HASA 2022 CONFERENCE

RESILIENCE THROUGH COLLABORATION

COLLIDING CRISES: A CALL TO ACTION

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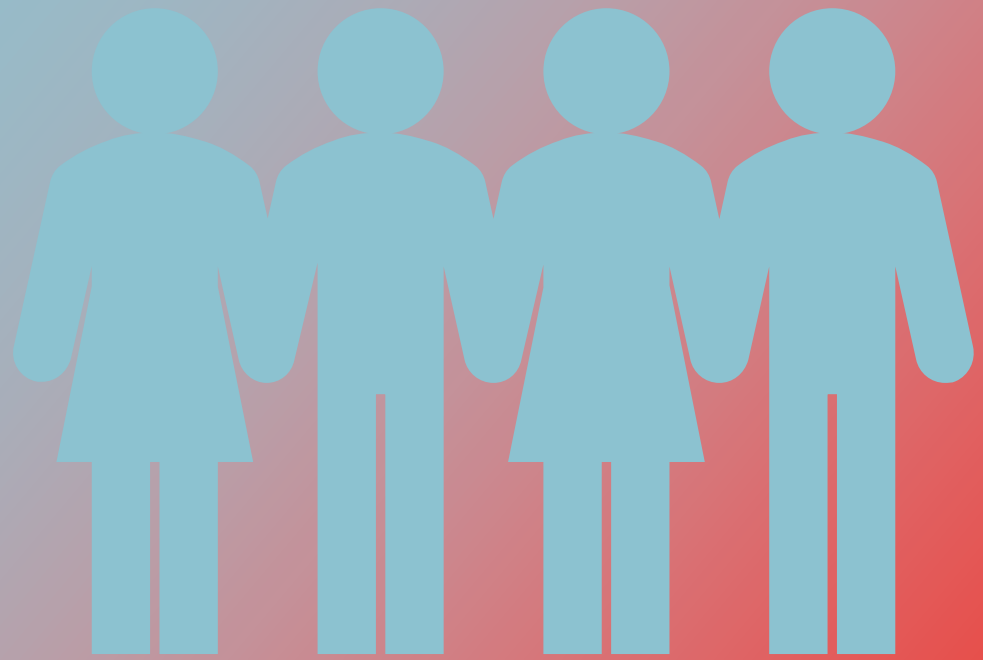
A tale of two crises.

The HRH Crisis

- Dire shortage of some specialties
- Maldistribution of doctors geographically and between public and private sectors
- Disjoint between training platforms and service delivery platforms

The figure illustrates the number of full-time equivalent specialists per 100,000 population across the public (7) and private (69) sectors, and relative to international benchmarks.



The NCD public health emergency

- Epidemiologic transition
- Lifelong nature of NCDs
- High and inter-related burden in SA
- Disproportionate burden

