

# **Memorandum**

**Date: 13 July 2009**

**To: Secretary General  
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**From: Bandile Masuku  
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Education & Health**

## **Subject: National Health Insurance Policy (NHI) Proposal**

The above-mentioned subcommittee under a stewardship of Cde Zweli Mkhize, had taken strides in realizing the resolution of implementing of the NHI in the next five years. The subcommittee appointed a Task Team led by Dr Shisana, to prepare a policy proposal for consideration by the subcommittee and later by the NEC.

Previously the subcommittee made presentation to the NEC and was given a go ahead to continue with their work, hence its inclusion in the ANC National Manifesto in the recent National & Provincial Election. The Task Team had completed its work, has handed over the policy proposal to the subcommittee for consideration and adoption.

The subcommittee also noted a barrage of attack on the NHI, from the opposition, media and business and we anticipate resistance and opposition on its implementation. Thus we established a NHI Campaigns' Committee, which comprise of ANC (SGO, Organizing & Mobilizing, Media & Communication, Policy Institute and Political Education & Training); SACP; COSATU and SANCO. The committee met three time to date and developed a plan of action aimed at mass mobilization of our members and the general public behind the NHI.

The Subcommittee presents a NHI Policy Proposal (Annexure A) and plan of action. (Annexure B)

The subcommittee hopes that both documents will be considered by the NEC for adoption and the NHI Task Team will be available to make a presentation if the NEC so wishes.

Hope you find the above in order

Yours in Free Health & Education

**A**

**NATIONAL HEALTH INSURANCE  
POLICY PROPOSAL - 22 JUNE  
2009**

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## I INTRODUCTION

1. South Africa inherited a highly inequitable health system from the Apartheid era. Although South Africa has relatively high levels of health care expenditure as a percentage of GDP compared to other middle-income countries, it still has relatively worse health status indicators. This is due to other social and economic determinants such as unhealthy life style such as smoking, alcohol abuse, risky sexual behaviours that fuel HIV/AIDS and other sexually transmitted diseases, and the increasing chronic illness burden. Various forms of injuries also contribute to worse health outcomes. Key to differential access to quality health care and hence poor health outcomes is the mal-distribution of human, financial and physical resources between the public and private sectors. The majority of financial and human resources for health services are located in the private health sector serving a minority section of the population (largely those who are medical scheme members who constitute about 15% of the population). In contrast, the public health system continues to struggle to meet the health care needs of the majority of the population with extremely limited resources.

### **Achievements since 1994**

2. Since 1994, the government scored several public policy successes, which include, *inter alia*, expansion of primary care, revitalisation and refurbishment of hospitals, scaling-up ART roll-out, improvements in the pharmaceutical logistics chain, medical research, maintaining and growing health professional training, and combating smoking and piloting innovative public-private partnerships. Furthermore, significant progress has been made in establishing a legislative and regulatory framework for the medical schemes industry.
3. The ANC Health Plan of 1994 was an informed transformation process which began with the integration of the fourteen [14] departments of health of the

apartheid era into a single health system consisting of a central ministry and nine [9] provincial departments of health. The principle here was to create a unified national health system integrating the public and private sectors with the objective of reducing inequities and expanding access to essential health care for all.

4. Much has been achieved beyond the establishment of structures and development of policies and strategies. The focus on Primary Health Care (PHC) resulted in the re-prioritisation of budgets and resources to bring about an equitable redistribution between PHC and sophisticated curative and tertiary care. An essential PHC package was formulated which sets the norms for the provision of comprehensive primary care services. To increase access to these services, user fees for public PHC and all fees [including at hospitals] for pregnant women and children under the age of 6 years were removed. To support the expansion of these services, 1 800 clinics and community health centers were built since 1994. Today 95% of the population of South Africans can access health care within a five kilometres radius of their homes.
5. Hospital infrastructure was also improved significantly beginning with the Hospital Revitalization Programme which focused on the improvement of infrastructure, equipment, management and quality of care. To date, 250 hospitals have been revitalised, and 18 new hospitals built of which three are teaching hospitals.
6. In order to remedy shortages in the number of health professionals in rural areas, the government recruited Cuban doctors in the immediate post-1994 period, introduced compulsory community service for recent medical graduates, introduced scarce skills and rural allowances for health professionals, and more recently developed a strategy for the retention of skilled workers: Occupation Specific Dispensation for specific occupational categories such as nurse , doctors and others.

7. To make medicines affordable, the State introduced a comprehensive national drug policy in 1996, one of the main pillars of which was the Essential Drug List (EDL) for the public sector. It provided for much more rational drug prescribing and the introduction of generic prescribing throughout the health system. However, there is a need to review this policy to evaluate its impact and to improve where necessary.
8. The government also introduced many targeted health care programmes, including those focusing on women, children and diseases such as HIV/AIDs, TB, alcohol and tobacco use, malaria control, mental health and nutrition.
9. Notwithstanding these achievements, there are many challenges facing the health care system.

#### **Challenges facing the public health sector**

10. South Africa has a two-tiered health system, with a large private sector serving the higher income minority, while the public sector serves the majority of the population. About 40% of total health care funds in South Africa flow via public sector financing intermediaries (primarily the national, provincial and local Departments of Health), while 60% flows via private intermediaries. Medical schemes are the largest financing intermediaries, accounting for nearly 46% of health care expenditure. Although medical schemes are private intermediaries, they are also funded by government through tax subsidies. Provincial health departments follow as the next largest intermediary, with 38% of all health care funds flowing via them. Households' out-of-pocket payments directly to health care providers also account for a sizeable contribution, at nearly 14% of all health care expenditure.
11. One of the major challenges that has faced the public health sector since the 1994 democratic elections is the stagnation in funding allocations for the public health

sector. In real per capita terms, government expenditure on health declined consistently from the mid 1990s until 2002, and only returned to its 1996 levels in 2005 (McIntyre et al. 2007). This was largely due to the constrained government expenditure associated with the Growth, Employment and Redistribution (GEAR) policy. Since 2005, there have been some increases in real per capita public health budgets.

### **Inability to treatment people with TB**

12. According to the Department of Health and the WHO, South Africa is one of the 22 High Burden Countries that contribute approximately 80% of the total global burden of all TB cases. It has the seventh highest TB incidence in the world as a result of the double burden of disease, related to co-infection with HIV. South Africa has seen a rise in the incidence of tuberculosis in the adult population with a threefold increase in the numbers of people with TB from 109,000 in 1996 to 341,165 in 2006 or 269 cases of TB cases per 100,000 to 720 per 100,000 population. This has resulted in increased morbidity, mortality and poor performance on the MDG 2015 targets.

13. Drug resistant TB arises as a result of failures of the public and private health system to adequately deal with patients who have TB. According to the Medical Research Council's Drug Resistant Surveillance, (MRC: 2001-2002), the proportion of people with extra-pulmonary TB trebled to around 15% and the proportion of people who were co-infected with HIV in 2002 was around 55%. TB patients who are HIV positive need to commence ARV's early. In addition, 900 cases of Extensive Drug Resistant TB were reported between 2004 and 2007. Although the cure rates and treatment success have gradually increased from over the last five years with 66% in 2000 to 70% in 2004, the defaulter rates remain

high. This has created hurdles in achieving the targets for treatment success and cure and has increased the probability for drug resistance.

14. The most critical component in the management and eradication of TB pertains to addressing the social determinants of TB. These include poverty eradication, nutrition, housing and improvement of living and working conditions. However, effective public health, as well as clinical interventions, is also critical in ensuring adequate and effective management and eradication of TB and its complications. To this effect, the Department of Health developed the Draft Tuberculosis Strategic Plan for South Africa 2007-2011.

The financial barriers to seeking health care at the early and latent stages of TB mean that a significant number of household and others are infected before diagnosis of TB has been made.

### **Inequities in the health sector**

15. Inequities in access to health care remain a key challenge that should be addressed in a fundamental way.
16. A major access dimension that has posed problems for South Africans is that of the affordability of health services. In a population survey undertaken in 2005, 16.6% or 5.2 million people indicated that they experienced difficulties in accessing health care, including medicines (Shisana et al, 2007).
17. Furthermore, inequities in the public-private health care mix have increased. Government expenditure on health care per person dependent on the public health sector has barely kept pace with inflation, while real medical scheme expenditure per beneficiary has doubled in the past decade, with excessive cost increases in key parts of the private health sector. At the same time, despite policy efforts, public sector health services continued to face severe budget constraints and still fall

significantly short of the goal of a unified, comprehensive, equitable and integrated national health system.

18. The mismatch of resources in the public and private health sectors relative to the size of the population each serves, and the inefficiencies in the use of available resources, has contributed to the very poor health status of South Africans, particularly in the lowest income population. We have far higher infant and child mortality rates and far lower life expectancy than other countries with similar levels of economic development. This is not only attributable to the HIV/AIDS and Tuberculosis epidemics confronting our country, but also due to the massive inequalities in the distribution of income and health and other social services.

### **Human resource challenges**

19. There is a serious mal-distribution of health workers in the country, with 60% of the nurses and 40% of the doctors serving 85% of the population using the public health sector. Most of the health workers work in urban areas while there is a serious shortage in the rural areas. This disproportionate distribution obtains by province, with the Western Cape and Gauteng having high numbers of doctor-to-population ratios when compared with the rest of the provinces.
20. Nurses form the backbone of the health care system, and yet they are in short supply. This is largely due to a number of factors including cuts in the provincial budgets and the closure of nursing colleges, which has resulted in fewer nurses being trained. But even those who were trained do not all go on to practice in this country. For example, it is estimated that about 67% of nurses who trained in the period 1997 to 2005 do not appear on the South African Nursing Council (SANC) register (Breier, et al, 2008). Some leave the country to seek greener pastures in

countries that pay them higher salaries such as Saudi Arabia, Oman, United Kingdom, United States of America, Canada and Australia.

21. Another indicator of staff shortage is the vacancy rate. PERSAL data suggest that the vacancy rate was between 31.5% in 2006 to 36 % in 2007 (HST, 2007), which translates to 25 701 nurses that would be needed for different positions (Breier et al., 2008). A good measure of shortage is failure to fill vacant posts following advertisements. Researchers at the Human Sciences Research Council (HSRC) found that the vacancy fill rate for registered nurses and midwives was 56%, suggesting that there is a shortage of nurses in general. Some of the reasons given by employers for the failure to fill the vacant posts were that nursing is not a well-paying job, that it has low recognition, low promotion potential and long unsociable hours of work, that nurses run the risk of contracting HIV and that many migrate to other countries (cited in Breier et al., 2008). A major concern is that 16% of health workers are living with HIV (Shisana, et al, 2004) and 18.9% of the HIV positive workers are classified as eligible for ARV therapy (Connelly, et al., 2007).
22. Linked to the issue of nurses is the shortage of medical practitioners and other allied professionals. Access to quality health care for the majority of South Africans using the public health sector is negatively affected by inadequate supply of medical practitioners and allied professionals. Many migrate to developed countries in the North. In 2001, the OECD estimated that 8,921 South African doctors were in these countries. Reasons advanced for migration of these doctors include crime, deteriorating public education, better pay abroad, deteriorating conditions in the public sector and active foreign recruitment. These are challenges that the State must address if South Africa is to retain the doctors that it trains at a high cost of R780 000 per doctor (Breier & Wildschut, 2006).
23. The shortage of key health professionals is being experienced at a time when the size of the population dependent on public health services has been increasing, and

the burden of ill-health among the population, primarily due to the HIV/AIDS and associated TB epidemics is increasing. This has placed incredible strain on public sector health services, and on the staff who work in public sector facilities.

