REFORMING HEALTH CARE

AgangSA’s Plan to Support Universal Access to Health Care, Improve Health Care Facilities and Services, and Enhance Performance Management in the Health Sector in South Africa
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1. Introduction

Years of mismanagement have created a healthcare system that is failing our citizens. Health outcomes are dismal and in many cases have gotten worse, human resources are insufficient and clinics and hospitals cannot even count on basic supplies and infrastructure being available. The public sector, in particular, is in critical condition. It is starved of health professionals; the district health and primary care system does not work; hospitals are mismanaged; patients and staff cannot count on drugs and supplies to be available; and patients suffer long waits and poor service. Poor management, corruption of tender processes, poor coordination of care, lack of accountability and lack of authority to improve things locally are all to blame for the dismal performance of the public health system.

Unsurprisingly within this context, in the past 20 years life expectancy has decreased; HIV infection rates have skyrocketed; and in many other areas like tuberculosis (TB), and infant and maternal mortality, our outcomes are more like the poorest countries than our middle income peers. South Africa spends more on health than any other middle income country as a percentage of gross domestic product (GDP), but consistently records inferior health outcomes.

Yet, while most South Africans are suffering, our politicians do not. They and their families use the world class private sector system that more than 80% of South Africans can only dream of accessing. There are currently two vastly disparate healthcare systems operating in South Africa, with the healthcare system available to the rich and that accessed by the poor characterised by very different levels of quality and service. This two tier healthcare system is a betrayal of our values. Every South African has a right to quality healthcare irrespective of where they live, their employment status or level of income. Universal access to healthcare is the only sustainable and just way to provide healthcare in South Africa.
2. The Current State of the Health Sector in South Africa

In 1994, the newly elected democratic government in South Africa inherited a health system facing considerable challenges. The legacy of apartheid – which was marked by racial and gender discrimination, the entrenchment of the migrant labour system, vast income inequalities and the fragmentation of healthcare services – had a deleterious effect on the country’s health indicators. In particular, the apartheid system’s role in the impoverishment of the majority black population had a notable impact on the health of black South Africans and has contributed to the very high burden of poverty-related diseases. At the same time, under apartheid the highly skewed distribution of infrastructure and financial and human resources between geographical areas, and inequities in the levels of care undermined the quality of healthcare services available to the majority of South Africans.

Since 1994, some progress has been made towards addressing South Africa’s health challenges. Important policy and legislative changes have seen the introduction of free primary healthcare, an essential drugs programme, anti-tobacco legislation and improvements in the availability of human resources in the public health sector through the introduction of community service for graduating health professionals. These changes have been accompanied by an increase in the number and range of healthcare programmes, particularly within the realm of primary healthcare.

Efforts to restructure and rationalise the public health system have led to improvements in health systems management and healthcare innovations, particularly at the district and local levels. These improvements have resulted in a more equitable distribution of district healthcare expenditure, increases in the number of clinics and hospitals, and advances in immunisation and disease control programmes. The introduction of a district-based health system has meant that healthcare services are better tailored to local conditions and has facilitated a more
geographically equitable distribution of resources. At the same time, improvements in disease management – particularly related to HIV/AIDS and tuberculosis— have been achieved by enhancing access to condoms, scaling-up antiretroviral treatment (more than 500 000 people were on antiretroviral treatment in South Africa in 2009), and expanding initiatives to control TB.

Despite this progress, nearly two decades since the end of apartheid, South Africa’s health system continues to underperform. The existing public health system is weak at almost every level, with the level and quality of public health services often falling short of acceptable standards. The inadequacies in the public health system have played an important role in contributing to South Africa’s poor health outcomes. The country has experienced substantial increases in mortality and morbidity rates despite relatively high levels of healthcare expenditure and a progressive and support policy environment. In the post-apartheid era, South Africa’s progress towards the achievement of the Millennium Development Goals (MDGs) has been poor. Average life expectancy at birth in South Africa has fallen considerably since 1994, from 62 years during apartheid to just 50 years for men and 54 years for women in 2001 and in 2011 better at 57 years for men and 60 years for women. South Africa’s share of the global burden of disease is disproportionately high given the size of the population.

