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OVERVIEW OF HEALTH SECTOR REFORMS IN SOUTH AFRICA

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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
APP	Annual Performance Plan
CEO	Chief Executive Officer
CHW	Community Health Worker
DBSA	Development Bank of Southern Africa
DFID	Department for International Development
DHIS	District Health Information System
DHMT	District Health Management Team
DHS	District Health System
DPME	Department of Performance Monitoring and Evaluation
DPSA	Department of Public Service and Administration
EDC	Early Childhood Development
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HR	Human Resources
HPTTT	Health Products Technical Task Team
ICT	Information and Communication Technologies
IST	Integrated Support Teams
MAC	Ministerial Advisory Committee on NHI
MACH	Ministerial Advisory Committee on Health
MCC	Medicines Control Council
MCH	Mother and Child Health
MDG	Millennium Development Goal
MEC	Member of Executive Committee
MRA	Medicines Regulatory Affairs
MTSF	Medium Term Strategic Framework
NCD	Non-communicable diseases
NDOH	National Department of Health
NEC	National Executive Committee
NGO	Non-governmental Organisation
NHI	National Health Insurance
NSDA	Negotiated Service Delivery Agreement
OHSC	Office of Health Standards Compliance
PHC	Primary Health Care
PMDS	Performance Management and Development System
QA	Quality Assurance
SAHPRA	South African Health Products Regulatory Agency
STP	Service Transformation Plans
TB	Tuberculosis
UN	United Nations
WHO	World Health Organization

Executive Summary

The UK Department for International Development (DFID) has been supporting the development of the health system in South Africa through a number of mechanisms, notably through the current programme of Strengthening South Africa Revitalised Response to HIV & AIDS and Health (SARRAH). In November 2010 DFID commissioned two complementary papers, an overview of national-level reform initiatives, and an analysis of the main health sector stakeholders, with focus on those relevant to SARRAH's workstreams.¹ The purpose of the papers is to ensure efficient coordination and sequencing of DFID programme support.

This paper provides an overview of key reforms and organisational development initiatives currently underway within the South African public health sector at the national level.

South Africa has made significant progress in terms of certain aspects of the health care system. For example, it has developed sound and progressive public health legislation and policies, established a unified national health system, increased infrastructure at primary care level, removed user fees for maternal and child health services and introduced a system of social support grants, ensured the steady increase of immunisation coverage, and supported the world's largest HIV/AIDS treatment programme.

Despite these major achievements, the country has made insufficient progress towards Millennium Development Goal 5 (on child health) and 6 (on HIV/AIDS, TB and malaria), and progress towards MDG 4 (on maternal health) has even reversed. The health sector continues to face significant challenges, which include a quadruple burden of disease, economic and social inequity, barriers to accessing health services, inequitable distribution of health resources, and continuing human resource capacity needs. Other weaknesses in the areas of human resources and leadership are also cause for concern.

The South African Government has initiated a number of reforms to address the recognised crisis in the health sector, commencing with the post-Polokwane Health Sector Road-map and the development of the Ten Point Plan for health reform. In turn, this plan paved the way for the development of the National Department of Health (NDOH) Strategic Plan 2010/11–2012/13 and the requirements for Provincial Departments of Health to develop long-term Service Transformation Plans. The current health reforms take place in the context of overall public sector reforms which focus on an outcome-based approach to monitoring and evaluation.

Specific legislative and policy reforms under way in the health sector include:

- **Re-engineering Primary Health Care** in South Africa, with the necessary strengthening of the district health system, greater emphasis on the delivery of community-based services and a focus on the social determinants of health;
- The implementation of a **National Health Insurance (NHI)** as a financing mechanism to promote universal coverage;
- A renewed focus on **quality assurance and improvement**, which has included a revised set of core national standards and the identification of six critical areas for fast-tracking of the attainment of quality standards across all facilities, and the proposed establishment the Office of Health Standards Compliance;

¹ All references to SARRAH in the two papers relate to the workstreams as they were shaped in late 2010, when the reviews were commissioned.

- **Governance reforms**, with focus on a competency-based ranking system for public hospital CEOs and district managers, and the development of a governance model for a strengthened district health system;
- The establishment of a new public entity (South African Health Products Regulatory Agency – SAHPRA) to manage the registration, regulation and control of **health products**; and
- **Performance management** reform initiatives which include, the organisational review of the National Department of Health, financial management improvement project and other initiatives, such as those aimed at the strengthening the provision of quality health care by healthcare facilities.

The paper discusses the appropriateness, potential synergies and sequencing of these reforms, as well as potential gaps and risks.

Overall, the health reforms analysed are appropriate to most of the identified priorities in NDOH's Ten Point Plan for the Health Sector. The intent of the current health sector reform process is progressive and there appears to be coherence between the broad commitments established for the health sector (that is, the 'strategic outputs' of the Negotiated Service Delivery Agreement for health) and the resulting interpretation within the Department's strategic framework.

The linkages between the PHC Re-engineering initiative and the NHI are crucial, and their success relies on the creation of an efficient and effective district health system. Key initiatives are those related to the strengthening of District Managers and District Management Teams, establishing appropriate governance models and the development of a comprehensive strategy towards more decentralised decision-making and greater accountability and responsiveness to the served communities. Close cooperation with other public service line departments (such as Department of Public Service and Administration, National Treasury and the Department of Cooperative Governance and Traditional Affairs) is critical. Quality assurance reform initiatives also constitute a central cross-cutting element of health system strengthening.

There remain significant issues of health management capacity which should be an urgent government priority. Here it is important to distinguish between competency and performance, and devise the relevant strategies to address both, as well as recognising that individual performance is also dependent on systemic factors (i.e. enablers).

There are potential risks or gaps, particularly in relation to the sequencing of interventions. Key issues include:

- The fact that coherence and sequencing is not apparent;
- The reforms are complex and ambitious, raising questions as to whether an already over-burdened system can actually implement them;
- The sense that inadequate recognition is given to health human resource capacity needed to translate policy into plans;
- A perceived gap between policy and implementation; and
- The increasing emphasis on regulation and compliance – and their actual impact on performance.

General recommendations include the need to focus the various health sector reforms on empowering the front line health care workers, and the need to establish mechanisms and processes through which the reforms can be both synthesised *and* translated into concrete and manageable plans, that can be realistically operationalised. Identifying competent health

system managers and experts from a range of institutions can help assist with the process of translating policy into practice.

The report highlights the need for strengthening engagement with stakeholders, commentators and civil society on the NHI reform process, and for better articulation of the distinction and linkages between the 'PHC Re-engineering' initiative and the NHI initiative.

The primary health care approach is seen as the core platform for reform and the basis for building a restructured and effective health care system - rather than an additional reform. As such, the 'PHC Re-engineering' initiative should be properly resourced, piloted, and rolled out in a systematic and planned manner. The implementation of this core platform will require a properly functioning district health system, with real administration and decision making powers delegated down to semi-autonomous and accountable district health authorities, and in turn to health facilities – a requirement articulated in Chapter 5 of the National Health Act, but as yet unimplemented. Fiscal and human resource decentralisation should accompany this process.

The Health Care Management Project, facilitated by the Development Bank of Southern Africa (DBSA), has laid the basis for initiating such a process of decentralisation. The results of the CEO assessments it provided ought now to be used to inform the subsequent steps in this process – strengthening capacity within the Department of Health so as to address the various human resource issues highlighted by the assessment. The DBSA-commissioned report on potential governance models for districts and public hospitals could form the basis of an engagement over the next period with relevant public sector officials and key stakeholders to develop a clear set of proposals for governance, delegations, training and performance management.

1. Introduction

Over the last few years the South African National Department of Health (NDOH) has initiated a number of reform initiatives to improve governance of the health system and service delivery. One of the considerations, in terms of implementation, is that the various reform initiatives need efficient co-ordination and sequencing for maximum contribution to the Government's vision of 'A Long and Healthy Life for All South Africans' (as expressed in the Negotiated Service Delivery Agreement for Outcome 2, 2010).

'It can no longer be business as usual. Planning, organisation, and delivery of health services must reflect an added sense of urgency.'

(Dr P.A. Motsoaledi, Minister of Health, NDoH Strategic Plan 2010/11–2012/13:4)

This paper provides an overview of the broad spectrum of reform and organisational development initiatives currently underway within the South African public health sector at national level. These reforms will affect service delivery at provincial and local level, and ultimately, the attainment of the four health sector strategic priorities identified in the Negotiated Service Delivery Agreement (NSDA).

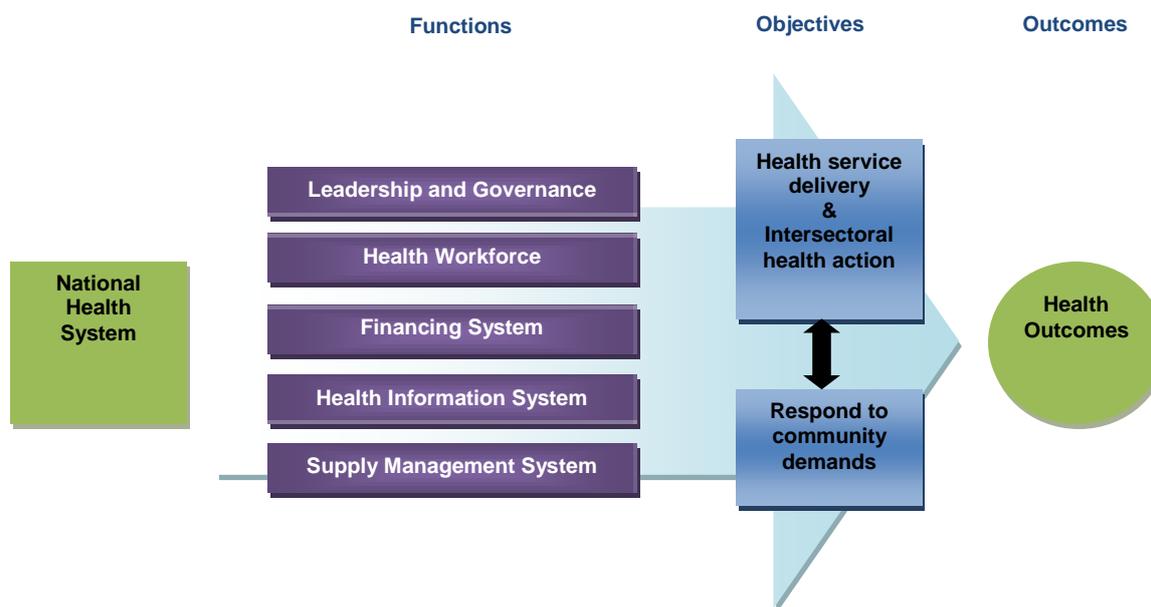
This is followed by an analysis of the strategic linkages between the reforms, and an assessment of their relevance to the intended health service outcomes and health impacts as outlined in The Ten Point Plan and Outcome 2 of the Negotiated Service Delivery Agreement (NSDA): 'A Long and Healthy Life for All South Africans'. The paper highlights the potential areas of risk or the possible gaps, including those related to the sequencing of different interventions, and makes recommendations for creating greater synergy between the various reforms.

This paper is structured in five sections:

1. A description of the health crisis that prompted the need for reform.
2. A summary of the main government-led interventions to address the recognised crisis.
3. An overview of the key legislative and policy reforms currently underway in the health sector, along with a description of some of the key initiatives to implement these reforms.
4. An analysis of the appropriateness, potential synergies and sequencing of these reforms, as well as the potential gaps and risks.
5. A set of recommendations.

Conceptual framework

The conceptual framework guiding this analysis is based on the WHO frameworks for strengthening and assessing the performance of health systems (WHO 2002 and 2007). Both have specifically been interpreted from the perspective of the Primary Health Care (PHC) approach. The PHC approach formed the basis of the transformation of the South African health system, at the advent of democracy in 1994. Currently it is seen as the strategy to revitalise the health system and successfully deliver on the 20 priorities outlined in the National Department of Health Strategic Plan (2010/11–2012/13) and the complementary strategic outputs of Outcome 2 of the NSDA.

Figure 1: The conceptual framework

Note: WHO's Framework has been adapted for the purpose of this paper.

