



DA

ONE NATION. ONE FUTURE

QUALITY CARE FOR ALL

**THE DA'S PLAN FOR HEALTH CARE
IN AN OPEN OPPORTUNITY SOCIETY
FOR ALL**

**Democratic Alliance
November 2008**

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INTRODUCTION: Health Care in an Open Opportunity Society for All

Only people who are healthy, energetic and mobile are able to properly use their talents, follow their dreams and care for their families. Therefore no society can prosper without an affordable, high quality and easily accessible health system that allows people to manage chronic diseases, overcome serious illnesses and recover from accidents.

Such a system requires both a dependable primary care network – that prevents diseases and treats minor illnesses – and a quality secondary and tertiary network to provide hospital-based care for more serious illnesses.

It is the responsibility of every government to ensure that such a system is in place, whether it provides it itself or creates an environment in which others can provide it.

South Africa's health system as it is currently structured is divided into great extremes of quality, efficiency and customer-friendliness, which has created a situation where no single part of the system is able to meet all the needs of South African patients.

In the public sector, an affordable and accessible system is available. But the service is increasingly threadbare and rudimentary as demotivated and over-worked staff leave in droves, discouraged by a lack of resources, lack of political support and a cumbersome bureaucratic management system that leaves them feeling exposed and powerless.

In March 2008, the Every Death Counts report found that 42 000 babies a year were dying unnecessarily in South Africa. A report released one month later on South Africa's progress in meeting its millennium development goals - Countdown to 2015: Maternal, Newborn and Child Survival report for 2008 - showed that, despite a substantial budget for health care, South Africa is unlikely to meet these goals. In fact, we are one of only twelve countries in the world where child mortality rates are increasing.

While some diseases, such as malaria, have been tackled with some success in the public sector, the incidents of other diseases, and Aids and TB in particular, have sky-rocketed. The number of reported TB cases, for example, shot up from around 70 000 in 1995 to around 280 000 in 2004.

At the same time, a world-class service exists in the private sector, but its costs put it beyond the reach of most South Africans.

In contemplating reform of the health care system, we need to move away from the problems of the unresponsive and cumbersome bureaucracy in the public sector, and that causes a lack of accountability, slow decision-making, poor quality, and a lack of innovation and customer-friendliness.

At the same time, we need to recognise that the state has an important function in guaranteeing the overall effectiveness and smooth co-ordination of the health system (even if it does not provide all services directly) and ensuring that the basic requirements for an effective health system are in place. If it does not undertake these responsibilities with the necessary rigour and sophistication, the lesson of history is that the result would be an expensive service accessible only by an elite – or no functional health service at all.

The potential exists for our country to deliver a high quality health service that meets the needs of all its people, and the DA's proposals are aimed at delivering such a service.

The DA believes, and international experience supports this, that the most effective model of health care delivery involves a partnership between the state and the private sector. The DA's proposals require the state to provide an overall regulatory framework which would create a transparent and competitive environment, deliver some services and fund health care for the poorest citizens. It would also require the state to meet the overall strategic needs of the health system, and in particular, ensure that our human resources needs are met, that we have an adequate, affordable supply of medicines, and that the health system is properly geared up to meeting our key health challenges.

Within this environment the private sector would co-operate with the state to deploy its expertise, currently only available to a small number of paying patients, to provide quality health care on a far larger scale.

Primary health care is vital in preventing illnesses before they need expensive, hospital-based treatment. At this level, attention needs to be devoted to bringing together the efforts of all the numerous organisations involved in health care, inside and outside of government, to ensure that the most productive value is gained from these efforts.

The single biggest challenge facing South Africa's health service is a lack of doctors and nurses. This must be confronted head-on with a dynamic campaign to both increase the number of doctors and nurses available to our health system and retain them.

Finally, special attention must also be devoted to our major health challenges, and in particular HIV/Aids and TB. Both of these require a properly co-ordinated treatment response as well as more concerted efforts to help families of the infected to cope, to care for the orphans of these plagues, protect health workers from infection.

PART ONE: Making Quality Count in Hospitals

South Africa's highly centralised model for health care delivery in the public sector means that many basic functions of hospital management, including staff procurement and maintenance, are conducted on behalf of hospitals by provincial health departments. Even patient fees are required to be added to provincial coffers and make no contribution to hospital revenue. This system creates long delays, inefficiencies and an inability on the part of hospitals to diversify according to their particular needs and circumstances.

This model also entrenches a rigid divide between public and private sectors, which ensures a limited market for the private sector and a spiralling cycle of high costs.

A radically different management model is required which allows us to capitalize on the best that each of these sectors has to offer.

1.1 Central Government oversight

In its view of a future health care system, the DA believes that the state must continue to subsidise health care for the poor and oversee its delivery, and it is ultimately responsible for meeting the constitutional requirement to provide health care.

The government at national level must ensure that quality of service remains high at all health delivery points by:

- Determining a national health policy which outlines the roles of the public and private sectors at all different levels of health care,
- Setting targets for health care delivery; and
- Devising quality standards for health institutions.

At provincial level the government must be responsible for implementing and enforcing these standards and allocating funds to health delivery points on the basis of their compliance with these standards. But if hospitals are to become more effective, they must be given more capacity to manage themselves.

1.2 On-the-ground accountability

The DA would allow every public hospital to be run as a single non-profit entity. Each would be obliged to accept all patients and to make a prescribed package of free services available to all indigent patients.

These hospitals would be able to set their own rates for patients with incomes above a certain prescribed level, appoint staff, collect fees, and respond to the health needs of the area they serve in the way that they see as most appropriate, within an overall national framework. They would also be free to attract as many fee-paying patients as they wish, and employ more staff and upgrade their facilities if they are able to generate the means to do so.

1.3 Performance-based funding

Each health delivery point will be funded through a block subsidy, which the state would pay every six months, which will be determined for each hospital on the basis of:

- A per-patient calculation, based on a sliding scale according to the income of each patient that the institution attended to over the previous six months. Indigent patients would receive the full subsidy allocation, while patients with an income above a certain level would receive no subsidy.
- Various relevant performance factors, including services and level of care provided, facilities available and staffing. Health outcomes would also be a relevant consideration once a measurement system is in place that is sufficiently sophisticated to measure these outcomes accurately and fairly; and

In addition to a block service provision subsidy, the state would:

- Pay the salaries of the health staff required; and
- Subsidise some specific services that it deems to be particularly important, such as a basic package of care for the indigent.

Ideally, poor patients should be funded directly to allow them to purchase the medical services of their choice. An investigation needs to be done into the feasibility in South African conditions of using smart cards which enable the recipient to go to the medical practitioners, clinics and pharmacies of his or her choice. Suppliers would then compete with each other for the business of smart card holders, encouraging them to treat recipients with the same concern and respect that private patients receive.

