# Health Roadmap

November 2008

# 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**: **Ms. Barbara Hogan**, National Minister of Health; **Dr. Zweli Mkhize**, MEC Finance and Economic Development, KwaZulu-Natal and Chairperson: ANC subcommittee on Health and Education; and **Mr. Jay Naidoo**, Chairperson of the Board, Development Bank of Southern Africa (DBSA)
- 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)
- Consultative meeting (8 November 2008) concluded 10-point plan

## *There have been some achievements*

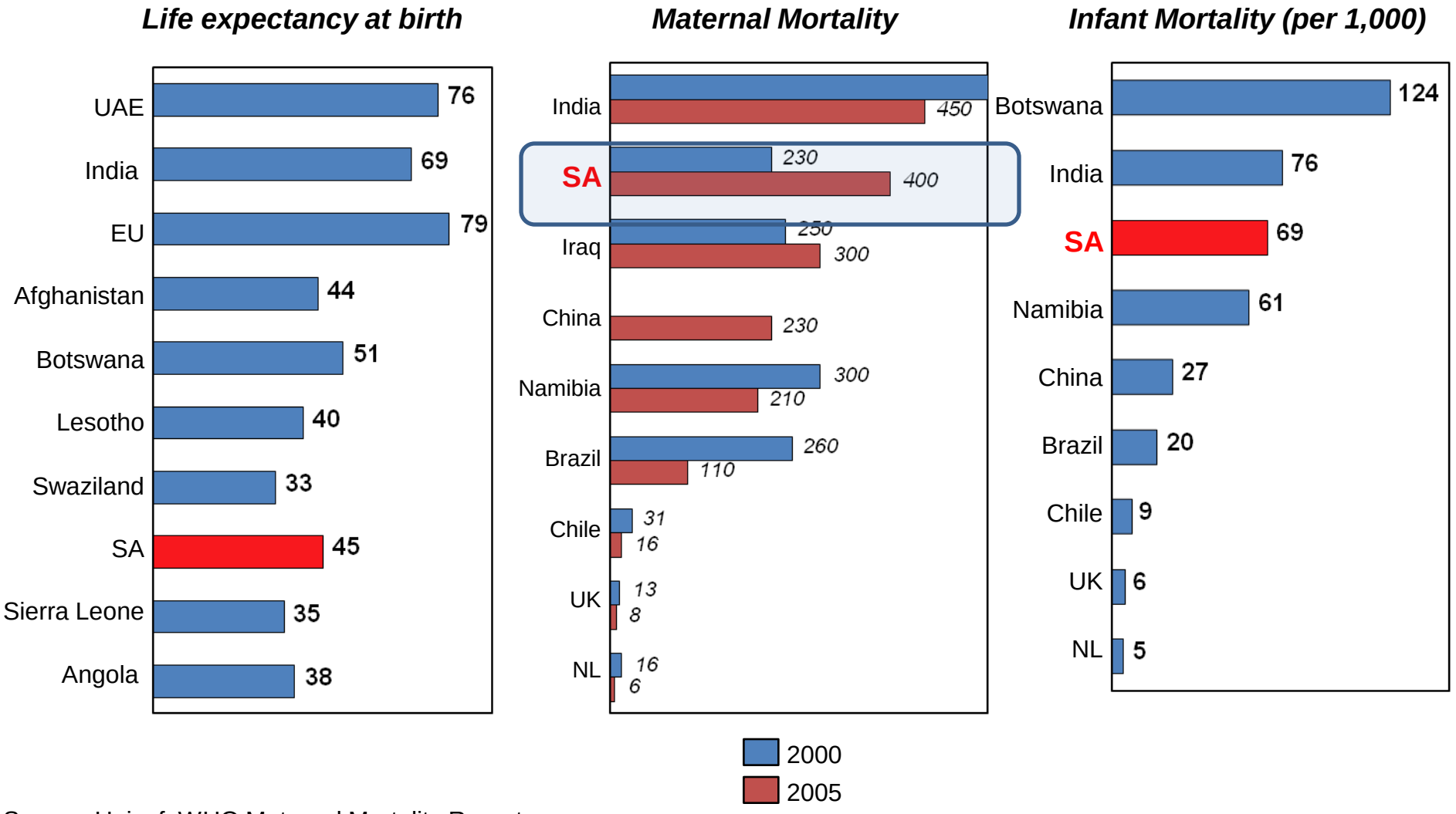
# Achievements since 1994

- 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…*

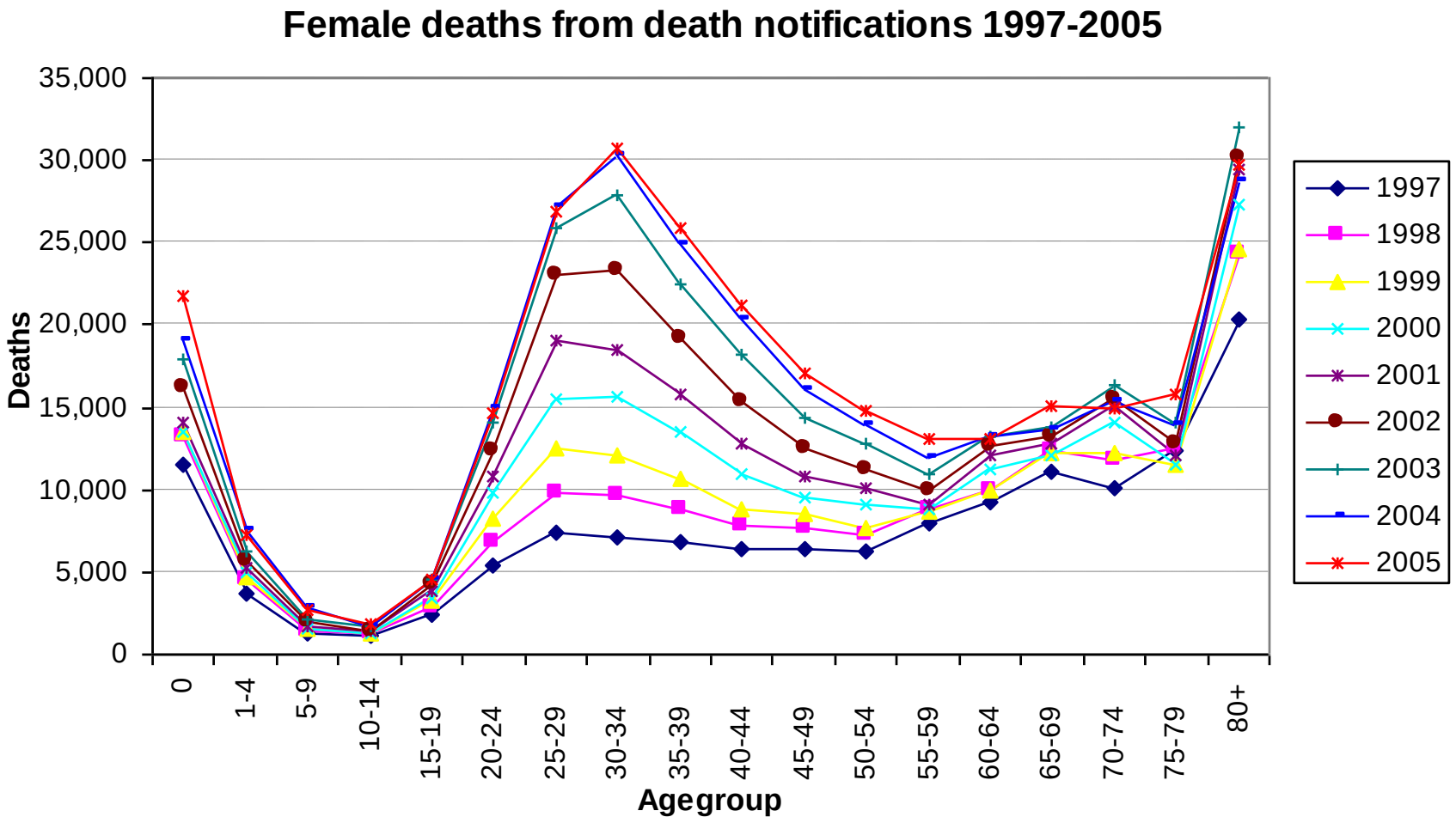
***…our health outcomes are bad…..***

# Health outcomes are bad




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

# South Africa's war-like death statistics



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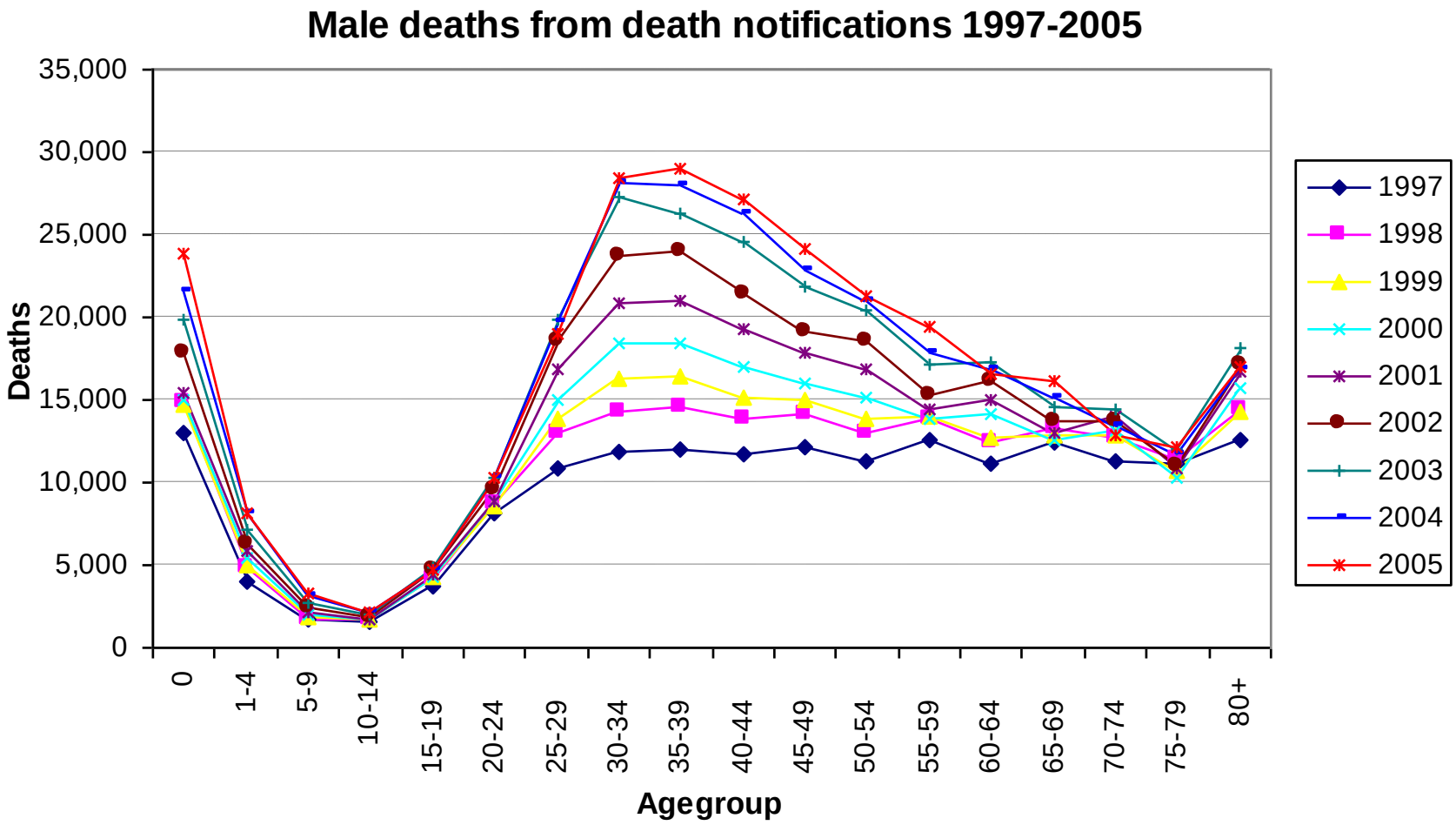
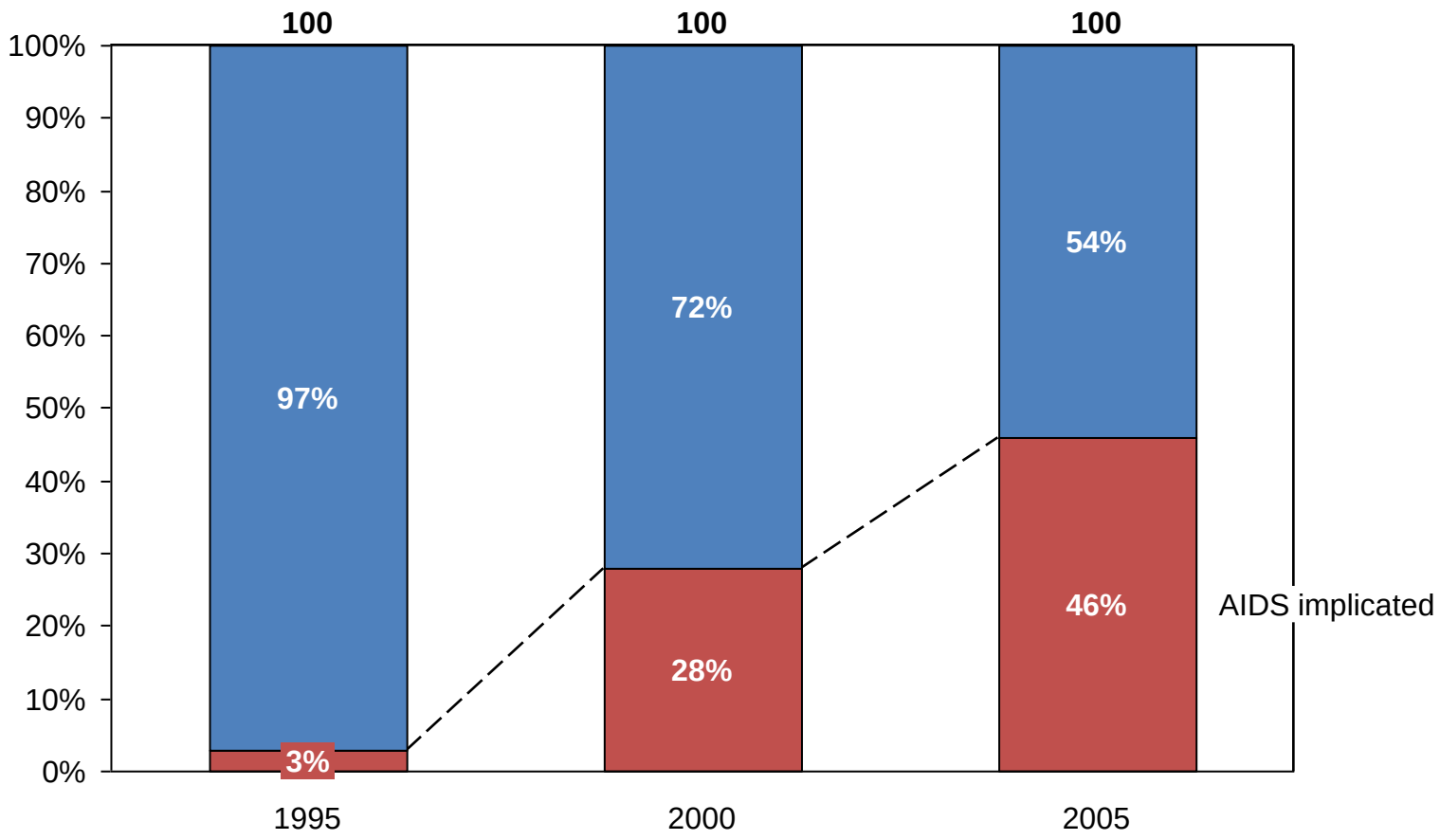


