

**Revised Draft of the Health Charter  
Released by the Minister of Health  
28 October 2005**

**CHARTER**

**The Charter of the Health Sector of The  
Republic Of South Africa**

**CHAPTER ONE: FUNDAMENTAL PRINCIPLES**

**1.1 Opening Declaration**

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

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

The Parties acknowledge that it is essential to ensure the sustainability and efficiency of the health sector in order to achieve the transformation goals for each of the four key areas of access to health services, equity in health services, quality of health services and Broad Based Black Economic Empowerment.

The Parties further acknowledge the urgent need to effect transformation of the national health system in a co-operative, constructive and mutually beneficial relationship in such a manner as to reflect the diversity and meet the various health care needs of the total population of South Africa and recognise the important role of all stakeholders in achieving the objectives of access equity, quality and Broad Based Black Economic Empowerment.

This Charter includes in the scope of its benefits, the rectification of the injustices of the past and the restoration of the imbalance that was created between historically disadvantaged individuals and others.

**THEREFORE** the Parties -

**RECOGNIZING:**

1. That there is a legacy of apartheid in terms of which access to and distribution of health care and ownership of health care establishments was grossly inequitable and disadvantaged the vast majority of South Africans on the basis of their race, gender and economic status;
2. That there is an urgent and compelling need to effect transformation throughout the South African health sector in order to remedy the wrongs of the past;
3. That the government of the Republic of South Africa is mandated in section 7(2) of the Constitution to respect, protect, promote and fulfil the rights in the Bill of Rights;
4. That the government of the Republic of South Africa is mandated in section 27 of the Constitution to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the rights of access to health care services, including reproductive health care, sufficient food and water, and social security, including appropriate social assistance where people are unable to support themselves and their dependants;
5. That the rights in the Bill of Rights may be limited only in terms of section 36 of the Constitution;
6. Generally that the powers and functions, roles and responsibilities of the national, provincial and local spheres of government and of the legislature, the executive and the judiciary are as set out in the Constitution and that such powers and functions, roles and responsibilities may not lawfully be fettered or restricted by any other law, agreement or transaction;

7. That the government in 2004 passed the National Health Act No 61 of 2003 into law which is intended inter alia to remedy the inequities of the past in the distribution of health care and to create a national health system that is patient centred and for the good of all;
8. That it is the constitutional role and function of the national government of the Republic of South Africa to exercise executive authority by -
  - (a) implementing national legislation;
  - (b) developing and implementing national policy;
  - (c) co-ordinating the functions of state departments and administrations
  - (d) preparing and initiating legislation
  - (e) performing any other executive functions provided for in the Constitution or in national legislation;
9. That the national, provincial and municipal spheres of government have the power and the duty to deliver health services to the people of the Republic of South Africa and that an efficient and effective regulatory framework is necessary to counter adverse impacts on health care;
10. That within the context of paragraphs 1 to 6 of this Preamble, when read together with the Constitution and the laws made by the Government of the Republic of South Africa, the health sector, including the for profit private sector, the not for profit private sector, non-governmental organisations, employee organisations, statutory councils, academic institutions organisations, the public sector and other stakeholders have an important and meaningful role to play in –
  - (a) working together in a spirit of constructive, mutual co-operation and respect in order to fulfil the government's constitutional mandates;
  - (b) contributing to the health and wellbeing of the people of South Africa through the provision of products and services in accordance with internationally recognised and legally prescribed norms and standards, as the case may be, with the object of promoting, maintaining, preserving or restoring human health and wellbeing;

- (c) ensuring that the national health system remains financially sustainable in the long term and that products and services delivered provide value for money and are affordable and accessible;
- (d) conducting their business in a manner that it is ethical, honest, and fair and that satisfies the needs of consumers of health products and services while promoting a culture of compliance with professional ethical codes and avoiding any scheme, practice or arrangement which might be viewed as detracting from the general body of ethical frameworks as determined by various statutory health councils and in particular, refraining from :
  - (i) overservicing or over-charging consumers of health services;
  - (ii) exploiting healthcare professionals for ends which might contradict the ethical codes of those professionals;
  - (iii) interfering with the independence of practitioners in the practice of their professions in the best interests of their patients; and
  - (iv) providing or inducing or seeking to induce health professionals to engage in or receive perverse incentives or to in any way influence or prevail upon them to act contrary to the ethical codes as determined by their registering bodies.
- (e) ensuring the safety of consumers and the adequate protection of both people and the environment in the use of products and services that may be dangerous to health or life;
- (f) respecting and observing the right of consumers to information and to be protected against dishonest or misleading advertising and labelling;
- (g) accepting and respecting the power of consumers to choose from a range of products and services offered at competitive prices with the assurance of externally recognised and accepted standards of quality;

- (h) recognising the right of consumers to fair compensation for misrepresentations by providers of goods and services, for the failure of goods and services to adequately address the health needs of consumers and the failure to comply with externally recognised and accepted standards of safety, quality and efficacy;
- (i) ensuring that the rights of patients reflected in the Patient Charter as published by the National Department of Health are entrenched and that the Health Charter is implemented in a manner that is consistent with the Patient Charter.
- (j) upholding the rights of providers of health care products and services to human dignity, a safe working environment that is not detrimental to their wellbeing or to their psychological and bodily integrity;

***AND NOTING THE NEED:***

1. for stakeholders in the health sector to constructively engage in dialogue and discussion on health matters;
2. for the interests and views of the private sector to be taken into consideration by the government when introducing legislative and other reform;
3. for the rational and equitable distribution of health services in the Republic of South Africa;
4. to achieve the most effective, economic and efficient utilisation of resources within the health sector, including human resources, so as to adequately address the health needs of the greatest possible number of people in South Africa;
5. to establish a rational and consistent framework for public-private initiatives within the South African health sector within the parameters set by the Public Finance Management Act No 1 of 1999 and the regulations thereto. In this regard the Parties acknowledge that PPIs –

- (i) must be developed in accordance with a clear framework that allows for a thorough investigation of the case for each PPI, a sound and cost effective implementation and sufficient public reporting mechanisms;
  - (ii) must contribute to the overall sustainability of the national health system;
  - (iii) must contribute to promoting equity of access to primary care;
  - (iv) must contribute to promoting equity of access to affordable health care and strengthened public hospital care;
  - (v) must contribute to promoting equity in financing of health services;
  - (vi) must promote the full participation of users in the structures proposed by the National Health Act, including committees, hospital boards and district health forums.
6. to unite all Parties to the Charter to work together towards achieving the Charter objectives;
7. to remedy imbalances in the South African health system;

**AGREE -**

- 1. to create for South Africa a health system that is coherent, patient centred efficient, cost-effective and quality driven and which optimises the utilisation of public and private sector resources within the health system for the benefit of the entire population;
- 2. that the stakeholders must work together in a relationship of mutual co-operation, trust and respect in order to improve the scope, accessibility and quality of care at all levels of the health system;
- 3. to the undertakings and commitments reflected in this Charter with regard to each of the four key areas of transformation;

4. to uphold and give effect to the principles and the spirit of this Charter in the course of their activities as stakeholders within the South African Health Sector; and
5. that the weighting of various factors shall be in terms of a balanced scorecard that incorporates all of the areas of transformation outlined in this Charter;
6. that those elements of this Charter relating to Broad-Based Black Economic Empowerment will be read and interpreted in the light of the BBBEE Act and the Codes of Good Practice as issued and amended from time to time in terms of that Act;
7. to develop effective and efficient strategies to improve access to, quality of and equity in health services and to develop reasonable measures within available resources to effect transformation of the South African health sector.

## **1.2 DEFINITIONS AND INTERPRETATION**

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

“Access”	means having the capacity and means to obtain and use an affordable package of health care services in South Africa in manner that is equitable;
“Affirmative Procurement or Preferential Procurement “	means targeted procurement of commercial goods and services from persons disadvantaged by unfair discrimination on the basis of race, gender, disability or similar grounds;
“BBBEE”	means broad based Black Economic Empowerment as contemplated in the BBBEE Act;
“BBBEE Act”	means the Broad-Based Black Economic Empowerment Act No 53 of 2003;

“Beneficially Owned or Beneficially Interested”	in relation to a share or like instrument, shall include, without limitation, the right to receive dividends and capital distributions in respect of, and exercise the votes attached to, that share or like instrument;
“black aged people”	means black people who are also aged people as defined in the Aged Persons Act No 81 of 1967 as amended;
“black designated groups”	means black workers, black unemployed people, black youth, black aged people, black disabled people and black people living in rural areas;
“black empowered enterprise”	is one that is at least 25,1% owned by black persons and where there is substantial management control;
“black people” with disabilities	means black people who also satisfy all the criteria in the definitions of “persons with disabilities” set out in paragraph 5.1 of the “code of good practice on the employment of people with disabilities” (as amended or substituted from time to time) issued in terms of section 54(1)(a) of the Employment Equity Act No 55 of 1998;
“Black Enterprise”	means one that is at least 50.1% owned by black people and in which black people have substantial participation in the management control of the enterprise;
“black people”	is a generic term which means Africans, Coloureds and Indians;
“black unemployed people”	means black people who are unemployed, are not attending or required by law to attend an educational institution and who are not awaiting admission to an educational institution;
“broad-based black	means the economic empowerment of all economic

empowerment”	<p>black people including women, workers, youth, people with disabilities and people living in rural areas through diverse but integrated socio-economic strategies that include, but are not limited to-</p> <ul style="list-style-type: none"> <li>(a) increasing the number of black people that manage, own and control enterprises and productive assets;</li> <li>(b) facilitating ownership and management of enterprises and productive assets by communities, workers, cooperatives and other collective enterprises;</li> <li>(c) human resource and skills development;</li> <li>(d) achieving equitable representation in all occupational categories and levels in the workforce;</li> <li>(e) preferential procurement; and</li> <li>(f) investment in enterprises that are owned or managed by black people; (definition from BBBEE Act No 53 of 2003);</li> </ul>
“Charter”	means the Charter for the South African health sector;
“coherent”	means rationally co-ordinated and unified;
“Company””	means a legal entity registered in accordance with the laws of the Republic of South Africa for the purpose of conducting business;
“Control”	means the right or the ability to direct or otherwise control the majority of the votes attaching to the shareholders’ issued shares, the right or ability to

appoint or remove directors holding a majority of voting rights at meetings of the board of directors, as well as the right to control the management of the enterprise;

