

A CRITICAL REVIEW OF THE SUSTAINABILITY OF SOUTH AFRICA'S HEALTH SYSTEM, USER SATISFACTION AND KEY PERFORMANCE SCORES

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Abstract:

The South African Government has made accessibility and equity the primary focus of its health policy objectives since 1994. However, the extent to which these policies achieve their aims of lessening inequality needs to be synthetically documented. This study critically reviews and synthesizes the literature on the nature of the South African health system, user satisfaction and critical performance scores. The study conducted a content analysis of several research papers and policy papers in the South African health sector. The review showed that the current health system is dualistic, indicating that the public health system needs to be living up to the National Core Scores. The evidence demonstrated ongoing discrepancies in access to and use of health services, notwithstanding legislative initiatives. It has negatively impacted households' satisfaction levels.

Moreover, the review showed that users' perceptions of the quality of public healthcare services are deteriorating in South Africa. There is evidence of treatment delays, long waiting times, acute shortages of doctors, specialists and nurses, a lack of appropriate medication and poor health services delivery. The evidence provided about the South African health system can contribute to global policy discussions about health equity, the use of health services by households from different socioeconomic backgrounds, and how policies can increase access to quality Sustainability, Health System, Patient Safety, Leadership, Corporate Governance, Operational Management, National Core Standards health care for low-income households.

Keywords: Sustainability, Health System, Patient Safety, Leadership, Corporate Governance, Operational Management, National Core Standards.

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INTRODUCTION

The South African Government and other stakeholders have made some initiatives to improve and alter the country's health system, particularly access to health care and infrastructure. It has led to several health reforms, legislation passing, and policies (Lebeso et al., 2018; Maseko & Harris, 2018). Enhancing the health system, which would extend to economic prosperity, is the primary goal of the health reforms. Due to this, numerous policy frameworks and techniques to accomplish this goal have been discussed (Belli et al., 2018). These actions and policies implemented by the South African Government are meant to improve and expand access to healthcare and the capacity of health practitioners. These policy frameworks and initiatives aim to achieve the South African Government's transformation goal (Maphumulo & Bhengu, 2019).

Another area for characterizing the primary healthcare dilemma in South Africa is inadequate capacity. Unusually, policymakers, management, healthcare professionals, associations, and healthcare consumers agree on the significance of reviving primary care. This

consensus results from a shared understanding that healthcare delivery is the anchor of a country's prosperity and productivity while having the potential to enhance patient outcomes and keep costs under control (Michel et al., 2020). These policies and guidelines aim to increase the proportion of patients with a primary care physician while providing them with new tools to improve service delivery (Docrat et al., 2019).

There have been debates and discussions on improving the South African health system at various levels. Key issues dominating the discussion include the following: What is the nature and state of the South African health system? What types of performance account for health system improvement, and how are they measured? Moreover, how can the South African health system improve, and how should the health system be structured, among other subjects that have been debated in the health system debate? Despite the numerous debates, there is a consensus that the health system and the various health facilities and departments should improve how they operate and positively impact healthcare delivery in the country (Maseko & Harris, 2018; Gilson et al., 2020). These ideas also demand that organizational structure and system-level funding be based on evidence of their functioning. Given the size of the investment required to rejuvenate the South African health system, it is reasonable to question whether the evidence substantiates current initiatives to expand, outfit, and empower the health sector.

It is evident that various stakeholders, especially the government and health professionals, seek ways to improve the South African health system (Malakoane et al., 2020; Michel et al., 2020). A thorough understanding of the current health system should be a starting point. However, no study provides a comprehensive review of the health system in South Africa and the satisfaction of users. Given this gap in the literature, this study critically reviews and synthesizes the literature on the nature of South Africa's health system, user satisfaction and critical performance scores.

This paper presents a critical analysis of the state of health in South Africa. The study focuses on the nature of South Africa's current health status along with information on South Africa's current health status, the satisfaction of healthcare users, essential performance indicators, and government-designated priority areas. The paper further provides a critical review of the effectiveness, equity, and efficiency of healthcare services in South Africa by reviewing the access to healthcare, the quality of healthcare being provided, and the financial stability of the health system. Critical areas reviewed include the resources at the disposal of the public health sector; the standard of health care being provided to South African citizens; the management of healthcare facilities, and the factors that have impacted the provision of health services. Understanding the nature, effectiveness, relevance, and consequences of the South African health system and policy frameworks in achieving transformations is made more accessible by this review which exposes the sorry state of affairs of the South African health system.

