



DA Health Policy

Affordable, accessible, high quality health care for all

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1. Introduction – Our Vision

The DA believes that a caring government must ensure that accessible, affordable, high quality health care is available to every South African.

We subscribe to the nationally agreed Vision 2030 which sets out to significantly **reduce the burden of disease**, to raise the life expectancy of South Africans to at least 70 years, to ensure that the generation of under-20s is largely free of HIV, and to achieve infant mortality of less than 20 deaths per thousand live births and an under-5 mortality rate of less than 5 per thousand.

The DA pledges itself to pursue the goal of adequate **universal access to health care** for all South African citizens and to giving effect to the Constitutional provision for guaranteed access to emergency medical treatment.

Everyone has the right to have access to (a) health care services, including reproductive health care; No one may be refused emergency medical treatment

South African Constitution: Section 27(1) and (3)

Based on our experience in running the Western Cape Health Department since 2009, we believe that such an outcome can be achieved largely within the existing administrative structures and the available resource envelope. Our experience shows that the actions of a politically-accountable provincial executive – and the cascading of quality and professionalism from that point through the entire system (primary, secondary and tertiary) – is the critical variable in tightening and improving the quality of health care.

The DA stands for universal access to health care for all citizens. We believe the key to this, over the next five years, is not big policy developments but making the current regional management model work.

Better health governance is most meaningful to the most **poor and marginalised**, who are not covered by medical aids and lack the resources to access private health care. For these citizens to play a role in the DA's overarching vision – The Open Opportunity Society for All – their free access to health care needs to be ensured. This is an essential component of our proposal to combat poverty-related diseases and is an absolute minimum requirement if South Africa is to win the war against HIV/AIDS and Tuberculosis (TB).

The DA envisages a strong doctor-driven Primary Health Care (PHC) system, based on the social model of health and thus equipped to contribute to dealing with the full range of social determinants of health. This model allows for localised health care service delivery through strong community-based structures.

The DA will act to move public health to focus on **wellness for all**. The concept of 'wellness' is an outcome of growth, education and social development; it is thus a transversal issue with its outcomes most visible in the health sector. At present, the tendency is for patients to present

themselves to in the public health system only when diseases become disabling. Wellness requires regular general check-ups and behavioural modification as happens among those fortunate enough to enjoy private medical aids.

Health is not just a medical issue. The social determinants of health need to be addressed, including promoting healthy behaviours and lifestyle.

(National Planning Commission, 2012. National Development Plan)

The DA envisages a society in which citizens take increasing personal responsibility for healthy lifestyles, and in so doing reduce the burden of non-communicable lifestyle diseases. The growing desire of South Africans to know their HIV status is an indicator of an appetite for such responsibility. The DA envisages **citizens actively managing their health** thereby freeing the public health system to focus more on basic health, disability, mental health and special needs cases.

The over-centralised and statist proposals contained in the National Health Insurance (NHI) Green Paper are not only dangerous but are unnecessary if the public health systems in all nine provinces can be managed effectively.

The NHI Green Paper also implies that the failings of public health are the fault of the private sector. The DA disagrees with this analysis. **We envisage a solution where the strengths of the private sector are leveraged to improve public health through partnerships.** Our vision is a system embracing public and private health service providers where the state offered service is of sufficient quality to compete with the private sector and to spur it on.

2. Health challenges

The DA envisages a health system where the public sector is run sufficiently well to be a full partner with the private sector in dealing with South Africa's quadruple burden of disease:

- HIV/AIDS and related diseases such as Tuberculosis and Sexually Transmitted Infections (STIs);
- Maternal and child morbidity and mortality;
- Non-communicable diseases mainly related to lifestyle; and
- Violence, injuries and trauma.

Section 27 of the South African Constitution provides the **right of access to health care services** and commits the state to 'reasonable legislative and other measures, with in its available resources, to achieve the progressive realisation of... these rights'.¹ The DA believes 'health' includes mental health which is often underestimated as a disease in South Africa. Research suggests that one in six South Africans had suffered a common mental disorder in the last year² and that 1 in 5 South Africans will suffer from some sort of mental illness in their life.

