

PRIMARY HEALTH CARE SYSTEMS (PRIMASYS)

Case study from South Africa

Abridged Version



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Primary Health Care Systems (PRIMASYS)

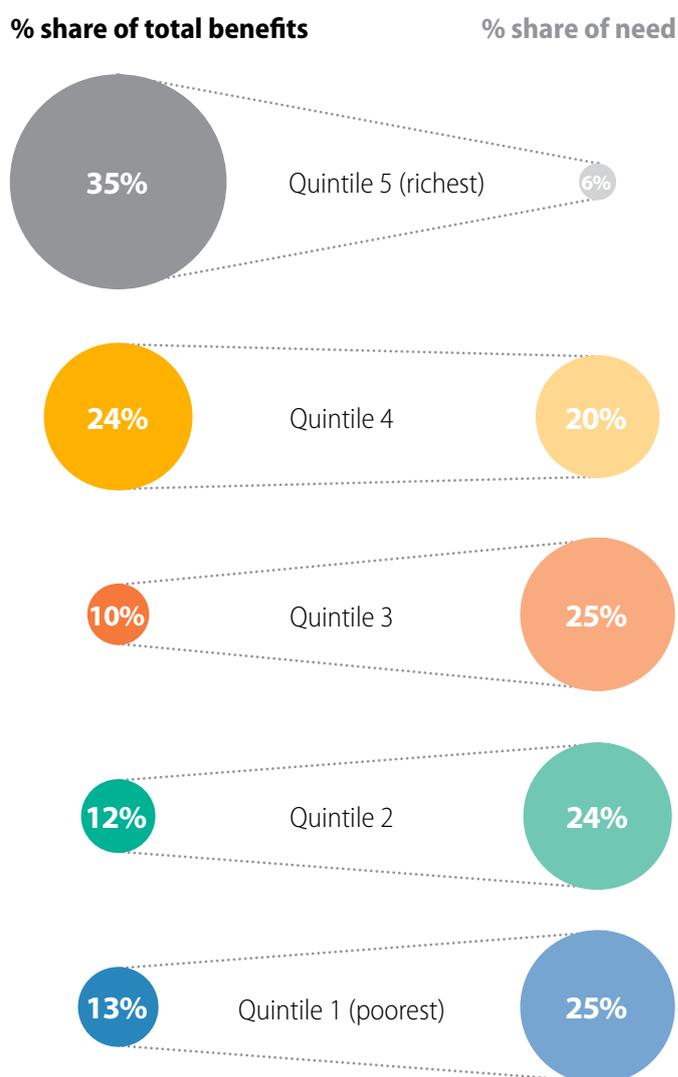
Case study from South Africa

Overview

South Africa is a middle-income country of around 55 million people, two thirds of whom live in urban areas. Public primary health care (PHC) is provided through a nurse-based, doctor-supported infrastructure of over 3500 clinics and community health centres, available within 5 kms to more than 90% of the population, and free at the point of use. It is supported by an emerging system of community-based outreach teams consisting of community health workers. This PHC system has enabled access to antiretroviral therapy (ART) to more than 3 million people, and reduced mother-to-child transmission of HIV to 1.5%. In parallel, primary care is also provided by private, fee-for-service general practitioners as well as traditional healers.

PHC progress has been achieved in South Africa despite a backdrop of significant health system, social and economic challenges. South Africa has one of the highest levels of income inequality in the world, with a Gini co-efficient of 0.69. In the health sector, these inequalities are visible as stark differences between two realities: A well-resourced, insurance-based private sector serving only 16% of the population, but consuming half the total funds flowing through the health sector in the country; and the tax-funded, public health system providing care for the remaining 84%.¹ The distribution of health benefits relative to need is still highly inequitable, as illustrated in the figure at right.

Figure 1. Comparing health benefits with health needs in South Africa (2008)



Source: Ataguba & McIntyre, 2012²

1 Department of Health. White Paper on National Health Insurance for South Africa. Pretoria: Department of Health, 2015.

2 Ataguba J.E and McIntyre D. Paying for and receiving benefits from health services in South Africa: is the health system equitable? Health Policy and Planning 2012;27:i35-i45.