“cost-effective” means a ratio between cost and efficacy with regard to expenditure such that within any given circumstance, optimum and demonstrable benefit is derived through the most efficient utilisation of the resources required to create that benefit;

“direct ownership” means ownership of an equity interest together with control over voting rights attaching to that equity interest;

“discretionary expenditure” includes all optional expenditure to acquire goods and/or services, including capital expenditure, that is not non-discretionary;

“discrimination” means discrimination as defined in the Promotion of Equality and Prevention of Unfair Discrimination Act (2000);

“Economic interest” means a member's entitlement to receive any payment from an enterprise which arises by virtue of the member's holding an equity interest. Economic interest specifically includes any entitlement of a member to receive any payment consequent to the winding up of an enterprise. Economic interest excludes entitlement to receive payment pursuant to the member's status as an employee within the enterprise or as a supplier to the enterprise, unless such payments are not market related, or are without commercial rationale or are intended to achieve a circumvention of the provisions of the BBBEE Act or the Codes of issued in terms thereof. Terms and concepts analogous to economic interests include, but are not limited to:

- (a) a shareholder's entitlement to payment of the dividends of a company limited by shareholding, or their entitlement to the dividends of a co-operative society,
- (b) a partner's entitlement to share in the distributions of a partnership, and
- (c) a beneficiary's entitlement to share in the distributions of a trading trust.

“efficiency” refers to both technical and allocative efficiency which are defined as follows –

- (a) technical efficiency means maximising health service outputs at the lowest possible cost while maintaining quality of care;
- (b) allocative efficiency means the distribution of limited resources between different types of services to maximise health outcomes (health status improvements);

“emergency medical treatment” means treatment as contemplated in section 27(3) of the Constitution (Act 108 of 1996);

“Employment Equity” has the meaning ascribed to it in the Employment Equity Act (Act No 55 of 1998);

“enterprise” means the person(s) conducting a business, trade or profession in the Republic of South Africa and recognised in terms of the laws of the Republic of South Africa, whether such enterprise is incorporated or not;

“Enterprise Development” means investment (financial or non financial) in, and/or development of and/or joint ventures with black owned or black empowered enterprises, SMMEs, and/or communities with real economic benefit flowing to the recipient enterprise allowing it to be set up and run on a sustainable basis;

“Equity” (in the context of access) in the context of access to the national health system means the fair and rational distribution of an affordable package of quality health care services to the entire population of South Africa, irrespective of patients’ ability to pay for such services and irrespective of their race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language or birth; and ‘equitable’ has a corresponding meaning;

“Equity” (in relation to enterprise) in relation to any form of enterprise, means the capital invested in that enterprise in respect of which members have a claim against the enterprise or against the other members of that enterprise by reason of holding an equity interest. Analogous terms and concepts include, but are not limited to:

- (a) issued share capital in a company limited by shareholding or share capital in a co-operative society,
- (b) the total of members’ interests in a close corporation, and
- (c) the total interest of all of the partners in a partnership; and
- (d) and the total capital value of a trading trust or of a sole proprietorship.

“equity interest” in relation to a member, means that portion of the equity which the individual members of an enterprise have as claims against the enterprise or against the other members of that enterprise, as the case may be, expressed as a percentage of the total equity in that enterprise. Specifically excluded from the definition of equity interest is a preference share, or a similar instrument or right, or that portion of debenture, similar instrument or right that represents debt. In addition, any

instrument or right that does not confer upon the holder thereof a right to participate in the economic interest of the enterprise, shall not be considered to be an equity interest. Analogous terms and concepts include, but are not limited to:

- (a) shares (or similar instruments conferring a right in respect of a company), in a company limited by shareholding, or shares in a co-operative society,
- (b) members' interests in a close corporation, and
- (c) a partnership interest in a partnership.

“exercisable voting right” has the meaning ascribed to it in Statement 100 of Code 100: Measurement of the Ownership Element of Broad Base Black Economic Empowerment issued in terms of the BBBEE Act;

“fronting” means any entity, mechanism or structure established in order to circumvent the BEE requirements as required under various policy instruments. Fronting structures generally claim a higher BEE status than the actual substantive economic benefits flowing to black beneficiaries would suggest. The claims can be in the form of direct ownership, human resource development and indirect ownership components as per the balanced scorecard;

“GDP” means Gross Domestic Product i.e. the market value of all final goods and services being produced within the borders of a country;

'harassment' means unwanted conduct which is persistent or serious and demeans, humiliates or creates a hostile or intimidating environment or is calculated to induce submission by actual or threatened adverse consequences and which is related to-

- (a) sex, gender or sexual orientation, or

(b) a person's membership or presumed membership of a group identified by one or more of the prohibited grounds or a characteristic associated with such group;

“health care personnel” means health care providers and health workers as defined in the National Health Act No 61 of 2003;

“Health sector” means natural persons and other entities involved in the provision, delivery or funding of health services in one or more of its aspects to people in South Africa;

“health services” means health services as defined in the National Health Act No 61 of 2003;

“independent practitioner” means a person who is qualified and authorised in terms of the Health Professions Act, 1974 (Act No 56 of 1974), the Nursing Act, 1978 (Act No 50 of 1978) the Pharmacy Act 1974 (Act No 53 of 1974), the Allied Health Professions Act, 1982 (Act No 63 of 1982) the Dental Technicians Act, 1979 (Act No19 of 1979) or the Traditional Health Practitioners Act, 2004 to own and operate his or her own professional practice;

“Junior Management” means the level of management below middle management and includes academically qualified workers who possess technical knowledge, skill and experience in their chosen field;

“key area” means one of the four key areas of the Charter namely access to health services; equity in health services, quality of health services or broad based black economic empowerment;

“Management” refers to representation on the governing body of the enterprise. Representatives of the governing body of the enterprise are those individuals who are involved in

the determination of the strategy of the enterprise as well as in the operational implementation of such strategy. This is the case regardless of whether or not the operational implementation of the strategy is delegated by management to one or more individuals who are not representatives of the board or similar governing body of the enterprise;

“management control”

means an ability to direct or cause the direction of the business and management policies or practices of the enterprise;

“Member”

(in relation to any form of enterprise), means a person having an equity interest in the equity of that enterprise. Analogous terms and concepts include, but are not limited to:

- a) a shareholder of a company limited by shareholding in a co-operative society;
- b) a member of a close corporation,
- c) a partner in a partnership,
- d) a beneficiary in a trading trust, and
- e) the sole proprietor in a sole proprietorship;

“Middle Management”

means the level of management below senior executive management and includes people who possess a high level of professional knowledge and experience in their chosen field;

“Narrow-based BEE”

means a set of transactions transferring corporate assets from white to black ownership;

“Narrow-based BEE status”

means the categorisation of companies and economic entities by their ownership and management status. These include but are not limited to:  
(a) “Black enterprise” defined as an enterprise or economic entity that is 50,1% owned by black

persons and where black management has majority control.

Note: Ownership is a term that bears the same meaning as defined in Statement 100 of the Code of Good Practice.

- (b) “Black empowered enterprise” is one that is at least 25,1% owned by black persons and where there is substantial management control by black people.
- (c) “Black influenced enterprise” is one that is at least 5,1% owned by black persons and where there is tangible influence by black people.
- (d) “Black engendered enterprise” is one with at least 25,1% representation of black women within the black equity and management portion.
- (e) “Community or broad-based enterprise” has an empowerment shareholder who represents a broad base of members.

