The game is on…but will NDoH drop the ball?

Dr Jenny Nash

Family Physician

Amathole District Clinical Specialist Team, EC

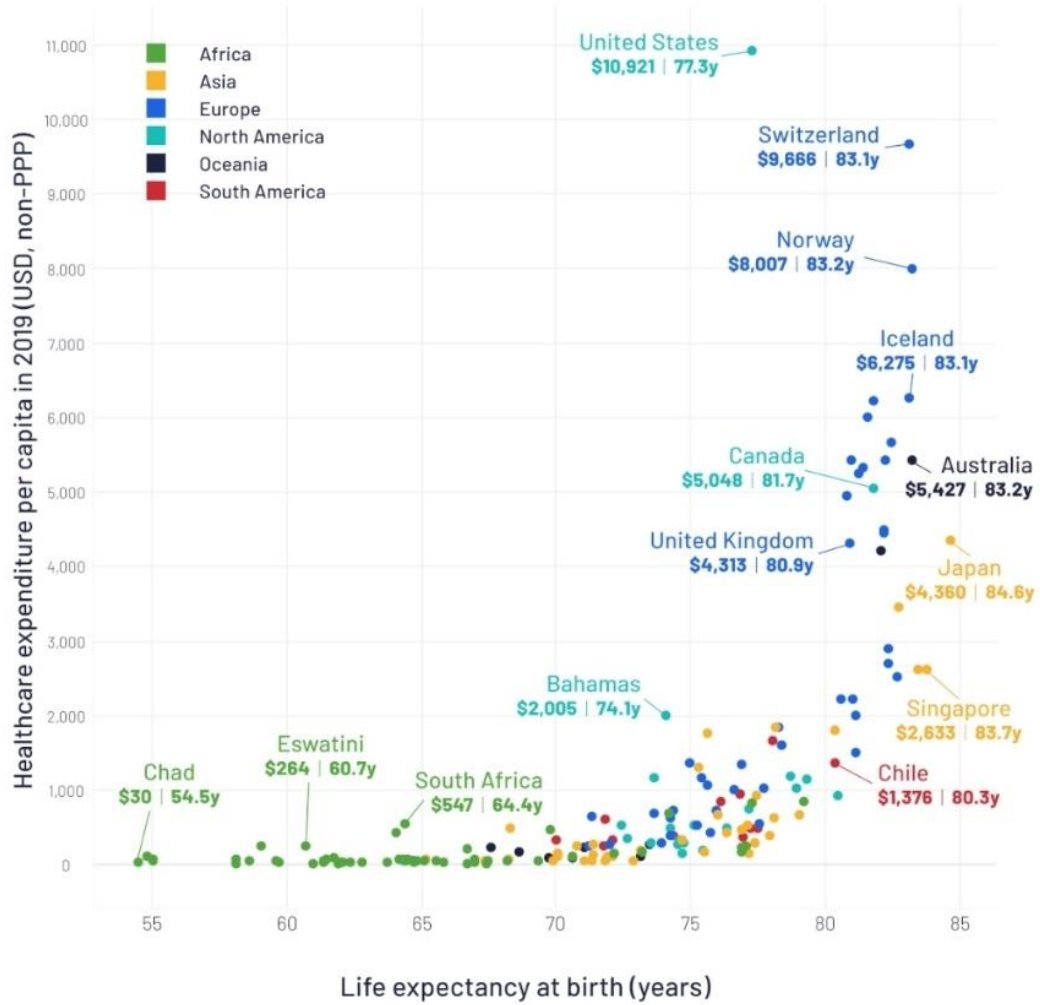

GILBERT


MTN

Outline

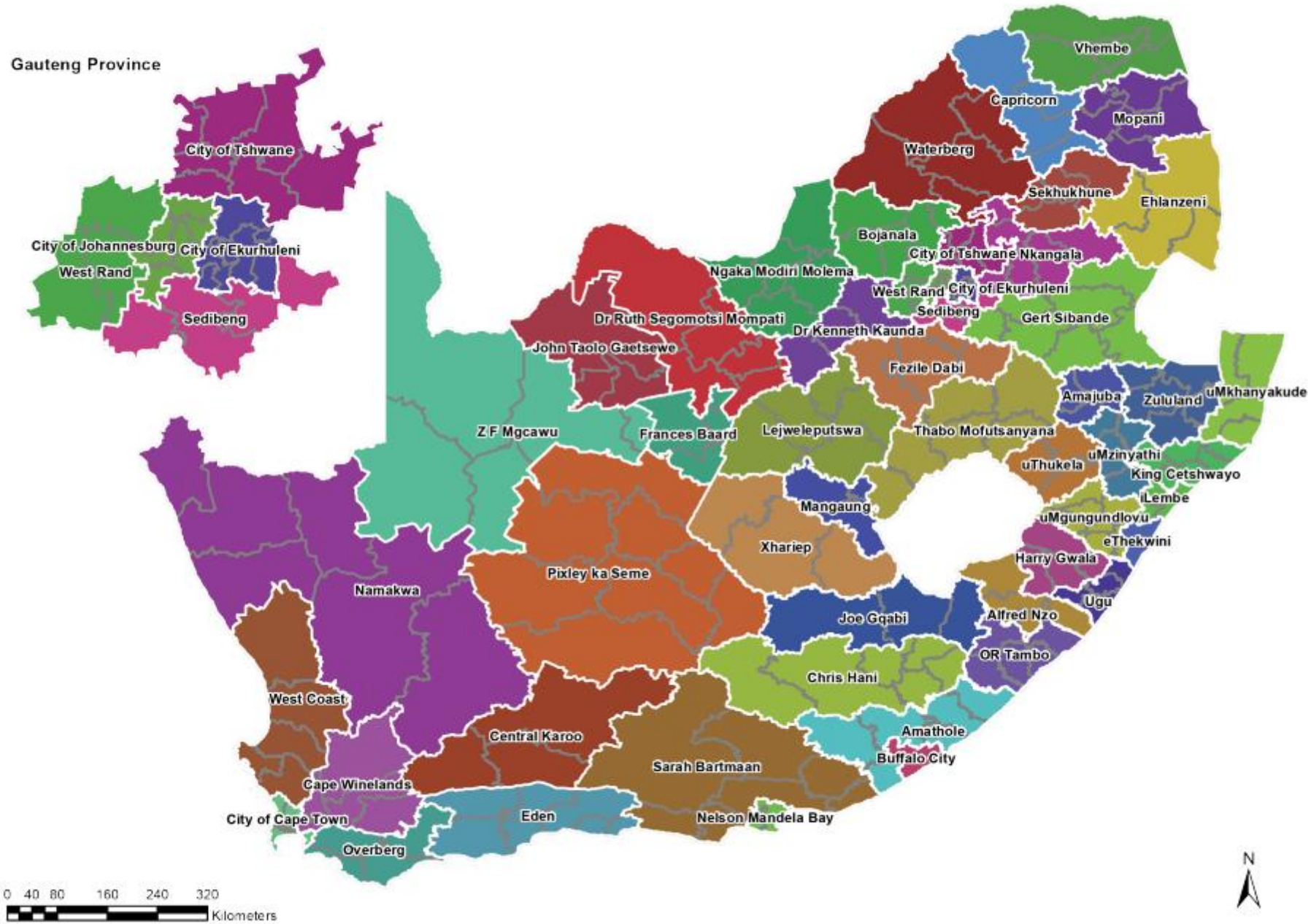
- Recent updates in the NDoH
- Group discussions
- Feedback
- Summary for submission to conference organisers

Healthcare expenditure per capita vs life expectancy

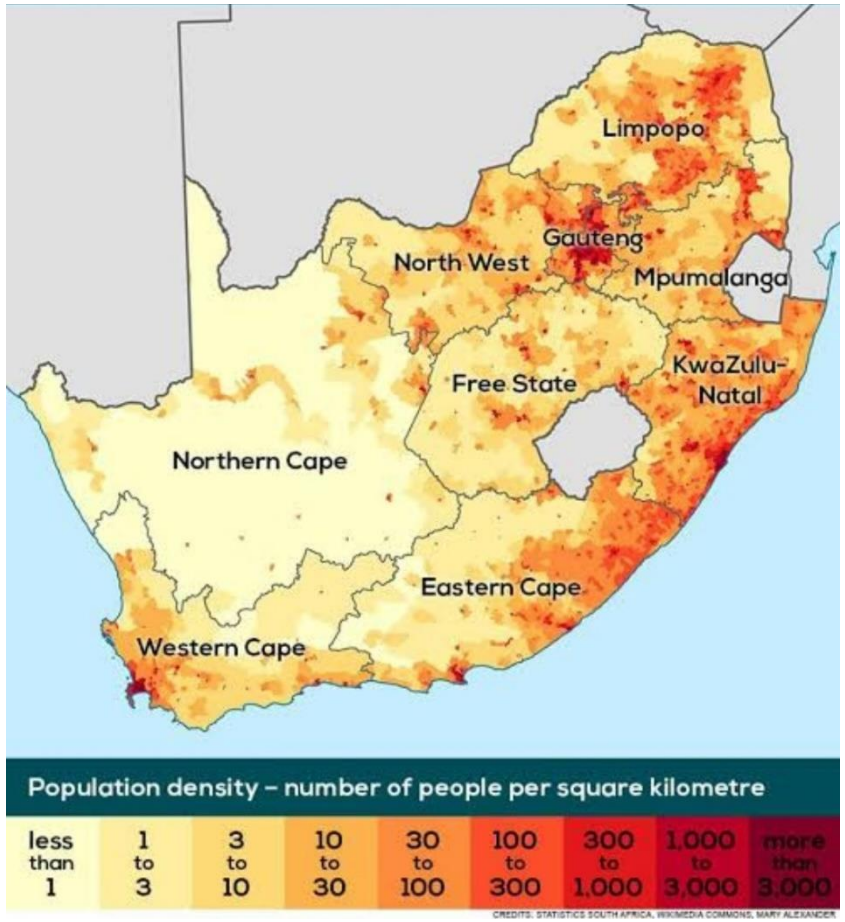


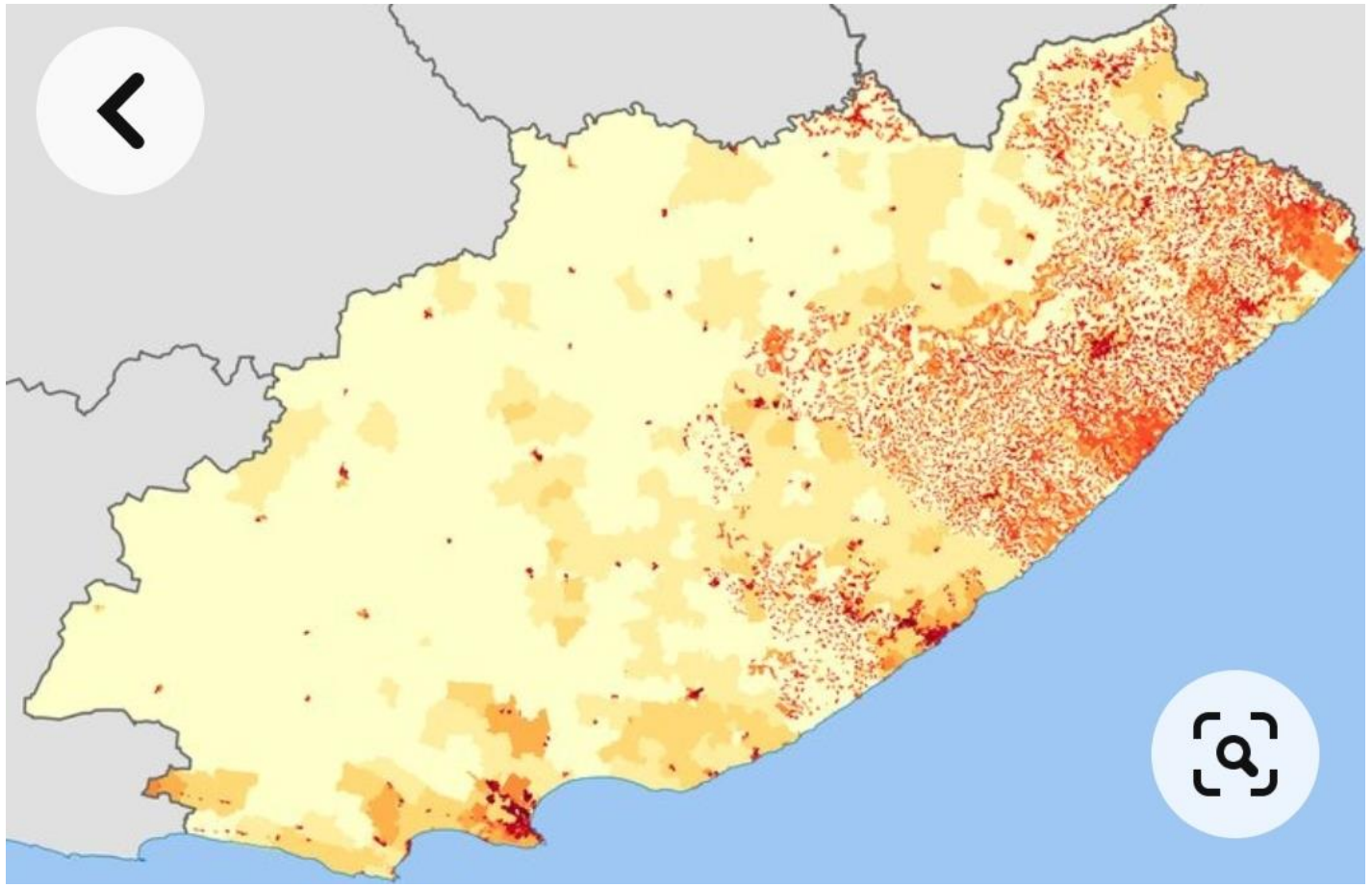
Source: World Bank Global Health Expenditure Database 2019

