# MEC consultative engagement on improving health towards UHC in the Western Cape

## CONSOLIDATED REPORT OF SESSION HELD 5 SEPTEMBER 2019

WESTERN CAPE GOVERNMENT HEALTH

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## ACRONYMS

NHI – National Health Insurance

UHC – Universal Health Coverage

COPC - Community Oriented Primary Care

CTICC – Cape Town International Convention Centre

WOSA – Whole of Society Approach

CHW - Community Health Worker

CNP - Clinical Nurse Practitioner

HPCSA – Health Practitioner Council of South Africa

GP – General Practitioner

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## INTRODUCTION

The Western Cape Government MEC for Health, Minister Nomafrench Mbombo, together with the Western Cape Head of Health, Dr Beth Engelbrecht hosted a consultative engagement on improving health towards universal health coverage (UHC) in the Western Cape. The session was held on 5 September 2019 at the CTICC and comprised of a wide range of interested parties and stakeholders.

This report captures the main themes and discussion points that were held during the engagement.

The session was structured as follows:

**Section 1:** Introductory session - Provincial Strategy and Approach to UHC

**Section 2:** Group discussion - Opportunities to collaborate for UHC

**Section 3:** Panel Discussion – Exploring UHC perspectives

**Section 4:** Way forward/ next steps

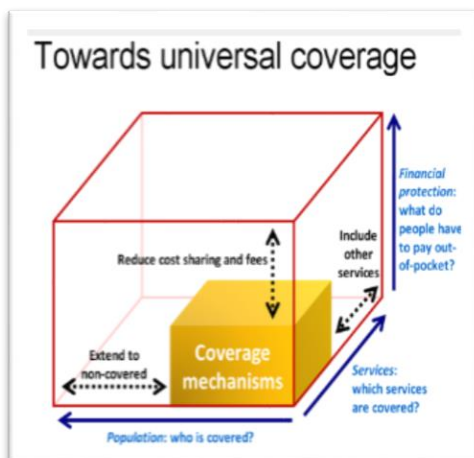
For the full programme please refer to the Annexures.

## SECTION 1 - INTRODUCTORY SESSION

The introductory session included a welcoming address from Dr Beth Engelbrecht, followed by a presentation made by Dr Keith Cloete.

The following points were highlighted during the introductory session:

### UHC DEFINED




1. **Universal Health Coverage (UHC)** is achieved when **all people** who need health services (promotion, prevention, treatment, rehabilitation, and palliation) **receive them**, **without undue financial hardship**.

2. **Service coverage** can be measured using tracer interventions in **promotion, preventive, treatment, rehabilitation and palliative** services.

3. **Financial protection** can be captured by tracking the incidence of **household health spending** that it is either **"impoverishing"** (it pushes households below the poverty line) or **"catastrophic"** (it absorbs a defined high percentage of a household's annual income).

(Cloete, 2019)

### CLARIFYING THE CONTEXT

- Commitment to Universal Health Coverage
  - South Africa is committed to implement UHC as part of an international UHC drive.
  - The Western Cape is committed to UHC implementation, together with other provinces

- The Financing system will change:
  - The NHI Bill introduces proposals for a change in the health financing system.
  - The specific mechanisms for the change in financing system will follow.

### CLARIFYING THE ROLE OF THE WCGH

- Assuming a stewardship role:
  - Stepping into a stewardship role for the health system in the Western Cape.
  - Taking responsibility for the overall governance of the health system in the Western Cape.
- Testing workable models:
  - Committed to formulate and test workable UHC models, with multiple role-players.

(Engelbrecht, 2019)

## RECOMMENDATIONS FOR UHC IN THE FUTURE (WORLD BANK/ UNICEF/ JICA)

***What would a hopeful picture look like for future health systems?***

### PEOPLE ARE AT THE CENTRE OF HEALTH SYSTEMS

- Health systems empower and enable people to maintain wellness and prevent disease before it happens.
- Supporting reforms (e.g. financial behavioural incentives, sin taxes, patient charters, etc.) are implemented.
- Health services acknowledge that disease morbidity and mortality are greater in poorer and otherwise marginalized groups of society, and explicitly prioritize services for those communities

### DIGITAL HEALTH

- The internet, mobile phones, blockchains and other tools for collecting, storing, analysing, and sharing information increasingly penetrate the health sector.
- Technology helps empower beneficiaries, improve quality of care, detect disease outbreaks, facilitate payments, and enhance accountability.

### HEALTH SERVICES REIMAGINED

- Process innovation is brought to bear to help reconfigure health systems and improve quality.
- Health systems become learning systems. Successful innovations are rapidly and widely disseminated.
- Innovative experiences in non- health sectors are adapted to accelerate health progress.

### PLURALISTIC HEALTH SYSTEMS

- The distinctive capacities of non-state actors are leveraged, with the private sector, civil society, and other stakeholders, including from outside the health sector, playing multiple roles
- This pluralism presents challenges for governments, but also new opportunities to solve persistent problems.

### GLOBALIZATION OF HEALTH

- In this new era, approaches successfully implemented in one setting can be almost instantaneously available for consideration on the other side of the world.
- New collaborative networks are emerging, spanning countries, regions, and the globe. Horizontal, peer-to-peer connections increasingly circumvent traditional hierarchies of power and knowledge and democratize innovation. New ideas and practices are burgeoning in places once considered peripheral. Expertise is everywhere.

(Cloete, 2019)

## SECTION 2: GROUP WORK

The forum attendees were divided up into 15 groups with an allocated facilitator and scribe to explore conversations around:

1. Opportunities for **innovation, collaboration** for service delivery models
2. Opportunities to **pool existing resources** to improve population access, coverage and impact
3. Exploring collaborative **governance** models for accountability for UHC

### PRINCIPLES

The consolidated group work can be summarised according to the following key principles that emerged:

- A clear willingness to work together
- Clear collaboration framework guidelines required
- High standards of care
- Improved quality
- Improved outcomes
- Collaboration and knowledge sharing
- Patient at the centre
- improved accountability
- Shared governance
- Fair incentivisation for state and private
- Increased standardisation of care

### MAIN THEMES

The group discussions created a space for open conversations, whereby the following main themes emerged:

### QUESTION 1: OPPORTUNITIES FOR **INNOVATION, COLLABORATION** FOR SERVICE DELIVERY MODELS

### Health technology

- Data mining
- Unique identifier for continuity of care
- Interoperable platform
- Develop technologies in collaboration and not isolation
- There are many central patient databases being developed. All these efforts should be collaborated.
- Private sector can support systems development
- Standardization of health records
- Household Assessments - Public Health intelligence
- Harnessing patient records for intelligent care at right level
- Decision support algorithms
- Improve disease management through use of technology
- Patient empowerment

### Strengthening COPC

Addressing social determinants to health
- Community worker can initiate referral to a minor ailment service
- Use digital decisioning to scale community health worker strategy -unemployment
- Improving triage services in community

App development for patients and Community Healthcare Workers (CHWs)

### Incentivisation of population health outcomes

- Incentives put in place to deal with e.g. substance abuse, give up smoking, exercise
- Value based outcomes: Reimbursement models
- Identify high risk patients
- Quality system with outcome-based reimbursement

### Health promotion and prevention

- Health workshops in community and schools
- Health promotion and prevention on the radio stations
- Active participation of communities and provide feedback to communities
- Free screening services by partners e.g. Dis-chem for NCD and HIV/TB

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### Legislative reform

- Current legislation does not allow for opportunities for collaboration e.g. Pharmacy Council vs HPCSA
- Better utilisation of CNP - legal implications of multi-disciplinary private practices
- Support required for practitioners who require e.g. dispensing licences
- Red-tape reduction
- Longer term contracts

### Standardisation of care

- Decision support algorithms
- National cataloguing system for various groups of people for medication
- Managed workflow models with best practice protocols supported by technology
- PIMART and NIMART training
- PACK training
- IT platforms to support standardised guidelines
- Service innovation: Essential package of service

### Tele-medicine, Video medicine and mobile services

- Remote patient monitoring - move away from managing patients at hospital and increase coverage at community-based level
- Remote radiology and mobile radiology
- Remote consultation- Dr does remote consultation with nurses present with patient

### Smart patient referral

- Apps for CHWs - digital decisioning to scale community health worker strategy
- Mobile apps to enable linkages between prescribers and dispensers
- Referral system that connects the entry point
- Align referral pathways

### WOSA

- Collaborate with other departments ito specific diseases e.g. diarrhoea hotspots to be followed up by public works ito water quality.
- e.g. Births connected to Department of Home Affairs
- To include significant civil society partners

### Patient centred approaches

- Easy medicine collection points e.g. ATM disperses or drones (e.g. Malawi drone blood bank)
- More private sector dispensing
- Education and ownership of health by patients e.g. Vitality health model
- Redefine models in private healthcare to also include home-based care
- Creating more affordable options for persons to join medical aid funds
- Increase distribution points for chronic medication

### Multi-disciplinary team approach

- Improving the role of GP's and relationship with nursing sisters: Improve collaboration
- Multidisciplinary team approach
- E.g. Birthing teams led by midwives with support from Obstetrician /Gynae

## QUESTION 2: OPPORTUNITIES TO **POOL EXISTING RESOURCES** TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT

### Sharing resources: Physical infrastructure and assets

- More efficient ways of utilitsing operating theatres
- Identify where infrastructure gaps are and collaborate on those
- Medicine collection at private pharmacies
- Bed-occupancy optimisation between public and private
- Pharmacies can supply minor ailment service - where triaged by public clinic
- Use of existing pharmacy courier infrastructure - to increase the compliance to chronic programmes and relieve the burden on public facilities
- EMS

### Sharing resources: Health professionals

- Public health mutuals for nurses and doctors
- Optimal utilisation of Health Science Students as a service resource e.g. Community outreach programmes
- Creating opportunities for retired professionals to provide an oversight role
- Upskilling and better utilisation of allied health care workers
- Creating centres of excellence for specific diseases - multidisciplinary centres
- RWOPS an opportunity to retain the skills professionals may not be using in the public space (and vice versa)

### Sharing resources: Health data and software

- Shared patient records - with patient consent
- Sharing of health technology in the private sector

### Knowledge sharing

- Quantify spare capacity in private sector
- Geographic mapping of all available resources
- Leadership and management experience
- Forums between public and private health managers
- Sharing of skills e.g. Radiology
- Actively involve and participatory approaches as a model to involve representatives from communities - building ownership through NGO and NPO
- Assessments and studies done must translate back into improved patient care e.g. Asthma care research - less than 40% of doctors follow protocols recommended by asthma studies
- Care coordination across the service delivery models

### Data and technology sharing

- Monitoring system for effective coverage

### Financial load

- Medical scheme levies/ cross subsidisation of existing schemes
- Medical aid risk pool fragmentation
- Could potentially identify specific groups of patients to private sector facilities and ask medical aids to administer the extra resources
- Quantifying total cost of care

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**Training**

- Training platform should be a shared responsibility between private and state

**NPO sector inclusion**

- Boost community care environment in private healthcare including collaboration with NGO's

**Administrative load**

- Share administrative load

**Outsourcing**

- Some services can be outsourced to private sector e.g. Optometry services
- Renal dialyses spare capacity in private sector
- Leverage corporate EAPs and wellness clinics for scaled screening and health promotion
- Leverage spare capacity in private sector for patients on waiting lists e.g. hip replacements
- Maternal health and specialised birthing units for low risk pregnancies

## QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC

**WCGH stewardship role**

- Strong acceptance that WCGH plays the stewardship role
- Stewardship role from district office. Encompass all healthcare providers

**Clinical governance**

- Creating opportunities for retired personnel to provide an oversight role
- Digital sign off on clinical treatment plans
- Integrated/inclusive clinical governance model with decision and oversight powers

**Financial governance**

- Digital compliance tracking system

**Standardised master referencing**

- Minimum standards
- Standardised codes e.g. ICN vs Nappi code

**Collaboration guidelines**

- WCGH to be stewards
- Network management tool
- Clear guidelines for framework collaboration
- Set meeting structures
- Community oversight and involvement
- Governance structures must be comprised of multiple departments and sectors
- Community engagement through health statutory bodies

**Public information**

- Share performance of facilities publicly

**Technology driven governance**

- Apps for accountability

**Regulatory / audits**

- Publicly available results

**Governance structures**

- Independent district governance boards comprised of competent liable members.
- Members must be transparent and declare any conflicting interests.
- Must have standardised criteria and to be appointed as a member
- User must be part of governance system
- Should incorporate consequence management for non-performance. Aimed at improving services.
- Linked accountability

**Standardised principles**

- Standardised protocols, guidelines, audits, outcomes, adherence to upscaling models
- Standardised quality metrics across private and public

**Data governance**

- Need for data stewardship and minimum standards

**Legal governance**

- Anti-competitive practices mitigation
- Ethical government collaboration
- Legislation e.g. HPSCA regulations prohibiting collaborative relationships

**Self-governance and self-audit**

## SECTION 3 – REFLECTING ON GROUP SESSIONS

Each group was asked to submit 5 key words or phrases, per question, which is representative of the main ideas discussed in the group. The below word clouds represent the collective ideas that emerged, where the larger fonts indicate that the idea was repeated by other groups and therefore represent a strong emerging theme.

### QUESTION 1: OPPORTUNITIES FOR **INNOVATION, COLLABORATION** FOR SERVICE DELIVERY MODELS

competent liable members
test models
innovation
community engagement
strengthening phc
independent gov boards
education
holistic approach
patient data
trust
competencies
pilot
technology
data
patient centred
person centered
infrastructure
integrated data
person centred
financing
resource management
unique identifier
scalability
capacity building
collaboration
network
value for money
digitization
health prevention
training
it
partnerships
public private
systems approach
private care
demedicalization
interoperability
fair renumeration
address under serviced
copc
health promotion
patient centered
central databases
outcomes based care
sharing of skills
digital health
quality metrics
case mix
standard master reference
primary care gp networkrk
incentivization
population health benefit
compliance tracking
shared service provision
multidisciplinary models
risk pool fragmentation

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## QUESTION 2: OPPORTUNITIES TO **POOL EXISTING RESOURCES** TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT

mutual benefit
paradigm shift
sharing of data
incentives
best practices
efficiencies
private healthcare
build trust
decrease regulation
sharing experiences
leverage excess capacity
services shared
use unemployed youth
high vol low cost model
skills sharing
demand
public private mixed serv
wosa model
clinical governance
co-payment gap cover
prod co-payment
integration across levels
communication
local level control
human resources
control probono work
phc re-engineering
digitization
collaboration
use of private resources
needs driven funding
increase bed occupancy
improving efficiency
upfs
outcomes based care
centre of excellence
move beyond binaries
csi
quality of care
enabling legislation
cdu
affordable insurance
strengthening pp
videomed
leverage latent capacity
control renal dialysis
cost effectiveness
intangible software
copc
build relationships
man resources optimally
corp shared governance
sharing technology
public private forums
procurement
community engagement
cross sectoral dialogue
central databases
leadership
cost recovery
real communication
person-centered access
geographical area mapping
shared expertise
assets sharing
optimisation of resources
optimise referral pathway
partnerships
win-win opportunities
improved accessibility
supply
creativity
sourcing of technology
pilot strat purchasing
mapping resources
shared procurement
mobile healthcare
pooling resources
management

## QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC

quality care
sharing protocol
anti competition
funding clarity
performance reviews
voice of the patient
emulate good practices
share successes
focus groups
equal access of care
resource stewardship
false binaries
infrastructure
share failures
monitoring and evaluation
user part of governance
case management
prominent health committe
learned experience
accountability
digital health solutions
intersectoral pooling
managed health care
not forcing solutions
capacity enhancement
standards
integration of it systems
increase bed access
business innovation
increase competition
leadership
data infrastructure
challenge assumptions
interoperability
trust
unique identifier
mutual benefit
openness
attitudes
it architecture
chw opportunities
support local economies
health to lead
staff distribution
shared learning
existing infrastructure
pool data
stewardship
governance
staff attitude
bottom up approach
transparency
insensitives
skills pooling
nurturing npo growth
sensitization
frameworks
mindset change
distribution
leverage regulation
care standards
collaboration framework
competent purchasers
esponsive regulations
outcomes care
patient voice
rethink power
resource pool

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## SECTION 4: PANEL DISCUSSIONS

A panel discussion comprising of the following guests followed the group sessions:

**Dr Nicholas Crisp,** Consultant NHI Fund Office: Ministry of Health

**Dr Sugen Naidoo,** Chairperson: Emerging Market Health Care

**Dr Biren Valodia,** Chief Marketing Officer: Mediclinic

**Dr Arlene Adams,** Councillor: City of Cape Town

**Dr Rajesh Patel,** Head: Benefits and Risk, Board of Healthcare Funders

The panel discussion mirrored the collective inputs received from the group work

### MAIN DISCUSSION POINTS:

Establish a **one system partnership** which can be beneficial by both sectors across the country and can address all challenges.

**Artificial Intelligence** is needed to detect financial abuse. The **financing system** should consider existing context, available resourcing and financing mechanisms. Private sector has a cost and quality problem and public sector has a quality problem.

Committees consisting of healthcare workers and practitioners would need to **define the packages of care** which will clarify the role of medical aid schemes. Risk equalisation profiles can sort memberships and risk profiles to avoid risk-based solvency for more efficient use of contributions. Help employment through more cost-effective living models. **Leadership** is needed to regulate medical aid schemes acts and policies and other legislature. Reforms are needed in the industry. **Preventative care** should be applied in practice. A component for primary care should be the neighbourhood of family care which should range from the community healthcare workers and nurses, to the optometrist and family practitioners or GP. The second component should be the **referral** pockets and there should be co-ordination from the family practitioner to the specialist. Feedback is non-existent because this is a competitive space. **Primary care** centres should be seen as prominent in terms of disbursements and controls. The system advisors across the county should be strengthened to have proper co-ordination.

Stigmatisation of disease should be decreased. **People should be empowered** to treat and address the causes of psycho social illnesses. Part of addressing the issues is to change what is happening in the communities. At the clinics there are very little or no assistance for women to deal with the psycho social issues. The same should be applied in the private sector as well by medical aid schemes.

The private hospital industry, HF and the funding industry offers their skills and expertise and is ready to dedicate resources to enable quality healthcare for all. The benefits can be shared with the public sector.  **All providers present would like to embrace the principles of the NHI.**

Their focus is working with parties to achieve and understand the case mix and team-based care by learning from the patients and the providers to better address the burden of diseases.

