PRESIDENTIAL HEALTH SUMMIT 2018

Strengthening the South African health system towards an integrated and unified health system

Birchwood Conference Centre, Johannesburg
19 – 20 October 2018

THE PRESIDENCY
REPUBLIC OF SOUTH AFRICA

The report contains the output of the deliberations of the first Presidential Health Summit held in Boksburg on the 19th and 20th of October 2018. The Summit was convened with the aim to find solutions to the concern that the South African health system is in a crisis. A wide range of stakeholders comprising government, health professionals, civil society, labour, business, academia, scientists and health users attended the two-day Summit. Nine Commissions were arranged to enable participants to deliberate on the massive challenges the health system is facing and suggested interventions to improve its quality. The Post-Presidential Health Summit Working Group that includes vital stakeholders is currently preparing a health compact to be jointly signed by the President of South Africa and representatives of stakeholder groups. The signing aims to ensure that the interventions suggested are implemented not only by the government but by all stakeholders. This is part of a new initiative to encourage all partners to find solutions to the health system. This report will contribute significantly to enable South Africans to receive the best care.

Dr. Olive Shisana,
Social Policy Special Advisor to the President of the Republic of South Africa

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

World Health Organization

PRESIDENTIAL HEALTH SUMMIT 2018

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ACRONYMS

Acronym	Meaning
AIDS	Acquired Immune Deficiency Syndrome
CHC	Community Health Clinic
CHW	Community Health Worker
COGTA	Cooperative Governance and Traditional Affairs
COE	Cost of Equity
CoN	Certificate of Need
CONTRALESA	Congress of Traditional Leaders of South Africa
CSI	Corporate Social Investment
CSIR	Council for Scientific and Industrial Research
DENOSA	Democratic Nursing Organisation of South Africa
DG	Director-General
DHET	Department of Higher Education and Training
DHS	District Health System
DBSA	Development Bank of South Africa
DPSA	Department of Public Service and Administration
DPME	Department of Planning, Monitoring and Evaluation
DPW	Department of Public Works
DSD	Department of Social Development
DST	Department of Science and Technology
DTPS	Department of Telecommunications and Postal Services
EHC	Essential Health Care
EHR	Electronic Health Record
GDP	Gross Domestic Product
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMI	Health Market Inquiry
HPCSA	Health Professions Council of South Africa
HNSF	Health Normative Standards Framework
HR	Human Resource
HRH	Human Resource for Health
HWSETA	Health and Welfare Sector Education and Training Authority
ICT	Information, Communication and Technology
IDMS	Infrastructure Delivery Management System
IDT	Independent Development Trust
KPIs	Key Performance Indicators
KZN	Kwa-Zulu Natal
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MEC	Member of Executive Council
NCD	Non-Communicable Diseases
NDOH	National Department of Health
NDP	National Development Plan
NHI	National Health Insurance
NTHSP	National Treasury Health Service Plan
OECD	Economic Co-operation and Development
OHSC	Office of Health Standards Compliance
PERSAL	Personnel and Salary System
PFMA	Public Finance Management Act
PHC	Primary Health Care
PPP	Public Private Partnership
ROI	Return on Investment
RWOPS	Remuneration of Work Outside Public Sector
SAMA	South African Medical Association
SAMATU	South African Medical Association Trade Union
SASSA	South African Social Security Agency
SCM	Supply Chain Management
SITA	State Information Technology Agency
SIU	Special Investigations Unit
SLA	Service Level Agreement
SMEs	Small and Medium Enterprises
STI	Sexually Transmitted Infections
TB	Tuberculosis
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VHI	Voluntary Health Insurance
WBOTS	Ward-based PHC Outreach Teams
WHO	World Health Organisation

MESSAGE FROM THE PRESIDENT

PRESIDENTIAL HEALTH SUMMIT REPORT

"Strengthening the South African health system towards an integrated and unified health system"

Since becoming the President of South Africa, I have received numerous complaints about the poor quality of health care that people experience in our clinics and hospitals during their moments of vulnerability. The complaints include inadequate access to medicines, equipment and technology, and numbers of staff in our facilities, unprofessional conduct of staff, labour unrest, corruption and theft of hospital property. They also experience poor delivery of mental health services and delays in accessing health care. Others experience above-inflation increases in medical schemes contributions, and failure of medical schemes to pay for patient services that have been rendered. Several organisations have also raised concerns with me regarding the dysfunctionality of the health system, to the point that it became clear that the system is in crisis and needs urgent rehabilitation. This does not mean that the system has completely collapsed, but that it is edging to a tipping point where it will be impossible to deliver needed services if we do not rescue it.

In a country with more than seven million people living with HIV, a nation with rising diabetes, hypertension and cancer rates, and high maternal death and neonatal death rates, poor mental health status, and prevalent disability rates, we cannot afford to have a faltering health system. Too many people do not receive quality preventive, promotive, curative and rehabilitative health care services they deserve while others, on the other hand, receive more superior health care services. Chief among the causes of the problem is inadequate resourcing of the public health system. There is a need for strategic direction to steer the ship through turbulent waters. It became apparent that to heal this system will require efforts beyond the Department of Health.

It will require leadership and stewardship at the highest level to chart a way forward. It will also require resourcing of the health system through the long-awaited National Health Insurance system to ensure universal health coverage so that all South Africans receive quality health care. However, this will need a concerted effort to improve the quality of health care that includes the involvement of various stakeholders who can not only identify the problems but find sustainable solutions. It was for this reason that we convened the Presidential Health Summit.

The broad aim of the Summit, which was held on 19-20 October 2018, was to allow stakeholders from diverse backgrounds to collectively plan good health for all, with signposts on a roadmap towards a unified quality health care system. To achieve this goal will require improving coordination that will ensure health system efficiency in service provision, accountability, and transparency through dealing with corruption, waste, and abuse.

This collective approach has unleashed the energy of all stakeholders. including government departments, labour,civilsociety, patient advocacy groups,the academic sector and health professionals from diverse fields in the public and private sectors. Public health requires a multi-sectoral approach because together we can leverage the pool of technical know-how, expertise, reach and human, physical and infrastructural resources. Through this approach, we are collectively able to bring our mighty strength to optimise the use of our resources to improve the quality of the health system. We will seal this collective approach to fixing the health system through a Presidential Health System Compact, where, over the next five years, we will have achieved a sustainable quality health system. We will implement a Quality Health Improvement Plan that will accompany the implementation of the National Health Insurance.

This Presidential Health Summit comes as we lead the process of unlocking the implementation of National Health Insurance that was delayed by several obstacles over the last nine years. If we use the same collective approach, we can reach our goal of universal health coverage for all South Africans in the foreseeable future.

Although there are benefits in working collectively, there may be risks if stakeholders feel excluded from the process.Anyone who has solutions to offer the country is very much welcome to work with the stakeholder groups who are actively engaged in the post-summit activities. These stakeholders include government, business. labour, civil society, the private sector, health professionals, labour unions, health care service users, statutory councils, academia, and researchers.

At the Presidential Health Summit, we may not have identified all the challenges that face the health system. But we have started the journey and we now have a mechanism to identify problems and collectively find solutions.

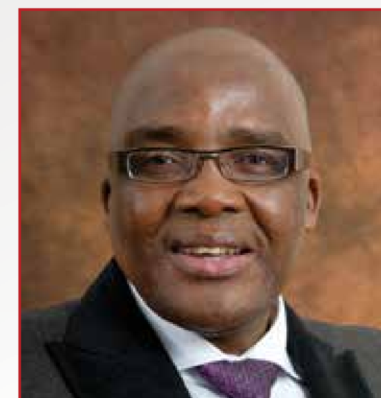
I wish to express my gratitude for the Deputy President, Mr.David Mabuza for steering the ship in my absence on the dates of the Summit. Thank you to the Task Team that organised the Health Summit led by the Minister of Health, Dr Aaron Motsoaledi, President's Special Advisor on Social Policy, Dr Olive Shisana, Dr Anban Pillay (Department of Health), Dr Fazel Randera (Progressive Health Forum), Dr Sipho Kabane (Council of Medical Schemes), Ms Lebogang Mulaisi (Labour), Ms Tanya Cohen (BUSA), Dr John Ataguba (Academia), Mr Anele Yawa (Health Services Users), Mr Mabalane Mfundise (Civil Society), Dr Mzukisi Grootboom (SAMA), Dr Mpho Pooe (SAMA Union), and Mr Kwena Manamela (DENOSA).

I also wish to thank the Presidency and the Department of Health staff who ensured the summit functioned smoothly.

I also wish to thank the World Health Organization for its financial support and for the information shared to guide us on universal health cover.

Together we will change the direction of the health system and improve its quality and efficiency as we care for all our people.

Mr Matamela Cyril Ramaphosa
President of the Republic of South Africa



MESSAGE FROM THE MINISTER OF HEALTH

The decision by President Ramaphosa to host the first ever Presidential Health Summit was a historic event. This highlights the importance that the President and our government attach to the health of our people.

The Summit brought together a wide range of stakeholders to analyse our achievements as a country, to tease out the challenges and to develop solutions. It is clear that whilst we have made major gains in decreasing mortality and increasing life expectancy in the past 10 years we need to do more to reach the goals set in the National Development Plan.

We have a major opportunity in the global push towards universal health coverage. Most low and middle income countries around the world are currently designing and implementing UHC. We have decided to call our transformation of the health system towards universal health coverage, National Health Insurance (NHI). The Summit therefore provided a unique platform for all stakeholders to articulate their views on the current system and what needs to be done to both prepare for and implement NHI.

In my analysis of the health system I repeated many times that the key to functionality of our health system are the following: financial management; human resource management; procurement and supply chain; and maintenance of equipment and infrastructure. I am pleased that the nine commissions covered these issues and more!

The nine thematic commissions of the Summit provided stakeholders the space to clearly articulate their concerns, visions as well as proposals on what needs to be done to strengthen the health system, both public and private. The Summit, as outlined in this Report, generate a host of brilliant ideas which we will use to transform the health system towards the vision of universal health coverage.

The World Health Organisation's guidance to countries is clear with regards to both the building blocks of a health system as well as what constitutes universal health system. As noted in the NHI White Paper, we must start by building the system from the bottom up based on a strong primary health care foundation in which the promotion of health and wellness and the prevention of disease is primary. The importance of primary health care was first emphasised in the Alma Ata Declaration in 1978 and reinforced in Astana in 2018 - 40 years later!

In my view this historic Presidential Health Summit was a major success which we must build on and I therefore welcome the Report as well as its recommendations.

Working together we can strengthen our health system and ensure good health for all South Africans.

Dr PA Motsaoledi, MP

1. EXECUTIVE SUMMARY

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By 2030, the health system should provide quality care to all, free at the point of service, or paid by publicly provided, or privately funded insurance[1]. The primary district health service should provide universal access, with focus on prevention, education, disease management and treatment. Hospitals should be effective and efficient, providing quality secondary and tertiary care for those who need it[2].

The *Presidential Health Summit* brought together key stakeholders from a wide range of constituencies in the health sector, to deliberate and propose solutions to address the challenges facing the South African health system. Delegates worked towards solutions to strengthen the health system to ensure that it provides access to quality health services for all, in line with the principles of Universal Health Coverage (UHC) through an inclusive process. There was a unanimous support for the principles of National Health Insurance (NHI), which include: universal quality health care, social solidarity and equity in health access, and a call for NHI and its implementation.

Nine commissions were set up to provide a basis of discussions, namely:

1) Human Resources for Health (Health Workforce);
2) Supply Chain Management, Medical Products, Equipment and Machinery;
3) Infrastructure Plan;
4) Private Sector Engagement;
5) Health Service Provision (Delivery);
6) Public Sector Financial Management;
7) Leadership and Governance;
8) Community Engagement and
9) Information Systems.

This report provides an overview of the solutions tabled by the participants to the *Presidential Health Summit*, recognising that they must be put into a practical, prioritised and realistic action plan with immediate, short term and medium-term interventions.

To address challenges relating to human resources for health (HRH) it is imperative that the moratorium on human resources be lifted; a human resource (HR) roadmap is required and should include occupational health and safety; recognition and reward for personnel; talent management; attraction and incentivisation; retention and support. More so fast-tracking implementation of policy on foreign trained medical practitioners is imperative and the ability of the state to fulfil its obligation with regards to statutory employment of health professionals.

A Remuneration of Work Outside Public Sector (RWOPS) should be reviewed, taking into account the final recommendations of the Health Market Inquiry (HMI) in relation to the establishment of a Supply Side Regulator. Key to improving human resources for health challenges is to validate and optimise the use of "Integrated Human Resource, Personnel and Salary System" (PERSAL) and HR management information system. Most importantly staffing and funding policy must meet the needs of the health system.

World Health Organisation (WHO) notes that "a well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use[3]." In South Africa, many of these may be gaps that need to be addressed in the supply chain processes and procedures to ensure that funds available for medical products, equipment and machinery are optimally utilised to achieve universal health coverage. Pharmaceutical budgets must be ring-fenced to avoid budgets being redirected for non-medical expenditure which result in medicine unavailability. To deal with challenges around medical equipment and medical consumables, a database with medical equipment specifications where equipment is also defined in clinical and/or functional terms is a must. For the successful implementation of NHI, an efficient supply chain management (SCM) system that is unequivocally patient-centred is crucial.

1 National Development Plan: 2030
2 Ibid
3 World Health Organisation Framework for Action: Strengthening Health Systems to Improve Health outcomes, 2007

A centralised procurement system with standardised procurement system and processes at national and provincial level must be considered to deal with corruption, economy of skills and scale. Critical to enable efficient procurement processes is an information technology (IT) system.

The National Department of Health (NDOH) has a health infrastructure plan but to date the country has had neither the expertise nor adequate funding to implement the plan. In some cases, health infrastructure construction that has been successfully completed has either cost more than the initial budgeted amount or facilities have been constructed that either fail to meet the need for the services required or have not been provided with adequate funding to operationalise the new facilities fully. The infrastructure plan must respond to changing population and clinical dynamics, it cannot be static. Further, there is a need to co-ordinate interventions with other government departments, notably the Department of Public Works. Overall, infrastructure in both the public and private health sectors must meet the requirements of the Office of Health Standards Compliance (OHSC).

The reality of the existence of both the public and private sectors in South Africa must be recognised. Private sector has a critical role to play in the realisation of UHC and the vision of the NHI, thus, a harmonious working relationship between private and public sectors is key. To engage private sector meaningfully, the inclusive process and mechanism started through the *Presidential Health Summit* should be sustained by providing collective leadership and stewardship to unify both these sectors around common goals.

Quality of health services in the public sector has been associated with dissatisfaction among the users of health services with respect to acceptability of health care services and patient experience. Health service delivery is essential to the attainment of South Africa's health goals. Under the unified national health system, service delivery should ensure quality and comprehensiveness in the range of services, namely; preventive, curative, palliative, rehabilitative and promotive.

These services must be accessible to South Africans in terms of affordability, availability and acceptability of services. There is an urgent need for health facilities to meet the OHSC standards, considering that contracting in NHI will require certification from OHSC.