Created by genuine impact


Gauteng Province
City of Tshwane
City of Johannesburg
City of Ekurhuleni
West Rand
Sedibeng
Vhembe
Capricorn
Mopani
Waterberg
Sekhukhune
Ehlanzeni
Bojanala
City of Tshwane Nkangala
Ngaka Modiri Molema
West Rand
City of Ekurhuleni
Sedibeng
Gert Sibande
Dr Ruth Segomotsi Mompati
Dr Kenneth Kaunda
John Taolo Gaetsewe
Fezile Dabi
Amajuba
Zululand
uMkhanyakude
Z F Mgcawu
Frances Baard
Lejweleputswa
Thabo Mofutsanyana
uMzinyathi
uThukela
King Cetshwayo
iLembe
Mangaung
uMgungundlovu
eThekwini
Xhariep
Harry Gwala
Pixley ka Seme
Namakwa
Ugu
Joe Gqabi
Alfred Nzo
OR Tambo
Chris Hani
West Coast
Amathole
Central Karoo
Buffalo City
Sarah Bartmaan
Cape Winelands
City of Cape Town
Eden
Nelson Mandela Bay
Overberg
0 40 80 160 240 320
Kilometers
N

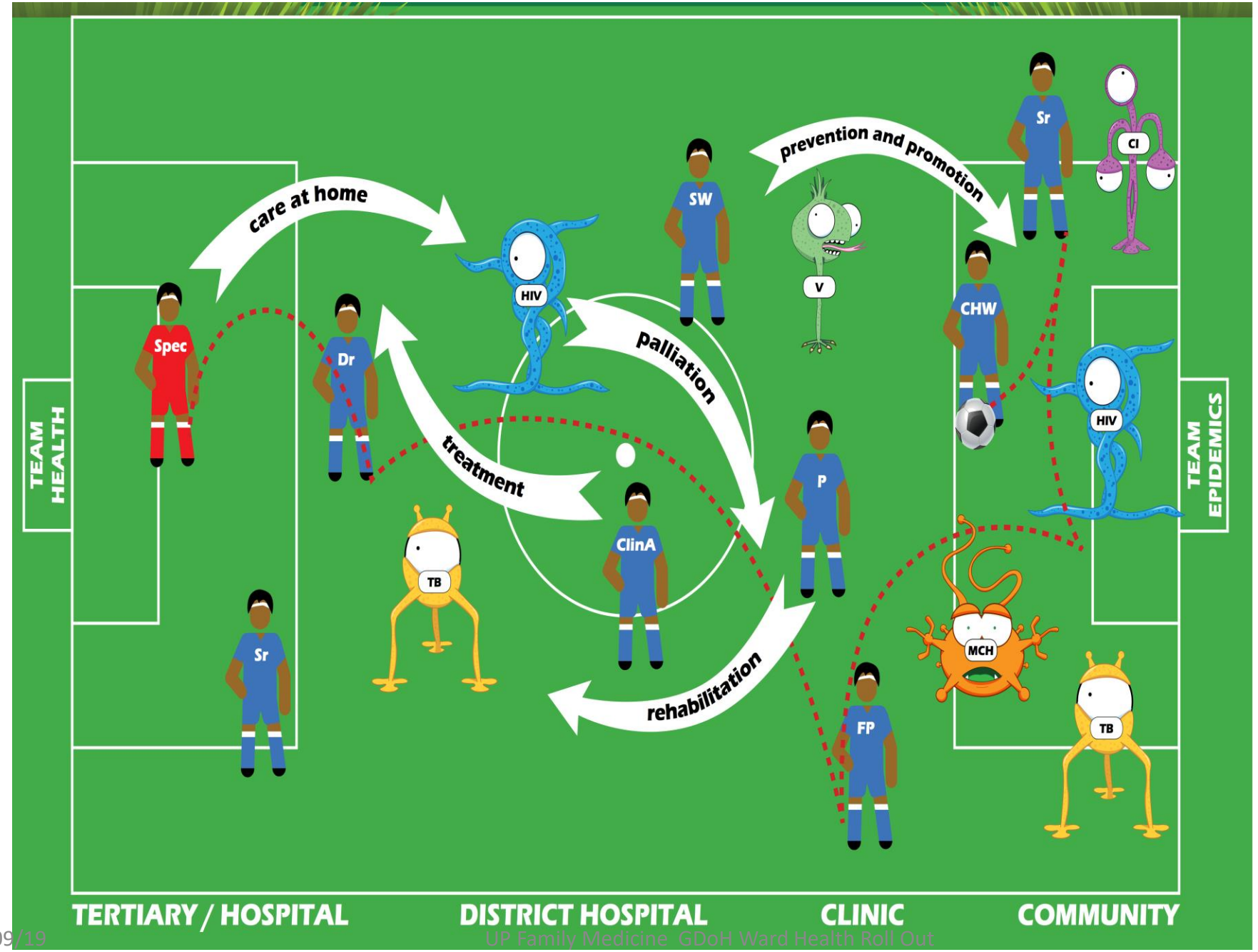
Population density





Universal health coverage

- WHO: Access to the full range of quality health care when and where it is needed, without suffering financial hardship.
  - Includes health promotion, prevention, treatment, rehabilitation and palliative care over the life course
- To deliver UHC: countries need strong, efficient and equitable health systems that are rooted in the communities they serve.
- Primary health care is the most effective and cost efficient way to reach UHC.
- Each country has a different path to achieving UHC and need to decide what benefits to cover depending on the needs of the population and resources available.



Prof Jannie Hugo (UP)

supplies (5).

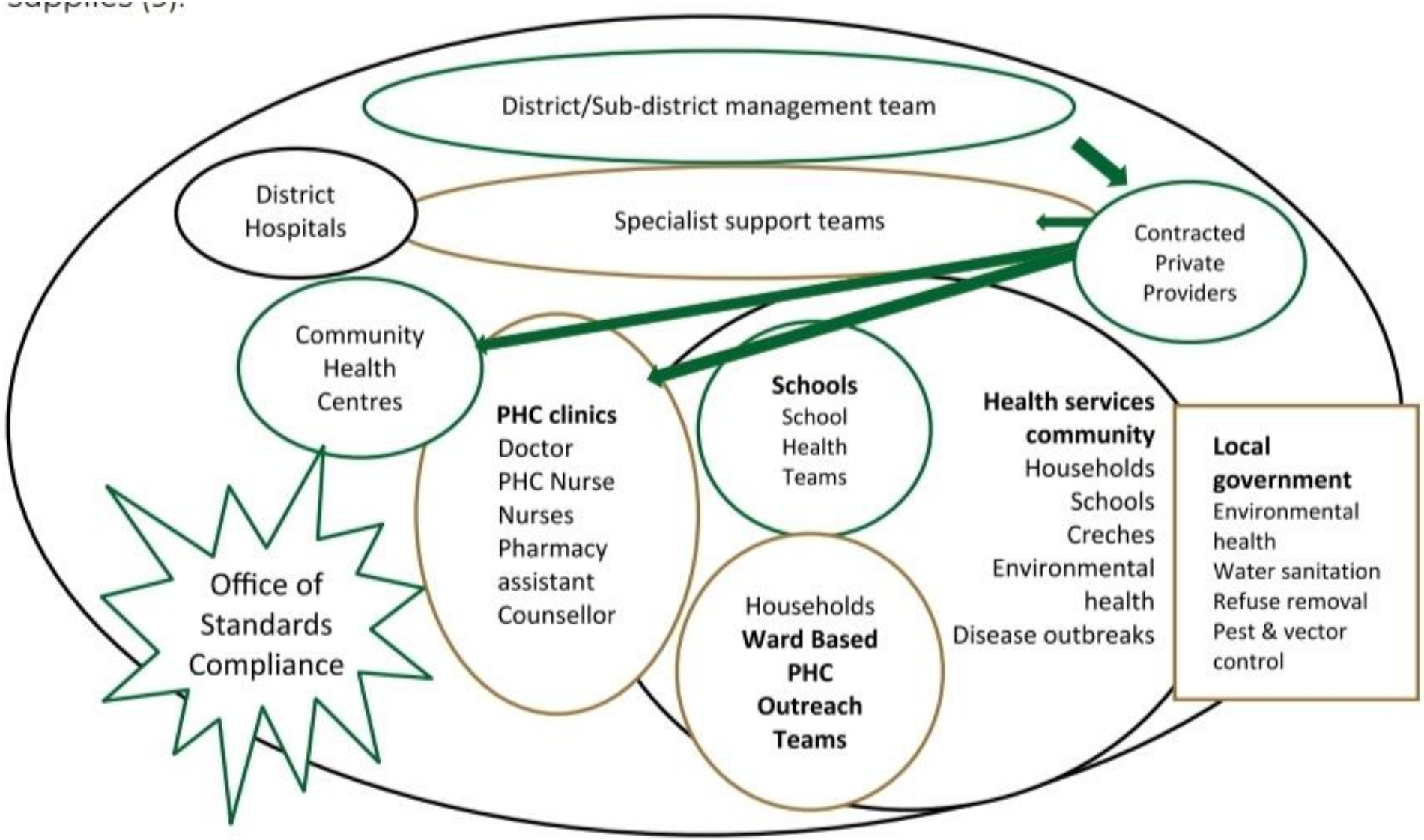
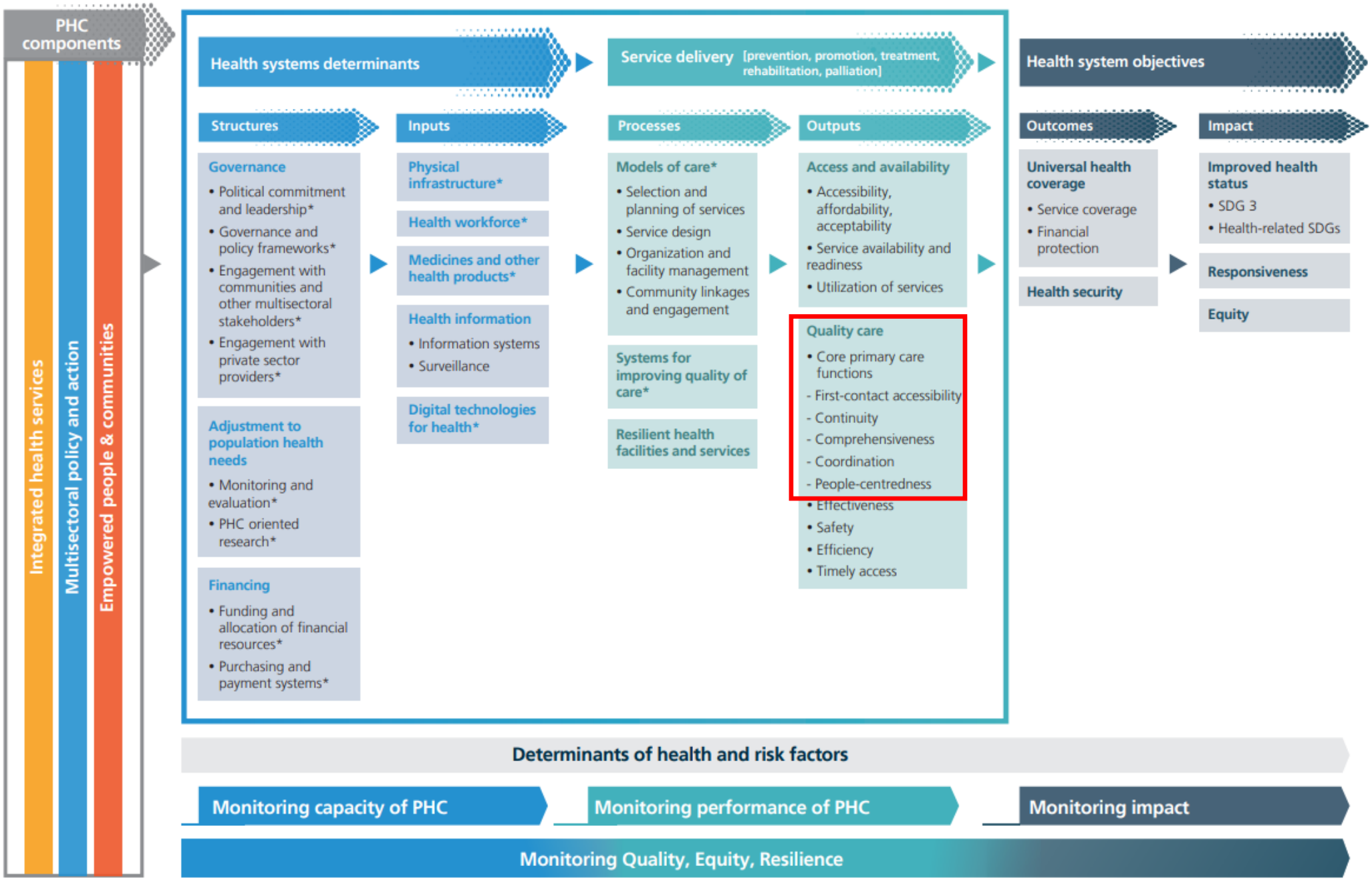


