Accelerating Health System Strengthening and National Health Insurance (NHI) Implementation

2nd PRESIDENTIAL HEALTH COMPACT 2024-2029

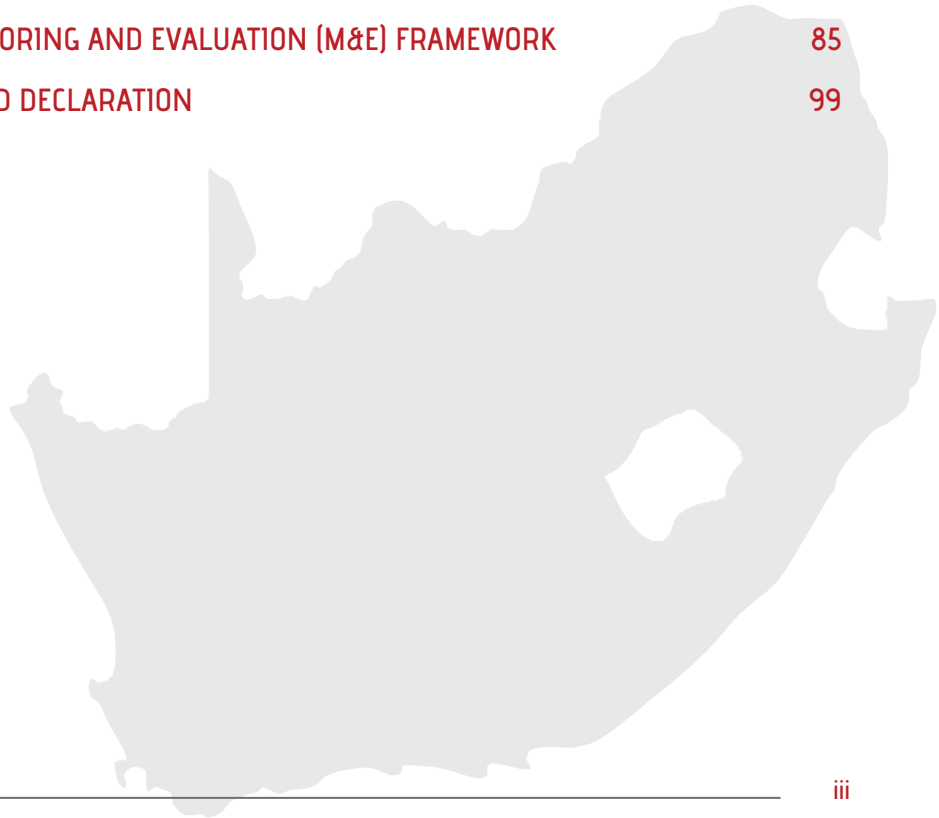
REPUBLIC OF SOUTH AFRICA

2030 NDP

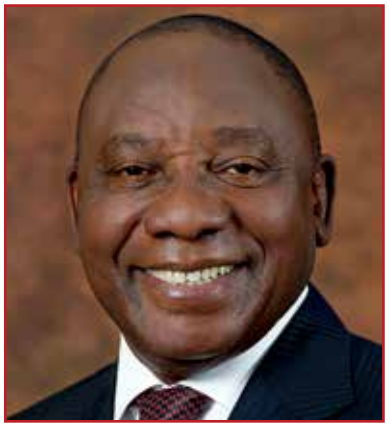
2nd PRESIDENTIAL HEALTH COMPACT 2024-2029


2nd
PRESIDENTIAL
HEALTH SUMMIT
2023
2nd
HEALTH SUMMIT

TABLE OF CONTENTS



MESSAGE FROM THE PRESIDENT



PRESIDENTIAL HEALTH COMPACT

"Accelerating Health System Strengthening and National Health Insurance (NHI) Implementation."

Last year, I was honoured to address the Presidential Health Summit II with key stakeholders. Together, we have been tracking the progress of our health system's improvement and preparing our country to implement the National Health Insurance (NHI). Despite the challenges that remain, I am deeply inspired by the collective efforts of the government and these stakeholders. Your dedication and hard work have been instrumental in upgrading our health system, and I am proud to be a part of this journey with you.

One of the most inspiring aspects of our progress is implementing the national health quality improvement plan. This initiative has led to the establishment of more than 420 quality learning centres covering over 3,500 health facilities. As a result, we have seen significant improvements in patient satisfaction across various areas.

These improvements are not just numbers; they represent real, positive changes in the lives of South Africans. Patients are now experiencing better access to care, essential medicines are more readily available, and health facilities are state-of-art, cleaner and safer. The positive changes in values and attitudes, along with reduced waiting times, have collectively enhanced the overall patient experience. This is a testament to our shared commitment to improving healthcare in our country.

We have excellent examples of healthcare facilities ready to deliver high-quality healthcare. Notably, the Nuclear Medicine Research Infrastructure at Steve Biko Academic Hospital, staffed by highly competent professionals, showcases our commitment to excellence in healthcare. Additionally, the opening of the Dr. Pixley Ka Isaka Seme Memorial Hospital in KwaMashu, a regional high-technology hospital with specialists, marks another significant milestone. The government has also been able to revamp the much-criticized Mamelodi Regional Hospital, giving it a facelift and transforming it into a state-of-the-art facility akin to the Dr. Pixley Ka Isaka Seme Memorial Hospital. Many other hospitals are undergoing similar upgrades, ensuring they meet the highest standards of care.

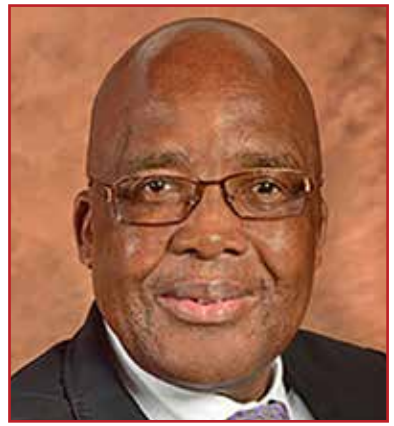
With Parliament passing National Health Insurance into law, it is now crucial that we embark on this journey together to implement it, ensuring everyone can access quality healthcare in both the public and private sectors. Notably, compliance during inspections of clinics, hospitals, and community health centres has increased from 40% to over 75%. In re-inspections of hospitals, compliance has risen to 94%. All these have occurred in the two years since the program was introduced.

The success of the quality learning centres, the heartbeat of the national quality improvement program, is evident in their role in preparing clinics, hospitals, and community health centres for UHC implementation. Seeing the private sector actively participating in this program is also pleasing.

The stakeholders are not just observers but are integral to supporting the Department of Health in improving the health system. Your role is crucial in making the National Health Insurance program successful. We are counting on the Department of Health and all these stakeholders to continue their support. Together, we can ensure a healthier future for all South Africans. Your support is invaluable and greatly appreciated. Let us continue to build on this momentum, working collaboratively to overcome challenges and create a publicly funded, publicly and privately provided healthcare system that truly serves the needs of every individual in our country.

Matamela Cyril Ramaphosa
President of The Republic of South Africa

FOREWORD FROM THE MINISTER OF HEALTH



As the incoming Minister of Health, I am deeply appreciative of the comprehensive guidance contained in the second Presidential Health Compact as we push ahead with the implementation of the National Health Insurance (NHI). This document serves as a pivotal roadmap for our health sector, guiding our efforts to enhance the well-being of our citizens.

Recognizing the critical importance of a well-prepared workforce, we are prioritizing the revision of the Human Resources for Health Strategy and finance plan for the years 2024 to 2029. This will ensure that our health professionals are adequately trained, motivated, and equipped to meet the evolving health needs of our population. In our pursuit to secure health products, we are committed to strengthening local manufacturing through preferential procurement, regulatory harmonisation, and streamlining supply chain mechanisms. This strategy will not only enhance the availability of essential health products but also stimulate local economic growth.

Our dedication to innovative financing mechanisms for health infrastructure development remains unwavering. By leveraging public-private partnerships, we aim to develop robust health infrastructure that meets the highest normative standards, ensuring sustainability and quality.

As we roll out the NHI, we are fostering continuous public and private dialogue to explore feasible collaborative service delivery initiatives. This collaboration is vital to ensuring the alignment of standards and regulations, with Primary Health Care as the foundation. We will adopt patient-centric health care models, maintain a healthy and motivated workforce, and uphold a strong laboratory ecosystem. Quality improvement is the bedrock of successful NHI implementation. I am committed to ensuring that all contracting facilities meet the Office of Health Standards Compliance (OHSC) requirements as part of the National Quality Improvement Plan. This commitment underscores our focus on delivering high-quality health services.

With over 8% of the Gross Domestic Product spent on health, our focus is on deriving value for money, promoting clean governance, eliminating corruption, and leveraging global financing instruments. To mitigate losses from litigation, we will pursue acceptable alternate dispute resolution mechanisms and make better use of the Health Sector Anticorruption Forum. Transparency and community engagement are crucial for building public trust. We welcome the call to increase the transparency of hospital boards and revive consultative forums as part of a robust community engagement programme.

We are also committed to advancing towards a world-class information system for health. This includes optimizing the Electronic Medical Record (EMR) system, enhancing the 2024-2029 Digital Health Roadmap, establishing a Digital Health Governance Framework, and promoting intelligent data use and capacity building.

Finally, to ensure resilience to health shocks, we commit to formalizing the coordination structures for Pandemic Prevention, Preparedness, and Response (PPPR). This includes establishing a national emergency operation centre supported by provincial centres, with a clear day-zero financing plan that is well coordinated and governed.

I look forward to working together with the Government of National Unity and all of society to implement the priorities laid out in the second health compact. I extend my gratitude to President Matamela Cyril Ramaphosa for his continued leadership in realizing health for all.

Dr Aaron Motsoaledi
Minister of Health

ACKNOWLEDGMENTS AND LIST OF CONTRIBUTING STAKEHOLDERS AND ORGANISATIONS

We extend our deepest gratitude to the President of South Africa, His Excellency, Matamela Cyril Ramaphosa, for his exceptional leadership in articulating the vision of National Health Insurance during the second Presidential Health Summit in May 2023. His guidance and vision have been instrumental in shaping our collective efforts to prepare the health system for the implementation of the National Health Insurance. We also appreciate the contribution of all participants of the second Health Summit for their pivotal role in this process. The dedication and insight of the National Department of Health and these key stakeholders have significantly enhanced our collective efforts in drafting the second Presidential Health Compact.

Special appreciation is directed towards the contributors for their detailed and expert write-ups in the areas of human resources for health; improvement of access to medicines; implementation of the infrastructure plan; engagement with the private sector; improving the quality of the health care system; enhancing financial management systems; community engagement; development of an information system; and finally establishing an initiative to ensure Pandemic Prevention, Preparedness, and Response. We have edited and finalised the Second Presidential Health Summit Report and integrated the monitoring and evaluation system that all stakeholders including the Departments of Health and Planning, Monitoring and Evaluation (DPME) developed, meticulously blending and refining all information. We extend our deep appreciation to the pillar leads for coordinating the inputs to ensure a successful process.

Further, we are grateful to the Department for its thorough report on progress toward attaining the targets set in 2018, including candid assessments of areas needing improvement. Their contributions to the report's preparation have been invaluable. Our acknowledgement extends to the health professionals, community representatives, academic sectors, statutory bodies, patient user groups and the private sector, whose ongoing commitment enriches our health system as we implement the National Health Insurance Act no 20, 2023.

Dr. Lwazi Manzi

Dr. Thulani Masilela

Dr. Olive Shisana, Hon Professor

Finally, we recognise the World Health Organization for its pivotal role in finalising and distributing the document. Their meticulous work in preparing the document for printing, ensuring its quality, and widespread distribution has been invaluable in our efforts to share this important information.

Looking forward, we remain hopeful and enthusiastic about the continued engagement of all stakeholders in achieving the ambitious targets outlined in the Presidential Health Compact over the next five years. Together, we are committed to a healthier future for all as we implement the National Health Insurance.

PILLAR LEADS

Pillar 1
Dr Mathabo Hlahane

Pillar 2
Prof. Nicholas Crisp
DDG NHI

Pillar 3
Mr Christoffel Engelbrecht

Pillar 4
Dr. Stavros Nicolaou

Pillar 5
Dr Sizeka Maweya

Pillar 6
Mr. Fareed Abdulla

Pillar 7
Mr. Mogologolo Phasha

Pillar 8
Mr. Mabalane Mfundisi

Pillar 9
Dr. David Kabane

Pillar 10
Dr. Lwazi Manzi

Cross Cutting Patient User Groups
Ms. Lauren Pretorius

Secretariat
Ms Ayanda Zwane
Presidency

ABBREVIATIONS

ACFTA	Africa Continental Free Trade Agreement
ADR	Alternative Dispute Resolution
Africa CDC/ ACDC	Africa Centres for Disease Control and Prevention
AG	Auditor General
AIDS	Acquired Immune Deficiency Syndrome
ASCM	Association of Supply Chain Management
AU	African Union
AVMA	African Vaccine Manufacturing Accelerator
BI	Business Intelligence
BUSA	Business Unity SA
CEHS	Continuity of Essential Health Services
CHE	Council on Higher Education
CHW	Community Health Workers
CSI	Corporate Social Investment
CUP	Contracting Unit for Primary Health Care
DCST	District Clinical Specialist Team
DDM	District Development Model
DEL	Department of Employment and Labour
DHET	Department of Higher Education and Training
DHIS	District Health Information System
DPME	Department of Planning, Monitoring and Evaluation
DPWI	Department of Public Works and Infrastructure
DRG	Diagnosis-Related Group
DSI	Department of Science and Innovation
DTIC	Department of Trade Industry and Competition
EC	Eastern Cape
EML	Essential Medicines List

EOC	Emergency Operations Centre
EVDS	Electronic Vaccination Data System
FIDPM	Framework for Infrastructure Delivery and Procurement Management)
FS	Free State
G20	Group of 20
GAVI	The Global Vaccine Alliance
GCIS	Government Communication and Information System
GDP	Gross Domestic Product
GISRS	Global Influenza Surveillance and Response System
GP	Gauteng Province
GS1	GS1 Barcode
HASA	Hospital Association of South Africa
HCW	Health Care Worker
HEPR	Health Emergency Preparedness and Response
HFRG	Health Facility Revitalisation Grant
HIE	Health Information Exchange
HIV	Human Immunodeficiency Virus
HMI	Health Market Inquiry
HNSF	Health Normative Standards Framework
HPCSA	Health Professionals Council of South Africa
HPRS	Health Patient Registration System
HRH	Human Resources for Health
HSACF	Health Sector Anticorruption Forum
HTA	Health Technology Assessment
ICU	Intensive Care Unit
IDSM	Infrastructure Delivery Management System
IDSR	Integrated Disease Surveillance and Response

ABBREVIATIONS

IHR	International Health Regulations
IMT	Incidence Management Team
IPC	Infection Prevention and Control
ISHPs	Independent Sector Healthcare Providers
JSOC	Joint Strategic Oversight Committee
KZN	KwaZulu Natal
LCBO	Low-Cost Benefit Option
LMIC	Low to Middle Income Countries
LP	Limpopo
MDT	Multidisciplinary Teams
MEC	Member of the Executive
MHFL	Master Health Facility List
MP	Mpumalanga
MTEF	Medium Term Expenditure Framework
NAPHISA	National Public Health Institute of South Africa
NATJOINTS	National Joint Operational and Intelligence Structure
NC	Northern Cape
NCD	Non-Communicable Disease
NCP	National Coronavirus Partnership
NDOH	National Department of Health
NDVP	National Deployment and Vaccination Plan
NHA	National Health Act
NHC	National Health Council
NHI	National Health Insurance
NHISSA	National Health Information System of South Africa
NHLS	National Health Laboratory Services
NIDS	National Indicator Data Set
NQIP	National Quality Improvement Plan
NW	Northwest Province
OHS	Occupational Health and Safety
OHSC	Office of Health Standards Compliance
OSD	Occupation Specific Dispensation
PEC	Patient Experience of Care
PFMA	Public Finance Management Act
PHC	Primary Health Care
PHECS	Public Health Emergency of Continental Security
PHEF	Public Health Enhancement Fund
PHEIC	Public Health Emergency of International Concern
PHSM	Public Health and Social Measures
PLWHIV	People Living With HIV
POPIA	Protection of Personal Information Act
PPP	Public Private Partnership
PPPR	Pandemic Prevention, Preparedness and Response
PRET	Preparedness and Resilience of Emergency Threats
RCCE	Risk Communication and Community Engagement
RWOPS	Remunerative Work Outside of Public Service
SACOMD	South African Committee of Medical Deans
SAHPRA	South African Health Products Regulatory Authority
SAICE	South African Institution of Civil Engineering
SALRC	South African Law Reform Commission
SAPICS	The Professional Body for Supply Chain Management
SAQA	South African Qualifications Authority
SDG	Sustainable Development Goals
SEIAS	Socioeconomic Impact Assessment System
SEP	Single Exit Price
SETA	Sector Education and Training Authority

ABBREVIATIONS

SIPS	Scope and Influence of Procurement and Supply
SLA	Service Level Agreement
STI	Sexually Transmitted Infections
TB	Tuberculosis
THE	Total Health Expenditure
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
WASH	Water Sanitation and Hygiene
WBOT	Ward Based Outreach Teams
WBPHCOT	Ward Based Primary Health Care Outreach Team
WC	Western Cape
WHO	World Health Organization

LIST OF SUMMIT PARTICIPANTS

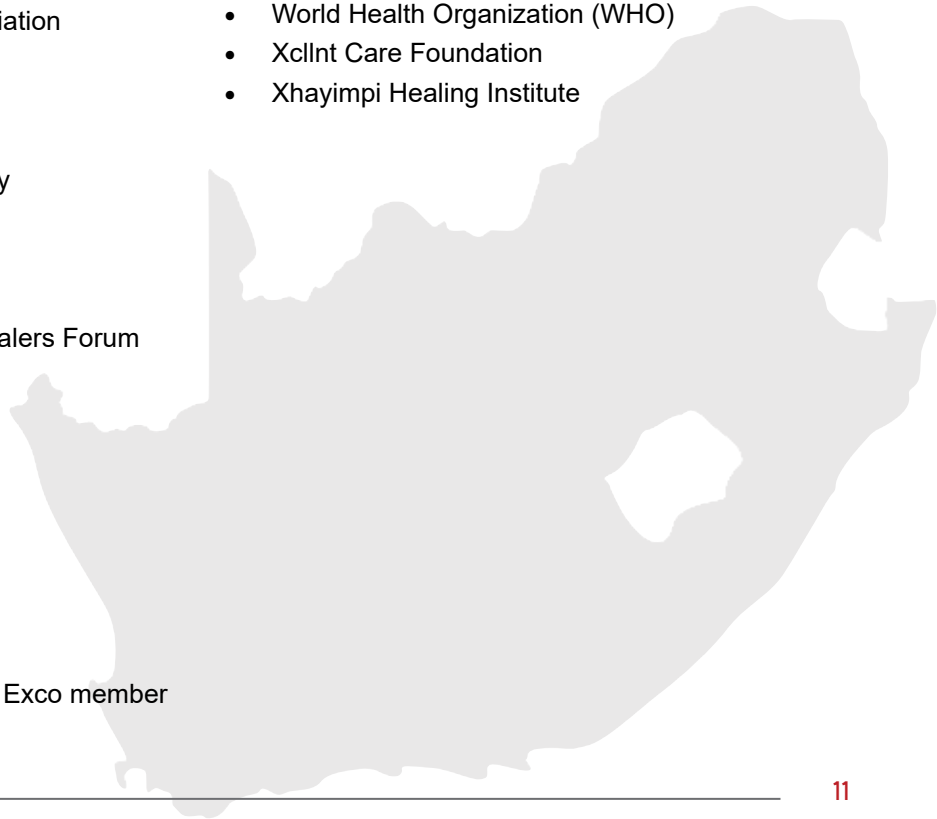
- Nursing Education Association (NEA)
- Abbott Point of Care Division
- Acino
- ADSA
- African National Congress
- African Union COVID-19 Commission
- Alliance for Science
- AlternativeFutures
- APHA
- Aquity Innovations
- ASSA
- Astellas Pharma Pty Ltd
- Astrazeneca
- Aurora Medical Group
- Bhekisisa Centre for Health Journalism
- BMGF
- Board of Healthcare Funders (BHF)
- Bonitas
- Boxfusion Healthcare (Pty)Ltd
- Business Day
- Cape Peninsula University of Technology
- Chairperson Ministerial Advisory Committee mental health
- Chamash Pharmacy
- CHIROPRACTIC ASSOCIATION OF SOUTH AFRICA
- Chris Hani Institute
- Cipla
- Cipla Pharmaceuticals
- Clinton Health Access Initiative (CHAI)
- CMSA
- COSATU
- Council for Medical Schemes
- CSF Cape Metro, THP Chairperson
- DENOSA (Democratic Nursing Organization of S.A)
- DENOSA/University of Pretoria
- Department of Health - KZN
- Department of Health: NHI
- Department of Planning Monitoring and Evaluation
- DGMAH
- DGMT - KeReady
- Diabetes South Africa
- Discovery Health
- Discovery Health Medical Scheme
- DKMS Africa
- Doctors Without Borders
- DPME
- Dr KK District AIDS Council
- DSV Healthcare
- EAPA SA
- Eastern Cape Department of Health
- Eco Girls SA
- EMS
- Epilepsy South Africa
- EU Delegation to South Africa
- Excellent 2030 Projects
- Face of Tshwane Ambassador NPO
- Faculty of Health Sciences Durban University of Technology
- FEDUSA
- Femmepower_rsa
- FPNL Dr Alberts Bouwer Jordaan Oncology
- Gauteng ANC Health Subcommittee
- Gauteng Department of Health and Wellness
- Gauteng Office of the Premier
- GCIS
- GDoH
- GDOHW
- GE Healthcare
- Generic and Biosimilar Medicines of SA
- German International Cooperation (GIZ GmbH)
- Government communications and Information systems
- Grow Great
- Haleon
- Hartbeesfontein Pastors Ministries Fraternal
- Health
- Health Cover
- Health Professions Council of South Africa
- Hedley Lewis
- Homeopathic Association of South Africa (HSA)
- Hospital Association of South Africa (HASA)
- HPCA - Hospice Palliative Care Association
- HPCSA
- Human foundation
- IHealth Clinics
- Imperial Health Sciences

LIST OF SUMMIT PARTICIPANTS

- Independent Community Pharmacy Association (ICPA)
- Innovative Pharmaceutical Association of South Africa
- iNova Pharmaceuticals
- IPASA
- JJ BRITZ ORTHOTICS & PROSTHETICS
- Joint Medical Holdings Proprietary Limited
- Jozi Captions
- Khula Natural Health Centre NPC
- KZN Department of Health
- Lenmed
- Leo Rex
- Life Healthcare Group
- Lifeline South Africa
- Lupus Foundation of South friva
- Médecins Sans Frontières /Doctors Without Borders Southern Africa
- Medicine Pricing NDOH
- Mediclinic
- Member IMASA. /private
- Ministry of Health
- Mpumalanga Department of Health
- MRA Regulatory Consultants
- MSD (Pty) Ltd
- MSD Pty Ltd
- MSF - Doctors Without Borders
- Nactu
- Nactu
- National Assembly - Parliament SA
- National Health Laboratory Service
- National Health Research Committee (NHRC)
- National Institute for Communicable Diseases
- National Planning Commission
- National Unitary Professional Association for African Traditional Health Practitioners of South Africa
- NEHAWU
- Nelson Mandela University
- News 24
- NEWS CENTRAL TV
- NHLS, CMSA and UP
- NICD
- North West Department of Health
- Novo Nordisk
- NUFBWSAW
- Numolux Group
- NUPAATHPSA
- NUPAATHPSA (National Unitary Professional Association for African Traditional Health Practitioners of South Africa)
- NUPAATHPSA (THP)
- NUPAATHSA
- NUPAATHSA Western Cape
- NUPPASA
- NUPTHOSA
- Nutrition Society of South Africa
- NW DEPARMENT OF HEALTH
- Oethmaan Biosims
- Office of Health Standards Compliance (OHSC)
- Ophthalmological Society of South Africa
- OSSA - Ophthalmological Society of South Africa
- OTASA
- PatchSA, UCT, Paedspal
- PATH
- People's health Movement
- Pfizer
- Pharmaceutical Logistics association of South Africa (PLASA)
- PHARMISA
- PinkDrive NPC
- PLASA (Pharmaceutical Logistics Association of South Africa)
- Police and prisons civil right union
- Polmed and BHF
- POPCRU
- PPF
- Premier of Gauteng
- Private
- Private
- Project Last Mile
- QIAGEN
- Rare Diseases South Africa
- Rare Diseases South Africa & PKDSA
- Reach Digital Health (previously Praekelt.org)
- Regulatory for Africa
- RETINA SOUTH AFRICA
- Right to care
- Rural Health advocacy project

LIST OF SUMMIT PARTICIPANTS

- Rural Rehab South Africa
- SA Depression and Anxiety Group (SADAG)
- SA Federation for Mental Health
- SA Non-Communicable Diseases Alliance
- SAEPU
- SAHPRA
- SALDA
- SAMATU
- SAMED
- SAMRC
- SANAC
- SANAC FAITH SECTOR
- SANDA
- SATAWU
- Security services
- Show Me Your Number HIV Prevention NPC
- SIU
- Smile Foundation
- SMU/DGMAH
- South African alliance of Healthcare Professionals
- South African Alliance of Healthcare Workers ; ADTF; SADTA;;Public Health Association of SA
- South African Clinical Technology Association
- South African Clinical Technology Association (SACTA)
- South African Dental Technicians Council
- South African Institute of Environmental Health
- South African institute of Medicolegal experts
- South African Medical Research Council
- South African National Council for the Blind
- South African Nursing Council
- South African Pharmacy Council
- South African Red Cross Society
- South African Society of Physiotherapy
- Special Investigating Unit
- Spotlight
- Suppple.ORG
- TalkAfrica
- Telemedicine Africa PTY LTD
- The Presidency
- The South African Medical association
- THO
- Thpo
- Tshwane Deaf Association
- Tshwane University of Technology
- Tweelaagte mine company
- U.S. CDC
- U.S. Embassy - PEPFAR
- Ubombam Luvuyo Traditional Healers Forum
- UNAIDS
- UNICEF
- UNISA
- United Nations RCS
- University of Cape Town
- University of Fort Hare
- University of Pretoria
- University of Pretoria/SACOHSD
- University of Pretoria/SACOHSD Exco member
- University of South Africa
- University of the Free State
- University of the Witwatersrand
- University of Venda
- USAID SA
- UWC
- WCGH&W
- Western Cape Department of Health & Wellness
- Wits centre for palliative
- Wits School of Public Health
- World Health Organization (WHO)
- XcIInt Care Foundation
- Xhayimpi Healing Institute




2nd
PRESIDENTIAL
HEALTH SUMMIT
2023
Strengthening

EXECUTIVE SUMMARY

In 2019, President Cyril Ramaphosa launched a Presidential Health Compact, which outlined a nine-pillar plan of action emanating from the Presidential Health Summit of 2018 to address the pervasive challenges that plagued the South African Health System:

1. Augment Human Resources for Health Operational Plan.
2. Better management of supply chain equipment and machinery can ensure improved access to essential medicines, vaccines, and medical products.
3. Execute the infrastructure plan to ensure adequate, appropriately distributed, well-maintained health facilities.
4. Engage the private sector in improving health services' access, coverage and quality.
5. Improve health services' quality, safety, and quantity, focusing on primary health care.
6. Improve the efficiency of public sector financial management systems and processes.
7. Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels.
8. Engage and empower the community to ensure adequate and appropriate community-based care; and
9. Develop an information system to guide the health system's policies, strategies, and investments.

Implementation of the Compact Pillars began in earnest in 2019. However, no one could have anticipated that the Director General of the World Health Organisation would declare SARS-COV-2 (COVID-19) a Public Health Emergency of International Concern (PHEIC) on 30 January 2020. Even beyond the end of the PHEIC on 5 May 2023, the disruptive effects of the global COVID-19 pandemic continue to reverberate, and the Health Compact was not spared the upheaval.

Nevertheless, stakeholders continued to work collaboratively with the government to attain many of the objectives laid out in the first compact, calling for a mid-term assessment of the action plan, which took the form of the Second Presidential Health Summit on 4 and 5 May 2023, indeed coinciding with the declaration of the end of the PHEIC. The second health summit convened over 1400 participants (750 in-person and 700 online attendants) representing various stakeholders from government, industry, private sector, academia, civil society, patient user groups, non-state actors and other key groupings. The theme of the Second Summit was Accelerating Health System Strengthening and National Health Insurance (NHI) Implementation.

In taking stock of the progress made since the Summit of 2018, stakeholders acknowledged the progress that has been made yet highlighted that the country still had much work to do to ensure the health system could successfully execute the obligations of the NHI framework. Stakeholders agreed on some key common themes, which included the need for expanded health workforce development and deployment, addressing inequities, health systems strengthening and quality improvement, eliminating corruption, maladministration and incompetence and strengthening governance at national, provincial, district, ward, and facility levels. Stakeholders participated in breakaway sessions in their respective pillars to dive deeply into their thematic areas and unpack areas of advancements and opportunities for improvement, identify new and appropriate interventions and, where necessary, de-implement redundant or ineffective interventions.

1. Augment Human Resources for Health Operational Plan.

This pillar remains a priority, not least because of the devastating losses from the COVID-19 pandemic and the increasing pressure on the workforce due to the growing burden of disease, especially non-communicable diseases. However, the increasing health workforce demands face a shrinking fiscal environment, making absorbing and retaining the health workforce difficult for both the state and private sectors.

The stakeholders agreed that the policy frameworks for HRH were well developed and that the second health compact should focus on implementation towards growing a fit-for-purpose and compassionate workforce that could operate under the multidisciplinary team framework called for by the National Health Insurance. A key outcome from the first Compact was the publication of the 2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage in 2020, including the HRH Plan 2020/21 – 2024/25. Stakeholders agreed that, given that the strategy was developed before COVID-19 and that the plan ended in 2025, the top priority for the HRH pillar would be to revise the strategy and produce an HRH plan for 2023 to 2029. In the same vein, participants called for the finalisation of the draft Human Resource Regulations to support the implementation of the HRH agenda.

To build out the multidisciplinary teams, participants agreed that the NDOH, the Provincial Health Department and the Department of Employment and Labour would need to comprehensively map the current workforce to ascertain gaps and distribution across the landscape. Emphasis was placed on the absorption of community health workers as they are viewed as the bedrock of primary health care provision. To support this, the human resource information system needs to be strengthened. Finally, to regulate work outside of public office, the stakeholders agreed to review approvals and compliance with the RWOPS to ensure workers can give their best in public service.

2. Improve access to essential medicines, vaccines, and medical products by better managing supply chain equipment and machinery.

Participants were pleased with most of the progress made from the first Compact, noting that the evidence of South Africa's resilience in this thematic area was that medicine availability was maintained at over 85% of required stock during the COVID-19 pandemic with no major shortages reported. However, participants were acutely aware of the inequities experienced in accessing health and health-related products during the COVID-19 pandemic. They were also keen to ensure that equitable access to products for all, including vulnerable populations, is a non-negotiable with the national health insurance.

