2025 Pholela Lecture

"Health Systems Reform in South Africa: The indispensable role of medical specialists"?

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Health Systems Reform in South Africa

1. **Why Reform?**
   - What's the problem? Why reform? Why massive systemic health sector reform is needed
2. **What Reform? What is NHI all about?**
   - What reform is required? [funding (purchaser) and providers (medical model vs multi-disciplinary PHC approach)]
   - What the NHI aims to achieve and what the Act provides for by way of a statutory mandate
   - Interventions and response plans to operationalise and implement the NHI
3. **What role should medical specialists play?**
   - Role of clinical specialists
   - Role of PHM specialists in particular

- After delays due to the Covid-19 pandemic, the National Assembly passed the amended Bill in **June 2023**, after which the National Council of Provinces (NCOP) took over the process. Some 60 community consultations were held in all nine provinces. The NCOP adopted the Bill by a majority of eight provinces to one in **December 2023**.
- President Ramaphosa assented to the National Health Insurance Act (NHI), 2023, on **15 May 2024**. This marked the culmination of a lengthy legislative process that commenced in 2019 with the tabling of the Bill in Parliament.
- Now that we have reached this critical milestone, we are able gradually to phase in the NHI using a progressive and programmatic approach based on financial resource availability, as required in the Act.
- The NHI must be implemented in two phases, phase 1 from 2023 to 2026 and phase 2 from 2026 to 2028.

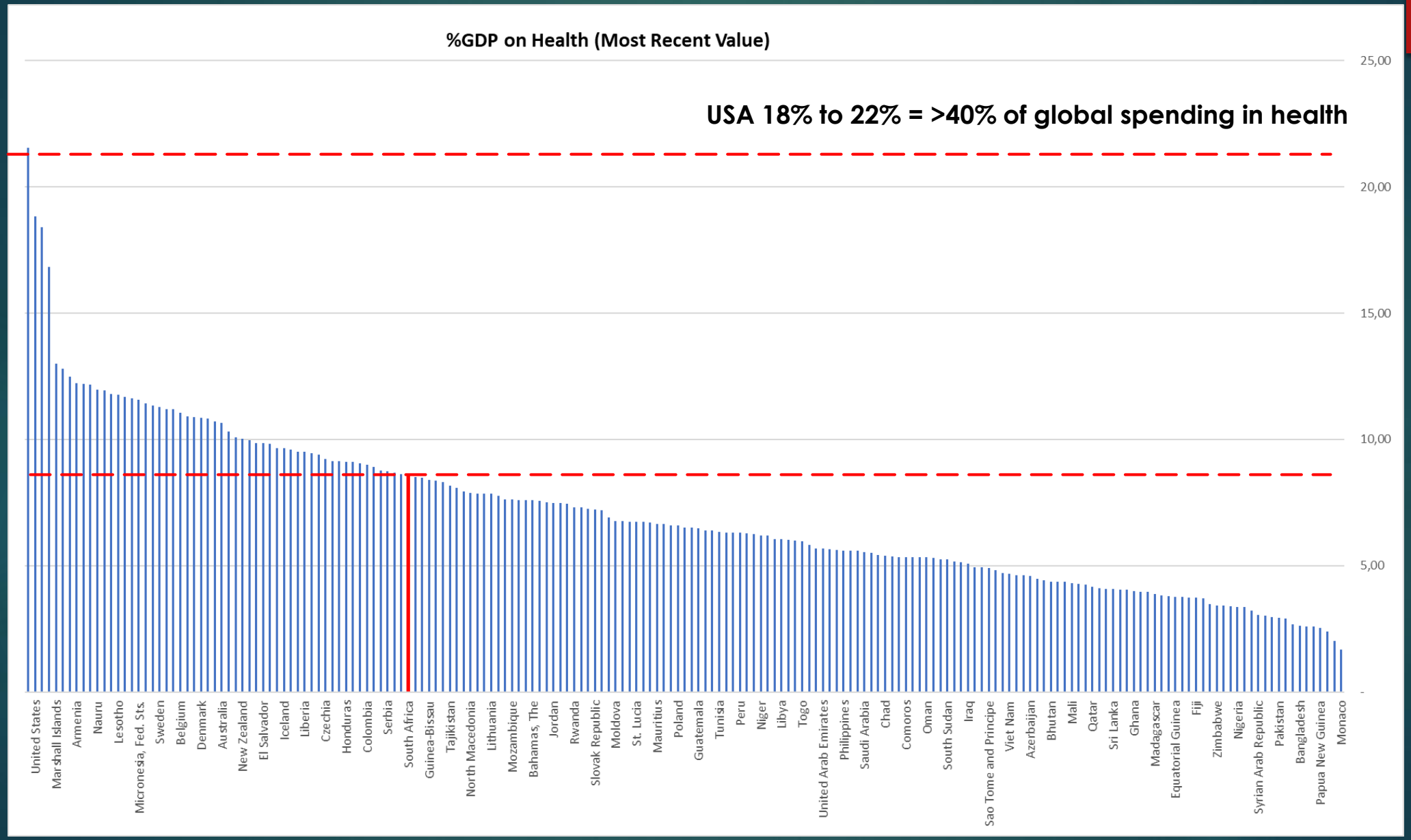
PART 1:
Why reform?

What are we aiming to ‘fix’?

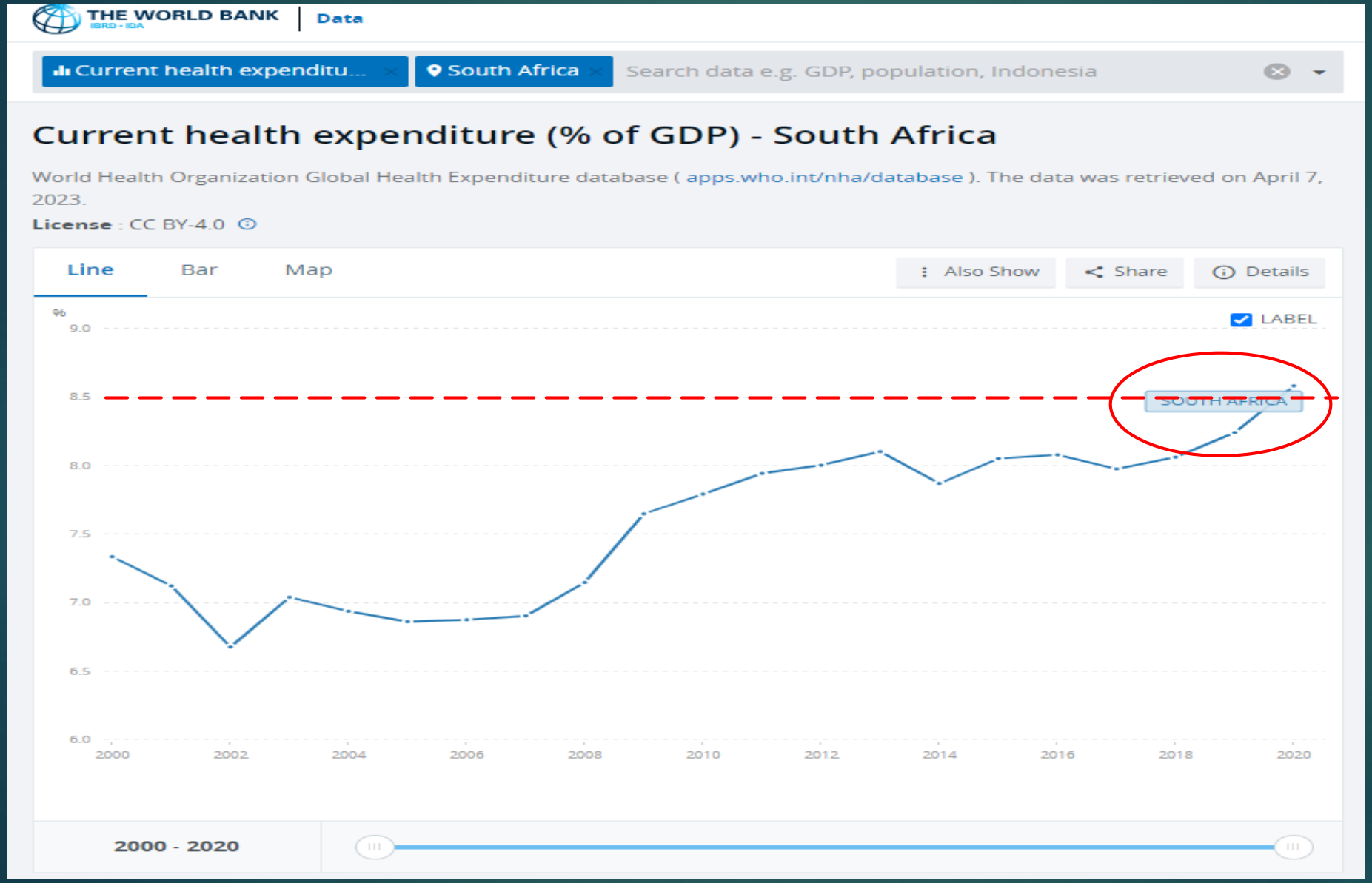
Why massive systemic health sector reform is needed

