



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

NATIONAL HEALTH INSURANCE CONFERENCE

“Lessons for South Africa”

National Consultative Health Forum (NCHF)

Venue: Gallagher Convention Centre

Date: 7th to 8th December 2011

Sponsors: The United Kingdom’s Department for International Development
The European Union TDCA Facility

**Conference on National Health Insurance:
Lessons for South Africa – December 7th – 8th, 2011**

Contents

EXECUTIVE SUMMARY	3
INTRODUCTION.....	9
DAY ONE: WEDNESDAY 7 TH DECEMBER 2011	10
SESSION 1: OPENING SESSION.....	10
A: Opening and Welcome by Director-General of Health	10
B: Keynote Address by the Minister of Health, Dr. Aaron Motsoaledi, MP	10
C: Overview on Universal Coverage and Social Determinants of Health.....	12
D: Global Perspective on Health Financing	12
E: Comments by Dr. Olive Shisana, Chair of the Ministerial Advisory Committee on National Health Insurance.....	14
SESSION 2: FINANCING, SERVICE PROVISION, INSTITUTIONAL ARRANGEMENTS AND GOVERNANCE OPTIONS IN DEVELOPING COUNTRIES.....	16
A: Lessons from South Korea	16
B: Lessons from Thailand	18
C: Lessons from Turkey	20
D: Lessons from Ghana	21
RESPONDENTS TO LESSONS FOR SOUTH AFRICA FROM THE DEVELOPING COUNTRIES.....	22
Respondent 1: Dr. Mark Blecher, National Treasury.....	22
Respondent 2: Professor Di McIntyre, Health Economics Unit, University of Cape Town	24
SESSION 3: FINANCING, SERVICE PROVISION, INSTITUTIONAL ARRANGEMENTS AND GOVERNANCE OPTIONS IN DEVELOPED COUNTRIES	25
A: Lessons from Germany	25
B: Lessons from Australia	26
C: Lessons from France.....	27
D: Lessons from the United States of America (US)	28
RESPONDENTS TO LESSONS FOR SOUTH AFRICA FROM THE DEVELOPED COUNTRIES.....	28
Respondent 1: Dr. Christoph Schwierz, European Commission	28
Respondent 2: Professor Di McIntyre, Health Economics Unit, University of Cape Town	29
DAY TWO: THURSDAY 8 TH DECEMBER 2011	30

SESSION 4: GOVERNANCE ARRANGEMENTS	30
Governance for Universal Health Coverage	30
SESSION 5: HEALTH EQUITY, SOCIAL SOLIDARITY AND FINANCIAL RISK PROTECTION	31
Health equity, social solidarity and financial risk protection.....	31
SESSION 6: EXPERIENCES FROM REGIONS: FINANCING, SERVICE PROVISION, INSTITUTIONAL ARRANGEMENTS AND GOVERNANCE	32
A: Lessons from EU Countries.....	32
B: Lessons from Low Income Countries.....	33
C: Lessons from Middle Income Countries	33
SESSION 7: INNOVATIVE HEALTH FINANCING	34
A: International Experiences.....	34
B: Civil Society Perspective on NHI and Innovative Financing.....	35
SESSION 8: LESSONS FOR SOUTH AFRICA.....	38
A: Ethics.....	38
B: Rights and the Law	38
C: Service Provision.....	39
D: Financing Options	40
SESSION 9: OPTIONS FOR SOUTH AFRICA.....	41
A: Governance and Institutional Arrangements.....	41
B: Financing	42
C: Service Provision.....	42
CONFERENCE CONCLUSION.....	43
Annexure A: CONFERENCE AGENDA.....	46
Annexure B: SPEAKER PROFILES.....	49

EXECUTIVE SUMMARY

The South African health system is plagued by a number of interrelated challenges, which all combine to adversely impact on the performance of the system and the health outcomes that are associated with the population's wellbeing. These challenges are both systemic and operational, in that they range from shortages of human resources, the inequitable distribution of resources between the public and private health sectors as well as to the poor financial management of allocated resources and the imbalance in financial resources between the public and private sectors.

In recognition of these inherent systemic challenges, the National Department of Health has identified 10 key priorities that need to be addressed holistically in order to significantly improve the health and wellbeing of the South African population. These 10 priorities are outlined in the Department's 10 Point Plan for the health system which aims to address challenges in the areas of health system stewardship, healthcare financing, human resources planning, quality of health care, health facilities management, infrastructure refurbishment and planning, addressing the problem of HIV, AIDS and Tuberculosis, overhauling the management of health facilities, reviewing the country's drug policy and enhancing health systems research. These areas are also incorporated into the Department's Health Sector Negotiated Service Delivery Agreement which aims to increase life expectancy, decrease maternal and child mortality, combat HIV, AIDS and TB and other related diseases and strengthening the health system's effectiveness.

The focus of the National Health Insurance Conference, themed "*Lessons for South Africa*", was to create a national consultative health forum as a platform for South Africans to engage with local and international experts in the areas of health financing and health systems reforms and how these have been undertaken in other contexts to ensure that universal coverage to quality health services is achieved for the entire national population. The Conference was organised as part of the Department's strategy to consult as many stakeholders as is possible on the contents of the Green Paper on National Health Insurance (NHI) which was published in Gazette Number 34523 on 12th August 2011 to initiate a process of eliciting comments from the public. The Conference was held at Gallagher Estate Convention Centre, from 7th to 8th December 2012.

International delegates at the Conference included guest speakers from international organisations such as the World Bank, the World Health Organisation, the OECD Health

Division and the European Union. Local delegates included speakers from academia, research institutions and the private health sector. Participants were given information and key lessons that could be drawn upon by South Africa from various countries including Australia, Ghana, Germany, France, South Korea, Thailand and Turkey.

The important lessons for South Africa that emerged during the two days of presentations and deliberations at the Conference are summarised in the following key areas:

a) Financing, Service Provision, Institutional Arrangements and Governance Options

The policy reforms around the implementation of NHI in South Africa must focus on entrenching hospital price controls early and introduce mechanisms for channel volume expansion towards basic primary care for the under-served. This will help promote efficiency and impact positively on future sustainability of the envisaged system. A single payer insurance system is a good starting point but active purchasing is needed as this has been shown to be a necessary ingredient for containing hospital prices and volumes is critical to promoting efficiency and effectiveness.

South Africa must also ensure that it adequately invests in primary care to reduce avoidable admissions. A common fallacy of insurance institutions is that they are often more concerned with financial management with little or no focus on extending health promotion and prevention services – therefore, South Africa must try at best to establish need a ‘policy-savvy’ insurer, one that adequately focuses on financial management but also ensures adequate health protection for the population. The government needs to be able to flexibly invest in the institutional development of primary care as well the management and treatment of HIV, AIDS & TB and non-communicable diseases (NCDs) through community-based chronic disease management programmes. The benefit package of health services should be comprehensive and there must be a strong emphasis on primary health care services such as health promotion, prevention and community outreach programmes.

To ensure that NHI yields the positive outcomes, there is the need to implement a single payer system that is supported by comprehensive planning, risk pooling to deal with fragmentation, implementation of proactive price regulation, active purchasing and the provision of equivalent services. This requires the transformation of the public health system and the incentivisation of health and not services through innovative

reimbursement mechanisms such as capitation for PHC services, case-based global budgets for hospitals and even clinical budgeting. Fee-for-service should not be the main provider reimbursement tool within a universal health coverage system. Finally, a strong monitoring and evaluation system must be in place so that data is collected to ensure that the reform remains pro-poor.

Furthermore, for South Africa to reach universal coverage in health requires real political and financial commitment. There must be resilient leadership. Furthermore, responsive health systems are the foundation for successful universal coverage implementation. It is important that there is a policy champion with sufficient political power to sustain the policy reform process. The involvement of the grassroots organisations will help to create a needed civic movement that could prove pivotal in the progress towards implementation of NHI in South Africa.

b) Governance for Universal Coverage

It is important to note that there is a combination of factors that influence organizational behaviour and what governance system will work most appropriately. These factors include a coherent decision making process, stakeholder participation, transparency and willingness to share information, supervision, and adequate consumer protection.

For the National Health Insurance strengthening governance includes active mentoring and feedback, strong community participation, regulation and a robust structure for oversight. The Ministry of Health and the NHI Fund will need to clarify roles and responsibilities. A recommendation is that for the Ministry or the Department of Health focus should be on matters pertaining to stewardship, systems management, and quality assurance while for the NHI focus must be on the collection of funds, pooling of funds, a well-described benefits package, and stakeholder liaison. There is no perfect governance model that South Africa can adopt from other contexts. Effectiveness of governance systems vary according to context and the existence of supporting factors. Political support and will is very important and strong oversight mechanisms and the involvement of stakeholders plays a very important role in strengthening governance systems.

c) Health Equity, Social Solidarity and Financial Risk Protection

South Africa must not wait for global assistance before deciding to move towards universal coverage in health. NHI can deliver social justice, equity, efficiency and social solidarity. NHI is not just about health but about building a good South Africa, a country that everyone will be proud of. The voice of the public is often missing and undermined when it comes to such massive social policies. Efforts must be ensured that people who will be the direct beneficiaries of such a system are involved at all levels throughout the implementation process. South Africa must note that it is in the interest of the rich to pay for their healthcare and not to pay higher taxes for health care for all – therefore the rich will try by all means to resist any policy measures to make them pay higher taxes to the benefit of the non-rich. The current health system is unconstitutional, inefficient, not accessible, and unequal and undermines human dignity.

South Africa could learn some valuable lessons from the EU in terms of health systems reform to realise universal health coverage. For instance, the various health care frameworks that have been published by the EU could be used as learning platforms for South Africa to define responsibilities, targets, modes of provision of care, financing and benefit packages, how to ensure affordable care, the implementation of workable public governance arrangements, to set public health priorities, pooling of funds and ensuring value for money for all resources allocated to the health sector.

d) Innovative Health Financing

Government must carefully consider the pros and cons of alternative financing mechanisms before choosing the most appropriate and least likely to burden the vulnerable groups. A variety of alternative considerations are available to the South African government as mechanisms for mobilising additional funding for the implementation of NHI. These include (1) a Special levy on large and profitable companies; (2) a levy on currency transactions; (3) a tax on bonds sold to nationals living abroad; (4) a financial transactions tax; (5) mobile phone voluntary solidarity contributions; (6) Sin taxes on alcohol and tobacco; (7) Excise taxes on unhealthy foods e.g. salt, sugar and other food ingredients; (8) the sale of franchised products e.g. the Global Funds Product RED project; and (9) a Tourism tax. South Africa must avoid dependence on overseas development assistance (ODA) in the implementation of key programmes such as NHI.

South Africa's social context must also be accounted for in the health reform initiatives, particularly the high unemployment rate and the large number of people dependent on social grants. As a result of these factors, it would be unfair to expect everyone to contribute towards funding NHI, let alone contribute the same amount. Instead, everyone who earns an income must contribute a nationally prescribed proportion of their income to NHI. NHI must be funded either through Pay-As-You-Earn (PAYE) or employer payroll tax or a combination of both. However, Value Added Tax must not be increased to fund NHI as it would unfairly affect the poor. Exemptions for contributions should be considered for the poor, those who fall below the tax bracket, children, recipients of social grants, the elderly, and people who are unemployed.

e) Ethics, Rights and the Law

The current South African health system is unfair and thus unjust. Health financing is not universal and it marginalizes the poor and the disadvantaged. There is a moral imperative and ethical obligation for the South African health system to be changed for the better. There are also duties for the State and civil society that should be undertaken in a manner that ensures that the health and wellbeing of the South African citizen are adequately catered for. As government proceeds with the phased implementation of NHI, South Africans must make informed trade-offs in order to design a fair system. People and society must be willing to give up some things. Efforts must be directed at a transparent system of identifying the values of the health system and this must be used to determine what people are willing to forgo. To ensure that the NHI is adequately implemented, the Constitution must be used as the yardstick for the various contents of the legislative framework that is put into place to enable the phased implementation of NHI. The principles that guide policy development in South Africa according to the Constitution include the need for any policy to prioritize the poor in the manner in which it is enacted; rural areas are priority; and if a policy is to be reasonable it must account for short term needs and must be implementable – this implies mechanisms must be in place for budgeting, functions and oversight that includes adequate representation.

In conclusion, the Conference provided a wealth of positive and negative lessons that South Africa would have to consider as it proceeds with the implementation of NHI. These lessons include the importance of introducing fair financing mechanisms to augment resources allocated from general taxes, the need to ensure that there is appropriate separation between the stewardship and provision functions within the health system, the relevance of

ensuring that adequate checks and balances are built into the system so that proactive governance is in place and the importance of referring to the Constitution as the platform for creating the enabling legislative framework for the progressive implementation of NHI in South Africa.

