ROLE OF MEDICAL SCHOOLS IN HEALTH REFORM : ACCESS TO QUALITY HEALTHCARE SERVICES IN VULNERABLE COMMUNITIES.

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UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

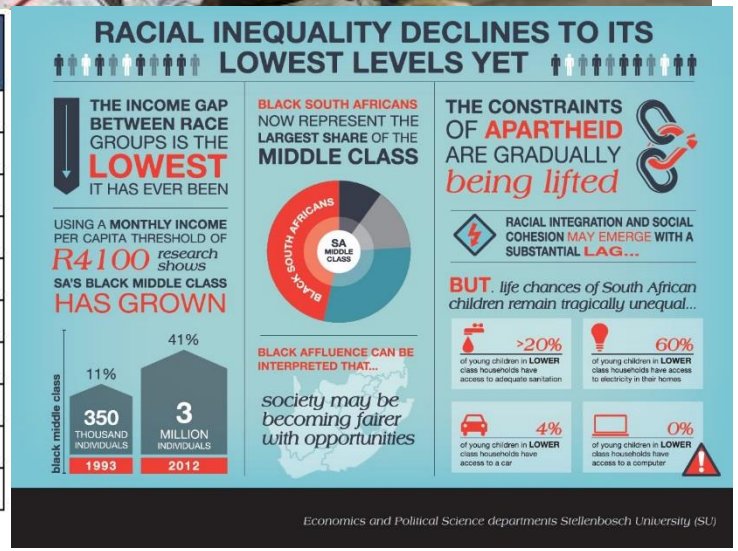
WORLD BANK,2015

Countries With The Worst Gini Coefficients	
Seychelles	65.8
Comoros	64.3
Namibia	63.9
South Africa	63.1
Botswana	61.0
Haiti	59.2
Angola	58.6
Honduras	57.0
Bolivia	56.3
Central African Republic	56.3

Source: World Book

Countries With The Best Gini Coefficients	
Denmark	24.7
Japan	24.9
Sweden	25.0
Czech Republic	25.8
Norway	25.8
Slovakia	26.0
Ukraine	26.4
Finland	26.9
Bulgaria	28.2
Germany	28.3

Source: World Book



Access to Health care

- Using health services requires considerable work on the part of people.
  - People have to mobilise a range of resources, including knowledge and information resources, social, language and support resources, and practical resources.
  - There is evidence that socio- economically deprived people, older people, and people with disability may be disadvantaged in their access to these resources.

Commission on Social Determinants of Health : 2008

- Recommended a two-pronged approach to redressing health inequities – improving people's daily living conditions and tackling inequitable distribution of power, money and resources.
- Although medical professionals can only have a limited role in implementing these recommendations, they nonetheless have a clear responsibility to address health

★*WHO. Commission on Social Determinants of Health.2008*

No clear definition of Health reform

- Precise definitions of access to health care and equity of access have remained elusive.
- All countries differ considerably in their historical, economic and political contexts, though they also share a number of important problems and specific policy instruments in approaching health sector reform. Therefore, there is no single formula, recipe or agenda for national health sector reform.

- However, it is clear that good leadership are most important for a reform movement and the implementation of change.

National Health sector reform

Health care reform is a general guide for discussing major health policy changes—for the most part, governmental policy that affects health care delivery in a given place.

What would be reason for health reform:

- ❑Broaden the population that receives health care coverage through either public sector or private sector
- ❑Expand the array of health care providers consumers may choose among
- ❑Improve the access to health care including specialists
- ❑Improve the quality of health care
- ❑Give more care to citizens
- ❑Decrease the cost of health care -

Example of Health Reforms …..

The proposed NHI is a step towards health care reform as espoused in the Constitution and the National Health Act and a move towards the Alma-Ata's Health for All.

The seven principles of the NHI, i.e. the right to access, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency, could be interpreted as the value assumptions of the proposed reforms.

The objectives of the NHI are?

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Health car
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What wou

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- Expand
- Improve
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#NHI 1

NHI will cover comprehensive services:

a) All medically -necessary health care, including dental and eye care, including:
   - Primary Health Care services: visits to clinics, community health centres and accredited multi-disciplinary group practices and centres at a non-specialist level, community health care outreach workers, integrated school health services,
   - Hospital services: out-patient and in-patient visits at all accredited hospital levels, using a referral system
   - Rehabilitation health services
   - Palliative Care
   - Mental health services
b) Emergency medical services
c) Transportation for patients who are referred to and from another health facility;
d) Medicines specified on the Essential Medicine List;
e) Diagnostic procedures specified in the Treatment Guidelines and protocols.

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

e delivery

ither

ong

NATIONAL HEALTH INSURANCE BILL, July 2019 :

- Fast-tracking the implementation of a National Health Insurance scheme, which will eventually cover all South Africans.
- The public sector is stretched and under-resourced in places.
- While the state contributes about 40% of all expenditure on health, the public health sector is under pressure to deliver services to about 80% of the population

A ROADMAP FOR THE REFORM OF THE SOUTH AFRICAN HEALTH SYSTEM : convened and facilitated by the *DBSA*

HUMAN RESOURCES

The South African health system has operated for many years with an unplanned human resource policy framework. The absence of an active policy framework to plan for the human resource needs of the country has resulted in shortages within the public sector and more generally. There are also concerns that the ability to produce new health professionals is becoming compromised due to the weakening of health sciences faculties. This section therefore covers the broad strategic requirement to implement a strategic planning framework for human resources serving the national health system.

