FIXING OUR BROKEN HEALTH SYSTEM

By Madeleine Hicklin

INTRODUCTION

The state of South Africa's healthcare industry is not good. We have two healthcare systems working parallel to each other - a public and a private system. The public healthcare system is characterised by mismanagement, nepotism, chronyism and unequal healthcare access. The private healthcare system is characterised by ever soaring costs and the burden on the average citizen is becoming difficult to manage. Add to that a countrywide dramatic shortage of adequately-trained healthcare professionals - from specialists to doctors, peri-operative practitioners to nursing staff - and we are sitting on a time bomb waiting to explode.

As a City Councillor and a member of the City of Joburg's Health and Social Development Section 79 Committee, I attended a Health Summit at the City of Joburg's Municipal Chambers on 24 April entitled *Let's Talk About Health*. The purpose of the health summit was to evaluate many of the issues faced by healthcare professionals in South Africa and to look at ways of addressing these challenges.

The plans presented are those devised and created by the Democratic Alliance (DA) and they offer concrete and comprehensive ways in which to deal with the healthcare and healthcare education challenges found in South Africa today.

Madeleine Hicklin, in conversation with Dr Wilmot James, DA Shadow Health Minister, and Professor Brenda Bozzoli, DA Shadow Minister for Higher Education

Madeleine Hicklin (MH): *Dr James, please contextualise the healthcare challenges faced by South Africans and what plans do you have in place to address them?*
Dr Wilmot James (WJ): In South Africa, private and public health systems exist in parallel. The public healthcare system serves the vast majority of the population, but it is chronically mismanaged and under-staffed. The better off, more affluent 20% of the population who use the private healthcare system are far better served. The DA will introduce strategic reforms to extend the coverage provided by medical aid and health insurance to progressively serve all those with jobs - in the region of about 65% of our population. This will take the pressure from the public health system, at the same time creating the opportunity to upgrade the public health sector to meet international standards of care. While every part of our health system should be modernised, priority must be given to building a highly-effective primary healthcare system that responds to our healthcare burden, specifically to fight and prevent preventable infectious diseases such as HIV/AIDS and TB and non-infectious diseases of lifestyle such as diabetes and obesity.

MH: *Does this not happen at the moment?*
WJ: In short no it doesn't - despite it being a provision in our Constitution. Section 27 (1) of our Constitution mandates that "Everyone has the right to (a) health care services, including

reproductive health care". At present we have a very inequitable health service that does not provide healthcare services to all South African citizens in a timeous manner. We want to allocate a universal health subsidy to every citizen and legal resident, regardless of whether they covered by the public sector or private sector. The value of the subsidy would be set in relation to an affordable package of services available in the public health sector. Within medical and health insurance schemes, benefits will be standardised in line with the public sector package, schemes will be able to provide top-up cover and there will be state-guaranteed re-insurance.

Municipalities have a constitutional responsibility to provide sanitation, sewerage, garbage collection, rodent control, food inspections and water provision services (social determinants of health). However, many if not all municipalities, finance, maintain and build primary healthcare clinics. This is a long-standing historical practise that was changed in the 1990s when the responsibility for clinics was handed over to provinces. It is in effect an unfunded mandate for necessary services that municipalities must morally perforce provide. We want to resolve this issue in the best interest of the healthcare-seeking individual or patient. If the province can provide the best service it should do so - and it shall be paid for from the provincial budget. If, on the other hand, the municipality provides the best service, the province should fund this service as a subsidy to the municipality. This will free up considerable resources for municipalities to do what they are constitutionally required to do.

MH: *How will this health insurance scheme be funded and what measures will be put in place to combat nepotism, chronyism and corruption?*
WJ: The universal subsidy will be funded by the current consolidated public expenditure on health (R168.4 billion in 2016/2017 financial year) and reversal of the private medical aid tax credits (R17.43-billion in 2016/2017 financial year), providing sufficient resources of R185.4-billion for a professionally-organised clinical outcomes-based and accessible healthcare system.