INTRODUCTION

The Minister of Health, Dr. Aaron Motsoaledi, MP published the Green Paper on National Health Insurance (NHI) on 12th August 2011 in Gazette Number 34523 as part of the Department of Health's processes of initiating the public consultation on the policy proposals for the implementation of NHI in South Africa. To further the depth of the public consultation process as well as to elicit inputs from as wide a set of stakeholders as possible, the Department has invited international experts on health financing and health systems reform to a conference to share relevant experiences on key aspects related to NHI in developed, low and middle income countries. The Conference themed "*Lessons for South Africa*" was held from 7th to 8th December 2011, at Gallagher Estate Convention Centre in Midrand.

The three (03) main objectives of the conference were:

1. To promote a sharing of experiences in key areas of health financing such as revenue mobilisation, governance arrangements, ethics, human rights and health services provision;
2. To learn from international experiences of countries that have implemented policies to promote universal coverage in health; AND
3. To determine key lessons from other contexts that could be used to inform the practical approaches to the implementation of NHI in South Africa

The main topics of the Conference will focus on addressing matters relating to:

1. Equity, Human Rights and Justice perspectives on Universal Coverage in Health
2. Financing Options – A perspective for Low and Middle Income Countries
3. Revenue Mobilisation Options
4. Health Service Provisions – International experiences on approaches to health services provision; AND
5. Governance and Institutional Arrangements to support Universal Coverage in Health

This report contains the details of the key discussion points raised in the presentations, deliberations and related proceedings during the two days of the National Health Insurance Conference. The full agenda, indicating all the topics and speakers, respondents and session facilitators at the conference is attached as **Annexure A**. The speaker profiles are included as **Annexure B**.

DAY ONE: WEDNESDAY 7TH DECEMBER 2011

SESSION 1: OPENING SESSION

Facilitator: Ms Malebona P. Matsoso, Director-General: Health

A: Opening and Welcome by Director-General of Health

Delegates to the Conference were officially welcomed by the Director-General of Health, Ms. Malebona Precious Matsoso. As part of the welcome address, the Director-General informed the Conference participants that the main purpose of the gathering was to use the Conference as an opportunity for South Africa and more specifically the National Department of Health to learn and where appropriate draw from international experiences and lessons from other countries that have implemented NHI to guide the refinement of the Green Paper as part of the processes of drafting the White Paper on the implementation of NHI in South Africa. It was also indicated that in addition to identifying necessary lessons, the Conference would be used as a national health consultative forum to learn about innovative models for service provision and health financing to achieve universal coverage and how these can be applied within the South African context.

B: Keynote Address by the Minister of Health, Dr. Aaron Motsoaledi, MP

The keynote address by the Minister of Health, Dr. A Motsoaledi, MP covered a wide number of areas. The Minister emphasised the importance of all role players being involved in the policy making and development processes to ensure that they share in the Department's vision and plans for the national health system. The Minister further indicated that in order to ensure that South Africans from all walks of life live and enjoy a long and healthy life, health must be treated as a public good and not as a commodity that can be sold on the open market and whose price, affordability and accessibility are left to the whims of the free market. He referred to Section 27 of the Constitution of the Republic of South Africa which clearly outlines that everyone is entitled to have access to healthcare and that the State has an explicit obligation to ensure that this right is progressively achieved within the resources available. Part of the progressive steps that the State is taking to realise this right are outlined in the National Department of Health's 10 Point Plan, in which the implementation of NHI is listed as priority two.

Further, the Minister made reference to the 1978 Alma Ata Declaration which defined health in a way that emphasizes health as a fundamental human right that includes the mental, physical and social wellbeing of the individual, not only the absence of disease or infirmity. The Minister went on to stress the pivotal role that health plays in ensuring that countries attain sustainable levels of economic growth, and how this is good for human progress. Some of the challenges that the Minister identified as adversely contributing towards why South Africa has poor health outcomes and significantly lags behind in achieving universal coverage in health are:

1. A hospi-centric system
2. Fragmentation
3. Uncontrolled commercialization of health services

The Minister also noted that the health care system in South Africa in both the public and private sectors is unsustainable, costly, hospi-centric, and destructive. This is because the system is structured in manner that significantly ignores the importance of health promotion, prevention and community outreach programmes.

The Conference was informed that as a result of having identified these challenges, the National Department of Health (NDoH) has identified several areas in which strategic interventions had already been rolled out to reverse the poor performance of the health systems. These areas include the establishment of an independent Office of Health Standards Compliance to address challenges related to quality of care; the rationalisation of the infrastructure programme to speed up health facilities planning, refurbishment and building of new ones; the finalisation of the Human Resources for Health Strategy document as tool to support strategies and initiatives for the training, recruitment, development and retention of health professionals, the overhauling of the management capabilities of facility managers, the re-designation of public hospitals and the roll-out of the Re-engineered Primary Health Care (PHC) approach. Three PHC streams have been launched as part of the programme of work to shift focus from curative to preventive health. These streams are the District Clinical Specialists Support Teams which will be deployed to the health districts to address the burden of disease, with specific focus on matters pertaining to maternal, child and women's health; School health teams to address the health problems that many school going children encounter as well as to promote early interventions; and the Municipal Ward

based Primary Health Care agents to undertake community outreach programmes and health promotion.

The Minister concluded by thanking all delegates for making the time to participate in this important Conference and emphasised that the deliberations of the next two days must be held in an open and transparent manner to ensure that South African learns from the good and bad experiences of other countries.

C: Overview on Universal Coverage and Social Determinants of Health

Dr. Ruediger Krech, World Health Organization

In his presentation, Dr. Krech noted that universal coverage in health is possible and affordable for South Africa. He further noted that in the processes of planning and implementing initiatives linked to NHI South Africa must ensure that it uses the best available evidence. In this endeavour, innovative approaches must be emphasized as they have been shown to lead to positive outcomes in other contexts. The introduction of the NHI can serve as a model for social transformation. The World Health Organization (WHO) believes that there ought to be a comprehensive approach to address complex systems issues. No single instrument by itself can work and there is no magic bullet. Country contexts will be different and so solutions must be home-grown.

On the matter of the social determinants of health, Dr. Krech noted that within any given context the burden of disease arises in all the environments where we live. Therefore, it is important for countries, South Africa included, to implement a holistic approach to dealing with the population's burden of disease. Public health interventions must involve all stakeholders within the various spheres of government as well as social partners.

D: Global Perspective on Health Financing

Dr. Joseph Kutzin, World Health Organization

Dr. Kutzin stated that it is of paramount importance that any country's health financing mechanisms must provide access to needed health services for all people and in so doing must also limit exposure to financial burden especially for the most vulnerable groups in society. He noted that huge sums of money are spent on private health care in South Africa. Therefore, any additional savings, which we can realize from more judicious use of these

resources, must be used smartly to improve health outcomes. He reiterated the point raised earlier by Dr. Krech that in any health system reform programme there ought to be a comprehensive approach to address complex systems. Policy makers and decision makers must take full cognisance of the fact that there is no single instrument that can be used to address all health system challenges; there is no magic bullet. Country contexts have a strong bearing on what can best be implemented and so solutions must be home-grown.

Dr. Kutzin went on to further note that no country has succeeded in using private voluntary health insurance as a mechanism to achieving universal coverage in health. Compulsion or mandatory participation is essential as it allows for the effective pooling of health risks and enhances social solidarity. He emphasised that in the move towards implementing NHI, South Africa must note that fragmentation poses a risk to universal coverage. This is because there are barriers to the redistribution of prepaid funds, it reduces the insurance potential of available funds and small, fragmented pools limit cross subsidisation between the young and the old and the healthy and the sick and hence inequality is entrenched. For universal financial protection, South Africa must consider a large and diverse funding pool that integrates health risks and financial resources.

He concluded by making firm recommendations on the key action areas that South Africa must focus on as it progresses towards achieving universal health coverage through the implementation of the proposed NHI. He recommended that:

1. Mandatory insurance must be the path which South Africa adopts;
2. Risk pooling must be employed to avoid fragmentation;
3. The objective of the NHI reform must be to ensure that all the people are covered;
4. Better governance requires transparent and inclusive decision making, fairness and measurable goals;
5. There must be widespread stakeholder participation in the policy processes so as to improve global governance;
6. Reorientation of the health services must be implemented in order to reduce inequalities;
7. The policy reform programme for promoting universal health coverage must focus on reducing discrimination, entrenching fairness and ensuring value-for-money; AND
8. Single payer systems are preferred to multi-payer approach.

E: Comments by Dr. Olive Shisana, Chair of the Ministerial Advisory Committee on National Health Insurance

The comment raised by Dr. Krech regarding spending R200 billion and yet getting poor health outcomes in South Africa is a valid one. South Africa can alleviate this problem by setting up clear targets and implementing interventions linked directly to improving health outcomes. With regards to the social determinants as key to improving health of the population, my suggestion is that this has to be balanced against the importance of technology and use of scientific evidence in improving health outcomes. The advent of vaccines, ARVs, and medicine for chronic diseases among others has contributed to substantial reductions of mortality in many countries. So, we need to focus also on the improvement of health service delivery to allow for implementation of evidence-based interventions.

Dr. Kutzin's presentation provided us with a global and international perspective with lessons for South Africa. Key messages that have application for South Africa are outlined here (a) we cannot achieve universal coverage mainly through voluntary health insurance, suggesting that we consider compulsory enrolment or entitlement into NHI. The path of universal coverage via medical schemes is not likely to take us to our goal of making health care accessible to all. (b) On his comment on fragmentation being a threat to universal coverage, and that risk pooling must be an objective of health care reform in South Africa is excellent advice. In South Africa risk pooling, which comprises general revenue and contributions from the employers and employees, has occurred only for public funds. (c) On the question of reform and whether should it not be to remove the barriers in access to funds in the private sector (the 4.2% of the GDP of health spend in the private sector)? Well this is something we should discuss in South Africa, because health care financing in has only concentrated on the public sector sources. The big question to ask is 'can we end disparity in resourcing with positive consequences for equity of access? (d) Can we truly cross-subsidize without eliminating the barrier between the insured and uninsured? This needs to be debated.

Dr. Kutzin's presentation usefully reminds us that we can learn from Medicaid program in the US, which leads to two tier health care systems where doctors give second class services to Medicaid patients because the capitation fee is less than that paid by private health insurance. South Africans may want to debate whether contracted doctors should be allowed to provide care to both NHI patients and medical aid patients. The pros and cons of type of

service provision should be discussed to ensure NHI patients are not disadvantaged. Another approach may be to consider requiring different packages of care offered by NHI and medical aids. These are issues to be pondered.

Single payer system seems to be the most appropriate for South Africa because of the benefits that will accrue due to cost-containment, pooling of risk and growing the pie for redistribution. Examples of Moldova and Kyrgyzstan as stated by Dr. Kutzin are instructive for us. The key is setting a quasi-government organization that functions efficiently to purchase services on behalf of the population. Further, the examples of Kyrgyzstan and Moldova of introducing output-based payments are worth considering. Much remains to be done to develop a systematic approach to identify indicators of outputs. In South Africa, in order for us to improve the provision of health services, it might be necessary to ensure managers have management autonomy. The green paper still has to clearly articulate how management autonomy will be attained. The=is matter is linked to the issue of governance which was also raised as an important matter for consideration. This is one area where in South Africa we need to debate and articulate more clearly. Specifically, we have not done much to clarify how governance will be achieved in the NHI. We need to spell out a bit more on how we will prevent corruption that might occur in the health care system. We need to discuss more on how to structure the risk engine as a fraud prevention tool.

SESSION 2: FINANCING, SERVICE PROVISION, INSTITUTIONAL ARRANGEMENTS AND GOVERNANCE OPTIONS IN DEVELOPING COUNTRIES

Facilitator: Dr Humphrey Zokufa, Board of Health Care Funders

A: Lessons from South Korea

Mr. Ankit Kumar, OECD Health Division

Mr. Kumar's starting point was a cautionary note that South Korea's starting point was very different to South Africa today. While South Africa is classified as an upper middle-income country, South Korea was a poor agrarian economy with little medical workforce and health infrastructure. The health insurance system in South Korea was based on *chaebols* driving industrial development and health insurance was a labour benefit. The drive to expand insurance coverage was part of the State's efforts for the *industrial* development of a health sector which was publicly funded but mainly a private driven system. Over the years, South Korea has enjoyed remarkable economic and social development – GDP per capita is more than 6 times compared to before and the country has added about 6 years to its life expectancy since 2000. South Korea achieved universal coverage of 98.5% in 2004 and more in 2010. It previously had multiple funding pools based on the economic sectors but since 2000, it passed a law for the integration of all funding pools into a single insurer. This helped improve equity and resulted in the highest reduction in out-of-pocket spending as a share of current expenditure on health during the period 2000 – 09.

In the current South Korean health system, NHI underpins universal coverage, with compulsory wage-based contributions and Medical Aids Scheme for the poor; fee for service payment to almost all health care service providers remains dominant; and there is an overwhelmingly high level of private provision of health care service. The South Korean health system is also considered as one of the most competitive systems in the world and there is a growing hospital sector, with more people going to hospitals than clinics. Consequently, hospitals and technology are driving spending and so are chronic conditions – with hospitals dealing with rising chronic conditions which can be dealt with at clinic level.

