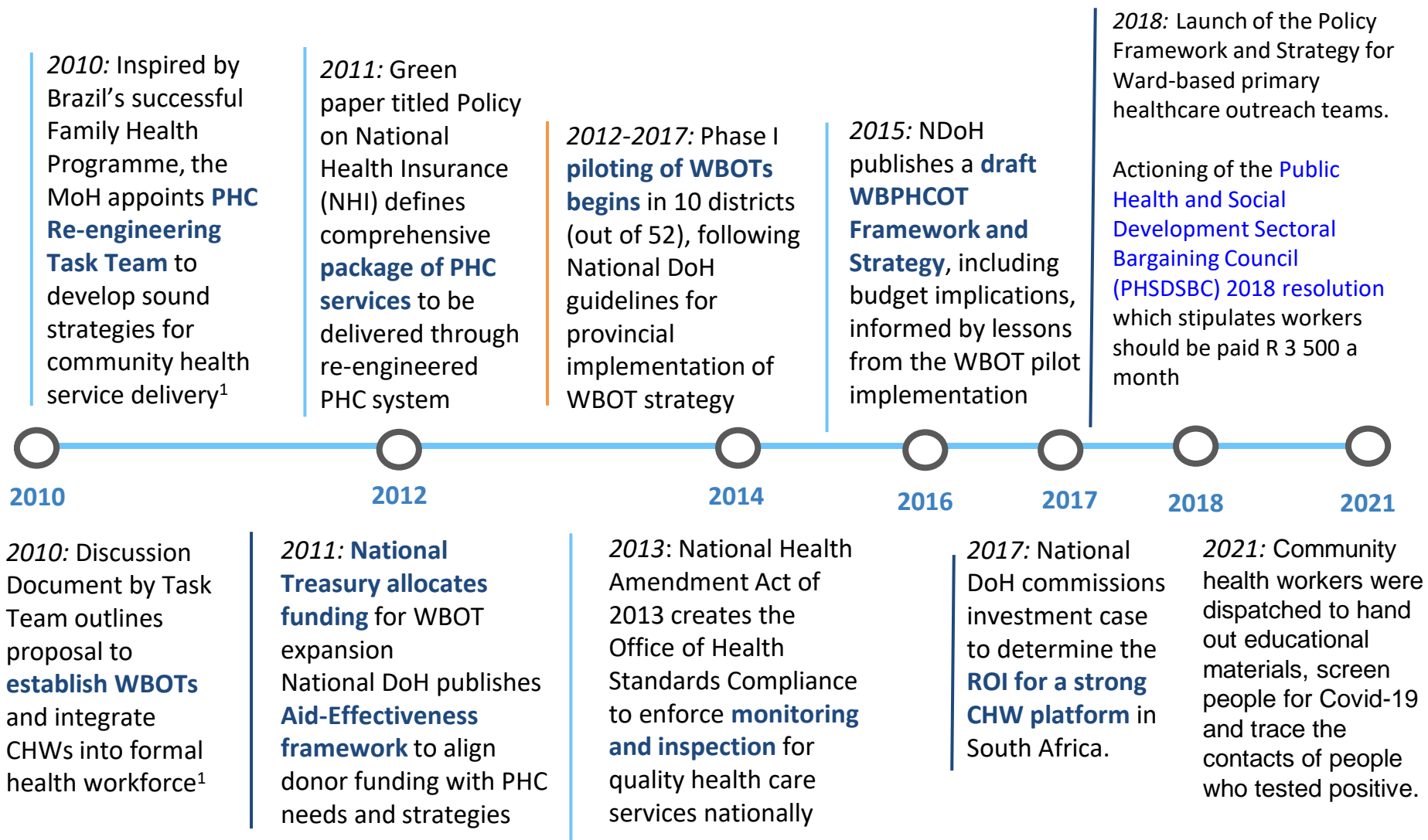


Financing Alliance for **Health**

The need for community health financing
and the financing mobilization process

South Africa Case Study

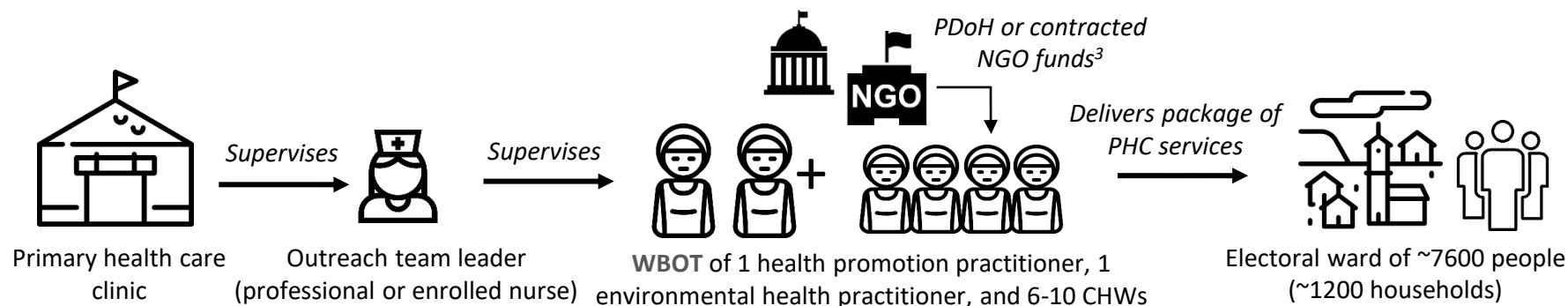
South Africa began a PHC re-engineering process in 2010



(1) Schneider, H., & Nxumalo, N. (2017). Leadership and governance of community health worker programmes at scale. *International Journal for Equity in Health*, 16(1), 1–13. (2) Naidoo, S. (2012). The South African national health insurance: A revolution in health-care delivery! *Journal of Public Health*, 34(1), 149–150. (3) Padarath, A., & Barron, P. (2017). *South African Health Review 2017*. Durban.

South Africa's district health system is the vehicle for service delivery by WBOTs

Ward-Based Outreach Team (WBOT) operating structure (2012-Present)