South Africa also faces a formidable burden of disease, disproportionately impacting the poor. It has serious generalized human immunodeficiency virus (HIV) and tuberculosis (TB) epidemics, a rapidly growing burden of noncommunicable diseases (NCD), high rates of injury and violence, and still unacceptably high levels of maternal and child mortality. The HIV epidemic has had a particularly devastating effect on the health system and on society at all levels, including a rapid decline in life expectancy, overwhelming health care needs, and social and political crises. A concerted national response over the past decade, including a programme of universal access to ART, has reversed

some of these impacts (e.g. rising life expectancy) and stimulated broader health system strengthening (e.g. increased staffing of PHC facilities) but only recently has there been a shift in focus to other health care needs (e.g. NCDs). However, there is general consensus that despite a high overall proportion of gross national income (8.6%) spent on health, health outcomes are poor. The key issues facing the health sector are the redistribution of resources within the sector, improving the functioning of the public health system, and addressing the social determinants of ill-health, which have their roots in poverty and inequality.

Table 1. Indicators

Indicator	Results	Year	Source
Population	55 million	2015	Stats SA ³
Distribution of the population	64% urban	2015	http://data.worldbank.org/indicator
Life expectancy at birth (years)	53.5	2005	Stats SA ³
	62.5	2015	
Under 5 mortality (per 1000 live births)	79.1	2005	Stats SA ³
	45.1	2015	
Maternal mortality in facility ratio (per 100,000 live births)	160.0	2010	HSTa ⁴
	132.5	2014	
HIV infected population (%)	6.2 million (11.2%)	2015	Stats SA ³
Total health expenditure as % of GDP	8.6%	2015	NDOH ¹
Public expenditure as % total health expenditure	48.3%	2015	NDOH ¹
% of total provincial public sector expenditure on District Health Services	46%	2015	HSTb ⁵
% total provincial public sector expenditure on PHC	26%	2015	HSTb ⁵
Per capita provincial expenditure public sector expenditure on PHC	US\$60	2015	HSTb ⁵
Physicians registered (per 1000 population)	0.93	2014	HSTb ⁵
Nurses registered (all categories, per 1000 population)	6.1	2014	HSTb ⁵
Number on anti-retroviral therapy	3.1 million	2015	NDOH ⁶
Mother-to-child transmission of HIV at 6 weeks	1.5%	2015	NDOH ⁶
Immunisation coverage under 1 year (including pneumococcal & rotavirus)	70%	2015	UNICEF/WHO ⁷
TB cure rates (new smear-positive cases)	80%	2014	HSTa ⁴

3 Statistics South Africa. Mid-year population estimates 2015. Statistical Release P0302. Pretoria: Statistics South Africa, 2015.