The national Ministry will also decide on major capital expenditure such as tertiary hospitals and medical schools. But health services themselves will be responsible for their own day-to-day operations.

1.4 Rigorous quality management

To ensure that quality is always maintained at an acceptable level, hospitals would be subject to strict standards and rigorous performance requirements.

a. Service level agreements

Private hospitals are currently required to meet detailed specifications (outlined in Regulation 158) in terms of building structure, furniture, equipment and numerous other requirements. Requirements are as detailed as specifying the height of walls, the amount of space around each bed, the kind of paint to be used on walls. Public hospitals are exempted from these.

The DA would ensure that all hospitals are required to fulfilled detailed specifications, and that their continued funding be dependent on meeting these requirements. In addition:

- Each health facility would sign a detailed performance agreement with the state stipulating any additional requirements they would be expected to meet.
- A CEO at the head of each hospital would be responsible for delivery and directly accountable for the hospital's performance. Strict requirements must be applied to CEOs, who must meet minimum standards with regard to qualifications and management experience.
- A Department of Health Controller would be allocated to each hospital and clinic, on a full time or part-time basis depending on the size of the institution, to monitor the fulfilment of performance criteria.

Hospitals which fail to meet the requirements of their service agreements would be subject to fines, to be determined by an independent arbitrator, with the ultimate sanction being the cancellation of the contract.

The powers, functions, responsibilities and structure of these hospitals will be outlined in legislation, either in an umbrella act catering for all possible variations, or, if particular circumstances require it, in a specific act for a specific institution – as is the case with universities.

b. Measuring health outcomes

There is a dire shortage across both health sectors of information that can be used to judge the effectiveness of health care services. While the private sector does monitor compliance with quality standards (such as staff:patient ratios) closely, it does not measure the actual consequences of treatment provided in terms of patient survival rates, complications, and other measurable indicators. In the public sector, neither quality standards nor health outcomes are measures in any consistent and reliable way.

Patients in both the public and the private sectors need to be empowered to compare benefits and costs of the service they need. Quality and outcomes comparisons on hospital performance need to be widely available, and patients need to know with certainty that they have all the information at their disposal required to make informed decisions. The DA's proposals for a new health system therefore include substantial improvements to the measuring and availability of health quality information.

In 2005, Discovery Health implemented a star rating system for South African hospitals, based on similar systems available to patients in the United States and aimed at giving patients the ability to choose a hospital that offers quality care, and that is also cost-effective.

The quality of the hospitals used by Discovery members was assessed from data about the mortality rate of the members who were admitted, the number of members who suffered complications and the number who had to be readmitted to hospital within 30 days of their first admission,

adjusted in line with the mix of cases and range and type of patients that the hospitals treat. The substantiation for Discovery's calculations was controversial, and the system is being revised.

The DA believes that a quality rating system must be developed and applied across the board to all hospitals in both the public and private sectors. All hospitals must be measured according to the same standards with the objective of both sectors ultimately being able to offer an equivalent quality of care.

This would require significant technological and administrative improvements to management and reporting systems which are not, in either the public or the private sector, currently well geared for producing this kind of information. It would also require ensuring that hospitals operate with enough control over their own operations to be legitimately held responsible for them. The prohibition on the direct employment of doctors by private hospitals would, for example, need to be removed, because a hospital cannot be made accountable for the performance of a doctor whose appointment it has little control over.

The DA's proposed devolution of operational control of hospitals would ensure that public hospitals have sufficient responsibility for their own management to allow such a system to be meaningful.

c. Regulating uncompetitive practices

In the recent past various examples of collusive tendering and price fixing in the private sector were investigated and brought to the attention of the Competition Commission, and have resulted in some improvements in the level of transparency in this industry. It is important that the Competition Commission continue with this work. Further improvements to the system to ensure competitiveness should also be considered.

The DA would, for example:

- Require all parties involved in tendering processes to sign an affidavit stating that there have been no discussions with competitors prior to the submission of tender bids; and
- Hold company employees found to have been complicit in irregular business practices personally liable for compensation.

d. Office of Standards Compliance

In terms of the National Health Act, the Director-General of health is required to "establish an Office of Standards Compliance within the national department which must include a person who acts as ombudsperson in respect of complaints in terms of this Act. The Office of Standards Compliance must keep the Minister informed of the quality of the health services provided throughout the Republic as measured against prescribed health standards". It would exercise oversight over both the public and the private sectors.

This office has not yet been established.

The DA believes that this is a very necessary institution, and must be created as a matter of priority. Moreover, it must exist as an autonomous institution outside of the Department of Health, governed by regulation and funded partly by the state and partly by private hospitals themselves.

1.5 Integrating public and private

A key component of the success of the DA's proposals for decentralisation is the integration of the private health sector into the public sector. Not only will this allow for the sophisticated health-care and management skills in this sector to be used more widely, but it will bring in a fresh perspective to an environment which has remained stultified and visionless for many years.

a. Private hospitals in the public sphere

The management of every public hospital and clinic will be put out to tender, and this tender will be subject to review every year to ensure that performance continues to comply with requirements. The service provider could be any group of individuals capable of meeting the qualifying requirements, and the door would be open to any of South Africa's current private health care providers to submit tenders for a contract to run any of these hospitals.

The most relevant example of a similar successful scheme in the South African context would be two privatised prisons – Mangaung and Khatama Sinthumule. Run by UK-based company Group 4 since 2001, these prisons are required to meet strict contractual requirements relating to conditions and treatment.

It has been demonstrated repeatedly that the standards maintained in these prisons significantly exceed those in publicly run prisons. While most prisons provide little in the way of rehabilitation, for example, Mangaung Prison offers a range of rehabilitation programmes and various vocational training courses.

The DA would specifically target for management transfer those public hospitals that have been most plagued by delivery problems – such as Frere Hospital. On the other hand, there are some state hospitals which have developed sound reputations for excellence in both management and service delivery, and the management structure of these hospitals would have a clear in-built advantage if they chose to offer themselves as service providers.

Ownership of teaching hospitals would be placed with universities, which would give universities an incentive to manage the facilities soundly. Provincial health services would buy tertiary services from them at predetermined tariffs.

b. Other areas for co-operation

In addition to the complete decentralisation of the management of individual hospitals described above, there are various other mechanisms whereby the skills and resources of the private sector could be co-opted for the greater public good.