Another development that was cause for celebration is SAHPRA's maturity level three and maturity level four status for vaccines – this is key to SAHPRA's future status in the global reliance system – which will be critical for expediting market authorisation of new products.

Some of the objectives attained from the first Compact were the establishment of a centralised procurement and logistical management system with standardised procurement systems and processes at the national level; the establishment of the Health Technology Assessment (HTA) Technical Working Group I (inclusive of the private sector) which has developed a Health Technology Assessment Strategy and; the establishment of the joint support training programs to improve the supply chain skills amongst supply chain officials.

However, budgetary constraints, human resource capacity, the underdeveloped medicine data system, ageing medicine depot infrastructure, other logistical challenges, and misinformation about medicine availability continue to challenge access to medicines.

Stakeholders also identified the need to regulate non-pharmaceutical products by agreeing on a clear definition to guide the formulation of an Essential Equipment List to be regulated by SAHPRA.

Finally, stakeholders agreed that the sustainability of local manufacturing is imperative for national health security. However, without the government's political commitment to "Proudly South African," global competition will always threaten the industry. As such, they agreed that the government must implement measures to fully take advantage of PFMA provisions for preferential procurement of locally manufactured products.

To deal with the above-identified issues, stakeholders agreed to consider the following:

Firstly, to explore the feasibility of ring-fencing the provincial and national health products budget- a conversation that the National Health Council should engage. Secondly, they recommended that all health products be GS1 certified and have a single exit price. Thirdly, the NDOH should develop a concept paper for standard organisational structure for pharmaceutical

warehouses. Fourthly, when SAHPRA has refined the definition of medical products, including non-pharmaceutical products, the NDOH must establish a parallel system for managing non-pharmaceutical products with similar governance processes to those used for medicines. The fifth intervention by the RCCE unit in NDOH should address misinformation about the availability of medicines by tailor-making a communications campaign targeting communities and health journalists to provide language that accurately interprets the status quo of medicine availability. Finally, preferential procurement policies must be developed and adopted through an Intradepartmental Committee of the NDOH, DTIC, DSI and Treasury to sustain local manufacturing. To be globally competitive, pharmaceutical companies should produce 30-day packs.

3. Execute the infrastructure plan to ensure adequate, appropriately distributed, well-maintained health facilities.

The public and private sectors have significantly invested in South Africa's health infrastructure between 2019 and 2023. By the end of the 2023/ 2024 financial year, the public sector will have completed 55 projects, and the private sector will have completed 22 projects in the same period (details in the pillar 3 chapter).

However, there remains a significant financing gap (about 200 billion rand) to ensure the country's infrastructure can support NHI. The state cannot finance this gap; therefore, the main priority is to agree with the national Treasury on an innovative financing mechanism for health infrastructure development based on public-private partnerships.

Some contributors to the work that has been attained thus far include the NDOH reviewing and updating the 10-Year National Health Infrastructure plan, incorporating an interactive platform that provides health planning tools to facilitate integration between private and public sector health infrastructure planning. However, this progress has been marred by gross underperformance in conducting equipment audits, with only 66 facilities audited by 2022. Considering that the South African Institution of Civil Engineering has given most of the existing health facilities a "condition rating" of "D" (A being a world-class health facility and E being a facility that is no longer fit for purpose or use), this underperformance must be urgently corrected.

A key condition of successful infrastructure development is strict adherence to the Infrastructure Delivery Management System and the Treasury's Framework for Infrastructure Delivery and Procurement Management. As part of this, front-end loading or planning is a critical element, which can reduce the total design and construction costs by 20% and the total design and construction schedule by 39% compared to authorisation estimates. Participants emphasised the importance of using available tools and resources to facilitate IDSM and FIDPM adherence.

To avoid being overwhelmed by the need, participants suggested prioritising project portfolios given the fiscal constraints and recommended using utility curves, i-Labs, and the Project Readiness matrix as existing tools for impact assessments.

Finally, participants emphasised that the health infrastructure development remains guided by the National Quality Improvement Plan Core Standards, of which Facilities and Infrastructure defines the seventh domain.

4. Engage the private sector in improving health services' access, coverage and quality.

Pillar 4 participants began by examining success scenarios of public-private partnerships, such as the COVID-19 vaccine rollout and Solidarity Fund during COVID-19, the Public Health Enhancement Fund, which invested 300 million rands through pooled CSI funding to train and deploy over 100 medical doctors and 34 PhD candidates, and PPP infrastructure developments like the Inkosi Albert Luthuli Hospitals.

It was acknowledged that the private sector services 16% of the population with 4.2% of the GDP, while the state sector services 86% of the population with only 3.7%. Participants acknowledged that with the advent of NHI, the public and private sectors would need to cooperate to eliminate the persisting two-tiered health system and form one health system that delivers equitable health to all South Africans.

Some proposed strategies included establishing and institutionalising a platform for sustained public and private dialogue on feasible collaborative service delivery initiatives, particularly in the context of NHI, with a particular focus on aligning standards and regulations. An example was the Joint Strategic Organising Committee (JSOC) established to coordinate COVID-19 vaccinations.

Another critical recommendation is that the NDOH and BUSA must finalise the blueprint for public/private clinical collaboration using the SLA templates developed for COVID-19 to enable sustainable clinical collaboration between the public and private sectors. This will form the basis for standardising services for all facilities contracting with the NHI.

Pillar four stakeholders are keen to build on the work done through the PHEF; however, they cited several institutional and regulatory barriers that impeded PPP for health workforce development. As such, they recommend building on the Presidency's initial concept of an Intersectoral Committee on Health Workforce to ease the business of multisectoral collaboration for health workforce development, deployment, and retention.

Pillar four stakeholders also identified an increasingly litigious environment straining health financing in the private and state sectors. As such, they support the recommendation of the SA Law Reform Commission to resolve medicolegal disputes through alternative dispute resolution mechanisms and are encouraged to see that the legal system has placed increasing importance on this pathway as a key step in dispute resolution.

5. Improve health services' quality, safety, and quantity, focusing on primary health care.

As a people-centred measurement of health quality, stakeholders are encouraged to note that 85% of public health facility (hospital and clinic) users report a positive care experience in the latest Patient Experience of Care Surveys (2023). The push to implement the National Quality Improvement Plan, which saw 73% of public and private facilities implement the plan by the third quarter of 2023, may have been a key factor in this success.

However, the NHI demands all contracting facilities meet the Office of Health Standards Compliance (OHSC) requirements. OHSC should inspect facilities that are part of the National Quality Improvement Plan to be aligned with the introduction of NHI. In addition, losses to medicolegal action must be curbed to ensure that much-needed funds are not diverted away from financing quality health service delivery. Improve the efficiency of public sector financial management systems and processes. In March 2019, the National Treasury requested the Health Financing team investigate the nationwide medicolegal situation. However, this report is still pending. Even though actions have been taken to mitigate the ballooning medicolegal liability, this report must be delivered urgently to guide further action. However, the stakeholders are also aligned with the SALRC's recommendation to favour alternate resolution disputes. The SALRC further recommends that the provincial and national departments of health be firmer in adopting the Litigation Strategy developed by the Legal Forum in line with this recommendation.

Stakeholders also identified the need for enhanced intersectional collaboration as quality improvement is a multisectoral project. The NDOH has subjected 90% of the received draft policies, bills, and regulations to the DPME SEIAS process.

Issues of access for priority populations in the primary health care contexts have been studied, as well as cost. A costing report of the Preventative and Primary Healthcare Package was completed by March 2022. A phased implementation of the Preventative and Primary Healthcare Package is being recommended, pending submission to and approval by the Minister of Health.

Going forward, the second presidential health compact pillar five focus moves from generalised improvements in the healthcare system to preparing the healthcare system for the National Health Insurance (NHI). As such, pillar five stakeholders recommend a set of five rights-centred priority areas, which are unpacked in the relevant chapter:

- Developing and Aligning Regulatory Policies
- Improving Access to Healthcare, Focusing on Primary Healthcare Services
- Developing and Implementing Patient-Centric Healthcare Models

- Keeping the Health Workforce Healthy and Motivated
- Laboratory Strengthening

To maximise the attainment of these objectives, participants advise improving the approach to work by fundraising to support the pillar's work, creating a better coordination framework with the different pillars, and improving communication with stakeholders and the public.

6. Improve the efficiency of public sector financial management systems and processes

In 2024, health expenditures in South Africa will be approximately 8% of the GDP- which has slightly declined; by global standards this is considered a relatively high proportion of the national budget. Pillar 6 stakeholders have focused on deriving value for money, mainly due to fiscal constraints and budget cuts. The stakeholders focused on addressing persistent challenges in key aspects of financial management, manifested by repeated audits in almost all provinces and an average of 6 billion rands in irregular expenditure in each province, among other seriously concerning findings.

Accountability and health system performance at all levels stakeholders tabled a comprehensive set of ten strategic shifts, unpacked further in the pillar chapter, to prepare for budget cuts and ensure a more prudent attitude in the financial management culture. These changes include better planning of the health service platform, increasing both allocative and operational efficiencies, extracting more value for money and improving the management of finances, procurement, contracting, controls, and compliance.

Finally, considering the challenging fiscal forecast for the country and the world, the Treasury must work with experts in innovative financing to create the necessary regulatory environment for innovative financing instruments and a pathway for approvals of innovative financing transactions. Options like outcomes-based contracts, social impact bonds and debt for health swaps present an opportunity to build better value for money and a more significant impact on government expenditure and to increase the funding envelope by including funding from the private sector, donors and philanthropies that is fully aligned with government plans.

7. Strengthen Governance and Leadership to Improve Oversight.

In the 2018 summit, pillar seven stakeholders identified a number of troubling governance issues, mainly the pervasive heterogeneity of the governance landscape, which compromised standards and the ability to hold governors and leaders accountable. Compounding the issue of heterogeneity was the fact that data systems were fragmented and not standardised, making it difficult to assess the effects of governance frameworks and the people who were their custodians. In considering the progress made, they also reviewed some of the recommendations of the Health Market Enquiry Report and were concerned that the recommendations had been slowly implemented. However, there should be no blanket implementation of these recommendations without assessing the impact they would have on the NHI.

Although norms and standards governed some sectors of the health system, many of these were outdated or too open to interpretation, causing confusion among stakeholders.

The stakeholders also addressed fraud and corruption, submitting that the public and private health sectors were most vulnerable to fraud and corruption because of large and varied numbers of malicious transactions on goods and services. In this regard, an important success story was the launch of The Health Sector Anticorruption Forum in 2019, which has made excellent progress in identifying criminal activity in both the private and public sectors, culminating in the recovery of millions of rands, convictions, and disciplinary actions. The Forum has appealed for maximal engagement to utilise its capabilities fully.

The stakeholders were also concerned that implementing the Compact's resolutions would be easier with dedicated funding for the Presidential Health Compact. In preparing the budget, the NDOH should factor in the budget for the Compact.

To address these issues identified as part of the second Presidential Health Compact, pillar seven stakeholders have recommended the enhanced

use of the Health Sector Anticorruption Forum, the establishment of a National Health Commission to drive intersectional action, a review of the implementation of the Health Market Inquiry Report; that establishment of a coordinator that provides a direct line of communication between hospital boards and MEC's; and an executive leadership and governance programme as part of the National Health Council.

8. Engage and empower the community to ensure adequate and appropriate community-based care

The first Presidential Health Compact emphasised community engagement as a key determinant of good health outcomes at the community level.

Stakeholders had set out to ensure that every facility has a governance structure. Although the number of established hospital boards and clinic committees increased between 2019 and 2023, there is marked variation in the number and effectiveness of these structures year on year, and data are not available on this.

In addition, the pillar stakeholders are concerned that appointing boards and committees is politically driven and often takes too long, compromising the integrity and competencies of the governance structures.

Pillar stakeholders also cited the underrepresentation of patient user groups, vulnerable populations, and special groups, such as people living with disabilities, which meant that these issues were under-explored by the governance structures, and this was evident in the lack of care for vulnerable groups at the facilities.

Community engagement still needs improvement. Although Pillar 8 stakeholders had resolved to convene annually National and Provincial Consultative Forums on health with appropriate community engagement, only three provinces had convened these forums in 2019- Eastern Cape, Mpumalanga, and Western Cape. Since then, there have been no forums convened. National Consultative Forum has not been held as required by the law.

To address such challenges Pillar 8 stakeholders proposed that the Consultative forums be revived, that regulations governing the appointment of hospital boards and clinic committees be revised to reflect similar procedures for the appointment of school boards, that data systems are improved and streamlined, ensuring integration of community derived data. Diversion and inclusion should be operationalised in the casting of governance structures.

9. Develop an information system that will guide the health system's policies, strategies, and investments.

Pillar 9 witnessed remarkable progress in the digital transformation of information systems in the South African health system, achieving key objectives set forth in the first Presidential Health Compact. Notable advancements include:

- Implementation of the **Health Patient Registration System (HPRS)**, facilitating a streamlined patient identification and registration process across healthcare facilities
- The development and implementation of the **Electronic Vaccination Data System for COVID-19 (EVDS)** to record COVID-19 vaccinations. This was the first government developed system in healthcare used by both public and private sector
- Development and implementation of the **Master Health Facility List (MHFL)**, providing an updated inventory of health facilities to optimise resource distribution and planning
- Enhancement of **Data Centre hosting**, ensuring robust, secure data storage solutions that support the health information exchange
- The establishment of the **Health Information Exchange (HIE)** enabling seamless data sharing across health systems to support integrated care
- Development of the second iteration of the **Health Normative Standards Framework (HNSF)** and a comprehensive **Suite of Clinical Coding Recommendations,** standardizing health data for better analysis and decision-making

While these achievements have laid a strong foundation for a digitized health ecosystem, there remains much work to be done towards achieving a fully integrated health information system under the National Health Insurance (NHI) framework.

The COVID-19 pandemic highlighted the urgent need for enhanced, integrated disease surveillance that integrates data from various sectors including health, social development, home affairs, statistics South Africa, and other relevant departments and agencies.

To build on the initial successes and address some persistent challenges, the following strategic actions are planned:

- Accelerating the **Electronic Medical Record (EMR)** development: we will outline clear, actionable steps towards the development and national implementation of the EMR, detailing pilot testing, stakeholder engagement, and integration with existing platforms like the HPRS and EVDS
- Reviewing and enhancing the **Digital Health Strategy**: A comprehensive review of the existing Digital Health Strategy will be undertaken, incorporating insights from the pandemic response. This review will include public and stakeholder consultations to ensure the strategy meets current and future healthcare needs. The strategy will form the basis for the developing development of the 2024-2029 Digital Health Roadmap
- Establishing a **Digital Health Governance Framework**; A detailed governance framework will be developed to ensure digital health initiatives are accountable, patient data is protected, and systems are secure. This framework will align with broader health legislation and policy objectives around Digital Health
- **Promoting intelligent Data Use and capacity building**: Initiatives will be launched to enhance the use of health data in policy-making and clinical decision-making. This will include significant investment in training for healthcare workers and IT professionals on the use of digital health tools and data analytics

Engaging patients and healthcare providers will be crucial in the design and implementation phase to ensure the digital health solutions developed are user-centric and widely adopted. A robust Monitoring and Evaluation (M&E) framework will also be established to assess the impact of digital health initiatives, guide continuous improvement, and ensure alignment with the health system's broader goals.

By addressing these strategic areas, Pillar 9 aims to not only overcome existing challenges but also pave the way for a health information system that robustly supports the National Health Insurance's objectives and fosters a more efficient, equitable, and responsive healthcare system in South Africa.

Pillar 10 Pandemic Prevention, Preparedness and Response

South Africa played a leading role in the COVID-19 pandemic response at the global and regional and national levels. The President led the country through challenging times to respond to COVID-19.

The country co-chaired the Access to COVID-19 Tools Accelerator, a 24-billion-dollar WHO initiative to coordinate the global COVID-19 response strategy. In addition, President Ramaphosa was the chair of the African Union in 2020 when the PHEIC was declared, appointed as the AU Champion on COVID-19 in 2021 and reappointed as the Champion on Pandemic, Prevention and Respond in the AU Assembly of 2024.

South Africa's COVID-19 response strategy was characterised by a unique risk-adjusted, securitised approach that significantly diverted it from the normal healthcare business. In assessing the unique surge demands occasioned by the COVID-19 pandemic and the whole government, the whole of society strategy that was necessary to combat the pandemic, as well as the global and regional developments on pandemic preparedness, Health Compact stakeholders resolved to establish a tenth pillar that focused on pandemic prevention preparedness and response and that would align with regional and global policy and legal developments, like the Pandemic Agreement.

The Stakeholders began by drawing key lessons from the COVID-19 response and configuring a PPPR plan for an improved future response

that safeguards both lives and livelihoods. At the agenda's core is health systems resilience to public health shocks.

The interventions proposed are derived from the discussions during the Presidential Health Summit in May, the second Presidential Health Compact Pillar 10 Pandemic Preparedness webinar in July 2023 and the NDOH's draft Preparedness and Resilience to Emerging Threats: Planning for Respiratory Pathogen Epidemics (2023). They are aligned with the WHO's five core components of the WHO Health Emergency Preparedness and Resilience (HEPR) architecture and the Preparedness and Resilience for Emerging Threats (PRET) framework. The five system components of the PRET framework are:

- Emergency Coordination
- Collaborative Surveillance
- Access to Countermeasures
- Clinical Care
- Community Protection

Under this framework, there are eight key interventions proposed, which are:

1. The need to identify PPPR principles for South Africa to define a pandemic better and ensure clear and appropriate trigger mechanisms for declaring a disaster or public health emergency for the country.
2. A review of the lawmaking process during COVID-19 has been recommended to be carried out by a commission of enquiry to ensure that future lawmaking is more rational and does not need unnecessary socioeconomic harm.
3. Formalise the coordination structures for PPPR, including the establishment of a national emergency operation centre, ideally supported by provincial EOCs.
4. Ensuring day-zero financing mechanisms for pandemics that are well coordinated and governed.
5. Ensuring that there is a medical countermeasures platform that can guarantee equitable access to pandemic-related medical countermeasures.
6. Safeguarding the resilience of the health system to ensure continuity of essential health services by defining a non-negotiable compendium of care that must persist even in the most dire health emergencies.
7. Capacity building for surge health workforce deployment, including a financing plan, occupational protections and a scale-down plan to either absorb the workforce into the general health sector or redeploy to other countries or sectors.
8. Maintaining a robust risk communications and community engagement plan that builds trust in inter-pandemic times and can be intensified during a health emergency.

Conclusion

Participants in the second Presidential Health Summit all agreed that a concerted effort and dedicated financing would be needed to realise all the objectives of the second Presidential Health Compact and that fixing the health system in preparation for NHI was urgent.

There was a strong sense of solidarity as all stakeholders renewed their NHI pledge and committed to a collaborative approach to successfully implementing the Compact and NHI.

A. Presidential Health Summit 1

In 2019, President Cyril Ramaphosa launched the Presidential Health Compact. The Compact emanated from the first Presidential Health Summit (2018), which the President convened to address the wide-ranging and pervasive challenges in health service delivery across the country. The Summit marked a significant step towards addressing these challenges by bringing together a broad range of stakeholders who jointly formulated strategies to improve the country's healthcare system.

In summary, the stakeholders identified nine pillars under which a transformative plan would be undertaken to fix the health system and prepare it for the implementation of Universal Health Coverage:

1. Augment Human Resources for Health Operational Plan.
2. Ensure improved access to essential medicines, vaccines and medical products through better supply chain equipment and machinery management.
3. Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities.
4. Engage the private sector in improving health services' access, coverage and quality.
5. Improve the quality, safety, and quantity of health services, focusing on primary health care.
6. Improve the efficiency of public sector financial management systems and processes.
7. Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels.
8. Engage and empower the community to ensure adequate and appropriate community-based care; and
9. Develop an Information System to guide health system policies, strategies and investments.

One of the summit's significant outcomes was a renewed commitment to collaboration and partnership among all stakeholders involved in healthcare delivery. Participants acknowledged the importance of working together to address systemic issues and create a more efficient and effective healthcare system. This spirit of collaboration was seen as essential in tackling the sector's complex challenges.

A key area of focus during the summit was the importance of primary healthcare as the foundation of the health system. Participants emphasised the need to strengthen primary healthcare services to ensure all South Africans can access essential healthcare services close to their homes. This emphasis on primary healthcare was seen as crucial in promoting preventive health measures and reducing the burden on the healthcare system's more specialised and resource-intensive aspects.

Of the nine pillars, the need to address the human resource challenges in the healthcare sector emerged as a leading priority. Participants discussed strategies to attract, properly train and retain healthcare professionals and ways to ensure that healthcare workers are appropriately deployed to areas where they are most needed. This focus on human resources was seen as essential in improving healthcare service quality and addressing existing service delivery gaps.

Additionally, the summit highlighted the government's commitment to implementing the National Health Insurance (NHI). The NHI aims to provide Universal Health Coverage for all South Africans, regardless of their socio-economic status. Participants discussed the importance of this in achieving healthcare equity and ensuring that all citizens have access to high-quality healthcare services.

B. Background on the Presidential Health Summit-II and its objectives

On 4 and 5 May 2023, President Cyril Ramaphosa convened the Second Presidential Health Summit: Accelerating Health System Strengthening and National Health Insurance (NHI) Implementation.

In his keynote address, the President outlined his vision for a healthcare system "that is the world's envy; that is accessible, efficient, and effective in meeting the needs of all citizens."

The Summit-II convened a broad range of stakeholders in the health and social sciences sector, including labour, academia, civil society, the private sector, health service user constituencies, innovators, and captains of industry.

The Summit-II took stock of the progress made since the adoption of the Presidential Health Compact in 2018, assessing mitigating and aggravating factors that have affected the ability of the country to implement the determinations of the 2019 health compact. Whilst the participants acknowledged that progress was being made by implementing the nine pillars of the Compact, the global, regional, and national health landscape had experienced major disruptions that would demand significant strategic shifts to ensure that the country can regain its pathway towards attaining Universal Health Coverage by 2030, through the implementation of the National Health Insurance (NHI).

C. Why the need for a second compact?

2023 marks five years since the Presidential Health Summit of 2018 and seven years before South Africa's commitment to the United Nations to attain Universal Health Coverage by 2030.

Several factors rendered 2023 an opportune moment to take stock and reconfigure the roadmap towards the health system all stakeholders aspire to realise for South Africa:

a. The significant disruption but also novel opportunities occasioned by the COVID-19 pandemic.

b. The advancement of the NHI Bill in the National Assembly and the National Council of Provinces prompted scrutiny of the system's readiness to support the new health regime.

c. The significant shift of disease burden from predominantly infectious diseases to the increasing burden of non-communicable diseases.

d. The impact of climate change, which is driving the increasing frequency of outbreaks and the increasing burden of non-communicable diseases, thus putting further pressure on health systems and the health workforce that runs the systems.

e. We need to remain aligned with a dynamic global health diplomacy arena where new policies have been introduced, new lawmaking processes are underway, and health priorities are being reconfigured to respond to emerging disease trends while onboarding new health technologies.

As stakeholders project into the future, it is also important to consider the strides made in democratic history to leverage the institutional knowledge that has led to success. According to Statistics South Africa, some of the significant improvements in health outcomes between 1994 and 2022 include:

- Increase in life expectancy: Life expectancy has increased significantly since 1994, with males and females living longer on average
- Decline in infant mortality rate: The infant mortality rate has decreased over the years, indicating improved child health outcomes and better access to healthcare
- Reduction in HIV/AIDS prevalence and transmission: South Africa has made progress in the fight against HIV/AIDS, with a decrease in HIV prevalence and transmission rates due to improved treatment and prevention efforts
- Decrease in maternal mortality rate: Maternal mortality rates have declined, indicating improved maternal healthcare and access to antenatal and postnatal services
- Improved access to healthcare services: There has been increased access to healthcare services for the population, resulting in better health outcomes and reduced morbidity and mortality rates

However, the health system continues to face numerous challenges and disruptions in recent years, including the shortage of health workers, inadequate funding, and limited access to health facilities. These challenges have had a significant impact on the health status of the population, with South Africa being amongst the 50 countries with the highest death rates in the world (ranked 49th with a death rate of 9.4/ 1000 people per year)[1].

In terms of the prevalent diseases in South Africa, HIV/AIDS, STIs, TB, mental health disorders, and non-communicable diseases such as cancer, diabetes, hypertension, and heart diseases remain significant challenges. For its societal impact, the soaring teenage pregnancies mean we also have a lot of work to do for youth-friendly sexual reproductive health services. According to the South African National AIDS Council, an estimated 7.8 million people were living with HIV in South Africa in 2020, with approximately 84,000 AIDS-related deaths reported. In terms of TB, South Africa has the highest TB incidence rate globally, with an estimated 192,000 new cases in 2020. These contribute to South Africa ranking number 49 in mortality rate.

The COVID-19 pandemic has further highlighted the challenges that the South African health system faces. The country has reported over 2.8 million cases and approximately 83,000 deaths as of April 2023. The pandemic has significantly strained the healthcare system, resulting in further shortages of healthcare workers, hospital beds, and medical supplies.

The contents of this document outline, pillar by pillar, what has been achieved from implementing the first health compact, new opportunities that were leveraged along the way, persistent gaps and the root causes that need to be addressed, and some potential areas of redundancy that can be considered for de-implementation.

The second health compact provides a timely post-pandemic intervention to reconfigure a pathway towards the health-related SDG targets. It takes into account past successes, objectives that have been achieved, those that still require energy and investment, and innovative approaches that can catalyse accelerated action.

[1] https://worldpopulationreview.com/country-rankings/death-rate-by-country

D. Assessing South Africa's Health Status Against the WHO Six Building Blocks[2]

Regarding the WHO's six building blocks, South Africa's health system faces numerous challenges.

The first building block, service delivery, is hampered by a non-integrated two-tiered healthcare system comprising the public and private health sectors. The public sector caters to most of the population, while the private sector serves a smaller portion. However, the public sector needs to be more staffed, is under-resourced, and overcrowded, leading to longer waiting times and inadequate care. The state system experiences a further burden of servicing undocumented persons living in South Africa and absorbing the increasing number of documented persons, including citizens, that are no longer covered by the dwindling medical aid sector. Many health facilities provide excellent health care, which is reflected in the findings of the countrywide survey, which showed that the percentage of patients reporting a positive experience of care in the public sector increased from 76,5% in 2017 to 90% in 2022.[3] However, the Summit must acknowledge that the quality of care provided in some public health facilities is inadequate, leading to negative perceptions in the health system by the population.

The second building block, the health workforce, faces significant challenges in South Africa. The country has a shortage of healthcare workers, particularly doctors and nurses, and this has resulted in a high patient-to-healthcare worker ratio.[4] Furthermore, the public health sector needs to be better staffed, leading to long waiting times and inadequate care. During the COVID-19 pandemic, the government mobilised resources from the state's reserves to recruit many more workers, even from retirement and from abroad. However, there were few resources to retain them, and the demands on the health system continued to grow. What is of concern is the large number of unemployed nurses. Although the number of unemployed doctors is smaller, no health worker should be unemployed when there is a health workforce shortage. The major factor of this issue is the ability of the contracting fiscus to absorb and provide all occupational protections to the number of health workers required for the country.

The Summit heard that South Africa was working closely with Africa CDC Health Economics Programme to address this continental-wide issue in line with the AU's health workforce agenda under the New Public Health Order, which emphasises health workforce retention.

The third building block, health information systems, is an issue that South Africa is overcoming thanks to the leapfrogging initiatives that were occasioned by the COVID-19 pandemic as well as other policy directives like the 2021 National Normative Standards Framework for Interoperability in Digital Health. The country needed a centralised system for managing health data, which has resulted in fragmented data collection and analysis, leading to inaccurate health statistics. However, success is palpable here, and we got a taste of this with the Electronic Vaccination Data System. The Department of Health continues to progress with the Health Patient Record System, which has been introduced in 3 150 facilities with more than 60 million registered users and 35 million with ID verification. This will become the source of NHI users.

The fourth building block, medical products and technologies, is where South Africa has shown leadership both on the continent and in the world. The country has a well-developed pharmaceutical industry and access to medical products and technologies. However, access to these products and technologies is often limited to the private sector due to their high cost[5]. Despite the capacity of the pharmaceutical industry and a stringent regulatory authority (SAHPRA, which has recently attained maturity level three, confirmed by the WHO), the country faces challenges in medical products, vaccines, and technologies in supply chain management and procurement. Although the continent espouses the sustenance of local manufacturing under the New Public Health Order, this only sometimes translates at the bureaucratic level. The example of the NDOH issuing a tender to a non-South African supplier instead of a local pharmaceutical state-owned company highlighted policy malalignment. It led to a quadrilateral convening of the Departments of Trade and Industry, Treasury, Health and Science and Innovation to ensure policy alignment to secure the future of South Africa and Africa's pharmaceutical industry.

2 https://iris.who.int/bitstream/handle/10665/258734/9789241564052-eng.pdf
3 (Patient Experiences of Care (PEC) surveys, conducted annually from 2017 to 2022).
4 WHO Global Health Observatory Data Repository, 2020; National Health Workforce Accounts, 2021
5 Pharmaceutical Society of South Africa, 2021; WHO Global Health Expenditure Database, 2020)

The fifth building block, health financing, is typified by gross inequity, which poses a significant challenge and calls for a paradigm shift in health financing. The country's public health sector is underfunded, spending R271,9 billion to serve 85% of the population or 3,7% of GDP. In comparison, the private sector absorbs proportionately more from the fiscus at 4.2% of the GDP money for 15% of the population. This results in inadequate resources to provide quality care for all. The promulgation of the NHI Bill into law shall address this inequitable situation by creating a single-payer fund founded on the principle of social solidarity.

Finally, the sixth building block, leadership and governance, needs strengthening to address the challenges in South Africa. The country has a complex health system with multiple stakeholders, leading to inadequate coordination and accountability. Additionally, corruption in the procurement of healthcare services and medical products has been a significant challenge, further limiting access to quality care. The formation and launch of the Health Sector Anti-corruption Forum in 2019 was an excellent step in addressing endemic corruption- the forum has already made significant progress not only in assisting Chapter Nine institutions to claw back some losses due to corruption but also in preventing billions of rands being transacted irregularly or unlawfully.

E. The Second Health Compact as a Tool for Galvanising Accelerated Action

A health compact is necessary between the state and key stakeholders in health to ensure collaboration and coordination in achieving better health outcomes for the population. The state, as the main provider of healthcare services, cannot address all the health challenges on its own, and it needs the support of other stakeholders, including the labour, private sector, civil society organisations, and communities.

A health compact can establish a shared vision and goals for the health system and provide a framework for stakeholder collaboration. It can facilitate the development of evidence-based, inclusive, and transparent policies and strategies and ensure that resources are used efficiently and effectively. The Compact can also promote accountability by establishing clear roles and responsibilities for each stakeholder and monitoring and evaluating progress towards the agreed-upon goals.

Furthermore, a health compact can help to mobilise resources for the health system by engaging with the private sector and other stakeholders on innovative financing mechanisms, such as social impact financing bond facilities or public-private partnerships. It can also help to ensure that resources are allocated equitably, and that vulnerable and marginalised populations have access to quality health services.

