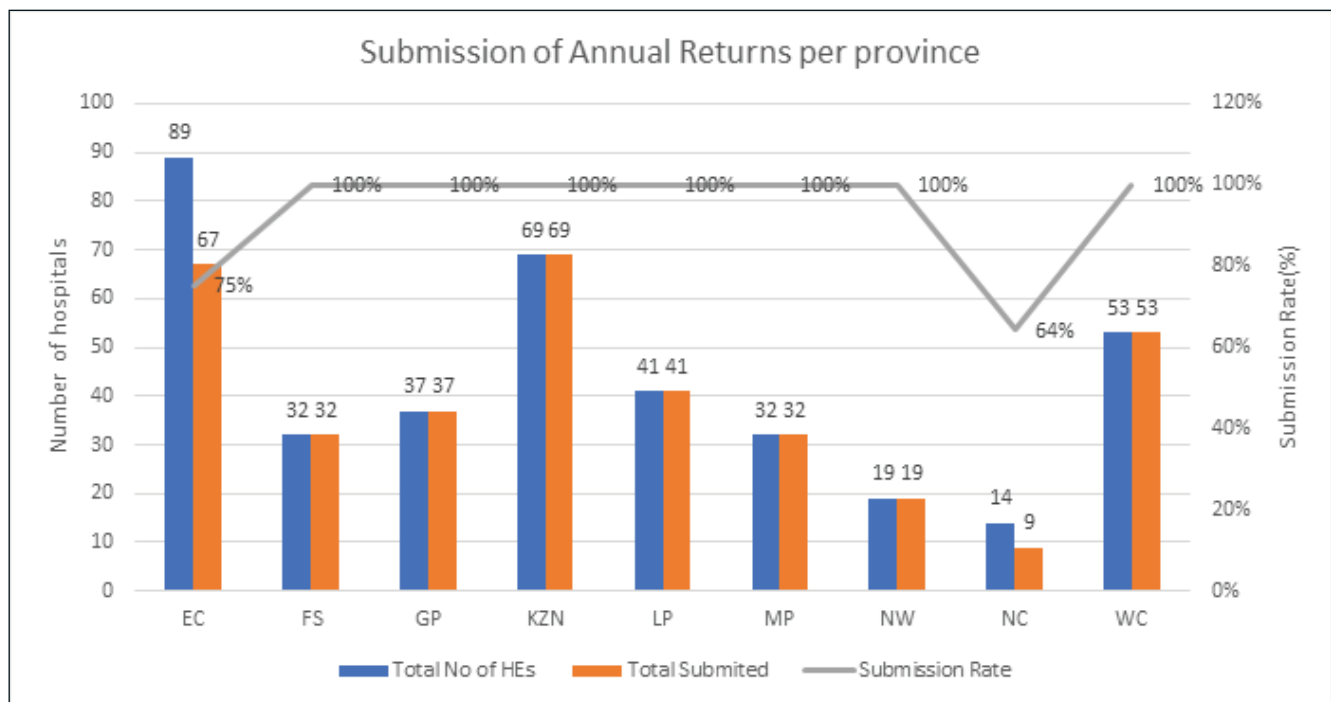


Figure 2: Number and percentage of submissions per province

2.3. Submission trends by due date

Figure 3 below shows adherence to submission due date (30 April 2023) by hospitals per province. Hospitals were given 30 days to complete their AR submissions in 2023, as opposed to 90 days given in the 2022 submission period. There was a total of 243 hospitals that submitted their ARs by the due date as compared to 116 hospitals that submitted ARs after the submission due date in 2023. The increase in the late submissions in 2023 as compared to 2022 is indicative of the need for hospitals to adjust to the stringent 30-day period submission timelines.

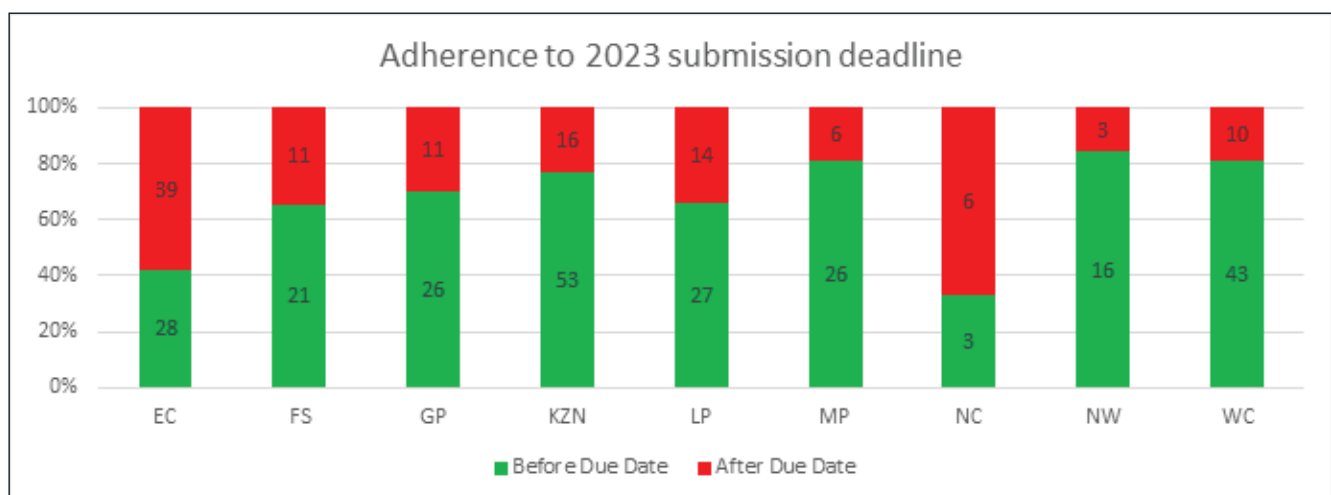


Figure 3: Number of hospitals that submitted AR by due date

2.4. Reported bed capacity per province

Usable bed capacity considered in conjunction with other health planning factors such as catchment population, burden of disease, referral facilities, and package of services is a useful proxy measure for access to healthcare services for a defined population. Figure 4 below depicts the number of approved beds versus usable beds per province. In all provinces, approved beds exceeded usable beds indicating that there was residual bed capacity within the hospitals. The residual bed capacity may indicate the overestimation of the required capacity during the health planning process as a result of inaccurate projections related to catchment population and burden of disease. In addition, the persistence of residual bed capacity could be further compounded by possible infrastructural inadequacies or defects, and human resources for health planning challenges which may impact service coverage within hospitals.

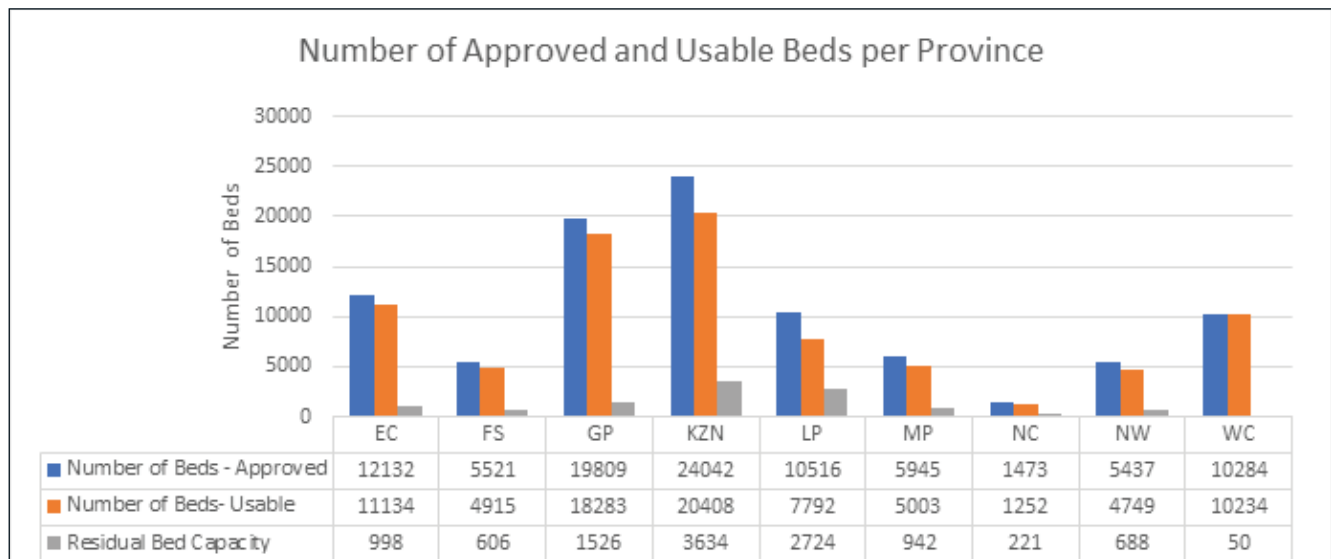


Figure 4: Number of approved and usable beds by province

2.5. Usable beds trends

Variations have been noted in the reported usable beds from 2022 to 2023 AR submissions across all provinces as shown in Figure 5 and Table 3 below. Comparison in usable bed trends from year to year could not be made for Eastern Cape and Northern Cape as these provinces did not meet the 100% submission rate for their hospitals to make meaningful observations. Provinces that have shown a decrease in their usable beds were, KZN, Mpumalanga (MP), Limpopo (LP) and WC, whilst Free State (FS), Gauteng (GP) and North West (NW) demonstrated an increase in the number of their usable beds.

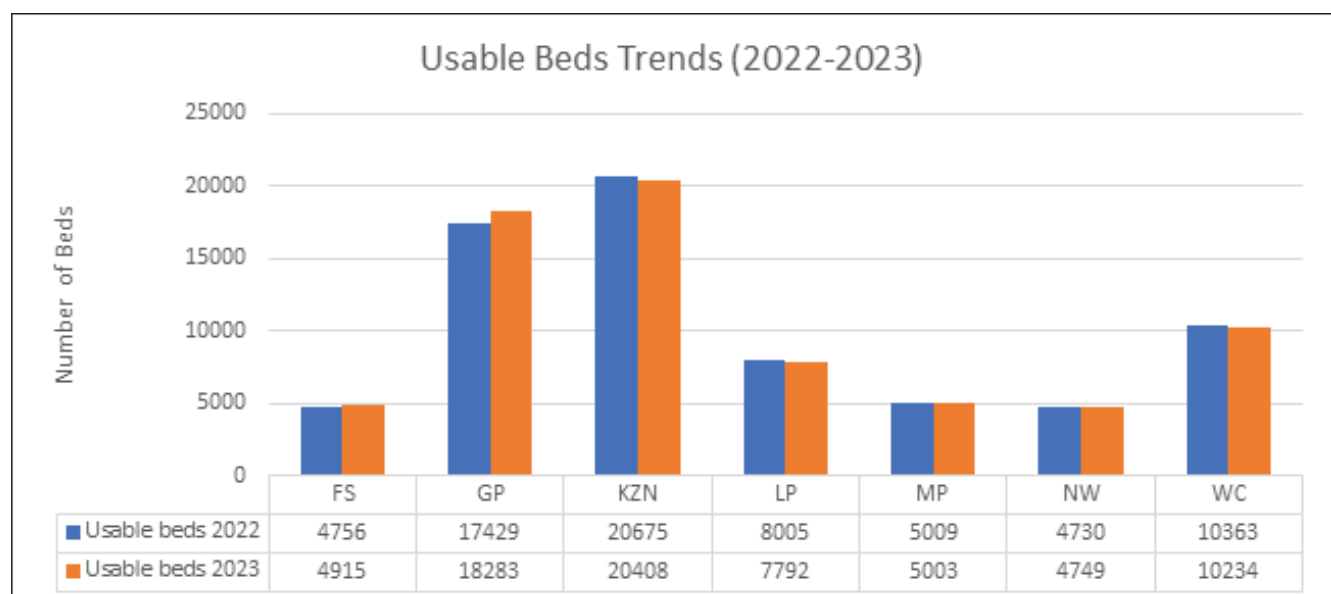


Figure 5: Number of approved and usable beds by province 2022 – 2023

Table 3 below depicts the percentage changes in usable beds from 2022 to 2023. The Gauteng Province showed the highest increase in usable beds between the two years at approximately 5%, followed by FS and NW at approximately 3% and less than 1% respectively. Limpopo province on the other hand, exhibited the highest decrease in usable beds at approximately 3%, KZN and WC both reported a decrease of just over 1%, whilst MP reported a negligible decrease at 0.1%.

