



PHASA
NEWSLETTER



The Pulse

September 2018 Edition

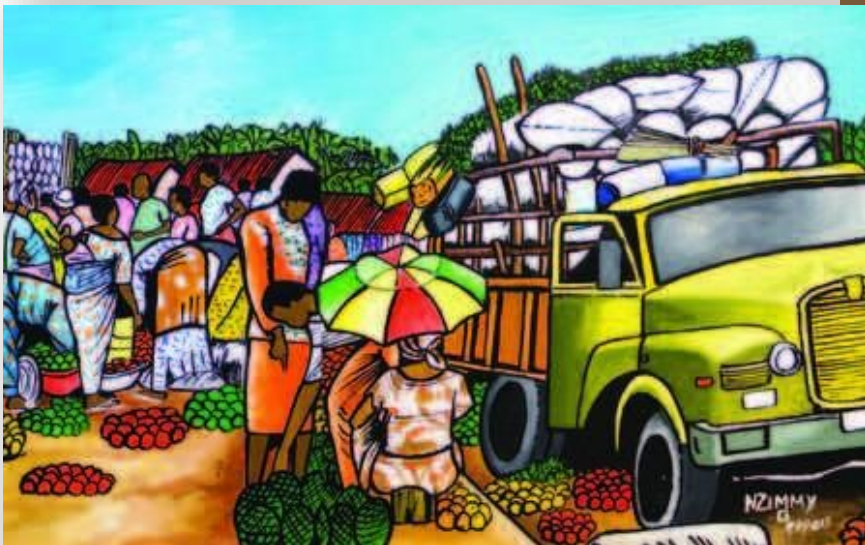


From the Desk of
Dr ANDRÉ ROSE
PHASA President

Welcome. This is our 3rd Edition and I am grateful to all those who have put their time and expertise into writing and contributing to the newsletter.

My Article focuses around a quote from *Animal Farm* by George Orwell, "All animals are equal, but some animals are more equal than others."

Enjoy the read and make sure to attend our Annual Conference



Above: "Village Life", by Boniface Nzimy

70TH

Anniversary of the
World Health
Organisation (WHO)



PHASA

Annual Conference 2018

Khaya iBhubesi, Parys 10 - 12 Sep



Health for All, Thinking Globally Acting Locally

ALL HEALTHCARE SYSTEMS ARE EQUAL, BUT SOME HEALTHCARE SYSTEMS ARE MORE EQUAL THAN OTHERS

FROM THE EDITORS DESK

I am almost 16. I am sitting in the library. I should be studying. Instead I am browsing through the novels. George Orwell's *Animal Farm* grabs my attention. I start reading and manage to get through half the book before I hide it so I can walk home before dark. The following day I return to finish the book. And my worldview on equity is shaped.

Health as a Right is enshrined in the Bill of Rights and in South Africa's constitution. We have a responsibility and obligation to ensure that this Right is upheld and that all South African's (and humanity at large) attain it. Healthcare however has to be equitable. It has to embrace and reflect the essence of what makes us human. In an equitable health system there is no room for a tiered provision of healthcare. South Africa has suffered the ravages of an apartheid system that distorted healthcare provision along racial lines. The ramifications of this division created gaping wounds that continue to plague our health system till today. Our jaded past should be a warning to us not to embark on such a segregated route again.

The World Health Organisation states that the Right to Health means that people have access to Universal Health Coverage (UHC). This coverage is defined within a framework which defines that healthcare needs to be good quality, acceptable to the recipients, appropriate to the communities it is delivered in, affordable and delivered timely. The healthcare system under apartheid failed the majority of South Africans on all these facets. The current healthcare system has vastly improved the health outcomes of many South Africans but continues to fail to meet the most basic healthcare needs of the majority of the most marginalised in our society. The National Health Insurance (NHI) is an ambitious and necessary change needed to provide UHC to all the citizens in this country. The current proposition for its implementation is however systematically flawed. There are glaring gaps in the architecture of the proposed new structure. Flaws that may change and retard the implementation of an equitable system.