World Bank Report %GDP on Health (07 April 2023)

World Bank Report %GDP on Health (07 April 2023)

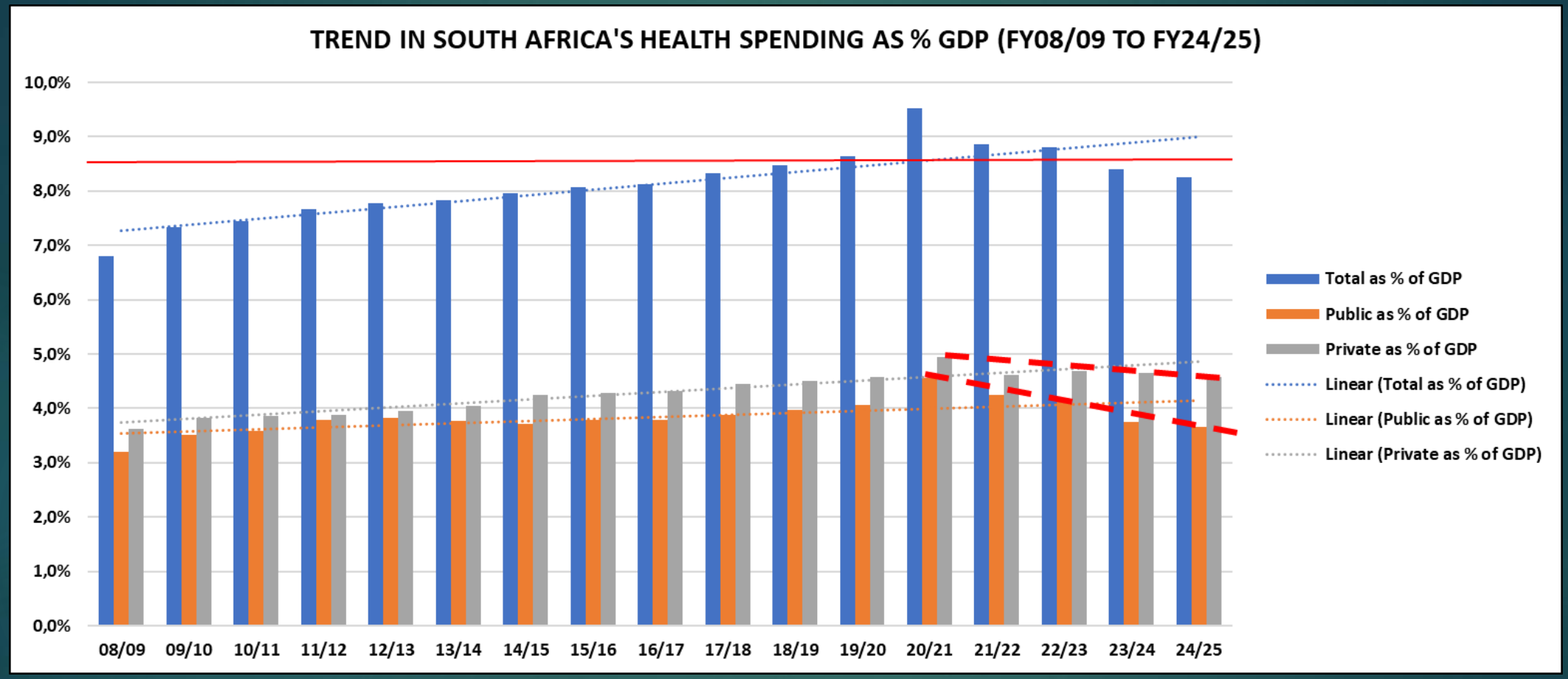


World Bank Report RSA %GDP on Health (07 April 2023)



SA 8,5% of GDP spending on health

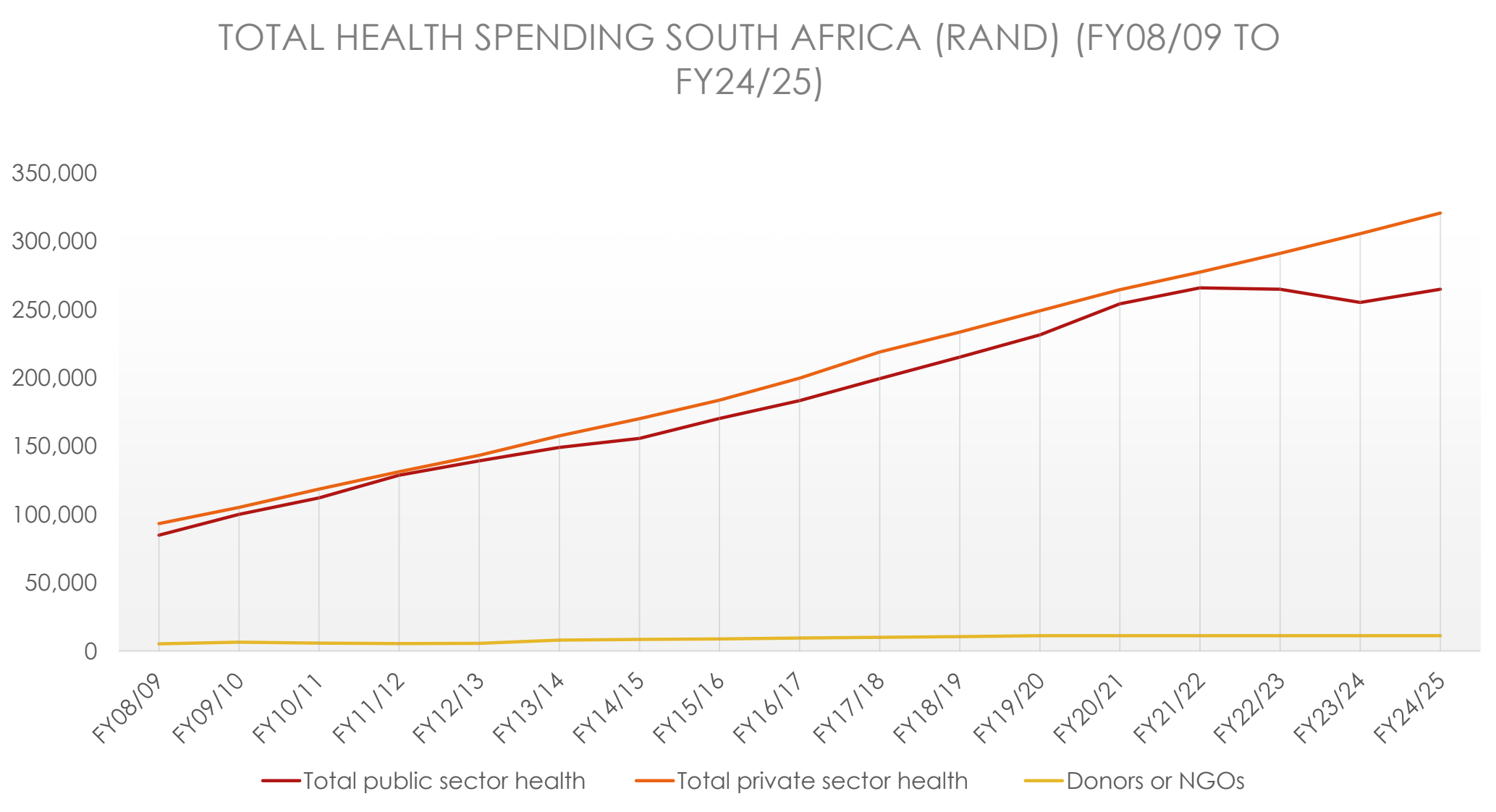
Health sector funding trends as % GDP over the past 15 years



