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Localised Service Delivery Takes Centre Stage

On August 3, 2016, millions of South Africans cast their vote in the municipal elections. They did so to underscore the importance of local government in changing their lives where they reside. The local government sphere has been described as the “hands” in South Africa’s cooperative governance and administrative system.

The hundreds of local councils play a crucial role in translating national policies into positive service delivery experiences. It is at the level of municipal wards that the hand of government is often truly and intimately felt.

In this edition we carry a set of articles that highlight some of the issues that the new local government administrations will have to take into account over the next five years. The lead article, Building the City, contains reportage and analysis based on the 2016 State of Cities Report (SoCR IV) which is published every four years by the South African Cities Network (SACN).

Like those before it, the recent SoCR IV does more than tally the achievements and challenges of the country’s eight metropolitan municipalities. It also helps locate the debate on the role and the importance of the local government sector in the national discourse. In the article, as in the SoCR IV, the point is made that the rising tide of urbanisation worldwide puts pressure on local administration. They also illustrate how progressive cities, including some here at home, are learning to embrace the migrations to towns and cities as potential forces for good and national economic development.

Worth noting as well is the article titled ‘Taking Services to the People’, which details the results of the Geographic Accessibility Study of Thusong Service Centres and Thusong Cluster Departments. Briefly, the study looks at how Thusong Service Centres could be optimally distributed to both widen the coverage of Government services and therefore ensure equitable access.

Similarly, the focus on the National Health Insurance (NHI) reflects the importance of highly localised health care interventions. The study called ‘Paving the Way for the NHI’, is about re-engineering primary health care. It shows the effectiveness of Ward-Based Outreach Teams (WBOT) and School Health Services (SHS) in the provisioning of primary health care in the uMzinyathi Health District, in the KwaZulu-Natal Province.

The edition is also packed with many other articles and case studies that we hope the incoming local government legislators, administrators and communities would benefit from as they put local issues top of the national agenda.

Dudley Moloi
The National Development Plan (NDP) highlights the imperative of building the kind of “state that is capable of playing a developmental and transformative role”, or what is commonly referred to as a “Developmental State”. A Developmental State - by definition and practice - is the kind that is not only development-oriented, but also demonstrably attempts to construct and deploy its administrative and political resources to the overall development of the nation. Significantly, Chapter 13 of the NDP particularly singles out the Public Service as one of the key levers of a Developmental State.

What distinguishes successful developmental states worldwide is their commitment to building the kind of Public Service that is truly capable of directing the development pathways of their respective nations, through effective, selective and sustained interventions. In turn, the most defining features of the public services of the most successful Developmental States are, that they are meritocratic, career-oriented and professional.

Once again, the NDP provides clear indications as to what constitutes the kind of Public Service which is fit for a Developmental State. According to the NDP, a capable and professional Public Service is one that eschews political partisanship and encourages professionalism and administrative autonomy. The NDP further makes a call to making the Public Service an employer of choice who puts professionalism at the heart of service delivery.

Although the Constitution provides for the appointment of a number of persons “on policy considerations” [section 195(4)], such “deployments” are restricted to the two top levels of the Public Service, namely, those of Deputy Directors-General, Directors-General and Ministerial Advisors. The Ministerial Directive on Public Administration and Management Delegations [DPSA, 2014] also tries to ensure that appointments to posts of Chief Director and below are left to Heads of Department and that interference in the day-to-day administration of departments is contained to the minimum that is required for ministerial accountability.

However, even as the NDP points to the vision of the kind of Public Service that makes for an efficient and effective machinery of the Developmental State. It is important to also keep in mind the fact that public administration is a developing discipline. Therefore, we cannot argue that the models we have put in place are ideally suited to our context and the needs of South Africa. Many have simply been adopted, especially from the Anglophone countries. So, all the structures, processes and systems of public administration need constant innovation, renewal and transformation.

In South Africa, we have a unique opportunity to build a new public administration that can contribute to the development of the field internationally. Transformation is therefore the very difficult process of building something better, and to this end, academic departments of public administration and schools of governance should play a prominent role. This will, however, require academia to be fully immersed in the daily practice of public administration.

Adv. Ngoako Ramatlhlodi, MP, Minister for Public Service and Administration.
Collins Chabane YouthBuild School Piloted

Hundreds of young people from Edendale, in the KwaZulu-Natal Province, are set to benefit from the National Youth Development Agency’s (NYDA) initiated Collins Chabane YouthBuild School. The trade and artisanal skills development school is one of many Government initiatives that are aimed at tackling the triple challenges of poverty, unemployment and inequality, which takes an especially severe form among South African youth.

The Collins Chabane YouthBuild School has been so named after the late struggle stalwart and former Minister for Public Administration, Collins Chabane, from whom the school draws its inspiration. The YouthBuild model itself has been tried and tested in many countries worldwide as a dynamic remedy to the many difficulties that young people continue to face. A large part of the mandate of the NYDA is that of ensuring that young people acquire the necessary skills that would enable them to break the vicious cycle of poverty, unemployment and inequality. In particular, the research that the NYDA conducted over the years has consistently shown a correlation between youth employability and the demand for specific technical skills in the labour market.

Accordingly, the Collins Chabane YouthBuild School is being piloted with the enrolment of 50 young people, between the ages of 18 and 35, and who reside within the Greater Edendale area of Msunduzi Local Municipality. The admission criteria included a minimum of Grade 12 qualification with either pure Mathematics or Mathematics Literacy, and the ability to read and write in English. Twenty five of the 2016/17 intake will be trained in Mechanics: Boilermaking Technology (NQF level 2) and the other half in Construction Plumbing (NQF level 3). In addition, the young people will be exposed to practical training with reputable institutions in both the public and private sectors.

The objectives of the Collins Chabane YouthBuild School are in line with the White Paper, the White Paper for Post-School Education and Training in South Africa, which is administered by the Department of Higher Education and Training (DHET). For this reason the Collins Chabane YouthBuild School will be handed over to the DHET when the pilot project runs its course in six years’ time.

By Staff writer, SDR

South African Govt. steps up investment in ICT

Departments across the public sector are planning to introduce e-Government services with the objective of improving information, communication and technology (ICT) infrastructure in South Africa. To achieve this, there will be an increased investment in software licenses, specialised computer services, system advisers and system development.

New analysis from Frost & Sullivan’s, ICT Spend in South Africa: Public Sector saw an ICT spend of $615.9 million in 2014 and estimates that this will reach $707.6 million in 2019. Managed services, combined with fixed and non-cellular connectivity, accounted for 73.1 percent of these investments.

“South Africa’s National Development Plan, the National Integrated ICT Policy Green Paper, and the Broadband Policy are expected to drive the development and uptake of e-Government services,” said Frost & Sullivan ICT Industry Analyst Naila Govan-Vassen. “ICT spend will centre around updating IT hardware and data centres and on supporting systems integration, especially within the health, education and administrative departments.”

Current expenditure is mainly limited to day-to-day ICT requirements across national and provincial departments. Creating a fully digital government is challenged by:

- Legacy systems necessitating upgrades
- Limited infrastructure investment to connect all public sector buildings
- Lack of a coordinated plan to enforce ICT standards and ensure interoperability within national and provincial departments
- Security concerns surrounding shared and cloud computing services
- Shortage of skilled human resources
- Limited Internet reach and citizen access to online content, preventing two-way interaction with the Government

“Defining clear roles for ICT agencies and building partnerships with the private sector will be crucial to this endeavour,” noted Govan-Vassen. “The breadth of knowledge and expertise that the private sector can bring on board will complement Government’s commitment to strengthening ICT integration and accelerate digitisation in the South African public sector.”

IT News Africa
E-government a powerful tool for achieving Sustainable Development Goals

The United Kingdom, followed by Australia and the Republic of Korea, lead the world in providing government services and information through the Internet, e-Government, according to a new survey released by the United Nations, showing the progress of nations in promoting e-Government. The 2016 UN e-Government Survey provides new evidence that e-Government has the potential to help support the implementation of the 2030 Agenda and its 17 Sustainable Development Goals (SDGs).

The survey found that the United Kingdom has pursued continued development on e-Government innovation, and its Government Digital Service has been replicated by other countries around the world. Australia and the Republic of Korea recently established robust telecommunications infrastructure, invested in developing their human resources, expanded usage of e-Government facilities and extended service delivery.

World and regional e-Government leaders

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The rankings are based on E-Government Development Index (EGDI) reports, which rank countries by measuring their use of Information and Communications Technologies (ICTs) to deliver public services. The Index captures three dimensions: scope and quality of online services, status of telecommunication infrastructure and existing human capacity. A key theme is how ICT and e-Government can best contribute to the implementation of the SDGs.

E-government has grown with a rapid pace over the past 15 years. In the 2016 Survey, 29 countries score “very-high,” with EGDI values in the range of 0.75 to 1.00, as compared to only 10 countries in 2003. Since 2014, all 193 Member States of the UN have delivered some form of online presence. This is in stark contrast to 2003, when 18 countries, or about 10 percent of all countries, were without any online presence. In 2016, 51 percent of countries had “low-EGDI” or “medium EGDI” values, down from over 73 percent of countries in 2003.

According to the report, there have been increased efforts to utilise advanced electronic and mobile services for the benefit of all. But fixed and wireless broadband subscriptions have increased unevenly across regions. Europe leads the world and is coming closer to market maturation, while Africa is still lagging behind. While the overall availability of broadband has increased, substantial regional disparities and a growing divide persist. All countries agreed, in SDG 9, that a major effort is required to ensure universal access to internet in the least developed countries. The survey indicates that countries in all regions are increasingly utilising new information and communication technologies to deliver services and engage people in decision-making processes. One of the most important new trends is the advancement of people-driven services - services that reflect people’s needs and are driven by them.

The UN E-Government Survey is produced every two years by the UN Department of Economic and Social Affairs. It is the only global report that assesses the e-Government development status of the 193 UN Member States. It aims to serve as a tool for countries to learn from each other, identify areas of strength and challenges in e-Government and shapes their policies and strategies in this area. It is also aimed at facilitating discussions of intergovernmental bodies, including the United Nations General Assembly and the Economic and Social Council, on issues related to e-Government development and to the critical role of ICT in development.

UN Department of Public Information
Home Affairs turnaround strategy yields results

The Department of Home Affairs (DHA) has more than halved the average time it takes for a person to get an Identity Document (ID), thanks to the implementation of its turnaround strategy. Detailing the success of the turnaround strategy, DHA Deputy Director-General, Avril Williamson, said the Department was able to reduce the turnaround time for an ID from 127 days to less than 45 days. The strategy was introduced in 2007, with the major focus on ID related processes and customer interactions.

In June 2007, it took an average of 127 days to get an ID, with some customers waiting as long as 250 days, Williamson said. The long wait resulted in some people applying for multiple IDs, while others had to renew their temporary IDs a number of times. There were long queues, frustrated customers, complaints and bad publicity. In addition, there was no mechanism to track and monitor the status or progress of ID applications and backlogs.

“The ID book production process was analysed and a new end-to-end process was designed, reducing the production steps from 80 to 15,” Williamson explained.

Kuruman Hospital introduces patient transport overnight accommodation

In some areas of the Northern Cape, patients seeking treatment including chemotherapy and hysterectomies, must travel about 230 km from Kuruman to Kimberley for such care. These patients must arrive at Kuruman Hospital the afternoon before the patient transport shuttle leaves for Kimberley Provincial Hospital the next morning at 3 am. For those already suffering from debilitating illnesses, this meant spending a cold night sleeping on the floor until now.

The John Taolo Gaetsewe Developmental Trust recently donated two park homes equipped with beds, showers and toilets to Kuruman Hospital. This means that patients can now sleep in the park homes before departing early from Kuruman Hospital or returning late from the provincial hospital to ensure they do not have to travel in the middle of the night or sleep on the floor. Patrick Mosime regularly attends the provincial hospital for chemotherapy and said the park homes have made a big difference to him and others.

By James Miller, SA - the Good News

By Mpho Lekgetho, Health-e News.
R10.5 billion towards affordable housing for government employees

The Government Employees Pension Fund (GEPF), through its investment manager, Public Investment Corporation (PIC), has committed R10.5 billion into SA Home Loans (SAHL) to facilitate housing financing for qualifying government employees and members of the public. The investment aims to provide government employees and qualifying members of the public with end-user home finance and development finance for approved affordable housing projects. It comprises of the following:

- R5 billion for public service employees
- R2 billion for affordable housing end user financing as defined in terms of the Financial Sector Code
- R2 billion to enable SAHL to extend home loans to the rest of qualifying home loan applicants
- R1.5 billion will be used to fund affordable housing developers

The investment in SAHL is part of the developmental investment mandate that the PIC is carrying out on behalf of the GEPF. Specifically, this investment addresses the social infrastructure element which has housing as one of the key components. Lack of access to housing has been identified by the National Development Plan (NDP) as one of the challenges facing South Africa. In its diagnostic report, the NDP notes that: “the growth of property value has led to an overall average house price that has made housing unaffordable to many South Africans, and has further excluded participation in the property market by historically excluded groups. The growth has largely benefitted middle and higher income groups.”

Abel Sithole, Principal Executive Officer of the GEPF, said: “We believe there are many GEPF members who often do not qualify for bank-issued housing loans and housing subsidies offered by the Government. We are, therefore, excited about this investment as it will enable many government employees to own their own houses at a much more affordable rate. Most importantly, we believe home ownership can restore people’s dignity.”

The Government Employees Housing Scheme (GEHS), an agency of the Department of Public Services and Administration, will assist government employees to access funding from SAHL. Mashwahle Diphofa, Director-General of the Department of Public Service and Administration said: “The DPSA welcomes the participation of the GEPF through the PIC in the Government Employees Housing Scheme. The GEHS housing finance access service seeks to secure and deliver affordable housing finance to government employees. It is even more pleasing to see the PIC stepping forward as the first investor and participant in the GEHS housing finance service to bring this much needed value-added service to government employees.” Interface systems between GEHS and SAHL have already been developed and are operational. Government employees may also approach SAHL directly to apply for home loans.
The run-up to South Africa’s fourth fully democratic local government elections saw the release of a barrage of end-of-term reports. Most analysed, tabulated and assessed the country’s localities, ostensibly to help the incoming batch of councillors to better navigate the difficult terrain, that is, local government administration.

Similarly, the South African Cities Network (SACN) released the fourth edition of the State of Cities Report 2016 (SoCR IV). Like the many reports that were published ahead of the August 3, 2016 municipal elections, the current edition of the SoCR IV took advantage of the heightened national interest arising from the electoral cycle in order to highlight crucial issues pertaining to this often-neglected sphere of government.

Beyond the basics

Apt in content and deliberate in the timing of its release, the report takes a sweeping end-of-term assessment of the past performance of the country’s eight metros. The data is based on the State of the Cities Open Data Almanac (SCODA), which in turn uses eight broad thematic areas.

Two of the themes, “City Finance” and “Service Delivery” respectively, seek to answer the questions: “How financially secure are our cities?” and “Do urban residents have reliable access to basic services?” by interrogating a set of indicators. In answering these questions, the SoCR IV notes the strides the eight metros have made in the provision of basic services, with the majority of the cities reporting coverage in the region of 90% in the delivery of water, sanitation and electricity, among other service delivery indicators.

However, what may come as a bit of surprise to many is that South Africa’s metros show impressive scores in their ability to independently raise their own revenue. The proportion of “own revenue”, for example, far outweighs the “equitable share” and “grants”, which are the two other main sources of revenue.

The positive service delivery figures dovetails with government’s Back-to-Basics (B2B) programme. Under the B2B programme, municipalities are expected master their core competencies. Their ability to get the basics right, says the B2B programme, would better predispose them to handling more ambitious mandates, such as the ones contained in the National Development Plan (NDP) and the far-reaching vision underpinning the “New Deal for South Africa’s towns and cities”, which is the rallying call of the recently adopted Integrated Urban Development Framework (IUDF).

However, the report does more than look back at billing issues, filling up potholes and clearing up of refuse. As crucial as these activities may be to the core responsibilities of municipalities, it is also a veritable roadmap for the new term in local administration and beyond.

Living in the city

The ever-changing nature of cities (and the choices they have to make) is such that there are increasingly no trade-offs between the provisioning of basic services to increasing populations and undertaking visionary projects. Already, towns and cities do not only have to juggle their core service delivery mandates in response to increasing urban populations, they are also increasingly expected to shoulder the biggest weight in ensuring social cohesion, as well as spurring up national economic development.

It goes without saying that the furious pace with which South Africa is undergoing urbanisation, makes the overall thrust of the report. After all, urbanisation is intrinsic to the growth and development of towns and cities. The NDP, for example, estimates that as much as 70% of South Africans will be living in urban areas by 2030, as cities and towns have more and more sway on the dreams of many people, both from within the country and elsewhere.

Cities worldwide tend to have nasty reputations, with crime and grime co-mingling with the allure of city life. Although acknowledging the difficulties, the SoCR IV report argues that urbanisation should be regarded as a “transformational force” for good and not as a harbinger of chaos.

There is a body of evidence which indicates that some of the most successful nations in the world have achieved their enviable status by not fighting off the tide of urbanisation of their cities and towns. They have instead embraced and harnessed the clustering of people and reaped the benefits arising from economies of scale and thoughtful use of spaces in order to spur up national, economic and social development.

Economic powerhouses

The SoCR IV report notes a correlation between the overall high performance of the world’s top cities and the progressive nature of their urban development policies.

“The top 600 cities in the world account for a fifth (20%) of global population and generate 60% of global gross domestic product (GDP), while the top 100 cities in the world are responsible for 38% of global GDP,” the report notes.
Similarly, the SoCR IV report makes an observations on the extent to which the country’s economic fate is closely tied up to the performance of urban areas. In South Africa, for example, as much as 70% of the GDP is directly attributable to the economic activities of some of the major metros, or their respective “City-Regions”.