Table 3: Changes of Usable Bed Trends 2022 Compared to 2023

Province	FS	GP	KZN	LP	MP	NW	WC
Percentage Change (2022 to 2023)	▲ 3.3%	▲ 4.9%	▼ 1.3%	▼ 2.7%	▼ 0.1%	▲ 0.4%	▼ 1.2%

2.6. Average Inpatient bed utilisation rate by hospital category

Inpatient bed utilisation rate (IBUR) is a measure of bed occupancy of available beds and is an important factor in assessing the efficiency levels of the hospitals when considered in combination with other hospital efficiency indicators, such as average length of stay (ALOS) and cost per patient day equivalent (PDE). When determining IBUR, there is consideration of the following elements: inpatient days, outpatients' headcount, and emergency (casualty) headcount and bed occupancy days for a defined period. It is worth noting that IBUR is affected by multiple factors such as epidemiological profile (disease burden) of the catchment population, package of healthcare services offered, healthcare services utilisation trends, and the effectiveness of the referral pathways.

Figure 6 below depicts national average IBUR per hospital category, the values received from some hospitals needed to be subjected to statistical adjustment methods to make reasonable estimates in instances of glaring errors so that the data became usable by the OHSC. The statistical adjustment process considered variables such as usable beds, hospital category as well as geographical area. The categories of specialised hospitals were excluded as some of the calculation elements of the IBUR formula are not applicable within their operational contexts. From a health system perspective, it would be expected that the average IBUR would progressively increase as you move up to the higher categories of hospitals. The increase in IBUR is premised on the fact higher level hospitals generally cater for more complicated cases with higher acuity levels. The picture in Figure 6 below therefore does not fit perfectly with what is expected as the national average IBUR for district hospitals is higher than that for regional and provincial tertiary hospitals.

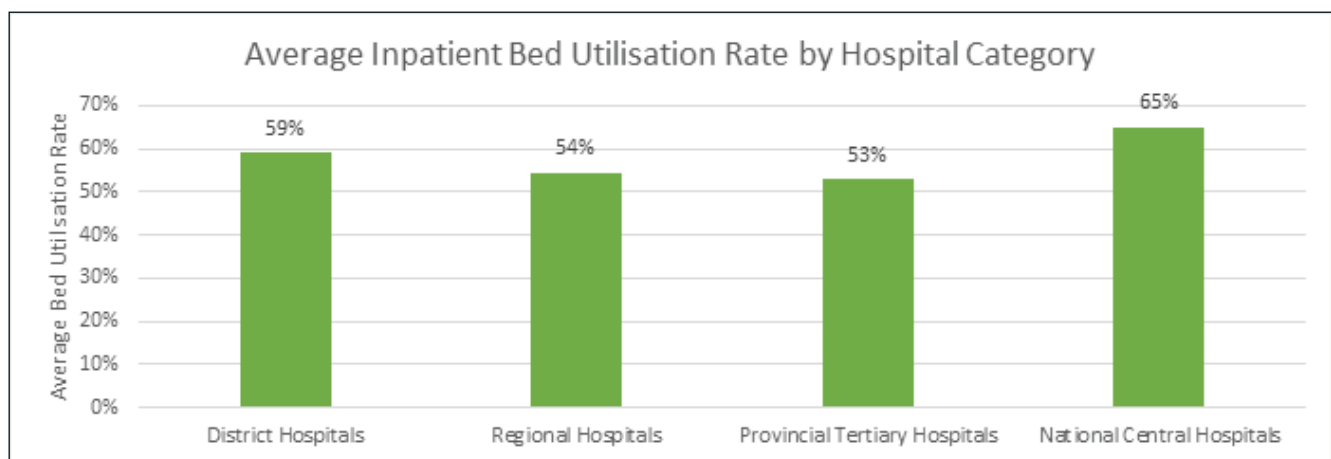


Figure 6: Average inpatient bed utilisation rate by hospital category

Figure 7 below presents the referral pathways of health establishments in the country. Form the figure, it is evident that there are hospitals that are referring users to other hospital within the same category. This may point to differing services being offered at the same level of care across the country. According to the information collected from the hospitals there are approximately 2 district hospitals referring to one district hospital. The ratio of regional hospitals referring to other regional hospitals is 3:1. It was further noted that there are health categories that are not referring to the next level of care but referring to the highest level of care or the level above the next level of care. This is seen in the in the fact that national central hospitals reported that there is a ratio of approximate 48:1 PHC HEs referring directly to them. This contrasts with a ratio of approximately 25:1 PHC HEs referring to district hospitals.

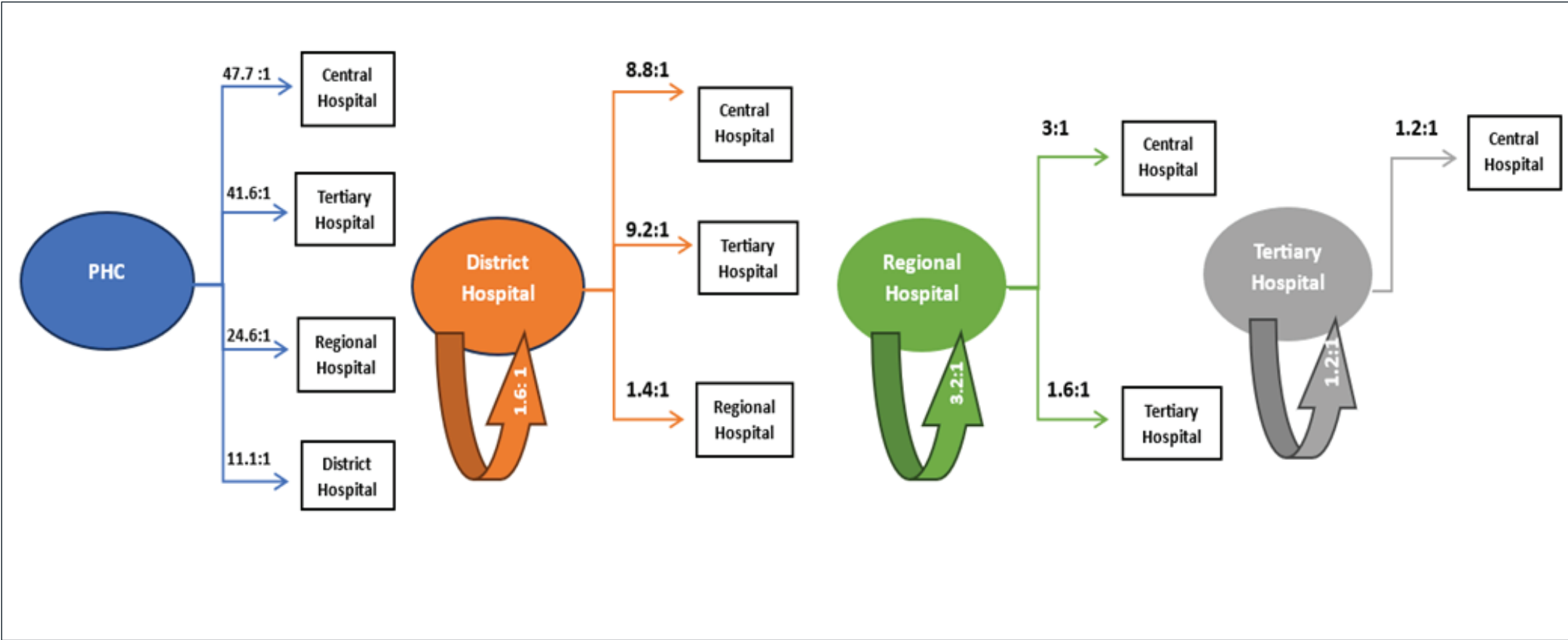


Figure 7: Health establishments’ upward referral pathways

2.7. Percentage of permanently appointed hospital chief executive officers per province

The role of the Chief Executive Officer (CEO) in a hospital is crucial for leadership and management of the hospital. A hospital's overall performance may be positively or negatively impacted upon by the permanent or acting status of the person in charge of the facility. Table 4 displays the number and proportion of filled and vacant CEO positions per province. Table 5 shows the change, (increase and decrease) in the status of appointments per province from 2022 to 2023. An increase in appointment of CEOs has been noted in the Eastern Cape, KwaZulu Natal, Mpumalanga, and the North West provinces. The changes seen for Eastern Cape and Northern Cape may not be an accurate reflection of the current status as the submission rates for 2022 and 2023 were not 100% in both provinces.

Table 4: Number of appointed and acting CEOs of hospitals (2023)

Person in charge (Appointed/Acting)	Province								
	EC	FS	GP	KZN	LP	MP	NC	NW	WC
Appointed	47	16	26	50	21	28	6	14	45
Acting (vacant)	20	16	11	19	20	4	3	5	8
Proportion of Appointed CEOs	70%	50%	70%	72%	51%	88%	67%	74%	85%

Table 5: Percentage change in permanent CEO appointments (2022 – 2023)

YEAR	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2022	65%	56%	78%	67%	59%	81%	50%	70%	96%
2023	70%	50%	70%	72%	51%	88%	67%	74%	85%
Percentage Change	▲5%	▼6%	▼8%	▲6%	▼7%	▲6%	▲17%	▲4%	▼11%

2.8. Proportion of staff vacancies by category per hospital category

Adequate Human Resources for Health (HRH) planning and implementation are important priority areas as South Africa moves toward Universal Health Coverage (UHC). As part of the information that is collected through the AR process, the number of healthcare workers per category at hospitals is requested to determine the hospitals’ ability to render the appropriate package of services in line with their categorisation. It is worth noting that the information on clinical medical staff (doctors) for the 2023 submission was not collected due to a technical glitch on the system, and therefore the figures for medical doctors presented in this report are those collected in the 2022 submission period.