The objectives of any health system are to deliver accessible, equitable and good quality health services which are both responsive to community demands and based on the principle of intersectoral collaboration. As illustrated in Figure 1, in order to achieve these objectives a health system must perform a number of basic functions. These include ensuring appropriate stewardship; developing human resources for health; mobilising and allocating adequate finances and other key resources; developing and maintaining a well-functioning health information system and ensuring equitable access to essential medical products, vaccines and technologies. All these basic functions are required to improve health and health equity.

To paraphrase other well-qualified policy analysts, an analysis that seeks to interpret the perspectives of a set of key reforms targeting the South African health sector and the complex relationships between them is bound to be incomplete and interpretive (Schneider, 2007). As such, it can only attempt to highlight the potential strengths and weaknesses of these initiatives and some key actions to maximise their positive potential.

Methodology

The analysis is based on a desk review of policy documents, peer-reviewed scientific publications, commissioned reports and evaluations, and on the views of key informants. In-depth interviews were conducted with 16 key informants specifically selected for their experience and insights into health policy, planning and implementation. They included senior and mid-level managers from national, provincial and district levels of the health service as well as experienced health analysts from academic institutions and a representative from Treasury, all of whom work closely with health departments.²

² The names of key informants are not provided. They were guaranteed anonymity so that they could speak frankly during the interviews.

The purpose was to identify reforms and organisational development initiatives likely to have a substantive impact on the functioning of the health system, and, with respect to each initiative, assess factors including: scale and application to the public health sector; timeframes for delivery and impact; likely impact on the effectiveness and efficiency of health care services; linkages with other related reform initiatives (in terms of dependencies and consequential impact); effectiveness of the management of the initiative and its likelihood of success. The review focused on initiatives relevant to DFID's support to the development of the health system in South Africa, notably through the programme of Strengthening South Africa Revitalised Response to HIV & AIDS and Health (SARRAH).

The documents consulted for this paper are listed in the References section.

2. Background: the health situation in South Africa

Over the last decade there has been recognition of a growing health and health systems crisis in South Africa. The specific challenges faced by the health sector have been highlighted in public reviews and studies (see Box 1) and have been the subject of a series of national policy reform initiatives and government-led investigations.

Box 1: Key documents highlighting the challenges of the South Africa health sector

A series of six papers on health in South Africa published by *The Lancet* in 2009 presents an overview of the unique features of South Africa's history that have contributed to the systemic problems existing today, and assesses the burden of disease in relation to maternal, newborn, and child health, HIV and tuberculosis (TB), chronic non-communicable diseases, and the effect of violence and injury in the population.

Other similar papers include a discussion document commissioned by the Henry J. Kaiser Family Foundation, *An overview of health and health care in South Africa 1994–2010: priorities, progress and prospects for new gains*. Two chapters in *State of the Nation: South Africa 2007* (by the Human Sciences Research Council) focus on the state of South Africa's health system in general and hospitals in particular, and analyse the process of transformation in the health sector and some of the sector-wide and institutional failures since 1994 (Schneider, 2007; von Holdt, 2007).

Importantly, the South African Health Review (2008), with its focus on primary health care (PHC), examined the extent to which the vision of PHC as the centerpiece of the country's national health strategy had been achieved over the past 14 years. The current South African Health Review (2010) looked at progress to date in relation to attainment of the Millennium Development Goals (MDGs) and the evolving policy process concerning the National Health Insurance.

In addition, the South African Child Gauge 2009/10 focused specifically on MDG 4 and examined the status of child health (including children's rights) in South Africa (Kibel, 2010).

The analyses have identified common areas of concern:

- A greatly increased burden of disease, primarily related to HIV and AIDS.
- Significant areas of weakness in health system management.
- Poor health outcomes relative to the country's wealth and health expenditure.

In the WHO (2000) league table of health system performance, South Africa was ranked 175th out of 191 member states.

2.1 The burden of disease

In terms of the burden of disease, life expectancy in South Africa is currently 53.9 years for males and 57.2 years for females (Statistics South Africa, 2009). Although South Africa spends more per capita on health than any other African country – 8.7% of its gross domestic product (World Bank, 2008) – it is one of only twelve countries in the world where child mortality has increased since the Millennium Development Goals (MDGs) baseline was set in 1990 (Bradshaw, 2008). The *Countdown to 2015 Decade Report 2000-2010: Taking Stock of Maternal, Newborn & Child Survival*, shows that South Africa's under-five mortality rate increased from 57 in 1990 to 67 in 2008.

The country's maternal mortality ratio is estimated to be 625 per 100,000 live births (MDG Country Report 2010). In the *Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa* the assessors noted that 38% of the maternal deaths that occurred within the health-care system were avoidable. Most occurred as a direct result of failures in obstetric care such as management of postpartum haemorrhage, complications of hypertension, and sepsis (Chopra, 2009).

South Africa faces a quadruple burden of disease, consisting of HIV and AIDS and TB; high maternal, infectious diseases and undernutrition resulting in neonatal and child mortality; a growing burden of chronic non-communicable diseases; with violence and injuries constituting a further cause of premature deaths and disability. The status of these four 'colliding' or concurrent epidemics is documented in a recent series of six papers on health in South Africa published by *The Lancet* in 2009. (Box 2).

Box 2: A quadruple burden of disease

In their *Lancet* paper, Abdool Karim et al. noted that in 2007, with 0.7% of the world's population, South Africa had 17% of the global burden of HIV infection and one of the world's worst TB epidemics, compounded by rising drug resistance and HIV co-infection. Infections, including HIV, are a leading cause of death for both mothers and children under five.

Apart from the increasing rates of child mortality, Chopra et al. (2009) also noted that the rates of malnutrition remain persistently high: one in three women and children are anaemic; one in three children and one in four women have subclinical vitamin A deficiency; and 45% of children have inadequate zinc status.

In relation to non-communicable diseases (NCD) the WHO estimates of the burden of disease in South Africa suggest that NCD caused 28% of the total burden of disease measured by disability-adjusted life years (DALYs) in 2004 (Mayosi, 2009). Currently the burden from NCD is estimated to be two to three times higher than that in developed countries, and similar to the burden in other sub-Saharan and central European countries falling into the highest burden quintile. The distribution of NCD reflects socioeconomic disparities, with the heaviest burden on poor communities in urban areas.

The 2003 *South African Demographic and Health Survey* found that roughly a tenth (8.3%) of adult men and a quarter (23.3%) of adult women were obese – a major risk factor for cardiovascular diseases and diabetes mellitus (Harrison, 2008).

For a country not at war, South Africa faces an unprecedented burden of morbidity and mortality in relation to violence and injuries. The overall injury death rate of 157.8 per 100,000 population is higher than the African continental average of 139.5 per 100,000 population, and nearly twice that of the global average of 86.9 per 100,000 population. The rate of homicide of women by intimate partners is six times the global average (Seedat, 2009).

2.2 The paradox of apparent progress yet worsening health outcomes

The South African government has made tremendous gains over the last 17 years in establishing excellent public health legislation and policies and a unified national health system, increasing infrastructure at primary care level, removing user fees for maternal and child health services, introducing a system of social support grants, ensuring the steady increase of immunisation coverage, and supporting the world's largest HIV/AIDS treatment programme. However, despite this, a review of the country's progress towards the MDGs showed that while the country had made some progress towards several intersectoral goals,

its progress has been insufficient in others (MDG 5 and MDG 6) or even receded (MDG 4) (Chopra, 2009).

Chopra (2009) suggests that South Africa, with a supportive policy and funding environment, is facing a 'paradox of apparent progress yet worsening health outcomes'. Similarly Schneider (2007) refers to 'the gap between the promise of transformation and its practice'.

2.3 Critical challenges faced by the health sector

South Africa is the second most unequal country in the world as measured by the Gini coefficient³, which increased from 0.56 in 1995 to 0.73 in 2005 (cited in Coovadia, 2009). Currently, the richest 10% of the population accounts for 51% of income, whereas the poorest 10% accounts for just 0.2% of income (from work activities and social security grants). Mirroring the increasing disparities in wealth, marked differences in rates of disease and mortality between races continue to persist, reflecting racial differences in basic household living conditions and other social determinants of health, with the brunt of the disease burden still carried by the poorest families (Day, 2010).

Numerous barriers still exist in relation to accessing health care. One of the more obvious is the distance to health facilities. The overall average travelling time to a health facility for the poorest 20% of households is nearly 40 minutes and a single visit costs on average 11% of the households' monthly expenditure (McIntyre, 2010).

Access is also adversely affected by the persistently skewed allocation of resources (both financial and human) between public and private sectors, with disproportionate financing of the private sector, relative to the number of beneficiaries. Five times more is spent on the average medical aid member than on an uninsured person using the public sector. Less than 15% of the population are members of private sector medical schemes, yet 46% of all health-care expenditure is attributable to these schemes (Harrison 2009; Coovadia, 2009).

Despite the development of a national human resources strategy in 1999/2000 and the framework of a human resources plan in 2006, there remains a significant human resource crisis, especially at community and primary levels in the public health sector, with poor availability of health personnel in disadvantaged areas further reducing access.

Issues of inadequate supply and uneven distribution are clearly illustrated in the decrease in the nurse-to-population ratio, from 149 public sector professional (or registered) nurses per 100,000 population in 1998 to 110 per 100,000 population in 2007; the increasing percentage of doctors working in the private sector (from about 40% in the 1980s to 79% in 2007) and the significant vacancy rate amongst health professionals (42.5% in 2010) in the public health sector (Coovadia, 2009, Lloyd, 2010).

Additionally, weaknesses in training, support, and supervision, and lack of managerial capacity and appropriate leadership to manage underperformance in the public sector have been raised as issues of concern.

A growing number of studies point to deficiencies in stewardship, leadership, and management of different aspects of the health system – as evidenced by the varying quality of care delivered within the public sector, inefficient management of health facilities, and an absence of managerial oversight and accountability for performance in key national health

³ The Gini coefficient is a measure of income inequality; it ranges from 0 (which reflects complete equality) to 1 (which reflects the maximum possible level of inequality).

programmes such as HIV and TB. Poor leadership is evident in facilitating two important components of the Primary Health Care (PHC) approach: namely, intersectoral collaboration (through, for example, the Primary School Nutrition Programme, and community involvement through clinic committees and hospital boards).

As highlighted by others, Coovadia et al. noted that 'The Ministry of Health's role in providing overall guidance on activities that contribute to improving levels of health in South Africa has generally been characterised by good policies, but without equivalent emphasis on the implementation, monitoring, and assessment of these policies throughout the system'. The failure to establish the District Health System in most parts of the country is illustrative of this policy-implementation gap.

3. The reforms: government led interventions to address the health crisis

In light of the growing concern about the country's health outcomes in the period post *Polokwane*⁴, the Presidency and the Department of Health addressed the need for some form of decisive action to strengthen the country's health system and take forward the country's health-related policy vision. This has resulted in a series of government-led interventions, spearheaded by senior members of the African National Congress (ANC) and State Officials.

The first was the **Health Sector Road-map** a diagnostic process of the key challenges facing the health sector commissioned by the ANC's National Executive Committee (NEC) Sub-Committee on Education and Health in 2008 and co-ordinated by the Development Bank of Southern Africa (DBSA).

The 'Road-map' report, along with its accompanying consultations and background papers, resulted in an important output: a **Ten Point Plan** intended 'to guide government health policy and identify opportunities for coordinated public and private health sector efforts, in order to improve access to affordable, quality health care in South Africa' (Rispel, 2010).

The proposed Ten Point Plan (See Box 3) paved the way for the development of the **National Department of Health Strategic Plan 2010/11–2012/13**, in which many of the DBSA Road-map's recommendations were incorporated into its priorities.

Box 3: NDOH's *Strategic Plan 2010/11–2012/13*: Ten Point Plan for the Health Sector

Intended to assist the country meet the MDGs and monitor improvements in the health system, the 10 priorities are:

1. Provision of strategic leadership and creation of a social compact for better health outcomes.
2. Implementation of the National Health Insurance.
3. Health service quality improvement.
4. Strengthen health care system management.
5. Improve Human Resource development, planning and management.
6. Infrastructural revitalisation.
7. Accelerated implementation of HIV, STI & TB-related strategic plans.
8. Intensify health promotion programmes and mass mobilisation.
9. Review of drug policy.
10. Strengthen research and development.

⁴ The African National Congress's 52nd National Conference, held in December 2007 in Polokwane, Limpopo at which President Jacob Zuma was elected as leader of the African National Congress.

