

**A CRITICAL DISCUSSION OF THE RIGHT OF ACCESS TO  
HEALTH CARE SERVICES AND THE NATIONAL HEALTH  
INSURANCE SCHEME**

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## **ABSTRACT**

The South African government gazzetted the Green Paper introducing the NHI on 12 August 2012. This policy seeks to progressively realize the right of access to quality health care services for everyone. Those who cannot provide for themselves will be assisted by government at the expense of the elite. The NHI was first recommended by the Taylor Commission and it has been under the discussion since then. Since this announcement, there has been growing pressure for mandatory health insurance to be included in the development of a comprehensive social security system, as was envisaged by the Taylor Committee of Inquiry. This discussion was further debated at the 52<sup>nd</sup> conference of the African National Congress (ANC) in Polokwane in December 2007 where numerous resolutions were taken with regard to the NHI. The Freedom Charter of 1955 and also section 27 and 28 also provided some guidance.

**DECLARATION BY SUPERVISOR**

I, **Adv. Lufuno Tokyo Nevondwe**, hereby declare that this mini-dissertation by Mrs. **Mabidi Mpho Brendah** for the degree of Master of Laws (LLM) in Labour Law be accepted for examination.

Signed : .....

Date : .....

**Adv. Lufuno Tokyo Nevondwe**

**DECLARATION BY STUDENT**

I, **Mabidi Mpho Brendah** declare that this mini-dissertation submitted to the University of Limpopo (Turfloop Campus) for the degree of Masters of Laws (LLM) in Labour Law has not been previously submitted by me for a degree at this university or any other university, that it is my own work and in design and execution all material contain herein has been duly acknowledged.

Signed : .....

Date : .....

**Mabidi Mpho Brendah**

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## DEDICATION

To my father, **Jerry Mogale Matloga** and my mother **Merriam Mokgadi Matloga** for being such wonderful parents to me and for supporting me since childhood, with love and gratitude, I would like to thank you and I will always work hard to make you proud.

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Venda. Finally, I would like to thank my classmates and colleagues especially Mrs. Zodwa Maluleke who kept me plugging away when I felt I could not do no more. The faith and love you showed me when it mattered most can never be quantified.

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### **LIST OF INTERNATIONAL INSTRUMENTS**

African Charter of Human and People's Rights (*"Banjul Charter"*), 27 June 1981

African Charter on the Rights and Welfare of the Child

Committee on Economic, Social and Cultural Rights

Convention on the Elimination of All Forms of Discrimination against Women, 1979

Convention on the Rights of the Child, 20 November 1989.

Convention on the Rights of Persons with Disabilities

Conventions Protecting Vulnerable Groups

Declaration of Alma Ata

European Social Charter, 18 October 1961.

International Covenant on Economic, Social and Cultural Right, 16 December 1966.

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Medical Schemes Act, 131 of 1998.

Mental Health Care Act, 17 of 2002.

National Health Act, 61 of 2003.

Prevention and Combating of Corrupt Activities Act 12 of 2004.

Sterilisation Act, 44 of 1998.

Traditional Health Practitioners Act, 22 of 2007.

White Paper on the Transformation of the Health Care System in South Africa, 1997.

### LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ARV	Antiretroviral
AZT	Zidovudine
BBP	Basic Benefit Package
CEDAW Women	Convention on the Elimination of all forms of Discrimination against
CESCR	Committee on Economic, Social and Cultural Rights
CEO	Chief Executive Officer
Codesa	Convention for a Democratic South Africa
COSATU	Congress of South African Trade Unions
DA	Democratic Alliance
DoH	Department of Health
ICECS	International Covenant on Economic, Social and Cultural Rights
FCBP	Fully Comprehensive Benefit Package
GEMS	Government Employees Medical Scheme
GDP	Gross Domestic Product

HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
OHSC	Office of Health Standards Compliance
OSD	Occupation Specific Dispensation
NDP	National Drug Policy
NEC	National Executive Council
NGC	National General Council
NGO	Non-governmental organisations
NHI	National Health Insurance
NHIA	National Health Insurance Agency
NHIF	National Health Insurance Fund
MDG	Millennium Development Goals
PEPUDA	Promotion of Equality and the Prevention of Unfair Discrimination Act
PHC	Primary Health Care
PMB	Prescribed Minimum Benefits
PPP	Public Private Partnership
RDP	Reconstruction and Development Programme
SERAC	Social and Economic Rights Action Centre
TAC	Treatment Action Campaign
TB	Tuberculosis
UDHR	Universal Declaration of Human Rights
UN	United Nations (UN)
UNICEF	United Nations International Children's Emergency Fund
VAT	Value Added Tax
WHO	World Health Organisation

**TABLE OF CASES**

*Grootboom v Oostenberg Municipality and others* 2000 (3) BCLR 277 (C).

*Khosa & Others v Minister of Social Development & Others & Mahlaule and Another v Minister of Social Development* 2004(6) BCLR 569 (CC).

*Minister of Health v Treatment Action Campaign* 2002 (1) SA 46 (CC).

*Prince v President of the Cape Law Society and Others* 2001 (2) BCLR 133.

*S v Makwanyane* 1995 (3) SA 391 (CC).

*S v Williams and Others* 1995(3) SA 632 (CC).

*Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 (1) SA 765 (CC).

*Van Biljon v Minister of Correctional Services*, 1997 (4) SA 441 (C).

**International**

*Ahamefule v Imperial Medical Center & Another* (Suit ID #1627/2000), Notice of Appeal, Court of Appeal (Lagos), 16 February 200.

*Carlos UsmaLemus, Edgar Castle Cifuentes and Mayan Polished Ramiro v Secretariat Distrital de Salud of Bogota and the Simon Hospital Bolivar*, 25 October 2001 Case number: T-1132/01.

*Eresa Del Nino Jesus Restrepo v Susalud E.P.S. Seccional Medellin*, 10 March 2003, Case number: T-202/03.

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*Marina Ester Sánchez v Ministry of Public Health and Social Assistance* case no: 45-2003 (14 September 2004).

*Walter Schmidt Barrios v Clinic of the Centre of Institutional Attention The Reformation*, Case Number: 10680, 29 September 2004.

## CHAPTER ONE: INTRODUCTION

### 1.1. Historical background to the study

The history of National Health Insurance ( 'NHI' sometimes called statutory health insurance) is a health insurance<sup>1</sup> which can be traced back in 1883 when Otto von Bismarck<sup>2</sup> through his socialist ideology legislate the Health Insurance Bill of 1883 which marked Germany as the world's oldest national health insurance, through the world's oldest universal health care<sup>3</sup> system. This social exercise included Accident Insurance Bill of 1884, and Old Age and Disability Insurance Bill of 1889.

National health insurance is health insurance<sup>4</sup> that insures a national population for the costs of health care<sup>5</sup> and usually is instituted as a program of healthcare reform.<sup>6</sup> It is enforced by law. It may be administered by the public sector, the private sector, or a combination of both. Funding mechanisms vary with the particular program and

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<sup>1</sup>Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care expenses among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity.

<sup>2</sup>First Chancellor of the Germany Empire.

<sup>3</sup>According to 2010 World Health Report, universal health care sometimes referred to as universal health coverage, universal coverage, universal care or social health protection - describes health care systems organized around providing a specified package of benefits to all members of a society with the end goal of providing financial risk protection, improved access to health services, and improved health outcomes. Universal health care is not a one-size-fits-all concept; nor does it imply coverage for all people for everything. Universal health care is determined by three critical dimensions: who is covered, what services are covered, and how much of the cost is covered.

<sup>4</sup>Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care expenses among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity.

<sup>5</sup> Health care (or healthcare) is the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in humans. Health care is delivered by practitioners in medicine, chiropractic, dentistry, nursing, pharmacy, allied health, and other care providers. It refers to the work done in providing primary care, secondary care and tertiary care, as well as in public health.

<sup>6</sup> Health care reform is a general rubric used for discussing major health policy creation or changes, for the most part, governmental policy that affects health care delivery in a given place. Health care reform typically attempts to: Broaden the population that receives health care coverage through either public sector insurance programs or private sector insurance companies; expand the array of health care providers consumers may choose among; Improve the access to health care specialists; Improve the quality of health care; give more care to citizens; and decrease the cost of health care.

country. National or statutory health insurance does not equate to government run or government financed health care, but is usually established by national legislation. In some countries, such as Australia's Medicare system or the United Kingdom (UK)'s NHS, contributions to the NHI or SHI system are made via taxation and therefore are not optional even though membership of the health scheme it finances is. In practice of course, most people paying for NHI will join the insurance scheme. Where the NHI scheme involves a choice of multiple insurance funds, the rates of contributions may vary and the person has to choose which insurance fund to belong to.

Contrary to common belief, the history of reforming the healthcare financing system in South Africa actually dates back more than 80 years. In 1928 a Commission on Old Age Pension and National Insurance recommended that a health insurance scheme should be established to cover medical, maternity and funeral benefits for all low income formal, sector employees in urban areas. A Committee of Enquiry into National Health Insurance recommended in 1935 similar proposals as those made in 1928. Neither of the proposals of these two Committees was ever taken forward.

Between 1942 and 1944 commission led by Dr Henry Gluckman was set up. It was called the National Health Service Commission. It recommended the implementation of a National Health Tax to ensure that health services could be provided free 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 their needs, and without regard to race, colour, means or station in life”. Health centres, providing comprehensive primary care services, were proposed as a core component of the health system.

By the early 1990's the spotlight had again turned to the possibility of introducing some form of mandatory health insurance and after the 1994 elections, there were

several policy initiatives that considered either social or national health insurance. The Health Care Financial Committee of 1994 recommended that all formally employed individuals and their immediate dependents should initially form the core membership of social health insurance arrangements with a view to expanding coverage to other groups over time. It was also suggested that there should be a multi-funder (or multi-payer) environment and that private funders, namely medical schemes, should act as financial intermediaries for channelling funds to providers. It was also proposed that there should be a risk- equalization<sup>7</sup> mechanism between individual insurers to help stabilise the medical schemes industry. It was further recommended that a comprehensive set of services be covered under such a system and that both public and private providers will be involved in the delivery and provision of these services. The main challenge with respect to these sets of recommendations was the inability of the State to fully finance the recommended package of services.

The 1994 Finance Committee was followed by the 1995 Commission of Enquiry on National Health Insurance which fully supported the recommendations of the Health Finance Committee. The key difference was on the benefit package. This committee as well as the healthcare finance committee made a strong case for primary health care services.

In 1997 the Social Health Insurance Working Group developed the regulatory framework that resulted in the enactment of the Medical Schemes Act in 1998.<sup>8</sup> This Act was meant to regulate the private health insurance as well as to entrench the principles of open enrolment, community rating, prescribed minimum benefits and

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<sup>7</sup> Risk Equalisation- This is a mechanism that is applied to equalise the risk profiles of separate insurance pools in order to avoid loading premiums on the insured members based on some pre-determined health factors.

<sup>8</sup>Act, 131 of 1998.

better governance of medical schemes. However, despite the introduction of the Act and the supporting principles the level of coverage for the national population has remained below 16 percent and is only affordable to the relatively well-off.

In 2002, Department of Social Development appointed Professor Vivienne Taylor to chair the Committee of Inquiry into a Comprehensive Social Security for South Africa. The Commission recommended that there must be mandatory cover for all those in the formal sector earning above a given tax threshold and that contributions should be income-related and collected as a dedicated tax for health. The Committee also recommended that the State should create a national health fund through which resources should be channelled to public facilities through the government budget processes.

To implement the recommendations of the Taylor Committee, the of Department of Health established the Ministerial Task Team on Social Health Insurance in 2002 to draft an implementation plan with concrete proposals on how to move towards social health insurance and to create supporting legislative and institutional mechanisms that will in the long term result in the realisation of National Health Insurance<sup>9</sup> in South Africa. However, the path to achieving universal coverage through a social health insurance model was not widely supported and the implementation of the supporting proposals thus stalled.

In August 2009, the Ministerial Advisory Committee on Health Insurance was established which had been tasked with providing the Minister of Health and the Department of Health with recommendations regarding the relevant health system

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<sup>9</sup>Herein referred to as 'NHI' or 'scheme'. The National Health Insurance in South Africa Policy Paper defines NHI as "an approach to health system financing that is structured to ensure universal access to a defined, comprehensive package of health services for all citizens, irrespective of their social, economic and/or any other consideration that affects their status".

reforms and matters to the design and roll-out of National Health Insurance. This was to carry forward the Resolution passed at the ruling party's African National Congress<sup>10</sup> Conference in December 2007 in Polokwane (Limpopo Province).<sup>11</sup> In his recent state of the nation address, President Zuma noted that the government has prioritised NHI implementation through “critical social infrastructure projects.”<sup>12</sup>

The rationale for introducing NHI is therefore to eliminate the current tiered system where those with the greatest need have the least access and have poor health outcomes. National Health Insurance will improve access to quality healthcare services and provide financial risk protection against health-related catastrophic expenditures for the whole population. Such a system will provide a mechanism for improving cross-subsidization in the overall health system, whereby funding contributions would be linked to an individual's ability-to-pay and benefits from health services would be in line with an individual's need for care. Moreover, by significantly reducing direct costs for health care, families and households under National Health Insurance are less likely to face impoverishing health care costs.

Currently, the Minister of Health Dr. Aaron Motsoaledi has begun to take action to facilitate the implementation of the NHI and revitalise the system's capacity for quality healthcare service provision. Included in these efforts are the improvements of the facilities of six major public hospitals supported by private companies, and the drafting of legislation to ensure that all those in supervisory or management roles are appropriately qualified and experienced. A regulative body called the Office of Health Standards Compliance (OHSC) will be responsible for the inspection and

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<sup>10</sup>Herein referred to as the 'ANC'.

