



NATIONAL HEALTH INSURANCE: CAN IT SOLVE SOUTH AFRICA'S HEALTH CRISIS?

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Outline of Presentation

- South Africa's comparative performance in health
- Premature mortality – levels and causes
- Health policy and the health sector: advances and continuing challenges
- A major challenge to successful implementation of a NHI
- The health human resource situation
- Proposed skills mix for each level, including CHW's and Mid level workers
- Proposed initiatives to address health challenges

Health Indicators in Selected Low and Middle-Income Countries

	GDP per capita (PPP US\$)	Public health expenditure (% of GDP)	One-year-olds fully immunized against Measles (%)	Life expectancy at birth (years)		Infant mortality rate (per 1,000 live births)	
	2002	2001	2002	1970-75	2000-05	1970	2002
Cuba	5,259	6.2	98	70.7	76.7	34	7
Brazil	7,770	3.2	93	59.5	68.1	95	30
Thailand	7,010	2.1	94	61	69.3	74	24
China	4,580	2	79	63.2	71	85	31
South Africa	10,070	3.6	78	53.7	47.7	..	52

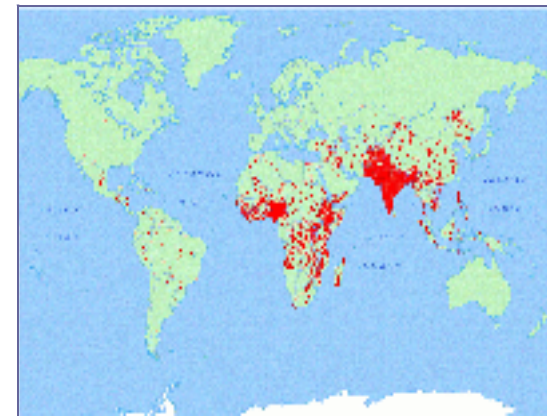
U5MR: the top 10 — & the faltering 9

The 10 countries with highest U5MR:

- Sierra Leone 316
- Niger 270
- Angola 260
- Afghanistan 257
- Liberia 235
- Mali 233
- Somalia 225
- Guinea-Bissau 215
- D R Congo 205
- Mozambique & Chad 200

The 9 countries with increasing U5MR

- Botswana
- Swaziland
- Zimbabwe
- Kenya
- Cote d'Ivoire
- ➔ **South Africa**
- Cambodia
- Turkmenistan
- Kazakhstan



Millennium Development Goals

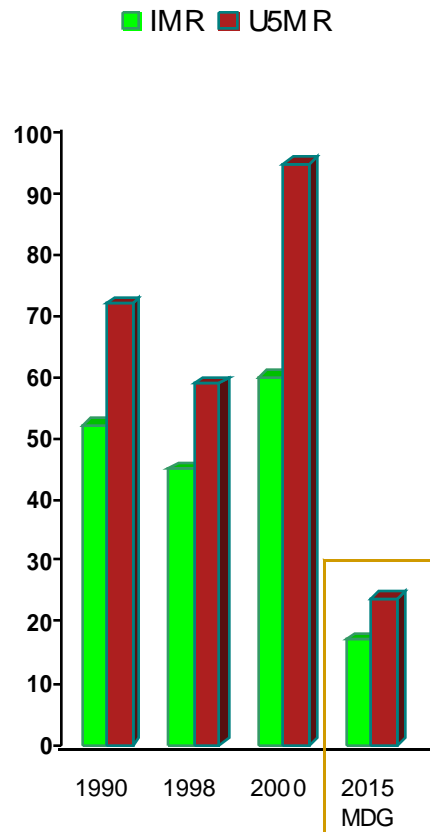
Goal 4: Reduce child mortality

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Indicators:

- Under-five mortality rate
- Infant mortality rate
- Proportion of one-year-old children immunised against measles

Prospects for achieving MDG 4



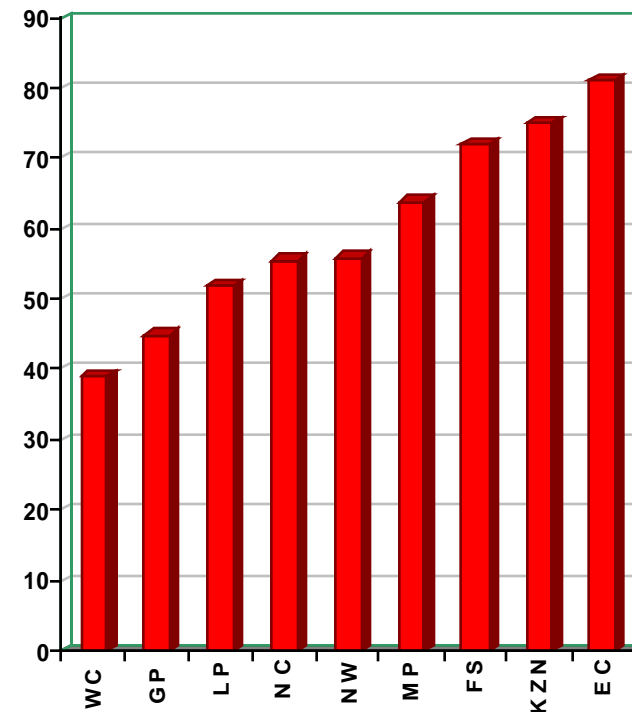
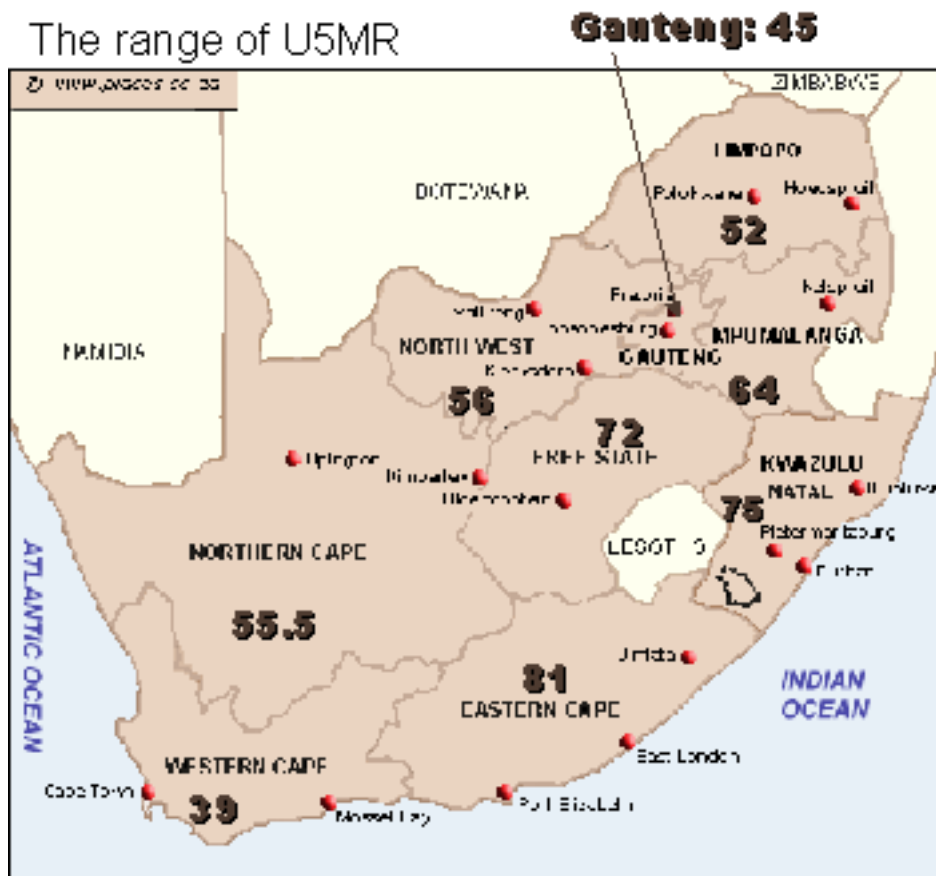
Children's rights to health & MDGs:
•Are we meeting the challenge?



