Commission 5
Transforming Health Care and Overhauling the Health System

KZN Health Summit

Report Back

04 September 2011

KwaZulu-Natal Department of Health

Noting:

- That health care is a human right,
- That the cost of health care is continuously becoming unaffordable,
- That curative health care level can not be assumed to be right entry for users,
- That prevention is better than cure (cost, socially, and technically), and;
- The need to increase the life expectancy at birth for all South Africans.

Contextual Matters

- Government Programme of Action (derived from the National health policy, Polokwane 2007 resolutions, The MTSF 2009-14)
  - Priority 2: “A Long and Healthy Life for All South Africans”
- The 10 Point Plan
  - Priority 3 – Improving the quality of Health Care
  - Priority 4 – Overhauling the health care system and improving its management
  - Priority 5 – Improving HR Planning, Dev, & Mgt.
  - Commitment to ensure that NHI is implemented
- Provincial Health Priorities

Quality Improvement Strategy I

- The Strategy is relevant and generally accepted
  - There must be strategic determination of cycles within which quality audits and accreditation must be undertaken
  - Criteria and methods must also be developed to deal with special areas e.g. Rehabilitation; Mental Health services
  - There must be proper allocation of budgets to support achievement of core standards
  - There must be an organizational redesign in order to respond and embrace NHI & QI.

Quality Improvement Strategy II

- Integrated approach to QIP and QAP is important to avoid facilities “slacking off”
  - Advocacy campaigns to ensure that all involved in service delivery own the quality initiatives
  - There must also be concerted efforts to educate health workers that quality improvement is not only the responsibility of the clinical staff.
- Performance management must be looked into as a means to achieve good turnaround in quality improvement in facilities
    - Managers must be held directly accountable

PHC Re-engineering I

- The strategy was welcomed as opportune
  - KZN leading in many aspects of this roll-out
  - Creating a strong DMT working , Functional Sub-districts, and a ward-based health care approach.
- Nonetheless key matters were raised
  - The composition of the PHC teams was questioned
    - Skills mix: there is no “mental health specialist”
  - Accountability and reporting systems are important
    - Integrated reporting structures most desirable for all streams >>> supports integrated planning & avoids fragmentation
    - Statistics should be collected on occupational health and school health service utilization

PHC Re-engineering II

- Consideration must be given to the workload at the PHC level so that staff are not over-burdened
- Primary Health Care nurses have been trained in curative medicine and should be reoriented towards community focus
- Strengthening/ acceleration of the implementation of District Health Councils

PHC Re-engineering III

- There is a need to recognise and adopt an intersectoral approach to delivery of PHC services
  - e.g. Environmental Health under Local Govt
  - Department of Education has jurisdiction over schools and this impacts on ability to roll-out School Health Teams (MOU needed)
- Financing of PHC must also be re-engineered
  - Cost centre approach
  - Increase in *per capita* allocations to support effective delivery

PHC Re-engineering IV

- Specialists (scare skills) must be at a district level and support the teams at sub-district level
  - Comprehensive approach to attracting & retaining specialists skills not only within the PHC teams but also in existing facilities
- There was also a recommendation that a PHC Forum be held before further interaction with external stakeholders
  - Allows those at the service delivery point to share experiences and practical solutions to challenges

Hospital Reform I

- Concerns were raised regarding the recently published regulations on re-designation of hospitals
  - KZN has a peculiar mix of “combination” facilities
  - The proposed re-designations are supported where practically applicable and possible
  - Impossible to purely classify a facility in a mutually exclusive manner
  - This might have implications for access in some areas as some services might be removed
  - Creates perverse incentives for managers as they all want their facilities/positions to be at the higher end of the designations

Hospital Reform II

- Managers must be given appropriate powers relating to functioning of the facility they manage
  - Current delink between budgets and scope of delegations is detrimental to effective management
  - Reforms must not just be focused on financial matters, important to also cover human resources, procurement & maintenance aspects

Human Resources I

- Support was expressed for the HR Strategy
- Key matters raised included
  - Staff vacancy rates are very high in rural facilities
    - General Doctors, Specialists and Pharmacy
  - National & Province must do more to address challenges faced in "rural health"
    - Career pathing, flying doctors/ health workers, secondments from well resourced.
  - Need to ensure a comprehensive plan on recruitment, retention, planning, training and output from relevant institutions
  - Work ethic of staff must be addressed as it impacts on quality of care
    - "Scarcity of smiling"
    - Poor supervision

Human Resources II

- There is a need for a uniform and consistent approach to incentive structures at facilities
  - Rural vs. Urban facilities i.r.o incentives to attract staff e.g. Pharmacists
- Bursary systems must be developed and implemented as a means to retain staff
  - Contractual obligations possible as a means to commit staff to sector
  - Mechanisms can also be used as a means to attract new talent from disadvantaged areas

THANK YOU