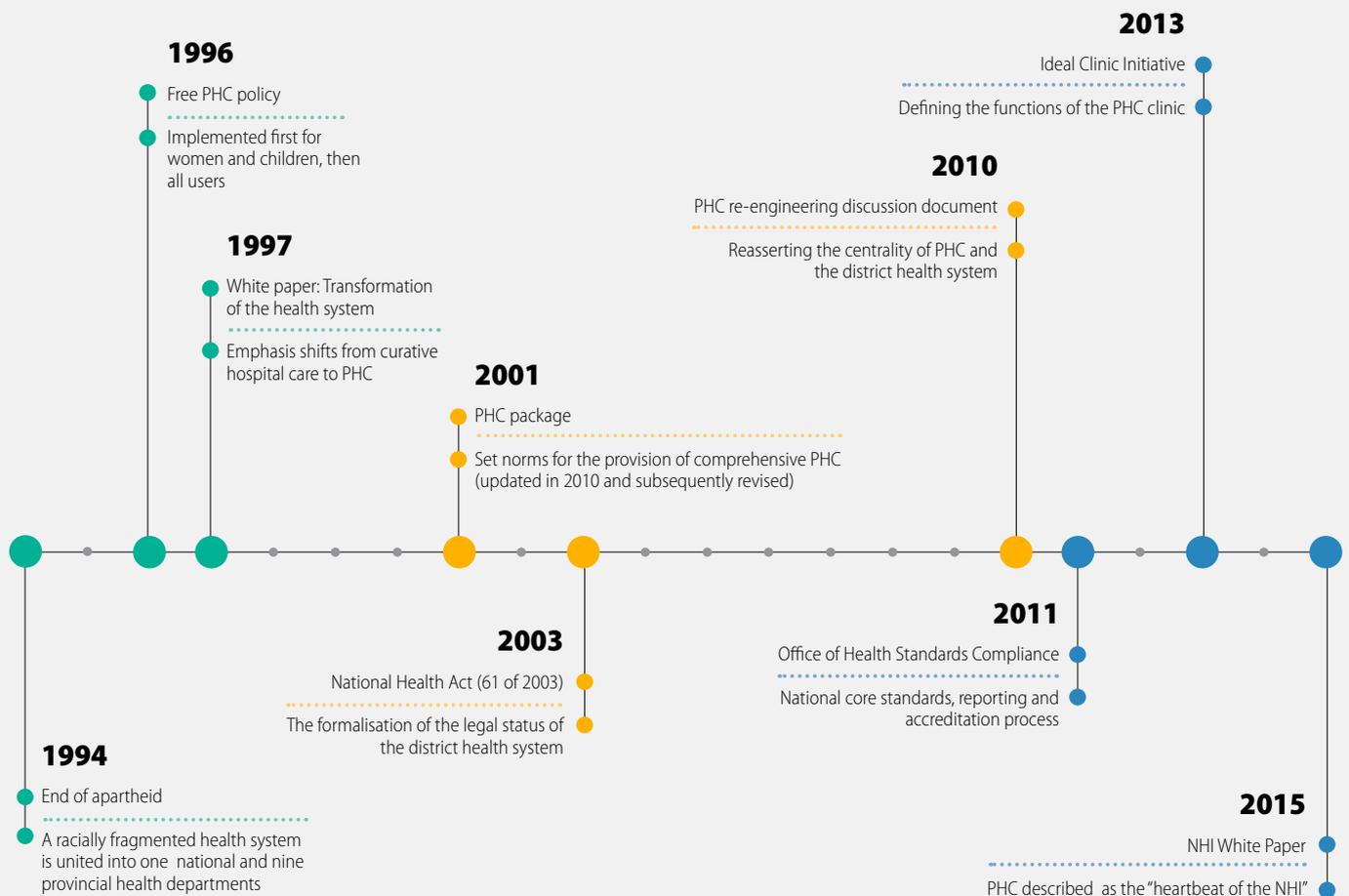
4 Massyn N, Peer N, Padarath A, Barron P, Day C, editors. District Health Barometer 2014/15. Durban: Health Systems Trust, 2015.

5 Padarath A, King J, English R, editors. South African Health Review 2014/15. Durban: Health Systems Trust, 2015.

6 Department of Health. Annual Report 2014/15. Pretoria: Department of Health, 2015

7 UNICEF/WHO. Countdown to 2015: A Decade of Tracking Progress for Maternal, Newborn and Child Survival The 2015 Report. New York: UNICEF/WHO, 2015.

Timeline



Since the advent of democracy in 1994, key policy statements such as the *White Paper for the Transformation of the Health System* (1997),⁸ and the *National Health Act* (2003)⁹ have placed primary health care (PHC) at the heart of the transformation of South Africa's national health system. South Africa is a signatory to the 2008 *Ouagadougou Declaration on Primary Health Care and Health Systems in Africa*, which commemorates the 30th anniversary of the *Alma Ata Declaration on Primary Health Care*.¹⁰ In 2010, the Department of Health adopted the national PHC re-engineering strategy¹¹ seeking to strengthen, amongst others, community-based and

preventive strategies. A commitment to PHC is further entrenched in the recently released *White Paper on National Health Insurance*.¹ Since 1994, there has been a clinic building and upgrading programme involving 1500 facilities,¹ and a considerable expansion of resources and entitlements through, and utilisation of, the PHC system. In 1998, there were 68 million visits (1.6 visits per capita) to PHC facilities; by 2015 this had risen to 120 million visits (2.2 visits per capita). These reforms have been implemented with other measures by the state to address absolute poverty – a large programme of social grants (reaching 16 million people), and expanded access to water, sanitation, electricity and housing.

8 Department of Health. *White Paper on the Transformation of the Health System in South Africa*. Pretoria: Department of Health, 1997.

9 National Health Act, No. 61 of 2003. Pretoria: Government Gazette, no. 26595, 2014

10 Ouagadougou Declaration On Primary Health Care And Health Systems In Africa: Achieving Better Health For Africa In The New Millennium, WHO/AFRO, 30 April 2008.