“City-Regions”, by definition, usually extend beyond the political boundaries. They look outwards to broader socio-economic regional nodes, rather than individual metros. The Gauteng City-Region, made up of the cities of Tshwane, Johannesburg and Ekurhuleni, contributes 31.9% or a third of South Africa’s gross value added (GVA), which measures economic activity at a city or regional level. The individual GVAs of four of the major cities between 1995 and 2013 were, Johannesburg (11.7% to 13.9%), Cape Town (10.3% to 10.9%), Tshwane (8.9% to 9.2%) and Ekurhuleni (8.2% to 8.8%).

The report further shows the high levels of specialisation on the part of the country’s major cities. For instance, over a third of the GVA in the cities of Johannesburg (33.6%) and Cape Town (35.8%) comes from financial and business services. The economy of the City of Tshwane, and the administrative hub of the country, is naturally dominated by “government services” (26.3%), followed by financial and business services (25.7%). The Ekurhuleni metro has a strong manufacturing base (27.2%) and also leads Gauteng’s transportation and communication sector (26.3%), with the latter hinging on the location of OR Tambo International Airport. The GVAs of the other four metros - eThekwini, Mangaung, Nelson Mandela Bay and Buffalo City are in the range of between 1.4% and 2.4% of South Africa’s output.

Urbanisation could be a “force” for good or potentially wreck havoc. The SoCR IV report consequently identifies a number of “red flags” that the newly sworn-in councillors, the people they serve as well as public servants, need take note of in order to build inclusive and sustainable cities.

Moreover, the report touches on a number of interrelated thematic areas that require urgent and persistent attention. While all are equally important, the sections on the “spatial transformation” and the “inclusivity”, in particular, strike at the core of the country’s cityscapes, given the peculiar legacies of apartheid urban planning.

**Not making space**

It does not take a city planner to realise that South African cities, or urban areas broadly, are incongruent with the lived experiences of many a city-dweller. The report acknowledges the persistence of the so-called apartheid geography, even as the whole of government continues to push a vision of urbanity that is closer to the best of what the new South Africa stands for.

The report bemoans the fact that as much as the post-1994 dispensation gave birth to the so-called “black diamonds” who, through the agency of high incomes, have somewhat managed to break the barriers into the previously white suburbs, the majority of mostly black, poor, urban residents either live on the peripheries of struggling cities, towns or still crowd the old townships and similar localities.

“What is clear is that South African cities are not yet working for all, and certain trends and dynamics are preventing the post-apartheid spatial vision from being achieved,” the report laments.

According to the SoCR IV, the stumbling blocks to spatial transformation arise from a litany of factors, including “unaligned and uncoordinated development” interventions across all spheres of government. Also, the proliferation of private sector-driven initiatives, such as gated housing estates and cluster housing, not only hoards much needed urban land, but also displays a serious disconnect to the “existing city fabric”. The consequence, the report concludes, is the emergence of “new cities” that “entrench spatial and social exclusion, segregation and inequality, based on class/income in place of race, and those excluded are predominantly poor and black”.

**By Dudley Moloi**
On August 3 2016, millions of South Africans once again put their faith in the nation’s democratic institutions when they voted their representatives of choice to serve in the various municipalities countrywide. The recent local government elections, however, represented more than an affirmation of the efficacy of South Africa’s democratic due process. They also reflected the collective faith of the electorate in the important role that is played by local government in changing lives and communities for the better. It is a faith that is backed by the lived experiences of communities in the ability of municipalities to provide much needed services and their potential to even do better by building on the current milestones.

**Delivery milestones**

In his Departmental Budget Vote of 2016, the Cooperative Governance and Traditional Affairs (CoGTA) Minister, Des Van Rooyen, noted the following service delivery milestones over the past fifteen years:

- The share of households accessing electricity went up from 69.7 percent in 2001 to 86 percent in 2014
- About 5.8 million households have received electricity, with over two million indigent households benefitting from the provision of electricity through indigent support systems
- The provision of water infrastructure rose from 61.3 percent to 90 percent
- The provision of free basic water services rose from over seven million citizens in 2007 to over 11 million in 2013
- Access to basic sanitation services increased from over 62 percent in 2002 to over 79 percent in 2014

“What this says is that local government has been successful in changing the lives of our citizens for the better. It is a good story of excellent government performance,” said Minister Des Van Rooyen.

**Building on Back-2-Basics**

An assessment of the first phase of the Back to Basics Programme (B2B) confirmed that tackling development challenges created by many years of colonisation and apartheid systems was a mammoth assignment, requiring long-term and sustainable solutions. The second phase involved the execution of the 10-Point Plan that government believes will vastly improve the state of local government. One of the key elements of the 10-Point Plan is fostering more positive community experiences.

“To this end, we are developing ward-based service delivery dashboards and implementing Ward Improvement Plans that ensure basic services, such as, the cutting of grass, ensuring working streetlights and the timeous fixing of water leaks,” said Minister Des Van Rooyen.

**Municipal Infrastructure**

In the past year, the Municipal Infrastructure Support Agent (MISA) supported 75 municipalities in the development of new infrastructure as well as the refurbishment of existing assets to improve the provision of services. MISA was also involved in the training of learners and technical officials in municipalities. For example, as a result of technical support from MISA, the Elundini Municipality, in the Joe Gqabi District Municipality of the Eastern Cape, completed a feasibility study that enabled it to secure funding through the Municipal Infrastructure Grant (MIG) and donor funding from the Netherlands, amounting to R296 million, for new infrastructure development. Once completed, this project will ultimately benefit 12 176 households in the area.

The project also has the potential to create at least 2 000 temporary jobs and 107 permanent jobs. In the coming year, MISA will implement the Regional Management Support Contracts to improve infrastructure delivery, management and operations in order to help municipalities with improving their management systems and processes for infrastructure delivery.
Municipal debt

According to Minister Van Rooyen, one of the other issues that need to be looked at, is that of municipal debt and payments to the national electricity provider Eskom, which initiated a debt collection process that could lead to municipal disconnections of bulk electricity supply in various provinces. Following an intervention involving the ministers of CoGTA, Finance and Public Enterprises, new or revised agreements were considered for the affected municipalities. The facilitated agreements take into account the financial circumstances of individual municipalities and include the adoption of recovery plans that identify opportunities that will assist the municipalities to improve revenue collection and reduce non-revenue electricity.

Best practice

The Community Work Programme (CWP) continues to be an important intervention by Government to deal with poverty, unemployment and inequality. In fact, the CWP is recognised by the International Labour Organisation (ILO) as one of the best in the world, and the reasons for the accolade are evident in the successes the programme continues to net. Of its budget, which is R3.2 billion for the 2016/17 financial year, the CWP programme typically expends 95 percent towards implementation and five percent on administration. Of this, 70 percent or R2.1 billion will go into the pockets and on the tables of participants. CWP participants contribute by doing useful work identified by the community. In Gauteng, for example, CWP participants cleaned:

- almost 300 000 square metres of public spaces, rivers and canals
- 81 000 square metres of cemeteries
- 1 051 illegal dumping sites
- maintained 2 076 community gardens

In addition, 10 800 children benefitted at créches, 2 058 desks were refurbished and 34 000 learners benefitted from scholar patrols. The CWP is active in 234 municipalities countrywide where it involves CoGTA working alongside other departments, civil society and business in order to increase its reach and impact.

Beyond poverty alleviation, the “CWP aims to provide participants with skills, both to do useful work in communities and to enhance their employability and ability to start their own ventures,” the CoGTA Deputy Minister Andries Nel explained.

Urbanisation

The unprecedented rate of urbanisation worldwide is going to define the agendas of local government for a long time. According to the United Nations (UN), 54 percent of the world’s population live in urban areas. By 2050, this figure is expected to increase to 66 percent. In 1950, only three in 10 people lived in urban areas. The UN also says that Africa is expected to be the fastest urbanising region between 2020 to 2050. While here is South Africa, sixty-three percent of South Africans already live in urban areas and the figure will rise to 71 percent by 2030 and by 2050, eight in 10 South Africans will live in urban areas.

The Integrated Urban Development Framework (IUDF) that Cabinet recently approved is not only meant to manage the colossal rate of urbanisation, but also to harness its potential for the development of South African cities and towns.

“The IUDF provides key principles and policy levers for creating better urban spaces. We will strengthen rural-urban linkages, promote urban resilience, create safe urban spaces and ensure that the needs of the most vulnerable groups are addressed,” said Deputy Minister Nel.

The Framework recognises that the country has different types of cities and towns with different roles and requirements. To this end, the IUDF must be implemented in locally relevant ways that also promote sustainable rural development and strengthen rural-urban linkages. Achieving this vision of spatial transformation, according to Nel, would require the combined efforts of all spheres of government, the private sector, labour and civil society, and most importantly the citizens of our municipalities.

The framework proposes, among other things, that jobs, housing and transport should be used to promote urban restructuring as outlined in the National Development Plan (NDP) by:

- Reducing travel costs and distances
- Preventing further development of housing in marginal places
- Increasing urban densities to reduce sprawl
- Improving public transport and the coordination between transport modes
- Shifting jobs and investment towards dense peripheral townships

LOCAL GOVERNMENT
LOCAL GOVERNMENT

BUILDING INCLUSIVE, LIVEABLE, PRODUCTIVE AND RESILIENT CITIES AND TOWNS

The world is becoming more and more urban: by 2050, at least 70% of the world’s population will be living in urban areas. This is a massive increase – in 1950, only 30% of the global population was urban. South Africa is no exception to the urbanisation phenomenon: by 2050, eight out of every ten South Africans will live in urban areas (80%, compared to 63% in 2011). That is a lot of people who will need to get from home to work or to school, to be provided with services such as water and energy, and to have access to parks or open spaces, as well as companies that will have to get goods to market every day.

If well planned and managed, urban growth can bring tremendous benefits. Urbanisation has always been an accelerator of growth and development, bringing enormous changes in the spatial distribution of people and resources. This is because urban spaces are hubs for ideas, commerce, culture, science, productivity, social development and much more. They enable a country to build a dynamic competitive advantage and allow its people to advance socially and economically. Therefore, our cities and towns are the key for sustained social and economic development, and addressing the challenges of poverty, inequality and unemployment.

In contrast, the downside of urbanisation, namely, poorly planned and managed urban growth, leads to poor quality of life, traffic congestion, crime and grime. This version of urbanisation is, unfortunately, what the majority of our cities and towns are experiencing, in large part as a result of the apartheid legacy of segregation and exclusion. South Africa’s urban spaces are characterised by sprawl, high densities and unsustainable infrastructure networks and consumption patterns.

New deal for cities and towns

In response to this urban phenomenon, and to ensure that we reap the benefits of urbanisation, Cabinet has approved the Integrated Urban Development Framework (IUDF). The IUDF’s overall objective is to ensure that the increasing urban concentration of the economically active population translates into higher levels of economic activity, greater productivity and faster growth rates. It acknowledges that the potential of urban areas can be maximised by aligning and integrating investments in transportation, human settlements, infrastructure networks, which should be underpinned by supportive land-use regulation and governance systems.

The IUDF takes forward the National Development Plan (NDP) vision of ensuring that by 2030 South Africa observes meaningful and measurable progress in “reviving rural areas and in creating more functionally integrated, balanced and vibrant urban settlements”.

The IUDF marks a new deal for South African cities and towns, by steering urban growth towards a sustainable growth model of compact, connected and coordinated cities and towns. The overall outcome of spatial transformation is aimed at addressing the legacy of racial segregation, poverty and exclusion from social and economic opportunities that continue to hamper our urban spaces.

What underpins the vision of the IUDF is the need to create: liveable, safe, resource-efficient cities and towns that are socially integrated, economically inclusive and globally competitive, where residents participate in urban life. This vision will be achieved by planning and investing in urban spaces in a way that creates new spatial forms, ensuring that people have access to social and economic services, opportunities and choices. This will further enable us to harness urban dynamism for inclusive and sustainable economic growth and development.

The IUDF identifies nine policy levers, which are premised on the understanding that (1) integrated urban planning and management forms the basis for achieving integrated urban development, which follows a specific sequence of urban policy actions: (2) integrated transport that informs (3) targeted investments into integrated human settlements, underpinned by (4) integrated infrastructure network systems and (5) efficient land governance, which all together can trigger (6) economic diversification and inclusion, and (7) empowered communities, which in turn will demand (8) effective governance and (9) financial reform to enable and sustain all of the above.

These policy levers are crucial for addressing the three-cross cutting priorities identified in the IUDF: to strengthen the linkages between rural and urban areas, create safe urban spaces and build resilient urban spaces.

The IUDF strategic goals – of spatial integration, inclusive growth, access and governance – will ensure that socio-economic development is at the forefront of developing a new urban reality. This new urban reality is one that develops and does not divide, that promotes access instead of control and that allows for opportunity, not restriction. To achieve our vision, the 2016–2019 IUDF Implementation Plan identifies a number of short-term actions that are aligned to the priorities identified in the 2019 Medium Term Strategic Framework (MTSF).

Attaining the IUDF’s vision and the goals will require a highly coordinated, systematic and collaborative approach across all spheres of government and all sectors of society, as well as an understanding of the respective roles and responsibilities needed to achieve spatial transformation. Leadership and strong political will at all levels of Government will be required to oversee and support the implementation of the IUDF. This new discipline, of engagements, collaboration and trade-offs, will enable us to redress the spatial imbalances.

Let us all work together to create cities and towns that are great places where we safely work, play and live.■

By Modjadja Malahlela,
Department of Cooperative Government and Traditional Affairs.
Human Settlements Reimagined

Rapid urbanisation with fewer available resources compels us to not only re-invent how we work, but also how we improve the lives of everyone. This is according to Human Settlements Minister, Lindiwe Sisulu, in this edited version of a speech given at a recent conference of planning professionals.

About six decades ago, South Africans were faced with a choice between two contending ideologies. One sought to divide, while the other sought to unite the country. By the time the apartheid ideology had been defeated, the country’s geography had been scarred almost irreversibly. This fitted well with apartheid spatial planning.

For the architect of apartheid, Dr. Hendrik Verwoerd, the instruction to successive administrations was unambiguous. He told the then parliament that “we must take the implementation of separate development so far that no future government will ever be able to reverse it”. Colonial and apartheid legacies still structure spaces across different scales. Whatever we may say about that evil system, apartheid, they planned it well!

What constitutes a “city”?

The challenge before us now is two-fold. First, reverse the legacy of apartheid. Second, imagine the future that we would want while we simultaneously respond to the present day challenges. This would require that we should transform our cities to be not only places of residence but also to become “laboratories for innovation” if we are to address the endemic socio-economic and developmental challenges.

If we are to make sense of the future we can look back at what we have achieved – what type of settlements we have created and look to the future of what needs to change – what needs to be reinvented and how we must change our thinking. Old planning paradigms no longer hold true. The Planning Profession in particular cannot carry on with business as usual – it will have to adapt to the rapidly changing environment, and help us change the way we think, as we find ourselves at a cross roads with increasing pressures on our cities and towns, and the natural environment due to rapid urbanisation, and the effects of global warming. In short, we need to be more creative and change our thinking about the future of our human settlements.

Fortunately, every challenge presents us with an opportunity. This is what we should use to help us change our thinking and to think beyond ourselves. The UN Habitat report on the State of African Cities (2014) provides valuable insight into the scale of the challenges in the African Region. The latest data provided reiterate that Africa is experiencing unprecedented population growth. The total African population is projected to nearly double from around one billion in 2010 to almost two billion by 2040 and may well surpass three billion by 2070. The good thing about 2070 is that none of us will be here!

The shift from rural to urban population majorities is, perhaps, the most decisive phenomenon since independence in most African nations. Increasing levels of urban poverty, inequality, inefficiency, and the concomitant impacts on vital renewable and non-renewable natural resources have so far, mirrored urban economic growth in Africa. We have accepted that the time is ripe for a rethinking of past and present development trajectory choices and for exploring new visions, interventions and adaptations in response to changing contexts.

A bold re-imagining of how Africa could best guide these transitions requires careful consideration of all the options. Africa and the world community need to rethink what constitutes a “city”, since the Western concept is no longer the sole legitimate template for its application in Africa. Whereas a ‘re-imagined African urbanism’ would undoubtedly embrace some parts of the ‘Western urban model’, Africa has an opportunity to also seek policy and strategic directions that incorporate long-term sustainability for social, environmental and economic development, that are more conducive to our situation and that will better deliver than the imported urban paradigms have done so far. African cities may therefore have a competitive advantage because, for instance their development could leapfrog conventional urban development paths to greener urban economies. Greener solutions, climate change adaptations, vulnerability reduction, technological innovation, urbanisation and the economic development of African cities, all go hand in hand in this context.

We have seen the devastating effects of exclusion and inequality brought about by the planning decisions made by the apartheid regime. Twenty years on, we are still struggling to reverse these. Many of the challenges ahead are of a trans-boundary nature and involve significant trans-boundary migrations, sometimes overwhelming our cities and towns limited resources. Often in the past, planning in African cities had been focused on removing informal development rather than identifying and rectifying existing segregatory practices brought about by our colonial heritage.

Urbanisation has been with us for a long time, and with it comes concomitant urbanisation of poverty. Therefore, the planning profession has to re-invent the ways in which we plan for inclusive settlements that will find a balance between embracing informality, while planning for sustainable service delivery. We have also found that over pre-occupation with removal of informality has deprived us of the opportunity to reverse apartheid spatial planning.

Sustainable urban planning is necessary to eliminate the causes of segregation and exclusion. Urban planning needs to review how investment is made in African cities to enable adaptive planning and management that is risk averse, pro-poor and sustainable. The roots of the planning profession lie in the industrial revolution in Europe, and designing and regulating for health and safety. It has since grown in complexity in theory and practice, but has largely focused on ensuring the efficiency of the formal city. How it will address the pressing issues of social, economic and spatial exclusion and informality remains to be seen. This is the challenge of the New Urban Agenda for Africa.

