

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



PRESIDENTIAL
HEALTH
SUMMIT
2018

COMPACT



REPUBLIC OF SOUTH AFRICA





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Suggested citation "South African Government: Strengthening the South African health system towards an integrated and unified health system, Presidential Health Summit Compact, 25 July 2019





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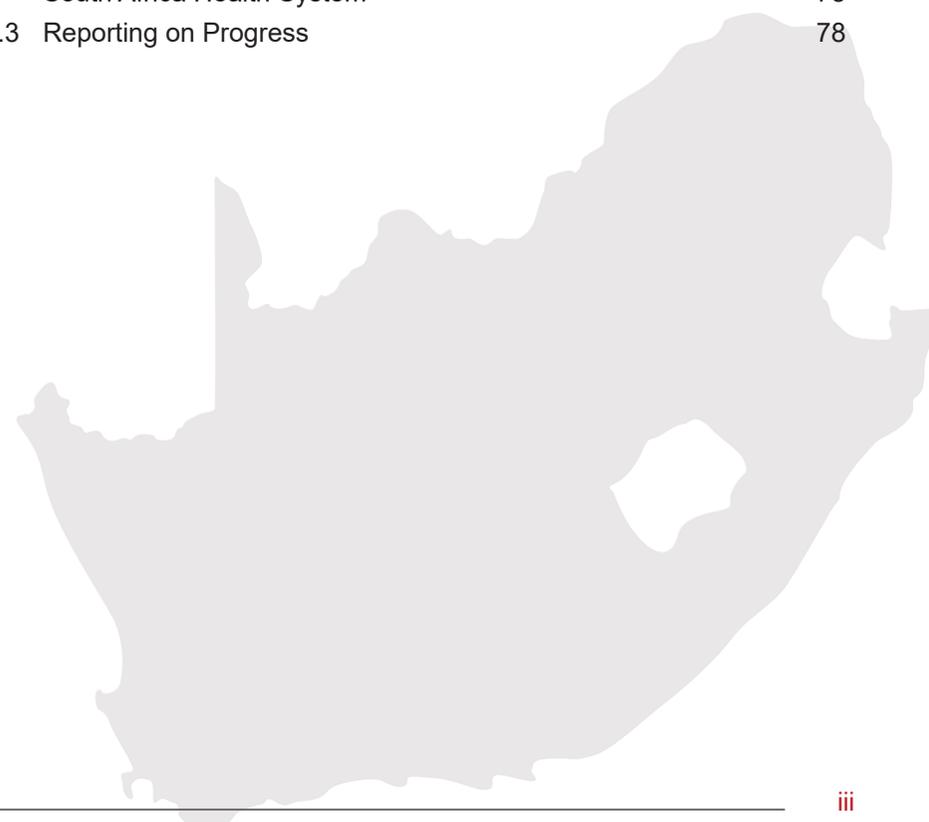


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MESSAGE FROM THE PRESIDENT

PRESIDENTIAL HEALTH SUMMIT COMPACT

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

From ending apartheid rule to opening new vistas of opportunity for South Africans and reintegrating our country into the international community, South Africa’s progress has consistently centered on our ability to build consensus and establish compacts that draw on the viewpoints, expertise and contributions of diverse partners.

Currently, the vision of growing South Africa together is taking shape once more in the vital area of health where Section of 27 of our Constitution affirms the right of all for all people to have access to health care services, including reproductive health care, sufficient food and water, and social security including appropriate social assistance.

To give effect to this right, government and social partners have engaged intensively and collaboratively in a national effort to create one health system and introduce universal health coverage in the form of National Health Insurance (NHI). For NHI to be successful, it has to be implemented simultaneously with a quality improvement programme.

This engagement has been collaborative based on the understanding of government and civil society and private sector alike that none of our constitutionally enshrined rights can be realised without the meaningful participation of society in all its formations.

It was in light of this imperative that we convened the Presidential Health Summit in October 2018 to diagnose and propose solutions to end the identified crises in the health system that are hampering our progress towards creating a unified,

people-centered and responsive health system that leaves no one behind. We drew great encouragement and strength from the high level of participation in the Summit, both in terms of the number of delegates and the quality of their input. The thought leadership and practical proposals generated by the Summit informed the comprehensive Summit report titled “Strengthening the South African health system towards an integrated and unified health system”.

Following the Summit and the publication of the report, social partners turned their energy and attention to the development of the Presidential Health Compact which follows in this document.

Representatives of stakeholders comprising government, health and allied health professionals, labour, business, community, academics and researchers, statutory councils, traditional health practitioners, and public health entities have spent recent months in intensive consultation with their constituencies.

This Presidential Health Compact is an agreement consented to by government and key stakeholders whose work impacts on the health system. The Compact places the accountability on stakeholders to meet the commitments made within the allocated timeframe. The parties to this document are committed to implementing this Compact, the results of which should be visible to all in the country.

The Compact encourages all signatories to play their part in ending the crisis in the health system.

Primary focus areas in health improvement are:

- (a) the urgent need to augment and better distribute human resources for health,
- (b) improving supply chain management to improve access to essential medicines, equipment and supplies;
- (c) executing the health infrastructure plan;
- (d) engaging the private sector;
- (e) involving the community;
- (f) improving the health system in terms of quality, safety and quantity;
- (g) increasing efficiency in financial management;
- (i) developing national health information systems to guide policies, strategies and investment, and
- (j) strengthening governance and leadership to ensure accountability.

These interventions are coupled with detailed action plans that spell out the actions to be taken, outcomes/results, accountable partners, critical success factors and time frame to complete the action items.

This Compact fulfils the call issued in the 2018 State of the Nation Address for South Africans to seize this moment of hope and renewal and to work together to ensure that it makes a meaningful difference in the lives of our people.

We committed ourselves to initiate measures to set the country on a new path of growth, employment and transformation. We pledged to meet these commitments by getting social partners in our country to collaborate in building a social compact on which we will create drivers of economic recovery.

With this Compact, government and stakeholders have undertaken to collaborate towards establishing a unified, integrated and responsive health system. As social partners, we pledge to work towards “one country, one health system”.

This will create a universal health system that applies uniform standards throughout the system and that serves the whole population and embraces accountability, transparency and the importance of communication in the implementation of this Compact.

I sincerely appreciate the contribution of those who served on the Steering Committee to prepare this Compact, as well as those who worked in various task teams. I also appreciate the support of the World Health Organisation for providing technical support, editing and printing the Compact.

We are indeed growing a healthier South Africa together.



Matamela Cyril Ramaphosa
President of The Republic of South Africa



FOREWORD FROM THE MINISTER OF HEALTH

As a new Minister of Health, I came at the end of the process of finalising the drafting of the Presidential Health Compact, driven by the Presidency. I immediately familiarised myself with the Compact and found it to be a critical document to help to guide the 6th Democratic Administration as we begin to improve the quality of the health system.

Upon my arrival, one of the first tasks I had was to engage the Department of Health to determine their level of involvement in the crafting of the Presidential Health Summit Compact. I was pleased that they participated in the plan and are beginning to integrate the Compact in their work. The Department of Health will work collaboratively with the other sectors to achieve the targets in the Compact. We hope that this approach would herald the beginning of a new era in our response to challenges in the health system.

I appreciate the contribution made by all these Government Departments and the stakeholders who have committed themselves to improve the quality of the health system. No health system can be significantly enhanced without a deep involvement of other sectors and key stakeholders. Health, unlike other sectors, is one that each one of us will use at some point or another. When we do, we want to find it welcoming. I find the delivery approach proposed in the Compact to be compatible with the new 6th Democratic Administration which requires that we work with various stakeholders to “khawuleza” (quicken our pace in implementation) in our effort to respond to the call for “Thuma Mina” to end the crisis in the health sector.

If we all work together and bring our synergies to change the health system, the entire population of South Africa will benefit from the quality of the health services to arise from the implementation of this Compact.

As we move to implement National Health Insurance (NHI), we need a fully functional quality health system. This Compact, coupled with the National Quality Improvement Plan and the NHI Implementation Office, will take us very far in our effort to make quality health care a reality for all South Africans.

As we monitor and evaluate the implementation of this Compact and find that there are newer even more urgent tasks to implement, we expect those interested in improving the health system to come forward and be counted amongst those who want to create a health system we want.

I look forward to working with you in our effort to collectively improve the country's health system on our journey to Universal Health Coverage through our domestic programme of National Health Insurance.

Dr Zwelini Mkhize
Minister of Health



SECURITY
DEPARTMENT

Emergency
Department



ACKNOWLEDGEMENTS

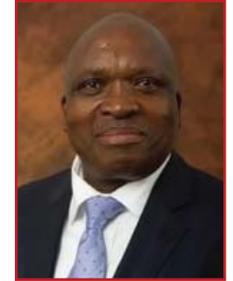
On behalf of the team from the Presidency we would like to express our sincerest appreciation to the Steering Committee who provided valuable and constructive contributions during the planning and development of the Presidential Health Summit Compact. The energy and determination to reach consensus among the diverse group of stakeholders was remarkable. They all enthusiastically gave time so generously without any remuneration, all because they loved our country enough to contribute to ending the crisis in the health system. We truly appreciate their selfless contribution, which has produced a solid plan of action for the next five years. Post signing of this compact, they have committed themselves and their constituencies to play respective part in the implementation of this Compact and the accompanying action plan, which is published on the website www.presidency.gov.za.



We appreciate the support of the *former Minister of Health, Dr Aaron Motsoaledi* for ensuring that the input from the National and Provincial Health Department is prepared for submission to the Steering Committee of the Presidential Health Summit.



We thank the *Minister of Health, Dr Zwelini Mkhize* and his *Deputy Dr Joe Phaahla* for their support in finalizing this Compact and for their readiness to prepare their programme of action going forward. The energy they bring to this process suggests that we will see a rapid improvement in the quality of the health system.



The Presidency stands ready to support them from the Presidential War Room on National Health Insurance and Health Systems Quality Improvement.



We sincerely thank **Ms Precious Matsoso, Director General of Health** for working closely with the heads of provincial departments to prepare the input of the Department of Health.

The contribution of the members of the Steering Committee who convened their constituencies and patiently engaged them in the process of seeking input and consensus on the Presidential Health Summit Compact is listed below:



Ms Lebogang Mulaisi, *Congress of South African Trade Unions (COSATU)*, who on behalf of Organised labour, led a group of 12 labour organisations as they sought ways to contribute to the compact. She brought her National Economic Development and Labour Council (NEDLAC) skills to the process of developing the compact, which facilitated the drafting of the compact. She also led the task team that prepared Pillar 1: Augment Human Resources for Health.



Dr Anban Pillay, *Deputy Director General*, coordinated the input from 16 government Departments, including the National Department of Health and provinces. He also led the team that developed Pillar 2: Ensure improved access to essential medicines, vaccines and medical products through better management of supply chains, equipment and machinery.



Ms Tanya Cohen, then *Chief Executive Officer (CEO) of Business Unity South Africa (BUSA)*, who organised the Business sector comprising 48 organisations to commit to contribute to improving the health system and was the task team leader who coordinated the development of Pillar 4: Engage the private sector in improving the access, coverage and quality of health services.



Dr Angelique Coetzee, *South African medical Association (SAMA) Chairperson*, who organized a diverse group of 76 health professional organisations across the length and breadth of this country and engaged them to contribute to the development of the compact. She also led the task team that developed Pillar 5: Improve the quality, safety and quantity of health services provided with a focus on primary health care.



Dr Fared Abdullah, *Medical Research Council*, who coordinated the input of the public Health Entities and also led the task team that developed Pillar 6: Improve the efficiency of public sector financial management systems and processes.



Dr Kgosi Letlape, *President of the Health Professions Council of South Africa (HPSCA)*, Deputy Chairperson of the Steering Committee, led a team of 6 Statutory Health Councils in the development of the compact. He also led a team that developed Pillar 7: Strengthen the governance and leadership to improve oversight, accountability and health system performance at all levels



Dr Sipho Kabane, *CEO of Council of Medical Schemes*, led the task team that developed Pillar 9: Develop an information system that will guide the health system policies, strategies and investments



Mr Mabalane Mfundisi, *South African National AIDS Council (SANAC) Civil Society Forum: Sport, Arts & Culture Sector Chairperson, Co-Chairperson of Resource Mobilization Committee & Civil Society Convener of NHI & UHC* organised 14 civil society organisations. He also led the task team that developed Pillar 8: Engage and empower the community to ensure adequate and appropriate community-based care.



Dr Fazel Randera, *Progressive Health Forum*, whose organisation was key to a decision by the President to convene the Presidential Health Summit. He contributed to the discussion and all aspects of the compact.



Ms Lauren Pretorius, *CEO, Campaigning for Cancer*, who organised 118 health service user groups who were involved in the overall preparation of the Presidential Health Summit Compact ensuring that the compact is sensitive to the needs of users. She also contributed with her editorial skills.



Professor Martin Veller, *Dean of the Faculty of Health Sciences at the University of the Witwatersrand*, who organised the academic sector and specifically the South African committees of medical, health sciences and dental deans and ensured they contributed to the development of the plan. His editorial skills came in very handy towards the end of the process.



Mr Solly Nduku, *General Secretary, National Unitary Professional Association for African Traditional Health Practitioners of South Africa (NUPAATHPSA)*, brought together Traditional Health Practitioners together with 11 Professions that fall under the Allied Health Professionals Council to contribute to various pillars of the Compact.



Dr Mpho Pooe, *Captain, Military Hospital*, a member of the Steering Committee, representing the SAMA Trade Union (SAMATU) and contributed their input into labour.



Mr Kwena, Manamela, *Deputy General Secretary, Democratic Nursing Organisation of South Africa (DENOSA)* who coordinated inputs from the largest nursing union in South Africa, into labour.



Dr Nicholas Crisp, *Independent Public Health Specialist*, who coordinated the infrastructure team Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities.



Ms Gladina Loots, *Director, Health Innovation, Department of Science and Technology*, who coordinated input from the 5 science councils and the Department of Science and Technology.



Professor John E. Ataguba, *University of Cape Town* who has contributed to the overall development of the compact. He played a critical role in mobilising the academic sector to support the development of the Presidential Summit input, which in turn contributed to the compact.



Dr Rajesh Narwal, *Health Systems Advisor, World Health Organisation (WHO)*, who provided technical assistance to the development of the compact and facilitated the civil society, allied health and other constituencies. The support of the World Health Organisation to the Presidency is deeply appreciated. The WHO was always willing to support the Presidency, even at short notice.

We are grateful for the Secretariat Support provided by:



Dr Aquina Thulare, *National Department of Health* for providing secretarial support and assisting the chairperson to combine the inputs, review and ensure policy coherence across all submissions.



Ms Nondumiso Khumalo, *Council for Medical Schemes (CMS)*, for supporting the chairperson to collate all the inputs, drafting the compact and verify the action plans against the compact.



Ms Amu Chauke, *The Presidency*, who organised meetings and ensured that the logistics for the meeting were in accordance with the plan

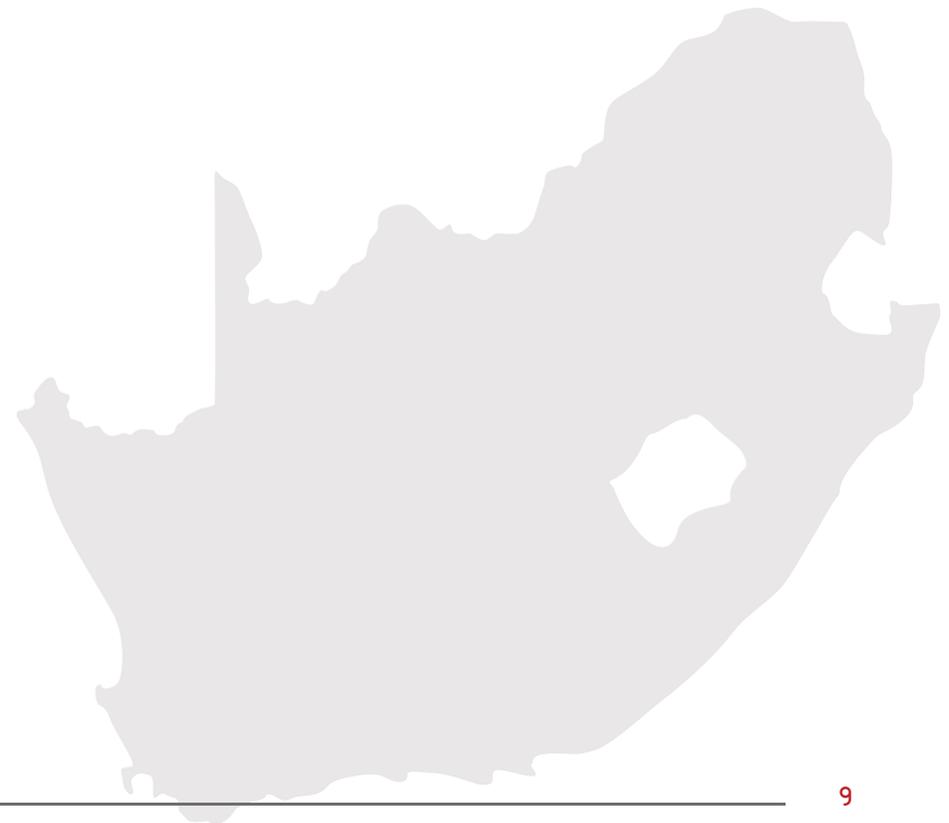


Dr Olive Shisana, *Hon Professor, University of Cape Town (UCT)*, Special Advisor to the President of South Africa served as Chairperson of the Steering Committee and later towards the end supported by the Deputy Chairperson, Dr Kgosi Letlape.

I have been privileged to serve as chairperson of the Steering Committee during the Presidential Health Summit and the period when the Compact was developed. We learned a lot from the experience of many skilled persons in the government departments and stakeholders. Above all, we thank our President, the champion who requested the development of the social compact, that motivated all of us to put together this Presidential Health Summit Compact. In the spirit of “Thuma Mina”, we sincerely hope that we will “Khawuleza” and make a real difference to all those who seek health care in the South African health system.

Dr Olive Shisana, Hon Professor (UCT)

Chairperson of the Steering Committee on the Presidential Health Summit





DEPARTMENT
OF
HEALTH



WORLD DIABETES DAY

DEFEATING
IN OUR
DIABETES
LIFE TIME.





GLOSSARY

ADR	Alternative Dispute Resolution	DHET	Department of Higher Education and Training
ADs	Assistive Devices	DPME	Department of Planning, Monitoring and Evaluation
AIDS	Acquired Immunodeficiency Syndrome	EML	Essential Medicines List
API	Active Pharmaceutical Ingredients	FBOs	Faith Based Organisations
ARVs	Antiretroviral	FY	Financial Year
BBBEE	Broad-Based Black Economic Empowerment	GDP	Gross Domestic Product
BUSA	Business Unity South Africa	GPs	General Practitioners
CBOs	Community Based Organisations	GIAMA	Government Immovable Asset Management Act
CCOD	Compensation Commissioner for Occupational Diseases	GDP	Gross Domestic Product
CCMDD	Central Chronic Medicine Dispensing and Distribution	HASA	Hospital Association of South Africa
CHWs	Community Health Workers	HCP	Health Care Professionals
CHC	Community Health Centres	HRH	Human Resources for Health
CMS	Council for Medical Schemes	HRIS	Human Resource Information Systems
COPC	Community Oriented Primary Health Care	HQA	Health Quality Assessment
CPD	Continuing Professional Development	HPRS	Health Patient Registration System
CSIR	Council of Scientific and Industrial Research	HR	Human Resources
CSI	Corporate Social Investment	HIV	Human Immunodeficiency Virus
DBSA	Development Bank of Southern Africa	HTA	Health Technology assessment
DBE	Department of Basic Education	IDEAS	International Development Evaluation Association
DCT	Decentralised Community Training	IDMS	Infrastructure Delivery Management System
D&R	Disability & Rehabilitation	IEC	Information Education and Communication
DSP	Designated Service Provider Networks	IEG	Independent Evaluation Group
DSD	Department of Social Development	IUSS	Infrastructure Unit Support Systems
DoH	Department of Health	IVDs	In-vitro Diagnostic Device

IT	Information Technology	PPIs	Public Private Investments
KZN	KwaZulu Natal	PWD	People with Disabilities
MGEP	Medical Genetics Education Programme	RDP	Reconstruction and Development Program
MMDS	Medicine Master Data System	RWOPS	Remuneration of Work Outside Public Sector
MTEF	Medium Term Expenditure Framework	SAQA	South African Qualifications Authority
MOU	Memorandum of Understanding	SAMA	South African Medical Association
M&E	Monitoring and Evaluation	SASA	South African Social security Agency
NCDs	Non-Communicable Diseases	SAHPRA	South African Health Products Regulatory Authority
NDP	National Development Plan	SAMRC	South African Medical Research Council
NGOs	Non-Governmental Organizations	SDG	Sustainable Development Goals
NHS	National Health Service	SETA	Sector Education and Training Authority
NHLS	National Health Laboratory Services	SIPDM	Standard for Infrastructure Procurement and Delivery Management
NHI	National Health Insurance	SLA	Service Level Agreements
OHSC	Office of Health Standards Compliance	TB	Tuberculosis
OOP	Out of Pocket Payments	UHC	Universal Health Coverage
OT	Occupational Therapy	UNEG	United Nations Evaluation Group
PCDT	Primary Care Drug Therapy	WBOTs	Ward Based Outreach Teams
PDOH	Provincial Departments of Health	WHO	World Health Organisation
PES	Provincial equitable Share		
PERSAL	Personnel and Salary System		
PFMA	Public Finance Management Act		
PHC	Primary Health Care		
PHISC	Private Healthcare Information Standards Committee		
PMB	Prescribed Minimum Benefits		
PM	Precision Management		
POC	Point of Care		
PPPs	Public Private Partnerships		



LIST OF ORGANISATIONS THAT CONTRIBUTED TO THE PRESIDENTIAL HEALTH COMPACT

LIST OF HEALTH PROFESSIONAL ORGANIZATIONS

1. Association of Surgeons of South Africa
2. South African Association of Paediatric Surgeons
3. Vascular Association of South Africa
4. Association for Dietetics in South Africa
5. Association for Dieticians in South Africa
6. Association of Neurosurgeons of South Africa
7. Association of Plastic and Reconstructive Surgeons of SA
8. Biokinetics Association of South Africa
9. Democratic Nursing Association of South Africa
10. Division of Neuropsychology and Forensic Psychology
11. Emergency Medicine Society of South Africa
12. Emergency Nursing Society of South Africa
13. Independent Community Pharmacy Association
14. Islamic Medical Association of South Africa
15. National Healthcare Professionals Association
16. National Pathology Group
17. Neurological Association of South Africa
18. Nursing Education Association (NEA)
19. Nutrition Society of South Africa
20. Occupational Therapy Association of South Africa
21. Occupational Therapy Association of South Africa
22. Ophthalmic Society of South Africa
23. Oral Hygienists Association of South Africa
24. Pharmaceutical Society of South Africa
25. Podiatry Association of South Africa
26. Professional Association of Clinical Associates of SA
27. Psychological Society of South Africa
28. Public Health Association of South Africa
29. Radiological Society of South Africa
30. Rural Doctors Association of South Africa
31. Rural Rehab South Africa
32. SDG & Progressive Health Forum (PHF)
33. Society of Anatomical Pathologists and Cytologists
34. Society of Cardiothoracic Surgeons of South Africa
35. Society of Medical Laboratory Technologists of South Africa
36. Society of Private Nurse Practitioners
37. Society of radiographers of South Africa
38. South African Academy of Family Physicians
39. South African Association of Radiation Oncologists
40. South African Clinical Technologists Association
41. South African Dental Association
42. South African Dental Therapy Association
43. South African Gastroenterology Society
44. South African Haematology Society (SASH)
45. South African Health Informatics Association (SAHIA)
46. South African Heart Association
47. South African Institute of Environmental Health
48. South African Medical Association
49. South African Optometric Association
50. South African Orthopaedic Association
51. South African Orthotic and Prosthetic Association
52. South African Paediatric Association

LIST OF HEALTH PROFESSIONAL ORGANIZATIONS (CONT.)

53. South African Renal Society (SARS)
54. South African Society of Anaesthesiologists
55. South African Society of Clinical and Radiation Oncologists
56. South African Society of Obstetricians and Gynaecologists
57. South African Society of Physical and Rehabilitation Medicine (SASPRM)
58. South African Society of Physiotherapy
59. South African Society of Psychiatrists
60. South African Speech Language Hearing Association
61. Southern African Spinal Cord Association (SASCA)
62. Specialist associations
63. The Association of Nuclear Physicians (SA Society of Nuclear Medicine)
64. The Dermatological Society of South Africa
65. The Ophthalmological Society of South Africa
66. The Radiological Society of South Africa
67. The Society of Psychiatrists of South Africa
68. The South African Heart Association
69. The South African Orthopaedic Association
70. The South African Society of Anaesthetists
71. The Vascular Association of South Africa
72. Urological Association of South Africa
73. SA Society for Occupational Health Nurses
74. SA Society for Occupational Medicine
75. Employee Assistance Professionals Association
76. Southern African HIV Clinicians Society
77. Rural Health Advocacy Project
78. South African Private Practitioners Forum

LIST OF USER GROUP CONSTITUENCY MAKE UP

1. Alpha Gal SA
2. Campaigning for Cancer; including:
 - (a) the Vuka Khuluma Project and

LIST OF USER GROUP CONSTITUENCY MAKE UP (CONT.)

- (b) Disease related Patient Advisory Boards
3. Cancer Alliance, including:
 - (a) amaBele Project Flamingo NPC
 - (b) Ari's Cancer Foundation
 - (c) Breast Course 4 Nurses
 - (d) Breast Health Foundation
 - (e) Cancer Association of South Africa
 - (f) Cancer Heroes
 - (g) Can-Sir
 - (h) CanSurvive Cancer Support
 - (i) Care for Cancer Foundation
 - (j) Childhood Cancer Foundation of South Africa
 - (k) Gladiators of Hope
 - (l) Hospice Association of South Africa
 - (m) Look Good Feel Better
 - (n) Love Your Nuts
 - (o) Lymphoedema Association of South Africa
 - (p) The Men's Foundation and Movember SA
 - (q) National Council Against Smoking
 - (r) National Oncology Nursing Society of SA
 - (s) Pancreatic Cancer Network of SA
 - (t) People Living With Cancer
 - (u) The Pink Parasol Project
 - (v) Pink Trees for Pauline
 - (w) Pocket Cancer Support
 - (x) Rainbows and Smiles
 - (y) Reach for Recovery
 - (z) South African Oncology Social Workers' Forum
 - (aa) The Sunflower Fund
 - (bb) VREDE Foundation for Young People with Cancer
 - (cc) Wings of Hope

LIST OF USER GROUP CONSTITUENCY MAKE UP (CONT.)

