

Achieving high-quality and accountable universal health coverage in South Africa: a synopsis of the Lancet National Commission Report

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Four overarching recommendations are made to ensure high-quality UHC in South Africa: enhance governance and leadership for quality and equity; revolutionise quality of care; invest in and transform human resources in support of a high-quality health system; and measure, monitor and evaluate to ensure high-quality UHC.

A high-quality health system is essential for universal health coverage (UHC), enunciated in the Sustainable Development Goals. In South Africa, the proposed National Health Insurance (NHI) is a health-financing system that pools funds to provide access to quality health services for all South Africans based on health needs and irrespective of socio-economic status. NHI aims to reform the health system towards the achievement of UHC. NHI also aims to give effect to Section 27 of the Constitution, which affirms the right of access to health services for all.

Drawing on the South African Lancet National Commission Report, this chapter summarises the progress made on the provision of quality health care in the 25 years of democracy, notably an enabling legal and policy environment, numerous quality-improvement initiatives, increased life expectancy of the population, and reduced mortality rates. However, significant

challenges remain. The Commission found that gaps in ethical leadership, management and governance contribute to poor quality of care, which results in unnecessary loss of lives. Malpractice and medical litigation are threats to the realisation of the right to health care in South Africa. The Commission underscored the potential of the human resources for health (HRH) crisis to undermine the achievement of high-quality UHC, that fragmentation of quality-of-care initiatives limits their impact, and that health information system gaps hamper the measurement and/or monitoring of quality and its improvements.

Four overarching recommendations are made to ensure high-quality UHC in South Africa: enhance governance and leadership for quality and equity; revolutionise quality of care; invest in and transform human resources in support of a high-quality health system; and measure, monitor and evaluate to ensure high-quality UHC.

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Introduction

Globally, universal health coverage (UHC) and quality health care were given renewed impetus with the 2015 United Nations Sustainable Development Goals (SDGs).¹ The values of human dignity and solidarity are central to SDG goal 3, which focuses on healthy lives and the promotion of well-being for all people.¹ In 2018, three global quality reports noted that billions of people will not gain from potential UHC benefits unless improvements in health system quality are realised.² The three reports highlighted the consequences of poor quality, namely patient safety hazards, underuse of evidence-based care, overuse of inappropriate care, lack of patient-centred care, delays, inefficiency, inequity, financial insecurity, collusion, and corruption.² The three reports noted that the “burden of poor quality care” is felt more acutely in low and middle-income countries, because of poverty, suboptimal governance, resource limitations, and lack of, or insufficient accountability.³⁻⁵

In 1994, South Africa emerged from decades of apartheid policies, which have had implications for health policy and for the discourse on a high-quality health system. The proposed National Health Insurance (NHI) is a health-financing system that pools funds to provide access to quality health services for all South Africans based on health needs and irrespective of socio-economic status. NHI aims to reform the health system towards the achievement of UHC.⁶ NHI also aims to give effect to Section 27 of the Constitution, which affirms the right of access to healthcare services for all.⁷

This chapter is a synopsis of the Consensus Report of the South African Lancet National Commission on a High-Quality Health System in the SDG era.⁸ The Commission was launched in May 2017 to conduct country-specific analyses on quality of care consistent with the overall aims and objectives of the Lancet Global Health Commission on High-Quality Health Systems in the SDG Era.⁹ The Commission consisted of 13 members with diverse experience and expertise in academia, health, policy and public and private health sector management.

The methodology of the South African Lancet Commission is described. This is followed by a description of the conceptual framework and definition of a high-quality health system in South Africa. The conceptual framework was used to highlight progress and present the state of quality of care in South Africa, specifically the key diagnostic findings of the Commission. Finally, the chapter presents four overarching recommendations of the Commission.

Methodology

The work of the South African Lancet Commission included several components. A literature review was done on high-quality health systems, including peer-reviewed journal

articles, technical reports, and various health ministerial task team reports. Ten interviews were conducted with key informants in government, the private sector and civil society as part of the Lancet Global Commission subcomponent on “Governing for Quality”. Monthly meetings of the Commission were held, with deliberation on the evidence obtained and inputs received. In December 2017, the Global and all the National Commissions attended a workshop to synthesise the evidence collected on quality of care. The Commission also considered the findings and recommendations of three global reports on quality: The Lancet Global Health Commission Report;³ the World Health Organization (WHO), Organisation for Economic Co-operation and Development (OECD) and World Bank Report;⁵ and the National Academies of Sciences, Engineering and Medicine Report.⁴

The Commission held four national consultative workshops with stakeholders and technical experts in May 2017, November 2017, December 2018 and March 2019. The final report is a synthesis and integration of the evidence and inputs from these processes.