The South Korean government has noted with concern some of the major challenges arising out of the dominance of fee-for-service as a reimbursement mechanism; the growth of the private hospital sector and the increase in the number of people with chronic diseases. As a result, new interventions are being implemented or considered to ensure better provider payment mechanisms – DRGs and prospective payments and different payment

mechanisms for primary care providers e.g. capitation; the implementation of a stronger gate-keeping function among doctors; the extension of the benefit package – coupled with greater regulation of new technologies and most importantly enactment of legislation and supporting policies to strengthen the public sector.

In terms of the lessons for South Africa, Mr. Kumar noted that a single insurer is a good starting point but active purchasing is needed as this has been shown to be a necessary ingredient for containing hospital prices and volumes is critical to promoting efficiency and effectiveness. South Africa must also ensure that it adequately invests in primary care to reduce avoidable admissions. A common fallacy of insurance institutions is that they are often more concerned with financial management with little or no focus on extending health promotion and prevention services – therefore, South Africa must try at best to establish need a *'policy-savvy'* insurer, one that adequately focuses on financial management but also ensures adequate health protection for the population. The insurer (or government) needs to be able to flexibly invest in the institutional development of primary care as well the management and treatment of HIV, AIDS & TB and non-communicable diseases (NCDs) through community-based chronic disease management programmes.

The policy reforms around the implementation of NHI in South Africa must also focus on entrenching hospital price controls early and also introducing mechanisms for channel volume expansion towards basic primary care for the under-served. This will help promote efficiency and impact positively on future sustainability of the envisaged system.

More importantly, the single-funder NHI will need to be nimble in purchasing across public and private sectors. This will require careful contracting with the private hospital sector, coupled with strong controls on technologies; the implementation of performance-based payments to encourage things that might otherwise not be done (incentives across different spheres of governance); strengthened accountability at the health district and facilities level and *putting the word 'force' back into workforce* – if South Africa wants people to work in rural areas it has to come up with a way of positively forcing them to do that or have really great financial incentives. Most successful modalities have been those with a level of compulsion. Alternatives are providing bursaries to people from disadvantaged areas on condition that they work in under-resourced areas once they graduate.

B: Lessons from Thailand

Dr. Viroj Tangcharoensathien, IHPP, Ministry of Public Health, Thailand

Dr. Tangcharoensathien gave a brief history of Thailand's health systems development, with links to historical milestones achieved over the 1970 – 2009 period. The population of Thailand is about 47 million and the main source of finance for the health system is through general taxation. The country spends an estimated US \$79 per capita (2011 figure). Under the Universal Coverage (UC) scheme, the benefit package contains a minimum negative list and entitles the population to a comprehensive package of outpatient, inpatient, prevention/promotion, an essential drug list, high cost care, ART, and zero co-payments. The UC scheme contracts with public and private provider networks of primary care [more than 95% were public, due to geographical monopoly] and primary care givers. Providers are reimbursed via capitation for outpatient services and DRGs under global budget for inpatient services. The UC scheme is managed by the National Health Security Office (NHSO) which was established as an independent public agency by law. The head of the agency is the Secretary-General who is appointed by Governing Board. The NHSO employs about 800 competent staff N800, and has no role on revenue collection. Additional technical expertise and support is mobilised from outside research institutions.

He noted that pre- the policy and political initiatives to expand universal coverage to health care in Thailand, the government implemented a number of reforms to improve health infrastructure and human resources. One of the key interventions in the area of human resources was the compulsion for community service for all categories of health professionals. As a result of these interventions the following positive results were recorded in short time:

1. Population per bed increased as a result of accelerated expansion of health infrastructure
2. Out of pocket (OOP) health expenditure as a % of income reduced 18% before 2008 and now lower
3. Patient utilisation improved as a result of capitation implementation
4. The patient admission rate increased mainly due to the roll-out of the DRG system
5. The incidence of catastrophic health expenditure declined significantly
6. Household health impoverishment declined after implementation of Universal Coverage (UC) Policy formulations

7. Over the same periods, spending in health increased at about the same rates as total economy, at a ratio of 3.5-4%.
8. A major achievement is the health share by household payment has reduced over time, while the public share consistently increased to almost 75% in 2007.
9. A decreasing trend in the rich-poor gap in health payment is largely due to a reducing OOP burden shouldered by the poor households.

Dr. Tangcharoensathien also stated that the low income scheme was introduced when the Gross National Income (GNI) per capita was 390 USD whereas community based health insurance scheme was introduced in 1983 when GNI was 760 USD. The occurrence of the Asian economic crisis in 1997 had an adverse impact on the ability of Thailand to progress rapidly towards universal coverage. However, universal coverage was eventually achieved despite the GNI per capita of less than 2000 US Dollar , when other countries that are richer cannot reach universal coverage.

He noted that in the drive towards achieving universal coverage in health, the Thai Ministry of Health implemented a lot of parallel local initiatives. These included:

1. The development of a unique citizen ID: the Ministry funded a project to count every birth and death completely since 1980s and the database was used as a basis for identifying beneficiaries;
2. The establishment of the Hospital Accreditation Institute in 1998, which was formally legislated in 2009
3. The development of DRG which was initiated in 1993, and implemented nation-wide in 2002
4. The implementation of innovative capitation which was applied by the Social Health Insurance scheme since 1990, and later adopted by the UC Scheme from 2002 onwards. This system was externally reviewed by the International Labour Organisation (ILO)
5. The enhancement of the country's Health Technology Assessment capacity—HITAP emerged in 2007
6. Specific disease registries established: e.g. ESRD, Thalassemia, Leukemia
7. The implementation of a strong monitoring and evaluation programme to support policy review and generate necessary evidence

Furthermore, Dr. Tangcharoensathien indicated that the UC was implemented when the Thai health system was ready. There was a dominant role played by the political leadership but direction was adequately guided by evidence and a huge role of health systems capacity, leadership, professional ethos supported by locally generated evidence for policy (re)formulation, fostering political / financial commitment and ensuring minimum catastrophic health spending and impoverishment for the population.

In his concluding remarks, he noted that reaching universal coverage in health requires real political and financial commitment. There must be resilient leadership. Furthermore, responsive health systems are the foundation for successful universal coverage implementation. There are three synergistic driving forces that South Africa must draw on as it implements the NHI – these are:

1. **Intelligence:** Evidence navigates direction and guides systems designs
2. **Engine:** Responsive politics and financial commitments translates universal coverage politics into tangible outcomes for the population
3. **Steering:** Citizens hold politics and governments accountable and responsive

It is important that there is a policy champion with sufficient political power to sustain the policy reform process. The involvement of the grassroots organisations will help to create a needed civic movement that could prove pivotal in the progress towards implementation of NHI in South Africa.

C: Lessons from Turkey

Professor Mehtap Tatar, Hacettepe University

Dr. Tatar noted that prior to 2003, the Turkish health system had characteristics very similar to those currently associated with South Africa's health system. The health system was highly fragmented with different schemes offering different benefit packages and coverage rules for different population groups and high levels of inequality, inaccessibility and poor quality problems for the majority of the Turkish population. The government decided to implement a wide set of policies and interventions as part of the **Health Transformation Programme**. These included initiatives to enable the purchaser-provider split, the introduction of the family practitioner scheme, expansion of health insurance and the

increased administrative and financial autonomy of public hospitals. These interventions were implemented through incremental steps to merge existing financing schemes, benefits were equalized at the highest level, health services access was gradually improved and most importantly the payment rules for providers were changed. According to the 2008 data, Turkey's health expenditure is split as total public at 74%, with 44% from Social Security Schemes; 20% from Government and other private at 10%. 26% is from purely private sources, mainly private health insurance.

Dr. Tatar noted that as a result of the Health Transformation Programme, the Turkish health system yielded a number of positive results. These include the following:

1. Increased outpatient visits per person per year to 7.7 visits in 2011 compared to 1.7 in 1994
2. Increasing share of private providers from 4,407 in 2003 to 47 618 in 2009
3. Increased user satisfaction rating to a high of 73.1 in 2010 compared to 39.5 in 2003
4. Increased health expenditures to 6.5 share of the GDP from 4.9 in 2000
5. Declining out of pocket expenditures from 32.1% in 2003 to 14.7% in 2009
6. Significant decline in the Infant Mortality Rate from 42.7 per 1000 live births in 1998 to 13.1 per 1000 in 2009

Despite these successes, the Turkish health system still faces additional challenges. The government has already started implementing mechanisms to holistically deal with challenges around cost containment, increased autonomy of public health institutions, hospital reorganization, the impact assessment of certain policies and the reorganization of the Ministry of Health.

D: Lessons from Ghana

Mr. Kwesi Eghan, Management Sciences for Health

Ghana has been through several policy changes on financing since independence 1957. These included the free health care era, cost recovery era that was commonly referred to as *cash and carry system* and more recently the Ghana National Health Insurance scheme. The current universal health care system in Ghana started prior to 1999 with 2 pilots on districts schemes but formally from 2003 with the passage of National Health Insurance Act of 2003. The guiding principles of the Act are solidarity and cross-subsidization. The main

sources of funding for the National Health Insurance Scheme (NHIS) are premiums and registration fees supplemented by a 2.5% mandatory contribution from formal sector worker pension's contributions and 2.5% Health Insurance levy that is added to address the funding Gaps. The benefit package covers 95% of commonly occurring diseases and health services are provided by predominantly public sector providers, private sector GPs, NGOs and faith-based organizations. The dominant reimbursement mechanism was fee-for-service in the initial stages of implementation but now the NHIS is proposing to implement capitation for GPs and DRGs for hospital level care. The major challenges that the NHIS faces in its operations is the lack of adequate IT capacity to handle increased volume, utilization and claims and a weak communication strategy to update stakeholders on new developments. Nonetheless, NHIS has rolled out a major programme to expand and enhance its IT capabilities through the implementation of four (04) regional offices to support improved claims processing and provider reimbursement.

RESPONDENTS TO LESSONS FOR SOUTH AFRICA FROM THE DEVELOPING COUNTRIES

Respondent 1: Dr. Mark Blecher, National Treasury

South Africa's population is faced with a high burden of disease requiring careful consideration against the backdrop of the NHI. The country has a third of all the doctors in middle income countries and has the largest share of GDP compared to the countries that presented this morning. In order to implement successful universal coverage (UC) in health, South Africa requires diverse revenue sources. The literature is very clear that for UC systems there is no clear winner between general tax funded or insurance payroll tax funded systems. Payroll taxes are important financing mechanisms in Korea, Turkey, and the Netherlands while general taxes play an important role internationally e.g. Brazil, Australia, UK and several of these countries. Ghana has used general taxes including VAT (2.5%) as well as a small payroll tax (2.5%). It is important to note that ser charges are not a major source of health financing in most countries but there are very high co-payments in Korea which are of concern.

With regards to pooling of funds, multiple examples are available in various contexts. Single payer (Beveridge model) and multi-payer (Bismarkian model) models are both very common internationally and both have pros and cons. In several countries the practical reality made it not possible to start from scratch with single-payer option and these countries show diverse

arrangements e.g. Korea – Bismarkian model; in Thailand the Civil servant scheme, social security scheme and UC (30 baht) scheme – UC has been achieved but still some variability across the three schemes; in Turkey: SSK scheme; Bang-kur (self-employed), Government employees retirement fund and Green card scheme for low income – Turkey has had fairly fragmented arrangements for many years but has recorded very recent progress on integrating schemes; while in Ghana they have the mutual health insurance schemes with implementation at District level.

Each of these countries implements a range of purchasing models. They each have a purchaser-provider split e.g. Korea: Competing multi-purchaser arrangement. Fee-for service associated with specialist and hospital orientated system made cost-containment difficult; Thailand: capitation for PHC; hospital global budgets based on case mix analysis; careful analysis of benefits e.g. debates around dialysis, vaccine for cancer of cervix; Ghana reimbursement of providers at district level; moving to case-based remuneration to contain costs.

In terms of health services provision various approaches are adopted in each country. In Korea there is a mix of public and private provision with substantial private provision and most doctors are specialists and hospital services are proving to be substantial cost drivers. In Ghana it is predominantly public sector, NGOs and faith based while in Thailand there is a lot of effort into rural infrastructure development e.g. clinics. Provision is predominantly public for UC scheme, more mixed for other two schemes. Thailand has adequate and appropriately manned rural health facilities and extensive production of appropriate cadres and motivated health personnel with mandatory public works. In Turkey they also use a mix of public and private establishments for service provision to the population.

In conclusion, South Africa can learn a lot from other country experiences. However each country is context specific and has a particular history and set of problems to solve. Each of the countries provide inspiring positive lessons and also show areas of challenges from which we hope to learn more.

