Health Sector Roadmap

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Critically examined the challenges in the health system

Outline, at a high-level, the strategic institutional options that could contribute most significantly to improving the performance of the health system as a whole.

Presentation outline

Roadmap process

Part 1

- A diagnostic: what has been happening

Part 2

- Emerging priorities

Part 3

- Proposed interventions

Part 4

- Concluding remarks – 10 point plan and opportunities for coordinated public and private health sector efforts towards improved access to affordable, quality healthcare in South Africa

Roadmap process

Key Pproject components

Short Term: Diagnose current status and future challenges, and collectively propose interventions, with particular focus on public sector

Phase 1
Diagnose the status of the Health Care System

Phase 2
Evaluate the health care system to identify reasons for the current health outcomes

Phase 3
Consolidate findings to make recommendations around short term interventions

Phase 4
Facilitate the implementation of the recommendations

Long Term: Support dialogue, social mobilisation and implementation process for improved Healthcare Delivery

Roadmap process

- **Participants:** National Department of Health, Provincial Departments of Health, ANC NEC sub-committee on Health & Education, Medical Research Council, Health Systems Trust, NEHAWU, Treatment Action Campaign, Development Bank of Southern Africa, AIDS Law Project, **Mediclinic, Board of Healthcare Funders**, Centre for Health Policy, Lovelife, Human Sciences Research Council, Reproductive Health Research Group, National Treasury, Provincial Treasury Departments, **Netcare, Council for Medical Schemes,** Statistics SA, DENOSA, **Chamber of Mines,** Centre for Public Service Innovation, Chris Hani Baragwanath Hospital, Johannesburg General Hospital, **Hospital Association of South Africa**, World Health Organisation, **Discovery Health**, UCT Health Economics Unit, Monitor Group, J&J Development Trust, South African Medical Association, NALEDI, Sociology of Work Unit, SWOP, School of Public Health (Wits), University of Pretoria, University of Western Cape, Clinton Foundation, **Metropolitan Life, AspenPharma**, National Union of Mineworkers, **Life Healthcare**, Presidency, KZN Premier's office, SARS, Public Investment Corporation, SITA, SASOP, SAMDP, Progressive Health, **Liberty Life** and various **independent experts**
- **Joint-chairs**: **Mr. Jay Naidoo**, Chairperson of the Board, Development Bank of Southern Africa (DBSA), South Africa; **Dr. Zweli Mkhize**, MEC Finance and Economic Development, KwaZulu-Natal and Chairperson: ANC subcommittee on Health and Education; and **Ms. Barbara Hogan**, then National Minister of Health
- DBSA tasked as roadmap **convenor**
- **Diagnostic session**, 10 July 2008, reached consensus on trends and key initiatives to explore
- **Working groups** (July-October) in following areas:
  - Diagnostics (data/ trends)
  - Institutional
  - HIV/ AIDS, malaria, TB
  - Human resources
  - Financing (converted WG in August: costing of proposals with function distributed across rest of roadmap process)
- Roadmap recommendations presented and agreed (8 November 2008)

Part one

SOUTH AFRICA – WHAT'S BEEN HAPPENING?

There have been some achievements

Achievements since 1994

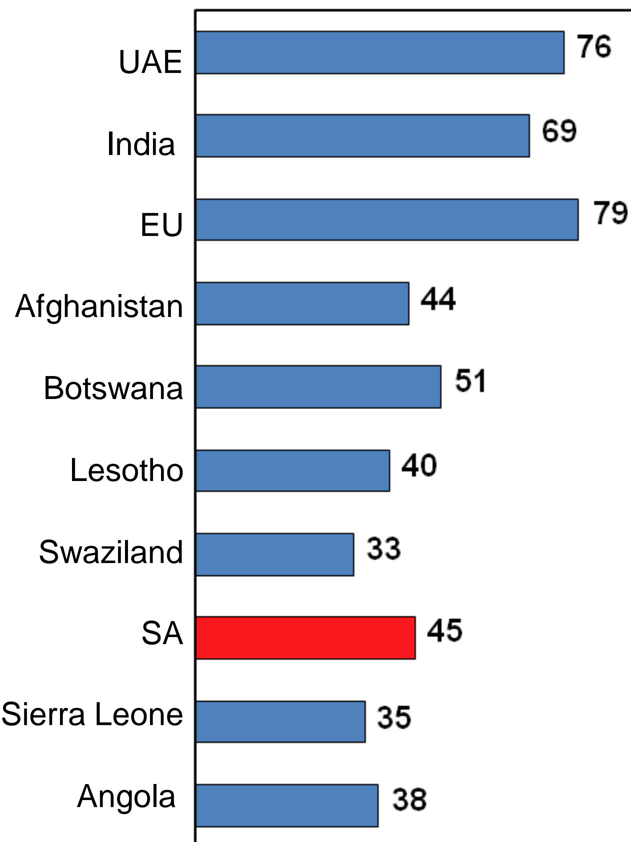
- Dismantling of the apartheid health system
- Legislative reform (National Health Act, Medical Schemes Act, etc.)
- Adopt District Health System, resulting in establishment of health districts and sub-districts
- Increased access to health services through:
  - The adoption of an essential PHC package of services, with norms for the provision of comprehensive PHC
  - Removal of user fees for public PHC and all fees (including hospitals) for pregnant women, children under six years of age and people living with disabilities
  - Construction of clinics/ community health centres and revitalisation of hospitals
  - Introduction of community service, scarce skills allowances, Community Health Care Workers and mid-level workers, mainly for the benefit of under-resourced rural areas
- Introduction of strategic programmatic initiatives for the prevention and treatment of HIV/ AIDS, TB, malaria, maternal and child illnesses, lifestyle diseases, etc.
- Private health sector reforms to, *inter alia*, stabilise the medical schemes environment and reduce the costs of drugs for increased access

There have been some achievements...

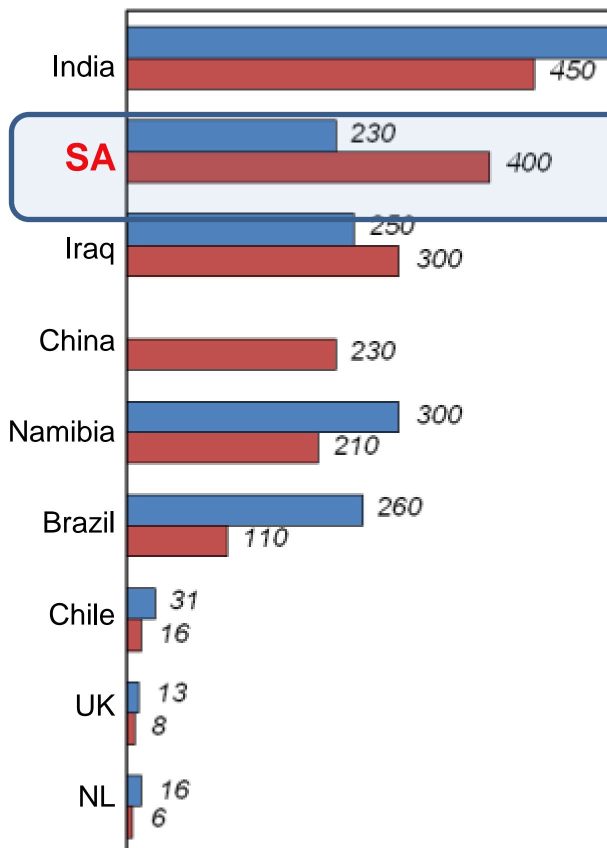
...our health outcomes are bad.....

