CONFRONTING THE RIGHT TO
ETHICAL
AND
ACCOUNTABLE
QUALITY
HEALTH CARE IN SOUTH AFRICA

2019
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In 2017, the journal *Lancet Global Health* asked me to convene a Commission on quality of health systems in low- and middle-income countries. Such a Commission called for an inclusive process, one that incorporated the views and expertise from countries leading and learning in the area of quality. South Africa played a critical role in many aspects of our work. We were delighted to have Director-General Precious Matsoso as one of our global Commissioners. The South African Health Department hosted the second meeting of the global Commission, in which we approved the key findings and drafted recommendations. South Africa, along with seven other countries, convened a National Quality Commission that examined quality in the local context. This report is the result of those efforts.

This report is a landmark achievement in several respects. First, the South Africa National Commission was highly participatory, comprising leaders in academia, medicine, education, and health system management. As such, it took a broad perspective on quality that incorporated ethical, clinical, and managerial concerns, rescuing the issue from the narrow technical silo to which it has traditionally been consigned. Second, it took an unflinching look at current quality deficits in the country. Despite a supportive policy environment and decades of substantial health system advances, the report finds that too many men, women, and children still die in South Africa from conditions treatable in the health system. Honest appraisal of performance is the starting point for improvement and the National Commission should be lauded for its willingness to hold the system to account.

The Commission’s recommendations are bold, as required by the diagnosis. The Commission is not papering over the challenges by suggesting incremental solutions—rather it is calling for reforms in the very structures of the health system and beyond. The Commission calls for stronger governance for quality from the Health Department on down to the clinic. Importantly, it calls for greater involvement of communities in reviewing performance and of health professional organisations in strengthening oversight. It proposes a Programme of Action to promote highest quality of clinical care for conditions contributing most to the country’s disease burden, including non-communicable diseases and mental health. This programme would involve and educate communities about their rights and expectations.

The Commission also recommends reinvesting in human resource training, posting, and remuneration to align these with the goal of a high-quality system. Finally, the Commission calls for stronger measurement, beginning with a dashboard that captures quality metrics across the system, public and private. The new measures would inform governance decisions and guide improvement.
Quality is a critical determinant of health and a high-quality health system is the driver of successful universal health coverage. It has been a privilege to work with the South African Lancet National Commission on clarifying what this means for each country and how we can make progress and learn from each other. I am confident that this report provides the starting point for a health system transformation that will lead to competent, kind, and valued care for every South African.

Dr Margaret E. Kruk, MD, MPH

Chair: Lancet Global Health Commission on High-Quality Health Systems in the SDG Era
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The views presented in this report are those of the Commissioners and based on literature reviewed, robust debates and discussions among commissioners, and the analysis and synthesis of the information obtained, and do not necessarily represent the decisions, policy or views of the National Department of Health, the European Union, EU- Lux-WHO UHC Partnership or any of the funders.
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<td>ICRM</td>
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<td>Promotion of Access to Information Act</td>
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<td>PEPFAR</td>
<td>United States President Emergency Plan for AIDS Relief</td>
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<td>PERSAL</td>
<td>Personnel Salary Administration System</td>
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<td>Standard Treatment Guidelines</td>
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<tr>
<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>United Nations AIDS Programme</td>
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<td>VBC</td>
<td>Value-based Contracting</td>
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<td>VLM</td>
<td>Viral Load Monitoring</td>
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<td>VLS</td>
<td>Viral Load Suppression</td>
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<td>VMMC</td>
<td>Voluntary Male Medical Circumcision</td>
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<tr>
<td>VR</td>
<td>Vital Registration</td>
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<tr>
<td>WBCOT</td>
<td>Ward-Based Clinical Outreach Teams</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>WMA</td>
<td>World Medical Association</td>
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EXECUTIVE SUMMARY

South Africa has made great strides since the end of apartheid in 1994 in improving overall population health and well-being, reflected in increased life expectancy and reductions in mortality rates. The rights-based Constitution and other enabling legislation and policies, strong institutions and available resources provide a strong health system foundation for universal health coverage.

However, South Africa’s democratic government faces significant challenges in providing high-quality health care. These challenges include: the quadruple burden of disease; the racialised nature of poverty levels and unemployment rates; huge spatial inequalities; inequities among provinces, between urban and rural areas, and between the public and private health sectors; inadequate resources (human, financial and physical); poor management and governance of the health system; gaps in ethical leadership and lack of accountability.

This report reflects the consensus of a 13-member South African Lancet National Commission, tasked with assessing critically the state of quality of care in the health system and proposing evidence-based recommendations to decision-makers and practitioners on achieving a high-quality health system. The accompanying report contains the background, methods, results and recommendations of the review conducted by the Lancet National Commission, established in May 2017.

Our intended audience for this consensus report is broad ranging and includes policy makers, health leaders and health managers and health care providers in both the public and private health sectors, academics, community-based and non-governmental organisations, organised labour and civil society in general.

We have structured the report into three sections.

**Section 1** focuses on Governing and Leading for Quality, and consists of two chapters: leadership, management and governance (Chapter 2) and information for quality (Chapter 3).

**Section II** examines the Current State of Quality through the lens of South Africa’s burden of disease: HIV and AIDS (Chapter 4); maternal and child health (Chapter 5); non-communicable diseases, specifically hypertension and diabetes (Chapter 6) and mental health (Chapter 7).

**Section III** examines Quality through a Health System Lens: financing (Chapter 8); health care providers (Chapter 9); quality improvement programmes (Chapter 10) and social justice and ethical, accountable quality health care (Chapter 11).
The concluding section (Chapter 12) integrates the key messages of the report and contains the key diagnostic findings and a detailed set of recommendations.

**KEY DIAGNOSTIC FINDINGS**

The Commission’s key diagnostic findings are listed below:

**Finding 1  Gaps in ethical leadership, management and governance contribute to poor quality of care.**

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 the poor quality of care. These gaps are exacerbated by evidence of mismanagement, inefficiencies and incompetence at various levels of the health system. Corruption and fraud are major threats to equitable access to quality health care.

There are several failures of governance in the private health sector, including a lack of transparency and lack of accountability to members of the public that belong to medical aid schemes.

There are governance weaknesses in the Health Professions Council of South Africa and the South African Nursing Council, which are the regulators of the majority of health professionals in South Africa.

There are numerous barriers to effective community participation, which in turn influences accountability, the essence of which is answerability.

**Finding 2  Poor quality of care costs lives.**

South Africa remains at the forefront of the fight against HIV & AIDS. Mortality rates have declined substantially in the past decade and the country has the largest anti-retroviral treatment programme in the world. However, the evidence shows that poor quality of care costs lives. Since 2008, around 60% of all institutional maternal deaths were potentially preventable, with rural areas worst affected compared to their urban counterparts. An estimated quarter of neonatal deaths are potentially preventable because of a combination of health system and provider reasons. There are also deficiencies in the quality of care provided to individuals with hypertension and diabetes. Mental illness contributes to premature mortality, high morbidity and loss of economic productivity. However, there is lack of prioritisation of mental health, and under-investment in service delivery. It is estimated that 75% of people with a mental disorder do not receive mental health services. It is mostly poor, black South Africans in rural areas who bear the brunt of this treatment gap.
Finding 3  Malpractice cases and medical litigation are threats to the realisation of the right to health care in South Africa.

In the 2016/17 financial year, the Auditor-General reported that litigation and claims in the public health sector amounted to R1.2 billion. In 2016, the South African Law Reform Commission estimated the total contingent liabilities for medical malpractice in provincial health departments at around R40 billion, thus placing a huge burden on the distressed health system and reducing financial resources available for health service provision. In the private health sector, the long-term average claim frequency for doctors was 27% higher in 2015 compared to 2009. In this sector, medico-legal cases also occur but are handled privately and are kept out of the public domain.

Finding 4  The human resources for health (HRH) crisis will undermine the achievement of high-quality universal health coverage.

This crisis is characterised by: staff shortages, inequities and mal-distribution between urban and rural areas and between the public and private health sectors; unprofessional behaviour and poor staff motivation and performance. This crisis will undermine the achievement of high-quality universal health coverage, if not addressed. In the public sector, the lack of knowledge and skills of doctors and nurses were contributory factors in the potentially preventable maternal deaths. In the private sector, nurses’ failure to follow guidelines, unresponsiveness to patients and knowledge gaps contributed to medico-legal claims.

Finding 5  Health information system gaps constrain the country’s ability to measure or monitor quality and its improvements.

The South African government’s commitment to measuring quality has been longstanding. There is an enabling legislative and policy environment for the development of a health information system to measure quality. Numerous health measurement platforms exist that provide information on health system inputs, processes, service delivery, outcomes and impacts. However, most of these do not provide sufficient and appropriate information on health outcomes and impacts, nor are they sufficiently person-centred. Quality of care indicators focus primarily on structure, process and outputs in both the public and private health sectors. Data quality remains a significant barrier to the assessment of health system performance on the quality of care provided. Health information systems are partially electronic, are not interoperable, do not make available patient-level data, and are not capable of reporting aggregated data across public and private health sectors, or across levels or care pathways.

Finding 6  There is fragmentation and limited impact of quality of care initiatives.

Although there are numerous and encouraging quality improvement initiatives in South Africa, the impact is limited because of fragmentation across health conditions, levels of care and between the public and private health sectors.
RECOMMENDATIONS

South Africa’s Constitutional values of human rights, equity and social justice underpin the Commission’s recommendations. We recognise the unacceptable inequities in health care access, quality of care and spending between the public and private health sectors, and the vulnerability of individuals with certain conditions (such as mental health) or by location (rural and/or poor areas).

Hence, the Commission considers it a moral and ethical imperative to provide high-quality universal health coverage (UHC) in South Africa, using an overall systems approach as enunciated in our definition and conceptual framework.

The planned national health insurance (NHI) system provides an opportunity to achieve a transformed, high-quality health system, responsive to people’s needs and to introduce innovative reforms that could enhance quality, health care access, reduce costs, and improve efficiency.

However, the implementation of our recommendations will require investment, responsibility and accountability on the part of all health system leaders, including politicians, health managers, front-line health workers, and their representative organisations.

The Commission proposes four overarching recommendations:

1. Enhance governance and leadership for quality and equity.
2. Revolutionise quality of care.
3. Invest in, and transform human resources in support of a high-quality health system.
4. Measure, monitor and evaluate to ensure a high-quality health system.
Recommendation 1: Enhance governance and leadership for quality and equity.

a. Prevent fraud and corruption.
   i. Inculcate ethical and effective leadership drawing on 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 proactively managed.
   ii. All health professions councils should re-iterate ethical codes and enforce ethical and professional behaviour of health professionals under their jurisdiction.
   iii. Health authorities (both public and private) should communicate a message of no tolerance to fraud and corruption in the health sector.
   iv. Alleged transgressions of managers and health workers should be investigated without delay, and swift action taken.
   v. The National Department of Health (NDoH) should draw on the expertise of the National Prosecuting Authority, the Public Service Commission and civil society organisations to combat corruption through prevention, detection, disciplinary action and possible prosecution.
   vi. The NDoH should be provided with copies of the provincial health departments’ prevention of fraud and corruption plans (which is a legislative requirement) and their implementation should be monitored at the National Health Council.
   vii. The NDoH should also request provincial treasuries to monitor the implementation of the plans on the prevention of fraud and corruption in health departments.
   viii. All health workers should be given the number of the hotline to report fraud and/or corruption.
   ix. Training for politicians in national parliament and provincial legislatures should be revitalised to instil basic knowledge on health outcomes and health system performance (including quality of care) to enable them to hold health departments accountable.

b. Strengthen community health structures.
   The NDoH should lead the strengthening of community health structures such as mental health review boards, hospital boards and community or clinic health committees.
   i. Implement the provisions of the National Health Act on community participation and community structures.
   ii. Ensure that at least one target on community health structures is included in the annual performance plans of provincial health departments, accompanied by the allocation of appropriate resources.
   iii. Implement a compendium of training materials that provide guidelines on the selection, training and functioning of community health structures.
   iv. Request development partners to provide bridging funding for training of all members of community health structures to enhance their capacity to provide oversight of quality initiatives.
   v. Conduct a biennial survey on the functioning and effectiveness of the various community health structures.
(c) Invest in, and increase the capacity of, the Office of Health Standards Compliance.

The OHSC is a quality of care regulator that is unique in a low-and middle-income country setting. We recommend the following.

i. Treasury should increase the financial resource allocation over the medium-term expenditure framework to enable the OHSC to:
   a. Appoint additional technical experts in quality of care and information management.
   b. Expand its inspection capacity for increased coverage in the public health sector.
   c. Include the private sector for inspection of health facilities.
   d. Implement an early warning system in all health facilities.
   e. Strengthen its employee assistance and support programme.

ii. The OHSC should enhance its communication capacity to enable it to share good practices across institutions and among provinces and to encourage a culture of learning, openness, and continuous quality improvement.

iii. The OHSC should enhance its capacity to enforce norms and standards.

iv. The OHSC should be encouraged to establish partnerships with academic institutions to increase its technical capacity in the short-term.

v. The Minister of Health should consider the separation of the OHSC and the Office of the Ombud to avoid a potential conflict of interest in future, and to enhance the effectiveness of both bodies.

(d) Enhance the capacity and effectiveness of the Council for Medical Schemes.

The Council for Medical Schemes (CMS) should enhance its ability to provide effective oversight of the private health insurance sector.

i. Implement the provisions of the Medical Schemes Act (as amended).

ii. Protect the interests of members or beneficiaries of private health insurance schemes.

iii. Create a dedicated unit to analyse data on quality of care indicators in the private health insurance industry.

iv. Ensure that private health insurance schemes report on measures taken to improve quality of care to their members.

v. Enhance its communication capacity to enable it to share good practices across medical aid schemes.

vi. Encourage a culture of learning and openness and voluntary compliance with the provisions of the Medical Schemes Act.

vii. The NDoH should hold the Board of the CMS accountable for fulfilling its legislative mandate.

(e) Strengthen governance, effectiveness and efficiency of the various health professions councils.

i. The NDoH should develop a minimum set of indicators (no more than 10) to ensure that each Council meets its legislative mandate, which is to ensure ethical conduct and professional behaviour of the health professionals under their jurisdiction and the provision of quality health care.

ii. Each Council should be required to conduct an annual board evaluation in line with the principles of good governance and submit the report to the NDoH together with its annual report.

iii. Each Council should ensure that the health professionals under its jurisdiction maintain quality of care competencies, in line with the best available scientific evidence.
iv. Each Council should use the annual registration process to communicate the importance of ethical and professional conduct and accountability of health professionals under its jurisdiction.

v. Each Council should investigate ethical or quality of care transgressions immediately and ensure that professionals under their jurisdiction are held accountable.

vi. The Forum of Statutory Health Professions Councils provides an important mechanism for the NDoH to ensure accountability of the various health professions councils. The Forum should be revitalised, and appropriate resources allocated so that it can achieve its intended objectives.

**Recommendation 2: Revolutionise quality of care.**

**(a) Revitalise the provision of responsive, high-quality clinical care that responds to the burden of disease.**

i. Enhance the current HIV care cascade, by situating it within the larger context of PHC, routinise HIV counselling and testing and encourage a cross-sectional continuum of care to ensure that the comprehensive health needs of HIV-positive patients are met.

ii. Minimise LTFU in HIV care, encourage re-entry to care and improve retention.

iii. Embark on a national, concerted effort to ensure implementation of the recommendations of the National Confidential Enquiry into Maternal deaths, especially measures to improve the quality of maternal and neonatal care.

iv. Prioritise screening for diabetes and hypertension at all health care facilities in the country.

v. Improve clinical care and case management of individuals with hypertension and diabetes, in partnership with them. This should include inter alia, standard treatment guidelines and the availability of essential equipment, health laboratory facilities, essential medicines and referral guidelines.

vi. Mental health deserves prioritisation at both political and implemental levels, through resource allocation (finances and human resources) that are commensurate with the burden of mental illness and substance use disorders.

vii. Ensure implementation of the provisions of the Mental Health Care Act and Policy Framework and Strategic Plan, prioritising community-based mental health services and respect for human rights.

**(b) Prevent medical malpractice and litigation.**

i. Develop strategies to prevent malpractice and medical litigation.

ii. Implement the 2016 Medico-legal Summit Declaration, together with expediting law reforms through the South African Law Reform Commission investigation into medical litigation.

iii. Compassion, competence and autonomy together with respect for fundamental human rights serve as the foundation of ethical practice in health care and must be promoted.

iv. Health professions councils should ensure ethical conduct and professional behaviour of the health professionals under their jurisdiction and the provision of quality health care.

**(c) Embark on a national campaign to educate patients and communities about their health rights and responsibilities.**

i. The NDoH should lead a national social mobilisation campaign to increase public awareness of quality of care issues.
ii. NDoH should design the campaign with inputs from, and partnerships with the Government Communication and Information Services, the Presidency, South African Human Rights Commission, OHSC, civil society organisations.

iii. The campaign should focus on health rights within the context of the Bill of Rights, the responsibilities of individuals for their health, and the rights and responsibilities of health workers.

iv. The campaign should include information on the importance of disease prevention, health promotion and protection, health outcomes, health system performance (including OHSC inspection reports) and mechanisms for remedy and redress at different levels of the health system. The latter should include the importance of mutual respect between community members and health workers, communication channels, where to initiate a complaint, when to escalate a complaint, and the number of the hot line of the OHSC.

v. The communication media should include mobile phones, radio, television, social media, print, and the utilisation of existing forums where the campaign would be visible to large numbers of people (such as shopping centres, pension pay-outs, places of worship, and schools).

(d) Design an integrated, quality improvement Programme of Action (POA).
The POA should cover the entire health system and all modes of health care delivery in the 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.

i. Recognising the vision on health in the National Development Plan and in various Department of Health Strategic Plans, the POA should take into account the following:
   a. South Africa’s burden of disease.
   b. Provision of safe and effective clinical care, that is respectful and responsive to the needs of both patients or communities and health care providers.
   c. The numerous disparate quality of care initiatives across the country.
   d. Key inspection findings of the OHSC.
   e. Financial, human and other resource requirements.

ii. An inclusive National Steering Committee should provide stewardship of the POA.

iii. In each province, there should be an extensive consultation process to develop a provincial POA that will ultimately feed into the national POA. The consultation should include:
   a. Front-line health care providers in both the public and private health sectors, including their supervisors and managers.
   b. Community health structures (hospital boards, community or clinic health committees).
   c. Local government.
   d. Organised labour.
   e. Academics and health experts.
   f. Patients’ rights groups.
   g. Relevant civil society organisations.
   h. Development partners.

iv. Each provincial POA should take into account the variations in the burden of disease, health [in] equity, the state of quality of care in its health care facilities, prevention of fraud and corruption,
the strategies for the prevention of medical litigation, and the creation of a positive practice environment that enable the provision of safe, respectful and effective care.

v. Each provincial POA should prioritise critical interventions needed to improve quality (e.g. competencies of clinical staff, quality supervision, professional accountability) and demonstrate a mind-set shift of ongoing, sustained improvement rather than contain a wish list of all possible quality improvement activities in the health system.

vi. The provincial POA should feed into the development of the national integrated quality-improvement POA. The National Steering Committee should use the current discourse of the NHI system as a lever to revolutionise quality of care in South Africa.

vii. The final POA (after extensive consultation) should include clear cost estimates, including additional resource requirements for its implementation. The POA should also contain financial estimates of the social and economic value that would accrue from the implementation of the POA in South Africa.

viii. The POA should have clear implementation targets and be included in the public sector health budget bid submitted to National Treasury, with prioritisation of rural areas in South Africa, and the implementation of the provisions of the Mental Health Care Act. The private sector should demonstrate resource allocation for the implementation of the POA.

ix. The Minister, supported by the National Steering Committee on the POA, should ensure annual monitoring of the implementation of the national POA.

Recommendation 3: Invest in, and transform, human resources for health in support of a high-quality health system.

(a) Develop a transformative HRH plan.

i. The NDoH should use the opportunity provided by the development of the HRH plan for the period 2019/20-2024/25 to partner with front-line health care providers for a high-quality health system and to make health equity and quality the foundation of the new HRH plan.

ii. Finalise staffing norms and standards that are informed by the national quality POA.

iii. Quality of care improvements should be part of the daily responsibility of every health worker, health manager or supervisor, regardless of setting or level of care.

iv. The NDoH should lead 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, the responsibilities of individuals for their health, and the rights, responsibilities and individual accountability of health workers.

v. In the public sector, health managers should be recruited based on merit and core competencies in line with the provisions of the Public Service Act, and their credentials must be screened prior to appointment.

vi. Each executive or responsible manager should be assessed in respect of the values of integrity, compassion, accountability, fairness and transparency, and be required to commit to the Public Service Code of Conduct in writing. All health managers should be held accountable for their actions.

vii. The NDoH should urge the Department of Public Service and Administration to develop
guidelines aimed at eliminating political interference in staff appointments, including a possible amendment of the PSA to be in line with the Public Finance Management Act.

viii. A review of the performance management system and its application should be undertaken to ensure that employee performance is linked to organisational performance, employee development and team-based performance (where appropriate). Rewards should be based on clear performance goals, including the consideration of models of team-based remuneration.

ix. Partner with front-line staff, organised labour and other staff representative organisations to ensure positive practice environments (including employee assistance programmes) that facilitate the provision of high-quality care.

x. The Public Service Commission should monitor whether appointments in the public sector are in line with existing legislation.

(b) **Strengthen or include a compulsory module on quality of care in both pre-service training and continuing professional development programmes of health professionals.**

i. 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.

ii. 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.

iii. 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.

**Recommendation 4: Measure, monitor and evaluate to ensure a high-quality health system.**

**Develop and enforce an integrated national health system performance dashboard.**

i. The NDoH should develop and enforce an integrated national health system performance dashboard with an initial list of performance indicators that measure quality outcomes in the health system. Theses indicators should be expanded over time.

ii. These indicators should be based on existing information that is collected.

iii. The NDoH should prioritise analysis, interpretation and feedback of these key indicators with interrogation of variances, similar to those for financial indicators.

iv. The health information system should be strengthened and implementation of the dashboard should be appropriately staffed and resourced.

v. Managers should be trained in the use of the dashboard for decision-making and action.

vi. The dashboard should be presented and explained to community structures, to enable effective oversight.

vii. The NDoH should strengthen its health information system oversight and analytical capacity.

viii. The collection, reporting and utilisation of appropriate quality information should be enhanced in both the public and private health sectors.

ix. The stewardship role of the National Health Information System of South (NHISSA) should be expanded and strengthened.
CONCLUSION

The implementation of the recommendations requires strong leadership and stewardship from the NDoH. The Department should 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.

There is an ethical and moral imperative to implement the recommendations of the South African Lancet Commission Report because our communities and the many committed, hard-working health managers and health care 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 universal health coverage.
CHAPTER 1: THE CASE FOR A HIGH-QUALITY HEALTH SYSTEM

1.1 INTRODUCTION

In 1994, South Africa emerged from decades of apartheid’s policies of legally enforced racial segregation and state-generated political, social and economic inequalities, which have implications on and for, health policy and for the discourse on a high-quality health system. Globally, the quest for universal health coverage (UHC) and access to quality health care have been given renewed impetus with the 2015 United Nations (UN) Sustainable Development Goals (SDGs) (1). Across the world, initiatives to improve the quality of health care have been developed to ensure patient safety and dignity, improve clinical effectiveness and promote accountability (2-4).

Despite these encouraging initiatives, health systems are constrained in their ability to provide quality care that improves health outcomes and are responsive to community needs (5). This is especially the case in many low- and middle-income countries (LMICs) like South Africa. The challenge to provide quality care is complicated by a dearth of research, standard definitions, and measurement tools that go beyond individual disease areas (5).

In response to these challenges, The Lancet Global Health Commission on High-Quality Health Systems in the Sustainable Development Goals (SDG) Era (HQSS Commission) was established in 2017 to “review current knowledge, undertake new empirical work and propose policy recommendations to measure and improve quality in pursuit of the Sustainable Development Goals (SDGs)” (5). Underpinned by themes of ethics and health equity, the Commission aimed to define health system quality, describe quality of care and its distribution across tracer SDG conditions, thereby proposing system-wide quality improvements (5). As part of the Global Commission, national commissions were established in several countries, including South Africa. Launched in May 2017, this is a consensus report of the South African (SA) Lancet National Commission.

Box 1: Key messages on the case for a high-quality health system

1. South Africa’s Constitutional values of human rights, equity and social justice underpin the work of the Commission and ensuing recommendations.
2. The socio-political-economic context of South Africa is linked inextricably to the achievement of a high-quality health system in the country.
3. A high-quality health system is able to achieve equitable health outcomes and a long and healthy life for all.
4. There is a moral and ethical imperative to provide high-quality universal health coverage in South Africa.
The overall approach to the work of the SA Lancet National Commission consisted of the following strands:

1. A critical review and synthesis of the literature on high-quality health systems including peer-reviewed journal articles, reports, as well as those produced previously by the National Department of Health (NDoH).
2. Interviews with ten key informants in government, private sector and civil society as part of the Lancet Global Commission subcomponent on governing for quality.
3. Monthly meetings and deliberations of the SA Lancet Commission, including a combined meeting with all other national commissions and the Global Commission in December 2017.
4. Taking account of the findings and recommendations of three global reports on quality: The Lancet Global Health Commission (2); the National Academies of Sciences, Engineering and Medicine (3); and the World Health Organization (WHO). World Bank and Organisation for Economic Co-operation and Development (OECD) (4).

1.2 **Defining a high-quality health system in South Africa**

The SA National Commission deliberated extensively on the definitions of quality and a framework that would be appropriate to the South African context. We were determined to distinguish between quality health care, and a quality health system, and developed a definition that emphasises an overall health systems approach to quality.

Perceptions of quality vary according to the needs of different stakeholders. Health care providers, for example, tend to emphasise the technical quality of care, such as adherence to treatment protocols, infection prevention and the desired outcomes related to successful treatment; reduction in morbidity, mortality and disability (6, 7). 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 health care managers focus on the health systems performance, value for money (7, 8) and population level outcomes (6, 7).
Our consensus as a National Commission is that a high-quality health system is able to achieve equitable health outcomes and a long and healthy life for all. It prioritises health promotion and protection as well as the prevention, treatment and rehabilitation of conditions that constitute South Africa’s disease burden. It is accountable through effective leadership and governance and is people-centred in its approach by facilitating patient, provider and community participation in health attainment. A high-quality health system is responsive to patient needs and provides comprehensive, timely and safe care, which ultimately results in quality outcomes. It adapts to the changing health needs by collecting, analysing and disseminating information and equitably allocating and distributing resources.

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<th>Table 1: Definition of a high-quality South African health system</th>
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<td>A high-quality health system achieves equitable health outcomes and a long and healthy life for all. Such a health system is:</td>
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<tr>
<td>o Designed to prioritise health promotion and protection, the prevention, treatment and rehabilitation of conditions that constitute South Africa’s disease burden.</td>
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<td>o Accountable through effective leadership and governance.</td>
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<td>o People-centred in its approach to realising good health by facilitating patient, provider and community participation in health attainment.</td>
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<td>o Responsive to patient needs by providing comprehensive care in a timely, respectful and safe manner resulting in quality outcomes.</td>
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<tr>
<td>o Adaptive to changing health needs through the collection, analysis and dissemination of information, to support decision-making and implementation.</td>
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<td>o Committed to equitable allocation and distribution of resources.</td>
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<td>o Effective in ensuring quality health service delivery to all regardless of gender, sexual orientation, socio-economic status and/or geographic location.</td>
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<tr>
<td>o Collaborative in its interaction with partners and other sectors to address the social determinants of health for quality health outcomes.</td>
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Our proposed conceptual framework (Figure 1) draws on our definition (Table 1) and takes an overall health systems approach as proposed by van Olmen et al (9). The values of human rights, equity and social justice, enshrined in the South African Constitution (10), underpin our conceptual framework. We recognise that the provision of quality health care on its own is unlikely to lead to optimal health outcomes. This is because socio-political-economic factors are critical in determining the success of health and other social services (11). Similarly, South Africa’s burden of disease is linked inextricably to the socio-economic context and these factors influence our conceptual framework. Hence, we have underscored these aspects in our conceptual framework.

