

**CAMPAIGNS AND ADVOCACY**  
**NATIONAL HEALTH INSURANCE CAMPAIGN**

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## Introduction

The National Health Insurance (NHI) campaign fell squarely within the PHM Global and South Africa Health for All and Right to Health campaign goals. Where there were natural alignments between other Civil Society Organisations (CSO) goals and People's Health Movement- South Africa (PHM-SA), alliances and coalitions were formed. In some cases, outside CSO's and PHM-SA would support each other with campaigns that were complimentary to the NHI campaign. In other cases, CSO's such as Treatment Action Campaign (TAC) developed their own NHI campaigns.

The cost of funding a National Health System, and Service through the NHI by 2025 by estimation is R 225 Billion (Eyles 2016). The private health sector receives more funds for a small portion of the country while the public health receives less funds for a larger portion of the country. The inequity is vast yet, while these are the facts the atmosphere in South becomes tenser as tax payers consider a payroll tax to pay for the health of no income and low income earners in South Africa as well as their own private medical aid. Freedom, fairness and equity are on the table for discussion at the Competition Commission. Never before has it been more crucial for the health system as a whole; private and public, to provide a holistic health service for all in South Africa. However, should the scale sway in favour of either the public or private sector, South Africa will continue to marginalise its citizens, which will largely have dire consequences for social security and solidarity as a country.

CSO's are aware that for quality HFA to be reached an overhaul of public and private sector needs to occur to ensure that the one doesn't influence the other in an iniquitous way, but instead work together in a mutually beneficial way. The public health system needs to be improved to the level of the private health sector and the private sector's prices and issues of quality need to be addressed through regulation.

Controversy over the use of terms such as NHI and Universal Health Coverage have been prevalent among all CSO stakeholders as the words insurance and coverage are largely private health insurance terms. These terms have been used interchangeably by all stakeholders over time to mean both coverage and care, insurance and system. At present, in South Africa when CSO's, Movements and activists advocate for HFA they advocate for health for all, quality health and a quality health system under the banner Universal Health Care using the NHI campaign but at other times this will also include cost coverage as the word insurance implies in the term, NHI. The term NHI has been useful to enable thinking around how an intended National Health System (NHS) would be funded.

Overtime, PHM-SA and public health and human rights activists campaigned and advocated for Health for All (HFA) before the NHS in the form of the NHI concept was shared with the public in the form of the Green Paper and the White Paper.

## Historical and political context

Health reforms were put on the agenda in South Africa as early as 1921 by doctors at the Transvaal mines who connected the dots between poverty linked to the Social Determinants of Health (SDH) and poor health status of miners and started activating social change (PHM-SA 2016). Later in the 1940's, Sydney and Emily Kark (Against The Odds 2016), and Edward and Amelia Jali (Kautzkyi and Tollman, 2008) with the support of the Gluckman Commission created by the Health Minister at the time, Henry Gluckman, developed the concept of a National Health Service, funded through taxation which would be available to 'all people in SA according to their

needs and not according to their means". These plans were shut down by the Apartheid Government (SAHR 2008: pg. 19).

The Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, in Kazakstan, USSR, between 6-12 September 1978 expressed 'the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world' (WHO 1978). The Alma Ata Declaration reaffirmed that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.' Many activists ideologically embedded the declaration into their philosophy and goals and still work toward achieving this goal. The Alma Ata declaration has since been reincarnated in a lesser form in the Millennium Development Goals and Sustainable Development Goals.

In 1994 South Africa saw the inauguration of the first black president of South Africa, Nelson Mandela who traded off land reform and economic power for leadership, governance and political power. The event was meant to signify the end of apartheid in South Africa but in the years that followed, South Africans of the opposite colour believed that they were now being discriminated against despite the fact that they were still the highest income earners and owners of land. The Redistribution and Development Programme (RDP) was implemented to develop a more equal society (SA History 2016). Black Economic Empowerment (BEE) (SA History 2016) was nested in the RDP plan to balance economic power and train managers but what it did was known as the class project. It implanted neo liberal ideology in a black minority who continued to implement inequity in South Africa. In 1996, the Growth Employment and Redistribution (GEAR) strategy was aimed at correcting the financial imprudence of the RDP. In 2005 GEAR was replaced by the Accelerated and Shared Growth Initiative for South Africa (ASGISA). ASGISA was meant to focus on diminishing poverty and halving unemployment but there was very little rhetoric about this by government. The New Growth Plan was introduced by President Jacob Zuma in 2010. Once again, neo liberal ideology was set within the NGP and was sold as a policy that would lower unemployment, poverty, and inequality by bettering South Africa's economic situation. In 2013, the National Development Plan was introduced as 'South Africa's long term socio-economic development roadmap.' The NDP's goal is to eliminate poverty and reduce inequality by 2030. Every few years, government repackages these economic strategies, plans and policies. At the core of these policies is economic ideology that continues to widen inequity and marginalise low income or no income earners.