Health outcomes are bad

Life expectancy at birth

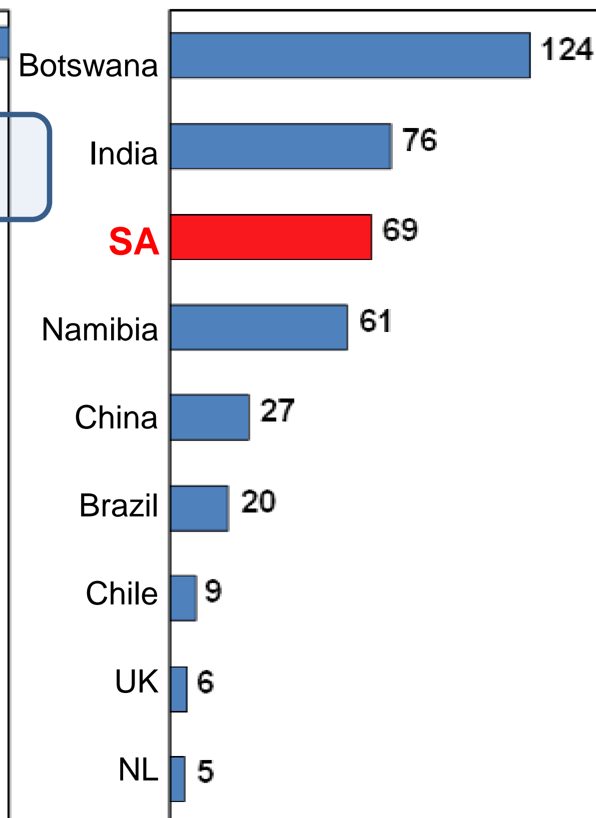


Maternal Mortality



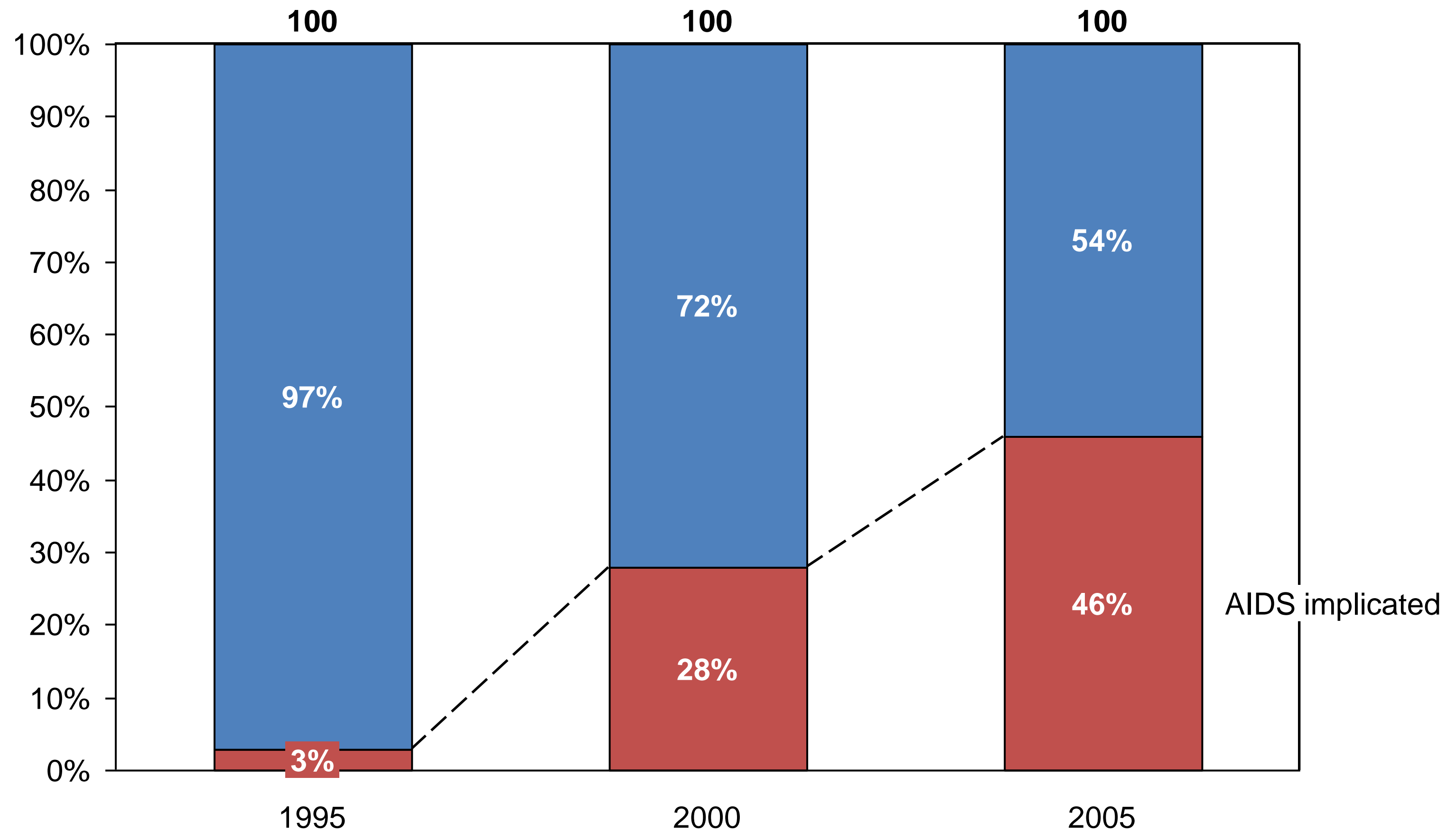
2000
2005

Infant Mortality (per 1,000)



Source: Unicef; WHO Maternal Mortality Report, 2007, StatsSA; Monitor Analysis

The proportion of AIDS-related deaths on increase in the last decade



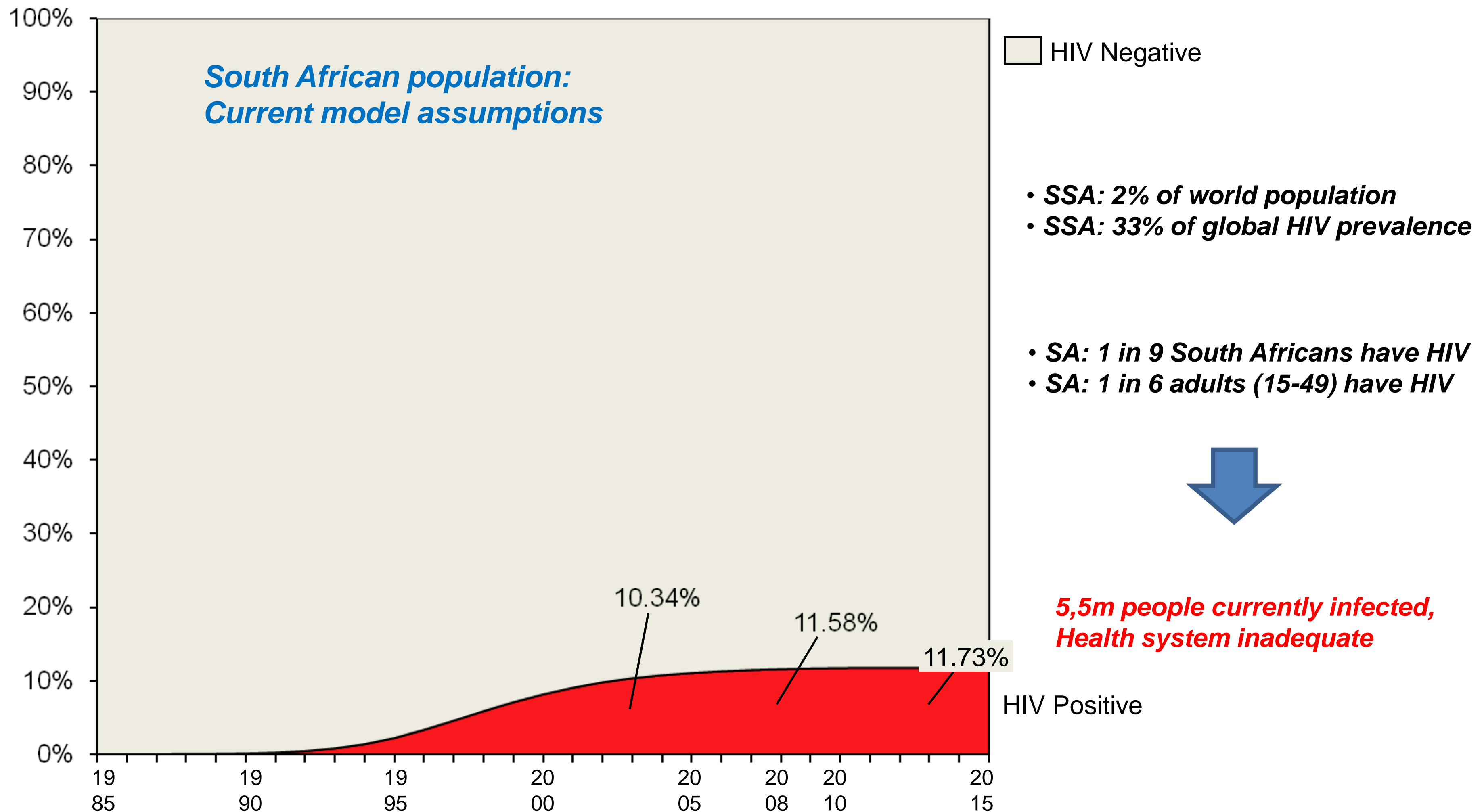
Source: ASSA2003 Model

There have been some achievements...

...our health outcomes are bad.....

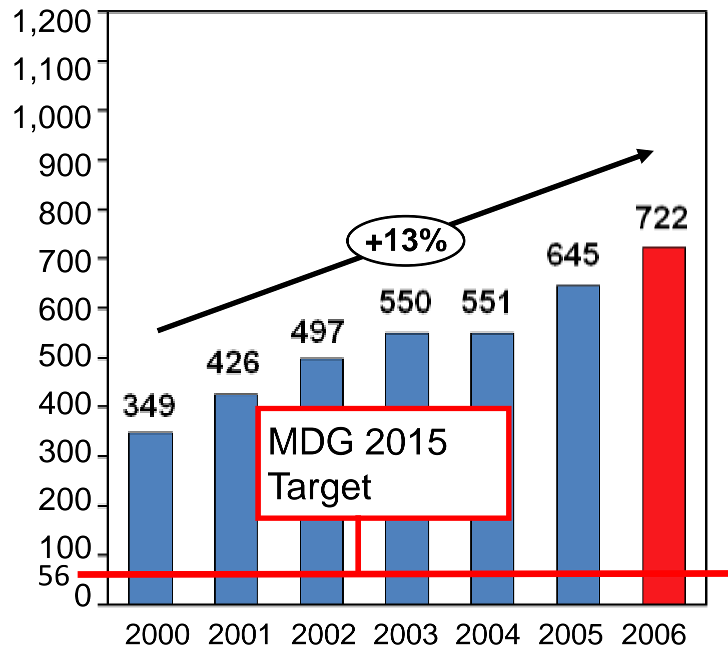
.... and we have a population with a heavy disease burden....

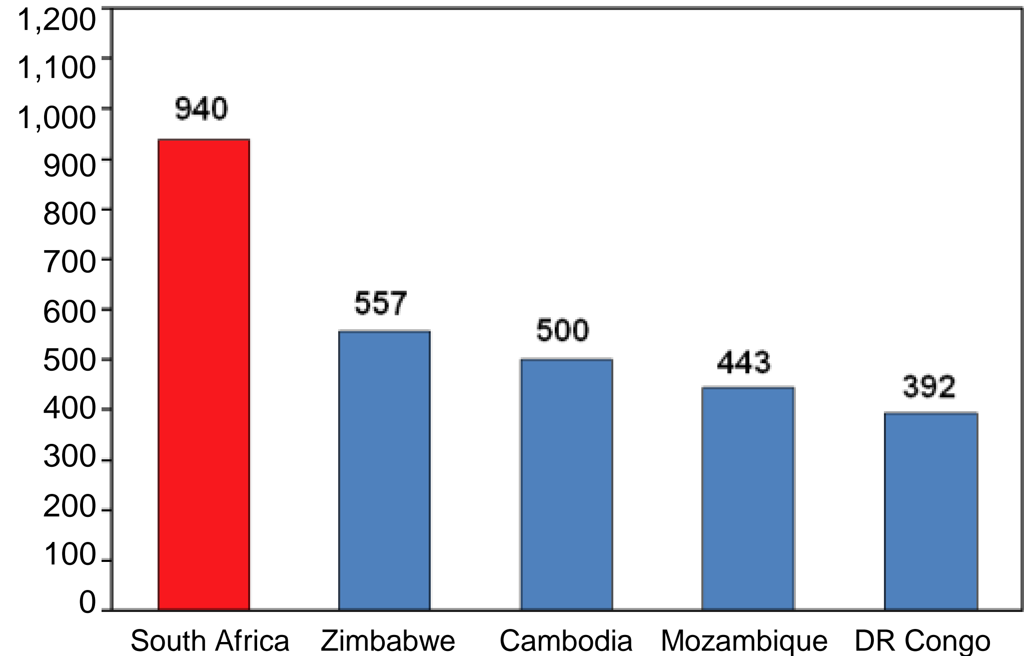
More than one in six adult South Africans currently HIV infected



