Legal Framework Regulating the National Health Insurance Scheme: Prospects and Challenges.

By

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ABSTRACT

This mini-dissertation examines the policies regulating the National Health Insurance Scheme. It explores the reforms on the health care system in South Africa. In addressing this issue, the mini-dissertation investigates the constitutional obligation of the South African government regarding the provision of health care services. It also focuses on the two primary issues relating to health care services. Firstly, South Africa has allocated significant budget to fix the ailing health care system. Secondly, South Africa commands huge health care resources compared with many other middle-income countries, however the bulk of these resources are in the private sector and serve a minority of the population. It further looks at the lessons that South Africa could learn from the successes of the National Health Insurance Scheme implementation in Organisation for Economic Co-operation and Development (OECD) countries as it proceeds with the implementation of the National Health Insurance.

DECLARATION BY SUPERVISOR

I, **Adv. Lufuno Tokyo Nevondwe**, hereby declare that this mini-dissertation by Mr **Dundu Davey Ngqolowa,** for the degree of Masters of Laws (LLM) in Development and Management Law be accepted for examination.

..... ……

Adv. Lufuno Tokyo Nevondwe **Date**

DECLARATION BY STUDENT

I, Mr **Dundu Davey Ngqolowa** declare that this mini-dissertation for the degree of Masters of Laws in Development and Management Law at the University of Limpopo (Turfloop Campus) hereby submitted, has not been previously submitted by me for a degree at this or any other university, this is my own work in design and execution and all material contained herein has been duly acknowledged.

…… ……

Ngqolowa DD **Date**

DEDICATION

This min-dissertation is specially dedication to my colleagues Hermit Phaladi and Isaiah Sefoka who has provided me with immeasurable moral, physical and spiritual support, without which the possibility of completing this work would have been far too remote. It is also dedicated to my supervisor, Adv. Lufuno Tokyo Nevondwe and my brother, Mr BB Ngqolowa for their academic and family support, patience and compassion. It is finally dedicated to my late grandfather, Mr BS Ngqolowa who could not physically see the achievement of his grandson due to his untimely death.

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LIST OF ABREVIATIONS

AIDS	:	Acquired Immune Deficiency Syndrome
ANC	:	African National Congress
APRM	:	African Peer Review Mechanisms
CARMMA	:	Campaign on Accelerated Reduction of Maternity Mortality in Africa
CEO	:	Chief Executive Officer
COSATU	:	Congress of South African Trade Unions
CBO	:	Community Based Organisation
CBHI	:	Community Based Health Insurance
ESKOM	:	Electricity Supply Commission of South Africa
GEAR	:	Growth, Employment and Redistribution
GP	:	General Practitioner
GDP	:	Growth Domestic Product
HIV	:	Human Immunodeficiency Virus
ICD	:	International Statistical Classification of Diseases
IFC	:	International Classification of Functioning
ICH	:	International Classification of Health Interventions
ICESCR	:	International Covenant on Economic, Social and Cultural Rights.
MGDs	:	Millennium Development Goals
MRC	:	Medical Research Council
MDA	:	Medical Savings Account
NDP	:	National Development Plan
NHA	:	National Health Act
NHIS	:	National Health Insurance Scheme
NPF	:	National Providence Fund
NEEDS	:	New Economic Empowerment and Development Strategy
OECD	:	Organisation for economic Co-operation and Development
OPD	:	Out Patients Department
PMTCT	:	Mother to Child Transmission Programme
RDP	:	Reconstruction and Development programme
SHFUCSHI	:	Sustainable Health Financing, Universal Coverage and social health insurance
SAA	:	South African Airways
SABC	:	South African Broadcasting Corporation

SAPO	:	South African Post Office
TAC	:	Treatment Action Campaign
TB	:	Tuberculosis
UN	:	United Nations
UNICEF	:	United Nations Children's Fund
UNCESCR	:	United Nations Committee on Economic, Social and Cultural Rights
UNCESCR	:	United Nations Committee on Economic, Social and Cultural Rights
UDHR	:	United Declaration of Human Rights
UPFS	:	Uniform Patient fee Schedule
WHO	:	World Health Organisation
VAT	:	Value Added Tax
WHO	:	World Health Organisation
WHA	:	World Health Assembly