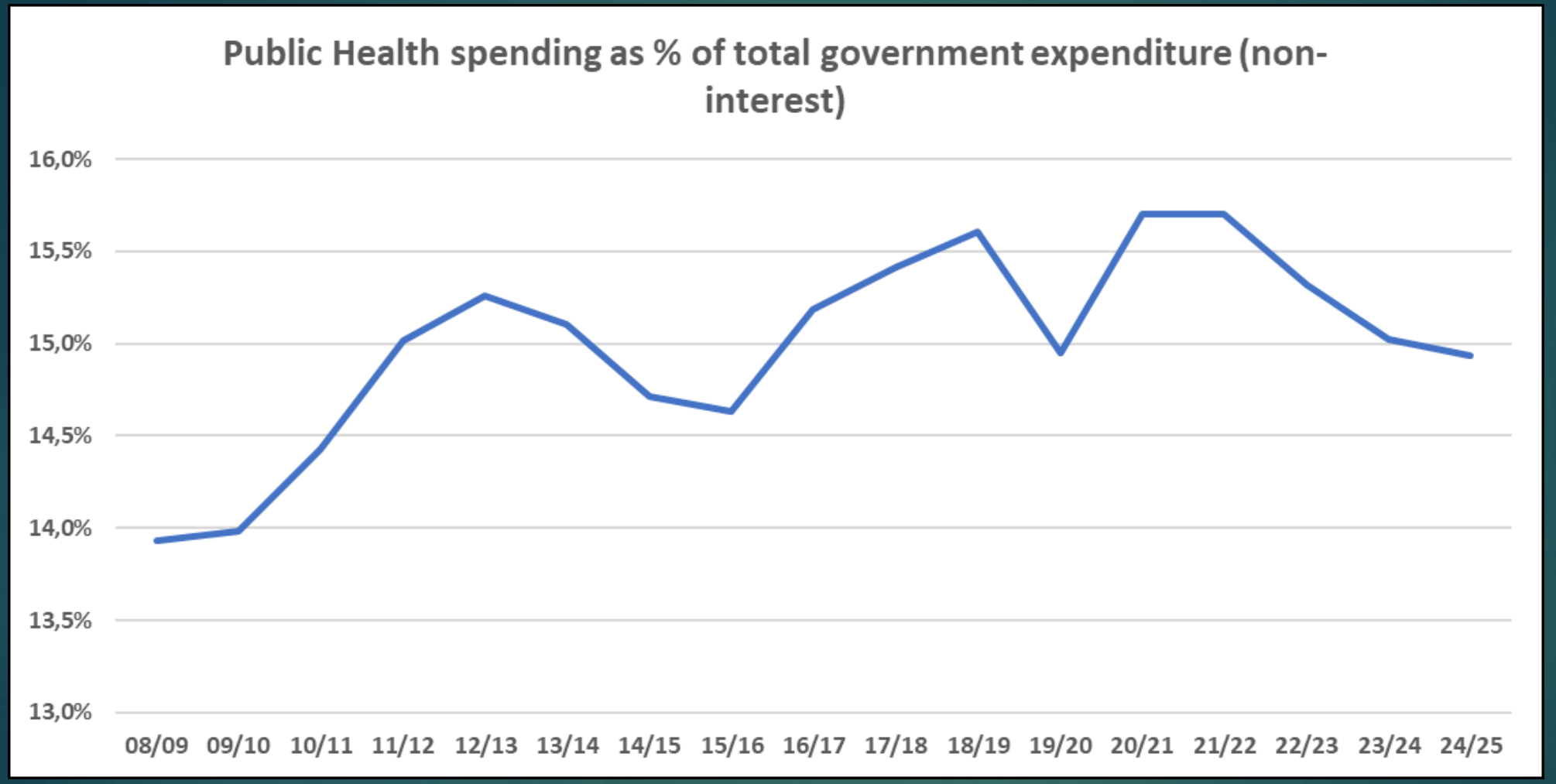
High level

- National spend currently is around 8,5%GDP (up from below 7% in 2008/09)
- Both Public and Private spending increased as %'s of GDP until 2020/21 but both are decreasing, public faster than private – this is too rapid

Inequitable health sector funding trends over the past 15 years



Government spend on health

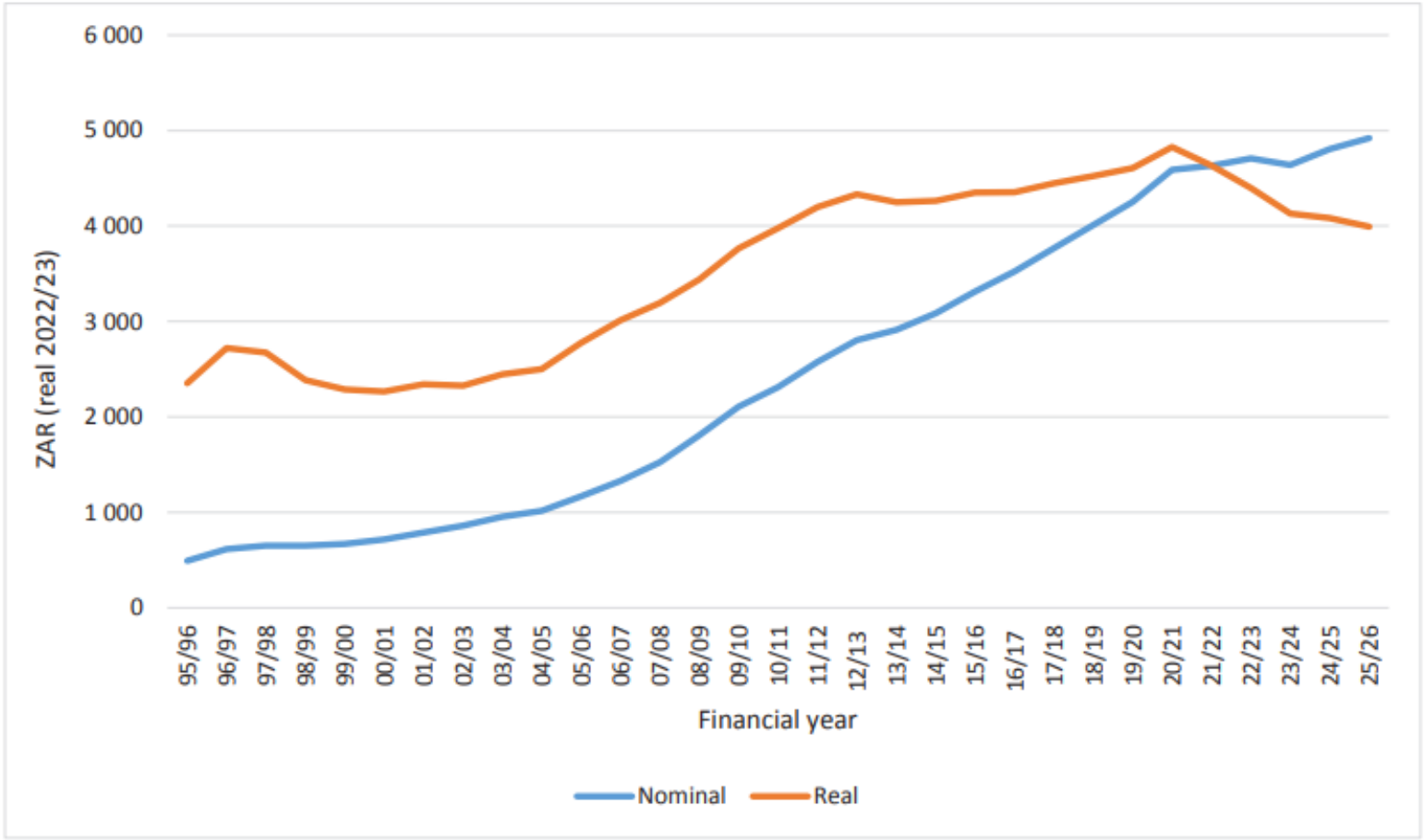


High level

- **Spending by government on health has increased as a % of allocations from the fiscus (from 14% to 15,5% and now at around 15%)**

Declining allocation to public health services

Figure 1: Provincial health expenditure per capita, 1995/96–2025/26



Source: Authors' calculations based on published provincial budgets

Real public health expenditure (allocations from fiscus) per capita are decreasing since 2019/20