Quality of health care challenges include among others: negative staff attitudes; long waiting times; facilities that are not clean; drug stock-outs; poor infection control; and inadequate safety and security of patients and staff. With NHI, health care services should be based on clinical need and not ability to pay and these services will be free to users at the point of entry. One of the key objectives of the NHI will be to bring dignity and security to every user with great impact across the health sector.

The overall financial position and capability of the provincial governments and that of the provincial departments of health has impacted on the ability of the hospitals to fulfill their mandate of providing quality health care. Significant budgetary pressures exist with over expenditure and accruals including personnel expenditure such as overtime and rank promotions. Provincial treasury departments should be engaged on the baseline allocations to the provincial Departments of Health and priorities in terms of health care services particularly given the very high dependency of rural communities on the public health sector. Budget allocations to hospitals need to be urgently reviewed with a view to temporary relief of the unmanageable budgetary allocation. This is necessary because 75% or more of the budget is consumed by personnel salaries.

Leadership, governance and accountability – which are an intrinsic part of governance, remain as important building blocks of the health system. In fact, these are cross-cutting themes that should be assessed across the board. They need to be approached within a multi-level governance framework where issues of governance are not just addressed within the Department of Health alone.

A coherent and aligned network of 'structures' across the health system that spread responsibility downwards in the hierarchy must be developed to improve accountability in leadership and governance. This must include a legislative framework that underpins the structures and their authority to act and hold everyone accountable. Roles and responsibilities of each sphere of government need to be reviewed with clear separation of political vs administrative leadership, taking into account the relevant constitutional and legislative prescripts.

The community, including health service users must be actively engaged in the processes of unifying the health system. Community Health Workers (CHW) are a vital link between communities and health facilities. WHO notes the importance of Essential Health Care (EHC) based on practical, scientifically sound and socially accepted methods and technology. These made universally accessible to individuals and families in their community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination[4].

The success of a quality health system rests on information systems that can generate valid information at the right time and in the right format for decision making and monitoring at all levels of the management, taking into account the need for patient confidentiality. Electronic Health Record (EHR) is a building block of the health information system in the era of NHI. The current health information system is fragmented with 42 systems with no unified electronic health record. Standardisation of systems using the normative framework for interoperability is paramount for use of information for evidence-based decision making. Budget allocation is insufficient with a lack of prioritisation of eHealth and health information systems.

Utilising an existing IT infrastructure despite challenges for maximum benefit is crucial to get started with NHI implementation. The existing IT infrastructure system should be enhanced by improving information, communication and technology (ICT) infrastructure connectivity and use of ICTs to support data collection and reporting for assessment, screening and intervention programmes.

The interventions proposed at the health summit are therefore intended to address the obstacles to the achievement of UHC, that is, everyone should have access to quality health services, as required, for such care to be adequate. These services should provide access to comprehensive care inclusive of promotive, prevention, curative, rehabilitative, palliative and should not be too costly to accommodate the poor who need the services but cannot afford to pay.

In the context of South Africa, the NHI is a tool for the achievement of UHC. It should be acknowledged that addressing the challenges faced by the South African health system and achieving UHC requires the involvement of both the public and private sectors.

4 International Conference on Primary Health Care: Alma-Ata, USSR, 6-12: WHO, 1978

2. INTRODUCTION

PRESIDENTIAL HEALTH SUMMIT 2018

The World Health Organisation constitution declares health a fundamental human right[5] and South African Constitution Bill of Rights[6] states that:

- Section 27(1)(a) "Everyone has the right to have access to health care services, including reproductive health"
- Section 27(1)(c) "no-one may be refused emergency medical treatment"
- Section 27(2) "the State must take reasonable legislative and other measures within its available resources, to achieve the progressive realisation of each of these rights"

South Africa has a two-tiered health system consisting of the public and private sectors. The current structure of the health system is significantly different from the apartheid era one which had fourteen public sector health departments serving different ethnic and population groups. A significant additional change is the private sector which grew from being a complementary service provider in the 1960s to becoming a substantial source of funding and delivery of health care after the promulgation of Medical Schemes Act no.131 of 1998.

While there have been significant achievements and improvement in access to public health system and increased financing post 1994, some areas remain unattended to, leading to a characterisation of the health system as being in a crisis. Some of the challenges in the public health sector include poor governance structures; inadequate management capacity and administrative systems; underfunding; human resource shortages and maldistribution; inadequate and poorly maintained infrastructure and equipment; inadequate information systems, overall inefficiencies amongst others.

Similarly, the private sector, which is perceived to provide better quality health care by most South Africans, is challenged by unaffordable prices, maldistribution of providers and facilities and perceptions of over-servicing, perverse incentives and lack of accountability as identified in the draft report of the Health Market Inquiry (HMI). The National Development Plan (NDP) notes that "the national health system needs to be strengthened by improving governance and eliminating infrastructure backlogs." While the attainment of good health is not the responsibility of the health sector alone, the sector plays a significant role in ensuring that the population has access to quality health services. South Africa is facing a quadruple burden of disease and this strains the health care system:

i. HIV/AIDS and related diseases such as tuberculosis (TB), and sexually transmitted infections (STI);
ii. Maternal and child morbidity and mortality;
iii. Non-communicable diseases (NCDs);
iv. Violence, injuries and trauma, and these put a burden on health care services.

The recognition of these complex and immense challenges identified by several groups around the country; the provisions in the NDP; and reports of the Office of Health Standards Compliance and the concern of the President on the state of the health system warranted the hosting of a *Presidential Health Summit*. The *Presidential Health Summit* served as an avenue to bring together key stakeholders from different constituencies, to deliberate and propose solutions to address the health system challenges through an inclusive process. The proposed interventions are intended to address the barriers to the achievement of universal health coverage – i.e. everyone should have access to health services as required without any financial hardship resulting from the use of or the need for these services.

While it could be argued that the public health care system provides universal health care access since users are billed based on their ability to pay, this cannot be taken as an indication of the achievement of UHC in South Africa because barriers to access and concerns with the quality of care remain prevalent.

In the context of South Africa, the NHI provides an avenue towards ensuring UHC. To address the challenges faced by the South African health system,

5 World Health Organisation Constitution, 1948
6 South African Constitution: The Bill of Rights

and to achieve UHC, requires the involvement of both the public and private sectors. The *Presidential Health Summit* focused on challenges in the public and the private health sector that pose a barrier to the achievement of UHC. The summit aimed to suggest recommendable interventions to address these challenges and concomitant recommendations to improve the health system. In total approximately 600 delegates attended the summit.

The immediate objective of the Presidency and the National Department of Health, working with other departments and other stakeholders, was to be able to take steps to facilitate rapid improvement of the quality of the health system.

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3. AIMS, OBJECTIVES AND OUTCOMES OF THE SUMMIT

The *Presidential Health Summit* aimed to address the numerous challenges facing the South African health system and work towards strengthening the health system – to ensure that it provides access to quality health services for all in line with the principles of universal health coverage. To achieve this, the *Presidential Health Summit* recognises the centrality of NHI and the combined roles of the public and private health sectors in meeting the overall aspirations and goals of South Africa's national health system in achieving UHC.

The **objectives** of the *Presidential Health Summit* were to:

- Advance collective efforts to promote good health care services as an essential foundation to health for all in South Africa
- Outline the roadmap towards a unified health care system by committing to rebuild the health system to provide quality health care to all
- Identify actions to strengthen co-ordination, monitoring and evaluation of the health system
- Identify actions to strengthen co-ordination to deal with corruption, waste and abuse to improve accountability and transparency in the health system
- Address and action solutions to end the crisis in the health system

The expected outcome of the *Presidential Health Summit* was that the objectives stated above will be met through the development of a mutually accepted and agreed action-oriented health compact. The *Presidential Health Summit* was also aimed at developing a roadmap for the implementation of the identified interventions. A commitment from all stakeholders including the private sector, civil society, health professionals, labour unions, health service users, academics and the public is required to achieve the broad goals of ensuring access to quality health services for all.

Overall, the *Presidential Health Summit's* intentions were that it would contribute towards a consensus on the way forward to address the current health systems crisis in South Africa. To meet this expected outcome, it was proposed that the *Presidential Health Summit* be organised in the form of commissions that are based on the broad areas identified through a collaborative process, as central to addressing the health systems challenges. Members of the various commissions were comprised of stakeholders with sufficient knowledge of the issues that pertain to the focus area of the commission to ensure effective contributions. The *Presidential Health Summit* was focused mainly on action-orientated solutions and finding the way out of the current health system challenges.

4. KEY MESSAGES FROM THE SPEECHES

Mr David Mabuza,

Deputy President of the Republic of South Africa

The health system is in crisis and needs urgent attention. The Presidency has taken stewardship of the NHI process and consequently the development of a quality health system in support of NDOH to ensure that the country achieves affordable quality health care. Under the leadership of the President, all key players and stakeholders in the health sector are mobilised and galvanised to work together in finding solutions aimed at turning the health system around. Among other key priority issues the *Presidential Health Summit* resolved to pay special attention to are four major issues that impact negatively on public health system namely: human resources, procurement or supply chain systems, financial management and maintenance of equipment and infrastructure.

In transforming the health care system for the better, the country needs to ensure that there is commitment and appropriately skilled health care professionals. According to WHO, one of the six building blocks of a healthy and resilient health care system, is the health workforce. Over the past few months, there has been an outcry from all corners of the country about the shortages of the workforce in the public sector. Whereas the President has agreed to inject a certain number of the health workforce as part of his stimulus package, this is just but a temporary measure for immediate relief.

The other challenge in the provision of good quality health care is poor procurement or supply chain management systems that make it impossible to have adequate medicines and other important health commodities. Although there is an essential medical equipment list and an essential medicine list accompanied by the delivery of chronic medicines distribution programme, there are still challenges resulting from inadequate maintenance of equipment and stock-outs of medicines. Government needs to work with civil society groups to monitor the availability of medicines and other commodities in the health system. To ensure quality, safe and relevant technologies end-users – primarily the health workers must be involved in the procurement of equipment to ensure it can be used effectively and efficiently.

For South Africans to have access to care that is affordable, available and acceptable; it is essential that the services should be of good quality. There is inadequate regulation of the private and public sectors in terms of quality of health care. As South Africa plans to introduce NHI in a phased approach from 2019, incrementally, certification of health facilities is required to meet the standards set by the Office of Health Standards Compliance, followed by accreditation of NHI by the NHI Fund. Most importantly, proper governance systems must be in place to improve accountability for performance across all levels of health care delivery in the system.

The private sector provision costs are affordable only to a few, as per the provisional findings of the Health Market Inquiry. Most Medical scheme contributions have increased faster than inflation and there has been a failure to grow membership. The challenges in both the public and private health sectors require a new approach to serve all South Africans and meet the constitutional mandate of the progressive realisation of the right to health care. An integrated health system for all – through an NHI is required where access to quality health care is not dependent on one's economic status as is currently the case.

Financing of health care in South Africa has resulted in a very inequitable system of health care between the public and private users, between urban and rural areas and between provinces and local government. The private sector, funded by largely economically endowed users directly or through contributions to medical schemes, is far better resourced than the public sector that is funded through the fiscus. Alongside these transformation initiatives, prioritising the development of new infrastructure in previously under-serviced areas is crucial to ensure that existing infrastructure is properly maintained to meet the required standards. A 10-year infrastructure plan, using identified and ring-fenced infrastructure resources must be developed.

The Deputy President officially launched the National Wellness Campaign, which focuses on testing and treating people who have HIV, TB, sexually transmitted infections and non-communicable diseases such as diabetes and hypertension. The emphasis of the campaign will be on the provision of comprehensive health and wellness services targeted at men, adolescent girls and young women as well as key and vulnerable population groups. The campaign reinforces the implementation of prevention strategies, linkages to care, management, treatment and support. As part of the package of services for the *"Cheka Impilo"* campaign, the focus will be to increase information, education and communication activities, promotion of HIV testing, widespread distribution of condoms, and provision of pre- and post-exposure prophylaxis against HIV.

Dr Nkosazana Dlamini-Zuma,

Minister in the Presidency: Planning, Monitoring and Evaluation

NDP 2030 envisages a health system that works for everyone. According to WHO's constitution (1948)[7], *"the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being."* UHC should be accessible to all individuals and communities and at a cost that the community and the country can afford.

South Africa is committed to UHC through NHI and the *Presidential Health Summit* will be looking at how to achieve that. Below are some of the challenges in relation to the health care system in South Africa:

- In 1994 government adopted an unequal health care system resulting in inequalities in South Africa's health care
- Inequalities are also seen in distribution of health professionals
- Resources are shrinking due to economic challenges
- According to Health Professions Council of South Africa (HPCSA), there are 29 310 medical practitioners in South Africa and only 14 046 are in the public sector
- The unequal distribution of resources for public and private sector users. using a higher proportion of the GDP to serve only 16% of the population, while the public sector uses a lower proportion of the GDP to service 84% of the population
- Absence of health data to illustrate that interventions produce required health outcomes

Given the above challenges the deliberations from the summit should take the following into consideration:

- Proposals are aligned to resources to be utilised for the benefit of all South Africans
- Use of technology for a database for all South Africans, that can be interoperable whether in private or public sector
- A need for a well-maintained infrastructure
- Decentralised delegation of powers
- A collaboration between labour, civil society, academia and private sector to improve the health care system

Dr Aaron Motsoaledi,

Minister of Health

The Alma Ata Declaration (1978)[8] has three key declarations in relation to health care:

a) The Declaration of Health as not just the absence of disease or infirmity, but as a state of good physical, mental and social wellbeing.

b) The Declaration that the existing gross inequalities of the health status of people, between developed and developing nations and even within borders of countries themselves is politically, economically and socially unacceptable and of common concern to all.

c) The Declaration of "Health for All by the year 2000."

*"Is a concept of **Health for All** just but a pipe dream or is it achievable?"* UHC is a necessary means to an end – the end being **"Health for All"**. This first ever *Presidential Health Summit* marks a turning point in the history of health care in South Africa.

7 World Health Organisation Constitution, 1948

8 International Conference on Primary Health Care, Alma-Ata, USSR, 6-12: WHO, 1978

Dr Gwen Ramokgopa,

MEC Gauteng Department of Health

It is imperative to deal with the disease burden and its socio-economic impacts. This requires a comprehensive approach in investing in all South Africans by striving for a quality health system for everyone. The commitment by the President towards health care and the assurance that investment towards health is priority is inspiring.

Gauteng province has additional challenges of high urbanisation rate which overburdens the health system, however Gauteng Department of Health has made progress in the following:

- Advanced registration of the population for NHI with over 7 million citizens already registered
- Improvement of health facilities in the ideal clinic project, which is aimed at improving health service provision
- The province has taken lessons from the incident of "Life Esidimeni"
- Stakeholders must work together and design a NHI that will work for all South Africans and meet the objectives of access to health care regardless of one's social status.

Mr Michael Shingange,

Labour Representative

The labour constituency completely supports the objectives of the *Presidential Health Summit*, however the practical solutions from the summit should culminate in action plans to ultimately change the health care system. One of the key challenges in the public sector is that health care workers are over worked due vacancies that are not being filled as well as unfunded mandates. The constituency welcomes the release of the two Bills (NHI and Medical Schemes Amendment Bill) to address health care challenges in South Africa. Both the OHSC and the Health Market Inquiry reports give an indication that the health system is failing the people of South Africa. NHI is a realistic aspiration, both private and public sectors combined have enough resources to meet the NHI objectives.