Source: current 'best knowledge' as captured in ASSA models

In addition: Highest TB incidence and prevalence

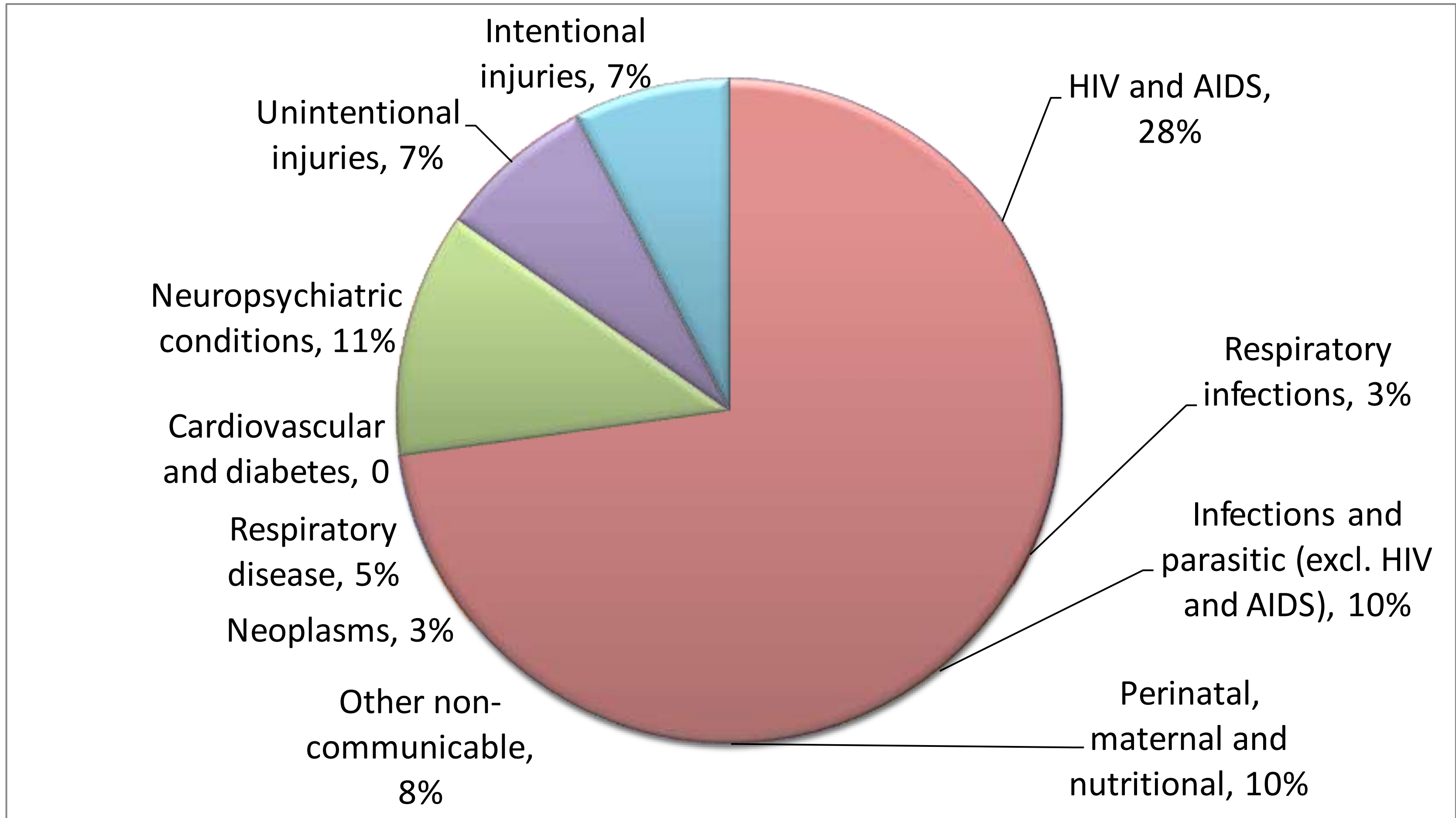




- *TB-HIV co-infection was approximately 55% in 2002*
- *The number of people diagnosed with TB trebled between 1996 and 2006 (from 269 to 720 cases of TB per 100 000)*
- *900 cases of Extensive Drug Resistant TB were reported between 2004 and 2007*

Source: Health Systems Trust reported 722 number; WHO: Global Tuberculosis Control, Surveillance, Planning, Financing reported 940

Growing incidence of non-communicable diseases



There have been some achievements...

...our health outcomes are bad.....

.... and we have a population with a heavy disease burden....

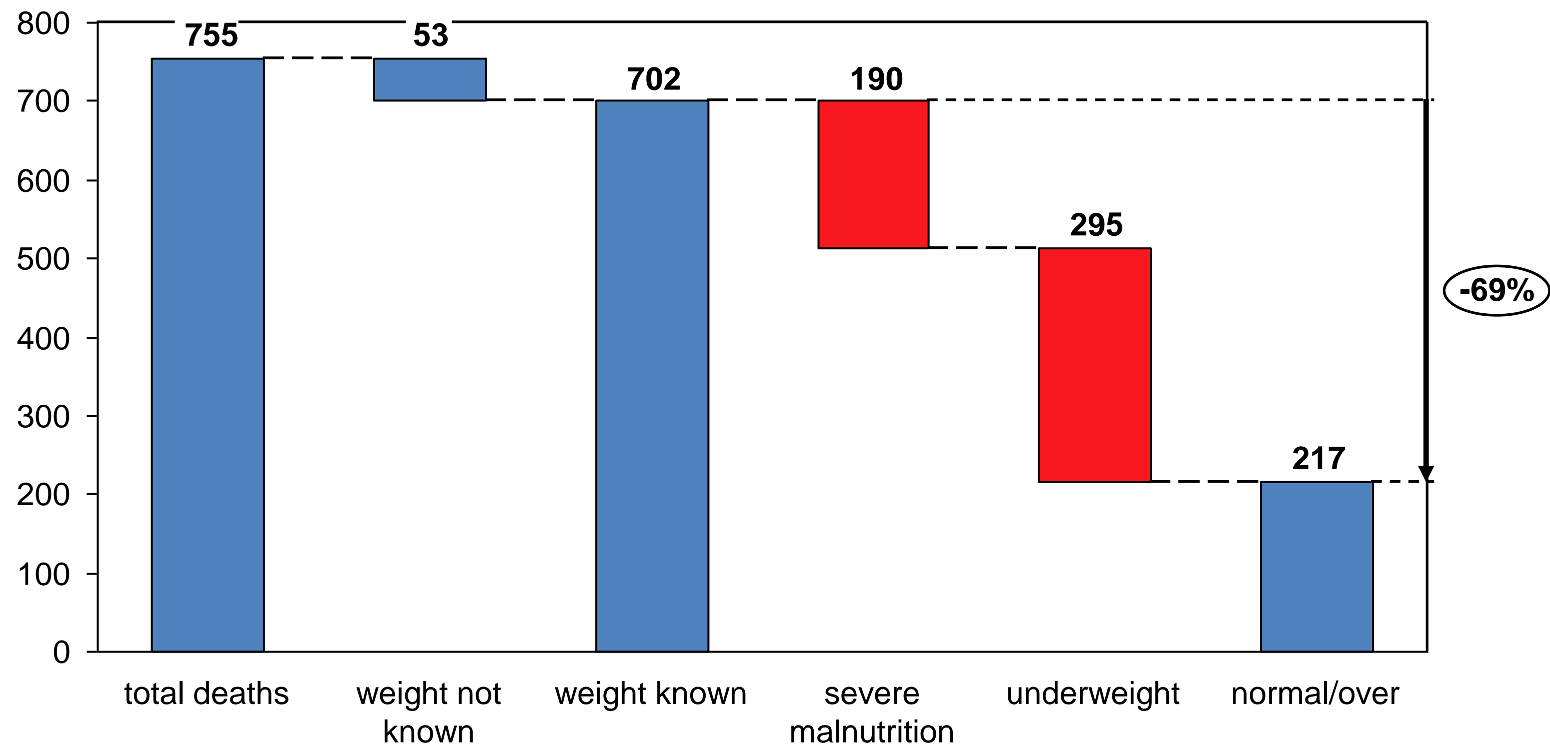
.... who continue to live in conditions which challenge their health ....

Extreme poverty remains pervasive

	Headcount rate		Poverty gap ratio	
	1995	2005	1995	2005
	R322 a month poverty line			
African	63,04%	56,34%	31,86%	24,44%
Coloured	39,00%	34,19%	14,66%	12,98%
Asian	4,71%	8,43%	1,03%	2,17%
White	0,53%	0,38%	0,22%	0,11%
Total	**52,54%**	**47,99%**	**26,04%**	**20,61%**

Source: Towards a 15-year Review, 2008

Nutrition status in audit of 755 child-deaths



- of the known weights at death, 69% were underweight (including severe malnutrition)
- being underweight more than doubles case fatality rate for infectious diseases (risk of dying)
- Severe malnutrition in Mafikeng went from 22% in 2001 to 31% in 2003/4

Source: Saving Children, a Pilot Survey of Child Healthcare in South Africa. The MRC Unit for maternal and infant health care strategies - a study in 8 healthcare facilities September 2003 – February 2004

There have been some achievements...

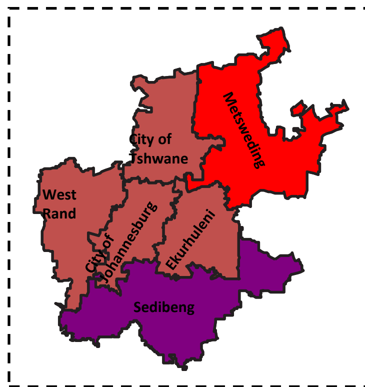
...our health outcomes are bad.....

.... and we have a population with a heavy disease burden....

.... who continue to live in conditions which challenge their health ....