4. CannaLand
5. CANSA
6. CHBAH Palliative Care Steering Committee for Palliative Care
7. Curesma Africa
8. Dementia South Africa
9. Diabetes South Africa
10. Endometriosis SA, including:
 - (a) Individual S.A endometriosis support group
 - (b) Endometriosis Nutrition and Holistic Support
 - (c) Endometriosis Society of South Africa (Endo-SA)
 - (d) Endo Focus
 - (e) Endo Warriors
 - (f) Endometriosis Support South Africa (ESSA)
 - (g) Raising Royalty
 - (h) Endometriosis Foundation Africa
 - (i) Foundation for Endometriosis Awareness Advocacy and Support
11. Epilepsy South Africa
12. Genetic Alliance SA, including 21 established patient support groups for common congenital disorders.
13. HCSMSA
14. Hospice Palliative Care Association
15. Igazi Foundation
16. Jumping Kids
17. Life Esidimeni Family Committee
18. Lupus Foundation of South Africa
19. NACOSA
20. National Interfaith Council of South Africa, Including:
21. All Faiths in South Africa, 9 provinces, districts and municipalities:
 - (a) Muslims
 - (b) Jewish Board of Deputies
 - (c) Bahai

LIST OF USER GROUP CONSTITUENCY MAKE UP (CONT.)

- (d) Church of Scientology
- (e) Hindus
- (f) African Traditional Religious People
- (g) African Indigenous Churches
- (h) Christians
- (i) Buddhism
22. Palliative Treatment for Children (PatchSA), including:
 - (a) Paedspal
 - (b) Umduduzi
 - (c) Sunflower Children's Hospice
 - (d) Footprints 4 Sam
 - (e) Tygerberg Hospital
 - (f) Wits Palliative Care
 - (g) Lambano
 - (h) Knysna Sedgfield Hospice
 - (i) St Francis Hospice
 - (j) Frere Hospital – Oncology and Haematology
 - (k) Stanger Provincial Hospital
 - (l) Viljoenskroon Hospice
 - (m) Stepping Stones
 - (n) Tender HBC
 - (o) Steve Biko Academic Hospital
 - (p) Choice Trust
 - (q) Khululeka Grief Support
 - (r) Hearts of Compassion
 - (s) St Josephs
 - (t) Breede River Hospice
 - (u) Drakenstein Hospice
 - (v) Camdeboo Hospice
 - (w) Heartlands Baby Sanctuary
 - (x) Helderberg Hospice

LIST OF USER GROUP CONSTITUENCY MAKE UP (CONT.)

- (y) PlettAid, Northwood Hospice PE
- (z) St Lukes Hospice
 - (aa) Ladybrand Hospice
 - (bb) Najojo Living Mission
 - (cc) CANSA
 - (dd) CHILDHOOD CANCER NETWORK (CCN)
 - (ee) Sunflower Fund
- 23. PinkDrive
- 24. More Balls Than Most
- 25. PKD Support Group
- 26. Rare Diseases SA; including 140 disease specific support groups.
- 27. Rural Health Advocacy Project
- 28. S.A. Haemophilia Foundation
- 29. SA National Mental Health Alliance Partners
- 30. SA NCD Alliance, including:
 - (a) CANSA,
 - (b) Diabetes South Africa,
 - (c) Heart and Stroke Foundation South Africa
- 31. SADA
- 32. SADAG
- 33. Section 27
- 34. Smile Foundation
- 35. The Max Foundation South Africa Trust
- 36. Wings of Hope

LIST OF BUSINESS ORGANISATIONS

BUSA

LIST OF PUBLIC HEALTH ENTITIES

1. National Health Laboratory Service
2. Council for Medical Schemes
3. South African Health Products Regulatory Authority
4. Office of Health Standards Compliance
5. Discovery Health
6. Momentum Health
7. Smile Foundation (USERS GROUP)
8. Committee of Dean's (ACADEMIC)

LIST OF GOVERNMENT DEPARTMENTS

1. National Department of Health
2. Gauteng Department of Health
3. Mpumalanga Department of Health
4. Limpopo Department of Health
5. Kwazulu Natal Department of Health
6. Free State Department of Health
7. Northern Cape Department of Health
8. North west Department of Health
9. Eastern Cape Department of Health
10. Western Cape Department of Health
11. National Treasury
12. Department of Science and Technology
13. Department of Social Development
14. Department of Planning Monitoring and Evaluation
15. Department of Justice
16. Department of Higher Education and Training



LIST OF ACADEMIC AND RESEARCH ORGANIZATIONS

The South African Committee of Dental Deans:

1. Sefako Makgatho Health Sciences University
2. University of Pretoria
3. University of the Western Cape
4. University of the Witwatersrand

The South African Committee of Health Sciences Deans

1. Cape Peninsula University of Technology
2. Central University of Technology
3. Durban University of Technology
4. Nelson Mandela University
5. North-West University
6. Sefako Makgatho Health Sciences University
7. Tshwane University of Technology
8. University of Cape Town
9. University of the Free State
10. University of Kwa-Zulu Natal
11. University of Johannesburg
12. University of Limpopo
13. University of Pretoria
14. University of Stellenbosch
15. University of Venda
16. University of the Western Cape
17. University of the Witwatersrand
18. Walter Sisulu University

The South African Committee of Medical Deans

1. Nelson Mandela University
2. Sefako Makgatho Health Sciences University
3. University of Cape Town
4. University of the Free State

5. University of Kwa-Zulu Natal
6. University of Limpopo
7. University of Pretoria
8. University of Stellenbosch
9. University of the Witwatersrand
10. Walter Sisulu University

LIST OF CIVIL SOCIETY ORGANIZATIONS

1. Sport, Arts & Culture Sector
2. Lesbian, Gay, Bi-Sexual, Transgender, Intersex and Non-Gender Conforming Sector (LGBTI+)
3. Disability Sector
4. Children Sector
5. Men Sector
6. Women Sector
7. NGO Sector
8. Faith/ Religious Sector
9. Traditional Leaders Sectors
10. Youth Sector
11. Sex Workers Sector
12. Higher Education
13. Research
14. Law & Human Rights

SCIENCE COUNCILS

1. South African Medical Research Council (SAMRC)
2. Council of Scientific and Industrial Research (CSIR)
3. National Research Foundation (NRF)
4. Human Sciences Research Organizations (HSRC)
5. Technology Innovation Agency (TIA)

LIST OF STATUTORY COUNCILS

1. Health Professions Council of South Africa (HPCSA)
2. South African Nursing Council (SANC)
3. South African Pharmacy Council (SAPC)
4. South African Dental Technicians Council (SADTC)
5. Allied Health Professions Council of South Africa (AHPCSA)
6. Traditional Healers Council of South Africa

LIST OF LABOUR ORGANIZATIONS

1. Congress of South African Trade Unions (COSATU)
2. Federation of Unions of South Africa (FEDUSA)
3. National Council of Trade Unions (NACTU)

LIST OF ALLIED HEALTH PROFESSIONS

1. Chiropractic Allied Health Professions
2. Phytotherapy Allied Health Professions
3. Unani-Tibb Allied Health Professions
4. Chinese Medicine & Acupuncture Allied Health Professions
5. Homeopathy Allied Health Professions
6. Naturopathy Allied Health Professions
7. Therapeutic Aromatherapy Allied Health Professions
8. Ayurveda Allied Health Professions
9. Therapeutic Massage Therapy Allied Health Professions
10. Osteopathy Allied Health Professions
11. Therapeutic Reflexology Allied Health Professions

LIST OF TRADITIONAL HEALTH PRACTITIONERS

1. Traditional Healers Organisation (THO)
2. National Unitary Professional Association for Traditional Health Practitioners (NUPAATHPSA)
3. Gauteng African Traditional Health Practitioners Provincial Chapter

4. Kwa-Zulu Natal African Traditional Health Practitioners Provincial Chapter
5. Free State African Traditional Health Practitioners Provincial Chapter
6. Western Cape African Traditional Health Practitioners Provincial Chapter
7. Northern Cape African Traditional Health Practitioners Provincial Chapter
8. Limpopo African Traditional Health Practitioners Provincial Chapter
9. Eastern Cape African Traditional Health Practitioners Provincial Chapter
10. Mpumalanga African Traditional Health Practitioners Provincial Chapter
11. North West African Traditional Health Practitioners Provincial Chapter



1. EXECUTIVE SUMMARY

The President of the Republic of South Africa, Mr Matamela Cyril Ramaphosa conceived of the Presidential Health Compact, following a series of events highlighting the need to make a substantial intervention to improve the quality of healthcare.

Many South Africans raised grave concerns about their experiences when seeking healthcare. Some of the organisations, included, among others, the South African Medical Association and Section 27. At the meeting which the President convened with the Progressive Health Forum, it became evident that there is a need for a process that would result in the Presidential Health Summit. The process brought together the Presidency and the Ministry of Health and key stakeholders with a view to identify key challenges facing the health system, and most importantly seek solutions to prevent further deterioration of the quality of the health system.

In the lead up to the Presidential Health Summit, the President convened the Health Colloquium in August 2018. The meeting formed the precursor to the Presidential Health Summit, emphasising the crisis facing the public health sector and the need for urgent and concerted action. A multi-stakeholder steering committee was convened in the Presidency in order to prepare for the Presidential Health Summit.

The Presidential Health Summit was held on the 19th and 20th of October 2018. This consultative meeting generated an unparalleled surge of energy directed at collaborating in order to solve problems facing the public health sector. Solutions emerged from the rich contributions made by many of the key stakeholders within the health sector, including various government departments, health professionals, allied health professionals, traditional healers, the business community, civil society, health service user groups, labour, regulators, academia and research organisations as well as health entities.

Following the Presidential Health Summit, many stakeholder organisations spent six months developing a plan which, when implemented, will fundamentally alter the experience of health service users when visiting public sector health facilities. The groups comprised of 76 health professional organisations, 11 allied health

professionals, 118 user groups, 14 civil society groups, 32 academic and research organisations, 5 science councils, 48 business (private sector organisations), 8 public health entities, 11 traditional healer practitioner organisations, 16 Government Departments, 12 labour organisations, 12 Statutory Councils. As far as we know, this is the largest health consultative meeting ever convened to work together to develop a plan to remedy the crisis in the health system in South Africa.

What is exciting is the realisation and acceptance by all the participants of the notion that the health system can never be fixed by the Health Department alone – it requires a focused, practical and collaborative approach. The government and participating stakeholders continue to demonstrate their commitment to improving the health system to bring new dawn with a desire to see not only a halt in the deterioration of the health system but a massive improvement in its functioning for the benefit of all South Africans. The stakeholders are committed to working together for the next five years to improve the health system.

The plan entails improvement of the health system in nine fundamental pillars of the health system, which, when dysfunctional leads to a path toward collapse. In the first pillar, the plan outlines pivotal interventions related to human resources for health with a focus on human resources policy, governance, leadership and management in human resources, education, training, and development, working with partners, ensuring health workforce wellbeing and advocacy. Specifically, the plan proposes intervening through the design of human resource development and management road map that includes forecasting, production, posting, retention, and continuous training and management improvement.

There is an urgent need to fast-track the implementation of the policy to employ foreign-trained medical practitioners to fill the vacant posts as well as the employment of interns and community service professionals, including the unfreezing and financing of critical posts. Management should also attract talented professionals and engage them, provide positive or negative incentives to staff concerning performance. The government should pay attention to creating a supportive and healthy environment to improve performance.

The top-heavy management structures of hospitals and clinics, with often duplication of roles and responsibilities, coupled with weak governance will be resolved through improved role definition in all levels of the health system, with clear accountability frameworks. Where employees lack appropriate management knowledge, skills, and competencies the plan requires that the statutory bodies in health and health and welfare sector authorities should review the curriculum and ensure that it includes the training of health professionals in preparation for universal health coverage implementation.

The inequality in access to health care due to the uneven distribution of health workers in the country will be resolved through service integration between the private sector. The barriers to integration will be resolved through ending backlog of primary care drug permit approvals, which will allow patients to be seen after hours and over weekends. Also, the plan aims to integrate the referral system between the public and private sectors to ensure health professionals function within multi-disciplinary teams, which is expected to improve the efficiency of service provision. Health workers are often not safe in their working environment. The plan entails introducing interventions that support fatigued professionals, including spiritual support. Studies on the on staff morale, risk factors for suicide and burn-out will contribute to the development of interventions to support health professionals to develop resilience in the work environment. There will be a programme to advocate for programmes that will increase human resources to alleviate the shortage and gaps in service provision.

The **second pillar** relates to improving access to essential medicines, vaccines, and medical products. The interventions relate to better management of supply chain equipment and machinery. Three interventions are planned: establish a centralised procurement system with a decentralised ordering and purchasing; develop a national policy on capital equipment purchasing and ensure skilled persons are involved in the development of specifications for tenders.

A joint programme of the government and the pharmaceutical industry aimed at addressing the lack of expertise in supply chain management for medicines and medical products will be implemented to support training as well as the professional councils who will be required to introduce the undergraduate curriculum to improve supply chain skills.

The poor communication between the contracted suppliers and the Department of Health ---which may lead to shortage of medicines--- will be resolved through commitment by the key stakeholders (pharmaceutical industry, the

South African Health Products Regulatory Authority (SAHPRA), provincial and national Department of Health) to ensure that potential shortage information is communicated in real time and contingency plans are made on time. A forum of all stakeholders will be established to resolve supply chain issues related to medical products.

Various challenges related to supply chain such as late awarding of tenders, suppliers no longer supplying the medical products, and deviations from supply agreements will be resolved through several interventions. These include better project planning at a national level, industry notifying the government in advance that they will no longer supply the product, provincial departments imposing penalties for supplier deviation from contracts, and government to be held accountable for late payment of suppliers.

The current SAHPRA backlog of registration of medicines will be addressed through interventions relating to prioritisation of medicines of public benefit, cutting bureaucracy by fast-tracking of overseas registered drugs, using automation and introduce collaborative structures to introduce new medicines to address high burden diseases.

To end the problem of the provincial health departments running out of funds for medicines before the end of the financial year will be resolved through the involvement of the heads of pharmaceutical services in the budget planning coupled with treasury earmarking funds for medicines. Furthermore, provincial departments will be required to implement a more efficient system of invoice verification and payment that is intended to achieve payment within 30 days.

To ensure that decisions to treat medical conditions are based on an in-depth assessment of the relative benefits of various therapeutic options at the population level will require that there be a costed Health Technology Assessment (HTA) Strategy accompanied by the Essential Equipment, Medical Devices and In-vitro Diagnostic Devices (IVDs). The Health Technology Assessment Committee will oversee the HTA implementation. HTA will be based on evidence-based medicine and should consider the value of innovation and innovative technologies.

The lack of standardisation of the health information system tender specifications to adequately describe and predict product volumes will be corrected and updated regularly to prevent shortages of medical products. This will be accompanied by an early warning stock shortage management system that identifies medicine availability and standard essential equipment at each type of facility. Furthermore,



there will be a Medicine Master Data System (MMDS) that identifies each medicine that is conventionally procured on tender and all provinces must use this database as the basis for procurement.

To increase pharmaceutical production capacity there will be support for knowledge/skills capabilities for local pharmaceutical manufacturers; encourage universities to incorporate pharmaceutical production skills in undergraduate and postgraduate training; and government and the private sector are to consider options to develop an innovative, competitive, diverse and highly skilled local pharmaceutical industry.

The plan also includes the finalisation of the South African National Policy on Intellectual property in a manner that balances the objectives of access with the need for Intellectual Property protection to encourage pharmaceutical innovation, promote further research and develop as well as attract future investment in the country.

Tuberculosis (TB), Human immunodeficiency virus (HIV), Malaria and Sexually Transmitted Diseases (STDs) are not detected and treated early and therefore affect disease progression. To solve this problem, the plan includes (a) support to the TB and Malaria drug discovery programmes; (b) strengthen microbicides in the prevention of HIV and other sexually transmitted infections; (c) develop locally genital inflammation test device that can reduce the prevalence of STIs, bacterial vaginosis and HIV risk in South African women; (d) develop and test subtype C candidate HIV-1 immunogens for the development of HIV vaccines; (e) evaluate the utility of an intra-uterine balloon tamponade device in the management of post-partum haemorrhage as well as Doppler ultrasound technology to identify foetuses at risk of stillbirth; (f) develop local medical device, biopharmaceuticals development and pharmaceutical technology innovation programmes; and (g) continue to develop new diagnostic modalities for TB and HIV.

There is a need to develop programmes for precision medicine for cancer, co-morbidities, epilepsy, Type 1 diabetes, adverse drug effects, and also profiling African microbiome.

The **third pillar** focused on the execution of the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities. The 10-year Health Infrastructure Plan has been developed but has not been adopted by the National Health Council nor shared with the private sector. The current infrastructure construction has either failed to meet the standards and or has

cost far more than it should. The plan also does not prioritise the maintenance of existing infrastructure as well as new capital (whether upgrades or new sites). To fast track the execution of this Health Infrastructure Plan, it is necessary to table the plan for review and updating and submitted to the National Health Council for adoption.

To ensure that budgets are optimally allocated to priority infrastructure requirements, the authorities and private sector must use the updated 10-Year Health Infrastructure Plan to identify new infrastructure capacity priorities and fund the capital for only identified priorities. The private sector would assist in the funding of the capital towards infrastructure. There will be a new model designed for the cooperation between the public and private sector in the construction and maintenance of health facilities which aim to improve the quality of the public health infrastructure.

Existing infrastructure cording structure such as the Infrastructure Unit Support System (IUSS) consisting of the NDOH/CSIR/DBSA which supports the planning and design of health facilities that are responsive to the disease prevalence and transmission, will be reinforced.

Health facility design will include specifications and a maintenance plan for patient rehabilitation units and that suitable qualified therapist/s, and end user/s will form part of design teams and transversal tender evaluation committees.

On an annual basis, equipment will be audited in all public health facilities to identify shortages (against standard asset lists) with the involvement of health user representatives. The plan is to review the policy on accountability for public health infrastructure. Similarly, the infrastructure tender processes will include health user representatives.

Currently, the private sector is not included in the infrastructure quality assessment regulation. The Office of Health Standards Compliance will be required to add the private sector in the inspection of health facilities to ensure they meet the standards for health service provision.

The Patient Rehabilitation units are expected to be universally accessible, including toilets, and that they enable physiotherapy, occupational therapy, speech, audiology, optometry and social work to be near shared office spaces and rehabilitation gyms.

With respect to infrastructure delivery, there are several deficiencies including (a) infrastructure costs that far exceed the initial budget or have been under-budgeted; (b) inconsistent roles of Public Works Department and Department of Health in different provinces and nationally; (c) different accountability mechanisms among provinces; and (d) the deficient capacity of the Department of Health to manage the infrastructure that in some cases has deteriorated beyond repair. It may be necessary to correct this by delaying new infrastructure and the focus on maintaining the existing ones to stay within budget.

The **fourth pillar** deals with engaging the private sector in improving the access, coverage, and quality of health services. South Africa has a low ratio of doctors to the general population, according to the World Bank about 0.78 per 1000 in 2015, which is lower than the norm for a middle-income country; the international average is 1.5 per 1000. In order to identify the gap between the number of health care professionals that currently exist in SA based on population needs and disease burden, a Baseline Audit of specialists is required. It is agreed that this will be conducted by the Department of Health, Statutory Councils such as HPCSA and Council for Medical Schemes and associations or entities that manage health professional numbering systems with the input from academia

Currently, there is no authentic consolidated report on situational analysis on nursing in South Africa. After analysing reports from the Department of Health (2011) and SA Nursing Council (2015) HASA (Hospital Association of South Africa) has estimated a shortage of 48 000 nurses in South Africa. Similarly, the 2013 Sector Skills Plan submitted to the Department of Higher Education and Training by the Health and Welfare Sector Education and Training Authority also noted the shortage of nursing skills. There is a dire need to improve the nursing capacity in terms of the number of nurses, the quality of their training and their definition. It entails the creation of a baseline audit of nurses and the development and provision of workshops and refresher programmes by specialist medical professionals to provide nurses with short-term and ad-hoc support.

Concerning several areas of extreme need among provinces, the Gauteng Department of Health (GDOH) is exploring areas of collaboration with the private healthcare providers and funders and will engage in relieving some of these areas. This process will allow for knowledge distribution cross-nationally and potential for further scale-up will be explored.

Furthermore, there is an absence of contracting frameworks. This requires that contracts be targeted at partnering with private sector providers for provision

and management of care. The contracting framework will be reviewed by the Department of Health and the private sector, to pilot new and innovative patient-centric private sector contracting. This will lead to the development of contracting frameworks for piloting on priority projects.

Access to quality care in the public sector is constrained, yet the private sector has systems, processes, and capabilities that can solve some of the challenges faced by the public sector. A study will be conducted by academics, the SA Alliance of Healthcare Professions, the private sector and the Department of Health to identify and prioritise areas with a need for gap filling in the public healthcare sector. Also, a pilot will be conducted in the Western Cape, where short term medical-legal indemnity will be provided for specialists volunteering in the public sector.

Many councils are not operating optimally, with allegations of corruption (investigations underway at the NHLS and HPCSA) and significant organisational weaknesses, resulting in delays and inefficiencies that undermine access to quality care. Through the public-private sector engagement mechanism, critical areas for improvement in several key entities will be identified with the private sector, providing expertise and support to address the priority needs among the entities.

The World Bank Human Capital Index 2018 states that South Africa's economic potential is at 0.41 out of a possible score of 1, due to poor health and education outcomes. The Department of Education Social Development and the SA Alliance of Health Professions will conduct a comprehensive assessment of current initiatives and programmes, in order to work towards an integrated school health programme (oral, eye care and audiology and primary healthcare nurses in schools, tooth keepers and alliance for a cavity-free future).

The lack of consistent messaging and education results in inefficiencies, the frustration of users and ultimately contribute to poor access to health services and health outcomes. The Department of Health and the private sector will collaborate to develop information education and communication (IEC) materials on user education on their right for access to quality health services, with user and practitioner groups broadly disseminating the material.

Medico-legal disputes are costly and time-consuming and result in win-lose outcomes. Alternative dispute resolution (ADR) often results in more sustainable outcomes. A task team will be constituted to develop a voluntary model for



medico-legal disputes to promote expeditious, affordable and sustainable resolution of medico-legal disputes.

While there are many ad hoc and a variety of engagement mechanisms between the public and private sectors, there is no formalised and legitimate structure whereby the private sector can voice concerns and align its actions to contribute to addressing the public health sector crisis coherently. A credible engagement structure between private and public sector will be developed to provide for a platform for contribution, cooperation and raising of concerns for both sides.

The **fifth pillar** focused on improving the quality, safety, and quantity of health services provided with emphasise to primary health care. Based on the inputs that were received from the nine sectors as well as the deliberations and discussions at the Presidential Health Summit held in October 2018, it was clear that South Africa needs to adopt an Integrated People-Centred Health Services (IPCHS). This WHO framework has two distinct components: 1) people centredness that puts people and communities at the center of health system instead of diseases and empowers people to take charge of their health; 2) Integrated health services which means promotive, preventive, curative, rehabilitative and palliative services that are organised, managed and delivered in a way that ensures continuum of care at the different levels and sites within the health system.

A lack of empowerment as a result of socio-economic factors results in poor active engagement and participation of patients and communities in managing their health status and care. Interventions include (a) integrated and multi-stakeholder involvement on awareness days and national health campaigns to promote early detection of diseases and risk factors; (b) implementation of the social contract with society which should serve as an advocacy and peer review mechanism to promote partnership between different stakeholders; and (c) reviewing of clinic and other health committees and hospital boards to strengthen representation and advocate for the inclusion/participation of community representatives, People with Disabilities (PWD), patient groups and members groups to improve governance, accountability and addressing integration with various structures and levels.

Recognising that healthcare extends beyond the boundaries of healthcare facilities, scaling up community-based health services will bring care closer to the populations and ensure that the community has access to appropriate health services. This requires the development of spiritual & chaplaincy guidelines and competencies to address mental and spiritual health challenges as well as

formalising employment status of community health workers (CHW), incorporate them in multi-disciplinary teams as well as expand their skill levels to provide appropriate community-based care, screening and referral of persons with disabilities (PWD).

Vulnerable population groups such as the elderly, children, women, people with disabilities (PWD), mental health patients and people with rare diseases, find it difficult to have access to good quality and affordable health services. They often face huge out of pockets payments as the majority of conditions are not adequately covered by medical schemes or government facilities as experienced by a lack of the necessary resources. This entails establishing an oversight committee that will uphold, promote and protect the human rights of the vulnerable population, e.g. PWD and those with mental health conditions.

Quality health outcomes and health planning are negatively affected due to the lack of evidence-informed package of health services for various levels of care. Coordinated research protocols, employed health researchers and a dedicated budget for health, rehabilitation & palliative research to provide evidence-based quality outcomes.

Service delivery packages are not always accessible or suitable to address the needs of the population and therefore needs to be redesigned. Prioritisation on District level must include local community primary healthcare practitioners and should not only be academic driven.

The lack of standardised South African evidence-based clinical guidelines, protocols, conflicting policies or aspects of policies, policies developed in silo and no or very little inter-sectoral collaboration between various departments e.g. Department of Basic Education (DBE), Department of Social Development (DSD) and the NDOH, affect the implementation at primary care level. These influence the quality of care provided to the population of South Africa (SA). Interventions include enforcing current prescribed minimum benefit regulations to ensure adequate funding of the chronic list of PMB conditions at PHC and expanding access to primary health care through contracting with approved private providers as to enhance coverage and better patient outcomes.

Care coordination is fragmented. Currently, there is not an integrated, streamlined and standardised referral system between the different levels within the public

sector and between private and public sector health professionals and facilities, which increases in waiting times, interrupted health services, duplications, inefficiencies, and poor outcomes. Guidelines on referral between public and private sector as well as between different levels of care (primary, secondary, tertiary) in public sector will be developed and implemented as well as robust management tools (including system-wide information and technology and data management capacities) to monitor and enhance health systems management through training, innovation and research.

The different government departments such as health, social services, finance, education, labour, housing, the private sector, and law enforcement, among others, are working in silos and often relevant policies contradict each other. This entails building networks of relationships with multiple health actors, to build trust in the health system. Also, to integrate traditional and complementary medicine with the modern health system to improve cooperation between health professionals providing health care.

Health outcomes are poor, and health expenditure is high due to focus on hospital-based curative services rather than addressing the health determinants such as environmental determinants of health. Interventions require collaboration with other sectors to manage the key social determinants of health. The interventions include addressing health aspects in other sectoral policies or what is known as 'Health in All Policies'. Other interventions include working with line ministries and communities to identify mechanisms for mitigating against the harmful effects of environmental determinants hazards arising from mining and other industries, as well as collaborating with Municipalities to improve the state of waste management, environmental management and water management.