Mr Thulani Tshefuta,

Community Representative

Convening the health summit is an acknowledgement that there are challenges in the health system requiring collaboration from all stakeholders. Good quality health care continues to be enjoyed by those that can afford and South Africa spends about 8.7 % of the GDP in health but almost half of that amount services only 16% of the population. This injustice makes a point for the importance of UHC for health quality services for all.

Ms Tanya Cohen,

Business Representative

All South Africans should have access to decent health care, which should be progressively achieved. The Business community has a role to play. Better public and private sector collaboration will contribute to the achievement of UHC. The private sector is committed to address the findings of the final HMI report and concurs that it must be business unusual to address the crisis in healthcare. To address all health care challenges, the *Presidential Health Summit* input should contribute towards a roadmap to help monitor actions and progress.

Dr Tedros Adhanom Ghebreyesus,

Director-General: World Health Organisation

WHO and South Africa constitutions have something in common, that is, *"health is a human right for all people and not a privilege for those who can afford."* NHI will make health for all a reality than a dream. The best investment in improving the health of populations and reducing inequalities is a strong health system that deliver people-centred primary care and quality services. *"UHC is a journey, there is no single path. Every country finds its own way to get there."* What is essential is the political commitment from the highest level.

9 World Health Report 2010, p.6

Mr Joe Kutzin,

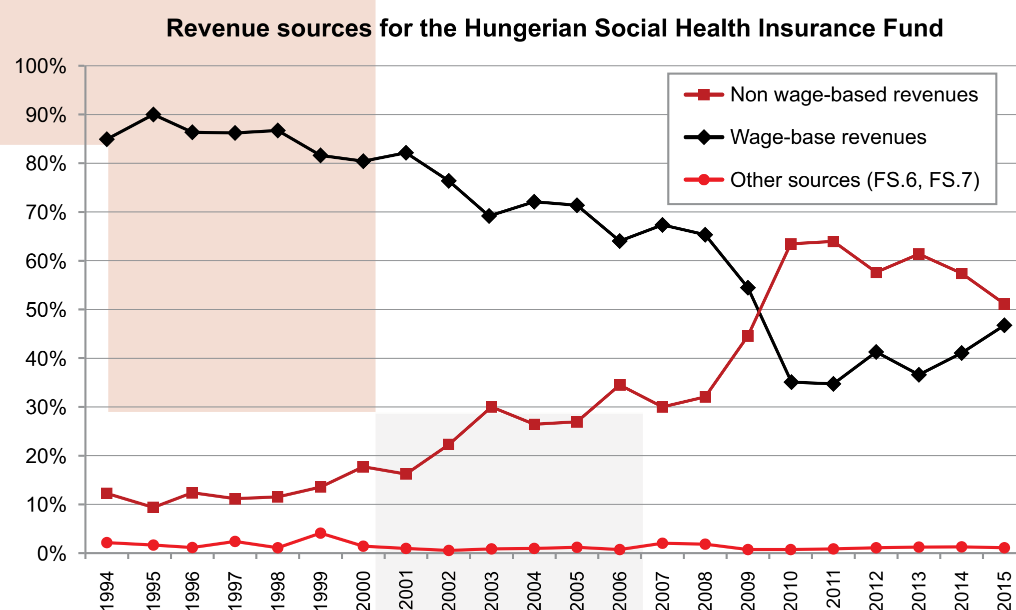
Coordinator, Health Financing and Policy:
World Health Organisation

UHC is defined as enabling **all people** to use health services that they need – that are of sufficient quality to be effective; and to ensure that the use of these services does not expose the user to financial hardship[9]. UHC should be operational – a direction, not a destination. "Moving towards UHC" means progressive realisation on one/some or all the following: 1) Reducing gap between need and use **(equity in use)**; 2) Improving **quality**; 3) Improving financial protection. UHC offers practical orientation for policy reforms regarding an approach that is relevant to all countries as a guide. A health care reform needs to be about solving health care problems and not picking a model.

UHC changed (or should have) the basis for public policy on health coverage. Coverage should be perceived as a "right" of citizenship rather than as just an employee benefit – a major but often unrecognised shift in the logic that prevailed prior to World-War 2. It is a system, not a scheme because a scheme can make its members better off at the expense of everyone else. The effects of a "scheme" or a "programme" is not of interest per se; what matters is the effect on UHC goals considered at level of the entire system and population. It is imperative for government to assess goals embedded in UHC at a population level.

In 1911 the UK had a very rudimentary health care system that was developed around work and for workers – and was never intended to cover the entire population. This meant that risk covered by "health insurance" was loss of wages when employees were ill and unable to work. What UHC implies for revenue sources and entitlement is that there should be a progressive de-linkage of health coverage from employment status. It also means that a shift in revenue mix from specific contributions for health insurance to general government revenues is critical. Recent coverage expansions in countries like India, Indonesia, Gabon, Thailand, Mexico, Peru, China, Philippines, Ghana etc. reflect this approach. Revenue collection does not determine other health financing functions, that is, pooling and purchasing arrangements. Below is an illustration of Hungarian Social Health Insurance Fund revenue sources.

Figure:1 Revenue Sources for the Hungarian Social Health Insurance Fund



Source: Szigeti et al (forthcoming). WHO/Hungary Country Office

WHO's health financing includes a functional approach that takes the following into consideration:

- Revenue raising and increase in public funding levels from a low base
- Make public revenue flows more stable
- To improve efficiency, obtain budget flexibility to enable purchasing reforms that move away from line-item budgets
- Pooling of funds
- Purchasing of services must be allocated to providers
- Policy (explicit or implicit) on benefit entitlements and rationing
- Establish a new autonomous purchasing agency with no political interference

WHO cares about how well government financing arrangements "insure" populations by promoting use in relation to need, financial protection, and quality. Countries need to tailor their financing arrangements to their context guided by these objectives. WHO is almost certain that South Africa's NHI need not conform to traditional notions of "insurance" – the country has choices. It does not matter what the UHC system is called – whatever works to communicate effectively to South Africans.

Transitional implementation lessons from experiences relevant to South Africa on health financing for UHC including *building foundations for more equitable, efficient, transparent, and adaptable health system* are:

- Choices made for implementation steps should reflect equitable, transparent and adaptable health system
- South Africa must avoid "locking in" inequalities and inefficiencies that will be hard to undo in the future
- There is no magic to NHI or UHC; it takes hard work as reflected in the commissions

Principles to guide UHC implementation include:

a. **Accountability, transparency and public reporting** – this means reducing fragmentation and strengthening purchasing power as the great potential advantage of single payer arrangements. Many good examples include countries like Costa Rica, Estonia, Turkey, Hungary, Lithuania, Kyrgyzstan, Moldova, Philippines and most recently Indonesia. However, putting all the money in one place is also a risk, for example, Kazakhstan's experience in late 1990s. Mandatory public reporting on the use of funds and results achieved by the new NHI agency should be non-negotiable.

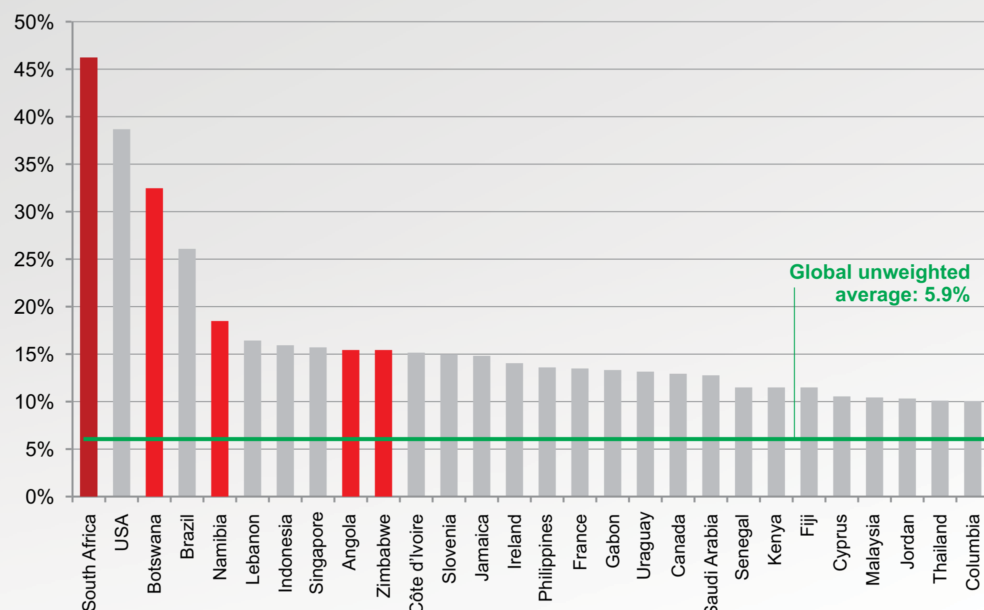
b. **Design in equity and universality and pro-poor approach into early implementation** – South Africa must be cautious not to start with the formal sector using contributory-based entitlement as this will result in the "lock in" segmentation. Vested interests block unified approach that includes informal sector and the poor. Even the reformers in Mexico and Thailand could not fully overcome the legacy of the historical link of health coverage to employment. South Africa should also avoid separate public schemes or pools for different population groups as this is a recipe for long-term inequity and inefficiency. Practical steps to lay a foundation for a universal system include:

   - Unifying information platform on patient activity, regardless of insurance affiliation status
   - Diversifying the pool and common benefits at first stage (e.g. poor, formal and informal), even if not everyone is in immediately – set the precedent e.g. countries like Moldova, Kyrgyzstan, Indonesia

c. **Address conflict of interest now** – this is a fundamental governance responsibility for those leading the health system. Conflict of interest is a source of inefficiency and potentially "bad medicine."

d. **One country – One health system** – the public and private health delivery and financing arrangements in the country, like any country, have interactions and spill overs. The core foundation for NHI is a recognition that the financing and delivery "architecture" of the health system has not changed much since 1994. Globally, South Africa is an extreme outlier, see below.

Figure: 2 Voluntary Health Insurance Spend



Source: WHO Global Health Expenditure Database

Voluntary health Insurance (VHI) is not necessarily a problem, but in South Africa, it is a driver of system inequity and inefficiency. Below is a population coverage with VHI compared to percent of health spending through VHI.

In South Africa as medical scheme membership increases, so do the earnings of administrators because there are no incentives to control cost growth; to realise that 70% caesarean section rate is a problem and to move away from open-ended fee-for-service reimbursement.

Premiums in private health sector rise and benefits shrink, and the consequences of these inefficiencies are shifted to patients (and employers, including government). South Africa must consider a way to alter these incentives so that they are aligned with public policy concerns. The private medical concern is a public policy concern because of the spill over effects that is – diversion of scarce (especially human resources) to serve the insured at the expense of the poorer population; high prices increase input costs across the health system; and the fiscal impact because of premium increases for civil servants.

Figure: 3 Voluntary Health Insurance Population Data

Country	Voluntary health insurance		
	Coverage	Share of health spend-ing	Role
France	90%	14%	Complementary
Slovenia	84%	16%	Complementary
UK	9%	4%	Supplementary
Kenya	1-2%	12%	Duplicative
South Africa	16-17%	47%	Duplicative

Source of European VHI population coverage data: Sagan and Thomson 2016; data for latest available year

e. **From "command and control" to local problem solving within clear policy framework** – South Africa must focus on accountability for results and not control of inputs or just executing budget line items. Central planning is good for setting high-level objectives, but not for responding to diverse needs of a large country in a timely manner. Many countries have had success with "managed autonomy" as well as harnessing the brainpower of local managers. For example, in Ghana in the 1990s, each Regional Directors of Health Services was encouraged to establish an Operations Research Unit to investigate and develop local solutions to local problems with empowered district health teams which formed part of the unit. Another example is Mexico's decentralised system with annual meeting of State Health Departments to review comparative performance data and share experience with changes introduced.

The gains from "strategic purchasing" can only be realized if managers have some degree of autonomy to manage their internal resources. Partial autonomy over reimbursements from single payer agency in Kyrgyzstan enabled hospital managers to make large efficiency gains in 2001 that translated into lower informal payments for patients. Autonomy was not a "giveaway" and is not "all-or-nothing" – providers still had to report on the use of funds and had some limits on their spending decisions.

f. **Implement, evaluate, learn and adapt** – A successful UHC requires a good plan but recognises that there are challenges and not everything can be anticipated, circumstances vary and needs change over time. South Africa must move towards a data-driven, adaptive system with a unified national provider payment database. What is also crucial is the excellent applied research capacity that exists in South Africa. Government needs to steer these to a common purpose.

5. METHODOLOGY OF THE SUMMIT

PRESIDENTIAL HEALTH SUMMIT 2018

The *Presidential Health Summit* brought together key stakeholders from various constituencies in the health sector, to deliberate and propose solutions to address the challenges facing the South African health system. Delegates worked towards strengthening the health system to ensure that it provides access to quality health services for all in line with the principles of universal health coverage through an inclusive process. There were nine commissions set up to provide a basis of discussions and deliberations, namely:

1. Human Resources for Health (Health Workforce)
2. Supply Chain Management, Medical Products, Equipment and Machinery
3. Public Financial Management
4. Infrastructure Planning
5. Private Sector Engagement
6. Health Service Provision (Delivery)
7. Leadership and Governance
8. Community Engagement
9. Information Systems

The expected outcomes of the commissions were to:

- Identify commission specific action solutions that will address the health crisis
- Identify areas of consensus among constituencies and highlight in plenary the key disagreements in the commissions
- Begin to identify key building blocks of the road map towards universal health coverage from the identified action solutions
- A report on the above presented in plenary

Each commission was introduced by a resource person providing a five-minute presentation highlighting a few challenges and possible sources of useful information. After the presentation, a facilitator allowed for questions of clarity and facilitated general discussion on the commission suggested areas of focus. The discussion provided an opportunity for the constituencies to raise pertinent issues in the health sector. Robust discussion between constituencies and stakeholders was encouraged as the health summit was an opportunity to conduct a critical diagnosis of the health care sector and to identify solutions to these challenges.

Where possible, each commission deliberated and provided recommendations spanning over the short-term, medium-term and long-term to tackle the challenges facing the health care system. Commissions broadly identified areas of consensus in some instances. While not binding resolutions, the actions identified under each of the Commissions will serve as input to the compact and action plan that will be developed.

Below is a category of stakeholders that participated in the Presidential Health Summit.