Fig 4: The district health services model of Primary Health care

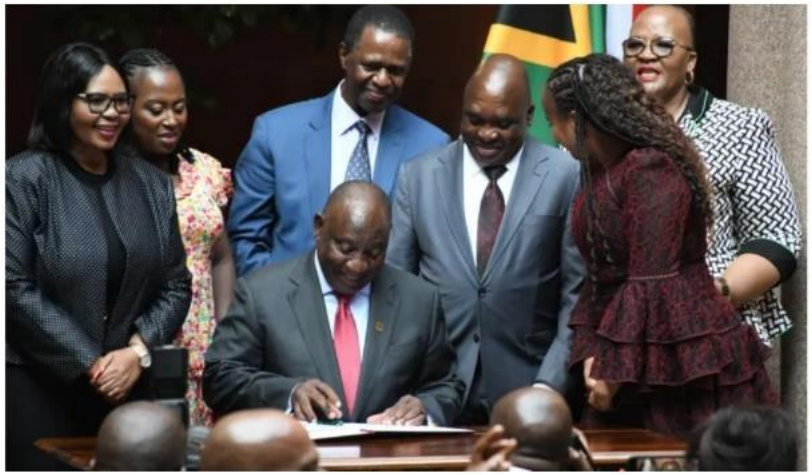

PHC components
Integrated health services
Multisectoral policy and action
Empowered people & communities
Health systems determinants
Service delivery [prevention, promotion, treatment, rehabilitation, palliation]
Health system objectives
Structures
Inputs
Processes
Outputs
Outcomes
Impact
Governance
• Political commitment and leadership*
• Governance and policy frameworks*
• Engagement with communities and other multisectoral stakeholders*
• Engagement with private sector providers*
Adjustment to population health needs
• Monitoring and evaluation*
• PHC oriented research*
Financing
• Funding and allocation of financial resources*
• Purchasing and payment systems*
Physical infrastructure*
Health workforce*
Medicines and other health products*
Health information
• Information systems
• Surveillance
Digital technologies for health*
Models of care*
• Selection and planning of services
• Service design
• Organization and facility management
• Community linkages and engagement
Systems for improving quality of care*
Resilient health facilities and services
Access and availability
• Accessibility, affordability, acceptability
• Service availability and readiness
• Utilization of services
Quality care
• Core primary care functions
- First-contact accessibility
- Continuity
- Comprehensiveness
- Coordination
- People-centredness
• Effectiveness
• Safety
• Efficiency
• Timely access
Universal health coverage
• Service coverage
• Financial protection
Health security
Improved health status
• SDG 3
• Health-related SDGs
Responsiveness
Equity
Determinants of health and risk factors
Monitoring capacity of PHC
Monitoring performance of PHC
Monitoring impact
Monitoring Quality, Equity, Resilience

DAILY MAVERICK

MAVERICK CITIZEN

NATIONAL HEALTH OP-ED

For universal healthcare and NHI to succeed, SA needs effective health promotion programmes and institutions



President Cyril Ramaphosa and the then health minister Joe Phaahla at the public signing into law of the National Health Insurance (NHI) Bill at the Union Buildings on 15 May in Pretoria,. (Photo: Gallo Images / Frennie Shivambu)

18 Aug 2024

In the debates about National Health Insurance (NHI), the focus has been on the envisaged cost and affordability. What is constantly overlooked are the social and financial costs of a growing burden of preventable diseases.

By: Sue Goldstein, Krish Vallabhjee, Tracey Naledi, Atiya Mosam, Mark Heywood

South African issues

- Non-communicable diseases – contribute towards approximately half of all deaths in SA.
- More than 20 million South Africans are overweight or obese…about 70% women either overweight or obese.
- Increasing levels of stunting and malnutrition with rising levels of food insecurity.
- Estimated cost of undernutrition and obesity estimated to be R62,33 billion per annum.

South African issues

- HIV: more than 400 South Africans are infected with HIV every day.
- Increasing number of teenage pregnancies.
  - Since April 2024-Aug 2024 about 100 girls 10-14 yrs have given birth.

South African issues

- Sugar sweetened beverages are a major cause of obesity.
- SA introduced tax in 2018 called Health Promotion Levy (HPL) in attempt to decrease obesity.
  - levy was introduced at a level lower than was thought to be impactful.
  - levy not been increased with inflation nor ring fenced for health promotion.
- Why was HPL not implemented at its optimal level? Vested interests. There was a shift in discussion from health to massive job losses.

South African issues

- SAs who drink consume average 28,9 litres pure alcohol per year – but only 40% SAs drink any alcohol.
- Smoking: Global adult tobacco survey showed prevalence 29,4% in adults – contributing to CVD risk and cancers

- World Health organisation advices to control alcohol use:
  - Liquor Amendment Bill of 2016.
  - Control of Marketing of Alcoholic beverages Bill, proposed in 2012
- In 2017 global alcohol sales exceeded $1,5 trillion

South African issues

- Possible reasons for these failures?
  - Political will?
  - Failure to prioritise resources?
  - Commercial and criminal interests?
  - Construction mafia?
  - Complacency?
    - In 2022 SA distributed 45% fewer condoms compared to 2018, despite the fact that there were more than 150 000 new HIV infections per annum
    - HIV prevention and treatment program cost SA R30 billion per year

Daily Maverick:

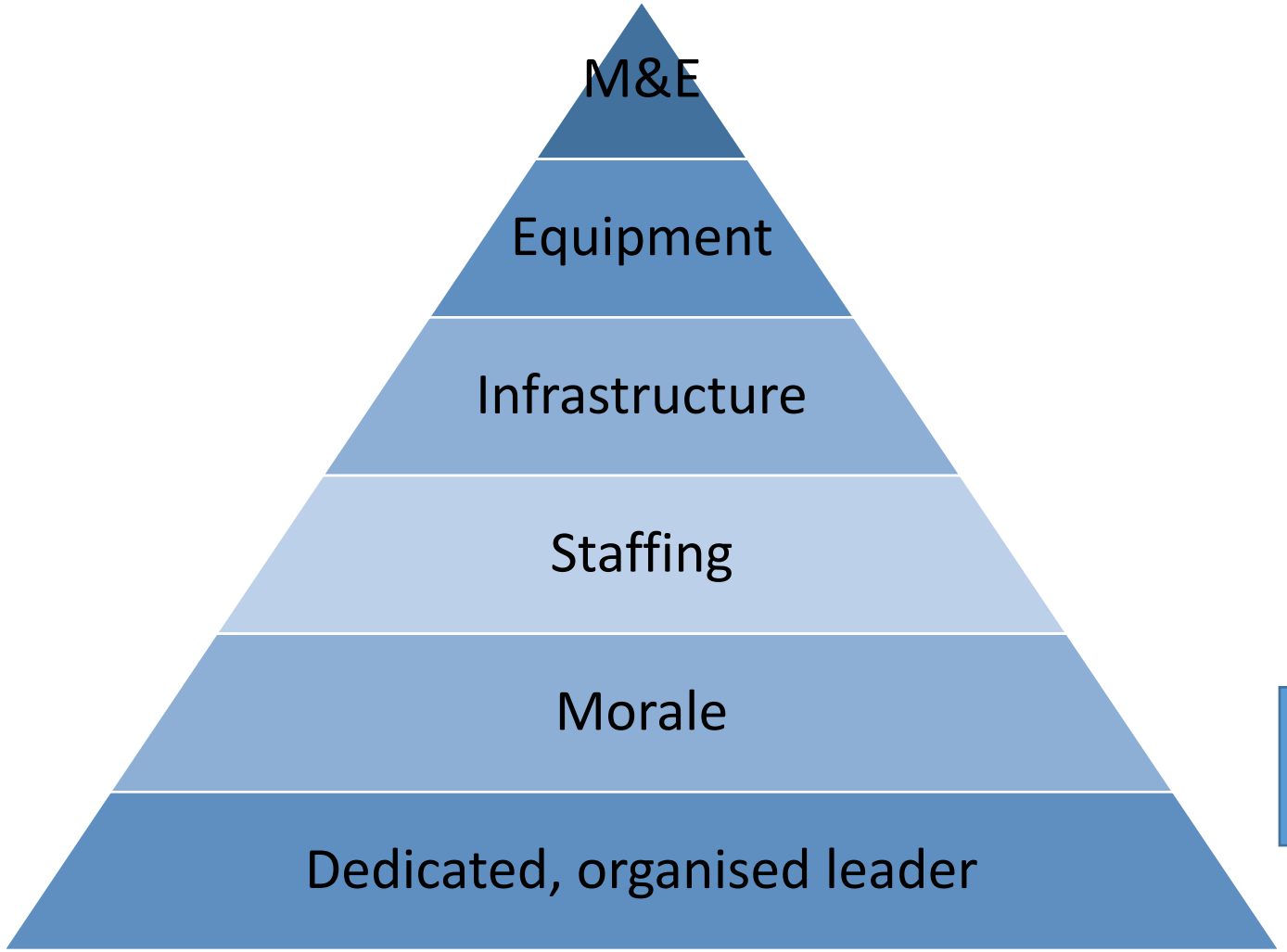
- “Unless there is formal and concerned attempt to promote health by dealing with social and economic determinants of disease there will never be enough money to provide universal access to health care services. NHI will struggle to have an impact on health outcomes.” Steps to take alongside NHI

- The National Department of Health has suggested that for health services to improve, provinces need to concentrate on a number of domains:
  - 1. Leadership, organisational development and human resources
  - 2. Financial sustainability
  - 3. Clinical and specialised services
  - 4. Infrastructure and equipment
  - 5. Digitization and medicolegal litigations.

Leadership

- Dr Aaron Motsoaledi was appointed the Minister of Health.
  - Dr Motsoaledi is no stranger to the health ministry, nor to the NHI, having been Minister of Health from 2009-2019. He helped champion the NHI journey which started in 2011.
- In July 2024 the courts found former Health Minister MEC Qedani Mahlangu and Dr Makgabo Manamela guilty of causing 9 Life Esidimeni deaths.
- Newly appointed health MECs: no health experience
- Many tertiary and regional hospitals with no permanently appointed CEOs and/or clinical managers
- No standardised dashboards for health managers (district, CEOs)

“Williams’ hierarchy” of needs for Medical Teams in District Hospitals

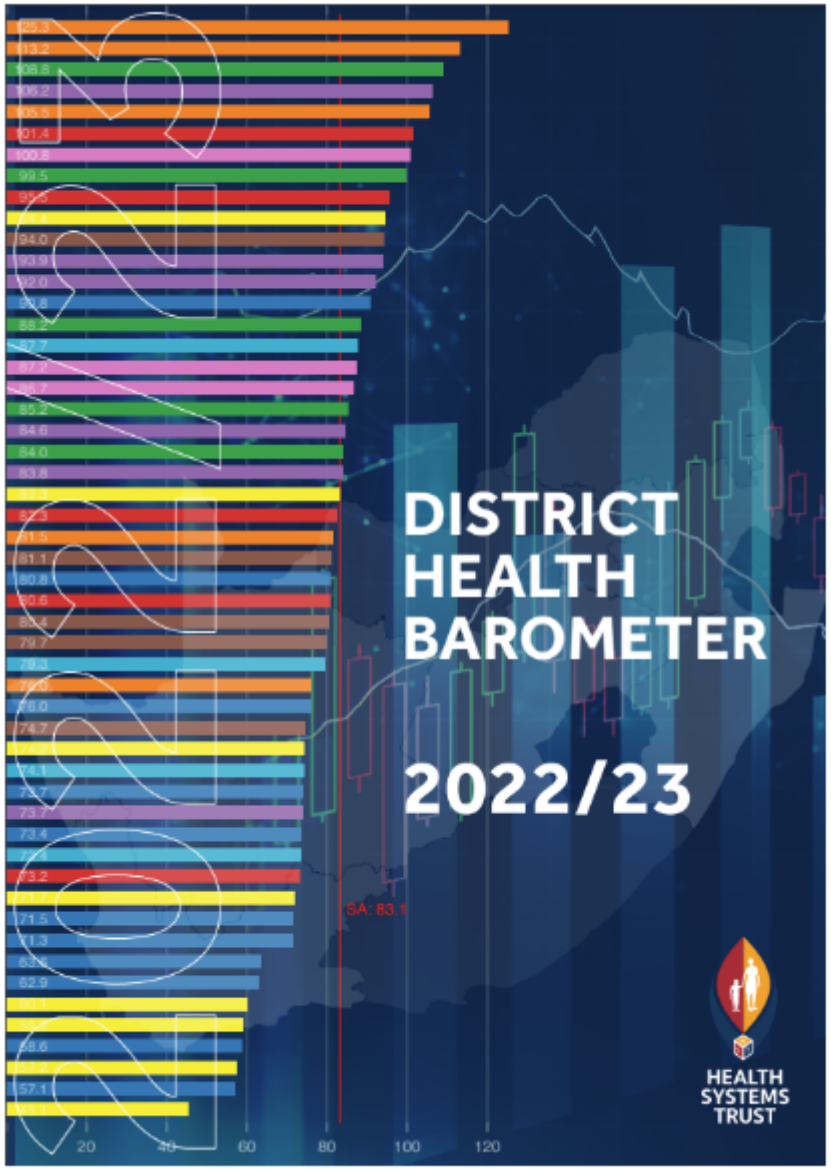


Dr Williams. DCST
FP Umkhanyakude

Financial sustainability

- Threatened by current austerity measures.
- Main threat is high medicolegal payments
- Lack of visibility of budgets
- Service delivery optimization that is needed.
  - Case study: Eastern Cape

EC: 63% rural population



DISTRICT HEALTH BAROMETER 2022/2023

Publication Date: *2024-02-27*
Author: *Health Systems Trust*

After a two-year hiatus, it is with great pleasure that I introduce the eagerly anticipated 2022/23 edition of the District Health Barometer (DHB), a vital statistical and analytical resource that provides an overall view of district health performance on key health systems indicators.

This 16th edition of the DHB provides information across a wide range of district health services, covers over 30 indicators and continues to provide policy-makers, health workers, planners, researchers, academics and stakeholders a unique overview of the performance of public health services in South Africa. By providing a detailed analysis of health indicators, trends, and challenges at the district level, the DHB equips district managers and other stakeholders with the data necessary to identify priorities, plan and implement targeted interventions, and monitor progress. This year's Barometer also includes a chapter on air quality and health as we introduce environmental drivers of health in the publication in response to the effects of climate change on health.