Building on the 2018 Summit and the 2019 Compact, the overarching objective of the Presidential Health Summit-II is to identify sustainable interventions that would prepare the healthcare system for introducing National Health Insurance.

The specific objectives of the Presidential Health Summit II were to build the contents for the Second Presidential Health Compact by:

1. Conducting a review on the implementation of the interventions agreed to in 2018 and assessing the health system's performance against the Health Compact.
2. Conducting a review of the working operations of the Pillars, eliciting best practices and encouraging aligned, streamlined, standardised and more robust participation.
3. Identifying alternative, sustainable interventions to ensure that measures are in place to implement the mechanisms that have not yet been implemented to recover towards the targets not yet attained.
4. Assessing the readiness of the health system to implement NHI and identify urgent measures needed to recalibrate the system and accelerate the NHI reforms; and
5. Synthesising international experiences and shaping approaches for moving closer to NHI and building health systems resilience in the South African context.

The participants of the Presidential Health Summit II set out to achieve the following outcomes:

1. The stakeholder engagement and commitment are reinvigorated for joint efforts to accelerate the journey towards National Health Insurance (NHI).
2. Progress is assessed and documented on all nine pillars of the Compact against the set targets, and mechanisms are identified to address the

bottlenecks and scale up the enabling functions for attaining the Compact targets and milestones.

3. The lessons from the journey taken so far towards NHI and the COVID-19 response are synthesised, and stakeholder views are collated to outline urgent measures to recalibrate the system and accelerate the NHI reforms.
4. Acknowledge the unsustainable escalation of demand on the public sector and mobilising an all-of-society alignment (particularly with the private sector) towards the implementation of NHI.
5. Acknowledge the lack of growth and stagnant number of medical scheme beneficiaries over the past ten years and the evident sustainability risks. There is, therefore, an increased need to improve the effectiveness of regulation of private health sector funding through a revised Medical Schemes Act and Regulations.
6. Ensure alignment of minimum standards across the public and private sectors to correct current inequalities in health service delivery.
7. Create awareness of government intention to procure health services from all service providers under NHI- including NGOs and public and private providers.
8. An action-oriented, aligned, and well-articulated Report of the Presidential Health Summit-II with clear strategic priorities for accelerating the rollout of NHI and implementing initiatives for strengthening health systems and resilience is produced.
9. Strategic priorities in the Action Oriented Report of the Presidential Health Summit-II will also aim to guide the national health system towards the attainment of the health goals of the National Development Plan (NDP) 2030 and the Sustainable Development Goals 2030, noting that the period 2024-2029 is the last 5-year planning horizon before the endpoint of both the NDP and SDGs 2030.

One critical outcome of the second Compact is the addition of a tenth pillar: Pandemic Prevention, Preparedness and Response (PPPR). This pillar was deemed a necessity given the devastating disruption of COVID-19 to the first Compact's agenda. Additionally, South Africa is positioned in the leadership of the regional and global PPPR agendas, having been the co-chair of the Access to COVID-19 Tools Accelerator, the President being the AU Champion on COVID-19 and now taking a leadership role as part of the Pandemic Accord Negotiations, in replenishing the Africa Epidemic Fund and setting up a continental legal instrument for PPPR. Stakeholders, therefore, resolved that a pillar focusing on PR is not only a national health security imperative but also essential to ensure alignment with the regional and global policy direction.

F. Importance of stakeholder engagement and commitment to NHI implementation

Stakeholder engagement and commitment are essential for implementing the NHI in South Africa. By actively involving all stakeholders in the planning and decision-making processes, fostering a sense of ownership and accountability, and building stakeholder trust and commitment, the NHI program can achieve its goals of providing quality healthcare services to all citizens.

Stakeholders in implementing the NHI include the government, the private sector, labour, patients and patient user groups, civil society, industry (including the pharmaceutical industry), financiers, non-profit organisations, and various other groups. Each stakeholder plays a crucial role in ensuring the success of the NHI program.

The most compelling example of stakeholder engagement and commitment to the NHI is the robust democratic process that the NHI Bill was subjected to before its consideration at the National Assembly. The process saw over 11,500 attending stakeholders and individuals across 33 districts making submissions between 25 October 2019 and 24 February 2020. These were followed by virtual parliamentary hearings where at least 114 organisations or stakeholders presented oral and written submissions to Parliament[6] The subsequent adoption of the Bill at the National Assembly and referral to the National Council of Provinces was the first crucial step that acknowledged consensus among multiple stakeholders while continuing to build and refine the Bill's provisions. Following an even more robust process that concluded with the National Council of Provinces adopting the Bill, the Bill was referred to the President for Ascension into law.

Once the Bill becomes an act, all of society must be mobilised to enhance the prospects of its success.

[6] https://www.timeslive.co.za/sunday-times/opinion-and-analysis/opinion/2023-07-16-nhi-balancing-choice-and-the-public-good/

The government is responsible for creating an enabling environment and implementing policies that support the NHI; healthcare providers deliver quality and compassionate care to patients; patients use the services provided by the NHI; the Fund must be governed with integrity and transparency; insurance companies may provide complementary services, and non-profit organisations can offer support and advocacy, particularly at community level.

Effective stakeholder engagement is crucial to ensuring that all parties are aligned with the goals of the NHI program. By actively involving stakeholders in the planning and decision-making processes, their diverse perspectives and expertise can be leveraged to address challenges and improve the overall implementation strategy. This collaboration can lead to innovative solutions and foster a sense of ownership and accountability among stakeholders.

Stakeholder commitment is equally important for the successful implementation of the NHI. Healthcare providers need to be committed to providing high-quality care under the NHI, patients should be willing to engage with the program and adhere to treatment plans, and government officials must demonstrate long-term commitment to funding and supporting the NHI.

Moreover, stakeholder commitment can help build trust and confidence in the NHI program. When stakeholders actively participate in decision-making processes and see the positive outcomes of their involvement, they are more likely to remain engaged and committed to the program in the long term. This commitment can lead to increased collaboration, improved communication, and better outcomes for all involved.

G. Vision for the National Health Insurance (NHI)

The vision for the NHI is to ensure that every South African, regardless of their socio-economic status, has equal access to high-quality healthcare services without financial hardship.

The NHI aims to shift the country's healthcare system from being predominantly market-driven to one that is based on social solidarity and equity. Healthcare will be funded through mandatory contributions to a single public fund, which will be used to ensure that all citizens have access to a comprehensive package of health services, including prevention, promotion, treatment, and rehabilitation.

One of the fundamental principles guiding the NHI vision is the promotion of social equity and justice. The NHI seeks to address the disparities in access to healthcare services that currently exist in South Africa, with a particular focus on serving historically disadvantaged communities. By pooling resources and risk across the entire population, the NHI aims to ensure that healthcare is provided based on need, not on the ability to pay.

Another critical aspect of the NHI vision is emphasising delivering high-quality healthcare services to all citizens. Through the NHI and the National Quality Improvement Plan, the government aims to strengthen the public healthcare system by investing in infrastructure, equipment, human resources, and information systems. This will help ensure that healthcare facilities can meet the population's needs and that healthcare professionals are adequately trained and supported to provide excellent and compassionate care.

In addition to ensuring access to healthcare services, the NHI also aims to improve the overall health outcomes of the population. By focusing on preventative healthcare measures and promoting healthy lifestyles, the NHI seeks to reduce the disease burden in South Africa and improve the health and well-being of all citizens.

The NHI ultimately adheres to international best practices for attaining health security and driving economic growth. Countries like the United Kingdom, Canada, Singapore, Japan, Germany, Australia, New Zealand, South Korea, Taiwan and many others all attribute their economic growth from the 19th century onward in large part to their political decisions to introduce state-led single-payer systems that delivered universal health coverage for their populations.[7]

[7] https://www.valueinhealthjournal.com/article/S1098-3015(12)04152-6/fulltext

H. Pillar 1: Augment human resources for health (HRH)

The first health compact focused on policy reformations and governance restructuring to create an enabling environment for the augmentation of numbers and quality training of human resources in health. In this regard, the NDOH and pillar stakeholders have made progress.

As per the recommendations of the first Compact, the **2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage** was published in February 2020 and included an HRH Plan 2020/21 – 2024/25. Policies that facilitate the effective implementation of the national strategy continue to be developed and updated.

The first Compact also called for policy reforms that would urgently address some impediments to building a capable and fit-for-purpose workforce.

As a result of the policy reforms, the moratorium on further employment of all health workers was implemented, resulting in an additional 10,508 Health Care Workers being recruited by May 2022. Since then, up to the first quarter of 2024, thousands of health workers have been appointed in the state sector.

The Presidential Health Summit Committee reviewed the HRH governance arrangements across spheres of government to ensure compatibility with the NHI policy and Bill. The need to meet statutory requirements for internship and community service was emphasised, and this policy directive has ensured that, notwithstanding funding challenges that have caused delays at times, all interns and community service practitioners who wish to practice are placed in the health care system each year.

South Africa has demonstrated the wherewithal to implement a surge in HRH response to health emergencies. During the COVID-19 pandemic between 2021 and 2022, pandemic surge capacity was supported through the Presidential Employment Stimulus package and COVID-19 response funding to employ nearly 33,000 health workers. In addition, The Department of Public Works contributed substantially to a 60,000-strong community health worker deployment for community screening and testing at the onset of the COVID-19 pandemic.

Finally, as part of the resolution to track equity in the distribution of Human Resources for Health between Provinces and Districts (in both public and private sectors), the processes of HRIS (Human Resources Information System) institutionalisation, program transition and monthly data updates have been sustained to institutionalise health workforce accounts and Report on equity in the provision of HRH across provinces and districts.

The Human Resources for Health Division at the NDOH continues to be stabilised. Since the first Compact, the government appointed a deputy director general in October 2022 and filled two new posts to capacitate the division further.

H.1. Strategies and commitments to address HRH challenges

Having strengthened the policy frameworks and the HRH division, the second Compact will focus on creating opportunities for continued monitoring, informed implementation, and action. As the Human Resources Strategy has reached the end of its prescribed period, the National HRH strategy needs to be revised to ensure a policy framework that supports the implementation of NHI and accommodates surge deployments during health emergencies.

Some of the challenges that will need to be overcome include:

- A persisting health workforce gap
- Fostering a multistakeholder approach to the issues of HRH
- Resource mobilisation and innovative financing in the face of a contracting fiscal space
- Sustaining a robust monitoring and feedback mechanism
- Addressing the maldistribution of the health workforce to ensure adequate coverage in rural and hard-to-reach populations
- Addressing the gaps in information systems
- Addressing policy uncertainty regarding Community Health Workers
- Eliminating siloed operations
- Cultivating the multidisciplinary team approach, particularly as the country prepares for the implementation of the National Health Insurance

H.2. Proposed Interventions for the Second Health Compact: 2024-2029

The HRH agenda will be action-driven and underpinned by the philosophy of multistakeholder, multisectoral, and multidisciplinary collaboration. All Compact pillars should be considered integral components of the HRH agenda. The HRH strategy will be guided by contemporary evidence to align with service needs and packages, ensuring responsiveness to the needs of health service users and communities. A direct causal link must be established between a capable, fit-for-purpose health workforce and good health outcomes at the population level. To advance these ambitions, the critical resolutions of the second health summit are:

1. Determined action towards the equitable distribution of skilled health providers: the pillar shall facilitate a distributional analysis of the health workforce by the district to provide evidence for strategies that work to attract and retain HRH in various settings, including rural and under-served areas.
2. Implement existing regulations and policies on occupational health, wellness, and safety to prioritise the health (especially mental health) and well-being of the health workforce.
3. The relevant stakeholders (NDOH, provincial health departments, Department of Labour; organised labour formations, etc.) to convene and revisit the framework on the integration of community health workers into the formal health workforce, fully appreciating that any outcomes of such a process will need to be reconciled with existing developments in the PHSDSBC (Public Health and Social Development Sectoral Bargaining Council).
4. Implement a comprehensive HRH information system by recruiting the necessary expertise and resources. As a low-hanging fruit, NDOH may oblige health professions councils to collect minimum information at annually registration, e.g. classify practice location (urban/rural).
5. Improve management and monitoring of Remuneration for Work Outside of the Public Sector for public sector employees as an indicator of performance and efficiency. This includes annually reporting by provincial health departments on approvals, compliance, etc. and a possible review and revision of the policy based on evidence.

H.3. Role of HRH in achieving NHI Goals

The National Health Insurance Bill's provisions call for a multidisciplinary team approach across the entire value chain of health service provision—from governance, standards, and administration to patient-facing care and post-care services. Of particular note, section 37 of the Bill warrants that a Contracting Unit for Primary Health Care 37 (established in terms of section 31B of the National Health Act "is the preferred organisational unit with which the Fund contracts for the provision of primary health care services… such as prevention, promotion, curative, rehabilitative ambulatory, home-based care and community care in a demarcated geographical area." This further highlights the importance of a multidisciplinary team approach

Multidisciplinary teams are crucial in the context of the National Health Insurance for various reasons:

1. Comprehensive Care: Different healthcare professionals from various disciplines bring diverse expertise, allowing for a more holistic approach to patient care. Collaboration among professionals ensures comprehensive care that addresses all aspects of a patient's health.
2. Better Health Outcomes: Multidisciplinary teams can lead to better patient health outcomes[9] due to their combined expertise and shared decision-making. By pooling their knowledge and skills, team members can develop more effective treatment plans tailored to patients' needs.
3. Efficiency and Cost-Effectiveness: Multidisciplinary teams can optimise resources and reduce redundancy in healthcare services. By coordinating care and streamlining communication among team members, unnecessary procedures and treatments can be minimised, leading to long-term cost savings.
4. Patient-Centered Care: Collaboration among different healthcare professionals ensures that the patient remains at the centre of care delivery[8] by involving patients in decision-making and treatment planning, multidisciplinary teams can provide personalised care that addresses each individual's unique preferences and needs.
5. Addressing Health Inequalities: In a country like South Africa with diverse health challenges and disparities, multidisciplinary teams can help address health inequalities by promoting access to quality healthcare services for all population groups[9]. This approach can help bridge the gaps in healthcare provision and improve health outcomes nationwide.

[8] https://www.jmirs.org/article/S1939-8654(16)30117-5/pdf
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6664355/

H.4. PILLAR ONE: MONITORING AND EVALUATION TOOL

PILLAR 1: AUGMENT HUMAN RESOURCES FOR HEALTH (HRH)

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Review of the National HRH Strategy and development of an HRH Financing Plan	Review the National HRH Plan and produce a revised plan for 2024-2029	Revised HRH Plan 2024-2029 produced	June 2025	NDOH	Provincial Departments of Health (DoHs) Department of Employment and Labour (DEL) Private Sector Organised Labour
	Review the National HRH plan and produce a revised plan for 2024-2029	HRH Financing Plan produced	March 2026		
Strengthen the Human Resources Information System (HRIS) to effectively monitor and survey the state of HRH	Design a reporting function in the HRIS to produce an annual report (or more frequent reports if required) on progress and gaps in the production, equitable distribution, management and development of HRH	Annual Report outlining progress and gaps in the production, equitable distribution, management and development of HRH	Annual HRH Reports produced, from December 2024	NDOH	Provincial DoHs DPSA
Finalisation and implementation of a revised policy on Remunerated Work Outside the Public Service (RWOPs)	Review the current RWOPs policy Develop and table before the National Health Council a revised RWOPs policy	Revised RWOPs policy approved by the National Health Council	June 2025	NDOH	Provincial Health Departments DPSA
	Institutionalise a system of annual reporting by Provincial DoHs on RWOPs	Number of provinces producing annual reports on approvals and compliance with RWOPs	All 9 Provinces annual, from September 2025	NDOH	Provincial Health Departments DPSA
Implementing, monitoring and reporting on existing regulations and policies on occupational health, wellness, and safety	Institutionalise a system of annual reporting by Provincial DoHs on existing regulations and policies on occupational health, wellness, and safety	Annual Report on the State of Occupational Health, Wellness and Safety	All 9 Provinces annual, from September 2025	NDOH	Provincial Health Departments DEL Organised labour

1. Pillar Two: Improved access to essential medicines, vaccines, and medical products through better supply chain management

I.1. Evaluation of supply chain management challenges

The collective efforts of stakeholders to implement the recommendations of the first compact have yielded green shoots in the pillar two agenda. A proud legacy that can be built on is the evident resilience of pharmaceutical supply chains during the COVID-19 pandemic, with medicine availability being maintained above 85% and no major shortages reported.

Several interventions have been made since the first compact was adopted in 2019, leading to some key areas of progress.

The NDOH has established a centralised procurement and logistical management system with standardised procurement systems and national processes for medicines and medical products. This resulted in Transversal contracts for medicines previously managed by the National Treasury being shifted to the NDOH, giving the country the best prices for antiretroviral medicines worldwide, which resulted in significant savings. The National Surveillance Centre has enabled interoperable supply chain information systems to enhance end-to-end medicine surveillance in the country.

The Director General of the NDOH established the Health Technology Assessment (HTA) Technical Working Group, which includes the private sector. This group has developed a Health Technology Assessment Strategy and costed the implementation plan in preparation for the National Health Insurance.

The South African Health Products Regulation Authority has cleared a significant authorisation backlog and achieved WHO maturity level four for regulating vaccines and maturity level three for regulating other health products.

The NDOH, with donor support and SAPICS (the Professional Body for Supply Chain Management), established joint support training programs to improve supply chain skills amongst supply chain officials. This included an introductory course for pharmaceutical staff regarding supply chain fundamentals with external support from WITS University. The training included the Scope and Influence of Procurement and Supply (SIPS) and a one-year membership to the Association of Supply Chain Management (ASCM) in 2021. By the end of September 2021, 75 officials (both National and Provincial) had signed up for this online training.

The Affordable Medicines Directorate within the NDOH established innovative ways of managing the supply chain, including replicating the existing private sector model. The key conditions of a successful supply chain management of pharmaceuticals include:

- An enabling legislative and regulatory framework
- Provision of adequate financial and human resources
- Co-operation and coordination between different arms of government and non-state actors
- Communication and improved transparency of health product availability and supply challenges across the sector
- Public-Private Collaboration

Notwithstanding these achievements and a measure of resilience, there remain some persistent challenges that impede reliable and equitable access to medical technologies, identified by the following thematic areas:

Pharmaceutical budget: Despite a robust scientific, evidence-based budget planning process, budgets still need to be allocated. Zero-based budgeting poses a challenge as accruals need to be considered. Pharmaceutical suppliers that participate in national tenders still face payment challenges.

Human resource and capacitation: A limited number of staff are suitably qualified in Supply Chain Management. A lack of funding halted staff training, and COVID-19 further slowed progress. The organisational structure of Pharmaceutical Services at Provincial Head Offices is not standardised, leading to inefficiencies in modernising the pharmaceutical supply chain.

Medicine Master Data System: The Medicine Master Data System serves as the foundational information layer that drives various processes and decisions in the supply chains. It is the backbone for inventory management, regulatory compliance, and decision-making, among other key functions. Accurate and standardised data ensures traceability, promotes interoperability, and facilitates financial planning, contributing to patient safety and operational efficiency. While significant strides have been made in developing a Medicine Master Data

System in the public sector, the data sourcing and capturing processes are still cumbersome. The National Department of Health (NDOH) also maintains the Single Exit Price (SEP) database, raising the potential for duplicated efforts in an already resource-constrained environment. The South African Health Products Regulatory Authority (SAHPRA) serves as, and should continue to be, the primary custodian of health product master data. However, the current landscape needs to be more cohesive, with multiple processes and stakeholders responsible for capturing and maintaining identical data sets across the sector. Collaboration and coordination are essential to streamline operations to eliminate redundant efforts, improve efficiency, and minimise the risk of human error.

Information about medicine availability information: there is a lack of understanding of supply challenges and management, a recurrent example being that "stockouts" do not necessarily mean there is no stock. Effective communication and transparent information sharing about medicine availability are vital for public awareness and coordinated health services. Therefore, the NDOH developed a specialised communication strategy focused on medicine availability.

This strategy targets all relevant stakeholders and applies to all medicines listed on the Essential Medicines List (EML) on National or Provincial contracts or procured through quotations. It's important to note that the scope of this strategy excludes medical devices, equipment, and other health technologies. The primary objective of this focused communication strategy is to outline a structured approach for communicating and disseminating any information related to challenges in the availability of these specified medicines.

Pharmaceutical Depots: ageing infrastructure and outdated information systems contribute to depots being unable to meet Auditor General and SAHPRA requirements

Non-pharmaceuticals: There is no clear definition of non-pharmaceutical medical products (non-pharmaceuticals). Products are not as highly regulated. Governance processes to manage non-pharmaceutical products are less robust and pose a high risk to the health system. There is a need for an Essential Equipment List. Different business processes for medicines are a major constraint towards centralisation. Inefficiencies in enforcing the rules and other structural problems result in procurement challenges and procuring at high prices.

Local procurement: The PFMA preferential procurement provisions are underutilised. There is a lack of alignment between different government arms on the structure and priorities to explore other procurement models. To achieve economies of scale, local manufacturers should be steered towards producing 30-day packs. Establishing an intradepartmental committee is imperative to foster local manufacturing and procurement within the healthcare sector. This committee will serve as a cross-functional platform, bringing together representatives from various sectors to explore and identify avenues for mutually beneficial local procurement strategies.

The primary objectives of this committee include:

- Achieving consensus on the relationship between local manufacturing and local procurement offers clarity and guidance on how these domains intersect and influence each other
- A sustainable and advantageous local procurement policy mutually benefits the government and manufacturers. This involves identifying incentives, optimising supply chain logistics, and outlining a framework for ongoing collaboration
- Exploring alternative reimbursement models that could incentivise and bolster local manufacturing efforts, ensuring economic feasibility and long-term sustainability

Proposed Initiatives to Enhance Access to Medical Technologies and Strengthen Supply Chains

Pharmaceutical budget: although the Pillar 2 stakeholders are strongly in favour of an earmarked pharmaceutical budget for medicines only, this has been a problematic consideration for provinces. The discourse should continue within Pillar 2, with compelling arguments on either side to be submitted to the National Health Council for consideration.

Human resource and capacitation: Strengthened supply Chain Management training with certification, recognition and upwardly mobile career pathways as part of the Review of the National HRH Strategy (Pillar 1 recommendation)

Medicine master data system: all SAHPRA registered products must have a Single Exit Price and be GS1 certified for track and trace. It is worth noting that GS1 has introduced an application where anyone, including ordinary citizens, can report suspected illicit or harmful goods, including medicines, on a feature or smart device and report criminal activity related to counterfeit goods and other crimes.

Information about medicine availability information: The NDOH RCCE mechanism must complete the development of a communication strategy for medicine availability to reach all relevant stakeholders. This includes documenting success stories within the Affordable Medicines Directorate, mainly on information systems used to manage supply.

Pharmaceutical depots: A concept paper for standard organisational structure for pharmaceutical warehouses is needed and should be produced by NDOH in consultation with provincial departments and other relevant parties.

Non pharmaceuticals: SAHPRA must refine the definition of medical products. NDOH must establish a parallel system for managing non-pharmaceutical products with similar governance processes to those used for medicines. The NDOH through a consultative process, must develop an essential list of Health Products (like medicines) that are safe of an acceptable quality, effective and affordable.

Local production: Preferential procurement policies must be developed and adopted through an Intradepartmental Committee. This committee should initially investigate opportunities for preferential procurement of local and African-produced health technologies, considering the opportunities afforded by the Africa Continental Free Trade Agreement and the AU policies on pooled and preferential procurement. Pharmaceutical companies should move to produce 30-day packs.

I.1. Importance of efficient supply chains for NHI implementation

Section 38 of the NHI establishes a Health Products Procurement Unit, which sets parameters for the public procurement of health products and health-related products. It further provides that the "Health Products Procurement Unit must support the Benefits Advisory Committee in the development and maintenance of the Formulary, comprised of the Essential Medicine List and Essential Equipment List as well as a list of health-related products used in the delivery of health care services as approved by the Minister in consultation with the National Health Council and the Fund." It is necessary to address key elements to ensure that the supply chain can meet the provisions of the national health insurance in South Africa.

Transparency and accountability: Ensure that the supply chain process is transparent and accountable for all transactions, from procurement to distribution of healthcare products and services.

Efficient inventory management: Implement systems and processes to manage inventory efficiently and ensure that essential healthcare products are available when needed.

Strategic purchasing: Develop strategies to procure quality healthcare products at competitive prices while promoting local suppliers and enhancing supply chain resilience.

Regulatory compliance: To ensure safety and quality, comply with all relevant regulations and standards governing the procurement, storage, and distribution of healthcare products.

Collaboration and partnerships: Foster collaboration and partnerships with key stakeholders, including healthcare providers, suppliers, and government agencies, to improve coordination and enhance the effectiveness of the supply chain.

Capacity building: Invest in training and capacity-building programs for supply chain staff to effectively enhance their skills and knowledge in managing healthcare supply chains.

Technology and innovation: Utilise technology and innovation, such as digital systems and data analytics, to streamline supply chain processes, improve visibility, and increase efficiency.

By addressing these key elements, the supply chain can better meet the provisions of South Africa's national health insurance and ensure the availability of essential healthcare products and services to all citizens.

1.2. PILLAR TWO MONITORING AND EVALUATION TOOL

PILLAR 2: IMPROVED ACCESS TO ESSENTIAL MEDICINES, VACCINES, AND MEDICAL PRODUCTS THROUGH BETTER SUPPLY CHAIN MANAGEMENT

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Development of a proposal for the earmarking of funds for health and health related products	Develop a Concept Note for discussion in the National Health Council (NHC) on the earmarking funds for Health and Health Related Products	Concept Note for the earmarking of funds for Health and Health Related Products tabled before the NHC	First sitting of the National Health Council after May 2024	NDOH	Provincial DoHs
Establishment of Medicine Master Data System	Develop and operationalize a digital Medicine Master Data System	Medicine Master Data System developed and operational	June 2025	NDOH	Provincial DoHs
GS1 Certification of all SAHPRA registered products	Develop a process and a system to ensure that all SAHPRA registered products are GS1 Certified	All SAHPRA registered products GS1 Certified	June 2027 (complete and up to date with no backlogs)	NDOH SAHPRA GS1	Pharmaceutical Industry
Establishment of an Essential List of Non Pharmaceutical Health Products	Define non- pharmaceutical health products and establish an Essential List of Non Pharmaceutical Health Products	Essential List of Non-Pharmaceutical Health Products developed	June 2025	NDOH	Provincial DoHs SAHPRA
Establishment of an Interdepartmental Committee on Preferential Procurement of local and African health products and technologies and development of policy guidelines on preferential procurement	Establishment of an Interdepartmental Committee on Preferential Procurement of local and African health products and technologies	An interdepartmental Committee of Directors General on Preferential Procurement established	December 2024	NDOH	DSI, DTI, National Treasury and SAHPRA
	Develop policy guidelines on preferential procurement	Draft Policy Framework for Preferential Procurement of South Africa and African Health Products and Technologies established	June 2025	NDOH	Provincial DoHs
Effective, specialised communication on availability of health and health related products	Implement the Specialised Communications Strategy on Availability of Medicines and produce Guidelines for Journalists	Communications Strategy on Availability of Medicines developed	December 2024	NDOH	Provincial DoHs

J. Pillar Three: Execution of the infrastructure plan for adequate and well-maintained health facilities

Assessment of infrastructure gaps and distribution challenges

Health infrastructure development is guided by the National Quality Improvement Plan Core Standards, of which Facilities and Infrastructure define the seventh domain.

The government has made strides in the health infrastructure programme, having invested R250 billion over 30 years of democracy into health infrastructure. However, there remains a significant gap in building up a health infrastructure that is fit for the rollout of NHI, which the NDOH has quantified at an anticipated cost of R200 billion. With only R27 billion (as of 2024) allocated over the MTEF period for health infrastructure by the National Treasury, and noting that the Health Facility Revitalisation Grant (HFRG) has been cut by R1 500 711 billion over the MTEF period, there is a need to adopt an innovative approach to financing the gap.

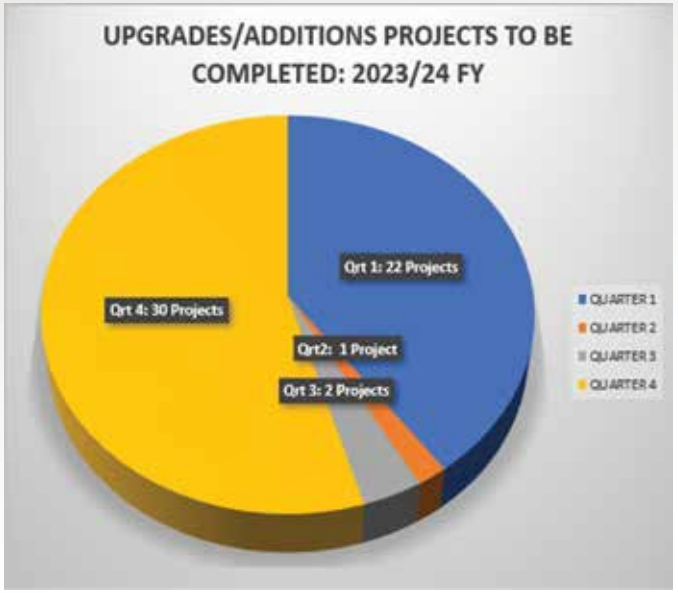
Although 98% of South Africans can access a government hospital within two hours at most in case of emergencies, only 58% of the country's district hospitals offer surgical capacity in the form of a surgical provider and a functional operating theatre[10].

Furthermore, an estimated 265 state hospitals and 1,903 primary healthcare facilities require urgent upgrades and maintenance to bring them up to acceptable standards for implementing NHI.

The public health sector faces a large health infrastructure maintenance backlog estimated to be more than 100 billion rands[11]. Based on the SAICE (South African Institution of Civil Engineering), most of the existing health facilities score a "condition rating" of "D" (A being a world-class health facility and E being a facility that is no longer fit for purpose or use).

[10] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-020-05637-0
[11] As reported by NDOH

J.1. Progress Made Since the First Health Compact



The Department has made significant progress in reviewing and updating the 10-Year National Health Infrastructure Plan, incorporating an interactive platform that provides tools for integrating private and public health sector infrastructure planning. Another critical area of advancement is the Department's enforcement of the Infrastructure Delivery Management System in all nine provinces for 100% of health facilities, which was attained by the 2022/ 2023 financial year.

There remains an opportunity to ensure that this implementation results in projects being completed on time, without additional costs to the original budgets and meeting the required services' needs. Related to this, the revised policy on accountability for public health infrastructure and clarification of responsibilities of the Department of Public Works and Departments of Health has been concluded and published.

The resolution to conduct equipment audits during the second quarter of the 2021/22 financial year has met challenges. Poor performance was reported in a total of 7 (MP = 1; WC = 3; FS = 3) equipment audits conducted during the period Jul-Sep 2021/22 and a further 5 (FS = 3; NW = 1; WC = 1) conducted during Jan-Mar 2022/23. However, a huge improvement was reported in the number

of equipment audits conducted from April to December 2022, with a total of 66 (KZN = 10; LP = 1; WC = 29; FS = 18; NW = 3; EC = 2; GP = 1; MP = 1; NC = 1).