- Academia
- Business Unity South Africa (BUSA)
- Civil society
- Communications Department of Health
- Commission Chairs and Resource Persons
- Congress of Traditional Leaders of South Africa
- Congress of South African Trade Unions COSATU (all three Federations)
- Cuban Trained Doctors
- Democratic Nursing Organisation of South Africa
- Department of Basic Education
- Department of Higher Education
- Democratic Nursing Organisation of South Africa
- Department of Health Chief Directors
- Department of Health Ministerial Advisor
- Department of Planning, Monitoring and Evaluation
- Department of Cooperative Governance and Traditional Affairs
- Department of Public Service and Administration (DPSA)
- Department of Public Works
- Department of Science and Technology
- Ekurhuleni Mayoral Office
- Gauteng Premiers' Office
- Government Ministers
- International Partners
- Kwa-Zulu Natal Doctors Healthcare Coalition
- Medical Schemes
- Ministerial Task Team - Nursing
- National Health Council
- National Department of Health
- NHI War room officials
- Office of the President
- Office of the Deputy President
- South African Medical Association
- South African Medical Association Trade Union
- Portfolio Committee on Health
- Progressive Health Platform
- Provincial Departments of Health Managers
- Public Health Care Users & Organisation
- Statutory Councils
- Security Department of Health
- USAID
- World Health Organisation
- World Bank

PRESIDENTIAL HEALTH SUMMIT 2018

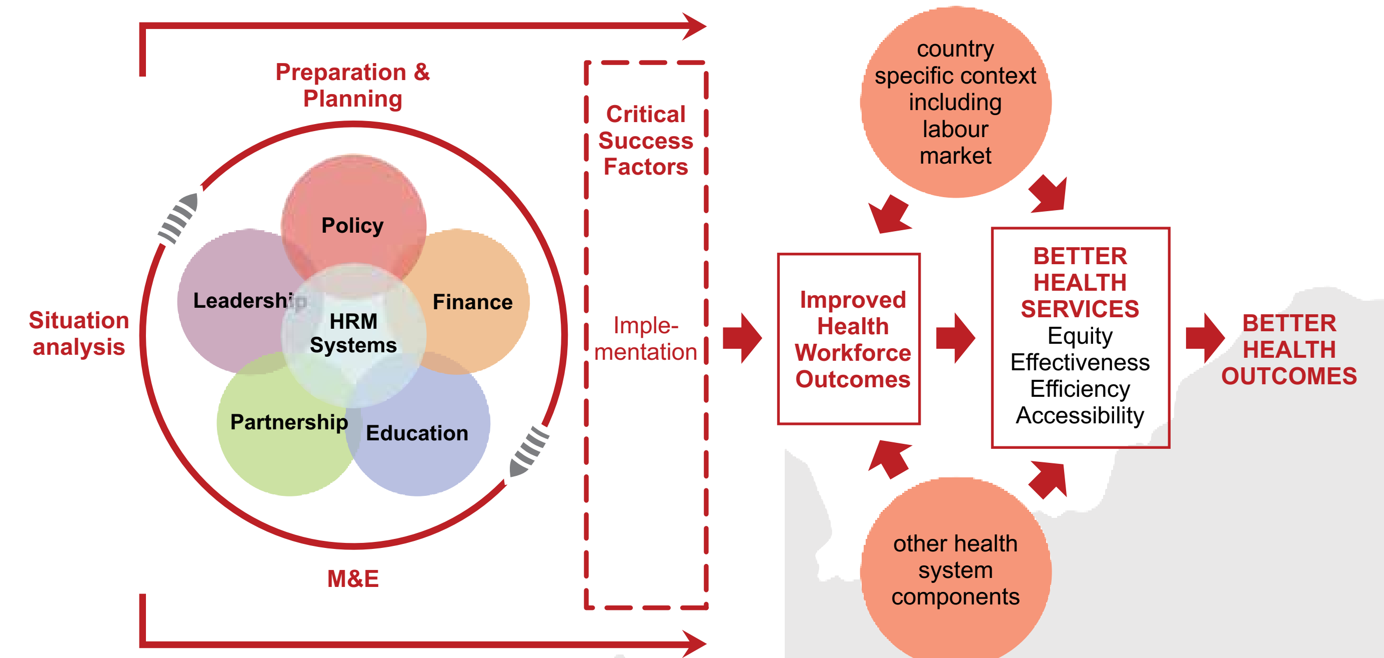
6. COMMISSION ONE: HUMAN RESOURCES FOR HEALTH (HEALTH WORKFORCE)

6.1. Overall Situation Analysis

Concerns were raised about several issues affecting human resources particularly vacant posts; performance management; poor planning; inadequate remuneration; poor coordination at different spheres of government; lack of leadership, management and governance; lack of delegation of authority; harmonisation and stewardship. Alignment and harmonisation is required which takes into consideration the importance of human resource for planning, including planning and budgeting to meet health needs. Education and training must be aligned to health system requirements.

Below is a diagram that summarises the human resources management system. A human resources management system has five pillars, namely: policy, finance, education, partnership and leadership that should be considered during planning. Continuous monitoring and evaluation is imperative to ensure that human resources are still aligned with the needs in the sector. When human resources are aligned to the needs, health workforce outcomes are improved, and service provision enhanced – that leads to better health outcomes. In planning for human resources government must always consider the country specific context including labour market.

Figure:4 Human Resource Management System



6.2. Challenges Identified

Below is a depiction of the current human resources for health challenges. The health system is plagued by endless challenges relating to: inadequate funded posts; maldistribution of posts relative to need; poor service delivery planning; clinicians who are over worked; safety concerns for staff in facilities; lack of financial resources to absorb junior doctors in the public health sector etc.

Figure:5 Challenges Facing Human Resources for Health

Regulatory environment between departments, that is, NDOH; Department of Public Service Administration (DPSA); Department of Higher Education and Training (DHET); Department of Social Department (DSD) and Treasury; and between public and private sectors should be reviewed to allow for a conducive environment for the implementation of NHI. Human resources challenges below have been categorised into a health resource management system, namely: 1) Policy; 2) Leadership, Governance and Management; 3) Management Systems; 4) Education, Training and Development; 5) Partnerships.

6.2.1. Policy

Remuneration of Work Outside Public Sector (RWOPS) needs to be reviewed as it impacts on service delivery. The implementation of policy on the registration of foreign trained doctors with the Health Professions Council of South Africa and their employment must be fast tracked to address shortages of skills. Currently there are inadequate posts to meet statutory obligations and poor service planning results in mal-distribution of posts according to need.

6.2.2. Governance, Leadership & Management

The leadership structure in hospitals and clinics requires urgent review. The organisational design in hospitals and clinics is characterised as top heavy, with many managers appointed and the duplication of roles. The leadership capacity of many leaders and managers in public health leaves much to be desired as leaders lack appropriate management capacity. Political interference and patronage networks in the management of public hospitals has resulted in the challenges that plague the public health sector.

6.2.3. Management Systems

The normal eight hours of work are not suitable for the 24 hour demands for health care services in the community, and staff planning is not informed by evidence. Working hours of all health care professionals are not aligned with the disease burden and the needs of the communities.

PRESIDENTIAL HEALTH SUMMIT 2018

6.2.4. Education, Training and Development

NHI white paper envisages that Primary Health Care (PHC) will be the heart-beat of the NHI. The PHC services will include health promotion, disease prevention, curative (acute and chronic clinical) services, rehabilitation and palliative services. However public health professionals are not currently trained to meet the needs of PHC and there are inadequate training posts.

6.2.5. Partnerships

The distribution of human resources between the public and private sector remains unevenly distributed. Half of the registered doctors serve more than 80% of the general population, with the remainder serving a small segment of the population with access to private medical care. The disparities in the distribution of human resources in health between the private and public sector is a serious concern, as the public sector is inadequately resourced. According to the South African Department of Health Human Resources for Health strategic plan, there are more health professionals per 10,000 in the private sector than in the public sector.

6.2.6. Workforce

Health workers and trainees are assaulted on duty – there is a need to ensure physical safety on the way to work and at work. Currently there is poor staff morale. Human resources planning doesn't include long-term transition and succession planning for sustainability.

6.3. Proposed Interventions

6.3.1. Policy

To address challenges relating to human resources an HR roadmap is required and should include staff engagement; recognition and reward for personnel; talent management; attraction and incentivisation; retention, support and occupational health

and safety. More so, government must fast-track implementation of policy on foreign trained medical practitioners. The state should fulfil its obligation for statutory employment of interns and community service professionals including unfreezing and financing of critical posts. Evidence and needs-based human resource planning and financing plus equitable distribution of human resources are necessary to meet the needs of the health system.

6.3.2. Governance, Leadership & Management

There is an urgent need to review the organisational design in the public sector to redress the top heavy organisational design. The roles and responsibilities of the different spheres of government require a review to ensure that human resource policies at a national level are effectively implemented by the provinces. There must be a separation between the political and administrative leadership in public health and all management must undergo continuous leadership and management training.

6.3.3. Management Systems

Human resource management information requires urgent attention with a need to validate the information from the “Integrated Human Resource, Personnel and Salary System” (PERSAL) so that it can be effectively utilised as a reliable human resource management tool. There is also a need to review the working hours of all health care professionals to ensure that workers are working according to the health care needs of the community, and within the reasonable capacity of the available staff.

6.3.4. Education, Training and Development

Training programmes must begin to capacitate human resource workforce for the needs of the NHI policy. Government must address the shortage of trainee posts and review training programmes.

6.3.5. Partnerships

There is room for improved private and public partnership collaborations in terms of developing the human resources needed for UHC. The mechanism to do so should be agreed, recognizing the benefits of public-private sector cooperation in this regard. Engagement with healthcare worker professional associations and their capacity must be improved.

6.3.6. Workforce

Improve safety of employees in facilities by putting the necessary security measures in place. Address staff morale by understanding the causes of such and improve work conditions for employees. The absence of senior colleagues and effective systems to supervise junior staff poses a risk for the entire healthcare system and can be addressed by a number of interventions, including reviewing application of RWOPS. Project planning must include long-term transition for sustainability.

Immediate Actions

i. Lift moratorium on posts in public health sector with priority placed on critical services.

ii. Review the policy on remuneration of work outside public service to limit its impact on service delivery.

iii. With immediate effect, ensure that statutory requirements for internship and community service posts are established by provincial health departments.

iv. Put in place mechanisms to address corruption related to the abuse of HR systems.

Short-Term Actions

i. Ensure that service plans are based on good information particularly population health needs, training capacity at institutions of higher education and availability of posts at provincial health departments to employ staff through use of evidence-based tools.

ii. Review of the policy on registration and employment of foreign trained medical practitioners to address shortages of skills.

iii. Provide training and tools for the support for HR leadership and management.

Medium-Term Actions

i. Ensure that the policies on funding and staffing meet the needs of the health system.

ii. Validate and optimise the use of PERSAL and HR management information system.

iii. Review the roles and responsibilities of each sphere of government in relation to health services.

6.4. Key Outcomes: Human Resources for Health Commission

a) Improve human resource planning, production, training, and financing so that human resources meet the health care needs of the population.

b) Lift moratorium on posts especially posts that impact directly on service delivery.

c) Meet statutory requirements through the creation of adequate posts for internship and community service in the health sector.

d) Key to improving human resources for health challenges is to validate and optimise the use of PERSAL and HR management information system.

e) Most importantly, evidence and needs-based human resource planning and financing plus equitable distribution of human resources are necessary to meet the needs of the health system.

7. COMMISSION TWO: SUPPLY CHAIN MANAGEMENT, MEDICAL PRODUCTS, EQUIPMENT AND MACHINERY

7.1. Overall Situation Analysis

WHO defines access to medicine as a priority for citizens. This means that medicine should be available at all times and in adequate amounts, in appropriate dosage and quality and at an affordable price for individuals and communities . WHO also notes that "a well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use ." Medicine is the second largest expenditure item in the health system, thus managing drug supply is essential. Managers should focus on procurement, selection, distribution and to ensure that there is an uninterrupted supply of medicine.

There have been several positive steps towards improving the availability of medicines at facilities. Innovative information technology systems such as the stock visibility system (SVS) and RxSolution (RxSolution is an electronic pharmaceutical management system used to manage inventory, purchase orders, stock issues to health facilities, and medication dispensing) have been developed to monitor the availability and supply of medicines at facility level. These systems require that information be captured accurately and timeously.

7.2. Challenges Identified

In South Africa, there are several gaps that need to be addressed in the supply chain processes and procedures; ensuring that funds are available for medical products, equipment and machinery and are optimally utilised to achieve universal health coverage.

Supply chain management has enormous challenges ranging from limited supply chain management skills; inadequate monitoring and governance on available systems; shortage of equipment and consumables exist leading to poor quality of care; corruption; tedious and cumbersome supply chain management processes; inadequate information systems; suppliers not being paid on time which impacts medicine availability; poor procurement systems and processes which are not standardised across all levels. In the case of medical consumables, there is no regulation on quality, non-adherence to a national catalogue of products and ineffective monitoring of availability systems

7.3. Proposed Interventions

7.3.1. A centralised procurement and logistical management system with standardised procurement systems and processes at national and provincial level must be considered to improve efficiency, deal with corruption and economy of skills and scale.

Capital equipment purchases should have a Service Level Agreement (SLA) and maintenance agreements with suppliers. Critical to enable efficient procurement processes is an information technology system.

7.3.2. Training/Human Resource Capacitation

Strong governance structures must be established at all levels including structures for planning. Institutions of higher education

must begin to offer training in pharmaceutical manufacturing and logistics. Clinical engineers for complex bio-medical equipment; technicians for minor medical equipment and involvement of end user expertise in the procurement processes is key.

7.3.3. Indigenisation of Pharmaceutical Production and Knowledge Capacity

- Establish knowledge/skills capabilities for local pharmaceutical manufacture and production – 'de-commodify' essential medicine supply to meet patient and national fiscal imperatives
- Establish a competitive state pharmaceutical company drawing on best international practices
- Support innovative private sector initiatives rooted in social responsibility ethos
- Research and Development – ensure state owned company is innovative, competitive and highly skilled (e.g. India)

Immediate Actions

i. Urgently address and deal with cases of corruption in the supply chain management system.
ii. Institute a performance management system regarding equipment maintenance.
iii. Ring-fence pharmaceutical budgets and insulate them from being overridden to avoid budgets being redirected for non-medical expenditure which result to stock-outs.
iv. Engage the private sector to advise on inventory management.

Short-Term Actions

i. Establish a catalogue and standards for non-medical items/consumables.
ii. Set up health technology assessment committees.
iii. Centralise procurement systems (with clear governance mechanisms) at national and provincial level.

Medium-Term Actions

i. Establish a competitive state owned pharmaceutical company.
ii. Invest in skills development for capacitation of pharmaceutical industry.

7.4. Key Outcomes: Supply Chain Management, Medical Products, Equipment and Machinery Commission

a) It is important to build a foundation for an equitable and universal NHI by capacitating the public health sector supply chain to deliver on its mandate by drawing on the best available local and international expertise.

b) A database with medical equipment specifications where equipment is defined in clinical and/or functional terms is required. For the successful implementation of NHI, an efficient supply chain management system that is unequivocally patient centred is required.

c) Establishment of a timely payment system of suppliers to avoid stock-outs.

d) National Treasury to investigate implications of sector specific procure-ment systems and to develop specific policies for NHI focused health care procurement.