The implementation of UHC is opportunistic to leverage systematic changes in the health system in South Africa on several levels. It is an opportunity to redress some of the injustices of the past perpetuated by a system that legislated and fostered inequality by its design. The atrocities of apartheid manifested in healthcare ensured unequal health outcomes for different members in our society. Increasing the equity gap between the extreme socio-economic groups.

A healthy society is a productive society. A productive society is the genesis for an economically thriving society. The inclusivity of all citizens in a prospering society paves the way for more equitable communities. The implementation of UHC affords us the opportunity to improve the quality of healthcare offered. Proper implementation also provides us with the prospect to introduce better governance and management procedures. The corruption that persists within the current system has to be deliberately eradicated. There is a dearth of strong leaders in healthcare in South Africa. We can address these shortcomings by strengthening the systems we implement for providing UHC.

The converse is however also true. Failing to address the weaknesses of the crippled current health system will only perpetuate the inadequacies of the current system within the NHI scheme. Our health system needs radical transformation. The status quo is not sustainable for an equitable, inclusive and prosperous South Africa. We should use the opportunity of transforming out health systems into one that benefits all South Africans irrespective of their social and economic standing and employments status. We have a responsibility to our future by learning from our past.

“All animals are equal, but some animals are more equal than others.” Animal Farm, George Orwell.

In this issue Somaroo explores how we are interconnected in our humanity. She paints the picture of the health inequity within our society and reflects on the responsibility government has in taking our society forward in this regard. Modisenyane reminds us of the ambitious goal of Health for All as envisioned within the Alma Ata Declaration. He contextualises the South Africa health-scape within a broader global context. Finally, London asks the difficult and relevant question of the capability of the NHI achieving Health For All. The 14th PHASA Conference is themed, Health For All, Thinking Globally, Acting Locally. The panel of speakers and plenary sessions offers much needed space to critically debate this pertinent issue in South Africa. We hope you will join as at this year’s Conference to voice your opinions.





Albertina Sisulu
Executive Leadership
Programme in Health
Excellence, Innovation, Transformation



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REPUBLIC OF SOUTH AFRICA

A PHASA SYMPOSIUM

HOSTED IN THE ALBERTINA SISULU CENTENARY YEAR
BY ALBERTINA SISULU EXECUTIVE LEADERSHIP PROGRAMME IN HEALTH
IN PARTNERSHIP WITH THE NATIONAL DEPARTMENT OF HEALTH

"ETHICAL LEADERSHIP FOCUSSED ON PROFESSIONALISM & CONFLICT OF INTEREST"

Date:
Sunday, 9 September 2018

Time:
08h00 - 17h00

Venue:
Khaya, iBhubesi, Parys,
Free State

For more information please contact
Ms Meyisi Hlabahlabi at:

Email: mhlabahlabi@ufh.ac.za

THE PURPOSE

The purpose of this SYMPOSIUM is to explore how to promote ethical leadership Focussing on professionalism and conflict of interest.

SESSION 1 (08:00 - 12:30)

Selected Presentations by Senior ASLEPH Fellows from the universities of Fort Hare and Pretoria on how they have tackled and overcame these Health Systems Challenges based on the results of their Case based research studies.

It will also explore the application of the Lessons & Learning to promote Ethical Leadership.

The first session will give the Albertina Sisulu Executive fellows an opportunity to share their presentations.

SESSION 2 (12:20 - 17:00)

This session will a dialogue involving the NDOH DG (providing the keynote address), the COO, DDGs, Provincial DOH representatives, as well as Academics and Ethicists.

These Executive and Senior Managers & Policy Makers will address the critical challenges facing the Public Health System in SA and the role of the NDOH in addressing them.

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USEFUL LINKS:

Global PHC strategy:

https://www.paho.org/ecc/index.php?option=com_docman&view=download&alias=23-global-trends-on-primary-health-care-strategy&category_slug=presentations&Itemid=154

People-centred health systems:

http://africahealthforum.afro.who.int/IMG/pdf/the_global_strategy_for_integrated_people_centred_health_services.pdf

<https://www.thelancet.com/commissions/future-health-Africa>

http://www.wpro.who.int/health_services/people_at_the_centre_of_care/definition/en/

QUOTES ON EQUALITY

“I have a dream that my four little children will one day live in a nation where they will not be judged by the color of their skin, but by the content of their character.”