# The proportion of AIDS-related deaths on increase in the last decade



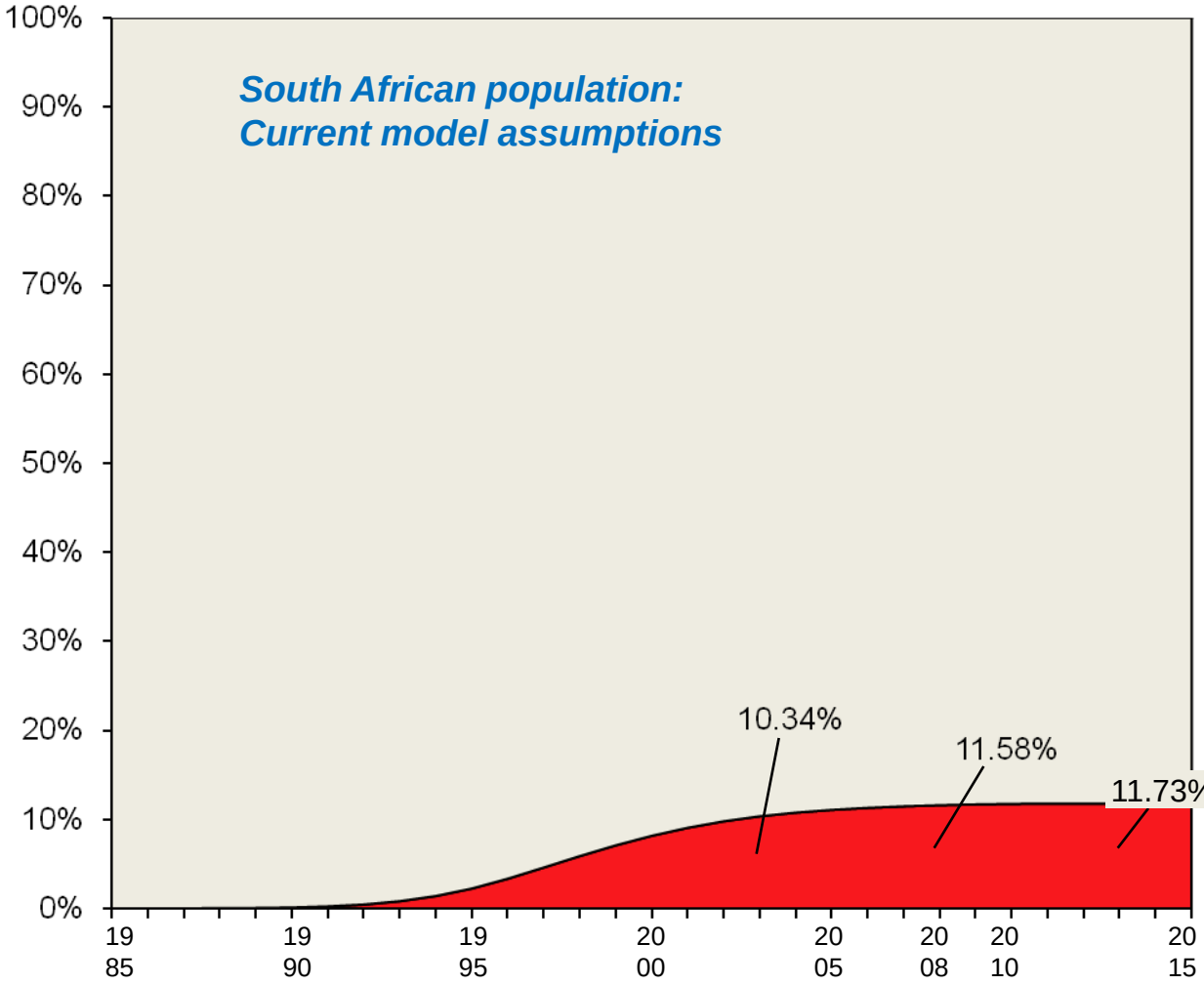

***Source: ASSA2003 Model***

*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




- ***SSA: 2% of world population***
- ***SSA: 33% of global HIV prevalence***

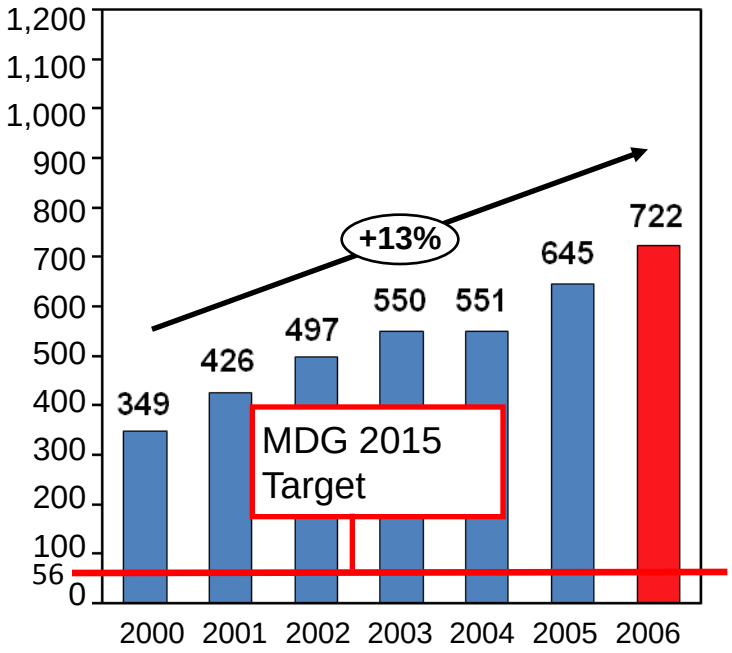
- ***SA: 1 in 9 South Africans have HIV***
- ***SA: 1 in 6 adults (15-49) have HIV***

