SASCI Submission

NDOH'S DRAFT POLICY ON NON-COMMUNICABLE DISEASES COMMENTS SUBMISSION

24 JANUARY 2020

## 1. ABOUT SASCI

There are about 200 registered cardiologists in the country of about 160 still in practice. This represents a ratio of three cardiologists per million population. To put that into context, the average country in European Union has average of 200 cardiologists per million population. South Africa is woefully short with >40% of practising cardiologists facing retirement age within the next 15 years. Despite this, the South African cardiology community have maintained standards of excellence equivalent to the best in the world with many becoming frequent faculty guests and participants in the major conferences of Europe, USA and elsewhere.

The South African heart Association is the official professional body recognised by the HPCSA and comprises several subspecialty interest groups within this specialty. SASCI represents cardiologists with an interest and activity in interventional cardiology which deals with invasive vascular procedures to open obstructive and diseased coronary and peripheral arteries. This technology is potentially lifesaving in patients having a myocardial infarction (heart attack) and stroke, as well as improving life expectancy and quality of life in many other patients. Although many other health professionals are involved in the fight against cardiovascular disease cardiologists remain the cornerstone of diagnosis and treatment of these patients. Therefore, any analysis of needs and resources must consider the availability and requirements of cardiologists in a national health service.

South African Society of Cardiovascular Intervention (SASCI) is an organisation of physicians, scientists and allied professionals with the purpose to advance the development of cardiology and coronary revascularisation and to provide minimally invasive, image-guided diagnosis and treatment of cardiac medical conditions.

It also acts in an advisory capacity to funders; industry; members and the government on matters relating to interventional cardiology. The latter is a branch of cardiology that deals specifically with catheter-based treatment of heart diseases and includes procedures such as angioplasty and Trans Aortic Valve Implantation (TAVI). The society is also a key enabler of CPD accredited education in interventional cardiology.

## 2. TIMING AND TIMELINES SET FOR COMMENT

SASCI would like to contribute in the process of commenting on the draft policy. However, the request to comment appears to be made at short notice making the compilation of contributions and comments extremely difficult and in some cases

impossible as we would not have adequate time to consult with our members and make meaningful collection of data on the matter. The request for comment comes during the festive season, (though extended to January 2020) at which time there are hardly any people to comment. The work undertaken for the profession in submitting comments is volunteer work.

## 3. GENERAL COMMENT ON THE DRAFT POLICY OF NON-COMMUNICABLE DISEASES.

According to the World Health Organization (WHO) cardiovascular disease is one of the four main Non-Communicable Diseases (NCD's) plaguing South Africa. The draft policy on NCDs is of significant importance to all SASCI members both as health system providers and healthcare users. While it is important to highlight the successes of government's attempt to reverse the impact of NCDs hitherto, but its own admission government believes that there is still room to do even more. This observation is commendable on the part of government.

### 3.1 Modifiable risk factors

While an acknowledgement is made to the effect that, The very substantial NCD modifiable risk factors require robust, evidence informed and comprehensive health promotion strategies, it is also mentioned that, the exact extent to which modifiable risk factors could prevent NCDs in South Africa has not been calculated.

## 4. CARDIOVASCULAR DISEASE (CVD)

Cardiovascular Disease (CVD) is the leading cause of death in South Africa after HIV/AIDS. More South Africans die of CVD than of all the cancers combined. CVD is responsible for almost 1 in 6 deaths (17.3%) in South Africa. Approximately 215 people die every day from heart disease or strokes. Every hour in South Africa, 5 people have heart attacks, 10 people have strokes and of those events, 10 people will actually die from it.

### 4.1 Chapter 1: Introduction

In terms of chapter 1 of the NCD Strategy, cardiovascular diseases are identified as one of the NCD (non-communicable disease) priorities (page 18). SASCI supports this position from government. On page Page 14 of the NCD strategy, it states that, "*Given very high levels of cardiovascular disease and diabetes in South Africa, the 90/60/50 model (similar to the 90/90/90 model that is applied to HIV) will be applied to blood pressure and blood glucose. That is 90% of all people over 15 will know whether they have hypertension and/or raised blood glucose or not; 60% of people with raised blood pressure or blood glucose will receive intervention and 50% that are receiving interventions will be controlled.*"

However, whilst the 90/60/50 model may be appropriate, even in the most sophisticated health systems, they are rarely obtainable and as a consequence the NCD strategy must cater for the chronic and acute management of established CV

disease. Adoption of effective diagnostic, therapeutic strategies and services are essential to yield optimal outcomes. Much of this will mandate provision of specialist service providers and technical facilities in order to be effective. Adoption of new technological innovations can bring greater efficiency within these services.

Other than a mention of coronary heart disease on page 7 and ischaemic heart disease on page 25 in the introduction, there are very few specific steps that are articulated in the plan relating to specific CVDs. Consequently, the strategy is reduced to a basic document with no bold strategies to achieve the intended targets.

On the adoption of the Integrated Clinical Services Model (ICSM), the NCD strategy states that, "*Within this model people are treated for all their conditions in a single session by a single health practitioner*." SASCI proposes that, the system should adopt a "holistic" approach to patient care. PHC providers must be trained enough to be able to escalate patients with poorly controlled risk factors and/or established NCD to a higher level of treatment quickly. Very often this would be to emergency stream of care as in the ICSM model. Most of the life-saving services in CVD care are done on emergency cases. This escalation of care is usually achieved in the private sector, but woefully lacking in public sector, largely because of lack of facilities.

Reference is made (Page 16) of limitation of resources that necessitate an investment initially in increasing numbers and quality of care within primary care. Improvements in higher level services would purportedly be addressed through general health systems reform. The belief that improving the efficiency at primary care level will immediately reduce the need for tertiary CVD care is incorrect. The opposite will happen there will be more and more patients being detected by the system and needing to be managed at higher levels. This is an economically unfortunate reality which must be addressed if an adequate care system for NCD is to be provided.

