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The Director-General told the meeting that the relationship between government and the industry had been somewhat negative; in fact, the relationship had been perceived as antagonistic. Despite this perception, it remained true that a health industry was needed and that it should be vibrant and competitive.

The members were requested to discuss and establish common ground on the kind of health industry the country needs and, by doing so, also evaluate the current industry and establish the contribution the health industry was making. Priority areas that could contribute towards growth in the industry should also be targeted for discussion.

3.3.2 Members' comments after the introduction by the Director-General:

- The health budget for the private sector only, amounts to approximately R51 billion per annum, of which approximately R 18 billion can be categorised as non-personnel funds (non capital) the largest portion is spent on consumables used in hospitals, clinics, etc.

  For the total health sector the figure should be double that amount, or even more. The consumables (pharmaceutical products, bandages, etc.) that are bought are largely imported. This fact necessitates the need for a forum to begin promoting a manufacturing industry for health products. This is one area in which the country thus far has not progressed and is falling far short of the motor industry, which imported most cars ten to fifteen years ago, but which is currently reporting a record level in the number of cars being exported.
- Discussions held by the Health Charter Committee are more centred around the hospital sector and do not address the private sector in primary

health care. The role of the private sector in primary health care should be determined.

- Considering the aim of ASGISA, it can be concluded that the health sector is an important role player in economic empowerment. It should be determined how the health sector, and the health industry in particular, are contributing to growth in the country and in what way it is contributing to the upliftment of the previously disadvantaged people, to empowerment and to employment equity?
- The National Health Council and the Health Charter Steering Committee are both important bodies with their own specific terms of reference and objectives and should not be compared with the NCHF. The latter can feed into the work of the Health Charter Steering Committee. Support was expressed for those issues the Director-General raised which could be dealt with by a body such as the NCHF, which can filter into the NHC process.

3.3.3 Summary and Conclusion

The Chairperson expressed the opinion that there seemed to be general consensus amongst the members that there was a role a committee dealing with health industry matters could play in the country, other than the Charter Committee and the NHC. How this forum should function, its terms of reference, its structure and membership should be discussed and determined.

It is important also that the forum should have a specific focus and issues to be addressed. It should be a forum that will forge particular partnerships and find ways of doing things differently. Such a forum should not just be

an information-sharing or discussion forum – it should be a forum where issues of disagreement can also be debated.

In summary, the Director-General assured the members that the government would do everything in its power to consult in a meaningful way since it was in the interest of government. At the same time areas of difference would be deliberated and common ground sought.

3.3.4 Presentation by the Department of Trade and Industry (DTI)

On the second day, the Department of Trade and Industry made a presentation on the South African healthcare industry's situation in the current global and domestic economic environment.

According to the March 2006 Quarterly Bulletin published by the SA Reserve Bank, the real growth of the South African economy increased from 4½% in 2004 to almost 5% in 2005 which represents the highest annual growth rate since 1984. The CPIX inflation index has been kept within the target of 3% to 6% for the last 34 months and the most recent Labour Survey (LFS) by Statistics SA shows that in the year to September 2005, overall employment in South Africa increased by 658,000 or 5.7 per cent over the year to around 12.3 million. However, the rate of unemployment remained almost unchanged at 26.7% in September 2005 compared to 26.2% in September 2004.

It was pointed out during the presentation on ASGISA that the country's current account and trade balance remained negative since the middle of 2003. The major cause of that is the rising cost of imports of crude oil (R 41 billion in 2005). The health sector also significantly contributes to the trade deficit, with imports

of pharmaceutical products, medical devices and diagnostics, combined, exceeding R 12 billion in 2005. The country imports 50% of its demand for pharmaceutical products (70% if active pharmaceutical ingredients and raw materials are included), 90% medical devices, 100% of medical diagnostics and 100% of human-grade vaccines. A number of pharmaceutical companies closed down during the ten years 1994 and 2004.

According to Econometrix published on 25 April 2006 under the heading ”SAVINGS DECLINE TO RECORD LOW”, the gross savings, as a percentage of overall GDP, declined to an all-time low of 13.7% of GDP in 2005 and an even lower than 13.0% of GDP in the fourth quarter of 2005. Saving by households declined to just 0.1% of national disposable income in 2005, from 0.3% in 2004 and 0.8% in 2003. Savings by corporate entities declined from 3.6% of disposable income in 2004, to 2.1% in 2005.