The DA would implement a system whereby groups or individuals would be able to claim benefits, including subsidies and VAT exemptions, if they choose to adopt one of several levels of involvement with health-related public-private initiatives. These might include:

- Hospitals or private hospital networks making some resources and equipment available to public sector patients on a lease or service basis. This might include the use of private hospital beds for public patients at specially negotiated DOH rates;
- Allowing doctors who work in the private sector to claim tax rebates and/or obtain CPD (Continued Professional Development) points for conducting a certain amount of public sector work. The DA would also consider a requirement that continued registration with the Health Professions Council be tied to a certain annual requirement for *pro bono* work. A similar requirement currently applies to attorneys and advocates; and
- Enhancing capacity within the public sector by providing management and administrative support. This could include seconding managers to the public sector for a defined period in return for state compensation, twinning of facilities or provision of in-service training by the private sector.

Hospitals not wishing to adopt any of these models would be free to operate purely for paying patients, but would receive none of the benefits and would, once hospitals in the public sphere begin to offer a higher quality and more competitive service, find it more difficult to attract patients.

PART TWO: Primary Solutions

Primary health clinics reduce the burden on higher-level facilities by treating illnesses before they become more complex problems, and by keeping simple problems out of hospitals where they are more expensive to deal with. Failure to provide properly for primary health care will lead to a collapse of service provision to communities at all levels of care.

1.1 Quality management

As with hospitals, the DA proposes localizing responsibility for management at the level of individual clinics, in conjunction with rigorous performance management requirements along the same lines as those that we would expect hospitals to fulfil. Clinics, like hospitals, could be run more effectively and efficiently if they are able to be responsible for their own management. As with hospitals, they would also be expected to measure outcomes and fulfil performance criteria.

1.2 Connecting providers

The DA will bring private, public, community and NGO health care providers, who currently operate on separate and sometimes conflicting tracks, together under an umbrella system, in order to make the system more efficient and more directly responsive to the people.

The need for primary health care services is only being partially met by government services: many services are already being provided by community organisations like churches and local NGOs. Although they are doing the job of the government, they are generally self-funded or donor-funded, and they often operate in isolation from other services.

The DA will:

- Set up a simple, practical system to incorporate all publicly run and privately run primary health services into a single structure on a voluntary basis. The objective will be to allow these organisations to provide a better service by giving them access to state funds, a support structure and training opportunities;
- Make far more use of the network of private general practitioners, especially in rural areas, who do much unheralded subsidised work for the indigent and could easily be contracted on a highly cost-effective basis to become involved in preventive programmes such as mass immunisation; and
- Use competitive tendering to delegate services that constitute small production units, such as state pharmacies, home-based care services and nutrition programmes, to community organisations or other providers.

This process will be aimed at meeting specific targets within three years, the most important of which will be:

- Increasing the percentage of children vaccinated against common childhood illnesses from 85% in 2007 to 90%;
- Increasing the number of clinics offering HIV testing from 68% in 2007 to 100%;
- Increasing the TB smear conversion rate (an indicator of the success of the initial TB treatment) from 56% to 70%;
- Increasing the number of HIV-positive pregnant women receiving nevirapine from 61% in 2007 to 95%; and
- Increasing the number of women who give birth in a health facility from 78% to 90%.

Devolution and delegation will be underpinned by legislation and implemented within an accountability framework, which will be based on defined contractual terms rather than central control. Service providers will need to meet specific sets of health and welfare outputs within a defined community. Enforcement mechanisms will include sanctions if agreed performance targets are not met. The Minister and MECs would retain residual powers that could be enacted under conditions of non-compliance with regulations, etc.

At the same time, a mechanism for wider community participation in health care will be created through Community Health Councils. Half of the members will come from the local community and health care providers, while the other half will represent local government. These Councils will have the power to define health care policy at the local level. The objective will be to enable individuals, families and the entire community to share responsibility for their health and well-being. Local people will be able to decide which services should be provided, how they should be provided, when they should be provided, and by whom.

1.3 Traditional Health Practitioners

It has been estimated that between 60 and 80% of the South African population currently use the traditional medical sector as their first contact for advice and/or treatment, and traditional health practitioners are therefore an integral part of our health care system.

It is imperative that traditional healers be incorporated into the formal health system structure so that their skills can be harnessed more effectively for better health for all. The DA believes that there should be a voluntary registration system for traditional health practitioners whereby registered healers would receive certain benefits for registering. In order to register, traditional healers would be required to:

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

Registered healers would:

- Be eligible to tender for the provision of some primary health care services;
- Form part of promotional activities by the health department that would make their services more widely known;
- Be integrated into local referral systems;
- Be eligible to become providers of traditional health benefits for medical aids that offer this as an option; and
- Have access to free or subsidised basic medicines, vaccinations etc.

At the same time, the government must take responsibility for cracking down hard on traditional healers who exploit or abuse their patients, provide them with ill-advised treatment or fail to refer on patients in obvious need of medication.

It has been calculated, for example, that of the 80 000 persons practising traditional healing in Gauteng, only about 10% are *bona fide* healers, i.e. healers who abide by the strict ethical code of this vocation. The consequences of consultation with counterfeit healers for peoples' health is evidenced by a finding that of the patients with poisonous intoxication admitted to a hospital near Pretoria, 15% were ascribed to traditional "medicines".

To minimise these problems it would be necessary to:

- Establish a "watch list" of traditional healers who have become associated with medical problems and false claims, either through reports of people who have attended them or of doctors who have attended to the consequent medical problems.
- This watch list must be publicly available and, where this is relevant, criminal charges must be actively pursued.

PART THREE: Medical Aid Schemes

Medical schemes are the principal financial intermediaries for fee-paying users of health care, accounting for almost two-thirds of total private spending on health services. They are a critical vehicle for spreading risk and making quality health care accessible and it is important that this industry be developed, expanded and made accessible to more people.

The cost of medical aid membership over the past three decades has consistently outpaced inflation, and membership has been virtually stagnant since 1996. Even low-cost medical schemes currently do not offer care to a family of four for less than R800 per month, and it is estimated that there are about 7 million people in formal employment who are not covered by a medical aid. This means that greater and greater demands are being made on the public sector by patients who can no longer afford medical aid membership.

In order to bring significant numbers of new members in, costs must be brought down substantially and many more South Africans must be persuaded to take out cover.

3.1 Regulation of Medical Aid Membership

In creating an environment in which medical aids can operate in the best interests of their members, a balance must be struck between giving medical aid schemes the freedom they need to operate efficiently, and ensuring that members' interests are served. The DA believes that some regulatory interventions are necessary to protect patients, ensure that coverage is as comprehensive as possible, and ensure a fair system which meets the needs of all South Africans.

a. Compulsory membership for the employed

The state should not have to subsidise or provide public health care facilities for those who can afford to finance their own basic medical needs. Yet many South Africans neglect to provide for their own health care. The DA therefore believes it should be obligatory for all people earning above a defined amount to belong to a medical aid scheme of their choice. However, this obligation would apply only to a prescribed set of minimum benefits, and rating flexibility should be allowed above this prescribed set.

