Health Policy 2026

Federal Policy Unit

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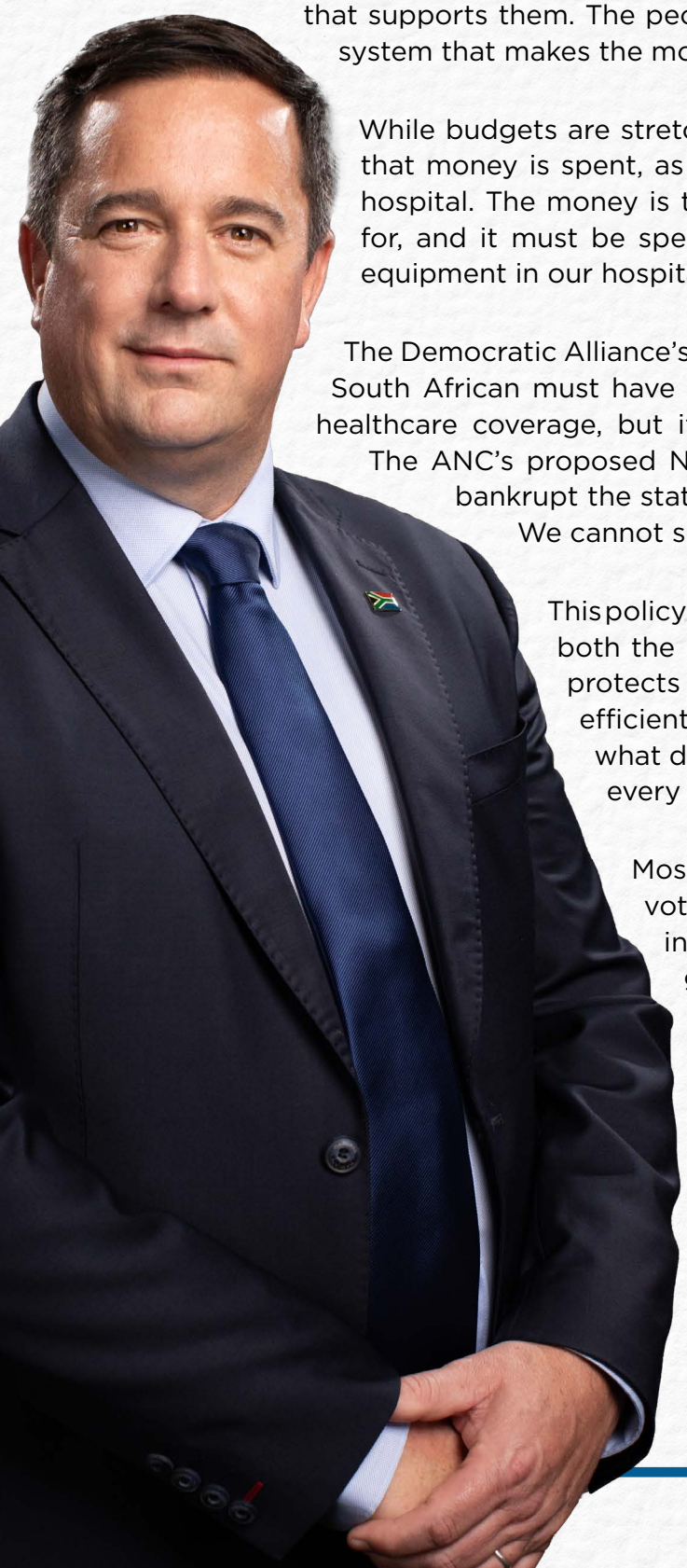
List of acronyms and abbreviations

AIDS	Acquired immunodeficiency syndrome
ANC	African National Congress
ARV	Antiretroviral
CHW	Community Health Worker
DA	Democratic Alliance
DHA	District Health Authority
DHS	District Health Systems
DoH	Department of Health
FAS	Foetal Alcohol Syndrome
GDP	Gross Domestic Product
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HRH	Human Resources for Health
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, plus
MDR-TB	Multidrug-Resistant Tuberculosis
NHAA	National Health Appointments Authority
NHI	National Health Insurance
NSFAS	National Student Financial Aid Scheme
PES	Provincial equitable share
PHC	Primary Health Care
PMB	Prescribed Minimum Benefit
PPE	Personal Protective Equipment
RHA	Reciprocal Healthcare Agreements
SADC	Southern African Development Community
SIU	Special Investigating Unit
SOE	State-owned enterprise
Stats SA	Statistics South Africa
TB	Tuberculosis
UHC	Universal Health Coverage
OHSC	Office of Health Standards Compliance

Foreword by DA Leader, John Steenhuisen

South Africa stands at a crossroads in healthcare. Every day, millions of citizens rely on a system that is under immense strain: understaffed clinics, failing infrastructure, collapsing provincial departments, and budgets stretched far beyond their limits. Yet despite these challenges, most of our healthcare workers continue to serve with dedication and courage. They deserve a system that supports them. The people of South Africa deserve an efficient healthcare system that makes the most of our resources.



While budgets are stretched, this is often because of the irresponsible way that money is spent, as is demonstrated by the tender scandal at Tembisa hospital. The money is there, but it must be properly managed, accounted for, and it must be spent on getting quality doctors, nurses and working equipment in our hospitals and clinics, not on crooked tenders.

The Democratic Alliance's Health Policy is grounded in the principle that every South African must have access to quality healthcare. We support universal healthcare coverage, but it must be affordable, sustainable, and achievable. The ANC's proposed National Health Insurance (NHI) model threatens to bankrupt the state and collapse what remains of our health capacity. We cannot solve one crisis by creating another.

This policy offers a credible alternative: a system that strengthens both the public and private sectors, improves accountability, protects patient choice, and ensures that funding is used efficiently and transparently. It builds on what works, it fixes what does not, and prioritises the dignity and well-being of every person who walks into a clinic or hospital.

Most importantly, this policy honours the trust that voters place in the DA wherever we govern. It shows, in clear and practical terms, how a DA-led national government will improve healthcare outcomes, expand access, and ensure value for money. It demonstrates how we will put people at the centre of policy and resources.

South Africa does not have to accept a failing health system. With the right policies, sound management, and a capable state, we can deliver world-class care to all. The DA can fix this.

John H. Steenhuisen

Mat Cuthbert, MP,

Head of Policy, DA Federal Policy Unit

South Africa's healthcare system is characterised by poor governance, chronic corruption, and limited access to quality healthcare services. The previous administration's response was to introduce the National Health Insurance Act (NHI), which sought to further centralise public healthcare, institutionalise political interference, and further burden an already overstretched tax base. This is why the DA opposes NHI and instead advocates for affordable, accessible, and high-quality healthcare by fixing what is wrong with the public healthcare system and improving access to private healthcare. This bold new policy offer sets out exactly how to achieve these goals.

Executive Summary

Healthcare is one of the most significant line items on the South African budget, receiving an allocation of 8.5 percent of the Gross Domestic Product (GDP, 2020) across all departments and entities. Despite the substantial expenditure on healthcare, the quality of healthcare services has deteriorated over the past 10 years.

Despite decades of failure, the National Government's proposed solution to deliver quality public healthcare to South Africans is based on the misguided belief that the only way to guarantee quality healthcare is by centralising all functions of the healthcare system through its **National Health Insurance (NHI) plan**. The NHI will centralise healthcare funding in a new state-owned entity for the health sector. The NHI aims to merge private sector resources (such as medical aid schemes) and state resources into a single funding pool controlled by the Minister of Health.

State control opens the door to maladministration and wholesale corruption, which has characterised almost all state-controlled entities. The most significant risk arises from the Minister of Health's power to appoint the NHI's board and the centralised nature of the NHI's functions. This will likely facilitate cadre deployment and corruption, as has happened in all State-Owned Entities. The populist proposals contained in the NHI risk bankrupting the fiscus and deepening the healthcare system crisis.

The current Universal Health Coverage (UHC) system is not meeting expectations, and the continuity of coverage is uncertain without comprehensive systemic changes. This underperformance can be categorised into three main areas. First, there are the areas that relate to the performance of the public sector alone. Second, there are areas that relate to the performance of the private sector alone. Third, there are the areas that affect how the public and private sectors interact with each other.

The DA is committed to **universal access to healthcare for all citizens**. The key to achieving this over the next five years is to make the current district management model work through governance reform. By leveraging the **strengths of the private sector in partnership with the public sector,** we can improve health facilities and the quality of care for all. The policy recommendations set out in this document are revenue-neutral and therefore place no additional strain on public resources.

Our first policy objective is focused on strengthening healthcare systems and infrastructure to ensure Universal Health Coverage (UHC). In South Africa, healthcare operates in a two-tiered system, where services are provided through both public and private sectors. However, despite being designed to offer universal health coverage, both sectors need help to realise this objective. The main reason for these failures lies in the prevalence of significant governance weaknesses within the public sector, which permeates the healthcare system and adversely impacts the quality of service delivery. Additionally, the District Healthcare System(DHS) has yet to achieve complete decentralisation and is managed in silos rather than through an integrated model from home to clinic to district hospital level. This hinders the implementation of time-sensitive decisions, such as the provisioning and monitoring of health services that meet the community's local needs.[1] Decentralisation will be pursued progressively, with health facilities being granted greater autonomy when they demonstrate sufficient capacity and competence. Lastly, the monopoly over public laboratories leads to considerable inefficiencies, and forensic pathology services are underperforming.

The national government obscures the actual state of healthcare by not being transparent about health facilities' performance. Entrenched political interference within the governance structures of national and public health entities worsens the situation.

Furthermore, the mechanisms we have in place to ensure accountability are rendered ineffective, as the very politicians who should be held accountable are the ones appointing the officials to oversight bodies. Consequently, our fight against the rampant corruption plaguing our public health sector is severely undermined. Governance weaknesses, coupled with dilapidating

infrastructure, overwhelmed and burnt-out healthcare professionals, and poor management of public hospitals, greatly diminish the quality of healthcare service delivery.

The Democratic Alliance (DA) proposes policy reforms to address governance shortfalls in the public sector with a strong emphasis on transparency and accountability. Our proposals will address conflicts of interest by implementing measures that will limit undue political interference within the administration, regulatory bodies and public entities.

Additionally, we aim to enhance oversight and tackle instances of fruitless, wasteful, and irregular spending by establishing an investigative body known as the **Independent Watchdog for Health Entities** (also known as supervisory structures). The Watchdog will supervise all regulators, all key hospitals and key health services. Furthermore, we will establish an independent **National Health Appointments Authority (NHAA).** The authority will be responsible for the nomination, appointment, and removal processes of members within the Watchdog (supervisory structures), shifting these duties away from the executive branch.

To enhance the management of public hospitals, our proposal involves **granting greater autonomy** to all competent regional, tertiary, specialised, and academic healthcare facilities within the accountability processes (as stated above) applicable to all public health entities. The Watchdog will oversee the appointment and removal of hospital chief executives, under the supervision of the relevant Provincial Ministers, thereby assisting them in achieving their overarching health policy goals within their respective provinces. The Chief Executives will, in turn, have complete control over every aspect of their hospital's procurement operations, such as resource allocation, patient safety, quality improvement, infrastructure maintenance and repair.

To tackle the issue of deteriorating health infrastructure, we commit to **ensuring that all capital expenditures for healthcare facilities are financed and managed directly by the facilities' administrators rather than by a public works department.** This approach will ensure that facilities are well-maintained and infrastructure projects can commence without unnecessary red tape. Regarding new facilities, we commit to finding new ways of attracting capital investment. We will create the conditions to encourage private investment in public health infrastructure.

State-of-the-art facilities cannot be effective without an energised health workforce. To ensure that our health workforce is satisfied and motivated, we will implement promotions based on merit rather than length of service. We need to incentivise leadership development capacity and professionalisation of our workforce by creating educational opportunities in partnership with both public and private institutions of higher education. We will also bolster recognition programs, implement reward systems, and invest in the training and development of our health workforce.

Improving access to quality healthcare is not a task for the public sector alone. The private sector also plays a crucial role alongside it. The DA aims to leverage the private sector's strengths and address some of its shortcomings. Specifically, market failures in the private sector have hindered our goal of broadening UHC, often leading to insurance companies competing over the healthiest individuals rather than on quality healthcare services or more comprehensive coverage.

To address the market failures in the private sector, the DA will focus on implementing policies that foster competition among health insurance companies, encouraging them to compete for customers by offering higher-quality services at more competitive prices. This will be done by introducing social reinsurance and a risk-equalisation mechanism for medical schemes. High-risk customers will have more benefits at a reduced cost, and medical schemes will remain viable and sustainable.

Our second policy objective focuses on enhancing the quality of care and patient safety. Unfortunately, our healthcare facilities are not adequately monitored and evaluated. Consequently, they are not held accountable for poor services, and remedial plans to address their challenges are not implemented. Medical negligence and subsequent medical-legal claims are skyrocketing as a result. Inadequate infection control in health facilities and resource shortages are also common features of our health system.

To improve healthcare quality, the DA will implement policies to strengthen **the monitoring and evaluation of healthcare facilities.** The DA will place the Office of Health Standards Compliance (OHSC) (responsible for monitoring health facilities) under independent supervision. We will also ensure that the OHSC is fully capacitated with the necessary resources and authority to investigate and rectify concerns. Furthermore, we will eliminate political interference within the OHSC by ensuring appointments in the entity are made through the NHAA rather than the Minister of Health. Finally, OHSC needs to have its measures carefully re-evaluated to ensure that critical aspects of medical care that lead to improved outcomes for patients are measured and identified easily and quickly.

Enhancing the quality of services delivered will significantly decrease the number of medical negligence cases and subsequent medico-legal claims. We will address the excessive legal costs associated with medico-legal claims by introducing compulsory mediation processes instead of approaching the courts as the first point of resolution. To reduce the time it takes to conclude medico-legal cases, we propose **establishing medico-litigation centres,** and over the long term, the DA will investigate introducing a no-fault claims mechanism through a council comprising an independent team of experienced clinicians that will assess each adverse event in the health sector and offer compensation where appropriate.

The DA will ensure that resources are effectively managed to prevent resource shortages or stock-outs. This will be done by ensuring every hospital has a qualified inventory manager and can order directly from suppliers, subject to checks and balances, when the need arises. Additionally, we will ensure that an **electronic medicine stock management system is implemented.** A dashboard for each hospital and clinic, indicating stock levels of the most important medications at each level, will be implemented to ensure that stockouts of critical items are flagged immediately and dealt with quickly.

Our third objective is thus aimed at enhancing access to health services. In South Africa, access is hampered by various factors, including geographical disparities. Rural areas often face shortages of health facilities, doctors and nurses, and resources crucial for the operation of health facilities, such as water and electricity. Limited access to emergency care services also remains an impediment to accessing sufficient health services.

The DA aims to enhance the availability of healthcare services in underserved areas by investigating the viability of **mobile clinics** and by strengthening the capacity of mobile health services (telemedicine). Mobile clinics can effectively reduce barriers to access to healthcare and provide more opportunities for underserved populations to screen for and manage health conditions.[2] Furthermore, the DA will ensure that every hospital has a **well-defined risk assessment and mitigation plan** to address geographical challenges that hinder service provision (such as droughts, which result in water shortages). This involves facilities identifying high risks within their locality and implementing pre-emptive solutions to mitigate them. For example, in areas with a high drought risk, facilities can work towards installing water tanks or boreholes. Infrastructure upgrading will also be considered to ensure that health facilities can withstand severe weather impacts. Furthermore, we aim to safeguard facilities from the effects of disasters by establishing **a civil protection mechanism.** This mechanism is intended to lessen the impact of disasters, provide security to municipalities, and protect them against catastrophic events.

The DA plans to address health workforce shortages by ensuring that any administrative barriers to employing our already trained doctors and nurses first are removed and offering incentives to encourage them to work in rural areas. The party would also consider welcoming foreign doctors to fill any specialist gaps left in our health system, particularly in our rural areas, where required. Furthermore, we are committed to ensuring everyone can access emergency care services.

In order to ensure **that emergency access is guaranteed to all**, regardless of income or type of coverage, the DA will implement policy that will ensure that all priority 1 patients have access to emergency services at the nearest treatment facility. The DA will also encourage greater interdepartmental collaboration with the Police Service to enable Emergency Medical Technicians (EMTs) in "red zones"[1] to service the public safely. A DA-led Department will be providing training in the management of emergency scenarios to all healthcare professionals

and ensuring that the procurement processes of ambulances take into consideration the terrain in which they will be travelling.

Lastly, in this objective, the DA plans to address the shortfalls in the Reciprocal Healthcare Agreements (RHA) by engaging with SADC, the AU and other governments for the signing of RHA agreements that specify the conditions of reimbursement for treating foreign nationals in our public healthcare system.

Our fourth policy objective is to encourage healthy lifestyles and overall well-being. Various diseases, including both communicable and non-communicable conditions, burden South Africa. The most significant impact on the health system comes from preventable health issues, such as substance abuse, inactive lifestyles, harmful behaviours, and mental health problems.

The DA will promote healthy lifestyles and well-being by addressing the social determinants of health and behavioural risk factors. This will be done by scaling up Community Health Services for non-communicable diseases through community healthcare workers and ensuring strong referral pathways between health facilities and other social services. This will require that a significant portion of health budgets be allocated towards community healthcare workers to ensure that there is sufficient training and a career path for them within the healthcare sector, to ensure that they are able to provide the necessary care to patients from a community level upwards. To address the poor state of mental health in South Africa, the DA will shift underutilised resources from psychiatric institutions or other programmes to primary healthcare facilities. This will enhance access at the lowest possible level. Additionally, the DA will encourage the rollout of sensitivity training for healthcare professionals to equip them with the necessary skills to identify and appropriately deal with mental health issues in patients and combat prejudice.

By addressing governance weaknesses, improving service delivery, ensuring quality healthcare access for all geographical areas (urban and rural), and fostering healthier communities, the DA aims to build a resilient health system that can truly realise the objective of UHC. The DA's health policy provides a roadmap for getting our health system back on track.

[1]Red zones, in the context of medical service delivery, refers to high-crime areas that serve as a danger to the EMTs and their patients.

Vision

To protect, promote and improve the health of people and their communities through making affordable, accessible, and high-quality healthcare services available to all.

Principles

National Narrative	DA Narrative
To enhance Universal Health Coverage, we must nationalise the health sector.	To enhance Universal Health Coverage, we must leverage the strengths of the private sector, such as their access to professionalised and specialised staff and state-of-the-art technologies, in partnership with the public sector.
Policy Binary	
Enhancing Universal Health Coverage by creating another state-owned entity through the National Health Insurance.	Enhancing Universal Health Coverage by building on existing capacity in the public healthcare system and improving access to private healthcare.
Addressing market failures in the private sector by absorbing the industry into the public sector through the National Health Insurance Bill.	Addressing market failures in the private sector by introducing a risk-equalisation mechanism for medical schemes.
Addressing corruption by redeploying politicians who have stolen from the public into other positions of influence in government.	Addressing corruption in the public sector by limiting undue political influence over administrators, regulators, and all public entities and enhancing accountability mechanisms (through establishing supervisory structures to ensure strict enforcement of accountability standards).
Ensuring an adequate number of medical professionals in the public sector by linking the granting of qualifications to community service.	Ensuring adequate medical professionals in the public sector by developing a health workforce governance framework, which includes planning, financial support, curriculum development, and public-private co-operation.
Centralising all healthcare system functions, thereby distancing services and accountability from the communities being served.	Decentralising functions to bring services and accountability closer to the people being served.

Objective 1:
Strengthening Healthcare Systems and Infrastructure to ensure UHC

The DA will ensure that every South African enjoys the highest attainable standard of healthcare. We further recognise that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[3]

The attainment of quality healthcare for all South Africans requires a whole-of-society approach. The DA is committed to universal access to quality health care for all citizens and firmly believes that it is the responsibility of the government to ensure the progressive realisation of access to good quality, comprehensive curative, preventative, promotive, rehabilitative and palliative health services for all, irrespective of socio-economic status or place of residence. [4]

The current lack of leadership and management capacity, combined with weaknesses in the private sector, is hindering the realisation of Universal Health Coverage (UHC). We believe that the key to achieving true UHC over the next five years is to invest in and strengthen the current district health system in an integrated, comprehensive manner while ensuring that the district management model works effectively. Governance is most meaningful for the poor and marginalised, who are not covered by medical aid and lack the resources to access private health care.

This section will unpack the challenges standing in the way of South Africa genuinely enhancing UHC within the existing two-tiered health sector (public and private). First, we begin by analysing various weaknesses in the public sector, such as mismanagement, corruption, and irresponsible spending, and propose policy recommendations to address these. We then look at the causes of market failures in the private sector, such as pooling and purchasing failures, resulting in decreased competition and high healthcare costs. We propose policy recommendations to increase competition and, thus, lower healthcare costs. Together, these recommendations form part of the DA's alternative health policy proposal to NHI, which will work towards enhancing UHC.

The Concept of Universal Health Coverage (UHC)

The World Health Assembly in 2005 defined Universal Health Coverage (UHC) as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost." The achievement of UHC does not require a specific system or arrangement. It can be implemented utilising varying approaches, as demonstrated in different high, middle-, and low-income countries. This policy paper views a health system as having Universal Health Coverage when there is a "fairer, more efficient financing that pools risk and encourages prepayment to share healthcare costs that are equitable across the population"[5] , as well as access to quality public healthcare for those unable to afford private healthcare.

