NHI 'won't work' but much to be said for aspects of it – HSF

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The Universal Health Coverage (UHC) system envisaged by South Africa's National Health Insurance (NHI) White Paper won't work. Amongst other things: it's too ambitious; too hostile to the private sector; too reliant on complex bureaucratic structures inherently ripe for inefficiency and abuse; and it totally ignores the many pitfalls that face single payer financing mechanisms. But, writes Andrew Barlow, a researcher at the Helen Suzman Foundation, there's also much to be said for some of the ideas within it.

Barlow writes: "One potentially promising idea is the re-engineering of the Primary Health Care (PHC) platform. PHC begins, it says, 'in the communities and is the first level of contact with the health system by individuals, the family and community'. It is the 'heart-beat of NHI. The PHC services include health promotion, disease prevention, curative (acute and chronic clinical) services, rehabilitation and palliative services.'

"Within this broad aim, the paper identifies four specific streams for re-engineering: municipal ward-based PHC Outreach Teams (WBPHCOTs); Integrated School Health Programme; District Clinical Specialist Teams; and contracting of private health practitioners at non-specialist level.

"In this brief I shall focus on the first of these streams: the rather clumsily termed WBPHCOTs. These outreach teams would be led by a nurse and linked to a PHC facility. The community health workers (CHWs), who make up the bulk of the team, would assess the health status of individuals in each household in their ward. Their main roles would be to promote health education, identify those in need of preventative or curative services, and refer those in need of services to the relevant PHC facility.

"Each team would be responsible for a specified number of households in a municipal ward. South Africa is divided into more than 4,000 of these wards. Teams would be allocated based on various criteria such as: population size and density; disease profile; geography; living environment; and social and health deprivation."

Barlow writes: "In the mid 1990s, a similar community health outreach programme was introduced in the north-eastern state of Ceará, Brazil to better and more efficiently meet maternal, post-natal and child health concerns. Very quickly, the programme – now termed the Family Health Strategy (FHS) – was rolled out nation-wide.

"It has evolved into an effective and robust approach to providing PHC, reflecting many best practices. It could thus be useful to consider Brazil's experience as a large-scale pilot study to both emulate and learn from."

Barlow points out that Brazil's health system is very similar to South Africa's in a number of ways: Brazil's constitution implicitly commits it to expanding access for all citizens to an equitable and efficient health care system; it has a two-tier system, with around 26% of the population enrolled in some sort of private health insurance plan. In South Africa, currently 18% of the population is enrolled on a medical aid scheme; both countries spend about 9% of GDP on health each year – just under the 9.3% average for OECD countries – and, similarly, less than half of this comes from public sources; the public health system in both countries is financed primarily through tax revenue, but shored up by federal and municipal budget contributions; administration of the public system is decentralised, and PHC service provision is a municipal responsibility; and publically financed health services are 'universally accessible and free of charge at the point of service for all citizens (including the 26% on private insurance if they so wish).

“In 1998, there were 2,000 Family Health Strategy (FHS) teams including 60 000 community health workers (CHWs) servicing 7m Brazilians (4% of total population). Just sixteen years later, in 2014, there were 39,000 teams including 265,000 CHWs serving 120m Brazilians (62% of total population). The rate of change plainly evidences just how effective the FHS has been.

“Each FHS team consists of a physician, a nurse, a nurse assistant, and between four and six full-time CHWs. Teams cover up to 1,000 households each. Each member has specific duties within the team: the CHWs go from door-to-door on a specified roster; the nurse and nurse assistant are called to households where needed; the physician acts as nucleus in an established clinic. This enhances efficiency when dealing with the vast majority of health problems, whilst aimed at ensuring that no member of the community’s health concerns slips through the net unnoticed.

“Due to the success of the model, teams have expanded to include dentists, and interdisciplinary primary care support teams have been developed to provide depth and breadth to the care provided. Support teams include ‘nutritionists, psychologists, social workers, psychiatrists, community pharmacists, physical education specifialists speech and hearing therapists, gynaecologist-obstetricians, geriatricians, general internists, pubic health specialists and others.’

“Every CHW has approximately 150 households that she/he is personally responsible for – and this mini catchment area is usually the area where the CHW actually lives. They must visit each household in their area at least once a month. During the visit, they promote healthy living as well as providing basic care and identifying when further care might be needed. They try to see that appointments aren’t missed and that prescriptions are taken regularly. If appointments are missed, they help reschedule them; if prescriptions aren’t being taken, they take steps to remedy this. They also ensure that children are attending school, that drug and/or alcohol abuse is monitored, and that any signs of domestic violence are reported.

“The model reflects many best practices: first-contact care is made close to people’s homes; longitudinal care – a holistic, dynamic and integrated care plan – is facilitated as every member of the community can be accounted for by the CHW responsible; comprehensive care is provided by the interdisciplinary support team; care is pro-active as CHWs actively look for problems before patients present themselves; and teams can deliver public health interventions such as immunization campaigns.”

Barlow writes: “The expansion of the FHS model has yielded tangible and encouraging results. Evidence suggests across-the-board improvement in child health and infant mortality, as well as a sharp reduction in post-neonatal death due to diarrhoea and infection. There is evidence suggesting a marked reduction in mortality from cardiovascular and cerebrovascular diseases and reduced rates of chronic conditions like diabetes. Even rates of tropical diseases have noticeably dropped.

“Moreover, rates of admittance to hospital have also dropped, as the model helps ensure that patients receive the care they need earlier and more efficiently. This means that hospitals are under less pressure and are, in turn, able to provide better care. The scheme also provides all CHWs with full-time employment that directly benefits their community. Currently, the scheme has provided over a quarter of a million Brazilians with jobs where they may not have had any. But neither has this proven overly expensive. Indeed, FHS seems to be extremely cost effective: the Brazilian government spends approximately $50 annually per person on the programme.”

In conclusion, Barlow writes: “Such programmes are not without their challenges. Due to geographical realities and disparities in population density, schemes like this require continuous adaption, significant investment – both human and capital – robust political support, and an evolving and committed medical practice.

“But these outreach teams have massive and empirically demonstrable potential: they represent a community-based, community-driven approach to providing PHC; they act as intermediaries between

members of a community and the health system at large; they foster efficiency in the health sector; they have been proven to significantly improve health indicators; they provide jobs; and they help to guarantee community welfare."

Barlow points out that the White Paper contends that community outreach teams, if implemented well, would be a "game changer". "A big 'if', no doubt, but surely worth exploring – even if the White Paper itself is not?"

By Andrew Barlow – Helen Suzman Foundation