It is a feature of the South African health system that the nursing category constitutes the largest proportion of the staff complement consistently across all types of hospitals. The reported proportion that makes up the nursing category in this report is an aggregation of all nursing professionals irrespective of their specialties. Table 6 below shows the number of posts that have been filled, the number of vacant posts and the vacancy rate per staff categories per hospital category, while Table 7 displays the 2022 number of posts that have been filled, the number of vacant posts and the vacancy rate for doctors per province.

Table 6: 2023 Vacancy rate per staff category by hospital category

Hospital Category	Executive Management			Nursing			Clinical Support			Admin			General Support		
	Total Filled Posts	Number of Vacant Posts	Vacancy Rate	Total Filled Posts	Number of Vacant Posts	Vacancy Rate	Total Filled Posts	Number of Vacant Posts	Vacancy Rate	Total Filled Posts	Number of Vacant Posts	Vacancy Rate	Total Filled Posts	Number of Vacant Posts	Vacancy Rate
National Central Hospital	99	18	15%	16,709	1,367	8%	3,057	275	8%	4,586	349	7%	5,986	450	7%
Provincial Tertiary Hospital	175	24	12%	15,328	3,183	17%	2,628	500	16%	3,865	745	16%	5,127	1,520	23%
Regional Hospital	394	33	8%	24,056	2,686	10%	4,055	363	8%	6,148	782	11%	7,667	763	9%
District Hospital	1,048	220	17%	35,920	4,514	11%	6,096	2,041	25%	10,424	3,011	22%	13,310	2,608	16%
Specialised TB Hospital	81	23	22%	1,363	170	11%	235	19	7%	400	71	15%	939	63	6%
Specialised Psychiatric Hospital	103	15	13%	5,710	481	8%	798	91	10%	1,235	124	9%	2,695	268	9%
Specialised Rehabilitation Hospital	19	2	10%	572	19	3%	133	7	5%	151	13	8%	196	4	2%
Oral Health Centre	20	0	0%	92	3	3%	248	11	4%	140	9	6%	51	2	4%
Other	12	0	0%	385	8	2%	77	0	0%	113	3	3%	53	2	4%

Table 6 above shows that oral health centres in the country are fully staffed when it comes to executive management positions, the same is true to the hospital category “other”. Specialised TB hospitals have the highest proportion of vacant executive management positions at 28% vacancy rate, while the provincial tertiary hospitals have the highest proportion of vacant general support positions at 30%. District hospital reported the highest proportion of vacant clinical support positions, at 33% vacancy rate, it is worth noting that this was the highest vacancy rate across all the staff categories as reported through the AR collection.

Table 7 below speaks to the 2022 vacancy rate for doctors per province, although the current submission period is 2023, the 2022 vacancy rates are considered as it is likely that the margins of change are not too wide and thus still relevant. The table shows that the highest proportion of vacancies in the category of medical specialists is in LP at 73%, followed by MP at 66% vacancy rate. The WC province had the lowest proportion of vacancy in the same category of medical specialists, with 4% vacancy rate.

Table 7: 2022 Vacancy rate for doctors per province

Province	Dental			External Visiting Medical Practitioner			External Visiting Medical Specialist			Registrars			Medical Specialist			Medical Practitioner			Medical Interns			Other		
	Filled Posts	Vacant Posts	Vacancy Rate	Filled Posts	Vacant Posts	Vacancy Rate	Filled Posts	Vacant Posts	Vacancy Rate	Filled Posts	Vacant Posts	Vacancy Rate	Filled Posts	Vacant Posts	Vacancy Rate	Filled Posts	Vacant Posts	Vacancy Rate	Filled Posts	Vacant Posts	Vacancy Rate	Filled Posts	Vacant Posts	Vacancy Rate
EC	108	27	20%	34	2	6%	22	0	0%	172	23	12%	179	38	18%	1,057	77	7%	499	1	0%	133	15	10%
FS	49	7	13%	40	5	11%	9	3	25%	81	135	63%	163	18	10%	289	73	20%	262	18	6%	118	10	8%
GP	237	10	4%	52	0	0%	51	0	0%	1,256	88	7%	1,231	128	9%	2,064	184	8%	1,459	62	4%	228	4	2%
KZN	153	20	12%	129	1	1%	51	1	2%	386	72	16%	618	184	23%	2,067	222	10%	1,322	6	0%	363	149	29%
LP	278	211	43%	38	0	0%	2	2	50%	0	104	100%	102	282	73%	915	421	32%	332	12	3%	162	169	51%
MP	111	31	22%	163	14	8%	15	3	17%	30	12	29%	62	121	66%	531	142	21%	247	28	10%	166	2	1%
NC	15	0	0%	1	0	0%	3	0	0%	26	4	13%	30	17	36%	156	17	10%	86	4	4%	55	2	4%
NW	4	0	0%	37	0	0%	19	1	5%	48	8	14%	110	31	22%	478	43	8%	337	16	5%	23	3	12%
WC	22	0	0%	160	0	0%	54	0	0%	579	13	2%	689	32	4%	797	21	3%	662	23	3%	124	11	8%

2.9. Package of Service

2.9.1. Clinical services

Hospitals provide various inpatient clinical services depending on the level of health care/ hospital category. Annexure 1 (In-Patient Services Register) shows the proportion of hospitals providing these services per province. There are some important insights emanating from the submitted data in relation to the package of services provided by the hospital platform across the nine provinces.

For example, in terms of the package of services, all hospitals from central down to the district hospitals should be providing maternal health and obstetric services including capacity to perform caesarean sections and other gynaecological procedures which would necessitate the availability of anaesthetic services. However, there is no single province out of the nine in which anaesthetic services is being offered universally in all their hospitals. It is therefore important to understand from the provincial authorities on the reasons why some of the facilities do not have anaesthetic services which are a key component of hospital services for all the various categories.

For instance, there are two provinces (EC and FS) in which more than 50% of all the hospitals do not offer any anaesthetic services but over 80% of them offer maternal health services including obstetrics as well as some surgical services. There were three (3) provinces in which less than 65% of hospitals have operating theatres. These findings have serious implications for access and quality of healthcare services especially obstetric and surgical services being provided in some of these health establishments.

There were four (4) provinces in which less than 70% of their hospitals provide psychiatry services. However, from an OHSC perspective, the concern is that access to good quality mental health services remain a persistent problem in the South African health system. There were also two provinces in which 22-26% of hospitals do not provide Accident and Emergency (casualty) services. These findings need to be contextualised to the architecture and operations of the overall hospital services platform in each of those provinces.

2.9.2. Clinical Support Services

Clinical support services are provided at different levels of care and hospital category. Annexure 2 (Clinical Support Services Register) shows the proportion of hospitals providing these services per province.

Annexure 2 contains information on the availability of clinical support services across the hospital platform. Of interest is the fact that there is generally low level of availability of laboratory services throughout the nine provinces. This finding could have implications for timeliness to certain diagnostic, monitoring and therapeutic services. The fact that this is seen widely across the platform may reflect a system's decision to centralise some of the services. There is a need for a more comprehensive explanation for this finding.

Another important finding is the fact that all the nine provinces report generally high availability of radiology services within hospitals. However, the OHSC has noted a trend in the reporting of disruption of radiology services by the hospitals through the Early Warning System (EWS).

The information from Annexure 1 and 2 is important to demonstrate that the mere presence of a health establishment and supposed availability of a service is not enough to guarantee access to good quality healthcare services for the population being served

2.10. Ambulance Services

Emergency Medical Services (EMS) are meant to be the designated health system initial responders to a medical emergency and the most appropriate method to transport users to the nearest health establishments in case of medical emergencies. The EMS personnel are responsible to respond, assess and stabilise the users in case of medical emergencies and if necessary transfer to the nearest health establishment.

In the context of the South African health system, the reality and assumption is that when ambulances are stationed at hospitals, they promote efficient and effective access to emergency medical services and care for the catchment population. However, the design and management of EMS services have been the subject of review and changes by the various provinces in response to various challenges. Therefore, the current organisation of the EMS services within the nine provinces may differ depending on the decisions of the provincial health authorities.

Table 8 below shows the proportion of facility-based EMS services per province as reported by the hospitals in the period under review.

Table 8: Ambulances based at hospital level per province

Ambulance at Facility (Yes/No)	EC	FS	GP	KZN	LP	MP	NC	NW	WC
No	46	8	24	47	19	15	5	10	37
Yes	21	24	13	22	22	17	4	9	16
Percentage with ambulance in Facility	31%	75%	35%	32%	54%	53%	44%	47%	30%

According table 8 above, FS province reported the highest proportion of hospital with ambulances based at the hospitals at 75%. The 3 provinces with the lowest proportion of hospital-based ambulances were KZN, EC and WC at 32%, 31% and 30% respectively.

2.11. Expenditure in financial year 2021/2022 and budget (2022/2023)

Health system financing is one of the six health system building blocks according to the World Health Organisation (WHO) framework. Every country has its unique context in terms of the organisation of the health system, and therefore the health financing architecture of the health system is a reflection of the socio-political framework of that country. The budget and expenditure information submitted through the AR is a reflection of the current way in which public hospitals are financed in South Africa.

The financing of hospitals is a key health system input that has direct implication for the provision of quality health services. In many health systems, including South Africa, the funding allocated to hospitals constitute a significant proportion of the budget as most of the systems are hospital-centric. South African health system. From the OHSC perspective, the degree to which hospitals are appropriately funded is expected to have a direct correlation with their ability to comply with the promulgated norms and standards.

For the purpose of this report, the hospitals were requested to provide expenditure data for the 2021/22 and budget data for 2022/23 financial years. In the previous financial years annual returns, the budget and expenditure data from the hospitals had substantial errors leading to inability of the OHSC to utilise this key data for analysis and generation of relevant recommendations. In this regard, the OHSC has engaged with the provincial and health establishments authorities to ensure improvement in the quality of submitted financial data.

For the 2023 AR submission period, there were still significant flaws and outright errors that were noted in the budget and expenditure figures provided by some hospitals. For instance, some of the errors identified included instances where individual hospitals reported total expenditure that exceeded the total provincial total expenditure on health and therefore rendering that information unusable. Having considered this fact, the OHSC has taken the decision to use statistical adjustment methods to make reasonable estimates in instances of glaring errors so that the data became usable.

