

**DISCUSSION DOCUMENT ON POLICY AND PLANNING FOR THE MEETING OF THE
NATIONAL CONSULTATIVE HEALTH FORUM
MAY 2006**

INTRODUCTION

This paper is intended purely as a briefing document on key health systems issues to determine a health systems performance. The issues will be applicable to both the public and private health sectors. The issues that will be covered are:

1. Financing of the Health System
2. Hospital Issues
3. Quality Improvement
4. Primary Health Care

FINANCING OF THE HEALTH SYSTEM

The financing of the health system covers a range of issues. This paper will focus on two issues, namely issues pertaining to equity and social health insurance.

Equity can be broadly defined as fairness or justice. There is agreement that, in assessing inequities, the focus should be on differences in health status and health service provision and financing between socio-economic groups, i.e. social inequalities. There is also growing consensus that inequity refers to differences between groups that are not only unfair and unjust, but are also avoidable and unacceptable.

In South Africa there remain disparities in public sector health care expenditure between provinces, and within provinces. The public-private health sector mix further contributes to differences in expenditure levels. There is an eight-fold difference on government spend on health services per person who is not a medical scheme member as compared to private sector expenditure per medical scheme member.

In this discussion, it will be taken as given that all participants would agree that significant health status and health system disparities exist in South Africa, and that these disparities are inequitable as they are not only unfair or unjust, but are also avoidable and unacceptable.

A vision of universal coverage drives health systems dedicated to the promotion of equity. Financing reform is one of the features of a health system moving towards universal coverage, with national or social health insurance being one of the reforms.

We have been grappling with the implementation of the social health insurance policy for quite some time now. The SHI system that we seek to implement has three (3) components, which are distinct but closely related. The first component is that of introducing mandatory participation and contribution in the medical schemes' environment so as to spread the financial risk and to address adverse selection phenomenon that exists as a result of the voluntary nature of the current market. The second component is aimed at preventing unfair exclusion of beneficiaries of schemes for accessing prescribed essential health care services. This component attempts to improve health related cross-subsidies by means of the risk

equalisation (REF) system between schemes. The third component encourages income-based cross-subsidies for essential health care services.

Tremendous effort has been done on the development and implementation of the system of risk equalisation between medical schemes, which will come into effect from 2007. The key challenge for us is, firstly, how to introduce employer or individual mandates for participation in the risk pooling framework given that the economy is expected to grow by 6% over the coming years, and secondly, how to convince all the stakeholders that in a country like ours, where income disparities, as measured by the Gini Coefficient, is at 0.59, that there is a need for income solidarity (wealthy cross-subsidizes the poor) within the medical schemes market. These two outstanding components need to be extensively discussed and accepted by all of us. Having said that, in the short to medium term, there are other issues that should be addressed in our health care system (both public and private) to ensure that our people can have access to affordable and good quality care, and this is regardless of whether we have the SHI in place or not.

Issues for discussion

Role of the private sector in promoting equity

- What role can the private health sector play in achieving equity? What should guide the practice of the private health sector to promote equity?

Role of the public sector in promoting health equity

- Within the public sector, how should limited public sector resources be allocated to achieve these principles? What other issues (other than equitable resource allocation decisions) should the government be concerned about/what other steps should be taken to promote equity within the public health sector?

HOSPITAL ISSUES

Public hospital expenditure constitutes the largest amount of the health budget. Delivering appropriate and affordable care is dependant on getting the right funding formula that promotes primary health care supported by an effective and efficient hospital system.

Our hospital system is hugely expensive and is plagued with many areas that are inefficient, with losses through wastage and theft. Building a strong Primary Health Care (PHC) system with an effective clinic and community health center base requires shifts of funding from Hospitals to primary care level without compromising our existing hospitals.

To do this, improvement in efficiency, reduction in theft and ensuring better outcomes are what provincial health department must focus on to ensure that increases in budgetary allocations are used to develop the primary care infrastructure. The key challenge facing provincial and hospital managers is strengthening and increasing PHC while protecting Hospitals.