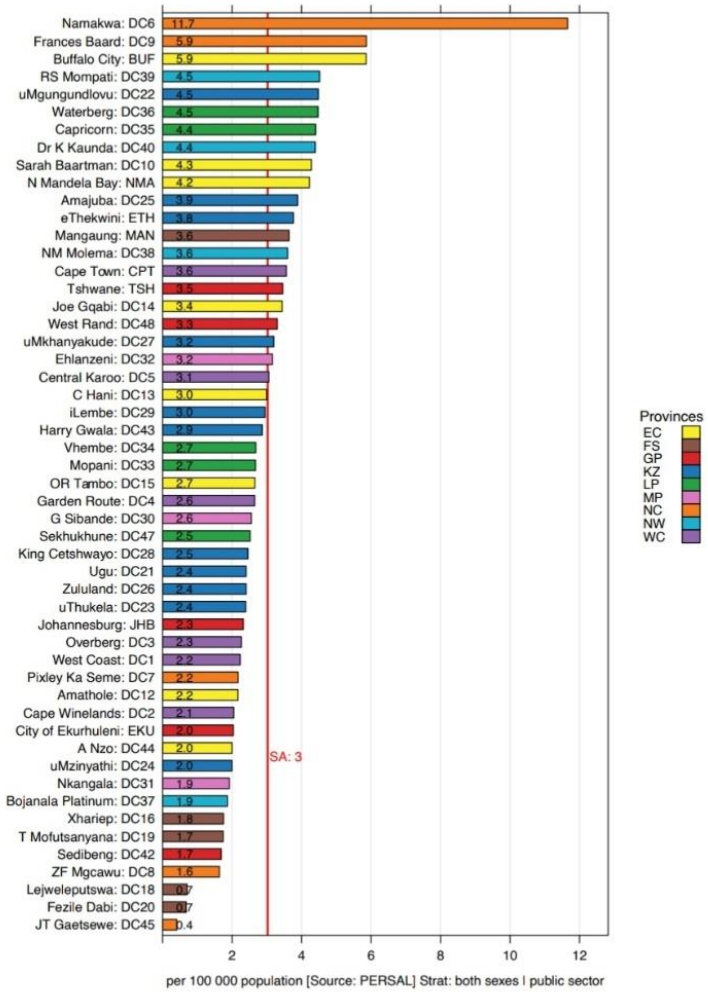
As an innovation for the publication, an online interactive dashboard has been developed. This dashboard will include all the indicators that have been compiled in the publication along with accompanying narratives on the key findings for the most recent year of data. It provides userled navigation, with the ability to drill down geographically from provincial to district level. Users will be able to decide what indicators to focus on, over what time window, and at the level of aggregation they choose. There are also timesliders available to navigate the most recent 5 years of data.

I extend my sincere appreciation to the HST team and the various contributors and collaborators who have dedicated their time, expertise and passion to the development of this invaluable resource.

We trust that the DHB will continue to serve as a catalyst for evidence-informed decision-making and action, propelling us toward a future where every district is able to make a meaningful impact towards a long and healthy life for all South Africans. As always, we welcome commentary and feedback on the DHB's usefulness and suggestions for improvement of future editions.

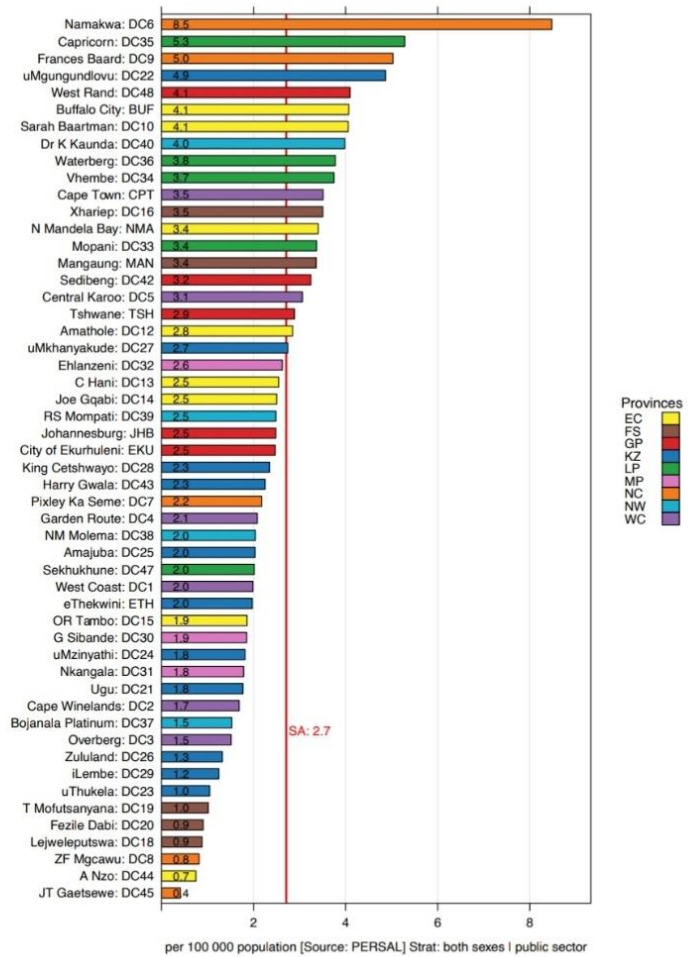
Dr Themba L. Moeti
Chief Executive Officer
Health Systems Trust

Figure 10: Physiotherapists per 100 000 uninsured population by district, March 2023



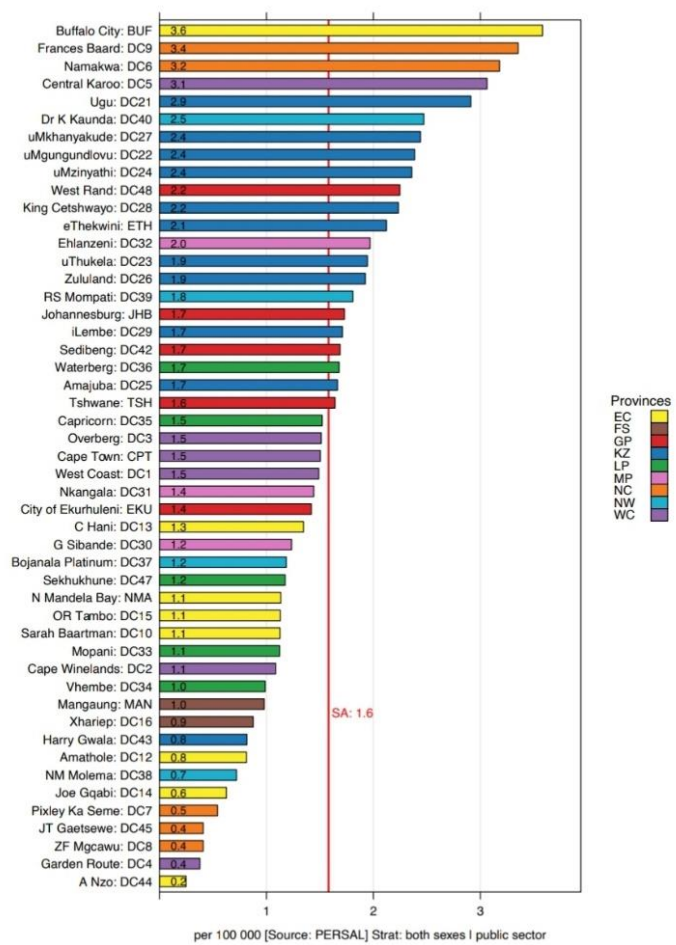
per 100 000 population [Source: PERSAL] Strat: both sexes | public sector

Figure 9: Occupational therapists per 100 000 uninsured population by district, March 2023



per 100 000 population [Source: PERSAL] Strat: both sexes | public sector

Figure 11: Speech therapists per 100 000 uninsured population by district, March 2023



per 100 000 [Source: PERSAL] Strat: both sexes | public sector

Figure 6: Professional nurse per 100 000 uninsured population by district, March 2023

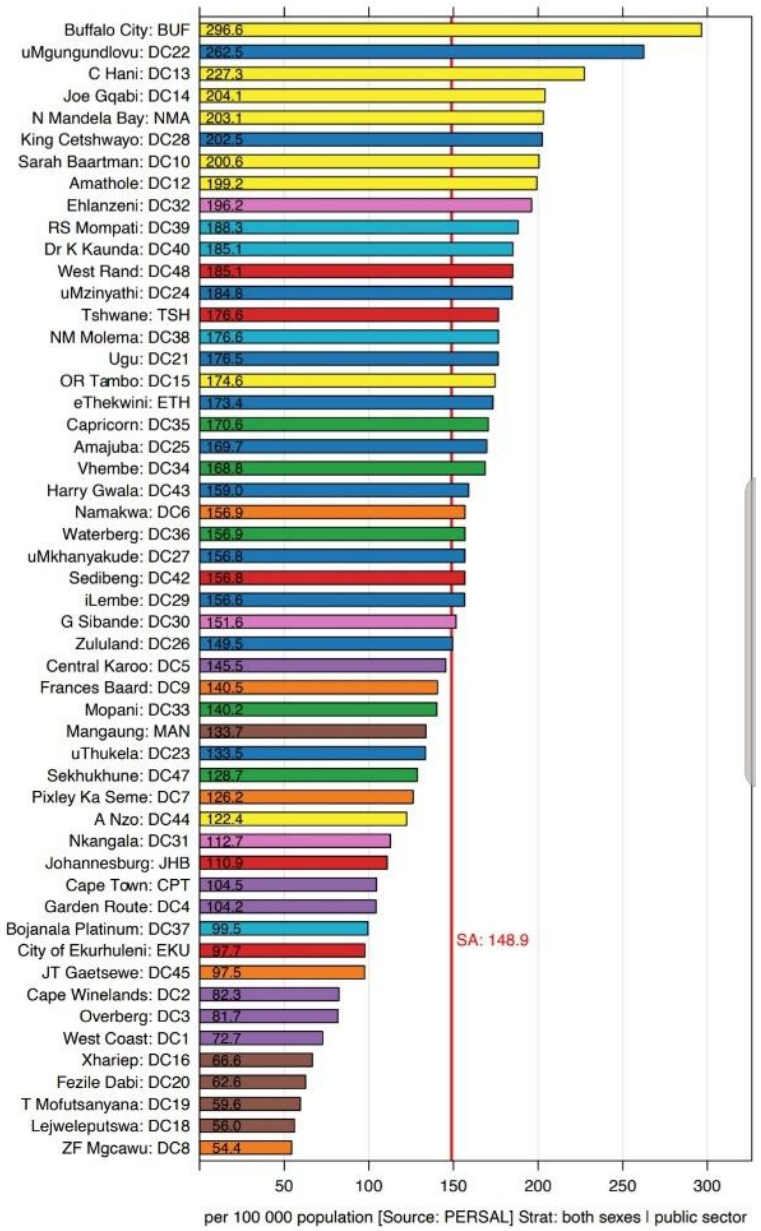


Figure 7: Nursing assistants per 100 000 uninsured population by district, March 2023

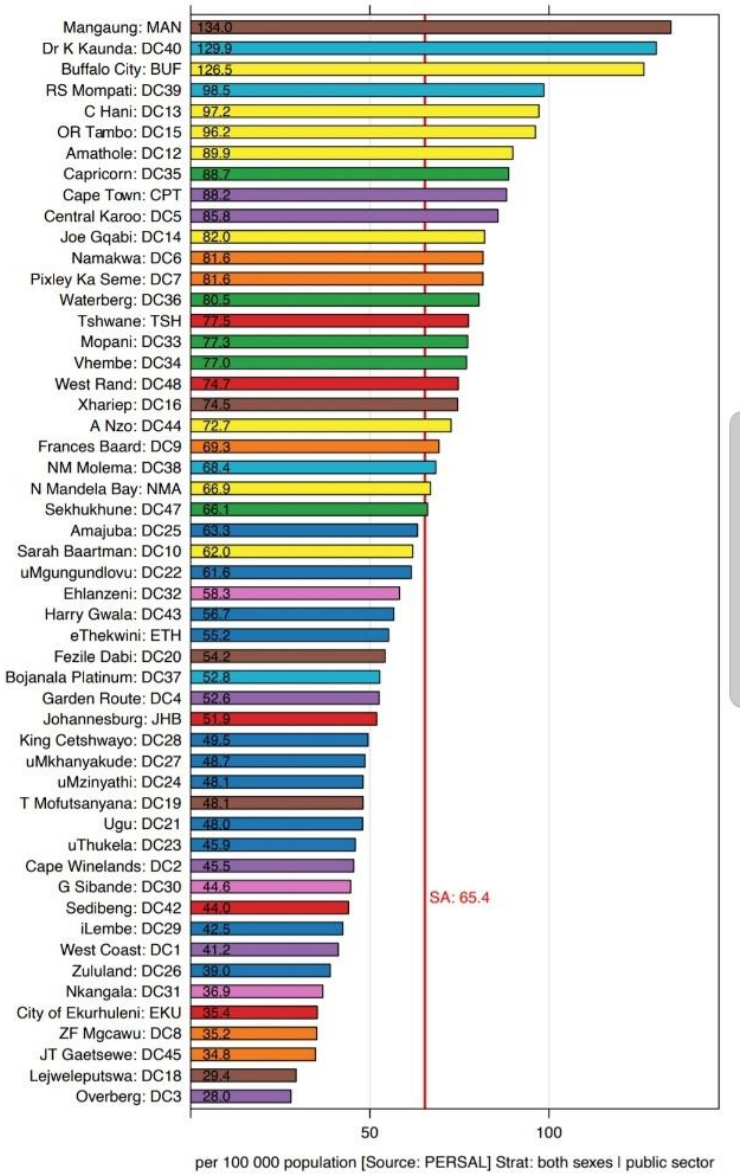


Figure 5: Medical practitioners per 100 000 uninsured population by district, March 2023