Figure 8 below shows aggregate expenditure and budget information submitted by hospitals for 2021/22 and 2022/23 financial years respectively per province

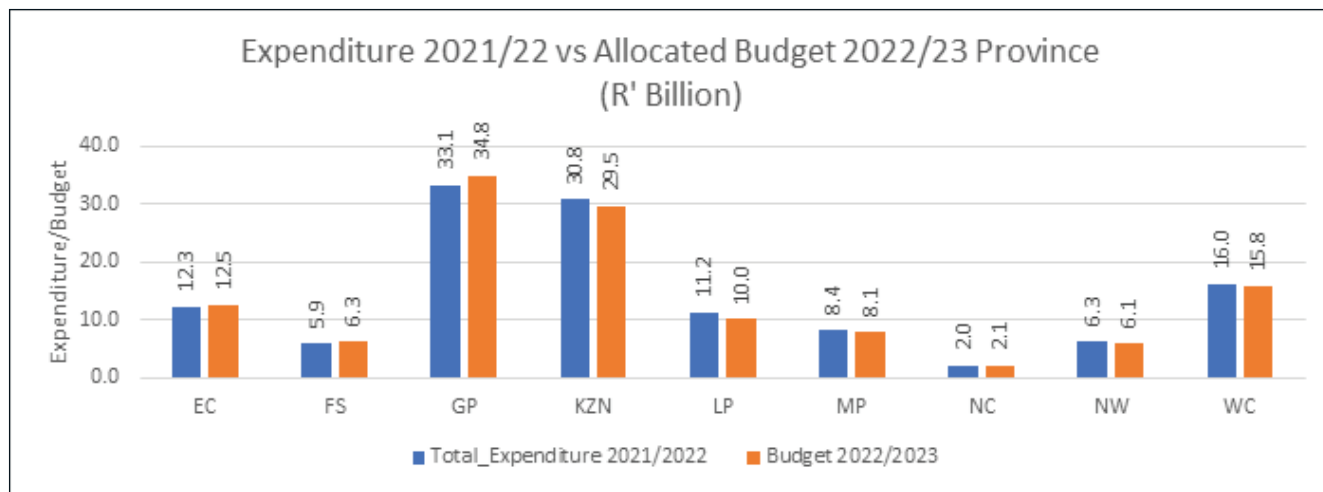


Figure 8: Total expenditure 2021/22 compared to allocated budget 2022/23

The results show that two provinces with highest expenditure were GP and KZN, with expenditures (2021/22) of R33.1 billion and R30.8 billion respectively. Furthermore, the allocated budget (2022/23) for GP and KZN was reported at R34.8 billion and R29.5 billion respectively. The abovementioned provinces are known to be the two most populated provinces in the country with a resultant increase in burden of disease, as well as having a high number of hospitals. These factors would therefore partially explain the relatively high proportion of funding allocated to hospitals in these two provinces. The converse is true for the NC province, which is the least populated province in the country with the least number of hospitals and one of the provinces where some of the hospitals did not submit their annual returns and therefore recorded the lowest budget and expenditure allocations.

2.12. State of hospital infrastructure

Hospital physical infrastructure, such as buildings, constitute a component of health system inputs and has an impact on the delivery of healthcare services, therefore making it a key component of the health system. In order to make sure that facilities adhere to the applicable building and occupational health and safety regulations, it is imperative that physical infrastructure be well maintained. Efficient maintenance of physical infrastructure is required to guarantee the buildings' integrity and an acceptable condition required for occupancy and provision of healthcare services. The integrity of the physical infrastructure is also important to support and enable the supply of key related amenities such as electricity and water supplies.

Table 9 displays the years since last refurbishment of the hospitals per province. Hospitals were asked to report on the years since the last refurbishment of the hospital building and table 9 below categorises the years since last refurbishment from 0 years to 20 years and then above 20 years. The FS province appears to be the province with the largest proportion of hospitals, at 34.4%, that have not been refurbished in the last 20 years. Gauteng province follows the FS with almost 30% of hospitals that have not been refurbished in the last 20 years as shown in table 10 below.

Table 9: Refurbishment of hospitals

PROVINCE	NUMBER OF FACILITIES & YEARS FACILITIES HAVE BEEN REFURBISHED				
	0 - 5 years	6 -10 years	11-15 years	16 - 20 years	Above 20years
Eastern Cape	34	11	4	3	15
Free State	8	4	5	4	11
Gauteng	22	2	1	1	11
KwaZulu Natal	35	12	10	2	10
Limpopo	22	5	2	2	10
Mpumalanga	20	2	4	1	5
Northern Cape	3	1	2	2	1
North West	9	2	1	1	6
Western Cape	18	11	8	2	14

Table 10: Proportion of hospitals not refurbished in the last 20 years

Province	EC	FS	GP	KZN	LP	MP	NC	NW	WC
Proportion of hospitals not refurbished in the last 20 years	17%	34%	30%	14%	24%	16%	7%	32%	26%

2.13. Power supply and backup power supply system

With the persistence of implementation of load shedding by Eskom in South Africa, there has been progressively more electrical power disruptions affecting hospitals in recent years. These power disruptions have the potential to negatively impact on the provision of healthcare services and ultimately clinical and population health outcomes. To mitigate the effects of the power outages and prevent interruptions to healthcare services, hospitals are expected to procure and be equipped with power backup systems.

Table 11 below shows the number of hospitals and the type of electrical power backup devices that are being used aggregated per province. While some hospitals in the various provinces have additional backup power via uninterruptible power supply (UPS) units and solar systems; generators appear to be the primary backup power source for most hospitals. Uninterruptible power supply (UPS) is the next popular back up power supply system after generators that is being used by hospitals per province. Generators at three hospitals, were reported to be available but not functional in EC, MP and NC, and one hospital in the WC reported to have no backup power system at all.

Table 11: Power and backup supply systems per province

Type of back-up power system	EC	FS	GP	KZN	LP	MP	NC	NW	WC
Generator	67 (100%)	32 (100%)	37 (100%)	69 (100%)	41 (100%)	32 (100%)	9 (100%)	19 (100%)	52 (98%)
Solar	0 (0)	1 (3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (2%)
UPS	8 (12%)	6 (19%)	11 (30%)	19 (28%)	8 (20%)	2 (6%)	1 (11%)	4 (12%)	11 (21%)
Other	0 (0%)	2 (6%)	1 (3%)	0 (0%)	1 (2%)	0 (0%)	0 (0%)	2 (0%)	1 (2%)

2.14 Internet connectivity

The World Health Organisation (WHO) recognises the potential for eHealth to strengthen health systems and to improve healthcare quality, safety and access to healthcare. Moreover, the health information management systems that are currently required to improve the performance of health systems and those already in place require that hospitals and other categories of health establishments have access to internet connectivity to enable their optimal functionality. Some of the health information systems currently in use include for example: District Health Information System (DHIS), various electronic patient records systems such as MEDICOM, TIER.Net, TB/HIV Information System (THIS), Ideal facility framework, OHSC portals and many others. It is against this premise that hospitals need reliable and consistent internet connectivity to access the various health information platforms.

Table 12: Proportion of Hospitals with Internet Connectivity per Province

Province	EC	FS	GP	KZN	LP	MP	NC	NW	WC
Number of hospitals without connection	9	5	1	2	0	1	0	0	0
Number of hospitals with connection	58	27	36	67	41	31	9	19	53
Proportion of hospitals with Internet	87%	84%	97%	97%	100%	97%	100%	100%	100%

2.15. Water Supply and Outages

South Africa is a water scarce country, characterised by persistent water supply disruptions and outages across the various provinces and municipalities. Water supply to health facilities is through the municipal water supply systems and therefore health facilities are not spared from the outages experienced. Unavailability of water for a prolonged period in a hospital constitutes a health risk and is a serious public health concern.

There have been a number of media reports that have covered events of shortages of water in many hospitals which are related to municipal water supply systems. The water disruptions have been associated with multiple challenges such as low water levels in dams, ailing infrastructure and disruptions in power supply to water reservoirs which is beyond the control of the hospitals. It is of utmost importance that all hospitals have reliable backup of water supply during outages. Even though the AR data collected could not establish the number of hospitals that experienced water outages in the period under review, it can be concluded that a significant proportion of hospitals experienced water outages given that 59 health establishments (hospitals and PHC included) in one province alone have been reported to be facing water shortages.

2.16 Crude death rates per 1000 admissions by hospital category

The crude institutional death rate is presented below from data received regarding the number of deaths in hospitals against the number of admissions. The data is aggregated national according to the various categories of hospitals. Figure 9 below shows that provincial tertiary and district hospitals experienced the highest crude death rates at 30 and 26 deaths per 1000 admissions respectively.

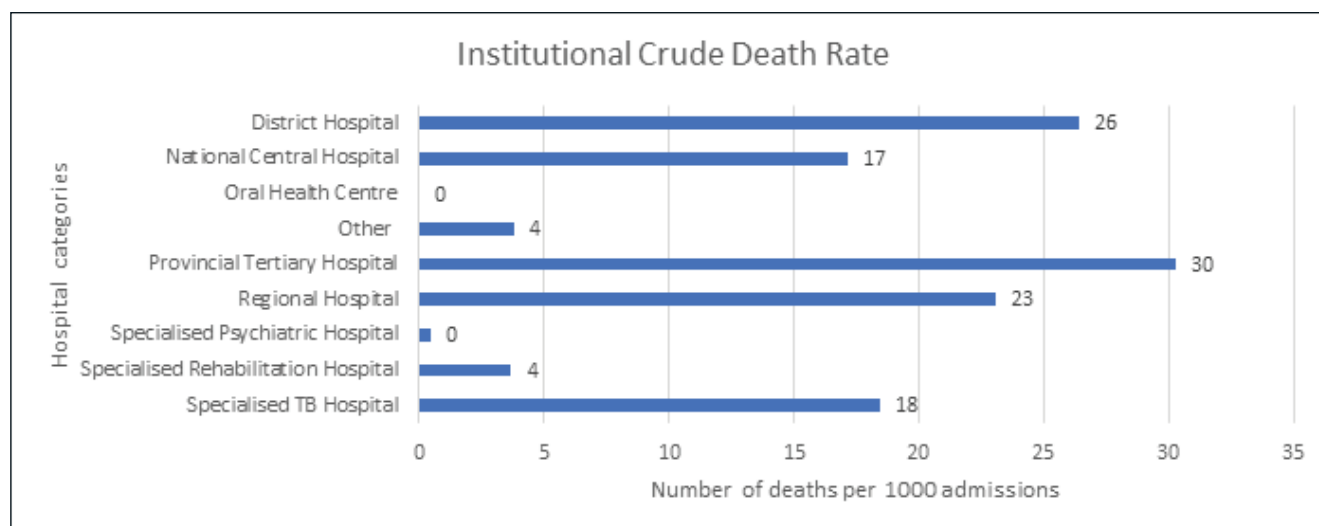


Figure 9: Crude death rates per 1000 admissions by hospital category

2.17 Quality Assurance initiatives

Achieving the goal of quality healthcare requires a commitment from hospitals to measure, improve and maintain high quality healthcare services for all users. Quality assurance and quality improvement is implemented through measuring the gap between actual practice and the expected level of care followed by working deliberately towards closing those gaps. As part of measuring and monitoring the quality of care, hospitals undertake self-assessments, staff satisfaction surveys and patient experience of care surveys. Table 13 – 16 below, show the proportion of hospitals that reported to have undertaken self-assessments, staff satisfaction surveys, patient experience of care surveys and have been inspected by the OHSC respectively. 2022/23

2.17.1 Self-assessment (Ideal facility framework)

The public hospitals are expected to carry out inspections at least once per financial year through a tool developed by the National Department of Health (NDoH). The inspections are aimed at identifying quality lapses in the hospitals. From the results, the hospitals are expected to develop quality improvement plans (QIP) to address the identified gaps. No meaningful analyses of the outcomes could be made as a result of some hospital providing the overall score, others providing the outcome (compliant or non-compliant).