PRESIDENTIAL HEALTH SUMMIT 2018

8. COMMISSION THREE: INFRASTRUCTURE PLAN

8.1. Overall Situation Analysis

The National Department of Health has a health infrastructure plan but to date the country has had neither the expertise nor adequate funding to implement the plan. In some cases, health infrastructure construction that has been successfully completed has either cost more than the initial budgeted amount or facilities have been constructed that either fail to meet the need for the services required. In other instances, facilities have not been provided with adequate funding to operationalise the new facilities fully. The result has been reactive crisis management to the consequences of this mismatch as well as the failure to replace facilities.

An assessment on the current infrastructure was conducted in 2015. The assessment modelled the actual data that was available plus a set of assumptions where the data was incomplete or unavailable. Below is a summary of key components covered in the assessment:

i. Priority sites for improving access and key infrastructure component markers that include planning units, beds and consulting rooms.

ii. Condition of existing infrastructure.

iii. Illustrate relative capital (replacement) value.

iv. Maintenance, refurbishment estimate and technology value estimate.

Regarding norms and objectives, it is important to recognise that just because a facility is overburdened, it does not mean that it is ideally placed nor the appropriate facility to expand/revitalise. Gaps were premised on general acute beds per 1000 population based on the minimum values for the gap analysis, adopted from the National Tertiary Health Service Plan (NTHSP).

Below are the results of the hospital infrastructure assessment:

8.1.1. Acute care hospital infrastructure in 2015

There are 813 hospitals with 133 387 beds in service providing acute health care in South Africa. 404 of these are in the public sector with 101 862 beds [69%] and 409 in private sector with 41 297 beds [31%].

8.1.2. Acute care public sector facilities

92 050 beds were declared *'useable beds'* in 2015 with Layer1[L1] at 82,39%; Layer 2 [L2] at 7,39%; and Layer3 [L3] at 10,22%. These had a replacement value of **R218,4 billion** (2015 prices and value); and only 1% of the replacement value of the public hospital assets, which is less than the 3% recommended in other studies. The annual maintenance requirement using 2015 price and value is at **R2,12 billion**. A requirement for major refurbishments and part/total replacement of existing infrastructure was **R14,74 billion** (2015 prices and value) and reduces the real asset replacement value to **R203,66 billion**. Below is a summary of the hospital grading findings:

- Eastern Cape has the most hospitals totalling 90 hospitals and Kwa-Zulu Natal (KZN) has the largest number of beds totalling to 22444
- There are 12 hospitals graded as condition 1/5
- There are 18 hospitals graded as condition 2/5
- In Limpopo and Eastern Cape there are mostly old, small, district hospitals with a couple of larger hospitals in very poor conditions

8.1.3. L1: Analysis of General Non-Specialist Acute Hospital Facilities

All nine provinces and 31 districts have, or will have, hospitals with <0,66 L1 beds/1000 public dependent population by 2025. Sixteen very substantial projects were proposed at the time of the assessment and will require significant site planning or alternatively an additional site with a new hospital. Five of the biggest projects are in Gauteng which has a rapid population growth and already pressured facilities.

8.1.4. L2: General Specialist Care Hospital Facilities

This layer included regional hospitals and the general specialist managed bed capacity for hospital care in tertiary and central hospitals.

- 66 public hospitals in all nine provinces have almost 6,800 L2 hospital beds
- 59 of these hospitals have capacity below the 0,33 L2 beds/1000 dependent population (as proposed in the NTHSP)
- Over 10,000 additional L2 beds are required to achieve the 0,33 L2 beds/1000 dependent population by 2025
- Over 2,800 more are needed in Gauteng alone and over 1,000 more are needed in Eastern Cape, KZN, Limpopo and Western Cape

The above does not necessarily reflect a net shortage of infrastructure because private hospital beds and L3 beds are available. If this capacity is considered then only 21 hospitals remain with <0,33 L2 beds/1000 total population. The implication is that there is infrastructure (and service) capacity that could be more effectively utilised. 6 of the 21 are designated tertiary hospitals and 15 are regional hospitals.

Gauteng, despite the many private hospitals, tertiary and central hospitals will still have at least 400 L2 beds deficient (compared to this norm) even if the total capacity of all public and private hospitals is available. This is half of the country's 'gap' of most vulnerable L2 bed capacity. 4 of the 12 affected hospitals are in major, rapidly growing townships.

8.1.5. Layer 3: Highly Specialised Care Hospital Facilities

There are 27 public hospitals with L3 beds: 10 Central hospitals; 16 Tertiary hospitals; 1 Regional Hospital (Rahima Moosa Hospital in Gauteng). L3 beds are reserved for highly specialised services and their designation is very dependent on the ability to recruit sub-specialist clinical professionals. Merely creating infrastructure is not, on its own, sufficient to attract the critical specialist professionals. Determining the distribution of L3 bed capacity is complex. On balance, the public health sector technically has an excess of L3 bed capacity. There will still be an excess of 2,500 L3 beds in 2025 according to the norm used in the NTSHP of 0,13 L3 beds/1000 dependent population. L3 beds are (or should always be) referral points and there should be no walk-in patients for L3 care. The main challenge for hospitals providing L3 care is the deficiency of L2 bed capacity.

8.1.6. Primary Health Care Infrastructure

There has generally been good access to primary health care across the country. There are 30 to 40 locations where access can be improved and where new facilities should be considered. Much of the existing infrastructure is in poor condition with as much as 20% requiring replacement at a cost of nearly R8 billion. The categorisation labels of facilities do not reflect the size and use of facilities. At the time of the assessment there were 3,868 PHC facilities (268 labelled Community Health Clinic (CHC) and 3,225 as 'clinic'). Data is generally inadequate for detailed planning. It is too poor and too inconsistent to use.

There is national annual requirement of at least R476 million for maintenance of the existing PHC infrastructure with almost 1/5th of this required to maintain Eastern Cape facilities. There is national refurbishment and replacement requirement of at least R7,87 billion for the existing exceptionally poor PHC infrastructure. There is a replacement value of R13,66 billion for the equipment with adequate and appropriate technology in all PHC facilities in the country.

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8.2. Challenges Identified

Modelled hospital infrastructure priorities are very different from the existing workplan. In most instances capacity of the authorities for project implementation, monitoring and evaluation is not sufficient. This is despite the existence of Infrastructure Delivery Management System (IDMS). Management capacity in health departments, both provincial and national is poor. There is inadequate alignment with the Department of Public Works in relation to health infrastructure.

The current scenario for the funding model is never likely to be sufficient, thus alternatives must be explored through:

- Infrastructure bonds (blended capital: social impact bonds and project bonds)
- Enhanced revenue collection
- Public Private Partnership (PPP) model
- Crowd funding as a donor mechanism

Table 2 Infrastructure Costs

Infrastructure	Replacement Value	Annual Maintenance	Refurb/Replace
Hospitals	**R218,4bn**	**R2,12bn**	**R14,74bn**
New Hospital			
Build Value			R23,74bn
Maintain pa		R2,57bn	
Technology Estimate			R4,59bn
PHC	**R38,5bn**	**R476m**	**R7,87bn**
New PHC			
Build Value			R700m
Maintain pa		R64m	
Technology Estimate			R230m
Total Health Service	**R256,9bn**	*****R5,23bn**	****R51,87bn**

***20% of existing capital value (+/- R5bn per annum for 10 years)*
**** 2% of capital value*

8.3. Proposed Interventions

- Infrastructure plans must respond to the changing population and clinical dynamics. There must be investigation of a national master plan to facilitate equity through well managed coordinating mechanisms (NDOH, Independent Development Trust (IDT), Council for Scientific and Industrial Research (CSIR), DBSA, National Treasury and Department of Public Works (DPW)
- Explore alternative funding mechanisms for the infrastructure plan, for example, through the PSI, CSI or social impact bonds

Immediate Actions

i. Establish a 'back to basics' system that will revitalise clinics and hospitals e.g. painting, toilets, furniture, broken windows.

Short Term Actions

i. Revise the existing national master infra-structure plan.
ii. Ensure that infrastructure plans respond to changing population and clinical dynamics.

Medium-Term Actions

i. Explore alternative funding mechanisms for health infrastructure e.g. special health infrastructure fund or social impact bonds.

ii. Work towards infrastructure in both the public and private health sectors meeting the requirements of the OHSC.

8.4. Key Outcomes: Infrastructure Planning Commission

a) Revise a national master infrastructure plan and the plan must respond to changing population and clinical dynamics, it cannot be static.

b) In preparing for NHI infrastructure **both** the public and private health sectors must meet the requirements of the OHSC and OHSC needs to be adequately resourced and capacitated to do this.

c) Alternative funding mechanisms for infrastructure must be considered e.g. special health infrastructure fund or social impact bonds.

9. COMMISSION FOUR: PRIVATE SECTOR ENGAGEMENT

9.1. Overall Situation Analysis

There is currently significant inequity in health care delivery between public and private provision. There needs to be a recognition of equity, fairness, efficiency and sustainability in engagements with the private sector. The public sector remains the bedrock of health care delivery in South Africa; however significant challenges to delivery and capacity exist. The diagram below depicts the financing of the current health system. It is important to note that 44% of funds are also (apart from the tax subsidies) out of pocket expenditure, as these do not come from the fiscus.

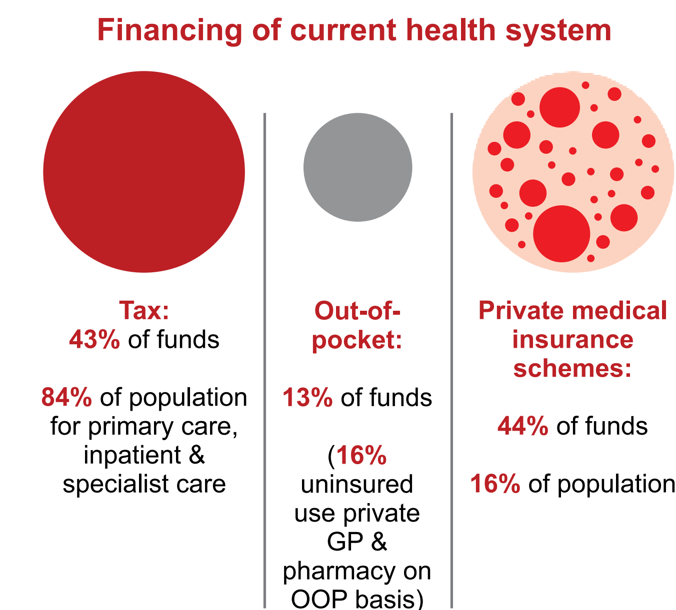
Currently private health care subscribers are paying an unsustainable amount. Moving towards UHC requires investigation into the merits of restructuring of medical scheme environment.

Challenges Identified

The relationship between private and public sector has had a history of challenges. For too long there has been an emphasis of two sectors – thus there is an urgency to move towards an integrated health system that has a shared vision, common higher purpose and tangible commitment to meeting the needs of the total population. Whilst the public sector forms the bedrock of the health system, the private sector's excess infrastructural capacity and capabilities can be leveraged to meet the unmet demands in public sector. The whole health system architecture and service design needs to be reviewed with a view to greater public and private sector cooperation.

Current regulations are outdated and do not address outcomes, quality, and norms for changing service delivery models. These regulations should be amended to promote multidisciplinary practices. The need to engage with the recommendations

Figure:6 Current Health System Financing



of the final report of the HMI was generally accepted by the commission. Costs in the private health sector and inequity between both sectors requires a multi-pronged strategy. Members of the commission felt that NHI pilots could provide an opportunity to understand contracting with private sector.

9.2. Proposed Interventions

- Develop a charter/framework and set of principles that provide permissions and boundaries and fosters and enables collaboration in practice between the public and private sectors
- Collective leadership and stewardship is required to unify both sectors around common goals
- Positive energy has been unleashed through the Summit, which indicates the willingness and palpable desire from both parties to be part of the solution leveraging their respective strengths
- The processes going forward must continue to harness this energy through transparency,

effective communication and feedback to stakeholders, thereby enabling opportunities to be part of the system response to the challenges facing health care

- Access to costing data, patient activity data, quality and outcomes etc. for both sectors needs to be addressed
- Closely monitor the movement of funds in this period especially the unintended consequences of weakening the public sector
- Enable the medico-legal cover for private practitioners operating in the public sector

Short to medium term actions

- Develop a Charter / Framework to mandate collaboration based on key principles including affordability, good governance – provide a basis for “modus co-operandi”
- Strengthen health care supply side regulation – including prices, establishment of new facilities as well as Certificate of Need (CoN)
- Define the public-sector service needs that could be met by the private sector – and specifically look at under-utilised capacity and actions to access for unmet needs
- Encourage local experiments with collaboration, innovative service delivery models and governance arrangements from which to learn
- Engage with addressing the recommendations from the final report of the Health Market Inquiry

9.3. Key Outcomes: Private Sector Engagement Commission

a) Outputs from the private sector commission, final Health Market Inquiry report and other commissions need to be coherently integrated.

b) Private sector has a critical role to play in the realisation of NHI, thus harmonious working relationship between private and public sectors in a way that puts the needs of the people of South Africa first is needed.

c) Data is a key enabler – government should have access to costing data from both private and public sector.

d) Social and commercial determinants must be addressed including health harming industries which impacts on health outcomes and service pressures.

e) To engage private sector meaningfully, the inclusive process and mechanism started through the *Presidential Health Summit* should be sustained by providing collective leadership and stewardship to unify both sectors around common goals.

f) Clarity of the model under NHI, roles and responsibilities that would inform contracting, service models is necessary.

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10. COMMISSION FIVE: HEALTH SERVICE PROVISION (DELIVERY)

10.1. Overall Situation Analysis

According to Global Lancet High Quality Commission study conducted in 137 countries with 17 Regions (Sept 2018) – Southern sub-Saharan Africa of which South Africa is part, an estimated 85 709 **(56,3%)** deaths occurred due to poor quality of care and an estimated 66 410 **(43,7%)** deaths occurred due to no access to health care. Thus, the concept of UHC that promotes access to care cannot succeed without providing quality health care. According to the same study, South Africa is commended for implementing the Ideal Clinic as a Quality Improvement initiative[13]. Some of the quality issues in service provision are in the areas of: long waiting times, negative staff attitudes, drug stock-outs, lack of infection control; and lack of safety and security of patients and staff[14].

The High-Level Panel commissioned report on access to quality health care and a recent series of inspections by the NDOH of two hundred hospitals found that the capacity of South African health care services to meet the needs of the citizens is impaired by:

- Variable leadership and management skills across the system
- Failure or inability to act on identified deficiencies
- Unsatisfactory maintenance and repair services
- Poor technology management
- Ineffective supply chain management systems
- Lack of accountability
- Poor disciplinary procedures and corruption
- Staff attitudes and absenteeism

The OHSC also conducted an assessment on the compliance of 696 facilities to health standards. The majority of the 696 facilities that were assessed did not reach accreditation as per OHSC benchmark.

The views of patients and service users are a critical factor in terms of the quality of health services. A new national web-based information system was launched in April 2018 to assess the experience of patients through complaints that are logged by the health care facilities.