11 Department of Health. *Re-engineering primary health care in South Africa: Discussion document*. Pretoria: National Department of Health, 2010.

Governance and architecture

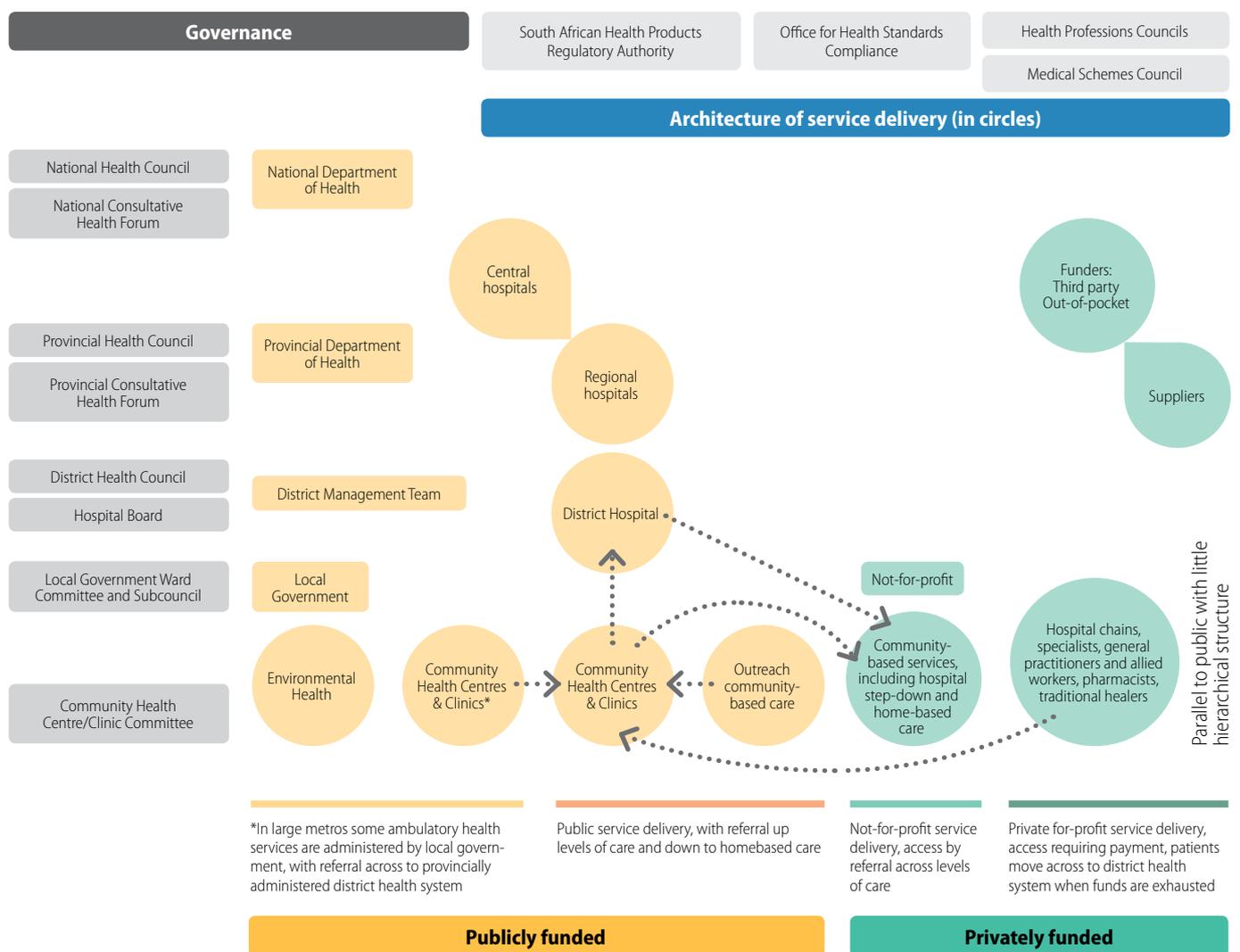
The health system consists of the national Department of Health, nine provincial health departments and 52 health districts. In South Africa's quasi-federal political system, the national sphere sets overall policy and frameworks, and provincial and local authorities are responsible for implementation. The provincial sphere has the main responsibility for service delivery, including PHC and the district health system, while local authorities provide environmental health services. In some metropolitan areas, they also provide clinic-based PHC in parallel to that of the provinces.