.... and with a healthcare system which produces varying outcomes across the country

MDG performance does differ by health district



Vhembe
Capricorn
Mopani
Waterberg
Greater Sekhukhune
Bohlabela
Ehlanzeni
Bojanala
Nkangala
Central
Bophirima
Southern
Gert Sibande
Kgalagadi
Fezile Dabi
Siyanda
Frances Baard
Lejweleputswa
Thabo Mofutsanyane
Amajuba
Zululand
Umkhanyakude
Umzinyathi
Uthukela
Uthungulu
Motheo
iLembe
Xhariep
eThekwini
Sisonke
Pixley ka Seme
A Nzo
Ugu
uMgungundlovu
Namakwa
Ukhahlamba
O.R. Tambo
Chris Hani
West Coast
Amathole
Central Karoo
Cacadu
Cape Winelands
City of Cape Town
Eden
Overberg
Nelson Mandela Bay Metro

Best performing health districts
Medium performing health districts
Worst performing health districts

Source: Health Systems Trust; District Health Barometer 2006/07, Monitor Analysis

Institutional Working Group

Institutional weaknesses at most levels of the health system:

- Policy decisions are systematically decentralised, and operational decisions systematically centralised
- Centralisation of operational decisions
  - *Efficiency and control of service delivery* from appropriate implementing agents?
  - *Accountability for service delivery* – responsibility for failures?
- Resource allocation disconnected from national policies
- Financing of public hospitals
  - *Population growth and burden of disease - outcomes?*
  - *Provincial equitable share and recurrent funding for hospitals*
  - *Link between budgets and outputs*

Hospital level

- Management provincial and hospital capacity – policy & oversight
- Appropriate delegation of management authority
- Operational decisions are centralised at provincial/national level
- Key decisions affecting patient quality of care largely made at national and provincial level (not directly accountable for patient outcomes)
- Decision-space and accountability
- Human resource, financial, information system and procurement staffing where level takes place – data management, stock management, resolution of employment issues, etc.
- Basic equipment, supplies, drugs and other resource shortages despite sufficient budgets often being available
- Clinical process is marginalised
- Quality of contact between staff and patients
- Morale: management, promotion prospects and staff shortages
- General accountability for the quality of health service delivery

System-wide problems driving outcomes

Reasons why mothers die: Modifiable Factors

Failing Healthcare System*

- **Healthcare Worker Issues**
- Substandard management
- Problem with recognition / diagnosis
- Delay in referring patient
- Initial assessment
- Managed at inappropriate level
- Infrequently monitored
- Incorrect management
- Prolonged abnormal monitoring without action

- **Administrative Issues**
- Lack of appropriately trained staff
- Lack of specific health care facilities
- Transport between institutions
- Lack of blood for transfusion
- Communication problems
- Transport home to institution
- Lack of accessibility
- Barriers to entry

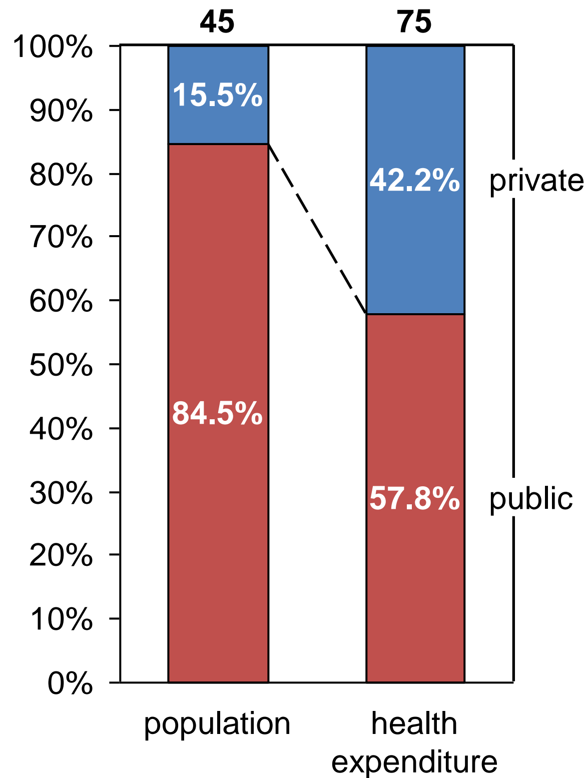
- **Patient Issues**
- Delay in seeking medical help
- Unsafe abortion
- No antenatal care
- Infrequent antenatal care

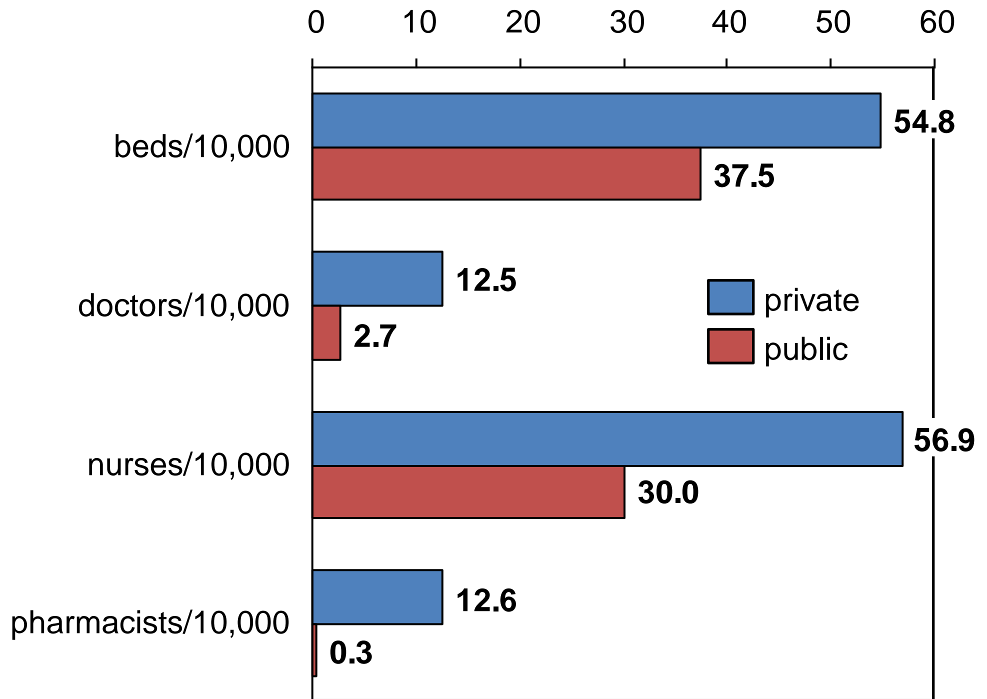
System-wide causes of poor quality of care – not a 'one problem issue'

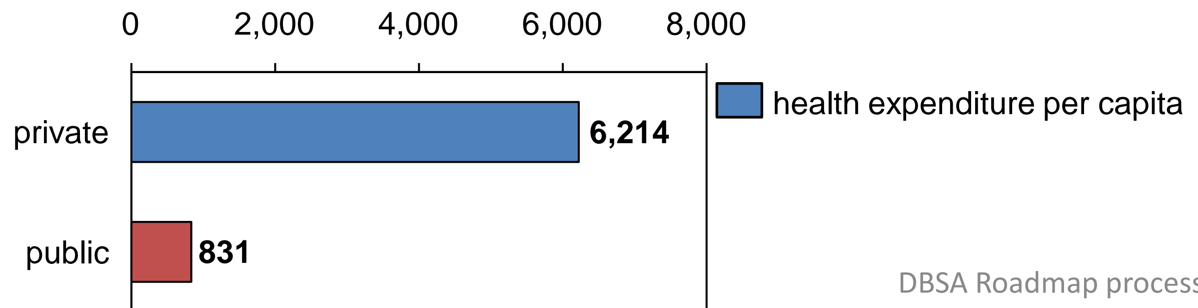
Note: *Modifiable Factors contributing to Maternal death used as a barometer of state of healthcare system
Source: Saving Mothers, Medical Research Council

Our private healthcare system absorbs the lion's share of resources, and serves a smaller part of the population

Old data, but directionally correct



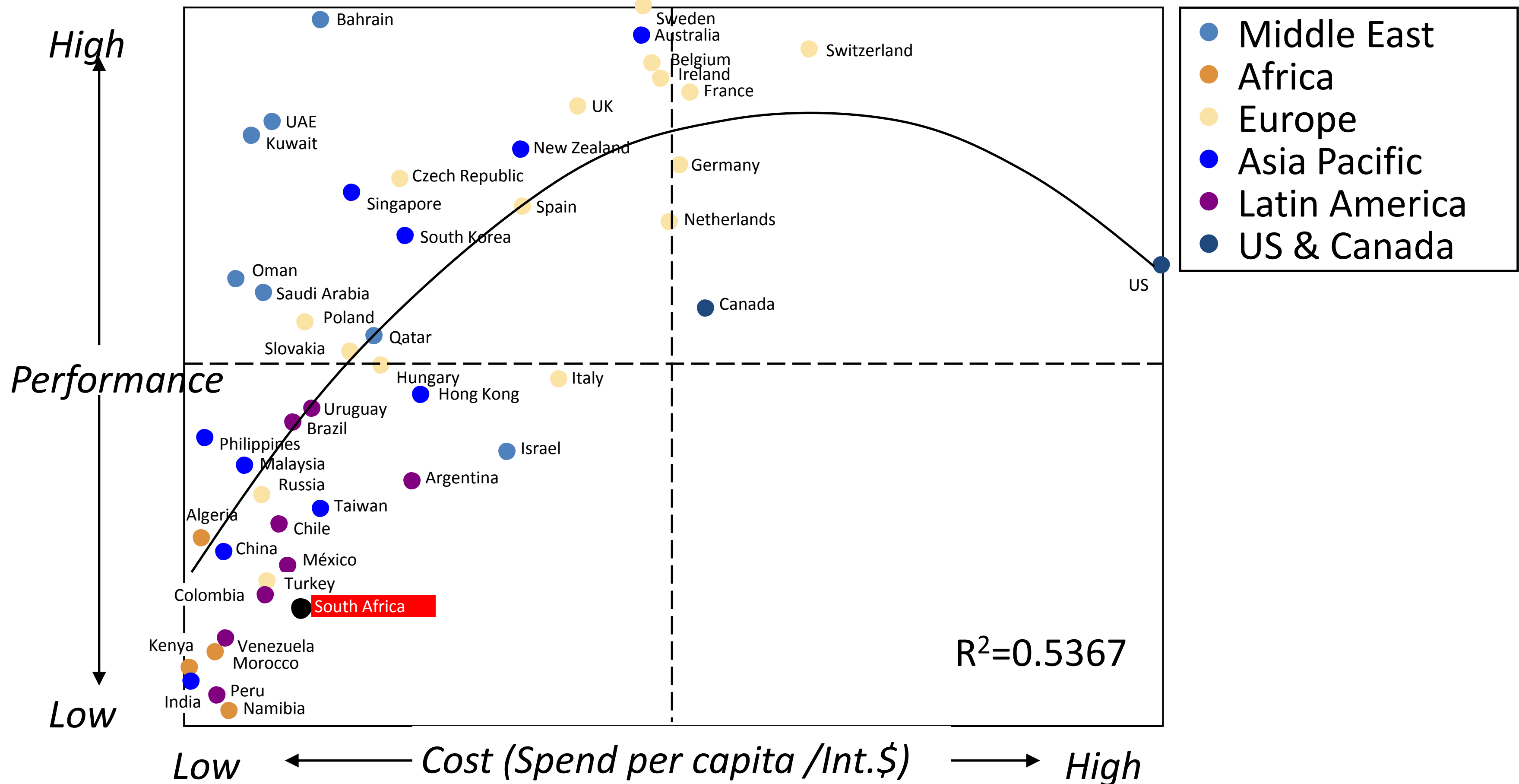




DBSA Roadmap process

Overall, South Africa getting poor performance relative to cost

Countries sitting above the trend line are producing relatively better performance for the cost per capita inputs that they are investing