Leadership and governance are critical to ensure the inputs required for quality care and are essential for health service delivery. The inputs in our framework are equivalent to the WHO building blocks of the health care system (12). The Commission envisages health service delivery that is based on the 1978 primary health care approach (PHC) as enunciated in Alma-Ata (13) and that prioritises 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 in highly specialised hospitals. Person-centredness is critical to treatment and care, facilitating and enabling both patient and health care 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 are a healthy SA population, equity in the level and distribution of health outcomes, and social and financial risk protection (Figure 1).

1.3 The Importance of Context to Quality of Care

The socio-political-economic context of South Africa is linked inextricably to the achievement of a high-quality health system in the country. The apartheid legacy continues to shape socio-economic status, disease burden, and access to care. Hence, “racial” classification is used in this report to illustrate these historical inequities, rather than to give credence to these social constructs.
South Africa is home to 57.7 million people: a diverse population of black African people who comprise the majority of the population (80.8%) and minority populations classified as Coloured (8.8%), White (7.8%), and Indian/Asian (2.5%) (14). Approximately 51% of the population is female (14). The country has a large population of young people aged 15 years or younger (29.5%) and a small but growing elderly population (8.5%) (14). On average, South Africa has a sex ratio of 95 males for every 100 females, which is in line with the demographics of other countries of similar economic status (14).

South Africa is a middle-income country with a gross domestic product (GDP) of US $ 296 billion in 2016, a drop from a high of $357 billion in 2013 (15). This GDP drop reflects the slow economic growth, which has had a ripple effect on poverty, unemployment, and inequality. Although the democratic South African government has used a combination of legal, structural interventions, progressive social programmes and fiscal policies to support redistributive measures, poverty, inequality and unemployment constitute a triple socio-economic burden in South Africa (15). The historical origins of this burden are in the decades of colonisation, apartheid and racial, gender and class oppression (16). More than two decades after democracy, and despite its upper middle-income level status, South Africa remains one of the most unequal countries in the world with a 2016 Gini coefficient of 63.4 (17).

Poverty remains intractable, with a demonstrable increase in vulnerability over a ten year period from 2006 to 2015 that is deeply disturbing (18). Between 2008 and 2015, 78% of South Africans slipped into poverty at least once, and rural poverty has outstripped those of urban areas (15). In 2015, 30.4 million or 55.5% of South Africans lived in poverty or survived on less than R992 per month (18). The number of people in extreme poverty—or on less than R441 per month—has increased by 12.8 million from 11 million in 2011 to 23.8 million in 2015 (18). Children under the age of 17 are the hardest hit. Poverty is further complicated by its racialised character, and was highest among Black Africans, rising from 36.4% to 40% followed closely by rates among Coloureds from 20.2% to 23.1% (18). In contrast, the rates of poverty have more than halved among Indians from 2.9% to 1.2%, and remains extremely low in the White population at 0.4% in 2015 (18). This suggests that poverty is growing and is differentiated by race, thus perpetuating the apartheid legacy.

Unemployment rates and the rates for young people who are not in employment, education or training (NEET) vary by race, age, and gender. The Quarterly Labour Force Survey (QLFS) for the second quarter of 2018 found that the official unemployment rate increased by 0.5 percentage point to 27.2% compared to the first quarter of 2018 (19). The female NEET rate was higher than that of their male counterparts for all population groups (19). Importantly, the highest NEET rate of over 40% was recorded among black African females aged 15 to 34 years (19).

Furthermore, the failure to transform institutionalised segregation in many spheres of the lived experience such as education, housing, and wealth distribution has had the effect of perpetuating and, in some cases, exacerbating socio-economic inequities (20).

Inequality is also reflected in the disease burden. In 2018, South Africans continue to be confronted with a quadruple burden of disease: the HIV/AIDS epidemic alongside a high burden of tuberculosis (TB); high maternal and child mortality; high levels of violence and injuries; and a growing burden of
non-communicable diseases (NCDs) (21, 22). An analysis of the distribution of illness across socio-economic groups shows that socially determined illnesses and disability disproportionately affect poor people. In 2016, tuberculosis and HIV disease accounted for the leading causes for death amongst black Africans, while ischaemic heart diseases were the leading cause of death among Whites (22).

The disparities in health status, which speak to the greater need for health care among poor people, is complicated by the country’s public health system that is resourced inadequately to meet the health needs of the poor. Inequities in health care access, quality of care and spending between the public and private health sectors remain acute (23). In 2016/17, the public sector health budget was R168.4 billion (24) while R158 billion was spent on medical aid schemes, which only covered 16% of the population through private health insurance (25).

There are also disparities in access to health care by race and sex. Black men were more likely to use private health facilities for care than Black women, regardless of the location of the facility. Furthermore, the majority of White people and the emerging Black middle class have access to well-resourced private health facilities through prepaid private health insurance (26). An estimated 72.2% of Whites are members of a medical aid scheme compared to 49.5% of Asians, 19.7% of Coloured and 10.5% of Black Africans (26). Rural and peri-urban indigent women and their children are still served predominantly by the under-resourced public health care system (26).

The disparities in access to health care by race are compounded by income and geographic inequities, with rural, Black Africans and poor people most disadvantaged (26). This reality adversely impacts on the 50% of the Black African population who reside in rural areas. Although 90% of South Africans live within 7 km of the nearest public clinic, 14% of Black African adults live more than 5 km from the nearest facility, compared to only 4% of Whites (26). Living far from health facilities contributes to the delay in seeking care, with Black African adults less likely to access medical care despite the fact that they bear the brunt of diseases such as HIV and AIDS and tuberculosis (26). Black Africans are also less likely to use private facilities, while South Africans in the poorest income quintiles, live further from the nearest health facility, compared to those with higher incomes (26).

A report by the South African Human Rights Commission (SAHRC) into access to health care services has found that access, especially for the poor, remains severely constrained by expensive, inadequate or non-existent transport, serious shortages with regard to medicines, emergency transport and long waiting times at clinics and other health care facilities (27).

The high levels of poverty and unemployment and socio-economic inequities mean that the majority of the South African population, particularly in rural areas, are dependent on the public health system. The implications are that the health system must collaborate with other sectors, prioritise the needs of the most vulnerable, and strive to provide caring and compassionate services. Intersectoral collaboration is enunciated in our definition (Table 1). Importantly, there is a moral and ethical imperative to provide high-quality universal health coverage (UHC) in South Africa.
The ethical dimensions of quality health systems are interwoven as a golden thread throughout the report. We define ethics as moral principles and values governing a person’s conduct, decision-making, and the relationship between the health system, its stakeholders and the broader society. We draw on basic concepts and fundamental principles of decent human conduct to deal with moral duty and obligation and outline what is good for society in the context of quality health systems. We underpin health as essential for well-being and hence healthcare as a basic good making it a fundamental human right. The principle of equity together with the Constitutional values of human dignity and the advancement of human rights and freedom are core to the transformation of the healthcare system in South Africa.

Although this consensus report is not exhaustive on all possible interventions, we present our key diagnostic findings, and propose major recommendations to achieve a high-quality health system.

1.4 Audience and Structure

Our intended audience for this consensus report is broad ranging, and includes policy makers, health leaders and health managers, and health care providers in both the public and private health sectors, academics, community-based and non-governmental organisations, organised labour, and civil society in general.

We have structured the remainder of the report as follows:

Section I focuses on Governing and Leading for Quality, and consists of two chapters: leadership, management and governance (Chapter 2), and information for quality (Chapter 3).

Section II examines the Current State of Quality through the lens of South Africa’s burden of disease: HIV and AIDS (Chapter 4); maternal and child health (Chapter 5); non-communicable diseases, specifically hypertension and diabetes (Chapter 6) and mental health (Chapter 7).

Section III examines Quality through a Health System Lens: financing (Chapter 8); health care providers (Chapter 9); quality improvement programmes (Chapter 10); and social justice and ethical, accountable quality health care (Chapter 11).

The concluding section (Chapter 12) integrates the key messages of the report, and contains the key diagnostic findings; and a detailed set of recommendations.
SECTION I: GOVERNING AND LEADING FOR QUALITY
CHAPTER 2: LEADERSHIP, MANAGEMENT AND GOVERNANCE

2.1 INTRODUCTION

The ability of a health system to achieve optimal health outcomes is determined by the legislative framework that it is built upon and the leadership, management and governance (LMG) structures to give effect to these legal provisions. Notwithstanding South Africa’s enabling Constitution, strong health legislation and numerous health policies that express Government’s commitment to a high-quality health system, LMG failures contribute to poor quality of care.

At face value, South Africa performs well in the area of policy and strategic plans. However, there are several deeper challenges. In the main are the de facto ten health departments in operation in South Africa, and huge inequities between urban and rural provinces (28) and between the public and private health sectors. In addition, evaluations of the LMG structures reflect widespread problems such as ineffective professional councils, fraud and corruption, a lack of financial accountability within provincial health departments and dysfunctional community health structures.

In 1994, the immediate task of the new democratic government was to create a unified health care system based on the

Box 2: Leadership, management and governance key findings
1. 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 evidence of mismanagement, inefficiencies and incompetence at some levels of the health system.
2. Fraud and corruption are major threats to equitable access to quality health care.
3. The financial audit outcomes of nine provincial health departments over several years illustrate poor financial management, which in turn affects the ability to provide quality health care.
4. There are governance weaknesses in the Health Professions Council of South Africa and the South African Nursing Council, which are the regulators of the majority of health professionals in South Africa.
5. There are numerous barriers to effective community participation, which in turn influences accountability, the essence of which is answerability.
6. There are several failures of governance in the private health sector, including a lack of transparency and lack of accountability to members of the public that belong to medical aid schemes.
vision for a quality health system enunciated in the Reconstruction and Development Programme (RDP) (29) and cemented in the 1996 Constitution (10).

The Constitution created one democratic state, separating the powers of the legislators, executive and the judiciary. The executive develops policies and implements programmes to meet the population’s needs. It has three spheres of government: national, provincial and local government. Parliament is constitutionally mandated to develop legislation and to hold the executive accountable for executing the law (10). Section 27 in the Bill of Rights—within chapter two of the Constitution—obliges government to ensure that all citizens have access to health care services, including reproductive health within available resources; and that no one is refused emergency medical treatment (10). Section 28 of the Constitution promotes and protects the right of children to basic health care services (10).

In the last two decades, various pieces of legislation, policies and initiatives have been put in place to improve the health system and its performance (30-37).

| 1994-1999 | • White Paper for the Transformation of the Health System - quality a key principle  
|           | • White Paper on Transforming Public Service Delivery - 8 Batho Pele principles of consultation, setting service standards, increasing access, ensuring courtesy, providing information, openness and transparency, redress and value for money.  
|           | • The Broomberg and Shisana Committee of Inquiry into a National Health Insurance System.  
|           | • Integration and overhaul of fragmented, discriminatory health system.  
|           | • Tobacco control legislation.  
|           | • Provision of strategic leadership and creation of social compact for better health outcomes.  
|           | • Development of the essential drugs list.  
|           | • Development of clinical protocols, training and development of human resources for health.  
|           | • Improvement of the conditions of service of nurses following a major strike in 1995.  
|           | • Revitalisation of physical infrastructure.  
|           | • Massive investment in training of health care providers and managers.  
|           | • Compulsory, one-year community service for health professionals.  
|           | • Clinic building programme.  
|           | • Prioritisation of and free primary health care. |
| 1999-2004 | Committee of Inquiry into a comprehensive system of social security for South Africa, which includes a chapter on health insurance.  
|           | Health department’s Ministerial Task Team (MTT) on Social Health Insurance.  
|           | Primary health care package for South Africa – a set of norms and standards.  
|           | National Health Act.  
|           | Mental Health Care Act.  
|           | Patient Rights Charter.  
|           | National Department of Health 10-point plan.  
|           | Standardisation of monthly stipend for CHWs.  
|           | Introduction of prevention of mother-to-child transmission programme and anti-retroviral treatment for HIV positive individuals.  
|           | Policy on quality in health care. |
| 2004-2009 | Health sector reviews conducted by Development Bank of South Africa and Integrated Support Teams.  
|           | District Health Barometer highlights performance of districts on a range of PHC indicators.  
|           | Clinic Supervisor’s Manual to ensure quality of primary health care delivery.  
|           | Introduction of Occupation Specific Dispensation, a major financial incentive for health professionals.  
|           | Accelerated implementation of HIV and AIDS plan and reduction of mortality due to TB and associated diseases. |
| 2009-2014 | Negotiated Service Delivery Agreement.  
|           | National Core Standards with 7 domains- patient rights; patient safety, clinical governance and care; public health; leadership and corporate governance; operational management; facilities and infrastructure.  
|           | National Development Plan.  
|           | Green Paper on NHI ties re-imbursement and facility accreditation to quality standards.  
|           | National Health Amendment Act-Establishment of the Office of Health Standards Compliance (OHSC). |
Table 2: Summary of initiatives to build a quality health system in democratic South Africa

<table>
<thead>
<tr>
<th>Year</th>
<th>Initiatives</th>
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<tbody>
<tr>
<td>2014-18</td>
<td>• Ideal Clinic Realisation and Maintenance Programme.</td>
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<tr>
<td></td>
<td>• Draft regulations on norms and standards published for comment.</td>
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<tr>
<td></td>
<td>• Appointment of Health Ombud.</td>
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<tr>
<td></td>
<td>• New salt regulations.</td>
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<tr>
<td></td>
<td>• White Paper on NHI.</td>
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<td></td>
<td>• Launch of the SA Lancet National Commission on High-quality Health Systems.</td>
</tr>
<tr>
<td></td>
<td>• Establishment of the High Level Panel on Poverty, Unemployment, Inequality,</td>
</tr>
<tr>
<td></td>
<td>Wealth Distribution, Land and Nation-building, which also assessed the</td>
</tr>
<tr>
<td></td>
<td>quality of health care and made recommendations.</td>
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<tr>
<td></td>
<td>• Patient Safety Incident Reporting and Learning and Guidelines for</td>
</tr>
<tr>
<td></td>
<td>Conducting Patient Experiences of Care.</td>
</tr>
<tr>
<td></td>
<td>• NHI and Medical Schemes Amendment Bills.</td>
</tr>
<tr>
<td></td>
<td>• Release of draft report of Health Market Inquiry.</td>
</tr>
<tr>
<td></td>
<td>• Promulgation of OHSC norms and standards regulations.</td>
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At the centre of these initiatives is the National Health Act (NHA) 61 of 2003 that provides the legislative framework for the delivery of health care services (38). The Act sets out the structures, mechanisms, resources and systems aimed at the progressive realisation of the right of access to health care services (38). It lists various governance structures from the National Health Council which includes the Minister of Health and the provincial MECs to Provincial Health Councils along with community health structures and consultative bodies like the Forum of Statutory Health Professions Council representing all the health professions councils (Section 50) (38).

2.2 Office of Health Standards Compliance

The Office of Health Standards Compliance (OHSC) was established in 2014 through an amendment of the National Health Act (39) 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 (Table 3). The OHSC regulates all health establishments in the public and private health sectors and will be responsible for monitoring compliance and patient safety (39).
Table 3: Functions of the OHSC

- Advise the Minister on determination and review of norms and standards.
- Inspect and certify health establishments as compliant or non-compliant.
- Investigate complaints relating to breaches of prescribed norms and standards.
- Monitor indicators of risk as an early warning system relating to serious breaches of norms and standards and report any breaches to the Minister.
- Identify areas and make recommendations for intervention by a national or provincial department of health or a health department of a municipality, where it is necessary, to ensure compliance with prescribed norms and standard.
- Publish information relating to prescribed norms and standards.
- Recommend quality assurance and management systems for the national health system.
- Keep records of all its activities.

Source: National Health Amendment Act (39).

The norms and standards prescribed by the Health Minister are central to the level of quality and safety achieved by public and private health establishments, and central to the long-term success of any quality improvement activity implemented in South Africa. The purpose of the norms and standards is to develop a common quality definition for all health establishments in South Africa to guide the public, managers and staff at all levels, to set a benchmark to assess health establishments, to identify gaps and appraise strengths; and to certify health establishments that comply with mandatory standards (39).

The current national core standards (NCS) are based on input from numerous stakeholders and extensive field experience, the evolution of which is shown in Figure 2.

Figure 2: Evolution of the National Core Standards, 2008 to 2018
2.3 **Health Professions Councils**

Individual health professional regulation will remain the responsibility of the relevant professional bodies. In South Africa, education and training and the scope of practice of health professionals are well regulated, which in turn facilitate the achievement of a high-quality health system.

The regulatory mandate and vision of the: Health Professions Council of South Africa (HPCSA); South African Nursing Council (SANC); and South African Pharmacy Council (SAPC) all underscore the competence of health professionals under their jurisdiction and quality of care as central elements.

Notwithstanding the enabling legislation and vision statements and intentions, the HPCSA and SANC have been accused of being reactive as opposed to proactive in the area of promoting quality of health care. This is because they wait for complaints to come to them before investigating and taking disciplinary action against the relevant professionals where appropriate.

A 2015 Ministerial investigation into the effectiveness of the Health Professions Council of South Africa (HPCSA) found inter alia that there was evidence of administrative irregularities, mismanagement and poor governance at the HPCSA (40). The task team concluded that: “The HPCSA is in a state of multi-system organisational dysfunction which is resulting in the failure of the organisation to deliver effectively and efficiently on its primary objects and functions in terms of the Health Professions Act 56 of 1974”(40). Policy studies on nursing education reforms (41, 42) have found ineffective governance by the South African Nursing Council and significant weaknesses in its policy-making and implementation capacity (42).

2.4 **Corruption in the Health Sector**

Corruption, defined as the abuse of resources, power or connections for private gain (43). A 2015 study on corruption in the health sector (44) and the triangulation of various sources shows that corruption in the South African health sector is a problem that warrants serious attention.

<table>
<thead>
<tr>
<th>Table 4: The challenge of fraud and corruption in the health sector</th>
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<tbody>
<tr>
<td>• The 2016/17 Auditor-General of South Africa (AGSA) report found that there was little improvement over the preceding four financial years in the internal controls in national and provincial government departments in the key areas of leadership, financial and performance management, and governance.</td>
</tr>
<tr>
<td>• In 2016/17, the AGSA found that the top 10 contributors to the irregular expenditure of R45.6 billion were responsible for 53% of the total amount. Departments of Health accounted for four of the top 10 contributors to irregular expenditure.</td>
</tr>
<tr>
<td>• The AGSA report underscored that an environment that is weak on consequence management is prone to corruption and fraud.</td>
</tr>
<tr>
<td>• The Public Service Commission reported that the bulk of the money involved in reported financial misconduct cases has not been recovered.</td>
</tr>
<tr>
<td>• The Health Market Inquiry (HMI) reported that in the preceding five years, fraud and theft accounted for the top three categories of complaints to the Health Professions Council of South Africa.</td>
</tr>
</tbody>
</table>

Sources: AGSA, 2016/17 (45); Public Service Commission (46); Competition Commission (47).
The numerous examples of corruption in the healthcare sector point to a lack of integrity at several LMG levels. These examples also highlight the disjuncture between the actual conduct of individuals and the many ethical guidelines and laws of democratic South Africa. These examples of fraud and corruption are major threats to equitable access to quality health care.

## 2.5 Financial Accountability

A useful indicator of financial accountability is to examine audit outcomes of provincial health departments. Table 3 shows the audit outcomes for the nine provincial health departments. The audit outcomes for the provincial health departments from 2008/09 to 2016/17 reveal a mixed picture, with great variation and inconsistency. Although a positive feature is that there were no disclaimers or adverse audit opinions, only four of the nine provincial health departments had unqualified audit outcomes, and these were with comments (45). The auditor-general (AG) highlighted the risk of chronic over-spending and outstanding liabilities at year-end in the provincial health departments, and the negative impact on the ability to pay creditors on time, deliver health services, and meet the needs of vulnerable communities (45).

| Table 5: Financial audit outcomes of provincial and national departments: 2008/09 - 2016/17 |
|-----------------------------------|---|---|---|---|---|---|---|---|---|
|                                  | 08/09 | 09/10 | 10/11 | 11/12 | 12/13 | 13/14 | 14/15 | 15/16 | 16/17 |
| Eastern Cape                     | 3     | 3     | 2     | 2     | 2     | 2     | 2     | 1     | 1     |
| Free State                       | 2     | 3     | 2     | 2     | 2     | 2     | 2     | 2     | 1     |
| Gauteng                          | 3     | 3     | 2     | 2     | 2     | 2     | 2     | 1     | 1     |
| Kwa-Zulu Natal                   | 2     | 2     | 2     | 2     | 2     | 2     | 2     | 2     | 2     |
| Limpopo                          | 2     | 2     | 3     | 3     | 3     | 2     | 1     | 2     | 2     |
| Mpumalanga                       | 2     | 2     | 2     | 2     | 2     | 2     | 2     | 2     | 2     |
| Northern Cape                    | 3     | 3     | 3     | 3     | 2     | 2     | 2     | 2     | 2     |
| North West                       | 2     | 1     | 1     | 2     | 1     | 1     | 1     | 2     | 2     |
| Western Cape                     | 1     | 1     | 1     | 1     | 1     | 1     | 1     | 1     | 1     |
| National DoH                     | 2     | 1     | 2     | 1     | 1     | 1     | 1     | 1     | 1     |

Legend: 1 = Unqualified with or without comments; 2 = Qualified; 3 = Adverse or disclaimer
Source: AGSA (45).
### 2.6 Community structures

Community members play a key role in two structures: hospital boards (Section 41) and health committees (Section 42) (38). The hospital board is an advisory structure. Sections of the NHA (38) outline the composition of structures in relation to hospitals and to clinics or health centres, respectively. However, the Act provides little guidance on the roles and functions of such structures. Rather, the Act leaves it to the Minister of Health (central hospitals), to the MEC for Health (other hospitals) and to provincial legislation (in the case of clinics or community health centres) to clarify (38). The Act cites the promotion of community participation as part of the responsibility of the national Director General (S21.2) and the provincial Head of Health (S25.2), but there is no explicit link made to either hospital boards or health committees in realising such participation (48).

Figure 3: Community-led health structures
Source: Health Systems Trust (49).

A 2015 review of health governance found several challenges in relation to community participation and community health structures, summarised in Table 6 (50).
Table 6: Key challenges on community participation and community health structures

- Poor understanding of the concept and definition of health governance.
- 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 actors, especially those at the lowest levels of the health system.
- Tensions between administrative and community structures, exacerbated by bombardment of staff with a broad range of strategies, policies and service-delivery initiatives in a fragmented fashion.
- Inappropriate appointments of candidates to hospital boards or clinic committees.
- Lack of skills and technical support to promote public participation.
- The multiple spheres of government present significant barriers to health governance and introduce bureaucratic red tape, as does policy-makers’ lack of political will. This reinforces the tension that exists between formal and informal governance.
- Disjunctures and lack of cohesion between national policy and provincial implementation.
- Inadequate health information management.
- Poor intersectoral collaboration.

Source: Levendal et al, 2015 (50).

2.7 Governance in the private health sector

The challenges seen in the public sector also permeate the private health sector. Management structures in the private sector tend to be smaller and influenced by the governing structures of the relevant private sector group.

The Council for Medical Schemes (CMS) is a statutory body established by the Medical Schemes Act (#131 of 1998) to provide regulatory supervision of private health financing through medical schemes (51). The CMS regulates and supervises a massive and very important industry comprising more than 80 registered medical schemes, covering nine million lives in South Africa. In the last decade, it has had leadership and stewardship problems, and deteriorating relations with the constituency it regulates. The Medical Schemes Act, which had noble intentions, inadvertently created barriers to promote affordable care. Examples include the rapidly rising cost of the prescribed minimum benefits (PMBs) and medical scheme prescribed reserves that has locked in an additional R30 billion. The PMB content is predominantly hospital-centric. There have also been numerous successful applications to the court to place schemes under curatorship, indicating governance concerns. Furthermore, the CMS has done little in the area of quality of care; where it has done some work, it is without an overall quality improvement framework.

The Health Market Inquiry (HMI) found several challenges in relation to governance of the private health sector, shown in Table 7 (47).
Table 7: Key challenges in private sector governance

- Failures in regulation and governance, and perverse incentives associated with the current private health market structure, contribute to lack of competition and innovation.
- The trustees of medical aid schemes do not ensure that members receive value for money or that administrators deliver the best possible value.
- In some instances, the process of electing trustees is not always fair and transparent as there are features of administrator capture, manipulation and undue influence.
- The ‘separation’ between medical aid schemes and administrators appear artificial, particularly in the case of large open schemes, and this failure in governance is severe.
- At the heart of the failure of funders to deliver better value to consumers lie multiple problems:
  - A lack of transparency (including on scheme options and quality of outcomes).
  - A lack of accountability of schemes to members.
  - Failure of governance that align scheme interests too closely with that of administrators.

Source: Competition Commission, 2018 (47).

2.8 Recommendations

The analysis of leadership, management and governance reveals that South Africa is legislation and policy rich, but implementation is poor. Flowing from this analysis, the key recommendations are listed below, and expanded in the final chapter:

1. Effective regulatory enforcement and oversight by the National Department of Health (NDoH) as the overall steward of the health system.
2. Enhance leadership, management and governance at all levels of the health system:
   a. Inculcate effective leadership drawing on 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 proactively managed.
   b. Invest in, and increase the capacity of, the Office of Health Standards Compliance.
   c. Enhance the capacity and effectiveness of the Council for Medical Schemes.
   d. Strengthen governance, effectiveness and efficiency of the various health professions councils.
   e. Strengthen community structures.
3. Prevent fraud and corruption.
CHAPTER 3: INFORMATION FOR QUALITY

3.1 Introduction

Information systems are one of the building blocks of the health system, and an essential part of governance (12). A high-quality health system requires reliable health information collected accurately in a timely and harmonised manner (4, 52). Health information systems enable the monitoring of progress in delivering and sustaining quality health services and achieving a country’s health goals (4). Information enhances accountability and this, in turn, improves quality (2).

Information is used in many different ways (53). Community members or patients typically require information on quality to inform decisions about health care practitioners or cost-effective private medical schemes. Health care practitioners may require risk-adjusted data that report on health care outcomes to benchmark and improve care delivery. Funders or purchasers of health care services may require value-based patient relevant information that determines contracting mechanisms and processes (53).

The South African government’s commitment to measuring quality has been longstanding, and this commitment is articulated in various policy documents, including the National Development Plan (NDP) (16).

Box 3: Key findings on information for quality

1. The South African government’s commitment to measuring quality has been longstanding.
2. There is enabling legislative and policy environment for the development of a health information system to measure quality.
3. Numerous health measurement platforms exist that provide information on health system inputs, processes, service delivery, outcomes and impact. However, most of these do not provide sufficient and appropriate information on health outcomes and impact, nor are they sufficiently person-centred.
4. Data quality remains a significant barrier to assess health system performance on the quality of care provided.
5. Health information systems are partially electronic, are not interoperable, do not make available patient-level data, and are not capable of reporting aggregated data across public and private health sectors, or across levels or care pathways.
6. There is suboptimal collection, utilisation and reporting of data by health care professionals and managers.
7. There are insufficient expertise and skills within the public sector to support data analysis, feedback and reporting.
3.2 Non-negotiables for measurement of a high-quality health system

Health quality measures are only as good as the systems that enable its collection, reporting and utilisation. These include: (1) an enabling legislative and policy environment; (2) harmonisation of data collection systems and elements to enable transparent reporting and comparability across public and private health sectors, facilities, providers, and levels of care; and (3) the establishment and relative independent functioning of bodies that provide oversight, guidance and standards (52).