<sup>11</sup> This was Resolution fifty three (53) of the African National Congress (ANC) which called for the establishment of a National Health Insurance.

<sup>12</sup>Zuma, J., 'State of the Nation address by His Excellency Jacob G Zuma, President of the Republic of South', 9 February 2012, South Africa Government Online, <http://www.info.gov.za>.

accreditation of hospitals, facilities and practitioners to ensure that they are in compliance with the required standards. This regulatory body will be legislated through three main divisions: inspection, norms and standards, and the office of the ombudsperson. All healthcare providers that wish to be considered for rendering health services will have to meet set standards of quality to be accredited by the OHSC. Regular assessments will be conducted to ensure that set standards are maintained. The results will be used to guide recommendations for quality improvement in public healthcare facilities with associated training.

The Green Paper lays out a timeline in three phases over a projected 14 years, beginning in 2011 with the publication of the White Paper and reaching full implementation in 2025. This is based on estimates from implementation processes from other countries, which have suggested that capacitation of facilities and healthcare providers to accommodate the utilisation increases associated with the NHI will take time.

Beginning April 2012, the NHI has been piloted in 10 priority districts, selected on the basis of an audit conducted by the National Department of Health. The audit took into account the state of healthcare facilities, as well as a number of key indicators. Selection was informed by district demographic and health profiles, service delivery and performance, income levels, quality standards compliance and socio-cultural profiles. This pilot will inform the structure of governance and district management systems, as well as serve as a mechanism for testing the rollout of the proposed NHI service package. The pilot will be extended at a later point to 20 districts. Ultimately this capacitation process will serve to strengthen the proposed District Health Authority - a contracting unit charged with managing contracts through the relevant accredited provider.

As human beings, our health and the health of those we care about is a matter of daily concern. Regardless of our age, gender, socio-economic or ethnic background, we consider our health to be our most basic and essential asset. Ill health, on the other hand, can keep us from going to school or to work, from attending to our family responsibilities or from participating fully in the activities of our community. By the same token, we are willing to make many sacrifices if only that would guarantee us and our families a longer and healthier life. In short, when we talk about well-being, health is often what we have in mind.

South Africa is a young and developing democracy. Today, during the second decade of this new democratic order, one often hears questions and comments about problems in the functioning of South Africa's health system. The right to access to health care is a universally recognised socio-economic human right and in South Africa it is similarly guaranteed and protected in section 27 of the Constitution.<sup>13</sup>

Based on this constitutional obligation, every resident of South Africa should be able to enjoy high-quality healthcare that is affordable, responsive and sustainable. The major obstacle to realizing this goal, thus far, has been a public health system that delivers low-quality healthcare to the majority of our population. South Africa has the resources and skills-base to provide excellent healthcare for all who need it.<sup>14</sup> It is against this background that the South African government had an obligation to provide health treatment and attention on equal basis to everyone irrespective of one's financial muscles. NHI will ensure that everyone has access to a defined equal comprehensive healthcare service.

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<sup>13</sup>*Constitution of the Republic of South Africa*, 1996 (hereafter Constitution).

<sup>14</sup>The DA's alternative to NHI, dated 29 Nov 2011, P2, accessed from <http://www.health-e.org.za/documents/6540023f3f76fe3473ebcace5a413087.pdf> on 2012/04/15.

## **1.2. Statement of the research problem**

Prior to the 1994 democratic break through, South Africa had a fragmented dual health system designed along racial lines. One system was highly resourced and benefitted the white minority. The other was systematically under-resourced and was for the black majority. The Constitution has outlawed any of racial discrimination and guarantees the principles of socio-economic rights including the right to health.

Attempts to deal with these disparities and to integrate the fragmented services that resulted from fourteen health departments (serving the four race groups, including the ten Bantustans) did not fully address the inequities. Problems linked to health financing that are biased towards the privileged few have not been adequately addressed.

Post 1994 attempts to transform the healthcare system and introduce healthcare financing reforms were thwarted. This has entrenched a two-tiered health system, public and private, based on socioeconomic status and it continues to perpetuate inequalities in the current health system. Attempts to reform the health system have not gone far enough to extend coverage to bring about equity in healthcare.

The two-tiered system of healthcare did not and still does not embrace the principles of equity and access and the current health financing mode does not facilitate the attainment of these noble goals. An analogy of the preceding description can be drawn with the negative attributes of the South African two-tier healthcare system, which are unsustainable, destructive, very costly and highly curative or hospi-centric.

The national health system has a myriad of challenges, among these being the worsening quadruple burden of disease and shortage of key human resources. The

public sector has underperforming institutions that have been attributed to poor management, underfunding, and deteriorating infrastructure.

In many areas access has increased in the public sector, but the quality of healthcare service has deteriorated or remained poor. The public health sector will have to be significantly changed so as to shed the image of poor quality services that have been scientifically shown to be a major barrier to access.<sup>15</sup>

Similarly to the public health system, the private sector also has its own problems albeit these are of a different nature and mainly relate to the costs of services. This relates to the pricing and utilisation of services. The high costs are linked to high service tariffs, provider-induced utilization of services and the continued over-servicing of patients on a fee-for-service basis. Evidently, the private health sector will not be sustainable over medium to long term.

Other contributing factors to the given problems and challenges includes HIV/AIDS and TB, maternal, child and infant mortality, non-communicable diseases and the high level of injury and violence within our society. These factors will be discussed individually in order to clarify these challenges in a more detailed manner.

### **1.3. Literature Review**

The concept of access to health care services is not new in the South African legal system.<sup>16</sup> Scholars have already researched about the right of access to health care

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<sup>15</sup> Sara Bennett and Lucy Gilson (2001) Pro-poor policies - Health financing: designing and implementing; HSRC- DFID Health Systems Resource Centre.

<sup>16</sup> The first medical legislation in South Africa to deal with health is the Contagious Diseases Act 1 of 1856 and the second is the Contagious Diseases Act 25 of 1868. These statutes were enacted to deal with regular outbreaks of measles and chicken pox. See also Olivier M.P, Smit N & Kalula E.R "Social Security: A Legal Analysis" 2003 1st edition, LexisNexis, p358.

services.<sup>17</sup> However, there seems to be mixed feelings amongst the relevant health services stake-holders including some political parties, leaders, health practitioners, and writers. The Congress of South African Trade Unions (COSATU) has welcomed the NHI but also openly expressed its concern regarding the inclusion of medical schemes in a “multi-payer” system, suggesting that this will sustain inequitable service delivery and “undermine” the implementation of the NHI.<sup>18</sup>

The Democratic Alliance (DA), the ANC’s primary opposition, has released a position paper which suggests that the Green Paper is founded on the faulty notion that the government’s failures in health service delivery are as a result of private sector success.<sup>19</sup> The DA hold the view that the only way to improve the health of the population is to make sure that healthcare is fully accessible and of a high-quality. While the public sector provides the requisite level of accessibility, it does not offer enough quality. According to them, this is why so many people seek private healthcare, despite its costs. This, then, is the great challenge for the public sector: to enhance its level of quality so that it can actually improve the health of the population.<sup>20</sup> It further contends that, “the promotion of such an argument suggests that the Health Ministry not only misunderstands what is wrong with healthcare, but remains blind to its own responsibility in creating the problems the health system now faces.”<sup>21</sup>

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<sup>17</sup> See Marius Pieterse “Enforcing the right not to be refused emergency medical treatment: towards an appropriate relief” Stellenbosch Law Review 2007 1; Marius Pieterse “Indirect Horizontal application of the Right to have Access to Health Care Services” (2007) 23 SAJHR 157-179; Ngwena C “The Recognition of Access to Health Care as a Human Right in South Africa: Is it enough?” Health & Human Rights Vol no: 5; No: 1, P 26-44.

<sup>18</sup> Craven, P., ‘NHI Green Paper welcomed’, COSATU, 11 August 2011, <http://www.cosatu.org.za>.

<sup>19</sup> The DA’s alternative to NHI, dated 29 Nov 2011 P4, accessed from <http://www.health.org.za/documents/6540023f3f76fe3473ebcace5a413087.pdf> on 2012/04/15.

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

The Helen Suzman Foundation has echoed this sentiment in their position paper, highlighting a lack of evidence-based support for claims that private and public sector inequalities are the primary cause for poor health outcomes and the state of South African healthcare.<sup>22</sup>Kate Francis<sup>23</sup> provides that “South Africa’s health outcomes have historically been plagued by policy stagnation, a lack of positive and practical action and failure to hold those responsible for preventable deaths and poor management to account. Attempting to implement an inappropriate policy at this stage may well result in further deterioration of a health system which is in dire need of constructive and practical reform”.<sup>24</sup>According to her the two-tiered health system and inequalities between the public and the private sector are not the root causes of the majority of South Africa’s poor health outcomes. She reasons that “citizens and stakeholders need to urge the Department of Health to provide clear and reliable evidence to demonstrate that its proposals will improve the ability of South Africans to access health care”.

The Foundation’s analysis shows that lack of governance and accountability, ineffective monitoring and evaluation, poor management, lack of implementation of existing policies, over-centralisation and corruption are primarily responsible for the poorly functioning public health system. The Helen Suzman Foundation also identified lack of management capacity as a key cause of South Africa’s poor health outcomes. South Africa’s health system is thus clearly underperforming given the level of health expenditure. This suggests that management, not money, is the problem.

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<sup>22</sup>Submission to National Department of Health: National Health Insurance Green Paper’, Helen Suzman Foundation, December 2011, <http://www.hsf.org.za>.

<sup>23</sup> Kate Francis, a Researcher at the Helen Suzman Foundation. The Helen Suzman Foundation is a policy think tank that seeks to promote liberal constitutional democracy and human rights.

<sup>24</sup>Submission to National Department of Health: National Health Insurance Green Paper’, Helen Suzman Foundation, December 2011, <http://www.hsf.org.za>.

The DA also notes an approximately 30% difference in levels of patient satisfaction between public and private health consumers, with the latter experiencing considerably higher levels of satisfaction. They also recommend that by incentivizing healthcare practitioners to enhance performance, levels of patient satisfaction in the public sector may increase.<sup>25</sup> The DA offers ten reasons why the NHI is not the solution to the nation's current health crisis, including statements such as "We lack the human resources to implement NHI," "NHI does not adequately attend to accountability and management structures" and "NHI eradicates freedom of choice for healthcare consumers."

Professor Alex van den Heever has suggested that the establishment of a centralized fund may carry considerable risk and destabilize an already unsteady, under-performing public health sector. He suggests that decentralization of funding is critical to efficient functioning at a provincial level, and that political governance models may be insufficient to accommodate the administrative and procurement responsibilities central to an effectively implemented NHI.<sup>26</sup>

Professor Heather McLeod has called attention to an interesting clarification that must be made between universal coverage for healthcare, and universal coverage for health insurance. She points out that while less than one in five South Africans have insurance coverage, all has access to healthcare through various channels of service delivery.<sup>27</sup>

According to Gerhard Joubert, Head of Group Marketing and Stakeholder Relations at PPS, the quarterly PPS Graduate Professionals Confidence Index, which tracks

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<sup>25</sup> The DA's alternative to the NHI', Health-e News Services, 2011, <http://www.health-e.org.za>.

<sup>26</sup> Van den Heever, A., 'Evaluation of the Green Paper on National Health Insurance', 20 December 2011, <http://www.hsf.org.za>.

<sup>27</sup> Thom, A., 'NHI plan needs clarity on the "how"', Health-e News Services, 22 September 2011, <http://www.health-e.org.za>.

confidence levels of about 6000 graduate professionals, found that a large number of professionals believe NHI is not the cure for the ailing health system. “We continue to suffer from an acute skills shortage in South Africa, particularly amongst a number of skilled professions such as medicine, accountancy and engineering. It is important that the concerns of all South Africans, not just graduate professionals, are taken into account and efforts are made to deal with these issues to keep our current skills and to attract expats back to the country,”<sup>28</sup>

According to Charles Ngwena, “the new South Africa is taking a holistic approach to respect health care as a basic human right.”<sup>29</sup> The Human Rights Commission has been with monitoring the realisation of the right to health care services.<sup>30</sup> The government is there to encourage efficient use of resources and equally distribute resources to require positive constitutional duties to enforce the right to health care services.

Nivashni Nair holds the opinion that NHI and a shortage of maths and science graduates are pushing graduate professionals to consider emigration.<sup>31</sup>

Ngwena provides that “our courts are given jurisdiction to adjudicate over matters of policy, including budgetary appropriations. A right of access to health care means being able to access health care that is affordable, available and effective. The state

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<sup>28</sup> New survey provides key insight into confidence levels amongst SA’s graduate professionals accessed from <https://www.pps.co.za/portal/news/archive/Professional%20Confidence%20Index.pdf> on

<sup>29</sup>Supra.

<sup>30</sup>Supra. Section 184 of the Constitution states that: “each year the Human Rights Commission must require relevant Organs of State to provide the Commission with information on the measures that they have taken towards the realisation of rights in the Bill of Rights concerning housing, health care, food, water, social security, education, and the environment.” See also J. Sarkin, “The development of a Human Rights Culture in South Africa,” *Human Rights Quarterly* 1998, 20:628-65.