Respondent 2: Professor Di McIntyre, Health Economics Unit, University of Cape Town

The key question that South Africa needs to ask is how do we actually fund universal coverage for those that are outside of the formal sector – there is limited emphasis on the informal sector in the green paper and the four countries that presented this morning took the route of some kind of mechanisms for the informal sector – mostly on a contributory basis. Some interesting points emerged in that even if one is trying to get the informal sector to contribute, essentially there will have to substantial tax-funded system for the poor. Further what we are starting to see is that after time, most countries are moving away from the contributory scheme for the informal sector – it is incredibly expensive and you have to go door to door to raise funds. For instance, in Ghana, they went for VAT to augment or address the funding gaps. Therefore, if South Africa wants to raise funding from informal sector, it is better to use indirect funding mechanisms (e.g. VAT, which is progressive in Ghana and has a range of exemptions, compared to South Africa and it is less ideal).

Regarding the debate about the single or multiple purchaser system, most of the countries presented this morning have single player. Some of these countries had initially started with the multiple payer system but have since moved to a single payer system. For example, South Korea started with multiple players and found that this is unsustainable and Ghana went straight for a single fund model. It is important for South Africa to look at implementing a single payer NHI fund taking into account the strong economies of scale that this is likely to yield for the country.

Finally, on the matter of co-payments it is important to note that Korea has very high co-payments and some of the most detailed research on the impact of co-payments comes from that country. The results from that country are unequivocal in that OOP has generally had no impact for the richer groups but meaningful impact for the low income groups. Thailand has gone for no co-payments and provided good examples of getting good gate-keeping and ensure that people go to the right level for the required healthcare.

SESSION 3: FINANCING, SERVICE PROVISION, INSTITUTIONAL ARRANGEMENTS AND GOVERNANCE OPTIONS IN DEVELOPED COUNTRIES

Facilitator: Professor Steve Reid, University of Cape Town

A: Lessons from Germany

Dr. Matthias Rompel, GIZ Head of Section Social Protection

Dr. Rompel noted that it took Germany 100 years to reach universal coverage. As had been echoed by earlier speakers, there is no blue print for realising universal coverage across all contexts and advice must be tailored to country needs and conditions. The German Health Financing system occupies a middle ground between public and private mechanisms. Adequate and almost equal access to benefits can be achieved within a pluralistic environment, and successful cost containment is achievable within a universal coverage system.

The guiding principles of the German health system are:

1. Social Cohesion
2. Free choice of providers: Patients have freedom to choose providers and social insurance carriers. Germany has more than 100 – multiple payer system. Unified compensation system for the providers, negotiated price schedules and provider competition based on need
3. Solidarity, Fair financing and equity: Ethical platform: same benefit package, Payment according to needs and wealthy pay for the poor, healthy for the sick
4. Subsidiarity: Solve problems at the lowest possible level – higher levels only intervene in terms of failure or inability

Since 2009 Germany has reached formally universal coverage of population. It has defined compulsory members of social health insurance. Individuals can choose to be a member of the publicly administered Social health Insurance (SHI) or Private health Insurance, not both. 87.7% of population are under a public insurance fund, and the rest are private with only 0.2% of population with no insurance. SHI carriers have to accept everyone. There is a division of purchaser and provider functions or roles and no cash payment for patients. Physicians become members of associations for physicians and get provider payments from the associations.

The lessons and conclusions that are relevant for the South African context are:

1. **Systems matter:** coherence in the broader picture is necessary. Clear objectives directed at promoting efficiency, access and equity. Context needs to be considered. Consider other building blocks of the health system. Mechanisms for good quality services should be in place to earn faith and trust in the system by the users
2. **Vision matters:** what system the country wants to have in the future
3. Political economy matters
4. **Regulation matters:** Human rights and patient safety must be the core of legislation
5. **Value for Money:** More health for the money – improve efficiency which is more important than generating resources
6. **Effective mechanisms matter:** Contracting, provider payments (e.g. DRG) and strategic purchasing for efficient service delivery.

B: Lessons from Australia

Professor Gavin Mooney, Sydney School of Public Health

In the Australian health system 70.7% is funded by government at the federal level, 7.5% through private sources and 16.8% is through out of pocket. In terms of public financing, primarily 82% is from general taxation, 18% from the Medicare levy and contributions based on income. The private sector co-exists with public sector. Private health insurance does not discriminate and there is the possibility of lifetime health coverage if taken early and premiums are low. The Australian **Medicare** was introduced in 1975 as a result of major social reform intended to achieve a simple fair and affordable. It is now part of the social fabric of Australia and accepted by all major political parties. As a single funder **Medicare** faces some challenges due to the lack of priority setting and hence inefficiency, the lack of concern with equity and hence inequities exist, especially geographically and high costs and blame shifting.

Within the **Medicare** set-up, Primary Health Care is dominated by GPs who are reimbursed on a fee for service basis. Thus Australian PHC is not into health, population health, prevention, equity, multi-disciplinary care but only into service and payments. Patient payments are unaffordable and this has been shown to undermine **Medicare** objectives of universal coverage.

In terms of relevant lessons for South Africa, policy makers and implementers must keep a watch on demand led services, keep patient payments to a bare minimum, and note that multiple payers lead to multiple problems. The South African system must be based on the principles of universality, equity, efficiency, and cost containment. The NHI must be part of the South African social fabric.

C: Lessons from France

*Dr. Michele Brami,
French Technical Agency for Information on Hospitalization (ATIH)*

The general scheme in France was founded in 1945 after World War II to realise the need for the right to health care institutions for all. There is the co-existence of both public and private health care systems – ambulatory and in hospitalizations include NPOs. Job insurance was created in 1958 as part of social protection with the health insurance and the achievement of universal coverage has thus been progressive. Currently health system funding is split as 75.5% from NHI, 13.8% from complementary private health insurance and 9.4% from out of pocket. The French Health system today costs about 10.9% of GDP and the annual growth of health expenditure lower than most OECD countries. French health insurance has two parts: basic service coverage and optional supplementary cover provided by NPOs or private insurers. In terms of governance arrangements, the State is responsible for hospital care and medical products while social partners share in the management of NHI through their board of directors.

The main sources of funding for the French system are social security revenue, employers and employees contributions as well as “Sin tax” from tobacco and alcohol.

The French system has been encountering some challenges recently, paramount of which is the issue of efficiency and costs containment. There is also the rise of Non Communicable Diseases and chronic illnesses. The key lessons for South Africa are that the funding sources for the NHI must be robust enough to ensure medium to long-term sustainability of the system and that adequate systems must be implemented to promote rational use of covered health services, especially specialists and hospital services.

D: Lessons from the United States of America (US)

*Professor Tim Westmoreland,
O'Neill Institute on Health Law, Georgetown University Law Centre*

The United States of America has a highly fragmented healthcare system. The population has a life expectancy of 85 years. The country has the most expensive health system in the world, spending about R20 trillion in 2010 approximately R50 000 per capita. This translates to about 20% of GDP. Within the American system, healthcare is pro-rich and unfriendly to the poor. Americans over 65 years are covered by Medicare. Health care for the elderly is relatively very good. Employers, private insurance and Medicaid caters for the under 65 years. However, private health insurance is very expensive for both employers and employees. Individual insurance refuses insurance to the sick or the likely to be sick. 20% of Americans covered are under Medicaid which is subsidized by federal and state government. Each of the 50 states have their own schemes which stipulates categories such as poor and pregnant, poor and mentally ill. Accessibility to doctors is challenging and limited under Medicaid and a significant number of Americans, about 50 million, are without any insurance at all and are mostly catered by charities. The Affordable Health Care Act was introduced in 2010 envisioned to cater for 28 million more people and drop unemployment to less than 8% once fully implemented.

RESPONDENTS TO LESSONS FOR SOUTH AFRICA FROM THE DEVELOPED COUNTRIES

Respondent 1: Dr. Christoph Schwierz, European Commission

Most countries advocate for a single payer system as a progressive tool towards social cohesion, universal coverage and solidarity. However, it is important to realise that universal coverage is difficult to achieve and it took countries decades and centuries. Critical message is that it is as much about resource injection as it is about efficiencies. The State must ensure that access to healthcare expands beyond reforming the health system and use it to unite the fragmented SA community. To achieve this, the NHI plan must have clear objectives and targets and there must be a uniform and comprehensive benefit package for all.

Respondent 2: Professor Di McIntyre, Health Economics Unit, University of Cape Town

There are three (03) Types of healthcare financing that can be considered within the South African context: mandatory prepayments, voluntary prepayments (private insurance) and out-of-pocket payments. The South African health system compares to the USA system which is not pro-poor with very high voluntary prepayments and significant levels of fragmentation across risk pools. Therefore, South Africa needs to introduce some form of mandatory prepayments to ensure affordable health for all. NHI should be a tool to realize the human right of access to health for all and should be guided by the provisions of Section 27 of Constitution of South Africa. In terms of governance systems, there is a need for strong leadership, clear management structures with roles and responsibilities between the fund and the Department with mechanisms for adequate purchasing put into place.

DAY TWO: THURSDAY 8TH DECEMBER 2011

SESSION 4: GOVERNANCE ARRANGEMENTS

Facilitator: Dr. Jane Doherty, University of the Witwatersrand

Governance for Universal Health Coverage

Professor Lucy Gilson, University of Cape Town

The Conference has raised the important question of what are the necessary governance arrangements to support the effective implementation of a reform such as NHI. These questions must be looked at in terms of the fundamental *choice between a single payer as opposed to multiple payer* model and the use of integrated or separate insurance carriers and modalities for health care provision requires discussion and resolution, including the centralized or decentralized management of the NHI fund. As answers are sought to these questions, it is important to note that there is a combination of factors that influence organizational behaviour. For the NHI – it includes active mentoring and feedback, regulation, oversight and a robust structure for oversight. The Ministry of Health and the NHI fund will need to clarify roles and responsibilities. A suggestion is that for the Ministry or the Department of Health focus should be on matters pertaining to stewardship, systems management, and quality assurance while for the NHI focus must be on the collection of funds, pooling of funds, a well-described benefits package, and stakeholder liaison.

A framework to describe the relationship between the state, citizens and providers is important. Findings from a World Bank study have suggested that for successful implementation there must be the following:

1. A coherent decision making process
2. Stakeholder participation
3. Transparency to share information
4. Supervision – hold insurers accountable
5. Consumer protection

Governance is likely to be influenced by a variety of factors such as budget constraints, a lack of benchmarking information and political will.

SESSION 5: HEALTH EQUITY, SOCIAL SOLIDARITY AND FINANCIAL RISK PROTECTION

Facilitator: Dr. Jane Doherty, University of the Witwatersrand

Health equity, social solidarity and financial risk protection

Professor Gavin Mooney, University of Sydney

The implementation of health reforms to promote universal coverage is about narrowing the gap between rich and poor in health care access. In so doing, there is the need for continuous local commitment and will. South Africa must not wait for global assistance before deciding to move towards universal coverage in health. NHI can deliver social justice, equity and efficiency and social solidarity. NHI is not just about health but about building a good South Africa, a country that everyone will be proud of. The voice of the public is often missing and undermined when it comes to such massive social policies. Efforts must be ensured that people who will be the direct beneficiaries of such a system are involved at all levels throughout the implementation process. South Africa must note that it is in the interest of the rich to pay for their healthcare and not to pay high taxes for health care for all – therefore the rich will try by all means to resist any policy measures to make them pay higher taxes to the benefit of the non-rich. The current health system is unconstitutional. It is inefficient, not accessible, and unequal and undermines human dignity. The NHI Policy should be more than about health delivery – it should be about building a social institution for a united country post 1994. South Africa must use it to heal the fragmented nation and to be ready for global warming. South Africa can afford an NHI. It is a question of will rather than money. NHIs in the UK are not flawless but successful and always needing to be improved. The same will hold true for South Africa's NHI once implemented.

SESSION 6: EXPERIENCES FROM REGIONS: FINANCING, SERVICE PROVISION, INSTITUTIONAL ARRANGEMENTS AND GOVERNANCE

Facilitator: Dr. Jane Doherty, Independent Researcher

A: Lessons from EU Countries

Dr. Christoph Schwierz, European Union Commission

The EU comprises 27 member states, with a combined population of about 500 million people with a quarter of global GDP, and therefore, 27 health care systems. Different countries took different periods to achieve universal coverage. Some countries had achieved almost 100% by 2009. Within the EU system, 15% of expenditure is on health, 7.8% of GDP on health 10.8% total spending on health 2008/9 with 2.2% spending on prevention, and 3.1% spent on administration.

The common health system challenges within the EU are:

1. Sustainability of health care expenditure
2. Cost-sharing against catastrophic spending
3. Overspending and little Value For Money
4. Rising health expenditure
5. Cost effectiveness is an issue – benefits of some treatments is questionable and this important for benefit packages
6. Health technology assessments are under-utilized
7. Costs differ widely for same benefits in pharmaceutical consumption
8. Cost differ widely for same hospital services within and across countries
9. Reforms are often partial and never ending: No long term impact of any reform

South Africa could learn some valuable lessons from the EU in terms of health systems reform to realise universal health coverage. For instance, the health care frameworks could be used to define responsibilities, targets, modes of provision of care, financing and benefit packages, how to ensure affordable care, the implementation of workable public governance arrangements, to set public health priorities, pooling of funds and ensuring value for money for all resources allocated to the health sector.