The objective of UHC is to minimise out-of-pocket payments. A country can be considered to provide UHC if everyone has access to the healthcare services that they need without incurring detrimental out-of-pocket payments. High out-of-pocket costs inhibit the poor and disadvantaged from seeking health services because they cannot afford them,[6] while also undermining the uptake of preventative care measures that may prevent the need for healthcare services in the first place.

To protect, promote and improve the health of people and their communities through making affordable, accessible, and high-quality healthcare services available to all.

Understanding Health Coverage in South Africa: A Two-Tiered System

South Africa has a two-tiered healthcare system. Healthcare is delivered through both the public and private sectors. The public sector is financed and delivered by the government at various levels (national, provincial, and local). The private sector is financed by the health insurance system (medical schemes) or out-of-pocket payments, where households contribute to their coverage.

Together, the two sectors achieve health coverage for South African households. The government fully subsidises those with inadequate incomes and partially subsidises households that can contribute somewhat to their own health care. Households with adequate incomes include at least one breadwinner earning more than the tax threshold (i.e., paying taxes to the South African Revenue Services).

Background: Public Health Sector

In the public sector, services are provided free of charge to all persons subject to a means test (the public sector covers 52 million people). The means test applies to hospital-based services and requires higher-income groups and medical scheme members to pay the total cost of any treatments. Primary care services are free to all, but are often not used by medical scheme members. The implementation of health service delivery has largely been allocated to provinces, although major metropolitan governments have historically played an important role in providing primary care clinic services.[7]

The public sector is financed by vertical cross-subsidies, where higher-income households subsidise lower-income households. The per capita value of the vertical cross-subsidy from medical scheme members to public sector users is R20 812 versus R26 925 spent on their contributions to medical schemes. In other words, for every R1000 paid in private medical aid premiums, R773 is additionally contributed to the Government Healthcare sector. (Table 1 and Figure 1).

Vertical cross-subsidies are invariably financed through systems of general taxation and government appropriations. While higher-income groups contribute virtually all the direct and indirect tax revenue that finances the public health system (roughly 74.5 percent), they are excluded from receiving subsidised coverage in the public health system (Table 1). In practice, households with medical scheme coverage rarely use public health services, with household expenditure on provincial hospital services amounting to a mere 0.32 percent of total expenditure on hospital services (Table 1 and Figure 2). [2] [3]

[2]It is often remarked that medical scheme members require public hospital care when their benefits run out. This may occur when a member can no longer afford a medical scheme, while a member does not qualify for free care, and medical schemes are required, in terms of section 29(1)(p) of the Medical Schemes Act (Republic of South Africa, 1998) medical schemes must reimburse public hospitals for hospital-based care. As coverage is maintained for major medical care, medical scheme members systematically choose private over public hospital care.
[3]The total expenditure by medical schemes on public hospital care in 2021 amounted to R361 million out of a total expenditure on hospital services of R74 billion (0.32 percent of total).

Figure 1: Medical Scheme Households' Contributions to Coverage and the Public Sector Allocation Per Capita to Services and the Medical Scheme Tax Credit[8]

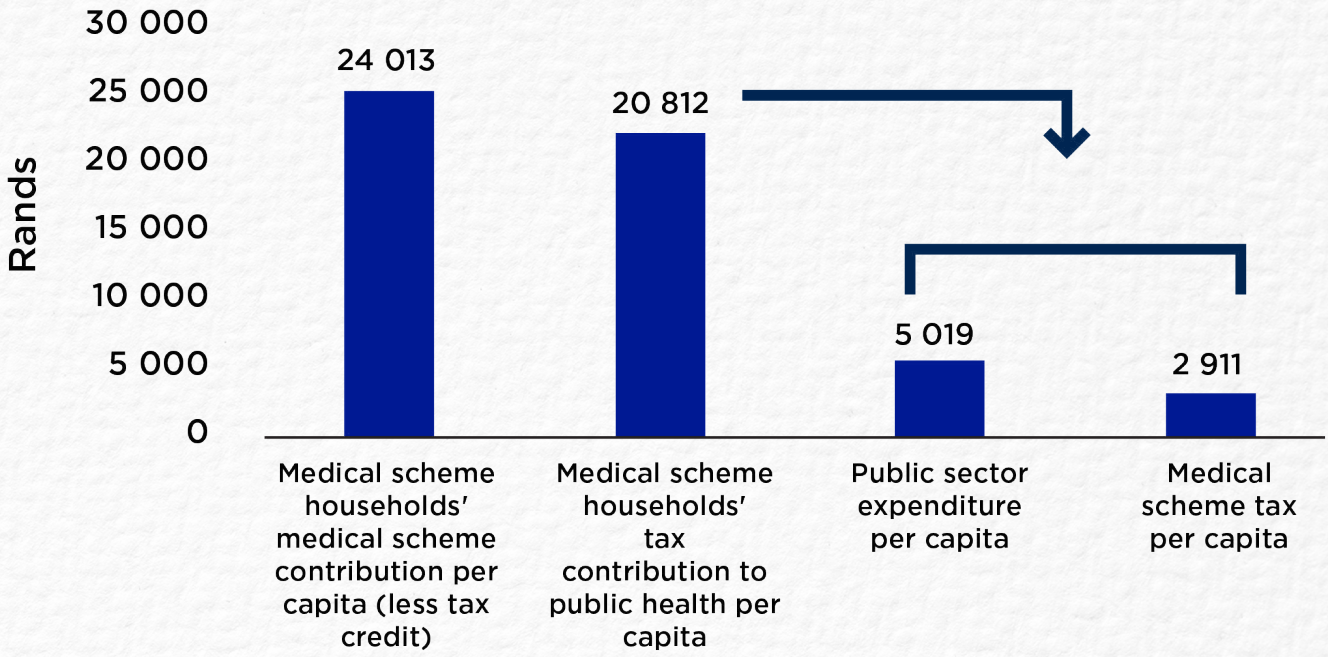


Figure 1 contrasts the individual financial contributions made by medical scheme households to both private medical schemes and public health through taxes, the public sector's spending on health per person and the tax credit benefit received by those in medical schemes. As illustrated in Figure 1, the per capita expenditure value for public sector users is lower than the per capita tax contribution made by medical scheme members, as the same funds are distributed across a much larger population. This is a consequence of having a very narrow tax base.

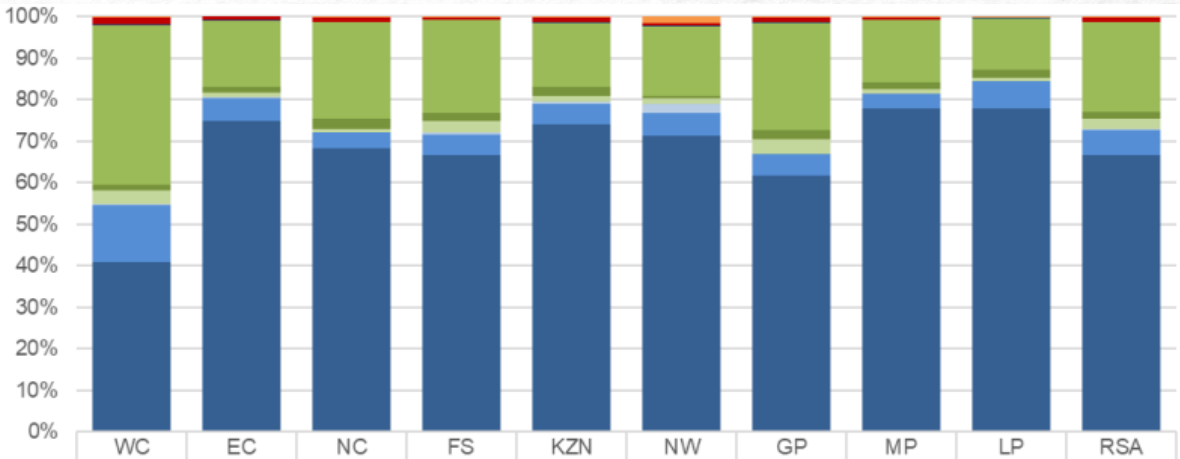
The vertical cross-subsidies[4] are, therefore, substantial, with higher-income groups contributing most of the revenue toward public health services but not making use of any of those services. There is also a significant burden placed on these households, which effectively contributes 97.2 percent toward their coverage[5] and 85.5 percent out of the total UHC expenditure, equivalent to 6.6 percent of GDP (Table 1 and Figure 2).

[4]In this analysis, an estimate is generated of the consolidated tax contributions made by medical scheme households across the full spectrum of tax bases, which includes both direct and indirect taxes. Corporate tax contributions, which are not attributable to individuals, are also assumed to be paid indirectly by these households. See Table 1 "Sources" for more information on the assumptions.
[5]This includes the direct contribution (excluding the tax credit) plus 74.5 percent of the tax credit which is indirectly contributed through the tax contributions by medical scheme members. This implies that medical scheme members, directly and indirectly, pay for R235 billion out of a total of R241 billion (Table 1) or 97.2 percent.

Table 1: Overview of Key Indicators of the South Africa System of UHC (2022)

Indicator	Public	Medical schemes
Population covered (000)	**51 687**	**8 967**
% of total	*85.2%*	*14.8%*
Health expenditure total (includes value of tax credit)	**285 551**	
% of GDP	*4.4%*	
Medical schemes gross contribution income (GCI) (includes tax credit) (R'million)		**241 441**
Medical schemes own contributions by members (R'million)		**215 335**
Tax credit for medical schemes (R'million)		**26 107**
% of GDP		*0.4%*
% of public health expenditure total		*9.1%*
Health expenditure by subsystem (public and medical scheme GCI)	**259 445**	**241 441**
% of GDP	*4.0%*	*3.7%*
Health expenditure per capita (Rands) (public sector and tax credit)	5 019	2 911
Health expenditure by subsystem per capita (Rands)	5 019	26 925
Tax payments for public health by household (HH) type (R'million)	**72 816**	**212 736**
% of GDP	*1.1%*	*3.3%*
% of total public health expenditure	*25.5%*	*74.5%*
Contributions/tax payments to UHC (includes own contribution by medical scheme members)	**72 816**	**428 070**
% of GDP	*1.1%*	*6.6%*
% of total UHC expenditure	*14.5%*	*85.5%*
per capita (Rands)	1 409	47 737
Medical scheme HH subsidy to public sector users - per capita (Rands)		20 812

Figure 2: Percentage Distribution of the Type of Healthcare Facility Consulted First by Households per Province, 2022 (Stats SA)[9]



	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Other	0,3	0,1	0,3	0,2	0,3	1,7	0,4	0,4	0,1	0,4
Pharmacy	1,7	0,7	1,1	0,6	1,2	0,6	1,1	0,5	0,0	0,9
Traditional healer	0,1	0,1	0,0	0,1	0,1	0,2	0,1	0,0	0,3	0,1
Private doctor	38,3	16,1	23,3	22,4	15,5	16,8	25,8	15,1	12,4	21,5
Private clinic	1,5	1,2	2,3	1,8	2,1	0,6	2,2	1,6	1,9	1,8
Private hospital	3,2	1,2	0,9	2,9	1,5	1,2	3,6	0,9	0,7	2,2
Other public institution	0,3	0,2	0,0	0,4	0,5	2,4	0,0	0,1	0,0	0,3
Public hospital	13,7	5,6	3,8	5,0	4,8	5,4	5,3	3,6	6,6	6,1
Public clinic	41,0	74,7	68,3	66,5	74,1	71,2	61,7	77,9	77,9	66,6

Most South Africans rely on publicly funded healthcare services, whereas private healthcare services are only accessed by those with medical aid or who can afford to pay out of pocket. The graph above illustrates that 73 percent of households initially seek medical attention at a public health facility, with 66.6 percent of persons, on average, using public primary care clinics. Notably, private doctors are the third most accessed healthcare provider nationally, which amounts to 21.5 percent of households. A significant portion of the population continues to seek healthcare services within the private sector first and chooses to rather pay out of pocket for what is perceived as better quality care. Contrastingly, only 1.8 percent of households use private clinics.

The public health system serves the majority of South Africans. The stark difference between the quality of services provided by public and private healthcare facilities has resulted in differential access to quality healthcare services.[10] Those who can afford to turn to private healthcare are far better served. Despite most South Africans relying heavily on the public health system, the system is understaffed, under-resourced, and chronically mismanaged. This comes as R296.1 billion[11] of the 2025 national budget is allocated to the Health Department, ultimately pointing to an inadequate delivery of services paid for.

Governance Failures in the Public Sector

The healthcare system can significantly improve within the current administrative, structural, and budget configuration. South Africa's multi-level government model retains much potential for high-quality service provision. The existing public system, based on a concurrent set of powers between the national government and provinces, allows for a coherent distribution of authority, accountability, and responsibility across the country. This model has worked for many countries by decentralising accountability for service delivery to be as close as possible to the community served.

Many of the country's health challenges can be traced back to our painful past. However, several decades after the advent of democracy, improvements to the quality of healthcare provided remain inadequate. This has been exacerbated by incompetent leadership, corruption, mismanagement, irresponsible spending, an unproductive healthcare workforce and billions in irregular expenditure.

There are various weaknesses in the public health system, which include:

- **An incomplete, decentralised District Health System:** The district healthcare system (DHS) comprises small management units adapted to cater to the local needs of the community. South Africa has 52 health districts, all vital in delivering primary health care.[12] The DHS is designed with a decentralised approach, aiming to bring decision-making and service delivery closer to the communities served. Unfortunately, the system has struggled to achieve its objectives due to the following reasons:
    - **The DHS lacks a coherent operational focus.** Given its structure, it is hard for the services to evolve and strengthen over time. Currently, the district system falls within an administrative hierarchy that harms effective decision-making as it creates layers of bureaucracy, which can slow down the time it takes to make and implement a decision.
    - **The DHS fails to effectively organise the delivery of preventative and promotive services near where people live and work.** Such services play an essential role in managing chronic diseases, which require responsive access to routine tests and medication away from a hospital setting.
    - **The prevalence of manual or paper-based information systems.**[13] Despite some evidence of effective information systems in South Africa, more than half of the country's public health

facilities still use paper-based filing systems. Manual systems create a time-consuming administrative burden for healthcare workers and pose limitations on the optimal use of health data.[14] Furthermore, should patients lose their appointment card, which has crucial information required to access their patient files, they must open a new patient file. Creating a new patient file can result in the patient losing access to their medical history connected to their original file.[15]

- **Health information systems lack integration.** Due to their manual/paper-based nature, there is limited information sharing between health facilities. When a patient visits a health facility for the first time during an emergency, the lack of integrated information systems means that their health records, stored at another facility, are not immediately available. This leads to delays in decision-making and service delivery. Existing health information (the District Health Information System in particular) can contain too many indicators and parameters, which results in significant burdens being placed on healthcare workers within facilities that lack dedicated data-capturing capacity.[16]
- **District Hospitals have been separated from the delivery of PHC services within clinics.** This has led to PHC clinics becoming siloed and separated from the district hospitals, which they often refer patients to. These services have to be managed by properly staffed and constituted district councils, who should provide the specialised expertise and oversight that is required. Well-run district hospitals can attract and retain a core community of skilled healthcare workers who can support the planning and delivery of PHC services in rural areas. There is a need for greater involvement of district hospitals in the delivery of PHC services, in particular to serve as a hub of expertise, training, supervision and support for feeder clinics which fall within its geographical region.[17]

- **Public laboratories are inefficient due to a state monopoly on services:** The existing system for laboratory services in the public sector is rigid, leading to slow turnaround times and the inefficient duplication of tests. Provincial hospitals and clinics lack the autonomy to manage laboratory service functions, as the laboratories fall outside their hierarchical decision-making. The management of diagnostic services is central to efficient patient care. If these services fall outside the control of the facilities, patient care cannot be properly controlled. It is imperative that a more coherent framework that gives control of the laboratory services needed directly to the laboratory be established. A consequence of this inefficiency can be found in the growing number of backlogs. In the 2018/19, the backlog stood at 10 000 cases. This number has since dramatically risen, reaching 308 000 cases by the 2021/22 period.[18] These services need to be made independent of political influence and provide high-quality, timeous support to the investigations of unnatural deaths and criminal investigations.
- **There is a lack of transparency regarding the performance of health facilities.** Information on the supply and performance of health facilities across the public and private sectors is not routinely collected and made available to the public. Information on services, staffing, financial performance, patient activities, and entry and exit diagnoses is not consistently collected. Information presently made available cannot reasonably be validated, as the underlying systems of collection and reporting are typically unreliable (as frequently noted in the Auditor General reports on provincial health services).
- **An underdeveloped governance framework:** The governance framework required to effectively support a public health system delivered through three tiers of government has, to date, not been properly developed. The leading causes of a poor governance framework include:
  - A failure to implement measures and systems that render the health service, directly and indirectly, accountable[7] to communities continuously.
  - A lack of adequate supervisory arrangements[8] that can ensure a complete system of prospective, concurrent and retrospective accountability.[9] An effective supervisory arrangement should include monitoring and evaluation that ensures accountability before, during, and after any action or decision is taken.

- **The Life Esidimeni Tragedy is a stark example of the consequences of failing to implement adequate accountability mechanisms.** The incident involved the deaths of hundreds of mentally ill patients when they were transferred from Life Esidimeni (a private psychiatric hospital in Gauteng) to community organisations to save money and as part of the national health department's policy to deinstitutionalise mental healthcare.[19] These transfer patients were known as the Gauteng Mental Health Marathon Project and were characterised by mismanagement, a lack of accountability and transparency, and unknown ulterior motives, resulting in suffering and death for mental health care patients.[20]

  This is attributable to numerous factors, including the lack of a clear plan to track who was responsible for a particular task. Additionally, the project only considered the cost implications without considering the steps required for effective implementation. Furthermore, it did not factor in how long it would take or what was to be achieved. Consequently, no one was explicitly in charge of ensuring each component and stage of the project was implemented correctly. Without clear responsibility for oversight and ensuring the completion of each task (such as the steps required for a safe patient transfer plan), it was impossible to hold anyone fully accountable for any shortcomings or catastrophic failures that occurred during or after the project's implementation.

- **Weak strategic policy leadership:** The national government's strategic policymaking functions have been poorly led, structured, and capacitated. For example, there is no framework for human resource planning (discussed in more detail under Objective 3), no attempt to develop a coherent governance framework for hospitals, health districts and other health entities, and medical schemes PMBs have not been reviewed. Furthermore, none of the investigative powers of the national department has been used to address corruption in the provinces, and no norms and standards of any value have been developed that underpin minimum service requirements across South Africa.

- **Political interference in national and public entities:** This interference extends to the appointment of leadership, cadre deployment, the independent implementation of statutory mandates, the deployment of resources, transparent reporting to the public related to statutory mandates and their ability to advise on policy independently.

  For example, the National Health Act states that the Minister has control over the direct appointment of the Chairperson of the Forum of Statutory Health Professions Council, the National Blood Transfusion Service inspectors, and health officers.[21] The Minister also has direct control over the appointment of the Board of Authority and the approval of the appointment of the executive committee at the South African Health Products Regulatory Authority (SAHPRA). The approach adopted in South African public organisations to date is that they must never advise against prevailing positions adopted by the executive. This is a flawed approach that suppresses expert policy advice.

- **A weak investigative structure to address irregular expenditure:** Given the weaknesses in the governance framework of the public health system of the past 30 years, irregular expenditure by national, provincial and local government structures and facilities delivering healthcare services is prevalent in many provinces. In October 2022, the Health Department incurred R1.3 billion in irregular expenditure. There was a 42 percent increase in irregular expenditure from the previous year.[22] The

[7]Indirect accountability is achieved using specialist supervisory structures that must hold a public health organisation to account using criteria developed through public deliberations. While the community does not intervene through direct action, it does so indirectly through the criteria that must be impartially administered. Indirect approaches are required where expert supervision is needed to get to the root causes of performance variations. These approaches can be supplemented by more direct accountability approaches.
[8]These include independent supervisory boards, complaints regimes and regulators. To ensure continuous accountability, the governance framework must provide for prospective, concurrent and retrospective approaches to supervision. Communities also require more than just a "voice" to ensure that services serve their needs.
[9]Prospective accountability before an action or decision is taken. It is about setting standards, rules, and expectations upfront to guide behaviour and decisions in a way that aligns with established goals or values. This approach aims to prevent problems or errors before they happen by having clear policies, oversight, and guidelines that individuals or organisations must follow.

slow response rate of existing national investigative structures, such as the Special Investigative Unit (SIU) and the Directorate for Priority Crime Investigations (referred to hereafter as the Hawks), has established a culture of impunity, perpetuating criminal exploitation of public health services. In 2020, when the COVID-19 pandemic started, political elites and entrepreneurs with political connections to the ANC viewed the health crisis as another opportunity to make a quick buck, gambling with citizens' lives. Emergency procurement processes served to enable greedy government officials to fill their pockets. Dodgy business deals and flawed procurement systems characterised the pandemic. Emergency procurement processes were not conducted per the law, resulting in over R13 billion in irregular contracts, sub-optimal quality of PPEs, inflated payments, and payments for products and services not being delivered.

The former Minister of Health, Dr Zweli Mkhize, was directly implicated in corruption, benefiting from the Digital Vibes contract. Digital Vibes was responsible for NHI communications. However, it was revealed that the bulk of the money paid to Digital Vibes was diverted to the Minister's and his family's pockets.