LIST OF INTERNATIONAL INSTRUMENTS

1. World Health Organization
2. United nations children's fund
3. Unilateral declaration of human rights
4. International covenant on economic social and cultural rights
5. United nations committee on economic social and cultural rights
6. Organization for economic co-operation and development
7. Universal Declaration of Human Rights, Article no. 25
8. Article 16 – 25 of the International Covenant on Economic, Social and Cultural Rights.
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6. National Health Act No. 61 of 2003.
7. Section 27(3) of the South African Constitution, 1996.
8. Section 24of the South African Constitution, 1996.
9. Section 2 of the National Health Act No. 61 of 2003.
10. Section 28(1) (c) of the South African Constitution, 1996.
11. Section 27(1) (a) of the South African Constitution, 1996.
12. Section 28(1) (c) of the South African Constitution, 1996.
13. Section 2 of the South African Constitution, 1996.
14. Section 27(2) of the South African Constitution, 1996.
15. Section 24(a) of the South African Constitution, 1996.
16. Section 7(2) of the South African Constitution, 1996.
17. Choice of Termination of Pregnancy Act No.92 of 1996.
18. Health Professional Act No. 56 of 1974.
19. The Medicines and Related Substances Act No. 101 of 1965.
20. The Medical Schemes Act No.131 of 1998.
21. The Nursing Act No. 33 of 2005.
22. The Traditional Health Practitioners Act No. 22 of 2007.
23. National Assembly Act No. 35 of 1999.

CHAPTER ONE: INTRODUCTION

1.1 Historical background to the study

South Africa's first national public health measure was passed in 1919, just over 95 years ago. It was passed as a result of the influenza epidemic that spread over Europe and even beyond after the World War 1.[1] It remained South Africa's basic public health measure until 1977 where upon the Public Health Measure was replaced by the Health Act.[2] Since 1977, the country's health and health infrastructure was governed by the Health Act. The Health Act provided for measures and promotion of the health of the inhabitants of the Republic; provided for the rendering of health services; defined the duties, powers and responsibilities of certain authorities which render health services in the Republic; provided for the co-ordination of such health services; Repealed the Public Health Act, 1919; and provided for incidental matters.[3]

The history of the South Africa is tainted with a highly fragmented administrative health care system. At an organisational level, there were multiple ministries and departments based on race and ethnicity. Public health services for whites were better than those for blacks and those in the rural areas were significantly worse off in terms of access to services compared to their urban counterparts.[4] A lot of money was invested on tertiary health services than on Primary Health Care services. Inequities were created through the development of private health facilities aimed at making profit, that were unregulated but well supported and organised through private financing (health insurance funds or 'medical aids'), private hospitals, pharmacies and health practitioners.

The past health statistic records showed the Infant mortality, maternal mortality, life expectancy at birth, and the incidence of infectious diseases like tuberculosis and measles were all higher among black people. For instance, in 1985, the infant mortality for white infants was 13.1/1000 but 70/1000 for black infants.[5] The health status of the population reflected the social and economic divisions of an apartheid society. Poor

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1 The Public Health measures of 1919.
2 Health Act No. 63 of 1977.
3 Ibid.
4 Ngwena C "The recognition of access to health care as a human right in South Africa-"Is it enough", Health and human rights (Harvard school public health) 2000, vol. 5 no. 1. 28 – 29.
5 Rajendra Kale, South Africa's impression of health in the new South Africa.

access to clean water, sanitation, housing and food contributed to the poor health status of black South Africans.

The Constitution of 1961 didn't provide any provision of access to health care services.[6] On 22nd September 1983, Parliament assented to the Republic of South Africa a Constitutional Act in 1983.[7] This Constitution like the former did nothing in assisting to change the complexion of the national health system. However, the interim Constitution of 1993 provided the Bill of Rights which contained human or fundamental rights.

In 1995, the former Health Minister, Dr Nkosazana Dlamini-Zuma assembled a Committee of Inquiry on National Health, which proposed different benefit packages from the 1994 reform. The Social Health Insurance Working Group of 1997 resulted in the framework that regulated the development of the Medical Schemes Act, meant for private health insurance, which was unfortunately affordable by less than 16 % of the population. In 2002, a further Committee of Inquiry into a Comprehensive Social Security for South Africa was chaired by Prof. Vivienne Taylor, who recommended a dedicated tax for health that would finance compulsory cover for those who were in the formal sector, earning above the stipulated tax threshold. However, like previous other proposed models, Taylor's social health insurance did not succeed.[8]

The initiatives were further debated at the 52nd conference of the African National Congress (ANC) in Polokwane in December 2007, where numerous resolutions were taken with regard to the NHI.[9] The Freedom Charter of 1955 and also section 27 and 28 of the Constitution also provided some guidance.[10] The Presidency and the Department of Health addressed the need for some form of decisive action to strengthen the country's health system and take forward the country's health-related policy vision. This resulted in a series of government-led interventions, spearheaded by senior members of the African National Congress (ANC) and State Officials.