Major challenges facing public Hospitals

Hospital revitalization programme

Public hospital stocks are varying states of disrepair. A facilities audit undertaken in 1996 showed that a third of institutions required replacement or major repair. Budget pressures impact negatively on ongoing maintenance with between 1%-1,5% of capital value being spend on regular maintenance of hospital infrastructure. This amount is far below the industry standard of 3% to 4.5% of capital value. Of concern is fact that the cost of upgrading and rehabilitation far exceed the funds available.

While the National Hospital Revitalisation programme in on track with significant allocations to provinces to upgrade and improve infrastructure, progress is slow. Provincial capacity to spend together with putting in place appropriate skills needs to be significantly scaled up.

Medical equipment

The ability to deliver quality care is seriously compromised due to problems with the deterioration of medical equipment. Further medical equipment is ageing and poorly maintained resulting in huge repair bills and ongoing machine down times contributing to longer lengths of stays with resultant increase in cost of care.

A key component to the ability to deliver cost effective care is reliable medical equipment. Quality postgraduate medical training required the latest available medical equipment to ensure we train competent specialists and sub specialist. The Modernisation of Tertiary Services Plan identified diagnostic radiology as a major bottleneck in improving efficiency in hospitals.

Proper investments in latest medical equipment also offer the possibility of reducing the unit cost of delivery expensive care. Unless expenditure levels and capital investments are addressed state of medical equipment will continue to deteriorate.

Management of Hospital services

Hospital managers are required to deliver efficient, more effective service and be more accountable in future. Hospitals consume a significant part of the provincial health budget. Understandably, better resource allocation and use at hospital level is a primary requirement of managers.

The Health MINMEC approved the following critical elements on decentralised management:

- Appointment of Chief Executive Officers (CEOs) with management skills and competencies.
- Introduction of general management structures in hospitals with professional and technically competent human resources, labour relations, financial, procurement, facilities and information management and technology managers.
- Development of modern, efficient management structures and systems.

- Delegation of substantial powers over Human resources management, finances, procurement and other critical management functions.

Delegation of authority to hospital CEOs has been identified as a Presidential priority during the State of the Nation address in 2006.

QUALITY OF CARE

The Department of Health's strategic framework identifies improvements in quality of care as one of the key challenges currently facing the health sector.

Measures to address the mal-distribution of resources are clearly vital preconditions for improved quality in South Africa. The inequities of the current health system are a critical matter of debate in this consultative forum and are covered in the financing section. This section focuses exclusively on dimensions of quality in facilities in order to concentrate discussion. Whilst central to the discussion on quality is the issue of human resources, this section will not cover those aspects, as it will be discussed by another group.

In summary, quality of health care in South Africa (both in the public and private sectors) faces a number of over-arching problems:

- 1 *Inadequate or absent data on quality* at facility and higher levels. Management information systems are poor. Process and outcome data are seldom collected and analysed at facility level, except in relation to specific initiatives. Very little is known on the private sector. This problem suggests that *quality management systems* in our health system as a whole are weak or absent. Managers at all levels are often more concerned with balancing budgets than ensuring quality of care, and frequently lack the skills to manage quality.
- 2 A distinction must be made between clinical quality, access and the "hotel" services. An analysis of patient complaints shows that patient concerns relate mainly to access issues and "hotel services". The include:
 - Poor hygiene in the institution
 - Long waiting times
 - Long waiting lists
 - Poor quality of food
 - Drug availability
 - Linen availability
 - Safety
- 3 *Lack of patient-centeredness in the public sector.* The most common complaint of public sector users is provider attitudes. Lack of respect and, at times, overt abuse of patients are universal complaints.

- 4 *Financial disincentives to effective and efficient quality in the private sector.* The private sector has a number of financial disincentives to quality. The fee-for-service, third payment system is internationally recognised as a major cause of inefficiency through over-servicing.
- 5 *Few or weak mechanisms of patient redress.* Efforts have been made to establish patient complaints mechanism. Nonetheless, ensuring the effectiveness of these mechanisms remains a challenge everywhere. Patient voices remain largely unheard and existing mechanisms are criticised for not resulting in clear and publicized action.

