



Primary Health Care

Now More Than Ever

# PRIMARY HEALTH CARE

**FUNDAMENTAL TO THE SUCCESS OF  
THE NHI**

Nkaki Matlala

RSA has been a global leader throughout the 20th century in the conceptualization and development of the PHC approach.

This PHC approach partially traces its origins to a small health unit in rural KZN in 1940 called Pholela Health Centre, which was a forerunner to Community Oriented Primary Care .This was among the earliest demonstration efforts to inform and define the practice of PHC.

Pholela was established by Dr Sidney Kark, who later brought his experiences to the Gluckman Commission as technical advisor in 1942.

The Commission(then called the National Health Services Commission, was tasked with the establishment of a National Health Service capable of providing adequate health services to **all sections of the South African Population.**

Due to the fundamental inability of the apartheid philosophy to accommodate the inherently progressive ,egalitarian and pro-poor principles of the PHC.....all these decades long efforts achieved very little.

**Box 1: The international dispersion of South Africa's Primary Health Care leadership**

<b>Destination of key South African community-oriented primary care practitioners</b>		
Sidney & Emily Kark	USA	University of North Carolina (Chapel Hill) – School of Public Health
	Israel	Hebrew University – Hadassah Medical School
Helen Cohn	Israel	
	Iran	World Health Organization (WHO)
	USA	Harvard University - School of Public Health
John Cassel	USA	University of North Carolina (Chapel Hill) – School of Public Health
Harry Phillips	USA	Harvard University - School of Public Health
	USA	University of North Carolina (Chapel Hill) – School of Public Health
Eva Salber	USA	Harvard University – School of Public Health
	USA	Duke University – Department of Family & Community Medicine
George Gale	Uganda	Makerere University – Medical School
	Malaysia	WHO
	Thailand	WHO
John & Grace Bennett	Uganda	Makerere University - Medical School
	Tanzania	
	Kenya	United Nations Children's Fund (UNICEF)
Langford Letlhaku	Uganda	Makerere University – Medical School
Miriam & Gershon Gitlin	Israel	Hebrew University – Hadassah Medical School
Charlotte Hopp	Israel	Hadassah Family & Community Health Centre
Joe Abramson	Israel	Hebrew University - Hadassah School of Public Health
Helen Pridan	Israel	Hebrew University - Hadassah School of Public Health

Source: Derived from multiple sources, including Kark and Kark, 2001.<sup>1</sup>

i. RSA introduced universal access to  
PHC in 1994.

ii. 53 Health Districts established

iii. Expansion of a network of clinics  
and an increase in the PHC budget.

iv. Norms and Standards for PHC  
package established in 2000

## MULTIPLE FACTORS LIMIT THE SUCCESS OF PHC

Medical migration

Health worker shortages

Resource imbalances

Personnel mal-distribution

Burden of disease

Curative orientation

Managerial capacity deficiencies

WHO (2003) reported that:

- i. 60% of healthcare institutions struggle to fill posts.
- ii. 4000 vacancies for GPs and 32000 for nurses.
- iii. 31% overall unfilled posts in the Public Sector.

This critical shortage of trained personnel and the inability to fill essential posts constitutes a key barrier to achieving the implementation and provision of district based health services in RSA.

Access is not only about physically entering a health care facility, it is also about having access to a qualified health provider.

An innovative way of incorporating the 63% of GPs who are in the private sector in the PHC **must** be found.

Many studies have indicated that the increased provision of PHC , as well as a greater supply of GPs is indeed associated with lower **medical expenses** at individual , district , country and medical insurance levels.(Grumback K. 2009)

