

# CHARTER

## The Charter of the Public and Private Health Sectors of The Republic Of South Africa

### CHAPTER ONE: FUNDAMENTAL PRINCIPLES

#### 1.1 Opening Declaration

The Parties to this Health Charter earnestly and sincerely desire to facilitate and effect transformation of the health sector in the following key areas:

1. Access to health services
2. Equity in health services
3. Quality of health services
4. Black Economic Empowerment

They acknowledge that it is essential to ensure the sustainability and efficiency of the health sector in order to achieve the transformation goals for each of these areas.

They further acknowledge the urgent need to effect transformation of the national health system in a co-operative, constructive and mutually beneficial relationship in such a manner as to reflect the diversity and meet the various health care needs of the total population of South Africa.

**THEREFORE** the Parties -

#### **RECOGNIZING:**

1. That there is a legacy of apartheid in terms of which access to and distribution of health care and ownership of health care establishments was grossly inequitable and disadvantaged the vast majority of South Africans on the basis of their race, gender and economic status;

2. That there is an urgent and compelling need to effect transformation throughout the South African health sector in order to remedy the wrongs of the past;
3. That the government of the Republic of South Africa is mandated in section 7(2) of the Constitution to respect, protect, promote and fulfil the rights in the Bill of Rights;
4. That the government of the Republic of South Africa is mandated in section 27 of the Constitution to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the rights of access to health care services, including reproductive health care, sufficient food and water, and social security, including appropriate social assistance where people are unable to support themselves and their dependants;
5. That the rights in the Bill of Rights may be limited only in terms of section 36 of the Constitution;
6. Generally that the powers and functions, roles and responsibilities of the national, provincial and local spheres of government and of the legislature, the executive and the judiciary are as set out in the Constitution and that such powers and functions, roles and responsibilities may not lawfully be fettered or restricted by any other law, agreement or transaction;
7. That the government in 2004 passed the National Health Act No 61 of 2003 into law which is intended inter alia to remedy the inequities of the past in the distribution of health care and to create a national health system that is patient centred and for the good of all;
8. That it is the constitutional role and function of the national government of the Republic of South Africa to exercise executive authority by -
  - (a) implementing national legislation;
  - (b) developing and implementing national policy;
  - (c) co-ordinating the functions of state departments and administrations
  - (d) preparing and initiating legislation

- (e) performing any other executive functions provided for in the Constitution or in national legislation;
9. That the national, provincial and municipal spheres of government have the power and the duty to deliver health services to the people of the Republic of South Africa;
10. That within the context of paragraphs 1 to 6 of this Preamble, when read together with the Constitution and the laws made by the Government of the Republic of South Africa, the private health sector has an important and meaningful role to play in –
- (a) working with the Government of the Republic of South Africa in a spirit of constructive, mutual co-operation and respect in order to fulfil the government's constitutional mandates;
  - (b) contributing to the health and wellbeing of the people of South Africa through the provision of products and services in accordance with internationally recognised or legally prescribed norms and standards, as the case may be, with the object of promoting, maintaining, preserving or restoring human health and wellbeing;
  - (c) ensuring that while it makes sufficient profits from its business activities to remain financially sustainable in the long term, the products and services it delivers provide value for money to consumers;
  - (d) conducting its business in a manner that it is ethical, honest, and fair and that satisfies the needs of consumers of health products and services,
  - (e) ensuring the safety of consumers and the adequate protection of both people and the environment in the use of products and services that may be dangerous to health or life;
  - (f) respecting and observing the right of consumers to information and to be protected against dishonest or misleading advertising and labelling;

- (g) accepting and respecting the power of consumers to choose from a range of products and services offered at competitive prices with the assurance of externally recognised and accepted standards of quality;
- (h) recognising the right of consumers to fair compensation for misrepresentations by providers of goods and services, for the failure of goods and services to adequately address the health needs of consumers and the failure to comply with externally recognised and accepted standards of safety, quality and efficacy;
- (i) ensuring that the rights of patients reflected in the Patient Charter as published by the National Department of Health are observed;
- (j) upholding the rights of providers of health care products and services to human dignity, a safe working environment that is not detrimental to their wellbeing and to psychological and bodily integrity;

***AND NOTING THE NEED:***

1. for the public and private health sectors to constructively engage in dialogue and discussion on health matters;
2. for the interests and views of the private sector to be taken into consideration by the government when introducing legislative and other reform;
3. for the rational and equitable distribution of health services in the Republic of South Africa;
4. to achieve the most effective, economic and efficient utilisation of resources within the health sector, including human resources, so as to adequately address the health needs of the greatest possible number of people in South Africa;
5. to establish a rational and consistent framework for public-private initiatives within the South African health sector within the parameters set by the Public

Finance Management Act No 1 of 1999 and the regulations thereto. In this regard the Parties acknowledge that PPIs –

