

# NHI will put GPs 'back at the centre' – Motsoaledi



National Health Minister, Dr Aaron Motsoaledi.

**Under universal health coverage South Africa's general practitioners will reclaim their rightful place at the heart of the primary healthcare delivery system and slowly but surely increase their share of a hugely enlarged national 'medical aid' cake.**

That was the core message to thousands of private sector doctors from National Health Minister, Dr Aaron Motsoaledi, during an 8-month charm offensive across the 11 National Health Insurance (NHI) pilot districts which he completed this October. Speaking exclusively

to *Izindaba* a fortnight after his marathon tour ended, an upbeat Motsoaledi believes his well-aimed arrows found their target. 'I think I proved to them that the present system is making them poorer than an NHI ever could. I mean GPs getting R6 billion out of the R84.7 billion medical aid basket (2010 figures – 2011 was worse) with private hospitals' specialists, pharmacies and even non-healthcare workers (administrators and brokers) getting more, is unfair and unsustainable,' he said.

### Getting facilities ship shape for GP entry

The GPs' response to his briefings had been 'overwhelmingly positive' and he was expecting growing numbers to contract into working at public sector clinics to deliver unprecedented services. A swat team from his office have just completed auditing equipment and staff at every pilot NHI clinic to ensure the private GPs 'do not arrive there and find there's no nurse or no scale to weigh babies,' Motsoaledi said. This audit was due on his desk on 5 November and he would use it to say to contracted GPs: 'OK, now you can move in' (wherever clinics were 'ready').

'I want to bring my side of the agreement. I don't want them phoning me from the clinic to complain,' he said. Motsoaledi was unable at the time (of interview) to say how many GPs had contracted in but believed he would be able to quantify this once his clinic and

GP national review was complete. Treasury has set aside R1 billion for all aspects of the NHI pilot launch while the European Union has contributed R1.2 billion, mainly for high-tech equipment – much of it to support nurse-led primary healthcare teams, using 30 custom-made trucks to immunise, educate and health-test school pupils and deep rural communities. Motsoaledi is determined to address the booming teenage pregnancy incidence and the spike in both illegal and legal termination of pregnancies. HIV counselling and testing programmes will be part of the schools' intervention, with condoms and male circumcision also available. He emphasised that these services would not interfere with the children's school time, moving to outlying communities and farms while the children wrote exams or tests.