Creating an enabling environment that brings together the different stakeholders to undertake transformational change will require coordinated research protocols, employment of health researchers and a dedicated budget for health, rehabilitation & palliative research to provide evidence-based quality outcomes. In addition, to develop collaborative research with a focus on epidemiology, health systems strengthening, health financing aspects, Health Technology Assessment (HTA) at the district hospital and PHC levels of care.

Patchy and fragmented implementation of norms and standards of all health facilities and service delivery result in long waiting times, poor outcomes and dissatisfied patients. A nationally coordinated Quality Improvement Plan in all health facilities, especially at the PHC level, with regular monitoring and

evaluation in progress towards universal health coverage, will be implemented. Ensure adequate capacity and resources at OHSC to perform its mandate.

Medico-legal and litigation cases are increasing with costs escalating an alarming rate and are commonly a result of incompetence of health professionals, specialist needs not addressed at district hospital level, red tape delaying the turn-around time in purchasing or repairing critical medical equipment, emergency services without any tracking systems in ambulances for abuse prevention and accountability, poor record keeping. There will an assessment conducted into the supply and demand side factors contributing to increasing rates of medico-legal litigations, compared with private sector statistics and assess the private sector strategies to mitigate these factors.

Regulation plays a crucial role in establishing the rules within which professionals and organisations must operate within a more people-centred and integrated health system. To remedy, institute a full organisational review of the legislation on health and propose new governance and administrative structures. Furthermore, the office of the Ombudsman must be separated from the HPCSA to ensure independence, transparency and good governance.

The **sixth pillar** concentrated on improving the health efficiency of public sector financial management systems and processes. Insufficient capacity exists in the National and provincial health departments and health entities to address the challenges of financial management in the sector. There is a need for setting up a unit that will work closely with the Special Investigative Unit (SIU) to prevent and address corruption and wastage in the health sector both at national and provincial levels. Also, capacitate the critical staff in NDOH and provinces to effectively manage the public sector financial management (PFM) function.

Urgent attention must be given to address accruals (unpaid debts rolling over from the previous financial year) in the Provincial Health Departments and to ensure that management processes are in place to prevent a recurrence. Such steps imply that the National Treasury, together with the NDOH and provincial treasuries, address the issue of accruals over three years as per the package of measures contained in the Joint Action Plan.

Furthermore, better alignment of procurement plans to approved budgets and cash flow projections, and expansion of the financial management improvement programme managed by the National Department of Health will be implemented.



Budget allocations are not in line with best practice and integrated care resulting in poor service delivery and patient outcomes. Identified interventions include the introduction of a budgeting and payment system that prioritises promotive and preventative health care and allows for the functioning of multi-disciplinary teams, centralising procurement of certain services and equipment, and standardising provincial ring-fenced budgets and ensure these are used appropriately.

The public health sector is underfunded, and the allocations between provinces and allocations to Health by provincial legislatures have led to inequities between levels of care and between provinces. It will be necessary to review the existing provincial equitable share formula and update it based on a standardised and transparent approach ---taking into account the epidemiological, health systems, demographic and other key variables. Such an approach will ensure that the provinces receive funding according to context and need. Furthermore, it will be necessary to conduct cross-nationally a review of the budget allocation for the Health function within the public sector, including a review of the legislative powers of provinces.

The HIV Conditional Grant has become unwieldy and now constitutes earmarked funding for HIV, TB, Malaria and Community Outreach Services, in the amount of R19 billion. The grant purpose and size needs evaluation and review. A review of the system for a conditional grant will be conducted to improve the functionality of provincial management teams. HIV conditional grants, which now include TB, Malaria and Community Outreach Services for the effective financial management of priority programmes, will also be reviewed.

Donor funding is also subject to unpredictable changes in the level of support. The recent decision by PEPFAR to reduce its allocation to SA by US\$200 million in the next Country Operational Plan (COP) cycle is a case in point wherein the country is not given sufficient time to plan for such declines in donor funding leading to a disruption of critical programmes. There needs to be a comprehensive review of donor funding and the allocation of donor funding to the health sector with a view to their integration into the overall budgeting system within the public sector.

The central hospitals, tertiary services, and training grants have not changed for the last two decades, and an urgent review is needed. A special multi-stakeholder task team needs to be constituted to review the governance of the central hospitals, together with their teaching platforms. Furthermore, the level of funding for central hospitals and the teaching and training platform needs to be urgently reviewed together with the conditional grants that are associated with these services.

Public sector hospital revenues are negligible. It is essential that the public sector attract paying patients who are members of medical schemes. A key challenge is the lack of appropriate billing systems and administrative skills required to get revenue from medical schemes. Public sector facilities must create special arrangements that will be attractive to paying public sector patients or out of pocket paying patients.

Public Entities in the health sector, such as the NHLS, SAMRC, SAHPRA, OHSC, CMS, and the CCOD are essential components of the public health sector. These entities have good potential to improve their roles and their contributions to the effective functioning of the health system, both private and public. The level of funding of these institutions needs to be reviewed together with the review of the budget allocations to the public health sector and the provincial and municipal health services. An objective system of determining the allocation of resources to these entities needs to be established.

The Office of the Health Ombudsman is under-capacitated to fulfil one of the most critical functions in quality improvement. The current budget of the Health Ombudsman is R8 million per annum, and the staff complement is two. This situation needs to be addressed and the funding to the Office of the Health Ombudsman should increase from its current level in the next financial year and subsequent years. There is also a need to implement the decision of the DPSA on the funding of the Office of the Health Ombudsman over the next five years.

The **seventh pillar** dealt with Strengthen accountability mechanisms at the national, provincial and institutional level within the current Constitutional framework. Each of the three levels South Africa's government: national; nine provinces; and 278 municipality governments, is semi-autonomous and structures and capacities differ across and within these levels, making the uniform implementation of national health policies, norms and standards and strategies an arduous task.

The National Department of Health should review its organisational structure to ensure a harmonised reporting structure from national to provincial levels. The policies and processes should also be reviewed to ensure the recruitment of competent and skilled incumbents in the health system. A review of the legislative frameworks should be conducted and a proposal for structural reforms aimed at One Nation One Health System Policy would be developed.

A number of the healthcare sector governance structures in the country are not functioning optimally because these governance structures are not being held accountable for their lack of performance. A review and update of existing health strategies and financial policies would be conducted. This would ensure policy coherence within across the levels of government - from national to province and local government. Additionally, a detailed Annual Performance Plan with clear deliverables and line budgets at all levels should be developed which is aligned to National Health Strategy.

The health information systems are fragmented, Granular data on health inequities is not routinely captured and the evidence from research and survey data does not necessarily inform the policy process. This requires strengthening National Health Research System to be capable of generating knowledge and new products for promoting, restoring and maintaining health while also feeding into the policy process aimed at existing health needs. Further, it is necessary to build on the existing national platforms to establish a standardised National Health Information System with interoperability capacity; and establishing mechanisms for information and data sharing from the private sector which will feed into health decision making and priority setting process.

The health sector in both the public and private sectors is most vulnerable to fraud and corruption because of vast and varied numbers of transactions on goods and services in terms of fraudulent orders, tender irregularities, fiscal dumping through non-governmental organisations, bribery, over-pricing, poor governance, transfer of liabilities to the state, and bogus and fraudulent qualification. The Department of Justice should implement the use of specialised criminal courts for the investigation and adjudication on corruption by the matters and also put in place mechanisms to minimise political interference in procurement matters.

While some health systems and their components have explicit norms and standards, some of them are archaic or not comprehensive enough to meet the current health system requirements which create fragmentation and confusion with different stakeholders using different benchmarks, norms, and standards. A review of the current health regulatory environment should be conducted and proposal of updates to the regulatory frameworks governing health sector including- service delivery, pharmaceuticals, medical products, IT systems, technology, and artificial intelligence be made.

As per the available literature, up to 70% of all health conditions are preventable by addressing the social, environmental, economic and political determinants of

health. Such a programme entails (a) establishing platforms and mechanisms for working with other departments and sectors and addressing health aspects in their policies to remedy the social, environmental, economic and political determinants of health, including public health emergencies and antimicrobial resistance; (b) creating a 'Health Stakeholder Platform' to strengthen engagement between key stakeholders; (c) as well as harmonising and aligning the work of the development partners and non-governmental organisations towards the achievement of national health outcomes.

The **eighth pillar** focused on engaging and empowering the community to ensure adequate and appropriate community-based care. Community engagement is an effective method for promoting participation and empowering communities among a wide range of health and non-health benefits and is identified as one of the essential pillars of a people-centred health system, and therefore it also forms one of the core tenets in NDP 2030. According to the Reconstruction and Development Program (RDP), communities must be encouraged to participate actively in the planning, managing, delivery, monitoring, and evaluation of the health services in their areas.

However, communities and populations are often not consulted in the organisation of health services about their health needs and expectations from the health systems. Although the patient charter and feedback system exist, these are not working optimally. Referral and outreach services, including poor road infrastructure and shortage of fleet, are also a critical area of concern which impacts on the health and safety of communities.

Lack of investment in capacity building of Hospital Boards and Clinic Committees to strengthen accountability and performance has rendered them mostly dysfunctional. It requires reviewing of governance structures (Clinic and Hospital Boards) and assesses performance in health service delivery at Community, District & Provincial levels.

A community-oriented and easy to use monitoring and evaluation system does not exist, which makes it difficult to ensure quality health provision at all levels. Similarly, regular compliance checks against the agreed norms and standards are not fully institutionalised with community involvement. There is a need for strengthening and improving quality of care services through an effective and non-politicised multi-stakeholder Clinic Committees and Hospital Boards and any other structure that may be established to strengthen the health system. Monitor the community health workers' compliance with the prescribed standard



operating procedures (SOPs) for service delivery, M&E, and any other assigned functions. Inadequate availability and appropriately trained health personnel contribute to the inefficiencies that continue to beset the provision of health care. This is exacerbated by the inequitable deployment of appropriately trained personnel to all health facilities, especially those in rural areas. The focus must be on integrating and re-orientating undergraduate health professionals training to PHC and community engagement, including the expansion and resourcing of decentralised training platforms and an emphasis on multi-disciplinary team training.

Social determinants of health are known to play a significant role in health outcomes. An overall lack of integration across and within government departments as well as with Traditional Authorities, Traditional and Allied Health Practitioners and the Religious Sector at the community level poses a significant challenge to holistically address many of these social determinants, as well as the participation of community groups in service planning and delivery. This entails advocating for a specialised cadre of community health workers specialising in health services that focus on mental health, spiritual wellbeing and disability specific interventions including peer support.

Poor adherence to treatment by patients results in sub-optimal results when it comes to epidemic control, especially in anti-retroviral treatment for people living with HIV and TB. Healthy behaviours for the prevention of disease and risk factors should be promoted using all communication platforms (such as social media, radio, television, community dialogues, newspapers, IEC materials).

Community health workers (CHWs) form the interface between community and health. The success of the latest primary health care (PHC) strategy relies on the availability of a regulated, competent, dedicated, supported and capacitated CHW cadre. The ability of multi-disciplinary staff to provide adequate outreach support is also imperative to the functioning of this critical cadre. There is a need for the establishment and use of appropriate referral and outreach systems to enhance the provision of treatment (e.g. CCMDD). Improve management and deployment health resources like ambulances through using mobile applications as a means available to public users to improve efficiency and effectiveness.

Fragmentation of platforms between local government and health sectors risk duplicating efforts and further weaken inter-sectoral collaboration. The interventions include advocating for and promoting inter-sectoral collaboration between government (within government and between spheres of government),

civil society and business to improve the provision of health services, and using existing community structures to ensure and improve patients' safety & safety of the health professionals and facilities.

Developing an Information System that will guide the health system policies, strategies and investments was a focus of the **ninth pillar**. The current health information systems, within both the public and private health sectors and between these two sectors, are fragmented. Digital technologies provide concrete opportunities to tackle health system challenges, and thereby offer the potential to enhance the coverage and quality of health practices and services (WHO, 2019).

The development and implementation of an integrated health information system focussing on both the management of the system and the patient will bring efficiency and efficacy gains and quality to the health system. Recognising that there are many disparate systems implemented across the health system, a baseline assessment is required to assess the current health information systems being implemented, identify existing best practices and expertise, and perform a gap analysis. All sectors will collaborate and share critical lessons learned on patient information, sharing from collaborative projects across the health sector, including input from users.

The South African Healthcare system is characterised by a lack of uniformity in the use of intervention coding systems for diagnostics and procedures as well as billing purposes. There is also a discrepancy between public and private sector in the use of coding systems for standardisation of diagnosis and billing. The National Department of Health will have to coordinate a stakeholder forum to discuss and reach a consensus on the standardisation of the health diagnostic and procedure coding in the health systems. A national health diagnostic and procedure coding authority will be established. Also, there is a need to develop and implement compatible disease-based registers, contributing to surveillance of the burden of disease.

Healthcare technology infrastructure in South Africa is characterised by the adoption and use of different hardware platforms, connectivity, operating systems, software solutions and standards. Many health facilities in rural areas have poor or no access to reliable connectivity, ICT infrastructure, and affordable data. Advocating for and rendering technical assistance in a Health Information System baseline assessment across the health sector is required to determine



what infrastructure is available, broken, location (levels of care), functionality and connectivity. There is also a need for developing a national dedicated wide-area network (WAN) that supports health information systems and its uninterrupted availability across the country.

The effective digitisation of healthcare will require a workforce and consumer base, adequately skilled in the effective use of implemented health technology and systems. Interventions include identifying available Health Information System skills and expertise and training requirements across the health sector as part of the baseline assessment.

With the increasing number of data sources and systems as well as the complexity of data generated within the health sector, the need for advanced analytics to support decision-making is growing. The quality, standardisation, and accessibility to data for effective data mining, analysis and reporting across the health sector, is still in some areas fragmented, inequitable and uncoordinated. There is a need to identify business intelligence (BI) report requirements in close collaboration with relevant stakeholders and the drafting of BI Report specifications. In addition, consideration of all relevant legislation, policies, and frameworks are essential to ensure the development of an integrated Health Information System compliant with data requirements for Business Intelligence.

Conclusion

The implementation of this compact is expected to contribute significantly to improving the public healthcare system so that many more South Africans can access quality healthcare. The participation of the government and the critical stakeholders in the development and implementation of various components of the compact will deliver significant benefits to the health system, thereby making a significant contribution to the realisation of the Constitutional right to Health through enhancing South Africa's economic and social potential; and enabling people to live healthy and productive lives.



2. INTRODUCTION

Although most countries around the world have a health system that includes both public and private sectors, South Africa's is unique. Of the 186 countries for which WHO reported expenditure data for 2016, an average of about 52% of health expenditure was Government funded while 39% was privately funded (the remainder derived mainly from external aid). About 44% of South African health expenditure is in the private sector, which is higher than other upper-middle income countries where 37% of health expenditure is private. While that is not dramatically different from other countries, the composition of its spending is.

In particular, the share of spending that flows through private voluntary medical schemes remains the highest in the world, at over 47% in 2016. As is well-known, this spending serves only 16% of the population that has medical scheme coverage. So while the current health system has changed significantly from the system during the apartheid era, when there were fourteen public sector health departments, each serving different ethnic and population groups, this aspect of the "architecture" remains and is a crucial driver of inequalities in the system.

The public sector health system is tax-funded. Free access to public healthcare services is subject to the patient qualifying in terms of a financial means test. The public health system incurs expenditure equivalent to 3.5% of South Africa's gross domestic product (GDP). This figure excludes the additional estimated 0.9% of GDP of government expenditure that subsidises the purchase of private medical schemes (e.g. for civil servants). Private medical schemes cover approximately 16% of the population, with most of the principal members of these schemes working in the formal sector. The remaining 84% mostly use government health facilities. This situation is highly inequitable, as available health system resources are highly skewed to serve the rich, with Government inadvertently compounding the problem through the subsidies provided to the private medical schemes (directly as well as indirectly through the tax system). A smaller percentage of the population pay out of pocket to use the private health sector. In addition, 'out of pocket' (OOP) services are rendered in both the public and private healthcare sectors (estimated at 0.6% of GDP or 8% of total Health Expenditure – much lower than for upper-middle-income countries in 2015, although the low share of spending is partially due to the inflation of total spending arising from the high expenditures made through Medical Schemes).

From a funding perspective, the private sector has grown from being a complementary service provider in the 1960s to now being a significant source of healthcare funding and expenditures.

On the other hand, the public healthcare sector, while achieving significant strides in tackling South Africa's quadruple burden of disease (consisting of HIV/AIDS and TB, maternal and child mortality, non-communicable diseases, injuries and violence) now faces many challenges mostly related to poor quality and inequitable access to health services. The unresolved issues of unaffordable private health care and inadequate levels of service delivery in the public sector are now being used to characterise South Africa's health system to be in 'crisis'.

Some of the root causes for the challenges facing the public health sector include weak governance structures, inadequate management capacity and administrative systems. The systems fail to provide adequate oversight for implementation of national policies, strategies and regulations. The challenges include the (a) inequitable funding; (b) human resource shortages; (c) malpractice claims which have been escalating over the years; (d) inappropriate skill-mix and maldistribution; (e) inadequate and poorly maintained infrastructure and equipment; (f) inadequate and fragmented information systems; (g) and the lack of using evidence for guiding investments, reducing overall inefficiencies, and wastage in the system. Similarly, the private sector, which is perceived by most South Africans to provide better quality health care services, is challenged by high prices located predominantly in urban areas and mainly three provinces, fragmentation of providers and facilities and there are perceptions of over-servicing, perverse incentives.

The National Development Plan (NDP) states that "the national health system needs to be strengthened by improving governance and eliminating infrastructure backlogs". The attainment of good health is therefore not only the responsibility of the health sector but requires all other sectors of South Africa's society, that have an impact on health, to also play a role in ensuring improving standards of living good health and well-being for all South Africans. The interlinkage of health with the other sectors is well articulated in the Sustainable Development Goals (SDG) agenda.

PRESIDENTIAL HEALTH SUMMIT COMPACT

The recognition of the above challenges within South Africa's health sector and recognising the NDP's missive, warranted the hosting of a Presidential Health Summit to serve as an avenue to bring together key stakeholders from different constituencies, through an inclusive process, to deliberate and propose solutions to address the health system crisis. The proposed interventions are intended to address the barriers to achieving universal health coverage (UHC) in South Africa.

UHC policy requires that all people should have equitable access to the health services they need (promotive, prevention, curative, rehabilitative, palliative), without any financial hardship resulting from the use of or the need for these services. 'Quality' of the services rendered and 'equity' are inherent components of UHC. This requires healthcare services to be effective and accessible to the whole population with an emphasis on those with the most need.

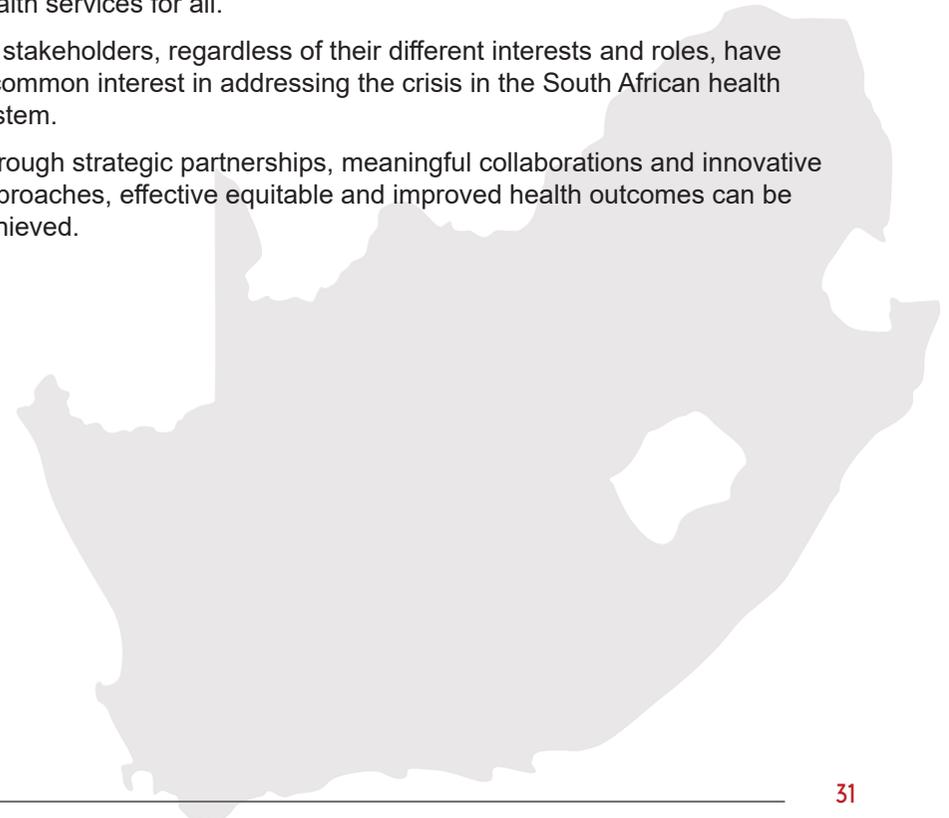


3. PREAMBLE



Recognising that:

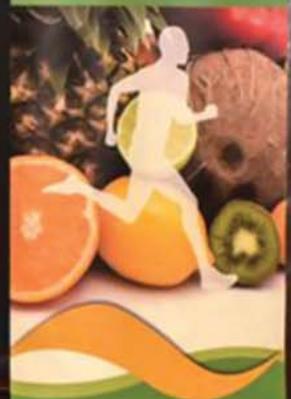
- Universal access to essential health services is a fundamental human right and clearly articulated in Section 27 of South Africa's Constitution, requiring the Government to apply available resources to realise this right progressively.
- South Africa has committed to Universal Health Coverage (UHC), which is the overarching target of Sustainable Development Goal-3 and a key target articulated in the National Development Plan (NDP) 2030.
- Achieving Universal Health Coverage will improve the social and economic prospects of South Africa and reduce inequities but will require responsive and robust health systems capable of delivering high-quality health services for all.
- All stakeholders, regardless of their different interests and roles, have a common interest in addressing the crisis in the South African health system.
- Through strategic partnerships, meaningful collaborations and innovative approaches, effective equitable and improved health outcomes can be achieved.





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and



4. STATEMENT OF PURPOSE

The Presidential Health Summit held on 19th and 20th October 2018 in Johannesburg, brought together key stakeholders from a wide range of constituencies in the health sector, which deliberated in nine commissions and proposed wide-ranging solutions to address the challenges facing the South African health system. As a follow-up, these social partners have continued to work tirelessly over the past six months to consult further, conduct root cause analyses and propose tangible solutions. Inputs to transform and improve the health system were received from a variety of stakeholder groups including the health professionals, government departments, the business community, civil society, patient advocacy, labour, financial institutions, regulators and the employers.

This Compact outlines the key interventions that the Government and stakeholders will undertake or support over the next five years (2019 - 2024). The collective objective is to strengthen the South African health system to ensure that it provides access to quality health services for all in an equitable, efficient and effective manner.

The Compact should be read in conjunction with the Monitoring and Evaluation section as well as action plans.

4.1 The Approach and Pledge

The following pledge provides an anchor for collaboration between stakeholders to work jointly towards improving South Africa's health system. The social partners pledge to:-

- Work towards “one country, one health system” by collective efforts to progress towards a uniform standard of healthcare across all levels of care provincial boundaries and public and private sectors.
- We embrace a people-centric health system
- Assist the Government in serving the whole population, so that all people can access the health services they need without financial hardship, and ‘no-one is left behind’.

- Embrace accountability and transparency while implementing the proposed interventions included in this Compact.
- Consistently communicate and report regularly to the nation on the progress made to improve the quality of the health system as outlined in this Compact.

4.2 The Health Systems and Service Improvement Plan

The deliberations of the Presidential Health Summit resulted in a plan to strengthen the quality of the health system. The Presidential Health Summit Report, adopted by all stakeholders, comprised of the following thematic pillars:

- **PILLAR 1:** Augment Human Resources for Health (HRH).
- **PILLAR 2:** Ensure improved access to essential medicines, vaccines and medical products through better management of supply chains, equipment and machinery.
- **PILLAR 3:** Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities.
- **PILLAR 4:** Engage the private sector in improving the access, coverage and quality of health services.
- **PILLAR 5:** Improve the quality, safety and quantity of health services provided with a focus on primary health care.
- **PILLAR 6:** Improve the efficiency of public sector financial management systems and processes.
- **PILLAR 7:** Strengthen the governance and leadership to improve oversight, accountability and health system performance at all levels.

- **PILLAR 8:** Engage and empower the community to ensure adequate and appropriate community-based care.
- **PILLAR 9:** Develop an information system that will guide the health system policies, strategies and investments.

4.3 Implementation and support structures

Social partners agreed that to avoid the natural deficiencies of previous summits not yielding tangible results in the form of instituting reforms in the health sector, this Presidential Health Summit must establish a structure that will be tasked with monitoring the implementation of a social compact (the Compact). Stakeholders also agreed to establish a “Joint Technical Monitoring Team” once the Health Summit compact has been signed by the President and the representatives of the stakeholder groups. The Joint Technical Monitoring Team, which will report to the Presidential Working Group, will undertake the following actions: -

1. develop a monitoring and evaluation framework based on the “health compact action plans” for each pillar;
2. ensure effective and sustainable collaboration between Government and stakeholders for delivering on the key outputs of each pillar;
3. meet regularly to consider and review progress reports from the accountable department/stakeholders;
4. report to the High-level Presidential Committee on Health (made up of the President as well as the signatories of the health compact);
5. develop progress reports in a specified format and ensure their availability on the Presidency website; and
6. any other responsibility as per the arising needs.

The Compact is a dynamic living document that is contextual and may require continuous review depending on the monitoring and evaluation of outcomes and contextual issues. A Monitoring and Evaluation Framework has been developed for high priority areas and will be reviewed regularly.

4.4 Guiding Principles

Social partners will be guided by the following principles to achieve the above purpose:

- Advancement of collective efforts to promote access to health care services as an essential foundation to health for all and to end inequity.
- Adherence to the principles of ‘Batho Pe’e’, and organise health services with ‘people at the centre’, focusing on their needs and expectations from the health systems.
- Contributing to an integrated healthcare system by committing to rebuild the South African health system to provide quality health services to all.
- Identify actions and implementing solutions to strengthen coordination, monitoring and evaluation in the South Africa health system.
- Identify actions to strengthen coordination to deal with corruption, waste and abuse to improve accountability.
- Ensure accountability, efficiency and integrity in the implementation of our interventions;
- Strengthening institutional capacity to deliver health services.
- Mutual respect in engagements.
- Meaningful partnerships by the Government and all stakeholders
- Consistent and transparent communication on progress in implementation.

