

SUBMISSION on the GREEN PAPER ON NATIONAL HEALTH INSURANCE

Rural Doctors Association of Southern Africa, Rural Health Advocacy Project, Wits Centre for Rural Health, UKZN Centre for Rural Health, Ukwanda Centre for Rural Health, UCT: PHC Directorate, Africa Health Placements and Rural Rehab South Africa

11 December 2011

RURAL NOW!

Submitting Partner Organisation:



Endorsed by: SECTION27, People's Health Movement and Black Sash

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Executive Summary

This submission sets out the potential effects of the proposed National Health Insurance on rural communities, in terms of access, quality and equity. As a result of previous disadvantage and current inequity in health status and access to health services affecting rural areas, as well as the relative lack of capacity to reverse the situation, a specific strategy is proposed to ensure that these inequities are not worsened in the future by the introduction of NHI, but instead are pro-actively addressed by weighting interventions in favour of those who are most disadvantaged.

Rural areas are characterized by a number of intrinsic disadvantages that have particular relevance to the ideal of universal coverage proposed by NHI: there is a higher burden of poverty; the social determinants of health have a more direct influence on health; the cost of accessing health services is higher; management capacity is relatively weak; and there is a relative paucity of private practitioners and specialists in rural areas.

This submission therefore proposes that rural districts are tackled first, and not last, in the implementation of the NHI. This will allow for a longer lead time in order to build the necessary capacity that will ensure that equity, access and quality issues are addressed as a priority. Secondly, a case is made for the subsidization of transport costs to enable access to health facilities by rural citizens. Thirdly, the Human Resources for Health (HRH) Strategy for South Africa is fully supported, particularly Strategic Priority Area 8 regarding Access in Rural and Remote Areas. Fourthly, the Re-Engineering of Primary Health Care plan is strongly supported overall, but the proposal is made for a higher number of Primary Health Care Agents in each team in rural areas compared to urban areas. Fifthly, rural communities and health care workers need to have a say in terms of the shape and benefits of the NHI. Finally, in terms of financing, the impact of each new intervention on the vulnerable situation of the rural poor needs to be considered carefully before it is implemented. In this regard, poor rural communities should not be charged increased VAT to help fund the NHI and all user fees should be abolished.

The NHI requires a strategy of progressive universalism. Progressive universalism is aimed at ensuring that the poor gain at least as much as the rich from every intervention. Rural areas need to be prioritized to compensate for their access and HRH constraints and high levels of deprivation. Therefore, we say **RURAL NOW!** The priority areas are:

Rural Accreditation First

User Fees Abolished and No Increase on VAT

Reverse the Existing Infrastructure/Inequality Trap through Needs-Based Budgeting

Access to Health by Addressing Social Determinants including Transport

Lure Sufficient Human Resources to Rural Areas

No to Delegated Management Responsibility WITHOUT Authority and Accountability

Only *through* Consultation with Communities, Health Workers and Activists

Wide-ranging PHC benefit package including Rehab, Mental Health Care and Eye Care at all levels of care

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By: RuDASA, RHAP, Wits Centre for Rural Health, UKZN Centre for Rural Health, Ukwanda Centre for Rural Health, UCT: PHC Directorate, Africa Health Placements and RuRESA

Endorsed by: SECTION27, People's Health Movement and Black Sash

RURAL NOW!

For too long, rural communities have waited for accessible and affordable health care. Rural health has not benefitted equitably from well-intended past interventions. Community service, pro-specialist OSD and the closure of nursing schools are examples. Therefore, we say that the National Health Insurance scheme should prioritise rural communities. RURAL NOW!

A) Introduction

1. On 12th August, the Department of Health released the Green Paper on National Health Insurance for public comment. As a collective of civil society organisations advocating for, and working towards, improved access to equitable, quality health care for rural communities, we wish to herewith make a submission on the Green Paper. From the outset, we wish to express our full support to the principles of the proposed National Health Insurance, which intends to, amongst other things (section 52, page 16-18):
 - Realise South Africa's people's right to access health care
 - Realise equity in access to health care regardless of one's socio-economic status
 - Promote effectiveness and efficiency within the health care system
2. Reversing the inequities and inefficiencies in the health care system is a legal obligation on Government as enshrined in the Bill of Rights and Section 27 of the Constitution of the Republic of South Africa, promising equality for all, and access to health care.
3. Poor rural communities experience several barriers to fully realise their right to access quality health care. The following stand out:
 - a. **Accessing the point of health care delivery:** this is a challenge primarily because of the limited number of health facilities in rural areas and the distances people must travel to these facilities; combined with the absence of reliable, affordable public transport and high levels of poverty. Indeed, the rural poor pay disproportionately more when accessing health care in South Africa, than any other demographic sector of the population.

b. **The quality and availability of health care at the point of delivery:** the challenges within the health system are well documented and interventions to counter these have been captured by the Department of Health in its Ten-Point-Plan. Some of the most critical challenges are the understaffing in rural clinics and hospitals and weak management. Both translate into long waiting times, poor quality of care, and avoidable deaths. Other inefficiencies in the health system relate to the often-weak continuity of care, leaving patients stranded and lost to follow-up.

c. **The acceptability of health care services provided:** In the context of the NHI this refers to whether rural communities have a say in the type and extent of services provided under the NHI.

4. We acknowledge that solutions to the above problems cannot be solved by National Health Insurance alone and we welcome the other policy processes that are underway in parallel to the NHI process. In particular, we make note of the Primary Health Care Re-Engineering Strategy, the new national Human Resources for Health Plan, the Classification of Hospitals and the Policy on Hospital Management.
5. In this submission we stress that for the NHI to be successful in achieving equity, a number of challenges need to be addressed prior to the introduction of the NHI. Failing this, the proposed NHI may not deliver on its promise of equitable access for all, and improving health outcomes. It may even entrench inequities further. Notably, these challenges are:
 - The infrastructure-inequity trap. Research¹ has shown that a greater portion of the available health-allocated funds flow towards maintaining existing infrastructure and paying existing health care workers. This inevitably results in a higher proportion of health funds flowing to the more resourced urban areas. Unless addressed, this will worsen under the NHI due to the heavy private sector presence in urban areas, versus the lack thereof in rural areas. We call for needs-based budgeting based on service platforms.
 - The absence of sufficient health care workers, undermining access to quality care, which requires a robust and urgent intervention.
 - The absence of reliable, affordable transport in many rural areas, hampering rural communities' access to health care and leading to delayed health-seeking behaviour and increased loss to follow up.

In our submission we also discuss a number of matters that need further clarity in order to make a comprehensive assessment of the proposed solution to the inequities in accessing health care. A full discussion is found in the main body of the submission.

6. This submission is made by the Rural Doctors Association of Southern Africa, the Rural Health Advocacy Project, the Wits Centre for Rural Health, the UKZN Centre for Rural Health, the Ukwanda Centre for Rural Health, Africa Health Placements, Rural Rehab South Africa and the University of Cape Town: Primary Health Care Directorate. We would welcome the opportunity to present our submission to the Department. We can be contacted through the office of the Rural Health Advocacy Project:
 - Focal point: Marije Versteeg
 - Landline: 011 356 4114
 - Fax:
 - Postal address:
 - Email: marije@rhap.org.za

The contact details of the individual organisations that form part of this submission can be found below.

¹ D. Stuckler, S. Basu, M. McKee Health Care Capacity and Allocations Among South Africa's Provinces: Infrastructure–Inequality Traps After the End of Apartheid. *American Journal of Public Health*; January 2011, Vol 101, No. 1

B) Structure of the submission

7. We begin this submission by setting out why the different organisations represented in this submission have an interest in the NHI. We have structured the remainder of our submission around 5 main themes: Access, Social Determinants of Health, Accreditation, Financing Rural Health Care, Private Sector and Transition Period. We finish with a conclusion.

C) Interests of organisations represented in this submission

RuDASA

8. As the voice of rural doctors in South Africa, the Rural Doctors Association of South Africa has a vision of all rural people in South Africa accessing quality health care. Implementation of the NHI must assist in this, particularly in the adequate staffing of rural health services by appropriately skilled medical staff. Contact details: Dr Karl Le Roux, Chairperson, karllerox@gmail.com, info@rudasa.org.za, www.rudasa.org.za

9. **RHAP**

The Rural Health Advocacy Project advocates for improved access to high quality, comprehensive health care services in rural areas. With the aim of improving the health of the South African Population, the RHAP stresses that a focus by the NHI on rural health will have a far-reaching effect, extending beyond rural communities, to impact South Africans at large. Contact details: Marije Versteeg, Project Manager, marije@rhap.org.za, www.rhap.org.za

10. **Wits Centre for Rural Health (GP)**

The overall focus of the Centre is the development of human resources for rural health care in South Africa. The Centre believes that the inequities faced by rural communities warrant the implementation of unique, tailored solutions for rural health care systems. In delivering on the NHI plans, rural health care must be prioritised. Contact details: Prof Ian Couper, Director Wits Centre for Rural Health, ian.couper@wits.ac.za, <http://www.wits.ac.za/academic/health/entities/ruralhealth/10095/home.html>

11. **University of Kwazulu Natal Centre for Rural Health (KZN)**

The Centre for Rural Health at UKZN focuses its research and interventions primarily on health care systems strengthening and community-level care in rural health services. The centrality of management in the performance of the health care system has been widely recognised and the NHI will need to pay particular attention to this in order to succeed in its objectives. Contact details: Dr Bernhard Gaede, Director UKZN Centre for Rural Health, Gaedeb@ukzn.ac.za, <http://crh.ukzn.ac.za/Home.aspx>

Ukwanda Centre for Rural Health (University of Stellenbosch)

The Ukwanda Centre for Rural Health coordinates and supports training and research initiatives in rural and underserved communities. Its objectives are to train and develop health workers to ensure they are optimally equipped for service to the South African community; to conduct and support community-based research that is relevant to the health needs of the specific study community, but also to the broader South African and African population; and to engage in constructive cooperation between various communities, health-service providers, and non-governmental organisations in order to promote broad-based community development and health. It is essential that the NHI process engages rural communities on their priorities and needs.