In the past two decades, South Africa’s health system has come under major strain as a result of the convergence of a number of health challenges. At the top of the list of challenges has been a substantial increase in the burden of disease related to HIV/AIDS. Today, more than 5.7 million South Africans (representing 12% of the total population) are infected with HIV. South Africa is home to the highest number of people living with HIV/AIDS in the world, accounting for 17% of the total global HIV/AIDS disease burden. The country has also experienced a sharp increase in reported cases of TB, which rose by 134% between 2000 and 2007 on
the back of low treatment success rates. Furthermore, child and maternal mortality rates have increased in South Africa since 1990, while equivalent rates in comparable peer countries have declined. One study conducted between 2005 and 2007 found that around 60% of maternal deaths in South Africa were avoidable, with 55% of these deaths attributable to failures in the health system.

High levels of violence and injury which manifest in high mortality and morbidity rates only compound the problem. Taken together, these health challenges impose a considerable burden on what is already a weak, underdeveloped and under-resourced public healthcare system.

The weaknesses in the public health system are manifold. In broad terms, these include poor administrative management, low staff morale (especially among nurses), a lack of funding and poor resourcing (particularly in public hospitals), an on-going brain drain, failures of leadership in combating the HIV epidemic, poor strategic decision-making, insufficient political will to address the underperformance of the public health sector, capacity limitations at every level, and deficiencies in the implementation and monitoring of public health policies and programmes.

Weak health systems management has contributed to poor quality health service provision. This is particularly evident in the district health system, where weak central stewardship has affected the establishment and operation of the system at the local level. More generally, operational inefficiencies, low morale among health workers, insufficient delegation of authority, inadequate leadership and innovation and a lack of accountability have all affected the quality of care provided in key health programmes.
Massive inequities in health indicators continue to persist in South Africa. For instance, disease and mortality rates differ vastly between racial groups. National HIV prevalence rates of 0.6% and 1.9% among whites and Indians respectively contrast sharply with the 13.3% prevalence rate within the black population. Back in 2002, infant mortality rates were as high as 67 per 1,000 people in the black population, compared with 7 per 1,000 whites. There are also vast gender differences in health indicators – the mortality rate, for instance, is 1.38 times higher for men in South Africa. Furthermore, there is evidence of sharp inequities in health outcomes across and within the country’s nine provinces.

These inequities extend to health expenditure and resource allocation between the public and private health sectors. Resources and healthcare expenditure are heavily skewed in favour of the private sector. As much as 48% of total health expenditure occurs in the private sector, which provides health services to just 16.2% of the South African population. In turn, a similar level of expenditure in the public sector covers 84% of the population. This represents a highly inequitable pattern of healthcare spending in relation to healthcare needs.

The inequities between the public and private sector are also evident in terms of medical personnel. The public health system is severely constrained by shortages of healthcare professionals, particularly at the district level. The number of doctors and nurses in the South African public health system is well below the benchmark of 230 per 100,000 people which the World Health Organisation (WHO) regards as necessary to achieve the MDGs related to health. At present, one doctor serves more than 7,000 people in the public sector in South Africa. The shortages in medical personnel, together with the poor skills of many health workers, has compromised the delivery of important health programmes and interventions related to HIV/AIDS, TB, child health, maternal health and mental health.
As a result, the differences in the quality of healthcare provision in the public and private sectors are stark. While South Africa’s private health sector is ranked in the top six in the world (and above developed nations such as the United States, Canada and Germany), the country’s public healthcare system was ranked seventh worst in the world at one point. Overall South Africa’s health system ranked 175th out of 190 countries in the WHO ranking of health systems in 2000. The persistence of this highly inequitable, two-tiered healthcare system is inconsistent with the rights of every South African to receive quality healthcare irrespective of where they live, their employment status or their level of income.
3. AgangSA’s Health Policy Approach

3.1 Principles to govern the health sector in South Africa

AgangSA’s vision of a vibrant, efficient and effective health sector in South Africa is grounded in the following principles:

- Universal access to quality health care for all South Africans, irrespective of where they live, their employment status or their level of income.
- A people and family centred health system that is respectful and ethical.
- Shared responsibility for the health of all South Africans and the success of the health care system.
- Transparency and accountability in the management of the health care system.
- A health system that values and respects our health care professionals and enables health professionals to give their best.
- A health system that promotes primary and preventative health care instead of hospital-centred care.
- A health system that is in line with South Africa’s Constitution and AgangSA’s principles of democracy, good governance and building a better South Africa.