Provincial Departments of Health are expected to develop long-term plans, known as **Service Transformation Plans (STPs)**, in alignment with this Ten Point Plan. Described as 'macro plans', which are based on the PHC approach and implemented through the district health system (DHS), they are expected to be produced for the period 2010–2020 and provide the necessary detail on the envisaged service delivery plan and platform and the related components of human resources (HR), quality improvement, drug supply and management, information and communication technologies (ICT) and health information system (HIS), communication and research and development and financing.

Secondly, in early 2009, the then Minister of Health, Ms Hogan, commissioned a financial and health system review of all nine provinces and the national Department of Health to quantify the extent of, and investigate the reasons for, 'the projected overspending in some of the provinces during the 2008/09 financial year' (Integrated Support Team, 2009). The projected overspend was seen to have the potential to undermine the capacity of the Department to improve health outcomes and in particular the health sector's response to the HIV epidemic. The comprehensive review, conducted by a number of **Integrated Support Teams (ISTs)** with funding support from DFID's Rapid Response Fund, provided key recommendations regarding both the national and provincial levels of government in relation to: finances; leadership, governance and service delivery; human resources; information management; medical products and laboratory; technology and infrastructure.

Although the provincial and consolidated reports were only made available to the public in May 2010, the findings were presented earlier to the new Minister of Health, Dr Motsoaledi, the National Health Council and the Ministerial Advisory Committee on Health (MACH). In November 2009 the Ministerial Advisory Committee on the National Health Insurance was appointed as part of the health sector review and planning processes.

Thirdly, an over-arching government initiative that emerged under the leadership of the Minister in the Presidency: Performance Monitoring and Evaluation, was the adoption of an **outcome-based approach to monitoring and evaluation** across government Ministries (this is outlined in the document: *Improving Government Performance: Our Approach*).

In alignment with this approach, the National Planning Ministry in the Presidency developed a frame of reference to guide planning and resource allocation across all spheres of government. Released in July 2009, the **Medium Term Strategic Framework (MTSF), 2009–2014**, described as a 'statement of government intent', identified five development objectives (one of which is to improve the nation's health profile) and highlighted the 10 strategic priorities of government for this period, one of which (Strategic Priority 5) is also related to improving health.

In turn, these strategic priorities were further developed into 12 key outcomes, together with high-level outputs, key activities and indicators. Of the 12 defined outcomes, *Outcome 2: A long and healthy life for all South Africans* and *Outcome 12: An efficient and development oriented public service and an empowered, fair and inclusive citizenship* apply directly to the health sector.

Box 4: Linkage between South Africa's national development planning and the MDGs

South Africa's 2010 Country Report: Millennium Development Goals locates the process towards achievement of the MDGs within the Medium Term Strategic Framework (MTSF) 2009–2014 and notes that MDG 4 (on child mortality), MDG 5 (on maternal health) and MDG 6 (on HIV/AIDS, malaria and other diseases) are directly related to the MTSF Strategic Priority 5: *Improve the health profile of all South Africans*.

It is on the basis of this framework that a performance agreement between the President and the Minister of Health was signed in October 2010 for the implementation of the **Negotiated Service Delivery Agreement (NSDA)** for the Health Sector, based on the vision to attain Outcome 2: *A Long and Healthy Life for All South Africans*. The NSDA process requires that government departments harmonise the implementation of their respective service delivery agreements so as facilitate delivery of the 12 key outcomes. To date, nine other ministries have entered into a formal agreement with the Minister of Health to co-ordinate their work towards the achievement of the health outcomes.

Box 5: Negotiated Service Delivery Agreement (NSDA) for the Health Sector, 2010-2014

For the health sector, the priority is improving the health status of the entire population and to contribute to the government's vision of 'A Long and Healthy Life for All South Africans'. To accomplish this vision the government has identified four strategic outputs which the health sector must achieve:

- Output 1: Increasing Life Expectancy
- Output 2: Decreasing Maternal and Child Mortality
- Output 3: Combating HIV and AIDS and decreasing the burden of diseases from Tuberculosis
- Output 4: Strengthening Health System Effectiveness.

The Health Minister's performance management agreement with the President is based on the delivery of these four outputs. Monitoring of these agreements will be done through Implementation or Delivery Forums, with the Department of Performance Monitoring and Evaluation (DPME) in the Presidency providing overall support and oversight to this review process.

4. The reforms: key legislative and policy reforms and related initiatives

With the renewed prioritisation of education and health by the ANC government post *Polokwane* and the articulation in the NSDA of an overall vision and set of strategic priorities for health, a suite of significant health sector reforms and organisational development initiatives have been spearheaded by the government. In his health Budget Speech of 2011 to the National Assembly, the Minister of Health reiterated the commitment of the Department of Health to realising all the outcomes set out in the NSDA through a complete re-engineering of both the private and public health care system and to heal the health care system which he describes as *'unsustainable, very destructive, extremely costly and very hospicentric or curative in nature.'*⁵

This section presents an overview of the major initiatives underway.

4.1 Re-engineering Primary Health Care in South Africa

[Alignment with Priority 4.1 of the Ten Point Plan]

This initiative was conceptualised as a result of a visit by the health minister and provincial health leaders to Brazil in May 2010 and the renewed global interest in Primary Health Care given the promising evidence that emerging from Thailand and Brazil in terms of its

⁵ Health Budget Vote Policy Speech presented at the National Assembly by Minister of Health, 31 May 2011. <http://www.info.gov.za/speech/DynamicAction?pageid=461&sid=18751&tid=34232>

application.⁶ The initiative is managed by the Deputy Director General: Strategic Programmes, and builds on current provincial initiatives which support a more community-orientated and participatory approach to health sector programming, such as the Premier's Flagship Project 'War on Poverty' in KwaZulu Natal, a ward based PHC model with Community Care Givers as its driving engine. It is informed by the Brazilian *Programa Saúde da Família* (or Family Health Programme) model (Macinko 2007); and current debates and growing consensus around the role, competencies, training, employing agency (non-profit organisations vs State) and formalisation of community care workers, as a category of health worker in South Africa.

In essence, the PHC Re-engineering initiative aims to:

- Strengthen the district health system (DHS), through the implementation of Chapter 5 of the National Health Act, with the District Health Management Team (DHMT) being given responsibility for the management of the DHS and consequent accountability for the health of its population.
- Place greater emphasis on the delivery of *community-based* services by 'more proactively reaching out to families', with an emphasis on disease prevention, health promotion and community participation. This represents a shift away from the predominantly curative focus that characterises the delivery of health services at present. It is envisaged that the community outreach activities will be facilitated by a PHC outreach team consisting of both nurses and community health workers, who in turn are supported by facility-based and specialist support teams of health professionals.
- Pay greater attention to those factors outside of the health sector that impact on health, i.e. the social determinants of health (or 'upstream factors'), for example through the alignment of intersectoral programmes at district level with integrated development planning processes.

Re-engineering will be addressed through the introduction of three main streams into the current primary health care system:

- i. The first stream is the deployment of District Specialist teams to each of the 52 districts in the country to strengthen clinical governance of district based maternal and child health services at hospitals, community and primary health care facilities and home based levels, in order to promote the well being of the population within a geographical catchment area. A district team will comprise four medical specialists (*family physician, obstetrician and gynaecologist, a paediatrician and an anaesthetist*) and three advanced nursing professionals (*an Advanced Primary Health Care nurse, an Advanced Midwife and an Advanced Paediatric Nurse*). This strategy aims to address the unacceptably high infant, child and maternal mortality at a district level in the effort to achieve NSDA outcome 2 and MDGs 4 and 5.
- ii. The second stream is the revitalisation and strengthening of the School Health Policy of 2003 in partnership with the Department of Basic Education and Social Development. A selected range of basic health services will be provided by a school health nurse to a group of schools, targeting the poorest schools first. These services will include screening of pupils in grade R and grade 1, ensuring that all those that

⁶ The interest in PHC as a strategy for organising health care systems and society to promote health and improve health outcomes is best illustrated in such publications as the WHO's 2008 World Health Report *Primary Health Care: Now More than Ever* and the 2008 Lancet series on PHC entitled *Alma-Ata: Rebirth and Revision*, both of which released to coincide with the 30th anniversary of the Alma Ata Declaration. Similarly, the final report of the WHO Commission on Social Determinants of Health, released in August 2008 (*Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*) elaborated on the importance of 'upstream' determinants of health and the importance of the PHC principle of inter-sectoral action.

- attend Early Childhood Development (ECD) and primary school are fully immunised, and strengthen life skills programmes in secondary schools - with specific focus on sexual and reproductive health and prevention of substance and alcohol abuse
- iii. The third stream is the ward based PHC outreach model, based on the model of reaching out to communities with community health workers (CHWs) used in Brazil and in KwaZulu Natal. Each ward would have one or more PHC outreach team depending on population size. The team will include a professional PHC nurse, environmental health and health promotion practitioners and four/five CHWs to serve a population of about 7,660 people. Their roles will include health promotion, prevention campaigns, early detection and interventions for health problems and illnesses, follow up, treatment support and basic health care support. Locally, the use of CHWs to visit families of patients and trace TB contacts has improved case finding in the TB programme. Introduction of these outreach teams is hoped to strengthen health care, improve access and health outcomes, especially in child and maternal health.

Ahead of the national plan, KwaZulu Natal has provided a successful model of how the ward based PHC outreach teams stream can be implemented. A key success factor has been the coordination of the many community level workers from different programmes within the health sector and from other departments (such as social development and local municipalities) into one cadre of 'Community Care Givers', who were provided with the same training and mentorship and made ward based.

The national initiative to 're-engineer' or revitalise the PHC approach in South Africa has already gained significant momentum in the Eastern Cape, where a similar model of health care delivery is being piloted in four sub-districts, with the aim of replicating it throughout the province (Eastern Cape DoH, 2011). Given that the establishment of family health teams has been placed as one of the strategic objectives under Programme 4 (Primary Health Care Services) in the National Department's Annual Performance Plan (2011/2012), it is likely that similar initiatives to this will gain momentum in other provinces as well.

While the relationship between this approach and the NHI has not as yet been elaborated upon in the public domain, the Discussion Document (2010) does suggest that: *'the likely outcome of this "re-engineered approach" will be better access to a wider range of services of higher quality and that this is one of the steps along the way towards a NHI'*.

It is anticipated that the move from the recommendations contained in the discussion document to action in the short to medium term will be 12-24 months, that a process of consultation and communication with key stakeholders will be embarked upon – along with further research, refinement and alignment of the proposed approach with current health and social sector practice, and that most provinces and districts will require some form of technical support to implement the model in practice.

4.2 The National Health Insurance scheme

[Alignment with Priority 2 of the Ten Point Plan]

The concept of a National Health Insurance (NHI) scheme was first introduced into the public sphere in 2007 at the ANC's national policy conference in Polokwane. The proposed NHI, as a funding mechanism, will pool mandatory contributions and public sector finance to purchase services from accredited public and private sector providers, with the aim of achieving universal health care coverage and access to quality health services.

In 2009 a 27-member Ministerial Advisory Committee (MAC) on the NHI was established to advise the Minister on the development of the policy, the drafting of legislation and the development of a detailed implementation plan on NHI introduction. Considerable investment has also been made in establishing a number of technical sub-groups, examining different costing scenarios and economic benefits of the NHI; and exploring how the transition from the current health system configuration to one based on a NHI would take place. The paucity of publicly available information about the NHI early on led, as noted by McIntyre (2010), to 'considerable speculation by key health sector stakeholders and the media on the form that this reform may take with some declaring that a NHI is unaffordable'.

The ANC's discussion document (released at the ANC National General Council meeting in September 2010) set out some key elements of the proposed NHI policy. In terms of the rollout of the NHI, it suggested that implementation will be phased over a 14-year period, with priorities in the first phase being:

'wide consultation to get input from the public and private stakeholders ... review (of) relevant legislation and (the) drafting of new legislation to facilitate NHI implementation; (an) increase (in the) funding of public sector health services from general tax revenue; (the) revitalisation of public health infrastructure; (the) introduction of quality improvement and quality assurance programmes; and (the) development of (a) human resources programme.'

The discussion document makes reference to 'concomitant improvement of the health system' in parallel with NHI implementation and to the NHI being 'premised on a revitalised and adequately financed district health system', the 're-engineering' of the primary health care system and the establishment of community based teams.

Key considerations in relation to the NHI and its financial feasibility, human resource requirements, health systems performance – along with private sector perspectives and legal and civil society perspectives – were also discussed in the South Africa Health Review (2010).