Primary Health Care Directorate, University of Cape Town (UCT)

The focus of the Primary Health Care Directorate is the coordination and integration of primary health care principles into education, research and service programmes at UCT and in the province of the Western Cape.

The multi-disciplinary team is involved in a wide variety of projects that link clinical care with community engagement, as well as a number of educational projects at undergraduate and postgraduate levels that are concerned with the broader determinants of health. The NHI affords an opportunity for universal coverage of health services in line with core PHC principles. The Director is a member of a panel of experts invited by the DG of Health to consult on the plan for NHI. Contact details: Prof S Reid, Director of Primary Health Care, UCT. Email: cha.johnston@uct.ac.za

Rural Rehab South Africa

RuReSA is a group of concerned and committed rural Physio, Occupational, and Speech and Language Therapists, Audiologists and Psychologists. The group seeks to promote access to appropriate rehabilitation services in rural areas by addressing current policy; providing input on curriculum; providing a support network for current rural therapists; and promoting advocacy for accessible and appropriate service delivery for children and adults with disabilities in South Africa. RuReSA appreciates the commitment in the NHI to provide accessible, affordable and appropriate health care to all people at grass-roots level. However, we are concerned that the current strategies will exclude people with disabilities from accessing the appropriate services required. Contact details: Maryke Bezuidenhout, RuReSA Member, marykebez@gmail.com, www.ruralrehab.co.za.

Africa Health Placements

The mission of AHP is to support and enhance healthcare systems in Africa, by finding, placing and retaining healthcare workers in rural and underserved areas. AHP pledges to continue supporting the South African Government in recruiting and retaining appropriately qualified health care workers to areas of greatest need, so that the Government can deliver on the NHI promise of equal access for all to comprehensive health care. Contact details: Saul Kornik, Chief, saul@ahp.org.za, www.ahp.org.za

D) What is Universal Access?

D.1) Accessing the point of care

12. The purpose of NHI is to achieve equity in access to health care and better health outcomes. The Green Paper states that “access should be free from any barriers and any inequalities in the system need to be minimised” (section 52e, page 17) and that “Everyone is accorded protection from financial hardships linked to accessing these health services” (section 53, 18). However, the Green Paper does not sufficiently explain how this protection is accorded, and how the barriers are eliminated. A narrow definition of access by focusing on “point of delivery” will not address the inequities in access to health care. Of particular concern to us are the following, which are deliberated further below:
 - The cost of accessing “the point of delivery”; due to the high levels of poverty in many rural communities, the large distances to health care facilities and the lack of a public transport system, these costs are higher for rural versus urban communities, and even more so for those who are very ill or who live with disabilities.
 - The lack of private sector facilities in rural areas. Unlike in urban areas, access to private sector facilities to households currently dependent on the public sector will not make much of a difference for rural communities, unless there are specific incentives to do so.
13. Affordable and reliable public transport is vital to accessing health care. Of poor households, 15% live more than an hour from the closest clinic and 20% live more than an hour from the closest hospital². A study aiming to answer the question “Why patients miss follow-up appointments”, found that lack of adequate

² Health Reform Note 1 , PHC, page 3, 2010

transport was the main reason for missed appointments, followed by health reasons and finances³. The Researching Equity in Access to Health Care (REACH) project⁴ also found that there are considerably greater access barriers experienced by rural communities compared to urban ones, with respect to distance, time and costs. The cost of accessing health care can have catastrophic implications for poor households, with transport costs being a significant contributor⁵. Lack of transport is an even greater barrier to access to health care for disabled people. There are few public transport systems available for disabled people in rural areas, particularly people using wheelchairs. The situation is the same for the elderly, the frail and the very ill – the few ambulances that operate are difficult to call and often cannot access the most remote areas. The implications are delayed health-seeking behaviour and an increase in loss to follow-up. This has negative implications for the NHI’s objective to improve equity and health outcomes. Other countries have attempted to overcome this issue by introducing transport vouchers to poor households⁶ ⁷. Studies have shown improved health outcomes after the introduction of such vouchers in China, Taiwan, Korea, Nicaragua and Mexico⁷. An exclusion of transport costs to facility level from the NHI package of services will severely disadvantage the poorest households. The introduction of transport vouchers financed through the NHI does not dismiss the Department of Transport and the Department of Rural Development and Land Reform from implementing a Rural Transport Strategy with utmost urgency to ensure that the infrastructure is available to transport poor health care seekers in the most remote areas of our country. Indeed, close collaboration between the Department of Health, the Department of Transport and the Department of Rural Development is required.

14. The Green Paper states that access will be improved through a unified health care system which will effectively provide South Africans with access to both private and public facilities. This will improve access in urban areas. It will also improve the quality of care that urban communities will receive due to the often-higher standards of care in private facilities. Yet, the same logic does not apply to rural areas. There are few private GPs in rural areas and significantly fewer private sector health centres and hospitals. Looking at both private and public health care, in 2007 the Western Cape had 60 private hospitals, 55 public hospitals and 1246 doctors serving a population of 4.8 million, compared to what was then 6 private hospitals, 44 public hospitals, and 882 doctors serving a population of 5.7 million in Limpopo. The following table illustrates the inequities between private sector facilities in urban versus rural provinces:

Private sector facilities per province ⁸									
	LP	NC	EC	MP	NW	KZN	FS	WC	GP
Total population	5238 286	1058 060	6527 747	3643 435	3271 948	1025 9230	2773 059	5278 585	10451 713
% of population rural	90%	80%	62%	61%	59%	55%	25%	10%	4%
Number of private hospitals	5	3	13	9	10	27	15	39	95
Number of private hospitals per 100 000 rural population	0.11	0.35	0.32	0.40	0.53	0.48	2.16	7.39	22.72

Table 1

³ G. Van der Meer and J.W. Loock. Why patients miss follow-up appointments: a prospective control-matched study. *East African Journal of Public Health* 2008; Volume 5, Number 3.

⁴ Researching Equity in Access to Health Care Project. Phase 1 Results: Access challenges in TB, ART and Maternal Health Services. December 2009. Susan M Cleary, Stephen Birch, Mosa Moshabelad, Helen Schneider. Unequal access to ART: exploratory results from rural and urban case studies of ART use. *Sexually Transmitted Infections* (in press).

⁵ Goudge J, Gilson L, Russel S, Gumede T, Mills S. Affordability, availability and acceptability barriers to health care for the chronically ill: Longitudinal case studies from South Africa. *BMC HealthServices Research* 2009; 9-75.

⁶ See for instance: <http://rtc.ruralinstitute.umn.edu/IL/RuralFacts/TrnVoucherfacts.htm>, <http://www.grant-tracker.org/news/rural-transport-fund-voucher-schem>

⁷ Rob U, Rahman M, Bellows, B. Using vouchers to increase access to maternal healthcare in Bangladesh. *Int'l. Quarterly of Community Health Education*, Vol. 30(4) 293-309, 2009-2010.

⁸ Kok P, Collinson M. Migration and Urbanisation in South Africa. Pretoria: Statistics South Africa 2006. Report No.: 03-04-02, 20. Community Survey 2007 - Basic Results. Pretoria: Statistics South Africa 2007.

21. Matsebula T, Willie M. Private Hospitals. In: Harrison S, Bhana R, Ntuli A, editors. *South African Health Review* 2007. Durban: Health Systems Trust; 2007.

15. Only citizens registered with Home Affairs will be eligible for NHI coverage. Provision needs to be made for the health rights of refugees, and asylum seekers in terms of applicable laws. Certain services, such as emergency medical services and primary health care, also ought to be made available to undocumented migrants. For a full motivation of this argument, we refer to SECTION27's submission⁹.
16. In terms of registered citizens, the Green Paper does not state clearly how these will be identified. If a South African ID book will be the condition for South African citizens to obtain an NHI card, then a country-wide ward-level drive to assist all eligible residents to obtain their ID document needs to precede the introduction of the NHI. Many South Africans continue to face massive challenges in procuring South African ID documents, especially marginalised groups such as the rural poor, people with disabilities and orphans and vulnerable children.
17. Considering all of the above, we argue that the concept of Universal Access needs to be defined differently. We argue that the NHI should not only promote equity in access to health care regardless of socio-economic status, but should also promote equity in access "regardless of geographical location". All reasonable measures should be put in place to ensure rural communities' access is not limited by their place of residence.