South Africa's health care system comprises a network of health facilities providing **primary health care**, supported by several higher levels of care (the Structured Service model). About 80% of public

¹ Constitution of South Africa (1996) Section 27

² Sorsdahl, K. Stein, D.J. and Lund, C. (2012) 'Mental Health Services in South Africa: Scaling up and future directions'. *African Journal of Psychiatry*. 15:161-171

health expenditure (over R100bn/year) is made by the provinces, with the national department having policy, regulatory and grant-making roles. The biggest single spending item is the District Health System, which receives 40% of the national budget and is responsible for primary treatment. This is an appropriate system for a developing country like South Africa.

However, far from the progressive realisation of health rights, **available indicators suggest a critical decline** in the health of South African citizens. Death notifications doubled between 1998 and 2008. In this period, deaths of infants and young women have trebled to 60, 000 per year and both communicable and non-communicable diseases have escalated up to six times in certain categories (e.g. young women with Tuberculosis).³ In the World Economic Forum's Global Competitiveness Report, public health in South Africa ranks between 111th and 141st (out of 142 countries) on four key indicators: TB incidence, HIV prevalence, life expectancy and infant mortality.⁴

There are also significant disparities in emergency medical response times. The widely-accepted (although unofficial) South African standards for Priority 1 call-outs are 15 min in urban systems and 40 min in some rural areas⁵. Outside the Western Cape the percentage of call-outs that meet these standards is very low.

The problem with public health in South Africa is **not primarily a matter of money**. South Africa compares well to other countries at a similar level of development. Public health expenditure per capita is well ahead of countries like India and Malaysia, slightly better than Mexico and Turkey and almost exactly on a par with Brazil. But South Africa's health outcomes are far worse than any of these countries.

In 2013, South Africans can expect to live to the age of 60 (women) and 59 (men). In Brazil, which according to the World Health Organisation (WHO) spends almost exactly the same on public health (US\$280/person/year), life expectancy is 72 years for both sexes.

The management of the health system is centralised and top-down. Poor authority, feeble accountability, the marginalisation of clinicians, and low staff morale are characteristics of the health system. Centralised control has not worked because health personnel lack discipline, perform inappropriate functions, are not held accountable, do not adhere to policy, and are inadequately overseen. In addition, the institutional links between the different levels of services are weak.

(National Planning Commission, 2012. National Development Plan)

National Treasury admits to considerable problems in health:

- 'the large burden of disease, especially from HIV and TB (is) not being adequately prevented;
- slower than expected progress with Millennium Development Goals, especially in child and maternal mortality; and
- weaknesses in governance and accountability procedures'.⁶

³ NDP (2012) p. 332

⁴ World Economic Forum (2012) Global Competitiveness Report 2011/12.

⁵ MacFarlane, C., van Loggerenberg, C. & Kloock, W. 2005. 'International EMS systems in South Africa: past, present, and future', *Resuscitation*. 64(2): 145-8.

⁶ National Treasury (2009) Intergovernmental Fiscal Review.

The first two problems above are outcomes. The third bullet point goes to the essence of the South African health challenge: mismanagement, poor use of scarce resources and a failure of political accountability.

It is poor management, compounded over time, which is behind the enormous disparities in the quality of health services across the nine provinces.

The Eastern Cape has absorbed more than an extra R1 billion every year since 2009/10 in an attempt to resolve its problems. Yet a national government audit in 2012 found that if the National Norms and Standards Bill were passed and applied to the province, most of its health facilities would have to close down. The study estimated the infrastructure backlog in the Eastern Cape to be around R20 billion. The province's health Superintendent-General admitted that it "cannot afford the salaries for trained clinical personnel".⁷ In 2012, the province was reported to have 27 267 vacancies of which 16 000 were nurses positions.⁸

