

## Chapter 3

# South Africa's ailing health system: how should it be treated?

*By Jonathan Berger*

### Introduction

Ours is not a healthy nation. Home to more people living with HIV than any other nation on earth and the epicentre of the global tuberculosis (TB) pandemic, South Africa also fares badly on a wide range of health indicators such as infant mortality, maternal mortality and adult life expectancy. Yet our Constitution recognises that everyone – regardless of race, gender, age, sexual orientation, socio-economic status, nationality or any other related ground – has the right to have access to health care services. In so doing, it expressly imposes obligations – primarily on the state – progressively to realise this fundamental right.

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Despite over R150 billion being spent every year in the public and private sectors, health outcomes in South Africa are often worse than in other African countries with far fewer resources, both human and financial. As Mark Heywood describes in chapter one, many of the problems can and should be attributed to the mismanagement of and abuse of power within the national Department of Health (DoH) from 1999 to 2008. Central to the thesis, however, is an understanding that we should guard against being lulled into a sense of security now that the AIDS denialism that characterised

the Mbeki administration has ended.

Put differently, undoing the damage will require far more than a reversal of those policies and practices that undermined the constitutional vision. In addition to locating the development of

policy and law and the provision of health care services within a rights-based framework, the DoH must ensure openness and accountability in all of its programmes and processes. And now that AIDS denialism is officially over, we once more have to square up to the same challenges that we faced in 1994 – except that they have become more extreme, in large part as a result of the conduct of the Mbeki administration.

## Structure of the chapter

With this context in mind, this chapter begins by providing a brief update on key legal and policy developments in health considered in our previous review.

The chapter goes on to argue that the Constitution places an express duty on the state to address the following three key challenges: clarifying ambiguities in the legal framework and the obligations imposed by the Constitution; the largely unmitigated human resources for health (HRH) crisis; and the need to strengthen health governance institutions. Addressing these issues, we believe, will improve all aspects of health care delivery.

In conclusion, the chapter considers the official government process underway to establish a system of national health insurance (NHI) for South Africa, the context within which the NHI debate is unfolding, and its implications for SECTION27, the new organisation into which the ALP will be incorporated.

## Update on previous review

The previous ALP review focused on a number of developments in health policy and law reform. In particular, the chapter entitled “Rethinking health reform: constitutionalism, law and policy” looked at the work of the ANC’s NHI committee, the outcomes of the health roadmap process held under the auspices of the Development Bank of Southern Africa (DBSA), and the tabling in Parliament of three important bills: the Medicines and Related Substances Amendment Bill [B 44—2008], the Medical Schemes Amendment Bill [B 58—2008] and the National Health Amendment Bill [B 65—2008].

The chapter noted that –

- The ANC committee’s policy on NHI was finalised and adopted by the ANC’s National Executive Committee in late 2008;
- The findings and recommendations of the roadmap process formed the basis of the development of a 10-point plan that was agreed to by most stakeholders in health care provision and thereafter adopted by former Health Minister Barbara Hogan as official DoH policy;
- Parliament passed the Medicines and Related Substances Amendment Bill [B 44D—2008], which – although still deeply flawed – was significantly better than the Bill tabled in June 2008 by Manto Tshabalala-Msimang, Minister of Health throughout the Mbeki administration; and
- Bills B 58—2008 and B 65—2008, both dealing with important aspects of health reform, effectively remained on ice.

As already indicated, the new Minister of Health – Aaron Motsoaledi – has now initiated an official process to establish an NHI system. This is discussed towards the end of the chapter. So too is the relationship between the NHI process and the 10-point plan that underpins current DoH strategic planning. What remains to be discussed now are the proposed amendments to national health statutes.

Although it was passed by Parliament in late 2008, the Medicines and Related Substances Amendment Act 72 of 2008 was only assented to by former President Kgalema Motlanthe on 19 April 2009.<sup>1</sup> But to date, it has yet to be brought into force. This is in line with the recommendations of the Medical Products Technical Task Team (MPTTT) of the Ministerial Advisory Committee on Health (MACH), which was appointed by former Health Minister Barbara Hogan in March 2009.

Amongst other things, the MPTTT – whose membership included the ALP’s Jonathan Berger – focused on the issue of drug regulation. In so doing, it considered the appropriateness and constitutionality of Act 72 of 2008, pointing out that concerns had been raised about three aspects of the new law:

- The lack of independence of the proposed South African Health Products Regulatory Authority (SAHPRA);
- SAHPRA’s ability to operate transparently and accountably; and
- The manner in which subordinate regulatory authority and discretionary powers are addressed.

With this in mind, the MPTTT recommended that the Act only be brought into effect “if and when the constitutional defects are cured by way of a further amendment that is tabled in and processed by Parliament whilst the DoH prepares new regulations to give effect to the full package of law reform.” It further noted that this approach would “leave untouched those provisions of the Medicines [and Related Substances] Amendment Act that are sorely needed”.<sup>2</sup> The ALP understands that the concerns raised by the MPTTT are being addressed in draft legislation that is to be published in 2010 for public comment.