A further move that will assist to ensure an accountable public health system will see a system not characterised by political appointments in public service and related organs of state. We advocate a health system where all appointment processes will be decentralised and professionalised with all vulnerabilities to capture by special interests will be removed. Autonomous public hospitals and district health authorities - each having independent boards - will be introduced and wide operational discretion will be allocated to executive heads to carry out their mandates.

All CEOs and managers of health facilties (including hospitals) will have appropriate and adequate clinical training before being appointed; while all civil service appointments will be fit-for-purpose linked to robust performance-based accountability frameworks. In addition, the tender process for health infrastructure construction, maintenance and management will be open to strictly regulated private entities. We will introduce a robust regulatory system to ensure compliance with national governance, financial and accountability requirements in the best interests of the patient/healthcare user. This will be accomplished by a number of measures, including the introduction of an Information and Information Technology (IT) regulator to achieve data standardisation and information pooling on all parts of the health system, both public and private. This must be funded by a small levy on medical schemes with matching allocations from public entities.

At the same time, we will introduce reforms to the Council of Medical Schemes (CMS), the prudential and market conduct regulator for medical schemes, to function independently of the Minister of Health and the entities it regulates. We will ensure the implementation of the strategic recommendations of the Health Professions Council of South Africa's (HPCSA) Ministerial Task Team's November 2015 Report. This will see the replacement of the dysfunctional HPCSA with new councils that can fulfill the necessary statutory mandates; and we will ensure the introduction of a Quality of Care Regulator to replace the weak Office of Health Standards Compliance (OHSC). This regulator will audit and have the right to visit - unannounced - all public and private health entities to ensure that norms and standards are maintained.

In addition, we will support innovations that continuously improve the enabling environment for health. This includes the restructuring of the National Health Laboratory Services (NHLS) as a support pathology service to provinces that would have wide discretion to work with private and university-based laboratories where required. We will prevent so-called stock-outs, reform provincial logistics by incorporating their costs into tender prices and we will run medicine depots like businesses. This will be supplemented by the national extension of the Western Cape dispensing system where public sector medical scripts are made available through private retail pharmacies and incentivising home delivery of medicines to senior citizens. All these are measures that will benefit every vulnerable South African citizen while holding the officials to account.

MH: *What priority programmes will you introduce to improve the health mandate for citizens?*
WJ: In the light of our health burden, as a matter of national importance, we will urgently establish a number of initiatives that will significantly impact on the healthcare landscape of the country. These include an Expanded Clinic Programme (ECP) especially in under-served areas nationwide. This will be funded by an additional R2-billion in conditional grants; an Expanded Maternal and Child Health (EMCH) services that will be funded by an additional R2-billion in conditional grants; and a single number national public-private emergency service governed by an independent board and funded at a cost of an additional R1-billion.

For South Africans who have no medical aid or health insurance, these reforms will herald improved service at clinics and hospitals, enhanced maternal and childcare provision and access to efficient emergency services in urban areas, free at the point of service. For South Africans who are on medical aid or have health insurance, the universal health subsidy will result in the reduction of their contributions, provide for better choices and give access to more efficient ambulance services, free at the point of service.

By bringing the medical aid tax credits on budget, and allocating some of it to build better services in the public health sector, those South Africans with medical aid will be cross-subsidising those without - a necessary act of health justice.

Madeleine Hicklin (MH): *Our current health workforce development platform is dysfunctional such that we are not educating and retaining our health professionals on scale. How do we best address the provision of adequate human resources for health in the coming years?*
Professor Brenda Bozolli (BB): There are several ways one could approach the national development of health skills. One would be to perform a 'gap' analysis, in which one would ask:

how many people with X skills do we have in South Africa? And then: How many do we need if we are to meet international standards? And then: how would we bridge the gap? The Our Health Plan (OHP) document does a minor gap analysis when it points out that according to WHO norms, we fall below the threshold of one doctor per 1 000. We currently sit at we are at 0.78, and only 41% of these doctors work in the public sector.

This is not the method used in this document. Gap analyses have been performed in the South African context and will continue to be performed in future - indeed they are recommended as one of the outputs of the OHP. But they tend to be idealistic, usually presenting unattainable goals.

