Building the next 20 years of healthcare delivery on a solid foundation of health system strengthening
Introduction
Healthcare has undergone a series of reforms since 1994. Because of the shock of demand placed on the system, a conscious but perhaps unconscious decision was made between 1994 and 2014 to address the immediate needs of the majority of people in South Africa. This happened at a time when our HIV and AIDS problem was growing fast and when there was limited access to healthcare, which resulted in the creation or reform of deep capabilities. This helped to build deep-seated capabilities where they were desperately needed, such as Central Medical Stores, National Health Laboratory Services, HIV clinics and district structures. Together with these, approximately 20 health programmes were created in an effort to guarantee the basket of primary healthcare services rendered by our state health facilities.

This has unfortunately created a system of vertical structures that has limited integrated service delivery, which today is a priority for the Ministry of Health. As a country, we have matured and are building up our healthcare system to face various service delivery challenges and the growing disease burden. Over time, there has been a strong focus on specific programmes (such as HIV and AIDS programmes and TB programmes) that have resulted in improved healthcare outcomes. Experience gained from these interventions enables us to address the current challenges to improve access and to drive service delivery. Looking back at the Alma Ata declaration of 1978 ("Health for All"), appreciable progress has been made through strong political will, robust policies and protocols, as illustrated in Figure 1.

Great strides have been made in improving the healthcare system over the past 20 years

- Free healthcare policy at primary level for pregnant women and children under the age of six years
- Revised immune schedule in April 1995 aligned South Africa with internationally accepted immunisation practice. In 1996 and 1997, a nationwide vaccination campaign was launched. The deviation of the vaccination rates across the provinces decreased. South Africa reported no lower than 70% vaccination across all provinces.
- Standard Treatment Guidelines (STGs) and Essential Drugs List (EDL) published for mandatory use by healthcare facilities; most provinces complied with the guidelines, resulting in the more efficient and rational use of drugs.
- The Clinic Upgrading Programme and Building Programme oversaw 400 new clinics and 810 clinic residential units to be built. These new clinics were on pace with the increasing South Africa population. Access to healthcare for marginalised communities increased as a result of this.
- Infant mortality decreased by 2.54%.
- Condom use increased from 22% to 92% (15-to-59-year-olds)
- Free-healthcare policy at primary level was extended to all users from 1 April 2006.
- The published Essential Drug Guidelines was supplemented with STG/EDLs for adult and paediatric care in 2003; the supplementation also resulted in the more efficient and rational use of drugs in healthcare facilities.
- A one-year community service programme for health professionals was introduced; the programme had its first intake of doctors, dentists and pharmacists in 2001.
- Aggressive stance undertaken to prosecute users of Nyaope (a drug cocktail that contains ARVs).
- Initiation of the National Healthcare Insurance policy, potential universal access effective health café promotion programmes (still in pilot phase)
- Improved HIV treatment programme from the dysfunctional structure (mainly because of Msimag’s unscientific promoted remedies) to providing healthcare to more than 2 million infected people
- In February 2014, he made a subdermal contraceptive (effects takes 12 months to wear off) device available for free to women at public hospitals around the country.
- The Life Expectancy improved from 54 to 60 in 2009.
- The cost per month to provide ARVs to patients decreased from R313.59 to R33 per patient to the Department.
- The number of people receiving ARV treatment increased from R923 000 to R2.4 million under his tenure.

Figure 1 - Major achievement made since 1994
Looking ahead at the next 20 years.

There is a need for a more sustainable healthcare system. From our experience, we’ve learnt that simple, practical and implementable solutions often work better than elaborate solutions. These building blocks need to be enabled to implement sustainable healthcare programmes and interventions. Health system strengthening has been the foundation on which many countries have been tasked to build their healthcare system. It’s not that the framework is misleading or too complicated; the challenge lies in how to make it actionable to drive the service delivery transformation that government/providers seek to realise.

Most governments have succeeded in driving reforms in specific building blocks, as depicted in Figure 2. Rwanda and Kenya are both good examples of how this has been achieved for the Financing and Medical Products building blocks respectively. The Rwanda focus was on performance-based financing, while the Kenya example is Medicine Supply reforms. Both these cases are detailed further to demonstrate the approach taken and the value realised.