***5,5m people currently infected, Health system inadequate***

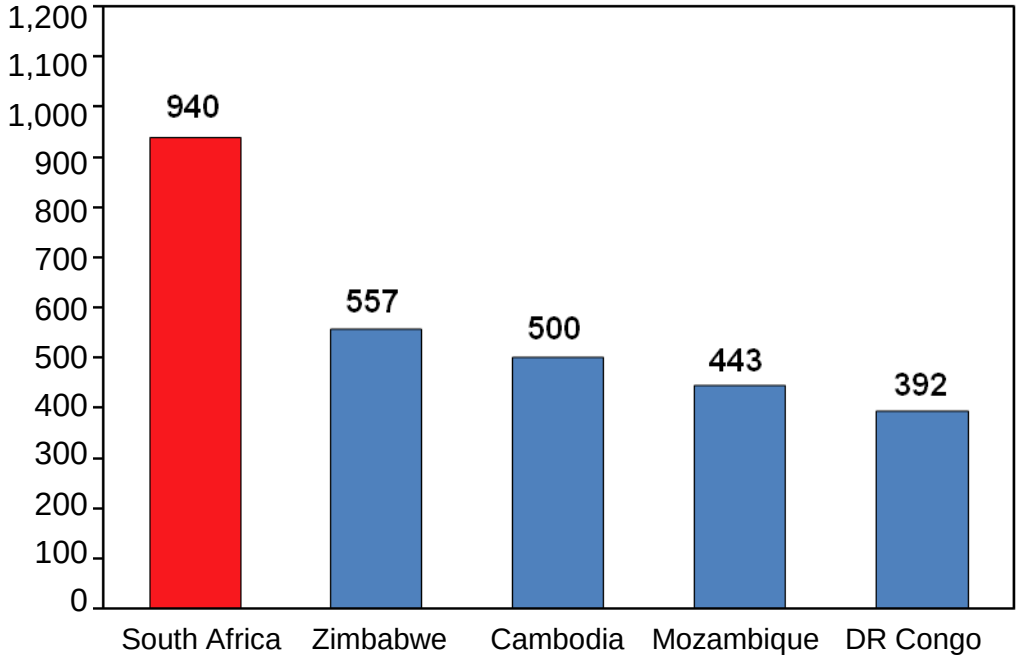
*Source: current 'best knowledge' as captured in ASSA models*

# In addition: Highest TB incidence and prevalence

***Incidence of TB per 100,000 population***




***Top-5 TB Prevalence (per 100,000) Geographies: 2006***

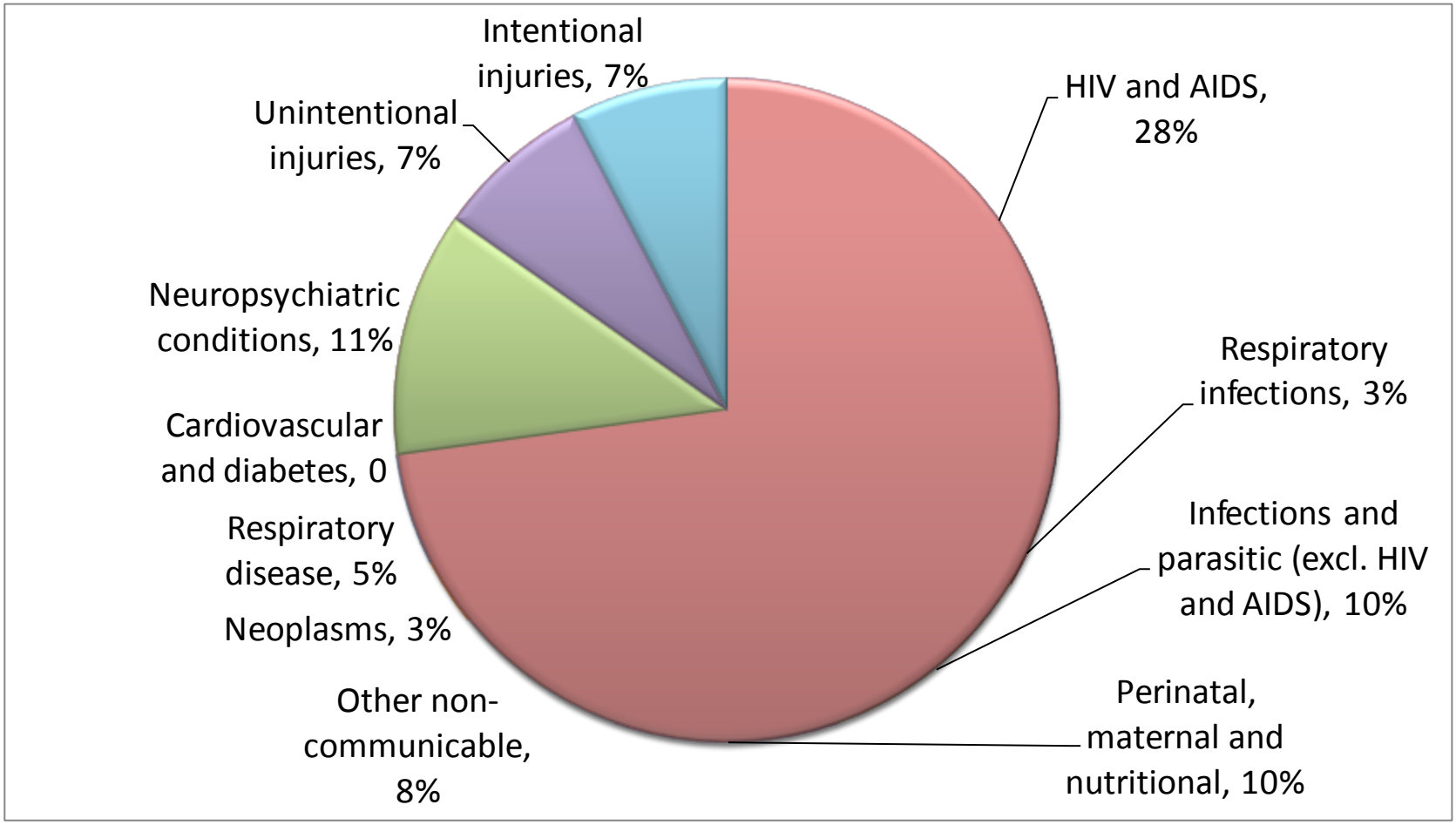



- *TB-HIV co-infection was approximately 55% in 2002*
- *The number of people diagnosed with TB trebled between 1996 and 2006 (from 269 to 720 cases of TB per 100 000)*
- *900 cases of Extensive Drug Resistant TB were reported between 2004 and 2007*