Some sense of the scale of the disaster in the Eastern Cape is captured by noting that its 27 000 vacancies are not far short of the total staff complement for the Western Cape (34 000). Despite the fact that all such posts are funded by the National Treasury, the failure to fill them is the single outstanding feature of ANC health governance. Limpopo is even worse than the Eastern Cape with 39 653 vacant health posts that would cost R14 billion per year to fill.⁹

Indeed when the DA came to office in the Western Cape in 2009 the provincial vacancy rate for trained nurses was 34%.¹⁰ This has been managed down to 4%, a figure consistent with normal staff turnover. By comparison, the national vacancy rate for doctors is 56% and nurses 46%.¹¹

It should not be thought that ANC run provinces are failing to spend on staff because they are making productive use of resources elsewhere. In 2012, 17 hospitals and 168 clinics were operating without piped water in the Eastern Cape. A 2013 audit by a group of respected NGOs revealed "a complete breakdown in the ability (of hospitals and clinics in Johannesburg) to provide services of a reasonable standard to patients".¹² The report attributes "increased morbidity, disability, stillbirth and death" in the province to "a debilitating range of operational difficulties" and remarks that the Gauteng Department of Health has "consistently failed to properly budget and allocate sufficient finances for medicines, equipment, staff and infrastructure".¹³

⁷ Williams, D. (2012) 'Health on life support 20' Times Live. 20 September.

⁸ Joint press statement by Mmusi Maimane, DA National Spokesperson and Patricia Kopane MP, DA Shadow Minister of Health, Memorandum Cape in 2009m of Demands to Limpopo and EC health departments (29/05/2012)

⁹ SAPA (2012) 'R9bn needed to fill E Cape health posts'. News24. 15 March.

¹⁰ SAIRR (2012) South Africa Survey 2012. National vacancy rates were given as 56 percent for doctors and 46 for nurses. Based on NDoH (2011) Human Resources Strategy (which used 2010 figures); see also: Auditor-General of South Africa (2011) Vacancies and the impact on service delivery: Health Sector

¹¹ SAIRR 2013 (reported by) Tamar Khan, Business Day, 17 Jan 2013(from the 2012 SAIRR Survey – Based on DoH Human Resources Strategy 2012) All figures for 2010:

¹² Section 27, Centre for Applied Legal Studies, Treatment action Campaign, SA HIV Clinicians Society (2013) Monitoring Our health: A Report of the Breakdown in Healthcare Services in Selected Gauteng Facilities Jan-Dec 2012, 4 March

¹³ Section 27 et al (2013) Ibid p.2

In Gauteng, the list of critical medicines that have been unavailable during the last four months of 2012 ('stockouts'), runs to five pages and implies repeated breaks in the treatment of life-threatening diseases.

It also needs to be noted that the staff vacancies in provincial health complements have nothing to do with the limited availability of medical skills in South Africa. Although there are supply side problems in health skills, the fundamental problem is that financial resources have been so mismanaged at a provincial level, that there is nothing left for employing doctors or nurses. Of the 11 700 medical school graduates in South Africa between 2002 and 2010, the public health sector could absorb only 4 403.¹⁴

With the notable exception of the Western Cape, which has built three new district hospitals in the last five years, provincial infrastructure spending has been abysmal. Although total provincial capital expenditure on health increased by 1.4% to R8.3-billion (85.5% of the budgeted R8.8-billion) in 2012, this spending is occurring in an environment where years of mismanagement has caused immeasurable damage. In 2011, this mismanagement was so dramatic that the National Treasury has suspended health infrastructure grants to all ANC-run provinces. In 2012/13 Gauteng only managed to spend 52.1% of its available infrastructure grant.

3. The DA's solution

The DA's answer is not to make sweeping policy changes but to get the provincial health departments working adequately. Unnecessary changes have caused too many problems in the past. As the NDP points out: "In the first years of the democratic dispensation... there was a misguided attempt to change everything at once, when many aspects of the system were not faulty."¹⁵ Where we do make critical changes, our actions will be based on what has proven successful in getting the Regional Management model to work where we govern in the Western Cape.