The following operational principles will apply:

- The primary goal of the Health Summit Compact is to strengthen and improve universal access to health and healthcare in South Africa. To achieve this, all parties, commit to this goal and to ensure that self-interests do not derail or detract from this goal.
- Ethically execute responsibilities as outlined in this Compact.
- Structured programme teams with committed participation and accountability.
- Transparent funding modalities and impact assessment.
- Clear role allocation and responsibilities.
- Inclusive communication and sharing of information.



5. COMMITMENTS TO STRENGTHENING THE SOUTH AFRICAN HEALTH SYSTEM

5.1 Pillar 1: Augment Human Resource for Health Operational Plan

Human resources for health (HRH) is at the centre of health systems. Evidence shows that adequate numbers of well-distributed health care workers with the right skills mix, of a high standard, result in improved coverage of essential services, and an overall improvement in key health outcomes. Although HRH is the most significant single component of the health system, on which more than 50% of health funding is spent, it is often not well planned or managed due to numerous complex and intertwining issues. Planning for HRH has proven to be challenging over the years because the future workforce is often difficult to predict. Workforce planning is further compounded by the time that it takes to train staff - it takes at least three years for basic health professional training and up to fifteen years for specialisation.

To address challenges relating to HRH, human resource development and management, a roadmap is required that includes forecasting, production, posting, retention as well as continued training and management aspects. Sub-components must include staff engagement, incentivising, recognition and reward for personnel; talent attraction, management and support, and occupational health and safety. Fast-tracking the implementation of a policy that allows foreign-trained medical practitioners to practice in the country is imperative. The State should fulfil its obligation for statutory employment of interns and community service professionals, including the unfreezing and financing of critical posts.

5.1.1 Human Resources for Health Policy

Evidence and needs-based 'human resource for health planning and financing strategy' that ensures adequate numbers of equitably distributed

human resources with the right skills-mix is necessary to meet the needs of the health system. Key to improving HRH is strengthening of Human Resource Information Systems (HRIS), such as Personnel and Salary System (PERSAL). The Remuneration of Work Outside Public Sector (RWOPS) policy, also needs to be reviewed to ensure effective use of the existing workforce. The skills and competencies of various categories of healthcare workers should be mapped to ensure that these human resources are appropriately deployed, and skills leveraged optimally for the benefit of patients.

Interventions:

- Review and update existing policies/ strategies governing HRH.
 - o The National Department of Health must lift the moratorium on filling posts in the public health sector with priority placed on critical services.
 - o The National Department of Health in collaboration with organised labour, must review the policy on RWOPS to limit its impact on service delivery.
 - o The National Department must review the human resource plan for the health workforce with the support of health professionals, organised labour and the private sector.
 - o The private sector, in collaboration with the National Department of Health, will conduct an audit of currently practising healthcare professionals and forecast of capacity requirements based on population needs to develop workforce model in the public and private sectors.
 - o With immediate effect, the National Department of Health must ensure that statutory requirements for internship and community service are met.

- o The provincial health departments undertake to contract in non-core skills supported by robust contract management.
- o Ensure that policies on funding and staffing meet the needs of the health system within budgetary constraints based on the normative standards established by the National Department of Health
- Monitor and evaluate status and practices in human resources for health.
 - o The Health professionals grouping to assess levels of equitable distribution of health personnel, primarily rural versus urban and human resources distribution and level of care, in community services.
 - o The health professionals will identify areas of good practice where comprehensive care is available, review staffing numbers and mix (considering rurality, province, and level of care) in the various setting as guidelines.
 - o The health professionals undertake to determine the essential skills mix to deliver on the core mandate of the department, to know what skills are inadequately supplied and in which provinces.
 - o Organised labour undertakes to provide policy input with regards to the staffing needs of the health system
 - o The National Department of Health must reduce the top-heavy and inefficient centralised administrative and management layers in departments, which makes it bloated and costs more to manage the health system.
- Strengthen HRH research and evidence.
 - o The National Department of Health must expand the national capacity to research, with the support of the health professionals, users group, organised labour as well as the academic group, to develop and implement a revised human resource for a health plan.

5.1.2 Governance, Leadership & Management in Human Resources

The leadership structure in hospitals and clinics requires urgent review. The organisational design in public sector hospitals and clinics is

characterised as being top-heavy, with many managers appointed, with the duplication of roles in the public sector. The governance capacity of many leaders and managers in public health facilities is sub-optimal with these employees often lacking appropriate management knowledge, skills and competencies. Political interference and patronage networks present in management levels of public hospitals have negatively impacted the delivery of services in the public health sector.

Interventions:

- There must be clear roles and responsibilities of all categories of health professionals at all levels of the health system.
- Clear accountability frameworks for each level of care.
- Implementation of the training programmes for health professionals.
- Expand or implement management training programmes for health professionals and managers working in all aspects of the current health system.

5.1.3 Education Training and Development

The Draft National Health Insurance Act positions Primary Health Care (PHC) as the heartbeat of National Health Insurance (NHI). The PHC services include health promotion, disease prevention, curative (acute and chronic clinical) services, rehabilitation and palliative services. However, not all public health professionals are currently adequately trained to meet the need of PHC.

Interventions:

- The regulatory entities, i.e., Health Professional Council of South Africa, Nursing Council, Pharmaceutical Council and the Dental Technician Council adjust and confirm that health professions training curricula are based on the needs of the universal health coverage including a focus on management within the health system, ethics, human rights and the legal framework on which the health system is grounded. The National Department of Health is accountable for this intervention.
- The user group undertake to obtain Sector Education and Training Authority (SETA) Continuous Professional Development (CPD) accreditation for neglected professions; such as Medical Genetics



- Education Programme (MGEP) and other nursing and community healthcare courses.
- The user group will participate in the facilitation the training and supervision at public health facilities of healthcare professionals in therapeutic disciplines, e.g. student optometrist placed in public sector facilities to complete practical training.
 - The user group undertakes to inform career pathways to capacitate provincial eye care directorate or eye care management within non-communicable diseases.
 - Board of Healthcare Funders offers to assist national departments with the development of the healthcare workforce model, particularly on PHC practitioners.

5.1.4 Partnerships

There is a general shortage of health care professionals in the country, which is compounded by disparities in the distribution of human resources in the health system between the private and public sectors. This is of concern. The distribution of human resources between the public and private sectors is uneven; and there are less registered doctors per capita available to public sector patients, that to private sector patients with private medical aid.

According to the 2010 South African National Department of Health's Human Resources for Health strategic plan, more health professionals are working in the private sector than in the public sector and significant disparities between the provision of health professionals in the provinces.

Interventions:

- Currently, the average waiting time for Primary Care Drug Therapy (PCDT) permit approval is 7-12 months. Stakeholders must work with the National Department of Health must address the PCDT permit backlog to ensure that services can be provided after hours and over weekends to patients.
- The private sector will develop a concept document, together with the DoH on the feasibility of private-public collaboration on nurse training and review the role of community services for nursing.

- Integrate the referral system between the public and private health sectors to improve access and efficiency, thereby allowing health professionals to function within multi-disciplinary teams seamlessly.

5.1.5 Health workforce wellbeing

The health, safety and wellbeing of health professionals are essential. There is an imperative to address the wellbeing of our scarce health workforce in order to provide good quality of health care to the population,

Interventions:

- Develop interventions such as compassion fatigue workshops for health professionals, including paramedics and to address additional issues identified, such as inputs relating to palliative care and spiritual care. The Patient Advocacy Group is accountable for this intervention
- The user group will review the existing and available support services for health professionals, identify gaps in service provision to ensure support, treatment and care of health professionals.
- The user group undertakes to conduct studies to assess staff morale and risk factors for suicide and burnout amongst health professionals and students as well as assessing coping skills and personality traits that contribute to the resilience of health professionals intending to develop programmes to support them.
- The health professionals with the support of organised labour will implement adequate health professional training and capacitation to ensure resilience with appropriate skills within the national health sector workforce.

5.1.6 Advocacy

Public awareness has been identified as a vital tool by sector representatives to achieve equitable access to health for all.

Interventions:

- The collaborative user group will advocate for employment, and retention, across all cadres of health professionals, family physicians,

medical officers and registrars, community service graduates and specialist, in rural and underserved areas at Primary Health Care and District Health offices, particularly in areas of rehabilitation, nutrition, pharmacy, oral and eye service providers. The collaborative user group is accountable for this intervention. The following stakeholders will also collaborate: User Groups, Health Professionals, NDoH, AHP, Traditional Health, Business, organised labour and BHF.

- The user group to advocate for amendment of the National Mental Health Policy Framework 2013-2020 Strategic Plan that allows registered counsellors and Psychologists in PHC clinics and CHC as part of the Mental Health Support Team to help with the overflow of patients who need basic counselling, patient information and screening of mental health issues
- The user group to advocate for capacity building for eye care service delivery in the public sector.
- The user group to advocate for increased awareness of multi-disciplinary teamwork.
- The health professionals and the user group to advocate for realistic financial support for the implementation of decentralised/ distributed training.
- Advocate for partnership between GPs and pharmacists with Primary Care Drug Therapy (PCDT) qualifications to clarify the defined scope of practice of PCDT pharmacists and referral system and highlight the collaborative and complementary efforts in communities without access to healthcare services. This will be a collaborative project between DoH, Statutory Bodies and associations. The National Department of Health is accountable for this deliverable.





5.2 Pillar 2: Ensure improved access to essential medicines, vaccines and medical products through better management of supply chain equipment and machinery

Essential medicines should be available at all times and in adequate amounts, appropriate dosage, quality and at an affordable price for individuals and communities. WHO also endorses the requirements set out for a well-functioning health system to ensure 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 a significant expenditure item in both the public and private health care sectors, thus managing the cost of medicines is essential in improving the efficiency of the system. Managers should focus on procurement, selection and distribution to ensure that there is an uninterrupted supply of medicine.

Several gaps need to be addressed in the supply chain processes and procedures including; ensuring that adequate funds are available for medical products, equipment and machinery. Supply chain management in the public sector has numerous challenges: limited skills; inadequate monitoring and governance; suppliers unable to deliver ordered quantities timeously; inefficient supply chain management processes; inadequate information systems; and suppliers not being paid on time and this impacts negatively on medicine availability. In the case of medical consumables, there is no regulation of quality, absence of a national catalogue of products and there is also ineffective monitoring of availability of these consumables.

5.2.1 Centralised Procurement

There are several challenges with the procurement of medicines which is currently being administered by the National Treasury through transversal tenders. Medical products and consumables are not uniformly managed at a national level, thereby losing the efficiency gains of centralised purchasing. The purchase of capital equipment is not always accompanied by an appropriate maintenance plan which leads to obsolete

equipment in facilities. There is also a weakness in the development of tender specifications and the evaluation of bids, particularly for medical products, biomedical equipment, and radiological equipment.

Interventions:

- The National Department of Health should establish a centralised procurement and supply chain management system at a national level for medicines and medical products, ordering and purchasing will be done at a decentralised level, that is capable of speedily and cost effectively which will ensure access to medicines at a local level;
- The National Department of Health should establish a policy on capital equipment purchases which should be accompanied by a Service Level Agreement (SLA) and maintenance agreements with suppliers. Critical to enable efficient procurement processes is an information technology system; and
- The Department of Health must ensure that the appropriate experts are (such as clinical engineers and technicians) are involved in the development of specification and evaluation of tenders for medical equipment (basic and complex), medical consumables and related items.

5.2.2 Training/Human Resource Capacitation

The Department of Health has limited supply chain skills and expertise for medicines and medical products, leading to the non-availability of medicines and medical products.

Interventions:

- The National Department of Health and the Pharmaceutical Industry should jointly support training programmes to improve the supply chain skills amongst those involved in the supply chain.
- The Pharmacy Council and Nursing Council will be engaged also to introduce supply chain courses in the undergraduate curriculum to improve supply chain skills.

5.2.3 Communication Strategy

Contracted suppliers of medicines/equipment do not routinely inform the Department, upon when they first become aware of this, of a potential supply interruption. Consequently, the Department has limited opportunity and time to arrange alternative supplies. Additionally, information relating to a medicine shortage/ alternative medicines does not reach all health professionals involved in the prescribing and dispensing of medicines. The South African Health Products Regulatory Authority's (SAHPRA) does not timeously communicate to the decisions that affect medicines availability.

Interventions:

- Pharmaceutical manufacturers must to commit to providing information on a potential shortage of medicine on first knowledge of the information;
- National Department of Health to publish medicine availability challenges experienced by suppliers on the NDOH website and disseminate this information through circulars to all stakeholders;
- Provincial health departments must develop escalation protocols for shortages of medicines, consumables and medical equipment; and
- The SAHPRA should advise the National Department of Health on regulatory actions that are likely to affect medicine availability.
- A multi-stakeholder approach should be developed to keep all relevant parties informed in real time as to stock availability and any other related information which will aid in supply and production planning with the use of appropriate technology.

5.2.4 Supply Chain Management

Tenders are not always awarded on time, which results in provincial health departments having to purchase products at high costs and also results in delays in the delivery. Suppliers sometimes do not submit bids for products that they historically supplied on tender resulting in medicine non-availability. Provincial departments do not impose penalties on suppliers where there are supply agreement deviations, which perpetuates the inadequate supply from manufacturers.

Interventions:

- The National Department of Health will develop a project plan with appropriate timelines that plan for the award of new tenders several months before the expiry of the existing tenders;
- Pharmaceutical companies supplying products on tender should inform the National Department of Health of supply interruptions timeously and the intention not to continue supply in the case of a new tender; and
- Provincial departments must impose penalties on suppliers as contained in supplier contracts.
- Likewise, suppliers should be provided with a mechanism to hold provincial departments accountable for late payments and tenders awarded but orders not placed, which will impact companies in terms of planning, supply and cash flow.

5.2.5 Regulation and Registration

The South African Health Products Regulatory Authority (SAHPRA) is a key stakeholder in medicine availability. SAHPRA has a backlog of registration applications of vital essential medicines, backlogs in the change of API source applications, as well as limited access to section 21 unregistered medicines.

Interventions:

- SAHPRA should prioritise medicine applications based on the public health need, and expedited process that takes into account mutual recognition for medicines of public health benefit is critical;
- SAHPRA should re-engineer regulatory processes to reduce unnecessary bureaucracy and delays. This should include fast-tracking of overseas registered drugs, by automatic registration if drugs are registered in other countries, such as having FDA + one other regulator, approval;
- SAHPRA must create collaborative structures to introduce new medicines into pilot programmes to address high burden diseases particularly HIV, TB, Cancer and other diseases of priority.



5.2.6 Budget and financing

Provincial health departments often run out of funds for medicines several months before the end of the financial year. Suppliers are not always paid within 30 days of delivery of goods.

Interventions:

- Provincial Departments must budget adequately for medicines by involving the heads of pharmaceutical services in budget planning;
- Treasury must earmark funds for medicines such that the head of pharmaceutical services can manage the purchasing of medicines per the available budget; and
- Provincial departments must implement a more efficient system of invoice verification and payment that is intended to achieve payment within 30 days.

5.2.7 Health Technology Assessment

The decision to treat a medical condition with a selected intervention is not necessarily based on an in-depth assessment of the relative benefits of various therapeutic options at the population level.

Interventions:

- National Department of Health to develop a Health Technology Assessment (HTA) Strategy and a costed implementation plan; which takes into consideration the level of skills in the private sector and government to conduct and review such assessments
- User groups to develop a stakeholder database of all HTA stakeholders, including patient groups;
- National Department of Health to establish an independent Health Technology Assessment Committee which will include experts representation by the public and private stakeholders as well as academia.;
- User groups to recommend options for innovative access models; based on the current legal framework and where required make recommendations for amendment to the policy frameworks

- HTA should be based on evidence-based medicine and should consider the value of innovation and innovative technologies. Potentially higher acquisition costs are offset through downstream savings throughout the healthcare continuum. Innovation also results in longer-term improved patient outcomes.
- National Department of Health to develop an Essential Equipment, Medical Devices and In-vitro Diagnostic Devices (IVDs) List.

5.2.8 Health Information Systems

To effectively develop tender specifications, the health information systems and specifications must be standardized to describe and predict product volumes accurately. Stock availability requires a standardized information system that is regularly updated, which can be used to respond to shortages in facilities effectively.

Interventions:

- The National Department of Health will develop an early warning stock shortage management system that identifies medicine availability at all public health facilities. A similar system that identifies the standard essential equipment that should be available at each type of facility and their availability must be developed; and
- The National Department of Health must develop a Medicine Master Data System (MMDS) that identifies each medicine that is conventionally procured on tender and all provinces must use this database as the basis for procurement.

5.2.9 Indigenisation of Pharmaceutical Production

South Africa has a limited pharmaceutical production capacity which is limited to formulation with no Active Pharmaceutical Ingredients (API) production in the country. There are many essential medicines which cannot be sourced in South Africa since they are not available from any of the manufacturers in South Africa.

Interventions:

- The Department of Science and Technology to support knowledge/skills capabilities for local pharmaceutical manufacturers; and
- Department of Higher Education (DHET) to encourage universities to incorporate pharmaceutical production skills in undergraduate and postgraduate training.

5.2.10 Improving access to medicine and essential devices

Access to appropriate, essential and affordable medication that enhance outcomes-based patient care and Assistive Devices (ADs) are inappropriately managed and distributed, especially when a patient is discharged from tertiary care to PHC.

Interventions

- Develop mechanisms to promote local manufacturing of essential medicines to reduce the cost of medicines. The partners: Business, SAHPRA and the Pharmacy Council agreed to save costs by making use of locally manufactured medicines.
- Upscaling of Central Chronic Medicine Dispensing and Distribution (CCMDD) programmes to improve integration into PHC, reducing waiting times at health facilities and involved private family practitioner where needed. The partners: NDOH, Pharmacists and Health providers have agreed to participate and upscale the CCMDD programme.
- Facilitating access to chronic tertiary and quaternary medicine at local facilities to improve compliance with medicine and reduce the burden of travel for the user. The partners: SAMA, PSSA, Pharmacy Council, NDOH, supply chain management in PDOHs and RUDASA have agreed to this proposal.
- Ensure adequate provision of appropriate Assistive Devices (AD's) and self-monitoring devices through adequate budgeting and planning, e.g. a National priority assistive product list, to help people with disabilities to function effectively in their daily living. The partners: Companies providing AD's and self-monitoring devices, NDOH, PDOHs and Health Professionals have agreed to work towards budgeting of these devices to improve access to holistic care for users.

- Finalise the South African National Policy on Intellectual property in a manner which balances the objectives of access with the need for IP protection to encourage pharmaceutical innovation, promote further research and development as well as attract future investment in the country. The partner: SAMA and PSSA agreed to lead this process.

5.2.11 Partnerships

Non-availability of medicines, medical products and equipment are due to a complex range of factors that involve suppliers, national and provincial health departments and user groups. The resolution of problems relating to non-availability requires the collective efforts of all of these stakeholders to resolve these challenges.

Intervention:

- A forum must be established that involves all stakeholders to discuss challenges and develop interventions to address these challenges collectively.

5.2.12 Innovating and incorporating new technologies

Poor health outcomes and limited preventative care can be partly attributed to the limited incorporation of new technologies as well as poor communication with the community it wishes to serve. TB, HIV, Malaria and STD's are not detected and treated early and therefore affect disease progression. To further support increased access for all patients, appropriate (Intellectual Property) IP protection of innovative technologies needs to be promoted and ensured. Patents protection should be implemented in a manner that benefits public health.

To further support increased access for all patients, appropriate IP protection of innovative technologies needs to be promoted and ensured. Patents benefit public policy as they are aimed at stimulating innovation, further R&D and localisation, which patients will gain future benefit. It is essential for the Government to maintain a thoughtful balance between incentivising innovation through patent protection and ensuring that essential medicines are available for the majority patients based on the established TRIPS flexibilities that have been agreed upon.

Interventions

- Continue to support the TB and Malaria drug discovery programmes.
- Continue and strengthen programmes developing microbicides in the prevention of HIV and other sexually transmitted infections.
- Locally developed genital inflammation test device that can reduce the prevalence of STIs, bacterial vaginosis and HIV risk in South African women.
- Development of and testing of subtype C candidate HIV-1 immunogens for the development of HIV vaccines.
- Evaluate the utility of an intra-uterine balloon tamponade device in the management of post-partum haemorrhage as well as Doppler ultrasound technology to identify fetuses at risk of stillbirth.
- Development of local medical device, biopharmaceuticals development and pharmaceutical technology innovation programmes
- Continue developing new diagnostic modalities for TB and HIV.
- Programmes in precision medicine:
 - Fully incorporated Precision cancer medicine diagnosis and treatment program to be rolled out within the public health system.
 - Development of a rapid ParaDNA test kit for improved clinical management of patients with breast cancer and associated co-morbidities.
 - Incorporation of a wearable device for Precision management (PM) of Epilepsy in South African children within the public health system.
 - Delivery of Genomic Testing in Remote Locations using a point of care (POC) long read sequencing system for diagnosis of Type 1 Diabetes.
 - Development of companion diagnostics.
 - Using a stem cell platform for the screening of adverse drug effects.
 - Profiling of African microbiome.

Partnerships: The DST, with critical stakeholders in the industry, they agreed to lead processes for new technologies. Key stakeholders are Government, Science councils, Academia, and Industry.







5.3 Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities

5.3.1 Health Infrastructure Planning to ensure appropriate facilities on a sustainable basis

The National Department of Health has a 10-Year Health Infrastructure Plan, but the National Health Council has not adopted it nor shared with the private sector. The department does not have the expertise or adequate funding to implement the plan, and most provincial health departments also have limited capacity. In some cases, health infrastructure construction that has been completed has cost more than the initial budgeted amount or facilities have been constructed that either fail to meet the need or have not been provided with adequate funding to be fully operationalised.

The accountability for Facilities Management is inconsistent between provinces. The roles of public works and health departments differ across provinces. The National Health Infrastructure Plan must respond to changing population, epidemiology and clinical dynamics. The plan must also prioritise maintenance of existing infrastructure as well as new capital (whether upgrades or new sites). Infrastructure in both the public and private health sectors must be universally accessible and meet the requirements of the Office of Health Standards Compliance (OHSC). While planning occurs, the budgets must be redressed, and new sustainable financing mechanisms must be identified. The planning must be inclusive of provincial departments of health and the private sector, and the National Health Council must adopt the plan.

Interventions - Short-Term (1 year)

- The 10-Year Health Infrastructure plan which identified the gaps in universally accessible infrastructure of different types relative to a range of target norms, and responsive to population, epidemiological and clinical dynamics, needs to be reviewed and updated. It is agreed that this will be conducted by the national Department of Health, in consultation with provincial departments of health and the private sector.

- The Infrastructure Unit Support System (IUSS) established by collaboration between the NDOH/CSIR/DBSA is an initiative to support the planning and design of health facilities that are responsive to the disease prevalence and transmission, needs to be reinforced. More attention must be given to modifying health facility design to include specifications and a maintenance plan for patient rehabilitation units. It is agreed that this will be facilitated by the National Department of Health, in consultation with provincial departments of health and the private sector, and that suitable qualified therapist/s and end user/s should form part of design teams and transversal tender evaluation committees.
- The revised 10-Year Health Infrastructure Plan needs to be extended to accurately report on infrastructure and equipment available to support therapists at health institutions. It is agreed that this will be conducted by the National Department of Health, in consultation with provincial departments of health and the private sector, and that suitable qualified therapist/s and end user/s should form part of design teams and transversal tender evaluation committees.
- The IUSS (NDOH/CSIR/DBSA) initiative to support the development, monitoring and assessment of health infrastructure need to be reinforced and institutionalised so that public health infrastructure facility condition and suitability are routinely monitored. It is agreed that this will be conducted by the national Department of Health, in consultation with provincial departments of health and the private sector.
- Annual audits of equipment must be conducted in all public health facilities to identify shortages (against standard lists), and a formal process must be established where patient representative organisations can contribute to reporting shortfalls in health infrastructure and equipment. It is agreed that these audits will be conducted by the National Department of Health, in consultation with provincial departments of health, the private sector and patient representative organisations.
- There is a need to systematically strengthen the capacity of public health facilities to develop and implement maintenance plans (as required by the Government Immovable Asset Management

Act - GIAMA). It is agreed that the National Department of Health will create the necessary capacity and will support the provincial departments of health to do so.

- There is a need to review the policy on accountability for public health infrastructure and for a consistent and workable solution to be found as to whether health departments or public works departments are accountable. It is agreed that the National Health Council will engage with National Treasury and the Department of Public Works (DPW) to clarify.
- There is a need to explore new models of cooperation between the public and private sectors, which may be different for PHC compared with hospitals and to adopt practical policies for the provision of public health infrastructure. It is agreed that the national Department of Health, provincial departments of health and the private sector will engage with National Treasury to find innovative solutions.
- There is a need to review the infrastructure tender processes to include patient representative organisations in the tender process. It is agreed that the national Department of Health and provincial departments of health will engage with National Treasury to amend the tender specifications accordingly.

Interventions - Medium-term (2-3 years)

- There is a need for the implementation of monitoring and reporting tools, training and inspections for infrastructure in both the public and private health sectors that aim to ensure that the requirements of the Office of Health Standards Compliance (OHSC) and relevant statutory bodies are met. It is agreed that the national Department of Health, provincial departments of health and the private sector will work with OHSC to ensure that the compliance reports are submitted.
- To ensure that budgets are optimally allocated to priority infrastructure requirements, the authorities and private sector must use the updated 10-Year Health Infrastructure Plan to identify new infrastructure capacity priorities and fund the capital for only identified priorities. It is agreed that the National Department of Health, provincial departments of health and the private sector will work with National Treasury to fund priority health infrastructure projects.

- There is a need to ensure that Patient Rehabilitation units are universally accessible, including toilets, and that they enable physiotherapy, OT, speech, audiology, optometry and social work to be near shared office spaces and rehabilitation gyms. It is agreed that the National Department of Health and provincial departments of health will work purposefully to improve Patient Rehabilitation capacity and physical access to health facilities.

5.3.2 Health Infrastructure Delivery

In some cases, health infrastructure construction that has been 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 accountability for Facilities Management is inconsistent between provinces. The roles of public works and health departments, national and provincial, differ from one province to another. Despite a national programme to improve capacity, backed up by a funded, Treasury approved, organisational structure, the capacity of health departments to manage health infrastructure is deficient. Maintenance of infrastructure has deteriorated to the extent that some infrastructure needs to be condemned and others constitute safety risks for patients and staff. For the coming MTEF cycle, deliberate plans must be made to address maintenance, even if new capital projects are delayed accommodating budgets.

Interventions - Medium-term

- There is a need for the Infrastructure Delivery Management System (IDMS) Management Capacity to be implemented as a matter of immediate priority in all Health departments. The public health Facilities Management Programme for buildings and grounds must ensure compliance certificates, maintenance plans, emergency access, and ventilation (OHSC Regulation 14) and that engineering services (electricity, lighting, medical gas, water, sewage system) are available and functional without interruptions (OHSC Regulation 15). It is agreed that the national Department of Health and the provincial departments of health will work with National Treasury to implement adequate IDMS capacity.



