SOUTH AFRICA’S MOVE TOWARDS UNIVERSAL COVERAGE

Challenges & Lessons Learnt

HEALTH SYSTEMS RESEARCH SYMPOSIUM
Beijing, CHINA
Director-General, National Department of Health
31st OCTOBER 2012
South Africa

- Middle-income: $10,360 GDP pc (PPP)
- Population over 50 million (>60% urban)
- High inequality (Gini-coefficient 0.63)
- Life expectancy 60 years (2011)
- High burden of disease
  - HIV & AIDS and TB (over 30%)
  - Maternal, new-born & child
  - Non-communicable
  - Violence, trauma & injuries
- ± 4,000 public sector facilities
- ± 27,000 independent practitioners
**Increasing Life Expectancy & Reducing U5M & IMR**

### LIFE EXPECTANCY AND ADULT MORTALITY (OUTPUT 1)

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>TARGET 2014</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth: Total</td>
<td>58.5</td>
<td>56.5</td>
<td>58.1</td>
<td>60.0</td>
</tr>
<tr>
<td></td>
<td>(Increase of 2 years)</td>
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### MATERNAL AND CHILD MORTALITY (OUTPUT 2)

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>TARGET 2014</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-5 mortality rate (U5MR) per 1 000 live births</td>
<td>50</td>
<td>56</td>
<td>53</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>(10% reduction)</td>
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</tr>
<tr>
<td>Infant mortality rate (IMR) per 1 000 live births</td>
<td>36</td>
<td>40</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>(10% reduction)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal mortality rate¹ (&lt;28 days) per 1 000 live births</td>
<td>12</td>
<td>14</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>(10% reduction)</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>TARGET 2014</th>
<th>2008*</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio² (MMR) per 100 000 live births</td>
<td>270</td>
<td>310</td>
<td>333</td>
</tr>
<tr>
<td></td>
<td>(Reverse increasing trend and achieve 10% reduction)</td>
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</tbody>
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Approaches to reform

• Guiding principles
  – Equity
  – Access
  – Affordability
  – Accountability & transparency

• Pillars of reform
  – Financing
  – Service provision
  – Governance
  – Institutional arrangements
Financing

• Health spend is 8.3% of GDP
  – 4.1% in the private sector for 16.2% of the population
  – 4.2% in the public sector for 84% of the population

• Move to universal NHI
  – Single fund entity
  – Sources (tax, pay-roll, innovative financing)

• Focus on:
  – Equity
  – Reduced fragmentation
  – Decentralization
Service Provision (1)

• Current challenges
  – Public: comprehensive services, limited access
  – Private: Variable benefit options linked to price
  – Hospital centered delivery

• Pockets of excellence

• Move to Primary Health Care to address
  – Social determinants
  – Burden of disease (MMR, IMR, TB/HIV, NCDs)
  – Improve quality of services in hospitals
Service Provision (2)

Decentralised services based on district health model
- Ward based municipal PHC teams
- District specialist teams
- School health services
- Private GPs

- Quality
  - Office of Health Standards Compliance
  - Quality audits of all facilities
  - Quality Improvement teams

- Academy for Leadership & Management
  - Competencies of all CEOs & District managers
  - Standards & accreditation

- Human Resources for Health Strategy
  - WHO norms & standards
Legislation

- Reviewing laws with implications for NHI
- Compliance with Constitution

- Enabling legislation eg:
  - Health service tariffs
  - Quality (Office of Health Standards & Compliance)
  - District Health Authorities
Governance

• Devolved decision making
• Stakeholder participation
• Accountability at all levels
  – District Health Authorities
  – Hospital boards
  – Exploring Hospital Trusts
  – Exploring NHI Fund
• Challenges include:
  – relationship with medical (insurance) schemes
Institutional Arrangements

• Three new institutions
  – Single NHI funder, publicly administered
  – Office for Health Standards & Compliance
  – Public Health Institute

• District structural reforms
  – Separate purchaser & provider functions
  – Strengthen districts (Contracting, planning, M&E, Delegated Finances, HR, Procurement, SCM)
  – ‘Autonomous, accountable providers’
NHI Pilots: Objectives

1. To assess the ability of districts to assume greater responsibility with a ‘purchaser-provider split’
2. To assess the feasibility, acceptability, effectiveness and affordability of engaging the private sector
3. To assess the costs of introducing a fully fledged District Health Authority and implications for scaling-up.
Key Lessons

• Political will and oversight

• Stakeholders: proactively engage and encourage with participation

• Universal coverage an unwavering objective: health is a public good; social justice, equity and fairness as basis for reform

• ‘Hardware’ (infrastructure, HR etc) AND ‘software’ (culture, leadership) both critical

• Move from voluntary prepayment & OOPs to mandatory prepayment

• Not a one-size fits all set of reforms
Every country is unique....

.....Every reform is different

Thank You.