

# POLICY DEVELOPMENTS SINCE 1994 FOR CHRONIC DISEASES

BY THE NATIONAL DEPARTMENT OF HEALTH

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## 1. INTRODUCTION

South Africa has witnessed considerable changes over the last ten years as we celebrate a decade of democracy. This period is significant for non-communicable diseases (NCDs, Note: terminology used for chronic diseases of lifestyle), which previously received scanty attention in the public health sector.

Health can be described in many ways and goes beyond medicine and the scope of the health-care system. It includes changes in the labour market, changes from a social-economic and political perspective, and biological, behavioural and psychosocial processes that operate from gestation to old age. All have potent influences on health outcomes and chronic disease risk factors, situations of families with children, consumption patterns and access to health care. People's circumstances and life habits contribute to illness, injury and other forms of ill health. Most illnesses need more than medical solutions, and this includes political and social changes.

The demographic transition, globalisation and development have brought about a new disease profile, an epidemiological transition, which is especially noticeable in the developing world. Firstly, there has been a decline of infectious diseases, an upsurge of new infections (HIV and AIDS), and the re-emergence of "old" infections (i.e. TB, cholera, malaria). Secondly, there is the emergence of NCDs and marked changes in consumption patterns of food, alcohol and tobacco, as well as increased sedentary lifestyles. These risk factors are causing an alarming increase in the development of chronic diseases of lifestyle, which unfortunately cannot be cured by pharmaceuticals and chemical tools only, although they can be prevented.

South Africa is said to have a quadruple burden of disease: Health-care requirements are greater than available resources, necessitating cost-containment and cost-effective measures relevant to health systems reform. However, additional resources are required to provide for the health needs of the population.

## 2. ORGANISATION OF THE HEALTH SYSTEM

Although NCDs are among the most common and most costly health problems, they are also among those that are most preventable and treatable. The public health system delivers health on three different levels – the primary level, through a district health system, which includes municipal health services; the secondary or hospital level; and the tertiary level, which includes highly specialised services and technology.

## 3. CONCEPTUAL FRAMEWORK OF THE ORGANISATION OF THE HEALTH SYSTEM

An organisational framework should be developed within the framework of an existing constitution, which is very clear about the competencies of the three different spheres of government, as well as the structures of governance and its integration in South Africa. The following are important provisions of the constitution:

- the need for corporate governance; and
- decentralisation of powers and functions to the most appropriate level.

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The overall vision of the integrated health system is to ensure:

- health promotion and protection of social security, i.e. support to the social grant system, and free health services
- justice, fairness and solidarity
- dignity
- independence
- participation/partnerships.

The vision reflects the fundamental values and underlying beliefs of most South Africans.

The National Health Act, 2003 (Act No 61 of 2003), also makes a definite contribution to the organisation of the health system, by prescribing certain structures, their functions, obligations, rights and duties.

A support system, within and outside the formal health system, is essential for the promotion of good health. It was soon realised that the success of health-care delivery is influenced by social support systems and voluntary organisations that can plan and work together.

The principles of a unified health system are:

- appropriate defined roles for each sphere of government
- coordination of policy making
- coordination of services (range and levels)
- monitoring and evaluation of health services and health status.

In 1996, the Directorate: Chronic Diseases, Disabilities and Geriatrics was activated when the first director was appointed. This was the beginning of a period of progress in the prioritising of NCDs in the Department, but also in the provincial departments of health. For the first time provinces appointed persons who were responsible for NCDs. This was a milestone in the organisation of long-term care delivery in the health system.

In December 2003, a cluster for NCDs was instituted and a cluster manager appointed. This was a major achievement after many years of motivation to prioritise NCDs within the health sector, and an acknowledgement and demonstration of the vision of the political leaders regarding health care in South Africa.

#### **4. GOVERNANCE/MANAGERIAL PROCESS**

It is also possible to separate the responsibilities of political accountable (governance) bodies from management and technical structures and committee structures. The Government has three levels of responsibility towards the public health sector (see point 5), which are: financing health care, responsibility as a service provider, and that of a regulator. The overall governance of the health system is based on the following principles:

- cooperative governance
- of having a patient-centred strategic vision
- to focus on the core business of the system or programme
- to be customer-focused and quality-driven
- of developing people and multidisciplinary teams
- of successful collaboration and cooperation, and
- to implement positive changes and improve the governance position of the public health sector overall, and the health programmes specifically.