In 2005, the World Investment Report showed that the African continent attracted a mere 3% of the global foreign direct investment (FDI) in both 2003 and 2004. The top 10 FDI recipients in Africa in 2003 and 2004 were oil and gas-rich countries, such as Nigeria, Angola, Equatorial Guinea, Sudan, etc. South Africa is a net foreign direct investor, with SA companies investing overseas US$ 1.6 billion in 2004 - most of that in Africa. The recent global boom in metallurgical commodities has, so far, not resulted in a significant increase of investment in the SA mining and metallurgical sectors.

The range of economic incentives which the DTI can offer to attract foreign and domestic investment is rather limited. After the phase-out of the Strategic Industrial Programme (SIP) at the end of 2005, the only remaining key incentive is the National Industrial Participation (NIP) programme.

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In the health sector, the following projects were the beneficiaries of the SIP and NIP incentives:

② The Strategic Industrial Programme (SIP) sponsored Aspen's R 180 M Oral Solid Dose (OSD) project in Port Elizabeth and received an SIP incentive of R 111 million and Roche's R 115 M Fansidar project in Isando for which it received an SIP incentive of R 113 M.

③ The National Industrial Participation (NIP) programme sponsored three projects, namely the manufacture of vaccines which is a joint venture between the national Department of Health (DoH) and the Biovac Consortium, as well as the "Triclinium" clinical research enterprise project and the "Hivex" HIV and AIDS research project.

Intellectual property rights are the most fiercely protected and contested domain in the global pharmaceutical industry. In the generic industry competition is fierce, with manufacturing moving more and more to low-cost countries, mainly India and China.

Over the past decade - 1996 to 2005 - imports of pharmaceutical products have risen at an average rate of 17% *per annum,* from R 2.14 billion in 1996 to R 7.44 billion in 2005. Exports of pharmaceutical products grew from R 230 million in 1996 to R 773 million in 2005. Export growth over the past six years has been sluggish, below 3% *per annum* (from R 677 million in 2000 to R 773 million last year). The sector's trade balance was profoundly negative at minus R 6.7 billion last year (excluding active pharmaceutical ingredients, APs). Including APIs, the sector's trade deficit was roughly R 9 billion last year.

Africa remains the major destination for South African pharmaceuticals, accounting for 60% of our exports. Until 2001, Zimbabwe was the major export

destination for SA pharmaceuticals, accounting for roughly 50% of the country's exports.

Nearly 90% of pharmaceuticals, by value, are imported from developed countries, the main suppliers being the UK, Germany, France, Ireland and Switzerland. Imports from India have been steadily growing, reaching 5% in 2005. Puerto Rico is an emerging exporter of pharmaceuticals, accounting for 5% of our imports in 2005. Imports from China are 1% of the total; China, however, is the main supplier of generic APIs, followed by India. Detailed statistics of imports of APIs are not available.

Medical devices encompass a broad range of products, ranging from simple syringes, surgical blades, catheters, etc. up to the most sophisticated magnetic resonance imaging (MRI) and positron emission topography (PET) scanners. With the exception of plastic syringes, needles and sterile wound dressing, gauze, plasters, etc, or the so-called *medical textiles,* all these products are imported duty-free.

There has been a remarkable upturn in the trade balance in *medical textiles*. South Africa was a net importer of these products until 2002. Our exports surged from R 71 m in 2001, to R 214 m in both 2002 and 2003, as a result of a major investment in the sub-sector by BSN Medical in Pinetown, KwaZulu-Natal.

While the trade balance remained positive in 2005, the sub-sector has been negatively affected by the strengthening of the Rand, the loss of some export markets owing to the flood of low-priced Chinese products, and a loss of a large part of orders from state hospitals, owing to new tender rules, diluting the preference for local manufacturers resulting in BSN being forced to shut down some production units and retrench over 50% of its work force.