The Constitution of 1996 provides for the human and fundamental rights enshrined in the Bill of Rights. Section 27 of the Constitution provides that everyone have access

6 South African Constitution Act No. 32 of 1961.
7 South African Constitution Act No. 110 of 1983.
8 Ibid.
9 Resolution 52 of the 52nd ANC conference in Polokwane Dec 2007.
10 South African Constitution, Act 1996.

to health care services and no one may be refused emergency medical treatment at state expense. Under the Constitution the state is obliged to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of the rights in the Bill of Rights. To this effect the government of the Republic of South Africa advocated for a legislative framework, the National Health Act (NHA) to regulate the National Health Insurance policy, and with effect from 2011 National Health Insurance commenced.[11]

The NHA is the culmination of key health system policies dating from 1994. It reflects elements of the ANC Health Plan of 1994 as well as the White Paper on Health Systems Transformation.[12] The NHA sets the foundation of the health care system; it works in combination with other pieces of legislation which relate to other areas of the health care system such as the development, registration, regulation and access to medicines.

1.2 The statement of the research problem

The policies and legal frameworks in the past have failed to remedy the unprecedented inequalities and a dysfunctional public health service, this impacted in epidemics of communicable and non-communicable diseases in South Africa. Racial and gender discrimination, the migrant labour system, the destruction of family life, vast income inequalities, and extreme violence have negatively affected South Africa‘s health system in the past, and the impact persist to this date.

In 1994, when apartheid ended, the health system faced massive challenges, many of which still persist. Macro-economic policies, fostering growth rather than redistribution, contributed to the persistence of economic disparities between races despite a large expansion in social grants. Therefore there is a need to transform the public health system into an integrated, comprehensive national service.

Pivotal facets of primary health care are not in place and there is a substantial human resources crisis facing the health sector.[13] The HIV/ AIDS epidemic has contributed to these challenges. All of these factors need to be addressed by the new government

11 National Health Insurance policy.
12 The 1997 White Paper on Health Systems Transformation.
13 African peer review document 2010.

to ensure that an improved health system is achieved, with paying similar focus on the Millennium Development Goals.[14]

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 socio-economic 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.

1.3 Literature review

Both the National Health Act, and the National Health Insurance faces similar prejudices, the National Health Act has still to be tested as to whether its provisions fully comply with the South African Constitution. The right to health service is enshrined in the Constitution. It is however to be seen as to whether provisions of the National Health Act well complies with the Constitution.[15]

However, constitutional non-compliance of the provisions of the Act would not yield any good results and progress. The Constitution is the supreme law of the land, and any law that is not in line with the Constitution is invalid.[16]

In instances of non-compliance of the National Health Act in line with the constitution, the legislature would be required to amend such Sections of the Act. This would cause a delay in the implementation of the National Health Insurance Scheme. There are also issues and challenges identified in regard to the implementation of the project.

The National Health Insurance is expected to be a successful project unlike the other previous policies, commissions, and legal frameworks that failed. The National Health Act is poised to guide the National Health Insurance Scheme to achieve the constitutional mandate set on government for the provision of health care service for all, and further achieve the millennium development goals.[17] The National Health Act

[14] Health in South Africa: The Lancet, published in August 24, 2009.
[15] Section 27(1)(a), and 28(1)(c) of the Constitution of South Africa.
[16] Section 2 of the Constitution of South Africa Act 108 0f 1996.

is a remarkable legal framework from which results are expected and progress. Those who are beneficiaries together with stakeholders in this regard must participate closely with each other, co-operate for a common goal.

However, it is not clear where the funding of this project will come from to implement this big project. The National Health Insurance Scheme requires a huge funding to roll out. With the idea in mind that the NHI is seen to perpetuate a socialist ideology the capitalists may not fund it hoping for its failure. In previous occasions similar policies were later abandoned due to lack of funds. Soon after 1994, the government policy known as the Reconstruction and Development Program (RDP) which was aimed at accelerating basic service delivery was abandoned due to lack of funds.[18]

Those who made recommendation of the RDP didn't anticipate such shortfalls and shortcomings. Instead, it was given a strong and great manifestation by academics, leftist political economist and labour leaders. However, it was later met with a lot of criticisms to the extent that it left the government coffins empty. The major concerns were that the RDP policy couldn't facilitate economic growth. Instead, saw a rise in unemployment figures.