Ideally, health management information systems should be electronic and should collect data at the patient level (e.g. electronic patient records with unique patient identifiers). Further, health and health-related data systems, regardless of whether in the public or private sectors or at practice or population levels, should be interoperable. Data should also be aggregated and reported to provide vital information of process, outcome and impact measures across disease-specific continuums of care. Data collection should be undertaken by trained, competent staff who understand the importance and value of the information collected. Similarly, data analysis should be such that biases and inaccuracies are minimised as can be observed if outcome data at facility or population level are not risk-adjusted. This process will require specific skills and expertise (52).

Performance measures should be tailored to measure the various domains of the quality conceptual framework accurately. For example, using the South African high-quality health systems framework (Chapter 1), the measures should enable adequate assessments of quality concerning inputs, health service delivery, outcomes and impact. Information specific to the South African context will also be required. Importantly, quality measures should be should be patient-centred and developed in collaboration with decision-makers, practitioners, patients and purchasers, a practice that has been shown to be effective (54). These measures should be reported to those who generate the data to assess performance and to inform potential quality improvements (54). If made public, it enables benchmarking, value-based decisions by funders and informed decision-making by communities or patients. These levels of transparency generate a competitive environment, which in turn drives quality improvement and thus the achievement of the goals of the health system.

These non-negotiables can be used as the lens through which to explore the status of measurement and information for quality in South Africa.
The South African government’s commitment to quality is articulated in various laws and policies as outlined in Chapter 2. Box 5 summarises critical aspects of the National Health Act (NHA) (Act 61 of 2003) on a comprehensive national health information system (38).

The Promotion of Access to Information Act (PAIA), namely the right of access to information held by another individual, which is required for the exercise or protection of any rights, only applies to recorded information (55). This limitation highlights the importance of ensuring that the collection and reporting of quality measures such as outcomes should be mandatory for all healthcare providers. The Health Professions Act (Section 53(1)) requires that patients know the cost of their healthcare before they access the services (56). The Medical Schemes Act states that the CMS should recommend criteria for quality and outcomes measurement of health services provided for by medical schemes, thus measuring the performance of private healthcare providers (51). Importantly, the mandate of the OHSC as a juristic organisation (Chapter 2) is to assess compliance of all private and public health facilities in the country with nationally accepted standards (39).

The numerous policy documents in Table 2 (Chapter 2) demonstrate the country’s intent concerning high-quality health care provision and system strengthening. The 2011 National Health Information Management Policy outlines important data management approaches in the public sector, from facility to national levels (57). In February 2012, the Health Data Advisory and Co-ordination Committee (HDACC) released a report that listed recommendations for a set of appropriate national high-level indicators, identification of future needs, strengthening national population-based health surveys and routine health information and health facility surveys. Three sub-committees focusing on the measurement of life expectancy, child and maternal mortality; HIV and AIDS and TB; and health systems strengthening were established. The National Health Information System of South Africa (NHISSA) is a nationally coordinated body that meets on a quarterly basis and provides oversight and leadership in this field. It comprises of representatives from government, academia, research and implementation organisations, and multilateral and other development agencies.

In 2017, the NDoH released the policy documents on Patient Safety Incident Reporting and Learning (58) and Guidelines for Conducting Patient Experiences of Care (59).
While the legislative framework provides for an enabling environment for the collection and reporting of health data and information, there are also safeguards to reassure the public that the data will be kept confidential. Section 14 of the Bill of Rights of the Constitution affirms everyone’s right to privacy, including privacy of their communications (10). The National Health Act provides that all information concerning patients, including information regarding their health status, treatment or stay in a healthcare establishment should be kept confidential (Section 14(1)) (38). Furthermore, no person may disclose any information about a patient unless the patient consents to the disclosure in writing; a court order or any law requires the disclosure; or non-disclosure represents a serious threat to public health.

3.4 HEALTH INFORMATION SYSTEMS IN SOUTH AFRICA

The Commission identified all relevant health and health-related data collection tools. We extracted data elements from each tool and categorised these according to various domains of the Commission’s quality framework. Table 8 presents an overview of the broad measurement platforms.

As is illustrated in Table 8, data used to provide information on quality are collected on many health measurement platforms. The vast majority of routine health data are collected in public sector facilities, primarily as count (or tick) – as opposed to longitudinal (cohort) - data and are manually recorded in registers and presented as aggregated data. Data are reported each month to the district offices (primarily via sub-district offices) and captured into the District Health Information System (DHIS) electronic platform and validated to assess data quality. After data quality issues are addressed, it is reported to provincial levels, provincially aggregated and reported to the national level. These routinely collected data, which form indicators known as the National Indicator Dataset (NIDS), are determined every two years by the NDoH. The intention is to use a results-driven process and a logic model framework approach as a guide for the development of the NIDS, thus facilitating health programme planning and monitoring.
<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency of data collection</th>
<th>Level(s) at which data collected</th>
<th>Information for quality**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service, administrative data, including surveillance data (e.g. DHIS, BAS, PERSAL)***</td>
<td>Routine, periodic</td>
<td>Household/Community, Health facility, hospital, sub-district, district, province</td>
<td>Provides information on health system inputs; health service delivery (process). Information limited with regards to person-centred care, patient participation, safe and responsive health systems. Outcome indicators primarily focused on in-facility health outcomes.</td>
</tr>
<tr>
<td>Electronic health records (primarily disease-specific (HIV))</td>
<td>Routine</td>
<td>Patient (collected in health facilities)</td>
<td>Available in limited number of settings, and primarily focused on HIV services. Allows for assessment of continuum of care and health outcomes.</td>
</tr>
<tr>
<td>Population surveys</td>
<td>Periodic</td>
<td>Household</td>
<td>A range of surveys assesses aspects of inputs (knowledge and information); service delivery (person-centeredness; responsiveness; prevention, promotion and protection); outcomes and impact (access and coverage, equity and social and financial risk protection). Also provides information on context (poverty, social determinants of health)</td>
</tr>
<tr>
<td>Facility-based surveys/audits, including complaints, compliments and patient safety, confidential enquiries</td>
<td>Periodic, continuous</td>
<td>Health system</td>
<td>Assesses health service delivery and health outcomes and impacts.</td>
</tr>
<tr>
<td>Vital, civic registries</td>
<td>Routine</td>
<td>Population</td>
<td>Provides information on the South African context and health outcomes</td>
</tr>
</tbody>
</table>

*Framework adapted from the Lancet Global Commission’s report (2)

** Using the South African Commission’s conceptual framework (Chapter 1)

***DHIS: District Health Information System; BAS: Basic Accounting System; PERSAL: Personnel Salary System
In preparation for the NHI implementation, the primary health care ward-based outreach teams (PHCW-BOTS) provide community-level services. Routine data reflecting community health worker (CHW) team activities are collected within homes, and are reported to, and incorporated into, facility data. The data are mostly input, process and output in nature, and the community impact is not routinely measured through this programme.

Data quality remains a barrier to the accurate assessment of health system performance. The built-in validation functions and statistical checks in the DHIS assess the accuracy and reliability of routinely reported data. Completeness, correctness, consistency and timelines are assessed. A 2014 review of routine data quality deficiencies highlighted ongoing data quality issues that reflect poor understanding of the importance of collecting data and poor understanding of data definitions (60). In contrast, the HIV and AIDS (TIER.Net) and TB (ETR.net) programmes have evolved to enable cohort analyses and thus better quality data at a patient level. These programmes provide ongoing examples of the value-add of electronic patient records and the linking of data to the patient in that patient outcomes can be monitored across the continuum of care.

Periodic population-based surveys provide a wealth of information on a range of quality-related domains, with a focus on outcomes and impact, albeit not comprehensive. However, these are infrequent, costly, labour-intensive, and not designed to measure all aspects of quality. Further, these surveys are not always responsive to changes in health systems contexts and may not be representative of the broader population.

Additional challenges, if one considers the need for information that enhances accountability and service delivery, are that the various health information systems are not interoperable and are not designed to aggregate data across a range of sectors or levels of care. The lack of integration speaks to the need to address system-wide information technology and related infrastructural challenges. Finances need to be made available to enable the expansion and uptake thereof. Further, the data collection tools and databases are not designed to provide quality assessments across the various pathways of care, particularly for non-communicable diseases, which constitute an increasing burden.

Quality across the life course cannot be assessed either due to the inherent limitations of the design of the health information systems. Health data can only accurately reflect the status of care and health outcomes if accurately collected, reported and used. Data quality however remains poor due to limited understanding and a lack of commitment to managing health data by health professionals, or lack of accountability and promotion of transparency at management levels. Further expertise is also often lacking within government to analyse, aggregate and report on large, integrated datasets. These deficiencies hinder planning and implementation, and ultimately monitoring of health system quality.
3.5 MEASURING PERFORMANCE ACROSS THE QUALITY DOMAINS

Internationally, developing appropriate measures to assess performance within the various health quality domains has gained increased attention (61). Specific focus has been on developing measures that are more patient-centred and responsive (e.g. patient-reported outcome measures (PROMs)), and beyond measuring access to also focusing on effective coverage. This new focus works in tandem with a shift from measuring primarily input and process actions to measuring outcomes and impacts.

The analysis of information collected through the various routine health information system platforms shows that most health services indicators measure the structure (inputs), process and outputs of clinical services or activities. Longer-term outcome (impact) measures are limited to the facility level, namely in the form of mortality and some morbidity indicators for maternal, newborn and child health. As indicated above, population level information is limited in terms of reporting on quality outcomes and impacts.

Greater emphasis on measuring population health beyond premature mortality measures (namely, years of life lost) is needed to assess the contribution of disability-adjusted life years to measures of the burden of disease. Individual health outcome measures also require more attention. Measuring patient-reported outcomes (e.g. quality of life, function, pain) and satisfaction (e.g. patient experience of care and satisfaction surveys) should be prioritised. Better attention should be paid to measuring and reporting on postoperative patient outcomes, readmission and in-facility mortality rates.

With the ultimate aim of UHC in mind, the Lancet Global Commission describes an illustrative approach to measuring population health using outcome indicators to calculate effective coverage of the population in need, access to care and quality of care received. As an illustration of this approach the indicator, “Proportion of the target population covered by all vaccines included in their national programme” is replaced with “Proportion of target population with detectable antibodies for vaccines in the national programme” coverage indicator (2). Undoubtedly, strengthening quality measures will require a shift in the way South Africa designs its health information systems, datasets, as well as the manner in which data are collected, analysed and reported. Finally, high-level collaborative bodies should be established to provide guidance and oversight to designing, implementing and sustaining a comprehensive health information system that has quality measurements at its centre. Ultimately, these bodies should enable benchmarking, value-based decisions by funders and informed consumer-decision-making. Transparency and accountability should be overarching principles guiding their work.

3.6 PRIVATE SECTOR PERSPECTIVES

A single system that mandates the reporting of quality data using standardised measures, or that enable comparisons between the public and private health sectors, does not exist. The absence of sufficient data on quality in this sector precludes competition driven by quality (47). Some examples of quality reporting initiatives in the private (and public) sector include Best Care...Always!. This programme aims at reducing preventable hospital-associated infections and encourage the correct use of antibiotics. The
three hospital groups report on infection related matters routinely. Patient experience is published for one hospital group. Finally, the Discovery Health Hospital Rating Index examined hospital admissions data to report on the performance of private hospitals.

In 2018, the draft report of the HMI, released by the Competition Commission of South Africa, identified information asymmetry as a significant challenge and proposed the need for a system to enhance transparency on health outcomes to facilitate value-based decision making, including purchasing in the private sector (47). The HMI found that a multiplicity of scheme options and service providers coupled with a paucity of information on health outcomes limit consumer decision-making (47). The report also identified the absence of publicly available information on the cost-effectiveness of technologies and how these influence health outcomes in the private sector (47). Other measurement-related deficiencies related to hospital licensing, where suboptimal application of hospital licensing legislation creates missed opportunities for daily collection of useful data daily. In addition, the HMI proposed a change to the way in which medical aid schemes are structured and recommended the introduction of a “supply side regulator”.

In terms of the National Health Act, the mandate of the OHSC is to regulate the quality of care in health establishments in the South African health system by inspecting, certifying and enforcing compliance to prescribed norms and standards. In February 2018 norms and standards regulations were promulgated and will come into operation in February 2019, thus making comparisons across the public and private health sectors possible in the future.

### 3.7 Recommendations

South Africa has made significant strides towards creating a legislative and policy environment for the measurement of quality, especially in the public health sector. There are numerous opportunities for improvement and for strengthening health information management system to create one that ultimately provides information that accurately reflects the state of whole-system ethical and accountable quality in the country. Our summary recommendations are listed below and expanded in the final chapter of this report.

1. Develop and enforce an integrated national health system performance dashboard.
2. Strengthen the capacity of the NDOH to provide oversight and monitor implementation of all aspects of the health information system in the public health sector.
3. Strengthen public and private sector collection, reporting and use of appropriate quality information.
4. Expand and strengthen the stewardship role of the National Health Information System of South Africa (NHISSA).
SECTION II: THE STATE OF QUALITY OF CARE IN SOUTH AFRICA: A Burden of Disease Lens
CHAPTER 4: HIV, AIDS AND QUALITY

4.1 INTRODUCTION

In 2016, the UN General Assembly adopted the Political Declaration on Ending AIDS and affirmed its commitment to eradicating the epidemic by 2030 (62). The agreement commits signatory member states to the 90-90-90 treatment targets. By 2020, 90% of people living with the human immunodeficiency virus (HIV) will know their status, 90% of people diagnosed with HIV will receive sustained antiretroviral (ARV) therapy and 90% of people receiving ARV therapy will achieve viral suppression (62). In parallel, the UN developed 169 targets to measure progress toward its 17 SDGs that included the goal of ending the HIV epidemic by 2030 (63). Specifically, SDGs related to health information and governance (birth [SDG 16.9.1] and death registration [SDG 17.19.2]), access to a core set of relevant essential medicines [SDG 3.b.3], and HIV incidence rate [SDG 3.3.1] are important (64).

South Africa has the largest number of people living with HIV (PLHIV) and the largest antiretroviral therapy (ART) programme in the world. In September 2016, ART eligibility was extended to all 7.1 million HIV-positive South Africans (65). Predictive models suggest that the first 90% target will be met, with the expected fraction of HIV-positive adults diagnosed increasing to 93% by 2020. However, meeting the second and third 90% targets will be more challenging: the fraction of

Box 7: Key messages on quality and the HIV epidemic

1. South Africa has the largest ART programme in the world, and ART coverage is higher in women than in men.
2. Adult mortality levels in South Africa have declined substantially because of widespread ART access. Similarly, the contribution of HIV/AIDS to under-5 and maternal mortality has declined significantly in the past decade.
3. The country remains at the forefront of the fight against HIV &AIDS with a fully funded government public health care system.
4. Progress toward the National Strategic Plan targets for HIV prevalence and incidence reveals a mixed picture.
5. Gender, race and geographical region (province) account for the variation in HIV prevalence.
6. Prioritising HIV prevention and eliminating gender inequalities will be central in ending HIV and AIDS.
7. Notwithstanding expanding ART eligibility criteria, poor linkage to care following HIV diagnosis is of concern.
8. There are insufficient linkages between HIV care and sexual and reproductive health services.
9. Annual new ART enrolment in children has declined which may reflect both the success of the prevention of mother to child transmission programme and inadequate testing of exposed children.
10. Leaks in treatment cascades, loss-to-follow-up and poor adherence contribute to low viral load suppression and need to be addressed.
HIV-diagnosed adults on ART is expected to increase to 83% by 2020, and the assumed uncertainty regarding future viral suppression rates implies that only 80% of ART patients are likely to achieve viral suppression in 2020 (66).

In the context of the South African epidemic, it is crucial to understand engagement in the different stages of HIV care. Such information provides a summary measure of the success of the ART programme in terms of population-level viral suppression, and highlights the specific stages of the continuum of care at which people are lost to care, risking death, morbidity and onward transmission (67). With the SDGs, monitoring treatment and HIV prevention changed in three important ways. First, treatment monitoring has shifted from numbers to coverage and gaps in a cascade of services to achieve universal access. Second, this requires greater emphasis on disaggregated, individual level patient and case monitoring systems, which can better support linkage, retention and chronic, long-term care. Third, the prevention, testing and treatment cascade, with a clear results chain, links treatment numbers to impact in terms of reduced viral load, mortality and incidence.

This chapter uses the WHO’s recommended ten indicators for global HIV monitoring (Figure 4) (68). The care cascade serves as the organising framework for the guidelines overall and the cascade of prevention, care, treatment and support, which structures the consolidation of the indicators to support quality services. Health care services in the cascade encompass prevention, treatment and care interventions. The term cascade emphasises that a sequence of services is needed to achieve desired impacts. The cascade concept also informs tracking of patients from one service to the next and highlights the gradual attrition of coverage of the eligible population over the steps of the sequence. Monitoring the cascade of services requires a consolidated set of indicators covering the entire sequence.

Although numerous indicators exist for HIV prevention, care, and treatment, we use the National Indicator Data Set (NIDS) (69) and available literature to describe the current status of the HIV care cascade in South Africa.

![Figure 4: HIV Prevention and Care Cascade Framework](source: WHO (68))
4.2 Overview of South Africa’s HIV Epidemic

The 2017 South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (SABSSM V) provides useful information on the HIV epidemic and impact of South Africa’s national HIV response. South Africa has a high-prevalence, heterosexual, generalised HIV epidemic, characterised by high levels of tuberculosis (TB) infection (70). In 2017, an estimated 7.9 million people of all ages were living with HIV. HIV prevalence among adults aged 15 to 49 years in South Africa is estimated at 20.6%, 26.3% among females and 14.8% among males (70).

HIV prevalence among Black Africans is 16.6%; followed by Coloureds (5.3%); Whites (1.1%); and Indian/Asian (0.8%). The overall HIV peak prevalence occurs in 35 to 39 year-olds at 31.5% (females at 39.4% and males at 23.7%) but differs by sex, peaking at an older age among males (45 to 49 years) at 24.8%, compared to females (35 to 39 years) (70). This disparity in HIV prevalence by gender is most pronounced among young adults: HIV prevalence among 20 to 24 year-olds is three times higher among females (15.6%) than males (4.8%). Among adults aged 15 to 49 years, HIV prevalence varies geographically across South Africa, ranging from 12.6% in Western Cape to 27.0% in KwaZulu-Natal (70). However, the progress toward the National Strategic Plan (NSP) targets for HIV prevalence and incidence has been mixed. Measurement of progress for HIV prevalence in key populations is limited by lack of baseline survey data. According to UNAIDS, prevalence in men who have sex with men (MSM) increased by 888% from 2012 to 2015 (71).

4.3 Inputs

Health care financing is a critical component in reaching the national HIV response targets. South Africa remains at the forefront of countries with a fully funded government public health care system. There are a number of funding policy documents and structures for HIV & AIDS funding, including the conditional grants funding model managed by the NDoH, the National Development Plan, National Health Insurance (NHI) and partnership funding by the Global Fund and President’s Emergency Plan for AIDS Relief (PEPFAR) (72).

In 2013, an estimated R22.1 billion from a combination of government and donor funding was invested in HIV- and TB-related activities in South Africa. Between 2011 and 2013, total funding for HIV and TB activities increased by 27% (including a 15% increase in 2013 alone). Over those three years, the share of spending by the South Africa government rose (from 76% to 80%), while the proportion financed by PEPFAR declined (from 22% to 17%). This is due to the transition of responsibility for PEPFAR-funded programmes from the United States government to South Africa (73). In 2016, it was projected that spending on HIV and TB will continue to increase in future years and that the share of spending covered by the South Africa government will continue to rise. However, current projections indicate that these increases are unlikely to meet resource needs, with a substantial resource gap projected for each of the next five years (73). Although different data sources report different funding amounts, the funding target has not been met and is not on track based on current trajectory. Note that indicators should measure spending as a proportion of need, but need is not measured in any source (71).
4.4 HIV Care Cascade: Prevention

Notwithstanding numerous HIV prevention programmes in South Africa, behaviours such as early sexual debut, multiple sexual partnerships and unprotected sex have not declined in the general population. The levels of some high-risk behaviours have actually increased. These behaviours are also high among MSM and people who inject drugs (PWID). The high and increasing levels of these behavioural drivers portend high HIV incidence with time, thus underscoring the need for HIV prevention strategies (72).

SABSSM V found a slight but not statistically significant increase in the percentage of 15 to 24 year olds who had sex before 15 (early sexual debut) from 10% to 10.7%. However, analysis by gender showed different patterns for males and females (70). Early sexual debut increased steeply in males aged 15 to 24 years from 11.3% to 16.7% while in females it was lower and more stable from 5.9% in 2008 to 5.0% in 2012. The distribution of early sexual debut varied markedly by province in 2012. It was lowest in KwaZulu-Natal (7.6%) and Mpumalanga (7.7%) and highest in the Eastern Cape (16.8%) and Western Cape (14.2%) (72).

For male condom distribution in 2014 to 2015, 50% of the target was reached. This measure was not on track to achieve target by 2016. However, female condom distribution was on track, reaching the target of 83% in 2014/15 (71).

The levels of circumcision among men remain low, despite increasing trends. According to the 2012 National Communications Survey (NCS), only 54% of men were circumcised (46.4% in the 2012 HSRC survey). Cumulatively, 1.7 million circumcisions were done from 2012/13 to 2015/16. This achievement is missing the target of 4.3 million circumcisions by 2015 by a large margin. A number of factors are responsible for this. First, society has only moderate knowledge of HIV risk-reduction provided by voluntary medical male circumcision (VMMC). Second, the doctor-centred approach of the programme has limited its expansion. Thirdly, there has also been resistance to VMMC from some traditional leaders (72). The number of VMMCs has nearly quadrupled from 2010 to 2015. However, the 2014/15 achievement is less than one-third of the target and it is not on track to reach the target. For the number of people reached by prevention communication at least twice a year, data from post-2012 is not yet available so it cannot be determined whether the target will be reached (71).

According to the 2018 HSRC study, among individuals aged 15 to 64 years with two or more sexual partners in the last year, self-reported condom use at last sex was 55.6%. Of those aged 25 to 49 years, both males (53.0%) and females (53.4%) had similar proportions of condom use. Sixty-eight percent of young males (15 to 24 years) with multiple partners reported condom use at last sex compared to 47.3% of females of the same age. Only 33.3% of older adults (50 to 64) years with multiple partners used condoms at last sex (70).

Future HIV incidence rates in South Africa may not be strongly influenced by the introduction of pre-exposure prophylaxis (PrEP) in sex workers but are likely to be influenced by the introduction of PrEP among youth, young women, and older males in the general population. This inconsistency might be explained by differences in the rates of condom usage in different risk groups and the potential for risk compensation. Other modelling studies have shown that when condom usage is already very high, as is
the case in sex worker–client relationships in most of sub-Saharan Africa (74), the benefit of introducing PrEP is likely to be small, and the benefit may well be offset by reductions in condom use (75). In contrast, when condom usage is relatively modest (as in girls with limited power to negotiate condom use), the likely gains from PrEP are more substantial. If PrEP were made available to particular high-risk groups, it would be important to monitor trends in condom usage in those risk groups to ensure that PrEP does not have a negative net effect on HIV transmission rates (66).

**Key Populations**

Key populations such as female sex workers (FSW) and PWID are important sub-groups of the population, who should be targeted either because they are at higher risk of being infected by HIV or because they play a key role in the spread of HIV. Key populations have received increased attention in South Africa between 2013 and 2015. However, many continue to face discrimination and stigma and experience barriers to seeking healthcare. These vulnerabilities derive from the criminal status of their activities. Yet for other key and vulnerable populations like MSM, adolescent girls and young women, it is due to marginalisation arising from social norms. These differences in underlying causes of vulnerabilities are important for designing evidence-based interventions (72). Based on the HIV stigma experienced by these groups in both the 2012 and 2015 study, levels of stigma experienced by PLHIV have not changed from 2012 to 2014. This is a difficult measure to assess because there is no baseline value or target (71).

Despite recent progress in the policy environment around drug use, the political landscape remains a difficult one. PWID and people who use drugs have been relatively left behind in South Africa’s response to HIV. HIV prevention and harm reduction services are low. Although some NGOs now provide HIV prevention and harm reduction services, the reach is still low and not all services are provided. There are no Opioid Substitution Therapy programmes (72).

Eliminating gender inequalities will be central in ending HIV & AIDS because of its role in HIV transmission and access to treatment. Because gender inequalities are embedded in norms and existing structures, interventions to tackle them need to be comprehensive and far reaching across many sectors of society. Community-based, clinic-based and institution-based interventions are needed. Social and behaviour communication change messaging needs to be clear and resounding. Also, structures for providing support to women who have experienced gender-based violence (GBV) and for prosecuting perpetrators need to become more visible and effective. Policies around sex workers and other key populations should be reviewed and updated to minimise human rights abuses in these groups (72).

Aggregated outcomes and progress data may mask significant inequalities in sub-populations. Reporting only HIV data combined for men and women may suggest population-level achievements while masking significant sex-differences. Sherwood *et al.* found that sex-disaggregation is most often specified for HIV prevention targets, but less so for treatment and retention in care (76). Since sex differences occur in the acquisition of HIV, its diagnosis, treatment initiation, and retention in care, it is crucial for national governments to include sex-disaggregated targets at all stages of the care continuum (76).
4.5 HIV Care Cascade: Knowing Your HIV Status

Knowledge of one’s HIV status is the first step to accessing treatment and care services and it is also central to behavioural modification. In 2012, the national communication survey found that 38% of respondents (10.7 million) tested in the preceding year, compared to 32.2% in 2009. The results were similar to those from HSRC surveys, which estimated that 19.9% and 37.5% of adults tested in the preceding year in 2008 and 2012 respectively. Both surveys showed that women were more likely to test than men. While the government’s HIV Testing and Counselling (HCT) drive explains the overall increase in HCT uptake, differences in health-seeking behaviour between men and women, and antenatal care attendance explain the observed differentials by gender. According to the NDoH annual reports in 2012/13, close to 9 million people were tested for HIV infection. This increased to almost 12 million in 2015/16. However, the 11.9 million tests in 2015/16 represent only 40% of the 30 million target for 2016 set out in the NSP 2012 to 2016 (72).

UNAIDS has set targets that by 2020, 90% of all PLHIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART); and 90% of all people receiving ART will have viral suppression. As of 2017, in South Africa, 84.9% of PLHIV aged 15 to 64 years know their HIV status: 88.9% of HIV-positive females and 78.0% of HIV-positive males know their status. Among PLHIV aged 15 to 64 years who know their HIV status, 70.6% are on ART: 72.2% of HIV-positive females and 67.4% of HIV-positive males who know their HIV status are on ART. Among PLHIV aged 15 to 64 years currently on ART, 87.5% have viral suppression: 89.9% of HIV-positive females and 82.1% of HIV-positive males who are on ART have viral suppression (70).

It is important to link the 90-90-90 goals to each other to ensure consistent methods and routine reporting in the public domain. In South Africa, it has been difficult to link the national data from the districts to national programme data to the National Health Laboratory Service (NHLS) electronic data in order to get a full picture of the 90-90-90 status (77). A standardised monitoring and evaluation approach could improve the use of scarce resources to achieve 90-90-90 through improved transparency, accountability, and efficiency (77). Achieving the 90-90-90 targets will require that at least 73% of HIV-positive individuals are on ART and have viral suppression by 2020. With the proportion treated and suppressed at 38% in 2015, South Africa still has a long way to go towards meeting the targets. However, the successes seen in Botswana, Rwanda and Malawi offer hope that the targets can be achieved. South Africa could learn from these success stories in order to maximise the impact of its ART programme (66).