METHODS

The research entails a desktop document analysis of published materials, particularly those on health systems produced by researchers, experts and the South African Government. The study conducted a content analysis of several research papers and policy papers in the South African health sector. Researchers like Maama (2020) and Sogfa et al. (2022) agree that reading and analyzing public documents using a content analysis research strategy is valid and reliable. The documents and literature were read from cover to cover to comprehend the significant goals and their strategic ramifications. The websites of research databases, the Department of Health and other government entities in charge of health were visited to download research papers and policy documents about healthcare delivery in South Africa. These documents were critically evaluated to determine how well the healthcare in South Africa is administered to support the South African

Government's transformation objective. The scope of this paper needed to allow for a complete examination of the literature. Given this delimitation, the study focused on South African health sector literature. The literature search started with a recent systematic literature review of the efficacy of primary care in South Africa to find relevant research to include in the study.

Several keywords, including the health system, patient safety, health leadership, health sector corporate governance, operational health management, national core standards, and South African health policies and regulations, among others, were used for the literature search. Then, starting with papers that focused on health system efficiency, the study looked for studies that had been published in the following databases: the Web of Science, Scopus, Emeralds, Elsevier and PubMed. Studies were considered as long as they addressed one or more of the definitions of the South African health system, assessed the effects on quality, outcomes, or costs, and presented or quoted original, peer-reviewed analyses. The study only referenced a portion of these publications to prevent repetition, selecting those that highlight ideas particularly relevant to the current policy recommendations while attempting to represent the documents consulted accurately. The reference list contains the complete list of the documents and publications that served as the foundation for the review.

RESULT AND DISCUSSION

An overview of the South African Health System. South Africa's public health sector is responsible for servicing around 84% of the population (NDoH, 2013a). However, there are concerns about the public health sector needing to be more funded and capitated, which has significantly affected the quality of health delivery in the sector (Docrat et al., 2019). The causes for the poor quality of health services are diverse and complex, and it is only through establishing a benchmark that quality can be assessed for creating room for improvement (Gilson et al., 2020). This paper proceeds by first defining the quality of health care. The paper defines quality in health care as the six dimensions of quality that can be intrinsically measured, as set out by the WHO in 2006 (Market al., 2010; NDoH, 2013a, p. 2). They are:

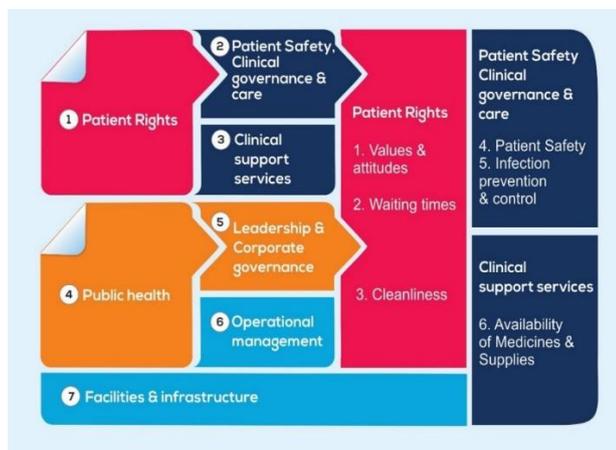
1. Safety: providing healthcare in a way that reduces user hazards.
2. Efficiency: providing healthcare services that minimize waste and maximize the utilization of limited resources.
3. Patient-centredness: Delivering healthcare that considers patients' preferences, rights and cultural variations.
4. Accessibility: prompt delivery of medical treatments while maximizing coverage.
5. Equity: Equity provides healthcare without regard to a person's gender, race, ethnicity, or socioeconomic standing.
6. Effectiveness: providing healthcare in a way that meets policy objectives and intended health effects.

Governments could better understand the idea of quality in healthcare thanks to the WHO's recommendations. Two different quality assurance systems have emerged globally to guarantee the quality of medical services. The first is governed by specific regulation, as practiced in the United Kingdom, where a regulatory body is established through law and given specific inspection and enforcement powers to regulate health facilities (NDoH, 2013a, p. 4). The second type of quality assurance system is more voluntary and informal, where health facilities voluntarily comply with accreditation and certification processes. This quality assurance system usually has no enforcement powers (NDoH, 2013a, p. 4). Government is responsible for the well-being of its citizens. Governments need to regulate the affairs of their country to protect their citizens from harm. Specific sectors may be regulated for specific reasons, the most pertinent of

these being in the public's best interest. It is for this reason that the health sector is so highly regulated. By regulating the industry, better healthcare quality can be attained (NDoH, 2013a, p. 4). The Office of Health Standards Compliance (OHSC), a body mandated to monitor and enforce compliance to ensure excellent health care, was established in South Africa as a result of the following significant changes:

1. In 2003, the National Health Act was passed. The Act offers the overall legal basis for a planned and standardized healthcare system. The Act specifies the rights and obligations of healthcare providers and users to ensure an improvement in the standard of healthcare; The Act called for the NDoH to establish an Office of Standards Compliance (OHSC, 2017:3).
2. The South African Policy on Quality in Health Care was issued in 2007. The significance of the Office of Standards Compliance in assessing the quality of healthcare services was reaffirmed in this paper (OHSC, 2017:3).
3. The Core Standards for Health Establishments were introduced in April 2008. It introduced a group of quality standards that are well-regarded and research-supported (OHSC, 2017:3).
4. The 10-Point plan was released in 2009, reiterating the government's dedication to providing high-quality healthcare (NDoH, 2013a, p. 8).
5. In January 2011, a revised set of National Core Standards (NCS) was published, and this set of evaluation instruments is extensively employed in the public sector to measure performance. A second subset of the NCS, consisting of the six areas of most serious patient concern, was developed and used in the baseline audit of all public health facilities during the 2011–12 fiscal year (OHSC, 2017:3).
6. The Negotiated Service Delivery Agreement (NSDA) between the President and the Minister of Health entitled “A Long and Healthy Life for all South Africans” was developed in 2011. Outcomes 2 and 4 specifically deal with health services reform (OHSC, 2017:3).
7. In August 2011, the Green Paper was published, the Policy Paper for NHI in South Africa (NDoH, 2013a, p. 10).
8. In 2017 the White Paper was gazetted and is now the NHI Policy Paper, the foundation of new health insurance.

The NCS describes the essentials for healthcare quality based on six quality elements: acceptability, safety, reliability, equity, accessibility, and efficiency. These elements are called the ministerial priority areas. These six ministerial priority areas are further grouped into seven domains. The six ministerial priority areas, primarily anchored in patient rights, clinical governance and care, and clinical support services, are shown graphically in Figure 1. The six aspects of quality inform these domains.



Source: OHSC 2017:4

Figure 1. Structure of the seven domains of the six ministerial priority areas

Figure 1 presents the structure of the seven domains of the six ministerial priority areas. The National Core Standards set the benchmark for high-quality medical care. These criteria are concentrated at the healthcare facility's level, where healthcare is provided. Patient rights, safety, clinical governance and care, and clinical support services are the first three domains, and they are all closely related to giving patients high-quality medical care (Mail & Guardian, 2012, p. 1). The remaining categories include operational management, public health, leadership and corporate governance, and facilities and infrastructure, which form the support network that would guarantee the availability of health care (Mail & Guardian, 2012, p. 1).

As a result of the above journey, the OHSC in South Africa was established in 2013 following the amendment to the National Health Act No. 61 of 2003, "to protect and promote the health and safety of people as the cornerstone of quality healthcare" (OHSC, 2017:3). The annual inspection report aims to determine compliance of public health facilities with the NCS and more specifically the core standards as depicted in Figure 1.

Since its inception, the reports produced by the OHSC have given details of the results of the inspections conducted over the years. These outcomes relate to applying clinical recommendations, procedures, efficient referral networks, and leadership and governance following NHI policy (OHSC, 2017:3). The 2016/17 yearly inspection report serves as an example of the work done by the OHSC. It noted gaps between the prescribed and actual situation. These gaps were similar to previous inspection reports. The report mentioned that governance structures could have been more effective, with a negative impact on leadership, and there needed to be more evidence of oversight, accountability and good management.

Public Health Expenditure, Access to Health Services and users' satisfaction The South African Government spent R15.6bn of its consolidated national and provincial budget on health in 1994/95. It represented 10.5% of its consolidated national and provincial budget spending and 3.5% of GDP (National Treasury, 1995). This amount increased by 1050% to R183bn in 2016/17 (DoH, 2015, p. 47). The increase amounted to 11.7% of the government's consolidated national and provincial budget expenditure. This reallocation of resources and increase in health spending suggests that South Africa needs to consider the value it is receiving for the money spent on health. Notwithstanding these increases, inequality is more significant today in South Africa than it was at the end of apartheid, as evidenced by the Gini coefficient (Deghaye, McKenzie & Chirawu, 2014:7). One reason is that, in 1990, when apartheid was ending, the health system was extended without increasing the capacity to close the inequality gaps in the distribution of

health/social services and resources. To some extent, the introduction of PHC and system reform has contributed towards improving the health services for people experiencing poverty but still needs significant disparities between previously disadvantaged people (Burger, Bredenkamp, Grobler & Van der Berg, 2012).