The key challenges to improved quality

Measures to address the mal-distribution of resources in the South African health care system are clearly important preconditions for improved quality.

Given the range of existing problems, the key challenges to improved quality in South African health facilities are:

- 1 *Change workplace cultures:* management styles need to shift from top-down, authoritarian approaches to more democratic practices, through greater shared decision-making, a focus on teamwork, a supportive rather than punitive approach to supervision, and an ethos of fairness and respect towards others whether subordinate or superior.
- 2 *Promote ethical practice:* in the public sector this means addressing patronage and corruption, and instituting clear and appropriate systems of reward and sanction. In the private sector this means addressing kickbacks and under or over servicing, through regulation, education and other measures.
- 3 *Establish routine and participatory monitoring and evaluation systems:* the collection, collation and analysis of quality data needs to happen at all levels: at facility, regional and national levels, and in both the public and private sectors.
- 4 *Quality management systems* need to be developed in facilities and managers trained in their use. Quality should become part of performance criteria.
- 5 Establish and strengthen *patient accountability mechanisms* to ensure that the whole health system is patient-centred, and so geared towards the joint production of health between provider and patient.

Questions for discussion

What are the key quality issues that should be focused on in the short term

How can patient voices and concerns be drawn more effectively into health care management?

How can data on quality in the private and public sectors be obtained?

Who are the key stakeholders to involve in improving quality in the public and private sectors?

PRIMARY HEALTH CARE SERVICES IN SOUTH AFRICA

Prior to 1994 there was extensive fragmentation and duplication of PHC services between all three spheres of government. The fragmentation and duplication between the national and provincial spheres was addressed and rapidly eliminated in 1994. However, the same was not done between the provincial and local spheres. PHC services are provided by all provincial departments of health in all municipalities and also by many municipalities. Generally, the provinces provide comprehensive PHC services while most municipalities provide a more limited range of PHC services. However metropolitan municipalities and some local municipalities that include cities also provide a more or less comprehensive range of services in some municipal facilities.

There are several problems with the current situation, which the Department of Health, in collaboration with other relevant departments, is trying to resolve.

The first issue is the inherited fragmentation and duplication of services. In some areas different PHC services are provided at different clinics. In other areas or for other services there is duplication. A municipality may render part of the package of PHC services and for the rest a patient will have to be referred to a provincial facility, and/or provincial and local authorities may provide overlapping packages of services to the same community.

A second issue how to ensure that funds currently provided for PHC services, whether by provinces or municipalities, remain available for PHC services when functions shift between the different authorities.

A third issue is that in South Africa, as elsewhere in the world, clinical practice is changing and this is changing the shape of the health services. Patients are spending shorter and shorter periods in hospital and then being referred to a PHC service. As a result, more and more clinical and financial responsibility is being transferred from hospitals to PHC services.

A fourth issue is how to ensure that municipal health services are adequately funded, particularly in rural areas.

A fifth issue is that of inter- and intra- provincial inequities in funding PHC.

POLICY DECISIONS, SHIFTS OF FUNCTION AND IMPLICATIONS

After wide consultation and after proposals had been endorsed by the Health and Local Government MINMEC meetings and approved by Cabinet, some of issues raised above have been resolved. Fragmentation and duplication must be eliminated, municipal health services

has been defined narrowly in the National Health Act, and the Minister of Provincial and Local Government has published a notice to the effect that the function of municipal health services will be with metropolitan and district municipalities.

In order to ensure that there is sufficient funding, that municipalities can fulfil new roles (especially district municipalities) and that service gaps do not appear (with very negative consequences for local communities) as a consequence of municipal health services being defined for the first time, it is vital that national, provincial and local government consensus is reached on these issues.

This means that the mechanisms to finance municipal health services and the other PHC services currently provided by local, district and metropolitan municipalities need to be agreed and actual budgets need to be negotiated.

At the same time it is necessary to consider the broader issue of financing primary health care services (of which municipal health services are a part).