Health Inequalities in South Africa

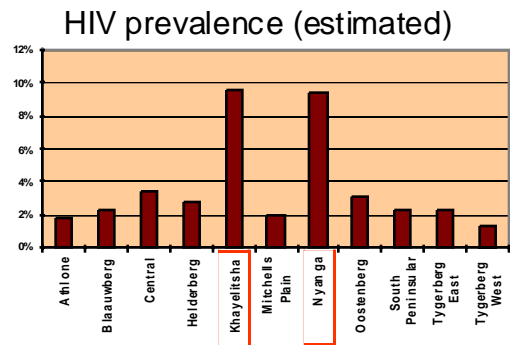
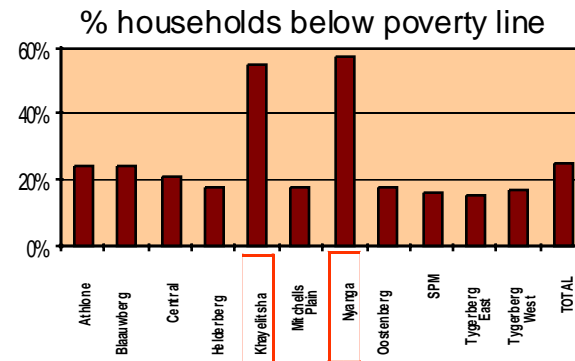
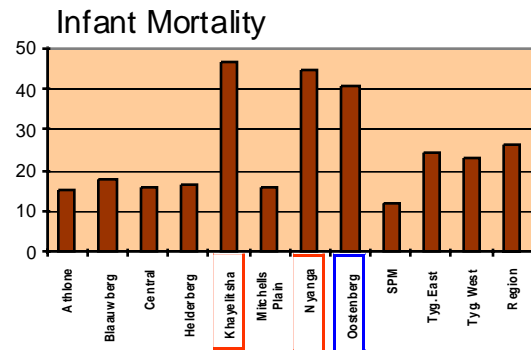
Child mortality in South Africa

The range of U5MR



Sources: Lagerdien K. Reviewing child deaths in South Africa – a rights perspective. [CI] 2005

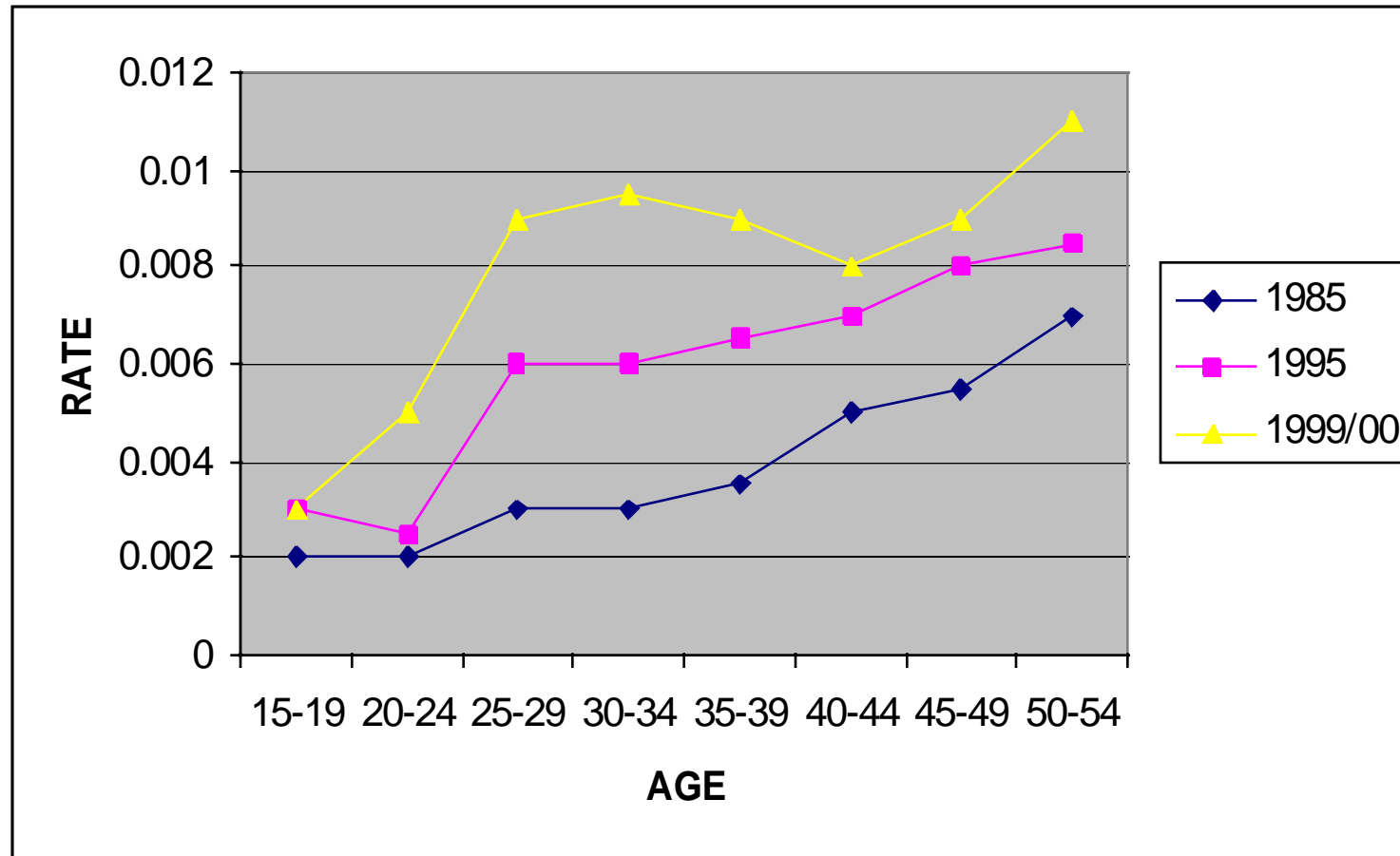
Health & inequity in Cape Town



Cape Town Equity Gauge, UWC SOPH, 2002

Causes of Premature Mortality

Rise in mortality amongst young women



(Dorrington et al. 2001)

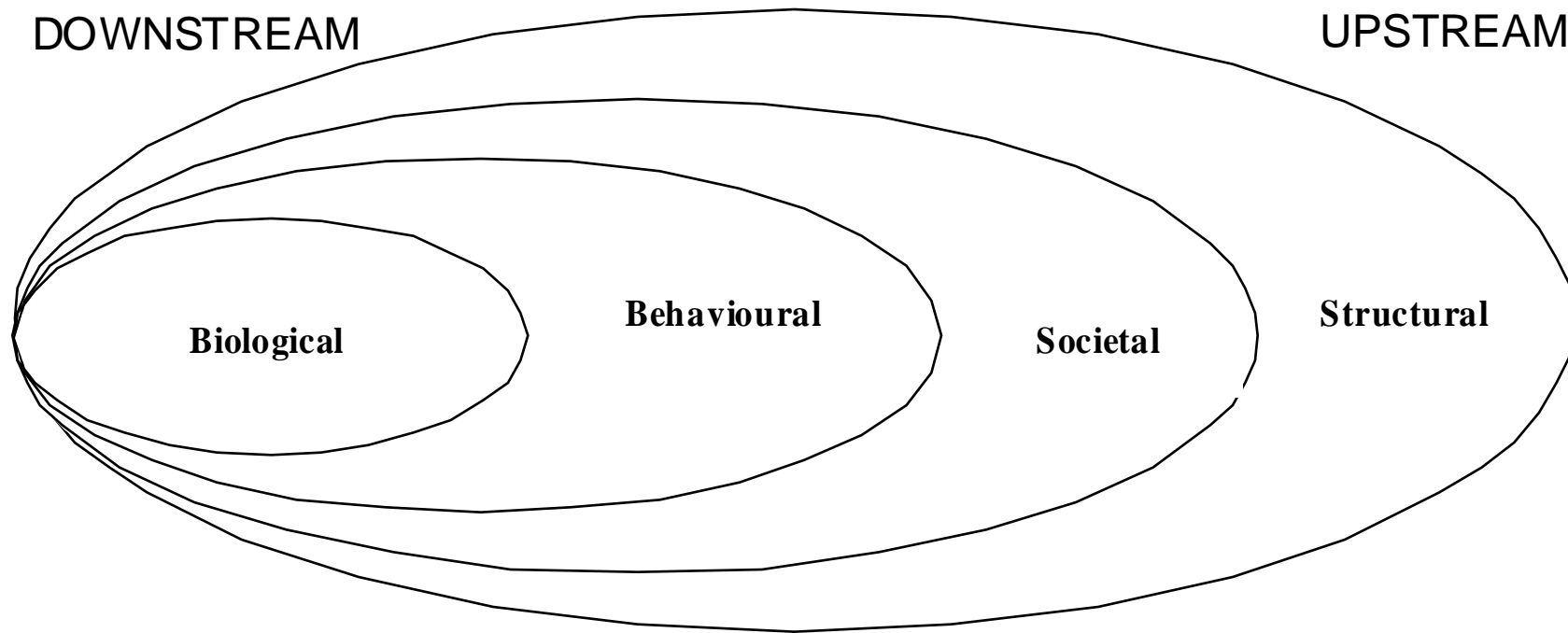
Quadruple burden of disease

- pre-transitional diseases and poverty related conditions eg childhood undernutrition and infections, maternal mortality
- emerging chronic diseases eg obesity, heart disease, diabetes
- injuries - including interpersonal violence
- HIV/AIDS and TB epidemics (TB cases increased from 109,000 in 1996 to 341,165 in 2006. 55% cases also have HIV)