New Urban Agenda

The Third United Nations Conference on Human Settlements (Habitat III), set to take place in Quito, Ecuador in 2016 presents an opportunity to craft a New Urban Agenda for the world at large, and in particular for Africa. A point of emphasis for Habitat III is an integrated
planning approach that brings together the strands of spatial, economic and social planning and development.

The good news is that as a region, Africa has made a good start in preparing for the discussions in Quito by the African Union approving a Common African Position on Habitat III, earlier this year. A substantive South African Country report has also been submitted to the UN. Both these reports recognise urbanisation as an opportunity for economic, social and spatial transformation by harnessing the advantages of agglomeration and concentration of the population to share in the so-called “urban dividend”. In particular, the African Position notes the current efforts to harness the creative energies of the informal sector, as well as to consolidate the accumulated and diverse human and physical assets embedded within it, through especially the empowerment of women and the participation of the youth.

South Africa’s cities still reflect apartheid planning with the poorest communities tending to live far away from services and employment. They suffer not only spatial, but also social and economic exclusion. The form and structure of apartheid cities could also not cope with the dismantling of apartheid, especially the continuing massive rural to urban, and urban to urban migration. The resultant growth of informal settlements, that lack connections to public transport and infrastructure networks, makes it costly for new urbanites to commute and find and retain formal employment.

We are very aware of the sometimes less than optimal outcomes of our policy and practice, over the past twenty years – often continuing the legacy of urban apartheid - and the need to rethink how in future we develop our settlements to be more inclusive, sustainable and liveable. We are turning this around.

Hence, the New South African Urban Agenda promotes a new model of urban development that is able to integrate all facets of sustainable development to promote equity, welfare and shared prosperity. We build this on some 20 years of experience and learning in implementing housing and related human settlements programmes, targeting the most vulnerable members of our society: the indigent, the elderly, people with disabilities and child headed households and the people’s housing projects for the able bodied.

Our “New” Urban Agenda encourages an integrated approach to human settlements planning that is based on a sustainable livelihoods approach and promotes higher densities in good locations, universal design (ensuring access to all), an emphasis on the green economy, spatial economic inclusivity and the revitalisation of our inner cities. Our Agenda includes the provision of transport, a healthy and ‘liveable’ urban environment, clean drinking water, energy provision, sanitation, health, education, roads, job opportunities and food security. And importantly, cities with by-laws that are enforced, ensuring among other things that we have clean, well maintained cities.

The catalytic projects

One of the important lessons we have learnt is that small isolated “housing” projects are not conducive to fostering integrated and inclusive human settlements and delivery at scale in order to deal expeditiously with housing and service backlogs. We have thus embarked on repositioning the human settlement projects, based on the so-called 3C Protocol: Coordination, Cooperation and Collaboration, to develop catalytic Mega projects of no less than 15 000 rental, subsidised and mortgaged housing units supported by engineering, social and economic infrastructure. These projects will each provide housing for an estimated 45 000 to 60 000 individuals. The strategic levers for the successful delivery of the Mega projects include:

- Integrated development planning
- Radical spatial transformation
- Mixed housing and tenure typologies
- Security of tenure
- Urban renewal
- Strengthening institutional delivery capacity
- End user management
- Strategic partnerships with the financial sector, developers, the built environment professions and communities

Partnerships and the role of the professions

We are all partners in this great venture to turn our common destiny around and make our cities, towns and other settlements vibrant, productive, sustainable and great places to live in. A key success factor for our collective New Urban Agenda is that all stakeholders need to be behind the Agenda. To quote Mr Josep Roig, the Secretary-General of United Cities and Local Governments: “The only sustainable city is the one created by all of us.” In South Africa, we are well on our way to a new urban development paradigm. I have given you a glimpse of our New Urban Agenda and how we rely on partnerships to achieve our vision.

We have formed a Social Compact with all our stakeholders including the planning profession. The Planning Profession has undertaken to assist government with training officials, assisting the youth to enter the planning profession, and empowering communities to plan their settlements and fulfil their own settlement needs. Every human settlement has common, but also locally specific needs as far as planning and interventions go. I believe that together in partnership we can “make sense of the future” and “re-invent” our cities and towns. We have already begun to do so. Africa has agreed on the pillars of our common urban future. I therefore challenge planners across the continent to let go of the old paradigms that no longer serve our needs, and to develop and embrace new approaches that are locally appropriate. We cannot afford to lose this twenty-year opportunity to fully participate in setting a New Agenda.
The Geographic Accessibility Study of Thusong Service Centres (TSCs) And Thusong Cluster looks at how best TSCs could be geographically distributed in order to ensure equitable access to services by all South Africans.

INTRODUCTION

In 1999, Government initiated the Thusong Service Centre (TSC) programme as a way of supporting departmental front line services. The TSC programme sought to ensure equitable access to services by all South Africans (especially those living in outlying rural areas and underserviced communities in urban areas) through integrated service delivery.

The DPSA undertook Geographic Accessibility Study of Thusong Service Centres And Thusong Cluster Departments in order to provide guidance on how to improve access by citizens to key Government services. It does this by exploring how TSCs and/or the clustering of departmental service points could be more equitably distributed in order to reach as many people as possible. For example, optimum locations of TSCs were identified in such a way that maximum possible population coverage is ensured with fewer additional facilities and minimum costs in terms of setting up new infrastructure.

The study covers all provinces, except the Western Cape, which had already conducted a similar study in collaboration with the Council for Scientific and Industrial Research (CSIR). Only some of the findings and recommendations of the study are presented in this article, though some of the study’s methodological underpinnings are noted for purposes of context.

METHODOLOGY

Development of differentiated settlement typology

Given the absence of a uniform settlement typology for the country, a typology was developed for the purpose of this study. The typology is derived from the Statistic SA (StatsSA) settlement classification and the CSIR guidelines for the provision of social facilities. This typology differentiates between areas that are classified as urban and rural spaces and includes five types of settlements (Table 1).

<table>
<thead>
<tr>
<th>Type</th>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Metro</td>
<td>Areas classified as urban and situated in Metropolitan areas</td>
</tr>
<tr>
<td>Urban</td>
<td>Major Urban Town</td>
<td>Urban areas with population above 25 000</td>
</tr>
<tr>
<td>Urban</td>
<td>Urban Town</td>
<td>Urban areas with population below 25 000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type</th>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>Rural Town</td>
<td>Rural areas with population above 25 000</td>
</tr>
<tr>
<td>Rural</td>
<td>Rural (Sparse)</td>
<td>Rural areas with population below 25 000</td>
</tr>
</tbody>
</table>
INTEGRATED GOVERNMENT

Figure 1 shows a map of the settlement typologies emphasising the uniqueness of each province. KwaZulu-Natal, Mpumalanga and Limpopo provinces are mostly rural, with urban and major urban towns in between. Due to the sparsely populated areas and large geographical size of Northern Cape, the province consists of large rural areas and small urban towns. Eastern Cape consists of densely populated rural towns in the east and more sparsely populated rural areas in the west, while metropolitan areas predominantly cover Gauteng.

Figure 1: Settlement Typology

Maximum travel distance for urban and rural settlements

The absence of access standards for Thusong Service Centres meant that these needed to be developed for the purposes of this study. An iterative modelling exercise was done using Geographic Information System (GIS) software to evaluate various distances and to provide direction in the development of access standards for Thusong Service Centres. These distances were benchmarked against the access standards of the Department of Home Affairs and those contained in the CSIR Guidelines for the Provision of Social Facilities in South African Settlements.
TABLE 2: DISTANCE STANDARDS DEVELOPED FOR THE ACCESSIBILITY STUDY

<table>
<thead>
<tr>
<th>Urban areas</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan</td>
<td>Maximum 15 km</td>
</tr>
<tr>
<td>Major Urban Town</td>
<td>Maximum 15 km</td>
</tr>
<tr>
<td>Urban Town</td>
<td>Maximum 15 km</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rural areas</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Town</td>
<td>Maximum 25 km</td>
</tr>
<tr>
<td>Rural (Sparse)</td>
<td>Maximum 25 km</td>
</tr>
</tbody>
</table>

Development of population thresholds

Minimum and maximum population thresholds were also developed for different types of Thusong Service Centres. The Service Centres are classified as Large, Small and Satellite, or Mobile Services, which provide periodic services. Table 3 provides the population thresholds for each Centre size and were informed by the results of the accessibility analysis. A maximum population threshold of 300,000 was considered for metropolitan areas, based on the results of this accessibility study, in order to limit the number of additional facilities that would be required and to minimise the need for further infrastructure investment.

TABLE 3: POPULATION THRESHOLD PER TYPE OF THUSONG SERVICE CENTRE

<table>
<thead>
<tr>
<th>Thusong Service Centre Size</th>
<th>Population threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large</td>
<td>60,000 to 200,000</td>
</tr>
<tr>
<td>Small</td>
<td>20,000 to 60,000</td>
</tr>
<tr>
<td>Satellite</td>
<td>10,000 to 20,000</td>
</tr>
<tr>
<td>Mobile Service</td>
<td>2,000 to 10,000</td>
</tr>
<tr>
<td>Outreach Project</td>
<td>Less than 2,000</td>
</tr>
</tbody>
</table>

Steps applied in the methodology

Step 1: Collection and preparation of data

- This step included the collection of various data sets and the preparation of the data for use in a Geographic Information System (GIS). A mapping exercise was done together with provincial managers of the Thusong Service Centre Programme to verify the current locations of Thusong Service Centres in the provinces.

Step 2: Assessment of the current provisioning and location of facilities

- Accessibility modelling was conducted to determine the current population coverage of Thusong Service Centres and Thusong Service Clusters. From this, backlog statistics and maps were then produced in relation to the current provisioning of Service Centres (using specially developed access standards).

Step 3: Facility location analysis to optimise the provisioning of facilities

- Location analyses were conducted to identify the optimum number and location of facilities and to explore other possible options for meeting the unserved population demand. In the process, the analyses took account of existing TSCs when the minimum number of additional locations was determined to increase population coverage to set percentages.

FINDINGS: CURRENT PROVISIONING AND ACCESSIBILITY OF THUSONG SERVICE CENTRES

HOW MANY AND WHERE ARE THESE CENTRES LOCATED?

At the time of the accessibility study in 2014, there were 178 Thusong Service Centres and 165 Service Clusters comprising facilities of the SA Police Service, SA Social Security Agency and the Departments of Home Affairs and Labour that are located in close proximity to one another (between 1-2 km apart). These Service Clusters are regarded as virtual Thusong Service Centres for the purpose of the study. Before the study, the number and location of these clusters were unknown to Government planners. By including the 165 Thusong Service Clusters in the analysis, the total number of Service Centres in the country increases to 343 as indicated in Table 4.

TABLE 4: THUSONG SERVICE CENTRES AND CLUSTERS PER PROVINCE

<table>
<thead>
<tr>
<th>Province</th>
<th>Thusong Service Centre</th>
<th>Thusong Service Cluster</th>
<th>Total Number of Service Centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>11</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>Free State</td>
<td>10</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>Gauteng</td>
<td>41</td>
<td>16</td>
<td>57</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>22</td>
<td>33</td>
<td>55</td>
</tr>
<tr>
<td>Limpopo</td>
<td>22</td>
<td>19</td>
<td>41</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>18</td>
<td>23</td>
<td>41</td>
</tr>
<tr>
<td>North West</td>
<td>16</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Western Cape</td>
<td>33</td>
<td>6</td>
<td>39</td>
</tr>
<tr>
<td>National</td>
<td>178</td>
<td>165</td>
<td>343</td>
</tr>
</tbody>
</table>
Existing Service Centres (including Thusong Service Centres and Clusters) are mostly situated in the east of the country. These include provinces such as Gauteng (57), KwaZulu-Natal (55), the Eastern Cape (46), Mpumalanga (41) and Limpopo (41) where population counts are higher. Some are located close to provincial boundaries and their coverage extends to people living in adjacent provinces. The current distribution of Thusong Service Centres and Clusters is illustrated in Figure 2.

**FIGURE 2: THUSONG SERVICE CENTRES AND CLUSTERS**

![Map of South Africa showing Thusong Service Centres and Clusters](image)

**LEGEND**
- Thusong Service Centre
- Thusong Service Cluster

**HOW MANY PEOPLE HAVE ACCESS TO THESE THUSONG SERVICE CENTRES?**

Results of the study show that 38,968,331 (75%) people currently have access to a Thusong Service Centre within a maximum travel distance of 15 km in urban areas, and 25 km in more sparsely populated rural areas. These percentages are illustrated in the pie chart in Figure 3.

**FIGURE 3: CURRENT POPULATION COVERAGE PROVIDED SERVICE CENTRES**

![Pie chart showing population access to Thusong Service Centres](image)

Thusong Service Clusters play a significant role in providing coverage and extending access to more people (22 million) in most
provinces than traditional Thusong Service Centres (17 million) as in Figure 4.

**FIGURE 4: RATIOS OF THUSONG SERVICE CENTRES TO THUSONG SERVICE CLUSTERS PER PROVINCE**

<table>
<thead>
<tr>
<th>Province</th>
<th>Service Centres</th>
<th>Service Clusters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauteng</td>
<td>41</td>
<td>16</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>22</td>
<td>33</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>11</td>
<td>35</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>Limpopo</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td>Western Cape</td>
<td>33</td>
<td>6</td>
</tr>
<tr>
<td>North West</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Free State</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

**ACCESS IN THE PROVINCES?**

Population coverage provided by Service Centres is uneven across and within provinces. Coverage is very good in Gauteng (96.99%), Mpumalanga (81.13%) and Western Cape (77.69%), but lower in Free State (62.85%), the Eastern Cape (61.04%) and North West (59.08%). Coverage is lowest in the Northern Cape (51.26%) given its sparse population and long travel distances. Figure 5 indicates the current coverage per province.

**FIGURE 5: POPULATION COVERAGE THAT IS CURRENTLY PROVIDED BY SERVICE CENTRES PER PROVINCE**

Population coverage varies considerably in different types of settlements. Of the 12,793 million people that currently lack access,
6.3 million live in rural towns followed by urban towns with 2.2 million. The lack of population coverage in different types of settlement is illustrated in Figure 7.

**FIGURE 7: LACK OF POPULATION COVERAGE PER SETTLEMENT TYPE**

Currently the national average travel distance to a Service Centre is 15.6 km. However, distances vary considerably across and within provinces. The average travel distance of 34.8 km in Northern Cape is highest given its vast sparsely populated areas whereas the average distance in Gauteng is 5.9 km. Figure 8 illustrates the average travel distance that people travel to their nearest Service Centre.

**FIGURE 8: AVERAGE TRAVEL DISTANCE TO A SERVICE CENTRE PER PROVINCE**
Average travel distances also vary extensively in different types of settlements. Generally, travel distances are longer in rural areas (41.2 km), urban towns (33.7 km) and rural towns (22.2 km); they are much shorter in major urban towns (10.8 km) and in densely populated metropolitan areas as depicted in Figure 9.

**FIGURE 9: AVERAGE TRAVEL DISTANCE TO A SERVICE CENTRE PER SETTLEMENT TYPE**

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**ACCESSIBILITY CHALLENGES**

Accessibility challenges that were identified during the study include:

- The highest number of people that lack adequate access to Service Centres (including Thusong Service Centres and Clusters) reside in populated areas of KwaZulu-Natal and Eastern Cape and in some densely populated formal and traditional residential areas of Limpopo.
- Most Service Centres are currently located in urban areas where access tends to be better. Even though 98 Service Centres are located in rural towns, 6 334 402 people in such areas currently lack adequate access to Service Centres. These constitute 50% of the total population that are currently unable to reach a facility within a distance of 25 km.
- The Northern Cape is characterised by many small and isolated urban and quasi-urban settlements across its vast area and the average travel distance to the nearest Service Centre in the province is 34.8 km. In more remote areas, the average travel distance is 67.4 km.
- Access is inadequate in areas of the Free State where urban towns are scattered far apart with large commercial farming areas in between.
- Eastern Cape and KwaZulu-Natal have a diverse geographical landscape. These provinces have limited road infrastructure and contain numerous mountains and rivers in some areas causing natural barriers that affect accessibility. These regions also consist of densely populated traditional residential areas that currently lack access to Service Centres. Similar patterns were observed in parts of Limpopo where the Waterberg and Soutpansberg mountain ranges limit accessibility.
- 25 existing Service Centres serve population catchments that are larger than 300 000 people. These may experience difficulty
INTEGRATED GOVERNMENT

in meeting the high population demand. They are mainly located in metropolitan areas and major urban towns such as those in Gauteng, KwaZulu-Natal and Eastern Cape. Examples of Service Centres that provide service coverage to more than 500 000 people include the two Thusong Service Clusters in the central business districts of Johannesburg and Pretoria and the two Thusong Service Centres in Alexandra and Mamelodi.

- On the other hand, 49 existing Service Centres serve population catchments that are less than 20 000. These are primarily located in sparsely populated rural areas and small rural towns. It is possible that these Service Centres are being underutilised.

Figure 10 highlights densely populated urban and rural areas where people lack adequate access to Service Centres. These areas are highlighted by red circles and, in some instances, span municipal boundaries.

**FIGURE 10: DENSELY POPULATED AREAS WHERE PEOPLE LACK ADEQUATE ACCESS TO SERVICE CENTRES**

PROPOSED PROVISIONING AND LOCATION OF THUSONG SERVICE CENTRES

Whereas the national population coverage that is currently provided by Service Centres is 75.28%, this coverage is very uneven across provinces and different types of settlement. Hence, the overall objective of the analysis was to achieve a more equitable distribution of Service Centres across the country and to achieve minimum population coverage of 75% in each of the provinces.