Figure 2 - World Health Organisation Health System Strengthening Framework
Case study:  
Rwanda’s performance-based finance experience.

In 2005, the Ministry of Health in Rwanda, with the support of the Belgian Technical Cooperation, launched a strategy of performance-based financing (PBF) in a group of 74 health centres (HCs), covering 2 million inhabitants. In 2006, PBF was extended to an additional group of 85 HCs, thus reaching 3.8 million inhabitants. Based on a study that evaluated the effect of PBF on HC performance from 2005 to 2007, there were some radical improvements.

Composite indicators for measuring quantity and quality of services were developed and evaluated through monthly formative supervisions by qualified and well-trained district supervisors. The strategy was based on a fixed fee per quality-approved service. The entire budget spent on the implementation of PBF amounted to R12.06/cap/year, of which R2.21/cap/year for subsidies and an estimated R0.55/cap/year for administration, supervision and training. A positive effect on utilisation rates was only seen for activities that were previously less well organised: in this case, growth monitoring services and institutional deliveries. The quality of services, defined as the compliance rate with national and international norms, rose considerably for all services in both groups. A sustained level of quality between 80% and 95% was reached within 18 months in the first group. A similar result was reached in the second group in eight months. In Rwanda, performance-based financing helped to trigger a major reform of human resource management.

The number of health workers increased by 62% between 2005 and 2008, and public subsidies for health worker remuneration more than tripled. Moreover, the average remuneration increased by 60% to 100%, depending on the facility.

The successful experience with performance-based financing convinced the central Government of Rwanda that facilities could successfully manage wage payments. It subsequently devolved this responsibility to health facilities, while also giving them the power to hire and fire staff. Performance-based financing can also better align donor initiatives with country frameworks. The management of funds from global health initiatives and “verticalised” aid programmes present important challenges. The Rwanda experience, however, has shown that if the performance-based financing system is harmonised, properly designed and adopted by all funders, it can facilitate the pooling and integration of all financing sources, including the government budget and specific programmes, such as the United States President’s Emergency Plan for AIDS Relief.

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L. Rusa, J. Ngirabega, W. Janssen et al. (2009), Tropical Medicine and International Health  

Case study:  
KEMSA Support Programme.

In line with the Global Health Initiative principles, “country-led, country-owned, country-managed”, the Government of Kenya and the United States Agency for International Development (USAID) had a shared vision of strengthening the national health system in Kenya. To execute this vision, USAID created the Kenya Medical Supplies Agency (KEMSA) Support Program to help KEMSA deliver on its core mandate to procure, warehouse and distribute medical commodities.

The programme began on 10 May 2011 with Deloitte Consulting LLP as the lead implementing partner, in collaboration with Deloitte Kenya, Deloitte South Africa and various Kenyan public and private-sector organisations. KEMSA’s improvements as an organisation overall are underscored by quantitative performance measurements. Seventy-five percent (75%) of project indicators outperformed their baseline during the second year of the project, and 79% met or exceeded their second-year target during one or more project quarters.

Key project achievements include:

- **Strengthening legal status** by working with KEMSA and public, private and non-profit stakeholder groups to transition it from an agency to an authority through the enactment of the Kenya Medical Supplies Authority Act No. 20 of 2013
- **Enhancing distribution performance** by collaborating with KEMSA’s Operations Department to implement performance-based contracts with cost-effective routes for distribution (This improved commodity delivery through 43% shorter transit times for hospitals, increased coverage of Kenya’s over 3 600 health facilities, and strengthened security and quality of over 1 100 medical commodities in transit.)
- **Increasing customer service effectiveness** through redesign of the Customer Service Department and integrating the Logistics Management Unit (LMU)
- **Improving financial standing** by legally securing the land they own and assessed market value of approximately R24 840 000 worth of land and properties
- **Integrating planning** made possible by the development of a Planning Department with a proposed eight full-time equivalents to facilitate collaborative supply chain planning across Customer Service, Finance and Operations departments
- **Improving KEMSA’s brand visibility** by conducting a media campaign to better inform stakeholders and customers on KEMSA’s role and capacity
- **Institutionalising performance management** by identifying 74 indicators aligned to their strategic pillars and then integrating measurement of 27 of these performance metrics across departments to inform internal decisions and share results with stakeholders