Martin Luther King, Jr.





-Thuma Mina/Send Me ~ Reflecting on the vision of health equity

*Dr Harsha Somaroo
Affiliation: Charlotte Maxeke Johannesburg
Academic Hospital, Gauteng Department of
Health/ WITS School of Public Health*

The Zulu word Ubuntu translates to "I am because we are." This simple yet profound philosophy indicates the interconnectedness among us all, and enlightens us to the fact that we will not prosper as individuals unless the fundamental rights, and opportunities for health and happiness, are equitably distributed among the collective. Increasing levels of inequity have produced discontent and conflict at various levels of our society, demanding that we act decisively to correct these injustices and create a world where each child born has the same potential to not only dream their dreams; but to be able to also live their dreams.

We live in a society that is often divided by differences- differences in terms of social status, income level, educational achievement, racial category, cultural preference, employment grouping; the list can go on. Privilege is associated with all these different characteristics, and this privilege might have been more acceptable if it did not systematically erode and deny the rights of the many who are less privileged. Equity refers to an absence of avoidable differences among individuals or groups, despite inherited privilege, so that all people have equal opportunity for prosperity during their lifetimes. Relatedly, health equity involves ensuring that everyone has equal opportunity to attain their full health potential, and that this is not prevented by differences in avoidable health risks. Health equity, and thus health inequity, results from a complex interaction between individual risky behaviours and preventable exposures to risk factors for ill-health, social determinants of health, the quality of accessible healthcare systems, and the pervading political environment. In South Africa, unfair health disparities developed over decades, largely along racial divides during apartheid and due to failures to adequately and equitably address the systematic discrepancies thus far during the course of our democratic journey. Health equity in our country will not become a reality unless all causal factors implicated in these disparities, those related to health and those arising outside the healthcare environment, are appropriately addressed.

Differences in access to healthcare and health outcomes, due to avoidable factors, vary markedly in different settings. A child born in sub-Saharan Africa is 14 times more likely to die before the age of five-years, compared to a child born in the rest of the world (WHO, 2018).

The under-five mortality rate in South Africa was 42 deaths per 1000 live births in the five-year period between 2011 and 2016 and much effort and care is needed to meet the Sustainable Development Goal target, of lower than 25 per 1000 live births. When looking at the South African population, it is alarming that 10% of households are vulnerable to hunger every day and many people still do not have access to basic services: 26% do not have access to on-site piped water and 17.8% do not have access to improved sanitation. Additionally, 43% report problems with waste removal and 20% consider air pollution to be a problem in the area that they live in (StatsSA, 2017). It has been reported that 10% of South Africans earn 58% of the income in the country (Benatar, 2013). Healthcare spending in the country also leaves much to be desired. When considering the 8% of the Gross Domestic Product that is spent on healthcare, approximately 50% is spent in the private sector, approximately 47% in the public sector, and 3% is attributable to donor funding. The gross inequity arises with the fact that the private sector provides healthcare services for only 17% of the population (Econex, 2013).

The dangerous levels of inequity related to healthcare in South Africa demand that we act now. The National Department of Health has taken the bold and necessary step to provide universal health coverage via a National Health Insurance scheme. However, such monumental change will need to be pragmatically feasible, responsively sustainable, and requires commitment from each individual and every sector of society; for it to be a success for all South Africans. Vitally, we need to place the realisation of health equity at the heart of all efforts. This requires that the collective will of every person in our society, the privileged and the less privileged, come together and echo the call of “thuma mina.”



CENTRE FOR HEALTH SYSTEMS RESEARCH & DEVELOPMENT (CHSR&D)



The CHSR&D is in the Faculty of The Humanities at the University of the Free State. We generate and disseminate scientific knowledge on **health and health systems** and use this knowledge to promote health systems strengthening.