★DBSA 2008

Do South African universities provide the required training platforms to address access to quality Health Care services?

The Status of our Medical Schools in SA?

- Lack of capacity,
- variations in quality,
- differences in resource allocation and features of service configuration, including geographical patterning and concentration of services,

The Stat … SA?

- Lack of …
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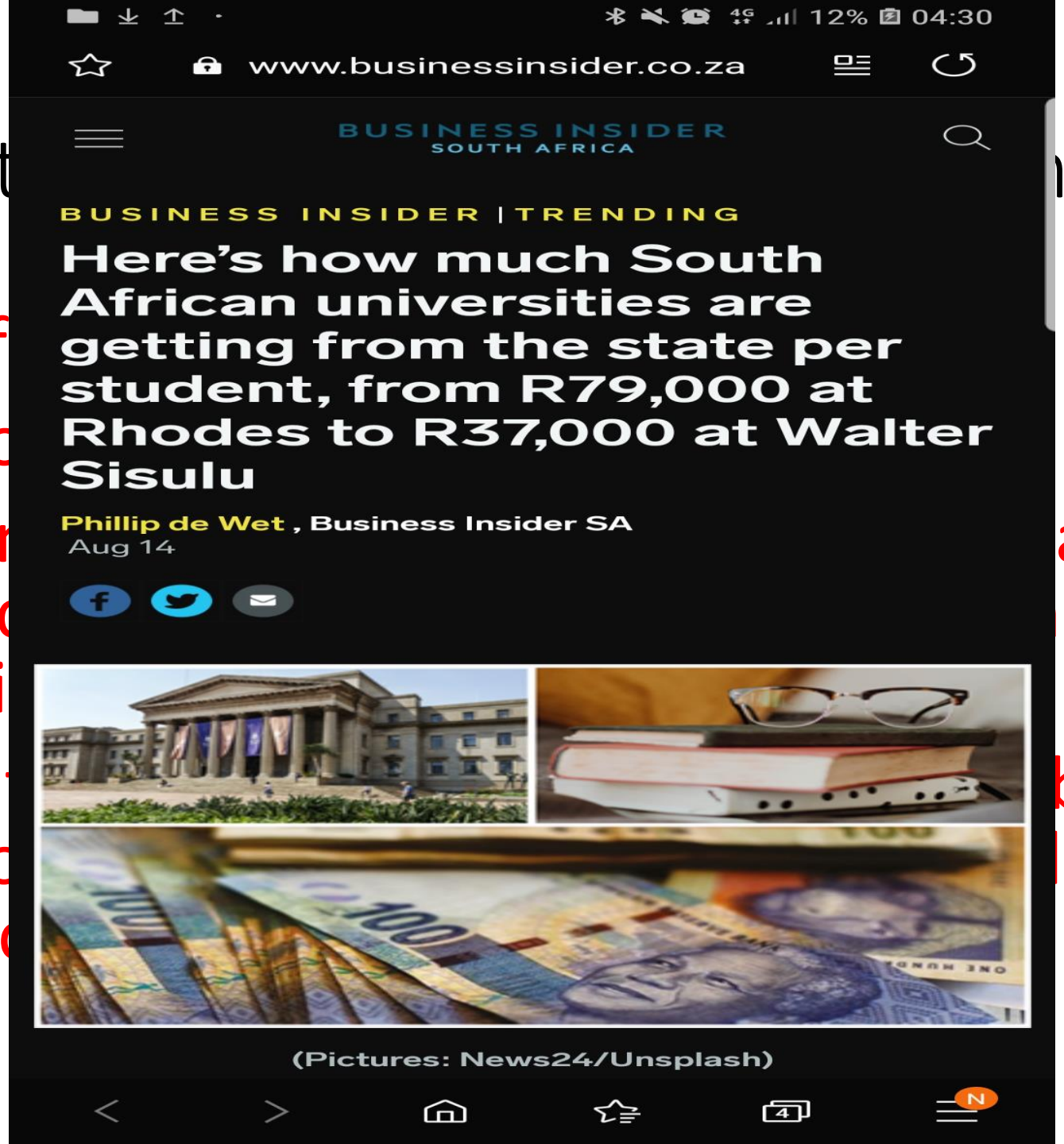


Universities are often accused of doing little to tackle this inequality

- Despite efforts by successive governments to improve social mobility , wealth and opportunity continue to be concentrated within relatively small sections of the population.
- A ‘growing social divide by income and by class’. As well as being socially divisive, evidence shows that inequality is bad for economic growth and productivity.
- Universities are often accused of doing little to tackle this inequality and even of supporting the status quo.
- On the one hand, high tariff institutions tend to recruit from the social elite who then go on to gain high status jobs.
- On the other hand, some argue that too many people are encouraged to undertake an expensive university education when they would be better served by following a vocational pathway.
- A third accusation is that the concentration of knowledge workers around universities can actually be a key driver of inequality as their greater affluence drives up prices for certain goods.

What is the Problem now with the Medical Schools in SA?

"Due to the roll-out of effective measles vaccines, there has been a steady decrease in measles cases all over the world since the 1970s.

€2 500 (R40 000) for parents who didn't vaccinate their school-age children against measles.

Democratic Republic of the Congo 1 414

Sources: WHO, Unicef, CDC, Statista

Doctors take on 'discriminatory' CMSA

MSINDISI FENGU
msindisi.fengu@citypress.co.za

Phume Peter Moletsane has given up appealing for his exam scripts to be remarked by the Colleges of Medicine of SA (CMSA).