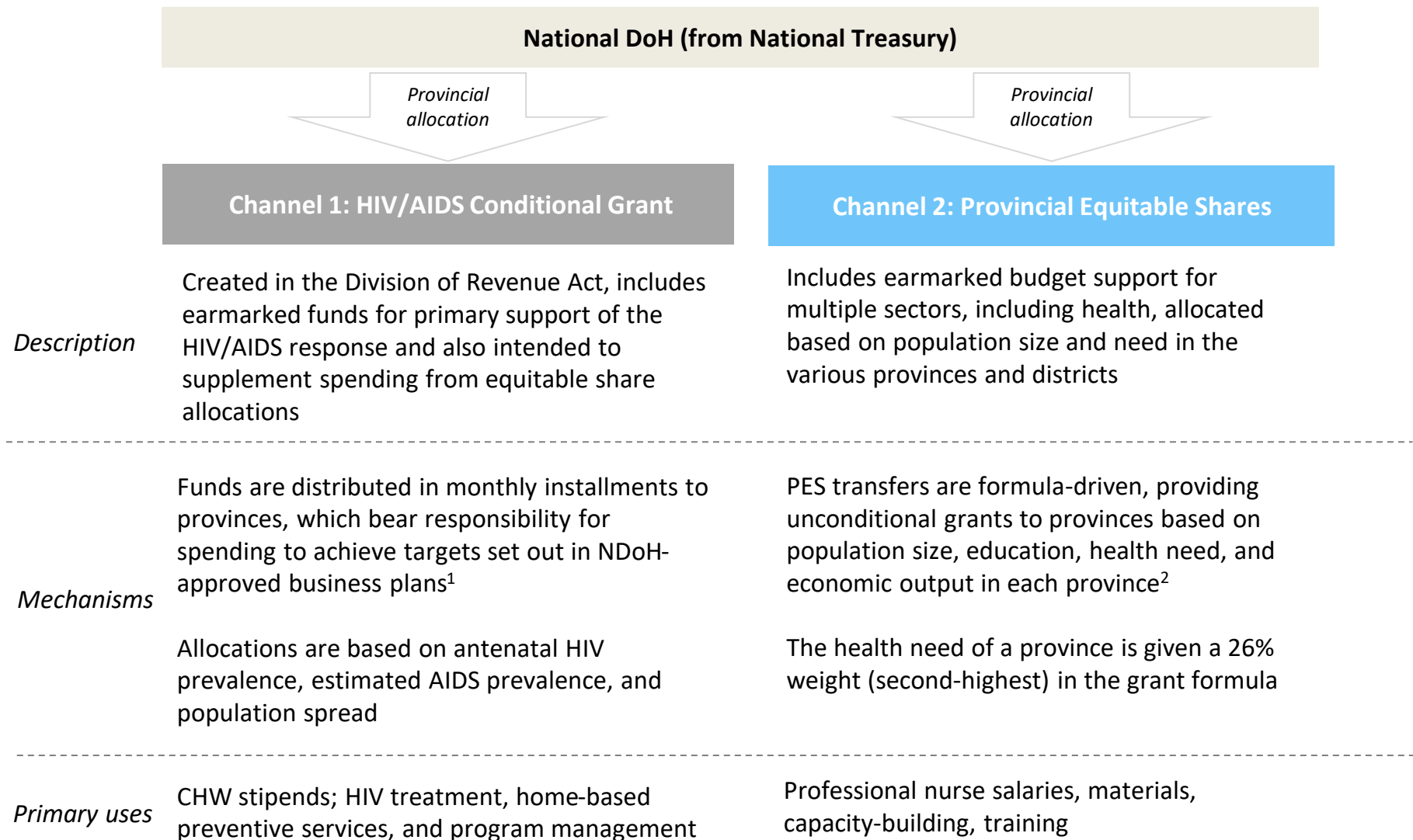
Community Health Workers

- **# in workforce:** ~65,000 (1:1000 population)
- **Time spent:** Varies greatly across rural, urban, and peri-urban settings²
- **Interventions:** 1) health education 2) disease prevention & control 2) hygiene & sanitation 3) family health 4) health needs assessments⁴
- **Selection:** Local residence + literate + 1 year experience as informal CHW + some training (un-accredited or accredited NQF level 1-4)
The National Qualifications Framework (NQF) is the principal instrument through which national education and training qualifications are recognized and quality assured
- **Training:** Phase I (10 days theoretical + 5 days practical) and Phase II training workshops¹
- **Health system linkage:** Refer clients to formal health services
- **Incentives:** R2500/month stipend (**\$208 USD**)

PHC Outreach Team Leaders

- **Time spent:** Full time, 55% on WBOTs, 45% on other clinical duties/consultations²
- **Duties:** Train, mentor, and supervise CHWs; manage team resources (financial, human, & material)
- **Selection:** registered nurse (4 year B nursing degree) or enrolled nurse
- **Training:** 5-day training around WBOT model

Funding for WBOTs flows from the NDoH through two channels for provincial allocation



A well-resourced WBOT strategy provides significant benefits for South Africa's health sector and economy

Investment Case for CHWs in South Africa

- In 2017, the NDoH commissioned an investment case to determine the ROI for a high-performing and well-resourced community health worker system in South Africa