The NHI policy paper (or Green Paper) was gazetted by the Government on 12 August 2011 for public comment (with a December 2011 deadline). It was welcomed and stimulated critical debates and dialogue within the South African community at large, the private sector, health economists, opposition political parties, and others.

The NHI is introduced in the Green Paper as an innovative system of healthcare financing that will ensure that everyone has access to appropriate, efficient and quality health services as a result of major changes in the service delivery structures, administrative and management systems. Although the policy paper does not provide the detail on how the national health insurance system will be implemented, piloting will start in April 2012 in ten selected districts (which are yet to be announced). In the first five years of the phased roll out of the NHI system, the key focus is on strengthening of the health system through:

- Management of health facilities and health districts.
- Quality improvement.
- Infrastructure development.
- Medical devices and equipment.
- Human resources planning, development and management.
- Information management and systems support.
- Establishment of the NHI fund as a government-owned entity that is publicly administered.

Areas that are yet to be determined from ongoing consultations with national and international experts include: funding sources and funding flows; regulatory systems; service

models to manage migration from the current fragmented health system into the NHI environment of universal access and equitable healthcare; and – of great interest to the private sector – its future role and that of medical aid schemes in healthcare.

Through the DFID SARRAH programme support, six pieces of research were undertaken by independent consultants to provide evidence from international experience with health insurance, and its application to the South African context. These papers were submitted to the MAC to inform discussions and preparation of recommendations to the Ministry on the following key questions:

- How to allocate the funds, and recommend resource allocation mechanisms.
- What services to purchase, and recommend the service benefit package design.
- How to purchase the services, and recommend purchasing strategies that can be considered by South Africa. In addition to this paper, a brief on the purchaser-provider split was prepared.
- How much to pay for services, and recommend price determination processes.
- How to run the services looking at hospital autonomy issues.
- Requirements for introducing an NHI system in South Africa.

The Green Paper considers some of the recommendations that are made in the six papers and by the MAC, and indicates that existing provider payment mechanisms and associated accountability processes will be changed. Accredited providers at a primary care level will be reimbursed using a risk-adjusted capitation system linked to a performance based mechanism.

4.3 National Quality Health Programme and Office of Health Standards Compliance

[Alignment with Priority 3 of the Ten Point Plan]

In recognition of the need and importance of improving the quality of care in public health institutions, the Ministry of Health has initiated a number of quality assurance and quality improvement mechanisms.

First, based on existing sets of policies and guidelines and through an extensive consultation and piloting process, a revised set of core standards the **National Core Standards for Health Establishment in South Africa** (2011) has been developed, approved and published for implementation in both the public and private health sectors. These standards provide an overall guide to quality of care and set out a common definition of the type of quality of care that should be found in all health establishments. They establish a benchmark against which health establishments can be assessed, gaps identified and strengths appraised, and provide a national framework to certify health establishments as compliant with standards.

The Core Standards consist of seven domains, the first three of which relate to ‘the core business of the health system: delivering quality health care to our users or patients’. These are: Patient Rights; Safety, Clinical Governance and Care; and Clinical Support Services.

The remaining four domains are essentially the support systems that ensure ‘this core business is delivered’, with staff seen as key to achieving this. They are: Public Health, Leadership and Corporate Governance, Operational Management, and, Facilities and Infrastructure. For measurement purposes, a set of criteria for each National Core Standard, along with an auditing tool aligned to the District Health Information System (a module of the DHIS) have been designed to assess health facilities’ compliance with these standards. To

support facilities in implementing self assessments and quality improvement, the NDOH has developed an 'implementation guide' and a 'database guide' which will assist teams to incorporate their quality-related assessments as part of the routine DHIS.

A baseline assessment process is being progressively rolled-out across the country to enable public establishments to assess their compliance with the National Core Standards and some infrastructure and health technology requirements. These assessments will serve as a baseline, which establishments can use to identify and address critical gaps and benchmark themselves against similar establishments prior to external inspection.

Acknowledging that compliance with the full set of Core Standards may take time to accomplish, and in recognition of concerns received from patients, the general public and in the media, a sub-set of the Core Standards have been fast-tracked for immediate quality improvement. The rationale is that:

'In choosing a few basic things and making sure they work well NOW, we will improve the way patients feel about the care they are receiving. They (the 6 priority areas) must be part of all our performance plans and all managers must focus on achieving these basic outputs every day.' (Fast track to Quality, 2011)

Box 5: Fast Track to Quality: the six most critical areas for patient-centred care

Launched at the National Consultative Conference on Quality of Health Services (6 October 2010) the six most critical areas for patient-centred care were noted as:

- Improving staff attitudes and the values under-pinning them.
- Reducing the long waiting times or delays in receiving care.
- Ensuring all facilities are spotlessly clean and tidy.
- Protecting the clinical as well as the physical safety of the patients and staff.
- Ensuring that the required measures to avoid transmission of infections and cross-infection are in place.
- Ensuring that basic medicines and supplies are available when patients are seen.

(Annual Performance Plan 2011/2012, p.24)

Thirdly, in order to be able to ensure compliance with these core standards an amendment to the National Health Act (2003) – the National Health Amendment Bill, 2011 – is being proposed so as to establish **The Office of Health Standards Compliance (OHSC)**, which will consist of three units (*Inspectorate, Norms, Standards & Quality Surveillance* – including norms & standards development – and a *Health Complaints Investigative Unit*). Described as an independent body, the Office will advise the Minister on mandatory norms, standards and systems to improve functionality of all health facilities – particularly those delivering PHC services at community level; will inspect all establishments to assess compliance; and will also have powers to investigate and report on any serious complaint regarding the quality of care or services provided. The Office of Health Standards Compliance is seen as an important aspect of the preparatory work for the start up of the National Health Insurance.

The above interventions all form part of an overall vision created by the Ministry and related to the quality of healthcare delivery in South Africa, the overarching vision of which is contained in a draft **Framework for Policy on the Quality of Healthcare in South Africa** (September 2010). This new draft quality policy, while built on the foundations of the previous *National Policy on Quality in Health Care for South Africa*, is also an attempt to eliminate some of the shortcomings of the current legislative and regulatory framework in relation to quality assurance.

The finalisation of this framework into the new National Quality Policy is expected to occur by March 2012, once the legislative processes are completed with the Amendments to the National Health Act.

4.4 Healthcare Management and Governance Project

[Alignment with Priority 4.2 of the Ten Point Plan]

The aim of the Health Care Management Project, initiated by the Ministry of Health and facilitated by the Development Bank of South Africa (DBSA), was to assess the competency of public hospital CEOs and district managers, based on a competency ranking system. The DBSA's work on the health roadmap highlighted the problem of inappropriately skilled managers in charge of district health services and hospitals. Management has a critical role to play in the transformation of the health system. The ultimate aim of the project is to establish the appropriate placement, support and re-training of CEOs and district managers, and improve systems for performance management. This would enable a proper system of delegation of administrative responsibilities to hospital and district managers, since effective delegation depends on the capacity and competence of CEOs.

The data obtained from the CEO assessment will serve as an input to the content and sequencing of new delegations. It will also inform training and mentorship programmes, and will help shape human resources policy. It is envisaged that delegations will be tailored to the capacity of each institution. The study will assist the NDOH and provinces in better targeting in-service training and supervision. Re-determining at least some CEO roles is a possible outcome of the study, in order to ensure that appropriate retention and redeployment policies are in place.

The project has developed a governance model for hospitals and district health services, in relation to future delegations and management competencies. It also investigated systemic and institutional factors affecting the performance of hospitals and districts in the public health sector. A set of proposals for the governance of public hospitals and health districts, based on international experience and appropriate for the South African context, has been presented to the NDOH for review.

By the end of 2010, approximately 400 hospital CEO and district manager assessments had been completed. The results have been released to Premiers of the provinces but have not been made more broadly available. Despite its politically sensitive nature, this knowledge needs to be placed in the hands of provincial managers empowered to act on it, before the high degree of mobility at a management level within the health sector renders the information irrelevant.

In his health budget speech of 2011 to the National Assembly, the Minister of Health, acknowledges that the Department cannot move forward with the proposed major reforms such as the re-engineering of the PHC system and NHI without looking at health workforce development and improving the management of the healthcare institutions and health districts. Hence, in August 2011, a government gazette was released for public comment on the *Policy on the Management of Hospitals*. The National Policy on Regulating Management of Hospitals is aimed at ensuring that the management of hospitals is underpinned by the principles of effectiveness, efficiency and transparency, and with the objectives of:

- Ensuring implementation of applicable legislation and policies to improve functionality of hospitals;
- Ensuring the appointment of competent and skilled hospital managers to halt the practice that allows unqualified persons to manage health institutions;
- Providing for the development of accountability frameworks;

- Ensuring training of managers in leadership, management and governance.

South African Health Products Regulatory Agency (SAHPRA)

[Alignment with Priority 9 of the Ten Point Plan]

Another important regulatory reform in the process of being finalised is the establishment of a new public entity to manage the registration, regulation and control (inspection and law enforcement) of health products (medicines medical devices and in vitro diagnostics): the South African Health Products Regulatory Agency (SAHPRA).

SAHPRA was established following extensive consultation and policy analysis, dating back prior than 2008, and subsequently facilitated by the Ministerial Task Team on the Restructuring of the Medicines Regulatory Affairs and Medicines Control Council and the Health Products Technical Task Team (HPTTT).

Essentially, SAHPRA will replace the Medicines Control Council (MCC) and the Medicines Regulatory Affairs (MRA). It will be a separate National Public Entity, rather than being situated within the National Department of Health as the MCC/MRA. Oversight and governance of SAHPRA, and its Regulatory Councils, Committees and staff will be provided by a Board. However the NDOH will remain ultimately responsible for constantly monitoring and reviewing the functioning of this new entity and advising the Minister, particularly in relation to its oversight and governance, financial management and service delivery/performance.

The transition from the MRA/MCC and devices components of NDOH to the SAHPRA is likely to take at least two years owing to the legislative changes that will need to go through Parliament. A set of transitional objectives have been established so as to ensure that the process of change from one authority to the next is well managed and, importantly, there is no service disruption.

4.5 Performance Management Reform Initiatives

In addition to the major reforms described in the previous sections, a suite of complementary reform initiatives is underway, with focus on strengthening the health system and, ultimately, enhancing the performance of the public health sector. One such initiative, commenced in July 2010 and facilitated by McKinsey & Company, is the **organisational review of the National Department of Health**.

Identified by the Minister of Health and the Director General as a priority project, the organisational review aims to improve overall organisational effectiveness and capabilities. A thorough diagnostic exercise has highlighted some systematic weaknesses within the national department: the current management infrastructure is ineffective, and the working culture reflects high levels of disillusionment. While staff strongly desire change, the current context prevents them from performing to their potential. The organisational structure is also misaligned with strategy, with unclear roles and responsibilities, significant duplication, management level inflation, lack of the necessary skills and capacity, and ineffective performance and talent management. It was also noted that the NDOH does not engage effectively with provinces to drive performance. It tends to manage the relationship with provinces through instruction by memorandum, rather than by making use of the full set of influencing options available, such as conditional grants.

It is expected that the review process will facilitate greater alignment between the NDOH's core purpose and functions, and its structure. With a refined organisational structure in place, which *follows* rather than leads the strategy, it is anticipated that the NDOH will be in a stronger position to fulfil its mandate and enable the delivery of the target outcomes, priorities and strategic objectives of the NSDA, the Ten Point Plan, the MDGs, and the associated strategic and operational plans of the Department.

Apart from the realignment of the NDOH structure to fit its purpose, the organisational review process has involved the development of key performance areas and competencies for critical positions in the new structure. It also included an analysis of the associated changes required in the existing human resources and performance management systems, and the development of an implementation plan to operationalise the new structure and mobilise and sustain change management processes within the NDOH. The reconfigured NDOH organogram is aligned to departmental functions, creates a structure that will facilitate delivery of the NSDA outputs and, most importantly, enhance departmental capacity for the implementation of NHI in the long term.

The organisational restructuring has been organised around six key themes:

1. Implementing a planning process that enables aligned priorities and plans.
2. Transforming the culture of NDOH.
3. Fixing the performance management and development system (PMDS) to improve accountability and create a talent engine.
4. Improving governance of the system.
5. Using a broader suite of influence options with the provinces.
6. Implementing a fit-for-purpose structure.