4.6 HIV Care Cascade: HIV Care

By mid-2015, 11 years after the inception of the programme, an estimated 3.39 million individuals were on ART (66). In September 2016, South Africa implemented universal ART eligibility, extending ART eligibility to all 7.1 million HIV-positive South Africans. Using the progress report numbers, by 2014, HIV treatment has increased by 26% from baseline, achieving 91% of the target (71). While the benefits of universal HIV treatment are evident, concerns that further expansion of ART programmes may compromise quality of care make it essential to monitor trends in the mortality of patients on ART.
As of 2018, of PLHIV aged 15 to 64 years who know their HIV status, 70.6% are on ART: 72.2% of HIV-positive females and 67.4% of HIV-positive males (70). These percentages are similar to the UNAIDS estimates for South Africa. If these percentages were calculated using the number of PLHIV eligible for treatment, the 2015 figure would be 80%. This would mean that the NSP 2012 to 2016 target was achieved by 2015.

The slowdown in adult ART enrolment is of concern given the broadening of ART eligibility criteria in August 2011 and January 2015. Poor linkage to care following diagnosis is likely to be a key explanation: in a recent randomised trial in rural KwaZulu-Natal, less than half of HIV-positive adults not in care sought HIV care within six months. Even when linked to HIV care, adults with higher CD4 counts have significantly lower rates of ART initiation. Thus the broadening of ART eligibility criteria to include patients in higher CD4 categories may have less impact on enrolment than might be expected if patients at higher CD4 counts had the same rates of ART initiation as patients at lower CD4 counts (66).

Despite efforts to promote earlier treatment initiation, limited data are available on the existing burden of advanced HIV disease in South Africa and trends over time. Recent analysis of unlinked laboratory CD4 results suggests that the proportion of patients with advanced (CD4 <200 cells/µL) and very advanced (CD4 <100 cells/µL) HIV disease remains high, despite advances in access to, and increased enrolment into, care in recent years (78). From 2005 to 2011, the proportion of patients entering into care with CD4 count <200 cells/µL declined from 46.8% to 35.6%. From 2011 onward, the proportion of patients entering ART with advanced HIV disease has remained relatively unchanged. In 2016, it was estimated that of 654,868 patients entering care, 32.9% had advanced HIV disease and 16.8% had very advanced HIV disease. Men were almost twice as likely as women (23.1% vs 12.6%) to enter care with very advanced HIV disease (78).

Annual new ART enrolment in children has declined substantially in the last five years. Although this is partly because of the success of prevention of mother-to-child transmission (PMTCT) programmes, new enrolment has declined even when expressed as a fraction of annual new infections. This might be because of inadequate HIV testing. Although great emphasis has been placed on HIV testing in early infancy, there has been little focus on HIV testing in children after infancy and in children who are not known to have been exposed to HIV. It is likely that an increasingly high fraction of mother-to-child transmission is postnatal transmission and transmission from mothers who have not been diagnosed positive, and thus an increasingly high fraction of transmission is likely to be missed by the current screening strategy. It is important that children are not neglected in the scale-up of HIV testing and ART, and there is an urgent need for better monitoring of HIV testing and diagnosis in children (66).

One study used visits to a random sample of facilities in high-priority districts in South Africa with large numbers of people on HIV treatment to gather a useful picture of how PEPFAR policy shifts are being translated into practice and how funding is reaching the front-lines of the AIDS response (79). The study found that the distribution of PEPFAR-supported Human Resources for Health (HRH) is not well aligned with the patient load of a facility. In the larger clinics, it is likely that a significantly larger complement of both clinical and lay workers is necessary to change the trajectory of scale-up and retention. While existing mentoring and training activities are valued by front-line facility leaders, they
are valued less than other inputs, and there is some reason to believe they are not making significant changes in practice (79).

Additionally, while PEPFAR implementing partners have targets they are required to achieve and are incentivised to speed testing and enrolment and increase retention rates, there was no incentive for the public sector staff managing the facilities to scale-up faster or improve retention rates. In fact, doing so would be likely to result in increased workloads and few benefits to themselves, the clinic or their staff (79).

There is also concern that a high proportion of HIV-related deaths occurring in individuals who have been diagnosed but have not started ART suggests that many individuals who know they are HIV-positive and are ART-eligible are either reluctant or unable to start ART (80). This is consistent with the experience of a recent trial of treatment-as-prevention in rural South Africa, in which only 47% of newly-diagnosed adults linked to care within six months of diagnosis (81). Estimates from the same community show that most HIV deaths occur pre-ART (82). In order for ART to be more effective, both in reducing AIDS mortality and in preventing HIV transmission, it is critical to ensure more timely ART initiation after HIV diagnosis (80).

Simplified models of ART initiation are needed in order to achieve greater uptake of ART following diagnosis, for example, same-day ART initiation or expedited ART initiation (83, 84). The models also suggest that an increasingly high proportion of HIV-related deaths (30% in 2014) occur more than six months after ART initiation. Interventions to improve ART retention and increase viral suppression will therefore also be important in reducing future levels of AIDS mortality in South Africa (80).

4.7 HIV CARE CASCADE: CURRENTLY ON ART

Expressed as a proportion of new HIV infections, new ART enrolment rose to 1.00 (95% CI: 0.94–1.06) in the 2009/2010 period, then continued to increase in the subsequent years as ART eligibility criteria were revised and as HIV incidence declined. However, the enrolment ratio dropped from 1.66 (95% CI: 1.48–1.84) in 2012–2013 to 1.37 (95% CI: 1.10–1.67) in 2014 to 2015. Although the drop was not significant in adults, the enrolment ratio declined significantly in children, from 1.26 (95% CI: 1.14–1.39) in 2010–2011 to 0.65 (95% CI: 0.45–0.90) in 2014 to 2015 (66).

By mid-2015, 3.39 million South Africans were on ART, a more than 30-fold increase on the total in 2005. Approximately 287,000 ART patients in 2015 (8.5%) were receiving treatment from the private sector or NGOs. Over the period from mid-2010 to mid-2013, the annual number of new ART patients was relatively stable at around 560,000 per annum, but in the more recent years enrolment declined, reaching 413,000 over the period from mid-2014 to mid-2015. The decline in annual new enrolment was particularly pronounced in children: from 39,500 in 2010/2011 to 13,700 in 2014/2015 (66).

In 2015, expressed as a fraction of all HIV-positive individuals, ART coverage in South Africa was 48.6% (95% CI: 46.0%–51.2%), more than double the ART coverage in 2010. ART coverage was substantially higher in women (52.0%, 95% CI: 49.3%–54.7%) than in men (43.2%, 95% CI: 40.2%–46.2%), with coverage in children being between the two (47.4%, 95% CI: 44.0%–50.8%). Coverage differed substantially by province, ranging from 43.0% (95% CI: 40.9%–45.2%) in Gauteng to 62.0% (95% CI: 40.2%–46.2%) in the Limpopo province.
58.4%–64.9%) in Northern Cape. Similar differences were observed when coverage was expressed as a fraction of all HIV-diagnosed adults: 56.9% (95% CI: 55.3%–58.7%) of all HIV-diagnosed adults were on ART, with this proportion ranging from 50.8% (95% CI: 47.5%–54.6%) in North West to 72.7% (95% CI: 68.8%–75.8%) in Northern Cape (66).

In 2017, Fox and Rosen investigated patients lost to follow up (LTFU) according to the continuum of care (85). Adult retention on treatment is globally at 94% and 83% at six and 12 months, respectively (86). Much of the data on retention come from well-resourced clinics that have better retention than national averages. On the other hand, the inability to track patients who move between clinics, the so-called silent transfers, leads many studies to overestimate LTFU (87). In that same review, we estimated long-term retention on ART and found that adult retention globally was 74%, 68%, 64%, and 60% at 24, 36, 48, and 60 months, respectively (86). Estimates within sub-Saharan Africa and among children were similar (88). Retention after the first 12 months appears to decline at a much slower rate than the rate that occurs over the first year on treatment.

Despite the extremely high prevention of mother-to-child transmission (PMTCT) coverage in South Africa (>95%), ART coverage in children living with HIV remains comparatively low. In 2013 and 2014, the rates were reported to be 40% and 49% respectively. Non-disclosure on the part of parents, lack of sufficient skills for paediatric ART and missed opportunities for HCT in other programmes such as maternal and child health (MCH) are the main factors for this low rate (72). Current school attendance among orphans and among non-orphans aged 10 to 14 (UNGASS 12; MDG indicator), appears to be on track to achieving the target. None of the datasets referenced as potential data sources for progress monitoring are available (71).

Additionally, South African ART programmes have had less success in ensuring equitable access to ART for men. Despite overwhelming evidence of men’s poorer access to HIV testing (89) and ART initiation, men still started ART at older ages and with more advanced HIV disease than women in all calendar periods. Furthermore, the proportion of men starting ART did not increase over twelve years according to one cohort sample. This is in line with findings from a large national study by the NHLS which analysed nearly four million CD4 count and viral load measurements from 2012 to estimate progress towards the UNAIDS 90-90-90 targets (65).

### 4.8 HIV Care Cascade: ART Retention

Retention of PLHIV in care remains the utmost challenge of the national HIV care and treatment programme especially in the pre-ART period. The adult LTFU data for patients started on ART from January to December 2013 show a national average of 27% LTFU among patients who completed 12 months of ART (90). An analysis of a cohort of 66,865 patients who initiated ART during 2004/2005 and followed through to March 2015 showed that after nine years, 16.7% were retained when considering retention within the specific clinic. This increased to 55% when considering retention within the health system (i.e. any clinic).

Migration and clinical transfers may lead to an overestimation of attrition (death and loss to follow-up), using a newly-linked national laboratory database in South Africa (91). The NHLS has maintained
a database of all public-sector CD4 count and viral load results since 2004. In a 2018 study, linked individual laboratory results to patients using probabilistic matching techniques, creating a national HIV cohort (90). Since most analyses are from the perspective of individual cohorts where researchers cannot trace patient movement, HIV care retention was substantially higher when viewed from a national perspective than from a facility perspective. Additionally, national attrition was higher among patients initiating at lower CD4 counts and higher viral loads, and among patients initiating ART at larger facilities.

The NSP target was 94% retention after 12 months and 70% after 60 months. There is need for improvements in HIV diagnosis, treatment initiation and engagement in care to achieve the 90-90-90 target by 2020 (72). However, without a baseline for patients alive and on treatment at various time points (12, 24, 26, 48, and 60 months), it is difficult to tell whether progress has been made. UNAIDS reports much lower 12 month retention than the South African NDoH (42% vs. 75%) does, although this may be due to variable definition (71).

There were also several barriers to increasing the number of people identified, initiated and retained in care. Staff shortages, resulting in lack of capacity to trace lost patients and build effective retention programmes, especially for mobile populations, as well as lack of physical space and laboratory infrastructure remain significant problems. Particularly notable was the sense among respondents that clinics were not particularly well suited to supporting patient retention in many cases, and that some barriers might best be addressed by community-based service delivery (79).

4.9 HIV Care Cascade: Viral Suppression

South Africa’s national guidelines provide for viral load monitoring (VLM) in patients on ART, in line with WHO guidelines, to ensure adherence, treatment success and choice of drugs. Of the patients who started ART in 2013 and completed 12 months of ART, 46.8% were previously reported to have had a viral load test. Of active patients on ART in 2014, 59.6% had a viral load done at 96 months in 2014. These rates have increased recently, due to improvement in the data systems. Seventy-five percent of ART patients had received a VL test in the 12 months from April 2014 to March 2015. The percentage of ART patients with one or more viral load tests during 2015 in South Africa was 87% (72).

In 2018, viral load suppression (VLS) prevalence among PLHIV aged 15 to 49 years in South Africa was 61.0%: 66.7% among females and 50.8% among males. Based on point estimates, VLS prevalence is lowest among 0 to 14 year olds at 51.9%. VLS prevalence among PLHIV in South Africa is highest among older adults: 74.6% among HIV positive females aged 45 to 49 years and 76.4% among HIV-positive males aged 50 years or older. In contrast, VLS prevalence is distinctly lower in younger adults: among PLHIV aged 15 to 24 years, females are lowest at 47.1% (males 49.1%) and among PLHIV aged 25 to 34 years males are lowest at 41.5% (females 68.5%). Among PLHIV aged 15 to 64 years currently on ART, 87.5% with viral suppression: 89.9% of HIV-positive females and 82.1% of HIV-positive males who are on ART with viral suppression (70). Although the percentage of ART patients with viral suppression increased from 78.4% to 87.5% nationally in 2018 (70) rates of viral suppression decreased at the provincial level, from 69.7% to 61.9% in Limpopo, from 70.3% to 61.3% in Mpumalanga, from 85.8% to 57.9% in North West and 85.9% to 54.7% in Western Cape (70). No districts in South Africa
have yet achieved the 90-90-90 target of viral suppression and the leakages in treatment cascades, LTFU, as well as poor adherence contribute to low viral load suppression (72).

Viral suppression has been identified as the most important determinant of future HIV incidence trends in South Africa, and it is therefore concerning that rates of viral suppression are as low as 61% in Limpopo and Mpumalanga. Efforts to improve viral suppression could include adherence support interventions, community-supported models of care to improve retention, better supply chain management to avoid drug stock-outs and potentially new drugs, such as Dolutegravir.

4.10 Evaluate Impact

HIV-related Deaths

From 2010 to 2014, mortality as a percent of total deaths increased by 41%, according to mortality reports from Stats South Africa, therefore the target has not been met. According to UNAIDS data, the total number of AIDS-related deaths decreased by 33%. In the NSP interim report, the authors note that the HIV mortality decline in UNAIDS data is a major improvement due to improved reporting (71).

In their paper, Bamford et al. demonstrated the remarkable drop in in-patient mortality rates (around 40 to 50%) for three of the most important causes of mortality in children under five years of age, i.e. pneumonia, diarrhoea and malnutrition (92). Similar to its impact on maternal mortality, the contribution of HIV & AIDS to under-5 mortality has declined significantly in the past few years, but it remains high. This lack of apparent decline in AIDS-related deaths is not because these major causes accounted for the majority of HIV related deaths, but rather that their decline in both HIV positive and negative children was at a much larger scale than other HIV related causes, such as TB.

Although we are unable to quantify the reduction in HIV-related deaths, we can quantify the success of the PMTCT programme. Notwithstanding these dramatic improvements, Bamford et al. make the point that SA has a much higher child mortality rate than comparable middle-income countries such as Brazil and Mexico (92). The authors also suggest a number of interventions (e.g. increased exclusive breastfeeding, and greater access to water and sanitation), which would further reduce fatality rates from these diseases (92).

Several studies have shown that adult mortality levels in South Africa and other African countries have declined substantially since ART became widely available. However, it is not clear how much of the decline in mortality is attributable to ART. The ART programmes in many African countries are massive public health investments, and it is important to quantify the return on these investments, for both local and international funders, in terms of life years saved (80). From an investment standpoint, ART has had a dramatic impact on adult mortality in South Africa, but models that are not calibrated to population-level recorded death statistics may overestimate HIV mortality. However, the burden of HIV mortality remains sizable for women, despite their better engagement with HIV care services. Women, who have so far gained more adult life-years than men, continue to bear the highest burden of HIV mortality (93).
**New Infections**

The NSP 2012 to 2016 aimed to achieve a 50% decline in HIV incidence among adults in South Africa. In 2012, the HSRC survey estimated the annual incidence rate to be 1.72% among men and women aged 15 to 49 years, translating to an estimated 396,000 new infections in that year. For the entire population, two years and above, the incidence rate was 1.07%, which is an estimated 469,000 new infections. The rate was higher among females (1.46%) than males (0.71%). Among young adults aged 15 to 24 years, the incidence was 1.49% (139,000 new infections) while among those aged 15 to 49, the incidence rate was 1.72% (396,000 new infections) in that year. The NSP 2012 to 2016 used the estimate of the Actuarial Society of South Africa (ASSA) of 0.94% incidence rate in adults in 2012 as baseline (updated to 1.79 using the Thembisa model) (72).

In 2017 the HIV annual survey incidence among adults aged 15 to 49 years in South Africa was 0.79%: 0.93% among females and 0.69% among males. This corresponds to approximately 199,700 people newly infected with HIV aged 15 to 49 years in 2017. Annual incidence in children aged 2 to 14 years is 0.13 (95% CI: 0.03–0.23) (70). The Thembisa model estimate of HIV incidence in 2016-17 is 1.02% (95% CI: 0.94–1.11%), slightly higher than that estimated in the 2017 survey (0.79%) (70). Details regarding the assumptions made in producing the 2017 survey estimate have not yet been published.

Estimates using the Thembisa model showed that HIV incidence decreased in both sexes and in all age groups between 2005 and 2012. Furthermore, estimates from Statistics South Africa showed a consistent decline in HIV incidence among people aged 15 to 49 years from 1.31% in 2012 to 1.22% in 2015 (from 1.25% in 2012 to 1.02% in 2015 according to the Thembisa model) (72).

For HIV incidence measures, the target is 50% reduction with final baseline incidence rate, target constitutes a 74% reduction in incidence. However, this target was not achieved. According to the Thembisa model, incidence decreased by 18% from 2008 to 2012, and according to UNAIDS, incidence increased by 1% from 2012 to 2015 (71). By the middle of 2015, high levels of HIV diagnosis were achieved in South Africa, with an estimated 85.5% (95% CI: 84.5%–86.5%) of HIV-positive adults diagnosed. Rates of HIV diagnosis were similar across provinces, ranging from 82.0% in Gauteng to 88.3% in KwaZulu-Natal (66).

In adults aged 15 to 49, HIV incidence is most strongly correlated with the rate of viral suppression after initiating ART, the level of condom use in non-marital relationships, the year of introducing intensified risk-reduction counselling for HIV-positive adults, the uptake of medical male circumcision (MMC), the year of introducing universal ART eligibility, and the average delay of ART initiation in previously diagnosed, ART-eligible adults (66).

According to the data referred to by the NSP and interim report from UNAIDS estimates, the targets for Mother-to-Child Transmission (MTCT) rate at both 6 weeks and 18 months have been met. Without a baseline for MTCT rate at 18 months, the magnitude of progress achieved is not evident and would require additional sources to verify. According to the United Nations Children’s Fund (UNICEF) data, a 50% reduction in MTCT rate has been achieved, although the target of <2% is not achieved (71).
4.11 Conclusion

The HIV epidemic has taken its toll but increasingly is being brought under control with consequent declines in both maternal and child mortality. The following steps will require much greater consistency in improvement of quality throughout the health system. The current evidence based on HIV prevention shows that we have methods that work at the individual level, and that the goal of ensuring population-level effect is achievable through the use of interventions that support demand for HIV prevention, supply of HIV prevention technologies, and adherence to the direct mechanisms that prevent HIV. The use of an HIV prevention cascade that includes these domains provides a framework to understand why a proven direct mechanism is failing to have a population-level impact and support the development and implementation of interventions to target these domains. Future research that builds on the current evidence base and shows approaches to gaining impact for HIV prevention methods is necessary to ensure intervention effectiveness.

Broad social and structural factors have been shown to be key influencers of the HIV epidemic in adolescent girls and young women across many sub-Saharan African settings. NSPs that are highly gender-responsive will move beyond targets that track individual behaviour to include a comprehensive set of targets to measure gender equality in addition as a major structural driver of local epidemics (76). The future development of NSPs must ensure that all general population targets are disaggregated by sex and age, where applicable. International funders and technical partners, such as the Global Fund, that participate in NSP development should provide increased technical assistance around target setting to ensure that sex-disaggregated targets are set and that data are reported for any differences (76). In addition to technical assistance to facilitate meeting the 90-90-90 targets, South Africa also needs funding to improve or build reporting and recording systems that are interoperable between clinic, laboratory and pharmacy.

Additionally, it is critical to embrace new ideas for measurement and analysis of indicators as South Africa continues to improve and target their response to the HIV epidemic. For example, the UNAIDS 2018 Report used epidemic transition metrics to calculate South Africa’s change in new HIV infections since 2010 (−31%), change in AIDS-related deaths since 2010 (−43%), and incidence: prevalence ratio (0.04) (94). According to predictive modelling, the most important epidemiological parameter to target will be the infectiousness of patients receiving ART. It has also been suggested that the timing of universal ART eligibility does not rank as highly as a number of other epidemiological parameters. Consequently, less emphasis on ART eligibility criteria and substantially more emphasis on programmes to maximise viral suppression may be useful (66). Differentiated service delivery; community-based drug pick-up and adherence support; and disruptive models that are better at reaching young people, working people, men, and key populations, are likely strategies to achieving ambitious goals.

Analysis suggests that MMC is likely to be another important HIV prevention strategy for South Africa. Additionally, if PrEP were made available to particular high-risk groups, it would be important to monitor trends in condom usage in those risk groups to ensure that PrEP does not have a negative net effect on HIV transmission rates (66). There may be an opportunity to move funding to the front-lines of the AIDS response, including both a greater focus on filling key gaps in direct service at facilities and helping take community models of care to scale (79).
WHO’s Consolidated Guidelines on Person-Centred HIV Patient Monitoring and Case Surveillance call for the utilisation of a cascade supportive to linkage and retention in care and systematic reporting (95). Achieving this goal in South Africa, as in many countries, will require investments in data systems, unique identifiers, interoperability and security. Additionally, indicators measuring quality of care should become part of routine monitoring and evaluation systems in order to articulate the complex challenges in the provision of quality health care, disparities in the provision of quality health services, measurement issues, and macro-economic issues. Expanding and enhancing the focus on quality of care in South Africa will continue to improve health access, outcomes as well as life expectancy by consistently delivering care that improves health in response to population needs.

**4.12 Recommendations**

1) **Enhance the current HIV care cascade.** Situating the HIV care cascade within the larger context of primary health care may reinforce attempts to routinise HIV counselling and testing and to ensure that the comprehensive health needs of HIV-positive patients are met. Although a cross-sectional continuum of care is a useful tool for assessing the potential public health impact of programmatic performance, understanding patterns and determinants of both disengagement and re-engagement with care and the role of migration is important for improving retention of individuals within the HIV care pathway.

2) **Strengthen data systems to measure quality.** In order to maximise the usefulness of routine data, the ability to link individuals is necessary. This enables the identification of persons lost to follow-up, allows for strategic information based on de-duplicated individual-level records to complement traditional reporting, and health facility staff and community health workers can effectively use data capture systems and newer technology.

3) **Minimise loss-to-follow-up.** Re-presentation to care after initial LTFU is one of the most challenging aspects of the cascade to measure. Future work should seek to develop retention metrics that can be adapted to capture this complexity across settings.
CHAPTER 5: MATERNAL AND CHILD HEALTH AND QUALITY

5.1 INTRODUCTION

South Africa has made phenomenal progress in improving maternal and child health (MCH) over the last decade (96). This chapter examines quality of care through the lens of MCH, drawing primarily from a 2018 special supplement of the South African Medical Journal on the topic (96) and the 2018 Child Health Gauge (97).

5.2 MATERNAL MORTALITY

In 1997, South Africa introduced confidential enquiries into maternal deaths. South Africa is the only country in Africa to have a sustained and functional National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD) (98). The NCCEMD estimated the institutional maternal mortality ratio (iMMR) at 134.3 per 100,000 live births for the triennial period from 2014-2016 (98). Existing evidence shows that there has been a decrease in the number of institutional maternal deaths since 2009 (the peak period of the MMR), due to a major reduction in deaths due to non-pregnancy related infections such as HIV, tuberculosis, pneumonia, meningitis and malaria (98). The reduction reflects the success of the PMTCT and ART programmes, because the majority of these women were HIV-infected (98). In contrast, there has been a slight increase in deaths due to the complications of hypertension in pregnancy, and a concerning increase in the numbers of and case fatality rates (CFRs) for excessive bleeding associated with caesarean delivery (98).

Box 8: Key findings on maternal and child health and quality

1. In the last decade, there have been encouraging and major decreases in maternal, child and infant deaths.

2. Since 2008, around 60% of all institutional maternal deaths were potentially preventable suggesting the need for ongoing efforts to improve quality of care.

3. During the 2014-2016 period, there was an almost fivefold difference in the case fatality rates for excessive bleeding associated with caesarean delivery between the rural Mpumalanga Province and the urban Western Cape Province, highlighting huge geographical inequities in resources and quality of care provided.

4. An estimated quarter of neonatal deaths are potentially preventable because of a combination of health system and provider reasons.

5. An overall health systems approach, training of health care providers, combined with addressing social determinants of MCH, inclusive of community-related factors, are needed to achieve the necessary reductions in maternal and neonatal mortality.
The majority of these deaths (98%) occurred at district hospitals in the public sector, because of a lack of skilled staff and delays in referral to higher levels of care (99). There were also large provincial inequities in the CFRs of excessive bleeding associated with caesarean delivery, ranging from 76.05/100 000 in Mpumalanga to 15.6/100 000 CD in the Western Cape during the 2014 to 2016 period (98).

Since 2008, there has been a consistent decline of around 17% in the iMMR of preventable deaths since 2008, which suggests improvements in the quality of care provided (98). Interventions to enhance the clinical skills of health professionals included the training of clinicians in the Essential Steps in the Management of Obstetric Emergencies (ESMOE) and the Emergency Obstetric Simulation Training (EOST). The 2014-2016 triennial report on confidential enquiries into maternal deaths found that the ESMOE-EOST programme resulted in a 29.3% overall reduction in iMMR, and a 17.5% reduction in the direct causes of maternal deaths (99). Since the 2008-2010 triennium, the NCCEMD classified around 60% of all the maternal deaths in the health system as potentially preventable (98), as shown in Figure 5.

Health care provider factors were an important contributor to iMMR. For the triennium 2014-2016, the NCCEMD found that the lack of knowledge and skills of doctors was reported as a contributory factor in 39% of all potentially preventable maternal deaths (99). The reported lack of skilled doctors as a contributory factor in potentially preventable maternal deaths ranged from 33% of women who died due to miscarriages, to 71% of women who died due to anaesthetic related cases (99). Similarly, the lack of skilled nurses was reported as a contributory factor in 25% of potentially preventable maternal deaths (99).

The potentially preventable maternal deaths could be seen as two sides of the same coin: one side is an indictment on the health system for the deaths of 800 mothers per year in the prime of their lives; the other side represents an opportunity for improvement on a large scale, using evidence-based strategies that are easy to implement (96). The key areas for intervention to achieve a further reduction in MMR are shown in Table 9 (98).
Table 9: Interventions to achieve further reductions in maternal mortality

- Safe caesarean delivery (CD) through:
  - Clinical protocols and clinical audits.
  - Practical training in the Essential Steps in Managing Obstetric Emergencies.
  - Health Care Facilities to meet minimum standards for safe CD.
  - Training of doctors to perform safe CD.
  - Developments of accreditation tools to assess the competencies of the surgeon performing the operation and the anaesthetist.

- Improve antenatal care at primary health care facilities:
  - Train nurses and midwives.
  - Supervision to ensure adherence to clinical protocols for referral.

- Continuously improve the knowledge and skills of all healthcare professionals.

- Development of strategies to improve the identification of patient/community-related factors in maternal deaths, including the identification of those maternal deaths that occur outside the health care system.

Source: Moodley et al, 2018 (98).

Of equal importance is an assessment of near misses. An audit of maternal near-misses in the Metro West maternity service, in Cape Town found that the major causes were hypertension, haemorrhage and puerperal sepsis (100). More than half of the near misses (56.3%) occurred at the primary health care level (100). The potentially preventable factors that contributed to the near-misses included lack of antenatal clinic attendance, inter-facility transport problems and health provider-related factors (100).