#### **5. THE ROLES AND RESPONSIBILITIES OF THE THREE SPHERES OF GOVERNMENT**

##### **5.1 The National Department of Health**

This National Department is responsible for national policymaking, developing norms and standards, developing national legislation, monitoring and evaluating national policies, international liaison, and providing those services, which should be provided nationally because of economies of scale.

##### **5.2 The Provincial Departments of Health**

These provincial departments are responsible for provincial policymaking, drafting provincial legislation, rendering provincial and regional services (largely hospital-based services), which should be provided provincially or regionally because of economies of scale.

### 5.3 Local sphere

The governing body for the district, known as the District Health Authority (DHA), makes policy decisions on matters that affect the local community. The DHA should ensure that:

- (i) adequate and effective consultation with communities takes place; and
- (ii) that they are accountable to the communities that they serve for the decisions that they make.

The management structure of the Departments of Health, and to a lesser extent the CDL programme, is divided into junior managers, middle managers and senior managers. These managers function at technical level, programme level and policy level (see Fig. 1). The intellectual capital required by managers at the different levels is not different from any other programme. They require technical skills to accomplish the mechanisms of the particular job, talent, competencies, education, innovation, problem solving, and the ability and knowledge to understand, coordinate and integrate the programme activities. To attract or even find human capital with the technical and the intellectual capital for this specific broader discipline is difficult, since people have not specifically been trained in the management of NCDs.

## 6. GOVERNMENT'S LEVELS OF RESPONSIBILITY

### 6.1 Financier of health care

The Public Finance Management Act, 1999 (Act No 1 of 1999) stipulates in detail the rules and regulations related to financial management.

The total budget for the National Department of Health in 2003/04 was about R8.5 billion. The revised allocation of the budget for the Cluster: NCDs (Disease Prevention and Control) 2003/04 was R258 048 000 of which R213 070 000 was spent. The Cluster consisted of eight units of which the Directorate: Chronic Diseases, Disabilities and Geriatrics received the largest slice ± R19 million. This is not the only money spent on NCDs. Other programmes also contributed, e.g. hospital services, pharmaceutical services, and health promotion, but these are hidden in their total budgets.

### 6.2 Service provider

There are 3 560 clinics in the country and ± 100 hospitals, the latter providing long-term care for people diagnosed with NCDs.

The Government provides and finances preventative, curative and rehabilitative services to ± 80% of the population:

- all primary health care throughout the country is free of direct costs to the consumer. In 1999, the Primary Health-Care package was adopted, including the management of NCDs.
- at hospital level, a fee for service, sliding scale system is implemented, according to the income of the patient
- all health care is free for persons with disabilities, as well as for children < 6 years, and pregnant and lactating mothers, inclusive of any long-term care for NCDs.

In an effort to support professionals in rural areas, a telemedicine programme was initiated. At present, the total number of telemedicine sites is 57.

### 6.3 Regulator

Health care in South Africa is regulated by numerous acts, strategies and regulations, of which the most relevant ones for this section are:

- The Constitution of South Africa Act, 1966 (Act No 108 of 1996), which refers to the right to equality, freedom, security of the person, privacy, and access to basic health care.
- The National Health Act, 2003 (Act No 61 of 2003), which governs the entire health sector.
- The Medicines Control Act, amendment.
- The Pharmacy Act, amendment.
- The Mental Health-Care Act, 2002 (Act No 17 of 2002).
- The Nursing Act, amendment.

## 7. NATIONAL HEALTH-INFORMATION SYSTEM

A national health-information system was developed, with a link to the district health-information system, in pursuance of an effective and efficient national health policy. The system originally did not include indicators of NCDs, but since 2004 these have been included. Yet the system focuses very much on morbidity, with mortality and qualitative data lacking.

The system needs to be adapted for the programme to benefit from information on health, and the different requirements of the programmes and other relevant departments need to be included.

Surveillance of NCDs has its own difficulties because of the very personal nature of the questions related to behavioural risk factors, the difficulty in measuring incidence and the fact that data are mostly self-reported and difficult to verify.

The selection of priority diseases is difficult because it should incur a substantial public health burden, which in itself is difficult to prove without available data.

## 8. STRATEGIES TO ACHIEVE INTEGRATED/COORDINATED CARE

When discussing integration/coordination of the long-term care of NCDs, we refer to two types of integration/coordination:

1. integration/coordination between the programme for chronic diseases (service) and other health and social programmes (services); and
2. integration/coordination between the different components within the programme.