While the ALP’s interventions – in Parliament and by way of participation in the work of the MPTTT – in respect of medicines regulation appear to have borne fruit, its submissions in respect of the other two health bills tabled in 2008 appear to have fallen on deaf ears. Despite the urgent need for Parliament to consider and process the Medical Schemes Amendment Bill [B 58—2008], the bill has been allowed to lapse. All indications suggest that it is unlikely to be revived.

While the National Health Amendment Bill [B 65—2008] has also lapsed, the future of the substantive issues it sought to address is somewhat brighter. This is because Parliament’s legislative programme for 2010 lists a Health Pricing Commission Bill that is to be submitted for Cabinet approval in June 2010 and introduced

to Parliament in October 2010. Given the Minister of Health’s refreshing approach to consensus building and his avoidance of unnecessary confrontation, we believe that the Health Pricing Commission Bill will be a significant improvement on Bill B 65—2008.

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## Clarifying legal ambiguities and constitutional obligations

Much has been said about the right to have access to health care services and the obligations it imposes on the state regarding its progressive realisation within available resources. Ordinarily, however, such discussions and debates have focused quite narrowly on the provision of public health services. Seldom have seemingly technical issues – such as health budgeting and expenditure monitoring, fiscal federalism and public procurement – been considered by many in government as integral to the realisation of rights.

In contrast, the work of the ALP is underpinned by respect for the rule of law and the supremacy of the Constitution. In combining research and legal work with social movement strengthening and coalition building, the ALP places the Constitution at the heart of its work, focusing on using and developing the law to defend and advance fundamental human rights – at both a jurisprudential and a practical level. Absent either of these pillars of our constitutional democracy, the ALP's use of the law as a tool of progressive social change – its *raison d'être* – would fall away.

In large part, this explains the ALP's growing focus on fundamental rule of law questions. While some of this work has looked beyond the fields of HIV/AIDS and health, much of it has considered the topic in relation to the “technical” issues identified above. The focus of this section of the chapter is therefore threefold: first, to frame these issues as human rights concerns; second, to clarify any ambiguities that may exist in respect of the relevant legislative frameworks; and third, to consider these frameworks within the context and overarching structure provided by the Constitution.

## Health budgeting and expenditure monitoring

Outside of the context of NHI and health sector reform, the amount of money budgeted for health ordinarily dominates any discussion on public health sector funding. While the quantum of financial resources allocated is always going to be an important part of the broader discussion, so too are the following three related issues: the basis upon which the specific amounts have been allocated in any particular budget; the process in terms of which the budget is developed; and expenditure monitoring. In our view, the Constitution imposes obligations on the state in respect of all three of these issues.

### *Forecasting and costing need*

The ALP's 2006/2007 review referred to submissions made in April/May 2007 to the South African Human Rights Commission (SAHRC) regarding its public hearings into the right to have access to health care services. In considering the concept of “needs-based budgeting”, which our submissions firmly advanced, former Health Minister Manto Tshabalala-Msimang stated that she did “not agree ... that ... the Commission must hold the government bound to certain methodologies of ... budgeting for the realization of the right to health care services”, insisting that “budget processes must be left to government”.



SAHRC report on access to health care services

In its report, which was only published in April 2009, the SAHRC considered the issue of needs-based budgeting in a particularly cautious manner:

The case for a needs-based approach to budgeting was explored and supported in a number of submissions to the SAHRC. The process followed in the development of the National Strategic Plan for HIV and AIDS was held up as an example of best practice, in which broad consultation laid the foundation for the plan which was budgeted for according to need. The budgeting exercise resulted in a figure much higher than the funds provided for in the allocated budget, and a commitment was therefore made to seek additional funding to meet the shortfall. The debate as to whether to adopt a needs-based funding approach has been discussed in Cabinet, and there appears to be concern as to whether the costly process of determining resource requirements would be worthwhile in light of overarching funding constraints.<sup>3</sup>

Having said that, however, the SAHRC expressly called for “a recognition and realignment of the location of health in national priorities ... [that] should be reflected in resource allocation and the design and implementation of an effective and functional needs-based system.”<sup>4</sup> It explained further:

[T]he integrity of a needs-based system relies on ... accurate measurement. ... Health information systems and population data must be improved continuously, because it is essential to be able to monitor progress and inequities. Institutional capacity to collect, analyse and utilise health data at national, provincial and local levels need[s] to be strengthened, so that programme[s] and policies can be responsive to the changing burden of disease profile.<sup>5</sup>

Today, South Africa appears to be no closer either to developing or implementing a budgeting process that is well aligned to the country’s health needs and identified priorities. In large part, this appears to be the result of a weak health information system, an inability and/or unwillingness on the part of provinces to forecast appropriately, poor national oversight and a generalised failure to monitor and evaluate programme implementation and budget expenditure. As the ALP argued in a March 2010 submission to the Select Committee on Appropriations in the National Council of Provinces (NCOP):

[B]oth the Free State and Limpopo [Integrated Support Team (IST)] reports identify unexpected increases in the number of patients on [antiretroviral (ARV)] therapy in each province as a third cause [of provincial over-spending]. The fact that provinces have seemingly “over-performed” their targets has, unfortunately, far less to do with over-performance than with inadequate monitoring and evaluation (M&E) programmes able to forecast patient need in the province. ...