MRC Burden of Disease Unit, 2004

Key Determinants of Disease and Death

Risk Factors/Determinants



Burden of Disease study, PGWC

Understanding the determinants & mechanisms of health disparities

Examples of determinants:

- Education
- Access to basic needs – water, sanitation etc
- Diets and food security
- Income
- Alcohol
- Smoking
- Access to care
- ? Low levels of social capital

Income inequalities

Gini coefficient:

➤ 0.56 in 1995

➤ 0.73 in 2005 (0.8 without grants)

Share of income for richest 10% of population: 51%
(2005)

Share of income for poorest 10% of population: 0.2%
(2005)

Nutrition and Dietary Intake

The National Food Consumption Survey (1999) showed that in a large national sample of children aged 1-3

45% received less than two-thirds of their daily energy requirements

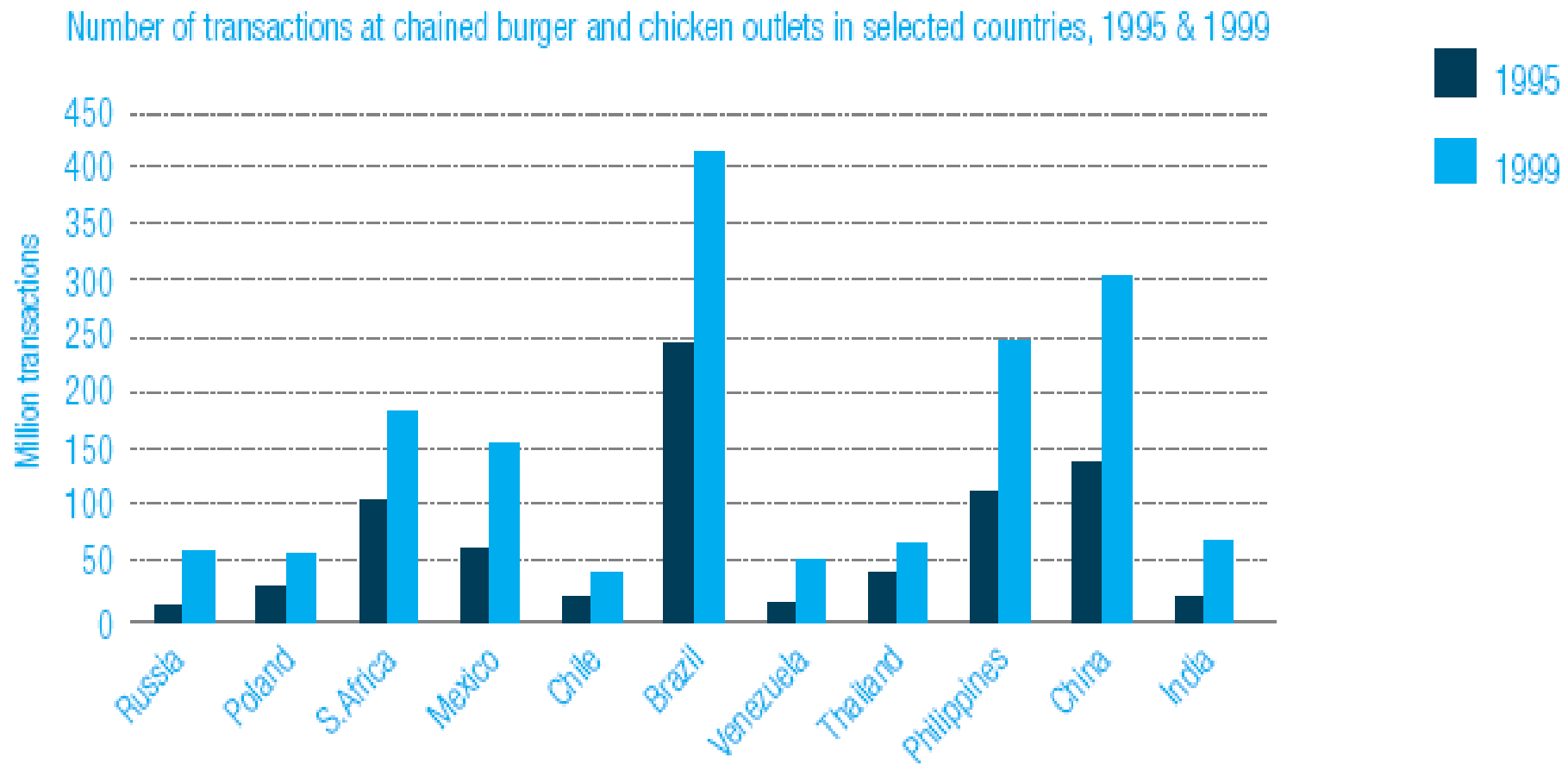
80% received less than two-thirds of their daily iron requirements

65% received less than two-thirds of their daily Vitamin A requirements

The National Food Consumption Survey (2005) showed:

- 1 in 3 women and children are anaemic
- 1 in 3 children and 1 in 4 women have Vit A deficiency
- 45% of children are Zinc deficient

Figure 12.1 Fast food consumption (1995 and 1999) in selected countries.

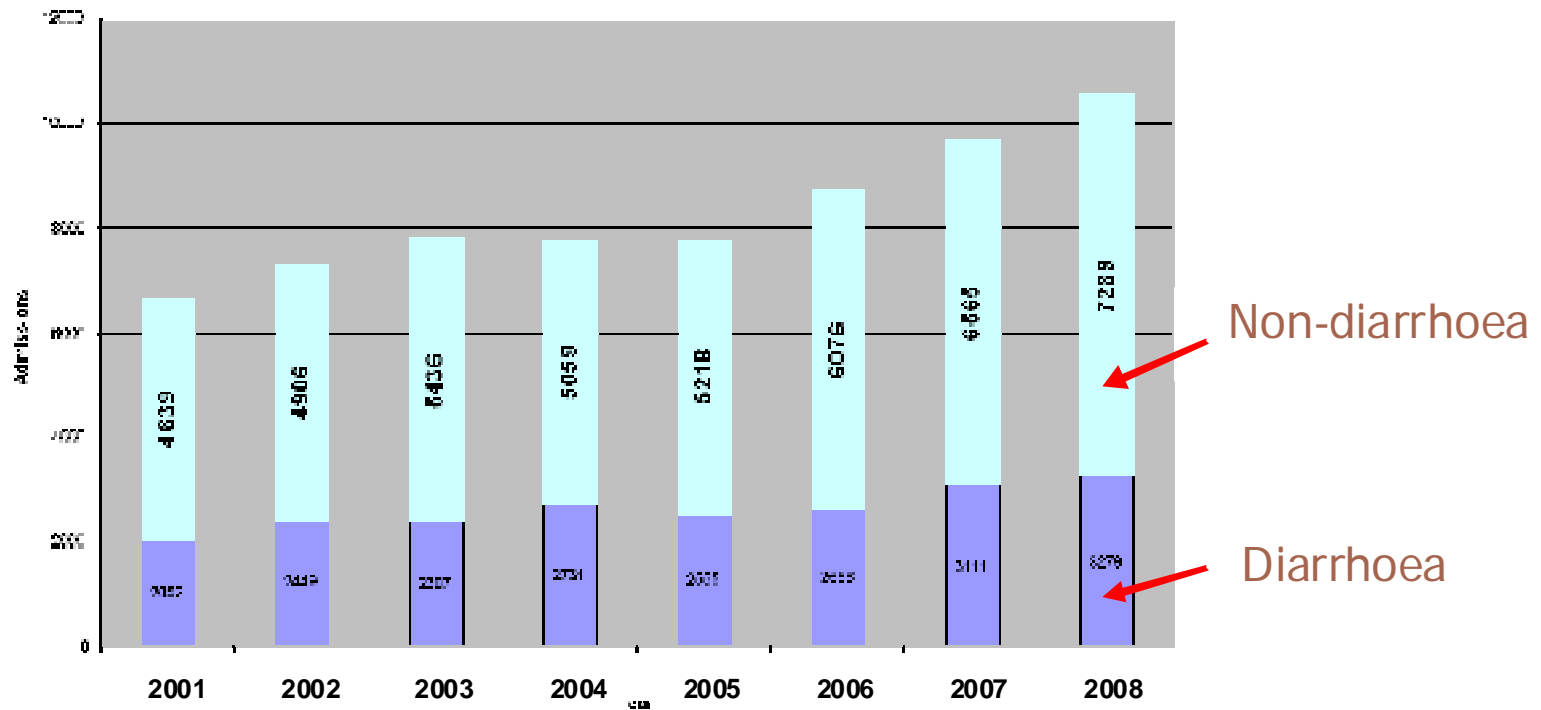


Reprinted, with permission of the publisher, from Hawkes (2002).

Source: Euromonitor data in Hawkes (2002).

An example of the impact on the health services of failing to address social determinants

Annual admissions to O/N Ward, RCCH



RCCH serves children from the poorest parts of Cape Town

Source: Prof A Westwood.