“national health system” means the system within the Republic, whether within the public or private sector, in which the individual components are concerned with the financing, provision or delivery of health services;

“NGO” means any foreign or local body or association of persons, corporate or unincorporate, or any institution, the objects of which include or are one or more of the following—

- (a) the provision of all or any of the material, mental, physical or social needs of persons or families;
- (b) the rendering of assistance to persons or families in distress;
- (c) the prevention of social distress or destitution of persons or families;
- (d) the provision of assistance in, or promotion of, activities aimed at uplifting the standard of living of persons or families;

- (e) the provision of funds for legal aid;
- (g) the promotion and protection of human rights and good governance;
- (h) the promotion and protection of environmental rights and interests and sustainable development;

but does not include—

- (ii) any governmental or quasi-governmental organisation or institution whose legal status is that of an instrumentality or arm of any foreign government; or
- (iii) any institution or service maintained and controlled by the State or a local authority; or
- (iv) any religious body in respect of activities confined to religious work; or
- (vi) any body or association of persons, corporate or unincorporate, the benefits from which are exclusively for its own members; or
- (vii) any health institution registered under the Health Professions Act, the Pharmacy Act, the Nursing Act, the Dental Technicians Act, the Traditional Health Practitioners Act or the Allied Health Professions Act;

“NPO”

is a non-profit organisation that is not an NGO;

“non - discretionary expenditure”

means procurement spending where there is a natural monopoly, where there is no local supplier or procurement of items where the procurer is restricted by legal, technical, commercial or other limitations, including global agreements or procurement policies or where there is no local supplier or where concerns of patient quality of care and choice is the determining factor;

“Parties”

means the parties to this Charter;

“pillar”	means a sub area within a key area of this Charter. For example BBBEE is said to have seven pillars.
“PPI”	means a Public Private Interaction in terms of which one or more persons or entities involved in health care within the public sector interact with one or more persons or entities involved in health care within the private sector or the NGO sector with the object of achieving a mutual benefit or goal and includes but is not limited to a PPP; PPIs include: public financing of health services provided by the private and/or NGO sectors; private financing of publicly provided health services; innovative healthcare delivery models and business models for health practices; delivery models aimed at skill retention and effective distribution and utilisation of skills; use of public assets for the provision of health services by the private sector; use of private assets for the provision of health services by the public sector;
“PPP”	means Public Private Partnership as defined in Regulation 16 of the Treasury Regulations issued in terms of section 76 of the Public Finance Management Act, 1999 (Act 1 of 1999);
“PPPF Act”	means the Preferential Procurement Policy Framework Act No 5 of 2000;
“Private sector”	means persons and entities who are not within the “public sector” and includes NGOs;
“Procurement”	means all expenditure to acquire goods and or services including capital expenditure but excluding – <ul style="list-style-type: none"> <li>a non-discretionary expenditure;</li> <li>a. reinsurance premiums;</li> <li>b. commissions paid to financial intermediaries;</li> </ul>

- c. property and rental purchases (although property management is specifically included);
- d. expenditure classes covered elsewhere in the Charter eg salaries and wages (contract staff are regarded for this purpose as own staff and are excluded)
- e. procurement spending where there is a natural monopoly
- f. any items of procurement where the supplier is imposed in terms of global policy for technical (but specifically non commercial) reasons
- g. inter-entity charges for services rendered by other members of the group
- h. social investment expenditure and donations; and
- i. all VAT payable;

“Public sector”

means government departments, organs of state and institutions exercising a public power or performing a public function in terms of legislation;

“Quality”

is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Quality has a number of different dimensions:

- (a) Effective: delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- (b) Efficient: delivering health care in a manner which maximizes resource use and avoids waste;

- (c) Accessible: delivering care in settings and at times which are readily accessible to the communities served;
- (d) Acceptable: delivering care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
- (e) Equitable: delivering care which does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status;
- (f) Safe: delivering care which minimizes risks and harm to service users.

“Quality improvement” is a planned, systematic, organisation wide approach to the monitoring, analysis, and improvement of organisation performance, thereby continually improving the quality of patient care and services provided.

“replacement offering” means a contribution towards the attainment of a specified target reflected in the balanced scorecard that is equivalent in value to the specified target but that is located in a key area, or a pillar within a key area, other than that for which the target is specified with the objective of strengthening the public health sector.

“Senior Executive Management” means employees of an Enterprise who are appointed by or upon the authority of the Board of that enterprise to undertake the day to day management of that Enterprise and who have individual responsibility for the overall management and for the financial management of that Enterprise and who are actively involved in the development and/or implementation of the Enterprise’s strategy. Common examples of Senior Executive Management include without limitation, chief

executive officers, chief operating officers and chief financial officers;

“SETA” means a sector education and training authority established in terms of section 9 (1) of the Skills Development Act 97 of 1998;

“Skills Development” means the process of enhancing individuals’ specialised capabilities in order to provide them with career advancement opportunities;

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

“Social Investment” means investments and/or participation (financial and non-financial) by a person or business entity and/or an enterprise in a project that adds value to and uplifts one or more communities, thus facilitating socio-economic growth and development, with specific preference focus given to previously disadvantaged communities although such should not be to the exclusion of other needy communities;

“sustainability” means the progressive meeting of the needs of the present without compromising the ability of future generations to meet their needs with regard to those critical success factors that define and affect the viability of a particular enterprise over time as defined by stakeholders in such type of enterprise whilst ensuring timely access to quality health services;

“unfair discrimination” means any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly-

(a) imposes burdens, obligations or disadvantage on; or

- (b) withholds benefits, opportunities or advantages from, any person on one or more of the prohibited grounds: (Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 (Act No 4 of 2000));

“Voting Right”

(in relation to a member) is the level of control exercised by that member over the affairs of the enterprise. The voting right of a member is expressed as the percentage of the votes to which that member is entitled, over the total number of votes to which all members of that enterprise are entitled at a meeting of the members. Analogous terms and concepts include, but are not limited to:

- a) the percentage of votes held by a shareholder of a company or a cooperative society at a meeting of the shareholders;
- b) the percentage of votes held by a member of a close corporation at a meeting of the members; and
- c) the percentage of votes held by a partner at a partnership meeting.

“vulnerable groups”

means women, children, the poor, persons with disabilities, aged persons and persons suffering from debilitating illnesses;

### **1.3 SCOPE AND APPLICATION**

#### **SCOPE**

This Charter applies to and governs the conduct of:

1.3.1 Persons whose occupations, professions or businesses are governed by -

- The National Health Act No 61 of 2003
- The Medicines and Related Substances Act No 65 of 2003

- The Health Professions Act
- The Nursing Act
- The Dental Technicians Act
- The Pharmacy Act
- The Allied Health Professions Act
- The Medical Schemes Act
- The Medical Research Council Act
- The National Health Laboratory Services Act
- The Traditional Health Practitioners Act

1.3.2 Persons not covered by paragraph 1.3.1 who provide products or services, excluding housing, food and water and services relating to the supply of same, which are designed or intended to promote, maintain, sustain or restore the health of human beings including non-governmental associations other than foreign donor organisations, and non-profit organisations.

1.3.3 The National Department of Health and provincial health departments which must be distinguished from other stakeholders in that they exercise a stewardship role over the health sector and ensure the implementation of national and provincial government policy and law.

## **APPLICATION**

1.3.3 The Parties to the Charter include the public health sector, the private health sector, NGOs and NPOs, trade unions involved in the health sector, academic health institutions, representative associations within the health sector, statutory health councils and representative health consumer organisations.

1.3.4 This Charter is drafted in accordance with the provisions of the BBBEE Act and applies to all enterprises in the health sector. However, due to the varied nature of the health sector, the various forms of ownership and structures as well as varying sizes and functions (service, provisions, agency, funding, administration, etc) the following enterprises may contribute to varying degrees and in varying manners to the fulfilment of the Charter objectives to the extent as set out in this Charter and as agreed to by such constituents:

- a. SMMEs
- b. Independent professional practices
- c. State owned enterprises
- d. Not for profit entities (NPOs) and NGOs
- e. Foreign owned multinational enterprises
- f. Others subject to demonstrable barriers to fulfilling Charter requirements
- g. Sole proprietors

**A. SMMEs**

A1 SMMEs constitute 35% of the South African market for medical devices. Due to their relative size and lack of available resources, SMMEs may find it impossible to comply with some of the indicators as stipulated in the balanced scorecard. Any company that can demonstrate that compliance with the balanced scorecard will cause inherent commercial harm to its business is exempted from such compliance. This includes in particular, the targets for ownership as well as discretionary and non-discretionary procurement.

A2 Discretionary procurement is an issue as a major portion of products in the medical devices industry are imported.

A3 However the medical devices companies can make a contribution towards the objectives of the Charter whilst allowing for viable and sustainable operation in those enterprises. These can be offered in terms of funding, skills and time dedicated towards projects in collaboration with the public sector. The following are examples of replacement offerings that can be considered:

- (i) Skills development within the enterprise;
- (ii) Funding of training and development of health care professionals;
- (iii) Active participation in developing and executing PPIs.

**B Independent Professional Practices**

B1 Due to their relative size and the lack of available resources, independent professional practices will find it almost impossible to comply with some of the indicators as stipulated in the Scorecard. From a legal and ethical perspective

the implementation of non-discretionary procurement is a major challenge. Health professionals are bound by the ethical rules, rulings and policies of their statutory councils as regards corporate ownership and involvement. The contents of policy statements by their councils on perverse incentives and undesirable business practices are also restrictive concerning these issues.

B2 Any independent professional practice that can demonstrate that compliance with the balanced scorecard will cause inherent commercial harm to its practice, or is bound by legal and ethical rules which restrict its ability to comply with the requirements of the Charter, is exempted.

B3 However independent health professional practices can make a contribution towards the objectives of the Charter whilst allowing for viable and sustainable operation in those enterprises. These can be offered in terms of skills and time dedicated towards projects in collaboration with the public sector. Once again the rules and policies of the respective professional councils and boards differ on the extent of the latitude afforded health professionals when participating in educational campaigns, lectures at public forums, marketing practices and the like.

