

The Green Paper on National Health Insurance

Civil Society Discussion Document

November 2011

INTRODUCTION

The release in August 2011 of the Green Paper on National Health Insurance (“the NHI Green Paper”) has rekindled the heated debate around reforming South Africa’s health system. After the tragedy of over a decade of denialism and neglect in the public health sector, we welcome the recognition that health is in a state of crisis and that urgent, real change is necessary.

The critical state of healthcare is not accidental, nor just the result of a massive burden of disease. Policy decisions taken by government over the last fifteen years such as the introduction of GEAR, fiscal discipline, privatisation, retrenchment of health workers and deliberate strengthening of the private sector have all contributed to bring us to where we are today. We need to look beyond the philosophical statements in the green paper and ask whether NHI will address and attempt to reverse the negative effects of these processes.

While we support its statement of intent, the NHI Green Paper is vague on many contentious issues. This may reflect the conflicting vested interests within the health sector and even within government itself, which are likely to bedevil the finalisation of the policy and its implementation. Indeed, we note that the closed and non-transparent way in which the Green Paper was developed, has contradicted the principles of public consultation and participation that is central to the Primary Health Care approach and which is enshrined in the Constitution of the Republic of South Africa, 1996 (“the Constitution”).

There are a number of areas which ensure that the inequality between the two health sectors is perpetuated, these include:

1. The way that money is spent in the respective sectors and on patients. South Africa spends 7.6% of its GDP on health (3.3% come from tax funded health services, 3.3% from medical schemes, 1% is individual out-of-pocket spending¹). These resources are distributed as follows:

	Private sector	Public sector
Percentage of population using and covered by the sector	16% of the population	84% of the remaining population
Per capita expenditure per patient	R11,390	R1,880

¹ Updated from: McIntyre D, Thiede M, Nkosi M, Mutyambizi V, Castillo-Riquelme M, Goudge J, Gilson L, Erasmus E (2007). *A critical analysis of the current South African health system*. Cape Town: Health Economics Unit, University of Cape Town and Centre for Health Policy, University of the Witwatersrand

Once again, this is not accidental. Neoliberal policy decisions have resulted in a continuous undermining of the public sector and subsidisation of the private sector.

2. South Africa's doctors, nurses, specialists, physiotherapists, pharmacists and other health workers are trained in the public sector, however, the majority work in the private sector.
3. Medical aid contributions are tax deductible which effectively subsidises private medical schemes and results in a massive loss of public tax revenue.
4. More directly, the private sector frequently treats patients until the medical aid funds are exhausted and then dumps them on the public hospitals for further care. This was the basis for a now famous, ground-breaking but tragic case in which Mr Soobramoney approached the Constitutional Court for access to dialysis services in the public sector following exhaustion of his private medical aid benefits.

The NHI Green Paper correctly outlines many of these problems and also sets out the burden of disease in South Africa which is a very important consideration for any health system. It outlines a philosophical approach to ensuring universal access for everyone with a focus on primary health care.

THE POSITIVE ASPECTS OF THE GREEN PAPER

1. We welcome the guiding principles stated in the NHI Green Paper. Among these are the principles of social solidarity, right to access, equity and affordability. (We do have a concern that the right to access appears to be limited to "South Africans, legal permanent residents, refugees and asylum seekers").
2. In order to address the current two-tiered health system, the NHI aims to mobilise additional resources for health through the implementation of a "health tax" which will be mandatory for all, and also aims to ensure universal access when the two tier system will slowly become integrated. Through purchasing reforms implemented over time, distinctions between public and private providers would blur as services in the two sectors become comparable, not just in improved quality, availability of medicines, equipment and staff in public sector, but also through changes in the way in which private sector operates so that it serves public policy objectives rather than primarily profits.
3. Further positive aspects are the stated emphasis on primary health care as well as practical strategies to implement this by Re-engineering Primary Health Care. The three strategies outlined are: School-based Primary Health Care teams, Municipal Ward-based primary health care teams and District Clinical Specialists.
4. The Department of Health also aims to register the entire population and sort out informatics so that patient records are computerised and accessible nationally. There is a plan to open nursing colleges, refurbish large public hospitals, develop a real human resources strategy including the training of more health workers and building the capacity of districts. All of these practical strategies will strengthen the public sector and should be strongly supported.
5. There is some recognition in the NHI Green Paper of the centrality of the Social Determinants of Health, though we believe the document would be strengthened if the importance of the