Another route is to pursue the possible rather than the ideal. This entails estimating the available resources for health skills development and creating a vision which will make the best possible use of those resources to further the sector. The OHP document has already set out a series of provisions for the funding of an expansion of the numbers of nurses, doctors and others to produce a better health system. Here we set out each component of the plan and how it will cater for the substantial Human Resources required. The funding proposed in the plan for skills expansion is approximately R2-billion per annum.

MH: *Can we unpack the OHP document?*
BB: There are a number of options and proposals. In **OHP Proposal 1** we will provide for an expanded education and training, medical and nursing platform to realise a scientifically planned sustainable pipeline of health care professionals. This must be linked to the OHP conceptualisation of the revamped health care system itself. The OHP envisages a new healthcare system with the following features:

- The ideal is to have 90% of the population managed at primary healthcare level; 8% at regional hospitals and 2% at the tertiary services level, with robust referral systems
- The maternal and child healthcare system will be expanded; obstetric and ante-natal service will be extended to rural and underserved areas
- The emergency services will be expanded
- We will need some sort of 'public sector incentive' to draw doctors away from the private sector or to encourage them to take dual positions. At the moment the main incentive is the prestige and broadening of opportunity offered by 'joint posts' between universities and the public sector. But these are plagued by problems at provincial level, and by the dire conditions in public hospitals. These have weakened steadily over the years and a robust new model for these positions needs to be developed

In light of this, we advocate the following:

- A growth in medical school places for multiple skills. This includes doctors, specialist nurses, occupational therapists, physiotherapists, public health specialists and miscellaneous other professions
- The revamping and possible re-opening of nursing colleges, moved from the Department of Health to sit under the aegis of the Department of Higher Education and Training. These nursing colleges will be used to train:
    - Conventional nurses in four-year degrees linked to universities with a strengthened practical component and a revamped, updated curriculum
    - Other similar professionals

- Community nurses in three-year practice-oriented diplomas for primary, maternal and child healthcare for the expanded primary healthcare system

- Through these means - and probably with direct assistance to the university of college sector - the plan will fund:
  - The training of about 250 additional doctors/dentists per year. By the sixth year this will cost R360-million per annum
  - The training of about 400 conventional nurses, occupational therapists, physiotherapists and similar. By the fourth year this will cost R320-million per annum
  - The training of an additional 1 600 community nurses per year. By the third year this will cost R480-million per annum
- The development of a specialist visa scheme to import foreign-trained doctors, nurses and other professionals to fill gaps until our own expanded pipeline is established. This includes incentives such as tax exemptions for highly desirable professionals, costs of relocation and providing a basic initial immigration fund for imported staff. Through this scheme we envisage 100 new professionals being imported per annum

MH: *This is a very ambitious plan. What would an exercise like OHP Proposal 1 cost?*
BB: The exercise is not cheap, but will be an investment in the future healthcare of South Africa

- An upfront investment of R300-million in infrastructure in medical schools and colleges, and an additional R200-million towards the costs of the public-private partnerships (PPPs) that will be used for the building of the teaching hospitals required
- An on-going annual investment of R100-million in new staff for medical schools and colleges
- An on-going annual investment of R100-million in infrastructure and development (including staff expansion where possible) grants for medical schools and colleges
- An annual investment of R1.16-billion in actual training (by the sixth year, when all training programmes will have completed their first cycle at least)
- The introduction of a tax exemption or other incentive for immigrating professionals, to the value of about R100-million per annum. In addition, we would look at incentive grants for newcomers valued at R100-million per annum

MH: *What other proposals are on the cards?*
BB: Through **OHP Proposal 2** we will improve resource flows into clinical research via the Health Professions Training Grant and have much more effective partnerships with private sector research, development and training initiatives. Clinicians will be incentivised to develop their work into viable research programmes through an intervention in the CPD points system, to be negotiated with the Health Professionals Council, which will give value to research outputs.

Five-year to eight-year grants will be made available to professionals for this purpose; each grant will be substantial enough to cover the costs of research staff and students to assist the busy clinician. Models derived from universities with highly-successful clinical research will be explored. A figure of R100-million per annum seed funding will be set aside for this.