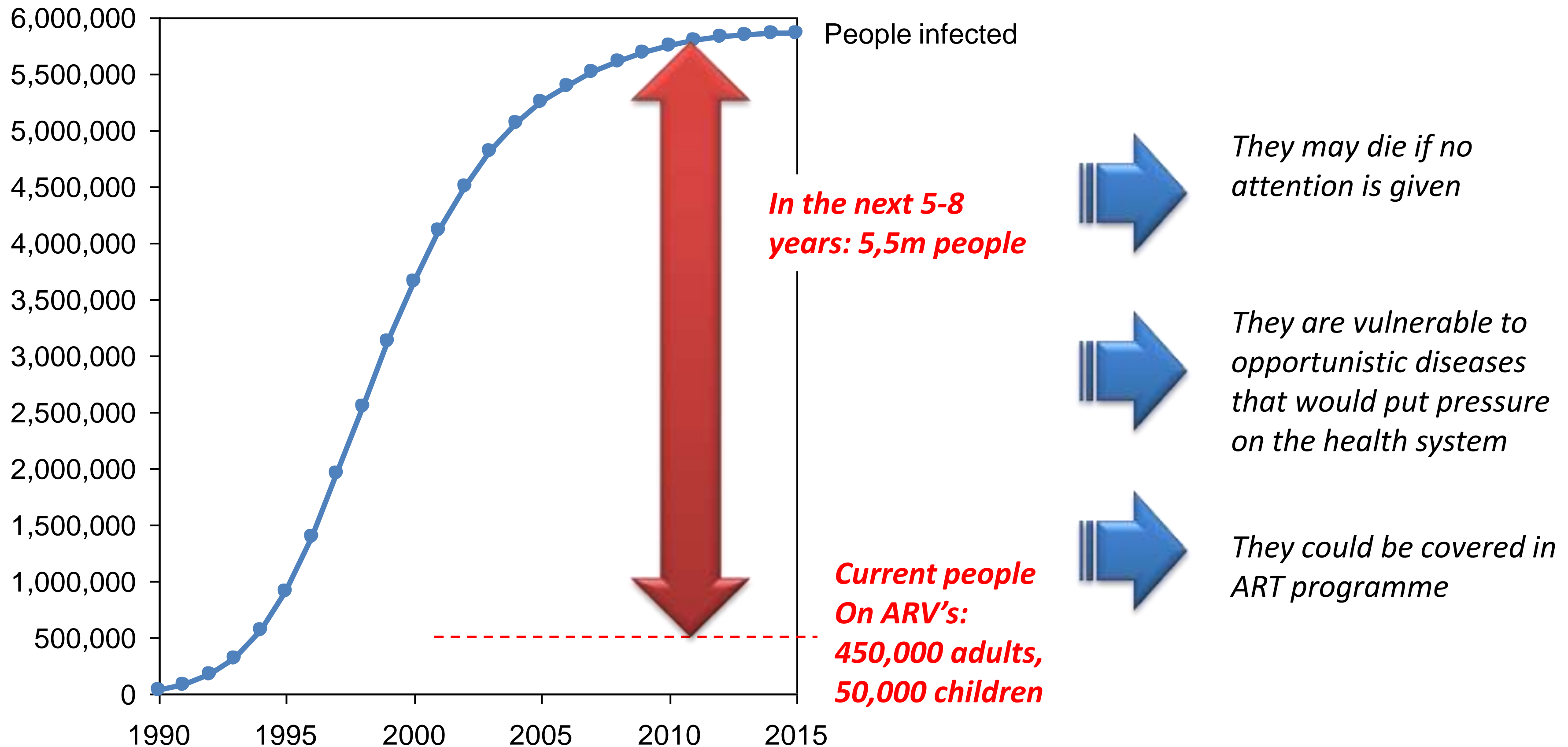


Note: Trend line is a polynomial
Source: Discovery Health Pool Stream Database, Monitor Analysis

Part two

EMERGING PRIORITIES

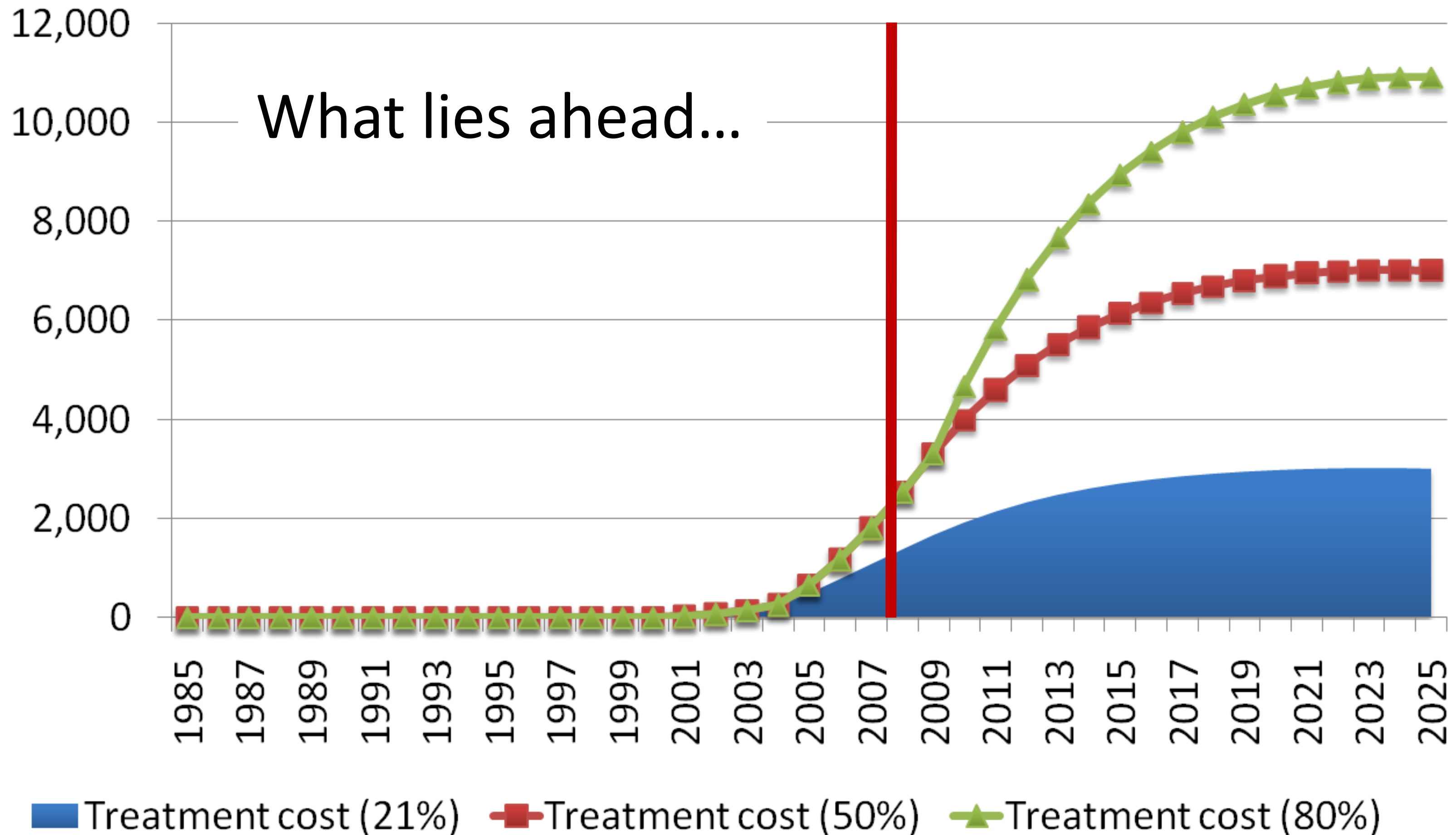
AIDS pandemic



- 5,5m people ***are already infected***
- people on current treatment represents a (disputed) estimate
- the slope can be argued, but not the peak

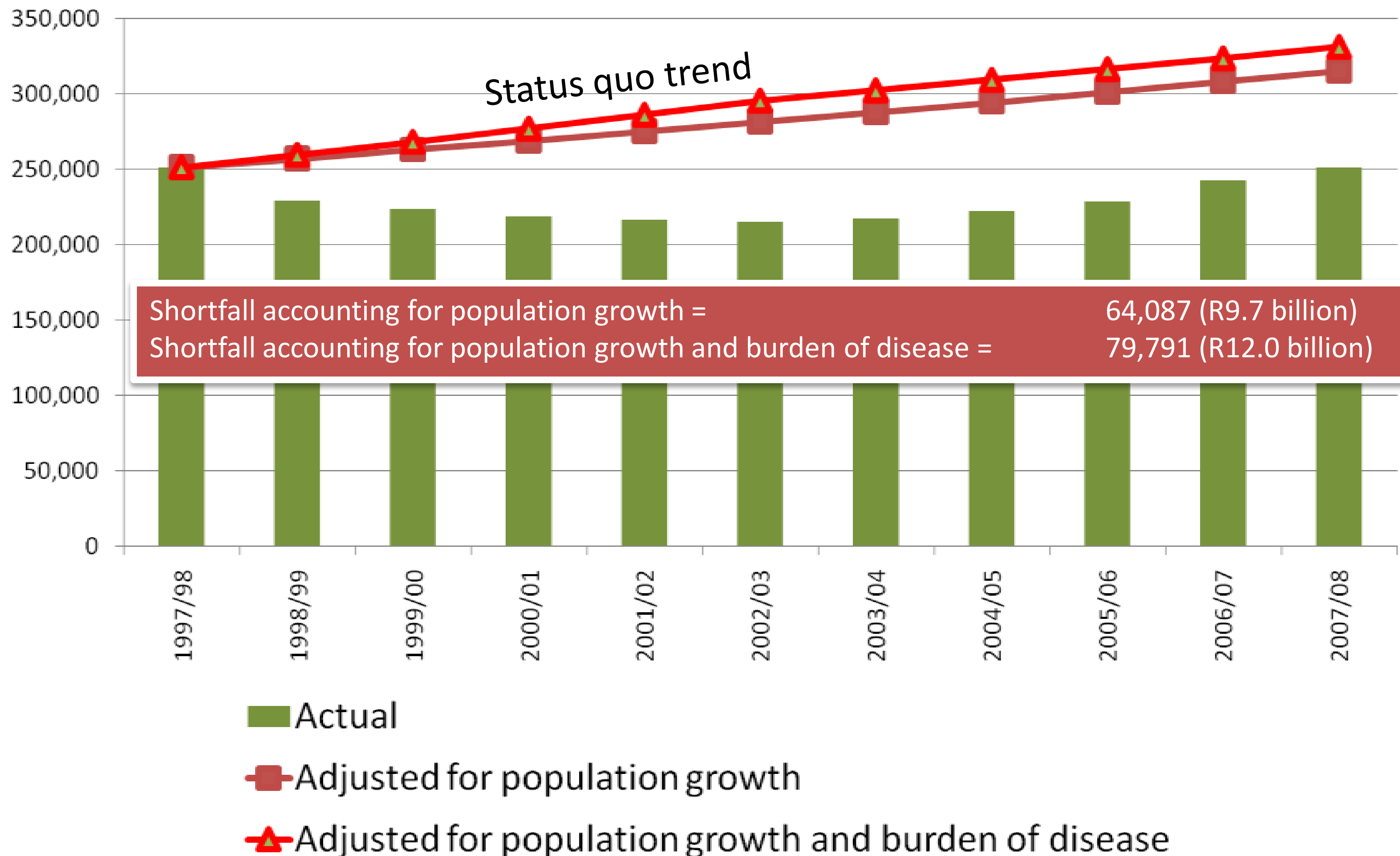
Source: Current projections from the ASSA models

