TPG International Health Academy

South Africa CEO Trade/Study Mission
April 3-9, 2016

Executive Summary

Introduction

In April 2016, TPG International Health Academy (TPG-IHA) and its 18 member delegation visited Cape Town, South Africa. The delegates were introduced to one of the three countries who share the American system of financing health care. While there are many similarities, the degree of economic and health disparities far exceeds anything seen in the United States. The delegates were able to interact with individuals from a broad cross section of the health sector, including: a university professor; health scheme (insurers) regulators and senior managers; and Non-Governmental Organizations (NGOs) who provide many services in attempts to fill gaps created by the funding and services shortfall inherent in the government funded system. The Academy delegation also had opportunities to visit private and government facilities.

Overview

South Africa has a relatively large land mass with two thirds of its 53 million people living in urban areas, but also still retains a significant migrant population comprised of both its own citizens and immigrants (legal and illegal) who have families in one location but work in another. South Africa spends approximately 8.8% of its GDP on health care, which is slightly below the OECD average of 8.9%. As noted above, like the United States, South Africa has privately funded and publicly funded health services sectors. The private sector hospitals are generally for-profit and physicians in the private sector are self-employed, while government sector physicians are employees who earn “good” salaries by South African standards.

Significant barriers to care present themselves to much of the public due to the broad economic discrepancies and the urban/rural mix in the country. In addition, the HIV positive and Tuberculosis rates are among the highest in the world. South Africa is home to nearly 17% of the world’s HIV positive individuals. These factors conspire to present barriers to access and quality of care. While significantly improved, the public’s and certain political leaders’ prior denial of the disease has impeded progress in treating HIV and AIDS. The epidemic is the leading factor in reducing life expectancy in South Africa, which reached a low of 49 years in 2005. It has started a slow but steady increase up to 61 years in 2014 because of increased use of anti-retroviral treatment, among other factors. Women, particularly those in their child bearing years, are most vulnerable to the epidemic. This is exacerbated by sexual politics (male dominant social structure) and the prevalence of multiple concurrent sex partners for many males, especially within the migrant worker lifestyle. Male circumcision is the most effective tool at reducing infection rates and is being promoted as a positive step for the population. South Africa has one area of notable success in its fight against the spread of the virus—it is achieving mother to child transmission rates well below 10%, which is comparable to the rate achieved in the developed world.

The country is also facing a near epidemic of Tuberculosis both as a singular disease and as a co-morbidity with HIV. Unfortunately, there is a high prevalence of both drug resistant and extreme drug resistant TB. Even though only around 40% of the HIV infected individuals receive anti-retrovirals, the country spends nearly $1 billion US per month on the therapy.

Only approximately 20% of the population receives private health insurance while the remainder of South Africans access care through the government funded sector. Although approximately 25% of the population earns enough to pay income taxes, value-added tax (VAT) is the primary income source for the government. The system faces additional strain in retaining trained health care professionals, especially physicians. Many physicians have emigrated to seek better economic opportunities. The quality of care in the private systems appears to be of a high standard but lags behind many other developed countries in areas like care coordination and prescription management. There appears to be a general lack of electronic health records and interoperability of those that exist in both the government and private sectors, making the sharing of patient data and coordinating care difficult.

The government health system is administered through a number of regional entities with overview from the capitol, Pretoria. Health education is publicly funded through the university system. The government has been opposed to the creation of privately-funded medical schools. In both the private and public system access to primary care is relatively available, but there are significant delays in access to specialist care. In the government system primary care is largely delivered by nurses, many of whom have specialized qualifications including midwifery, pediatrics, and mental health. Mental health services fall short of physical health access, as is common in many countries.

It is worth noting that certain vestigial impacts of the old Apartheid system remain. Education and health statistics continue to identify Black African, Coloured, and White. Although the exclusionary and separateness polices have been eliminated, the impact on access to health services and educational opportunities continue to cause significant disparities, although they now reflect level of economic attainment rather just than skin color.

Role of NGOs

The delegation visited several NGOs who attempt to fill gaps in the health and education systems. The NGOs and their roles are described below:

SHAWCO

SHAWCO is a student volunteer organization that began in 1943. It focuses on two areas: childhood education and primary care. It is largely staffed by volunteer students from the University of Cape Town. The delegates visited one of its education centers which focuses on augmenting the education, nutrition and health services for disadvantaged youth. Their programs provide services similar to Head Start and after school programs for inner city youth in the United States. The goals are to help ensure the kids remain in school and to provide positive alternatives to gang life, which is prevalent in those areas. The center faces a daunting task as it is situated in a residential area that is surrounded by gang controlled areas. The center strives to retain its students until they finish their schooling. They also provide educational opportunities for the parents and elders. In particular, through funding from Microsoft and Dell, they have created a very effective computer learning lab.

SHAWCO's other and original focus is on providing primary care services to underserved communities. They have created mobile clinics that are staffed primarily by medical students and faculty. Roughly 20%

of the medical students participate in the clinics. Uniquely, the clinics are trailers that are fitted out with exam rooms and lab spaces. It is much more economic to outfit the trailers than to build a self-propelled vehicle. It also means one driver can position more than one "clinic" per evening. The clinics are open in the late afternoon and evening, thus providing access to individuals who can't be seen during regular business hours at the government clinics. Like the other parts of the health system, the clinics see many patients with HIV and both co-morbid and standalone Tuberculosis.