*Please refer to the Annexures for the detailed notes. A video download is also available from the PPHF website: https://www.westerncape.gov.za/general-publication/public-private-health-forum-pphf*

## REFLECTIONS ON THE PANEL DISCUSSION

### QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS:

**Reflections**

**Dr Beth Engelbrecht** highlighted that the Departments key learnings for partnerships revolved around collaboration, having a learning culture, being adaptable and on areas of pooling of resources and processes.

**Ms Damaris Kiewiets** added that the co-creation of knowledge is also a missing gap in innovation and partnerships.

**Further comment from attendees:** Innovation must focus on the delivery model, we have a broken delivery models in both private and public sector, there must be team-based models and value-based outcomes must be part of the core principles.

**Dr Beth Engelbrecht** added that the Department will continue to explore working with e.g. a medical scheme in a demographic are to see to what extent we could collaborate on better health coverage but that the Department still has a lot of lessons to learn.

### QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT

**Reflections**

**Dr Beth Engelbrecht** highlighted some of the financing wording which emerged were: skill sharing, cost recovery, a UPFS review, co-payment, integration across levels of care, outcomes-based care, piloting of strategic purchasing, cross sectoral dialogues, geographic area mapping, affordable insurance.

**Dr Shaheem De Vries** highlighted that it's not only about finance but also about the intangible resources that can be pooled such as pooling of creativity, opportunity, the social capital aspects like relationships and networks. Beth agreed that we need to start thinking broader when we are talking about resources and what this means.

**Dr Keith Cloete** stated that there was a consensus in Group 1 that within the existing financial streams, there are existing mechanisms that we can redirect to meet the needs of the most vulnerable and poorest population groups. Secondly, there was a commitment to move towards fair remuneration and away from fee for service. He questioned how we would move towards that as a collaborative activity. He agreed with Shaheem that there are also capacities between public and private, and where does that pool of capacities sit, and how do we leverage that capacity for better outcomes for the general population.

**Dr Saadiq Kariem** added that things like cost recovery, UPFS tariff review, from Group 12 perspective they agreed that using outcomes-based care and the tying of such into appropriate mechanisms. Cross subsidization was discussed, but there are lessons that both the public and private sectors can learn still from financing mechanisms

**Dr Beth Engelbrecht** said one of the groups highlighted that if we prioritize children, perhaps we need to have funding in specific geographic areas, and then systematically work on the life course approach. She noted that the MEC will refer to this under the First 1000 Days initiative where we can make sure that every pregnancy in the Province has the best care possible by pooling resources and collaboration.

**A comment from the floor** was that there should be an infrastructure fund between private and public providers to build new hospitals in the Province. Currently 86 percent of infrastructure development is done by the Western Cape Government and this needs to be changed to place a greater share of the burden onto partnerships.

**Dr Beth Engelbrecht** responded that the hospital bed plan for the province which forms part of Healthcare 2030, helps with the planning of infrastructure issues. This indicates which hospitals are needed and when. The challenge usually lies not with the infrastructure but rather the operational costs. The groups had thoughts around looking at private hospitals that has capacity to assist.

**Prof Harry Hausler of TB HIV Care:** noted that we need to explore going beyond binary thinking of public and private, as NPO's or civil society organizations particularly have value to add and bring services to the most vulnerable populations. NPO's can help because they bring in donor funding.

When cost effectiveness is mentioned, one of the things not highlighted are the inefficiencies. At SCOPA, departments are monitored by comparing annual reports and performance reports to ensure that they carry out their mandate. This can be done together to save expense. This can be applied in the private sector between companies doing the same things and can save them millions if one company did it for everyone.

Does existing resources mean that we should work with what we have, or should it be anticipated that within the next 5 to 10 years, the need for healthcare is going to increase and need to move beyond the existing? This includes human and financial resources. The challenge is that we are already limited in both sectors. Are people going to pay for their own healthcare services? The projection for employment is not

looking promising. We can see that the public health system is still going to bear the brunt. How is the public health system going to absorb the needs such as NHI and how will it be distributed?

**Dr Beth Engelbrecht** responded that it will require a good understanding of the need and available resources. Given the economy of our country and that many people don't have medical aid cover, we know that we are extremely limited. The plan is to make the best of what we have collectively and then look at the shortages.

**Ms Esmeraldah Isaacs** noted that one should not forget the expertise in the private financial sector. We have one of the best in the world, we need active financial and economic modelling. While focusing on delivering services, we need the backbone of the financial health systems to develop these models.

**Mr Martin Weiss, Jembi Health Systems:** noted that as there is an opportunity to allow donor funding. There is a lot of fragmentation.

**Dr Beth Engelbrecht** responded that the risk is donor driven services. How do we manage that without becoming dependent on donors?

## QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC

**Reflections**

**Dr Beth Engelbrecht** mentioned that the thinking around governance is data infrastructure. This was also in the first question, the issues of opportunities for data. Therefore, data infrastructure is very critical. There is an issue about increased competition although there is also a notion of reduced competitiveness and that drives cost.

Therefore, we need to look at how to increase competition. The unique identifier came out very strongly in some groups. Currently when a patient uses any public facility in the Province they will use one single identifier. The Public sector serves over 70% of the population. This means that if we can get to a point, the rest of the population can be added. A single unique identifier will help to connect across both sectors to have some limited data.

Key factors when building relationships are: transparency, trust, resourcefulness and outcomes care. These are also the value issues that emerge from governance. We need to show leadership in a way that installs confidence, trust, transparency and that it brings the collaborative approach and solutions together.

**Speaker from group**: Key focus is that all resources are not public, private, NGO's or civil society. There are also various groups within the public sector such as correctional services, defense force, police services, etc. Pool resources could be deemed at the procurement stage already for both equipment and human resources. The planning of end to end stage and on how to do this. This could be shared in areas between

public, private and NGO's where human resource or equipment cannot be fully utilized. Lack of efficiency is a lack of resource.

**MS Kim Lowenherz** mentioned that data was the most common issue highlighted. The understanding is that data is kept by the state or an entity. The possibility that the patient should own their own data and manage it should be considered.

**Dr Beth Engelbrecht** mentioned that the patient's capacity is often underestimated. How can a partnership be harnessed with the patient and how can a patient express their voice when they are already overburdened in their personal capacity? **Minister Mbombo** will ask the question as to how we made a difference in the average person's life. We need to answer that question.

**Dr Brian Ruff**: **PPO Serve - Integrated Healthcare for South Africa** added to governance and clinical data. Governance is meaningless in the healthcare sector if there isn't case mix information at the primary level as well as at the hospital level

**Ms Amanda Wilde, Umsinsi Health Care** - Governance comes with ownership in terms of how anything is operating such as a business or any system. An example of a business model was discussed. The UK has a governance based socially orientated business model and used it to spin out from the National Health Service (NHS). Some nurses were given their own businesses then contracted them back to provide services to the NHS. This created very strong governance levels. The passion and the commitment was created to be there and to deliver a service to patients. They ditched the insurance to bring in a service in terms of inspiring everyone to do deliver a proper service.

**Dr Beth Engelbrecht** responded that it is very powerful. The debate has been well about the financing part but not the service. How do we get the service right and what are the models? This group had a lot of examples as to how that type of model will work and there was a lot of synergy in their thinking.

**Dr Rene English, University of Stellenbosch** – The group discussed what the common goals, skills and resources are. To have collaborative governance and bring all our resources to work together and if we don't have a common goal it will be very fragmented.

**Dr Beth Engelbrecht** said that one of the groups discussed that the hospital board in the public sector could share some learnings of governance across the board from public and private. One of the observations was the type of leaderships skills required now, which the system is demanding, is different to what it was years ago. How can this be detected and improved going forward? This is learning by doing and how do we get the learning adaptation?

**Dr Saadiq Kariem:** We look at the stewardship role of the Health department as being the leadership and navigator. We discussed sharing managerial skills in that collaborative governance role across the board. Sharing guidelines in the stewardship role which is not necessarily the standard across all sectors but which the Department could consider.

**Dr Shaheem de Vries**: We have not explored tapping onto the young people's ideas. Elders may have the experience to transform the health sector, but youngsters have new ideas that can take the health sector into the next 20 to 30 years. They could participate in hospital boards and hospital communities who might have some fresh ideas of how to transform the sector.

One of the things that the system is demanding from us is trust and with that trust is the idea of surfacing assumptions. One of the discussions often raised was the assumption of the other person's work. Before we even look at governance, we need to understand one another and the assumptions that are false which we hold over the other. That should be the departure point in building the trust amongst sectors.

**Mr Simon Kaye**: The concept of a community health steward was introduced in this group. There is mistrust and conflict between the traditional medicine environment and biomed medicine environment. Talking about the social structures that exist in the communities in the traditional environment. Very important to not force solutions down from the top, it should rather be built from the bottom up. Allow for the opportunity to provide input.

**Mr Bernard Schoeman, Carevision** (Primary Optometric care): mentioned in optometry, trying to find benchmarks is very difficult. Which means there is probably no accountability. To find good measurable benchmarks in the industry should be very simple. If there is transparency in benchmarks such as in dental, optometry and hearing then things could work out better. There is an example of the Department who partnered with a private optometry company and the cost per patient was a 5$^{th}$ of that which private fees charge. This indicates a partnership with accountability and trust could have endless possibilities.

**Dr Beth Engelbrecht** asked what is the framework of collaboration and could we define the principles by which this collaboration could work? The Department is the steward for health in the Province therefore government should take the lead in taking this process forward. How do we connect everything from the bottom up?

**Dr Keith Cloete** noted that**:** Three things were raised regarding governance. The need for legislative and regulatory reform to allow for collaborative service provision. There are currently legislative and regulatory things that are mitigating against people working together. What is the framework for collaboration that the different parties need to do, whereby everyone can collaborate within? What is the affirmation of the stewardship of the province and how the role is executed?

Shared governance should be done as a partnership between the public and private role considering the percentage of the population. Leadership versus management - upskill the managers to be accountable.

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# SECTION 5 – OVERVIEW AND THE WAY FORWARD (AND FURTHER QUESTIONS)

## OVERVIEW AND FURTHER ENGAGEMENTS

- The following key themes emerged during the session:
  - There was a general consensus and support for the WCGH taking up a stewardship role for the health system in the Western Cape
  - There was general support for a collaborative model of governance (incorporating a wide range of stakeholders) of the health system towards Universal Health Coverage (UHC) in the Province
  - There was significant appetite from the wide range of private sector and other stakeholders, to explore innovative service delivery and resourcing models towards the UHC goals in the Province
  - There was support for the WCGH developing a Draft UHC Framework, for consultation and co-creation with all stakeholders in the Province over the coming months
- The WCGH has undertaken to have further engagement sessions with:
  - WCGH staff
  - Community structures and Civil Society
  - Higher Education Institutions
  - National and other Provincial Health Departments
- The WCGH has undertaken to reconvene the PPHF early in 2020, to:
  - Provide feedback on the progress on the UHC framework
  - Explore practical next steps for collaboration towards UHC

## FURTHER DEVELOP WCDOH'S DRAFT UHC FRAMEWORK OF ACTION

### ACTION AREAS

1. **Service Delivery Capability**

   *A high-quality health system for people*

2. **Governance Capability**

   *A resilient health system*

3. **Workforce Capability**

   *High performance health system*

4. **Learning Capability**

   *A learning health system*

## ACTION AREAS

### I. Service Delivery Capability
A high quality health system for people

**STRATEGY**

1. Re-defining what the service does
2. Re-design of how the service works in practise

Targets the **'re-design service delivery'** universal action for improving quality

### II. Governance Capability
A resilient health system

**STRATEGY**

3. Re-defining the system's governing ideas
4. Re-defining core health actor relationships
5. Re-design of management controls
6. Re-defining core governance roles & responsibilities

Targets the **'Governance for Quality'** & **'Igniting Demand for Quality'** universal actions for improving quality

### III. Workforce Capability
High performance health system

**STRATEGY**

7. Re-defining the capability profile of the workforce
8. Re-defining core workforce performance enablers

Targets the **'Transform health workforce'** universal action for improving quality

### IV. Learning Capability
A learning health system

**STRATEGY**

9. Re-defining how knowledge is managed in the health system

## FURTHER DEVELOP AND INVESTIGATE THE KEY ROLES/ CONSIDERATIONS

### GOVERNANCE FOR UHC

- Stewardship role – what does this mean?
- Strategic purchasing – What does this mean?
- Provider role
- Regulator role
- Funder role

## QUESTIONS RAISED DURING SESSION

The following list of questions was raised during the session, directed at the speakers and panel members. Many of these questions however, cannot be answered at this stage by the WCGH.

The questions revolved around the following themes:

| **Question themes** | | | |
|---|---|---|---|
| Collaboration | Funding / Payment model | Whole of Society Approach | Patient centredness |
| Leadership | Glossary | Complaint process | Primary Healthcare |
| NHI Bill contents | Patient registration | Current deficits | Private Sector profit motive |
| PPCF | Quality of services | Data management and Information system | Public Private Partnerships |
| Timelines | Rural areas | HMI | Purchased / Provider split |
| Central hospitals | Service specific | Incentive programmes | Remuneration / Funding |
| Compliance culture | System inheritance | Stewardship | Stakeholders |
| Corruption | Transparency | Package of care | Standardisation of care |
| Best practices | | | |

* Please refer to the Annexures for the list of questions

# ANNEXURES

## ANNEXURE A: EVENT PROGRAMME

Western Cape Government

Health

CONSULTATIVE ENGAGEMENT ON IMPROVING HEALTH TOWARDS UNIVERSAL HEALTH COVERAGE (UHC) IN THE WESTERN CAPE.

- Purpose: An Open Conversation Towards Universal Health Coverage
- Programme Chair: Dr Beth Engelbrecht (Head of Department)
- Venue: Lagoon Beach Hotel, 1 Lagoon Gate Drive, Milnerton

| Time | Title | Presenter |
|---|---|---|
| 08:30 - 09:00 | **Registration / Coffee** | |
| 09:00 – 09:15 | Welcome & Introductory remarks | Dr Beth Engelbrecht |
| 09:15 – 10:00 | Provincial Strategy and Approach to UHC | Dr Krish Vallabhjee<br>Dr Keith Cloete |
| 10:00 – 12: 00 | Group discussion: Opportunities to collaborate for UHC | Designated Facilitators and Scribes assigned to each of the groups |
| | CONVERSATION(S) TO EXPLORE:<br>1. Opportunities for innovation, collaboration for service delivery models<br>2. Opportunities to pool existing resources to improve population access, coverage and impact<br>3. Exploring collaborative governance models for accountability for UHC | |
| 12:00 – 13:00 | Reflecting on Group Session discussions | Dr Beth Engelbrecht |
| 13:00 – 13:45 | **LUNCH** | |
| 13:45 – 14: 45 | Panel Discussion: Exploring UHC Perspectives | Dr Beth Engelbrecht |
| | 1. Dr Nicholas Crisp, National Department of Health<br>2. Dr Ali Hamdulay, Chairman of Board of Healthcare Funders (BHF)<br>3. Dr Biren Valodia, Chairman of Hospital Association of South Africa (HASA)<br>4. Mrs Lize Hayes, Chief Executive Officer, The Colleges of Medicine of South Africa (CMSA)<br>5. Dr Zaheed Badroodien (Metro District Health Council representative)<br>6. Dr Sugen Naidoo (General Practitioner Group) | |
| 14:45 – 15:15 | Closing remarks | Dr Nomafrench Mbombo |
| 15:15 – 15:30 | Closing and Next steps | Dr Beth Engelbrecht |
| 15:30 | **Tea/ Coffee on Departure** | |

Hosted By

Dr Nomafrench Mbombo
Western Cape Minister of Health

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ANNEXURE B: GROUP WORK SUMMARY

# GROUP WORK SUMMARY

NOTE: THIS SUMMARY FOCUSES MORE ON THE 'HOW?', RATHER THAN THE 'WHY?'.

## QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS:

### IMPROVING HEALTH TECHNOLOGY PLATFORMS

- Data mining
- unique identifier for continuity of care
- Interoperable platform
- Develop technologies in collaboration and not isolation
- There are so many central patient databases being developed. All these efforts should be collaborated.
- Private sector can support systems development
- Standardization of health records

### COPC & WOSA

- To include significant civil society partners
- App development for patients and Community Healthcare Workers (CHWs).
- Addressing social determinants to health
- Community worker can initiate referral to a minor ailment service
- Use digital decisioning to scale community health worker strategy -unemployment

### INCENTIVISATION OF POPULATION HEALTH OUTCOMES

- Incentive to put in place to deal with e.g. substance abuse, give up smoking, exercise, (carrot and stick approach
- Service innovation: Essential package of service
- Value based outcomes: Reimbursement models
- Multidisciplinary team approach
- Improving the role of GP's and relationship with nursing sisters: Improve collaboration
- Referral system that connects the entry point
- Align referral pathways

### EXAMPLES

- Legislation does not allow opportunities collaboration e.g. pharmacy council vs HPCSA
- Funding models to be revisited, i.e. automated payment mechanisms
- More efficient ways of utilising operating theatres
- Decision support algorithms
- National cataloguing system for various groups of people for medication
- Public health Mutuals for nurses & Doctors
- Improving triage services in community
- Assist the PHC (DVG user) to collect medication at malls & shopping centres in our areas which will have a larger impact especially for accessibility & impact on WOSA.
- Household Assessments - Public Health intelligence. Digital patient records through App. Community mapping through App has shown great PHC results. Save money time COPC site, App, operating in Nomzamo – 100k people a year. Can identify hotspots.
- Harnessing patient records for intelligent care at right level – Effective diagnosis. Harness current technology ito AI – streamlining and eliminating redundant process. Automation of relevant processes. How does hotspots and burdens also get communicated to other departments e.g. Housing public works. Integration with other services and departments e.g. IT can assist referral

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process and deploy resources appropriately according to need. IT can also reduce duplication in the system

- Discharge summary at RXH, Current program happening whereby diarrhoea patients' deaths are followed up – connected with works to investigate water contamination for example. Try and improve the living conditions.
- Tele-medicine – connecting CCW with specialists. Via screens and refer appropriately. Teleradiology and Artificial Intelligence (AI) for radiology reporting with scarce radiology resources.
- Artificial Intelligence (AI), machine learning – write clinic guidelines, if you see blood pressure, give this kind or meds or see a Doctor, one can use the power of machines to community health worker, you can decentralize public healthcare by including telemedicine, referral, Reinventing the wheel with digitization, we should partner with software companies.
- Gov can create revenue streams where there currently are none
- Health workshops in community and schools
- Health promotion and prevention on the radio stations
- Active participation of communities and provide feedback to communities
- Bed occupancy between public and private. Increase volume at private the costs will come down
- App development for patients and Community Healthcare Workers (CHWs), Community worker can initiate referral to a minor ailment service, use digital decisioning to scale community health worker strategy -unemployment
- Role of pharmacy – Supply Minor ailment service delivered by community pharmacy; Pharmacists contribution in supply of medication; Access to basic medicines by community pharmacy; Triage queue at public clinic and minor ailments referred to private community pharmacy, creates capacity at public clinic; Private pharmacy acting as "health hubs" in community (open after hours and weekends)
- Having mobile services to deliver especially preventative
- Mobile Apps: to be able to have linkages between the prescribers and Dispensers
- Implementing health and wellness programmes such as the Discovery Health programme with incentives
- UBERizing the mobile services
- Managed workflow models with best practice protocols supported by technology
- pick up points – ATM disperses or drones
- more private sector dispensing
- Optimal utilization of Health Science Students as a service resource e.g. Community Outreach Programmes
- EDUCATION AND OWNERSHIP OF HEALTH BY PATIENTS. Look at available models EG Vitality Health Model
- TELEMEDS, remote patient monitoring, move away from managing patients at hospital and increase coverage at community-based level

## QUESTION 2: OPPORTUNITIES TO **POOL EXISTING RESOURCES** TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT

- Leverage excess capacity (private & public sector) - Spared bed capacity and sharing patient load, System load, Pooling of resources: Do we have a quantified sense of capacity in primary care in private sector. Quantify the oversupply in private sector
- Mapping all available resources in geographic areas
- Share the training platform
- Sharing Technology & Data access
- Sharing Management & Leadership experiences
- Children's Fund to be created
- Tweak business models to consider more social objectives
- Forums between public and private health managers
- Medical scheme levies/ Cross subsidization of existing schemes
- Leverage of SCM in private sector
- Monitoring system for effective coverage
- Mapping services by geographic area

- Training platform is a shared responsibility between private and government

EXAMPLES:

- Boost community care environment in private healthcare including collaboration with NGO's
- Also, inefficiencies in private – need to also redefine models in private healthcare. to also include home based care. accentuates hospi-centre.
- Better utilization of CNP – legal implications of multi-disciplinary private practices -CNP.
- Medical Aid risk pool fragmentation - Funding mech in private sector that accentuates hospi-centre approach. Risk pool fragmentation – REF. Too many plans REF – Risk equalization across medical funds. To create affordable options for persons to join medical aids. NHI aims to achieve this. Sustaining healthcare needs to go back to social health
- Digital compliance tracking system of Top-down financial and clinical governance. Creating opportunities for retired professionals to provide an oversight role.
- Role NGO's can play in private sector
- Need to have standardised master referencing e.g. ICN vs Nappi code Need for data stewardship and minimum standards
- Netcare: baby wellness clinic WCGH provide vaccines and NETCARE provides immunisation service; Dept of Home Affairs provide birth certificates; Legal services – MRI machine connected to theatre for toddlers and scan provide to WCGH to use in legal
- EPI and family planning programme – collaboration between state and private pharmacies. Vaccine provided by WCGH and pharmacy provide service
- -partnering with other service providers to get desired outcomes. E.g. Dis-Chem and Clicks offering free screening – which can be used to reach the wider population. Can there be contracts between state and private for some services private providers can offer? A mechanism can be worked out for private providers to report back to the department in order to capture the information at a central point.
- 
- Optometry services outsourced in MHS.
- Imobi Mamma – improve maternal and mortality rate. Showed could do basic tests using IPAD and see where person must come into the system. Model needs 2000-3000 care workers to give effect. Need access to consumables
- Medscheme – Knowledge to share e.g. DRGs to measure cost efficiencies and systems in place to identify high risk patient and quality system and outcome-based reimbursement. The work has been done and could contribute on administrative side. Could contribute to data and quality matrix as well as costing of services.
- Collaborate is not only about health also about disability. Netcare started with hearing test for new-born's and cochlear implants.
- Pharmacies underutilised e.g. screening for NCD and HIV/TB; training of pharmacists PIMART; emergency contraceptives; PREP; PEP; IT platform being developed to support the PIMART and will be made available free of charge to the WCGH. SOP and guidelines related to PIMART available – only 1st line initiation.
- Radiology – sharing of expertise and skills. Can do remote radiology and mobile radiology services
- CCT partner with Cape Radiology to access patient files and would like to partner with Morton & Partners
- Sharing of skills e.g. radiology
- Videomed – Dr does remote consultation with nurse present with patient
- Renal Dialysis – private sector better control in WC. Not all private facilities run on full capacity
- Leverage corporate EAPs and wellness clinics for scaled screening and health promotion
- Increase distribution points for chronic medication.
- Use of existing pharmacy courier infrastructure to increase compliance to chronic programmes and relive the burden on public facilities CCMDD
- Actively involve and participatory approaches as a model to involve representatives from communities-building ownership NGO & NPO
- Upskilling and better utilization of Allied Health Care workers
- COULD POTENTIALLY IDENDITY SPECIFIC GROUPS OF PATIENTS TO PRIVATE SECTOR FACILITIES AND ASK MEDICAL AIDS TO ADMINISTRER THE EXTRA RESOURCES

- Improve productivity, as currently we are receiving poor service value from money spent. An example of an innovation in the private sector space was a 'birthing team': Led by midwives and back up from Obs/gynae Dr's. It uses IT, currently through out of pocket payments but GEMS is considering paying for this for its members.
- Work done - (assessments, studies) are not translated into improving patient care. E.g. Asthma care research – less than 40% of Drs follow protocols recommended from asthma studies. E.g. Studies around seizures and management of such also available.
- Innovations – cancer: India reduced the cost of cancer care by 80% by:
  - using hub and spoke model – it's everybody's responsibility
  - task shifting (necessary in order to achieve UHC)
  - health outcomes measurement (currently there's no structured outcomes report)
  - patient empowerment
  - improving disease management through using technology
  - look at care coordination across the service delivery levels
  - consider telemedicine
  - consider creating centres of excellence for specific diseases – multidisciplinary centres
  - there's little information on total cost of care

- Some experiences from the Presidential Health Summit
- Netcare presented a paper re private opening doors to public patients Friday to Sunday because private facilities are generally low occupancy over weekends. This can relieve some pressures on state health facilities.
- E.g. Hip replacements waiting lists which can be done at private facilities over weekends
- support required for practitioners to get good TAT for services. E.g. Obtaining dispensing license for PHC Nurse can take years.
- Possibility of Red-Tape reduction Unit for the health care centre.
- DSD and DOH lack of collaboration when it comes to the elderly; chronic care for the elderly, the population is increasing
- No posts in public sector to accommodate specialists they are training
- Technology in private sector that can be used
- RWOPs an opportunity to keep the skills they may not be using in the public space
- Exchange in both directions in terms of RWOPS
- Maternal health – already models of collaboration: midwife driven units running in the public sector (specialist car such as endoscopic care), birthing units, "reducing the workload from public"
- CANSA care – PPP for breast cancer patient's radiology at George hospital, Project Flamingo
- NGO delivery models – and the WC is leading on this Nationally … NGO's can offer services closer to where people are at. But, currently annual contracts & needs to be more long term e.g. 3-5-year cycles
- EMS collaborations in Ocean view with CMR
- Living care with the WCGH
- Private GPS's at Gugulethu clinic
-

## QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC

- Anti-competitive practices mitigation
- Accountability to be improved at all government levels
- Ethical government collaboration
- Shared governance
- FAIR INCENTIVISATION FOR STATE AND PRIVATE
- Self-governance and self-audit
- network management tool
- Share information on performance of facilities publicly
- Set up NHI through existing medical schemes?
- Clear guidelines for framework collaboration
- Apps for accountability: check in; sign off on medicine added

- Governance model: 1) board meeting (monthly, quarterly; bi-annually) 2) community meeting - oversight
- Regulatory / audits
- Integrated/Inclusive clinical governance model with decision and oversight powers.
- Stewardship role from district office. Encompass all healthcare providers
- Skills needed to manage pool of funds, contract with medical schemes in short term on affixed fee basis. Gov must manage risk of patient, but PP provides service e.g. hip replacement.
- Governance structures must be comprised of multiple departments. Inter and intra sectoral representation
- Independent district governance boards comprised of competent liable members. Must be transparent, declaration of interest. Will there be personal liability ito the board members? Board members need to have a standardised appointment and competency.
- User as part of governance system
- Managed health care
- The same principles apply to both private and public providers: i.e. protocols, guidelines, audits, outcomes, adherence to upscaling models.
- Standardizing quality metrics across private and public
- Community engagement through health statutory bodies
- Governance – putting processes in place to ensure that there is accountability. There should be consequence management for non-performance. It means feedback processes be established to talk to improving services. E.g. Ideal clinic tools developed over 5 years but not fully implemented to date. What accountability is linked to that?

# ANNEXURE C: GROUP WORK INDIVIDUAL SUBMISSIONS

## GROUP 1

**"Sticky Notes" Discussion:**

- Anti-competitive practices mitigation
- Focus on areas of need
- Align referral pathways
- Employer of choice
- Children's Fund to be created
- Existing schemes
- Medical scheme levies/ Cross subsidization of existing schemes
- Data mining
- Improving triage services in community
- Quality service delivery implementation
- Innovative strategies require data
- Private sector and government working together
- Accountability to be improved at all government levels
- Ethical government collaboration
- Spared bed capacity and sharing patient load
- System load
- Share the training platform

- Leverage of SCM in private sector
- Shared governance
- Set up NHI through existing medical schemes?
- Private sector can support systems development
- Governance must not be restrictive
- Courage to test new ideas
- Patient centeredness
- Clear guidelines for framework collaboration
- Service innovation: Essential package of service
- Real interventions to improve quality of care
- Pooling of resources: Do we have a quantified sense of capacity in primary care in private sector
- Quantify the oversupply in private sector
- Certificate of need
- Monitoring system for effective coverage
- Defining the governance activities: Proposals are in place
- Track collectively joint coverage goals: Can we track progress?
- Reduce the "competition" amongst health care providers
- Providing data at point of care
- Value based outcomes: Reimbursement models
- How will information be shared?
- Fair distribution of workload
- Monitoring performance
- Upskilling and training for carers: Working more efficiently
- Creating a decentralized access point for the patient: Defined pathways/Access points to be determined/Redirection
- Enough specialty care
- Standardization of health records
- Multidisciplinary team approach
- Treatment guidelines and protocols
- Patient records: Confidentiality
- Regulatory impediments to work together
- Fair remuneration for work done
- Unique patient identifier
- Dealing with patient needs/ dealing with access to medicine
- Building blocks for wellness: How do we improve wellness in impoverished society?
- Improving the role of GP's and relationship with nursing sisters: Improve collaboration
- Sites: Where do we place the nurses?
- Services: What do we provide where?
- Systems: Provide information

- Sustainability of services that are provided
- The conversations held today should be the start of many amongst all health care partners

**Dr Keith Cloete's summary of "sticky notes":**

- Entry point as diverse as possible
- Entry point focus must be on wellness
- Why are certain areas under/ over served? How do we deal with this?
- Enabler to connect the system
- Use of a unique identifier
- Governance: What are the rules of engagement?
- What is the framework for governance collaboration?
- Defining the need and responding to it
- Allow for innovation

**Emerging themes:**

1. Defining the Services
2. Addressing the need
3. Funding/ Resources
4. Training and capacity
5. Information and data
6. Governance

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS:**

- ADDRESSING THE NEED
- SERVICES

| | |
|---|---|
| **1** | Entry point into the health system |
| **2** | Wellness to be the basis at entry point |
| **3** | Addressing the disproportionate need |
| **4** | Referral system that connects the entry point |
| **5** | Allowing for customization of local need |

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

- FUNDING/RESOURCES
- TRAINING

| | |
|---|---|
| **1** | Pool existing capacity to improve services |
| **2** | Redirect existing resources to ensure a fair distribution |
| **3** | Training platform is a shared responsibility between private and government |
| **4** | Fair remuneration away from fee for service |
| **5** | Re/ up skilling of carers/ utilize existing skills |

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

- INFORMATION/DATA ACCESS
- UNIQUE IDENTIFIER
- LEADERSHIP
- GOVERNANCE

| | |
|---|---|
| **1** | The principle of pool data for better patient care |
| **2** | Anti-competition |
| **3** | The potential for a unique patient identifier to improve patient care |
| **4** | A clear framework for collaboration |
| **5** | Stewardship |

## GROUP 2

**CONVERSATION(S) TO EXPLORE:**

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

| | |
|---|---|
| **1** | Partnership |
| **2** | Process efficiencies |
| **3** | Resource sharing |
| **4** | IT |
| **5** | Value for Money |

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

| | |
|---|---|
| **1** | Collaboration |
| **2** | Paradigm shift |
| **3** | Cost effectiveness |
| **4** | Enabling legislation |
| **5** | Efficiencies |

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

| | |
|---|---|
| **1** | Interoperability |
| **2** | Architecture |
| **3** | Resource stewardship |
| **4** | Standards |
| **5** | Transparency |

| | |
|---|---|
| Q1. Opportunities for innovation, collaboration for service delivery models | Financial:<br>✓ Standard pricing<br>✓ Transparent pricing<br>✓ Bulk purchasing<br>✓ Payment models – alternative reimbursement<br>✓ Medication availability (procurement Province. vs National.)<br>✓ Regulate (law) cost of medication<br>✓ Cost effectiveness (not price and points)<br>Partnership:<br>✓ Business models = more social<br>✓ Inter-governmental Relations / co-ordination<br>✓ Partnerships – public/private<br>✓ International …. & learning<br>✓ Higher education<br>Processes:<br>✓ Multidisciplinary procurement groups<br>✓ Control distribution<br>✓ Standardised computer system<br>✓ Process: operational / implementation |

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| | |
|---|---|
| | ✓ Monitoring & evaluation<br>✓ More efficient ways of utilising operating theatres<br>✓ National catalogues for primary and secondary care<br>Resource sharing:<br>✓ Workforce planning<br>✓ Mechanism to utilise existing capacity – private hospitals<br>✓ Workforce: Clinical: Specialist nurses; PHC services; pharmacist.<br>✓ Workforce: Non-clinical: Actuarial specialists<br>✓ Training in private facilities<br>✓ Appropriate training of staff<br>✓ Public/Private sharing facility & staff<br>✓ DSP groups: Not having access to hospitals near them.<br>IT:<br>✓ Standardised system<br>✓ Legal framework to protect vulnerable groups to ensure that centralized systems categorize them in the system<br>✓ Users data protection<br>✓ Infrastructure – physical and software<br>✓ 4th Industrial revolution |
| Parking Lot | ✓ DSPs<br>✓ Over servicing<br>✓ Data protecting |
| Q2. Opportunities to pool existing resources to improve population access, coverage & impact | 1. Collaboration:<br>✓ Public Private Partnership<br>✓ Skill share & Planning<br>✓ CSI + SED<br>✓ Much more collaboration + state & private.<br>✓ Common projects<br>✓ Neutral stewardship<br>✓ New + more legislation<br>✓ National cataloguing system for various groups of people for medication<br>✓ Public health Mutuals for nurses & Doctors<br>2. Change Mindsets:<br>✓ Clinic committees<br>✓ Community development workers<br>✓ Hospital Boards<br>✓ Funders<br>✓ School health & clinic services *TB *HIV GET PREVENTATIVE MEASURES<br>3a) Efficiencies (system + processes):<br>✓ People centricity<br>✓ Standardization of products and system costs<br>✓ Assist the PHC (DVG user) to collect medication at malls & shopping centres in our areas which will have a larger impact especially for accessibility & impact on WOSA.<br>3b) Cost-effective spending:<br>✓ Effective pool of resources: DoH; Local authority; private; education<br>4. Artificial Intelligence: (4th Industrial Revolution)<br>✓ AI & Digital data<br>5. Change legislation<br>✓ Integrated legislation = people centricity<br>✓ Legislation amendments<br>✓ Budget<br>✓ Change & restructure: 1) Systems; (operating); 2) Policies & Procedures (Referral systems) of Dr's in general<br>✓ Tweak business models to consider more social objectives |

<table>
<tr>
<td>Q3 Exploring collaborative governance models for accountability for UHC</td>
<td>
1. Interoperability:<br>
✓ People centric<br>
✓ Real time reporting<br>
✓ Apps for accountability: check in; sign off on medicine added<br>
✓ Governance model: 1) board meeting (monthly, quarterly; bi-annually) 2) community meeting - oversight<br>
✓ Regulatory / audits<br>
✓ Integrated/Inclusive clinical governance model with decision and oversight powers.<br>
2. Structure & Process<br>
✓ Interoperability<br>
✓ Engagement structure/board<br>
✓ District / geographic board<br>
✓ Define: patient outcomes – process and clinical<br>
✓ Bridging the gap between: Government – Service providers (public + private) – education institutions<br>
✓ Multi-sectoral<br>
✓ Financial planning<br>
3. Resources (people, finance, equipment):<br>
✓ Workforce planning<br>
✓ Skills<br>
✓ Safety & governance: Metro via *SAPS<br>
✓ Service delivery areas: *Metro staff; *DoH structures; *staff (private security is not enough)<br>
4. Measurement:<br>
✓ Outcomes<br>
✓ Standard benchmarks<br>
✓ Targets<br>
✓ Objectives<br>
✓ Criteria<br>
5. Transparency<br>
✓ Transparency on all levels<br>
✓ Standardised pricing & transparent pricing<br>
✓ Independent auditing<br>
✓ Transparent reporting
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**PARKING LOT: OPPOSING VIEWS**

None

## GROUP 3

**CONVERSATION(S) TO EXPLORE:**

Group main thoughts on NHI on sticky notes:

- Better effective healthcare for all – Vision
- Digital integration and implementation -need access to data – you can't manage what you can't measure
- Free access

- Streamlining access
- Better administrative efficiency
- Need for education on NHI and what it means for private practitioners
- Need for central communication platform
- Importance of monitoring governance, compliance whilst utilizing digital platforms.
- Need for properly capacitated facilities in terms of equipment, staff etc.
- Strengthened PHC, close to community. Especially focus on children and creating equal opportunities.
- Vulnerable populations and comprehensive care. Care must be integrated between stakeholders i.e. break down lack of trust, care pathway, seamless
- Deliver services according to need

**Question 1 Discussions**

Stewardship role from district office. Encompass all healthcare providers

Household Assessments

Public Health intelligence. Digital patient records through App. Community mapping through App has shown great PHC results. Save money time COPC site, App, operating in Nomzamo – 100k people a year. Can identify hotspots. Harnessing patient records for intelligent care at right level – Effective diagnosis.