B3 The following are examples of replacement offerings that may be considered:

- (i) Skills development within enterprises;
- (ii) Patient education and information sessions;
- (iii) Active participation in the development of a defined set of benefits;
- (iv) Active participation in developing and executing alternative service delivery models (eg PPIs, session based services in public facilities);
- (v) Marketing of the profession in order to ensure increased interest in entering the health professions from previously disadvantaged groupings;
- (vi) Retention of locally qualified professionals.

## **C State Owned Enterprises**

C1. State owned enterprises are usually statutory bodies or entities created in terms of the Companies Act in consequence of a statutory mandate to do so. Ownership in such entities is restricted to the state in terms of legislation and

so state owned enterprises would not necessarily be able to comply with the BBBEEE ownership provisions of the Charter.

C2 Ownership of such enterprises by the state is usually for strategic reasons and is a matter of national policy and national interest. However, such enterprises can ensure that there is sufficient and appropriate representation of black people on the controlling bodies of such enterprises and that employment equity requirements are met.

C2 They could also comply with the procurement requirements of the Charter to the extent that these are consistent with the Preferential Procurement Policy Framework Act by which such enterprises are likely to be bound. The mandate of state owned enterprises to enter into PPIs and to commit to Corporate Social Investment and enterprise development programmes may be limited by statute but to the extent that the relevant law allows, they can undertake such initiatives in order to improve access, equity and quality with regard to health care services.

#### **D NPOs and NGOs**

D1 This group includes several private hospitals currently owned by the communities they serve and/or church affiliated organisations. Arguments similar to those for professional health practices and SMMEs apply to NPOs that are small health facilities such as hospitals and step-down facilities

D2 They are exempted from the provisions relating to equity and may instead utilise funds (including funds earned) by investing as an offset into the community, social investments and/or improved access.

#### **E Multinationals**

E1 Foreign owned multinationals face certain limitations in terms of the implementation of BBBEE with regard to ownership. These barriers are not unique to the health sector and are faced by all multinational enterprises owned by foreign concerns. The barriers faced by foreign owned multinational enterprises can be categorised into legal, cost, commercial, governance and others.

- E2 Other charters, notably the Information, Communications and Technology Charter, the Financial Services Charter and the Maritime Transport and Service Industry Charter have recognised this in the form of exemptions from ownership requirements. A code of good practice is still awaited from the Department of Trade and Industry on the subject of multinational enterprises.
- E3 The foreign owned multinational pharmaceutical and medical devices subsectors can contribute to the objectives of both the BBBEE Act and those of the National Department of Health through a series of replacement offerings. This contribution is over and above their full participation in all of the remaining six pillars of BBBEEE.
- E4 The foreign owned multinational subsector proposes a basket of replacement offerings in lieu of compliance with the ownership requirements of the Charter with regard to BBBEE. These replacement offerings can take the form of industry, sector, or individual enterprise initiatives.
- E5 The following principles will apply to multinational and other enterprises concerning replacement offerings and a replacement offering that does not conform to all of these principles will not be regarded as a replacement offering for the purposes of the Charter-
- (i) The enterprise demonstrates a true commitment to transformation of the health sector and to BBBEE;
  - (ii) Exemptions from ownership requirements in terms of BBBEE are applicable only to the extent of the demonstrable inability of the enterprise to comply and shareholding transfer requirements must be offset against equivalent acceptable replacement offerings;
  - (iii) A replacement offering must be rationally related to the objectives of the BBBEE Act and/or the charter requirements as regards access, quality and equity in health care;
  - (iv) The replacement offerings can be delivered by individual enterprises independently or jointly across a subsector.

- (v) A replacement offering may not be less than the value of the equity interest it seeks to replace calculated as at the date when the replacement offering is made;
- (vi) Replacement offerings must be based on a percentage of turnover guided by the Department of Trade and Industry Codes on BBBEE over at least a 10 year period;
- (vii) Proposals for replacement offerings must be accompanied by a business plan which includes provision for monitoring and evaluation of the implementation and efficacy of the replacement offering;
- (viii) Replacement offerings must strengthen or be supportive of the public health sector;
- (ix) Replacement offerings must be consistent with applicable national and provincial health policy;
- (x) Replacement offerings must be over and above current or existing corporate social investment and enterprise development projects and must not detract or divert funding away from such projects.
- (xi) Replacement offerings must support or advance one or more of the critical elements of the health sector strategy listed in paragraph 1.3.5 below

## **F The State**

The role of the public health sector is as stated in the National Health Act No 61 of 2003 generally but with particular regard to the functions and duties of the national, provincial and municipal spheres of government and the relevant departments of health.

The state exercises a stewardship role over the health sector as a whole. Its function is to provide constitutionally sound, good government through the development and implementation of law and policy, the monitoring and evaluation of compliance with such law and policy and the taking of corrective measures as and when necessary.

### **1.3.5 Critical Elements of the Health Sector Strategy**

- (a) A basic healthcare package that is guaranteed for all, including the indigent in both rural and urban areas. The package must cover all forms of care including primary tertiary and emergency services. Clear plans must ensure that the package is accessible to all South Africans in terms of both physical availability and affordability. These plans must spell out the burdens for the public system as well as the private sector, both for profit and not-for-profit.
- (b) Strategies to strengthen the public health system through improved management systems, a robust strategy for human resource development and retention and equitable and sustainable funding.
- (c) Acceleration of training and sustained output of healthcare professionals to improve staffing across the country and achieve racial equity.
- (d) A commitment to strengthening not-for-profit health care including the public health system, collectively or co-operatively owned institutions, clinics run by labour unions and bargaining councils, closed medical schemes and co-operative health insurance schemes.
- (e) Strategies to address basic health needs in an affordable way by providing an attractive option for lower and middle income households that preclude the manipulation of the health care market or the regulatory framework to force working people to pay more.
- (f) Proposals on training, staff development, retention and representivity in the private sector that are integral to the broader view of human resource development for the health sector.
- (g) Commitments to increase economic capacity and create jobs.

- (h) The sustainability of both the for profit and the not-for-profit private health sector
  
- (i) Programmes to eliminate stigmatisation of health conditions related to poverty such as tuberculosis, HIV and AIDS and health interventions such as termination of pregnancy.

## CHAPTER TWO: CHALLENGES

### 2.1 Access

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

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

- (i) relevant health policy;
- (ii) range of health services required;
- (iii) nature and type of health services required;
- (iv) necessary human and other resources and infrastructure;
- (v) need for communication and information concerning health services;
- (vi) other relevant factors specific to the particular community;

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

- (i) information relating to health and health services options to all patients, providers and employers in order to promote informed decision-making;
- (ii) information designed to address the health needs in particular of vulnerable groups, including elderly people, people living in rural and under-serviced areas, people with disabilities and the illiterate;
- (iii) information relating to the purchase of health insurance products (i.e. value for money, richness of benefits); and

(iv) information relating to quality of care (i.e. appropriateness, necessity, cost-effectiveness);

(v) information regarding health status, health needs of the population to assist in planning for complementary activities, eg, training and education programmes for health service providers and health workers.

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

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

2.1.6 A sustainability framework will be incorporated into all health care planning and decision-making processes across all areas. Such framework will include assessments of social economic and environmental impacts of healthcare programmes and undertakings. Such a system will draw together the key elements of access, equity and quality, within the boundaries of effectiveness and efficiency in order to ensure sustainability

2.1.7 The Parties will undertake research to identify barriers to access and equity and how these barriers could be addressed.

### 2.1.8 Human Resources

- (i) The Parties to this Charter hereby acknowledge that human resources are critical to adequate access to health services. Access to health services training is essential for the attainment of the Charter objectives. There is a need to ensure that historically disadvantaged individuals in particular have access to training or other institutions, for purposes of obtaining academic, or other training in all aspects of health services. The area of human resources in the health sector includes the development and retention of skills relating *inter alia* to – health financing, health systems management, manufacturing and distribution.
- (ii) There are currently shortages of health care personnel in a number of different areas. These include specialised nursing, general medical practice, specialised medical practice, clinical technology, pharmacy, radiology and pathology. If the skills necessary to ensure access to a basic minimum package of care and services are not maintained throughout the national health system then access is not achievable.
- (iii) A comprehensive analysis, involving tertiary institutions, must be undertaken to identify gaps in all the areas that relate to healthcare supply and service delivery, and that skills development and human resources targets in the health scorecard are set commensurately.
- (iv) Various sectors may also contribute to human resource development by participating in national projects and programmes that could enlarge the pools of available candidates for their specific sub-sector, whilst addressing specific South African health needs. In this regard comprehensive engagement with the various sub-sectors will be undertaken to facilitate participation in these types of initiatives.
- (v) There is no common baseline of information involving certain key parameters with regard to human resources. A baseline study is a fundamental step necessary to establish targets with regard to human resources within this Charter. There is currently inadequate benchmarking of salaries and conditions of service within the health professions or with regard to health care personnel generally.

- (vi) There are different salary ranges in the public and private health sectors which create significant disparities in human resources and incentive structures.
- (vii) A further challenge is to eliminate harassment at all health facilities and establishments since it undermines access to health services, the equality and human dignity of all and affects the availability of human resources to perform those services.