D.2) Accessing quality of health care at the point of delivery

18. In the above section we focused on patients' difficulties in reaching facilities. In this section we move the focus from the demand for health services to the supply thereof: the need for a sufficient number of well supported health care workers, in order to provide quality health care at the lowest level possible. This is a critical element of the strategy to address access barriers.
19. Section 61 on page 21 of the Green Paper notes that "for NHI to have this positive macro-economic implication, it needs to address the current institutional and staff constraints..." We wish to state our full support of this statement. One of the major constraints is the insufficient and inequitable distribution of human resources for health, and the hospital-centric and curative health care system. Another issue is the weak organisational culture in many facilities, characterised by weak leadership, poor work ethic amongst some health care workers, and a resultant poor quality of care¹⁰. Part of the strategy by Government to address these matters is a range of interventions parallel to the phasing-in of the NHI. Notably, the establishment of the Office of Standards Compliance, the "Re-Engineering Primary Health Care System" and the new national Human Resources for Health Strategy. We strongly support these parallel interventions and the outcomes they wish to achieve. A number of critical interventions are to be prioritised if rural communities are to have access to equivalent benefits to the ones which urban communities enjoy¹¹. Merely changing the funding mechanisms for the provision of health care will not address the absolute shortage of health professionals in South Africa.

HUMAN RESOURCES FOR RURAL HEALTH

20. The new Human Resources for Health (HRH) Strategy for South Africa acknowledges the need to take urgent and firm action to address the staffing crisis in rural areas. Strategic Priority Area 8 speaks to "Access in Rural and Remote Areas". We fully support all five objectives, which are:

⁹ SECTION27's submission will be available on www.section27.org.za

¹⁰ Versteeg M, Couper I. Position Paper: Rural Health - Key to a Healthy Nation. Johannesburg: Rural Health Advocacy Project 2010. Chopra M, Daviaud E, Pattinson R, Fonn S, Lawn JE. Saving the lives of South Africa's mothers, babies, and children: can the health system deliver? *The Lancet*. 2009;374(9692):835-46.

¹¹ Our views and recommendations on this are discussed in more detailed in a number of recently released documents: RHAP Position Paper, WHO Global Policy on accessing health professionals in rural and remote areas: SA context, Rural-Proofing of the PHC Re-engineering Plan.

- 1) Implement short term strategies on access to professionals in rural and remote areas
- 2) Design and implement an educational strategy based on WHO guidelines for rural and remote areas (in consultation with Faculties of Health Sciences)
- 3) Develop regulatory strategies to improve access to health professionals in rural and remote areas and quality of care
- 4) Develop financial incentives to attract health professionals to work in rural areas
- 5) Provide personal and professional support to health professionals working and training in rural areas

The urgency of implementing the above strategies and related activities captured in the Strategy cannot be emphasised enough. In particular we stress the following:

- Appointment of a rural HRH strategy task team (working group) under the National Health Council, to develop the details of the Rural HRH Strategy and to support the NDoH in implementing them
- Development of minimum staffing norms to facilitate equitable distribution
- Agreement on a definition of 'rurality and remoteness' to inform resource allocations such as a rural allowance, and policies such as OSD, and to measure and compare progress in closing the equity gap between rural and urban areas
- Start negotiations with Higher Education Institutions on curriculum and admission policies
- Increase the proportion of rural students in health professional courses in South Africa
- Increase the proportion of training of health professionals that occurs in rural areas
- Increase the uptake of suitably qualified foreign health workers
- Prioritise outreach support from referral hospitals
- Improve living conditions for rural health care workers including accommodation

21. Furthermore, HR Managers need to be trained with a specific focus on workforce planning, strategic workflow initiatives and retention methodologies.

22. Ideally, the target number of health professionals serving a community should be proportionate to the measure of overall need, including social determinants of health and burden of disease in the community in question¹². Given the gross HRH shortages, however, ensuring a minimum level of staffing is the starting point. Table 2 presents the formula recommended by the Rural Doctors Association of Southern Africa for the determination of doctor posts, as an accepted **minimum** level requiring no motivation for filling of posts, regardless of the financial situation, job freezes and budget cuts:

Minimum staffing norms for doctors at DISTRICT HOSPITALS	
1000 uninsured population	1 bed
10 beds (10,000 uninsured population)	1 doctor
100 beds (100,000 uninsured population)	10 doctors

Table 2

Interns still undergoing training should not be included in this pool, and not more than two community service doctors should be part of the minimum doctors/population.

23. In terms of rehab workers and therapists, Rural Rehab South Africa recommends minimum staffing norms of 1 physiotherapist and 1 occupational therapist per 22 000 population, 1 speech and language therapist per 50 000 population, and 1 audio therapist per 100 000 population. The above excludes students and assistants. This staffing should not be without at least one, preferably 2 cars for outreach.

24. As South Africa has not produced and retained a sufficient number of locally-qualified doctors to staff the public sector, and in particular rural areas, for delivering health services through the NHI mechanism, it is

¹² The Deprivation Index 2008 is a composite measure of overall need of a community, using the sub-district as the relevant unit of analysis; compiled by the Health Systems Trust. Available at www.hst.org.za

critical that the South African Government focuses on attracting foreign-qualified doctors as a resource with which to make up the shortfall. However, in order to effectively compete for these globally scarce and mobile resources, the Government needs to make a number of urgent and critical reforms in this regard:

- a) The extensive and fractured bureaucracy required for a foreign doctor to register to work in South Africa needs to be re-engineered. This includes creating a uniform online portal to accept applications for all steps in the process (including HPCSA and DOH), removal of duplication of certain steps and documents, as well as working with the HPCSA to remove severe bureaucratic barriers (such as requiring ECFMG verification prior to registration for non-exam track doctors). Streamlining this process will result in quicker turnaround times and a less onerous and more competitive process.
- b) The Government needs to work with the HPCSA to expand the number and type of doctors and specialists who can work in South Africa without needing to come to South Africa to write a qualifying exam before proceeding with the registration process.
- c) The Government needs to revise its policies on who can and cannot work in the country. This is particularly important for health workers who are already living in the country but who cannot register to work.
- d) The Government needs to formally contract independent organisations who can market to foreign doctors from developed-world countries. This is the key method that is being used by the developed world, who have attracted and placed South African health workers, contributing to the country's brain drain.

RE-ENGINEERING OF THE PRIMARY HEALTH CARE SYSTEM

25. We applaud the re-engineering of the primary health care system (section 66-78 on pages 23-26) and the three streams of health care delivery (section 70, page 24). The PHC approach will be the primary delivery model of health care financed through the NHI. For the NHI to reach its aim, its delivery model needs to be: effective, efficient, equitable, comprehensive in its service package and of high quality. In this context, we wish to highlight a few issues:
26. The District Clinical Specialist Support Teams, the first stream of health care delivery, are fully supported. However, the focus should be on district hospitals, with mentoring and training of the primary care physicians and nurses who work in the district i.e. the role of the specialists is not in the community, but to support and train those who work in the community:
 - a) The Public Health specialist should be included in this specialist team; exclusion of this discipline, or ideas of separately linking this specialist to the district management team, will not provide an adequate influence of public health goals on improving clinical health outcomes.
 - b) Apart from the anaesthetist, these specialists should not be placed in regional hospitals, where they will be completely absorbed and not fulfil their outreach mandate, but rather under a district clinical coordinator, who is, in many instances where such people are already in place, a family physician.
 - c) At the same time, it is critical that the staffing of the regional hospitals is improved, so that the required range of general specialists is available, in order to ensure functional referral pathways in support of these teams.
 - d) The specialists themselves will need specific training for this particular role, which is very different from the current tertiary-based specialist training. Rotations for postgraduate trainees (registrars) into regional hospitals and into working with these district teams should be mandatory. Linked to this, undergraduate medical and nursing students should also have the chance to work alongside and be exposed to these district specialist teams.
 - e) The importance of continuity and an understanding of the context are critical for these teams to be effective. There is a risk that they can be a disruptive force and a burden on district health professionals if they do not function in a collaborative way with the development of meaningful relationships over time.