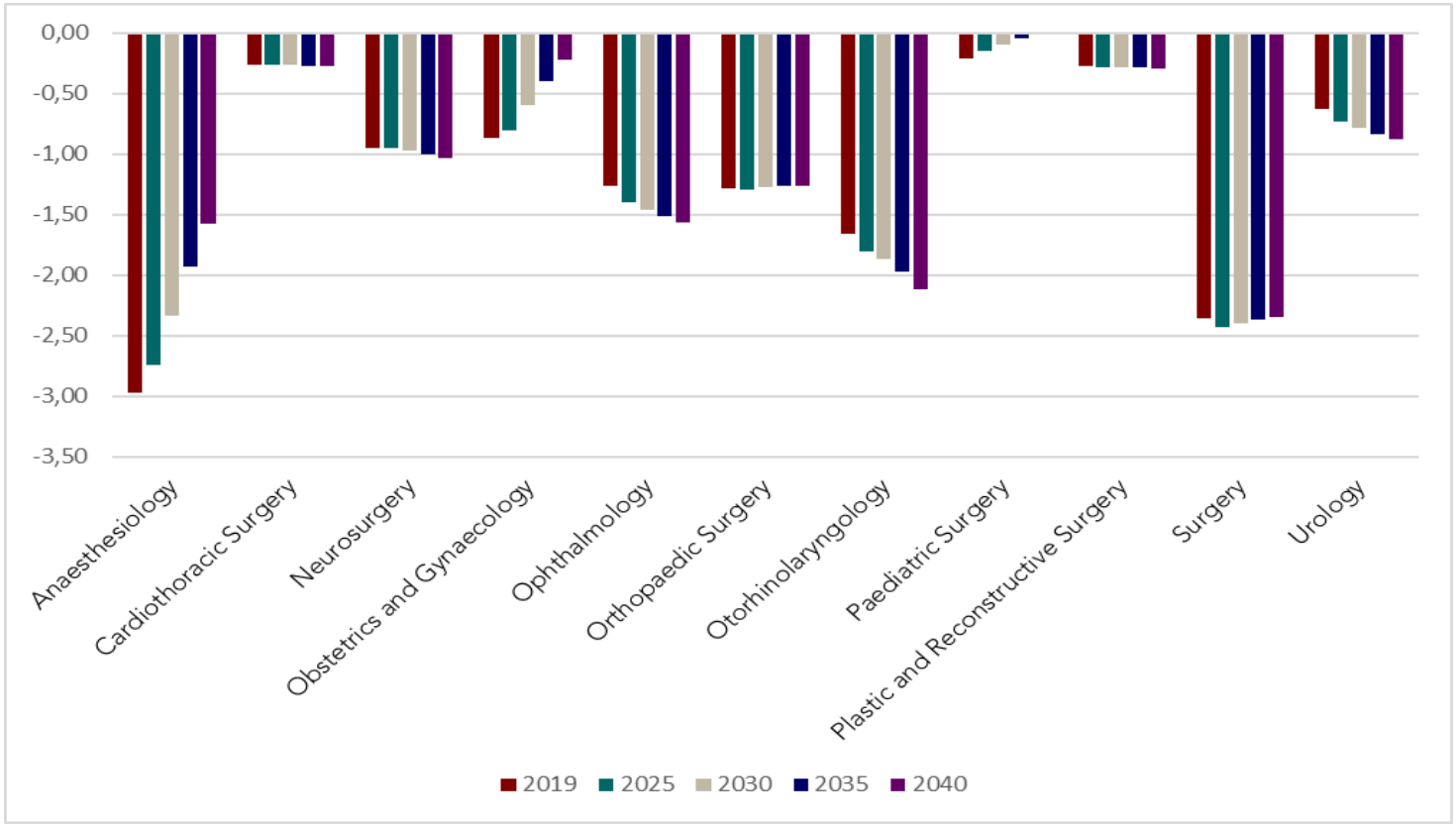
With an alarming trajectory

The prevalence of NCDs is on the rise

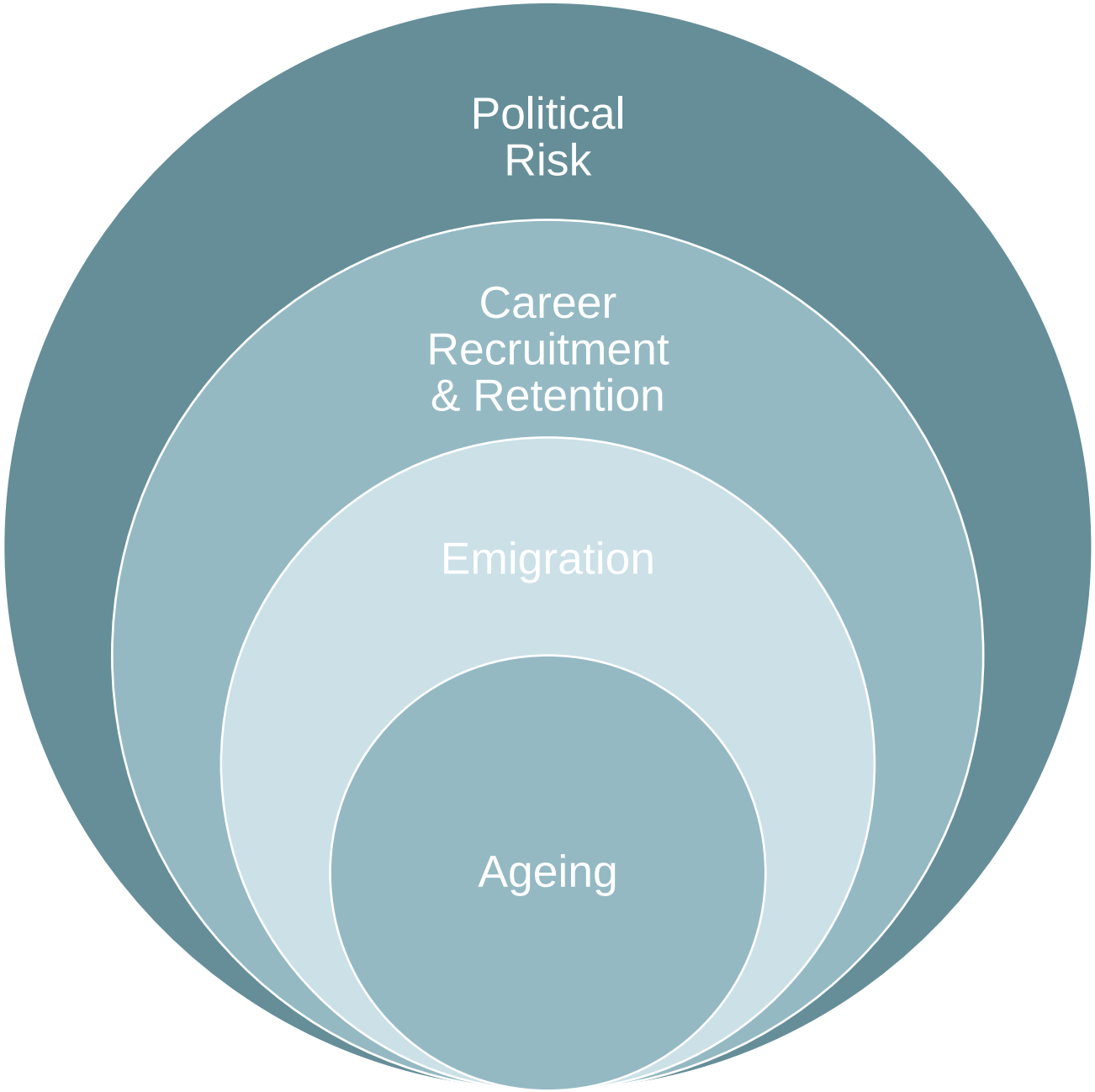
Estimated number and proportion of people living with NCDs: 2020-2040, by NCD (Percept NCD Model, 2021)

Year	2020	2030	2040
Comorbidities	4 819 412 (8.2%)	6 125 769 (9.3%)	7 516 430 (10.4%)
Depression	6 872 765 (11.7%)	7 909 798 (12.0%)	8 913 333 (12.3%)
