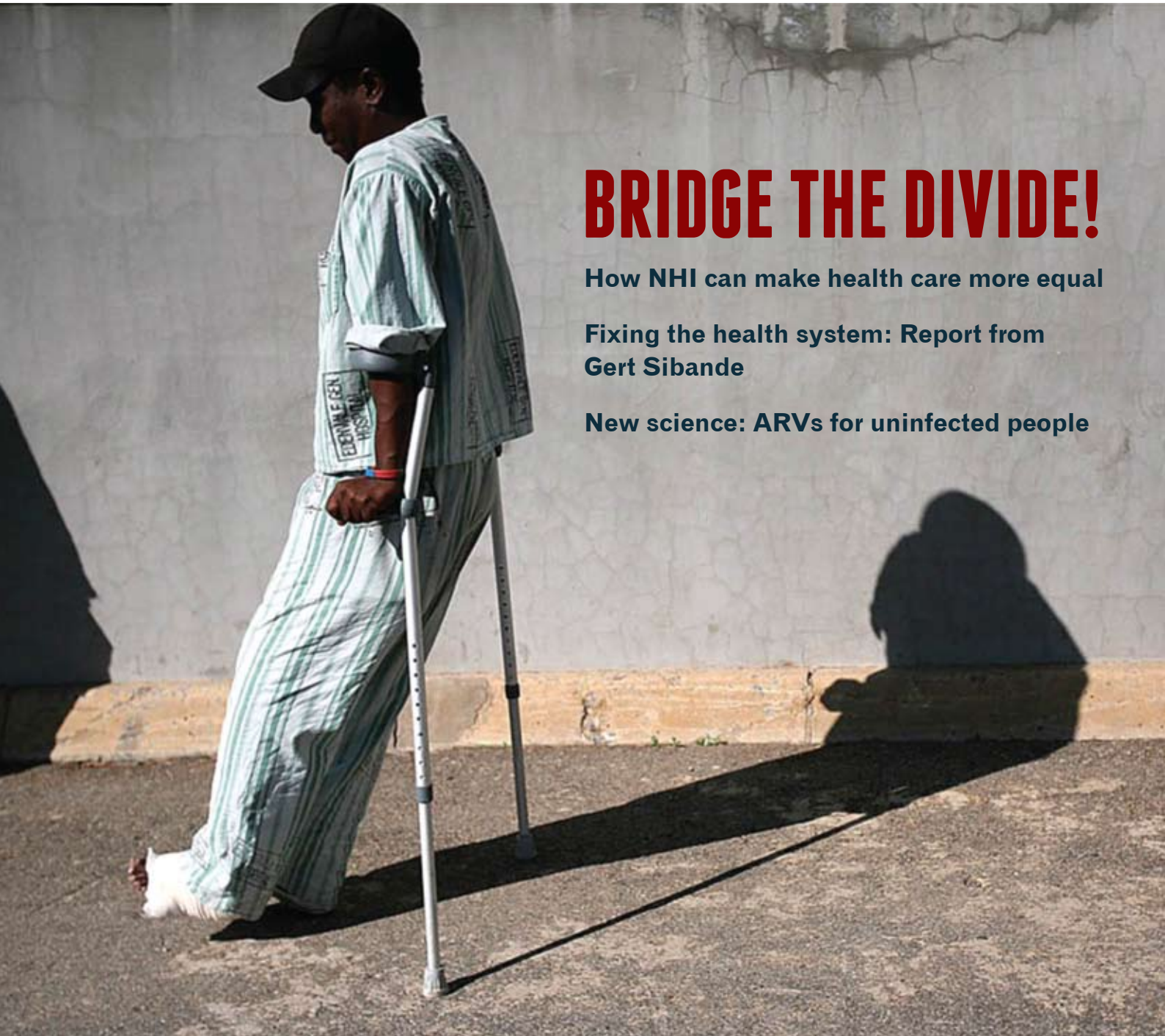
EQUAL treatment

Magazine of the Treatment Action Campaign April 2011



BRIDGE THE DIVIDE!

How NHI can make health care more equal

Fixing the health system: Report from Gert Sibande

New science: ARVs for uninfected people

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TAC is committed to providing people with HIV, their families and caregivers accurate information about life-saving medicines and treatment. TAC and its leaders are independent of the pharmaceutical industry as well as of the natural and alternative medicine industries and have no financial interests with them.

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Photo by Alon Skuy/The *Times*.

Editorial

In 1994 the new South African government inherited a health sector that delivered care unequally through the apartheid system. This system denied poor people healthy lives. It created an environment where many were malnourished and suffered diseases like tuberculosis because they lacked decent housing, education, employment and sanitation.

The ANC's Freedom Charter emphasised the principle of free and inclusive health services when it stated: "A preventive health scheme shall be run by the state; Free medical care and hospitalisation shall be provided for all, with special care for mothers and young children." Statements like these created the expectation that health services would improve dramatically after the 1994 elections.

The ANC did indeed take a progressive stance. It aimed to develop a national health system offering affordable care, with a focus on primary health care. Furthermore, the new South African constitution guaranteed the right to life and to health. This same constitution later made it possible for TAC to force the Department of Health to roll out prevention of mother-to-child transmission services.

There has been progress since 1994. Today, we have one National Health Department rather than the 14 racially-grouped departments that existed under apartheid. Many hospitals and clinics have been built. There have been important victories in relation to drug patents and access to health care for women and children. We also have progressive new legislation like the Choice on Termination of Pregnancy Act. To top it off, over the last few years, we have built the world's largest HIV treatment programme.

Even so, we cannot deny that since 1994, South Africa has suffered a major health crisis due to HIV. The disease has killed hundreds of thousands of people in the prime of their lives. In 1990, life expectancy in South Africa was 63 years. Now it is estimated to be only 52, whereas a comparable country like Brazil has a life expectancy of 71 years.

Poor governance and state-sponsored AIDS denialism worsened the impact of HIV. It was further intensified by fragmentation and underfunding in our public health system. Together, these have contributed to tremendous health inequalities. Government spending on public health has stagnated at about R2,206 per patient per year. Meanwhile, the private health system spends about R9,605 per patient per year. The situation is similarly unequal as regards human resources, with about 60% of doctors and around 40% of nurses working in the private sector. To add to this challenge, our public health system faces high vacancy rates, especially in rural areas. Many demoralised health workers have simply left the country because of the dire conditions under which they worked.

The current public-private divide in South Africa treats health as a privilege, not a right. However, the constitution does not say that you have a right to health as long as you can pay. It says that you have a right to health, no matter what.

Government's proposed National Health Insurance (NHI) has the potential to bring about major improvements in health care delivery for all South Africans. If implemented properly, NHI will help our country to manage its enormous health burden. As more information becomes available, we must inform ourselves about NHI and insist on a place at the table.

Vuyiseka Dubula,
TAC General Secretary

Time to end the sufferi

While some people get five-star treatment in expensive private hospitals, others spend most of their income just to get to a clinic – and on arrival they wait hours for care. South Africa isn't just one of the most unequal countries on earth, we also have one of the most unequal health systems. NHI is a rare opportunity to change this.

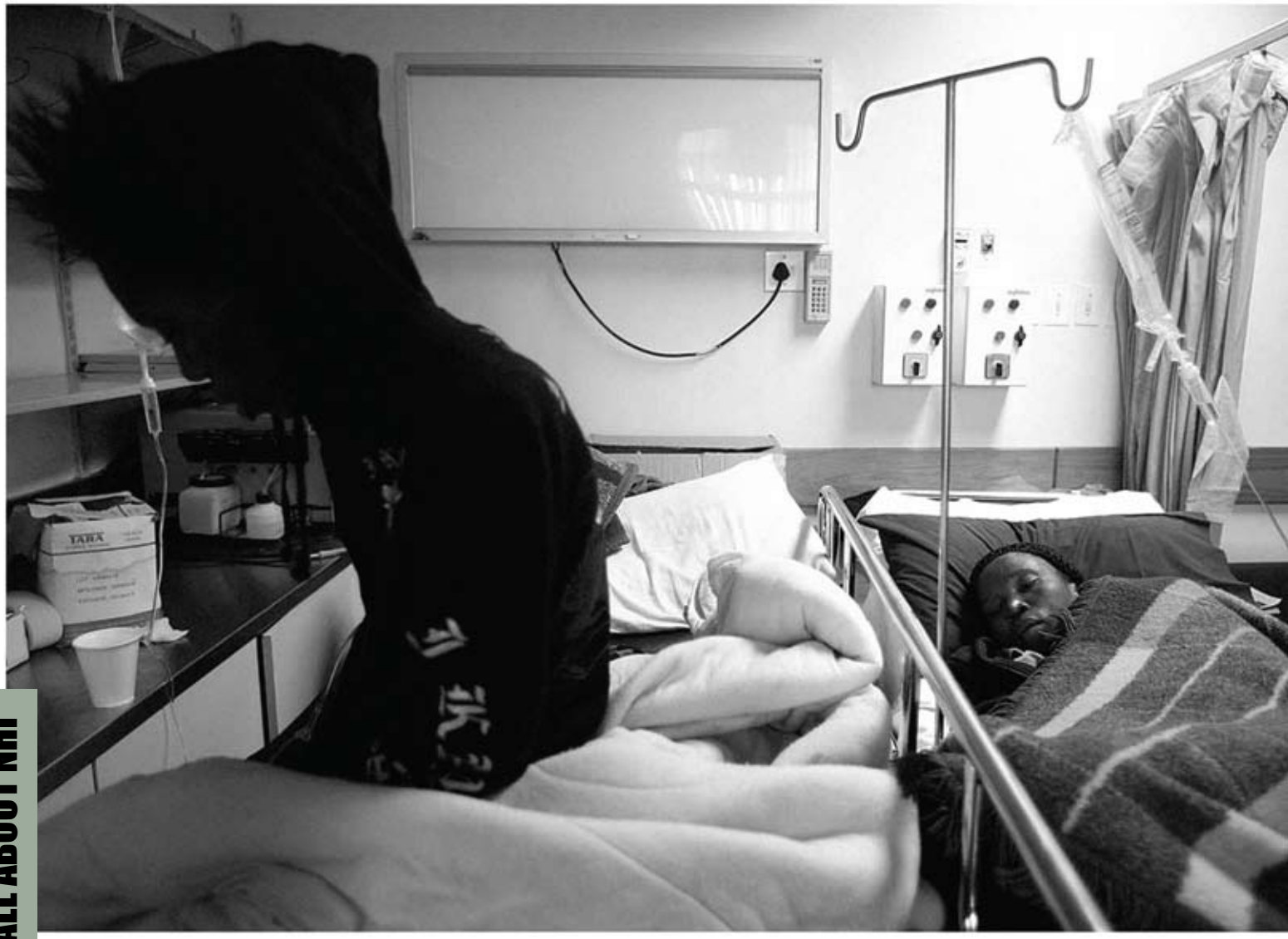

Photo by Alon Skuy/The *Times*.

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What is NHI?

NHI (National Health Insurance) is a new model by which government will collect and spend money on health care, so that everyone can use it free of charge. It is part and parcel of a bigger plan to revitalise and improve the public health system.

NHI also aims to promote what is called primary health care. In short, primary health care is about taking health care to communities and focusing on earlier treatment or prevention (rather than waiting until people are really sick to receive care). Increasing primary health care will mean better health care for all.