Frameworks for financial and performance accountability are provided nationally, and include systems of budgeting, planning and accounting, including reporting on a set of core national indicators. Public accountability is through

statutorily mandated councils and consultative fora at various levels, hospital boards and clinic committees. In practice, however, these structures are very unevenly constituted. Key regulatory bodies include the Medicines Control Council, which in due course will become the South African Health Products Regulatory Authority (manufacture, registration, distribution and pricing of medicines), health professions councils (training and professional registration), the Office of Health Standards Compliance (facility accreditation in private and public sectors), and the Medical Schemes Council (regulating private health insurance).

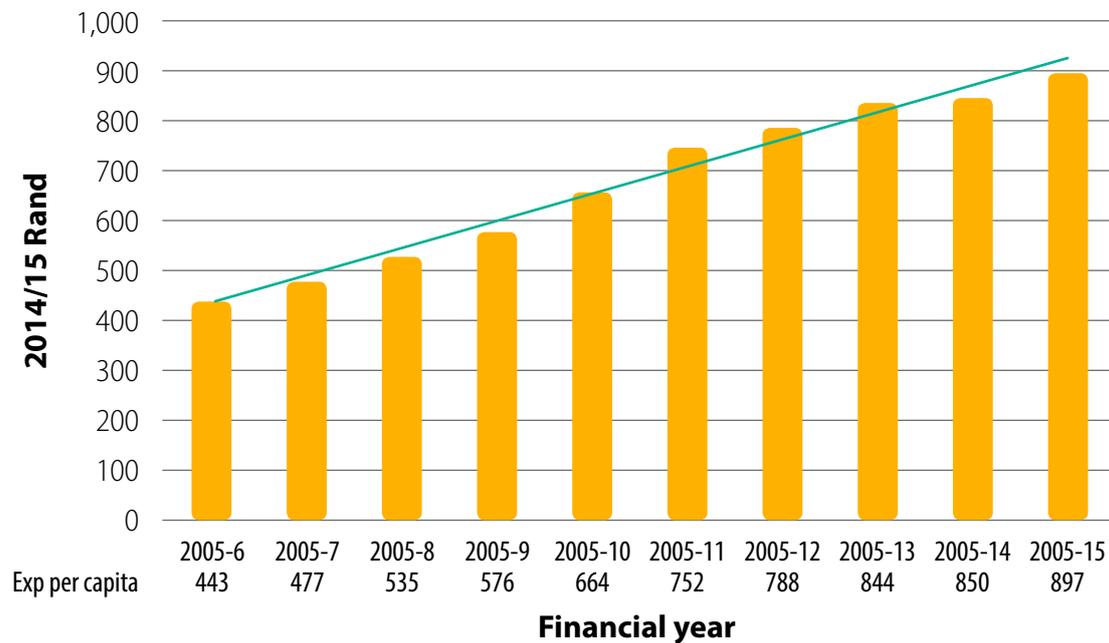
Figure 2 provides a summary of the official health system architecture and governance mechanisms.

Figure 2. Governance and architecture of South Africa's health system



Financing

Figure 3. General government expenditure on PHC services per capita 2005/6–2014/15 (real 2014/15 prices)



Source: HSTa⁵

Over the past ten years, there has been a doubling of expenditure (in real terms) on public sector PHC from R443 (US\$27) in 2005/6 to R897 (US\$56) in 2014/15. This is in large part due to a rapidly expanding programme of access to HIV treatment, integrated into the PHC system through the nurse-initiated management of ART (NIMART). Since 2009, 24,000 nurses have been trained as part of the NIMART scheme.

Government revenue is collected nationally and redistributed to provinces in the form of block grants (the so-called 'equitable share' based on a formula that is generally dependent on population size), which are then allocated to sectors, including health. Certain funds, notably for the HIV/AIDS and tuberculosis (TB) programme are ring-fenced nationally and transferred as conditional grants. Private sector funding flows through a fragmented system of 83 individual medical schemes. The *National Health Insurance White Paper* outlines proposals to pool these resources with the tax-funded base into one National Health Insurance (NHI) fund that will ensure more equitable distribution of resources across the country. However, the NHI White Paper is written very generally

and still requires elaboration in many areas. The NHI fund will purchase PHC services from service providers (public or private) able to ensure comprehensive (i.e. preventive, promotive, curative and rehabilitative) provision for geographically-defined populations. The role of district, provincial and national authorities in the purchasing and contracting of services is currently being further defined. Increasing investment in, and strengthening the quality of, the public health system is a first step.