The private sector made greenfield investments in constructing 22 facilities between 2019 and 2024. This excludes the primary health infrastructure that pharmaceutical chains like Dischem and Clicks and independent community pharmacies have added through their pharmaceutical-based primary health clinics.

Greenfields Builds: Private Sector Hospitals **HOSPITAL NAME**	**Opening Date**
eThekwini Hospital and Heart Centre	2022
Johannesburg Surgical Hospital	2023
Ribumed Medical Care Ballito (Day clinic)	2022
Chatsworth Cheshire Rehabilitation Centre	2019
Scottburgh Private Hospital	2022
The Edge Private Clinic	2021
Cape Eye Hospital	2020
Mediclinic Capegate Day Hospital	2020
New Market Day Hospital	2023
New Era Health(ex Cape View Medical Clinic)	2021
Raslouw Private Hospital	2022
Dr GM Pitje Day Hospital (Application Name: Clinix Day Clinic)	2022
Lifepath St Catherine's (Mental Health)	2023
Nurture Health Alberton (Rehab and sub-acute))	2022
Royal Buffalo Specialist Hospital	2022
Stirling Healthcare Centre (Day hospital)	2020
Hibiscus Hospital Cato Ridge	2020
Akeso Richard's Bay (Mental Health)	2022
Akeso Gqbergha (Mental Health)	2023
Glanmarks Clinic (Mental Health)_Durban	2024
iTheku Wellness Hospital (Mental Health)_Durban	2024
Mediclinic Legae (Mental health) _ Pretoria	2023
TOTAL	**22**

Persistent Challenges and Areas of Underachievement

1. Underperformance in implementing the IDSM framework.
2. Poor coordination and collaboration.
3. Poor project preparation.
4. Poor infrastructure delivery and spending caused by progressive budget cuts.
5. Lack of secure revenue streams.
6. Ineffective project pipeline.
7. Inefficiencies within the project value chain.
8. Failure to link infrastructure projects with MTEF planning, despite the enforcement of IDSM, which is designed to align with MTEF.

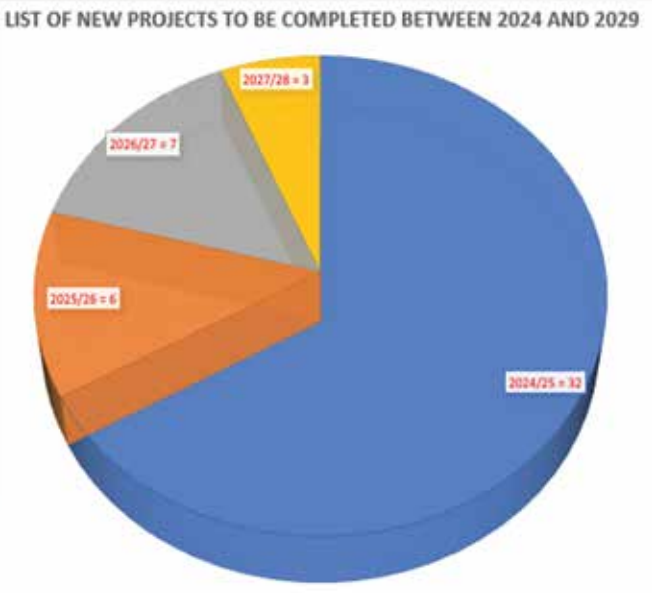
The roots of these persisting challenges are:

- Lack of adherence to IDMS (Infrastructure Delivery Management System) and FIDPM (Framework for Infrastructure Delivery and Procurement Management)
- Lack of or insufficient ongoing maintenance of health facilities
- Lack of best practices
- Limited funding to address maintenance/infrastructure backlog
- Poor planning
- Lack of skills and inappropriate skills in technical positions
- Lack of uniformity in procurement procedures
- Poor reporting and monitoring

The impact of these persistent challenges may result in limited access to comprehensive, high-quality healthcare services, lack of compliance with the Office of Health Standards requirements, and limited potential socioeconomic benefits, like job creation.

J.2. Strategies for executing the infrastructure plan

South Africa has an imperative to realise an ambitious infrastructure plan in preparation for the rollout of NHI, as illustrated in the following graphs:



With the quantum of financial need around 200 billion rand, alternative and innovative funding mechanisms still need to be explored. These discussions could have focused more on financing the response to and socioeconomic recovery from COVID-19. However, it is encouraging that stakeholders, in particular the private sector, pay particular attention to the revival of this discussion at the second summit, and this resolution, as well as ways of advancing the health infrastructure financing, will be discussed as part of the strategic interventions under the second health compact.

Project-related challenges must be eliminated, such as poor governance, poor planning, and lack of accountability. To correct the persistent challenges outlined above and set the country on the path towards a fully developed health infrastructure, ready for the rollout of NHI, the second summit proposed key recommendations expressed under the following three thematic areas:

- Improve the Execution of Projects
- Optimise the Project Portfolio
- Measure the Impact of the Projects

In improving the execution of projects, participants emphasised the importance of front-end planning, which can reduce the total design and construction costs by 20% and the total design and construction schedule by 39% compared to authorisation estimates. Further, Front End Planning provides more predictability and a better opportunity for intermittent evaluation of team alignment. It can also assist in aligning the project with MTEF planning. Strict adherence to the IDSM and the Framework for Infrastructure Delivery and Procurement Management (FIDPM) was emphasised, and recommendations were made to use available tools and resources that facilitate adherence to the IDSM and FIDPM.

Regarding optimising Project portfolios, participants raised the need for a defined priority portfolio given the fiscal constraints. They also recommended an ongoing evaluation of the "value-for-money" of anticipated and ongoing projects. They further recommended strengthening existing technologies to ensure data-driven policy and decision-making across the infrastructure value chain.

To monitor the impact of projects, participants recommended the use of utility curves, i-Labs and the Project Readiness Matrix to enhance the value of projects. Impact assessments should be done at a higher frequency. Overall, the participants encouraged the leveraging and adoption of best practices from other infrastructural organisations.

Finally, regarding financing, the participants resolved to attract much-needed private-sector investment and capacity by pursuing public-private partnerships and exploring innovative financing solutions that reduce risk and optimise financial, social, and multiplier returns. Traditional procurement approaches such as the tendering system, outsourcing, and privatisation have posed considerable risks to efficiency gains and, therefore, need to be reviewed for risk reduction.

J.3. Link between infrastructure development and NHI roll-out

All health infrastructure must meet the specifications of the Quality Improvement Plan and comply with the Office of the Health Standards Compliance (OHSC) in time for contracting with the national health insurance. The following steps can be taken to meet these specifications:

- **Establish a Monitoring and Evaluation System:** Implement a robust monitoring and evaluation system to regularly assess the performance of health facilities against the quality improvement plan and OHSC standards
- **Provide Technical Assistance:** Offer training and technical assistance to health facilities to help them understand and meet the required standards
- **Create Incentives:** Provide incentives or rewards for facilities that consistently meet or exceed the quality standards set by the OHSC
- **Enforce Compliance:** Use progressive enforcement measures to ensure compliance, such as making certification contingent on meeting specific standards
- **Engage Stakeholders:** To promote transparency and accountability, stakeholders such as healthcare staff, patients, and community members should be involved in the quality improvement process
- **Regular Inspections:** Conduct inspections and audits of health facilities to verify compliance with quality standards
- **Public Reporting:** Publish information on compliance levels and the quality of care health facilities provide to create greater public awareness and accountability

By implementing these strategies, South Africa can help to ensure that all health facilities comply with quality improvement plans and OHSC requirements, making them eligible to contract with the National Health Insurance. Beyond health infrastructure, other infrastructural issues constitute key determinants of equitable access to health care. Social determinants of Health (SDOH) that have significant infrastructural implications include:

- Safe and efficient housing, transportation, and neighbourhoods
- Education, job opportunities and income security
- Access to nutritious foods and physical activity
- Clean air and water

One opportunity for an integrated approach to infrastructure development for health is to engage the District Development Model by adopting good health outcomes as a critical indicator for successful community development.

J.4. PILLAR THREE MONITORING AND EVALUATION TOOL

PILLAR 3: EXECUTION OF THE INFRASTRUCTURE PLAN FOR ADEQUATE AND WELL-MAINTAINED HEALTH FACILITIES

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Improvement of the Execution of Projects	Assess the extent to which projects align with the IDSM and FIDPM: All projects completed between 2024 and 2029	Annual Report analysing all projects completed in the financial Year	Annual from April 2025	NDOH	National Treasury
Optimisation of the Project Portfolio	Define a priority portfolio	A portfolio of Priority infrastructure for 2024-2029 Defined	June 2025	NDOH	Provincial DoH
Measurement of the Impact of the Projects	High frequency impact assessments, including health outcome, job creation, socioeconomic impact and environmental impact	Annual impact assessments of ongoing or completed projects, conducted and reports produced	Annual	NDOH	Research institutions e.g. SAMRC, HSRC Pillar 8 Stakeholders
Explore innovative financing options for infrastructure development and maintenance	Develop a policy framework for innovative financing of health infrastructure	A Policy Framework for Practical Innovative Financing of Health Infrastructure	June 2025	NDOH	National Treasury Pillar 6 Stakeholders

K. Pillar Four: Engagement of the private sector in improving access, coverage, and quality of health services

K.1. The importance of public-private sector collaboration in healthcare

Shortly after the dawn of democratic South Africa, the White Paper on the Transformation of the Health Sector was published. It stated that "the activities of the public and private health care sectors should be integrated in a manner that makes optimal use of all available health care resources." The reason for this was to reverse the decision of the last apartheid Minister of Health, Rina Venter, who promoted and supported the establishment of the private health sector by giving licenses and incentives to establish medical aid schemes to the detriment of the public health sector. Furthermore, it led to separate health care provision by race; the overwhelming number of whites obtained care in the private health sector while the majority of blacks relied on an underfunded public health care system. This disparity in access is a consequence of the state diverting resources to fund care in the private sector for a minority population through medical aid subsidies for those who enrolled in medical schemes.

The public-private mix of health care should promote equity in service provision rather than entrench inequalities. The reversal of this trend has taken almost 30 years; the government is ending the two-tiered health system through the National Health Insurance.

Unfortunately, at this juncture, the state sector- which spends about 3,7% of GDP to service about 84% of the population- is characterised by resource constraints, escalating disease burden and lack of human resources[12] whilst the Health Market Inquiry Report of 2019 found that the private health sector, which services about 16% of the population and spends 4,2% of the GDP, is "characterised by high and rising costs of healthcare and medical scheme cover, and significant overutilisation without stakeholders having been able to demonstrate associated improvements in health outcomes[13].

There have been some green shoots of productive public-private partnerships in the health sector, which provide opportunities to draw lessons and create a more interstitial environment that fosters seamless public-private partnerships as the sector prepares for the rollout of NHI.

The Inkosi Albert Luthuli Hospital in South Africa is one infrastructure example in the World Bank's Public-Private Partnership Resource Centre. Overall, a successful PPP venture, some of the lessons drawn from this experience include the wisdom of investing in a reasonable transaction advisor, the importance of investing in high-quality goods and services for long-term sustainability and an opportunity to improve mitigating foreign exchange risks.[14]

The Public Health Enhancement Fund (PHEF) was a partnership established in 2012 by the NDOH and a network of private sector partners to "strengthen and improve public healthcare in South Africa, through increased cross-sector collaboration and the pooling of corporate social investment (CSI) in health[15]. The Fund has currently raised around R300 million, leading to the graduation of over 100 medical doctors and 34 research graduates, all from historically disadvantaged and resource-constrained communities and many returning to work in their communities or other under-resourced areas[16] In addition, the PHEF has supported 78 postgraduate healthcare students, most of whom are PHDs and 80% of whom are black females. The Fund continues to help them; however, COVID-19 caused significant disruption to the PHEF.

COVID-19 was the era when the power of PPP was genuinely evident, with the Solidarity Fund and the COVID-19 vaccination campaigns showcasing a spectrum of merits that can be derived from successful PPP. The impact of PPP in South Africa during COVID-19 was profound, ensuring the country could conduct tests at and sometimes above the WHO gold standard; to treat hospitalised patients in any facility, whether public or private; to procure and even manufacture enough ventilators, to mitigate supply chain disruptions of other critical medicines (due to export bans and other trade embargoes); and to provide enough vaccines to attain population immunity against COVID-19. Indeed, COVID-19 gave the country a taste of the promise of the NHI to deliver equity by integrating the health systems and eliminating fragmentation.

12 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6556866/
13 https://www.compcom.co.za/wp-content/uploads/2020/01/Executive-summary-Presentation-of-the-final-findings-and-recommendations-report.pdf

14 https://ppp.worldbank.org/public-private-partnership/print/pdf/node/7383
15 https://trialogueknowledgehub.co.za/topical-public-health-enhancement-fund/
16 https://www.engineeringnews.co.za/article/fund-gives-public-healthcare-sectors-human-resources-a-boost-2020-02-24

K.2. Measures to engage the private sector in NHI implementation.

The participants of the second health summit considered strengthening PPP in the context of the impending rollout of NHI. They began by assessing the progress made on the five recommendations set out in the first Compact, which were:

1. Expand training of medical specialists (through PPP) and other cadres as required to meet country needs.
2. Bolster the training of nurses to meet country needs.
3. Develop a Public-Private Engagement Mechanism.
4. Share knowledge and learnings on systems and processes in healthcare facilities.
5. Develop capacity to resolve medico-legal disputes through alternative dispute resolution (ADR).

McKinsey conducted a 2020 study (not audit) as a collaboration between the NDOH and the private sector – the study showed a severe shortage of nurses across the board. The private sector has ramped up its capacity to offer new nursing qualifications. There is spare capacity for nurse training in the private sector, including specialist nurse training. Still, there is very little training in the private sector because of the numerous regulatory obstacles. HASA has supported BUSA in analysing specialists. The report demonstrates an overall shortage of healthcare professionals with specific data per discipline.

The Solidarity Fund and B4SA have demonstrated the potential for cooperation during the COVID-19 pandemic era. Replicating this model for crucial health priorities, such as oncology, could benefit healthcare access. The private hospital sector has developed a Service Level Agreement template to refine a public-private engagement mechanism.

Medical schemes have developed alternative dispute resolution (ADR) mechanisms relating to forensic investigations and critical learnings and can support ADR for medico-legal matters. Medical schemes and private hospitals submitted to the SALRC regarding the reform of medico-legal awards, which will impact the contingent liability amounts and the cost of professional indemnity cover.

K.3. Persistent Challenges and Areas of Underachievement

Due to numerous regulatory obstacles, the private sector attenuated its nursing training during the first Compact. Collaboration between the private hospital sector and the South African Committee of Medical Deans (SACOMD) has stopped—no collaborative work is formally underway to "Expand training of medical specialists and other cadres as required to meet country needs."

No formally constituted team, committee or platform has been established to lead and coordinate the required exchange to "Share knowledge and learnings" save for B4SA/Government collaboration during COVID-19.

No agreed transacting tool exists to "Develop a Public/Private Engagement Mechanism."

Other than regular reporting meetings, there is no effective mechanism for holding all stakeholders accountable for their Health Compact undertakings.

Outside of the COVID-19-related work, public and private actors who are part of the Compact have not moved closer to each other. The template SLA developed by the private sector has not been adopted or operationalised meaningfully to enable the DoH to contract with the private sector. The NHI Bill being debated in Parliament was part of the breakdown in the relationship between the two sectors.

K.4. Proposed Priorities for 2024 to 2029

The NDOH is advised to set up, lead, and institutionalise a platform for sustained, inclusive dialogue on feasible collaborative service delivery initiatives, particularly in the context of NHI, with a particular focus on aligning standards and regulations. Concerning standards, the public and private health sector have already demonstrated their alignment with the National Quality Improvement Plan- as of quarter three, 2023, 75% of public and private facilities were implementing the NQIP. Pillar 4 stakeholders recommend reviving the Joint Strategic Oversight Committee from COVID-19 (chaired by the Director General of Health) as a precursor to a more institutionalised entity.

It should be grounded in an accountability framework to ensure a monitoring system and encourage stakeholders to be accountable for their undertakings. NDOH and BUSA must finalise the blueprint for public/private clinical collaboration. The SLA templates developed for COVID-19 to enable sustainable clinical collaboration between the public and private sectors may be used as a basis, or new templates may be drafted.

Pillar 4 stakeholders recommend building on the Presidency's initial concept of an Intersectoral Committee on Health Workforce to foster a collaborative health workforce development framework. Such a committee can, among other things:

- Address regulatory barriers to training and deploying health workforce, ensuring full use of private sector training capacity to complement public training
- Facilitate the cooperation of SACOMD and HPCSA to lead an inclusive process of onboarding suitable private facilities for the postgraduate training of doctors
- Foster collaboration between the CHE, SAQA, DHET and other relevant entities to streamline the accreditation of Nursing Education Institutions
- Develop a Critical Skills List to temporarily relieve service delivery pressures when required in both the public and private sectors

Pillar four stakeholders support and align with the recommendation of the SA Law Reform Commission to resolve medico-legal disputes through alternative dispute resolution mechanisms.

K.5. PILLAR FOUR MONITORING AND EVALUATION TOOL

PILLAR 4: ENGAGEMENT OF THE PRIVATE SECTOR IN IMPROVING ACCESS, COVERAGE, AND QUALITY OF HEALTH SERVICES

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Sustained inclusive dialogue on feasible collaborative service delivery initiatives	Establish a Joint Strategic Oversight Committee or a Project Management Office, initially chaired by the Director General of Health	JSOC revived	December 2024	NDOH Private Sector	Treasury
		Institutionalised, permanent platform for sustained strategic joint operations between public and private sectors established	June 2025	NDOH Private Sector	Provincial Departments of Health
Finalisation of a blueprint for public/private collaboration	Review, finalise and adopt the blueprint SLA	A blueprint SLA for private sector contracting with NHI developed	2024-2026	NDOH Private Sector	Provincial Departments of Health Pillar 8 Stakeholders (Civil Society; Labour)
Establishment of a multisectoral committee for health workforce development	Coordinate the establishment of a multi sectoral committee for health workforce development	A multisectoral committee on health workforce development	December 2024	Presidency	NDOH

L. Pillar Five: Improvement of Quality, Safety, and Quantity of Health Services with a Focus on Primary Healthcare

L.1. Analysis of primary healthcare challenges and disparities

Globally, the importance of primary health care (PHC) in all high-performing health systems is becoming more widely recognised, and there is growing evidence that PHC should be a key component of universal health coverage (UHC)[17]. For this reason, the World Health Organization and the World Bank have made calls for a 1% increase in PHC investment[18].

The PHC system performance is still largely poor and fraught with significant challenges, particularly in LMICs[19]. As a result, PHC systems cannot provide the essential PHC functions of continuity, first-contact accessibility, comprehensiveness, and coordination.

While post-apartheid policies in South Africa have been lauded for expanding healthcare access by boosting the number of healthcare facilities and doing away with PHC user fees, there are still several structural gaps in PHC.[20]. The two-tiered health system has fragmented funding pools, multiple payers and purchasers, low quality, high out-of-pocket costs, hospicentric care, and high inequity.

According to Health Market Inquiry findings, private healthcare remains greatly unaffordable, and public sector litigation is high.

[17] https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(22)00005-5/fulltext
[18] WHO & World Bank. (2021). Tracking Universal Health Coverage 2021 Global Monitoring Report.
[19] Bitton, A., Fifield, J., Ratcliffe, H., Karlage, A., Wang, H., Veillard, J. H., Schwarz, D., & Hirschhorn, L. R. (2019). Primary healthcare system performance in low-income and middle-income countries: a scoping review of the evidence from 2010 to 2017. BMJ Global Health, 4(Suppl 8).
[20] Burger, R., & Christian, C. (2020). Access to health care in post-apartheid South Africa: availability, affordability, acceptability. Health Economics, Policy and Law
[21] South African Health Review, 2019
[22] https://journals.co.za/doi/full/10.7196/SAMJ.2023.v113i4.134

It is encouraging that 85% of facility users report a positive care experience in the latest Patient Experience of Care Surveys (2023).

However, stakeholders must maintain momentum to address inequalities in coverage and resource allocation, a curative emphasis, low prioritisation of prevention and promotion, a high burden of disease, poor leadership, and corruption[21]. In addition, PHC is still impacted by the maldistribution of healthcare workers (HCWs) across public-private and rural-urban settings, low staff motivation, migration of HCWs, and fiscal constraints.

L.2. Initiatives for enhancing quality, safety, and quantity of services

The interventions proposed in the first Presidential Health Compact were as follows:

- Reduce medico-legal claims and litigation
- Roll out of the National Quality Improvement Plan (NQIP)
- Provide patient-centric health services that meet the needs and expectations of users
- Achieve Inter-sectoral collaboration to address social determinants of health
- Improve access to health care for priority populations and conditions

Stakeholders under this pillar have demonstrated great commitment to realising an integrated sector characterised by high-quality goods and services. All nine provinces conduct annually Patient Experience of Care (PEC) surveys per the approved national PEC survey guideline to continue monitoring real patient perceptions of quality of care. By the third quarter of 2023, 85% of participating patients reported a positive care experience in the public sector.

When investigating the state's ballooning liability for medicolegal cases, it was discovered that there was not necessarily a causal relationship between the size of the liability and the quality of care that users generally experience. Many factors have led to the sharp increase in medicolegal claims over the past two decades, not only in South Africa but the world, and these include [22]:

- Clinical errors, maladministration and mismanagement
- The legal profession contributing to a litigious society
- Patient-centric legal developments and increased patient awareness

- Patient expectations
- Poor doctor-patient rapport
- To combat these issues, the government, together with the key stakeholders, made some targeted interventions

In March 2019, the National Treasury requested the Health Financing team to investigate the medico-legal situation nationwide. Both qualitative and quantitative data were collected and considered. The qualitative data collection involved interviewing those managing medical litigation in each province to understand the scope and significant drivers of the problem. The aim was to determine whether identified trends were similar across provinces and whether any examples of best practices could be shared with other provinces. Eight (8) of the nine (9) provinces (WC, LP, KZN, NC, EC, NW, MP and FS) were engaged. The Report of this investigation is still pending, and it must be noted that it is unacceptable that a report requested in 2019 is still pending.

Secondly, the African Law Reform Commission (SALRC) published a discussion paper under Project 141, which promoted the pursuit of alternative dispute resolution[23] by recommending that, "while the constitutional right of access to courts can never be denied, taking a matter to court should be avoided as far as possible". The discussion went further to recommend "a system that starts at the hospital when a serious adverse event occurs, through prescribed compulsory procedures to attempt early resolution, ending in compensation that provides fair restitution to the aggrieved health care user without bankrupting and eventually crippling the public health system."

Pillar five stakeholders recommended that a medicolegal case management system be developed by a service provider and implemented in all provinces. In this regard, two service providers were appointed to assist provinces with handling medicolegal cases. This reduced the total number of claims from 12 948 claims submitted by Provincial Departments to 6 072. The contracts for the service providers have ended, and the process undertaken to reduce the medicolegal claims has been handed over to the Department of Health

After the approval of the Medicolegal Declaration, the Legal Forum developed a litigation strategy. The strategy aims to provide efficient and effective medico-litigation management through short-term, medium-term, and long-term solutions, as the Medico-legal Summit Declaration stipulated. Eighteen (18) officials from provinces have been trained in mediation.

The Ideal Health Facility Programme is a quality improvement programme that strives to improve the quality and enhance the profile of PHC services in the country, not only in anticipation of the forthcoming NHI system but also as a routine responsibility to provide accessible, affordable and acceptable services to all communities. The alignment of the Ideal Health Facility Framework to the Norms and Standards Regulations in 2019 enabled facilities to be certified by the Office of Health Standard Compliance (OHSC). By the end of the 2023/24 financial year, the country had produced 2589 PHC facilities (75%) that achieved Ideal status.

The National Quality Improvement Plan is being implemented. As of the second health summit, there were more than 420 Quality Learning Centres, with over 3,500 health facilities implementing the NQIP. These comprised 3,025 Primary Health Care facilities; 283 hospitals and 83 EMS facilities in the public sector, as well as 112 private sector facilities. Moving forward, the NDOH recommends the following targets for sustained quality across all facilities:

1. Private Sector Facilities to submit annually self-assessments to the OHSC.
2. Public Sector Facilities to submit annually self-assessments to the Ideal Health Facility programme.
3. At least 85% of public sector hospitals, clinics and CHCs actively participating[24] in sub-district and district quality management forums.
4. At least 85% of private hospitals actively participate in local sub-district and district quality management forums.
5. Private primary care providers in each sub-district actively participate in local sub-district and district quality management forums.

Intersectoral Collaboration remains a concept that has yet to manifest fully. The Department of Planning, Monitoring and Evaluation (DPME) Socioeconomic Impact Assessment System (SEIAS) analysis reflects that, as of December

[23] https://www.cliffedekkerhofmeyr.com/export/sites/cdh/news/publications/2022/Practice/Dispute/Downloads/Dispute-Resolution-Alert-22-February-2022.pdf

[24] Definition for active participation: Attending meetings, making presentations at meetings or sharing information from their establishment for the creation of reports for the meeting, evidence of implementation of the decisions of meetings in their health establishments, evidence of change in practice at their health establishments as a result of participation in local quality management forums.

2022, only 5% (10 / 203) of studied policies contribute to the health priorities. The NDOH has subjected 90% of the draft policies, bills and regulations to the DPME SEIAS. The need to align the policies with priorities is urgent.

Research has focused on access challenges for priority populations in primary healthcare settings and associated costs. By March 2022, a report detailing the costs of the Preventative and Primary Healthcare Package was finalised. Subsequently, an affordability assessment of the package and the costing report were presented to the Executive Authority for review. The Preventative and Primary Healthcare Package is now proposed to be implemented gradually, and it is awaiting submission to and approval by the Minister of Health. Some measures could have maximised the achievement of the above Pillar interventions. These include better integration between Pillar's work and NDOH efforts, innovations in fundraising to support the pillar's work, a better coordination framework for the different pillars, and improved communication.

L.3. Proposed Priorities and Interventions for 2024-2029

The second presidential health compact moves from generalised improvements in the healthcare system to preparing the healthcare system for the National Health Insurance (NHI). In a review entitled "National Health Insurance: vision, challenges, and potential solutions," Blecher et al. identify that one key hindrance to the implementation of NHI is the "slow progress in building a mixed delivery platform, such as capitation arrangements with independent general practitioners, and weaknesses in public sector provision and quality.[25]"

Taking this observation and the assessments of Pillar 5 stakeholders into account, we submit a set of recommendations that adopts a combination of frameworks, including the Donabedian Framework for measuring quality of care (which comprises the three components of structure, process and outcomes to assess the gap between expected and actual performance of health systems) and the World Health Organization (WHO) Framework on Integrated comprehensive People-Centred Health Services to build interventions toward the Pillar 5 goals:

- Developing and Aligning Regulatory Policies
- Improving Access to Healthcare, Focusing on Primary Healthcare Services
- Developing and Implementing Patient-Centric Healthcare Models
- Keeping the Health Workforce Healthy and Motivated
- Laboratory Strengthening

L.4. Developing and Aligning Regulatory Policies

In a review article by Mofolo et al. entitled "Towards National Health Insurance: Alignment of Strategic Human Resources in South Africa, the authors observe that "the current lack of alignment of HRH policies needs to portend better for the successful implementation of NHI and PHC re-engineering Knowledge gaps include the need for further clarification of ideal multidisciplinary team compositions and responsibilities" They contend that while the policy frameworks may espouse the ideals, they do not address the impeding practicalities, such as absolute shortage and maldistribution of health workforce and the "extant education and accreditation challenges delaying HRH policy implementation.[26]" Considering this, we submit the following recommendations:

- Developing collaboration between professional bodies and regulatory bodies (e.g., HPCSA) for alignment of efforts towards improved access to healthcare, appropriate task sharing, and regulatory alignment across professions
- Develop policies for the implementation of clinical multidisciplinary teams and holistic healthcare teams
- Develop or review policy on referral pathways, including inter-disciplinary, public-private, and mental health referrals
- Develop policies for different components of value-based healthcare models considering social determinants of health
- Review and improve practice environment, security, mental health, and occupation-specific policies for healthcare workers
- Drive the implementation of the medico-legal declaration

L.5. Improving Access to Healthcare with a Focus on Primary Healthcare Services

Despite a context-specific study which looked at *"Patients' Lived Experience on the Barriers to Accessing Low Back Pain Health Services*,[27] the barriers that were identified can be considered universal for many people who live in South

[25] https://journals.co.za/doi/pdf/10.10520/EJC-1d2aa54be5
[26] http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S2071-29362019000100043
[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9772776/
[28] https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf

Africa and included “travel, long waiting periods, shortage of personnel, poor infrastructural development, inadequate healthcare personnel, communication barrier, social influence, beliefs around cause and effect, misdiagnosis and inappropriate and/or ineffective treatment approaches.” With this insight, we submit the following recommendations:

- Develop plans for the optimal distribution of healthcare workforce and services inwards and sub-districts, considering dispersed settlements, designated groups, and vulnerable and key populations
- Develop standards for healthcare services per 1000 population, including WBOTs, ISHPs, DCSTs, GPs, dental practitioners, and allied health professionals
- Develop strategies to meet healthcare services per 1000 population, considering dispersed settlements
- Develop integration plans for cost-effective, well-funded healthcare programs and inclusion of underfunded diseases

Developing and Implementing Patient-Centric Healthcare Models:

We recommend a research study on global best practices, including healthcare access, public-private partnerships, patient-reported outcomes, social and behavioural change, multidisciplinary teams, healthcare worker retention, and impactful healthcare issues. The following should be derived from this exercise:

- Develop indicators and reporting systems for patient-reported healthcare outcomes
- Develop value-based healthcare models for adoption by public and private sector providers, empowering healthcare workers
- Empower communities with healthcare knowledge, reporting procedures, and access to disease-specific interventions
- Include health education in the primary school curriculum; establish optimal referral pathways
- Improve the referral system, enhance interdisciplinary referrals, and use digital technology for guidance
- Develop a multidisciplinary team framework across patient groups
- Prevent commodification in the private health sector
- Develop appropriate contracting units for primary care models (CUPs) through a multi-stakeholder process
- Conduct webinars to educate healthcare workers on multidisciplinary and holistic healthcare teams

Keeping the Healthcare Workforce Healthy and Motivated:

The COVID-19 pandemic deeply highlighted the importance of a capable, motivated and healthy workforce, not just in South Africa but all over the world. Following the COVID-19 pandemic, the world witnessed an extraordinary brain drain due to death, chronic illness and “the Great Resignation”, which has resulted in unprecedented pressure to replenish the health workforce. Further compounding brain drain from low- to middle-income countries, high-income countries are seeing an ageing population and waning interest in young people’s training in the health sciences, prompting those economies to source health workforce from other territories. To mitigate against these threats and foster compassion and capability amongst the health workforce, we recommend the following:

- Implement activities that drive positive practice environments in the healthcare sector
- Develop and drive strategies to improve security at healthcare facilities
- Implement programs and policies to support the mental health of healthcare workers
- Work with the relevant government departments to optimise remuneration policies for healthcare workers (OSD/COT)
- Promote research, training and continuous professional development of the healthcare workforce

Laboratory Strengthening

Our alignment with the WHO people-centred policy has fundamental implications for laboratory services that put people rather than institutions first. The framework demands a reorientation of the model of care that “encompasses the shift from inpatient to outpatient and ambulatory care and from curative to preventive care.[28]“

To align with these principles, we recommend the following concerning laboratory strengthening:

- Promote standardisation in the ordering, processing, and reviewing of laboratory tests and procedures
- Development of strategies to mitigate and monitor turnaround times for sample processing
- Improve the implementation of quality assurance measures.
- Ensure compliance with regulations
- Develop capacity to provide data and detect new pathogens, epidemics, and pandemics timeously
- Develop strategies to ensure that the current laboratory staff is adequately competent
- Improve trainee recruitment processes and develop adequate mentorship programmes

L.6. Integration of primary healthcare into the NHI framework

Primary health care (PHC) development in South Africa can be traced back to the Pholela Health Centre Model developed in a small rural centre in KwaZulu Natal in the 1940s. This is considered a precursor to the Community Orientated Primary Care model, which formed one of the earliest definitions of primary health care.[29]

The Alma Ata Declaration of 1978 was a major global health milestone in redefining the state of health and defining a primary health care policy. Though South Africa only officially committed to Alma Ata 20 years later, the country did make some vaulting advancements[30], buoyed by the publication of the 1997 White Paper that pledged to create a 'unified health system capable of delivery of quality health care to all citizens efficiently and in a caring environment'.