Harness current technology ito AI – streamlining and eliminating redundant process. Automation of relevant processes

How does hotspots and burdens also get communicated to other departments e.g. Housing public works. Integration with other services and departments e.g.

IT can assist referral process and deploy resources appropriately according to need.

IT can also reduce duplication in the system

e.g. Discharge summary at RXH, Current program happening whereby diarrhoea patients' deaths are followed up – connected with works to investigate water contamination for example. Try and improve the living conditions.

e.g. Tele-medicine – connecting CCW with specialists. Via screens and refer appropriately.

Challenge with digitization ito a systems inter-operability.

Challenge with Patient data ito POPI – ito utilizing patient data on an open space. Concerns around legal liability of private practitioners.

Telemedicine

Real time data

Professional and legal Protection and coverage of PP's working in telemedicine or any other service must be a priority and good experience to ensure safe and favourable interaction and collaboration

Need for the minimum standards ito governance and IT.

Coherent HC policy aligned to what is happening on the ground.

CCW – powerful resource and their education is important

Service delivery aspects:

Skills needed to manage pool of funds, contract with medical schemes in short term on affixed fee basis. Gov must manage risk of patient, but PP provides service e.g. hip replacement. Need to contract more creatively. Gov can create revenue streams where there currently are none.

Prophylactic medicines – diets and wellness to prevent disease.

Health workshops in community

Integration of services in private sector to create patient comprehensive care. Ensuring continuity of care

Incorrect service pathways followed should be addressed e.g. patient pathway differs across sector. Need to make sure resources at first level of care is appropriate. Realtime data and decision making. Realtime data to reduce bottlenecks and reduce system flow challenges

How we communicate communication platforms

Budget fragmentation to uplift community should be appropriated more effectively.

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

| | |
|---|---|
| **1** | Digital health, that allows specific controlled access throughout system |
| **2** | Use and Protection of patient information |
| **3** | Education and competency and access to information for people close to the ground |
| **4** | use Patient information to identify burden areas and hotspots. 3 – Minimum standards for electronic records – unique identifier for continuity of care |
| **5** | Professional and legal Protection and coverage of PP's working in telemedicine or any other service must be a priority and good experience to ensure safe and favourable interaction and collaboration<br><br>Interoperable platform |

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

| | |
|---|---|
| **1** | Boost community care environment in private healthcare including collaboration with NGO's<br><br>Also, inefficiencies in private – need to also redefine models in private healthcare. to also include home based care. accentuates hospi-centre.<br><br>Better utilization of CNP – legal implications of multi-disciplinary private practices -CNP. |
| **2** | Medical Aid risk pool fragmentation<br><br>Funding mech in private sector that accentuates hospi-centre approach. Risk pool fragmentation – REF. Too many plans REF – Risk equalization across medical funds. To create affordable options for persons to join medical aids. NHI aims to achieve this. Sustaining healthcare needs to go back to social health |
| **3** | Medical aid Cannot have enough cross subsidization medical aid. Need to relook at PMB's |
| **4** | Role NGO's can play in private sector |
| **5** | MSET (Multi-sectoral ….) is a community board that was used a platform to continue needs to the health department. Was a link between community and healthcare providers?<br><br>Pooling structures at a local level to facilitate right level of engagement. Local level structure for engagement<br><br>Health promotion and prevention on the radio stations. Diet and focus and education adolescents, health promoting schools |

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

| | |
|---|---|
| **1** | Digital compliance tracking system of Top-down financial - clinical governance. Creating opportunities for retired professionals to provide an oversight role. |
| **2** | Need for properly accredited network of providers for referral from state. Bottom up, WOSA including private sector towards common goal |
| **3** | Need to have standardised master referencing e.g. ICN vs Nappi code Need for data stewardship and minimum standards. E.g. |
| **4** | Governance structures must be comprised of multiple departments. Inter and intra sectoral representation |
| **5** | Independent district governance boards comprised of competent liable members. Must be transparent, declaration of interest. Will there be personal liability ito the board members? Board members need to have a standardised appointment and competency. |

**PARKING LOT: OPPOSING VIEWS**

Explore fixed fee structure capitation vs global fees

## GROUP 4

**OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

**Examples of current collaborations:**

Netcare: baby wellness clinic WCGH provide vaccines and NETCARE provides immunization service; Dept of Home Affairs provide birth certificates; Legal services – MRI machine connected to theatre for toddlers and scan provide to WCGH to use in legal

EPI and family planning programme – collaboration between state and private pharmacies. Vaccine provided by WCGH and pharmacy provide service

Optometry services outsourced in MHS.

**Why want to collaborate?**

What do we want to achieve with collaboration? Its outcome is access. How can providers collaborate to create access?

Need to look at people and all things that affect people and not only health. Do not focus on silo.

Want to make an impact

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WCGH must shift its resources and properly fund the NPO to ensure proper collaboration and service delivery.

**Possibilities/Potential:**

WCGH to identify current challenges and then identify areas of collaboration: quadruple burden of disease (TB/HIV; NCD; Maternal and Child health; IPV); increase need and limited ability to address all the needs.

Imobi Mamma – improve maternal and mortality rate. Showed could do basic tests using IPAD and see where person must come into the system. Model needs 2000-3000 care workers to give effect. Need access to consumables

Medscheme – Knowledge to share e.g. DRGs to measure cost efficiencies and systems in place to identify high risk patient and quality system and outcome-based reimbursement. The work has been done and could contribute on administrative side. Could contribute to data and quality matrix as well as costing of services.

Collaborate is not only about health also about disability. Netcare started with hearing test for new-borns and cochlear implants.

Pharmacies underutilized e.g. screening for NCD and HIV/TB; training of pharmacists PIMART; emergency contraceptives; PREP; PEP; IT platform being developing to support the PIMART and will be made available free of charge to the WCGH. SOP and guidelines related to PIMART available – only 1st line initiation.

Radiology – sharing of expertise and skills. Can do remote radiology and mobile radiology services

CCT partner with Cape Radiology to access patient files and would like to partner with Morton & Partners

Using existing administrator to support UHC

**How does it impact on core duties?**

If state patients, need to get consumables and medicine

must be fee for service

Lack of intersectoral collaborating to support collaboration e.g. impact on safety and violence

Need to open and make it easy to collaborate.

**THEMES**

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

| | |
|---|---|
| **1** | Shared service provisioning |
| **2** | Sharing of knowledge and expertise |
| **3** | Sharing of skills e.g. radiology |

| | |
|---|---|
| **4** | Breaking down barriers for collaboration e.g. IT firewall |
| **5** | Population health is beneficial for everyone |

**PARKING LOT**

None

**OPPORTUNITIES TO POOL EXISTING, RESOURCES TO IMPROVE POPULATION ACCESS, COVERGAE AND IMPACT**

Mutual benefit to all should be aim

CDU

Digital system e.g. points of care testing, diagnosis

Videomed – Dr does remote consultation with nurse present with patient

Renal Dialysis – private sector better control in WC. Not all private facilities run on full capacity

Sharing of equipment across private sector

How pool all resources of all sectors and interlink private and public to increase prevention should be focus and linked to the smaller geographical area.

Pooling human resources to lowest level at community level – well trained

Integration of information systems

Bed occupancy between public and private. Increase volume at private the costs will come down

**How does group feel about pooling of funds?**

Funds need to be pooled to ensure access to services.

Controlling at local level better than centralized.

Need to customize rules to local level

Shareholders goal vs hospital manager goals are different.

Pooling should be done at local geographical area

**Probono work: should it be considered?**

Will not be easy to control bono work. Currently private doctors do already pro bono work on a voluntary basis.

Need to consider the challenge that private practitioners experience.

Need to incentive practitioners

Inherent that all health care workers are helpers and do pro bono work and should it be regulated it will impact on current voluntary work.

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It needs to be easy and practitioners need to work in their own environment.

**THEMES**

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

| | |
|---|---|
| **1** | Digital systems |
| **2** | Intersectoral pooling |
| **3** | Integration of information management systems |
| **4** | Increase in bed access |
| **5** | Mutual benefit |

**PARKING LOT**

Legislation does not allow opportunities collaboration e.g. pharmacy council vs HPCSA

**EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

Understanding:

How do we do the things that we do?

Multiple skills, independent and controls must be in place to ensure that you do the right thing.

Public and private relationship

WCGH and NPO relationship – not sure whether the relationship will continue in future as NDOH direction

Take best practice from public and private and design governance according.

Ethical way of utilising money.

Efficiency, measurable outcomes and comparable

Managed health care vs current public sector management vs WCA patients in private sector – for UHC to effective an element of managed health care should be considered

Take lessons from private sector

People as part of governance model to be included

Triangle: public, private and user

Correct incentives must be in place

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Monitoring system must be in place

**THEMES**

| | **QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC** |
|---|---|
| **1** | Learned experience from private and public sectors |
| **2** | Right incentives |
| **3** | Monitoring system |
| **4** | User as part of governance system |
| **5** | Managed health care |

**PARKING LOT**

None

**GENERAL**

Will slides be made available?

Culture of accountability is missing in public sector. Biggest hurdle is the two sectors difference in culture.

Relationships is important and will lead to better outcomes

Change management process is important

Patient centeredness should be focus

Need to accept profit that must be made.

Legislation impacts and barrier to UHC

Mistrust impacts on collaboration

Collaboration improve standards and training

Creates opportunity to learn from each other's mistakes and what works

Collaboration provides opportunity for sharing of training, equipment, services

Academic could support with providing evidence

Need to move away from fragmentation and collaboration should facilitate this

Active participation of communities and provide feedback to communities

Collaboration should bring back the passion

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## GROUP 5

**CONVERSATION(S) TO EXPLORE:**

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

| | |
|---|---|
| 1 | **Health and Patient Education:**<br>• Healthcare talks or training and education programs<br>• School programmes (role models)<br>• App development for patients and Community Healthcare Workers (CHWs)<br>• Addressing social determinants to health<br>• Community worker can initiate referral to a minor ailment service<br>• Use digital decisioning to scale community health worker strategy -unemployment |
| 2 | **Reduce Backlogs by using facilities smarter**<br>• Use private and public facilities fully to clear all backlogs - weekend time etc. especially surgical ones<br>• Partnerships between the state and private sector-need more collaboration<br>• Commitment to work together - Private and State<br>• Innovative medicine delivery access<br>• Existing pharmacy infrastructure in communities (create P.H.C centers within communities, Long hours of operation weekdays/public holidays/afterwork etc.)<br>• Enable "self-care" through better access, behaviour change in community<br>• Access healthcare at appropriate level (e.g. primary healthcare level and refer up if required) |
| 3 | **Telemedicine**<br>• Virtual doctor consultations<br>• Electronic Patient records and EML |
| 4 | **Exclusive access to health care**<br>• Access by geographical area<br>• Map services/provides per geographic area |

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| | |
|---|---|
| | • Special population clinics that are PPP because they have special needs or smaller pools e.g. rare diseases; elderly; palliative care, dialysis |
| **5** | **Financing**<br>• Should fiat money be the only form of payment?<br>• Healthcare can be financed by Bitcoin etc. |

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

| | |
|---|---|
| **1** | **Digitization**<br>• IT innovation to automate processes for health outcomes<br>• Through a comprehensive database of healthcare institutions and healthcare services (referrals)<br>• Block chain<br>• Teleradiology and Artificial Intelligence (AI) for radiology reporting with scarce radiology resources. |
| **2** | **Demand**<br>• Inclusion of comprehensive healthcare for transgender persons and for the wider LGBTIQ + community and other marginalized groups.<br>• Create employment, train and upskill community, wellness screening and health outreaches e.g. school health<br>• Addressing the issue of access to gender affirming healthcare for transgender and gender diverse persons<br>• Addressing the barriers in accessing healthcare for LGBTIQ persons based on discrimination, stigma, prejudice directed towards these individuals |
| **3** | **Supply**<br>• Minor ailment service delivered by community pharmacy<br>• Pharmacists contribution in supply of medication<br>• Access to basic medicines by community pharmacy<br>• Triage queue at public clinic and minor ailments referred to private community pharmacy, creates capacity at public clinic<br>• Private pharmacy acting as “health hubs” in community (open after hours and weekends) |

| | |
|---|---|
| | • Understanding quality vs price |
| 4 | **Geographic based service delivery model**<br>• Reduce the regulatory gaps or requirements<br>• All private clinics to form part of UHC<br>• Determine the burden of disease/client health needs for geographic area<br>• Mapping services by geographic area |
| 5 | **Pooling the resources to upskill health economies**<br>• Linking NGOs with the health care for those that do not access health care<br>• Leverage corporate EAPs and wellness clinics for scaled screening and health promotion |

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

| | |
|---|---|
| 1 | **Distribution:**<br>• Increase competition between public and private hospitals to raise accountability.<br>• Increase distribution points for chronic medication. |
| 2 | **Data Infrastructure:**<br>• Digital health solutions for end to end governance<br>• Framework of reforms to strengthen governance and accountability mechanisms.<br>• Shared training of leaders – companies and hospital managers all need it. May allow cross-pooling of ideas at the same time.<br>• Patient and Client Unique Identifier.<br>Unique identifier across platforms to prevent patient hopping.<br>• Use existing IT infrastructure in pharmacies to report back/monitor progress. Data very important. |
| 3 | **Support Local:**<br>• To stimulate the economy. |
| 4 | **Transparency:**<br>• Transparent and open government processes |
| 5 | **Measure Staff Performance:**<br>• Improve staff attitudes<br>• Sensitization and capacity enhancement of healthcare. Practitioners to be able to work with key populations and marginalized groups.<br>• Create awareness of losing your job in public sector if poor performance. |

| | • Increase access to professional health workers in both private and public sectors. |
|---|---|

**PARKING LOT: OPPOSING VIEWS**

| | |
|---|---|
| Wesfleur Board: Health education in rural areas is a problem, creates political confusion | **ENVIRONMENTAL HEALTH**<br>- Water<br>- Sanitation |
| **UHC vs NHI debate**<br>Vonita: what does it mean for<br>We cannot reengineer the public sector alone, we need a whole of South Africa.<br>ICPA: Give everyone a choice to opt in or opt out to be part of UHC<br>Move away from "free healthcare", there are no "free healthcare", it is either subsidized. | **INCENTIVISATION**<br>CLICKS: Rewards for good health, Discovery has a good model to incentivize good health. |
| **Transgender views** – deliver gender affirming healthcare services<br>Distribution of trained transgender healthcare practitioners – how do we locate these practitioners who are already sensitive towards<br>Open a vulnerable group centre where MSM (Men sleeping with Men), transgender etc. can access healthcare<br>Stigma, homophobic attacks | **PALLATIVE CARE, CARE FOR ELDERLY**<br>Have exclusive access to healthcare |
| **PHARMACY ROLES:**<br>Increase access to healthcare by transforming pharmacies with the ICPA and Clicks for example, it can be rolled as PHC centers out tomorrow!<br>Pharmacies can act as a central database via ID number and permit as unique identifiers. There is still the POPI issue. | **SURGICAL BACKLOGS:**<br>Medscheme: Private healthcare does not operate until full capacity. Specialists are more in private sector – pool resources |
| Legislation | Champion of Love - Why are private clinics diverted every week |
| **Health Education:**<br>Educate patients that the do not need to see a doctor first, the could be attended by a nurse first. | Move away from paper based, have healthcare facilities do accreditation online. |

| Service delivery models: We no longer need a hospital to render a service<br>Geographic access of healthcare<br>In area | Artificial Intelligence (AI), machine learning – write clinic guidelines, if you see blood pressure, give this kind or meds or see a Doctor<br>One can use the power of machines to community health worker<br>You can decentralize public healthcare by including telemedicine, referral<br>Reinventing the wheel with digitization, we should partner with software companies. |
|---|---|
| **FINANCING MODELS:**<br>Payment Mechanisms: Using fiat money may not be the future to fund healthcare. We can use other currency such as Bitcoin etc.<br>Why can't health providers get a tax exemption<br>**Funding:** we can save money on unnecessary specialist consultations | **DATA AND DATA WAREHOUSING:**<br>ICPA - Health data must be owned by the state, data security and who gets to access.<br>Medscheme – does not agree, data needs to be mobile! Healthcare workers need to see where the patient access healthcare.<br>ICPA - Access to data needs to be controlled.<br>HealthCraft - Data can be owned by the patient |
| **PRIVATE AND PUBLIC COMMUNICATION**<br>Pathcare: the 2 sectors do not speak to each other | |

## GROUP 6

**CONVERSATION(S) TO EXPLORE:**

| | **QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS** |
|---|---|
| **1** | **Improving health technology platforms** |
| **2** | **Network and partner strengthening** |
| **3** | **Strengthening PHC platform &wellness through prevention programmes** |
| **4** | **Being able to test models and rapidly scale up** |
| **5** | |

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Key Words: TECHNOLOGY, PARTNERSHIPS, PHC, PILOTING

Additional floor comments: Co-creation of knowledge, 4th industrial revolution,

**DISCUSSION POINTS**

It Platforms: how can we optimize the use of existing data, SPV, central patient database. SPV or patient identity to be able to see a full patient profile. This will also assist in addressing the doctor shopping.

There are so many central patient databases being developed. All these efforts should be collaborated.

Patient confidentiality and the ability to share patient information across the platform.

Small scale testing is needed for new systems, to avoid interruptions to the whole system when piloting.

Having mobile services to deliver especially preventative

Mobile Apps: to be able to have linkages between the prescribers and Dispensers

Preventative care: should be strengthened. Should be taken into the community. Focus on nutrition, wellness, fitness, adherence to treatment, youth education. Should be taken to schools. Can start at the school tuck-shop.

Implementing health and wellness programmes such as the Discovery Health programme with incentives.

There boundaries and UHC will not be able to solve all problems such as poverty. We should set the boundaries.