- The case quantifies mortality and morbidity avoided with an effective WBOT system, clarifies the benefits to the South African economy and society, and estimates costs to inform improved financing strategies

IMPACTS OF A WELL-FUNCTIONING WBOT PLATFORM:

Maternal & Child Health

- A modest increase in coverage (10%) of key MCH interventions by WBOTs would **prevent 3,500 under-five deaths** on average each year
- Case detection and referral by WBOTs for pneumonia and diarrhea would save more than 900 lives yearly (28% of under-five deaths prevented)

HIV/AIDS & Tuberculosis

- When WBOTs take a proactive role in case finding and adherence support, **96,923 deaths and 343,743 new infections can be avoided** over 10 years
- R18.3 billion will be saved if patients are managed in HIV treatment adherence clubs compared to standard management
- When WBOTs provide DOTS to TB patients in communities, TB-associated health system **costs will decrease by 4%**, despite 16% additional patients treated

NCDS: Diabetes & Hypertension

- Spending 10% of their time on hypertensives, WBOTs can prevent 6,588 deaths and 73,717 DALYS over 10 years
- **WBOT hypertension interventions are cost-saving at \$6.50** if they reduce blood pressure by 5 mmHg or greater per patient
- Spending 10% of their time on diabetes care, WBOTs can control an additional 248,400 diabetes cases each year and **save R710 million in hospitalization costs**

Four primary lessons have emerged from South Africa's WBOT implementation strategy