3.2 National Health Insurance

3.2.1 The importance of National Health Insurance

Countries across the world are faced with the challenge of ensuring access to quality healthcare for their citizens. This has prompted the introduction of a range of government initiated healthcare reforms designed to ensure that all citizens,
regardless of their financial status, have access to healthcare. A great deal of focus in this regard has gone towards ensuring that unemployed or uninsured citizens are not denied access to healthcare services.

South Africa’s public healthcare system is currently stretched to the limit, both in terms of human and financial resources. In contrast, the private sector affords access to excellent healthcare infrastructure (for the insured and the wealthy) but there is no guarantee of quality and accessing private healthcare services is extremely expensive (and beyond the means of many South Africans). The result is the juxtaposition of a very sophisticated and world-class private healthcare system with a public healthcare system that is in constant danger of grinding to a halt.

Within this context, the principal objective of the National Health Insurance (NHI) is to guarantee access to healthcare for indigent citizens and the uninsured. Despite this positive intention, the framework through which this will be achieved, and the manner in which the current healthcare system will fit into the NHI’s broader vision, remain sources of considerable debate.

3.2.2 Critique of the existing National Health Insurance proposals

The Green Paper on NHI expresses the need to capacitate primary care in South Africa. However, despite its admirable intentions, the practicalities of its design and implementation are fraught with problems. The costs outlined in the Green Paper are simply extrapolated from the current situation in the private sector and the government has become preoccupied with ‘improving’ hospital management, while placing insufficient focus on primary healthcare (PHC). In terms of the latter, the government has published the PHC Re-engineering Guidelines. The value of school health care services and PHC outreach teams has been undermined by a lack of managerial accountability within the current DHS system.
At the same time, the Department of Health (DoH) has failed to take on board pertinent lessons from the experiences of the National Health Service (NHS) in the United Kingdom and Family Health Teams in Brazil. Instead, the implementation of DHS is increasingly influenced by electioneering and politically linked community health workers. There is evidence to show that some community health workers simply go from door-to-door referring patients to clinics that provide unsatisfactory levels of service. As a result, patients often make the decision to avoid using public healthcare services altogether.

The detail provided in terms of the focus and emphasis on types of care and healthcare services in the NHI proposal is inadequate. For instance, there seems to be a lack of provision for mental healthcare within the NHI district specialist teams (which include a family physician, gynaecologist, paediatrician, midwife, PHC nurse and anaesthetist). In addition, the DoH has not identified or specified what should be considered to be basic health services or emergency healthcare. Defining what health services should be in the basket of care provided for by the NHI is an important part of the discussion.

There are also issues related to the accessibility of the NHI. The Green Paper notes that only legal residents with an identity document (ID) will be able to access healthcare services. However, the high number of illegal immigrants in South Africa – which are estimated to account for between 10-20% of users of public healthcare services – is likely to be problematic. Healthcare professionals cannot be expected to deal with illegal immigration and turn patients away based on their residency status. Furthermore, when illegal immigrants cannot access regular preventative healthcare due to the NHI rules, they will end up burdening the health system even more when they finally attend a hospital in a very ill state and end up costing the state more in emergency care than preventative care would have
cost. At the same time, illegal immigrants that do not have easy access to care pose a public health risk.

Finally, there is a need for further consideration of issues related to the inclusion of community health workers (CHW) as part of the primary health team. At present, CHWs do not have a regulatory body and, while training is available for CHWs, they are not subject to a regulatory council like the Health Professions Council of South Africa (HPCSA) or Nursing Council. Another problem with the current system of CHWs is that of high turnover arising from the reality that they are often young people with poor levels of education who are working as CHWs as a “stop-gap” while they wait for another job. This undermines the development of relationships between patients and CHWs that is a critical aspect of effective primary care.

3.2.3 AgangSA’s approach to National Health Insurance in South Africa

AgangSA supports universal health care access through the NHI. Access to health care is a human right under our Constitution and, therefore, South Africa should move towards universal access to health care.