- f) Members of the teams should be joint appointees with the appropriate university, both as a support and incentive to them but also to facilitate the involvement of faculties of health science at district level and develop a rural teaching platform¹³.
27. The third stream aimed at bringing PHC closer to its beneficiaries under the NHI are Primary Health Care Teams and Primary Health Care agents, as referred to in paragraph 70c of the NHI Green Paper (page 24). It states that each PHC team will be headed by a professional nurse and that each team will be allocated a number of households. This is a critical opportunity to improve access to health care for remotely-based rural communities. To make this opportunity a real benefit for rural health, the following is needed:
- a) The Primary Health Care Agents that work at ward level should include both community health workers and home-based caregivers. They play distinctive roles and need equal support and recognition.
 - b) The ward-based Primary Health Care Teams should include at least one therapist and one mental health practitioner in addition to the other members of the team.
 - c) Training in aspects of disability and specific referral criteria is critical for all those involved on the municipal ward-based teams as well as for community care givers (CCG's).
 - d) The distribution of Primary Health Care agents should be determined by a range of factors and not only population numbers. In rural areas it takes more time, and it is more costly, to reach remote villages. Yet, the rights of the remote residents are equal and their unmet needs are often higher than urban populations due to the stated access problems. Whereas the need in each area needs to be calculated individually with regards to population density and access to transport, in some rural areas this may result in a ratio of 1:1,5 Primary Health Care Agent between urban and rural populations.
 - e) Lastly, the role of the doctor in this team is understated. The success of the Brazilian and Cuban models is that there are doctors at the community level, in a team with the nurses and working with the community health workers. Nurse-based teams should be seen as an interim measure, with the long-term aim of community-based doctors becoming part of these teams
28. The designation of hospitals (paragraphs 88-96 on pages 29-31) refers to the overhaul of the health system, which goes beyond primary health care. A key feature of the overhaul, which is not addressed, is to restructure the health system towards outreach so that every level reaches out to and supports the level which refers into it i.e. central and specialised hospitals support tertiary hospitals; tertiary hospitals support regional; regional support district; district hospitals support clinics, etc. This requires a change in performance agreements with staff and how managers understand the role of staff, as well as a change in mind-set of health professionals themselves. Faculties of Health Science can assist in driving this change.
29. The Policy on Management of Hospitals¹⁴ underpins the designation of hospital as referred to above. In its entirety, this policy is not commented on here, except to underline the importance of clinical staff needing a clinical manager, not an administrator. This is acknowledged as preferable in the policy document, but there are specific rural considerations making it vital:
- a) Qualification as a health professional is correctly seen as the principle selection criteria, as supported by the Policy of Management of Hospitals. The reality in rural areas, however, is that traditionally there is no shortage of candidates who apply for an advertised hospital manager post (under a management structure where the CEO was not based at the hospital) but often no more than "one-or-none" to an advert for a clinical manager. There is a real likelihood, therefore, that the option to employ an administration manager in the absence of a suitable health professional will be exercised. This must be avoided. At the same time, clinical managers need to be supported to focus on clinical issues so they are not drawn into long administrative meetings with little clinical relevance when they should be focusing on clinical governance. They should be given appropriate

¹³ It is concerning that the policy document Classification of Hospitals (available at www.doh.org.za) does not stress that district hospitals are part of an academic platform with other larger hospitals.

¹⁴ Gazetted 12 August 2011. Available at www.doh.org.za.

management training, which ideally should be part of the training of all clinicians, but in reality does not occur in most cases.

- b) Junior staff rate the clinical guidance provided by senior staff highly; clinical support and mentorship are significant factors in the retention of junior doctors.
- c) Multi-disciplinary teamwork contributes significantly to job satisfaction of clinical staff in rural facilities. This teamwork is more easily realised at a smaller rural facility, but needs facilitation by a senior clinical manager with experience in managing clinical staff. According to the district hospital organogram, clinical managers operate alongside a “clinical support services manager”. The latter is responsible for the pharmacy, rehabilitation services and others. In reality, this latter post remains unfilled in many rural areas, and the responsibility falls to the clinical manager. It is only after some years of clinical management, over and above administrative management, that the skill and experience are gained to properly carry out this role. Does future policy on DH management include this post? Even if not, the argument remains valid.
- d) Many rural facilities operate at or below the critical staff levels required to retain health professionals. Should staff numbers drop below this critical level, good leadership by a clinical manager offers some time (a month or two at most) during which an emergency recruitment plan can be effected, before the rest of the clinical staff might leave owing to increased workloads. Patients in turn risk being turned away as remaining doctors cannot cope with the workload.

30. In addition, both the NHI Green Paper and the Policy on Management of Hospitals need to recognise that a hospital being smaller in size does not always equate to being smaller in work load:
- a) The definition of hospital size by infrastructure alone (i.e. number of beds) does not reflect the reality, particularly in rural areas. The current focus on PHC will increase the outreach required from district hospitals. Resources required for outreach are defined by frequency, activity (including different disciplines) and duration of visit (including distance and time). In rural facilities, more resources are often required by these criteria.
 - b) Inequity in access to health care is a stark reality in rural areas. Many rural patients can only access the health care system with difficulty. The quality of care provided to out-patients at a clinic or district hospital in a rural areas is, therefore, especially important in ensuring correct admissions, referrals and follow-up according to standard clinical guidelines. The workload at a rural facility is increased considering the demands of the catchment population requiring continuity of care over time. Bed numbers, and the utilisation thereof, are only part of the full picture.
 - c) Clinical staff numbers do not increase with bed numbers. HR shortages ensure that, when assuming high bed occupancy rates (BURs), each worker's work load increases as bed numbers increase. This affects rural hospitals more. Larger district hospitals are often in urban areas, and are better staffed.

31. The lack of efficient, effective and accountable management at all levels of the health service, and the failure to devolve authority and responsibility to the appropriate level (districts and hospitals) is a major problem. NHI funds will continue to be wasted unless this is addressed. Appropriate management training, including HRH training, for all in the service – including all health professionals – and the allocation of meaningful responsibility with accountability is needed.

PEOPLE WITH DISABILITIES

32. Section 69 of the Green Paper (page 24) states that all South Africans will be entitled to a defined comprehensive package of health services at all levels of health care. We argue that the health rights of people with disabilities should be included in this package. This is motivated for in more detail below.
33. 24.2% of South Africans have at least one disability - making them SA's largest minority group¹⁵. 50% of disabilities are preventable and directly linked to poverty¹⁶. 77.6% of HIV positive children have a physical

¹⁵ WHO, World Disability Report (2011)

delay, 63.5% a cognitive delay and 49.2% a language delay - this is lessened but not preventable by timeous initiation of ARVs¹⁷. Half a million South Africans have a visual impairment, but 80% of blindness is avoidable.

- a) As disability almost always impacts not only on the disabled person but also on the entire household, especially in impoverished rural areas¹⁸, it must be acknowledged that promoting access to care for disabled people enhances access to care for many others as well¹⁹.
- b) Rehabilitation and mental health services should be available at *all levels of care* (household to tertiary) and in all 3 “streams” of PHC: school services, specialist teams and outreach teams. Psychiatrists and psychologists need to form part of the district specialist teams; and therapists and psychologists need to be an integral part of the PHC stream delivering services at clinics, and the community and household level. Occupational therapists, speech therapists, audiologists and psychologists all need to form part of the school health team.
- c) In addition to rehabilitative services, therapists need to be involved in prevention, promotion and screening at clinic, community and household level in order to address the aims of the NHI. There need to be sufficient posts for therapists at community level so that therapists employed at district hospital level are not expected to cover all service areas - this results in centralised services with reduced coverage of those who require home based rehabilitation.
- d) Comprehensive primary and secondary eye care services can, and should be, offered in rural areas.
- e) To meet the health rights of people with disabilities, the preparations for the NHI need to promote a shift from quantitative survival to qualitative development, and the integration of people with disabilities into mainstream health care. This requires earmarked resources and a set of norms and standards to be developed for such services such as rehabilitation, eye care and mental health care services, including resources, staff and services. A large emphasis must be placed on outreach as many patients are unable to access clinics due to physical and transport barriers. Moreover, interventions are often more appropriate in a home setting.
- f) On the important matter of disability, we draw attention to two separate submissions which unpack the above matters in more detail. These are submitted by Rural Rehab South Africa and SIYABONAKALA²⁰.

D.3) Acceptability of health care services

34. Given that the majority of the country’s total health budget will be dispersed through the NHI, it is essential that the fund supports a health system and package of services that is acceptable to, and preferred by, its primary beneficiaries. In this regard, we echo the People’s Health Movement assertion that what is required is “an open and inclusive process where community organisations, health workers, activists and trade unions are consulted on what they would like to see in a reformed health system (...). There should be mechanisms and structures established which provide an avenue for community and civil society input to determining what goes into the package²¹.” Key challenges identified by communities during the NHI Community Consultations facilitated by the Black Sash in 2010 and 2011 included: shortages of staff, the large distances to health facilities and services, insufficient medication, patient transport and a shortage of ambulance services. The role of health care workers and communities in the delivery of health care emphasises some of the basic principles of primary health care, also reflected in South Africa’s National Health Act: participatory

¹⁶ Department for International Development (2000) Disability, Poverty and Development. DFID

¹⁷ Potterton et al, 2009; Ferguson and Jelsma, 2009; Baillieu and Potterton, 2008).

¹⁸ Duncan E, Watson R (2009).The occupational dimensions of poverty and disability. Institute for Poverty, Land and Agrarian Studies (PLAAS) Working Paper 14.