Defining a high-quality health system in South Africa

The South African National Commission deliberated extensively on definitions of quality and a framework appropriate to the South African context. A distinction was made between quality health care and a quality health system, and a definition was developed emphasising an overall health systems approach to quality.

Perceptions of quality vary according to the needs of different stakeholders. Healthcare providers, for example, tend to emphasise the technical quality of care, such as adherence to treatment protocols, infection prevention, and successful treatment outcomes (reduced morbidity, mortality and disability).^{10,11} Patients or community members are more concerned with their experience in the facility, such as cleanliness, amenities, waiting time, and/or the behaviour of staff. Policymakers and healthcare managers focus on health system performance, value for money^{11,12} and population-level outcomes.^{10,11}

The consensus of the National Commission is that a high-quality health system is able to achieve equitable health outcomes and a long and healthy life for all.⁸ The consensus definition is given in Box 1.

The proposed conceptual framework (Figure 1) draws on the definition in Box 1 and takes an overall health systems approach, as proposed by van Olmen et al.¹³ The values of human rights, equity and social justice, enshrined in the South African Constitution,⁷ underpin the conceptual framework. The Commission recognised that the provision of quality health care on its own is unlikely to lead to optimal

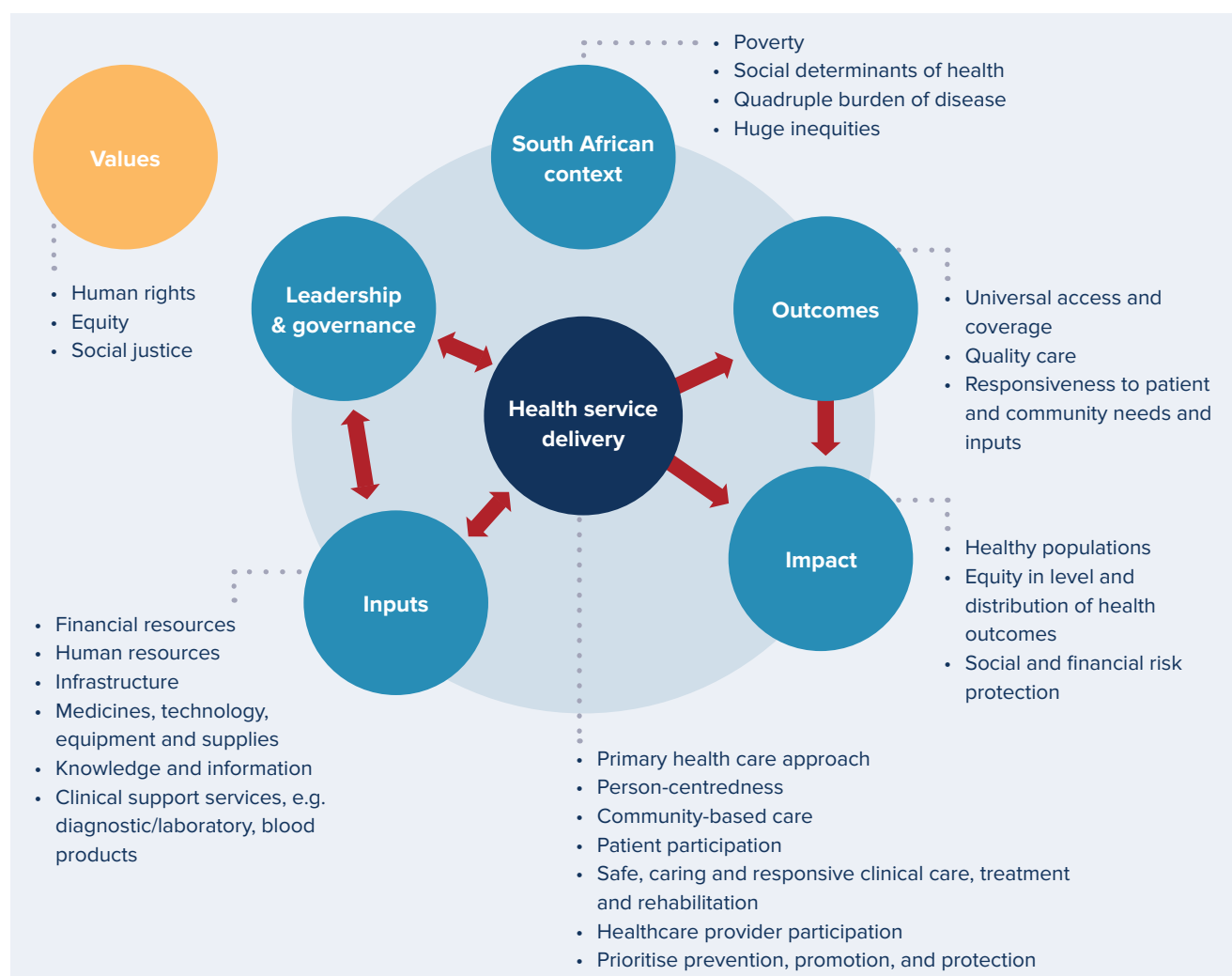
Box 1: Definition of a high-quality South African health system