This also has implications for the way that illegal immigrants and undocumented citizens are accommodated within the health care system. The right to health is a universal right and health professionals cannot deny medical care to undocumented persons (who may include South African citizens who do not have an ID). Instead, the problem of illegal immigration must be dealt with by the government in a more effective manner in order to prevent the burden on the public sector (or future NHI system) and not place health care workers in a moral predicament.
Unfortunately, in the foreseeable future there is no way that the public sector is going to be ready to deliver universal coverage of healthcare to all South Africans. First and foremost, modern healthcare requires a solid and well-functioning PHC system that has a doctor available at the first point of care. Access to a general practitioner (GP) and team is crucial. The current public healthcare system in South Africa does not revolve around doctor-based PHC and is, instead, a nurse-driven clinic system. The delivery of a primary physician-driven system will require the involvement of GPs who are currently involved in private practice. It will also require the recruitment of many more doctors from other countries. To this end, public-private collaboration in the delivery of healthcare is imperative and unavoidable.

In this respect, we believe that it is necessary to differentiate between the NHI as a financing mechanism and a national health service, which is public service. While we are in favour of the NHI as a financing mechanism, it does not mean that the provision of healthcare under the NHI needs to come from public service facilities; instead it could be provided through a mix of public and private service providers. Indeed, we believe that primary care under the NHI primary care system should be driven predominantly by private GPs in charge of a multiple disciplinary team of nurses and CHWs.

According to the District Health Barometer, in 2010/2011 total health expenditure in South Africa amounted to R110 billion. In turn, total expenditure on PHC amounted to R45.1 billion, with this sum covering an uninsured population of 41 million people. This equates to R1100 per capita in South Africa (ranging from R2064 in rural settings to R739 in urban areas). A study of GPs has shown that they could provide services at almost the same price as that in the existing metropolitan health districts. Furthermore, they can do so based on a practice list (10000) that exceeds international standards (1500-3000), with additions to their
team including nurses that manage risk proactively given adjustments based on utilization.

Capitation could be implemented from a simple starting point of R1500 pa for basic solo GP/PHC ambulatory services (with formularies), and progress upwards to include a greater number of services at higher levels – for example, R3000 pa including multidisciplinary/specialist ambulatory services. This figure is in line with current Medical Aid Scheme credits, which stand at R3000 pa. For 40 years, this was the method of implementation followed by the NHS in the UK, before the Labour party implemented performance management. All providers, including GPs and current DHS clinics (deemed ready by DHS), should go through basic accreditation for the NHI.

This system would need to be backed by performance management which maintains some of the capitation at risk, based on clinical indicators and patient satisfaction. Referrals can be managed at a more comprehensive level after data emerges from pilots. The fee for service can be implemented for specific extras (such as day hospital procedures). This need not threaten the current public service or the private sector. The entire process can be implemented in stages. Years 1 through 5, for instance, could target 10 million people pa (providing a simple clinic service), starting at R15 billion in Year 1. Professionalism and peer review can be built in more reliably as a regulatory approach in the contracting of GPs.

The costs of implementation for the South African uninsured population of 41 million at R1500 - R3000 pa amount to between R67 billion and R123 billion (50% of the budget mentioned by the national DoH) by Year 10 (without adjustment for inflation). Importantly, the costs of higher-level private and public health care could potentially decline considerably as the NHI PHC system improves over time.
Finally, with respect to CHWs, AgangSA believes that if the NHI and PHC re-engineering process is dependent on CHWs to improve preventative healthcare then careful consideration would need to be given as to how to make the work of CHWs more meaningful and rewarding in order to retain them. To this end, there needs to be vocational respect and career development for CHWs.

3.3 Public health facilities and resources

3.3.1 Current problems with public health facilities and resources

South Africa’s public health facilities are in dire straits due to poor management. The primary problem in the public sector is not a lack of resources but poor management of resources. South Africa spends 8.3% of total GDP on health but health outcomes are considerably poorer relative to the amount expended in comparison to our peers. As the NHI Green Paper noted in 2011:

“The 8.3% of GDP spent on health is split as 4.1% in the private sector and 4.2% in the public sector. The 4.1% spend covers 16.2% of the population (8.2 million people) who are largely on medical schemes. The remaining 4.2% is spent on 84% of the population (42 million people) who mainly utilize the public healthcare sector.”