24. Professional assistants or mid-level workers are a relatively new cadre of semi-skilled health care workers in the health sector in South Africa. This cadre of workers improves access to health care to all sectors of the population based on the Primary Health Care Approach, irrespective of geographical location, by making up for the scarcity or absence of professionals such as doctors, dentists, pharmacists, physiotherapists or nurses, etc. Professional assistants play a particularly important role in staffing rural health centres, primary health facilities and district hospitals, to bridge the gap between the urban and rural divide, and well resourced and under-serviced areas.

### **Access to medicines**

25. Another challenge facing the public health sector is the shortage of drugs at public health facilities especially AIDS drugs and the ability to access medicines at lower prices. The private sector on the other hand actually has an oversupply of pharmacists resulting in pharmacies being located in close proximity to one another in urban areas. The rural populations on the other hand have little or no access to pharmacies. This mal-distribution is the result of the disproportionate healthcare financing system. Despite government efforts to reduce the prices of medicines in the private sector, they remain unaffordable to the majority of South Africans. Private insurance members often exhaust their medicines benefit before the end of each year and have to access their drugs through out of pocket payments or waiting in the long queues in the public sector.

### **Challenges in the private sector**

26. In contrast to the public sector, expenditure in the private sector has continued to increase, at annual rates far exceeding the inflation rate since the 1980s. Membership of medical schemes has become increasingly unaffordable for South Africans; as expenditure increases, so do the contribution rates or premiums that are charged by medical schemes. In the late 1980s and early 1990s, contribution rates were increasing at between 25% to 30% per year in real terms (McIntyre et al., 1995). The rate of annual contribution increases has reduced dramatically in recent years, but the average annual real increase in contributions of 7% between 2000 and 2005 is still of concern. Although medical scheme membership increased from about 6.5 million in the early 1990s to 6.9 million by 1997, the absolute total number of beneficiaries decreased in some years thereafter and had only remained at 6.9 million by 2005. Medical scheme membership has declined considerably as a percentage of the population, from 17% of the population in 1992 (McIntyre et al. 1995) to less than 15% in 2005 (Council for Medical Schemes, 2006).
27. The main cost drivers of medical schemes expenditure have been private hospitals, specialists and medicines, administration and brokers. While in the 1980s and first part of the 1990s, expenditure on medicines was increasing more rapidly than other categories of medical schemes expenditure, expenditure on private hospitals rapidly increased in the latter part of the 1990s and the 2000s (McIntyre and Doherty 2004). Real per beneficiary expenditure on specialists increased by 53% between 1997 and 2005, while that on hospitals increased by 74% over this period. Very little of the hospitals expenditure was directed to public sector hospitals; spending on private hospitals accounted for 98.5% of all medical scheme expenditure on hospitals in 2005 (Council for Medical schemes 2006).

Medical scheme expenditure on hospitals per beneficiary increased three times more than inflation between 1997 and 2005 (McIntyre et al. 2007).

28. The current expenditure subsidy for medical schemes was estimated to be in the range of R10-billion of foregone revenue in 2005, or 20% of the public health sector budget. This tax policy has major flaws. Firstly it is inconsistent with the principles of access, efficiencies and equity. The current tax expenditure subsidy on medical schemes' deduction has not contributed to increased access by low income earners in medical scheme membership nor improved the rising costs of the industry. Those in the high income tax brackets continue to benefit more from the subsidy than the middle and low income groups. Furthermore, the workers, including the informal workers, not covered by medical schemes, do not benefit from the tax subsidy at all. Secondly, even when low income earners get tax subsidy, they would not be able to afford adequate coverage, leaving them with modest benefits and high cost sharing that will often make health care unaffordable.

29. There are a range of reasons for the large increases in medical scheme expenditure, including the fee-for-service reimbursement mechanism which encourages providers to supply more services than may be strictly necessary from a clinical perspective. There has also been a growing imbalance in the relationship between purchasers (medical schemes) and providers. This is particularly the case with private hospitals, where three large hospital groups own about 84% of all private hospitals (van den Heever 2007).

### **Low bed occupancy**

30. Whilst hospital beds in the public sector have declined, the number of private hospitals and clinics continues to grow. The private sector has added almost 7 000

beds between 1998 and 2006. The 2007-2008 Council for Medical Schemes (CMS) Annual Report indicates that there are presently 28,000 private beds in South Africa, with an additional 4,000 added between 2004 and 2008. The bed occupancy rate in the private sector is currently at 65%. and the bed over-supply is roughly 10,000. Bed occupancy in the private sector increased slightly from 62,09% to 64.52% between 2006 and 2007.. The mining industry also provides its own hospitals, and has 60 hospitals and clinics around the country with surplus capacity.

31. The 2007-2008 CMS Annual Report reflects increases on the total amount spent on healthcare in the private sector by schemes. Schemes paid R20.2 billion (36.0% as % of total spent) to hospitals. This translates to a 12.5% unadjusted increase or a 5.3% real increase in expenditure on private hospitals when adjusted for inflation.
32. The CMS Annual Report also indicates that specialists are the key drivers of increased hospital utilization and costs, as they are the professionals who predominantly admit patients in private hospitals. Specialists generate around 70% to 80% of hospital costs incurred, aside from their own professional fees and costs. Private hospital cost increases could also be a result of the excessive issuing of licensing for acute beds and expensive technology by provincial health administrations.

### **Challenges in public-private health sector mix**

33. Another significant challenge facing the South African health system is the need to address the inefficient and inequitable distribution of resources between the public and private health care sectors relative to the population served by each. Table 1 summarises the disparities that exist between these two sectors in relation to hospital beds and human resources. As mentioned earlier, there is more than twice as many hospital beds per beneficiary of private sector hospital services as there are for those dependent on the public sector. The disparities are even greater in relation

to health professionals; each pharmacist in the public sector serves 12 to 30 times, and each generalist doctor in the public sector serves 7 to 17 times, more people than those in the private sector. There is a six-fold difference in the number of people served per nurse, and a 23 times difference in the number of people served per specialist doctor, working in the public and private sectors in South Africa.

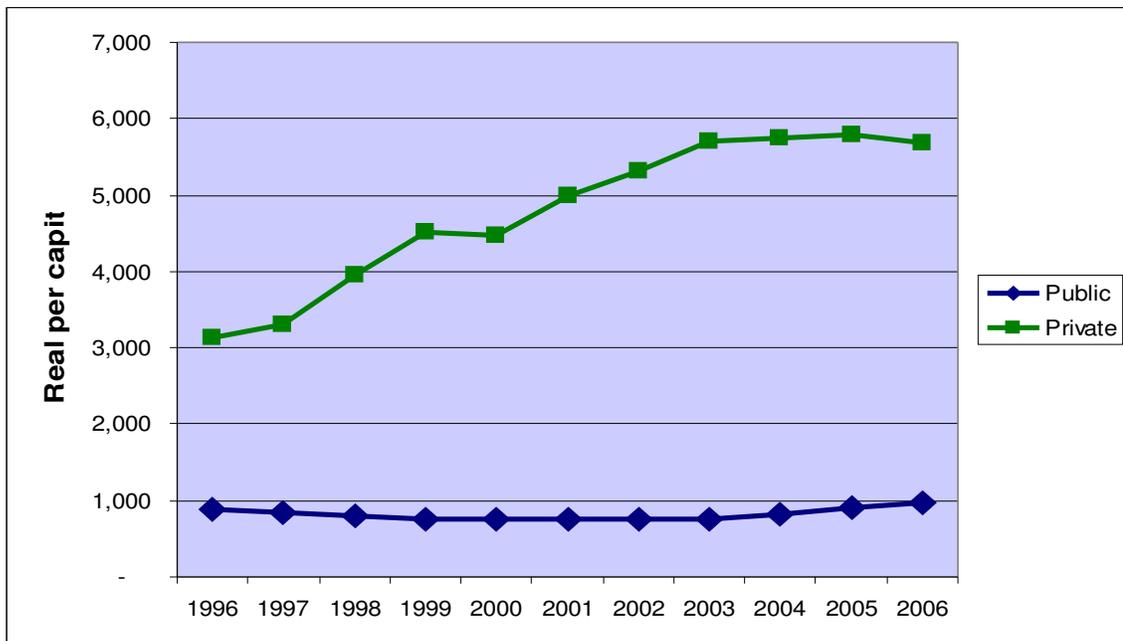
Table 1: Distribution of health care resources between public and private sectors (2005)

Item	Private sector	Public sector
Population per general doctor	(243) 588*	4,193
Population per specialist	470	10,811
Population per nurse	102	616
Population per pharmacist	(765) 1,852*	22,879
Population per hospital bed	194	399

\* Data in brackets represents only medical scheme members (14.8% of the population), main estimate assumes that private GPs and pharmacists may be used by up to 35.8% of South Africans. **Source:** Data on personnel and bed numbers from Health Systems Trust's South African Health Review, 2005/06.

34. What is of concern is that public-private mix disparities have deteriorated remarkably over the past decade (see **Figure 1** below). While real expenditure per medical scheme member (health care benefits and administration and other management costs) were about three times greater than government health care expenditure per person who is not a medical scheme beneficiary in 1996, the difference in expenditure was about six times greater on medical scheme beneficiaries by 2006. This is due to the fact that real per capita expenditure in the public sector was relatively stagnant over this period, while medical scheme contributions and expenditure have been growing at rates far exceeding overall inflation throughout the period. This pattern of diverging public and private sector expenditure patterns was seen throughout the 1990s as well.