STICKY NOTE FEEDBACK

- Enable small scale, rapidly deployed innovation models for quick testing of ideas.
- The same principles apply to both private and public providers: i.e. protocols, guidelines, audits, outcomes, adherence to upscaling models.
- Use of existing pharmacy courier infrastructure to increase compliance to chronic programmes and relive the burden on public facilities CCMDD
- Where people reside into consideration informal settlements.
- Utilize chronic disease management capabilities to improve health outcomes and reduce admissions.
- At PHC level or GP level
- Focus on PHC but incorporating all access points.
- Service Delivery Models: strengthening the PHC platform which is the first level of care for all communities based on the burden of disease.
- Actively involve and participatory approaches as a model to involve representatives from communities-building ownership NGO & NPO

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- Partnerships with NGO
- Support to NGO
- Explore what is out there and the impact.
- Incorporating GPs into the PHC platform and having a geographic approach
- Develop an APP –user friendly for the elderly.
- Create synergy in the innovation between private and public to the benefit of the patient.
- How do we create synergistic job creation and training to avoid one stealing from the other?
- UBERizing the mobile services
- Streamlining the service by using IT platforms for referral to your nearest healthcare facility
- We need accurate info on database
- Collaboration – pharmacy involvement in public patient counselling
- Unified patient viewer across multiple points of care allowing for value-based compensation models
- Leverage technology solutions developed in private sector such as tele-health to create access in more areas.
- Managed workflow models with best practice protocols supported by technology
- The effect of mobiles in service delivery.

| | **QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT** |
|---|---|
| **1** | Sharing of Assets (equipment, technology, etc.) |
| **2** | Sharing Human Resources |
| **3** | Targeted CSI toward investment in health |
| **4** | Pooling of Funds with a link to incentives |
| **5** | |

Key Words: ASSETS, HUMAN-RESOURCES, CSI, INCENTIVES

Additional floor comments: fair remuneration, defining resources, pooling ideas, funding for infrastructure

**DISCUSSION POINTS**

Pooling equipment and resources

Sharing data resources (health clinical data)

Social responsibilities of private companies

Funding

CSI: How do we enforce this, e.g. VAT

Donor funding

Ring-fenced tax for healthcare- how is this then managed effectively?

Can we pool the workforce? Human resources in the form of training, pro bono consults

**STICKY NOTE FEEDBACK**

- Sharing workplace expertise across sectors
- Decongest public facilities by outsourcing medicine collection etc.
- Human resource networks
- Financial resource including whatnots
- Employ and centralize IT access to patient info.
- To direct CSI funds towards health technology and medicines.
- Stakeholder relations access to private and public resources to cover poor communities through CSI and government making it compulsory for cigarette companies.
- Govt should come up with a strategy to ensure targeted corporate social responsibility from private sector entities.
- Single pool of resources for NHI.
- Incentivize wellness and screening programmes, e.g. Discovery
- Public resources and international donor funding can only be accessed by the govt social/health services.

| | **QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC** |
|---|---|
| **1** | Same Standard of care (Ideal Health Standard) |
| **2** | Distributed Leadership |
| **3** | Geo Governance Structure |
| **4** | State as governor |
| **5** | Shared governance learnings |

Key Words: CARE-STANDARDS, DISTRIBUTED LEADERSHIP, GEOGRAPHIC GOVERNANCE, SHARED LEARNINGS, PUBLIC-SECTOR

**DISCUSSION POINTS**

Governance belongs with government. Private have business interests.

Both sectors to learn from each other's governance models

Adherence to ideal clinic/hospital standards

Custodian of all healthcare models

Platform where information technology

Governance in the WC is better than in the rest of the country

Where is the learning about governance?

**STICKY NOTE FEEDBACK**

- Collaborative governance models in terms investing in software through partnerships
- Governance belongs with the elected government
- Both public and private can learn from each other's governance models.
- Standards of care (policies, audits, outcomes,) adherence to ideal clinic
- Custodian of all healthcare models
- Policy private PHC model per geographic area (Drs, Pharmacy, CBS, Allied Health's etc.)

**PARKING LOT: OPPOSING VIEWS**

None

## GROUP 7

**CONVERSATION(S) TO EXPLORE:**

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

**STICKIES:**

- ACCOUNTABILITY FOR UHC
- WILLING WORKFORCE
- CAPABLE WORKFORCE
- PARTNERS TO IMPROVE COVERAGE
- RESPECT FOR THE PERSON YOU ARE SERVING
- PICK UP POINTS – ATM DISPERSES OR DRONES

- ELECTRONIC SYSTEMS TO SUPPORT OVERLAP
- QUALITY/STANDARDS/NORMS
- MORE PRIVATE SECTOR DISPENSING
- STANDARDISING QUALITY METRICS ACROSS PRIVATE AND PUBLIC
- TEAM BASED CARE DELEIVERY
- PARTNERSHIPS WITH OTHER DEPARTMENTS
- HAVE NURSES DO MORE – TASK SHIFTING
- EDUCATIONAL INFO
- PREVENTATIVE CARE IN DELIVERY OF HEALTH
- RESPECT PATIENT AUTONOMY

| | |
|---|---|
| **1** | Upskilling and better utilization of Allied Health Care workers |
| **2** | Decision support algorithms |
| **3** | Standardizing quality metrics across private and public |
| **4** | Centralized databases for health records |
| **5** | Funding models to be revisited, i.e. automated payment mechanisms |

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

**STICKIES:**

- PRIVATE THEATRE TIME AND EQUIPMENT IN PRIVATE HOSPITALS.
- TESTING FACILITIES AVAILABLE IN THE PUBLIC SECTOR.
- EXPERIMENTATION WITH NEW PAYMENT MECHANISMS
- TIMELINESS AND EFFICIENCY OF PAYMENTS
- CAPITATION TO ENABLE NEW MODELS
- AUTOMATED PAYMENT MECHANISMS
- FAIR INCENTIVISATION FOR STATE AND PRIVATE
- AUTOMATION OF NON-ESSENTIAL FUNCTION
- DECENTRALISE SERVCES TO IMPROVE ACCESSIBILITY
- CENTRAL DATAKKBASE OF ALL RESOURCES
- ASSESS MANPOWER AND IDENTIFY GAPS
- STOPPING PISSING OFF PRIVATE DOCTORS
- POLITICAL WILL

*Important notice: The contents of this document does not necessarily reflect the views of the WCGH, but rather the collective inputs received through the consultative forum.*

| | |
|---|---|
| **1** | Central databases of all resources |
| **2** | Decentralize services to improve accessibility |
| **3** | Sharing of data across all stakeholders |
| **4** | WOSA Model |
| **5** | Centre of Excellence |

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

**STICKIES:**

- SELF GOVERNANCE,
- SELF AUDIT
- PRODUCTIVITY MIX – SERVCIE PROVOIDERS TO BE LINKED
- DATA ANALYSIS OVER ARCHING
- NETWORK MANAGEMENT TOOL
- OUTCOMES PERFORMANCE BASED
- SELF-REGULATED – LOCALISED
- COMMIUNITY INVLVEMENT IN GOVERNANCE
- PROVIDING 6-8 WEEKS OF TREATMENT FOR CHRONIC PATIENTS
- SUPPORTING INSTITUTIONAL CRECHE, THAT EASE ON THE BURDEN OF THE WORKFORCE
- GOOD EMPLOYEE RELATIONS
- DATA DRIVEN INSIGHTS – BUSINESS INTELLIGENCE
- ACCOUNTABLE AND VISIBLE LEADERSHIP
- MODELS OF ENGAGEMENT
- **PROMOTING A CULTURE OF COMMUNITY OWNERSHIP**

| | |
|---|---|
| **1** | Rethink power of Minister. Multiple levels of accountability. |
| **2** | Accountable and visible leadership |
| **3** | Transparency between all stakeholders, both public and private |
| **4** | Bottom-up accountability – Allow client choice/provider switching. |
| **5** | Share information on performance of facilities publicly |

**PARKING LOT: OPPOSING VIEWS**

None.

## GROUP 8

**CONVERSATION(S) TO EXPLORE:**

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

**JC: WOSA – WHAT IS IT THAT WE SHOULD BE DOING DIFFERENTNLY TO BECOME MORE PROACTIVE, ALSO UNDERSTANDING WHO ONE SHOULD BE COLLABORATING WITH TO IMPROVE HEALTH. COMPLEXITIES AND KEY LEARNINGS ARE AVAILABLE 1. LOOK AT END-TO-END SOLUTIONS. TRANSFORM SERVICES BECAUSE CURRENT CONFIGURATION IS NOT SUSTAINABLE. 2. PROFILE COMMUNITY. 3. WHO ELSE IS ACTIVE IN THAT SPACE. 4. WORK OUT HOW TO COLLABORATE. SINGLE PATIENT VIEWER (TECHNOLOGY). COMMUNICATE AMONGST ALL THE RELEVANT ROLE PLAYERS.**

**NOWI NDAYI: FOCUS FIRST ON ENVIRONMENT: EDUCATION, LIFES STYLE, SOCIAL DETERMINANTS TO PREVENT ILLNESS. DIFFERENT DEPARTMENTS SHOULD WORK TOGETHER BETTER**

**SALIE-AHMED KATHREE: THERE IS OPPORTUNITY FOR COLLABORATION, GOOD EXAMPLES AND MODELS FOR GOVERNANCE TO BUILD UPON. COULD POTENTIALLY IDENDITY SPECIFIC GROUPS OF PATIENTS TO PRIVATE SECTOR FACILITIES AND ASK MEDICAL AIDS TO ADMINISTRER THE EXTRA RESOURCES**

**PHILIPS: INNOVATION IS KEY, AND HEALTH WILL CONTINUE TO IMPROVE AND EXCELL TECHNOLOGY IMPROVEMENTS INTO THE FUTURE. YOU NEED TO BE RELEVANT AND INVOLVED. PARTNERS SHOULD SUBSCRIBE TO CORE FOCUS AND PRINCILPLES. PHILIPS ALLREADY POSITION THEMSELVES TO PROVIDE SOLUTIONS**

**MEDICLINIC: HAVE TO TAKE HEALTH CARE TO THE PEOPLE AND INNOVATE IN DOING THAT. MEDICLINIC SEE THEMSELVES CONTRIBUTING TO THAT AND WANT TO EXPLORE WAYS TO COLLABORATE. SOME GOOD PRACTICES FROM ELSEWHERE IN THE WORLD WERE MENTIONED**

Bd Diabetes Care: medical device company. Focusing on preventative medicine vs curative, including educating patients and providers. Digital solutions are probably key.

End-to-end solutions – private equipment providers should provide full solutions.

Marcelino Julies: Agrees with Salie Kathree that some patients should be treated by private providers to reduce waiting times and that technology can provide excellent solutions. Use churches better to take messages to the community and have an important role.

UWC: changing curriculum to focus more on student's education to prevent curable diseases. Important to include community to involve them. It is important to trace patients, paperless (technology) by educated workers and communities to do the right things. It is important to understand what drives illness, like poverty. Collaboration is a key word that emerged.

Hanlie Fourie: Experience is around and available from various angles. We must take hands (collaborate), we must change our attitude and not protect our own interests. A huge challenge is self-preservation that works against collaboration. There is a gap when patients are discharged and require out of facility after care. People require education on preventative health strategies. She also empathized that technology can be a big level.

Preggie Naidoo: a huge repository of skills in the private sector is not accessed and carried by the public health services. He shares initiatives that they launched and operationalize that could be used wider. Interventions can be better delivered by using technology, datasets, though early detection. <u>Comprehensive care at primary level</u> = basket of service in an equitable portion. Data can be shared between public and private. Specialized services are lost to public services because specialists are in the private sector. Opportunities are lost because we don't collaborate. There are huge opportunities available already but not. Public service should consider privatizing its resources where it will be better utilized and who will be able to serve more patients.

St Luke's: experienced some frustration in becoming part of public service talks to improve health care:

Melomed: lots of infrastructure and resources available. Hospital and ambulance service, and even located within the poorer communities.

How. Support fully UHC. Collaboration can only happen with human resources. Nursing colleges cannot be closed. Education training is important for any improvement to succeed. There are already collaborative networks within training forum to increase access to human resource training. Funding must be clarified because without funding you can't do anything. Private facilities are there to generate revenue. Private providers should be paid timeously. Private providers would be reluctant to provide services if they will struggle to get paid. Some good systems were not sustained over time and will have to be started again. Collaboration Trust is important.

**POLLSMOOR: COLLABORATION IS SUPPORTED TO IMPROVE HEALTH CARE**

Social Determinants WOSA

Use untapped resources

Tapping into underutilize resources in private sector with reasonable

**TECHNOLOGY – ACCESS TO DATA – SHARING PATIENT INOFRMATION**

**VARIOUS EXAMPLES OF SOLUTIONS**

Education

**GOVERNANCE SHOULD PLAY A ROLE IN REGULATION SHARING PATIENT INFORMATION**

| | |
|---|---|
| **1** | HOLISTICAL APPROACH TO SOCIAL DETERMINANTS |
| **2** | USE UNTAPPED RESOURCES |
| **3** | TAKE CARE TO PATIENTS |
| **4** | TECHNOLOGY |
| **5** | ADDRESS UNDER-SERVED NICHE AREAS |

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

**POOLING OF FUNDS**

**ESTABLISHING A PUPLIC-PRIVATE-PARTNERSHIP FUND**

**POOLING INFRASTRUCTURE & HR RESOURCES**

**PROVIDE PRIVATE PROVIDERS ACCESS TO PATIENTS AND EXPECT SOME ADDED ON WELLNESS SERVICES**

TENDERS SHOULD INCUDE TRAINING AND FOLLOW UP SERVICES

EDUCATION & COMMUNICATION

TAP INTO TRAINED STUDENTS AT EDUCATION ESTABLISHMENTS

| | |
|---|---|
| **1** | POOLING RESOURSES |
| **2** | PUPLIC-PRIVATE MIXED SERVICES |
| **3** | SHARED PROCUREMENT |
| **4** | IMPROVING EFFECIENCTY |
| **5** | UNITLISE UMEMPLOYED YOUTH |

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

| | |
|---|---|
| **1** | Patient voice prominent |
| **2** | Review facility committees |
| **3** | Emulate good existing practices (WC regulations) |
| **4** | Trust |
| **5** | Clarity on funding mechanism and Clarity on outcome mechanisms |

## GROUP 9

**CONVERSATION(S) TO EXPLORE:**

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

| | |
|---|---|
| **1** | Interdisciplinary collaboration, planning and profiling of the service needs across geographical service areas with a focus on health promotion and prevention. (COPC) |
| **2** | Optimal utilization of Health Science Students as a service resource e.g. Community Outreach Programmes |
| **3** | Strengthen Public, Private Partnerships to improve health outcomes. |
| **4** | Capacity building and role clarification of Community Health Workers |
| **5** | Strategic sourcing of appropriate health technology based on disease profiles. |

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| | |
|---|---|
| **6** | 4IR & Technology optimization |

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

| | |
|---|---|
| **1** | Strengthening collaborative relationships in healthcare provision |
| **2** | Improving the referral pathways to optimize health coverage |
| **3** | Partner with the private sector and other stakeholders in the sourcing of technology and training health practitioners to improve health coverage and outcomes |
| **4** | Strategic sourcing of appropriate health technology based on needs analysis to ensure alignment and integration. |
| **5** | Shared infrastructure between private and public stakeholders. |
| **6** | Social capital pooling (finances, people, technology, infrastructure) |
| **7** | Co-payment gap cover |
| **8** | Traversing the public/private binary to include civil society, academic institutes in bringing health services to the public |

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

| | |
|---|---|
| **1** | Clinical governance of hospitals (compliance with national core standards) |
| **2** | There's a need for accountability, transparency and values-driven in leadership |
| **3** | Community engagement through health statutory bodies |
| **4** | Shared corporate governance PPP |
| **5** | Optimal and efficient management of resources e.g. medicine, HR |
| **6** | Developing the need for personal agency & self-governance. |

**PARKING LOT: OPPOSING VIEWS**

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| **How do external partners and stakeholders' comment of the NHI Bill, 2019?** | |
|---|---|
| | |
| | |
| **Social and economic determinants of health is not the problem of the Health Department alone – it requires a collaborative and multi-sectoral approach** | |
| | |
| | |
| | |
| | |

**Beth's Introductory Remarks:**

1. Health is a human right
2. Health is an industry
3. Health is required for economic growth
4. A health system is a Complex Adaptive System

**Group 9: Discussion**

Anthea Rhoda: Innovative & Collaborative Service Delivery Models

- Working collaboratively as professionals – multi-sectoral teams
- Optimal utilization of Health Science Students as a service resource
- *Capacity building, role clarification of Community Health Workers*

Magda Kriel: Service delivery models

- Analysis of resources over geographical areas: focusing on health promotion and prevention
- Leverage of available public/private partnerships (pooling resources and needs identification)
- Proposes a model like COPC
- *Interesting in knowing more about the Dept model for appointing, training and absorption of Community Health Workers*

Romulen Pillay: Innovative & Collaborative Service Delivery Models

- Ideal Clinic Infrastructure (Health Technology is important)
- Phillips Southern Africa, offering to partner with the WCG: Health with the sourcing of technology and training health practitioners to improve health coverage and improve health outcomes
- *Strengthening collaborative relationships*

Mari Bruwer: Innovative & Collaborative Service Delivery Models

- Analysing and profiling disease prevalence (understanding the burden of diseases through disease surveillance)
- Strategic sourcing of appropriate health technology based on appropriate disease diagnosis
- Improving the referral pathways to optimize health provision

Magesh Naidoo: Innovative & Collaborative Service Delivery Models

- Using innovative technology to improve health outcomes (TB screening, patient tracking and improved adherence)
- PHC re-engineering (strengthening collaboration amongst community outreach teams to improve health outcomes)

Maralyn Keegan: Governance

- Clinics and hospitals need to undergo accreditation via the OHSC
- Monitoring is important but adherence to health standards to improve the quality of care
- *Leadership and accountability at local level – values driven leadership*
- *Continuous quality improvement*

Vuyiseka: Governance

- Clinical governance of hospitals (compliance with national core standards)
- Current public infrastructure challenges – poor quality of clinics
- Oversight, accountability and transparency in management and treatment of patients – holding staff accountable (bring patients at the centre of healthcare)
- Strengthening the voice of the patient through health statutory bodies
- *Involving communities in health planning and management – improves collaborative relationships*
- *Community participation – transparent and accountable leadership*

Momentum Health Services:

- Study best practice models of Community Based Care

Carl Abrahams: Proper planning and management of medicines to ensure availability of adequate stock

