

# IMPROVING THE PERFORMANCE OF THE HEALTH SYSTEM

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**The envisaged reform of the health system towards universal coverage is a necessary albeit ambitious one...**

*There is sufficient evidence that, for the resources to its avail, the South African health system is performing poorly. Using the World Health Organization Performance Model, this chapter unpacks strategies and mechanisms to improve performance whilst the financing functions of collecting, pooling and purchasing are being worked out. There is a range of immediately applicable inputs that could make an immediate difference to health outcomes. These will, however, require decisive leadership and strengthening of management support systems – as well as additional financial and human resources. The District Health System, as the vehicle to implement Primary Health Care, is key to improving service delivery, with Provincial Departments of Health strengthening such decentralised management while also holding district and hospital managers accountable.*

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## Introduction

The South African health system performs poorly when comparing its impact on the health status of the nation to countries with a similar or poorer per capita Gross Domestic Product (GDP). The Lancet series on Health in South Africa<sup>1</sup> confirms that South Africa spends more on health than any other African country – 8,7% of its GDP, which is just slightly less than Sweden (8,9%). Yet South Africa is one of only 12 countries in which maternal mortality and mortality for children younger than 5 years have actually increased since 1990. While there is no doubt that HIV and AIDS contribute to this sad reality, it is clear that innovative strategies will be necessary to improve the situation.

This chapter focuses on those elements other than financing mechanisms that need to be addressed in order to improve the performance of the South African health system towards achieving universal coverage in the country. Whilst financing mechanisms in terms of collecting, pooling and purchasing are critical to leverage the necessary funding, improving the performance of the health system will require new design and management paradigms, as well as providing the staff necessary to deliver an up-scaled and responsive health system.

It must be stated that, in theory, the current health system provides universal coverage. Yet, from a service delivery, resourcing and quality perspective, the distribution and level of services is inequitable with many communities and patients experiencing great difficulty in accessing the public health system. Furthermore, both the public and private health sectors of the South African health system are unsustainable and fail the challenges of coverage, quality and cost.

Based on evidence of this poor performance the Lancet series, in its section on the challenges to meet Millennium Development Goals (MDGs), indicates that 15 years after liberation from apartheid South Africans are facing new challenges for which the highest calibre of leadership, vision and commitment is needed.<sup>2</sup>

The National Health Act (Act 61 of 2003) mandates the Minister of Health to bind the entire health system – public and private – into a provider system for universal coverage. On 3 October 2010 Minister Motsoaledi proclaimed at an international consultative workshop on quality improvement that South Africa has commenced “one of the most ambitious reforms that our government has introduced and preparatory work requires a comprehensive and systematic approach.”<sup>3</sup> He confirmed the objective of putting into place the necessary funding and health service delivery mechanisms that will enable the creation of an efficient, equitable and sustainable health system in South Africa.

The implementation plan for universal coverage must improve all dimensions of the health system. These dimensions include the ‘breadth’ (number of people protected), the ‘height’ (proportion of costs covered), and the ‘depth’ (range of services and benefits covered), as well as those additional factors that influence quality and safe services that contribute to improving health status.<sup>4</sup>

McIntyre, in an article published in the Cape Times, indicates that:

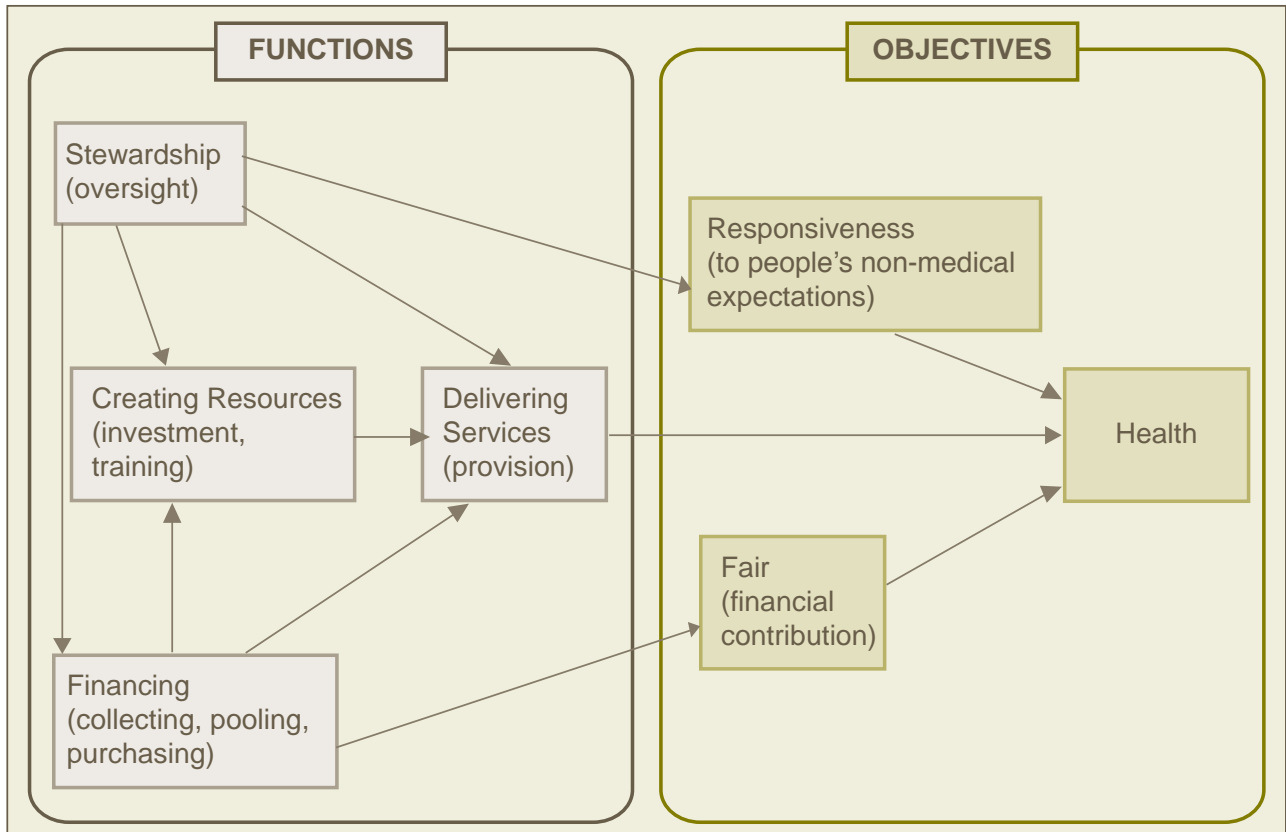
We currently have a window of opportunity to transform our health system from a highly inequitable and unsustainable system to one that meets the health care needs of all South Africans in an efficient and sustainable way.<sup>5</sup>

McIntyre’s chapter in this Review explains that in South Africa, real access to appropriate, efficient and quality services are necessary and that lack of proper design is a critical challenge. It is clear that a wide range of performance issues, other than structural, must be addressed to improve the health status of the population.

## The WHO perspective on improving performance

The World Health Organization’s (WHO) World Health Report 2000 describes and analyses the functions and objectives of a health system, identifying the ultimate objective of the health system as impacting positively on the health status of its community.<sup>6</sup> Figure 1 below outlines the critical elements needed to address improved performance. Whilst new financing mechanisms will provide the much needed funds, functions such as stewardship, creating resources and delivery of services are necessary to achieve the objectives of responsiveness, fair contribution and distribution of resources required to move towards equity and ultimately health for all citizens.

Figure 1: Performance model: relations between functions and objectives of a health system



Source: World Health Organization, 2000.<sup>6</sup>

The aim of this chapter is to identify, using the WHO performance model (Figure 1), some of the interventions required to turn the poor performance of the current health system around.

- Improving life expectancy;
- Lowering maternal and child mortality;
- Lowering rates of HIV and tuberculosis (TB); and
- Improving health system effectiveness.

## Stewardship

### Box 1: What is stewardship?

Stewardship in health is the very essence of good government and entails

- Careful and responsible management of the well-being of the population
- Establishing the best and fairest health system possible
- Concern about the trust and legitimacy with which its activities are viewed by the citizenry
- Maintaining and improving national resources for the benefit of the population

Source: World Health Organization, 2000.<sup>6</sup>

The present system is clearly not the “best and fairest health system possible” and does not use “national resources for the benefit of the population”.<sup>6</sup> The National Health Minister, Minister Motsoaledi, is championing health system reforms – with his focus on improvement. His own National Service Delivery Agreement priorities, captured in his performance agreement with the President, are as follows and set the agenda for the country:

This agenda must be underpinned with clear health policies, supported by the development of national, provincial and district health plans and targets that, in turn, guide resourcing.