While better overall leadership and regulation of the health system will have enormous benefits for the reform agenda, it is the revised approach to engaging with the provinces (the direct managers of health service delivery) that holds the most promise. This will involve setting out targets and priorities for the health system and helping provinces develop plans that are aligned with these. The NDOH intends to serve the system with a greater balance between directing and supporting/enabling activities, augmented by capacity to track progress against provincial commitments and convene performance dialogues, and the linking of disbursements to performance.

To further create an enabling environment for successful implementation of the concurrent reforms and achieve its goals, the Department presented its national Human Resource Health (HRH) Strategy to parliament in June 2011. Wide consultations have been conducted to get inputs and ensure the relevance and appropriateness of the HRH strategy in fulfilling the health mandate. There is acknowledgement that the number of health care workers produced in the country needs to increase to meet the demand for services posed by the burden of disease and improve health care. The Minister of Health refers, in his speeches, to a two-pronged strategy where 1) Deans of medical schools have been asked to find innovative ways of increasing the intake of medical students even under current restricted space. There are currently eight medical schools in the country producing about 1200 doctors per annum and a ninth medical school will be built in Limpopo; 2) New infrastructure will be established in four tertiary hospitals and their medical schools namely, George Mukhari Hospital, Chris Hani Baragwanath, King Edward VIII and Nelson Mandela Academic Hospitals to provide space for at least a three-fold increase in the number of medical students. There are also plans to rebuild and expand Medunsa. The above efforts are viewed as part of preparation for the NHI to ensure that there is smooth referral to higher-level institutions.

The **NDOH Financial Management Improvement Project** is another health systems strengthening intervention, which focuses specifically on financial management. It was commissioned by the Office of the Acting Chief Financial Officer, NDOH April/May 2010, and in response to the various management challenges faced by the Department. The project aimed to review and advise on a range of health-related financing issues. These included: identifying gaps in policies, procedures and human resources practices; identifying trends and budget performance in the past five years (2005/6–2009/10) for Provincial Health Departments, and factors affecting each cost driver at the provincial level; reviewing the alignment of provincial plans and budgets with that of the 10 Point Plan, the MTSF and Annual Performance Plans (APP); and developing an Integrated Action Plan to improve operational planning, budgeting and monitoring for the Department and the Provinces.

The project, which ended in October 2010, proposed a series of interventions to strengthen financial management in the public health sector, notably: the establishment of Provincial Financial Management Steering Committees and the implementation of a Financial Management Plan and Financial Management Checklist across all provinces (HLSP, 2010).

5. Analysis of strategic linkages

The second aim of this paper is to analyse the strategic linkages between health sector reform initiatives currently underway, and how, collectively, they will enable achieving the NDOH Strategic Plan Objectives, and the four NSDA strategic priorities for the health sector. The analysis is based on both a document review and interviews.

A significant number of key informants viewed the overall intent of the current health sector reform process as positive. The particular emphasis placed on health in the MTSF 2009-2014 and in turn the conceptualisation and development of Outcome 2 of the NSDA, were welcomed as a decisive and considered attempt to address the current burden of ill-health in the country. In particular, the signing of the NSDA by the Minister of Health was seen as a bold, if not daunting, illustration of the Minister's commitment to 'no longer business as usual', 'to identify solutions and develop new strategies', and to focus on improving health outcomes with a renewed sense of urgency .

In addition, some stakeholders suggested that in the current period there appeared to be much greater coherence between the broad commitments established for the health sector, as described in the NSDA, and their interpretation within the Department's strategic framework (represented in the Ten Point Plan) and the current Annual Performance Plan 2011-2012. The concerted attempt made by the NDOH to align its organisational structure to its purpose through an organisational review process was also highlighted as example of the Health Department's current commitment to foster more streamlined and congruent planning processes within the sector.

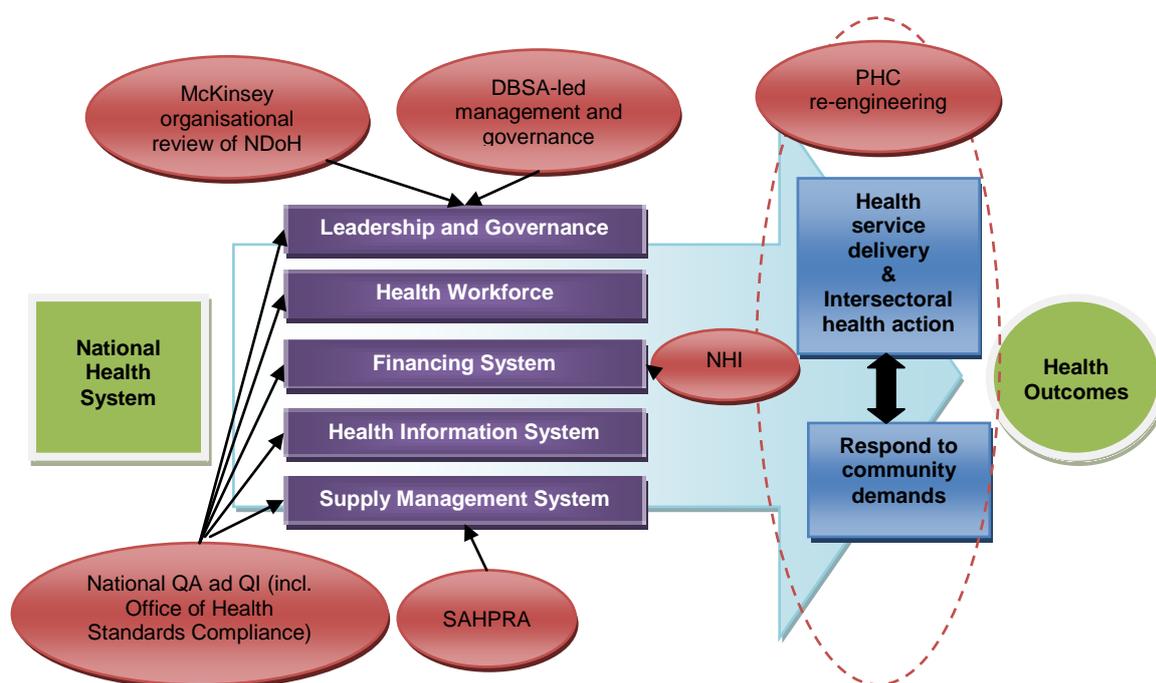
As Rispel and Moorman (2010) suggest in their review of current health legislation and policy, in the aftermath of Polokwane in South Africa there is an enabling context – referred to as the 'legal, policy and fiscal environment' – to facilitate achievement of the MDGs.

5.1 Strategic linkages between health sector reform initiatives

Together with the NHI, one of the most significant health sector reform initiatives to emerge over the recent period is the 'PHC Re-engineering' initiative. The Health Department has not yet released any formal policy document, guideline or briefing about this initiative. It was adopted by the National Health Council in January 2011 and mentioned in the recent Budget speech (17 February 2011) as a 'new community-based family health care programme ... to be introduced as part of the national health insurance'. Related activities are also occurring in many of the provinces.

Interestingly, unlike the other health key sector reform initiatives underway which tend to focus on *one* of the WHO health system 'building blocks' (health financing – the NHI; the health workforce – the Healthcare Management Project; medical products, vaccines and technologies – SAHPRA), the PHC Re-engineering initiative focuses on the configuration, the form or the 'architecture' of the health system as a whole, as illustrated in Figure 2.

Figure 2: PHC Re-engineering initiative and the health system architecture



As such, just as the PHC approach was conceptualised as the ‘underlying philosophy for the restructuring of the health system’ in 1994, now it is seen as the preferred approach through which the health system will ‘re-find its focus’, thereby creating a stronger district health system on which the NHI can be based and increase its potential to achieve better health outcomes. In a sense, if implemented as it is currently being imagined, it has considerable potential to revitalise or ‘re-engineer’ (as the Department has chosen to refer to it) a comprehensive, community-based health service delivery model which was originally envisaged for the country post apartheid.

The recent budget allocations to health reflect a commitment by government to revitalising infrastructure and capacity, including human resources, in provinces and districts so that they can better support health system strengthening and the rollout of primary health care.

5.2 PHC Re-engineering initiative and the NHI

The way in which these two major reforms are programmatically or operationally interlinked is not yet explicit, however the linkages should become clearer as the NHI policy is further developed.

It is understood that at the district level, even with the introduction of the NHI, the model of service delivery will broadly follow what has been recommended by the PHC Re-engineering initiative and that the DHMT would then purchase selected services from private providers where these skills are not available in the public sector. Nonetheless, the current lack of clarity about the nature of the relationship between the two initiatives is one of the critical issues that require resolution in the policy arena. As one key informant suggested:

‘Whilst there have been repeated attempts to bring these two initiatives together at various points ...these attempts at synergy appear to have had little effect...because right now the

NHI and PHC projects seem to be working in parallel to one another. One of the critical things at the moment is how the PHC work is brought together with the NHI work. It can't be two separate things – it must be integrated.' [Key informant 11]

5.3 PHC Re-engineering and Healthcare Management and Governance Project

There are obvious synergies between the PHC Re-engineering initiative and the Healthcare Management and Governance Project which the DBSA facilitated for the Ministry of Health.

Not only does the PHC Re-engineering initiative require competent District Managers and District Management Teams, but it also requires that Chapter 5 of the National Health Act (which deals with the DHS) be fully implemented, that provincial legislation be put in place to provide for the formal creation of District Health Councils, and that all personal services be taken over by the provinces (the so-called 'provincialisation option'). However, as Van den Heever (2010) notes in his report for the DBSA on the potential governance models for public hospitals and the district health system, while attempts have been made to introduce a framework for health districts via the National Health Act, the framework failed to specify clearly defined governance and executive arrangements and a financing system for health districts.

Thus, in order to fully operationalise the 're-engineered PHC strategy' – a strategy which is based, among other things, on the notion of local accountability and community participation – mechanisms to establish more decentralised decision-making and greater accountability and responsiveness to the served communities will need to be formulated by both the National and Provincial Health Departments. The DBSA-commissioned report on potential governance models for districts and public hospitals (2010) could form the basis of engagement with relevant public sector officials and key stakeholders in the near future.

Health-related governance models in the context of public sector reforms

It will be crucial that the process of debate about health-related governance models take into account the new institutional forms provided in the 2007 amendments to the Public Service Act.

In particular, the government component model and the specialised delivery unit model provided for in the amendments are potential institutional forms for hospitals and districts which would facilitate decentralised delegations. However, the more institutionally independent government component model (with a separate accounting officer capacity) will require further amendments to the Public Services Act before it can be made available to the health sector. The characteristics of the Government Component and the Specialised Service Delivery Unit are summarised in the table below.

Government Component	Specialised Service Delivery Unit
<ul style="list-style-type: none"> • Provide services on a larger scale than a SSD Unit. • Can be a separate entity from a department. • Head of Component is Accounting Officer. • Government Component is provided with its own administrative resources e.g. HR, financial, and other resources. • Addresses its own corporate services if 	<ul style="list-style-type: none"> • Provides specialised services, e.g. hospitals which require compulsory financial and HR delegations to sustain operations • Closely connected to the mother department although entities must function autonomously. • Stays part of department: Head of Department is the Accounting Officer. • Operates within the programme structure of a

required.	department. • Shares corporate services of department where it resides.
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It is envisaged that the government component could be an appropriate model for large tertiary hospitals, while the service delivery unit could be appropriate for health districts and secondary hospitals.

In this regard, the Department of Public Service and Administration (DPSA), in conjunction with the National Treasury and the Department of Cooperative Governance and Traditional Affairs, has developed new guidelines to provide for the delegation of public sector financial and human resource management functions as close to the point of service as practical.

The DBSA-led health management initiative, which assessed the competency of all the public sector hospital CEOs and district managers, has obvious links to the notion of decentralised decision-making.

Development of health management capacity and improving performance

The Ten Point Plan envisages a clear definition of the delegations of authority to hospital CEOs and district managers, linked to performance monitoring.

However, the decentralisation of management, if incorrectly implemented, carries risks such as over-expenditure, mismanagement and abuse of procurement procedures in an environment where legal accountability in terms of the Public Finance Management Act still rests with the Provincial Head of Department as the Accounting Officer. Delegations must therefore be carefully aligned with the capacity of existing managers in hospitals and districts. The analysis of current health manager competencies, along with the development of a competency framework describing the 'ideal' qualifications, experience and competencies required by senior health managers in the public service underlies the importance of the recent assessment process undertaken by the DBSA.