¹⁹ Idem

²⁰ The full submission by SIYABONAKALA is named "**Comprehensive Eye Health: Focused Primary Care to Prevent Avoidable Blindness**" and endorsed by **Right to Sight**, Dublin - member of the International Agency for the Prevention of Blindness

²¹ People’s Health Movement Discussion Document

health planning, decision-making and the monitoring of service delivery²². In support of these principles in rural areas, it is recommended that²³:

- a) The District Health System, as defined in the Government White Paper of 1997²⁴, should be changed to include:
 - The relevant unit of analysis, namely the sub-district (or ward where applicable)
 - Increased community and NPO representation
 - Consideration of the social determinants of health as an additional area of responsibility for all stakeholders
 - Emphasis on collaboration (including intersectoral where relevant)
- b) An extensive audit/mapping process be undertaken at sub-district / ward level to identify:
 - NPOs and CBOs and services provided
 - Human resource capacity and skill sets at all management levels within all organisations involved in service delivery
 - Gaps in/needs for service delivery where evident, and organisations who may address these gaps/need

E) Social Determinants of Health

35. While the ultimate purpose of the NHI is to improve health outcomes, it is known that access to health care is only one determinant of improved health. The health sector needs to be commended for its radical overhaul of the health system and the many new strategies being implemented. We call for Government to lead a similar drive and sense of urgency in the other sectors with a direct bearing on health, notably Local Government, Housing and the Department of Transport. In terms of the social determinants, rural districts are once again left behind. The country's most deprived districts are located in three provinces: KZN, Limpopo and Eastern Cape²⁵. The deprivation index is a measure of relative deprivation across districts within South Africa. Variables included for calculating the deprivation index are²⁶:

- The proportion of the area's population whose household heads have no schooling
- The proportion of area's adults between 25 and 59 classified as both not working and looking for work, or not working and not looking
- The proportion of the area's population that live in a traditional dwelling, informal shack or tent
- The proportion of the area's population that have no piped water in their house or on site
- The proportion of the area's population that have a pit or bucket toilet or no form of toilet
- The proportion of the area's population that do not have access to electricity or solar power for lighting, heating or cooking
- The proportion of the area's population that are black Africans
- The proportion of the area's population that are from a household that is headed by a female

This illustrates once again that more effort is needed to uplift rural communities. We acknowledge that the NHI fund cannot fund all the expenses related to the social determinants of health. Yet the level of deprivation is illustrative of the additional support that rural communities need to have to obtain a higher level of well-being.

²² RHAP Position Paper Rural Health Care, 2011

²³ The outcome of the PHC Symposium of NGOs held in September 2011 included these two recommendations. All recommendations available at www.cmt.org.za

²⁴ White Paper for the Transformation of the Health System in South Africa Department of Health, April 1997. Chapter 2. Reorganising the Health Service; Section 2.3 The District Health System. Available at www.info.gov.za/whitepapers/1997/health.htm

²⁵ Available from www.hst.org.za/./dhb0708_sec1.pdf.

²⁶ For a detailed definition of "deprivation", see the District Health Barometer 2006/2007, Appendix 1. Available from www.hst.org.za

F) Accreditation

36. Facilities that want to contract with the NHI need to be accredited first. In principle, the aim is for all public health facilities to become NHI facilities. Given the state of many rural facilities, which are plagued by infrastructure decay and understaffing, there is a risk that many, though not all, rural facilities will take a long period of time to meet the accreditation criteria. Private sector facilities, however, are more likely to be the first to be accredited, followed by urban-based public facilities. This scenario is presented in the figure below:

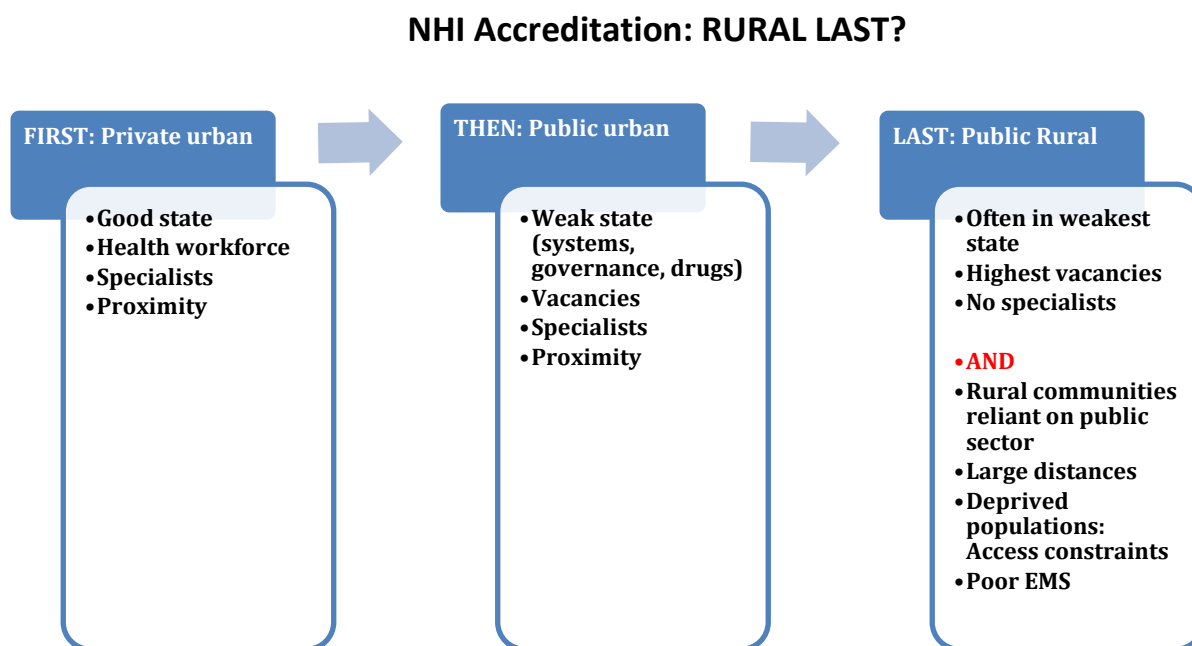


Figure 1

It is unclear what will happen to the facilities that do not immediately meet the criteria:

- a) Will they receive more financial resources to meet the criteria whilst also sustaining, and improving a service as equal as possible to the NHI accredited facilities?
- b) Many facilities have infrastructure problems due to their reliance on the Department of Public Works. Critical infrastructure, such as generators, are lacking, which have caused avoidable infant deaths during power outages. To what extent is the Department of Public Works actively involved in supporting the preparations for the NHI?
- c) Or will the standards simply be lowered to the detriment of rural patients?

The NHI needs to be explicit in the plans of how the playing field is being levelled, and how rural hospitals and services will be supported to meet the NHI standards.

37. It is unclear what happens to areas where private and/or public hospitals are mushrooming. Will they all be accredited? This should be avoided as it will lead to a concentration of NHI fund allocation to a small pool of beneficiaries. This money should instead be used to increase access to services in rural areas.
38. The NHI Green Paper states that there will be HR staffing norms for each category of services (section 120, page 37). As discussed in point 29, the understaffing may present real challenges to accreditation. This provides further urgency to the implementation of the HRH plan discussed in section 16. However, the staffing of facilities by mostly junior staff needs to be avoided, as this is not a solution to the HRH crisis, nor to meeting NHI staffing norms. Junior health care workers need senior support and supervision. In this

regard, the Community Service Policy is a good example of a well-intended policy not benefitting rural areas equitably. In many case community service officers (CSOs), from different professional backgrounds, are placed in facilities without being given adequate support. They are subsequently lost to rural health forever due to their negative experience. Yet, unfortunately, in most cases, CSOs are not placed in rural areas at all, but predominantly in a more urban setting. This trend has been demonstrated over many years and continues in 2012, requiring radical intervention by National and Provincial Governments. CSOs need to be placed in rural hospitals where minimum support structures are available and provided.

39. The accreditation of providers (sections 97-107 on pages 31-33) further provides an opportunity to support the development of health professional education in regional and district hospitals. Such training is critical to the improvement of facilities and to the future workforce, and as such, should be embedded in the process of accreditation. The understanding of the National Health Act of 2004 that “academic health complexes ... may consist of one or more health establishments at all levels of the national health system, including peripheral facilities” can and should be realised through this process. Incorporating health professional training into these hospitals can be one way of ensuring that the necessary standard are met and are maintained, and can also be an incentive or reward for hospitals that achieve the standards.

G) Rural Health Financing

40. We welcome the proposed equalisation of risk across the national population. It is agreed that the rich should be paying progressively more than the poor for their health care. All forms of indirect “taxes”, such as VAT, should not be increased to pay for the NHI. This increases the burden on the poor, both urban and rural, and should not be allowed.
41. The NHI policy is unclear on its stance about the issue of co-payments and user fees. These need to be disbanded completely as they impose catastrophic health expenditure on any household marginally above the poverty level. Services should be free at point-of-delivery. We further argue in this submission that the cost of accessing the point of delivery also needs to be subsidised for households below a particular income.
42. The ending of tax subsidies for those citizens who choose to continue with medical scheme cover is supported (section 137, page 43). Tax subsidies do not benefit the poor; such subsidies lower income tax which could be invested in equitable health care.
43. Effective cross-subsidisation between rich and poor, and the healthy and the sick, requires an understanding of the added costs for poor rural communities. Inequities experienced by the rural poor - particularly related to inadequate access to care and shortage of health professionals - need to be explicitly addressed by the NHI fund allocation:
 - It is the rural poor who are the most difficult to cover with respect to the three dimensions of universal coverage²⁷ (section 62, page 21): full population coverage, optimal service coverage, and the exposure to financial risks associated with health.
 - As a result, more resources are required to realise similar health outcomes in a rural patient, as compared to otherwise similar urban patient.
 - The consequences of the health system failing the rural individual are often more expensive to rectify than if the same eventuality should happen to an urban patient. There are often unexpected reasons why follow-up and referral are delayed, which happens to both rural and urban patients. Access to the health system, however, is more difficult for the rural patient in the first place; therefore initial pathology presentations are likely to be more advanced. Rectifying the problem of missed follow-up is, similarly, more difficult to ensure.