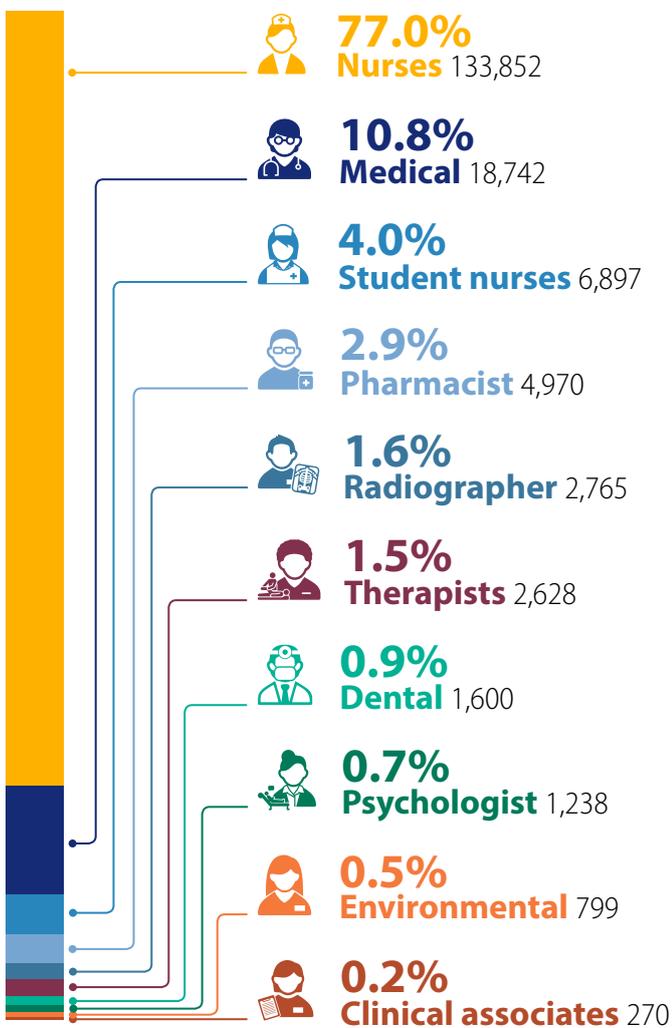
Overall, donor funds form a small proportion of the total budget, at less than 5% of total public health sector expenditure. However, they do have a significant presence in the HIV/AIDS programme, making up one third of spending. Public PHC services are free at the point of use (a policy implemented first in 1994 for pregnant women and children and then universally in 1996). Out of pocket payments are relatively small – 7% of total health expenditure, although this does not take into account the costs of utilizing health services (mainly transport), especially for chronic conditions.¹²

¹² Cleary S, Birch S, Chimbindi N, Silal S, McIntyre D. Investigating the affordability of key health services in South Africa. *Social Science and Medicine* 2013; 80:37–46.

Human resources

Nurses are by far the largest category of health workers in South Africa. Of the 173,761 health professionals working in the public health system in 2015, 77% were nurses, 11% were doctors (generalists and specialists), and the remainder distributed between other cadres – pharmacists, dentists, therapists, psychologists and environmental health practitioners (Figure 4).⁵ Nurses form the backbone of PHC in South Africa, and are made up of three cadres – professional nurses (4 years training), enrolled nurses (2 years training), and nursing assistants (1 year training). Initiatives to train mid-level cadres for the other professions exist, but are still at early stages of development, and are not yet part of the mainstream thinking in health professional development.