In addition, responsive and respectful maternity care has assumed increasing importance. A 2018 study that explored the quality of care provided to women at the time of birth found that health care providers did not allow women to make choices for themselves (101). The women felt that they did not receive quality of care, mainly because of the negative attitudes of providers and insufficient communication (101). Furthermore, a combination of structural and organisational problems influenced the providers’ ability to provide good quality care. Good clinical leadership improved the behaviour of healthcare providers (101). The authors recommended quality enhancements that emphasise caring and provider competence, as well as improved communication between women and health care providers (101).

5.3 CHILD HEALTH

The infant and under-five mortality rates (Figure 6) are key indicators of health and development (97). In 2015, under-5 mortality was estimated at 37 - 40 deaths per 1 000 live births, while infant mortality rate was estimated at 27 - 33 deaths per 1 000 live births (92). Existing evidence shows that there have been encouraging reductions in under-5 and infant mortality rates in South Africa in the past decade, from a peak in the early 2000s (92, 102, 103). The neonatal mortality rate has remained constant and account for approximately one-third of under-5 deaths (92).

Diarrhoea, pneumonia and HIV infection remain the most important causes of death outside of the newborn period, but the proportion of deaths owing to non-natural causes, congenital disorders and non-communicable diseases has increased (92).
Figure 6: Trends in under-five, infant and neonatal mortality rates, 2002-2015

Legend: NMR- neonatal mortality rate; IMR-Infant mortality rate; U5MR-under five mortality rate; DHIS-district health information system; RMS-rapid mortality surveillance; VR-vital registration
Sources: Dorrington et al, 2018; Rhoda et al, 2018; Bamford et al, 2018 (92, 102, 103).

Figure 7 shows the number of early neonatal deaths by province (103). In all provinces, the number of deaths have remained static, and the variations in the Eastern Cape could be due to poor data quality (103). 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 is not commensurate with the level of government investment in healthcare (103).

Figure 7: Early neonatal deaths by province, 2012-2016
Source: Rhoda et al, 2018 (103).
In 2016, the main causes of all neonatal deaths (birth weight ≥500 grams) were complications of prematurity (47.9%); intrapartum-related events, mainly intrapartum hypoxia (24.3%); and infections (including pneumonia (11.6%) (103). Rhoda et al have estimated that one quarter of neonatal deaths are potentially preventable, and are due do health system-related factors (Table 10), which in turn centre on the quality of care provided (103).

<table>
<thead>
<tr>
<th>Modifiable factor</th>
<th>Number of potentially preventable deaths (n=3105)</th>
<th>Health System</th>
<th>Health Provider</th>
<th>SDH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate facilities/equipment in neonatal unit/ nursery</td>
<td>617</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nosocomial infection</td>
<td>423</td>
<td>X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal distress not detected intrapartum; fetus monitored</td>
<td>417</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delay in referring patient for secondary/ternary treatment</td>
<td>337</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No accessible neonatal ICU bed with ventilator</td>
<td>306</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal care: management plan inadequate</td>
<td>288</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal care: inadequate monitoring</td>
<td>254</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insufficient nurses on duty to manage the patient adequately</td>
<td>167</td>
<td>X X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of transport – home to institution</td>
<td>148</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lack of transport – institution to institution</td>
<td>148</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Rhoda et al, 2018: page S11 (103).

In the preceding decade, there have been high-level political commitment in South Africa and a plethora of policies, plans, programmes and initiatives to reduce neonatal mortality. All of these focus on improvements in the quality of care for mothers and babies in order to reduce preventable neonatal deaths (103). The key priorities have focused on improving the health system for mothers and babies; improving the skills of health care providers in maternal and neonatal care; and preventing deaths due to asphyxia, prematurity and infection. However, implementation of these interventions varies greatly across the nine provinces (103).
A number of priority interventions have been proposed to reduce neonatal deaths, summarised in Table 11 below.

### Table 11: Strategies to reduce neonatal deaths

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>•</td>
<td>Strong provincial leadership to ensure accountability at health facility level.</td>
</tr>
<tr>
<td>•</td>
<td>Improve the quality of perinatal and intrapartum care provided by healthcare workers, and the ability of facilities to provide essential emergency and basic neonatal care:</td>
</tr>
<tr>
<td></td>
<td>o Scale up evidence-based medical interventions to at least 80% coverage.</td>
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<tr>
<td></td>
<td>o Increase usage of antenatal steroids in preterm labour.</td>
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<tr>
<td></td>
<td>o Provide a postnatal care package (including the supportive role of community health workers) in neonatal care.</td>
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<tr>
<td>•</td>
<td>Train the existing health workforce to deliver better-quality care:</td>
</tr>
<tr>
<td></td>
<td>o Clinical protocols.</td>
</tr>
<tr>
<td></td>
<td>o Supervision to ensure adherence to clinical protocols for referral.</td>
</tr>
<tr>
<td>•</td>
<td>Improve the quality of the data collected to support monitoring and decision-making.</td>
</tr>
</tbody>
</table>

Source: Adapted from Rhoda *et al*, 2018.

### 5.4 Social determinants of Child Health

The 2018 Child Health Gauge reported on various social determinants of child health (97). In 2017, 2.3 million children (12%) lived in households where child hunger was reported, with large disparities among provinces. KwaZulu-Natal had the highest reported child hunger. There are also huge inequities by “race”, with a reported 2.2 million African children who lived in households that reported child hunger (96% of all reported cases) (97).

The Child Health Gauge also reported on children’s access to health facilities, with distance measured as the “length of time travelled to reach the health facility, by whatever form of transport is used. The health facility is regarded as “far” if a child would have to travel more than 30 minutes to reach it, irrespective of mode of transport” (97), page 145. This is important because health care utilisation is influenced by the distance to the facility, with those living further away less likely to use services (97). Key findings on South African children’s access to health care facilities are summarised in Table 12.
Table 12: Children’s physical access to health care facilities

- One fifth (20%) of South Africa’s children live far from the primary health care facility they normally use, which is an improvement from 36% in 2002.

- Poor children bear the greatest burden of disease, due to under-nutrition and poorer living conditions and access to services (water and sanitation).

- Health facilities are least accessible to the poor. More than a quarter of children (28%) in the poorest 20% of households have to travel far to access health care, compared with 7% of children in the richest 20% of households.

- The urban provinces of the Western Cape (6% of children live far) and Gauteng (8% of children live far) have much higher access, compared to the more rural provinces.

- Eastern Cape (poor access dropped from 53% in 2002 to 24% in 2017); KwaZulu-Natal (down from 48% to 30%), Limpopo (from 42% to 23%) and North West (from 39% to 25%); Free State (dropped from 26% to 18.5%); Mpumalanga (dropped from 35.4% to 25.2%); Northern Cape (dropped from 27.2% to 14.6%).

- A quarter (22%) of African children travel far to reach a health care facility, compared with between 6%, 8% and 9% of Indian, White and Coloured children respectively.

- Racial inequalities are made worse by access to transport: if in need of medical attention, 90% of White children would be transported to their health facility in a private car, compared with only 10% of African children and 23% of Coloured children.


5.5 CONCLUSION

The large reductions in maternal, under-five and infant deaths are encouraging. However, a large number of maternal and neonatal deaths are potentially preventable. Although these intersect with the social determinants of health (such as poverty, transport, etc.) and apartheid’s legacy of racial deprivation, there are major opportunities to improve quality of care.

In addition to the specific recommendations of MCH experts, we recommend the following:

1. Strengthen or include a compulsory module on quality of care in both pre-service training and continuing professional development programmes of health professionals:
   a. 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.
   b. Based on the results of the audit, quality of care should be integrated in all courses, and a mandatory and compulsory competency of health professionals, prior to registration.
   c. 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.

2. National, concerted effort to ensure implementation of the NCCEMD recommendations, especially measures to improve the quality of maternal and neonatal care.

3. Capacitation of all hospitals to roll-out the implementation of the Essential Steps in the Management of Obstetric Emergencies (ESMOE) and the Emergency Obstetric Simulation Training (EOST), with specific focus on district hospitals, where skills gaps are more pronounced.
CHAPTER 6: HYPERTENSION AND DIABETES

6.1 Introduction

Non-communicable diseases (NCDs) such as hypertension and diabetes constitute a growing public health problem, but remains relatively neglected because of the burden of infectious diseases in South Africa (104). Nonetheless, in 2011 numerous initiatives were launched both internationally and in South Africa to recognise and prioritise NCDs (104). In addition, the Global Burden of Disease study highlighted the increase of premature deaths caused by NCDs, such as diabetes and hypertension (105). This chapter examines quality of care through the lens of hypertension and diabetes, the burden of which remains under-appreciated and under-estimated, particularly in the private health sector. The chapter excludes a discussion on hypertension and diabetes in pregnant women and in children.

6.2 Disease profile

The NDoH has noted that there is inadequate surveillance and research on NCDs, which contributes to information gaps (104). Similarly, the Lancet Diabetes and Endocrinology Commission on Diabetes in sub-Saharan Africa has also pointed to knowledge gaps on the burden of diabetes in sub-Saharan Africa (106). Despite these knowledge gaps, Table 13 presents information from different sources to give an indication of the burden on hypertension and diabetes in South Africa.

Box 9: Key findings on hypertension and diabetes and quality
1. There is an increasing burden of hypertension and diabetes in South Africa. Inadequate surveillance systems and information gaps in both public and private health sectors constrain disease prevention and management efforts.
2. Existing studies found deficiencies in the quality of care provided- almost 1 in 2 individuals with hypertension (48.7%) were unscreened and undiagnosed; 1 in 5 screened (23%) but undiagnosed and less than 10% controlled.
3. 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 or for comorbidity.
4. Preventing and improving the quality of care provided to individuals with hypertension and diabetes will require:
   a. Greater prioritisation of NCDs.
   b. Implementation of the targets contained in the national strategic plan on NCDs.
   c. Appropriate investment and resourcing.
   d. Training of health care providers for quality.
   e. Ensuring that individuals with these conditions take control of their own health.
Table 13: Prevalence estimates of hypertension and diabetes in South Africa

<table>
<thead>
<tr>
<th></th>
<th>Hypertension Prevalence %</th>
<th>Diabetes Prevalence %</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected (Practice Guideline)</td>
<td>30.4</td>
<td>6.5</td>
<td></td>
</tr>
<tr>
<td>Health Quality Assessment 2016 Report (Medical schemes)</td>
<td>15</td>
<td>5.5</td>
<td></td>
</tr>
<tr>
<td>Council for Medical Schemes Report 2015</td>
<td>9</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>SANHANES 2012</td>
<td>30.8</td>
<td>9.5</td>
<td></td>
</tr>
<tr>
<td>SA Demographic and Health Survey 2016</td>
<td>44</td>
<td>Males &gt;=15 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>46</td>
<td>Females &gt;=15 years</td>
<td></td>
</tr>
</tbody>
</table>

Sources: Health Quality Assessment, 2016 (107); Council for Medical Schemes (108); Shisana et al 2013 (109); NDoH et al 2017 (110); Day et al, 2018 (106).

6.3 Quality of Care for Hypertension and Diabetes

According to both the SANHANES 2012 (109) and the SA Demographic and Health Survey 2016 (110), blood pressure is controlled in less than 10% of treated hypertensive patients. Less than 10% of treated diabetes patients have glucose, cholesterol and blood pressure levels under control.

Berry et al in a follow-up to the SANHANES 2012 study described the hypertension care cascade (2011-2012) as follows: “Of those with hypertension, 51% have ever been screened for hypertension, a 49% loss. Of those who have ever had their blood pressure measured, 50% received a diagnosis of high blood pressure, a 49% loss. Of those who received a diagnosis, 77% were being treated with blood pressure medication, a 23% loss. Of those who had taken blood pressure medication in the last 30 days, 52% had controlled blood pressure (<140/90 mm Hg), a 48% loss” (111).

Figure 8: Hypertension care cascade

Source: Berry et al, 2017 (111).
A study on the quality of integrated chronic disease care in rural South Africa found a combination of factors that mitigated against the provision of high-quality care (112). There were malfunctioning blood pressure machines, staff shortages, irregular prepacking of drugs and long waiting times at the facilities (112). Patients attributed long waiting hours to late arrival of health workers and complained of shortage of hypertensive medicines, and rigid appointment schedules (112). Patients also felt stigmatised by the defaulter tracing method used by the community health workers (112). In contrast, health facility managers attributed long waiting times to staff shortages and missed appointments by patients (112).

Stokes et al described quality of care gaps in diabetes. They described the care cascade as follows: “Of those with diabetes, 55% have ever been screened for diabetes, a 45% loss. Of those who have ever had their blood sugar measured, 73% received a diagnosis of high blood sugar or sugar diabetes, a 27% loss. Of those who received a diagnosis, 94% were being treated with oral glycaemic medication or insulin, a 6% loss. Of those who were currently taking medication, 51% had controlled blood sugar (HbA1c < 7.0%), a 49% loss” (113).

A 2015 study that examined the quality of diabetes care in PHC facilities of the Tshwane district found that there was acceptable glycaemic control and LDL-cholesterol for only 27% and 33% of patients, respectively (114). Although more than 79% of patients reporting to be hypertensive, 68% of patients had a systolic blood pressure above 130mmHg and 64% had a diastolic blood pressure above 80mmHg. Patient records in the preceding year showed that screening for eye, feet, kidney or cardiovascular complications was sub-optimal (114).

However, there are best practice examples as was shown in a study that compared quality of care delivered to type 2 diabetes mellitus patients in public and private sector facilities in Johannesburg. Although private patients had higher socio-economic indicators and education levels and experienced fewer access barriers to clinical care, rates of micro- and macrovascular disease as well as health related
quality of life scores and sub-scores were similar between the two sites (115). Although this study is not representative of the public or private sectors, it presents some hope of what may be possible in terms of the quality of care for individuals with NCDs.

6.4 Conclusion and Recommendations

There is much to be done in South Africa to improve screening, quality of clinical care, and monitoring and evaluation initiatives in diabetes and hypertension specifically, and non-communicable diseases in general. The NDoH should prioritise the implementation of the targets enunciated in its strategic plan on NCDs. Our key recommendations are listed below and detailed in Chapter 12.

1. Establish the National Health Commission whose primary focus will be NCDs. The Commission should provide overall leadership to prevent NCDs. The Commission will bring together all relevant stakeholders and ensure the implementation of proposed strategies to prevent or manage the risk factors of obesity, smoking and alcohol and promote healthy lifestyle in relation to NCDs.

2. Prioritise screening for diabetes and hypertension at all health care facilities in the country.

3. Improve clinical care and case management of individuals with hypertension and diabetes, in partnership with them. This should include inter alia, standard treatment guidelines (STGs) and the availability of essential equipment, health laboratory facilities, essential medicines and referral guidelines.

4. Strengthen monitoring and evaluation to ensure that the management and treatment efforts are commensurate with the burden of NCDs.
CHAPTER 7: MENTAL HEALTH AND QUALITY

7.1 INTRODUCTION

Mental health, essential to overall health and well-being, has not received priority at international or national level. Although mental illness contributes significantly to premature mortality, high morbidity and loss of economic productivity (116), there was no focus in the original Millennium Development Goals (MDGs). The SDGs make two specific references to mental health. Target 3.4 undertakes by 2030 to ‘reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being’, and Target 3.5 to ‘Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol’ (1).

In South Africa, mental health and HIV fall on different ends of the burden of disease (BOD) spectrum. Mental health has been relegated to the back seat in national health and health systems discourse and planning, with infectious and non-communicable diseases occupying much of the attention and priority. This chapter examines the intersection between the burden of mental illness, substance use disorder, health policy, service delivery and quality of care.

7.2 MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

In South Africa, mental illness and substance use disorders account for a sizable proportion of the BOD but there is a dearth of research on the epidemiology of these conditions. The main source of data remains the 2004 South African Stress and Health Survey. The study found that 16.5% of South Africans reported having suffered

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Box 10: Key findings on mental health and quality

1. There is an enabling legal and policy framework, but implementation is inadequate.
2. The 2004 Mental Health Care Act emphasises a human rights approach to care, treatment and rehabilitation of mental health care users
3. Mental illness contributes significantly to premature mortality, high morbidity and loss of economic productivity.
4. There is lack of prioritisation of mental health, under-investment in service delivery, and lack of financial and human resources.
5. The Gauteng Mental Health Marathon Project tragedy, which resulted in 144 deaths, is the most egregious manifestation of the neglect of individuals with mental illness.
6. It is estimated that 75% of people with a mental disorder do not receive mental health services. It is mostly, poor black South Africans in rural areas who bear the brunt of the treatment gap.
7. In 2015/16, only 3 of the 9 provinces had fully functioning Mental Health Review Boards.
from a mental disorder (117). In the same study, lifetime prevalence of mental (DSM-IV/CIDI) disorders in South Africa was 15.8% for anxiety disorders, 9.8% for mood disorders, 13.4% for substance use disorders and 30.3% of any mental disorder (117). Lifetime prevalence of substance use disorders differed significantly across ethnic groups. Median age at onset was earlier for substance use disorders (21 years) than for anxiety disorders (32 years) or mood disorders (37 years) (117). Poor mental health and poverty are closely linked and interact in a complex, negative cycle (118). In 2012, the South African National Health and Nutrition Examination Survey (SANHANES-I) found a 28.4% prevalence of psychological distress among participants 15 years and older (109).

Mental health is influenced negatively by the legacy of apartheid that subjected people to social exclusion, and gross human rights violations, poverty, disease, stressors and violence (119-121). Discrimination and stigmatisation, as well as lack of prioritisation of mental health, under-investment in service delivery, and lack of financial and human resources exacerbate mental disorders.

Evaluating the quality of mental health services in South Africa requires the interrogation of several areas: the legislative and policy framework; governance of mental health services; mental health service organisation; decentralisation and the rights of people with mental illness; resources for mental health services; and information systems.

7.3 Legislative and Policy Framework

The South African Constitution underscores the protection of human rights of all people (10). Furthermore, the importance of mental health to overall well-being is enunciated in numerous policy documents, including the Reconstruction and Development Programme (29) and the White Paper for the Transformation of the Health System in South Africa (122).

The Mental Health Care Act of 2002 represented an important step towards addressing process and quality issues in mental health care (123). The Act underscored the importance of community-based care, and foregrounded human rights issues including respect, human dignity, privacy, confidentiality, and protection from exploitation and abuse (123). It makes provision for provincial Mental Health Review Boards as critical governance structures to ensure accountability (123). The Boards are empowered to conduct human rights inspections, impose penalties for non-compliance and even close down facilities.

A doctoral study that analysed the implementation of the Mental Health Care Act for the period 2005 until 2010 found that advocacy for human rights, the broader transformation of the South African health system, and the need for enhanced governance and accountability in mental health, facilitated the implementation of some aspects of the Act (124). However, implementation of the Act was hindered by: the relatively low prioritisation of mental health; stigma and discrimination; poor planning and preparation for implementation; resource constraints; and suboptimal stakeholder consultation (124).

Notwithstanding the enabling provisions of the Mental Health Care Act, South Africa only adopted the National Mental Health Policy Framework and Strategic Plan in 2013, more than a decade after the passage of the Act (125). The stated objectives outlined in the Policy Framework and Strategic Plan are to: develop district based mental health services and PHC; build institutional capacity across
the national, provincial and district levels; ensure surveillance, research and innovation; improve the infrastructure and capacity of facilities; improve mental health technology and medicines; ensure inter-sectoral collaboration; improve human resources for mental health; and promote advocacy, mental health promotion and prevention of mental illness (125).

However, existing evidence suggests that enabling legislation and a robust mental health policy framework are insufficient to ensure implementation (126, 127). 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 (128). The barriers to implementation are shown in Table 14.

<table>
<thead>
<tr>
<th>Table 14: Barriers to mental health policy implementation</th>
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<tbody>
<tr>
<td>• Insufficient political will.</td>
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<tr>
<td>• Low prioritisation of mental health at national and provincial health levels.</td>
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<tr>
<td>• Limited capacity for policy development in the mental health sector.</td>
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<tr>
<td>• poor planning and preparation for implementation.</td>
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<tr>
<td>• ‘Invisibility’ of mental disorders (compared to physical conditions).</td>
</tr>
<tr>
<td>• Limited bargaining power of provincial mental health coordinators to promote prioritisation and resourcing of mental health services.</td>
</tr>
<tr>
<td>• Stigma and discrimination.</td>
</tr>
<tr>
<td>• Resource constraints.</td>
</tr>
<tr>
<td>• Suboptimal stakeholder engagement and buy-in.</td>
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</tbody>
</table>

Sources: Mental Health and Poverty Project 2008 (129); Mulutsi 2017 (124).

Hence successful policy implementation requires these barriers to be addressed.

### 7.4 Governance of Mental Health Services

Mulutsi examined the functioning of the Mental Health Review Boards against the prescripts of the Mental Health Care Act (124). The study focused on appointment of board members, availability of a strategic plan, budget, equipment, office space and administrative support, and reporting or accountability lines or structures. She also examined the records of involuntary psychiatric admissions to determine compliance with the Act (124). The study found that in 2015/16, only three of the nine provinces had fully functioning Mental Health Review Boards and that there were leadership gaps, insufficient autonomy and powers of the Boards; poor operational procedures, and inability of the Review Boards to execute their oversight functions as prescribed in the Act (124). Other challenges identified included a lack of training for board members, as well as lack of equipment and infrastructure to enable them to execute their mandate. The study found that there was poor compliance with the prescribed procedures for involuntary psychiatric admissions in the selected psychiatric hospitals. Combined with the suboptimal
governance by, and functioning of, the Mental Health Review Boards, this meant the *de facto* illegal detention of patients who were admitted involuntarily (124).

### 7.5 Mental Health Service Organisation

In South Africa, health services are a concurrent competency of national and provincial governments. In the public health sector, the National Directorate: Mental Health and Substance Abuse, provides strategic and policy oversight on mental health services and is responsible for monitoring and evaluation of the strategic plan (124). In each province, a mental health directorate or sub-directorate coordinates service provision (124). The provincial health departments are responsible for planning, health service management and all aspects of health service delivery (124).

In concert with the WHO’s mental health service delivery model, the Mental Health Care Act (123) and the National Mental Health Policy Framework and Strategic Plan (125) underscore a model of community-based services for improved access to mental health care. The goal is to structure mental health services in the form of a pyramid, with long-stay facilities (mental hospitals) and specialist psychiatrist services occupying the narrow apex; psychiatric services in general hospitals or community health services in the upper middle; primary care services in the lower middle; followed by informal community care and self-care at the base (125).

However, mental health services are predominantly hospital-based in South Africa with a ratio of 18 beds per 100 000 population in psychiatric hospitals, compared to 2.8 beds per 100 000 in general hospitals (130). Furthermore, mental health services in South Africa have been modelled on institutional care that thwart efforts towards social inclusion, empowerment and independence (131). There are limited community-based mental health services which include day care and residential mental health facilities (132-135).

A 2017 audit of community mental health services (CMHS) in Gauteng, South Africa’s wealthiest province, found that the organisation of services was not in line with the provisions of the Mental Health Policy, and specialist CMHS were inappropriately situated within PHC (136). The audit found that around 2% of clinic visits were for mental health and 80% of these were at specialist CMHS. Overall mental health coverage was approximately 0.3% of the population for adults and 0.02% for children and adolescents. Staffing, residential facilities and day care were far below the cited norms for minimal cover (136). The researchers concluded that the CMHS in Southern Gauteng did not meet any of the norms in the Mental Health Policy (136). Sadly, the deaths of individuals with mental illness in Gauteng Province as part of the Gauteng Mental Health Marathon Project (GMHMP) are a further illustration of the lack of community-based mental health facilities (137).

The lack of community-based services impacts on psychiatric hospitals which are used inappropriately (138). In addition, the provision of mental health services in psychiatric units attached to general hospitals – in order to mainstream mental health services - is constrained by inadequate infrastructure, staff shortages and lack of finances (124).
### 7.6 De-institutionalisation, Decentralisation and Human Rights

Both the Mental Health Care Act (123) and the National Mental Health Policy Framework and Strategic Plan (125) promote de-institutionalisation, decentralisation of mental health services and integration of mental health care into the mainstream of general health care. These are facilitated by the improved availability of psychotropic drugs for use in community-based settings.

Mulutsi found that a combination of factors mitigated against the achievement of the goals of decentralisation and deinstitutionalisation in the Mental Health Care Act (124). These factors include: the lack of a national mental health policy and implementation plan to guide provinces; resource constraints; the lack of community-based mental health services and insufficient training, knowledge and orientation of staff in the district health system. In some instances, there were shortages of mental health assessment forms in general hospitals, that added to the resentment of staff who felt ill-prepared for managing mental health care users (124).

The Gauteng Mental Health Marathon Project (GMHMP) – commonly known as Life Esidimeni – tarnished the concept of deinstitutionalisation (139). The rationale for the GMHMP was cost-saving and to give effect to the policy of deinstitutionalisation of mental health care (139). The patients were transferred from an established and well-managed mental health care facility to unlicensed homes masquerading as non-governmental organisations (NGOs) for mental health care but without appropriate accommodation and supplies, or professional or trained support staff (137). Two official investigations, one by the Health Ombudsman (137) and the other by the retired Deputy Chief Justice of the Constitutional Court (140) both found that patients’ human rights had been grossly violated by the actions of the Gauteng Provincial Government. The tragedy resulted in 144 deaths and is perhaps the most egregious manifestation of the human rights violations of mental health care users, at the hand of a provincial health department (Table 15).

<table>
<thead>
<tr>
<th>Table 15: The Gauteng Mental Health Marathon Project: Quality of care lessons</th>
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<tbody>
<tr>
<td><strong>Background</strong></td>
</tr>
<tr>
<td>• Between October 2015, and June 2016, the Gauteng Department of Health moved 1711 mental health-care users with severe mental illness or severe and profound intellectual disability out of facilities managed by a private health organisation, Life Esidimeni, into the care of NGOs and families.</td>
</tr>
<tr>
<td>• The plan was called the Gauteng Mental Health Marathon Project.</td>
</tr>
<tr>
<td>• In a rushed and flawed process, 144 people died and the whereabouts of more than 20 people remain unknown.</td>
</tr>
<tr>
<td>• The tragedy raises ethical, moral, political, legal, governance, accountability and quality of care issues.</td>
</tr>
</tbody>
</table>
Table 15: The Gauteng Mental Health Marathon Project: Quality of care lessons

**Key diagnosis**

1. Failure of provincial government to uphold the constitutional values and Bill of Rights of individuals with mental illness and the provisions of the Mental Health Care Act.
2. Failure of governance, chaotic management and incompetence.
3. Poor planning and insufficient resource allocation.
4. Lack of accountability.
5. Inferior quality of mental health services.
6. Violation of human rights of the mentally ill patients, including of the right to human dignity; right to life; right to freedom and security of person; right to privacy, right to protection from an environment that is not harmful to their health or well-being, right to access to quality health care services, sufficient food and water and right to an administrative action that is lawful, reasonable and procedurally fair.
7. Breaches in standards of clinical care and lack of compassion and caring.
8. Cruel, inhuman or degrading treatment of individuals with mental illness.
9. Failure on the part of managers and senior public servants to uphold professional codes of conduct.
10. Lack of professionalism, with health professionals failing to use their professional judgement and commitment to protect the lives of patients. The staff did not exercise their profession to the best of their knowledge and ability for the safety and welfare of patients and for the health and well-being of the community. They did not promote ethical standards in community engagement and service. Dual loyalty conflicts are particularly problematic when the health professional chooses to support the interests of the state and other third parties instead of that of patients, thus resulting in harm to patients. The duties conferred on healthcare practitioners require them to act responsibly and be accountable for their actions at all times.