This is a solution which ensures that all members are covered for basic health needs, but which still enables a degree of accurate pricing of risk that is necessary to ensure the overall profitability and survival of properly funded and managed schemes.

Not only will this ensure that that South Africans who can afford to, do prioritise health care, but it will also help to reduce costs for all medical aid members by expanding the risk pool.

b. Prohibitions on 'dumping'

The DA supports a prohibition on medical aids “dumping” elderly or sickly members, or refusing membership to these patients in the first place. At the same time, people who previously qualified to be members of medical aid schemes but chose not to join, should not be entitled to do so only when they have a serious or chronic complaint, without being penalised in some way.

c. Prescribed Minimum benefits

Protection for South Africans against finding themselves with inadequate cover has been provided in the form of Prescribed Minimum Benefits, which are mandatory for all schemes. These were designed with the intention of providing minimum protection cover for 170 diseases and conditions to members of medical schemes.

However, the cost of providing these benefits has made medical scheme cover unaffordable to many, and the lack of precise definition of the procedures that fall within the definition of the PMBs has created enormous ambiguity.

A balance needs to be struck between cost and need. The DA proposes that, rather than being defined in terms of conditions, PMBs should be defined in terms of procedures, and that the number of procedures be evaluated against defined affordability criteria.

3.2 Reducing costs

a. Expanding usage of the public sector

The rising cost of medical aid membership is closely tied to the rising cost of private health care in particular. The DA's proposals for decentralising hospital management, bringing the private sector into public health care provision and improving quality will make the public sector a more acceptable alternative for many current medical aid members.

With costs being significantly lower in the public sector than in the private, greater usage of public hospitals will reduce the costs that medical aids incur for subsidizing hospital treatment. Medical aids will therefore be able to make extensive use of low-cost health care packages that make substantial use of treatment within the public sector.

b. Supplementing the Fee-for-Service model

The fee-for-service reimbursement system used by most public and private hospitals has been cited as one of the primary cost-drivers for private medical care. It creates incentives for providers to over-supply services, and the system of third-party payment means that both providers and patients are shielded from the true costs of services.

The DA will address this by developing mechanisms to promote risk-sharing between medical schemes and hospitals. At present, schemes

carry all the risk and hospitals are incentivised to maximise the services delivered.

The DA believes that doctors in the private sector should be funded by medical aids on the basis of a stipend for each of their patients. It should be larger for patients with complicated medical conditions and smaller for those who are healthy, and it should not be influenced by the number of services or tests a doctor orders.

For overhead costs, doctors should be paid an amount that covers the typical cost of tests and treatments needed to address a patient's condition. The hospital receives a payment for dealing with a patient's underlying condition rather than individual payments for each test and treatment. This approach offers no incentive to run unneeded tests, and it has been credited with substantially slowing the growth in Medicare payments to hospitals in the United States.

c. Tax Deductions for Medical Aids

As private hospitals remove the burden on the state of delivering health services to many people, there is justification for allowing tax deductions for medical expenses. The current system, which offers tax rebates as an incentive for employers and employees to belong to medical aid schemes, should continue. Contributions to hospitalisation insurance cover should also be accepted as a legitimate medical expense.

In order to encourage provision for high medical expenses in old age, investments in Medical Individual Retirement Annuities (MIRAs) should also be tax-deductible. These would be geared to cover most medical expenses after retirement.

Tax deductions should encourage long-term and portable individual self-insurance schemes such as the above, the principle being that each generation should fund its own way rather than being a burden on the next.

d. Consumer pressure

Consumers have a great deal of power in moving health care funders and providers towards an environment driven by lower costs. The DA supports the use of medical savings accounts and other mechanisms to create incentives for the managed health costs, provided these mechanisms do not allow consumers to sign away core minimum benefits.

PART FOUR: National Health Insurance

4.1 Government Proposals

The Health Department has presented to Cabinet a plan for a National Health Insurance scheme, which will involve a progressive move towards a national state-sponsored medical scheme (NHI) and compulsory contributions by all employed South Africans towards this NHI. It is envisaged that all or almost all funding of public health care will be provided via the NHI rather than via the state's general tax revenue, with the NHI being funded partly by the state and partly by compulsory contributions from all except the unemployed. Contributions to private medical aids over and above this will be compulsory top-up contributions for individuals earning above a certain amount. The plan also embraces plans to bring private fees under the umbrella of a state-managed process for negotiating fees.

4.2 DA Response

The DA supports some individual aspects of the broad social health insurance plan. For example, we support compulsory medical aid contributions because we believe that individuals who are able to should be expected to make their own plans for medical cover.

However, we object, on grounds of both principle and practicality, to the broader framework of the NHI.

These proposals amount primarily to a restructuring of the way in which health care is financed, with the imposition of a more complex and layered system, more government involvement in the financing of private health care and the creation of centralised payment collection unit.

The DA believes that the priority in health care does not relate to changing how the system is funded, but rather to improving the basics of delivery. Furthermore, the government's proposals remove many of the elements from the market for health care that have been shown across the world to be essential components of any properly functioning market, and competition and choice in particular.

Reform should therefore rather be focused on improving health care services, so that the money that is available is spent as effectively as possible, rather than developing different ways to accumulate the money that is needed to fund the system.

If more money is to be allocated to public health care, and the DA believes this is necessary, this money should come from the general tax revenue pool rather from ring-fenced funds, because ring-fencing is less efficient and direct and involves the creation of further cumbersome layers of bureaucracy. It also is also likely to foster resentment on the part of tax-payers that they are being doubly taxed (for general revenue, some of which will still go to health care, as well as for a dedicated tax).

The Health Department argues that the NHI will reduce private sector costs while improving quality in the public sector. The DA, on the other hand, believes that this cannot be done unless one tackles first and foremost the reasons for the problems with quality and price in the health system. It is for this reason that we make detailed proposals (elsewhere in this document) for integrating the public and private health providers.

PART FIVE: Human Resources

No health system can function without enough dedicated and well trained doctors, nurses and managers. South Africa is fortunate in having a large number of highly trained, skilled and dedicated doctors and nurses, but it is becoming increasingly difficult to retain them, particularly in the public sector.

A reply to a Parliamentary question in 2008 indicated that there were 9 700 vacancies for doctors and 46 000 nurses in the public sector. Yet the number of newly qualified doctors and nurses do not come close to meeting the need and every year there is a substantial gap between the need for nurses and the actual number available to South Africa.