**Figure 1: Trends in real per capita health care expenditure in public sector and medical schemes (2000 base year); 1996-2006**



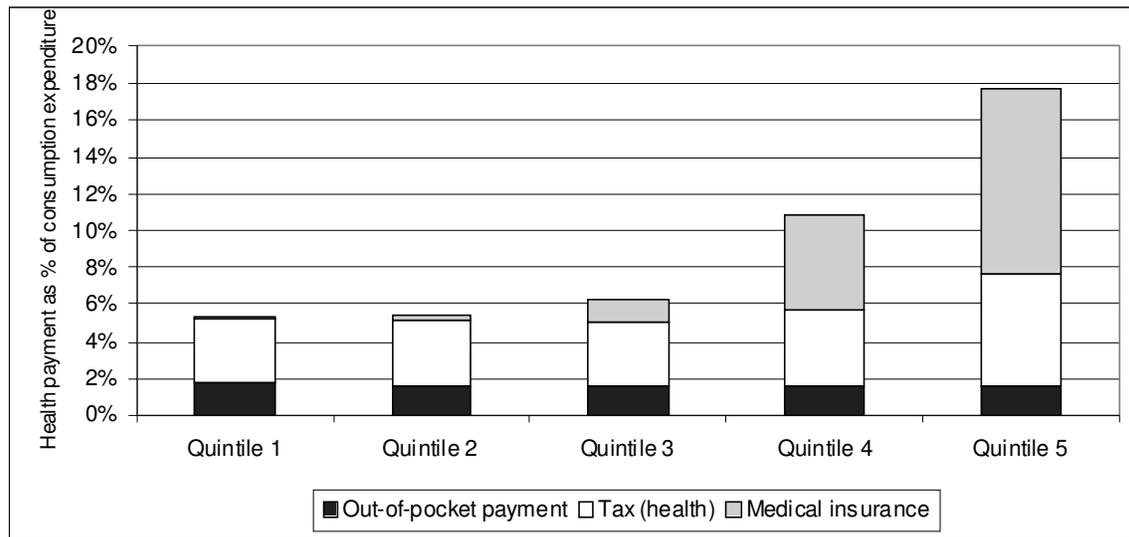
Source: McIntyre et al. (2007)

### **The incidence of health care financing and service benefits in South Africa**

35. The disparities in health care financing and service benefits alluded to above can best be illustrated through comprehensive financing incidence and benefit incidence analyses. A financing incidence analysis determines which socio-economic groups bear what burden of funding health services. A benefit incidence analysis determines what benefit (expressed in monetary terms) different socio-economic groups derive from utilising health services. These analyses enable one to assess how equitable a health system is; financing is regarded as equitable if contributions to funding health care are according to ability to pay, and health service use is regarded as equitable if benefits are distributed according to need for health care.
36. Figure 2 shows the distribution of the burden of health care financing across socio-economic groups. It shows that the poorest 20% of the population (quintile 1) contribute almost 6% of their household income towards funding health care. This

is mainly through making out-of-pocket payments (e.g. fees at public hospitals or payments to a private GP or pharmacy) and through tax contributions (in the lowest income households, this mainly takes the form of indirect taxes such as VAT, excise duties, fuel levies etc.). This is similar for the next two quintiles. The richest 20% of the population contribute about 18% of their household income towards health care, with most of this in the form of contributions to medical schemes; their contributions to health care funding in the form of out-of-pocket payments and general tax payments is less than 8% of their income. The second richest 20% of the population contributes just over 10% of their average household income to health care payments, with nearly 6% being in the form of out-of-pocket payments and general tax payments.

**Figure 2: Incidence of health care financing in South Africa, 2006**



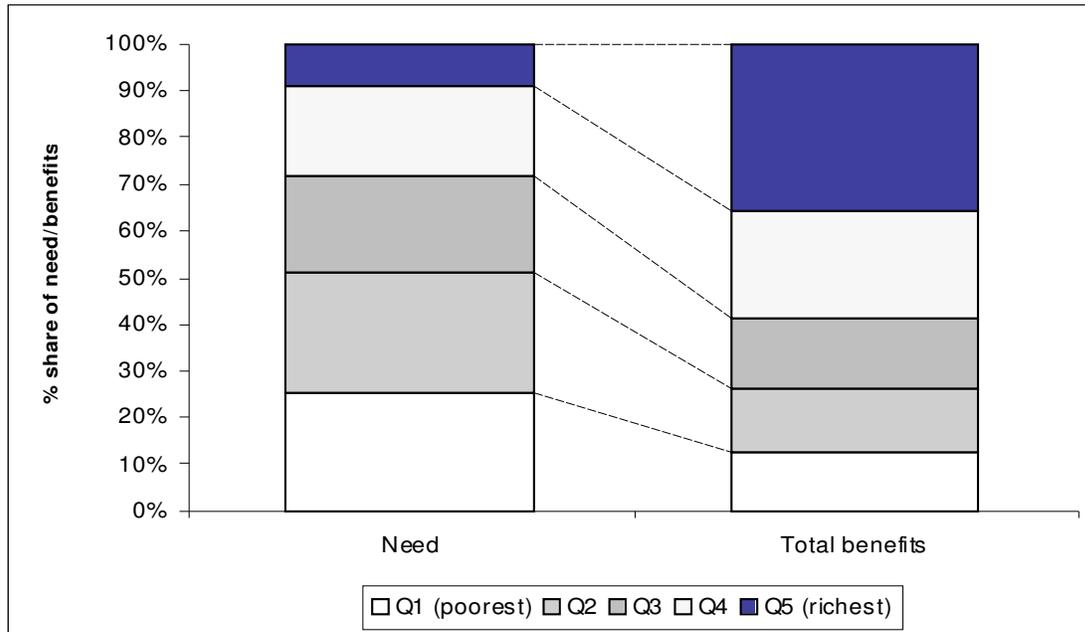
Source: Ataguba & McIntyre (2009)

37. The information depicted in Figure 2 clearly indicates that payments towards the cost of health care are progressive in South Africa (i.e. payments to health care as a percentage of household income increases as the level of income increases). However, it should be noted that almost all of the 'progressivity' of health care funding is attributable to medical scheme contributions as it is only the richest groups which contribute to medical schemes. However, it is also only those who contribute to medical scheme who benefit from funds in medical schemes. The distribution of health care funding in the form of out-of-pocket payments and general tax payments is relatively evenly distributed across socio-economic groups – although general tax payments are progressive, they are only slightly so, with the poorest 80% of the population (quintiles 1 to 4) bearing a very similar burden of funding these payments.

38. The fact that a large share of health care funding is attributable to medical schemes contributions and that only a small share (14%) of the South African population benefit from the services funded by these schemes heavily influences the distribution of benefits from health care utilisation across socio-economic groups. Figure 3 shows that benefits are heavily concentrated on the richest 40% of the

population, who receive about 60% of the health care benefits. This is particularly due to the use of private providers by this group, but also due to this group deriving the greatest share of benefits from the most highly specialized public hospitals.

**Figure 3: Comparing total benefit incidence with levels of health care need**



Source: Ataguba & McIntyre (2009)

39. What is even more striking is that health care benefits are not distributed in line with need for health care services. The benefit incidence of health care in South Africa is very ‘pro-rich’, with the richest 20% of the population receiving 36% of total benefits (despite having a ‘health need share’ of less than 10%) while the poorest 20% receive only 12.5% of the benefits (despite having a ‘health need share’ of more than 25%).

40. In summary: “there is a lack of cross-subsidies in the overall health system in South Africa. Although health care financing is ‘progressive’, this is largely due to the richest groups bearing the burden of medical scheme funding; however, the richest groups are the exclusive beneficiaries of these funds. It is indisputable that benefit

incidence in South Africa is inequitable; benefits from health care are not distributed according to the need for health care,” (Ataguba & McIntyre 2009).

## II TOWARDS NEW FINANCING STRATEGY AND ACCELERATED HEALTH SYSTEM REFORM

41. To address these imbalances in access and utilisation of health services as well as health outcomes, the health care system requires a fundamental transformation through the introduction of the National Health Insurance system (NHI) that enables an integrated, pre-payment-based mechanism and ensures the realisation of the right to health care for all.

42. The introduction of a national health insurance system has been on the agenda of government since 1994. The key objective of such a system is to address the problems of the dual health system by promoting social solidarity in order to achieve universal coverage. Despite considerable debate over the past two or more decades, no progress has been made in transforming the health system along these lines.

**43. The case for change in health care financing in South Africa through the introduction of mandatory NHI health is both strong and urgent. The case for change should also be considered in the light of the lack of achievement of the Millennium Development Goals (MDGs) for health, and the stagnation and even deterioration in mortality rates and life expectancy.**

44. This policy outlines the essential elements required for a comprehensive transformation of the health system through the introduction of a National Health Insurance (NHI). Support for the implementation of NHI will also require parallel efforts to improve the public health services system, with the major focus on improved infrastructure, human resources for health and management. The NHI is therefore being developed within the context of intensified health system reform.

## **Rationale for the establishment of a National Health Insurance in South Africa**

45. The status quo in the South African health system as described above cannot continue. The rationale for introducing a National Health Insurance is that it would provide a mechanism for improving cross-subsidization in the overall health system, whereby funding contributions would be linked to an individual's ability-to-pay and benefits from health services would be in line with an individual's need for care. This would be achieved through having a single funding pool.

### **Public and Political Support for the National Health Insurance**

46. There is public and political support for the establishment of the national health insurance as a means to increase access to good quality health care for all and to promote social solidarity.

47. A recent national household survey, conducted in 2008, shows that there is good support for NHI amongst the general public. There is a good understanding of the need for pre-payment to ensure financial protection from the costs of health care with 76% of all respondents agreeing with the statement: "I would agree to pay a small amount each month so that if I get sick, health care will be free, even if I am not sick now". More than two-thirds of respondents (67%) agreed with the statement: "I would join a publicly supported health insurance scheme if my monthly contribution was less than for current medical schemes". Importantly, an even greater number of medical scheme members (71%) agreed with this statement, strongly suggesting that there is widespread dissatisfaction with the high costs of medical scheme membership. Another important finding of this survey is that despite reported widespread concern about the quality of care in public sector

facilities, 73% of South Africans agreed with the statement: “I would join a publicly supported health insurance scheme if I could use public health services for free” (McIntyre et al. 2008).

## **Economic Rationale for Introducing the National Health Insurance**

48. Not only will public spending on the health sector contribute to economic growth through improving the health status, and hence productivity, of the population, but also through employment creation for healthcare professionals. The health sector is very human resource intensive and it is well documented that the South African health system, particularly the public sector, is significantly understaffed relative to what is required to address the health care needs of the population. The NHI, through its integrated funding pool and cost-containment benefits (see later), will provide the financial resources to fill currently vacant posts within the public health sector and open new posts. In addition, additional employment opportunities will be created for trainers of health professionals in tertiary education institutions (including nursing colleges), given the urgent need to increase health professional training outputs.
49. An economic benefit of the NHI will be cost-containment within the health sector. As indicated in Figure 1, the medical schemes sector is experiencing expenditure increases that far exceed inflation, despite serving a small share of the population that is not increasing. This is largely because of increases in fee levels charged by health care providers that are not matched by health service outputs and outcomes. Furthermore, the mismatch in the balance of power between a large number of fragmented purchasers (medical schemes) and concentration among health care providers, especially in the for-profit, private hospital market exacerbates the situation. The system of a single NHI purchaser has been shown internationally to contribute greatly to cost containment in the health sector.
50. There are two major benefits from such cost-containment. Firstly, the health sector will be a more efficient contributor to the South African economy by ensuring healthier and productive individuals. Secondly, there are concerns about the

potential of NHI increasing the cost of labour but this supposes no productivity increases. The NHI contribution will not impose a greater burden on employers than the current medical scheme contributions. More importantly, the inherent cost-containment mechanisms within the single funder NHI model that is proposed here will ensure that employers are not faced with annual contribution increases that are far above the inflation rate as currently occurs with medical scheme contributions.