NHI aims to improve the health system by changing the way financial and human resources are used, making the system more equitable as a whole. At present, more than half of the money spent on health in South Africa is spent in the private health system. Only 16% of people have dependable access to the private health system.

Government will use tax money to create a single NHI fund. Everyone in South Africa will contribute to this fund. This money will then be used to provide health care for all. Very importantly, NHI will not only be about spending more money on health, but it will change the ways in which money is spent so as to make it more efficient.

Many of the details of NHI have still not been announced. As it stands, we might get an NHI that makes a big difference to our communities, or we might get an NHI that ends up only making private companies more profitable. It all depends on the details. Over the coming year, the general public, health workers and civil society must insist on a place at the table and campaign hard for a progressive NHI that will truly make a difference at ground level.

The three principles of NHI

The right to health:

According to Section 27 of the South African constitution everyone has a right to access health care services. Even so, many people still cannot get decent services. NHI aims to change this and to give everyone equal access to quality, free health care. Among other things, this must mean an end to user fees and to the transport problems that are often a barrier to obtaining health care in South Africa.

Social solidarity and universal coverage:

All South Africans will contribute to NHI funding and all will enjoy equal cover, receiving the same services regardless of how much money they make, whether they are employed, or where they live. However, progressive taxation means that the rich will contribute more than the poor. The idea is that people should have access to quality health care according to their need and not their ability to pay.

Public administration:

NHI will pool money raised through taxation and mandatory contributions (for example an extra tax on income) into a central fund. This fund will be administered by the national government and overseen by the Minister of Health. It will be used to purchase services, pay providers and work towards redistributing health resources more equitably amongst the population. Public administration will help to take the profit motive out of health care and to keep prices down.

Questions & Answers

Q: Will I have to pay when I go to a clinic or hospital?

A: No. If we get the NHI we want, treatment will be free at the point of service. At the moment, many people must still pay user fees when they go to hospital. A progressive NHI will do away with user fees. All health services will be paid for by the NHI fund.

Q: Where will the money for the NHI fund come from?

A: The exact details are not yet clear. It seems that some money will come from general tax revenue and the rest from specific sources like mandatory NHI contributions from employers and employees as part of income tax. In a progressive NHI, the rich will contribute significantly more than the poor. If you are not in formal employment, you will only contribute to NHI through the VAT that you pay on everyday products.

Q: Will I be able to go to any clinic or hospital when I need treatment?

A: For most health issues you will still have to register with your nearest clinic and then be referred onward to specialists or hospitals from there. Only those who need hospital care will be sent to hospital. This will help to prevent hospitals from becoming overloaded. The aim of NHI is also to provide more and better services at primary health care level so that people only go to hospital in an emergency or if they are very sick. In an emergency you will be able to go to any hospital that forms part of the NHI system.

Q: Will foreign nationals be covered?

A: All South African citizens and legal residents will be covered. This means that under the current plans, foreign nationals living in South Africa without legal documents will have no NHI coverage. This was raised as a concern at the recent Cosatu-Civil Society Conference.

Q: Will there still be a private health system?

A: Yes. According to current plans private hospitals will still exist. Exactly how big the private health sector will be will depend on the details of NHI that are yet to be finalised. Government might buy some services from private hospitals or doctors through NHI. However, as the public health care system is upgraded, it is hoped that private hospitals will become less viable. If people are satisfied with public care there will be less demand for private care and medical aid coverage.

Q: Will NHI change the quality of HIV treatment?

A: NHI will not have a negative effect on HIV treatment as it stands. The ANC discussion document on NHI states that, "The services to the public cannot be less than what they are currently

Photo by Adam Malapa.

"We will see improved quality health care and I believe that NHI is a good concept for South Africans, especially for rural communities and poor people, including people working for NGOs who are not getting any stipends or compensation."

– Mabu Letsoalo, founder of Reakgona National Health Promotion (RANHPO), based in Lenyenye outside Tzaneen.

Photo by Adam Malapa.

receiving." The aim of NHI is to make health care more equitable and accessible to South Africans by removing user-fees and extending the reach of the health system. These improvements will also benefit HIV treatment and care. Regardless of NHI, we must continue to campaign for better access to treatment and care for people with HIV.

Q: How will NHI be implemented?

A: According to the ANC, NHI will be implemented gradually over a 14-year period. If the legislation is passed this year, government plans to start implementing NHI in 2012, with a focus on the under-served rural areas of South Africa first.

Q: Will NHI really improve health care at ground level?

A: This depends on the type of NHI that we end up with. Together, we can influence this. If we do not educate ourselves about NHI and campaign for the NHI that we need, we might not get it. Some businesses in the private health sector stand to lose a lot of money under a progressive NHI programme. These parties will do all they can to water down NHI in order to serve their business interests. The more NHI is watered down, the less improvement we will see on the ground. It is also important that government is transparent in its planning for NHI, so that we can make sure it stays on the right track.

Photo by Eli Weinberg, courtesy Adler Museum of Medicine, University of the Witwatersrand.

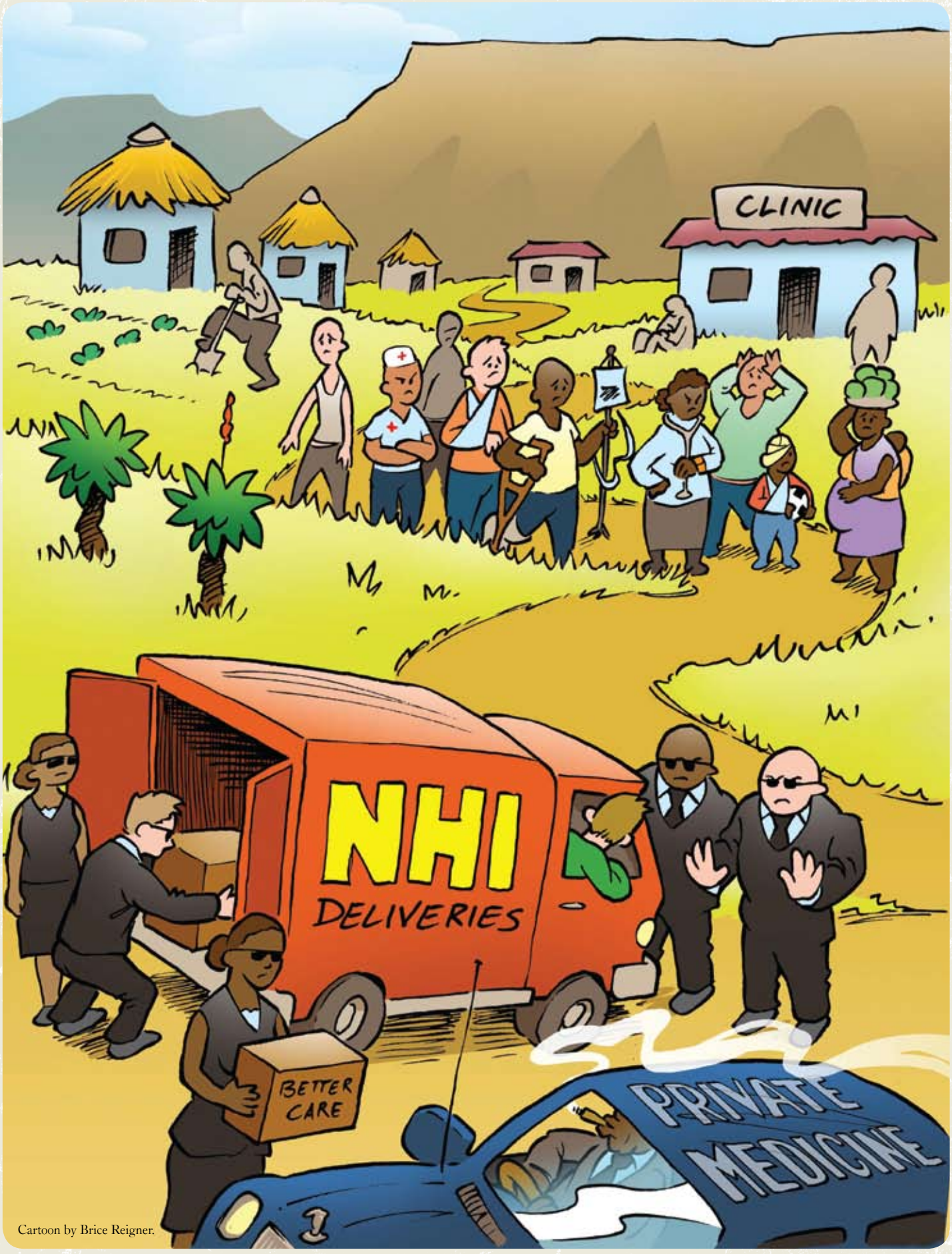
Gluckman and the missed opportunity

In the 1940s the commission chaired by Henry Gluckman proposed something very close to today's NHI. The commission recommended the introduction of a national health tax to ensure free health care at the point of service for all South Africans. The aim was to bring health services within reach of all sections of the population, according to need, and without regard to race, colour, means or station in life. Although the Gluckman Commission proposals were accepted, government decided to implement them as a series of measures rather than in a single step. The introduction of community-based health centres was taken forward, with 44 centres being established within two years. However, other aspects of the proposals were never implemented. Any gains from the Gluckman Commission process were reversed after the Nationalist Party government was elected in 1948.

"Without proper roads and other infrastructure in rural areas, things will not work right, we will never see improvement. In so many instances, ambulances have to stop hundreds of metres away from the patient's home and the sick person has to be picked up on people's backs or pushed in a wheelbarrow to reach the ambulance."

– Jimmy Mongwe, TAC Branch Member, Dan, in Tzaneen.

Photo by Samantha Reinders.



Cartoon by Brice Reigner.

Photo by Samantha Reinders.

Give us the NHI that we need

Various aspects of NHI are still under negotiation. Private medical schemes, hospital groups, product manufacturers and others are all trying to turn NHI into something that serves their interests rather than achieving its original goal of good and equitable care for all. If some of these groups have their way, NHI will be watered down so much that it will make little difference on the ground. That is why we must campaign to ensure that we get a progressive NHI that helps to bring free, quality health care to all.

1. We must be consulted

So far much of the NHI process has been happening behind closed doors. This must change. The general public, health workers and civil society must all be consulted throughout the NHI planning stages. Government needs to publish their NHI documentation for public consultation and give sufficient notice and opportunity for comment. If the public and health workers are not on board, NHI will struggle to get off the ground.

2. Make access real

The few NHI documents that have been published say many of the right things about access for all. However, we need guarantees that user fees will be abolished and we need concrete strategies as to how NHI will deal with problems such as a lack of transport.

3. We want more coverage

The NHI benefit package must cover a wide variety of services. Everything from clinic visits to hospital and specialist visits must be free. Clinics must still be the entry point into the health system, but they must have far more resources and provide much higher quality services. From clinics, patients should be referred and transported to hospitals or specialists. It is imperative that no user payments are required at any stage.

4. Train and retain workers

There is a massive shortage of health workers in the public sector. NHI needs to provide clear incentives to attract doctors and nurses from the private sector into the public sector, to train more health professionals, and to provide decent employment for existing health workers.