- (a) must be developed in accordance with a clear framework that allows for a thorough investigation of the case for each PPI, a sound and cost effective implementation and sufficient public reporting mechanisms;
- (b) must contribute to the overall sustainability of the national health system;
- (c) must contribute to promoting equity of access to primary care;
- (d) must contribute to promoting equity of access to affordable health care and strengthened public hospital care;
- (e) must contribute to promoting equity in financing of health services;

**AGREE -**

1. to create for South Africa a health system that is coherent, efficient, cost-effective and quality driven and which optimises the utilisation of public and private sector resources within the health system for the benefit of the entire population;
2. for the public and private sectors to work together in a relationship of mutual cooperation, trust and respect in order to improve the scope, accessibility and quality of care at all levels of the health system;
3. to the undertakings and commitments reflected in this Charter with regard to each of the four areas of transformation;
4. to uphold and give effect to the principles and the spirit of this Charter in the course of their activities as stakeholders within the South African Health Sector; and
5. that the weighing of various factors shall be in terms of a balanced scorecard that incorporates all of the areas of transformation outlined in this Charter.

## 1.2 DEFINITIONS AND INTERPRETATION

In this Charter, except where the context clearly indicates a contrary intention the following words and phrases have the meaning ascribed to them below :

“Access”	means having the capacity and means to obtain and use an affordable package of health care services in South Africa in manner that is equitable;
“Affirmative Procurement or Preferential Procurement “	means targeted procurement of commercial goods and services from persons disadvantaged by unfair discrimination on the basis of race, gender, disability or similar grounds
“BEE Act”	means the Broad-Based Black Economic Empowerment Act No 53 of 2003;
“black people”	has the meaning ascribed to it in the BEE Act and “black person” has a corresponding meaning;
“broad-based black empowerment”	means the economic empowerment of all economic black people including women, workers, youth, people with disabilities and people living in rural areas through diverse but integrated socio-economic strategies that include, but are not limited to-  (a) increasing the number of black people that manage, own and control enterprises and productive assets;  (b) facilitating ownership and management of enterprises and productive assets by communities, workers, cooperatives and other collective enterprises;  (c) human resource and skills development;

- (d) achieving equitable representation in all occupational categories and levels in the workforce;
- (e) preferential procurement; and
- (f) investment in enterprises that are owned or managed by black people; (definition from BEE Act No 53 of 2003);

“Charter”	means the Charter for the South African health sector
“coherent”	means rationally co-ordinated and unified;
“Company”	means a legal entity registered in accordance with the laws of the Republic of South Africa for the purpose of conducting business;
“Control”	means the right or the ability to direct or otherwise control the majority of the votes attaching to the shareholders’ issued shares, the right or ability to appoint or remove directors holding a majority of voting rights at meetings of the board of directors, as well as the right to control the management of the enterprise;
“cost-effective”	means a ratio between cost and efficacy with regard to expenditure such that within any given circumstance, optimum and demonstrable benefit is derived through the most efficient utilisation of the resources required to create that benefit;
“Direct ownership”	means ownership of an equity interest together with control over voting rights attaching to that equity interest;

“Discrimination”	means discrimination as defined in the Promotion of Equality and Prevention of Unfair Discrimination Act (2000)
“efficient”	means the utilisation of limited inputs or resources in order to obtain or achieve a specific output or outcome in such a manner as to ensure the attainment or achievement of that output or outcome at optimal level;
“Employment Equity”	has the meaning ascribed to it in the Employment Equity Act (Act No 55 of 1998);
“Enterprise Development”	means investment in, and/or development of and/or joint ventures with black owned or black empowered enterprises and SMMEs, with real economic benefit flowing to the recipient enterprise allowing it to be set up and run on a sustainable basis;
“Equity”	means the fair and rational distribution of an affordable package of quality health care services to the entire population of South Africa, irrespective of patients’ ability to pay for such services and irrespective of their race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language or birth; and ‘equitable’ has a corresponding meaning;
“Executive management”	means those managers who have a significant leadership role in the enterprises, have control over day to day operations, have decision making powers and report directly to the Chief Executive Officer and / or equivalent or the board of directors;
“GDP”	means Gross Domestic Product i.e. the market value of all final goods and services being produced within the borders of a country;



“HDI”	<p>means a South African citizen-</p> <p>(1) who, due to the apartheid policy that had been in place, had no franchise in national elections prior to the introduction of the Constitution of the Republic of South Africa, 1983 (Act 110 of 1983) or the Constitution of the Republic of South Africa, 1993 (Act 200 of 1993) ('the Interim Constitution'); and / or</p> <p>(2) who is a female; and / or</p> <p>(3) who has a disability;</p> <p>Provided that a person who obtained South African citizenship on or after the coming to effect of the Interim Constitution, is deemed not to be an HDI; (2001 Regulations to the Preferential Procurement Policy Framework Act No 5 of 2000</p>
“health care personnel”	means health care providers and health workers as defined in the National Health Act No 61 of 2003;
“Health sector”	means natural persons and other entities involved in the provision or funding of health services in one or more of its aspects to people in South Africa;
“health services”	means health services as defined in the National Health Act No 61 of 2003
“national health system”	means the system within the Republic, whether within the public or private sector, in which the individual components are concerned with the financing, provision or delivery of health services;
“Junior Management”	means the level of management below middle management and includes academically qualified workers who possess technical knowledge and experience in their chosen field;