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3.3.5 Discussion

After discussion of the presentation by the DTI it materialised that it was imperative that a common approach should be followed in the acquisition of all medical devices and pharmaceuticals.

It was further suggested that, in future, the Work Group investigate the role of SA in retail, the pharmaceutical industry, medicines devices and the hospital sector. To this effect the necessary papers should be prepared and presented by the relevant persons. Such an exercise would assist in determining where South Africa was going in this regard.

The Director-General reiterated that the main concerns in the country were the citizens of the country and access to health care. Expertise and capacity in this regard should be properly balanced.

A first topic for deliberation could be that concerning the country's position as a country as opposed to a region, from an industry point of view. To this end the pharmaceutical industry, the devices industry and the hospital sector should make imports, after which the government could provide an overview of all these from its own perspective in order ultimately to determine where the country was going, the process it should follow to get there and also to pinpoint the enabling mechanisms necessary to get the country there.

The suggestion was also made that, initially, the matter be discussed with those who own the industry but not excluding civil society, after which the parameters could be broadened also to include other interested parties. It is important to remember that nobody with a vested interest should be excluded. It would be

feasible to combine the hospital-clinic industry for discussion purposes. The members also agreed that the pharmaceutical industry should be requested to present its approach from the perspective of its impact on the region.

For the purpose of the first meeting the members decided that they would concentrate on the shaping and the describing of the role of South Africa in terms of being a regional player focusing on the following four issues.

1. South Africa as a regional player
2. Strategic partnership issues between the government and the health industry and how to forge these
3. Health tourism (and all the aspects connected with that)
4. Issues underpinning constitutional order.

The members also agreed that the industry should be allowed to choose its own representatives and/or presenters.

3.4 Health Policy and Planning

3.4.1 Introduction

The members were welcomed by the Chairperson, Dr Chetty, and encouraged to contribute to the discussions. She further advised that the discussion document distributed was intended as a guideline to focus discussion and should, therefore, not be treated as the final word on the issue of Planning and Policy for the health sector.

During the presentation the following key health system issues to determine health system performance, were covered:

(a) Financing of the Health System

(b) Hospital Issues

(c) Quality Improvement

(d) Primary Health Care

(a) Financing of the Health System

The financing of the health system covers a range of issues; however, the presentation focused on issues pertaining to equity and social health insurance.

Equity can be broadly defined as fairness or justice. There is agreement that, in assessing inequalities, the focus should be on differences in health status and health service provision and on financing between socio-economic groups, i.e. social inequalities.

In South Africa disparities can be found in public sector health-care expenditure between and within provinces. The public-private health sector mix further contributes to differences in expenditure levels. There is an eight-fold difference between *per capita* expenditure in the public and private health sectors.

Members accepted that significant health status and health system disparities exist in South Africa and that these disparities are inequitable as they are not only unfair or unjust, but are also avoidable and unacceptable.

Health financing reform is one of the features of a health system moving towards universal coverage, with national or social health insurance being one of the reforms. The Department of Health has been grappling with the implementation of the social health insurance policy for quite some time. The Social Health Insurance (SHI) system, which the Department seeks to

implement, has three (3) components. The first component is that of introducing compulsory participation and contribution in the medical schemes' environment so as to spread the financial risk. The second component is aimed at preventing unfair exclusion of beneficiaries of schemes from accessing prescribed essential health-care services and is also aimed at improving health-related cross-subsidies by means of the risk equalisation fund (REF) system. The third component encourages income-based cross-subsidies for essential health care services.

Tremendous effort has been put into the development and implementation of the system of risk equalisation among medical schemes, which will come into effect in 2007. The key challenge is that of how to introduce employer or individual mandates for participation in the risk pooling framework given that the economy is expected to grow by 6% over the coming years, and also to determine how to convince all the stakeholders that in a country like ours there is a need for income solidarity within the medical schemes market. These two outstanding components need to be extensively discussed and accepted by all stakeholders.

It needs to be determined what role the private health sector can play in achieving equity and what should guide the practice of the private health sector to promote equity.

(b) Role of the public sector in promoting health equity

Within the public sector, how should limited public sector resources be allocated to achieve these principles? What issues, other than equitable resource allocation decisions, should the government be concerned about and what other steps should be taken to promote equity within the public health sector?