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USAID (2013), KEMSA Support Programme, End of project report
Most healthcare providers, be it government or private organisations, face the challenge of unlocking the real value of each of the Health System Strengthening building blocks. However, the real value to be realised is in how organisations systematically harness the real impact and use them in a synergistic and augmented manner to serve as a foundation for integrated and continued healthcare delivery, with the intention of the patient being at the centre. Placing the patient at the centre of the design of the healthcare system can fundamentally shift healthcare delivery; for example, healthcare providers are fast realising that mothers die not because they do not receive antenatal care but because they are sometimes not tested for TB or their blood pressure is not managed throughout their pregnancy. There has thus been a call for a single task team for maternal women, child health and HIV and AIDS, STIs and TB. This example can be taken a step further when one explores the reasons for insufficient medicines at facilities because of a lack of funds to purchase essential medicine. However, upon deeper analysis, one will uncover that the primary reason for this issue is that the medicine supply chain is malfunctioning. Unfortunately, this is often a symptom of deeper issues, such as poor handover between Central Medicine Stores, Finance and the District delivery team. These issues are pervasive to large enterprises, because the system has been designed in silos.

Building an aspirational healthcare system

This is the start of an eight-part series that will demonstrate the value to be gained by focusing on each of the building blocks in the context of South Africa’s healthcare reform, as suggested by the National Development Plan that brings together all stakeholders of the healthcare system and their partners, such as social development, donors and business. Each insert will provide potential solutions to the major challenges, lessons to be learnt from past experiences and opportunities to be gained by embarking on this journey and will culminate in how each of the building blocks must be harmonised to realise the synergies as depicted in Figure 3.

By focusing on the South African healthcare environment, there is a focus to create a healthcare system that is required to deliver against its National Development Plan mandate. This starts with integrating the Department of Health’s strategy planning framework with the National Development Plan and cascading this integrated strategy to the various provinces.

A preview to the upcoming papers

1. At the outset, if we look at leadership and accountability, there must be a drive to establish leadership discipline and capacity at all levels, to enable leadership succession planning at all levels and finally to design the implementation of a governance structure to support the strategy.
2. Developing on that human resourcing capacity and looking at this wider in terms of healthcare workforce delivery, a plan is required to meet workforce demands for the next 20 years, to gear the system to mobilise and retain an effective workforce and a programme to accelerate the development of scarce skills (clinical and not clinical).
3. People can only be successful in an environment that sets them up to be successful. Therefore, the service delivery transformation building block will focus on reconfiguring health services to support changing healthcare needs and delivery models to ensure efficient and effective delivery. This will be enhanced by developing a working integration model with all relevant ministry portfolios to the DoH (e.g. Public Works, Social Development and dti) and finally by adopting a patient-centred service approach in all spheres of delivery.
4. Enabling services, such as medicine supply, require a unique focus to strengthen some very core capabilities such as research and development, local manufacturing and Pharmacovigilance.

5. The role of information technology as an enabler and accelerator in healthcare transformation is essential. Therefore, to enable South Africa to take advantage of these platforms, there must be a focus on developing a sustainable operational capacity for collection of health information and the development of a Health Information model for integrated monitoring and evaluation. This will enable the successful implementation of an electronic health record/clinical information system solution.

6. Finally, the healthcare system needs to be funded in a sustainable manner, and therefore Project Financing and Pay for Performance financing capabilities need to be established. This will also improve the ability to transition from global funding to activity level financial planning to improve cost reduction and transparency. Ultimately, this will allow for the development and implementation of a universal healthcare coverage model.

The intention is to rally all leaders in a call to action to adopt the very essence of the National Development Plan, to make it their own and to reform, in camaraderie, the healthcare system for the next 20 years.

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Figure 3 - Using HSS building blocks in a synergistic and augmented manner to transform the Healthcare System
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