Table 13: Proportion of hospitals that conducted Self-Assessment

Province	Number of hospitals that conducted self assessment	Number of hospitals that did not conduct self assessment	Proportion of hospitals that conducted self assesment
EC	50	17	75%
FS	31	1	97%
GP	33	4	89%
KZN	54	15	78%
LP	32	9	78%
MP	26	6	81%
NC	4	5	44%
NW	16	3	84%
WC	42	11	79%

As seen in Table 12 above, the NC province exhibited the lowest proportion of hospitals that have conducted self-assessment in 2022/23 financial year, with 44% of the hospitals reporting that they conducted self-assessments through the ideal facility framework. Free State on the other hand reported that 97% of the hospitals in the province conducted self-assessments.

2.17.2 Staff satisfaction survey

Table 13 below illustrates the proportion of hospitals that conducted staff satisfaction surveys in 2022/23, per province. The results show that MP province had the highest proportion of hospitals that conducted staff satisfaction surveys at 88%. The NC province had the lowest proportion of hospitals conducting staff satisfaction surveys in 2022/23.

Table 14: Proportion of hospitals that conducted Staff Satisfaction Survey

Province	Number of hospitals that conducted staff satisfaction survey	Number of hospitals that did not conduct staff satisfaction survey	Proportion of hospitals that conducted staff satisfaction
EC	28	39	42%
FS	26	6	81%
GP	25	12	68%
KZN	56	13	81%
LP	29	12	71%
MP	28	4	88%
NC	3	6	33%
NW	12	7	63%
WC	43	10	81%

2.17.3 Patient experience of care

Table 14 below shows the proportion of hospitals that conducted patient experience of care surveys in 2022/23. The FS province has reported the highest proportion of hospitals that conducted patient experience of care surveys. The NC province reported that a proportion of 44% hospitals conducted patient experience of care, this proportion is the least in the country.

Table 15: Proportion of hospitals that conducted Patient Experience of Care Survey

Province	Number of hospitals that conducted patient experience of care survey	Number of hospitals that did not conduct patient experience of care survey	Proportion of hospitals that conducted patient experience of care survey
EC	48	19	72%
FS	30	2	94%
GP	34	3	92%
KZN	59	10	86%
LP	38	3	93%
MP	20	12	63%
NC	4	5	44%
NW	16	3	84%
WC	46	7	87%

2.17.4 Inspection by the OHSC

The OHSC has been inspecting district and regional hospitals according to the promulgated norms and standards since 2021/22. Once inspected and found to be compliant, hospitals are issued certification of compliance, and the certification is valid for 4 years from the date of issue. The analysis only considered those district and regional hospitals that were inspected from 2021/22 and 2022/23. All the other hospitals that indicated that they were inspected and fall outside of these criteria were not considered as being inspected. Table 15 Below depicts the proportion of district and regional hospitals that were inspected by the OHSC.

Table 16: Proportion of district and regional hospitals that have been inspected by OHSC

Province	Number of hospitals inspected by OHSC	Number of hospitals not inspected by OHSC	Proportion of hospitals inspected by OHSC
EC	16	51	24%
FS	15	17	47%
GP	7	30	19%
KZN	17	52	25%
LP	12	29	29%
MP	12	20	38%
NC	1	8	11%
NW	4	15	21%
WC	6	47	11%

3. Private Sector

3.1 Distribution of Hospitals per category and hospital group

The total number of private hospitals at the time of the 2023 AR submission was 405. Figure 10 below illustrates distribution of the hospitals according to the hospital groups as well as the categories of the hospitals. As there is a continuous turnover (throughout the year) of hospitals affiliating and de-affiliating with hospital groups, the above number only considered hospitals that were affiliated with the hospital groups on and before the time of the 2023 AR submission. Furthermore, there were 14 private hospitals that indicated that they were not affiliated with any hospital group at the time of the 2023 AR submission, for the purpose of this report these hospitals are presented as “independent” for hospital group. The information regarding the private hospitals is presented according to hospital category and hospital groups. The category “other” denotes specialised ophthalmology, mother and child as well as maternity hospital.

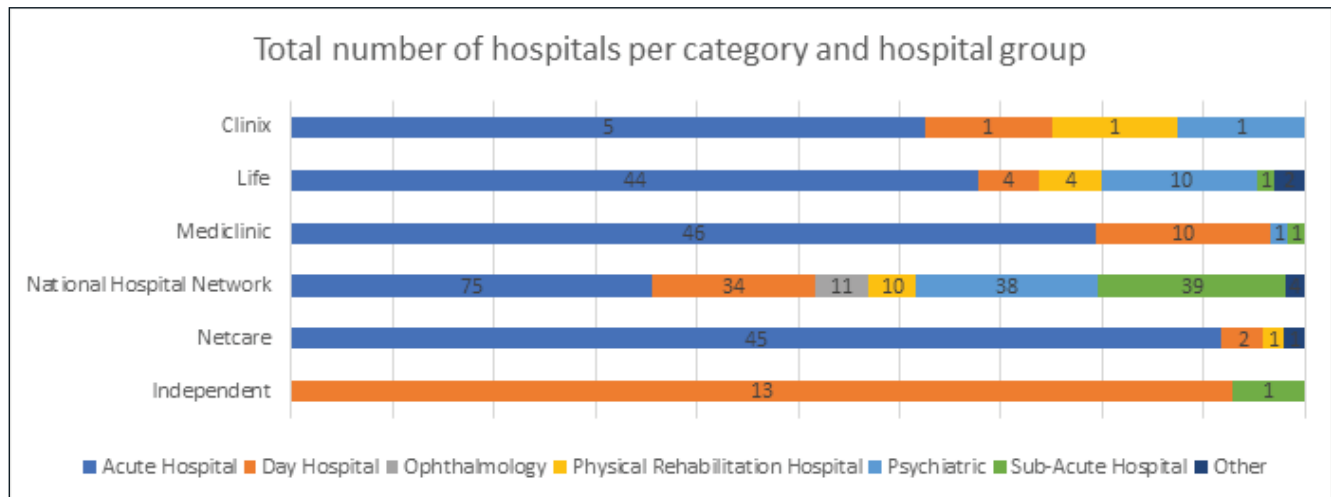


Figure 10: Total number of hospitals per category and hospital group

The figure illustrates that a great proportion of the private hospitals are affiliated with the National Health Network group with a total of 211 hospitals. Clinix healthcare group has the least number of hospitals, with a total of eight. A total of 14 private hospitals are not affiliated with any of the healthcare groups and these are referred to as “independent” in the figure.

3.2 Submissions received per hospital group

A total of 311 private hospitals submitted their annual returns during the 2023 submission period. The submission rate per hospital group ranged from 55% to 100% and the overall submission rate for the private hospitals stands at approximately 77%. There was a total of 84 private hospitals that did not submit profiles in the 2023 submission period, and these were from the National Health Network hospital group. Figure 11 below presents the submission rate per hospital group.

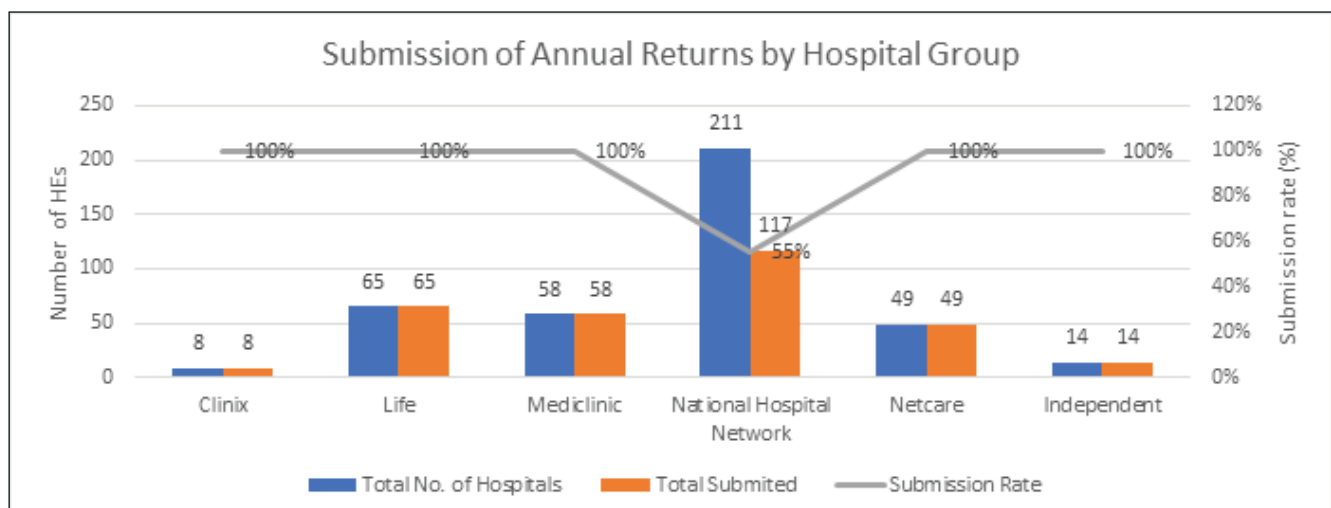


Figure 11: Number and percentage of submissions per hospital group

3.3 Submission trends by due date

As stated above in the methodology section, the 2023 AR submission period opened 1 April 2023 with closing date on 30 April 2023. Of the 311 hospitals that submitted their AR, 220 hospitals submitted by due date whilst 91 hospitals submitted after the due date did not manage to meet the submission deadline as shown in figure 12 below. It is worth noting that all the hospitals affiliated with the Life Healthcare hospital group submitted their AR within the prescribed submission period. On the other hand, the independent hospitals have shown a higher proportion of hospitals submitting after the deadline