The Minister has the responsibility to unite the private, public and non-governmental sectors as a collective into a national health system. The challenge is that these sectors currently do not share a single set of values, a common vision or a joint strategy for the health of the country as a whole. The public sector, comprising nine provinces, a national Department of Health (NDoH) and several municipalities, is also not united. The country, therefore, has a system of fragmented pieces in competition with each other – a great challenge to the Minister’s stewardship role.

However, it is not the Minister alone who is responsible for the well-being of the population, who must establish the best and fairest health system possible, build trust in and the legitimacy of the system and maintain and improve the national resources for the benefit of the population. This stewardship task lies with every role player and stakeholder – each one

must participate in designing a health system that can truly claim universal coverage. Such design must increase height, breadth and depth of the current health system's coverage. Sound judgement and judicious prioritising will be necessary to formulate a policy based on evidence, with a sound implementation plan – and this prior to announcing policy changes.

### Improving design

In order to overcome the fragmentation, improve the quality and to ensure equitable access to the essential package of services tailored to the communities' health needs, national leadership must redesign the National Health System in a systematic and structured way. Ad-hoc attempts to restructure the system will divert attention and resources from the primary task. It is neither possible nor necessary to make all reforms at the same time. It is necessary, however, to chart the course of the reforms according to definable and implementable targets over feasible timeframes.

Using the three dimensional view of the health system<sup>a</sup> to illustrate the point, reforms to achieve universal coverage must adequately address the following parameters:

- *breadth* – increasing the number of people protected by the health system, including addressing physical, financial and access limitations. These coverage and impact measures would indicate how and where to strengthen the system. Strategies may include increasing the staffing levels of primary health care (PHC) facilities, changing opening times of clinics, encouraging and rewarding collective and integrated group practices, changing policies to encourage task-shifting or task-sharing, building more clinics, expanding mobile outreach services and home-based care, subsidising transport to and from health facilities and expanding patient transport services.
- *height* – increasing the proportion of costs covered by pre-financing (more funding and less waste). These may include a range of financing options but for purposes of this chapter include improving procurement and administrative efficiencies, together with using the inputs of other sectors and departments that impact on health determinants, such as water and sanitation, education and human settlements.
- *depth* – increasing the range of services and benefits covered by the system. Service packages for various levels of care, aligned to local burden of disease, will define access and related services. This may require changes in facility staffing to allow a greater range of services to be provided at designated PHC service delivery points, task-shifting or task-sharing to reduce the time costs of highly skilled professionals (including shifting nursing tasks

from professional nurses to nursing assistants and from doctors to nurses and other assistants) and spending more on health services than in the past. Debate is necessary on the scope of the essential service package and on initiating periodic reviews of the package.

Every one of these examples has already been tried somewhere in the world and every example will have its challenges, proponents and detractors. Examples of effective and coherent health system planning exist in some provinces, yet also not without challenges, proponents and detractors. Fundamental reform must take place and choices must, therefore, be made and implemented systematically. The NDoH must utilise the available skills and experiences, initially from within the country but also from outside, to develop a health delivery plan that can be implemented systematically towards achieving universal coverage.

### Leadership, governance and effective management

Good leadership and management are imperative within and across every level of the health system. Areas must be identified where strengthening would result in the highest returns in improving performance and health status. While the front-line managers interface directly with the public and are often the target of attention, the national and the provincial levels need competent management to fulfil their role in enabling successful delivery at primary health care and hospital levels. Supervision and support, which are the role of the provincial and district managers, is critical.

### General management

Referring to the public health service, Harrison, in his overview towards prospects for new gains for the South African health system, indicates that “success has been hamstrung by the failure to devolve authority fully, and by the erosion of efficiencies through lack of leadership and low staff morale” and “generally weak health systems management” resulting in poor health outcomes relative to total health expenditure.<sup>7</sup> Developing managers' leadership skills is a priority if these poor outcomes are to be addressed.