Indicative ARV Treatment Cost: at 21%, 50% and 80% coverage from 2008 (R million)



Source: Assumed cost of R500 pm, treatment requirements estimated using the ASSA2003 model

Public health sector employment increased but falling behind health needs



DBSA Roadmap process

Dysfunctional prioritisation and management system

System

Poorly aligned and structurally disconnected system

- No quantifiable and auditable policy framework
- Unreal budgets, lack of financial systems, unconditional allocations
- Poor governance, poorly configured incentives, roles, responsibilities
- Resource allocation is structurally disconnected from national policies

Information

Effective information systems are not in place

- Performance in relation to health priorities are not quantified or quantifiable
- Informed policy choices cannot be made
- Responsibility for performance, whether good or bad, cannot be attributed
- Good practice cannot be identified and generalised
- Bad practices cannot be isolated and removed

Choices

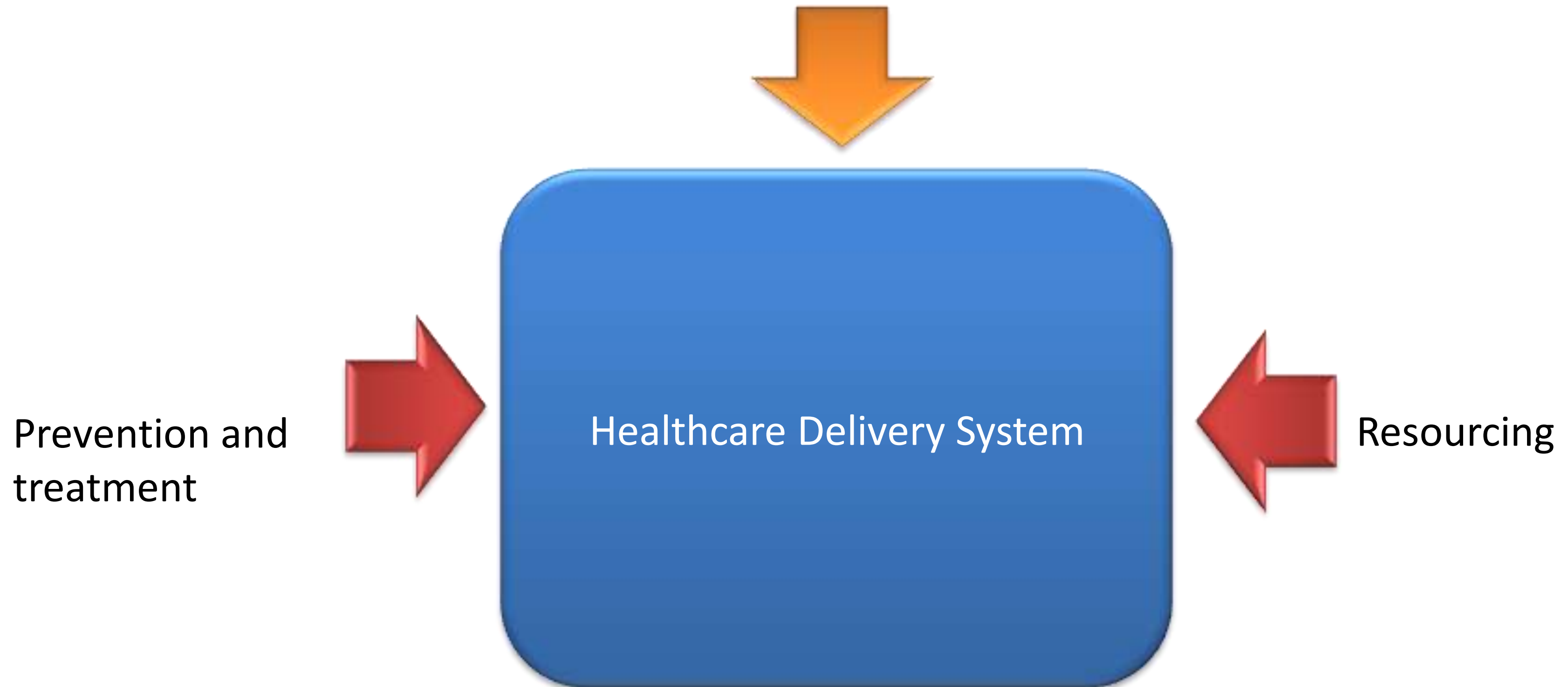
Decision-making is incorrectly located

- Operational decisions (e.g. staff appointments, organisational structures, conditions of service, asset purchases and maintenance) are centralised at the provincial or national level
- Inadequate regulatory framework for private sector participation
- Supply-side and Demand-side

Part three

PROPOSED INTERVENTIONS

Proposed interventions



Intervention 1

NATIONAL PRIORITISATION, DECENTRALISATION AND ACCOUNTABILITY

Priority: strengthen effectiveness at all levels of the health system

- Decentralise operational functions within the context of a clear national policy framework
  - Health districts
  - Public hospitals
- An altered governance framework for public hospitals:
  - clarification of national and provincial policy and oversight functions; devolution of key decision-making powers; establishment of independent Board(s) with powers to

    appoint and remove a hospital CEO; clear definition of executive roles and responsibilities (accounts, procurement, maintenance, subject to oversight and budget constraints; HR management, etc)
- Develop focus on policy-making and resource allocation (centralize allocative efficiency decisions)
- Strengthen dedicated capacity for critical functions
- National consultation processes for critical policy areas

Engage the private sector

- The private health sector is operating at lower levels of capacity utilisation (e.g. bed occupancy) than public health
- Given AIDS pandemic and other pressing health challenges, there is an urgent need to reduce pressure on public health
- Need for improved engagement of private health sector in efforts towards driving down health care costs
- Private sector catchment population is 7.5m. Estimated that private sector could serve substantially larger group
- If private sector increased its catchment population, it could reduce burden on public health sector
- If achieved, this could create R6 billion in fiscal space for hospitals alone (hospital budget = R31 billion). The total fiscal space created including all services would be roughly R12 billion

Several options for consideration

- Policy framework for private sector participation
- Proactive and sustained engagement
- Public-private mix
- Concerted effort to drive down healthcare costs
- Robust discussions: change current tax subsidy and integrate with new risk-equalisation approach
  - State currently provides tax subsidies of approximately R13bn per annum to medical scheme membership
  - Engage private medical schemes to equalise risks and take on lower-income groups
  - Re-allocate tax subsidy to lower-income earners
- Further analysis and options to be developed as part of National Health Insurance process.

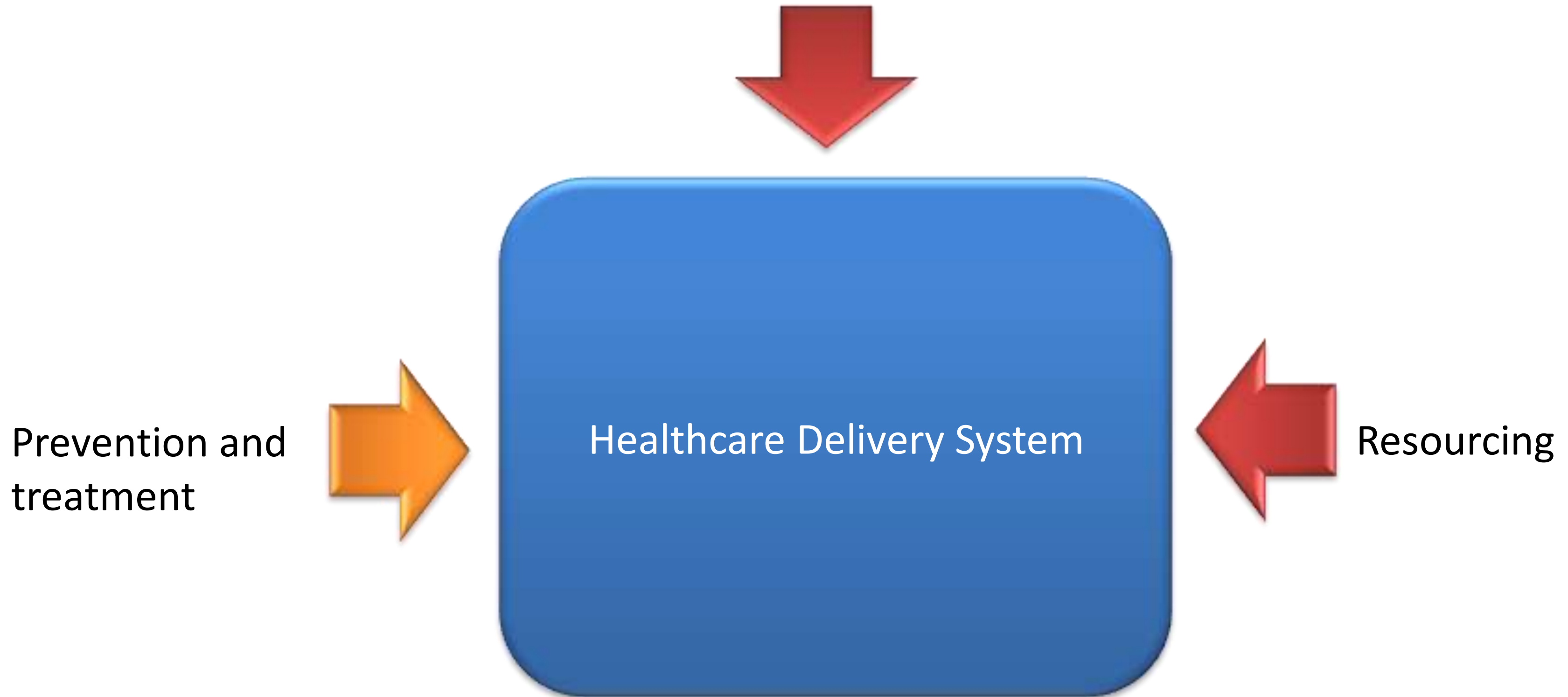
Consultation processes need to be strengthened