*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….*

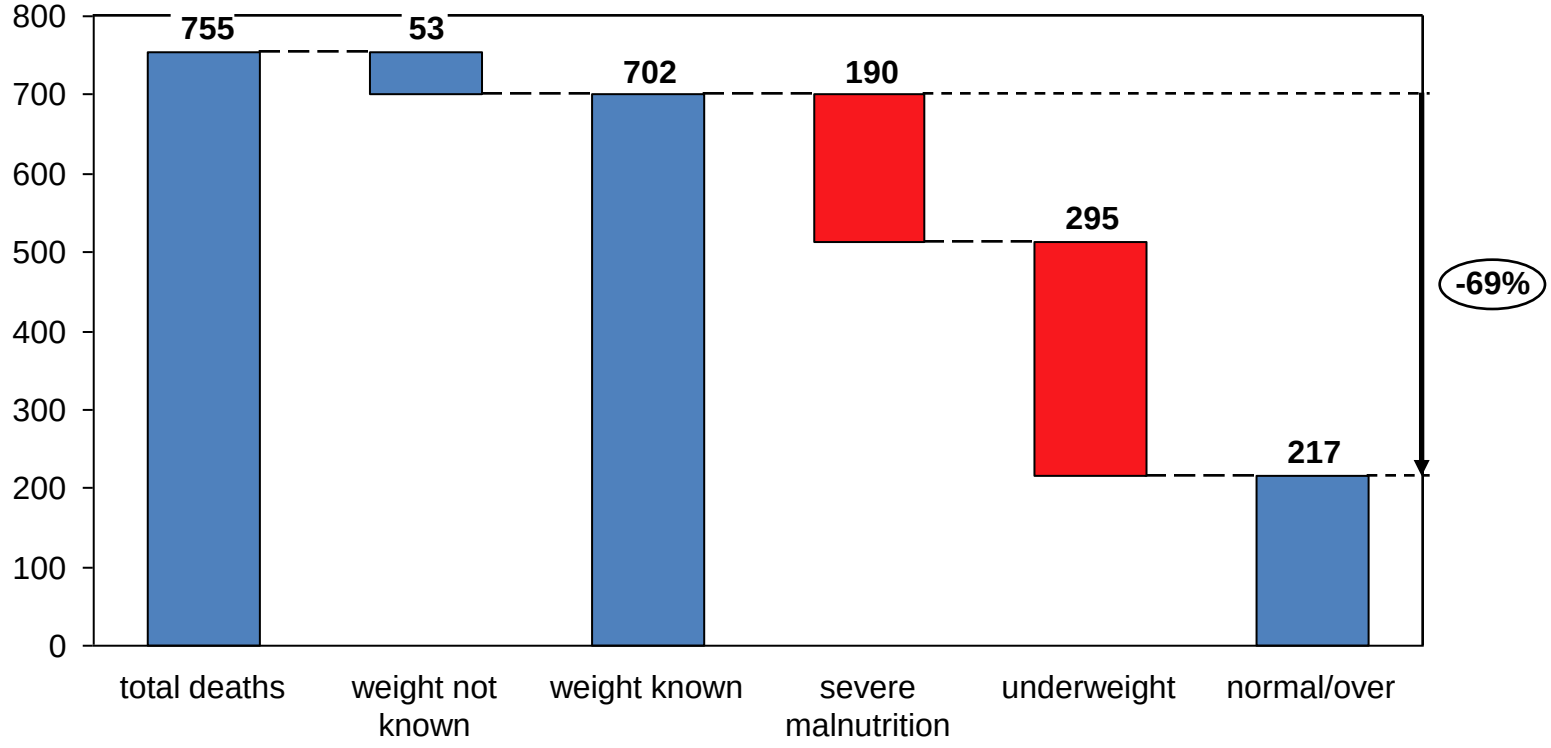
***…. who continue to live in conditions which challenge their health ….***

# Public health is undermined by poverty, inequality and inadequate basic services

| | 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: malnutrition a serious social determinant of poor health outcomes