#### 2.1.9 *Financing*

- (i) Access to medical schemes is diminishing in real terms. Medical schemes provide financing for almost 7 million people but over the years membership figures have declined as a percentage of the general population. This is due in part to major increases in non-health expenditure by medical schemes on items such as administration and brokers' fees.
- (ii) While the exact figures may be disputed by some, the Parties are in agreement that there are significant financing inequities in the system that must be addressed. This is a complex issue that requires thorough investigation and research with the participation of all stakeholders. Recognition has to be given to the attempts by government, schemes and private healthcare stakeholders to increase membership numbers, including the Government Employees Medical Scheme (GEMS) and Low Income Medical Scheme (LIMS).
- (iii) There needs to be a greater urgency to expedite the development of a low cost medical aid package. The expansion of cover does not necessarily mean the broadening of the base for the private sector only as expansion of cover will be beneficial to and strengthen the public health sector.
- (iv) A key challenge to improving access would be to redesign medical aid benefit packages to ensure that they are not ill defined and underfunded and are transparent and understandable to medical scheme members.
- (v) Given that health care expenditure in South Africa was approximately R107 billion in 2003/4 equivalent to 8.7% of GDP in that year, and that this

compares favourably with many other countries in terms of percentage of GDP, there is a strong basis for arguing that the key challenge facing the national health system is not necessarily one of inadequate resources but inequitable and inefficient application of resources. Inequitable application of resources results in inadequate access for many. In 2003/4 medical schemes spent approximately R8 800 per beneficiary while in the public sector the figure was approximately R1050 for persons who were not members of medical schemes.

- (vi) There are geographical inequities in the provision of health care financing which is skewed towards the urban and private sector. This clearly affects access in the rural and public sector. The challenge is to find a way of providing health services that are affordable to people living in under-served areas. Whilst some health service providers are interested in meeting the needs in these areas, they are discouraged by the fact that it is difficult to find funding solutions both for themselves and their patients.
- (vii) A further challenge is that there is insufficient interaction between stakeholders in the health sector in the area of health financing and service provision.
- (viii) These are challenges which the Parties to this Charter will address by means of the strategies and targets set out in a chapter three.

## **2.2 Equity**

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

2.2.2 The package of health services should not be confused with-

- (a) the setting in which service-delivery takes place; or

- (b) the options available in the provision of such services and choices in terms of formularies and treatment guidelines; or
- (c) the contribution levels set for various packages of care; or
- (d) the prescribed minimum benefits set out in the Medical Schemes Act.

2.2.3 The set of defined benefits at its most basic level in terms of content and choice should be a safety-net for all. It should be at its very least provide a minimum acceptable standard of care.

2.2.4 “The minimum acceptable standard” must not be viewed from a cost perspective only but must strive for a balance between, efficacy and cost (i.e. value) within the boundaries of affordability. In considering the costs of offering the set of defined benefits, stakeholders should consider more than just direct medical costs but also other potential cost drivers such as direct non-medical costs (transportation, informal care, social services, etc) and indirect costs associated with poor health (i.e. reduced productivity, patient inconvenience, etc).

2.2.5 Even for a basic set of defined benefits, quality of outcome should be considered as paramount.

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

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

2.2.8 Health outcomes and life expectancy for the poor and medium income groups are generally worse than those for high-income groups due to inequity in

health services, nutrition, provision, access to socioeconomic services such as water, sanitation etc. The services to which the minority has access are far superior in terms of quality and quantity, to those to which the majority has access.

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

- (i) The lack of availability of a minimum defined basic package of health services to which everyone can have access irrespective of their ability to pay;
- (ii) Discrepancies in the quality of health services across different groupings within the socio-economic spectrum;
- (iii) To eliminate stigmatisation of persons by the broader community, health personnel and health establishments on the basis of health conditions, reproductive decisions or treatment choices;
- (iv) To eliminate unfair discrimination from within health establishments, the health professions, health services and the broader communities they serve.

2.2.10 *Human Resources*

- (i) The Parties acknowledge that the availability of human resources is central to the question of equity in health services between the public and the private sectors, between rural and urban communities and between historically disadvantaged individuals and those not historically disadvantaged. For this reason appropriate numbers of suitably qualified and trained health care personnel must be assured throughout the national health system. This is presently not the case.
- (ii) In order to be able to act in a rational and integrated way in relation to human resources one needs accurate information including projections, planning, negotiation and co-operation.

- (iii) Harassment also impacts on equity in the national health system since it is unwanted conduct which is persistent or serious and demeans, humiliates or creates a hostile or intimidating environment or is calculated to induce submission by actual or threatened adverse consequences.

#### 2.2.11 *Financing*

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

- (iv) In the private sector membership of medical schemes has become increasingly unaffordable thus widening the gap between the high-income group and the middle-income group in terms of equitable access to health care. Medical scheme membership has decreased in absolute terms and has declined as a percentage of the population. This is due in part to rapid increases in expenditure on private hospitals in the late 1990s and early 2000s. Another area of rapid increase in expenditure by medical schemes is non-health items such as scheme administration fees (R4.5 billion in 2003), managed care initiatives (R1.1 billion) and brokers fees (which increased 64% from R354 million in 2002 to R581 million in 2003).
- (v) The challenge is to control the rapid spiral of medical scheme contributions and expenditure. It is significant that direct out-of-pocket payments, the most regressive form of health financing, account for almost a quarter of private health care financing. The majority of such expenditure is by medical scheme members (for instance for co-payments and services not covered by the scheme).
- (vi) These are challenges that the Parties to this Charter will address using the methods and strategies set out in Chapter three.

## **2.3 Quality**

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

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

- (i) The need within the national health system to focus more on the patient in terms of his or her social and clinical needs, health service options and health service choices;

- (ii) The need to devote more attention and effort to the measurement of health outcomes;
- (iii) The need to inculcate a more caring ethos within the health professions;
- (iv) The need to improve quality assurance and quality measurement programmes in health establishments;
- (v) The need to ensure more efficient or effective utilisation of health services in order to achieve improved quality;
- (vi) The need to improve feedback by mechanisms such as patient complaint systems into the planning and implementation of health services.
- (vii) The need for proper support for and protection of health care workers, the need for appropriate and suitable working equipment to ensure safety for both staff and health care users,
- (viii) The need for skilled management of both human and other resources and service delivery; and
- (ix) The need for the employer to provide the facilities the resources and the equipment for the effective functioning health system for outcomes that meet the standards of care

2.3.3 Measurement of quality in health services on an ongoing basis is critical to promote and maintain the delivery tracking, publication and feedback processes to ensure awareness of health outcomes in relation to quality of services. It is recommended that an audit of health facilities is conducted to ensure compliance with the requirements for the delivery of safe effective quality care.

#### 2.3.4 *Human Resources*

- (i) Specifically in the area of human resources the Parties to this Charter hereby acknowledge that quality in health services is heavily dependent upon the availability and work ethic of health care personnel.

- (ii) They concede that for a number of years there have been concerns about the attitudes of health care personnel towards patients and the fact that the health care system needs to become patient centred. While the majority of health care personnel are trying their best to deliver the best possible health care services under sometimes suboptimal circumstances, a lack of respect for the human dignity and freedom of patients on the part of some health care personnel continues to be an obstacle to the achievement of quality in health services. The statutory health councils should play a meaningful role in instilling a sense of discipline and pride in the professions for which they are responsible by maintaining a set of professional and ethical standards and ensuring that there are effective mechanisms to monitor and enforce adherence to those standards.
- (iii) The Parties further acknowledge that quality is also affected by the skills shortages in the health sector. The resultant psychological, and physical work pressures upon those who work in such fields leads to a downward spiral of diminished availability of such personnel within the national health system as a whole. In some instances, failure on the part of employers in some instances to implement adequate employment equity programmes, to actively develop historically disadvantaged individuals and to ensure the transformation of employment practices at all levels within health establishments, quality of working conditions and conditions of employment of health care workers further contributes to lack of motivation amongst human resources.
- (iv) The Parties further acknowledge that quality is also affected in situations where there is ineffective management and where effective business processes are lacking.

#### 2.3.5 *Financing*

- (i) One of the challenges with regard to quality in particular is that low cost options should not be perceived as, or become, low quality options. The quality of health services that are offered by low cost options must be the same as that offered by other options. The absence of low cost solutions is due *inter alia* to the cost of providing health care on the supply side with high

concentrations of services and vertical integration. In the private sector this is evidenced by limited growth.

- (ii) Linked to the high costs are the current business practices and pricing models in the provider market.
- (iii) A further challenge is that it is difficult for new entrants to get into the hospital services market by small medium and micro enterprises. This is due to the concentration of suppliers in the hospital sector and financing requirements for such services. Improved price competition would have the effect of forcing prices downwards, leading to lower cost at acceptable levels of quality. The lack of competition in the hospital services sector needs to be addressed.
- (iv) In order to ensure its sustainability the national health system must be able to produce and reproduce all the resources needed to deliver quality, affordable health services in the medium to long-term. The sustainability of the national health system is dependent upon its efficient use, management and generation of resources including financial, human, technological, scientific, clinical, managerial, infrastructural resources in the area of materials and equipment and research and development.
- (v) Inefficiency in the national health system threatens its sustainability since it leads to maldistribution of resources, and negates or undermines policies and procedures designed to give effect to the distribution, allocation or utilisation of resources. Policies and procedures should be developed with an awareness of the need for sustainability of the national health system and with a view to the elimination of inefficiencies within the system that could arise for instance from wasteful duplication of resources, under-utilisation of resources and cost ineffective application of resources.