To successfully integrate and improve the performance of any programme, linkages between the independent actors/resources should be formalised, and structures to provide an organised system should be coordinated. Once this has taken place, full integration to provide a package of long-term care can be implemented.

Integration/coordination is necessary to access the identified source of provision without difficulty, and personnel can be utilised in a more efficient way by combining roles and providing continuum care.

The elements that are referred to for integration/coordination are:

- finance
- administrative responsibilities, and
- organisation of care.

Because South Africa has a semi-federal system, integration/coordination between the chronic disease programme and other services is difficult. Each level of service will have its own budget. Functions that are decentralised for integration at a lower level do not necessarily guarantee reallocation of funding and other resources, which then very often are claimed as an unfunded mandate. In putting together service packages, a shared vision and goals are needed to encourage productive dialogue between different services and especially to agree on the sharing or pooling of financial (and other) resources. Simply merging funding streams will not suffice. To ensure a successful funding system for long-term care, it needs to be separately identifiable, which is not the case in our health system at present. Different programmes are very often planned autonomously, making integrated/coordinated implementation impossible.

To integrate administrative responsibilities does not create major problems because administrative processes, procedures, directives, etc. are the same at different levels and in different government services. What does create problems is where different criteria, norms and standards are used in processes, procedures, directives, etc. However, this does not pose a major risk to the system other than the difficulty to coordinate plans, programmes, etc., effectively and may confuse patients.

Each service will organise care to fit in with the specific system. Similar to other developing countries, the previous disease pattern in South Africa has influenced the health system to deal with acute and curable diseases. Globally, the disease burden has changed towards chronic disease, however, health systems have not changed. There is confusion between service delivery systems and service delivery models. This has hampered the integration/coordination of chronic diseases into the primary health-care system. The example that can be cited here is everybody agrees the integrated care-delivery system at primary level (district health system) is the best practice. Service providers do not understand that different care-delivery models are needed for acute/curative care, for chronic care, and for long-term care. Therefore, the incentive to provide long-term or chronic care at primary level is not always certain, and may be perceived as a conflict of interest. Over the past eight years, much improvement can be reported; however, the high turnover of staff has required an ongoing education/training process to maintain this improvement.

Another major challenge with integrating/coordinating the different services is the referral system, especially as far as long-term care is concerned. The referral system is not continuous and interrupted, and therefore not very effective. This means that the system does not go through all the levels of care and inappropriate health-care workers sometimes see the patient.

A referral system for the long-term care of patients allows care providers to:

- discuss alternative care with the patient and family, and to obtain consent/agreement and acceptability based on informed decisions;
- assess patients' readiness for referral;
- inform and prepare the care provider to whom the patient is being referred;
- send a referral form to the primary-care site that will take over the care of the patient;
- provide written or pictographic instructions regarding medication, the purpose for use, and the dosage;
- observe the understanding of the caregiver and/or patient of the usage of medication;
- inform the patient and/or caregiver of follow-up care, appointments, details on the patient-retained card, etc.;
- advise on any specific care, e.g. nutrition, hygiene, infection control, mobility;
- give contact details of the referral role players, as well as the primary role players;
- provide pharmaceutical supplies and dietary supplements as required;
- provide sick-leave certificates, social assistance forms, etc.;
- arrange transport for patients to their home on discharge, and to the referral care providers; and
- accept patients at a recognised referral facility when being referred from community level. Health-care facilities currently do not accept people who are referred by community health workers, which is a major problem that should be corrected.

Another major challenge is that the health district boundaries and other social sector district boundaries at local level are not identical. Therefore, to promote better integration and coordination they were forced to resort to legislation (National Health Act, 2003 (Act 16 of 2003)).

To integrate the different components of the programme is straightforward because of duplication at all levels in most of the provinces, e.g. prevention, promotion, treatment and care. These components function as separate cost centres.

## **9. LESSONS LEARNED IN DEVELOPING A LONG-TERM CARE PROGRAMME FOR CHRONIC DISEASES**

- Cultural sensitivity is important.
- Volunteers (support groups) are an important resource, and should be utilised.
- Effective long-term care requires more than adding additional interventions to an existing system.
- To improve care and compliance, families should be trained and educated.
- Incorporating long-term care into the existing primary care infrastructure may be efficient and cost effective, considering different models to provide and finance these services.
- The burden of chronic diseases can be reduced and prevented ONLY if health-care leaders are committed to do so.
- The instability of systems makes implementing good policy in most areas very difficult.
- Long-term care is considered a low priority in many developing countries.
- The skills and knowledge which health professionals need at primary level to diagnose and treat chronic NCDs are similar to what they will need at provincial level. Nurses in South Africa lack knowledge and skills to deal with NCDs.
- When approaching national and provincial governments with proposals for long-term care service development, it is important to remember that cost-effectiveness is a top priority for most policy-makers.
- To mobilise resources for "new" services, it has been proven beneficial to work with NGOs, the private sector and committees (PPIs).