The Human Sciences Research Council estimates that by 2011, there will be a difference of 18 758 between the nurses we can supply and the need¹. Findings by the South African Medical Journal indicate that rural hospitals are running at 30% or less of their doctor complement, with only half of professional nursing posts occupied.

Attracting and retaining enough of the people who can deliver health care must go to the top of the list of priorities for health care and the DA would aim to fill every single vacancy in the public sector within five years. National government needs to be responsible for a national human resources plan aimed at creating conditions under which South Africa can succeed in attracting and keeping enough doctors and nurses to meet our needs.

5.1 Training

South Africa's human resources crisis does not appear to be caused by a lack of available potential students, but rather by a lack of available training opportunities. At a Health Systems Trust Conference in October 2007 it was reported that a survey of 15 small rural schools had shown that there were a total of 37 learners who wanted to be nurses. Multiplied over several thousand primary schools, this amounts to tens of thousands of young South Africans. A reply to a DA question on applications to medical schools shows that in 2006, there were 15 794 applications for only 1 226 places – and the number of available places at these schools has hardly increased at all over the past eight years.

However, their ambitions are frustrated by the massive shortage of training opportunities. The HST conference also revealed that the training provided for nursing is of an extremely poor quality, because there is a massive shortage of acceptable facilities, equipment and people who are able to train nurses.

Given this need, we must substantially increase the number of training opportunities for doctors and nurses. To do this we need to both speed up

¹ HSRC HRD report

the provision of more state training facilities and harness the assistance of the private sector.

a. Determining Training Needs

South Africa has not carried out any recent investigation into what our actual medical training needs are. The DA will rectify this through a nation-wide training needs assessment, examining the quantity and quality of training available in the public and private sectors for the various categories of health worker and the constraints on expanding these training opportunities.

We will follow this up with a coherent training plan which will set targets for expansion of training, propose solutions to the current constraints and develop a framework for an expanded training system.

Our approach to expansion of training will be based on the following foundations:

- Partnerships with academic and training institutions and the private sector. It is also absurd that private hospitals are constrained by quotas in the number of nurses they may train, and that government policy prohibits the creation of private medical schools. The government cannot and should not meet the demand for medical training on its own and it needs to actively pursue ways to bring in other players.
- The development of creative mechanisms to support trainee medical staff in the workplace through mentoring, apprenticeship, and ongoing support. Training programmes should look beyond the immediate requirement of delivering qualified graduates, and also recognise that, if we are to keep them, we need to look after the doctors and nurses that we train.
- Redistributing teaching and research funds to lower levels of care so that not all teaching is done at hospitals. Not only does this allow for more affordable training opportunities, but it also distributes the skills of trainers and trainees more widely through the system and gives medical trainees a wider range of training experiences to suit their needs and ambitions.
- A flexible approach to training that allows methods of teaching and contents of courses to be adapted quickly according to changing needs. This will require a change in the approach of accreditation bodies such as the South African Qualifications Authority and the South African Nursing Council.

b. More public nursing colleges

While the DA encourages the provision of training by non-government bodies, the state must take primary responsibility for ensuring that we meet our training needs for nurses. While a decision taken in the 1990s to close several nursing colleges has recently been reversed, the number of training spaces actually opened as a result is still pitifully small. The DA calculates that the re-opened colleges would in fact only increase the number of nurses trained by a total of 1 580 a year, which would only

deliver nurses to fill 4% of the vacancies in five years – without taking into account those who drop out or go overseas after qualifying.

The DA will set the target of at least trebling the number of opportunities in the public sector for nursing training, and will draw up a budget, a plan of action and a timetable to carry this out.

c. Removing the barriers to private nursing colleges

Even with a substantial increase in spending, the state cannot meet the need for nurses on its own. The private sector already makes a substantial contribution to South Africa's pool of nurses, training about 6000 nurses a year. However, there are several obstacles which limit this supply:

- The department of health restricts the number of nurses the private sector can train through an old formula of 19:12. The formula makes no concessions to actual need or ability to supply. So although the ability of the state to train nurses has fallen dramatically over the last ten years, and the private sector has ample capacity to improve on its current training levels, it is restricted from doing so by an unfathomable formula.
- There is currently a complete moratorium in place on new nursing facilities because of certain changes to accreditation contained in the Nursing Act which have not yet been implemented; and
- Protracted processes are needed to get courses approved and secure the approval of training and clinical facilities.

Therefore the DA proposes that:

- The quota regulating the number of privately trained nurses must be scrapped. There is no argument to support such a quota in an environment where there is both a local and an international shortage of nursing skills;
- Regulations in terms of the Nursing Act relating to the accreditation of nurses need to be urgently implemented. Failing this, the moratorium on private nursing training needs to be suspended and the old regime applied. Delays in the processing of legislation cannot be allowed to hold up this critical function;
- The Department of Health needs to create a forum where interested parties can meet with SANC to resolve problems within the Council that cause delays to the development of new training opportunities; and
- Public and private training providers need to meet to discuss ways in which resources, facilities and skills can be shared.

d. Making space for private medical schools

The state trains, at most, 1 400 doctors every year; not nearly enough to meet the demand. The number of medical graduates leaving medical schools has not increased over the past five years and there is no plan to increase the number of medical schools, or the capacity of the existing ones.

The DA believes that the capacity problem should be addressed by creating space for privately run medical schools. While there is no

legislative prohibition on such schools, resistance to this idea by the Department of Health has meant that all initiatives in this regard have been rebuffed.

Such public private partnerships, modelled on other examples around the world and in Africa, could substantially boost the number of doctors available in South Africa. The University of Edinburgh, for example, is involved in funding and running the College of Surgeons of East Central and Southern Africa (COSECSA) which came into being in 2001, and trains surgeons throughout the Eastern and Southern parts of Africa.

e. Community Service

The community service programme has in many cases been helpful in alleviating shortages in understaffed areas. But surveys show that its success has depended very much on the attitudes of the students and the staff at the relevant facility.

Better results could be obtained from the programme by moving away from coercion and towards incentives, and ensuring that community service doctors go to facilities that both need them and will be able to use them. The challenge is to make the benefits of this service such that students will want to volunteer to participate in it.

To make a voluntary community service programme more user-friendly, the DA will:

- Ensure that information on voluntary community service is available to graduates widely and timeously, that they are given ample information on which to make their choices, and that they are informed about the hospitals needing community service doctors and are given sufficient time to prepare;
- Grade posts according to a deprivation index, with the more inhospitable posts being accompanied by higher pay and other incentives; and
- Give preference for the better posts to students who commit to serving in the public service for at least a year after qualifying, and offer benefits to bursary holders which would reduce the payback period.