- There is a need for capital funding budgets of public health infrastructure to be redirected to focus on maintenance/upgrading of health infrastructure for 2 to 3 years. It is agreed that the National Department of Health and the provincial departments of health will work with National Treasury to review and redirect budgets. There is also exploratory work underway with the private sector and DoH and National Treasury to determine whether and how the private sector can contribute to funding health infrastructure priority projects.
- There is an urgent need for a 'back to basics' programme to revitalise clinics and hospitals (e.g. painting, toilets, furniture, broken windows) to respond to the condition assessments and equipment audits. It is agreed that the national Department of Health and the provincial departments of health will work with national and provincial treasuries, with private sector inputs, to develop and finance a small project programme.
- There is a need to revisit the allocate allocation of budgets to ensure adequate maintenance of medical equipment. It is agreed that the national Department of Health and the provincial departments of health will work with national and provincial treasuries, with private sector inputs, to improve medical equipment maintenance programmes.
- There is a need for the staffing and equipping of maintenance hubs at all public hospitals to maintain the hospital and all surrounding PHC infrastructure. It is agreed that the national Department of Health and the provincial departments of health will work with national and provincial treasuries to explore possible private sector inputs and to establish maintenance hubs at public hospitals.

5.3.3 Health Infrastructure Financing

Over the past 25 years, different financing methods have been used to build new public health infrastructure, including through budgets, conditional grants and PPPs. Some funding has been channelled through the National Department of Health, some from provincial equitable shares through provincial health departments. Maintenance budgets are part of provincial health departments in some provinces and public works budgets in others. The provisions for both maintenance and new capital is inadequate to sustain and develop public health infrastructure. At the same time, the private sector has built many hospitals and clinics, often at a fraction of

the cost of the public building programme and in far less time.

The procurement process for large capital projects involves a very complicated and time-consuming Standard for Infrastructure Procurement and Delivery Management (SIPDM). Further procurement requirements include Broad-Based Black Economic Empowerment (BBBEE) and preferential procurement policies that require complex contracting arrangements. Public health services are delivered through a hierarchy of facilities that concentrate scarce, highly skilled capacity into few facilities to optimise available staff and equipment. The arrangement of services across facilities can only be efficient and effective if patients can be moved between facilities for appropriate care. Patient transport, including bus and taxi stations and private parking, is, therefore, an integral part of health infrastructure planning.

Interventions - Medium-term

- There is a need to review the experience with several public-private partnerships that have been implemented. It is agreed that the National Department of Health and the provincial departments of health will work with national and provincial treasuries, and with the private sector to conduct the reviews.
- There is a need to explore alternative funding sources for public health infrastructure (including a National Health Infrastructure Fund). It is agreed that the National Department of Health and the provincial departments of health will work with national and provincial treasuries, and with the private sector, to explore alternative funding sources for public health infrastructure.
- To ensure equitable access to facility-based health care, there is a need to develop and budget for improved planned patient transport services (especially for disabled, chronic, poor and rural patients). It is agreed that the national Department of Health and the provincial departments of health will work with national and provincial treasuries, and with the private sector, to improve planned patient transport services.

Interventions - Long-term (5yrs)

- There is a need to establish alternative funding platforms for health infrastructure development. It is agreed that the national Department of Health, National Treasury and the private sector will explore and exploit alternative funding sources for public health infrastructure.
- It is essential that infrastructure in both private and public sectors must meet the requirements of the OHSC for accreditation to supply

services to the NHI. It is agreed that the national Department of Health and the provincial departments of health will work with national and provincial treasuries, and with the private sector, to ensure that all (public and private) health infrastructure meets the requirements of the OHSC for accreditation to supply services to the NHI.



5.4 Pillar 4: Engage the private sector in improving the access, coverage and quality of health services

5.4.1 Support to alleviate staffing shortages on a sustainable basis

There is a significant challenge relating to the shortage of health sciences professionals. South Africa has a low ratio of doctors to the general population, according to the World Bank about 0.78 per 1000 in 2015, which is lower than the norm for a middle-income country; the international average is 1.5 per 1000. According to the South African Committee of Medical Deans (SACOMD) South Africa has about 50,000 doctors (benchmarked to upper middle-income countries), there is a need to double this number in order to provide access to quality health services for all South African's. It is going to require an incremental and sustained approach to get there.

Interventions:

- A baseline audit of specialists is necessary in order to identify the gap between the number of health care professionals that currently exist in SA based on population needs and disease burden. The Department of Health, Statutory Councils such as HPCSA and with the input from the academic sector, will conduct this baseline audit.
- The Department of Health in conjunction HPCSA will develop a workable proposal on the job training and rotation of specialists in the public sector for clinical disciplines that are more comprehensively practised in the private sector than in the public sector. This will enable the creation of a platform for the private sector to contribute more to the capacitation of the public sector with specialists.
- The requirements set out by the Department of Higher Education and Training as well as HPCSA must be met by those entities that wish to provide this training to expand the training platform in the private sector for postgraduate doctors. The private sector will engage particularly with the HPCSA to identify and unblock perceived constraints to their ability to provide post-graduate training for medical specialists.

5.4.2 Bolster the training of nurses to meet country needs

Currently, there is no authentic consolidated report on South Africa's situational analysis on nursing. After analysing reports from the Department of Health (2011) and SA Nursing Council (2015) HASA has estimated a shortage of 48 000 nurses in South Africa.

The 2013 Sector Skills Plan submitted to the Department of Higher Education and Training by the Health and Welfare Sector Education and Training Authority also noted that "the shortage of nursing skills is acute and post-basic training for nurses in specialized fields must be stepped up. Nurse specialists are needed in advanced midwifery, post-natal care, [primary healthcare], paediatrics, psychiatry and other specialist areas". It was also recorded that the Department of Health had reported significant public sector shortages. "The largest shortages were for nurses (22 352 professional nurses, 19 805 staff nurses and 6 434 enrolled nursing assistants)" Key challenges are changes in Curriculum and delays in the accreditation of private education institutions by SA Nursing Council. Current nurse training does not always prepare the nurses for the roles required of them within the facility (private and public sector), especially where specialist programmes do not exist. There is a dire need to improve the country's nursing capacity in terms of the number of nurses, the quality of their training and their definition. The specialist medical practitioners can facilitate the development and provision of workshops and refresher programmes for nurses with whom they work closely within their specific fields. This provides short-term and ad hoc support while other solutions are being sought. A pilot programme in anaesthesia is in development, and this will be shared with other specialist groups through the SAMA structures.

Interventions:

- There is a need to identify the gap between the numbers of nurses that currently exist in SA relative to the current need. A baseline audit of nurses will be developed as agreed between the Department of Health, South African Nursing Council, in consultation with all relevant stakeholders in both the public and private sectors.



- Existing staff do not always have the necessary specialist skills to perform their work. Short term skills enhancement workshops for nurses will be provided to the nursing staff by an accredited provider.
- Timely recognition/approval of the curriculum of accredited public and private Nursing Education Institutions by the South African Nursing Council

5.4.3 Contribute to patient-centric contractual model

There are several areas of extreme need in many provinces. Given the pressures on the public health system, the Gauteng Department of Health (GDOH) is exploring areas of collaboration with private healthcare providers and funders to relieve some areas of extreme need.

There is an absence of contracting frameworks. Contracts will be targeted at partnering with private sector providers for the provision and management of care. Contract pilots need to be measured on factors such as clinical outcomes, patient satisfaction, efficiency and cost-effectiveness to ensure a patient-centred focus.

Interventions:

- Private hospitals sector will engage with and work with the Gauteng Provincial health to the team to identify and agree on areas of need, e.g. casualty, psychiatry. The lessons learnt from Gauteng experience would be shared widely, and potential for further scale up would be explored.
- In order to contribute to a patient-centric contractual model, CPD Training on ethics, governance, coding and business principles will be developed and rolled out by SAMA on behalf of healthcare practitioners and in conjunction with Private Healthcare Information Standards Committee.
- The Department of Health will review the contracting framework after consultation with the private sector to investigate new and innovative patient-centric contracting models.
- Enhance private sector service delivery by identifying bottlenecks such as the current HPCSA ethical rules that inhibit innovative service delivery models and governance arrangements, as this will facilitate the introduction of new healthcare delivery models in the public and private sector and help take off some burden from the public sector.

5.4.4 Twinning solutions to contribute to improved management of healthcare facilities

Access to quality care in the public sector is constrained, yet the private sector has systems, processes and capabilities that can solve some of the challenges faced by the public sector. Where public health facilities are located in the same geographic catchment areas as private health facilities, there could be an opportunity to share knowledge and learnings on systems and processes between private and public and fostering these relationships could overtime also result in solutions around the delivery of patient care.

Backlog exists in many services in the public sector, which inhibits access to quality care. The spare capacity in the private sector can assist with backlog reduction. Private sector specialists are willing to work in the public sector voluntarily or service public sector patients in private facilities. However, when working in the public sector, there is no provision for volunteers they are not covered by indemnity insurance, which is necessary in order to enable such volunteer efforts responsibly. There is an absence of systems and processes to guide and manage procurement in the public sector efficiently. The private sector can lend expertise in this regard.

Interventions:

- Academics, the South African Alliance of Healthcare Professions, the private sector and the Department of Health will conduct a study to identify and prioritise areas with a need to fill the gap in the public healthcare sector.
- The Western Cape and SASA will conduct a pilot to enable private specialists to volunteer in the public sector and provide short term medical-legal indemnity for specialists volunteering in the public sector.
- There is an absence of critical principles guiding procurement. This includes procurement policies for medicines, equipment, clinical services and other goods and services. The South African Alliance of Health Professions, with input from private sector actors and the Department of Health will design principles for a procurement framework, which will include effective implementation and monitoring strategies.



5.4.5 Governance assistance based on the needs identified in specific regulatory entities

Many councils are not operating optimally, with allegations of corruption (investigations underway at the CMS, NHLS, and HPCSA) and significant organisational weaknesses, resulting in delays and inefficiencies that undermine access to quality care. There is a need to strengthen statutory health entities and councils for optimal and efficient implementation of regulations. The private sector is willing to contribute to assist such entities to be more productive. Such contribution could, by example, be in the form of systems and process enhancement, improved governance and transparency frameworks, and training. This requires identification of the priority needs and an implementable plan for private sector support. This has to be underpinned by cooperation and a commitment to expeditiously implement solutions.

Interventions:

It is agreed that through the public-private sector engagement mechanism, critical areas for improvement in several vital entities will be identified. Based thereon, the Government and the private sector will work together to provide expertise and support to address the priority needs in the following entities:

- Council for Medical Schemes
- Health Professionals Council of South Africa
- Nursing Council
- Office of Health Standards and Compliance

5.4.6 Expand healthcare access for those at school

Education and health for children and youth are inextricably entwined and a pressing need for the country in order to lift our economic and social potential. The World Bank Human Capital Index 2018 states that South Africa's economic potential is at 0.41 out of a possible score of 1, due to poor health and education outcomes.

A learner who is not healthy suffers from an undetected vision or hearing deficit, has severe dental or other diseases or who is malnourished, or who is impaired by drugs or alcohol, will not perform to their potential educational process. Likewise, an individual who has not been assisted

in the shaping of healthy attitudes, beliefs and habits early in life, will be more likely to suffer the consequences of reduced productivity in later years. This calls for a dedicated focus on care for scholars.

Despite the apparent need to prioritise healthcare access for those at school, public resources are limited, lack alignment and could better leverage the resources and contribution of the private sector. Recently tenders were awarded for the NHI priority projects which included school health services. After the tender was awarded, the budget was adjusted, and funds are no longer available to do this work.

Interventions:

- A comprehensive assessment of current initiatives and programmes is required to work towards an integrated school health programme (oral, eye care and audiology and primary healthcare nurses in schools, tooth keepers and alliance for a cavity-free future). The Department of Health, together with the Department of Education, Social Development and the South African Alliance of Health Professions will conduct the assessment; and
- The same parties will develop a coordination and tracking mechanism for school healthcare. This tracking tool will be piloted to ascertain if this can be leveraged and co-ordinated more broadly going forward.

5.4.7 Patient Education to empower the healthcare user

The lack of consistent messaging and education results in inefficiencies, the frustration of users and ultimately contribute to poor access to health services and health outcomes. Empowerment of communities and health care users, therefore, is the need for more effective resource utilisation.

Interventions:

- User education The Department of Health and the private sector will collaborate to develop information education and communication (IEC) materials on user education on their right for access to quality health services.; and
- In order to expand the production and dissemination of information, educational and communication material, the user and practitioner groups have undertaken to disseminate the materials broadly.

5.4.8 Improved processes and outcomes of medico-legal disputes

Medico-legal disputes are costly and time-consuming and result in win-lose outcomes. Alternative dispute resolution (ADR) often results in more sustainable outcomes. There is currently no legal requirement to use ADR, but a voluntary agreement to it is possible and should be encouraged.

Also, underlying causes for matters that result in medico-legal action should be better understood to address them.

Interventions:

- A task team will be constituted to develop a model for medico-legal disputes to promote expeditious, affordable and sustainable resolution of medico-legal disputes. The task team will include representatives from the Department of Health, the SA Medico-legal Association, and expert input secured from ADR experts in other fields; and
- The task team will establish an alternative dispute resolution model that can be activated voluntarily and serve as a basis for consideration in legal reform in the future.

5.4.9 Public Private Engagement Mechanism

While there are many ad hoc and a variety of engagement mechanisms between the public and private sectors, there is no formalised and legitimate structure whereby the private sector can voice concerns and align its actions to contribute to addressing the public health sector crisis coherently. This results in duplication, inefficiencies and lost opportunities to strengthen the health system. The absence of a structured engagement forum also contributes to an ineffective and sometimes circumspect relationship between the public and private sector. There is a need for a representative and structured stakeholder engagement mechanism between the private sector and the national DoH that meets at regular intervals.

Interventions:

- To provide a platform for contribution, cooperation and raising of concerns for both sides, a credible engagement structure between the private and public sector will be developed. The Department of Health and the private health sector will work together to agree on a Terms of Reference, and whereafter the structure will be constituted by the parties.
- The public-private engagement mechanism must serve to address the current health crisis and exists well into the future as a bilateral platform for consultation in the health policy development process.





5.5 Pillar 5: Improve the quality, safety and quantity of health services provided with a focus on to primary health care

Based on the inputs that were received from the nine sectors as well as the deliberations and discussions at the Presidential Health Summit held in October 2018, it was clear that South Africa needs to adopt an Integrated People-Centred Health Services (IPCHS). WHO framework is an Integrated People-Centred Health Services approach, which has two distinct components: (a) people centredness that puts people and communities, not diseases, at the centre of health systems, and empowers people to take charge of their own health rather than being passive recipients of services; and (b) Integrated health services which means promotive, preventive, curative, rehabilitative and palliative services that are organised, managed and delivered in a way that ensures continuum of care at the different levels and sites within the health system (primary, secondary, tertiary), public and private sectors and throughout the life course. Evidence shows that health systems oriented around the needs of people and communities are more effective, cost less, improve health literacy and patient engagement, and are better prepared to respond to health crises. We have thus presented the proposed interventions in line with the IPCHS framework.

5.5.1 Engaging and empowering people and communities

An empowered patient is defined as an individual who has the knowledge, skill and confidence to manage his/her health. A lack of empowerment, as a result of socio-economic factors, result in poor active engagement and participation of patients in managing their health status and care. This, on a macro level, leads to a lack of patient participation in co-producing healthy environments and accountability, creating a dependency. This strategy seeks to unlock empowerment and participation of the community and individual patients through resource mobilisation.

Interventions

1. Integrated and multi-stakeholder involvement on awareness days and national health campaigns to promote early detection of diseases and risk factors. The partners: User groups, NDOH, the Health

Professionals, Business and C4C, agreed to develop and distribute posters and health information in support of the NDOH's health campaigns. (See Pillar 4 on patient education)

2. Community engagement as to take ownership of own health and that of others living in the dedicated geographical area crossing barriers, thereby restoring dignity to such a community as a collective. The partner: Western Cape DOH's HOD and TEXCO agreed to build key health relationships.
3. Implement a social contract with society, which should serve as an advocacy and peer review mechanism to promote partnership between different stakeholders. The partners: South African Society of Psychiatrists (SASOP), the NDOH and Health Professionals, agreed to implement such a professional social contract.
4. Review clinic and other health committees and hospital boards to strengthen the representation and advocate for the inclusion/participation of community representatives, People with Disabilities (PWD), patient groups and members groups to improve governance, accountability and addressing integration with various structures and levels. The partners: User Groups, Disability Sector, Civil Society, MECs of PDOH, relevant committees and hospital boards as well as the Geostatistical Association of Southern Africa (GASA) agreed to include the groups mentioned above to facilitate better representation and decision-making by the communities.
5. Scaling up the rollout of a modified version of MomConnect called Teen MomConnect, which showed promise after being piloted in 16 clinics in the City of Cape Town, as a mHealth programme. The partners: Department of Science and Technology (DST), NDOH Health Information System (HIS), Provincial DOH (PDOHs) and Health Professionals, agreed to participate in this project to improve health behaviours among teenage mothers, identify high-risk pregnancies and Health Professionals to be trained as facilitators.

5.5.2 Scaling up community-based health services and bring care closer to people Empowering and engaging communities:

Recognising that healthcare extends beyond the boundaries of healthcare facilities, scaling up community-based health services will bring care closer to the populations and ensure that the community has access to appropriate health services.

Interventions:

- Develop spiritual & chaplaincy guidelines and competencies to address mental and spiritual health challenges. The partners: User groups, Traditional and Spiritual leaders, agreed to make resources available to assist with this process.
- Involve and mainstream spiritual, religious and traditional healers in human resource planning and service delivery, given their far-reaching presence closer to communities. It was agreed that NDOH-Human Resource for Health (HRH), User groups, Traditional Healers and Organised Labour should work together to ensure holistic patient care.
- Formalise employment status of community health workers (CHW), incorporate them in multi-disciplinary teams as well as expand their skill levels to provide appropriate community-based care, screening and referral of persons with disabilities (PWD). The partners: NDOH, Professional Associations, Civil Society, Academia and Rural health Alliance, agreed to upskill the mid-level cadres to improve the continuum of care and early referral to the relevant health services.

5.5.3 Reaching the underserved, marginalised and vulnerable populations

“A nation’s greatness is measured by how it treats its weakest members.”
Mahatma Gandhi

Vulnerable population groups such as the elderly, children, women, people with disabilities (PWD), mental health patients and people with rare diseases, find it difficult to have access to good quality and affordable health services. They often face huge out of pockets payments as the majority of conditions are not adequately covered by medical schemes or government facilities as experienced by a lack of the necessary resources.

Distributive justice refers to providing health care based on need. The neediest in our population are the vulnerable groups, therefore, focusing on the vulnerable group will reduce gaps in health outcomes while ultimately benefiting the entire society.

Interventions:

- Establish an oversight committee to uphold, promote and protect the human rights of the vulnerable population, e.g. PWD and those with mental health conditions. The partners: PDOH, NDOH, Health Professionals, SASOP and the Rural Mental health campaign agreed to establish community-based mental health and rehabilitation services.
- Build the capacity of citizens to hold service providers and government to account for health service provision for marginalised and underserved populations and to participate in health policy development processes. The partners: User groups and Health Professionals agreed to build the capacity of citizens to effectively participate as they serve in governance structures and what to expect from health services and policies.
- Promote equitable access to essential health products and services for the vulnerable groups by:
- Improving access to medicines for rare diseases and those required by the most vulnerable populations by assigning weights during scientific review and inclusion on essential medicine lists (EML). The partners: South African Medical Association (SAMA), Pharmaceutical Society of South Africa (PSSA), Health Professionals and Rural Doctors Association of SA (RUDASA) agreed to provide access to clinical guidelines and SAMA will provide the EML list to their members on their website.
- Proposed Medical Schemes Amendment Act and Prescribed Minimum Benefit (PMB) review should consider the health needs and priorities of vulnerable populations, recognising the need to expand coverage for mental health, rare diseases and the unique challenges faced by people living with disabilities and the elderly. The partners: Business (Private health Funders), NDOH, Council for Medical Schemes (CMS) agreed to review PMB benefits and legislation to ensure that all funders continue paying for all PMB conditions.



- Ensuring that the health system is responsive to people living with disabilities and that their needs are taken into consideration when health packages are developed. The partner: NDOH, the Health professionals and User groups, agreed to advocate for including PWDs' needs at all times.
- Capacitate Disabled Peoples Organisations to enable them to identify key focus areas for action, mobilise effectively, sustain activities and engage meaningfully in policy areas affecting them. The partners: Disability Sector and User groups, agreed to engage with policymakers.

5.5.4 Reorienting the model of care: Defining an essential package of health services based on life course needs

WHO conceptualises an integrated people-centred framework which the Compact adopts. This approach involves appraising the package of health services offered at different levels of the care delivery system based on the best available evidence, covering the entire life course. It uses a blend of methods to understand both the particular health needs of the population, including social preferences and the cost-effectiveness of alternative health interventions, guiding decision making on the allocation of resources to health care. It also includes a health technology assessment.

Quality health outcomes and health planning are negatively affected due to the lack of evidence-informed package of health services for various levels of care. Coordinated research protocols, employed health researchers and a dedicated budget for health, rehabilitation & palliative research to provide evidence-based quality outcomes.

Service delivery packages are not always accessible or suitable to address the needs of the population and therefore needs to be redesigned. Prioritisation on District level must include local community primary healthcare practitioners and should not only be academic driven. Access to initial rehabilitation at primary, secondary and tertiary levels for PWD will need to be accommodated.

This approach means appraising the package of health services offered at different levels of the care delivery system based on the best available evidence, covering the entire life course. It uses a blend of methods to

understand both the particular health needs of the population, including social preferences and the cost-effectiveness of alternative health interventions, guiding decision making on the allocation of resources to health care. It also includes a health technology assessment.

Interventions

- Define at all levels of care, a cost-effective and affordable package of health services based on health technology assessment using national and global best practices for prioritisation. The partners: Western Cape DOH's HOD and TEXCO in collaboration with the NDOH and Health professionals agreed to participate in defining health packages based on the needs of the population in the Western Cape.
- Implement evidence-based standard clinical guidelines across to improve quality, safety and efficacy in addressing the health needs of the population.
- Promote a multi-disciplinary approach for the management of common diseases, including palliative care, across all levels of care, including considering the HPCSA rules to allow for these alternative delivery models.
- A multi-disciplinary approach must also be applied mainly for rare diseases, cancer, organ transplantation and mental health

The partners: Statutory Councils, NDOH, National Treasury (NT), CMS, Business, Academia, Organised Labour and the Western Cape DOH agreed to promote multi-disciplinary approach nationally

- Enhance/expand existing research to evaluate South Africa's burden of disease, risk factors and population health needs. The partners: DST, Medical Research Council (MRC) Academia and Health professionals agreed to initiate and participate in research projects.
- Implement a specific prioritisation exercise for District, Regional and Central hospital care, with a generalist, specialist and rehabilitation service focus, and clear, scientifically driven criteria for prioritisation and selection of - specialised care intervention. The partners: Western Cape DOH's HOD and TEXCO in collaboration with the NDOH

and Health professionals agreed to participate in prioritising highly specialised care in the Western Cape.

- DSP relationships between medical schemes and the state must demonstrate that access to health care will not be to the detriment of the public patient.
- Identify bottlenecks – such as the HPCSA ethical rules that inhibit innovative service delivery models and governance arrangements to ensure the introduction of new delivery models.

The partners: CMS, Business and NDOH, agreed to investigate the cost-effectiveness of DSP arrangements as a Managed Care tool.

5.5.5 Building reliable primary healthcare-based systems in both the public and private sectors

The lack of standardised South African evidence-based clinical guidelines, protocols, conflicting policies or aspects of policies, policies developed in silo and no or very little inter-sectoral collaboration between various departments e.g., Department of Basic Education (DBE), Department of Social Development (DSD) and the NDOH, affect the implementation at primary care level. Consequently, it influences the quality of care provided to the population of South Africa (SA).

A lack of early engagement and integration of Disability & Rehabilitation (D&R) into all levels of policy planning and implementation across the various departments and programmes resulting in these services being greatly excluded from health provisions.

There is a lack of policies and guidance for the formation of Public-Private Investments (PPIs) on central procurement purposes to ensure competitive pricing, affordability and accessibility on all levels of care.

Interventions

- Enforce current prescribed minimum benefit regulations to ensure adequate funding of the chronic list of PMB conditions at PHC. The partners: Health professionals, CMS and User groups agreed to continue supporting PMB review process, benefits definition including subject to affordability, PHC as a PMB and advocate for consultation with PWD.

- Expand access to primary health care through contracting with approved private providers to enhance coverage and better patient outcomes. The partners: Statutory Councils, private sector, Health professionals, Organised Labour, NT and PDOHs agreed to investigate possibilities to improve access to PHC.

5.5.6 Coordinating services for a continuum of care: Coordinating individuals, health programmes and providers

Care coordination is fragmented. Currently, there is not an integrated, streamlined and standardised referral system between the different levels within the public sector and between private and public sector health professionals and facilities, which increases in waiting times, interrupted health services, duplications, inefficiencies and poor outcomes. The partners: Health professionals, NDOH & PDOHs, Organised Labour, Statutory Councils, Traditional healers, User groups, Business (private funders) and health Entities agreed to the introduction of an integrated and streamlined referral system in health.

Interventions

- Develop and implements guidelines on referral between public and private sector as well as between different levels of care (primary, secondary, tertiary) in the public sector. The partner: NDOH agreed to develop guidelines for inter-referrals within the health system in collaboration with Business and Health Professionals.
- Standardised protocols and referral letters to improve communication between Healthcare Professionals (HCPs). The partners: Health professionals and Traditional Healers agreed to initiate protocols and referrals letters.
- Develop a database of existing health services offered in each district at all levels, including private facilities and non-profit organisations. The partners: User Groups, Business and Health Professionals agreed to provide the necessary information for the database to be included in the Health Information Systems development by NDOH.
- Improve access to National Health Laboratory Services (NHLS) test results for the patients and providers to improve efficiency and reduce wastage. The partner: NDOH agreed to collaborate with NHLS on this matter.



- Implement mechanisms to facilitate referral of patients involved in road accidents to a nearest appropriate health facility- public and private. Correct registration and triage of patients will ensure appropriate case management with the Road Accident Fund (RAF). The partners: RAF agreed to collaborate with NDOH, Health Professionals and Business agreed to collaborate with the RAF for effective triage of patients.
- Develop and implement robust management tools (including system-wide information and technology and data management capacities) to monitor and enhance health systems management through training, innovation and research. The partner: DST agreed to develop a management tool.
- Facilitate implementation of the District Health System Strategy as detailed in the 2018-2022 policy document, including strengthening of the District Management Teams and District Clinical Specialist Teams. The partners: PDOHs and their Districts in collaboration with the NDOH agreed to implement the policy.