In this respect, a two-tier health system still exists, whereby the government subsidizes the private sector through tax rebates and other hidden subsidies in the general training of doctors and other medical personnel (Obuaku-Igwe, 2015, p. 120). Following this, the White Paper presented two primary rationales for establishing National Health Insurance (NHI): the heavy burden of the disease plaguing the country and the structural problems in the health sector. A significant difference exists between the satisfaction levels of households receiving health care in the public and private sectors. The statistics released by StatsSA (2017b:21) in the GHS for 2017 indicated that just more than half of the households surveyed (55.1%) were very satisfied with their healthcare service received from public healthcare facilities. In contrast, Table 1 shows that 91.5% of households receiving healthcare services from the private sector were delighted (StatsSA, 2017b).

Table 1. Level of satisfaction with public and private healthcare facilities by province

Level of satisfaction with the healthcare institution	Province									
	WP	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Public Health Care										
Very satisfied	48,3	59,1	49,7	48,1	46,9	46,7	55,8	62,3	75,1	55,1
Somewhat satisfied	22,1	30,2	28,8	23,0	34,0	27,6	26,8	24,2	14,9	26,7
Neither satisfied nor dissatisfied	11,3	4,6	7,6	10,9	12,5	7,2	8,7	5,3	4,2	8,4
Somewhat dissatisfied	6,8	3,8	4,8	9,5	3,2	6,4	3,9	4,3	4,1	4,5
Very dissatisfied	11,5	2,3	9,1	8,6	3,4	12,1	4,9	4,0	1,7	5,3
Total	100,0									
Private Health Care										
Very satisfied	93,2	96,0	86,9	86,6	86,6	90,9	92,0	95,0	93,2	91,5
Somewhat satisfied	3,7	3,4	7,0	8,3	10,6	7,2	5,8	2,7	3,5	5,8
Neither satisfied nor dissatisfied	1,0	0,2	3,9	2,4	2,0	0,5	1,4	1,3	1,8	1,4
Somewhat dissatisfied	0,9	0,5	0,4	1,4	0,6	1,1	0,5	0,0	0,6	0,7
Very dissatisfied	1,3	0,0	1,7	1,3	0,3	0,3	0,4	1,0	0,9	0,6
Total	100,0									

Source: StatsSA 2017b:23

Table 1 demonstrates that private medical aid coverage in the country was 16.9% of the population or 9.5 million people in 2017, and at least one member of a household belonging to a medical aid scheme, as depicted in Table 2 (StatsSA, 2017b, p. 24)

Table 2. Medical aid coverage, 2002-2017

Indicator (Numbers in	YEAR											
	2002	2004	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017

thousands)												
The number covered by a medical aid scheme	7284	7268	8057	8502	8967	8312	9157	9608	9470	9307	9447	9475
Number not covered by a medical aid scheme	3844	3966	4126	4128	4160	4301	4281	4330	4394	4506	4564	4665
Sub-total	4578	4693	4932	4978	5057	5132	5197	5290	5341	5437	5509	5612
The percentage covered by a medical aid scheme	159	155	163	17.1	177	162	176	182	177	17.1	17.1	169
Do not know	140	58	101	19	23	0	58	36	46	71	53	24
Unspecified	53	57	56	347	254	249	291	161	541	308	474	369
Total population	4592	4704	4947	5015	5085	5157	5232	5310	5391	5475	5562	5652
	1	9	9	2	0	4	5	4	2	0	0	2

Source: StatsSA 2017b:24

However, the above is survey data, which, by its nature, tends to differ from actual numbers. For a more accurate depiction of the number of people who had access to private healthcare services, the Council for Medical Schemes (CMS) data was consulted. According to the CMS 2018-19 Annual Report, there were 4.039 million principal members of medical schemes and 8.916 million beneficiaries. It is less than the numbers of StatsSA. Thus, the public health system is responsible for more people than suggested by the survey. Nevertheless, it should keep the proportionate satisfaction levels the same as the difference is not substantial, that is around 600000 people.