Our main focus areas are:

- Studies of health policies, strategies and operational functioning
- Human resources for health and occupational health issues
- Health communication
- Priority programmes:
 - Tuberculosis (TB)
 - HIV & AIDS
 - TB-HIV co-epidemic
 - Sexual and reproductive health

Study with us

We offer a **Master of Health Systems Studies (MHSysStud)**

This specialist degree integrates theory with in-depth knowledge of health systems. Students will identify a health / health systems issue and address it via research.

Where feasible, you will have the opportunity to base your Master's on our Centre's ongoing research projects. Studying side-by-side with experienced health systems researchers on a 'real-life' research project is a very valuable form of mentorship and should impact positively on your dissertations/articles, as well as your practical research skills and experience.

See our website for more info about us, our projects, and the Masters:

<https://www.ufs.ac.za/humanities/departments-and-divisions/centre-for-health-systems-research-development-home>

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Can the NHI achieve Health for All?

Prof Leslie London

Affiliation: School of Public Health and Family Medicine, University of Cape Town and People's Health Movement

Nothing in the health sector has captured the public eye more systematically over the past 7 years than the drive for a National Health Insurance (NHI), recently culminating in the issuing of an NHI Bill, closing for comments on September 21st 2018. To its detractors, it is unaffordable; over-ambitious; an assault on private insurance and downright dangerous. To the Minister of Health, Aaron Motsoaledi, it is ambitious, but rightly so, because it heralds a complete “reorganisation of the current health system, both public and private.” It is a bold step to address the deep inequities in our current health care system, inequities that are unsustainable and getting worse. It is also a response to growing price rises in the private sector, stagnant medical scheme membership and increasing dissatisfaction amongst medical scheme members with shrinking benefits under rising subscriptions.

However, can the NHI achieve Health for All, as promised? A fundamental misconception about the NHI is that it is only about insurance. In a sense, the term ‘National Health Insurance’ is unfortunate because it suggests it is only about creating one grand medical scheme, when what is planned is, in reality, the restructuring of the entire health system for universal access. Even the Minister, who has been at pains to emphasise equity in his NHI presentations, seems to be falling into the same trap, albeit from a different perspective. His view is that the public sector can only be strengthened if funding in the private and public sectors is pooled first because, he claims, there is no more money in the public system.

However, there is much that can be done that does not require huge injections of money – improved management systems, greater accountability, enforcement of controls over corruption and better training programmes for health professionals at all levels of the health system. Additionally, we do also need to mobilise substantial additional public money, whilst simultaneously constructing the system to pool private and public funds, so as to make sure our public hospitals and clinics are places where all South Africans experience good quality service. Less than 1% of our facilities met the OHSC standards in 2016/17, and in some provinces and districts, audits scores have gotten worse, not better, since the first round of audits 2 years previously. Getting this right will need major investment in equipment, infrastructure and personnel, not another quality improvement policy. Brazil’s SUS achieved its impressive health outcomes by spending more public money – a LOT more – to set up its Family Health Programme. We should learn from Brazil’s experience that one has to spend more to get more – and save in the long term. The lack of recognition of the crisis in the public sector has mobilised vociferous public opinion, even amongst those supportive of an NHI.

At the root of the problem lies a belief that achieving the NHI is dependent on the co-operation of medical schemes to work. In the 2011 Green Paper, the medical schemes did not feature very strongly, and their expertise was noted as useful to the extent that it would be drawn upon “where necessary and relevant” “... to ensure adequate in house capacity is developed.” Fast forward to 2017, where the NHI Policy White Paper locates medical scheme administrators, actuaries, private sector actors and other stakeholders with a direct interest in the perpetuation of the private insurance environment within the key committees tasked with implementing the NHI. They are no longer passengers on this NHI, they are in the cockpit, helping to fly the plane. By comparison, Civil Society was excluded from all committees until a wave of protest against the ‘capture’ of the NHI by private sector interests led to a partial revision of the task teams’ composition.