The total of 8.3% of GDP is higher than average expenditure by other upper middle income countries (which was around 6% of GDP in 2011). For their part, lower middle income countries spent, on average, 4.3% of GDP on health in 2011—which is very similar to the percentage of GDP spent on health in the public sector (4.2%) in South Africa. In terms of health outcomes, average life expectancy for upper middle income countries is 72 at birth and for lower middle income countries the life expectancy at birth is 64. By comparison, in South Africa life expectancy at birth was just 58 years in 2011.1 Furthermore, the Institutional

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1 However, it is important to note that the median age of death in South Africa was 43 in 2007 at the peak of the HIV epidemic and the DoH has done very well to improve it since then.
Maternal Mortality Ratio has increased overall and in every level of care when compared with 2005-2007. According to a report published by the National Committee for Confidential Enquiry into Maternal Deaths in 2012, “maternal deaths due to obstetric haemorrhage and hypertension were thought to be possibly and probably preventable in 81% and 61% of cases respectively”. Even if only the percentage of GDP spent on the public sector is considered and compared to lower middle income countries, it is clear that we are not getting adequate health care for our money.

Poor management of public health care facilities and a lack of accountability in the public sector are largely responsible for these suboptimal health outcomes. Another major problem is the lack of retention of health professionals in the public sector. According to a report released by Human Resources for Health in 2011, attrition from health care professions in South Africa is estimated at around 25% per annum. Poor career prospects, problems related to organizational culture and poor management are prominent reasons for the high attrition rate from the public sector.

While all developing countries lose health professionals, the situation in South Africa is worse than in our fellow African states. Results from a study by Blaauw et al. (2013), indicated that 52.1% of health workers in South Africa were satisfied with their jobs compared to 71% from Malawi and 82.6% from Tanzania. The same study found that 18.8% of health workers in Tanzania and 26.5% in Malawi were actively seeking employment elsewhere, compared to 41.4% in South Africa.

At the same time, recruitment of foreign health professionals is also a problem. This is due, in part, to the reality that the government only recruits health professionals from countries with which South Africa has an existing bilateral agreement.
3.3.2 AgangSA’s approach to improving health care facilities and resources

We believe that improvements to the existing management and organisational culture within the public health sector in South Africa are necessary to increase the retention of health professionals within the system. In the case of nurses, for example, there is a need to address issues related to poor working conditions, long and inconvenient working hours, uncompetitive salaries and limited professional development opportunities.

We also believe that new approaches to the training of health professionals are required. This is particularly relevant with respect to the training of foreign doctors and other foreign health professionals, which is currently undertaken overseas (for example, in Cuba). We believe that the training of foreign health professionals should rather be undertaken within South Africa.

3.4 Health care service provision in rural areas in South Africa

3.4.1 Current problems with healthcare service provision in rural areas

Rural patients face a range of difficulties in accessing healthcare within South Africa. For instance, a lack of transport to health care facilities is a major barrier to access to healthcare services in rural areas. That said, the difficulties faced by patients go far beyond transport, with a number of socio-economic factors playing a role in rural health settings.

Perhaps most pertinent is the reality that rural areas in South Africa suffer from an Infrastructure-Inequality trap. This refers to the situation in which areas with
greater existing healthcare capacity tend to attract greater healthcare expenditure; a disparity that may become even more pronounced under the NHI system.

3.4.2 AgangSA’s approach to improving healthcare service provision in rural areas

AgangSA believes that a multi-sectorial approach to rural healthcare is required. This must include measures to generate improved contact with healthcare workers and to enhance patients’ accessibility to health workers. More generally, there is a need to investigate the unique needs of rural healthcare and bring the specific challenges of rural healthcare into the broader healthcare debate.

Echoing some of the proposals made by Rudasa and partners (2011) in their submission on the NHI, AgangSA believes that the following issues must be addressed to improve the accessibility and quality of healthcare service provision in South Africa’s rural areas:

- Reverse the existing Infrastructure/Inequality trap.
- Address the main social determinants (including transport) of access to healthcare in rural areas.
- Lure sufficient human resources to rural areas.
- Design measures to improve rural healthcare through in-depth consultation with communities, health workers and activists.

We also believe that private healthcare providers have a valuable role to play in rural healthcare provision. With a NHI system in place, private GPs operating in rural settings would have enhanced income generating opportunities (as the number of patients that can afford private fees is significantly smaller in rural areas). If rural GPs are able to earn a good living and, through hard work and dedication to good clinical care, grow their patient base and subsequent income
then they are more likely to stay in a rural area. Furthermore, participating in a solo or group practice would create a sense of autonomy and ensure that GPs feel that they are able to control their working conditions – thereby alleviating potential ‘push’ factors out of the public sector. Private GPs that are able to admit patients to public hospitals and follow their patients could add further value to rural healthcare. In this respect, private GPs could form an important part of PHC provision. Rural GP practices will also employ nurses and CHWs, which creates jobs. Long term commitment to the community, stemming from the personal financial risk that private GPs have taken on in starting a small practice, may also lead to better relationships with patients and enhanced health outcomes in comparison to public clinics that are staffed by community service doctors or foreign doctors all employed on short term contracts.