Inadequate M&E systems will inevitably lead to failures to budget according to actual needs in each province and ultimately to further over-expenditures. This is in accordance with the findings of both the Free State and Limpopo IST reports. In this regard, there is great public interest in having all the IST reports published and we call on the Committee to inquire on their status and to hold further public hearings on the reports or to allow the ALP and other civil society organisations to brief the Committee on the issues raised in the reports – including M&E – that fall within its mandate.<sup>6</sup>

The ALP's work on budgeting and expenditure monitoring has not been limited to policy submissions. In August 2009, we helped to establish the Budget Expenditure and Monitoring Forum (BEMF).<sup>7</sup> In addition, as is explained in greater detail elsewhere in this review, the ALP's intervention to address the ARV treatment moratorium in the Free State – which lasted from November 2008 through March 2009 – included engagement with the National Treasury and its provincial counterpart in Bloemfontein. Central to this engagement was the ALP's insistence that the two treasuries account for their failure to provide oversight as contemplated by the Constitution and the Public Finance Management Act 1 of 1999.

### *Developing budgets and monitoring expenditure*

Despite the intended representative and participatory nature of South Africa's democracy, two of the most important pieces of legislation passed by Parliament each year – the Division of Revenue Act and the Appropriations Act – are routinely passed without meaningful parliamentary and public participation. In short, what the Minister of Finance proposes Parliament simply rubber-stamps. This will change significantly if and when the Money Bills Amendment Procedure and Related Matters Act, 2009 ("the Money Bills Act") is fully and appropriately implemented.

Despite coming into force on 16 April 2009, the Money Bills Act had little impact on the 2010/11 budget. To try to rectify this in future, the ALP's submission to Parliament on the Division of Revenue Bill, 2010, called for the urgent establishment of the Parliamentary Budget Office (PBO) – a key structure set up by the Money Bills Act – and for it to be provided with the necessary financial and human resources it requires to begin its work on the 2011/12 financial year budget. The submission contextualised the new statute and substantiated its call for the PBO to be set up and appropriately resourced urgently:

The Constitution vests Parliament with the responsibility for establishing budgeting procedures and passing the annual national budget. More fundamentally, Parliament has the responsibility to ensure that the manner in which resources are raised, appropriated and ultimately spent advances the constitutional project, the cornerstone of which is the Bill of Rights and the obligation it imposes on the state to respect, protect, promote and fulfil those rights, including the progressive realisation of the right to have access to health care services.

...

The Money Bills Act, as required by section 77(3) of the Constitution, provides Parliament for the first time with the statutory powers necessary to fulfil its constitutional mandate in respect of the budget. However, implementation of the Money Bills Act must be prioritised urgently by Parliament. Given the limited timeframes in the Money Bills Act and the complexity of the budget, there is insufficient time to engage substantively with the [Division of Revenue Bill] as tabled. However, for Parliament to implement fully this constitutional mandate for the 2011/12 financial year, it is essential that the PBO be established urgently.

Our submission also expanded on an appropriate role for the PBO. Recognising that Parliament – on its own – "is ill equipped for the mammoth task of tackling the entire budget within the very tight timeframes required", the Money Bills Act nevertheless "provides little guidance on how the PBO is to conduct its research and provides little direction to National Treasury on how to include the PBO in the budgeting process." With this in mind, we recommended that the PBO be granted –

- Sufficient financial resources;
- A sufficient number of members of staff with appropriate skills and experience to engage with the budget and related processes; and
- An observational role in the National Executive's development of the annual budget.

Once the Money Bills Act is appropriately implemented, it will provide Parliament and civil society with the requisite space to participate fully in the national budget process. However, as important as this is, it will not – in and of itself – ensure that public health programmes, for example, are fully funded. For this to happen, Parliament must play the oversight role entrusted to it by the Constitution. So too must institutions of civil society – such as the BEMF – continue to monitor and evaluate expenditure for and the implementation of such programmes.

### Addressing concerns about “fiscal federalism”

The Constitution makes health a functional area of concurrent national and provincial legislative competence. By doing so it introduces the possibility of fiscal federalism, that is provinces making decisions about expenditure on health services independently of national priorities and thereby subverting and/or departing from national priorities.