An African National Congress (ANC) conference in Polokwane in 2007 marked the passing of a resolution 'calling for urgent implementation of a comprehensive NHI scheme' (ANC 2007). Also, the Congress of the South African Trade Union (COSATU) and the National Education Health Allied Workers Union (NEHAWU) with its Secretary General (SG) The South African Communist Party (SACP) were mainstreaming the NHI through its internal resolutions in minutes of meetings (COSATU 2016) (NEHAWU 2010).

Post the Acquired Immunodeficiency Syndrome (AIDS) denialism period of President Thabo Mbeki, Matthias Raith and the then Health Minister, Dr Manto Tshabala Msimang (Goldacre 2008), the new Minister of Health, Dr Aaron Motsoaledi arrives on the scene in 2009. The ANC health committee was formed. In addition to, the NHI Ministerial Committee (MC) of NHI. 2009 is also the year that the ANC included into their election manifesto, that they would aim to

implement the NHI within 5 years before the 2014 general elections. At this time, COSATU also passed a resolution 'calling for urgent implementation of a comprehensive NHI scheme'

A national priority in the 2009 ANC elections manifesto is the implementation of a NHI within the 5 years before the 2014 general elections (ANC 2009: pg 11). The ANC National General Council reaffirmed the commitment to the NHI but indicated that the implementation would be from 2012 to 2025

Formulation of the NHI Green Paper was underway in 2010 but at this stage, NEHAWU considered it a delay see 2010 resolution document. A consultative conference was held at Gallagher Estate in Johannesburg for all stakeholders. The NHI Green Paper was officially published in August 2011 which underpinned the formation of the NHI Coalition to formulate a discussion paper in response to the philosophical and perforated nature of the Green Paper. TAC co-hosted a meeting with PHM at UCT in March 2012. The meeting was productive and allowed several activists and organisations who were interested in building a campaign around the NHI to meet each other/network and to share information. It also built awareness amongst senior TAC members about the importance of the NHI. There was very little follow-up in the post the meeting and subsequent efforts to work within the NHIC fizzled out. The Green Paper eventually was pulled out of the public domain; the Department took control over it. It went through numerous drafts within the Department. Nobody really knew what was going on whilst there continued to be discussions about NHI.

Also, in 2012, S27 had co created Corruption Watch with the Congress of the South African Trade Unions (COSATU).

In 2014 the Competition Commission's Market Inquiry into the Private Health Sector commences and continues into 2016. The long awaited 40<sup>th</sup> version of NHI Whitepaper is released to the public on 15 December 2015. Specialists and experts across South Africa prepare to submit responses to the White Paper. PHM-SA held a NHI White Paper Meeting in Khayelitsha on 20 February 2016 that attracted roughly 120 people but the momentum, for other CSO's, it seems, had deflated.

PHM-SA moved forward with NHI consultation meetings in Khayelitsha, Klapmuts and a student meeting at UCT in 2016. In addition to submitting joint responses to the White Paper at the end of May 2016.

In March 2016, the Constitutional Court (Con Court) found Zuma guilty of spending tax payer funds to install non-security upgrades to his private home which included a visitor's centre, amphitheatre, a swimming pool, a cattle kraal and chicken run (News24 2016). Con Court ruled that Zuma must pay back a portion of what he spend which was to be determined by Treasury. This was a tipping point for the HFA movement and a perfectly primed moment to mobilise civil society to engage in a Zuma Must Go Campaign. And while Zuma and other government officials continued to be involved in corruption and misappropriation of funds South Africa was being told that "There isn't a pot of gold for the NHI" by the South African Health Minister (Cullinan 2016).

## **National Health Insurance Coalition (NHIC)**

Soon after the release of the Green Paper, PHM took a strategic decision to start the NHIC to ensure that health activists were speaking on the NHI issue with one voice, and to increase the visibility of the NHI in public discourse. But also to work with and influence other CSO groups.