Why more & more sick children?

▣ **An increasing child population?**

- CT population ▫ 20.9% since 2001 and 36.4% since 1996 [SA ▫ by 8.2% 2001 – 2007]
- Overwhelmingly: black African group; informal settlements
- 27% under-14; 14.4% under-5
- ⇒ Birth rates ▫ 10 – 15% per year over past 3 years
- ⇒ PLUS inward migration

▣ **Deteriorating child health?**

- **Only 52.6% Black African households had piped water by 2007**
- **In some areas up 90 to 100 households, or 300 to 400 people share a single standpipe**
- **6.9% of Black African households used bucket toilets, 9.1% had none**

Small, 2007 Community Survey Analysis, SDI&G Information Branch, Cape Town, October 2008

where a water source is distant or shared, water usage declines

Water & sanitation

- Of black families, 47% had no piped water inside;
- 15% used bucket or no toilet facilities

Population Growth since 2001

- 17% in the Western Cape ;
- 20% in Cape Metro
- □ births
- In-Migration!

Decline in staff numbers

- Work conditions
- Low pay
- Stress
- Job dissatisfaction
- Low morale

Vacant posts ↑ 40%



ESBL Klebsiella outbreak

- 10 children infected
- 8 hospital-acquired
- 2 died

The "Best Interests of the Child" Principle [SA Constitution & UN CRC]:

"... ensure that the institutions, services and facilities responsible for the care ... of children ... conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision."

Policy endorsement of PHC

“...the underlying philosophy for restructuring the health system is the ***primary health care approach***, with emphasis on appropriate, comprehensive, promotive, preventive, rehabilitative and curative care provided by appropriate PHC facilities, with priority for PHC service in rural areas and poor urban areas...based on ***full community participation...***”

National Health Plan 1994

SELECTED KEY POLICY ADVANCES AND IMPLEMENTATION SUCCESSES

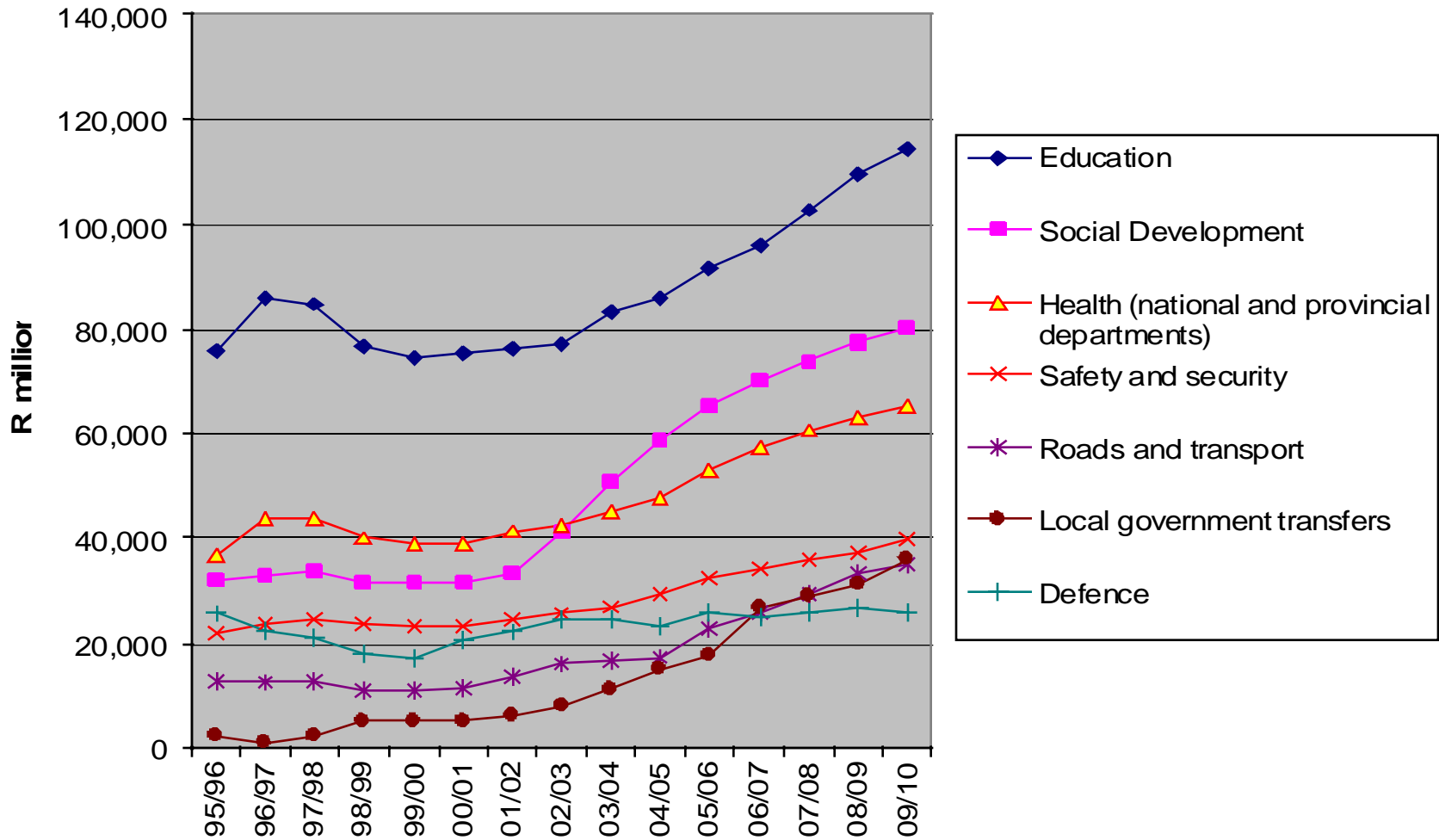
- Unification of separate health services
- Establishment of districts
- Anti-smoking legislation
- Free health care for mothers and children
- Choice on Termination of Pregnancy Bill
- Notification of and enquiry into maternal deaths
- Clinic building programme (1800 built)
- Essential drugs list
- Primary School Nutrition Programme
- HIV/AIDS programmes expanded (PMTCT & ART)

ADVERSE EFFECTS OF CONSERVATIVE ECONOMIC POLICIES AND BIOMEDICAL DOMINATION

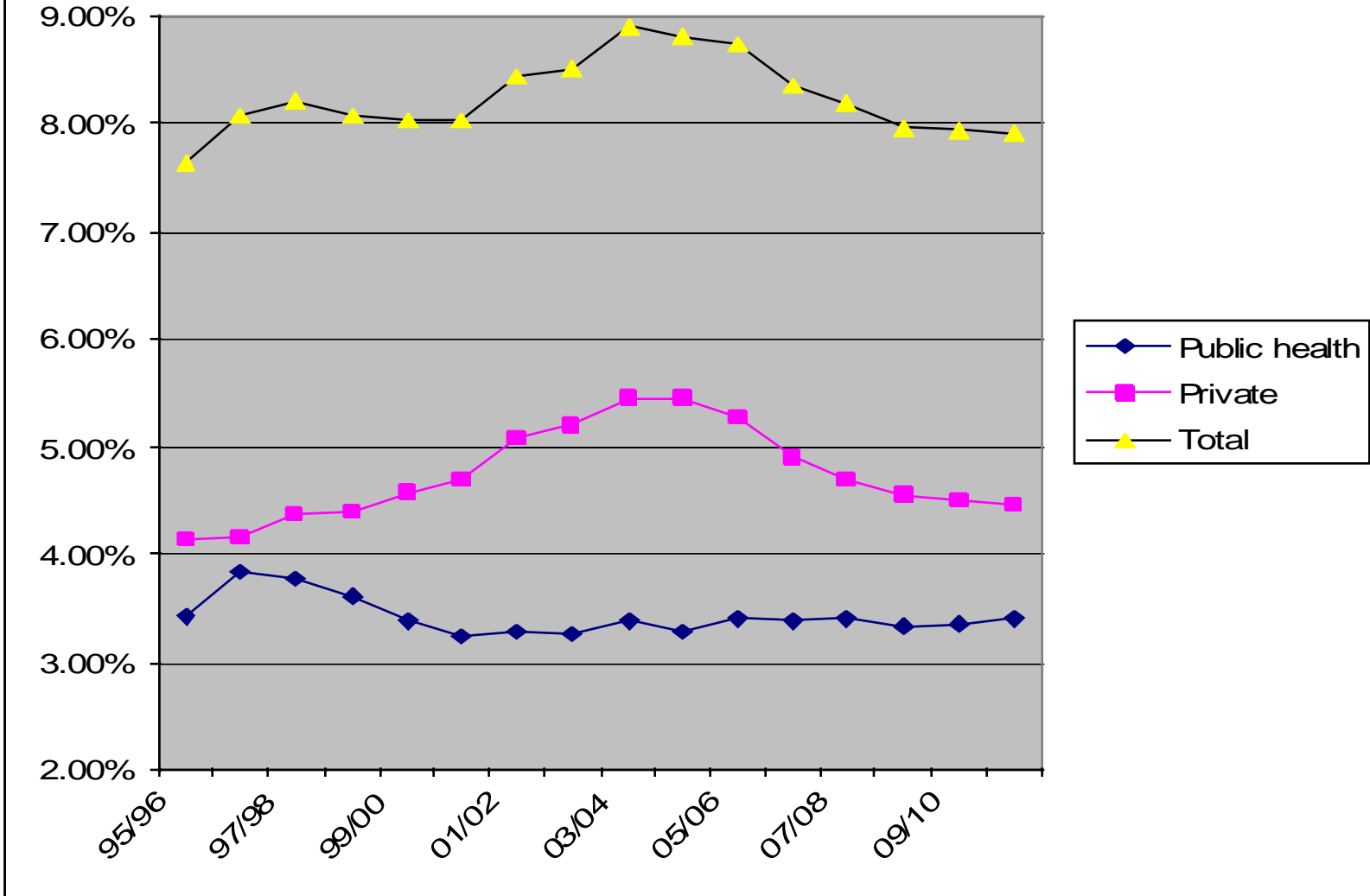
- Failure to address inequities between public and private sectors
- Voluntary severance packages and downsizing of health workforce
- Ringfenced funding of tertiary and academic care but not primary
- Grossly inadequate funding (until recently) of priority programmes e.g. HIV/TB
- Failure to implement intersectoral approaches
- Slow transformation of training programmes
- Increasing dominance of managerialism
- Abandonment for 10 years of community health worker programmes