Performance scores of the South African Health System according to the NCS's six priority areas South Africa has around 3200 public clinics, 325 public hospitals and 324 community health centers (OHSC, 2017:10). These health service providers provide health services to citizens. It was made evident during a regular inspection conducted by the OHSC. For instance, the latest inspection conducted by the OHSC was in the 2016/17 financial year. The inspection provided the following facts: 649 (17%) public health facilities were inspected to monitor compliance with the NCS. According to the OHSC, facilities inspected should score at least 80% to be accredited facilities with an acceptable level of care. The inspection further provided some facts about the quality of health services in the various provinces. For instance, only two of the 59 Limpopo clinics inspected scored over 50%.

In the Eastern Cape, only 12 of the 100 clinics inspected achieved over 50%, with the remaining clinics scoring between 30% and 39% (Cullinan, 2017, p. 1). Similarly, of the 53 clinics inspected in the Free State, only five scored over 50%. The following paragraphs discuss the findings of the OHSC according to the six priority areas identified by the NCS. The OHSC reported individually on the performance scores of each of the nine South African provinces, distinguishing between hospitals, community health centers and clinics. Overall, hospitals had higher average

performance scores than community health centers and clinics (OHSC, 2017:18). Table 3 lists the scores for the six NCS priority areas.

Table 3. Six Ministerial Priority Areas

Priority Area	Percentage range for different provinces
Availability of medicines and supplies	47% to 69%
Cleanliness	46% to 55%
Patient safety	45% to 60%
Infection prevention and control	51% to 59%
Values and attitudes of staff	56% to 66%
Waiting times	64% to 68%

Source: OHSC 2017:18

Availability of medicines and supplies. An essential supply in any health center or hospital is medicine. A lack of it can be disastrous as patients may not receive the needed care. However, there have been reports of nonavailability of medicines and supplies at these health facilities. According to a former head of a trauma unit in one of the hospitals, "*Government hospitals often ran out of pain-killing drugs...one day we ran out of Panado, so we had to use morphine even on small babies*" (Kane-Berman, 2014, p. 4). Confirming the claim by the head of the trauma unit, the Stop Stockouts Project, run by a civil society organization, also conducted a national survey in 2015 that revealed that stockouts had increased from 2014 to 2015 (Stop Stockouts, 2015, p. 1). The 2015 report indicated that one in three facilities was affected by ARV or TB medicines stockouts in the three months before the survey. Table 4 shows the percentage of facilities, according to province, reporting at least one ARV or TB medicine stockout in the three months before the survey for 2013–2015.

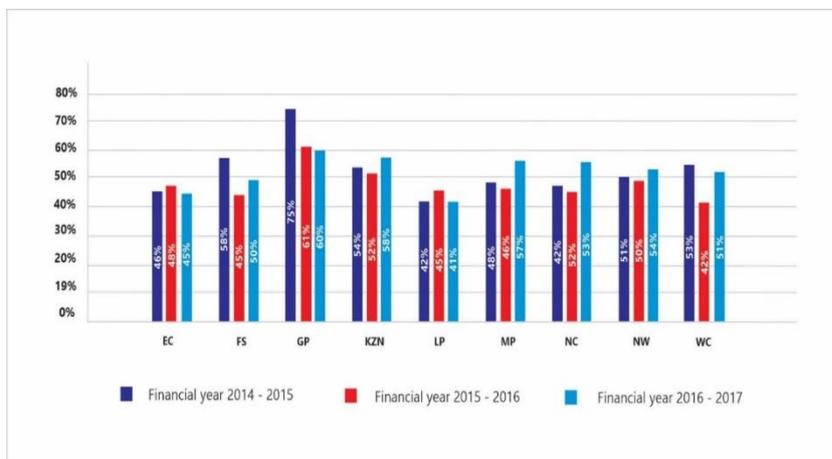
Table 4. Percentage of Facilities Reporting at Least One ARV or TB Medicine Stockout

Province	Facilities reporting at least one ARV or TB medicine stockout %(n/N)		
	2013	2014	2015
Eastern Cape	20% (89/447)	28% (141/509)	32% (148/465)
Free State	54% (90/167)	28% (41/147)	53% (71/135)
Gauteng	20% (58/284)	25% (71/283)	56% (157/278)
KwaZulu-Natal	14% (45/322)	19% (83/436)	26% (108/417)
Limpopo	41% (989/218)	29% (77/266)	25% (63/248)
Mpumalanga	26% (58/224)	40% (82/205)	74% (163/220)
Northern Cape	18% (11/62)	21% (23/107)	23% (28/123)
North West	4% (8/182)	39% (86/222)	41% (92/223)
Western Cape	5% (11/223)	4% (10/279)	12% (32/261)
South Africa	21% (459/2139)	25% (614/2454)	36% (862/2370)