The coalition was a civil society initiative and/or approach that says to turn a radical set of proposals into health reforms.

Additionally, it was seen as an opportunity for progressive forces to coalesce within civil society, and the trade unions such as NEHAWU who were all working on the right to health and so different CSO's, Movements and Unions started to speak to each other.

The Green Paper Discussion Document was a policy reform that no CSO could afford to dismiss and so PHM-SA, Soul City, S27, TAC, Black Sash, RHAP RuRe, RuDASA, Passop, Earth Life Africa, NEHAWU, and Africa Health Placements (AHP) became signatories of the discussion paper while some became members of the NHIC.

The Department of Health held a meeting at Gallagher Estate in Johannesburg – a one-day thing with civil society about the NHI. PHM-SA shared the NHIC Green Paper critique response and distributed that at that meeting. Then held a bigger meeting than the coalition actually around the Gallagher meeting to keep up the pressure on some of the key sticking points of the Green Paper.

PHM-SA was responsible for initiating NHIC meetings but also held empowerment workshops in communities that analysed the links between broader social determinants of health and the specific health problems of each community. Ten principles were developed that should underpin a people's NHI; the idea was that these principles could be used to evaluate the NHI White Paper upon its eventual publication.

Notably, the first South African People's Health University (SAPHU) was formed to support the work of the NHIC, which was initiated partly to train a new "layer" of health activists. While PHM-SA undertook the drafting of NHI pamphlets these were never printed or distributed.

TAC did most of its campaigning work around the NHI through organisational initiatives and activities rather than as a member of the NHIC.

It seems that NHIC members continued with NHI campaigns independently of the NHIC. For example: TAC reports having a dedicated staff member who is dedicated to doing research on universal health coverage.

Since 2012 TAC has done campaigning/awareness-raising about the NHI through its organisational work. It has sought to engage TAC members, policymakers, and government officials (MPs, ministers, Competition Commission) in conversations about the NHI. It has not engaged the private sector

## Mobilisation

PHM-SA particularly worked with organisations who were already advocating for human rights NHI Campaign Enablers. By way the story is told by some activists, some CSO's strategically developed the Eastern Cape Health Crisis Action Coalition (ECHAC) using the resources created by the NHIC. If one perceives PHM-SA as a movement, one could say that PHM-SA's influence, led to the formation of ECHAC.

From observation, CSO's form alliances with other organisations for skills mixes needed to achieve successful campaign outcomes. For example, BS's tripartite alliance with UCT's Health Economics Unit, Health Systems Trust and Africa Health Placements provided their community

responses initiative with technical, communication and media, human resource skills. Close relationships with TAC allowed BS to mobilise meetings and workshop attendees in droves.

## Activities

PHM-SA coordinated meetings for the NHIC, empowerment workshops in communities which analysed the links between the broader social determinants of health and the specific health problems of each community. 10 principles were developed to underpin a people's NHI. The idea was that these principles could be used to evaluate the NHI White Paper when it was eventually published. Pamphlets were drafted but never printed or distributed.

TAC included information about the NHI in its workshops with activists. They sent Media statements that are supportive of the NHI in principle but that criticise delays in releasing the White Paper or raise questions about how it will be funded, or whether it will result in universal health coverage. The NHI was discussed in national council meetings, particularly around 2012. They were involved in monitoring activities at NHI Pilot Sites; compiling a report evaluating progress in this regard and circulating it to members of parliament in an effort to raise awareness and create discussion about the difficulties of implementing the NHI at pilot sites. TAC assisted in building knowledge about the NHI and similar initiatives elsewhere amongst the TAC research team and National Council members. TAC also discussed the NHI in two of its meetings with Motsoaledi since 2012 but it has never been the main reason for calling a meeting, nor a key point of discussion in any of its meetings with the Minister.

Funding has allowed TAC to dedicate a point person to work on the NHI. Since 2012 TAC has done campaigning/awareness-raising about the NHI through its organisational work. It has sought to engage TAC members, policymakers, and government officials' MPs, ministers, and the Competition Commission in conversations about the NHI. It has not engaged the private sector.