5. Cover foreign nationals

Under current plans NHI will only cover South African citizens and those foreign nationals who have permanent resident status. This will exclude many foreign nationals living in the country. Such exclusion is not only morally wrong, it also has negative implications for disease control since diseases do not distinguish between foreign and South African nationals. We must campaign for NHI to cover every single person in South Africa.

6. Set high standards

To ensure NHI delivers real change, we must set very high standards for both health care and administration, and not allow poor management or corruption to derail our efforts. An office of standards compliance must be developed. This office must be independent of the Department of Health so that it can provide meaningful and effective oversight.

7. No quackery under NHI

The challenges facing our health system are huge. We cannot afford to spend public funds on unproven treatments or unsafe devices. NHI funds must be spent only on scientifically-proven treatments.

8. Drive down prices

NHI will create a huge fund which will put the Department of Health in a position to negotiate much better prices from providers – whether those be the prices of hospital gloves or expensive scanning equipment. Not only must bulk discounts be negotiated, the balance of power must shift from provider to purchaser.

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Lloyd, B., Sanders, D. and Lehmann, U. 2010. Human Resource Requirements for National Health Insurance. South African Health Review, pp 171 - 178.

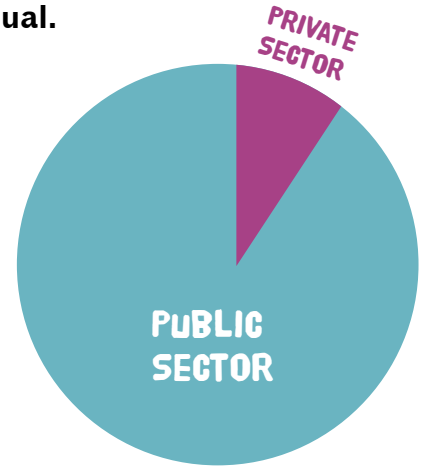
McIntyre, D. 2010. National Health Insurance: Providing a vocabulary for public engagement. South African Health Review, pp.145-156.

Further reading can be found at the University of Cape Town's Health Economic Unit. Visit http://web.uct.ac.za/depts/heu/SHIELD/about/about.htm to learn more about SHIELD.

PUBLIC + PRIVATE HEALTH CARE IN SOUTH AFRICA

Our current health care system is extremely unequal.

Over **85%** of the population depends on the public sector, while just **15%** relies exclusively on the private sector.



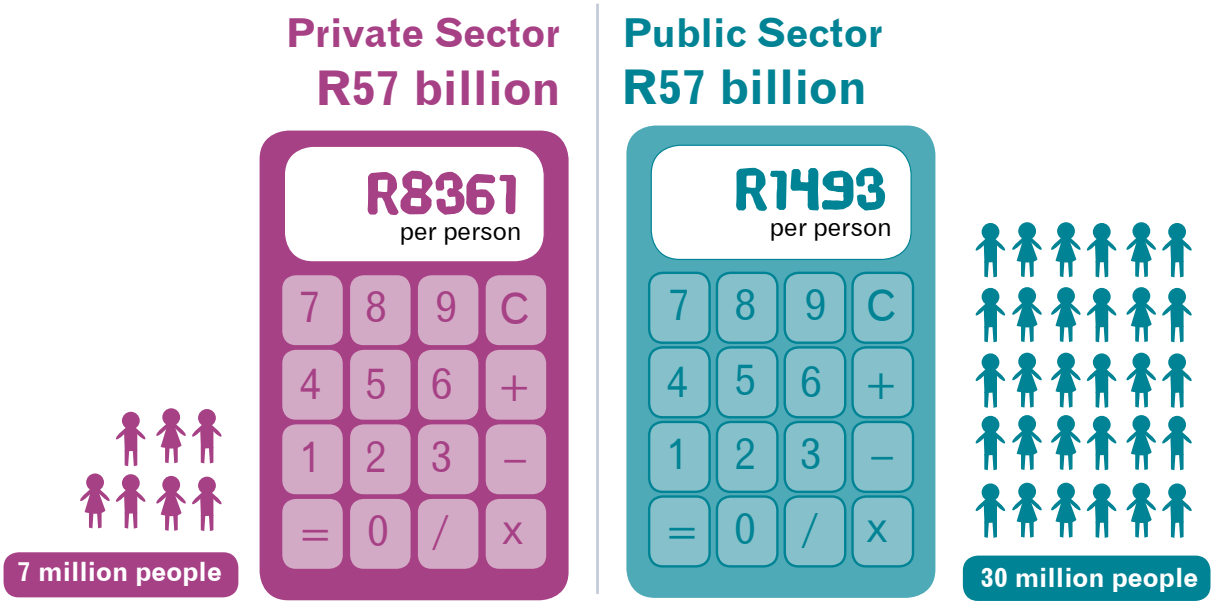
Yet almost the same amount of money is invested in each sector.

This means that people who can afford to buy private medical services enjoy significantly better care, with more resources for health. By strengthening the public sector, NHI will help to make health care in South Africa more equal, ensuring that everyone has access to good quality care, regardless of whether or not they can afford to pay for private services.

RESOURCES PER PERSON

Although over three times as many people rely on the public sector as rely on the private sector, spending for each is nearly identical at R57 billion per year.

This means more resources per person in the private health system. For example, there are twice as many beds per patient in the private sector as in the state sector.



"The mismatch of resources in the public and private health sectors relative to the size of the population each serves, and the inefficiencies in the use of available resources, has contributed to the very poor health status of South Africans, particularly the lowest income population"
— ANC discussion document, 2010

Sources: ANC National General Council 2010: Additional Discussion Documents. Section 1: National Health Insurance.

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WE NEED MORE HEALTH CARE WORKERS!

The need for health care workers has risen over the past five years. As of 2010, nationally over 40% of health professionals' posts were unfilled.

Some provinces were worse off than others: in Limpopo, over two-thirds of professional nursing posts and 80% of all health worker jobs were unfilled.

PRIVATE SECTOR

In 2005, each nurse in the private sector served 102 people. By comparison, each public sector nurse attended 616 people. Pharmacists were also overwhelmed: in 2005, each private sector pharmacist served 1,853, whereas in the public sector each pharmacist served 22,879 people. This uneven distribution of health workers meant that doctors in the public sector cared for 7 – 17 times more people than those working in the private sector. Similarly, each public sector pharmacist served 7 – 20 times more people than he or she would have done in the private sector.

243 patients per doctor per year

x10

PUBLIC SECTOR

4193 patients per doctor per year

x10

A day in a Lusikisiki clinic

Millions of South Africans rely exclusively on the public system for their medical care. But poverty, limited transport, and under-serviced health centres mean that care is often inadequate and difficult to obtain. **Thandeka Vinjwa** *looks at one woman's experience at a clinic in Lusikisiki.*

Nontandabuzo Bhokhwayidli travels 20 kilometers from her hometown to the nearest clinic. The trip often takes a whole day. Photos by Thandeka Vinjwa.

Nontandabuzo Bhokhwayidli was born and raised at Mfinizweni location in Lusikisiki. To collect her medication on appointment dates she leaves home at 5am for Xurana clinic, 20 kilometres from town. During winter when it is cold and dark Nontandabuzo is scared to travel alone in the early morning. The clinic opens at 7am. If she walks there, Nontandabuzo normally arrives around 8am. "Sometimes when travelling to […] the clinic by foot it takes three hours," she notes. If Nontandabuzo goes by taxi she must spend R32 on two different vehicles, getting to the clinic around 7am.

Xurana clinic consists of five consulting rooms, a dispensary, and a waiting room. It serves about 800-900 people a month and is staffed by two professional nurses, one assistant nurse, one data capturer, seven community health workers and one adherence counsellor. All programmes are integrated and provided under one roof. The staff keep windows and doors open to control TB infection.

There are times when Nontandabuzo waits in the queue until 2:30pm before being attended to by a nurse, who serves 60-70 people a day. Nontandabuzo usually gets home by 4pm. "I [feel] tired after travelling [on foot] for a few hours and am frustrated when I have to borrow money to collect my medication," she says.

The Mechanisms of NHI

A car with faulty wiring under the hood will not take you far. Similarly, if we don't get the fine details of National Health Insurance (NHI) right, we might end up with a stuttering health system that fails us when we need it most. Here are some of the financial details of the NHI that will matter to you.

1 Where will the money come from?

In principle, there are two ways to pay for health services. Either you pay for them yourself when you go to a clinic or hospital, which is called *out-of-pocket spending*, or the services are paid for beforehand through taxes or medical scheme contributions, which is called *pre-payment*. All taxes are forms of pre-payment. So, for example, using the taxes we pay to government, doctors and nurses are employed to work in public clinics and ARVs and other drugs are bought to treat those who are sick.

When trying to address health inequalities pre-payment is the better option, because out-of-pocket spending has been shown to put a greater burden on the poor. Out-of-pocket spending can only work for people with enough money in their pockets.

There are different types of pre-payment:

- One form of pre-payment is *tax.* All South Africans pay money to the government, which is collected and combined as *general tax revenue*. General tax revenue contributions include *income tax,* which is deducted from a person's salary, *value-added tax* (VAT), which is paid on almost all the products and services that we buy, and various other taxes.
- Another type of pre-payment is a *mandatory payroll contribution*, which requires workers in formal employment to contribute part of their pay to the health system.
- Lastly, medical schemes are a form of pre-payment. **However, such schemes operate within the private health care system and are only available to those who can afford the relatively high monthly costs.**

In South Africa, only about 15% of the population is enrolled in medical schemes, while the vast majority depend on tax-funded health services.

Who will pay for NHI?

The ANC has proposed that most of the funds for NHI should come from *general tax revenue*. In addition, formal-sector workers will be asked to make a *mandatory payroll contribution* to health care.

Building a progressive system to fund health care

When considering how to raise money for health care, we should aim for a progressive funding system. Such systems require the rich to pay a higher percentage of their household income to fund health care than the poor. This helps to address existing inequalities.

- **The rich must contribute:** The compulsory payroll contribution must be non-negotiable, so that wealthy people cannot opt out of mandatory payments.
- **No cap:** No upper limit should be placed on the contributions payable by any individual to the health care system. A cap on mandatory payments would allow the rich to limit their contributions, thus potentially paying a lower percentage of their earnings towards health care than the poor. A person's contribution to NHI should depend on their ability to pay, as determined by their income.
- **Don't use VAT to fund NHI:** NHI must be funded through general tax revenue and mandatory payments but not through VAT. Everyone pays VAT on the products that they buy, but poor people spend a larger portion of their income on such items and therefore end up paying a larger percentage of their income as VAT. VAT as a source of NHI funds will not give us a progressive NHI.

2 Who will the money be spent on?

Once the revenue for NHI is collected, the funds are pooled. Pooling takes place when a group of individuals put their money together as a form of insurance, so that if any member of the group is in need, they can draw on group funds. For NHI, pooling will be achieved by combining general tax revenue and mandatory payroll contributions. Government will oversee this large pool of funds and distribute to those in need by paying for all the services provided by NHI.

Not everyone will need health care at the same time, so the healthy members of society will always provide for those who fall ill. But those who are healthy now could become sick in future. Then it would be their turn to benefit from the pooled funds.