The National Government's Approach to Universal Health Coverage

In 2019, the National Department of Health (DoH) introduced the National Health Insurance (NHI) Bill in Parliament, which was signed into law by the President in 2023. The Act aims to establish a National Health Insurance Fund, which will act as a single payer for healthcare-related expenses for all South Africans and address the high levels of inequality in accessing quality health services. However, considering the ANC's poor track record in managing SOEs, it is unlikely that the NHI will meet its objectives. Instead, another failed SOE will be established to burden taxpayers.

The NHI plans to enhance access by making health services free to persons who need them. Fees will cease to exist at health facilities. The ANC aims to achieve this goal by creating a health financing system designed to pool funds into one single fund that will be managed by the state, aiming to provide access to health services to all South Africans, irrespective of their socio-economic status.[23] The single fund will be financed through income, payroll and general taxes. In theory, South Africans will access free healthcare services at the first point of use at accredited health facilities.[24] The problem, however, is that the NHI does not address the chronic problems within the healthcare system. Implementing the NHI, without effective governance reforms to prevent corruption and hold those accountable, will open the national health purse to grand theft and mismanagement, as evident in many other state-owned enterprises.

The second major problem is that the NHI has not been adequately costed, bringing into question its affordability and ability to be implemented. According to FTI Consulting, the NHI will cost an additional R200 billion over and above existing health expenditure.[25] To put this into perspective, the total health expenditure costs were estimated to cost the country R267 billion as of 2024.[26] The Freedom Foundation, however, estimates the costs of NHI to be R1 trillion, and Krutham's managing director, Peter Attard Montalto, estimates the NHI will cost the country between R300 and R460 billion. The funding for NHI will be raised through various forms of taxation. Should the NHI cost the estimated R200 billion, the following options need to be considered to raise these funds:

1. VAT is increased from 15 percent to 21.5 percent or;
2. Personal income tax rates increase by 31 percent or;
3. A payroll tax is implemented, amounting to R1 500 in the formal sector[27]

The DA fundamentally opposed additional taxation on an already overburdened tax-paying

population, as this would lower purchasing power, lead to capital flight, and inflict further damage on an already ailing economy. Given South Africa's constrained fiscal environment, the imposition of further taxes on our populace is an unimplementable solution.

A further problem with NHI lies in its unclear operational model. Section 33 of the NHI Act will prevent medical schemes from covering services reimbursable by the Fund. This will progressively reduce the number of services a medical scheme can offer, thereby limiting healthcare options for South Africans rather than expanding them. In addition, the Department has refused to reassure healthcare providers that they will still receive all the funds necessary to continue operating at their current standard and quality levels. This is important as doctors and other healthcare professionals are highly skilled and can decide to take their services to other countries where they will receive better remuneration. This has already occurred in nations such as the United Kingdom, where healthcare workers are emigrating to other markets where they are paid better than what their national health services are willing to pay.[28,29]

Instead of making access to quality healthcare services more affordable for all South Africans, the NHI's insufficient remuneration levels may reduce the pool of available quality healthcare services for all South Africans.

DA Policy Recommendations: Enhancing Public Sector Governance for the Realisation of Universal Health Coverage

The DA's healthcare model will focus on two key areas: strengthening governance in the public sector, enhancing private sector competition, and increasing access in the private sector. The aim is to address the challenges within the current UHC system and propose evidence-based policy recommendations for ensuring access, affordability, and quality within healthcare service provision. The DA will begin by enhancing the governance framework in the public health system by:

- **Limiting undue political interference in the work of administrations, regulators, and all public entities** responsible for delivering healthcare services. As a result, harmful conflicts of interest in personnel appointments and procurement processes will be prevented, ensuring politics does not get in the way of good governance and service delivery.
- **Addressing corruption by establishing a Chapter-9 Anti-Corruption Commission,** which will be accountable to Parliament and follow independent budgetary processes that are removed from executive control. See the DA's Crime Prevention Policy for further details. By establishing the unit, the DA will effectively address fruitless, wasteful and irregular expenditure. Given the lack of financial controls, irregular expenditure amounted to R4.5 billion, and fruitless and wasteful expenditure across all entities amounted to R3.3 billion as of 2022.
- **Establishing an Independent Watchdog for Health Entities (also known as supervisory structures).** The independent watchdog will supervise all regulators, all key hospitals, key health services and health districts. They will also have the powers to supervise procurement processes and oversee human resource matters.
- **Establishing an independent National Health Appointments Authority (NHAA)** to guarantee the autonomy of the Watchdog (supervisory structures). The NHAA will handle the nomination, appointment, and removal processes of supervisory structure members, moving these responsibilities away from the executive and ensuring merit-based appointments are prioritised.
    - **To ensure the NHAA's independence, it will be supervised by an independent board**, where the nominations, appointments, and removal aspects of the board are administered by a statutory process that ensures that appointments are fit and proper and independent of the executive branch of government.
- **Mandating the relevant chief executive or equivalent of health entities to also report to the Watchdog while allowing for appropriate political oversight.** They will be responsible for all aspects of their organisation, including finance, procurement, human resources, equipment, all administrative functions, and all capital expenditure, under the supervision of the relevant Provincial Ministers, thereby assisting them in achieving their overarching health policy goals within their respective provinces.
- **Allowing all capital expenditure to be directly financed and controlled by the relevant healthcare facility** and not a public works department, whether national or provincial.
- **Ensuring that forensic health services are placed under the supervision of independent supervisory boards (the Watchdog) to which they report.**
- **Implementing a decentralised governance model for the National Health Laboratory Service** so that its services better match the needs of the local or provincial health services. The model will be gradually implemented after the supervisory board structure has been operationalised, with its ultimate aim being to ensure complete independence from the government's executive.

The proposed decentralised model within the public sector context resembles the structure suggested for hospital CEOs in the following section of this paper. Administrators of laboratory facilities will enjoy complete autonomy in decision-making concerning their respective facilities. It is crucial to highlight that the efficacy of this framework heavily relies on the design of supervisory boards and the establishment of governance and accountability mechanisms for more direct oversight of significant decisions and performance. The allocation of decision-making authority encompasses all facets of the relevant entity or facility, such as procurement, human resource management, control over finances, and capital expenditure.

The district healthcare system will be strengthened by:

- **Integrating health information systems.** This will be done by implementing new digital technologies, such as a unique patient identification number system.[30] These health information systems must also be simplified at the data entry level to reduce the data-capturing burden placed on health care workers.[31]
- **Establishing definitive, decentralised district health authorities (DHA),** which will be implemented over several years. This will substantially strengthen the delivery of primary care services. These authorities will have clear budget allocations and powers to act locally. Furthermore, they will be given significant autonomy to adhere to their mandates. Currently, the district system falls within an administrative hierarchy that harms effective decision-making. Further policy proposals to enhance the DHS system include:
    - Ensuring that each DHA has authority over all clinic-based services and at least one district hospital within its spatial area of responsibility.
    - Ensuring that each DHA has a designated administration supervised by a supervisory board set up by the NHAA and operates according to the proposed accountability process.
    - Ensuring that each DHA receives funding from the relevant province.

Poor Management of Public Hospitals

The governance framework for public hospital services is inadequate, leading to failures in properly implementing accountability systems, workforce management, clinical governance, information technology, facilities maintenance, responsive patient administration and quality improvement systems. It is impossible to correct the failures in many public facilities using top-down interventions or when politicians are involved in critical appointments.

A case in point of poor management is evident at Charlotte Maxeke Academic Hospital, which, in August 2023, had to postpone vital surgeries due to the premature decommissioning of equipment without timely replacements. Patients in need of vascular surgery faced delays of up to three months while waiting for the necessary equipment to become available. Spotlight, a news outlet, reported that hospital staff attributed these postponements to questionable management practices and poor planning. [32]

The quality of South Africa's public hospitals is declining at a rapid pace. The main causes of these challenges include:[33]

- **Political influence in the management of central hospitals:** The political patronage system created by the ANC's cadre deployment policy rewards party supporters with managerial positions. Cadre deployment ultimately affects management effectiveness and shields managers from accountability.[34] Additionally, the power of the Minister in relation to the establishment of the hospital board and management system is significant.[35] The challenge arises when both hospital chief executive officers, boards and accountability bodies (such as the OHSC) are appointed, with the Minister having the final say. This governance structure creates a scenario where diligent and honest employees feel vulnerable and are at a higher risk of being terminated, whereas those engaged in corrupt practices are shielded from facing repercussions for their actions.[36]

Suspicions about political interference were raised at Tembisa Hospital when lengthy delays in disciplinary procedures were reported. Babita Deokoran exposed the illegal awarding of tenders to illegitimate companies. This led to the suspension of the CEO, Dr Ashley Mthunzi and CFO Lerato Madyo in August 2022. The SIU recommended that the disciplinary process start in December 2022; however, it only started a year later, in October 2023. The prolonged postponement of proceedings has raised concerns of political interference to protect individuals from action being taken against them. Among those implicated is Hangwani Morgan Maumela, a nephew of President Cyril Ramaphosa. Companies associated with Maumela received procurements worth R356 million from Tembisa hospital, R22 million from the Mamelodi hospital and a further 2.4 million from other hospitals. [37]

- **Insufficient operational authority for hospital managers to manage their facilities:**[38,39] Hospital managers lack adequate control over their operations due to the highly bureaucratic nature of managing public facilities. These processes were initially established to curb corruption but have proven ineffective. Additionally, they have led to operational inefficiencies within these facilities. For example, the running of a facility involves numerous governmental departments. The task of managing hospital infrastructure, which one might expect to fall under the health department, is instead assigned to the Department of Infrastructure and Development or Public Works. As a result, hospital CEOs do not directly manage the maintenance of hospital buildings, illustrating the disconnect between authority and operational control in hospitals. This can lead to delays in the delivery of crucial infrastructure maintenance projects. [40]
- **Unfair and untransparent cost sharing between provinces.** There is considerable discretion in the system of provincial financing at the national level. It is fairly easy to manipulate the Provincial

Equitable Share (PES) formula and conditional grant allocations to favour some provinces over others. This has been used to bail out failing provinces at the expense of well-performing provinces. Provinces should only be bailed out using temporary bridging allocations and not permanent measures, such as meddling with the PES formula or the conditional grants. This entire framework needs to be recalibrated and made transparent.

- **There is a lack of merit-based upward mobility within the healthcare system.** Whilst weak leadership and management are often-stated criticisms of the public sector, there has never been a sustained effort by any South African government to address this problem at scale. A central coordinating body is needed in this terrain - working in partnership with provincial departments of health and with higher educational institutions and other training providers. Such a coordinating body is different from the National School of Government, which serves all civil servants and addresses generic management functions, rather than the specific leadership and management needs of the health sector.

Policy Recommendations for Improving Governance at South Africa's Public Hospitals

Changes in leadership and management, coupled with properly designed accountability mechanisms, are needed to ensure that the key day-to-day decisions achieve continuous improvement in systems and performance. The DA will address the management challenges in our hospitals by:

- **Ensuring that all regional, tertiary, specialised and academic facilities become autonomous**, subject to the accountability processes established for all public health entities.
- **Allowing all hospital chief executives to have complete control over all aspects of their hospital's operations.** This encompasses financial management, procurement, workforce planning and spending on capital projects (such as infrastructure maintenance).
    - The provincial government, as the strategic purchaser of the services, would determine each hospital's service mix. However, to the extent that revenues are obtained from sources other than the province, the hospital would be free to use these funds in accordance with its localised needs in consultation with the relevant supervisory board.
- **Providing educational opportunities for the professionalisation and management within our healthcare system** through collaboration with public and private institutions of higher education. This will ensure the implementation of leadership capacity building, prioritising merit-based continuous development opportunities and pathways for professionals to work themselves up through the system.
- **Ensuring that hospital and clinic-based services are adequately funded for the populations they serve.** This will be done by implementing a system of fair and transparent cost-sharing between provinces and health districts, which is required to supplement the provincial equitable share allocation.[10]

[10]Provinces are financed in part by an unallocated block grant in lieu of provincial tax revenue collected by national government on their behalf. This is referred to as the provincial equitable share (PES) grant and is unallocated to permit provinces to determine their own priorities as they see fit.

The Critical State of Health Infrastructure

Healthcare institutions are experiencing capacity challenges exacerbated by poor health infrastructure investment and maintenance.[41] South Africa's public health system comprises 422 hospitals and 3 842 clinics and health centres.[42] By the end of 2022, the Minister of Health, Joe Phaahla, disclosed that the health infrastructure backlog was sitting at R200 billion.[43] In the same year, the Minister asserted that the infrastructure backlog was R23.9 billion from 2022/23 to 2023/24.[44] Additionally, it has been estimated that 265 (62 percent) public hospitals and 1903 primary healthcare facilities urgently need upgrades and maintenance. There are, however, no consolidated reports on the state of health infrastructure nationally, and inconsistencies in available reports make it extremely difficult to ascertain the actual state of health infrastructure.[45]

As discussed in the previous section, the maintenance of public health facilities is presently centralised in many provinces in public works departments, with hospital managers unable to manage their facilities' needs directly. With the resulting corruption, healthcare facilities are not properly maintained, leading to crises with severe implications for service provision. In addition to the red tape involved in infrastructure maintenance, the following challenges are identified:

1. Overcrowding and long waiting times: There are too many patients for the number of existing hospitals and clinics, resulting in bed shortages and long waiting times. According to the WHO, the ideal hospital bed per population ratio for a middle-income country is 3.5 per 1000 people.[46] The long-term trend in South Africa has seen a gradual decline in the availability of beds per 1000 people. In 2008, South Africa had 2.39 beds per 1000 population; this decreased to 2.30 in 2010,[47] and as of 2022, South Africa had 1.7 beds per 1000 population.[48] Despite such a downward trend in bed availability, from 2012 to 2022, the DoH only built 17 new hospitals nationally. In Mpumalanga, only one new public hospital was built during the same period.[49] This is despite the province having a bed-to-population ratio of 1.3 beds per 1000 people, below the national average. Limited expansion of health infrastructure to meet population growth results in hospital overcrowding.[50]

2. Water shortages: Public hospitals and clinics face water shortages, and some use water that fails to meet quality standards. In a study investigating hygiene access and standards in 50 public healthcare facilities in Vhembe District municipality, 38 percent of taps showed total coliform counts,[11] which were higher than safe drinking guidelines.[51] In 2022, 48 clinics and 3 hospitals in Nelson Mandela Bay closed due to water supply challenges. [52]

"Clinic services are constantly disrupted due to intermittent water supply. Sometimes we are forced to shut our doors ... leaving patients stranded"
– Nurse at Kariega Clinic[53]

3. Electricity shortages: Rolling blackouts severely restrict access to crucial public healthcare services. Across South Africa, there are 422 hospitals, but as of November 2022, only 18 percent (76) of public hospitals received exemptions from load-shedding.[54] Load-shedding leads to several challenges, including life-threatening challenges. It can shut down life-supporting equipment, cause cold storage systems to fail, resulting in degradation of medication, and inflict enormous damage on medical devices caused by power surges.[55,56] Furthermore, during load-shedding, elevators become inoperative, making it challenging for patients and staff to navigate around the hospital.

"Pumps can't pump water, so no water.
Lights come back and surge and break equipment.
We have one-third of our dialysis machines out of commission"
- Doctor at Helen Joseph Hospital[57]

4. Dilapidated mortuary service infrastructure: Mortuary facilities are struggling with a lack of funding and infrastructure maintenance. In 2024, around half of all state mortuary facilities have not met inspection standards, leaving staff to work under unacceptable conditions and grieving families traumatised.[58] Broken fridges, unhygienic working conditions and poor medical waste management are just some of the reasons given as to why these facilities failed inspection. A recent case in Bloemfontein (Mangaung) highlights the severity of this situation. In October 2024, the local government mortuary service was closed by the Department of Labour for no longer complying with health and safety standards. The drains from autopsy tables were blocked, extractor fans and fridges did not work, and there was a shortage of staff and essential equipment.[59]

Recommendations for Addressing Infrastructural Challenges

The DA will enhance the quality of our healthcare infrastructure by:

- **Ensuring that all capital expenditure is directly financed and controlled by healthcare facility administrators** and not a public works department, whether national or provincial. For hospitals, all revenues raised outside of budgeted allocations will be retained and managed by the relevant hospital and deployed in accordance with their needs.

[11]Coliform counts give an indication of the quality of water supply. Total coliforms are bacteria that can be found in soil or water than has been contaminated by human or animal waste.

- **Ensuring that there is an official annual report on the status of health infrastructure targets and projects.** This report should include information on outstanding health infrastructure needs, projects that are starting, their projected completion dates, and current status.
- **Creating conditions that will encourage private sector investment in public health infrastructure.** We will establish public-private partnerships to ensure a win-win relationship between parties. The inclusion of risk-sharing instruments could assist in attracting private investment.[60] Risk-sharing is the principle of allocating project risks to the company or public institution best suited to manage such risks. For example, the public sector would manage regulatory and political risks, while the private sector would better manage construction and operating risks. [61]
- **Investing in alternative sources of power,** which are off the national grid, to connect healthcare facilities, especially in under-resourced areas, to ensure a reliable power supply.[62] The DA's Energy Policy proposes various recommendations which will provide energy security. Our policy can be found here.

DA-led Western Cape Government: Safegaurding Health Services from Loadshedding

To protect health services for residents during loadshedding, as of 2024, the Western Cape Government has ensured that:

- 195 health facilities have generator capacity to continue essential services during loadshedding.
- 47 clinics have inverter installations.
- 10 hospitals have been exempted from up to Stage 6 loadshedding. The hospitals include: George, Groote Schuur, Karl Bremer, Mitchells Plain, Mowbray Maternity, New Somerset, Red Cross, Tygerberg, Victoria, and Wesfleur.

- **Investing in the growth of virtual care, or telemedicine, within the public sector.** Telemedicine can help reduce strain on health infrastructure by providing care that does not require a physical examination to be carried out.[63,64] Examples of where telemedicine may be useful include the monitoring of a discharged patient's recovery[65] or providing advice on dermatological issues through the sending of photographs or videos on digital channels.[66] South Africa initiated its telemedicine project in 1998, yet the extent of its integration into public healthcare facilities remains uncertain. Despite the initial launch, telemedicine is notably absent from the National Digital Health Strategy for South Africa and the department's Annual Report for 2022.
- **Ensuring that all healthcare facilities have an emergency water supply plan.** Emergency plans can include water restrictions, the identification of water-saving mechanisms (for example, the hospital can temporarily use disposable plates, utensils, and waterless hygiene products),[67] and the identification of minimum water needs.
- **Ensuring that the Department of Health and other relevant departments oversee the maintenance and resource management of all government mortuaries.** This will ensure good working conditions for the workers and that the bodies of the deceased will be treated with the dignity they deserve.

A Dissatisfied and Burnt-out Health Workforce

Challenges impacting job satisfaction, motivation and retention are common features within the health sector. Various factors affect the country's health workforce job satisfaction, which ultimately affects the public health sector's ability to retain staff and keep them motivated. They are listed as follows: [68]

- **A management and leadership crisis at hospitals and clinics:** Promotions are based on length of service rather than merit, resulting in inexperienced hospital managers taking charge of critical health institutions. Promotions for certain roles should not occur only based on length of service alone; however, skills should also be considered.
- **Unsatisfactory working conditions:** Health workers are dissatisfied with their pay, long working hours, an unconducive workplace culture, shiftwork, infrequency of training opportunities, and limited resources available (such as medication and equipment).[69] In addition, healthcare workers can face poor leadership and management, which results in insufficient support being provided, and can directly impact staff morale.[70,71]
- **Unsafe working environments:** Facilities fail to manage infections effectively, resulting in a higher risk of contracting diseases in the workplace. Additionally, insufficient security at health facilities significantly endangers nurses, paramedics, and other medical staff.
- **Lack of performance monitoring and appraisals.** When employers implement performance appraisals, employees receive detailed feedback on their performance and are informed of decisions regarding salary increases, bonuses, and dismissals. A lack of performance appraisals can lead to unclear reward systems, the inability to establish and apply quality standards, and the absence of clearly stipulated objectives. Consequently, this may cause a decrease in workforce motivation and a deterioration in quality standards.[72]

Recommendations for Keeping our Health Workforce Happy and Motivated

Keeping the health workforce motivated is crucial for maintaining high standards of patient care. A happy and motivated health workforce enhances the quality of care provided to patients and can contribute to a positive work environment, leading to better overall health outcomes. The DA will ensure our health workforce is motivated by:

- **Implementing promotions that are based on merit rather than length of service.**
- **Implementing recognition programmes** to ensure that high-performing medical staff are recognised for their contribution. Recognition programmes can boost morale and assist in retaining health workers.[73]
- **Implementing reward systems such as performance bonuses at all public facilities** to promote and encourage high performance. Incentives can play an important role in job satisfaction.[74]
- **Encouraging open communication between entry-level health workers and senior managers.** Getting the health workforce on board with decisions is key to successful implementation. It will also foster a sense of belonging and purpose in hospitals and clinics where all voices are heard. Additionally, open lines of communication will ensure that concerns and needs are clearly communicated and addressed.[75] Management of health facilities must respond quickly to issues raised and provide support to team members where required.

- **Investing in the training and development of health workers.** Implementing annual training sessions would assist health workers in continuous upskilling. Consistent training would improve the quality of healthcare provided and reduce high employee turnover. A study involving 855 South African healthcare workers examined the impact of various factors on job preferences in the workplace. Factors included the workplace culture, salary, benefits, workload, and equipment. The study found that opportunities for training and development were key factors influencing job preferences, ranking more highly than the type of healthcare facility the employer worked at or whether the employment was in the public or private sector.[76]
- **Implementing legislation training for all healthcare professionals and administrative staff.** Introducing mandatory legislation training would assist the Department of Health in upholding health standards and prevent malpractice by ensuring that all staff are aware of relevant legislative provisions and protocols.