Figure 4. Distribution of personnel in public health system



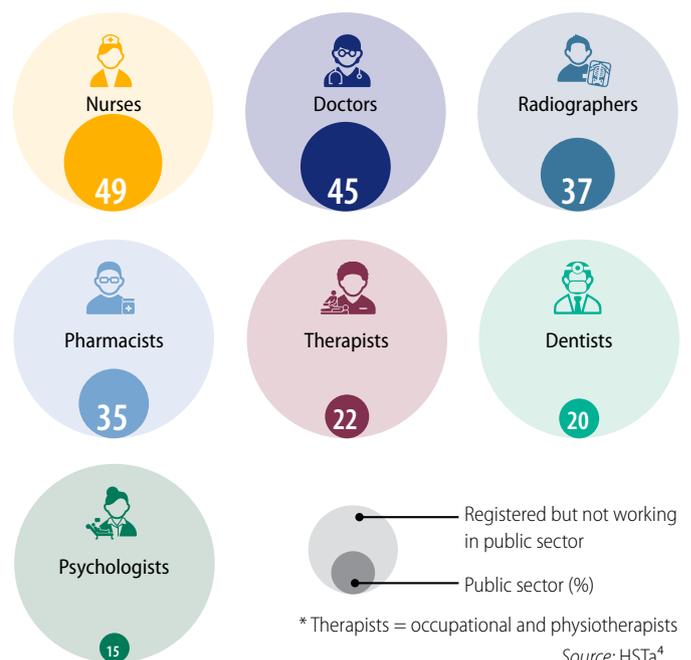
Over the past 15 years there has been a rapid growth in lay health worker involvement in the health sector, largely to support the HIV/AIDS programme, and deployed through a system of nongovernmental organisation contracting.

In 2011, a national audit¹³ counted more than 72,000 such workers, fulfilling both community- and facility-based functions. The *PHC Re-engineering Strategy* seeks to integrate, formalize and strengthen this infrastructure into a system of 'ward-based outreach teams' (WBOTs) comprising community health workers (CHWs) and a nurse team leader closely associated with the local PHC facility. The WBOTs are intended to proactively engage households and communities, and address health needs comprehensively. A nationally accredited curriculum for CHWs has been developed and a monitoring and evaluation system through the district health information system (DHIS). By 2014/15, nearly 3000 teams had been established out of a total of 4200 electoral wards (68% coverage), although less than half (41%) were reporting data through the DHIS.

There are large inequities in the distribution of personnel between public and private sectors. Of the 41,000 doctors registered with the Health Professions Council in 2014, less than half (45%) worked in the public sector (Figure 5).⁴

Three different bodies regulate the health professions in South Africa: the Nursing Council, the Pharmacy Council and the Health Professions Council (grouping a number of professionals). The consensus is that, despite numerous proposals and task teams, there is still a disconnect between health needs/policies and the orientation of professional training, which is heavily curative and hospital-centric.

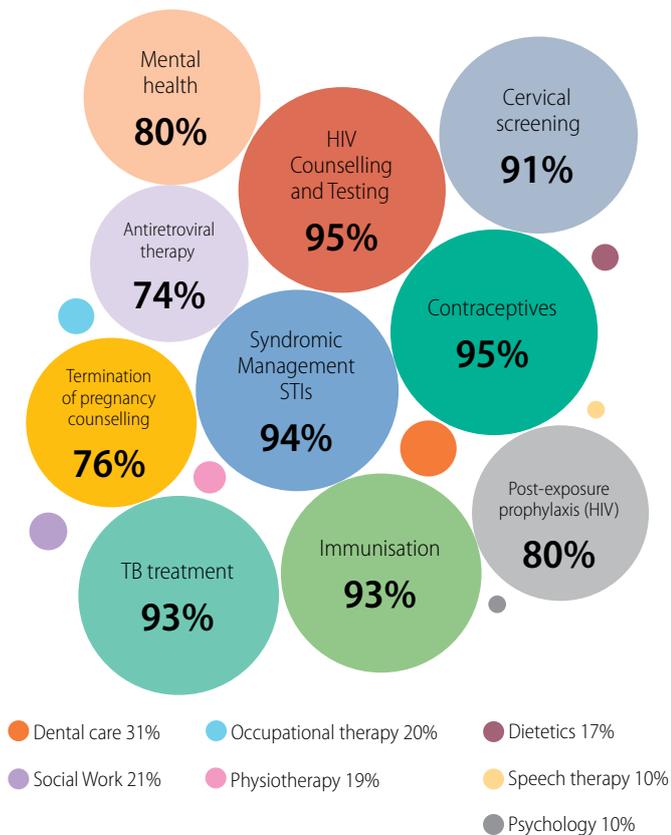
Figure 5. Percentage of total registered health professionals working in the public sector in 2014



13 National Department of Health. CHW Audit Report – Draft 1. Pretoria: Department of Health, 2011.

Appropriate and responsive services

Figure 6. Availability of services in PHC facilities 2011/12



Source: HSTc¹⁴

A National Health Facility Audit in 2011/2012,¹⁴ drawing on the *National Core Standards*, assessed nearly 3500 public PHC health facilities across the country. Although a basic package of services was almost universally available, access to dental and therapeutic services, for example, was still low (Figure 6).