Moletsane (53), a general practitioner in Kroonstad, Free State, says CMSA is also refusing him access to his exam scripts.

He is now considering enrolling with the Royal College of Physicians and Surgeons of Canada, but is unsure if his foreign qualification would be recognised by the Health Professions Council of SA (HPCSA) because HPCSA was not forthcoming when he asked what his options were in April.

The council has a contract with CMSA to administer exit exams for medical practitioners who want to be specialists. Successful completion of university administered research and CMSA exams are required for a specialist to register and practise in the country.

Moletsane wants to be a specialist in internal medicine and is studying at the University of the Free State.

However, he has failed his CMSA exam twice – during the first semester in 2017 and again in the second semester last year.

"I failed both exams and have been denied access to my scripts on both occasions. We sit for exams with no set pass mark. The pass mark is determined after marking," he said.

CMSA chief executive Lize Hayes declined to comment on Moletsane's matter, citing confidentiality.

However, she referred City Press to a section in the medical care quality custodian's policy, dated November last year, which allows appeals, but not reviews, and does not allow candidates to access their multiple choice questions (MCQ) scripts.

The policy was approved after HPCSA held a stakeholders' meeting in October last year to discuss similar complaints pertaining to CMSA exams at its council chambers in Pretoria.

Moletsane was among six medical practitioners whose complaints led to the meeting. At the same meeting, universities raised similar concerns regarding the CMSA exams.

Hayes said, without making reference to Moletsane, that the recalculation of candidate exam papers was done after a formal request to do so.

"MCQ papers cannot be reviewed and are not made available to candidates, in line with international trends. A good bank is essential to running a fair and defensible examination," Hayes said.

Moletsane said his requests to CMSA were about his MCQ scripts and that the policy had not changed anything.

"There's nothing new; totally none," he said.

At the HPCSA meeting, stakeholders alleged that:

- There was a low throughput rate of local African specialists, coupled with unfair treatment and discriminatory practices towards African registrars, specialists and academics as a result of CMSA exams;
- The exams lacked transparency, leading to a flood of litigations by black candidates against the manner in which scripts were marked and the issuing of results;
- Black candidates were singled out and their fate was decided before exams, and sometimes performance in written exams was disregarded;
- Black candidates were separated from their white counterparts on the basis of the command of English and were failed deliberately; and
- There was gate-keeping, which directly inhibited the production of an acceptable number of specialists.

Recommendations agreed on at the meeting were submitted to the HPCSA board for consideration.

Some of the conclusions made by stakeholders were that the council failed its oversight role and its board was to consider reviewing the contract it had with CMSA because of lack of transparency in the administration of exams.

City Press has seen an email Moletsane wrote to HPCSA chief executive Dr Raymond Billa last month, asking whether there was an external body that was recognised by the council with which he could write his exams.

"Having tried to get a fair and transparent exam from CMSA without any success, I wish to be informed as to which examining body you recognise outside South Africa. I will make arrangements to be examined there, with the expectation of being registered after passing," Moletsane wrote.

Billa said he had not been able to obtain information on his request on a local student wishing to write the exams of a foreign body without having studied in that country.

"The only consideration we make is for foreign-qualified practitioners after undergoing training in those countries and writing examinations in those countries, upon completion of their studies and training programmes.

"I am not aware of the specific condition as you have raised it."

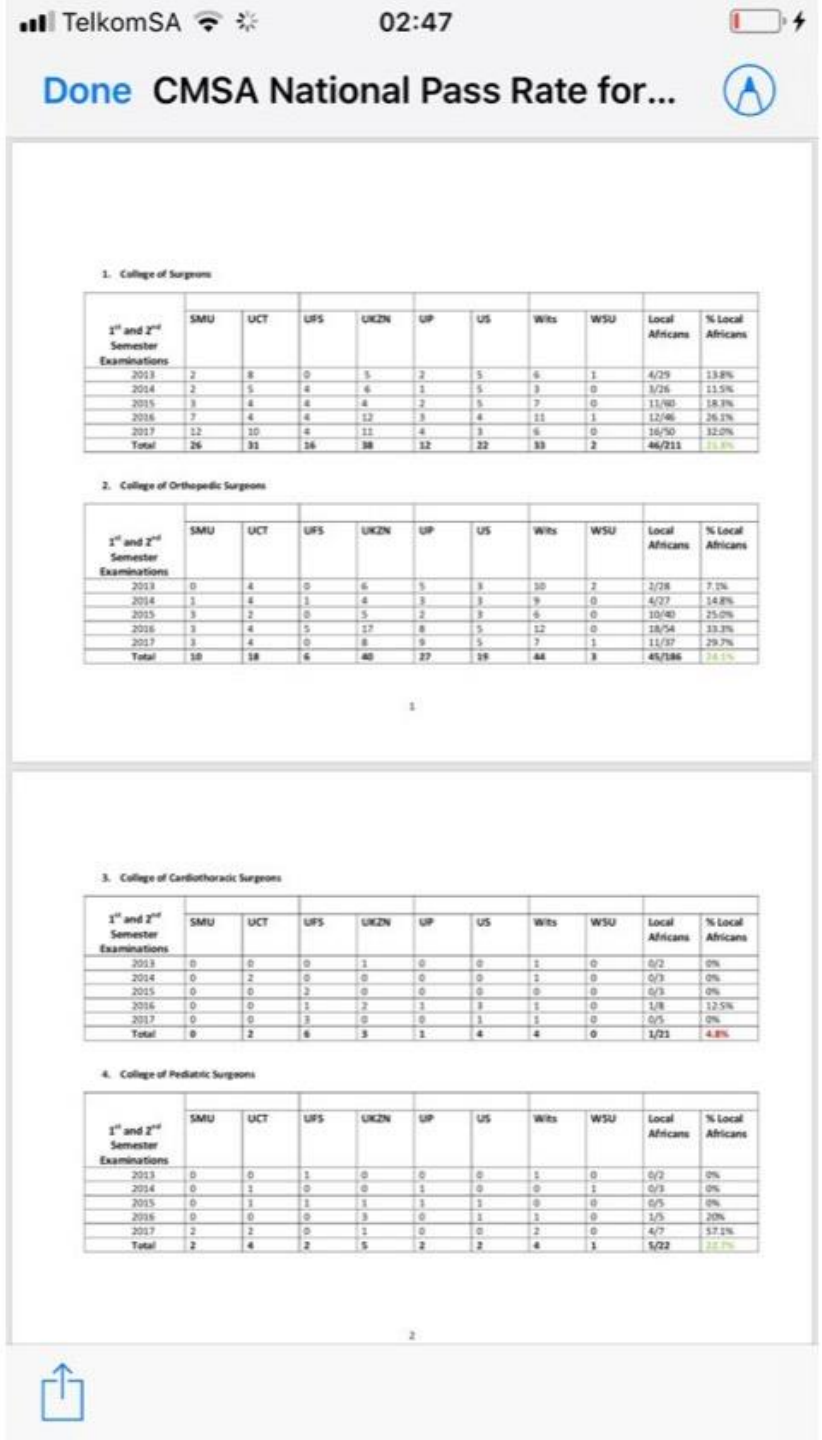
The HPCSA failed to respond to questions from City Press.