Source: Stop Stockouts 2015:2

The evidence in Table 4 demonstrates that the overall stockout has increased since 2014 from 25% to 36% in 2015. The increase was partially attributed to a widespread national stockout of adult ART products during the survey period (Stop Stockouts, 2015, p. 2). According to the 2016/17 Office of Health Standards report, there was no significant improvement in the

availability of medicines and supplies from 2014 to 2017. Figure 2 shows the availability of medicines and supplies. The improvement across provinces has yet to be demonstrated.



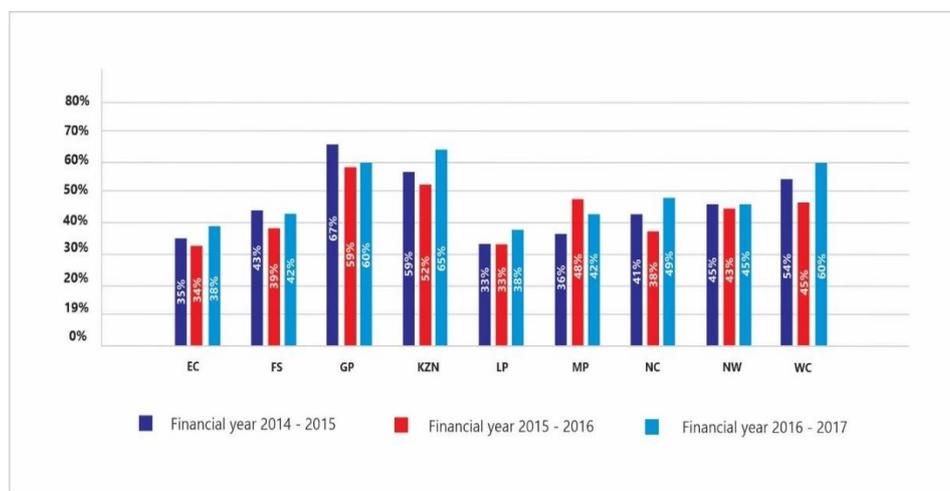
Source: OHSC 2017:19

Figure 2. Availability of medicines and supplies scores per province from 2014/15 to 2016/17

Medication stockout problems are aggravated by the persistent failure to pay suppliers. The problem of non-payment has also impacted staffing, and there have been significant losses in nursing staff (Kalonji & Mahomed, 2019). The National Health Laboratory Service (NHLS), responsible for HIV and TB testing and cancer screening in the public health system, was in a critical condition in 2015 due to the outstanding funds owed by provincial administrations. With diagnostic facilities, doctors can treat and medicate patients. It was also understood that the NHLS was "lacking skilled staff" such as pathologists with extensive experience who were demoralized by the situation and being replaced by young inexperienced personnel (Bhekisisa, 2015; Beli et al., 2018).

Treatment delays have been a common problem, which is still unresolved. In 2017, the Chris Hani Baragwanath Hospital in Soweto had a backlog of thousand patients waiting for various medical procedures. Mrs. Kubheka, a 55-year-old female, was advised in February 2017 that she would have to wait seven years for hip replacement surgery. There was also a backlog of 26 000 surgeries in Limpopo, and patients diagnosed with cancer needed to wait 12 months from diagnosis to start treatment (Wilson, 2018). This information paints a gloomy picture of the South African health system. Clinical support services are necessary to provide clinical care, such as ensuring the timeous availability of medicines and efficient provision of diagnostic, therapeutic and other support services.

Cleanliness. Hospitals continue to get media complaints about the state of cleanliness of facilities regularly. According to reports, many hospitals and clinics are perceived by patients and users as being unclean, disorganized, and unsanitary (NDoH, 2013a, p. 16). The unhygienic health environment may lead to infections associated with health care, which could compromise the health outcomes of the patients. These observations are reflected by the 2016/17 OHSC report results. Figure 3 shows the cleanliness priority area scores by province. Figure 3 demonstrates that Gauteng and KwaZulu-Natal had the highest cleanliness priority scores compared to other provinces (OHSC, 2017:20).