- 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…*

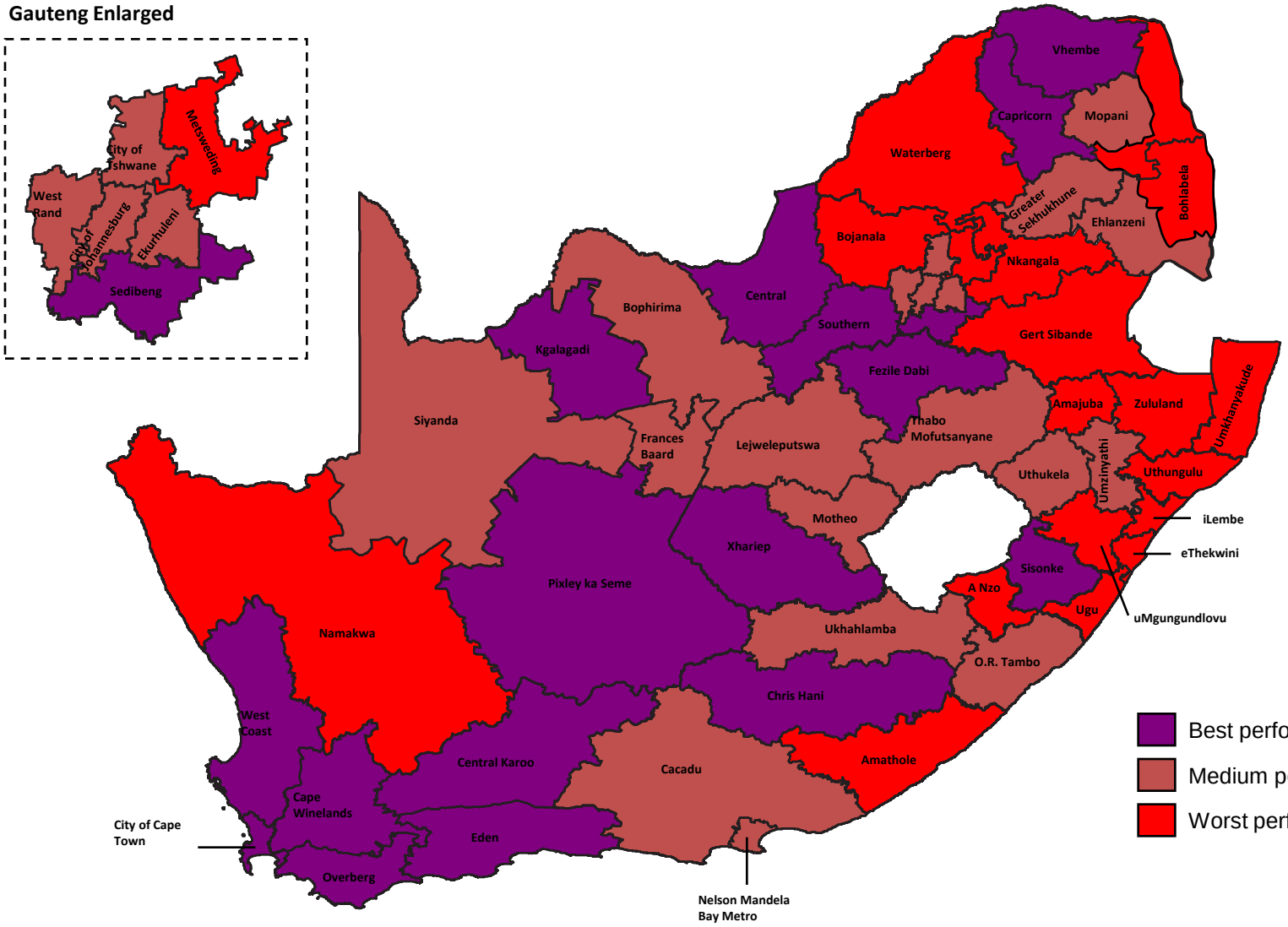
*…our health outcomes are bad…..*

*…. 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

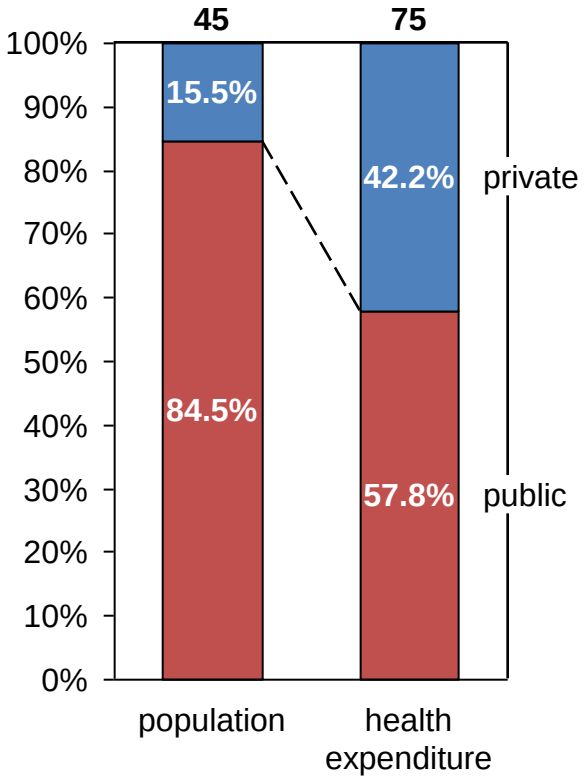


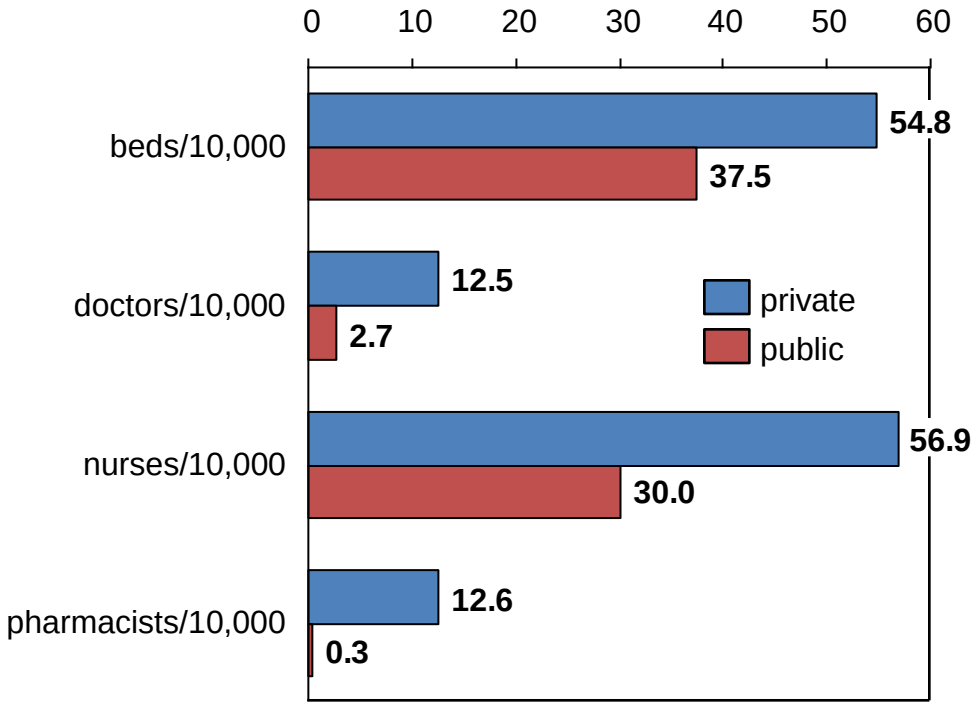


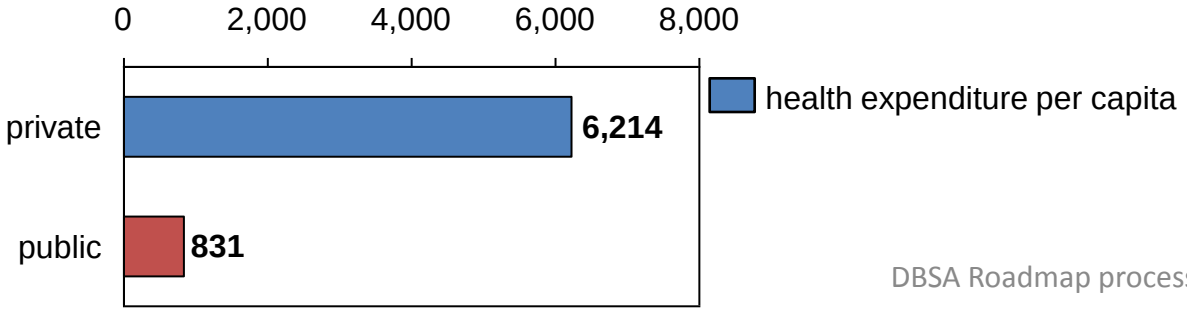

Source: Health Systems Trust; District Health Barometer 2006/07, Monitor Analysis