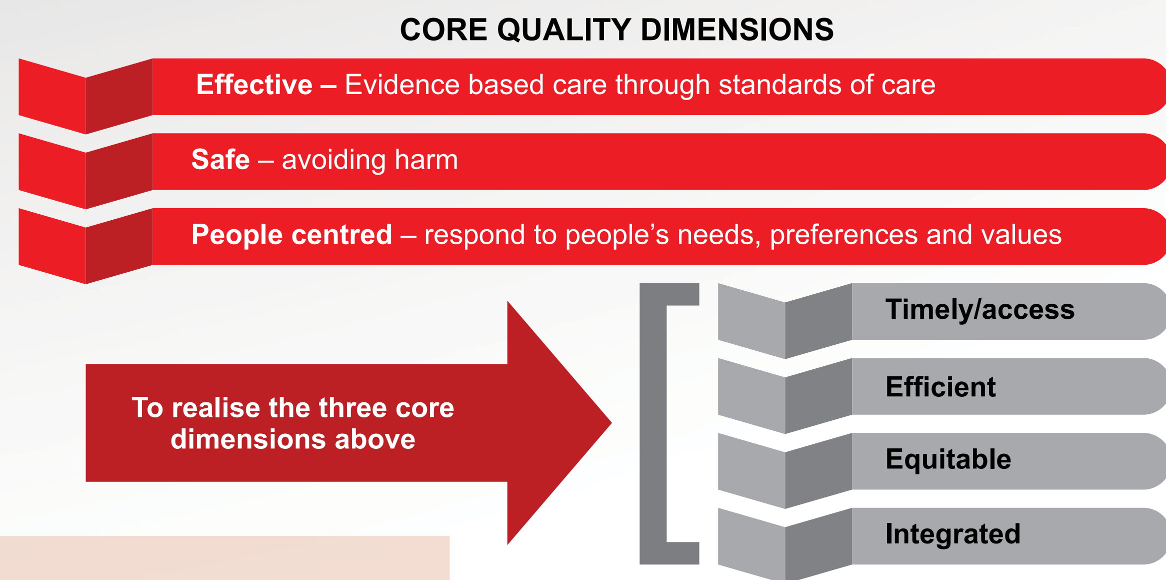
Below diagram illustrates the core quality dimensions of care[15]. Dimensions of health care performance are therefore – those definable, preferably measurable and actionable, attributes of the system that are related to its functioning to maintain, restore or improve health[16]. There are a range of dimensions of care that are assessed. The dimensions are grouped according to the most commonly used:

- ***Effectiveness*** which is the degree of achieving desirable outcomes – given the correct provision of evidence-based health care services to all who could benefit, but not to those who would not benefit (Arah, et al. 2003; WHO, 2000; AHRQ, 2004)

13 Kruk ME, Gage AD, Joseph NT, Danaei G, Garca-Sais S, Salomon JA. Mortality due to low-quality health systems in the universal health coverage era: A systematic analysis of amenable deaths in 137 countries. The Lancet. 2018
14 Office of the Health Ombud Report, 2017
15 Organisation for Economic Co-operation and Development (OECD), World Health Organisation (WHO), United States Institute of Medicine
16 Health Care Quality Indicators Project Conceptual Framework Paper, Edward Kelley and Jeremy Hurst, 2006

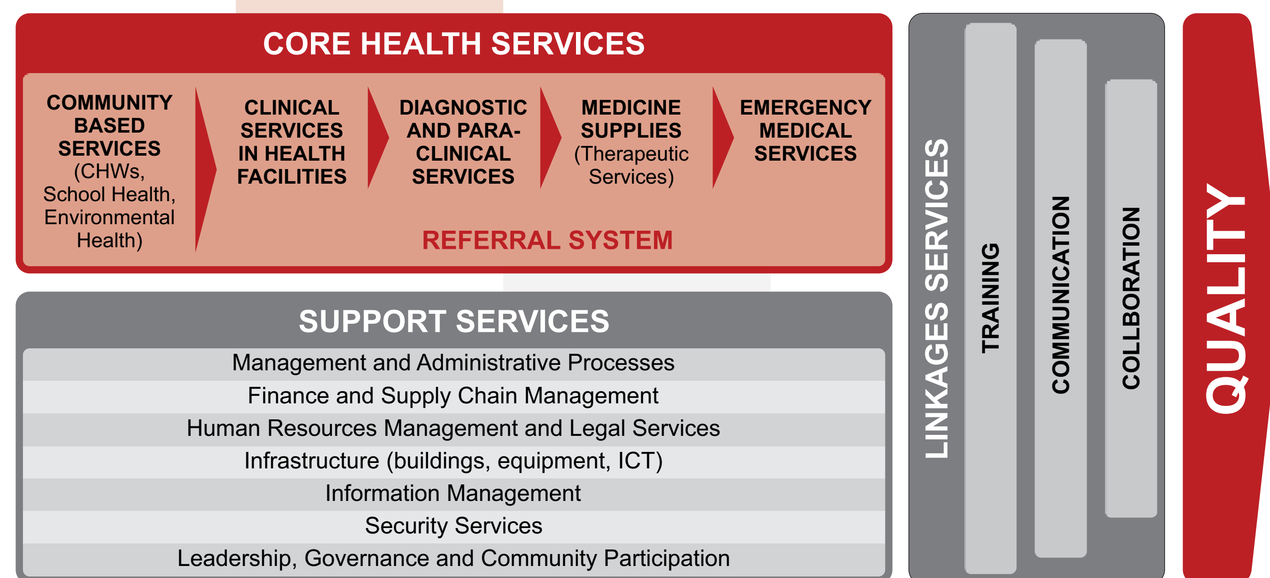
- ***Safety*** means the degree to which health care processes avoid, prevent, and ameliorate adverse outcomes or injuries that stem from the processes of health care itself[17]
- ***Patient centredness*** is the degree to which a system functions by placing the patient/ user at the centre of its delivery of health care and is often assessed in terms of patient's experience of their health care[18]
- To measure health care performance the following dimensions are also crucial: ***accessibility/timeliness, efficiency, equity and integrated health care***.

Figure:7 Health Care Core Quality Dimensions



The diagram below illustrates South Africa's service delivery platform which provides a structure for service delivery. The service delivery model is divided into three key components, that is; core health services (community based services, clinical services, diagnostic services, medicine supplies and emergency medical services); support services (management processes, finance and supply chain management, human resources and legal services, infrastructure, information management, security services and leadership and governance) and linkage services (training, communication and collaboration) – all underpinned by a referral system and provision of quality of health care services.

Figure:8 Service Delivery Model



17 National Patient Safety Foundation, 2000
18 Health Care Quality Indicators Project Conceptual Framework Paper, Edward Kelley and Jeremy Hurst, 2006

10.2. Challenges Identified

10.2.1.Health System Challenges

The infrastructure of health facilities is substandard, ageing with unsafe facilities. Revenue collection is inadequate which adds to the funding constraints in the public sector. Inadequate human resource availability, distribution and allocation – with critical posts unfilled is a major challenge in service delivery. Corruption at all levels and lack of consequences and criminal proceedings is crippling the health system. The political interference in health care operations results in the deployment of incompetent managers for party political reasons. Community members are subjected to enormous abuse by health workers and in turn abuse of health care workers by the public they serve. The health system has a fragmented health information systems and lack of data for planning. Facilities are overcrowded with long waiting times for treatment.

10.2.2. Quality of Health Care

The health system is mainly hospi-centric. Marginalised vulnerable people, elderly and people with disabilities are unable to access services with lack of equal access in rural areas. The de-professionalisation of health care professions e.g. nursing education has caused a considerable strain in the health system. South Africa's health system has lack of focus on promotive and preventative health care.

10.3. Proposed Interventions

10.3.1. Expanding primary health care systems

- Implement coordinated quality improvement plan in all health facilities
- Decentralise health care to households
- Streamline referrals systems
- Increase budget for promotive and preventative health care

10.3.2. Financial Aspects

- Increase investments to a community-based health system
- Containment of malpractice expenditure and consider a separate "No Fault Fund" for this with a focus on the protection of victims.
- Introduce mechanisms for mediation as a first effort settlement in medico-legal cases
- Budgeting for the NHI should consider the impact of migration

10.3.3. Human Resources

- Formalise training and increase appointment of CHWs
- Emphasis on recruitment of health workers delivering rehabilitative services

Immediate Actions

i. Increase human resource capacity through prioritising vacancies at PHC level.
ii. Introduce integrated and streamlined referral systems throughout the health services.

Short-Term Actions

i. Develop a policy that will formalise roles and appointment of Community Health Workers.
ii. Develop a policy that will stop political interference in service delivery and unfunded mandates within all departments and provincial administrations.
iii. Introduce a budgeting system that prioritises promotive and preventive health care.

Medium-Term Actions

i. Increase investments towards a community-based health system.
ii. Shift the focus from curative to promotive and preventive health care through entrenching multidisciplinary health teams.
iii. Consider the impact of migration from neighbouring countries on the South African health system.

10.3.4.Key Outcomes: Health Service Provision Commission

a) Abolishing medical schemes tax rebates and redirecting these funds to the NHI Fund.

b) Budgeting for NHI should consider the impact of migration from neighbouring countries into South Africa.

c) Develop a policy that will stop political interference in service delivery and unfunded mandates within all departments and provincial administrations.

PRESIDENTIAL HEALTH SUMMIT 2018

11. COMMISSION SIX: PUBLIC SECTOR FINANCIAL MANAGEMENT

11.1. Overall Situation Analysis

In South Africa as in many countries – social services depend on funding from a common pool derived from tax revenue. The total national health expenditure is 8.8% of the South African GDP which is below the organisation for economic co-operation and development (OECD) average of 9.3%. In 2016 public sector health budget was R168.4 billion for predominantly uninsured 40 million population. Private sector health estimated annual expenditure is R180 billion for predominantly insured or self-paying 16 million population.

11.1.1.Provincial public-sector health funding

The equitable share and conditional grants are the two main sources of financing for provincial health budgets, with a minor contribution from revenue collection. Expenditure of conditional grants is set against specific conditions determined nationally and is transferred from the National Department of Health to provinces.

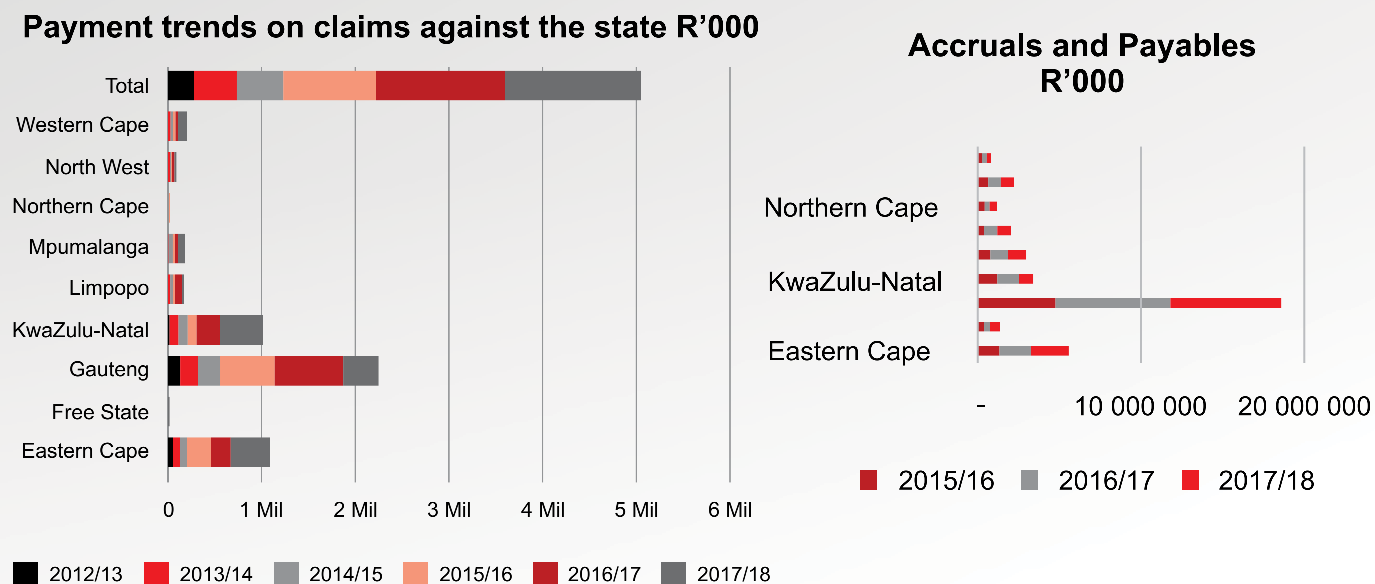
Recently, a ministerial task team was responsible for investigating conditions at hospitals in South Africa. Sample hospitals were assessed in six provinces:

- Limpopo – 2 hospitals
- Eastern Cape – 6 hospitals
- Free State – 4 hospitals
- KwaZulu-Natal – 4 hospitals
- Northern Cape – 5 hospitals
- Mpumalanga – 4 hospitals

Findings revealed that in general there are similar issues affecting hospital performance in all the provinces assessed. The overall financial position of the provincial governments and that of the provincial departments of health has impacted on the ability of hospitals to fulfill their mandate of providing quality health care. Significant budgetary pressures exist with over expenditure and accruals including accruals for personnel expenditure such as overtime and rank promotions. Below is an illustration of selected provincial health departments accruals and payment trends on claims against the state. A view of the medico legal claims for all the provinces for financial year 2014/15 and 2017/18 is also provided.

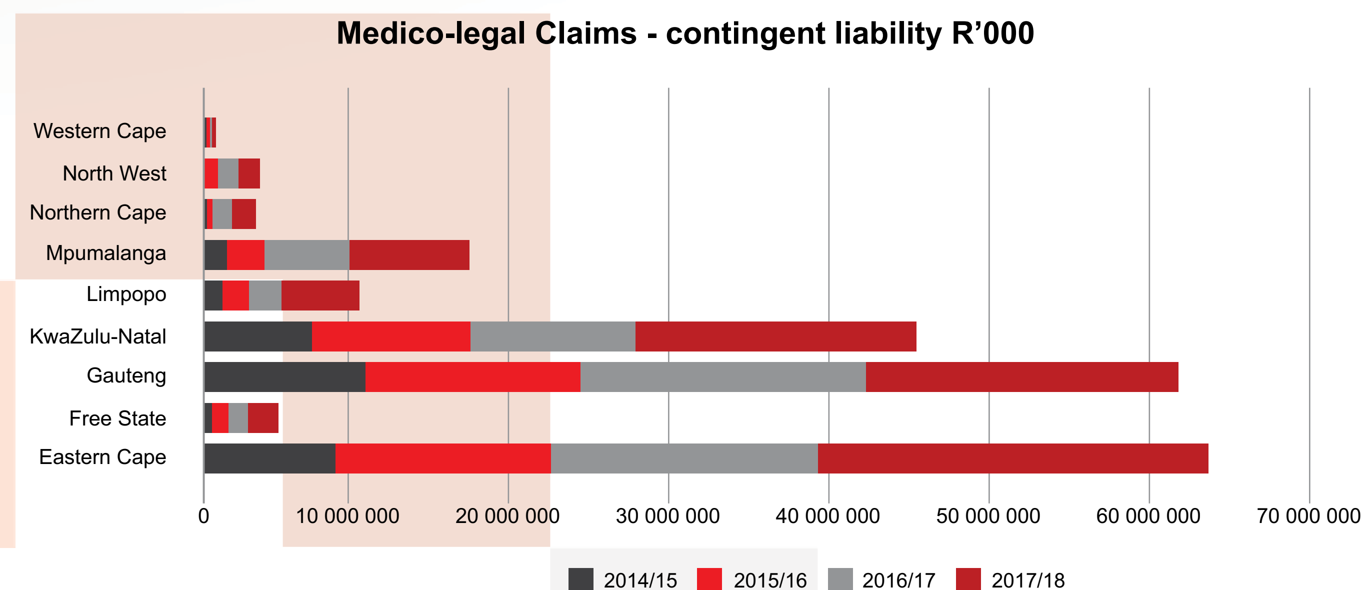
11.1.2. Provincial Health Department Accruals

Figure:9 Accruals and Payment Trends on Claims



11.1.3. Provincial Medico Legal Claims

Figure:10 Medico-Legal Claims



11.2. Challenges Identified

The overall financial position of the provincial governments and that of the provincial departments of health has impacted on the ability of the hospitals to fulfill their mandate of providing quality health care. Significant budgetary pressures exist with over expenditure and accruals including accruals for personnel expenditure such as overtime and rank promotions. The provincial treasuries should be engaged on the baseline allocations (equitable share formula) to the provincial Departments of Health. The priority in terms of health care services particularly given the very high dependency of rural communities on the public health sector should be considered.