Moreover, the issue of health management capacity remains a significant priority for government:

'In the health sector, this year we will emphasise the appointment of appropriate and qualified personnel to the right positions. We need qualified heads of department, chief financial officers, hospital chief executive officers, district health managers and clinic managers.'
[President Jacob Zuma, State of the Nation Address, 10 February 2011]

At the outset it was envisaged that the health manager competency assessment process would have three key outputs:

- a global analysis of hospital CEO and district health manager competencies in the public service
- an analysis of the health managers' perspectives on their current competencies and those that they will require in the future, and
- an individual assessment report for each health manager.

The results of the assessment would inform the future development of personal development plans, the design of management training programmes, and criteria for the recruitment and redeployment of managers.

However, it appears that senior managers who participated in the assessment process have not yet had any feedback. While it is awaited, lack of communication from the DBSA team has led to considerable anxiety among senior health managers. As one senior manager noted:

'The purpose of the assessment, when and how we will be provided with feedback and what the 'next steps' would be, were never clearly spelt out to us as managers. Would they (the Department of Health) be contracting out service providers to train us if we lacked skills in a certain area? Would this be done on an individual level or in separate categories of professional staff? My colleagues are also concerned about what happens if their competency assessment was bad – will they then be fired?' [Key informant 2]

Notwithstanding their experiences of this process, those interviewed felt that the intention behind the assessment was 'noble' and 'valid', that it had been 'rigorous' and that, if managed more appropriately, could certainly be of beneficial to health managers. Another senior manager commented:

'There is a sense that people would have appreciated some form of feedback, or been told what their employer was going to do about the results of their assessment. But the DBSA consultants came in, did their assessments...and then there was no follow up. Not one person (in the department) has got any feedback as yet.' [Key informant 3]

Another key informant working in the area of health management also emphasised that competency was just *one* of the many elements of management strengthening, and that, while the DBSA-led competency assessment initiative was an important input to a continuing process, there ought to be much 'more imaginative debate', in the context of human resource development, about how 'collectively we strengthen health management' in South Africa.

In this regard, the importance of distinguishing between competency and performance was raised by another informant:

'The competency assessment did not include a performance assessment. What is missing in the DBSA assessment is the measure of how well someone is functioning in their position...The assessment will tell us whether people are qualified to be in those positions or not. But the issue is that if you find out that only 5% of those assessed are not qualified to be in that position it does not tell you why, with the other 95% being qualified for their jobs, those institutions are running so badly.' [Key informant 14]

The distinction between competency assessment and the dynamic process of performance improvement is also made in an earlier review of the Healthcare Management and Governance Project:

'The assessment of CEO and management competencies is not intended to substitute for performance management. However having the appropriately skilled people in place is a necessary requirement for performance management systems to be able to function effectively.'

In addition, individual performance is also dependent on making sure that the *systemic* factors that impact on organisational performance are addressed. The analysis of the managers' perceptions of what type of support they need to improve institutional performance and the results of the stakeholder consultations might shed some light on the systemic factors that impede or support 'good management' – and how, in turn, these factors can be taken into consideration during the process of public health sector management strengthening.

It is also recognised that there is considerable unevenness in the way in which the existing performance management system is implemented across provinces. Further, performance management has been highlighted as one of standards of human resource management and development in the *National Core Standards for Health Establishments in South Africa*.

Apart from closing the communication gap between the DBSA assessors and senior health managers and articulating a suitable way forward for all those who have been assessed, what would be essential in terms of the Healthcare Management initiative is a stronger link between the competency framework developed as a result of this intervention, the newly instituted national core standards and the Department of Health's overall human resource strategy. Without progress in elaboration and implementation of a comprehensive and concrete human resource development plan, achievement of the desired standard of improved performance by managers remains under threat.

5.4 Supply chain management in the context of the regulatory reforms

Implementation of a 're-engineered' health system based on PHC will require an efficient and reliable supply chain management system. Although most medical prescriptions are in accordance with the National Essential Drugs List, there have been instances of drug stock-outs (Thom 2010) as well as significant delays in processing applications for drug registration as well as, in an earlier period, the flooding of the market with quack remedies. (Berger 2010).

It is hoped that the establishment of SAHPRA will help minimise some of these problems. However, as with management performance, the extent to which the establishment of this agency will correct problems will depend very significantly on sufficient numbers and capacity of the human resources both employed in this new regulatory body, and key actors lower down the supply chain, such as provincial and district pharmacy personnel and store managers. Here the role of provincial departments in ensuring a reliable supply of drugs and other products will need to be very clearly defined and supported.

5.5 Quality assurance, quality improvement initiatives and the other reforms

Improving quality in the public health sector has been emphasised over the past period. Additionally, in the latest budget speech (2011), the Minister of Finance, Mr Pravin Gordhan, specifically highlighted the allocations made to 'improve quality in health facilities, medical equipment and hospital systems... [and] a new Office of Health Standards Compliance to inspect and certify hospitals.'

From the perspective of service providers interviewed, the quality improvement initiatives recently put in place were seen as particularly positive and 'well meaning'. As one hospital CEO put it:

'I have embarked on a process of quality improvement based on six core areas: this is a response to the public's concerns about the poor quality of care in our institutions. Furthermore this work is aimed at overhauling the health system in preparation for the National Health Insurance (NHI).'

(Dr Motsoaledi, Minister of Health, Annual Performance Plan 2011/2012: 7-8)

'The establishment of norms and standards has enabled services to put in place much stricter guidelines for monitoring and evaluating the quality of care being delivered. For example, QA directorates, portfolios and actual staff have been put in place which has facilitated the

implementation of more robust mechanisms for the reporting on the quality of care and the analysis of problems.’ [Key informant 5]

The *National Core Standards for Health Establishments in South Africa* include a number of domains and sub-domains in keeping with the principles of PHC. For example, the principles of access and of social justice, both intrinsic to PHC, are reflected in the domain of ‘Patient Rights’. The importance of intersectoral collaboration and community involvement in the process of planning and delivery of local health services is recognised in the domain of ‘Public Health’ – as is the emphasis on health promotion and disease prevention.

These domains, and others concerned with facilities and infrastructure, clinical support services, leadership and governance and operational management, will be assessed and monitored by the Office of Health Standards Compliance. It is understood from statements made by the Minister of Health that this process of quality assessment will be core to the accreditation of providers to be funded under the NHI.

In conclusion, it is generally the case that the major health reforms respond to most of the identified priorities in NDOH’s Ten Point Plan for the Health Sector.

5.6 Potential risks or possible gaps

As seen earlier, there are clear linkages between the health sector reforms. However key informants have also identified a number of significant gaps which need to be addressed. These gaps can be summarised as:

- a) Insufficient coherence between the different initiatives.
- b) Complexity of reforms.
- c) Inadequate recognition to health human resource capacity.
- d) Policy and practice interface.
- e) Increasing emphasis on regulation and compliance.

5.7 Insufficient coherence, articulation and sequencing

Despite welcoming the positive intent and general orientation of these new policies, most of the key informants suggested that the various reform initiatives lacked overall coherence. Rather than emanating from a single, coherent and overall policy, they perceived the reforms as driven by separate interest groups as well as different directorates within the National Department of Health. As one key informant suggested:

‘You can make anything cohere if you want to... but these all seem to me like a bunch of individual initiatives ... [which] are all useful in themselves.’ [Key informant 20]

From a service delivery perspective the various reforms thus appear to be disjointed, lacking cohesion and create an impression of operating as a collection of vertical policy silos without consistent or uniform direction. As one senior health manager noted:

‘From my position as the head of this institution I am being asked by National to implement a variety of different policies – each with their own objectives: for example, there are the NSDA objectives, those relating to the MDGs, and the 6 quality assurance priorities and the related 7 domains – and shortly there will be the NHI. I also have to consider the objectives established by the Province and the various objectives we have established for our own programmes and services [at this institution]...It often feels as if all these policies are colliding and one is getting conflicting messages.’ [Key informant 2]

In addition, the sequencing of reform implementation was not apparent to those interviewed. As another Senior Facility Manager noted:

'It would appear that there is not really a logical sequence at this stage...one gets the impression that things are running like whatever is ready is done and there is not an overall scheme of things. It's like the concept of the 'critical path' in the project management process has not been considered...in other words, no one seems to be really thinking about the sequencing of the policies and the activities and considering 'if we don't address X first then Y is not going to happen...' [Key informant 5]

The perceived lack of policy coherence suggested by many of the key informants has been similarly highlighted by Rispel and Moorman (2010). Their analysis suggests 'potential overlap, fragmentation and lack of co-ordination of the various laws and policy initiatives ... [and] there does not seem to be any prioritisation.'

The Department itself has identified the multiplicity of reform initiatives as one of the factors that make it challenging for public health sector workers to manage effectively and to hold people to account for defined outcomes. Apart from having to manage a *multiplicity* of reforms, some of those interviewed suggested that managers also have to meet a competing array of expectations from the various 'policy champions' with regard to the importance of their particular initiative. This leaves a health manager, as one key informant suggested, in an unenviable position:

'Every (policy maker) expects their policy and objectives to be prioritised above the others.' [Key informant 2]

5.8 Ambitious, elaborate and complex reforms

Despite acknowledging the good intentions of this policy process, key informants were concerned that the reform initiatives currently underway were too ornate and elaborate to be accommodated and implemented by an already over-burdened system.

Similarly key informants working at a service delivery level expressed concern that many of the current initiatives were too complex and ambitious for the existing capacity of the country's public health service. For example:

'There are far too many policies...all saying vaguely similar things but having separate objectives...We need to trim down the [policy] noise: lets decide on some key objectives we need to achieve, and synthesise these into a single, coherent framework.' [Key informant 2]

Health service managers also experience uncertainty about which reform is *most* important and which initiative ought to take precedence at service delivery level.

Presumably, it is in recognition of the complexity of the task at hand that those leading the *National Quality Health Programme* have prioritised and simplified the national core standards into six priority areas for quality improvement. However, even the distillation was seen by some as too ambitious. As one key informant mentioned:

'(The reform) is well meaning and a good idea but in our context it's too ambitious and elaborate. Like the other reforms, the concepts are positive but it's driven by an ideological approach that is not based in reality...Everything and the kitchen sink is in there...and managers down the line don't know how or what to prioritise... there are just too many things in here...' [Key informant 3]

These perceived over ambitious reforms must be seen in light of a third area of potential risk – lack of capacity amongst staff at all levels of the health department, and especially at the service delivery level.

5.9 Capacity to translate policy into practice

Rispel and Moolman (2010) observed a ‘lack of capacity in the public health sector to ensure successful implementation of the many good laws and policy recommendations’. Their key informants suggested that the public health sector was ‘denuded of competent managers’. Indeed, the current draft of the *Framework for Policy on the Quality of Healthcare in South Africa* (2010) also acknowledges that ‘healthcare workers lack the requisite skills and knowledge to provide quality healthcare’. As one of the most senior managers noted:

‘We have to consider that there is a skills deficit in our staff and have to build up slowly from this: by doing simple things like increasing our staff’s level of numeracy and literacy. For example, we have good and sound financial management systems in place which provide us with reasonable control. We need to increase the skills of our staff to be able to use them.’ [Key informant 3]

Without the requisite skills to synthesise and translate the objectives and requirements of the various proposed reforms, there is a risk that managers may promote a ‘haphazard’ pattern of service delivery between the provinces and facilities:

‘What is missing between the broad vision and these policy type objectives and the clinical protocols we have in our services is the level in between: the ability of those working at a programmatic and service delivery level to develop an operational framework which outlines exactly what we need to do, who is going to do what and how we can practically do it...And then with all this policy confusion – if managers don’t have the necessary skills set to translate (the policies) into actions within their programmes or institution, they get confused.’ [Key informant 2]

The interface between policy and practice is important, and all too often the translation and articulation of the policy vision into practice is plagued by multiple challenges. As Walt (1994) notes: ‘...experience suggests that in the real world there is all too often a major separation between policy formulation and implementation, with little focus on the realities of putting policy into practice.’

As Rispel and Moorman (2010) point out, many policy analysts have suggested that legislation and policy guidelines are ‘only the starting point and that health legislation and policy is brought alive by the ways in which stakeholders (actors) translate their understanding of legislation/policies into their behaviours and practices’.

