

The South African National Health Insurance: Where are we now?

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South Africa took on a revolutionary new direction for its national health system with the publication of the government's Green Paper on National Health Insurance (NHI) (1). It proposed four key interventions: i) A complete transformation of healthcare service provision and delivery; ii) A total overhaul of the health care system; iii) A radical change of administration and management; iv) The provision of a comprehensive package of care underpinned by a re-engineered system of primary healthcare (PHC). The NHI policy is guided by the following social justice principles: a) The Right To Access, a constitutional right of every South African guaranteed enshrined in the Bill of Rights; b) Social Solidarity, financial risk protection for the entire population; c) Effectiveness, through the adoption of evidence-based interventions; iii) Appropriateness, through the adoption of fit-for-purpose health service delivery models; e) Equity, ensuring universal coverage with care according to need; f) Affordability, services procured at reasonable cost recognising that health is a public good and not a tradable commodity; and g) Efficiency, ensured by creating new administrative structures that avoid duplication across national, provincial and district spheres of governance.

There is provision in the policy for the delivery of PHC through private providers accredited and contracted within districts. Hospital-based benefits are also described according to the designation of the hospital. An Office of Health Standards and Compliance (OHSC) has been established to inspect and accredit facilities and services, set norms and standards for these facilities and services and offer an independent office for ombudsman services. The government has published the regulations on norms and standards this year (2). The NHI policy document also covers the principles for payment of providers and pushes a risk-adjusted capitation system as its favoured method of payment. It also does preliminary costing estimates using the approach recommended by the International Labour Office (ILO). So in essence, the objective of the NHI policy is to provide improved access to cost effective and quality health services for all South Africans.

One of the main priorities of the NHI policy was to strengthen the public health system within the first five years and this was to be done by focussing on the following areas:

- Improving the management of public health services
- Quality Improvement Audits
- Infrastructure upgrades
- Medical devices and equipment upgrade
- Human resources planning, development and support
- Information management modernisation
- Setting up an NHI fund

What has been achieved thus far?

The Minister realised the need to move away from a hospicentric curative model of health care and proposed a 're-engineered PHC system' which aims to encourage a more responsive patient centred health service promoting health, rather than the current primarily passive one reacting to disease. This bases its approach largely on the Brazilian experience modelled on family health teams in defined communities. The re-engineered approach will be delivered through three streams as follows:

- a) District-based clinical specialist support teams supporting delivery of priority healthcare programmes at district level have been appointed in many districts with varying degrees of success (notably Tshwane and the districts in KwaZulu-Natal have reported success). To address the high maternal and child health mortality and to improve general health outcomes each team would ideally include a principal obstetrician and gynaecologist; a principal paediatrician; a principal family physician; a principal anaesthetist; a principal midwife, a principal child health nurse and a principal primary health care professional nurse as a start. Their roles and functions have been defined by the National Department of Health (NDoH) and their main focus is on clinical governance in maternal and child health services. The District Clinical Specialist Teams (DCSTs) have been put in place in many districts at a huge cost, though the specialists required to man these teams have been a challenge to recruit particularly in the rural provinces (where there is a severe shortage of health professionals generally). The real impact of established DCSTs is still to be measured.
- b) School health services are to be delivered by a team headed by a professional nurse which will provide health promotion, prevention and curative services that address the health needs of school-going children, particularly for grade R and grade 1. Some provinces have employed school health nurses (particularly in KwaZulu-Natal) but their full impact has still to be realised. School Health teams have also been introduced incrementally in other provinces and are assisting with screening thousands of children. The plan is to have these school health services to target older children in the long term where sexual- and reproductive-health issues can also be addressed.
- c) Municipal Ward Based Outreach Teams (WBOTS), with a nurse heading each team and each team allocated a certain number of households, have already been established nearly country wide. Ideally, the teams would comprise of at least six community health workers (CHWs), and would be supported by environmental and health promotion practitioners and other health professionals. The WBOTS provide basic health information, education and make the necessary referrals to clinics where required. WBOTs are being rolled out in a phased manner in many districts other than the NHI pilot sites with varying degrees of success. There are guidelines developed by NDOH for provinces for the implementation of the WBOTs, even though a national policy is still being finalized. The main functions of the WBOTs have been defined and include HIV/TB treatment support, maternal and child health services support, monitoring and referral of chronic non-communicable diseases, basic health care for children under five, home based care and referrals to social services and health facilities where appropriate.

However the WBOTs success depends on a strengthened and supportive PHC system with appropriate resource allocation. The PHC system in turn depends on a well-run district health service, supported by a strong provincial team. The public health medicine specialist within a public health unit (PHU) can support the district management team by providing the necessary technical skill to provide inputs into policy planning, monitoring and evaluation. Two districts have implemented these PHUs as per the Human Resources for Health (HRH) policy document (3).

How are challenges in the health care system being addressed?