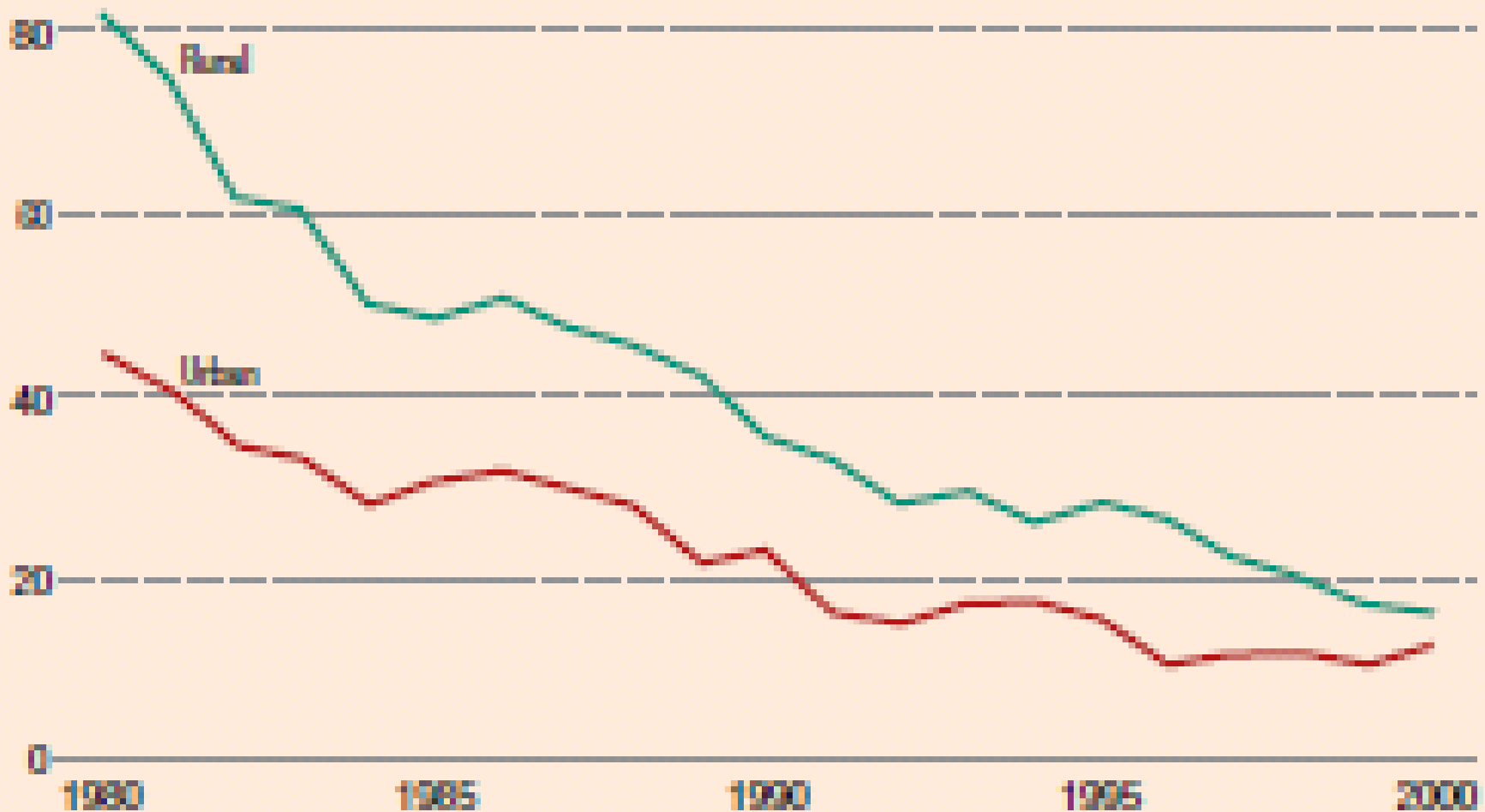
An increase in general practitioners per 10000 population is associated with a significant increase in the **quality of health services** as well as a **reduction in costs** per beneficiary.( Baicher and Chandra 2004)

An increase of 1 primary care physician per 10000 population was associated with a reduction of **34.6 deaths per 100,000 population!**(Shi 2004)

(Farmer , F. 1991) also showed that the higher the ratio of primary care physicians to population, the better the outcomes as measured by age-specific mortality rates.