The accessibility analysis has identified 67 optimum locations for the establishment of additional Service Centres, including 42 Thusong Service Clusters and 25 Thusong Service Centres, which will increase the total number of Service Centres in the country from 343 to 410.
The number of proposed locations varies per province. More locations were identified in KwaZulu-Natal, the Free State, the Eastern Cape and North West, where the current provision and location of Service Centres are inadequate to meet the high population demand.

Even though Limpopo and Mpumalanga are currently well supplied with Service Centres, additional locations were identified in densely populated areas where access to services is currently inadequate. The population demand on some facilities in Gauteng is extremely high and hence additional locations were identified along key access routes to spread the population demand. The geographic distribution of the proposed locations is illustrated in Figure 11 and 12.

FIGURE 11: DISTRIBUTION OF THE PROPOSED LOCATIONS ACROSS THE COUNTRY
The establishment of additional Service Centres at the 67 proposed locations could potentially increase the population coverage in the country from 75.28% to 83.19%. This coverage could be increased even further through the provisioning of mobile services. Coverage could potentially be extended to more than 4 million people and all settlement types would benefit, particularly major towns and rural towns, where the majority of un-served population currently resides.

It is evident in Table 5 that the greatest improvements in population coverage could be achieved in the Eastern Cape (1 023 937 people), KwaZulu-Natal (896 919 people) and the North West (608 671 people), followed by Limpopo (531 932 people). Gauteng and Mpumalanga benefit least in terms of improved coverage as additional locations were mainly identified to reduce the excessive population demand on some existing Thusong Service Centres and Clusters.

**TABLE 5: POPULATION COVERAGE PER PROVINCE BASED ON THE OPTIMUM PROVISIONING OF SERVICE CENTRES**

<table>
<thead>
<tr>
<th>Province</th>
<th>Number of additional locations</th>
<th>Potential improvement in population coverage (number of people)</th>
<th>Percentage improvement in coverage</th>
<th>Total envisaged population coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>11</td>
<td>1 023 937</td>
<td>20.36%</td>
<td>5 028 053</td>
</tr>
<tr>
<td>Free State</td>
<td>12</td>
<td>455 782</td>
<td>20.90%</td>
<td>2 181 171</td>
</tr>
<tr>
<td>Gauteng</td>
<td>7</td>
<td>157 897</td>
<td>1.31%</td>
<td>12 060 077</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>14</td>
<td>896 919</td>
<td>10.99%</td>
<td>8 158 162</td>
</tr>
<tr>
<td>Limpopo</td>
<td>5</td>
<td>531 932</td>
<td>12.82%</td>
<td>4 147 856</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>5</td>
<td>131 643</td>
<td>3.86%</td>
<td>3 408 692</td>
</tr>
<tr>
<td>North West</td>
<td>8</td>
<td>608 671</td>
<td>22.69%</td>
<td>2 682 189</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>5</td>
<td>283 564</td>
<td>32.59%</td>
<td>870 080</td>
</tr>
<tr>
<td>Western Cape</td>
<td>-</td>
<td>0</td>
<td>0.00%</td>
<td>4 522 396</td>
</tr>
<tr>
<td>National</td>
<td>67</td>
<td>4 090 345</td>
<td>9.50%</td>
<td>43 058 676</td>
</tr>
</tbody>
</table>
The greatest improvement in population coverage (an additional 1.9 million people) could be achieved in rural towns, particularly in the Eastern Cape, Limpopo, KwaZulu-Natal and North West. Metropolitan areas could also benefit significantly, especially in the Eastern Cape and KwaZulu-Natal, and major urban towns in the Free State and North West could benefit. Population coverage increases from 82% to 90% in major urban towns followed by rural towns where coverage increases from 65% to 75.85% with the inclusion of proposed locations as in Table 6.

TABLE 6: POPULATION COVERAGE PER SETTLEMENT TYPE BASED ON THE PROPOSED PROVISIONING OF SERVICE CENTRES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban-Metro</td>
<td>17 727 881</td>
<td>90.43%</td>
<td>18 648 352</td>
<td>95.13%</td>
</tr>
<tr>
<td>Urban-Major Town</td>
<td>7 978 549</td>
<td>82.00%</td>
<td>8 772 116</td>
<td>90.16%</td>
</tr>
<tr>
<td>Urban-Town</td>
<td>1 155 577</td>
<td>34.17%</td>
<td>1 499 663</td>
<td>44.35%</td>
</tr>
<tr>
<td>Rural Town</td>
<td>11 764 914</td>
<td>65.00%</td>
<td>13 728 935</td>
<td>75.85%</td>
</tr>
<tr>
<td>Rural (sparse)</td>
<td>341 410</td>
<td>36.00%</td>
<td>409 610</td>
<td>43.19%</td>
</tr>
<tr>
<td>Total</td>
<td>38 968 331</td>
<td>75.28%</td>
<td>43 058 676</td>
<td>83.19%</td>
</tr>
</tbody>
</table>

The establishment of Service Centres at the 67 proposed locations could potentially reduce travel distances in all provinces and the different types of settlements. The average travel distance to a Service Centre could be reduced from 16 km to 12.9 km nationally, with the greatest improvements occurring in Free State (reduction of 8.1 km), followed by North West Province (reduction of 7 km) and Northern Cape (reduction of 6.8 km). The greatest reduction would be in urban towns, rural and sparsely populated areas. However, the exact locations for possible additional Centres have not been determined since final decisions on the provisioning of Thusong Service Centres need to take into account factors such as local conditions, the needs of communities, availability of suitable land and the availability of basic infrastructure services.

RECOMMENDATIONS

Development of an Integrated Delivery Model for Thusong Service Centres: A hierarchical network of Service Centres.

In order to provide a more effective network of various types of Services Centres a standards-based approach should be followed. The access standards that have been developed for different types and sizes of Service Centres should be adopted and the notion of a hierarchy of services should be applied to various orders of settlements:

- Large Thusong Service Centres and Thusong Service Clusters should provide higher order services in key nodes and towns where there are high concentrations of human, economic and/or transport interaction. These should provide much more extensive and specialised services to a larger population. Hence, population thresholds for these centres may be larger and travel distances may be longer.

- Smaller Thusong Service Centres, Clusters and Satellite Services should be provided at local nodes or points of lower activity and concentration, such as smaller and more remote settlements. Facilities that are used almost daily should be located closer to communities that they serve. They may also have lower population thresholds.

- Special Purpose Thusong Service Centres could be established to respond to particular needs at local level. An example is the Thusong Youth Centre in Alexandra, which has a very special focus on women and children that are at risk of falling victim to crimes or abuse. Such services could take the form of joint ventures between Government and/or non-profit organizations and local residents with a view to achieving planned aims and objectives.

- Mobile services could be used effectively to provide services to communities outside the catchment areas of permanent service points and especially in areas where there are sparse populations and where people would otherwise have to travel long distances to access services.

- Thusong outreach programmes and projects could be extended periodically by departments to remote areas where the population density does not warrant a Thusong Mobile Service or Satellite Service Centre. The roles that Community Development Workers could play in identifying the need for such initiatives, arranging Thusong Service outreach programmes, the coordinated deployment of mobile services, the facilitation of community-participatory processes and the fostering of rural social innovations and support networks should be highlighted in the Thusong Service Centre programme.
INTEGRATED GOVERNMENT

Whereas the establishment of additional Service Centres would improve access to services, there is a need to review the current Thusong Service Centre model as defined in the 2004-2014 Business Plan. This will ensure that the Programme is financially sustainable and effectively responds to societal challenges and policy priorities outlined in the National Development Plan. Consideration should be given to alternative service delivery channels and innovations, which could supplement the roles played by traditional Thusong Service Centres and service points of departments. These should be incorporated into a fully integrated delivery model for the Programme.

The profiling of settlements according to their demographic, social and economic characteristics. Such profiles would assist the Thusong Service Centre Programme in determining which service packages should be provided in different areas to respond to changing social, economic and demographic conditions and anticipated population shifts in South Africa. It will also assist in identifying particular areas that should be given priority.

Volunteerism and partnerships should be encouraged to allow grassroots initiatives in communities to be fostered and for culturally appropriate management of programmes, projects and resources to be developed. Thusong Service Centres could potentially serve as hubs for rural social innovation where local solutions are developed through participatory processes, for instance, the establishment of community cooperatives, the management of local services, the organisation of cultural activities and the coordination of youth outreach programmes.

E-Government and embedding information and communications technologies (ICTs) effectively into its day-to-day activities of Thusong Service Centres. These technologies reduce the need for proximity, as people are able to access services and information where they live. The roll out of broadband and ICT connectivity across the country could assist people in overcoming access barriers such as technical skills, literacy, disability, language and/or financial means.

Clustering of services

The accessibility study has identified 67 geographic locations for the possible establishment of additional Service Centres that could potentially provide services to an additional 4 million people in areas where access is currently inadequate. Preference should be given to those geographic locations that could potentially provide the greatest improvement in population coverage, especially in rural and urban towns where access is currently inadequate.

As part of the proposed 67 locations, the study identified 42 locations where the establishment of Thusong Service Clusters should be considered. Some Government services are already provided at these locations, but additional services are required to establish fully functional Thusong Service Clusters. These could provide cost savings and greater convenience to citizens. Further analysis is required to determine the feasibility of establishing such clusters and to determine the implications for sector departments. Departments may need to review their service delivery models to provide for the clustering of services. Optimum configurations for the clustering of various types of services also need to be determined.

Demand assessment of existing Centres.

Apart from the 67 proposed locations, and to ensure the effectiveness and financial sustainability of the Thusong Service Centre Programme, it is proposed that:

- A feasibility study should be done in relation to the possible establishment of additional Service Centres and other measures, which could be implemented to reduce the very high population demand on some existing Service Centres. This study has identified 25 Service Centres where population demand far exceeds 300,000 per facility.
- A review should be done in relation to the 49 existing Service Centres where population demand is very low to determine whether such centres should be closed or whether they should be converted to Satellite Centres/mobile facilities providing periodical services. Most of these are located in small rural towns and sparsely populated rural areas.
- Consideration should also be given to the coordinated deployment of mobile services of various departments in areas that were identified in the study. Localised studies will be required to determine optimum routes and stopping points for such vehicles.

User statistics

- Government Communications and Information Systems should take responsibility for the monthly collection of user statistics for each Service Centre and these should be analysed to assess the performance and functionality of Thusong Service Centres and the demand for particular services.

Spatial data

- Departments should take responsibility for collecting, maintaining and disseminating spatial information on their services to citizens and other departments.

CONCLUSION

The fact that Service Centres provide population coverage that cuts across municipal and provincial boundaries calls for a strong programmatic approach in the delivery of services that these facilities provide. Moreover, such an approach should be linked to Government priorities and further allow for the coordination of interventions of multiple departments in such a manner that these respond to the needs of citizens in a holistic and integrated manner.

For more information, please contact:
Mrs M van Blerk (mariev@dpsa.gov.za) or Mr T Holdsworth (trevorh@dpsa.gov.za).
In this article, the Minister of Health, DR AARON MOTSOALEDI, says the state of the nation’s health care leaves both the poor and the wealthy equally vulnerable.

The government released the White Paper on the National Health Insurance (NHI) in December last year for public participation. We have received many thoughtful comments. However, some recent newspaper articles have continued to dish out misinformation, distortions, hyperbole and Afro-pessimism, and attacked South Africa’s public health system. In writing this article, the intention is to put the dialogue back on a responsible footing.

NHI is designed to finance high-quality, affordable healthcare for all South Africans. It will also help to control the exorbitant prices now being charged for private healthcare. The UN’s Sustainable Development Goal 3.8 of universal health coverage by 2030 states: “Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”

NHI will provide access to quality health services for all South Africans irrespective of socio-economic status. Currently, South Africa spends 8.5% of its gross domestic product (GDP) on health, which is comparable with most European countries. However, almost 59% of this spending goes towards the healthcare of only 16% of our people, meaning only 41% of our spending goes to 84% of our people. Today, 80% of specialist physicians service only 16% of the population.

The concept of comprehensive health insurance regulated by the government is not new to South Africa. Care based on patient needs, state-regulated prices and a tariff commission established by the Minister of Health and led by a judge are features of the 1967 Medical Schemes Act designed for whites only. The NHI White Paper makes similar offerings, but this time not for whites only. It is interesting that a few critics find it objectionable when it is proposed that benefits be extended as mandated by our constitution. Some irresponsible people have said NHI is designed to destroy private healthcare. There is no intention to destroy private healthcare. All we are saying is that both public and private-sector health providers must be available to all. We are also saying that the exorbitant costs of private healthcare needs to be brought under control.

The National Development Plan, or Vision 2030, implores us to do so. How do I justify that two premature babies are charged R750 000 for lying in an incubator for only 10 days? What do I tell a man charged R300 000 for a pacemaker with a defibrillator when the provider of the device refuses to change the battery because the medical scheme has run out of money? The state health system had to change the battery for him. What happens to these unfortunate patients is not an exception, but has become the norm. When your medical scheme benefits are exhausted before the end of the year, you have to pay from your own pocket or be dumped on the public system.

NHI is going to abolish this inhuman practice and bring us in line with other mature democracies. Irresponsible critics also claim that the NHI is an attack on the middle-class. In fact, private healthcare costs are squeezing the middle-class. Medical scheme premiums are rocketing while benefits are declining, requiring more people to pay from their own pockets. Irresponsible critics also claim that providing NHI to all South Africans will be unaffordable and that the government will be incapable of coordinating it. But recent history contradicts these claims.

In 2002, many people said that it would be too costly to scale up HIV/AIDS treatment. Yet by combining all South Africans into one purchasing pool, we were able to make HIV/AIDS care affordable. Back then it used to cost almost R10 000 per person per year to buy first-line drugs to treat someone with HIV/AIDS. Today, it costs the government R1 728 per person per year.

The power of pooling has changed things for the better. Those who say it would be too costly to provide NHI, base their claims on high prices in the private sector, but NHI is simply not going to accept these prices and the present model of healthcare. By combining all South Africans into one purchasing pool and regulating prices, we can afford to insure everyone adequately. We welcome a vigorous discussion of our proposals but hope it will be based on factual evidence rather than scare tactics.

“We need all specialists to be available to the entire population and this can only happen if the pooling of funds to finance quality healthcare is done for the whole population and not just a select few.”
In just 10 years from now, South Africans could be paying significantly less for private health services. The healthcare system envisioned in the recently published National Health Insurance (NHI) White Paper, provides a detailed plan of reforms in both the public and private sectors to make affordable, good-quality healthcare accessible to all South Africans. Its implementation is likely to be complex, if not controversial, as have similar far-reaching overhauls of health systems in other countries.

Underlying rationale

Research indicates that middle-income countries, such as South Africa, that are implementing NHI type systems have benefited from a healthier population. The White Paper estimates that “a one-year increase in a nation’s average life expectancy can increase gross domestic product (GDP) per capita by 4% in the long run”.

In South Africa, only 16% of the population belong to medical aid schemes and have access to private medical treatment. The remainder of the population depend on the public sector for health services, which are often of a much poorer quality.

Speaking at the release of the White Paper, Health Minister Aaron Motsoaledi said “the existence of medical schemes in South Africa is a punishment for poor people” because 80% of the specialists in South Africa work in the private sector where they treat only 16% of the population — about eight million people. Motsoaledi also pointed out that health service prices in South Africa are very close to those of the United States, which has the most expensive healthcare system in the world.

Implementation timelines

Although it has taken four years since the publication of the Green Paper for the NHI White Paper to be released, the Department of Health is determined to introduce the scheme. The NHI is being implemented over a 14-year period, which will be divided into three phases.

The first, which started in 2012 and is due to run until 2017, will see the NHI “tested” in 11 health districts. The main focus of the pilot scheme is to fix the system and lay the foundation for the NHI. Since 2012, several reforms have taken place, such as, the introduction of the integrated school health programme, district clinical specialist teams and the establishment in 2013 of the Office of Health Standards Compliance. More than 300 private general practitioners have been contracted to work in government clinics in the pilot districts. But there is still a lot of work to be done, especially in the NHI pilot districts, where there are still reports of systemic failures.

The second phase, which is due to take place over five years between the 2017-2018 and 2019-2021 financial years, will see funds from the Compensation Fund and the Road Accident Fund being redirected to the NHI Fund. Subsidies paid to medical schemes by government departments will also be allocated to the fund, which is due to be fully functional by end of this phase. The registration process for people who will be covered by the NHI will start in this phase, with “vulnerable groups” given priority.

The third and final phase will take place over four years, between the 2021-2022 and 2024-2025 financial years, when a mandatory contribution in the form of taxes will be enforced. The NHI Fund will contract private hospitals and specialists to provide services where the government is unable to. By 2025, medical aids will only provide top-up cover to pay for services, such as, elective cosmetic surgery that will not be paid for by the NHI.

Single health system

When the scheme is fully implemented, there will be only one health system. By using their NHI card, South Africans will be able to access health services from any doctor or clinic, public or private that is certified and accredited by the NHI. The scheme will provide a “comprehensive” package of health services, but it will not cover everything for everyone. All health care will be provided at the primary healthcare level, and hospitals and specialists will only be for referrals. Though it is yet to be finalised, the basic NHI package will cover the following services: HIV and tuberculosis, reproductive healthcare, optometry and mental health.

While considerable progress has been made thus far, implementing reform on this scale is a mammoth task, and one which requires skills, resources and leadership.

By Ina Skosana, Mail and Guardian
PAVING THE WAY FOR THE NHI

uMzinyathi Health District is a one of KwaZulu-Natal’s three, and the country’s 11, National Health Insurance (NHI) pilot sites. The district is thus at the forefront of rolling out the Primary Health Care (PHC) Re-engineering strategy, a timely and useful tool for improving health outcomes and furthering the intentions behind the NHI.