5.5.7 Coordinating across sectors

The different government departments such as health, social services, finance, education, Labour, housing, the private sector and law enforcement, among others, are working in silos and often relevant policies contradict each other. The health system is thus not functioning optimally. It necessitates strong leadership from the Health Ministry and the Presidency to coordinate intersectoral action, including coordination for early detection and rapid response to the health crises and effectively mitigate the critical social determinants of health.

Interventions

- Build networks of relationships with multiple health actors, to build trust in the health system. Establish inter-sectoral partnerships within each province, and across all levels, to address social determinants of health. The partners: Western Cape DOH, Health Professionals, Civil Society, NDOH and User groups agreed to build these relationships and restore trust in the health system.
- Integrating traditional and complementary medicine with the modern health system to improve cooperation between health professionals providing health care. The partner: The Statutory Councils agreed

to facilitate recognition between different stakeholders to improve access to care.

- Training of health professionals to respond to needs of the society, technology and burden of disease.

The partners: Health Professionals, Academia, Statutory Councils, User groups and Traditional Healers agreed to engage in the relevant training required actively.

5.5.8 Addressing health determinants; Prioritising promotion, prevention and public health

Health outcomes are poor, and health expenditure is high due to focus on hospital-based curative services rather than addressing the health determinants such as environmental determinants of health, the effect that mining and industry have on the health status of the surrounding communities and municipalities' poor state of waste, environmental and water management.

Interventions

- Work collaboratively with other sectors to effectively manage the critical social determinants of health; this includes addressing health aspects in other sectoral policies or what is known as 'Health in All Policies'. It is agreed by stakeholders in the health sector, that the Presidency is the only entity that has the power to facilitate collaboration between different government departments.
- Work with line ministries and communities to identify mechanisms for mitigating against the harmful effects of environmental determinants hazards arising from mining and other industries (notably coal, fracking, water pollution, pesticides). The partners: Civil Society, Department of Trade and Industry (DTI), and the Department of Environmental Affairs (DEA) agreed to improve the health status of the surrounding communities.
- Collaborate with Municipalities to improve the state of waste management, environmental management and water management. The partner: Local governments agreed to improve and the general poor status of environmental management affecting the health of the users.

- Utilise mobile, school and community based oral health education, awareness, screening and basic preventive vectors to implement oral disease surveillance control and appropriate referral pathways – partner with existing programs to spread the reach into communities. The partners: South African Dental Therapy Association (SADTA) agreed to collaborate with the Department of Basic Education (DBE) and the User groups to improve appropriate service delivery to target communities with disease surveillance and measurable health outcomes.
- Develop a partnership with the ToothKeepers organisation (currently approved by National Oral Health Consultative Forum) by utilising the digital education and health promotion tools viz: ToothKeepers – Keep Teeth for Life initiatives to boost people-centric ownership of oral health – incentivising oral health behavioural change in individuals and communities. The partners: SADTA agreed to lead the process in collaboration with the DBE, User groups and the ToothKeepers organisation to boost behaviour modification and better oral health outcomes – keeping teeth for a Lifetime.

5.5.9 Creating an enabling environment: Conduct appropriate research to inform the health transformation agenda

It is necessary to create an enabling environment that brings together the different stakeholders to undertake transformational change. This is a complex task involving a diverse set of processes to bring about the necessary changes in legislative frameworks, financial arrangements and incentives and the reorientation of the workforce and public policy-making. Multiple stakeholders, as mentioned below, agreed to collaborate, participate and work together to enable the environment for an effective health system in SA.

Quality health outcomes and health planning can be improved with coordinated research protocols, employment of health researchers and with a dedicated budget for health, rehabilitation & palliative research to provide evidence-based quality outcomes.

Interventions

- Establish a research agenda for health in SA across universities to ensure context specific management of rehabilitation, hospital and

specialist services for ease of access, quality, frequency and cost-benefit analyses. University therapy departments to collaborate with therapists on the ground level to test and pilot different service delivery models. The partners: The DST, Health professionals, Universities (Academia and DHET), User groups, Civil Society and the MRC agreed to participate in setting the research agenda for SA.

- Continue with epidemiological research to determine the burden of Non-Communicable Diseases (NCDs), infectious diseases in a community and the burden of disease amongst youth and persons with risky behaviours. The partners: The Mpumalanga DOH, Family physicians, Organised Labour, and the DST agreed to collaborate in the research as mentioned above.
- Allocate sufficient financial and human resources for research of the health needs in South African public hospitals and research institutions to:
 - o Include vaccine development, women and child health, precision medicine for South African populations, and the use of indigenous therapeutics. The partner: DST agreed to initiate this process.
 - o Ensure health researchers are employed to do research development and coordination of research protocols for quality outcomes. The partners: DST, MRC and Academia, agreed to work together with National Treasury for funding for such employment.
- Perform studies of medico-legal cases to establish the reasons and costs of medico-legal cases to identify the problem areas, training needs and to develop a remedial plan to reduce these costs. The partners: Academia and Health professionals agreed to lead this project.
- Development of collaborative research with a focus on epidemiology, health systems strengthening, health financing aspects, Health Technology Assessment (HTA) at the district hospital and PHC levels of care. The partners: The DST, Health professionals and Universities agreed to participate in research projects making use of Decentralised Training (DCT) site clinicians using students for data collection.
- Development of a South African medical device and diagnostics cluster to enhance local innovation and production opportunities. The partner: DST and critical stakeholders in the industry have

come together and have decided to formalise this industry support and coordination role through the establishment of a Technology Innovation Cluster Programme for the industry.

5.5.10 Striving for Quality improvement and safety

Patchy and fragmented implementation of norms and standards of all health facilities and service delivery result in long waiting times, poor outcomes and dissatisfied patients. A coordinated quality improvement plan, including monitoring and evaluation indicators, should be implemented in all health facilities.

Interventions:

- Map and harmonise all the quality improvement initiatives in the health sector, e.g., the norms and standards set by the Office of Health Standards Compliance (OHSC), National core standards, Ideal clinic and hospital, disease-specific evidence-based guidelines, Council for Medical Schemes (CMS) quality of Managed Health Care, into a unified system and nationwide Quality improvement plan with a single Monitoring and Evaluation (M&E) and budget framework. This should build on existing initiatives and other key recommendations such as the SA National Lancet Commission, OHSC findings, the Health Quality Assessment (HQA) and CMS findings. The partners: NDOH, OHSC, Health professionals, Human Science Research Council (HSRC), Academia, PDOHs, Business, MpuDOH and National Treasury agreed to participate in working towards harmonising all quality improvement initiatives.
- Implement the National coordinated Quality Improvement Plan in all health facilities, especially at the PHC level, with regular monitoring and evaluation in progress towards universal health coverage. The partners: NDOH and Academia agreed to lead this process.
- Ensure adequate capacity and resources at OHSC to perform its mandate. The partners: Business, OHSC, National Treasury, MpuDOH and NDOH agreed to work together in building capacity at OHSC.
- Revise the District Health Information System indicators, by developing a set of indicators to monitor the quality of care appropriate for each level of care (e.g. TB, HIV, diabetes, cancers, and hypertension). The partner: NDOH Health Infrastructure System (HIS) agreed to lead this process.

- Implementation of registries for specialised services (e.g. arthroplasties). The partner: Health professionals agreed to lead this process.



5.5.11 Reduce the incidence and impact of malpractice and medical litigation

Medico-legal and litigation cases are increasing with costs escalating an alarming rate. There are numerous reasons for this such as the incompetence of health professionals, specialist needs not addressed at district hospital level, red tape delaying the turn-around time in purchasing or repairing critical medical equipment, emergency services without any tracking systems in ambulances to prevent abuse and improve accountability/visibility, poor record keeping, loss of files and documents and lack of accountability.

Interventions:

- Conducting an assessment into supply and demand side factors contributing to increasing rates of medico-legal litigations, compared with private sector statistics and assess the private sector strategies to mitigate these factors.
- Consider feasibility and establishment of a “No Fault Fund.”
- Addressing the identified root causes of the medico-legal crisis, e.g. insufficient staff numbers, procurement and management problems.
- Introduce mechanisms for mediation as a first effort in the settlement in medico-legal cases
 - o Providing clinicians as mediators for State medico-legal claims (See pillar 4).
 - o Developing a database of accessible experts and developing ethical standards to guide the experts. In developing the database, it is imperative to ensure that rural communities are adequately covered.
 - o Improve health services in general in public hospital to reduce the magnitude of litigation and to provide adequate health care to affected parties.

- o Increasing competencies of health professionals to prevent litigation.

The partners: National Department of Health, provincial health departments, Statutory Councils, Academia and Health professionals, Professional Associations, Civil Society and Business agreed to collaborate to decrease medico-legal expenses.

5.5.12 Aligning regulatory frameworks

Regulation plays a crucial role in establishing the rules within which professionals and organisations must operate within a more people-centred and integrated health system. Furthermore, SA has suffered the ill-effects of regulatory disharmony. To be people-centred means that legislation needs to be reviewed to benefit society.

Interventions

- Institute a full organisational review of the legislation about health and propose new governance and administrative structures. The Mayosi Task Team recommended that consideration be given to the unbundling of the HPCSA into at least two entities: the historic Medical and Dental Council (which constitutes a third of the current membership of the HPCSA) and a Health and Rehabilitation Council (for the rest of the professional membership of the HPCSA). The partners: SAMA and other Professional Associations agreed to lead this process.
- The office of the Ombudsman: must be separated from the OHSC to ensure independence, transparency and good governance as presented in section 4.6.9. The partner: Minister of Health is the only person who would be able to separate this function in collaboration with the Office of the Health Standards Compliance in particular.
- Develop a policy and guidelines on public-private investments (PPIs) with an emphasis on contract for primary health care delivery. The partners: Professional Associations agreed to collaborate with the PDOHs and the NDOH as well as the private sector, to develop such a policy.
- Reduce the duplicative role of two HPCSA boards that regulate oral health in SA into one cohesive board that regulates the oral and dental professions in one board. The partners: SADTA agreed to lead discussions with HPCSA, NDOH and the National Oral Health

Consultative Forum of Dental Deans (Academia) to reduce the regulatory costs and the interprofessional conflict in Oral Health.

- Merge the Oral Hygienist and Dental Therapist professions into a single midlevel oral health resource Oral Health Therapist – new category (keeping with global trends) to effectively and efficiently address the primary oral healthcare needs of South Africans. The partners: SADTA agreed to collaborate with NDOH and the Committee of Dental Deans (Academia) to develop skills and save costs on training.
- Implement the South African human resources policies for Oral Health to increase primary oral healthcare providers in addressing the current biomedical oral health approach to oral disease containment and prevention and remove mandatory in-service training for dentists. The partners: SADTA agreed to lead the discussions for implementation with NDOH and the Committee of Dental Deans (Academia).



5.6 Pillar 6: Improve the efficiency of public sector financial management systems and processes

5.6.1 Improve health sector capacity to effectively manage the public sector financial management and address corruption and wastage

Insufficient capacity exists in the National and provincial health departments and health entities to address the challenges of financial management in the sector. Accruals have arisen because of inadequate skills, systems and funding levels.

Interventions:

- Set up a unit to prevent and address corruption and wastage in the health sector both at national and provincial levels. This unit should work closely with the Special Investigative Unit, which is currently addressing corruption in the health sector.
- Capacitate the critical staff in NDOH and provinces to effectively manage the public sector financial management (PFM) function. This should include the expertise to reform and continuously revise the budget breakdown within health, the ability to negotiate improvements with National Treasury and the ability to address corruption within the health sector.
- National Treasury will develop a PFM training programme
- Implement an extensive training programme, and the recruitment of skills for the provinces is necessary to ensure that the high levels of accruals do not arise in the future.

5.6.2 Fund the accumulated accruals in the provincial health budgets

Urgent attention must be given to address accruals (unpaid debts rolling over from the previous financial year) in the Provincial Health Departments and to ensure that management processes are in place to prevent a recurrence. The high levels of accruals mean that provincial departments would spend all available cash for the financial year before the end of the year. The North West and Gauteng Treasuries have partially addressed the

issue of accruals. Accruals must be addressed by the provincial treasuries as well as the National Treasury. Leaving this responsibility to the provincial treasuries alone is unlikely to resolve this issue. The combined accumulated accruals in provinces are approximately R14 billion; unless provinces address the issue of accruals, there will not be meaningful improvements in the delivery and quality of health services.

Interventions:

- The National Treasury, together with the NDOH and provincial treasuries must address the issue of accruals over a period of three years as per the package of measures contained in the Joint Action Plan proposed by the National Treasury. The plans include measures such as PDOF and PT accrual intervention strategies, better alignment of procurement plans to approved budgets and cash flow projections, and expansion of the financial management improvement programme managed by the National Department of Health.
- Specific funds must be allocated to cover the accumulated shortfalls as soon as acceptable control mechanisms are in place to avoid recurrence.
- Funding from provincial and national treasuries and management plans from provincial health departments must be in place to ensure the eradication of the backlogs.

5.6.3 Improving funding and reforming payment systems

Budget allocation is not in line with best practice and integrated care resulting in poor service delivery and patient outcomes.

Interventions

- Introduce a budgeting and payment system that prioritises promotive and preventative health care and allows for the functioning of multi-disciplinary teams.
- Centralise procurement of certain services and equipment.
- Ensure appropriate use of standardised provincial ring-fenced budgets.

The partner: National Treasury agreed to work with health stakeholders to improve budgeting based on integrated care and best practice.

- Provincial budgets to allocate sufficient funding for implementation of Multi-Disciplinary Teams (MDT), including Revisions of Health Professions rules that prohibit implementation of MDTs for Primary Health Care. The partners: Statutory Councils agreed to revise ethical rules for inclusion of MDTs and PDOHs and NT agreed to evaluate provincial budgets to fund for PHC services in their provinces.

5.6.4 Equitable allocation of budgetary resources across national, provincial and district levels

The public health sector is underfunded, and the allocations between provinces and allocations to health by provincial legislatures have led to inequities between levels of care and between provinces. There is a wide variation across the provinces in the proportion of the equitable share allocated to health, leading to inequities across provinces. On average, 37% of provincial budget allocations are for healthcare; the percentage allocated for healthcare varies from 26% in North West up to 46% in Gauteng. This results in a per capita allocation that varies from R2,402 in North West up to R3,982 per person per year in the Free State. This variation may be explained by the differences in demographics, in disease distribution, and Medical scheme membership across the provinces. The level of variation amongst the provinces from the average must be explained, or mechanisms must be developed to ensure that funds are spent per national health policy.

Also, the system of earmarked, conditional grants and indirect grants placed on the respective components of provincial budgets restricts the optimal allocation of available resources. The equitable share has not been reviewed for a long time, and the current allocations are outdated. The review needs to be open and transparent and adjusted for internal migration between provinces. The Task Team considers it to be more important than the entire health allocation be reviewed as health sector funding has had real declines in the last decade and has lagged behind the growth in the budgets for basic and higher education.

Intervention:

- Review the existing provincial equitable share formula and update this based on a standardised and transparent approach taking into account the epidemiological, health systems, demographic and other key variables to ensure that the provinces receive funding according to context and need.
- Conduct a review of the budget allocation for the health function nationally across the public sector, including allocation of budgets across provinces, municipalities, districts, and hospitals.'
- Conduct a review of the legislative powers of provinces to allocate the budget for health appropriately.
- Provide technical expertise to national and provincial health departments and treasuries to conduct such a review.
- Conduct a review to determine the optimal system for integrating the equitable share with conditional grant funding, earmarked funding and indirect grants to provinces. Such a review must be led by National and provincial treasuries with the involvement of the national and provincial health departments. This should be an open and transparent process
- Explore the development of stronger policy-making instruments, including legislation for ensuring that provinces implement policies of the national department.
- Conduct a scientific review, National and Provincial Treasuries and Departments of Health to set national standards for health funding that must be applied in all provinces.
- Department of Health and National Treasury will monitor the redirection of medical budgets to non-medical expenditure by introducing tracer studies.

5.6.5 Review the efficiency of HIV and other Conditional Grants

The HIV Conditional Grant has become unwieldy and now constitutes earmarked funding for HIV, TB, Malaria and Community Outreach Services, in the amount of R19 billion. The grant purpose and size needs evaluation and review.

**Intervention:**

- Review the system of conditional grants to improve the functionality of provincial management teams. The process should consider whether a fixed percentage (e.g. 32%) is desirable rather than the current Provincial Equitable Share formula or a range of say between 32 and 38 per cent or a more scientifically defined range. Research must be done to determine what a “fair share” is in consideration of the fact that the level other demands may vary from province to province
- Conduct a review of the HIV conditional grants, which now includes TB, Malaria and Community Outreach Services for the effective financial management of priority programmes. Review of conditional grants, i.e. structure, level of funding (especially considering PEPFAR report). This is to ensure improved coordination of grant funding.

Donor funding is not used optimally and is not integrated into the mainstream budgeting process. There is chronic under expenditure in many donor-funded programmes in the health sector. Donor funding is also subject to unpredictable changes in the level of support. The recent decision by PEPFAR to reduce its allocation to SA by US\$200 million in the next Country Operational Plan (COP) cycle is a case in point wherein the country is not given sufficient time to plan for such declines in donor funding leading to a disruption of critical programmes.

Interventions:

- Optimise the use of donor funding in the health sector
- There needs to be a comprehensive review of donor funding and the allocation of donor funding to the health sector with a view to their integration into the overall budgeting system within the public sector;
- Technical review of donor funding and better coordination of donor funding by Treasury and NDOH; and
- The needs to be better planning and active management of donor-funded programmes so that donor funding can be more predictable and sustainable.

5.6.6 Improve the financing and management of Central Hospitals and the training of health professionals including specialists

The central hospitals, tertiary services and training grants have not changed for the last two decades, and an urgent review is needed. The changes to these grants must be made in the context of a holistic review of the governance and planning for the central hospitals and medical schools and the human resource needs for the training of specialists, medical, nursing and allied health professionals, as proposed by the Academics and Research Task team. Consideration must be given to integrated training in the private sector as many of those who graduate from undergraduate and postgraduate programmes end up in the private sector. This may deprive the public sector of employing registrars and affect access to services for the majority of the population. The resolution of RWOPS in central hospitals is an integral part of addressing the financial woes of the central hospitals. Underfunding and poor management and planning of central hospitals and the training platform.

Interventions:

- A special multi-stakeholder task team needs to be constituted to review the governance of the central hospitals together with their teaching platforms;
- The level of funding for central hospitals and the teaching and training platform needs to be urgently reviewed together with the conditional grants that are associated with these services; and
- Review of financial allocations, staffing, equipment and infrastructure needs of central hospitals and delegations of authority to hospital and university leadership.

5.6.7 Increase public sector hospital revenue

Public sector hospital revenues are negligible. It is essential that the public sector attract paying patients who are members of medical schemes if and where surplus capacity exists. A key challenge is the lack of appropriate billing systems and administrative skills required to get revenue from medical schemes. This is the most effective way of bringing private, post-tax resources into the public sector. Hospitals, especially the central

hospitals, are well placed to attract private patients by offering quality services at competitive prices.

Interventions:

- Public sector facilities must create special arrangements that will be attractive to paying public sector patients or out of pocket paying patients. This includes increased capacity to bill medical schemes correctly for services rendered, the creation of effective funding streams through low-cost medical scheme options, and PPPs whereby public and private facilities are utilised for low-cost medical scheme options.
- Improve the administration to bill and receive payment from medical schemes and from out of pocket payments. The accountability is with the National Department of Health.

Collaboration will be between the user groups, Council for Medical Schemes, the private sector and the National Department of Health.

5.6.8 Optimise the funding needs of health entities, institutions and Health Ombudsman

Public Entities in the health sector such as the NHLS, SAMRC, SAHPRA, OHSC, CMS and the CCOD are essential components of the public health sector. These entities have good potential to improve their roles and their contributions to the effective functioning of the health system, both private and public. Currently, budgets for these entities are largely based on their historical allocations.

Interventions:

- The level of funding of these institutions needs to be reviewed together with the review of the budget allocations to the national health sector and the provincial and municipal health services;
- An objective system of determining the allocation of resources to these entities needs to be established. The current system of historical budgeting needs to be reformed; and
- An objective mechanism involving the Treasury and NDOH should be established to accurately assess the requirements of entities and ensuring adequate resources to carry out their mandates fully.

5.6.9 Strengthen the Office of the Health Ombudsman

The Office of the Health Ombudsman is under-capacitated to fulfil one of the most critical functions in quality improvement. The current budget of the Health Ombudsman is R8 million per annum, and the staff complement is two. Despite being one of the essential functions in the improvement of quality in the public health sector, the funding level for this institution is minuscule. The DPSA has determined that the Health Ombudsman should have a staff complement of 113 and a budget of R133 million to be phased in over five years.

Interventions:

- This situation needs to be addressed and the funding to the Office of the Health Ombudsman should increase from its current level of R8 million to R16 million in the next financial year and then to R32 million and R64 million in the following years to achieve its full funding level by year 5;
- Implement the decision of the DPSA on the funding of the Office of the Health Ombudsman over the next five years; and
- Treasury, the NDOH and the OHSC should work together to address this situation.





5.7 Pillar 7: Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels

5.7.1 Strengthen accountability mechanisms at the national, provincial and institutional level within the current Constitutional framework

Each of the three levels government: a national government; nine provincial governments; and 278 municipality governments/councils, is semi-autonomous and structures and capacities differ across and within these levels, making the uniform implementation of national health policies, norms and standards and strategies an arduous task. The other problem identified by the task team is that the current workforce is not adequately skilled or competent for the leadership roles they have been tasked with. This has led to poor service delivery as well as a lack of accountability for the management of the healthcare providers. A coherent and harmonised national framework is required to strengthen accountability mechanisms.

Interventions:

- The National Department of Health should review its organisational structure to ensure a harmonised reporting structure from national to provincial levels.
- The recruitment policies and processes should also be reviewed to ensure that competent and skilled incumbents are recruited into the healthcare system;
- Develop training modules and offer to the incumbents who would entail strengthening the capacity of high- level managers and policy makers in health diplomacy, stewardship and business acumen. The training on leadership offered to the incumbents should also be monitored and evaluated to ensure that it is appropriate. The training should also address succession planning, mentoring and ethics; and the National Department of Health with support from the Presidency is accountable for this intervention. The objective is

to ensure that challenges associated with political appointments without consideration of capability are addressed.

- Conduct a review of the legislative frameworks and develop a proposal for structural reforms aimed at One Nation One Health System Policy.
- Policy options need to be identified to tackle remunerative work outside of service (RWOPS) including the provision of adequate funding to deter the incumbents from conducting remunerative services outside of their permanent placement. This would ensure that the incumbents are focused to providing quality healthcare to the patients as well as being available for the day to day running of the facilities; Statutory Bodies and National Department of Health are accountable for this intervention.

5.7.2 Provide practical policy guidance across the health sector

A number of the healthcare sector governance structures in the country are not functioning optimally. This is because these governance structures are not being held accountable for their lack of performance.

Interventions

- Revision of transport policy and working collaboratively with the Department of Transport to improve access to all levels of health care and reduce travel costs borne by vulnerable populations, including PWD, school children and the elderly. The partners: The Department of Transport, User groups, Health Professionals, PDOH, Department of Basic Education (DBE), Business, Rural Health Advocacy Project (RHAP), Rural Rehabilitation of SA (RuReSA) and NDOH agreed to advocate and collaborate for more user-friendly and cost-effective patient transport to ensure access to care.
- Conduct a review and update of existing health strategies and financial policies. This would ensure policy coherence within across the levels of Government - from national to province and Local Government.
- Develop a detailed Annual Performance Plan, which is aligned to National Health Strategy with clear deliverables and line budgets at all levels. This would assist in ensuring accountability for the performance of all structures within the health sector, which in turn would result in properly functioning governance structures.

- Conduct a review of the existing roles and responsibilities of each level of Government as well as appointed boards, and other health entities.
- Propose a clear separation of political versus administrative mandates/ delegation of authority---politicians must have oversight but not get involved in the administrative execution of policies.
- The Department of Health to develop and legislate instruments to deter political interference in the governance structures of the health care sector. This would ensure the autonomy of the governance structures and thus hold them accountable for the management of the structures within their leadership. The accountability is with the National Department of Health with oversight by the Presidency.

5.7.3 Ensure effective oversight through robust health information, research and evidence

The health information systems are fragmented, Granular data on health inequities is not routinely captured, and the evidence from research and survey data does not necessarily inform the policy process. There is no National Health Observatory set-up as a data warehouse to centrally capture and store health data from conventional systems, research community and other departments to monitor trends in the health sector. At the same time, regular health policy and strategy reviews or sector-wide assessments are required to inform course corrections.

Interventions:

- Strengthen the National Health Research System to be capable of generating knowledge and new products for promoting, restoring and maintaining health while also feeding into the policy process aimed at existing health needs;
- Build on the existing national platforms to establish a standardised National Health Information System with interoperability capacity, the capability of capturing and sharing institutional as well as patient-level data across the nation (levels of care, provinces, departments, public-private).
- Establish mechanisms for information and data sharing from the private sector (hospitals, medical schemes and other health industries), so that it can feed into health decision making and priority setting process

5.7.4 Address Corruption Decisively

The health sector in both the public and private sectors is most vulnerable to fraud and corruption because of large and varied numbers of transactions on goods and services in terms of fraudulent orders, tender irregularities, fiscal dumping through NGO's, bribery, over-pricing, poor governance, transfer of liabilities to the state, and bogus and fraudulent qualification. In the public sector, a lack of adherence to PFMA and transparent transactions in line with Supply Chain Management Policies in awarding of tenders for services to be rendered at the healthcare facilities. This is due to a lack of an apparent conflict of interest policy and declaration thereof mechanism. A whistle-blowing policy should be developed to ensure the ease of reporting to relevant authorities. Political interference should also be considered as a corrupt activity.

Interventions:

- The Department of Justice should implement the use of specialised criminal courts for the investigation and adjudication on corruption? by the matters.
- Support strategic interventions that have been identified by the Special Investing Unit through the Health Sector Anti-Corruption Forum to foster collaboration and cooperation to combat fraud and corruption
- Put in place mechanisms to minimise political interference in procurement matters

5.7.5 Update and reinforce health sector regulations to improve quality, transparency, accountability and efficiency in the Health sector (Public and Private)

While some health system and its components have explicit norms and standards, some of them are archaic or not comprehensive enough to meet the current health system requirements which create fragmentation and confusion with different stakeholders using different benchmarks, norms and standards. The current health regulatory environment should, therefore, be reviewed and updated to ensure that it addresses the lack of common standards. Uniform standards would also assist in guiding the policymakers and professionals as well as protecting the public interest

Interventions:

- A review of the current health regulatory environment should be conducted and proposal of updates to the regulatory frameworks governing health sector including- service delivery, pharmaceuticals, medical products, IT systems, technology and artificial intelligence be made.

