A Strategy for SA Heart

Following an EXCO Workshop on 3 and 4 February 2012

Version 2.0
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Executive Summary: SA Heart Strategy in Brief

This section provides a summary of the most salient points from the newly developed strategy. The full arguments and motivation for the statements here should be read in the main body of the document that outlines the processes followed and the decisions made at the strategy workshop in February 2012.

Vision

The vision for SA Heart is:

“Influencing and enabling cardiovascular health in South Africa”

Mission

To achieve this vision, SA Heart sets itself a mission to do the following:

- Support and promote all aspects of cardiac health and well-being in the country
- Endeavour that all South Africans should have access to cardiac assessment and care
- Being aware of the shortcomings in the health care sector related to access to cardiac assessment and care
- Facilitate the training of cardiologists and address numbers, lack of equipment, limitation of resources, etc.
- Advocate a holistic approach under the umbrella of SA Heart to cardiac health promotion, in alliance with allied organisations, Regional Branches and SIGs and amplify their important contributions that are currently being offered
- Promote a public and government understanding that cardiac disease is common (it affects one in three medical admissions to any hospital) and is not all expensive and high powered and should specifically not be overshadowed by a policy of primary health care

This strategy is a statement of intent that SA Heart is exploring, pursuing and promoting the above ideals and desires to align its services to members and impact in the health care industry to achieve better cardiovascular health in South Africa.

To achieve this mission, SA Heart will continue to:

- Provide services to its members to enable them to focus on practicing as cardiologists
- Publish a mouthpiece, the SA Heart Journal
- Organise an annual congress
- Speak out on issues of cardiovascular health care in South Africa
- Represent its members in communications and consultation with industry, the Department of Health of the National and Provincial Governments, The South African Medical Association (SAMA), The Council for Medical Schemes (CMS), Funders, the Health Professions Council of South Africa (HPSCA) and other regulatory bodies
- Provide guidance to its members on ethical and clinical issues, matters and practice
Strategic interventions
To implement the mission, the following strategic interventions are listed:

Branding and Marketing (Identity, visibility, profile and perception of SA Heart)

The association will be known as “SA Heart” and not the “South African Heart Association.”

The identity of SA Heart is stated as:

“SA Heart is a voluntary professional non-statutory body representing the interest of professionals and allied professionals in the field of cardiovascular health care in South Africa.”

SA Heart should be visible as a notable influence. It must create the climate of an association in unity and be inspirational. This it will achieve through earning respect and awareness. Its logo must represent its brand and be known to all its stakeholders and is shown below:

It is important that the SIGs are seen as being united with SA Heart. For this reason, SIGs should always state in their branding that they are associated with and linked to SA Heart and respect the use of the logo and the positioning of the SIG as “a SIG of SA Heart”. In making SA Heart more visible, it should start with its members. Members should be well-informed about what SA Heart is about and the benefits they receive. In this way members will become inspired advocates of SA Heart.

Leadership and member representation
SA Heart takes on a leadership role by providing information, guidance and support in areas of cardiovascular professional activity such as guidelines, education, sustainability, etc. Its position on relevant issues such as training, standards, research focus and policy interventions should be clear. SA Heart will publish regular position papers on such issues and communicate this to the broader stakeholder base through press releases. An immediate intervention is that SA Heart will negotiate with funders on the abolishment of chronic forms. The prescription should be sufficient information to funders to authorise payment. SA Heart will also draw up a road map for the cardiovascular profession in South Africa, containing various scenarios, foresight and targets.

Response from cardiology on the NHI
The cardiology profession should be well understood by government in laying down the principles for the NHI. SA Heart will develop a policy input paper on its position on the NHI and the role cardiology should and could play, with a clear view of what will be required to optimise the
contribution of the profession in a national health system. An important input in the NHI debate is the service package for cardiologists and Cardiothoracic Surgeons. SA Heart will take up negotiations with government in collaboration with the South African Medical Association (SAMA) on inputs required from the cardiovascular profession.

Guarding standards of excellence
SA Heart will continue to guard and enforce standards of excellence in cardiovascular practice as it is currently doing it through its Ethics and Guidelines Standing Committee. SA Heart will update and publish guidelines on standards of excellence on a regular basis. Private practice largely follows European standards, either in its original form or in a modified form. In the public sector, the same standards of excellence should apply, but sensitivity should exist about the reality of the situation and a compromise between the ideal and what is practical should be reached.

Education and knowledge retention
SA Heart should lobby government with higher education and training institutions to increase the number of registrar posts made available for cardiology. The private sector could be another potential source of funding for registrar posts. SA Heart should also set goals for what the make-up of a specialist should be if he/she wants to become a cardiologist. SA Heart could also provide guidelines for the right balance of cardiologists in private and public practice. SA Heart should lobby with the authorities to extend the retirement age to keep more experienced practicing cardiologists in the profession. To enable cardiologists to focus more on their specialisation, an understanding needs to be developed with general practitioners to take over patients for care after an intervention or operation sooner and more comprehensively. More technologists can also be trained to do certain procedures (e.g. echo screening). This will further alleviate the situation in hospitals and clinics where there are no cardiology services. In terms of reversing the brain drain, models have to be developed to attract expatriates back from abroad. SA Heart has to assist training institutions to develop an education and training model for cardiology. The training institutions has autonomous responsibility for training but through the Education Standing Committee, of which the Departmental Heads of the Training institutions are members by default, a unified and endorsed proposal should be presented to the College of Physicians presently responsible for certification of training. This is the feasible route in the absence of a College of Cardiology that has this function as in the USA.

Research
SA Heart will provide guidance and enablement for research through lobbying for funding and facilitating partnerships for research in cardiology. Two types of research are recognised: basic, normally undertaken by universities and clinical, normally supported by the industry. Coordination and consolidation of existing research initiatives will result in a focused endeavour, providing research outcomes required by the profession and industry. SA Heart will pro-actively get involved in the promotion and motivation for doing the right research. SA Heart will also involve itself in ethical issues of research through its Ethics and Guidelines Standing Committee.
Billing
SA Heart should guide its members to determine an appropriate fee structure. The principles by which these are determined and implemented should be communicated to the funders.

Collective bargaining
SA Heart could play a role in collective bargaining in the public sector. This will result in lower prices for state hospitals. In the private sector, though, devices are sold directly by the distributor to the patient and no power through collective bargaining can be exerted on the industry. SA Heart should, however, play the role of a price watchdog in the private sector and assist its members to negotiate on behalf of the patient to get a fair deal.

Proportional distribution of professionals (state and private)
The disproportional distribution of specialists in the private and public sector will be addressed by SA Heart as part of input towards the position of the profession for the NHI. The education and training model mentioned above will also consider this concerning issue.

Communication with stakeholders
A need exists for a high level professional to represent SA Heart as a Public Relations Officer/Communication Officer. This individual must become the SA Heart face with government and other stakeholders. This position should be reflected in a revised management structure and should be reserved for a black (African, Coloured or Indian) person. A complete communication plan is to be developed by EXCO. Communication media suggested include social media, the website, the annual congress, the SA Heart Journal, a monthly electronic newsletter.

Member benefit
SA Heart will draw up a statement on member benefits. This statement will be published on the SA Heart web site. The benefits are defined from the discussion on the reason to exist and include:

- Belonging to a unified professional landscape
- Access to locally organised congresses and meetings
- Access to an effective communication channel to and amongst healthcare professionals
- Access to and opportunity to contribute easily to accurate data under strong data custodianship
- Unified international representation through formal relationship agreements with similar associations
- Having a mouthpiece towards guidance, facilitation and lobbying for improvement of the environment to deliver effective cardiovascular healthcare
- Access to and representation for enhanced negotiating power with funders and regulatory bodies
- Added value of belonging to optimally coordinated Special Interest Groups
- Working in high quality environments through the monitoring of standards by SA Heart
- Experiencing coherence in guidance on policy interpretation and influence
- Experiencing a sense of belonging and seeing SA Heart as a professional “home”
Influencing high level decision making
With the availability of a dedicated communicator, SA Heart will be in a position to influence decision making directly. This applies to all stakeholders but especially in providing input into the NHI development and for communicating the service package for cardiology in the NHI. A position statement should be developed for SA Heart and how it sees itself in interacting with the decision makers. This will ensure a uniform message going out from the association.