The National Department of Health (NDoH) adopted a three-stream approach for implementing the strategy, and later on, a fourth stream was added as a way of increasing medical coverage:

1. Creating a Ward-Based Outreach Team (WBOT) for each electoral ward
2. Strengthening the School Health Services (SHS)
3. Establishing District-Based Clinical Specialist Teams (DCSTs)
4. Contracting General Practitioners (GPs) to work in the PHC facilities

In the first stream, the District’s PHC Outreach Teams are a vehicle for community-based interventions, making optimal support for these teams a worthwhile contribution to promoting self-reliant communities. The Outreach Teams extend the focus on the vulnerable sectors of society – women, children, the elderly and people with disabilities.

Although the second stream’s SHS concept goes back to 1993, the formal School Health Policy was only adopted in 2003. Now new impetus resulting from the inclusion of SHS as one leg of the PHC Re-engineering strategy has allowed for dedicated staff to be assigned to servicing the Integrated School Health Teams (SHT) approach.

Implementing the third leg of PHC Re-engineering strategy in uMzinyathi is progressing slowly. District Clinical Specialist Teams comprise seven specialists – paediatrician, anaesthetist, paediatric nurse, family physician, advanced PHC nurse, obstetrician and gynaecologist, and advanced midwife. To date, three professional nurses – an advanced midwife, a paediatric nurse and a PHC nurse – have been appointed, but as yet, no doctors. Recruitment is being done centrally by the provincial office.

The Umzinyathi Rural Spread

uMzinyathi Health District is situated in an under-developed environment with limited economic growth. The district comprises four local municipalities, namely, Msinga, Nqutu, uMvoti and Endumeni.

According to the District Health Information System’s 2013 mid-term estimates, the district’s population of 514,217 people (4.9% of the province’s total population) resides in 8,079 square kilometres (sq. km) (8.6% of the province’s total area). This reflects a relatively low population density of around 64 people/sq. km. The proportion of the district’s population with medical scheme coverage is estimated at 7%.

In the more rural sub-districts (Msinga and Nqutu), however, the density is markedly higher (84 and 71 people/sq. km) than in the other two sub-districts that have large areas covered by commercial farms. Of the district’s total population, 13% are children younger than five years and 7% are aged 60 years and older.

Nqutu sub-district ranks as the most deprived on a national scale, while Msinga and uMvoti sub-districts rank 21st and 41st of the country’s 232 municipalities. Endumeni sub-district, with the smallest population but the largest economy of the local authorities in the district, focusing as it does on the main urban areas of Dundee and Glencoe, ranks 184 in the Deprivation Index, or 45th up the scale towards the least deprived.
Aspects Of Umzinyathi District’s Phc Infrastructure

Table 1 reflects a breakdown in each sub-district of the number of wards, the number of clinics with their associated WBOTs and Community Caregivers (CCGs), and the number of Quintile 1 and 2 schools with the associated number of SHTs. The WBOT and SHT members serve full-time on the outreach teams and, although they are operationally attached to the clinics, they do not have in-house clinical duties. The leaders of the two ward-based teams report to their local clinic’s operational manager. The allocation of CCGs to WBOTs varies according to the number of homesteads in the ward or the clinic’s catchment area.

Table 1: Breakdown of wards, health facilities and schools per sub-district, with the number of teams available per sub-district

<table>
<thead>
<tr>
<th>Sub-district</th>
<th>Wards</th>
<th>Clinics</th>
<th>WBOTs</th>
<th>CCGs</th>
<th>Quintile 1 &amp; 2 schools</th>
<th>SHTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endumeni</td>
<td>6</td>
<td>8 + 2 mobiles</td>
<td>5</td>
<td>67</td>
<td>57</td>
<td>5</td>
</tr>
<tr>
<td>Msinga</td>
<td>19</td>
<td>15 + 3 mobiles</td>
<td>4</td>
<td>238</td>
<td>173</td>
<td>6</td>
</tr>
<tr>
<td>Nqutu</td>
<td>17</td>
<td>14 + 4 mobiles</td>
<td>5</td>
<td>134</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
<td>uMvoti</td>
<td>11</td>
<td>12 + 3 mobiles</td>
<td>1</td>
<td>83</td>
<td>74</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>49 + 12 mobiles</td>
<td>15</td>
<td>522</td>
<td>398</td>
<td>21</td>
</tr>
</tbody>
</table>

Particular Health Challenges In Umzinyathi District

The following health challenges were highlighted as far back as 2014:

- **High teenage pregnancy rate** 10%, increasing every year (SA target 6.9%)
- **Low ante-natal care attendance before 20 weeks** 60%, instead of 75% and more
- **Increasing still birth rate** 18.4/1 000 total births (District was 18.0/1 000 in 2012/13)
- **Increasing early neo-natal death rate** 11.4% (District was 7.5% in 2012/13)
- **Low immunisation coverage** 77.2% (SA target 90%)
- **Increasing HIV prevalence** 30% (District was 24.6% in 2011/12)
- **Increasing case fatality rate for diarrhoea in children under 5 years** 5.6% (SA target 3.8%)
- **Increasing case fatality rate for pneumonia in children under 5 years** 6.1% (SA target 3.4%)
- **High case fatality rate for severe acute malnutrition in children under 5 years** 12.7% (SA target 11.4%)
- **Patients bypassing PHC facilities to hospital** 70%
The Pros And Cons Of Being An NHI Pilot

The European Union funded the acquisition of three Outreach Team mobile clinics for the uMzinyathi District – one for an eye care outreach programme, one for a dental health programme and the third for generalised PHC work. The first two specialised mobile clinics deliver eye care and dental services to the schools in the sub-districts during the week. The PHC mobile clinic renders comprehensive PHC services to the sub-districts, including medical male circumcision campaigns.

As an NHI pilot site, the district receives a grant from the NDoH to ensure delivery in five prescribed outputs. The first of these five outputs is ensuring that existing municipal WBOTs are equipped to collect relevant data from households. The second output deals with monitoring and evaluation, including assessing the impact and effectiveness of the existing municipal WBOTs activities. The third requires monitoring and evaluation of the direct delivery of chronic medication to patients that is undertaken to support efficient and effective provision of health services within the district. The fourth output promotes the application of ‘lean principles’ for supply chain management relating to the ‘non-negotiables’, or essential acquisitions. Lastly, the fifth output requires the district to develop capacity for district-wide monitoring and evaluation, including researching and then reporting on the impact of the district’s selected interventions.

Since the WBOTs and SHTs are expected to work independently in the field, the vision is to develop a new cadre that is strongly community-orientated and able to resolve issues ‘out there’. Training conducted by the University of Pretoria’s School of Public Health has built the outreach teams’ capacity with the expectation that this will ultimately translate into self-reliant communities. In preparation for NHI, managers have undergone training in leadership, governance, supply chain management (SCM), diversity management, customer care, financial management and budgeting, as well as other clinical training, including emergency care. The district’s physical infrastructure has been improved through building a number of clinics, such as, the Elandskraal Clinic in Msinga sub-district.
However, being an NHI pilot site also has its challenges. The district is expected to be innovative in its approach to rolling out universal healthcare, yet the NHI grant is prescriptive and in some way restricts the very innovativeness that it is meant to promote. An example of this is the procurement process. Part of the NHI-preparedness training dealt with the procurement processes and left the district leaders wanting to try out new purchasing methods. The SCM processes, however, still follow the same route, which often delays the delivery of what has been ordered and results in under-expenditure on the budget. Revisiting the district regulations has not provided any solutions, since districts have an authorising ceiling (cut-off) of R200 000 and procurement for amounts exceeding this, are done at provincial level.

Reflections On The Ward-Based Outreach Teams

uMzinyathi District’s first WBOT was created in July 2012, working from Mpathe Clinic. Since then, the number of teams have risen to 15, operating from 15 clinics and serving 17 wards. In uMzinyathi District, the WBOTS are also called Family Health Teams, which emphasises their focus on providing services to communities, families and individuals at community-based institutions (such as drop-in centres) and at household level.

Each WBOT comprises a Team Leader, who is a Professional Nurse, an Enrolled Nurse and six to 12 Community Caregivers. The activities of the WBOTS include:

- Providing health talks on preventing disease and promoting good health
- Assessing the family members’ health and social situation, diagnosing health problems and, where appropriate, referring household members to the relevant partners
- Encouraging pregnant mothers to book early (pre-20 weeks) for antenatal care and conducting the procedurally-stipulated postnatal visit
- Checking children’s Road-to-Health cards, their immunisation details, monitoring their growth (using mid-upper arm circumference and weight), and checking for administration of vitamin A and Zentel (a deworming medicine for children)

The WBOTS approach and message varies depending on age group. The WBOTS strengthen teenagers’ understanding of family planning, Pap smears, HIV counselling and testing (HCT) services, TB screening, and recruiting young males for medical male circumcision. When interacting with adults, the team members focus on screening for chronic disease and for monitoring treatment adherence, screening for HIV and for TB, while using the opportunities arising from household visits to trace chronic medication defaulters.

On the community and stakeholder front, WBOTS attend Operation Sukuma Sakhe ‘war-room’ meetings, supporting interventions where applicable, plan and execute awareness campaigns, promote sustainable support groups, support Phila Mtwana centres, support luncheon clubs and refer issues to the relevant government departments. Since 2012, the outreach into the communities by all the teams has yielded impressive results. As at the end of Quarter 3, 2014, a total of 18 307 community members (of which 35% were under-5 children) have been seen in 3 048 homesteads. A total of 73 defaulters were traced during the visits and 2 636 community members were referred to their closest clinic for attention regarding non-communicable diseases.

Achievements ascribed to the successful implementation of the WBOT concept include the initiation of a ‘Household Champions’ programme, which aims at supporting households to become health-orientated and self-reliant. The concept of the Household Champion is to identify a person in the household who is health-orientated and is capable of looking after their entire family. This can be anyone, including a brother or a father, who is well-versed with the family members’ lives. uMzinyathi has identified 200 household champions thus far – 50 in each sub-district. Capacity-building has been completed for 117 of them.

The WBOTs continue to pass information on different health issues to them, thereby building the pool of knowledge. The district is visualising families that are self-reliant and ultimately, self-reliant communities.

Household champions undergoing training

The WBOTs achievements are often tempered by challenges in the field, limiting the teams’ capacity to achieve at a level that matches their commitment to the task. Insufficient or inappropriate vehicles, commonly together with poor rural roads and mountainous terrain, can make reaching specific homesteads an arduous undertaking.

Conditions of dire poverty in some homesteads take an emotional toll on the team members, even leading to them on occasions reaching into their own pockets to effect immediate relief. Food insecurity in some homesteads has been found to negatively affect treatment adherence as the instruction
is that medication must be taken with food. An unusual and unintended effect of the teams taking the health services to the people is that this has, on occasions, led to a delay in community members linking with and seeking health services from their local health facility.

**A Lesson In Health**

In the uMzinyathi Health District, 42 schools have acquired the status of “health-promoting schools”. The Integrated School Health (ISH) programme aims not only to promote the absence of disease but to ensure a state of learners’ complete physical well-being.

Since 2012, learners in Grades 1, 4, 8, 10 and 12 have been undergoing physical screening, while the SHTs conduct only physical assessments for the rest of the learners. Specialised interventions, such as, administering tetanus, diphtheria (Td) vaccinations to 6- and 12-year-olds and deworming and vitamin A booster shots for Grades R and 1 learners, are an added responsibility of the teams. Those learners requiring specialised management – such as, dental care – or who are experiencing social problems, are referred to the appropriate authority. Where cases appear to reflect issues at household level, the SHT conducts a home visit to interview the learner’s parents and where appropriate, formally refers the case to the linked WBOT.

The team’s Mobile Eye Clinic has identified allergic conjunctivitis as rife among 50% of the children screened and 6% have presented with refractive errors.

The incidence of teenage pregnancies is rising in the district and is currently recorded at 10.5%, reflecting the proportion of women younger than 18 years to the total number of deliveries in public health facilities (mostly hospital-based). The scenario of high teenage pregnancies is exacerbated by the pregnant girls failing to disclose their status, with the result that few of them book for antenatal care before 20 weeks, thus forfeiting the chance for optimal medical care in cases that are often already compromised.

As with the WBOTs, the SHTs work closely with other stakeholders promoting health and well-being, such as government departments, NGOs, the South African Police Services and Operation Sukuma Sakhe forums for cases to be referred, the relevant local municipalities and the South African Social Security Agency that manages social grants.

Finally, the SHTs work closely with the “ground-breakers”, a group of young men and women who are placed in 15 clinics where there are SHTs with the aim of encouraging healthy behaviours among the youth. The concept of “ground-breakers” is an innovation of uMzinyathi District and is based on a LoveLife strategy. The “ground-breakers” receive a stipend of R1 400 and their contribution is measured by the increase in the uptake of HCT and family planning at the clinic from which they work.

Practical issues, such as the learners’ parents not returning consent forms giving permission for ISH procedures, the learners’ Road-to-Health cards not being available, and the lack of facilities to accommodate private consultations with the learners, all add to the challenges experienced by the SHTs.

The work of the SHTs is underpinned by the maxim that “healthy learners leads to good performance and good results”.

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**School Health Teams’ mobile clinics in action**

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**NATIONAL HEALTH INSURANCE**
Status of NHI Pilot districts

The summary below is an edited excerpt from the 2014/2015 “Status of NHI districts” report of the National Department of Health (NDoH). Since the report was published a while ago, it ought to be read with caution as some of the details may have changed.

There has been significant and encouraging progress in almost all NHI related activities. Most important to note, is the continuing expansion of pilot activities and activities focussing on strengthening of the general public health system. New activities such as e-health strategies, distribution of medicines, expansion of school health and the introduction of human papilloma virus HPV vaccine among young girls and the introduction of a Diagnosis Related Groupers (DRGs), show positive signs. The introduction of OPERATION PHAKISA for the expansion of the ideal clinics initiative is another encouraging development, which will see a country-wide rollout in the 2015/16 financial year.

The introduction of an Independent Service Provider (ISP) for the contracting of general practitioners (GPs)/doctors has seen a rapid expansion of the number of public health clinics (PHC) facilities now serviced by doctors. The current level of staffing allows the PHC facilities in the nine NHI pilot districts to provide an additional 1.5 to 2 million doctor consultations per year. Assuming an average rate of PHC clinics visits of 2/annum, this means up to one million South Africans now have ready access to a GP.

There are some areas that require dedicated focus or enhancement, such as, quality of infrastructure and infrastructure development as a whole. It must be noted that decreased budget allocations threaten the impact and potentially might regress some gains made during 2014/15.

Achievements

• In 2014/15, all districts reported integration, coordination and alignment between District Health planning and implementation with that of the NHI pilot activities. This is a significant improvement over the previous financial year, 2013/14, where only six out of 10 districts reported integration of the NHI pilot activities into routine District management planning and implementation.

• All districts indicated that they have plans for infrastructure improvements. All districts continue with variable results - mostly poor scores for PHC facilities and slightly better scores for hospitals being achieved in most pilot districts.

• As with the 2013/14 assessment, districts report that referral mechanisms are in place in all pilot districts.

• District Clinical Specialist Teams DCSTs have been established in all pilot districts.

• In an environment where there is a lack of specialists available to take on these roles, especially in deep rural areas, the NDOH and National Treasury have agreed to expand the scope of GP contracting to include the DCSTs as part of the funding conditions.

• Currently the DCSTs, even though their scope has largely been in the Maternal, Child and Women’s Health area, can only support a portion of the district facilities, with a focus on neonates and maternal deaths being addressed.

• A key change from the previous assessment was the largely successful implementation of HPV. Data from the districts and the NDOH show that more than 95% of the targeted number of girls were reached, averaged across two outreach activities during April/May 2014 and September/October 2014.

• The introduction of an ISP to recruit and place GPs in facilities has significantly increased the number of GPs to just over 300. The service provider has access to a further 300 doctors in the recruitment pipeline.

• During 2015/16 the intention is to supply a minimum of 180 000 hours to clinics in the nine pilot districts. This means that between 1.5 to 2 million visits will be made by GPs under this initiative, translating into almost one million people having access to doctors at a PHC level.

• The Central Chronic Medicines Dispensing and Distribution Programme (CCMDD) is currently being rolled out in 10 districts, as well as in two hospitals that are not in the NHI districts.
Concerns

- There is a significant disconnect between district teams and the NDOH on the implementation, scope and timing of the projects. This has narrowed in the past 12 months but continues to be a serious concern.

- There are significant differences in the NHI management structures. All pilot districts have appointed or have proxy NHI coordinators, at both the provincial and district levels.

- The NHI conditional grant continues to be used on the procurement of equipment. However, only 55% of the spending is on medical equipment.

- At the NDOH level, there is a strong view that the conditional grant should be transformed and reprioritised to be of greater strategic value. The officials at the National Treasury are also supportive of the view that this grant should be used to support the Ideal Clinic rollout.

- The extremely poor coordination of infrastructure spending between the National Health grant managed by the NDOH, the provincial grants for Infrastructure Revitalisation and the small amounts of the NHI conditional grant spent on infrastructure:
  ✓ All district managers indicated that they did not know what the National Health grant infrastructure money was being spent on.
  ✓ In addition, there was no involvement in the planning of the use of the grants. Two districts indicated that both the province and NDOH had plans to refurbish the same clinic, which was already upgraded through the supply of park-home structures from the Development Bank of South Africa (DBSA) using European Union (EU) funds.

- Access to transport and vehicles are major constraints to the Emergency Medical Services EMS and school health programme.

- There are many concerns that remain around the GP contracting initiative, including: (a) GP placement vs. need; (b) Monitoring of impact and (c) Introduction of performance framework.

- The ISP has supplied data on the placement and utilisation of GPs, including data on patients being seen. This data is currently still being evaluated, but was not supported with similar data from the GPs on the NDOH contract.

- The NDOH should conduct an assessment of the value and benefits of the GP contracting programme.