One particular committee charged with consolidating transitional financing arrangements, is responsible for implementing the consolidation of financing into 5 transitional funding arrangements: For the Unemployed; Informal sector; Formal Sector large employers; Formal Sector SMMEs; Civil servants. It is also charged with overseeing the extension of mandatory insurance cover for the formally employed. Evidence internationally is conclusive that once different packages of benefits are established, it is very difficult to change. As Kutzin points out, “where insurance begins by covering the formal sector, they tend to concentrate resources on a relatively small and economically advantaged part of the population. Such schemes do not naturally “evolve” to include the rest of the population. Instead, the initially covered groups, who tend to be well organized and influential, use their power to increase their benefits and subsidies, rather than to extend the same benefits to the rest of the population.”

Although the Bill does not mention this committee, and the Minister remains adamant about one funding pool, he continues in his public presentations to use the slide outlining 5 distinct funding streams, leaving many anxious whether this NHI will get off on the best equity-promoting foot.

The NHI faces many other challenges - the desperate need for better management capacity in the health system, particularly if sub-district teams are going to have to negotiate primary care contracts; a greater focus on prevention; the need to foreground community participation; an urgently required human resources for health plan – to mention only a few. But grounding the NHI in an equitable start-up is going to shape the NHI forever. We have to get that right, and do so from the start. Building the public sector must be the primary focus of the NHI because that is where the most vulnerable access care. Harnessing pooled private and public sector funds must happen but at the same time as we invest heavily in the public sector – that is the only way to create a single fund with a single package of benefits that will advance Health for All.

PHM and other civil society organisations, including PHASA, have called for an extension on the deadline for submissions on the Bill so that civil society, unions and communities can meaningfully participate. For more information, see <http://phm-sa.org/nhi-bill-request-for-extension-of-public-comment-period/> or contact anneleen@phm-sa.org



The Alma Ata Declaration – Ensuring Health for All in the times of economic crises

Dr Moeketsi Modisenyane
PHASA Affiliation

It's 40 years since the iconic WHO Alma-Ata Declaration on Primary Health Care vowed to achieve Health for All by the Year 2000. The Declaration — or 'Alma-Ata' as it is universally known — placed health in the foremost of all human rights. It made bold claims for the link between health and socioeconomic inequalities. Alma-Ata celebrated, and sought to enhance, the role of the patient in managing his or her own care — and also the role of communities in planning and evaluating services. It recognised that effective primary health care needs an evidence base, and called for research funding to explore the burden, causes, and management of illness. It highlighted the close relationship between primary health care, public health, community development, patient education, housing, and people's diet and lifestyles. However, in 2000, this was not achieved in South Africa and elsewhere.

BUT where have we come from?

In South Africa, the roots of Health in All Policies (HiAP) goes back to the 1940s, before the Alma-Ata Declaration and in response to the inadequate provision of primary health care under the apartheid system. In 1940, the South African Health Ministry developed the Pholela Health Centre model of community-orientated primary care (COPC) where efforts were made to provide holistic health care to rural communities in Natal.

However, following the introduction of apartheid principles by the National Party in 1948, the PHC movement lost significant leadership and health care worsened in the 1960s and 1970s. Despite gains made towards a primary care-centered and community based health care system, during the latter 1970s to 1980s we saw the presentation of 'selective' primary healthcare; the rise of neoliberal governments, economic recessions in many countries, low prices of key commodities, compounded by recurrent natural disasters and political instability. This period saw the imposition of structural adjustment programmes by the World Bank and the International Monetary Fund which emphasised public sector restraint and market-driven reforms. In South Africa, apartheid system entrench fragmentation, focused on the hospital sector, the growth of the private sector was largely stimulated by corporate capital, particularly the mining houses.

Since the end of apartheid, the new governments published a National Health Plan which had elements promoted at Alma Ata and envisioned a system based on community health centres. This Plan coincidentally reflected some of the recommendations of the Gluckman Commission. Indeed, there have been progress made towards #HealthForAll in South Africa, such as building new clinics; mass immunization campaigns; increasing the health budget; and several progressive public health legislations were passed such as policy to allow for safe, legal termination of pregnancy. These interventions have resulted in an increase in life expectancy. Despite these successes, government's ability to take forward new policies have been constrained by several factors, such as concentration of resources in the private sector; inequalities in the distribution of infrastructure; financial and human resources between geographic areas; inefficiencies in the in the distribution of resources and the increased stress on the public health system caused by the HIV and TB epidemic.