A high-quality health system achieves equitable health outcomes and a long and healthy life for all. Such a health system is:

- Designed to prioritise health promotion and protection, and the prevention, treatment and rehabilitation of conditions constituting South Africa's disease burden.
- Accountable through effective leadership and governance.
- People-centred in its approach to realising good health by facilitating patient, provider and community participation in health attainment.
- Responsive to patient needs by providing comprehensive care in a timely, respectful and safe manner resulting in quality outcomes.
- Adaptive to changing health needs through the collection, analysis and dissemination of information, to support decision-making and implementation.
- Committed to equitable allocation and distribution of resources.
- Effective in ensuring quality health service delivery to all regardless of gender, sexual orientation, socio-economic status and/or geographical location.
- Collaborative in its interaction with partners and other sectors to address the social determinants of health for quality health outcomes.

Source: South African Lancet National Commission; 2019.⁸

Figure 1: Conceptual framework for a high-quality South African health system



Sources: Adapted from van Olmen et al.; 2010,¹³ and the South African Lancet National Commission; 2019.⁸

health outcomes. This is because socio-political-economic factors are critical in influencing health and wellbeing.¹⁴ Similarly, South Africa's burden of disease is linked inextricably to the socio-economic context. Hence, these aspects were emphasised in the conceptual framework.

Leadership and governance are critical to ensure the inputs required for quality care, and essential for health-service delivery. The inputs in the framework are equivalent to the WHO healthcare system building blocks.¹⁵ The Commission envisaged health-service delivery based on the 1978 Alma Ata primary healthcare (PHC) approach,¹⁶ prioritising disease prevention, health promotion and health protection. At the same time, the necessary treatment and care would span the continuum from community-based care, to safe, caring and responsive clinical care, treatment and rehabilitation.⁸ Person-centredness is critical to treatment and care, facilitating and enabling both patient and healthcare provider participation.

The anticipated outcomes are universal access and coverage, quality care, and responsiveness to patient and community needs and inputs, while the impact of a high-quality health system is a healthy South African population, equity in the level and distribution of health outcomes, and social and financial risk protection (Figure 1).⁸

The state of quality of care in South Africa

The key diagnostic findings of the South African Lancet Commission are shown in Table 1, and discussed briefly below.

Finding 1: Gaps in ethical leadership, management and governance

Section 27 of the South African Constitution obliges government to ensure the right of all citizens to access

healthcare services, including reproductive health, and to ensure that no one is refused emergency medical treatment.⁷

Since 1994, various laws, policies and initiatives have been put in place to improve the South African health system and its performance.¹⁷⁻²⁴ The seminal quality of care initiatives are shown in Figure 2.

The National Health Act (NHA) (Act No. 61 of 2003) provides the legislative framework for the delivery of healthcare services.²⁵ The Act sets out the structures, mechanisms, resources and systems aimed at the progressive realisation of the right of access to healthcare services.²⁵ It lists various governance structures, from the National Health Council, which includes the Minister of Health and the provincial members of executive councils for health, to Provincial Health Councils along with community-led structures and consultative bodies like the Forum of the Statutory Health Professions Council representing all the health professions councils (Section 50).²⁵

The Office of Health Standards Compliance (OHSC) was established in 2014 through an amendment of the NHA²⁶ to regulate quality of care. The OHSC protects and promotes the health and safety of health-service users by effectively managing patient complaints and enforcing compliance with prescribed norms and standards. The OHSC regulates all health establishments in the country and is responsible for monitoring compliance and patient safety.²⁶

Notwithstanding the enabling Constitution, strong health legislation and numerous health policies that express Government's commitment to a high-quality health system, gaps in ethical leadership, management and governance contribute to poor quality of care. These gaps are exacerbated by mismanagement, inefficiencies, and incompetence at various levels of the health system. Corruption and fraud are major threats to equitable access to quality health care.⁸