Diabetes	5 227 127 (8.9%)	6 636 718 (10.0%)	8 120 821 (11.2%)
Heart Disease	1 357 445 (2.3%)	1 791 310 (2.7%)	2 299 981 (3.2%)
Hypertension	14 900 054 (25.3%)	18 426 372 (27.8%)	21 962 237 (30.4%)
% of the population that is aged 50+	**18%**	**21%**	**26%**

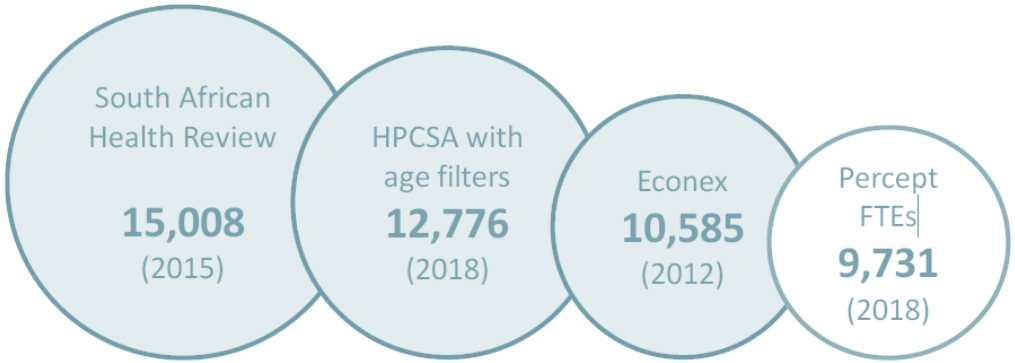
Surgical specialties against Epidemiology Impact targets