## GROUP 10

**CONVERSATION(S) TO EXPLORE:**

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

| | Issues raised and shared: Shared approach and responsibility by Public and Private sectors<br>• We need to agree on how to measure QUALITY as a standard across both Public and Private sectors.<br>• We need to understand that our lens is patient load and case- mixes flow and the way of measuring patient This cannot happen without proper IT systems<br>• Services should be rendered at APPROPRIATE LEVELS<br>• Improving ADMINISTRATIVE INEFFICIENCIES, including processes (from procurement to distribution to dispensing), and the availability of equipment.<br>• FLOW OF AND COLLECTION OF INFORMATION<br>• Capacity building: across all levels from security, cleaning.<br>• ALL SYSTEMS ARE TOO REACTIVE. GOOD INFORMATION TECHNOLOGY AND CLINICAL INFORMATION SYSTEMS WILL ALLOW FOR A PROACTIVE APPROACH TO CARE.<br>• EDUCATION AND OWNERSHIP OF HEALTH BY PATIENTS. Look at available models EG Vitality Health Model<br>• FOCUS ON PREVENTION AND PROMOTION OF HEALTH. Investing in health through providing incentives. Link outcomes to incentives<br>• Consider appropriate payment by who can afford it e.g., payment for meds.<br>• Create a system where health care providers work in teams. |
|---|---|

- Community based programmes, people centered programmes. Consider the role of the private sector and NGOs in a PHC-orientated collaborative.
- Opportunities to shape the system on the CHW model. (who trains them, how they work, respect and trust in communities, their Knowledge of and acceptance by the communities.) Here is place for collaboration and opportunity.
- Integration of information. A shared patient-centric system and not only a clinician-based system.
- Opportunity of using IT to reduce the burden on labour force. E.g. distribution of chronic meds (innovation)…Look for solutions using less people.
- The availability of meds impacting on offering a service is offered but stock not available. Improving Communication is vital to role players. Also, to look at infrastructure of distribution.
- distribution and the critical role this play in rendering safe patient care. INFRASTRUCTURE is key to be addressed: blockages and the knock-on effects. E.g. Availability of files.
- How to fix what we have and build toward improved Health systems.
- Problem in Public Sector is MANAGEMENT capacity and competency, while in the Private sector the problem is INCENTIVES with a system that is orientated as a low volume and High cost care)
- How to create a model that's acceptable to patients, clinicians and value for society. *Build a system to produce High volume, low cost and good quality systems.*
- Do we know what services will be provided (in the NHI) or additional services that need to be purchased?
- Review the disparity between the numbers seen and services offered in different sectors. It would be important to prioritize who does what.
- What are the opinions on UHC by Private sector
- You need a system to manage the demands e.g. Dutch health system. We must talk about a system and How to serve people who cannot afford. To create a different system.
- Single purchasing: challenges and consequences.
- Creating an environment to develop leadership at all levels.
- Identify gaps and instate cost effective measures. Apply evidence-based methodologies to address deficiencies in the health system (innovation, TELEMEDS, remote patient monitoring, move away from managing patients at hospital and increase coverage at community-based level.
- Challenges in both: management and leadership as well as governance.
- Improve productivity, as currently we are receiving poor service value from money spent. An example of an innovation in the private sector space was a 'birthing team': Led by midwives and back up from Obs/gynae Dr's. It uses IT, currently through out of pocket payments but GEMS is considering paying for this for its members.
- There are enough resources. They are not used optimally. New models in the private sector could be piloted. The private sector does not focus on health outcomes ito morbidity (and mortality), and their geographic distribution. Assessing the Case mix is important (not just head-counts). Need for health data is important: clinical outcomes as well as patient satisfaction:

**KEY ISSUES**

1. **USE OF IT TO GENERATE IMPROVED HEALTH INTELLIGENCE AND PATIENT MANAGEMENT**
2. **PERSON CENTRED WITH AN OUTCOMES BASED MODEL**
3. **CARE TEAM APPROACH WITH APPROPRPRITAE CASE MIX**
4. **HEALTH PROMOTION AND PREVENTION**
5. **INFRASTRUCTURE**
6. **TEAM BASED, VALUES BASED**

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

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|---|---|
| | • TELEMEDS is difficult due to Legislation, HPCSA GUIDELINES. Limitations in obtaining CONSENT, PRESCRIBING GUIDELINES). Changes in regulations could facilitate excellent use of resources for telemedicine using information technology.<br>• Sustainable funding model: To focus on Value Creating Contracting<br>• BUILD Capacity to take patient load away from facilities, providing services elsewhere.<br>• Tap into available knowledge and experience to enable people to set up practices. (Currently nurses cannot advertise their services in the private sector)<br>• Sharing of expertise and skills transfer, including training between private and public sector.<br>• Create Learning spaces across and between P&P sectors.<br>• Tap into IT and data expertise in private sector; values-based contracting, management and leadership…<br>• Value care teams: culture of shared care of patients through care teams.<br>• Integrated care across the referral pathway…to make sure that services work as an integrated system. |
| **KEY ISSUES** | **1. Shared Learning Space and Expertise**<br>**2. Develop A Care Culture Through Care Teams**<br>**3. Integration Across Care Pathway**<br>**4. Accountability**<br>**5. High Volume, Low Cost Models**<br>**6. Management and Leadership Development** |

***QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC***

| | |
|---|---|
| | • INDEPENDENT Audits for standardised care and governance models<br>• Performance management is possibly a shared conversation.<br>• Clinical governance to be revisited and share best practices.<br>• Monitoring and evaluation.<br>• Risk management models/tools data intelligence: case mix data<br>• Consider expertise in contracting. |
| **KEY ISSUES** | ***1. Clinical governance and ensuring quality of care***<br>***2. Advocacy for community and accountability***<br>***3. Formalize the voice of the patient***<br>***4. Opportunity with CHW'S***<br>***5. Competent purchasers***<br>***6. Responsive and relevant, adaptable health regulations*** |

**PARKING LOT: TO BE CONSIDERED**

| How do we establish common goals between public and private sectors (profit vs public value)? | How can we keep abreast on this engagement and the process we started? |
|---|---|
| How do we pool our assets to improve service delivery? | How does the DOH move from being a budget and service provider to a purchaser? |
| How do we use a leadership paradigm to increase public accountability and transparency? | What enablers drives patient engagement and health ownership as part of the value chain |

## GROUP 11

Checking in

-Healthcare and community needs have changed over time.

Training of healthcare professionals must fit in with the change in patient needs.

-The urgent need for translation of ideas into action.

-disparity ito access to care. Therefore, UHC supported, however, the approach needs to be thought out. All role-players (sectors of society) need to come to the party to make UHC a success

Question 1

-Current system not working. There's needing to fix the current system in the journey towards introducing the new.

-Plenty of expertise in the health industry. Need to pull resources together.

-76% of the population in the WC depends on state services. 11% cared for by both public and private sector. – can we start by sharing views and ideas on how to services the 11% then we learn lessons from that. From those lessons we can expand to UHC.

The economic impact of accessing health care, particularly care to the 76% of the population serviced by state. Waiting time are too long. There's needing to be cost-effective ways to render care communities.

-partnering with other service providers to get desired outcomes. E.g. Dis-Chem and Clicks offering free screening – which can be used to reach the wider population. Can there be contracts between state and private for some services private providers can offer? A mechanism can be worked out for private providers to report back to the department to capture the information at a central point.

-DOH needs a clear review/ situational analysis of current situation.

-Work done - (assessments, studies) are not translated into improving patient care. E.g. Asthma care research – less than 40% of Drs follow protocols recommended from asthma studies. E.g. Studies around seizures and management of such also available.

Innovations – cancer: India reduced the cost of cancer care by 80% by:

-using hub and spoke model – it's everybody's responsibility

-task shifting (necessary to achieve UHC)

-health outcomes measurement (currently there's no structured outcomes report)

-patient empowerment

-improving disease management through using technology

-look at care coordination across the service delivery levels

-consider telemedicine

-consider creating centres of excellence for specific diseases – multidisciplinary centres

-there's little information on total cost of care

-Some experiences from the Presidential Health Summit

-Netcare presented a paper re private opening doors to public patients Friday to Sunday because private facilities are generally low occupancy over weekends. This can relieve some pressures on state health facilities.

-the system for private and public to collaborate for service delivery needs to be formalized (PPPs).

-Let's not wait for NHI or UHC. Let's start exploring collaboration options now already.

Explicit workplan for the collaboration. Measuring success of the current commitment to collaboration.

<u>5 words</u>

1. Review
2. Collaborative-systems
3. Synergy
4. Enabling environment
5. Pilot-just-do-it

<u>Question 2</u>

-Examples given of previous attempts from private involvement in relieving pressures on state services.

e.g. Hip replacements waiting lists which can be done at private facilities over weekends

-All health professionals should be used optimally across public and private

-support required for practitioners to get good TAT for services. E.g. Obtaining dispensing license for PHC Nurse can take years.

-Possibility of Red-Tape reduction Unit for the health care centre.

-Creation of A structure for regular interaction between public and private. (the PPHF exists now but there seems to be a delay in getting information to everyone in the format of meetings. Need to create other communication platforms for sharing and giving inputs)

-individual consultants need to be involved in the planning space

5 words

1. Real-communication
2. Win-win-opportunity
3. Optimization-of-resources
4. Person-centered access
5. Whole-of-society-involvement

Question 3

-Governance – putting processes in place to ensure that there is accountability. There should be consequence management for non-performance. It means feedback processes be established to talk to improving services. e.g. Ideal clinic tools developed over 5 years but not fully implemented to date. What accountability is linked to that?

-Clarity and transparency are key. Clear distinction between good governance and bad governance is required.

-there needs to be clarity on the shared vision for health care to the population.

-Governance also talks to "ethical Leadership"

-Progressively work towards an inclusive governance structure

-continuity in the political and administrative fronts

-pillars of governance – complex

5 words

1. Accountability-structures
2. Inclusive-governance
3. Continuity-and-legislation
4. Measurement-and-evaluation
5. Standardized-governance

Parking slot

-In the NPO and Private spaces, there seems not to be a head body who is the voice. e.g. In DOH – HOD is the voice / accounting officer.

-there needs to be engagement to discuss specifically joint governance

-Tapping into inter-governmental collaboration

-Role clarification in the joint governance structures

## GROUP 12

**CONVERSATION(S) TO EXPLORE:**

**Reflections from the HOD and Keith's presentation**

Resonated: Unique needs for patients in this day

UHC: suspension of ego, skills can be used in the private and public space

Session a week ago: great discussion between public and private focused on the ideal system;

NHI Bill: High level of anxiety from private sector

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

| | |
|---|---|
| **1** | Lot of expertise that could be used in public sector which ever form the system takes to achieve the ideal; Also, a lot of skills in public that may be useful in private sector<br>The ideal should take precedence |
| **2** | Competition Commission Health Enquiry: private sector hugely over servicing; public sector has huge challenges too<br>It's not time to look at private sector pricing but how it can help; Example UK NHI: purchase service from private and have governance structures in place<br>Use of the DRG model by Private sector: Western Cape currently creating model |
| **3** | Patients going to private sector GP to get referral to public hospital; longer waiting time causes disease progression at faster rate; Transport, training of PHC staff members on protocols |
| **4** | Investment model: Global models developed in the private sector are |
| **5** | Regulatory mechanisms limit what private sector wants to achieve |

| | |
|---|---|
| **6** | Collaboration in Family planning. i.e. clinic at workplaces don't have the<br>Private Doctors provide services on Weekend at Karl Bremer; but must pay nursing staff<br>Theatre that could be used but no one to run it |
| **7** | Payment of specialists in public and private result in lack of specialists |
| **8** | High prices of cancer treatment in private unacceptable; Government needs to regulate |
| **9** | Use of Private GP contracting on capitation basis as the first implementation strategy for PPP; will help referral pathway, relieve facility overcrowding |
| **10** | Government Communication with private hospitals should be more transparent |
| **11** | Bed capacity above 100%, no staff to manage bed pressures i.e. Human resources must be increased for UHC to work out |
| **12** | Private Nursing collages desperate to train more nurses |
| **13** | Create a culture of excellence; learn from each other |
| **14** | PHC not trained for follow up on oncology, cardiology follow ups: Beef up PHC; Need Multi-Disciplinary teams e.g. a social work in the facility<br>Private has more doctor focus model whilst the Public is more multi-disciplinary community focused |
| **15** | DSD and DOH lack of collaboration when it comes to the elderly; chronic care for the elderly, the population is increasing |
| **16** | Challenges in private sector; NH restrictive to hospital in your area when the service is elsewhere; transport system model to transfer patients |
| **17** | Occupational health; Some nurses must go to PHC yet working in clinics where the doctor can refer to secondary care |
| **18.** | Outcomes measuring: patients need to see outcomes to what they are paying for; Reward for maintaining good adherence system |
| | |
| **5 KEY WORD** | **Collaboration at Primary Health Care, Training, Primary Care GP network, Multi-disciplinary models,** Outcomes based care |

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

| | |
|---|---|
| **1** | RWOP to manage skills shortages: others saying stop public sector doctors working in private sector: system is set up that people retire early more in public sector than private due to issues of medico legal<br>Pharmaceutical: low medical prices in public is due to substitution by private prices<br>No posts in public sector to accommodate specialists they are training<br>Technology in private sector that can be used<br>RWOPs an opportunity to keep the skills they may not be using in the public space<br>Exchange in both directions in terms of RWOPS |
| **2** | Create more insurance products that one can afford: cross subsidization; public and private need to start talking (could fall under short term insurance) PHC insurance product; encourage younger and less sick who don't want to buy; Choice in PMB |
| **3** | Public service render services to people who should be paying (cost recovery) |
| **4** | More family physicians: CNP can't write prescriptions above level 4 |
| **5** | SAPS involvement in mental health care: intergovernmental forum |
| **6** | COPC: collaboration with other stakeholders |
| 5 KEY WORDS | Co-Payment-Gap Cover, Skills sharing; Pooling Resources; Affordable insurance products; COPC; Cost Recovery/UPFS review, Outcomes based care |

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

| | |
|---|---|
| **1** | Promote into leadership clinical staff that are not prepared properly for leadership but have technical skills |

| | |
|---|---|
| **2** | Case manager's scarcity / Someone to help the patient navigator |
| **3** | Compliance /Regulatory framework |
| **4** | Monitoring and Evaluation |
| **5** | Sharing managerial skills, **Sharing Protocol and guidelines** |
| **6** | Gatekeeper function: use of GPs |
| **7** | Across continuum of care: match service required (Primary, Acute, sub-acute, HBC) |
| **8.** | Outcomes bases defined under governance |
| **5 KEY WORDS** | **Case Management, Leadership, Navigator, Sharing Protocol and guidelines** |

**PARKING LOT: OPPOSING VIEWS**

None.

## GROUP 13

**CONVERSATION(S) TO EXPLORE:**

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

| | |
|---|---|
| **1** | 'Focus on Threats can freeze your mind and minimize the opportunity for change while focus on opportunities will lead to innovative ideas' |
| **2** | **Systems approach** |
| **3** | Big picture view<br>Whole of Society Approach…Take Big Picture Approach…. Foster common understanding of how this system looks. Foster a systemic view of the health sector and see how connect with our resources.<br>Mental Health-Covers all aspects of health. Focus on health rather than illness. COPC-Primary health is agreed upon as a focus area.<br>Move away from 'Hospi-centric' Approach |
| **4** | **Wellness focus** |
| **5** | **Patient voice and patient view** |

| | |
|---|---|
| | Communities are partners in their health journey. We need to look at flexibility in our service packages. This can only be done when engagement is real and meaningful. 'Who reps the patients.<br>Exploit patients-Outcomes based approach. Do patients know the goals of treatment given? Are we as practitioners driven to ensure outcomes in the shortest time possible?<br>Staff attitude: We need to address this, and the impact negative attitudes have on patient confidence<br>Where should this engagement have started???Can this current engagement be top down???? |
| | |
| | |
| | Desire to build trust- Open dialogue to foster to trust to scale trusts for better future. To be Transparent and Honest with people we serve. Acknowledge limitations. How do we take hands with civil society and others? See how ourselves as the collective. How can we… and not how can I…. Trust can be fostered by shared audits of facilities and thereby looking at best practice models. |
| | Look at current functioning -share openness about Gaps and pockets of excellence. How do we align our systems-Establish platforms to engage on relevance? Where is the real need? Agree to share our processes. The latter has reference between Public and private entities. The comment again refers to the trust relationship that needs to foster.<br>Identify the clear opportunities<br>The role of Academia, NGO etc.: How do they assist with dealing with health issues in a geographical area.<br>This is the First dialogue of its kind from different sectors in realizing UHC, so it embodies a positive sentiment.<br>Leverage on Quality of services and skills sets that is available<br>Avoid Training is in silos. Look at the social determinants when setting up training programs. Move away from training in silos ito different professions, community health workers (include relevant role-players)<br>Academia become relevant in the community and understands the BOD in the community.<br>Pilot interdisciplinary and intersectoral approach at community levels<br>Work towards a preferred service delivery model.<br>Technology: from a systems point of view-Centralized information systems,<br>Patient centric views-what does this mean? "Lack of access to information from patients side tell them instead of showing them"<br>CHW's: Core users of devices- "use her money, user phone, user data etc.<br>Curated information. provide people with the right tools. Why are we using manual data….!!!!!<br>Leverage on existing Technology |

| | |
|---|---|
| | Health look outside of health:<br>***Salient points***<br>**Whole systems approach**<br>**Key issue the patient voices the patient perspective in terms of their own health**<br>**Focus on wellness**<br>**The training should address needs on wellness side-Move away from hospi-centric approach**<br>**Keep our people healthy**<br>**Move away from medicalizing health** |

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

| | |
|---|---|
| **1** | Breakdown the Us and Them mentality |
| **2** | A lack of "Political Will" will stifle growth and development |
| **3** | Misalignment of what we are funded in relation to what we need. |
| **4** | Department must be clear on their needs with Donors. We need a need driven approach and not Donor Driven Approach. This can lead to duplication and omission of other important interventions. |
| **5** | Waiting time experience of patients: How do we leverage this to improve systems,' treat as whole person.' Strong opportunity<br>Mobile health facilities-leverage partners who can support these initiatives.<br>Repurpose facilities-Many old buildings in the department which can be utilized more effectively in partnerships to render services on many spectra.<br><br>**What does it look like what are the gaps and pockets of excellence**<br>**Prioritize funding. We must determine the need and not allow donors to determine our needs**<br>**Role of technology in the above mentioned** |