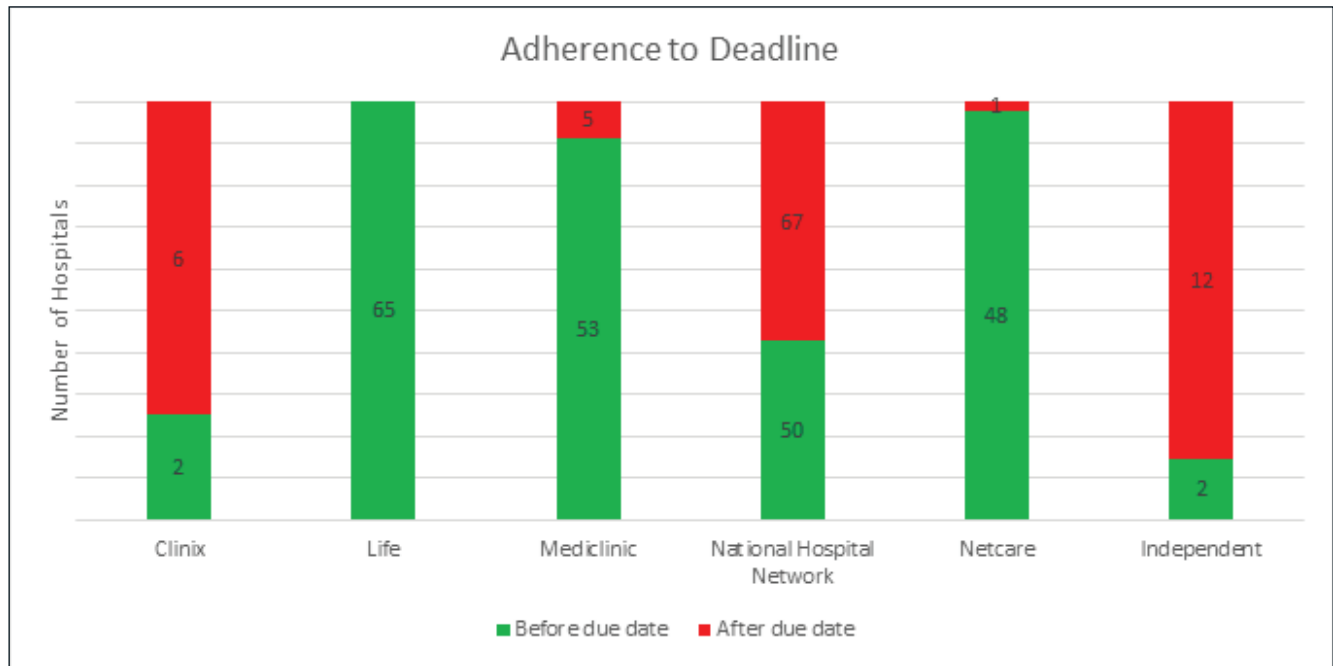


Figure 12: Hospital groups' submission trends by due date

3.4 Reported bed capacity per hospital group

Figure 13 below shows that the number of licensed beds exceeds the number of operational beds in all of the hospital groups, except for the independent hospitals. The difference between licenced and operational beds demonstrates residual bed capacity in these hospital groups. The independent hospitals reported on aggregate, licensed beds that are equal to operational beds .

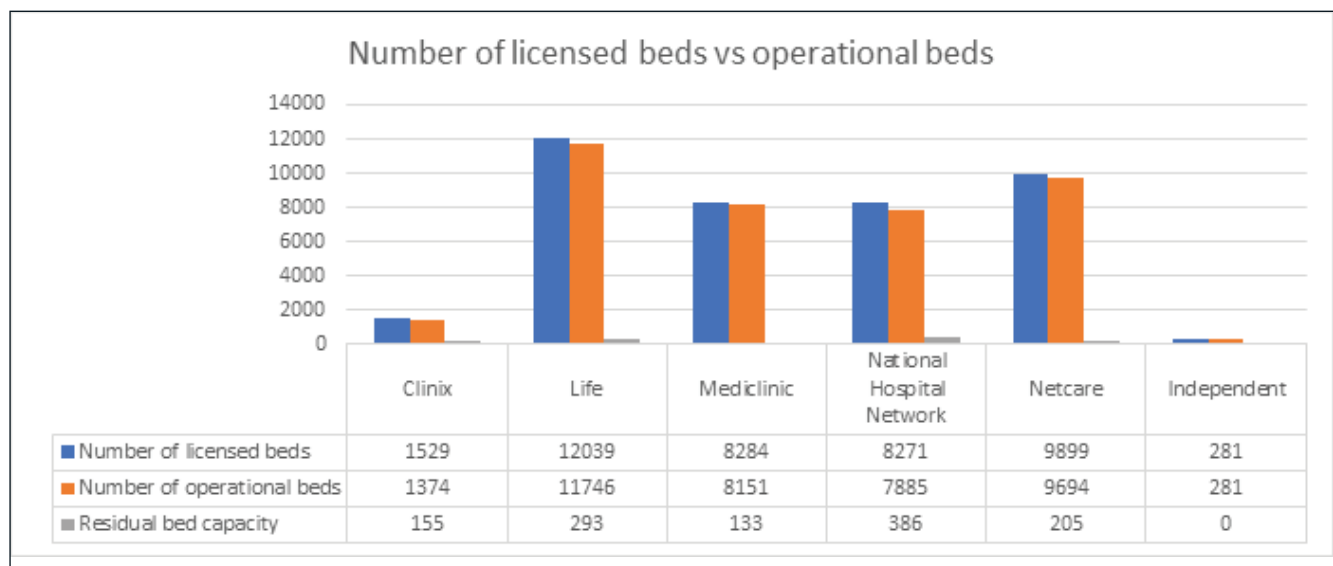


Figure 13: Bed capacity per hospital group

3.5 Percentage of permanently appointed hospital managers per hospital group

The data received, as presented in Table 16 below, suggests that independent hospitals all have appointed hospital managers. Hospitals in the Netcare hospital group reported that 96% of their hospital have appointed hospital managers. It is encouraging to see that even the hospital group that reported the lowest proportion of appointed hospital managers is sitting at above 85%.

Table 17: Proportion of appointed hospital managers

Person in charge (Acting/Appointed)	Network group/Affiliation					
	Clinix	Life	Mediclinic	National Hospital Network	Netcare	Independent
Acting	1	7	1	5	4	0
Appointed	7	58	57	112	45	14
Proportion of appointed hospital managers	88%	89%	98%	96%	92%	100%

3.6 State of hospital infrastructure

As stated in section 2.12 above, hospital infrastructure is a crucial component of the health system as it has an impact on the delivery of health services. Table 17 below illustrates that a higher proportion of the hospitals have been refurbished within the last 10 years at all the private hospitals across all the hospital groups. From the submitted AR data, it can be concluded that the majority of private sector hospital infrastructure is relatively new.

Table 18: Refurbishment of hospitals

Network group/ Affiliation	NUMBER OF FACILITIES & YEARS FACILITIES HAVE BEEN REFURBISHED				
	0-5 Years	6-10 Years	11-15 Years	16-20 Years	Above 20 Years
Clinix	7	1	0	0	0
Life	48	14	3	0	0
Mediclinic	30	19	5	3	1
National Hospital Network	80	28	5	2	2
Netcare	25	16	3	1	4
Independent	4	10	0	0	0

3.7 Power Supply and Backup

Interruptions in power supply, as has been observed in South Africa, has a detrimental effect on healthcare service delivery. Thus, health establishments have had to find ways of having uninterrupted power supply to ensure continuity of healthcare services. There is one private hospital that reported that their main source of power supply is solar as opposed to the national electricity grid. Table 18 below shows that generators are a leading source of back-up power, followed by UPS and solar systems.

Table 19: Power supply and backup systems per hospital group

Network group/Affiliation	Generator	Solar	UPS	Other
Clinix	8 (100%)	0(0%)	4 (50%)	0 (0%)
Life	64 (98%)	9 (14%)	28 (43%)	6 (9%)
Mediclinic	58 (100%)	14 (24%)	50 (86%)	1 (2%)
National Hospital Network	112 (96%)	12 (10%)	75 (64%)	5 (4%)
Netcare	49 (100%)	18 (37%)	44 (90%)	3 (6%)
Independent	14 (100%)	0(0%)	3 (21%)	0(0%)

3.8 Water Supply and Outages

There has been a rise in water outages/disruptions, in some instances water disruptions have been directly linked to the interruption in power supply in the country. According to the information collected, the independent private hospitals have not had disruptions in the period between 1 April 2022 and 31 March 2023. Clinix hospital group had the leading proportion of reported water outages with 38% of the hospitals in the group experiencing water outages in the period under review.

Table 20: Proportion of hospitals with water outages

Water disruption	Network group/Affiliation					
	Clinix	Life	Mediclinic	National Hospital Network	Netcare	Independent
No	5	45	40	91	32	14
Yes	3	20	18	26	17	0
Proportion with disruptions	38%	31%	31%	22%	35%	0%

In some instances where no water outages were reported, private hospitals indicated that they had a backup water system in place, borehole was the main source of water backup system. One hospital stated that they were solely reliant on borehole water.

3.9 Quality assurance initiatives

3.9.1 Staff satisfaction survey

Hospitals need to periodically gauge the moral and overall satisfaction of the staff and make the necessary changes to ensure staff satisfaction. Staff satisfaction impacts the level of commitment of staff members thus the quality of the service they render to the users. The proportion of hospitals that have conducted staff satisfaction survey is presented in table 20 below. Only hospitals that reported to have conducted the survey between April 2022 and March 2023 were considered to have conducted the survey because the period under review is 2022/23. According to the information submitted, Clinix hospitals have the lowest purporting of hospitals that have carried out the staff satisfaction survey at 13% and Netcare hospitals have the highest proportion at 78% of hospitals having conducted the staff satisfaction survey. No meaningful conclusions could be made with the results / outcomes of the surveys because some hospitals gave scores while others gave the overall outcome (satisfied, optimistic, good, etc).

Table 21: Proportion of hospitals that conducted staff satisfaction survey (2022/23)

Network group/Affiliation	Total submitted	Proportion of hospitals that conducted staff satisfaction survey
Clinix	8	13%
Life	65	28%
Mediclinic	58	74%
National Hospital Network	117	50%
Netcare	49	78%
Independent	14	21%

3.9.2 Patient satisfaction survey

Staff satisfaction survey is a tool that hospitals can use to ensure that healthcare users are receiving the best quality possible, the tool also helps the hospitals identify gaps and make plans to improve. 21 below shows the proportion of hospitals that conducted patient satisfaction survey; the proportion of hospitals not affiliated to a hospital group were found to only have 7% of the hospitals that conducted patient satisfaction survey. Mediclinic on the other hand had 72% of hospitals affiliated with the group conducted patient satisfaction surveys in 2022/23. It was found that there were different ways in which hospital conduct the patient satisfaction survey, the one that was highlighted the most was where all users complete an electronic survey upon discharge. Once again, we could not make meaningful inferences from the data as the because of the different ways that the hospitals report on this question.

Table 22: Proportion of hospitals that conducted patient satisfaction survey (2022/23)

Network group/Affiliation	Total submitted	Proportion of hospitals that conducted patient satisfaction survey
Clinix	8	13%
Life	65	68%
Mediclinic	58	72%
National Hospital Network	117	50%
Netcare	49	69%
Independent	14	7%

3.9.3 Inspection by OHSC

The OHSC has been inspecting acute private hospitals according to the promulgated norms and standards since 2022/23 financial year. Private hospitals which reported to have been inspected by the OHSC are presented in table 22 below. From the data, it is evident that 19% of hospitals affiliated with the National Hospital Network have been inspected by the OHSC. This figure is followed by hospitals affiliated with Clinix healthcare group at 13%.

Table 23: Proportion of private hospitals inspected by the OHSC

Network group/Affiliation	Total submitted	Proportion of private hospitals inspected
Clinix	8	13%
Life	65	6%
Mediclinic	58	9%
National Hospital Network	117	19%
Netcare	49	10%
Independent	14	7%

4. Discussion

4.1 Compliance with submission of annual returns

The AR submission trends across both health sectors remains satisfactory with 93% of public hospitals and approximately 77% of private hospitals having submitted in the period under review. The 2023 AR submission window period was one (1) calendar month as compared to the previous years in which the period was extended to three (3) month in order to allow the hospitals to get used to the regulatory requirement and navigation of the online submission system. It is expected that the hospital sector is now familiar with the AR system as part of the OHSC's regulatory functions and hence the strict adherence to the one (1) month submission window period.