Better financing and financial planning
A financing plan must be drawn up for SA Heart. This plan is not intended to provide a detailed budget, but addresses issues such as sources of revenue, type of expenditure to support the strategic direction and interventions, financial governance, financial reporting and transparency. New potential sponsors must be identified, aligned with new projects, the membership subscription structure could be reviewed and financial management processes ideal to SA Heart must be found. Having an agreed income and expenditure plan and not relying on what was internally termed “pay as you go” is an important aspect of this plan.

Structure
Structural changes are complying with the constitution of the association. The EXCO has the executive function and calls together the National Advisory Council on which the Chairs of Regional Branches, the Chairs of the SIGs and the Chairs of the Standing Committees are represented on an ad hoc basis as requested by the President of SA Heart. For day-to-day management the EXCO has a mandate to operate with chosen members and the Standing Committee represented by the Chair Persons Committee. The SIGs are represented in the Standing Committees. The Standing Committees implement decisions made by EXCO and the SIGs. Currently, two of the SIGs (HeFSSA & SASCI) have outsourced their management to a Management Office. It is proposed that a Management Office is rather associated with the EXCO. This Management Office then provides services as required to EXCO, the Standing Committees and the SIGs.

The motivation behind the structural changes is:

- The constitution of the association is supported
- The structure reflects unity
- Duplication is avoided
- The Standing Committees are revitalised and become active
- Finances are optimised
- The not-for-profit principle applies
- A services rendered principle is introduced
- The SIGs and Regional Branches are kept as sub-groups in the SA Heart “family” although they remain autonomous
- Collective interest is promoted
- Multinationals will be more prepared to fund a consolidated structure
SA Heart Values

SA Heart and all its members promote the following values:

- Promoting competence
- Integrity and ethics in conduct
- Caring and compassion for patients
- Responsibility and commitment by volunteer officials
- Advocacy of the cardiology profession
- Maintaining confidentiality
- Encouraging the spirit of enquiry

In an environment governed by strong ethics, this value statement is aligned with ethics principles of the profession, but also point out the intent to govern in a highly responsible and sensitive fashion.

Monitoring and evaluation

A strategy is only as good as its implementation. A monitoring and evaluation process in terms of following the strategic routes identified here will be put in place and the Management Office inside SA Heart will be given the responsibility of controlling quality at this level.
Full Strategy Document: Processes and Outcomes of the EXCO Strategy Workshop

This part of the document constrains the full details of the deliberations that led to the SA Heart Strategy.

Introduction and background

The South African Heart Association (SA Heart) was formally constituted in September 1999, from the amalgamation of the Southern African Cardiac Society and the South African Society of Cardiac Practitioners, becoming the sole organisation representing the professional interests of all cardiologists and cardio-thoracic surgeons in the country. Membership now includes many medical technologists, nursing personnel and scientists involved in cardiovascular research.

The Special Interest Groups (SIGs) affiliated to SA Heart include the Paediatric Cardiac Society, the Arrhythmia Society, the Cardiac Imaging Society, the Surgical Group, the Society of Cardiovascular Intervention, Heart Failure Society of South Africa, South African Society of Cardiovascular Research and the Lipid and Atherosclerosis Society.

The Standing Committees of SA Heart EXCO include: Education; Ethics and Guidelines; Finance; Full-time Salaried Practice; Private Practice and SHARE.

Purpose of the strategy session

The purpose of the strategy session was highlighted\(^1\) as to:

- Develop a strategic framework for reference and to guide decision making for SA Heart
- Get to know how to make the SA Heart more visible to its stakeholders and members
- Raise the profile and impact of SA Heart
- Ensure that burning issues identified by EXCO are addressed in a strategy
- Consider communication strategies with stakeholders
- Obtain clarity on added benefit for SA Heart members
- Understand how to finance the strategy
- Ensure that the status of the profession is recognised
- Consider whether SA Heart requires a unique model

Expectations for a strategy

The following expectations were raised by the strategic planning group\(^2\) in EXCO:

- SA Heart should unite its members as a force and not let them operate as individuals
- The role of Special Interest Groups (SIGs) should be clarified
- The service provision to the South African public should be optimised
- Imbalances between the public and private sectors should be addressed
- The lack of proper data is a critical problem and should be addressed

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\(^1\) Dr Adriaan Snyders, President of SA Heart

\(^2\) See Appendix A: Workshop Delegates
• SA Heart should be operated as an efficient organisation
• SA Heart should represent its members in the National Health Insurance (NHI) debate with government
• The definition of a cardiologist as a specialist should be clear to the NHI
• The foundation of SA Heart should be the promotion of patient care
• The financial status of SA Heart should be addressed and fund-raising mechanisms should be identified
• Education and training of cardiologists should be addressed and the interface with the Department of Health (DoH) on these matters clarified
• Public-private partnerships (PPPs) should be understood
• The strategy session should finalise repetitive issues
• SA Heart should emerge with an elevated profile from this strategy
• The relationship between SA Heart and SIGs should be clarified and formulated
• The strategy should bring back the passion of members
• The sub-speciality passion in SIGs should be rekindled
• A spokesperson/communicator from the profession should be identified to represent SA Heart in discussions with decision makers
• Decision making in EXCO must be clarified
• The relationship between EXCO and the Standing Committees need to be redefined
• SA Heart should inform patients about their rights and options to be funded by medical schemes
• SA Heart should negotiate with funders to abolish chronic medicine forms
• Knowledge sharing on procedures should be promoted

Most pressing issues
The most pressing issues that the strategy should address have been identified by SA Heart EXCO before the session and include:

• SA Heart needs to speak out on the issues such as the lack of cardiologists; lack of funds for training and education and document an opinion on the NHI.
• Better communication is required with SIGs; SAMA; Funders; Industry; CMS and even SAPPF and DoH.
• SA Heart members are looking for added benefit to them as members of SA Heart. The common question that needs to be addressed is “why should I be a member of SA Heart?”
• Financial planning needs re-evaluation. Even a non-profit organisation needs a retained income to promote its projects.
• Cardiologists; Cardiothoracic Surgeons; Scientists and Allied Cardiology Professionals should not undersell themselves.
• SA Heart is based on what is being done in Europe, but is this appropriate? Is an own identity an imperative?

The strategic planning process
A workshop was held by the South African Heart Association Executive Committee (EXCO) to formalise a strategy for the association. The strategic planning process followed a route outlined in the diagram below. These components also form the structure of the strategy document.
The macro-environment

The international trends and dynamics of the world of cardiac research and practice and similar professional association were highlighted\(^3\) to set the scene for the strategy planning. The views are of a non-technical nature and consider the state of the profession on a global level.

Cardiology Associations

A case study was considered on the American College of Cardiology\(^4\). The American College of Cardiology (ACC) is a 39 000 member non-profit medical society, is dedicated to enhancing the lives of cardiovascular patients through continuous quality improvement, patient-centred care, payment innovation and professionalism. Comprised of physicians, nurses, nurse practitioners, physician assistants, pharmacists and practice managers, the College bestows credentials upon cardiovascular specialists who meet its stringent qualifications. Above all, the commitment from the ACC to its members and their patients has driven the College to be a leader in the formulation of health policy, standards and guidelines, and a steadfast supporter of cardiovascular research. The ACC provides professional education and operates national registries for the measurement and improvement of quality care. It has a published code of ethics and emphasises the importance of its existence having a recognised value for its members. It makes available a clinical tool, support practice management and publishes a Journal of the American College of Cardiology (JACC) that is also accessible over mobile media such as iPad. It is seeking and recognising international membership, also with SA Heart. The ACC is headquartered in the Heart House in Washington.