“Middle Management”	means the level of management below senior management and includes people who possess a high level of professional knowledge and experience in their chosen field;
“NGO”	means an organization which is independent from government and its policies, which is generally, a non-profit organisation that obtains a significant proportion of its funding by way of donations from private sources and includes a non profit organization as defined in the Nonprofit Organisations Act No 71 of 1997
“parties”	means the parties to this Charter;
“PPI”	means a Public Private Interaction in terms of which one or more persons or entities involved in health care within the public sector interact with one or more persons or entities involved in health care within the private sector or the NGO sector with the object of achieving a mutual benefit or goal and includes but is not limited to a PPP; PPIs include: public financing of health services provided by the private and/or NGO sectors; private financing of publicly provided health services; innovative healthcare delivery models and business models for health practices; delivery models aimed at skill retention and effective distribution and utilisation of skills; use of public assets for the provision of health services by the private sector; use of private assets for the provision of health services by the public sector;
“PPP”	means Public Private Partnership as defined in Regulation 16 of the Treasury Regulations issued in terms of section 76 of the Public Finance Management Act, 1999 (Act 1 of 1999);

“PPPF Act”	means the Preferential Procurement Policy Framework Act No 5 of 2000;
“Private sector”	means persons and entities who are not within the “public sector” and includes NGOs;
“Procurement”	means procedures and expenditure, including capital expenditure, for the purpose of acquiring goods and / or services and which, in the case of the public sector, are governed by legislation;
“Public sector”	means government departments, organs of state and institutions exercising a public power or performing a public function in terms of legislation;
“Quality”	in relation to health care means input of such a nature and applied in such a manner as to ensure optimum results within the available resources and the circumstances of each case, taking into account the constitutional rights of the patient, including the rights to life, human dignity, freedom and security of the person, bodily and psychological integrity, freedom of religion, belief and opinion and privacy;
“Senior Management”	means people who plan, direct and co-ordinate the activities of a business/organization and who have the authority to hire, discipline and dismiss employees;
“SETA”	means a sector education and training authority established in terms of section 9 (1) of the Skills Development Act 97 of 1998;
“Skills Development”	means the process of enhancing individuals’ specialised capabilities in order to provide them with career advancement opportunities;

“SMME” means a small, medium or micro enterprise as defined in the National Small Business Act 102 of 1996;

“sustainability” means having a reasonable prospect of continued, successful existence in the present and the foreseeable future with regard to those critical success factors that define and affect the viability of a particular enterprise over time;

## CHAPTER TWO: CHALLENGES

### 2.1 Access

2.1.1 Access to health care is a complex issue of constitutional significance. There are significant numbers of people in South Africa who do not have adequate access to health services due to geographical, financial, physical, communication, sociological (such as unfair discrimination and stigmatisation) and other barriers.

2.1.2 The general challenges to improved access for all are to identify specifically such barriers as and where they occur in communities throughout South Africa and to implement interventions that are explicitly designed to overcome them with due regard to the -

- a. relevant health policy and the need for access to policy makers
- b. range of health services required;
- c. nature and type of health services required;
- d. necessary human and other resources and infrastructure;
- e. need for communication and information concerning health services;
- f. other relevant factors specific to the particular community.

2.1.3 A specific challenge with regard to information in the context of access to health services is to make available-

- a. information relating to health and health services options to all patients, providers and employers in order to promote informed decision-making;
- b. information designed to address the particular needs of vulnerable groups, including people living in rural and under-serviced areas, and the illiterate;
- c. information relating to the purchase of health insurance products (i.e. value for money, richness of benefits); and
- d. information relating to quality of care (i.e. appropriateness, necessity, cost-effectiveness).

Improved “access” requires improved efficiency, since increases in efficiency should lead to increased access. The sustainability of the national health system is dependent upon its efficient use, management and generation of resources including financial, human, technological, scientific, clinical, managerial, infrastructural and resources in the area of materials and equipment and research and development.

Inefficiency in the national health system threatens its sustainability since it leads to maldistribution of resources, and negates or undermines policies and procedures designed to give effect to the distribution, allocation or utilisation of resources. Policies and procedures should be developed with an awareness of the need for sustainability of the national health system and with a view to the elimination of inefficiencies within the system that could arise for instance from wasteful duplication of resources, under-utilisation of resources and cost ineffective application of resources.

#### 2.1.4 *Human Resources*

- (a) The Parties to this Charter hereby acknowledge that human resources are critical to adequate access to health services. Access to health services training is essential for the attainment of the Charter objectives. There is a need to ensure that historically disadvantaged individuals in particular have access to training institutions or other institutions, for purposes of obtaining academic, or other training in all aspects of health services.
- (b) There are currently shortages of health care personnel in a number of different areas. These include specialised nursing, general medical practice, specialised medical practice, clinical technology, pharmacy, radiology and pathology. If the skills necessary to ensure access to a basic minimum package of care and services are not maintained throughout the national health system then access is not achievable.
- (c) There is no common baseline of information involving certain key parameters with regard to human resources. A baseline is a fundamental step necessary to establish targets with regard to human resources within this Charter. There is currently inadequate benchmarking of salaries and

conditions of service within the health professions or with regard to health care personnel generally.