SA Medical Association board member Dr Eddie Ngwenya said medical registrars, who are represented by registrars' organisations within his organisation, had also raised concerns relating to CMSA exam fees and assessment mechanisms, but these were being addressed with CMSA.

LIVID DOC
Dr Phume Peter Moletsane

What is the Problem now with the Medical Schools in SA?

What is the Problem now with the Medical Schools in SA?



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Done CMSA National Pass Rate for...

1. College of Surgeons

1st and 2nd Semester Examinations	SMU	UCT	UFS	UKZN	UP	US	Wits	WSU	Local Africans	% Local Africans
2013	2	8	0	5	2	5	6	1	4/29	13.8%
2014	2	5	4	6	1	5	3	0	3/26	11.5%
2015	3	4	4	4	2	5	7	0	11/40	18.3%
2016	7	4	4	12	3	4	11	1	12/46	26.1%
2017	12	10	4	11	4	3	6	0	16/50	32.0%
Total	26	31	16	38	12	22	33	2	46/211	21.8%

2. College of Orthopedic Surgeons

1st and 2nd Semester Examinations	SMU	UCT	UFS	UKZN	UP	US	Wits	WSU	Local Africans	% Local Africans
2013	0	4	0	6	5	3	10	2	2/28	7.1%
2014	1	4	1	4	3	3	9	0	4/27	14.8%
2015	3	2	0	5	2	3	6	0	10/40	25.0%
2016	3	4	5	17	8	5	12	0	18/54	33.3%
2017	1	4	0	8	9	5	7	1	11/37	29.7%
Total	10	18	6	40	27	19	44	3	45/186	24.1%

1

3. College of Cardiothoracic Surgeons

1st and 2nd Semester Examinations	SMU	UCT	UFS	UKZN	UP	US	Wits	WSU	Local Africans	% Local Africans
2013	0	0	0	1	0	0	1	0	0/2	0%
2014	0	2	0	0	0	0	1	0	0/3	0%
2015	0	0	2	0	0	0	0	0	0/3	0%
2016	0	0	1	2	1	3	1	0	1/8	12.5%
2017	0	0	3	0	0	1	1	0	0/5	0%
Total	0	2	6	3	1	4	4	0	1/21	4.8%

4. College of Pediatric Surgeons

1st and 2nd Semester Examinations	SMU	UCT	UFS	UKZN	UP	US	Wits	WSU	Local Africans	% Local Africans
2013	0	0	1	0	0	0	1	0	0/2	0%
2014	0	1	0	0	1	0	0	1	0/3	0%
2015	0	1	1	1	1	1	0	0	0/5	0%
2016	0	0	0	3	0	1	1	0	1/5	20%
2017	2	2	0	1	0	0	2	0	4/7	57.1%
Total	2	4	2	5	2	2	4	1	5/22	22.7%

2

CMSA

The Colleges of Medicine of South Africa NPC

Nonprofit Company (Reg No.1955/000003/08)
Nonprofit Organisation (Reg. No. 009-874 NPO)
Vat No. 4210273191

17 Milner Road, RONDEBOSCH 7700

Tel: +27 21 689-9533/4/5; +27 21 689-3161 Fax: +27 21 685-3766

26 March 2019

Dear Colleague

REGISTRAR SURVEY

The Colleges of Medicine of South Africa (CMSA) was founded in 1954 by members of the medical profession. CMSA is mandated to conduct examinations in the following:

a) "Fellowships", recognised by the HPCSA for specialist registration, and by the universities as a component of the MMed degree;

b) Certificate Examinations which are recognised by the HPCSA for the registration of subspecialists;

c) Examinations for Diploma and Higher Diploma qualifications recognised by the HPCSA as additional non-specialist qualifications.