<sup>31</sup> NHI, crime drive brain drain, *Sunday Times*, 16 May, 2012.

must seek to deliver a package of essential health services according to universal standards within a scheduled period of time.<sup>32</sup>

Marius Pieterse also sees health care as a basic human right issue.<sup>33</sup> He states that “section 27 (1) (a)’s determination that ‘everyone’ is entitled to access health care services may be understood to indicate that rationing decisions may not be discriminatory and should adhere to the dictates of the right to equality. When read with the obligation of the state to “respect” the right in the Bill of Rights in section 7 (2) of the Constitution, section 27 (1) (a) may further be understood to require that rationing process and decisions respect existing access to health care services and may not have the effect of obstructing diminishing access (by for instance, directing resources away from provision of services to which patients already have access.”<sup>34</sup>

According to Mubangizi J.C, he provides that health is a basic human right issue as well. He states that “the right to health is grounded in the fact that they guarantee everyone the right of access not only to important components of adequate standard of living, but also to things that are ordinarily regarded as basic necessities of life.”<sup>35</sup>

Karl le Roux<sup>36</sup> said: “Physicians do not understand how the NHI is planning to improve health systems, management and staffing.”<sup>37</sup> Le Roux said there was often a “fragile” relationship between clinicians and administrators, especially when

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<sup>32</sup>Supra.

<sup>33</sup> See Marius Pieterse, “Health Care Rights, Resources and Rationing” SALJ p522-523.

<sup>34</sup>Supra.

<sup>35</sup> See Mubangizi J.C, Prospects and Challenges in the protection and enforcement of socio-economic rights: Lessons from the South African experience, Paper presented on VII World Congress of the International Association of Constitutional Law at Athens, 11-15 June 2007.

<sup>36</sup> Chairperson of the Rural Doctors’ Association of Southern Africa, , who works at Zithulele Hospital in the district.

<sup>37</sup> Mia Malan, *Mail and guardian*, 4 June 2012.

administrators failed to order basic equipment and supplies for clinicians to do their jobs.<sup>38</sup>

Mia Malan<sup>39</sup> wrote that Simon Puttergill<sup>40</sup> steadfastly believes all citizens should have equal access to quality healthcare. But he strongly doubts the government's "administrative ability" to make this a reality.<sup>41</sup> Puttergill is concerned that the scheme will introduce more bureaucracy to a system "strangled" by red tape and that its administrators will not be sufficiently competent to prevent it from creating an "even bigger mess" of the health sector. "If the government cannot even sort out the salary payments of the few doctors in the rural Eastern Cape, how will it manage to process double the amount of payments for the healthcare workers needed for an effective NHI?"<sup>42</sup>

Puttergill said: "Most rural Doctors I know are reasonable people and we do not expect the government to 'do it all'. We know it is going to be little steps towards getting quality healthcare in reach of most South Africans. But what we do expect is that one of those little steps will be to inform doctors about how a system that they are expected to drive will work. What we do expect is that officials who cannot even process basic salary invoices do not form part of the NHI in any way. We want the NHI to take us forwards, not backwards."<sup>43</sup>

South African s' Health Minister Dr. Motsoaledi reminds that although the private sector and medical schemes are also affected by the introduction of the NHI, the NHI

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<sup>38</sup> Ibid.

<sup>39</sup> Mia Malan works for the Discovery Health Journalism Centre at Rhodes University.

<sup>40</sup> Simon Puttergill is a clinical manager at a state hospital in an isolated part of the Eastern Cape.

<sup>41</sup> *Mail and guardian*, 4 June 2012.

<sup>42</sup> Ibid.

<sup>43</sup> Ibid.

should not be conceptualised as a war between private and public sector health coverage.<sup>44</sup>

The discussion above show that South Africa has taken the bold step by recognizing health as one of the necessities of life by constitutionally entrenching this right in the 1996 Constitution, and implementing strategies such as NHI which will ensure the full realization of this right. Although some hold a different view in as far as this health reform through the implementation of NHI is concerned. However is clear that majority are in favour of the reform in that regard.

#### **1.4. Aims and Objectives of the Study**

- Basically the mini-dissertation will discuss the meaning and content of the right to health care with reference to the Constitution, case law and relevant international human rights instruments. This will be done in order to check whether the government's initiative of implementing the NHI in both public and private sectors of health institution will in effect benefit the poor majority of South Africans.
- The study will also check the progress in the realization of the right to health care services by analyzing a factual description of measures instituted by government during the period under review and their impact, especially on vulnerable groups.
- The study will further identify current challenges for the realization of the right to health and in some cases, government's response to these challenges. A

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<sup>44</sup>Motsoaledi, A., 'Media statement - release of Green Paper on National Health Insurance', Department of Health of the Republic of South Africa website, 11 August 2011, <http://www.doh.gov.za>

consideration of some of the shortcomings of the measures instituted by government will also be highlighted.

- The mini-dissertation will further give a description of key future challenges that may hamper the realization of the right to health after the implementation of the NHI, while on the other hand providing with recommendations aimed at preventing or reducing the negative impact thereof.
- Lastly, the study will benefit students and practitioner within law, medical, commercial and actuarial fraternity, government, non-governmental organizations, and the public at large in adding the knowledge or insight on how the scheme will work in the current South African health system.

### **1.5. Research Methodology**

Basically, the research methodology to be adopted in this study is qualitative. Consequently, a combination of legal comparative and legal historical methods, based on jurisprudential analysis, is employed. Legal comparative method will be applied to find solutions, especially for the interpretation section 27 (1) (a) (1) (3), section 28 (1) (c) of the Constitution and other international related instruments in the implementation of the NHI within the South African health care system.

The purpose of historical research method on the other hand, will be to establish the development of legal rules, the interaction between law and social justice, and also to propose solutions or amendments to the existing law or constitutional arrangement, based on practical or empirical and historical facts. Concepts will be analysed, arguments based on discourse analysis, developed. A literature and case law survey of the constitutional prescriptions and interpretation of statute will be

made. This research is library based and reliance is made of library materials like textbooks, reports, legislations, regulations, case laws, articles and papers presented on the subject in conferences.

### **1.6. Scope and the Limitation of the Study**

The study consists of four interrelated chapters. The first chapter deals with the introduction which will lay down the foundation of the study. Chapter two looks at the legislation protecting the right of access to health care services in South Africa. Chapter three deal with the link between right to have access to health care services and other pertinent constitutional rights through the operation of NHI in SA. The last chapter will conclude the study and also provide the recommendations.

## CHAPTER TWO: LEGISLATION PROTECTING THE RIGHT OF ACCESS TO HEALTH CARE IN SOUTH AFRICA

### 2.1. Introduction

The objective of this section is to look at the legal regime that governs the provision of health care services in the public sector in South Africa. The right to health care is generally referred to as fundamental to the physical and mental well-being of all individuals, and as a necessary condition for the exercise of other human rights including the pursuit of an adequate standard of living.<sup>45</sup>

According to former Deputy Minister of Health, Ms Nozizwe Madlala-Routledge, reports from the World Health Organisation (“WHO”) show “that governments that invest in health will derive benefits in development and equality. Put another way this means that ensuring that people can live in dignity, free from disease, is good for government”.<sup>46</sup> Below is a summary of key health care legislation changes introduced after 1994.

### 2.2. The Constitution

The South African Constitution Act, 1996, specifically recognises the right of access to health care in section 27: health care, food, water and social security

- i. “Everyone has the right to have access to –
  - (a) health care services, including reproductive health care;
  - (b) sufficient food and water; and

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<sup>45</sup>Deputy Minister of Health, Ms Nozizwe Madlala-Routledge. Speech given at the launch of *Health & Democracy*, held at Constitutional Hill, 27 February 2007.

<sup>46</sup> *Ibid.*

- (c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- ii. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
- iii. No one may be refused emergency medical treatment.”

In terms of the above provision, the South African government has an obligation to provide health care services for everyone, to ensure that legislation and programmes are in place to provide these services and ensure that everyone is able to access these services.

South Africa has many poor people who are dependent on the state for the provision of health care services. Given this reality, isn't the state then obliged to provide these necessary health care services and treatment when called upon by poor people to provide them? In the case of *Soobramoney v Minister of Health(Kwazulu-Natal)*,<sup>47</sup> Justice Chaskalson also referred to the South African reality in which our Bill of Rights must find application:

“We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them, and to transform our society into one in which there will be human dignity, freedom and equality, lies at the heart of our new constitutional order. For as long as these conditions continue to exist aspirations will have a hollow ring.”<sup>48</sup>

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<sup>47</sup> 1998 (1) SA 765 (CC).

<sup>48</sup> *Ibid*, at Para 8.

The Appellant in this case, an unemployed man in the final stages of chronic renal failure, had approached a hospital with a view to receiving on-going dialysis treatment in its' renal unit. The hospital in question had refused him admission to its renal unit as it followed a set policy in regard to the use of dialysis resources. It was submitted that the State's failure to provide renal dialysis facilities for all persons suffering from chronic renal failure constituted a breach of its obligations under section 27 of the Constitution. In this case the Constitutional Court was of the opinion that, given the socio-historical context of South Africa, the scarcity of resources available to the State was reason enough to prevent Mr. Soobramoney from exercising his right to emergency medical treatment.

Section 27 (1)(b) of the Constitution provides for the State to "take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of the right".

According to the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights,<sup>49</sup> progressive realisation does not imply that the State can defer indefinitely, efforts towards the full realisation of the right. On the contrary, state parties are to "move as expeditiously as possible towards the full realisation of the right".<sup>50</sup> States are further urged to take immediate steps to provide minimum core entitlements.

In the case of *Government of the Republic of South Africa v Grootboom and Others* the government of the Republic of South Africa (the National Department of Housing), the Premier of the Province of the Western Cape representing the Western Cape Provincial Government (the Western Cape government), the Cape

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<sup>49</sup>Limburg Principles on the Implementation of the International Covenant of Economic, Social and Cultural Rights. pp. 63-78 in *Economic, Social and Cultural Rights: A Compilation of Essential Documents*, International Commission of Jurists, 1977.

<sup>50</sup>Ibid at Para 21.

Metropolitan Council (the Cape Metro) and the Oostenberg Municipality challenged the correctness of the judgement in *Grootboom v Oostenberg Municipality and others*,<sup>51</sup> in which the Cape of Good Hope Provincial Division of the High Court ordered government to provide those respondents who were children (and their parents) with adequate basic shelter or housing until they obtained permanent accommodation. The judgement of the court provisionally indicated that “tents, portable latrines, and a regular supply of water (albeit transported) would constitute the bare minimum”.

The Constitutional Court defined the parameters of what constitutes “reasonable measures”, by questioning the reasonableness of a programme that excludes a significant segment of society. The Court stated that “[i]t may not be sufficient to meet the test of reasonableness to show that the measures are capable of achieving a statistical advance in the realisation of the right...if the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the test”.<sup>52</sup>

It is also clear from our court judgments that there must be a reasoned justification for policies, which affect people’s rights. In the case of *Minister of Health v Treatment Action Campaign*,<sup>53</sup> the government had refused to allow medical personnel in hospitals and clinics to provide their patients with Nevirapine, a life-saving drug, which helps to prevent the transmission of HIV from mothers to their babies. The Court held that this refusal was unreasonable, and that the State could not withhold an inexpensive drug that may save lives. This case further illustrates that

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<sup>51</sup>2000 (3) BCLR 277 (C).

<sup>52</sup>Ibid at Para 42.

<sup>53</sup> 2002 (1) SA 46 (CC).

governmental policies in South Africa can be tested against the requirements of the Constitution.

In the remainder of this mini-dissertation we will continue to look at both the legal regime that governs health care in South Africa, as well as international human rights instruments related to health care, which impose further obligations on the South African government.

### **2.3. The White Paper on the Transformation of the Health Care System in South Africa, 1997**

The White Paper sets out a detailed framework for health care delivery. It states that government's overall objective is to develop a unified health care system capable of delivering quality health care to all, guided by the strategic approach of providing comprehensive PHC. According to the White Paper, all health care sector policies and legislation would be

“based on a common vision which reflects the principles of the Reconstruction and Development Programme (“RDP”):

- The health care sector must play its part in promoting equity by developing a single, unified health care system
- The health care system will focus on districts as the major locus of implementation, and emphasise the PHC approach
- The three spheres of government, NGOs and the private sector will unite in the promotion of community goals

- An integrated package of essential PHC services will be available to the entire population at the first point of contact”.

#### **2.4. Choice of Termination of Pregnancy Act<sup>54</sup>**

This Act made the option of termination of pregnancy available to women on request within certain parameters. This was in accordance with the constitutional mandate to take reasonable legislative and other measures to progressively realise the right of access to reproductive health care services. This Act recognises the Constitutional right of women to reproductive choices.

#### **2.5. Amendments to the Medicine and Related Substances of Medicine<sup>55</sup>**

In keeping with the National Drug Policy (“NDP”) relating to pricing of medicine, the amendments includes provision for the parallel importation of medicines, the establishment of a medicine price committee and the introduction of a transparent, non-discriminatory pricing system for medicines. The bonusing and sampling practices in the sale of medicines were prohibited by amendments to the Act.

#### **2.6. Amendments to the Pharmacy Act<sup>56</sup>**

Amendments to this Act saw the opening up of a pharmacy ownership in South Africa to non-pharmacists subject to regulatory requirements to be imposed by the Minister of Health. It was the hope of government that this move would increase access to pharmacy services and encourage the opening of pharmacy services and encourage the opening of pharmacies in rural and under-serviced areas. In the year

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<sup>54</sup>Act, 92 of 1996.

<sup>55</sup>Act 101 of 1965.

<sup>56</sup>Act, 53 of 1974.

2000, amendments to the Pharmacy Act,<sup>57</sup> required newly qualified pharmacists to perform a year of community service for the first time.