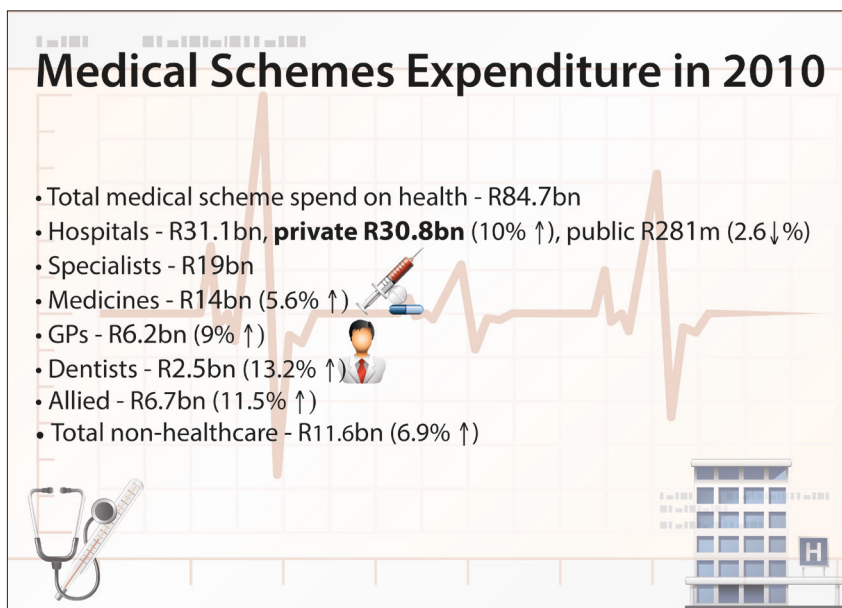
### GPs will restore community trust

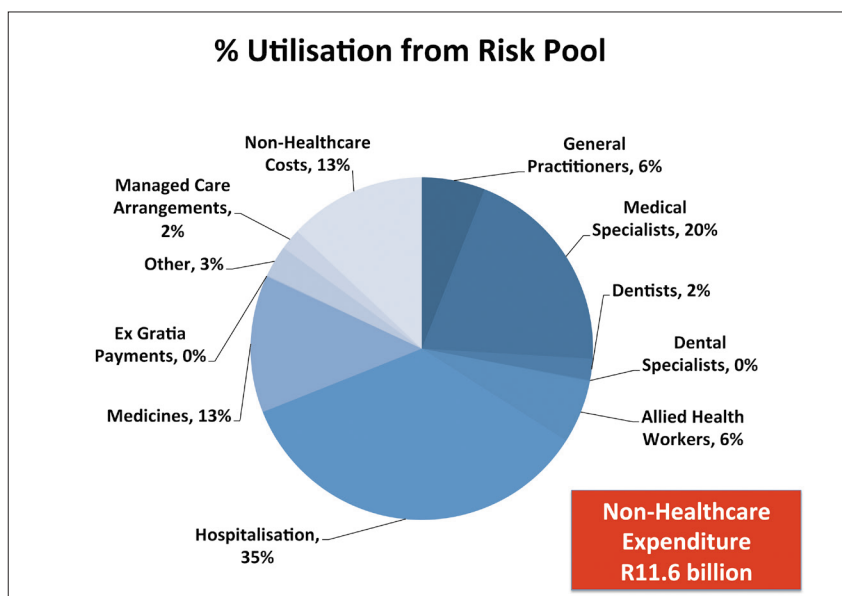
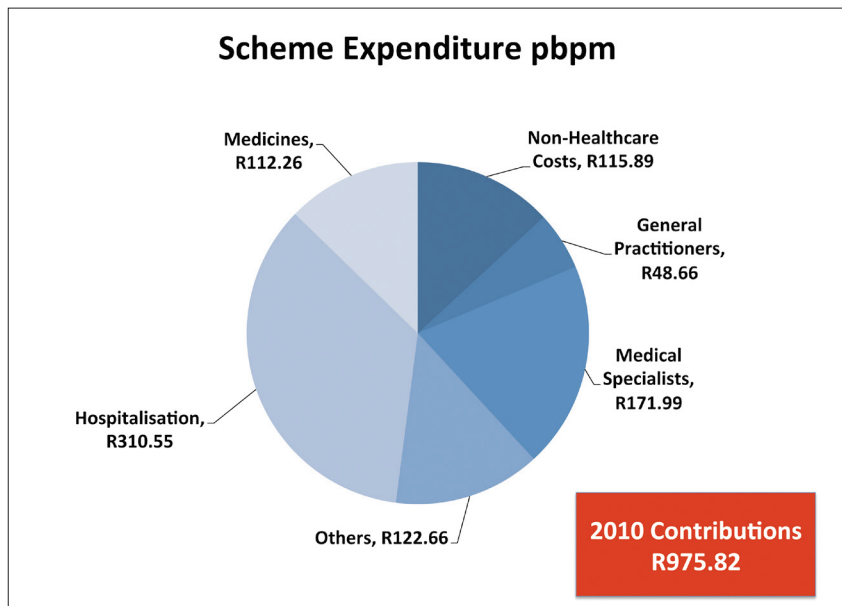
Turning back to GPs, he reiterated that they will be paid out of national funds, openly doubting that many of his dysfunctional provincial counterparts would honour such payment obligations. One way or another he's not going to risk souring a budding new relationship upon which so much turns. He's confident that by offering GP-led services in clinics, community trust will quickly be restored with patients flocking to facilities aimed at serving those without medical aids or cash and, as importantly, decongesting hard-pressed district hospitals.

Motsoaledi conceded that the much-touted specialist district health teams consisting of a gynaecologist, paediatrician, family physician, anaesthetist, midwife, paediatric nurse and primary healthcare nurse were so far 'not uniform everywhere' (i.e. in the pilot districts). 'The last time I checked two (out of 11 pilot) districts (Tshwane (Pretoria) in Gauteng and Umkungundlovu (Pietermaritzburg) in KwaZulu-Natal) were fully manned. Unfortunately both districts are urban, but that's where the human resources are. We're busy with induction. They'll spend about two days undergoing induction, and many teams (although understaffed) have already started working,' he said.