51. While there are other economic benefits of the proposed NHI, the abovementioned examples illustrate the positive economic gains that are likely to be yielded when the NHI is fully implemented.
52. At present funding for health services in South Africa is fragmented on a number of different legislative and policy planes which leads to inefficient utilisation of resources, wasteful duplication of health cover and unnecessary overlapping of functions between various agencies. People continue to ‘fall between the cracks’ in the current health system with the result that their constitutional rights to human dignity and access to health services are being adversely compromised. Therefore, it is necessary to create a single focus for the funding of health care services that respects the rights of the wealthy, the poverty- stricken and all those in between alike.
53. The constitutional mandate of government to ensure the progressive realization of the right of access to health services requires the most efficient and effective utilization of resources in order to ensure such access for South Africans and permanent residents. There are urgent health care needs, for example those of the elderly, the indigent and very young that are not being adequately met due in part to the continued fragmentation of the current health system combined with historical inequities within this system.

54. The rationale for introducing a NHI system is that it would provide a mechanism for improving cross-subsidisation in the overall health system, whereby funding contributions would be linked to an individual's ability to pay while benefits would be in line with an individual's need for care.. Health services would be accessible to all on an equitable basis, on the principle of non-discrimination. It should be noted that increases in contribution rates in a national health insurance system are subject to changes in the implementing regulations of the core legislation.
55. The introduction of a National Health Insurance system is aimed at strengthening the under-funded and overworked public sector and pooling resources in both sectors in order to progressively realise the right of all to access quality health care services. The introduction of a National Health Insurance system will go a long way towards establishing a health care system in compliance with our constitutional rights.

#### **The right to health as a human right**

56. The South African constitution is a transformative and progressive one in that it seeks to transform the inequitable economic and social conditions inherited from the apartheid era to a more equitable one – where human dignity, equality and advancement of human rights and freedoms, non-racialism and non-sexism form the founding values of the constitution. It is also one of the few constitutions in the world that includes socio-economic rights in the Bill of Rights. These include the right to access health care services as well as the underlying determinants of health such as the right to clean drinking water, the right to adequate housing, the right to a clean and a safe environment, the right to sufficient food & nutrition and social security. For a person to enjoy good health, it is therefore essential that the underlying social determinants of health are also enjoyed. In other words these rights are indivisible and interdependent and that the government is obliged to take steps to ensure that everyone has access to quality health care.



### III PRINCIPLES AND GOALS OF NHI

The core principles on which the proposed NHI will be established include:

57. ***The right to health:*** The State must take reasonable legislative and other measures, within its resources, to achieve the progressive realisation of the right to access health care services. A key aspect of ensuring access to health care is that services must be free of any charges at the point of use.

58. ***Social solidarity and universal coverage:*** There is a commitment to social solidarity in the South African health system, which means that:

- Mandatory contribution by South Africans to funding health care according to their ability to pay. Given the massive income inequalities, progressive funding mechanisms will be used.
- There should be universal access to health services that meet established quality standards so that everyone is able to use health services according to their *need* for health care and *not* on the basis of their ability to pay.

59. **Public administration:** A mandatory national health insurance system that is structured as a single funder public entity supports the strategies to achieve economies of scale, promote redistribution of health resources and cost-containment.

60. The **goals** of the national health insurance include:

- Providing universal coverage for all South Africans, irrespective of whether they are employed or not;

- Equity and solidarity among the population through the pooling of risks and funds;
- Accelerated national health system reform, especially in the public health sector;
- Increased strength of the health purchaser in negotiations with providers for both supply of services, rational provider payment levels with quality assurance;
- Creation of one public fund with adequate reserves and funds for high cost care, health promotion and prevention, and appropriate research and documentation on the development on national health insurance;
- Promoting efficient and effective service delivery in both public and private sectors; and
- Assurance of continuity and portability of national health insurance within the country.

#### **IV KEY PROPOSALS FOR A NATIONAL HEALTH INSURANCE**

The key proposals for a National Health Insurance Policy are as follows:

##### **Creation of National Health Insurance Fund**

61. At the core of the proposed health sector reforms is the reconfiguration of the institutions and organisations involved in the funding, pooling, purchasing and provision of health care services in the South African health system. An NHI Fund will be established within the provisions of the appropriate laws and regulations, including regulations and guidelines on the short-term investment of reserves. The main responsibility of the NHI Fund will be to receive funds, pool these resources and purchase services on behalf of the entire population. The Fund will be a publicly administered as a single purchaser with sub-national offices at the provincial levels to negotiate and contract with the health care providers.
62. A single payer system is effective in collecting revenue, distributing risks through one large risk pool; and offers government a high degree of control over total expenditure on health. Evidence from other countries has shown that a single payer is administratively more efficient (with costs around 3 percent) than a multi-payer system. A single payer system is better able to negotiate prices, purchase commodities in bulk and more importantly control utilization using various methods.
63. At national level, the NHI Fund will be managed by a Chief Executive Officer (CEO) who will directly report to the Minister of Health. The CEO will be supported by an Executive Management Team and specific technical committees including the technical advisory committee, audit committee, pricing committee, remuneration committee, benefits advisory committee (BAC) and others.

64. The NHI Fund will be advised by a committee made up of representatives of the relevant government authorities, the health care providers and representatives of civil society.
65. The Minister of Health will remain responsible for oversight of NHI Fund, the development of national health insurance policy and any amendments that impact on the NHI Fund to meet changes in the country's health care needs as determined through changes in population demography, epidemiological profile and health technology development.
66. Of necessity and supported by international practice and experience, the Fund must be an independent body for it to effectively perform its core functions: revenue collection and pooling, and most importantly purchasing of services. The National Department of Health will continue to play its overall stewardship role of the health care system, and also remain a major provider of services through its national, provincial and district level structures and facilities. In addition, the NDoH will continue to provide non-personal services including overall responsibility for infrastructure development for which it receives a budget. It remains critical that the responsibility of coordinating the development of overall health plans including personal services reside with the NDoH. The only function that the NDoH will capitulate is the purchasing function for personal services since the NHI Fund will contract and directly reimburse both public and private providers. However, the fund will only purchase personal services in accordance with approved plans by the NDoH.

### **Coverage**

67. The NHI Fund will cover all South African citizens and legal residents. The cover will entitle individuals and households to a defined, comprehensive package of

healthcare services provided through appropriately accredited and contracted public and private health services providers.

### **NHI Healthcare Benefits**

68. The NHI Fund will provide a comprehensive package of health services which includes all levels of care namely: primary, secondary, and tertiary. Quaternary health care services will remain the responsibility of the NDoH.

69. The comprehensive package of services covered by the NHI Fund will be based on the National Department of Health's comprehensive package of services that includes the following components:

- Primary care and preventive services
- Inpatient care
- Outpatient care
- Emergency care
- Prescription drugs
- Appropriate technologies for diagnosis and treatment
- Rehabilitation
- Mental health services
- The full scope of dental services (other than cosmetic dentistry)
- Substance abuse treatment services
- Chiropractic services
- Basic vision care and vision correction (other than laser vision correction for cosmetic purposes)
- Hearing services, including the provision of hearing aids

70. A list of pharmaceutical, medical supplies and devices will be linked to the Essential Drug List (EDL) and updated on a regular basis by the BAC. Emphasis will be placed on primary health care, with referral to specialists and in-patient care. Through a defined allocation of the NHI Fund revenues, the national health insurance benefits will include personal preventive services, in accordance with developments in the disease burden in the covered population.
71. Though the NHI benefits will be comprehensive because it will cut across all levels of the health system, it will exclude medically unnecessary services. The exclusion list will be regularly reviewed at agreed intervals by the BAC taking into account a number of factors including the population's epidemiological and demographic profiles and the emerging evidence of health technology development locally and internationally.

### **Provision of Health Care Benefits**

72. Public and private health care providers will be accredited according to criteria to be developed as described below. The criteria will specify the minimum range of services provided by primary, second, tertiary and quaternary health care facilities. Providers will then be classified according to these levels. As indicated earlier, the NHI Fund will contract accredited providers (both public and private) to provide a defined comprehensive package of services at each appropriate level of the referral hierarchy namely: primary, secondary, tertiary, and quaternary health services. In addition, a referral process will be defined for services within and outside the district and province to assure continuity of care and effective cost containment.
73. At the primary care level, existing private general practitioners (GPs) can be accredited if they work in multi-disciplinary practices which include primary health care nurses and a range of allied health professionals. However, in areas where there are human resource constraints GPs will be allowed to provide NHI services

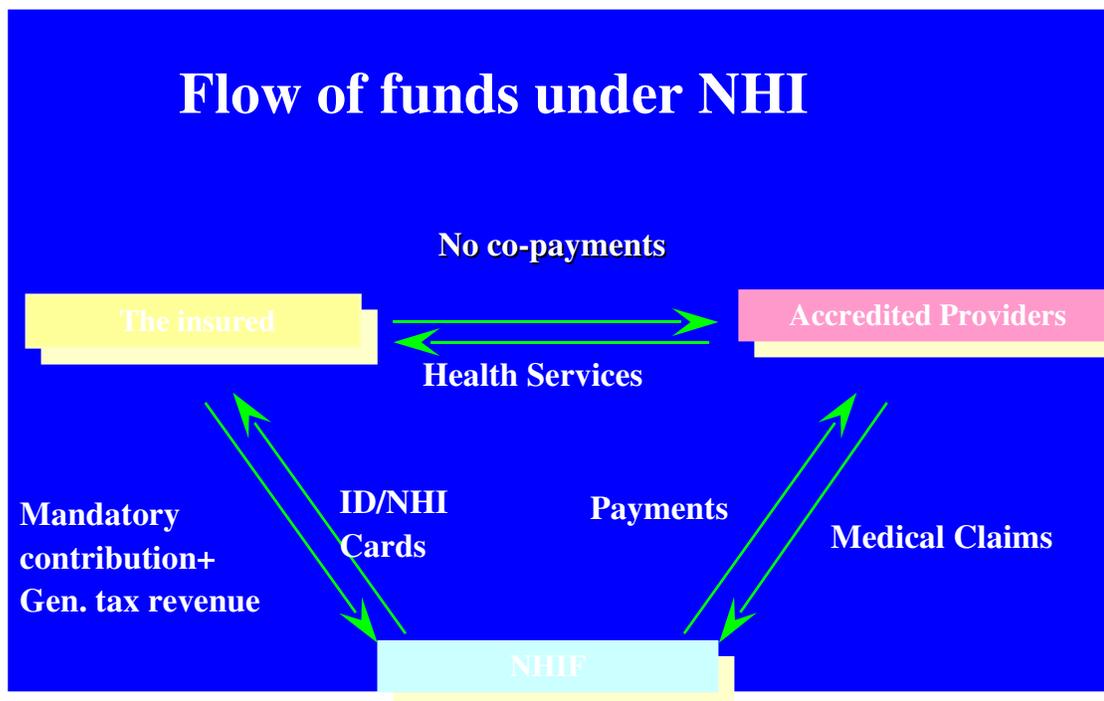
and will be encouraged to develop multi-disciplinary practices. All South Africans can then choose which primary health care provider (which would generally include a number of different public sector clinics/community health centres and accredited multi-disciplinary practices) in the district they would like to register with and utilise health services.