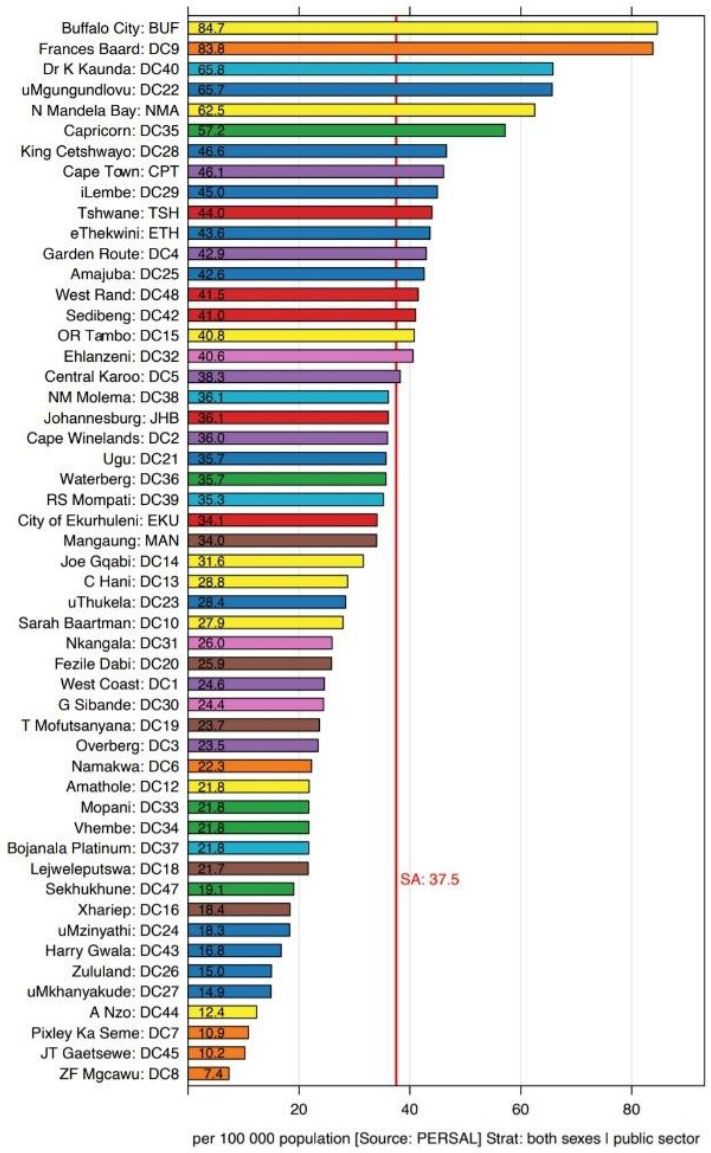
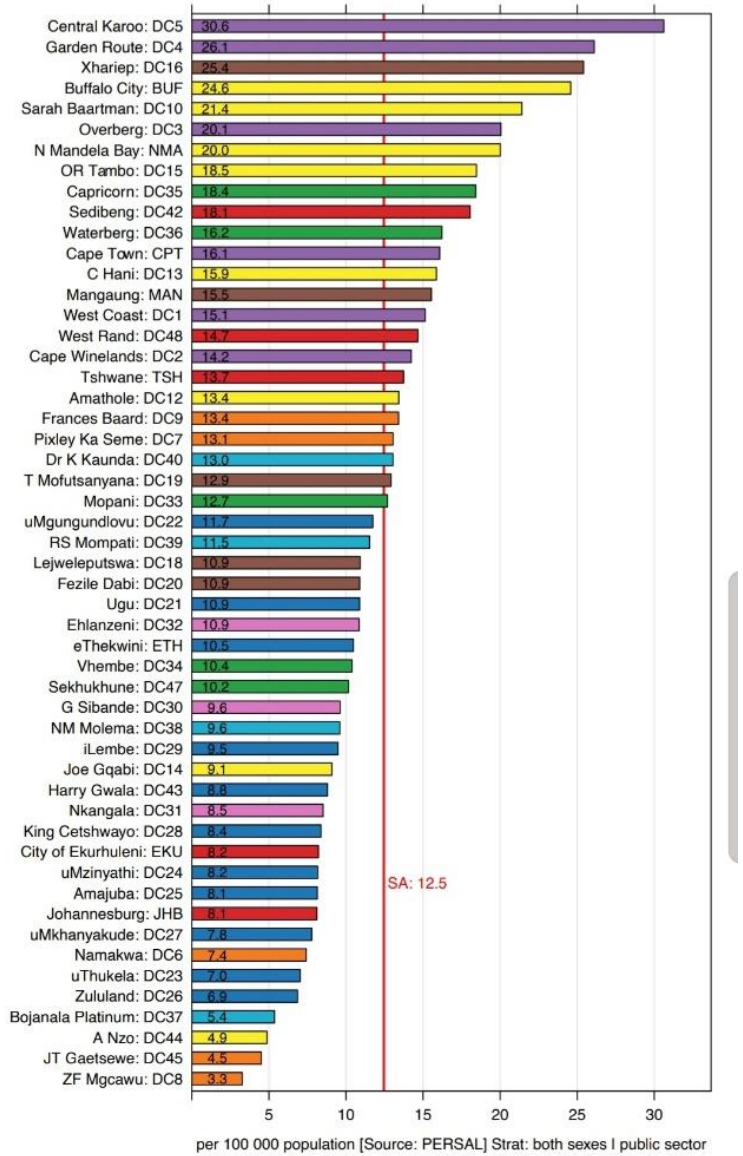
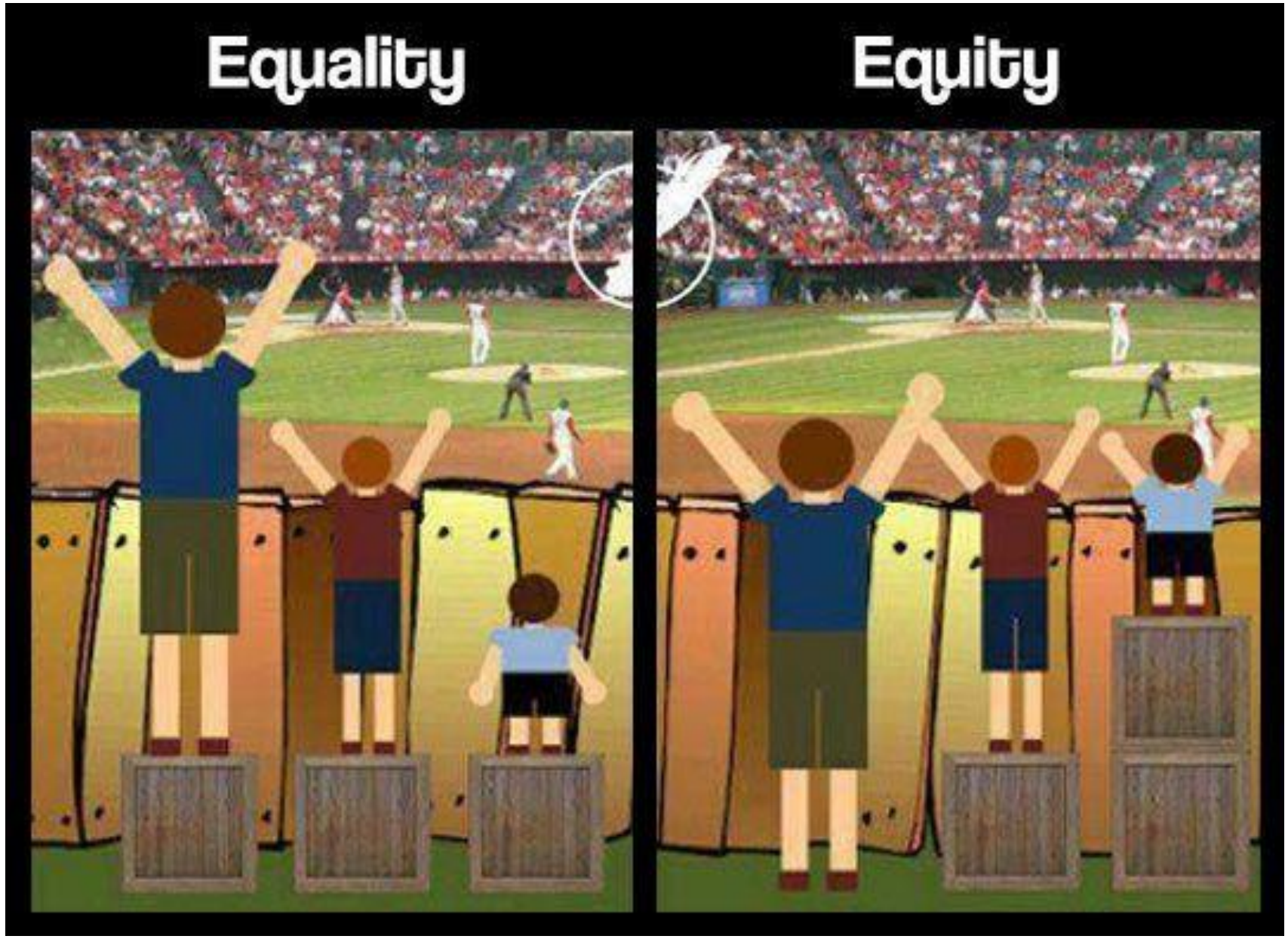


Figure 8: Pharmacists per 100 000 uninsured population by district, March 2023




Equality
Equity

Clinical and specialised services

- Currently we are seeing stressed tertiary services
- In most provinces mental health services are very poor.
- Many dysfunctional district hospitals.
- Service delivery optimization is needed

HEALTHCARE DELIVERY

Rural district hospitals – essential cogs in the district health system – and primary healthcare re-engineering

K W D P le Roux, I Couper

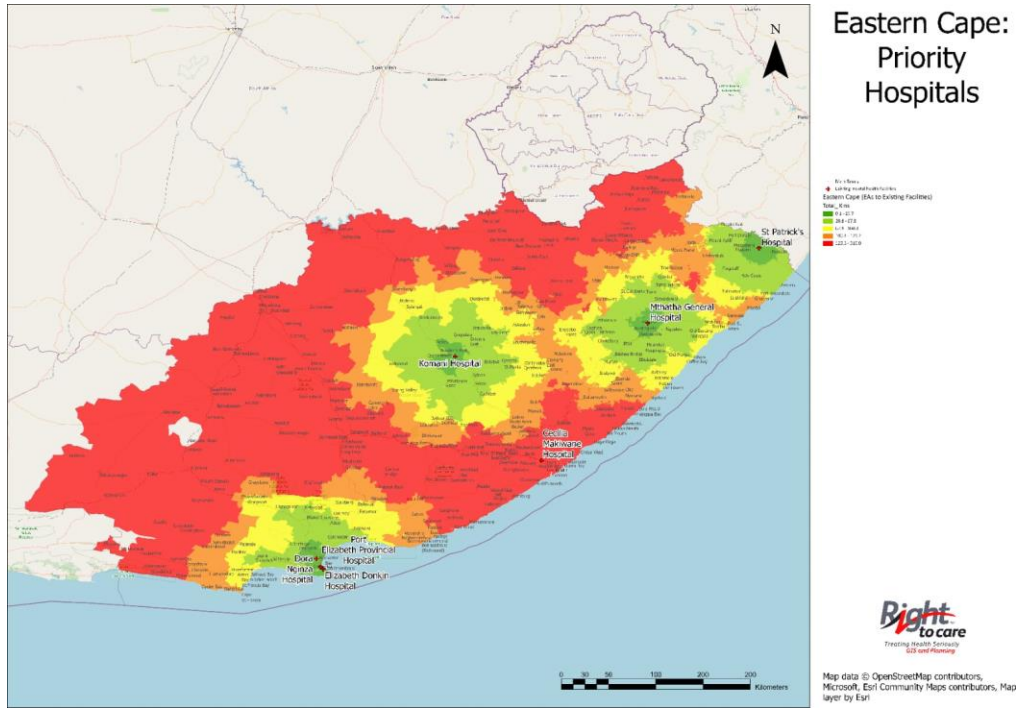
Karl le Roux is based at Zithulele Hospital, Eastern Cape, South Africa. He is an honorary lecturer in the Primary Health Care Directorate, Faculty of Health Sciences, University of Cape Town, and a member of the Rural Doctors Association of South Africa Executive Committee. Ian Couper, a family physician by training, is Professor of Rural Health at the University of the Witwatersrand, Johannesburg, South Africa. He is Director of the Wits Centre for Rural Health, which was launched in 2009 with a focus on human resources for rural health, and holds a joint appointment in the North West Provincial Department of Health as Head: Clinical Unit (Rural Medicine). His areas of interest are health service development, undergraduate and postgraduate education, research and advocacy.

Corresponding author: *K le Roux (karlleroux@gmail.com)*

The re-engineering of primary healthcare (PHC) is regarded as an essential precursor to the implementation of National Health Insurance in South Africa, but improvements in the provision of PHC services have been patchy. The authors contend that the role of well-functioning rural district hospitals as a hub from which PHC services can be most efficiently managed has been underestimated, and that the management of district hospitals and PHC clinics need to be co-located at the level of the rural district hospital, to allow for proper integration of care and effective healthcare provision.