11.2.1. Adequate, equitable health allocation

There is no widely accepted formula to determine equitable provincial health allocation leading to significant variations in provincial health allocations, often less than the required funding. There is inequity between public and private sector health expenditures at R4 200 vs R11 250 per capita annually. Over expenditure, unfunded mandates, rising accruals and deteriorating service delivery are amongst other challenges facing the health system.

11.2.2. Provincial health allocation

There is little protection of the health financial allocations as health funds can be reprioritised by provincial treasuries; with provincial health allocation mostly, the discretion of the provincial treasuries and departments.

11.2.3. Delegation and implementation

Financial delegation to facility managers has not been fully implemented resulting in a negative impact on service delivery. Currently there are structural, functional and capacity challenges with lack of norms and standards enforcement mechanisms and support.

11.2.4. Medical malpractice lawsuits

Financial impact of medical malpractice claims against the state on provincial health budgets continues resulting in provincial health departments struggling with their obligation to provide health care services.

11.3. Proposed Interventions

Provincial health departments must reduce accruals and make efforts to understand cost drivers. They must stick to budgets allocated and monitor expenditure against service delivery standards. Provincial health departments must also establish budget and expenditure rules, e.g. maximum cost of equity (COE) share of the allocated budget. Moreover, they must instil accountability and transparency in governance and procurement.

11.3.1. Revise Resource Allocation Processes

- Urgently address accruals – develop a strategy and mechanisms to address these
- Revisit the equitable share formula for health, taking into account the burden of disease, and other relevant issues (e.g. cross border flows)
- Revisit the provincial budget % allocation upwards (currently 27% and should be closer to 38%)
- Stop unfunded mandates from national to provincial and within provincial administrations to health; no new mandate without clear resource allocation plan

11.3.2. Conditional grants

- Limit the role of conditional grants as a core resource allocation mechanism
- There should not be a mechanism to hollow out provincial budgets
- Assess inefficiency and fragmentation created by restrictive conditionalities

11.3.3. Monitor and manage budget allocations (action required at national, provincial, district and facility level)

- Stop political interference (directly or indirectly) in resource allocation
- Ensure appropriate delegations
- Develop benchmarking processes and systems of monitoring
- Build capacity: people and systems in financial management

11.3.4. Value for money

- Prioritise PHC and District Health System (DHS) as the most cost-effective components of a health system
- Accept the need to design a system that is affordable: reconsider the human resource mix of the health system
- Address bloated management structures, focus on staffing service delivery

11.3.5. Revenue collection

- Create incentives for better revenue collection (e.g. retention)
- Develop billing systems (drawing on private sector expertise)
- Revise tariff structure

11.4. Key Outcomes: Public Sector Financial Management Commission

a) Budget allocations to hospitals must be reviewed with a view to relieve the current budgetary pressures where 75% of budgets are spent on salaries leaving very limited funds available for goods and services.

b) Develop a policy that will allow re-negotiation of accruals.

c) Limit the role of conditional grants as a core resource allocation mechanism and it should not be a mechanism to hollow out provincial budgets.

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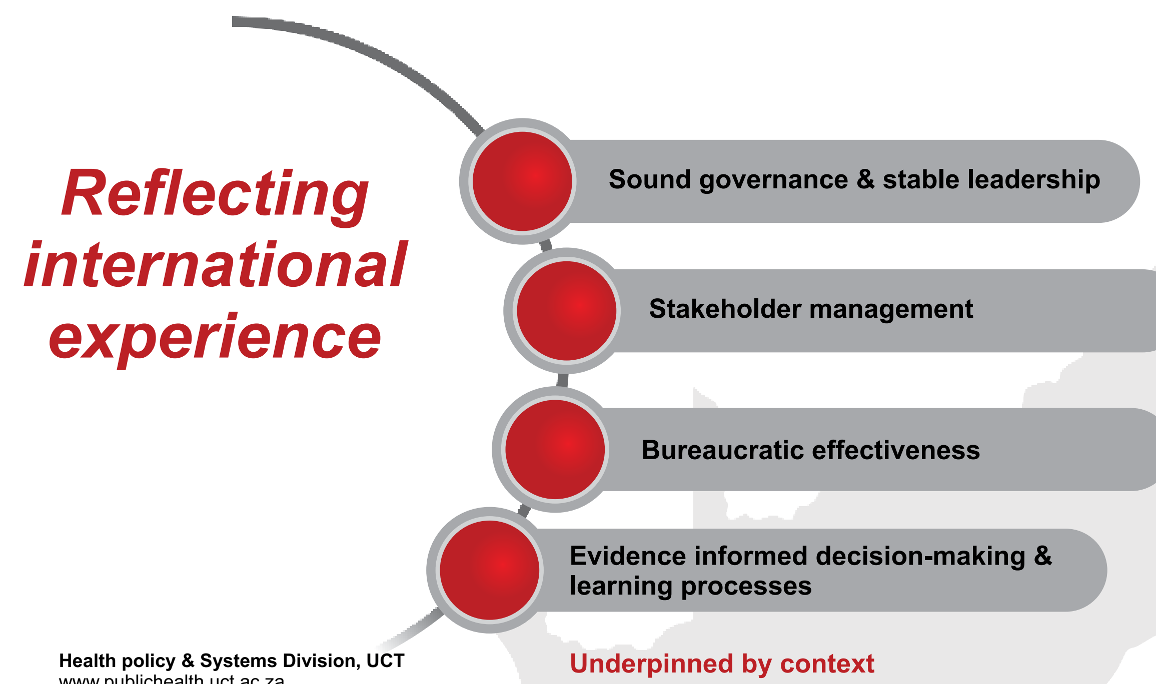
12. COMMISSION SEVEN: LEADERSHIP AND GOVERNANCE

12.1. Overall Situation Analysis

Leadership and governance needs to be approached with a multi-level governance framework where issues of governance are not just sitting within the departments of health alone. It is about the role of the government in health and its relation to other actors whose activities impact on health[19]. This involves overseeing and guiding the whole health system, private as well as public, to protect the public interest. It is important to note that governance is a practice, dependent on arrangements set at political or national level, but which needs to be operationalised by individuals at lower levels in the health system[20].

There are key governance issues for the health system, namely: establishment of frameworks of accountability to regulate power; enabling the responsible governance and exercise of power across the system and maintaining a consistent path. Currently governance is split between health and treasury; political and technical accountability; vertical programmes and service delivery; managers and clinicians/ health workers. Below is the governance framework reflecting international experience. Key components of a leadership and governance framework include: sound governance and a stable leadership; stakeholder management; bureaucratic effectiveness; evidence informed decision making and learning processes – underpinned by context.

Figure:11 Leadership and Governance



19 World Health Organisation, 2007:23
20 Pyone et al, 2017: p.720

12.2. Challenges Identified

Leadership and governance, and accountability which is an intrinsic part of governance, remain an important building block of the health system. In fact, it is a cross-cutting theme that should be assessed across the board. It needs to be approached with a multi-level governance framework where issues of governance are not just sitting within the departments of health alone.

There is poor implementation of governance policies and lack of policy clarity between national, provincial and institutional authority and poorly aligned roles and responsibilities across levels of system. Separation of powers between the role of politicians and administrators is increasingly blurry. There is political interference in management with corruption eroding the ability to deliver heath care. Communities, including youth, are insufficiently involved. Training for clinicians on leadership, ethics and governance and for management on patient-centred care is poor. There is lack of transparency and standards for clinic committees and hospital boards' appointments.

'Probably the most complex challenge in health systems is to nurture persons who can develop the strategic vision, technical knowledge, political skills, and ethical orientation to lead the complex processes of policy formulation and implementation. Without leaders, even the best designed systems will fail[21]' (Frenk 2010: 2).

12.3. Proposed Interventions

12.3.1. Implement policies that are in place

- Start with an analysis of the NDP and existing policies with a view to implementation
- Clarify the ability of the Minister to exercise authority in implementing policy at provincial level
- Streamlining of governance policies within and across the provinces
- Policies to be evidence based and involve all affected parties

12.3.2. Strengthen governance, leadership and management capacity

- Training, education of management in leadership and governance to be strengthened, and cascaded down – starting with undergraduate training
- Utilise existing capability through leadership training e.g. Albertina Sisulu Leadership Academy
- Ensuring that management key performance indicators are patient-centred and part of induction on appointment
- Professionalise the public service employment based on ability and care, not political affiliation and include the youth at all levels as part of succession planning
- Professionalise the management of health care including appropriate financial and human resource skills to ensure good management
- Enhance training of all health professionals with clinical governance, human rights and medical law
- Performance assessment to be based on patient outcomes e.g. waiting times, health outcomes
- Ethical leadership should be a key area of focus

12.3.3. Enhance the role of clinical committees and hospital boards

- Set up a structured and transparent process and criteria to appoint and manage members of clinic committees and hospital boards
- Capacitate the committees and boards and the structures according to standardised guidelines as part of the quality improvement plan
- Ensure involvement of affected people including the youth
- Ensure that committees are sufficiently empowered to act within clear accountability frameworks
- Advisory committees in universal coverage including the NHI should be inclusive of all relevant constituencies
- Ensure inclusive structures that bring in all relevant voices

12.3.4. Address corruption decisively

- Prevent corruption at source with systems in place to do so, and segregation of responsibilities in the supply chain
- Establish anti-corruption forum in the health care system
- Expand Special Investigations Unit (SIU) – anticorruption task team in programme 4, to analyse corruption in vulnerable sectors – detection, reporting, and independent investigations and actions as well as ensuring consequence management at all levels, i.e. – criminal, civil and disciplinary actions, etc. as may be appropriate.
- Harness existing skills and resources, with appropriate and competent oversight
- Act on reports, and ensure consequence and punishment of offenders

12.3.5. Restore values

- Restoring the priority on patient care
- Focus on ethics training and capacitation
- Include leadership and ethics in the curriculum of health care professionals
- Change the culture of institutions to one that is inclusive and patient – centred

12.3.6. Separation of powers within the health care system

- Resolve accountability at national, provincial and institutional level within the current constitutional framework.
- Apply clear separation of powers and ensure clear delegations of authority is in place
- Appoint administrators, from the Director-General down and people in provinces based on capability
- Consider innovative business models
- Resolve and respect the lines of authority and accountability between trade unions and management, while still engaging staff in solutions – bring staff and unions to the table, including service delivery, accountability and ethics.
- Understand and implement collective agreements
- Provide clear systems of support, accountability and authority to operate, ensuring consequences for non-performance
- Empower people from the bottom up

12.3.7. Strengthen Institutions

- Bring in new and fresh thinking
- Appropriate budgeting and capacitation of Institutions
- Ensure office bearers understand their roles, including through induction processes
- Do not ignore training and capacitation of institutions
- Tap into private sector expertise
- Leverage partnerships between Higher Education and Health, and with the private sector
- Strengthen cooperation between departments e.g. public works to build hospitals and clinics

12.3.8. Enhance IT Systems

- Improve systems for aligned performance management, monitoring and measurement
- Single health care patient information system across public and private sector e.g. India registered close to a billion people in 1 year onto a common system

12.3.9. Expand War Room Activity to Address the Immediate Crisis in Health care

- Focus on the crisis interventions required
- Solutions need to recognise the failure in leadership and management that has resulted in the current crisis, focusing on short, medium and long-term interventions
- Inclusive of all groups instrumental to implementation and key stakeholders

21 Health Professionals for a New Century, Frenk, Julio, Lincoln Chen, Zulfiqar A. Bhutta, Jordan Cohen, Nigel Crisp, Timothy Evans, Harvey Fineberg, *et al.*: 2010: 2

- Should not undermine legitimate accountability and processes, but deal with the crisis

Immediate Actions

i. Establish anti-corruption forum in the health care system.

ii. Clarify, differentiate and enhance the role of clinical committees and hospital boards.

iii. Utilise existing capacity from government-supported leadership training programmes e.g. Albertina Sisulu Executive Leadership Programme.

iv. Ensure that the KPI's of management are patient-centred and part of induction on appointment.

Short-Term Actions

i. Resolve accountability at national, provincial and institutional level within the current Constitutional framework.

ii. Review the roles and responsibilities of each sphere of government with clear separation of political versus administrative leadership (politicians must have oversight but not get involved in the administrative execution of policies).

iii. Perform an analysis of the National Development Plan 2030 and other policies to establish progress.

Medium-Term Actions

i. Professionalise the public service ensuring that employment is based on ability and care, not political affiliation.

ii. Include the youth at all levels of leadership and governance as part of succession planning.

iii. Include leadership and ethics in the curriculum of all health professionals.

12.4. Key Outcomes: Leadership and Governance Commission

a) The Minister must have the ability to exercise authority in implementing policy at provincial level.

b) Roles and responsibilities of each sphere of government need to be reviewed with clear separation of political vs administrative leadership.

c) Establish anti-corruption forum in the health care system.

d) Politicians must have oversight but not get involved in the execution of policies.

e) Enhance the role of clinical committees and hospital boards.

f) To improve accountability in leadership and governance, a coherent and aligned network of 'structures' across the health system This must include a legislative framework that underpins the structures and their power to act and hold everyone accountable.

13. COMMISSION EIGHT: COMMUNITY ENGAGEMENT

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13.1. Overall Situation Analysis

According to the Reconstruction and Development Programme (RDP)[22], communities must be encouraged to participate actively in the planning, managing, delivery, monitoring and evaluation of the health services in their areas. The population or community including health service users must be actively engaged in the processes of unifying the health system. CHW are a vital link between communities and health facilities. WHO notes the importance of essential health care based on practical, scientifically sound and socially accepted methods and technology made universally accessible to individuals and families in their community through their full participation. This, at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination[23]. Below are examples of legislations and policies that advocate for community participation as a right.