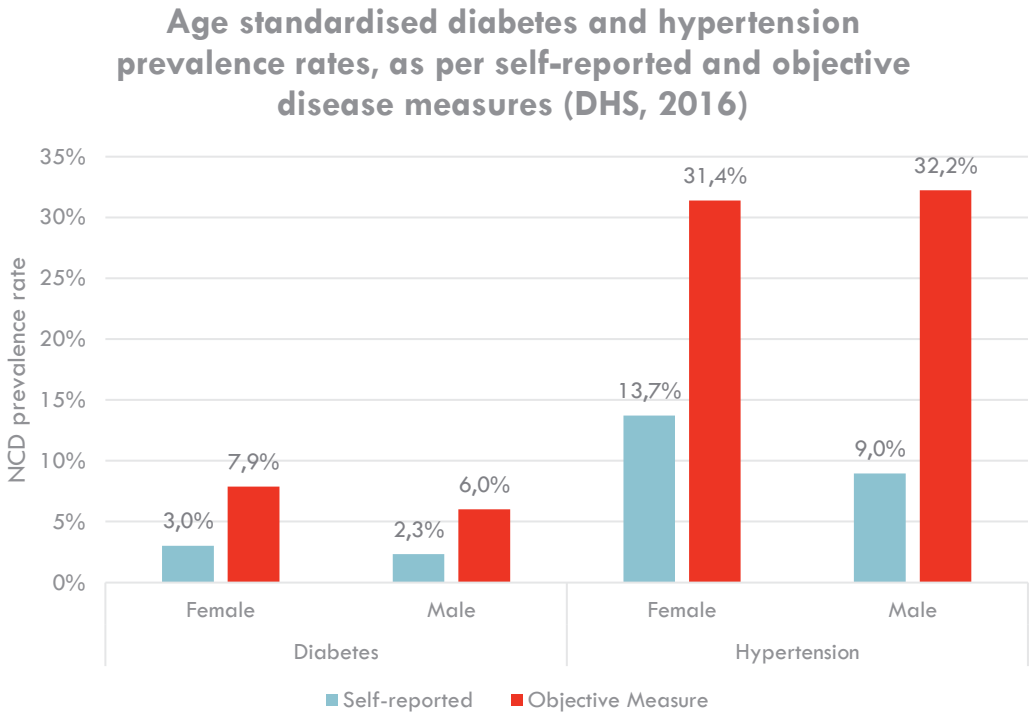


The HRH Vortex



Where we are flying blind


South African Health Review
15,008
(2015)
HPCSA with age filters
12,776
(2018)
Econex
10,585
(2012)
Percept FTEs
9,731
(2018)


Age standardised diabetes and hypertension prevalence rates, as per self-reported and objective disease measures (DHS, 2016)
NCD prevalence rate
35%
30%
25%
20%
15%
10%
5%
0%
3,0%
7,9%
2,3%
6,0%
13,7%
31,4%
9,0%
32,2%
Female
Male
Female
Male
Diabetes
Hypertension
Self-reported
Objective Measure