Pooling helps us to spread health risks and to share the burden of care. This is because while it is difficult to predict the health care costs of an individual since you never know when he or she may fall ill, it is easier to predict health care costs for groups. By pooling resources with others, each individual limits their own risk and receives support. This is a powerful form of social solidarity

Why we need an integrated risk pool

- **Social solidarity:** If we want to build a system that provides quality health care to everyone free of charge, the rich must contribute to helping the poor, and the healthy to the ill. The risk pool must be integrated across these divides in order to reduce health care inequalities. The greater the degree of risk pooling, the more we can achieve.
- **Bridging the public-private divide:** An integrated risk pool would give more South Africans access to highly-skilled health professionals. At the moment, most of our highly-skilled professionals are attracted to the private sector. This means that only a small number of people who can afford private health care benefit from these high-quality services. An integrated pool of funds would give the government more money, allowing them to purchase services from both public and private health providers, to the benefit of all South Africans. This would help to tilt the power balance in favour of those who need health care as opposed to the clinics and hospitals that provide health care.

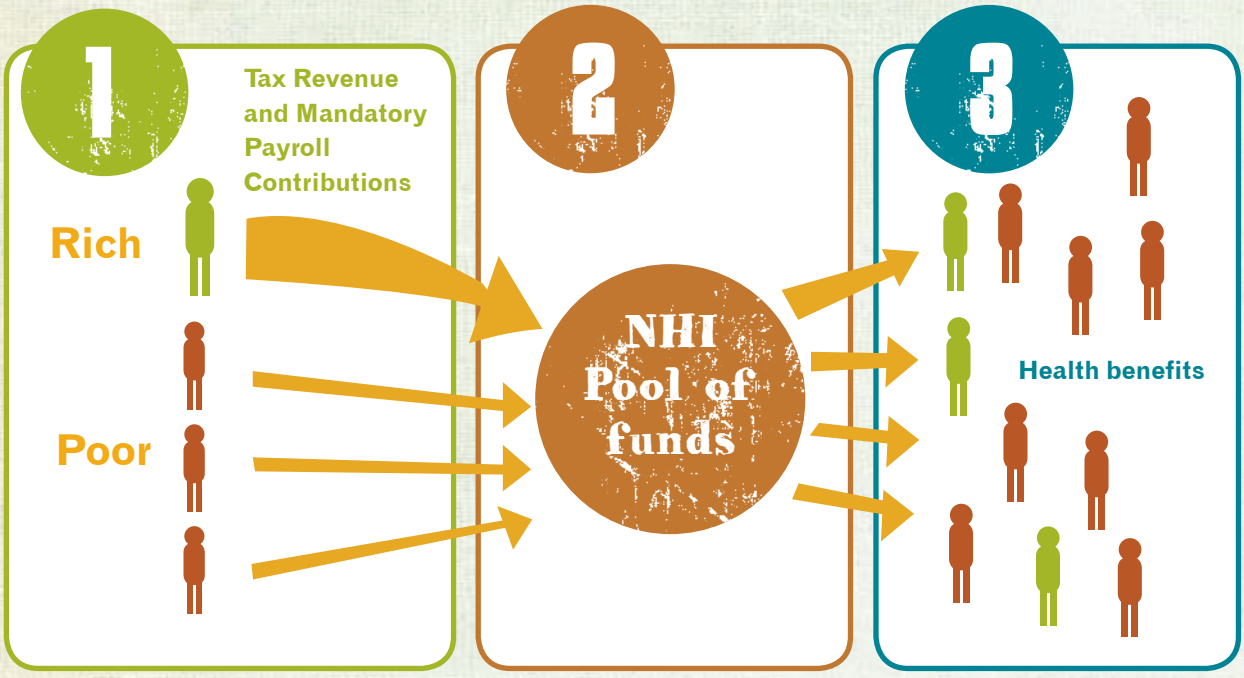
3 What will the money be spent on?

Once the money is pooled, the government must decide how to spend it and which services to include in the *benefit package* covered by NHI.

We need a comprehensive benefit package

- **NHI must cover both primary care and hospital services:** The NHI must cover a *comprehensive* package of services, including both primary health care and hospital care. In order that people do not go straight to a hospital when they feel sick, they need to be referred there by their local clinic or primary health care facility. We do not know yet exactly which services will be available as part of NHI.
- **Not just curative care:** The focus of NHI cannot be only on helping those who are sick to regain their health. We also want the package to include *preventative* services that stop people from becoming ill in the first place, as well as *promotive* services that encourage a healthy lifestyle. If the benefit package includes both prevention and health promotion, South Africa will save money on health care because fewer people will become ill.
- **No user fees:** Health services should be free at the point of provision, because user fees often create a barrier to obtaining health care. At the moment, only primary care is available without a user fee in South Africa. Everyone must pay hospital fees, which are decided according to a person's income.

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
Martin Luther King, Jr.



While the rich will contribute more than the poor to National Health Insurance, everyone will get the same amount and quality of care.

No matter how promising plans for the public health system may be, without good budgeting and effective spending little will change on the ground.

Time to follow the money

When Fikelephi Sithole and Mlungisi Vilakazi of the Treatment Action Campaign (TAC) KwaZulu Natal get onto the subject of budget monitoring they talk so fast that you can hardly keep up. A year ago such excitement about public finance would have been unimaginable for them.

It all started when TAC and the Centre for Economic Governance and AIDS in Africa (CEGAA) partnered in 2009 to keep a close eye on how money is allocated and spent on HIV/AIDS and TB. The resulting Budget Monitoring and Expenditure Tracking (BMET) Project, will run to the end of 2011 in Lusikisiki (Eastern Cape) and Umgungundlovu (KwaZulu-Natal).

The BMET project is built on the foundations of community empowerment and relationship-building with government. Through BMET, Vilakazi and Sithole have been trained to monitor how budgets are spent, and TAC branch members are also involved in the project. Contacts with government are kept cooperative and non-confrontational. As a result, officials are more willing to share budget information and to listen to what TAC and CEGAA have to say.

The BMET project team analysed national and provincial budgets and spending for HIV/AIDS and TB and linked these to service delivery on the ground. They then presented their analysis in simplified budget briefs to government officials, partner organisations, and community members.

To get a clearer picture of service delivery, BMET conducted a survey of community access to, and government delivery of, health services for people with HIV and TB. TAC branch members interviewed HIV/AIDS and TB patients. Sithole, Vilakazi, and CEGAA staff conducted interviews at health facilities. At a provincial public hearing, the MBET team shared their findings with the community. District and provincial representatives from the Department of Health attended the hearing, along with programme managers from clinic and hospital ART units, and a wide range of partner organisations.

Fikelephi: "Since I started with the TAC/CEGAA project I have learnt how to work with Microsoft Excel, do budget and expenditure analyses [at] national, provincial and district levels [for] HIV/AIDS [care]. I now know how to monitor budgets, study strategic and operational plans and write budget briefs."

Mlungisi: "When I first started working on the project, I was confused, but I started learning a lot of new things. As time went on I realised the importance of Budget Monitoring and Expenditure Tracking (BMET). Now I can do budget analysis and write a budget brief. I understand the national and provincial budgets."

Participants from a CEGAA/TAC public meeting. Photo by Nhlanhla Ndlovu.

The BMET project shows that anyone can understand budgets. More of us need to learn about public finance so that we can engage with our local authorities and hold them accountable.

Diagnosis of a health system

The IST (Integrated Support Team) reports are a series of documents that tell us about the state of provincial health departments in South Africa. These reports are important because they provide us with a well-researched, honest account of problems in the health care system and they give us tools to mobilise for better service delivery.

The IST reports were commissioned in 2009 by former Minister of Health, Barbara Hogan, because provincial health departments were heavily in debt and suffering from bad management. This situation had reached crisis point at the end of 2008, when the Free State Department of Health issued a moratorium on putting new patients onto antiretroviral treatment.

For a long time the IST reports were hidden from public view. Eventually, the organisation SECTION27 leaked a summary of the reports so that the public could hold government accountable.

The reports give a worrying diagnosis of poor leadership, mismanagement, inadequate human resources and a lack of funding. Overall, provincial health departments have not been open about their spending and have often wasted money.

The IST reports recommend how best to address these problems. As we try to heal our health system it is crucial that we pay attention to the diagnoses and prescriptions in the reports.

You can download the IST report for your province from this website: www.section27.org.za/2010/09/03/reports-of-the-integrated-support-teams/

Gauteng

TAC Gauteng has analysed the IST report for their province and will hold public hearings on what they have discovered. Amongst other things, they learnt the following:

- Budgeting and financial management are sub-optimal
- There is a lack of cooperation between those responsible for policy formulation, planning, budgets and resources.
- Clinics and community health centres are limited in number and not easily accessible to the communities that they serve
- The operating hours of health facilities are short and some patients are therefore unable to obtain services
- Even though health facilities are short-staffed, nurses are expected to implement new programmes without an increase in staffing levels.
- Because of the split between local and provincial government health facilities, different clinics offer different primary health care services.
- Monitoring and evaluation is inadequate and there is a lack of accountability among officials.

Photo by Alon Skuy/The *Times*.

Plugging the leaks in Gert Sibande

A progressive National Health Insurance (NHI) will play an important part in bringing health care to all in South Africa. However, NHI is only part of the solution. As the money begins to flow, we must plug the leaks that have plagued our public health system for years. Simonia Mashangoane reports on the primary health care situation in Gert Sibande, Mpumalanga province.

We need more health workers

It is difficult to attract health workers to rural districts like Gert Sibande in Mpumalanga. Specialists are particularly rare, and the majority work only part-time in the public sector. As a result, when patients are referred to Gert Sibande hospitals, they are often referred onward to other hospitals in different districts or in Gauteng province. This means that money must be spent on transport between facilities, and patients in need of emergency treatment often do not receive the rapid care that they need.

Many of these human resource problems are the result of poor management and a lack of funding. For example, the Gert Sibande district relies heavily on external funding from NGOs for essential positions relating to HIV care. The clinic at Bethal has 15 staff members, but only five of these are employed by the Department of Health. Of the five, one is a cleaner, one is a data capturer, and just three are health professionals hired to care for over 4,000 patients. The other staff members are employees of the non-profit organisation Right to Care, and TAC also provides a treatment literacy trainer.

The danger with NGO funding for essential health care positions is that the money might dry up. Last year the only doctor at Amsterdam Clinic in Gert Sibande was retrenched because the NGO that paid him ran out of funds. The clinic nurses had not yet been trained to initiate patients onto ARVs and the facility could no longer offer this service. TAC intervened by arranging a meeting with the head of the Mpumalanga Department of Health, Dr J J Mahlangu. We obtained a promise to reinstate the doctor on the Department of Health payroll.

Similar funding problems plague the employment of community health workers in Gert Sibande. Often they are simply not paid. In some areas, home-based caregivers are paid just once a year. Here too, NGOs step in to pay monthly salaries. However, if government is serious about NHI, these community health workers must be made an integral part of the health system, receiving a decent and timely wage.

The short-staffing seen in Gert Sibande is endemic across South Africa, particularly in rural areas. To implement NHI, South Africa needs to attract and retain more health workers, address their training needs, and make better use of staff – particularly community health workers. We need to address the poor distribution of staff that worsens shortages in rural areas. TAC will continue to support government as it expands services, by providing health education and counselling in health facilities.