Table 1: Key diagnostic findings of the South African Lancet Commission, 2019

Finding 1	Gaps in ethical leadership, management and governance contribute to poor quality of care
Finding 2	Poor quality of care costs lives
Finding 3	Malpractice cases and medical litigation are threats to the realisation of the right to health care in South Africa
Finding 4	The human resources for health (HRH) crisis will undermine the achievement of high-quality universal health coverage
Finding 5	Health information system gaps constrain the country's ability to measure or monitor quality and its improvements
Finding 6	There is fragmentation and limited impact of quality-of-care initiatives

Source: South African Lancet National Commission; 2019.⁸

The Health Market Inquiry (HMI) has demonstrated several failures of governance in the private health sector, including failure of funders, health facilities and health professionals.²⁷ The HMI noted that the National Department of Health (NDoH) has failed to use “existing legislated powers to manage the private healthcare market, to ensure regular reviews as required by law, and to hold regulators sufficiently accountable”.²⁷ Consequently, the private sector is neither efficient nor competitive.²⁷ The HMI also found lack of transparency, and lack of accountability to medical aid scheme members, combined with a flawed governance model that aligns scheme interests with those of administrators rather than with those of scheme members.²⁷

There are also governance weaknesses in the Health Professions Council of South Africa (HPCSA)^{27,28} and the South African Nursing Council,²⁹ which are the regulators of the majority of health professionals in South Africa.

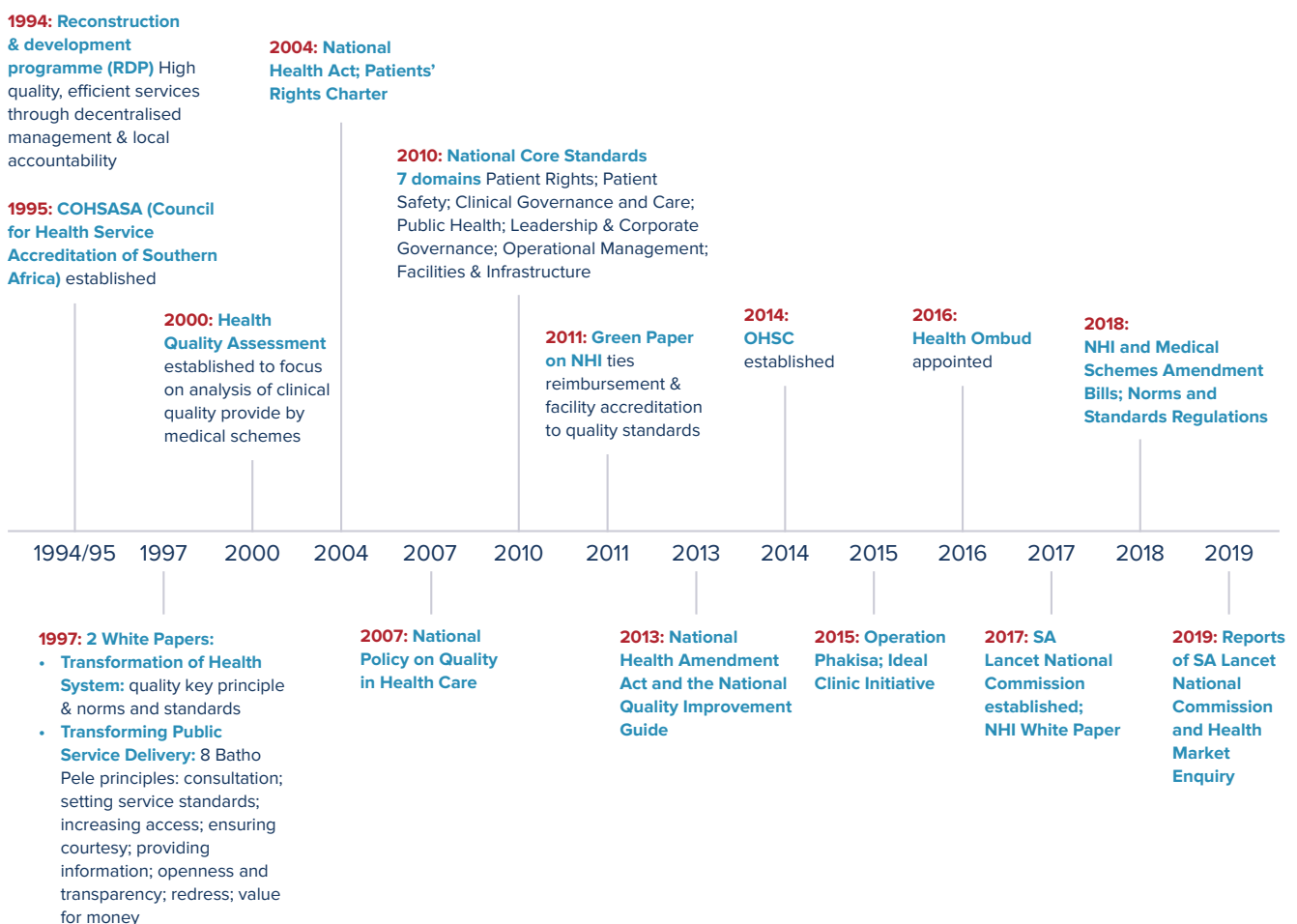
There are numerous barriers to effective community participation, which in turn influence accountability. A 2015 review of community-led governance structures found several challenges in relation to community participation.³⁰ These challenges include: inappropriate