**Figure 2.5 Under-five mortality in rural and urban areas, the Islamic Republic of Iran, 1980–2000<sup>37</sup>**

Mortality per 1000 children under five



# More evidence.....

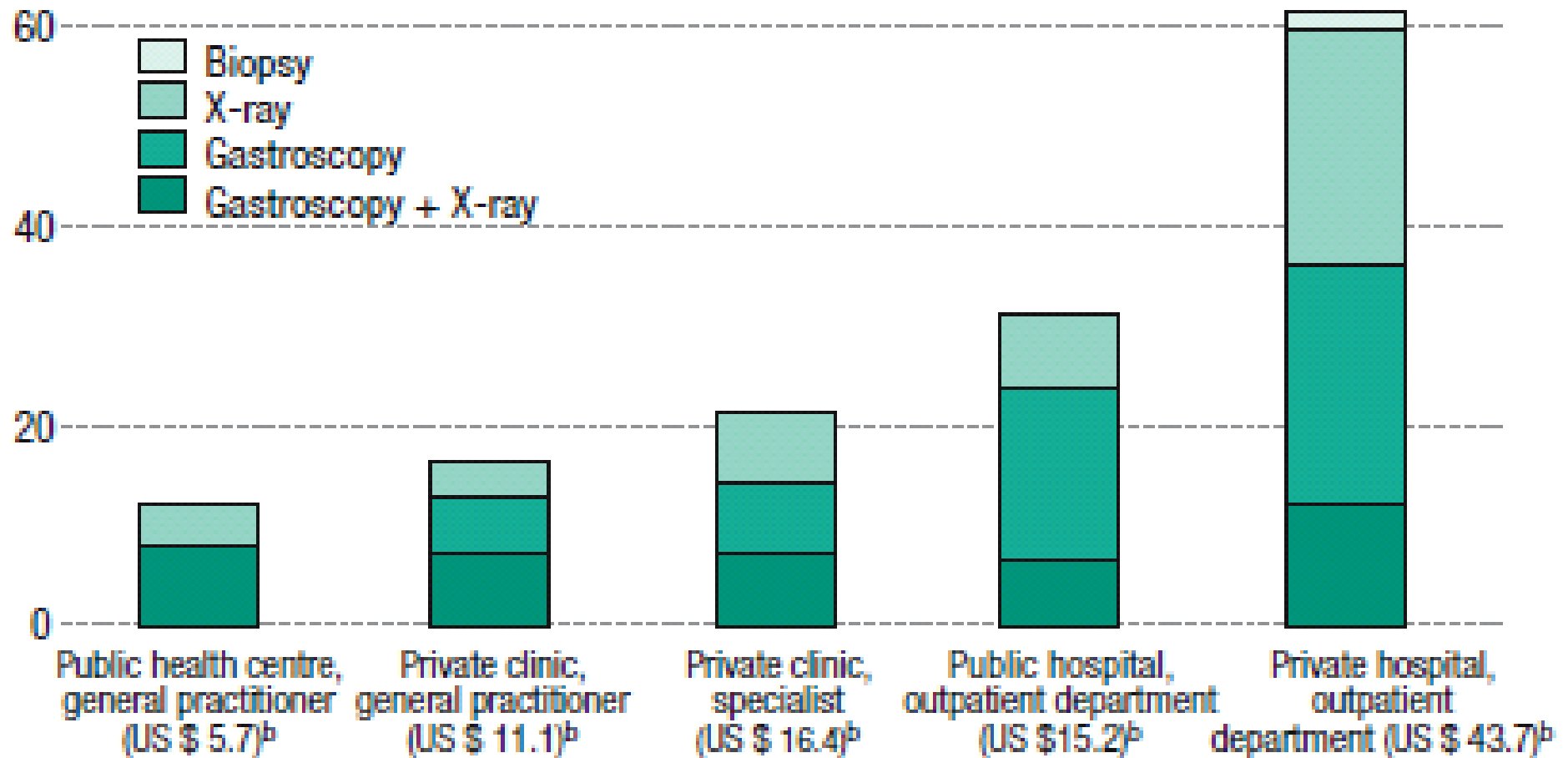
- 1/10<sup>th</sup> percentile increase in primary care physician supply  $\approx$  significant 4% increase in early breast cancer diagnosis.
- High specialist to population ratio  $\approx$  greater likelihood of late stage diagnosis of colorectal cancer.
- Advanced stage cervical ca less common in areas well supplied with GPs.
- Melanoma...identified at an early stage in areas of high family physician supply.

(Starfield, Shi and associates 2005)

“Individuals with poor access to PHC and its associated benefits are more likely to be hospitalized ; to delay seeking needed and timely preventative care; to receive care in ER and to have higher subsequent mortality and higher healthcare costs”  
(Starfield B )

**Figure 3.4 Inappropriate investigations prescribed for simulated patients presenting with a minor stomach complaint, Thailand<sup>a,b, 162</sup>**

Patients for whom inappropriate investigations were prescribed (%)



<sup>a</sup> Observation made in 2000, before introduction of Thailand's universal coverage scheme.

<sup>b</sup> Cost to the patient, including doctor's fees, drugs, laboratory and technical investigations.

The latest debate around the NHI is about the cost thereof.

Both the opponents and supporters of the NHI agree that the costs are astronomical.

It is therefore logical that the “**Big Bang**” approach that came through in the early debates around the NHI is impracticable without major disruptions.

The MOH has admitted that the NHI might take up to 5 years to implement.

While the architects of the NHI are still debating behind closed doors, the public should take the discussion forward and begin to structure processes that might actually assist the MOH ;the MAC and the nation at large.

The greatest barrier to consulting private primary physicians is OOP expense.