The Western Cape Exemplar

While it would be foolish to claim that public health provision in the Western Cape cannot be improved, its outcomes are significantly ahead of the other eight provinces and provide a good basic model for health service delivery.

Under the DA, the Western Cape has managed down its staff deficit to normal staff turnover levels. It has fully utilised its available capital grant every year and has built three new district hospitals (Khayelitsha, Mitchell's Plain and George).

Above all it has properly managed the rolling-out of campaigns to reduce disease. The province increased Anti Retroviral Treatment provision from 14 370 to 132 279, and brought down the mother-to-child HIV transmission rate to 1.8%, the lowest in the country¹⁶.

¹⁴ NDP p. 335

¹⁵ NDP p. 332

¹⁶ Zille, H. 2013. 'W Cape partners to expand healthcare to patients'. SA News.

The cure rate for tuberculosis is over 85% in 2013, the best in South Africa. The effort to ensure treatment is unbroken include SMS reminders and household/office deliveries (of drugs to fill 200 000 prescriptions) by a closely-monitored private specialist courier.

Other health indicators could be cited. The important point however is that the system works. Staff are at their posts, drugs are made available and above all, individuals are held responsible. When the national Minister of Health announced a review of the qualifications of hospital managers in 2012, the Western Cape asked to be exempted as it has no worries on this score. The DA provincial government has indeed fired a number of incompetent hospital managers.

Improved efficiencies can be identified throughout the Western Cape provincial health system under the DA. Emergency Services response times, for example, have been improved by 50%. Around 82% of Priority 1 call-outs now reach the scene within 15 minutes in urban areas. In Gauteng the corresponding rate is 33%.

Once public health had been placed on a firm administrative and financial basis the Western Cape Government was in a position to innovate in four critical areas:

- *Partnerships with the private sector.* Initiated through the Western Cape Health Foundation, this includes a landmark agreement to roll out immunisation services through commercial pharmacies. The approach is both to leverage the skills and expertise of big private health care providers and to create openings where private health practitioners can work in the public sphere (e.g. private beds in public hospitals). More generally, the DA provincial government aspires to the creation of a genuine ‘health economy’ in the Western Cape.
- *Tackle the behavioural and lifestyle issues associated with non-communicable diseases* e.g. sexual behaviour, drug and alcohol abuse, and exercise and health. The province has increased the number of ‘rehab’ from seven under the ANC to 27 in 2013. An HIV-awareness campaign saw a fifth of the province’s population submit to voluntary testing over a 14 month period in 2011/12.
- Reduce the pressure on the public health system through *transversal governance* under the motto ‘Better Together’. The greatest success has been to reduce pressure on emergency services by bringing down road crash fatalities by 30% in four years, a reduction almost unprecedented in the world.
- The DA has *prioritised the patient experience*. While there will always be matters for complaint regarding scarce resources, the professionalism of health management in the province aims to improve frontline service. The SMS complaint line initiated in 2012 has been tested by the local media and found effective.¹⁷ The DA has introduced the Independent Complaints Committee Bill to the Western Cape Legislature to establish an independent body to investigate and make recommendation in cases of medical malpractice in the public health system.

¹⁷ Fokazi, Sipokazi (2012) ‘SMS hotline passes test’, The Argus. 14 August 2012.

Poor communities are benefitting from the improved health system the DA has brought about in the Western Cape. Approximately 75% of the department's budget is spent in low income areas and 80% of patients treated at public health facilities in the province receive free health care. In pursuit of the goal of wellness for all through public health, mobile and static wellness centres have been established to service low income areas.

The DA has improved health care in rural districts through both infrastructure spend and innovative public-private partnerships. The Oncology Centre at the new George Hospital is an example of an initiative which would have been unviable if attempted by the public or private sector alone. But it works as a partnership and spares residents of the south-eastern Cape and Little Karoo the difficulties of a long trip to Cape Town.

Even though it is so much better than systems in any other province, the Western Cape knows that there is room for further improvement. The ambition is to approach the quality of the offering of the private sector in terms of patient experience and health outcomes.