²⁷ WHO 2010 World Health Report

44. The NHI paper states that the costing model makes allowances for large increases in utilisation (70% increase in outpatient care and 80% increase in inpatient care) (section 121, page37). The NHI, as it is currently planned, will not result in increased access to care of these magnitudes in rural areas, unless tailored solutions for rural health care are resourced and implemented.

G.1) Infrastructure-Inequality Trap

45. The Bill of Rights and Section27 of the Constitutions places an obligation on Government to progressively realise the right to health care equally for everyone, within the available resources. Government thus has a duty to take all reasonable measures to improve the access of rural communities to health care to the best of its ability. This includes equitable spending of resources within areas of the greatest need. Yet, the provinces with the greatest health burdens, the least economic resources and the largest populations receive the smallest share of national public health care funds. A study looking into provincial resource allocations found that provinces with greater existing capacity, in terms of hospitals and number of doctors, benefited from higher funding allocations²⁸. The inequities are explained by the “Infrastructure-Inequality trap”, referring to areas with greater existing capacity attracting higher health care expenditure than areas with less existing capacity. This pattern may be entrenched under the NHI, as per our previous argument that urban areas will benefit from access to private sector facilities, which are almost absent in rural areas. In the section below we explain why service-platforms and needs-based budgeting are the most equitable manner in which to allocate NHI funds.

G.2) Provider payment at hospital level

46. The Green Paper states that at the hospital level, accredited and contracted facilities will be reimbursed using global budgets (1); initially, moving towards diagnosis-related groups (DRGs) (2); with a strong emphasis on performance management (3) (section 102, page 32). Global budgets, utilisation/population-based approaches, and allocations on the basis of Disease Related Groups will not lead to equitable financing.

Global Budgets:

- a) Global budgets are centralised (at province or district). The sharing of this pool of funds between different hospitals is often decided using the previous budget allocation or expenditure as a baseline. Such decisions made on historical grounds must cease. This is the current method of allocation of budgets at most rural district facilities, and entrenches the inherited imbalances of the health system. This system is also inefficient because allocation is based on the size of infrastructure capacity rather than level of activities of facilities.²⁹
- b) Decentralisation of budgets and authority to the facilities and districts is welcomed. Up until to date, however, geographical isolation from urban provincial and district offices often means that decisions are made without awareness of, or taking into account, the actual health needs.
- c) If not allocated simply based on historical funding, global budgets will be allocated using a formula-based approach. Allocation to rural facilities may be unfair under any one of the three main ways in which the formula is calculated:
 - a population-based formula is aimed at enhancing equality but may disadvantage rural communities (the reasons why are relevant to the calculation of capitation payments to accredited or contracted primary health providers; this is discussed in paragraphs 46-47)
 - a utilisation-based formula is aimed at enhancing efficiency but may disadvantage rural communities (the reasons why are relevant to the discussion on DRGs in paragraph 39(d)).

²⁸ D. Stuckler, S. Basu, M. McKee Health Care Capacity and Allocations Among South Africa’s Provinces: Infrastructure–Inequality Traps After the End of Apartheid. *American Journal of Public Health*; January 2011, Vol 101, No. 1

²⁹ T. Ensor, A. Hossain, L. Ali, S. Begum and H. Moral. Geographic resource allocation of the public health budget in Bangladesh, Health Economics Unit, PRU, MOHFW, Research Paper 21, Dhaka; 2001

- a needs-based formula is aimed at enhancing equity. Such an approach can help calculate facility provider payments or capitation of accredited PHC providers by including measures or proxies of 'health need', for example infant mortality for burden of disease. This approach can, however, entrench inequitable service delivery to rural areas unless needs are identified accurately and comprehensively. If there is no variable used as a proxy of 'rurality' (and adequately weighted in the formula), then the allocation of budgets will be inequitable and unfair. The equitable share formula, used to calculate split of national budget to provinces is an example of a formula where 'rurality' is not considered sufficiently.³⁰ We are concerned the NHI may attempt to use a complex formula without actually considering rural community and service delivery needs.

Diagnosis-Related Groups (DRGs):

d) The NHI proposes "moving towards" budget allocation on the basis of Diagnosis-Related Groups. Patients who have been treated in hospitals are classified in groups where other patients have the same condition (based on diagnosis, procedures, and age), co-morbidities and individual needs. These groups are known as Diagnosis Related Groups (DRGs). The use of DRGs provides a means of defining and measuring a hospital's case mix complexity (glossary, page56). Normally, the term "case mix complexity" is used to refer to a set of patient attributes which include severity of illness, risk of dying, prognosis, treatment difficulty, need for intervention, and resource intensity. The more complex the case mix, the more costly to manage; sufficient funds will then be allocated under the NHI. It is an example of a utilisation-based formula to enhance efficiency, but offers specific challenges to equitable resource allocation in rural hospitals. In reality, it can be anti-rural. Rural hospitals require, in fact, allocation of proportionately more funds because:

- Case mix complexity must not be evaluated on clinical criteria alone. The logistics associated with management of patients in rural areas increases the complexity and costs, for which more budget must be allocated.
- DRGs are concerned with in-patient numbers and case mix; but rural facilities spend proportionately more time and resources on comprehensive outpatient consultations than others, owing to the problems around continuity of care (referrals and admissions).
- Access to the health system will remain difficult in rural communities; this will mean outreach from the rural hospital will continue as a cost-effective method of health care delivery. This requires significant funding (transport, extra staff), and should be considered in/in addition to DRG funding mechanisms.
- Continuity of care and referral processes are, even if working well, more difficult between rural and their urban referral centres, resulting in greater treatment difficulty, higher resource intensity, and greater severity of illness (on average) being found at rural facilities, compared to similar urban facilities.
- Rural health needs are far greater than the current demand. It is vital to tie funding to health needs, rather than demand. Funding might be easy to calculate for the latter, based simply on provision of services and existing infrastructure and workforce, but this favours better-resourced, usually urban, facilities. This is referred to as the Infrastructure-Inequity trap as explained earlier; defined as the cycle of greater capacity leading to greater allocations leading to greater capacity etc.³¹
- DRGs are part of a utilisation-based model which incentivises unnecessary and inappropriate use of services.

³⁰ In Tanzania, the Basket Financing Committee (BFC) approved the use of a revised resource allocation formula, as from January 2004. Besides the expected variables for population size, poverty levels and a proxy for burden of disease, the formula included "the mileage covered for service supervision and distribution of supplies (10% weighting)". Available at www.equinet africa.org/bibl/docs/DIS33fin.pdf

³¹ D. Stuckler, S. Basu, M. McKee Health Care Capacity and Allocations Among South Africa's Provinces: Infrastructure-Inequality Traps After the End of Apartheid. *American Journal of Public Health*; January 2011, Vol 101, No. 1 The study found that provinces with greater existing capacity (hospitals and number of doctors) in South Africa have historically benefited from higher funding allocations. The inequities are explained by the "Infrastructure-inequality" trap, referring to the link between greater existing capacity to a rise in health care spending.

- e) Using a case-based approach to reimburse public emergency medical services (section 105) is supported, but must account for the extra distance travelled to and from rural facilities, as well as the wear and tear on the vehicles used in rural areas.
- f) Severity of illness is generally associated with greater intervention and higher cost. Administrators must be cautious in identifying exceptions in a bid to contain costs. In palliative care, for example, a patient with a poorer prognosis does not always need fewer interventions.

Needs-based budget allocations:

- g) To be guaranteed equitable finance under the NHI, rural health care requires resources and budgets based on a service-platform approach; not a formula-based approach. An effective and equitable distribution of facilities and services is decided first. This is used to determine an appropriate allocation of resources, which is then used as a basis for the allocation of budgets.
 - h) This service-platform approach avoids the continuation of the Infrastructure-Inequality trap. Without such budgeting, financial resources are likely to flow where resources already exist (relative to under-resourced areas). Table 1 of this submission demonstrates the skewed distribution of private facilities between provinces. As argued earlier, equity would instead be promoted by improving capacity in under-served regions³².
 - i) Effectively, the NHI should support a service-platform approach to determine the distribution of services and resources, and the budgets will then follow suit. For example, should a certain population have an above average prevalence of people living with disabilities (a need weighted in a formula), then a plan and money must follow for allocation of therapists and assistive devices to the health system for that area. This approach is in line with existing planning processes, namely the development of long-term strategic plans (including the primary health care re-engineering approach and community-oriented primary care COPC³³). The service platform approach is then, clearly, the most appropriate method.
47. In the context of the above argument, it is important to note that other countries with national health insurance have made provision for the additional costs to run rural hospitals and rural health care services³⁴.