Source: OHSC 2017:20

Figure 3. Cleanliness Scores Per Province from 2014/15 To 2016/17

Patient Safety. The research titled "Saving Babies" by the Medical Research Council was published in May 2015. It tracked the number of live births, neonatal fatalities, and reasons for newborn mortality in South African healthcare facilities between January 2012 and December 2013. According to the research findings, more than 80 000 infant deaths were recorded in 588 public facilities over two years (MRC, 2015). Another incident pointing to a lack of attention to the safety of patients is when on 2 March 2017, the roof at the entrance to Charlotte Maxeke Academic Hospital in Johannesburg collapsed. Two people were trapped under the rubble, and five sustained minor injuries (Khoza, 2018). The Life Esidimeni disaster, during which 144 people died, also highlights the issue of patient safety within the public health sector. This tragedy's positive outcome is its extensive coverage, highlighting the need for patient safety (Zille, 2018).

These previous incidences show continued poor management in the public health sector, highlighting how the healthcare system is being destroyed. It draws attention to the appalling disrepair of many hospital buildings, where elevators break down regularly, and patients must be carried up and down the stairs on stretchers. Renovations, if initiated, are "often halted midway without any explanation," and the works are usually "amateurish and sub-standard" (GroundUp, 2017).

Infection Prevention and Control. Regarding infection prevention and control in the South African health system, the OHSC noted the following deficiencies per the 2016/17 inspection; Hospitals are not providing isolation facilities for infectious and communicable diseases, which impacts patient safety. There were no policies or procedure manuals relating to the isolation of patients; There was no evidence of hand washing campaigns; There was no evidence of educational material for staff and patients regarding common healthcare-associated infections; Educational material relating to specific infections such as swine flu, cholera and Methicillin-resistant Staphylococcus aureus (MRSA) was not available (OHSC, 2017)

Values and Attitudes. The values and attitudes of health workers are the personifications of any health system (WHO, 2015). It has been accepted by politicians and health managers alike, and if the human resources being applied in health do not improve, the overall performance in health will not improve. Since 1994 there have been several positive initiatives to address this element of health, including financial incentives offered to those engaged in public health. Unfortunately, the roll-out of these initiatives has been hampered by implementation flaws (Gray & Vawda, 2016).

The Human Resources for Health (HRH) strategic plan was formulated in 2011 and concedes that the human resource element of health requires much attention (DoH, 2011a, p. 7). The values embedded in the Human Resources for Health (HRH) strategic plan include the need to; Provide patient-centered quality health care; Ensure universal coverage and universal access to health care; and Enable an innovative and caring environment for health professional development and patient care (DoH, 2011a, p. 76).

The HRH strategic plan also acknowledges that the attitudes of healthcare providers need to be determined, and the document proposes an audit of attitudes (DoH, 2011a, p. 113). Illegal labor strike action by healthcare workers and nurses also creates the impression of an absence of care for patients and speaks to the attitudes of the healthcare workers and nurses. News 24 reported in 2017 that the Gauteng health department had paid more than R1 billion to settle 185 medical negligence cases since January 2015. In addition, another 51 cases before the court were expected to claim some R414 million. Babies with brain damage accounted for 76% of these claims (Raborife, 2017).

The annual report by the DoH for the 2016/17 year indicated that R13.4 billion had been allocated to medico-legal liability, which represents a growing portion of the department's budget that could be better spent on providing quality care. According to the then Gauteng Health MEC Gwen Ramokgopa, the more disturbing revelation was that none of the staff members involved in the negligence cases had been disciplined (Raborife, 2017). This lack of accountability is further evidence of a failing public health system, and these failures would need to be corrected as the first step toward achieving UHC.

Waiting times. An unequal distribution of health professionals across the various provinces plagues the South African health system. The unequal distribution of health services across the country is evidenced by the 33 specialists per 100 000 residents in the Western Cape compared to 1.3 specialists per 100 000 in Limpopo. According to the GroundUp (2017b) report issued in November 2017, the state of clinics in East London was cause for concern. After receiving complaints from community members, GroundUp decided to investigate the Newlands Clinic, which is responsible for servicing close to eight villages in Nxarhuni outside Mdantsane in East London. The investigation revealed that the registration of patients was done in a tent that was not insulated against rain or severe heat. The day the clinic was visited, only one nurse was on duty. One patient who arrived before 07:00 had to walk five km to the clinic. There was no certainty that he would be attended to that day, even though he was only there to take his treatment and did not require the nurse's service.