74. The successful implementation of the NHI system will rest on the accelerated, visible and sustained improvements in the provision of quality services to all. Both public and private facilities will be accredited by an independent National Office of Standards Compliance using agreed national norms and standards. The independent status of the National Office of Standards Compliance will be established through the appropriate amendment of the National Health Act of 2004 and will play the role of ensuring that all health care facilities are appropriately licensed and accredited. The OSC office, just like SARS which reports to the Minister of Finance, will report directly to the Minister of Health based on clearly defined terms of reference. It needs to operate with flexibility in order to rapidly help in identifying areas where facilities do not meet the standards that are to be addressed by the Department of Health and speed up the accreditation. The aim is to accredit at least 25% of all facilities annually until all facilities are fully accredited during a five year phased period.

75. The accreditation process will be supported by quality improvement and quality assurance programmes to make sure that all facilities reach accreditation status (see section on quality improvement below). In addition, providers will be reimbursed on the basis of their willingness to accept negotiated payment levels as agreed to with the NHI, and the need for such providers within a particular area.

## Sources of Revenue and Pooling Functions

76. The main sources of revenue for the NHI Fund will be general taxation and mandatory contribution (See figure below). Additional funding from other sources such as Road Accident Fund (RAF), Compensation for Occupational Injuries and Diseases Act (COIDA) and others will be considered at a later stage. All of these funds will be combined in the NHI Fund, from which all services covered by the NHI system will be purchased.



77. Funding of the health sector from general tax revenue should be significantly increased. At present, the total government budget devoted to the health sector is insufficient to adequately meet the health needs of the country. Since all citizens will be entitled to benefit from NHI services, coverage is not dependent on employment status or whether or not one contributes via the mandatory contribution. Conceptually, universal coverage is achieved because government makes contributions via the allocations from general tax revenue to the NHI on

behalf of those who are unemployed, poor and earning below the taxable income threshold.

78. Allocations from general tax revenue will be supplemented by a mandatory, payroll-related contribution. This mandatory contribution will be progressively structured and it will be collected by the South African Revenue Services (SARS). Everyone earning above the income tax threshold (adjusted annually) would be required to make this contribution (i.e. no one may 'opt-out' of the NHI), which will be shared between employers and employees.

79. This mandatory contribution will not cover the full costs of the NHI, but it is to supplement allocations from general tax revenue. The main rationale for introducing such a mandatory contribution is to establish a link between contributions that individuals make to public funds and the health service benefits to which they will be entitled under the NHI. Importantly, it provides a mechanism for cementing social solidarity in the health system through income-related contributions to a single pool of funds that will benefit all.

80. Additional funding for the NHI system will include the elimination of the current tax-deductions for medical scheme contributions and channelling these funds to the NHI Fund to provide additional funds into the NHI system.

81. As there will be no charges at the point of service use for the insured under the NHI for the defined benefits to be covered by NHI, out-of-pocket payments are not seen as a source of funding health care for services covered by NHI.

**82. The exact level of mandatory contribution to be introduced and the magnitude of general tax funding required for the proposed NHI are still being refined and discussed. However, at this stage it is necessary to indicate**

**that a policy commitment to a considerable increase in public funding of health services (through an appropriate mix of general tax allocations and progressive mandatory contributions) is required, to reach a funding level consistent with the needs of a publicly funded health system.**

### **Provider Payment Mechanisms**

83. Changing provider payment mechanisms is critical to ensuring effective cost-containment and the future sustainability of the NHI. The provider payment arrangements that the NHI Fund will use to reimburse all accredited providers will be risk-adjusted per capita payments (i.e. capitation) and global budgeting. The annual capitation amount will be linked to target utilization and cost levels. Facilities that do not meet the requisite standards will continue to get the global budgets until such time they meet requisite standards through support for a given period.
84. This applies to public and private providers in each category of service provision. The provider payment mechanisms must assure incentives for the health workers in the public sector, through supplements for specific tasks or sessional payment. It is also important to consider the implementation of performance-based payment mechanisms.
85. At district level, the capitation payment could be shared between health centres and district hospital, with a defined allocation for referrals to tertiary care providers. This would be determined by the supply and level of providers in each district and province.

86. While capitation should be maintained as one of the basic forms of provider payment, adjustment should be made in its application, with the following recommendations:

- The capitation amount should be a uniform amount for the defined levels of providers, regardless of public or private ownership.
- The capitation amount should be linked to an appropriate index such as CPI.
- The public and private health providers, contracted by the NHI Fund, will be assisted in controlling the expenditure through recommended formula, and corresponding to protocols for the treatment of common diseases. This will be necessary to assure the appropriate level of service provision and avoid under-servicing in a capitation payment system.
- High costs care for services excluded from the list of benefits under capitation will be reimbursed from a separate allocation of the NHI

87. There will be no co-payments or out-of-pocket payments to accredited providers at the point of health service use. Out-of-pocket payments and other direct fee-for-service charges to providers will apply only to the non-insured (such as tourists) or for health services excluded from the list of NHI benefits.

88. During the transitional phase, budget allocations to the health care providers, through the provincial allocations will continue to be used for both primary care and hospital level providers in the public sector until such time that the minimum range of facilities (primary and secondary health services) in the specific district have been accredited and contracted with the NHI Fund. In the transition phase, the budgets will nonetheless be calculated on the basis of a risk-adjusted capitation formula taking into account key factors such as population age and gender distributions.

## **Allocation of NHI Fund Revenues**

89. The allocation of health insurance revenues should facilitate the provision of the covered health care benefits with improved quality, recognized incentives to recruit and retain qualified health workers, attention to special health and health system issues, and a reasonable level of reserves.
  
90. It is important that administrative costs are kept to a minimum as existing registration and existing contribution collection mechanisms will be used for a significant proportion of the population covered. In the initial years and until analysis of the actual utilisation and cost information, it is proposed that a needs-based formula for the allocation of resources be developed, implemented and regularly monitored and evaluated. The information systems, training activities and NHI Fund promotion will need to be adequately budgeted for in the initial stage to help ensure effective implementation.

## **Registration of the population**

91. The registration of the national population will be based on a health facility approach. Using the green, bar-coded identity document or equivalent legal document people will be registered for the NHI system and eventually be issued with an NHI card that will be used to keep their health information history which allows for ease of access to patient information and for the portability of health services.

**To ensure that all eligible citizens and permanent residents have access to the defined comprehensive package of health care services, people will be registered with the NHI Fund. The NHI card will include health information history which allows for ease of access to patient information and for the portability of health services. If more than one accredited provider is available close to the area of residence of the members, they will be enabled to select the provider of choice. Members will be entitled to request changes in their provider selections only once a year.**

92. NHI cards for all population sectors, regardless of their contributory status, will be the same, to avoid the stigma of subsidised households.

## **Information systems and quality assurance**

93. The NHI Fund will contribute to an integrated and enhanced National Health Information System (NHIS) that is based on an electronic patient record platform. This will enable any person who visits a health facility in any province or health district to be allocated a unique identifier and have their medical history recorded and stored electronically on an electronic health record that is linked to the NHI

card. This system will be crucial for the implementation of the NHI system and the portability of services for the population.

94. The information systems of the NHI Fund will be developed to support:

- Monitoring of the extension of coverage in all population sectors
- All the financial and management functions
- Utilization of health care benefits by the NHI members
- Quality assurance programmes for the health care providers
- Production of reports for health facilities and health system management, and
- Research and documentation to support changes as the health care needs of the population change

95. To the extent possible, the NHI Fund's information system will be computerized, with linkage between the NHI Fund membership data base (with updated contribution status) and the accredited health care providers.

#### **Promotion of the NHI system**

96. Through a transparent communications programme, a proactive social marketing approach will be taken to increase knowledge and understanding of the NHI Fund's functions and activities, including the health benefits that members of the national population are entitled to. The sensitisation and promotion activities at national, provincial and district must include:

- Awareness raising among politicians and community leaders at all levels to enlist their active support for the NHI
- Development and updating of brochures and posters detailing the contributions, benefits, enrolment procedures and entitlement to benefits
- Development of audio-visual material for regular display at relevant sites
- Development of materials on rational health seeking behaviour

- Prominent placing of the NHI Fund logo in contracted health centres and hospitals, indicating accreditation and affiliation
- TV broadcasts by senior level politicians and officials
- Regular radio and TV spots and newspaper articles on progress with respect to NHI implementation and proposed changes

### **The future role existing medical schemes**

97. While the NHI calls for mandatory membership for all South Africans through mandatory contributions and social solidarity, it is up to the general public to continue with voluntary medical schemes cover after they have contributed to the NHI Fund.

## **V CONCURRENT HEALTH SYSTEM STRENGTHENING PLAN**

98. The improvement, expansion and revitalisation of public healthcare infrastructure is critical to realising the principle of universal coverage and reducing inequalities of access. Therefore, a parallel health systems strengthening plan has been developed to assure infrastructure maintenance, improvement and expansion (capital costs), and service provision (recurrent costs).

99. The health system strengthening plan has several key components, as outlined below:

### **General Infrastructure Inventory and Development**

100. The plan proposes that a detailed inventory of both public and private facilities, including infrastructure, human resources and technology, in all parts of the country must be done in order to establish the stock and distribution of these facilities. The

inventory will serve a dual purpose: Firstly, as an assessment of the current capacity of the national health system to provide services at different levels and where this capacity is located, and secondly, to identify gaps for expansion and facilities that require refurbishment. A subsequent facilities refurbishment and expansion plan will be developed, in line with the existing health care facilities revitalisation programme.

### **Strengthening of District Health Councils**

101. Capacity to deliver quality primary health services under a NHI system is premised on a revitalised and adequately financed district health system to meet the needs of the catchment population. District Health Councils (DHCs) throughout the country will be strengthened by improving political governance, managerial oversight and accountability structures. The focus on strengthening the DHCs will primarily be on improving service integration, the quality of services offered within facilities and outreach programmes, efficiency and effectiveness, as well as community participation, developmental and multi-sectoral approaches. Significant and sustained improvements in managerial capacity will be fundamental to achieving all this.

102. The district level offices will assist to manage the flow of funds from the NHI Fund to providers based on agreed plans and using a combination of agreed payment mechanisms.

### **Increased Autonomy of Public Health Care Providers**

103. As part of the concurrent health systems strengthening plan, actions will be taken to create concrete mechanisms for increasing the efficiency of public health facilities, particularly of hospitals by increasing managerial autonomy in public health care facilities in order to improve decision making and accountability. At the

same time, the current efficiency in the use of provincial allocations will be reviewed to assure reduction in duplication and optimal use of the allocations. Procurement and supply functions will also be revised where necessary and improved.

### **Development of Human Resources Plan for Health**

104.Changing the financial arrangements of the health sector without dealing with the Human Resources for Health (HRH) challenges will not yield the desired results. It is for this specific reason that the NHI plan proposes a set of comprehensive strategies for increasing the supply, quality, distribution and retention of various categories of health workers in the country.