The ‘black box between policy and implementation

Our key informants repeatedly noted the disjuncture between policies and intended reforms on the one hand, and their translation into practice on the other. Without sufficient and clear guidelines from the National level on operationalising the reforms at a provincial and district level, their effective translation into practice is threatened.

One informant suggested that what started out as a very ‘clear’ vision for the Health Sector in the NSDA, has become ‘blurred’ in the field:

‘I strongly sense this gap between what the Minister has signed and what’s happening on the ground....There is just not a common understanding of what needs to be done – and then (how) to actually do it. People sense the answer, they know the answer, they talk about the

answer, but it has not got to the point of everyone waking up in the morning and saying: 'ok: this is what we do differently today – here!' [Key informant 8]

The renewed focus of the National Department on maternal and child health was used as an illustration of this issue by one senior government official, who suggested that despite the overall understanding in Health of the imperative to reduce maternal and child mortality, provinces appeared to be very 'unclear of what *kinds* of interventions they actually want to do':

'National needs to give strong guidance to the Provinces about what the changes are in child health programmes that need to be done...because it's no good if a Province gets a notional allocation ... for improving MCH if they don't actually know what they should be using the money for. It's not very clear to them what programme they are meant to be accelerating, what they meant to be doing with this money. Because the National Department is not spelling it out for them: these are the key things you are meant to be doing...'

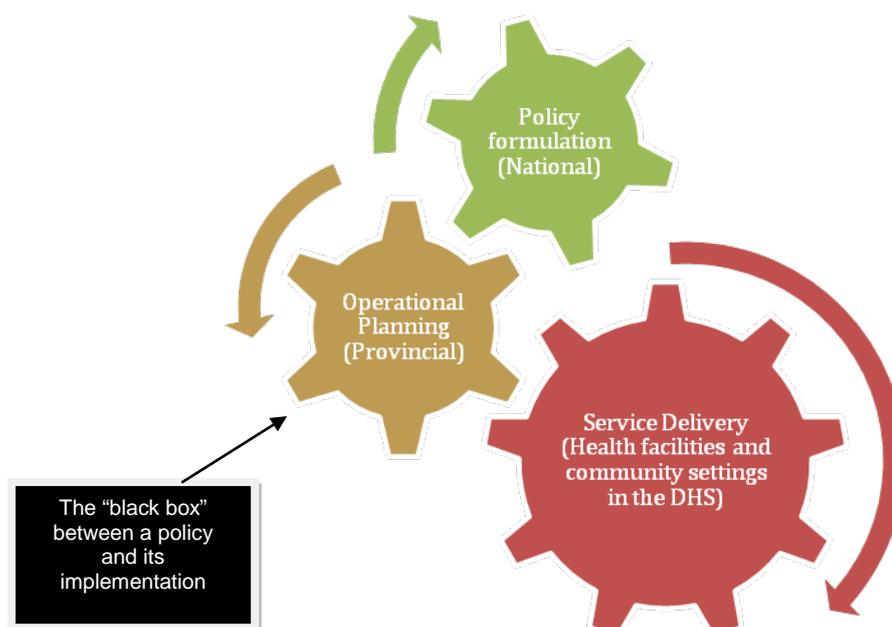
Here you have a situation where maternal mortality and child mortality is so high. The outcome areas are terribly important...The budget is there...but the Provinces are very unclear of what kinds of interventions they actually want to do in MCH... they can't decide if they should employ more family practitioners, or should they put in place more paediatricians or more obstetricians, or supervise better at the district hospitals. They talk about these things but they don't decide: this is what we are going to do and then do it!' [Key informant 8]

While acknowledging the need for more supportive direction and guidance in operationalising these reforms, another informant emphasised the importance of complementing this with strengthening the capacity of provinces and districts by creating learning opportunities for their managers:

'I agree that policies are not sufficiently translated into implementation plans – but I don't think you can ever have the perfect plan. I think it's about creating enabling frameworks for implementation in which one then allows some experimentation on the ground – which is why one needs good leadership throughout the system. And I would think that any of these reforms, if implemented with attention to process, could themselves contribute to supporting the development of that leadership...(for example) It would seem that any implementation process should create fora for experience sharing and for support in some way.'
[Key informant 11]

Ultimately, there ought to be much greater articulation between the policies formulated at national level, their translation into operational plans at provincial and district levels and their incorporation into practice at service delivery level. As Walt, in her seminal book *'Health Policy: An Introduction to Process and Power'* notes, the policy process is *interactive* – rarely is there a perfect path of implementation with the health policy 'percolating' downwards to be put into practice (as was originally envisaged) in health care institutions and programmes. In reality, there is not a clear division between policy formulation and policy execution and the pathway between the two is certainly not linear. As Walt suggest: 'Rather than seeing implementation as a stage in the sequential transmission of policy from formulation to implementation, it should be seen as a more interactive process'.

The importance of establishing congruency between the interlocking spheres of policy formulation, translation into operational plans, programmes and guidelines, and finally its incorporation into practice at a service delivery level is illustrated in Figure 3. We suggest that operational plans, programmes and guidelines lie in the 'black box'. The figure also illustrates the recognition that the policy process is not merely linear or unidirectional; providing support to the implementers and receiving feedback from the 'bottom-up' are critical components in the 'continuous loop' of policy formulation and implementation (Walt, 1994).

Figure 3: The loop of policy formulation and implementation

5.10 Increasing emphasis on regulation and compliance

The growth of new regulatory bodies, along with the emphasis on compliance, concerned several of our key informants. As one suggested:

'(There is now) a tendency to try to regulate and legislate and control our way out of the problems we face. In the past, we looked at policies as being the solution to the problems we were facing in health – now regulatory frameworks are seen as the solution'. [Key informant 3]

Many of our informants stated the importance of these bodies being perceived as impartial, autonomous and independent of the State and to function to support health gain. The recently gazetted National Health Amendment Bill and the proposed establishment of the *Office of Health Standards Compliance* was frequently used to illustrate this concern.

Although those interviewed did not doubt the need for and importance of establishing a regulatory body to oversee standards for quality and safety, two important issues emerged. First, concerns were raised about the impartiality of the *Office of Health Standards Compliance* and whether the *Office*, with its Executive Director being appointed by the Minister of Health, could in fact fulfil its role as an independent mechanism for quality assurance.

'This is a fundamentally correct and pivotal intervention if done properly....However, given the Minister appoints the person in charge of this Office they will likely be subject to political influence and pressure, which means it is not an independent and neutral body. There is thus the possibility that some investigations might be 'nudged off', some people followed up and others not.... You have to have the Regulator completely impartial and free of interference – so that it can't be interfered with in its decisions and must be able to intrusively investigate the areas of non-compliance, and must be able to publish public reports, and impose remedial action'. [Key informant 14]

Secondly, some concern was raised that the criteria used for accreditation could potentially be used as ‘tick boxes’ measuring ‘a whole lot of things that are not that important’⁷ and ultimately do not hold a facility accountable for performance:

‘When designing the accreditation criteria – they need to be reasonable and well designed to be effective....They have to be at the end of the day something that you can hold someone accountable for. And they must also not be ‘tick box’ compliance issues... (where you) have lots of things that look like you are complying with standards but these do not materially relate to quality assurance, and ultimately to improving health outcomes.’ [Key informant 14]

‘The way an Office of Standards Compliance works – they deal a lot with inputs rather than programmatic issues. Is there a patient chart on the wall, is there an x-ray machine and does it work, does the water flow out of the taps, is there the appropriately qualified staff in place to perform the functions of this level of facility – it won’t be looking at a clinical type of audit or the processes within the facility.’ [Key informant 8]

In addition, with the increasing number of new regulatory bodies, one key informant wondered whether there would be some form of governing framework which linked the different regulators, and whether this had been considered in any way by the National Department:

‘Then there is also SAHPRA – so that is also another regulatory body... obviously that is important and you can see the value of a well established [if that is what it is going to be!] and independent authority – and that makes sense but if there are going to be lots of independent authorities - and say there is also going to be an NHI authority and then a QA body – then you will need some governing framework for all of these different bodies as well – and I wonder if that is being considered.’ [Key informant 11]

⁷ Quoted from key informant 14.

6 Conclusions and recommendations

Both the document review and key informant interviews affirm the positive nature and relevance of the four NSDA 'outputs'. At the same time there is agreement some key areas require strengthening if an NHI-funded and 're-engineered' health system based on PHC is to succeed. The inadequate recognition of the fundamental gap between this set of policies and the capacity of the current services to implement them is also strongly felt.

The informants, all experienced and senior managers, planners and analysts, welcomed each initiative in its own right, but questioned their overall coherence and complexity. They insisted that synthesis, prioritisation and translation of these reforms into sequenced and manageable operational plans is urgently required. This is confirmed by other important policy assessments reviewed for this paper, emphasising the need to analyse and address the capacity deficit of health personnel at planning and especially service delivery level. To achieve this, the recent HRH Strategy requires a detailed and concrete human resource development plan. This needs, *inter alia*, the identification of capacity within the departments of health, training and research institutions and NGOs to be drawn upon, and quantification of new resources needed to address the current and impending health human resource crisis, which, if unresolved, will render all the reforms analysed in this document meaningless (Chopra 2009).

Based on the review and analysis presented in this paper, the following recommendations are proposed:

1. The findings of this analysis, and in particular the reaction by front line managers on health sector reforms underway, should be drawn to the attention of key national policy makers.
2. The focus of the various health sector reforms should be on empowering the front line health care workers, who are the primary providers of health care. At present there is too much emphasis on national-level policies and reorganisation, and too little emphasis on practical ways of supporting the efforts of health care workers on the ground.
3. In order to redress this imbalance, national policy makers should consider appropriate mechanisms and processes by which the current health sector reforms can be both synthesised *and* translated into concrete and manageable plans which health service managers and providers can realistically operationalise. The department could develop an internal communication system through the departmental website and regular newsletters to inform and update all health care workers on the status of all major reforms. The most effective strategy however, would be to engage provincial, district and facility managers in the discussions, planning processes and writing of policies and operational plans.
4. Competent health system managers and experts from research and training institutions and NGOs could be identified to assist with the process of translating policy into practical measures for health services managers and providers. Experience could be drawn from forums like the different Ministerial Advisory Committees (MACs) and other existing ministerial committees on how to engage with researchers and international experts. Such committees could be replicated at provincial level to inform implementation of policies.

5. As part of the above process, the distinction and linkages between the 'PHC Re-engineering' initiative and the NHI should be considered a priority. The linkages between these two reforms should be articulated and disseminated widely as part of a critical engagement undertaken with key stakeholders and commentators (and importantly, with members of civil society).
6. The PHC approach must form the core platform for health sector reform and serve as the basis for building a restructured and effective health care system, rather than being viewed as simply an additional reform. As such, the 'PHC Re-engineering' initiative needs to be properly resourced, piloted in each of the provinces, and rolled out in a systematic and planned manner.
7. The implementation of this core platform requires a properly functioning district health system, with real administration and decision-making powers delegated down to semi-autonomous and accountable district health authorities – a requirement articulated in Chapter 5 of the National Health Act but as yet unimplemented.
8. In order to establish this, a real and substantive process of decentralising power within the health system is required, not only from national to provincial levels, but from the provincial to the district level and in turn to the health facilities. Fiscal and human resource decentralisation must accompany this process.
9. The DBSA Health Care Management Project has laid the basis for initiating such a decentralisation exercise in a systematic way. However, the results of the CEO assessments have not been made broadly available within the health sector. A successful translation of the various reforms into efficient, effective, responsive and integrated services requires the urgent and substantial improvement of performance (technical, managerial and problem-solving). Informed by the results of the CEO assessment process, existing capacity within the department of health, training and research institutions and NGOs will need to be strengthened to address these human resource issues.
10. The DBSA-commissioned report on potential governance models for districts and public hospitals could form the basis of an engagement over the next period with relevant public sector officials and key stakeholders to develop a clear set of proposals for governance, delegations, training and performance management.
11. Lastly, this policy analysis could be augmented with an review of international good practice in implementation of health reforms, particularly from selected low and middle income countries (for example Brazil, Rwanda, Thailand, Bangladesh, Iran).

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Appendix 1: Terms of Reference

The Terms of Reference, 30th August 2010, for this assignment are set out below.⁸

1. Context to work to be undertaken

The proposed work forms part of the United Kingdom's programme of support to South Africa on Strengthening South Africa's Revitalised Response to HIV & AIDS and Health (SARRAH). The programme is funded through the UK Department of International Development (DFID), who has contracted HLSP as the service provider responsible for managing the programme.