The OHSC has provided the guideline to ensure complete and accurate collection of data, as well as to ensure uniformity and common understanding of variables to improve the quality of data submitted.

There were various hospitals that could not start the submission process on time and had to request for the opportunity to submit when it was almost closing time, which was granted. The delays in submissions have a negative impact on other related processes that need to unfold after submission such as data validation in order to enable the OHSC to verify missing data or errors as well as to engage the health establishments correct the related errors.

4.2. Data Quality

Whilst the submission rates for ARs by hospitals are satisfactory, there remains several gaps in the quality of the submitted data. The OHSC continued to make efforts to follow up with specific hospitals for verification and correction of data where necessary. Despite these efforts, some hospitals were still unable to submit corrected data for some of the variables and indicators. The main issues identified in terms of data quality were related to the budget and expenditure and the bed utilisation rate variables as discussed below.

4.2.1. Budget and Expenditure data

Due to the differences in the financing models between the private and public sectors, the discussion on this section refers to the public sector alone. The figures provided for the budget allocation need to reflect the budget that has been allocated to the hospital in the financial year 2022/2023 whilst the expenditure should be for 2021/2022. The allocated budget is often closely correlated to the allocation and expenditure for the previous financial year adjusted for consumer price index (CPI). One of the main criticisms for the current budget allocation model for hospitals is that it generally does not adequately account for the package of services provided; the change in the epidemiological profile of the catchment population; and health specific inflation which is generally higher than inflation. This weakness in hospital budget allocation poses a risk of potential misallocation of budget with resultant impact on the quality of healthcare services provided.

There has been a misrepresentation or outright errors in terms of the values provided for the budget and expenditure in all 9 provinces from some hospitals. In this regard, the expenditure and budget values which seemed grossly erroneous were imputed to produce a pragmatic and meaningful presentation as illustrated in Figure 8. It is therefore crucial for the data capturers and the approvers of the AR data to be mindful and verify all figures prior to submission to the OHSC.

It is therefore very unfortunate that the quality of the budget and expenditure data makes it impossible for the OHSC to provide a comprehensive analysis of trends and weaknesses in the financial resource allocation of hospitals and how these resources could potentially hamper the compliance of HEs with the norms and standards regulations.

4.2.2. Inpatient bed utilisation rate (IBUR)

Inpatient bed utilisation rate is an indicator that is collected and reported on by all hospitals as part of their performance in line with systems including, but not limited to the District Health Information System (DHIS).

The IBUR indicator, together with the ALOS and cost per patient day equivalent indicators constitute a measure of hospital efficiency. The trends seen in IBUR are in line with expectation as it relates to the different categories of hospitals. The higher levels of acuity associated with higher levels of care and the referral patterns generally explains the higher utilisation rates.

The quality data challenges noted in this variable was related to the implausible high number of admissions some hospitals captured especially considering their catchment population, their level of care and the number of beds. For this information to have a meaningful interpretation, the OHSC used other remedial measures through data imputation. Data imputation is a technique that replaces missing data with a different value while keeping most of the dataset's information and data. However, the OHSC is mindful that in some instances these outliers could be reflecting a true state of affairs which displays the burdens over the specific hospitals.

4.3. Additional factors

4.3.1. Hospital management

The hospital profiles continue to show that, despite slight improvement in 2023 seen in other provinces, there remain a gap in filling positions for hospital CEOs and this remains a concern for leadership and governance of hospitals. The filling of CEO position is an important factor in the functioning of hospitals. Leadership and governance of HEs is essential for the effective provision of safe and quality healthcare. It is therefore important that provincial health authorities must prioritise the filling of the critical positions with appropriately qualified professionals to ensure effective and efficient running of these facilities.

4.3.2. Human resources for health (HRH)

The provision of healthcare services requires appropriately qualified and skilled health professionals in adequate numbers (density), distributed equitably according to population health needs. High vacancy rates have a negative impact on the provisioning of quality healthcare at hospital level. Furthermore, it may also lead to unnecessary referrals to hospitals that may cater for the health needs of the community.

The vacancy rate observed in the submitted data requires geographic, hospital category, as well as medical and nursing specialty disaggregation to have a more comprehensive picture of the gaps in human resources allocation within the hospital sector. Although data for clinical staff (doctors) was not captured in this period under review, it is unlikely to have changed significantly from the previous year.

4.3.3. Hospital infrastructure

There are indications that the hospital physical infrastructure fleet in the public sector is getting progressively old and therefore will require more intensive maintenance and, in some cases, partial or total refurbishments. Infrastructure is an important prerequisite for the provision of good quality healthcare services. Poor infrastructure impacts the running of health services negatively and may disrupt the continuity of quality of healthcare provision. In this regard, provincial health authorities will be required to prioritise maintenance of the physical infrastructure of hospitals.

4.3.4. Power supply

South Africa's challenges with availability of reliable energy supply have serious ramifications for the provision of healthcare services. The data collected showed that almost all hospitals in the country had some form of power back-up supply which is mostly a generator. The availability of back-up systems within Hospitals might not be appropriately geared up to deal with prolonged power outages due to load shedding as some of these systems were meant for temporary outages. Long power outages and power surges can take a toll on hospital equipment and lead to mechanical failures. These surges have left many hospitals with disruptions and backlog of certain important lifesaving procedures, where users had to be turned away and rescheduled for later times, if they do not succumb to their conditions by the time, they are called in. National and provincial health authorities need to come up with financially sustainable plans to ensure provision of energy to HEs during load shedding to prevent interruptions to the provision of healthcare services.

4.3.5. Water supply

South Africa is a water scarce country and unpredictable change in climatic conditions and patterns means that the country is going to increasingly face water shortages in the short to medium term. Various parts of the country currently face water challenges and, in some instances, have impacted municipal water supplies including supplies to hospitals. The challenge with electricity supply directly impacts the water supply. Interruptions in the electrical supply may result in untreated effluent overflows when raw sewage pumping systems and wastewater treatment facilities are dependent on electricity. There is also an impact on the ability to deliver water to elevated tanks and supply water to high-lying areas, as well as the reduction or total loss of water supply even to lower-lying areas fed by gravity from reservoirs. Just as in the case of energy supply, national and provincial health authorities need to come up with financially sustainable plans to ensure provision of water to health establishments during water outages or restrictions to prevent interruptions to the provision of healthcare services.

5. Recommendations

5.1 Annual Returns Guideline

It is recommended that the hospitals engage adequately with the guidance provided to improve the quality of information submitted for AR for the benefit of the health system. The quality of the AR data is a prerequisite for the proper profiling of health establishments and to ensure that the health authorities meaningfully understand the challenges that exist in order to address them.

5.2 Role of persons in charge in the review of the information submitted

- It is recommended that provincial authorities communicate clearly to the persons in charge of the hospitals that it is their ultimate responsibility to submit accurate and good quality information to the OHSC and possibly make it part of their key performance measures.
- It is also recommended that budget and expenditure information be verified and validated by persons with competency in financial matters prior to submission to ensure that valid and reliable data is submitted, with potential to inform critical decision-making.

5.3. Recommendations based on the analysis of collected data

5.3.1. Human Resources

- It is recommended that provinces prioritise the permanent appointment of persons in charge of hospitals to ensure stability but also consistency and efficiency in leadership and governance of these important facilities for the provision of consistent safe and quality healthcare services.

5.3.2. Hospital infrastructure

- It is recommended that provincial health authorities prioritise the maintenance of physical infrastructure of hospitals as an essential input towards compliance with the norms and standards regulations and overall functioning of the health system.

5.3.3 Water and Power backup supply

- The Office recommends that more reliable and functional sources of energy be procured or installed in hospitals to ensure uninterrupted power supply to strengthen provision of continuous quality and safe healthcare services. Energy sources include but may not be limited to solar and UPS Invertors
- It is recommended that all hospitals be exempted from load-shedding and water shedding schedules.
- In cases of water outages, the Office recommends that all HEs must be prioritised for back-up water supply.
- To mitigate water shortages within the healthcare settings, an installation of boreholes is highly recommended as back up rather than depending on delivery of water tanks by municipalities which are already overwhelmed by lack of water in the communities.

5.3.4 Inpatient Bed Utilisation Rate and Finances

- In relation to the two variables namely, IBUR and issues of finance (budget and expenditure), the OHSC recommends that the health establishments emphasise the importance of validation of data collected and captured by persons with relevant competencies before submitting hospital profiles. The exercise will be beneficial for the OHSC to produce meaningful analyses and recommendations, based on accurate information.

6. Conclusion

To evaluate and put the condition of hospitals in perspective, the OHSC uses data gathered from the AR. In order to guarantee that quality assurance and improvement programs are supported by evidence and help to promote and safeguard the health and safety of both users and providers, the quality of the AR data is crucial to this significant endeavour. As a crucial component of the regulatory functions governing healthcare quality and the general administration of the health system, the OHSC will persist in advocating for the implementation of measures to guarantee the timely and accurate submission of AR data.

Each province will receive periodic feedback from the OHSC in a variety of forms to help enhance the quality of the AR data. The OHSC utilises the hospital data it collects to help drive its recommendations for raising standards of care across the entire healthcare system. The timely dissemination of recommendations to the appropriate authorities is adversely affected by the quality of data submitted and the timespan between the health establishments' responses.

ANNEXURE 1: Package of Service (Clinical)