Unfortunately the ANC's national health policy appears to be heading towards both greater centralisation and state intervention. Centralisation has already failed once with hospitals and clinics being disempowered in favour of provincial departments, especially in areas like procurement. **The government's response to the on-going crisis is to centralise further.**

It has proposed to take responsibility for teaching hospitals from the competency of the provinces. More troubling is that in 2011, it published a **Green Paper on National Health Insurance**. Although the DA entirely supports the concept of universal health cover for all and has participated in the pilot projects, we believe the Green Paper sketches an unrealistic proposal which does not address the real obstacles to achieving universal access to quality health care.

What's wrong with the NHI proposal?

The national Minister of Health has proposed a National Health Insurance scheme that will pool public and private finance, become the single channel for health funding in South Africa and supposedly eliminate what the minister calls 'the current tiered system' in health care.

The DA believes the Green Paper both misdiagnoses the problem and fails to provide a realistic alternative.

- It is incorrect to imply, as the Green Paper does, that the failure of the public health system in the ANC controlled provinces is linked to 'the success' of private health. The two are fundamentally linked and stand or fail together, as the success of both in the Western Cape demonstrates.
- The proposed NHI does not address the real problem which is low-quality provision in the public sector.
- The proposed NHI does not adequately attend to accountability and management structures which are already failing in ANC-controlled provinces.

- Centralisation of health care funding will be bureaucratic and inefficient.
- South Africa lacks the human resources to implement the NHI.
- The proposed NHI eliminates freedom of choice for health care consumers.
- The true cost of the NHI is unclear with the numbers appearing in the Green Paper being, at best, vague estimates.
- The proposed NHI creates a massive risk of unintended consequences because it proposes comprehensive and not incremental change.
- The proposed NHI believes money – not accountability, governance and functionality – is the answer to all of South Africa’s health care problems.
- The proposed NHI may be unconstitutional as it threatens provincial authority.

3.1. The role of government

To achieve the goal of universal access to high-quality health care, we propose clearly defined roles for various levels of government.

National Government

The DA wants the National Department of Health’s role to be limited to the setting and overseeing of **norms and standards** as well as providing focussed **grants** such as that for HIV/Aids (as it is at present). However the DA will be far more proactive in exercising **oversight** prerogatives and holding political appointees **accountable**.

In national government, the DA would prioritise the following:

- Conducting a study to determine the nature and scale of **vacancies** in public health and to determine the resources available and required.
- Intervening decisively in dysfunctional or **struggling provinces** and cooperating with other actors, including National Treasury, provincial departments, professional organisations such as the SA Medical Association, and other civil society organisations, to restore struggling provincial health systems.
- Ensuring that all **hospital management teams** are appropriately qualified and effective (as per the model currently used in the Western Cape).
- Holding provincial departments **politically accountable** and **financially responsible**.
- **Modernising** the health system and using information technology to bring about systemic improvements – including improvements to the system of procuring and distributing medicines. The DA will use the tools available to ensure that **there is medicine in every clinic**.
- Improving the management of the **National Health Laboratory Service (NHLS)**. Laboratories are currently badly run-down and underfinanced. Improving provincial health management across the country will go some way towards improving the situation (most provinces do not pay their accounts to the NHLS at present). The DA will also amend the National Health Act to create space for properly registered private laboratories.
- Restructuring the **Medicines Control Council** and staffing it with full-time professionals to eliminate lags in medicines certification.