S Afr Med J 2015;105(6):440-441. DOI:10.7196/SAMJ.9284

28 Priority hospitals: distance to travel



Eastern Cape:
Priority
Hospitals

Right to care

Map data © OpenStreetMap contributors, Microsoft, Esri Community Maps contributors, Map layer by Esri

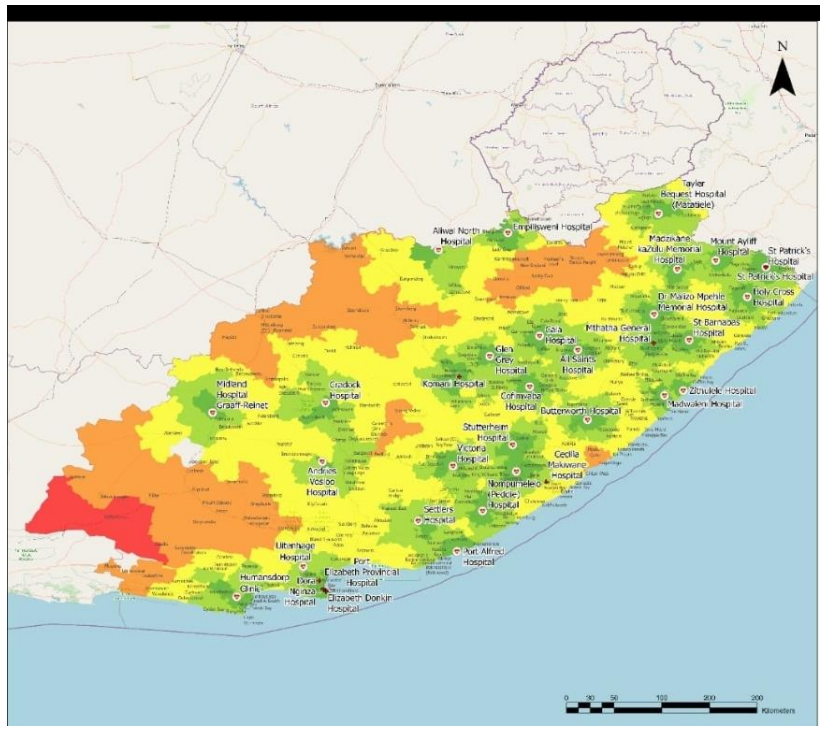


Table:

Green: 0-20km

Light green: 21-40km

Yellow: 41-80km

Orange: 81-160km

Red: 160-227km

Workload June 2024

Service delivery optimization: Attention needs to first focus on district hospitals that have high workloads. Workload needs to match human resources.

2023 / 202	District Hospitals	Cas headcount	OPD headcount	Patient Day Equivalent	Live birth in facility	Delivery by caesarean section	Live birth under 2500g	Monthly Work-load
1	ec Uitenhage Hospital	25912	24179	74319	2901	1169	559	21437
2	ec Butterworth Hospital	23381	28309	66264	2370	1185	260	19035
3	ec Tayler Bequest Hospital (Matatiele)	12955	35965	65799	2031	532	247	18283
4	ec St Patrick's Hospital	15760	28926	59518	3016	938	451	17689
5	ec Madzikane kaZulu Memorial Hospital	13153	35840	60065	1742	608	186	16677
6	ec Zitulele Hospital	21481	21962	45991	1414	361	133	12769
7	ec St Barnabas Hospital	6134	27043	38182	2046	610	258	11436
8	ec Settlers Hospital	16454	19824	40433	793	282	124	10868
9	ec Bhisho Hospital	6979	21389	37758	1526	290	153	10753
10	ec Holy Cross Hospital	6838	12542	34887	1393	506	144	10062
11	ec Humansdorp Hospital	14101	29259	34158	1467	405	188	9876
12	ec All Saints Hospital	8273	15338	34188	1403	302	137	9775
13	ec Mount Ayliff Hospital	9334	22551	33253	1448	546	145	9718
14	ec Dr Malizo Mpehle Memorial Hospital	8356	19053	32730	1498	540	189	9621
15	ec Madwaleni Hospital	5678	15153	33401	1105	258	113	9330
16	ec Tayler Bequest Hospital (Elundini)	5370	30555	33180	947	365	119	9218
17	ec Cofimvaba Hospital	8728	17873	33862	853	155	116	9196
18	ec Glen Grey Hospital	5909	14859	30489	454	75	57	8007
19	ec Empilisweni Hospital	9192	15173	28086	933	69	113	7762
20	ec Greenville Hospital	2772	14292	28702	509	177	59	7661
21	ec Victoria Hospital	8102	16486	25909	643	231	50	7094
22	ec Sipetu Hospital	3643	29311	26150	547	129	74	7023
23	ec Midland Hospital	8135	17436	24840	708	286	126	6908
24	ec Grey Hospital	15040	25009	27115	0	0	0	6779
25	ec SS Gida Hospital	1508	11811	24229	158	33	20	6195
26	ec Hewu Hospital	5937	16676	22825	502	87	67	6134
27	ec Isilimela Hospital	2336	11711	21350	858	231	88	6116
28	ec Aliwal North Hospital	12909	16192	22147	521	83	61	5976
29	ec Port Alfred Hospital	12078	14102	21633	588	124	83	5922
30	ec Bambisana Hospital	16653	16653	21281	339	93	18	5629

Human resources

FACILITIES WITHOUT 24HR CS SERVICE (i.e. only one first on call onsite overtime at a time, no standby)

Day of the week	Working hours	Overtime hours	Total Hours on call	Post call time	Total hours 1st onsite on call (on call subtract post call)	Total hours standby on call (on call subtract post call, divided by 3)
Monday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**11h 30m**	**NA**
Tuesday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**11h 30m**	**NA**
Wednesday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**11h 30m**	**NA**
Thursday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**11h 30m**	**NA**
Friday AM	08h00 - 16h30	16h30 - 08h00	15h 30m	NA (post call Saturday)	**15h 30m**	**NA**
Saturday AM	-	08h00 - 08h00	24 hours	NA (post call Sunday)	**24h 00m**	**NA**
Sunday PM	-	08h00 - 08h00	24 hours	12h00	**20h 00m**	**NA**
				Total:	**105h 30m**	**0**

Assumptions

Working day from 08h00 to 16h30 (30min lunch)
Post call from 12pm, hours subtracted from overtime hours
No lunch taken post call
1st on call is onsite overtime

A district hopsital without a 24 hour CS service that requires only one "on site" first on call and no standby or call doctor. They would need paid overtime to equal a total of 105h 30m on site a week

Permutations for staffing numbers and how many hours of overtime this equates to:

Numbers of doctors doing overtime:	Indivudual overtime hours per week:	Contracted number of hours (3.2. group 3)	Meeting contractual requirements:
2 doctors	52h 40m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
3 doctors	35h 10m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
4 doctors	26h 20m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
5 doctors	21h 10m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
6 doctors	17h 30m	13 - 20 (average not less than 16)	Yes
7 doctors	15h 00m	13 - 20 (average not less than 16)	Yes
8 doctors	13h 20m	13 - 20 (average not less than 16)	Yes
9 doctors	11h 40m	13 - 20 (average not less than 16)	No, too few hours
10 doctors	10h 30m	13 - 20 (average not less than 16)	No, too few hours
11 doctors	9h 40m	13 - 20 (average not less than 16)	No, too few hours
12 doctors	8h 50m	13 - 20 (average not less than 16)	No, too few hours
13 doctors	8h 10m	13 - 20 (average not less than 16)	No, too few hours

FACILITIES WITH 24HR CS SERVICE (i.e. one first on call onsite overtime, one standby on call for theatre)

Day of the week	Working hours	Overtime hours	Total Hours on call	Post call time	Total hours 1st onsite on call (on call subtract post call)	Total hours standby on call (on call subtract post call, divided by 3)
Monday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**11h 30m**	**5h 10m**
Tuesday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**11h 30m**	**5h 10m**
Wednesday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**11h 30m**	**5h 10m**
Thursday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**11h 30m**	**5h 10m**
Friday AM	08h00 - 16h30	16h30 - 08h00	15h 30m	NA (post call Saturday)	**15h 30m**	**5h 10m**
Saturday AM	-	08h00 - 08h00	24 hours	NA (post call Sunday)	**24h 00m**	**8h 00m**
Sunday PM	-	08h00 - 08h00	24 hours	12h00	**20h 00m**	**8h 00m**
				Total:	**105h 30m**	**41h 50m**

Assumptions

Working day from 08h00 to 16h30 (30min lunch)
Post call from 12pm, hours subtracted from overtime hours
No lunch taken post call
1st on call is onsite overtime
Standby on call hours counted as 1/3rd overtime, plus onsite hours
No post call for standby on call

A district hopsital with a 24 hour CS service that requires one "on site" first on call and a second standby on call doctor would need paid overtime to equal a total of 105h 30m on site a week and effectively 41h 50m standby paid a week. This totals 147h 20m a week

Permutations for staffing numbers and how many hours of overtime this equates to:

Numbers of doctors doing overtime:	Indivudual overtime hours per week:	Contracted number of hours (3.2. group 3)	Meeting contractual requirements:
4 doctors	36h 50m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
5 doctors	29h 30m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
6 doctors	24h 30m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
7 doctors	21h 00m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
8 doctors	18h 30m	13 - 20 (average not less than 16)	Yes
9 doctors	16h 20m	13 - 20 (average not less than 16)	Yes
10 doctors	14h 40m	13 - 20 (average not less than 16)	Yes
11 doctors	13h 20m	13 - 20 (average not less than 16)	Yes
12 doctors	12h 20m	13 - 20 (average not less than 16)	No, too few hours
13 doctors	11h 20m	13 - 20 (average not less than 16)	No, too few hours
14 doctors	10h 30m	13 - 20 (average not less than 16)	No, too few hours
15 doctors	9h 50m	13 - 20 (average not less than 16)	No, too few hours

FACILITIES WITH 24HR CS SERVICE REQUIRING A THIRD DOCTOR

(i.e. two first on call onsite overtime, one standby on call for theatre)

Day of the week	Working hours	Overtime hours	Total Hours on call	Post call time	Total hours 1st onsite on call (on call subtract post call, x2)	Total hours standby on call (on call subtract post call, divided by 3)
Monday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**23h 00m**	**5h 10m**
Tuesday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**23h 00m**	**5h 10m**
Wednesday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**23h 00m**	**5h 10m**
Thursday	08h00 - 16h30	16h30 - 08h00	15h 30m	12h00	**23h 00m**	**5h 10m**
Friday AM	08h00 - 16h30	16h30 - 08h00	15h 30m	NA (post call Saturday)	**31h 00m**	**5h 10m**
Saturday AM	-	08h00 - 08h00	24 hours	NA (post call Sunday)	**48h 00m**	**8h 00m**
Sunday PM	-	08h00 - 08h00	24 hours	12h00	**40h 00m**	**8h 00m**
				Total:	**211h 00m**	**41h 50m**

Assumptions

Working day from 08h00 to 16h30 (30min lunch)
Post call from 12pm, hours subtracted from overtime hours
No lunch taken post call
Tow doctors performing 1st on call are onsite overtime
Standby on call hours counted as 1/3rd overtime, plus onsite hours
No post call for standby on call

A district hopsital with a 24 hour CS service that requires two "on site" first on call and a third standby on call doctor would need paid overtime to equal a total of 211h 00m on site a week and effectively 41h 50m standby paid a week. This totals 252h 50m a week

Permutations for staffing numbers and how many hours of overtime this equates to:

Numbers of doctors doing overtime:	Indivudual overtime hours per week:	Contracted number of hours (3.2. group 3)	Meeting contractual requirements:
9 doctors	28h 00m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
10 doctors	25h 20m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
11 doctors	23h 00m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
12 doctors	21h 10m	13 - 20 (average not less than 16)	No, too many hours (additional overtime as per group 4)
13 doctors	19h 30m	13 - 20 (average not less than 16)	Yes
14 doctors	18h 00m	13 - 20 (average not less than 16)	Yes
15 doctors	16h 50m	13 - 20 (average not less than 16)	Yes
16 doctors	15h 40m	13 - 20 (average not less than 16)	Yes
17 doctors	14h 50m	13 - 20 (average not less than 16)	Yes
18 doctors	14h 00m	13 - 20 (average not less than 16)	Yes
19 doctors	13h 20m	13 - 20 (average not less than 16)	Yes
20 doctors	12h 40m	13 - 20 (average not less than 16)	No, too few hours
21 doctors	12h 00m	13 - 20 (average not less than 16)	No, too few hours

Infrastructure and equipment

- Ideal clinic and hospital programs
- Equipment is often purchased haphazardly, with little input from clinicians on the ground

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Ideal Clinic South Africa

HOME | LOGIN | SNAP SHOT OF PROGRESS MADE | DOCUMENTS | CONTACT US

Ideal Clinic Monitoring System

Progress on facilities

Ideal Primary Health Care Facilities

Provinces	# of Facilities	2015/2016		2016/2017		2017/2018		2018/2019		2019/2020		2020/2021		2021/2022		2022/2023		2023/2024	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
EC	777	14	2	139	18	157	20	249	32	251	33	100	13	178	23	192	25	491	63
FS	219	22	10	78	35	114	51	168	76	153	69	94	43	143	66	154	70	200	91
GP	372	89	24	215	58	291	79	330	90	335	91	322	88	341	92	358	97	357	96
KZN	608	141	23	288	47	383	63	461	76	449	74	450	74	551	84	559	92	592	97
LP	477	27	6	51	11	121	25	165	34	139	29	72	15	167	35	109	23	201	42
MP	295	19	7	66	23	87	30	133	46	147	51	86	30	173	59	235	80	287	97
NC	161	3	2	67	41	89	55	92	57	56	35	19	12	35	22	27	17	57	35
NW	309	7	2	92	30	121	40	141	46	173	56	147	47	180	58	205	67	299	97
WC	255	0	0	41	16	144	55	181	69	203	77	154	59	200	76	207	81	222	87
SA	3473	322	9	1037	30	1507	43	1920	55	1906	55	1444	42	1928	55	2046	59	2706	78

Medicolegal and digitalization

- There is increasing need to use data to make decisions
- Implementation of HPRS at clinics
- HMS2 as a tool

iv. Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance

323. This Committee will be established to advise the Minister on Health Technology Assessment

(HTA). It will be a precursor to the HTA agency that will regularly review the range of health interventions and technology using the best available evidence on cost-effectiveness, allocative, productive and technical efficiency and HTA. It will consist of a panel of multi-disciplinary experts to recommend prioritisation, selection, distribution, management and introduction of interventions for health promotion, disease prevention, diagnosis, treatment and rehabilitation.

