BHPSA
BETTER HEALTH PROGRAMME
SOUTH AFRICA

BHPSA COMMENTARY

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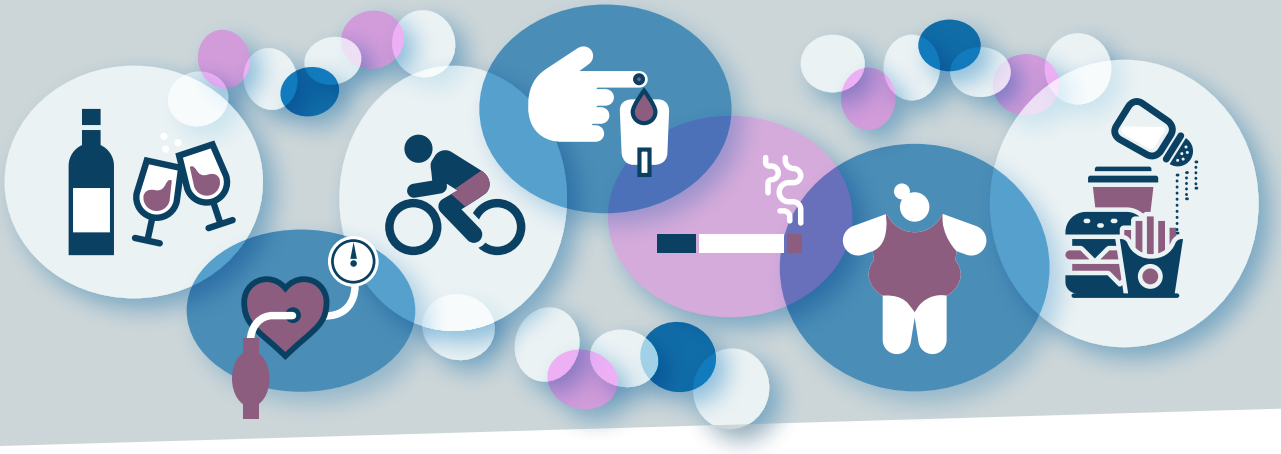
NCDS, UHC AND NHI

UNPACKING THE LINKS – AND THE ACRONYMS



UHC

The World Health Organization (WHO) describes Universal Health Coverage (UHC) as health care where "all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course."[1] UHC was one of the targets set when world leaders adopted the Sustainable Development Goals (SDGs) in 2015.

South Africa has confirmed its commitment to UHC and has translated it into a concrete programme – National Health Insurance (NHI) – which aims to provide universal, quality health care to all South Africans regardless of their socio-economic status. Currently, Parliament is hearing submissions on the NHI Bill of 2019, which is in its final stages.

NCDs

The rising global burden of noncommunicable diseases (NCDs) and its economic cost have long been of concern to world leaders who have committed to addressing NCDs at UN General Assembly high-level meetings since 2011. In 2016, NCDs were included in SDG Target 3.4: "By 2030, reduce by one-third, premature mortality from NCDs through prevention and treatment and promote mental health and well-being".

The 2018 UN General Assembly identified the key NCDs as cardiovascular disease, chronic respiratory diseases, cancer, diabetes, and mental health conditions, which together cause 71% of deaths worldwide. Key NCD risks are unhealthy diet, tobacco use, air pollution, harmful use of alcohol and physical inactivity.[2]

The 2020 Lancet NCDs and injuries (NCDI) Poverty Commission argues for a broader approach that includes those NCDs not linked to preventable risk behaviour, which disproportionately impact the poor. These are type 1 and malnutrition-associated diabetes, rheumatic heart disease, childhood cancers, asthma, chronic kidney disease, epilepsy, mental health conditions, trauma, and other conditions. The Commission investigated the impact of NCDI Poverty for the world's poorest billion and found that NCDIs constitute more than a third of the disease burden; around half of this burden is due to causes afflicting children and young adults.3

1 https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

2 World Health Organization. (2018). Third United nations high-level meeting on NCDS. In *WHO https://www. who. int/ncds/governance/third-un-meeting/en.*

3 Bukhman, G., Mocumbi, A. O., Atun, R., Becker, A. E., Bhutta, Z., Binagwaho, A., ... & Wroe, E. B. (2020). The Lancet NCDI Poverty Commission: bridging a gap in universal health coverage for the poorest billion. *The Lancet*, *396*(10256), 991-1044.