Expenditure by sector

Expenditure trends by function (real 2007/08 prices)

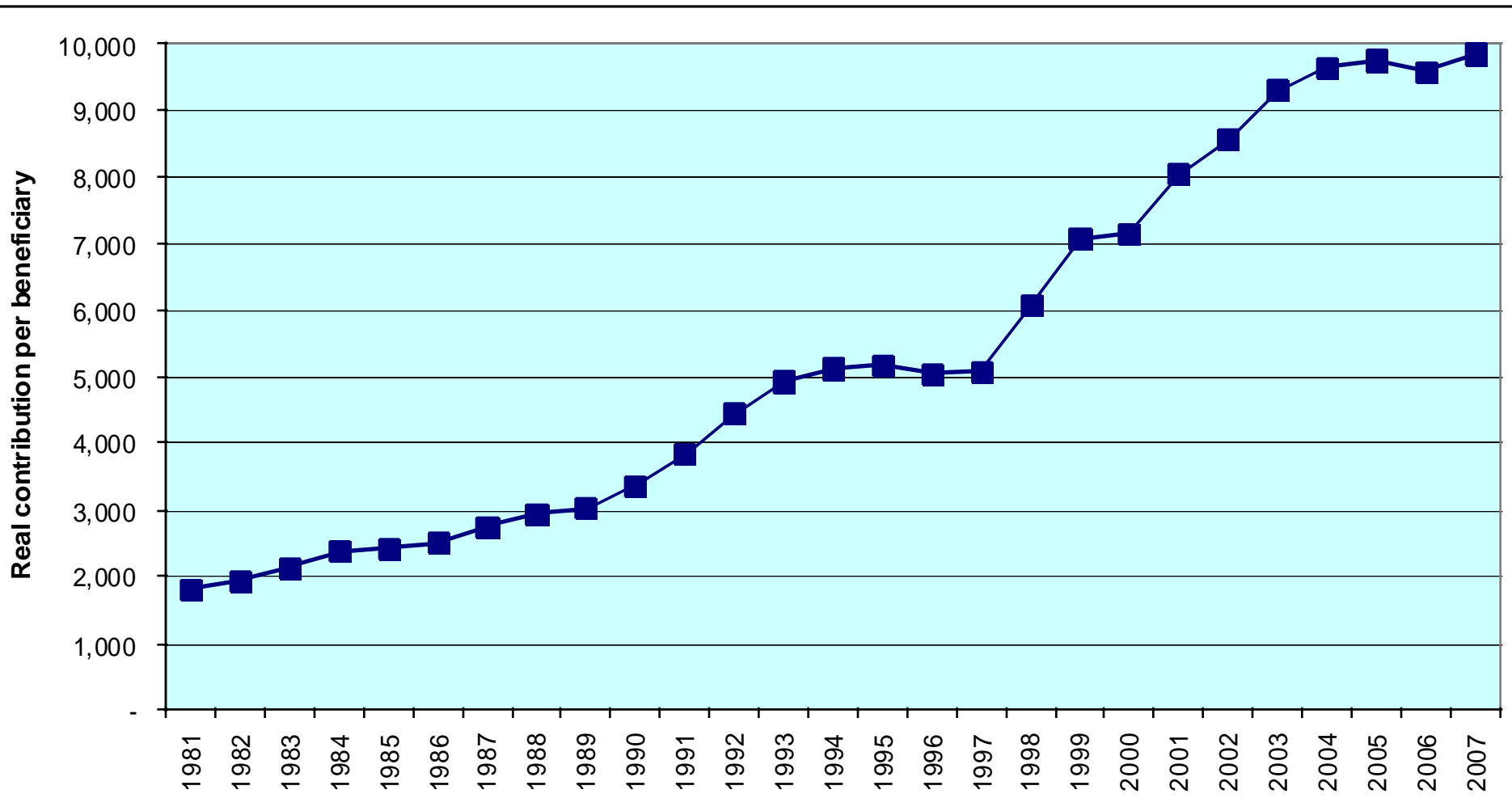


Health spending as % of GDP



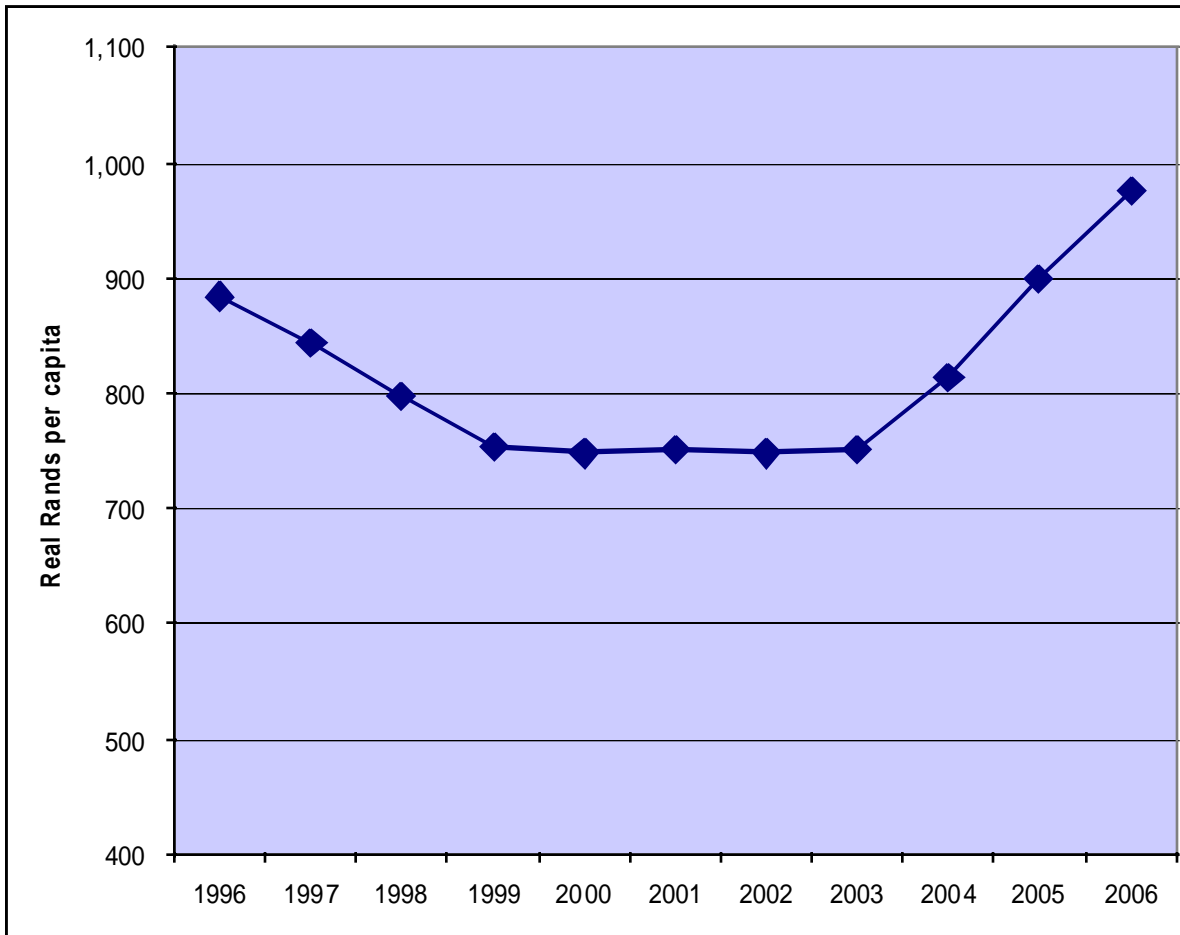
Private medical aids cater for 16% of population and a percentage of people pay out-of-pocket