B: Lessons from Low Income Countries

Dr. Patrick Osewe, World Bank

There are some key matters to resolve as a country when looking at health systems reform and related governance matters. These include whether to implement a single payer or multiple payer system; whether to have integrated or separate insurance and health care provision; centralized or decentralized payer; political involvement or complete autonomy; and importantly how to involve stakeholders. Governance is the combination of factors that influence the behaviour of an organisation. In health insurance systems governance requires active monitoring with good feedback, strong regulation and oversight structures. There is also the need for clear separation of roles and responsibilities between stewardship and insurance functions. To achieve good governance, countries require the following:

1. Coherent decision making structures
2. Stakeholder participation
3. Transparency and information
4. Supervision and regulation
5. Consistency and stability

There is no perfect governance model that South Africa can adopt. Effectiveness of governance systems vary according to context and the existence of supporting factors. Political is very important and strong oversight mechanisms and the involvement of stakeholders plays a very important role in strengthening governance systems.

C: Lessons from Middle Income Countries

Dr. Jack Langenbrunner, World Bank

Another important matter related to governance is the matter between funds or revenues. The question is whether premium contributions or general revenue taxes must be used for the NHI fund. There should be a positive correlation between life expectancy and expenditure. South Africa is doing badly on the major health indicators. Spending is based on allocations from the fiscus and the use of a priority setting process. South Africa's expenditure on health is high relative to BRICS and yet it is a poor performer. South Africa has fiscal capacity but share of public priorities is very low. The country must avoid tax on

the private sector labour. There is a high level of informality (37%) in South Africa and additional taxation could adversely influence this sector. A better idea – is to increase general revenues, earmarked taxes e.g. Sin tax such as tobacco may be used since South African levels are still low compared to other countries.

In terms of the success factors that South Africa can use as part of good practice in health coverage reforms, these are three fold. Firstly, institutional and societal factors which include strong and sustained economic growth, long term political stability and sustained political commitment, a strong policy environment and high levels of population awareness. Secondly, there must be key policy factors such as commitment to equity and solidarity, consolidation of risk pools and a strong focus on primary health care. Thirdly, the implementation factors must allow for flexibility and mid-course corrections, coverage changes accompanied by carefully sequenced health service delivery and provider payment reforms, good and reliable information systems and evidence-based decision making and strong stakeholder support.

SESSION 7: INNOVATIVE HEALTH FINANCING

Facilitator: Dr. Mark Claassen, Ministerial Advisory Committee

A: International Experiences

Dr. Robert Fryatt, United Kingdom Department for International Development

Changing the way health services are funded is central to the changes envisaged in the National Health Insurance: “Universal coverage to affordable health care services is best achieved through a prepayment health financing mechanism”. The possible sources of funds are also under discussion, with a clear commitment to avoid co-payments with some possible exceptions (such as services that are not in a nationally agreed service package or those that fall outside the agreed scope of NHI). Whilst more funds would help reach the objectives in the NHI Green Paper, there are also opportunities for more efficient use of public and private health financing to achieve national health goals. The 2010 World Health Report stated that “*There are two main ways to increase domestic funding for health: one is to allocate more of the existing financial resources to health...; the other is to find new methods to raise funds or to diversify the sources*”.

A variety of alternative considerations are available to the South African government, these include (1) a Special levy on large and profitable companies; (2) a levy on currency transactions; (3) a tax on bonds sold to nationals living abroad; (4) a financial transactions tax; (5) mobile phone voluntary solidarity contribution; (6) Sin taxes on alcohol and tobacco; (7) Excise taxes on unhealthy foods e.g. salt, sugar and other ingredients; (8) the sale of franchised products e.g. the Global Funds Product RED project; and (9) a Tourism tax. Once the extra funds are raised through these mechanisms, there still remains a debate as to whether they should be 'ring-fenced' (or hypothecated) to improve health. This reasoning suggests that if South Africa is already increasing funds to health through general revenue than the arguments for hypothecation are not strong. However, South Africa has major competing, short term priorities such as ART/TB treatment and tackling maternal and child deaths, so there may be an argument for hypothecating tax for under-resourced areas of long term importance such as health promotion. This has happened in the use of tobacco tax in many parts of Asia.

B: Civil Society Perspective on NHI and Innovative Financing

Mr. Elroy Paulus, Black Sash

The South African population has huge burden of disease coupled with high levels of unemployment and poverty. The most vulnerable groups of the population have the least access to needed social services such as education, access to clean water and sanitation and health services. The country has the highest Gini coefficient with a low life expectancy among countries with its level of economic development and health spending. Through a systematic consultation process, Black Sash in collaboration with Health-e news and the Health Economics Unit at the University of Cape Town elicited public views about the values that should underpin the South African health system and the priorities that government must focus on. The elicited views were consistent with the provisions of Section 27 of the Constitution. Further, the priorities that were raised included the need to address infrastructure backlogs, addressing human resources shortages, increasing access to ambulances, improving access to medicines, accelerating partnerships with health facilities and improving monitoring and evaluation of health care delivery and provision.

On the funding options for NHI, majority of the participants supported the introduction of a tax funded system on condition that it would be used to substantially improve the health system and the quality of health services which must be accessible to everyone. South Africa's social context must also be accounted for in the health reform initiatives, particularly the high unemployment rate and the large number of people dependent on social grants. As a result of these factors, many people recommended that it would be unfair to expect everyone to contribute towards funding NHI, let alone contribute the same amount. Instead, everyone who earns an income must contribute a nationally prescribed proportion of their income to NHI. NHI must be funded either through PAYE or employer payroll tax or a combination of both. However, people also felt that VAT must not be increased to fund NHI as it would unfairly affect the poor. Exemptions for contributions should be considered for the poor, those who fall below the tax bracket, children, recipients of social grants, the elderly, and people who are unemployed.

Mr. Mark Heywood, Section 27

Society supports the introduction of the NHI in SA and the contents of the Green Paper. Civil Society will engage the Minister of Health on aspects of the NHI policy to ensure that the Constitution becomes the premise from which the NHI is implemented in South Africa.

There needs to be measures to improve health outcomes and reduce costs to health. If Brazil spends almost same on health as Brazil, we need to understand why the SA health outcomes are poor than similar countries. Life expectancy remains very low and comparable countries like Brazil have achieved significantly despite relatively same levels of expenditure and economic development. If we have been increasing our spending on health why has the quality of health then been deteriorating instead of improving with the budget? Do we then seek more accountability or innovation in financing to address existing problems in health? Current health spending is violating section 215 of the constitution as it is neither transparent nor efficiently spent.

There is also a range of Acts that dictate accountable financing like the Public Finance Management Act, Municipal Finances Management Act, and the National Health Act. Thus before looking at reforming we need to properly implement existing Acts. Corruption consumes around 10% of all health expenditure and this must be eliminated as a matter of

urgency. Within the private sector corruption also amounts to around R5 – R15 billion. There is a duty on the State to stamp out corruption to proceed forward successfully by utilising the resources to better the lives of all South Africans.

Another important factor is to regulate pricing as a matter of urgency. The Department must investigate and regulate private sector prices and improve efficiency. This must be done in consultation with other stakeholders in government. There can be a number of domestic innovative financing mechanisms like sin tax on soft drinks, alcohol and cigarettes. However, increases in Valued Added Tax (VAT) must be avoided as this will simply further marginalize the poor. South Africa must avoid dependence on overseas development assistance (ODA). Instead attempts must be made to find the funds at home through innovative tools such as introducing a Financial Transactions Tax, Medicines Patent Pool, and establishing a Health Impact Fund. Further, the Department needs to look at strategies to contain cost – interrogate cost drivers for health e.g. health workers. More resources must be directed at strengthening health systems research and to involve the users of health services in processes and activities around planning, implementation, and accountability and performance improvement. Government must carefully consider the pros and cons of alternative financing mechanisms before choosing the most appropriate and least likely to burden the vulnerable groups.

SESSION 8: LESSONS FOR SOUTH AFRICA

Facilitator: Professor Lesley London, University of Cape Town

A: Ethics

Professor Ames Dhai, University of the Witwatersrand

Health is not just a human right but also an ethical right. Health is desired for its own good as it has intrinsic value and at the same time it also allows people to attain social and other goals. The current South African health system is unfair and thus unjust. Health financing is not universal and it marginalizes the poor and the disadvantaged. The World Health Organisation (WHO) framework indicates that a *fair* health is one that provides individuals with protection from financial ruin as result of health needs and one where payment for health services is progressive and not regressive. Fairness requires the pooling of risks, whereby the healthy subsidise the sick and the young subsidise the old.

In the case of lessons for South Africa, the population and the country at large must make informed trade-offs in order to design a fair system. People and society must be willing to give up some things. Efforts must be directed at a transparent system of identifying the values of the health system and this must be used to determine what people are willing to forgo. It is heartening to note the health system values that the proposed NHI is premised on. Nonetheless the most important matter is the realisation of these values as reality for all South Africans as NHI is implemented. Government must take progressive and proactive steps to deal with barriers to access such as transport costs, lost in income due to long waiting times and queues, and systemic inefficiencies that lead to avoidable wastage

B: Rights and the Law

Dr. Adila Hassim, Section 27

There is a moral imperative and ethical obligation for the South African health system to be changed for the better. There are also duties for the State and civil society that should be undertaken in a manner that ensures that the health and wellbeing of the South African citizen are adequately catered for. An important question that we must ask as we move forward on the path towards universal health coverage is *What does the legal environment demands us to do and the constitution?* The proposals outlined in The Green Paper have

many legal implications. Independent research clearly shows that South Africa has one of the highest inequities measured by the *Gini* coefficient. South Africa records about 800 new HIV infections a day and the burden of disease is very high. Therefore, NHI has a huge task of helping not only to address the health needs of the national population but also to contribute towards reversing the high inequities that are associated with the health system.

To ensure that the NHI is adequately implemented, the Constitution must be used as the yardstick for the various contents of the legislative framework that is put into place to enable the phased implementation of NHI. The principles that guide policy development in South Africa according to the Constitution include that no matter how well the policy is developed it is not lawful if it does not cater for the people in most desperate need; any policy that is pro-poor must prioritize the poor in the manner in which it is enacted; rural areas are priority; and if a policy is to be reasonable it must account for short term needs and must be implementable – this implies mechanisms must be in place for budgeting, functions and oversight that includes adequate representation.

Within the South African context, the aspect of the fiscal federal structure needs to be addressed. This is a complex issue and is directly linked to the matter of provincial autonomy and concurrent functions that must be met by both national and provincial administrations. Paragraph 52 defines what is meant by provincial autonomy while complying to national laws and policies. The Constitution makes it clear that the State has the responsibility to take reasonable measures directed at regulating prices and of the private sector. Section 8 of the Constitution applies to private parties and does not in any way leave the private sector immune to obeying and observing the laws of the country.

C: Service Provision

Dr. Jane Doherty, Independent Researcher

The process of moving towards universal coverage within the South African health system must be values driven. The design of the system should be informed by values and social objectives. The benefit package of health services should be comprehensive and there must be a strong emphasis on PHC services. It must be supported by explicit mechanisms for prioritization (and reprioritisation), the Essential Drugs List (EDL), clinical guidelines, technology assessments, gate-keeping, and strong referral systems. As per the provisions of

the Constitution, there is the need to manage the progressive realization of this package with full involvement of stakeholders. With respect to what providers to use in the process of service deliver and providers, the public sector must be the foundation of the NHI strengthened by infrastructure improvements, increased human resources (especially rural recruitment and retention), enhanced provider autonomy, partnerships with the private sector and improved access, quality and efficiency. The private sector plays a crucial complementary role through contracting with providers like GPs and pharmacies.

To ensure that NHI yields the positive intended outcomes, there is the need to implement a single payer system that is supported by comprehensive planning, risk pooling to deal with fragmentation, implementation of proactive price regulation, active purchasing and the provision of equivalent services. This requires the transformation of the public health system and the incentivisation of health and not services through innovative reimbursement mechanisms such as capitation for PHC services, case-based global budgets for hospitals and even clinical budgeting. Fee-for-service should not be the main provider reimbursement tool within a universal health coverage system. Finally, a strong monitoring and evaluation system must be in place so that data is collected to ensure that the reform remains pro-poor.

D: Financing Options

Mr. Andrew Donaldson, National Treasury (South Africa)

Building an NHI is a long term project and requires the strategic sequencing of reforms towards the progressive building of social cohesion. Various revenue combinations and insurance arrangements are possible, with complementary existence of public and private systems even in mature systems. There is also increasing complexity of NHI systems across the world, with stronger focus on financial management arrangements more important than financial modes – e.g. systems to fight corruption. There has been a strong growth in public health spending in most countries over the past three decades. However, three key factors threaten this trend going forward i.e. global growth slowdown, debt reduction and fiscal difficulties in some countries, and competing policy priorities.

Health care reform remains a major fiscal challenge everywhere. In emerging markets such as South Africa, the challenge is to expand coverage and enhance efficiency while at the same time avoiding the high costs of more advanced health systems. The long term

dynamics are also important to manage especially in terms of technology and related research and development, institutional arrangements, provider reimbursement mechanisms.