A clinic in Gert Sibande. Photo by Simonia Mashangoane.

No more stock-outs

In the past few years Mpumalanga has experienced numerous drug shortages. In 2010 Health-e reported shortfalls lasting several months at a time in over 80 different types of medication. Hospitals and clinics borrowed medicines and supplies from each other. During the third and fourth quarters of 2010 ARVs were so scarce that TAC demanded an urgent meeting with the provincial MEC for Health. Following this meeting the ARV stock-out was resolved in facilities that TAC actively monitors. In other areas, shortages of essential medicines continue.

The Mpumalanga Integrated Support Team (IST) report, released in 2010, indicated that stock-outs are widespread in the province. The report found that this was due to poor supply-chain management, and also to poor financial management, which resulted in government being unable to pay suppliers on time.

Stock-outs of essential medicines prevent the delivery of quality care as envisioned by NHI. TAC will continue to campaign against stock-outs and to help patients get treatment.

Bring ARVs to the people

At the end of 2009 government announced a number of important changes to HIV treatment policy. Amongst other initiatives, all community health care clinics would be accredited to start new patients on ARVs. In addition, HIV/TB and HIV/antenatal services would be integrated. In keeping with the principles of primary health care, these changes would allow patients easier access to ARVs at their local health facility.

However, in parts of Gert Sibande these changes have been extremely slow to take hold. In Msukaligwa municipality the process is alarmingly slow – only three of the ten clinics previously identified for accreditation are now able to start new patients on ARVs**.** When TAC Gert Sibande questioned the lack of progress, they were told the delays are due to health facilities switching from municipal to provincial management.

The integration of care in Gert Sibande also continues to be a long-winded affair. Some wellness clinics still do not offer antenatal services for HIV-positive pregnant women due to a lack of staff or resources. Shortages also affect follow-up care for mothers after delivery. Such care is essential to monitor the mother's health, and to support practices such as safe infant feeding, which help to prevent HIV transmission.

The accreditation of clinics and the integration of services are key to expanding primary health care services under NHI. By monitoring these processes and volunteering in health facilities, TAC aims to help government achieve these goals.

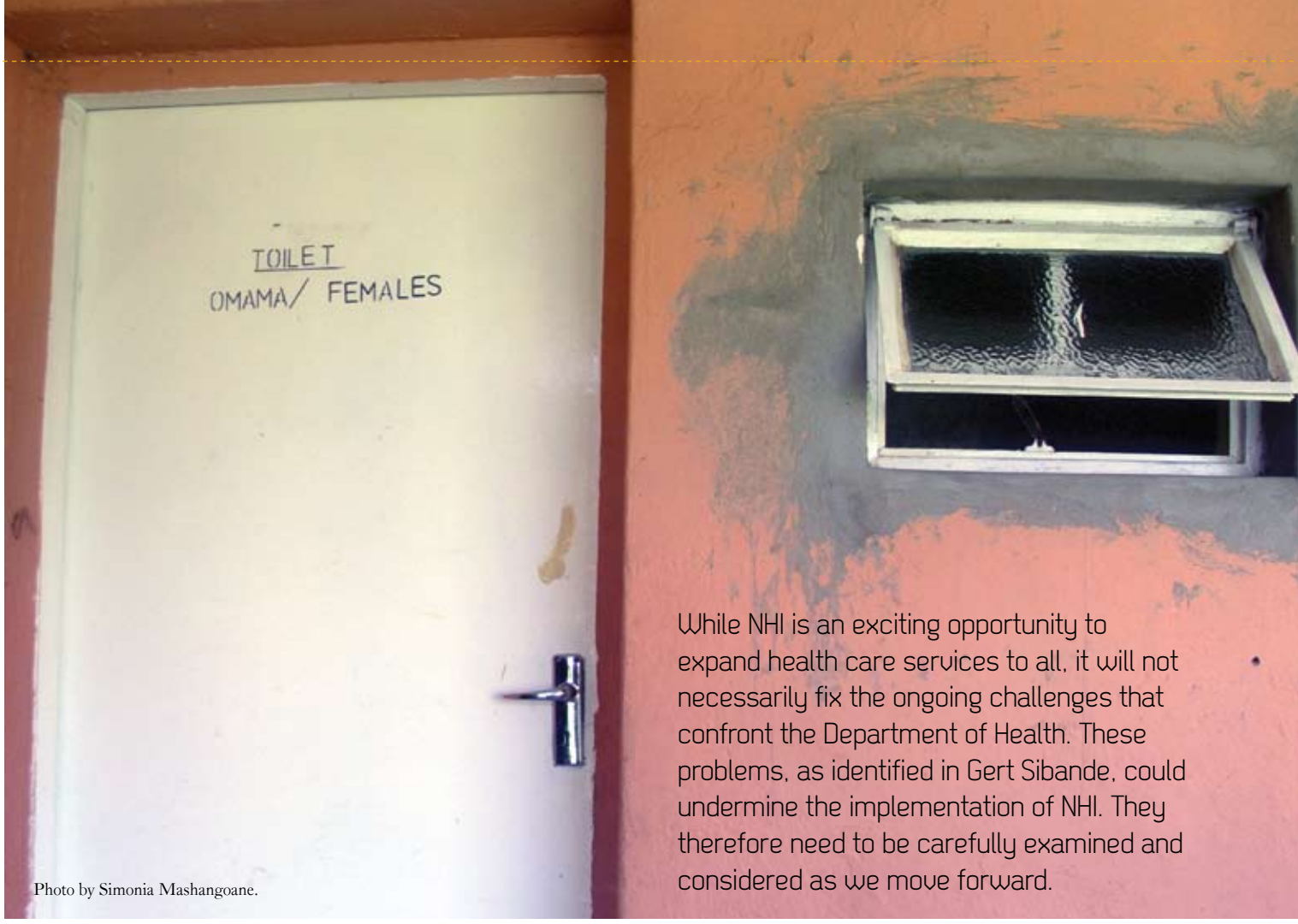


Photo by Simonia Mashangoane.

While NHI is an exciting opportunity to expand health care services to all, it will not necessarily fix the ongoing challenges that confront the Department of Health. These problems, as identified in Gert Sibande, could undermine the implementation of NHI. They therefore need to be carefully examined and considered as we move forward.

We need better management

Poor management and a lack of accountability amongst those in leadership are the major reasons why our health system struggles to cope. The Mpumalanga IST report identified areas of managerial weakness – in particular, poor financial management due to a lack of skills. According to the report, half of financial posts are vacant.

The document also highlighted friction between political and financial managers, with some politicians making policy decisions without consulting the people responsible for budgets. The report noted "[…] political interference in key management processes over a relatively long period of time has [eroded] good management practices."

This political interference was also fingered as a key reason for the number of 'acting' or unqualified personnel in top positions. The combined IST report for all provinces restates "concerns about politically-motivated appointments", which indicates that this is not only a problem in Mpumalanga.

Without effective management, NHI will struggle to bring better health care to our communities. Together with partners such as SECTION27 and CEGAA (The Centre for Economic Governance and AIDS in Africa), TAC will continue to monitor government spending in the coming years and will work with local government to improve financial management.

Canada has a national health system that is considered to be one of the best in the world. Implementation of universal health coverage was staggered over 14 years and by 1975 it was in place across the country. Community health workers play an important role in the success of the system, ensuring that health care programmes reach marginalised and rural populations. Canada has a single-payer system (see box below).

Canada

Statistics	Canada	USA
Percentage of GDP spent on health	10.1%	14.6%
Proportion of expenditure on public/ private health	70/30	45.5/54.5
Per capita government expenditure on health	$2730/ person	$3317/ person

South Africa's health care system both reflects and perpetuates the country's social and economic inequality: the under-resourced public health system serves 85% of the population, with the well-resourced private health sector serving only 15%. South Africa also has a high HIV prevalence, with almost six million people living with the virus. The prevalence of HIV both affects and is affected by an under-resourced and over-burdened public health system. Large portions of the population living in rural areas are not able to access public services. Over-stretched health care personnel, limited material resources, and a high burden of disease impact on the limited services available in urban areas. This contributes to high infant mortality and low life expectancy compared to other countries of a similar socio-economic status, such as Brazil.

RSA

While South Africa and Brazil have similar social and economic indicators, their health systems are significantly different. Although Brazil and South Africa spend comparable percentages of their per capita GDP on health care, the infant mortality, life expectancy and HIV prevalence in South Africa are far worse than in Brazil. This is largely due to the implementation of different health care models: while Brazil prioritises primary and preventative health care, South Africa focuses on caring for people when they are already sick. Each country's response to HIV has also been different, with the Brazilian government ensuring access to ARVs much earlier than the South African.

Sources: African National Congress, 'National Health Insurance' in *Additional Discussion Documents,* 2010. ANC National General Council.

Boseley, Sarah. 'Health worker shortage is truly a global crisis.' The *Guardian*. 18 January 2011. http://www.guardian.co.uk/global-health-workers/a-truly-global-health-worker-crisis

'Which countries are faced with a 'critical' health worker shortage?' The Guardian. 18 January 2011. http://www.guardian.co.uk/global-health-workers/interactive/infographic-mortatlity-rates-health-workers-uk-us-worlld

Bureau of European and Eurasian Affairs. 'Background note: Switzerland.' U.S. Department of State, 7 December, 2010. http://www.state.gov/r/pa/ei/bgn/3431.htm

WHO, *World health Statistics,* 2010. World Health Organization.

Single-payer health system: A funding tool in which everyone receives health care through a single pool of money. Funding for the central pool is drawn from a range of sources, including individual and business taxes and government funding. Canada's Medicare, the United Kingdom's National Health System and Taiwan's National Health Insurance are examples of single-payer systems. South Africa's NHI will also be a single-payer system.

S

USA

More money per person is spent on health care in the USA than in any other country in the world. The country has a mix of private and public coverage. Only the poor, old, and military veterans rely exclusively on public care. The rest must look to their employers to provide coverage, paying out of pocket or relying on charity if they don't have a job or their employer refuses to pay for them. In 2009, 16.7% of the population, or 50.7 million people, did not have health coverage. In comparison with other wealthy countries, the USA has the worst infant mortality and life expectancy. In an attempt to address these inequalities, President Obama's administration passed the Health Care Reform bill in 2010.

Canada and the USA are high-income countries, with both spending a lot of money on health care. Canada has implemented a national health system with a majority of the population using high-quality public services. The USA, on the other hand, has a strong private sector and weak public sector, resulting in one of the most starkly unequal health care systems in the world. **Despite being one of the wealthiest countries on the planet, millions of Americans receive no health coverage at all. As a result, health indicators in Canada are significantly better than those in the USA.**

S

Brazil

Brazil's public health system focuses on providing primary, prevention-based health care. Reforms since the early 1990s have contributed to large reductions in child mortality, improvements in nutrition, and increased life expectancy, making health care more equal between the rich and poor. Family Health Teams form the core of Brazil's health system; each team includes a doctor, nurse, assistant nurse and six community health workers. The teams are assigned a specific geographic area, and care for between 1000 and 2000 families. (Current NHI plans include similar primary health care teams for South Africa.) The government funds Schools of Public Health across the country to train and retain health personnel.