However, there are some long standing challenges that we still need to deal with. Referral pathways are still a problem with patients either overcrowding facilities far from their own areas or where patients are being turned away from facilities because they don't come from a particular catchment area or are not properly referred. Neither is acceptable. No patient should ever be turned away from a health care facility in my opinion. There needs to be clear referral pathways that are accessible and efficient, and acceptable to communities. The waiting times at most institutions are still a huge problem. However, an integrated chronic service management (ICSM) approach is being introduced across many PHC facilities nationally, which aims to improve and deliver integrated care for chronic and acute patients by re-organising patient flow at facility level, implementing an appointment/booking system, delivery of chronic medications, reduce waiting times and overall improve the patient experience at facility level. These are not without challenges, but they are slowly making a difference.

Another major problem nationwide has been the running out of medical supplies (including drugs and vaccines) as well as lack of or poorly maintained medical equipment. This has to be addressed by improving the supply chain management systems in all provinces. It requires competent supply chain managers with the necessary support.

The vetting and re-appointment of CEO's and district managers in over 100 facilities countrywide is a move towards improving health facility management. Hospitals have been categorised as central, tertiary, regional, specialist and district hospitals. The legislation guiding this is the Policy on the Management of Hospitals (4). It intends to delegate more responsibility and accountability to hospital CEOs and district managers. This is a critical mechanism that needs to be implemented as soon as possible. It has also defined the new role of hospital boards. This has been elaborated upon by the recently published draft regulations relating to the development and implementation of new governance structures for central hospitals or groups of central hospitals (5).

Universities have responded to the Minister's call for improved management of health facilities, by developing executive leadership and management training programs targeting district and hospital managers both in the public and private sectors. The thrust is about developing innovative change agents supporting the transformation of the health system. The HRH challenges are also slowly being addressed through a number of strategies not mentioned here. HR norms for PHC facilities have been developed and are being

implemented. Public Health facilities are introducing workload indicators for staffing needs (WISN) in order to understand and define their human resource needs.

The national core standards for quality health care are a significant achievement for the national health system. The OHSC has been established and has already audited many facilities. All hospitals and districts have improved their planning processes, and have conducted self-audits which have identified many challenges. There is greater awareness amongst public servants of the need to improve quality of health care delivery, this is critical, as the first step towards improvement is to identify and admit to problems. Through a process of careful deliberation and consultation, the NDoH has also developed components of an ideal clinic which PHC facilities aim to strive towards. The Ideal clinic takes into consideration all of the six building blocks of the health system as well the inter-sectoral and community engagement required to ensure efficient, effective and quality health services.

Way forward

However, much more needs to be done. In the Minister's 2015 budget speech he made a brief reference to the NHI. And when asked to elaborate more upon the NHI he promised that the White Paper on the NHI and its planned financing would be brought to parliament by the end of the current year. We look forward toward this in anticipation.

The plan for the NHI is to phase it in over a 14 year period with the initial phase being the piloting in 11 districts (of the 52 in the country). The OHSC has been established and the investment in infrastructure which includes the building of a new medical school has started. The real challenge will be in successful and sustainable implementation of the financing model and the involvement of the private sector in a much more structured way than is currently described in the green paper. The contracting of GPs especially in the NHI pilot sites is a step towards engaging the private sector, though the response from the sector could have been better. There have been over 300 GPs contracted so far but they face huge challenges in carrying out their tasks and this has mainly been due to shortages of medicines and appropriate equipment at the PHC facilities where they work.

'Health' is a national goal, and should not just be the target of government, for with a healthy nation we can forge towards a stronger, better South Africa for all. The National Development Plan seeks to address the inter-sectoral developmental areas that drive the social determinants of health. And while the private health sector is mainly profit driven, and therefore driven by disease, there is an opportunity here for this sector to explore how it can promote and support a healthier nation within a national health insurance scheme. The NHI can enable universal health coverage for all South Africans, but only with a sustainable, affordable health system that emphasizes disease prevention rather than cure. The Minister's PHC re-engineering strategy in this regard is commendable. It is anticipated that the much awaited White Paper will have considered this.

In the meantime we all must and should support the Minister and the National Department of Health for its visionary policy that places a much needed emphasis on equity and social

justice in health care. We cannot leave it to government alone. All of us have a moral and social responsibility to do what we can for a better South Africa for all.

References:

1. National Health Act, 2003: Policy on National Health Insurance. Government Notice No. 657. Pretoria: Government Printers; 2011.
2. National Health Act, 2003: Norms and Standards Regulations in Terms of section 90 (1)(b) and (c) of the National Health Act, 2003 (Act No. 61 of 2003), applicable to certain categories of health establishments. Government Notice No. R. 109. Pretoria: Government Printers; 2015.
3. Human Resources for Health for South Africa 2030: HRH Strategy for the Health Sector 2012/13-2016/17. Pretoria: Government Printers; 2011.
4. National Health Act, 2003: Policy on the Management of Hospitals. Pretoria: Government Printers; 2012.
5. National Health Act, 2003: Regulations Relating to the Development and Implementation of New Governance Structure for Central Hospital or Group of Central Hospitals. Pretoria: Government Printers; 2015.