Business Day

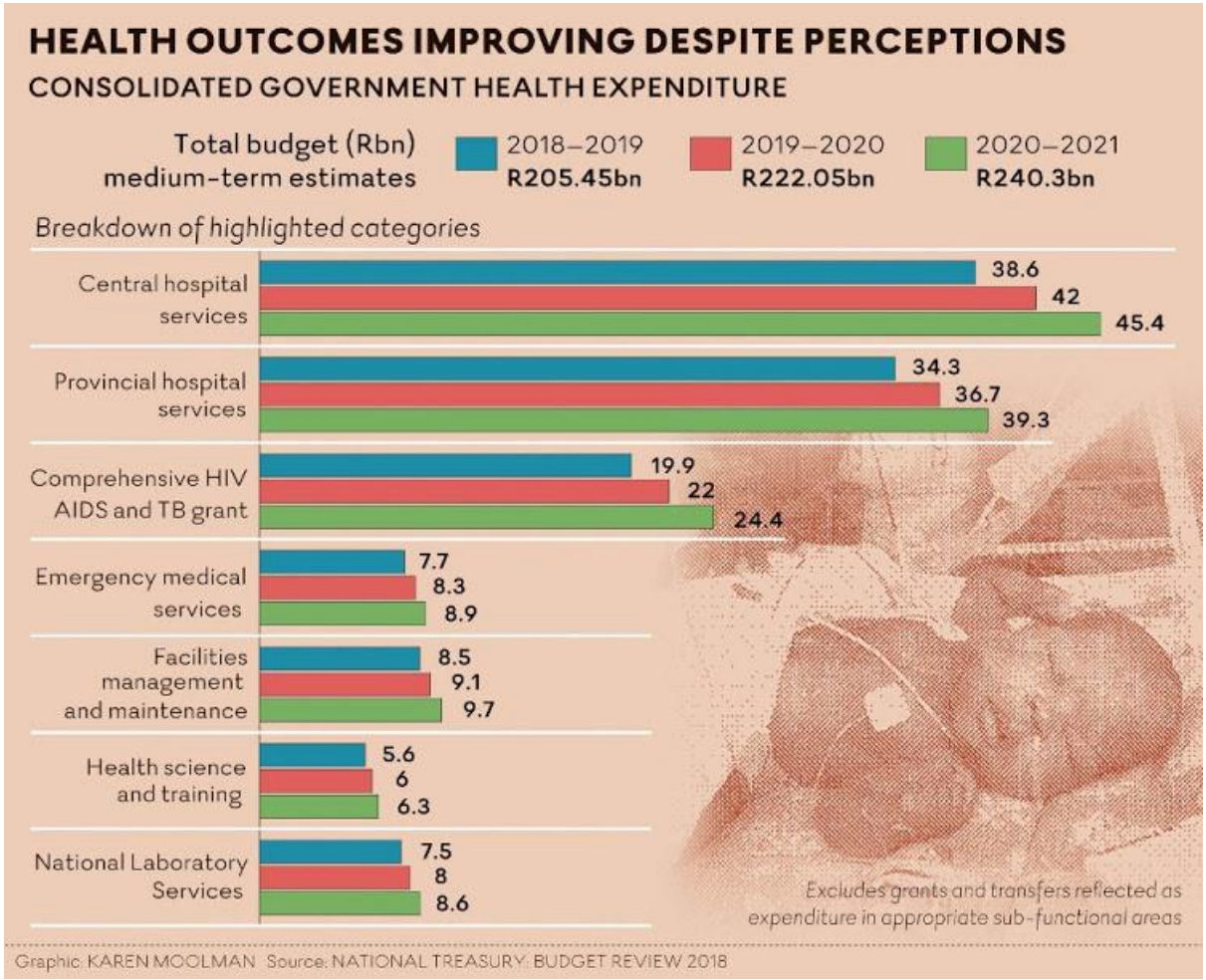
Challenges facing healthcare system are structural rather than clinical

26 JUNE 2018 - 05:07 EDDIE RAKABE

Healthcare services in SA are set to undergo drastic reforms with the recent promulgation of the long-awaited National Health Insurance (NHI) Bill and Medical Schemes Amendment Bill. These reforms are meant to address what has seemingly become a national outcry over inefficient public healthcare services and inaccessible private healthcare.

Accessing quality health services is nigh on impossible for many South Africans as they have to contend with generally poor services in the public sector or unaffordable medical bills from private health facilities.

Public health facilities remain the only option for the more than 42-million citizens who do not have private health insurance, who are evidently growing more ill by the day. SA has the highest level of HIV prevalence in the world, TB remains the leading cause of death and lifestyle diseases are on the rise.