Where are we now?

The world of 2018 presents some similar challenges—South Africa's fall in commodity prices is slowing the economy and shrinking budgets; there are concerns that foreign aid may drop significantly or will become more explicitly self-interested; etc. So too does the unavoidable tension between idealism and pragmatism evident in the debate on selective versus comprehensive primary healthcare continue 40 years on.

So where are we going?

While solutions to South Africa's political and macroeconomic instability are important, they lie beyond the scope of this commentary. And while we recognize the fact that the impact of the economic crisis will be uneven across other countries and continents, I argue that past experiences point to the general need to consider a certain set of multisectoral sector-specific policies.

At a macro level, efforts must be made to keep expanding the fiscal space for health. Priority should be to enhance health equity to ensure that everyone has the opportunity to attain their full health potential and no one is disadvantaged from doing so because of their social, economic, demographic or geographic circumstances.

At the meso (sector-wide) level, there is a need for more investments made at decentralised and district level of health administration and that local health communities have the potential to boost system resilience. Private providers and resources should be brought into the UHC equation to be regulated and harnessed to manage increased costs of care along with the tendency to provide more services than are necessary.

At the micro (health programme implementation) level, priority should be given to preventive primary services as well as to the procurement and distribution of basic drugs; recruit and retain key personnel; managerial efficiency and effectiveness (and autonomy); conducting minimum infrastructure and equipment maintenance interventions to avoid irreversible deterioration; and explore technological advances such as mobile telephones which may create opportunities for the introduction of more cost-effective interventions such as telemedicine.

At Individual, family and community level, there is a need to improve health literacy and capacity for health decision-making; and empower patients and families through self-efficacy and peer-support groups.

QUOTES ON LEADERSHIP

“If you want to see the true measure of a man, watch how he treats his inferiors, not his equals.”

J. K. Rowling



USEFUL LINKS:

Universal health coverage:

<http://www.who.int/dg/priorities/health-for-all/en/>

<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)60244-6/fulltext?rss%3Dyes&utm_source=newsletter_40&utm_medium=email&utm_campaign=wfpha-newsletter-july-2015](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60244-6/fulltext?rss%3Dyes&utm_source=newsletter_40&utm_medium=email&utm_campaign=wfpha-newsletter-july-2015)

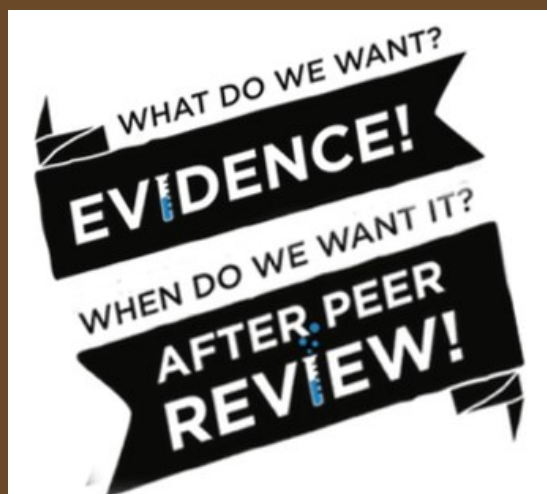
<http://www.worldbank.org/en/topic/universalhealthcoverage/publication/universal-health-coverage-in-africa-a-framework-for-action>

<https://www.sciencedirect.com/science/article/pii/S0140673615600022>

<http://www.who.int/bulletin/volumes/94/1/15-165050.pdf>

<http://www.who.int/campaigns/world-health-day/2018/World-Health-Day-2018-Policy-Advocacy-Toolkit-Final.pdf?ua=1>

<http://www.who.int/mediacentre/commentaries/universal-health-coverage/en/>



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PLEASE NOTE

The views expressed in “the Pulse” are not necessarily the views of PHASA, but rather the views of the respective authors

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LinkedIn: <https://www.linkedin.com/company/public-health-association-of-south-africa-phaa-/>



QUOTES ON LEADERSHIP

“If we cannot now end our differences, at least we can help make the world safe for diversity.”

John F. Kennedy