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

*Important notice: The contents of this document does not necessarily reflect the views of the WCGH, but rather the collective inputs received through the consultative forum.*

| | |
|---|---|
| 1 | **Trust between role-players**<br>Trust is the key - NGO vs Government, Private vs Public |
| 2 | Look at strengths and pockets of excellence |
| 3 | Outcomes based measures-Motivate to heal and not find problems continually. Promote wellness and track wellness reward Drs ito this approach. |
| 4 | **Role of data and technology-** |
| 5 | Teachable moments-Wi-Fi hotspots curated material while patients are waiting.<br>**Data surveys to improve service delivery**<br>Look at innovative existing business models and incorporate into service delivery processes<br>'When you are looking how organizations are working, is there an impact that matters and benefits those receiving the services'<br>**Reflect on the key points of the presidential summit and MDG as this can also help focus what partners can work on together. 'Could be a useful starting point'** |

**PARKING LOT: OPPOSING VIEWS**

Consensus so no divergent views were forthcoming

## GROUP 14

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

| | |
|---|---|
| 1 | Leverage existing collaborations: There are many existing collaborations – how do we learn from these? There is a myth that the private sector is always better, but there is a lot of expertise in the public sector, and vice versa. How do we learn from each other? |
| 2 | Integration of diverse data systems across sectors and provinces: Innovation and data: Need to be using technology to work with data more effectively -- & linking between public, private, NPO's and CBO's and across provinces. Many types of data are important: unique patient identifiers, utilisation data, financial data. Ensuring security of data is essential. |
| 3 | "Reach people where they are" models of care should be prioritized: Brining more patient voices into policy and decision-making spaces |
| 4 | Bridging a trust deficit: Building trust between sectors in important. Mistrust of all sectors is pervasive. |
| 5 | It's important to better understanding current obstacles to collaboration: |

Longer notes:

- Need to be using technology to work with data more effectively -- & linking between public, private, NPO's and CBO's and across provinces:
    - unique patient identifier VS protection of data. Security of data = NB but needs a safe online storage, military system has secure records for example but on a memory stick (records get burnt, get robbed etc.), suggestions to hide data under a rock, or at the post-box office. Debate = online records vs hard copy. Consensus = unique patient identifier
    - Get utilization data to help plan services
    - Financial data across all services
- Think about models of care/mobile health services that meet the needs of people "reach them where they are"
- WOSA approach – peer educators, focus on people in our communities
- Access issues in rural areas especially – need innovations that address this issue. Crime/violence – some people bear the burden of this much greater than others
- Existing collaborations:
    - Maternal health – already models of collaboration: midwife driven units running in the public sector (specialist car such as endoscopic care), birthing units, "reducing the workload from public"
    - CANSA care – PPP for breast cancer pt's radiology at George hospital, Project Flamingo
    - NGO delivery models – and the WC is leading on this Nationally … NGO's can offer services closer to where people are at. But, currently annual contracts & needs to be more long term e.g. 3-5-year cycles
    - EMS collaborations in Ocean view with CMR
    - Living care with the WCGH
    - Private GPS's at Gugulethu clinic
- Learning from each other: (there is a myth that the private sector is always better, but there is a lot of expertise in the public sector)
    - Clinical pathways: Tygerberg Hospital is ahead of the private sector "says LIFE" regarding referral pathway. The private sector could be learning from public too …
    - Public sector looks after 75% of the population and has a lot of expertise…
    - Private has the funds…
- Current obstacles to collaboration across sectors:
    - Funding cycles
    - Access to different meds, clinical regimes so patients moving between sectors can stay on their medication. = EDL also should apply to the private sector. Need a standardized

system across sectors – clinical governance is NB. Generic meds… cost saving opportunity. Would require changes in patent laws.
  - Resources – HR especially e.g. oncology in KZN.
  - Different access in public & private – we need principles
  - Trust deficit between public and private (and the mistrust goes both ways)
  - Private is very silo-ed need to work on more interdisciplinary teams
- PHC operation for patients who can't afford medical aid. (cost = 20 % of medical aid)
- The GP practice model of care needs to build in somehow, looking at the choice of patients
- Leave no-one behind

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

| | |
|---|---|
| **1** | Moving beyond binary understandings of the different sectors: public, private and civil society, NPS's etc. Need to move beyond the binaries – the divided between public, private, NPO, CBOs are more porous, and many people move between these sectors (and work in both) |
| **2** | More conversations about collaboration to build trust: So much mistrust and misperceptions – need to have more conversations about collaboration to build trust. |
| **3** | We have a limited idea of what resources are: need to think more broadly and acknowledge that resources include best practice, relationships with community etc. |
| **4** | Strategic purchasing pilots to learn from |
| **5** | Overall, we raised more questions than answers |

Longer notes:

- Limited total resources. Different kinds of resources in the public and the private – how do we pool these? How do we monetize the resources we have?
- How do we maximize benefit for the greatest number of people? We are very service driven, everything is about our patients – but what about the business models? Private sector could help a lot with business modelling
- There is a perception that medical scheme contributions will go into NHI. That will never go to NHI. Instead we need collaborations.
- How do we T/F resources from the privileged 16% to the broader public service.
- Not about averaging out to poor care – but using these two models to design an even better system. How do we find the best of both?

- So much mistrust and misperceptions – need to have more conversations about collaboration to build trust.
- Strategic purchasing -- need to have a better understanding of the costs in public and private to start making smarter choices. Capital needs to be raised in private, public gets allocated: so, what are the implications of this?
- Need piloting of strategic purchasing and learn as we go along the strategic purchasing journey.
- Recognize the importance of choice of people -- how do we include more patient groups in planning services
- We need to move beyond the binary: it's not public VS private – there is a lot of other possibilities that exist.

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

| | |
|---|---|
| **1** | Shared learning: Learning from experience: NGO's have strict government models. Sharing best practice across sectors: Public and private have good governance structures in place and often the same person is performing a governance function in more than one sector. |
| **2** | Capacity building – enabling and supporting governance in the public sector |
| **3** | Nurturing NPO growth: civil society (NPO's and CBO's) perform a very important function and the NHI needs to leverage those |
| **4** | Regulation is both a leverage and an obstacle |
| **5** | So many false assumptions we hold about each other – we need to find ways to discuss these. In this context, how do we build trust? And without trust we can't' build models of collaborative governance. |

Longer notes:

- Learning from experience: Small CBO's struggle with governance, but NGO's have strict government models… e.g. Current NGOs' only contracted if they have these governance structures in place.

- Capacity building of organizations needs to be built in e.g. DSD gets evaluated by the AG. MOU's and M&E is very difficult – need to look at this much more closely
- Clinical governance
- But how do we build trust?
- Assumption is that the private sector needs to be regulated because they are trying to 'maximize profit' and the assumption that the private sector is bad. Need more collaboration between the sectors.
- Public and private have good governance structures in place. Some hospital boards are working well, but some are totally dysfunctional. The public – private binary is quite unhelpful because there is so much in-between and there are lessons to be learnt from both

**PARKING LOT: OPPOSING VIEWS**

None.

## GROUP 15

**CONVERSATION(S) TO EXPLORE:**

**QUESTION 1: OPPORTUNITIES FOR INNOVATION, COLLABORATION FOR SERVICE DELIVERY MODELS**

| | |
|---|---|
| **1** | COPC to include significant civil society partners |
| **2** | Incentivization of population health outcomes |
| **3** | Develop technologies in collaboration and not isolation |
| **4** | Incorporation of non-traditional health systems |
| **5** | Developing true partnerships to ensure effective social collaboration |

**QUESTION 2: OPPORTUNITIES TO POOL EXISTING RESOURCES TO IMPROVE POPULATION ACCESS, COVERAGE AND IMPACT**

| | |
|---|---|
| **1** | Sharing Technology & Data access |

| | |
|---|---|
| **2** | Leverage excess capacity (private & public sector) |
| **3** | Mapping all available resources in geographic areas |
| **4** | Sharing Management & Leadership experiences |
| **5** | Forums between public and private health managers |

**QUESTION 3: EXPLORING COLLABORATIVE GOVERNANCE MODELS FOR ACCOUNTABILITY FOR UHC**

| | |
|---|---|
| **1** | Focus groups to pool management skills in the province |
| **2** | One big health system or intra-operability. |
| **3** | Health should lead |
| **4** | Mindset change |
| **5** | Not forcing solutions and systems from top down approach |

**<u>Conversation Notes</u>**:

- Use of remote consultation – get services where it is needed, and patient do not have to travel - bank of data
- Government work with a certain system, system ad apps are not talking to the society's systems and apps. Need a system to which community
- Open data and access, keeping client confidentiality.
- Getting customer involved
- Business perspective – root cause
- Incentive to put in place to deal with e.g. substance abuse, give up smoking, exercise, (carrot and stick approach
- Concern re top down approach need to move to discussion to a system responsive to communities, prevention and health promotion, social dependence issues. Linking up with health system in the community and other resources. Collaborations for the better of the community.
- Not re-invent the wheel. Technology is available. Draw medical into this conversation to get effective service delivery. Models work in CT won't necessary not work in rural areas
- Lack of funding a challenge to service delivery models. Mobile outreach bus – costly exercise – if no resources in an area how do you collaborate to deliver a service in e.g. rural.
- There are a lot of resources – how to pull together.

- Proper mapping of current services. – detailed inventory
- Partnerships could overcome HR issues
- Fear for stopping resources e.g. COPC pilot. What will happen after pilot has been stopped. How to continue rendering the service if the funding is no longer there.
- Resource sharing: from private sector's view cost is probably the elephant in the room. Focus groups to pool management skills in the province
- Patients do not need to see multiple doctors
- How do we leverage excess capacity from private sector? Capacity versus huge over demand. Need to be agile and dynamic. How do we shift that dynamic?
- Do we know the need of service?
- Big field of non-specialist/professionals in existence – traditional healers, experienced people in the community. Do not always need a specialist – COPC? – volunteers.
- Capacity (HR & Infrastructure) constraints in small rural community results in poor service delivery – opportunity to collaborate with private sector in that community.
- Private sector doctor driven service, Public sector nurse driven service – who's responsibility? E.g. on a farm a farmer take responsibility for his workers, who realized that a healthy worker is a productive worker.
- Social determents – inequity finance, training (washing hands)
- Multiple players, not only health driven
- People from the community knows what is going on a community = needs – how do we use technology to link the service e.g. TN patient not taking his medication. Trace the defaulter moved from Villiersdorp to Eastern Cape – Heli copter view" one big health system or intra-operability.
- How do we incentivize private providers?
- Misconceptions result in distrust
- Ability to share information between medical aids – No go – business.
- Stewardship role.
- Do we separate provider and service deliverer?
- Reality exist because easy to fall back to comfort zone. – Public sector needs to be rigid due numbers staff etc. and become inflexible.
- COPC excluded several roles COPC – collaboration with civil society, model need to be influenced, no non-profit civil society included yet. players. Having current discussion and need to become reality. – Partnerships COPC not respondent to what is needed at ground level
- Uneven distribution of resources
- Metro different from rural areas – advanced technology to be brought to rural areas.
- Traditional Health Care – include community's existing resources
- Leadership and human resource sharing
- Agility to respond to patients

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## ANNEXURE D: LIST OF QUESTIONS

| **Input** | **Category** | **Can WCGH answer?** | **Answer** |
|---|---|---|---|
| How do you believe TRUST can be built/recovered among all role players to achieve NHI? | Collaboration | Yes | |
| We talk about collaboration between multiple stakeholders-is DoH really committed to this or is this just a political response/lip service? | Collaboration | Yes | |
| The Department is undergoing a management alignment process. Is it taking NHI into consideration in planning future corporate structures? | Leadership | Yes | |
| How do external partners and stakeholders' comment of the recent NHI Bill, 2019? | NHI Bill | Yes | |
| Will delegates receive copies of the presentations of this afternoon? | PPCF | Yes | Available on website |
| Is an incremental approach to NHI not rather required? As Dr Engelbrecht said: "A health system is a complex, adaptive system." A big bang approach may destabilise everything. | Timelines | Yes | |
| If central hospitals get moved to NDOH – will this not increase fragmentation? Will they compete with private hospitals? | Central hospitals | TBC | |
| there is a lot of talk about private public collaboration but the doh has an anti-private bias ? why as it ostracises potential private public alignment | Collaboration | TBC | |
| What forums have been created and how do they work? | Collaboration | TBC | |
| An obsession with compliance squashes creativity and opportunities for organisational learning - how do we make sure NHI doesn't further entrench a compliance culture? | Compliance culture | TBC | |
| How to deal with corruption in public&private? Both public sector who stand to gain via corruption AND private corporations who stand to gain through being contracted to provide care to larger pool. | Corruption | TBC | |

| Input | Category | Can WCGH answer? | Answer |
| --- | --- | --- | --- |
| The biggest threat to the NHI is private sector capture: huge danger that health will be considered a commodity. How do we ensure the principle of heath as a human right remains at the centre? | Corruption | TBC | |
| With regards to the NHI fund - it is described as an autonomous entity. What is the difference between an autonomous entity and an SOE? | Funding / Payment model | TBC | |
| How does the governance structure of the fund compare to the governance structure of other autonomous entities we are familiar with (e.g. MRC and HSRC)? | Funding / Payment model | TBC | |
| What's the difference (in governance structure) between SOE and autonomous entity? | Funding / Payment model | TBC | |
| Glossary to clarify concepts | Glossary | TBC | |
| What happens if someone decides not to register for the fund? | Patient registration | TBC | |
| How do we make sure universal access raises the quality of primary health care for everyone and does not drag everyone to the lowest common denominator across geographic areas and income levels | Quality of services | TBC | |
| How will NHI be rolled out in rural areas where distances to the nearest facility is huge, there are lack of medication and the health transport for these patients is not able to cope | Rural areas | TBC | |
| What is the NHI intention wrt the Forensic Pathology Service | Service specific | TBC | |
| Will we take the current system along unfixed | System inheritance | TBC | |
| How inclusive will these processes be if we not open and transparent | Transparency | TBC | |
| the social determinates of health are overwhelming and not only the responsibility of health how are we going to include all relevant stakeholders to address the ongoing violence and trauma its impact | WOSA | TBC | |

| Input | Category | Can WCGH answer? | Answer |
| --- | --- | --- | --- |
| How is NHI going to assist the schizophrenic illegal substance abuser in society in the prisons, in our civil society causing a community in crises! Murders, assaults, abuse in households & all public services | WOSA | TBC | |
| When do we stop chasing bad health and start intensive focusing on safety, eliminating poverty inequity poor education psychosocial pain ? | WOSA | TBC | |
| Health is an integrated system. Shifting the admin, management, budgeting and governance of central hospitals from provinces to national poses major risks (fracture. How will NDoH mitigate this risk? | Central hospitals | No | |
| In terms of the right to complain: Chapter 3 says the fund is the body that will investigate its own complaints? Surely this is a conflict of interest? | Complaint process | No | |
| What is the plan to address current deficits w.r.t. services BEFORE NHI is implemented - issues of lack of medication, lack of staff, waiting times etc. | Current deficits | No | |
| How will the private sector change to address its shortcomings and meet the challenges of NHI? | Current deficits | No | |
| has the doh looked recently at manpower and skills need for uhc | Current deficits | No | |
| How will capacity development to support public sector organizations to be in level playing field with private sector organizations be done? | Current deficits | No | |
| NHI envisions a very ambitious data management and information system. Can you give us an update on the progress so far? | Data management and Information system | No | |
| What data sources will the DoH utilize to identify which services must be covered by the NHI? | Data management and Information system | No | |
| Was HASA engaged about the payment model suggested by the NHI to pay them? | Funding / Payment model | No | |

| Input | Category | Can WCGH answer? | Answer |
|---|---|---|---|
| How will the NDOH respond to the findings of the HMI? | HMI | No | |
| Will there be incentives for wellness programmes? Client and provider based | Incentive programmes | No | |
| What will be the balance between central control and local autonomy? How will the centre that is weak at present be strengthened? | Leadership | No | |
| We are expecting a funding model(NHI) to bring solution to health systems failures. Managers must improve infrastructure, maintenance and human resources. We need accountability from DOH | Leadership | No | |
| Why are these questions not being answered? | n/a | no | |
| What is the thinking behind not allowing people to buy their own cover for services that will be covered by the NHI? | Package of care | No | |
| What defines the packages of care delivered by the PHC Platform? Do we have a standardized definition for these packages? | Package of care | No | |
| What will be the scope of the packages of care offered by NHI? I attended the organ and tissue donation workshop and wanted to know if NHI will support this service. | Package of care | No | |
| Patient satisfaction is currently a make believe to be good. Will the NHI change this thinking | Patient centredness | No | |
| Under UHC and the NHIF can public sector patient seen at a CHC be seen at a local private hospital for investigation and care if necessary? | Patient centredness | No | |
| Will the NHI be phased in starting with Primary Healthcare ? | Primary Healthcare | No | |
| Will NHI be phased in starting with Primary healthcare? | Primary Healthcare | No | |

| **Input** | **Category** | **Can WCGH answer?** | **Answer** |
|---|---|---|---|
| Current private sector ethos is one of self-interest - whether a hospital group, individual medical aid scheme or individual practitioners. How will perverse incentives be managed? | Profit motive | No | |
| Why does NDoH refuse to take lessons from the W Cape DoH initiatives e.g. EPI  and Family Planning services via community pharmacies, and expand these services to other provinces? | Public Private Partnerships | No | |
| How will the transition to central purchasing and implantation work with provincial autonomy wrt healthcare local provision | Purchased / Provider split | No | |
| How are the skills sets for contracting and purchasing services going to be built? | Purchased / Provider split | No | |
| If medical schemes may not fund primary healthcare (as supplied by NHI), will all private providers be contracted by NHI? | Purchased / Provider split | No | |
| How will you monitor quality improvement and patient safety in the NHI? Are you using existing resources? | Quality of services | No | |
| Will for example specialists  working in a public hospital and similar one in a private hospital earn the same? | Remuneration / Funding | No | |
| Public sector employees are remunerated fairly, so why is it that when we speak of collaboration then the private sector is not expected to be remunerated? | Remuneration / Funding | No | |
| What exactly will the role of  private specialists (in private hospitals)be in NHI the women and child health sector i.e. Ob/Gyn's and Paed's | Service specific | No | |
| Could MS get around NHI by providing a slightly different package of care (i.e. treatment with drugs that aren't on the EDL, or surgeries that are part of the benefit package? | Service specific | No | |
| Mental health is an issue. Will NHI increase screening and access to care? | Service specific | No | |

| **Input** | **Category** | **Can WCGH answer?** | **Answer** |
|---|---|---|---|
| The stakeholder advisory committee is the only mechanism through which civil society can contribute – but it has no powers or roles in NHI Bill. Why? | Stakeholders | No | |
| What will be the powers of the stakeholder advisory committee? | Stakeholders | No | |
| Why are professional associations not represented on the NHI Benefit Package Committee? | Stakeholders | No | |
| Current public sector child health advocates for community-based child health. This is in sharp contrast to over servicing in the private sector - how will NHI prevent this? | Standardisation of care | No | |
| What balance see in role of Centre between control/direction and enablement? How do you understand stewardship in terms of central role? | Stewardship | No | |
| It's been more than 10 years now talking about the NHI, why is it taking to implement. | Timelines | No | |
| Breakdown of implementation timelines and priorities? | Timelines | No | |
| Please tell us more about the NHI implementation unit? | Timelines | No | |
| Dr crisp addresses provider claiming fraud but what about state corruption? | Transparency | No | |
| What information exactly about the running of the fund will be public (contracts with providers, performance reviews of contracted providers, provider profits, provider ownership?) and in what form? | Transparency | No | |
| We can learn the lessons from Mongolia that turned their health system around without NHI | Best practices | Comment | |
| Create multiple consultation opportunities | Collaboration | Comment | |
| Decide on units of engagement with community members | Collaboration | Comment | |

| **Input** | **Category** | **Can WCGH answer?** | **Answer** |
|---|---|---|---|
| Int lessons = NB Colombia set up a SHI fund that liquidated and is now run by the private sector. This private compulsory SHI offers differentiated care = widening the inequality gap. How to prevent? | Funding / Payment model | Comment | |
| We need the capacity for 'case holding' , to manage person focused care in an efficient yet comprehensive way | Patient centredness | Comment | |
| My concern is that in the psychosocial context we will FORGET about spirituality of the patient, the family and the service team. It will be catastrophic to merge spirituality into psychosocial. | Patient centredness | Comment | |
| Open Contracting and Open Budgetary is what we need within this process | Transparency | Comment | |
| What is defined as quality in providing 'quality' health services? How will that be monitored, and action taken if poor? | Quality of services | | |