TAC has published an issue of Equal Treatment magazine that explained the NHI and some of the strengths and weaknesses of the scheme as set out in the Green Paper. The purpose of this was to make information about the NHI more accessible to TAC members and to raise the level of public discussion about the NHI. TAC has drawn on existing knowledge, particularly scholarly publications and inputs from academics, in its works around the NHI. TAC feels it has contributed new knowledge in the sense that it has translated expert knowledge about the NHI into language that can be understood more easily by its membership (e.g. the issue of Equal Treatment that focuses on the NHI). This is not new knowledge but decoded knowledge.

TAC's work around the NHI would be reactivated once the White Paper is released and that the organisation would most likely work quite closely with Section 27 and maybe MSF in formulating a response to the White Paper. TAC would not necessarily reactivate the contacts it made through the NHIC as these relationships had become dormant/had not been maintained after the 2012 meeting of the NHIC.

S27's work around the NHI included monitoring two NHI pilot sites, OR Tambo and Gert Sibande in Mpumalanga, which were part of the 2010 NHI plan. There have been a few reports of failure and no improvement. Getting private sector doctors to come and work in the clinics for a long time, did not achieve improvement.

## Knowledge

Peter Benjamin then from Cell-Life assisted with a SMS survey about the NHI. Thousands of responses as a kind of mass consultation was submitted with the discussion paper to government.

Ground-breaking research was done by Black Sash (BS) in a tripartite alliance with the UCT Health Economics Unit's Di McIntyre, Health-e, and Health Systems Trust. in 2010 on eliciting public preferences for health system reform including the NHI in the form of public consultations. After being exposed to Gavin Mooney's Citizen Jury approach, approximately 900 community members shared their responses.

TAC has drawn on existing knowledge, particularly scholarly publications and inputs from academics, in its works around the NHI. It has contributed new knowledge in the sense that it has translated expert knowledge about the NHI into language that can be accessed and understood more easily by its membership also to raise the level of public discussion about the NHI. In one edition of TAC's Equal Treatment magazine the NHI and some of the strengths and weaknesses of the scheme as set out in the Green Paper is explained.

## Enablers

At the time, when Elroy Paulus was Chairperson of PHM-SA's meetings were convened at times that were convenient to people. Meetings were held on a Saturday once a month or once every second month and that's the time is convenient to other people.

At that time, after care facilities were made available at such People's Health Movement meetings. At the time, PHM-SA's visible focus was people on the ground not academic institutions. PHM leaders at the time facilitated resources to be made available to people who want to speak.

Being able to work well with the Director General (DH) of Health Precious Matsoso and Motsoaledi has been enabling due to his commitment to a primary health care approach.

One interviewee said that a strong sense of Ubuntu was witnessed at hearings, consultations indicating that people have a strong sense of social justice what equity is. Also, the willingness for people to meet after hours and to give sacrificially and to engage in a manner that is selfless.

Ground Up (GU) publication has been a great enabler. GU Enabled the voices of people on the ground to come through by publishing stories from the ground showing the inequities including health and social assistance.

## Barriers

### capacity

A lack of capacity to do the NHI work has always been a challenge for all stakeholders also limited time means prioritising more urgent issues; stock outs; poor access to emergency health services; human resources for health; intellectual property rights; TB which in turn disallowed sustained efforts for the NHIC.

Over the span of three years, PHM-SA had three different coordinators each with differing skill sets. History has shown that the release of timeous content has been a persisting issue but given that the Steering Committee all had full time jobs and were doing the best they could with the time they had, this was to be expected. Burnout amongst activists, and the fact that they



were overstretched was one of the main impediments to the NHIC's effectiveness. This was a problem within the NHIC but also amongst PHM Steering Committee members.

Two activists expressed that overall, the NHIC was not experienced as a real coalition or that it was really committed to building a campaign. In 2011, there were no visible individuals who acted or "drove" and led the NHI campaign. Face-to-face meetings were limited and coalition members did not have many opportunities to consolidate their relationships with each other. Such meetings mainly took place on an ad hoc basis – usually when members of the NHIC happened to be in the same place (e.g. because they were all attending a conference). One interviewee felt that the work of the NHIC could not be sustained only through emails and teleconferencing.

### organisational structure

PHM-SA plays the role of movement and at times as organisation structure, to an extent this impedes its ability to sustain a NHIC or robust NHI campaign. Two interviewees explain the nature of PHM-SA to be fast paced at times, slow at others, constantly changing as that of a movement. At one recent meeting there seemed to be competing views of PHM-SA's role as movement and as of an organisation.