- 1 Integration of CHW strategy into existing **district and sub-district mechanisms** for resource allocation and monitoring is imperative for scaling sustainable programs
- 2 **Detailed evaluation and data management** systems are needed to ensure cost-effective service provision and generate compelling evidence for financial support
- 3 **Strong sub-national leadership** and financial commitment is critical for catalyzing changes to community-based services systematically
- 4 Flexible funding streams and **standardized remuneration policies** are needed to sustain WBOTs

Integration of WBOT strategy into existing sub-district mechanisms helped to scale sustainable WBOTs

Resource Allocation & Planning

In the North West province, implementation was **aligned with existing district systems**:

- Use of district health information system (DHIS)
- Planning and training
- Household campaigns

Payment of CHW stipends in some provinces was directed through the government payroll to **improve timeliness and reliability**

Resource allocation priorities regarding staff and space were shifted at sub-district levels from treatment to prevention and health promotion

Despite budget constraints, “districts were being encouraged to ‘work differently’ within the PHC re-engineering framework and obtain necessary budget accordingly.” – Senior Provincial Manager¹

Coordination

In provinces with well-established NGO contracting systems, **cooperation and reallocation of responsibilities** were required

- Collaboration across all sectors and NGO partners must be a key indicator of WBOT performance²
- In the Western Cape, sub-district authorities took over NGO contracting to better incorporate local priorities

While national guidelines promoted WBOTs as an add-on service of PHC facilities, implementation varied across districts to **accommodate existing practices**²

- Teams in the Eastern Cape are organized around service points while Gauteng utilizes health posts situated at sites that already provide local services

Existing **professional relationships and monitoring mechanisms were reconfigured** to support WBOTs

- In Sedibeng, the sub-district management team attuned to community-oriented PHC practices mediated new relationships among WBOTs and PHC facilities

Effective data management is critical for high-quality service provision and generation of financial support

WBOTs have improved health system coverage and linkages

- Since PHC re-engineering began, the percentage of PHC facilities with functional clinic committees has increased to 73%, and WBOTs have proliferated, increasing communities' access to primary care services⁴
- DHIS data indicate positive associations between WBOT activities and under-five PHC facility utilization (8% reduction), hypertension screening (43% increase), and antenatal care coverage since 2014¹

Data connecting WBOTs to patient diagnoses and outcomes is needed to mobilize additional resources

DHIS data capture

The District Health Information System (DHIS) lacks data fields for capturing and analyzing household registration data and indicators of WBOT performance¹

To enhance MCH in particular, women seen postnatally by WBOTs should be recorded and linked with the postnatal visits already recorded in the DHIS³

Health identification and tracking

South Africa lacks a unique health identification system, that includes clinical coding data

Enhanced data capture would allow WBOTs to tailor services to individual needs, monitor local burdens of disease, and integrate priorities with district and municipal budget planning²

Outcomes and performance assessment

The paper health information system of most WBOTs hinders accuracy and timely reporting

“With data in a paper format, it is difficult to use...It stands in the file of the clinic. [Electronic] data and referral mechanisms are available at all times...I get the information on time from the WBOT.” –Northern Cape OTL²

Strong sub-national leadership catalyzed WBOT financing and implementation

Set sub-national priorities

Mobilize local actors

Forge collective visions

National policy provided the overall WBOT design, however, provinces were required to lead full development and implementation processes¹

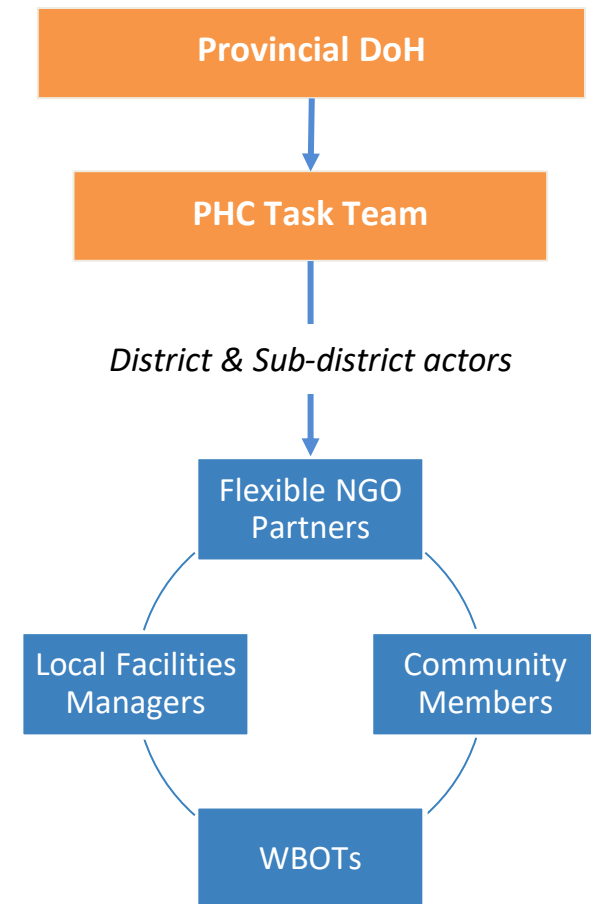
- Sub-national governments adapted national frameworks to local conditions, set priorities, and mobilized local actors
- Successful scale-up in the North West province is attributed to formation of common visions and privileging of local input through community dialogues