It is important to create conditions that will allow community service students to feel that they are really making a difference, not just treading water. Therefore no posts will be awarded to any health facility until it demonstrates a willingness and a capacity to make space and opportunities for graduates. Health facilities will be required to:

- Specifically apply for graduates
- Designate a person who will take responsibility for providing support and supervision to graduates.

As the intention of the voluntary community service programme is largely to improve staffing in isolated areas, city hospitals will be excluded. Community service doctors with genuine reasons to stay in urban areas

will be offered places at regional hospitals. Hospitals which are already adequately staffed will also not be entitled to community service doctors.

5.2 Recruitment

While thousands of doctors and nurses have fled our shores, we do very little to attract health professionals from other countries here. It is important to bear in mind the ethical problems of poaching from other countries, and developing countries in particular. But we must also recognize that we live in a globalised world in which people cross the globe for many different reasons, and that South Africa loses out by not attempting to appeal to migrant health workers. The DA therefore proposes various measures to improve our ability to attract health workers.

a. A national recruitment strategy

South Africa needs to make sure that we make the most of our possibilities as a destination for foreign-qualified workers, and make it as easy as possible for anyone who qualified in another country to work here. Yet reports of many individuals, and the low number of foreign-qualified health workers who actually do work in South Africa, indicate that it is a slow, tortuous process to obtain the necessary approval to work in South Africa.

The DA would therefore draw up a detailed recruitment strategy aimed at:

- Publicising South Africa's opportunities as a destination for health workers in both the public and the privates sectors;
- Auditing existing processes for the approval of foreign qualifications, and of the responsiveness of the various relevant institutions (such as the South African Nursing Council), to ensure that processes are as user-friendly and convenient as possible; and
- Ensuring that foreign-qualified workers are successfully absorbed into the South African system.

b. An SADC health workers' protocol

The Department of Health currently enforces a policy of not issuing visas to health workers from other African countries. The DA believes that this moratorium is an unimaginative and ultimately ineffective response to the problem. It means that refugees and economic migrants with high level skills who arrive in South Africa seeking refuge from political or economic problems at home cannot use their skills, and South Africans do not benefit from them either. Nobody wins.

A government-sponsored process, allowing health workers to move into South Africa from within the region on the basis of certain conditions, could be beneficial to all sides.

The DA would initiate the development of a protocol for the ethical employment of health staff across the region, based on the recognition of the fact that health workers have a right to move around, but also that

the loss of health workers deprives countries of the benefits of expenditure on their training.

This code might include a list of countries whose workers should not be accepted for specific reasons, and must include a mechanism to ensure compliance, including the voiding of any contracts where the terms of the code are found not to have been met.

c. Defining health skills as Critical Skills

Certain categories of workers are designated by the Department of Home Affairs as possessing critical or scarce skills, and a special fast-track process exists to allow these workers' applications for permits to be processed quickly and smoothly. Despite the enormous vacancy rates in all state hospitals, and the destructive consequences this has for the availability of health care, no health skills are lists as scarce or critical.

The DA would ensure that the Department of Home Affairs includes the most critical medical skills as Scarce Skills.

d. Scrap quotas on foreign doctors

In 2006 the Department of Health announced a plan to thin out the number of foreign doctors in South Africa, from about 16% of the total to 5%. The DA believes that, in the context of the loss of 150 South African-trained doctors a year and the inability of many public hospitals to fill posts, it makes no sense to restrict the number of suitably qualified foreign-trained doctors.

The DA would scrap any restrictions on foreign-qualified doctors working in South Africa, and in fact we will actively recruit such doctors.

6.3 Retention

a. Improving Working Conditions

Measures to ensure that health care staff are satisfied with their jobs and motivated to go the extra mile would make a significant contribution to a better health service. In this regard the first priority is to ensure that health staff are treated with more respect and that their legitimate grievances are heard. While physical working conditions are important, simply allowing our doctors and nurses to feel valued and respected would make an enormous difference to their willingness to stay and make a contribution.

In addition the DA would:

- Develop an adequate referral network for health professionals, including in particular an internet-based consultation system, to reduce the isolation and demoralisation of health care workers in remote areas.

- Work with medical schools to introduce recognised and workable distance learning models. This would prevent medical staff in remote areas from feeling cut off from opportunities to further their studies.
- Permit public sector doctors to treat some private patients in public hospitals to compensate for what they could otherwise be earning. Raising salary levels to those in the private sector is unlikely to be affordable, so it is important to give health staff a vehicle to use their skills elsewhere to improve their salaries. This must be subject to careful regulation to prevent abuse.
- Provide effective and appropriate support to health staff. Services to alleviate stress and burnout, including counseling and peer support groups, are few and far between for public sector health workers, although this is a key part of any human resource development plan, and especially one which must deal with the enormous problems faced by public health care staff.
- Running exchange programmes with hospitals in other countries. This would allow health staff to work overseas and earn in foreign currency, but be tied to returning to South Africa after designated periods.
- Promote excellence and job satisfaction of our best professionals by systematically exposing our health services to the best international standards, and measuring them against those standards.
- Ensure that all hospitals meet minimum criteria, including adequate accommodation for staff, proper security, reasonable workloads and appropriate equipment.

b. *Pro bono* work for private sector health professionals

It is currently required of advocates and attorneys that they conduct a certain amount of *pro bono* work (24 hours a year) in designated legal clinics and legal services in order to meet the requirements of enrolment. The DA believes that the same requirement should be expected of all doctors, nurses, specialists and other health professionals who work in the private sector.

In terms of this proposal, a health professional's continued registration with the Health Professions Council would become dependent on having carried out a certain amount of *pro bono* work in any state hospital or clinic.

c. Health priority sectors

The DA will use Health Priority Sectors as a mechanism to attract health workers, both public and private, back to under-served areas. Medical personnel can be designated as HPS providers, and hospitals, nursing homes and other facilities can become HPS facilities, if they are primarily providing services for low-income and indigent families.

For facilities defined as HPSs, certain benefits will apply. For example:

- Health professionals will have access to incentive programmes, including a shorter repayment period for bursaries repayable by service and same pay for a shorter working week.

- Foreign medical graduates wishing to work in South Africa will be required to conduct a short, three month period internship in an HPS.
- There will be a strong focus on improving infrastructure, including transport, electricity, water, telephones, and internet facilities. Target dates will be set by which prescribed standards must be complied with.
- The Boards of Directors at hospitals within these zones will work together with the relevant Provincial Health Service to implement plans of action to meet targets. Failure to meet them will have real consequences for the members of both the Boards of Directors and the Provincial Health Service.