Even if the Money Bills Act were to be fully and appropriately implemented, this would not adequately address concerns relating to provincial budgeting processes and outcomes. In particular, both national government and civil society are considering how best to ensure that nationally agreed priorities in health are appropriately funded.<sup>8</sup>

The problem of fiscal federalism may arise because of one or more of a number of factors, including – but not limited to – the following:

- Although provincial equitable shares are allocated with particular national priorities in mind, there is nothing in law that requires provincial budgets to reflect these priorities;
- Conditional grants are often allocated in a manner that provides for too much flexibility in the way national money is spent at a provincial level; and
- Provinces have yet to enact legislation similar to the Money Bill Act, despite the requirement in section 120(3) of the Constitution that a “provincial Act must provide for a procedure by which the province's legislature may amend a money Bill”

The issue of fiscal federalism was dealt with extensively in a memorandum prepared by the ALP for the Health Financing Technical Task Team of Hogan's MACH.<sup>9</sup> We argued “that while there are constraints on the national government, there are circumstances where it is appropriate and constitutional (indeed, at times necessary) for national government intervention at the provincial level.” The ALP's submission further argued that “there is space for reform of the fiscal system in order to ensure efficiency of budgeting and expenditure within the constitutional framework.”

Central to this submission was the argument rebutting the claim that the “lack of alignment between provincial spending and national priorities ... is an unforeseen result of the federalist nature

of the fiscal system and ... short of a constitutional amendment, the national government is unable to intervene in the provinces to ensure service delivery that is compatible with national priorities." In particular, it focused attention on how the Constitution deals with national override powers, co-operative government, and unity of purpose in relation to duties. This input featured strongly in the task team's report to the Minister.

In our later submission on the Money Bills Act, recognising that the Constitution places certain restrictions on national government's reach into the provincial sphere, the ALP recommended that one way to counter fiscal federalism is to adopt a more aggressive approach to conditional grant allocations so as to achieve appropriate funding levels for priority public health programmes. In particular, the submission argued the following in respect of the HIV Conditional Grant:

If we look at the conditions in the HIV Conditional Grant, they provide few actual conditions other than where such funds must be spent. Of concern is that they do not recognise the importance of adequately funding those aspects of provincial health systems necessary for proper implementation of the HIV sub-programme in each province. ... In our opinion, these conditions [in the business plans that the DoH and National Treasury must still approve] do little to ensure a functional environment in which the HIV sub-programme is to operate. It does little good to fund HIV sub-programmes adequately or substantially through a conditional grant allocation if the remainder of the provincial health care system is chronically underfunded. ... We believe that the [Division of Revenue Bill] should impose an additional condition on certain conditional grants through a matching funds requirement.

## Public procurement

Legitimate concerns about "tenderpreneurs", corruption in the award of state tenders and collusive practices amongst bidders ordinarily dominate debate on public procurement. Less popular topics for debate include legislative frameworks and departmental practices that undermine access to health care services in a somewhat subtler manner. Unsurprisingly, there is some degree of overlap between the two categories of issues, as weak frameworks and opaque and unaccountable practices either facilitate or provide some cover to the headline-grabbing tender-related practices.

The ALP has worked on three aspects of procurement. First, it provided legal advice to a task team appointed to advise the Minister of Health on procurement and supply chain management reform in relation to medical products.<sup>10</sup> Second, it made a detailed submission in late 2009 on draft Preferential Procurement Regulations published by National Treasury.<sup>11</sup> Finally, in conjunction with the BEMF (which organised a special meeting to focus on the ARV tender), it has been providing legal support to the DoH in relation to the upcoming 2010 ARV tender. Work in this area is ongoing, aimed at ensuring that the state is able to procure medicines of proven quality, safety and efficacy at the lowest possible price.

In all aspects of its work on public procurement, the ALP has sought to flesh out the guidance provided by the Constitution, to clarify ambiguities in the legislative framework, and to recommend

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how best to amend various statutes and regulations that do not give full and proper effect to the Constitution. The ALP's work on public procurement is based on respect for the Constitution and the overarching framework it provides, understanding that amendments to the Constitution should only ever be contemplated as a matter of last resort.

### Addressing the HRH crisis

Concerns regarding HRH have been on the ALP's agenda for many years. In this review, we focus on three issues that – if properly addressed – could make a significant dent in the HRH vacancy rate as well as ensure that we make use of our limited human resources more efficiently and effectively:

- Implementation of the Occupation-specific Dispensation (OSD) – effectively a salary supplement – for nurses and doctors;
- Scope of practice and task shifting; and
- Employment of foreign-trained health care professionals.

As important as these issues are, they are – unfortunately – not the only HRH matters of concern. More broadly, the DoH has yet to develop a reasonable plan that commits the state to “taking all reasonable steps to ensure that sufficient numbers of appropriately trained HCWs – including health care providers and other non-health personnel – are trained, attracted to and retained in the public and private health sectors health system to provide and manage the provision of health care services.” This, the ALP argued first in 2005, is necessary for the state to “discharge its constitutional obligations regarding health care services”.<sup>12</sup> Fortunately, Minister Motsoaledi, in his health budget vote for 2010/2011, promised a reworking of the HRH plan.