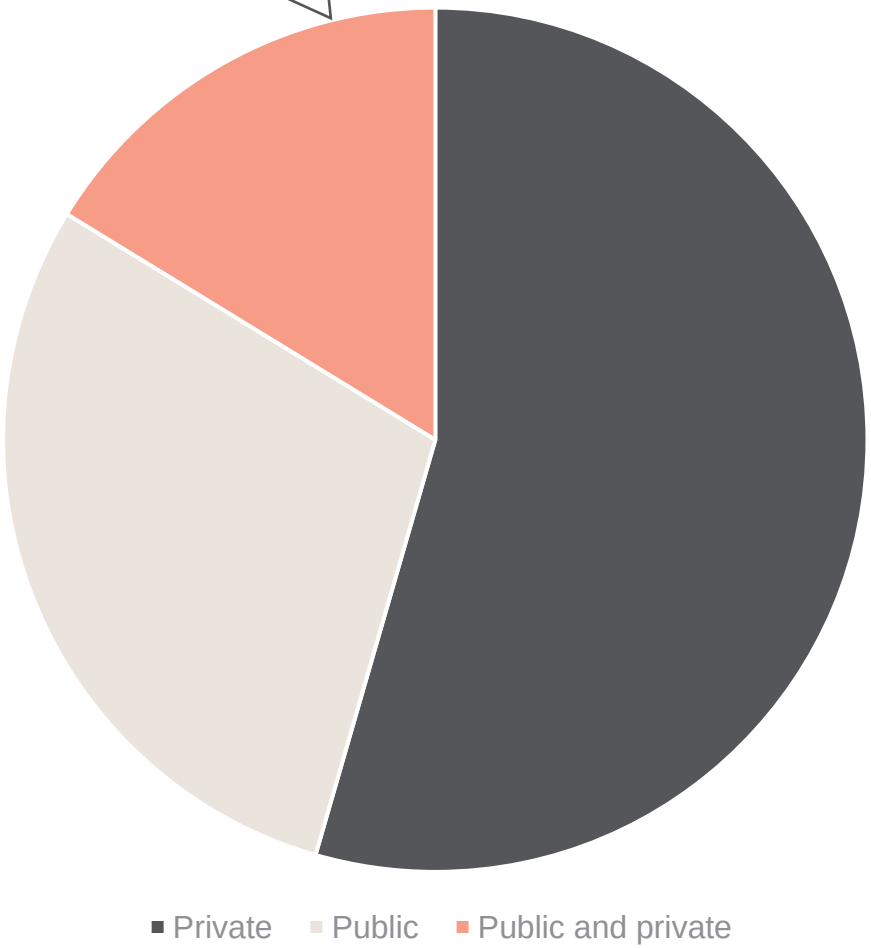
DAILY MAVERICK

MAVERICK CITIZEN

BHEKISISA

Moonlight sonata — the illegal cash cow draining specialist care at SA's state hospitals

36% of public-sector specialists appear to make use of RWOPS – the extent of the time spent in the private sector is unknown



We need to think differently

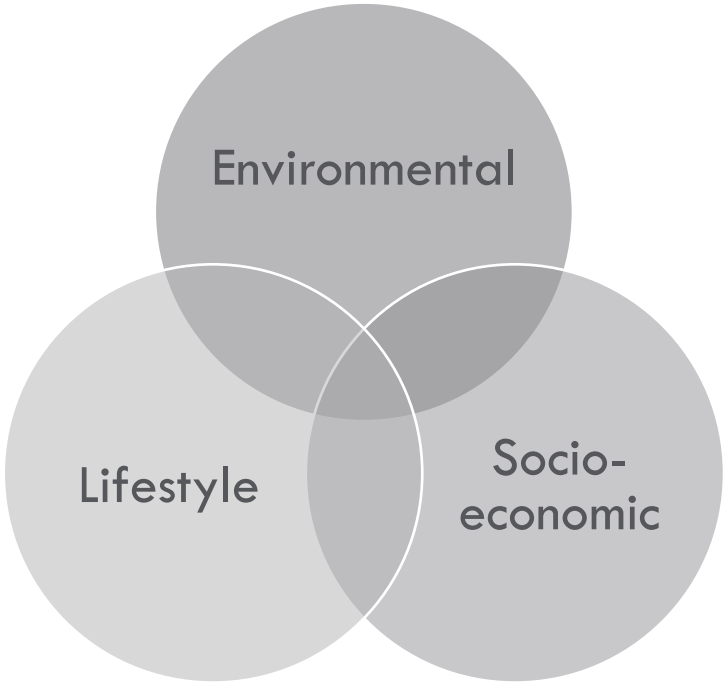
Polarisation stops us from problem solving

NHI as panacea	A middle way?	NHI as crisis

Finding ways to reconcile the systemic with the individual

Individual | **System-level**

- Tobacco use
- Harmful alcohol use
- Unhealthy diet
- Physical inactivity
- Living environment
- Childhood adversity