The CMSA has commissioned an independent committee to conduct a survey that will be completed anonymously. The survey has been approved by the Human Research Ethics Committee of the Faculty of Health Sciences at the University of Cape Town.

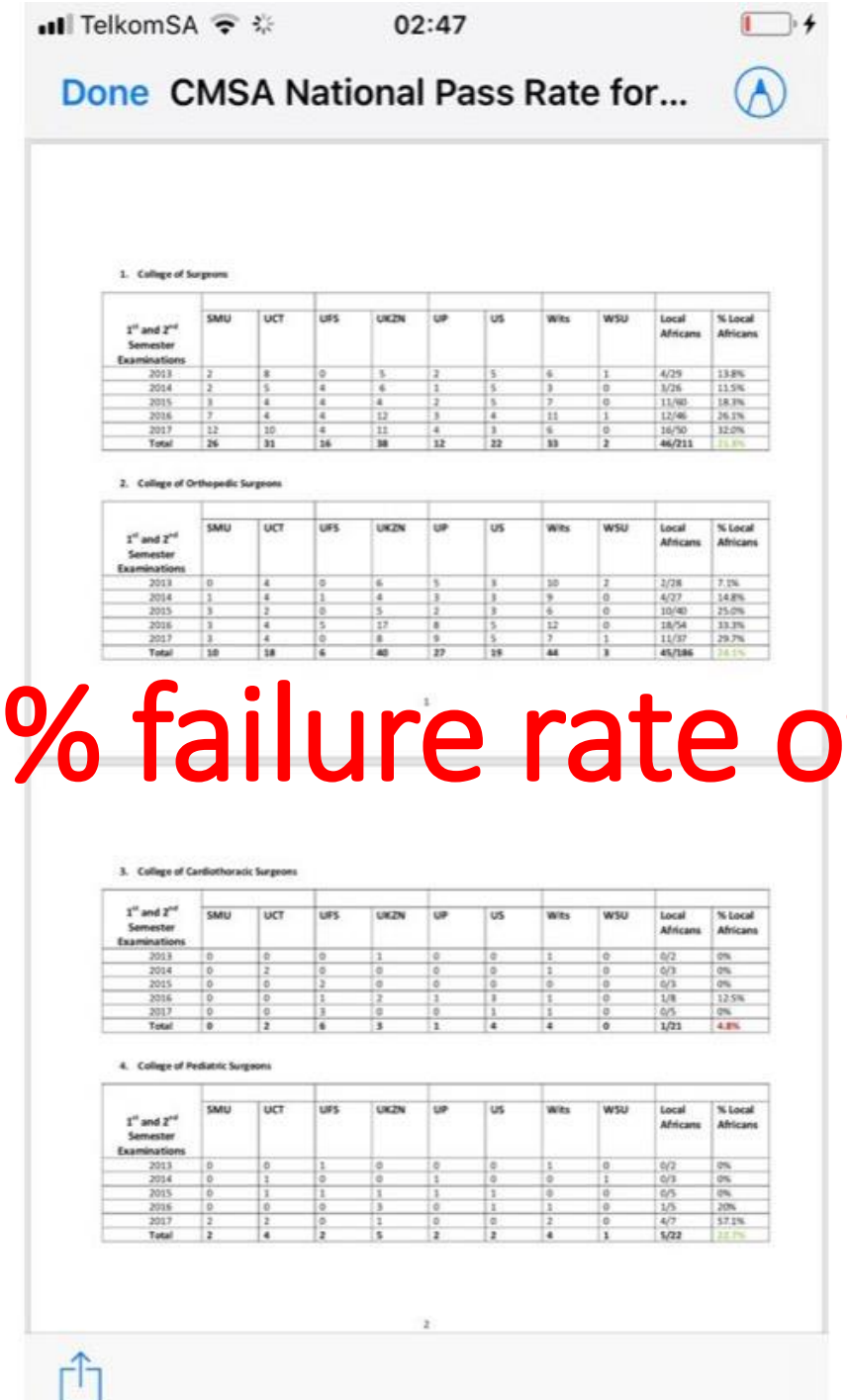
The goal of the survey is to understand Registrars' views on Postgraduate Training, Education and Examination Experience. The survey will help us to identify the causes of the high failure rate, which is likely to include the tuition and supervision of Registrars during training.

Please take ten minutes to complete the survey and assist in ensuring that we understand what needs to be done to assist you and your colleagues to deliver quality care and to achieve work satisfaction. **Please make sure to only complete the survey once.**

Follow the link to complete the survey: https://www.surveymonkey.com/r/5M5M79F

Yours faithfully,

Prof Mike Sathekge
PRESIDENT



70% failure rate of Blacks across board

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Yours faithfully,

Prof Mike Sathekge
PRESIDENT

Cost : Currently Access to medical learning is too costly DUE TO THE IMPOSED MIDDLE MEN(CMSA)

- ❑TUITION FEES COST PER YEAR AT UFS: R7300, this caters for two semester examinations
- CMSA: DIPLOMA =R8 400.00 per examination
- PRIMARIES =R7 200.00 per examination
- INTERMEDIATE =R7 700.00 per examination
- FINALLY SPECIALIST EXAMINATION=R12 100.00 per examination

CMSA AS A FINANCIAL MONEY MAKING SCHEME:

THE FINANCIAL TRANSACTIONS OF THE CMSA HAS NEVER BEEN SCHRUTINIZED

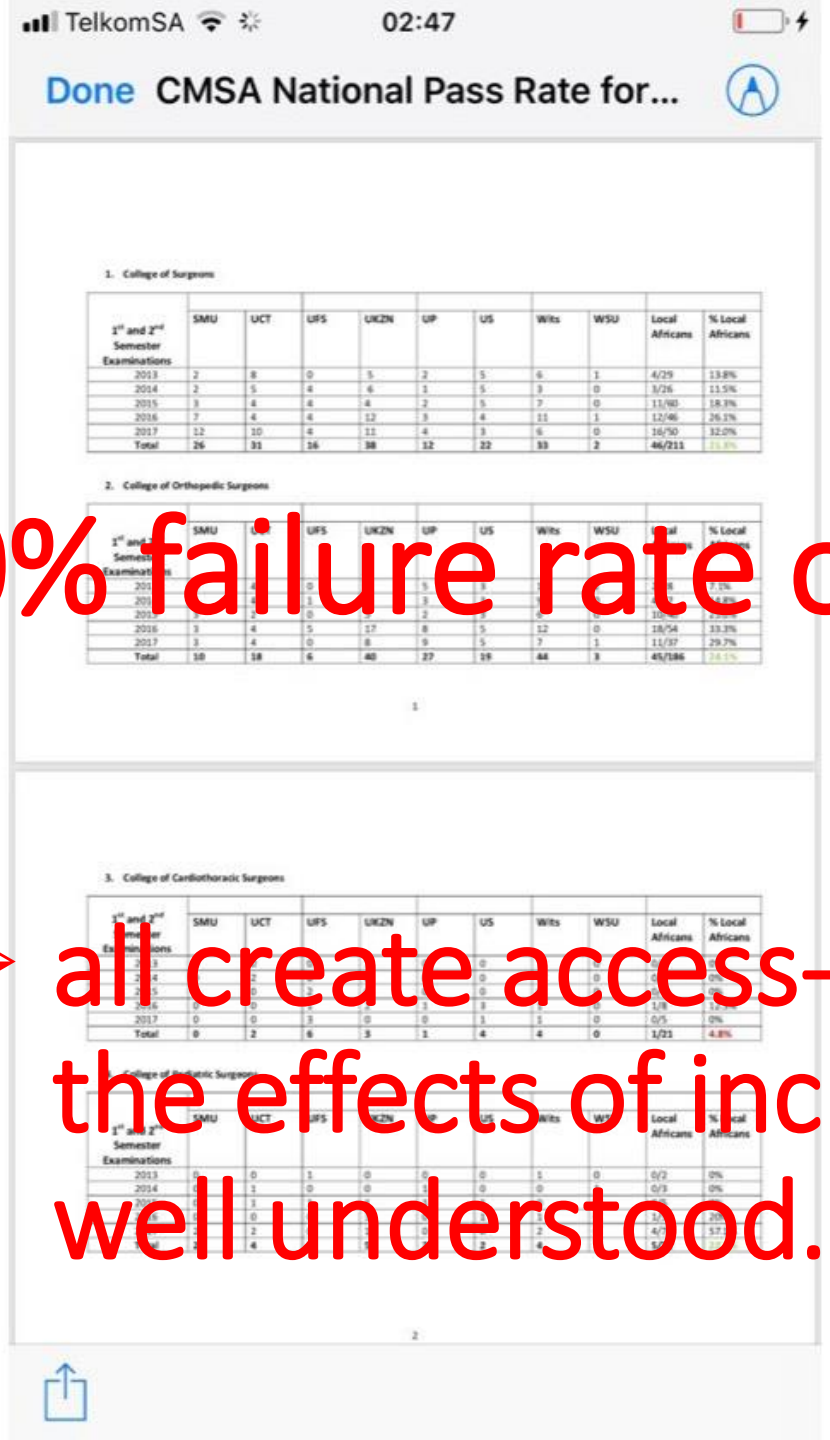
- ONE COLLEGE WHICH IS PART OF THE COLLEGES OF MEDICINE OF SOUTH AFRICA ,THE COLLEGE OF OBSTETRICS AND GYNAECOLOGY REGISTRAR TRAINING.
- THIS COLLEGE IN THE FIRST SEMESTER OF 2019 HAD 36 CANDIDATES WHO REGISTERED TO SIT FOR THE FINAL EXIT EXAMINATIONS (FCOG PART II).
- TO REGISTER TO WRITE THIS EXAMINATION IS R12 100.00 = R12 100.00 × 36=R435 600.00 Received. OUT OF 36 CANDIDATES, 16 CANDIDATES FAILED AND THESE CANDIDATES WILL BE FORCED TO PAY AGAIN THE REGISTRATION FEES TO REGISTER FOR THE EXAMS(16 × R12100.OO= R1936000.00 MADE FREE)
- THESE CANDIDATES ARE ALL CURRENTLY FORCED TO DO THEIR SPECIALISATION THROUGH AN ACADEMIC INSTITUTION/ MEDICAL SCHOOLS UNIVERSITY WHO HAVE CHARGED THEM ANNUAL TUITION FEES WHICH IS AROUND R7 300.00 IN OUR UNIVERSITY, WHICH BECOMES A DOUBLE TUITION FEES. THE COLLEGE HAS NEVER EXPLAINED HOW IT DEALS WITH THESE HUGE SUMS OF MONEY OF THE FAILED CANDIDATES.