- (d) There are different salary ranges in the public and private health sectors which create significant disparities in human resources and incentive structures.
- (f) A further challenge is to eliminate harassment from workplaces since it undermines access to health services by consumers and affects the availability of human resources to perform those services.

#### 2.1.5 *Financing*

- (a) Access to medical schemes is diminishing in real terms. Medical schemes provide financing for almost 7 million people but over the years membership figures have declined as a percentage of the general population. This is due in part to major increases in non-health expenditure by medical schemes on items such as administration and brokers fees.
- (b) Given that health care expenditure in South Africa was approximately R107 billion in 2003/4 equivalent to 8.7% of GDP in that year, and that this compares favourably with many other countries in terms of percentage of GDP there is a strong basis for arguing that the key challenge facing the national health system is not necessarily one of inadequate resources but inequitable and inefficient application of resources. Inequitable application of resources results in inadequate access for many. In 2003/4 medical schemes spent approximately R8 800 per beneficiary while in the public sector the figure was approximately R1050 for persons who were not members of medical schemes.
- (c) There are geographical inequities in the provision of health care financing which is skewed towards the urban and private sector. This clearly affects access in the rural and public sector. The challenge is to find a way of providing health services at a low cost to what are perceived by health care financiers as high risk areas such as townships, rural areas and poor provinces. Whilst health service providers are interested in meeting the needs

in these areas, they are discouraged by the fact that it is difficult to find appropriately structured funding solutions.

- (d) These are challenges which the Parties to this Charter will address by means of the strategies and targets set out in a chapter three.

## **2.2 Equity**

2.2.1 Equity in health care involves ensuring equal access to equal care for equal need in a situation in which resources are efficiently utilised in a fair manner. The challenge is to develop a minimum defined basic package of health services without detracting from the principle of buy-ups and other mechanisms of funding levels of care that are higher than the basic minimum.

2.2.2 The basic package of care must reflect the minimum acceptable standard of health services to be made available as the health care safety net for all. This will not preclude the purchase or provision of larger baskets of health services by persons who can afford to do so.

2.2.3 There is a small minority of South Africans, (between 15 and 20 percent of the population) who have a high degree of access to health services and a large majority (between 75 and 80 percent of the population) who have limited access to health services. According to the latest figures, the state spends some R33.2 billion on health care for 38 million people while the private sector spends some R43 billion servicing 7 million people.

2.2.4 Health outcomes and life expectancy for the poor and medium income groups are generally worse than those for high-income groups due to inequity in health services. The services to which the minority has access are far superior in terms of quality and quantity, to those to which the majority has access.

2.2.5 The general challenges with regard to equity in health services are –

- a. The lack of availability of a minimum defined basic package of health services to which everyone can have access irrespective of their ability to pay;



- b. Discrepancies in the quality of health services across different groupings within the socio-economic spectrum;
- c. To eliminate stigmatisation of persons by the broader community, health personnel and health establishments on the basis of health conditions, reproductive decisions or treatment choices;
- d. To eliminate unfair discrimination on the basis of sex, sexual orientation, gender, disability, health status, race, culture, religious beliefs and other prohibited grounds, from within health establishments, the health professions, health services and the broader communities they serve. Unfair discrimination consists of acts or omissions, policies, laws, rules, practices, conditions or situations which directly or indirectly impose burdens, obligations or disadvantage on, or withhold benefits, opportunities or advantages from persons on one or more legally prohibited grounds;

#### 2.2.6 *Human Resources*

- (a) The Parties acknowledge that the availability of human resources is central to the question of equity in health services between the public and the private sectors, between rural and urban communities and between historically disadvantaged individuals and those not historically disadvantaged. For this reason appropriate numbers of suitably qualified and trained health care personnel must be assured throughout the national health system. This is presently not the case.
- (b) Harassment also impacts on equity in the national health system since it is unwanted conduct which is persistent or serious and demeans, humiliates or creates a hostile or intimidating environment or is calculated to induce submission by actual or threatened adverse consequences. Harassment is related to sex, gender or sexual orientation or a person's membership or presumed membership of a group identified by one or more of the prohibited grounds or a characteristic associated with such group.