### OSD for nurses and doctors

In 2008, the DoH negotiated and agreed to the OSD for nurses. The OSD has been widely cited in the media and in other reports as one of the largest factors in provincial over-spending over the 2008/2009 and 2009/2010 financial years. As stated in both the Free State and Limpopo IST reports, the flaws in the implementation of the OSD stem from a lack of communication, costing of national policy decisions and insufficient allocation of resources to implement. In respect of the latter, the Eastern Cape Provincial Health Department has acknowledged that it ran out of funds to pay the OSD for nurses.<sup>13</sup>



*Dr Zola Ntshona, an obstetrician at Polokwane Hospital, gets ready for surgery (reproduced with kind permission of Health-e News Service)*

In our submission to Parliament on the Division of Revenue Bill, 2010, we noted National Treasury's attempt to cushion the impact of the OSD by allocating additional resources through the Adjustment Appropriation Act, 2008. However, we also noted that this allocation was according to the standard equitable share distribution formula, not on the basis of a costing exercise designed to cover the actual expenses being faced in each province. Put differently, government adopted and implemented a temporary band-aid solution that is unlikely to resolve the problem in any sustainable way.

This review is not the place to discuss various alternatives open to national government to ensure that it allocates sufficient financial resources to the provinces to ensure the reasonable implementation of the OSD, as well as the mechanism by which it is able to ensure that provinces use the allocated resources appropriately. Suffice it to say that while the DoH has negotiated an OSD for each of an additional number of categories of health workers, in particular doctors and pharmacists, the Division of Revenue Bill, 2010 has not put in place measures to ensure that the OSD is properly implemented.

### Scope of practice and task shifting

For almost 30 years, the HIV pandemic has turned various aspects of public health policy upside down. Consistently challenging conventional wisdom in respect of a wide range of sacred cows, many AIDS activists across the world have been unwilling to accept an ordinary, unexceptional response to what is generally understood as an extraordinary threat. The HIV epidemic has revealed flaws in traditional wisdoms about the delivery of health care services and has forced innovation. This "out-of-the box" thinking has also characterised responses to the global HRH crisis and its impact on HIV prevention and treatment programmes. Put simply, traditional scopes of practice have been reconsidered so as to maximise the use of available skills.

Over the last few years, the ALP, TAC and our allies have worked through the South African National AIDS Council (SANAC) to focus discussion on three aspects of this broad topic: nurse-initiation of ARV treatment; counsellors drawing blood by way of finger pricks for rapid HIV tests; and the work conditions of community care workers (CCWs) such as HIV test counsellors, treatment supporters and home-based care workers. In terms of policy, the DoH has made significant strides in relation to the first two issues. In principle, it has agreed that nurse-initiation of ARV treatment will become the norm, as will finger pricking by counsellors for HIV rapid tests.

In contrast, progress to resolve policy about the role and conditions of employment of CCWs has been slow. Of concern to the ALP is the DoH's apparent unwillingness to recognise that CCWs provide a range of health services that are central to its core function, and that they should therefore be properly employed and integrated into the health system. The list of complaints raised



*Adila Hassim considers the impact of HIV/AIDS on the health system in Health Management Review Africa*

by CCWs is long, including the quantum of the “stipend” paid (which is lower than the Expanded Public Works Programme wage), delays – sometimes running to months – in payment, and a general lack of DoH oversight. However, instead of employing CCWs directly, which would regularise their work conditions and safeguard their constitutionally guaranteed workplace rights, the DoH has been developing a new policy that retains the status quo, effectively seeking to continue employing CCWs indirectly through non-profit organisations that are often better characterised as labour brokers.

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The ALP has worked with a range of organisations to try to halt this process. In June 2009, for example, we co-authored a letter to the Ministers of Health, Labour, Social Development and Economic Development that aimed to draw their attention to the issue.<sup>14</sup> This led to an informal civil society alliance on the issue, as well as to concessions by the DoH to halt finalisation of the contested policy. To date, however, government and civil society have yet to reach consensus on a set of core principles, let alone the details of a policy on CCWs. Unless resolved, many public health programmes, particularly those on HIV and TB, will remain at risk.

### Foreign-trained workforce

The final HRH issue considered in this review relates to the difficulties faced by foreign-trained health care professionals to register and work in South Africa. While the ALP recognises that South Africa should not be poaching health professionals from other developing countries, it does not support the DoH’s current inflexible approach to the matter – one which results in pushing such doctors and nurses, for example, to seek jobs in developed countries such as Canada and the United Kingdom (UK). Put differently, closing doors in South Africa does not result in foreign nationals returning to their countries of origin.

The inflexibility appears to result from a misunderstanding of South Africa’s international obligations relating to the recruitment of health workers from developing countries. In the ALP’s view, there should be a clear distinction between recruiting health workers from developing countries and allowing those who seek work in South Africa to practice. While the former is clearly prohibited, the latter is indeed permitted. The impact on South Africa of the DoH’s inflexible approach is great, particularly given that foreign-trained health care professionals would ordinarily be expected to take up positions in (largely rural) underserved areas.

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The ALP has already started to provide legal advice and litigation services to foreign nationals who have encountered bureaucratic and legal obstacles in the way of them practising in the country. One case, involving a UK-trained doctor with over six years’ experience in the provision of ARV treatment in the South African public sector, was successfully resolved – the doctor received a work permit shortly after consulting the ALP and acting on its advice. Another case, involving a permanent resident who has not been able to register as a specialist, is ongoing.