TAC is a membership-based organisation which has limited the extent to which it could prioritise the NHI. TAC members elect their provincial and national leadership. Members and office bearers take the lead in deciding which issues the organisation should prioritise in its work. The NHI has not been a priority issue for members despite the awareness-raising work that has been done around it.

One interviewee said that they were never asked to officially be a member of the NHIC and that there was no media statement or press release.

### absence of the White Paper

CSO's perceived the absence of the White Paper as the NHIC having nothing concrete to respond to and engage with.' This effectively meant that there was no urgency around the issue of the NHI. The delay in releasing the NHI White Paper was described as the main political constraint in sustaining mobilisation around the NHI. To one interviewee, it seemed as if the coalition was 'shadow boxing' therefore it was very difficult to organise activities such as mass marches or to establish a media profile for the NHIC.

### complexity of the NHI

An NHI Campaign needs to address the whole health system and therefore if a campaign is not planned and adequate strategy applied it appears to be an unmanageable task which is perhaps one of the reasons the NHIC wasn't as successful as it should have been, that, linked to the capacity and fund issue.

### funding

Face to face meetings were difficult to organise as PHM and the NHIC did not have the financial resources needed to cover the expenses associated with them (e.g. travel, food, and accommodation costs) which meant that member of the NHIC had to dip into their own resources. Barriers to campaigning as with any campaign in South Africa is access to resources. Any campaign requires resources for transporting and feeding people. So typically we have a lack of access to transportation, communication even communicating a message has to be on a non-smart phone otherwise people who don't have access to airtime and data wouldn't know that there is meeting on Saturday afternoon at the clinic so a huge barrier is

resources; transport, communication, food, cost of hiring equipment and so on. So access to resources also disproportionately affects voice.

In the 2016, Treasury meeting it was made clear there is limited health budget and a recent article where Motsoaledi made it clear that 'There isn't a pot of gold for the NHI (Cullinan 2016). It requires reorganising money that is already there' which indicates that perhaps the HFA movement should consider redirecting its NHI campaign activities to considering how it can put pressure on the Competition Commission (CC) to produce their verdict on the regulation of the private health sector more speedily as the CC may take another two to three years to come up with a verdict. Motsoaledi goes on to say that the NDOH is committed to the implementation of the NHI but the grapevine has expressed that there is in reality no political will from the ANC to execute the NHI and that Motsoaledi's voice may be turned down a notch on the NHI as it will affect his career and his ability to move change in the long run (NSP 2015).

### *politics and 'lack of political opportunity' and political will*

Both internally (CSO's) and externally (government) perceptions of lack of political opportunity and political will hinders NHI campaigns. One interviewee thought there was dissatisfaction with the Green Paper, therefore it was inevitable that the coalition wouldn't hold together. Now in 2016, one interviewee felt the White Paper was 'half baked'.

One interviewee described political differences: 'some of it is petty, some of party politics poses critical barriers to campaign activities. The minute there is a perception that an initiative that is actually entirely citizen based is in any way associated with a particular political party then there seems to be an unwillingness to participate or people have personal agendas.'

Additionally, will within the NDoH is low. Motsoaledi has been called an enabler, his department not. 'There are vested interests in the directorates that are resistant to a primary health care re-engineering approach as they realize that changes in the institutional arrangements in the national department of health means they may be without a job or be absorbed into a directorate that needs to find and realize the mandate of the programme- the re-engineering approach.'

### *Lack of Consultation*

According to one CSO, the NHIC's work was made difficult by the fact that the government did not consult left organisations about the NHI. The drafting process has been opaque and secretive and there has been a lot of confusion and misinformation about when the NHI White Paper will be published, however, post the discussion paper, a one-day consultation was held at Gallagher Estate in Johannesburg in December 2011, organised by the DoH with civil society. The National Consultative Health Forum (NCHF) released a report describing events. DS attended this event while Leslie London, Elroy Paulus, Gavin Mooney and Mark Heywood spoke at this event.

One interviewee reported that policy makers and government officials in countries such as Brazil, Thailand and Kenya take a civil servant approach to engaging and ensuring a participatory government. Officials go to places where people are afterhours and they have meetings there. They don't say I am only available from 8 to 4 and come to the twentieth floor after you have declared your laptop and gone through security checks. This is an inhibitor in South Africa.

Geographically, CSO's such as RHAP, RuDASA, S27, and TAC are closer to the Pretoria NDoH where policy consultations take place. One interviewee felt there could be a more central location which would make it affordable for all CSO's to attend.