Using a combination of patient interviews, observations and document reviews, the audit found that only 25% of PHC facilities met the assigned standards for “positive and caring attitudes”. These challenges are underpinned by significant issues of staff morale and burnout, and weak leadership and management capacity at the frontline of delivery.¹⁵

The ‘Ideal Clinic’ initiative is a recently instituted comprehensive intervention seeking to improve the quality of PHC, with a wide-ranging focus on staffing norms, monitoring of infrastructure and resourcing, and responding to staff needs.

Community participation

In South Africa, the value of community participation and accountability as one of the central components of a PHC approach is highlighted in legislation, policy documents and strategic plans. Clinic or health facility committees (HFCs) have been identified as the principal organizational arrangement through which this occurs. However, the last national assessment of HFCs, conducted in 2003, found that a committee existed in only three out of five facilities in the country with only 35% of these structures reportedly having met recently.¹⁶ Factors that have been identified as impacting negatively on HFCs’ successful functioning include:

- a lack of political commitment, co-operation and support from the health services;
- the limited participation by facility managers and local government councillors in such structures;
- the negative attitude of health workers towards committees and their members;
- a general lack of resources;
- the limited capacity and skills of committee members;
- lack of clarity about the role and mandate of committees.

Monitoring and evaluation

The PHC system is supported by a well-established District Health Information System (DHIS), which was developed and trialled in a bottom-up fashion from the mid-1990’s, and rolled out to the rest of the country from 2002, with support from a national non-governmental partner. Since 2004, the data have been reported annually in the *District Health Barometer*.⁴ A sub-committee of the National Health Council – the National Health Information Systems Committee of South Africa – defines and reviews a National Indicator Data Set for routine reporting by provincial and district authorities. Data sources from the DHIS and other sources (e.g. surveillance, population surveys, management information) are integrated in a National Health Information Repository and Database (<http://dd.dhmis.org/index.html>), and made available to managers. Steps are also being taken to develop the information technology (IT) infrastructure of PHC facilities, to enable the implementation of the electronic patient registration and record systems required for NHI.

14 National Health Care Facilities Baseline Audit, National Summary Report, Health Systems Trust, revised February 2013.

15 Wilson T, Davids S, Voce A. Frontline managers matter: Wellness for Effective Leadership. In: Padarath A, King J, English R, editors. South African Health Review 2014/15. Durban: Health Systems Trust; 2015.

16 Padarath A, Friedman I. The status of clinic committees in primary-level public health sector facilities in South Africa. Durban: Health Systems Trust; 2008.

Way forward and policy considerations

Going forward, the key priorities for primary health care in South Africa are as follows:

- Addressing the large burden of disease through a much stronger focus on health promotion and wellness, and concerted action on upstream factors, including through national/local inter-sectoral action on social determinants of health;
- Linked to this, developing the capacity of communities to engage meaningfully with the health sector through formal and informal mechanisms of participation and enhanced community-based services;
- Strengthening the uneven District Health System in South Africa, including defining the roles, functions and capacity required of the District Health Authority that forms the core governance structure of the future NHI;
- Strengthening the human resource base of PHC: ensuring that the training curricula of PHC cadres (especially nurses) are re-oriented towards PHC; expanding the PHC team to include rehabilitation therapists and other cadres; reviewing and developing policy on mid-level cadres; formalizing the status and conditions of employment of community health workers; and developing the management and leadership capacity of front-line managers;
- Translating the innovations from the HIV and TB programmes – particularly in relation to adherence support, community-based follow-up, monitoring, quality assurance, and resource mobilization – into other programme areas and the PHC system as a whole;
- Underpinning the above, better systems of accountability – to communities, for performance and use of resources – at all levels.

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