- Harmonise and align the work of the development partners and NGOs towards the achievement of national health outcomes.

5.7.6 Coordination across the health sector and building strategic partnerships

As per the available literature, up to 70% of all health conditions are preventable by addressing the social, environmental, economic and political determinants of health. Several sectors can have direct positive or negative impacts on health, including food, beverage, alcohol and tobacco industry, road transportation and law and order, housing and urban planning, industries and telecommunications (amongst others). Therefore, it is vital for the health sector to engage with other sectors and address health issues in their policies- often termed as 'Health in all policies.' At the same time, South Africa's regional, continental and international leadership role necessitates it works with relevant structures to deal with public health emergencies, workforce migration and cross-sharing of knowledge and health information to forward its cause but also championing health in the region.

Interventions:

- Establish platforms and mechanisms for working with other department and sectors and addressing health aspects in their policies to address the social, environmental, economic and political determinants of health, including public health emergencies and antimicrobial resistance. Strengthen South Africa's regional, continental and international leaders working with relevant structures to deal with public health emergencies, workforce migration and cross-sharing of knowledge and health information The accountability is with the National Department of Health with support from the Department of International Relations.
- Establish a 'Health Stakeholder Platform' to strengthen engagement between key stakeholders including community, academia, private sector, health professionals/workers from various cadres to identify innovative means for strengthening health systems



5.8 Pillar 8: Engage and empower the community to ensure adequate and appropriate community-based care

Community engagement is an effective method for promoting participation and empowering communities among a wide range of health and non-health benefits. The evidence from developing and developed countries show that Community Engagement is one of the essential pillars of the people-centred health system, and therefore, it also forms one of the core tenets in NDP 2030.

The National Development Plan (NDP) foresees the active involvement of citizens in their development processes – this it terms ‘active citizenship’. As a result, the NDP proposes that the state actively supports and incentivises citizen engagement to advance development within communities and hold the government to account.

According to the Reconstruction and Development Program (RDP), communities must be encouraged to participate actively in the planning, managing, delivery, monitoring and evaluation of the health services in their areas.

The South African Constitution, through section 27 states as follows “Everyone has the right to have access to 27(1)(a) health care services, including reproductive health care and 27. (3) No one may be refused emergency medical treatment”. This constitutional imperative provides a platform for the implementation of a patient centred universal health coverage that will include views and a clear role for communities.

WHO notes the importance of Essential Health Care based on practical, scientifically sound and socially acceptable methods and technology 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 .

Key Challenges Identified

- The communities and populations are often not consulted in the organisation of health services about their health needs and expectations from the health systems.
- Although the patient charter and feedback system exist, these are not working optimally
- The community health programme is uncoordinated and has no clear standards and guidelines. The community health programmes provided by Non-Governmental Organisations most often lack coordination and compliance monitoring to ensure the safety of the users of the services.
- Referral and outreach services, including poor road infrastructure and shortage of fleet (e.g. ambulances), are also a critical area of concern which impacts on the health and safety of communities.
- Furthermore, public education about universal health coverage has not been prioritised to ensure a well-informed citizenry as South Africa readies itself to discuss the nature and form of its option through the National Health Insurance (NHI)

5.8.1 Strengthen Governance capacity of bodies involving communities

Lack of investment in capacity building of Hospital Boards and Clinic Committees to strengthen accountability and performance has rendered them mostly dysfunctional. The politicisation of Hospital Boards and Clinic Committees is also at the centre of sub-optimal governance of health facilities. Transparency in budget allocation and non-involvement of stakeholders in the budgeting process deters strong governance. Additionally, there is a perception of inadequate stakeholder involvement in health decision making despite a provision in the National Health Act.

Interventions:

- Review the governance structures (Clinic and Hospital Boards) and asses performance in health service delivery at Community, District & Provincial levels



- Develop capacity building programmes and training tools for those serving on Hospital Boards & Clinic Committees in order to better discharge their responsibilities;
- Assess the budgetary allocations for governance structures (Clinic and Hospital Boards) and align them for adequate functioning of these bodies at Community, District and Provincial levels; and
- Hold government accountable and ensure it hosts annual district, Provincial and National Consultative Summits on health with appropriate community engagement.

5.8.2 Monitoring, Evaluation & Compliance

A community-oriented and easy to use monitoring and evaluation system does not exist, which makes it difficult to ensure quality health provision at all levels. Similarly, regular compliance checks against the agreed norms and standards are not fully institutionalised with community involvement. Additionally, the community-based programmes involving community health workers are not well monitored.

Interventions:

- Strengthen and improve quality of care services through a practical and non-politicised multi-stakeholder Clinic Committees and Hospital Boards and any other structure that may be established to strengthen the health system.
- Establish platforms for regular engagement between end-user groups and health professionals (multi-disciplinary) especially in rural and primary health care contexts- and while developing policy, monitoring tools and guiding strategies. This will ensure people-centred health strategies and maximum buy-in
- Regularly update community interventions and approaches based on the latest evidence and research and monitoring and evaluation;
- Monitor the community health workers' compliance with the prescribed SOPs for service delivery, M&E and any other assigned functions

5.8.3 Training and Education of community health workers and health professionals

Inadequate availability and appropriately trained health personnel contribute to the inefficiencies that continue to beset the provision of health care. This is exacerbated by the inequitable deployment of appropriately trained personnel to all health facilities, especially those in rural areas. There is an inadequate or no clinical supervision of CHW and poor understanding of the critical role of WBOTs in health delivery. There continues to be resistance to changes to the curriculum by academia to address the current health challenges. Clear leadership from government and academia in re-orientating undergraduate training of health care professionals towards multi-disciplinary primary health care practice is urgently required and cannot be left in the theoretical learning space. Substantial financial investment is required to optimise the decentralisation and inclusivity of the undergraduate training platform.

Interventions:

- Integrate and re-orientate undergraduate health professionals training to PHC and community engagement, including the expansion and resourcing of decentralised training platforms and an emphasis on multi-disciplinary team training. The government will coordinate activities for this intervention. Participation will include Civil Society, Private Sector, Academia and Statutory Bodies
- Clinical supervision by multi-disciplinary health professional teams integrated into the work of CHW's to ensure efficiency and effectiveness of delivery of services;
- Review of WBOT's composition to strengthen multi-disciplinary input & include user groups (linked to HRH pillar no 1);
- Advocate for curriculum review that includes interpersonal communication for all health professionals and should form a vital part of all undergraduate and postgraduate modules; and
- Establish and resource a task team with support from the private sector to consider needs, contribution, training and financing of Community Health Workers (CHW), including their role in early childhood development, care of people with disabilities and elderly care in collaboration with professional bodies in health.

5.8.4 Community Health Services

Social determinants of health play a significant role in health outcomes. An overall lack of integration across and within government departments as well as with Traditional Authorities, Traditional and Allied Health Practitioners and the Religious Sector at the community level poses a significant challenge to holistically addressing many of these social determinants, as well as the participation of community groups in service planning and delivery. Resistance to the training, deployment and funding of posts for the specialised cadre providing mental, spiritual & disability health services reduces health to only being the absence of disease, against the WHO definition that includes mental and social well-being components as well. South Africa continues to prioritise curative health at the expense of preventative/ social & behavioural health approach.

Interventions:

- Advocate for a specialised cadre of community health workers specialising in health services that focus on mental health, spiritual well-being and disability specific interventions including peer support. Civil society is accountable for this intervention with participation from Labour, patient advocacy groups & Health Professionals.
- Household mapping by CHWs and HCPs at the community level to ensure real-time household data per area with which to make informed health service delivery decisions and monitor outcomes-mapping through using apps;
- Integrate spiritual care workers & services in health care delivery to ensure up-scaling and sustenance of education and adherence to treatment from a spiritual point of view;
- Enable meaningful engagement and input by patients on ongoing solutions to improve health services (user groups);
- Meaningful integration, engagement and use of traditional health and allied (complimentary) health services as options available to public users; and
- Promotion of preventative health services at all levels of the health system (primary, secondary, tertiary and quaternary health). (Acknowledgement of primary, secondary and tertiary levels of prevention and the role that the multi-disciplinary team, including peer support/ complementary/ traditional and spiritual health practitioners, have in ensuring this).

5.8.5 Enhance Health literacy for better outcomes: Enhance health literacy and use of technology for better health

Poor adherence to treatment by patients results in sub-optimal results when it comes to epidemic control, especially in anti-retroviral treatment for people living with HIV and TB. We need to turn the tide and ensure that there is involvement of family and community members and leaders in promoting adherence to treatment. The delays in implementing unique patient identifier to help track and follow patients must be addressed with great speed to assist the efforts of using technology tools in tracking patients. Persistent lack of acknowledgement of the needs of vulnerable groups, the disengagement with civil society groups and health policy which remains rooted in the biomedical model produces a policy which addresses a limited set of needs.

Interventions:

- Promote healthy behaviours for the prevention of disease and risk factors National Department of Health is accountable for this intervention with support from Health Professionals and Civil Society
- Enhance adherence to treatment (medication, checkups and lifestyle) by all patients (HIV, TB, Mental Health, NCDs & people with disabilities, realising that each client may have multiple comorbidities) through patient education and regular follow up;
- Public education and campaigns on health budget literacy by public user groups and other stakeholders;
- Champion a Social & Behavior communication for health using all communication platforms (such as social media, radio, television, community dialogues, newspapers, IEC materials);
- Improve understanding of universal health coverage amongst communities through ongoing health education to the public and ensure monitoring of outcomes;
- Collection and use of data by community health workers, health managers and health personnel, facilities, not-for-profit organisations providing health services (CBOs, NGOs, FBOs, Private Sector) noting issues of confidentiality regarding patient data



5.8.6 Referral and Outreach Systems

Community health workers (CHWs) form the interface between community and health. The success of the latest primary health care (PHC) strategy relies on the availability of a regulated, competent, dedicated, supported and capacitated CHW cadre. The availability and acceptability of services at the clinic and district hospital level and the ability of multi-disciplinary staff to provide adequate outreach support are also imperative to the functioning of this critical cadre. Without up to date community data, it is unlikely that any strategy will be successful.

Government has implemented systems like Sukuma-Sakhe in KZN and the CCMDD referral system that have demonstrated successes while there are some challenges identified. Other alternative referral and outreach systems have been developed by civil society, the private sector and academia. It is essential to reflect on lessons learnt to improve to a single system that all stakeholders can use for maximum uptake and impact. Creation of competing systems rather than strengthening existing referral systems results in wastage of resources and efforts. Disempowerment of local level management through the centralisation of resources and critical management functions, as well as a dysfunctional complaints system, have further eroded community trust in achieving outcomes resulting from their engagement with management.

Interventions:

- Development and use of appropriate referral and outreach systems to enhance the provision of treatment (e.g. CCMDD). National Department of Health is accountable for this activity with support from Health Professionals, Private Sector, Civil Society, Labour, Traditional Health & Allied Health Professionals
- Establish a Call Centre manned by trained Call Centre agents from user groups to provide the first layer of compliance and referral to ensure ongoing advice and support for patients;
- Improve management and deployment health resources like ambulances through using mobile applications as a means available to public users to improve efficiency and effectiveness; and
- Use Apps to provide specialist clinical support to front line health workers

5.8.7 Inter-Sectoral Collaborations

Fragmentation of platforms between local government and health sectors risk duplicating efforts and further weaken inter-sectoral collaboration. Resistance by different stakeholders to meaningfully collaborate has resulted in opportunities for turning around the health system. This multi-stakeholder approach will ensure that prevention becomes key in planning to avoid people having to seek medical attention for things that could have been prevented early on.

Interventions:

- Advocate for and promote inter-sectoral collaboration between government (within government and between spheres of government), civil society and business to improve the provision of health services;
- Use existing community structures to ensure and improve patients' safety & safety of the health professionals and facilities;
- Improved collaboration between Department of Health at all levels and the other Government departments (including water, mining and energy and environmental affairs) is critically needed. These partners should form part of any prevention/ promotion/ screening drives and campaigns). It is an acknowledgement of the social determinants of health, for example, the impact of climate and environmental mismanagement that contribute to acute and chronic diseases; and
- Regular independent assessments of infrastructure and health facilities (hospitals and clinics) fleet roadworthiness and quantity/ appropriateness of outreach vehicles to ensure patient and staff safety.

5.8.8 Partnership

Various stakeholders that formed part of the Presidential Health Summit in October 2018 and through further engagement in the Community Engagement Task Team have agreed to contribute to fixing the health system as part of community engagement. The stakeholders agreed that they would use their goodwill and resources (financial, human, intellectual, networks and infrastructure) to actively engage in the processes of unifying

the health system. These stakeholders that will work with government are the following: Civil society, Health professionals, Private sector, Traditional Health & Allied Health Practitioners, Organised Labour, User Groups, Academia and Statutory Bodies.





5.9 Pillar 9: Develop an Information System that will guide the health system policies, strategies and investments

The current health information systems, within both the public and private health sectors and between these two sectors, are fragmented. This is a missed opportunity for the development and implementation of an effective, efficient and quality health information system that guide South Africa's policies, strategies and investments for health. Digital technologies provide concrete opportunities to tackle health system challenges, and thereby offer the potential to enhance the coverage and quality of health practices and services (WHO, 2019).

The exponential growth in health digitisation and digitalisation over the past two years presents a strategic opportunity to put South Africa on a positive trajectory towards universal health coverage. The implementation of digital health technology will require the combination of health digitisation and digitalisation.

The implementation of Digital Technologies in the South African Health sector requires several interventions along with the following themes

- Integrated Health Information System (Patient and Management).
- Standardisation of health diagnostic and procedure coding systems, taking into account a multiplicity of such systems
- Improving the healthcare technology infrastructure and architecture platform.
- Capacity building and skills transfer for Digital Health.
- Development of business intelligence for the Health Sector.

5.9.1 Integrated Health Information System (Patient and Management)

The development and implementation of an integrated health information system focussing on both the management of the system and the patient will bring efficiency and efficacy gains and quality to the health system.

This will require a structured and coordinated approach between all stakeholders that will allow for building on current investments and developments. Although automation will assist in achieving a robust information platform, we must err on the side of caution that automation is not the silver bullet (as per WHO digital health guideline).

The integration of information systems will require that the Health Normative Standards Framework (HNSF) which was gazetted in 2014 and is currently (2019) under review should form the basis for facilitating interoperability between different systems. This should be governed and supported by the Health Information Exchange (HIE).

Interventions:

- Recognising that there are many disparate systems implemented across the health system, a baseline assessment is required to assess the current health information systems being implemented, identify existing best practices and expertise, and perform a gap analysis. Results of this baseline assessment will feed into the development of a strategy and plan for an integrated health information system.
- All sectors will collaborate and share critical lessons learned on patient information, sharing from collaborative projects across the health sector, including input from users with a view to:
 - o Prioritise policy development and implementation that focus on data governance, privacy and information security
 - o Ensure a patient-centric approach in the implementation of strategic ICT solutions and projects.
 - o Ensure interoperability between the various health information systems using the normative framework for interoperability and by developing a position paper on a South African Health Information Exchange Service.
 - o Reach agreement and assurance on matters related to the protection of personal information and cybersecurity.
 - o Implement the Master Patient Index (Health Patient Registration System) develop an identity management solution that will

- o facilitate access to, and seamless provision of relevant government social services.
- o Integration of patient information systems in the Health Sector and the future development of an Electronic Health Record will require as a minimum the development of registries with unique identifiers for Health Population Beneficiaries, Health Care Services Providers and Health establishments.
- Ensure interoperability of health information systems and identify solutions for social, ethical and legal issues related to data sharing with patients to facilitate the availability of health records at the point of care.
- Establish partnerships to build capacity to conduct relevant research, development and innovation for health information systems and digital health, particularly leveraging technologies associated with the fourth industrial revolution.

5.9.2 Standardisation of diagnostic and procedure coding systems

The South African Healthcare system is characterised by a lack of uniformity in the use of intervention coding systems for diagnostics and procedures as well as billing purposes. There is also a discrepancy between public and private sector in the use of coding systems for standardisation of diagnosis and billing. Public facilities are often unable to charge for services rendered due to a lack of effective billing systems. A lack in interoperability of health-related billing systems can also lead to fraud, missed opportunities to generate and collect funds from specific categories of patients and medical aids as well as the potential abuse of the billing systems.

Interventions:

- The National Department of Health is to coordinate a stakeholder forum to discuss and reach consensus on the standardisation of the health diagnostic and procedure coding in the health systems to:
 - o Implement a harmonised WHO classification for topographical, diagnostic (general and specialised), procedural, pharmaceutical and outcome coding across the health system including but not limited to the transition of revised systems, e.g. ICD-10 to ICD-11, the introduction of International Classification of Health Interventions (ICHI)

- o Establish a national health diagnostic and procedure coding authority.
- o Support the public health sector hospitals to optimise the use of Digitised Billing Systems
- o Modernise and improve interoperability of health-related billing systems.
- o Develop and implement compatible disease-based registers, contributing to surveillance of the burden of disease.
- o Develop a medical and rehabilitation interventions, medical devices, assistive devices, technologies and claims registry within the health sector.
- Advocate for standardisation of clinical guidelines and protocols and its use to inform health diagnostic and procedure coding across the health system to improve efficiencies and health outcomes.

5.9.3 Healthcare technology infrastructure and architecture

Healthcare technology infrastructure in South Africa is characterised by the adoption and use of different hardware platforms, connectivity, operating systems, software solutions and standards. Many health facilities in rural areas have poor or no access to reliable connectivity, ICT infrastructure and affordable data. This places an immediate constraint on effective digitisation of healthcare.

Interventions:

- Advocate for and render technical assistance in a Health Information System baseline assessment across the health sector to determine what infrastructure is available, broken, location (levels of care), functionality and connectivity.
- Conduct an analysis of current Health Information Systems Contracts at various level in the Public Health sector (What contracts are in place and the status of these contracts)
- Reach agreement on high-level architecture design or blueprint of an integrated Health Information System, incorporating the findings of the baseline assessment, including technical requirements and standards. This architecture design will incorporate the audit findings of the health information systems as described under the preceding section



- Develop a national dedicated wide-area network (WAN) that support health information systems and its uninterrupted availability across the country;
- Support the establishment of Public-Private Investments (PPI) with regards to the rollout of the essential IT infrastructure (hardware and software) with redundancy at all points of health care following the outcome of the baseline assessment.
- Reach consensus between all role players in the health sector on acceptable data centres and hosting environments within the parameters of the current legislative framework (i.e. cloud-based, on-premise or hybrid hosting).
- Harness healthcare technology infrastructure towards addressing the needs of the previously disadvantaged and poor by:
 - o Developing fit for purpose mobile platforms which consider the uniqueness of the South African landscape, aiming to provide access to users with and without smartphones (mobile web-based as well as Unstructured Supplementary Service (USSD),
 - o Implementing reverse charge billing to overcome data costs as a barrier to access and considering connectivity/data access and digital literacy constraints in all geographical locations.
- Advocate for dedicated maintenance funding for all ICT systems including hardware and software maintenance, backup services for load shedding and power outages, infrastructure management, information security, backup and disaster recovery services.
- Improve accessibility to health information systems by patients and health care professionals, through the implementation of innovative technologies, such as patient care portals with a point of care devices as part of a telemedicine platform and use of mobile technologies.

5.9.4 Capacity building and skills transfer for digital health

The effective digitisation of healthcare will require a workforce and consumer base, adequately skilled in the effective use of implemented health technology and systems.

Interventions:

- Identify available Health Information System skills and expertise and training requirements across the health sector as part of the baseline assessment.
- Engage with stakeholders and identify constraints and concerns around the use of technology to identify actions for improving uptake.
- Prepare for a unified Health Information System by:
 - o Undertaking digital health literacy to ensure the readiness of stakeholders (provider and users)
 - o Identifying core competencies required, including necessary IT skills, and
 - o Considering an incentivisation scheme for quality participation in the process.
- Develop agreed in-service training programs and ongoing support to ensure correct capturing of codes at the point of care.
- Scale-up the implementation of the Knowledge hub (as the eLearning platform) to make training more accessible and save on costs for in-service training.
- Engage the institutions of higher learning to align the supply and demand of digital health skills in the health sector.
- Identify training needs for the provision and maintenance of IT equipment on all levels to ensure optimisation and longevity of IT infrastructure and capacitate different role players with the requisite knowledge.

5.9.5 Development of business intelligence for the health sector

With the continually increasing number of data sources and systems as well as the complexity of data generated within the health sector, the need for advanced analytics to support decision-making is growing. Healthcare is increasingly dependent on digital technology to support the operations of a well-functioning health system.

Health managers and providers need an environment that supports the daily practices of decision-makers, clinicians and support staff in their endeavour to save lives and optimise the allocation and utilisation of limited resources.

Business Intelligence for healthcare is critical to managing the massive amounts of both structured and unstructured data that health care providers and facilities deal with daily. The quality, standardisation and accessibility to data for data mining, analysis and reporting across the health sector, is still in some areas fragmented, inequitable and uncoordinated.

Interventions:

- As part of the baselines assessment of the Health Information System, identify business intelligence (BI) report requirements in close collaboration with relevant stakeholders and drafting of BI Report specifications. Ensure the inclusion of all relevant existing health-related data systems, currently contribution the policy development, implementation and monitoring, in the baseline assessment.
- Consider all relevant legislation, policies and frameworks to ensure the development of an integrated Health Information System compliant with data requirements for Business Intelligence.
- Develop a centrally shared Business Intelligence portal, that allows for Business Intelligence Reports that include:
 - Monthly morbidity and mortality (clinical) audit conducted. Findings will inform improvement plans for Primary Health Care and Hospital services.
 - Incorporating feedback from data contained in the Health Information System Registries (beneficiaries, providers, facilities and disease-based registries) to improve health policy and planning.
 - Support health-seeking behaviour and decision-making as well as stewardship of the South African population as users of the health system;
 - Predictive analytics to support decision-making and policy development to improve impact and health outcomes based on trends from various data sources





6. COMMITMENTS TO STRENGTHENING THE SOUTH AFRICAN HEALTH SYSTEM

6.1 Current Monitoring and Evaluation Landscape in the South Africa Health System

The Social Compact assigns to the Department of Planning, Monitoring and Evaluation (DPME) the responsibility for the development of an M&E Framework. The Social Compact considers the evaluation of the performance against the objectives of the Compact as a fundamental ingredient that fosters accountability, promotes good governance and improves program performance. It can help deepen democracy by creating conditions for holding governments accountable for performance and increasing transparency. The Social Compact further states that: “When the evaluation of the programme is undertaken, it will be critical to consider the historical and current political, economic and social context, especially given the changes taking place in South Africa. This type of monitoring and evaluation is expected to be complex because there are multiple partners with different political dynamics, institutional arrangements, and technical capacity. Therefore, the monitoring and evaluation system to be established will become a powerful learning tool”. This is fundamental to the design of the M&E system.

The Social Compact outlines several attributes for assessing the utility of the M&E Framework, namely:

Independence - which generally refers to freedom from political influence, and organisational pressures. The United Nations Evaluation Group (UNEG) states that an Evaluation is said to be independent when its objectives are free from undue influence and has full authority to submit reports directly to the appropriate levels of decision-making bodies. This implies that Government and stakeholders must not impose restrictions to DPME on the scope, context, comments and recommendations.

- **The credibility of Evaluations** - generally depends on the expertise and independence of the evaluators, the degree of transparency of the evaluation process and the quality of the evaluation outputs. DPME will be required to design and implement evaluation system, utilising National and International quality standards and must make explicit the methodology for data collection, analysis and interpretation. It must be carried in an ethical way respecting data integrity with no manipulation of the results to influence conclusions unduly.
- **The utility of Evaluations**- for the DPME evaluation to have an impact on the Government and Stakeholder decision-making it must be perceived as relevant, useful and clearly and concisely presented and should fully reflect the interests and needs of different stakeholders. The Government and its partners will judge DPME’s evaluation of the Compact by the extent to which it assesses the impact of the interventions on the improvement of the functioning as well as the quality of the health system.

In its seminal publication entitled Monitoring, Evaluation and Review of National Health Strategies, WHO (2011) emphatically states that the prerequisite for a sound monitoring, evaluation and review platform is a comprehensive and robust National Health Strategy. WHO (2011) further asserts an excellent national health strategy, in terms of its Joint Assessment of National Strategies (JANS), is one that is:

- based on sound analysis and response to the context;
- has been developed in a transparent and participatory process with multi-stakeholder endorsement;
- is accompanied by a sound financial and auditing framework and plan;

- specifies arrangements and systems for implementing and managing the programmes in the national strategy; and
- relies on country-led monitoring, evaluation and review mechanisms.

Except for the sound financial and auditing framework, the Social Compact from the Presidential Health Summit complies with the WHO criteria outlined above. In its current form, the Social Compact has 324 interventions. The detailed Action Plans consist of 52 themes, 433 actions (including sub-actions) and 105 responsible stakeholders. While government officials and representatives of the private sector, civil society and other stakeholders can jointly monitor all these activities, a truncated, high-level set of priorities will have to be identified, implemented, monitored and reported on to the principals.

6.2 Current Monitoring and Evaluation Landscape in the South Africa Health System

A legal framework for Monitoring and Evaluation exists in the South African health sector. The National Health Act of 2004 (Section 74) empowers the national department of health to facilitate and coordinate the establishment, implementation and maintenance of the information systems by provincial departments, district health councils, municipalities and the private health sector at national, provincial and local levels in order to create a comprehensive national health information system. The Act further empowers the Minister of Health to prescribe the categories or kinds of data for submission and collection and the manner and format in which and by whom the data must be compiled or collated and must be submitted to the national department. This section of the National Health Act has not yet been promulgated, as it requires specific regulations.

National Treasury Regulations issued in terms of the Public Finance Management Act (PFMA, Act 1 of 1999) of 1999 require Accounting Officers of institutions to establish procedures for quarterly reporting to the executive authority to facilitate effective performance monitoring, evaluation and corrective action. The PFMA of 1999 also empowers Treasury to require Strategic Plans and Annual Performance Plans from government departments and entities. This function has since been transferred to the DPME

A mechanism that is immediately available to the Presidency, after 08 May 2019, is the Performance Agreements between Ministers and the President. Commitments made in the Social Compact could be infused into these Agreements, Premiers could be requested to do the same with MECs for Health. However, to achieve this, even at a political level, the Social Compact must reflect any hierarchy of the desired results, focusing on impacts. This would require the prioritisation of the required interventions and actions. Clear timebound targets would also have to be set, including quantitative, measurable and relevant targets.