### *Lack of broader coalition formation*

There's a lack of a broader coalition formation which included the voices of public health facility users. One point of view expressed that one of PHM-SA's perceived shortcomings during 2011 was that it didn't focus on forming a broader coalition that brings in representative groups from marginalized populations while another pointed out that PHM-SA did in fact give voice to the marginalised which was striking as few CSO's did this.

### *Leadership and relationships weak in South Africa*

South Africa is a young democracy and sometimes activists and executives confuse their hats. Relationships between community leaders and people in power is another barrier in particular in the Western Cape. For example: The strategic health plan in the Western Cape is not being implemented or that is being implemented in very inequitable manner. More activism is needed around this.

One interviewee reports that the former MEC of health called civil society 'a bunch of bloody trinkets' when the Death and Dying report and the response from the MEC of health versus the national minister of health rejecting with contempt at a local level which is regrettable and the national minister of health says I never knew about this, I take it very seriously and you will have a response in 7 days and he flew down to respond and corroborate the facts.

### *corrupt government*

One of the reasons why there is no progress on NHI, reports one interviewee, is that you can't have a roll out of an immensely progressive but complex and controversial policy, 'when it comes to vested pounds in the context of a government that governs poorly and is corrupt.' Addressing NHI shortcomings becomes compounded when considering the effects corruption and poor leadership and governance of the public health system which adds to the complexity of the task, however, CSO's have started organising around mitigating this factor with the #ZumaMustGo campaign and using the #ZumaMustFall campaign to help toward that end. S27 also started the Corruption Watch in 2012.

## **Changes**

An NSP (2015) article indicates that there's no political will to implement the NHI. Motsoaledi's rhetoric in media articles seem as if he's straddling the lines about what needs to happen for there to be true health system reform. "We don't think it will be fair to say that private schemes like Discovery are no longer going to work. We want people to make their own choice- we want to make it clear that NHI will be mandatory, just like it is in England. No millionaire is not part of the (UK) National Health Service but if he wants to do something privately, it's allowed."

In another, he seems subdued about the NHI and the funds available for it. Health-e article (Cullinan 2016), he states, "There isn't a pot of gold for the NHI'.

Activists have started purveying government messaging about the NHI. This is troubling as they are meant to be creating resistance against this sort of propaganda. Activists within PHM-SA and on the periphery are embedding negative messaging that limits NHI campaigns. While there are elements of truth and validity to these messages, they mostly indicate a lack of belief in the NHIC, lack of literacy about the NHI, more specifically an inability to make the link between the

NHI, an NHS (both system and service) and the everyday experiences of people on the ground whether it be a stock out, poor service, poor treatment, lack of clinic or hospital infrastructure. While many CSO's participated and to an extent engaged in activities relating to the NHIC, they still harboured reservations.

## Recommendations

There is no political will to implement the NHI because civil society, the people who use public health facilities are not being adequately engaged on why the NHI is integral to their existence and prosperity. Monitoring and Evaluation of programmatic or 'content' work needs to be addressed to supply solutions to meet contemporary demands. There is no political will because there is no solidarity among activists about the NHI. One activist thought, the 2011 plan around how to popularize NHI, how to intervene in the debate, how to influence the actual shape of the NHI, was ambitious. This already points to an attitude issue about the NHI that needs to be addressed.

It's concerning that CSO's and key activists explained that there was nothing to respond to because the White Paper had not been released. Inside PHM-SA this view was also prevalent largely due to the dual roles that key members played and their affiliations with S27 and TAC. Literacy among activists does remain a concern as it informs what activists responds to. The NHI is model developed to figure out how to pay for the NHI. The NHI is linked with a National Health System or Service and funds an NHS. It is imperative that PHM-SA campaigns start framing the NHI in a way that CSO's and activists identify that urgent issues that take up their time in place of the NHI, as they put it, are linked to the NHI and an NHS. For example: A stock out issues or privacy issue=National Health System issue=National Health Service Issue=National Health Insurance issue. To a degree, it's about capacity and time but it's also about how we manage our time and the resources that we do have. There are specific activists who continue to frame campaigning and advocacy work around the NHI in a way that is disabling to the work that is being done by other activists, framing it in ways that casts shadows and disables activity. This needs to be addressed. Questions around why activists are being influenced by government propaganda needs to be asked. Questions around why NHIC signatories and members felt that ECHAC was a better investment of their resources than the NHIC. Whatever the answer, PHM-SA was a substantial influencer of NHI campaigns and advocacy among CSO's as is evident in the development of other CSO's development of their NHI campaigns post the events of the NHIC.