## **2.7. Medical Schemes Act<sup>58</sup>**

This Act was passed into law, repealing the previous Medical Schemes Act.<sup>59</sup> The Medical Schemes Act,<sup>60</sup> re-introduced community-rating into a medical schemes environment that was practising predominantly risk-taking on the heels of a 1993 amendment to the previous legislation.<sup>61</sup> This was a bid to promote equity of access to medical scheme benefits for the sick and elderly. There was also a concern on the part of government that medical schemes were designing their benefits in such a way that acutely ill and injured were absorbed by the public health care sector when their treatment became too expensive. The stated objects of the Prescribed Minimum Benefits (“PMB”) are:

- Avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfounded utilisation of public hospitals; and
- To encourage improved efficiency in the allocation of private and public health care resources.

This is consistent with the policy objective of the White Paper of integrating the activities of the public and private health care sectors in ways that maximise the effectiveness and efficiency of all available health care resources.

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<sup>57</sup> Ibid.

<sup>58</sup> Act, 131 of 1998.

<sup>59</sup> Act, 72 of 1967.

<sup>60</sup> Act, 131 of 1998.

<sup>61</sup> Pearmain, D. (2007) Health Policy and Legislation, *South African Health Review 2007*, Durban, Health Systems Trust, pp. 19-31.

In 2001, the Medical Schemes Act of 1998 was amended to extend certain rights to dependents of medical aid members, further regulating the practice of re-insurance and strengthening the powers of the Council and the Registrar to act in the interest of beneficiaries. The Act also made provision for the regulation of marketing of medical schemes, for more frequent reporting by schemes to the Registrar and defined circumstances in which schemes may be inspected. These amendments constitute a refinement of the existing Act.

## **2.8. Sterilisation Act<sup>62</sup>**

This Act deals with the circumstances under which sterilisation and in particular, sterilisation of persons incompetent or incapable of consenting due to mental disability may occur. The previous legislation had combined legislative provisions on abortion and sterilisation and required revision due to the passage of the Choice on Termination of Pregnancy Act<sup>63</sup>, and the Constitution in 1996.

## **2.9. Mental Health Care Act.<sup>64</sup>**

This Act repealed the previous Mental Health Act<sup>65</sup>, and set out procedures for the admission of the mentally ill to health care establishments and the steps to be taken by family members and caregivers to ensure that they obtain the necessary treatment. The new procedures included an increase in the number of checks and balances and gave more rights to the South African Police Service to intervene in mental health cases. The overarching goal of the new Act was to make mental health care services in the country more accessible and to prohibit unfair discrimination against the mentally ill.

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<sup>62</sup>Act, 44 of 1998.

<sup>63</sup>Act, 92 of 1996.

<sup>64</sup>Act, 17 of 2002.

<sup>65</sup>Act, 18 of 1973.

## **2.10. National Health Act.<sup>66</sup>**

The purpose of the National Health Act, 61 of 2003, was to enable the creation of a uniform health care system in South Africa, which would take into account the constitutional and legislative obligations imposed on the Department of Health. The Act also acknowledged the socio-economic injustices of the past and sought to eliminate these past divisions through a system based on the promotion of democracy and human rights. It also took into account the responsibility of the government to make use of its available resources to ensure the progressive realisation of the right to health care for all South Africans. Special mention was made of the protection of this right for women, children, older persons and persons with disabilities.

The Act aspired to improve the national health care system and through cooperative governance and management, to establish uniform standards of quality health care service delivery. It also advocates for a mutual responsibility and co-operation among private and public health care professionals. The responsibility to prioritise the health care services the State can provide was afforded to the Minister of Health, along with the responsibility to determine the eligibility for persons to access free primary health care services at public establishments.

## **2.11. The Traditional Health Practitioners Act.<sup>67</sup>**

It would be inaccurate to consider the formal health care sector of South Africa in isolation from traditional medicine, as it is estimated that 70% of the South African population consult traditional health practitioners.<sup>48</sup> It is therefore necessary that a framework be available for the regulation of these services. The Traditional Health

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<sup>66</sup>61 of 2003.

<sup>67</sup>22 of 2007.

Practitioners Act, 22 of 2007, is the Act that provides this framework. It ensures that quality, safety and efficacy of these services is regulated and maintained through the control of management, training and registration of traditional health practitioners. The main purpose of the Act is to create a juristic person to be known as the Interim Traditional Health Practitioners Council of South Africa. The Council's responsibilities would include a variety of duties such as promoting public health awareness, encouraging research and education within the traditional health sector and distinguishing between the specific categories of health care in the traditional health practitioners' profession.

The four main categories to which recognition was given included diviners (izangoma), herbalists (izinyanga), traditional birth attendants and traditional surgeons (iingcibi). The Council would be responsible for establishing a code of conduct, a minimum training requirement for registered traditional health professionals and investigating complaints and allegations of misconduct, including taking disciplinary action against traditional health practitioners when necessary. Furthermore, it would be required that the Council ensures that traditional health practice complies with universally accepted medical norms and values, therefore making it possible for the Council to liaise with other health professionals as required by law. The Traditional Health Practitioners' Act also looked at the remuneration of registered traditional practitioners through Medical Aid Schemes. However, this regulation has not yet materialised.

It was estimated that in 2006 only 15% of all South Africans had Medical Aid cover and that coverage has since declined to approximately 14% of the country's total

population.<sup>68</sup> With the elevated cost of living and challenges such as the continued growth in unemployment, the alarmingly low number of people with private health insurance cover is not surprising. It should also be noted that private health insurance in South Africa is dominated by private companies; although in recent times there has been a motion of intervention from the government.

## **Conclusion**

From the legislation discussed above, there is no doubt that the right to have access to health care in South Africa is well protected and regulated. The question whether the regulation is strictly adhered to still remains a challenge since the public sector seems to be limping and staggering in providing health services to majority of people. On the other hand bogus medical practitioners and training centers are increasing despite the regulation discussed above. However these challenges due to limitation of space cannot be discussed in this work.

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<sup>68</sup>Matomela, N., “Recognition of Traditional Healers”, [http://www.southafrica.info/ess\\_info/sa\\_glance/health/update/traditionalhealersbill.htm](http://www.southafrica.info/ess_info/sa_glance/health/update/traditionalhealersbill.htm).

## **CHAPTER THREE: LINKING THE RIGHT TO HAVE ACCESS TO HEALTH CARE SERVICES AND OTHER PERTINENT CONSTITUTIONAL RIGHTS THROUGH THE OPERATION OF NHI IN SA**

### **3.1. Introduction**

The Constitution of South Africa recognises the injustices of the past and aims to 'heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights'.<sup>69</sup> It calls for the improvement of the quality of life and health care of all and equal protection under the law. The inclusion of a range of socio-economic rights in the Bill of Rights is central to the achievement of these fundamental constitutional purposes.

These rights include the entitlement and or right of access to health care services<sup>70</sup> housing,<sup>71</sup> food, water,<sup>72</sup> social security and children's rights.<sup>73</sup> This chapter seeks to discuss the constitutional protection of socio-economic rights as well as the relationship between these rights and the role played by the courts in trying to enforce them. The operation of the NHI will also be discussed in this chapter.

### **3.2. The ambit of the right to have access to health care services**

Section 27 of the Constitution provides that:

- (1) Everyone has the right to have access to –
  - (a) health care services, including reproductive health care;
  - (b) sufficient food and water; and

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<sup>69</sup>Preamble to the Constitution.

<sup>70</sup>Section 27 of the Constitution.

<sup>71</sup>Section 26.

<sup>72</sup>Section 27 (1) (b).

<sup>73</sup>Section 28. See also, Janet Kentridge who pointed out in Chaskalson *et al* (eds) *Constitutional Law of South Africa*, at 14-3 that "Equality is not simply a matter of likeness. It is equally a matter of difference. That those who are different should be differently treated is as vital to equality as is the requirement that those who are like are treated alike."

- (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
- (3) No one may be refused emergency medical treatment.

It is clear from the interpretation of the section that it places a duty on the state to adopt appropriate measures to ensure that the right of access to health care services is effectively realised on a progressive basis. However, it should be noted that it is not only the state that is responsible for the provision of access to health care, but individuals and other agents within the society must be enabled by legislative and other measures to provide health care services.

The state's duty is to create the conditions for access to health care for people at all economic levels. It can thus be said that section 27 in the Constitution entails that it has both a vertical and horizontal application. This argument is based on the fact that section 8 of the Constitution provides that the Bill of Rights applies to and binds both the State and private individuals.

### **3.3. The right of access to health care services**

Although there is a difference between section 27 (1) (a) (providing for the right of access to health care service) and section 27(3) (providing that no one may be refused emergency medical treatment), the two subsections may be read together.

The right to health care service should also be seen in the light of the preamble to the Constitution, which envisions the adoption of the Constitution as the supreme law of the Republic in order to, inter alia, improve the quality of life of all citizens and (to) free the potential of each person. Health care services are unfortunately not defined.

It has, however, been suggested that such services must include proper medical care, prevention and diagnosis of diseases and vaccination. This suggestion, it is submitted, does not give much clarity and still leaves the provision open to criticism and vagueness. It does not, for example, define the quality of health care to be accessed, nor does it indicate the extent of that access. It is also not clear what constitutes emergency medical treatment (under section 27(3)) because, it is submitted, most medical conditions are emergencies when viewed from the patient's perspective. It should be noted that the right, like many other socio-economic rights, is couched in negative terms. This, it has been argued, is intended to impose a duty on the state and ensure that treatment is given in an emergency, and not frustrated by bureaucratic requirements or other formalities.

Even though, the right of access to health care services is guaranteed in the Constitution of South Africa (section 27(1)(a)). In addition, the Medical Schemes Act<sup>74</sup> seeks to promote access to affordable private health care for those who are unable to pay for their health care. Also, the National Health Act<sup>75</sup> mandates the Minister of Health to ensure the provision of health services within the limits of available resources (section 3). Furthermore, the Department of Health has adopted several policies, including the Policy on Quality in Health Care for South Africa, aimed at implementing this right.

However, the constitutional rights (including the right of access to health care services) and freedoms are not absolute. They have boundaries set by the rights of others and by important social concerns such as public order, safety health, and

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<sup>74</sup>Act, 131 of 1998.

<sup>75</sup>Act, 61 of 2003.

democratic values.<sup>76</sup> In the South African Constitution, a general limitation<sup>77</sup> sets out specific criteria for the justification of restrictions of the rights in the Bill of Rights.

### **3.4. The application of the right to health care**

The right of access to health care services and to emergency medical treatment may obviously be applied both horizontally and vertically. In its horizontal application, a duty is imposed on private hospitals and private medical practitioners. However, it is to be vertical application of the right that most significance has to be attached because, as with other socio-economic rights, the state is duty-bound to provide social goods and services.

In respect of this obligation, the ability of the state to deliver on the right of access to health was put to the test in *Soobramoney v Minister of Health KwaZulu -Natal*.<sup>78</sup> In finding against the appellant, the Constitutional Court held that the claim could not succeed on the grounds of emergency medical care under section 27(3) and the right to life under section 11 of the Constitution. It was the opinion of the court that the claim should rather have been based on section 27(1), which provides for the rights to health care services. However, the Court also expressed doubt as to whether the appellant would have succeeded under s 27(1) in view of insufficient resources at the hospital.

Although the Constitutional Court seems to have redeemed itself in the case of *Minister of Health & others Treatment Action Campaign & others*<sup>79</sup> (discussed below), it is in anticipation of such constitutional challenges that provision was made in what must be seen as a form of limitation that 'the state must take reasonable

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<sup>76</sup>Ian Currie and Johan de Waal, *Bill of Rights Handbook*, 2005, P 163.

<sup>77</sup>Section 36.

<sup>78</sup> 1997 (12) BCLR 1696 (CC).

<sup>79</sup>2002 (5) SA 721 (CC).

legislative and other measures, within its available resources, to achieve progressive realization of each of these rights'. It is submitted that the express reference to available resources and progressive realization automatically qualifies the right to the extent of making it almost untenable.<sup>80</sup>

### **3.5. Children's right to access to health care**

Section 28 of the Constitution provides that:

(1) Every child has the right-

(c) to basic nutrition, shelter, basic health care services and social services;

It is clear from the wording of the above mentioned provisions that the former offers a general protection of the right to access to health care while the former specifically protect children. A similar provision was contained in the interim Constitution,<sup>81</sup> where it had provided a conspicuous instance of a second generation right functioning in what was predominantly a first generation Bill of Rights.<sup>82</sup> It was noticeable, for example, that under the interim Constitution persons over the age of 18 years had no equivalent constitutional right to basic nutrition or health services. Such discrepancies have to a large extent been removed under the new Constitution, which confers a range of social-welfare rights on all persons irrespective of their age.<sup>83</sup>

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<sup>80</sup>Mubangizi C.J. The protection of human rights in South Africa: *a legal and practical guide*, (2004) P 133.

<sup>81</sup>Constitution of the Republic of South Africa Act 200 of 1993 s 30(1)(c).

<sup>82</sup>Cachalia *et al Fundamental Rights in the New Constitution* 101-102; Du Plessis and Corder *Understanding South Africa's Transitional Bill of Rights* 186; Basson *South Africa's Interim Constitution: Text and Notes* 46; De Vos "The economic and social rights of children and South Africa's transitional Constitution" 1995 *SAPL* 233.

<sup>83</sup>See e.g. section 26 (the right to access to housing) and s 27 (the right to access to health care, food, water and social security).

### 3.5.1. What does NHI offer to children?

The NHI is based on the principles of the right to health care, universal coverage, social solidarity, and a single public administration where access to health will be based on need rather than the ability to pay. The NHI Fund intends to include comprehensive cover extending from primary to quaternary services provided by accredited public and private providers. Quality health care that meets pre-defined standards is pledged. At the core of NHI is primary health care (PHC), the entry point into the health system.