In the Western Cape we have clearly seen a dramatic rise in caseload [doubling in the number of angiograms performed in the last roughly 10yrs] since implementing better primary and secondary screening. A crucial principle is that better primary care will lead to better risk factor management but also increased diagnosis of established disease that will require tertiary level input. This is because we have a large burden of undiagnosed disease. SASCI would therefore only support improving of primary level care if it is supported by an appropriate improvement in specialist care to deal with the complex cases.

While it is important to focus on primary healthcare as the space in which NCDs can generally be dealt with, it is important to also provide spaces for which specialist in our case cardiovascular specialists can contribute to the containment of NCDs. While the importance of primary health care cannot be overemphasised, it should be borne in mind that there are many cases that are from the onset the scope of competency of specialists health care and concomitant focus should therefore

be placed also on areas of specialization such as cardiovascular diseases. The 90-60-50 model is given to explain how the NCDs will be dealt with, but the document is silent on how this model is arrived at and the rationale behind it.

Essential care under the National Health insurance (NHI) is discussed on page 17 of the NCD Strategy. Page 17 further discusses the notion of "*equitable care*". SASCI is in full agreement with this principle and are alert to the fact that the rural areas are deplorably short of any NCD care but the very basics. Diagnostic, therapeutic and interventional services must take into consideration many of the new technological advances which would improve care in this regard. Cell phones for ECG transmissions; for emergency ambulance services; rhythm detection devices; AI diagnostics; multi-disciplinary ultrasound devices on a cell phone for a tenth of the price of current machines. Much of the specialist service in rural could be delivered by proxy using digital communication.

Reference is made to the concept of Universal Health Coverage in Chapter 1 and Chapter 6. Universal Health Coverage is set by the 1996 constitution. SASCI supports the objective of achieving an equitable sustainable healthcare system. SASCI acknowledges that there have been historical inequalities and exclusions regarding healthcare for all which this plan seeks to address.

SASCI is concerned with uncertainty surrounding the issue of cost of achieving the universal health coverage. Although the issue of cost effectiveness is alluded to, yet it is just 'cost effectiveness' in isolation, that is without any reference point. The question as to who determines cost effectiveness is not address. There is need to define certain terms. For instance, 'equity' would mean different things in different contexts but there is no attempt to define 'equity' in the context of healthcare.

Investing in prevention and control of NCD in a way that it is carefully planned and prioritized may indeed be highly cost effective provided the means of translating this ideal into practical outcomes is also clearly articulated.

### 4.2 Chapter 2: mortality, morbidity and behaviour

Page 27 recognises "the need for primary prevention, secondary prevention (screening), effective referral and high-quality treatment". SASCI believes there are pre-requisites that must be present in order to refer to terms such as "high quality treatment" in hypertension. Such is the availability of essential drugs; adequate diagnostic equipment; patient education; early recognition of complications and need for escalation e.g. stroke; heart failure; kidney failure.

### 4.3 Chapter 3: Current responses

The Integrated Clinical Service Model is hailed (page 58), and page 59 refers to the full inclusion of CVD in the PHC packages in 2015, and that medicines for stable patients are available via the CCMDD model and "Five commonly used medicines for NCDs are taken here as representative of NCD drug availability" (page 59). The issues of drug availability have been dealt with earlier on in this document.

### 4.4 CHAPTER 4: Scope and structure

Page 61 confirms that the plan is focussed primarily on NCDs that "*cause the highest morbidity and mortality and their main causes*". It reiterates the data in chapter 1 and elsewhere and addresses co-morbidities (page 65). Page 66 alludes the "*genesis of Type 2 Diabetes and Coronary Heart Disease often begins in childhood, with childhood obesity serving as an important factor*". SASCI is aligned to these positioning statements.

### 4.5 CHAPTER 5: Vision, goals and targets

The overarching objective of this plan is that South Africa reaches the Sustainable Development goal to reduce by one third premature mortality from NCDs through prevention and treatment and promoting mental health and wellbeing by 2030. In as much as one death is one too many, the government target seems overambitions given the general state of public healthcare system. The multi sectorial approach mooted by government may seem on the face of it invaluable but due to the highly compartmentalized nature of our system, coming up with operational parameters could be a challenge. A table of 2025 targets is provided. The NCD strategy however needs to recognize that CVD remains and will emerge even further on top of the table.

### 4.6 CHAPTER 7: Implementation

Immediate and additional high-quality evidence based, and focused intervention are needed to promote health, prevent diseases, and provide more effective and equitable care and treatment for people living with NCDs at all levels of the health system. The 2018 United Nations General Assembly on NCDs high level meeting set an agenda from strategy to action. Just like many other government programs the adoption of policies has not translated into the envisioned outcomes because of lack of implementation.

Implementation research can be useful for identifying the challenges faced by NCD programs and how to deal with them. Identifying groups whose interests may oppose NCD control strategies and methods of dealing with them would probably be achieved by conducting a stakeholder analysis. In many countries, aggressive marketing of tobacco is a tough opponent in promotion of positive health messages. Similarly, notwithstanding South Africa's imposition of such taxes as 'sin tax' and sugar tax, these deterrents have not worked as anticipated hence the need to rethink new approaches going forward.

Stakeholders in the NCD plan may see implementation challenges differently. Government especially policy makers in health and finance, healthcare providers, citizen groups, inter alia see implementation challenges differently. This diversity of interest of and power impacts on the plan. NCDs plan can be more effective if they identify barriers to implementation.

## 5. Conclusion

SASCI appreciates the opportunity and hopes that this submission adds value, further that the submissions we have made in this document are considered.