A further case study was done on the European Society of Cardiology\(^5\) (ESC). This association has 79 000 members, comprises 5 Associations (Echocardiography, Heart Rhythm, Heart Failure, Prevention and Rehabilitation and Percutaneous Interventions). It represents councils for basic cardiovascular science, cardiology practice, cardiovascular imaging, cardiovascular nursing and allied

\(1\) Dr Adriaan Snyders  
\(2\) www.cardiosource.org  
\(3\) www.escardio.org
professions, and cardiovascular primary care. It further has 19 working groups and 54 national societies and several affiliated societies, of which SA Heart is one, since 2005. The European Heart House is the administrative headquarters of the European Society of Cardiology. The European Heart House also serves as a meeting centre for educational courses and ESC meetings.

Characteristics of other continental associations include the central role congresses are playing, strong membership basis, streamlined official communications, education and training, knowledge transfer, setting strategic goals and international networking.

On the contrary, South Africa has an official registered number of 198 Cardiologists, 110 Cardio-thoracic Surgeons, and 38 Paediatric Cardiologists. Only two thirds of these professionals are members of SA Heart.

Cardiovascular disease is the number one non-communicable disease in the world. It requires sound scientific approaches and is supported by innovative technology. There are many opportunities for cardiologists in the professions to still improve their knowledge and practice.

**Cardiovascular disease prevalence**

The changing prevalence for cardiovascular disease (CVD) was shown as background information.

- It is estimated in 2002 that 29% (16.7 deaths annually) and 43% of DALY (Disability-Adjusted Life Year) are due to cardiovascular disease (CVD) worldwide.
- Estimates around 1996 were that 78% of global mortality and 86% of mortality and morbidity occurs in developing countries.
- In 1998 CVD was estimated to account for 73% of global mortality and 56% of global morbidity by 2020.
- In Africa CVD was in 1999 the second most common cause of death and rated at 11% - The World Health Organisation (WHO) estimates that this will double by 2020 and most victims will be middle aged with massive implications on the poverty cycle.
- The present mortality in Africa occurs between 30-69 years of age which is 10 years younger than in the Industrialised World.
- The direct cost of CVD in the United States is estimated at USD 300 billion annually. That approaches the GDP of sub-Saharan Africa.

There are three drivers for epidemiological transition:

- Declining Infant and Child Mortality – an increase in survival until middle age is observed. By 2025 Africans surviving beyond 60 years will increase from 39 million to 80 million.
- Lifestyle changes include an increase in tobacco use, increased calorie intake and decrease in exercise.
- Declining death rates from Communicable Disease are the result from better primary health care, socio-economic development and vaccination.

Specific challenges for Africa include:

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6 Some are not in active practice or working overseas but are still registered

7 Prof F Smit
• Data is extremely unreliable
• Complete under-estimation of future impact of cardiovascular disease on death rates
• Complete under-estimation of cardiovascular disease impact on the poverty cycle
• Up to 90% of health budgets is spent on salaries
• Donor funding focus on social development, communicable disease, maternal and paediatric care

A situational analysis

After looking at what was happening in the global context, a situational analysis was done9 of the local environment and to provide a base for a discussion on the factors and forces that will shape the way the local profession operates in future and to consider the emerging strengths, weaknesses, opportunities and threats for SA Heart.

In an article on the development of cardiology in South Africa, it is stated that “Cardiology has become a leading discipline of South African medicine. It provides sophisticated services for clinical conditions at all levels and has the support of skilled cardiac surgeons. Training of under- and post-graduate students is outstanding and research has contributed greatly to our knowledge. The time may well have come for the [SA Heart Association] to set up a physical ‘heart house’. This should be established at a neutral site and not be attached to any major institution.”

The history of the South African Heart Association was outlined from the first formal professional society in 1957 through the political changes in the country in 1994. The skills resource following democracy in 1994 has been discussed in detail in a 2002 article10 on “Cardiology after Apartheid: brain-drain and brain gain at the tip of Africa”. In that year there were 42 million people in South Africa, and 25% of deaths were HIV/AIDS related. What is significant is that 22% of deaths were heart attack and stroke related. In 2002 the country had 30 000 doctors of which only 156 were cardiologists. The situation then was characterised by an emphasis on Primary Health Care in health policy, the lack of funding for teaching hospitals, and increasing burden of cardiovascular disease, exacerbated by a total overhaul of education and the threat of the brain drain and resultant loss of specialist expertise. A large division between the private sector and public health care existed.

In 2012, ten years later, the state of cardiology in South Africa has evolved to 198 cardiologists for 49 million people (of which 20% are privately insured). There are 135 cardio-thoracic surgeons and 38 paediatric cardiologists.

The cardiologists in private practice work increasingly under higher pressure (patient load, time constraints, no time for adequate deliberation, fire fighting instead of fire prevention); difficult circumstances for maintaining standards of excellence (Continuing Medical Education and after hours work); increased financial pressure (running a practice, regulated fee structures, honour vs expediency, motivation); increased patient expectations and responsibilities (taking sole responsibility of individuals, litigation threats); problematic relationship with funders (medical

9 Dr Adrian Horak
schemes (frustration and resentment, inordinate influence, enormous administrative loads); peer pressure (positive motivators, but also perceived rivalries, territorial imperatives, a deficit mentality, feeling of isolation); deciding on which associations or societies to belong (accreditation, assistance, guidelines); dealing with pharmaceutical companies and device suppliers (filtering through biased information, resisting subtle and sometimes overt pressure); and pressure to produce and unrealistic expectations from hospital groups.

The changing world of cardiologists include shifts from: being reactive to becoming pro-active; practicing a science instead of an art; being expected to rely more on evidence than experience; working as a member of a society more than as an individual; putting practicality before idealism; worrying more about economics than care and becoming marketers more than medicine people. Compromises on these opposing poles have to be made on a daily basis.

Many cardiologists experience burnout with the symptoms of: lack of energy and motivation; negativity and cynicism; lack of interest in own work; antagonism towards colleagues and family; feeling nothing more can be given; resistance to go to work; touchiness - becoming angry and irritable for little reason; suffering from chronic diseases; becoming a workaholic and being absent minded; often being late or finding difficulty in beginning and ending tasks.

The risk factors for individuals with burn-out include: being performance driven; tending not to accept support; finding it difficult to delegate responsibility; preferring to work alone; avoiding discussing personal problems; displaying personal identity rather than a professional identity; being totally overworked because not being able to show work away; developing asymmetrical working relations and displaying a lack of positive feedback outside the work environment.

Work load increase is the result of patient load; severe understaffing; teaching commitments and a growing dissatisfaction with respect to constraints in resources. The erosion of resources results mainly from a shift in policy from tertiary to primary health care and the inadequate facilities available for work. Research is severely hampered by not having sufficient time, the lack of funding and the lack of acknowledgment for research findings. Those involved in academic programmes have to deal with academic politics. Frustrations with private practice mainly result from the sense of isolation.

The main challenges faced by cardiac surgeons result from the changing environment, the difficulty on maintenance of standards, uncertainty about future training and the impact of new technologies.

Several societies are accessible to cardiologists to assist them in alleviating some of these frustrations. These include SA Heart and the Specialist Interest Groups (SIGs) such as:

- Arrhythmia Society (SASSA)
- Paediatric Cardiac Society of South Africa (PCSSA)
- Cardiac Imaging Society of SA (CISSA)
- SA Heart Association Surgical Group (SAHASG)
- South African Society of Cardiovascular Interventions (SACCI)
- Lipid and Atherosclerosis Society (LASSA)
- Heart Failure Society (HeFSSA)
- South African Society for Cardiovascular Research (SASCAR)
Societies are the custodians of clinical excellence through setting standards and guidelines, interacting and linking internationally, monitoring performance (registries) and peer review. Societies are also responsible for furthering education through publishing journals and newsletters, organising and presenting workshops and congresses, inviting visiting professionals to present lectures, organising overseas fellowships and being involved with training.

The debate about whether societies should get involved in accreditation is a live one. There are several logistical difficulties as well as suspicion and resentment.

Societies represent members in negotiations with e.g. funders and fee structures. They need to be more proactive and aggressive in representing their members. Furthermore societies uphold ethical standards by providing guidelines, advisory bodies and by mediating disputes. Establishing a sense of community is an important role of societies. This can only be achieved through good communication, encouragement, leadership and by lifting the morale.