### 2.2.7 *Financing*

- (a) The most significant challenge facing the South African health system is to address the inefficient and inequitable distribution of resources between the public and private health care sectors relative to the population served by each.
- (b) The financing of health care in South Africa currently contributes to the inequity between the public and private health sectors. Slightly more than 38% of total health care funds in South Africa flow via public sector financing intermediaries (primarily the national, provincial and local departments of health) while 62% flows via private intermediaries. Medical schemes are the single largest financing intermediary accounting for nearly 47% of all healthcare expenditure followed by the provincial health departments at 33% and households (in terms of out-of-pocket payments directly to health care providers) at 14% of all health care expenditure. The national and local government health departments and direct expenditure by firms account for less than 6%. In relation to the original sources of finance, the vast majority of funds flowing through public sector financing intermediaries are funded through nationally collected general tax and other revenues. From the provider perspective, about 39% of all health care expenditure occurs on public sector providers and 61% on private sector providers. This is inequitable when one considers the number of persons treated by private sector providers as opposed to public sector providers.
- (c) A further challenge in the area of health financing in the public sector is the inequitable distribution of health care resources between provinces. There are considerable differences between provinces in public sector expenditure per person. The challenge is how to gradually reduce disparities so that South Africans are not disadvantaged in their access to health services purely as a result of their place of residence without unduly infringing on provincial autonomy with regard to budgetary allocations.
- (d) In the private sector membership of medical schemes has become increasingly unaffordable thus widening the gap between the high-income group and the middle-income group in terms of equitable access to health care. Medical scheme membership has decreased in absolute terms and has

declined as a percentage of the population. This is due in part to rapid increases in expenditure on private hospitals in the late 1990s and early 2000s. Another area of rapid increase in expenditure by medical schemes is non-health items such as scheme administration fees (R4.5 billion in 2003), managed care initiatives (R1.1 billion) and brokers fees (which increased 64% from R354 million in 2002 to R581 million in 2003).

- (e) The challenge is to control the rapid spiral of medical scheme contributions and expenditure. It is significant that direct out-of-pocket payments, the most regressive form of health financing, account for almost a quarter of private health care financing. The majority of such expenditure is by medical scheme members (for instance for co-payments and services not covered by the scheme).

These are challenges that the Parties to this Charter will address using the methods and strategies set out in Chapter three.

## **2.3 Quality**

2.3.1 To achieve quality in health services the best health outcomes must be secured with regard to the available resources. The issue of quality of health services is inextricably connected to issues of both access and equity. Access to health services of unacceptable quality is not access. Access by some categories of people to health services of inferior quality to those accessible by others creates inequity.

2.3.2 General challenges in the area of quality in health services include –

- a. Failure within the national health system to focus on the patient in terms of his or her social and clinical needs, health service options and health service choices;
- b. Failure to measure health outcomes;
- c. The absence of a caring ethos within the health professions;

- d. Poor or inadequate quality assurance and quality measurement programmes in health establishments;
- e. Inefficient or ineffective utilisation of health services in order to achieve improved quality;
- f. Inadequate feedback by mechanisms such as patient complaint systems into the planning and implementation of health services.

2.3.3 Measurement of quality in health services on an ongoing basis is critical to promote and maintain the delivery tracking, publication and feedback processes to ensure awareness of health outcomes in relation to quality of services.

#### 2.3.4 *Human Resources*

- (a) Specifically in the area of human resources the Parties to this Charter hereby acknowledge that quality in health services is heavily dependent upon the availability and work ethic of health care personnel.
- (b) They concede that for a number of years there have been concerns about the attitudes of health care personnel towards patients and the fact that the health care system needs to become patient centred. A lack of respect for the human dignity and freedom of patients on the part of some health care personnel continues to be an obstacle to the achievement of quality in health services.
- (c) The Parties further acknowledge that quality is also affected by the skills shortages in the health sector. The resultant psychological, and physical work pressures upon those who work in such fields leads to a downward spiral of diminished availability of such personnel within the national health system as a whole. In some instances, failure on the part of employers in some instances to implement adequate employment equity programmes, to actively develop historically disadvantaged individuals and to ensure the transformation of employment practices at all levels within health establishments further contributes to lack of motivation amongst human resources.

### 2.3.5 *Financing*

- (a) One of the challenges with regard to quality in particular is that low cost options should not be perceived as, or become, low quality options. The quality of health services that are offered by low-cost options must be the same as that offered by other options. The absence of low cost solutions is largely due to the cost of providing health care on the supply side with high concentrations of services and vertical integration. In the private sector this is evidenced by limited growth.
- (b) Linked to the high costs are the current business practices and pricing models in the provider market.
- (c) A further challenge is that it is difficult for new entrants to get into the hospital services market by small medium and micro enterprises. This is due to the concentration of suppliers in the hospital sector and financing requirements for such services. Improved price competition would have the effect of forcing prices downwards, leading to lower cost at acceptable levels of quality.
- (d) In order to ensure its sustainability the national health system must be able to produce and reproduce all the resources needed to deliver quality, affordable health services in the medium to long-term. The sustainability of the national health system is dependent upon its efficient use, management and generation of resources including financial, human, technological, scientific, clinical, managerial, infrastructural resources in the area of materials and equipment and research and development.
- (e) Inefficiency in the national health system threatens its sustainability since it leads to maldistribution of resources, and negates or undermines policies and procedures designed to give effect to the distribution, allocation or utilisation of resources. Policies and procedures should be developed with an awareness of the need for sustainability of the national health system and with a view to the elimination of inefficiencies within the system that could arise for instance from wasteful duplication of resources, under-utilisation of resources and cost ineffective application of resources.