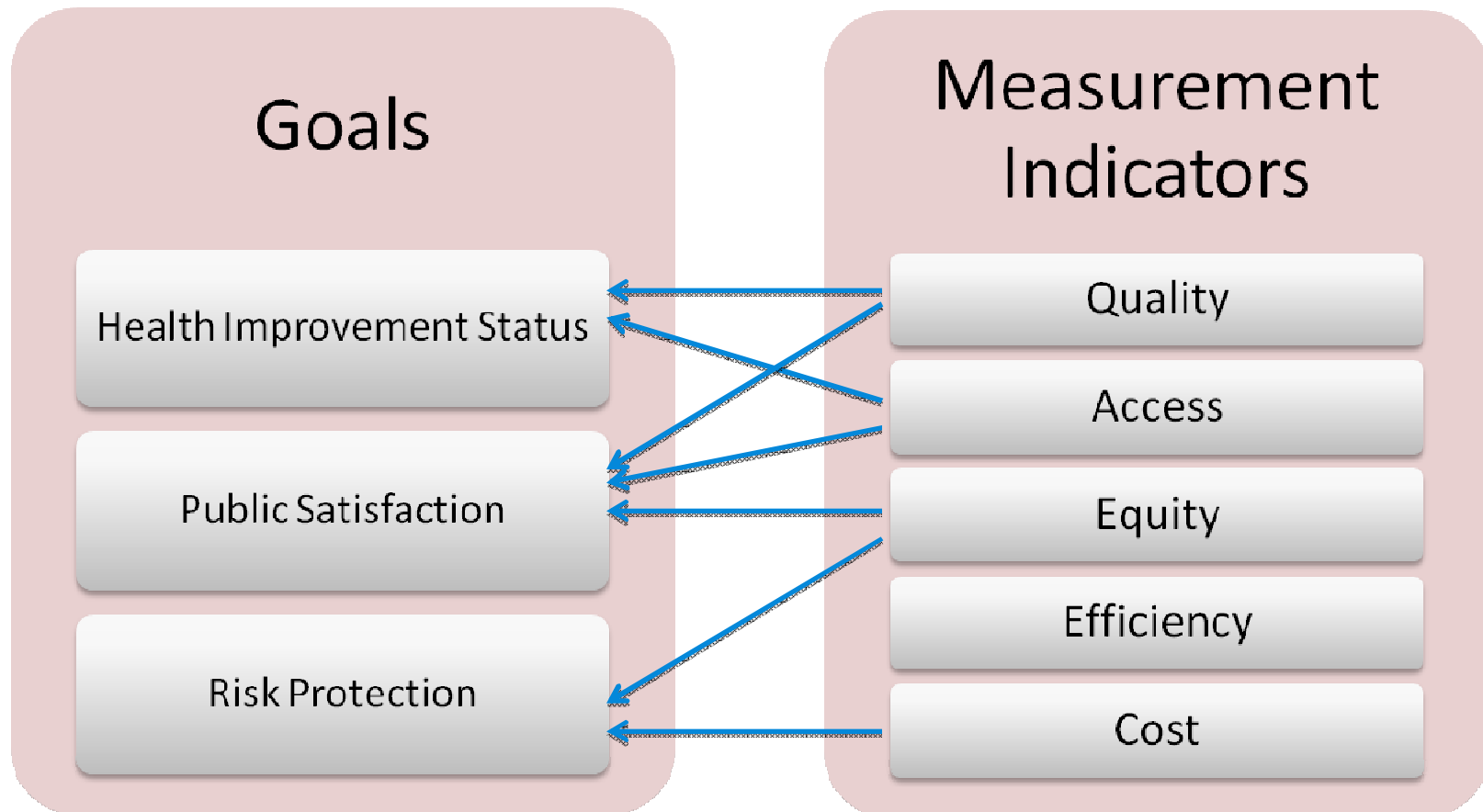
Funders ; Business and Government must come with an innovative way of pooling funds for the poorest in order to eliminate OOP expense at primary care level as a first step.

The WHO in its Technical Briefs for Policy makers No.1 (2005) ; recommends that “realizing universal coverage means coordinating or combining private , community, cooperative and employer based schemes progressively into a coherent whole that ensures coverage to all population groups.

## This will result in .....

- Immediate increase in access to GPs, an internationally proven critical component of PHC
- Increased usage of primary care services.
- Reduction in self referrals to secondary, tertiary and quaternary services.
- Improvement of health related MDGs.
- The beginning of a roll-out of the NHI

# and will also achieve the main goals of Healthcare Reform



# **In conclusion one proposes**

- 1. Improvement of PHC by among others ,expanding the service with the inclusion of GPs/family practitioners.**
- 2. Having a conversation between funders ; business; government and healthcare providers to arrive at a practical solution.**

**I THANK YOU HEARTILY**