105.Data on the employment of health professionals indicates that there has been growth in professional registrations across most health professions (see Table 2 below) and fairly substantial increases in public sector full-time permanent appointments. However, these increases conceal the fact that in many categories of staff, South Africa is heavily undersupplied with key health professionals and is facing a huge challenge in the medium to long-term:

**Table 2 Growth in professional registrations, 2002 to 2008**

Professional Category	2002	2003	2004	2005	2006	2007	2008	%change	Annual av. growth
Medical practitioners	29,903	30,578	31,214	32,198	33,220	34,324	34,687	16.0%	2.5%
Professional nurses	94,948	96,715	98,490	99,534	101,295	103,792		9.3%	1.8%
Enrolled nurses (staff nurses)	32,495	33,575	35,266	37,085	39,305	40,582		24.9%	4.5%
Enrolled nursing assistant	45,426	47,431	50,703	54,650	56,314	59,574		31.1%	5.6%
Dental practitioners	4,505	4,500	4,514	4,620	4,815	4,937	5,110	13.4%	2.1%
Dental therapists	364	381	390	417	443	450	455	25.0%	3.8%
Student dental therapists	92	102	143	123	131		166	80.4%	10.3%
Pharmacists		10,629	10,891	10,824		11,547	11,905	12.0%	2.3%
Dental assistants	not yet	not yet	not yet	16	131	375	2,147	13318.8%	412.0%
Oral hygienists	851	885	933	929	952	953	946	11.2%	1.8%
EMS practitioners	18,242	23,899	28,937	31,346	36,496	41,831	46,888	157.0%	17.0%
Environmental Health Officer	2,215	2,307	2,513	2,540	2,607	2,602	2,567	15.9%	2.5%
Medical technicians	1,001	1,095	1,193	1,214	1,276	1,271	1,378	37.7%	5.5%
Medical physicist	88	82	84	83	88	86	93	5.7%	0.9%
Medical orthotist prosthetist	292	294	323	344	345	342	351	20.2%	3.1%
Orthopaedic footwear technicians	39	37	39	34	50	52	52	33.3%	4.9%
Nutritionists/ Dieticians	1,322	1,433	1,592	1,575	1,687	1,795	1,844	39.5%	5.7%
Occupational Therapists	2,465	2,511	2,819	2,808	2,922	3,159	3,189	29.4%	4.4%
Optometrists	2,146	2,218	2,401	2,516	2,633	2,733	2,882	34.3%	5.0%
Physiotherapists	4,196	4,400	4,785	4,760	4,915	5,240	5,372	28.0%	4.2%
Physiotherapy Assistants	283	269	275	272	257	249	263	-7.1%	-1.2%
Occupational therapy assistants	495	501	511	506	527	519	475	-4.0%	-0.7%
Psychologists	5,302	5,401	5,774	5,878	6,130	6,391	6,598	24.4%	3.7%
Radiographers	4,669	4,789	5,221	5,237	5,433	5,624	5,757	23.3%	3.6%
Speech therapists and audiologists	1,282	1,345	1,397	1,391	1,396	1,441	1,294	0.9%	0.2%

Speech therapy assistants	7	7	6	6	5	5	4	-42.9%	-8.9%
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**Sources:** Health Professions Council of South Africa (HPCSA), South African Nursing Council (SANC), South African Pharmacy Council (SAPC).

106. Research shows that the HIV/AIDS and TB epidemics are a major factor contributing to disillusionment with the public sector (see Breier et al, in press) and also that many health workers are themselves infected with HIV. Therefore, the planning for human resources for health outputs will have to account for the impact of the HIV/AIDS and TB epidemics in terms of training numbers to fill the existing vacancies and to meet the needs of the future generation with regards to healthcare services.

## **Human Resources for Health norms and standards**

107. Human resources are critical to the accelerated and effective delivery of quality services for all. As part of strengthening the district health service system which forms the basic unit of a unified health care system, primary care providers must be adequately staffed to deal with the bulk of services needed at that level.

108. Accordingly the following key strategic issues need to be taken to address staff shortages and ensure sustained capacity for the provision of quality health services. These issues will require proactive engagement of all stakeholders in the human resource supply and demand chain. This will help to ensure that the health system has a sustainable and reliable source of human resources for health to effectively deliver the package of services as defined for the NHI Fund.

<b>KEY STRATEGIC STEPS</b>	<b>TIME FRAME</b>
<ul style="list-style-type: none"> <li>Address decline in production of doctors</li> </ul>	Medium-term
<ul style="list-style-type: none"> <li>Re-assessment of public sector nurse training - continue opening nursing colleges</li> </ul>	Short-term to Medium-term
<ul style="list-style-type: none"> <li>Reprioritisation in provincial and hospital budgets so that public sector resumes its role in the production of enrolled nurses and enrolled nurse assistants.</li> </ul>	Short-term to Medium-term
<ul style="list-style-type: none"> <li>Re-assess projected health professional production totals in the light of the HIV, AIDS and TB epidemics</li> </ul>	Short-term
<ul style="list-style-type: none"> <li>Address career progression of community and mid-level cadres particularly the need for HIV/AIDS lay counsellors.</li> </ul>	Short-term
<ul style="list-style-type: none"> <li>Address training of emergency care practitioners with attention to the implications of stopping modular training.</li> </ul>	Short-term
<ul style="list-style-type: none"> <li>Allocation of more resources to public institutions of higher education including strengthening responsive institutions such as Medunsa.</li> </ul>	Medium-term
<ul style="list-style-type: none"> <li>Establishment of additional tertiary institutions and/or satellites in each province and/or at community level such as in Cuba.</li> </ul>	Short-term to Medium-term
<ul style="list-style-type: none"> <li>Strengthen teaching, training and research capability of the tertiary institutions awarding scholarships for training of specialists and super-specialists</li> </ul>	Medium-term
<ul style="list-style-type: none"> <li>Extend internship and community service programme to all health professionals</li> </ul>	Short-term
<ul style="list-style-type: none"> <li>Address Continuing Professional Development for mid-level workers</li> </ul>	Medium-term
<ul style="list-style-type: none"> <li>Extend training and development programme in Cuba to other health professionals and support workers</li> </ul>	Short-term to Medium-term
<ul style="list-style-type: none"> <li>Review the efficacy and efficiency of current management development programmes</li> </ul>	Short-term
<ul style="list-style-type: none"> <li>Undertake audit of management qualifications of all National and Provincial Health Care managers</li> </ul>	Short-term
<ul style="list-style-type: none"> <li>Integrated generic management training with specific material related to health care management</li> </ul>	Short-term
<ul style="list-style-type: none"> <li>Introduce specialised courses on the PFMA</li> </ul>	Short-term
<ul style="list-style-type: none"> <li>New and creative training approaches that combines formal instruction with informal practices to be on team-building interventions to create synergy amongst managers in a particular district/institution</li> </ul>	Short-term
<ul style="list-style-type: none"> <li>Base formal instruction on an experiential approach and include case studies drawn specifically from the experience of the participants</li> </ul>	Short-term
<ul style="list-style-type: none"> <li>Include mentoring and coaching, networking with colleagues and in-house programmes in management training programmes</li> </ul>	Short to Medium-term
<ul style="list-style-type: none"> <li>Monitor and evaluate performance of managers on courses</li> </ul>	Short -term to Medium-term
<ul style="list-style-type: none"> <li>Formal training courses to be provided by accredited providers – public bodies (universities) or private organisations</li> </ul>	Short -term to medium

## **VIQUALITY IMPROVEMENT PLAN**

109. The degree to which the South African public healthcare services meet the needs of the employed, unemployed, and indigent South Africans in the face of an HIV and AIDS epidemic, rampant tuberculosis, malaria, childhood diarrhoea and malnutrition varies from excellent to extremely poor. Similarly, the capacity to meet community needs varies from institution to institution and by district and province. Poverty, substance abuse, violence and related trauma also seriously impacts on the capacity of the public health services.

110. Although poor infrastructure and a lack of resources is often blamed for the provision of poor healthcare, the attitude of staff towards their work and to their patients, associated with poor skills and corruption is equally, if not more, important.

111. In general, the capacity of South African healthcare services to meet the needs of the citizens is impaired by:

- a lack of management skills;
- a lack of induction and in-service training;
- failure to act on identified deficiencies;
- delayed response to quality improvement requirements;
- unsatisfactory maintenance and repair services;
- poor technology management;
- ineffective supply chain management systems;
- inability of individuals to take responsibility for their actions;
- poor disciplinary procedures and corruption; and
- the significant problems in clinical areas related to training and the poor attitudes of some of the staff.

112.To address the significant patient-care problems within the South African public health system, a carefully planned, organised, articulated, and documented quality improvement and quality assurance plan is required. It should be systematic and incorporate the setting of priorities for improvement through a performance assessment process that uses reliable methodology.

113.This should be followed by the implementation of quality improvement activities that are based on regular assessments. A key activity in sustained improvement of the health services is a formal, structured process to maintain improvements that have been achieved and to improve upon them over time.

114.It is essential that the quality improvement approach be organisation-wide involving both clinical and non-clinical managers and their functions. The improvement processes should be collaborative, using an interdisciplinary, cross-functional approach organised around the flow of patient care and involving all departments/services, settings and disciplines.

115.This multidisciplinary approach should be guided by multidisciplinary standards that provide a blueprint for quality service provision. The management and staff should be actively involved with the multidisciplinary team. Of paramount importance is capacity building and skills transfer at all levels of the organisation to entrench both quality improvement and quality assurance in the national health system and to ensure their sustainability.

### **The Quality Improvement Plan for South African Public Healthcare Facilities**

116.The types of facilities included in this quality improvement plan are hospitals, clinics, ambulance services and ART sites in both the public and private sectors.

117. The proposed quality improvement approach utilises a continuous, collaborative, participatory, systems approach, integrating quality improvement into routine management functions. This approach regards quality improvement as a progressive and gradual process that relies on the guiding principles of teamwork, systems and processes, patient-centeredness and measurement.

118. The plan outlines how quality improvement support and development may be carried out most effectively in South African public healthcare facilities and focuses on:

- Developing local capacity within the National Department of Health to support and monitor the quality improvement work in the provinces;
- Developing capacity within provinces and health institutions to develop and maintain continuous quality improvement programmes;
- Providing training to healthcare facilities in quality improvement methodology and monitoring and evaluation using an appropriate information system.
- The importance of peer review and benchmarking as the mechanisms to share best practice, which is essential if variations across facilities, district, provinces and the country are to be reduced.
- The systems required to provide coordinated hospital care. These include managerial, clinical, clinical support and hotel systems. Similar systems, modified as necessary, are set for primary healthcare and ambulance services. Standards are set for the component departments and services within each system.
- Institutions are required to develop human resources performance improvement plans that focus on workplace skills which indicate priorities for training. Plans will be collated into district and provincial plans to contribute to sector skills plans developed by the Health and Welfare

Sector Training Authority (HWSETA). Development plans will be based on identified competency gaps of individuals.