The situation in the South African government is not encouraging. There is a critical shortage of cardiologists, a lack of training posts, limited funding for tertiary hospitals and a flight of skills through emigration. The impact of the newly announced National Health Insurance (NHI) plan is causing a lot of uncertainty.

There is a severe shortage of electrophysiology (EP) specialists in South Africa. Reference to a paper on the state of arrhythmias and electrophysiology states that there is only a handful of interventional cardiac electrophysiologists, all in private practice, except for one employed in the state sector/university teaching hospital. Most of the EP specialists do general cardiology and not full-time EP. This is in comparison where in the United States there is one EP specialist per 260 000 of the population. Pacemaker implant rates in South Africa are as low as 40 per million, with large sections of the community at 10 per million compared to 600 per million in the United States and Europe. Incidences of conditions that justify pacemaker implants are not less in South Africa, showing the under-serviced state of patients locally.

Although the discussion above focuses on problems, there are many positives and opportunities. South African cardiology still enjoys the highest standard of care, knowledge and ability. It is internationally recognised and supported by world-class research. Cardiologists form a collegiate group with good interpersonal goodwill. Incredible standards are maintained by this small and overburdened group in the face of many pressures, obstacles and problems. Much can be done and needs to be done to improve the situation. SA Heart as a society can contribute significantly to achieving this. Practical examples are: better communication between “Town and Gown”; a concerted action against unreasonable “funders”; aggressive representations to Government and efforts towards unification of the small community.

**Achievements and milestones of SA Heart**

SA Heart has achieved the following since its existence:

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11 A Okreglicki, Arrhythmias and electrophysiology: The State of the Nation
• Establishment and maintenance of a single body that represents the entire national professional body which provides cardiac care in South Africa
• Development of the SIGs
• Holding of the annual meeting
• Production of a South African cardiac journal
• Accepting ESC Guidelines as standard medical care
• Subsidised online Journal access for members
• Development of the SHARE registry
• Development of SA Heart website
• Support of young professionals’ research and travel to overseas meetings
• Maintained solvency

**SA Heart stakeholders**
The discussion on stakeholders was conducted under the guidance of the following understanding of the concept “stakeholder”.

The categories of stakeholders as outlined and defined in the diagram were then listed. This understanding will enable SA Heart to determine the desired relationships it will have to develop with each stakeholder grouping or individual stakeholders.

The stakeholders are:
### Vectors of change

Given a generic understanding of the main international trends and how they are influenced, the local situational analysis, who the stakeholders are, the key factors and forces over which control can be exercised and those key uncertainties that cannot be influenced, can be extracted. These vectors of change are main forces that will determine the direction of the professions and are:

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<thead>
<tr>
<th>Type</th>
<th>Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customers</td>
<td>Members, Patients</td>
</tr>
<tr>
<td>Facilitators</td>
<td>Funders (Medical Schemes), State, Private hospital groups, Government (through legislation), CMS (Council for Medical Schemes), Health Professions Council of South Africa (HPSCA), Health Professions Council Ombudsman</td>
</tr>
<tr>
<td>Suppliers</td>
<td>Pharmaceuticals, Equipment, Devices, Consumables, Knowledge (R&amp;D), Representatives</td>
</tr>
<tr>
<td>Competitors</td>
<td>Peers, Traditional medicine/practitioners/alternative medicines, Nutraceuticals, Conflicting priorities- level of Health Care, Compete for money from state, Patient apathy towards health, Discount pharmacies</td>
</tr>
<tr>
<td>Influencers</td>
<td>Devices industry, SAMED (South African Medical Device Industry Association), Education &amp; training institutions, Litigators, Health Professional Council of South Africa, Funders (Medical Schemes), Government policies, SAMA (South African Medical Association - trade union role), SAPPF (South African Private Practitioners Forum), PASCAR (Pan-African Society of Cardiology), World Health Federation (WHF), European Society of Cardiology (ESC)</td>
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</tbody>
</table>
### Vectors of change

<table>
<thead>
<tr>
<th>Key Uncertainties</th>
<th>Type and examples</th>
<th>Examples</th>
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<tbody>
<tr>
<td></td>
<td>Policy</td>
<td>NHI</td>
</tr>
<tr>
<td>Environment</td>
<td>Policy</td>
<td>State of hospitals, training</td>
</tr>
<tr>
<td>Social</td>
<td>Policy</td>
<td>Changes in heart disease patterns</td>
</tr>
<tr>
<td>Economic</td>
<td>Policy</td>
<td>Affordability of treatment, medical schemes</td>
</tr>
<tr>
<td>Legislation</td>
<td>Policy</td>
<td>Liability, registration, training</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Factors and Forces (Controllable)</th>
<th>Type and examples</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>Policy</td>
<td>Professional skills training, registrar post availability</td>
</tr>
<tr>
<td>Practice</td>
<td>Policy</td>
<td>Private, public, partnerships</td>
</tr>
<tr>
<td>R&amp;D</td>
<td>Policy</td>
<td>Experimental surgery, longitudinal studies, clinical trials, research infrastructure, lack of data</td>
</tr>
<tr>
<td>Technology</td>
<td>Policy</td>
<td>Diagnostic, interventional, surgery</td>
</tr>
</tbody>
</table>

### SWOT Analysis

A SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis for SA Heart has been done based on an understanding of the internal strengths and weaknesses and the external opportunities and threats. These were listed as shown below.

<table>
<thead>
<tr>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths</strong></td>
<td><strong>Weaknesses</strong></td>
</tr>
<tr>
<td>• Well-defined community</td>
<td>• Branding and communication</td>
</tr>
<tr>
<td>• Only body representing cardiology</td>
<td>• Finance</td>
</tr>
<tr>
<td>• Custodian of all the skills/excellence</td>
<td>• Relationship with SIGs</td>
</tr>
<tr>
<td>• High levels of passion</td>
<td>• No time available by professionals to get involved in management</td>
</tr>
<tr>
<td>• Practice a high level of skills</td>
<td>• Solo private practice</td>
</tr>
<tr>
<td>• Represent an important and emotive issue</td>
<td>• Small numbers</td>
</tr>
<tr>
<td>• Goodwill in diversity - collegiality</td>
<td>• Lack of strategic planning</td>
</tr>
<tr>
<td></td>
<td><strong>Opportunities</strong></td>
</tr>
<tr>
<td>• Lot of possibilities within constraints</td>
<td>• Finance - general availability limited</td>
</tr>
<tr>
<td>• Leadership required</td>
<td>• Government policy</td>
</tr>
<tr>
<td>• Potential to influence funders, NHI</td>
<td>• Litigation</td>
</tr>
<tr>
<td>• Better media relations</td>
<td>• Division of society</td>
</tr>
<tr>
<td>• Available finance from market</td>
<td>• Empire building and hidden agendas</td>
</tr>
<tr>
<td></td>
<td>• New industry exclusions on what is funded</td>
</tr>
<tr>
<td></td>
<td>• Apathy of SA Heart members</td>
</tr>
</tbody>
</table>
Main outcomes of environmental scanning

The views represented above provide a good understanding of the environment in which SA Heart operates and its relationships with its stakeholders. The following summary is provided to guide the rest of the strategy development.