- The contracting of allied health professionals has not yet started.
EYE HEALTH CARE TAKES A LONG VIEW

The NHl provides a favourable platform for primary to make a meaningful contribution towards the envisaged new Primary Health Care (PHC) approach in South Africa, writes DR LAWRENCE SITHOLE.

The South African government has embarked on a process of transforming the state of health care services through the introduction of the National Health Insurance (NHI) in South Africa. The aim of this transformation is to promote access to health care among all South African citizens irrespective of their ability to pay for health care needs, in the hope of increasing utilisation of health care services for better health. The NHI therefore provides a favourable platform for primary eye health care practitioners, such as, optometrists to make a meaningful contribution towards the envisaged new Primary Health Care (PHC) approach in South Africa.

The introduction of the NHI is important because the state of health care and health care systems in South Africa is currently presented with major challenges, such as, poor infrastructure, inadequate human resources, inequalities in funding and poor governance. Unfortunately, these challenges are as a result of the health care system used during the era of apartheid in South Africa. During this era, health care services were racially based with more resources allocated for the white minority and less resources allocated for the black majority. The end result was a health care system that was curative in approach, thus increasing the burden of diseases among South Africans. Also, the system encouraged the formulation of two separate health care systems, namely, public health care facilities for the poor and private health care facilities for the rich. Consequently, after the dawn of democracy in 1994, the new government, under the auspices of the late former President Nelson Mandela adopted a dysfunctional health care system that was detrimental to the people of South Africa. Unfortunately, these proceedings have a direct consequence on how eye care services are currently being delivered in South Africa. Eye health care services are also divided into public eye health care for the majority of the population and private eye health care for the minority of the population.

In the light of these unfortunate circumstances, the African National Congress (ANC) recognised the need for a complete transformation of the public health care system and thus developed a National Health Plan (NHP) to redress the imbalances brought by the apartheid system. The first draft of the NHP was initiated by the Department of Health of the ANC together with the Word Health Organisation and United Nations Children’s Fund in 1994. The document adopted a primary health care approach and also involved the Reconstruction and Development Programme, including all sectors of government. Thus, this document became the cornerstone of health development perspectives that were integral for the socio-economic development of the people of South Africa. As a consequence of the NHP, the NHl has been proposed for implementation as documented in the Green Paper released on the 12 August 2011. Through the NHI, there is hope that eye care delivery in the public health sector will be improved and it further creates an opportunity for new regulations to be developed on how eye care services should be delivered in South Africa at PHC level.

According to the South African Department of Health, the NHl will be implemented in a period of 14 years and in three phases. During the implementation phases, the NHl will cover five key areas that are integral to its success. These key areas will also have a direct bearing on how eye care services in South Africa will be delivered and include the following:

Service provision

The provision of services is directly linked to accessibility and availability. The accessibility of services is linked to the availability of proper infrastructure development whereas the availability of services may be associated with the presence of medical equipment and human resources. The NHI Green Paper, and more recently, the White Paper, seeks to address these issues for the successful implementation of this initiative. Therefore, this has a direct consequence on the provision of eye care services for the people of South Africa in that health services provision also refers to the availability of human resources, such as, ophthalmic nurses, optometrists and ophthalmologists (It is important to note that there are 532 ophthalmologists and 4 874 optometrists registered with the Health Professions Council of South Africa, of which only 70 and 239, ophthalmologists and optometrists respectively, are working in the public health care system). The NHl will need to ensure that primary eye care practitioners, such as, optometrists and/or ophthalmic nurses are available in the primary level of care or optometrists in the private sector are contracted to the NHI to offer services to the general public.

Population coverage

According to the NHI White Paper, the system will seek to improve access to quality health care for the entire population and also provide financial risk protection against health-related catastrophic expenditures. It will entail provision of health care without making payments, thus making health care service freely available. The system will also create fairness in the sharing of health care finance and other resources including skilled health care professionals, such as, ophthalmic nurses, optometrists and ophthalmologists. Unfortunately, the roles of ophthalmic nurses and optometrists in the NHl are not yet clearly defined, whereas it is expected that ophthalmologists may be placed at a tertiary level of care and will see patients as per the referral system that will be adopted. It is therefore expected that more ophthalmic nurses will be trained in order to meet the PHC requirements for the NHl and that optometry as a profession will duly be recognised in terms of the scope, as defined in terms of the Government Gazette No. 29748 of 2007, Regulation 2 and as amended in Government Gazette No. 33546 of 2010, Regulation 2.

The Act states that an optometrist is deemed as a primary health care professional whose responsibilities include the performance of eye examinations on patients with the purpose of detecting visual errors in order to provide clear, comfortable and effective vision; and the correction of errors of refraction and related factors by the provision of spectacles, spectacle lenses, spectacle frames and the supply and fitting of contact lenses to the members of the public, and the maintenance thereof, and the provision of vision therapy to members of the public and the use of scheduled substances as approved by the Board and the Medicines Control Council or by any means other than surgical procedures.
Interestingly, the Medicines Control Council of South Africa (MCCSA) has recently approved the use of scheduled substances for diagnostic and therapeutic purposes in optometry and further training is underway. This may be seen as a sign that the NHI will provide optometry with a platform to execute its responsibilities to cover the majority of South Africans, even at PHC level. Although optometry is currently largely private, those interested in joining the NHI to serve the public will do so voluntarily, as will be the case with the rest of the other health care professions.

Furthermore, as the NHI will ensure equitable resource provision to both private and public health care sectors, primary eye care services and possibly visual aids acquisition, such as, spectacles, contact lenses, low vision devices, etc., will be directly funded by the NHI with no co-payments, much to the benefit of the population. However, it is important to note that the NHI will adopt a capitation system, therefore, expensive assistive devices (e.g., high cost spectacle frames) will not be covered and in such cases, the patient may have to make a co-payment.

In addition, the system will also adopt a sound referral system from primary to tertiary level of care. Because the focus will be on health promotion, the system will use family health teams that will provide home-based care services where necessary. Those patients who may require primary health care at a community clinic level will then be referred by a member of the family health team. The composition of the family health team will be determined by a system that will consider the kinds of health risks that affect a given community. Most importantly, the family health team is likely to also focus on eye health care at a household level. However, it is important to recognise that the NHI approach will be based on the PHC system, as recommended in the District Clinical Specialist Teams (DCSTs) report. It will be composed of experts in the clinical disciplines, such as, obstetrics and gynaecology, paediatrics, nursing, family medicine and public health. Therefore, the composition of the family health teams is likely to be similar to the DCSTs, thus possibly leaving eye care practitioners out of the system at a community level.

**Financing**

All citizens will contribute to the fund and those who choose to remain contracted to private medical services will do so at an additional cost. Thus belonging to both the NHI and a private medical scheme may not be possible due to the high costs involved. Therefore, all South Africans, regardless of creed, gender, race and social status will be compelled to contribute to the scheme. However, low income earners, as may be determined by the finalised funding model, will be exempted from contributing into the NHI.

**Governance**

The NHI White Paper recognises the importance of strengthening governance in the public health care system. It recognises that public health care facilities require a complete overhaul to meet the proposed standards of the NHI. Therefore, in order to improve the functioning systems of the public health care facilities, radical changes in management and administration of community health centres and hospitals have to be made. Issues of funding, staffing and poor patient-doctor ratio should be drastically improved through proper management and administration in health care institutions. This will then eliminate problems such as those that existed in the Northern Cape Province where there were no optometrists in the public health care system by the year 2013 and only two optometrists were available in the public health care system of the Western Cape Province in the same year. Such a lack of these important role players in primary health care will not meet the operational standards of the NHI, if governance structures surrounding this problem are not improved.

**Institutional arrangements**

Every institution will have to comply with core basic standards as may be outlined by a watchdog body called Office of Health Standards and Compliance (OHSC) that has already been established. The OHSC will monitor public health services and address complaints of non-compliance, while developing guidelines and providing information on the implementation of set health service standards. The OHSC will lead the much-needed improvement in health service quality, change in public health care management, and institution of core health standards in public and private service providers. This move will lay the groundwork for the rollout of the NHI initiative. Therefore, optometric clinics in both private and public sectors will have to meet certain set standards of compliance to participate in the NHI.

Interestingly, the South African Optometric Association (SAOA) is currently in the process of developing optometric clinical guidelines which may be incorporated into the standards and compliance requirements for optometrists to be contracted to the NHI initiative. However, proper systems must be put in place to ensure that the SAOA plays a major role as the custodians of optometric eye care in South Africa.

**Current progress**

The initiative has already started with a pilot project in 11 districts which was launched in April 2011 and covered every province, focusing on under-served communities. Also, a PHC platform is being established across the country, based on three complementary components:

- Ward-based PHC with 40 000 community health workers having been trained in the new PHC approach. It is possible some members of the community health workers may have adequate expertise in eye health care issues.
- School health services where mobile health care clinics will visit schools and focus on preventive and health promotion services aimed at reducing barriers to learning and promoting access to other services. There is hope that eye care professionals who provide services at PHC level will be part of the school health services.
• Establishment of DCSTs across all provinces. Over 43% of positions have been filled so far, and the induction programme for these professionals is underway. Unfortunately, eye care personnel are currently not included, as is the case with other important allied health care personnel that are vital for the success of the NHI at PHC level.

Challenges

The NHI initiative has received a considerable amount of criticisms before its implementation. In his response to some of the criticisms that compared South Africa with other international countries, such as, the United States of America (USA), United Kingdom (UK), and Australia, the Minister of Health, Dr Aaron Motsoaledi has painted a picture of the state of the South African budget for this initiative as compared to these international countries. In comparing these countries’ health expenditures, the Minister indicated that there is a need to first establish their Gross Domestic Products (GDPs), their total per capita expenditure and the cost of living in each country. According to the Minister, the critics compare the health costs of the USA, the UK, Australia and South Africa, but fail to point out that the GDP of the USA is $16 trillion (21.9% of the global economy), that of the UK is $2 trillion and Australia’s $961 billion (2.1% of the global economy), whereas South Africa’s GDP is only $576 billion (0.5% of the global economy). The total per capita expenditure on health in the USA is $11,000, that of the UK is $36,000, and in Australia it is $41,000. In South Africa it is $11,000. In simple terms, the American and Australian economies are five and two times the size of South Africa’s economy respectively. In using these figures, one can calculate that Americans spend only 6.6 times per capita a year more on health than the South African private health sector – regardless of the fact that the USA economy is a massive five times bigger than that of South Africa’s. In support of the Minister’s assertions, one study has reported that although the USA is the biggest economy in the world, some of the Americans were opposed to the implementation of the National Health System citing costs concerns. Based on these concerns, it is therefore expected that some South Africans may be worried about the costs involved in the implementation of this health care system.

According to this study, despite the reported criticism on the feasibility of the implementation of this initiative, the NHI is an idealistic proposition that has many other challenges to overcome. The first challenging issue may include spending of the budgeted allocations and poor infrastructure. For example, about five provinces underspent their budget allocations for the revitalisation of health facilities programme by nearly R2 billion in 2012. In addition, findings of a high-level audit has revealed that most health facilities in a certain province would have to close down once the current Norms and Standards Bill became law and would therefore not participate in the NHI due to non-compliance. In the same province, health institutions were already condemned but continued operating out of necessity with 168 clinics and 17 hospitals lacking piped water, and 42 health facilities had no proper electricity and operated on generators. Also, 68% of the hospitals lacked essential medical equipment and 16% of the facilities had no telephone lines and were accessible by road and only in good weather. Furthermore, overall staff vacancy rates stood at 46% (mostly clinical posts), requiring an unfeasible R9 billion extra to fill. Although the reported challenges are in this one province, it is possible that the situation may be similar even in some other provinces in South Africa. If this is the case, the NHI initiative will face insurmountable challenges to an extent that it may not be possible to implement.

However, it is important to note that the same province fares much better than most other provinces that have none or a very few optometrists in their health departments as shown in Figure 1.

Figure 1: Showing the distribution of optometrists in South Africa. The Northern Cape Province had no optometrists in the public health sector in 2013.

Conclusion

The details of how the NHI will be rolled out are still sketchy. The release of the White Paper has not shed much light on the implementation processes, including issues of human resources, financing and poor infrastructure. Furthermore, there still seems to be no adequate advocacy for eye health to be fully implemented as part of the NHI in the manner that eye health care professionals would expect. During the South African Optometric Association Conference held in 2014 at the Cape Town International Convention Centre, a Chief Director from the Directorate of Chronic Diseases, Disability and Geriatrics reported that the establishment of a new directorate for eye health care is on the cards. However, such a directorate and the once reported Health Minister’s advisory committee on issues of eye health care have not been established. It therefore remains to be seen whether the NHI will be fully implemented as envisaged in the White Paper and whether issues of eye health care will be incorporated into the entire system. Currently, eye health care issues remain in the periphery, despite efforts to overhaul the entire public health care system.

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THE PATIENTS’ CEO

Worldwide, Chief Executive Officers (CEOs) are a highly busy lot. And so, getting a very generous time slot on the already cramped up to-do-list of Frere Hospital CEO, Dr Rolene Wagner, is in itself a scoop. Dr Wagner, or “call me Rolene” - as she would later insist - is running late. From across her clutter-free desk, the Personal Assistant (PA), Nomakaya Mashiyi, relays apologetic updates on the CEO’s progress to the office.

Apart from the missing rows of chairs, the waiting area to the CEO’s office is similar to a General Practitioner’s (GP). Next to the bright coloured two-seater sofa, the glass of the small coffee table is typically adorned with well-thumbed magazines of various interests. But unlike other GP’s consulting premises, those flipping through the magazines are mostly not seeing the doctor with their own health in mind, but the health of Frere Hospital itself.

Taking flak

A couple of minutes later, Rolene walks into the office. The Frere Hospital CEO is of shorter stature than the picture that accompanies an article in this morning’s edition of the Daily Dispatch. The story is about the launch of East London’s first Mandarin Language Learning Centre, at which Rolene was guest speaker.

That the CEO also dabbles in Public Relations (PR) over and above keeping an ever-watchful eye on Frere Hospital’s vital signs is unsurprising. For a long time, the approximately 900-bed tertiary and academic hospital on the fringes of the East London business district had been attracting bad press like flies to a festering wound. At the time, everyone was extremely fed up with the degenerative state of affairs at Frere Hospital, and the press made this much clearer through the seemingly endless splashes of gory newspaper headlines.

In addition, the Office of the Public Protector and the Human Rights Commission had issued stern words following their visits to investigate complaints against the hospital.

“I was ‘klapped’ by the media for the first six months after taking over the position as CEO,” Rolene explains.

Now in its 135th year of existence, the goings-on at Frere Hospital are a big deal. Not only is the heritage hospital tightly woven into the social fabric of the region. Also, what particularly goes wrong at Frere Hospital goes beyond sentimentality for the 2.8 million people it continues to serve.

“Warm welcome”

Within Frere Hospital itself, tempers were equally palpable. In essence, the newly appointed CEO was knowingly occupying the proverbial “hot seat”. Worse still, being at the receiving end of the hostility of people who ought to be your team is something that most would find hard to bear.

Barely settled inside her new office, the new CEO could hear the hospital’s striking staff as they tried to shout their long held grievances over to management on the fourth floor (chief among the employees’ expressed grievances were the issues of owed salaries and other benefits). In hindsight and with every corner of Frere Hospital seemingly bustling with efficiencies, the CEO exudes a quiet confidence of one who has things under control. She jokingly refers to the strike by staff that she walked into on her first day at work - back in December 2012 - as her “warm welcome” into the Frere family.

“The irony was that the very same people who were out there striking, were the people that we really needed in order to turnaround the institution,” she thinks back.

Walter Canon, the acclaimed American neurologist, has described the typical response to a conflict situation in what is known as “fight/flight” reaction. Inside the troubled hospital the mood veered between frustration and apathy with no solution in sight. Instead, “there was a lot of blaming of each other as to why things were the way they were,” as the CEO recalls.

“I always say that there are two key points to any turnaround,” she explains, “you need a good plan, but also great people to deliver that plan,” she comments.

A “plan” Rolene certainly had. But more importantly, the medically trained CEO also had an impeccable private and public sector experience to see the turnaround of Frere Hospital through. She has held a number of high profile positions that included that of Chief Operations Officer for the provincial Department of Health. Her appointment to the position of Frere Hospital’s CEO in December 2012 was preceded by a stint in the private sector, where she turned a private practice from a lacklustre annual turnover of about R450,000 to approximately R3 million.

NATIONAL HEALTH INSURANCE

THE PATIENTS’ CEO
Inspiring leadership

On her first day at work, Rolene and her Executive Management Team (EMT) had remarkably mediated the resolution of the wildcat strike. Nevertheless, what the CEO describes as a “turnaround moment” was a small but significant start to what still lay ahead.

“How we managed the strike was going to make or break my team,” she concludes.

Though the strike was amicably resolved, the entire staff was utterly demoralised. Even the very EMT that was key to chaperoning the necessary changes at the institution was not faring any better. What the CEO realised was that she had to unleash the potential of the employees needed in her corner to be the “great people” that would carry out the mammoth task of re-invigorating the ailing hospital.

Given the highly emotionally charged workplace, the pervasive leadership and organisational cultures were characterised by units working in silos, if at all, as inertia was the order of the day, due to low staff morale.

An enthusiast of Emotional Intelligence (EI) approaches in management, the CEO had to lead her team (and organisation by extension) through the “forming”, “storming”, “norming” and “performing” phases. In the team building jargon, these respectively marked the stages when the individuals committed to the need for change, coalesced into a team and actively worked towards the attainment of the organisational turnaround strategy. Throughout these stages there were also doses of coaching and mentoring as well. As Rolene remarks, highly successful CEOs worldwide are distinguishable not only by technical capacity, but also by their ability manage themselves and others.

“We spend a lot of time as government recruiting and training. But we also need to spend some time thinking about how we engage our employees and how to inspire them, and that has been the focus of what we have done,” she explains.

