The National Health Insurance, the decentralised clinical training platform, and specialist outreach

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According to the Constitution of South Africa (SA), citizens living in remote areas are entitled to the same level of healthcare as those with access to tertiary hospitals. Specialist outreach has been shown to achieve this. When SA’s National Health Services Commission convened (1942 - 1944), Gluckman summarised: ‘Where the need is greatest the supply of hospitals is least.’ Primary healthcare (PHC) characterised the Kark’s Pholela Health Centre and was highly regarded. Although PHC underpins National Health Insurance (NHI) planning, both preventive and curative healthcare are needed. The KwaZulu-Natal (KZN) provincial Department of Health and the University of KZN College of Health Sciences’ 5-year plan for a decentralised clinical teaching platform (DCTP) is ambitious, requiring optimum co-operation between health department and university. Reservations can be addressed through sustained specialist outreach. Above all, the patient must be the chief beneficiary. The NHI and DCTP overlap with specialist outreach, but cannot do without it.

Discussion

In line with NHI philosophy, the KZN provincial Department of Health (DoH) and the University of KwaZulu-Natal (UKZN) College of Health Sciences have an ambitious CBTPHCM/DCTP 5-year plan: piecemeal social engineering in its most well-intentioned manner, perhaps? The programme could achieve the following: embodying PHC principles; doubling the 1st-year MB ChB intake at UKZN in 2017 to 512 students; mechanisms for the retention of doctors in rural areas; training of under- and postgraduates away from the major centres; and registrars available to staff these sites.

Reservations include provision of three specialists in each discipline for every site when it is problematic to fill posts at regional hospitals, as an unfilled consultant-registrar-undergraduate ratio (1:3:12) would be contrary to Health Professions Council of SA (HPCS) regulations. Although studies have suggested that doctors originating from rural areas are more likely to practise in such areas, this is not guaranteed. The programme could achieve the following: embodying PHC principles; doubling the 1st-year MB ChB intake at UKZN in 2017 to 512 students; mechanisms for the retention of doctors in rural areas; training of under- and postgraduates away from the major centres; and registrars available to staff these sites.

Apart from optimum co-operation between the DoH and UKZN, DCTP requires the contribution of specialist outreach alongside focused PHC development. Specialist outreach serves disadvantaged patients in remote areas. Infrastructure in KZN includes a competent transport provider, i.e. the Red Cross Air Mercy Service – if their contract is renewed. This programme already provides specialist outreach experience in KZN and yet provide specialist outreach.

The DCTP envisages a service to its patients, and under- and postgraduate training, dovetailing best with specialist outreach; indeed, it cannot do without it. Outreach consultants increase the
specialist presence on site, improve service delivery to patients, establish liaison between peripheral and central hospitals, and provide under- and postgraduate teaching. This may obviate or postpone physical referral and transport, as appropriate treatment can be recommended and initiated at the base hospital, or it may facilitate rapid acceptance and transfer of patients when it is apparent that urgent specialist intervention is needed. For ‘in-between’ degrees of urgency, there may be an opportunity for patients to be assessed by a specialist during the regular monthly outreach visit.

However, the only reference to peripheral specialist contribution in the NHI White Paper of early 2016 is in the form of ‘district specialist’. These are limited to four disciplines: paediatrics, obstetrics, anaesthetics and family medicine, whose consultants travel to hospitals within a particular health district. Therefore, if excluded from formal policy in the NHI, long-established multifaceted specialist outreach programmes of proven ability to ‘deliver the goods’ might come to an end, denying the sustainability that is a prerequisite for the full benefit of such outreach.

Above all, there has to be assurance that the patient is the chief beneficiary in the three-way process involving patient, health department and university. The sheer necessity is that the NHI must include specialist outreach. Consequently, both will be compatible with the DCTP, as the NHI is based on the principles of PHC and CHCs.

Conclusion
Specialist outreach is a proven strategy worldwide and has an indispensable role to play in both the DCTP and the NHI. These have much to be commended, but there are serious reservations that need to be researched and answered.[23] Preventive health is vital – but so is curative medicine. Certainly, as Prof. Dan Ncayiyana stated in 1994 in support of Karkian philosophy, ‘there is no need to rediscover the wheel’. Equally, one must be sure not to throw the baby out with the bathwater.[24,25]


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