Statistics	South Africa	Brazil
Per capita government expenditure on health	$340/ person	$348/ person
Doctors per 10 000 people	8	17
Life expectancy (years)	51.5	72.4

Community Health Worker (CHWs): CHWs are given basic medical training to provide essential and effective health services to people in under-served areas. CHWs are considered to be central in the successful implementation of universal health coverage in Canada and Brazil, and provide a critical service in many countries, particularly those in Sub-Saharan Africa, with a shortage of professional health workers, a high demand for health care, and large populations living in under-served regions. They are a key aspect of the proposed NHI for South Africa.

PRIVATE PERSPECTIVES

Some people think that NHI and other plans to reform the public health sector should strive to make it just like the current private health sector. That is wrong. The plan is to make the public health system better, more affordable and efficient than the private health system. The truth is, private health care is not necessarily as wonderful as some may think.

Private health is not sustainable

Many South Africans who can afford it pay large monthly contributions to medical aid schemes. The size of these contributions is growing faster than inflation – mostly due to ballooning hospital and specialist costs and an increased uptake in medical services.

Despite large monthly contributions, medical aid scheme members often find themselves saddled with deductibles and top-up payments that they must make out of their own pockets. Due to the complexity of some schemes, users do not always fully understand the limits of their coverage.

Source: McIntyre, D. 2010. Modelling the estimated resource requirements of alternative health care financing reforms in South Africa. SHIELD (Strategies for Health Insurance for Equity in Less Developed countries) Report. Health Economics Unit, University of Cape Town.

COST 15 YEARS FROM NOW

Cost as percentage of GDP

Current health care model

Universal coverage (NHI)

This graphic shows the estimated total health spending for South Africa fifteen years from now as a percentage of GDP. The study on which it is based found that, even though public spending would go up under NHI, private spending would go down and the country as a whole would end up spending less money on health than if we kept the current model.

Unnecessary testing

Sometimes a patient might not really need to go for a scan, but under the private health care system they might be sent for one anyway. This can happen if the doctor benefits financially whenever he or she refers a patient to be scanned. In this way, the profit motive can lead to an inefficient use of resources.

This kind of thing is such a big problem in the United States that in 2009 President Barack Obama committed USD $1.1 billion to so-called comparative effectiveness research. This research is aimed at clarifying which procedures are really worth spending money on and which ones are not.

Profit motive can reduce quality

One serious problem with running health care as a business, is that market competition could lead to dangerous cost cutting. If your aim is to make profits, you might be tempted to do ten procedures a day when you only really have time to do five well. Cutting corners could also lead to reduced infection control or other quality control measures. For example, poor hospital cleaning can result in patients catching dangerous infections.

Not so private

Even though we refer to the private health care sector in South Africa as private, it is not really all that private. Currently the state provides a tax exemption of between R10 billion and R15 billion per year on medical aid contributions. In effect, this means that the government is helping to fund the private health care industry. Many have called for these funds to be reallocated to the public sector.

NHI might save us money

Some people say that South Africa cannot afford NHI. However, the most reliable financial models we have suggest that South Africa's total health care spending under NHI would be lower than our total health care spending if we continue with the current system. This means that most individuals will also pay less for health care.

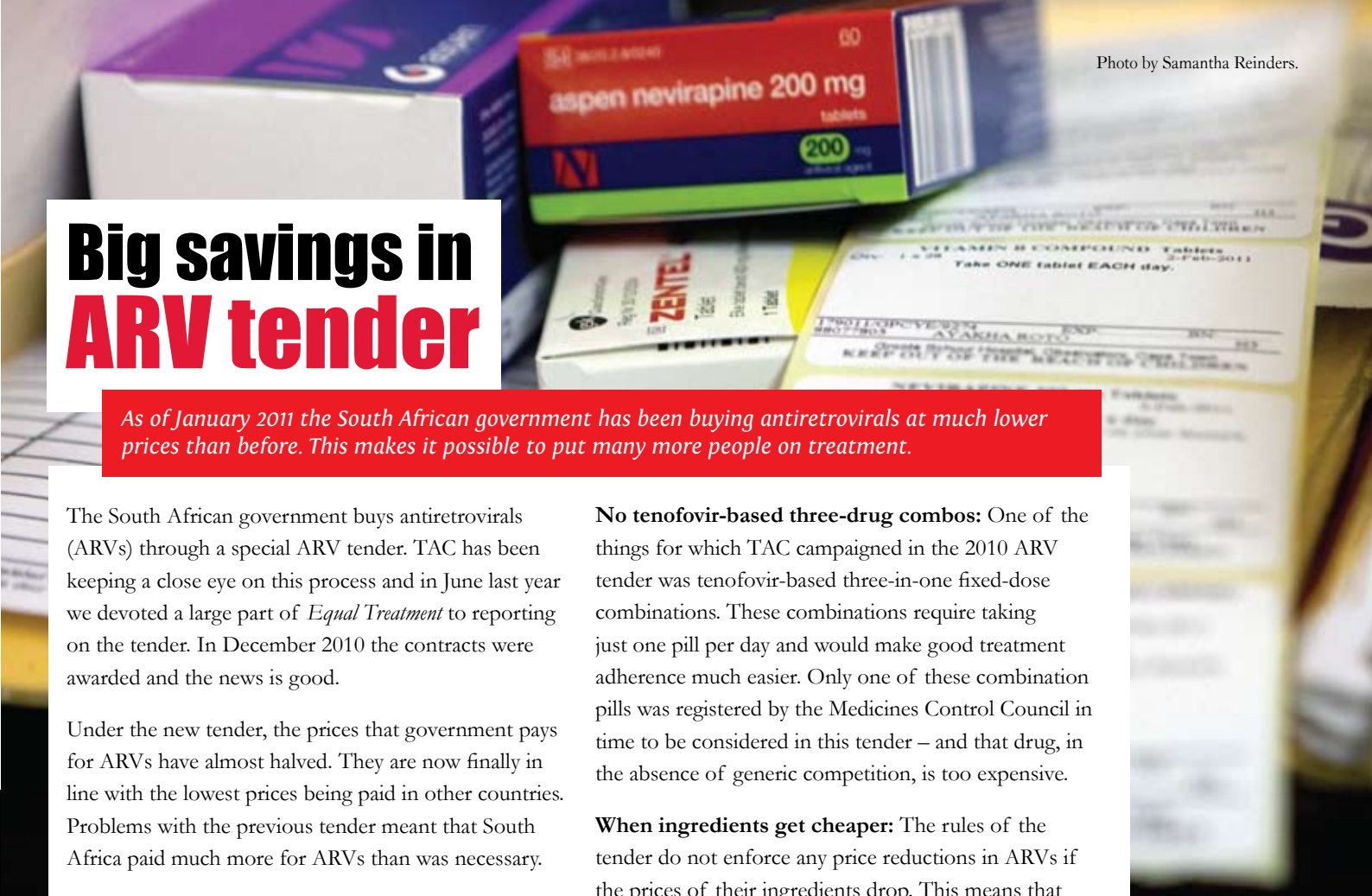


Photo by Samantha Reinders.

Big savings in ARV tender

As of January 2011 the South African government has been buying antiretrovirals at much lower prices than before. This makes it possible to put many more people on treatment.

The South African government buys antiretrovirals (ARVs) through a special ARV tender. TAC has been keeping a close eye on this process and in June last year we devoted a large part of *Equal Treatment* to reporting on the tender. In December 2010 the contracts were awarded and the news is good.

Under the new tender, the prices that government pays for ARVs have almost halved. They are now finally in line with the lowest prices being paid in other countries. Problems with the previous tender meant that South Africa paid much more for ARVs than was necessary.

For example, government will now pay about R115 per patient per month for the standard combination of tenofovir (TDF), lamivudine (3TC) and efavirenz (EFV). Under the previous tender, we paid about R110 for efavirenz alone – just a few rands less for only one drug. Tenofovir now costs on average 65% less and efavirenz 64% less than before.

The price of the children's version of abacavir (ABC) has also nearly halved since the last tender. This is mainly due to a 2008 decision by the Competition Commission that required the pharmaceutical company GlaxoSmithKline (GSK) to allow generic manufacturers to produce abacavir. This introduced more competition to the market, which pushed the price down. TAC and SECTION27 (incorporating the AIDS Law Project) were involved in getting the Competition Commission to include the licensing of abacavir as a condition for allowing the merger between GSK and Aspen Pharmacare to go ahead.

Concerns with the tender

Whereas the savings in the 2010 tender are excellent news, not everything went as we would have wanted. Some of our concerns include:

No tenofovir-based three-drug combos: One of the things for which TAC campaigned in the 2010 ARV tender was tenofovir-based three-in-one fixed-dose combinations. These combinations require taking just one pill per day and would make good treatment adherence much easier. Only one of these combination pills was registered by the Medicines Control Council in time to be considered in this tender – and that drug, in the absence of generic competition, is too expensive.

When ingredients get cheaper: The rules of the tender do not enforce any price reductions in ARVs if the prices of their ingredients drop. This means that even if the main ingredient of a specific ARV halves in price, the company can continue to charge government the same price.

Lack of transparency: The tenders were awarded using a points system that scored for factors such as price and whether or not the manufacturer was a South African company. The tender documentation does not show how much companies scored in the different categories. It only gives the totals. However, there is no reason to withold these details.

- The 2010 ARV tender covers the period from 1 January 2011 to 31 December 2012.
- The total value of the tender is R4.3 billion.
- The tender was split between ten pharmaceutical companies.
- Many of these companies are the same ones that charged much higher prices in the previous tender.
- South Africa accounts for about 20% of worldwide demand for ARVs – with most of this demand coming from the public sector.

THE BIG LET-DOWN

Just as we're beginning to turn the tide on HIV, many governments are backtracking on their funding commitments.

By Margaret Farmer

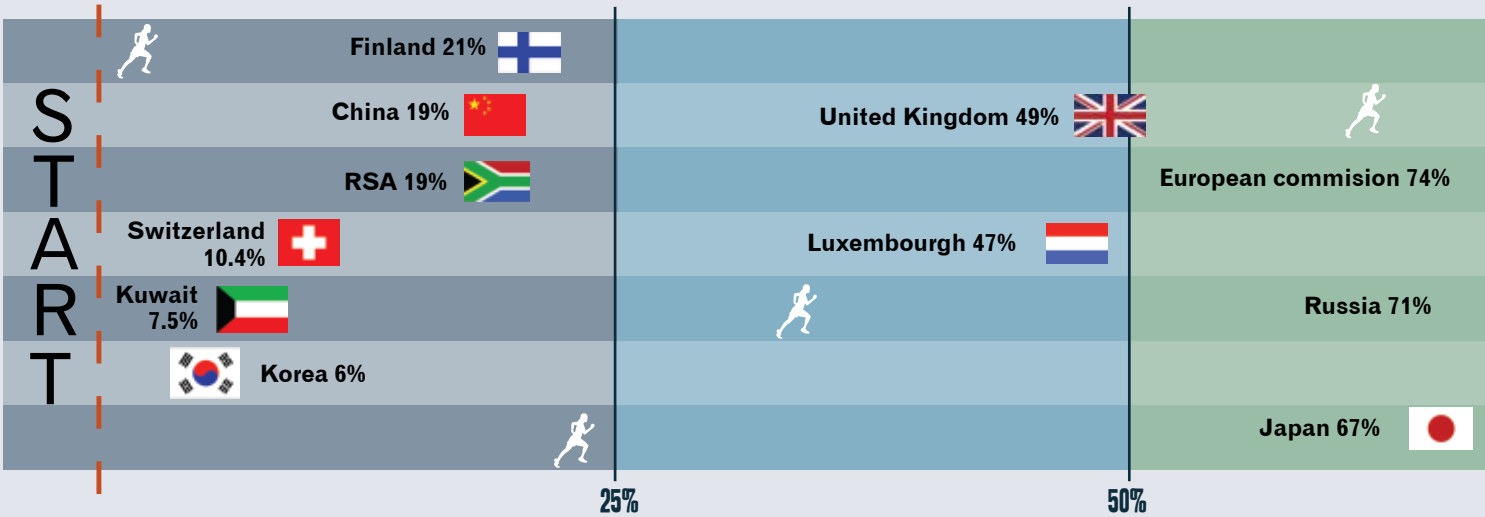
Photo by Samantha Reinders.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is an organisation that collects funds from donor governments and individuals and distributes them to HIV, TB and malaria programmes worldwide. The fund has helped to build successful programmes in many African countries. But now, the money might be drying up.