The purpose of the SARRAH programme is to improve the governance of an integrated, effective response to HIV, AIDS and health through catalytic funding and technical support to key partners in the national health and AIDS response – in particular, the National Department of Health, the South African National AIDS Council (SANAC) and leading NGOs such as the Treatment Action Campaign (TAC). The SARRAH programme seeks alignment with the four key priorities of government for health for 2010-2014, namely:

- Improving Life Expectancy;
- Reducing Maternal Mortality Rates and Child Mortality Rates;
- Combating HIV/AIDS & TB; and
- Enhancing Health Systems Effectiveness.

These are closely aligned with the strategic priorities for revitalising the Health System established in the National Department of Health Strategic Plan 2010/11 – 1012/13. A number of reform initiatives to improve governance of the health system and service delivery have been initiated by the National Department of Health (NDOH). In order to ensure the efficient co-ordination and sequencing of these initiatives, it is important that the full spectrum of reform initiatives underway is documented and analysed. At the same time it is vital that the principal stakeholders operating at national and provincial level are analysed in terms of the relationship to the health priorities of government, in order to determine how best to engage them in the process of reform.

Accordingly two related research projects are proposed to address the above requirements, namely:

- An overview of reform initiatives within the South African public health sector, and an analysis of the strategic Linkages between NDOH and related initiatives to achieve the NDOH Strategic Plan
- A Stakeholder Analysis of the South African Health System in relation to the four strategic priorities for the health sector. Given the relationship of the SSARRAH programme to the four strategic priorities, this stakeholder analysis will also act as a proxy stakeholder analysis with respect to the SSARRAH programme.

With the approval of DFID, HLSP have contracted Dr Crispian Olver to undertake the two related research projects to. Both pieces of work are part of the SSARRAH programme approved by the Minister of Health. It is envisaged that a letter of introduction will be drafted for distribution within the National and Provincial Departments of Health to facilitate co-operation with the project manager and his team.

2. Stakeholder analysis

Scope and purpose: The stakeholder analysis will provide a crucial overview of the main stakeholder groups that are able to influence or impact on the process of improving health services and reform initiatives within the health sector. It will provide an overview of the different organisations involved in the delivery of health services, including a description of their roles and interests in relation to the health system. Stakeholders are defined as any persons, groups or institutions that have an interest in

⁸ The contract was signed on the 12 November 2010 and the end date extended to 30 April 2011. A work in progress report was presented to HLSP and DFID at the end of November 2010 wherein revisions to ToR were agreed.

the initiative or project that is being undertaken i.e. a stakeholder analysis is conducted in relation to a specific set of proposals or initiatives. Specifically the analysis will seek to map the level of interest, power and influence of different stakeholders in relation to the four strategic health priorities for government, namely:

- Improving Life Expectancy;
- Reducing Maternal Mortality Rates and Child Mortality Rates;
- Combating HIV/AIDS & TB; and
- Enhancing Health Systems Effectiveness.

The DFID funded SARRAH programme is directly aligned with these priorities and the National Department of Health Strategic Plan, and consequently the stakeholder analysis will also serve as a proxy stakeholder analysis in relation to the SSARRAH programme itself. The stakeholder analysis will be conducted at both a national and provincial level, with four provinces selected as a sample.

The proposed four provinces are:

- Gauteng – selected as an example of a predominantly urban province with a well functioning health system and infrastructure.
- Mpumalanga and Eastern Cape – selected as examples of provinces with secondary cities and a large rural hinterland, facing significant health needs and challenges in delivery of health services
- Limpopo – selected as an example of a predominantly rural province with massive health needs and challenges in health services.

Methodology: The methodology will consist of the following:

- Collation and desk top analysis of available documentation in order to develop a preliminary list of stakeholders.
- A facilitated workshop with project principals in which a preliminary mapping of interest, power and influence is undertaken.
- A series of stakeholder interviews in order to more accurately quantify potential project impact and priority of interest.
- Report writing and analysis.

Stakeholders will be categorised into primary stakeholders i.e. those stakeholder who are directly affected (positively or negatively) by the project, and secondary stakeholders, who are intermediaries in the delivery of the project. For each stakeholder the research will seek to assign a value in terms of their interests in relation to the problems being addressed by the project, their potential project impact and their relative priority of interest. This will enable the classification of stakeholders in terms of the following table:

Importance / Influence Table	
A	B
Stakeholders of high importance to the project, but low influence or power. This implies that they will require special initiatives if their interests are to be protected.	Stakeholders with a high degree of influence or power on the project, who are also of high importance for its success. Good working relationships are necessary with these stakeholders to ensure an effective coalition of support for the project.
D	C
Stakeholders with low influence on, or importance to the project objectives. They may require limited monitoring or evaluation, but are of low priority.	Stakeholders with high power, which could affect the project outcomes, but whose interests are not the target of the project. This implies that these stakeholders may be a source of significant risk, and they need careful monitoring and management.

Outputs: The outputs of the project will be:

- A preliminary list of stakeholders for the purposes of a workshop with project principals.
- A comprehensive 100 page document that analyses all primary and secondary stakeholders in terms of their interests in relation to the project, their potential project impact and their relative priority of interest.

3. Overview of reform initiatives

Scope and purpose: The overview of reform initiatives will aim to document the broad spectrum of reform and organisational development initiatives that are currently underway within the public health sector at national, provincial and local level. The starting point for the research will be the current policy framework of the DoH, including the four strategic priorities and the National Strategic Plan. Initiatives that will specifically be included:

- The restructuring of the national Department of Health.
- Provincial restructuring initiatives.
- Proposed decentralisation of responsibility to district and hospital level.
- Competency assessment of district and hospital managers.
- Efforts to build performance culture and strengthen performance management systems.
- Interventions to build the capacity of managers and institutions within the health sector.
- Systems for quality assurance and quality improvement, including measures to address systemic weaknesses in health system.

Related initiatives which might impact on the reform process, such as law reform, financial restructuring, changes to human resources management systems and government policies on restructuring and governance will be included in the overview. Such an exercise will enable better alignment of existing initiatives to strengthen the management of health services and hospitals and identify opportunities for integration and linkage.

The need for this report has been agreed with the Minister of Health and senior officials in the NDOH. It will identify potential synergies between the different reform initiatives, suggest possible sequencing requirements, and identify operational requirements.

Methodology: The research will consist of a desktop analysis of available documentation and a series of interviews with the main stakeholders in the health sector. To save costs, these interviews will be combined with the stakeholder analysis in the following section. The purpose of both exercises will be to identify reform and OD initiatives that are likely to have a substantive impact on the functioning of the health system, and with respect to each initiative, assess its:

- Scale and application to the public health sector.
- Timeframes for delivery and impact.
- Likely impact on the effectiveness and efficiency of health care services.
- Linkages with other related reform initiatives in terms of dependencies and consequential impact.
- The effectiveness of the management of the initiative and its likelihood of success.

On the basis of this analysis, the linkages between the different initiatives can be comprehensively mapped, and recommendations formulated regarding ways to optimise alignment and coordination. National initiatives will be comprehensively documented, starting with the strategic priorities for revitalising the Health System established in the National Department of Health Strategic Plan 2010/11 – 1012/13, and related initiatives underway in NDOH regarding personnel, financial and governance reforms. Initiatives in other related departments such as the Presidency, National Treasury and DPSA will also be analysed. At a provincial level, a maximum of three provinces will be selected for detailed analysis. These provinces will be identified in consultation with NDOH, DFID and HLSP. District and local level reform initiatives of relevance will be included in the provincial analysis.

Outputs: The outputs of the project will be:

- A preliminary list of reform initiatives for the purposes of discussion and comment with project principals.
- A comprehensive document approximately 100 pages in length that documents all substantive initiatives, and analyses their scale and application to the public health sector, timeframes for delivery, likely impact on the effectiveness and efficiency of health care services, linkages with other related reform initiatives in terms of dependencies and consequential impact, and the effectiveness of the management of the initiative and its likelihood of success.

4. Work Programme

Due to the high degree of overlap between these two assignments, it will be logical to conduct the work simultaneously as part of an integrated work programme. The work will be undertaken in three phases, consisting of a desktop review, stakeholder consultation, and drafting of the research papers.

Desktop Review

The project manager will supervise the sourcing and analysis of relevant documentation, including:

- national and provincial health legislation and policy,
- strategic plans and programme action plans,
- health improvement plans,
- health standards
- Discussion documents and white papers

The immediate outcome will be a summary providing a contextual analysis of health systems policy and strategy that will preface both of the research papers that form the primary deliverables of the work. It will also include the production of an electronic stakeholder database that will include contact details of all health system stakeholders that will form part of the stakeholder analysis.

Phase one will conclude with a facilitated workshop of HLSP technical managers at which a preliminary mapping of stakeholders will take place. The purpose of the workshop is to make sure that the universe of stakeholders impacting on the project has been populated, and to assign preliminary values in terms of interest, power and affinity to each stakeholder. These preliminary values will then be explored and verified in the process of stakeholder consultation.

At the conclusion of the phase the first draft of the contextual analysis will be presented, an electronic archive of the health system documentation will be handed over, and the electronic stakeholder database will be handed over. HLSP and DFID will then have an opportunity to review and comment on these so as to inform the subsequent work.

Stakeholder Consultation

This work will be performed by the research team with the assistance of researchers with suitable experience of the health system and stakeholder consultation. It will consist of interviews with stakeholders in the health system as identified in preliminary form in the addendum, and as amended by DFID and HLSP if required. The project manager will conduct interviews with senior officials and representatives personally e.g. DG's of national departments.

A general protocol for interviews will be drawn up, and this will be submitted, together with a proposed schedule, to DFID and HLSP. However, it should be noted that it is in the nature of the work that considerable discretion and judgement will be required on the part of the interviewer in engaging with stakeholders due to the range and variety of stakeholders concerned, and the different requirements in terms of each interview.

Transcripts and/or minutes of each interview will be recorded and made available to DFID and HLSP at the conclusion of this phase.

Drafting of Research Papers

The drafting of the research papers will draw upon the work undertaken in the previous phases of the project. The project manager will closely supervise the drafting process and will be responsible for the final edit of the first draft. This first draft of each paper will be circulated within the Department and amongst stakeholders for comment, and on the basis of these a second and final version of the papers will be produced. The paper on strategic linkages will be released for comment first, and the stakeholder analysis will be released once the strategic linkages paper has been finalised.

5. Project Timeline

A preliminary activity timeline and schedule for project meetings is described in the table below.

Timeline for Research Activities and Outputs

Date (2010)	Activity
1 st Sept – 10 th Sept	Phase 1: Desktop Review <i>Source and analyse health systems documentation and data, compile list of stakeholders</i>
13 th – 17 th Sept	Facilitated workshop of core group to map out stakeholders: <i>Project meeting - Review of phase 1, Planning for Phase 2</i>
20 th Sept – 15 th Oct	Phase 2: Stakeholder Consultation and Data Gathering <i>Conduct stakeholder interviews</i>
15 th Oct	Project Meeting: <i>Review of phase 2, Planning for Phase 3</i>
18 th Oct – 29 th Oct	Phase 3: Drafting of Linkages Paper and Stakeholder Analysis
29 th Oct	Project Meeting: <i>Review and approval of Linkages paper</i>
1 st – 12 th Nov	Period of comment for Linkages Paper
15 th – 26 th Nov	Revision of Linkages and Stakeholder Analysis Papers <i>Incorporate comments from stakeholders</i>
26 th November	Project Meeting: <i>Approval of final draft of Stakeholder Analysis</i>

6. Project Administration and Reporting

Dr Olver will be responsible for leading the research project, and will be accountable to the project meeting, which will be convened by Mr Bob Fryatt, Senior Health Advisor for DFID, and will be attended by Mr Kevin Bellis, HLSP project manager for the SARRAH programme.

As the agency responsible for the SARRAH program, DFID will be responsible for representing the project to the NDoH, including distributing the letter of introduction for the research team to stakeholders.

As the service provider responsible for project management of the SARRAH program, HLSP will assist the research team with the scheduling of appointments during the stakeholder consultation, and will in general facilitate access to Department of Health personnel and documentation.

Payment of disbursements will be based on the basis of receipts for economy-class airfare, transport at agreed rates per km, and accommodation at an agreed rate and per diem.

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