- Continue and accelerate education programmes related to HIV/AIDS and general health issues. Initiate a mental health awareness campaign designed to combat the widespread perception that mental health issues are simply 'part of the stress of everyday life'.
- Applying a **quality rating system** to all hospitals and establishing an Independent Office for Standards Compliance to conduct regular evaluations and propose interventions where necessary. The ratings system must be applied across the board to all hospitals in both the public and private sectors so that all hospitals are measured according to the same standard. Ratings will be made publicly available, to facilitate choice.
- Initiating measures to better **integrate public and private health care**, including: (i) putting the management of public hospitals and clinics out to tender under tightly defined conditions and adequate monitoring, especially by provincial departments; (ii) leasing private facilities for public health patients; (iii) allowing for tax rebates and/or Continued Professional Development (CPD) points for private medical practitioners who do work in the public sectors; and (iv) making wider use of contacts with private general practitioners, especially in rural areas.
- Implement South Africa's obligations in terms of the United Nations Bill of Rights of Persons with Disabilities.
- Developing **standardised response times for emergency medical services** in both urban and rural areas, and supporting the development of health and emergency services to bring emergency care to international standards.

Our general approach will be to separate policy-making from oversight and operations and to focus on capacitating oversight and operational functions.

Provinces

Provincial disparities in the quality and availability of health care show that **performance at provincial level is critical**. Where it is voted into government, the DA would like to implement all the innovations it has brought to the public health system in the Western Cape in other provinces. However it is first necessary to salvage the health system in ANC-controlled provinces. Remedies will vary between provinces as will the time needed to assess problems, appoint staff and rectify problems.

It will be all but impossible to turn around the most damaged provinces – Eastern Cape and Limpopo – in a single five year term of office. Even more capacitated provinces like Gauteng will require considerable National Treasury assistance once appropriate governance structures are in place.

When the DA wins power in another province, comprehensive formal consultations with the private sector will be held as soon as possible to identify points of **cooperation**.

Consideration will be given to:

- Using **competitive tendering** to delegate some services, such as nutrition programmes and preventative health, to community organisations and private providers;
- **Introducing technology and systems** that will allow patients to collect medicines from any accredited pharmacy, making collection more convenient and less time consuming; and

- **Using private specialist medical delivery companies** to deliver chronic medications to convenient points such as homes, workplaces and pharmacies in order to relieve overcrowding at public facilities.

Provinces will also have a clear mandate to **monitor** the performance of public hospitals and holding management teams to **account for outcomes**.

The Primary Health Care System

The present Primary () Health System should embody a decentralised, area-based, people-centred approach to health care. But it only does so in the Western Cape. Where the DA governs, we will ensure that the World Health Organisation’s (WHO) six key elements of a successful system are implemented:

- Service delivery
- The health workforce
- Health information
- Medical products vaccines and technologies
- Sound health financing
- Good leadership and governance¹⁸

Much of this task involves doing the things that are routinely done in the Western Cape in other provinces. Adequate numbers of staff must be employed and managed; stock-outs of especially critical medications must not be tolerated; referral systems, technologies, private sector partnerships and sound financial management must be implemented.

Beyond present policy, there is a pressing need for the greater integration of Primary Health Care Services into through cross-sectoral actions involving human settlements, urban planning, transport, basic services, energy, agriculture and food security, and rural development. Mental health, including addictions, will be addressed more thoroughly by employing qualified personnel at clinic level. Rather than simply adding to establishment costs, the DA will ensure, through engagement with health education institutions, that district health staff are able to gain additional qualifications in this area.

Better Together

Good health care outcomes require many actors to ‘**play the game together**’, including all departments of provincial government, their national counterparts, hospitals of all sizes, clinics, municipalities, the private sector, education institutions and civil society. Partnerships are the key. The DA will set out to establish these using a **consultative** and not a hierarchical approach.

Many South Africans access health services through traditional healers. The DA will also prioritise the identification of appropriate measures to **incorporate traditional healers into the formal health system**. This could include setting up a voluntary registration system which will give traditional

¹⁸ National Development Commission (2011) National Development Plan, p. 331

healers access to certain benefits (including access to basic medicines and vaccinations in addition to being allowed to tender to provide primary health care services). To register, traditional healers will be required to:

- Complete courses in basic primary health, TB and HIV management;
- Maintain proper patient records;
- Operate according to a code of ethics and meet basic health and safety requirements;
- Offer basic primary health care services, such as vaccinations and HIV, TB and pregnancy testing; and
- Communicate regularly with the local clinic.