Medical scheme trends



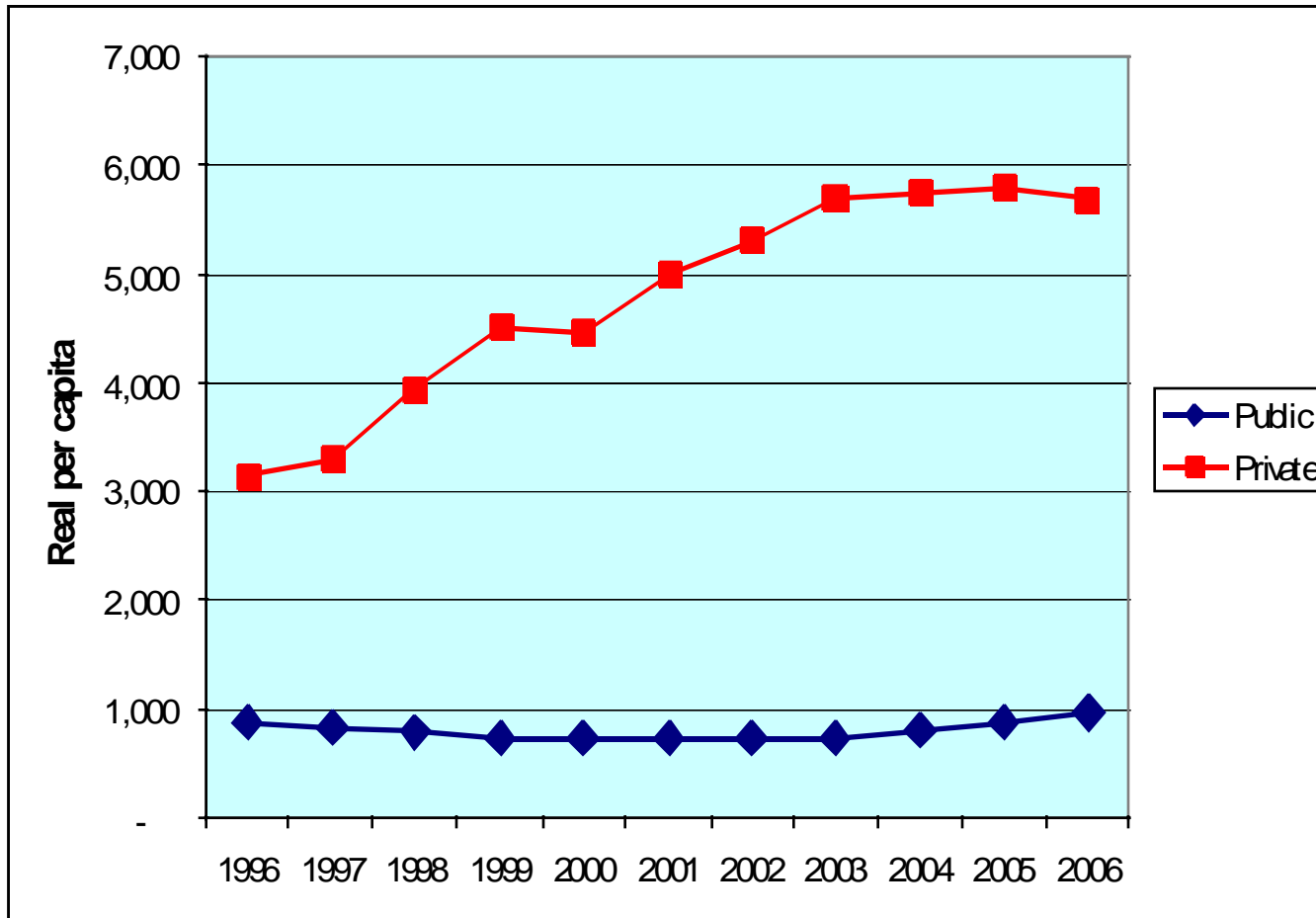
Source: McIntyre

Public sector funding



Source; McIntyre

'Progress' since 1994



Source; McIntyre

Rationale for NHI

Mechanism for addressing:

- Existing health system challenges

Ensuring whole population is:

- Able to get care when needed - 16.6% experience difficulty in accessing health care (Shisana et al 2007)
- Financially protected from the costs of care (currently 14% of health care spending is out-of-pocket)

Funding of NHI

Increase funding of health services through:

- Increased allocations from general tax revenue
- Mandatory health care contributions by employees and employers
- Removal of tax subsidies to medical aids
- Pool these funds

How is NHI planning to improve access?

Purchase from accredited providers (public and private):

Medical schemes will remain:

- Likely that membership will decline

- Fewer schemes

What are the key challenges to improving access to quality health care?

Key Challenges

- Improve governance of public health sector facilities and programmes
- Promote authority with accountability
- Restore public sector hospitals and ensure increased management autonomy;
- **Human resource development and retention strategy**

Importance of health personnel numbers and skills

- Personnel account for 57% of recurrent expenditure
- Health personnel development is primary step in health systems development
- PHC incorporates both personal clinical care (curative and rehabilitative components) and public health actions (preventive and promotive components)

Table 1: Cross-country comparison of physician and nurse density per 1 000 population, 2006

Country	Physician density per 1 000 population	Nurse density per 1 000 population
Mozambique	0.03	0.21
Lesotho	0.05	0.62
Zambia	0.12	1.74
Zimbabwe	0.16	0.72
Namibia	0.30	3.06
Botswana	0.40	2.65
South Africa	0.77	4.08
United States of America	2.56	9.37
France	3.37	7.24
United Kingdom	2.30	12.12

Source: WHO, 2006.¹

HR Situation

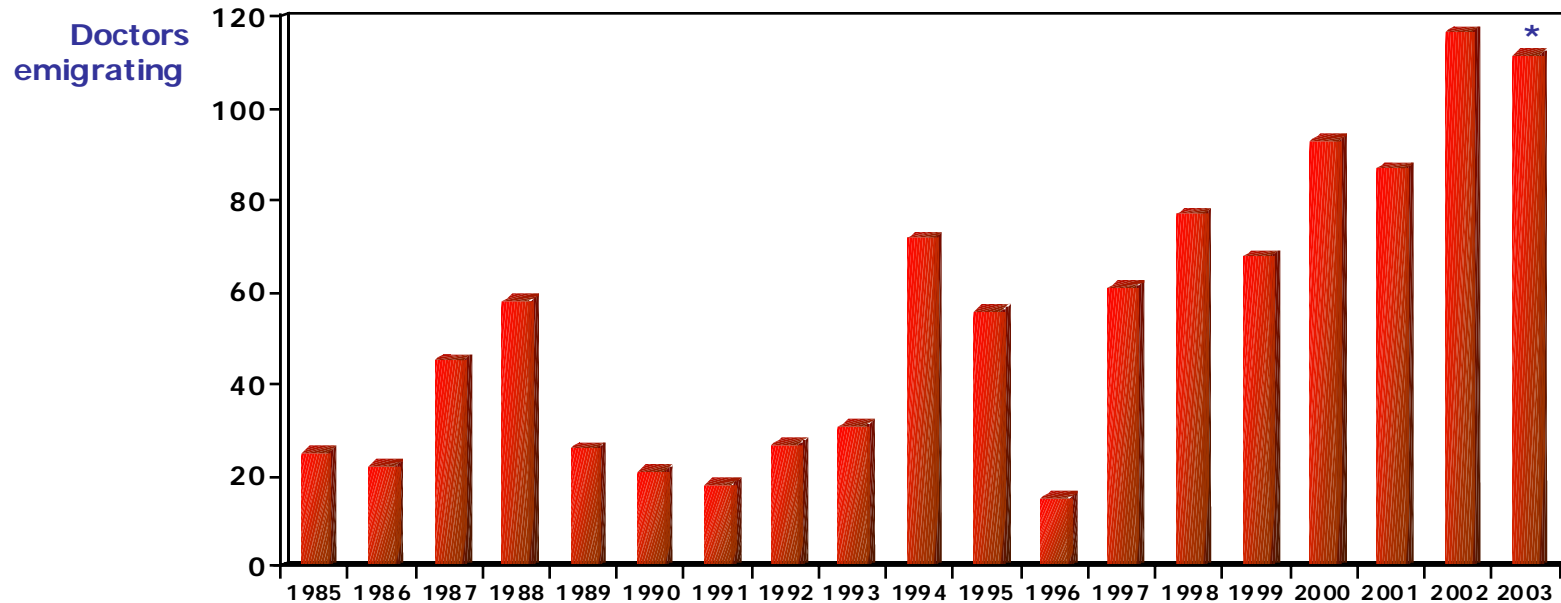
- Inadequate data
- Maldistribution
- Medical practitioners:
 - 34 687 registered – 10 653 in public sector
 - Western Cape - 7396 registered but only 1418 in public sector.
 - **Only 30% of doctors work in the public sector**
 - **70% serve 16% of the population with private medical insurance and some uninsured who pay out-of-pocket.**