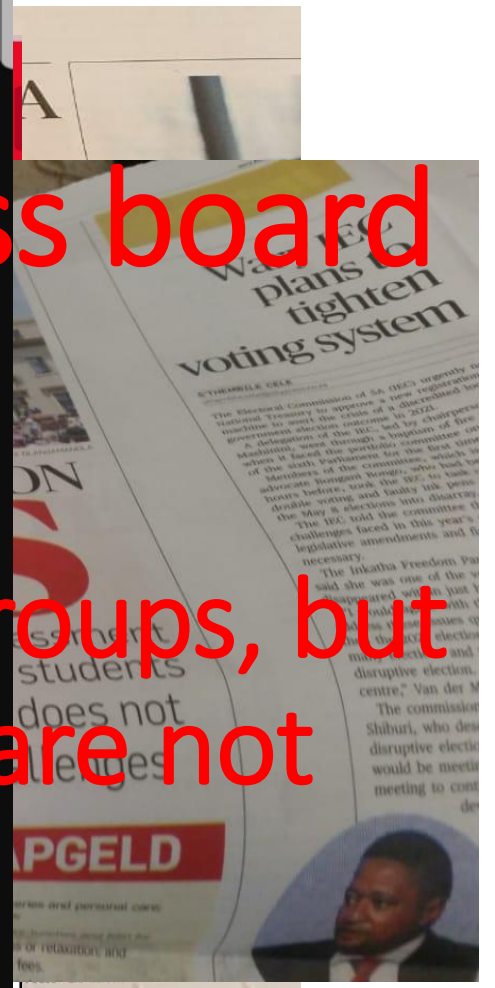
HPCSA

Health Professions Council of South Africa

- Further concerns have been that the Health Professions Council of South Africa (HPCSA) inadequately polices the specialist training programmes

Medical





70% failure rate of Blacks across board

- all create access-disadvantaged groups, but the effects of increasing capacity are not well understood.

- Few would disagree with the idea that everyone should have an equal chance to succeed on the basis of their individual merit. But our local communities can also benefit and thrive as a result.
- People’s potential is fulfilled while social cohesion improves as a direct consequence of creating and supporting life chances.
- Yet too often this is not the reality of life in South Africa.

Doctor- patient population ratio

- World Health Organization recommended doctor to population ratio of 1:1,000 the “Golden Finishing Line” in the year 2018
- In SA doctor-patient ratios in both public and private healthcare :
  - **2012 HPCSA Data :165,371** qualified health practitioners in South Africa. Of these, **38,236** were doctors.
  - HSTMarch 2016: 14,036 general practitioners and 4,737 specialists on the state’s payroll
  - This was one doctor for 2,457 people in the public healthcare sector,

★Density of Physicians (Total Number per 1000 Population, Latest Available Year), Global Health Observatory (GHO) Data. 2018

Doctor- patieint population ratio

- SA aims to increase the current number of doctors trained in SA from 1 200 to 3 600 a year, with the existing medical schools already having upped their intake by 160 in 2012.
- With the population growing at 1.5 % we need about 25 000.00 extra doctors HST 2013

★Density of Physicians (Total Number per 1000 Population, Latest Available Year), Global Health Observatory (GHO) Data. 2018

Medical training out put in the SA: January 2013

- The Nelson R Mandela School of Medicine at the University of KZN received 5 500 applications for 210 first year places this year while the University of Cape Town's Faculty of Health Sciences received 5 380 applications for its first year MBChB programme.
- Wits University in Johannesburg had 12 928 applications for 600 spots for its first year medical programmes.

➢There are many students who qualify to study but do not get in (to university). It is not only necessary for us to increase the number of medical schools but also to expand the existing ones by ensuring we have faculties that can teach these students."

The role of medical schools is in a process of change.

- The WHO has declared that they can no longer be ivory towers whose primary focus is the production of specialist physicians and cutting edge laboratory research.
- They must also be socially accountable and direct their activities towards meeting the priority health concerns of the areas they serve.
- The agenda must be set in partnership with stakeholders including governments, health care organisations and the public.

★*Global Consensus for Social Accountability of Medical Schools (GCSA 2010)*

Paradigm shift Model: Social accountability

How can medical schools contribute to bringing about health equity?

- ❑Embedding improvement in community health with innovations in health professional education, with delivery and health policy at the core of their business.
- ❑These schools engaged initially in establishing a network of community orientated medical schools
- ❑The concept was taken further at a groundbreaking international meeting in SA in 2009 bringing 130 organisations and individual experts from around the world with responsibility for health education, professional regulation and policy making to produce a Global Consensus for Social Accountability of Medical Schools (GCSA 2010)

Bar Ilan Faculty of Medicine in the Galilee, Ben Gurion University

★*Rudolf et al. 2014*

Paradigm shift Model: Social accountability

- The Consensus underlined the social obligation for medical schools to direct their activities to the priority health concerns of the areas they serve, adapting to local context and priorities
- that are agreed in partnership with stakeholders nationally and locally.
- **What is meant by social accountability?**
  - it is the next stage in the service, research and education revolution started several decades ago by the Community Oriented Primary Care movement

Social accountability

- How can social accountability be achieved?
  - the ideology incorporates human rights, solidarity, pluralism, and empowerment.
  - Equality in services with proportionate universalism should be the goal, where services are augmented for those in greater need with community engagement,

- Three forms of action were the principal foci –
  - augmentation of the medical curriculum,
  - direct action through community engagement and
  - political advocacy.
- University must invest in activity in promoting equity

Reducing inequality – and how can universities help?