Establishment of strong sub-national implementation structures enabled feedback and accountability

- In the North West province, creation of a PHC Task Team (chaired by a provincial manager) helped to coordinate local actors
- Flexible NGO partnerships and consensus-building regarding changing roles supported sustainable implementation

Autonomy of WBOTs from PHC facilities improved team efficacy

- Creation of health posts in some provinces allow for controlled and effective WBOT autonomy from facility-based providers
- To reduce burdens of administration and oversight on PHC facilities, growing evidence suggests reporting and accountability by a designated sub-district manager is more effective²



Flexible funding streams and standardized remuneration policies are needed to sustain WBOTs

Challenges

Funding for CHWs via HIV conditional grant promotes emphasis on HIV prevention and care, rather than general service delivery³

- CHWs are trained on general service delivery, but focus primarily on HIV treatment adherence and follow-up
- Professional health care workforce is resistant to allowing CHWs to provide ICCM and general curative services

Inadequate remuneration and lack of full employee status promotes CHW attrition, demotivation, and lack of accountability¹

- CHWs are not integrated into the formal health workforce and do not receive benefits under current labor laws
- Stipends for CHWs through the HIV conditional grant vary widely across provinces from R1800-to R3500³

Functional authority over WBOTs creates practical and cultural management challenges¹

- WBOTs are organized under supervision of PHC facilities, however, this is often burdensome to CHWs and facility managers (outreach team leaders) who must balance work inside and outside the facility
- Facility-based managers cannot effectively coordinate and manage CHWs deployed to WBOTs by NGOs²

Proposed Solutions

- Standardized CHW stipends at the national minimum wage of R3,500 is imperative for improving CHW retention, morale, and effectiveness⁵
- Expanding conditional funding streams can allow for more effective provision of comprehensive PHC services
- As evidenced in the Western Cape, local situation appraisals can be conducted to identify key design challenges for reshaping existing community services and coordinating among governments and implementing partners⁴

New financing strategies are essential to reap maximum benefits from the WBOT platform

Challenges

Additional funding must be provided to optimize the WBOT platform

- The NHI White Paper's proposed financing methods will result in a shortfall in covering NHI costs, including full WBOT implementation²
- Stipends for CHWs do not fully cover transportation and health post development¹
- To reduce expenditures on private health services, the public health sector must be accessible and cost-effective for patients²

Multiple strategies are under consideration to sustainably fund WBOTs as part of NHI Fund implementation

- Tax structure revisions: PwC estimates a surcharge on taxable income, payroll tax, or increase in VAT must be 0.5-1% higher than presented in the White Paper²
- Medical schemes: State subsidies to private medical aid schemes will be reallocated to the NHI fund to support increased public health sector investment
- CHW salaries: Funding for salaries of R3500 should move outside the HIV conditional grant to meet the total R5 million required³

Proposed solutions

| Optimal WBOT platform in South Africa: | |
|--|--|
| Non-insured households in SA | 12.4 million |
| Home visits needed per year | 81 million |
| WBOTs required | 9,596 |
| CHWs required | 95,962 |
| Yearly total financial cost | R7.5 billion \$622 million USD |
| Provincial PHC expenditure | 15% Currently 4% |
| Additional spending required | R5.5 billion \$456 million USD |
| Total savings for health sector | R37.2 billion (10 years) \$3.1 billion USD |
| Additions to GDP (employment & productivity) | R424.5 billion \$35.2 billion USD |