PART SIX: Affordable Medicines

A more affordable, competitive and accessible health care system requires changes to the way patients obtain medicines. Drugs and specialised medical equipment are a major component of the cost of medical procedures. Reining in these costs is an urgent priority. In addition, the artificial separation between the public and private sectors causes distortions in access and pricing which must be addressed.

6.1 An income-based medicine pricing index

Currently, the state negotiates heavy discounts for drugs distributed through public health facilities. The sellers Pharmaceutical manufacturers recoup the cost of these discounts in the prices they charge to the private sector. This drives up the cost of drugs to private patients and is a severe constraint on the ability of the private sector to compete on an equal footing with public hospitals.

The DA proposes that this uncompetitive practice be stopped.

The single exit price regulation which bans discounts on medicine pricing within the private sector should be extended to include the public sector and medicines should be marked at the same price wherever they are sold.

At the same time, patients would be able to claim rebates on the cost of these drugs according to the income-based formula that already applies to public hospital admissions, whereby the poorest patients receive free services, and fees are charged at progressively higher rates according to income. Thus, for example, a poor patient with no income, once registered for a medicine benefit and with a valid prescription, would be able to collect his or her medicine at any public or private hospital or any chemist.

The effect of this would be to three-fold:

- It would widen the choice available to public sector patients as to where they could obtain their medicines, and they would no longer be compelled to queue for hours or days in public hospital pharmacies, and they would be able to collect their medicines from facilities that are conveniently located;
- It would remove substantial pressure from public hospitals, which often simply cannot cope with the demand and cannot fill their posts for pharmacists; and
- It would give private hospitals the opportunity to compete on a fair basis for public sector patients, and it would increase the number of clients using pharmacies, thus helping to reduce the financial hardship introduced by medicine pricing regulations.

6.2 Protecting consumers

Outside of the regulated medicines market, consumers also need to be actively protected against uncompetitive practices and misinformation.

The DA will do this by:

- Putting in place strong measures to ensure competitiveness in the market for medical products, including generic drug policies, bulk purchasing, and international procurement; and
- Providing adequate consumer protection, particularly against exaggerated product benefit claims, by creating legislative provisions for substantial fines and boosting the capacity and power of the Medicines Control Council (see below).

6.3 The Medicines Control Council

The Medicines Control Council, which was established in 1965, operates in terms of an archaic structure which is unable to cope with the volume and sophistication of the modern medicines environment. The DA will restructure it to ensure it has the capacity to carry out its functions, and at the same time introduce reforms to make it more effective and responsive.

The MCC must be expanded to become a body with real power, staffed by full-time professionals, rather than part-time workers employed under the current structure. A new act of parliament must prescribe a revitalised structure, and the DA supports the levying of higher fees to applicants to fund this.

In addition, the DA would:

- Amend secrecy provisions to make the Council more accountable and less able to hide behind the law in refusing to explain its decisions;
- Place appeals against Council decisions in the hands of a Medical Ombudsman rather than the Minister of Health; and
- Oblige the council to formally commit itself to a Code of Good Practice.

PART SEVEN: Special Categories of Diseases

No sick individual should be neglected in favour of any other, but there are certain categories of disease that, because of their incidence rates and severity need particular attention in national policy.

7.1 HIV/AIDS

With one of the highest infection rates in the world, South Africa is feeling the full force of the devastation wrought by HIV/Aids. A comprehensive antiretroviral programme will keep infected people healthy for many years and is therefore a key part of a comprehensive response. In addition, we must:

- Reduce the number of new infections by convincing South Africans to act to reduce their risk of infection;
- Back this up with practical interventions to support behaviour changes; and
- Develop strategies to help and support AIDS orphans.

a. Prevention

It is obviously far better to prevent people from being infected with HIV in the first place than have to deal with the consequences of their infection. Various countries have been successful in containing the spread of HIV, and South Africa must learn from these experiences.

i. Dedicated leadership

Only with the full, public and active support of a country's leaders can South Africa respond to this epidemic in a way that will make a real impact on infection rates.

Our Aids prevention programme must therefore be led by someone who is capable of communicating directly, clearly and candidly, and who is respected enough that people will listen. He or she must be responsible for this job and no other. The DA will therefore establish a deputy ministry of HIV/AIDS.

Under a DA government, the party's leadership at all levels will be fully integrated into the national prevention programme. In addition to the role played by the Minister of HIV/AIDS, every public representative will be obliged to:

- Show that he or she knows enough about the disease by attending a basic AIDS counselling and training course;
- Make reference to AIDS in every possible public address; and
- Adopt one non-government prevention or treatment programme and act as its public champion.

In countries where HIV/AIDS campaigns have succeeded, it has been largely due to local-level interaction through community organisations. The HIV/AIDS Directorate will enter into discussions with representatives

of NGOs and CBOs in order to hammer out an Agreement for Co-operation, and overhaul the HIV/AIDS budget to direct substantially more resources towards NGOs.

ii. Better communication

Low-tech, social communication has been shown to personalise the risk of AIDS more effectively than mass-based communication. The DA will emphasise community-based, face-to-face interaction over electronic and print communication by:

- Integrating faith-based organisations into the campaign
- Supporting and developing private-sector prevention initiatives. All companies will be encouraged to have a policy addressing specific issues around discrimination and health management.

iii. Tolerance and Equality

HIV in South Africa is driven to a large extent by unequal power relationships between men and women. Addressing the root causes of the epidemic requires attention to the social attitudes which make it difficult for women to assert themselves. The DA will entrench a culture of tolerance by:

- Integrating HIV education and sexual behaviour change more strongly into school curricula
- Stamping down hard and publicly on sexual abuse
- Putting in place a programme aimed at creating income-earning opportunities for the poor and the disempowered, for example through opportunity vouchers, Export Processing Zones and making property ownership easier for the poor.

b. Medical interventions

i. Preventive drugs

The DA will ensure that drugs to prevent the transmission of HIV to newborn babies are available in every public hospital and clinic, and that every nurse is trained to administer them and provide correct advice to HIV-positive mothers. This must be accompanied by an intensive public education campaign to ensure that all pregnant mothers know what they need.²

The government owes it to rape survivors to do everything it can to protect them from further harm. So drugs to minimise the chances of a rape survivor being infected with HIV must be available, free of charge, in every public hospital. In addition:

² Only a little more than half (53,2 percent) of South Africans know that a baby can become HIV-positive through breast-feeding.

- Police officers and nurses must be trained to inform rape survivors of the risk of infection as a result of rape, and of the risks and benefits of taking preventive drugs timeously.
- Posters stating clearly the medical options available to rape survivors must be visible in every hospital, clinic and police station.

