Infrastructure commission feedback

PRESIDENTIAL HEALTH SUMMIT

Major Challenges

- Infrastructure is in crisis
  - Failure of management
  - Lead, govern and crack the whip
  - ‘Back-to-basics’ purely management tidying up, painting, basic maintenance, moveable asset management cycles
- All role-players must revert to honesty, integrity, , respect and ethics
  - Patient first
  - ALL people, not just those making most noise or easiest access to authorities
  - Governance (Boards and committees)
  - Management, accountability and consequences
- Maintain, maintain, maintain, plus repurpose/refurbish and add capacity

Current infrastructure

- Short term - Greatest pressure is
  - MNCH
  - acute psychiatry in general hospitals
  - student accommodation for training
  - specialised rehab care and disability design/logistics
  - may be places where private capacity can be made available
- Medium to long term
  - infrastructure must respond to the service plan
  - MTEF capex committed 3 years, tenders awarded
  - maybe flexibility at mid-term reviews
  - 10 year infrastructure plan shows objectively where demand/need is greatest
- There is also health infrastructure in:
  - NGO sector, SAMHS, Correctional Services and private occupational services

Cross-cutting impediments

- Dept of Public Works – high levels of frustration
  - health departments must not be compelled to use public works departments as infrastructure implementing agents
  - (Noting statutory provisions of GIAMA and its mechanisms)
- Supply chain (SIPDM) – tail wagging the dog
  - separate capex supply chain from general supply chain management
  - tendering problems in rural areas means additional support required, not neglect
- Procurement requirements
  - SMME participation is creating extra costs and backlogs – need to rethink how
- IT and data

Capacity to manage infrastructure

- Public sector building costs greater but only partly explained by risk and different utilisation pressures
  - excessive design space
  - inefficiencies owing to failure to consult clinical professions
  - corruption, price inflation not all justified
  - consequences for failures and corruption, destroying property, etc
- Human resource capacity in health to manage infrastructure
  - NDOH and provincial DOHs need correct professionals

Optimising infrastructure

- Righting historical imbalances and inequity
  - tertiary capacity fundamental to training and peripheral clinical strengthening
- Clinical management choices, communication & referrals
- Poorly utilised capacity results in patients sent elsewhere
  - theatres, Linac and radiology equipment

Roadmap

- Plan must respond to changing population and clinical dynamics, cannot be static
- National master planning to facilitate equity
  - well managed coordinating mechanism (health, IDT, CSIR, DBSA, Treasury, DPW) and not each province just doing its own thing
- but local:
  - built environment professionals with:
  - inputs from clinical professions and organised labour involvement in design throughout life of infrastructure
  - modernisation, refurbishment, fit-for-purpose
  - review reg: categorisation, definitions, approved bed numbers, etc
  - operational budgets to be more flexible to follow functions
- Alternative funding mechanisms
  - special health infrastructure fund (PIC, CSI, other)
  - social impact bonds