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

Old data, but directionally correct



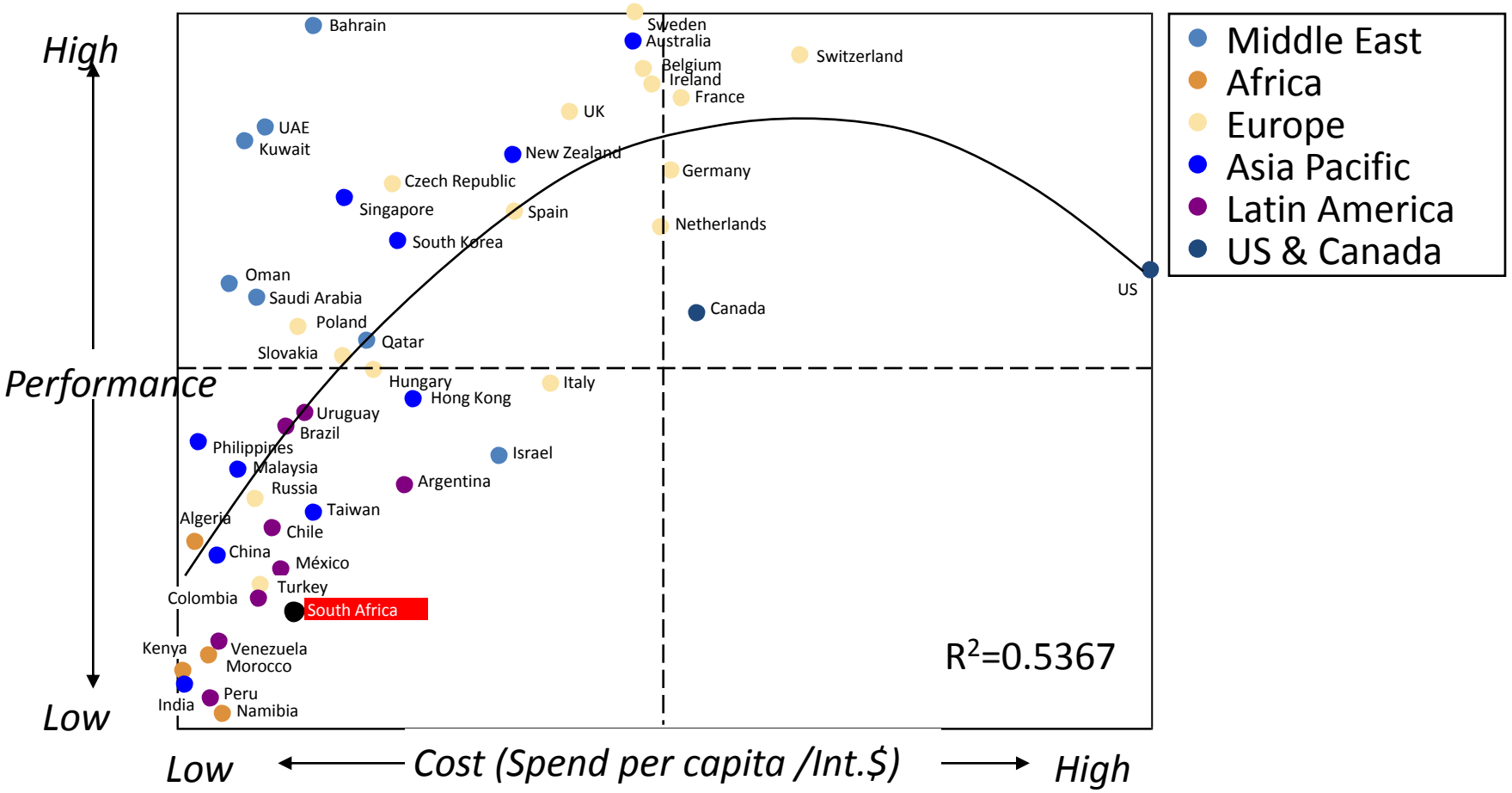



# Overall, South Africa getting poor performance relative to cost

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

## Performance vs. Cost Comparison, 2008




Note: Trend line is a polynomial

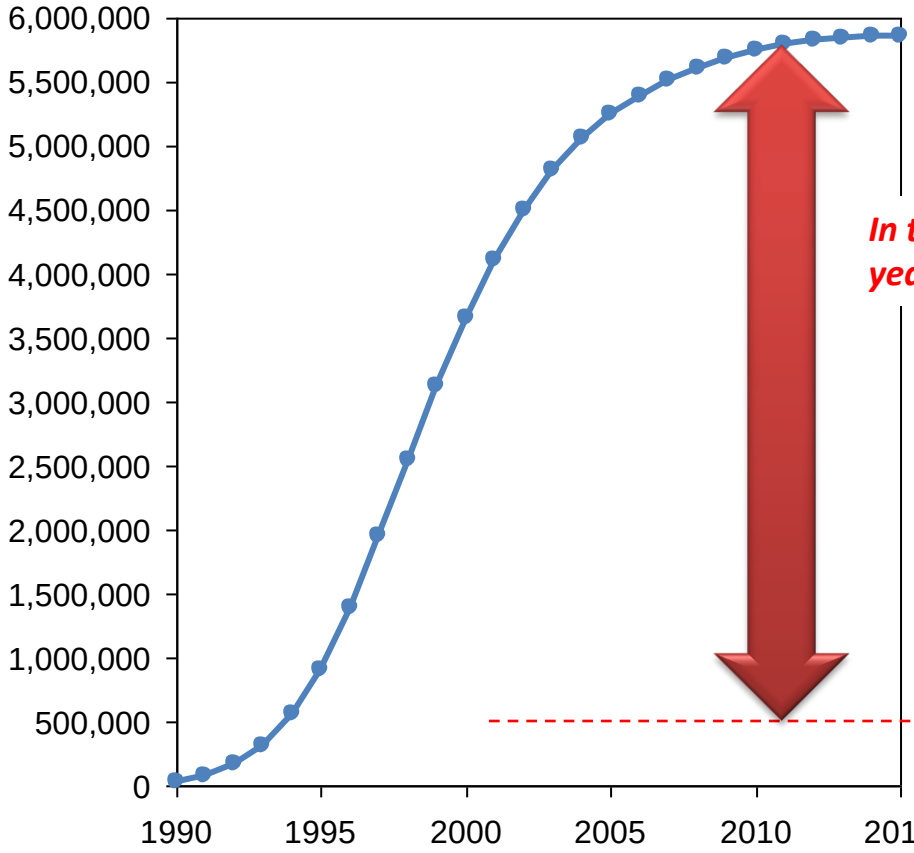
Source: Discovery Health Pool Stream Database, Monitor Analysis

# PRIORITIES

Intervention 1

# PREVENTION AND TREATMENT

# AIDS pandemic




***In the next 5-8 years: 5,5m people***

***Current people On ARV's: 450,000 adults, 50,000 children***

*They may die if no attention is given*

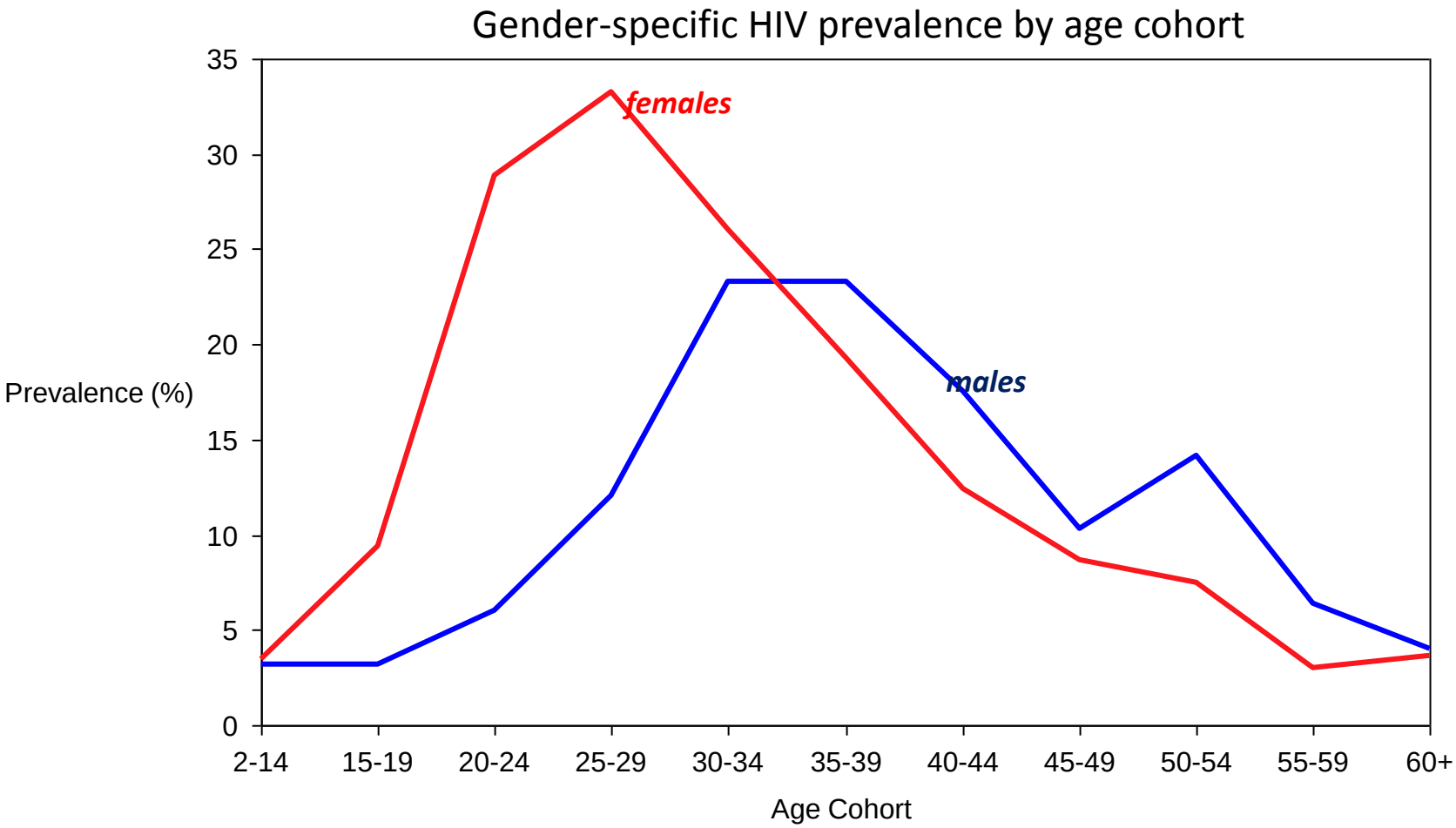
*They are vulnerable to opportunistic diseases that would put pressure on the health system*