The government later abandoned the RDP and adopted the Growth Employment, and Redistribution (GEAR), which was aimed at growing the economy and creation of employment.[19] The National Health Insurance is focused to address the inequalities, various issues and challenges in the National Health Care System. Therefore, it is hoped not to fail since it addresses critical important issues, and challenges our country has suffered for many decades.

According to Bauer, the increase of Value Added Tax (VAT) has been identified as one of the means to fund the NHI project.[20]However, the Congress of South African Trade Union (COSATU) argues that those who are supposed to benefit will suffer the most if Value added Tax is increased. According to Ebril's comparison analysis

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[17] Section 27(2) of the Constitution provides that: The state must make reasonable legislative and other measures within its available resources, to achieve the progressive realisation of each of these rights.

[18] 1994 government policy (The Reconstruction and development plan).

[19] Reconstruction and Development plan (RDP) together with Growth Employment, and Redistribution (GEAR) were Government policies adopted to facilitate basic service delivery, economic growth and creation of employment.

[20] Bauer N 2011. Pushing up VAT the Least Damaging way to fund NHI. From http://mg.co.za/article/ 2011-09-12-push-up-vat-its-the-right-thing-to-do.(Retrieved on the 21 March 2015).mini-dissertation.

confirms that South Africa has the least VAT rate of 14%, as compared to European union who are on an average of 21%, and the average global who are on between 18% - 20%.[21]

The National Health Insurance is a big project; it is a matter of doubt as to whether South Africa will be able to carry out such a great project. History indicates that South Africa has been able to host the 2010 world cup which was of a great magnitude. Stadiums were built and some upgraded on time to host the spectacular world soccer event. According to Nhlapho, it may be argued that South Africa has got a financial resource, capacity and potential that is capable to carry out even a complex project in the instance of the NHI.[22] However, the NHI would be no doubt seeking a sustainable source of funding since it will have to operate for many years to come.

The other question is about whether the National Health Insurance will be affordable to all. According to Tshivhase, it is confirmed that the majority funding for the NHI will come from the government- owned entity that is publicly administered through tax revenue and mandatory contributions. Government has given assurance on the sustainability of funding of the NHI to enhance the public health sector‘s capacity to provide quality health care to poor and disadvantaged people.[23]

The National Department of Health will seek to have a strong leadership, leadership that is visionary and committed to lead on the forefront for the success of this project. In other instances, government enterprises have failed to progress well due to poor leadership. The SABC, SAA, ESKOM and the South African Post Office are the current government entities which have been at the helm of leadership crisis.[24]

The National Health Insurance Scheme together with the National Health Act must serve the interest of all South Africans, and not only a portion of a certain ethnic group, and therefore seek the support of everybody to succeed. If the National Health Insurance is to succeed, the government must ensure that all corruption and corrupt

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[21] Ebril LP 2001. The Modern VAT Washington, USA: International Monetary Fund Publishing services.

[22] Nhlapho SJM 2011. FIFA 2010 soccer world cup in South Africa. An analysis of the perception of public sector workers in Kwazulu Natal, Durban.
-From http://uzspace.uzulu.ac.za/handle/10530/1072 (Retrieved on 20 March 2015).

[23] Tshivhase T 2013. The impact of HIV/AIDS on the South African health system, Post NHI implementation. From http://www.dspace.up.ac.za/handle/2263/23057/ (Retrieved on 25 March 2015).

[24] SABC, SAA, ESKOM and the South African Post Office are government entities also run by the State.

elements in the system are eradicated. There is no doubt that this project will succeed if it is closely and well monitored.

1.4 Aims and objectives of the study

This mini-dissertation seeks to address a disproportionate existence between the public and private healthcare sectors with reference to human resources and financial strength. It further seeks to elaborate on the Constitution, National Health Act and other legal frameworks as vehicles used in the implementation of the National Health Insurance Scheme, aimed to address the imbalances of human resources and finances between the respective healthcare sectors in South Africa, to transform the health system "into an integrated, prepayment-based health financing system that effectively promotes the progressive realisation of the right to healthcare for all."[25]

It aims to realise the rights set out in the Constitution by providing a framework for a structured and quality uniform health system in South Africa. The mini-dissertation outlines the laws that govern national, provincial and local government with regard to health services. This mini-dissertation also seeks to clarify the State's duty to do what it can to address the right of access to health care services. The Constitution recognises that no person may be refused emergency medical treatment and that everyone has the right to an environment that is not harmful to their health.[26]

The objective of this mini-dissertation is to educate the community about the National Health Insurance Scheme of its objectives to advance access to quality health services for all South Africans, irrespective of their employment status. This is important, because it has been shown that there has been a swift decline in the working class's ability to afford a medical aid, thus increasing the need for improved access to this basic right.[27] This mini-dissertation establishes that everyone has the right of access to equal health care services regardless of his or her employment status; no one may be refused emergency medical treatment.