Table 5: Distribution of medical practitioners by public sector dependent and private sector (medical scheme coverage) dependent persons, 2007

	Ratio medical practitioner to population	Medical practitioner per 100 000
Public sector dependants	1 per 4,219	23.7
Medical scheme beneficiaries	1 per 601	166.3

Source: Derived using PERSAL, PCNS and StatsSA, 2006.¹⁰

Doctor emigration, SA 1985 – 2003*



*2003 Jan - June

STATISTICS SOUTH AFRICA DATA: Tourism & migration
<http://www.dti.gov.za/econdb/cssrap/SsaM40D00003.html>
<http://www.dti.gov.za/econdb/cssrap/SsaM30D00004.html>

Cost of training a doctor – R780,000 (Breier and Wildschut, 2006)

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HR situation

□ Nurses

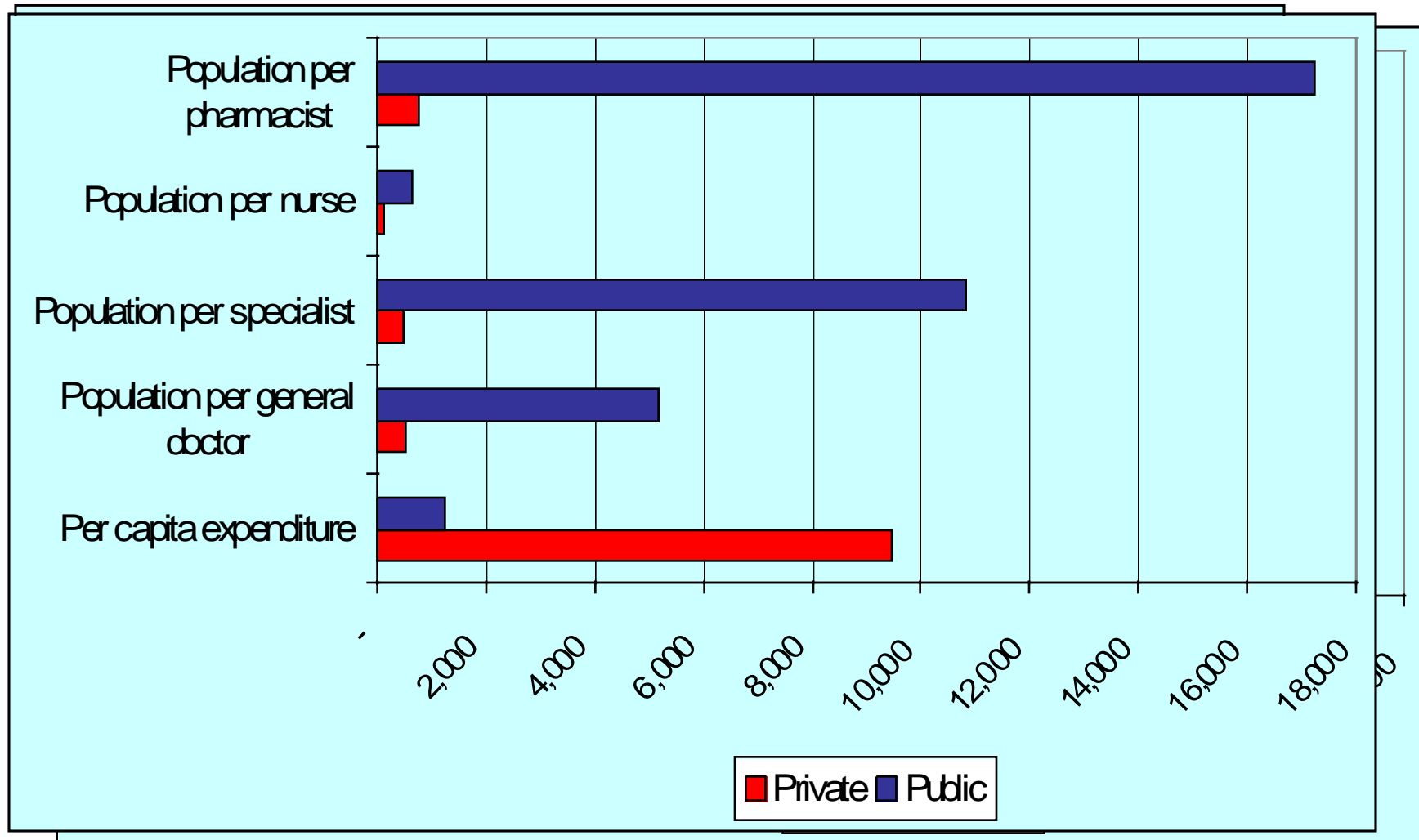
- 178 404 nurses (Nurse, EN, NA) with 104 571 in public sector so is above the minimum recommended by WHO...but some registered /not working; double registration, absenteeism;
- HIV high in nurses
- Ageing – 40% retiring 5 – 10 years

□ CHW's:

- Underutilised and not organised
- Underpaid or volunteer

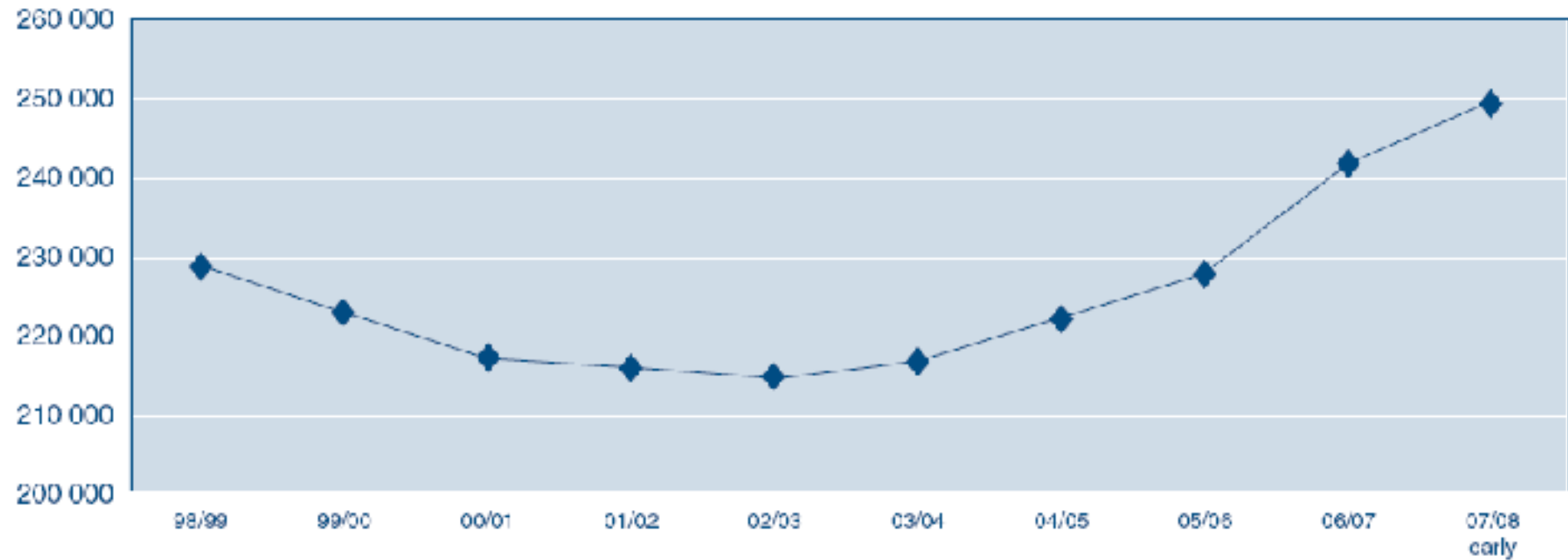
Unequal distribution of human resources

2005



SA trend

Figure 24: Trends in health sector employees, 1998-2007



Source: National Treasury, 2007.

Note that this includes all categories of health sector employees, not only the professional categories shown in Table 4.4.