appointment of candidates to hospital boards or clinic committees; limited capacity and readiness of the various actors and structures to fulfil their governance functions; lack of clarity regarding the roles and responsibilities of the various policy actors, especially those at the lowest levels of the health system; and tensions between administrative and community structures.³⁰ The challenges were exacerbated by competing priorities of health managers and providers, lack of skills and technical support to promote public participation, and the complexity of the health bureaucracy in the three spheres of government.³⁰ Furthermore, a 2017 Patient Experience of Care Survey found that of the 168 clinics sampled, only 17.9% had functional clinical committees.³¹

Finding 2: Poor quality of care costs lives

South Africa remains at the forefront of the fight against HIV and AIDS, and has the largest anti-retroviral therapy (ART) programme in the world.³² Adult mortality levels in South Africa have declined substantially because of widespread ART access.^{33,34} Similarly, in the past decade HIV and AIDS has declined significantly as a cause of under-five^{35,36} and maternal mortality.³⁷ However, poor linkage to care following HIV diagnosis and retention in care are of concern, despite

Figure 2 : Key quality of care initiatives since democracy



Sources: South African Health Reviews, 1995-2018.¹⁷⁻²⁴

the expansion in ART eligibility criteria.³⁸ In addition, ART coverage in children living with HIV remains comparatively low at 40% and 49% in 2013 and 2014 respectively.³³ This is despite effective and high coverage in excess of 95% of the prevention of mother-to-child transmission (PMTCT) programme.³³ The main factors for this low ART coverage rate are parental non-disclosure of HIV status, lack of sufficient skills for paediatric ART, and missed opportunities for counselling and testing in other programmes such as maternal and child health.³³

Although the reduction in mortality rates is encouraging, the evidence shows that poor quality of care costs lives.⁸ Since 2008, around 60% of all institutional maternal deaths were potentially preventable, with rural areas more affected than their urban counterparts.³⁷ Rhoda et al. have pointed out that the absolute number of neonatal deaths is unacceptably high for a middle-income country such as South Africa, and that the neonatal mortality rate is not commensurate with the level of government investment in health care.³⁹ An estimated quarter of neonatal deaths are caused by a combination of health system and provider failings, and are thus potentially preventable.³⁹

There is an increasing burden of hypertension and diabetes in South Africa, but inadequate surveillance systems and information gaps in both public and private health sectors constrain disease prevention and management efforts. Existing cascade studies found major deficiencies in the quality of care provided: almost one in two individuals with hypertension were unscreened and undiagnosed (48.7%), one in five were screened but undiagnosed (23%), and less than 10% were controlled.⁴⁰⁻⁴² There are also deficiencies in the quality of care provided to diabetic patients, with poor control of the majority of patients and insufficient screening of complications and/or for co-morbidity.^{43,44}

A study on the quality of integrated chronic disease care in rural South Africa found that a combination of factors mitigated against the provision of high-quality care.⁴⁵ There were malfunctioning blood pressure machines, staff shortages, irregular prepacking of drugs, and long waiting times at facilities.⁴⁵ Patients attributed long waiting hours to late arrival of health workers, shortage of hypertensive medicines, and rigid appointment schedules.⁴⁵ Patients also felt stigmatised by the defaulter tracing method used by community health workers.⁴⁵ In contrast, health-facility managers attributed long waiting times to staff shortages and missed appointments by patients.⁴⁵

Mental illness and substance-use disorders account for a sizeable proportion of the burden of disease, but there is a dearth of research on the epidemiology of these conditions. The main data source remains the 2004 South African Stress and Health Survey.⁴⁶ The study found that 30.3% of South Africans reported having suffered from a mental disorder. In the same study, lifetime prevalence of mental disorders in South Africa was 15.8% for anxiety disorders,