Within the first decade of democracy, a district health system with a PHC package of norms and standards was implemented, supported by a strong infrastructure programme focused on building community clinics. By 2013, South Africa had recorded 120 million visits to primary health care facilities[31].

In November 2023, at the South African Primary Health Care Conference, the Minister of Health outlined his vision of a strengthened primary health system, building on the advancements made over 30 years of democracy whilst highlighting persistent challenges that the system still faced. He outlined the broadly distributed services in community health, which include "the community health worker programme, the school health programme, environmental health services and the central chronic medicine dispensing and distribution programme," whilst emphasising the importance of sound "administrative, financial, supply chain, information and communication" support.

As the NHI will be imminently signed into law, we recall the WHO's firm recommendation that reorientating health systems to Primary Health Care is fundamental to attaining Universal Health Coverage[32]. Echoing the Minister's sentiments, we affirm that integrating PHC into the NHI framework requires a multifaceted approach that addresses infrastructure, preventive care, community engagement, technology, collaborative care models, performance measurement, and public-private partnerships:

1. **Investing in Infrastructure and Resources:** A key aspect of integrating PHC into the NHI framework is ensuring that health facilities are adequately equipped and staffed. This involves investing in infrastructure, medical equipment, and training healthcare workers. Mobile clinics, using existing infrastructure like schools and the school health system, and telemedicine can also be employed to reach remote or underserved areas.
2. **Emphasising Preventive Care:** Promoting preventive care is essential in reducing the burden on the healthcare system and thus reducing the costs to the NHI Fund. Education and awareness campaigns on lifestyle modifications, early detection of diseases, and immunisation can help prevent illnesses before they escalate, ultimately reducing the cost of healthcare. Investing in wearables for target disease populations like hypertensives, diabetics, anaemia, heart disease, etc., may have long-term financial benefits for the NHI Fund.

[29] https://www.hst.org.za/publications/South%20African%20Health%20Reviews/2%20A%20Perspective%20on%20Primary%20Health%20Care%20in%20South%20Africa%20SAHR%202008.pdf
[30] http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742008000900001
[31] https://www.gov.za/news/speeches/minister-joe-phaahla-south-african-primary-health-care-conference-15-nov-2023.
[32] https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(UHC)

3. **Community Engagement and Empowerment:** Engaging communities in decision-making and empowering them to take ownership of their health can significantly improve health outcomes. Community health workers can bridge the gap between healthcare facilities and communities by providing education, guidance, support, and home-based care.
4. **Utilising Technology and Innovation:** Leveraging technology, such as electronic health records, telehealth services, mobile health apps, and wearables, can enhance the efficiency and effectiveness of PHC delivery. Innovations like artificial intelligence and machine learning can also personalise care and predict health outcomes. Predictive models can provide efficiency gains by producing planning and cost mitigation scenarios.
5. **Collaborative Care Models:** Implementing collaborative care models that involve multidisciplinary teams (MDTs) can ensure comprehensive and coordinated healthcare services. Patients can receive holistic and integrated care by integrating primary care with specialist care, mental health services, and social support systems.
6. **Performance Measurement and Quality Assurance:** Establishing robust monitoring and evaluation mechanisms is crucial to assess the impact of integrating PHC into the NHI framework. Regular audits, feedback mechanisms, and quality assurance programs can help identify areas for improvement and ensure that services meet quality standards.
7. **Public-Private Partnerships:** Collaborating with the private sector can leverage resources, expertise, and innovation to strengthen PHC services. Engaging private providers through streamlined contracting models and accreditation systems can expand coverage and improve access to care.

L.7. PILLAR FIVE MONITORING AND EVALUATION TOOL

PILLAR 5: IMPROVEMENT OF QUALITY, SAFETY, AND QUANTITY OF HEALTH SERVICES WITH A FOCUS ON PRIMARY HEALTHCARE

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Development and Alignment of regulatory policies	Strengthen collaboration between professional bodies and regulatory bodies	Framework For Alignment of Regulatory Policies developed	December 2025	HPCSA	SAMA Other Professional Bodies NDOH
Improved access to healthcare, focusing on Primary Healthcare Services	Implement the National Quality Improvement Plan (NQIP)	At least 85% of health facilities submitting annual self assessments to the relevant authorities National and Provincial DoHs	Q3 2025	NDOH	Provincial DoHs Civil Society Forum Patient User Groups Pillar 4 Stakeholders
Development and Implementation of Patient-Centric Healthcare Models	Sustain the Patient Experience of Care Surveys	Annual Patient Experience of Care Survey Report produced and Disseminated	Annual	NDOH Civil Society Forum	Provincial DoHs Patient User Groups
Keeping the Health Workforce Healthy and Motivated	Implement policies that protect health workers, promote professional growth and development and enhance remuneration and benefits	Annual Health Worker Experience of Work Survey conducted and report produced and disseminated	Annual	NDOH	Provincial DoHs SAMA Other Professional Bodies
Strengthening Laboratory services	Streamlining standards and operations of private and state laboratory services	Annual State of Laboratory Services Report produced and disseminated	Annual	NDOH NHLS	Private Sector Laboratories SAHPRA

M. Pillar Six: Improvement of public sector financial management systems and processes

The health expenditure in South Africa is approximately 8% of the GDP in 2024- around 4,2% contributes to the private sector whilst 3,7% contributes to the state sector[33]. Having conducted a "Quality in Health Outcomes and Health Budget Framework" study between 2016 and 2021, UNICEF has suggested that South Africa could derive better value for money in health outcomes in this statement: "While South Africa's overall Total Health Expenditure (THE) is relatively high (~8.5 per cent of GDP), Brazil shows spending levels more similar to South Africa (9.59 per cent) while Mexico has much lower health spending as a proportion of GDP at 5.43 per cent. Under five years old, child mortality per 1,000 live births in 2020 was 15 in Brazil, 14 in Mexico, and 32 in South Africa.[34]" While it is not possible to cover a comprehensive literature review on the issue of value, this statement already captures the imagination and prompts the question- how can we get better value for money?

The essential efficiency equation is the number of financial inputs entered into a health system and the outputs derived from user-facility interfacing, key public health outcome indicators and economic multiplier effects.

Pillar 6 of the First Presidential Compact compiled a list of urgent and important tasks to address the provinces' finances, such as managing down accruals and reducing wasteful expenditures. Pillar 6 of the Second Presidential Health Compact takes a more strategic approach. It sets out a minimum programme of strategies and actions to strengthen the financial health of the public health sector and the management of public finances, together with building the necessary human and systems capacity to meet this overall objective.

M.1. Evaluation of financial management challenges in the public sector

The financial management challenges that have existed for many years became more evident during the period of the First Presidential Health Compact (2018-2023): monitoring of critical aspects of financial management showed systemic weaknesses in the following areas:

- Repeated qualified audit opinions in most components of the public health sector in almost all provinces, with minimal improvements in some provinces
- Inadequate action plans were developed, and slow implementation of these audit action plans resulted in repeat findings
- Lack of oversight and monitoring of compliance results in irregular expenditure, massive in the case of the Northern Cape and Northwest provinces, where irregular expenditure accounts for 350 and 150 per cent of non-compensation expenditure
- An average of R6 billion irregular expenditure per year and health departments (national and provinces) account for 5 of the top 10 worst offenders across all departments in the country
- Total irregular expenditure accumulates, reaching nearly R60 billion in 2020. This reflects the departments' failure to get condonation, hold people accountable, recover misspent funds or otherwise resolve the findings of previous years. Where the issue is technical – for instance, spending on unbudgeted medico-legal claims – condonation should be straightforward, and the failure of the sector to resolve the issues may reflect deeper underlying problems
- In 2020, the Gauteng Department of Health was responsible for the second largest amount of 'fruitless and wasteful' expenditure in the country due to service providers overcharging for personal protective equipment. Gauteng, Free State, Northern Cape and Northwest continue to waste scarce resources at an unacceptably high rate

M.2. Strategies for improving financial efficiency and accountability.

The public health sector is entering an era of budget cuts, and the behaviour of the leadership and management culture in the sector needs to change to reflect this. These changes include better planning of the health service platform, increasing allocative and operational efficiencies, extracting more value for money, and improving the management of finances, procurement, contracting, controls, and compliance.

The following ten vital strategic shifts are proposed:

[33] Figures received from Treasury
[34] https://www.unicef.org/southafrica/media/7551/file/ZAF-health-budget-brief-2022.pdf

M.2.1. Improve Financial Planning for the Public Health Sector

The Minister of Finance announced the following in his Budget Speech, 2024:

"Health is allocated a total of R848 billion over the MTEF. These allocations include R11.6 billion to address the 2023 wage agreement, R27.3 billion for infrastructure, and R1.4 billion for the NHI grant over the same period. Such activities include building a national health information system and digital patient records; upgrading health facilities and improving quality of care to ensure that they meet the minimum criteria to be certified and accredited for contracting under NHI; strengthening facility and district management in preparation for contracting; granting semi-autonomous status for central (and potentially other) hospitals and; developing reference prices and provider payment methods for hospitals."

The budget review for 2024/2025[35] reflects that R271,9 billion is allocated to health, which will increase to R295.2 billion by 2026/27.

Building on these government-expressed priorities, Pillar 6 stakeholders recommend a comprehensive review of the funding needs for health care in the country, considering population, age and gender distribution, the burden of disease and key political goals, e.g. the SDG health-related goals. They further recommend reforming the funding mechanisms to incentivise the rational application of funds across primary and secondary prevention, primary health care (clinics and community health centres) and district provincial and tertiary hospitals, including academic complexes. Due consideration should be given to distinctive provincial circumstances, and rationalisation should be based on evidence and comprehensive stakeholder consultation. The state must pay special attention to the costs of human resources for health- as part of the Pillar 4 recommendation; the intersectoral health workforce committee should comprehensively define a cost management solution that considers the rising demand for health workforce against the contracting fiscal ability to absorb a growing health workforce. Sector wage negotiations should be preceded by agreements between national and provincial governments about how the salary increases will be funded, including considering costs that can be deferred to other relevant line departments.

[35] https://www.treasury.gov.za/documents/National%20Budget/2024/review/FullBR.pdf

M.2.2. Improving Financial Management in the Public Health Sector

Each provincial department must balance budgeting for salaries, goods and services, equipment and maintenance, and transfers. This must consider the right balance between budgeting for accruals and other unforeseen expenditures such as medico-legal claims.

A multi-year financial planning approach needs to inform these decisions, as no balance sheet can be fixed in a single year. The National Department of Health needs to provide technical assistance to provinces to develop these plans and build the capacity to execute them.

Each province must address irregular, fruitless, wasteful, and corruption more aggressively. The National Department and Treasury should reposition the Joint Action Plan to provide provinces with the support they need to address these issues.

The National Department of Health and National Treasury, together with the Presidential Health Compact Steering Committee, should drive the process of socialising the importance of addressing audit outcomes and irregular expenditure and improving oversight and monitoring compliance, especially with senior management and the provincial political leadership.

Increasing financial management capacity in provincial health departments, districts, and institutions is an area where the private and not-for-profit sectors can provide support.

Addressing accruals (unpaid invoices) remains a key priority for provincial health departments, both due to insufficient management capacity and inefficiencies and when budget pressures cause them. Provinces that show progress with addressing accruals should be rewarded with additional allocations to address remaining accruals.

A comprehensive national plan that addresses both the timeous resolution and settlements of claims, addressing vexatious claims and reducing negligence that gives rise to bona fide claims needs to be refined and implemented. All must understand this to be a significant risk to the balance sheets of provincial health departments.

M.2.3. Preparing for the Budget Cuts

In the face of budget cuts, the government must take bold actions to derive value for money.

Salary costs will need meticulous planning and management, possibly leveraging artificial intelligence and other health technologies to reduce absolute staff numbers. Each provincial health department will be required to review its staff establishments several times and jointly, under the guidance of the Department of Public Service and Administration and key stakeholders, to meet staff reduction targets. Expenditure Control on Goods and Services can be managed if provinces prioritise the most critical functions and services and reduce expenditure on lower-priority items. This is a better approach than "across the board" type decisions, and that usually starts with freezing all posts, which has disastrous consequences. Provincial health departments will also need to put strict measures in place to ensure that new projects are started after guardians of the budget have scrutinised them.

The cost of medical countermeasures has escalated, given the weakening of the currency and inflation in the medical technologies sector. Provincial health departments will need to reduce laboratory and medicine costs by auditing the adherence of clinical staff to nationally prescribed clinical guidelines and deploying stringent electronic gatekeeping to reduce wastage. The National Department of Health should continue its excellent work to reduce the price of essential medicines during the tender process; however, it needs to ensure that when a South African company tenders, it should be prioritised over foreign companies. This is because we need to grow our local manufacturing sector, create jobs and ensure sustainability in case of shortage. Whilst training and convenings are essential to ensure adherence to best practice and clinical guidelines, there should also be strict measures in place to reduce all expenses related to meetings and workshops, including food, accommodation and travel, including guidelines for holding effective online meetings and strict criteria for approvals of in-person meetings or workshops. Such stringent measures will ensure efficiency in the use of limited resources.

M.2.4. Increasing Efficiency and Value for Money

Actions to support increased efficiency should be guided by evidence provided by integrated health information systems that guide good spending for health. This implies that good spending for health does not necessarily fall under the health budget- an example of this being the WHO's Safe WASH (Safe Drinking Water and Sanitation) policy, where good health outcomes would be derived from spending undertaken by the Department of Water and Sanitation.

A review of health systems is recommended to understand better how to improve health promotion within communities and identify which major upstream non-health factors limit prevention efforts. Therefore, defining what constitutes good spending for health may be a helpful starting point, and this should be a multisectoral exercise that the Presidency can undertake under the banner of the second compact.

Training staff to make informed decisions and implement continuous quality improvement measures will be key. A better analysis of the outputs and outcomes of the provincial health services at each institution needs to be conducted. Institutions must increase staff productivity in areas where there is underperformance. Provinces must ensure that procurement results in value-for-money contracts at competitive market-benchmarked prices. State facilities should introduce Diagnosis Related Groups (DRGs) to report on hospital activity. This allows case-mix adjusted reporting to evaluate regions, hospitals, and clinical teams.

M.2.5. Preparing the Provinces and Public Sector Institutions for NHI

A well-coordinated transition is a key condition for the successful implementation of NHI.

Provincial governments need to start preparing for the implications for their services.

Provincial governments will need to scrutinise the cost structure of their services to ensure they fall within the pricing structure being developed by the NHI Fund to ensure adequate funding for their institutions.

The provisions in the NHI Bill related to the transition of central hospitals into semi-autonomous entities need to be given force by the requirements of Section 7 of the Public Service Act. Proper arrangements should be made in line with the Public Service Act.

Provinces and Districts should prepare to meet the NHI's requirements. The latter will focus on active purchasing. Instead of simply reimbursing providers based on services rendered or historical budgets, active purchasing will involve allocating funds based on population health needs and provider performance. The NHI will use an approach that requires careful assessment of the population's healthcare needs and the available providers.

Districts and Primary Health Care (PHC) Providers must adopt a new payment approach. Payment will be made on a risk-adjusted capitation basis, where providers are paid a set amount for each enrolled person assigned to them, adjusted for the health risk of the person(s). This might be supplemented with performance-related payments to encourage better service delivery.

In contrast, hospital payments will be different. A case-mix-adjusted activity system, such as diagnosis-related groups (DRGs), will be used, where hospitals are paid based on the type and complexity of the cases treated. This system might also include performance-related payments.

Introducing these payment mechanisms will rely on accurate and routine data collection such as the one used with the Health Patient Records Systems. The Pricing Committee will recommend payment rates to the Minister, requiring extensive costing information and good cost-centre financial management information systems within hospitals and at the district level. The NHI digital system will assist in managing cases and the associated benefits of purchasing.

The overarching goal is to use financial incentives to improve efficiency and quality in healthcare provision, ensuring that services are aligned with the population's needs and are sustainably managed within the NHI framework.

The National Department of Health, through the appropriate legislative process, should engage stakeholders about the various alternatives under discussion, including a mechanism within the NHI Fund.

Provincial governments and institutions (hospitals and district or sub-district units) will need to prepare their billing services to ensure that their institutions meet the minimum requirements to participate in the NHI Fund. Central hospitals need to understand how the additional costs they incur because of training doctors, specialists and sub-specialists will be factored into the billing to the NHI Fund.

M.2.6. Preparing the Private Sector Facilities for NHI

The private sector will have an integral role to play in the delivery of services under the NHI. At the local level, GPs and allied professionals (such as physio and occupational therapists, audiologists, etc) will have to align their businesses to provide services at prices set by the NHI Fund under a DRG-based and capitation-based remuneration system. They must ensure that they are linked to registration and billing systems for their services. At the level of hospitals, there will need to be a service delivery platform that delivers quality service at a lower price than the current price. Instead of servicing the same people at high costs, the private sector will provide care to more people at a lower rate. They may make the same amount as they do now through economies of scale.

M.2.7. Better Use of Donor Funds

The Lusaka Agenda, a global initiative adopted by the African Union at the 37th Assembly (2024), prescribes a set of strategic shifts to guide better dispensation of global funds in pursuit of health systems strengthening for successfully integrated primary health care.

Another key consideration is the volatility of the donor architecture; PEPFAR's non-authorisation is an important wake-up call, for example.

Considering this global and regional context, and in the current constrained fiscal environment domestically, donor funding needs to be more closely integrated with provincial budgets to optimise the use and impact of these funds, enhance cost-effectiveness and value-for-money, and plan for sustainability of the services being funded by donors when they eventually out-transition their funding- this is in line with the Lusaka agenda.

To do this, provincial departments must fully understand the donor funding envelope, what services are being provided and their impact and cost. Finally, there should be tracking and accountability for unspent donor funds that are returned to donors, given the dire need for the country's health system. Ideally, donor budgets should be 'on budget' and be governed with the same rigour as public funds with all the contingent oversight of the public sector.

M.2.8. Innovative Financing

The time is right for South Africa to consider innovative forms of financing. The constrained fiscal environment calls for extra funding sources and a focus on maximising impact and value for money for the government's significant expenditures.

The Treasury should work with innovative financing experts to create the regulatory environment for innovative financing instruments and a pathway for approvals of innovative financing transactions.

Innovative financing options like outcomes-based contracts, social impact bonds and debt for health swaps present an opportunity to build better value for money and a more significant impact on government expenditure and increase the funding envelope by including funding from the private sector, donors and philanthropies that is fully aligned with government plans. These focus on enhancing the performance and cost-effectiveness of programmes to address ongoing social challenges that drain the fiscus in the short and long term and lead to significant morbidity and social disease.

Pillar six stakeholders recommend some actions to trigger a more innovative approach to financing. The National Treasury can develop a guideline for innovative financing that includes using government funding as outcomes funding. Similarly, the National Treasury may consider allocating funds for outcomes-based contracts and social impact bonds to address key social issues at the national and provincial levels.

M.2.9. Social Compact on Salaries, Headcount, Staff Mix and Productivity

Rationalising the spending on human resources for health can be fraught with political and social volatility that could seriously threaten the stability of the healthcare system. Whatever choices are made, there needs to be an agreement on reasonable productivity expectations and how these should be measured. These are not unilateral discussions and need meaningful engagement and a social compact to result in the correct mix of headcount, salaries, the mix of staff, the number of training positions, levels of productivity or outputs and outcomes achieved.

[36] Diagnosis Related Group

DRG[36]-based productivity reporting is used in many countries to measure hospital performance. To deal with this great matter, Pillar 6 stakeholders recommend that the Presidency convene a dialogue between the National and provincial Departments of Health, National Treasury, labour, institution managers, community, and patient groups to develop a common agreement on these issues and its implementation. Provincial health departments should take the initiative and lead these discussions at the provincial level to test the genuine appetite of labour for this discussion. Where there are limitations regarding the agreements that can be reached about salaries, the discussions should focus on the headcount, mix of staff and productivity in the provincial departments. A detailed analysis of the current headcount by institution and district and the current mix of staff and outputs needs to be carried out and assessed against the multidisciplinary team model that the NHI demands.

M.2.10. Building the Evidence-Base

Health financing is extensive and multi-layered. It involves technical expertise in public finance, macroeconomics, taxation, fiscal planning and budgeting, innovative financing and the disciplines of health policy and planning and health economics.

In light of the difficulties the country's public and private sectors face, there is a clear need to build an evidence base in health financing to guide decision-makers about the choices and threats facing the sector.

The Presidential Health Compact Pillar 6 team should convene all research and technical bodies to collaborate on a joint research and evidence-gathering programme to deepen knowledge and evidence in health financing. This information shall be processed to produce regular updates and findings that can be shared with national and provincial healthcare leaders and other stakeholders in the health sector.

M.3. Financial implications of NHI implementation and funding mechanisms

The NHI bill fundamentally addresses the pervasive inequity of the current two-tiered health sector, where 37% of the envelope is allocated to 84% of the population and bulk to 16% of the population. Having already highlighted the

Health Market Inquiry's finding of this fundamental flaw, the NHI is an exercise of resource allocation based on equity and social solidarity principles. Some of the resources that have financed overuse, excessive prices, price fixing, fee-for-service models, and the results of anti-competitive behaviour (as reported by the Competition Commission) will be divested into the under-resourced and overburdened state sector to correct inequities and lift standards for previously disadvantaged communities.

Although many concerns have been voiced about the affordability of the NHI, many countries implement single-payer state-led funds for Universal Health Coverage under difficult financial situations (for example, post-war) as a political strategy for economic growth. Two examples are Japan and South Korea. Japan introduced its National Health Insurance system in 1961 as part of its efforts to rebuild its economy after the devastation of World War II. South Korea also established a National Health Insurance system in 1989 to provide affordable healthcare to its population and promote economic growth. These countries demonstrated that investing in a universal health coverage system can contribute to economic development by improving public health, increasing workforce productivity, and reducing healthcare costs in the long run.

Given that comprehensive primary health care is already provided to 84% of the population, with limited resources, the NHI must expand the funding envelope to cover the entire population. The Minister of Health has assured the country that the NHI will be implemented affordably, starting with the R1.4 billion allocated to concentrate on triggers for health system strengthening. After that, the NHI fund will be implemented in a phased manner based on international best practices.

A key determinant of success will be the state and private sector's ability to collaborate on the health sector's finance reformation. Here are some considered joint implications:

- Public-Private Partnerships: The government should engage in robust advocacy to prepare the private service providers for contracting with the NHI. As part of this advocacy, experiences should be exchanged to provide additional expertise and resources to improve service delivery. As discussed by Pillar 4 stakeholders with the Inkosi Albert Luthuli case study, public-private partnerships should also be encouraged to finance and sustain infrastructure development
- Risk-sharing Mechanisms: The state and the private sector can develop risk-sharing mechanisms to manage financial risks associated with implementing national health insurance. This can help protect stakeholders from unexpected financial burdens
- Innovative Financing Models: The state and private sector can explore innovative financing models, such as social impact bonds or blended financing mechanisms, to mobilise additional funds for the national health insurance system

M.4. PILLAR SIX MONITORING AND EVALUATION TOOL

PILLAR 6: IMPROVEMENT OF PUBLIC SECTOR FINANCIAL MANAGEMENT SYSTEMS AND PROCESSES

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Comprehensive review of the funding needs, taking into account disaggregated population data, burden of disease and key political goals	Conduct and publish an Economic and Financial Review of South Africa's Health and Funding Needs	Review of Economic and Funding Needs for South Africa's Health Priorities and NHI	June 2025	NDOH	Pillar 6 Stakeholders Africa CDC Presidency
Development by provinces of multi-year financial plans with technical assistance building from NDOH	Each province to develop a multi-year financial plan for 2024-2029 and submit it to NDOH	Each province submits a financial plan for the period 2024-2029	June 2025	Provincial DOH	NDOH National Treasury
Preparation of the Provinces, public sector institutions and private sector for the financial implications of NHI	Annual report on preparations of the health sector for financial management under NHI	Produce a report on the state of preparedness of the public and private sector for financial management under NHI	Annual from April 2026	NDOH NHI Fund to coordinate	Provincial Departments of Health Private Sector Civil Society Forum
Improved coordination of donor funding	Stakeholders will develop proposals for a more streamlined management of donor funding	Recommendations for streamlining the management of donor funding for health	June 2025	NDOH	Pillar 6 Stakeholders Civil Society Forum
Creation of a regulatory environment for innovative financing instruments and a pathway for approvals of innovative financing transactions	National Treasury to produce technical guidelines on innovative financing for health	Technical Guidelines on Innovative Financing for Health in South Africa	June 2025	National Treasury	SAMRC Pillar 6 Stakeholders

N. Pillar Seven: Strengthening governance and leadership for oversight, accountability, and health system performance.

N.1. Importance of effective governance and leadership in healthcare

The importance of strong governance and leadership cannot be overstated as the country transitions into a cohesive system to deliver universal health coverage.

For the success of the National Health Insurance and to advance rapidly towards the SDG goals for health by 2030, the health sector needs to establish clear lines of authority and accountability, promote ethical behaviour and compliance with regulations, and ensure that limited resources are used efficiently and effectively.

Strong leadership is essential for navigating the complex and rapidly changing landscape of the healthcare sector as the NHI is being rolled out, making strategic decisions, and addressing challenges and opportunities proactively:

1. **Patient Safety and Quality of Care:** Good governance ensures that patient safety is a top priority and that quality of care standards are met or exceeded. Effective leadership establishes a culture of safety and continuous quality improvement, resulting in better patient outcomes.
2. **Financial Sustainability:** Given the current fiscal constraints, sound governance practices will be crucial to managing finances prudently and ensuring long-term sustainability. Strong leadership fosters financial accountability, strategic planning, and resource allocation to support the organisation's mission and goals.
3. **Regulatory Compliance:** Robust governance structures and competent, accountable leadership are essential for ensuring compliance with laws, regulations, and industry standards, thereby minimising risk and liability.
4. **Stakeholder Engagement:** Effective governance and leadership to facilitate communication, collaboration, and engagement with stakeholders, fostering trust and alignment of interests.
5. **Innovation and Adaptability:** Strong governance and leadership promote a culture of innovation, risk-taking, and continuous learning. The African Union's New Public Health Order—which calls for strengthened public health institutions, ramping up pharmaceutical manufacturing, a capable health workforce, domestic health financing, and action-oriented partnerships—demands that we innovate, given the myriad of existing challenges that could threaten this agenda.

In the 2018 summit, Pillar 7 stakeholders identified several troubling governance issues.

The most concerning issue was that each sphere of government, nine provinces, and 278 municipality governments were severally semi-autonomous structures whose capacities differed across and within these levels. This made ensuring uniform implementation of national health policies, norms, and standards difficult. In addition, the stakeholders observed that several of the healthcare sector governance structures in the country were not functioning optimally and were not being held accountable.

Regarding health systems intelligence, stakeholders found that the health information systems needed to be more cohesive, and survey data did not necessarily inform the policy process.

The stakeholders also addressed fraud and corruption, submitting that the public and private sectors were most vulnerable to fraud and corruption because of large and varied numbers of malicious transactions on goods and services.

On normative instruments, stakeholders were concerned that although certain health system components had explicit norms and standards, these no longer suited the changing health system requirements, which led to confusion and sometimes compromised compliance amongst stakeholders.

To address these and other findings, the stakeholders outlined the following recommendations in Pillar 7:

- Strengthen accountability mechanisms at the national, provincial and institutional levels within the current Constitutional framework
- Ensure effective oversight through robust health information, research and evidence
- Provide effective oversight and policy guidance across the health sector
- Address corruption decisively

- Update and reinforce health sector regulations to improve quality, transparency, accountability and efficiency in the health sector (Public and private)
- Coordination across the health sector and building strategic partnerships

N.2. Areas of Progress and Persistent Challenges

A whistle-blowing policy was developed and completed to ensure the ease of reporting to relevant authorities.

The Health Sector Anticorruption Forum was launched in 2019. In September 2023, the Forum convened a meeting to take stock of progress made since its launch. It noted the "progress made on the investigations, which has resulted in the recovery of millions of rands, convictions and disciplinary actions. HSACF is also impressed by the reported incidents of fraud in the health sector."[37]

However, as Pillar 6 stakeholders pointed out, weaknesses in leadership and governance, compounded by corruption, mean the sector is not gaining value for money.

There is a disjuncture between Presidential Health Compact reporting, NDOH resources and Non-Health Sector departments. Pillar 6 stakeholders have addressed this issue by recommending an approach that identifies good spending for health. This should be accompanied by a systematic review of the governance of such a framework to ensure reporting is streamlined based on a multi-departmental, multi-sectoral approach.

The lack of dedicated, full-time resources to support the implementation of the Presidential Health Compact makes it too difficult to hold responsible parties accountable. However, no budget was ever set aside to implement the compact.

N.3. Proposed Priorities for 2024 - 2029

- Evaluate the work done by the Health Sector Anti-Corruption Forum since 2019 and annually support strategic interventions that the Special Investing Unit has identified through the Health Sector Anti-Corruption Forum to foster collaboration and cooperation to combat fraud and corruption
- Ensure that the Intersectoral Health Workforce Committee proposed by pillar four provides a framework to formalise the participation of Community Health Workers in the health system, particularly within the context of multidisciplinary teams
- Formulate and implement the agreement between the Public Sector (Provinces) and the Private Sector (Hospitals) about Remunerative Work Outside of Public Service (RWOPS) and the Moonlighting work done by nurses (Actions 1 and 5)
- Implement Health information sharing between the public and private sector
- Implement more targeted research by the consumer of research information produced

N.4. New Interventions Proposed

The Presidency will collaborate with the Treasury and agree on a financing plan that ensures the Health Compact is fully resourced to support implementation. The funds do not have to come from the fiscus but should be raised and ring-fenced for this purpose, with a governance and accountability framework developed.