### **The National Office of Standards Compliance and the standards and norms development process**

119. The National Office of Standards Compliance will:

- Meet internationally accredited standards set for accreditation agencies by an approved evaluative agency
- Facilitate the development of multidisciplinary organisational standards for healthcare facilities using principles set by the International Society for Quality in Healthcare (ISQua) for standard development
- Evaluate the compliance of standards in health care facilities
- Use a customised computerised information system to collate and integrate data, calculate performance indicators and generate deficiency reports that can form the basis of quality improvement programmes
- Have the ability to report on the progress of quality improvement programmes aimed at achieving standard compliance
- Accredits facilities that meet agreed quality standards
- Provide certification to participating facilities that have not met accreditation requirements to recognise degrees of progress made since entering the accreditation programme.

120. The National Office of Standards Compliance will have to employ sufficient and appropriately qualified staff in the following categories:

- doctors with experience in community medicine and other disciplines;
- professional nurses with experience in both primary and secondary care;
- paramedical staff with experience in a range of healthcare sectors and disciplines;

- project managers;
- administrative support staff; and
- training staff with experience in information systems

121. Efforts will be made to identify existing accreditation and quality improvement organisations with proven track records that meet the above requirements. These organisations will be evaluated to determine whether they have the competence and capacity to assist the National Office of Standards Compliance with the implementation of the accreditation process in South Africa and where necessary will be contracted to augment its activities and functions.

### **Standard development**

122. The development of standards requires a formal approach and consists of a normative phase where experts give input as to what should ideally be in place. This is followed by an empirical phase when normative standards are tested in practice and thereafter there is a consensus phase in which standards that are reliable, understandable, believable, measurable and achievable are developed.

123. During this process, the principles developed by the International Society for Quality in Health Care (ISQua), in collaboration with over 40 countries, will be used to guide the content and structure of the standards.

124. The underlying philosophy of the standards is based on the principles of quality management and continuous quality improvement and aims to accommodate legal and ethical aspects.

125. Standards are grouped to provide specific indicators of performance, which can be used as points of reference in evaluating actual performance compared to targeted objectives.

126. In order to expedite the implementation of the quality improvement and accreditation programmes required to improve the performance of healthcare organisations, standards currently in use, or in development that meet the above principles and requirements will be identified and utilised, with modifications if necessary.

### **Assessing standards compliance and introducing quality improvement interventions**

127. At the facility level, healthcare organisations (hospitals, primary health clinics and ambulance services) will be surveyed against the appropriate standards to obtain a baseline assessment of the facility.

128. Deviations from the standards will be prioritised according to the impact they have on quality and patient and staff safety. Based on the detailed analysis of prioritised deficiencies, an integrated quality improvement programme for the facility will be developed with inputs from the multidisciplinary team.

129. All quality improvement interventions will be formally monitored. Time-frames and responsible people will be clearly identified for ease of monitoring and evaluation. A database will be established and will be regularly referred to for the identification of when time-frames are met and not met. When not met, remedial actions will be speedily taken to re-establish the quality improvement programme's objective of achieving facility-wide standard compliance.

### **Trainers of the quality improvement plan**

130. All training will be provided using a "Train-the-Trainer" methodology to enhance rapid skills and knowledge transfer. At a provincial level, quality assurance units will be trained by quality experts to understand multi-disciplinary quality standards, quality data collection and analytical systems.

131. At a facility level a cascading “Train-the-Trainer” approach will be used whereby dedicated trainers will be identified to receive training and they, in turn, will train staff members in basic quality improvement techniques. These trained staff will be empowered to pass on their acquired skills as part of the induction process when new colleagues enter services in the facility.

132. Four ‘Expert Centres’ will be identified in each province to be ‘Centres of Learning’ for the province. These will incorporate a hospital and three primary care facilities.

133. The ‘Expert Centres’ will be the focal point for training to address identified skills deficiencies such as management and leadership; quality improvement techniques; evaluation and monitoring skills as well as additional skills-based training for supply chain, hotel, technology, and maintenance staff. This approach can be used for hospital services; primary health care services and ambulance service.

### **Quality Assurance Monitoring System**

134. A secure, web-based information system that provides access via the Internet to current standard compliance scores and other related information is an important monitoring component of the plan.

135. The monitoring of ongoing quality improvement initiatives in facility departments and services will enable management to make informed decisions and prioritise their interventions.

136.To facilitate this process, staff will be trained to evaluate their facility against the set standards, input their standard compliance data into the information system, extract the resulting information from the database via the web and then use it to manage their facilities better.

137.Monitoring of the standard compliance scores of facilities can be carried out on individual or grouped facilities. Using this process, national and regional staff will be in a position to use the information to monitor the performance of any facility that falls under their jurisdiction and to encourage staff to improve their clinical performance on a continual basis.

138.Determining the outcomes of the quality improvement process

139.At the end of the standard implementation phase, facility-wide surveys are carried out against the standards. Facilities are awarded certificates according to the level of standard compliance achieved. Facilities that achieve substantial compliance with the standards are awarded an accreditation certificate.

140.Facilities that do not achieve accreditation will be encouraged to continue their efforts towards achieving overall standard compliance through a graded certification programme, based on the recognition of improvements achieved.

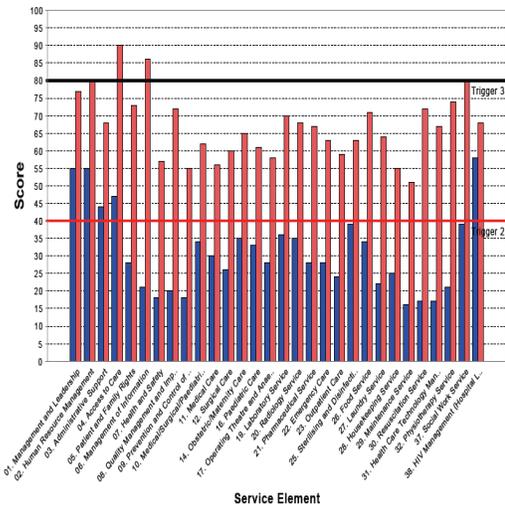
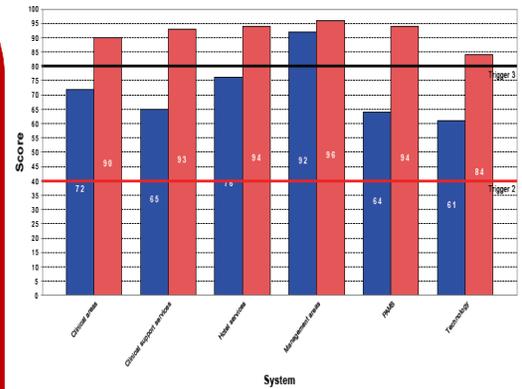
141.An example of the system to be used is shown in figure 2.

**Figure 4: The Quality Assurance Monitoring System**

**Quality Information System that:**

- provides continuous access to current standard compliance data.
- allows facilities to input their own data and monitor their own performance.
- supports ongoing quality improvement programmes.
- enables management at all levels to make informed decisions.
- assists facilities to reach and maintain accreditation standards.
- is a tool for the ongoing monitoring of performance indicators.

SE Number	Service Element	Critical Criteria Remaining	AB	External	
9	Prevention and Control of Infections	0	76	96	
11	Medical Care	0	67	95	
12	Surgical Care	5	87	85	
14	Obstetric/Maternity Care	0	100	97	
15	Psychiatric Care (Ward)	0	91	90	
16	Paediatric Care	5	88	85	
17	Operating Theatre and Anaesthesia Service	2	48	81	
20	Radiology Service	0	95	100	
21	Pharmaceutical Service	0	45	93	
24	Ambulatory Care	4	53	88	
25	Sterilising and Disinfecting Unit	0	54	85	
30	Resuscitation Service	0	38	94	
Performance Area Average (Clinical & Clinical Support)				91	



Criterion	Criterion / Deficiency Identified	Action / Recommendation	Responsible	Date Due	Date Reassessed	Date Completed	Progress	Comment
1.1.1.1 C Basic Management Very Serious Score: 100 Priority	The organisation's governance structure is described in written documents, which are known to staff in the organisation.  Baseline comment: Written documents kept in management offices, not known to staff in the organisation.	PMx1 Refer to baseline comment and begin addressing identified deficiency. PMx2 Finalising process of distributing to all staff. PMx3 Monitor process. PMx4 No progress since last visit.	PMx1 Dr Bitchong, Mr Leonard Diamini, Matron V Bhembe	14/09/2007	PMx1 16/07/2007 PMx2 17/09/2007 PMx3 19/11/2007 PMx4 18/02/2008 PMx5 27/10/2008	04/05/2009	AB New Deficiency PMx1 In Process PMx2 Due date lapsed PMx3 Due date lapsed PMx4 Due date lapsed	PMx7 Previous C to PC.

**Adverse Events Monitoring**

142. Patient safety in the hospital environment has become a global and regional issue of immense importance in both first and third world contexts. About 50% of healthcare errors are considered preventable, with an estimated average of 10% of all in-patient visits resulting in some form of unintended harm. The overall costs of

adverse events can be considerable. As well as causing avoidable human suffering, the financial and opportunity costs to health services are estimated at between 5% and 10% of health expenditure.

143. In May 2002, the World Health Assembly passed resolution WHA55.18, which urged countries to pay the greatest possible attention to patient safety.

144. A number of provinces in South Africa have introduced pilot adverse event monitoring and management programmes over the past three to four years. One of the most far reaching of these is the research project set up to investigate the feasibility of establishing an adverse event management system in the Free State. The project is beginning to produce useful results that may lead the way to developing a national reporting and learning programme. Patient safety is challenged by the complexity of care processes and a culture of denial and blame. This has resulted in inconsistent reporting and learning that has prevented the collection and dissemination of information in any meaningful way. The Free State has introduced a 'Just Culture' approach that has shown to significantly improve the level of incident reporting.

### **Goals of the National Quality Improvement Plan**

Objective 1: Quality Improvement within facilities

145. To provide the technical expertise to enable the National Department of Health and provincial health services to bring about an internationally accredited quality improvement and accreditation programme for hospitals, primary healthcare and ambulance services.

Objective 2: Increasing Access to HIV Treatment to meet the 2011 NSP goals.

146.To focus on meeting the treatment gap, improving quality of care, and addressing bottlenecks in the accreditation process that occur at the provincial, district and facility level to ensure that quality is maintained in a sustainable manner.

#### Objective 3: Patient Safety

147.To provide a system for the collection, classification and analysis of incidents that occur during the delivery of healthcare facilities and services,(including adverse events, near-misses and hazards) that will lead to the reduction and prevention of adverse incidents and improved patient safety.

#### Objective 4: Disease Management:

148.To provide the technical expertise to enable the National Department of Health and provincial health services to deliver effective services for conditions such as HIV / AIDS, TB and other long-term conditions at all levels of health service delivery.