Social Determinants of Health were made more explicit in the strategic priorities resonating throughout the document.

CONCERNS WITH THE GREEN PAPER

However, while there are a number of positive aspects to the Green Paper, there are also concerns that there isn't sufficient clarity provided on a number of very important issues, in particular financing. This means that while the NHI green paper is a statement of intent, the actual form and implementation is still contested terrain. As activists striving for a people's health system, we need to identify the critical areas of struggle, critique the inconsistencies and identify dangerous areas within the green paper. While doing this, it is useful to restate that our vision is for a single national health service which is free at the point of service and funded collectively in the spirit of social solidarity. Keeping this in mind, a number of areas within the Green Paper are a cause for concern, these include the following:

1. Cost of the NHI

There is considerable controversy regarding the cost of NHI with economists representing different class interest groups pushing different figures. Real costs are difficult to estimate, and certain doomsayers, predicting the collapse of the South African economy, have vested interests in making NHI look totally infeasible. The Green Paper estimates that NHI will cost R255 billion by 2025. The 2011/12 budget for health was R125 billion. Superficially this appears to be a massive increase but real annual increase in health expenditure at current trends would have reached approximately R180 billion by 2025.

In April 2001 African Union countries met in Abuja, Nigeria, and pledged to increase government funding for health to at least 15% of the national budget. Thus if the South African government implements the Abuja Declaration and increases health expenditure from 12 to 15% of the national budget, health expenditure would then be estimated to be over R200 billion in 2025. Also, the 2010 total private and public sector spend on health is R227 billion. Which would indicate that while there is clearly a need to generate additional resources, the gap may be smaller than portrayed in the media. In fact, for a real change in the health system to take place, appropriate strategies must be adopted, and a shift takes place of resources from the private to the public sector.

However, before one can truly evaluate the contribution resources currently spent in the private sector could potentially make towards the NHI, as well as from the shift of resources to the public sector, a better understanding of the costs of private health care and its cost drivers must be established. There is currently no transparency on the issue and the private health sector is also not forthcoming with this information.

We recommend that a market inquiry should be held to investigate why private health care is so expensive and to look into possible unlawful practices in the private sector which are driving the cost of health care beyond reasonable levels. This could be done by the Competition Commission, which is an independent body and has the power to investigate complaints of anti-competitive conduct by firms.

The Competition Amendment Act, 2009 (“Amendment Act”), which has been signed by the President, but which has not yet been brought into force, gives the Competition Commission specific powers to conduct a market inquiry into any market if it believes that features of a market prevents, distorts or restricts competition within the that market. A similar enquiry was conducted into the banking industry and while it took two years to complete, it provided detailed recommendations for the industry which benefited the consumer, for example, it recommended that ATM fees be reduced. Further details on market enquiries are provided in attached SECTION27 factsheet.

We also want to reframe the debate away from one simply of costs but rather to how to meet health needs and to ask all South Africans what kind of health system we want for the country. Whether the NHI can pay for such a health system will depend on the amount of money that comes into the fund on the one hand, and the cost of the services [the package] on the other. Both issues should be subject to open and transparent discussion and informed by the principles of equity, effectiveness, comprehensiveness, accessibility, and by the burden of disease in the country and prioritization of those most in need. The way in which the current discussion on costs is being framed is to simply assume that the current inequitable and inefficient emphasis on curative care would be replicated in a future NHI.