- Agreement has been reached on the need for a strategy for SA Heart and clear indications on implementation must be developed
- A thorough understanding exists of the state of the profession and what influences it
- A clear delineation of issues to be resolved include:
  - Elevate the profile of SA Heart
  - Establish a known and respected brand among stakeholders
  - Exert more influence over government, funders and industry
  - Have a strong voice in the NHI debate
  - Quality of data is crucial for an evidence-based debate
  - A funding plan is required
  - Good communication among members and to outside stakeholders is crucial
  - Critically low numbers of professionals and disproportional distribution among state and private practice exist
  - A clear definition of the service package offering for cardiology is required for the NHI
  - SA Heart must provide leadership to its members
  - SA Heart must remain the guardian of standards of excellence
  - The internal relationship with SIGs needs to be defined and strengthened
  - Interaction between public and private sectors and stakeholders must be facilitated
- There is a clear need for a road map in the profession
- Misconceptions exist of the real impact and influence professionals have
- A good grasp on strengths, weaknesses, opportunities and threats has been developed
- Stakeholder identification and classification has been done with an understanding of their role and influence
- Controllable and uncontrollable forces that shape the future of the profession have been defined

The reason for existence for SA Heart

This discussion started with the question “What will happen if we are not here tomorrow?” It relates to the perception of value that SA Heart has for its various stakeholders that were defined earlier. It then interrogates that value-addition and leads to a clear understanding of what difference should be made by being there. Considerations if SA Heart would not be there are:

- Fragmentation of member representation
- No coordination of congresses and meetings
- No effective communications to and amongst healthcare professionals
- No possibility to gather accurate data
- No unified international representation
- Decrease of the possibility to improve environment to deliver effective cardiovascular healthcare
SA Heart Strategy

• Reduced negotiating power with funders and regulatory bodies
• No coordination between and with Special Interest Groups
• No or limited monitoring of standards
• No uniformity in policy interpretation
• No sense of belonging by members

These considerations translate in enough of a reason for existence for SA Heart. The question, however, is how effectively does the association provide services in this respect?

SA Heart vision and mission

SA Heart does not have a stated vision or mission. This leaves its purpose and direction open for interpretation. The vision statement provides future tension between the “as-is” and the “should-be.” The mission statement identifies possible routes to the future destination, without the details of how to navigate on those routes. This gives common purpose of motion towards the future for an organisation. The vision and mission statements should also be in line with the Constitution of the Association.

The exercise to arrive at a vision statement involved the EXCO members to write a newspaper headline on where they see SA Heart being in three years time. The headlines that emerged are shown in the text box.

The following are common aspects that should guide the vision statement formulation:

• The ability to influence and lead
• SA Heart being a spokesperson on behalf of members
• Creating an enabling environment for members

Vision

The vision for SA Heart is:

“Influencing and enabling cardiovascular health in South Africa”

Mission

To achieve this vision, SA Heart sets itself a mission to do the following:

• Support and promote all aspects of cardiac health and well-being in the country
• Endeavour that all South Africans should have access to cardiac assessment and care
• Being aware of the shortcomings in the health care sector related to access to cardiac assessment and care
• Facilitate the training of cardiologists and address numbers, lack of equipment, limitation of resources, etc.
• Advocate a holistic approach under the umbrella of SA Heart to cardiac health promotion, in alliance with allied organisations, Regional Branches and SIGs and amplify their important contributions that are currently being offered
• Promote a public and government understanding that cardiac disease is common (it affects one in three medical admissions to any hospital) and is not all expensive and high powered and should specifically not be overshadowed by a policy of primary health care

This strategy is a statement of intent that SA Heart is exploring, pursuing and promoting the above ideals and desires to align its services to members and impact in the health care industry to achieve better cardiovascular health in South Africa.

To achieve this mission, SA Heart will continue to:

• Provide services to its members to enable them to focus on practicing as cardiologists
• Publish a mouthpiece, the SA Heart Journal
• Organise an annual congress
• Speak out on issues of cardiovascular health care in South Africa
• Represent its members in communications and consultation with industry, the Department of Health of the National and Provincial Governments, The South African Medical Association (SAMA), The Council for Medical Schemes (CMS), Funders, the Health Professions Council of South Africa (HPSCA) and other regulatory bodies
• Provide guidance to its members on ethical and clinical issues, matters and practice

The strategic gap

Knowing what the common destination is through the vision statement and how to move there through the mission statement, the gap between what SA Heart can do at present and what it must do in future is defined. This relates to deciding whether the right issues are addressed at present, whether new ones need to be added and whether the capacity is there from a knowledge, skills, experience, motivation and financial point of view.

The following strategic issues that need attention were recognised:

• Branding and Marketing (Identity, visibility, profile and perception of SA Heart)
• Leadership and member representation
• Response from cardiology on the NHI
• Guarding standards of excellence
• Ensuring quality of data
• Education and knowledge retention
• Research
SA Heart Strategy

- Billing
- Collective bargaining
- Proportional distribution of professionals (state and private)
- Communication with stakeholders
  - Web site
  - Congress
  - SA Heart Journal
  - Newsletter
- Member benefits
- Influencing high level decision making
- Better financing and financial planning
- Structure
  - Committees
  - SIGs
  - Demography of Exco

Strategic interventions

Actions are now laid down on how to navigate the routes indicated by the mission statement and how to address the identified strategic gaps. These will lead to implementation of actions and operational issues.

Branding and Marketing (Identity, visibility, profile and perception of SA Heart)

The association will be known as “SA Heart” and not the “South African Heart Association.”

The identity of SA Heart is stated as:

“SA Heart is a voluntary professional non-statutory body representing the interest of professionals and allied professionals in the field of cardiovascular health care in South Africa.”

SA Heart should be visible as a notable influence. It must create the climate of an association in unity and be inspirational. This it will achieve through earning respect and awareness. Its logo must represent its brand and be known to all its stakeholders.

The logo is maintained and used either as a single graphic:

Or with the shortened name of the association:
The logo should be displayed on all communication media to ensure visibility and association with the brand.

A trademark application will be submitted to the Companies and Intellectual Property Registration Office (CIPRO) to protect the logo and short name (“SA Heart”) of the association.

With time, as the brand becomes entrenched, SA Heart may consider to take part in brand surveys among various population demographies to establish how well known the brand is and whether people associate benefits and good service with the brand. The brand should have meaning for both the members, patients and all listed stakeholders of SA Heart.

It is important that the SIGs are seen as being united with SA Heart. For this reason, SIGs should always state in their branding that they are associated with and linked to SA Heart and respect the use of the logo and the positioning of the SIG as “a SIG of SA Heart”.

In making SA Heart more visible, it should start with its members. Members should be well-informed about what SA Heart is about and the benefits they receive. In this way members will become inspired advocates of SA Heart.

Branding of SA Heart will be done according to the intervention on establishing the identity, visibility, profile and perception of SA Heart. The branding should clearly promote the clinical, social and benevolent relevance of SA Heart.

**Leadership and member representation**

SA Heart takes on a leadership role by providing information, guidance and support in areas of cardiovascular professional activity such as guidelines, education, sustainability, etc. Its position on relevant issues such as training, standards, research focus and policy interventions should be clear. SA Heart will publish regular position papers on such issues and communicate this to the broader stakeholder base through press releases.

An immediate intervention is that SA Heart will negotiate with funders on the abolishment of chronic forms. The prescription should be sufficient information to funders to authorise payment.

SA Heart will also draw up a road map for the cardiovascular profession in South Africa, containing various scenarios, foresight and targets.

**Response from cardiology on the NHI**

The cardiology profession should be well understood by government in laying down the principles for the NHI. SA Heart will develop a policy input paper on its position on the NHI and the role cardiology should and could play, with a clear view of what will be required to optimise the
contribution of the profession in a national health system. An important input in the NHI debate is the service package for cardiologists. SA Heart will take up negotiations with government in collaboration with the South African Medical Association (SAMA) on inputs required from the cardiovascular profession.

Guarding standards of excellence
SA Heart will continue to guard and enforce standards of excellence in cardiovascular practice as it is currently doing it through its Ethics and Guidelines Standing Committee. SA Heart will update and publish guidelines on standards of excellence on a regular basis. Private practice largely follows European standards, either in its original form or in a modified form. In the public sector, the same standards of excellence should apply, but sensitivity should exist about the reality of the situation and a compromise between the ideal and what is practical should be reached.

The impact of suggested standards on funders needs to be clearly articulated. The Prescribed Minimum Benefits (PMBs) are considered as the minimum standard of treatment. Should standards be increased, this needs to be negotiated with funders to adapt the PMB.

Standards of the environment should also be influenced. Concerns over the state of infrastructure, training and the clinical environment should be addressed with the relevant authorities. Guidelines for minimum clinical environment need to be set and communicated with private hospital groups and state hospitals. Standards of new technology used should also be set and communicated to members.