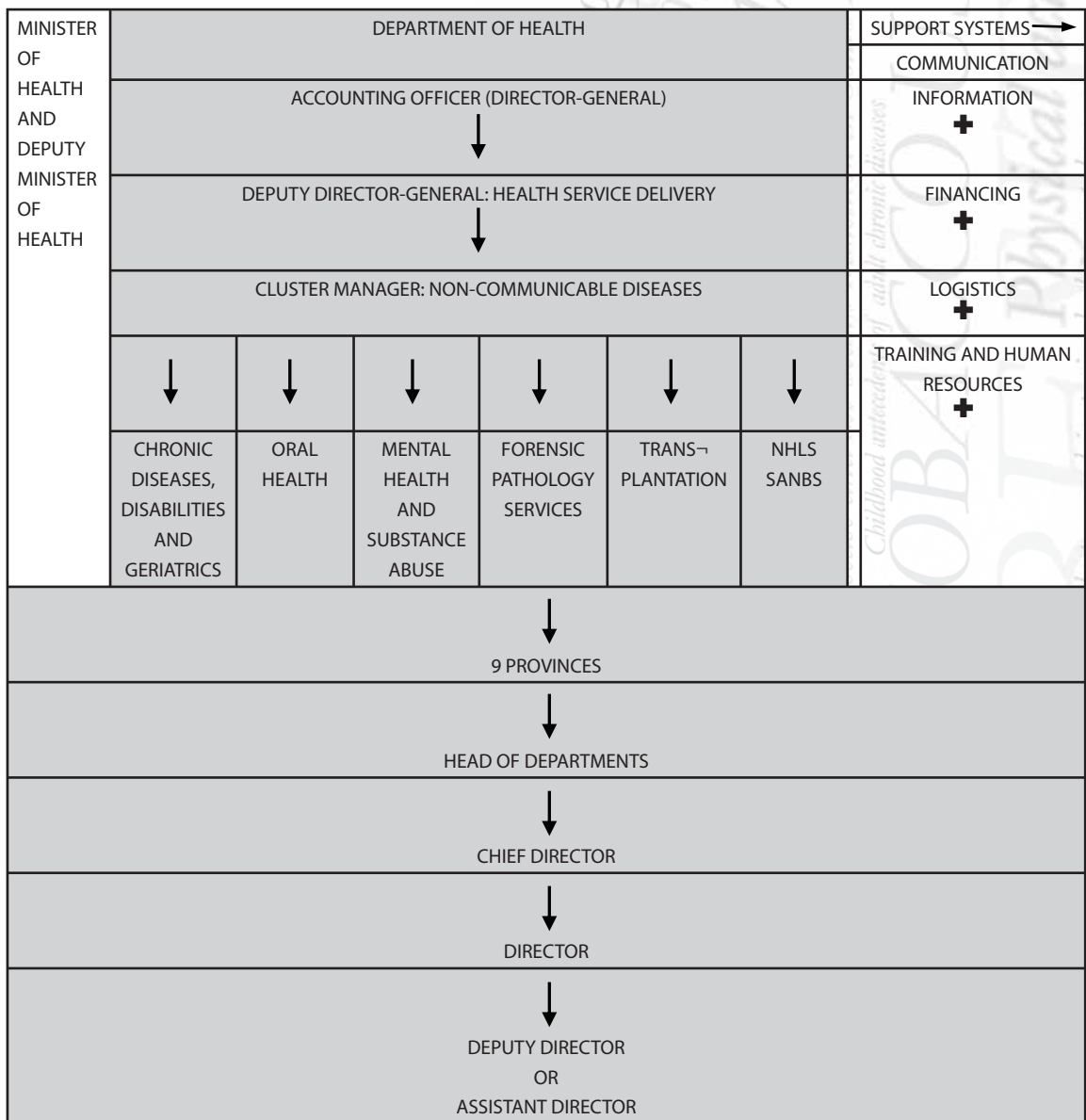


Figure 1: Health System and Governance Model (NCDs)