Medical Scheme payment trends

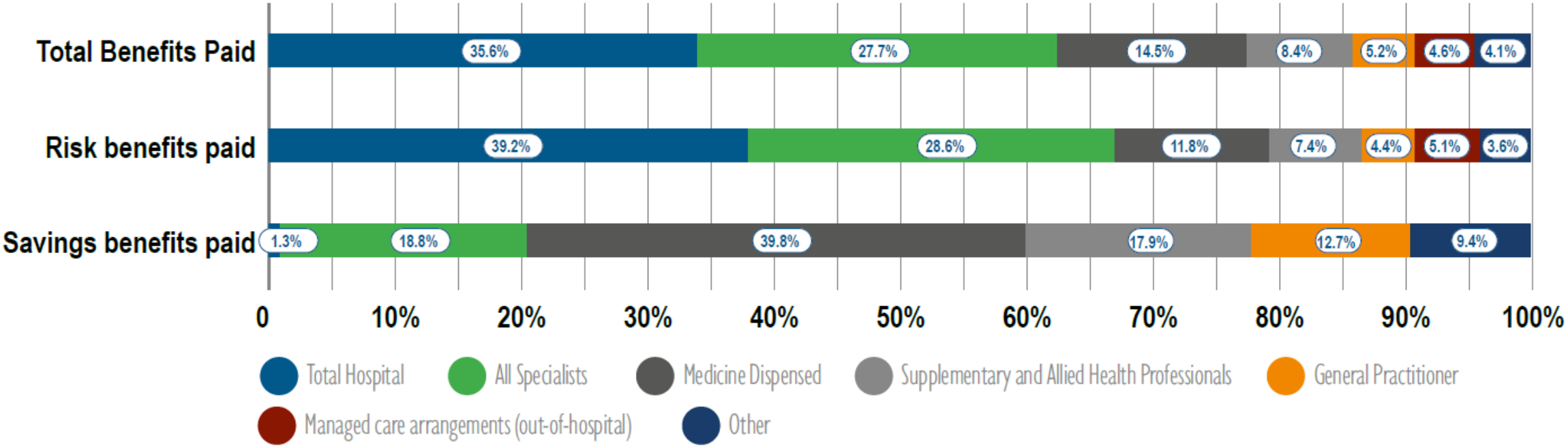
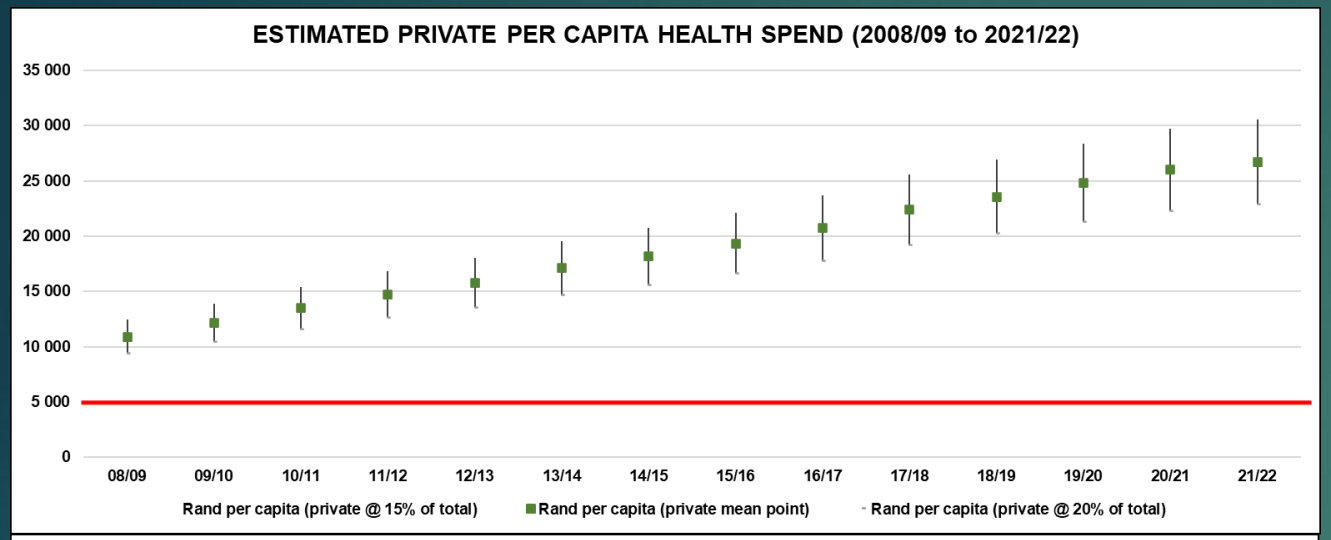


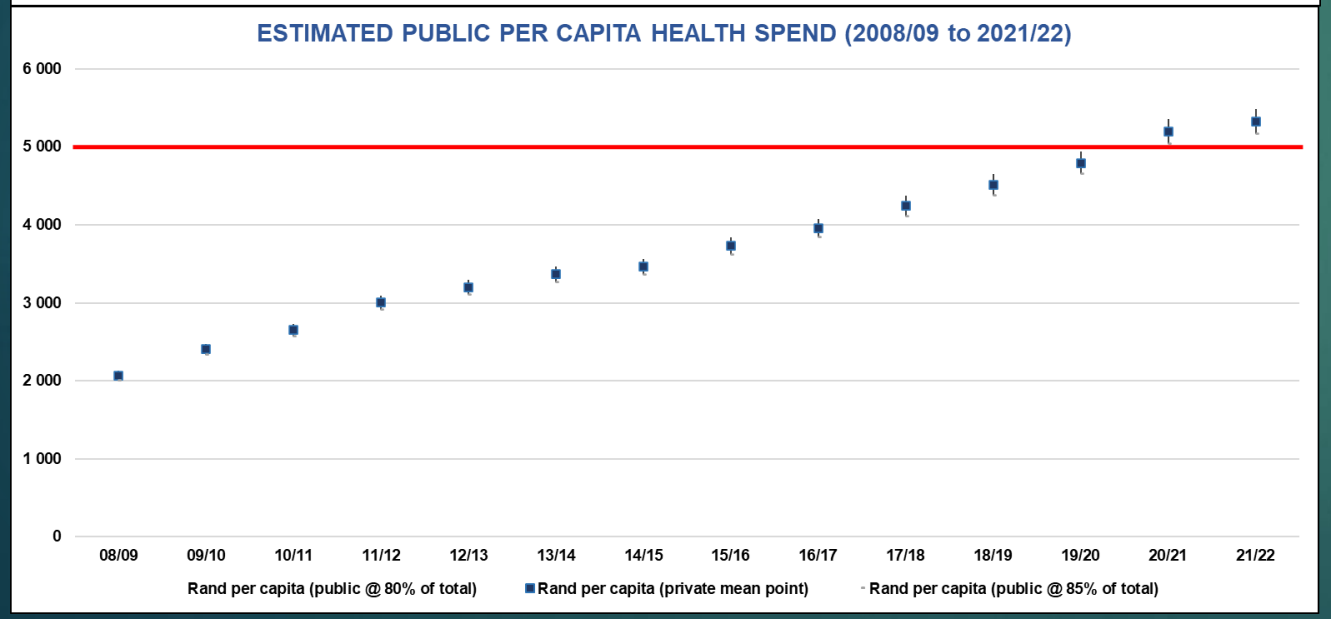
Figure 13: Distribution of healthcare benefits paid in 2023

*Other consists of other health services, dentists, dental specialists, ex-gratia payments and other unspecified benefits

CMS Industry Report 2023

Per capita spending on Health 2008/09 to 2021/22





Rand per capita spend on health

- public @ 80% and private at 20% of total
- mean point Rand per capita
- public @ 85% and private at 15% of total