2. Tax subsidies on medical aids:

Currently, medical aid scheme contributions are tax deductible and this means medical scheme membership is encouraged through this incentive. What we often overlook is that the private sector is in fact indirectly subsidised by the public sector through tax incentives and there is a massive loss of public revenue through this channel. One of the assumptions of NHI is that up to 40 – 50% of medical aid scheme members will move terminate their membership of the medical aid schemes if the public health sector begins to deliver a quality service under NHI. This shift is less likely to happen if there remains a tax incentive to stay within the medical aid scheme environment. Currently, the tax system allows personal income tax payers to claim deductions for medical scheme contributions and out-of-pocket medical expenses. It is widely accepted, however, that this system is inherently flawed and serves to sustain inequity in health care financing and consumption in a number of ways:

1. The benefits afforded in respect of medical scheme contributions and out-of-pocket expenses increase as income increases, resulting in a greater subsidy for high-income earners
2. Low-income earners who fall below the personal income tax threshold and who do not qualify for a full package of free services in the public system receive no subsidy from government at all in contrast to high-income earners who receive a large subsidy for medical -related expenses
3. It promotes over-consumption of health care resources amongst high-income earners by offering a significant tax deduction for high-end scheme membership and out-of-pocket expenses.

It is clear that such a system cannot persist if the NHI is going to achieve its goal of ensuring equity in the provision of health care. It is for this reason that the provision of tax incentives for medical scheme membership and medical expenses to be covered by the NHI should ultimately be withdrawn. However, until NHI has been fully implemented (meaning that a comprehensive package of care is provided free of charge at the point of service delivery), it will neither be feasible nor desirable to scrap the provision of tax relief for medical-related expenses altogether. What is needed in the interim is the implementation of a system which more equitably provides for some form of subsidy for medical-related expenditure for individuals who are most vulnerable to catastrophic out-of-pocket medical related expenses. This is especially important for those low-income earners who do not qualify for free services at public hospitals and who receive no subsidy from government for treatment at these facilities. It must also include people, such as those with disabilities and the elderly, who use a significant proportion of their income on assistive devices and/or require the aid of professional caregivers. This should be done by extending the system of medical tax credits to vulnerable groups and those who are below the tax threshold by making these credits refundable. This would mean that regardless of whether or not one pays tax, all who do not qualify for free treatment at public hospitals would receive the credit for out-of-pocket expenses. This would, however, require that non-tax payers are registered on a South African Revenue Services (SARS) database or a database accessible to SARS.

While the NHI Green Paper states that medical aid scheme contributions will no longer be tax deductible, there is no time frame for when this will be implemented. Additionally, there has been extensive public and media discussion about creating a tax credit. The current tax subsidy is unequal in its effect, in that not only is the private sector subsidised but the inequality and difference in the benefits derived from it by wealthier and poorer medical aid scheme members is further perpetuated. The way the current tax system is structured means that the amount of money given back to the tax payer through a medical aid deduction depends on the taxpayer's tax bracket. Thus lower income earners with a tax rate of, for example, 25% will receive less money back on medical costs than higher earners with a tax rate closer to 40%. If less well-off medical aid scheme members, who are on basic medical aid scheme plans, run out of savings on their plans they then would have to resort to paying out of pocket for their own and their families medical expenses, money that should rather be used for food for their families or their children's education. The tax credit will be based on a sliding scale and not directly linked to the tax bracket, therefore partly addressing this inequality. It will not, however, address the loss of public resources in terms of taxation nor will it encourage the necessary shift away from private sector membership. The possible compromise of a tax credit should be opposed by activists interested in strengthening and building the public sector and a call should be made for the immediate scrapping of any tax incentives to belong to medical aid schemes. The estimated revenue generated by removing this tax was R10 – 15 billion for 2009 – 2010 and is estimated to be up to a quarter of the annual health budget. These funds could immediately be used to upgrade public facilities and staff vacant posts.