The DA supports compulsory HIV testing of persons charged with rape to give rape survivors some information about their likely risk of infection

ii. Antiretroviral treatment

A comprehensive antiretroviral treatment programme is a key part of South Africa's onslaught on AIDS. A treatment programme has, after many hold-ups, finally been implemented in the public sector in South Africa. But there remain many short-comings, particularly in the ability of patients to access drugs and the state's ability to monitor its successes and failures.

To improve the service available, the DA will:

- Establish a Central Antiretroviral Treatment Centre, with a branch in each province, to manage the implementation of the programme, collate information and report on results.
- Develop a national internet-based antiretroviral expert advice service aimed at helping health staff in remote areas. Experts in antiretroviral drugs would be able to determine treatment regimes from a distance, and many patients could be monitored by a single person. Crucial to the success of the project would be a plan and a budget to get the 50 percent of clinics which currently do not have an internet connection linked up.
- Integrate traditional healers into the programme by establishing a registration system at local clinics, where traditional healers who are willing to provide care to patients with HIV can complete a course and thereafter collaborate with clinics in providing treatment.
- Help businesses to develop their own treatment programmes by developing guidelines which can be adapted to different environments and developing an accreditation system for treatment programmes which will allow businesses to receive some funding and implementation assistance.
- Allow companies to deduct all medical expenses incurred in the treatment of their HIV-positive employees from their taxable income.

c. Restructuring the health system for HIV

Africa needs to create new models and levels of care to properly manage the HIV epidemic.

i. Community Support

Community organisations, of one sort or another, community volunteers and families do most of the work in looking after Aids-sick patients. But these services are not integrated in any way with the formal services offered by clinics and hospitals. The DA will:

- Implement a system whereby NGOs and other formally constituted organisations can tender for contracts to provide services like home-based care.
- Set up referral networks between government services and community structures so that they operate smoothly in conjunction with each other.

ii. Home-based care

Many NGOs and some employers have already developed sophisticated home care models. These must be investigated and analysed. Those which can work on a national level must be used, and public-private partnerships must be established to strengthen and extend these efforts.

d. Taking care of orphans

More and more children whose parents have died from Aids are desperately trying to survive on their own. The best solution to the orphan crisis is to keep parents alive. However, for children whose parents have already died, the antiretroviral programme will be too late. The DA will develop a proactive and decisive response to this crisis, with the goal of ensuring that orphans have a home and access to food, education and health care.

i. Orphan support committees

The DA will create Orphan Support Committees across the country to provide orphans with the practical help that will allow them to adapt to their circumstances successfully. Children, extended family members and anyone else with an interest in any orphaned child or children will be able to benefit from a range of free services:

- Help with obtaining birth certificates, identity documents and welfare benefits
- Help with solving other problems, such as arranging exemptions from school fees and negotiating with banks when evictions are threatened
- Linking up children with guardians and tracking down extended family members
- Trauma counselling and support groups

ii. Legal measures

Various legislative changes will help to ease the plight of AIDS orphans. A legal mechanism must be developed to allow orphans under the age of 18 to access the Child Support Grant. In addition, creative foster care options need to be investigated. For example, the criteria for acceptance as a foster parent must be broadened to make it easier for more care-givers to become adoptive parents.

iii. Housing

Following the death of their parents, many orphans have their problems compounded by the threat of eviction from their homes when bonds can no longer be paid.

The DA will introduce legislation to forbid banks from repossessing a house for non-payment when the occupiers of the house are all under the age of 18, for a period of one year. This will give children and their extended families time to consider options and negotiate with the bank.

A Code of Practice on discrimination, to be negotiated between the state and banks and adopted by all lending institutions, will help to prevent unfair discrimination on the basis of HIV status.

The DA will also interact with the banking sector to develop policies on specific issues: for example the transfer of bonds to other family members on the death of the bond-holder.

7.2 Tuberculosis

TB, with its close connection to HIV, is spreading rapidly across South Africa and the development of a new epidemic of extreme drug resistant TB – which emerges when treatment regimes are not properly adhered to – is testament to the failure of our treatment programmes. The DA will ensure that TB receives dedicated and close attention in order to increase the TB smear conversion rate (an indicator of the success of the initial TB treatment) from 56% to 70%.

a. Integrating TB and HIV treatment

Because TB infection so often follows in the tracks of HIV, and there are many similarities in the treatment regimes required, it makes sense to have closely connected HIV and TB treatment centres. This means, for example, utilising TB treatment centres also as HIV counselling and testing facilities and ensuring that training given to health workers on using antiretrovirals goes hand-in-hand with training on TB.

b. Dedicated TB in-patient treatment hospitals

Facilities must be available where TB patients, and in particular those with drug resistant strains, can be isolated and treated for a period of at least six months. This arrangement is extremely difficult to accommodate in an ordinary hospital. While dedicated TB hospitals already exist, priority must be given to ensuring that there are enough of these facilities across the country, and that they are adequately equipped and staffed.

All possible steps must be taken to avoid detaining patients with TB against their will and where this is possible patients must be allowed to return to their communities, taking the necessary protective measures. However, it will sometimes be necessary to detain patients with multi-drug resistant TB against their will. While the constraints imposed on their freedom would be impossible to justify under any other circumstances,

the high probability that they will infect those around them makes this a necessary step.

This requirement makes it all the more important that hospital conditions are congenial and professional and that opportunities are created for family visits.

c. Getting the message across

Empowering South Africans to take charge of their own health is the most important step that can be taken in stopping the wildfire spread of TB; patients' failure to comply with their treatment regimes contributes enormously to our high infection rate.

As with HIV, community-based, face-to-face interaction is the most effective in getting the message across and all opportunities, including radio, schools, health facilities and public events, must be used to make patients aware of TB and to know that it can be successfully treated.

d. Protecting health workers

Despite the life-threatening conditions that they face, health workers in the forefront of the fight against this disease continue to do their best for their patients at the risk of being infected with TB themselves. It is therefore the Health Department's responsibility to ensure that everything possible is done to protect them. There are, however, many failures, with tragic consequences. Reports suggest that over 100 health workers in KwaZulu-Natal alone have become infected with TB over the past few years and several health workers across the country have died from TB.

All public hospitals and clinics should have in place systems and equipment to ensure that TB cannot be spread either between patients, or between patients and health workers. There remain many challenges to ensuring that this becomes a reality. In particular:

- Hospitals are not properly ventilated;
- Masks are not always available; and
- Insufficient provision is made to separate TB patients from non-infected patients and XDR-TB patients from all other patients.

A national audit is therefore needed of each hospital where TB patients are treated of their compliance with basic infection control standards, followed by an action plan to make them compliant.