In considering how best to take up the issue in a sustainable and systematic manner, the ALP is working closely with Africa Health Placements (AHP) and the Rural Health Advocacy Project (RHAP). AHP, a joint venture between the Foundation for Professional Development and the Rural Health Initiative, seeks to place foreign-trained health care professionals in public sector posts in

South Africa. RHAP, a partnership between the Wits University Centre for Rural Health, the Rural Doctors Association of South Africa (RuDASA) and the ALP, focuses much attention on addressing the even greater rural HRH crisis.

## Strengthening health governance institutions

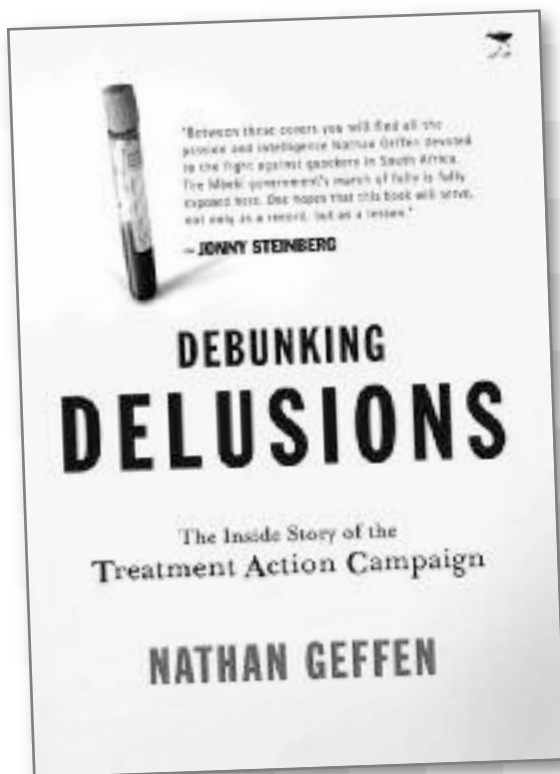
As a result of denialism and neglect the public health sector is characterised by a systemic lack of capacity at the DoH, most of its provincial counterparts,<sup>15</sup> as well as a collection of weakened regulatory and oversight institutions. When talking about lack of capacity, we are not only referring to the capacity of hospitals, health centres and clinics to deliver public health services, but also to the lack of strategic, technical, managerial and administrative capacity.

In addition to concerns about the quality and performance of many deputy directors-general and chief directors, a quick scan of the DoH's organogram indicates a number of vacancies at this crucial level. This has resulted in burdening those who are already responsible for other directorates with additional responsibilities in the form of acting chief directorships. This has been a hallmark of the DoH for many years. For example, one person (at a time) was assigned responsibility for both the Medicines Regulatory Affairs (MRA) and Pharmaceutical Policy and Planning (PPP) directorates from 2005 to 2009.<sup>16</sup>

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Medicines regulation provides a disturbing picture of the type of damage caused by a combination of neglect, mismanagement and political interference in the work of a health governance institution. Established in terms of the Medicines and Related Substances Act 101 of 1965, the Medicines Control Council (MCC) has a mandate focused on ensuring the quality, safety and efficacy of medicines used in South Africa. The MCC was established in the wake of the thalidomide tragedy, which drew attention to the dangers of untested medicines.

In a recently published book entitled *Debunking Delusions*, the ALP's Nathan Geffen shows how state-sponsored AIDS denialism was a primary driver of attacks on the independence and integrity of the MCC.<sup>17</sup> These attacks began under former President Mandela's administration in response to the MCC's principled opposition to Virodene, a toxic industrial solvent that was being pushed as a cure for AIDS.<sup>18</sup> Once purged of its "problematic" chairperson, the MCC became more compliant. After that, as Geffen notes,



*Nathan Geffen takes on quacks, charlatans and their supporters in government*

“[m]easures to control quackery went unimplemented and a large backlog developed of medicines waiting to be registered.” He adds: “The authority that the MCC had had over the regulation of medicine eroded and the market began to flood with quack remedies.”<sup>19</sup>

Concerns regarding the structure and capacity of the MCC were central to the work of the MPTTT.

Amongst other things, it recommended that work start urgently to address the massive backlog of applications for registration. In addition, as already discussed in this chapter, the MPTTT made a series of recommendations in relation to the structure and mandate of the proposed successor to the MCC. Further, a number of other concerns relating to its role in the post-Virodene era were placed on the MCC’s agenda, including the vexed question of the regulation of so-called complementary and alternative medicines.

