UNITAS Policy Brief

Universal coverage in Tanzania and South Africa: Monitoring and evaluating progress

South Africa's efforts to get doctors into public clinics

This policy brief forms part of the research undertaken for the UNITAS (Universal coverage in Tanzania and South Africa: Monitoring and evaluating progress) project.

UNITAS aims to support the implementation of reforms intended to make progress towards universal coverage in South Africa and Tanzania by monitoring and evaluating the policy formulation and implementation processes.

UNITAS has received funding from the European Commission's Seventh Framework Programme (FP7-CP-FP-SICA) under grant agreement number 261349

Key Points

- As part of its efforts to improve access to health care, SA is exploring ways to draw doctors into public PHC clinics
- Getting doctors into public clinics is benefiting patients and nursing staff alike
- However, a number of issues require detailed consideration before scaling-up this initiative, including:
  - The extent to which private GPs can be drawn on;
  - Whether attempts to recruit doctors to clinics will keep newly qualified doctors in the public sector, or simply redistribute public sector doctors from hospitals to clinics;
  - The costs and financial sustainability of this initiative
  - The effects on patient perceptions of nurses' clinical competence of introducing doctors into traditionally nurse-led services

Background

There is a mal-distribution of doctors between the public and private health sectors in South Africa. While the exact number of doctors working in each sector is contested, it is undisputed that there are more doctors working in the private than public sector relative to the population served by each.

Insufficient doctors in public sector primary health care (PHC) facilities can lead to high referral rates, increasing the burden on public hospitals and inconveniencing patients.

One way of addressing this problem is to draw on the human resources located in the private health sector.

South Africa has a long history of such arrangements. Prior to the first democratic elections in 1994, a 'part-time district surgeon' (PTDS) operated in small towns, whereby public patients were referred from nurse-run clinics to be seen by private general practitioners (GPs) in their rooms when care by a doctor was needed. This system was abolished shortly after 1994, due to discriminatory 'front-door, back-door' treatment of private and public patients respectively and fraudulent claims by some PTDS.

Over the years, some provinces contracted with GPs to undertake sessional work in public PHC facilities, but most frequently in district hospitals. With the growing HIV/AIDS

and associated TB epidemics, since 2005 there has been an initiative for GPs to undertake sessions in public PHC facilities to see HIV and TB patients. Participating GPs had to undergo training in HIV and TB management and adhere to national health department treatment guidelines.

The National Health Insurance (NHI) Green Paper released in August 2011 proposed wide-scale sessional contracting with GPs to provide a range of services in public clinics. Clinics are PHC facilities that historically have not had full-time doctors, but are almost exclusively staffed by nurses. This was implemented in 2013, but was replaced with an alternative strategy for employing doctors to work in public clinics in late 2014.

This policy brief reviews recent efforts to ensure that patients in public clinics benefit from some level of doctor service and critically assesses the implications of different approaches to achieve this goal. It is based on two rounds of detailed interviews with district, sub-district and facility managers as well as frontline health workers in three of the NHI pilot districts (one each in North West, Eastern Cape and KwaZulu-Natal)[1].

GP contracting

The National Department of Health (NDoH) advertised for GPs to take on sessional contract work in public clinics in March 2013. Ambitious targets were set with a goal of contracting 600 GPs in the 11 NHI pilot districts. This initiative was supported by a 'Ministerial Roadshow', where the Minister of Health visited each pilot district, including a meeting with local GPs to encourage them to take up these contracts. There were also considerable efforts to get clinics 'GP ready' by ensuring that the full range of essential equipment that doctors would require are available. In some clinics, additional consulting rooms were built.

Uptake was relatively slow, with only just over 100 GPs having signed contracts by March 2014, and with the greatest uptake being in districts that are largely urban. A key factor was the sessional payment rate, which was regarded as inadequate: *"The rate is far too low, and we won't be covering overheads if doing DoH clinic sessions.*" (South African Medical Association official).

There were also concerns about government's ability to pay GPs timeously, based on previously poor performance in this regard. It was partly for this reason that the contracts were managed by the national DoH as many of the previous problems related to payments by provincial health departments. However, national level contracting posed some challenges, particularly in terms of monitoring and accountability at district and facility levels.

In November 2014, a new model for 'getting doctors into public clinics' had been adopted.

The 'FPD model'

This model involves a somewhat complex arrangement involving a number of private, not-for-profit groups. The national DoH has contracted with the Foundation for Professional Development (FPD), which was established by the South African Medical Association (SAMA) some years ago. Africa Health Placements (AHP), which is part of the FPD group, recruits doctors who then contract with FPD to work in public clinics. Another organisation, Aurum (and in one district, the WRHI – Wits Reproductive Health & HIV Institute) provides day-to-day support for these doctors.

Under the FPD model, doctors are recruited and generally employed on a full-time basis. They are then required to work in one or more public clinics (e.g. spend 3 days a week in one clinic and 2 days a week in another). Many rural clinics have a low patient load and do not necessarily need a full-time doctor.

It appears that this initiative has been very successful in recruiting doctors to work in public clinics. One manager in the North West province said: *"It is amazing because they have been able to get us 25 doctors."* However, this number has since fallen to 15 due to resignations.

Early experience with doctors in clinics

There have generally been very positive responses from both nurses and patients to both initiatives to get doctors into public clinics. As expressed by a facility manager in KwaZulu-Natal:
"So, that is very helpful because our numbers of referrals to the hospital have declined, have gone down because the doctors are right here. Patients are benefiting and we also benefit because the workload on us is much less because if, if we not too sure of what to do the doctor is right here to ask. So it's good for us and it's good for patients."

