SAHeart response to SDGs and CVD crisis in South Africa

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NCDs ACROSS THE SDGs
A CALL FOR AN INTEGRATED APPROACH

The inclusion of NCDs in the 2030 Agenda reaffirms that NCDs are a priority for sustainable development. It is now imperative that governments act on their commitments on NCDs and health more broadly.

NCDs – including cardiovascular disease, cancer, diabetes, chronic respiratory disease, and mental and neurological disorders – account for 68% of global mortality, and are the leading cause of death and disability worldwide.

More than 40% of these deaths were premature deaths under age 70 and 82% of these occurred in LMICs.

Mortality among people in their most productive years has significant impact on economic development and can undermine progress.

The projected cumulative lost output due to NCDs in LMICs for 2011-2025 is 7 trillion USD. This far outweighs the estimated 11.2 billion USD cost of implementing a set of high-impact, cost-effective interventions to reduce the burden of NCDs.
#WORKFORCE2030
and the Sustainable Development Goals

HEALTH WORKERS - A PROVEN RETURN ON INVESTMENT

GOAL 1
NO POVERTY
Healthy societies are engines for economic growth. Health workers are at the core of health systems ensuring healthy lives and well-being.

GOAL 2
ZERO HUNGER
Substantive and strategic investments in the global health workforce are essential to provide essential health services including those related to nutrition.

GOAL 3
HEALTH AND WELL-BEING
The health workforce is central in translating the vision of universal health coverage into reality. Goal 3: "To substantially increase health financing and the recruitment, development, training and retention of the health workforce ... sets the foundation for the vision and objectives of the Global Strategy on Human Resources for Health: Workforce2030, which provides guidance and policy options for countries looking to improve the health of their populations.

GOAL 4
QUALITY EDUCATION
Girls' education is a strategic development investment. Inclusive and equitable education can lead to greater economic growth, better health outcomes, and improved global security. Equal opportunities to affordable and quality technical, vocational and tertiary education will improve the pool of high-school graduates and qualified health workers.

GOAL 5
GENDER EQUALITY
Women are a large part of the health workforce and obtaining qualified jobs in the formal sector of the economy can be a driver of gender empowerment. However, opportunities for women to engage in high level professions are constrained. Health workers' employment conditions need to be gender-sensitive allowing equal opportunities for career development, violence, harassment and discrimination during training, recruitment, employment and in the workplace must be eliminated.

GOAL 8
REDUCED INEQUALITIES
Migration and mobility of health workers can result in inequitable access to health care, within and among countries. The WHO Code of Practice on International Recruitment of Health Personnel is a framework for guiding national dialogue among sectors and stakeholders to inform solutions to the challenges of health system sustainability and workforce mobility.

GOAL 10
REDUCED INEQUALITIES
The health care sector is one of the largest employment sectors in most countries. It is a source for full and productive employment and decent work for all women & men and can actively counter high rates of youth unemployment in urban, rural and remote areas.

GOAL 11
SUSTAINABLE CITIES AND COMMUNITIES
The majority of the world’s population lives in urban areas. Over 3.9 billion in 2014, of which 629 million live in slum conditions. Equitable access to health care will improve basic services for all.

GOAL 17
PARTNERSHIP FOR THE GOALS
Multi-stakeholder partnerships: The design and implementation of effective health workforce policies rest on collaboration across different sectors (health, education, finance, labour) and stakeholders (public and private employees, professional associations, trade unions). Strengthening such collaborative platforms can have positive cascade effects on national and global partnerships for sustainable development.

Data, monitoring and accountability: The Global Strategy on Human Resources for Health: Workforce 2030 calls for investments in strengthening country analytical capacities of human resources for health and health system data.
Cardiology–cardiothoracic subspeciality training in South Africa: a position paper of the South Africa Heart Association

Karen Sliwa, Liesl Zühlke, Robert Kleinloog, Anton Doubell, Iftikhar Ebrahim, Mohammed Essop, Dave Kettles, David Jankelow, Sajidah Khan, Eric Klug, Sandrine Lecour, David Marais, Martin Mpe, Mpiko Ntsekhe, Les Osrin, Francis Smit, Adriaan Snyders, Jean Paul Theron, Andrew Thornton, Ashley Chin, Nico van der Merwe, Erika Dau, Andrew Sarkin
TRAINING OF DOCTORS AND HEALTHCARE PERSONNEL IN SOUTH AFRICA

- Between 2000 and 2012, the number of medical students per annum increased by 34%, with a major and deliberate demographic shift towards more female students and African blacks.
- Subsequently, the number of graduating doctors has increased by 18% in the same time period.
- However, the ratio of physicians per 1 000 population remained the same (0.77 in 2004 vs 0.76 in 2011) and is failing to keep up with the growth of the population.
Fig. 3. Registered specialists in South Africa versus number of specialists needed per million population.
Gaps identified