- Formalise in national legislation (NHA) allowing these fora to have a standing advisory function
- Focus on areas where participative consultation is likely to productively contribute to ongoing policy improvements

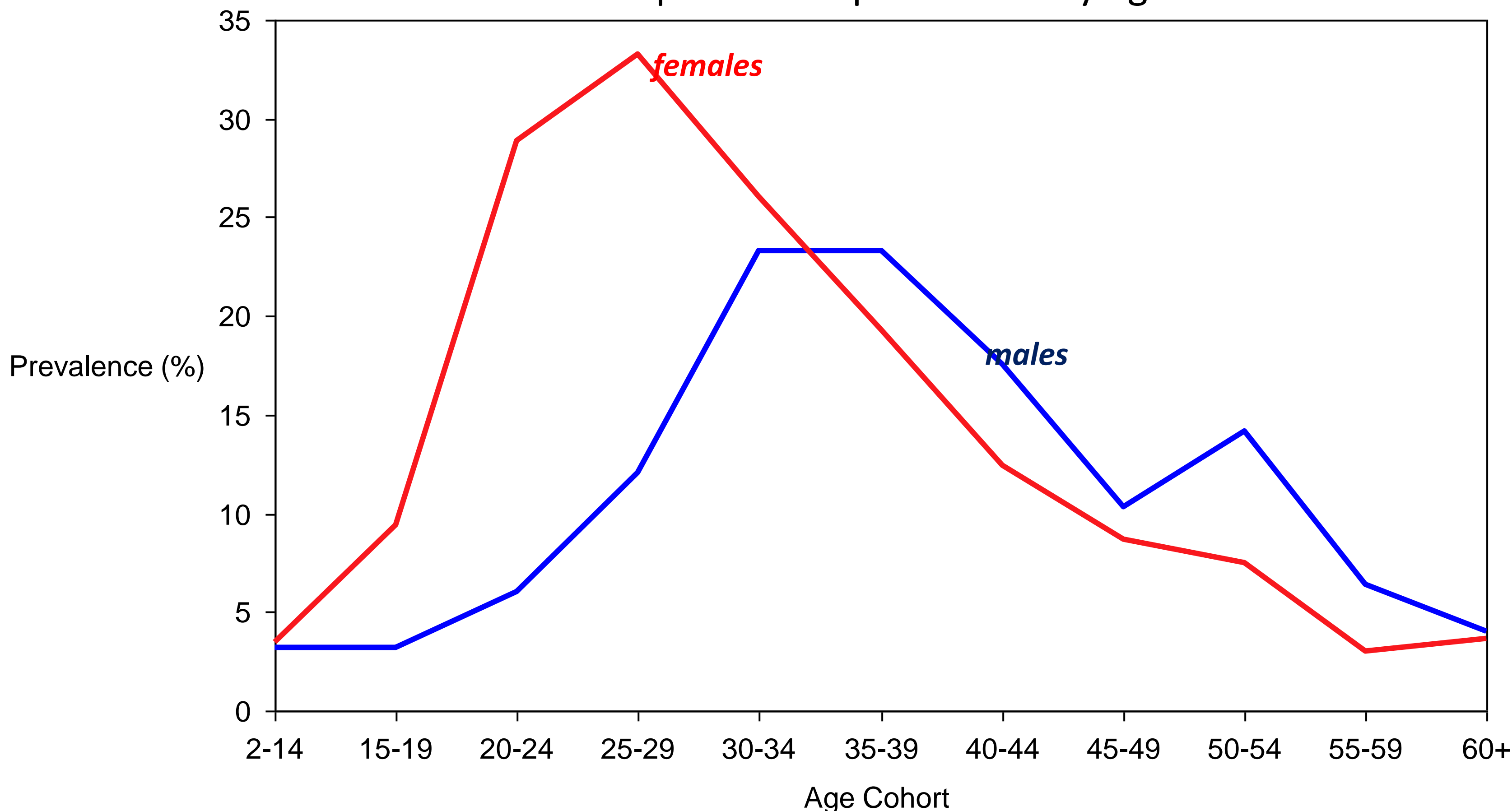
Intervention 2

PREVENTION AND TREATMENT

Proposed interventions

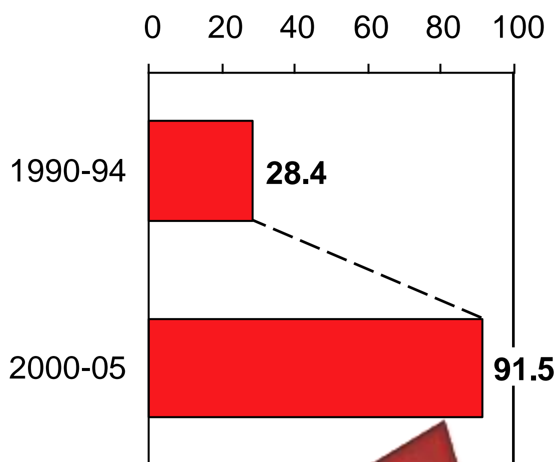


Need a national effort to change behaviour to reduce the 520,000+ new infections annually (1,450 per day)



Source: *SA National HIV Prevalence, HIV Incidence – Behaviour and Communication Survey 2005*, Nelson Mandela Foundation, Research conducted by HSRC, MRC, CADRE

Need PMTCT roll-out to reduce new infections and reach MDG targets



The reported national rate of 60/1,000 most likely is too low – but still represents an infant dying every 8 minutes

- ASSA model assumes median survival of HIV+ baby is around 1 year, if infected perinatally (in this case, ***7.5% of all tested babies***. Without NVP (as between 2000-2005) this would have been almost 10%)
- Vertical transmission rates can be further improved:
  - *Combining with AZT (since become protocol)*
  - *Women knowing their real status*
  - *Breast milk transmission (which is additional to these numbers)*
- ***50/1,000 babies died because of HIV*** infection – accounting for the bulk of the growth in Infant mortality (of 63/1,000)
- A similar effect would be true for the Under-5 mortality
- For South Africa to reach the MDG target, PMTCT roll-out is essential
- PMTCT is also an important entry program for the mothers – so we don't simply end up with surviving orphans

Source: Rollins etal: *Surveillance of mother-to-child transmission prevention programmes at immunization clinics: the case for universal screening,* March 2007; ASSA model assumptions

Opportunities for significant gains in these areas if we improve and scale-up response

- Each year, about **60,000 babies** are infected by mother-to-child transmission during birth or through breastfeeding. Only half the babies born to HIV positive mothers receive the full anti-retroviral prevention during and following birth
- At best, **40% of the population has sustained access to community-level HIV prevention.** Modelling of program impact shows that community-level coverage should be much higher for maximum impact – at least 65-70%
- *At most*, **50% of people eligible for anti-retroviral treatment currently receive it**
- South Africa has among **the worst TB completion and cure rates in the world**
- **Care and support programme** data shows that many orphans and vulnerable children(~30%) still do not have access to social security and drop out of school
- **Poor communication on HIV/ AIDS**

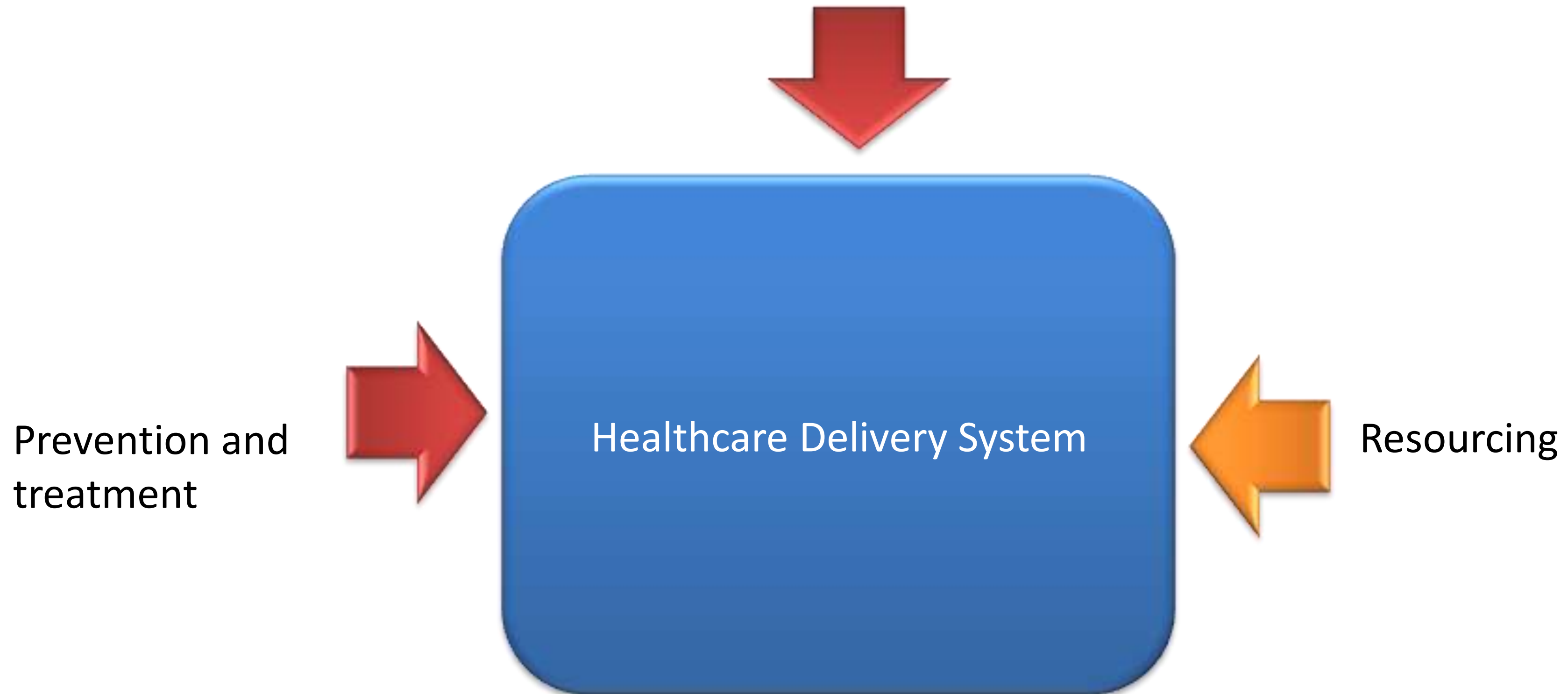
Recommendations for immediate action

- **Communication campaign by Minister and Presidency**
  - Ensure entire society addresses HIV and AIDS as *their* problem: e.g. concurrency of partnerships, consistent condom use with non-regular partners, other STIs, male circumcision
  - 60% of South Africans heard of ART but most do not know the role of ART
  - Prioritise prevention of mother-to-child transmission of HIV (i.e. create demand for PMTCT)
- **Fully mobilize all sectors of society**
  - Assert role of parents in HIV prevention
  - Mobilise SAMA, DENOSA, and healthcare associations
  - Assert the role of **business,** trade unions, schools, faith-based organisations
  - Role of Cabinet, provinces, political parties
  - Putting quality at the centre of what we do by living the "philosophy" and applying the methodology of quality
- Revive **SANAC** to implement National Strategic Plan