The objective of this mini-dissertation is to further encourage those affected and impose an awareness that they should guard against violation of their right of access to health care services. Where there is violation of such right they should take legislative measures to protect their right of access to health care services or even to

[25] Werksmans: Introduction of the National Health Insurance Scheme 131.KB
[26] National Health Act 61 of 2003, also see Constitution: Section 27(3) and Section 24
[27] Ibid

approach the courts in defend of their right or claim compensation if so required to do so.

1.5 Research methodology

The research methodology used in this study is qualitative as opposed to quantitative. This research is library based and reliance is on library materials such as textbooks, reports, legislations, regulations, case laws and articles. Consequently, a combination of legal comparative and legal historical methods, based on jurisprudential analysis was employed.

A legal comparative method was applied to find solutions, especially an investigation on the way forward for National Health Insurance Scheme and its implementation. The study established the development of legal rules, the interaction between law and social justice, and proposed solutions or amendments to the existing law or constitutional arrangement, based on practical or empirical and historical facts. Concepts were analysed and arguments based on discourse analysis were developed. A literature and case law survey of the constitutional prescriptions and interpretation of statutes were done.

1.6 Scope and limitations of the study

This mini-dissertation consists of five interrelated chapters. Chapter one is the introductory chapter laying down the foundation. Chapter two deals with the legislatives and regulatory frameworks while chapter three deals with international law framework and comparative study. Chapter four deals with prospects and challenges of the National Health Insurance Scheme, and Chapter five is the conclusion drawn from the whole study and makes recommendations**.**

CHAPTER TWO: LEGISLATIVE AND REGULATORY FRAMEWORKS

2.1 Introduction

South Africa has a track record of regrettably unsuccessful health insurance systems, and the healthcare reforms that began in the late 1920s. In 1928, there was a Commission on Old Age Pension and National Insurance, which supported the coverage of medical, maternity and funeral benefits for low-income employees working in the formal sector in urban areas.

A few years later, in 1935, there was a commission of enquiry to promote a scheme similar to the insurance policy set in; nonetheless, it did not succeed.[28] Thereafter, there was a National Health Service Commission between1942–1944. Much later, in 1994 the Health Care Finance Committee recommended that all formally employed individuals, together with their immediate dependants, should mandatorily hold membership of health insurance; however this system was unsuccessful due to the state's inability to adequately finance the recommended service packages.

The democratic government led by the ANC adopted the National Health Insurance scheme as an attempt to resuscitate the fragmented national health system which is two tied, i.e. Public health and private health services. The National Health Insurance Scheme is a government policy aimed at making provision for access to health for all South Africans.

2.2 The Constitutional imperatives

The right for access to health care services is enshrined in the Constitution. Section 27, set an obligation to the state to make reasonable and legislative measures to achieve the progressive realisation of this right. It is therefore that the government has enacted various legislative frameworks to guide the implementation of the National Health Insurance, in compliance with the Constitution. The National Health Act together with other legislative frameworks is poised to guide the implementation of the NHI.[29]

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[28] Werksmans: Introduction of the National Health Insurance Scheme 131.KB.
[29] National Health Act no. 61 of 2003.

2.3 The government policy: the National Health Insurance Scheme

In 2012, the government of the Republic of South Africa adopted the National Health Insurance Scheme policy. The adoption of the National Health Insurance Scheme policy was informed by the African National Congress policy on health derived from the Freedom Charter of 1955, and section 27 and 28 of the Constitution also provided some guidance.[30] The Presidency and the Department of Health addressed the need for some form of decisive action to strengthen the country's health system and take forward the country's health-related policy vision.