2021/22 FY

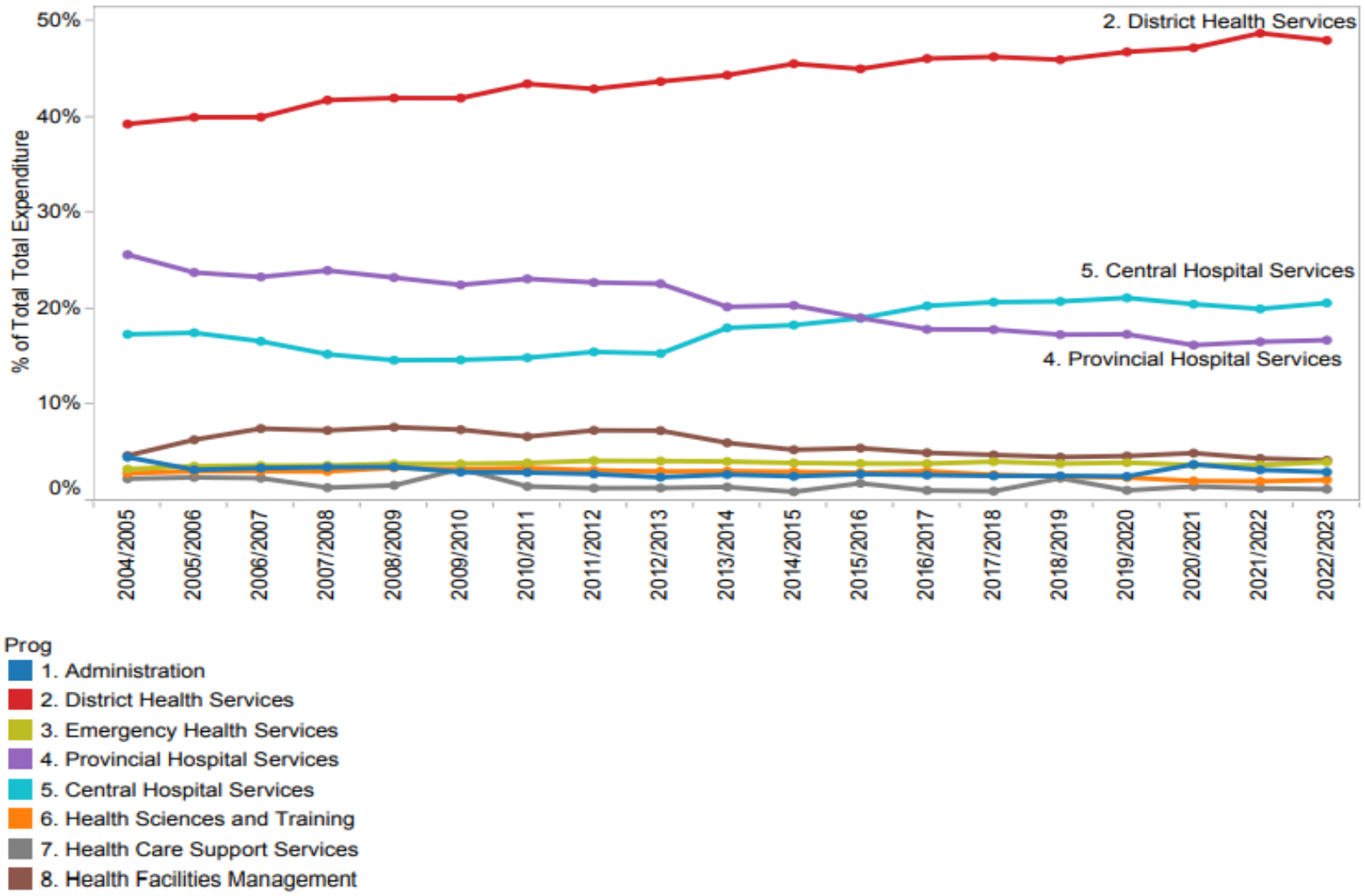
- **Private spend per person is 5,0 times that of public**
- Range 4,4 to 5,6 times depending on proportion of the population regularly using private providers

Per capita spending on Health 2021/22	
Rand per capita (private @ 15% of total)	R30 515
Rand per capita (private mean point)	**R26 700**
Rand per capita (private @ 20% of total)	R22 886
Rand per capita (public @ 80% of total)	R5 483
Rand per capita (private mean point)	**R5 322**
Rand per capita (public @ 85% of total)	R5 161

Administrative cost of maintaining medical schemes

- At the start of 2024 there were 71 schemes offering 311 ‘options’
- Schemes had 833 trustees in 2022, at a cost of over R104m
- Principal Officers cost almost **R140m** (several paid over R6m per annum)
- **Gross administration cost of schemes was almost R21bn (9% of R230bn)**
- Despite this cost the reported fraud, waste and abuse in 2023 was R28bn in one year (around 6 times the AGSA reported unauthorised expenditure in the public sector)
- The problem is massive perverse incentives with such complex pathways that are easy to defraud

Figure 2: Percentage of provincial health expenditure by programme

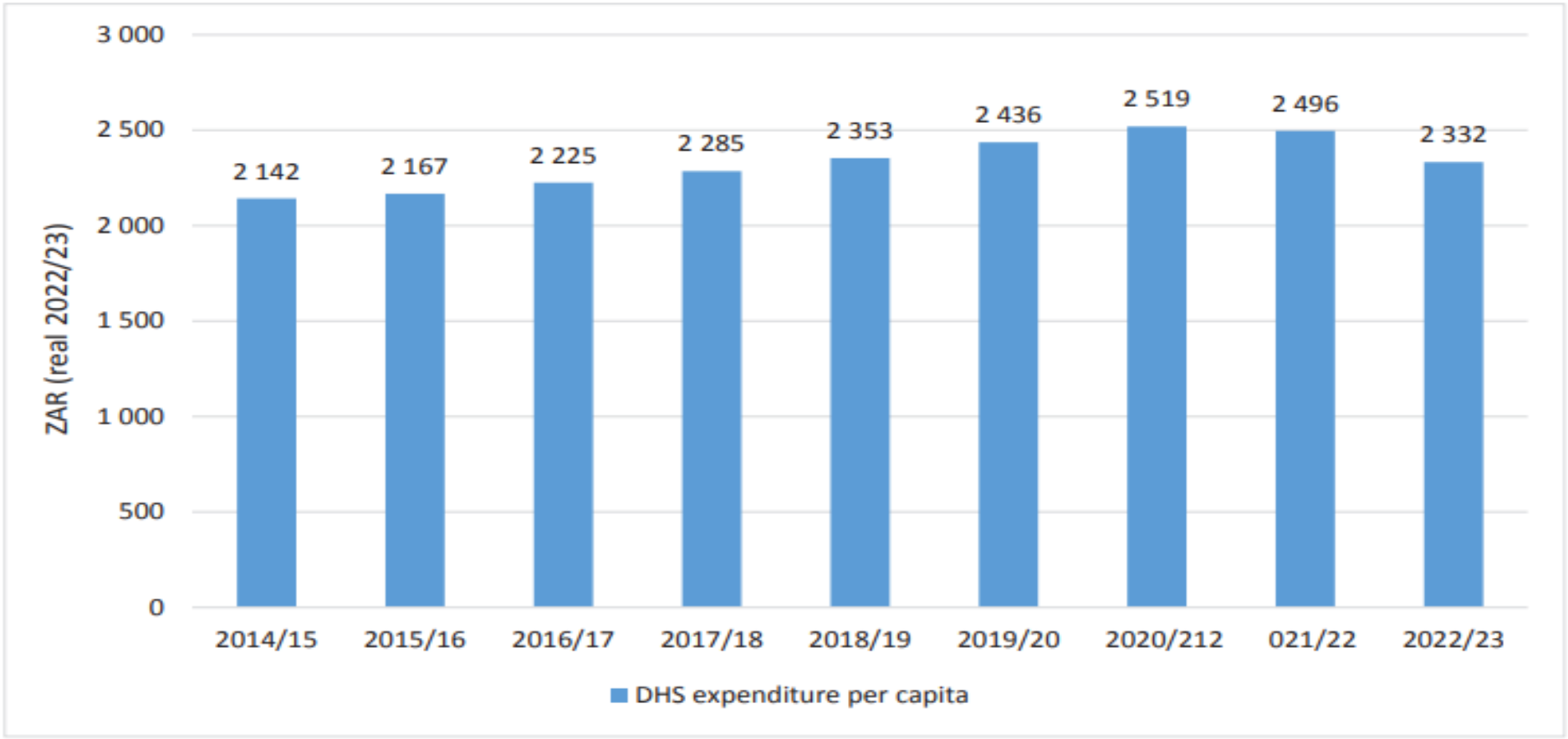


Source: BAS

Where does the money go in the public health service?