Figure:12 Community Participation as a Right

Framework for Community Participation as a Right

There has been a steady decrease in organised input from communities through mandated community structures. CHWs form an important point of interconnection and intermediaries between communities and the health sector. The nature of the relationship of the CHWs is with both communities and the health sector which then influences their motivation and performance and affects community relationships with the health sector. Often this relationship is marred with lack of confidentiality and professionalism and distrust between CHW and the community[24].

In the NHI Bill there is a Stakeholder Advisory Committee which comprises of two representatives from health-related NGOs and two representatives from civil society. Below is an illustration of some of the documents developed to enhance community engagement.

22 Reconstruction and Development Program, 1994
23 Primary Health Care: Alma Ata (WHO 1978)
24 Grant, M., Wilford, A., Haskins, L., Phakathi, S., Mntambo, N. and Horwood, C.M., 2017. Trust of community health workers influences the acceptance of community-based maternal and child health services. African journal of primary health care & family medicine, 9(1), pp.1-8.

Figure:13 Current Health System Financing

13.2 Challenges Identified

In facilities, governance structures including boards and committees are not functional and are seen as an extension of political power. There is lack of clarity on accountability of these structures in relation to both health and community systems. The existing provincial consultative forums are non-functional. There is lack of CHW supportive supervision and CHW programme requires further review to consider the following:

- Role clarification
- Absorption by employer
- PERSAL benefits visa-vie access to other benefits e.g. South African Social Security Agency (SASSA) grants
- Clarity on who CHWs are accountable to in the ecosystem
- Accurate report on functionality of Ward Based Outreach Teams (WBOTS)
- Career-pathing for CHWs and recognition of training of CHWs by universities and colleges

13.3 Possible Interventions

- Health facility committees and boards should adopt a social accountability approach through which they hold health officials answerable for meeting mutually agreed upon objectives
- Build an understanding and strengthen the capacity of health sector personnel on how to work with community participation structures and CHWs
- Civil society groups in oversight structures such as parliamentary committees, hospital boards and clinic committees must represent citizens' voices and need to function optimally
- Inclusion of community structures in the budget planning cycle and monitoring of spending reports
- Strengthen and invest in community health systems
- Health starts at home, schools and community; thus education, empowerment and ownership of one's health is key
- Leave no one behind: equality, equity and justice are key for Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI), Sex Workers, People with Disability amongst others

Immediate Actions

i. Review the concept of community participation in health to clarify roles and responsibilities.

ii. Revisit the definition of community/communities involved in community health.

Short-term Actions

i. Inclusion of community structures in the budget planning cycle and monitoring of budget spending reports.

ii. Implement education about the NHI through direct engagement with communities.

iii. Develop a national database of CHW.

Medium-Term Actions

i. Review health services in the context of social determinants.

ii. Review government and academic involvement in community health.

iii. Address funding of community health programmes.

13.4 Key Outcomes: Community Engagement Commission

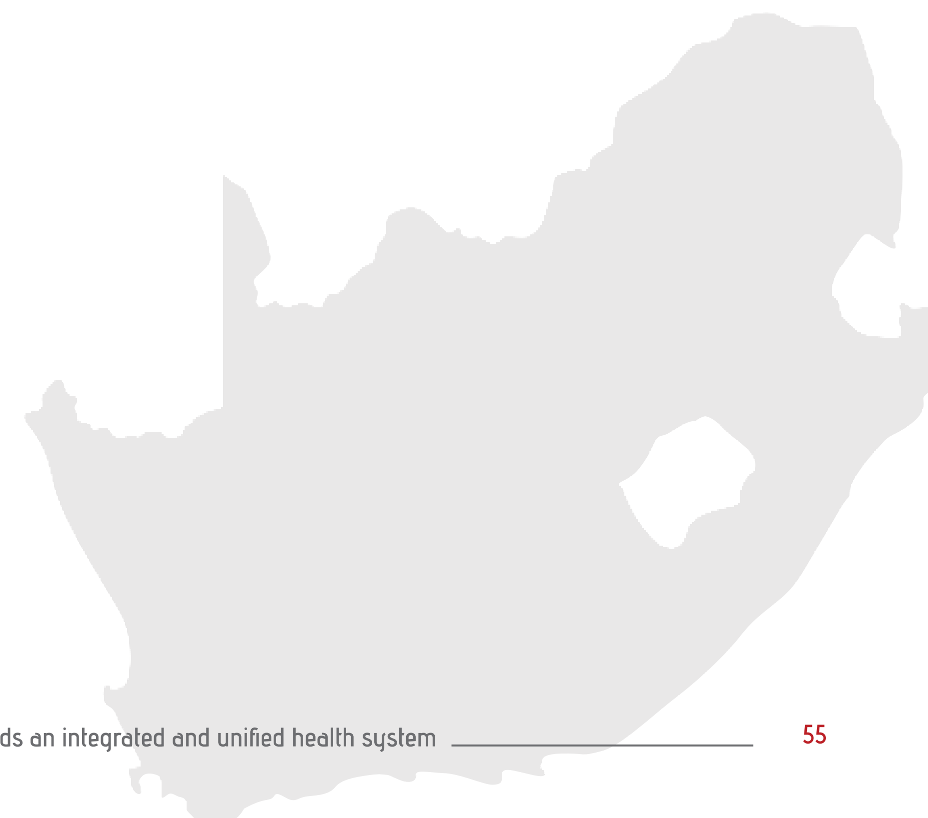
a) Enhance accountability at different levels, i.e. political, professional and societal level.

b) CHWs scope of work, remuneration and roles and responsibility should be deliberated and formal qualifications developed.

c) Health beyond health sector – implement the multi-sector approach including Health Users, Civil Society, Religious and Traditional Leaders, LGBTI, Sex Workers, People with Disability amongst others.

d) Consider socioeconomic and structural drivers in the preventative and curative response.

e) Fast-track the education, engagement and implementation in communities of essential healthcare services.



14. COMMISSION NINE: INFORMATION SYSTEMS

14.1. Overall Situation Analysis

The current health information systems within the public health sector and between the public and private health sectors is fragmented and poses a major challenge to effective stewardship of the health system. Information systems require appropriate governance frameworks to ensure that information is protected and managed.

Promotion of data and information utilisation in management and rational decision making is key for NHI. IT systems should include development of monitoring and evaluation tools to indicate implementation progress in relevant areas according to annual performance plans. The coding systems for medical information are currently not standardised.

Efforts should be on how to utilise existing IT infrastructure despite challenges for maximum benefit. This will ensure promotion and assurance of accurate recording of the data stored within government systems for meaningful synthesis and analysis.

14.2. Challenges Identified

Health information systems are fragmentated with no integrated electronic health record. There are currently 42 health information systems, however one platform is required whereby information can be exchanged between the disparate systems. To achieve this it is important that interoperability standards be developed and adhered to. eHealth concepts are not contextualised with health outcome with poor compliance to the health normative standards framework (HNSF) by existing systems in the country.

Budget allocation are insufficient with lack of prioritisation of eHealth and health information systems. Progress in information systems is still plagued by inadequate connectivity at most facilities particularly at primary health care level; high costs of broadband connectivity and network infrastructure; as well as cybersecurity issues.

14.3. Proposed Interventions

14.3.1. Infrastructure

- Connectivity and reliable bandwidth at a reasonable cost for the health care system
- Explore the bandwidth of the health systems network
- Leapfrog connectivity and health information system – to match countries like Kenya, Rwanda, etc.
- IT connectivity grant and investment in the IT infrastructure is required to rationalise with National Treasury and Department of Telecommunications and Postal Services (DTPS) efforts
- Improve basic infrastructure (computers, mobile devices, internet connectivity, databases to store data, components of cybersecurity) and consider return on investment (ROI)
- Return on investment includes creation of jobs (i.e. increase in economic growth), improvement in health through improved monitoring, early detection of diseases, reduction in litigation and improved access to better education as education facilities can use same infrastructure that is used by health
- Connectivity at all facilities is a must to ensure technology is utilised, especially in remote health facilities
- A data center that pulls data from different systems and levels of care plus a health observatory including registries to be created with a standardised e-health enterprise architecture and increasing digitisation to improve productivity and effectiveness

- Hold service providers like State Information Technology Agency (SITA) accountable

14.3.2. Strategic Interventions

- NDP, NHI green and white paper, national e-health strategy – all demonstrate support for use of technology and health information systems, thus, investments should follow strategies
- Use of technologies alone will not resolve South Africa's problems. Technology must be accompanied by robust change management processes
- Communities, clinicians and health workers (end users) must be engaged in the design and development of the health information system and the use of the IT
- Stop vendor driven system becoming policy e.g. SVS, Rx Solution etc.
- Ministerial task team on information systems to explore long term view of health information systems in South Africa
- Use of existing private sector business (banks, Clicks etc.) platforms such as biometric systems to capture patient data and save costs

14.3.3. Workforce

- A pre-requisite for NHI is a dynamic and innovative cadre of health informaticians and e-health technicians to sustain health information systems
- Create a workforce that is responsive to the health information system
- Define areas for up-skilling of the current health workforce in the health information systems
- Explore ways through which graduates from universities can be brought on board to help support development of the health information system

14.3.4. Information Access and Use

- Explore open access to information to the public
- Privacy and security measures must be enhanced
- Implement health observatories with analysed data and research outputs that can be put on a public platform for improved accountability
- Human resources and supply chain systems data to be cleaned up and effectively used
- Leverage existing skills across other government agencies (e.g. Statistics South Africa field workers and CHW's)

14.3.5. Leadership and Governance

- Establish a platform for continued dialogue with stakeholders on e-health
- Ministerial advisory committee to continue with the revision of the e-health strategy to promote a unified HIS for both the private and public sector

14.3.6. Services and Applications

- Electronic Health Record is a building block of the health information system in the era of NHI
- Shift from aggregated data to patient level clinical information shared by patients and health care providers
- Standardisation of systems using the normative framework for interoperability
- Health Information Systems should focus on structural processes, health outcomes and use of information for evidence-based decision making
- Digital health care for the population, an opportunity that must not be missed (through use of health observatories) with patients being custodians of the health record
- Investments to follow strategy on health information and management information system
- Health departments to focus on its core business and training – connectivity to be managed by the respective departments outside health. State Information Technology Agency should be able to guide the process
- A platform for e-health dialogue to be established to continue with the conversation as part of governance
- Unique identifiers using national ID as a verifier and biometry/linking with home-affairs
- Explore ways through which patients without identification will be addressed
- M&E systems to demonstrate return on investments

14.4. Key Outcomes: Information Systems Commission

a) Develop fit for purpose policy and stop vendor driven policy systems.

b) Review policies in relation to engaging State Information Technology Agency (SITA) to fast track NHI implementation.

c) Ministerial task team on information systems to explore long term view of health information systems in South Africa.

d) Standardise systems using the health standards normative framework (for interoperability and develop a policy to decisively deal with the 42 systems currently in use in the health system across the country.

e) Establish patient unique identifiers using national ID's as a verifier and link these with the Department of Home Affairs.

f) IT connectivity grant and investment in the IT infrastructure is required urgently.

g) Directors-General should not be political appointments and should be stable regardless of changes in administration.

15. CONCLUSION

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A foundation for an equitable and UHC requires capacitating the public health sector to deliver on its mandate by drawing on the best available local and international expertise. "Moving towards UHC" means a progressive realisation on one or some or all the following: 1) Reducing the gap between need and use (equity in use); 2) Improving quality of health care services; 3) Improving financial protection.

While there have been significant achievements in several areas of the health system, some areas remain unattended to, leading to a characterisation of the health system as being in a crisis. These challenges relate to both the private and public sectors.

The *Presidential Health Summit* successfully met its intended objectives to advance collective efforts to promote good health care services as an essential foundation to health for all in South Africa. This was achieved through a robust engagement with many key stakeholders from different sectors – business, labour, civil society, government, private sector, health professionals, labour unions, health service users and academia on action items and proposed interventions on how to promote good health care services. Contributions to a road map with identified actions to strengthen co-ordination, monitoring and evaluation of the health system was outlined as the basis in committing to rebuild the health system to provide quality health care to all.

The methodology used at the summit – establishing commissions on 1) Human Resources for Health (Health Workforce); 2) Supply Chain Management, Medical Products, Equipment and Machinery; 3) Public Financial Management; 4) Infrastructure Planning; 5) Private Sector Engagement; 6) Health Service Provision (Delivery); 7) Leadership and Governance; 8) Community Engagement and 9) Information Systems to engage all stakeholders yielded the intended outcomes. Commissions identified specific action solutions that could address the health system challenges by providing immediate, short term and medium-term solutions. Commissions also began to identify key building blocks of the road map towards universal health coverage from the identified action solutions.

Delegates worked towards solutions to strengthen the health system to ensure that it provides access to quality health services for all in line with the principles of universal health coverage through an inclusive process. There was unanimous support for NHI, and for the principles of universal quality health care, social solidarity and equity in health access and a call for implementation. The principle of ***"One Country - One Health System"*** for South Africa was adopted. Under the stewardship of the President there is renewed energy and commitment to improve the health system to ensure that South Africans receive quality health care.

Government must prioritise the filling of critical vacant posts to stabilise shortages in key areas of the health system urgently. Provinces will be expected to prioritise their financial resource allocations in a manner that will ensure that the delivery of quality health care is not compromised. The summit highlighted the need to develop a sustainable financing model and National Treasury will be tasked to ensure that this is finalised soon. The objective with the NHI, is to embed the principle that health care services will be based on clinical need and not ability to pay and these services will be free at the point of entry.

All speakers acknowledged the importance of collaboration amongst stakeholders, most notably between private and public sector in addressing challenges facing the health system. They emphasised the critical role the private sector need to play in improving the health system. A combined strength between these two sectors and all stakeholders will be used to galvanise action for real change. They all spoke in unison in emphasising the importance of universal health coverage and pointing out that UHC is not negotiable and supported the position that NHI is a means to get there.

Accountability and transparency in implementing NHI interventions was over emphasised. This must include a plan to have consistent and comprehensive communication in ongoing engagements and to report regularly to the nation on the progress made to improve the quality of the health system.

16. WAY FORWARD

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The outcomes of the Presidential Summit will be communicated widely through all types of media, including social media.

Practical steps were identified to operationalise the outcomes of the summit namely:

a) To identify the representatives of the sectors to develop a *Presidential Health Summit* compact based on the outcomes presented at the Summit – to commit to work together to implement identified solutions. The initial sectors identified are: government, civil society, labour, health services users, business, private providers, funders, academia, health professionals and allied health workers.

b) Representatives to consult their key constituencies on the interventions to be implemented and craft a plan including clear objectives, methods, timelines, milestones and indicators as well as financial resources to address the interventions. This is to be undertaken and concluded by the 1st week of December for each stakeholder group.

c) In preparation for this submission, sectors to meet at the end of November – date to be finalised and communicated, to consolidate all the plans into a social compact.

d) The Presidency to convene the Stakeholders by December 10, 2018 – the date to publicly sign the Presidential Health Compact will be communicated.

The Presidency will have oversight and stewardship leading implementing government departments, namely: Health, National Treasury, Cooperative Governance and Traditional Affairs (COGTA), Public Services and Administration, Public Works, Home Affairs and Science and Technology.