G.3) Performance management

48. While linking such capitation to a performance-based mechanism is vital (section 106, pg 33), there are characteristics of rural communities that impact on the success of health care delivery more than in urban areas:
- Extra emphasis must be placed on the importance of recruitment and retention of staff
 - District hospitals form the link between the district health system and the hospital system. The communication, suitability and timeliness of the referrals and the level of continuity of care must reflect the importance of this link, which can be weak in rural areas
 - Budgets must incentivise the balance between treatment on-site, and support of health promotion and prevention at the other levels of primary health care, as well as home care
 - Monitoring of financial performance is supported. Mismanagement at some rural hospitals undermines the required change to a new way of thinking around budget allocations.
49. Financial incentives for working in rural areas must be matched by clear performance indicators, against which rural health practitioners' work must be closely assessed (section 106).

³² D. Stuckler, S. Basu, M. McKee Health Care Capacity and Allocations Among South Africa's Provinces: Infrastructure–Inequality Traps After the End of Apartheid. *American Journal of Public Health*; January 2011, Vol 101, No. 1

³³ Tollman SM. The Pholela Health Centre--the origins of community-oriented primary health care (COPC). An appreciation of the work of Sidney and Emily Kark. *South African Medical Journal* 1994 Oct;84(10):653-8

³⁴ Presentations by Prof Tim Westmoreland (USA) and Prof Gavin Mooney (Australia) at the National Health Insurance Conference, Lessons for South Africa, 7-8 December 2011.

50. A lack of knowledge at the local level is preventing calculations of budgets based on need. Considerable funds must be allocated through the NHI to monitoring and evaluation of health care initiatives, as well as research, at a community and sub-district level.

G.4 Capitation system at primary health care level

51. The NHI Green Paper states that at the primary health care level, accredited providers will be reimbursed using a risk-adjusted capitation system linked to a performance-based mechanism. The annual capitation amount will be linked to: the size of the registered population(1); epidemiological profile(2); and target utilisation and cost levels(3) (section 102, pg32).
52. We support the reimbursement of accredited providers through a risk-adjusted capitation system at primary health care level.
53. There are models of a minimum package of services being provided on a per capitation basis in South Africa³⁵. Caution must be taken to benchmark healthcare models providing comprehensive, not selective, primary health care. Comprehensive PHC provided in a capitation model is untested. Two of the significant cost-controllers in a diabetes programme were the payment for both the medication and hospitalisation by the health care provider; these are too expensive for the average public sector to bear.

Size of the population:

54. The service in remote areas is often not provided there because of high population numbers. Instead, it is provided to improve access and realise the right to health care. Therefore it will always under-perform on efficiency indicators and would lose out in capitation models based on population numbers.
55. Increasing the numbers of the registered population helps to reduce the financial risk borne by the providers, so those health providers in scarcely populated rural areas must be ring-fenced against insolvency created by large swings in costs and service demand.
56. If registered numbers go up, risk goes down. Rural health providers should be incentivised where there are only 1 or 2 providers in the area, compared to a dense supply of providers in urban areas. Districts must demand that performance targets are met, however, to prevent capacity of limited providers being over-overstretched.
57. The size of the population allows the calculation of per capita financial data, which can easily be misused in the NHI analyses. Owing to the smaller populations served by correspondingly rural primary care facilities as opposed to in urban areas, economies of scale do not exist to drive costs down. Where possible central purchasing may help with greater cost economy, but the decentralisation of budget to district and provider level (as supported in the re-engineering of PHC plan) will work against this outcome. Higher cost per capita does not equate to inefficiency in this instance.
58. Furthermore, costs faced by PHC practitioners will be higher than equivalent urban services. Transport costs spent on outreach are often higher, as well as the additional time and assistance required for the average patient because health care visits occur less frequently for each. Costs involved in drug distribution and supervision are also higher.

³⁵ L. Distiller Diabetes Voice June 2004 Volume 49 Issue 2 pg; pg 16-18 Diabetes Management Programme run by the Centre for Diabetes and Endocrinology.

59. Similarly, the budget/capita calculations are used as a measure of equity by some authorities. Statistically, using this ratio is valid for those PHC accredited providers with roughly similar budgets and catchment populations. For example, each resident of the Town X (12 000 pop, budget R12.5 million/annum) receiving equal money for primary health care as the residents of Town Y (13 000 pop, R 13.1 million/annum) – all things being equal. Rural populations, on the other hand, are often significantly smaller, and falsely elevate the per capita budget allocations.

Epidemiological profile:

60. Clinical indicators, such as infant mortality, or HIV prevalence rates must be considered in an index that is linked to the capitation amount. As when deciding facility budgets, capitation amounts must increase proportionate to a measure of “rurality”, as well as the usual variables related to social determinants of health (poverty, proportion of child-headed households, income levels, etc.). Clinical indicators that have the potential to cause disability must contribute towards the need for therapists.
61. Providers will be defined according to their level of service provided (section107, pg 33), each of which will have a separate capitation amount. Rural communities, however, have such unique needs that ‘level’ defined by rurality, rather than provision of service, may be warranted.
62. In addition, a proxy for measuring “ease of operating” may have to be considered, to boost capitation amounts for rural primary health care practices, unless other appropriate incentives are implemented to attract providers to rural areas.

G.5 Target utilisation and cost levels:

63. District health authorities will contract with the NHI in the purchasing decisions for health services (section110, pg 34). Although the financial risk is shared with the accredited providers, the district still has to manage their finances well. Larger (more populated) districts/providers tend to manage their financial risk better than smaller ones, in terms of predictability and preparation for changes in costs and demands. Targets are more easily met, and cost levels are more easily managed. Where rural providers are generally smaller, they will need financial protection against these variations, particularly against increases in costs and decreased liquidity.
64. Incentivising health providers to consider the cost of treatment is supported. But as stated previously, more expense is often required to achieve similar health outcomes in rural areas.
65. In conclusion, we call for needs-based funding formula which take into account the rural health care context, and which reverse the existing inequity trap.
66. Given the fewer facilities in rural areas and the greater cost burden on rural patients to access the health services, it is also reasonable and fair to compensate poor rural communities for their transport costs through the funds generated by the NHI. This should include caregivers accompanying patients with disabilities, the very old and very young.

H) Role of the private sector

67. As discussed in this submission, there is little private sector presence in rural areas and this has two negative implications for rural health:
1. Rural communities, already challenged in accessing health care by distance, transport costs and understaffing, will not benefit from the same improved access to private health care facilities like urban communities.

2. Yet, the urban-based facilities need to be funded, once accredited, and this draws away available NHI funds from the areas in most need: the poor rural districts.
68. As a result we call for urgent interventions in terms of private sector involvement:
1. To halt with immediate effect the licensing of new private sector facilities in urban areas, unless a clear gap in existing service levels can be proven.
 2. Accreditation on the basis of service need per geographic area.
 3. Incentives for private sector facilities, including GPs, to settle in rural areas.

I) Governance

69. The NHI green paper speaks of a number of structures that will need to be created in order to administer the NHI, including the NHI Fund (section 131 – 136), the sub-national NHI structures (section 136) and the District Health Authority (section 1x and 136).
70. A number of key issues around the governance of the fund and the health care services are not addressed adequately. These are, in particular, the relationships and the relative legislated mandates of the District Health Authority in relation to the District Health Councils and the District Health Management Teams. The mechanisms to ensure accountability, transparency, and particularly equity (one of the stated objectives of the NHI), are unclear. More specifically, the mechanisms that allow impoverished and disenfranchised communities to exercise control over their health care service are not evident. It appears that the NHI structures will only be accountable to the national Minister of Health and Parliament, and that the District Health Authority will have an oversight function in terms of health care delivery. It is implied that the District Health Authority will be accountable to the sub-national NHI structures. It appears that there is no mechanism of local accountability to the communities, or even district structures.
71. The lack of clarity relates not only to the specific systems of accountability of the NHI, but more broadly to the systems of accountability as part of the re-engineering of PHC. The questions raised relate not only to a notional process of improved equity, but specifically, interrogates how the provincial Departments of Health, whose mandate it is to provide health care services, are held accountable in concrete ways for the service delivery and funding received. The lack of governance structures for the NHI beyond the parliamentary oversight has important consequences for how the NHI will be able to address equity. For instance, the Green Paper does not explain in sufficient detail how the norms for capitation will be developed, how these will be reviewed or who will be responsible for them being equitable, particularly with regards to the needs of rural communities. There is no clarity as to how these could be challenged and how the process can be transparent and accountable.

J) Kagisano-Molopo Sub-District: A Case-Study

72. So far this submission has made many recommendations as to the measures required to ensure the NHI will benefit rural communities as equitably as possible. In this section we underline our argument by giving a real-life example. Kagisano-Molopo is a sub-district of Dr Ruth Segomotsi Mompati district in the North West Province. It borders Botswana and the Northern Cape and is a deeply rural area with many farming communities. On the map below, we visualise the limitations of the NHI principle of “access at point of delivery”.