- Access : through outreach work and by reducing bias and barriers at the application stage.
- Retention : inspiring and supporting new adult learners from key target groups.
- Community engagement : Universities play an important role in creating thriving cities and region. To ensure they can maximise their impact LEPs should be required to consider higher level skills within their core remit and they should also be obliged to proactively involve their local university(ies) in discussions about economic and social development and local and regional skills policy.

- Research : Universities play a key role in producing knowledge and bringing this to bear on the causes and consequences of inequality.

★*University Alliance Regional Leadership Series 2016*

Reducing inequality – and how can universities help? Graduate success

❑Graduate success :

- ➢Universities should do more to adjust institutional practices and processes – for example, ensuring that they are interrogating their entry processes, curriculum design and assessment procedures – to ensure students' diverse learning and employment needs are met.
- ➢Government could support this by requiring universities to report and evidence to OFFA the mechanisms they have in place to support different types of students to achieve their potential.

FIGURE 1: POLICY DETERMINANTS

Adapted from: *Health Policy and Systems Development: An agenda for research. WHO/SHS/NHP/96.1, WHO, Geneva, 1996*

POLICY CHANGE/ FORMULATION

- that universities and teaching hospitals have to ensured adequate teaching facilities.
- We must also reach out to our communities to ensure the benefits of higher education are felt beyond our student populations.
- Best way to achieve impact is through a sustained and strategic commitment to widening participation and ensuring student success.
- This also requires us to work actively with our local communities.
- This activity should be a core part of all university missions.
- It adds value to our communities, to our institutions and to our students. And with increasing devolution, which sees regional civic leaders gaining more direct influence in creating opportunities, universities can be important partners to ensure we can maximise talent and contribute to prosperous places.

Making Medical Training Accessible to all the people who wishes

- Decentralisation of training platforms and Widen Training Platforms : Practical skill training at a specified point and theoretical learning can be co-coordinated anywhere in the world by the vast advance available electronic media e.g
  - Limpopo Case while I was A Provincial Specialist Head(Obst& Gyn) Situation,
  - Past training of specialist family Physicians and Internal Medicine Specialist, Paeds, Surgery and Radiology

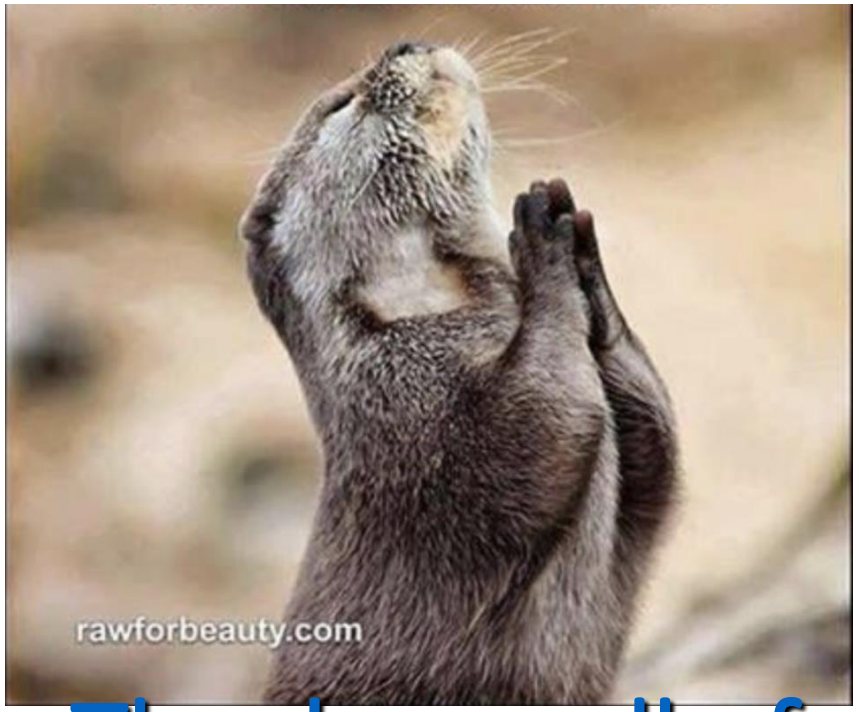
Summary

- ❑However, the debate about the role of higher education in tackling inequality has disproportionately focused on access for young people to a small number of universities. This approach is too narrow.
- ❑high tariff institutions have not significantly diversified their intake and the approach only captures a small proportion of the student population: at best one third of full-time, and one fifth of part-time, students.
- ❑It is time to give attention to helping the full range of potential students to choose the best course and institution for them, and to give the same focus that is given to access, to retention and student success.
- "We need to be getting more doctors from rural areas that are under-served so that when they finish they can go and work there,". "There is no need for us to have an over concentration of doctors in urban areas. We need to be able to spread them across the country so that" Olive Shisana January 2013
- CMSA NEEDS URGENT ATTENTION: MUST BE REGULATED
- COSTING : Remove the middle men causing duplication cost

Endnote

- aKol Israel arevim ze la’ ze’ - All Israel is responsible one to another - is a Talmudic idiom (Sifra Behukotai 7:8) originally implying shared responsibility for proper social and moral conduct in the community, but used in more recent centuries to connote mutual responsibility for social welfare.
- “Tiqqun ’olam” was translated in the title of Jonathan Sacks’ book as “To heal a fractured world – the ethics of responsibility” (Schocken, New York, 2005).

Shukriya !!! Atchaa!!!



Thank you all of you Just for being here for me