Maintained clinic services but hospital spending decreasing (hence the bad press)

Figure 4: Provincial and LG DHS expenditure per capita (uninsured real 2022/23 prices), 2014/15–2022/23



Source: BAS

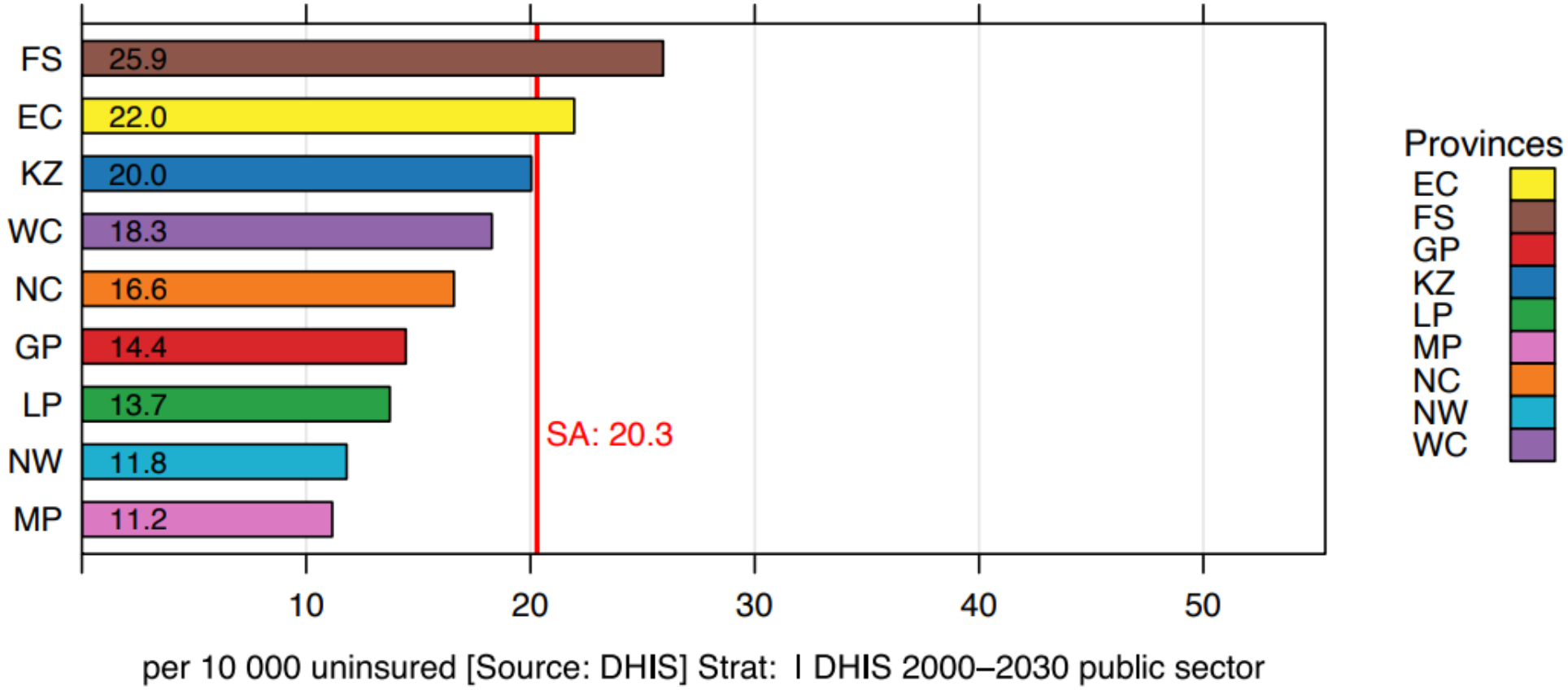
But per capital spending in Primary Health Care is decreasing as the population increases

(Private dependents remain 9m for past >5 years)

Public health service hospital bed inequity

https://www.hst.org.za/publications/District%20Health%20Barometers/DHB%202022-23%20Section%20A,%20chapter%204%20-%20Service%20capacity%20and%20access.pdf

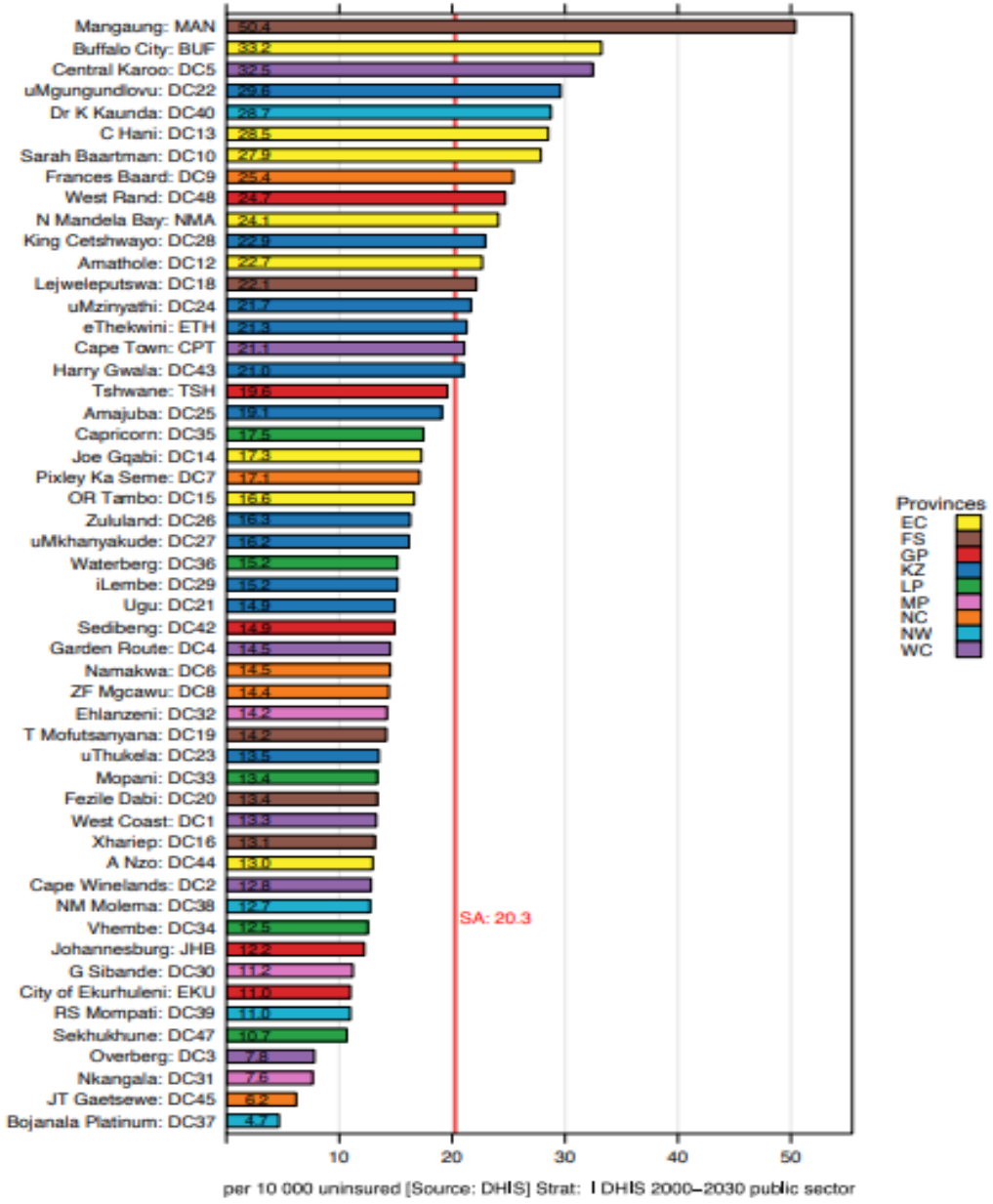
Figure 2: Hospital beds per 10 000 uninsured population by province, March 2023 (all types of hospitals)



per 10 000 uninsured [Source: DHIS] Strat: I DHIS 2000–2030 public sector

Plenty inequity in public service

Figure 3: Hospital beds per 10 000 uninsured population by district, March 2023 (all types of hospitals)