#### **Resource Management and Support**

149.The key stakeholders in the project will be the National Department of Health, provincial departments of health, healthcare facility staff across South Africa and the National Office of Standards Compliance.

150.Public sector staff with the required expertise and skills to effectively roll out of this project will be identified. Such staff will include:

- medical doctors, some with management experience who have worked in a variety of health care facilities;

- professional nurses, ideally with management experience that have worked in a hospital and/or primary health care facilities;
- experienced paramedical staff;
- project managers;
- administrative and clerical staff;
- trainers.

### **Roles and Responsibilities of Stakeholders**

151. The following is a high level outline of the impact and engagement of stakeholders:

152. Government

- Set the long term policy agenda
- Identification of the impact of the burden of disease and shortfalls in health service delivery resulting in, for example, long waiting lists – e.g. 150 000 people awaiting cataract surgery
- Support the initiative and monitoring progress nationally
- Set the policy framework and associated regulations
- Delegate responsibility for programme and accreditation process to external agency
- Implementation of timetable
- National leadership Task Force

153. Provincial Authorities

- Identify priorities in the province
- Set up Quality Assurance units
- Agree on local implementation plans
- Resource allocation

- Monitor performance, acknowledge success, motivate stragglers, identify local champions and task teams

#### 154. District Teams

- Identify implementation teams
- Resource distribution
- Implement programme according to identified priorities
- Monitor progress and provide local support
- Introduce district-wide interventions as appropriate
- Support local champions

#### 155. Facility Managers

- Lead local implementation and monitoring
- Resource utilisation
- Introduce performance-based initiatives for departments
- Identify facility champions
- Facility level training
- Inter-facility cooperation

#### 156. Facility staff

- Implement programmes
- Train the trainers
- Local knowledge sharing and skills transfer

#### 157. Quality Improvement providers

- Work with the accreditation agency to identify priority quality improvement interventions
- Provide technical knowledge and assistance

- Provide training on quality improvement using “Train-the-Trainer” methodology
- Assist facilities to implement priority quality improvement requirements

#### 158. Accreditation agency

- Coordinate and monitor the progress of quality improvement interventions
- Provide technical knowledge and assistance
- Provide training on all aspects of the standard implementation and self-evaluation programme using “Train-the-Trainer” methodology
- Monitoring and evaluation of progress made towards accreditation
- Provide regular reports on progress made by facilities, singly and grouped as the work towards achieving substantial standard compliance and accreditation status
- Conduct accreditation surveys and determine accreditation status of facilities
- Report on the accreditation status of facilities

#### 159. Trade Unions

- Fundamental rights for labour relations
- Trade unions participation in the workplace to ensure improvement of service delivery
- Shop stewards monitor employers’ compliance with laws regulating terms of condition of employment whilst ensuring that the process of service delivery is uninterrupted and high levels of productivity are maintained
- Unions make inputs towards improving quality at provincial and national levels as regulated by the labour Relations Act No 50 of 1995.
- Unions monitor compliance with the relevant legislation to ensure a therapeutic environment for both the healthcare users and providers

- Unions play a role in ensuring that equipment, appliances and technology are of the required standards.
- Unions monitor the setting of quality management structures such as Committees for Infection Control, Occupational health and safety and Quality Assurance and their performance.
- Unions should monitor training in the development of personnel
- Unions share experiences with unions from developed countries in particular and learn important lessons for benchmarking and improving the quality of health.

## **VII PHASED IMPLEMENTATION OF THE PROPOSED NHI**

160. The introduction of an NHI requires a substantial transformation of the aspects of funding and providing health services in South Africa. For this reason, its implementation will be phased in over some time. The priorities for the first phase will include, but not limited to: wide consultation to get inputs from the public and private, stakeholders (labour, employers, community groups, NGOs, civil society); comprehensively review relevant legislation and drafting of new legislation to facilitate NHI implementation; increase funding of public sector health services from general tax revenue; revitalisation of public health infrastructure;; introduce quality improvement and quality assurance programmes; and development of human resources programme.

161. Together, let us work towards achieving health care for all. Particularly at this time of global economic crisis, we need to assure social safety nets for health for all, through a concerted effort to create a National Health Insurance Fund.

## XI BIBLIOGRAPHY

Andrews, G. and Y. Pillay (2005): Strategic Priorities for the National Health System (2004-2009) contributions towards building a model development state in South Africa. South African Health Review 2005. P. Ijumba and P. Barron. Durban, Health Systems Trust.

Ataguba J, McIntyre D (2009): Financing and benefit incidence in the South African health system: Preliminary results. Cape Town: Health Economics Unit, University of Cape Town.

Barron P (2008): The Phased Implementation of the District Health System in the Western Cape Province - A case study. Department of Health, Western Cape, 2008.

Beksinka M, Mullick S, Kunene B (2006): Maternal Care: Antenatal, peri and postnatal. In Ijumba P and Padarath A editors. South African Health Review 2006. Durban: Health Systems Trust.

Bourne D. E, Thompson M.L. , Linne B., Brody L, Cotton M, Draper B, Laubscher R, Fareed Abdullahe M and Myers J.E (in press): Emergence of a peak in early infant mortality due to HIV/AIDS in South Africa.

Bradshaw D, Nannan N, Laubscher R, Groenewald P, Joubert J, Nojilana B, Norman R, Pieterse D, Schneider M (2006): South African National Burden of Disease Study 2000. Estimates of provincial mortality: Summary Report, March 2006. Parow: Medical Research Council.

Breier M, Wildschut A and Mgqolozana T (in press): *Nursing in a New Era: the profession and education of nurses in South Africa*. Cape Town: HSRC Press.

Breier M, Wildschut A and Mgqolozana T (2008): *Nursing in a New Era*. Research brief.

Breier M and Wildschut, A (2006): Doctors in a divided society: the profession and education of medical practitioners in South Africa. Research Monograph, HSRC Press: 2006.

Broomberg J and Shisana O (1995): *Restructuring the National Health System for Universal Primary Health Care*. Main report of the Committee of Inquiry into a National Health Insurance System. Pretoria: Department of Health

Canadian Population Health Initiative (2004): Charting the course – Progress report: *Two years later, how are we doing?* Canadian Institutes for Health research, Population and Public Health.

Carrin G & James C (2005): Social health insurance – key factors affecting the transition towards universal coverage. *J Int Social Security Review* Vol. 58, 2005. International Social Security Association, Geneva.

Pillay R (2007): *The skills gap in hospital management: a comparative analysis of hospital managers in the public and private sectors in South Africa* – UWC

Plusnews (undated) South Africa: Money delayed is ARVs denied. <http://www.plusnews.org/Report.aspx?ReportId=81562> accessed 03/12/08.

Provincial Government Western Cape (2007): Comprehensive Service Plan for the Implementation of Healthcare 2010. [[www.pgwc.gov.za](http://www.pgwc.gov.za)] Accessed 20 January 2009.

Schneider H., Barron P., and Fonn S (2005): The promise and the practice of transformation in South Africa's Health System; *HSRC State of the Nation 2007*

Sen G, Östlin P, & George A (2007): Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it. Final Report to the WHO Commission on Social Determinants of Health (September 2007). Karolinska Institute.

Shisana O, Hall EJ, Maluleke R, Chauveau J, Schwabe C(2004): HIV prevalence among South African health workers. *S Afr Med J* 2004; 94: 846-850.

Shisana, O, Hall, E, Maluleke, KR, Stoker, DJ, Schwabe, C, Colvin, M, Chauveau, J, Botha, C, Gumede, T, Fomundam, H, Shaikh, N, Rehle, T, Udjo, E & Gisselquist, D (2003): *The impact of HIV/AIDS on the Health Sector: National survey of health personnel, ambulatory and hospitalized patients and health facilities, 2002*. Report prepared for the South African Department of Health. Funded by the Department of Health and the Centre for Disease Control. Cape Town: HSRC Press.

South African Health Review (2002): Funding flows in the South African health system. Durban, HST.

South African Nursing Council (2007): Analysis of nursing statistics 1997 – 2007. SANC.

Statistics South Africa (2004): General Household Survey 2003. Pretoria: Statistics South Africa.

Statistics South Africa (2009). Quarterly CPIX figures. Pretoria: Statistics South Africa.

Statistics South Africa. Income and Expenditure of Households: 2000: South Africa. Statistical Release P0111, Pretoria, 2000.

Tangcharoensathien V, Srithamrongsawat S, & Pitayarangsarit S (2002): "Health Insurance Systems in Thailand", Chapter 2, German Foundation for International Development, Health Insurance Office, Thailand, and Health Systems Research Institute, Thailand.

Tarimo E (1991): Towards a healthy district. Organising and managing district health systems based on primary health care. World Health Organisation, Geneva.

UNICEF Country Statistics.

[[http://www.unicef.org/infobycountry/southafrica\\_statistics.html](http://www.unicef.org/infobycountry/southafrica_statistics.html)] Accessed 03/12/08.

van den Heever, A. M. (2007): Evaluation of the merger between Network Healthcare Holdings and Community Healthcare. Pretoria: Council for Medical Schemes

Veriava, Y, Connelly, S D, Jordan, R, Roberts, S, Tsotetsi, J, Bachman, M & Rosen, S (2005): *The impact of HIV/AIDS on Health Service Personnel at Two Public Hospitals in Johannesburg*. Unpublished report.

World Bank (2009): Good Practice Notes – Health. New York, The World Bank Group.

World Health Organisation (2005): *Investing in health: A summary of the findings of the Commission on Macroeconomics and Health*. Geneva: WHO.

WHO. "WHO Indicators." WHO Statistical Information System. Accessed 2009 May 20 at <http://apps.who.int/whosis/data/Search.jsp>, 2009.

**B**

## NHI Campaign 2009

Free Health for All

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1. Following a resolution of the 52<sup>nd</sup> National Conference on the implementation of the NHI in the next five years and the pronouncement of the State Nation of Hon Jacob Zuma where he said ***“We will introduce a National Health Insurance scheme in a phased and incremental manner. In order to initiate the NHI, the urgent rehabilitation of public hospitals will be undertaken through Public-Private Partnerships”***
2. The remaining task is for the ANC and the Tripartite Alliance to lead a popular mass campaign with the following objectives & activities.
3. The campaign is also envisaged to educate & mobilize the public about healthy lifestyles and risky behaviors.
4. The time lines for this campaign are very tight. We envisage that this campaign should be adopted by the NWC & NEC in their next meetings in July 2009.

### Points on the Way forward

1. **Time Frames:** The NHI Policy Proposal and & NHI Campaign be presented to the NEC subcommittee for discussion and adoption.
2. **Platform:** The meeting agreed that will utilize the all available platforms to advance the campaign. The following platforms were identified: NEDLAC, Bargaining Councils for 2010, Labour Caucus, COSATU Congress Preparations and the Congress itself, COSATU Winter School, SANAC and etc
3. **Process:** The NHI Campaign Committee resolved that the process of engagement will be run concurrently with that of Government and legislation process.
4. **NHI Campaign Committee:** This committee will oversee the running of the campaign. It will comprise of ANC, COSATU, SACP, and SANCO & MDM.