Management capacity of hospital managers has been identified as a particularly critical concern, largely due to the size of the budgets managed in hospitals and the complexity of the environment. National level attempts to develop effective management training programmes for hospital managers have largely failed. Providing a broad curriculum outlining the most important elements of hospital management is appropriate, but decentralised, accredited, provincial level programmes can be more responsive and relevant to local challenges. Institutes of Higher Education are probably better placed to deliver courses locally and, together with the senior managers

<sup>a</sup> This model is fully described in chapter 15 of this Review.

in the service, to mentor their students.

Hospital and other health managers do not function as independent entities, but within a bigger health system. Their performance is a symptom of the support and guidance they receive from their provincial management structures. General management competence is strengthened by giving managers authority, decentralising decision-making and making them accountable. However, this needs to be done within a structured system of supportive supervision and monitoring and evaluation from the provincial level, which should make the system more resilient while motivating individual performance and accountability. Such performance and accountability should be linked to incentivised performance contracts.

With an effective support system, the vision for more responsive hospitals should be to decentralise the management of large hospitals and convert them into semi-autonomous structures with performance-linked funding.

## Financial resources

The high percentage of GDP spent on the health system is misleading since it is concentrated in a well-financed private sector. The public health system actually needs additional financial resources. Apart from being systematically under-funded over time, the public health system also carries a large burden of 'unfunded mandates'. For example, services are compromised because the full cost of Occupation Specific Dispensation for health professionals was under-funded, resulting in the funds for goods and services being used or the services being reduced to fund the shortfall. Another example is when health programme policy changes are made, such as dual therapy for prevention of mother-to-child transmission (PMTCT), but the consequences thereof are not fully funded. This is symptomatic of poor inter-departmental co-operation and the centre's disjuncture from activities on the ground.

The NDoH has a critical role to play in ensuring the financing of the health system towards universal coverage. NDoH leadership must improve bidding for improved financial resourcing in prioritised areas and protect provinces from unfunded mandates. Likewise, provincial departments of health must fully co-operate with one another and the NDoH to ensure that the quality of the data and evidence to support the bids is irrefutable. Collective stewardship is thus critical in the sector's efforts in securing funding for services.

Both national and provincial departments of health must improve their capacity to monitor service impact and return on investment (value for money) and to use financing mechanisms to leverage improved performance. Well-quantified service and performance targets captured in incentivised contracts are important tools to leverage improved perform-

ance. Furthermore, a new set of skills in the health management field is required to manage purchasing mechanisms and strategies. Funding to hospitals should be aligned to the case mix and acuity of patients. The diagnostic-related groups approach with public sector benchmarks would need to be developed and implemented. The private sector is much more experienced in this field and their expertise will be critical for this purpose.

Provincial departments of health collectively overspent their budgets by more than R7.5bn in 2009/10. While this signals the need for increased funding it is very clear from the Auditor-General's findings that poor financial management pervades in almost all provinces. Provincial departments of health, supported by National and Provincial Treasuries, must put together plans of action to improve compliance with the Public Finance Management Act (PFMA) and take steps to further decentralise decision-making and internal accountability. The capacity of public accountability representatives (for example standing committees and health facility boards) in a specialised field such as health is poor and these representatives need to be empowered so as to improve the relevance of their inquiry.

Slavish compliance with the PFMA, however, does not necessarily constitute good financial management. Managers in the health sector need to understand when rationing of certain services to remain within budget is actually more costly. They must monitor the variance of spending against budget on an almost daily basis and analyse the demands carefully so as to move funds to achieve their greatest impact.

The NHI service model budgets will probably have to be totally redesigned and funds allocated differently. Whether block grant funds will still be allocated to provinces through the provincial equitable share (PES) or if health budgets will be centralised out of the PES and allocated by the NHI/NDoH, is still not clear. The NHI model might fund at least PHC services through a capitation system, using an 'equitable share formula' locally. This could, however, have grave consequences for wasteful and inefficient services and, therefore, the recipient communities. Budget management mechanisms may need more flexibility than is currently the case to respond to capitation funding of private providers – leading to new rules being devised applicable to the public sector providers as well. Conceivably the provincial departments of health could be appointed as the authorities to manage private sector accountability at provincial level.

Finally, doing away with point-of-care payments will not necessarily reduce the administrative load although it will certainly change the financial clerical responsibilities in the services. NHI membership documentation will, for instance, have to be carefully maintained and capitation payments managed.