324. Activities to be undertaken by the Implementation Team include:

f) Health Patient Registration Process (HPRS)

325. Health Patient Registration is an activity that will take place throughout the life-cycle of the population and NHI.

Vulnerable groups, such as women, children, older persons and people with disabilities, orphans, adolescents and rural populations will be prioritised. The identification of the population with the greatest need will be based on criteria consistent with the principles of the Constitution. The **population will be registered using the unique identifier that is linked to the Department of Home Affairs' identification system**. The registration information will be from cradle to grave and will be encrypted.

The **information will be utilised to access services at different levels of the health system.**

Province of the EASTERN CAPE HEALTH

National Digital Health Strategy for South Africa 2019 - 2024

STAY SAFE
VACCINATE TO SAVE SOUTH AFRICA

The strategy proposes nine strategic interventions to be achieved by 2024.

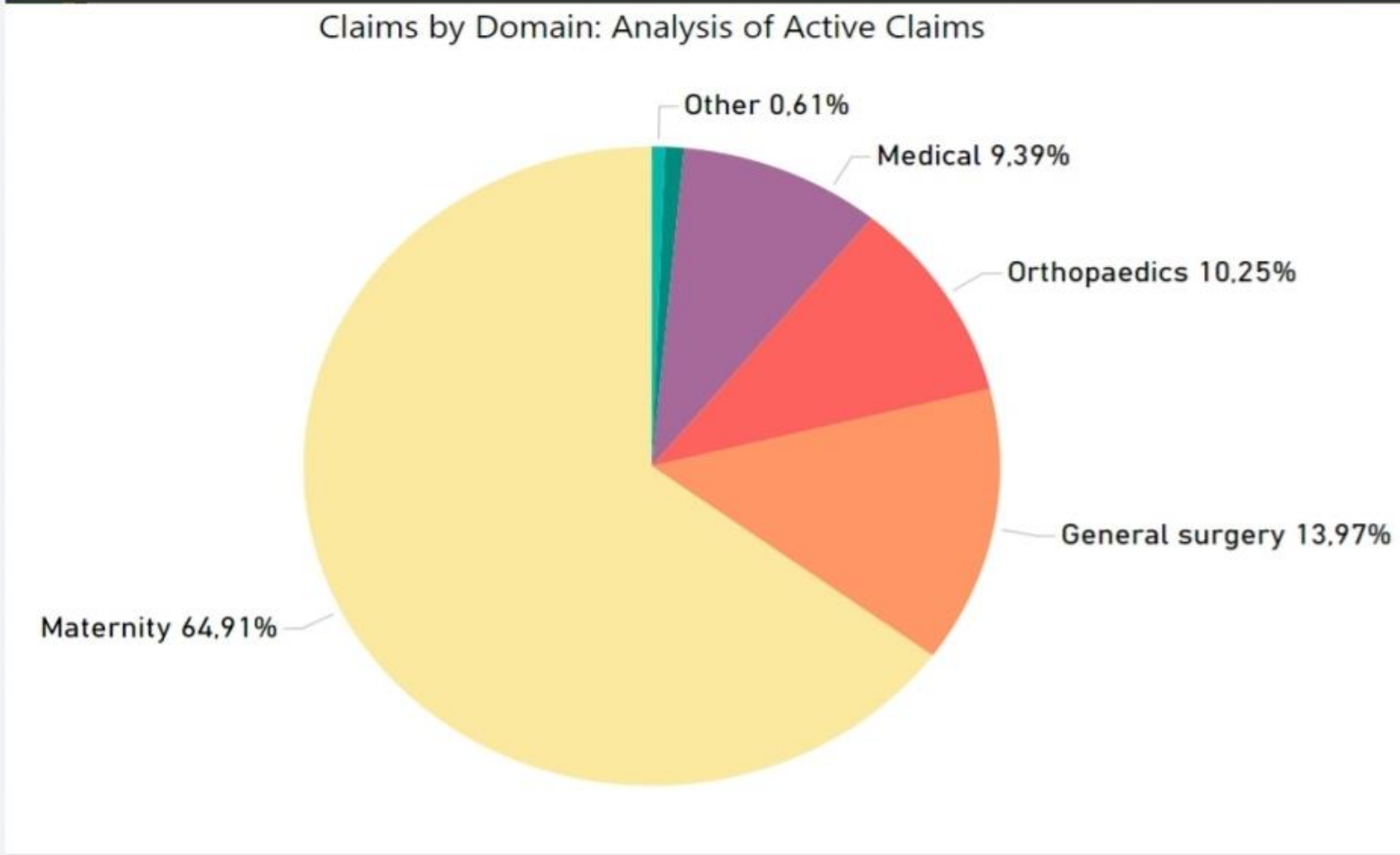
- Develop **appropriate digital applications** and services that **improve health services for patients and health workers.**
- Establish an integrated information architecture for **interoperability** and **effective, safe sharing of health information** across health systems and services.
- An **open standards and open architecture approach** will be adopted, expanding the National Health Normative Standards Framework for Interoperability in eHealth in South Africa, 2014 and extending the health enterprise architecture.
- A **Master Patient Index (MPI) will be established for all South Africans,** leveraging work already accomplished, with all patient information systems implementing a **unique identifier** to **facilitate the movement of patients within and across provinces. Health normative standards framework conformance testing** will be conducted on all health information systems.
- A South African **digital health platform** will be established to **support digital innovation, promote utilisation of digital solutions for improved health services and to contribute to economic development.** A governance structure will be established to reinforce digital health standards and interoperability.

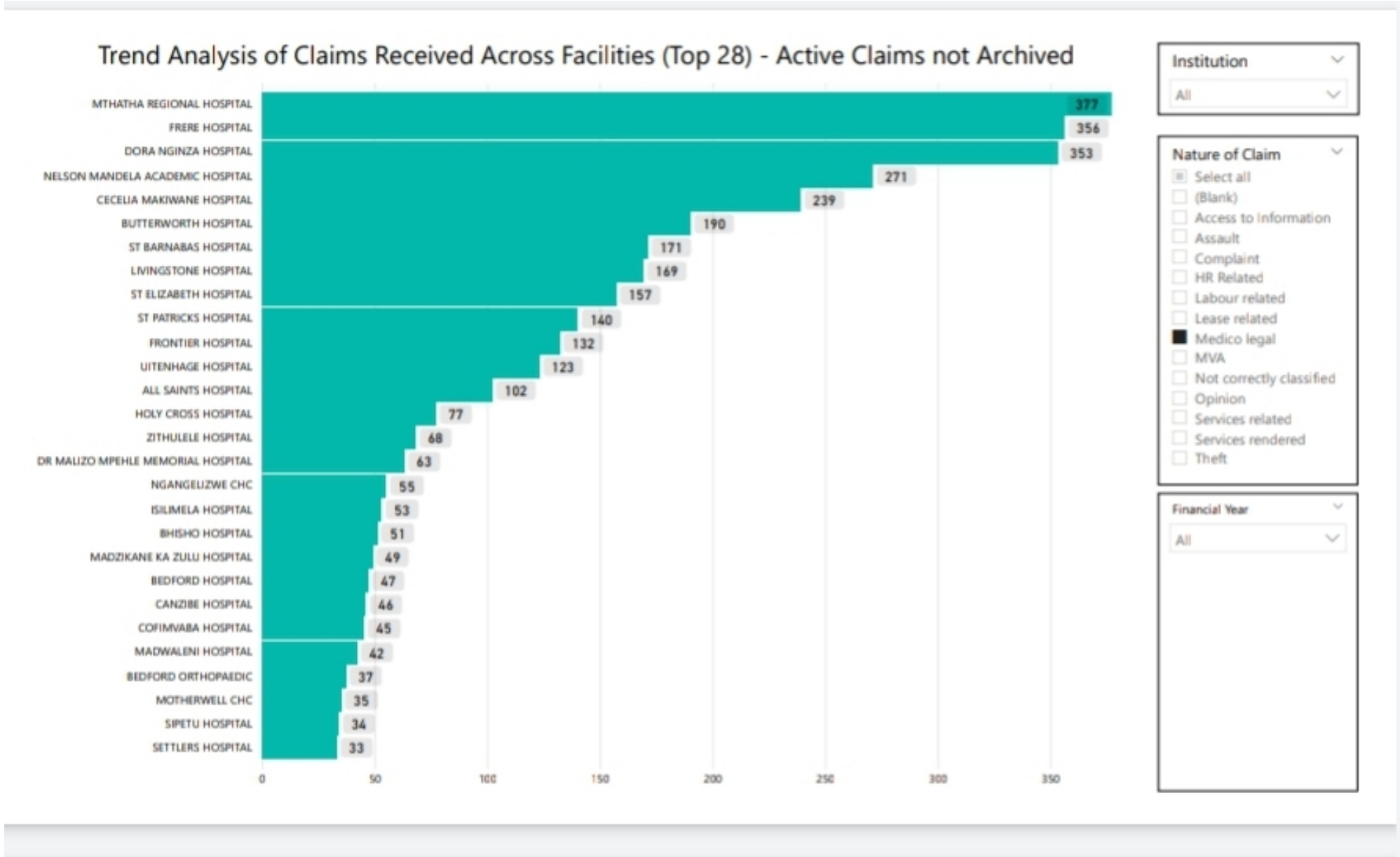
The department acknowledges the significance of the Digital Health Strategy, and it is committed to aligning the HMS² system with an open standards architecture and the SA HNSF.

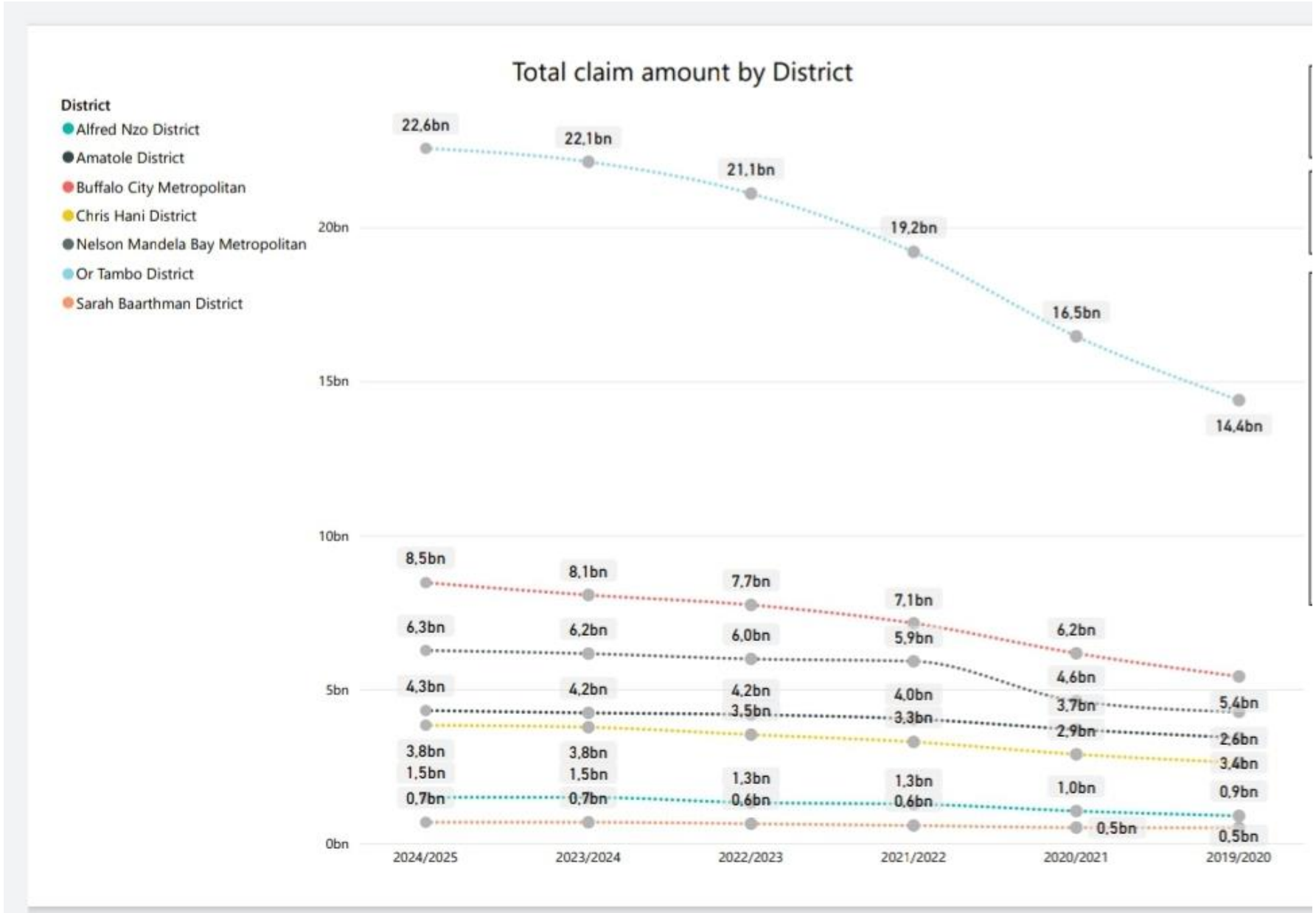
This alignment will enable the department to contribute to the digital health platform, thereby improving overall patient care in South Africa.