To the extent that section 28(1)(c) seems to place a duty on the state to provide children with the necessary services,<sup>84</sup> it raises well-known jurisprudential controversies regarding the appropriateness of decisions regarding the allocation of scarce economic resources being made by courts.<sup>85</sup> These complex constitutional issues will not be rehearsed here, other than to observe that the provision which has been repeated in the context of other social-welfare rights in an effort to restrict the individual enforcement of the relevant right<sup>86</sup> is conspicuous by its absence in section 28. Whatever the effect of this omission, the repeated use of the word “basic”

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<sup>84</sup> It seems uncontroversial that this constitutional right may also impose a correlative duty on the parents of a child. This duty on the part of parents is in any event part of the common-law duty of support, and is further bolstered by the Child Care Act 74 of 1983 s 50(2) which provides that any person legally liable to maintain a child who (while able to do so) fails to provide that child with adequate food, clothing, lodging and medical aid, shall be guilty of an offence.

<sup>85</sup> See the discussion of the position under the interim Constitution in Cachalia *et al Fundamental Rights in the New Constitution* 102; De Vos “The economic and social rights of children and South Africa’s transitional Constitution” 1995 *SAPL* 233; De Wet “A German perspective on the constitutional enforceability of children’s and labour rights in the interim bill of rights with special reference to *Drittwirkung*” 1996 *THRHR* 577 586-588. For discussion of the new Constitution, see De Vos “Pious wishes or directly enforceable human rights? Social and economic rights in South Africa’s 1996 Constitution” 1997 *SAJHR* 67 87-88.

<sup>86</sup> See e.g. s 26(2) and s 27(2), which provide that the state must take “reasonable legislative and other measures, within its available resources, to achieve the progressive realisation” of the right to have access to housing, health care, food, water and security. While these provisions are formulated as rights to have “access to” the relevant social and economic entitlement, it is noticeable that children’s rights in terms of s 28(1)(c) are not qualified by the “access to” formulation.

in section 28(1)(c) seems designed to ensure that this right should serve as a safety net in cases of extreme deprivation or impoverishment.

Both the sections are aimed at ensuring that every person has access to health care treatment and other necessary related services. The justifiability and enforcement of the right to health care finds its basis in section 7 of the Constitution, which provides that the State must respect, protect, promote, and fulfil the rights in the Bill of Rights.<sup>87</sup>

### **3.6. The role played by the courts in ensuring the right of access to health care services**

The constitutional provisions pertaining to socio-economic rights require the State to “take reasonable legislative and other measures within its available resources, to achieve the progressive realisation of these rights.” This requirement, read with the provision on the obligation of the State to “respect, protect, promote and fulfil the rights in the Bill of rights” in section 7(2) of the Constitution ensures an effective guarantee of socio-economic rights in South Africa. The judicial enforcement of these rights by the courts and the constitutional mandate of the South African Human Rights Commission to monitor and assess the observance of the rights by the State and non-State entities also contribute to the effectiveness of the constitutional guarantee of these rights.

The Constitutional Court has played a significant role in ensuring the effective guarantee of socio-economic rights in our country. On the obligation of the State, Judge Yacoob held in the case of *Government of the Republic of South Africa v Grootboom and Others*: “The State is obliged to take positive action to meet the needs of those

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<sup>87</sup>Section 7(2) of the Constitution.

living in extreme conditions of poverty, homelessness or intolerable housing.”<sup>88</sup>On the effective guarantee of basic necessities of life for the poor, Judge Yacoob further said:

“This case shows the desperation of hundreds of thousands of people living in deplorable conditions throughout the country. The Constitution obliges the State to act positively to ameliorate these conditions. The obligation is to provide access to housing, health-care, sufficient food and water, and social security to those unable to support themselves and their dependants. The State must also foster conditions to enable citizens to gain access to land on an equitable basis. Those in need have a corresponding right to demand that this be done.”<sup>89</sup>

On the role of the courts in ensuring that the State fulfils its role in giving effect to these rights and thus ensuring that there is an effective guarantee of these rights, Judge Yacoob said:

“I am conscious that it is an extremely difficult task for the State to meet these obligations in the conditions that prevail in our country. This is recognised by the Constitution which expressly provides that the State is not obliged to go beyond available resources or to realise these rights immediately. I stress however, that despite all these qualifications, these are rights, and the Constitution obliges the State to give effect to them. This is an obligation that Courts can, and in appropriate circumstances, must enforce.”<sup>90</sup>

A similar position was taken by the Constitutional Court in another seminal judgment, *Minister of Health and Others v Treatment Action Campaign and Others*<sup>91</sup>, where the Court held: The state is obliged to take reasonable measures progressively to eliminate or reduce the large areas of severe deprivation that afflicts our society. The courts will guarantee that the democratic processes are protected so as to ensure accountability, responsiveness and openness, as the Constitution requires in its section 1. As the Bill of Rights indicates, their function in respect of

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<sup>88</sup>2000(11) BCLR 1169 (CC) at Para 24.

<sup>89</sup>Ibid at Para 93.

<sup>90</sup>Ibid at Para 94.

<sup>91</sup>2002 (5) SA 721 (CC).

socio-economic rights is directed towards ensuring that legislative and other measures taken by the state are reasonable.<sup>92</sup>

In outlining the role of the courts, the Court also stated: The primary duty of courts is to the Constitution and the law...Where state policy is challenged as inconsistent with the Constitution, courts have to consider whether in formulating and implementing such policy the state has given effect to its constitutional obligations. If it should hold in any given case that the state has failed to do so, it is obliged by the Constitution to do so.<sup>93</sup>

While there might be some criticism directed at the Constitutional Court pertaining to the determination of when there are no available resources for the State to fulfil its obligation pertaining to socio-economic rights, the courts, particularly the Constitutional Court, have and will continue to play an important role in ensuring that the provisions in the Bill of Rights are effectively guaranteed for our people.

In *Grootboom*, the Constitutional Court found the state's housing programme to be unreasonable as it made no provision for access to housing for people in desperate need. Regarding the children, it held that the primary obligation to provide for children's needs lies with their parents and on the state only when the children have been removed from the care of their parents. The possible prospects and challenges which may be brought by the implementation of the scheme.

### **3.7. The right to health care services in the context of HIV/AIDS**

In the general context of human rights, some landmark judgments regarding confidentially and HIV testing have been passed by the South African courts. In the specific context of the rights of access to health care services, it is interesting to note that the courts, particularly the Constitutional Court, have been rather sympathetic

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<sup>92</sup>Ibid at Para 36.

<sup>93</sup>Ibid at Para 99.

and more empathetic in their judgment. In the case of *Van Biljon v Minister of Correctional Services*,<sup>94</sup> the applicants were HIV-infected prisoners who sought, inter alia, a declaratory order that their right to adequate medical treatment entitled them to the provision of expensive anti-retroviral medication. It was contended on behalf of the applicants that because the right to adequate medical treatment was guaranteed in the Bill of Rights, prison authorities could not on the basis of lack of funds refuse to provide treatment that was medically indicated. The court accepted this argument. In the view of the court, the lack of funds could not be an answer to a prisoner's constitutional claim to adequate treatment. A prisoner had a constitutional right to form of medical treatment that was adequate. According to the court:

What is adequate medical treatment cannot be determined in *vacuo*. In determining what is adequate, regard must be had to, inter alia, what the state can afford. If the prison authorities should, therefore, make out a case that as a result of budgetary constraints they cannot afford a particular form of medical treatment or that the provision of such medical treatment would place an unwarranted burden on the state, the court may very well decide that the less effective medical treatment which is affordable to the state must in the circumstances be accepted as sufficient or adequate medical treatment.

The applicant's order was granted and the respondents were ordered to supply them with the combination of anti-retroviral medication that had been prescribed for them for so long as such medication continued to be prescribed. Although the *Van Biljon* case was decided in the context of prisoners and their constitutional rights to adequate medical treatment (under section 35 (2) (e)) it has important ramifications for everyone's right to health care services (under section 27 (1)).

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<sup>94</sup>1997 (4) SA 441 (C).

The ramifications were reflected in the constitutional Court's decision in *Minister of Health & Others v Treatment Action Campaign & Others*.<sup>95</sup> The Treatment Action Campaign (TAC), a non-governmental organization, brought the case in a bid to force government to provide anti-retroviral drugs under the public health care system. The TAC was specifically demanding that nevarapine, a drug that could reduce by half the rate of transmission from mothers to babies, be freely distributed to pregnant women infected with HIV. They argue that current health policies violated constitutional rights including the right to health care, life, dignity and equality.

The *court a quo* ruled in favour of the applicants and held that the state had violated the constitutional rights of expectant HIV-positive mothers by not supplying them with free nevarapine. The state was ordered not only to make the drug freely available to pregnant women but also to come up, within three months, with a detailed blueprint on how it intended to extend the mother-to-child transmission prevention programme. The government decided to appeal to the Constitutional Court. In upholding the decision of the lower court, the Constitutional Court pointed out that it was constitutionally bound to require the state to take reasonable measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. The court said such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budget. The court further held that the government's policy fell short of compliance with sections 27 (1) and (2) of the Constitution. The court found that the government had

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<sup>95</sup>2002 (5) SA 721 (CC).

not reasonably addressed the need to reduce the mother-to-child transmission of HIV.<sup>96</sup>

### **3.8. Introducing a National Health Insurance<sup>97</sup>**

The South African healthcare system includes private and public service providers.<sup>98</sup>

The public healthcare system is funded primarily by the fiscus and, as far as possible, provides free care at the point of service to the majority of South Africans.

Due to high patient volumes and poor funding, the public healthcare system is often associated with being poor on safety, patient management, stock availability and infection control. This has resulted in poor staff morale, under-maintained facilities and an overall compromised quality of service provision in public health facilities.<sup>99</sup>

The private sector services a smaller portion of the population who, by virtue of their employment status, elect to purchase benefit options through a medical scheme or pay out-of-pocket.

### **3.9. How will new NHI system work?**

At completion, the principle will be that you pay according to your means and receive health care according to your needs. There will be a National Health Insurance Fund (NHIF), where monies will be pooled from contributions from salaried persons, the road accident fund and general tax, in order to secure greater buying power. The Fund will be administered by a National Health Insurance Agency (NHIA), with a Chief Executive Officer (CEO) reporting to the Minister of Health. The NHIA will buy

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<sup>96</sup>Mubangizi C.J. The protection of human rights in South Africa: *a legal and practical guide*, Pg.134.

<sup>97</sup>This section is based primarily on the NHI Green Paper. Unless otherwise stated, references are assumed to be from: 'National Health Insurance in South Africa: Policy Paper', Department of Health of the Republic of South Africa Government Gazette No. 34523, 12 August 2011, <http://www.samedical.org>.

<sup>98</sup>'Republic of South Africa: National Health Bill', Department of Health of the Republic of South Africa website, 2003, <http://www.doh.gov.za>

<sup>99</sup>McIntyre, D., 'Why we need NHI now', Health-e News Services, 17 June 2009, <http://www.health-e.org.za>.

all health care services and products on behalf of the total South African population. In that way both the public and private sectors will deliver care to NHI patients at a uniform level. Patients will be expected to register at a private practice, so that that practice can be paid a per-head amount for that practice seeing the patient. All employees who earn say for example, more than about R5 000 per month (the approximate current tax threshold) will have to pay a payroll tax to the NHIF and the employers will also have to pay the same amount into the Fund. It is not clear what that amount will be. Medical schemes will continue to exist, but it is likely that medical schemes will provide top-up cover as some members will find paying both NHI contributions and same cover medical scheme premiums too much.

### **3.10. Objectives of NHI**

NHI is aimed at providing universal coverage. The WHO defines this term as " the progressive development of a health system including its financing mechanisms into one that ensures that everyone has access to quality, needed health services and where everyone is accorded protection from financial hardships linked to accessing these health services".

A number of countries have reformed their health systems to achieve the above goals. This has brought about equity in access for services, administrative efficiency, increased revenue and quality improvements.

The main objectives of the NHI are:

- To provide improve access to quality health services for all south Africans irrespective of whether they are employed or not;

- To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund;
- To procure services on behalf of the entire population and efficiently mobilize and control key financial resources. This will obviate the weak purchasing power that has been demonstrated to have been a major limitation of some of the medical schemes resulting in spiralling costs;
- To strengthen the under-resourced and strained public sector so as to improve health systems performance.

### **3.11. Principles of NHI in South Africa**

Section 27 of the Bill of Rights of the Constitution states that everyone has a right of access to health care services including reproductive health care and the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights.<sup>100</sup> The reform of health care is an important step towards the realisation of these rights and the key aspect of this is that access to health services must be free at the point of use that people will benefit according to their health profile. This is where social solidarity becomes important. Social solidarity in this context refers to the creation of financial risk protection for the entire population that ensures sufficient cross-subsidisation between the rich and the poor, and the healthy and sick. Such a system allows for the spreading of health costs over a person's lifecycle, paying contributions when one is young and healthy and drawing on them in the event of illness later in life.

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<sup>100</sup> See section 36 of the Constitution.

### **3.11.1. Effectiveness**

This can be achieved through evidence based interventions, strengthened management systems and better performance of the healthcare system that will contribute to positive health outcomes and overall improved life expectancy for the entire population.

### **3.11.2. Appropriateness**

This refers to the adoption of new and innovative health service delivery models that take account of the local context and acceptability and tailored to respond to local needs. The health services delivery model will be based on a properly structured referral system rendered via a re-engineered Primary Health Care model.