Ensuring quality of data
It is acknowledged that not enough data is available at the right quality level in many areas of cardiology. SA Heart will encourage the acquisition of data from its members through the SHARE registry and the generation of data from local research. The SHARE registry is to be maintained and expanded. It is unacceptable that members do not participate in building the SHARE registry. SA Heart will undertake to investigate incentives for providing data or the role legislation can play to enforce it.

Education and knowledge retention
The Standing Committee on Education is focusing on cardiological training and not on surgical training as well. The professional council regulates training with the heads of departments (HoDs) at the medical schools. They are lobbying for more registrar posts and are sometimes successful. One way of approaching this is to change the ratio that there should be one consultant for every two registrars, to 1:4. HODs all belong to Colleges of Medicine which are the controlling bodies setting the standards for education and training.

SA Heart should lobby government with higher education and training institutions government to increase the number of registrar posts made available for cardiology. The private sector could be another potential source of funding for registrar posts. SA Heart should also set goals for what the make-up of a specialist should be if he/she wants to become a cardiologist. Although there is no mandate for this, the association can volunteer to take a strong position on this and set a minimum standard. SA Heart could also provide guidelines for the right balance of cardiologists in private and public practice.
The average age of a cardiologist in South Africa is 52. SA Heart should lobby with the authorities to extend the retirement age for full time practice cardiologists to keep more experienced practicing cardiologists in the profession. To enable cardiologists to focus more on their specialisation, an understanding needs to be developed with general practitioners to take over patients for care after an intervention or operation sooner and more comprehensively. More technologists can also be trained to do certain procedures (e.g. echo screening). This will further alleviate the situation in hospitals and clinics where there are no cardiology services.

In terms of reversing the brain drain, models have to be developed to attract expatriates back from abroad. There are many South African cardiologists who have trained overseas but who find it difficult to come back because of red tape around immigration. SA Heart should alleviate that through negotiations with government and the HSPCA. Furthermore, SA Heart should identify international expertise and non-South African cardiologists with an interest in coming to South Africa, especially for positions in the public hospitals, not to leave those decisions over to government officials on their own. It should then advise the Department of Health on such potential talent, should an expansion of posts occur in public hospitals.

SA Heart has to assist training institutions to develop an education and training model for cardiology. The training institutions has autonomous responsibility for training but through the Education Standing Committee, of which the Departmental Heads of the Training institutions are members by default, a unified and endorsed proposal should be presented to the College of Physicians presently responsible for certification of training. This is the feasible route in the absence of a College of Cardiology that has this function as in the USA.

Research

SA Heart will provide guidance and enablement for research through lobbying for funding and facilitating partnerships for research in cardiology. Two types of research are recognised: basic, normally undertaken by universities and clinical, normally supported by the industry. Coordination and consolidation of existing research initiatives will result in a focused endeavour, providing research outcomes required by the profession and industry. SA Heart will pro-actively get involved in the promotion and motivation for doing the right research. SA Heart will also involve itself in ethical issues of research through its Ethics and Guidelines Standing Committee.

Research funding could become an income stream in SA Heart and the association should guide, direct and fund research that it believes will strengthen the profession. SA Heart should prioritise and phase research to ensure the whole profession, members and patients benefit from it. SA Heart should assist researchers in obtaining research infrastructure. Guidelines for research are required, but it is difficult to propose guidelines without substantial data being available. Research data can be consolidated in the SHARE registry. Of particular importance are South African population studies and longitudinal studies.

Extensive cardiovascular knowledge emanating from research in universities should also be disseminated through SA Heart to members. The South African Society for Cardiovascular Research (SASCAR) as a Special Interest Group should assist with the research related issues that SA Heart must strategically address.
Although there is a role for SA Heart to play in guiding research, it should, on the other hand, be careful not to be too regulatory and aim to control too much. It should rather facilitate research and research funding in close collaboration with clients for research and researchers.

**Billing**
SA Heart should guide its members to determine an appropriate fee structure. The principles by which these are determined and implemented should be communicated to the funders.

**Collective bargaining**
SA Heart could play a role in collective bargaining in the public sector. This will result in lower prices for state hospitals. In the private sector, though, devices are sold directly by the distributor to the patient and no power through collective bargaining can be exerted on the industry. SA Heart should, however, play the role of a price watchdog in the private sector and assist its members to negotiate on behalf of the patient to get a fair deal.

**Proportional distribution of professionals (state and private)**
The disproportional distribution of specialists in the private and public sector will be addressed by SA Heart as part of input towards the position of the profession for the NHI. The education and training model mentioned above will also consider this concerning issue.

**Communication with stakeholders**
A need exists for a high level professional to represent SA Heart as a Public Relations Officer/Communication Officer. This individual must become the SA Heart face with government and other stakeholders. Following the American model, this may be a full time practitioner who takes a year off from practice to do this. However, the cost implications of this in South Africa may be prohibitive. This position should be reflected in a revised management structure and should be reserved for a black (African, Coloured or Indian) person. A complete communication plan is to be developed by EXCO.

**Social media**
In addition to making communication a critical function of SA Heart, it will introduce communication through the social media of Facebook and Twitter as soon as possible. This will complement its web site.

**Web site**
The SA Heart web site is operational, informative and kept up to date. It could however, have a more dynamic page where recent events, breakthroughs, policy issues, relevant news and notifications to members could be made on a dynamic and timely manner. Linkage with the social media of Facebook and Twitter can also be supplied on such a web page as well as RSS updates on breaking news. Such a web page could also contain banner adverts that are paid for by industry to assist in the funding of SA Heart initiatives.

**Congress**
The Annual Congress is the most active platform for professional communication among members and for meeting with international peers. It is also the largest source of income for SA Heart. The
congress should be maintained as a flagship professional event and the organising may be facilitated by the appointment of a Congress Standing Committee as suggested later.

**SA Heart Journal**

The SA Heart Journal is the official publication of SA Heart. It is published at least four times per annum. It is an absolutely essential mouthpiece of the profession in South Africa. It contains scientific, clinical and research articles. Currently it is the only communication portal to SA Heart members with the Newsletter included. It is not yet listed in Pubmed but can be easily found and cited. It is different from the Cardiovascular Journal of Africa (CVJA) which is also the official publication of PASCAR. Up till now the SA Heart Journal has been published in-house without external financial support. It also has no advertisements as a source of income and is distributed to all members as part of their membership fee. It has been initiated and managed by the editor, Prof Anton Doubell, without whose continued efforts it would not exist.

SA Heart EXCO has, however, realised that the SA Heart Journal can no longer afford the luxury of financial independence. Consultation is needed to procure sponsorship and/or outside financial support. Efforts should also be continued to have the Journal listed on Pubmed. The Journal should also receive administrative support from the Management Office (to be introduced later). The SA Heart EXCO and the editor need specific discussion on the way forward with the Journal. A survey amongst members as to what they want from this publication should be performed.

The quarterly newsletter should provisionally stay part of the SA Heart Journal, but should be supplemented by at least a monthly “e-News/Bulletin”. Making the Journal compatible with new media such as tablet computers (IPad and others) should be considered. This will mean that members have easy and ready access to articles in the Journal, even when they are mobile.

**Newsletter**

The new newsletter, decoupled from the Journal should appear electronically on a monthly basis. The Communication Standing Committee, suggested later, together with the Management Office should take responsibility for the Newsletter.

**Member benefit**

SA Heart will draw up a statement on member benefits. This statement will be published on the SA Heart web site. The benefits are defined from the discussion on the reason to exist and include:

- Belonging to a unified professional landscape
- Access to locally organised congresses and meetings
- Access to an effective communication channel to and amongst healthcare professionals
- Access to and opportunity to contribute easily to accurate data under strong data custodianship
- Unified international representation through formal relationship agreements with similar associations
- Having a mouthpiece towards guidance, facilitation and lobbying for improvement of the environment to deliver effective cardiovascular healthcare
- Access to and representation for enhanced negotiating power with funders and regulatory bodies
• Added value of belonging to optimally coordinated Special Interest Groups
• Working in high quality environments through the monitoring of standards by SA Heart
• Experiencing coherence in guidance on policy interpretation and influence
• Experiencing a sense of belonging and seeing SA Heart as a professional “home”

The Private Practice Standing Committee should be the channel that engages in personalised communication with members. This should be the norm for all members, whether they are active in private or public environments.