NCDs IN SOUTH AFRICA

The true scale of NCDs in South Africa is difficult to estimate with any certainty due to data challenges and the complexity of NCD conditions. However, many studies point to a heavy burden of disease with the WHO estimating that NCDs accounted for 51% of all deaths in the country in 2016.[4]

The 2010 Burden of Disease study by the SA Medical Research Council (SAMRC) showed that by 2010, NCDs accounted for 39% of total deaths in South Africa.[5] More than a third (36%) of these deaths occurred in people younger than 60 years, ostensibly the economically productive workforce. While overall mortality from NCDs declined slightly (by 0.4%) between 1997 and 2010, trends for different diseases varied. For example, there was an increase in mortality from diabetes mellitus, renal disease and endocrine/ nutritional and blood disorders, which was attributed to lifestyle changes. The decrease in mortality rates from ischaemic heart disease, lung cancer, chronic obstructive pulmonary disease and asthma was attributed to the effects of tobacco control interventions.

The annual SAMRC report on mortality discusses the probability of dying prematurely, between the ages of 30 and 70 years, due to an NCD. In 2017, this probability was 34% for males, 24% for females, and 29% overall, with no significant change between 2011 and 2016. The highest single cause of death from NCDs was cardiovascular disease, followed by cancer, diabetes and chronic respiratory disease.[6]

This epidemic of NCDs is not confined to urban areas. One study in rural KwaZulu-Natal found that out of 570 people screened 71% were obese, 33% had hypertension, 20% had high blood cholesterol and 12% had major depressive symptoms.[7]

Obesity, in itself considered an NCD as well as a major risk factor for other NCDs, is a serious condition among female South Africans. A 2016 survey in South Africa found that 27% of women were overweight, and 41% were obese (a fifth were severely obese). The majority of men were in the normal range, with 31% being overweight or obese.[8]

NCDs AND UHC

The Lancet NCDI Poverty Commission concluded that NCDI poverty is one of the largest gaps and largest opportunities for UHC. "The Commission shows that addressing NCDIs is key to achieving progress towards universal health coverage (UHC), with NCDIs accounting for 60–70% of the UHC financing needs in the low-income and lower middle-income countries".[9]

The global NCD Alliance argues that the NCD epidemic poses a unique challenge to three dimensions of UHC. Firstly, access and availability to essential NCD services remains unacceptably low in many low- and middle-income countries (LMICs) ; secondly, major inequalities exist in terms of NCD risk, access to services, and health outcomes; and thirdly, the NCD epidemic imposes a huge economic burden on national budgets and can push households into poverty. Achievement of UHC will therefore be dependent on prioritising NCD prevention and control in UHC design.[10]

On the other hand, the Alliance argues that lessons learned from the NCD response can help support pathways to UHC. These include a focus on health promotion and prevention, multisectoral approaches, addressing the social and commercial determinants of health, and domestic innovative financing mechanisms (including taxation on unhealthy products). Reducing the NCD burden will also strengthen a country's capacity to achieve universal health access by reducing the huge economic burden these diseases place on the state.

The WHO's Global Action Plan for the Control of NCDs 2013–2020 recommends that countries strengthen their health systems and address NCDs through people-centred primary healthcare (PHC) and UHC. Recommendations include 'Best Buys', guidance on the most cost-effective interventions to prevent NCDs, which include the WHO Package of Essential Noncommunicable disease interventions (WHO PEN), cost-effective interventions for the early detection and management of NCDs.[11] More recently, PEN-Plus has emerged as an integrated strategy that builds on the WHO PEN to increase the quality of services for severe chronic NCDs at primary referral facilities and focuses on the broader set of conditions relating to NCDI Poverty.[12]

SA'S NCD SERVICE GAP

There is no comprehensive analysis of access to NCD screening, treatment, support and prevention services in South Africa, but several studies suggest that there are significant NCD service gaps.

Studies primarily focussed on HIV screening point to high levels of undiagnosed NCDs. For example, a recent study in northern KwaZulu-Natal screened over 17,000 HIV-positive people for diabetes, high blood pressure, nutritional status (obesity and malnutrition), tobacco and alcohol use, as well as HIV and tuberculosis. The study found that the majority of people with tuberculosis, diabetes or hypertension were either undiagnosed or not well controlled. Among the study participants, half of those 15 years

4 World Health Organization. (2018) Noncommunicable Diseases (NCD) Country Profiles: South Africa. https://www.who.int/nmh/countries/zaf_en.pdf

5 Nojilana, B., Bradshaw, D., Pillay-van Wyk, V., Msemburi, W., Somdyala, N., Joubert, J. D., ... & Dorrington, R. E. (2016). Persistent burden from non-communicable diseases in South Africa needs strong action. *South African Medical Journal, 106*(5), 436-437.

6 Dorrington, R.E., Bradshaw, D., Laubscher, R., Nannan, N. (2019). Rapid mortality surveillance report, 2017. Cape Town: South African Medical Research Council. ISBN: 978-1-928340-36-2.