### **3.11.3. Equity**

This refers to the health system that ensures that those with the greatest health need are provided with timely access to health services, it should be free from any barriers<sup>101</sup> and any inequalities in the system should be minimised. Equity in the health system should lead to expansion of access to quality health services by vulnerable groups and in underserved areas.<sup>102</sup> The principle of equality has been elaborately articulated as 'fairness' by the Director-General of the World Health Organisation (WHO), Dr Margaret Chan.<sup>103</sup>

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<sup>101</sup> Barriers may be regulatory, cultural, geographic and administrative. This should be understood within available resources in the country.

<sup>102</sup> See also section 9 of the Constitution which prohibits all forms of unfair discrimination.

<sup>103</sup> Dr. Margaret Chan Address to the United Nations General Assembly on the theme "Advancing Global Health in the Face of Crisis", 15 June 2009.

### **3.11.4. Efficiency**

This will be ensured through creating administrative structures that minimize or eliminate duplication across the national, provincial and district spheres. The key will be to ensure that minimal resources are spent on the administrative structures of the National Health Insurance and that value-for-money is achieved in the translation of resources into actual health service delivery.

### **3.12. Financial implications likely to be involved in the implementation of the NHI**

About R500 million has been set aside in the 2012 Budget to fund pilot sites for the NHI system, the Minister of Finance Pravin Gordhan revealed on 25 October 2011.<sup>104</sup> Part of the first phase also involved revitalising hospitals, improving nursing and getting the public health system to provide a more caring environment. The pilots would form the first part of a fourteen-year programme to introduce the NHI system.<sup>105</sup>

It is thus estimated that during the first fourteen (14) year period a big stake of approximately R240 billion will be used to roll over the NHI. The money will be used to increase infrastructure and capacity, for example more health practitioners (doctors, nurses, pharmacists, etc...) and other support staff will have to be hired.<sup>106</sup> Based on these financial challenges, will government be able to administer the system efficiently, given its very poor track record in governing the current public health care system, for example, in the governance of the Compensation for

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<sup>104</sup> Medical Aid news, R500m to fund NHI pilot, dated 26 Oct 2011 accessed from <http://www.bizcommunity.com/Article/196/320/66233.html> on 2012/05/03.

<sup>105</sup> Ibid.

<sup>106</sup> South African Private Practitioner Forum, National Health Insurance in South Africa: SAPPF submissions on the Green Paper on National Health Insurance, 2011-12-06., at 19 Para 11.2.

Occupational Injury and Diseases Fund and the Road Accident Fund? Will the NHI be able to attract and retain the number and quality of health care professionals needed, or simply cause an even larger exodus?

### **3.13. Financing models and international comparative systems**

Few compatriots will disagree with the statement that our current health system is “sick”. South Africa is spending 8.5% of its Gross Domestic Product (GDP) on health care, ranking number 32 in the world, and yet, in terms of the WHO’s rating measuring health outcomes, we are only number 175. This means we are spending a lot of money, probably all we can afford, but are not getting good results due to inefficiency. Yet the biggest obstacle to the NHI programme is cost, which is estimated from R100 billion to R300 billion, depending on the benefits made available.<sup>107</sup>

#### **3.13. 1. Tax *versus* insurance system financing**

If the government is to adopt and implement NHI, it can be funded in two ways: general taxation or compulsory health insurance. Both routes are capable of achieving the solidarity principle in health care financing. The United Kingdom (UK) and Sweden have used the tax route while countries such as France, Germany and South Korea and some in Latin America have chosen the insurance route.

The UK established its tax-funded National Health Service in 1948. This system is governed by principles of universality and comprehensiveness (thereby covering everything and everyone). It is equitable and free at the point of use. However,

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<sup>107</sup> David Carte National, Health Insurance Multi-billion rand NHI to be put on hold, Money web’s Personal Finance, December 2009, P4.

problems in the UK system include over-centralisation with disempowered patients, a lack of national standards and underinvestment in the system. In addition, resource constraints lead to choices and prioritisation so that the concept of comprehensive and universal care becomes elusive. South Korea introduced mandatory social health insurance for industrial workers in large corporations in 1977. It extended this to cover the entire population in 1989.<sup>108</sup> In relation to the tax-versus insurance debate, therefore, South Korea's 31 years of national health insurance can provide valuable lessons on key issues in health care financing policy.

If the insurance route is taken, the question arises: should it be based on the individual or the employer? The South African government has taken an initiative through the Government Employees Medical Scheme (GEMS) to introduce the employer based mandate. However, research reveals that companies are abdicating their responsibility with regard to the financing and provision of health care, which may make the mandate unachievable.<sup>109</sup> It is suggested that in the medium term, medical scheme contributions should be mandatory for those who can afford to make some contribution towards their health care. Such individual-based mandates would have to be effected in a systematic and a phased manner, starting with either high-income earners or specific groups of employers.

### **3.13.2. Single-payer versus multiple-payer models**

Another question is whether a single-payer or multiple-payer model should be adopted. Both have advantages and disadvantages. A single-payer model is one in which health care is financed by the government and delivered by privately owned

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<sup>108</sup>Kwon, S, Thirty years of national health insurance in South Korea: Lessons for achieving universal health care coverage, 2009, 24(1) *Health Policy and Planning*, P 63-71.

<sup>109</sup>Tshabalala-Msimang, M 2008. Health within a comprehensive system of social security: Is national health insurance an appropriate response? In C Botha and M Hendricks (eds), *Financing South Africa's national health system through national health insurance: Possibilities and challenges*. Colloquium proceedings. HSRC Press.

and operated health care providers.<sup>110</sup> Typically, it establishes one uniform remuneration scheme.<sup>111</sup> Here the key player remains the government. This model has been used in Australia, Canada, Sweden and Taiwan.

A single-payer system generally promotes equality and universality. Its rationale is that the majority of people should not suffer because they lack health insurance. Economically, this model is also thought to be less costly. Its downside is that it is prone to underfunding by a hostile government, mismanagement and recession. A multi-payer system, on the other hand, is one in which health care is funded by private and public contributions. Hence it presents a choice of several funds to provide a basic service.<sup>112</sup> It has been used by Germany, France and Japan. It is credited with providing diversity in insurance products and more flexible purchasing arrangements.<sup>113</sup> But risk selection is a big problem in this system as it leads to 'cream skimming.'<sup>114</sup> Under this system, individuals with a high risk may tend to buy more complete insurance coverage than low-risk individuals, who will tend to opt for low-cost, low coverage policies or no policies at all. This, in turn, affects quality (Hussey and Anderson, 2003: 218). South Africa is leaning towards a multi-payer system, through the expansion of private insurance as a supplement to the public single-payer system.<sup>115</sup> This system will cater for better-off individuals, as they will have the option to purchase supplementary private coverage, while still supporting the public system. All in all, it has been argued that there is no universal paradigm

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<sup>110</sup>Tuohy, C 2009. Single payers, multiple systems: The scope and limits of sub-national variation under a federal health policy framework. 34(4) *Journal of Health Politics, Policy and Law*. P 453-496.

<sup>111</sup>Zweifel, P 2004. *Multiple payers in health care: A framework for assessment*. HEN Discussion Paper. International Bank for Reconstruction and Development/World Bank.

<sup>112</sup>Hussey, P and Anderson, G 2003. A comparison of single- and multi-payer health insurance systems and options for reform. 66 *Health Policy*. P 215-228.

<sup>113</sup>Ibid at 223.

<sup>114</sup>A practice in which individuals with pre-existing conditions may not be offered a policy with coverage of that condition.

<sup>115</sup>Hussey, P and Anderson, G 2003. A comparison of single- and multi-payer health insurance systems and options for reform. 66 *Health Policy*. P225.

for the design of health insurance.<sup>116</sup> South Africa will have to set its priorities in relation to its population and system of government. It will also have to bear in mind some of the challenges that low- and middle income countries face in providing health insurance, such as the ability to raise public sector revenue as a GDP share, higher numbers in the informal sector, and disparities in income, resources and health status.

In South Africa finance Minister Pravin Gordhan has been tight-lipped about how a National Health Insurance Scheme would be funded. However, the Treasury has suggested four national health insurance "funding avenues", including tax, mandatory employer contributions, user charges and public-private partnerships.

The South African government might raise value-added tax (VAT) to fund NHI. The Minister said "VAT ensures that those who manage to escape the income tax net pay some tax, and that, VAT does not impact on savings negatively or on the cost of employment." He further said that "South Africa's 14% value added tax (VAT) rate is "relatively low when compared to the worldwide average of 16.4%". It is asserted that the tax generation method seems to be better, however one starts to be worried about the government's plans and means of generating revenue. In a country which is characterised by severe socio-economic challenges such as poverty, unemployment, Maternal, Child and Infant Mortality coupled with the burden of disease such as HIV/AIDS<sup>117</sup> and TB<sup>118</sup>, the tax funding avenue was supposed to be the last option, however that's seems to be vice versa in South Africa.

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<sup>116</sup>Ibid at 226.

<sup>117</sup> Human immunodeficiency virus or acquired immunodeficiency syndrome.

<sup>118</sup>Tuberculosis.

Universal coverage<sup>119</sup> of health care is now receiving substantial worldwide and national attention, but debate continues on the best mix of financing mechanisms, especially to protect people outside the formal employment sector. Crucial issues are the equity implications of different financing mechanisms, and patterns of service use. The report of a whole system analysis integrating both public and private sectors of the equity of health system financing and service was used in South Africa, Ghana, and Tanzania.<sup>120</sup>

The findings were that, the overall healthcare financing was progressive in all three countries, as were direct taxes. Indirect taxes were regressive in South Africa but progressive in Ghana and Tanzania. Out-of-pocket payments were regressive in all three countries. Health insurance contributions by those outside the formal sector were regressive in both Ghana and Tanzania. The overall distribution of service benefits in all three countries favoured richer people, although the burden of illness was greater for lower-income groups. Access to needed, appropriate services was the biggest challenge to universal coverage in all three countries.

The interpretation of the report is that analyses of the equity of financing and service use provide guidance on which financing mechanisms to expand, and especially raise questions over the appropriate financing mechanism for the health care of

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<sup>119</sup> The National Health Insurance in South Africa Policy Paper defines 'Universal Coverage' as the progressive development of the health system, including its financing mechanisms, into one that ensures that everyone has access to quality, needed health services and where everyone is accorded protection from financial hardships linked to accessing these health services. This does not imply that the State must provide everything and anything to the population. Instead, it implies that everyone must be given an equitable and timely opportunity to access needed health services, which must include an appropriate mix of promotion, prevention, curative and rehabilitation care, P 59. The WHO defines a universal health system as one that provides all citizens with adequate health care at an affordable cost.

<sup>120</sup> Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage The Lancet, Early Online Publication, 15 may 2012 accessed from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)60357-2/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60357-2/fulltext) on 2012/05/21.

people outside the formal sector. Physical and financial barriers to service access must be addressed if universal coverage is to become a reality.

Universal coverage to affordable health care services is best achieved through a prepayment health financing mechanism. To achieve universal coverage, pooling of funds requires that payments for health care are made in advance of an illness, and these payments are pooled and used to fund health services for the population. The funds can be from a combination of sources (e.g. the fiscus employers and individuals). The precise combination of these sources is the subject of continuing technical work.<sup>121</sup>

An important consideration is that the revenue base should be as broad as possible in order to achieve the lowest contributions rates and still generate sufficient funds to supplement the general tax allocation to the NHI. As the NHI matures, consideration will be given to the alignment and consolidation of health benefits offered by other relevant statutory entities.<sup>122</sup>

The national health insurance proposed for South Africa aims to achieve a universal health system. The best way to identify the financing mechanism that is best suited to achieving this goal is to consider international evidence on funding in universal health systems. The evidence from Organisation for Economic Cooperation and Development countries and a number of middle-income countries<sup>123</sup> that have achieved universal coverage clearly indicates that mandatory pre-payment financing mechanisms (i.e. general tax funding, in some cases supplemented by mandatory

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<sup>121</sup>Department of Health, National Health Insurance in South Africa Policy Paper, February 2012, P 114 P35.

<sup>122</sup>Ibid at P115 P35.

<sup>123</sup>Such as Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Korea, Netherlands, new Zealand, Norway, Portugal, Spain, Sweden, Switzerland and United Kingdom.

health insurance) must dominate, with a clearly specified, complementary role for voluntary or private health insurance.<sup>124</sup>

DA hold the opinion that, the public sector, which is funded from the general fiscus through a progressive taxation system, provides free healthcare for those lacking the funds to pay for themselves. A means test determines who is eligible for free public healthcare and who must seek additional support from private medical insurance. This has reduced out-of-pocket expenses for the poor to a minimum, but it has left some low-wage and middle-income earners vulnerable to the vagaries of co-payments that can sometimes arise from medical procedures.<sup>125</sup> According to them, financial fairness is best achieved from a mix of pre-payment systems and the pooling of funds. The ideal in healthcare financing is for the ratio of total health contributions to be identical for all households irrespective of their income, health status or use of the health system.<sup>126</sup> This means that out of pocket payments, which are payments made directly to the healthcare provider from the patient, should be kept to a reasonable level for those who can afford it.

Currently, South Africa's out-of-pocket expenditure for healthcare 18.1% of all total health expenditure is comparatively low by international standards. It is lower than countries like Taiwan and South Korea (30% and 36.8% respectively), both of which have NHI-based healthcare systems.<sup>127</sup> Thus, together, our public and private systems do well to protect people financially, though more attention should be given

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<sup>124</sup>See Diane McIntyre 'What healthcare financing changes are needed to reach universal coverage in South Africa?' SAMJ 102(6):489-490.