3. A new health tax?

There are three main possible types of taxation that may be implemented to finance NHI:

1. A surcharge on income tax, which is an employee tax for all who earn an income
2. a company tax which could be a payroll tax or a surcharge on profit; or
3. an increase in VAT

We should argue strongly that any taxation should be progressive in nature, in other words contribute to narrowing the gap between rich and poor. This is particularly critical in South Africa given the extent of current income inequalities – where the richest 10% of the population have 51% of the income and the poorest 10% have 0.2% of the income. An increase in VAT with its current structure, while harnessing funds in the informal sector, is inherently regressive. All residents in South Africa pay VAT at the same rate, regardless of income. Unless VAT is significantly restructured, a highly unlikely short term prospect, using VAT will merely increase the burden on the poor and should therefore be opposed.

The Green Paper is silent on the form of taxation that will be used. It appears that significant disagreement, even within government, may exist with regards to how NHI should be funded. In addition, the final decision will probably rest with Treasury. Thus in our mobilisation and campaigning around this we should identify two areas to make demands: eliminating tax incentives for medical schemes and ensuring progressive taxation which narrows the gap between rich and poor. These demands must be put not only to the DOH but also to National Treasury where the real decision will be made.

4. Health care benefits under NHI:

NHI will provide a “benefit package” which will be specific to each level of care: district, regional and tertiary hospital level. The aim is to make this package comprehensive and rational. Details of the package are not available in the Green Paper, and this is making it difficult to comment on whether or not it will truly be comprehensive. The content of the benefits package will ultimately determine the form and quality of the health system created and should be legally defined. It should be appropriate, comprehensive and incorporate preventive and promotive health strategies. It should also include the kinds of services delivered by a wide range of health care workers, professionals and community health care workers (CHWs), and not only concentrate on curative services currently delivered by doctors and other professionals on a mainly fee-for-service basis.

Indeed, the ‘Re-engineering Primary Health Care’ policy² affirms the importance of addressing the social determinants of health through intersectoral actions, including those addressing local environmental factors. The NHI must therefore include funding of personnel to undertake such activities as lobbying, advocacy and social mobilization to ensure access to technologies and resources needed for health such as improved sanitation and water supply, as well as disposal of solid

² See World Health Organisation: <http://www.who.int/whr/2008/en/index.html>

waste. In this regard significantly increased numbers of community-based workers, equipped with the requisite skills are a key component of the human resource complement to be funded by a NHI.

The Green Paper is also weak in identifying a broader conception of services considered within the ambit of health care. We believe it is essential that the NHI fund psychosocial and community-based services that help to strengthen social cohesion and services for particularly vulnerable groups in their local settings, such as, for example, community-based services for survivors of gender violence, or services for persons with disability. We also hold the view that facilitating transport to health services, particularly for rural communities, is an essential requirement of a future NHI seeking to establish universal coverage and to address the barriers to accessing health care services such as lack of transport to health facilities. The only way to ensure this is to demand an open and inclusive process where community organisations, health workers, activists and trade unions are consulted on what they would like to see provided in a reformed health system. The current Green Paper appears to frame the process of determining the package as a technical one, decided by experts. We do not believe such a process will deliver the best options for care, nor is it consistent with the spirit of the Green Paper or the Constitution. We believe there should be mechanisms and structures established which provide an avenue for community and civil society to provide input to determining what goes into the package, how it is legally defined, and into oversight of the NHI performance.

Strong community participation in health and development (including addressing social determinants) is essential for empowering people to take care of their health. CHWs and other community based health workers can play a key role in this, provided that they are recognized as change agents and given the necessary training, support and affirmation. Their role is therefore not merely a transitional role, but they should become a permanent part of human resource planning and community health work seen as a key employment opportunity for women, especially those from poor communities.