Background: The Private Health Sector

The private sector income sources include individual contributions[12] to medical schemes, vertical cross-subsidies and tax credits.[13] Medical schemes that are not for profit currently cover around 9 million people. These non-profit schemes are split into two types: open schemes[14] and non-competing restricted schemes (Table 1). Open schemes, which compete in the market, are legally required to accept all applicants without discrimination based on health status. By law, all these insurance schemes must treat all members equally in terms of pricing (known as community rating) and must cover a basic set of essential health benefits for everyone, also known as prescribed minimum benefits or PMBs.

Figure 3: An Overview of South Africa's Health System (with the Distribution of Expenditure as a Percentage of GDP, 2022/23)[77,78,79,80,81]

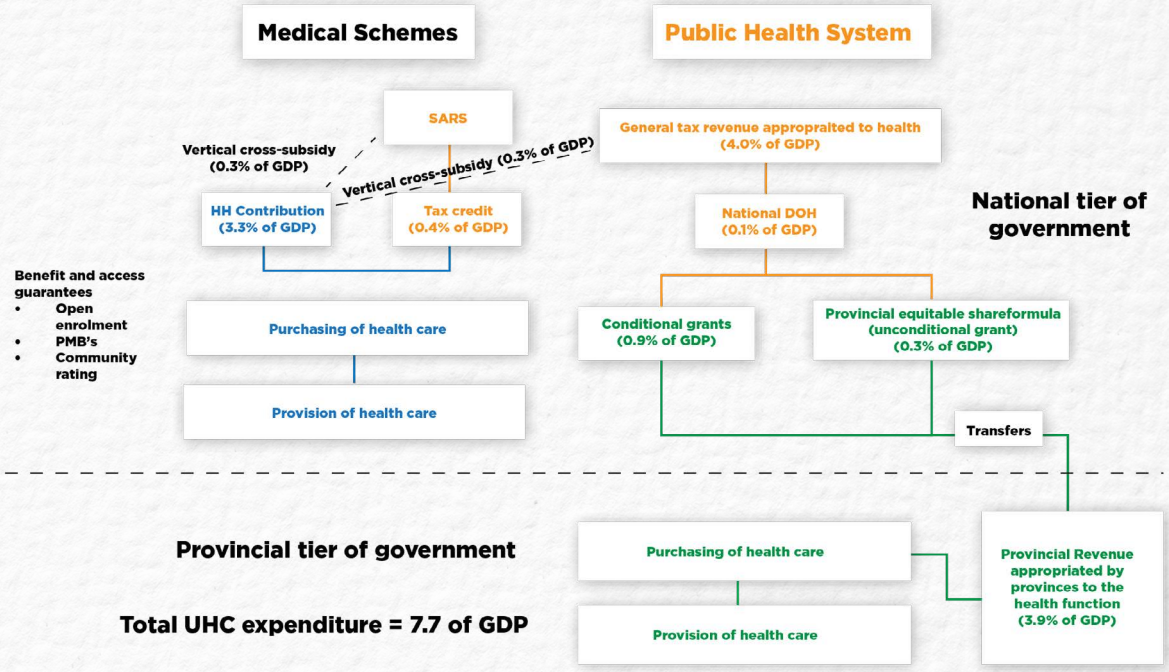


Figure 3 provides an overview of South Africa's Health System, including the expenditure as a percentage of GDP for the 2022/23 financial year, classifying between different schemes and levels of government. Figure 3 shows that medical schemes have three financial sources for purchasing health care. These include Household (HH) Contribution, which is 3.3 percent of GDP, vertical cross-subsidy at 0.3 percent, and tax credit at 0.4 percent of GDP. This section also notes benefit and access guarantees such as open enrolment, prescribed minimum benefits (PMBs), and community rating.

The public health system is funded by general tax revenue appropriated to health at 4.0 percent of GDP, which is channelled to the National Department of Health (DoH) at 0.1 percent of GDP and conditional grants at 0.9 percent of GDP. Lastly, the national tier of government receives a Provincial Equitable Share Formula at 3.0 percent of GDP as an unconditional grant. This is used for purchasing and the provision of health care.

[12] Individual contributions refer to household contributions (such as their premiums) to medical schemes.
[13] Tax credits refer to the provision in the tax code that allows taxpayers to subtract a certain amount from the taxes they owe to the government. Tax credits are designed to encourage certain behaviours or investments. In this case, it is used to encourage individuals to subscribe to a medical scheme.
[14] These schemes offer coverage to multiple employers and individuals.

Provincial governments receive transfers, and provincial revenue appropriated by provinces to the health function; this currently stands at 3.9 percent of GDP. The horizontal arrow shows the flow of funds and responsibilities from different tiers of government and schemes to the actual purchasing and provision of health care services. The total universal health care expenditure is summarised at the bottom as 7.7 percent of GDP.

Figure 3 shows that the combined efforts of various funding sources and government tiers contribute to a health system that aims for Universal Health Coverage.

Together, public and private healthcare subsystems technically achieve universal coverage with one of the lowest levels of out-of-pocket expenditure in any country.[82] Out of 187 countries listed by the World Health Organisation (WHO), South Africa has the 11th lowest out-of-pocket expenditure at 5.4 percent of total health expenditure. This is a testament to the large public sector allocations to health, equivalent to 4.0 percent of GDP, and the extent of pre-paid (insurance-related) coverage attained through medical schemes with expenditure equivalent to 3.7 percent of GDP (Table 1 and Figure 2).

The issue, however, emerges when there is a significant disparity in healthcare quality between the public and private sectors. This situation forces most South Africans to choose between utilising inadequate healthcare services in an overwhelmed public system or incurring high costs for medical aid coverage.

As a result of the high costs of medical aid in South Africa, the uptake of medical aid coverage is relatively poor and serves only 9 million of the population (Table 1). From 2002 until 2020, the average number of covered people decreased from 15.9 percent to 15.2 percent. According to Statistics South Africa (Stats SA), coverage has reached its lowest recorded levels.[83] Considering that South Africans are experiencing a rising cost-of-living, the costs of private medical aid are becoming unaffordable. For example, the costs of entry-level medical aid plans in 2023 ranged from R986 (Discovery)[84], R1 424 (Momentum)[85] and R1 338 (Bonitas)[86]. Many South Africans struggle to afford these rates, as illustrated by the decline in the number of persons with medical aid coverage.

Figure 4: Percentage of Individuals who are Members of Medical Aid Schemes per Province, 2022[87]

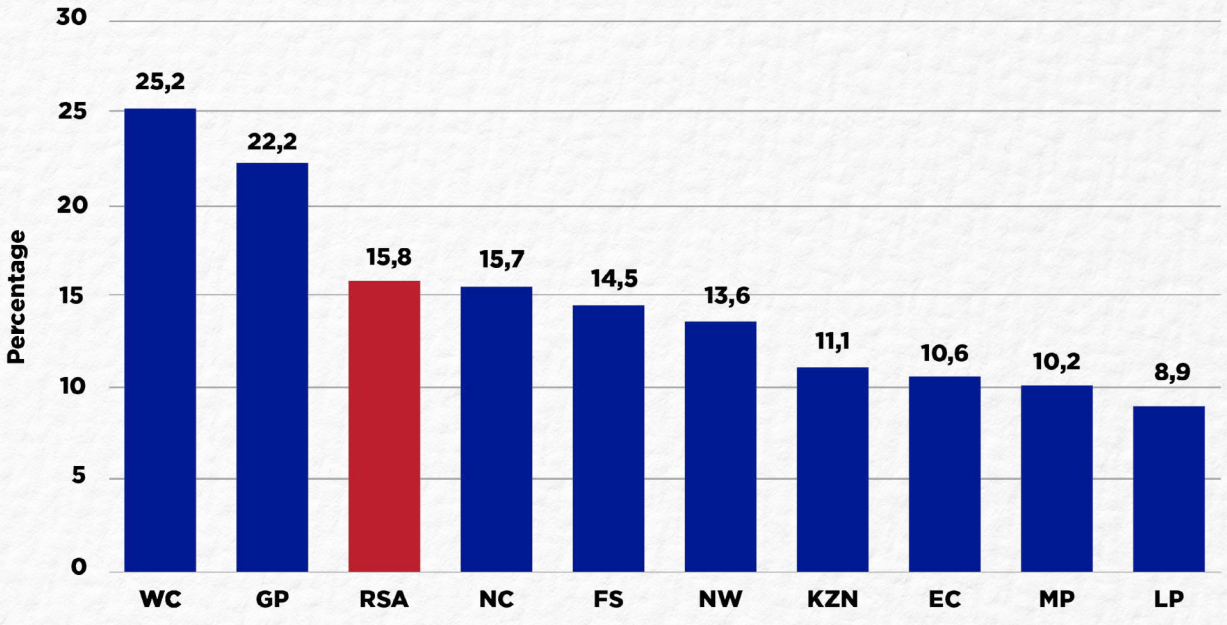
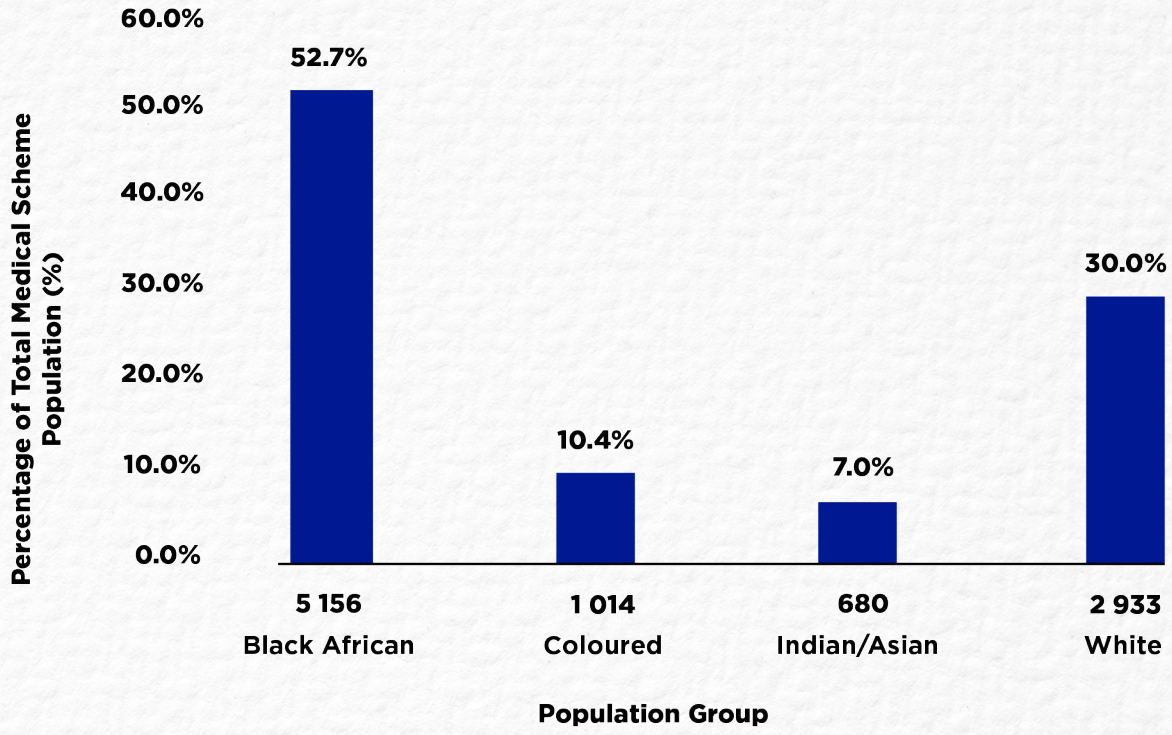


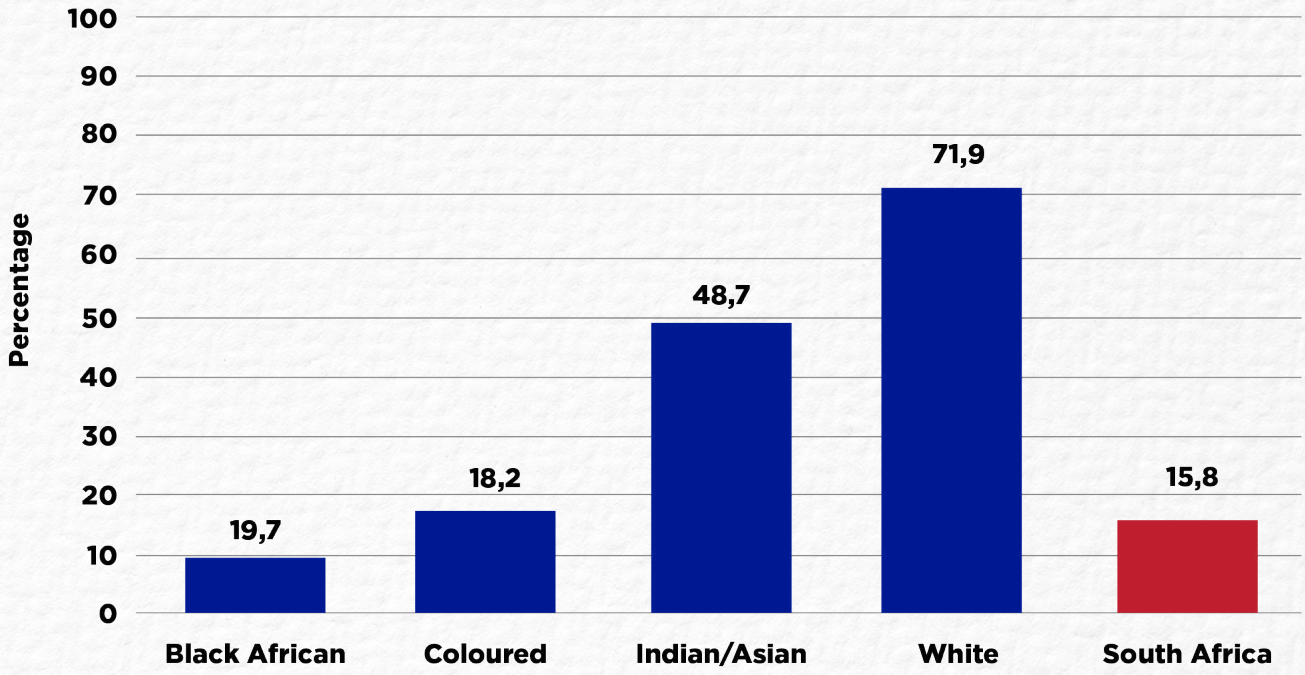
Figure 4 illustrates the percentage of persons covered by medical aid per province. The geographical divide in terms of healthcare access is clear in this graph, as those who live in more rural provinces such as Limpopo and Mpumalanga have the least medical aid coverage, whereas those living in more developed provinces such as Gauteng and the Western Cape have the most.

Figure 5: Percentage of Individuals who are Members of Medical Aid Schemes by Population Group, 2024[88]



As Figure 5 illustrates, the largest number of beneficiaries of medical aid is those who identify as "Black Africans". However, the **difference in access to medical aid between racial groups represents a socioeconomic divide in healthcare.** Figure 6 represents the percentage of each population group being a member of a medical aid scheme. Those who are better off can afford private medical aid, leaving the majority of people experiencing poverty, most of whom are black South Africans, without the financial ability to access private medical aid coverage. Interventions need to be implemented to lower the cost of private healthcare services.

Figure 6: Percentage of Individuals who are Members of Medical Aid Schemes by Population Group, 2022[89]



It holds true that many South Africans choose not to have medical aid because they can afford to pay out-of-pocket for healthcare services. However, the increasing unemployment rate, combined with inflation, cannot be overlooked. The reality is that many South Africans are struggling to keep up with the rising cost-of-living. As a result, medical aid, for many, has become a luxury. According to Stats SA, in the fourth quarter of 2023, the unemployment rate was 32.1 percent.[90] Additionally, the trends in grant beneficiaries show that the number of individuals dependent on the state for assistance is increasing.

To illustrate this trend, the number of beneficiaries dependent on the South African Social Security Agency for grants increased from 16.9 million in 2015/16 to 18.6 million in 2021/22 and 18.8 million in 2022/23.[91,92] This means that one in three South Africans is dependent on grants. Despite the socio-economic context, medical aid coverage increased incrementally amongst all racial groups between 2020 and 2022.

Market Failures in The Private Sector

Market failures can be divided into three main features:

1. Pooling failures: In insurance, 'pooling' is spreading risk across a large group of people. A pooling failure means that this risk-spreading does not work effectively. The schemes can use indirect methods to manage this risk, such as designing their insurance products in specific ways or adding complexity to products. This refers to a situation where 'bad risks', or individuals more likely to require healthcare services (due to age, pre-existing conditions, etc.), are systematically excluded from coverage.

2. Purchasing failures: This reflects a failure in how health insurance is purchased, as insurance providers compete against each other based on trying to attract the healthiest individuals (therefore saving on paying out medical fees) instead of competing based on providing the best comprehensive healthcare packages. Under existing regulations, it is easier for these schemes to compete by adjusting the price of their insurance products or marketing their products to attract healthier individuals, often at the expense of coverage quality, especially for high-risk groups. This results in a lack of competition in the private health system.

The failure of both pooling and purchasing results in diminished motivation for insurers to improve their coverage. Rather than providing better healthcare or more comprehensive coverage, they may develop schemes to attract healthy individuals who are less likely to utilise healthcare services. This can lead to a lack of genuine competition, which is not based on quality and cost-effectiveness but instead on attracting healthier individuals. This can lead to a general decline in the quality of health insurance products available.

As a result, those who need insurance the most might find quality packages, or their coverage might be prohibitively expensive. Exclusion based on risk is a significant issue in the insurance industry because it defeats the purpose of risk pooling, which is to make healthcare accessible to all, including those with high health risks.

Both pooling and purchasing failures result in medical schemes facing demographic risk, which refers to the varying health risks and costs associated with different groups of people. For example, older populations might have more significant healthcare needs than younger ones. These risks are uneven and not entirely under the control of the medical schemes.

3. Supplier-induced demand: A "supplier-induced demand" is where providers might artificially influence the demand for their services. In most cases, the supplier (health practitioner) advises on the need for services and supplies the recommended service. Since providers' earnings are based on the number of services they provide, there is a profit-maximising incentive to recommend more services, not less.[93] For example, providers can order unnecessary blood tests or admit patients to the hospital for more extended periods.[94] 'Supplier-induced demand' exposes the system to continuous increases in service demand, followed by provider costs, which increase the overall cost of healthcare without corresponding improvements in quality or efficiency.

DA Policy Recommendations: Enhancing Private Sector Competition for the Realisation of Universal Health Coverage

The DA is committed to **universal access to healthcare for all** citizens. The key to achieving this over the next five years is to make the current district management model work through governance reform. We argue that by leveraging the **strengths of the private sector**, such as its extensive professionalised and specialised staff and access to state-of-the-art technologies, in partnership with the public sector, we can improve health facilities and the quality of care for all.

The DA will ensure that all South Africans, regardless of income and health status, have access to sustainable Universal Health Coverage. We will develop a clear and guaranteed package of services that will be regularly updated, considering public preferences and evidence-related factors. We will introduce social reinsurance and implement a risk equalisation mechanism. This will be done by:

- **Introducing social reinsurance for medical schemes.** The solution to pooling problems and the consequences of demographic risk management in private health insurance markets is establishing schemes that can transfer the risks that individual insurers find challenging to cover. Instead of relying on private companies for this (reinsurance), a publicly run program will be established. All primary insurers (medical schemes) would need to be a part of this program. Social re-insurance ensures that we maintain the regular insurance market but still achieve the goal of bringing together risks into one larger insurance fund. The social reinsurance arrangement should lower the barriers to entry of new medical schemes into the market, increasing competitive pressure on incumbents and reversing existing high levels of market concentration amongst funders (medical schemes, administrators, and managed care companies).
    - **This will function as a public secondary insurer.** Social reinsurance works by reimbursing actual expenses for expensive medical claims after they occur. See Figure 7 below. Currently, medical aid companies reduce the benefits they offer, making it profitable to take on high-risk customers. Establishing a public secondary insurer for medical aid companies will address pooling failures by lowering the risk they take when considering high-risk customers.
- **Introducing a risk-equalisation plan for medical schemes.** Risk equalisation plans involve transferring funds between different health insurance plans to adjust for the expected costs of medical care. This is done in advance and is based on the average costs for a set of essential services for a population. The goal is to treat all insurance plans as part of one large fund. This helps prevent individual plans from favouring healthier individuals over those with higher health risks. Instead, it encourages insurers to focus on managing costs and providing quality coverage to compete with other plans. See Figure 8 below.

Risk-equalisation means that high-risk customers will have more benefits at a reduced cost, and medical schemes will still be profitable. This will address the problem of private secondary insurers in the market, where medical aid reduces benefits for primary insurers (households) because taking on such high-risk cases is not profitable. Our plan will enhance healthcare coverage without overhauling the entire system. Figure 7 below illustrates the private sector system framework.