Through **OHP Proposal 3**, we will provide for clinically trained chief executives of hospitals and managers of health facilities who will be grounded in both experiential and health training; healthcare management will be established as a respected profession in its own right. For this to be realised we will need to ensure that senior post-graduate courses in hospital management be

introduced. They should be at a similar level to the MBA and should only be offered to more senior staff who already have clinical and some management experience.

For this an initial investment will be needed, but the courses will eventually become self-sustaining. Selected universities will be given an up-front investment grant to plan and develop internationally-accredited MBA-type programmes, appoint staff and provide some initial bursaries. We envisage four grants of R50-million, totalling R200-million up front.

With **OHP Proposal 4** we will restructure the National Health Laboratory System (NHLS) and revamp it to ensure that it does not become simply a service-provider. In particular, we will expand and firm up research positions in the NHLS in areas related to issues of health research of a non-clinical nature, relevant to our region such as TB, AIDS, genetics, and non-communicable diseases, to name a few. We will follow the National Research Foundation (NRF) Research Chairs and Centres of Excellence models, which include in their expectations of researchers: international standing, international credibility, student training, collaborative research; fund-raising, interdisciplinary and strict answerability for quality.

We envisage that R5-million will be needed per research chair per annum, or R30-million per Centre of Excellence per annum. This would require R50-million per annum for 10 research chairs; and R90-million per annum for three Centres of Excellence.

Through **OHP Proposal 5** we will map our human resources needs in detail and a robust modelling system will be developed; the Human Resources for Heath (HRH) Strategy will be updated. We will avoid the danger of very long, time consuming, cumbersome and rapidly-dating projects of this nature. Our aim will be to develop a methodology through which we can undertake three-yearly 'snapshots' of the human resources landscape, and a way of projecting our needs on that basis. Our HRH strategy will similarly be focussed and minimalistic, taking a realistic rather than idealistic approach.

To this end we will provide an initial grant of R20-million for a task team responsible for the development of the methodology and the first 'snapshot', and a further R10-million once-off grant for the first strategic document. These will need to be completed within the first year of the plan's implementation.

Through **OHP Proposal 6** we will audit our current health training exhaustively, perform an assessment of recent medical school curricular reforms; produce a detailed report on the training deficiencies in nursing education; assess the training needs related to increasing the number of allied and mid-level health workers such as clinical associates. We envisage these tasks as being undertaken by three separate, simultaneously operating groups all with international experts included. One will assess recent medical school reforms; one will assess nursing education and one will work together with the HR task team to assess new training needs arising from the need for allied and mid-level workers - particular community nurses and emergency workers. All three task teams will be expected to report within the first year of the launch of the OHP.

The cost will be R20-million per team - translating to a R60-million figure as a once off, plus R5-million every three years to perform the follow-up surveys.

Through **OHP Proposal 7** we will establish 'regional health training zones'. Each will contain academic health complexes, nuclear energy institutes (NEIs) and emergency care training institutions. This should assist in health training planning, and provide greater scope for increasing teaching and research capacity resulting from an increased throughput of specialists and PhD graduates. Infrastructure development will be part of this. Some sort of bureaucratic structure would be necessary to manage these zones. It would likely become a provincial competency and as a result, the costs should probably not come out of a training budget.

OHP Proposal 8 will look at the idea that private finance should be mobilised to help build more teaching hospitals - using public-private partnerships (PPPs). All PPPs require public investment. This is only an indirect part of the production of skills, but should be part of the skills development package. Not only do hospitals provide teaching opportunities, but new hospitals require new staff, which is where our shortages lie. The HR budget could legitimately be used to assist in this process. The probable route would be through upfront financing of the costs of building and equipping such hospitals. We suggest that through **OHP Proposal 9** we will establish remote specialist training posts using telemedicine and visiting consultants for supervision and the costs of this could be absorbed into the budget for training.

Through our final OHP Proposal - **OHP Proposal 10** - we will provide bursaries for talented young people from rural areas on the promise they will return to serve those areas once they have qualified. This could be accompanied by the development of a series of courses on rural medicine in the various training colleges and could be absorbed into the budget for training.

For more information of the Democratic Alliance One Health Plan and any other policies, please log onto www.da.org.za