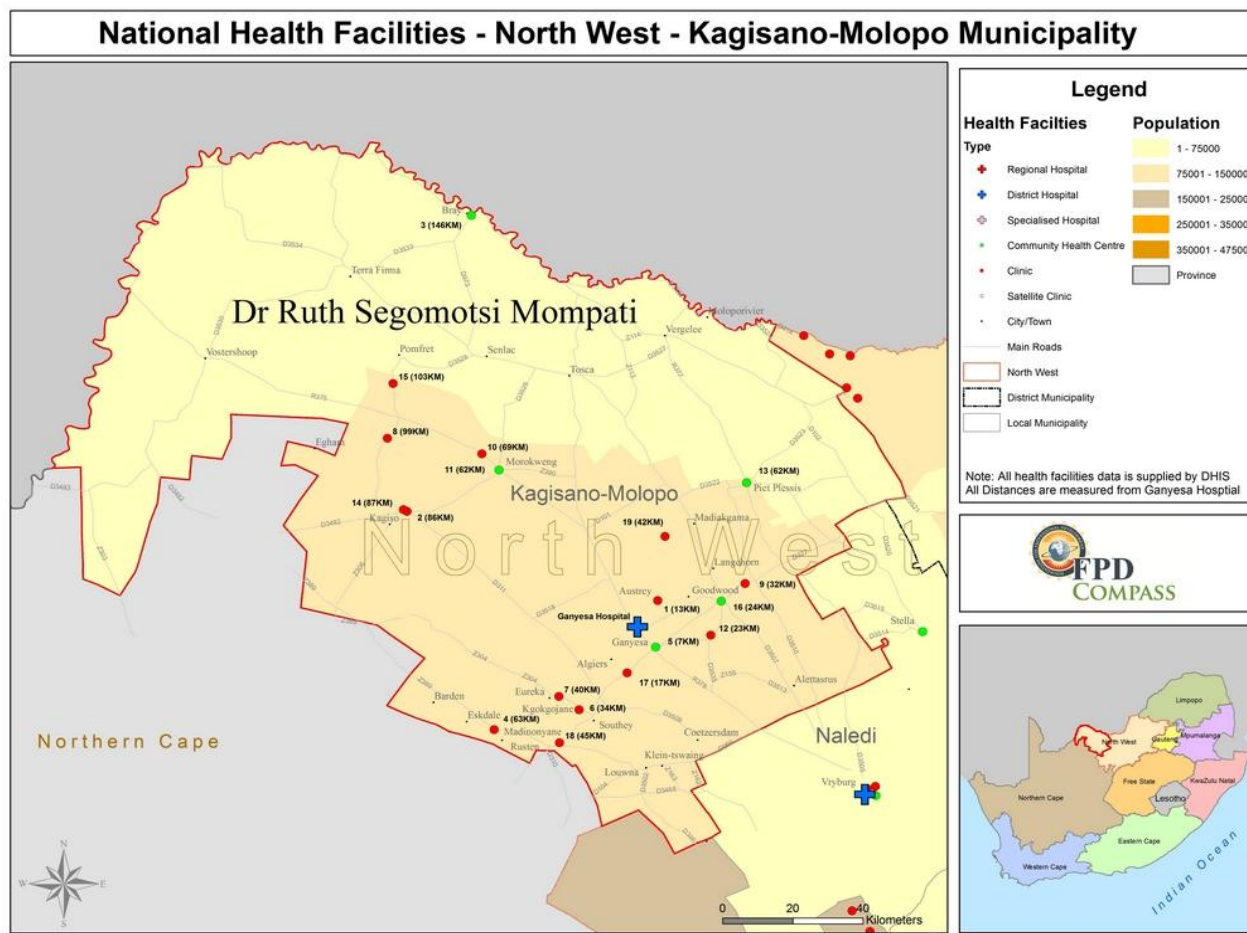


Figure 2: Map of facilities and distances in Kagisano-Malopo Sub-District (NW), provided by the Foundation of Professional Development

The map shows the distances from clinics and community health centres to the one single public hospital in the Sub-District. There is no private sector hospital and in the entire sub-district there are only two GPs; both are based in the town of Ganyesa. The map further shows that some communities live as far as between 80 and 150 kilometres from the nearest hospital. We also see a very thin spread of clinics in the upper region of the sub-district. To make access even more difficult, there is little to no public transport in this region. Patients, many from poor farming communities, needing to access the clinic or hospital wait alongside the roads for a full day without success.

The only hospital in this sub-district, Ganyesa Hospital, is plagued by a continuous staffing crisis, as do many other hospitals in North West Province. Indeed, there are hospitals in North West with less than 3 doctors, who are expected to run a 24-hour service, and to be on stand-by for emergencies. At Ganyesa Hospital, as many as 14 doctors resigned over the past 5 years. Working conditions and the inhospitable living environment are among the key reasons for this. There are unacceptable infrastructure constraints. A lack of water supply, from February - August 2011 resulted in patients having to be bathed with water warmed up in the microwave. The hospital's generator has not been functioning properly since 2008 and caused an avoidable infant death in March 2011. The Hospital and District Management have written a number of motivations for a new generator. Yet, budget constraints are said to be reason for the delays in installing a new generator. The community is served by an insufficient number of ambulances due to constant breakdowns.

Ganyesa Hospital is not an exception, nor is this situation constrained to North West Province. Indeed, this is common to many rural facilities country-wide.

Ten years after the implementation of the NHI, will we see the people of Kagisano-Molopo enjoying affordable access to quality care? Will we see the infrastructure/inequity gap closing? Or will we observe

that the greatest share of the NHI funds has been allocated to where the facilities are: the resourced urban areas? NHI CAN and MUST benefit rural communities. This requires a PRO-RURAL NHI, involving all the measures included in this submission: budgeting based on the service-platform, NHI allocation to include transport services for the vulnerable, and an urgent implementation of the rural recruitment and retention chapter of the new DOH Plan.

K) Transition Period

73. The fourteen year implementation period poses a number of challenges with respect to rural areas, in terms of equity and fairness. As the rollout progresses, it will be important to ensure that inequities are not accentuated despite the overall intention to the contrary. The potential for this scenario is greater in rural districts, where capacity is relatively vulnerable, and relatively small changes can have major effects.
74. Pilot districts: It is important that the ten pilot districts selected include at least five that are in rural areas. The challenges of management capacity and human resources, particularly where there are no private providers, are greatest in rural districts; it will take a longer period of time to build up capacity.
75. The question of which districts to select for the initial pilot sites will depend on the criteria used, which include health profiles; demographics; health delivery performance; management of health institutions; income levels; and social determinants of health and compliance with quality standards. It is clear from the District Health Barometer that the most deprived districts in terms of health profiles and income levels are all in rural areas, and it is likely that the quality of management is poorer. We would like to understand the process of selection that will be employed using these criteria, because it is ambiguous. If management capacity is used as a criterion, for example, it could mean that either the presence or the absence of adequate management capacity to deliver the revised packages will determine the likelihood of that district being selected.
76. Public hospital infrastructure and equipment: The refurbishing and equipping of 122 Nursing Colleges, many of which are in rural areas, is welcomed. However the six flagship hospitals indicated are all central or tertiary level hospitals situated in urban centres, and there needs to be some indication of equivalent attention to regional and district hospitals, which are found in rural areas.
77. From the start of the transition period, the Human Resources for Health plans need to include comprehensive incentives to attract and retain experienced professional and managerial staff in underserved areas. This is a prerequisite to further development of the broader NHI strategy. Without this as a first step, nothing significant will change in rural areas regardless of funding mechanisms at a central level.
78. The production of a greater net number of health professionals is undoubtedly important for rural areas, because they are unlikely to be attracted out of the private sector into rural districts in any great numbers. However the production of more health science and nursing graduates needs to be geared towards service in underserved areas and districts, otherwise the same patterns of distribution will pertain. The support and development of rural training colleges and rural clinical schools is therefore an urgent priority.
79. The time periods stated for the three phases of implementation contain “Key Features” that are very open-ended. Without a detailed implementation plan it is difficult to comment on whether they are feasible or not with respect to rural districts.

L) Conclusion

The National Health Insurance scheme presents a powerful opportunity to reform the overall health system on the basis of equity and solidarity. In this submission, we have stressed some of the important positive developments towards greater equity, such as the inclusion of rural access in the new HRH Plan and the opportunities presented by the drive to re-engineer primary health care. We also highlighted the gaps and pitfalls when considering whether rural populations will indeed benefit equitably. In the past, well-intended policies did not advance the health rights of rural communities on an equitable scale. We cannot allow this to happen under the NHI. In line with the principle of Progressive Universalism, rural areas need to be prioritized to compensate for their access and HRH constraints and high levels of deprivation. Therefore, we say: RURAL NOW!

- 1) **Rural Accreditation First**
- 2) **User Fees Abolished and No Increase on VAT**
- 3) **Reverse the existing Infrastructure/Inequality Trap through Needs-Based Budgeting**
- 4) **Access to Health by Addressing Social Determinants including Transport**
- 5) **Lure Sufficient Human Resources to Rural Areas**
- 6) **No to Delegated Management Responsibility WITHOUT Authority and Accountability**
- 7) **Only *through* Consultation with Communities, Health Workers and Activists**
- 8) **Wide-ranging PHC benefit package including Rehab, Mental Health Care and Eye Care at all levels of care**

We wish to present our recommendations to the Department of Health at a time suitable to the Department. We are available to answer any queries or comments.

Submitting organisations: RuDASA, RHAP, KZN Centre for Rural Health, Wits Centre for Rural Health, Ukwanda Centre for Rural Health, UCT: PHC Directorate, RuReSA, Africa Health Placement

Endorsed by: SECTION27, People's Health Movement and Black Sash