Figure 7: DA Model: Reforming the Private Sector Health Framework

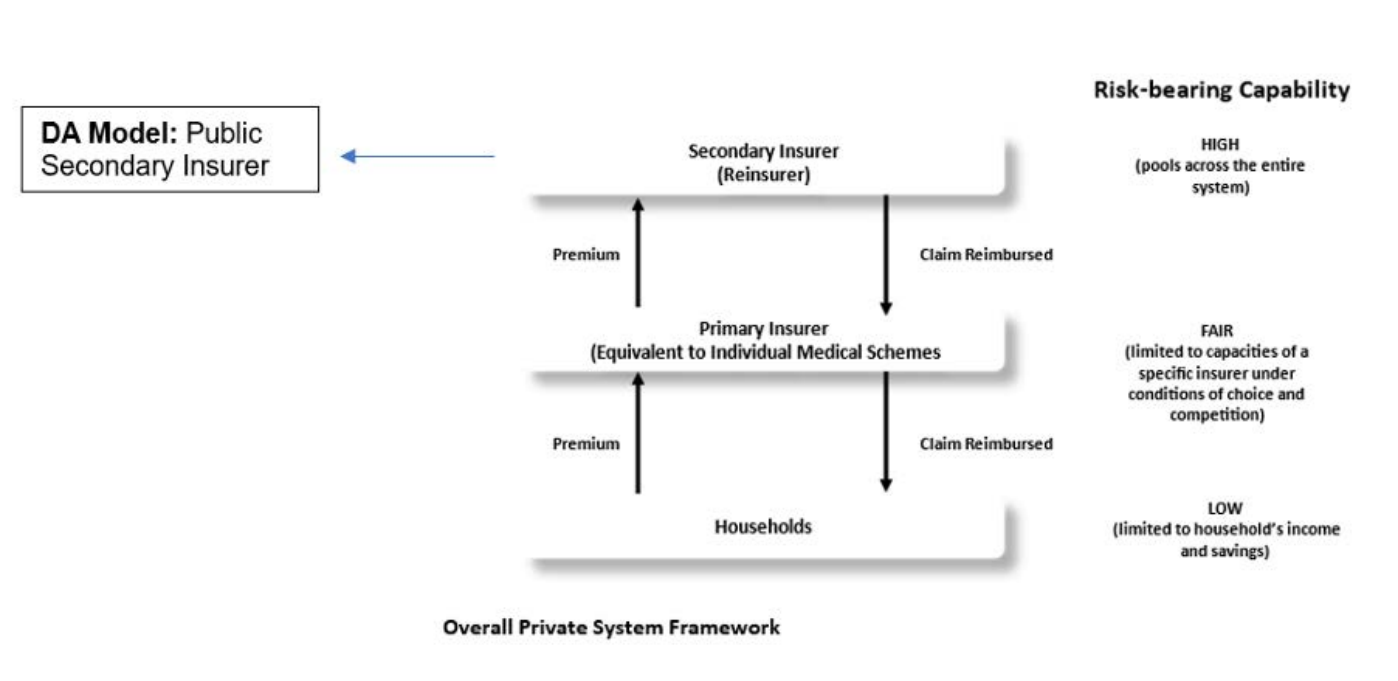


Figure 8: Strategic Pooling Framework for Medical Schemes

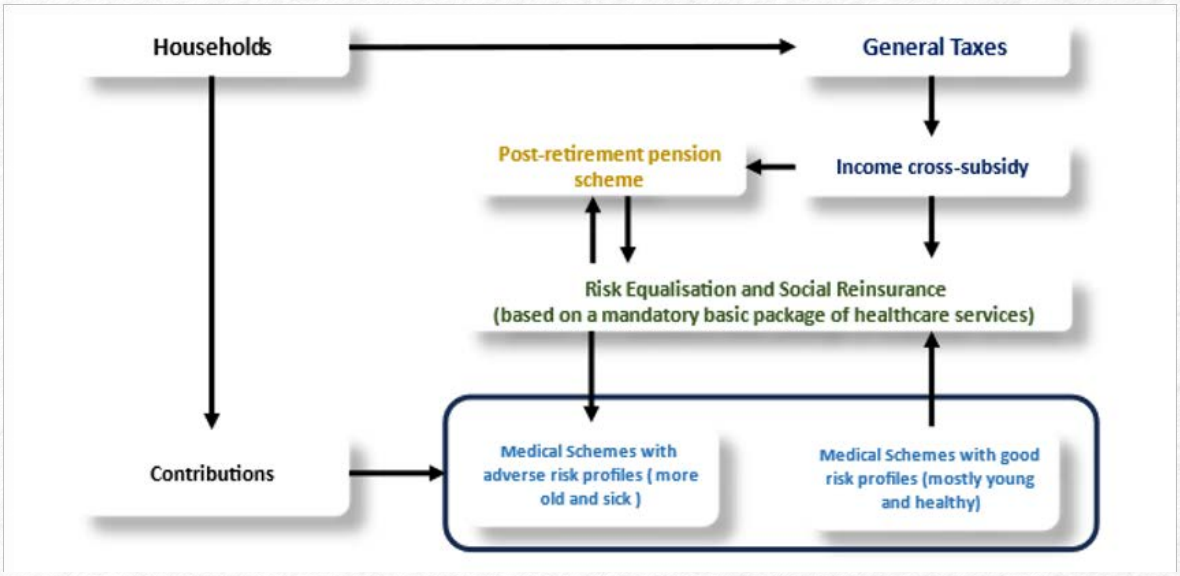


Figure 8 above shows the framework being proposed. In addition to risk equalisation, the DA will further enhance UHC by:

- **Implementing mandatory medical scheme membership for individuals earning above a pre-determined threshold.** This will reduce the burden placed on the public sector, thereby freeing up public sector resources to provide better services to citizens who use the public healthcare system.

- **Implementing an income cross-subsidy.** This new subsidy would be based on a person's income and assist lower-income groups with healthcare expenses. Instead of directly giving this subsidy to individuals, it would be provided indirectly to the medical insurance plans

they are a part of. This indirect subsidy would be managed through a secondary insurer and would be part of a system called "risk equalisation," which aims to ensure that the costs are spread fairly among different insurance plans.

- **Including post-retirement protection for pensioners (high-risk customers).** To ensure lifelong coverage in the system of medical schemes, we propose a system of cross-subsidies[15] be developed to subsidise contributions in the post-retirement period.

- **Ensuring data-sharing between private and public facilities** for UHC planning purposes.

[15]Cross-subsidisation is often used to promote fairness and equity in healthcare by spreading the financial burden more evenly across a diverse population, allowing everyone to access healthcare services when needed. This will be funded through general taxes.

Objective 2:
Enhancing Quality of Care and Patient Safety

Our second policy objective aims to enhance quality healthcare and patient safety. Regardless of their background or economic status, every individual must have access to the healthcare services they need. We believe that the quality of our healthcare services can be significantly enhanced by ensuring we have effective monitoring and evaluation processes in place to ensure that health facilities operate with a certain standard of care. This begins by ensuring we have a strong health ombud that can effectively monitor and evaluate healthcare services in South Africa and has the power to rectify facility shortcomings.

Poor Monitoring of Quality Healthcare Services

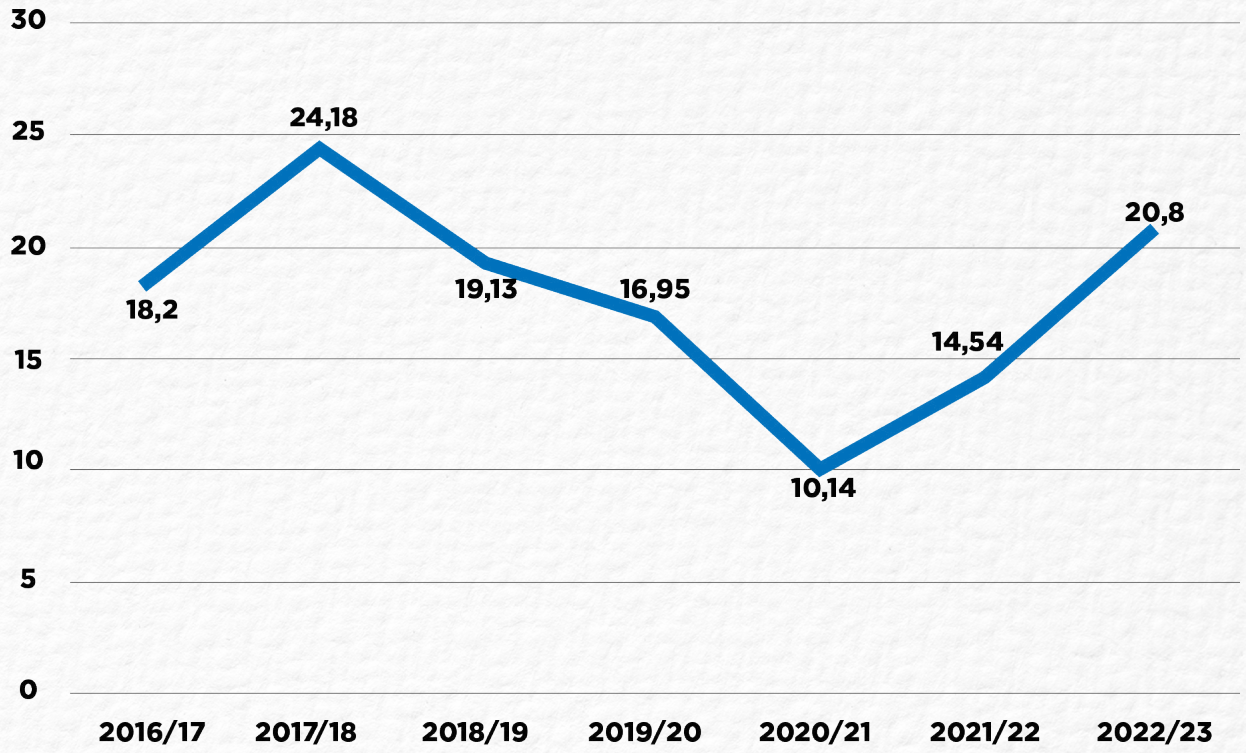
The existing model of quality assurance implemented through the Office of the OHSC is insufficient to institutionalise higher standards of care provision in both the public and private sectors. This failure is due to the following:

- **The body cannot be considered independent**, as political appointments are made to supervise and manage the organisation.
- **The quality assurance methodology fails to track health outcomes** and to incentivise improvements in the quality of care provided.
- **Detailed audits of health facilities are not publicly available.**
- **Due to a general culture of impunity, where adverse findings are made, health authorities fail to take appropriate corrective action.**
- CEO's are not held accountable for non-compliance with quality assurance standards.
- **The organisation cannot audit all facilities routinely** – leaving poor performance undetected for considerable periods.

In 2013, the OHSC was established to independently "monitor and enforce quality standards in health establishments."[95] In the 2021/2022 financial year, the number of facilities monitored increased marginally to 14.54 percent of health facilities, which means that only 544 out of the 3741 health facilities in the public sector were effectively monitored.[96]

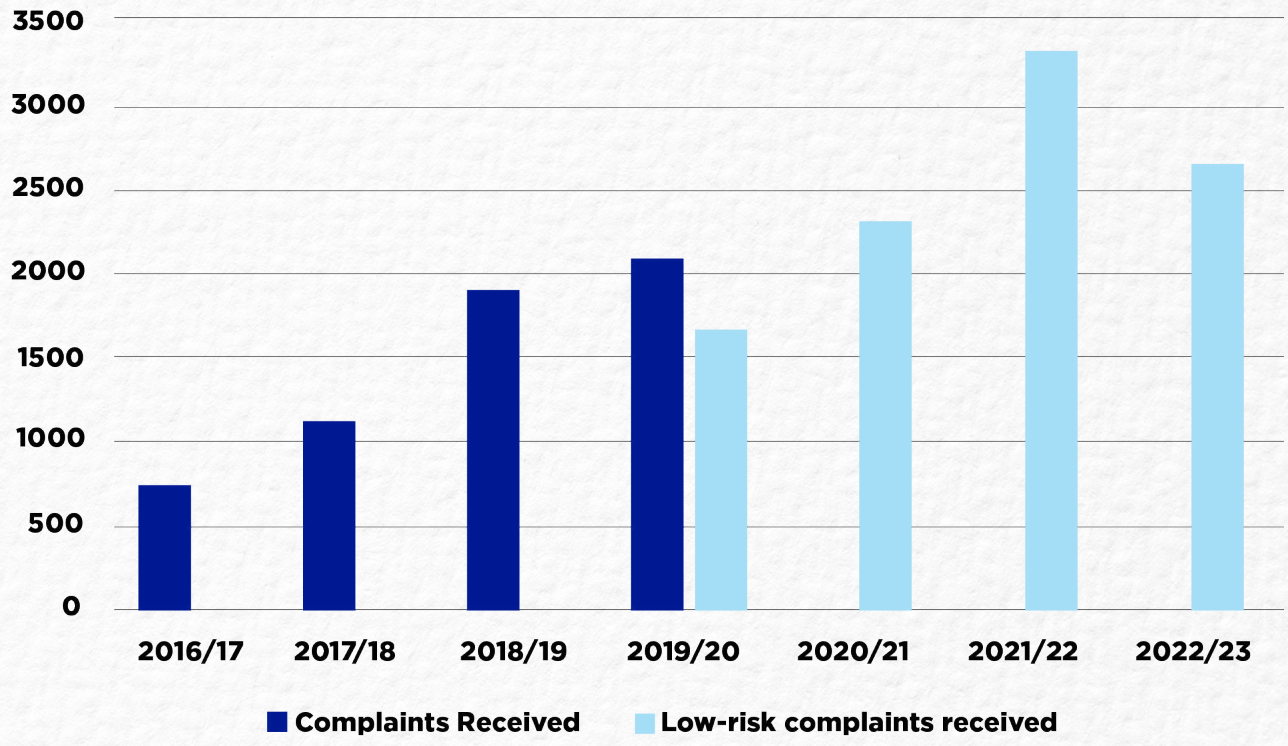
The Health Compliance Monitoring Trend: The OHSC's monitoring capacity is weak and inconsistent, while complaints received are on the rise.[97]

Figure 9: Percentage of Public Health Establishments Inspected, 2016-2022[98]



Since 2020, COVID-19 has been used as an excuse for under-spending and under-performance of the OHSC. However, as Figure 9 illustrates, the declining trend in monitoring and performance began before COVID-19 hit our shores. The OHSC cannot inspect even close to 50 percent of public health facilities, and completely omits private health facilities.

Figure 10: Number of Complaints Received, 2016-2021[99,100,101,102]



To note, the reporting style for complaints changed between 2019/20 and 2020/21. Total complaints are no longer shown (as was the case for years 2016 to 2019); instead, performance is the focus (e.g., percentage of low-risk complaints dealt with within 25 working days).

Figure 10 illustrates the annual increase in complaints received by the OHSC. Between the 2016/17 (730 complaints) and 2022/23 (2647) financial years, there was a 262 percent increase in complaints.

A consistent increase in complaints is representative of the health system's dire decline.

Recommendations for Increasing Compliance Monitoring

The DA will enhance the evaluation and monitoring of the OHSC by:

- **Ensuring that the OHSC is appointed by the NHAA and not the Minister of Health.** This will remove all political influence in such appointments.
- **Placing the OHSC under independent supervision.** As stated under Objective 1, the OHSC will report to the Independent Watchdog for Health Entities (also known as supervisory structures).
- **Fully capacitating the OHSC** to monitor the quality of health services before, during, and after they are provided, regardless of whether they are offered in the public or private sectors.
- **Ensuring that the OHSC is independent of the executive**, it is appropriately capacitated, and an enhanced quality review framework is developed.
- **Enhancing OHSC's power to take corrective action on their audit findings.** These can be directed at any part of the health system.
- **Implementing a system of administrative penalties for non-compliance** with health facilities in instances where they fail to implement recommendations of the OHSC facilities report.
- **Ensuring all information generated by the OHSC is made available to the general public.** Currently, no finalised investigation reports of facilities that received complaints are publicly available on the OHSC website.
- **Implementing a mentor programme for the training of junior inspectors.** Mentorship would provide a work opportunity for graduates and ensure that when senior inspectors leave, someone will replace them quickly to prevent inspection delays. Mentor programmes in the workplace positively contribute to skills development, succession planning, and leadership development.[103]

High Medico-Legal Claims

Medico-legal claims are skyrocketing and pose a significant threat to the fiscus. The increasing costs of medical litigation could be better used to offer quality services. Instead, scarce resources are being used to pay for medico-legal fees. Figure 12 below illustrates the payments made by the DoH for medical negligence claims.

Figure 12: Medical Claims Paid, 2012-2020[104]

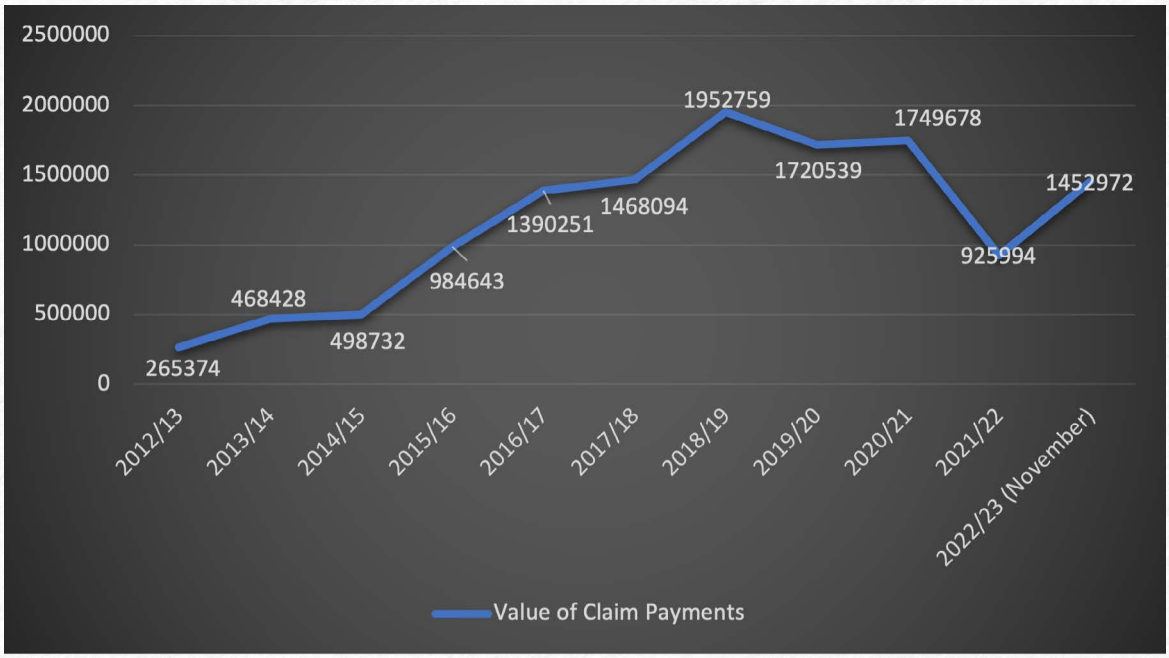


Figure 12 figures are enumerated in 'millions'. Of particular concern is the significant spike in payments made for medical negligence claims during the 2018/19 period, amounting to nearly R2 billion. This substantial sum reflects a worrisome trend within the healthcare sector. There has been a 36.8 percent increase in medico-legal claims since 2012. [105]

Furthermore, the growth of contingent claims (still awaiting legal outcomes) is particularly alarming. These claims have escalated from R28.6 billion in 2014/15 to R120.3 billion in 2020/21.[106] A significant increase in contingent claims indicates a considerable backlog of unresolved cases within the legal system. The simultaneous rise in both contingent claims and medical claims serves as a clear indicator of the deteriorating state of the health system.

Reasons for Increasing Medico-Legal Claims

The rise in medico-legal claims can be attributed to various challenges identified in the healthcare sector. These include, but are not limited to, governance failures, deficiencies in quality control, inadequate mechanisms for monitoring and evaluation, staffing shortages and faulty equipment. The failure of all of these can have life-changing, yet preventable, consequences.

To illustrate the extent of such consequences, in 2005, a healthy baby boy was deprived of oxygen during birth,[107] resulting in cerebral palsy. A would-be healthy child has been deprived of a healthy and happy life due to negligent actions by medical professionals. In August 2022, 17 years later, Judge LR Adams ordered 100 percent payment for damages the child had suffered during birth. What is distressing to know is that the boy and his family have suffered all these years without financial assistance to support him during his daily struggles.

In relation to medico-legal claims specifically, distinct challenges warrant attention. These challenges are directly linked to the occurrence of such claims and have a significant impact on the healthcare system. The challenges are as follows:

1. Unintended Consequences of the Consumer Protection Act, 68 of 2008:

Healthcare workers are bound by the Consumer Protection Act, which allows 'goods' within the act to include medical products such as anaesthetics or medication and 'suppliers' to refer to medical practitioners. The definition means that if a medical practitioner (a supplier) administers

faulty medication (a good), they can be held liable under the Consumer Protection Act.[108]

Therefore, medical practitioners take risks that are out of their control, such as failing equipment or default medication, which can result in medical malpractice lawsuits. For private practices, this has a knock-on effect on indemnity insurance costs. Increased indemnity costs can push doctors out of specific specialisations, as the increased risk and costs are not worth practising.[109] Consequently, it can result in a shortage of medical practitioners in specialised fields. For private obstetricians, indemnity insurance costs increased from R250 000 in 2013 to R850 000 in 2017.[110] Increasing costs for insurance in the private sector and poor working conditions in the public sector will either drive medical practitioners out of the industry[111] or reduce the number of procedures a practitioner is willing to perform. For example, should a practitioner be unable to afford the costs of indemnity insurance, they might choose instead to avoid performing 'risky' procedures, ultimately reducing the access to certain specialised services they historically provided.[112]

2. Colluding for a Payout:

The healthcare sector in South Africa is currently facing a profound ethical crisis. Disturbingly, there have been instances of collusion among state attorneys, medical practitioners, and legal representatives to defraud the state by submitting illegitimate medical claims and sharing the payout.[113,114] This unethical behaviour has resulted in the loss of excessive amounts of money.