*They could be covered in ART programme*

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

*Source: Current projections from the ASSA models*

# 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

# 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
  - Most South Africans do not yet 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
- 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)

Intervention 2

# NATIONAL PRIORITISATION, DECENTRALISATION AND ACCOUNTABILITY

# 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

# 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
- Private sector inadequately regulated
- Supply-side and Demand-side

# 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
- 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

# Regulate the private sector

- The private health sector is operating at lower levels of capacity utilisation (e.g. bed occupancy) than public health
- Need for State to better regulate private health sector to ensure that it carries more of the health burden at low costs/ prices.
- If private sector was made to carry more of the burden (whether 'encouraged' or 'compelled'), it could reduce burden on public health sector. If achieved in 2008 this would create R6 billion in fiscal space for public hospitals alone (19% of hospital budget).
- Given AIDS pandemic there is an urgent need to reduce pressure on public health sector in short- to medium-terms.

# Options for regulating private sector

- Change current tax subsidy and integrate with new risk-equalisation approach
  - State currently provides R13bn per annum tax subsidies of to medical scheme membership
  - Re-allocate the current tax subsidy away from higher-income earners to lower-income earners
- Regulatory changes to increase competition and bring down costs in the private sector
- Further analysis and options to be developed as part of National Health Insurance process.

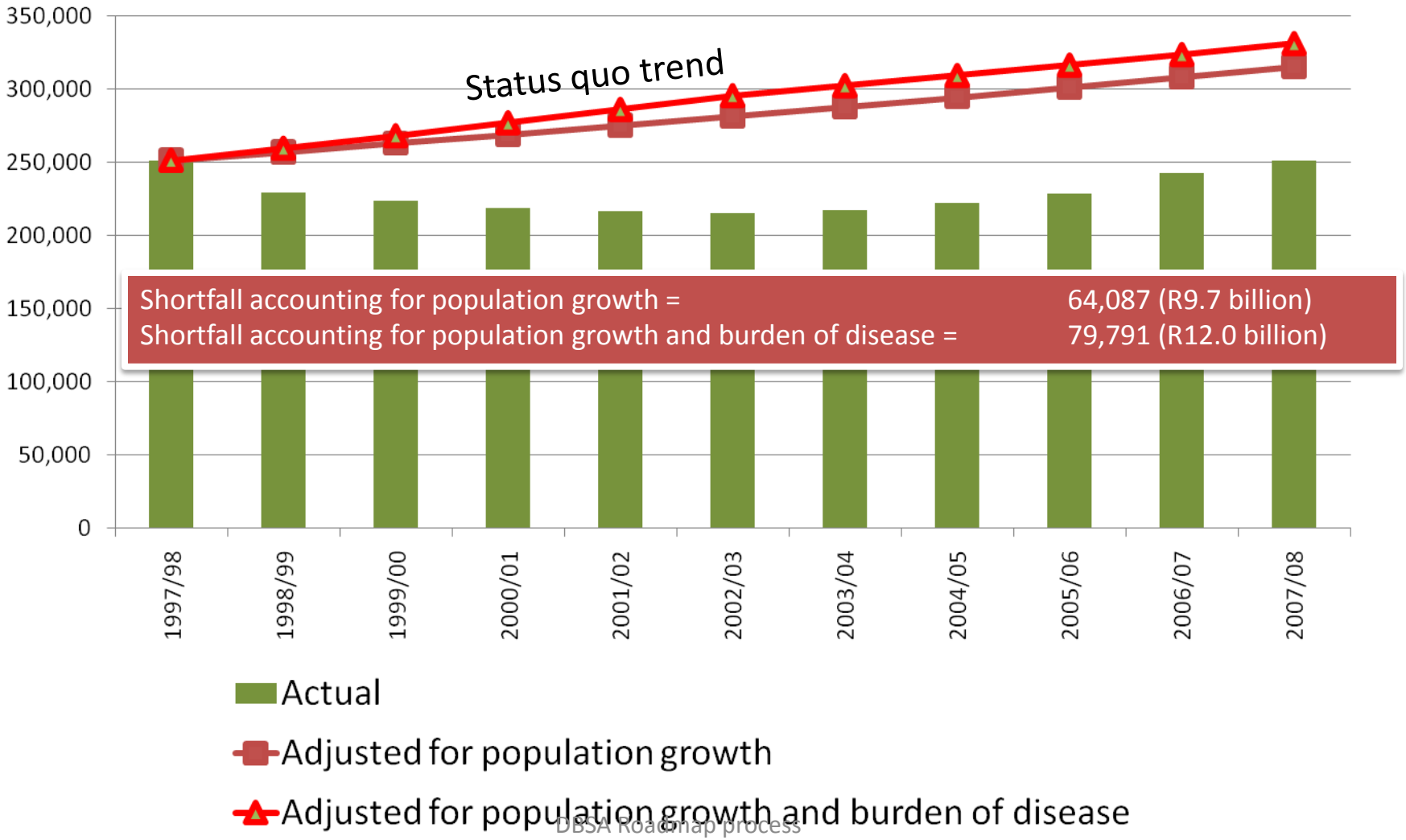
# Consultation processes need to be strengthened

- 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 3

# RESOURCING

# Public health sector employment increased but falling behind health needs



# 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)

# 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?
- 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***

# 10-POINT PLAN

# 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

# 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)

# Concluding remarks

- 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

# Next steps

- DBSA-convened Roadmap concluded
  - Government, constituencies and public to debate Roadmap and take ownership of health system improvements
  - Establish National Consultative Forum in legislation, to strengthen consultation and accountability
- SANAC to be revived and act as key catalyst in social mobilisation in fight against HIV/ AIDS
- NEDLAC and SANAC to play key role in World AIDS Day (1 December), and ignite improved approach
- Focus first interventions on 'worst' affected' health districts, and ensure good coordination between national/ provincial government, health workers, and communities