Take full advantage of the capacities offered by the Health Sector Anticorruption Forum (HSACF), as members report that there is capacity to do more. In addition, national and provincial departments of health must build up the necessary human and financial capacity to implement the recommendations of the HSACF and support the processes for successful law enforcement.

Pillar 3 Stakeholders want to determine the establishment of a National Health Commission to drive intersectoral action to address the social determinants of health. Such a determination will include clear terms of reference and institutional arrangements.

DPME is to report annually on the state of Implementing the Health Market Inquiry recommendations, where the recommendations advance and are not at odds with the pathway towards implementing the National Health Insurance.

[37] https://www.siu.org.za/health-sector-anti-corruption-forum-hsacf-voices-concern-on-the-increase-in-fraudulent-medico-legal-claims-and-organised-crime/

All Provincial MECs to establish a position of coordinator of Hospital Boards and Clinic committees in their office to provide a direct communication line.

Stakeholders recommend a leadership and governance programme at the executive level as part of the deliverables of the National Health Council.

N.5. Link between governance and leadership and successful NHI implementation

Following consultations with evaluation stakeholders at national, provincial, district and facility levels, the NDOH published The Evaluation of the NHI Pilot Project (entitled: Phase 1 Implementation of the Interventions in the National Health Insurance Pilot Districts in South Africa.) In terms of governance and leadership, the evaluation found four aspects of management that affected the implementation of the Pilot:

1. Achieving clarity of vision,
2. Setting priorities,
3. Performance management
4. Maintaining accountability

Operationalising the following four principles for successful implementation of the National Health Insurance (NHI) in South Africa involves the following steps:

1. **Achieving clarity of vision:**

   There is a pressing need for leadership and strategic direction from experienced and knowledgeable governmental leaders so that individuals on the ground can meet the desired objectives.

   There is a need to clearly define the vision and goals of the NHI in digestible language, ensuring that all stakeholders understand the purpose and objectives of the program.

   The vision of NHI must be communicated effectively to the public and healthcare providers to create awareness and buy-in.

   The NDOH must develop a detailed roadmap outlining the steps to achieve the vision, with clear milestones and key performance indicators.

   With the preferred contracting unit at the community level, district managers must be engaged and capacitated to operationalise the planned decentralised purchasing-provision function of the DHS within the NHI Bill to ensure solid governance and accountability at district and ward levels.

2. **Setting priorities:**

   Health Compact stakeholders must arrive at a consensus on priority areas of the healthcare system that require immediate attention and provide the most significant impact on the population's health outcomes.

   NDOH, PDOHs, and Treasury must allocate resources based on these priorities, focusing on areas such as primary care, human resources for health, infrastructure development, and disease prevention.

3. **Performance management:**

   The DPME must ensure a robust monitoring and evaluation framework to track progress toward achieving the NHI's goals.

   The NDOH must be willing to refine the indicators for measuring the health system's performance and regularly review performance data to inform decision-making, identify areas for improvement, and adjust implementation strategies as needed.

4. **Maintaining accountability:**

   The NDOH and DPME must clearly define the roles and responsibilities of all stakeholders involved in the NHI implementation, including government agencies, healthcare providers, and civil society organisations.

   The government must implement mechanisms for transparency and accountability, such as regular reporting on progress, financial audits, and public consultations. This includes holding key decision-makers accountable for meeting targets and delivering on commitments, with consequences for underperformance or misconduct. To this end, pillar 7 stakeholders recommend strengthening the Health Sector Anticorruption Forum, including its institutional framework.

N.5. PILLAR SEVEN MONITORING AND EVALUATION TOOL

PILLAR 7: STRENGTHENING GOVERNANCE AND LEADERSHIP FOR OVERSIGHT, ACCOUNTABILITY, AND HEALTH SYSTEM PERFORMANCE

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Dedicated financial and human resources to support the implementation of the Compact	The Presidency will collaborate with National Treasury and agree on a financing plan The funds do not have to come from the fiscus but should be raised and ring-fenced for this purpose, with a governance and accountability framework	A financing and governance plan to support the implementation of the Health Compact developed	December 2024	Presidency National Treasury	NDOH Pillar 6 Lead and Task Team Civil Society Forum
Optimisation of the NDOH and Provincial Departments' capacities to implement the recommendations of the of the Health Sector Anticorruption Forum	Pillar 7 Stakeholders to submit a set of recommenations to Presidency to optimize the capacity of the HSACF and the capacity of departments to implement its recommendations	Framework for successful implementation of the recommendations emanating from the Health Sector Anti-Corruption Forum	December 2024	NDOH Presidency	Civil Society Forum
Intersectoral action to address the social determinants of Health at the level of the Executive	Minister of Health to submit an annual report to the President on the state of intersectoral action in addressing the social determinants of Health	Ministerial Report on the State of Intersectoral Action to Address the Social Determinants of Health	Annual	Minister of Health	Pillar 7 Stakeholders Civil Society Forum
Implementation of the Health market inquiry Recommendations	NDOH to report on the Implementation of the Health market inquiry Recommendations	Annual report on Progress with Implementing the Health market Inquiry Recommendations	Annual	NDOH	Civil society forum
Provide a direct line of Communication between Hospital boards, clinic Committees and MECs	All provincial MEC to Establish a position of Coordinator of hospital Boards and clinic Committees	Every office of the MEC develops a coordination mechanism for hospital boards and clinic committees	Q4 2024	NDOH MEC's of provincial DoH's	Provincial DoH departments (through the nhc) Civil soiety forum

O. Pillar Eight: Engagement and empowerment of the community for community-based care

O.1. Role of community engagement in healthcare delivery

Community engagement is crucial in healthcare delivery, promoting collaboration between providers and community members. It involves understanding and addressing the needs and priorities of the community, fostering trust and building relationships. Community engagement improves access to healthcare services, increases awareness of health issues, and facilitates the development of tailored health programs and initiatives. By involving the community in decision-making processes and empowering individuals to take ownership of their health, community engagement can lead to better health outcomes and increased overall wellness.

Pillar 8 stakeholders reaffirm the relevance and continued focus on the three objectives that underpin Pillar 8, which remain as:

1. Strengthening the Governance capacity of bodies involving communities
2. Enhancing health literacy for better health outcomes
3. Re-orientating training and education of community health workers and health professionals

O.2. Areas of Progress

While the establishment of clinic committees and hospital boards has increased yearly since 2019, the functionality and impact of these governance structures have been mixed. As of quarter 4 2023/2024, NDOH reported that 1909 facilities out of 3880 had established and well-functioning health governance structures.

At the September 2020 National District Health System Committee meeting, participants discussed guidelines for monitoring the effectiveness of the clinic committee. They drafted a framework for training hospital board members and created training materials. They completed and piloted the final drafts of the Training Manual, Facilitation Guide, and Pocket Handbook for use by Hospital Board Members in 511 clinics across the country. While they adopted the assessment tool, the variable governance landscape described above suggests that it has been widely adopted, yielding mixed results.

Although Pillar 8 stakeholders had resolved to convene annually National and Provincial Consultative Forums on health with appropriate community engagement, only three provinces convened these forums in 2019—Eastern Cape, Mpumalanga, and Western Cape. Since then, no forums have been convened.

In pursuit of enhancing health literacy among community members for improved health outcomes, Pillar 8 stakeholders embarked on initiatives. They aimed to expand community-based data in the District Health Information Systems (DHIS). Throughout 2019, they developed the Ward Based Primary Health Care Outreach Team (WBPHCOT) Monitoring & Evaluation Framework and corresponding data collection tools, aligning them with the new Scopes of Work of Community Health Workers (CHW) and Outreach Team Leaders. These tools now facilitate the collection and utilization of data to monitor the WBPHCOT program. Notable progress has been made in CHW DHIS reporting, with performance being monitored quarterly. Twenty-three (23) WBPHCOT data elements have been integrated into the final National Indicator Data Set (NIDS 2023) for reporting through the Web DHIS.

In addition to the initial objectives set out in 2019, The PLHIV (People Living with HIV) sector has implemented the Ritshidze (www.ritshidze.org.za) Community-Monitoring project. This is an initiative for community-led clinic monitoring to assess the quality and accessibility of services in 400 clinics in 27 districts across all provinces except the Northern Cape (noting that the Northern Cape was excluded due to funders' focus and not by design of the PLHIV Sector).

Technology has also been leveraged to enhance community participation through Communities Matter App (www.sanaccsf.org.za)- a community-led monitoring platform that is used by 250 community mobilisers in 25 districts across all nine provinces to document and respond to human rights violations and gender-based violence and femicide experienced by community members. Over 45 000 cases have been documented and are currently being responded to by government and civil society actors.

O.3. Persistent Challenges

The variable results and inconsistent reporting of facility governance structures cause serious concern and imply that either the assessment tool is ineffective, its onboarding is ineffective, or there are reporting errors. These issues are due to a poor understanding of the roles, responsibilities, and selection criteria of

committee members serving in clinic committees and hospital boards, resulting in a dysfunctional reporting framework. One clear issue that poses a challenge is that it takes too long for MECs to appoint new members of Clinic Committees and Hospital Boards based on political principles, compromising the integrity and quality of governance.

The lack of understanding of the roles and responsibilities of a Community Liaison Officer has resulted in community outreach efforts beyond the healthcare facilities remaining persistently poor.

The health workforce's capability for realising good community health outcomes remains compromised because staff shortages result in personnel being forced to take on multiple roles beyond their scope of work in some health facilities. In addition, there is limited funding for community health workers and little occupational protection for them. Even if community-based organisations (like patient user groups) want to establish working partnerships with facilities, they encounter bureaucratic or political hurdles that make partnerships with district or ward-based facilities too demanding to succeed.

O.4. Root Causes of Challenges

The appointment of Clinic Committees and Hospital Board members is too politicised. This legislated power regarding the National Health Act needs urgent attention to address this challenge. Members make decisions based on political expediency rather than good health outcomes, which hampers implementation at the facility level and creates tensions at different levels of the public health system.

Due to the top-down nature of the Department of Health's decision-making, approval processes for issues like training, monitoring, and impact assessment are very slow. In most cases, directives are not implemented once approvals are received because they do not cascade to facilities at the expected speed.

The shortage of staff and human resource management challenges at all levels directly impact the users of the public health system.

There is a lack of integration of different health information systems. The DHIS (District Health Information System) is not agile enough and very rigid; thus, it does not provide platforms for inter-operability with work done by community actors who contribute to the public health system data gathering efforts.

The training of community health workers and other cadres of the community health workforce who work for the non-profit sector needs a more sustainable approach. Even if community workers are trained and deployed, they are not well equipped for community-based work as they often lack tools of trade, means of transport, identifiable uniforms or other identifiers and occupational protections. Many of them are contract workers, meaning their impact is time-bound- when they are retracted from the community, they leave behind a yawning healthcare gap, which can cause regressions in health outcomes for community members.

O.5 Priority actions for 2024- 2029

O.5.1 Improving Hospital Boards and Clinic Committees

Though we align ourselves with the Pillar 7 recommendation for a coordinating officer of hospital boards and clinic committees at the MEC's office, we recommend that the appointments should be decentralised, using a similar model of election that is used for the appointments of School Governing Boards (with some refinements). The National Health Act should be amended to implement this new approach.

Pillar 8 stakeholders will advocate for patient user groups to be represented in the clinic committees and hospital boards to ensure that people living with non-communicable and rare diseases are not left behind in the determinations of these governance structures. In addition, we will emphasize diversity that promotes a multi-faceted approach within the Clinic Committees and Hospital Boards to ensure inclusion of all populations being served- including but not limited to youth, sex workers, people with disabilities, and patient user groups.

O.5.2 Improving Health Outcomes for Vulnerable Groups

As previously mentioned, the role of the Community Liaison Officer needs to be clarified. As part of this clarification is the Officer's role in facilitating outreach and engagement with vulnerable groups such as hard-to-reach populations, people living with disabilities, people living with mental health disorders and their families, and older citizens.

The NDOH is encouraged to develop norms and standards for interfacing with people living with disabilities at community-level facilities to ensure that people with disabilities enjoy equal access to healthcare services.

As part of reviewing the guidelines for patient triage, the NDOH should make revisions to ensure the prioritisation of mental health screening and intervention at the community and facility levels.

O.5.3 Risk Communication and Community Engagement

The RCCE Unit in the NDOH can play a more significant role in public education and prevention drives in communities, including nuanced campaigns targeting vulnerable populations.

This intervention can begin by defining a community engagement framework that should be implemented across all provinces as part of standardisation. This framework must include a checklist for quality assurance of community interventions.

The RCCE unit can also leverage the District Development Model as a communication platform to support strong community ownership driven by political will and a focus on client care.

O.5.4. Human Resources for Good Community Health Outcomes

Drawing lessons from the human resources elements of the Solidarity Fund, Pillar 8 stakeholders recommend implementing a public-private co-investment approach to Human Resources for Health for an agile and primary healthcare-focused model that will strengthen the NHI by employing more community health workers, community liaison officers, social mobilisation officers, and ward-based community teams.

We reaffirm the importance of retaining a solid contingent of community health workers. This critical element of health workforce development should form part of the work of the Intersectoral Committee for Health Workforce Development (recommended by pillar 4), which we recommend should work on formalising the sector in preparation for NHI.

O.5.5 Multisectoral Health Approach

Pillar eight stakeholders align themselves with the Pillar 7 recommendation to "drive intersectoral action to address the social determinants of health at the level of the executive." As part of this, we recommend that the NDOH develop regulations to ensure recognition of referrals with traditional health practitioners and allied health professionals with the public and private health providers.

O.6 Community involvement in NHI implementation and decision-making

Several practical steps can be taken to ensure that communities are fully involved in the implementation of the National Health Insurance:

1. **Community meetings and consultations:** Organising community meetings and consultations to gather input, feedback, and concerns from community members can help ensure their voices are heard and considered during the implementation process. In this regard, Pillar 8 stakeholders recommend that the annually National and Provincial Consultative Forums be revived and that the NDOH assign a deputy director general to oversee the consistent and yearly sustained programme of these conventions
2. **Community health worker outreach:** Utilising community health workers to engage with local communities, provide information about the national health insurance, and facilitate discussions on how it can benefit them can help increase awareness and understanding among community members. This was demonstrated very well in the community screening outreach during the initial phases of the COVID-19 pandemic- around 60 000 community health workers engaged over 25 million South Africans to not only screen for COVID-19 but to educate them on the new virus and on the government's interventions to implement public health measures.
3. **Community advisory committees:** Establishing community advisory committees composed of residents, community leaders, and healthcare providers can help ensure that the community's needs and preferences are represented in decision-making processes related to national health insurance. Patient user groups can be leveraged to lead these committees.
4. **Public education campaigns:** Launching public education campaigns through various media channels, including radio, television, and social media, can help raise awareness about national health insurance and promote community involvement in its implementation. Engaging the Human

Science Research Council to ensure that the platforms used are evidence-based is crucial, as it was recognised during COVID-19 that television and radio consistently remained the top platforms from which individuals derived their COVID-19 information.

5. **Mobile technology and online platforms:** Leveraging mobile technology and online platforms to facilitate communication, gather feedback, and provide updates on the implementation of national health insurance can help engage a broader range of community members. The aforementioned "Community Matters" application has demonstrated this.

O.G. PILLAR EIGHT MONITORING AND EVALUATION TOOL

PILLAR 8: ENGAGEMENT AND EMPOWERMENT OF THE COMMUNITY FOR COMMUNITY-BASED CARE

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Strengthen Community Involvement in the Implementation of the NHI	Revive the Annual National and Provincial Consultative Forums with appropriate community engagement	Annual Reports to the National Health Council on the Involvement of Communities in the Implementation of NHI	Annual, from April 2025	NDOH	Civil Society Forum Patient User Groups
Improving the appointment of Hospital Boards and Clinic Committees, ensuring inclusivity and diversity	Amendments in the National Health Act 61 of 2003	NHA Amendments to improve the appointments of hospital boards and clinic committees	March 2029	NDOH	Pillar 8 Stakeholders Portfolio Committee on Health
People living with disabilities enjoy the highest attainable standards of services	NDOH to develop norms and standards for people living with disabilities	Norms and standards for provision of health care to people living with disabilities developed	March 2025	NDOH	Provincial Departments of Health Patient User Groups
Legitimisation of a referral system between traditional health practitioners and allied health professionals with the public and private health providers	Develop regulations for a referral system between indigenous knowledge practitioners and the health sector under the NHA	Regulations governing referral systems from traditional knowledge practitioners to health facilities developed	March 2029	NDOH	Civil Society Forum Patient User Groups
Strengthen Risk Communications and Community Engagement	Fully Capacitate RCCE structures at national, provincial district and ward levels	National Strategy to Fully Capacitate RCCE Structures at National, Provincial, District and Ward Levels and Finance Plan	March 2029	NDOH	Civil Society Forum

P. Pillar Nine: Development of an information system for guiding health system policies and investments

In response to the critical need for a robust and integrated health information system, Pillar 9 was established to address several foundational challenges. These included:

- The fragmented landscape of disparate systems across the health sector, lacking national integration
- An outdated digital strategy is in urgent need of revision
- No formalised platform for continuous dialogue among stakeholders in both the public and private sectors
- A notable gap in comprehensive patient registers affects both the public and private sectors
- The non-availability of essential patient health records at the point of care is due to fragmented patient information systems
- Resistance towards adopting new Health Information Systems (HIS)
- Inconsistent use of diagnostics, procedural, and billing codes across the health sector
- Deviation from the WHO's Best Practice Health Terminology Services Coding Systems
- Non-standardised clinical guidelines and protocols across the sector
- A shortfall in centralised and consistent digital health education to sustain required expertise

Since the first health compact, concerted efforts have substantially addressed these challenges, underscoring the sector's commitment to transformative health information management. However, realizing the full potential of Pillar 9 requires a focused approach to both immediate, medium and long-term challenges, leveraging the lessons learned to date.

P.1. Progress Made Since the First Health Compact

As the leading implementation stakeholder, the National Department of Health (NDOH) facilitated extensive stakeholder engagement through workshops to craft a cohesive implementation plan for Pillar 9. For the greater part of 2019, the NDOH convened several meetings to workshop an implementation plan amongst the stakeholders to ensure the plan's uniform and comprehensive understanding. The Pillar 9 implementation Plan had five major interventions and ten target indicators. Out of these ten target indicators, five were due between 2021 and 2022, and the remainder of the targeted indicators were due in 2024 and 2025.

These advancements underscored the urgent need for integrated disease surveillance systems. Although disruptive, the advent of COVID-19 catalysed significant advancements, including the development of the Electronic Vaccination Data System (EVDS), the COVID-19 track-and-trace applications, and the integration of laboratory information systems at NICD, including genomic surveillance and strengthening the NICD DATCOV—COVID 19 Hospital surveillance capabilities.

The excess COVID-19-related death reports highlighted the urgent need for integrated disease surveillance.

The areas of focus from the first Health Compact were:

- The Health Patient Registration System (HPRS)
- Electronic Vaccination Data System for COVID-19 (EVDS)
- Master Health Facility List (MHFL)
- Data Centre hosting
- Health Information Exchange (HIE)
- Health Normative Standards Framework (HNSF)
- A Suite of Clinical Coding Recommendations

There was an understanding that the goals that were set in 2019-2024 were a journey and that each would be achieved based on the enablers, resources and support extended to the implementers.

Partnerships formed during this period, particularly with academic, non-profit, and private sectors, have been instrumental in advancing Pillar 9 objectives. They led to the successful reconstitution of the National Health Information System of South Africa (NHISSA) and facilitated collaborative efforts to develop key health information management tools and standards.

P.2. Persistent Challenges

Despite notable progress, Pillar 9 faced ongoing challenges during the implementation of the first Health Compact that needs to be addressed urgently. These challenges include the following:

- Lack of digital health governance framework
- Lack of involvement of the private sector in the public sector planning and preparatory work.
- Trust deficit between public and private participants regarding data sharing
- Public Health Sector budget cuts
- Lack of funding for some initiatives
- Compliance with Legislative requirements (54 policies & legislation)
- Connectivity instability, often caused by load shedding
- Role confusion by some private sector participants
- Aligning Pillar 9 with stakeholder plans and with other Pillars
- Improved coordination and participation in Pillar activities
- Digital Literacy of users, clinicians and management

P.3. Strategies and Commitment to Address Identified Challenges

In response to the multifaceted challenges identified, Pillar 9 stakeholders have outlined a strategic approach underscored by developing a Digital Health Governance Framework. This pivotal framework is designed to lay the foundational principles for fostering trust and facilitating seamless collaboration across public and private sectors, ensuring that collaborative digital health projects enhance the health system without compromising all parties' unique mandates and interests.

The Digital Health Governance Framework aims to eliminate any apprehensions related to trust and vested interests, thereby setting a positive precedent for joint initiatives in the digital health arena.

Stakeholders recognize the critical role of this framework and are committed to its development and implementation as a cornerstone for advancing digital health across South Africa.

Regular and sustained engagements between public and private sectors are essential to complement this foundation. These interactions will deepen mutual understanding of the national digital health strategy and enhance the efficacy of monitoring and evaluation. We can cultivate targeted partnerships addressing specific challenges through such a collaborative model. These collaborations mustn't be misconstrued as avenues for the private sector to pursue undue business advantages or to circumvent procurement legislation through unethical practices.

Moreover, improving the quality and frequency of communication between government departments and between the government and other stakeholders is a critical measure for overcoming some of the abovementioned challenges. The purposeful and strategic dialogue will ensure alignment, coordination, and transparency across all digital health initiatives.

Despite these robust strategies, sustainable funding remains a key determinant of the success of Pillar 9 interventions. It requires a unified approach from all the key stakeholders, particularly emphasizing the role of the private sector in contributing to systems, processes, and intellectual capital in a manner beneficial to public health goals without incurring commercial harm. This collective effort towards resource sharing and capacity building is vital for the sustainable advancement of our digital health landscape.

Pillar 9 stakeholders are resolute in their belief that the strategic intervention plan developed for the 2024-2029 period will help systematically address these challenges. With a commitment to trust, collaboration, and shared progress, we are poised to navigate the complexities of the digital health transformation, thereby enhancing the effectiveness, accessibility, and resilience of South Africa's health information system.

P.4. Proposed Priorities for 2024 - 2029

The next phase of Pillar 9 will focus on the following identified key priorities for 2024-2029:

- Completing the outstanding interventions from the first Health Compact, which are:
    - Enhancing the Health Patient Registration System (HPRS) and extending its coverage to all health facilities
    - Conduct a health information infrastructure and architecture baseline assessment across the health sector (private and public)
    - Conduct a Health Information systems skills baseline assessment across the health sector (public and private)
    - Implementation of standardised health terminological systems for the national health system, applicable to the public and private sectors in which the individual components are concerned with the financing, providing or delivering health services
    - Accelerate the development of the Shared Electronic Health Record.
    - Review the current Digital Health Strategy and develop the 2024-2029 Blueprint and implementation Roadmap
    - Establishing a Digital Health Governance Framework
    - Aligning Digital Health policies and legislation
    - Promote the intelligent use of Data and Information
    - Capacity Building and Skills Transfer for Digital Health between the Public and Private Health Sectors

At the 2nd Presidential Health Summit in May 2023, these priorities were presented as the foundation for the new 2024-2029 Pillar 9 Implementation Plan. The 2024-2029 Pillar 9 Implementation plan is attached in the table below and is a product of the Pillar 9 engagements between August and December 2023:

P.5. Preparing For NHI: The Importance of Public-Private Sector Collaboration in Healthcare

The NDOH presented notable strides in public-private sector collaboration during the Pillar 9 meeting on 26 February 2024, especially highlighting advancements in Health Information Systems during and beyond the COVID-19 pandemic.

The National DoH has been urged to enact regulations under Section 74 of the National Health Act, focusing on establishing a comprehensive Health Information System. The urgency of this action cannot be overstated, as failing to integrate information systems across public and private sectors could lead to a fragmented foundation for the NHI, undermining its effectiveness and efficiency.

There can be no doubt about the potential and value-added benefits that a private-public partnership (PPPs) can bring in crafting a unified and robust health information system for the country. By bridging gaps and aligning efforts, we can mitigate fraud, corruption, and resource wastage, fostering a more effective use of our health resources.

Furthermore, these partnerships facilitate knowledge transfer and capacity building across the healthcare ecosystem, enriching the entire health system's competence and resilience.

Addressing the trust deficit between the public and private health sectors is critical for fostering meaningful collaboration. Acknowledging each sector's distinct interests and mandates serves as a foundation for transparent and honest dialogue. The public and private sectors must find common programmes or projects they can work on without threatening their mandates. The success of such projects will address the trust deficit to some extent, and this is one of the positive experiences we carry from the COVID-19 pandemic as the health sector and country. The next step would include key compact conduct such as joint planning, information sharing and joint implementation. The entire theme of the Presidential Health Compact 2024-2029 is moving the country towards Universal Health Coverage achieved through NHI.

The phased implementation of the NHI underscores the necessity of a data-rich environment for evidence-based decision-making and policy refinement. Data analytics will play a pivotal role in aligning NHI provisions with evolving health needs and challenges, enabling policymakers to tailor interventions, allocate resources judiciously, and develop policies that resonate with the unique needs of diverse population segments. This analytical approach will also be crucial in responding to global health trends, such as the rise in non-communicable diseases (NCDs) and the implications of climate change on public health.

The transparency afforded by publicly shared data analytics has proven invaluable in building trust, guiding public behaviour, and ensuring stakeholder accountability. As we move forward, embracing this level of openness will catalyse continuous improvement and spur innovation within healthcare delivery, making transparency a cornerstone of the NHI's success.

Moreover, adopting data-driven methodologies will be essential in sustaining the NHI. These methodologies will allow for the identification of inefficiencies, the optimization of resource distribution, and the effective management of financial risks. This strategic focus ensures that healthcare services remain accessible, equitable, and affordable for all South Africans.

Investing in advanced data security technologies is paramount to safeguarding the integrity of the healthcare system. While the journey towards adopting cutting-edge solutions like blockchain and quantum cryptography continues, prioritising technologies that pre-emptively address corruption and maladministration is crucial. The adoption is essential to mitigate the great concern of corruption and maladministration. The sector is far from scalable, near-impenetrable systems. South Africa must invest in the most secure technologies that focus on preventing criminal activity rather than detecting it after the fact.

In conclusion, integrating comprehensive, data-driven strategies within public-private collaborations is instrumental in realizing a healthcare system that is not only equipped to support the NHI but also resilient, equitable, and attuned to the needs and well-being of all South Africans.

P.6. PILLAR NINE MONITORING AND EVALUATION TOOL

PILLAR 9: DEVELOPMENT OF AN INFORMATION SYSTEM FOR GUIDING HEALTH SYSTEM POLICIES AND INVESTMENTS

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Integrated Disease Surveillance System (IDSR) developed	Develop a policy framework/ strategic plan for Integrated Disease Surveillance Finalise the list of conditions and case definitions to be included on the IDSR	A policy framework and/or strategic plan and list of conditions and case definitions to be included in the IDSR	September 2025	NDOH	WHO NICD
Integrated Health Information System	Facilitate interoperability between the various patient information systems using the normative standards framework for Digital Health in SA	Report on compliance with the identified interoperability standards by all provincial patient information systems Normative standards compliance testing laboratory established	December 2026 2024-2029	NDOH	CMS, Provincial Departments of Health, Private Sector, DSI, CSIR, Academia
	Develop and implement a South African Health Information Exchange Service that will allow data sharing between identified health information systems	Enterprise Architecture inclusive of 2nd phase of the Health Information Exchange developed	2024-2029	NDOH	Provincial DoHs, CMS, Private Sector, Civil Society
	Develop and Implement procedures and systems for Identity Verification Users of Health Systems (public and private)	Report on continued Development and rollout of the Health Patient Registration system and its related Master Patient Index Services	2024-2029	NDOH	CMS, Private Sector, Home Affairs
	Establish a Health Establishment Registry through the Master Health Facility List Platform	Health Establishment Registry established (through the Master Health Facility List Platform) Report on the expansion of the use of the Master Health Facility List Platform through the inclusion of Public and Private Health Establishments	2024-2029	NDOH	Provincial DoHs, CMS, Private Sector, Civil Society

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
	Implement section 74 of the National Health Act 63 of 2003 to strengthen information systems to ensure the attainment of a comprehensive and seamless National Health Information System	Regulations for implementing section 74 of the National Health Act 63 of 2003 published in the Government gazette Progress on the Utilisation of Health Terminology Services, Master Health Facility List Platform and the HPRS produced	2024-2029	NDOH	CMS, Private Sector, Civil Society
	Standardise health outcomes reporting for both public and private health sectors	Health impact indicator data from the public and private sectors is included in the national health information system and data available in the NDOH Big data platform is included in the national health information system and data	2024-2029	NDOH	Provincial DoHs, Health Funder Groups, Civil Society
Standardisation of health diagnostic and procedure coding systems	Implementation of the Health Terminology System	Inclusion of the identified Health Terminology System in Electronic Medical Record systems as well as the individual sub-systems feeding the EMR such as Laboratory test results and Radiology imaging	2024-2029	NDOH	CMS, Private Sector, Provincial DoHs, Civil Society
Capacity building and skills transfer for digital health	Conduct a health information systems skills baseline assessment across the health sector (public and private)	Report outlining accurate baseline health information skills and expertise across the health sector produced	March 2026	NDOH	Provincial DoHs, Private Sector, CMS, statutory Councils
Development of business intelligence for the health sector	Identify baseline business intelligence (BI) report requirements across the health sector	Business Intelligence Specification Document outlining report requirements across the health sector	March 2026	NDOH	Provincial DoHs, Private Sector, CMS, statutory Councils
Development of a Digital Health Governance Framework	Establish a framework that defines the collaboration and data governance between public and private sectors	A Comprehensive Digital Health Governance Framework developed, which serves as a framework for collaboration between public and private sectors	March 2026	NDOH	Provincial DoHs, Private Sector, CMS, statutory Councils

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Accelerate the development of an electronic health record	Fast-track the creation and deployment of an EHR that integrates across the health system	Shared Electronic Health Record system to support the portability of health services developed and implemented	2024 - 2029	NDOH	Provincial DoHs, Private Sector, CMS, statutory Councils
Promote the intelligent use of data and information	Enhance the analytical use of health data for better decision-making and policy development	Improved data utilization evidenced by data quality audits	2024 - 2029	NDOH	Provincial DoHs, CMS, statutory Councils
Capacity Building and skills transfer of digital health	Foster continuous learning and expertise development in digital health across sectors	Sustained programs for skills development and transfer established	2024 - 2029	NDOH	Provincial DoHs, CMS, statutory Councils

Q. Pillar Ten: Pandemic Preparedness and Response (PPPR)

Q.1. Lessons Learnt from the COVID-19 Response Strategy

South Africa's COVID-19 experience was defined by over 4 million confirmed cases and more than 104,000 deaths reported from March 2020 to March 2023. There were at least four waves of the pandemic, causing loss of lives and livelihoods and devastation across all sectors of society, including health workers.