Recommendations for first-year targets

- Support districts to achieve 95% coverage of **PMTCT**
- Campaign to tackle social norms to reach 67%-80% of 6-11 year olds and 12-17 year olds
- Improve the coverage and effectiveness of **ART** through putting in place system of monitoring and management of all HIV+ people presenting to health services
- Establish **national reference laboratory for TB,** including system of TB recording and reporting across the provinces
- Improve **care and support** (working closely with DoSD and deploying NGOs, CBOs, CHBC, CHWs) focusing on 4m orphans and AIDS sick
- Focus on infection rates of 17-21 year old women
  - Apart from education about high-risk behaviour, there need to be real dis/incentives (e.g. social mobility programmes, gender-based violence, statutory rape, etc.)
- Intensify HIV prevention among sex workers
- Target particular districts and informal settlements
  - Economies of scale effect through high population densities and infection rates
  - **Bring in partnerships to reinforce district capacity (while strengthening districts)**

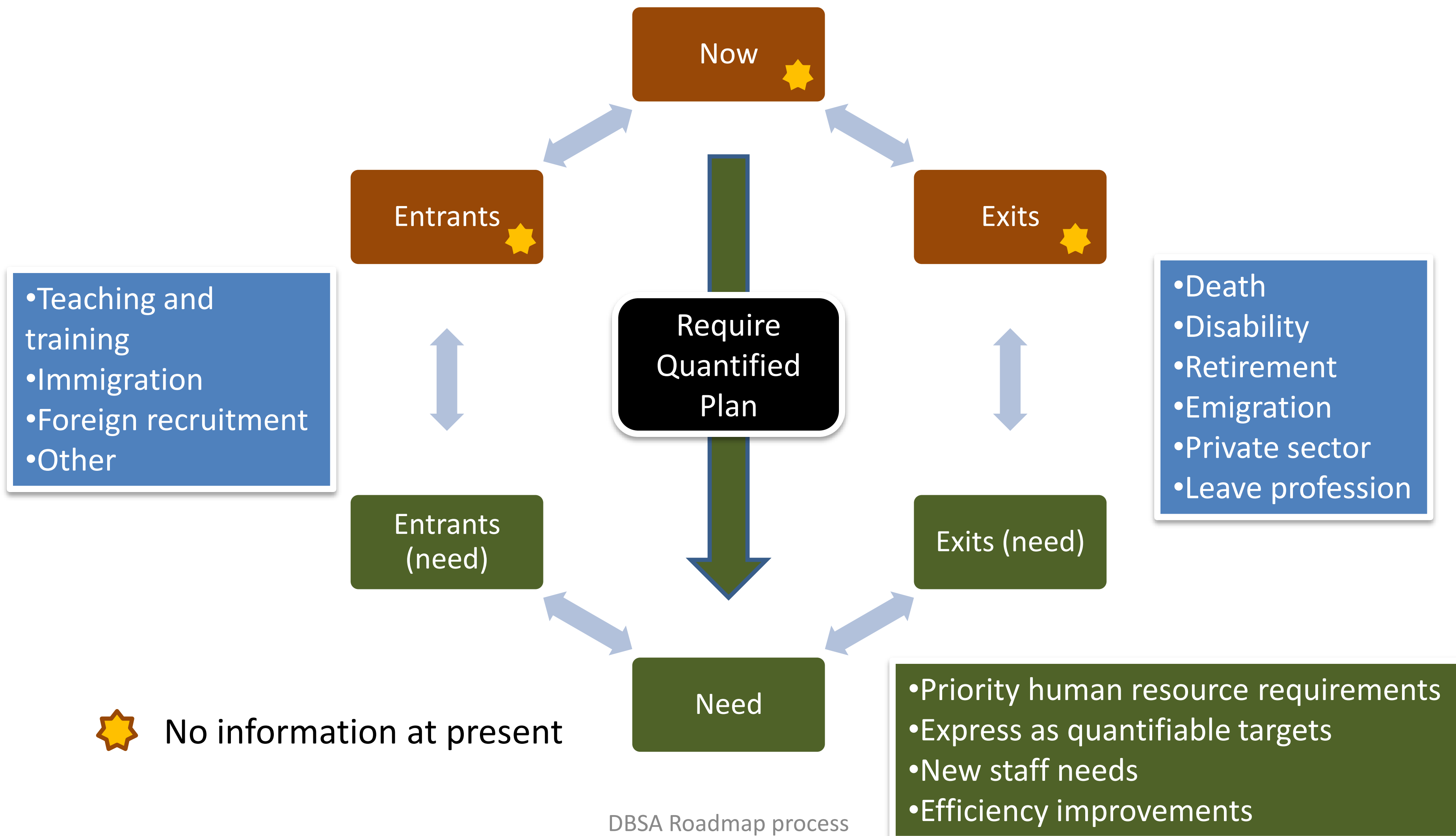
Proposed interventions



Intervention 3

RESOURCING

Human Resources for the Health System at all levels – roadmap to a plan



HR Recommendations

- Establish a standing consultation process that can routinely identify system needs and feed them into executive decision-making
  - Norms and standards
  - Gaps
  - Teaching targets
- Information
  - Track staff movements and dynamics via licensing data on health professionals (public and private sector)
  - Provide routine reports to decision-making processes
- Implement units within the NDoH capable of performing strategic human resource analysis

HR Recommendations

- Specify staff targets for key health professionals with approx. 64,000 - 80,000 needed over the next 5 years depending on available funds
- Focus on staff improvements, mainly to **public hospitals and district management**
- Explicitly fund the training and education of professionals central to the proper functioning of the health system using a specific purpose grant -
  - Teaching platform
  - Service platform
- Manage the coherent implementation of the Community Health Worker programme (requires, *inter alia*, a better functioning district system)
- Private sector participation in training and development

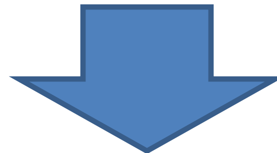
Need to address budgetary constraints

Estimated requirements if full implementation of proposals

- Human resources: R9.7bn – R12bn for 64,000-80,000 staff
- AIDS pandemic ART estimated at approx. R10bn for 80% coverage
- Hospital rehabilitation? Private sector participation
- National Health Information system: ?
- Strengthening district health system: ?

Initiate process for resourcing

- Resourcing can be phased in as implementation scales up (e.g. NSP)
- Manage input costs – properly negotiate/regulate prices down
- International donors (Global Fund and PEPFAR) and private sector (increase efficiency of coverage)
- Amend allocation of currently available budgetary resources
- Strengthen management to address under- and over-spending and programme disruption, esp. district level



Given funding constraints conduct a full, comprehensive review of health budgets and choices as they impact on available resources

CONCLUDING REMARKS… A SHARED COMMITMENT

Roadmap priorities: 10 point plan

1. Establish a coherent and vision-based executive-decision-making process, with inputs from a legislated consultation forum that can routinely identify system needs
   - Support a publicly embedded set of specific and time-bound targets
   - Create sub-committees to focus on: HIV and AIDS and TB (SANAC); human resources, non-communicable diseases; quality assurance; national health information; nutrition; relationship between public and private sector; social determinants of health
2. Develop appropriate messaging for communication campaign by Minister and Presidency (with other key stakeholders), with particular focus on ensuring entire society addresses HIV/ AIDS and TB as society's problem

Key messages

- Political support and buy-in
- Social compact and community-level support
- Clear, unambiguous and consistent messaging
- Doing the right things: set national priorities and budgets based on informed decision-making
- Doing things right: strengthen district health system and capacity; de-centralisation of operational management

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Roadmap priorities: 10 point plan

3. Implement a national health information system sufficient to ensure that all parts of the system have the required **information** to effectively achieve their responsibilities
4. Promote **quality**, including measuring and benchmarking actual performance against standards for quality
5. Define an appropriately **decentralised and more accountable operational management model (including governance and capacity requirements)** for health service delivery, including revised roles and responsibilities for national department, provinces, districts, and public hospitals
6. Bring in additional **capacity and expertise** to strengthen a result-based health system, particularly at the district level (including revised legislation to recruit foreign skills, partnerships with private and public sector, deployment and training for district health management teams, etc.)

Roadmap priorities: 10 point plan

7. Establish **Human Resource Strategy** with national norms and standards for staffing, linked to a package of care
8. Develop a strategic focus on **child and maternal health**:
   - Address constraints to districts reaching required PMTCT uptake
   - Ensure maternal health systems are optimised, e.g. PMTCT and ART
   - Eliminate nutritional deficiencies for all children under 3 years of age
9. Consider the implementation of specialised **national agencies** to focus on National Health Information System, quality assurance, certificates of need in relation to expensive technology, etc.
10. Develop an **implementation strategy and collaboration/ partnerships** to leverage funding, increase health sector efficiencies, and accelerate implementation of National Strategic Plan
    - Beginning with social mobilisation campaign linked to World AIDS Day (1 December)

National Key Priorities (10 Point Plan)

- Provision of **strategic leadership and creation of a social compact** for better health outcomes (unified action - MACH, Task Teams; leadership structures – Boards; Social compact – labour movement)
- Implementation of **National Health Insurance Plan** – revenue (general tax and an earmarked mandatory contribution), government's universal subsidy contribution, an intermediary health fund, critical steps – *informed* engagement, reforms/policies/ legislation; budgeting (package) and phased implementation
- Improving **Quality of Services** – colloquia, national quality management and accreditation body, national norms/standards and benchmarking of public and private sectors, call centres and ombudsman
- Improving **Human Resources Management** – HR Plan, OSD, private sector: training development , leveraging of resources
- Overhauling the health care system and improve **management**

National Key Priorities (10 Point Plan)

(MACH, TTTs, ISTs, DMTs, training in leadership, management and governance and accountability framework for public and private health

- Revitalisation of **physical infrastructure – private sector** participation especially in the Hospital Revitalisation Programme
- Accelerated implementation of **HIV and AIDS Plan** and reduction of mortality due to **TB** and associated diseases – coordination of resources and information from public, private sectors, donor community and civil society (SANAC)
- **Mass mobilisation** for better health for the population – health promotion towards meeting MDG 4, 5 and 6 (NSP, SANAC, etc.)
- Review of **Drug Policy** – drug manufacturing entity, drug supply management information system
- Strengthening **Research and Development** – health service planning, delivery and monitoring, infant mortality, etc.