**Quality of care lessons**

1. Health professionals should uphold constitutional values and ethical codes of conduct.
2. Resist an unlawful instruction if it violates ethics and moral codes.
3. Report transgressors to professional councils, professional organisations and/or to the media.
4. Appoint competent and ethical managers and professionals.
5. Ensure mechanisms in place for accountability by government to the public.
6. Ensure involvement of service users and families.
7. Set and monitor norms and standards for clinical care.
8. Adequate planning, including for resource allocation and phased implementation.
9. Monitoring and evaluation.

Sources: Dhai (141); Health Ombud, 2017 (137); Moseneke, 2018 (140); Freeman, 2018 (139).

### 7.7 Resources for Mental Health Services

Funding for health services is devolved to the provinces, and the provinces determine the budget allocations in respect of facilities, supplies and human resources. In 2007, the WHO-AIMS Report on the Mental Health System in South Africa found dismal tracking of, and accounting for, mental health expenditure among the provinces. Only three of the nine provinces were able to report on the proportion of the health budget dedicated to mental health services; and only four were able to report
on the proportion of mental health expenditure devoted to mental hospitals (142). Northern Cape spent 1% of the health budget on mental health services, North West 5% and Mpumalanga 8% (142). These figures suggest that provincial expenditure on mental health services amounts to around 5% of the total health budget (142). The bulk of this allocation (86%) is spent on psychiatric hospitals. Hence, financial resources for mental health services are not commensurate with the burden of mental illness.

There is a dearth of mental health care professionals in Africa. There are 0.7 psychiatrists per 100,000 population in Africa with 0.5 psychiatric nurses per 100,000 population and 0.1 psychologists per 100,000 population (116). In South Africa the total mental health workforce is estimated at 20.6 per 100,000 population (143), which is better compared to other countries in the Africa region (116), but the country lags behind the available workforce in high income countries. Despite its best efforts, South Africa has continued to face serious challenges in providing human resources for the delivery of essential mental services with workforce numbers well below the expected norms for a middle-income country.

The provision of mental health services is constrained by a shortage of professionals, inadequate number of posts in the public service, budgetary constraints and the maldistribution between the public and private health sectors as well as between rural and urban settings. A 2017 study found that less than 40% of psychiatrists were employed in the public sector, with the vast majority located in urban or peri-urban centres (144). The analysis found that as at 2014, a total of 762 psychiatrists were registered to practice in South Africa (including an unknown number of retired practitioners or those working overseas) and only seven of those employed in the public service were located in the public rural PHC facilities to serve nearly 18 million people (144). The situation is worsened by the dire shortage of non-specialist medical officers in PHC generally and in rural settings in particular. Without sufficient medically qualified staff, rural facilities are largely left without carers with the authority to make diagnoses and to prescribe medicines.

7.8 INFORMATION SYSTEMS

Notwithstanding the existence of the District Health Information System (DHIS), there are no nationally agreed indicators for mental health. In addition, the data lack the required levels of correctness, completeness, consistency and timeliness (Chapter 3). The 2017 Mental Health Atlas has highlighted the lack of or insufficient data availability and incomplete inputs which put limitations on reporting and monitoring (116).

In South Africa, data collection is woefully inadequate, ranging from scant to none. Records are poorly kept, collected or collated, exacerbated by lack of feedback and a culture of compliance (124).

7.9 RECOMMENDATIONS

1. Mental health deserves prioritisation at both political and implemental levels, through resource allocation (finances and human resources) that are commensurate with the burden of mental illness and substance use disorders.
2. Ensure implementation of the provisions of the Mental Health Care Act and Policy Framework and Strategic Plan, prioritising community-based mental health services and respect for human rights.
4. Develop indicators for mental health information systems.
SECTION III: QUALITY THROUGH A HEALTH SYSTEMS LENS
CHAPTER 8: FINANCING FOR A HIGH-QUALITY HEALTH SYSTEM

8.1 Introduction

The Constitution lists health services as a concurrent functional area and legislation can be passed at both national and provincial levels (10). Although South Africa spends around 8.6% of its Gross Domestic Product on health, half of this is spent in the private health sector. The total health care spending is not reflected in good population health outcomes. There is a large private health sector in the country that includes health providers (doctors and nurses), private health facilities (hospitals, laboratories), other funding mechanisms such as life and short-term insurance and traditional health practitioners (145). The private health sector is dominated by medical schemes funded primarily by contributions from employers and employees (146). Medical schemes cover about eight million South Africans or 16% of the total population (147). However, a larger proportion of South Africans use general practitioners and/or pharmacies (145), with out-of-pocket payments that further disadvantage poor people (148).

In 2016/17, the public sector health budget was R168.4 billion (24). In the same year, R158 billion was spent on medical aid schemes, but only 16% of the population was covered by them (25). Private hospitals and specialists have accounted for an increasing proportion of medical scheme expenditure since 1996, compared to general practitioner (GP) and dental services. Importantly, inequities in health care access, quality of care and spending between the public and private health sectors remain acute (145, 148).

There has been a rapid growth of expenditure in the private health sector (149). The Minister of Health has underscored the negative impact of the private health sector on the public health sector and the importance of transforming the entire health system (149).

Box 11: Key findings on financing for a high-quality health system

1. South Africa spends around 8.6% of its Gross Domestic Product on health.
2. A large private health sector accounts for half of the healthcare spending, but only covers 16% of the population. However, a larger proportion of South Africans use general practitioners and/or pharmacies with out-of-pocket payments that further disadvantage poor people.
3. Inequities in health care access, quality of care and spending between the public and private health sectors remain acute.
4. The proposed NHI System provides an opportunity for the introduction of innovative reforms that could enhance quality, health care access, reduce costs, and improve efficiency.
8.2 Financing and Quality of Care

In the public health sector quality of care is hampered by a decline in funding, despite increased access to HIV and tuberculosis priority health programmes, and reduced mortality rates (Chapter 4). Since 2012, the South African government has introduced cost-containment and reprioritisation measures, in part due to the global economic recession and poor economic growth (25). Public sector budgets have been under severe pressure, and strategies have included limiting personnel numbers, centralised tendering for medicines, delay of major capital projects, and reprioritisation within available budgets (25). The financial pressure has been exacerbated by ineffective management and poor accountability systems, often resulting in a deterioration of service delivery. In 2017 the Minister of Health released a report of a ministerial task team investigating service delivery in public sector hospitals (150). The report found that inappropriate responses to austerity measures introduced by Provincial Departments of Health, such as freezing of critical front-line health posts and delayed investment in the maintenance of facilities and equipment, had resulted in significant deterioration in the quality of care delivered (150).

In the private health sector, quality of care is also hampered by the lack of coordination between health care practitioners, a ‘fee-for-service’ (FFS) tariff system that pays providers for processes (consultations, and procedures) rather than outcomes, and practice models that favour single discipline practices rather than multi-disciplinary teams (151). In essence, this model promotes fragmentation of care delivery rather than teamwork and produces sub-optimal quality of care with gaps in needed care, duplication of effort, low productivity, and inefficient utilisation of highly skilled human resources (151). Fragmentation and FFS leads to over-servicing by individual practitioners, each separately striving to meet a ‘threshold income’ that will ensure the economic viability of their practices (47). Due to a chronic shortage of most health care professionals and perceived higher income potential in the private sector an oversupply of health care professionals has developed compared to the number of medical scheme funded patients (47). Inappropriate competition between individual practices on a FFS basis result in high medical insurance premiums, shrinking membership and variable quality of care (47).
8.3 Universal Health Coverage Reforms in South Africa

Universal health coverage (UHC) combines access to essential quality care and financial protection and is a key strategy to make progress towards other development goals (152). In South Africa, the proposed NHI system is the vehicle to achieve UHC (23). The NHI is a health financing system that is designed to pool funds to provide access to quality, affordable health services for all South Africans irrespective of their socio-economic status (23).

It is envisaged that the NHI will strengthen the hand of the healthcare consumer, reduce health care costs, while ensuring that healthcare providers receive fair reimbursement for their services (23). The NHI envisages purchasing services from health care providers that could include current public and private providers (23). However, neither the public nor the private sector has the mechanisms for contracting health professionals to ensure quality outcomes. The NHI White Paper identifies contracting in both sectors as ‘passive’ not ‘active’ purchasing (23). In the public sector provincial and municipal health departments are contracted to provide services predominantly through global budget allocations unlinked to any health care outcomes or achievement of quality standards. In the private sector contracting of providers as supplier networks can be linked to agreements to use specific treatment protocols, medicine formularies and other requirements linked to the insurance package of the patient predominantly designed to contain costs rather than promote quality.

In the 2018 NHI Bill, the government proposed a number reforms that could transform health care provision in the country (153). The Bill is premised on the reform of the health care market by consolidating the purchasing of health care services (153). While the Bill is silent on how the fund will be capitalised, the success of the scheme is premised on the splitting the financing and service provision, and on the provision of quality health services (153). However, the annual inspection report 2016/17 of the OHSC found that less than 30 % of the sample of public sector facilities that were inspected, complied with the inspection standards (154). This finding suggests that significant investment will be required in public health sector facilities.

8.4 Innovations towards UHC

The move towards an NHI with its intended purchaser-provider split, creates an opportunity to introduce value-based contracting (VBC) linked to health outcomes, as a mechanism to ensure good quality care for individuals, improve population health and reduce health care costs (155). VBS, also called outcomes-based contracting, links reimbursement rates of health care providers to actual health outcomes (156). Value-based contracting represents a shift away from a FFS model to one based on the value of the service rendered according to pre-agreed criteria (156).

This section highlights potential scenarios for VBC that takes into account ambulatory and in-patient services.
### 8.4.1 Contracting for outpatient/ambulatory care

Two major reforms are required within the contracting environment. The first requires the NHI to use its purchasing power to stimulate the creation of commercially viable local integrated and organised multi-disciplinary patient-centric teams (23). These teams can be contracted to provide services for a defined community. They should be established locally, as an economically viable business unit, and understand the local needs and peculiarities. The productivity of such business units should be driven by local competition for patients linked to contracts from the NHI purchasing authority (153). Contracts should be granted to teams for a fixed number of years, with the length of a contract being determined by the quality of care provided by a team. At the end of the contract period contract renewal should be based on a comparative process allowing other interested teams to compete for providing services to this community. Such a reform will represent an important change in the unit of competition: rather than competition between lone private sector health care professionals or poorly staffed government clinics, competition is now between teams of health care professionals organised into new efficient delivery models of multi-disciplinary teams (reflecting the professions needed to address community disease profiles) competing on institutional reputation for consistently delivering care of good quality (access, service and outcomes) at prudent prices.

Quality outcomes are achieved by compliance with relevant evidence-based medicine protocols (157). These autonomous business units will over time represent numerous competing ‘experiments’ that drive a culture of continuous national quality improvement. The creation of multi-disciplinary teams within the current private sector provider environment will require minor regulatory reform at the level of the health professions councils by refining current regulation clauses that assume solo practice and FFS claims (158). Hence, such changes are feasible within the current public sector regulatory environment.

The second reform requires a commitment to contracting by the NHI on a team-based remuneration mechanism with the right incentives for promoting good health care in the population and ensuring quality care of the sick (159). The aim would be to replace the current system of both variable (often low) productive salaried employees (in the public sector) and fragmentation and over-servicing (in the private sector) with a tariff schedule that promotes high productivity and prevents underservicing by carefully balancing all interests: good care for patients; viability and autonomy for health care professionals and sustainability for the funder. A two-part value fee, if carefully designed, will achieve these common aims by promoting teamwork and by balancing good patient outcomes with prudent costs (159).

For teams constituted from the current private sector professionals, the VBC design takes into account the current policy and regulatory intent of preserving clinician autonomy, by creating autonomous teams owned and managed by health care professionals, and not by hospitals or other corporations. This framework should also be applied to teams established by the public sector. The NHI would pay both fee components to the public sector (provincial and municipal), however as employees would be salaried such payments would underpin job certainty, promotion and bonus payment to specific teams.

The two-part value contract is an alternative to simple global fee models that are often employed in capitation models that do not include explicit quality measures and therefore seldom ensure quality care. Global fees have been experimented with in the private health insurers as an alternative to FFS, however over-simple formulation i.e. a single global fee without adjustment for need or reflecting patient outcomes raised legitimate concerns.
These include concerns around underservicing in order to maximise profit margins. Given that global fees inappropriately transfer risk from the funder to the practitioner, this creates an unsustainable financial risk for health care professionals who are self-employed (160). This happens when patient related expenditure not directly controlled by the contracted practitioner (hospital costs; radiology, pathology and medicine) are higher than anticipated and results in the contracted professional having to absorb this cost. Self-employed practitioners typically do not have the financial reserves to absorb such costs and consequently, must enter a relationship in which they are subordinate to a hospital or a corporate organisation which can carry the financial risk. That relationship may compromise their clinical decisions i.e. their professional autonomy.

New contracting models must combine appropriate incentives for quality care services for patients and communities and ensure financially viable practice for health care professionals and sustainability of the NHI. The key principles for successful VBC are shown in Table 16.

<table>
<thead>
<tr>
<th>Table 16: Key principles of Value-based Contracting in a future NHI</th>
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<tbody>
<tr>
<td>• Efficient multi-disciplinary teams, that use the best available evidence to inform health care provision.</td>
</tr>
<tr>
<td>• Promote quality care using a combination of incentives (e.g. additional reimbursement for quality outcomes indicators that include patients’ total experience of health care) and sanctions for poor performance (e.g. exclusion from NHI local networks).</td>
</tr>
<tr>
<td>• Ensure that professional teams not exposed to undue financial risk.</td>
</tr>
<tr>
<td>• Purchase the best quality at the most prudent costs - for individual patients and sustainable for populations.</td>
</tr>
<tr>
<td>• Quality measures should include both desired outcomes for populations and patient preferences that are rigorously and routinely measured and where the results have direct impact on the fees that are paid to the team.</td>
</tr>
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Source: Porter, 2008 (161).

**Proposed formulation of tariffs**

A key component of the proposed tariff system is that it should only be billable by a recognised clinical team (162), accountable for an enrolled population (members). To accommodate this, a system to generate practice numbers for integrated multidisciplinary teams would have to be created given that this does not exist at present.

Under the value contract, the clinical team bills a ‘value’ fee, with two components:

A monthly professional team fee that reflects the need / risk of the patients enrolled and the related composition of the professional team who take accountability. This global fee is the aggregate of the individual need for clinical care and should include provision for crucial outreach clinical services (such as home visits by social workers or community health workers) and managerial expenses to run the team. A sicker cohort requires a more sophisticated team and more services and so the team bills a higher fee (i.e. risk adjustment). The intent of the global fee is to enable teamwork and reduce fragmentation of care.
Figure 11: Example of team risk-adjusted capitation/global fees
Source: Ruff, 2018 (163).

An additional value-linked fee that the team can charge for once they have reached predefined value-based targets – these include both cost and quality measures. This fee is in respect of the total cost for the NHI linked to patient care and includes the “downstream costs” e.g. hospital; other non-team clinician’s bills (radiology, pathology) and medication. This additional value-linked fee is only payable when the team consistently reaches the value measures and the NHI can document improved outcomes i.e. better quality and lower costs. In this way, patients’ interests are protected and clinicians are potentially rewarded for achieving consistent excellence at reasonable costs (163).

Figure 12: Value-fee performance bands taking into account performance quality improvement indicators
Source: Ruff, 2018 (164).

‘Add on’ value linked fee:

i. Add fee once value levels reached

ii. Fee level = higher levels = higher value vs. current norm

iii. Benchmarks reviewed regularly - every 3 years?

- Value_{max} = quality_{max} / cost_{min}
- Align incentives: team; patient & Scheme
- Downstream cost measure & Quality measures e.g.s:
  - Structure: Multidisciplinary team
  - Process: Complex patient assessments %
  - Outcomes: PQI (avoidable admission rate)
This fee can be structured based on various quality levels.

Process levels can include those to promote population wellness, and the comprehensive management of people with chronic illness, amongst others. Outcomes include hard measures of the overall system performance for the covered population including standardised mortality and overall costs; they also include softer measures that reflect patient experience of the systems responsiveness. ‘Big dot’ system performance measures (165), as proposed by the Institute for Health Improvement (IHI), are whole-system measures used to evaluate overall organisational performance and the effectiveness of strategies. These are preferred to micro-level disease-specific measures which can create an inordinate focus to the detriment of other functions.

Figure 13: Institute for Health Improvement system performance measures
Source: Martin et al (166).

Composite measures are a combination of quality outcome and cost measures so that no rewards are possible based on substandard care. Once completed, these can be expressed as a star system for ease of understanding. Stars awarded are valid until the next evaluation, likely every six months based on a rolling year of data.
8.4.2 Contracting for hospital care

There are two approaches to value-based contracting with hospitals.

Including the hospital in the population medicine contract. If the community PHC service level contracting works well and the admission rate is low (as in the big dot measures), then overall hospital costs as a major overall cost driver ceases to be as large an issue. To achieve this, the hospital must stop to be a separate cost centre and instead become a component of a comprehensive budget for the area population. This is the preferred approach because it fully aligns the interests of all providers in the area rather than creating obstructive competition.

Case mix adjusted (Diagnosis-Related Groups [DRG] based) cost per event is a measure of hospital productivity that enables comparison with other hospitals (167). The process includes the following:

- Every admission is retrospectively characterised by diagnosis code (and procedure code if the admission included significant surgery or procedures) and a DRG name allocated e.g. pneumonia with comorbidity or uncomplicated hip replacement (167).
- From a national data set, every DRG carries a ‘case weight’ (its relative costs to 1, the average e.g. pneumonia may be 0.67 and hip replacement surgery 4.3 – so while prices change every year the case weights don’t shift much).
- By adding up all the case weights in a hospital over a period and dividing by the number of cases we get a case mix index e.g. Hospital A in a month – 430 total / 350 cases = 1.23. We thus expect the hospitals total cost to be 23% more than average. If its costs are higher, it is relatively inefficient, and visa versa. This approach can also be followed for outcomes.
- This approach is often used as a remuneration basis for hospital services in the private sector, as it contains overall hospital costs per admission. This model however has no impact on admission rates.
However, the relative differences in efficiencies between hospitals are often small. If Hospital B cost per case is 5% higher than expected, the NHI will pay R10 500 rather than R10 000 per case i.e. R500 extra per case. In practice trying to manage cost reductions on this basis is hard to achieve given the complexity of items that contribute to a hospital admission cost i.e. staff salaries, consumables, clinician prescription patterns.

By contrast, if the PHC based team are able to reduce the admission rate by 1% i.e. in a hospital with 350 monthly admissions at an average cost of R 10 500 per admission, they prevent 4 admissions and save the NHI R42 000. Should this team be able to reduce admission rate by 30% (and more) by strengthening the out of hospital ambulatory care services and aligning the hospital interest with, this arrangement by including it in the population medicine contract (as discussed above), the savings increase substantially.

Figure 15: Example of a diagnosis-related group
Source: Ruff, 2018 (168).

Over 300 base DRGs describe all hospital admissions: medical; surgical; obstetric; neonatal. Cases allocated by discharge principal diagnosis & surgery, then split by severity based on chronic co-morbidities and hospital complications.

Figure 16: The relationship between population and hospital admissions
Source: Ruff, 2018 (169)
Such an approach is required to develop a benchmark per district for admission rates and at what cost the hospital will be contracted for admissions given that admission rate and the case mix of admissions are relative to the population disease burden. A sicker population i.e. older average age with higher chronic illness prevalence, even in the most effective system will unavoidably result in a higher admission than a younger healthier population. With sufficient data from different regions and systems, this relationship can be defined i.e. the NHI can create an expected admission rate.

**Possible indicators for VBC**

Given the focus globally on reducing health care costs and improving quality, the International Consortium for Health Outcomes Measurement (ICHOM) has been established that organises global teams of physician leaders, outcomes researchers and patient advocates to define standard sets of outcomes per medical condition, designed to facilitate value-based contracting (http://www.ichom.org/). This organisation has already developed such indicator sets for 50% of the major disease entities and provides a base that can be rapidly adapted to service delivery realities. It provides an international benchmarked methodology to allow local development of additional indicator sets should the local disease profile not be fully covered by these international indicator sets.

### 8.5 Conclusion

In light of the huge inequities between the public and private health sectors in South Africa, the proposed NHI system provides an opportunity for the introduction of innovative reforms that could enhance quality, health care access, reduce costs, and improve efficiency.

The key recommendations are listed below:

1. Review current institutional arrangements on public health sector funding to reduce the impact of fiscal federalism.
2. Consider value-based contracting, linked to health outcomes, and quality of care criteria, using multi-disciplinary teams and prioritising a PHC approach under the proposed NHI.
3. Health care provision under the NHI must be led by a strong public sector supported by private health sector capacity.
4. Taking into account existing health information systems that are effective, the ICHOM indicator sets and methodological approach should be adapted for the South African context.
5. There should be monitoring and evaluation of reforms (such as VBC) to measure the impact on patients and/or the health care system.
CHAPTER 9: HEALTH CARE PROVIDERS AND QUALITY

9.1 Introduction

Human resources for health (HRH) are the personification of any health system (170) and critical to the achievement of UHC (171). South Africa has higher ratios of health professionals than the minimum WHO norms, when compared to many countries in Africa, Asia and South America (172). The country also 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 (173). Notwithstanding these strengths, South Africa’s HRH crisis is manifested as staff shortages, inequities and mal-distribution of HRH between urban and rural areas and between the public and private health sectors; there is ineffective and sub-optimal management and leadership at various levels of the health system; and evidence of unprofessional behaviour, poor staff motivation, sub-optimal performance and unacceptable attitudes of health workers towards patients (174). Human resource information systems are fragmented and unable to inform health workforce planning and training (175).

In the private sector, an over concentration of health care professionals often leads to unhealthy competition between providers to acquire sufficient patients to ensure financial viability, potential over-servicing and fragmented care (47). In the public sector poor or inadequate supervision, insufficient focus on productivity and the abuse of the policy of remunerative work outside the public sector further compound shortages (176).

The SA HRH Strategy 2012/2013 to 2016/2017 benchmarked the availability of health care professionals against other middle-income countries, demonstrating a severe shortage of health professionals (177). For example, if benchmarked against Brazil, SA has a shortage of 60 000 medical practitioners (177). Most countries that spend an equivalent percentage of GDP on health compared to South Africa (8 - 10%) opt for doctor-driven PHC,

Box 12: Key messages on health care providers and quality

1. 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.

2. The HRH crisis characterised by: staff shortages, inequities and mal-distribution between urban and rural areas and between the public and private health sectors; unprofessional behaviour, and poor staff motivation and performance, will undermine the achievement of high-quality UHC.
while those who spend less opt for nurse- or mid-level worker-driven systems (178). In South Africa, PHC in the public health sector is predominantly provided by nurses while in the private sector it is predominantly doctor-driven.

The shortage of skilled health care professionals in SA impacts on service delivery and is further compounded by disparities in the HRH distribution between the public and private sectors and between urban and rural areas (177) as well as attrition from the profession. There is inadequate focus on the retention of highly skilled professionals in South Africa, thus ignoring the realities of globalisation where health professionals have become a highly sought after and mobile resource (179).

9.2 Production

The National Strategy for Nursing Education, Training and Practice 2012/13 - 2016/17 set a target of 560 registered nurses per 100,000 of the population by 2020 (180) in line with ratios among economic peers. At the same time the HRH Strategy 2012/13 - 2016/17 (177) set a less ambitious target for 2015 of 387 registered nurses per 100,000 of the population. Both these targets are however, higher than the ratios reported by the WHO for upper-middle-income countries and are closer to the high-income country average of 869 per 100,000. The ratios to be achieved for doctors by 2025, suggested in the NDoH HRH Strategy 2012/13 - 2016/17, of 36.6 per 100,000 would be more in line with low income countries and fall far short of the upper-middle-income country ratio of 155 per 10,000. Projections for medical specialists in the HRH Strategy 2012/13 - 2016/17 set a target 28.5/100,000 (177).

The HRH Strategy articulates the need for increased production of health care professionals. The strategy states “health professional output from Higher Education Institutions has been stagnant in most health science programmes for the past 15 years and planned growth has not taken place in relation to population growth and in relation to health need” (177). The Workforce Model developed in 2010 identified shortages in most categories of health professions (177). At the time, the numbers of dental practitioners, dental technicians and dental therapists were considered to be sufficient to meet needs and forward projections showed a potential surplus. Enrolled nurses were the only category of health care professional where available numbers exceeded demand (177).

The reasons for the stagnant production in clinical disciplines include (177):

- Shortages in academic clinical staff due to a shortage of funding for academic posts. In 2018, the HPCSA expressed concern about the well-being of health professionals because of shortages of human capacity (181). According to the HPCSA, 591 (30%) of the accredited academic posts for medical specialists were unfilled or unfunded in 2010 (177). This situation developed because most of these teaching positions at academic complexes are funded from provincial health budgets through joint appointments between the university and the provincial health department. In most provinces 100% of the salary is covered by the health department. The one exception is the Western Cape, where the split is 51%/49% between the university and the province.
- The clinical training platform is mainly hospital-based and subject to budget and infrastructure shortages that have been plaguing public sector facilities. Limitations in the training platform influences the number of students that can be trained.
Production is predominantly via public sector academic institutions, with limited involvement of the private sector. In the few areas where the private sector is involved, their contribution has boosted production of nurses (through bridging programmes) and of pharmacy assistants.

The envisaged multi-disciplinary service model of the NHI raises questions around the fit-for-purpose of the current undergraduate and post graduate training models where the emphasis is still predominantly on profession-specific training rather than inter-professional, team-based training. The model also does not embrace the potential of e-learning and remains hospital-centred (182).

9.3 Distribution of Clinical Staff

Distribution of health professionals between the public and the private sector does not follow patient load. Only 16% of the population has access to private health insurance (183) but the percentage of professionals practising in the private sector is substantially higher.

There is a lack of reliable data on the actual numbers of health care professionals working in the public and private sectors. The HRH Strategy 2012 to 2017 found large discrepancies between the numbers of health care professionals working in the public sector reported by the NDoH and Treasury respectively (177). Despite the unreliability of data it is evident that there is maldistribution of most categories of skilled health care professionals between the public and private health sectors and between urban and rural areas.

The shortages of all health professionals in relation to population in the public sector and particularly in rural areas are well-described and well-known. Regardless of the numbers of professionals trained, the shortages remain acute. Increasing numbers may address national averages but do not address the maldistribution that results from the internal migration pipeline: doctors in particular move from rural to urban, primary care to tertiary care, generalisation to specialisation and public to private health sectors (37).

In addition, scaling up of production will not resolve HRH shortages and maldistribution in the absence of comprehensive policies designed to address all factors that influence the availability and distribution of human resources in the country (184).

9.4 Recommendations

The major recommendation is to transform, HRH in support of a high-quality health system. The NDoH should use the opportunity provided by the development of the HRH plan for the period 2019/20-2024/25 to partner with front-line health care providers for a high-quality health system and to make health equity and quality the foundation of the new HRH plan. Further details are contained in the concluding chapter.
CHAPTER 10: QUALITY IMPROVEMENT

10.1 INTRODUCTION

Quality Improvement (QI) is a change process which should lead to better patient outcomes (health), better system performance (care) and better professional development (learning) (185). QI builds on a foundation of quality planning and quality control and seeks to identify and implement appropriate evidence-based interventions in response to a problem analysis to change health care delivery mechanisms. Given the complexity of health systems and growing recognition that interventions to improve health systems performance often fail because of a lack of understanding of what works and how it works within the health system context, a whole systems approach is required to improve the quality of health systems (186). QI has thus shifted from quality assurance (QA) and single process clinical activities targeted at individual provider behaviour, to encompassing broader policy aspects and iterative behaviour changes at an organisational and systems level.