[1] 11 districts were chosen to pilot reforms to strengthen primary health care in preparation for introducing a National Health Insurance (NHI) system.

Nurses seem to particularly welcome the opportunity to discuss clinical issues with doctors and through these engagements, to continually improve their clinical skills. Chronic disease patients reap the greatest benefits as they no longer have to go to a referral hospital to see a doctor.

While there are clear benefits of the 'doctors in clinics' initiatives, there are some concerns and issues that require further consideration, particularly in relation to the FPD model.

Who's who?

There is some confusion about which doctors are on which contract. While this may not matter in some respects for front-line health workers and patients if doctors are delivering services in the clinics, some issues surfaced in our research.

In particular, there are differences in remuneration levels and in reporting lines across the contracts. There are also differences in the range of services provided (e.g. some GPs remain on a provincial health department contract and only provide HIV and TB services, while 'NHI contracted GPs' and FPD doctors see any patient referred by nurses). It remains to be seen whether the different conditions of service leads to discontent among the different categories of doctors. Facility and district managers may also find oversight and management of doctors on different contracts challenging.

Where do the FPD doctors come from?

There are some examples of doctors who have left clinical practice being attracted back, e.g. recruiting retired doctors or mothers with young children, but the latter has only occurred where part-time contracts have been granted.

There are growing reports that FPD doctors are being recruited from public hospitals. In some instances, these are doctors who have just completed their year of compulsory community service. This may in fact serve to keep these doctors within the public health system, as many community service graduates cannot find posts in public hospitals and would otherwise have moved into private practice. The key problem with this category of recruits is that they are relatively inexperienced. However, FPD has its own academy and the doctors on these contracts are expected to attend a series of short-courses that contribute towards a Diploma in General Practice.

Nevertheless, there are concerns that doctors may be 'poached' from public hospitals. Given the urgent need to improve public sector PHC services in South Africa, some have commented: "*Maybe an exodus of doctors out of hospitals to clinics is just what we need!"* (University rural health division). However, a redistribution of doctors from hospitals to clinics does not resolve the relative undersupply of doctors overall in the public sector; it defeats the objective of the initial policy of trying to draw on private sector doctors to serve patients dependent on public sector services.

Where do the FPD doctors go?

Another concern relates to the allocation of the FPD model doctors across clinics. In the Eastern Cape, FPD doctors can choose from a set of options which clinics they want to work in. This can continue inequities across geographic areas as doctors tend not to agree to work in the most remote clinics. However, in the North West the process is being managed slightly differently; the FPD doctors have been assigned to rural clinics. The process of allocating doctors to clinics requires further consideration.

What are the costs of the FPD model and is it sustainable?

One of the biggest concerns about the new contracting model relates to remuneration. FPD doctors' remuneration is set at levels usually reserved for experienced doctors, and is equivalent to a doctor working full-time with an allowance for their overtime work, even though the FPD doctors do not undertake any overtime. This makes their conditions of service more attractive than for many doctors working in public hospitals, which may lead doctors working in other public facilities to push for unaffordable salary increases or to leave the public service. The following reflections by district managers in the North West highlight some of these issues:

"Salary is top of MO [Medical Officer] Grade 3 that young person with two years' experience would never get in public sector."

"Being an NHI doctor is a really comfortable job that anyone would want"

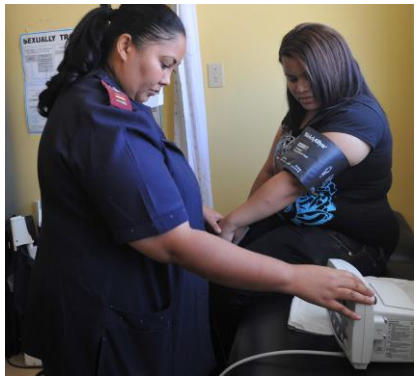
The administrative costs related to involvement of a range of organisations (AHP, FPD and Aurum/WRHI) in recruiting, contracting with and providing ongoing support to these doctors is currently unknown, but likely to be significant. These administration costs, along with the relatively high salary levels of FPD doctors, raises concerns about the long-term financial sustainability of this model.

It is unclear what is planned after the two-year contracts offered to FPD doctors expire. This is of considerable concern as there is previous experience of pharmacy assistants being recruited and given two-year contracts through Aurum. There was a lengthy delay in renewing these contracts, during which time clinics were left without pharmacy assistants.

As indicated previously, the FPD model signifies a move away from the initial intention to draw on private GPs to support the public PHC system; the FPD contracts are almost exclusively full-time employment contracts. The sudden move to this approach has damaged the relationship between GPs and the public sector in some respects. For example, the manager in one district worked very hard to persuade local GPs to be willing to take up NHI contracts. At the point when some GPs agreed to sign contracts, the FPD model was introduced with no prior notice to district managers.

This has further undermined private GPs' trust in the public health system and would make it very difficult revert to a model that seeks to draw on private GPs to support public clinics in future.

Moreover, the implications of scaling up the 'doctor in clinic' programme, but then having to scale down due to sustainability issues, are potentially quite serious. It creates expectations that referral to a doctor within the clinic will be available when needed. Nurses will face the difficult challenge of rebuilding the trust of patients in their clinical competence; there are reports that many patients are already demanding to be seen by the doctor, which is undermining the historically nurse-led public sector PHC system.



Conclusions

Increasing the availability of doctors in public sector clinics outside of the major urban areas has undoubted benefits for patients and nurses in these facilities and contributes to quality of care improvement objectives. However, a careful assessment of the alternative ways of doing this is required, before any of the options are scaled-up, to ensure long-term sustainability