Improved and incisive management will be required to effect the changes and to manage the system diligently.

### **The role of the private sector**

The private sector has many strengths – this in terms of both health care provision and insurance administration. In the case of the latter, medical schemes are likely to remain part of the new system towards universal coverage, but will have to re-examine their role once the NHI funding mechanisms and basic package are determined. The schemes will provide only top-up and are likely to lose those members whose pay-roll tax is equal to or more than their present scheme contributions. There would be no incentive for such people to remain members. Trustees of closed schemes will need to understand the unique benefits their scheme offers over and above the basic package that is appropriate to the particular work environment of their members. Open scheme trustees will need to understand what services the members who remain will want and restructure their packages for only those services. Realignment and consolidation of schemes is likely, along with further rationalisation due to a reduction in the number of schemes, in membership and in coverage. Scheme administrators who have the existing knowledge and skills may be appropriately placed to act as administrative agents for the NHI.

In respect of service provision, the private provider sector uses disproportionately more of the available human resources in comparison to the service that it provides. It is often accused of clinical care practices with costs disproportionate to quality-adjusted life years added. Such over-servicing practices need to be governed to protect the public. Mechanisms will have to be designed and implemented to bind the private provider sector into the national health system without reducing its potential role and without causing more skilled health professionals to leave the country. The design and implementation phase towards universal coverage should have private sector representation.

### **Information for management and decision-making**

The quality of health information remains a challenge. A fully functional and comprehensive health information system will be a mandatory requirement for the implementation of the NHI. Population dynamics, patterns of disease expression, impact monitoring and resource allocation towards equity need to be drawn from good quality information.

The current public health care system is burdened with a myriad of data elements to be collected, yet information is not sufficiently packaged for decision-making. It is important to reduce the unnecessary sets of data that are being collected to those critically important for decision-making and necessary to monitor the attainment of strategic targets. Input, process

and output indicators should be derived from pre-determined health outcome indicators that health districts could relate to their particular geographic areas. The Minister's national service delivery agreement indicators would be an important starting point.

Information systems should be designed in such a way that they can monitor incentive-linked performance contracts towards leveraging improved performance and impact. This would include the machinery and capacity necessary to monitor the appropriateness of the essential package of care and the implementation strategies selected in order to make adjustments and to monitor compliance of service providers.

The private sector must contribute to the health status of the whole population in the health district/s where it is located. This implies the inclusion of private sector health information into the national data set and that the private sector's vision and target is aligned with improving the millennium development targets.

### **Human resources**

Creating human resources (HR) requires a range of strategic policy decisions to leverage the numbers and quality of staff needed for health system reform towards universal care.

McIntyre quotes from the Development Bank of South Africa report that, compared to 1997, the system needs an additional 80 000 staff in the public sector simply to address the increase in population size and the greater burden of disease from HIV and AIDS.<sup>5</sup> This number refers largely to health-care professionals but it must be recognised that decentralising decision-making brings added administrative and managerial needs at the decentralised levels. Furthermore, an increase in the auditing of the management of financial, human and information systems have exposed ill-capacitated areas, e.g. information and supply chain management staff.

The chapter on HR in this Review deals more comprehensively with this matter but, in the context of creating resources, several critical HR issues must be highlighted because an effective health service is so dependent on personnel.

The need to significantly increase the capacity of nursing colleges is urgent. Several medical specialities (histopathology, forensic medicine, cytology, anaesthetics, and others) are threatened. Human resource plans must reflect strategies of production, recruitment and investment. Appropriate HR plans are, however, only relevant if the personnel budget in the health sector is increased and posts are made available for which graduates can apply. Recruitment and selection policies and processes for staff with scarce skills must be re-examined. People with the right skills, character and attitude must be attracted, irrespective of their gender, race, origin or

any other criteria. Under the present dire circumstances, the health services can simply not afford to exclude any potential candidates.

The policy framework for financing the cost of training health science students is still awaited. The cost for both the Institutes of Higher Education and the public health system is very large and yet poorly quantified. It is urgent that this be addressed because of the long lead-time for producing health science graduates. Furthermore, health sciences faculties, and particularly those that train medical students, are not easily replicable across the country. The departments of Health and Higher Education need a clear national plan that will deliver the numbers and qualities required for the country and to ensure that those service platforms where training happens are properly resourced.