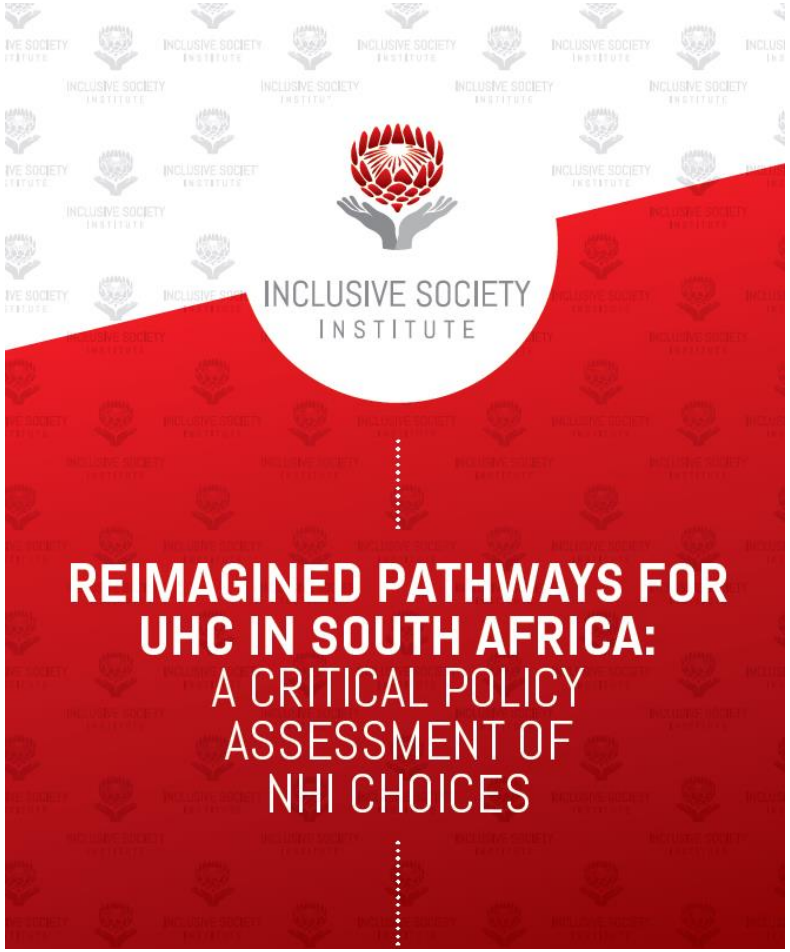
- Poverty
- Healthy food options
- Workplace standards
- Regulation

We need value-based solutions

VBC supports supply-side innovation, and supports the sort of care continuum that NCDs require

Taking a value-based approach to UHC is **strongly coherent** with the principles laid out in the South African reform process. The notion of 'value' is about optimising patient outcomes, within a financial envelope. It implies a **population health** perspective – optimising patient outcomes, not for individual patients, but across the system as a whole – which in turn implies a focus on equity and access.
In the conceptualisation of access to quality care for all, it **front-ends the notion of quality** and forces deeper thinking about what we mean by quality, how to measure quality and how to incentivise quality.
Approaching the reforms with value located front-and-centre provides an **alternative sequencing of reforms by starting with measurement**, then focusing on delivery, and only then considering mechanisms to pay for care. This approach to reform sequencing is referred to as the 'Leapfrog to Value' approach which has been designed with low-and-middle-income countries (LMIC) context in mind.

https://percept.co.za/2020/11/03/reimagined-pathways-for-uhc-in-south-africa-a-critical-policy-assessment-of-nhi-choices/



We need to invest in institutional capacity & data

Institutional Capacity

Establishment of a separate health workforce planning agency

Inclusive approach, bringing in key stakeholders and experts

Data

A centralised database for all HRH professionals in sufficient detail regarding cadre type, sector, level of effort, and demography is required for planning

A simple initial change that could aid HRH planning substantially is to capture more data on health workers in the PERSAL system

Providing patients with support may enable **self-management** which could lead to improved outcomes and decongestion of the healthcare system.

Incentive programmes are effective in increasing health promotion activities in the private sector. How do we translate this to the public sector context?

Home delivery of medication and adherence support through community healthcare workers are community-level interventions that ensure secondary disease prevention.

Covid-19 has highlighted the ability of **telemedicine** to improve outcomes and access to healthcare. This could be leveraged to a greater extent.

How does a monopsony purchaser support supply-side innovation? And how do we get there from where we are now where regulators are either actively anti-innovation or there is benign neglect?

A tale of two crises. With an alarming trajectory. Where we are flying blind.

We have the opportunity to think differently, to build inclusive solutions, to orient towards value, to ignite innovation.

What are we waiting for?