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(c) Hospital issues

Public hospital expenditure constitutes the largest percentage of the health budget. Delivering appropriate and affordable care is dependent upon finding the right funding formula that promotes primary health care supported by an effective and efficient hospital system.

The South African hospital system is very expensive and is plagued with many areas that are inefficient, with losses through wastage and theft. Building a strong Primary Health Care (PHC) system with an effective clinic and community health center base, will require the shifting of funding from hospitals to primary-care level without compromising existing hospitals.

To do this it is imperative that efficiency is improved, a reduction in theft is brought about and better outcomes are ensured. Provincial health departments must focus on ensuring that increases in budgetary allocations are used to develop the primary-care infrastructure. The key challenge facing provincial and hospital managers is that of strengthening and increasing PHC while protecting hospitals.

(i) Major challenges facing public Hospitals

A facilities audit undertaken in 1996 showed that a third of health institutions by value required replacement or major repair because public hospitals were in varying states of disrepair. Budget pressures impact negatively on ongoing maintenance, with between 1% - 1,5% of the capital value being spent on regular maintenance of hospital infrastructure. This amount is far below the industry standard of 3% to 4.5% of the capital value. Of concern is the fact that the costs of upgrading and rehabilitation far exceed the funds available. The

hospital revitalisation programme was embarked upon to address the problems that were experienced.

(ii) Medical equipment

The ability to deliver quality care is seriously compromised owing to problems with the deterioration of medical equipment, which is ageing and poorly maintained.

A key component to the ability to deliver cost-effective care is that of reliable medical equipment. Quality postgraduate medical training required the latest available medical equipment to ensure we train competent specialists and sub-specialists. The Modernisation of Tertiary Services Plan identified diagnostic radiology as a major bottleneck in improving efficiency in hospitals.

(iii) Management of Hospital services

Hospital managers are required to deliver efficient, more effective service and be more accountable in future. Hospitals consume a significant part of the provincial health budget. Understandably, better resource allocation and use at hospital level is a primary requirement of managers.

① The following critical elements on decentralised management were identified:

- Appointment of Chief Executive Officers (CEOs) with management skills and competencies.
- Introduction of general management structures in hospitals with professional and technically competent human resources, labour relations, financial, procurement, facilities and information management and technology managers.

- Development of modern, efficient management structures and systems.
- Delegation of substantial powers over human resources management, finances, procurement and other critical management functions.

② Delegation of authority to hospital CEOs has been identified as a Presidential priority during the State of the Nation address in 2006 where the President clearly indicated the government's intention:

To improve service delivery in our hospitals by September this year (2006), we will ensure that hospital managers are delegated authority and held accountable for the functioning of hospitals, with policy issues regarding training, job grading and accountability managed by provincial health departments which themselves will need restructuring properly to play their role.

③ Network and build relationships

It was imperative that stakeholders network and build relationships with and between the public and private sector. NGOs should not be left out of the process. Proper planning should be done for the next meeting of the forum and priorities should be determined. It was essential that the forum be held early to accommodate planning for the budget cycle of 2007 –2008.

3.4.2 Priority issues for the Work Group

(a) Financing of the health system

(i) Revenue retention at public health facilities with specific reference to medical-aid members utilising public health facilities.

(ii) Social Health Insurance with specific reference to the Risk Equalisation Fund which specifically seeks to improve health-related cross-subsidies between medical schemes.

(iii) The cost of hospital and health care in the private sector and the causes of rising costs.

(iv) A review of the costing of hospital and health care in the public sector.

(b) Hospital issues

(i) Working conditions of health professionals employed at public health facilities.

(ii) Training of hospital CEOs.

(iii) Quality of Care and Quality of Services at public health facilities.

(iv) Revitalisation of rural health facilities.

(v) Attitude of staff employed in both the public and private health sectors should change.

(c) Quality improvement

(i) Accessibility to public health facilities for deaf patients should be improved drastically.

(ii) Filling of vacant positions in the public health sector. Unless the Human Resources shortages are addressed as a matter of urgency, the quality of care and services at public health facilities cannot improve.