Finally, improving the organisational culture of health facilities is critical for a positive working environment. Part of the current poor culture may be attributable to poor leadership and management in institutions, poor human resource practices and poor communication. Furthermore, stress and high work burdens linked to very tight budgets add to the challenge. Strategies include practising shared values, fostering multi-disciplinary teamwork and having decentralised decision-making and accountability, with good labour relations.

## Delivering services

Sewankambo and Katamba, in their section in the Lancet series on Health Systems in Africa: Learning from South Africa, indicate with reference to policy makers and managers that: "their lack of stewardship and leadership has been evident in the highly variable quality of care delivered within the public health sector. For example, the Western Cape province had a TB cure rate of around 80% in 2007 whereas, for most of the districts in KwaZulu-Natal, the cure rates were between 40-60%".<sup>8</sup>

Harrison, in his article on priorities for new gains, systematically outlined the national priorities to reduce the burden of premature death.<sup>7</sup> Using the quadruple burden of disease he prioritised HIV and AIDS as the most compelling condition for action, with TB linked to it. He suggests injuries, chronic illnesses and maternal and child health as priorities and emphasizes that grand policy initiatives will only be applauded if they can be implemented effectively and produce demonstrable benefits. Tackling each of these conditions in silo and not addressing the systems' performance aspects comprehensively and systematically will not leverage higher impact with the resources available. For instance, health authorities need to ensure that there is appropriate targeting of upstream factors that impact on health status and that intersectoral activities are included in the delivery plans of the responsible

sectors, e.g. housing, sanitation and water quality.

The place to ensure this linkage is the district health system (DHS), which is the vehicle to deliver PHC and has been the policy directive since 1994. Health status indicators, community involvement and intersectoral collaboration have been improving where the DHS has been implemented well, such as in the Western Cape. All providers, public and private, in the area should be involved in and contribute to the achievement of the DHS targets of a health district. The providers of more specialised packages of care must fulfil a carefully structured and supportive role towards the health districts, actively manage referrals and govern access to expensive, highly specialised services, to avoid burdening the high-end services by referring uncomplicated cases. This will only happen if the clinicians trust the DHS to look after the patients which will, in turn, only happen if all levels of the system work together to build a coherent health care system.

There is nothing new in this approach – it is implementation of policies that remains a critical challenge. Mayosi, in a South African Medical Journal Editorial, indicates that the incidence of rheumatic heart disease for those aged 14 years and more in Soweto was 23.5 cases/100 000 per annum, which puts this urban community among the high incidence communities of the world.<sup>9</sup> He states that:

It is not surprising that this preventable condition remains common because of inadequate implementation of the guideline for the prevention of rheumatic fever in South Africa. A recent study showed that very few paediatricians were aware that rheumatic fever is a notifiable condition, and that the national notification system administered by the Department of Health was dysfunctional.

This is but one indicator of a dysfunctional system that comprises islands of independent services rather than a coherent, co-operative approach to delivering health care services in the country. Improvements are also needed in drug availability, health technology and infrastructure.

Much is made of equity of resource allocation, yet there are numerous examples of relatively poorly-resourced districts that have better outcomes than very well-resourced districts. Certain 'homeland' services of the past achieved better outcomes than many currently better-resourced districts achieve now. As preparations are made for the NHI it is important to acknowledge that efficiency is not directly related to resource equity. Soft issues of compassion and empathy, and concerned stewardship of resources at a local level, are critical to good outcomes. Whilst there are good examples of many devoted public health officials, the quality and commitment of many individuals in the Public Service leaves much to be desired. For the NHI to improve health outcomes, management will have to improve the training of staff and nurture a

real caring attitude. No amount of increased funding can buy an appropriate attitude. Every employee has a role to play in efficiency, controlling waste, avoiding duplication and shifting tasks to the health-care worker best placed to deliver the service. Without a fundamental shift in attitude and a refocus on the patient and the public beneficiary the aims of universal care will not be achieved. The challenge is to get the foundations right. It is not complicated science to ensure that all deliveries are supervised, to provide mobile antenatal and child health services across the country and to provide school health services to ensure that every child can hear and see and is able to learn at school.