## **2.4 Broad Based Black Economic Empowerment**

2.4.1 The Parties to this Charter acknowledge that transformation is a process that involves a comprehensive change in the status quo, the manner in which the national health system is structured and operates. It includes profound changes in the levels of ownership, concentration and representation of Black persons across the value chain within the health sector. Therefore, the outcomes of any transformation process should reflect a redressing of the imbalances created by apartheid policies and other discriminatory laws and practices of the past. Therefore the principles of Broad Based Black Economic Empowerment are applicable to all those firms and/or individuals that conduct business or economic activity in the health sector whether for profit or otherwise.

2.4.2 Equity in ownership refers to a state of affairs in which black people are fairly and proportionately represented in all areas of, and at all levels within, business in the health sector. This is to be achieved by a process of comprehensive transfer of ownership to, or acquisition of ownership by, black people throughout the value chain in the sector. The object of this process is to give practical effect to the recognition that apartheid and other discriminatory laws and practices resulted in excessive concentrations of ownership and control in the hands of the minority within the health sector and the need to redress this imbalance. Within this process, the imbalance must be remedied with particular regard to black people and with the object of the opening up of the health sector to ownership by greater numbers of South Africans

2.4.3 With regard to procurement, joint ventures, enterprise development and control, and other business activities, in the context of Broad Based Black Economic Empowerment it is necessary to be aware there are different varieties of BEE ventures.

- a. Black companies i.e. companies that are more than 50% owned and controlled by black people;
- b. Black empowered companies i.e. companies that are more than 25% owned by black people and where substantial participation in control is vested in black people;

- c. Black influenced companies i.e. companies that are between 5 and 25% owned by black people and with participation in control by black people;
- d. Black women-empowered enterprise i.e. companies that are more than 30% owned by black women, and where substantial participation in control is vested in black women;
- e. Indirect ownership is where an empowerment shareholder represents a broad base of members such as employees (to the extent that the options have actually been exercised), collectives and/or communities, or where the benefits support a target group, for example black women, people living with disabilities and the youth. Shares are held directly and indirectly through, for example non-profit organisations, trusts and pension funds. At the same time, directors and management of the groups should predominantly comprise black people;

2.4.4 A key challenge in the context of broad based BEE is to ensure that it is implemented in all of the following areas -

- a. Direct (BEE shareholding) and indirect ownership (employee or trust/community shareholding schemes);
- b. management & control (by Black people);
- c. Procurement (from BEE companies for example, Affirmative Procurement or Preferential Procurement);
- d. Enterprise development;
- e. Investment in joint ventures with BEE companies (in sustainable Department of Health or other accredited BEE programmes involving for instance, PPIs insofar as such programmes are proven to lead to, or contribute to broad-based BEE within the national health system);
- f. Employment equity and skills development;
- g. Corporate social investment.

2.4.5 A further major challenge in the context of BEE within the health sector is the lack of a common vision. Despite many players in the industry pledging allegiance to making the national health system robust and sustainable, overall health outcomes thus far do not give an indication that all are focusing on the same goal. The debate of quality versus profits still dominates discussions of transformation in many instances. It is therefore necessary to create a platform for the sharing of a common vision. Once there is a common vision impact indicators and measurable outcomes can be identified to evaluate the levels of participation of the Parties in working towards and contributing to the common vision.

2.4.6 There are a number of general challenges to BEE. These include the following –

- a. Whether equity should simply be transferred to those who were previously excluded or should they be obliged to acquire it in the same way as non-historically disadvantaged individuals. If so how could this be adequately financed given the significant inequities that still exist?
- b. How should transformation in this area be monitored?
- c. Empowerment is necessary in real terms which enable Black people to take up positions, opportunities and interests that were previously denied them. For instance a few years back a few years back ownership of pharmacies was opened to non-pharmacists but it did not lead to any noticeable increase in ownership of pharmacies by black people.
- d. Ownership of enterprises by health professionals raises some serious professional and ethical challenges. It is important that there are sufficient safeguards to ensure that with the rise in equity ownership by health professionals the challenges of unethical conduct and business practices based on perverse incentives are addressed.
- e. A process of comprehensive transfer of ownership to, or acquisition of ownership by, black people throughout the value chain is required in the health sector. The object of this process is to give practical effect to the recognition that apartheid and other discriminatory laws and practices



resulted in excessive concentrations of ownership and control in the hands of the minority within the health sector and the need to redress this imbalance. Within this process, the imbalance must be remedied with particular regard to black people and with the object of the opening up of the health sector to ownership by greater numbers of South Africans.

#### 2.4.7 *Human Resources*

- (a) This challenge is a challenge shared with institutions of higher learning. How far these institutions transform and whom they produce for this country is directly linked to the speed with which the health sector can be transformed.