South Africa must realise that the implementation of NHI requires a cooperative approach. There must be collective agreements on provider payment changes and the tariffs level. This must also include competitive contracting through proactive purchasing arrangements, increased professional training and stronger medical scheme regulation and insurance package design.

SESSION 9: OPTIONS FOR SOUTH AFRICA

Facilitator: Professor Ames Dhai, University of the Witwatersrand

A: Governance and Institutional Arrangements

Professor Lucy Gilson, University of Cape Town

Health system reforms to achieve universal coverage should be based on the principles that health is a public good and that social justice, equity and fairness should be basis of the reforms. The State must exercise its Constitutional obligation to govern in the public's interest. To realise these obligations, it is important that the State implements appropriate and transparent governance arrangements that support the implementation of accountable and transparent systems to allow for community involvement and participation in the policy process.

The aspects that must be considered in establishing these approaches involve both “**software**” and “**hardware**” of the health system. It was pointed out that within the South African context, the considerations would include addressing organisational culture at all levels of the health system, the relationships across the three spheres of government, creating mechanisms that enhance active citizenship and clarifying the accountability and legal framework for entities such as the NHI Fund. For South Africa to achieve the desired objectives of NHI, the governance arrangements must be proactively implemented. This should include appropriate delegation of authority to allow managers the space to manage, developing partnerships to support the change process and using a phased approach to learn lessons and apply them as the implementation process is scaled-up. It is important to

build a strong monitoring and evaluation component which can be used to generate necessary knowledge and build national analytic capacity.

B: Financing

Professor Di McIntyre, Health Economics Unit, University of Cape Town

There are three alternative sources from which finances to fund universal coverage in health can be mobilised. These are voluntary prepayments, mandatory prepayment and or out-of-pocket payments. South Africa has relatively high levels of voluntary prepayment and out-of-pocket payments. To achieve universal coverage, the health system must reduce reliance on voluntary prepayment and out-of-pocket payments and shift emphasis towards mandatory prepayment. This will help the country achieve universal coverage with adequate financial risk protection and access to quality health services.

The options for health financing reforms in South Africa should include gradually increasing the service delivery capacity of the public sector in terms of human resources, quality of care and re-engineering of the PHC approach. This must be coupled with the urgent roll-out of the pilot districts, securing increased general tax funding, building support for new innovative taxes and continuously demonstrating the good use of resources through developing purchasing and service delivery capacity over the phased implementation period.

C: Service Provision

Professor Charles Hongoro, Ministerial Advisory Committee on NHI

The package of health services that South Africa offers to the population under NHI must be comprehensive. It must cover the spectrum of primary, secondary and tertiary services including emergency services. It is necessary that the referral system across different levels of care and between the public and private sectors is adequately strengthened to ensure that continuity of care is realised. Other capacity aspects that must be addressed are health infrastructure, strategic purchasing for engaging private sector resources especially in underserved areas and improved management capacity at the national, provincial, health districts and facilities level.

CONFERENCE CONCLUSION

Closing Comments by Ms. Malebona P. Matsoso, Director-General: Health

The proceedings and discussions of the Conference were enlightening and thought provoking. The speakers shared experiences and lessons that many countries, both developed and developing, have undergone in their efforts to achieve universal health coverage for their populations. The lessons shared were eye-opening and will surely enrich the Department of Health's processes with respect to the implementation of National Health Insurance as proposed in the Green Paper that was published on 12th August 2011. The public consultation period on the Green Paper closes on 30th December 2011. So far we have received a number of comments from a variety of stakeholders indicating how the proposals contained in the Green Paper can be improved upon in order to ensure that the objective of universal coverage is realised. We still expect a number of stakeholders to provide us with written inputs before the closing of the comment period.

As we draft the White Paper, we will have to focus on the key themes that have emerged during the past two days.

The first theme is that of **financing** which relates to how we can mobilise financial resources to support initiatives and programmes directed at achieving universal health coverage through NHI. We have learnt that in terms of the financial resources that we as country spend on health, we are an outlier relative to what we achieve as health outcomes. As things currently stand, our health outcomes are not comparable to peer countries which in some instances spend less on health but achieve significantly better outcomes. The presentation from the World Bank speaker highlighted our country's fiscal capacity to address some of the problems associated with spending on health and that there are countries that we can label as good practice countries that we can learn from. Other speakers have shared with us some innovative ideas on how the health sector can mobilise additional finances to support the implementation of policies to achieve universal coverage in health. We intend to take some of these ideas forward by establishing a formal working group between the Department of Health and the Treasury to work on this area. We will keep in mind that as we propose mechanisms for mobilising additional resources for the health sector, we do not impose additional burdens on the poor in the process.

The second theme that has emerged is that we must focus on the pillars of **service delivery and provision**. In this respect we have learnt that it is important to ensure that the public health sector forms the foundation for the provision and delivery of health services in a universal health system. Where necessary and appropriate, it is important to draw on the private sector. Moreover, the health service delivery structure must focus strongly on primary health care as a means to effectively dealing with population health needs. Focusing on preventive and health promotion services has been shown to help with effectively dealing with costs in some contexts. This is important for the South African context as we have already embarked on the re-engineering of the primary health care model which I am certain will yield benefits for the population that are much broader than just cost containment.

However, it has also been pointed out that we must provide better clarity with respect to hospital services and how these will be rendered within the NHI as we move towards the White Paper. The question that we must answer in this respect includes the definition of the package of service and whether this should be accompanied by a negative list of some sort. A further question that we must address as we move forward is the costs associated with providing a comprehensive package of care taking into account the role of the private sector in these processes. As we discuss this and consider alternative options we keep in mind the need to create systems that promote active purchasing and the efficiencies that we can yield from changing provider payment mechanisms.

The third theme is the matter of developing an appropriate **legislative framework** that will enable us to implement the National Health Insurance. This process will be informed by the White Paper and will be accompanied by a transparent consultation process. Our legislative reform will be informed by our Constitution. We do recognise that there are multiple legal frameworks that will have to be reviewed as we proceed.

The fourth, and final theme, that has emerged is the importance of a **clear governance framework** which is closely linked to the issue of the legislative framework. It is important that we move further towards the path to achieve universal coverage we do not lose focus on aspects related to entrenching accountability, transparency, inclusivity and community participation at all levels of the policy process. This is clearly something that must be explicitly linked to operationalising a workable social compact between government, citizens and providers of health services.

To strengthen the stakeholder engagement processes around the proposals for National Health Insurance in South Africa, we will be establishing a National Health Insurance Stakeholders Forum that will meet on a quarterly basis. It will comprise various stakeholders including broader civil society members as well as community members, private sector, professional bodies, organised labour, medical insurance and medical schemes etc. Part of the main functions of this Forum will be to create a mechanism for ongoing engagements and information sharing among stakeholders with respect to the National Health Insurance as well as to allow the Department to elicit inputs on key aspects related to National Health Insurance as implementation progresses.

In order to ensure that we indeed do include the community voices in the finalisation and implementation of National Health Insurance in South Africa, we will be undertaking community dialogues and road-shows which will start in January 2012. This creates an opportunity for us to get the inputs of the people that the National Health Insurance is intended to benefit. Lessons can be learnt from the recently concluded process of the National Strategic Plan for HIV, AIDS and TB.

Annexure A: CONFERENCE AGENDA

Day 1	Event	Speaker/Presenter	Chair
08:30- 9:00	Registration		
09: 00-09:10	Opening and Welcome <ul style="list-style-type: none"> ▪ Welcome remarks ▪ Purpose of the meeting 	Ms M.P. Matsoso	Director-General: Health
09:10- 09:40	Keynote address by the Minister of Health	Dr. A. Motsoaledi, MP	
09.40 – 09.45	DVD address by the Director-General of the World Health Organisation, Dr. Margaret Chan		
	Overview and Global Perspectives		
09:45- 10:15	Overview on Universal Coverage and Social Determinants of Health	Dr. Ruediger Krech	
10:15-10:40	Global Perspectives on Health Financing for Universal Coverage	Dr. Joseph Kutzin	
10:40-10:50	Comments by the Chair of the Ministerial Advisory Committee on NHI	Professor Olive Shisana	
10:50-11:05	Tea Break		
	Financing, Service Provision, Institutional Arrangements and Governance Options in Developing Countries		Dr. Humphrey Zokufa
11:05- 11:30	<ul style="list-style-type: none"> ▪ Lessons from Korea ▪ Lessons from Thailand ▪ Lessons from Turkey ▪ Lessons from Ghana 	<ul style="list-style-type: none"> ▪ Mr Ankit Kumar ▪ Dr. Viroj Tangcharoensathien ▪ Professor Mehtap Tatar ▪ Mr. Kwesi Eghan 	
11:30- 11: 55			
11: 55-12:20			
12:20- 12:45			
12:45-13 05	Respondents	<ul style="list-style-type: none"> ▪ Dr. Mark Blecher ▪ Professor Diane McIntyre 	
13:05-13:30	Plenary Discussion		
13:30-14:30	Lunch		
	Financing, Service Provision, Institutional Arrangements and Governance Options in Developed Countries		Professor Steve Reid
14:30-14:55	<ul style="list-style-type: none"> ▪ Lessons from Germany ▪ Lessons from Australia ▪ Lessons from France ▪ Lessons from the USA 	<ul style="list-style-type: none"> ▪ Dr. Matthias Rompel ▪ Professor Gavin Mooney ▪ Dr. Michele BRAMI ▪ Professor Tim Westmoreland 	
14:55- 15:20			
15:20-15:45			
15:45-16:10			

16:10-16:30	Respondents	<ul style="list-style-type: none"> ▪ Dr. Christoph Schwiertz ▪ Professor Diane McIntyre 	
16:30-16:55	Plenary Discussion		
19:00	Cocktail Function		

DAY 2	Event	Speaker/Presenter	Chair
09:00-9:25	Governance for Universal Health Coverage	Professor Lucy Gilson	Dr. Jane Doherty
09:25-09:50	Health Equity, Social Solidarity and Financial Risk Protection	Professor Gavin Mooney	
09:30-09:55 09:55-10:20 10:20-10:45	Experiences from Regions: Financing, Service Provision, Institutional Arrangements and Governance <ul style="list-style-type: none"> ▪ Lessons from Developing Countries ▪ Lessons from Gulf States ▪ Lessons from Middle Income Countries 	<ul style="list-style-type: none"> ▪ Dr. Christopher Schwiertz ▪ Dr. Patrick Osewe ▪ Dr. Jack Langenbrunner 	
10:45-11:15	Plenary Discussion		
11:15-11:30	Tea break		
	Innovative Health Financing		
11:30-11:55 11:55-12:10 12:10-12:25	<ul style="list-style-type: none"> ▪ International Experiences ▪ Civil Society 	<ul style="list-style-type: none"> ▪ Dr. Robert Fryatt ▪ Mr. Elroy Paulus ▪ Mr. Mark Heywood 	Dr. Mark Claassen
12:25-13:00	Plenary Discussion		
13:00-14:00	Lunch		
	Lessons for South Africa		
14:00-14:20 14:20-14:40 14:40 -15:10 15:10-15:30	<ul style="list-style-type: none"> ▪ Ethics ▪ Rights and the Law ▪ Service Provision ▪ Financing Options 	<ul style="list-style-type: none"> ▪ Professor Ames Dhai ▪ Dr. (Adv) Adila Hassim ▪ Dr. Jane Doherty ▪ Dr. Mark Blecher 	Professor Lesley London
	Options for South Africa		
15:30-15:50 15:50-16:10	<ul style="list-style-type: none"> ▪ Financing ▪ Service Provision 	<ul style="list-style-type: none"> ▪ Professor Di McIntyre ▪ Professor Charles Hongoro 	Professor Ames Dhai

16:10-16:30	▪ Governance and Institutional Arrangements	▪ Professor Lucy Gilson	
16:00-16:30	Closing Remarks	• Ms M.P. Matsoso	Director-General
	END OF CONFERENCE		

Annexure B: SPEAKER PROFILES

SPEAKER PROFILE

Organisation

Dr. Joseph Kutzin

World Health Organization

Dr Kutzin is affiliated to the WHO and the Department of Economics Boston University Boston, Massachusetts in the USA. He is heading the Health Financing Policy team at WHO Headquarters in Geneva. He previously was the regional advisor for Health System Financing in the European Region of the WHO and the head of the WHO Barcelona Office for Health Systems Strengthening (Hospital & Health Care) which is part of the WHO European Regional Office. Dr. Kutzin has over the years provided technical support to several countries including Estonia, Kyrgyzstan, Moldova and Spain and believes that it is possible for developing countries to progressively implement a modern health-financing system whose organisation is coherent with the crucial objectives of providing financial protection to citizens and to align incentives to produce services efficiently and promoting the principle of universal coverage. He has published extensively on the health insurance and health reforms.