Making such a system work will require a close relationship between district specialist teams and both district hospital health professionals and rural healthcare providers.

3.5 Performance management in the health sector

3.5.1 Current problems with performance management in the health sector

At present, performance management in the public health sector is extremely ineffective. The existing performance management system is not specific enough to the different roles of health workers and the process does not assist in retaining health professionals.

Furthermore, there is a potential conflict of interest within the accreditation system, with the DoH acting as both a service provider and the accrediting authority through the Office of Health Standards Compliance. This may serve to
undermine accountability. In the NHI proposals, for instance, there is no provision for local community input into health services, a situation which implies that the district health authority will only be accountable to the minister of health and sub-national NHI structures.

3.5.2 AgangSA’s approach to improving performance management in the health sector

AgangSA believes that the accreditation authority must be independent, transparent and fair. To this end, rather than the DoH, an independent body such as the HPCSA or the Council for Health Service Accreditation of Southern Africa should serve as the accrediting authority. We are also in favour of greater local accountability within the performance management system. For instance, we believe that there should be more local community involvement in the NHI. Finally, we stress the importance of using clinical outcomes as performance indicators.
4. AgangSA’s Plans to Reform the Health Sector in South Africa

In recognition of the varied challenges and problems confronting the health sector in South Africa, AgangSA has developed the following concrete plans to address these issues on an individual basis.

- **INCREASE THE NUMBER OF HEALTH PROFESSIONALS:** expand public and private training places; re-open nursing colleges; recruit and rapidly accredit foreign professionals; develop appropriate training sites (particularly in rural areas) for doctors within South Africa; and enable the private sector to train doctors in a similar manner to that in which nurses are trained by private nursing schools.

- **EXPAND LOCAL CONTROL:** stop central government bureaucracy from handcuffing the system and allow provincial and local institutions more authority as they show themselves capable. This will require:
  - Strengthening district health systems and building a functioning primary care system by supporting the integration and capacitation of local public, private and civil society actors.
  - Making public hospitals non-profit entities; helping them to raise donations and letting them enter into contracts so that they do not rely on slow government for basic maintenance and order processing.
  - Using the private sector to run our supply chains in order to stop corruption and ensure that drugs and supplies are available in our clinics and hospitals.
• **MAKE PERFORMANCE TRANSPARENT:** define a comprehensive performance management framework and publish performance down to institutions so that the public can hold all levels of government accountable.

• **INCREASE PRIVATE SECTOR ACCESS:** contract certain services for public patients; provide tax incentives for private providers to work in the public sector; and let the private sector run some public assets.

• **TURN AROUND HEALTH OUTCOMES:** expand the war on HIV; aggressively tackle neglected areas of TB, as well as maternal and child mortality.

• **RECONCEPTUALISE THE NHI:** strengthen district health systems and build a functioning primary care system by supporting the integration and capacitation of local public, private and civil society actors.
  - Effectively integrate private actors into district health systems through the establishment of independent health teams run by private GPs and funded through health insurance. These health teams will be incentivized to follow up with patients through teams of CHWs. For their part, CHW should be a trained registered profession and have a regulatory body.
  - Include one mental health practitioner in district health specialist teams to provide support to the primary health care providers in terms of mental health.

• **DRAMATICALLY IMPROVE RURAL HEALTH CARE:**
  - Incentivize rural private practitioners though higher capitation amounts and clinical outcome measures for performance bonuses which take the complexities of rural health care into account.
- Enable a larger number of doctors to train as family physicians by, for instance, increasing the number of family medicine registrar posts in rural facilities and allowing private GPs to train as family physicians through distance learning and doing supervised sessions in government hospitals without the need for doctors to relocate to cities or urban areas. This will increase retention of staff in rural areas by enhancing prospects for career progression.

- Improve patient transport infrastructure by boosting the number of ambulances and other hospital patient transport options.

- Implement a needs-based budgeting approach to reverse the existing Infrastructure/Inequality trap.
Sources