Traditional healing practices can also play a constructive role in addressing mental health issues.

Leveraging our strengths

Given the diversity of its population and the nature of the disease profile in the country, South Africa offers a unique environment for international health experts to gain experience, to conduct research and to develop procedural innovations and new medicines. We must leverage this strength and **attract international health practitioners and researchers to South Africa** through:

- Dedicated funding to health research programmes at our tertiary institutions;
- Making it easier for experts to enter the country;
- Developing health innovation hubs; and
- Tying research support to human resource and research plough-backs into the public health system.

3.2. Human Resources

An adequate supply of nurses is critical in a primary health care based system such as South Africa's. It is unlikely that South Africa's 200 000 plus registered nurses are sufficient in numbers, but market forces (rather than bureaucratic planning) must become a greater part of the supply equation. The same applies to doctors who are undoubtedly in short supply (55 per 100 000 compared to Brazil's 185/100 000).

There are supply-side constraints on the production of **nurses and doctors** in South Africa. Many of these are bureaucratic and regulatory, and the DA proposes to review and simplify the processes needed to get private sector institutions more involved in training. There is no good reason why private medical schools should not add to the 1 200 doctors per year that currently graduate from South Africa's eight medical schools.

- The DA will invest in the expansion of existing medical schools.
- The DA will remove all regulatory and bureaucratic obstacles to the private training of doctors and nurses.
- At the national level, the DA is committed to the more systemic funding of academic medicine.

The number of **vacant posts**, as well as other characteristic deficiencies of the system under the ANC (like massive shortages of equipment), are a hurdle to the on-going professional development of health care skills. A very low number of registrar positions (future specialists) are taken up in the public sector. Addressing this issue needs both better public sector management and greater consultation with the private sector.

To address human resource constraints over the short term, we should also make it as easy as possible for **qualified medical health practitioners from outside of South Africa** to gain access to the country and to be allowed to work here. This could include:

- Working towards creating a protocol for the ethical employment of health staff across the SADC region.
- Defining medical skills as “scarce skills” to allow applications to work in the medical field in South Africa to be processed more rapidly.
- Incentivising medical students to extend their community service to two years and marketing this as a professional development opportunity to young professionals abroad.
- Ensure that the national Department of Home Affairs recognises the scarcity of medical skills and facilitates recruitment.

3.3. The Private Sector

Perhaps the biggest underlying problem with health care under ANC government is its extraordinary **mistrust of the private sector**. The Green Paper on a proposed NHI actually goes so far as to blame the private sector for the crisis in public health. It says: “poor performance has been attributed mainly to the inequalities between the public and private sector”.¹⁹

The DA believes the **private sector is part of the solution** and not the problem. Public and private do indeed constitute two different health sectors in South Africa; but they are so different in structure that they cannot be directly compared. Public-private interactions have been cited and suggested throughout this Green Paper. To recap, some of the key areas are:

- Training of doctors and nurses
- Research
- Competitive tendering, including management of health institutions
- Provision of technology
- Medicines delivery
- Private practitioners in the public system
- Tax and professional incentives
- Public-Private Partnerships

Properly managed, the **district-based primary health care system** is the **optimal** health solution for South Africa’s poorer citizens, an opinion the ANC itself agreed with when it introduced the system after 1994.

¹⁹ National Department of Health (2011) Green Paper on the NHI, p. 9

The role of the private sector is to retain its strengths and to lend these to assist that public system. The role of government is to broker and facilitate such an interaction. That is what the DA has done in the Western Cape and what it promises to do in the rest of the country.

4. Conclusion

To use their talents, follow their dreams and care for their families, South Africans must be healthy.

The DA is committed to achieving universal access to high quality health care.

We believe that this can be achieved through effective provincial administrations operating within a national system of clearly defined responsibilities and standards.

In the Western Cape our focus on management excellence, better human resource management and partnerships between private and public sector health service providers is delivering good results.

We want to build on our experiences in the Western Cape to improve health service delivery for all.