Vacancies in the Public Sector

Province	Feb-08			
	Total Posts	Total Posts Filled	Total Posts Vacant	Vacancy Rate
Eastern Cape	64,286	34,254	30,032	47%
Free State	27,252	16,209	11,043	41%
Gauteng	60,723	43,456	17,267	28%
Kwa Zulu Natal	97,453	66,909	30,544	31%
Limpopo	57,771	31,535	26,236	45%
Mpumalanga	24,638	15,668	8,970	36%
Northern Cape	8,214	5,580	2,634	32%
North West	18,278	15,665	2,613	14%
Western Cape	35,870	26,552	9,318	26%
Total	394,485	255,828	138,657	35%

Vacancies:

Medical practitioners - 34.9%

Nurses – 40.3%

**"IMPROVE PUBLIC SERVICE DELIVERY,
FILL VACANT POSTS NOW!"**

Mov...nt

Task-shifting as an alternative approach

- What is task-shifting? – WHO definition:
 - Task shifting is the name now given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting can make more efficient use of the human resources currently available. For example, when doctors are in short supply, a qualified nurse could often prescribe and dispense therapy. Further, community workers can potentially deliver a wide range of services, thus freeing the time of qualified nurses.

Experiences with task-shifting

Example Uganda

- In Uganda, task shifting is already the basis for providing antiretroviral therapy. With only one doctor for every 22 000 patients and an overall health worker deficit of up to 80%,
- Uganda's nurses are now undertaking a range of tasks that were formerly the responsibility of doctors. These include:
 - managing people living with HIV who have opportunistic infections; diagnosing tuberculosis sputum positive; prescribing medicine to prevent other infections;
 - determining the clinical stage of people living with HIV;
 - deciding whether people living with HIV have medical eligibility for antiretroviral therapy;
 - and managing people on antiretroviral therapy who have minor side effects such as nausea.

- In turn, tasks that were formerly the responsibility of nurses have been shifted to community health workers, who have training but not professional qualifications.
- These tasks include:
 - HIV testing; counselling and education on antiretroviral therapy; monitoring and supporting adherence to antiretroviral therapy; filling in registers; triage; clinical follow-up; taking weight and vital signs; and explaining how to store antiretroviral drugs.

Evidence for impact and cost-effectiveness of community health workers

- Outreach and family-community care in combination at 90% coverage could result in an 18-37% reduction in newborn mortality even before facility-based care is strengthened.
- A meta-analysis of community-based trials of pneumonia case management on mortality suggested an overall reduction of 24% in neonates, infants, and preschool children.
- A trial in Tigray, Ethiopia, of training local coordinators to teach mothers to give prompt home antimalarials showed a 40% reduction in under-5 mortality.

Haines, Sanders et al,
Lancet 2007

Caveats

- The experiences of case studies show that task shifting can only succeed under conditions where
 - a review of the organisation of health services,
 - revitalisation of health services,
 - availability of infrastructure support,
 - Training,
 - supportive supervision, and
 - community empowerment have been taken very seriously and attended to.
- These experiences are overwhelmingly confirmed by the international literature.

Brazil – a model?

- 190 million population
- 1990's Unified Health System (SUS)
- Family health teams - a doctor, nurses and assistant nurses and 6 community health workers and sometimes a dentist / 4 000– 10 000 people;
- Community participation & organisation
- Intersectoral action
- Promotion & prevention;
- 250 000 CHW's employed in system – link to community

Proposed SA model

- Community level
 - Care in community & homes
 - CHW's: but need to be formally recognised, paid & part of a team within health system;
 - Generalist CHW's supported by Clinical nurse practitioner;
 - Employment of between 46 000 – 96 000 CHW's (fewer households/CHW's in rural)
THROUGH NEW EPWP
 - Combines job creation with improving health

Primary Level

□ Clinic

- Doctor on regular basis (from District Hospital)
- Team of nurses (CNP, EN, etc)
- CHW's
- Pharmacist assistant
- Mid level workers (CRW, nutrition, health promotion), etc
- EHO

Mid Level Workers

- Work being done, but very slow
- Have pharmacy assistant and EN; Clinical Associates being trained (insignificant);
- Need to explore mental health, CRW; nutrition; social work, etc;
- Also specialist assistants
- Resistance by professionals & turf wars require high-level intervention

District Hospital

- PHC focus and population oriented approach;
- 6 doctors with family practice (skills: surgery; paediatrics, ortho, gynae, anaesthetics, etc);
- Team of nurses
- Mid level workers (CA's & others)
- Visits & support to clinics and CHC;
- Visits from specialists

Tertiary

- Contribute to whole population area
- KZN model with specialists taking responsibility for support to peripheral clinics;

Key interventions required

- Rapidly increase investment in training: re-open nursing colleges, increase output and appropriate training by medical schools and other HEIs
- Rapidly increase output of MLWs
- Rapidly increase output of CHWs and standardise and improve conditions of service (?EPWP)
- Reduce power of conservative professional bodies
- Improve incentives and support in rural areas
- Upgrade infrastructure in rural/peri-urban areas
- Address social determinants thro revised economic and social policies and intersectoral actions

NHI? Yes, but.....

NHI COULD be a mechanism to redistribute health care resources BUT some key challenges need to be addressed

- Definition of an acceptable 'package' of services
- Development of sufficient CAPACITY and ENSURING ACCOUNTABILITY in administration of NHI fund
- Resolution of the HRH crisis. This will require
 1. massive, targeted investment in relevant training
 2. confronting the professional and regulatory bodies
 3. Improving rural infrastructure and amenities

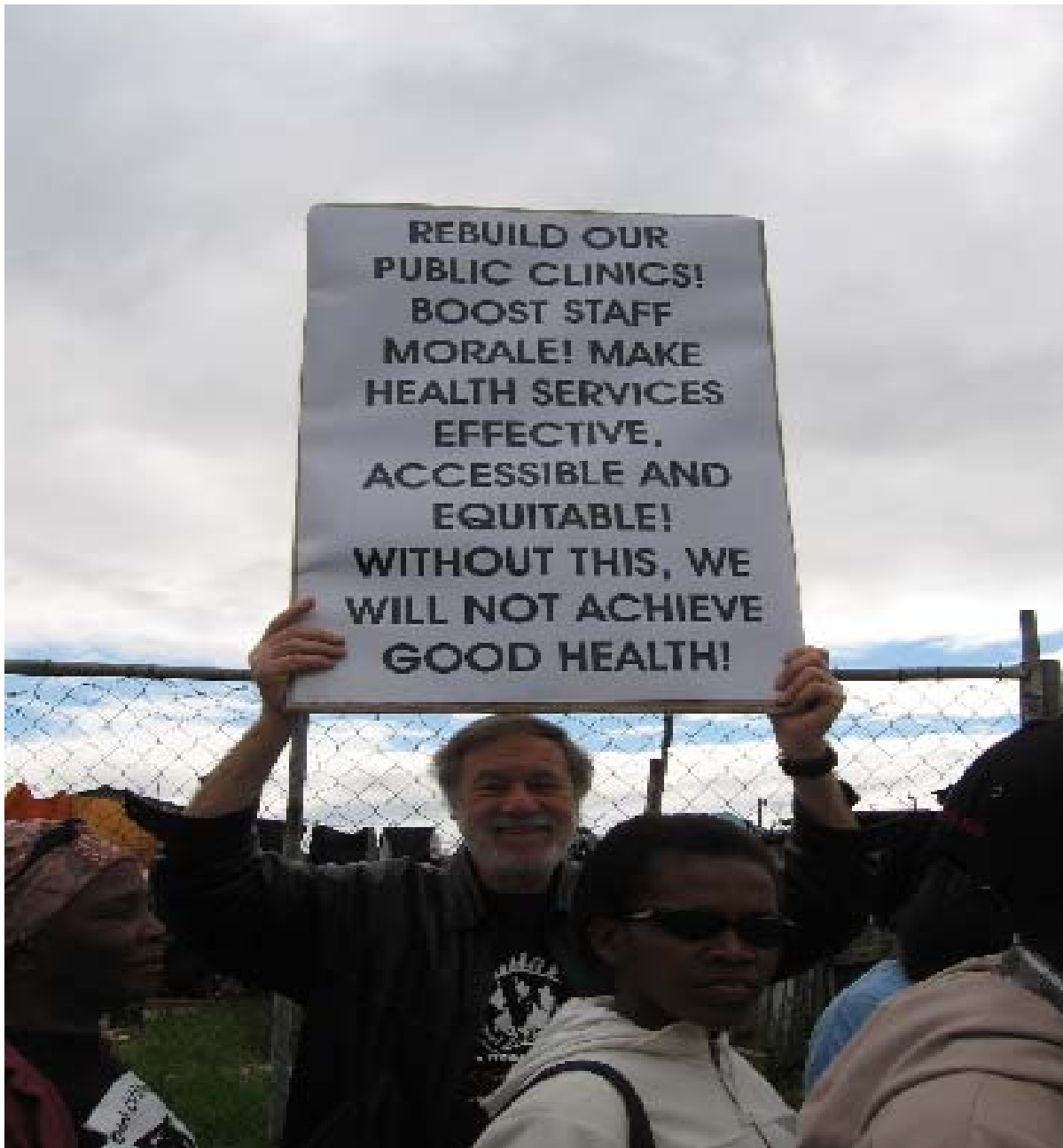




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