5. User fees and co-payments:

Public facilities in South Africa continue to charge unaffordable user fees from patients with any form of income above poverty levels. This mainly affects lower income workers who cannot afford medical aid scheme coverage and use the public sector only to be faced with crippling hospital bills. Workers earning as little as R4000 per month are often charged prohibitive fees in the public sector. Higher income workers are charged fees so close to or at times even higher than private rates; this means that there is no incentive to preferentially use funds in the public sector.

The ANC discussion document on NHI³ clearly states that user fees would be done away with and the service will be free at the point of service. There is also a large body of evidence pointing to the retrogressive impacts of fees on access, and that recovery of user fees is often cost-inefficient in populations unable to pay.

While the right to access health services is stated in the green paper, it is concerning that there is no specific mention of abolishing user fees nor is a timeline given for when this will occur. It is critical that we campaign for health that is free at the point of service and that is paid for via common taxation.

³ See <http://www.anc.org.za/show.php?id=6013>

Even more worrying is the mention of co-payments within NHI under certain circumstances. Co-payments are not payments for services outside of the NHI health package, such as for cosmetic surgery or expensive spectacle frames, but are additional payments for services within the package of care. While there is a statement that co-payments are discouraged, a loophole is left for co-payments to be implemented in certain circumstances and this must be addressed.

Co-payments have been used extensively in other NHI systems in the world where they have resulted in limiting access to care. They undermine the core principle of universal coverage and must therefore be opposed. In any event, the distinction between user fees and co-payments may well be immaterial in the way such measures are implemented. Accordingly, we are opposed to both forms of payment.

6. Accreditation of health service providers:

NHI will pool vast sums of money into a single fund. These resources will be used to “purchase” services from health providers both private and public. All facilities contracting with the NHI will have to be accredited by the Office of Health Standards Compliance, which is in the process of being established.

Civil society should closely monitor the accreditation process to ensure that there is no tendency to consider private or urban based public hospitals as being of sufficient quality and accredited, while hospitals and clinics in rural and poor urban communities will struggle to meet these standards and run the risk of not being accredited.

Information from the audit of health facilities should be made public and we should ensure that resources are targeted at facilities which fail their audits.

This could mean that public funds earmarked for the health sector could again end up benefiting only private facilities and already well run public facilities. In the worst case scenario, NHI could end up strengthening the private health industry which, there are indications, is in itself in financial crisis. The money in the NHI fund is public money and should be used to upgrade and build the public sector as the only reliable and sustainable way to deliver health care to the nation. We should therefore campaign for the upgrading and accreditation of public facilities first. There should also be a focus on rural and poor urban areas initially to reduce the current glaring inequities in access to health care services. We call on the licensing authorities when considering applications to expand existing private facilities or for new ones to consider the revitalisation programme and the goals of the NHI and to only grant licenses for private facilities under exceptional circumstances where overwhelming need is demonstrated. The upgrading of public sector facilities would strengthen and give effect to the progressive realization of the right of access to health care. Many general practitioners in rural and urban communities provide a health service where the public sector is failing. It will probably be necessary to bring these practitioners into the NHI system in order to successfully implement primary health care strategies. These GP’s should be brought in on a capitation basis as is already stated in the green paper. Capitation means a particular population will register with a general practitioner and payment will be received for treating that population. GP practices should, however, also be multidisciplinary and upgraded to deliver a comprehensive primary health care service, including the full spectrum of preventive, promotive, curative and rehabilitative services.

The integrity of the accreditation process must be maintained and monitored, in particular to ensure that every decision is one of merit where the need and current provision of health services in the area is carefully considered. One cannot have a situation where large urban private hospitals are accredited despite there being tertiary public hospitals nearby providing the same services. Power of the large private sector groups that own most private hospitals will make it difficult to negotiate terms which are favourable to the NHI and can potentially drain massive amounts of public funds for the treatment of a smaller percentage of patients but at higher prices. That is why it is important to hold a market enquiry into the private sector, as a potential outcome of the market inquiry could be recommendations for changes in the pricing practices in the private sector and/or regulation by the DoH that will lower prices and effectively increase access to health care services. Funds could then be better utilised to build or upgrade public facilities and to recruit specialists back into the public sector.