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

- 2.4.1 The Parties to this Charter acknowledge that transformation is a process that involves a comprehensive change in the status quo, the manner in which the national health system is structured and operates. It includes profound changes in the levels of ownership, concentration and representation of Black persons across the value chain within the health sector. Therefore, the

outcomes of any transformation process should reflect a redressing of the imbalances created by apartheid policies and other discriminatory laws and practices of the past. Therefore the principles of Broad Based Black Economic Empowerment are applicable to the extent indicated in the Charter to all those firms and/or individuals that conduct business or economic activity in the health sector whether for profit or otherwise.

2.4.2 Equity in ownership refers to a state of affairs in which black people and collective organisations directly benefiting black persons as beneficiaries (i.e. indirect ownership, as defined elsewhere) own a part of a business in the health sector. This is to be achieved by a process of comprehensive transfer of ownership to, or acquisition of ownership by, black people throughout the value chain in the sector. The object of this process is to give practical effect to the recognition that apartheid and other discriminatory laws and practices resulted in excessive concentrations of ownership and control in the hands of the minority within the health sector and the need to redress this imbalance. Within this process, the imbalance must be remedied with particular regard to black people and with the object of the opening up of the health sector to ownership by greater numbers of South Africans.

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

Level 1 contributor: scoring 100+ ; recognition level at 135%;  
Level 2 contributor : scoring between 85 & 100; recognition- at 125%;  
Level 3 contributor: scoring between 75 & 85; recognition- at 110%;  
Level 4 contributor: scoring between 65 & 75; recognition- at 100%;  
Level 5 contributor: scoring between 55 & 65; recognition- at 80%  
Level 6 contributor: scoring between 45 & 55; recognition- at 60%;  
Level 7 contributor: scoring between 40 & 45; recognition- at 50%  
Level 8 contributor: scoring between 30 & 40; recognition- at 10%;  
Non-compliant: scoring below 30; recognition level 0%.

2.4.4 Until all enterprises have accumulated the necessary data to measure their credentials according to a balanced scorecard, it will be necessary to evaluate suppliers according to narrow-based criteria. Therefore in year one

narrow based criteria will be used, while in years 2 to 10 levels 1 to 8 will be used. The following narrow-based criteria will be employed to rate contribution -

- (i) “**Black enterprise**” – enterprise that is 50.1% owned by black persons and where black management has majority control. A Black enterprise enjoys a 125% BEE recognition level;
  
- (ii) “**Black Empowered enterprise**” – enterprise that is at least 25.1% owned by black persons and where there is at least 25.1% control by black people. A Black Empowered enterprise enjoys a 100% BEE recognition level;
  
- (iii) “**Black Influenced enterprise**” – enterprise that is at least 5.1% owned by black persons and where there is at least 5.1% control by black people. A Black Influenced enterprise enjoys a 50% BEE recognition level;
  
- (iv) “**Black Women Owned enterprise**” – enterprise that is at least 25.1% owned by black women and where there is at least 25.1% control by black women. A Black Women Owned enterprise enjoys a 125% BEE recognition level; and
  
- (v) “**Community or Broad-based enterprise**” – enterprise that has an empowerment shareholder who represents a broad base of black members holding in aggregate 25.1% of the equity in the enterprise. A Community or Broad-based enterprise enjoys a 100% BEE recognition level.

2.4.5 In the case of multinationals, SMMEs, professional Practices and NGOs, special provisions will be required for rating of contribution.

2.4.6 A key challenge in the context of BBBBEE is to ensure that it is implemented in all of the following areas -

- (i) Direct (BBBEE shareholding) and indirect ownership (employee or trust/community shareholding schemes);

- (ii) Management & control (by Black people);
- (iii) Procurement (from BBBEE companies for example, Affirmative Procurement or Preferential Procurement);
- (iv) Enterprise development;
- (v) Investment in joint ventures with BBBEE companies (in sustainable Department of Health or other accredited BBBEE programmes involving for instance, PPIs insofar as such programmes are proven to lead to, or contribute to broad-based BEE within the national health system);
- (vi) Employment equity and skills development;
- (vii) Corporate social investment.

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

2.4.8 There are a number of general challenges to BBBEE. These include the following –

- (i) Whether equity should simply be transferred to those who were previously excluded or should they be obliged to acquire it in the same way as non-historically disadvantaged individuals. If so how could this be adequately financed given the significant inequities that still exist?

- (ii) How should transformation in this area be monitored?
- (iii) Empowerment is necessary in real terms which enable Black people to take up positions, opportunities and interests that were previously denied them. For instance a few years back a few years back ownership of pharmacies was opened to non-pharmacists but it did not lead to any noticeable increase in ownership of pharmacies by black people.
- (iv) Ownership of enterprises by health professionals raises some serious professional and ethical challenges. It is important that there are sufficient safeguards to ensure that with the rise in equity ownership by health professionals the challenges of unethical conduct and business practices based on perverse incentives are addressed. In seeking to broaden access to ownership of equity interests of enterprises in the health sector by health professionals, the Parties recognise that statutory health councils have existing regulatory and ethical frameworks for the guidance of all health professionals on questions of equity ownership of health enterprises. In particular, health professionals must not obtain shares in health enterprises in violation of the established ethical rules of their registering bodies.
- (v) A process of comprehensive transfer of ownership to, or acquisition of ownership by, black people throughout the value chain is required in the health sector. The object of this process is to give practical effect to the recognition that apartheid and other discriminatory laws and practices resulted in excessive concentrations of ownership and control in the hands of the minority within the health sector and the need to redress this imbalance. Within this process, the imbalance must be remedied with particular regard to black people and with the object of the opening up of the health sector to ownership by greater numbers of South Africans.
- (vi) How to ensure that there is true broadbased BBBEE, that new entrants are encouraged and that the same few people are not always enriched.
- (vii) CSI programmes should not be shifted to increase health care costs and this will be contrary to the objectives of access equity and quality.

#### 2.4.9 *Human Resources*

- (i) This challenge is a challenge shared with institutions of higher learning. How far these institutions transform and whom they produce for this country is directly linked to the speed with which the health sector can be transformed.
- (ii) Even though the skills development levy and affirmative action legislation are in place, there is little evidence to suggest that the health sector has made significant progress in addressing this issue. Accordingly a critical review must be undertaken of admissions criteria in the Higher Education Institutions (HEIs), the institution of deliberate support programmes for students who are historically disadvantaged and possible linking of accreditation of HEIs to achievements of set standards in terms of human resource development.
- (iii) Transformation of management echelons relates more to affirmative action legislation (Employment Equity Act No 55 of 1998). Despite the many years that this Act has been in place there is still paucity of representation at senior management level in the private sector. Not many black people have been promoted to management level. Lack of movement in this area is said to have led to a lot of job-hopping. The challenge is to ensure that genuine transformation takes place at this level?
- (iv) It is important that the process of transforming the workplace covers the total value chain. In identifying the appropriate levels at which changes must take place, the following broad categories are identified -
  - (a) Senior Executive Management;
  - (b) Middle Management;
  - (c) Junior Management;
  - (d) Professional and skilled workers – includes persons who are not in management and are employed because they have special knowledge or particular skill.

- (v) The question of the quality and orientation of leadership of company boards is a major issue of concern. The presence of black people on boards of companies does not necessarily guarantee the implementation of BEE and the other principles of this Charter. The challenge is how to empower Black people who sit in corporate governance provisions so that they are in a position to be able to influence or drive the implementation of the initiatives envisaged in the Charter.
  
- (vi) In the case of health professionals employed within the public health sector the following challenges need to be addressed –
  - (a) Recruitment and retention of health personnel;
  - (b) Working conditions;
  - (c) Workload;
  - (d) Career-pathing;
  - (e) Provision of supervision;
  - (f) Low salaries;
  - (g) Poor work ethos.
  
- (vii) These issues need to be addressed by means of the Strategic Framework for the Human Resources for Health Plan and human resources and skills will be aligned to the following major pillars in the Plan –
  - (a) Stewardship for healthcare lies with the National Department of Health;
  - (b) South Africa's role in international health issues contributing to leadership, scientific advances and global health professions is critical
  - (c) Planning and Human Resources linked to the needs and demands of the health system must be strengthened;
  - (d) The optimal balance, equitable distribution and use of skilled health professionals to promote access to health services must be developed;
  - (e) South Africans must enjoy a reliable supply of skilled and competent health professionals for self-sufficiency;
  - (f) South Africa's contribution in the short to medium term to the global health market must be managed such that it contributes to skills development of health professionals;

- (g) Health workers must have the capacity and skills to render accessible, appropriate, high quality care at all levels;
- (h) Work environments should be conducive for good management practice to maximize the potential for the health work force to deliver quality health services.