9.8% for mood disorders, and 13.3% for substance-use disorders.⁴⁶ Although there is enabling legislation and a robust mental health policy framework, the lack of implementation suggests a lack of prioritisation of mental health, and under-investment in service delivery.^{47,48} It is estimated that 75% of people with a mental disorder do not receive mental health services, the majority of whom are poor, black South Africans in rural areas.⁴⁹

Finding 3: Malpractice cases and medical litigation are threats

Medical negligence impacts on access to health care.^{50,51} The Medical Protection Society (MPS) estimated that “the long-term average claim frequency for doctors in 2015 was around 27% higher than that in 2009”, while the amounts claimed had escalated by an average of 14% per year from 2009 to 2015.⁵² However, the lack of robust, patient-centred complaint systems contributed to this increase, leaving litigation by patients as the only viable avenue for redress.⁵² Delays are endemic because of the lack of efficient and predictable legal processes for handling of clinical negligence claims. Claim sizes have therefore increased. The cost of settling claims also increases with protracted legal processes.⁵² Protection for patients in terms of the Constitution and the Consumer Protection Act, coupled with increasing patient expectations, have been positive, but they have also contributed to increased frequency of claims.⁵² Importantly, the current system for dealing with clinical negligence does not facilitate efficient and fair resolution of disputes.⁵² Hence, there is need for a system overhaul that addresses the root cause of the problem, namely quality-of-care failures that compromise patient safety and lead to potentially preventable deaths.⁸

Table 2 shows trends in the contingent liabilities for medical malpractice in provincial health departments. At the end of March 2019, National Treasury estimated the total contingent liabilities for medical malpractice in provincial health departments at around R104.5 billion,^a thus placing a huge burden on the distressed health system and reducing financial resources available for health-service provision. The Eastern Cape, Gauteng and KwaZulu-Natal had the biggest claims and highest proportion of contingent liabilities.

Table 3 shows claims payment trends between 2012/13 and 2017/18.^a With the exception of Limpopo, there has been a massive increase in claims paid by provincial health departments. This means that the provincial health departments conceded the medico-legal claims for a range of reasons.

The increased quantity of medico-legal claims and pay-outs are not limited to the public sector. The private healthcare sector is also under pressure, with a sharp increase in insurance for private medical practitioners over the past few years (Table 4). Furthermore, a 2018 study of nursing malpractice cases in Gauteng and the Western Cape highlighted areas of concern in private hospitals.⁵³

a National Treasury. Medico Legal Claims in Provincial Health Departments as at 31 March 2019, unpublished and unaudited data.

Finding 4: HRH crisis will undermine high-quality UHC

South Africa has well-established training institutions, skilled health professionals, regulation of health professional training and practice, and sufficient fiscal space for relatively high remuneration levels in the public health sector.⁵⁴

Notwithstanding these strengths, South Africa's HRH crisis has manifested as staff shortages, and inequities and maldistribution in HRH between urban and rural areas and between the public and private health sectors. There is also ineffective and suboptimal management and leadership at various levels of the health system, and evidence of

Table 2: Trends in contingent liability for medical malpractice in provincial health departments, 31 March 2019^a

Provinces	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)	2018/19 (R'000)	% Share 2018/19	Year-on-year increase (R'000)	% Year-on-year increase
Eastern Cape	8 210 838	13 421 136	16 772 732	24 193 619	29 052 620	27.8%	4 859 001	20.1%
Free State	540 365	940 545	1 306 928	1 842 917	2 510 594	2.4%	667 677	36.2%
Gauteng	10 079 281	13 452 064	17 844 047	21 701 514	28 913 749	27.7%	7 212 235	33.2%
KwaZulu-Natal	6 724 865	9 957 126	10 292 463	16 638 734	20 729 836	19.8%	4 091 102	24.6%
Limpopo	1 196 787	1 606 657	2 115 529	4 874 800	8 522 002	8.2%	3 647 202	74.8%
Mpumalanga	1 459 497	2 366 010	5 242 757	7 472 985	10 091 249	9.7%	2 618 264	35.0%
Northern Cape	174 111	342 829	1 220 527	1 605 291	2 440 116	2.3%	834 825	52.0%
North West	33 881	855 737	1 285 126	1 697 205	2 120 231	2.0%	423 026	24.9%
Western Cape	193 395	182 025	135 700	90 350	110 599	0.1%	20 249	22.4%
Total	28 613 020	43 124 129	56 215 809	80 117 415	104 490 996	100%	24 373 581	30.4%

Note: The Western Cape contingent liability does not include all the total claims.