Dr. Ruediger Krech

World Health Organization

Dr. Krech has studied educational sciences, medicine and public health and holds a PhD in public health from the University of Bielefeld, Germany. He re-joined the World Health Organization (WHO) in October 2009 as the Director for Ethics, Equity, Trade and Human Rights. He was previously Director for social security in India at the German Technical Cooperation (GTZ) and in charge of GTZ's projects and programmes in the area of health and social protection in Asia and Central and Eastern (2003-2008). Before joining GTZ, he held various management positions at the WHO Regional Office for Europe in the fields of health systems, health policies, health promotion and ageing.

Dr. Viroj Tangcharoensathien

Ministry of Public Health, Thailand

After graduating from Mahidol University in 1979, **Dr. Tangcharoensathien** worked in district hospitals in the North eastern Province of Ubon Ratchatani for almost a decade and gained extensive experience in rural health systems. He obtained a Ph.D. from the London School of Hygiene and Tropical Medicine in health economics and health care financing in 1990 before joining the Programme Budgeting Unit of the Health Planning Division in the Ministry of Public Health. In 1994, he was seconded to work at the Health Systems Research Institute in the areas of health care financing and health care reforms. He is currently the Director of the International Health Policy Programme in the Ministry of Public Health, Thailand. He has served in several positions in international forums such as the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, the task force on Tropical Diseases Control and Financing (1994-1996), the task force on Tropical Diseases Control and Health Care Reform (1997-present), the steering committee on

Comparative Studies in Health Sector Reform (1996-present), the Scientific and Technical Advisory Committee (1998-2000) and the Editorial Board of Health Policy and Planning Journal, London School of Hygiene and Tropical Medicine.

Dr. Mathias Rompel

German International Cooperation Agency (GIZ)

Dr. Rompel is a sociologist specializing in social policy and social protection systems including public health financing. He has a broad record of research and teaching at university level as well as policy advice and capacity development in Germany, developing countries and emerging economies. Through his position as Head of the Social Protection Section at the German International Cooperation Agency (GIZ), Dr Rompel is involved in capacity development and technical cooperation on social policy, public health financing and social protection reform processes in some 30 countries worldwide.)

During 2001-2005 he worked in Namibia on the DFG-research project and he has also worked in numerous other countries of Southern Africa, including South Africa, Botswana, Angola, and Zimbabwe. He was involved in the promotion of coping strategies for AIDS in the family context in Namibia. He holds a PhD and a MA in Sociology and is a lecturer at the University of Giessen and the University of Applied Sciences in Wiesbaden. He has been working in the development cooperation since 2006.

Professor Gavin Mooney

University of Sydney, Australia

Prof. Mooney has until recently been Director of the Social and Public Health Economics Research Group (SPHERE) and Professor of Health Economics at Curtin University in Perth, Australia. In June 2009 he was awarded an Honorary Degree in Social Sciences by the University of Cape Town as 'one of the founding fathers of health economics. He has honorary positions at the University of Sydney, Australia and the University of Cape Town, South Africa and visiting positions at Aarhus University, Denmark and the University of New South Wales, Australia. He has worked as a health economist for over 35 years, first in the UK, then Denmark and more recently in Australia. He has well over 200 publications in health economics, including 22 books. He has a recent book – Challenging Health Economics – published early in 2009 with Oxford University Press. He is currently working on two other books, one on citizens' juries in health care and the other on reforming health care. He has a strong interest in values and especially equity in health care, particularly with respect to Aboriginal health, and in the economics of the social determinants of health. He was at the forefront of the development of techniques for applying economic theory and principles to the health sector, challenging the prevailing orthodoxy of prioritising efficiency over equity considerations in health care decision-making. Professor Mooney is regarded as one of the leading health economics educators in the world and has taught on postgraduate programmes in nearly 30 countries. In recent years he has pioneered citizens' juries in health in Australia and has facilitated seven juries in WA and South Australia in health services generally, primary health care and Aboriginal health. Gavin has worked as an adviser on many occasions for WHO and OECD and for various governments and health departments. He is also recognised as a first rate teacher and runs a variety of short courses in health economics, especially for health service personnel. Prof Mooney is also Co-convenor, with Colin Pentler, of the WA Social Justice Network.

Professor Mehtap Tatar**Hacettepe University, Ankara, Turkey**

Professor Tatar is the president of the Turkish Association of Health Economics and Health Policy and deputy dean of the Faculty of Economics and Administrative Sciences at the Hacettepe University in Ankara, Turkey. He is also Adjunct Professor at the Centre for Health Services Research in Washington State University as well as Head Chair of the Institute for Reimbursement of Drugs of the Association of Turkish Pharmacists.

His interests are in pharmaceutical pricing and reimbursement policies, health technology assessment, pharmaceutical health information systems, improvements of hospital and health expenditure, contracting out in hospitals, national health accounts and formal and informal health expenditures

Mr. Ankit Kumar**OECD**

Mr. Kumar is an economist in the Health Division at the Organisation for Economic Co-operation and Development (OECD) who specialises in health systems financing, governance of health care systems and health system reform. Since joining the OECD earlier this year, Ankit's major project has been Reviews into the Quality of Health Care, a series of country publications that assess policy initiatives and highlight best practice reforms for improving the quality of care and driving health system efficiency across OECD countries. Mr Kumar coordinated the first Quality of Care Review for Korea (to be published early next year) which focuses on financing, primary care and cardiovascular care and will be leading the forthcoming review into Israel. He has also contributed to the OECD's 2011 Review of Switzerland's Health System, focusing on hospital financing and public health. Before moving to Paris, Mr Kumar was the Senior Policy Advisor for Health and Ageing in the Office of the Prime Minister of Australia, and served both Prime Ministers the Hon. Kevin Rudd and the Hon. Julia Gillard over the last four years. Mr Kumar was central to the development and delivery of a number of major reforms delivered by a newly elected Government, including introducing nationally consistent DRG funding, strengthening primary care, and reforming financial assistance to make private health insurance subsidies more equitable, reducing pharmaceutical outlays, alcohol taxation reform and developing plain paper packaging of cigarette products. Mr Kumar has also enjoyed brief roles in the private sector, as a consultant to Bupa Australia (a major private health insurer and health care provider) and as an analyst in a global investment bank. Prior to pursuing a career in health and public policy, Mr Kumar authored a high school economics textbook and lectured extensively on developments in the global and Australian economies.

Mr. Kwesi E Eghan**SPS/Health Commodities and Services Management Program**

Mr. Eghan is presently the Senior Program Associate / Country Manager for the SPS/Health Commodities and Services Management Program. He also leads the implementation of SPS' USAID funded Neglected tropical diseases program and the Pharmaceutical and health financing portfolio development activities. He was a primary facilitator for the development of the National health insurance policy framework of Ghana and the Health Insurance Act (Act 650) of Ghana and served on the National Health Insurance Council of Ghana as head of the National medicines and tariffs sub committees of the NHIC. And is providing inputs into its present review. As Senior Manager, Medical operations, for Ghana Healthcare Company Ltd a subsidiary of the Social Security and National Insurance Trust (SSNIT) he was responsible for the development of the reimbursable drug list, median, reference pricing and costing of

procedures and establishments of tariff and rates for the reimbursement of health services and medicines for improved quality of care under health insurance. Before then, Mr. Eghan served as the Director of Projects/Country Lead of Family Health International (FHI) in Ghana where he provided leadership for the DFID/Ghana Aids Commission funded Project for HIV/AIDS prevention, care and treatment, the National Aids Control Programme/ World Bank's "Treatment Accelerated Program" (TAP), and the FHI core-funded private sector ART network to provide Comprehensive HIV Care, support and treatment in the private sector of Ghana. He has over 18 years management experience in pharmaceutical service industry, health finance/insurance management, modeling private-public partnerships, public health (HIV, TB and Malaria) and development health program management. He is currently undertaking a Masters program in Health Economics and Pharmaco-economics. He holds a Masters degree in Business Administration (finance option) and a Bachelor degree in Pharmacy.

Dr Michele BRAMI

FRANCE ATIH

Dr BRAMI is a general practitioner who had her own practice for 6 years at the beginning of her career. She became Advisor for the French National Health Insurance (Assurance Maladie). She was in charge of hospital relations for 20 years. Then she specialized in hospitals information systems focusing on DRGs and case mix system. Dr BRAMI worked as a project manager at the French Mission for DRG prospective payment system, attached to the Ministry of Health, during the implementation of the reform, till the end of this mission in December, 2010. She is now project manager at the French Technical Agency for Information on Hospitalization (ATIH), attached to the Ministry of Health. She holds a Doctor in medicine, and is qualified in public health medicine, health statistics and economics and occupational medicine.

Dr Patrick Osewe

World Bank

Dr Osewe is a Senior HIV/AIDS Specialist with extensive experience at organizations such as the CDC, USAID, Harvard University and London School of Tropical Medicine and Hygiene. Before joining the World Bank, Dr. Osewe was the Senior HIV/AIDS Technical Advisor at USAID/Zimbabwe and provided USAID management, National AIDS Council, National AIDS and TB Unit, Zimbabwean counterparts, USAID contractors, and other donor representatives with technical leadership, expertise and policy guidance on controlling the HIV/AIDS epidemic. He was also responsible for programming a five-year \$65 million HIV/AIDS budget for USAID/Zimbabwe, together with the HIV/AIDS Crisis Mitigation Team.

Dr Christopher Knauth

EU-DEVCO

Dr Knauth (MCommH, Liverpool). Is a principal administrator in the European Commission since 1999. In different positions in charge of development co-operation in the health sector. 2007-2011 working in EuropeAid's quality support unit in accompanying EU support to sector programs in Asia. Particular interest in health financing accompanying health financing reforms in the Philippines and Vietnam. Since June 2011 in charge of health in the Southern and Eastern Africa Unit.

Dr John (“Jack”) Langenbrunner**World Bank**

Dr. Langenbrunner is a Health Economist with both research and operations experience with the World Bank. He has worked on health financing issues and health insurance design and development in issues in Eastern Europe in the European Union New Member States and in the former Soviet Union countries such as Russia, Kazakhstan, and Ukraine. He was stationed in Moscow from 2002 to 2005. He is currently working in selected countries in the Middle East including Saudi Arabia, Iran, Egypt, Jordan, and Lebanon. He has recently co-authored a book *Spending Wisely on Resource Allocation and Strategic Purchasing of health care services by insurers and other public and private organizations*. He also led the Bank’s work on a manual for National Health Accounts for low and middle income countries. This so-called NHA “Producers Guide” was published in 2003. Previous to his work at the Bank, Dr Langenbrunner was with the US Health Care Financing Administration, a government social health insurance program for primarily elderly and the poor covering over 80 million Americans. There he worked on both case-mix payment systems for hospitals and physician relative value scales. He later served on the Hillary Clinton Health Care Reform Task Force in 1993 for the US White House. Dr Langenbrunner holds Masters and Doctorate degrees in Economics and Public Health from the University of Michigan, United States.

Dr. Robert Fryatt (DFID)**UK - DFID**

Dr. Fryatt, is an Adviser in the Ministry of Health in South Africa on a secondment from the UK Department for International Development (DFID). He has worked for WHO on strategic planning, where he set up a new cluster of work on Health Systems Strengthening. He has set up and managed together with the World Bank, the first phase of the International Health Partnership (IHP+) and the Taskforce for Innovative International Financing for Health Systems. Dr Fryatt has a Medical Doctorate from London University on the Economic Evaluation of TB Programs. He is a Fellow of the UK Faculty of Public Health Medicine and a Member of the UK Royal College of Physicians. Dr Fryatt has a Masters in Public Health from the London School of Hygiene and Tropical Medicine and has completed executive management courses on “Consultancy and Change” at the Ashridge School of Management.

Dr Christoph Schwierz**EC DG ECFIN**

Dr. Schwierz has specialized in health economics focusing on acute care hospital and rehabilitative care markets. *He has* acquired complex quantitative analytical skills in applied econometrics. *He has* published and reported results to customers *and has* successfully raised funds for a research project and on-the-job training. He has programmed, developed and standardized quantitative tools for the analysis of healthcare markets. Dr Schwierz has specialties in healthcare markets, health economist, acute care hospitals, research, econometrics, and micro-econometrics. He received his education at the University of Bochum and holds a PhD, Economics; health economics; applied econometrics; stationary healthcare markets; policy evaluation. His thesis is in "German Acute Care Hospitals - Determinants of their Economic Performance and Quality of Care". He is currently working as an economist for the European Commission, DG ECFIN Government Agency and is presently based in Brussels, Belgium. He previously also worked for Healthcare Expert KCE, a Belgian Health Care Knowledge Centre Government Agency.

Professor Timothy M. Westmoreland**USA Georgetown University**

From 1979 through 1995, Professor Westmoreland served as Counsel to the Subcommittee on Health and the Environment in the U.S. House of Representatives. From 1995 through 1999, he was the Senior Policy Fellow at the Law Center's Federal Legislation Clinic. From mid-1999 through January 2001, Professor Westmoreland was the Director of the Medicaid program for the Federal government. He has worked extensively on public health and health finance policy. Professor Westmoreland was counsel to the Advisory Committee on Tobacco Policy and Public Health and an advisor to the Henry J. Kaiser Family Foundation and the Elizabeth Glaser Pediatric AIDS Foundation. He has also been the recipient of a Robert Wood Johnson Foundation Investigator in Health Policy Award, working on budget process and health policy.