## Responsiveness

Responsiveness is not only a measure of how the system responds to health needs, which is reflected in health outcomes, but also of how the system performs consistently and to every patient's need. Harrison warns that the challenge for policymakers is to demonstrate rapid improvements in the quality of service delivery indicators, such as waiting time and patient satisfaction.<sup>7</sup> This means that service managers must have the authority to tailor service delivery to respond to local, changing circumstances.

As the country moves towards universal coverage these public experiences must be measured and improved. Public expectations will, however, have to be managed so that citizens understand exactly what the system can provide and how to access services. The South African national health system will not be able to provide everything for everyone – it will, however, ensure equitable access to a pre-determined package of care with explicit rationing of certain services, with access and prioritisation according to explicit criteria.

Minister Motsoaledi, in recognising the constitutional principle of the right to quality health care, confirmed that a comprehensive approach to quality is required and identified six priority areas focused on patient experience and patient safety:<sup>3</sup>

- improved patient safety;
- infection prevention and control (IPC);
- availability of medicines;
- reduced waiting times;
- improved cleanliness; and
- positive and caring attitudes.

While the patient experience holds primacy, from a professional perspective, patient safety strategies require deliberate systems of clinical governance, including meaningful morbidity and mortality reviews, clinical audits and clinical risk management, with clinicians taking ownership and providing leadership. These activities should be structured and systematic, in

an environment safe for reporting.

Changes will be necessary to effect these new focal areas. Taking just one example, IPC training does not form part of the nurses and other health workers undergraduate training programme. IPC cannot be left to a few specialist IPC nurses in the country. All clinical staff and managers of clinical areas need to have some basic knowledge and skill in IPC and to practice it at all times. Health facility design should include IPC expert input. Focused IPC strategies should include hand-washing protocols, regular IPC audits in hospital wards and monitoring hospital-acquired infections from surgical sites, urinary and vascular catheters and in neonates.

Studies have shown that most errors and adverse events have similar underlying causes. The National Health Service in the United Kingdom (UK) incorporated this finding in its “Seven Steps to Patient Safety”,<sup>10</sup> namely:

- building the safety culture;
- leading and supporting staff;
- integrating risk management activity;
- promoting reporting;
- involvement and communication with patients and the public;
- learning and sharing safety lessons; and
- implementing solutions to prevent harm.

Being accountable for quality must be strengthened through including it in the performance contracts of all managers and all health workers, including cleaners. In the UK managers are now losing their jobs due to quality concerns.

The establishment of the Office of Standards Compliance (OSC) is an important development in South Africa to improve responsiveness. The Office must be provided with the necessary capacity and ‘space’ to develop a systematic improvement plan responsive to the quality challenges in the system, especially the public health system. However, all managers still need to be involved at all levels of the care chain and some aspects of its functioning should be delegated or devolved to provincial level in order to commit the provincial management to compliance.

The above are a few examples of the reforms that are necessary to improve the public's confidence in the public health care system.



## Conclusions

The NHI will require a far more efficient and effective health system than is currently the case. The universal coverage ideal will put pressure on an already stressed system. Reaching agreement on the financing system and its management is a crucial requirement but there are more immediate challenges, fundamental to a successful national health system, which must be addressed in the meantime. In this chapter the authors have identified the key strategies as follows:

- stewardship, with its related activities of leadership and management – especially at national and provincial levels;
- a single vision for health, uniting all players;
- strengthening the district health system, with provinces fulfilling their role as enablers, and decentralising decision-making and accountability to hospitals and health districts; and
- ensuring that health district-based outcome indicators are owned by all the providers and the community in the area.

## Recommendations

The envisaged reform of the health system towards universal coverage is a necessary, albeit ambitious, one. For this reform to achieve its purpose, careful planning and very decisive execution, with sufficient attention to improving performance as outlined in this chapter, must run in parallel to the finalisation of the financing mechanisms.

A critical aspect is that the National Minister involve the widest possible representation of health system managers to ensure buy-in to the vision, thereby preparing the health care system for universal coverage and improved performance. Representation must include public and private providers, national and provincial planners and health system managers and invited experts to work with experienced leadership in a National Health Planning Commission accountable to the National Health Council. The agenda for such collaboration should include aspects of design, resource allocation and performance improvement and may require focused sub-commissions to refine plans. A systematic, stepwise approach is required, drawing on the capacity available in the existing broad health system.

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