However, the problems that beset the MCC were not confined to it alone. Institutions such as the Health Professions Council of South Africa, the South African Nursing Council and the Medical Research Council have also been victims of denialism, undue Ministerial interference, parliamentary attacks on their independence, and DoH mismanagement.<sup>20</sup> In addition, there is no overarching framework within which regulatory and oversight institutions in health are located. In short, much work remains to ensure that these bodies are indeed able to operate in a constitutional manner.<sup>21</sup>

The only health governance institution that has emerged relatively unscathed from the Mbeki years is the Council for Medical Schemes (CMS). Established in terms of the Medical Schemes Act 131 of 1998, the CMS plays a central role in enabling the state to discharge its constitutional duty to deal appropriately with medical schemes operating in the private health sector. While it is important to strengthen the public sector and ensure the delivery of quality health care services, it remains equally important to regulate the private health industry, particularly given that its conduct has the potential to undermine the Constitution’s guarantee of access for all.

The CMS has, however, been undermined by Parliament allowing the Medical Schemes Amendment Bill [B 58—2008] to lapse. In our previous review we had warned that “a failure to process the bill in 2008 would leave open a legal loophole for ‘financial service providers to begin

introducing health insurance products designed to lure young and healthy persons away from the medical schemes environment.” We further argued that this, in turn, would “leave older and sicker persons behind, effectively undermining the ability of schemes to keep contributions and benefits at current levels.”

In addition to these concerns, the failure to process and adopt legislation that would also have introduced a mechanism for risk sharing between medical schemes – the Risk Equalisation Fund (REF) – is in part responsible for increasing pressure on scheme contributions. Put simply, the inability to share risks with others translates directly into higher premiums for some schemes. To protect themselves, they simply pass the risks onto their members.

Having said this, it is important to remember that high premiums are inevitable in a context of largely unregulated health provider costs and the prescribed minimum benefit (PMB) requirements appropriately imposed on schemes by the Medical Schemes Act. This is because schemes are required to cover the full costs of certain benefits for all members and beneficiaries,<sup>22</sup> and yet have little power to address spiralling provider costs. The ALP has thus identified the need for appropriate regulation of provider costs as an integral part of its ongoing work.

*However, the problems that beset the MCC were not confined to it alone. Institutions such as the Health Professions Council of South Africa, the South African Nursing Council and the Medical Research Council have also been victims of denialism, undue Ministerial interference, parliamentary attacks on their independence, and DoH mismanagement.*

## NHI: a magic bullet or a red flag?

Up to this point this chapter has focused on how to address the most pressing and obvious challenges facing the health system. In a sense it has focused on key aspects of the government's 10-point plan. However, throughout the period under review, another health process has been ongoing: NHI.

In our previous review we reported on the genesis of this policy within the ANC and the process that led to a commitment to a system of NHI becoming part of government policy. In line with these developments and the ANC's election mandate, Health Minister Aaron Motsoaledi established the National Health Insurance Advisory Committee ("the NHI Advisory Committee") on 11 September 2009. The ALP's Mark Heywood is one of the committee's 25 members.<sup>23</sup>

Set up in terms of section 91(1) of the National Health Act 61 of 2003 (NHA), the NHI Advisory Committee's mandate is "to advise the Minister on policy and legislation development and the implementation plan for the [NHI] system." Its terms of reference include the following expected outcomes and deliverables:

- Making progress reports to the Minister on a regular basis;
- Finalising a public consultation process on a draft NHI policy within three months of the draft policy's publication for general comment;
- Submitting draft proposals on NHI legislation to the Minister within three months of Cabinet approval of the final NHI policy;
- Finalisation of the NHI system implementation plan proposal, including transitional arrangements, by June 2010; and
- Providing regular reports to the Minister on the progress of the implementation of NHI over a five-year period.

The NHI Advisory Committee began its work in December 2009. At the time of going to press, some four months later, a draft NHI policy had not yet been published for public comment.

The ALP has paid close attention to the debate about NHI since its inception, and been part of various policy processes. During this period "NHI" has caused much sound and fury in the media, ironically even before a draft policy is on the table. On the political left, the Congress of South African Trade Unions (COSATU) and the South African Communist Party (SACP) have been vocal in demanding the "implementation of NHI". On the other hand, parts of the private health industry seem determined to leave their financial interests untouched, and therefore claim that the solution lies solely in repairing and building the public health system.

It is important, in this debate, to be crystal clear on the rationale for NHI, what must be done to make it feasible, and what it aims to achieve. In theory and in law, all people in South Africa have access to health care services. However, there is gross inequity in the quality and resources available to these services, skewed in favour of the rich and urban. In effect this means that many people do not actually have access to the services they need. There is both under-expenditure and over-expenditure on health, and

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the disjuncture between public and private health systems undermines health outcomes. As evidence of this is the gross mismatch between what is spent on public health and what is spent on private health.

In our view, NHI envisages a funding mechanism that levels the playing field by pooling all financial resources for health and targeting them much more rationally and efficiently at actual health needs. One aim is to use the funding mechanism better to integrate public and private health delivery systems and ensure the provision of quality health care services. But the ALP understands that NHI,

as a funding mechanism, does not in and of itself provide any guarantee of access. Put differently, the challenges facing the public and private health sectors and their eventual integration into a single national health system include but extend way beyond the allocation and management of rands and cents.

In the light of this, the big question is what model of NHI will meet these objectives and what needs to be done *first* to implement such a model?