South Africa has developed a quality control and assurance system which measures health care quality against national standards, in order to certify health facilities that meet the standards (39). This has been a critical step towards quality but is not sufficient to bring about the changes required to improve the quality of health care across South Africa. QA needs to be complemented by QI approaches to improve clinical processes and to strengthen the health system. South Africa has enabling legislation and several policies which support QI. There are also numerous programmes and projects which have tested different approaches to QI.

10.2 NATIONAL POLICY AND PROGRAMMES FOR QUALITY IMPROVEMENT

The first National Policy on Quality in Health Care in 2001 (revised in 2007) communicated the strategic intent and built consensus on goals for quality (187). It aimed to improve access to health care; increase patients’ participation and dignity; reduce illness, injury and disability through prevention and promotion;

Box 13: Key findings on Quality Improvement

1. South Africa has enabling legislation and several policies which support quality improvement (QI).
2. There are a wide range of QI programmes in South Africa by government, donor programmes, NGOs, academic and research institutions.
3. There are substantial gaps in the coordination and implementation of QI as a national strategy, in mobilising stakeholders, and in learning lessons from QI experience and expertise, to support implementation of QI across sectors and levels of the health system. Hence, the impact of QI initiatives is limited.
4. A whole systems approach, supported by appropriate technology, is required to improve quality across health conditions, levels of care and between the public and private health sectors.
use evidence-based actions and decision-making to ensure appropriate use of health care services; and reduce health care errors (187).

The National Health Act recognised the need to ensure quality but did not create dedicated structures or systems to give effect to this (38). In 2010, the NDoH emphasised its commitment to quality through the 10-point plan for Improvement of the Health Sector and the Negotiated Service Delivery Agreement. Improving quality of health services was prioritised through key activities of improved patient care and satisfaction and accreditation of health facilities (188).

The National Development Plan 2030 launched in 2012 also included ‘QI by using evidence’ as one of its nine health priorities (16). The Medium Term Strategic Framework (MTSF) 2014 - 2019 sub-outcome 2 focused on improving the quality of health care and the NDoH Strategic Goals 2015 – 2020 included the objective of improving health care by setting and monitoring national norms and standards, improving systems for user feedback, increasing safety in health care, and improving clinical governance’ (189).

The NDoH developed the NCS in 2010 which defined the minimum standard for quality of care in health establishments in South Africa (190). The standards, which have been updated, focus on structure and processes within health facilities which are assessed by mandatory inspections by the OHSC as part of a regulatory process. The OHSC was established in terms of the National Health Amendment Act (2013) as a regulator largely to measure quality and provide for certification of facility-based health care (39).

The NHI Policy gazetted in June 2017 highlighted poor quality of public and private health care as one of the problems which the implementation of a NHI seeks to address (23). It endorsed the re-engineering of PHC and national QI initiatives to strengthen service delivery including the role of the OHSC, NCS and the Ideal Clinic Realisation and Maintenance (ICRM) Programme (23).

10.3 Global Strategies and Evidence on Quality Improvement


A 2009 literature review of QI strategies found that clinician/patient driven QI strategies appear to be more effective than manager/policy-maker driven strategies, where less evidence was available (193). The former included clinician-directed audit and feedback cycles, clinical decision-support systems, specialty outreach programmes, chronic disease management programmes, continuing professional education based on interactive small-group case discussions, and patient-mediated clinician reminders (193).
A 2016 overview of systematic reviews of implementation strategies by Pantoja et al. found very few strategies targeting health care organisations, with most targeting health care workers (e.g. professional behaviours) and health care recipients (patient behaviours) and focusing on processes of care (194). Effective strategies (high or moderate evidence of effect on at least one outcome) targeting health care workers included educational meetings, educational outreach, practice facilitation, local opinion leaders, audit and feedback, communication with patients (patient centred training), and tailored interventions (194).

The available evidence on effects of QA processes is relatively weak, particularly accreditation and certification despite being extensively used globally (195). The findings suggested that measurement and accreditation are necessary but not sufficient to create the quality changes needed and should be complemented by other change interventions (195).

10.4 Quality Assurance in South Africa

10.4.1 The OHSC’s Role in Quality Improvement

The OHSC and its Inspectorate for Health Establishments monitor and enforce compliance with the regulated NCS to bring about quality, safe, efficient and effective health service provision in public and private health care establishments, through the following mandatory functions:

- Based on OHSC inspection results, advise establishments on areas that need attention;
- Monitor improvements following inspections;
- Enforce compliance if establishments fail to respond to reported deficiencies adequately;
- Monitor and respond to complaints made by patients and citizens about the quality of health services provided by establishments (39).

Inspections to date revealed that the quality of service provision was unacceptable in all levels of provincial establishments (Figure 17) (154).

![Figure 17: Trends in average provincial performance scores for patient safety, clinical governance and care, 2014/15-2016/17.](image)

Note: EC = Eastern Cape; FS = Free State; GP = Gauteng Province; KZN = KwaZulu-Natal; LP = Limpopo Province; MP = Mpumalanga Province; NC = Northern Cape; NW = North West; WC = Western Cape

Source: OHSC (154).
Section 47 of the NHA requires that all establishments must comply with quality requirements and standards. The OHSC cannot assist health establishments to carry out their actual QI activities since this would be equivalent to being both a referee and a player. Provincial Health Departments and their district structures are thus responsible to support QI implementation by health establishments. As from February 2019 the promulgated standards become active covering: user rights; clinical governance and clinical care; clinical support services; facilities and infrastructure; governance and human resources; and general provisions.

The promulgation of the regulated standards will also facilitate the implementation of Part 1, Clause 5(d) of the NHI Bill, which states that the Fund must enter into contracts with certified and accredited public and private service providers (153).

10.4.2 Voluntary Healthcare Facility Accreditation

The Council for Health Service Accreditation of Southern Africa NPC (COHSASA) developed the Facilitated Accreditation Programme (FAP) in late 1996 to support public and private healthcare facilities, many of which were poorly performing but were unfamiliar with QI processes (196). To assist the facilities to meet quality standards COHSASA developed a system strengthening approach using QI in its accreditation programme which included three progressive levels of recognition before full accreditation – progress, entry and intermediate (197).

COHSASA achieved ISQua accreditation status and remains the only internationally accredited QI and accreditation body for health care facilities in sub-Saharan Africa. A total of 226 South African public-sector facilities in seven provinces have achieved 382 accreditation or graded recognition awards since the programme started. These include tertiary, district and specialist hospitals, PHC clinics and environmental health offices. Private sector hospitals, hospices and non-acute facilities also entered the programme and achieved accreditation. The total number of awards by country is shown in Table 17.

<table>
<thead>
<tr>
<th>Country</th>
<th>Full Accreditation</th>
<th>Intermediate Level with Focus</th>
<th>Intermediate Level</th>
<th>Entry Level</th>
<th>Progress</th>
<th>Insufficient Progress</th>
<th>Grand Total</th>
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<td>95</td>
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</table>
10.5 Quality Improvement Initiatives in South Africa

A wide range of QI programmes have been delivered in South Africa by government and donor programmes, and a range of NGOs, academic and research institutions.

10.5.1 Re-engineering of Primary Health Care

In response to insufficient progress in achieving the intended outcomes of PHC, the NDoH developed guidelines for the ‘Re-engineering of PHC’ informed by the model of PHC in Brazil with the goal of improving the effectiveness of the PHC system in South Africa (198). The strategy aimed to improve the quality of care through stronger supervision, clinical governance and health systems improvements, including better district governance and management. Ward Based Clinical Outreach Teams (WBCOT) and District Clinical Specialist Teams (DCST) were established to strengthen supervision and clinical governance of key programmes, particularly of MCH (198).

The re-engineering of PHC was linked to Phase 1 of the NHI implementation from 2012 to 2017 and supported the testing of health systems strengthening components in 11 NHI pilot districts (199). A 2016 assessment of these pilots found that although progress had been made, many still fell short in terms of implementing the HRH components, particularly the DCSTs and WCBOTs, and in achieving the quality or health indicators (199).

10.5.2 Ideal Clinic Realisation and Maintenance

In response to the 2013 National Audit of Health Facilities, the ICRM programme was adopted by the NDoH and implemented from 2014 to address deficiencies in the quality of PHC services (200). There were three innovations in the ICRM framework:

- The requirements for well-functioning clinics were listed and defined;
- Detailed standard operating procedures were available in the form of the ICRM Manual;
- The clear focus and level of specificity with which the ICRM framework was applied to improve the quality of services at poorly functioning clinics.

The Integrated Clinical Services Management (ICSM) model developed out of the ICRM shifted the largely ‘QA’ approach to a more comprehensive QI approach to health systems improvement. This included strengthening district health management, using routine information systems, promoting a multidisciplinary team approach to quality of care and drew on various QI and management tools. The NDoH Annual Performance Plans 2018/19 – 2020/21 subsequently included targets to extend the ICRM and ICSM to district hospitals.

10.5.3 Strengthening District Health Systems

Between 1994 and 2000, several NGO led district health systems strengthening programmes were implemented in South Africa, including the Health Systems Trust’s (HST) Initiative for Sub District Support (ISDS) programme (201), and Management Sciences for Health’s (MSH) Equity programme (202). A 2001 Technical Review of Quality of Care to ‘review the lessons and best practices emerging
from the Equity project and other South African experiences in support of improved quality of care’
provided an overview of more than 20 projects across South Africa (202). The projects addressed three
themes: quality in PHC; quality in hospitals; and quality in management.

Recommendations for provinces included the establishment of provincial quality units, policy which is
translated into plans and budgets and implementation plans for QI (202).

10.5.4 Evidence-Based Health Care (EBHC)
Evidence based policy and practice is core to delivering quality health care. Institutions such as the
South African Cochrane Centre (SACC), the Knowledge Translation Unit (KTU) at the UCT Lung
Institute and a Centre of Evidence Based Health Care (CEBHC) at Stellenbosch University have been
resources to support evidence informed policy and practice in South Africa.

The KTU over a 20-year period produced packages of evidence informed clinical guidelines for PHC,
initially focused on TB, lung health and HIV care, but expanded to comprehensive integrated guidelines
for the management of commonly seen diseases in PHC. These guidelines were adopted nationally for
implementation through a network of trainers and implementers throughout the country (203).

10.5.5 Partner and local QI initiatives
The United States President Emergency Plan for AIDS Relief (PEPFAR) began in 2004 as a response
to the NDoH ARV rollout programme across the country and was subsequently influenced by the 2008
PEPFAR Quality Strategy incorporating a strong focus on QI in addressing the HIV epidemic (204,
205). PEPFAR’s Site Improvement through Monitoring System (SIMS), a QA activity was launched in
2014 to further support the impact of PEPFAR programmes through standardised monitoring of service
quality to achieve HIV epidemic control and the UNAIDS 90-90-90 goals (206).

The Institute for Health Improvement (IHI) has been involved in QI programmes in South Africa since
2005, particularly in improving the care of patients living with HIV and the quality and safety of patient
care in hospitals. IHI supported QI in PMTCT in all 11 Districts of KwaZulu-Natal, continuous QI
interventions with Lay Health Workers (LHWs) providing MCH services in the community in KwaZulu-
Natal and ART in the Western Cape and in strengthening HIV and TB prevention, care and treatment in
Gauteng, Limpopo and North West Provinces (207, 208). IHI also provided an approach of using data
and learning networks to support QI and developed local online QI training tools.

The SAMRC, using similar data driven participatory approaches, also improved PMTCT of HIV in
Amajuba District in KwaZulu-Natal (209). Nationally coordinated QI programmes in partnership with
organisations like IHI, research and academic institutions and NGOs played an important role in scaling
up the PMTCT programme in South Africa to reduce transmission to less than 2% by 2012 (210).

10.5.6 Hospital and Laboratory QI initiatives
The Best Care Always campaign was launched in 2009 to support South African hospitals to implement
evidence-based interventions to reduce hospital-acquired infections (HAI) and promote appropriate
use of antibiotics (http://www.bestcare.org.za/). More than 200 public and private hospitals participated
by implementing at least one infection prevention and control bundle (211). The Best Care Always campaign was advocated as a key strategy to reduce outbreaks of antibiotic resistant organisms in health care settings in South Africa (212).

Lean management, which strives to improve efficiencies in the workplace, has also been applied in public hospitals in South Africa to reduce waiting times for outpatient orthopaedic services (213) and in improving theatre starting times, triage, discharge planning and support services (214).

The major private hospital groups (Netcare, Mediclinic and Life Healthcare) participate in QA and external accreditation systems such as COHSASA or ISO (International Standards Organisation), and some have implemented QI systems such as IHI’s Triple Aim methodology. The emphasis has however been on measuring quality processes and costs. More recently there has been the inclusion of the patient experience and some clinical outcome measures. The 2016/17 CMS quality of care report also indicated poor overall compliance by medical schemes with recommended management of chronic diseases, with low rates of testing, screening and preventative interventions and the performance of preventive interventions (215).

The laboratory network in South Africa is among the best on the continent. However, the National Health Laboratory Service (NHLS) network of laboratories experienced shortages of human resources and scarcity of quality management and improvement systems. To increase the number of public laboratories reaching accreditation, PEPFAR supported the Strengthening Laboratory System Towards Accreditation (SLMTA), a structured QI programme which teaches laboratory managers how to implement practical quality management systems in resource-limited settings (216). In South Africa, all the major private laboratories are accredited by the South African National Accreditation System (SANAS) and eight out of 35 public laboratories enrolled in 2013 were SANAS accredited by May 2018.

10.6 Technical Innovation for Quality Improvement

Technological innovations in Information and Communication Technology (ICT) (eHealth), mobile phone technology (mHealth), telemedicine, and electronic information systems for data management or as clinical decision support systems, can provide solutions that improve quality and support health care professionals and patients.

10.6.1 mHealth

Evidence on mHealth indicated that mobile phone messaging for patients with long term illnesses including HIV probably improved treatment adherence and attendance at health care appointments but there was little evidence that it improved mortality (217-219). Examples of mHealth innovations in South Africa for patients, health professionals and CHWs include:

MomConnect: a nationally scaled and government-supported digital health initiative supporting universal pregnancy registration and a messaging service for pregnant women and mothers of infants using the public sector which reached 1.5 million pregnant women in South Africa by 2017 (220).
**Vula**: a mobile phone application linking rural health professionals to specialist care in the public sector which enabled front-line practitioners to communicate directly with specialists, providing photos, a brief medical history and to discuss patients over a messaging system. In surgical disciplines, Vula has reduced referrals to tertiary hospitals, and improved the quality of care provided by primary care clinicians (221).

**The Open Medicine Project**: developed several innovative mobile phone technological solutions in response to health systems’ problems, including: An emergency triage application using the South African Triage Scale (SATS) to reduce high rates of incorrect triaging; the MSF Guidance app to provide warzone and remote area doctors with easy access to information was developed with Medecins Sans Frontiers (MSF); several online clinical guidelines including EM Guidance, PHC Clinical Guide, HIV Clinical Guide, and Gene Xpert Support.

**AitaHealth**: developed by the University of Pretoria and the City of Tshwane (222) is supporting WBOT and community-oriented primary care (COPC).

**Catch and Match**: enables CHWs to capture data with mobile phones when visiting households and to refer patients to local health facilities for treatment in the Western Cape.

### 10.6.2 Telemedicine (eHealth)

EHealth projects (223) in South Africa which support QI have included:

- **NHLS TrakCare Lab Webviewer**: enables clinicians to access laboratory results online.
- **Surgibank**: an Electronic Emergency Surgery Triage System displays colour coded surgical emergency cases by their clinical urgency to improve the management of emergency surgical lists in busy operating theatres.
- **eCCR (Electronic Continuity of Care Record)**, a web-based application designed to integrate and digitise medical records for patients being discharged from public health facilities. This improved the follow up of TB and other chronic disease patients in primary care.
- **Electronic medical records**: including a unique health ID for each patient are provided by the Western Cape Provincial Data Centre which enables interoperability of information systems to support patient care and facilitate continuity of care.
- **The ECHO model™**: creates ongoing learning communities for primary care clinicians to receive support and develop their skills and thus provide comprehensive, best-practice care to patients with complex health conditions, where they live.

These few examples of technology enabling QI demonstrate that there are substantial opportunities for eHealth to support QI in the South African health system.

### 10.7 Conclusion

South Africa has sound policy and enabling legislation for QI, an established foundation of quality of care measurement and QA and experience with a large range of QI programmes and projects. However, there are substantial gaps in the coordination and implementation of QI as a national strategy, in mobilising
stakeholders and in learning lessons from QI experiences and expertise, to support implementation of
QI across sectors and levels of the health system.

To facilitate implementation of national policies supporting QI, there is a need for a clear national QI
programme of action (POA) which aligns the many activities with national goals and defines roles,
responsibilities and commitments. Such a POA would also clarify leadership and accountability for QI,
including national and provincial government, health professional organisations, statutory bodies, the
private health sector and other stakeholders.

Progress has been made in implementing QI in PHC and district hospitals through ICRM, but there is no
nationally coordinated QI process in secondary or tertiary level public hospitals nor in the private sector.
A whole systems approach, supported by appropriate technology, is required to improve quality across
health conditions, levels of care and between the public and private health sectors.

10.8 Recommendations

Design an integrated, quality improvement POA that covers the entire health system and all modes
of health care delivery in the public, private-for-profit, and non-governmental and community-based
organisations. The POA should prioritise implementation in rural and under-served areas, and in the
public health sector. This is expanded on in Chapter 12.
CHAPTER 11: SOCIAL JUSTICE AND ETHICAL, ACCOUNTABLE QUALITY HEALTH CARE

11.1 Introduction

The Constitutional values of social justice, human dignity and the advancement of human rights were central to the transformation of the post-apartheid healthcare system in South Africa (10). Any ethically acceptable standard of quality will need to be guided by an equitable and accessible health system, the vision of which was set out in the White Paper for the Transformation of the Health System (122). A high-quality health system, in turn, will achieve equitable health outcomes and a long and healthy life for all. Frameworks for health and human rights provide for theoretical and practical applications of general human rights principles in the healthcare context that include patient and provider well-being towards attaining quality health care.

Box 14: Key findings on social justice and ethical, accountable quality health care
1. Section 27 of the Bill of Rights of the Constitution, affirms the right of everyone to have access to healthcare services.
2. Priority must be given to the worse off groups, defined both in terms of health and vulnerability.
3. Equity has direct implications for rural health care and practice in South Africa, Hence, the quality of rural health care services is a barometer of success of government’s health reforms.
4. In 2016, South Africa had a health care quality and access index of 49.7 which shows that the country still has some way to go with improving access and quality in order to avoid potentially preventable deaths.
5. In May 2017, the estimated contingent liabilities in provincial health departments was around R40 billion, whereas medico-legal cases in private hospitals are kept out of the public domain.
6. In 2015, the long-term average claim frequency for doctors in 2015 was around 27% higher than that in 2009.
7. There is a need to revitalise the core ethical values, professionalism and accountability of health professionals.

11.2 The Right to Healthcare

The right to health has been recognised in several international human rights treaties and instruments. The first articulation of
this right was in 1948 in the Constitution of the WHO whose Preamble includes “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (224). Health was included in the right to an adequate standard of living in 1948 in the Universal Declaration of Human Rights (UDHR) (225). The International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966 is widely considered as the central international human rights law in terms of the protection of the right to health (226). It affirms health as being “… the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (226). This is similar to the WHO Constitution.

Regionally, the right to health is established in the African Charter on Human and People’s Rights (also known as the Banjul Charter) (227). In South Africa, section 27 of the Bill of Rights of the Constitution, affirms the right of everyone to have access to healthcare services with reproductive healthcare given specific mention (10). The state is obliged to institute reasonable legislative and other measures within its available resources in order to achieve progressive realisation of this right (10). Emergency medical treatment may not be refused. Legislative and policy measures that have been enacted towards South Africa’s Constitutional mandate on the progressive realisation of health, include the National Health Act (38) and the Patients’ Rights Charter (228). However, the NHI Policy, with its directive of realising UHC is unequivocally the most relevant response to section 27 of the Constitution (23).

The right to health must be read in conjunction with the right to a healthy environment, the right to adequate food and housing, safe drinking water, land, and social security (229). Despite the notion of “highest attainable standard” being decreed by international human rights law, direction on its meaning and attainment and whether or not quality is to be included is lacking. Member states, within their availability of resources, are given the freedom to make determinations on progressive realisation. Without any tangible obligation, a default position of not realising the right to health because of resource constraints could ensue. It is morally imperative that quality is ethically acceptable by both recipients and providers of healthcare (230). This ethically acceptable quality could serve as an equivalent of the “highest attainable standard” because the right to health cannot be separated from the quality of healthcare (230).

11.3 Distributive Justice and Equity

The discourse on human rights compel attention to issues of equity and distributive justice. Distributive justice is defined as “fair, equitable and appropriate distribution of benefits and burdens determined by norms that structure the terms of social cooperation” (231). Identifying substantive properties for distribution based on the principle of need is necessary for determining decisions on ethically acceptable levels of quality of healthcare. It may not be possible for essential health services to include all services, hence it is ethically acceptable to provide a comprehensive range of key services that are aligned with other social goals (232).

Core values in justice are fairness and equity. They influence fundamentally the critical and difficult moral choices that must be made in the process of priority setting when establishing an ethically acceptable level of quality (233). Central to this is health equity (232). It implies that ideally fair opportunities
should be afforded to everyone so that their full health potential can be achieved, and that no one is to be disadvantaged from achieving this potential where possible (234, 235). This translates to equity in health care being equal access to available care for equal need, equal utilisation for equal need and equal quality of care for all (235). The requirement here is for fair distribution on the coverage and use of services based on need. Priority must be given to the worse off groups, defined both in terms of health and socio-economic status, i.e. vulnerability (11). This will lead to equality, including equality of opportunity, equal respect and equal human dignity being promoted (236). Priority setting is integral to the realisation of the right to health and policymakers have an ethical obligation to set national spending priorities fairly and efficiently and to safeguard the right to health (235).

11.4 Challenges to the Realisation of the Right to Quality Healthcare

The NHI policy outlines several challenges that impact on the quality of healthcare (23) (Table 18).

- Huge inequities between public and private health sectors in terms of:
  - Health expenditure
  - Two-tier healthcare system where the affluent pool their health funds separately from the poor.
  - Other resource misalignment between the public and private sectors relative to the populations they serve
  - Human resources, especially medical and dental specialists.

- An under-resourced and overburdened public health system further exacerbating quality challenges.

- Inequity between urban and rural provinces.

- The high burden of disease seen in public sector with increased utilisation of services and associated increased patient loads.

- Negative staff attitudes, long waiting times, cleanliness, drug stock outs, infection control and unsafe environment of patients and staff in the public sector.

- Patient dissatisfaction with health services and negative experiences.

- Unhappiness with the quality of services resulting in increasing medico-legal claims in both sectors impacting both the fiscus and the healthcare professionals.

- Inefficiencies in the use of HRH with most working in urban facilities resulting in health being transformed into a commodity rather than a social investment and a human right.

- Shortage of key healthcare professionals coupled with a growing population dependent on public healthcare services.

- Suboptimal conditions for delivering quality health services.

- Lack of a coherent unified health information management system.

Source: NDoH (23)
11.4.1 Vulnerability as a Challenge

The National Health Act refers to group vulnerability and specifically identifies women, children, older persons and persons with disabilities as belonging to vulnerable groups (38). These groups are equal before the law and cannot be unfairly discriminated against, in line with section 9 of the Constitution (10). Not ensuring equity in access to an ethically acceptable level of quality health care could result in unfair exclusions and constitutional challenges of unfair discrimination. While specific reference to these groups in the Act is laudable, a weakness of the section is that it is silent on South Africa’s poor people who are vulnerable on the basis of their socio-economic status.

Two major classes of vulnerability in healthcare that could be of assistance to the ethical deliberation in this report are illness vulnerability, and access vulnerability (237). Often these two categories are interconnected with poverty and social inequalities being the common denominator. Poor people are more vulnerable to a range of illnesses. Poor people may also experience poor healthcare because of a lack of access. Historical and geographical influences coupled with social dynamics must also be considered when dealing with this type of vulnerability (237).

52% of South Africa’s total population and 75% of poor South Africans live in rural areas. Access to healthcare in this context is difficult because of high transport costs, large distances to be travelled resulting in late presentation of disease, traditional beliefs on illness and utilisation of traditional healers. Rural healthcare access has been influenced by South Africa’s apartheid history and as scholars have pointed out, “rural health has parallels with the health of people living in poverty and in the deliberately underdeveloped areas of the country, inhabited largely by Black community members” (237). It has been pointed out that “equity has direct implications for rural health care and practice in South Africa and that the quality of rural health care services can be seen as a barometer of success of government’s broader social reforms” (237).

11.4.2 The Healthcare Access and Quality Index

Notwithstanding significant efforts since 1994, the post-apartheid government continues to face significant challenges in its efforts to provide quality health care to the people of South Africa (154, 238). The Healthcare Access and Quality (HAQ) Index is a summary measure to assess personal health-care access and quality (239). The index is based on the 2016 Global Burden of Diseases, Injuries, and Risk Factors Study, specifically 32 causes from which death should not occur in the presence of effective care. The index is based on risk-standardised mortality rates or mortality-to-incidence ratios from causes that, in the presence of quality healthcare, should not result in death – also known as amenable mortality (239). The changes in the HAQ for South Africa between 1990 and 2016 are shown in Figure 18.
Although health-care access and quality improved since 1990, South Africa ranked 127 on the HAQ index, which shows that it still has some way to go with improving access and quality (239). In practical terms the index of 49.7 means that in 2016, a combination of poor access and poor quality care resulted in the potentially preventable deaths of more than 200,000 people in South Africa.

11.4.3 Malpractice and Medical Litigation Challenges

The price paid by society because of escalating and at times unreasonable medical negligence claims cannot be ignored because it impacts directly on access to healthcare (240, 241). Practising defensive medicine, irrespective of the sector in which healthcare is delivered, has become the norm with the focus being not just patient health and best interests but also that of safeguarding against possible medical malpractice liability, thereby increasing unnecessary clinical and diagnostic procedures (241). The fear of lawsuits holds hostage practitioners’ options and preferences for the delivery of ethically exercised care to their patients, leading to frustration and dissatisfaction among both practitioners and patients. Moreover, a culture of blame has become pervasive.

The Medical Protection Society (MPS), the largest indemnity backer of health care professionals in South Africa, 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 (242). However, the lack of robust, patient-centred complaints systems contributed to this increase, thereby leaving litigation by patients as the only viable avenue for redress (242). Delays are endemic because of the lack of efficient and predictable legal processes for the handling of clinical negligence claims. Claim sizes have therefore increased. The cost of settling claims also increase with protracted legal processes (242). Protection for patients in terms of their rights in the Constitution and the Consumer Protection Act, coupled with increasing patient expectations regarding greater involvement in and understanding of their healthcare, have also contributed to the increase in claims (242). The MPS further states that the clinical negligence system currently in place does not facilitate efficient and fair resolution of disputes. Rather, it is adversarial, time-consuming, expensive, lacks transparency and frequently gives rise to “trial by ambush” (242).
Another concern apparent from case law is the length of time claims take to be finalised (243). The South African Law Reform Commission (SALRC) reports that over 75% of claims take more than five years to be finalised, with some cases taking up to 15 - 16 years before conclusion. A major problem with pursuing claims through the courts in terms of the common law is that delays inevitably occur. Some of the reasons for the delays include the often sluggish legal processes, full court rolls, delays caused by witnesses being unavailable, and difficulty in obtaining evidence (243). Table 19 shows the contingent liabilities for medical malpractice in provincial health departments (243).