By the end of 2022, President Ramaphosa recognised the severity of this problem and requested the SIU conduct a comprehensive investigation across all nine provinces. The primary objective of this investigation was to uncover public officials, medical practitioners, and legal professionals involved in fraudulent activities, seeking personal financial gain through fraudulent medical malpractice claims.[115] The total amount under investigation by the SIU is R79.2 billion, with R500 million directly linked to the conduct of state attorneys in relation to medical negligence and legal service claims.[116]

In 2019, a striking example of such fraudulent activity occurred when a lawyer filed 6 false claims of cerebral palsy, amounting to R90 million. This case illustrates the extent to which people will go to manipulate the system for personal gain. Addressing this crisis of ethics within the healthcare sector is of the utmost importance.

3. Long Average Claim Times:

The average time it takes for a claim to be finalised is 9 years. The challenge with such a long timeframe is that it becomes difficult to prove or disprove the damages caused. Tragic health outcomes further complicate matters, as patients are required to demonstrate that adverse events were a direct result of substandard care. Practitioners cannot be held accountable for adverse effects alone, and the mere presence of adverse effects does not automatically imply negligence. Consequently, patients are tasked with the arduous burden of proving negligence in such cases.[117]

Another factor contributing to the lengthy claims process is the necessity for expert medical evidence. Given the advanced nature of medical interventions and treatments, providing comprehensive and specialised medical expertise is crucial in substantiating claims. Including expert medical evidence plays a pivotal role in supporting the claims made by patients and is an essential aspect of the overall claims process. An additional challenge in this process is that patients might find it difficult to obtain such medical expertise in their trial as practitioners are reluctant to testify due to the inconvenience it would entail due to lengthy and time-consuming court proceedings.[118]

4. The State-Liability Act of 1957:

The legal basis for resolving claims against the state can be found in the State Liability Act.[119] However, this Act's primary focus is to manage the financial impact of increasing claims, and therefore effectively regulates the costs of medico-legal claims; it fails to address the reasons

the claims happen in the first place.

Adopting a broader policy approach that goes beyond just the cost control of medico-legal claims is needed to effectively address the issue of negligence, improving patient care and reducing the need for after-the-fact crisis management. This would require improvements across the entire healthcare system to ensure enhanced service quality, as discussed under various sections in this policy paper (such as governance reforms, discussed under Objective 1 and enhancing compliance monitoring by the OHSC).

Table 2: The Value of Medico-Legal Claims Per Province[120]

Province	Total value of medio-legal claims		
	2023	2022	2021
LP	Audit outstanding	8 334 914	11 939 334
KZN	7 342 190	13 180 222	25 244 438
MP	7 049 098	7 716 031	9 543 267
NC	600 611	1 520 424	1 656 795
FS	5 130 112	4 663 463	4 501 077
NW	3 393 104	3 589 144	5 582 950
EC	26 345 655	25 076 798	38 608 606
GP	18 152 738	17 542 171	24 494 229
WP	0	186 532	229 655

The Western Cape had the lowest value of medico-legal claims in 2023, 2022, and 2021. The data in Table 2 is a testament to the Western Cape's outstanding performance within the provincial public health sector.

Recommendations for Reducing High Medico-Legal Claims

The drastic increase in medico-legal claims is a direct result of the ANC's decades of poor governance in the health sector. Lives are being lost due to sheer incompetence and a lack of political will to rectify performance failures. Policy reforms that focus on reducing sub-standard care must be implemented to reduce the high medico-legal claims.[121] Ultimately, the best quality of services needs to be provided. Considering the above, the DA will address the challenge of increasing medico-legal claims by:

- **Introducing compulsory mediation processes** before commencing with court proceedings. Solving cases during the mediation stage could save legal costs and time.
- **Establishing a medico-litigation centre** responsible for mediation, tracking and managing claims, and monitoring disciplinary procedures.[123] Establishing a dedicated medico-litigation centre using clinical advisors, a case management team, and legal officers offers a comprehensive solution to address the challenge of lengthy waiting times in medico-legal cases.[124] This approach expedites the claims process and serves as a mechanism for oversight, promoting transparency and accountability in the healthcare sector. Furthermore, a maximum timeframe for a claim to be concluded should be established and supported by the centre.[125]
- **Over the long term, the DA will investigate the feasibility of introducing a no-fault claims mechanism,** as implemented in Sweden, through a council comprising an independent team of experienced clinicians, who will assess each adverse event and offer compensation where appropriate. This approach can be more efficient and less costly in providing patient compensation.[126]
- **Enhancing the capacity of the Office of Health Standards Compliance (OHSC),** which has been detailed in the previous section. The subsequent section (objective 2) outlines specific policy proposals to strengthen the OHSC.
- **Ensure proper deterrence mechanisms are implemented** to prevent collusion between state attorneys, patients and medical practitioners. The DA's Crime Prevention and Criminal Justice policy offers a variety of effective deterrence measures.

Poor Infection Control

Hospitals and clinics are struggling to maintain good hygiene practices and infection control. Those who are hospitalised experience a high risk of contracting a hospital-associated infection. The most common infections that spread in hospitals are viral respiratory infections (such as COVID-19, Influenza, and TB) and gastrointestinal pathogens.[127] The problem is worsened by hospitals and clinics lacking effective surveillance and infection control measures, ultimately increasing the risk of preventable diseases and deaths.[128]

A study conducted in neonatal wards in South African district and regional hospitals reported that 33.3 percent of patients caught pneumonia, and 20 percent acquired a bloodstream infection.[129] Regionally, hospital-associated infections are estimated to be between 3 and 15 percent.[130] A study examining the prevalence of hospital-associated infections showed that in middle and low-income economies, 10 out of every 100 patients catch at least one hospital-associated infection.[131] The vast difference between these estimates results from hospital-associated infections being an under-researched topic. Accurately quantifying the problem is, therefore, a challenge.

"Hospital associated infections is an unquantified burden in South Africa"[132]
- W. Lowman

Recommendations for Preventing Hospital Infections

The DA will address hospital-associated infections by:

- **Continuing the infection prevention protocols** implemented in hospitals and clinics since the start of the Covid-19 pandemic. These protocols should also apply to patients and visitors who enter the facility, especially in high-care wards. These include cough etiquette, wearing appropriate personal protective equipment, and frequent hand washing.[133,134]
- **Ensuring that all hospitals have an assigned infection control monitor or teams** trained, educated and responsible for monitoring and surveillance of infection and diseases at health facilities. Functions of these teams would include conducting annual hospital-associated infection risk assessments, putting plans together for preventable exposure to infections, implementing education programmes for staff within the facility, and overseeing infection control mechanisms that have been implemented.[135]
- **Specifying appropriate air conditioner and ultraviolet (UV) filtration mechanisms during the design phase of new healthcare facilities.**[136] Although air conditioners play a positive role in air ventilation, particles can still pass through some filters, affecting patients. With the rise of multi-resistant bacteria and the risk they pose to hospital infections, it is important to use UV filtration that works by damaging the DNA of bacteria, viruses and fungi, preventing them from multiplying.[137] Appropriate filtration mechanisms could, therefore, prevent the spread of diseases.

Healthcare Resource Shortages

Hospitals and clinics are battling persistent shortages of essential resources, including medications, medical supplies, beds, staff, and equipment. These shortages often stem from inadequate stock control measures and delays in placing necessary orders, leading to medication stock-outs.[138] Patients suffer the most, with resource shortages resulting in traumatic medical experiences, permanent disability and preventable deaths.[139] In a study conducted in 2019, which included 2 370 (out of the 3 547) health facilities, 864 (36.5 percent) reported medication stock-outs for TB and ARV treatment.[140] Patients in urgent need of their chronic medications cannot receive them at the relevant facilities.

In 2017, Morris Matamo underwent a colostomy at Chris Hani Baragwanath Hospital in Gauteng.[141] A colostomy is a procedure whereby an opening (called a stoma) is created for the colon or large intestine. After the procedure, the patient drains stool into an external bag attached to the stoma (known as a colostomy bag). The procedure itself is traumatising and humiliating.[142]

His experience was made worse by the hospital running out of stock of colostomy bags. He initially received 22 bags per month, but due to the shortages, he only received 2 bags. The hospital then decided to give him an alternative bag, which is used for urine drainage. Unfortunately, having an inappropriate colostomy bag resulted in leakage. As a result of procurement failures and stock shortages, patients like Morris are left without dignity.

Recommendations for Ensuring Health Facilities Have Enough Resources

Shortages of resources have been exacerbated by the ANC's chronic mismanagement, corruption and inefficiency. The DA will address these inefficiencies by:

- **Addressing resource shortages by optimising facility use.** This can be done by attracting different types of patients at certain times of the day, alleviating peak hours and the challenges that come with them (such as a shortage of beds or personnel).[143]
- **Ensuring every hospital has a qualified inventory manager** and is able to order directly from suppliers, subject to checks and balances, when the need arises. Good managers can effectively manage hospital resources and ensure their availability.
- **Implementing electronic medicine stock management systems**, where possible, to ensure a consistent supply of medications, especially in rural areas.[144] Additionally, a dashboard for each hospital and clinic, indicating stock levels of the most important medications at each level, will be implemented to ensure that stockouts of critical items are flagged immediately and dealt with quickly. The DA's ICT Policy provides further recommendations for expanding and enhancing e-government services, including increasing access to connectivity. This recommendation will be implemented with those found within the DA's ICT Policy.
- **Rooting out corruption** to address chronic facility mismanagement. This can be done through effective OHSC monitoring and evaluation. Should hospitals receive a declining review, interventions with the relevant hospital leadership must be considered.
- **Ensuring hospital managers and relevant provincial DoH conduct bi-annual demand analysis to assess and predict health demands.** Based on the demand, hospital managers and provincial departments must ensure that hospitals and clinics are well-equipped.

Objective 3:
Enhancing Access to Healthcare Services

The Democratic Alliance (DA) pledges to fulfil the rights outlined in sections 27 (1) and (3) of the South African Constitution, which guarantee everyone's access to healthcare services, including reproductive healthcare, and state that no one should be denied emergency medical treatment. For this reason, our third objective focuses on overcoming the challenges in accessing healthcare caused by geographical differences, shortages of human resources, the absence of essential services like emergency, child, and maternal healthcare, and the lack of Reciprocal Healthcare Agreements (RHA).

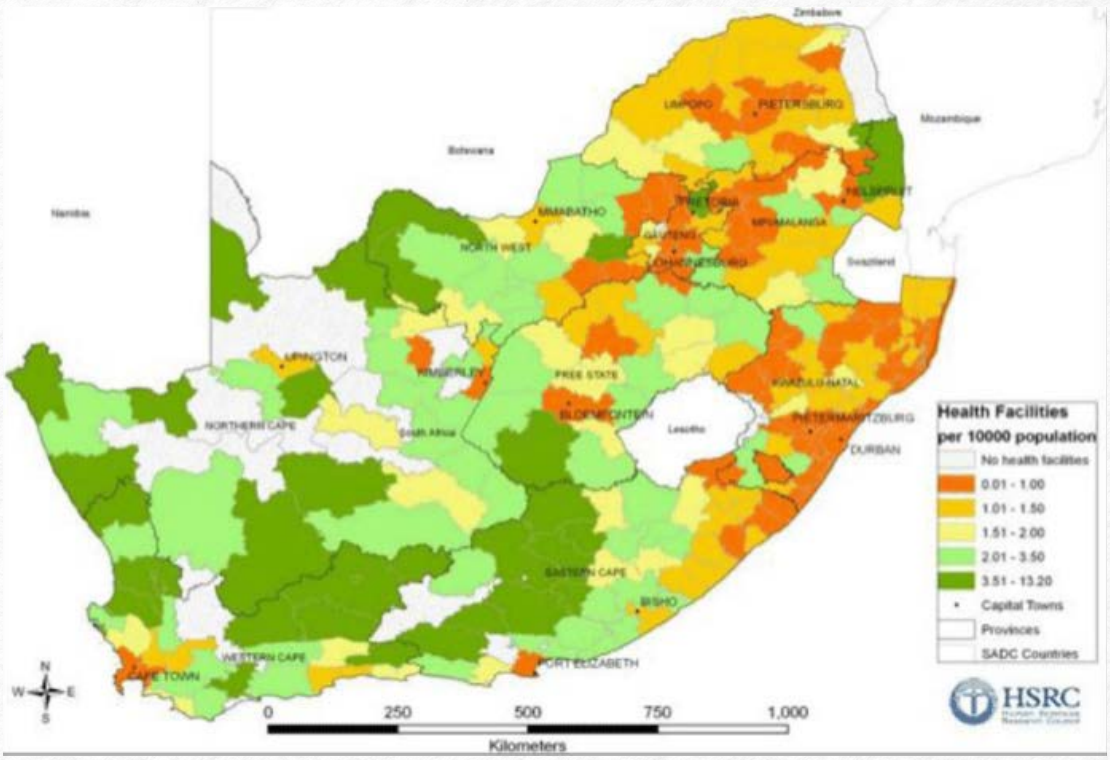
Geographical Challenges for Healthcare Access

The geographical location where individuals are born, reside, attend school, and work can significantly impede their access to healthcare services. These disparities in resources and healthcare quality are not limited to the distinction between public and private healthcare sectors but are also pronounced between rural and urban areas.[145] Such disparities impact the availability of care being provided in a given community. The availability of care refers to the location of facilities, their opening hours, waiting times, availability of medications, the range of services provided and the number of health workers employed.[146] This section will address the unique geographical issues hindering access to quality healthcare services. These issues are highlighted below:

1. Limited Availability of Care in Rural Areas

In South Africa, there are substantial disparities in the availability of primary healthcare and tertiary facilities for the population, depending on whether they are located in urban or rural areas. A comprehensive report conducted by the South African Human Sciences Research Council in 2012 examined the number of health facilities per 100 000 individuals across the country. See Figure 13 below.

Figure 13: Number of Facilities per 100 000 population[147]



Unfortunately, no recent, reliable data on facility disparities between urban and rural areas exists. However, the map provides an indication of the differences in the availability of healthcare facilities between geographical areas. Unfortunately, due to incompetent governance of the health sector, these disparities remain, with high-order public and private hospitals concentrated in urban areas. The consequence of these disparities is that many must travel beyond the recommended distance for clinics (5km) and hospitals (30km).[148]

2. Water Scarcity and Supply

South Africa is a water-scarce country, making it extremely difficult to ensure a consistent supply of safe and clean water to residents. Municipalities face several challenges resulting in poor water delivery services, including climate impacts, such as drought, increased water demand, illegal water connections, and deteriorating water infrastructure due to a chronic lack of investment.

The floods in Kwa-Zulu Natal in April 2022 are a good example of how the climate, particularly extreme weather conditions, can negatively affect the water supply. The floods caused severe damage to water and sanitation infrastructure, which resulted in an interrupted water supply. An interrupted water supply negatively affects healthcare workers' ability to effectively run their healthcare facilities, as a lack of water supply results in poor sanitation and an inability to control the spread of infections (as infection control measures such as hand washing cannot occur). This ultimately affects the quality of care that can be provided.

Furthermore, water is essential in the patient care process, as it is used for different purposes, including drinking water, food preparation, and personal hygiene. Patient health is threatened without adequate, reliable supplies of water because this makes the recovery of patients who are highly dependent on hydration or sanitation when sick or after surgical operations impossible. In the Eastern Cape, water restrictions are common due to persistent drought conditions.[149] In parts of Mpumalanga, residents were subjected to prolonged shortages for three months due to illegal connections in November 2022.[150] Proper sanitation practices are crucial for mitigating the spread of disease within health facilities. Without access to water, flushing of toilets becomes impossible, and wastewater cannot be effectively disposed of. This environment becomes unsanitary, increasing risks associated with existing health problems, and it may facilitate infection transmissions.

Poor management of water infrastructure and resources is reflected in preventable water shedding experienced in parts of the country.[151] Additionally, alarming data reveal a disheartening trend in water access from 2002 to 2022, with an average decline in 6 provinces. Significant decreases were observed in Mpumalanga, Limpopo, and Free State, where water access decreased by 3.8, 4.7, and 1.5 percentage points.[152] The water supply challenges have plagued the health sector as they impede service quality.

The challenges with water supply also led to service delivery protests, as seen in Vhembe District under the Thumalela Local Municipality. In 2023, frustrated residents resorted to vandalising water infrastructure at the Nandoni Dam.[153] These residents protested due to severe water supply issues. The vandalism of water infrastructure inflicted a direct blow on the water supply to hospitals in the area. The vandalism highlights the extreme consequences of a lack of access to basic services and demonstrates how such grievances can fuel civil unrest.

Policy Options for Addressing Geographical Challenges for Healthcare Access

The DA will address the geographical challenges that prevent adequate access to quality healthcare services by:

- **Enhancing the capacity of mobile health (telehealth or telemedicine) services in underserved communities** by equipping healthcare staff with telemedicine technologies and expertise.[154]
- **Prioritising departmental health budgets for mobile clinics in underserved regions,** which can effectively provide access to healthcare and provide more opportunities for underserved populations to screen for and manage existing health conditions.[155]

By scaling up successful models like Rwanda's 'Babyl', we shall be able to offer quality healthcare services, thus bridging the gap in rural healthcare delivery. The staff empowered with telemedicine will be able to do remote consultations, which provide for timely intervention and improved health outcomes of the rural and minority population. The advancement of mobile health services increases not only access to healthcare but also leads to improvement in care.

A Rwandan Telemedicine Success Story: The 'Babyl' Telehealth Service

Babylon was established in 2014 and is based in the United Kingdom. Babylon created Babyl, a mobile supplication that uses an Artificial Intelligence chatbot to assess healthcare needs. Babylon aims to enhance access to convenient and affordable healthcare in underserved areas.
The Rwandan Ministry for Health partnered with Babylon in 2018 to provide virtual healthcare services, referrals and prescriptions to address the high demand for these services in underserved areas.[156]

How It Works:

Patients begin by making an appointment by dialling a USSD code on their mobile device. Patients are then able to pay for their appointments using mobile money. The patient then receives a suggested appointment time via SMS. Subsequently, a nurse stationed at a Babyl call centre contacts the patient to assess if their condition qualifies for digital treatment, follow-up care, or a referral. Although initial advice is provided to all patients, digital treatment is restricted to a defined set of (mild) conditions that are typically managed within primary healthcare settings.

As of 2021, Babyl has successfully treated approximately 3000 patients daily and generated 300 job opportunities. One key factor contributing to its success is its partnerships with multiple pharmacies and laboratories. These partnerships have been effective in ensuring patients have access to legitimate e-prescriptions and that they can qualify for relevant laboratory tests. An unintended positive effect of Babyl's virtual care is establishing an efficient health record-keeping system. Lastly, the record-keeping system has the potential to identify health trends and potential outbreaks. For example, suppose many patients who use the virtual service show symptoms of a water-related disease. In that case, it can

be reported early on to the relevant department to investigate the source of the outbreak and prevent the spread of the disease.

Collaborative efforts with the Rwandan Ministry of Health have enabled seamless integration with existing care delivery systems and facilitated task-sharing among healthcare providers, ensuring the effectiveness of Babyl's services.

- **Ensuring municipal water supplies to hospitals are regularly monitored** to ensure they are pathogen-free.[157] See the DA's Environment Policy for comprehensive solutions to South Africa's water challenges.
- **Ensuring hospital management has well-defined risk assessment and mitigation plans** for water contamination, shortages, or disruptions. These plans may involve using backup temporary water tanks or reliable boreholes that meet quality standards.[158]
- **Establishing resilient health facilities by upgrading infrastructure in high-risk areas to withstand extreme weather effects and ensuring** facilities maintain an emergency stock of essential medical items.[159]
- **Establishing the Thunderbirds (a civil protection mechanism) to safeguard against disasters.** This mechanism's purpose would be to safeguard and provide timely emergency resources to municipalities to mitigate against natural disasters. This mechanism will be supported through international funding and through an opt-in system of municipal contributions.

The DA will engage in international diplomacy to secure a one-time grant or major endowment based on Articles 9 and 11 of the Paris Agreement. The Civil Protection Mechanism will consist of a fleet of highly specialised heavy assets with dedicated airlift capability. These resources will always be maintained in a high readiness state for deployment. The nationally deployable stand-by fleet will include emergency vehicles and air and ground assets specifically designed for disaster management responses.

The primary focus of the Thunderbirds Civil Protection Mechanism will be on disaster management, but it extends its influence to other sectors, including the health sector. Normally, pressure mounts on the health sector during disasters because of increased demand for emergency medical services, supplies, and facilities. The mere fact that there is a stand-by fleet of emergency vehicles and crews to service them means that resources can be rapidly deployed in an area with minimal time lost. This will support the health sector in providing timely and effective care to those who need it most during emergencies.

By investing in the establishment and capacity-building of the Thunderbirds Civil Protection Mechanism, South Africa demonstrates its commitment to protecting its citizens and supporting the health sector in times of crisis. It is a proactive approach that acknowledges the importance of disaster preparedness and emphasises the value of collaboration and resource-sharing among municipalities.