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(d) Primary health care

Strengthening systems for the improvement of health service delivery by planning, strengthening implementation as well as monitoring and evaluation.

3.4.3 Issues for further discussion in future

(a) Process

- Finalisation of the Terms of Reference
- Getting mandates from different organisations
- Defining the reporting process on progress made with recommendations

(b) Content Issues

- Strengthening the quality of data for planning and monitoring
- Strengthening information systems by more frequently publicising the health status indicators
- Providing more regular accurate health status information for effective planning and community participation
- Disaggregating results of the HIV antenatal survey to district level
- Improvement management response to issues and concerns raised by communities and users of health services
- Exploring Public-Private Partnerships (Initiatives) (PPPs/PPIs) further
- Pursuing revenue retention by institutions
- Conducting a health-needs assessment and linking it with resource allocation

- Considering both population size and burden of diseases in resource allocation
- Strengthening of recruitment and retention of health personnel including providing intersectoral infrastructure
- Improving strategies for Quality of Care
- Strengthening hospital management
- Strengthening training of primary health care personnel in disease management

3.4.4 Recommendations

The Work Group recommended that:

(a) A meeting be arranged with the Deaf Federation of South Africa (DEAFSA) to discuss the placement of sign language interpreters at public health facilities in order to ensure that these facilities become more accessible to deaf patients.

(b) The Directorate: Chronic Diseases, Disabilities and Geriatrics be requested to forward all information relevant to the involvement of the National Department of Health in the placement of sign language interpreters to DEAFSA.

(c) The Public-Private Partnership route as well as the Public-Public Partnership route be investigated as a possible means to solve the financing inequities between the public and the private health sectors.

(d) Quality of service within the public health sector be drastically improved and a monitoring and evaluation system be developed and implemented.

(e) The provincial departments of health investigate the possibility of establishing maintenance units at public health facilities to overcome the

problems caused by the Department of Public Works' maintenance backlogs.

(f) The next National Consultative Health Forum (NCHF) focus on specific aspects of health service delivery, examine issues and make specific recommendations

4. WAY FORWARD

In regard to the way forward with the four Work Groups the following emerged concerning composition, terms of reference and members.

4.1 Priority Health Programmes

4.1.1 Composition of the Work Group

(a) The delegates agreed that the work group would comprise but not be confined to, the following people:

- 3 officials from government departments
- 3 members of the organised civil society
- 1 member of the traditional health practitioners
- 1 member of an organised labour union
- 1 member of the academia
- 1 member of the private sector

(b) The delegates agreed that the work group would convene not more than four times before the National Consultative Health Forum (NCHF) of 2007.

(c) The national department of health will convene the first meeting and provide secretarial support. The meeting will then elect the chairperson and agree on a schedule for subsequent meetings.

4.1.2 The Terms of Reference

The Terms of reference were adopted as:

(a) Establishment of information network

(b) Building of sustainable relationships amongst the stakeholders

(c) Sharing of expertise

(d) Preparation of a discussion document, which will be presented at the NCHF of 2007

4.1.3 Membership

(a) Membership of the work group will be for a period of three years and will be subject to annual review.

(b) All organisations will be responsible for the funding or accommodation and travel expenses of their members serving on the work group

(c) The following delegates were elected to the work group

Mr Magic Nkwashu	Civil society
Ms Bukiwe Mapasa	Traditional Health Practitioners
Mr Sipho Mthathi	Civil society
Mr Garth Japhet	Civil society
Mr Chaka Masego a Leepo	Organised labour
Ms Zanele Mthembu	Government Department
Ms Vali Mthusi	Government Department
Prof Sanders	Academia

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4.2 Human Resources

4.2.1 Composition of the Work Group

No decision in this regard has been taken.

4.2.2 The Terms of Reference

(a) some professional organisations and bodies should be able to join the HR work group and in this respect the national department should identify those who would be participating as well as ensure that correspondence was maintained with those bodies and organisations; and

(b) the HR work group should meet again before September 2006 in order to start implementing the resolutions and proposals.