CLINICAL SERVICES	AVAILABLE (Yes/No)	EC	FS	GP	KZN	LP	MP	NC	NW	WC
Anaesthetics	No	39	17	13	15	10	8	3	8	24
	Yes	28	15	24	54	31	24	6	11	29
	Percentage Offering the Service	42%	47%	65%	78%	76%	75%	67%	58%	55%
Day surgery	No	37	20	12	28	14	15	3	10	23
	Yes	30	12	25	41	27	17	6	9	30
	Percentage Offering the Service	45%	38%	68%	59%	66%	53%	67%	47%	57%
Dermatology	No	61	31	24	58	36	29	8	17	42
	Yes	6	1	13	11	5	3	1	2	11
	Percentage Offering the Service	9%	3%	35%	16%	12%	9%	11%	11%	21%
Endocrinology	No	64	30	30	62	38	31	8	18	49
	Yes	3	2	7	7	3	1	1	1	4
	Percentage Offering the Service	4%	6%	19%	10%	7%	3%	11%	5%	8%
Gastroenterology	No	59	31	28	59	38	28	8	16	46
	Yes	8	1	9	10	3	4	1	3	7
	Percentage Offering the Service	12%	3%	24%	14%	7%	13%	11%	16%	13%
General (internal) Medicine	No	9	6	7	12	5	4	1	5	13
	Yes	58	26	30	57	36	28	8	14	40
	Percentage Offering the Service	87%	81%	81%	83%	88%	88%	89%	74%	75%
General Surgery	No	32	12	11	29	11	8	2	8	24
	Yes	35	20	26	40	30	24	7	11	29
	Percentage Offering the Service	52%	63%	70%	58%	73%	75%	78%	58%	55%
Geriatrics	No	51	23	27	49	23	18	5	17	42
	Yes	16	9	10	20	18	14	4	2	11
	Percentage Offering the Service	24%	28%	27%	29%	44%	44%	44%	11%	21%
Gynaecology	No	30	11	11	22	9	5	2	5	29
	Yes	37	21	26	47	32	27	7	14	24
	Percentage Offering the Service	55%	66%	70%	68%	78%	84%	78%	74%	45%
Maternal health including obstetrics	No	13	2	10	16	5	6	1	4	16
	Yes	54	30	27	53	36	26	8	15	37
	Percentage Offering the Service	81%	94%	73%	77%	88%	81%	89%	79%	70%
Psychiatry	No	34	6	8	20	6	10	3	9	15
	Yes	33	26	29	49	35	22	6	10	38
	Percentage Offering the Service	49%	81%	78%	71%	85%	69%	67%	53%	72%
Neonatology	No	35	19	16	28	15	12	2	8	30
	Yes	32	13	21	41	26	20	7	11	23
	Percentage Offering the Service	48%	41%	57%	59%	63%	63%	78%	58%	43%
Orthopaedics	No	30	17	17	32	11	14	3	7	28
	Yes	37	15	20	37	30	18	6	12	25
	Percentage Offering the Service	55%	47%	54%	54%	73%	56%	67%	63%	47%
Oral maxillo surgery	No	63	31	29	63	33	31	8	18	46
	Yes	4	1	8	6	8	1	1	1	7
	Percentage Offering the Service	6%	3%	22%	9%	20%	3%	11%	5%	13%
Operating Theatres	No	25	15	7	13	4	8	1	5	22
	Yes	42	17	30	56	37	24	8	14	31
	Percentage Offering the Service	63%	53%	81%	81%	90%	75%	89%	74%	58%
Paediatrics	No	8	3	9	13	4	5	1	5	15
	Yes	59	29	28	56	37	27	8	14	38
	Percentage Offering the Service	88%	91%	76%	81%	90%	84%	89%	74%	72%
Cardiology	No	62	31	30	62	40	31	7	17	46
	Yes	5	1	7	7	1	1	2	2	7
	Percentage Offering the Service	7%	3%	19%	10%	2%	3%	22%	11%	13%
Forensic services	No	56	24	30	57	24	15	3	14	46
	Yes	11	8	7	12	17	17	6	5	7
	Percentage Offering the Service	16%	25%	19%	17%	41%	53%	67%	26%	13%
High Care	No	49	25	19	36	28	24	5	12	42
	Yes	18	7	18	33	13	8	4	7	11
	Percentage Offering the Service	27%	22%	49%	48%	32%	25%	44%	37%	21%
Intensive Care	No	61	25	22	52	32	26	7	13	44
	Yes	6	7	15	17	9	6	2	6	9
	Percentage Offering the Service	9%	22%	41%	25%	22%	19%	22%	32%	17%

ANNEXURE 1: Package of Service (Clinical)

CLINICAL SERVICES	AVAILABLE (Yes/No)	EC	FS	GP	KZN	LP	MP	NC	NW	WC
Infectious Disease	No	20	13	17	26	10	6	3	9	27
	Yes	47	19	20	43	31	26	6	10	26
	Percentage Offering the Service	70%	59%	54%	62%	76%	81%	67%	53%	49%
Neurology	No	60	31	30	65	39	31	8	17	50
	Yes	7	1	7	4	2	1	1	2	3
	Percentage Offering the Service	10%	3%	19%	6%	5%	3%	11%	11%	6%
Nuclear medicine	No	64	31	33	65	40	32	9	18	50
	Yes	3	1	4	4	1			1	3
	Percentage Offering the Service	4%	3%	11%	6%	2%	0%	0%	5%	6%
Oncology	No	59	31	30	62	33	28	8	17	47
	Yes	8	1	7	7	8	4	1	2	6
	Percentage Offering the Service	12%	3%	19%	10%	20%	13%	11%	11%	11%
Radiation therapy	No	63	31	35	63	40	29	9	17	51
	Yes	4	1	2	6	1	3		2	2
	Percentage Offering the Service	6%	3%	5%	9%	2%	9%	0%	11%	4%
Cardio thoracic surgery	No	62	31	32	67	40	30	8	18	50
	Yes	5	1	5	2	1	2	1	1	3
	Percentage Offering the Service	7%	3%	14%	3%	2%	6%	11%	5%	6%
Cochlear implants	No	63	31	33	66	40	32	9	19	50
	Yes	4	1	4	3	1				3
	Percentage Offering the Service	6%	3%	11%	4%	2%	0%	0%	0%	6%
Ear nose and Throat surgery	No	63	30	23	61	39	31	7	15	39
	Yes	4	2	14	8	2	1	2	4	14
	Percentage Offering the Service	6%	6%	38%	12%	5%	3%	22%	21%	26%
Neuro surgery	No	64	30	28	67	40	30	8	18	48
	Yes	3	2	9	2	1	2	1	1	5
	Percentage Offering the Service	4%	6%	24%	3%	2%	6%	11%	5%	9%
Ophthalmology	No	59	28	21	47	32	20	6	14	39
	Yes	8	4	16	22	9	12	3	5	14
	Percentage Offering the Service	12%	13%	43%	32%	22%	38%	33%	26%	26%
Plastic and reconstructive surgery	No	64	31	30	65	40	32	8	18	49
	Yes	3	1	7	4	1		1	1	4
	Percentage Offering the Service	4%	3%	19%	6%	2%	0%	11%	5%	8%
Liver Transplants	No	67	32	35	69	41	32	9	19	51
	Yes			2						2
	Percentage Offering the Service	0%	0%	5%	0%	0%	0%	0%	0%	4%
Bone Marrow Transplants	No	66	31	35	68	41	32	9	18	50
	Yes	1	1	2	1				1	3
	Percentage Offering the Service	1%	3%	5%	1%	0%	0%	0%	5%	6%
Heart and Lung Transplants	No	67	32	36	69	41	32	9	19	50
	Yes			1						3
	Percentage Offering the Service	0%	0%	3%	0%	0%	0%	0%	0%	6%
Kidney Transplants	No	67	31	33	67	40	32	9	19	50
	Yes		1	4	2	1				3
	Percentage Offering the Service	0%	3%	11%	3%	2%	0%	0%	0%	6%
Trauma Surgery	No	59	30	27	54	38	25	6	13	43
	Yes	8	2	10	15	3	7	3	6	10
	Percentage Offering the Service	12%	6%	27%	22%	7%	22%	33%	32%	19%
Urology	No	61	29	25	58	40	27	8	14	42
	Yes	6	3	12	11	1	5	1	5	11
	Percentage Offering the Service	9%	9%	32%	16%	2%	16%	11%	26%	21%
Vascular surgery	No	65	31	32	66	40	31	8	18	47
	Yes	2	1	5	3	1	1	1	1	6
	Percentage Offering the Service	3%	3%	14%	4%	2%	3%	11%	5%	11%
Radiation	No	58	30	33	60	37	27	9	17	51
	Yes	9	2	4	9	4	5		2	2
	Percentage Offering the Service	13%	6%	11%	13%	10%	16%	0%	11%	4%
Mortuary	No	11	2	8	8	5	5	2	3	28
	Yes	56	30	29	61	36	27	7	16	25
	Percentage Offering the Service	84%	94%	78%	88%	88%	84%	78%	84%	47%
24 hr Accident and emergency services	No	11	4	8	14	4	6	1	3	14
	Yes	56	28	29	55	37	26	8	16	39
	Percentage Offering the Service	84%	88%	78%	80%	90%	81%	89%	84%	74%

ANNEXURE 2: Package of Service (Clinical support)

CLINICAL SUPPORT	AVAILABLE (Yes/No)	EC	FS	GP	KZN	LP	MP	NC	NW	WC
Pharmacy	No	1	0	2	0	0	1	0	0	1
	Yes	66	32	35	69	41	31	9	19	52
	Percentage Rendering this Service	99%	100%	95%	100%	100%	97%	100%	100%	98%
Audiology	No	47	27	9	20	8	9	4	8	33
	Yes	20	5	28	49	33	23	5	11	20
	Percentage Rendering this Service	30%	16%	76%	71%	80%	72%	56%	58%	38%
Occupational Therapy	No	23	8	4	9	1	4	0	2	6
	Yes	44	24	33	60	40	28	9	17	47
	Percentage Rendering this Service	66%	75%	89%	87%	98%	88%	100%	89%	89%
Physiotherapy	No	19	6	6	7	1	4	0	2	6
	Yes	48	26	31	62	40	28	9	17	47
	Percentage Rendering this Service	72%	81%	84%	90%	98%	88%	100%	89%	89%
Psychology	No	52	22	7	32	1	14	5	5	15
	Yes	15	10	30	37	40	18	4	14	38
	Percentage Rendering this Service	22%	31%	81%	54%	98%	56%	44%	74%	72%
Speech and Language Therapy	No	49	24	9	26	5	13	3	6	21
	Yes	18	8	28	43	36	19	6	13	32
	Percentage Rendering this Service	27%	25%	76%	62%	88%	59%	67%	68%	60%
Social services	No	19	13	3	1	3	5	2	2	8
	Yes	48	19	34	68	38	27	7	17	45
	Percentage Rendering this Service	72%	59%	92%	99%	93%	84%	78%	89%	85%
Optometry	No	55	27	17	23	4	20	7	12	42
	Yes	12	5	20	46	37	12	2	7	11
	Percentage Rendering this Service	18%	16%	54%	67%	90%	38%	22%	37%	21%
Dentistry	No	28	15	19	19	4	7	3	10	33
	Yes	39	17	18	50	37	25	6	9	20
	Percentage Rendering this Service	58%	53%	49%	72%	90%	78%	67%	47%	38%
Dietetics	No	21	5	3	7	1	1	0	2	10
	Yes	46	27	34	62	40	31	9	17	43
	Percentage Rendering this Service	69%	84%	92%	90%	98%	97%	100%	89%	81%
Laboratory	No	30	23	11	15	4	11	5	7	33
	Yes	37	9	26	54	37	21	4	12	20
	Percentage Rendering this Service	55%	28%	70%	78%	90%	66%	44%	63%	38%
Pathology	No	59	31	23	49	26	21	8	16	47
	Yes	8	1	14	20	15	11	1	3	6
	Percentage Rendering this Service	12%	3%	38%	29%	37%	34%	11%	16%	11%
Radiology	No	10	1	5	13	5	4	0	3	15
	Yes	57	31	32	56	36	28	9	16	38
	Percentage Rendering this Service	85%	97%	86%	81%	88%	88%	100%	84%	72%
Blood Bank	No	55	26	20	48	31	25	7	14	47
	Yes	12	6	17	21	10	7	2	5	6
	Percentage Rendering this Service	18%	19%	46%	30%	24%	22%	22%	26%	11%
CSSD	No	16	5	5	12	5	5	2	3	14
	Yes	51	27	32	57	36	27	7	16	39
	Percentage Rendering this Service	76%	84%	86%	83%	88%	84%	78%	84%	74%



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