If Motsoaledi's hands are tied by the ANC then it is up to CSO's to identify which Unions, Movements, Parties, or CSO's can peacefully organise sit ins, march, toyi toyi or other for the overhaul of the health system so that the inequity doesn't continue. It is obvious that it's in the interest of all South Africans that the private and public health system become one. It makes no sense and will cause social insecurity if citizens are paying for their private medical aid and for public medical aid although one does need to consider the level of chaos and social insecurity that will create PHM-SA could consider thinking about how such an overhaul could be endured by South Africans? At the moment, PHM-SA has all the technical and supporting skills it needs to campaign fervently about the NHI but it needs to strategise better around how it campaigns.

One interviewee discusses how there's a contrast to the recognition by the Gluckman commission that SDH and poor health are related, and that Motsoaledi's ten-point plan could address this now. If PHM-SA is to fulfil its goals, it needs to seriously provide support to SC members who advocate for these issues and nurture relationships with other organisations and people who do human rights and advocacy work in these areas too. The NEHAWU and

COSATU work remains pivotal to PHM-SA's activities. The Mining Activism and Climate Change work, the Water and Sanitation work, and The farm work. PHM-SA needs to start planning for gender, age, lifestyle factors, housing and food security Issues, if PHM-SA aims to authentically address the SDH and the causes of causes.

PHM-SA needs to continue to assess which skills are needed and build relationships with those organisations to supplement skills shortages within PHM-SA.

While it is known within PHM-SA that neo liberal policies and ideology has continued to marginalise health and in general citizens of South Africa, PHM-SA needs to consider how it will re organise itself to progressively address these issues without being disloyal to the citizens it serves. Moving landscapes, require adaption and strategic moves. Strategic meetings need to be separate from budget planning meetings and they need to be undertaken by members of PHM-SA who can implement the needed strategy. Strategic meeting should address each of the enablers and barriers to campaigns and ensure that they supported, adjusted and developed in a way that targets PHM-SA's goal.

PHM-SA needs to ensure that new SC members and employees receive a history of the organisation briefing them on goals and specific activities that are vital to the continuation and relationship building for nurturing and developing of alliances and coalitions. One of the participants expressly state that they had no knowledge of the NHI coalition or PHM-SA events between 2010-2012.

## Moving Forward

Overtime PHM-SA moved to the beat of whomever was actively leading it which has its merits but could be directed and controlled to reach outputs such as the improvement of people's living conditions or capacity improvement which in essence is why the NHIC was never really established as a robust coalition that directed and controlled NHI campaigns within other CSO's. It influenced and had a causal effect on other CSO's but within this movement establishing the NHIC was neglected.

What is most evident is that PHM-SA was successful in stimulating thought, plans and implementation among the NHIC members and signatories which allowed each of them to strategise around their own independent plans to campaign and advocate for a NHI but it was unable to get buy in from members to engage and participate fully through sustained and engaging meetings and events using one voice under the banner of a NHIC.

From inside and outside, the NHIC was seen as a failure but in the event that one wants to interpret PHM-SA as a movement rather than an organisation, one could perceive the NHIC as a catalyst that had succeeded in stimulating activity around the NHI which fell away when it's job was done, however, it is evident that PHM-SA wanted to establish the NHIC. Nevertheless, this work can still be done by addressing the enablers and barriers of the NHI campaign. PHM-SA could evoke movement around the NHI that rekindles the visions that PHM-SA had for the NHIC but through renewed and repackaged, compelling movement building.

## References

African National Congress. 2007. *52nd National Conference: Resolutions*. Available at: <http://www.anc.org.za/show.php?id=2536>. Accessed: June 2016.

African National Congress. 2009. *African National Congress Election Manifesto*. Available at: <http://www.anc.org.za/docs/manifesto/2009/manifesto.pdf>. Accessed: June 2016. Pg 11.