Even though the skills development levy and affirmative action legislation are in place, there is little evidence to suggest that the health sector has made significant progress in addressing this issue.

- (b) Transformation of management echelons relates more to affirmative action legislation (Employment Equity Act No 55 of 1998). Despite the many years that this Act has been in place there is still paucity of representation at senior management level in the private sector. Not many black people have been promoted to management level. Lack of movement in this area is said to have led to a lot of job-hopping. The challenge is to ensure that genuine transformation takes place at this level?
- (c) It is important that the process of transforming the workplace covers the total value chain. In identifying the appropriate levels at which changes must take place, the following broad categories are identified;
- (i) Executive Management- this includes the board of directors, members of the Executive Committee (Exco) and persons earning more than R600 000 p.a.
  - (ii) Senior/Middle Management – includes persons that report to members of Exco and any person earning between R 400 000 and R 599 999 p.a.

- (iii) Junior Management – includes supervisors and heads of section and any person that earns between R 200 000 and R 399 999 p. a.
  - (iv) Professional and skilled workers – includes persons who are not in management and are employed because they have special knowledge or particular skill.
- (d) The question of the quality and orientation of leadership of company boards is a major issue of concern. The presence of black people in the local or even international boards of multinational companies does not necessarily guarantee the implementation of BEE and the other principles of this Charter. The challenge is how to empower Black people who sit in corporate governance provisions so that they are in a position to be able to influence or drive the implementation of the initiatives envisaged in the Charter.

#### 2.4.8 *Financing*

- (a) Health care financing faces the challenge of geographical inequities in the provision of health care in South Africa, particularly looking at high and low density areas, rural and urban and making specific interventions to foster a more equitable approach. Currently health care financing is skewed to the urban and private sector.
- (b) There is very little development financing in the health sector. What financing is available is primarily finance to facilitate provision of health care services at the same returns that would be charged in the ordinary course of financing businesses. Often the cost of finance is so high that it is considered prohibitive. Investments in the health sector by Development Finance Institutions compete with other investments in their portfolio. Without development financing the cost of entry for black persons and black businesses in the health sector prevents the achievement of the objectives of this Charter.
- (c) Low cost service providers are still heavily dependent on the finance provided at costs that are not sensitive to the special Healthcare need for low cost solutions. Townships, rural areas and poor provinces are considered very

risky, and as a result, battle to attract appropriately structured funding solutions. Sometimes finance takes too long to be made available that people become discouraged. This kills the spirit of entrepreneurship. While there is a lot of talk around the need for low cost Healthcare services, financially there is very little that is being done to address such a need.

- (d) There is very little BEE in the Health Care sector except for a few recent transactions at equity level. The sector remains largely untransformed and the involvement of BEE is made more difficult by the concentration in the supply side and the funding side of the private sector.
- (e) The absence of low cost solutions is largely due to the high cost of providing health care on the supply side with high concentration of services and vertical integration. This can be seen by the limited growth in the private sector. Linked to the high costs are the current business practices and pricing models in the provider market.

## CHAPTER THREE: SOLUTIONS AND RESOLUTIONS

### 3.1 Access

The Parties hereby resolve and commit to move towards a coherent, unified health system offering financial protection for all the population in accessing a nationally affordable package of health care at the time of need and to improve access to health care services by -

- 3.1.1 Investigating the feasibility of the creation of a category of independent practitioners who will be contracted to the state in order to improve access to health care at the primary level;
- 3.1.2 Strengthening working relations between independent private practitioners and public services in the provision of primary health care;
- 3.1.3 Appropriately increasing the range of health services available to underserved communities. The Parties commit to tailoring solutions which meet the needs of the particular community concerned;
- 3.1.4 The provision of information designed to address the particular needs of vulnerable groups, including people living in rural and underserved areas and the illiterate;
- 3.1.5 Entering into public private initiatives in order to more efficiently utilise the available resources, reduce inequities and improve access to both provision and financing of health services for the benefit of all;
- 3.1.6 Not refusing anyone emergency medical treatment irrespective of whether or not they are able to pay.
- 3.1.7 Providing or sponsoring health profession education, training and development which includes -
  - (a) Formal health training and education;
  - (b) Continuing Professional Development education, sponsored programmes and events in relevant categories of health care personnel;

- (c) Management & Leadership programme provision or sponsorship;
- 3.1.8 Establishing a health sector education trust by contributing to provide financial support to students who wish to study in the health field.
- 3.1.9 Using existing funding mechanisms such as the skills development levy to more efficiently and effectively provide financial support to students who wish to study in the health field.
- 3.1.10 Embarking upon a sector marketing campaign and a career education campaign to introduce pupils and students to the careers and work opportunities within the national health system.
- 3.1.11 Exploring ways of marketing the health professions to attract home qualified South Africans.
- 3.1.12 Developing indicators within 6 months of the finalisation of the Charter to measure improved/increased access, in order to track the extent of progress made, and evaluate the sustainability and quality of such access.