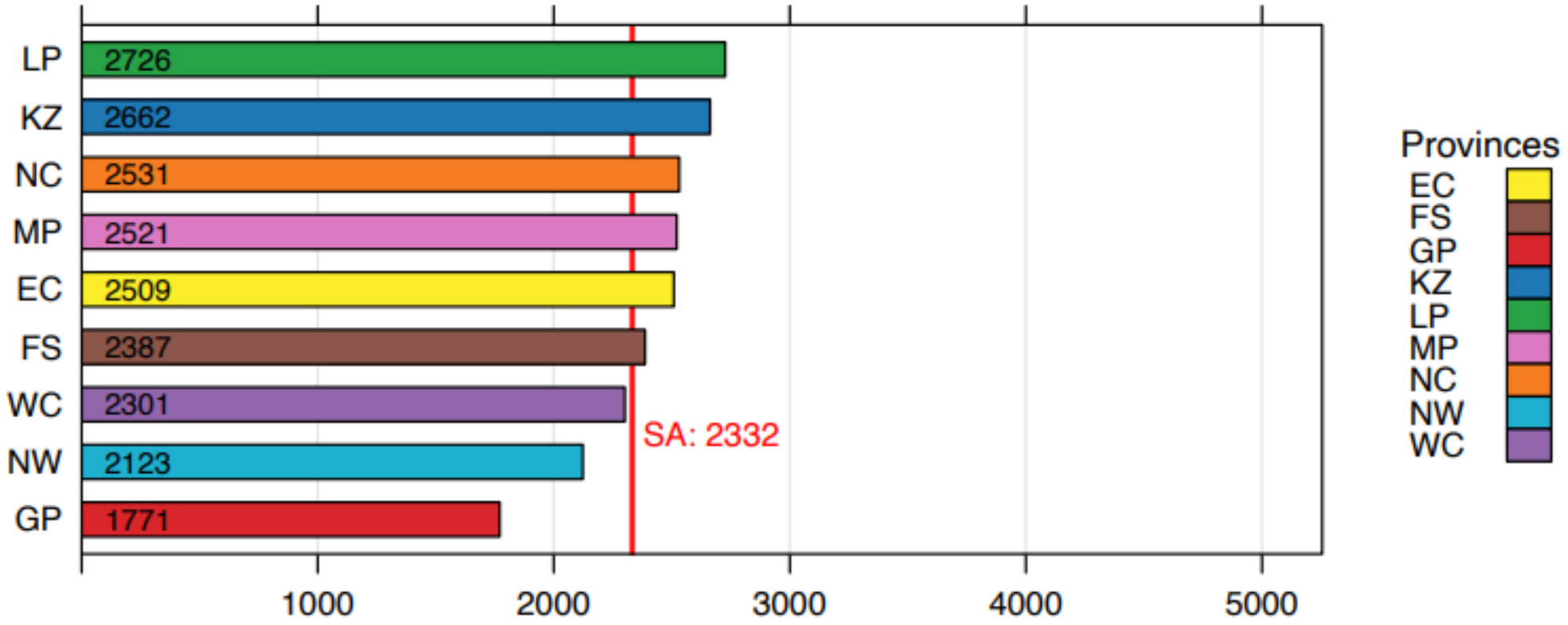
Disaggregated data to show inequity

Access to public hospitals differs greatly from one district to another, whether urban or rural

Ekurhuleni
Johannesburg
are amongst the worst

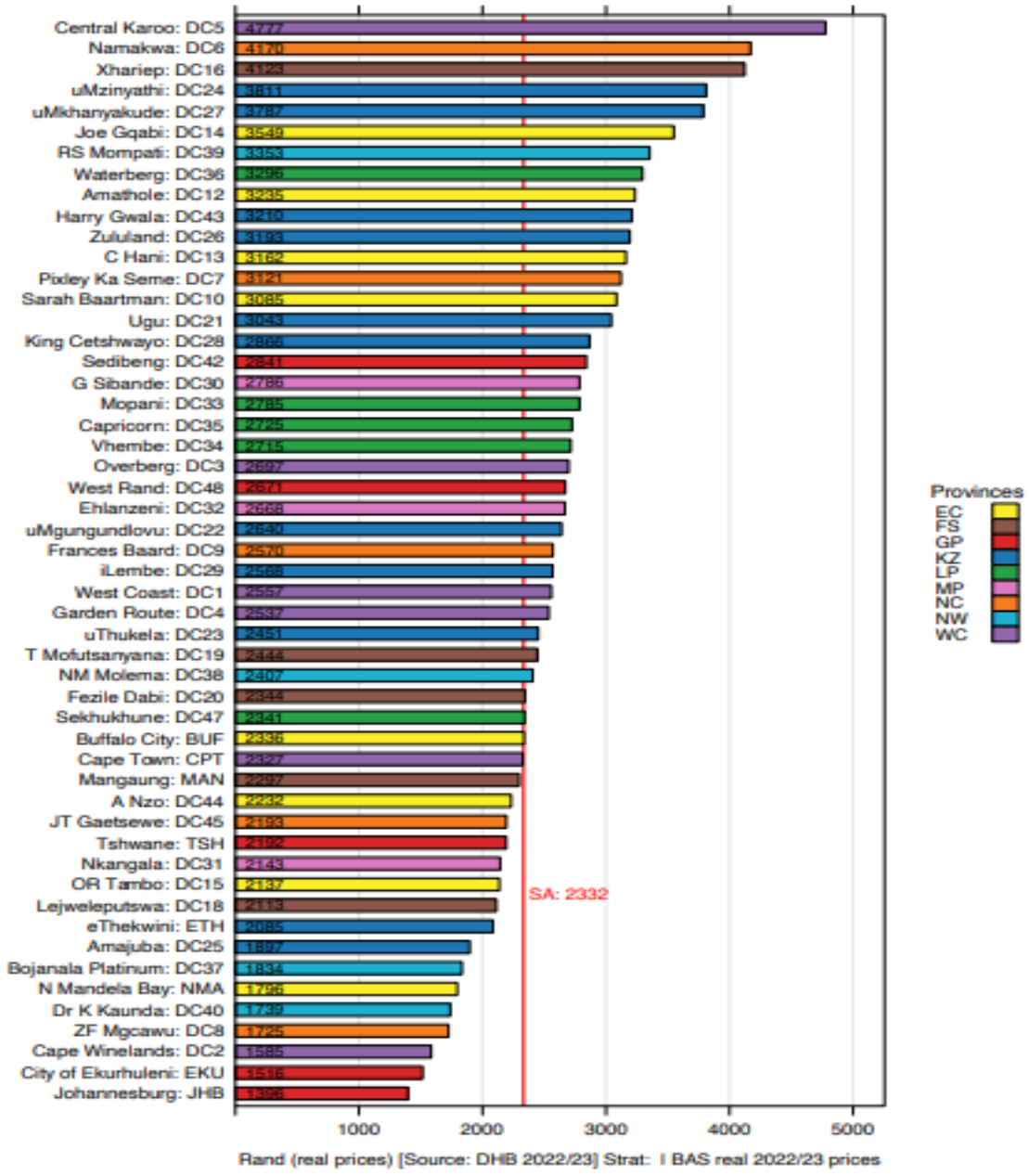
Public health service PHC inequity

Figure 5: Provincial and LG DHS expenditure per capita (uninsured) by province, 2022/23



Rand (real prices) [Source: DHB 2022/23] Strat: I BAS real 2022/23 prices

Figure 6: Provincial and LG DHS expenditure per capita (uninsured) by district, 2022/23



Rand (real prices) [Source: DHB 2022/23] Strat: I BAS real 2022/23 prices

Disaggregated data to show inequity

Total PHC spend varies enormously

Inequity three times R1500 to 4500

(distances and density matter for efficiency but this is bad)

Summary of what we need to fix

- There is plenty of money being spent on health care in the country
  - >8,5% of GDP
  - R543,246bn public and private spend (2021/22)
  - Including donors R554 341bn (2021/22)
- Duplication is costly
  - Public 10 DoHs, SAMHS, others, plus 71 medical schemes (311 options)
  - Increases administration, creates perverse incentives, increased fraud, poor coordination of care
- Inequity of access to resources
  - Concentration in private sector
  - Intra-provincial and inter-provincial public inequity of resource allocation
  - Massive quality disharmony
- Poor systems for coordinated data management
  - Difficult to plan holistically
  - Difficult to change direction, strategic planning and strategic purchasing

PART 2:
What is NHI all about?

What the NHI aims to achieve
What the Act provides for by way of a statutory mandate

Equity vs equality

If fairness is the goal, equality and equity are two processes through which we can achieve it

- **Equality** simply means everyone is treated the same exact way, regardless of need or any other individual difference
- **Equity** means everyone is provided with what they need to succeed

What is National Health Insurance (NHI)?

- NHI aims to achieve Universal Health Coverage (UHC) for all who live in South Africa

  "Every person gets the quality health care that they need, when they need, where they need and <u>without incurring financial hardship</u>"

- NHI (National Health Insurance) is a **health financing system** that is designed to pool funds to provide access to quality affordable personal health services for all South Africans, based on their health needs, irrespective of their socio-economic status
- Note:
  - The NHI Act goes beyond enabling financing and enhances/amends the National Health Act – but **does not repeal it**
  - The NHI Act enhances/amends other health Acts, including the Medical Schemes Act – but does not repeal them

How will NHI work?

- NHI will pool the vast majority of health resources into one NHI Fund

  (Publicly funded means collection through the tax system)
- NHI Fund will purchase services (benefits) on behalf of the whole nation from both the public and private health sectors
- The NHI Fund contracts directly with service providers
- The public (Users) must register with clinics and doctor/family practitioners to obtain services, and must start their care at this primary health care (PHC) level

- It is **not possible to address one part of the existing health dichotomy without addressing the other**, they are mutually dependent
- The whole system needs a 'face-lift' (revamp)
- There is a need for both systemic change and local changes

Big picture – Purchaser/Provider split

Purchaser of health care

NHI Fund Office
- Public Entity
- Administrative purchasing units

- (Private Medical Aids - complementary)

Providers of health care

Public
Private
PHC/Hospitals
Accreditation

When will NHI be implemented?