- Congress of South African Trade Union. 2016. COSATU welcomes NHI announcement. Available at: <http://www.cosatu.org.za/show.php?ID=4002>. Accessed: May 2016.
- Cullinan, K. 2016. South Africa moves to 'test and treat'. Health-e News. Available at: <https://www.health-e.org.za/2016/05/10/south-africa-moves-test-treat/>. Accessed: May 2016.
- Eyles. J. 2016. *National Health Insurance for South Africa Towards Universal Health Coverage*. Witwatersrand University Centre for Health Policy and Systems Research. Slides 1-38.
- Goldacre, B. 2008. *Bad Science*. Fourth Estate Harper Collins Publishers. London. Pg 184-185.
- Government. *The National Health Insurance Green Paper*. 2011. Available at: <http://www.gov.za/documents/green-papers> . Accessed: February-April 2013, May 2016.
- Government Gazette. 2015. [National Health Insurance for South Africa White Paper](http://www.gov.za/documents/national-health-insurance-south-africa-policy-paper). Available at: <http://www.gov.za/documents/national-health-insurance-south-africa-policy-paper>. Accessed: December 2015 - May 2016.
- Gray A, Vawda Y. Health Policy and Legislation. In: Padarath A, King J, Mackie E, Casciola J, editors. *South African Health Review 2016*. Durban: Health Systems Trust; 2016. URL: <http://www.hst.org.za/publications/south-african-health-review-2016>. Pg. 4,52.
- Kahn. T. 2016. *NHI: A Wing and A Prayer*. Financial Mail. Available at: <http://www.financialmail.co.za/coverstory/2016/02/25/national-health-insurance-a-wing-and-a-prayer>. Accessed: 21 May 2016.
- Kautzkyi. K and Tollman. S. M. 2008. Primary Health Care in South Africa. *South African Health Review*. Durban: Health Systems Trust. Pg. 19. Available at: [http://www.hst.org.za/uploads/files/chap2\\_08.pdf](http://www.hst.org.za/uploads/files/chap2_08.pdf). Accessed: May 2016.
- National Education Health Allied Workers Union. 2010. *9TH National Congress Presentation and Adoption of the Resolutions*. Available at: <http://www.nehawu.org.za/files/NEHAWU-9th-National-Congress-Resolutions.pdf>. Accessed: May 2016.
- National Education Health Allied Workers Union. 2013. *Declaration of the 10<sup>th</sup> NEHAWU National Congress*. Available at: <http://www.nehawu.org.za/files/Declaration-of-the-10th-NEHAWU-National-Congress.pdf>. Accessed: May-June 2016.
- News 24. 2016. *Full Judgement: Constitutional Court Rules on Nkandla*. Available at: <http://www.news24.com/SouthAfrica/News/full-text-constitutional-court-rules-on-nkandla-public-protector-20160331> Accessed: April 2016.
- NIH. 2016. *Against The Odds a Model for The World*. Available at: [https://apps.nlm.nih.gov/againsttheodds/exhibit/community\\_health/model\\_world.cfm](https://apps.nlm.nih.gov/againsttheodds/exhibit/community_health/model_world.cfm). Accessed: 24 May 2016.
- People's Health Movement-South Africa. 2016. *The People's Response to The NHI White Paper Pamphlet*.
- People's Health Movement-South Africa. 2016. *A Brief History*. Available at: <http://phm-sa.org/about/>. Accessed: May 2016.

Public Health Association of South Africa. 2013, *PHC and HiAP*. Available at: <https://www.phasa.org.za/primary-health-care-and-health-in-all-policies/>. Accessed: May 2016.

SA History. 2016. Available at: <http://www.sahistory.org.za/article/south-africa%E2%80%99s-key-economic-policies-changes-1994-2013>. Accessed: May-June 2016.

Section 27. 2011. *The newly formed National Health Insurance Coalition (NHIC) gives civil society voice on National Health Insurance*. Available at: <http://section27.org.za/2011/12/insurance-coalition-gives-civil-society-voice/> . Accessed: April 2016.

Section 27 and Treatment Action Campaign. 2015 *Minister Motsoaledi's curse: When politics trumps health, people pay the price*. The National Strategic Plan Review.

Section 27 and Treatment Action Campaign. 2013. *Death and Dying in the Eastern Cape– An investigation into the collapse of a health system report*.

Section 27 and Treatment Action Campaign. 2015. *Eastern Cape Health: Still not a pretty picture*. National Strategic Plan Review. Pg 17-18.

World Health Organisation. 1978. Declaration of Alma Ata. Available at: [http://www.who.int/publications/almaata\\_declaration\\_en.pdf](http://www.who.int/publications/almaata_declaration_en.pdf). Accessed: May 2016.