Diane McIntyre

<sup>125</sup> World Health Organization (2000), "World health report 2000: health systems – improving performance" Geneva: WHO. Available from: [www.who.int/whr/2000/en/index.html](http://www.who.int/whr/2000/en/index.html)

<sup>126</sup> The DA's alternative to NHI dated 29 Nov 2011 P4, accessed from <http://www.healthlink.org.za/documents/6540023f3f76fe3473ebcace5a413087.pdf> on 2012/04/15.

<sup>127</sup>Alex van den Heever (2010), "A Financial Feasibility Review of NHI Proposals for South Africa," South African Health Review 10:16, P.163. Available from: [www.healthlink.org.za/uploads/files/sahr10\\_16.pdf](http://www.healthlink.org.za/uploads/files/sahr10_16.pdf).

to the challenges facing low and middle-income families that earn too much for free medical care, but too little for comprehensive private care.<sup>128</sup>

### **3.13.3. The right of access to health care and other pertinent constitutional rights**

Human rights are interdependent, indivisible and interrelated.<sup>129</sup> This means that violating the right to health may often impair the enjoyment of other human rights, such as the rights to education or work, and vice versa. The importance given to the “underlying determinants of health”, that is, the factors and conditions which protect and promote the right to health beyond health services, goods and facilities, shows that the right to health is dependent on, and contributes to, the realization of many other human rights. These include the rights to food, to water,<sup>130</sup> to an adequate standard of living, to adequate housing,<sup>131</sup> to privacy,<sup>132</sup> to access to information,<sup>133</sup> to participation, and the right to benefit from scientific progress and its applications.

It is easy to see interdependence of rights in the context of poverty. For people living in poverty, their health may be the only asset on which they can draw for the exercise of other economic and social rights, such as the right to work or the right to education. Physical health and mental health enable adults to work and children to

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<sup>128</sup> Finance Technical Task Team (2009), *Financing Health Care for all in South Africa: A situation assessment and proposals for the future*, Report of the Minister’s Advisory Committee on Health, P.14. Available from: [https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B\\_-slGu8-FTxMTdmOTRkYjAtMjllMy00YzUxLTlmNzYtOWEyMjcxMDljOGU4&hl=en\\_US](https://docs.google.com/viewer?a=v&pid=explorer&chrome=true&srcid=0B_-slGu8-FTxMTdmOTRkYjAtMjllMy00YzUxLTlmNzYtOWEyMjcxMDljOGU4&hl=en_US)

<sup>129</sup> See Vienna Declaration and Programme of Action (A/CONF.157/23), adopted by the World Conference on Human Rights, held in Vienna, 14–25 June 1993.

<sup>130</sup> Links between the right to health and the right to water is found on the basis that ill health is associated with the ingestion of or contact with unsafe water, lack of clean water (linked to inadequate hygiene), lack of sanitation, and poor management of water resources and systems, including in agriculture. Most diarrhoeal disease in the world is attributable to unsafe water, sanitation and hygiene. See further World Health Organization, *Water, sanitation and hygiene: Quantifying the health impact at national and local levels in countries with incomplete water supply and sanitation coverage*, Environmental Burden of Disease Series, No. 15 (Geneva, 2007).

<sup>131</sup> Section 26 of the Constitution.

<sup>132</sup> Section 14 *ibid.*

<sup>133</sup> Section 32 *ibid.*

learn, whereas ill health is a liability to the individuals themselves and to those who must care for them. Conversely, individuals' right to health cannot be realized without realizing their other rights, the violations of which are at the root of poverty, such as the rights to work, food, housing and education, and the principle of non-discrimination.<sup>134</sup>

The Bill of Rights of the Constitution also contains other provisions that could be useful in enforcing health care rights. These provisions include, *inter alia*, the right to equality,<sup>135</sup> the right to dignity,<sup>136</sup> the right to life,<sup>137</sup> the right to just administrative action,<sup>138</sup> access to courts,<sup>139</sup> limitation of rights,<sup>140</sup> enforcement of rights<sup>141</sup> and interpretation of the Bill of Rights.<sup>142</sup> In addition to the Bill of Rights, chapters 3, 5, 6 and 7 of the Constitution stipulate the obligations and legislative requirements of the different spheres of government.

#### **3.13.4. The principle of non-discriminative NHI's application to the right to health care services**

Discrimination means any distinction, exclusion or restriction made on the basis of various grounds which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms. It is linked to the marginalization of specific population groups and is generally at the root

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<sup>134</sup> See, World Health Organization, *The Right to Health*, Fact Sheet No. 31, P6.

<sup>135</sup>Section 9 of the Constitution.

<sup>136</sup>Section 10 *ibid.*

<sup>137</sup>Section 11 *ibid.*

<sup>138</sup>Section 33 *ibid.*

<sup>139</sup>Section 34 *ibid.*

<sup>140</sup>Section 36 *ibid.*

<sup>141</sup>Section 38 *ibid.*

<sup>142</sup>Section 39 *ibid.*

of fundamental structural inequalities in society<sup>143</sup>. This, in turn, may make these groups more vulnerable to poverty and ill health. Not surprisingly, traditionally discriminated and marginalized groups often bear a disproportionate share of health problems. For example, studies have shown that, in some societies, ethnic minority groups and indigenous peoples enjoy fewer health services, receive less health information and are less likely to have adequate housing and safe drinking water, and their children have a higher mortality rate and suffer more severe malnutrition than the general population.<sup>144</sup>

The impact of discrimination is compounded when an individual suffers double or multiple discrimination, such as discrimination on the basis of sex and race or national origin or age. For example, in many rural places indigenous women receive fewer health and reproductive services and information, and are more vulnerable to physical and sexual violence than the general population.<sup>145</sup>

### **3.13.5. Challenges likely to be brought by the NHI**

One of the big concerns is that the Green Paper lacks a coherent diagnostic analysis as to why our health system is failing, nor does it address accountability within the healthcare system. In actual fact, the Green Paper on NHI is silent on governance and accountability of health departments across provinces since only 3% of provincial health departments received clean audit reports from the auditor general in 2009/2010, including the North West Province and Western Cape. Performance failures in the South African health system in both the public and private sectors stem from a failure in governance and supervisory structures. For example, in

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<sup>143</sup>Section 9 *ibid.*

<sup>144</sup>See, WHO, The Right to Health, Fact Sheet No. 31, P7.

<sup>145</sup>*Ibid.*

Gauteng six babies die at a public hospital, yet no one is held accountable, and in the Eastern Cape serious patient abuse in maternity wards is identified, but no further action taken."<sup>146</sup> This shows that poor governance would manifest in poor health outcomes.

The other related major challenge which has surfaced in the current debate over the introduction of NHI is the high level of bribery and corruption which continue to occupy a dominant position in our press and our society, namely to question how much better medical service could be offered to patients currently if corruption was eliminated in state hospitals. This ranges from apparently petty bribes to traffic officials to significant amounts paid as "commissions" for securing tenders. While the amount may differ, whether R100 or R1 million - the nature of the action is not different. It all amounts to bribery and corruption. It may be a naïve question to ask why this is happening. It is certainly not because those involved don't know what is right and wrong. Nor is it because they are in the grip of poverty? Rather, at the level of the bribe to a traffic official, it can be seen as an avoidance strategy. This could be merely to avoid a fine or, worse, to avoid being jailed for drunken driving. For tenders, there does not appear to be any other motivation than the money.<sup>147</sup>

A further cost relates to leadership, specifically because leaders exert the most powerful influence on ethics, defining by their behaviour what is and is not

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<sup>146</sup> Professor Alex van den Heever (University of Witwatersrand: Social Security Systems Administration and Management Studies) speaking at the Hospital Association of South Africa (HASA) conference in Cape Town, see also Public health news, Green Paper on NHI silent on governance, accountability – HASA, dated 30 Sep 2011 accessed from [http://www.bizcommunity.com/Article/196/330/65001.html#tag=national health insurance](http://www.bizcommunity.com/Article/196/330/65001.html#tag=national%20health%20insurance) on 2012/05/04.

<sup>147</sup> Cynthia Schoeman, Criminal Law news, accessed from [http://www.bizcommunity.com/Article/196/549/64893.html#tag=national health insurance](http://www.bizcommunity.com/Article/196/549/64893.html#tag=national%20health%20insurance) on 2012/05/04. Cynthia Schoeman is the MD of Ethics Monitoring & Management Services. She has developed a web-based survey, The Ethics Monitor ([www.ethicsmonitor.co.za](http://www.ethicsmonitor.co.za)), which is a practical tool to help organisations measure, monitor and proactively manage their ethics. The Deputy President Kgalema Motlanthe also addressed this issue in August 11 2011 at the Annual Ruth First Memorial Lecture at Wits University by acknowledging that, after racism, corruption was "the second most serious malady staring humanity in the face today".

acceptable. Therefore, when high profile citizens are involved in bribery and corruption, their impact as role models is very damaging. The message is not only that unethical and illegal behaviour is acceptable, but also that the pursuit of personal gain takes precedence over service delivery. This risks creating an unethical culture among ordinary citizens where such "lowest common denominator" behaviour predominates.<sup>148</sup>

The performance requirements is not linked to sanctions, information is not used to hold organisations to account and procurement processes had been captured by politically connected individuals across most provinces.<sup>149</sup>

At a national level, this also risks tainting the country's reputation. In this regard South Africa does not fare that well.<sup>150</sup> This may not yet be irreparably bad, but it still warrants a serious commitment to avoid the costs and consequences of an unethical national reputation, such as reduced foreign investment, decreased tourism, and the loss of our top talent to other countries.<sup>151</sup>

This may not yet be irreparably bad, but it still warrants a serious commitment to avoid the costs and consequences of an unethical national reputation, such as reduced foreign investment, decreased tourism, and the loss of our top talent to other countries.<sup>152</sup> The other worrying problem is why does South Africa have one of the highest maternal mortality rates, despite spending more on healthcare than other

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<sup>148</sup> Cynthia Schoeman, Criminal Law news, accessed from [http://www.bizcommunity.com/Article/196/549/64893.html#tag=national health insurance on 2012/05/04](http://www.bizcommunity.com/Article/196/549/64893.html#tag=national%20health%20insurance%20on%202012/05/04).

<sup>149</sup> Professor Alex van den Heever (University of Witwatersrand: Social Security Systems Administration and Management Studies), see also Public health news, Green Paper on NHI silent on governance, accountability – HASA, dated 30 Sep 2011 accessed from [http://www.bizcommunity.com/Article/196/330/65001.html#tag=national health insurance on 2012/05/04](http://www.bizcommunity.com/Article/196/330/65001.html#tag=national%20health%20insurance%20on%202012/05/04).

<sup>150</sup> A survey conducted by Transparency International in 2010, the Corruption Perception Index, measured the perceived level of public sector corruption on a scale of 0 to 10, where 0 is highly corrupt and 10 is highly clean. South Africa scored only 4.5.

<sup>151</sup> Cynthia Schoeman, Criminal Law news, accessed from [http://www.bizcommunity.com/Article/196/549/64893.html#tag=national health insurance on 2012/05/04](http://www.bizcommunity.com/Article/196/549/64893.html#tag=national%20health%20insurance%20on%202012/05/04).

<sup>152</sup> Ibid.

countries? Coupled to these problems is the introduction of the Protection of Information Bill which would make it easy for public institutions, including health institutions to bury and hide information.<sup>153</sup>

## **Conclusion**

Although NHI seems to be a good health care reform, many people are clueless whilst others have little knowledge as to how this scheme will work and how will change the current dual health system. From my discussion above, the covered healthcare services will be provided through appropriately accredited and contracted public and private providers and there will be a strong and sustained focus on the provision of health promotion and prevention services at the community and household level.

As to the funding of the scheme, the South African government is likely to raise VAT since this ensures that those who manage to escape the income tax net pay some tax, and that, VAT does not impact on savings negatively or on the cost of employment and these method seems to be doing pretty well in other countries.

According to the plan majority of South African who are poor are likely to benefit from the scheme since they will be subsidized by those who are able to provide enough for themselves and their dependants. By so doing, equity will be promoted in as far as the right to have access to health care services. The courts seem to be playing a crucial role in compelling the government within its available resources to provide socio-economic rights and necessities to those who are unable to provide for themselves.

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<sup>153</sup> Public health news, Green Paper on NHI silent on governance, accountability – HASA, dated 30 Sep 2011 accessed from [http://www.bizcommunity.com/Article/196/330/65001.html#tag=national health insurance](http://www.bizcommunity.com/Article/196/330/65001.html#tag=national%20health%20insurance) on 2012/05/04.

## CHAPTER FOUR: CONCLUSION AND RECOMMENDATIONS

This mini-dissertation presented a brief overview of the proposed introduction of a NHI in the context of South Africa's current health profile. The NHI aims to provide equitable, quality healthcare to all South Africans, regardless of employment or socio-economic status. By improving the quality of healthcare and ease of access, the health of the nation will be improved. The voices of proponents and opponents have resonated across sectors, and consolidation of the results of these stakeholder consultations has informed the ultimate form of the National Health Insurance Plan. All agree however that equal access to health services for all South African is and must remain the primary goal. The benefits package available to all citizens under the NHI will contain health promotion, disease prevention, curative and rehabilitative components.<sup>154</sup>

The adoption of NHI promises to address the inequities in the current South African health system. It will advance the right to health and the principles of equity, universality and comprehensiveness by addressing the plight of the poor and marginalised. It will also contribute towards fulfilling the 1994 Health Plan and the Reconstruction and Development Programme. Experience in other countries reveals that achieving universal coverage may take a long time; for example, it took Germany close to 100 years to achieve an inclusive social health insurance system. This means that we have to be patient before reaching to conclusions.