<table>
<thead>
<tr>
<th>Department of Health</th>
<th>Annual report for Year ending</th>
<th>Contingent liability at year end</th>
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<tr>
<td>Eastern Cape</td>
<td>31/03/2016</td>
<td>R 13 421 136 000</td>
</tr>
<tr>
<td>Western Cape</td>
<td>31/03/2016</td>
<td>R 182 025 000</td>
</tr>
<tr>
<td>Kwa-Zulu Natal</td>
<td>31/03/2016</td>
<td>R 9 957 126 000</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>31/03/2015</td>
<td>R 1 459 497 000</td>
</tr>
<tr>
<td>North West</td>
<td>31/03/2015</td>
<td>R 36 157 000</td>
</tr>
<tr>
<td>Limpopo</td>
<td>31/03/2015</td>
<td>R 1 356 921 000</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>31/03/2015</td>
<td>R 118 064 000</td>
</tr>
<tr>
<td>Free State</td>
<td>31/03/2016</td>
<td>R 940 545 000</td>
</tr>
<tr>
<td>Gauteng</td>
<td>31/03/2016</td>
<td>R 13 452 064 000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>R 40 923 535 000</td>
</tr>
</tbody>
</table>


The increased quantity of medico-legal claims and pay-outs for such claims are not limited to the public sector. The private health care sector is also under pressure, with a sharp rise in insurance for private medical practitioners over the past few years. Furthermore, a 2018 study of nursing malpractice cases in Gauteng and Western Cape highlighted areas of concern in private hospitals (244).
Table 20: Nursing malpractice and medico-legal claims in the private sector

Key findings

Case Outcomes

- 122 complete cases.
- 25 resulted in death.
- The malpractice affected the quality of life of about 69% of the 122 patients.
- About 43% of the patients had additional surgery.
- About 25% of the patients were left disabled.
- About 79% of the patients spent extra days in the hospital.
- Nurses did not pay attention to basic nursing procedures such as post-operative assessment.
- Nurses ignored critical complaints from patients resulting in severe consequences.
- Nurses were unable to interpret readings on machines monitoring patient conditions.
- Nurses’ failure to follow practice guidelines.
- Poor HRH governance: Auxiliary nurses were assigned to duties beyond their scope of practice even in critical units such as theatres.
- High costs of medico-legal claims - claims paid by the private hospitals but may be passed on to the consumers of private healthcare.
- The majority (74%) of the medico-legal cases were handled in secret, thus keeping this matter out of the public domain.

Source: Stellenberg et al. 2018 (244).

11.4.4 Addressing Medical Litigation in South Africa

The situation in South Africa reflects the experience of practitioners in many parts of the world. Various approaches towards addressing the problem have been considered and embarked upon, and alternative claims resolution (ACR) has been proposed (241). ACR approaches include non-judicial, specialised health courts systems with specialised judges and state-appointed neutral experts to adjudicate claims. Medical review and screening panels to weed out frivolous complaints and encourage swift settlement of meritorious claims have also been proposed. Peer review of expert testimony could be considered in order to curb the number of experts who are willing to make dogmatic statements irrespective of bias (241).

Negotiation and mediation as a form of ACR are valuable considerations as well. Negotiation is when two or more people work together towards mutually agreeable outcomes by creating a deal or resolving a conflict. Mediation is “… facilitated negotiation in which the parties involved in conflict meet in the presence and with the assistance of an impartial third party called the mediator” (245). Other forms of reform include staggered payments of damages should the award exceed a predefined threshold, the capping or limiting of claims on non-economic and punitive damage and reducing monetary incentives for attorneys by limiting their fees. This could include a sliding scale fee schedule that reduces contingency fees or a peer review process when contingency fees are charged (241, 245).
Early in 2015, the Minister of Health convened a Medico-Legal Summit. Inherent systems failures in the public health care sector were underscored as contributing to the escalating frequency of malpractice and negligence claims against the state (240). An outcome of the Summit was the establishment of a Ministerial Medico-Legal Task Team to develop a Declaration which would assist with addressing this South African crisis. The Medico-Legal Summit Declaration was signed into effect in March 2016 by the Minister. The Declaration addresses three categories of concerns: patient safety, administrative and legal. The resolutions in the Declaration will be implemented in a phased manner (240, 241).

The Minister of Health and Minister of Justice and Constitutional Development (as the Minister was referred to at the time) requested the SALRC to conduct an investigation into medico-legal claims, especially claims against the state (243). This resulted in an issue paper in May 2017 as the first document to be published during the course of the investigation. This issue paper aimed to announce the SALRC’s investigation into medico-legal claims, to elicit comment and suggestions from relevant stakeholders and to disseminate information to the public at large (243). Its purpose was to initiate and stimulate debate, to seek proposals for reform and to serve as a basis for further deliberation by the Commission. Since this issue paper was the first step in the investigation into medico-legal claims against the state, the paper does not contain clearly defined recommendations for law reform (243). While the call for written comments closed at the end of September 2017, no further communication from the SALRC has been made available in this regard. However, an assessment of core ethical values in healthcare also deserves exploration as the practice of ethical quality healthcare could assist in curbing the rise of litigation.

11.5 CORE ETHICAL VALUES FOR QUALITY HEALTHCARE

Compassion, competence and autonomy together with respect for fundamental human rights serve as the foundation of ethical practice in health care (246, 247). Compassion, described as understanding and concern for another’s distress, is essential in health care. It could be perceived as a crucial trait to deliver morally good care. It is closely linked to caring which is about a natural striving people have to relieve sorrow and misery and to transform the environment in such a way that life becomes liveable and human (247). Caring requires an attitude of empathy towards patients. Caring practitioners are able to put themselves in the patient’s situation of pain and suffering to such an extent that they can perceive accurately the patient’s care needs. Caring always entails an attitude of involvement mediated by practices of care. Caring practitioners are those who are involved with the needs of patients and commit themselves to meet those needs professionally (247).

A high degree of competence is both expected and required from healthcare practitioners because incompetence can result in serious morbidity or death (248). It is not just scientific knowledge and technical skills but ethical knowledge, skills and attitudes as well that are required for a health care professional to be truly competent and to deliver a quality of care that is ethically acceptable (246).

Autonomy or self-determination is the core value of medicine that has changed the most over the years. There has been widespread acceptance by practitioners worldwide of patient autonomy, which means that patients should be the ultimate decision-makers in matters that affect themselves. On the other hand, practitioners have traditionally enjoyed a high degree of autonomy in the management of patients.
However, governments and other authorities have imposed controls on practitioners which at times have challenged their core foundational values (230).

Practice in healthcare, no matter the level can be considered a moral and social contract between the profession and the public (230). Central to this is professionalism and professional integrity. Professionalism sets the standard of what patients and the public expect from health care professionals. Professionalism in healthcare is regulated to protect the public from unsafe practices, to set professional and ethical standards to ensure quality service, and to confer responsibility, accountability, identity and professional status upon practitioners (249). The duties conferred on healthcare practitioners require them to act responsibly and be accountable for their actions, with responsibility denoting a duty to perform some function in a satisfactory manner and accountability entailing that of giving an account of one’s acts or omissions (230). Duties and obligations are codified by the respective statutory health professions councils to regulate healthcare practice and confer moral authority on codes and declarations (230).

11.6 The Moral Authority of Codes and Oaths

Codes serve as a source of moral authority and are used among professionals and laypersons to set standards for ethical conduct, to define new ethical issues and to support one position or another in ethical discourse (250, 251). Professional codes in healthcare are as old as antiquity and despite the Hippocratic Oath being over 2500 years old, the principles have survived the test of time and have been included in modern versions of the Oath internationally by the World Medical Association (WMA) (252) and the International Council of Nurses (ICN) (253) and nationally by statutory councils including the Health Professions Council of South Africa (HPCSA) (56) and the South African Nursing Council (SANC) (254). Moreover, Health Science Faculties and Medical Schools in South Africa have developed their own versions of the Hippocratic Oath.

11.6.1 Nursing Codes and Oaths

The original Florence Nightingale Pledge (255), taken for the first time in 1893 is an adaptation of the Hippocratic Oath and emphasises the following principles: Leading by example; Faithfulness; Accountability; Responsibility; Confidentiality; Devotion and Quality. An international code of ethics for nurses was first adopted by the ICN in 1953. It has been revised and reaffirmed at various times, with the latest revision being in 2012 (253). In South Africa, while the South African Nursing Council Code of Ethics for Nursing Practitioners was promulgated in May 2013, the “Nurses Pledge of Service” as mandated by the Nursing Council to be taken by all nurses is close to 50 years old (256). Service to humanity, practising with conscience and with dignity, pursuing justice and advocating on behalf of vulnerable and disadvantaged patients are the principles that resonate through the Codes and Oath.

11.6.2 Medical Codes and Oaths

The Hippocratic Oath embodies the highest aspirations of the health care professional. It stipulates two categories of duties, those to the patient and those to other members of the profession. With regard to patients, it emphasises the duty of the practitioner to help and not harm patients (257).
The WMA Declaration of Geneva is widely recognised as the modern version of the Hippocratic Oath. It was adopted by the second General Assembly of the WMA in September 1948 and amended several times including in June 2017 (258). The pledge here is to devote life to the service of humanity, to practice with conscience and dignity, to ensure the health of the patient as the doctor’s first consideration, not to allow certain considerations including political affiliations to intervene with the doctor’s duty to the patient and to maintain the utmost respect for human life (258).

Currently graduates at the eight medical schools in the country take modified Hippocratic Oaths prior to commencing medical practice. While the texts differ, all pledge devotion to the service of humanity and conscientious and dignified practice.

Core principles that resonate through all the codes are: to devote life to service of humanity; to practise with conscience and dignity; to ensure health of the patient as first consideration; not to allow certain considerations including political affiliations to intervene with duty to patient; to maintain the utmost respect for human life; and to pursue justice and advocate on behalf of vulnerable and disadvantaged patients (233, 250, 251, 259).

11.7 Recommendations

1. The right to healthcare, distributive justice and equity must inform reforms towards high-quality UHC in South Africa, with prioritisation of vulnerable groups—whether by health, socio-economic status and/or geography.
2. Develop strategies to prevent malpractice and medical litigation.
3. Implement the 2016 Medico-legal Summit Declaration, together with expediting law reforms through the SALRC investigation into medical litigation.
4. Compassion, competence and autonomy together with respect for fundamental human rights serve as the foundation of ethical practice in health care and must be promoted.
5. Health professions councils should ensure ethical conduct and professional behaviour of the health professionals under their jurisdiction and the provision of quality health care.
12.1 Introduction

In this concluding chapter, we return to our definition of a high-quality health system and our conceptual framework presented in Chapter 1 to summarise our key diagnostic findings, and to propose key recommendations in line with these recommendations.

12.2 Key diagnostic findings

The Commission’s key diagnostic findings are listed below:

Finding 1  Gaps in ethical leadership, management and governance contribute to poor quality of care

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 the poor quality of care. These gaps are exacerbated by evidence of mismanagement, inefficiencies and incompetence at various levels of the health system. Corruption and fraud are major threats to equitable access to quality health care.

There are several failures of governance in the private health sector, including a lack of transparency and lack of accountability to members of the public that belong to medical aid schemes.

There are governance weaknesses in the Health Professions Council of South Africa and the South African Nursing Council, which are the regulators of the majority of health professionals in South Africa.

There are numerous barriers to effective community participation, which in turn influences accountability, the essence of which is answerability.
Finding 2  **Poor quality of care costs lives.**
South Africa remains at the forefront of the fight against HIV & AIDS. Mortality rates have declined substantially in the past decade and the country has the largest anti-retroviral treatment programme in the world. However, the evidence shows that poor quality of care costs lives. Since 2008, around 60% of all institutional maternal deaths were potentially preventable, with rural areas worst affected compared to their urban counterparts. An estimated quarter of neonatal deaths are potentially preventable because of a combination of health system and provider reasons. There are also deficiencies in the quality of care provided to individuals with hypertension and diabetes. Mental illness contributes to premature mortality, high morbidity and loss of economic productivity. However, there is lack of prioritisation of mental health, and under-investment in service delivery. It is estimated that 75% of people with a mental disorder do not receive mental health services. It is mostly poor, black South Africans in rural areas who bear the brunt of this treatment gap.

Finding 3  **Malpractice cases and medical litigation are threats to the realisation of the right to health care in South Africa.**
In the 2016/17 financial year, the Auditor-General reported that litigation and claims in the public health sector amounted to R1.2 billion. In 2016, the South African Law Reform Commission estimated the total contingent liabilities for medical malpractice in provincial health departments at around R40 billion, thus placing a huge burden on the distressed health system and reducing financial resources available for health service provision. In the private health sector, the long-term average claim frequency for doctors was 27% higher in 2015 compared to 2009. In this sector, medico-legal cases also occur but are handled privately and are kept out of the public domain.

Finding 4  **The human resources for health (HRH) crisis will undermine the achievement of high-quality universal health coverage.**
This crisis is characterised by: staff shortages, inequities and mal-distribution between urban and rural areas and between the public and private health sectors; unprofessional behaviour and poor staff motivation and performance. This crisis will undermine the achievement of high-quality universal health coverage, if not addressed. In the public sector, the lack of knowledge and skills of doctors and nurses were contributory factors in the potentially preventable maternal deaths. In the private sector, nurses’ failure to follow guidelines, unresponsiveness to patients and knowledge gaps contributed to medico-legal claims.
**Finding 5**  Health information system gaps constrain the country’s ability to measure or monitor quality and its improvements.

The South African government’s commitment to measuring quality has been longstanding. There is an enabling legislative and policy environment for the development of a health information system to measure quality. Numerous health measurement platforms exist that provide information on health system inputs, processes, service delivery, outcomes and impacts. However, most of these do not provide sufficient and appropriate information on health outcomes and impacts, nor are they sufficiently person-centred. Quality of care indicators focus primarily on structure, process and outputs in both the public and private health sectors. Data quality remains a significant barrier to the assessment of health system performance on the quality of care provided. Health information systems are partially electronic, are not interoperable, do not make available patient-level data, and are not capable of reporting aggregated data across public and private health sectors, or across levels or care pathways.

**Finding 6**  There is fragmentation and limited impact of quality of care initiatives.

Although there are numerous and encouraging quality improvement initiatives in South Africa, the impact is limited because of fragmentation across health conditions, levels of care and between the public and private health sectors.

### 12.3 Recommendations

South Africa’s Constitutional values of human rights, equity and social justice underpin the Commission’s recommendations. We recognise the unacceptable inequities in health care access, quality of care and spending between the public and private health sectors and the vulnerability of individuals with certain conditions (such as mental health) or by location (rural and/or poor areas).

Hence, the Commission considers it a moral and ethical imperative to provide high-quality universal health coverage (UHC) in South Africa, using an overall systems approach as enunciated in our definition and conceptual framework.

The planned NHI system provides an opportunity to achieve a transformed, high-quality health system, responsive to people’s needs, and to introduce innovative reforms that could enhance quality, health care access, reduce costs and improve efficiency.

However, the implementation of our recommendations will require investment, responsibility and accountability on the part of all health system leaders, including politicians, health managers, front-line health workers and their representative organisations.
The Commission proposes four overarching recommendations:

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

Recommendation 1: Enhance governance and leadership for quality and equity.

(a) Prevent fraud and corruption.
   i. Inculcate ethical and effective leadership drawing on 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 proactively managed.
   ii. All health professions councils should re-iterate ethical codes and enforce ethical and professional behaviour of health professionals under their jurisdiction.
   iii. Health authorities (both public and private) should communicate a message of no tolerance to fraud and corruption in the health sector.
   iv. Alleged transgressions of managers and health workers should be investigated without delay, and swift action taken.
   v. The NDoH should draw on the expertise of the National Prosecuting Authority, the Public Service Commission and civil society organisations to combat corruption through prevention, detection, disciplinary action and possible prosecution.
   vi. The NDoH should be provided with copies of the provincial health departments’ prevention of fraud and corruption plans (which is a legislative requirement) for discussion and monitoring at the NHC.
   vii. The NDoH should request provincial treasuries to monitor the implementation of the plans on the prevention of fraud and corruption in health departments.
   viii. All health workers should be given the number of the hotline to report fraud and/or corruption.
   ix. Training for politicians in national parliament and provincial legislatures should be revitalised to instil basic knowledge on health outcomes and health system performance (including quality of care) to enable them to hold health departments accountable.

(b). Strengthen community health structures.
The NDoH should lead the strengthening of community health structures such as mental health review boards, hospital boards and community or clinic health committees.

   i. Implement the provisions of the National Health Act on community participation and community structures.
   ii. Ensure that at least one target on community health structures is included in the annual performance plans of provincial health departments, accompanied by the allocation of appropriate resources.
   iii. Implement a compendium of training materials that provide guidelines on the selection, training and functioning of community health structures.
   iv. Request development partners to provide bridging funding for training of all members of community health structures to enhance their capacity to provide oversight of quality initiatives.
v. Conduct a biennial survey on the functioning and effectiveness of the various community health structures.

(c) Invest in, and increase the capacity of, the Office of Health Standards Compliance.
The OHSC is a quality of care regulator that is unique in a low-and middle-income country setting. We recommend the following:
   i. Treasury should increase the financial resource allocation over the medium term expenditure framework (MTEF) to enable the OHSC to:
      • Appoint additional technical experts in quality of care and information management.
      • Expand its inspection capacity for increased coverage in the public health sector.
      • Include the private sector for inspection of health facilities.
      • Implement an early warning system in all health facilities.
      • Strengthen its employee assistance and support programme.
   ii. The OHSC should enhance its communication capacity to enable it to share good practices across institutions and among provinces, and to encourage a culture of learning, openness, and ongoing quality improvement.
   iii. The OHSC should enhance its capacity to enforce norms and standards.
   iv. The OHSC should be encouraged to establish partnerships with academic institutions to increase its technical capacity in the short-term.
   v. The Minister of Health should consider the separation of the OHSC and the Office of the Ombud to avoid a potential conflict of interest in future, and to enhance the effectiveness of both bodies.

(d) Enhance the capacity and effectiveness of the Council for Medical Schemes.
The Council for Medical Schemes (CMS) should enhance its ability to provide effective oversight of the private health insurance sector.
   i. Implement the provisions of the Medical Schemes Act (as amended).
   ii. Protect the interests of members or beneficiaries of private health insurance schemes.
   iii. Create a dedicated unit to analyse data on quality of care indicators in the private health insurance industry.
   iv. Ensure that private health insurance schemes report on measures taken to improve quality of care to their members.
   v. Enhance its communication capacity to enable it to share good practices across medical aid schemes.
   vi. Encourage a culture of learning and openness, and voluntary compliance with the provisions of the Medical Schemes Act.
   vii. The NDoH should hold the Board of the CMS accountable for fulfilling its legislative mandate.

(c) Strengthen governance, effectiveness and efficiency of the various health professions councils.
i. The NDoH should develop a minimum set of indicators (no more than 10) to ensure that each Council meets its legislative mandate, which is to ensure ethical conduct and professional behaviour of the health professionals under their jurisdiction, and the provision of quality health care.
ii. Each Council should be required to conduct an annual board evaluation in line with the principles of good governance, and submit the report to the NDoH together with its annual report.

iii. Each Council should ensure that the health professionals under its jurisdiction maintain quality of care competencies, in line with the best available scientific evidence.

iv. Each Council should use the annual registration process to communicate the importance of ethical and professional conduct and accountability of health professionals under its jurisdiction.

v. Each Council should investigate ethical or quality of care transgressions immediately and ensure that professionals under their jurisdiction are held accountable.

vi. The Forum of Statutory Health Professions Councils provides an important mechanism for the NDoH to ensure accountability of the various health professions councils. The Forum should be revitalised, and appropriate resources allocated so that it can achieve its intended objectives.

Recommendation 2: Revolutionise quality of care.

(a) Revitalise the provision of responsive, high-quality clinical care that responds to the burden of disease.

i. Enhance the current HIV care cascade, by situating it within the larger context of PHC, routinise HIV counselling and testing and encourage a cross-sectional continuum of care to ensure that the comprehensive health needs of HIV-positive patients are met.

ii. Minimise LTFU in HIV care, encourage re-entry to care and improve retention.

iii. Embark on a national, concerted effort to ensure implementation of the recommendations of the National Confidential Enquiry into Maternal deaths, especially measures to improve the quality of maternal and neonatal care.

iv. Prioritise screening for diabetes and hypertension at all health care facilities in the country.

v. Improve clinical care and case management of individuals with hypertension and diabetes, in partnership with them. This should include inter alia, standard treatment guidelines (STG) and the availability of essential equipment, health laboratory facilities, essential medicines and referral guidelines.

vi. Mental health deserves prioritisation at both political and implemental levels, through resource allocation (finances and human resources) that are commensurate with the burden of mental illness and substance use disorders.

vii. Ensure implementation of the provisions of the Mental Health Care Act and Policy Framework and Strategic Plan, prioritising community-based mental health services and respect for human rights.

(b) Prevent medical malpractice and litigation.

i. Develop strategies to prevent malpractice and medical litigation.

ii. Implement the 2016 Medico-legal Summit Declaration, together with expediting law reforms through the South African Law Reform Commission investigation into medical litigation.

iii. Compassion, competence and autonomy together with respect for fundamental human rights serve as the foundation of ethical practice in health care and must be promoted.

iv. Health professions councils should ensure ethical conduct and professional behaviour of the health professionals under their jurisdiction and the provision of quality health care.
(c) Embark on a national campaign to educate patients and communities about their health rights and responsibilities.

i. The NDoH should lead a national social mobilisation campaign to increase public awareness of quality of care issues.

ii. NDoH should design the campaign with inputs from, and partnerships with the Government Communication and Information Services, the Presidency, South African Human Rights Commission, OHSC, civil society organisations.

iii. The campaign should focus on health rights within the context of the Bill of Rights, the responsibilities of individuals for their health, and the rights and responsibilities of health workers.

iv. The campaign should include information on the importance of disease prevention, health promotion and protection, health outcomes, health system performance (including OHSC inspection reports) and mechanisms for remedy and redress at different levels of the health system. The latter should include the importance of mutual respect between community members and health workers, communication channels, where to initiate a complaint, when to escalate a complaint, and the number of the hot line of the OHSC.

v. The communication media should include mobile phones, radio, television, social media, print, and the utilisation of existing forums where the campaign would be visible to large numbers of people (such as shopping centres, pension pay-outs, places of worship, and schools).

(d) Design an integrated, quality improvement Programme of Action (POA).

The POA should that covers the entire health system and all modes of health care delivery in the public, private-for-profit, and non-governmental and community-based organisations. The POA should prioritise implementation in rural and under-served areas, and in the public health sector.

i. Recognising the vision on health in the National Development Plan and in various Department of Health Strategic Plans, the POA should take into account the following:
   • South Africa’s burden of disease.
   • Provision of safe and effective clinical care, that is respectful and responsive to the needs of both patients or communities and health care providers.
   • The numerous disparate quality of care initiatives across the country.
   • Key inspection findings of the OHSC.
   • Financial, human and other resource requirements.

ii. An inclusive National Steering Committee should provide stewardship of the POA.

iii. In each province, there should be an extensive consultation process to develop a provincial POA that will ultimately feed into the national POA. The consultation should include:
   • Front-line health care providers in both the public and private health sectors, including their supervisors and managers.
   • Community health structures (hospital boards, community or clinic health committees).
   • Local government.
   • Organised labour.
   • Academics and health experts.
• Patients’ rights groups.
• Relevant civil society organisations.
• Development partners.

iv. Each provincial POA should take into account the variations in the burden of disease, health equity, the state of quality of care in its health care facilities, prevention of fraud and corruption, the strategies for the prevention of medical litigation, and the creation of a positive practice environment that enable the provision of safe, respectful, and effective care.

v. Each provincial POA should prioritise critical interventions needed to improve quality (e.g. competencies of clinical staff, quality supervision, professional accountability), rather than contain a wish list of all possible quality improvement activities in the health system.

vi. The provincial POA should feed into the development of the national integrated quality-improvement POA. The National Steering Committee should use the current discourse of the NHI System as a lever to revolutionise quality of care in South Africa.

vii. The final POA (after extensive consultation) should include clear cost estimates, including additional resource requirements for its implementation. The POA should also contain financial estimates of the social and economic value that would accrue from the implementation of the POA in South Africa.

viii. The POA should have clear implementation targets and be included in the public sector health budget bid submitted to National Treasury, with prioritisation of rural areas in South Africa, and the implementation of the provisions of the Mental Health Care Act. The private sector should demonstrate resource allocation for the implementation of the POA.

ix. The Minister, supported by the National Steering Committee on the POA, should ensure annual monitoring of the implementation of the national POA.

Recommendation 3: Invest in, and transform, human resources for health in support of a high-quality health system.

(a) Develop a transformative HRH plan.

i. The NDoH should use the opportunity provided by the development of the HRH plan for the period 2019/20-2024/25 to partner with front-line health care providers for a high-quality health system, and to make health equity and quality the foundation of the new HRH plan.

ii. Finalise staffing norms and standards that are informed by the national quality POA.

iii. Quality of care improvements should be mainstreamed in the responsibility of every health worker, health manager or supervisor, regardless of setting or level of care.

iv. The NDoH should lead 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, the responsibilities of individuals for their health, and the rights, responsibilities and individual accountability of health workers.

v. In the public sector, health managers should be recruited based on merit and core competencies in line with the provisions of the Public Service Act, and their credentials must be screened prior to appointment.
vi. Each executive or responsible manager should be assessed in respect of values of integrity, compassion, accountability, fairness and transparency, and be required to commit to the Public Service Code of Conduct in writing. All health managers should be held accountable for their action.

vii. The NDoH should urge the Department of Public Service and Administration to develop guidelines aimed at eliminating political interference in staff appointments, including a possible amendment of the PSA to be in line with the Public Finance Management Act.

viii. A review of the performance management system and its application should be undertaken to ensure that employee performance is linked to organisational performance, employee development, and team-based performance (where appropriate). Rewards should be based on clear performance goals, including the consideration of models of team-based remuneration.

ix. Partner with front-line staff, organised labour and other staff representative organisations to ensure positive practice environments (including employee assistance programmes) that facilitate the provision of high-quality care.

x. The Public Service Commission should monitor whether appointments in the public sector are in line with existing legislation.

(b) Strengthen or include a compulsory module on quality of care in both pre-service training and continuing professional development programmes of health professionals.

i. 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.

ii. Based on the results of the audit, quality of care should be integrated in all courses, and a mandatory and compulsory competency of health professionals, prior to registration.

iii. 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.

Recommendation 4: Measure, monitor and evaluate to ensure a high-quality health system.

Develop and enforce an integrated national health system performance dashboard.

i. The NDoH should develop and enforce an integrated national health system performance dashboard with an initial list of performance indicators that measure quality outcomes in the health system. Theses indicators should be expanded over time.

ii. These indicators should be based on existing information that is collected, rather than new information collection in both the public and private health sectors.

iii. The NDoH should prioritise analysis, interpretation and feedback of these key indicators with interrogation of variances, similar to those for financial indicators.

iv. The health information system should be strengthened and implementation of the dashboard should be appropriately staffed and resourced.

v. Managers should be trained in the use of the dashboard for decision-making and action.

vi. The dashboard should be presented and explained to community structures, to enable effective oversight.
vii. The NDoH should strengthen its health information system oversight and analytical capacity.
viii. The collection, reporting and utilisation of appropriate quality information should be enhanced in both the public and private health sectors.
ix. The stewardship role of the National Health Information System of South (NHISSA) should be expanded and strengthened.

CONCLUSION

The implementation of the recommendations requires strong leadership and stewardship from the NDoH. The Department should 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.

There is an ethical and moral imperative to implement the recommendations of the South African Lancet Commission Report because our communities and the many committed, hard-working health managers and health care 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 universal health coverage.
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