## **3.2 Equity**

The Parties hereby resolve and commit to improving equity in health services by –

- 3.2.1 Developing a minimum defined basic package of care that is available to all patients in both the public and the private sectors regardless of the ability to pay;
- 3.2.2 The elimination of inefficiencies from health service delivery;
- 3.2.3 Implementing a policy of zero tolerance of unfair discrimination by health care personnel which will be communicated to all health care personnel employed by them together with the nature of the disciplinary steps that will be taken;
- 3.2.4 To develop and implement a Human Capital programme that fairly plans for and meets the human resources requirements of South Africa over the next

15 years. Such programme will address the demographics and diversity of the people being trained and developed in the national health system;

- 3.2.5 Support existing initiatives to increase the number of black people and young women matriculating in higher grade science, mathematics and computer science;
- 3.2.6 Setting annual targets for recruiting, training and retention of health care personnel;
- 3.2.7 Setting out milestone leadership programmes with curricula that meet the needs of the Health organisations;
- 3.2.8 Eliminating harassment from workplaces through a policy of zero tolerance that is effectively and continuously communicated to staff and patients alike;
- 3.2.9 With regard to particular health service needs, considering whether a PPI would be an appropriate and feasible means by which the required improvements to access, equity, quality and efficiency within the national health system can be achieved;
- 3.2.10 Developing a code of practice on the ethical recruitment of health professionals;
- 3.2.11 Putting in place programmes that result in the broader representation of black persons in the workplace. It is the target at all levels in the chain that by 2010 the workplace will be 60% black across the value chain and will comprise 50% women. Further, it is the target that by 2014 the workplace will be 70% black across the value chain and shall comprise 60% women.

### **3.3 Quality**

The Parties hereby resolve to improve quality in health services by -

- 3.3.1 Conducting regular and sustained training programmes for health care personnel on the rights of patients and the Batho Pele principles;

- 3.3.2 Implementing comprehensive Employee Assistance Programmes to support and assist the health care personnel employed by them;
- 3.3.3 Committing to the development of low cost health service and financing options that are accessible to middle and low income groups and that assure value for money in terms of health outcomes;
- 3.3.4 The implementation of benchmarked quality assurance programmes that include a quality monitoring system and the measurement of health outcomes;
- 3.3.5 The consideration of complaints by users of the national health system and the creation of mechanisms whereby such complaints are used to inform the planning and delivery of health services so as to be able to continually improve the quality of health care

#### **3.4 Broad Based Black Economic Empowerment**

The Parties commit themselves to the transformation objective of equity in ownership and more particularly broad based black economic empowerment employing the strategies outlined in terms of section 11 of the BEE Act and this Charter.

- 3.4.1 Each of the firms or businesses in the healthcare sector shall be at least 26% owned and/or controlled by or black people. This process should commence immediately.
- 3.4.2 Further, by 2010 at least each of the firms or businesses in the healthcare sector shall be 35% owned and/or controlled by black people.
- 3.4.3 Equity ownership by black people shall increase to 51% by 2014.
- 3.4.4 Regulations will be developed under the National Health Act that facilitate Broad-Based Black Economic Empowerment. Procurement policies and processes that are favourable to firms owned or controlled by black people will be implemented. The stakeholders in the healthcare sector also commit to supporting government on these initiatives. In this regard the following areas should be noted for special focus:

- a. hospitality services and general procurement
- b. Pharmaceutical products and medicines
- c. medical equipment
- d. professional services
- e. IT systems
- f. Distribution and wholesaling services

3.4.5 At least 60% of all procurement shall be from black owned firms or black persons by 2010. By 2014 this should increase to 80%.

3.4.6 The private sector commits to expenditure of a fixed proportion of their annual income on social responsibility projects which include new and existing providing funding and resources for new and existing community development projects.

3.4.7 Development finance must be derived from three sources, partially from DFIs, particularly where the risk profile excludes other sources, with the majority sourced from mainstream financial institutions and vendors themselves.

3.4.8 Development Financing must be used –

(a) to fund small black owned businesses either entering into or wishing to expand their operations in the health sector. It is essential that existing risk and return profiles are modified with the financing over a longer duration;

(b) to finance PPIs and other initiatives to promote the objectives of this Charter.

3.4.9 There must be a concerted team effort from both public and private sector to approach parastatal funding institutions to come up with ways of funding BEE transactions in the health sector as it is not affordable for current banking institutions to fund such transactions.



### **3.5 Implementation**

Implementation of the Health Charter will be a process that allows for experimentation and discovery and must be flexible enough to allow for changes and adjustments to be made to strategies as new variables come to light and existing variables change.

3.5.1 The Parties agree that a mechanism to monitor the implementation of the Charter be established and to enable the public and private sectors to work together towards the common goals outlined in this Charter.

3.5.2 The eligibility of stakeholders that do not implement the Charter for state contracts and contracts with other parties to the Charter would be reduced or precluded altogether depending on the circumstances.

3.5.3 The National Department of Health undertakes, in collaboration with the National Treasury, to develop a practical framework for PPIs.