One other “visible change” that was adopted under the leadership of the CEO was the flattening of Frere Hospital’s management structure. For example, the implementation of the “patient-centric” turnaround strategy meant that reporting lines and representation on the Executive Management Team had to be based on function and not rank. Accordingly, the various units would identify problem areas, analyse their causes and institute Quality Improvement Plans (QIPs) in their respective operational areas, such as reducing patient waiting time at the pharmacy.

Just three years into the implementation of the turnaround strategy, many of the vitals signs to Frere Hospital’s health are looking up. Not only is Frere Hospital now “the darling” of the very newspaper which first exposed the death of babies at the hospital in 2007. The East London based newspaper is now a critical but supportive documenter of the transformation journey.

Rolene remarks that any criticism (especially if it is constructive) is indicative of concerns that are expressed on behalf on patients. Accordingly, says the CEO, advocating on behalf of the patient is as important to the leadership of the hospital as it is to vocal stakeholders such as the media.

“The question is what can we all do to make sure that the interests of the patient are adequately taken care of,” she asks.

Looking back at the impressive changes at Frere Hospital over the past three years or so, Wagner emphasises that it is fair to also ascribe the milestones at the institution to the cumulative impact of some of the earlier interventions or policy shifts on the part of the provincial health department. For example, the delinking of the previously jointly managed and financed Cecilia Makiwane and Frere Hospitals (referred to as the East London Hospital Complex) played no small indirect part in the turnaround Frere Hospital.

In simple terms, it could be argued that the “de-complexing” allowed for the appointment of a CEO at Frere, which in turn became a crucial factor in the unfolding of the turnaround strategy at the institution. Moreover, some of the institutional and administrative autonomy created spaces for the kind of manoeuvring that did not exist before the delinking of the two hospitals.

That said, most of the available evidence squarely marks the period starting December 2012 as the de facto start of the turnaround and continuous improvement seen to date. Unsurprisingly, the date also marks the start of tenure of the CEO for Frere Hospital. The coincidence underscores the over-arching, and possibly the most important element of the turnaround strategy, which is inspiring leadership.

By Dudley Moloi
LEADERSHIP IN CHALLENGING TIMES
The Frere Hospital Turnaround Strategy

INTRODUCTION

This case study focuses on the turnaround strategy at Frere Hospital between 2013 to date. It does this by touching on the challenges at the time and measures the actual performance as set out in the various intervention projects that were implemented in response to these challenges. Much of the material that is contained in the case study is based on internal documents from Frere Hospital itself. Consequently, the case study does not purport to be a “review” of the provincial public health sector. Its ultimate intention is that of sharing lessons learnt with fraternal institutions in the public and private sector.

BACKGROUND

Frere Hospital, which is situated on the fringes of East London, in the Eastern Cape Province, is an 890 bed academic tertiary hospital with 1,090 employees. The hospital has an operational budget of R954 million and is responsible for the provision of specialised hospital services to 2.8 million people (44%) living in the central region of the Eastern Cape Province. Despite having the highest service outputs of all tertiary hospitals in the country, within the EC Province the budget allocated to Frere Hospital is the same as the other two, similar hospitals in Port Elizabeth and Mthatha.

In addition, the increased allocation for this year compared to the 2015/16 financial year, is less than the cost of inflation. In a sector where medicines and capital equipment typically escalates year on year by approximately 12-15%, this allocation and growth is inadequate to maintain the current service levels. Moreover, data captured during the first quarter of the 2015/16 financial year indicates a 22% increase in demand for Frere Hospital services compared to the 2011/12 figures.

It has been argued that the “partitioning” of South Africa just before the historic 1994 dispensation actually left the Eastern Cape with very little by way of administrative capacity and revenue base as these largely went to what now constitutes the Western Cape Province. The public health sector was no less hamstrung than other public service sectors in this largely rural province. The piling up of stresses (such as inherent administrative and human resources incapacies as well corruption) over decades had pushed the provincial health system to the highest levels of notoriety for which it is widely perceived.

PROBLEM ANALYSIS

Most symptomatic of these underlying challenges in the case of Frere Hospital was the national outcry over the high number of babies dying whilst in the care of the institution. This followed a 2008 expose in a local newspaper that had consistently detailed horror after horror from the beleaguered hospital. At the time, the atmosphere at Frere Hospital was one that was characterised by massive demoralisation on the part of both management and staff, which in turn fuelled deterioration in the overall quality of care offered at the institution.

In 2012 the then newly appointed Chief Executive Officer (CEO) found a management team that felt disempowered by the highly centralised bureaucracy. The team’s ability to creatively problem solve was weakened by low morale throughout the organisation. Moreover, a pervasive culture of blame apportioning made it impossible for the different functional units to collectively tackle the overall underperformance and the poor quality of health services.

TURNAROUND STRATEGY

An important exercise in the development of the turnaround strategy was the need for Frere Hospital to go back to the basics. The entire leadership and staff needed to reacquaint themselves with the mandate, the vision and mission of the hospital. The turnaround strategy itself had two broad operational focus areas:

1. To render patient-centred care that is safe, effective and reliable; and of a standard that satisfied the quality of care that patients expect, while addressing the increasing demand for services.

2. To improve operational efficiency by ensuring sound governance of lean operations that are driven by valued employees working in teams to continuously improve the effectiveness and efficiency of all operations; and effecting changes that were mission critical and visible.

Flattening Management Structure

Most urgent to the implementation of the turnaround strategy was the imperative to reconfigure the organisation’s management structure. The existing Executive Management Team (EMT) was typical in form and character to the reporting and decision-making structures in the public sector. Heavily rank-based rather than function-based, its hierarchical and bureaucratic nature not only stifled creative approaches to problem-solving but, also tended to water down the flow of information and responsibilities and thereby affecting the quality of management reports. It also undermined agency and accountability of those staff who were actually at the coalface of the hospital’s operations.
To redress these issues, representation on the EMT was consequently broadened in order to include those functional areas that would be critical to the turnaround strategy to be brought into the top management discussions and decision space. The “flattened” management team, for example, made it possible for an Assistant Director: Quality Assurance Manager to be part of the discussions and decisions that would directly affect their day-to-day work. The number of people on the EMT increased from five to eighteen who reported to the CEO monthly and at special project meetings.

Developing an Inspired and Skilled Team

The EMT has evolved through the forming, storming and norming stages to being a high performing unit focussed on achieving the desired results. The team is now a strategic think tank that is capable of:

- Critically anticipating and appraising challenges
- Developing appropriate, cost-effective solutions and thereby mitigate against risks and rapidly responding to emergencies, which was demonstrated when the EMT managed the water outage that was experienced by the Buffalo City Municipality in April 2016.

Continuous Quality Improvement Focus

All Frere directorates implement quantifiable quality improvement projects that are focussed on achieving the strategic goals. These are integrated into the organisational operational plans of each sub-directorate and into the performance agreements of each of the managers who report to the CEO. The implementation of these projects is monitored through internally developed performance dashboards.

Systems Approach

The reduction in death rates and complications were achieved through multi-pronged strategies that included the following:

SYSTEMS CHANGES

- Improved governance (both clinical and corporate) by introducing:
  - Relevant and appropriately constituted structures, such as complaints committees and clinical audits,
  - Automating systems (web-based performance dashboards) and
  - Introducing newer communication channels (Frere website and social media platforms such as Facebook and Twitter; quarterly newsletters)

REPRIORITISING THE BUDGET SO THAT CRITICAL INVESTMENTS COULD BE MADE TO DRIVE QUALITY IMPROVEMENT PROJECTS(QIPs):

- Appointment of critical staff, both clinical and support staff
- Optimising major infrastructure projects, state of the art Intensive Care Units (ICUs) and theatres with high-end latest medical technology; and modern, well-designed wards that provide a therapeutic environment for patients but also improves the working conditions of the staff
- Investment in appropriate capital equipment, for example, Digitised X-ray machines that increased the throughput from 35 patients per machine per day to 90 patients per day.

Of importance is that QIPs were identified on the basis of whether they would support improved patient outcomes and experience of care.

Prudent Financial Management

Despite having the highest service outputs of all tertiary hospitals in the country, the budget allocated to Frere Hospital is the same as the other two, similar hospitals in Port Elisabeth and Mthatha, within the Eastern Cape Province. While there has been an increase in the 2016/17 allocation compared with 2015/16 financial year, this is less than the cost of inflation. Also, in a sector where medicines and capital equipment typically escalates year on year by approximately 12-15% means that the current budget allocation is inadequate to maintain the current service levels.

The public sector seems to put a lot of emphasis on clean audit outcomes and cost cutting to ensure adequate controls exist and that scarce financial resources are utilised for the intended purpose. However, financial management at Frere Hospital tries to go beyond this narrow view of public sector financing to be more entrepreneurial in outlook, but without breaking the law. The difference between the public and private sector is that private healthcare organisations are geared towards making profit for shareholders, while the objective of the public sector health care is that of ensuring healthy communities and thus contributing to the country’s development agenda.

A key aspect to maintaining current service delivery outputs and improving the quality of the Frere service has been in the deployment of some creative approaches:

1. Increasing the income streams by expanding the contributions of donors and incubating revenue generation projects that leverage Frere’s competitive advantage in niche areas such as arthroplasty, oncology and paediatric services
2. Continuing the cost-savings project initiatives, maintaining the savings gained in the preceding three years. Managers are incentivized to implement cost-savings/efficiency projects because they can use the savings to offset their cost-pressures within their cost-centre or to invest in developmental projects in their units. The rest of the savings go into the kitty for the wider organisation to tap into
3. Decreasing inefficiencies and expanding efficiency projects, thereby optimising utilisation of the allocated budgets
4. Investing in appropriate technology platforms that will improve patient outcomes
5. Strengthening collaboration and supporting the development of the regional hospitals and primary health care services in the central region of the province to ensure appropriate utilisation of Frere Hospital Services.
KEY RESULTS ACHIEVED

A key element in the Frere case was a shift in mind-set as to what constitutes an achievement. It is not considered an achievement at Frere Hospital to have appointed staff or bought equipment. Rather it becomes an achievement when that input or process improvement results in better outputs and outcomes in terms of the organisation’s mandate. In line with the key strategic areas, the achievements of the Frere Hospital attributable to the turnaround interventions for the service delivery mandate (but excludes the academic mandate achievements in terms of teaching, training and research outputs) include:

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<tr>
<th>STRATEGIC</th>
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<tr>
<td><strong>IMPROVED PATIENT OUTCOMES</strong></td>
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<tr>
<td><strong>Reduction In Case Fatality Rates</strong></td>
<td>Sustained reduction in case fatality rates- from 5.88 deaths per 100 cases in 2013 to 4.1 deaths/100 at the end of the 1st quarter, with approx. 31% reduction in the total number of death rates:- Average death rates at SA hospitals purported to be 6, 1 deaths/100 cases/ Frere is moving closer to the our goal of 2-3 deaths/100 as experienced in first world countries</td>
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<td><strong>Increased throughput in the new, state of the art Intensive Care Unit (ICU)</strong></td>
<td>Increased throughput in the new, state of the art ICU’s by 86% whilst at the same time decreasing the total number of deaths by up to 59% in both adult and paediatric ICUs: - Highest quarterly death rates in Frere adult ICU in 2013/14 was 38% reduced to 19% in 2015/16. - Highest quarterly death rates in Frere paediatric ICU in 2013/14 was 32% reduced - First world ICUs where death rates average around &lt;25%</td>
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<td><strong>Decreased Hospital Acquired Infection (HAI) Rates</strong></td>
<td>Sustained and further decreased Hospital Acquired Infection (HAI) Rates with: - 45% reduction in overall HAI rate average of 2.72% at the end of 2015/2016 compared to 5% at the end of 2014/15, and well within the national norm range of 2,5-5% - 17% reduction in Paediatric ICU average HAI rate of 4,06% at the end of 2015/2016 compared to 4,9% at the end of 2014/15 - Sustained Adult ICU average HAI of 7% with insignificant month to month variations - Both ICUs averages are well below accepted international first class experience of 7-10% range</td>
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<td><strong>Reduction of Hospital Acquired Pressure Ulcers (bedsores)</strong></td>
<td>- 50% reduction of Hospital Acquired Pressure Ulcers (bedsores) from 38 per quarter at the end of the first quarter 2013/14 to 19 per quarter at the end of the first quarter of 2016/17</td>
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<td><strong>Reduction in the total number of patient falls</strong></td>
<td>- 30% reduction in the total number of patient falls from average of 11 per quarter in 2013/2014 to 7,75 per quarter in 2015/16.</td>
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<td><strong>IMPROVED EXPERIENCE OF CARE</strong></td>
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<td><strong>Reduction in total number of complaints</strong></td>
<td>- 47% reduction in total number of complaints received (115 for 2015/16 compared to 215 for 2013/14; 9% reduction from 2014/15’s 127) - Through the Quality Improvement (QI) initiatives driven from the office of the CEO, Patient Satisfaction of Quality of Care Improved significantly to 85% for in-patients and out-patients</td>
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<td><strong>Increase in total number of compliments</strong></td>
<td>79% increase in total number of compliments received (536 for 2015/16 compared with 299 for 2013/14; 52% increase to 2014/15’s 352)</td>
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<td><strong>Reduction in waiting times</strong></td>
<td>- Out-patient pharmacy from 4-6 hours in 2013/14 to under 45 - 60 minutes in 2015/16 - Radiography investigations (eg X-rays) from 2 hours in out-patients to 30 minutes at the end of 2015/16 and from 10 days for in-patients to 24 hours in the same period - Eliminated the backlog for wheelchairs by the end of 2015/16 through reprioritising budget allocations and - Reduced the average waiting period from the national norm of three months to same day receipt for standard wheelchairs</td>
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<td><strong>IMPROVED ACCESS TO TERTIARY SERVICES</strong></td>
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NATIONAL HEALTH INSURANCE
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| Improved access to tertiary services               | In response to the burden of disease and demand for service and the preparation for National Health Insurance (NHI), additional tertiary services were introduced. Frere Hospital now has the competitive advantage over the private sector in that the hospital has the only following full-time specialists in the central and eastern regions, both public and private sectors:  
  - Neurologist  
  - Paediatric oncologist  
  - Infection Disease specialist (adult and paediatric)                           |

**IMPROVED EFFICIENCY & EFFECTIVENESS OF SUPPORT SERVICES**

| Greater cost-effectiveness and efficiencies         | - 9% reduction in drug expenditure from R34,7million in 2012-2013 to R31,6 million at the end of 2015/16 DESPITE a reported year on year global market increase of between 12-15% per annum.  
  - Reduction in food wastage from just under 45,000 kg in 2014 to less than 5,000kg in 2015 |

**CONCLUSION**

Overall, the Batho Pele (putting people first) approach of strategically realigning all hospital activities with the provision and support of patient-centric services has resulted in the literal turnaround in patient satisfaction and public perception of the quality of Frere Hospital services. In putting people first, Frere Hospital had invested and deployed appropriate interventions to ensure that the institution does indeed deliver on the mandate of being an academic public sector tertiary hospital.

However, most critical of the success factors have been in the area of leadership rejuvenation and team building. Just over three years ago both staff and management were utterly demoralised, which naturally showed in the quality of services outcomes at the institution. It was only after considerable effort at developing an “engaged and inspired” leadership and one that is focused on managing service delivery objectives that the wheel of the change began to turn in earnest - in management speak, the Flywheel effect.

Today, Frere Hospital boasts of a highly skilled and motivated workforce that continues to work together as a team to deliver on agreed performance targets and are rewarded for their achievements. The managers have undergone a paradigm shift because they realise that every investment- whether staff or capital equipment- must result in an improvement in outputs and/or outcomes in terms of the organisational mandate. So, if the hospital is in the business of saving lives, then the lives saved must be measured and monitored. If it is an objective that patients must be satisfied with the experience of care at Frere, then progress with achieving this objective must be measured and monitored. Interventions cannot occur in isolation; the impact of these interventions must be measured to ensure the desired goals of the intervention are achieved.

As a result of the turnaround, Frere Hospital has been invited by the National Department of Health (NDOH) and Lean Institute to partner with them and Groote Schuur Hospital in developing a clinical leadership programme for the country. In addition, the Frere initiative of developing emotional and social intelligence of the EMT has been recognised by NDOH, Health Partners SA and the Albertina Sisulu Executive Leadership in Public Health (ASELPH) programme – a partnership between Harvard, Fort Hare an Pretoria Universities. Furthermore, Frere Hospital is being proposed as a pilot with respect to emotional and social intelligence modelling for the strengthening of a national programme for leadership development in the health public sector.
NOLITHA PETER shares her experiences after spending a day at Frere Hospital where she had taken her mother for medical attention.

My story begins on the day that we had just buried my Makazi (that is my mom’s younger sister) in April this year. My mom, who is 85 old, fainted during the church service and was taken to a hospital in King William’s Town where she was given a drip and stabilised. We learnt that she had low blood pressure and was advised by family friend, who is a medical doctor, to take her to Frere Hospital in East London for more tests that Monday… and this is my (our) experience.

When we entered the gates of the hospital, we were assisted by security guards who were not only friendly but helpful. Just refreshingly nice! Remember, I was here ready to do battle and all defences fully charged knowing that I was at a government hospital, right? My experience was contrary to my expectations. They allowed us access to the ambulance drop off area and gave us clear directions to where we needed to go to. So, we moved along to the ‘ECHO’ section for the first tests, as directed. The staff were friendly and things were fast and computerised. Wow! Very nice indeed!