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# ANNEXURE E: ATTENDEE AND APOLOGIES LIST

**Attendees**

| **Name and Surname** | **Organisation** |
|---|---|
| Abdusamad Sidar | Aftinat & Bioclones |
| Abeeda English | Momentum Health Solutions |
| Adrian Labuschagne | Private |
| Ahmed Bayat | Independent Community Pharmacy Association (ICPA) |
| Ahmed Chohan | Melomed Hospital Holdings |
| Alana James | The Sunflower Fund |
| Amanda Wilde | Umsinsi Health Care |
| Andre de Koker | LA Health Medical Scheme |
| Andrea Zanetti | Faircape Health |
| Andrew Wright | Medscheme Holdings |
| Anita Josephs | Drug and Substance support Group Senako MSAT |
| Anja Smith | Percept |
| Anthia V. Johnson | Department of Correctional Services |
| Anthony Ghillino | QuadPara Association of the Western Cape (QAWC) |
| Anthony Pedersen | Medscheme Holdings |
| Antoinette Frontini | Private |
| Anton van Wyk | Netcare Hospital Group |
| Ari Fonarov | Morton & Partners Radiologists |
| Arie Kade | Vidamed |
| Arlene Adams | Panel Member |
| Aronica M | Private |
| B Joseph | Mandela Foundation |
| Barry Childs | Insight Actuaries & Consultants |
| Bernadette Arries | TEXCO Members |
| Bernard Schoeman | Carevision (Primary Optometric care) |
| Beth Engelbrecht | HOD |
| Billia Luwaca | South African National AIDS Council [SANAC] Trust |
| Biren Valodia | Panel Member |
| Bob Govender | Mediclinic Hospital Group |
| Bonanzo Gerber | Bonshell |
| Brian Ruff | PPO Serve - Integrated Healthcare for South Africa |
| Bronwyn Macauley | Clicks Group Limited |
| C Petro | UCT |

| | |
|---|---|
| Caren P | Private - Overberg |
| Carl Abrahams | Iyeza |
| Carol Dean | WCGH |
| Carolyn Clark | PricewaterhouseCoopers |
| Charlyn Goliath | WCGH |
| Charmaine Julies | MJ Foundation |
| Christine Malan | Life Kingsbury Hospital |
| Claire Winterton | BD Diabetes Care |
| Clinton Van Zitters | Aspen Pharmacare |
| Corne Heynes | Mediclinic Southern Africa |
| Damaris O. Kiewiets | Champion of Love |
| Daniel Matthew | Netcare Limited |
| David Green | Medclaim Assist |
| Dawn Hector | Stellenbosch University |
| De Vries Basson | WCGH Staff |
| Debre Barrett | Private |
| Diliza Mji | Busamed Hospital Group |
| Dimitri Erasmus | WCGH |
| Dirk Heyns | WCGH |
| Dominic Wilhelm | Private |
| Donna Stokes | WCGH Staff |
| Dorothy Du Plooy | Cancer Association of South Africa (CANSA) |
| Eduard Ross | National Independent Nurses Association |
| Ernst Marais | Icon Oncology |
| Esmereldah Isaacs | WCGH |
| Eugene Samuels | Vencorp |
| F.R. Newfeldt | Stay Different Consultant |
| FA Adam | National Department of Health (NDoH) KZN |
| Faegah Sambo | MEDICROSS HEALTHCARE |
| Felicity Stevens | Sr Stevens Professional Primary Health Care Services (Pty) Ltd. |
| Fredelene Smith | Living Hope |
| Gavin Reagon | WCGH |
| Gerrit de Villiers | Mediclinic International plc |
| Gillion Bosman | Parliament (WCPP) |
| Giovanni Perez | WCGH Staff |
| Glenda Malan | Department of Community Safety |
| Grant Pepler | Medxstaff |
| Guy Harris | Red Cross Hospital |

| | |
|---|---|
| Hanli de Wet | Life Employee Health Solutions |
| Hannelie Fourie | Spescore or Surgiology |
| Harold Amaler | CIPLA Foundation |
| Harry Hausler | TB HIV CARE |
| Hassan Mahomed | WCGH Staff |
| Helene Rossouw | Medicoop CFI |
| Heloise Buys | University of Cape Town |
| Hester Julie | UWC |
| Inge Cunningham | WCGH |
| Ingrid Daniels | Cape Mental Health |
| Jabulani Shinga | Department of Correctional Services |
| Jan Roos | Clicks Group Limited |
| Jane Choi | UK Department for International Trade-British Consulate-General |
| Janet Bradbury | Nurture Cape View |
| Japie du Toit | Life Health Care |
| JC Stegmann | Western Cape Government |
| Jeanette R Hunter | National Department of Health |
| Jeet Dayal | MedeMass |
| Jenni Noble | Medscheme Holdings |
| Joan Visser | Occu-Care South Afriica CC |
| John Ataguba | University of Cape Town |
| John Douglass | PathCare Laboratories |
| Jonathan Vaughan | WCGH |
| Jones Fernandes | Phillips Southern Africa |
| Joyce van Niekerk | Life Employee Health Solutions |
| Juanita Arendse | WCGH |
| Juliana Willemse | University of Western Cape |
| Karen Ching | WCGH |
| Karen Househam | WCGH |
| Kathryn Grammer | WCGH |
| Keith Cloete | WCGH |
| Keith Craig Hoseham | Health Management Consultant |
| Kevin Carelse | District Council Member |
| Khalid Abdulla | AEEI |
| Khaya Gobinca | Private |
| Kholekile Vili | WCGH Staff |
| Kim Lowenherz | WCGH Staff |
| Kobie van der Merwe | Alegra Health |

| Kobus Venter | Masincedane Community Service |
|---|---|
| L Moonsamy | Rondebosch Medical centre (Pty) Ltd |
| Laura Angeletti-duToit | WCGH |
| Leanne Brady | WCGH |
| Lee Moses | Medihelp |
| Leilah Najjaar | WCGH |
| Leon Schronen | LA Health Medical Scheme |
| Leon Wolmarans | Health Systems Technologies (HST) |
| Lewellyn Moodley | Healthbridge |
| Lieketseng Ned | Univeristy of Stellenbosch |
| Lientjie Malan | WCGH |
| Liezel van Deventer | Private |
| Lifutso Motsieloa | South African National Aids Council (SANAC) Trust |
| Linda Greeff | Cancercare |
| Linda Zakiyya Chamane | Gender Dynamix |
| Links Archery | Western Cape Blood Service |
| Lizelle Alexander-Petersen | Mediclinic Southern Africa |
| Louvaine van Rensburg | Momentum Health Solutions |
| Lucas Korver | Momentum Health Solutions |
| Lucette Geldenhuys | Caledon Representative for Overburg |
| Lungi Nyathi | MedScheme Holdings |
| Lynette v/d Berg | WCGH |
| Lynne Marais | Batsumi Claims Management Soultions (Pty)Ltd |
| M.Naidoo | Univeristy of Western Cape |
| Madichaba Milosevic | WEHEU (WOMEN, EMPOWERMENT,HEALTH,EQUITY,UPLIFT) |
| Malikah Van Der Schyff | Private Practice |
| Mandla Moyo | National Health Group |
| Mari Bruwer | Blaawuberg Hospital |
| Maria Rambauli | Road Accident Fund |
| Mariette Pittaway MPL | Democratic Alliance (Free State Province) Spokesperson for Health |
| Marilyn Keegan | Council for Health Services Accreditation of Southern Africa |
| Matodzi Mukosi | WCGH |
| Mehboob Cassim | Independent Community Pharmacy Association (ICPA) |
| Melvin Moodley | WCGH |
| Meshack Kanzi | WCGH |
| MI Shreef | Rondebosch Medical Centre (Pty) Ltd |
| Michael Manning | WCGH |
| Murray Izzett | Icon Oncology |

| Muzzammil Ismail | WCGH Staff |
|---|---|
| Mzwandile Panziso | Private |
| NA Moosa | Rondebosch Medical Centre (Pty) Ltd |
| Ndoda Mavela | WCGH |
| Neil Gregory | PathCare Laboratotories |
| Nell Browne | Lifestyle Focus |
| Nicholas Crisp | Panel Member |
| Nicolas Burger | Council for Health Services Accreditation of Southern Africa |
| Nomabali Makeleni | Private |
| Nomafrench Mbombo | MEC |
| Nomonde Jamce | Western Cape Provincial Parliament (WCPP) |
| Nowi Ndayi | District Hospital Council |
| Pamela Naidoo | The Heart and Stroke Foundation South Africa |
| Patti Olckers | WCGH |
| Paula Armstrong | FTI Consulting |
| Pearl Mbeje | District Hospital Council |
| Peter Muller | Isoleso |
| Plaxcedes Chiwire | WCGH |
| Praneet Valodia | Praneet Valodia Consulting |
| Preggie Naidoo | Isoleso |
| Priscilla Napoleon | Cancer Association of South Africa (CANSA) |
| Raeesa October | WCGH |
| Rajesh Patel | Panel Member |
| Rene Antoinette Annderson | Metropolitan Health |
| Riaan van Staden | WCGH |
| Ricardo Mc Kenzie | Standing Committtee Member |
| Richard Tuft | Radiological Society of South Africa |
| Roger Allingham | Masincedane Community Services |
| Romulen Pillay | Phillips Southern Africa |
| Ronald Mbana | National Education Health and Allied Workers Union (NEHAWU) |
| Ronita Mahilall | St Luke's Hospice |
| Roy Nagan | Wesfleur Board |
| Ryan Lobban | Mediclinic |
| S Hogarth | HealthCraft MD |
| S.Geldenhuys | Dischem Vlueroute Clinic Tokai |
| Saadiq Kariem | WCGH |
| Salie Ahmed-Kathree | WCGH Staff |
| Samantha Adams | Pebbles Project |

| | |
|---|---|
| Sandile Mzonyane | African Mobility Solutions |
| Sarah Pietersen | Faircape Health |
| Sary van Renssen | Private |
| Shaheem de Vries | WCGH |
| Sharon Leo | WCGH |
| Shelley Heunes | Private |
| Shona Sturgeon | Facilities Board |
| Simo Sithandathu | Treatment Action Campaign |
| Simon Kaye | WCGH |
| Siraaj Adams | Private |
| Soraya Elloker | City of Cape Town |
| Stanley Nomdo | National Department of Health (NDoH) |
| Stephan Meyer | Immploy |
| Sugen Naidoo | Emerging Market Health Care |
| Sydney Grove | Grovemedi Consulting |
| Tatum Jones | MTN |
| Thabisa Blayi | Private |
| Trevor JW Pols | S.A.M.E. Foundation |
| Tshisikhawe Ndou | Road Accident Fund |
| Vanessa Petersen | Heideveld Health Solutions |
| Varn Diab | Momentum Health Solutions |
| Vernon Chorn | Unity Health |
| Veronica Adriaanse | PSH |
| Victoria Barr | F T I Consulting |
| Virginia Zweigenthal | WCGH |
| Virignia Jansen | Overberg Community Representative MSAT |
| Vonita Thopson | WCGH Staff |
| Vuyiswa Rashe | University of the Western Cape |
| Waarisa Fareed | City of Cape Town |
| Wendy Waddington | WCGH Staff |
| WF Philander | Democratic Alliance (DA) |
| Willem Pretorius | Infocare Health |
| Wynand Goosen | SAMA Tygerberg-Boland |
| Y Osman | University of the Western Cape |
| Yaseen Harneker | Busamed Hospital Group |
| Zahid Badroodien | District Hospital Council |

**Apologies**

| **Name and Surname** | **Organisation** |
|---|---|
| Aarthi Sewpersad | Nurture Cape View |
| Alex van den Heever | Wits School of Governance |
| Amanda van Dieman | District Health Council |
| Anthea Abrahams | Private |
| AP Bans | African National Congress (ANC) |
| Basil Bonner | MEDICLINIC SOUTHERN AFRICA |
| Cathelijn Zeijlemaker | PPO Serve - Integrated Healthcare for South Africa |
| Cathy D.Kalombo | Catabrele & co Medical Suppliers (Pty) Ltd |
| Chantel Cooper | The Children's Hospital Trust |
| Cheryl Rudolph | Arjohuntleigh |
| Chibuzo Anaso | AnasoDiablTiz Inc. |
| Christelle de Jager | Busamed Hospital Group |
| Denise Barnes | ALT-MED (PTY) LTD |
| Dumisani Ndebele | PathCare Laboratories |
| Ellie M.Kalombo | Catabrele & Co Medical Suppliers (Pty) Ltd |
| Faldie Kamalie | Private |
| Gary Black | PSSA (CWP) Branch |
| Gerrit | Health Systems Trust (HST) |
| Giel Van Schalkwyk | Council for Health Service Accreditation of Southern Africa (COHASA) |
| Gillian Moses | DPSA |
| Gita November | University of Witwatersrand |
| Gladys Bakubaku-Vos | African National Congress (ANC) |
| Glen Cilliers | Private |
| H Julie | UWC |
| H Scheneider | UWC |
| Hanif Hamdulay | Cancercare |
| Hans Human | WCGH staff |
| Harry Grainger | The Health Foundation |
| Hazel Cooper | Dr F Surve and Associations/ Omnicare Family |
| Herman Grobler | Cipla Foundation |
| Igshaan De Vries | University of Witwatersrand |
| Imameleng Masitha | Sexual & Reproductive Justice Coalition |
| Jacyntha Twynam | WESGRO |
| Jako Kruger | Medipractice |
| Jan Pienaar | The Health Source |

| | |
|---|---|
| Janice Jacobs | |
| Jennie Martin | Greyton Red Cros |
| Jennifer-Anne Chipps | University of Cape Town |
| Joe Seoloane | SAMWUMED |
| Johan van Heerden | Private |
| Joyce Malebo | Private |
| Kevin Arendse | District Council Member |
| Khalid Abdulla | AEEI |
| Kim Edwards | Vizibiliti Management Services |
| Leana Olivier | FARR |
| Leonard Londa | Council for Health Service Acreditation of Southern Africa |
| Lerato Mouih | Health Funder Asociation |
| Lindsay John Curran | VIVA Medical |
| Lubabalo James Mnyaka | AFLU MED HEALTHCARE |
| M Xego | Economic Freedom Fighters |
| Magda Kriel | BD Diabetes Care |
| Mandla Babayi | Private |
| Marcelino Julies | Private |
| Martie Lureman | MediKredit Integrated Healthcare Solutions (Pty) Ltd |
| Mbulelo Bara | Member of Parliament |
| Melanie Beppo | Independent Community Pharmacy Association (ICPA) |
| Michael Phillps | WCGH staff |
| Mohammed Rawat | Dihlase |
| Muneeb Chohan | Melomed Hospital Holdings |
| Neil Nair | National Hospital Network |
| Nomsa Nkata | KA-NKATA (PTY) LTD |
| P. Bimray | University of the Western Cape |
| Pat Lekker | African National Congress (ANC) |
| Patricia De Lora | Partners in Sexual Health |
| Patricia Monthe | TECH FOR UNIVERSAL HEALTH COVERAGE |
| Patrick Godana | Private |
| Paul Fouche | Mbuso Medical Supplies |
| Paul Nkurunziza | CoCT |
| Peter Breitenbach | Vodacom |
| Petrus Wassermann | TRANSMED MEDICAL FUND |
| PJ Blomerus | Department of Correctional Services |
| Portia Jordan | Stellenbosch University |
| Portia Jordan | Stellenbosch University |

| | |
|---|---|
| Pumeza Runeyi | |
| Rene English | University of Stellenbosch |
| Risham Maharaj | Democratic Alliance (Free State) |
| Rithaa Dollie | Medipractice |
| S Jonkers | HOD Northern Cape |
| Sabela Petros | WCGH |
| Sandile Mhlongo | Akeso Behavioural Healthcare Group |
| Sarel F. Malan | University of the Western Cape |
| Siviwe Gwarube | Democratic Alliance (DA) |
| Solly Lison | Private |
| Thabani (Mishack) Noncungu | University of the Western Cape |
| Tony Healy | Priontex |
| Trevor Arendse | MTN |
| Tutu Madungandaba | Batsumi Claims Management Solutions (Pty) Ltd |
| Victor Edward Morris | Private |
| Vuyiseka Dubula-Majola | Stellenbosch University Africa Centre for HIV and AIDS |
| Zelda Jansen van Vuuren | Medipractice |
| Zule Vureen | Locumbase |