**Influencing high level decision making**

With the availability of a dedicated communicator, SA Heart will be in a position to influence decision making directly. This applies to all stakeholders but especially in providing input into the NHI development and for communicating the service package for cardiology in the NHI.

A position statement should be developed for SA Heart and how it sees itself in interacting with the decision makers. This will ensure a uniform message going out from the association.

**Better financing and financial planning**

A financing plan must be drawn up for SA Heart. This plan is not intended to provide a detailed budget, but addresses issues such as sources of revenue, type of expenditure to support the strategic direction and interventions, financial governance, financial reporting and transparency. New potential sponsors must be identified, aligned with new projects, the membership subscription structure could be reviewed and financial management processes ideal to SA Heart must be found. Having an agreed income and expenditure plan and not relying on what was internally termed “pay as you go” is an important aspect of this plan.

SA Heart does not have the luxury of an endowment or reserve of funds and no income is accrued from investment. The aim should be to do financial planning in such a way that enough money must be available at the start of the year for expenses and projects. SA Heart will actively seek sponsorship for grants, educational projects, to establish online Journal access and to assist in the publication of the SA Heart Journal. SA Heart will consult with the SIGs regarding financial obligations and support. Consultation with industry will be undertaken for transparent sponsorship. A re-evaluation of the sharing model for congress income will be done. The target is that industry should contribute in total up to R 10 million to various cardiac activities.

**Structure**

With a new understanding of strategic direction and the required interventions to get there, the structure of the association should be reviewed. Issues addressed include the representation on the executive committee, committee structures, special interest group structures, etc. Basically the organogram is revisited and decisions are made on whether it is still valid in the light of the new strategic thinking or whether it has to be changed. The relationships with advisory bodies, specialist bodies, members and other stakeholders are tested.

SA Heart is intimately associated with several stakeholders and structures for its operation. The EXCO is the main executive structure. It further has Standing Committees, sub-groups of Specialist Interest Groups (SIGs), Regional Branches and members. A National Advisory Council brings the
EXCO, Standing Committees and Regional Branches together. It is further associated with international peer associations (Europe, United States of America and Africa).

The current structure of SA Heart as described by the constitution of the association is as follows:

The current weaknesses in the structure are highlighted as:

- The National Advisory Council comprises the current EXCO, and the heads of the six regional branches and SIGs. It meets for half a day every second year and as such does not have a large impact.
- The SIGs, not represented on a permanent basis in EXCO and not being part of the day-to-day thinking in SA Heart, tend to operate independently.
- In revising the structure, it must be recognised that it is not practical to have all the representatives from all the standing committees and SIGs and regional branches in an EXCO meeting once per month. If SIGs are all represented on the standing committees, then only the standing committees can be represented on EXCO.
- The standing committees are currently not very active. The profile and activity of the standing committees should be changed. By incorporating representatives of SIGs in all Standing Committees, these committees will be strengthened, empowered and more active.

The new structure proposed is shown and discussed below.
Structural changes are complying with the constitution of the association. The EXCO has the executive function and also calls together the National Advisory Council through the President on which the Chairs of the Regional Branches, the Chairs of the SIGs and the Chairs of the Standing Committees are represented on an ad-hoc basis as required. For day-to-day management the EXCO has a mandate to operate with chosen members and the Standing Committee represented by the Chair Persons Committee. The SIGs are represented in the Standing Committees. The Standing Committees implement decisions made by EXCO and the SIGs.

Currently, two of the SIGs (HeFSSA & SASCI) have outsourced their management to a Management Office. It is proposed that a Management Office is rather associated with the EXCO. This Management Office then provides services as required to EXCO, the Standing Committees and the SIGs.

The motivation behind the structural changes is:

- The constitution of the association is supported
- The structure reflects unity
- Duplication is avoided
- The Standing Committees are revitalised and become active
- Finances are optimised
- The not-for-profit principle applies
- A services rendered principle is introduced
- The SIGs and Regional Branches are kept as sub-groups in the SA Heart “family” although they remain autonomous
- Collective interest is promoted
- Multinationals will be more prepared to fund a consolidated structure

The flow of finances is indicated in the diagram below and shows the source of funding and the entry point into the structure.
Members continue paying separate membership fees to SA Heart and to the respective Regional Branches or SIGs they belong to. The Annual Congress and meetings organised are a major source of income. This may flow through the Regional Branch or the SIG that organises it. An agreement exists on income sharing. Donations may be made to SA Heart or to the specific SIG, depending on the focus of the donor. The Management Office will be offering its services on a paid services rendered basis to Standing Committees and SIGs and external parties that may want to make use of these services.

It is estimated that the current annual income for SA Heart managed by EXCO is about R 1.5 million and for the SIGs combined about R 6 million. The aim is to increase and maintain the sponsorship income from industry to R 10 million.

**Standing Committees**

The Standing Committees are important working groups of SA Heart, responsible for implementation. SIGs will now be officially represented on each committee according to their interest. The Standing Committees will meet monthly by telephone conference; email communication or face to face as is necessary and possible. They will keep the SA Heart Management Office informed about their deliberations and formally discuss their reports on a three-monthly basis with EXCO.

The current Standing Committees that are retained are:

- Education
- Ethics and Guidelines
- Full-time Salaried Practice Committee
- Private Practice
- SHARE

The current Financial Standing Committee is not a committee at present, but only consists of the Treasurer. It is suggested that the financial function, be transferred to the Management Office and that the Treasurer works closely with the Management Office staff.

Given the importance of communication in the visibility of SA Heart and its marketing and branding initiatives that will follow from this strategy, it is recommended that a Communication Standing Committee be initiated.

Strong consideration should be given to also constitute a Standing Congress Committee, given the importance of the Annual Congress for visibility, as a meeting place for members to communicate and as the major source of income generated for SA Heart.

SIGs
The question is raised whether the SIGS contribute to fragmenting the already small community of cardiologists. SIGs will now have a representative on all Standing Committees according to their need. SA Heart must however, communicate the new plan with SIGS and be sure a clear understanding exists of what SIGs require of SA Heart.

The SIGs remain as they are:
- Arrhythmia Society (CASSA)
- Paediatric Cardiac Society of SA
- Cardiac Imaging Society of SA (CISSA)
- SA Society of Cardiovascular Interventions (SASCI)
- Lipid & Atherosclerosis Society (LASSA)
- Heart Failure Society (HeFSSA)
- SA Society for Cardiovascular Research (SASCAR)

It is required that the SIGs declare their affiliation with SA Heart in all correspondence, marketing, media reports and press releases. They are represented through the Chair Persons Committee of the Standing Committee on the SA Heart EXCO.

Demography of EXCO
Serious consideration must be given to making EXCO more representative of the demography in South Africa. This should be done by lobbying with black (African, Coloured and Indian) members to make themselves available for EXCO portfolio positions and for participating in Standing Committees.