7. Building of flagship hospitals with PPP's:

Part of the NHI implementation plan is the building of six flagship academic hospitals. Many of the hospitals named already exist so it must be assumed that a significant renovation and revitalisation of these facilities is envisaged. The concern is that the Green Paper implies in Table 1 (page 42) that financing this will be done through private public partnerships without providing any further details in this regard. It is not clear whether this will be with the private health industry or other private financiers and what the final ownership and management structure will be. Using the private health industry is fraught with danger if the facilities are then partly privately owned or even privately managed. Even if non private health funders are used, experience from other PPP's is that while projects may be completed sooner, the final costs are much more than simply using alternative, public funding⁴. The building of public hospitals should not be a source of profit for private companies and should remain wholly owned and managed by the public sector.

8. The NHI Fund and the Department of Health (DOH):

The necessity for a separate fund as a conduit for health resources has been a source of debate because of the dangers of a large bureaucracy running parallel to the DOH. While the green paper tries to delineate the roles of the NHI Fund (in the payment for health services) in contrast to the role of the DOH (in determining health policy and training health workers) this remains a major concern. District Health Authorities are identified as the key "purchasers" between the DOH and the NHI fund while the role of provincial government is not clarified. Despite the fact that provinces currently play a more important role in shaping the delivery of health care and of overall stewardship for health than do the districts. As a result, the current delivery of health services is significantly fragmented by the different responsibilities given to national government, provincial government and districts. While it is the vision of the DOH to use a District Health system to deliver services, eliminating the bureaucracy at

⁴ For more detail see: Canadian Union of Public Employees. Why privatization doesn't work Useful research and analysis about public-private partnerships. Available at <http://www.cupe.bc.ca/sites/default/files/Critiquing%20privatization%20Updated-Feb2010.pdf>

provincial level is not addressed. District Health Authorities as well as major secondary and tertiary hospitals need to have management authority to deal directly with the national NHI fund and not go through cumbersome provincial government structures. It is proposed that the NHI fund will pool the health budget and all supplementary health revenue received from health taxes. The NHI fund will be an autonomous government owned entity that is publically administered with the CEO answerable to the Minister of Health. It will be a huge, multibillion rand fund which makes the risk of looting and corruption very real. While this is part of a bigger problem, specific laws and policies should be passed to safeguard the Fund. In particular, the Green Paper is silent on accountability within the NHI and what mechanisms will be put in place to ensure that officials do not subvert the policy intentions outlined for the NHI, nor that systems are left to evolve in ways that undermine the goals of the NHI. We would argue for a more explicit outlining of the way in which accountability will be established in the NHI.

Furthermore, the principle of establishing one fund is to gain the advantages of pooling resources and using a single national payer to crowd out medical schemes.

A single line under section 16 of the green paper however, completely contradicts this by stating that “a multi-payer system in a National Health Insurance will also be explored as an alternative...”

A multi-payer system would mean the involvement of currently existing medical schemes in paying health providers. This has been used in other NHI systems with disastrous results. A multi-payer system maintains a role for the already powerful private medical insurance industry and completely undermines the principles of the NHI. We believe there should be absolutely no place for a multipayer system in the future NHI.

9. Information and protections

The NHI will most likely involve a centralization of patient records. We are concerned about the resulting information bureaucracy, the potential lack of privacy protections and guarantees that information will not be misused or compromised. The Protection of Personal Information Bill and related regulatory mechanisms have not received sufficient consultation or community participation to date, and these issues are unexplored insofar as the NHI is concerned. There is also no indication on exactly what kind of data will be collected by the Department, or the manner in which it will be used and safeguarded by the health services.