The law regulating the National health insurance scheme is primarily the National Health Act. South Africa is regarded as a constitutional democratic country since the dawn of democracy in 1994. In South Africa, however the Constitution is the supreme law of the country and all laws must conform to the Constitution. Any law that does not conform to the Constitution is regarded as invalid. Sections 27 and 28 of the Constitution provides that everyone has the right to have access to health care services, including reproductive health care and every child has the right to basic nutrition, shelter, basic health care services and social services respectively[31]. The state is obliged to take reasonable legislative and other measures within its available resources, to achieve the progressive realisation of each of these rights.

To this effect government advocated for a national policy, to address the woes that divided the national health system into two health sector namely private and public health sector. The adoption of the National Health Insurance scheme policy has constitutional imperatives[32]. The Constitution provides that everyone has the right to have access to health care services, including reproductive health care, and the state has a Constitutional obligation to achieve the progressive realisation of these rights. The courts have in previous instances played a significant role in enforcing compliance and in terms of justiciability of these rights. In the *Minister of Health and Others v Treatment Action Campaign and Others*,[33] following a number of failed attempts to convince the Minister of Health to broaden the prevention of Mother to Child

[30] South African Constitution, Act 108 of 1996: Chapter 2, Section 27
[31] Section 27 and 28 of the Constitution: Act 108 of 1996
[32] National Health Act 61 of 2003
[33] *Minister of Health and Others v Treatment Action Campaign and Others (No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002*

Transmission (MTCT) program, the Treatment Action Campaign (TAC) and two other plaintiffs filed a notice of motion with the Pretoria High Court alleging that the National Minister of Health as well as the members of council (MEC) responsible for health were in breach of their Constitutional and International obligations in failing to provide nevirapine to women outside the limited pilot sites.[34]On 14 December 2001, the High Court ruled in favour of TAC and ordered the Minister of Health to make nevirapine available in all public hospitals and clinics where testing and Counselling facilities existed.

The High Court also ordered the Minister of Health to come up with a comprehensive programme to prevent or reduce MTCT and to submit reports to the court outlining that programme. The Minister of Health appealed the execution order at the Constitutional Court, but the Constitutional Court upheld the High Court's decision. On 5 July, 2002 the Constitutional Court held that the Minister of Health did have a constitutional duty to give pregnant, HIV positive women access to nevirapine. The other instance was the *Soobramoney's case*.[35]

The Department of Health is focused on implementing an improved health system, which involves an emphasis focus on public health, as well as improving the functionality and management of the system through stringent budget and expenditure monitoring known as the "10-point plan", the strategic programme is improving hospital infrastructure and human resources management, as well as procurement of the necessary equipment and skills. Under this plan, health facilities such as nursing colleges and tertiary hospitals are being upgraded and rebuilt to lay the way for the implementation of the National Health Insurance (NHI) scheme.[36] Here is the 10 point plan strategic programme of improving the National health system:

- Provision of strategic leadership and creation of a social compact for better health outcomes.
- Implementation of a National Health Insurance Plan.
- Improving quality of services.
- Overhauling the health care system and improve its management.

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[34] Ibid.

[35] *Soobramoney v Minister of Health (Kwazulu-Natal) (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997).*

[36] Government Policy to transform the health system so that medical care can be accessible to all through the implementation of the National Health Insurance Scheme www.health24.com/Medical-scheme/Ne...

- Improving human resources management.
- Revitalization of physical infrastructure.
- Accelerated implementation of HIV and AIDS Plan and reduction of mortality due to TB and other communicable diseases.
- Mass mobilization for better health for the population.
- Review of the drug policy.
- Strengthening research and development.

The National Health Insurance is intended to bring about reform that will improve service provision and health care delivery. It will promote equity and efficiency to ensure that all South Africans have access to affordable, quality health care services regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund. The NHI will be phased in over 14 years, beginning in 2012. In 2012/13, the government earmarked R1-billion to its pilot projects. Apart from infrastructure and management overhauls, another factor for ensuring the success of the NHI will be the strict regulation of the sector to make it more affordable to all South Africans.

The concept of the National health insurance is a social security mechanism that guarantees the provision of needed health services to persons on the payment of some amount at regular intervals. It is designed to pay the costs associated with health care by paying the bills and therefore to protect people against high cost of health care by making payment in advance of falling ill.[37] The scheme therefore protects people from financial hardships occasioned by large or unexpected medical bills. It saves money on the short run and protects the poor from medical conditions that can lead to greater loss of money on the long run.[38]

It involves pooling of resources from persons of different illness-risk profiles and the cost of the risk of illness among those who are ill and those who are healthy, are shared. It has three main characteristics- prepayment, resource pooling and cost-burden sharing. Pre-payments under the scheme are fixed either as a property on of the pay-roll, or as flat rates contributed by the participants. This means that payment

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[37] Annadale MD 2010. Features for Viable Healthcare Models for South Africa (Retrieved on 25 August 2015).