(c) There was agreement that the Terms of Reference were only guidelines and that they provided a framework for further discussion and engagement. Consultations would be held with relevant stakeholders before the next meeting of the HR work group. It was also recommended that -

- the health sector should first determine its HR requirements at district, sub-district and local levels before ensuring that adequate resources are available; and
- the Terms of Reference should be as clear as possible but should be able to be augmented.

(d) The Terms of Reference would advise on the following –

- Ensuring adequate resources to meet HR requirements
- Ensuring education and training of health care personnel
- Creation of new health professional categories

- Dealing with shortages of key skills and expertise
- Effective strategies on recruitment and retention
- Planning, development and management structures
- Ensuring availability of institutional capacity for training

4.2.3 Membership

Nominations for the Work Group membership were not made.

4.3 Policy and Planning

4.3.1 Composition of the Work Group

No decisions in this regard were made.

4.3.2 The Terms of Reference

(a) Working Group to facilitate consultation with other stakeholders with an interest in health issues.
(b) Explore possibility of funding for the whole group to meet ahead of each NCHF.
(c) Define relationship between Provincial Consultative Health Forums (PCHFs) and the National Consultative Health Forum (NCHF).
(d) Non-governmental Organisations (NGOs) working at national level should engage at national level.
(e) Next NHCF should focus on specific aspects of health service delivery, examine issues and make specific recommendations.
(f) Feeding intersectoral issues into the Social Cluster

4.3.3 Membership

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Howard Johnson	Parliamentary Researcher
Ansuyiah Padayachee	Private Health Care Group
Seipati Makunyane	
Mark Heywood	AIDS Law Project
Duane Blaauw	Centre for Health Policy University of the Witwatersrand
Kamy Chetty	DDG: Health Service Delivery (DOH)
Thulani Masilela	Director: Strategic Planning (DOH)
Louis Claassen	Director: Quality Assurance (DOH)
Damaris Fritz	Cape Metro Health Forum

4.4 Health Industry

4.4.1 Composition of the Work Group

Members 'should' come from -

(a) Civil society
(b) Pharmaceutical industry
(c) Medical technology and devices industry
(d) Hospital sector
(e) Government (DTI) and provincial government.

4.4.2 The Terms of Reference

(a) For the purpose of the first meeting concentrate on the shaping and describing the role of SA in terms of being a regional player focusing on.
    (i) South Africa as a regional player
    (ii) Strategic partnership issues
    (iii) Health tourism (including all its connotations)
    (iv) Issues that support constitutional order.
(b) The first meeting should be held within three months

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(c) The pharmaceutical industry, the medical technology and devices industry and the hospital sector should provide a draft position paper for the Work Group to debate as point of departure after which the government would give an overview from its perspective and the DTI in particular, in regard to -

(i) Where the country and the industry are going

(ii) How to get there

(iii) Determining and proposing the enabling mechanisms to get there.

4.4.3 Membership

Specific names were not identified.

5. CLOSING REMARKS BY THE DEPUTY MINISTER OF HEALTH, MS N MADLALA-ROUTLEDGE

On behalf of the Minister, the Deputy Minister, Ms N Madlala-Routledge, thanked all participants, including Deputy Ministers, Members of Executive Councils (MECs) Members of the National Assembly and the NCOP, councillors, traditional leaders, representatives of the civil society, including NGOs and CBOs, organised labour, traditional healers, academics and researchers and government officials.

She thanked the Minister in *absentia* for the leadership she has given in establishing this Forum. She furthermore, congratulated the Director-General and the organising committee for a job well done.

She requested members, that as they depart they need to recognise and acknowledge the importance of dialogue among various sectors to strengthen democracy especially on health issues as they affect all the citizens of the country. The past few years have seen so many successes in the health sector such as the unification, integration and

transformation of health services, the move from a curative to a preventive health system and the building of a district health system.

The challenges the country was dealing with, such as migration of health workers, are not unique. Many developed and developing countries have similar problems. Together with the development of programmes and plans such as the Human Resources for Health Plan, which is one of the top priorities of the department, there are some corrective measures that are being implemented to ensure that the best services are delivered to our people while looking after the well being of our health personnel. The duty now as Department of Health, is to ensure that what have been achieved in past two days, filter through the National Health Council led by the Minister.

After wishing all participants a safe journey home the Deputy Minister closed the meeting.