#### 2.4.10 *Financing*

- (i) Health care financing faces the challenge of geographical inequities in the provision of health care in South Africa, particularly looking at high and low density areas, rural and urban and making specific interventions to foster a more equitable approach. Currently health care financing is skewed to the urban and private sector.
- (ii) There is very little development financing in the health sector. What financing is available is primarily finance to facilitate provision of health care services at the same returns that would be charged in the ordinary course of financing businesses. Often the cost of finance is so high that it is considered prohibitive. Investments in the health sector by Development Finance Institutions compete with other investments in their portfolio. Without development financing the cost of entry for black persons and black businesses in the health sector prevents the achievement of the objectives of this Charter.
- (iii) Low cost service providers are still heavily dependent on the finance provided at costs that are not sensitive to the special Healthcare need for low cost solutions. Townships, rural areas and poor provinces are considered very risky, and as a result, battle to attract appropriately structured funding solutions. Sometimes finance takes too long to be made available that people become discouraged. This kills the spirit of entrepreneurship. While there is a lot of talk around the need for low cost Healthcare services, financially there is very little that is being done to address such a need.
- (iv) There are two issues that have to be balanced in this regard-

- (a) The need for new healthcare establishments in the under-serviced areas that will provide investors and practitioners with a return on their investment; and
  - (b) the need for lower-cost services and products for such communities.
- (v) There is very little BBBEE in the Health Care sector except for a few recent transactions at equity level. The sector remains largely untransformed and the involvement of BBBEE is made more difficult by the concentration in the supply side and the funding side of the private sector.
- (vi) The absence of low cost solutions is largely due to the high cost of providing health care on the supply side with high concentration of services and vertical integration. This can be seen by the limited growth in the private sector. Linked to the high costs are the current business practices and pricing models in the provider market.

## **CHAPTER THREE: SOLUTIONS AND RESOLUTIONS**

### **3.1 Access**

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

- 3.1.1 Investigating the feasibility of the creation of a category of independent practitioners who will be contracted to the state in order to improve access to health care at the primary level;
- 3.1.2 Establishing programmes that will create and strengthen a cadre of mid level workers;
- 3.1.3 Strengthening working relations between independent private practitioners and public services in the provision of primary health care;
- 3.1.4 Appropriately increasing the range of health services available to under serviced communities. The Parties commit to tailoring solutions which meet the needs of the particular community concerned;
- 3.1.5 The provision of information relating to health, disease, medicines, and other matters designed to address the needs of vulnerable groups, including people living in rural and under serviced areas and the illiterate;
- 3.1.6 The development of an effective communication strategy in line with the needs of users. Members of medical schemes currently have little understanding of the medical scheme benefits they have purchased. This situation contributes to the imbalance in the number of people opting to belong to medical schemes. The design of benefit packages must be simplified in order to promote and improve purchasers' understanding of these packages. In particular the communication strategy must explain the rationale and benefits of the basic benefit package;

- 3.1.7 Ensuring that the communication strategy with regard to the use of public sector health services informs patients that such services are not necessarily free of charge in all cases and that patients who satisfy a means test are required to pay certain fees for these services;
- 3.1.8 Entering into public private initiatives in order to more efficiently utilise the available resources, reduce inequities and improve access to both provision and financing of health services for the benefit of all. There should be a particular focus on PPIs that improve access to services in poorer provinces and rural areas;
- 3.1.9 Establishing a system for co-ordination of the utilisation of health technology to ensure that the technology offers value for money, is appropriate and effective for the setting in which it is to be used, complements health technology that is currently in use and to avoid unnecessary and wasteful duplication of resources within the national health system;
- 3.1.10 Not refusing anyone emergency medical treatment irrespective of whether or not they are able to pay. A protocol will be developed on emergency medical treatment;
- 3.1.11 Providing or sponsoring health profession education, training and development which includes –
- (a) Formal health training and education;
  - (b) Continuing Professional Development education, sponsored programmes and events in relevant categories of health care personnel;
  - (c) Management & Leadership programme provision or sponsorship
- 3.1.12 Parties co-operating to streamline and improve business processes in a manner that leads to more efficient access to health care services for patients;

- 3.1.13 Establishing a health sector education trust by contributing to provide financial support to students who wish to study in the health field. This is over and above the skills development levy payable in terms of the Skills Development Act, 1998 (Act No 81 of 1998) and would be used to educate students at tertiary level in the health professions;
- 3.1.14 Using existing funding mechanisms such as the skills development levy to more efficiently and effectively provide financial support to students who wish to study in the health field;
- 3.1.15 Fostering a closer relationship between the education sector and the health sector so that the potential of the Higher Education Institutions (HEIs) can be utilised in meeting the education and training needs of the health sector;
- 3.1.16 Embarking upon a sector marketing campaign and a career education campaign to introduce learners to the careers and work opportunities within the national health system;
- 3.1.17 Exploring ways of marketing the health professions to attract home qualified South Africans, and investigate mechanisms to facilitate the re-entry of these health professionals into the health sector;
- 3.1.18 Developing indicators within 6 months of the finalisation of the Charter to measure improved/increased access, in order to track the extent of progress made, and evaluate the sustainability and quality of such access;
- 3.1.19 Significantly improving the physical facilities available in the public sector in order to ensure good working conditions so that the public sector can be perceived as preferred employers.

## **3.2 Equity**

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

- 3.2.1 Developing a minimum defined basic package of care that is available to all patients in both the public and the private sectors regardless of the ability to pay;

- 3.2.2 The elimination of inefficiencies from health service delivery;
- 3.2.3 Implementing a policy of zero tolerance of unfair discrimination by health care personnel which will be communicated to all health care personnel employed by them together with the nature of the disciplinary steps that will be taken and eliminating harassment from workplaces through a policy of zero tolerance that is effectively and continuously communicated to staff and patients alike. The processes will be based on the Promotion of Equality and Prevention of Unfair Discrimination Act and the Employment Equity Act.
- 3.2.4 To develop and implement a Human Capital programme that plans for and meets the human resources requirements of South Africa over the next 15 years. Such programme will address the demographics and diversity of the people being trained and developed in the national health system. Guidelines within the context of the Strategic Framework for Human Resources for Health Plan should be implemented. These guidelines should be measurable and include measurements on migration.
- 3.2.5 Support existing initiatives to increase the number of black people and young women matriculating in higher grade science, mathematics and computer science;
- 3.2.6 Setting annual targets for recruiting, training and retention of health care personnel;
- 3.2.7 Setting out leadership learning programmes that meet the needs of the health sector;
- 3.2.8 Developing a national code of practice on the ethical recruitment of health professionals. These codes must be developed in line with international codes.
- 3.2.9 Developing programmes that result in the workplace becoming representative of the demographics of the population of South Africa as a whole. It is the target across all job levels that by 2010 the workplace will be 40% black across the value chain and will comprise 30% women. Further, it is the target

that by 2014 the workplace will be at least 60% black across all job levels and shall comprise 50% women.

### **3.3 Quality**

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

- 3.3.1 Conducting regular and sustained training programmes for health care personnel on the rights of patients and the Batho Pele principles;
- 3.3.2 Implementing comprehensive Employee Assistance Programmes to support and assist the health care personnel employed by them;
- 3.3.3 Committing to the development of low cost health service and financing options that are accessible to middle and low income groups and that assure value for money in terms of health outcomes;
- 3.3.4 The implementation of benchmarked quality assurance programmes that include a quality monitoring system and the measurement of health outcomes;
- 3.3.5 The consideration of complaints by users of the national health system and the creation of mechanisms whereby such complaints are used to inform the planning and delivery of health services so as to be able to continually improve the quality of health care.
- 3.3.6 Instituting and monitoring quality enhancement mechanisms through such issues as peer review, rigorous reporting on adherence or failure to adhere to established ethical and professional standards, establishing clinical protocols as well as a robust continuing professional development system;
- 3.3.7 The promotion of participation by users of health services in the structures proposed by the National Health Act, including committees, hospital boards and district health forums, in order to facilitate the proper management of resources in the public health sector.

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

The Parties agree to implement Black Economic Empowerment in the health sector in a manner that is truly broad based and that favours new black entrants into the market as opposed to enriching a select few who have already gained entry.

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

Enterprises other than professional health care entities/practices or groupings registered or operating under the respective statutory health councils' legislation in the healthcare sector must strive to achieve exercisable voting rights of at least 26% for black people within the next 10 years.

3.4.1 Black people must have 31% of the total economic interest in enterprises within the health sector by the year 2014, provided that if this target cannot be met in full, up to 5% of that economic interest may be in the form of replacement offerings that serve to strengthen the public health sector.

3.4.2 Of the share to be held by black people of total economic interest referred to in paragraph 3.4.1 above, black women must hold at least 15% by the year 2014 provided that the provision for replacement offerings made in paragraph 3.4.1 above may be taken into account should the target set in that paragraph prove unattainable.

3.4.3 It is the intention, in allowing the 5% replacement offering referred to in paragraph 3.4.1 above, that wherever possible each BBBEE business deal that is concluded contributes to the strengthening of the public health sector.

3.4.4 It is understood that, in line with ethical frameworks regulating the conduct of practice by health professionals, professional practices will not be open for acquisition or control by persons or corporate entities that are not registered with the respective statutory councils except where an express provision to this effect has been made by the statutory council concerned. Solo and small professional practices will not be expected to open themselves up to ownership by non professionals in order to achieve BBBEE targets. Large

group practices with more than ten partners must progressively increase the demographic representivity in their partnerships or group practices over time as the demography of their profession permits. As far as is practicable, the timelines and percentage equity reflected in 3.4.1, 3.4.2 and 3.4.3 will *mutatis mutandis* apply to group practices or partnerships exceeding 10 health professionals.