7 Van Heerden, A., Barnabas, R. V., Norris, S. A., Micklesfield, L. K., van Rooyen, H., & Celum, C. (2017). High prevalence of HIV and non-communicable disease (NCD) risk factors in rural KwaZulu-Natal, South Africa. *Journal of the international AIDS society, 20*(2), e25012.

8 National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC), and ICF. (2019). South Africa demographic and health survey 2016. *Pretoria, South Africa.*

9 Zuccala, E., Horton, R. Reframing the NCD agenda: a matter of justice and equity. (2020) *The Lancet 396* (10256) 939-940.

10 NCD Alliance. Policy Brief: Universal Health Coverage and noncommunicable diseases, a mutually reinforcing agenda. 2014 https://ncdalliance.org/sites/default/files/resource_files/UHC%20and%20NCDs%202014_A4_final_web.pdf

11 Tesema, A. G., Ajisegiri, W. S., Abimbola, S., Balane, C., Kengne, A. P., Shiferaw, F., ... & Peiris, D. (2020). How well are non-communicable disease services being integrated into primary health care in Africa: a review of progress against World Health Organization's African regional targets. *PloS one*, *15*(10), e0240984.

12 http://www.ncdipoverty.org/penplus-implementation-rfi

and older had at least one active disease, and 12% had two or more diseases.[13]

Another study reviewed case folders from nine primary care centres in Cape Town of 491 adolescents (10-24 years) living with HIV and found limited NCD screening and health promotion.[14] Only 55% of folders had any information on other comorbidities, and only 62% had information on risk factors. Of the participants with documented comorbidities, 11% had an NCD diagnosis, with chronic respiratory diseases (60%) and mental disorders (37%) being most common. Despite this, only one participant was documented as receiving treatment for asthma. Of those with documented anthropometrics, 48% were overweight or obese. Only 26% had a documented health-promoting intervention. A key finding of this study was that poor documentation and screening demonstrates missed opportunities for detecting NCDs and NCD risk in primary health care, and for early intervention.

NCDs may be poorly controlled after diagnosis and initiation of care. For example, the 2019 Western Cape Burden of Disease review found that around 70% of diabetics in care had uncontrolled glucose levels.[15]

NCDs, NHI AND UHC

Closing the NCD service gap is fundamental to achieving UHC through NHI. This includes scaling up screening and treatment for NCDs as well as prevention through health promotion and addressing structural determinants of key NCD risks. Fundamental to this challenge is the strengthening of health information systems to provide timely and accurate data on NCDs and the NCD service gap.

The SA National Strategic Plan for NCDs, which is currently in development, commits the country to the SGD target of reducing NCDs by one third, by 2030. It is an integrated 'whole-of-health' plan that relies on multisectoral collaboration to address all aspects of NCDs. However, there are concerns that the NHI Bill in its current form is heavily focussed on curative aspects of NCDs.[16] A team commenting in BMJ Global Health concluded that this is a challenge common to many African countries: "The political will for UHC in Africa will miss the opportunity to turn the tide of this emerging NCD epidemic in Africa, if not oriented to a systems-for-health rather than a solely healthcare-centric approach. A successful approach needs to proactively incorporate wider health determinants (sectors)—housing, planning, waste management, education, governance and finance,

among others—in strategies to improve health. This includes aligning governance and accountability

mechanisms and strategic objectives of all 'health determinant' sectors for health creation and long-term cost savings."[17]

BHPSA is supporting the NDoH to close the NCD gap as one of the pathways to achieving UHC.

The work includes strengthening the national policy environment, community outreach and digital data sets for NCDs.

Key policy support has been for the development of the new multisectoral NCD NSP (2021-2026) and the five-year National Obesity Strategy (2021-2026). BHPSA is also supporting the strengthening of the NCD component in community health worker training through revising the training module and an implementation pilot.

Read more about BHPSA support for NCDs and UHC here

13 Wong, E. B., Olivier, S., Gunda, R., Koole, O., Surujdeen, A., Gareta, D., ... & Harilall, S. (2021). Convergence of infectious and non-communicable disease epidemics in rural South Africa: a cross-sectional, population-based multimorbidity study. *The Lancet Global Health*, *9*(7), e967-e976.

14 Kamkuemah, M., Gausi, B., & Oni, T. (2020). Missed opportunities for NCD multimorbidity prevention in adolescents and youth living with HIV in urban South Africa. *BMC public health*, *20*, 1-11.

15 ibid

16 Freeman, M., Simmonds, J. E., & Parry, C. D. H. (2020). Health promotion: How government can ensure that the National Health Insurance Fund has a fighting chance. *SAMJ: South African Medical Journal*, 110(3), 188-191.

17 Oni, T., Mogo, E., Ahmed, A., & Davies, J. I. (2019). Breaking down the silos of Universal Health Coverage: towards systems for the primary prevention of non-communicable diseases in Africa. *BMJ global health*, *4*(4), e001717.

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