[38] Ibid.

is not proportional to the risk of illness of individual beneficiaries. Many advantages accrue from participation in social health insurance, and they include:

- Broadening the sources of health care financing;
- Reducing the dependence and pressure on government budget;
- Increasing the financial resources and ensuring stable source of revenue for healthcare;
- Ensuring visible flow of funds to the sector;
- Assisting in establishing patients' rights as customers;
- Combines risk pooling with actual support by allocating services according to need and distributing financial burden according to ability to pay;
- Solves equity and affordability problem in providing and financing health services; and,
- Improves and harnesses private sector participation in the provision of health services.

National health insurance schemes also enable experts to reasonably predict the healthcare cost of a large group.[39] By lowering the personal costs of services, health insurance schemes induce individuals to seek health maintenance services more regularly than they otherwise would thereby preventing potentially serious illness. The scheme is government's response to the decay in the health care system in South Africa.[40] This manifests in government's acknowledgement of the poor state of the health care delivery system, and these have a combined effect on the health care delivery system leading to the inability to "deliver the optimum package of quality health care, including routine immunisation, emergency care, preventive and management of communicable and infectious diseases, especially malaria, tuberculosis and HIV/AIDS''. This ultimately led to expression of dissatisfaction in the quality of health care services by the public.

The NHI is speculated to propose that there be a single National Health Insurance Fund (NHIF) for health insurance. This fund is expected to draw its revenue from general taxes and some sort of health insurance contribution. The proposed fund is supposed to work as a way to purchase and provide health care to all South African

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[39] Ibid.

[40] National Health Insurance Scheme is a government policy aimed at transforming the South African Health system to be the one that caters for all. – www.gov.za/sites/ www.gov/files/n...

residents without detracting from other social services. Those receiving health care from both the public and private sectors will be mandated to contribute through taxes to the NHIF. The ANC hopes that the NHI plan will work to pay for health care costs for those who cannot pay for it at all themselves.

There are those who doubt the NHI and oppose its fundamental techniques. For example, many believe that the NHI will put a burden on the upper class to pay for all lower class health care. Currently, the vast majority of health care funds come from individual contributions coming from upper class patients paying directly for health care in the private sector. The NHI proposes that health care fund revenues be shifted from these individual contributions to general tax revenue. Because the NHI aims to provide free health care to all South Africans, the new system is expected to bring an end to the financial burden facing public sector patients

The public sector uses a Uniform Patient Fee Schedule as a guide to billing for services. This is being used in all the provinces of South Africa, although in Western Cape, Kwa-Zulu Natal, and Eastern Cape, it is being implemented on a phased schedule. Implemented in November 2000, the UPFS categorises the different fees for every type of patient and situation. It groups patients into three categories defined in general terms, and includes a classification system for placing all patients into either one of these categories depending on the situation and any other relevant variables.[41] The three categories include full paying patients :

- Patients who are either being treated by a private practitioner, who are externally funded, or who are some types of non-South African citizens fully subsidised patients.
- Patients who are referred to a hospital by Primary Healthcare Services and partially subsidised patients.
- Patients whose costs are partially covered based on their income. There are also specified occasions in which services are free of cost.

[41] Government‘s funding mechanism of the National Health Insurance Scheme, proposed categories - www.gov.za/sites/www.gov/files/n..., www.health24.com/Medical-scheme/Ne...

2.4 Constitutional framework

The Constitution of the Republic was as a result of the interim constitutional draft adopted in 1993 which paved a way from apartheid to transitional, democratic government. Most of the provisions which became the backbone of the interim constitution were derived from the principles of the freedom charter. The Charter was officially adopted on 26 June 1955 at a Congress of the People in Kliptown[42]. The charter also calls for democracy and human rights, land reform, labour rights, and nationalization[43]. The new Constitution of South Africa included many of the demands of the Freedom Charter. It addressed directly nearly all demands for equality of race and language, but made no reference to nationalization of industry or redistribution of land which were outlined in the charter.