6.3 Reporting on Progress

It is much easier to create a basic monitoring system by creating logical linkages between interventions, actions and outcomes than to ensure reporting by all stakeholders on their commitments. Ensuring reporting in-between high-profile events such as the Presidential Health Summit has previously proved to be formidable, mainly where stakeholders are not legally accountable to one another. Therefore, it is proposed through DPME that activity-based reporting, in which each of the stakeholders assigned responsibilities produce and submit progress reports to the Presidency, on a bi-annual (6 monthly basis), based on their commitments and actions they undertook to complete. This monitoring and evaluation framework will be reviewed quarterly by the Joint Technical Monitoring Team, convened by the Presidency, at which representatives of the stakeholder formations review progress towards the undertakings made in the Social Compact, identify blockages and design remedial interventions.

PILLAR 1: AUGMENT NATIONAL HUMAN RESOURCES FOR HEALTH PLAN

KEY INTERVENTIONS	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Costing and finalization of the Human Resources for Health (HRH) Strategy and Plan	Quantify the number of current healthcare professionals in the health system by discipline.	Report on the quantification and cost implications of the National HRH Strategy and Plan	December 2019	Lead: National DoH Support: Provincial DoHs Private Sector Organised Labour
	Cost the National Human Resources for Health (HRH) Strategy and Plan 2019-2024 to ensure that the policies on funding and staffing meet the needs of the health system.			
	Finalise and disseminate the National HRH Strategy and Plan 2019-2024	Human Resources for Health Strategy published	December 2019	Lead: National DoH Support: Provincial DoHs
	Track equity in the distribution of Human Resources for Health between Provinces and Districts (in both public and private sectors)	Institutionalise Health Workforce Accounts and report on equity in the provision of HRH across Provinces and Districts	Annually (5 annual reports produced from 01 September 2020 to 01 September 2024)	Lead: National DoH Support: Provincial DoHs
Development of effective Human Resources for Health Policies	Lift moratorium on posts in the public health sector with priority placed on critical services	Moratorium on posts in the public health sector officially lifted	December 2019	Lead: National DoH Support: Provincial DoHs
	Conduct a review of the HRH governance arrangements across spheres of government to ensure compatibility with the NHI policy and Bill	Report on HRH governance arrangements across spheres of government completed	April 2020	Lead: National DoH Support: Provincial DoHs Statutory Health Councils
	Ensure that statutory requirements for internship and community service are met	Annual plan for the placement of interns and community service candidates	September annually starting 2019	Lead: National DoH Support: Provincial DoHs Statutory Health Councils Health Professionals

PILLAR 2: ENSURE IMPROVED ACCESS TO ESSENTIAL MEDICINES, VACCINES AND MEDICAL PRODUCTS THROUGH BETTER MANAGEMENT OF SUPPLY CHAIN EQUIPMENT AND MACHINERY

KEY INTERVENTIONS	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Implement Centralised Procurement of Medicines and Medical technology	Establish a centralised procurement and logistical management system with standardised procurement systems and processes at the national level for medicines and medical products	Policy on centralised procurement finalized and adopted by the National Health Council	April 2021	Lead: National DoH Support: National Treasury Provincial DoH Provincial Treasuries Academia Private Sector
Training/Human Resource Capacitation	Establish joint support training programmes to improve the supply chain skills amongst supply chain officials.	Number of joint support training programmes established	Nine programmes by April 2021 (one in each Province)	Lead: National DoH Support: Pharmacy Council South African Nursing Council and Pharmaceutical Industry Private sector
Regulation and Registration	SAHPRA will, through a collaborative process re-engineer regulatory processes to reduce unnecessary bureaucracy, reduce delays in the registration of products and value innovation, thereby providing reasonable access to safe, effective and affordable products.	Reduction in the average time frame for the registration of products. Clear current backlog. Implement reliance model.	Dec 2019	Lead: SAHPRA Support: National DoH Private sector
Development of a Health Technology Assessment Strategy	Develop a Health Technology Assessment Strategy and costed implementation plan	Health Technology Assessment Strategy developed and costed, with an implementation plan An independent HTA Agency established	Dec 2020 April 2022	Lead: National DoH Support: National Treasury Schools of Public Health, User Groups, Private Sector
Public Private Partnerships to Indigenisation of Pharmaceutical Production	Explore options for collaborative partnerships for pharmaceutical production	Off-take agreements signed by the National DoH with Ketlaphela State-owned Pharmaceutical Company	April 2020	Lead: Ketlaphela State-owned Pharmaceutical Company Support: Science and Technology; National DoH; Trade and Industry (DTI); Public Enterprises, Academia

PILLAR 3: EXECUTE THE INFRASTRUCTURE PLAN TO ENSURE ADEQUATE, APPROPRIATELY DISTRIBUTED AND WELL-MAINTAINED HEALTH FACILITIES

KEY INTERVENTIONS	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Strengthen Health Infrastructure Planning to ensure the construction of appropriate health facilities on a sustainable basis	Review and update the 10-Year National Health Infrastructure plan.	Updated 10-Year National Health Infrastructure plan approved by the National Health Council	April 2020	Lead: IUSS (NDoH/CSIR/DBSA) Support: Provincial DoH private sector
	Conduct Annual audits of equipment in all public health facilities to identify shortages (against standard lists)	Annual Report on Audits of equipment in all public health facilities	Annually, from April 2020	Lead: IUSS (NDoH/CSIR/DBSA) Support: Provincial DoH Health Governance Structures
	Review the policy on accountability for public health infrastructure and clarify responsibilities of the Department of Public Works and DoHs	The revised policy presented to the National Health Council	April 2020	Lead: National Health Council will engage with National Treasury and the Department of Public Works to clarify. Support: Private Sector
Improve Health Infrastructure Delivery and ensure that health infrastructure is completed on time, without additional costs to the original budgets and meets the need for the services required	Implement the Infrastructure Delivery Management System (IDMS) in all health departments	Infrastructure Delivery Management System implemented in all health facilities (100%)	IDMS implemented by all 9 Health Departments in all health facilities by 2022/2023	Lead: National DoH Support: Provincial DoHs National Treasury Private sector
	Explore alternative funding sources and mechanisms for the development and maintenance of public health infrastructure	Report on alternative funding sources and mechanisms for public health infrastructure (including a National Health Infrastructure Fund) presented to the NHC	April 2021	Lead: National DoH Support: Provincial DoHs National Treasury Private Sector

PILLAR 4: ENGAGE THE PRIVATE SECTOR IN IMPROVING THE ACCESS, COVERAGE AND QUALITY OF HEALTH SERVICES

KEY INTERVENTIONS	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Expand training of medical specialists and other cadres as required to meet country needs	Conduct a baseline audit of medical specialists in South Africa to quantify the gaps between existing supply and existing need.	Terms of Reference Final Baseline audit report submitted to the National Health Council (NHC)	May 2019 December 2020	Lead: National Academic Institutions Support: HASA, DoH, Colleges of Medicines, Academic Institutions Private Health sector
	Create a platform for the job training of specialists through rotation in the private sector to enhance public sector capacity	Proposal and plan for the training of medical specialists	December 2019	Lead: National DoH Support: BUSA, HPCSA, Academics
Bolster the training of nurses to meet country needs	Conduct a baseline audit of nurses in South Africa to quantify the gaps between existing supply and existing need	Final Baseline audit report submitted to the National Health Council (NHC)	September 2019	Lead: National DoH Support: Academic Institutions Private Health sector
	Create a platform for the private sector to contribute more to training of nurses in the public sector	Address constraints for private sector to support training.	November 2019	Lead: National DoH Support: Academic Institutions SA Nursing Council BUSA and private Health sector
Share knowledge and learnings on systems and processes in healthcare facilities	Identify where public facilities are located in same geographic catchment areas as private facilities. Identify and contribute to backlog reduction.	Interventions to reduce backlog or contribute to patient care identified with related intervention plan.	Annually	Lead: HASA Support: DoH Alliance of Health Professionals Health Funders Association
Develop capacity to resolve medico-legal disputes through alternative dispute resolution (ADR)	Establish a task team of experts to develop a framework for voluntary ADR Develop capacity for ADR	Framework for voluntary alternative dispute resolution.	April 2020	Lead: Academics Support: SA Medico-legal Association Private Sector DoH
Develop a Public Private Engagement Mechanism	Develop a platform for contribution, cooperation and reflection between the public and private sectors	Terms of Reference for a coordination structure between the public and private sector established	November 2019	Lead: National DoH and BUSA

PILLAR 5: IMPROVE THE QUALITY, SAFETY AND QUANTITY OF HEALTH SERVICES PROVIDED WITH FOCUS ON TO PRIMARY HEALTH CARE.

KEY INTERVENTIONS	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Quality Improvement Plan	Map and harmonise all the quality improvement initiatives in the health sector and develop an integrated National Quality Improvement Plan	Number of public sector facilities implementing the National Quality Improvement Plan	80% by 2022 100% by 2024	Lead: National DoH Support: Provincial DoHs
Provide patient-centric health services that meet the needs and expectations of users	Conduct annual Patient Experiences of Care (PEC) surveys in the public sector	Number of Provinces conducting PEC surveys	All 9 Provinces	Lead: Provincial DoHs Support: National DoH Academics and Research Organizations (HSRC and MRC)
	Monitor levels of patients' positive experience of care in the public services	Percentage of patients reporting a positive experience of care in the public sector	Increase from 76,5% in 2017 to 90% in 2022 Increase to 95% in 2024 76,5% of patients reported a positive experience of care	Lead: Academics and Research Organisations (HSRC and MRC)
Improve access to health care for priority populations and conditions	Implement priority projects to promote access to care for vulnerable groups (e.g. cancer treatment, high-risk maternity)	Define and implement projects with measurable outcomes through direct contracts or PPIs.	100% by April 2021	Lead: Council for Medical Schemes and National DoH Support: Provincial DoHs Private sector
	Ensure that all medical schemes pay fully for all Prescribed Minimum Benefits (PMBs)	Complete the PMB review process		Lead: Council for Medical Schemes Support: Private sector User groups

KEY INTERVENTIONS	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Reduce Medico-legal claims and litigation	Conduct an assessment into supply and demand side factors contributing to increasing rates of medico-legal litigation and addressing the identified root causes	Report into the root causes of medico-legal litigation outlining interventions to curb the scourge	December 2020	Lead: National DoH Support: Provincial DoHs Academia Health Professionals Private sector
Achieve Inter-sectoral collaboration to address social determinants of health	Work collaboratively with other sectors to effectively mitigate the effects of key social determinants of health	Percentage of government policies assessed through the DPME SEIAS system which include addressing health aspects – under Health in All Policies’	50% increase in government policies that reflect “Health in all Policies” by April 2022 100% increase by April 2024	Lead: National DoH Support: Department of Planning Monitoring and Evaluation (DPME)

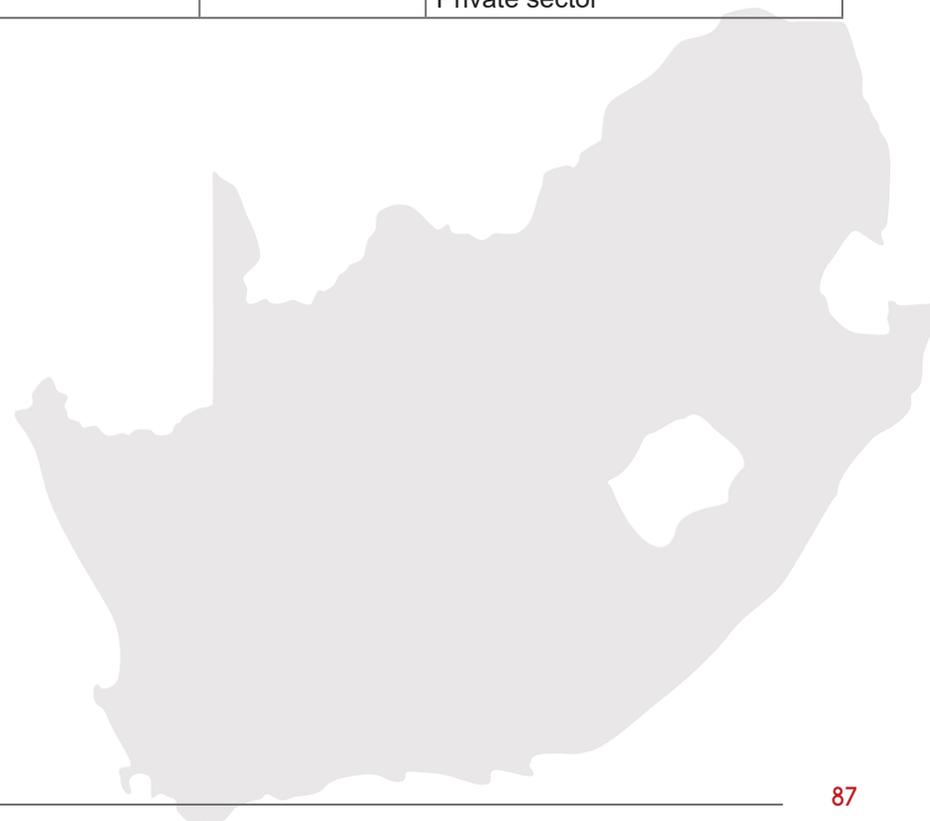
PILLAR 6: IMPROVE THE EFFICIENCY OF PUBLIC SECTOR FINANCIAL MANAGEMENT SYSTEMS AND PROCESSES

KEY INTERVENTIONS	KEY ACTIVITIES	INDICATORS	TARGETS	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Reduce accumulated accruals in the provincial health budgets	Develop a three-year plan for reducing provincial accruals	A three-year plan for reducing accruals approved by National Health Council	Plan finalized and approved by December 2019 Accruals reduced incrementally by 30% in 2020/21; 60% in 2021/22 and 90% in 2022/23	Lead: Provincial DoH Support: Provincial Treasury National DoH National Treasury
Reduce corruption and wastage in the health sector	Establish a dedicated unit in the National DoH to prevent and address corruption and wastage in the health sector	Dedicated fraud prevention unit established in the National DoH	December 2020	Lead: National DoH Support: Special Investigations Unit (SIU)
Equitable allocation of budgetary resources across national, provincial and district levels	Review the resource allocation to the health sector in conjunction with National and Provincial Treasuries, taking into account the epidemiological, health systems, demographic and other key variables.	Report on the review of resource allocation to the health sector, including Public Entities completed	April 2020	Lead: National Treasury Support: National DoH
	This should include a review of resource allocation to Public Entities: NHLS, SAMRC, SAHPRA, OHSC, CMS and CCOD	Resource envelope of the health sector revised upwards, based on key variables	April 2021	Provincial DoH Provincial Treasury Support: Special Investigations Unit (SIU)
Restructure the HIV Conditional Grant	Review of the purpose, effectiveness and volume of the HIV Conditional Grant. Review the decisions to include TB, Malaria and Community Outreach Services in this grant. Review the system to approve and monitor business plans.	Completed review report of the HIV Conditional Grant	Implement report recommendations on HIV Conditional Grant by March 2022	Treasury, the NDoH and CFO Forum

KEY INTERVENTIONS	KEY ACTIVITIES	INDICATORS	TARGETS	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Improve the financing and management of Central Hospitals and the training of health professionals including specialists	<p>Establish multi-to review governance of the central hospitals together with their teaching platforms.</p> <p>Review of financial allocations, staffing, equipment and infrastructure needs of central hospitals and delegations of authority to hospital and university leadership.</p>	<p>Completed report on management and funding of central hospitals by March 2020</p>	<p>Implement new governance arrangements and funding, staffing and infrastructure levels to ensure service levels and training obligations for the country are met by 2022.</p>	<p>NDoH, Treasury, provincial DoH and Committee of Deans</p>
Strengthen the Office of the Health Ombud	<p>Increase of funding for the Health Ombud. Health Ombud to report directly to Parliament</p>	<p>Increase funding to Health Ombud from R8m to R16m in 2020/21 and R32m in 2021/2022.</p> <p>Fully funded Health Ombud in 5 years.</p> <p>Approve legislation to transfer accountability of Health Ombud to Parliament</p>	<p>Funding increased to a level that fully funds the Health Ombud over 5 years</p>	<p>Treasury, the NDoH and the OHSC</p>

PILLAR 7: STRENGTHEN GOVERNANCE AND LEADERSHIP TO IMPROVE OVERSIGHT, ACCOUNTABILITY AND HEALTH SYSTEM PERFORMANCE AT ALL LEVELS

KEY INTERVENTIONS	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Strengthen accountability mechanisms at the national, provincial and institutional level within the current Constitutional framework	Develop clear policies separating political from administrative mandates in the health sector, without abrogating political oversight in the administrative execution of policies	Policy framework for separation of political from administrative mandates completed	April 2020	Lead: National DoH DPSA Department of Justice
Ensure effective oversight through robust health information, research and evidence	Develop Annual National Health Research priorities to continuously generate knowledge and new products for promoting, restoring and maintaining health	Annual National Health Research priorities list produced	Produced in April 2020, updated annually through to April 2024	Lead: National DoH DPSA Department of Justice Department of Science and Technology Private sector



PILLAR 8: ENGAGE AND EMPOWER THE COMMUNITY TO ENSURE ADEQUATE AND APPROPRIATE COMMUNITY-BASED CARE

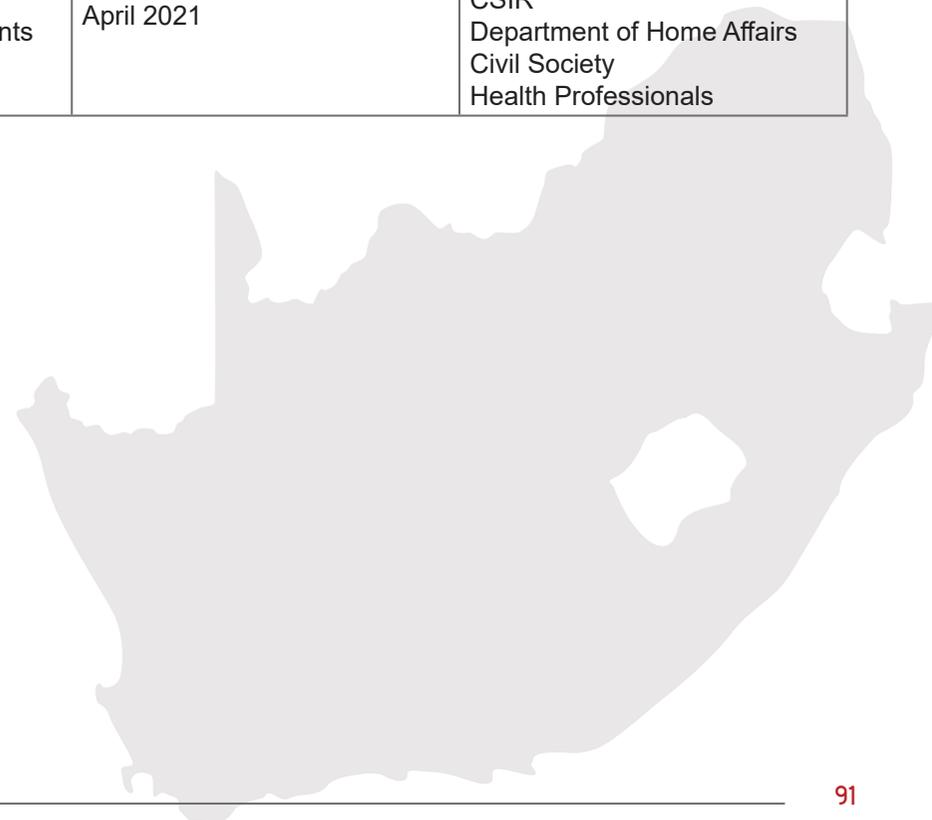
KEY INTERVENTIONS	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Strengthen Governance capacity of bodies involving communities	Establish health governance structures (Clinic Committees and Hospital Boards) in all levels of health facilities	All 3880 health facilities with established and well-functioning	April 2022	Lead: National DoH Support: Provincial DoHs Civil Society structures Private Sector Academia
	Convene annual National and, Provincial and National Consultative Summits on health with appropriate community engagement	Reports of National and Provincial Summits produced and disseminated	Annually April 2019 to April 2024	Lead: National DoH Support: Provincial DoHs Civil Society structures Organised labour Private sector
Re-orient training and Education of community health workers and health professionals	Re-orientate undergraduate health professionals training to PHC and community engagement including the expansion and resourcing of decentralized training platforms and an emphasis on multi-disciplinary team training	Report on the review of undergraduate curricula completed	April 2022	Lead: Academic Institutions Support National DoH Provincial DoHs User groups
Enhance health literacy for better health outcomes	Support collection and use of data by community health workers, health managers and health personnel, facilities, not-for-profit organisations providing health services (CBOs, NGOs, FBOs, Private Sector) – noting issues of confidentiality regarding patient data;	50% expansion of community-based data on the District Health Information System (DHIS)	April 2022	Lead: National DoH Support Civil Society CBOs, NGOs, FBOs, Private Sector)
		100% expansion of community-based data on the District Health Information System (DHIS)	April 2024	

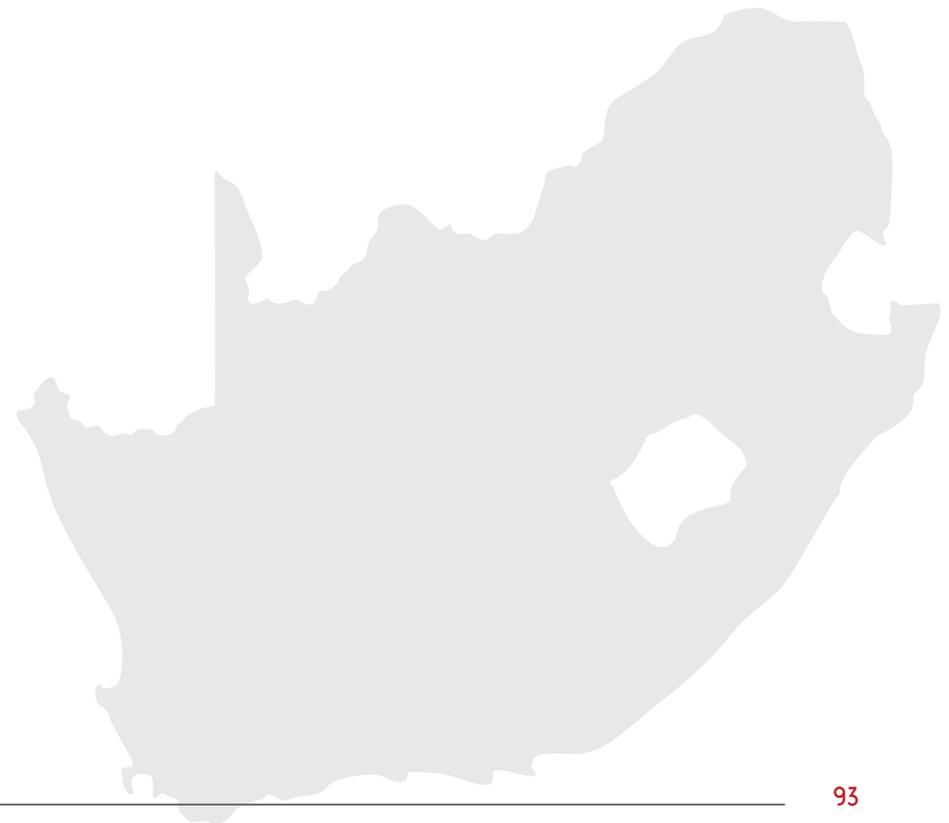
PILLAR 9: DEVELOP AN INFORMATION SYSTEM THAT WILL GUIDE THE HEALTH SYSTEM POLICIES, STRATEGIES AND INVESTMENTS

COMMUNITY-BASED CARE	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Integrated Health Information System	Implement inter-operability between the various patient information systems using the normative standards framework for interoperability for eHealth in SA publication.	Compliance with the identified interoperability standards	All systems by 2024	LEAD: National DoH CMS Provincial DoHs Private Sector National Treasury Department of Science and Technology, CSIR Academia
	Develop and implement a South African Health Information Exchange Service that will allow for the sharing of data between identified health information systems	Functional South African Health Information Exchange Service	By April 2024	Lead: National DoH Support: CSIR; CMS; Provincial DoHs
	Develop and Implement procedures and systems for Identity Verification of Users of the Health System (public and private)	To develop and implement Identity Verification of Health System users in Public and Private Health Care Facilities	By April 2024	Lead: National DoH Support: Provincial DoHs Department of Home Affairs CMS Health Funders Association Groups, Civil society organisations
	Establish a patient registry through the Implementation of a uniform Master Patient Index (MPI), in all public and private health care providers and facilities	Master Patient Index implemented by health care providers and health facilities (public and private)	April 2024	Lead: National DoH Support: Provincial DoHs CMS; Department of Home Affairs Civil Society Organisations

COMMUNITY-BASED CARE	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
	Implement section 74 of the National Health Act 63 of 2003 to strengthen information systems to ensure attainment of a comprehensive and seamless National Health Information System.	Regulations for implementing section 74 of the National Health Act 63 of 2003 published in the Government gazette		
	Standardize health outcomes reporting for both public and private health sectors	Health impact indicator data from both the public and private sectors included in the national health information system and data repository.	April 2022	Lead: National DoH Support: Provincial DoHs Private Sector, CMS, Statutory Councils
		Health impact indicator data from both the public and private sectors included in the national health information system and data repository.	April 2024	Lead: National DoH Support: Provincial DoHs Private Sector, CMS, Statutory Councils
Standardisation of health diagnostic and procedure coding systems	- Implement a harmonised WHO classification for topographical, diagnostic (general and specialized), procedural, pharmaceutical and outcome coding across the health system including but not limited to the transition of revised systems, e.g., ICD-10 to ICD-11 or introduction of International Classification of Health Interventions (ICHI)	50 % of public health facilities implementing identified coding systems	April 2024	National DoH Provincial DoHs CMS

COMMUNITY-BASED CARE	KEY ACTIVITIES	INDICATORS	TIMELINES	ACCOUNTABILITY (LEAD) / RESPONSIBILITY (SUPPORT)
Healthcare technology infrastructure and architecture platform	Conduct a health information infrastructure and architecture baseline assessment across the health sector (private and public).	Baseline assessment Report on available information systems infrastructure, operating and application systems, state of functionality as well as broadband connectivity status.	April 2021	Lead: National DoH Support: Provincial DoHs Statutory Councils CSIR
Capacity building and skills transfer for digital health	Conduct a Health Information systems skills baseline assessment across the health sector (public and private).	Report outlining accurate baseline health information skills and expertise across the health sector.	April 2021	Lead: National DoH Support: Provincial DoH Statutory Council, CSIR CMS
Development of business intelligence for health sector	Identify baseline business intelligence (BI) report requirements across the health sector.	Business Intelligence Specification Document outlining report requirements across the health sector.	April 2021	Lead: National DoH Support: Provincial DoH CSIR Department of Home Affairs Civil Society Health Professionals







Development and production of this document is supported by the WHO country office for South Africa