Table 3: Payment trends on claims against provincial health departments between 2012/13 and 2017/18^a

Provinces	2012/13 (R'000)	2013/14 (R'000)	2014/15 (R'000)	2015/16 (R'000)	2016/17 (R'000)	2017/18 (R'000)	2018/19 (R'000)	Growth rates 2012/13-2015/16 (%)
Eastern Cape	63 359	74 775	74 868	255 561	208 503	423 263	797 434	52.5%
Free State	440	700	196	1 728	1 560	376	3 600	42.0%
Gauteng	145 071	181 802	241 085	572 815	751 082	358 230	586 453	26.2%
KwaZulu-Natal	20 679	97 433	103 536	90 367	251 278	461 919	438 819	66.4%
Limpopo	8 040	25 022	35 073	9 622	74 830	26 773	7 045	(2.2%)
Mpumalanga	13 918	44 080	7 628	15 211	34 255	67 782	39 268	18.9%
Northern Cape	1 437	10 705	3 828	4 844	823	9 493	3 550	16.3%
North West	5 502	10 896	13 246	6 422	29 539	33 274	14 450	17.5%
Western Cape	6 928	23 015	19 272	28 073	38 381	86 984	62 140	44.1%
Total	265 374	468 428	498 732	984 643	1 390 251	1 468 094	1 952 759	39.5%

a National Treasury. Medico Legal Claims in Provincial Health Departments as at 31 March 2019, unpublished and unaudited data.

unprofessional behaviour, poor staff motivation, suboptimal performance and unacceptable attitudes of health workers towards patients.⁵⁵ Human resource information systems are fragmented and unable to inform health workforce planning and training.⁵⁶

In the private sector, an over-concentration of healthcare professionals often leads to unhealthy competition between providers to ensure financial viability, as well as potential over-servicing and fragmented care.⁵⁷ In the public sector, poor or inadequate supervision, insufficient focus on productivity, and abuse of the policy on remunerative work outside the public sector further compound shortages.⁵⁸ These HRH challenges have the potential to undermine the achievement of high-quality UHC, unless this crisis is addressed in a decisive manner.

Finding 5: Health information system gaps

Information systems are a building block of the health system, and an essential part of governance.¹⁵ A high-quality health system requires accurate, reliable and timely health information.^{5,59} Health-information systems enable monitoring of progress in delivering and sustaining quality health services and achieving national health goals.⁵ Information enhances accountability, which in turn improves quality.³

The South African government's commitment to measuring quality has been longstanding, and articulated in various policy documents, including the White Paper for the Transformation of the Health System⁶⁰ and the 2012 National Development Plan (NDP).⁶¹ Hence, there is an enabling policy environment for the development of a health-information system to measure quality.

However, South Africa's health-information systems are partially electronic, not inter-operable, do not make patient-level data available, and are not capable of reporting aggregated data across public and private health sectors, or across levels or care pathways.⁸ Numerous health-measurement platforms exist that provide information on health system inputs, processes, service delivery, outcomes and impacts.⁸ Most of these do not provide sufficient and appropriate information on health outcomes and impacts, nor are they sufficiently person-centred.⁸ Data quality remains a significant barrier to assessing health-system performance on quality of care.⁶²

There is also suboptimal collection, utilisation and reporting of data by healthcare professionals and managers. Furthermore, there are insufficient expertise and skills within the public sector to support data analysis, feedback and reporting.⁸

Finding 6: Fragmentation and limited impact of quality-of-care initiatives

Quality improvement is a change process that should lead to better patient outcomes (health), better system performance (care), and better professional development (learning).⁶³ The Commission found a wide range of quality-improvement programmes in South Africa delivered by government, non-governmental organisations, and academic and research institutions.⁸ However, there are substantial gaps in the coordination and implementation of quality improvement as a national strategy, namely in mobilising stakeholders, in learning lessons from quality improvement experience and expertise, and in supporting implementation across sectors and levels of the health system. Hence, the impact of quality-improvement initiatives is limited.⁸

Table 4: Nursing malpractice and medico-legal claims in the private sector

<p>Case outcomes</p> <ul style="list-style-type: none"> • 122 cases were closed. • 25 cases resulted in death. • The malpractice affected the quality of life of approximately 69% of the 122 patients. • Approximately 43% of the patients had additional surgery. • Approximately 25% of the patients were left disabled. • Approximately 79% of the patients spent extra days in the hospital.
<p>Audit analysis of malpractice litigation cases in nursing practice in private health care in South Africa</p> <ul style="list-style-type: none"> • Nurses did not pay attention to basic nursing procedures such as postoperative assessment. • Nurses ignored critical complaints from patients, resulting in severe consequences. • Nurses were unable to interpret readings on machines monitoring patient conditions. • Nurses failed to follow practice guidelines.
<ul style="list-style-type: none"> • Poor HRH governance: Auxiliary nurses were assigned to duties beyond their scope of practice, even in critical units such as theatres.
<ul style="list-style-type: none"> • High costs of medico-legal claims were paid by private hospitals but may be passed on to consumers of private health care.
<ul style="list-style-type: none"> • The majority (74%) of the medico-legal cases were handled in secret, out of the public domain.