Province of the EASTERN CAPE HEALTH

Claims Analysis by Domain for ECDOH




Trend Analysis of Claims Received Across Facilities (Top 28) - Active Claims not Archived
MTHATHA REGIONAL HOSPITAL 377
FRERE HOSPITAL 356
DORA NGINZA HOSPITAL 353
NELSON MANDELA ACADEMIC HOSPITAL 271
CECELIA MAKIWANE HOSPITAL 239
BUTTERWORTH HOSPITAL 190
ST BARNABAS HOSPITAL 171
LIVINGSTONE HOSPITAL 169
ST ELIZABETH HOSPITAL 157
ST PATRICKS HOSPITAL 140
FRONTIER HOSPITAL 132
UITENHAGE HOSPITAL 123
ALL SAINTS HOSPITAL 102
HOLY CROSS HOSPITAL 77
ZITHULELE HOSPITAL 68
DR MALIZO MPEHLE MEMORIAL HOSPITAL 63
NGANGELIZWE CHC 55
ISILIMELA HOSPITAL 53
BHISHO HOSPITAL 51
MADZIKANE KA ZULU HOSPITAL 49
BEDFORD HOSPITAL 47
CANZIBE HOSPITAL 46
COFIMVABA HOSPITAL 45
MADWALENI HOSPITAL 42
BEDFORD ORTHOPAEDIC 37
MOTHERWELL CHC 35
SIPETU HOSPITAL 34
SETTLERS HOSPITAL 33
0
50
100
150
200
250
300
350
Institution
All
Nature of Claim
Select all
(Blank)
Access to Information
Assault
Complaint
HR Related
Labour related
Lease related
Medico legal
MVA
Not correctly classified
Opinion
Services related
Services rendered
Theft
Financial Year
All


Total claim amount by District
District
Alfred Nzo District
Amatole District
Buffalo City Metropolitan
Chris Hani District
Nelson Mandela Bay Metropolitan
Or Tambo District
Sarah Baarthman District
20bn
15bn
10bn
5bn
0bn
22,6bn
22,1bn
21,1bn
19,2bn
16,5bn
14,4bn
8,5bn
8,1bn
7,7bn
7,1bn
6,2bn
5,4bn
6,3bn
6,2bn
6,0bn
5,9bn
4,6bn
2,6bn
4,3bn
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1,3bn
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0,7bn
0,6bn
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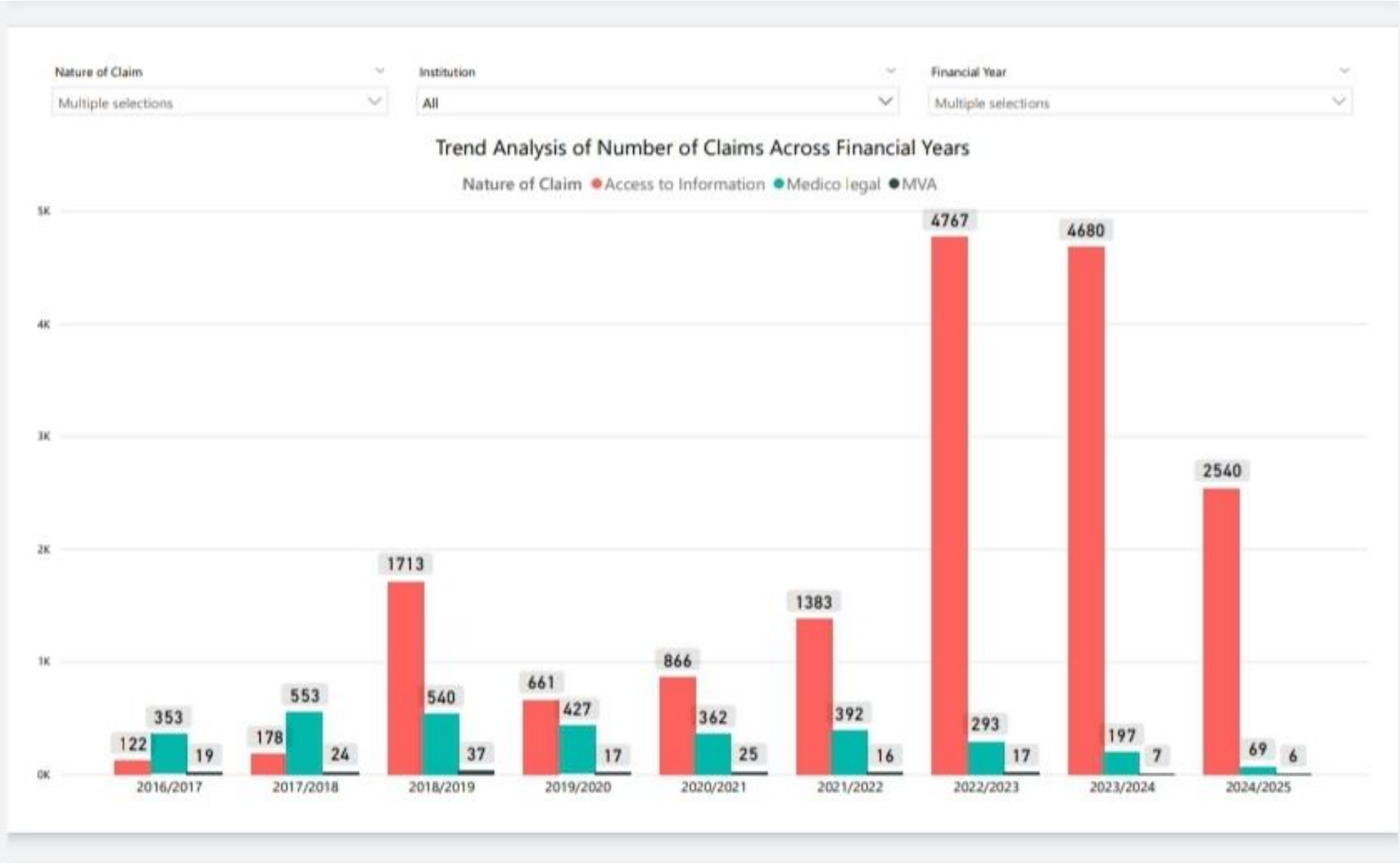
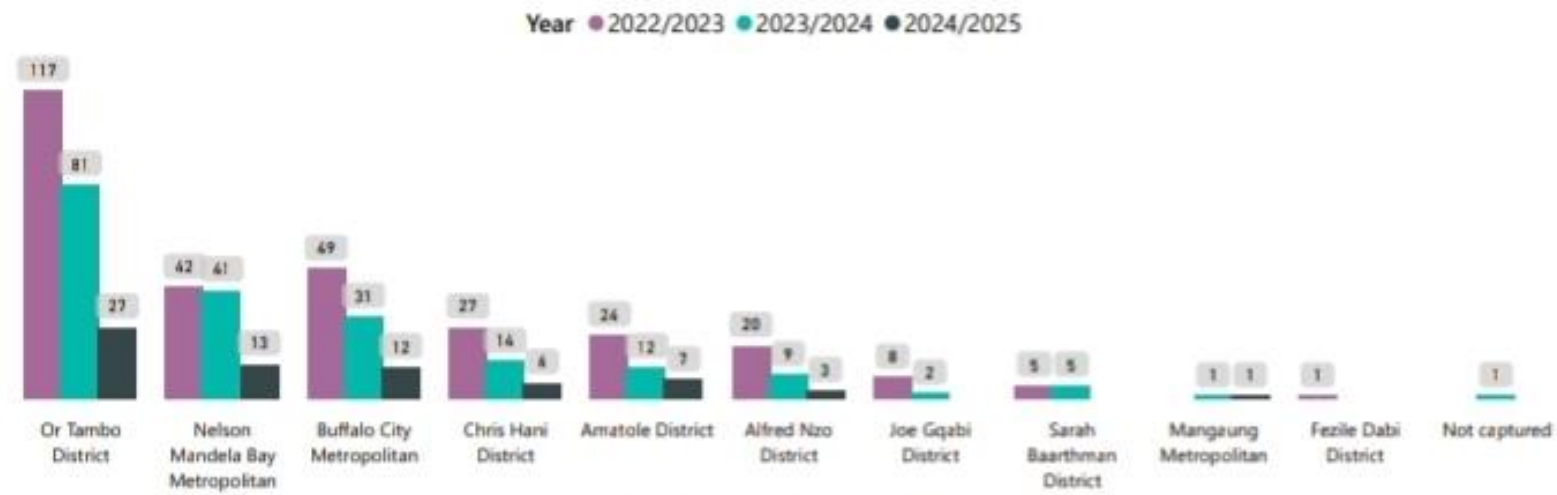
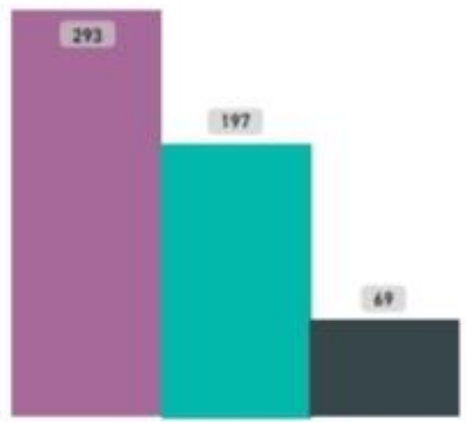
2024/2025
2023/2024
2022/2023
2021/2022
2020/2021
2019/2020


Nature of Claim
Multiple selections
Institution
All
Financial Year
Multiple selections
Trend Analysis of Number of Claims Across Financial Years
Nature of Claim
Access to Information
Medico legal
MVA
5K
4K
3K
2K
1K
0K
122
353
19
178
553
24
1713
540
37
661
427
17
866
362
25
1383
392
16
4767
293
17
4680
197
7
2540
69
6
2016/2017
2017/2018
2018/2019
2019/2020
2020/2021
2021/2022
2022/2023
2023/2024
2024/2025

New Cases by District



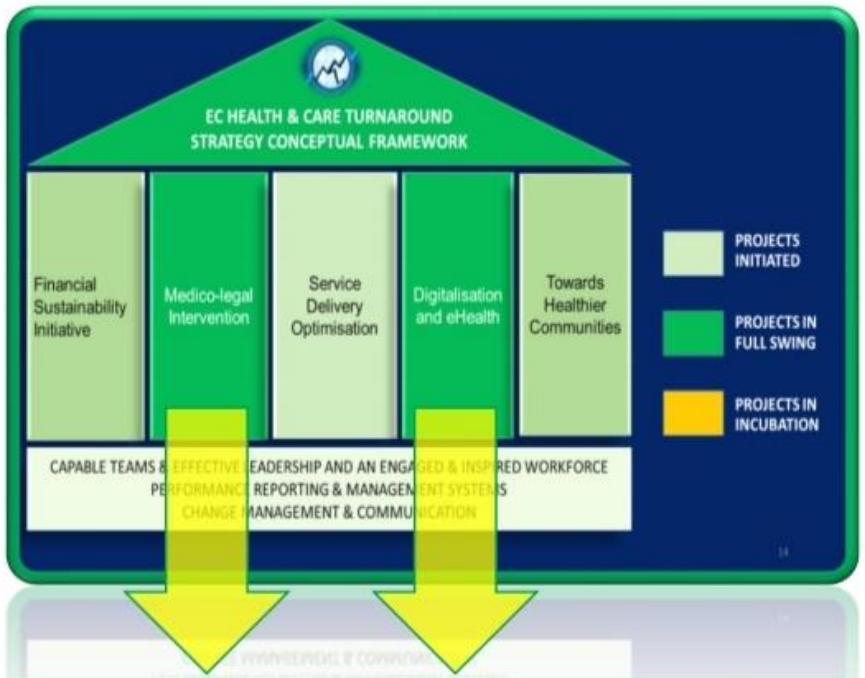
New Cases by Province



Province of the EASTERN CAPE HEALTH

Digitisation and eHealth

STAY SAFE VACCINATE TO SAVE SOUTH AFRICA



An Inter-Departmental **eHealth steering committee** has been established to provide strategic direction and drive systems development and implementation

A Health Turnaround Strategy has been developed and is being implemented, with some measurable improvements already being noted.

AIM OF THE HEALTH TURNAROUND STRATEGY

The **Health Turnaround Strategy aims to** address the **strategic, organisational and service challenges** and move the health system towards a **re-engineered sustainable service platform that is digitally enabled, data-driven and focused on disease prevention and health promotion.**

The foundation of the strategy is a **performance-driven organizational culture** that has three layers:

- Effective leadership, capable teams and valued employees;
- Institutionalizing performance reporting and management systems;
- Progressive change management, stakeholder engagement and strategic marketing & and communication.
- Improve access to healthcare for marginalized groups, including women.

Campaigning for ARVs resulted in one of the greatest victories in health care in SA:
Advocacy
Political negotiations
Civil society organisations

Challenges faced by healthcare workers:
Healthcare worker harassment
Professional victimization
Apathy by some members of society
Concern about “cost” issues

Questions

- What examples can you think of where the NDoH is doing well?
- What examples are there where NDoH “are dropping the ball”.
- What suggestions would you make under the headings: Leadership, Finances, clinical services, infrastructure and medicolegal?
- What steps need to be taken alongside NHI discussions to ensure UHC?
- What is the role of family physicians in the District Health System

"If you want to go fast, go alone. If you want to go far, go together."
African Proverb