Implementing the interventions
Although this is a strategy and not an implementation plan, identification of implementation paths and actions and responsibilities were discussed with guideline dates of completion. Detailed resourcing and scheduling will thus follow at a later stage and be handled by EXCO internally.
The interventions identified and discussed above are shown in the table with an indication of who will be responsible for execution and a suggested date of completion.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Deliverable</th>
<th>Responsible entity</th>
<th>Suggested delivery date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Branding and Marketing (Identity, visibility, profile and perception of SA Heart)</td>
<td>Communication document on branding; Registration of Trademark for logo and name</td>
<td>Secretariat</td>
<td>24 March 2012</td>
</tr>
<tr>
<td>Leadership and member representation</td>
<td>Position paper on SA Heart, its strategy and leadership role; (Communication Standing Committee to be formed); inform Standing Committees about their new role</td>
<td>Office of the President of SA Heart</td>
<td>Progress report ready for March 2012 meeting; 30 June 2012 - Discussion paper</td>
</tr>
<tr>
<td>Response from cardiology on the NHI</td>
<td>Develop a policy input paper – position it as an input document on the NHI; develop a service package for cardiology</td>
<td>Office of the President; each of the Chairs of the Standing Committees will have to prepare an input paper on their focus area</td>
<td>April 2012 – give short document to DOH indicating the SA Heart position - July 2012 – Complete policy paper, including a statement on a Cardiology and Cardiothoracic Surgery Service Package</td>
</tr>
<tr>
<td>Guarding standards of excellence</td>
<td>Regular publication of guidelines</td>
<td>Ethics and Guidelines Standing Committee</td>
<td>Continuous action - About 6 months after the European (ESC) guidelines have been published the South African one should be published</td>
</tr>
<tr>
<td>Intervention</td>
<td>Deliverable</td>
<td>Responsible entity</td>
<td>Suggested delivery date</td>
</tr>
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<tr>
<td>Ensuring quality of data</td>
<td>Newsletter: Notification to members of intention to make it mandatory; informing government on their expected role in mandating data contribution</td>
<td>SHARE Standing Committee</td>
<td>Next Newsletter; Early 2013 - Government communiqué</td>
</tr>
<tr>
<td>Education and knowledge retention</td>
<td>Develop model for discussion and consensus overview document between the two committees</td>
<td>Education Standing Committee and Full-time Practice Committee</td>
<td>End June 2012 - to be ready for July 2012 Congress</td>
</tr>
<tr>
<td>Research</td>
<td>Statement on how SA Heart sees research and what should be done</td>
<td>Dr Adrian Horak and Prof Francis Smit</td>
<td>End June 2012</td>
</tr>
<tr>
<td>Billing</td>
<td>Document on processes of how to establish billing standards</td>
<td>Private Practice Standing Committee</td>
<td>End June 2012</td>
</tr>
<tr>
<td>Collective bargaining</td>
<td>Document on collective bargaining in the public sector and price watchdog in the private sector</td>
<td>Full-time Practice Committee</td>
<td>End June 2012</td>
</tr>
<tr>
<td>Proportional distribution of professionals (state and private)</td>
<td>Part of education and knowledge retention model</td>
<td>Education Standing Committee and Full-time Practice Committee</td>
<td>End June 2012 - to be ready for July 2012 Congress</td>
</tr>
<tr>
<td>Communication with stakeholders</td>
<td>Communication strategy document following on this strategy and appointment of the Communication Standing Committee</td>
<td>Office of the President of SA Heart</td>
<td>End March 2012 – Decision on Communication Standing Committee; July 2012 – Roll out at Congress</td>
</tr>
<tr>
<td>Intervention</td>
<td>Deliverable</td>
<td>Responsible entity</td>
<td>Suggested delivery date</td>
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<tr>
<td>Member benefits</td>
<td>Document on promoting awareness and broadening of benefits</td>
<td>Office of the President of SA Heart</td>
<td>End June 2012</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prof Francis Smit to suggest someone to assist</td>
<td></td>
</tr>
<tr>
<td>Influencing high level decision making</td>
<td>Position statement on how SA Heart will interact with high level decision makers</td>
<td>Office of the President of SA Heart</td>
<td>End June 2012</td>
</tr>
<tr>
<td>Better financing and financial planning</td>
<td>Documented Financing Plan for submission to EXCO</td>
<td>Office of the President of SA Heart including the Treasurer</td>
<td>End March 2012</td>
</tr>
<tr>
<td>Structure</td>
<td>EXCO decision to adopt new structure</td>
<td>EXCO</td>
<td>End June 2012</td>
</tr>
</tbody>
</table>

**SA Heart Values**

SA Heart and all its members promote the following values:

- Promoting competence
- Integrity and ethics in conduct
- Caring and compassion for patients
- Responsibility and commitment by volunteer officials
- Advocacy of the cardiology profession
- Maintaining confidentiality
- Encouraging the spirit of enquiry

In an environment governed by strong ethics, this value statement is aligned with ethics principles of the profession, but also point out the intent to govern in a highly responsible and sensitive fashion.

**Monitoring and evaluation**

A strategy is only as good as its implementation. A monitoring and evaluation process in terms of following the strategic routes identified here will be put in place and the Management Office inside SA Heart will be given the responsibility of controlling quality at this level. This strategy should be revised after three years and when it reaches maturity, monitoring and evaluation should point out the need for a revision of the strategy. The following need to be monitored and evaluated:

- Implementation success of the strategic interventions
- The strategic outcomes achieved
- Stakeholder satisfaction
The manager of the Management Office should use this strategy document to link operational tasks following from the strategic interventions to milestones and measure it. The impact of new interventions could be measured in real time as they are released by using social media such as e-mail, Facebook and Twitter.
## Appendix A: Workshop Delegates

<table>
<thead>
<tr>
<th>Delegate</th>
<th>Affiliation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Adriaan Snyders</td>
<td>Wilgers Hospital, Pretoria</td>
<td>President SA Heart Association, Editor SA Heart Journal, Chair Congress 2012</td>
</tr>
<tr>
<td>Dr Martin Sussman</td>
<td>Milpark Netcare Hospital, Johannesburg</td>
<td>Immediate Past President SA Heart and representing the Surgeons</td>
</tr>
<tr>
<td>Prof Francis Smit</td>
<td>Head: Cardiothoracic Surgery, UFS, Bloemfontein</td>
<td>Treasurer, SHARE</td>
</tr>
<tr>
<td>Dr David Jankelow</td>
<td>Linksfield Netcare Hospital, Johannesburg</td>
<td>SA Heart Secretary</td>
</tr>
<tr>
<td>Dr Ronnie Jardine</td>
<td>Linmed Netcare Hospital, Benoni</td>
<td>Chair: Ethics &amp; Guidelines Committee and representing CASSA</td>
</tr>
<tr>
<td>Prof Andrew Sarkin</td>
<td>Head: Cardiology, UP, Pretoria</td>
<td>Chair: Full Time Practice Committee</td>
</tr>
<tr>
<td>Dr Makoali Makotoko</td>
<td>Pretoria Heart Hospital, Pretoria</td>
<td>Chair: Private Practice Committee</td>
</tr>
<tr>
<td>Dr Martin Mpe</td>
<td>Medi-Clinic Heart Hospital, Pretoria</td>
<td>Chair: Education Committee</td>
</tr>
<tr>
<td>Dr Andrew Thornton</td>
<td>Sunninghill Netcare Hospital, Johannesburg</td>
<td>Chair: SHARE Committee and representing CASSA</td>
</tr>
<tr>
<td>Mr George Nel</td>
<td>CEO, HeFSSA (Heart Failure SIG) &amp; SASCI (Interventional SIG)</td>
<td>On behalf of SASCI and HeFSSA</td>
</tr>
<tr>
<td>Mrs Erika Dau</td>
<td>SA Heart Association, Cape Town</td>
<td>Office Secretary and Bookkeeper</td>
</tr>
<tr>
<td>Dr Adrian Horak</td>
<td>St Vincent Pallotti Hospital, Cape Town</td>
<td>Speaker and Representing Members and SASCI</td>
</tr>
<tr>
<td>Dr Antoinette Cilliers</td>
<td>Paediatric Cardiology, Chris Hani Baragwanath Hospital, Soweto</td>
<td>Representing Paediatric Cardiologists</td>
</tr>
<tr>
<td>Dr Anthon Botha</td>
<td>TechnoScene (Pty) Ltd</td>
<td>Facilitator and Strategy Document developer</td>
</tr>
<tr>
<td>Mrs Thereza Botha</td>
<td>TechnoScene (Pty) Ltd</td>
<td>Assistant to facilitator</td>
</tr>
</tbody>
</table>
Appendix B: People invited but not attending

Dr Tony Dalby
Prof Anton Doubell
Prof Bongani Mayosi
Prof Danie Marx
Prof Karin Sliwa
Dr Eric Klug
Dr Darryl Smith