Answering such questions has understandably slowed the process down. In his 2010 State of the Nation Address, President Zuma noted that government would “continue preparations for the establishment of a[n] NHI system.” In the Parliamentary debate that followed, Health Minister Motsoaledi stated:

Many opponents of the NHI opportunistically cite ... problems of poor quality of our health care services as a reason why the NHI will not work, and why it should not see the light of the day. I have reassured them time and again that NHI is never going to be implemented in isolation away from the other items of our 10-point Plan. The quality of provision of health-care services is definitely going to be one of the criteri[a] used before a health institution is accredited for purposes of NHI.

And in his 2010 budget speech the Minister of Finance noted that “[a]longside longer-term reforms to the financing of health care, a closer partnership between the public and private health care systems is a prerequisite for the introduction of a[n] NHI system.”

It is likely that the debate on NHI will intensify in the period ahead. Through Heywood’s membership of the NHI Advisory Committee and independently, SECTION27 – the ALP’s successor – will do all that it can to make sure that the right choices are made.

## Endnotes

1. *Government Gazette* No. 32148 (21 April 2009)
2. Jonathan Berger, “Legislative Review for the Medical Products Technical Task Team (MPTTT)”, May 2009. The MPTTT’s recommendations have yet to be made public.
3. At page 31
4. At page 57
5. *Ibid*
6. The submission – on the Division of Revenue Bill, 2010 – is available at <http://section27.org.za/wp-content/uploads/2010/04/ALP-Submission-on-the-Division-of-Revenue-Bill-2010.pdf>. As explained in Chapter 1, former Health Minister Barbara Hogan established the ISTs in February 2009 to investigate and review the underlying causes of budget overspend by provincial health departments.
7. BEMF’s composition, mandate and work are addressed more fully in chapter 4. Reports of and correspondence from BEMF are available at <http://www.tac.org.za/community/BEMF>.
8. The same concern applies to education, which is similarly a functional area of concurrent national and provincial legislative competence.

*Put differently, the challenges facing the public and private health sectors and their eventual integration into a single national health system include but extend way beyond the allocation and management of rands and cents.*

9. The ALP memorandum is available at <http://section27.org.za/wp-content/uploads/2010/04/legal-perspective-on-health-budgeting-final.pdf>.
10. This work grew out of the recommendations of the MPTTT.
11. The submission is available at <http://www.section27.org.za/wp-content/uploads/2010/04/ALPSubmission-DraftPreferential-ProcurementRegulations2009.pdf>
12. See joint ALP/TAC submission entitled "A Strategic Framework for the Human Resources for Health Plan: Draft for Discussion", available at <http://section27.org.za/wp-content/uploads/2010/04/Strategic-Framework-for-the-Human-Resources-for-Health-Plan-2005-TAC-ALP.pdf>.
13. See "Joint Statement by the Treatment Action Campaign (TAC) and Public Service Accountability Monitor (PSAM) on OSD", available at <http://www.tac.org.za/community/node/2829>
14. The ALP's letter is available at <http://www.section27.org.za/wp-content/uploads/2010/04/LetterToMinistersOnCCGs.pdf>
15. The provincial sphere of government is primarily responsible for health service delivery.
16. On the recommendation of the MPTTT, Mandisa Hela was relieved of her responsibilities in respect of the PPP directorate to concentrate on the MRA (now known as the Pharmaceutical and Related Product Regulation and Management (PRPRM) directorate) and her duties as Registrar of Medicines. Unfortunately, another chief director, Anban Pillay, has now been assigned responsibilities in respect of the PPP directorate in addition to his responsibilities as chief director of health economics.
17. See also Jonathan Berger, "Exorcising the ghosts of Dr. No's war on science: exploring what the Constitution means for the institutions that regulate medicines", available at <http://papers.ssrn/abstract=1353944>
18. See also Nathan Geffen and Edwin Cameron, "The deadly hand of denial: governance and politically-instigated AIDS denialism in South Africa", Centre for Social Science Research Working Paper 257 (July 2009), available at <http://www.cssr.uct.ac.za/publications/working-paper/2009/257>
19. Nathan Geffen, *Debunking delusions: the inside story of the Treatment Action Campaign* (Jacana: Cape Town, 2010) at page 182
20. See the 2006/2007 and 2007/2008 ALP reviews for further information.
21. For example, section 50 of the National Health Act 61 of 2003, which establishes the Forum of Statutory Health Professional Councils, has yet to be brought into force.
22. A CMS investigation of systemic violations of the PMB requirements by schemes and administrators determined that medical schemes and administrators were creating bureaucratic barriers and implementing unlawful payment practices in order to avoid their obligations to make full payments for PMB claims. It resulted in the CMS issuing a directive in December 2009 ordering all medical schemes and administrators to end these practices. The ALP's press release welcoming the CMS action is available at <http://section27.org.za/wp-content/uploads/2010/04/CMS-press-statement-15-Dec.pdf>.
23. The committee's membership is set out at <http://www.doh.gov.za/docs/pr-f.html>