Health Workforce Shortages
The Problem: South Africa's Human Resource Crisis

A global shortage of 10 million health workers is predicted by 2030, with extreme shortages disproportionately affecting the African continent (the WHO African region is projected to constitute 52 percent of the global shortage by 2030).[160,161] A health sector cannot function optimally without its human capital. This means that human resource planning for health is important for securing access to quality healthcare services. South Africa has produced numerous human resource planning policies, the latest document being 'the 2030 Human Resources for Health Strategy' (2020). Unfortunately, South Africa's DoH is not implementing the existing Human Resources for Health (HRH) planning and policies.

Despite numerous HRH policies and strategies being developed, they have not resulted in effective HRH planning, with South Africa's HRH distribution uneven across the country. Rural areas experience more significant human resource shortages than urban areas, exacerbated by poor management and low retention rates[162] of the health workforce.

The performance of any health system is directly contingent on the quality of its health workforce. South Africa's health workforce is facing several challenges. These include:

- **An inability to collect health workforce information for HRH planning:** Health workforce information is not collated for monitoring and planning purposes, despite public and private systems allowing this. As a result, human resource plans are not adequately integrated with teaching and training platforms, student-related subsidies, the financing of in-service training and the financing of academic facilities at all levels of care. Without complete health information databases, strategic planning processes cannot be connected to their execution.

For instance, should South Africa experience a shortage of orthopaedic specialists, an effective health information system would highlight this deficit. Student subsidies should then be allocated towards those who intend to specialise in orthopaedics.

- **Poor HRH data collection results in an inappropriate skills supply** and a lack of nationally integrated supply-side planning based on such data.[163,164] Even though data can be collected from health professionals' registration bodies such as HPCSA, it does not consider health workers who have left South Africa.[165] Additionally, regulatory bodies do not account for whether health professionals are in the public or private sector or both.[166] At present, Community Health Workers (CHW) do not have a body where they need to register. This makes it increasingly difficult to predict demand and ensure supply without having access to registered data for these professionals.

The data is, therefore, not entirely accurate and poses a challenge for good HRH planning. For example, South Africa's bursaries, such as NSFAS, should offer funding for in-demand medical courses if there is a supply need for more general practitioners than nurses. Proper HRH planning can only occur if there is reliable HRH data.

South Africa does not have an up-to-date, accurate HRH information system suitable for evidence-based HRH planning and management.[167]

1. **Shortage of health workers:** In 2019 South Africa had 0.79 doctors per 1000 inhabitants. This number has decreased, and in 2022, South Africa had only 0.31 doctors per 1000 inhabitants.[168] This is much lower than in other middle-income countries such as India, which

had 0.7 doctors per 1000 inhabitants in 2020, and Brazil, which had 2.1 doctors per 1000 inhabitants in 2021. The OECD average is 3.8 doctors per 1000 inhabitants, and the average for low-middle-income countries is 1.4.[169] A consequence of staff shortages is long patient waiting times, long working hours, and overtime for medical staff. As previously stated, in 2019, South Africa spent 9.2 percent of its GDP on healthcare. Unfortunately, this has not resulted in increased efficiency in the system. See table 3 below:

Table 3: Waiting Time per Level of Hospital, 2015[170]

Level of a hospital	Patient waiting time (in hours) for service/s per visit	Total time (in hours) spent by a patient per visit
Specialised hospitals	1	2
PHC facilities	2	3
District Hospitals	2	3
Regional Hospitals	3	4
Tertiary Hospitals	3	4

Table 3 shows the average hours a patient spends waiting for healthcare services at a public healthcare facility. Waiting times are no less than two hours and can be as long as 4 hours. COVID-19 has only exacerbated staff shortages and backlogs, with long waiting times likely to be a trend for years.

2. **Inability to absorb community service doctors and interns:** In South Africa, to qualify for a medical degree, medical graduates need to complete a one-year internship and two years of community service. Annually, the DoH experiences chronic challenges absorbing medical graduates into internships and community service programmes because of spacing challenges due to the department's inability to predict how many placements will be needed.[171] Placement challenges leave between 1200 to 2000 medical graduates sitting at home for months.[172] Budget constraints further exacerbate the problem as the DoH cannot afford to hire graduate doctors.[173]

3. **Doctors are leaving the country:** The extent of the skills flight problem is difficult to measure, as medical practitioners who leave the country mostly remain registered with the Health Professions Council of South Africa. Additionally, the Department of Home Affairs does not track the specific professions that leave the country. Despite the lack of official data, it is widely known that medical practitioners leave South Africa to work in better-functioning health systems such as Australia, the United Kingdom, and Canada.[174] Furthermore, the signing of the National Health Insurance into law by President Ramaphosa in May 2024 can exacerbate the skills flight of our health professionals.

4. **Uneven workforce densities:** Health workers are unevenly distributed between urban and rural areas. Uneven workforce densities are not a unique phenomenon, and they occur throughout many professions. Inward migration has just as much of a negative effect on the availability of the health workforce as international migration. Better working conditions in urban areas and in the private sector are attractive to medical professionals, making it increasingly difficult to retain them in rural areas.

Figure 14: Profile of Family Medicine Practitioners in South Africa, 2019[175]

Total Number of Family Medicine Practitioners	
Medical Practitioners	278
Medical Specialists	969
Total	**1247**

HPCSA registrations up to May, 2019

Geographical Distribution* (N=1192)

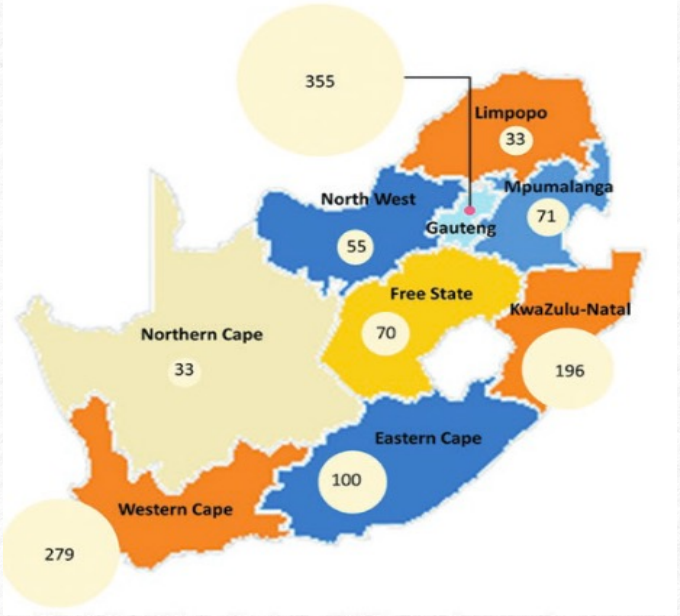


Figure 14 illustrates the distribution of medical specialists and practitioners across the country. Gauteng and the Western Cape have the highest densities of medical practitioners, with rural provinces such as Limpopo and the Northern Cape having the fewest.

DA Policy Recommendations: Getting our Health Workforce Back on Track

To adequately address HRH shortages, a significant focus must be placed on securing an adequate supply of medical practitioners. The DA will address HRH shortages by:

- **Ensuring that more funding is allocated towards medical degrees** to support local skills development in the medical sector.[176]
- **Ensuring more funding is allocated towards staffing of EMS service vehicles** to ensure that no patient is left stranded because of unstaffed vehicles.

The DA will expand South Africa's health workforce by:

- **Ensuring that medical professionals are included in Home Affairs' "scarce skills" list** to attract the migration of medical professionals to South Africa. In the most recent critical skills list from February 2022, only specific medical professionals were included: a biologist, a biotechnologist, a microbiologist, and a nurse educator. However, despite shortages in nurses, community health workers, and general practitioners, they were not included in the critical skills list. [177]

The DA will address geographic disparities for health workforce densities between rural and urban areas by:

- **Incentivising medical professionals to work in underserved areas.** These could include the following in their employment packages: bonuses, rewards programmes, personalised professional development opportunities, tuition reimbursements, research grants, and emergency financial assistance.[178]
- **Integrating foreign health professionals into the public health sector where skills shortages exist.** Those who come to the country as asylum seekers or are displaced from their home countries and possess the requisite skills to fill local gaps should be included in the DoH's Community Service and Internship program for health. The community service and internship programme was established in 1998 and traditionally only refers to medical graduates (2-year internship in the public sector) or professional graduates who want to register for independent practice (one year of community service).[179] The DA recommends that foreign health professionals be included in this programme to enter the country. South Africa would then benefit by distributing these professionals to underserved areas.

For planning for HRH to be effective, the DA will develop an integrated data source to enable such planning. This will be done by:

- **Establishing a technical workforce planning unit** that will encompass the appropriate capabilities.
    - This unit would establish real-time tracking of all key health professionals in South Africa, whether in the public or private sectors. This will be done by developing an integrated, publicly available, regularly updated HRH system. The system would be an integrated HRH data source that would be accessed by all relevant HRH stakeholders. This would allow policymakers and entities to understand workforce shortages better and would guide the improved development of supply plans for HRH.
    - This unit would provide support to planning exercises for health professionals at least 15 years into the future.
    - The unit will conduct an annual needs-based HRH audit. The audit would develop norms and standards for HRH needs.[180]
    - The unit will be tasked with implementing various needs-based approaches to HRH planning. This would include the following:

- The demand for HRH is predicted based on workforce-to-population ratios.
- Population needs would be considered to predict demand for HRH effectively. The types of personnel needed would be estimated based on the population's required services.[181]

The objective of this process will be long-term planning processes that align with the needs of new health professionals. It will also remove uncertainty experienced by interns, community service doctors, and registrars regarding placements, as any mismatches will be controlled for in the planning process.

Lack of Access to Emergency Care

There is currently no effective universal system in place to address the right of access to emergency medical care in both the public and private sector platforms, with many patients in need of emergency care unable to access it timeously despite having the right to do so (as enshrined in section 27 of the South African constitution) and the availability of facilities. Getting help during emergencies is very different from getting medical care that you elect to have. Any failure to access health services timeously in cases of an emergency is likely to result in avoidable death or disability.

In 2022, Michele Clarke, a Member of Parliament from the DA, filed a complaint with the OHSC regarding a tragic incident at the Motherwell NU 11 Clinic in the Eastern Cape. Clarke claimed that Thembi,* a 15-year-old girl who had been sexually assaulted, lost her life after being refused medical care at the clinic. The OHSC's investigation, which concluded in December 2023, found that the clinic's nurses did not provide her with the necessary care or examination. Instead of treating Thembi, they instructed her to go to the local police station, neglecting to call the police to the clinic or assist her in getting to the station. The investigation revealed that the healthcare workers involved did not escalate her case to the appropriate level of medical care, violating Regulation 5(1) and (2)(b) of the Norms and Standards Regulations for various categories of health establishments. According to the OHSC, "Thembi* was not attended to in a manner that was consistent with the nature and severity of her health condition." Unfortunately, she succumbed to her injuries while waiting for assistance at the police station.[182] Thembi's* story is one of many who face detrimental barriers to accessing emergency healthcare services.

The challenges standing in the way of providing enhanced access to quality emergency care services include:

- **The undergraduate training available to capacitate emergency care providers to conduct critical care transfers is weak.** In a study conducted in the Gauteng Province, participants felt that they were more prepared to manage primary response calls than emergency cases, including critical care transfers. Fewer health practitioners are available or confident enough to partake in emergency response.
- **Ambulances cannot be dispatched** due to vehicle unreliability, staff unavailability, or roads that are inaccessible for ambulances to travel through. This results in those needing emergency services and transport being unable to access them.
- **There is a shortage of operational ambulances nationwide.** In 2023, 3000 ambulances were operational nationwide.[183] This means that 0.48 ambulances are serving 10 000 people. This is far less than the national standard, set at 1 ambulance per 10 000 people.[184]

* Thembi is a pseudonym.

DA Policy Recommendations for Enhancing Access to Emergency Care

The DA will enhance access to emergency services by:

Ensuring that emergency access is guaranteed to all, regardless of income or type of coverage. A poorly designed system will either fail to comply with this principle or do so in a manner that is not sustainable. The goal would be to ensure that all priority 1 patients have access to emergency services at the nearest treatment facility. This will be achieved through a dedicated process to re-design the current healthcare system to include technical teams and collaboration between public and private healthcare entities.

- **Encouraging greater interdepartmental collaboration with the Police Service to enable Emergency Medical Technicians (EMTs) in "red zones[1]" to service the public safely.**
- **Providing training in the management of emergency scenarios to all healthcare professionals.**[185] This includes creating advanced training programs for doctors and nurses, fundamental emergency procedures, and developing certification routes for prehospital emergency care. In the case of Thembi, healthcare workers believed that they were not allowed to offer her care for fear that they would tamper with evidence. The healthcare workers were unable to assess the emergency adequately and fatally made the wrong call in sending her to the police station.
- **Ensuring the procurement processes of ambulances take into consideration the terrain in which they will be travelling.** For example, ambulances in rural areas struggle to access certain communities due to poor road infrastructure. These areas should prioritise the procurement of ambulances with off-road capabilities. [186]

Lack of Reciprocal Healthcare Agreements

Reciprocal Healthcare Agreements (RHA) are examples of international treaties between nation-states that outline the reciprocal treatment of their citizens in each other's public healthcare systems. Currently, South Africa has healthcare agreements with other Southern African Development Community (SADC) states that stipulate the referral of public healthcare patients to other member states without explicitly outlining the manner in which costs will be covered for said patients, except for the treaty signed between South Africa and Zambia that specifies reimbursement.[187]

DA Policy Recommendations for Implementing Reciprocal Healthcare Agreements

The DA will address the shortfalls in RHA's by:

- Engaging with SADC, the AU and other governments for the signing of RHA agreements that specify the conditions of reimbursement for treating foreign nationals in our public healthcare system.

[1]Red zones, in the context of medical service delivery, refer to high-crime areas that pose a danger to the EMTs and their patients.

Objective 4:
Promoting Healthy Lifestyles and Well-being

The DA envisages a society that takes responsibility for its health. Many individuals suffer from manageable diseases, such as diabetes, or diseases that arise from poor lifestyle choices. Lifestyle choices such as smoking, drinking alcohol, poor eating habits, and sedentary lifestyles increase the demand on our health system, which are often preventable. Ensuring that individuals make good health choices to prevent poor health outcomes can free up the public health system for those who need it most.[188] The DA seeks to address poor lifestyle choices by enhancing health education and promotion.[189]

The DA acknowledges that our environment plays a major role in our state of health. For example, being exposed to poor-quality air, contaminated water, or homelessness can negatively affect one's health. We aim to ensure that a person's lived experience does not become a determining factor in their health status or act as a barrier to accessing high-quality healthcare services. This approach recognises that health outcomes are influenced by an individual's physical, social, political, and economic surroundings.[190]

To address these interrelated issues, we have developed housing, education, and social development policies, which are essential features of our broader healthcare agenda. See our policy on housing, education, crime prevention and criminal justice and social development.

High Burden of Disease

South Africa's health system continues to grapple with high levels of communicable and non-communicable diseases, high maternal and child mortality rates, a high prevalence of violence and injury-related trauma, as well as common mental disorders. According to the 'NCD Countdown Report', South Africans have a 51.9 percent chance of dying from a non-communicable disease.[191] As a result, the country's health system is overburdened, and it cannot keep up with the demand.[192,193] Consequently, South Africa has been ranked in the top 20 countries for all three of the WHO's global lists of 'high burden of disease' for TB, HIV, and MDR-TB (2016-2020).[194]

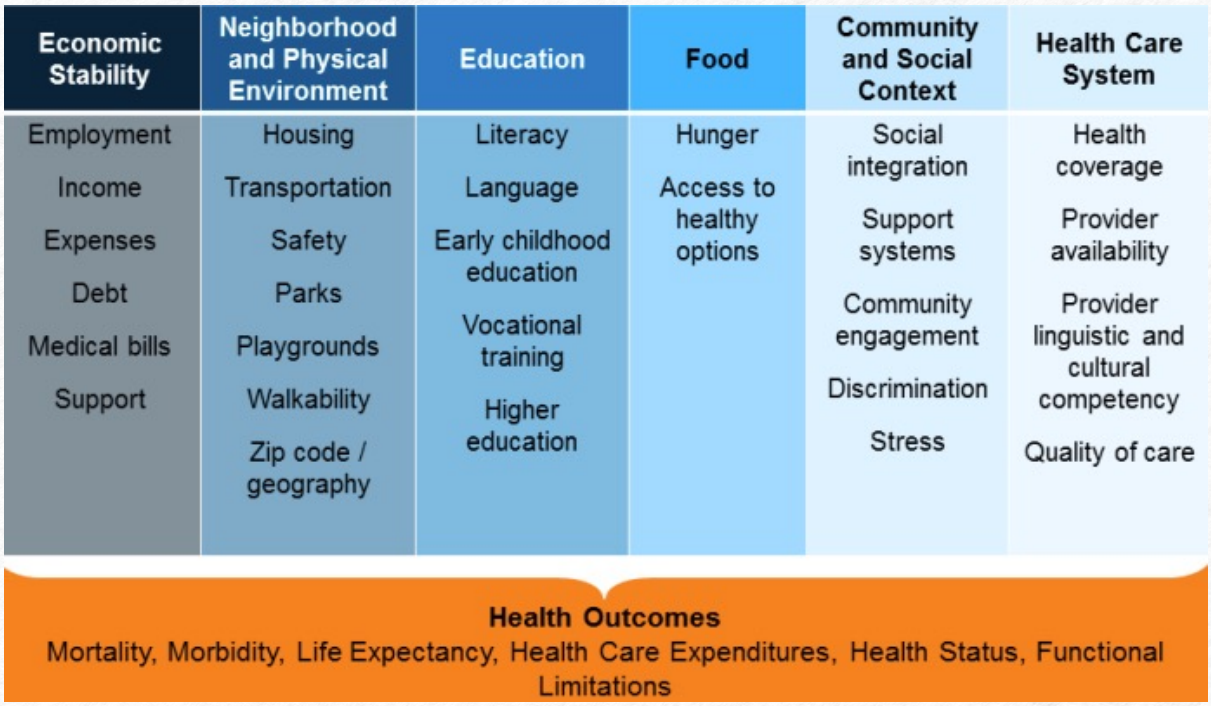
Preventable diseases pose the most significant burden on the healthcare system in South Africa, including those related to inadequate infection control and health and sex education. According to Stats SA, TB, influenza and pneumonia, HIV, cerebrovascular disease, and other forms of heart disease are the top 5 leading causes of death in the country, in hierarchical order.[195] Furthermore, 9.5 million people in the country suffer from common mental health disorders.[196]

Social Determinants of Health

Background

Medical factors do not solely determine health outcomes. Instead, a person's state of health can be influenced by social factors, which encompass an individual's socioeconomic status, physical environment, education, income level, and access to social systems, such as welfare, education and healthcare.[197] These factors play a critical role in shaping an individual's overall health and well-being and thus require careful consideration in developing policies to improve population health outcomes. Figure 16 illustrates the relationship between these various determinants and their ultimate impact on health outcomes.

Figure 16: The Social Determinants of Health[198]



As shown in Figure 16, many non-health factors affect health and health access. According to the WHO, social determinants "can be more important than healthcare or lifestyle choices in influencing health."[199] In South Africa, a lack of housing, poor access to quality water and sanitation, food shortages, crime and high levels of substance abuse are some of the leading causes of premature death and poor health.[200]

According to the 2022/23 SAPS report, there has been a clear upward trend in community-reported crimes over the last 3 years. See Table 4 below.

Table 4: Trends in Community-Reported Crime, 2020 to 2023[201]

Category	2020/2021	2021/2022	2022/2023	Counts Difference	% change
Contact Crime	535 217	607 163	654 053	46 890	7,7%
Contact-related Crime	102 269	117 505	118 744	1 239	1,1%
Property-related Crime	369 745	362 274	375 970	13 696	3,8%
Other serious Crimes	354 566	393 821	437 741	43 920	11.2%
17 Community-reproted serious crimes	1 361 797	1 480 763	1 586 508	105 745	7,1%

Table 4 shows that crimes have increased across various crime categories. These concerning trends endanger public safety and impose a growing burden on healthcare systems, demanding additional resources to address the physical and psychological aftermath of such incidents.

In addition to environmental and socio-economic risks, the health of individuals in South Africa is significantly influenced by their life choices, such as tobacco, drug and alcohol use, unhealthy diets, physical inactivity, and unprotected sex. [202]

Substance abuse carries a substantial economic impact on the healthcare sector, with smoking-related diseases already costing the economy R14.5 billion as of 2016.[203] The costs incurred on the economy are calculated by including direct costs (costs of healthcare) and indirect costs (the value of lost productivity due to days taken off work).[204] According to the latest National Health and Nutrition Examination Survey, 16.2 percent of South Africans have smoked "at some point in their lives." The 2021 Global Adult Tobacco Survey revealed that 25.8 percent currently smoke tobacco.[205] Furthermore, the intersectional case study on 'successful tobacco legislation in South Africa' (2013) highlighted that smoking results in 58 percent of lung cancer deaths, 20 percent of deaths related to chronic obstructive diseases and tuberculosis (TB), and 23 percent of deaths due to cardiovascular diseases.[206]

As of 2023, 13 percent of the general population met the criteria to be diagnosed with a lifetime substance use disorder,[207] with an estimated 10.3 percent of individuals aged 15 and above engaging in excessive alcohol consumption, and around 8.6 percent misusing illicit drugs. [208] Notably, a report published by the Government of the Western Cape in 2017 indicated that 54 percent of deaths caused by injuries in South Africa involved individuals having, on average, blood-alcohol levels twice that of the legal limit. Furthermore, high levels of alcohol consumption contribute to 56 percent of transportation-related deaths and 61 percent of deaths resulting from violence.[209]

Substance abuse during pregnancy is a significant cause for concern. Health consequences that arise include Foetal Alcohol Syndrome (FAS). According to Frontiers in Public Health, South Africa has one of the highest reported per capita rates of FAS.[210] Out of 1000 births, 111 babies are born with FAS. This is 14 times higher than the global average of 7.7 per 1000[211]. Babies exposed to alcohol during gestation can experience lifelong health challenges such as neurological disorders, impaired vision, hearing loss and learning disabilities. Babies are born with permanent disabilities, which could have been prevented if alcohol had been avoided during pregnancy.