The first case of COVID-19 was confirmed on 5 March 2020. Under the leadership of President Ramaphosa, the National Coronavirus Command Council was constituted as the overall pandemic coordination body. This body provided policy and strategic guidance to the Cabinet, which, in turn, implemented a multi-departmental, multisectoral response to the pandemic.

To flatten the curve and buy time to resource the pandemic response strategy and in line with the best practice of the day, the Cabinet resolved to declare a National State of Disaster on 15 March 2020 and enforce a 21-day lockdown. It is pertinent to remember that at that point, the R0 globally was estimated to be between 1,5 and 3,5 and the case fatality rate in Wuhan, China (where the virus was first identified) was close to 25% .

The technical response was led by the COVID-19 Incident Management Teams (IMTs) at national, provincial and district levels in collaboration with other disaster response entities, including the Ministerial Advisory Committee, NATJOINTS (which supported a securitised approach), the private sector, global health initiatives, multilateral organisations and donors.

The Centre for Strategic and International Studies attributed South Africa's "relative success" in responding to COVID-19 to the wisdom of "borrowing best practices from past responses to health emergencies… including mobilising the public and private sector, following guidance from the scientific community, and conducting outreach to religious leaders and political opponents. " The risk-adjusted strategy, which allowed for adjustments to public health measures as new variants drove new waves in the pandemic, is widely cited in academic literature as an effective strategy to mitigate against the spread of the virus while protecting lives and livelihoods.

The pillar ten stakeholders identified the following key lessons that can be derived from the national COVID-19 response strategy:

Q.1.1. Lesson 1: Governance and Coordination

Decisive and strong leadership at all levels is critical for effective pandemic preparedness and response. A national PPPR coordination platform for the development, stress testing, and implementation of the national PPPR plan is essential.

It is necessary to adapt existing emergency response structures, health systems, policies and programs to rapidly institutionalise best practices,

Pandemic preparedness, prevention, and response (PR) should be guided by defined principles appropriate to the country's context. This would ensure a whole-of-society and whole-of-government engagement, with no one left behind.

A well-considered legislative framework for PPPR is essential, as it must protect livelihoods and incorporate a gender-sensitive and responsive spirit.

Pandemic preparedness and prevention safety nets should include business continuity planning and social security networks to mitigate the impact of a pandemic.

International cooperation and coordination are essential to ensure the country is aligned with and can leverage the global and regional policy frameworks, legal agreements, financing mechanisms, medical countermeasures, supply chain platforms, and recovery instruments.

Q.1.2. Lesson 2: Health Systems

Investing in robust health systems and primary health care through Universal Health Coverage and bolstering capacities for emergency response can prevent or attenuate pandemics, foster resilience to health threats, increase efficiency and sustain essential health services.

Pre-planned surge capacities are critical for budgeting, rapid response, protecting the health workforce, sustaining supply chains, and maintaining essential health services.

Q.1.3. Lesson 3: Financing PPPR

It took too long for funds to be mobilised for the national, regional and global pandemic response. There must be access to funds upon declaring a public health emergency, i.e. day zero. After that, a finance plan should be configured ideally within weeks of a declaration.

As a country, we must hold governors of multilateral financing arrangements accountable for transparency, fairness, agility, and clean governance.

Q.1.4. Lesson 4: Surveillance and Intelligence

The excess deaths reports highlighted the need for an integrated surveillance and laboratory platform incorporating (but not limited to) data from health, home affairs, statistics SA, social development, and agriculture. Pathogen-specific, genomic, environmental, and sentinel surveillance components are critical from One Health's perspective.

Q.1.5. Lesson 4: Medical Countermeasures

Investing in research, regionalised manufacturing, and robust supply chain capacities (especially last-mile delivery) for medical countermeasures is critical for equitable access.

Q.1.6. Lesson 5: Health Workforce

Pandemic preparedness should include financial investments to increase the numbers, training, and occupational safety for surge health workforce deployments. A post-pandemic plan must also be in place to retain, redeploy or reconstitute the surge workforce.

Q.1.7. Lesson 6: Community Engagement

Effective community engagement on health risks is critical for optimising the uptake of recommended public health interventions during all pandemic stages and in inter-pandemic times.

Q.2. Strategies for strengthening pandemic preparedness and response capacities.

The interventions and activities proposed in this strategy are derived from the discussions during the Presidential Health Summit in May, the second Presidential Health Compact Pillar 10 Pandemic Preparedness webinar in July 2023 and the NDOH's draft Preparedness and Resilience to Emerging Threats: Planning for Respiratory Pathogen Epidemics, 2023.

The interventions have been classified under the five core components of the WHO Health Emergency Preparedness and Resilience (HEPR) architecture and the Preparedness and Resilience for Emerging Threats (PRET) framework for pandemic preparedness to respiratory pathogens. This is also in line with the NDOH draft emergency preparedness plan.

The five system components of the PRET framework are:

- Emergency Coordination
- Collaborative Surveillance
- Access to Countermeasures
- Clinical Care
- Community Protection

These components are interconnected and describe capacities required to prevent, prepare for, and respond effectively to health emergencies and pandemics, with resilient, multisectoral communities and core capacities for emergencies being the system's foundation. Pillar 10 stakeholders thus present the proposed interventions in line with the five core strategies and components of the PRET framework.

Q.2.1. Emergency Coordination

Pillar 10 stakeholders have agreed with NDOH to convene stakeholders regularly (at least quarterly) to assess the implementation of the NDOH Emergency Preparedness Plan and Financing Plan. This platform still needs an accountability framework and an implementation plan. The platform must also coordinate all regional and international PPPR developments, including the INB, the WGIHR Amendments, the Pandemic Fund and other financing instruments for PPPR and the AU PPPR Championship and its determinations. As such, the Presidency and NDOH should lead this coordination with DPME, monitoring the implementation.

A PPPR Technical Advisory Committee should be established to support the platform, with clear terms of reference, that will operate during inter-pandemic and pandemic times. Membership must be kept current. Its first task should be

to commission a review of the lawmaking process that governed the COVID-19 response strategy to strengthen national policy, legal, and normative instruments.

The Technical Advisory Committee should also review the adjusted risk strategy employed for the COVID-19 response to refine the definitions of public health threats, emergencies, and pandemics and the triggers for declaring a state of disaster or emergency and mobilising resources.

The Committee should posit a clear, comprehensive definition of pandemics based on the outcomes of the Pandemic Accord, the Amendments to the International Health Regulation, and the AU decisions on PR. It should also consider the decision to allow the Director General of Africa CDC the power to declare a Public Health Emergency of Continental Security.

The Committee should also develop an ethical and inclusive decision-making framework to provide a structured, systematic, and consistent approach to analysing PPPR ethical issues. In this regard, the Committee should establish or leverage an existing ethics review committee to advise on ethical considerations for PPPR interventions.

The Committee should explicitly make recommendations that give due consideration to high-risk and vulnerable groups.

Once the Pandemic Agreement and the IHR Amendments are ratified, a capacity-building framework must be developed to ensure the country can meet its legal obligations. Some of the key considerations in capacity include:

- The National Public Health Institute of South Africa (NAPHISA) should be established without further delay, ensuring the rollout of Public Health Emergency Operating Centres (governed by public health emergency coordinating committees) in all provinces that operate in line with International Health Regulations
- Encourage non-health sectors to develop sector-specific contingency plans for PPPR that clarify their roles and responsibilities during a pandemic
- Coordinating Financing at national, regional and global levels
    - Pillar 10 stakeholders recommend establishing a time-bound task team with terms of reference to deliver a national pandemic financing strategy
    - The task team should cost the national health emergency action plan based on a finalised PPPR plan for the entire cycle (emergency preparedness, response, recovery)
    - The work can leverage the G20 Joint Health and Finance Task Force to understand the funding landscape and consider traditional and innovative PPPR financing options during inter-pandemic and pandemic times
    - Alignment with Pillar 6 should occur, especially to ascertain whether provisions can be made in the existing fiscal space or if a financing gap must be filled. The provisions must include enough funds to fairly compensate for the surge in the health workforce, which may need to be sustained for several years
    - Treasury should secure a day-zero financing mechanism and work with the task team, NDOH and key stakeholders on fund-raising and future replenishment strategies. The mechanism must also easily and safely collect donations on an emergency basis
    - There must be an agreement on the triggers for the rapid release of funds during emergencies and pandemics, including investing in preparedness
    - Established data systems must inform the funding mechanism to ensure that funds are appropriately used
    - The Health Sector Anti-corruption Forum must submit recommendations for protecting funds from criminal activities, drawing lessons learnt from dealing with corruption and maladministration during the COVID-19 pandemic
    - Monitoring, evaluating, testing, and revising plans

Pillar 10 stakeholders will collaborate with NDOH and DPME to set indicators and establish systems to periodically assess the country's preparedness and the efficacy of a pandemic response. This may involve interpandemic stress testing and adopting existing intra-action and post-pandemic review frameworks.

Q.2.2. Collaborative Surveillance

The WHO's mosaic respiratory surveillance framework provides general guidance on an integrated disease surveillance approach.

However, South Africa must adopt a context-specific framework to capture and process information from diverse datasets.

The PPPR Technical Advisory Committee should define critical information and data that should be collected to facilitate early detection and precision tracking.

A desktop mapping of all the stakeholders and sources of data should be undertaken with a plan for periodic reviews.

The Department of Health has begun an integrated disease surveillance (IDS) pilot to standardise IDS in health surveillance. The ultimate holding entity for IDS is ideally the National Public Health Institute of South Africa (NAPHISA), as stated under coordination. In the meantime, the National Emergency Operation Centre is being established through donor funding. It will hold the development of IDS while NDOH (with advocacy from Pillar 10 stakeholders) continue to negotiate the establishment of NAPHISA with Treasury. The next step is to ensure that the government can sustain and optimise the use of the national EOC during interpandemic times and that the government can establish EOCs in each province to support the national EOC.

There should be one unique identifier across all systems.

An academic review of the legislative framework for data sharing, particularly interoperability, must be conducted to assess a pandemic response's speed, agility, and appropriateness. At the same time, strict adherence to the POPIA Act is preserved.

The government must sustain South Africa's participation in global surveillance networks such as the Expanded Global Influenza Surveillance and Response System (GISRS) as provided in the IHR Amendments.

Q.2.3. Equitable access to medical countermeasures

Global and Regional Developments

In line with the African Union's goals to attain biotechnological sovereignty, South Africa should focus on a sustained health technology manufacturing agenda in inter-pandemic times. The South African market should retain top priority, but the industry must target the African Union and global markets.

The African Union is establishing a legally pooled procurement instrument to sustain African manufacturers. Pillar 10 stakeholders and NDOH should engage in the processes and seek out or create national mechanisms that align with AU legal agreements.

Another sustenance mechanism is the Global Vaccine Alliance's (GAVI) African Vaccine Manufacturing Accelerator (AVMA). The AVMA is one-billion-US dollar fund that allows GAVI to purchase vaccines exclusively from Africa over ten years. Organised industries, such as Business Unity South Africa, should provide support to prepare South African vaccine manufacturers to take advantage of this opportunity. It is also recommended that SAHPRA lobby for a WHO prequalification process that does not threaten the AVMA's success.

The Pandemic Accord includes provisions for an Access and Benefit Sharing Framework at a global level. Pillar 10 stakeholders and NDOH must ensure South Africa's position is aligned with the Common Africa Position, which supports a fair, transparent, and equitable access and benefit-sharing agreement.

The WHO is socialising an interim medical countermeasures platform in preparation for the next pandemic, regardless of the maturation of the Pandemic Accord and Working Group on IHR Amendments Processes. The interim mechanism will adapt to the determinations of the legal instruments. Pillar 10 stakeholders must ensure that the South African government plays an active role in shaping the outcome of the interim mechanism, ensuring it delivers equity to all who live in South Africa.

Pillar 10 stakeholders should assess the standing policy and legal basis for influenza and COVID-19 vaccination of HCWs, workers in essential services and individuals at high risk and make recommendations if a revision is required.

Local Manufacturing and Innovation

Pillar 10 stakeholders should collaborate with Pillar 6 to recommend innovative funding mechanisms to increase investments in health technology innovation, research, and development in the country.

Academic institutions, the South African Medical Research Council, and the Council for Scientific and Industrial Research should collaborate and produce a joint strategy to fast-track research and development processes, mainly focusing on the co-development of state-owned intellectual property.

Essential medicines, products and materials

Pillar 10 recommends that NDOH maintains a robust mapping of available in-country resources and forecast requirements of quality-assured essential medicines, products and materials for priority respiratory pathogens at each level of health care.

We further recommend that NDOH provides a standing annually update to the Minister of Health on plans and systems to manage a surge in demand for key health technologies based on contemporary health emergency trends, the emergence of new technologies, and contemporary information on health workforce statistics.

We recommend that NDOH maintains and develops a secure national stockpile and secure access to an international stockpile of essential medicines, products, and materials for priority respiratory pathogens during the pandemic.

Emergency logistics and supply chain management

NDOH must update the national deployment and vaccination plan (NDVP) to address actions needed during a respiratory pathogen pandemic.

NDOH must review supply chain control and management systems (stockpiling, storage, security, transportation and distribution arrangements) for medical countermeasures.

Pillar 10 stakeholders recommend and commission an academic review of the country's capacity to scale up existing routine immunisation programmes across the life course.

Regulation and Protecting People from Adverse Events

SAHPRA must maintain the capacity to enhance regulatory pathways. Pillar 10 stakeholders must support SAHPRA's push towards attaining maturity level four for all health technologies. Political support is needed to position SAHPRA favourably in the global reliance system.

Pillar 10 stakeholders recommend that the Treasury sustains the No-Fault Compensation mechanism established during COVID-19 and NDOH to incorporate it into the National Health Insurance to cover users against medicine-related adverse events.

Pillar 10 stakeholders recommend that the South African government collaborate closely with the G7's Medical Countermeasures Delivery Partnership, established to enhance country-level last-mile delivery infrastructure and logistics, including strengthening health systems. The MCDP can attract the necessary investments in last-mile capacity.

Q.2.3. Clinical Care: Safe and scalable care

Surge Deployment of Health Workforce

Pillar 10 stakeholders align themselves with the Pillar 1 recommendation to review the National HRH Strategy and add a finance plan. The plan was developed before COVID-19 and published in 2020, so there is a need to ensure that the lessons learnt from COVID-19 are captured in the revised 2030 strategy, including a vital component of effective surge capacity strategies. The revision should provide clear guidelines on maintaining a high standard of working conditions, even when under pressure, including manageable workloads, occupational health and safety, psychosocial support, and appropriate infection prevention and control practices. It should also include refined regulatory guidelines on timely payment of salaries, overtime, sick leave, and other incentives, like danger pay for all responding workers, be they temporary, surge or permanent workers.

A desktop health and health-related skills mapping is recommended, and the distribution of the health and health-related workforce should be updated regularly.

An academic review of PPR training for health and relevant non-health workforce is recommended, with a view to publishing recommendations for training institutions on practical ways to introduce PPPR into their curricula. For example, training extended public works programme workers into community health workers for the COVID-19 Community Screening and Testing programme is a crucial learning opportunity.

Pillar 10 also aligns itself with Pillar 4's recommendations regarding public-private partnerships to boost the training and deployment of the health workforce and will collaborate further with Pillar 4 on their recommendations.

Case management

The NDOH should ensure that a living evidence-based clinical management guideline for patients with suspected or confirmed infection with a pandemic respiratory pathogen is regularly updated based on the latest evidence.

Pillar 10 stakeholders will align with Pillar 3 on mapping public and private health facilities and alternate facilities for managing pandemic patients to produce a dashboard reflecting the number of beds, isolation and ICU capacity, and surge capacity.

Re-establish the Knowledge Hub or another platform as a training resource for health workers and develop tools to evaluate staff training levels.

Infection prevention and control (IPC)

During COVID-19, the Minister of Health directed that Occupational Health and Safety (OHS) Committees be established at the National, Provincial, District, and Facility levels, in line with the Occupational Health and Safety Act. Pillar 10 stakeholders recommend a review of the state of OHS in the country to ascertain whether this capacity has been sustained. Pillar 10 can commission this review.

Continuity of Essential Health Services (CEHS)

We recommend a series of focus group discussions with health workers in all provinces to obtain their perspectives on building health systems resilience.

NDOH must build on and finalise the draft strategy for the Continuity of Essential Health Services Plan for the response phase of a pandemic. A vital component of consequence assessment in terms of outcomes and costs should be included.

We encourage developing facility-level plans to provide essential health services during a pandemic.

Safe management of a dead body

Pillar 10 stakeholders recommend reviewing and updating mortuary preparedness plans to manage increased bodies.

Q.2.4. Community Protection

The communities and priority groups should be targeted through proactive risk communication and infodemics management, applying and monitoring evidence-based Public Health and Social Measures (PHSM), and ensuring all interventions are appropriate to the local context.

We recommend investments into advocacy and tools for improved indoor air quality to reduce the risk of respiratory pathogen transmission in indoor spaces.

Pillar 10 stakeholders will explore mechanisms to monitor and gauge PHSM adherence during respiratory pathogen outbreaks, seasonal epidemics and pandemics to make recommendations on the most effective tactics that communities can comply with

We recommend a predictive mechanism that can assess unintended negative consequences of PHSM implemented in response to respiratory pathogen outbreaks and make advance recommendations to mitigate against collateral damage to communities.

Pillar 10 stakeholders will consider institutionalising the National Communications Partnership, which brought together government, the private sector, civil society, industry and community constituencies, including traditional health practitioners and leadership, to provide a platform for information sharing to childcare facilities, educational institutions and workplaces to develop respiratory pathogen pandemic preparedness plans, including implementation of PHSM and development of business continuity plans.

For Points of Entry and Border Health (PEBH), DPME is recommended to monitor the effectiveness of the Border Management Authority in implementing a one-health approach to prevent cross-border infections, detect pathogens of pandemic potential early and manage medical cases at the borders.

Q.2.5. Risk Communication and Community Engagement (RCCE)

The National Department of Health has established a robust RCCE framework that requires ongoing resource allocation and strengthening. RCCE should be continuous during peace times and ramped up during emergencies.

As previously suggested, we recommend that GCIS sustain the National Communications Partnership. The Partnership should strengthen scientific literacy and people's understanding of evidence about respiratory pathogens and pandemics through community dialogue, integration into educational curricula, and utilising networks, media, updated online content (including myth-busting pages), social media, and other appropriate communications platforms.

We also recommend the creation of a 3-digit public interface for health enquiries, health emergencies or health-related disaster hotlines, coupled with a WhatsApp-based citizen interfacing channel. This approach has been shown to establish routine social listening, manage infodemia, and conduct back-end data analysis. It should differ from the 112 number, which has experienced many challenges and does not accommodate general enquiries like the former COVID-19 hotline.

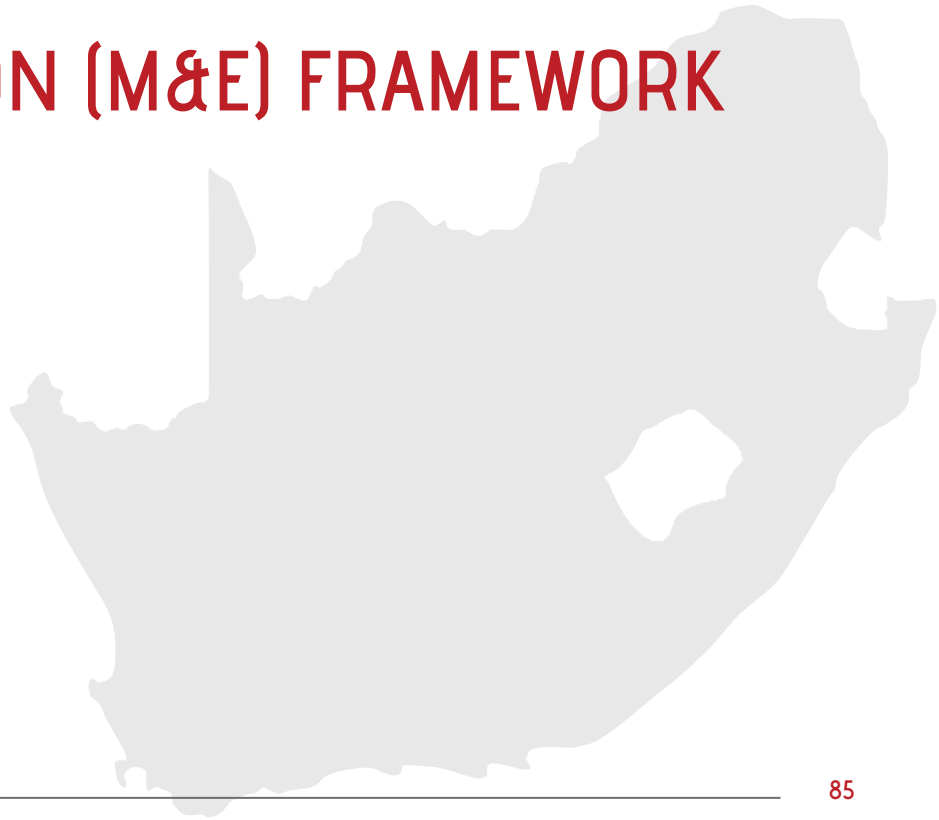
Q.3 PILLAR TEN MONITORING AND EVALUATION TOOL

PILLAR 10: PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE (PPPR)

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Define pandemics and triggers for PPPR. Refine South Africa's legislative framework and risk-adjusted strategy	Technical Reviews of South Africa's Legislative Framework and Adjusted Risk Strategy for PPPR	PPPR Technical Advisory Committee (TAC) established Definition of Pandemic Aligned with the Pandemic Accord and IHR Amendments and AU Decisions Review of law-making and risk-adjusted strategy during COVID-19 and a report with recommendations produced	TAC Established by December 2024 June 2025 June 2025	DSI Presidency	WHO, MRC, CMS, USAID, NICD, SAHPRA Civil Society Forum SANAC Trust
Successful Implementation of the PRET Framework in South Africa	Annual Assessment of the State of Pandemic Preparedness in South Africa Ensure Public-Private Partnership Periodic Simulation Exercises	Annual Report on the State of Pandemic Preparedness to the Minister of Health and the National Health Council	Annual	Pillar 10 stakeholders Pillar 4 Stakeholders NDOH	WHO, MRC, CMS USAID, NICD, SAHPRA
Finance Plan for Pandemic Preparedness and Day-Zero Response Financing Mechanism	Develop a costing of pandemic preparedness and pandemic response and establish a day-zero predictable financing mechanism	A Finance Plan for SA PPPR and a Day Zero financing mechanisms developed	March 2025	Treasury NDOH Pillar 10 Stakeholders	Pillar 6 Stakeholders Strongly recommend collaboration with the Africa CDC Health Economic Programme
Align with regional and global developments, e.g., the Pandemic Agreement, WGIHR, Pandemic Fund, and emerging PPPR financing instruments	Robust country engagement in regional and global developments and processes	PPPR Champion Reports to the AU Assembly on South Africa's engagement in regional and global PPPR developments produced	Forms part of PPPR Champion's Annual Report to the AU Assembly	DSI NDOH Presidency	WHO, MRC, CMS, USAID, NICD, SAHPRA

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Foster All of Society Approach by sustaining the National Communications Partnership	GCIS to Sustain the National Communications Partnership (NCP)	Annual NCP Summit	Annual 2025-2029	GCIS	Pillar 10 Stakeholders Civil Society Forum NEDLAC Community Constituency
Ensure that the BMA is effective in early detection and/or preventing cross border transmission of pathogens	NICD to monitor the efficacy of BMA in stopping the cross-border spread of pathogens	Annual Report on Efficacy of the BMA in Preventing cross border spread of Pathogens produced	Annual	NDOH	NICD Provincial DoHs

MONITORING AND EVALUATION (M&E) FRAMEWORK



PILLAR ONE: AUGMENT HUMAN RESOURCES FOR HEALTH (HRH)

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Review of the National HRH Strategy and development of an HRH Financing Plan	Review the National HRH Plan and produce a revised plan for 2024-2029	Revised HRH Plan 2024-2029 produced	June 2025	NDOH	Provincial Departments of Health (DoHs) Department of Employment and Labour (DEL) Private Sector Organised Labour
	Review the National HRH plan and produce a revised plan for 2024-2029	HRH Financing Plan produced	March 2026		
Strengthen the Human Resources Information System (HRIS) to effectively monitor and survey the state of HRH	Design a reporting function in the HRIS to produce an annual report (or more frequent reports if required) on progress and gaps in the production, equitable distribution, management and development of HRH	Annual Report outlining progress and gaps in the production, equitable distribution, management and development of HRH	Annual HRH Reports produced, from December 2024	NDOH	Provincial DoHs DPSA
Finalisation and implementation of a revised policy on Remunerated Work Outside the Public Service (RWOPs)	Review the current RWOPs policy Develop and table before the National Health Council a revised RWOPs policy	Revised RWOPs policy approved by the National Health Council	June 2025	NDOH	Provincial Health Departments DPSA
	Institutionalise a system of annual reporting by Provincial DoHs on RWOPs	Number of provinces producing annual reports on approvals and compliance with RWOPs	All 9 Provinces annual, from September 2025	NDOH	Provincial Health Departments DPSA
Implementing, monitoring and reporting on existing regulations and policies on occupational health, wellness, and safety	Institutionalise a system of annual reporting by Provincial DoHs on existing regulations and policies on occupational health, wellness, and safety	Annual Report on the State of Occupational Health, Wellness and Safety	All 9 Provinces annual, from September 2025	NDOH	Provincial Health Departments DEL Organised labour

PILLAR TWO: IMPROVED ACCESS TO ESSENTIAL MEDICINES, VACCINES, AND MEDICAL PRODUCTS THROUGH BETTER SUPPLY CHAIN MANAGEMENT

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Development of a proposal for the earmarking of funds for health and health related products	Develop a Concept Note for discussion in the National Health Council (NHC) on the earmarking funds for Health and Health Related Products	Concept Note for the earmarking of funds for Health and Health Related Products tabled before the NHC	First sitting of the National Health Council after May 2024	NDOH	Provincial DoHs
Establishment of Medicine Master Data System	Develop and operationalize a digital Medicine Master Data System	Medicine Master Data System developed and operational	June 2025	NDOH	Provincial DoHs
GS1 Certification of all SAHPRA registered products	Develop a process and a system to ensure that all SAHPRA registered products are GS1 Certified	All SAHPRA registered products GS1 Certified	June 2027 (complete and up to date with no backlogs)	NDOH SAHPRA GS1	Pharmaceutical Industry
Establishment of an Essential List of Non Pharmaceutical Health Products	Define non- pharmaceutical health products and establish an Essential List of Non Pharmaceutical Health Products	Essential List of Non-Pharmaceutical Health Products developed	June 2025	NDOH	Provincial DoHs SAHPRA
Establishment of an Interdepartmental Committee on Preferential Procurement of local and African health products and technologies and development of policy guidelines on preferential procurement	Establishment of an Interdepartmental Committee on Preferential Procurement of local and African health products and technologies	An interdepartmental Committee of Directors General on Preferential Procurement established	December 2024	NDOH	DSI, DTI, National Treasury and SAHPRA
	Develop policy guidelines on preferential procurement	Draft Policy Framework for Preferential Procurement of South Africa and African Health Products and Technologies established	June 2025	NDOH	Provincial DoHs
Effective, specialised communication on availability of health and health related products	Implement the Specialised Communications Strategy on Availability of Medicines and produce Guidelines for Journalists	Communications Strategy on Availability of Medicines developed	December 2024	NDOH	Provincial DoHs

PILLAR THREE: EXECUTION OF THE INFRASTRUCTURE PLAN FOR ADEQUATE AND WELL-MAINTAINED HEALTH FACILITIES

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Improvement of the Execution of Projects	Assess the extent to which projects align with the IDSM and FIDPM: All projects completed between 2024 and 2029	Annual Report analysing all projects completed in the financial Year	Annual from April 2025	NDOH	National Treasury
Optimisation of the Project Portfolio	Define a priority portfolio	A portfolio of Priority infrastructure for 2024-2029 Defined	June 2025	NDOH	Provincial DoH
Measurement of the Impact of the Projects	High frequency impact assessments, including health outcome, job creation, socioeconomic impact and environmental impact	Annual impact assessments of ongoing or completed projects, conducted and reports produced	Annual	NDOH	Research institutions e.g. SAMRC, HSRC Pillar 8 Stakeholders
Explore innovative financing options for infrastructure development and maintenance	Develop a policy framework for innovative financing of health infrastructure	A Policy Framework for Practical Innovative Financing of Health Infrastructure	June 2025	NDOH	National Treasury Pillar 6 Stakeholders

PILLAR FOUR: ENGAGEMENT OF THE PRIVATE SECTOR IN IMPROVING ACCESS, COVERAGE, AND QUALITY OF HEALTH SERVICEST

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Sustained inclusive dialogue on feasible collaborative service delivery initiatives	Establish a Joint Strategic Oversight Committee or a Project Management Office, initially chaired by the Director General of Health	JSOC revived	December 2024	NDOH Private Sector	Treasury
		Institutionalised, permanent platform for sustained strategic joint operations between public and private sectors established	June 2025	NDOH Private Sector	Provincial Departments of Health
Finalisation of a blueprint for public/private collaboration	Review, finalise and adopt the blueprint SLA	A blueprint SLA for private sector contracting with NHI developed	2024-2026	NDOH Private Sector	Provincial Departments of Health Pillar 8 Stakeholders (Civil Society; Labour)
Establishment of a multisectoral committee for health workforce development	Coordinate the establishment of a multi sectoral committee for health workforce development	A multisectoral committee on health workforce development	December 2024	Presidency	NDOH

PILLAR FIVE: IMPROVEMENT OF QUALITY, SAFETY, AND QUANTITY OF HEALTH SERVICES WITH A FOCUS ON PRIMARY HEALTHCARE

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Development and Alignment of regulatory policies	Strengthen collaboration between professional bodies and regulatory bodies	Framework For Alignment of Regulatory Policies developed	December 2025	HPCSA	SAMA Other Professional Bodies NDOH
Improved access to healthcare, focusing on Primary Healthcare Services	Implement the National Quality Improvement Plan (NQIP)	At least 85% of health facilities submitting annual self assessments to the relevant authorities National and Provincial DoHs	Q3 2025	NDOH	Provincial DoHs Civil Society Forum Patient User Groups Pillar 4 Stakeholders
Development and Implementation of Patient-Centric Healthcare Models	Sustain the Patient Experience of Care Surveys	Annual Patient Experience of Care Survey Report produced and Disseminated	Annual	NDOH Civil Society Forum	Provincial DoHs Patient User Groups
Keeping the Health Workforce Healthy and Motivated	Implement policies that protect health workers, promote professional growth and development and enhance remuneration and benefits	Annual Health Worker Experience of Work Survey conducted and report produced and disseminated	Annual	NDOH	Provincial DoHs SAMA Other Professional Bodies
Strengthening Laboratory services	Streamlining standards and operations of private and state laboratory services	Annual State of Laboratory Services Report produced and disseminated	Annual	NDOH NHLS	Private Sector Laboratories SAHPRA