Source: Stellenberg et al., 2018.⁵³

Recommendations

The Commission proposed four overarching recommendations, discussed below:

- Enhance governance and leadership for quality and equity.
- Revolutionise quality of care.
- Invest in and transform human resources in support of a high-quality health system.
- Measure, monitor and evaluate to ensure a high-quality health system.

Recommendation 1: Enhance governance and leadership

The Commission recommended that there should be emphasis on ethical and effective leadership and management at all levels of the health system. These individuals should embody the values of integrity, competence, responsibility, accountability, fairness and transparency. Leaders need to answer for the execution of their responsibilities, even when these are delegated. Conflicts of interests must be avoided or managed proactively.

Key strategies in ensuring governance and leadership for quality are: prevention of fraud and corruption; strengthening of community structures such as mental health review boards, hospital boards, and community or clinic health committees; investment in and increased capacity of the OHSC; enhancement of the capacity and effectiveness of the Council for Medical Schemes; and strengthening governance, effectiveness and efficiency in the various health professions councils.⁸

Recommendation 2: Revolutionise quality of care

Key strategies here are to: revitalise the provision of responsive, high-quality clinical care that responds to the burden of disease; prevent medical malpractice and litigation; embark on a national campaign to educate patients and communities about their health rights and responsibilities; and design an integrated, quality-improvement Programme of Action (POA).⁹ The POA should cover the entire health system and all modes of healthcare delivery in public, private-for-profit, non-governmental and community-based organisations. The POA should prioritise implementation in rural and under-served areas, and in the public health sector.

Recommendation 3: Invest in, and transform, HRH

The Commission recommended the development of a transformative HRH plan, and a complementary national social mobilisation campaign to increase health worker awareness of quality-of-care issues. The campaign should focus on health rights within the context of the Bill of Rights;⁷ the responsibilities of individuals for their health; and the rights, responsibilities and individual accountability of health

workers.⁸ Public-sector health managers should be recruited based on merit and core competencies in line with the provisions of the Public Service Act.

The Commission also proposed that a compulsory module on quality of care should be included in both pre-service training and continuing professional development programmes of health professionals. The Commission recommended that the NDoH should mandate each health professions council to do an audit of the time allocation on quality of care in the curriculum of pre-service education programmes.⁸ Based on the results of the audit, quality of care and improvement methods should be integrated in all courses, and a mandatory and compulsory competency of health professionals, prior to registration. Each health professions council should also stipulate continuing professional development in quality of care and encourage a culture of learning that rewards transparency, accountability and continuous improvement.⁸

Recommendation 4: Measure, monitor and evaluate

The Commission recommended that the NDoH should develop an initial list of performance targets that measure quality outcomes in the health system, to be expanded in the course of time. These targets should be based on existing information, rather than new information collected in both health sectors. The NDoH should prioritise analysis, interpretation and feedback of these key indicators (which would constitute a dashboard) with interrogation of variances, similar to those for financial indicators. The health information system should be strengthened, and implementation of the dashboard should be appropriately staffed and resourced. Managers should be trained in use of the dashboard for decision-making and action. The dashboard should be presented and explained to governance structures, to enable effective oversight.

The Commission recommended strengthening of the NDoH's Health Information System development, implementation and oversight, as well as the collection, reporting and use of appropriate quality information in both the public and private health sectors. Lastly, the Commission recommended the expansion and strengthening of the stewardship role of the National Health Information System of South Africa.

Conclusion

The Commission noted that implementation of the recommendations requires strong leadership and stewardship from the NDoH. This will require the Department to enhance its technical capacity to enable it to monitor the implementation of legislation and key policies in provincial health departments and in regulatory entities. This could be done through appointment of new staff, re-skilling of existing staff, and/or partnerships with universities and science councils.

The Commission stressed that it is an ethical and moral imperative to implement the proposed recommendations because the nation and the many committed, hard-working health managers and healthcare providers deserve a high-quality health system. The legislative and policy foundation for a well-performing health system is largely in place. Strong stewardship and leadership for implementation are the logical next steps to build on the global momentum for high-quality UHC.

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