It is not as if health authorities are sitting idle: they are continuously waging a seemingly losing battle to reduce the disease burden on the policy, clinical and financing fronts. It remains to be seen whether the extensive NHI reforms can turn the tide against deteriorating health outcomes.

The health sector derives its mandate from multiple policies that, among other things, outline plans to tackle the broader clinical and systemic challenges engulfing the system, and to improve national health outcomes.

Most notably the 10-point health plan lays out a comprehensive healthcare delivery improvement agenda straddling improvements in stewardship, quality and delivery efficiency, augmenting capacity and expertise, rolling out an NHI scheme and information management system and stemming the tide of a burgeoning disease burden.

On the financing front, the health sector has received no less than R1-trillion over the past decade, growing from an annual budget of R86bn in 2009 to just over R205bn in 2018. A combination of these policy and financial inputs has produced many commendable outputs and outcomes, though not many will admit this.

Despite waning perceptions of public health, the system accommodates more than 10-million primary healthcare visits a year for a myriad of health cases, including delivering more than 90% of new births in SA. Just more than 14-million people were tested for HIV in 2016, and among those infected by the virus 4-million receive the necessary drugs for treatment. This public-driven intervention has resulted in a gradual decline of HIV incidences, in particular mother-to-child transmission and AIDS-related deaths.

Similarly, public healthcare interventions are at the centre of improved TB treatment and a cure rate that has improved from 54% in 2000 to 80% in 2016. Most importantly, SA's overall health outcomes are improving as a result of concerted clinical and health system interventions. Both infant and child mortality rates have been markedly reduced but remain high by the standards of peer developing economies, while life expectancy has increased from below 50 years in 2006 to 66 years in 2016.

These outcomes clearly suggest that things are not out of control.

The hallmark of a great public health system is, however, not always in grandiose achievements at the national scale but rather the individual patient's lived and perceived experiences when coming into contact with public healthcare facilities. Patient experience is an integral part of quality health and is concerned with what the patient values when seeking or receiving services.

A good and responsive public health system is one that is able to make services available when needed, instead of keeping patients on long waiting lists (for treatment, diagnoses and even hospital admission). Equally, patients need assurance

that their prescribed medication will be available when needed, that their wards, bed linen and ablution facilities will be clean and safe from infections, and most importantly that healthcare professionals will treat them with respect and dignity.

SA's record on patient experience is uninspiring and the health authorities fall short in their job of monitoring this area. Anecdotes of poor patient experiences are rife, with the health ombudsman, the office of health standards compliance and the media reporting horrifying stories of patients sleeping on hospital floors or being unable to receive critical surgical treatment due to a shortage of doctors, medical supplies and equipment failure, or a lack thereof.

Surprisingly, the public outcry over the quality of healthcare delivery has been muted, with the exception of a few union-led protests. South Africans are well known for expressing their displeasure over poor public service through protest action, but public healthcare has largely been spared. This surprising response partly reflects the individualised attributes of the health service and the fact that the overall unpleasant experience is not restricted to a specific interest group or community. Rising medical legal claims are perhaps the single largest indicator of a concerted public campaign against the deteriorating healthcare service.

Even so, in the absence of hard evidence about patient experience, there is little by which to verify the claims of a failing health system and measure the performance of the system in its totality. Much of the uproar has relied on information snippets churned out by civil society organisations, the media and independent oversight agencies within the health sector.

This is not to say that the public healthcare system does not face serious challenges, or that the ongoing criticism of it is unwarranted.

Serious indictment

On the contrary, the recent takeover of the provincial health department in North West by national government and similar action in Limpopo and Gauteng in the past are a serious indictment on the sector.

But closer scrutiny suggests that the problem is not so much about clinical ineptitude as deficiencies in the bureaucratic machinery underpinning the delivery of public health services.

The institutional and organisational machinations of public healthcare are weak in the exercise of delegations, accountability and setting out connections of responsibility in the delivery chain. Provincial health departments have been generally reluctant (sometimes for good reason) to delegate managerial, procurement and financial responsibilities to healthcare facilities.

As a result, provincial health departments find it difficult to hold facilities accountable and facility managers find it easier to shift responsibility for poor services.

Similarly, the national health minister is unable to hold provincial departments accountable because of concurrency complexities and the absence of regular performance monitoring to enable effective oversight and timely intervention when delivery is failing. These institutional deficiencies inadvertently affect clinical operations and usually manifest as budget limitations.

Achieving a clean bill of health for public healthcare will require more than placing provincial health departments under administration. What is required is comprehensive business process re-engineering in the delivery of healthcare, linking outputs from the level of community health worker up to a national minister. Without these reforms even worthy causes such as the NHI will struggle to take off.

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