PILLAR SIX: IMPROVEMENT OF PUBLIC SECTOR FINANCIAL MANAGEMENT SYSTEMS AND PROCESSES

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Comprehensive review of the funding needs, taking into account disaggregated population data, burden of disease and key political goals	Conduct and publish an Economic and Financial Review of South Africa's Health and Funding Needs	Review of Economic and Funding Needs for South Africa's Health Priorities and NHI	June 2025	NDOH	Pillar 6 Stakeholders Africa CDC Presidency
Development by provinces of multi-year financial plans with technical assistance building from NDOH	Each province to develop a multi-year financial plan for 2024-2029 and submit it to NDOH	Each province submits a financial plan for the period 2024-2029	June 2025	Provincial DOH	NDOH National Treasury
Preparation of the Provinces, public sector institutions and private sector for the financial implications of NHI	Annual report on preparations of the health sector for financial management under NHI	Produce a report on the state of preparedness of the public and private sector for financial management under NHI	Annual from April 2026	NDOH NHI Fund to coordinate	Provincial Departments of Health Private Sector Civil Society Forum
Improved coordination of donor funding	Stakeholders will develop proposals for a more streamlined management of donor funding	Recommendations for streamlining the management of donor funding for health	June 2025	NDOH	Pillar 6 Stakeholders Civil Society Forum
Creation of a regulatory environment for innovative financing instruments and a pathway for approvals of innovative financing transactions	National Treasury to produce technical guidelines on innovative financing for health	Technical Guidelines on Innovative Financing for Health in South Africa	June 2025	National Treasury	SAMRC Pillar 6 Stakeholders

PILLAR SEVEN: STRENGTHENING GOVERNANCE AND LEADERSHIP FOR OVERSIGHT, ACCOUNTABILITY, AND HEALTH SYSTEM PERFORMANCE

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Dedicated financial and human resources to support the implementation of the Compact	The Presidency will collaborate with National Treasury and agree on a financing plan The funds do not have to come from the fiscus but should be raised and ring-fenced for this purpose, with a governance and accountability framework	A financing and governance plan to support the implementation of the Health Compact developed	December 2024	Presidency National Treasury	NDOH Pillar 6 Lead and Task Team Civil Society Forum
Optimisation of the NDOH and Provincial Departments' capacities to implement the recommendations of the of the Health Sector Anticorruption Forum	Pillar 7 Stakeholders to submit a set of recommenations to Presidency to optimize the capacity of the HSACF and the capacity of departments to implement its recommendations	Framework for successful implementation of the recommendations emanating from the Health Sector Anti-Corruption Forum	December 2024	NDOH Presidency	Civil Society Forum
Intersectoral action to address the social determinants of Health at the level of the Executive	Minister of Health to submit an annual report to the President on the state of intersectoral action in addressing the social determinants of Health	Ministerial Report on the State of Intersectoral Action to Address the Social Determinants of Health	Annual	Minister of Health	Pillar 7 Stakeholders Civil Society Forum
Implementation of the Health market inquiry Recommendations	NDOH to report on the Implementation of the Health market inquiry Recommendations	Annual report on Progress with Implementing the Health market Inquiry Recommendations	Annual	NDOH	Civil society forum
Provide a direct line of Communication between Hospital boards, clinic Committees and MECs	All provincial MEC to Establish a position of Coordinator of hospital Boards and clinic Committees	Every office of the MEC develops a coordination mechanism for hospital boards and clinic committees	Q4 2024	NDOH MEC's of provincial DoH's	Provincial DoH departments (through the nhc) Civil soiety forum

PILLAR EIGHT: ENGAGEMENT AND EMPOWERMENT OF THE COMMUNITY FOR COMMUNITY-BASED CARE

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Strengthen Community Involvement in the Implementation of the NHI	Revive the Annual National and Provincial Consultative Forums with appropriate community engagement	Annual Reports to the National Health Council on the Involvement of Communities in the Implementation of NHI	Annual, from April 2025	NDOH	Civil Society Forum Patient User Groups
Improving the appointment of Hospital Boards and Clinic Committees, ensuring inclusivity and diversity	Amendments in the National Health Act 61 of 2003	NHA Amendments to improve the appointments of hospital boards and clinic committees	March 2029	NDOH	Pillar 8 Stakeholders Portfolio Committee on Health
People living with disabilities enjoy the highest attainable standards of services	NDOH to develop norms and standards for people living with disabilities	Norms and standards for provision of health care to people living with disabilities developed	March 2025	NDOH	Provincial Departments of Health Patient User Groups
Legitimisation of a referral system between traditional health practitioners and allied health professionals with the public and private health providers	Develop regulations for a referral system between indigenous knowledge practitioners and the health sector under the NHA	Regulations governing referral systems from traditional knowledge practitioners to health facilities developed	March 2029	NDOH	Civil Society Forum Patient User Groups
Strengthen Risk Communications and Community Engagement	Fully Capacitate RCCE structures at national, provincial district and ward levels	National Strategy to Fully Capacitate RCCE Structures at National, Provincial, District and Ward Levels and Finance Plan	March 2029	NDOH	Civil Society Forum

PILLAR NINE: DEVELOPMENT OF AN INFORMATION SYSTEM FOR GUIDING HEALTH SYSTEM POLICIES AND INVESTMENTS

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Integrated Disease Surveillance System (IDSR) developed	Develop a policy framework/ strategic plan for Integrated Disease Surveillance Finalise the list of conditions and case definitions to be included on the IDSR	A policy framework and/or strategic plan and list of conditions and case definitions to be included in the IDSR	September 2025	NDOH	WHO NICD
Integrated Health Information System	Facilitate interoperability between the various patient information systems using the normative standards framework for Digital Health in SA	Report on compliance with the identified interoperability standards by all provincial patient information systems Normative standards compliance testing laboratory established	December 2026 2024-2029	NDOH	CMS, Provincial Departments of Health, Private Sector, DSI, CSIR, Academia
	Develop and implement a South African Health Information Exchange Service that will allow data sharing between identified health information systems	Enterprise Architecture inclusive of 2nd phase of the Health Information Exchange developed	2024-2029	NDOH	Provincial DoHs, CMS, Private Sector, Civil Society
	Develop and Implement procedures and systems for Identity Verification Users of Health Systems (public and private)	Report on continued Development and rollout of the Health Patient Registration system and its related Master Patient Index Services	2024-2029	NDOH	CMS, Private Sector, Home Affairs
	Establish a Health Establishment Registry through the Master Health Facility List Platform	Health Establishment Registry established (through the Master Health Facility List Platform) Report on the expansion of the use of the Master Health Facility List Platform through the inclusion of Public and Private Health Establishments	2024-2029	NDOH	Provincial DoHs, CMS, Private Sector, Civil Society

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
	Implement section 74 of the National Health Act 63 of 2003 to strengthen information systems to ensure the attainment of a comprehensive and seamless National Health Information System	Regulations for implementing section 74 of the National Health Act 63 of 2003 published in the Government gazette Progress on the Utilisation of Health Terminology Services, Master Health Facility List Platform and the HPRS produced	2024-2029	NDOH	CMS, Private Sector, Civil Society
	Standardise health outcomes reporting for both public and private health sectors	Health impact indicator data from the public and private sectors is included in the national health information system and data available in the NDOH Big data platform is included in the national health information system and data	2024-2029	NDOH	Provincial DoHs, Health Funder Groups, Civil Society
Standardisation of health diagnostic and procedure coding systems	Implementation of the Health Terminology System	Inclusion of the identified Health Terminology System in Electronic Medical Record systems as well as the individual sub-systems feeding the EMR such as Laboratory test results and Radiology imaging	2024-2029	NDOH	CMS, Private Sector, Provincial DoHs, Civil Society
Capacity building and skills transfer for digital health	Conduct a health information systems skills baseline assessment across the health sector (public and private)	Report outlining accurate baseline health information skills and expertise across the health sector produced	March 2026	NDOH	Provincial DoHs, Private Sector, CMS, statutory Councils
Development of business intelligence for the health sector	Identify baseline business intelligence (BI) report requirements across the health sector	Business Intelligence Specification Document outlining report requirements across the health sector	March 2026	NDOH	Provincial DoHs, Private Sector, CMS, statutory Councils
Development of a Digital Health Governance Framework	Establish a framework that defines the collaboration and data governance between public and private sectors	A Comprehensive Digital Health Governance Framework developed, which serves as a framework for collaboration between public and private sectors	March 2026	NDOH	Provincial DoHs, Private Sector, CMS, statutory Councils

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Accelerate the development of an electronic health record	Fast-track the creation and deployment of an EHR that integrates across the health system	Shared Electronic Health Record system to support the portability of health services developed and implemented	2024 - 2029	NDOH	Provincial DoHs, Private Sector, CMS, statutory Councils
Promote the intelligent use of data and information	Enhance the analytical use of health data for better decision-making and policy development	Improved data utilization evidenced by data quality audits	2024 - 2029	NDOH	Provincial DoHs, CMS, statutory Councils
Capacity Building and skills transfer of digital health	Foster continuous learning and expertise development in digital health across sectors	Sustained programs for skills development and transfer established	2024 - 2029	NDOH	Provincial DoHs, CMS, statutory Councils

PILLAR TEN: PANDEMIC PREVENTION, PREPAREDNESS AND RESPONSE (PPPR)

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Define pandemics and triggers for PPPR. Refine South Africa's legislative framework and risk-adjusted strategy	Technical Reviews of South Africa's Legislative Framework and Adjusted Risk Strategy for PPPR	PPPR Technical Advisory Committee (TAC) established Definition of Pandemic Aligned with the Pandemic Accord and IHR Amendments and AU Decisions Review of law-making and risk-adjusted strategy during COVID-19 and a report with recommendations produced	TAC Established by December 2024 June 2025 June 2025	DSI Presidency	WHO, MRC, CMS, USAID, NICD, SAHPRA Civil Society Forum SANAC Trust
Successful Implementation of the PRET Framework in South Africa	Annual Assessment of the State of Pandemic Preparedness in South Africa Ensure Public-Private Partnership Periodic Simulation Exercises	Annual Report on the State of Pandemic Preparedness to the Minister of Health and the National Health Council	Annual	Pillar 10 stakeholders Pillar 4 Stakeholders NDOH	WHO, MRC, CMS USAID, NICD, SAHPRA
Finance Plan for Pandemic Preparedness and Day-Zero Response Financing Mechanism	Develop a costing of pandemic preparedness and pandemic response and establish a day-zero predictable financing mechanism	A Finance Plan for SA PPPR and a Day Zero financing mechanisms developed	March 2025	Treasury NDOH Pillar 10 Stakeholders	Pillar 6 Stakeholders Strongly recommend collaboration with the Africa CDC Health Economic Programme
Align with regional and global developments, e.g., the Pandemic Agreement, WGIHR, Pandemic Fund, and emerging PPPR financing instruments	Robust country engagement in regional and global developments and processes	PPPR Champion Reports to the AU Assembly on South Africa's engagement in regional and global PPPR developments produced	Forms part of PPPR Champion's Annual Report to the AU Assembly	DSI NDOH Presidency	WHO, MRC, CMS, USAID, NICD, SAHPRA

OBJECTIVE	INTERVENTIONS	INDICATORS	TIMELINES (AND TARGETS)	ACCOUNTABILITY	
				LEAD	SUPPORT
Foster All of Society Approach by sustaining the National Communications Partnership	GCIS to Sustain the National Communications Partnership (NCP)	Annual NCP Summit	Annual 2025-2029	GCIS	Pillar 10 Stakeholders Civil Society Forum NEDLAC Community Constituency
Ensure that the BMA is effective in early detection and/or preventing cross border transmission of pathogens	NICD to monitor the efficacy of BMA in stopping the cross-border spread of pathogens	Annual Report on Efficacy of the BMA in Preventing cross border spread of Pathogens produced	Annual	NDOH	NICD Provincial DoHs

The Presidential Health Compact: 2024-2029: "Accelerating Health System Strengthening and National Health Insurance (NHI) Implementation"

22 August 2024

PREAMBLE

We, the delegates of the second Presidential Health Summit, held on the 4th and 5th of May 2023, in Boksburg and subsequent meetings, comprised of the following stakeholders: South African Government, Health Professionals, Labour, Business, Civil Society, Health Service Users, Academic and Research, Statutory Research Council, Health Entities, and Traditional Health and Allied Health Professionals.

RECOGNISING THAT:

- South Africa has committed to Universal Health Coverage (UHC), which is the overarching target of Sustainable Development Goal-3 and a key target articulated in the National Development Plan (NDP) 2030.
- Achieving Universal Health Coverage will improve the social and economic prospects of South Africa and reduce inequities but will require responsive and robust health systems capable of delivering high-quality health services for all.
- South Africa has chosen National Health Insurance (NHI) as its pathway to universal health coverage. The National Health Insurance Act, No. 20 of 2023, has been signed into law, ushering in the required legal framework for South Africa to achieve universal health coverage through NHI implementation.
- National Health Insurance is more dynamic than just a financing model for the health system. It is also a paradigm for the transformation of health service delivery and management to improve equitable access, quality, and effectiveness of health services, anchored on the Primary Health Care philosophy.
- Regardless of their different interests and roles, the government and all stakeholders have a common interest in enabling the implementation of National Health Insurance through health systems strengthening efforts and other policy reforms in both the public and private sectors.

- Through strategic partnerships, meaningful collaborations and innovation approaches, efficient, equitable and improved health outcomes can be achieved.
- The government will continue to consult on implementing health policy in accordance with the law and in the spirit of this compact.

FURTHER ACKNOWLEDGING the significant milestones and strides made since the 2019 Presidential Health Compact was signed and implemented, highlights of which encompass the following:

- The total life expectancy of South Africans improved from 64.6 years in 2019 to 66,5 years in 2024, only 3.5 years away from the National Development Plan (NDP) target of 70 years by 2030. This reflects a firm recovery from the impact of the Coronavirus Disease (COVID-19) during 2020 and 2021.
- Implementation of national health quality improvement initiatives in health facilities across our nine provinces has resulted in improved patient satisfaction across the country, reflecting real, positive changes in the lives of South Africans. Patients are now experiencing better access to care, essential medicines are more readily available, and health facilities are state-of-the-art, cleaner, and safer.
- Healthcare facilities ready to deliver innovative and high-quality healthcare, including the Nuclear Medicine Research Infrastructure at Steve Biko Academic Hospital, staffed by highly competent professionals, showcase our commitment to excellence in healthcare.
- Expansion of health infrastructure, with a total of 149 PHC facilities completed by November 2023, adding to 1,600 facilities built by the democratic government since 1994, as well 30 additional hospitals being in various stages of procurement or construction by 2023, supplementing the 38 hospitals built since 1994 through the hospital revitalisation programme. These facilities have enhanced access to healthcare services for our growing population, including the opening of the Dr Pixley Ka Isaka Seme Memorial Hospital in KwaMashu, a modern regional hospital with state-of-the-art technology.
- Almost 6 million (5,9 million) of the 7,8 million people living with AIDS in South Africa accessing antiretroviral treatment.

- The vibrant contribution of non-state role players and stakeholders in turning our health system around, including the private health sector civil society, academic institutions and research organisations, and community members across the country who serve in Clinic Committees, Community Health Centre (CHC) Committees, Hospital Boards, and Provincial and District Councils on AIDS, amongst other important structures of participation. These stakeholders are not just observers but are integral to supporting the Department of Health in improving the health system.

STILL CONCERNED that more still needs to be done to improve the quality of the public health sector and end inequitable access to health care.

STILL FURTHER CONCERNED that the private health sector may be challenged by unaffordable prices to a majority of South Africans, as well as the maldistribution of providers and facilities and lack of regulation.

SUPPORTING the President of the Republic of South Africa's call for the acceleration of the journey towards universal health coverage through National Health Insurance, with National Health Insurance being a lodestar for this voyage, and the President's enablement of this vision through the enactment of the NHI Act, No 20 of 2023 in May 2024, and his call that government and all other stakeholders whose work or investment has an impact on quality and quantity of health care should work together as government and social partners,

WE PLEDGE, with this compact and in so far as it falls within our area of responsibility, that the government and all other stakeholders will collaborate to establish a unified, integrated, and responsive health system that provides access to quality health care for the entire population.

WE HEREBY COMMIT THAT the articles hereunder provide the anchor for collaboration between the government and all other stakeholders to work jointly towards improving the public and private health sectors in the Republic of South Africa and creating a unified national health system.

ARTICLE 1

The government and all other stakeholders commit themselves to achieving universal health coverage in South Africa, enabled through the development and implementation of **National Health Insurance**, for which a legislative framework has been created. Every citizen must have access to high-quality health services whenever and wherever they need them without facing financial hardship. The UHC pledge, adopted by all stakeholders and participants at the Presidential Health Summit on 4-5 May 2023, is further endorsed by this Health Compact 2024-2029.

ARTICLE 2

The government and all its partners and stakeholders are fully cognisant that the successful implementation of **National Health Insurance requires healthcare providers equipped with the requisite skills**, competencies and caring attitudes to improve citizens' health care. The government and all its partners and stakeholders recognise the increasing pressure on the health workforce due to the growing burden of disease in the country, compounded by a shrinking fiscal environment. Therefore, the government and all stakeholders will work towards creating enabling conditions for the production, equitable distribution, effective management, retention and continuous professional development of diverse Human Resources for Health categories, including the community-based workforce. An evaluation of the implementation of the 2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage and the HRH Plan 2020/21 – 2024/25 produced in 2020 will be conducted to produce a Human Resources for Health plan for 2025 to 2029.

ARTICLE 3

The government and all stakeholders recognise the major progress attained in enhancing **medicine availability** across the health sector in the period of the previous health compact, including during the COVID-19 pandemic, as well as the strengthening of South Africa's health products regulatory authority. However, inequities were experienced in accessing health and health-related products.

Therefore, the government and all its partners and stakeholders will ensure equitable access to products for all, including vulnerable populations, **which is non-negotiable with the national health insurance dispensation.**

To ensure the sustainability of local manufacturing, measures will be implemented to promote and sustain preferential procurement of locally manufactured products. Amongst numerous key innovations, the state-of-the-art facility established for producing COVID-19 vaccines in Gqeberha, Eastern Cape Province, will manufacture human insulin for the African continent at a low cost.

ARTICLE 4

Appropriate **health infrastructure** creates an enabling environment for healthcare providers to deliver quality health care and provides a therapeutic environment for users of health services. While major progress was made with delivering additional PHC facilities and hospitals during 2019-2024, major resources are still required to ensure that the country's infrastructure can support **National Health Insurance.** The government and all stakeholders recognise that the state alone cannot finance this gap and that the main priority will be innovative financing mechanisms for health infrastructure development based on public-private partnerships. The government and all stakeholders are also committed to the development of health infrastructure, remaining guided by the established national quality improvement standards.

ARTICLE 5

Government and all other stakeholders recognise that **private sector participation** in improving access, coverage and quality of health services is an essential building block for implementing the **National Health Insurance.** Therefore, the government and all other stakeholders commit to an NHI dispensation in which the public and private sectors would fully cooperate to eliminate the inequitable two-tiered health system and jointly create one health system that delivers equitable health to all South Africans.

ARTICLE 6

The government and all other stakeholders affirm that the systematic and continuous **improvement of health services' quality, safety, and quantity** is the sine qua non of **National Health Insurance**.

Milestones throughout the previous Compact include improved reported positive care experiences in the public sector associated with implementing national quality improvement initiatives.

However, the main goal is to transform all health facilities to meet the requisite standards for certification and then accreditation to provide services in an NHI dispensation. Therefore, the government and all stakeholders will collaborate to align regulatory policies, improve access to healthcare focusing on Primary Health Care Services, which are the backbone of the health system, and develop and implement patient-centric healthcare models and measures to keep the health workforce healthy and motivated.

ARTICLE 7

The government and all other stakeholders acknowledge the imperative to **improve the efficiency of public sector financial management systems** and processes. Enhancing accountability, transparency, and health system performance at all levels is critical **to a national health insurance dispensation.** The government and all other stakeholders, therefore, commit to achieving better planning of the health service platform, increasing both allocative and operational efficiencies, extracting more value for money and improving the management of finances, procurement, contracting, controls, and compliance, as well as create the necessary regulatory environment for innovative financing instruments and a pathway for approvals of innovative financing transactions.

ARTICLE 8

Strengthening health sector **governance and leadership** to improve oversight is a critical enabler and a vital cog in implementing **National Health Insurance.** The government and all other stakeholders acknowledge that the public and private health sectors are most vulnerable to the scourge of fraud and corruption.

A significant development throughout the previous Health Compact is the creation of the Health Sector Anticorruption Forum in 2019, which has made excellent progress in identifying criminal activity in both the private and public sectors, culminating in the recovery of millions of rands, convictions, and disciplinary actions.

Over 2024-2029, the government and all other stakeholders will enhance and strengthen the work of the Health Sector Anticorruption Forum, establish a National Health Commission to drive intersectional action to achieve health outcomes and enhance continuous leadership and governance through apposite development programmes.

ARTICLE 9

Community engagement and empowerment are essential fundamentals of ensuring adequate and appropriate community-based care, consistent with the Primary Health Care philosophy and the spirit of **National Health Insurance.**

Milestones attained during the previous Health Compact include the improved establishment of governance structures such as hospital boards and clinic committees, which increased between 2019 and 2023, notwithstanding variations across geographic areas. Over 2024-2029, the government and all stakeholders commit to continuously buttress community involvement, including the representation in governance structures of patient user groups, vulnerable populations, and special groups, to enhance quality and responsive health services to all communities.

ARTICLE 10

Developing and implementing **information systems** to guide the health system's policies, strategies, and investments is a critical anchor of **National Health Insurance**. Progress made during 2019-2024 includes designing and implementing systems to streamline patient identification and registration processes across public health sector facilities and the electronic data system for recording COVID-19 vaccinations, which was used across the public and private sectors. The government and all stakeholders recognise the urgent need for enhanced, integrated disease surveillance that integrates data from various sectors, including Health, Social Development, Home Affairs, and Statistics South Africa. The government and all stakeholders will therefore design clear and actionable steps for the development and implementation of the electronic medical record, undertake a comprehensive review of the existing Digital Health Strategy, develop the 2024-2029 Digital Health Roadmap, and establish a detailed governance framework to ensure that digital health initiatives are accountable, patient data is protected, and systems are secure.

ARTICLE 11

Government and all other stakeholders accentuate the vital role of an established and institutionalised Pandemic Prevention, Preparedness and Response. South Africa played a leading role in the COVID-19 pandemic response at the global, regional, and national levels, including providing leadership to the African Union in various capacities by the Presidency. South Africa's COVID-19 response strategy was characterised by a unique risk-adjusted, secure approach while including a whole-of-government and whole-of-society strategy that was necessary to combat the pandemic. The government and all other stakeholders will, during 2024-2029, develop a Pandemic Prevention, Preparedness and Response Plan for an improved future response that safeguards both lives and livelihoods. The key objective will be strengthening health systems resilience to public health shocks. This is also essential in an **NHI dispensation.**

ARTICLE 12

The government and all other stakeholders will jointly implement the National Health Insurance-related health systems and service improvement plans, which comprise the following ten pillars, which now include Pillar 10, entitled Pandemic Preparedness and Response:

Pillar 1: Augment Human Resources for Health Operational Plan.

Pillar 2: Better supply chain equipment and machinery management to ensure improved access to essential medicines, vaccines, and medical products.

Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed, well-maintained health facilities.

Pillar 4: Engage the private sector in improving health services' access, coverage and quality.

Pillar 5: Improve health services' quality, safety, and quantity, focusing on primary health care.

Pillar 6: Improve the efficiency of public sector financial management systems and processes.

Pillar 7: Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels.

Pillar 8: Engage and empower the community to ensure adequate and appropriate community-based care.

Pillar 9: Develop an information system to guide the health system's policies, strategies, and investments.

Pillar 10: Pandemic Preparedness and Response

ARTICLE 13

13.1. A joint Technical Monitoring Team comprised of the National Department of Health and stakeholders representing Health Professionals, Labour, Business, Civil Society, Health Service Users, Academic and Research, Statutory Research Councils, Health Entities and Traditional Health and Allied Health Professionals, established in 2019, will continue to:

(a) Oversee the implementation of this compact by using a monitoring and evaluation framework based on the "health compact action plans" for each pillar;

(b) Ensure effective and sustainable collaboration amongst all stakeholders for delivering on the key outputs of each pillar;

(c) Meet quarterly to consider and review progress reports from the accountable department and other stakeholders.

13.2. The joint Monitoring Team will continue to report annually to the Presidential Health Committee, as defined in the full Compact accompanying this document.

ARTICLE 14

The signing of this Compact reflects our intention to work towards the achievement of the objectives and agreed interventions contained in this Compact, and it will-

(a) Be championed by the President of the Republic of South Africa, led by the Minister of Health and the representatives of all other stakeholders signing this Compact;

(b) Be allocated the necessary resources by the government, by the Public Finance Management Act,1999 (Act No.1 of 1999) and all other stakeholders to support its implementation; and

(c) Mobilise the entire health sector in the spirit of renewal to meet the commitments made in this Compact.

ARTICLE 15

This Compact must be interpreted per the spirit and purport of the Constitution of the Republic of South Africa,1996 and all other applicable law.

ARTICLE 16

16.1. This Compact enters into force on the date of signature thereof.

16.2. The undersigned, being duly authorised thereto, have signed and adopted this Compact.

On behalf of the Government of the Republic of South Africa

His Excellency Mr Matamela Cyril Ramaphosa
President of the Republic of South Africa
Date:

Dr. Phakishe Aaron Motsoaledi
Minister of Health
Date:

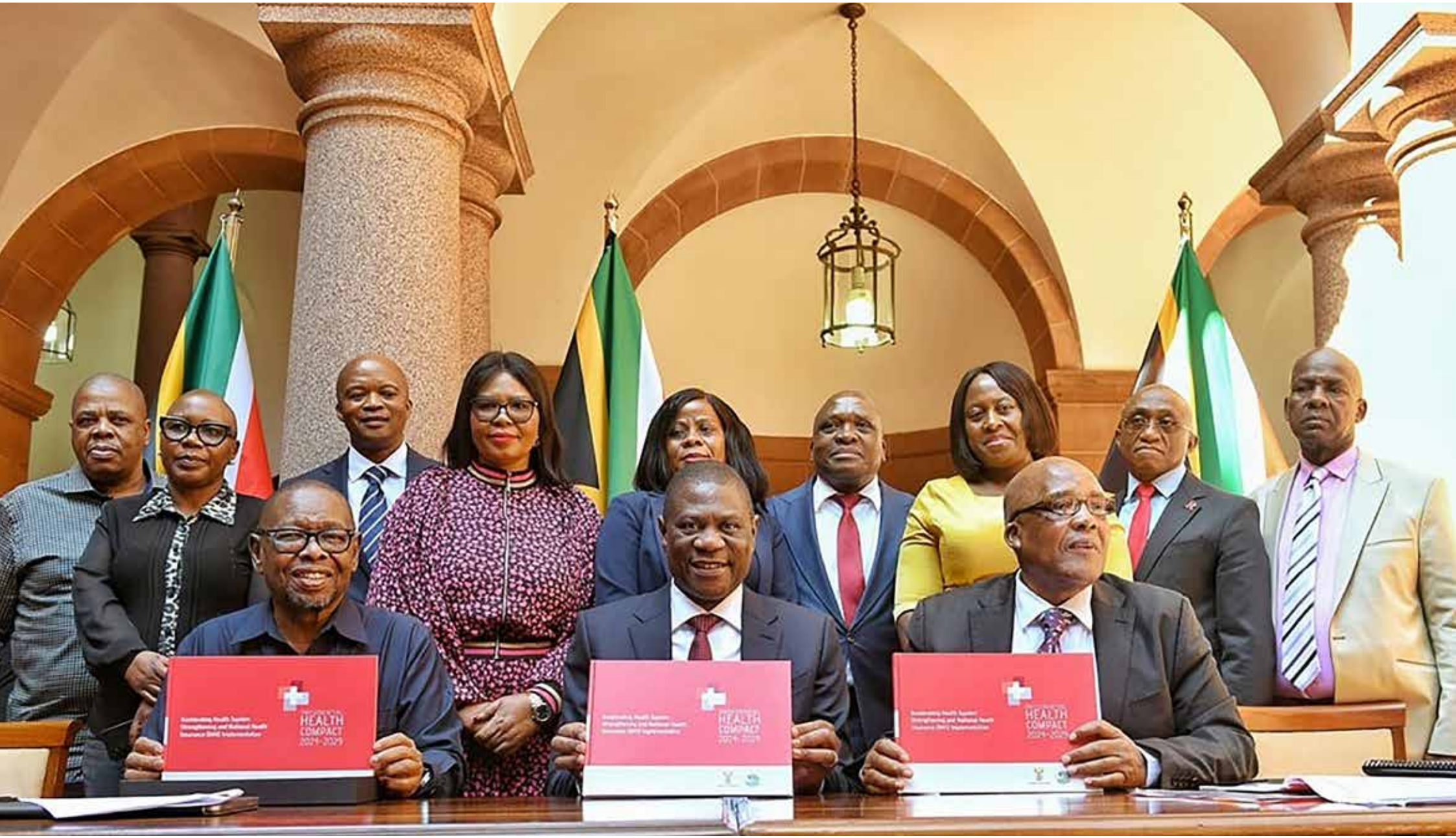
Dr. Bonginkosi Emmanuel Nzimande
Minister of Science and Innovation
Date:

The Presidential Health Compact: 2024-2029:

"Accelerating Health System Strengthening and National Health Insurance (NHI) Implementation"
22 August 2024

STAKEHOLDER	STAKEHOLDER REPRESENTATIVE	SIGNATURE AND DATE
1. Business	**Mr. Kgabo Cedrick Komape** Independent Community Pharmacy Association (ICPA)	
2. Civil Society	**Mr. Mabalane Mfundisi** SANAC Civil Society Forum	
	Mr. Jabulani Mcithakali Defend NHI Campaign	
3. Health Professionals	**Dr. Cedric Sihlangu** South African Medical Association Trade Union (SAMATU)	
4. Labour	**Mr. Michael Shingange** Congress of South African Trade Unions (COSATU)	
	Mr. Khaya Sodidi Democratic Nursing Organisation of South Africa (DENOSA)	
5. Health Service User	**Ms. Lauren Pretorius** Campaigning for Cancer	
6. Academic and Research	**Prof. Ntobeko Ntusi** South African Medical Research Council (SAMRC)	

STAKEHOLDER	STAKEHOLDER REPRESENTATIVE	SIGNATURE AND DATE
7. Statutory Health Councils	**Mr. Mogologolo Phasha** South African Pharmacy Council (SAPC)	
8. Traditional Health Practitioners and Allied Health Professional Registered by the Allied Health Professionals Council	**Mr. Solly Nduku** National Unitary Professional Association for African Traditional Health Practitioners of South Africa (NUPAATHPSA)	
9. World Health Organisation	**Dr. Fabian Ndenzako** WHO Country Officer in Charge	


HEALTH
COMPACT
2024-2029

THANK YOU

World Health Organization

Development and production of this document is
supported by the WHO country office for South Africa