The second visit to the clinic a week later also found only one nurse on duty, and it was an icy cold and windy day which was not made any easier by the tent. In addition, there was no electricity or running water available at the clinic that day, and patients had to relieve themselves in pit toilets. A doctor is only available at the clinic twice a month, and if communities desperately need the services of a doctor, they need to travel to Mdantsane, and transport money is required (GroundUp, 2017b). The 2017 report by the OHSC noted that patient privacy needed to be maximized in the provision of care, specifically where doors, screens and curtains would be left open while attending to patients. It points to patients being treated without respect and care. There needed to be more patient rights, and posters and help desks were not available at the entrance of hospitals.

Leadership and Corporate Governance. Damage to the leadership and corporate governance applicable to the public health sector came in several forms and ways. One example is then President Thabo Mbeki's refusal to acknowledge the growing HIV/AIDS pandemic and dismiss the use of ARVs. This denialist response compounded the burden of the disease. It served

Dihlabeng Hospital, around “300 patients on a waiting list for spectacles, but [could not] get it due to lack of funds”. Problems and issues listed included the ambulance crisis, the capped x-ray services, and doctors needing to be employed but unnecessary management positions being created (GroundUp, 2017a).

Discussion and Policy Implications. The literature review showed that adequate healthcare as a direction of health systems and as a set of health services provided in South Africa could enhance quality, outcomes, and cost of care. The evidence favors measures that improve infrastructure and service delivery and enhance practitioners' capacity to carry out their duties and realign health systems. There are various measures in the Policy Paper for NHI in South Africa, the Negotiated Service Delivery Agreement (NSDA) and the Core Standards for Health Establishments that are meant to strengthen primary care. These policies and frameworks hoped that the primary care workforce would be increased, primary care practitioners will be given new skills, and the current delivery system would be reoriented through organizational and payment reforms. The analysis of the evidence backs initiatives to improve providers' capacity to provide primary care services and to refocus health systems on primary care. There is less proof, though, that broadly expanding the number of South African doctors can improve health outcomes and slow healthcare spending growth unless these initiatives are effective. The evidence supports the expansion and ongoing review of the initiatives already in place to equip health professionals better to perform essential primary care functions. Payment reform (for instance, lessening the importance of fee-for-service payments), in-kind support (for instance, continued investment in health information technology), and technical help (for instance, a primary care "extension service") are all examples of policy interventions that are needed.

Increasing the quantity of primary care-trained physicians will be necessary to redirect the healthcare system. The public's perception of primary care needs to be improved. Capital investments need to be redirected away from high-tech procedural services with little impact on population health and toward community-based primary care. Communication between specialists and primary care providers needs to be improved. All these factors contribute to meaningful system-level change. Additionally, even if the workforce is reluctant to adapt, payment reforms to lessen the importance of 'cash and carry' payments and close the pay gap between cognitive and procedure-based services may contribute significantly to reorientation.

The analysis of the evidence indicates that these systems have a significant impact on patient care. The debate shows that despite policy interventions resulting from the reform, the long-established characteristics of the health system are likely to shift towards primary care slowly, even with significant incentives. Increasing the number of primary care professionals may lose a significant opportunity to enhance the quality of health care delivery in South Africa without focused measures to reorient local health systems and improve the capabilities of primary care professionals. The determined pursuit of primary care as a health systems approach, on the other hand, is expected to positively affect the quality, outcomes, and cost of healthcare in South Africa, according to the available research.

CONCLUSION

The degree to which the various health policies and frameworks in South Africa have succeeded in reducing inequality has yet to be discovered and synthetically documented. This study reviewed existing literature to evaluate the state of the health system in South Africa. This study aimed to examine the nature of healthcare delivery in South Africa. The state of the South African health system was assessed by researching the performance according to the six priority

areas and other performance scores. These priority areas comprised safety, efficiency, patient-centredness, accessibility, equity and effectiveness. The study performed a document analysis of research publications and policy documents in the South African health industry was done for the study. The evaluation revealed that the present health system needs to catch up to the National Core Scores and has a detrimental effect on household satisfaction levels. The results showed that, despite legislative efforts, there still needs to be more disparities in access to and use of health care. The review also revealed that users' opinions of South Africa's public healthcare systems are worsening. There is proof of treatment delays, lengthy wait times, severe shortages of physicians, specialists, and nurses, a lack of the proper medications, and subpar delivery of healthcare services. The information offered regarding the South African healthcare system can help inform talks about health equality, including how households from various socioeconomic backgrounds use healthcare services and how policies can make it easier for low-income households to get high-quality healthcare.

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