- The President will proclaim sections on different dates as required
- It will be **implemented in two phases**
- Phase 1: 2023 to 2026
- Phase 2: commences 2026/27 and should be well on its way by 2028/29 Financial Year

Many years of concentrated and consistent work

Broken up into manageable phases and parts each of shorter duration

PART 3:
Clinical medical specialists
What role should they play?

Who are our Medical Specialists?

CMSA Colleges

1. College of Anaesthetists
2. College of Cardiothoracic Surgeons
3. College of Clinical Pharmacologists
4. College of Dentistry
5. College of Dermatologists
6. College of Emergency Medicine
7. College of Family Physicians
8. College of Forensic Pathologists
9. College of Maxillo-Facial and Oral Surgeons
10. College of Medical Geneticists
11. College of Neurologists
12. College of Neurosurgeons
13. College of Nuclear Physicians
14. College of Obstetricians and Gynaecologists
15. College of Ophthalmologists
16. College of Orthopaedic Surgeons
17. College of Otorhinolaryngologists
18. College of Paediatric Surgeons
19. College of Paediatricians
20. College of Pathologists
21. College of Physicians
22. College of Plastic Surgeons
23. College of Psychiatrists
24. College of Public Health Medicine
25. College of Radiation Oncologists
26. College of Radiologists
27. College of Sport and Exercise Medicine
28. College of Surgeons
29. College of Urologists

- Clinical medical specialists play a vital role in healthcare by providing expert diagnosis and treatment for specific diseases and conditions, complementing the work of general practitioners
- They contribute to the overall health system by offering specialized care, participating in research, and educating future medical professionals

Medical Specialists

1. Specialized Expertise and Diagnosis:

- **In-depth Knowledge:**
  - Specialists possess advanced knowledge and skills in a specific area of medicine, allowing them to diagnose and treat complex or uncommon conditions that may be beyond the scope of general practitioners.
- **Advanced Diagnostics:**
  - They utilize specialized diagnostic tools and techniques to accurately identify the root causes of illnesses, enabling them to develop targeted treatment plans.

2. Treatment and Management:

- **Specialized Treatment:**
  - Specialists provide tailored treatment plans based on their expertise, including medical, surgical, or other therapeutic interventions.
- **Complex Cases:**
  - They manage patients with chronic, severe, or rare conditions, often requiring a multidisciplinary approach involving collaboration with other specialists and healthcare professionals.

Medical Specialists

3. Contribution to the Health System:

- **Referral Network:** Specialists should receive referrals from general practitioners, ensuring that patients with specific needs receive the appropriate level of care.
- **Education and Training:** Many specialists also contribute to the education and training of future doctors, including registrars and medical students, passing on their knowledge and expertise.
- **Research and Innovation:** Specialists are often involved in medical research, contributing to the advancement of knowledge and the development of new treatments and technologies.
- **Multidisciplinary Teams:** Specialists collaborate with other healthcare professionals (e.g., nurses, therapists, pharmacists) to provide comprehensive and coordinated patient care.
- **Public Health:** They may also be involved in public health initiatives, such as disease prevention programmes or health promotion campaigns, leveraging their expertise to improve the overall health of the population.
- **Leadership Roles:** Specialists may hold leadership positions in hospitals or other healthcare organisations, shaping policies and practices to enhance the quality of care.

In essence, clinical specialists are crucial for delivering specialized medical care, contributing to the advancement of medical knowledge, and ensuring the efficient functioning of the broader healthcare system

BUT, is specialist care always appropriate?

- Specialisation is needed to improve national clinical "*competitiveness, ability to innovate, extend life and explore the frontier of science and knowledge*"
- There are, of course, good clinical arguments for specialization
  1. procedures have become more complex and effective
  2. specialisation produces better outcomes for patients
  3. patients themselves will drive further specialization - consumers will demand the latest, best and most timely diagnosis and treatments available
  4. specialisation can be cost effective

- But if "*left unfettered and not harnessed to the role of the generalist in healthcare, we can look forward to painful debates about rationing, professional 'turf-war' and suboptimal patient care*"
- Better teamwork between the generalist and specialist has never been more important
- Doctors should get together to better serve their patients and the population at large, thus changing the pattern of healthcare that has built up over years
- Specialisation is not always appropriate for patient and population needs. the rapid growth of patients presenting with long-term conditions threatens to challenge the conventional wisdom on hospital-based, specialist care

https://pmc.ncbi.nlm.nih.gov/articles/PMC5873739/ (Mark Britnell)

Example: DISTRICT CLINICAL SPECIALIST TEAMS

- Improving quality of care outcomes by supporting medical officers and other health professionals
- Structure for a DCST consists of seven specialists in each district, comprising three medical and three nurse specialists from obstetrics and gynaecology, paediatrics and family medicine/PHC, and one anaesthetist
- The role of the DCSTs include:
  - providing clinical training and monitoring and evaluation
  - supporting district-level organisational activities
  - ensuring collaboration, communication and reporting
  - ensuring implementation of the four tiers of clinical governance; and
  - supporting the strengthening of management systems

https://www.hst.org.za/publications/Kwik%20Skwiz/KWIK%20SKWIZ_Vol3_Iss5.pdf

Who are Public Health Medicine Specialists?

- The practice of Public Health Medicine **focuses on the delivery of population-oriented clinical services aimed at promoting the health of communities and prevention of diseases**, teaching in public health and preventive medicine across disciplines and research to advance population health.
- Provide **clinical services broadly grouped** into disease prevention (communicable diseases, non-communicable diseases, maternal and child health), clinical public health (clinical health informatics, medical management, clinical economics), occupational and environmental health and social medicine
- **Master of Medicine (MMed) in Public Health Medicine**
  - Epidemiology
  - Biostats
  - Public Health & Society
  - Quantitative Research Methods
  - Health Systems
  - Health Policy and Planning
  - Economics of Health Systems
  - Evidence-Based Health Care
  - Epidemiology of Communicable Diseases and Non-Communicable Diseases

- As we seek to create a more responsive health system, which will intervene early with preventive care, and as funds become more constrained, it is the skills of the Public Health Medicine specialist that will become critical to evidence based decision-taking, hard economic decisions and formulation of agile, targeted policies
- The NHI Branch in the National Department of Health has actively sought to recruit Public Health Medicine specialists
- There is a case to be made for this to be a compulsory qualification for many management and policy positions in the health system

Key Principles of the CMSA Pledge:

- **Social Justice and Health Equity:** Upholding these values in medical practice.
- **Patient Care:** Prioritizing patient well-being, respecting their rights, and providing compassionate care.
- **Professional Integrity:** Avoiding conflicts of interest and maintaining objectivity in patient care.
- **Continuous Learning:** Dedication to advancing knowledge and skills for the benefit of patients and the profession.
- **Teaching and Mentorship:** Sharing knowledge and supporting colleagues and trainees.
- **Adherence to the CMSA's Code of Conduct:** Commitment to the organization's standards and values.

Pledge

The Colleges of Medicine of South Africa is dedicated to promoting the highest degree of skill and efficiency in medical and dental practice, and to cultivating the highest ethical standards and professional conduct for the betterment of humanity.

- I shall always advance and uphold the core ethical values of social justice and health equity.
- I shall always act in the best interests of my patients and respect their autonomy and rights and treat them with care and compassion.
- I shall never allow considerations of financial reward, career advancement, or reputation to compromise my judgement or care to my patients.
- I shall continue to advance my knowledge and skills to offer my patients the best care.
- I shall continue to learn and teach for the benefit of my patients, my trainees, my community, and my country.
- I shall respect my mentors and colleagues and readily offer them assistance and support.
- I undertake to support the mission of the Colleges of Medicine of South Africa and to abide by its code of conduct.

ngiyathokoza!

ro livhuwa!

dankie!

ke a leboga!

enkosi!

thank you!

ndo livhuwa!

inkomu!

ke a leboha!

ngiyabonga!

siyabonga!

Public Health Medicine

- https://publichealth.ukzn.ac.za/publichealthmedicinespecialist/
- https://www.up.ac.za/public-health-medicine
- https://publichealth.ukzn.ac.za/publichealthpractitioners/
- https://jobs.gauteng.gov.za/public/ViewJob.aspx?u=jkPV9MoxkqEsEQN7VRSPDg==
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