They guided us to the X-ray section which was packed. There was a notice on wall that read, “Waiting time: 30 minutes.” We could not believe that we waited only 10 minutes and when we were done, the rest of the room was totally cleared. The technician was really nice and easily adjusted the machines for my mom who was in a wheelchair and couldn’t stand on her legs at all. It was just too uncomfortable to place my mother on the stretcher in the previous exam room. She takes her shots and we are patiently guided to the next post, where we go to have bloods taken. Another lovely young nurse does her part so dutifully and within five minutes, we are done (including a profuse apology for forgetting to take a third sample). There was no queue there, so the nurse tells me she that she’s actually getting bored! She calls a porter to wheel Mama to Electrocardiograph (ECG).

What an eye-opening experience, and one that I will not forget. This kind of treatment would have cost an arm and a leg in a private hospital. Members of staff whom I’d spoken with, proudly told me that the real champion in this hospital was the Chief Executive Officer (CEO).

You know, the best part is, as you’re waiting on passages, any random worker will ask ‘hello, have you been helped?’ It is great to know that there are definitely some people who are making a positive difference in our country and we salute them.
Office Spaces

Creating the ideal workplace environment in which the needs of both employers and employees are considered and respected does not have to be a zero-sum game, argues ISMAIL DAVIDS, Director: Productivity & Efficiency Studies, Department of Public Service and Administration.

Open-plan offices have been with us since the early 1900s, thanks to modernist architects, such as, Frank Lloyd Wright, who favoured the design of large, spacious work areas. The original idea behind open-plan offices was a logical one: by creating an open and egalitarian work environment where employees are free to communicate, collaborate and share ideas with each other, organisations would hopefully foster innovation and boost employee effectiveness and collegiality. These benefits considered, the open-plan office revolution was almost inevitable and thus came swiftly – walls were razed, cubicles collapsed and light streamed in. But this much favoured design strategy – which eschews architectural dividers, rows of cubicles and private offices – have recently come under fire from productivity researchers and office workers alike, citing the negative effects of working in open-plan offices. These include concerns about noise, privacy and general wellness. And justifiably, the news media has caught on to this global backlash against open-plan office layouts.

Most employees loathe open-plan office layouts

In the UK, The Guardian headlined a report stating that ‘Open-plan offices can be bad for your health’ (Landau, 2014), while the British Broadcasting Corporation (BBC) reported on a ‘decline of privacy in open-plan offices’ (Kellaway, 2013). And in the United States of America (USA), the Washington Post warned that ‘The open-office trend is destroying the workplace’ (Kaufman, 2014), while an article on the American Broadcasting Company (ABC) News website even claimed the devil’s involvement with ‘Proof That Open-Plan Offices Are Satan’s Handiwork’ (Farnham, 2013). Not to be outdone on this topic of griping open offices, South Africa’s Mail & Guardian reported that open-plan offices ‘may be hazardous’ to the health of office-bound employees, adding that ‘people who feel anxious in social situations may find it difficult working in an open-plan office’ (Green, 2015).

The general theme of the aforementioned media pieces is that open-plan offices have a negative or even detrimental effect on employee productivity and morale and specifically the ability of employees to perform work that requires focus and concentration. Notwithstanding their alarmist tone, the claims of these media pieces should not simply be dismissed by public and private sector employers as ‘unscientific’ and sensationalist: they are all backed by empirical research studies conducted by, amongst others, the University of Sydney (2013), which collected more than 42 000 employee responses from Canada, Finland, USA and Australia over a 10-year period. This authoritative study found that open-plan offices indeed attract the highest level of employee dissatisfaction – which is in direct contrast to the notion that they support greater effectiveness and employee happiness. Other empirical studies by the World Green Building Council (2014) and South African academics like Kok, Meyer, Titus, Hollis-Turner and Bruwer (2015) also corroborate the current media frenzy against open-plan office layouts. The study by Kok et al. specifically captures the views of a diverse range of South African employees about how open-plan work environments impact on their productivity and overall job satisfaction, showing that a majority of these employees preferred private offices as opposed to open-plan offices as the latter is perceived to negatively influence employee’s concentration (focus), privacy and emotional well-being. The collective findings of these studies and media pieces raise an important question: if there is such a big backlash against open-plan offices, why then are we seeing a growing trend towards it in both the public and private sector?

Why employers prefer open-plan offices

Open-plan work environments enjoy preference by most employers. This trend towards open-plan offices is fast-growing across the world and across different sectors of the economy (Wong, 2013). Generally, employers view open-plan office layouts as a design strategy that promotes flexibility when the organisation needs to grow. Cost-effectiveness and environmental sustainability also rank high as key considerations of employers opting for open-plan offices as it can help the organisation save on building materials and construction costs, as well as reduce heating and cooling expenses through more efficient lighting and air flow. Employers also view open-plan office design as a strategy to encourage organisational egalitarianism and efficiency by sharing resources through features like communal kitchens (see Kok et al., 2015).

These flexibility, cost-effectiveness, egalitarian, efficiency and sustainability considerations are arguably done with the best intentions as influential ‘management and leadership gurus’ in both the public and private sectors are increasingly calling for more interaction, collaboration and shared spaces in order to attract and retain brilliant staff, to stimulate their creativity, and thereby multiply organisational productivity (see, for example, Stephen Covey; Richard Branson; Lynda Gratton; Tom Peters; Joseph Stiglitz). It is this collective ‘economics of space’ that
explains why open-plan office layouts are here to stay, and growing.

How to make open-plan offices work for you

The ‘economics of space’ may explain why open-plan office layouts dominate modern workplaces, but it does little to address the detrimental influence open-plan offices have on employee’s ability to concentrate at work. A 2011 study on noise-levels in open-plan work spaces by Jahncke et.al. concluded that these type of work environments tend to be ‘noisy’, resulting in employees having lower concentration levels during worktime. These findings were later corroborated by Brown (2013) who stressed that open-plan work environments negatively affects the ability of employees to concentrate, leading to lower levels of individual and organisational productivity.

The ability to focus and concentrate is particularly important in any work environment, given that employees generally enter in-and out of four different work modes throughout the day:

- Focus (the type of work that demands one’s full attention)
- Collaborate (working with others to achieve common organisational objectives)
- Learn (continuous learning is an essential part of work)
- Socialise (to promote collegiality and teamwork)

A 2013 workplace survey by Gensler, an integrated design company, found that employees are most satisfied when they are able to focus in the work environment. What frustrates most employees is when collaborating, learning and socialising happens in spaces designated for focusing. It is thus critical for employers to understand the nature of work in their respective organisations and to use this knowledge to ensure that the work environment has the appropriate balance between focus areas for work that requires focus and concentration and areas for collaboration, learning and socialising. All four modes of work cannot take place in a single, open work environment. If this is the case, organisational productivity will suffer. The most productive open-plan work environments are those that maintain the appropriate balance between employee needs for focus, collaboration, learning and socialising. This balance, the Gensler study found, coupled with natural lighting and an abundance of plants – shown to reduce stress levels – can do a lot to dissipate workplace anxiety so often associated with working in open-plan office environments.

It would seem that despite the backlash by employees against open-plan work environments, these minimalist work spaces are here to stay, mainly because of the multitude of benefits employers derive from the ‘economics of space’. But employees should not despair. Most employers are aware of the dynamic link between employee well-being, performance and productivity and will do their utmost to ensure that employee satisfaction is maintained, or even increased, in order to support high levels of employee performance and productivity.

Creating the ideal workplace environment in which the needs of both employers and employees are considered and respected does not have to be a zero-sum game. Both parties can be winners in this ongoing ‘battle of the open-plan office’ if they agree to find the right balance between focus, collaboration, learning and socialising, and work towards maintaining that vital balance.

References

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Knowledge Management For Effective Service Delivery In Government

Background

The Western Cape Government’s Department of Transport and Public Works (DTPW) is one of 13 Provincial departments and is responsible for the construction and maintenance of roads, educational and health facilities, general buildings and the provision of access to safe and efficient transport. In addition to infrastructure development, the Department has a responsibility to facilitate employment opportunities through various programmes. The Department is organised in five Branches, viz. Strategy, Planning and Co-ordination; Transport Management; Road Network Management; Provincial Public Works; and Finance.

The Department has a staff component of 1 700 employees, the majority of whom can be regarded as “knowledge workers” as knowledge workers. The footprint of DTPW includes a head office in the Cape Town central business district (CBD) and 27 regional offices throughout the province.

One of the key priority programmes, underlying the departmental strategic thrust, is the establishment of a highly effective department. The Department therefore decided to leverage its vast sets of tacit and explicit knowledge to develop and implement a Knowledge Management (KM) Strategy as an enabler of organisational effectiveness and performance. The focus of the KM initiative was therefore to identify and leverage mechanisms to embed a proactive approach to exchange, stimulate the generation and sharing of knowledge that facilitates continuous learning and thus a KM culture.

To embed a KM culture, it was acknowledged and agreed that a critical success factor to the KM initiative was facilitating behavioural change of staff in managing knowledge. The KM initiative needed to embrace inclusivity and involve staff, on all levels and across the width of DTPW, throughout the entire initiative lifecycle.

The Knowledge Initiative

A KM project was initiated in the Department and it consisted of a Knowledge Audit, Knowledge Management Maturity Assessment, developing a Knowledge Management Framework, developing a Knowledge Management Strategy and lastly, the Implementation Plan.

KM Audit

A KM Audit was undertaken to establish a baseline for the development of the KM strategy. The KM Audit sought to confirm and substantiate initial key concerns in both the tacit and explicit knowledge domains. The main initial concerns raised by were as follows:

- Tacit knowledge – When highly skilled subject matter experts, engineers and managers leave, they take with them years of hard-earned, experience-based knowledge, much of it undocumented and irreplaceable.
- Explicit knowledge – Structured and unstructured explicit knowledge is currently scattered and fragmented across the organisation. This hampers cross organisational access, sharing and the application of knowledge that ultimately results in low levels of effectiveness and efficiency.

The KM Audit also included management interviews. Representatives on management level from all Chief Directorates were interviewed to determine the status quo of the following topics:

- Management view of the current KM status
- Protection of intellectual capital towards sustainable service delivery
- Processes to find, create, capture, organise, share and apply knowledge
- Management view of desired state
- Suggestions and preferences in terms of the business enablers (people, process, technology) to KM

An inclusive project approach was deemed to be of critical importance. All staff members registered as Enterprise Content Management (ECM) users and were given the opportunity to complete an online KM survey. The KM survey tested similar criteria as in the management interviews and maturity assessment. The resultant yield of the KM survey could thus be summarised as follows:

- Awareness raising – All levels of staff were made aware of the KM initiative.
- Inclusivity – All staff members were given the opportunity to participate in the design of the future KM model. This simplifies change management and facilitates behavioural change.
- Management vs. staff – An opportunity to test the perceptions of staff against management feedback and thus identify potential areas of conflict.
- Identification of potential problem areas or success stories – current challenges to consider and best practices that the project could leverage on.

An Information Communication and Technology (ICT) audit was also to determine which systems and KM tools are used to enable the flow of knowledge between repositories, users and applications. This also assisted in the mapping of existing knowledge owned by the DTPW.

KM Maturity assessment

To measure the success of the initiative, a pre- and post-project knowledge management maturity assessment was performed. This will enable the monitoring of KM maturity development from project initiation and onwards. A comparison of the results
will indicate possible maturity growth and highlight areas that require additional focus going forward. Another advantage of the initial KM maturity assessment was that it could be used to partially substantiate the results of the management interviews conducted.

The Knowledge Management Maturity Matrix (KMMM) developed by Kruger and Snyman (2007) of the University of Pretoria was used as the assessment framework. By using the KMMM, a questionnaire containing 101 descriptive questions to determine maturity consisting of six levels, was used. The result of this maturity assessment established a baseline for future maturity assessments. This would enable management to measure the return on investment (ROI) of the KM initiative in future.

**KM Framework (KMF)**

The KMF was designed to encapsulate the management of intellectual capital using a structured KM process approach. To enable and facilitate a common understanding, business support and proper change management, the KMF design aimed to provide a simplified linkage between the concept, benefits of and requirements for successful KM. The following building blocks were used in the design of the KMF.

**KM strategy**

The KM strategy was developed using the KMF as baseline. For each of the six focus areas, specific interventions were designed. These are outlined below:

**Training and development:**

A skills development strategy is required to focus on staff development. This strategy will be closely aligned to the KM strategy to ensure that KM enabling elements are embedded therein. The main focus areas will be:

**INTERNAL FOCUS**

- Skills development – The programme designed will address the current and future skills gaps that exist in specific departmental functions. This will facilitate staff development and ensure the expansion of their knowledge base.
- Professional development – Focus on the development of employees who are in certain occupation-specific posts. They include candidate engineers/architects/quantity surveyors who require training and development under the supervision of professionally registered mentors. This assists with the registration with professional bodies. This focus area will also address knowledge retention through specialised mentoring programmes.

**EXTERNAL FOCUS**

- Skills development – Focus on PIVOTAL programmes aligned to the qualification requirements as stipulated by the Higher Education Institutions (HEIs).
- Expanded Public Works Programme – Coordinate and facilitate labour intensive construction training for emerging contractors. It will also focus on empowering and developing the unemployed, through targeted skills development programmes.

**Organisational Learning:**

A culture should be instilled where emphasis is placed on informal knowledge sharing and learning in order to become a learning organisation. Knowledge retention and informal learning activities will include the following:

- Knowledge retention – Address challenges relating to the lifecycle of employees. This covers induction, mentoring and coaching, succession planning and “Learn-from-Leavers”.
- Learning activities – Informal learning to convert tacit into explicit knowledge e.g. sharing of technical knowledge by experts with target audiences. This will be linked to the knowledge gaps determined in the Skills Development Plan.
- Innovation – Focus on the use of departmental intellectual capital to develop new ideas and creative solutions to business challenges.
Organisational Assets:

An approach to leverage on the knowledge within organisational assets will be used to improve business planning. These will be done as follows:

- Integrated planning – Strategy documents, business plans, operational plans and policy documents will be leveraged more effectively to communicate knowledge about the activities of the Department, horizontally and vertically.
- Processes – Knowledge on how to execute tasks will be embedded and conveyed in standard operating procedures (SOP’s).
- Legislation – Complex legislative knowledge of the Department will be used to contextualise and simplify the interpretation thereof. This will contribute towards more efficient and effective governance structures and processes.

Information Assets:

DTPW information assets will be leveraged to improve knowledge, sharing horizontally and vertically. This will be approached as follows:

- Unstructured information – Normally text-heavy and managed through records or content management systems. It will only become useful and actionable knowledge once it is structured by using taxonomies and metadata. Once it is structured, it can be used to create tacit knowledge.
- Structured information – This is currently fragmented and stored on various platforms. This hampers a holistic view of various business value chains, proper contextualisation of business challenges and the knowledge required to inform decision-making. Structured data sources will be integrated and centralised and thus enable improved access to knowledge, leading to more effective decision-making.

Business Intelligence:

Knowledge, best practices, lessons learnt and Business Intelligence (BI) from projects are captured here.

- Project knowledge – Project related information (planning, delivery, close-out) will be managed to create new knowledge via lessons learnt and best practices. This knowledge is cross-cutting and enables the aggregation and storing of departmental, client and service provider knowledge for BI purposes.

Stakeholder Management:

A communication strategy will be developed that covers:

- Internal communication mediums to inform staff (share knowledge) about the people, projects and activities of the Department.
- External communication will enable bi-directional knowledge sharing about the projects and activities of the Department with external stakeholders.

To further support the KM Framework, careful consideration was given to suitable governance and IT support structures.

Governance:

Successful implementation of the KM strategy requires strong and visible leadership from top management. Proper governance support structures and functions consist of the following:

- Accountability – The structure should ensure that accountability is properly balanced between strategic, tactical and operational levels (Barnes & Milton, 2015: 39):
  - Steering Committee
  - Chief Knowledge Officer (CKO)
  - KM Sub-strategy project teams
  - KM Champions
- Risk management
- Monitoring and evaluation

Technology is an enabler for successful KM. Databases, intranets, knowledge platforms and networks are the main building blocks that support knowledge management. The DTPW owns transactional, analytical and process solutions of which the integration will contribute towards a functional KM platform for better decision-making.
Conclusion

Over the next few years, the following areas of the strategy will be implemented by the KM unit.

ORGANISATIONAL LEARNING

- Department specific induction programme
- Mentoring and coaching programme
- Informal learning programme to stimulate innovation
- Environment to foster an innovation culture
- Learn from Leavers programme to capture tacit knowledge

BUSINESS INTELLIGENCE

- Design a Business Intelligence framework that encapsulates the Business Intelligence requirements of business
- Refinement of the project management methodology to include a close-out/review phase where knowledge on lessons learnt and best practices can be discussed, captured and shared to facilitate continuous learning
- Determine user requirements for a knowledge hub. These requirements will consider content, layout, accessibility, permissions, functionality (wiki’s, blogs, social media)
- Stakeholder management
- Design and manage a knowledge-hub/portal aligned to user requirements and to enable the effective collection and upload of information

KM STRATEGY IMPLEMENTATION GOVERNANCE

- Design a KM governance structure
- Design a reporting framework, reflecting quantitative and qualitative indicators to report progress to the KM Steering Committee
- Regular monitoring and evaluation of project implementation progress and interventions to address possible challenges
- Draft a proposal to balance knowledge management performance criteria with incentivised indicators. The aim will be to fast-track organisational behaviour and maximise the impact on change management.

CHANGE MANAGEMENT INITIATIVES

Change management will be in support of the projects listed above and will also include stakeholder mapping, analysis, impact assessments and engagements. A benefits realisation model and a delivery plan will also be designed.

In addition to the above, focus on Organisational Learning, Business Intelligence and Stakeholder Management, and other initiatives have already been completed in the Training and Development, and Stakeholder Management (communication projects) focus areas of the KMF. The respective business units will continue with the rollout in further projects in parallel to the above initiatives.

Successful KM will not be achieved by only addressing IT as an enabler. The focus should be on culture change, harnessing intellectual capital and creating a learning organisation by embedding the KM value chain in daily operations.

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References

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