In October 2010, governments who donate to the Global Fund came together in New York City to discuss how much to give the fund over the next three years. Before the meeting, three scenarios were put forward. The first scenario, which TAC advocated, called for donor governments to pledge a total of USD $20 billion. This would allow an expansion in programmes to reach the millions still needing antiretroviral therapy (ART). It would also make possible the near-elimination of mother-to-child transmission (MTCT) of HIV and prevent millions of new infections, significantly reducing TB prevalence and mortality. The second scenario considered donors pledging $17 billion. This figure would allow the Global Fund to continue its support for current programmes and to fund new ones, as it has done in past years. The worst-case scenario was a $13 billion commitment, which would fund existing programmes, but enable only a small number of new programmes.

THE FAST THE MEDIUM AND THE SLOW: HOW GLOBAL FUND DONORS STACK UP

A minimum of USD $13 billion is needed just to keep existing Global Fund programmes running. The below percentages show how well different donors are doing in contributing their fair share of this $13 billion.



Despite pressure from recipient governments and civil society groups, the fund did not come close to the $20 billion goal. Donors pledged only $11.7 billion. As a result, few new programmes will launch. Current programmes could see their funding cut. Although the pledge marks a 20% increase from the $9.7 billion promised in 2007, an $8.3 billion deficit remains for programmes in need.

Many countries such as Italy, Sweden and Spain did not contribute at all. Others, such as the USA, UK, and Germany pledged far below their fair share as determined by their Gross National Income, a measurement of a country's wealth.

The effects of limited funding will be felt on the ground as successful HIV programmes are frozen and perhaps forced to turn away new patients seeking life-saving ART. Some patients could lose existing access to the therapy. Worldwide, ten million people still need treatment. Without access to ART, the humanitarian organisation Médicins Sans Frontières estimates that "most of these people will die within a few years."

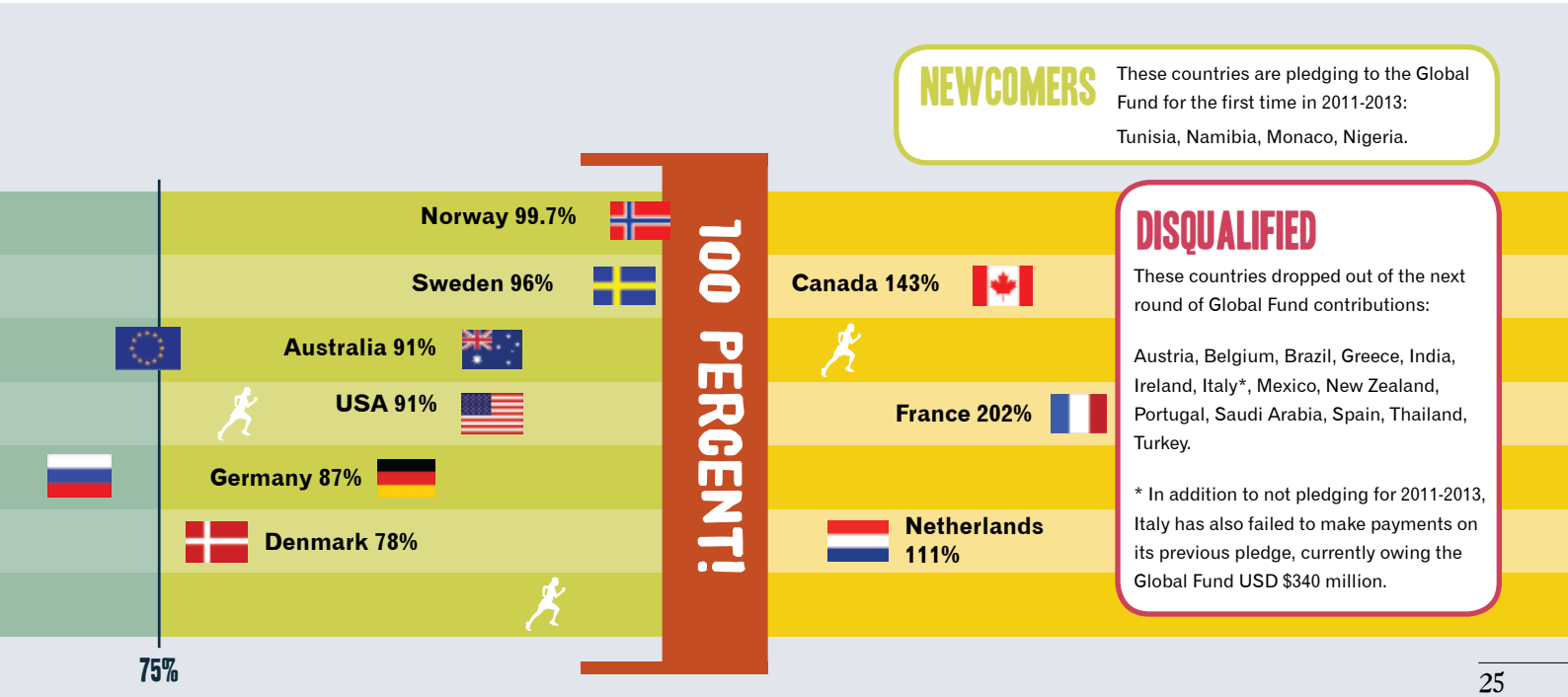
Flatlined funding has already led to the rejection of new, innovative programmes. Malawi proposed to reduce MTCT "by providing lifelong HIV/AIDS treatment to all HIV-positive pregnant women", to retain health workers by raising pay, and to step up male circumcision programmes. These programmes were all recently denied. A proposal by Uganda to increase the percentage of pregnant women with access to PMTCT (prevention of mother-to-child transmission) treatment – currently lagging below 50% – was also turned down. Many promising new projects that build on recent scientific research, and adhere to updated WHO guidelines, will be rejected for at least three more years because of the funding shortfall.

Approximately 80% of funding for the production and distribution of *Equal Treatment* comes from the Global Fund.

FUND LIFE NOT DEATH

Country	Defence spending		Global Fund pledge
USA	$1.983 trillion	vs.	$4 billion
China	$300 billion	vs.	$14 million
UK	$174.9 billion	vs.	$607.4 million
Russia	$174.9 billion	vs.	$60 million
Japan	$153 billion	vs.	$800 million
Germany	$136.8 billion	vs.	$822.4 million
Saudi Arabia	$123.6 billion	vs.	$0
India	$108.9 billion	vs.	$0
Italy	$107.4 billion	vs.	$0
Republic of Korea	$72.3 billion	vs.	$6 million

All figures shown above are in US Dollars



ARVs for uninfected people

Could the same ARVs currently used to treat HIV actually prevent infection altogether?

We know that HIV-positive people who are stable on antiretroviral (ARV) treatment have lower viral loads and are therefore less infectious. For this reason, ARVs already help to slow the spread of HIV. But rather than just making people with HIV less infectious, some researchers wonder whether you can give ARVs to HIV-negative people in order to prevent infection in the first place.

Photo by Damien Schumann.

What is iPrEx?

The iPrEx (Pre-exposure Prophylaxis Initiative) trial was designed to determine whether giving a daily dose of two ARVs to HIV-negative men who have sex with men would reduce their risk of becoming infected with HIV. Giving people pills to prevent HIV infection is referred to as pre-exposure prophylaxis (PrEP).

The trial was conducted from 2007 to 2009 in 11 venues across the world – including Cape Town.

A total of 2,499 men who have sex with men participated in the trial. Half of the men were given a daily dose of the PrEP pill (consisting of the ARVs tenofovir disoproxil fumarate (TDF) and emtricitabine (FTC)). The other half received a placebo – a pill containing no active ingredients. The placebo looked like the PrEP pill and neither the men in the study nor the health workers who handed out the treatments knew who was getting which pill.

All the men received a comprehensive package of HIV prevention services. This included regular HIV testing, risk-reduction counselling, condoms, and the treatment of sexually-transmitted infections.

What were the findings of iPrEx?

Of the 1,248 men who received the placebo, 64 became infected with HIV during the study period. By comparison, only 36 of the 1,251 men who received the PrEP pill became infected. This means that the men who received the PrEP pill were 43.8% less likely to become infected with HIV. Put another way, if 100 HIV-negative men like those in the study were to take the PrEP pill for one year, it is likely that two infections would be prevented.

The 43.8% risk reduction is for all the men who took the PrEP pill. It includes both those who remembered to take the pill every day and those who often forgot. Men who took the pill as prescribed showed much higher protection than those who did not. Among the men who used the PrEP pill on 90% or more of the days in the study, it reduced the risk of infection by 72.8%.

The researchers also found that the side effects of the PrEP pill were generally mild, infrequent and passed within a few weeks. Patients in the study who became HIV-positive also did not show any sign of having become resistant to the ARVs in the PrEP pill.

What does iPrEx mean for HIV in SA?

This trial offers the first evidence that a PrEP pill can be used to prevent infection in men who have sex with men. It provides good reason to hope that PrEP might in future become an effective part of HIV prevention efforts. However, before we can talk about rolling it out in the public health system, more research has to be done and a number of important questions need to be answered.

Some questions to which we still need answers include:

- Will a PrEP pill also offer protection to women and heterosexual men?
- What is the most effective combination of pills?
- Should pills be taken every day, or is there a more effective dosing schedule?
- How do we ensure good adherence?
- How safe would PrEP be over the medium to long term?
- Will the risk of drug resistance be higher in the real world than it was in this trial?

Some of these questions are being examined in PrEP studies that are underway at the moment. It is estimated that up to 20,000 trial participants are currently (or expected to be) enrolled in PrEP trials across the world, including in South Africa. Equal Treatment will be keeping a close eye on these trials as they report their findings.

Reviewed by Dr Linda-Gail Bekker of the Desmond Tutu HIV Centre at the University of Cape Town. Dr Bekker was involved with the Cape Town leg of the iPrEx trial.