10. Implementation:

Implementation phases at the end of the green paper are reassuringly focussed on strengthening the public sector and on building primary health care. This must be supported. The opening of posts for district specialists, ward based primary health care agents and school based services as well as the planned opening of nursing colleges are part of the 2011 – 2012 plan, if achieved, will be a great boost to the public sector. It is also intended that a Conditional Grant will be used to establish pilot projects in 10 health districts which will help clarify how the new system will work. Clearly, we must support these steps as being in line with the need to first build and capacitate the public sector

especially at district level and below. The establishment of the actual NHI Fund and the accreditation of private providers is only envisaged later and there is no timeframe for the implementation of the health tax. These are the areas where we will need to remain vigilant and organised to campaign for the most progressive and public sector friendly policies while at the same time calling for private health sector reform and regulation, which should start with the market enquiry into the sector.

11. Coverage and exclusion of undocumented migrants:

While the Green Paper speaks to universal access for South Africans, permanent residents and for refugees and asylum seekers, it leaves unaddressed the question of undocumented migrants who do not have legal status, or for whom the process to determine their legal status is still pending. Many such persons are amongst the most vulnerable in society and their further exclusion from access to facilities and services for health may only compound their vulnerability and adversely affect their and others' health status. We need to ensure that international laws and also our own Constitution, which states everyone is entitled to access health care services, is respected and reflected accordingly in NHI policy and papers. Paragraph 64 of the Green Paper states that refugees and asylum seekers will be covered in line with provisions of the Refugees Act, 130 of 1998 ("Refugees Act"), and International Human Rights Instruments that have been ratified by the State." However, it is currently unclear how the health rights of refugees and asylum seekers are to be protected as the Refugees Amendment Act 33 of 2008 has deleted the subsection in the Refugees Act which dealt expressly with health rights. It is therefore unclear whether health rights are now protected under a further more general provision in the Refugees Act which states that refugees are entitled to 'rights set out in Chapter 2 of the Constitution'.

Ultimately, the NHI bill must clearly set out the entitlements of refugees and all other categories of people in South Africa. These entitlements must be determined in terms of the Constitution and other relevant international laws and Conventions. They must also respect the dignity of all persons regardless of immigration status. Further, they must demonstrate that consideration has been given to the health risks that untreated communicable disease in refugee and asylum seeker populations pose to all people within South Africa. In this regard the NHI must be brought in line and speak the same language as other national health policies which promote public health, particularly the National Strategic Plan for HIV and AIDS, STIs and TB, 2012-2016 ('NSP') which ensures everyone is entitled to antiretroviral treatment (ART) and TB for example.

CONCLUSION

The Green Paper on the NHI is an open-ended document with broad health policy strategies which can largely be supported. However, there are numerous problematic areas related to funding and implementation, some of which contradict the stated principles underpinning NHI. Conflicting economic and political interests are reflected in the green paper which makes it imperative that civil society organises a progressive campaign to strengthen positive principles within the policy and oppose pro private sector and regressive aspects.

A broad based public campaign should include the demand for the abolition of user fees at public hospitals, the scrapping of medical aid tax incentives, accreditation of rural and poor urban public facilities first, the use of progressive taxation to fund NHI and a call for a market enquiry to be held into the private health sector. The powerful private health industry in South Africa will seek every opportunity to mould the NHI into a form which maintains profits and prevents radical transformation of the health sector. Only a strong grassroots campaign with clear and radical demands can shift the balance of forces and ensure that NHI takes us closer to and not further from the objective of a People's Health System.

This discussion paper has been developed and endorsed by the following organisations:

People's Health Movement South Africa (PHM-SA)

SECTION27

Treatment Action Campaign (TAC)

Black Sash

Rural Health Advocacy Project (RHAP)

Rural Rehab

Rural Doctor's Association of South Africa (RuDASA)

Passop

EarthLife Africa

Africa Health Placements (AHP)

If you would like to join this coalition contact Alex Muller (coordinator@phmsouthafrica.org). The organisations that are part of this coalition will also be making submissions to the Department of Health on the Green Paper.