In a constitutional democracy, evaluating any health reform policy or scheme entails determining whether it will improve the constitutionally enshrined right to access

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<sup>154</sup> Consultancy Africa Intelligence CAI, Health financing and the National Health Insurance in South Africa: An overview accessed from <http://www.polity.org.za/article/health-financing-and-the-national-health-insurance-in-south-africa-an-overview-2012-03-27>.

health care. Accountability, openness and transparency are the only path to ensure improvement in our right of access to quality health care for all South Africans.

A clear answer to the question of bribery and corruption is that their cost is very high, far higher than the country can afford. In trying to resolve this problem, an example can be followed in India where Anna Hazare, a social activist, mobilised significant numbers in anti-corruption protest action, and his hunger strike in April 2011 was successful in exerting pressure on the Indian government to enact tougher legislation against corruption. South Africa already has good anti-corruption legislation including, for example, the Prevention & Combating of Corrupt Activities Act, 2004.<sup>155</sup> However, while legislation is essential, it is not sufficient to curb corruption.<sup>156</sup>

Accountability will only be achieved by ruthlessly exposing corruption and implementing complete accountability frameworks in both the public and private healthcare sectors.<sup>157</sup> In the public sector, regulators need to be politically neutral and impartial and community participation with localised supervisory structures must be encouraged. Furthermore, collective and individual action is also necessary by all facets of society including, business, the media, schools and universities, the church, communities and families. This means actively promoting ethical behaviour, acting against misconduct, and, of course, not engaging in unethical behaviour. Cumulatively this can build a critical mass of people who can make a difference by

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<sup>155</sup>Prevention and Combating of Corrupt Activities Act 12 of 2004.

<sup>156</sup> Cynthia Schoeman, Criminal Law news, accessed from

[http://www.bizcommunity.com/Article/196/549/64893.html#tag=national health insurance](http://www.bizcommunity.com/Article/196/549/64893.html#tag=national%20health%20insurance) on 2012/05/04.

<sup>157</sup> Professor Alex van den Heever (University of Witwatersrand: Social Security Systems Administration and Management Studies) speaking at the Hospital Association of South Africa (HASA) conference in Cape Town, see also Public health news, Green Paper on NHI silent on governance, accountability – HASA, dated 30 Sep 2011 accessed from [http://www.bizcommunity.com/Article/196/330/65001.html#tag=national health insurance](http://www.bizcommunity.com/Article/196/330/65001.html#tag=national%20health%20insurance) on 2012/05/04.

contributing to an ethical tipping point where ethical behaviour becomes the norm, and not the exception. It is a goal worthy of support.<sup>158</sup>

Another challenging aspect to the NHI is the increasing number of the population. According to the South African Human Rights Commission 2009 public inquiry into the right to access to health care services, the population of South Africa is increasing. The question around the population is thus to what extent health care financing has adequately addressed increases in the population. This question can be looked at together with other important variables, such as inflation, medical prices, the GDP and so forth.

The discussion about the NHI re-emerged again in the 52<sup>nd</sup> Conference of the ANC where important resolutions were taken with regard to health which includes the following: Education and health should be the two key priorities of the ANC for the next years<sup>159</sup>; “reaffirm the implementation of the NHI system by further strengthening the public health care system and ensuring adequate provision of funding”,<sup>160</sup> to develop a reliable single health information system<sup>161</sup>; government should intervene in the high cost of health provision;<sup>162</sup>

Since then, the ANC National Executive Committee (NEC) has established a NEC Sub-committee on Health and Education to deal with the NHI<sup>163</sup> and liaise with the National Department of Health and the first discussion paper was discussed in the ANC National General Council (NGC) in 20-24 September 2010 in Durban and,

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<sup>158</sup> Cynthia Schoeman, Criminal Law news, accessed from [http://www.bizcommunity.com/Article/196/549/64893.html#tag=national health insurance](http://www.bizcommunity.com/Article/196/549/64893.html#tag=national%20health%20insurance) on 2012/05/04.

<sup>159</sup> Resolution 52 of the 52<sup>nd</sup> ANC Conference in Polokwane, December 2007.

<sup>160</sup> Resolution 53

<sup>161</sup> Resolution 54

<sup>162</sup> Resolution 55

<sup>163</sup> The NEC Sub-Committee on Health and Education has subsequently conducted a diagnostic process of analyzing the key challenges facing the health sector. The result of this process led to the development of the Road Map for Health, which was handed over to the National Department of Health.

among others, the following were discussed or noted in the first paper of NGC: the NGC noted the presentations to the commission on the Mid-Term Report and the NHI, the NGC further noted the resolution of meeting ANC Provincial Chairpersons and the Chairperson of the Portfolio Committee, that provinces should prepare ANC Quarterly Health Monitoring Reports, health as a national priority and support and implementation of NHI.

The NGC noted the overwhelming support for the NHI. The implementation of NHI should be fast-tracked, but done correctly within a reasonable time frame. Widespread publicity on the NHI needs to be undertaken, involving road shows, TV and radio adverts for example, "*NHI is here, feel it*".<sup>164</sup> According to NGC, ANC must lead the implementation of the NHI and its promotion among the general populace. The involvement and support of the Alliance is crucial. The roll out should begin in the rural areas. There should be freedom of choice of service providers. Accreditation shouldn't disadvantage under-resourced hospitals and clinics<sup>165</sup>.

The 2009 ANC Election Manifesto identified health as one of the five priorities of the ANC in the next four years. The manifesto makes it clear that the NHI would help to reduce inequalities in the health system.<sup>166</sup> Although there have been many achievements in improving access to health care, much more needs to be done in terms of quality of health care, and by making services available to all South Africans through ensuring better health outcomes<sup>167</sup>. South Africa commands huge health care resources compared with many middle-income countries, yet the bulk of these

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<sup>164</sup> ANC: Report of the African National Congress, on the National General Council (2010) accessed at <http://www.polity.org.za> - 15 April 2011.

<sup>165</sup> ANC National General Council Additional Documents, Section 1: National Health Insurance (2010), 5-6.

<sup>166</sup> The ANC Election Manifesto, 2009 states that the government will: "introduce the NHI system, which will be phased in over the next five years. NHI will be publicly funded and publicly administered and will provide the right of all to access quality health care, which will be free at the point of service. People will have a choice of which service provider to use a district.

<sup>167</sup> ANC's 2009 Election Manifesto Policy Framework.

resources are in the private sector and serve a minority of the population, thereby undermining the country's ability to produce quality care and improve health care outcomes. The ANC is determined to end the huge inequalities that exist in the public and private sectors by making sure that these sectors work together<sup>168</sup>. The ANC has identified the following ten priorities for a major improvement in our health care system: implement the national health insurance plan, improve quality of health services, overhaul management system, improved human resource management, physical infrastructure revitalization, accelerate implementation of the HIV and AIDS and STI plans, attaining better health for the population, social mobilization for better health, drug policy review and research and development<sup>169</sup>

The introduction of the NHI system, which will be phased out for fourteen, will address the following key principles: NHI will be publicly funded and publicly administered and will provide the right of every South African with access to quality health care, which will be free at the point of delivery. People will have a choice of which service provider to use within a district; the social solidarity principle will be applied and those who are eligible to contribute will be required to do so, according to their ability to pay, but access to health care will not be according to payment; and participation of private doctors working in other health facilities, in group practices and hospitals, will be encouraged to participate in the NHI system<sup>170</sup>.

Improving the quality of health care is an integral part of implementing NHI for the achievement of access to healthcare for all. An independent quality improvement and accreditation body will be established to set the quality national standards in both the public and private sectors. The body will be tasked with inspecting and

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<sup>168</sup> ANC National General Council Additional Documents, Section 1: National Health Insurance (2010) 5-6

<sup>169</sup> ANC National General Council Additional Documents, Section 1: National Health Insurance (2010), 5-6

<sup>170</sup> ANC's 2009 Election Manifesto Policy Framework

sanctioning health facilities in line with professionally determined standards of health care, including staffing ratios, management, etc<sup>171</sup>.

The NHI Fund will provide a comprehensive cover of health services primary, secondary, tertiary and quaternary (high-care services) which will be provided by accredited public and private providers to ensure quality health care standards. At the core of NHI would be primary health care, which is the first point of entry into the health system. The report foresees a "reengineered primary health-care system", served by teams, each consisting of a doctor or clinical associate, nurse and three to four community health workers. Membership to the NHI would be compulsory for the whole population, but the public can choose whether to continue with voluntary medical scheme cover<sup>172</sup>.

The Minister of Health had appointed an Advisory Committee for NHI in 2009 and the Ministerial Committee has since been established in the cabinet to develop policies on NHI. The Minister of Finance has made some proposals on his budget speech in February 2011 with regard to the funding of the NHI and the way forward. The Ministerial Committee has developed Green paper on NHI which was approved by cabinet on 12 August 2011 and the policy has since been gazetted.

This article seeks to recommend that the Government must involve all stakeholders especially the health sector in the NHI and avoid centralising it within the ruling party, the ANC and the alliance partners, Congress of South African Trade Unions and South African Communist Party. The Government must hold an indaba which

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<sup>171</sup> ANC National General Council Additional Documents, Section 1: National Health Insurance (2010) 5-6

<sup>172</sup> These statements were uttered by Dr. Zweli Mkhize, Chairperson of the NEC Health and Education Sub-Committee at the ANC National General Council.

involves people from academia, civil society organisations, nurses, doctors, pharmacists, medical practitioners and all health professionals to make recommendations on how best the NHI can be implemented and which models is viable. The current state of the infrastructure South Africa have cannot be able to accommodate the NHI proposals and a way forward of establishing a Public Private Partnership might be the best option going forward.

This article seeks to recommend that the NHI proposals must be legislated and clearly state who will be the administrator of the NHI. This will remove lot of uncertainties amongst different stakeholders. Further, the Government must also look at the options of giving incentives to students to encourage them to further their careers in the health fraternity either as doctors, nurses, paramedics, pharmacists and social workers and psychologists to develop capacity which will strengthen the NHI. Further, the NHI must promote the principle of corporate governance, accountability and transparency in the health sector. Unfortunately, the Green Paper is relatively silent on governance and accountability mechanisms. That needs to be addressed.

In conclusion, it could be argued that in order for the NHI discourse to be unleashed it should be grounded in “a substantive conception of the good society,” which should in turn facilitate the formulation of a coherent, need-focused theory of positive rights. Robin West contends, for instance, that the state in a “good society” committed to affirmation of and respect for the inherent dignity of all human beings, must “ensure some minimal level of well-being because such a threshold is

necessary if citizens are to live fully human lives and have the dignity to which their humanity entitles them.”<sup>173</sup>

This means that society must not only respect citizens’ moral agency and safeguard such civil and political liberties as are necessary for their individual and collective pursuit of the good life, but should also ensure that all individuals in society have meaningful access to such social amenities as enable them to live in accordance with their human dignity. It is in this context that the approach taken by ANC in its discussion documents relating to the introduction of the NHI finds support of the authors in the following respect. One is that any policy that is pro-poor should prioritise the poor. Secondly rural and other underserved areas that face barriers in accessing healthcare must be given special priority. Of course there are pitfalls that the NHI system will have to face, this relates to financial and administrative management.<sup>174</sup> These are challenges that can be won by creating systems that will oversee the whole administration of the NHI. In this respect, according to the recommendations made in the Consolidated Report of the Integrated Support Team’s (IST),<sup>175</sup> the following issues are crucial for the effective implementation of the NHI system;

- The need to accurately determine the exact amount of the financial backlogs in each province with the NDoH taking the lead,

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<sup>173</sup> Marius P. “Eating Socioeconomic Rights: The Usefulness of Rights Talk in Alleviating Social Hardship Revisited” *Human Rights Quarterly*, Volume 29, Number 3, August 2007, 801-802.

<sup>174</sup>According to the Consolidated Report of the Integrated Support Team’s (IST) Review of the Public Health System released by the Minister of Health (Dr Motsoaledi). The report is the product of the ISTs that were commissioned by former Minister of Health Barbara Hogan, in February 2009. The report reveals failures by the provincial departments of health and finance; the NDoH and the National Treasury were to take appropriate action as provincial departments of health accumulated debts beginning in the 2006/2007 financial year. The accumulated debt was estimated to have been R7.5 billion by 1 April 2009.

<sup>175</sup>*Ibid.*

- Before the implementation of the NHI, there must be accurate costing, guaranteed funding from a properly determined baseline budget,
- The Minister of Health in driving the development of the NHI, must engage the Provincial Health MEC's and health departments and other stakeholders,
- There should be alignment between the national vision and strategy, programme strategic plans and annual national health plan, as well as between targets and interventions within the NDoH. Secondly all plans should pay more attention to implementation, and such implementation should be aligned with each other and should contain a clear framework with performance targets,
- Proposed new structures should be carefully reviewed and restructured, with a view to establishing minimum staffing levels and optimal management and administrative positions. These processes should be undertaken based on objectively agreed benchmarks, optimal application of scarce skills, the public health sector's strategic and service delivery priorities and resource availability.
- These recommendations by the Report of the Integrated Support Team's (IST).<sup>176</sup>

Having said all this, it is clear that the government is increasingly realising the need to look at new avenues to ensure greater inclusivity of the right to have access to health care. It is hoped that the possibilities presented in this article are also explored as new ways in which to widen the social security net. The NHI has a potential of identifying human rights based practices and methods for development efforts in fighting the scourge of poverty and other ills aggravating the realisation of two highly interrelated human rights, namely the right to dignity and the right to health care . The mechanisms proposed in this article will, it is hoped, serve as a benchmark for stimulating debate and generating new ideas on how to improve the lives of the poor in South Africa, in particular the NHI will give effect to the right to have access to health care as provided in the Constitution.

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<sup>176</sup>Consolidated Report of the Integrated Support Team's (IST)Supra.

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