3.4.5 NGOs and NPOs are exempt from the ownership targets established in terms of the Charter.

3.4.6 Procurement policies and processes that are favourable to firms owned or controlled by black people will be implemented. The stakeholders in the healthcare sector also commit to supporting government on these initiatives. In this regard the following areas should be noted for special focus:

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

3.4.7 Measurement of procurement for the purpose of the Charter should be on discretionary expenditure only and differentiation should be based on any of the following grounds for measurement purposes –

- (a) A natural monopoly eg where no alternatives exist, such as in electricity, fixed line communications;
- (b) No local supplier or limited supplies locally, eg certain hi-tech equipment not readily available locally;
- (c) Uniformly applied restriction, regulation or directive imposed on an enterprise eg MCC regulations, international and/or long term existing supplier contracts, sometimes imposed and as a result of a global legally binding agreement;
- (d) Criteria relating to ethics and quality of supplies, e.g. a particular patient may need or choose a specific type of treatment which has to be available from a provider who has no financial links with the prescriber.

- 3.4.8 At least 40% % of all procurement shall be from black empowered firms or black persons by 2010. By 2015 this should increase to 60% %.
- 3.4.9 The private sector commits to expenditure of a fixed proportion of their annual income on social responsibility projects which include new and existing providing funding and resources for new and existing community development projects.
- 3.4.10 Development finance must be derived from three sources, partially from DFIs, particularly where the risk profile excludes other sources, with the majority sourced from mainstream financial institutions and vendors themselves.
- 3.4.11 Development Financing must be used –
- (e) to fund small black owned businesses either entering into or wishing to expand their operations in the health sector. It is essential that existing risk and return profiles are modified with the financing over a longer duration;
  - (f) to finance PPIs and other initiatives to promote the objectives of this Charter.

It must be noted that whilst DFIs provide financing for development they also have to ensure long term financial sustainability.

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

### **3.5 Implementation**

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

- 3.5.1 The Parties agree that a mechanism to monitor the implementation of the Charter be established and to enable the public and private sectors to work together towards the common goals outlined in this Charter.
- 3.5.2 The eligibility of stakeholders that do not implement the Charter for state contracts and contracts with other parties to the Charter would be reduced or precluded altogether depending on the circumstances.
- 3.5.3 The National Department of Health undertakes, in collaboration with the National Treasury, and in consultation with other stakeholders, to develop a practical framework for PPIs that contains clear and practical processes for the implementation of PPIs that strengthen or are supportive of the public health sector. A clear policy and regulatory environment for PPIs will be implemented.
- 3.5.4 A Charter monitoring committee is essential and the role it will play must be clearly defined and agreed. The Charter committee will be a subcommittee of the National Consultative Health Forum required to be established in terms of the National Health Act No 61 of 2003.
- 3.5.5 The Charter monitoring committee must ensure that there is transparency in the implementation of the Charter and must facilitate access to information to ensure that the health sector truly transforms.
- 3.5.6 The Charter monitoring committee must regularly measure the impact of health charter initiatives on the health sector and the progress made by enterprises in conforming with the Charter.
- 3.5.7 Health Charter initiatives must be accounted for and presented in accordance with their substance and economic reality and not merely their legal form. The Charter monitoring committee must evaluate the substance of all Charter initiatives to ensure that substantive and meaningful progress is made toward achieving the objectives of the Charter.
- 3.5.8 Charter implementation processes must adhere to sound economic principles. Sound economic principles are the fundamental principles that

govern the efficient and effective functioning of economies and are supported by rigorous empirical testing and broad application both globally and locally.

- 3.5.9 There must be uniformity in how the Health Charter initiatives are recognised and measured, in order to compare the progress made by an enterprise in different reporting periods as well as to facilitate the comparison of progress between different enterprises. Comparability is enhanced when recognition, measurement and disclosure of Charter initiatives is performed in a consistent manner across the health sector.
- 3.5.10 In interpreting and measuring implementation of the Charter, a balanced scorecard will be applied which includes core components of each of the four key areas of the Charter
- 3.5.11 The four main components of access to health services are: simplification of processes for obtaining health services; elimination of barriers to obtaining health services; the extent to and rate at which previously unmet health needs become met; increased availability of health professionals and health establishments to poor and low income groups or within underserved areas. These components may be further subdivided as necessary.
- 3.5.12 The three main components of equity in health services are: qualitatively and quantitatively improved access to health services by previously underserved communities; the distribution of health resources in accordance with the health needs of the population and particular communities; fairness in decisions involving the allocation of health resources. These components may be further subdivided as necessary.
- 3.5.13 The four main components of quality in health services are: satisfactory, evidence based, health outcomes following a health intervention; safety in the rendering of health services; efficiency in the rendering of health services; respecting the rights of patients as reflected in the Patient Charter. These components may be further subdivided as necessary.
- 3.5.14 The three main components of BBBEE are: direct empowerment, human resource development and indirect empowerment. These have been further subdivided into seven components, namely: equity ownership; management;

employment equity; skills development; preferential procurement; enterprise development and other residual elements.

3.5.15 Criteria for the measurement and attainment of targets in the balanced scorecard will be reviewed periodically by the Charter monitoring committee and adjusted where necessary in order to take account of changes in the health sector that impact upon the transformation processes required by the Charter.

## APPENDIX A

The proposed basket of replacement offerings by multinationals involving the key areas of access, equity and quality of the Charter includes, *by way of example*, the following:

### Access

- Human resource related offerings such as initiatives to repatriate South Africa health professionals, sponsorship of education and training of health professionals to fulfil future needs, building trust and campaigning to increase enrolment of learners, students and pupils in fields of study within the health professions
- Patient focussed initiatives such as strengthening understanding of individual patient rights
- Increasing the range of services offered and developing health professionals and employees accordingly
- Effective PPIs to optimise utilisation of resources and develop primary care
- Development and improvement of management capacity within the health sector
- Development of community health workers
- Development of primary health care, including the building of clinics and community health centres
- Technology transfer from foreign entities to the South African health sector for instance in the area of local manufacture of active pharmaceutical ingredients (APIs) and medicines and research and development of APIs and vaccines

### Equity

- Human resource related initiatives that include retention of staff and health professionals, leadership programmes, ethical recruitment of health professionals and other staff and development of mathematical skills at school level
- Fulfilment of employment equity targets
- Development of and contribution to a basic package of care
- Elimination of inefficiencies in the deliver of health services
- PPIs where there are specific and identified needs

- Elimination of unfair discrimination and harassment of employees

### **Quality**

- Training in patient rights and the Batho Pele principles
- Facilitation of the provision of low cost healthcare that offers value for money
- The implementation and maintenance of quality assurance programmes
- The implementation and maintenance of an effective system for the processing and resolution of complaints by patients and users of the national health system
- The implementation and maintenance of a national training programme on corporate governance

Practical examples of the foregoing include –

- A subsidy on medicines for low income medical schemes (LIMS) to increase access for the emerging sector
- Funding the training and development of health care professionals such as primary care nurses
- The implementation and maintenance of programmes addressing the information needs of patients with regard eg to diseases of public health concern such as TB, cholera and HIV and with regard to appropriate use of medicines
- Independent funding of quality assurance systems to ensure quality health outcomes
- Funding of wellness and health advocacy programmes
- Conducting health awareness campaigns and establishing patient advisory bodies
- Increased research and development investment in South Africa, particularly with regard to black investigators and or/HD centres
- Selling of certain rights in products, manufacturing or packaging facilities and brands to black investors.
- Building of primary health clinics and community health centres

## BALANCED SCORECARD

*For reference purposes the DTI scorecard is replicated below.*

Core component of BEE	Indicators	Total Score
Direct empowerment score		
Equity ownership	% share of economic benefits	20%
Management	% black persons in executive management and/or executive board and board committees	10%
Human Resource development and employment equity score		
<b>Employment equity</b>	<b>Weighted employment equity analysis</b>	<b>10%</b>
<b>Skills development</b>	<b>Skills development expenditure as a proportion of the total payroll</b>	<b>20%</b>
Indirect empowerment score		
<b>Preferential procurement</b>	<b>Procurement from black owned and empowered enterprises as a proportion of total procurement</b>	<b>20%</b>
<b>Enterprise development</b>	<b>Investment in black owned and empowered enterprises as a proportion of total assets</b>	<b>10%</b>
Residual 10%		
<b>To be defined</b>	<b>To be determined by sector/enterprise</b>	<b>10%</b>
Total score out of 100%		

## EMPLOYMENT EQUITY TARGETS

The employment equity targets with regard to management are as follows:

<b>Management Level</b>	<b>2010</b>	<b>2014</b>
<i>Senior Executive Management</i>		
Black persons:	25%	50%
Women	15%	30%
<i>Middle Management</i>		
Black Persons:	25%	50%
Women:	15%	30%
<i>Junior Management</i>		
Black Persons:	25%	50%
Women:	15%	30%
<i>Professional/Skilled Workers</i>		
Black Persons:	25%	50%
Women:	15%	30%