See our policy response to drug abuse in our Social Development Policy here.

Furthermore, many South Africans are living **sedentary lifestyles**, which are often combined with poor eating habits. Consequently, 20 million South Africans can be categorised as obese, according to Discovery's "ObeCity Index." In addition to sedentary lifestyles, the report identified poor food labelling, which prevents consumers from making informed food choices, as an additional contributing factor to obesity in the country. The report also argues that grocery stores encourage purchasing high-fat and high-sugar snacks and refreshments as they are often conveniently placed at checkout points.[212] Lastly, the rising cost of living renders healthy foods unaffordable for many.

As illustrated in Figure 16, various factors, often outside the health sector, such as access to housing, contribute to health outcomes. Economic growth is, therefore, closely linked with addressing the social determinants of health. If individuals have well-paying jobs, live in safe and secure homes, have access to the social services they need, and can make informed health choices, health risks can be better mitigated.[213]

Current Policy Context for Addressing Behavioural Risk Factors

The South African government has implemented various measures to combat NCDs. Some of the health-related policies include the National Health Promotion Policy and Strategy (2015), a proposed draft Bill on the Control of Tobacco Product and Electronic Delivery Systems (2018)[214], and the implementation of the Tobacco Products Control Act no 83 of 1993. The Act intends to regulate the production, sale and marketing of tobacco products to the public.[215] Additionally, the Act aims to reduce the consumption of tobacco, limit the public's exposure to second-hand smoke, and promote public education campaigns about the harms of tobacco consumption.[216]

Furthermore, there is the Liquor Bill (2016) and regulations pertaining to warning labels on alcohol products (2017). Other regulations focus on trans-fats in foodstuffs (2011), labelling and advertising of foods (2010, effective from 2012), and the reduction of sodium in commonly consumed food categories (2013, with amendments in 2017). Additionally, a health promotion levy on sugar-sweetened beverages (2018) has been implemented and extended to pure fruit juices (2023).[217]

Challenges for Addressing the Social Determinants of Health in the Health Sector

To effectively tackle the social determinants of health and the subsequent pressure these add to our health system, collective action is required, which cuts across various sectors. These include housing, education, employment, and social security. The DA has developed a range of policies, offering credible policy recommendations to address the various challenges faced in the country and ultimately improve people's lives. We recommend exploring the detailed solutions outlined in our Economic Justice Policy, Social Development, Housing, and Economic Policy.

However, it is important to note that in this paper, we will specifically concentrate on challenges and solutions related to the health sector's role in addressing the social determinants of health. These challenges are highlighted as follows:

1. **Poor implementation of key health legislation required to address behavioural health factors.**

Between 1993 and 2010, smoking prevalence declined from 32.6 percent to 20.9 percent. Despite the Tobacco Bill having the initial desired effect,[218] in 2021, the Global Adult Tobacco Survey revealed that smoking prevalence was 29.4 percent.[219] One of the main challenges lies in a lack of implementation. The DoH is responsible for drafting health-related policies and legislation, whereas the police are responsible for implementing the law.[220]

The enforcement of tobacco legislation is severely hindered by the fact that authorities lack an adequate understanding of the law and resource constraints. South Africa, as a society, suffers from more serious issues, such as violent crimes, and tobacco control measures are thus seen as of minor concern for a criminal justice system whose resources are stretched thin.[221]

2. **Failure of National Primary Health Care Re-Engineering Strategy.**

In 2011, the national government launched its Primary Health Care Re-Engineering Strategy, which included establishing community health worker (CHW) teams.[222] Community health

workers are responsible for disseminating health information, linking communities to various health services, raising disease awareness, and conducting health promotion activities. However, their role has been mainly limited to programmes for HIV/AIDS, maternal, neonatal and child health. Therefore, their role significantly excludes many social determinants that impact one's health.[223] Additionally, more of the Health Department's budget must be allocated to ensure that these workers have job security and a career path within the healthcare system.

3. Healthcare's narrow focus on diagnosing physical ailments has neglected to consider the impact of socio-economic factors.

One reason the healthcare system overlooks socio-economic factors is the insufficient training provided to healthcare professionals. They do not have a broad understanding of the many ways in which socioeconomic conditions can impact the health and well-being of an individual. Furthermore, they may not fully grasp their crucial role in advocating for their patients, nor do they possess the necessary capacity to address health outcomes beyond biological diagnosis and treatment.[224]

This narrow approach to healthcare fails to address the root causes of health issues, as these causes are often intertwined with social challenges. Due to the limited training healthcare practitioners receive in this area, they usually only focus on treating the physical symptoms of illness without looking at the deeper causes behind the illness. As a result, healthcare providers often focus solely on treating the biological symptoms without offering further assistance or referrals to address the underlying causes of ill health. Collaboration between the health sector and other sectors, such as education, housing, and employment, is essential for addressing social determinants. However, there is often a lack of coordination and collaboration between these sectors (such as social development and health departments), making it challenging to implement integrated interventions. For example, medical professionals treat symptoms of biological conditions and do not know of social programmes in the community from which the patient could benefit. This illustrates the poor referral pathways between the health and social development sectors.

4. There is discrimination in health facilities affecting access to healthcare.

Discrimination is defined as "unfair and unjust action towards an individual or group based on real or perceived status or attributes." Attributes can include, for example, an individual's socioeconomic status, race, gender, sexual identity, and occupation. Discrimination by health workers based on these characteristics can negatively affect treatment and diagnosis and impede positive health outcomes.[225]

To illustrate the impacts of discrimination on healthcare services in South Africa, Human Rights Watch conducted a report which looked at three main groups: asylum seekers, refugees and undocumented migrants. The report highlighted the barriers faced by vulnerable groups in accessing healthcare due to discrimination. These included individuals being denied access to emergency services and basic treatment because they were unable to furnish the health establishment with identity documents, or for "simply being foreign".[226] Another research program titled the "HIV Stigma Index" studied the overall experience of stigma and discrimination of persons living with HIV/AIDS. The study surveyed 10 473 respondents and found that 35.5 to 43 percent of respondents experienced HIV-related stigma and discrimination.[227]

Furthermore, a grassroots example of discrimination in healthcare can be seen in the work done by Ritshidze, a community-led organisation that has developed a health monitoring system. Ritshidze surveyed to monitor the experiences of specific population groups, including LGBTQIA+ individuals, drug users, and sex workers, about their interactions with the healthcare system. The report indicated that 19 percent of people who use drugs were denied health services, while in the Eastern Cape, 25 percent of sex workers were denied access to health services.[228]

Policy Recommendations for Addressing the Social Determinants of Health

The DA will address the social determinants of health by:

- **Ensuring laws related to addressing behavioural risk factors are adequately enforced.** Laws that address and reduce health risks associated with lifestyle choices, like the Tobacco Bill, require greater attention and commitment from the authorities responsible for enforcing them. To achieve this, attitudes and perceptions towards these laws need to change. The DoH should improve its communication efforts to emphasise the seriousness of behavioural health factors and the importance of enforcing these laws.

  The WHO emphasises the significant impact of tobacco-related healthcare costs (approximately R14.5 billion as of 2016)229 on the healthcare sector. It is essential to acknowledge that exposure to smoke poses severe risks, with potential immediate and long-term life-threatening consequences. This understanding highlights the need to address noncompliance with tobacco control laws as a matter of utmost importance.230

- **Scaling up Community Health Services for Non-Communicable Diseases through Community Health Workers (CHW).** It is imperative to bring prevention services for non-communicable diseases closer to communities to effectively tackle these diseases, often linked to individual lifestyle choices. Given the demonstrated effectiveness of CHWs in promoting the health of local communities, it is recommended that their scope be broadened beyond HIV/AIDS and TB to encompass a broader range of health conditions.

  The DA recommends expanding the scope of CHWs' responsibilities to include community education, screening, and implementing early disease management plans for those exhibiting health risk factors.[231,232] Moreover, the DA aims to increase the presence of CHW teams nationwide, focusing on underserved areas lacking adequate access to healthcare services. By doing so, we can ensure that a larger population is reached.

Poor State of Mental Health in SA

The system for addressing acute and chronic mental health care is underdeveloped in both the public and private sectors. Areas that require consideration include coverage, the supply of services and the effective management of outpatient care across the public and private systems.

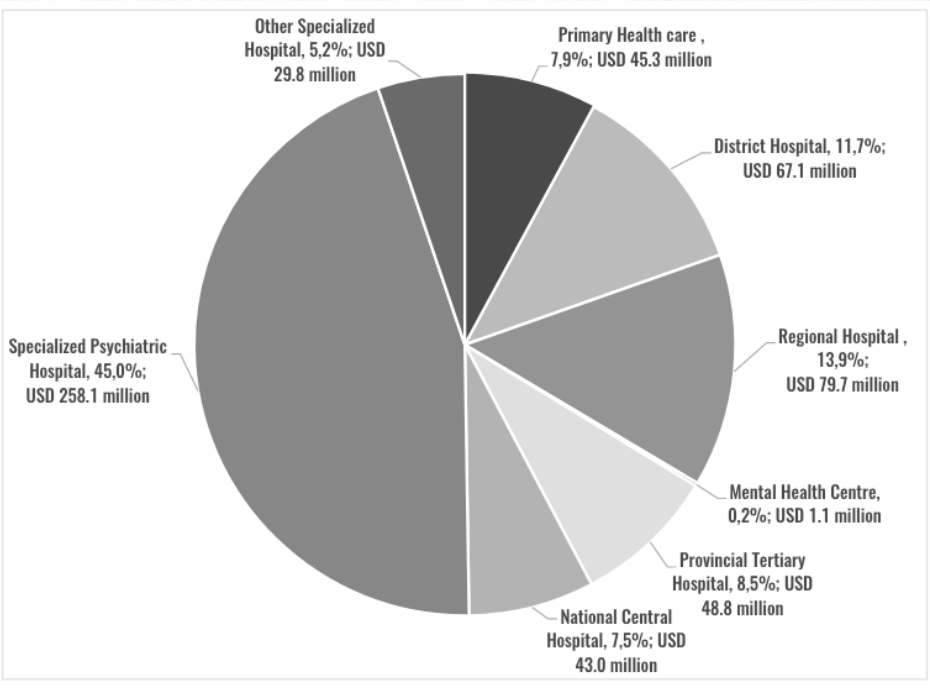
South Africa faces significant supply shortages for mental health treatments. Mental health disorders are becoming more prevalent, with depression being one of the leading causes of disability globally.[234,235,236] In South Africa, an estimated 9.5 million people are living with a mental disorder. Research shows that "one in three South Africans will experience a mental illness in their lifetime."[237] In the Mental State of the World report, 35 percent of South African respondents reported being distressed or struggling. Furthermore, South Africa ranks second last on the Mental Health Quotient Index,[16,238] making it one of the worst-performing countries regarding mental health illness.

Additionally, mental health disorders are one of the top 5 contributors to years lived with disability in the country.[239] Despite the apparent demand for mental health services, the treatment available is severely lacking. The treatment gap is estimated to be over 90 percent.[240]

Accessing treatment for mental health disorders can be a significant challenge for individuals in need. These challenges are listed below:

- **Stigma and discrimination prevent people from seeking and accessing quality services.** Stigma arises from individual or societal stereotypes and cultural and religious beliefs regarding mental illness, which discourages persons with a mental disorder from seeking treatment.[241] To illustrate this point, only 27 percent of the population who have reported mental illness have received treatment.[242] This includes delayed treatment, reduced access to health services and poor health outcomes.
- **There is poor mental health literacy and a lack of access to crucial information.** Very little information is made available to educate society on the importance of and availability of services for mental health. Access to information is essential as it can guide an individual to make more informed choices regarding the management of their mental health.[243]
- **There is a shortage of human resources for mental health service provision.** There are 3.1 public sector psychiatrists per 1 million of the uninsured population. These shortages are even more critical for mental health practitioners who specialise in psychiatric support for children.[244]
- **Local health facilities have limited access to quality mental health services.** Only 18 percent of district health hospitals have functioning inpatient psychiatric units, and many patients must travel long distances to get access to these units. A lack of access to quality mental health services is a challenge faced in both public and private health facilities.[245]
- **There needs to be consistent availability of medication, resulting in stock-outs.** Several factors contribute to this situation, including the late payment for medication deliveries (on the operational side), companies' inability to meet the required order quantities (on the supply side), and inadequate procurement and logistics management skills.[246] The consequence of medication stock-outs is that it can result in relapse and affect the progress a patient has made.
- **Mental health service provision is overly institutionalised in psychiatric facilities.[247]** Currently, mental health services and the allocation of resources are biased towards expensive psychiatric institutions. Figure 17 below illustrates the proportion spent on mental health in each institution type.

Figure 17: Proportion of Mental Health Service Inpatient and Outpatient Costs by Service Level, 2019 [248]



[16]The Mental Health Quotient is an assessment of mental health and well-being that covers symptoms across 10 major psychiatric disorders (such as anxiety, depression, and addiction).

As illustrated in Figure 17, mental health service costs are most significant in specialised psychiatric hospitals. While such institutions play a crucial role in severe mental health cases, the majority of South Africans suffer from common mental illnesses like anxiety and depression, which should be addressed at the primary healthcare level as early as possible.

Viewing funding as disproportionately focused on psychiatric institutions needs to be understood in the context of the average length of stay, the costs of inpatient care and re-admission rates. 1 in 4 patients are re-admitted to the hospital within three months of initial treatment for their mental health disorder.[249] This significantly increases the costs of the healthcare system. The total cost of re-admission across healthcare facilities in South Africa amounts to a staggering $224 million (equivalent to R3.2 billion in 2019).[250]

High readmission levels can be attributed to inadequate initial treatment and poor discharge planning. Consequently, patients do not transition smoothly to the next point of care in their community, primary healthcare facilities, which should play an important role.[251] Enhancing primary healthcare facilities with the relevant equipment is crucial to addressing mental health issues in communities. Investing in community-level care through ensuring consistent access to resources will additionally help with reducing re-admission rates.

DA Policy Recommendations for Addressing the Poor State of Mental Health in South Africa

The DA will promote mental health awareness and ensure access to effective treatment by:

- **Conducting long-term mental health education programmes** in schools, businesses, universities, and health institutions using educational resources like brochures and pamphlets to educate people about the signs of mental illness, seeking treatment, and supporting family members.

- **Involving families, with the patient's consent, in the treatment process** by educating them about the individual's condition and how to provide support, enhancing support and management.

- **Providing a short course on mental health and treatment for community health doctors and nurses.**

- **Collaborating with media houses to promote a positive mental health agenda.**[252]

- **Encouraging collaboration between formal healthcare providers and traditional/faith healers.**[253] Enhancing Traditional and Faith-based healers' understanding of the causes and treatments of mental illnesses through educational initiatives could ensure timely intervention and appropriate care, whilst still allowing for culturally influenced healing practices.

The DA will address the human resource shortage for mental healthcare by:

- **Offering additional training to the existing PHC workforce** to equip them with the necessary skills to confidently provide basic mental health services to patients.[254] Educational interventions targeting general practitioners, other non-psychiatric specialists, and nurses are an effective strategy to increase the confidence of non-specialist professionals in providing mental health treatment.[255] Utilising the existing workforce to expand mental health services will be the most efficient way to expand coverage of services. [256]

The DA will increase access to quality mental health services by:

- **Shifting underutilised resources from psychiatric institutions or other programs to primary healthcare facilities.**[257,258]

- **Mandating all provinces** to include District Mental Health Teams, community-based mental health care and child and adolescent mental health services in their annual budgeting plans. A needs assessment will guide budgets for the above, and budget allocations should reflect this.

- **Offering home-based care** for low-risk patients to alleviate the burden on the healthcare system.

The DA will prevent medication stock-outs by:

- **Establishing a National Prescription Registry** that will allow patients to collect repeat prescriptions at any pharmacy nationally. The pharmacy registry will allow patients to go to any pharmacy should their original pharmacy of choice be out of stock.

Conclusion

The Democratic Alliance's health policy sets a firm, revenue-neutral foundation for what needs to be done within the existing health framework to enhance access to quality healthcare significantly. The first and most critical reform for our policy recommendations to be successfully implemented is in relation to governance. The DA offers credible policy recommendations to strengthen our public healthcare systems' governance framework, including enhancing accountability mechanisms to reduce maladministration and corruption. Secondly, we aim to address market failures in the private sector so that competition can be enhanced, and the quality of care provided can be increased while private healthcare costs are reduced. Once these two crucial areas are enhanced, we can improve universal health coverage in a fiscally neutral manner without overhauling the entire health system.

The next step will be to improve the quality of healthcare services provided. We will begin by addressing the challenges the OHSC faces to ensure adequate monitoring of healthcare services. Ensuring healthcare facilities, both public and private, are monitored will allow for issues to be flagged and addressed before any grave healthcare consequences occur. This will play an important role in preventing medical negligence cases.

Furthermore, this paper considered the geographical challenges that impede health service delivery, such as extreme weather events, water and electricity shortages, health workforce shortages, and limited emergency care in rural areas. The DA has considered the Rwandan Telemedicine model to enhance access in these challenging environments, which has successfully offered primary healthcare services in underserved areas.

Lastly, we investigated the health impacts of social determinants of health and the effects of behavioural risk factors on the health system and proposed recommendations that can serve as preventative strategies to enhance the health of our population.

The challenge, however, will be implementing accountability frameworks, such as the National Health Appointments Authority (the Watchdog), and market reforms in the private sector, such as social reinsurance and risk equalisation. Lastly, funding challenges could impede the full realisation of the DA's policy recommendations.

End notes

[1] Red zones, in the context of medical service delivery, refers to high-crime areas that serve as a danger to the EMTs and their patients.

[2] It is often remarked that medical scheme members require public hospital care when their benefits run out. This may occur when a member can no longer afford a medical scheme, while a member does not qualify for free care, and medical schemes are required, in terms of section 29(1)(p) of the Medical Schemes Act (Republic of South Africa, 1998) medical schemes must reimburse public hospitals for hospital-based care. As coverage is maintained for major medical care, medical scheme members systematically choose private over public hospital care.

[3] The total expenditure by medical schemes on public hospital care in 2021 amounted to R361 million out of a total expenditure on hospital services of R74 billion (0.32 percent of total).

[4] In this analysis, an estimate is generated of the consolidated tax contributions made by medical scheme households across the full spectrum of tax bases, which includes both direct and indirect taxes. Corporate tax contributions, which are not attributable to individuals, are also assumed to be paid indirectly by these households. See Table 1 "Sources" for more information on the assumptions.

[5] This includes the direct contribution (excluding the tax credit) plus 74.5 percent of the tax credit which is indirectly contributed through the tax contributions by medical scheme members. This implies that medical scheme members, directly and indirectly, pay for R235 billion out of a total of R241 billion (Table 1) or 97.2 percent.

[6] R428 billion out of the total UHC expenditure of R501 billion or 85.5 percent.

[7] Indirect accountability is achieved using specialist supervisory structures that must hold a public health organisation to account using criteria developed through public deliberations. While the community does not intervene through direct action, it does so indirectly through the criteria that must be impartially administered. Indirect approaches are required where expert supervision is needed to get to the root causes of performance variations. These approaches can be supplemented by more direct accountability approaches.

[8] These include independent supervisory boards, complaints regimes and regulators. To ensure continuous accountability, the governance framework must provide for prospective, concurrent and retrospective approaches to supervision. Communities also require more than just a "voice" to ensure that services serve their needs.

[9] Prospective accountability before an action or decision is taken. It is about setting standards, rules, and expectations upfront to guide behaviour and decisions in a way that aligns with established goals or values. This approach aims to prevent problems or errors before they happen by having clear policies, oversight, and guidelines that individuals or organisations must follow.

[10] Provinces are financed in part by an unallocated block grant in lieu of provincial tax revenue collected by national government on their behalf. This is referred to as the provincial equitable share (PES) grant and is unallocated to permit provinces to determine their own priorities as they see fit.

[11] Coliform counts give an indication of the quality of water supply. Total coliforms are bacteria that can be found in soil or water than has been contaminated by human or animal waste.

[12] Individual contributions refer to household contributions (such as their premiums) to medical schemes.

[13] Tax credits refer to the provision in the tax code that allows taxpayers to subtract a certain amount from the taxes they owe to the government. Tax credits are designed to encourage certain behaviours or investments. In this case, it is used to encourage individuals to subscribe to a medical scheme.

[14] These schemes offer coverage to multiple employers and individuals.

[15] Cross-subsidisation is often used to promote fairness and equity in healthcare by spreading the financial burden more evenly across a diverse population, allowing everyone to access healthcare services when needed. This will be funded through general taxes.

[16] The Mental Health Quotient is an assessment of mental health and well-being that covers symptoms across 10 major psychiatric disorders (such as anxiety, depression, and addiction).

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