Kheth'Impilo

Kheth'Impilo is one of the NGOs that focuses on improving HIV care and prevention. It operates with government contracts to serve specific regions/districts of the country, but is largely funded by donors. Other NGOs serve other regions. Kheth'Impilo is the largest of its kind, but all attempt to coordinate and to share best practices. Kheth'Impilo operates in other parts of sub-Saharan Africa, however, its primary focus is in South Africa. It provides both direct care and patient/community education. Its goal for 2020 is 90, 90, 90: 90% of the population will know their status, 90% of positive individuals will have anti-retroviral therapy, and 90% will have viral suppression. (Current statistics aren't clear but it is believed only about 40% of individuals know their status, roughly only 50% of known positives consistently receive ARVs, and probably 40% have therapeutic efficacy). Their staff believes the next four to five years are critical to stem the tide of the epidemic. If the number of new cases can be reduced, then there is a chance that a crisis can be averted but, if it isn't, the prevalence of HIV positive individuals of child-bearing age will have a massive negative impact and further shorten the average life-expectancy in the country. In addition to the obvious issues, the epidemic's impact on productivity is profound.
One of Kheth'Impilo's innovative strategies is to create Chronic Care Clubs that help both reduce the stigma for HIV positive individuals by creating a community of like individuals, and create a supportive social environment to improve adherence. South Africa, like most countries, has a medication adherence issue which is particularly critical in the suppression of HIV.

They have also funded and developed curricula to educate and then to deploy 5,000 pharmacy assistants who can assist in distributing ARVs and other medications. There is chronic understaffing in pharmacies in the government sector.

Pebbles

Pebbles is an NGO focused on children in rural areas; specifically the wine region of Stellenbosch. Its mission is to focus on educating the children of the individuals who work on wine estates. They quickly realized that to improve the children's overall education, they needed to provide services in nutrition, health and family. They serve nearly 1,100 students in the region. Their primary site includes a pre-school facility and a very unique clinic. The clinic facility is a series of temporary metal buildings (similar to shipping containers) that have been fitted out with a dental operatory, a small lab, exam rooms, and a dispensary. They focus not only on care but educating the students and their parents in physical and dental hygiene. The latter is a particular problem in South African rural communities as many people do not routinely brush their teeth or have dental check-ups. The health professionals view their role as not only to provide care, but to provide on-going education to the students and their families. To further their mission, Pebbles has created a mobile computer lab that serves both the children and their parents.

The lab goes to various wine estates where staff can use their lunch hour or post-work time to gain computer proficiency. Computer proficiency is believed to be a critical skill to improve a family's economic situation. The lab also is used to teach computer literacy to the children Peebles serves.

Hospitals

The delegation visited two hospitals: the Khayelitsha Hospital (a nearly-new district hospital) and the Medi-Clinic Stellenbosch Hospital. The Khayelitsha Hospital was very impressive physically but had not yet been put into full operation. It will serve as the primary referral facility for Khayelitsha (a township with nearly 750,000 inhabitants).Townships are the South African name for "informal" housing that is predominantly occupied by Black Africans and might be called shanty towns in other countries. Interestingly, the hospital doesn't have advanced imaging equipment, although a CT scanner is on order.

The Medi-Clinic facility is owned by the publically traded Medi-Clinic company who is the largest owner/operator of hospitals in South Africa. The hospital seemed to be well-run and had an occupancy rate of approximately 80%. Its patient mix is primarily OB and general surgical services. Interestingly, pricing for hospitals is negotiated with the health schemes and varies somewhat by the negotiating power of each scheme. Hospitals cannot hire physicians as there are corporate practice–of-medicine laws in South Africa.

Khayelitsha hospital has electronic medical records but the feeder clinics do not. Medi-Clinic also does not have interoperability among its systems.

The delegation also learned that malpractice claims are an issue for the health system in South Africa. It appears the private system has more claims than the public sector.

Council for Medical Schemes (Health Insurance)

The Council for Medical Schemes is the national government's regulator for Medical Schemes. The medical schemes provide insurance coverage for all privately insured individuals in South Africa. The schemes are not-for-profit entities and are both closed (similar to individual company self-insurance in the United States) and open. Many of the schemes purchase claims processing and other administrative services from for-profit companies. This arrangement can create some conflicts that can lead to dissatisfaction from the "insureds" due to the co-pay portion of claims and a questioning of the amount of premium allocated to administration. In addition, South African law allows physicians to charge private pay clients any amount they choose. This leads to problems for the schemes and the insured. Schemes create "networks" where costs are based on negotiated rates, which tends to mitigate the issues but not all services are provided in-network.

All schemes are required to cover a mandatory minimum set of benefits and must accept anyone who applies for insurance (no pre-existing condition exclusions). This can lead to individuals signing up for schemes on an as needed basis. The government is considering legislation to make scheme enrollment mandatory for individuals above a certain income threshold. The schemes, like most insurance companies, are required to maintain minimum reserve balances. The reserves seem appropriate and many of the schemes maintain significantly more than the statutory minimums.

Members of our group noted that the entire staff of the Council of Schemes is substantially less than most US states' health insurance regulators.

Summary

At a very macro level, the South African healthcare system shares many of the characteristics of the US system—a combination of private sector and public sector, no mandatory enrollment, government regulation of benefits, and reserve requirements for the private sector. It, however, has many substantive differences—the dramatically greater level of income disparity, the impact of HIV and Tuberculosis, and the significantly lower portion of GDP deployed in the health sector. Its lack of infrastructure for clean water and sewage exacerbates some of the problems encountered in public health improvement initiatives.

It is worth noting the impact of NGOs on addressing some of the systemic health problems confronting the country. In particular, NGOs are playing a critical role in helping the country address the substantial issues associated with the prevalence of HIV and TB. They also fill gaps in care and social support that are critical to improving outcomes and longevity for the population.