Professor Olive Shisana**Ministerial Advisory Committee**

Dr. Olive Shisana holds a Doctor of Science degree from The Johns Hopkins University, Broomberg School of Public Health where in 1999 she was admitted into the Society of Scholars for her outstanding contribution to public health. She is Chief Executive Officer of the Human Sciences Research Council (HSRC); previously she served in the same organization as an Executive Director of a South African national research program on Social Aspects of HIV/AIDS and Health. Prior to that she served as Professor of Health Systems at the National School of Public Health at the Medical University of Southern Africa and later as Executive Director of Family and Community Health at the World Health Organization in Geneva. She is a principal or co-principal investigator on HIV surveillance studies and has published articles on social epidemiology of HIV and national health insurance. She serves as Chair of the Ministerial Advisory Committee on National Health Insurance. Currently she serves as President of the International Social Sciences Council, an organization based in Paris UNESCO and serves also on the UNESCO High Panel on Science and Technology for Development.

Professor Ames Dhai**Steve Biko Centre for Bioethics**

Professor Dhai established the Steve Biko Centre for Bioethics in 2006. She is currently Director of the Centre. She is an ethicist of international standing and can be credited with entrenching bioethics as an integral aspect of health sciences in South Africa. Her expertise is in demand nationally, on the African continent and internationally. She has been directly responsible for institutionalizing bioethics at the University of the Witwatersrand's Faculty of Health Sciences. Her special interest is in the field of research ethics. She is proactive within both research ethics at Wits University (where she is co-chair of the Human Research Ethics Committee) and research ethics further afield, including the National Health Research Ethics Council. She is an honorary senior lecturer in Obstetrics and Gynecology at University College, London. Professor Dhai serves as the Deputy Chair of the National Health Research Ethics Council. She also serves on the Medical Research Council Ethics Committee and is Convener and Chair of Hospice and Palliative Care of South Africa Research Ethics Committee. She co-chairs the Wits Human Research Ethics Committee (Medical) and also sits on the Health Professions Council of South Africa's Medical and Dental Board and Human Rights, Ethics and Professional Development Committee. Professor Dhai also serves as a councillor on the Colleges of Obstetricians and Gynaecologists of South Africa and on the South African Medical Association, Human Rights and Ethics Committee. Professor Dhai is also the Editor in Chief of the South African Journal of Bioethics and Law.

Dr. Jane Doherty**Independent Researcher**

Dr. Doherty is a health systems and policy researcher with over twenty years' experience. I specialise in issues affecting the equity and effectiveness of the South African public health sector. She also has an interest in using international evidence to inform the strategic direction of health systems in low- and middle-income countries. Between 1989 and 2001 she worked at the Centre for Health Policy at the University of the Witwatersrand (South Africa) where Dr Doherty eventually became Deputy Director. Since 2001 she has worked independently (mainly for universities and international agencies), although I remain a part-time lecturer in the School of Public Health at the University of the Witwatersrand. Her research interests include health financing policy, hospital planning and management, district health systems, human resource planning and production, the public-private mix and methodological issues in policy research. She use mixed research methods but have special skills in the qualitative analysis of semi-structured interviews. Dr. Doherty has produced around 40 reports, 10 book chapters and 15 journal articles, amongst other outputs. She also acts as a reviewer for a number of international journals. Beyond her research interests, Dr Doherty is committed to developing capacity for health systems and policy research in low- and middle-income countries. I have considerable experience in designing post-graduate courses, adult learning techniques and mentoring. Dr Doherty acts as an external examiner for Master's students and also conducts research on effective capacity-building approaches.

Dr (Adv) Adila Hassim**Section 27**

Dr. Hassim joined the AidsLaw Project in 2004 and was the head of litigation and legal services from 2006 until 2010. She has a BA LLB from the former University of Natal, Durban. In 1998 she was awarded the Franklin Thomas Fellowship to pursue an LLM at St Louis University, which she completed with distinction in 1999. In 2000 she was awarded the Rev Lewers – Bradlow Foundation Fellowship to pursue her doctorate at the University of Notre Dame. The doctorate was conferred on her with honours in 2006. Her dissertation was entitled "The protection of social rights in South Africa: from theory to practice". Dr. Hassim is a member of the Johannesburg Bar and an honorary research fellow at the School of Law of the University of Witwatersrand, Johannesburg. Most recently Adila has been appointed to the technical advisory group of the Global Commission on HIV and Law. A former law clerk to the Deputy Chief Justice Pius Langa, as well as then Acting Justice Edwin Cameron, Adila has continued passionately to defend constitutional rights, and socio-economic rights in particular.

Mr. Mark Heywood**Section 27**

Mr. Heywood grew up in Nigeria, Ghana, Botswana and England. He holds a BA (Hons) in English Language and Literature from Balliol College, Oxford University. After graduating from Oxford in 1986 he worked for the Marxist Workers Tendency of the ANC, first in London and then from 1989 to 1994 in South Africa. During this time he was instrumental in setting up campaigns such as the Philemon Mauku Defence Campaign, the Leeukop Political Prisoners Support Committee and the Johannesburg Inner City Community Forum. He also did an MA in African literature at the University of the Witwatersrand, Johannesburg, and lectured and wrote on the influences of Shakespeare on African writing and politics in South Africa. Mr. Heywood joined the ALP in 1994, becoming its head in 1997 and executive director in 2006. In 1998, he was one of the founders of the Treatment Action Campaign (TAC). In 2007, he was elected as deputy chairperson of the South African National AIDS Council. He is also the current chairperson of the UNAIDS Reference Group on HIV/AIDS

and Human Rights. In 2009, Mark was appointed as a member of the Ministerial Advisory Committee on National Health Insurance. Mr Heywood has written extensively on HIV, human rights and the law, including co-editing the AIDS and the Law Resource Manual and Health & Democracy: A guide to human rights, health law and policy in post-Apartheid South Africa. He has been part of the legal teams of the ALP and TAC that have been involved in all the major litigation around HIV and human rights

Professor Diane McIntyre

Ministerial Advisory Committee

Professor McIntyre is the South African Research Chair in 'Health and Wealth' and a Professor in the School of Public Health and Family Medicine at the University of Cape Town, where she has worked since 1988. She founded the Health Economics Unit (HEU) in 1990 and was its Director for 13 years. She has completed Bachelor of Commerce, Honours and Masters degrees in Economics at the University of Cape Town. She has also completed a PhD by dissertation, entitled "Health care financing and expenditure in South Africa: Towards equity and efficiency in policy making". In addition to general technical support activities in South Africa and other African countries, she has served on a number of policy committees. These include serving on the Health Care Finance Advisory Committee to the Department of Health of the Government of National Unity, the Minister of Health's Committee of Inquiry into a National Health Insurance for South Africa and the Medical Schemes Council. She also chaired the Minister of Health's Medicine Pricing Committee from its establishment in 2003 until 2008. She currently serves on the Ministerial Advisory Committee on National Health Insurance. Prof McIntyre's research interests are in health care financing, purchasing of health services, equity in the health sector, access to and utilisation of health services, geographic allocation of health care resources, and public/private sector mix issues.

Professor Lucy Gilson

University of Cape Town

Professor Gilson holds the appointment of professor both at the University of Cape Town and the London School of Hygiene and Tropical Medicine, UK, and is an honorary professor at the University of the Witwatersrand. She has a BA in Politics, Philosophy and Economics (Oxon), an MA in Development Economics (East Anglia) and was awarded her PhD by the University of London. Over the years, her research has been driven by concern for equity in health and health care. It has involved conceptual and empirical work on issues of health care financing, organisation, management and policy change. She has also played a leading role in developing the field of health policy analysis, and currently manages a continental initiative to strengthen training in this field. Prof Gilson has, as well, conducted collaborative research with colleagues in other countries in Eastern and Southern Africa, and in Asia. Her research interests are in health policy and systems research.

Professor Steve Reid

University of Cape Town

Professor Reid is a family physician with extensive experience in clinical practice, education and research in the field of rural health in South Africa. He holds a BSc (Med) and MBChB degrees from the University of Cape Town, a Masters in Family Medicine from Medunsa, and a PhD in Education from the University of KwaZulu-Natal. As a conscientious objector to military service in the 1980's at Bethesda Hospital in north-eastern KwaZulu-Natal, he was involved in community initiatives in health in the Bethesda health ward, and completed his Masters thesis in Family Medicine on the topic "The Community

Involvement of Rural Clinic Nurses". Moving back to Durban after 10 years, he established a Vocational Training Programme for rural doctors at McCord Hospital. Professor Reid then directed the Centre for Health and Social Studies (CHESS) at the University of Natal, and with his team pursued a number of training and operational research projects in rural districts in KwaZulu-Natal, Eastern Cape and Limpopo, focussing on the strengthening of the district health system. In 2001 the Centre was re-named the Centre for Rural Health, and Steve was involved in a number of projects in this field, including human resources for health, medical education, HIV and AIDS, anti-retroviral provision, PMTCT, management support, use of information, recruitment and retention of staff, and primary health care. Professor Reid completed a PhD in Education at the University of KwaZulu-Natal on the topic of "Education for Rural Medical Practice". He has published extensively on community-oriented primary care (COPC), the issue of compulsory community service, and medical education, and is a member of a WHO expert group on human resources for health in rural and remote areas. In January 2010 he took up the post of Glaxo-Wellcome Chair of Primary Health Care at UCT. He is developing this role to support UCT medical and health science graduates to become more relevant and appropriately skilled in Africa, by extending the teaching platform and reforming curricula. In the Western Cape Department of Health he is a consultant to the District Health Services Division on primary health care, community based services and human resources for health.

Dr. Mark Claassen

Ministerial Advisory Committee

Dr. Claassen currently heads the PricewaterhouseCoopers National Actuarial practice. He is a member of the Ministerial Advisory Committee on National Health Insurance and chairs the Costing and Revenue sub-committee. He sits on a number of professional, industry and leadership bodies. He has almost thirty years experience in financial services and academia. Dr Claassen has worked in insurance, health, employee benefits, asset management and banking and managed large projects in pricing, mergers and acquisitions, change and risk management, privatisation and capital management. He is a former professor of Actuarial Science. He is actuary by training, married with children and likes to do difficult things.

Professor Charles Hongoro

Ministerial Advisory Committee

Professor Hongoro is a health economist and research director at the Health Systems Research Unit of the South African Medical Research Council. He is professor extraordinaire research at Tshwane University of Technology in the Department of Environmental Health. He has over 20 years of experience working in public health policy and systems research. He previously was the director of research at the Human Sciences Research Council. He has also lectured at the London School of Hygiene and Tropical Medicine on health financing and health systems strengthening. He is a member of the Ministerial Advisory Committee on National Health Insurance. He has published extensively in peer reviewed journals on a number of areas including human resources, health financing and hospital services.

Dr. Mark Blecher

National Treasury

Dr. Blecher is director of Social Services in the National Treasury. He has gained extensive experience in public sector management, health finance planning and management and general public sector management through employment at provincial and national government levels.

Mr. Elroy Paulus**Black Sash**

Mr. Paulus joined the Black Sash in October 2007, having spent the past eleven years involved in community development and economic literacy training. Formerly a medical technologist in chemical pathology, Elroy soon realized that his real passion was with socio-economic justice issues. Between 1997 and 2003, he worked as a provincial coordinator and senior researcher for Fair Share, School of Government, based at the University of the Western Cape. Elroy then joined COSATU as the Research Coordinator at their Parliamentary Office and later consulted for various organisations on human and worker rights advocacy issues. The Black Sash, in partnership with Health-e and HEU-UCT, since mid 2010 – present, led by Elroy Paulus, helped to elicit public preferences for health system reform including the NHI – the outcomes of which is presented in this conference. He is also leading the national CMAP (Community Monitoring and Advocacy Programme), which includes monitoring local service delivery sites (including primary health care clinics) and promoting local advocacy. It is a project endorsed by SASSA (South African Social Services Agency) and has recently been presented at the Presidency as an interesting model for civil society monitoring initiative.

Professor Lesley London**University of Cape Town**

Professor London is a Senior Specialist in Public Health at the School of Public Health and Family Medicine, University of Cape Town, South Africa. He is Associate Director of the Occupational and Environmental Health Research Unit and has been widely published in the field of pesticides and chemical neurotoxicity. He serves on the Advisory Committee to the International Program on Chemical Safety Pesticide Poisoning Surveillance Project, on the Scientific Committee on Pesticides for the International Commission on Occupational Health and coordinates the sub-program on pesticides as part of the Biregional Program on Occupational Health for the Southern Africa Development Community (SADC). He teaches under- and postgraduates in the field of occupational and environmental epidemiology and serves on national committees dealing with professional ethics and human rights. He is a past recipient of awards from the Alan Pifer Foundation and the Society for Occupational and Environmental Health for his work on the hazards of pesticides for farm workers.