New TAC leadership

The Treatment Action Campaign (TAC) held its 5th National Congress in Johannesburg on 21-22 October 2010. Key resolutions made at the Congress call on TAC to:

- Continue to monitor and support implementation of the current National Strategic Plan (NSP), and play a key role in development of the next NSP (2012-2016).
- Call for the South African National AIDS Council (SANAC) to prioritise the development and strengthening of Provincial and District AIDS Councils. TAC will play a leading role in establishing and sustaining these councils in areas where we work.
- Educate members about National Health Insurance (NHI).
- Call on government to correct the failures of the health system as identified in the Integrated Support Team reports.
- Continue to campaign for more domestic and international funding for universal HIV prevention and treatment.
- Congress members also voted in new members of the Secretariat, which provides leadership for the organisation (see right).

These members include:

Photo by Janine Tilley.

Nonkosi Khumalo, Chairperson. This is Nonkosi's second term as Chairperson. She joined TAC in 2001 as Executive Secretary, later leading the Treatment Project. Nonkosi lives in Johannesburg but is from KwaZulu-Natal.

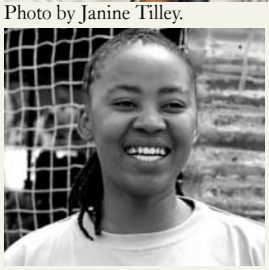


Photo by Melissa Visser.

Vuyiseka Dubula, General Secretary. This is Vuyiseka's second term as GS. She joined TAC in 2001, first volunteering and then working as the Western Cape treatment literacy coordinator. She represents PLHIV (People Living with HIV) on SANAC. Vuyiseka hails from the Eastern Cape.

Photo by Gerd-Matthias Hoeffchen, Bread for the World.

Nathan Geffen, Treasurer. This is Nathan's third term as Treasurer. He began volunteering with TAC in 2000, eventually serving as director of Policy, Communications and Research, being heavily involved in several major legal battles. Nathan was born and raised in Cape Town.

Photo by Alon Skuy/The *Times*.

Mark Heywood, Additional Member. Mark is one of the founding members of TAC, being on the Secretariat since the beginning. He is currently Executive Director of SECTION27 (formerly the AIDS Law Project), where he has worked since 1994. He is also the deputy chairperson of SANAC. Mark is based in Johannesburg.

Photo by Mara Kardas-Nelson.

Victor Lakay, Deputy Chairperson. This is Victor's first term as Deputy Chairperson. He began volunteering with TAC in 2000, later working with the Treatment Project and the Community Health Advocacy Programme. Victor is based in Cape Town, and was born on the Cape Flats.

Photo by Mara Kardas-Nelson.

Lihle Dlamini, Deputy General Secretary. This is Lihle's first term as Deputy General Secretary, after acting on the position in 2009 and 2010. She joined TAC in 2002 as a volunteer, later filling the position of Treatment Literacy practitioner, trainer, provincial organiser and provincial coordinator. Lihle is based in Cape Town, but her home is in the province of KwaZulu-Natal.

CONNECT THE DOTS

Equal Treatment 37

Answer each question by drawing a line from the question bubble to the matching country on the map. All the answers can be found in this issue of *Equal Treatment*. We will give a R200 Pick n Pay gift voucher to the first completed puzzle drawn from a hat.

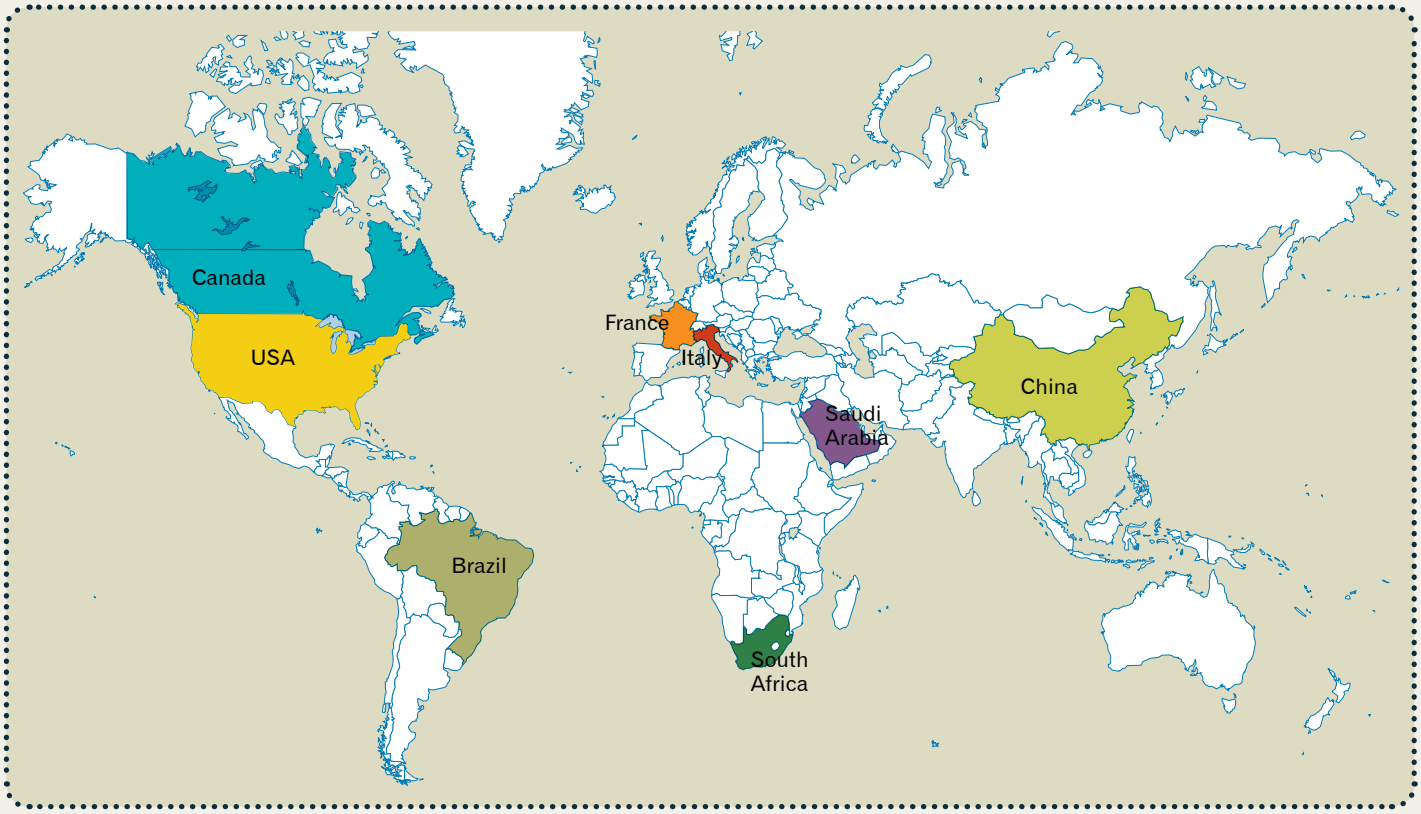
Fax or post your completed game, with your name, address and contact number. Address: Equal Treatment, PO Box 2069, Cape Town 8001 Fax: 021 422 1720

Which North American country spends the most on health care per person?

Which country is regarded as having the best functioning health care system?

Which country produced the highest percentage of their fair share to the Global Fund?

Which European country owes the Global Fund $340 million?

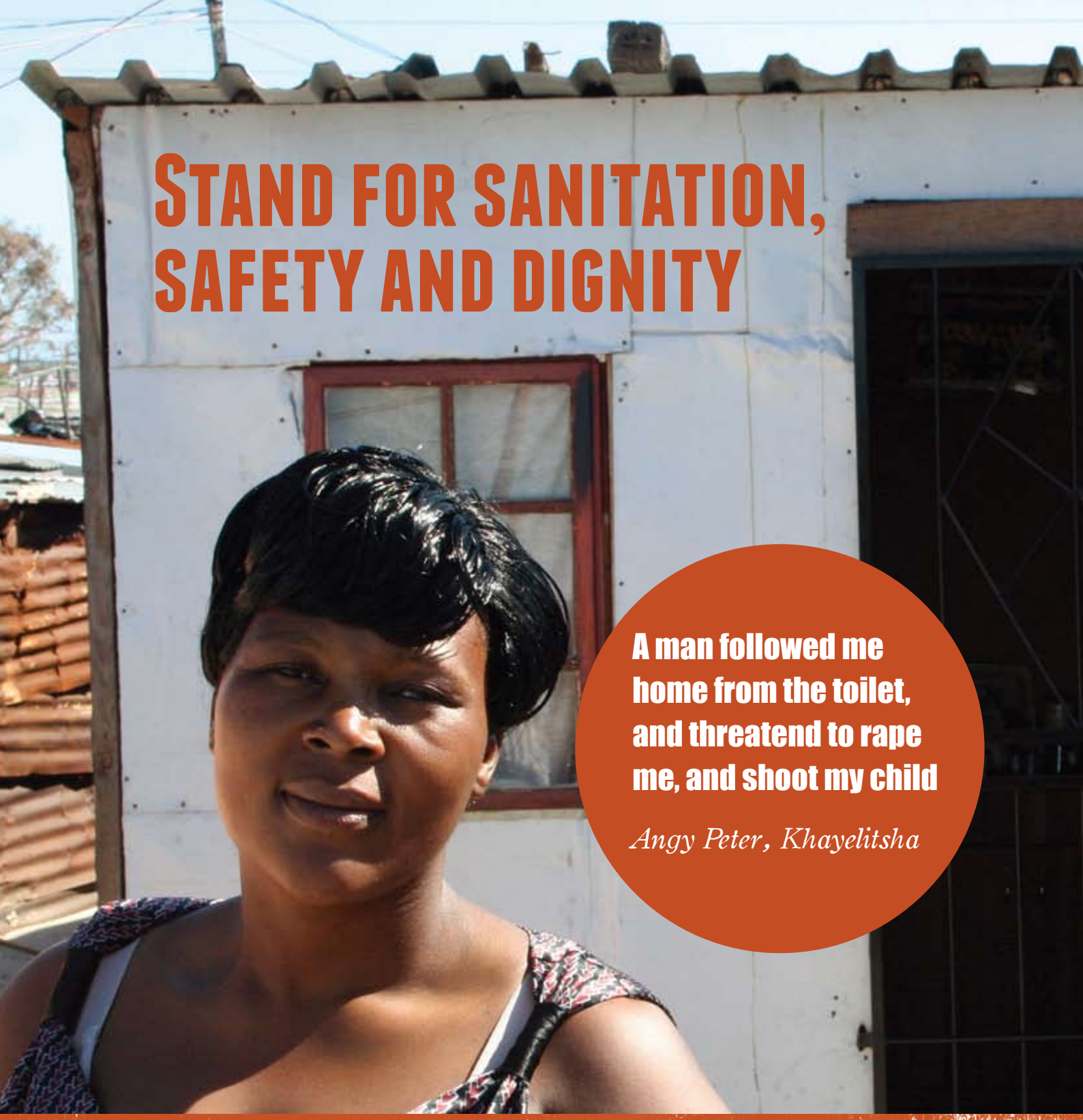


Which country has had great success with a primary health care model that makes use of small teams of health care professionals?

Which country is implementing national health insurance in 2012?

Which Middle Eastern country supports defence but does not contribute to the Global Fund?

Which Asian country's Global Fund pledge is a fraction of its military spending?



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