- Inadequate number of training posts.
- Inadequate pool of trained cardiovascular specialists particularly in the public sector.
- Internal and external brain drain.
- Specialists not used optimally considering low number of specialists in South Africa and therefore late or inappropriate referral from the community level.
Health system weaknesses in CVD space

- Lack of strategies for increase specialist training for cardiovascular disease in South Africa.
- Insufficient epidemiological data on CVD and it’s medical and surgical management in South Africa.
- Overall low CVD scientific output making health care planning difficult.
- Health policy decision makers and CV specialist inertia to increase training opportunities.
- Low investment in research & development infrastructure and lack of science and technology culture.
- Lack of recognition of the scientist’s role.
Suggested solutions for discussion

- Create more posts for cardiovascular academics, promote career development and other incentives for teaching roles.
- Close engagement of specialists in academic hospitals and private practice.
- The establishment of a private training Centre for Cardiologists following the same curriculum they follow in the state, based at a Centre of Excellence.
- Use of non-physician technicians, medical officers in the use of hand-held echocardiography for early cardiac disease detection facilitating early referral to cardiologist/cardiothoracic surgeon.
Suggested solutions for discussion

- Invest in regulation that promotes public-private partnerships on research.
- Improve science and technology infrastructure acquiring better epidemiological data on CVD as part of health system strengthening strategies.
- Progressive increase in the % of GDP allocated to research & development, better recognition of the role of the clinician –scientist and subsequent increase in scientific output related to cardiac disease.
Closer engagement with department of health and education to increase training posts

CVD diagnosis, treatment and management - The comprehensive service-human, technology and practical resources.
Strategic Operational Plan
Cardiovascular Disease
SA Heart® and the DOH
‘STILL NOT CLEAR’ WHERE MONEY WILL COME FROM

NHI to cost R69 billion over 4 years

Ana Reporter

THE implementation phase of the National Health Insurance (NHI), set to initially service women, children, the elderly and people with disabilities, is projected to cost taxpayers more than R69 billion over a four-year period, Health Minister Aaron Motsoaledi announced yesterday.

Motsoaledi was addressing journalists in Cape Town and Pretoria on details of the NHI white paper, the policy document which outlines how government aims to pool resources to create a quality health care system for all citizens, which will be published in the government gazette today.

Motsoaledi broke down the cost of the four-year implementation phase of NHI for targeted patients, irrespec-

sector R2 000 to pay for one dose of herceptin, an effective treatment for some forms of breast cancer, with 17 doses needed. Some medical aids do not pay for this treatment.

“Even people on medical aid who have good employment are struggling,” he said.

Motsoaledi said by pooling resources and buying herceptin in bulk, the drug would cost less.

South Africa exceeds the World Health Organisation target of spending 5% of GDP on health. Motsoaledi said South Africa spends 8.5% of its GDP on health care. However, health outcomes were worse than in other countries which spent less.

Motsoaledi said the problem was that 4.4% of South Africa’s GDP was spent by the private sector, which catered for only 16% of the population, while the remaining 41% was spent by the public sector which services 84% of the population.

While it’s still not clear where the money will come from, the minister quoted former colleague Pravin Gordhan during the February Budget speech, repeating that various funding options would be explored, including “possible adjustments to the tax credit on medical scheme contributions”.

At the time, Gordhan said further details would be provided in the medium-term Budget policy statement in October this year.

Motsoaledi said the face of emergency services would change under NHI.
### Long Term Goals:

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**System building blocks**

- Leadership / governance
- Health care financing
- Health workforce
- Medical products, technologies
- Information and research
- Service delivery

**Goals/outcomes**

- Improved health (level and equity)
- Responsiveness
- Financial risk protection
- Improved efficiency
| PEOPLE | Sufficient staff numbers to manage the patient load in all provinces |
|        | Strengthen the district health system by having suitably trained staff at various levels to do the screening and provide appropriate care |

| OPERATIONAL | Align infrastructure/equipment /consumables to improve levels of care at rural and urban primary, secondary and tertiary levels in all 9 provinces |
|             | Clearly defined care packages at all levels |
|             | Appropriate, streamlined referrals between primary, secondary and tertiary level of care |
|             | Provide specialist cardiovascular services in all provinces |
|             | Reliable NCD epidemiological database |
|             | Established collaborations with satellite training centers in the private sector |

| FINANCIAL | Ring fenced funds for cardiovascular care |

| STAKEHOLDERS | Changed perception of decision makers with regards to recognition of CVD as a serious health issue resulting in the will to improve standards of care |
|             | Collaboration at a National level with all entities that work in the NCD space |
|             | Raised profile of cardiovascular disease incorporating disease profiling and the actions that should be taken |
SA heart is deeply concerned that our public service has reduced and frozen training posts, progressively whittled down the number of tertiary hospital beds, and has failed to provide an environment conducive to the delivery of cardiovascular healthcare that would comply with internationally acceptable standards.
Projected change from 2015 to 2040 in percentage of disease burden due to noncommunicable diseases (NCDs) by score on the health system capacity index.
THANK YOU