### Specialist shortage proving difficult

Given the healthcare human resource crisis he 'expected problems' initially and has asked medical schools to 'help fill the gaps in





Adapted from: Stoltz MM (Chairperson, GP Private Practice committee, SAMA). 'The Doctor at the Centre of Healthcare Delivery in South Africa'. Presentation: Board of Healthcare Funders Conference, Drakensberg, 2012.

rotation'. Few specialists want to spend time in deep rural areas, so he's asked universities to send registrars or newly qualified specialists for 'perhaps a year' during training before returning to campus. 'It's a gentleman's agreement. There's a mutualism in the whole thing. We also want to help the specialist at ground level on how best to position themselves in advance of the NHI. We don't want a fragmented healthcare system which the World Health Organization (WHO) has identified as being one of top three trends influencing poor health outcomes,' he added.

Asked how he was going to address the R2 billion in provincial under-spending on revitalisation of clinics and hospitals, given

how crucial this will be to NHI delivery, Motsoaledi said his department was no longer 'totally at the mercy' of the Public Works Department. From having to submit the name of the facility to Public Works, asking them to build it (Motsoaledi adding: 'If they weren't interested, there was nothing we could do'), he now had 'five or six' engineers employed by as many provincial health departments and reporting to a national health department chief engineer. From unqualified staff checking up on Public Works after three months to find they'd 'done nothing', this new team was now 'chasing them every day'. 'If they (Public Works) don't do it we take it on contract to somebody else'. Gone were the

days when he was 'running a department that depends on the success of another'.

## Health Department hires own engineers

'We're not legally hamstrung. We now have the (limited) capacity to lead the process ourselves and can put it out to tender just like they'd have to anyway'. Motsoaledi cited the nine multiple/extreme drug-resistant tuberculosis centres that had recently been completed in (relatively) record time using engineers from the CSIR as an example of this. The changes began in 2009 and from 18 months ago the improvements in infrastructure delivery had been 'dramatic', he said, with under-spending from the 2010/2011 financial year to the financial year ending this March revealing 'tremendous' change. He predicted that next year some provinces would even require extra money for infrastructure, so well were they now spending. 'Just one engineer can make a massive difference,' he observed.

Quizzed on the plethora of reports of dysfunctional district hospitals in several more rural provinces and their likelihood of ever reaching the standards that would be demanded by Dr Carol Marshal's Office for Healthcare Standards Compliance, Motsoaledi had this to say: 'She will be holding them to the highest standards. At the moment we have 40 of her people (facility improvement specialists) travelling from hospital to hospital helping set up mechanisms that will enable them to comply. In this pilot I've given them two categories: vital and essential - in other words things that are good to have versus



Dr Carol Marshal, Head of the Office for Healthcare Standards Compliance.

things that are a matter of life and death, e.g. cleanliness. It's vital for a hospital to have clean toilets. If 99 out of their 100 toilets are clean that's a zero score, not 99%!' He said 20 of Marshal's staff had just returned from the UK, where they had undergone rigorous standards and facility-support training by that country's equivalent NHI officials. However, without the legislation to back an Office of Healthcare Standards Compliance (OHSC), his department was somewhat hamstrung. (The amendments and additions to the National Health Act have been passed by the National Assembly but are still subject to approval by the National Council of Provinces before they can be sent to President Zuma for signing

and gazetting.) In spite of this the OHSC was being pro-active in getting hospitals on the road towards compliance. Full compliance by a hospital entitles it to apply to the NHI for funding, opening a cash stream that is intended to boost both service delivery and capacity.

Motsoaledi said the limited role of GPs was one of the major weaknesses in the current fractured system (meaning public from private) which denied access to good-quality, affordable healthcare 'if and when needed' (co-incidentally the WHO definition of universal health coverage). 'In fact, they're being washed out of the system with the hospi-centric approach and general agreement that people can go

straight to the highest healthcare institution. We're destroying the lower echelons of the healthcare system and primary healthcare, including GPs.'

It seems the much lamented demise of the district surgeon is about to be replaced with a turbo-charged model which stands to begin delivering on the government's constitutional obligation to provide progressive access to healthcare for all.

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