The Interim Constitution was restricted largely to civil and political rights as it contained the Bill of Rights which guarantees the rights protected by international human rights conventions. The Interim Constitution provided that "everyone shall enjoy all universally accepted fundamental rights, freedoms and liberties". However, the Interim Constitution went further than these traditional rights and liberties by including what were relatively innovative rights for a national Constitution such as the right of access to information; the right to administrative justice; a qualified right to the free pursuit of economic activity; the right to an environment which is not harmful to health or well-being; the right of children to security, basic nutrition, basic health and social services; language and cultural rights; and educational rights. Other rights that were included were labour rights and property rights. Important constitutional institutions such Constitutional Court, the Human Rights Commission, and the Commission on Gender Equality were established in South Africa. The interim Constitution gave birth to the final Constitution, Act 108 of 1996.

The Constitution of the Republic of South Africa, 1996 was adopted on 8 May 1996 and amended on 11 October 1996 by the constitutional assembly. This Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and

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[42] Freedom charter – Wikipedia, thefreeencyclopedia,htm#cite_note2 – ''Father of freedom charter dies'' Johannesburg star 28 – 01 – 13.

[43] Pillay, Gerald J (1993), voices of liberation: Albert Lutuli – HSRC press. pp 82 – 91 ISBN 0–7969 1356 – 0.

obligations imposed by it must be fulfilled. The Constitution, Chapter 2 provides the Bill of Rights. The Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, quality and freedom. The state must respect, protect, promote and fulfil the rights in the Bill of Rights. The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state.

This research topic is the precisely based on provisions of Section 27 and 28 of the Constitution, which is contained in chapter 2: the Bill of Rights[44]. Section 27 provides for health care, food, water and social security. It 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
    (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.

Section 28 (1) (c) provides that every child has the right to basic nutrition, shelter, basic health care services and social services,[45] and in terms of section 24(a) of the Constitution everyone has the right to an environment that is not harmful to their health or well-being[46].The Constitution gives the state an obligation to take reasonable legislative and other measures within its available resources, to achieve the progressive realisation of each of the right in the Bill of Rights.

The Constitution provides and protects the right of access to health care services to all. However, the state in some instances fails to fulfil this constitution obligation. In *the Treatment Action Campaign case* (TAC)[47], the HIV/AIDS pandemic in South Africa was described as “an incomprehensible calamity” and “the most important challenge

[44] Constitution of the Republic of South Africa Act no. 108 of 1996, Section 27 and 28.
[45] Section 28(1) of the Constitution of the Republic of South Africa Act no. 108 of 1996.
[46] Section 24(a) of the Constitution of the Republic of South Africa, Act 108 of 1996.
[47] Ibid.

facing South Africa since the birth of our new democracy" and government's fight against "this scourge" as "a top priority". The case started as an application in the High Court in Pretoria on 21 August 2001. The applicants were a number of associations and members of civil society concerned with the treatment of people with HIV/AIDS and with the prevention of new infections. In this judgment they were referred to collectively as "the applicants". The principal actor among them was the Treatment Action Campaign (TAC). The respondents were the national Minister of Health and the respective members of the executive councils (MECs) responsible for health in all provinces save the Western Cape.[48] They were referred to collectively as "the government" or "government".

Government, as part of a formidable array of responses to the pandemic, devised a programme to deal with mother-to-child transmission of HIV at birth and identified nevirapine as its drug of choice for this purpose. The programme imposes restrictions on the availability of nevirapine in the public health sector. This was where the first of two main issues in the case arose. The applicants contended that these restrictions were unreasonable when measured against the Constitution, which commands the state and all its organs to give effect to the rights guaranteed by the Bill of Rights.

This duty is put thus by Sections 7(2) and 8(1) of the Constitution respectively: Section 7(2) provides that the state must respect, protect, promote and fulfil the rights in the Bill of Rights,[49] and Section 8(1) provides that the Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state."[50] At issue here is the right given to everyone to have access to public health care services and the right of children to be afforded special protection. The second main issue also arose out of the provisions of sections 27 and 28 of the Constitution.[51]It is whether government is constitutionally obliged and had to be ordered forthwith to plan and implement an effective, comprehensive and progressive programme for the prevention of mother-to-child transmission of HIV throughout the country.

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[48] Minister of Health and others v Treatment Action campaign and others (no.2) cct8-02 (2002) zacc15;2002(5) sa721; 2002(10) bclr 1033 (5 July 2002).htm#fn4.

[49] Constitution of the Republic of South Africa Act 108 0f 1996, Section 7(2).

[50] Constitution of the Republic of South Africa Act 108 0f 1996, Section 8(1).

[51] Section 27 and 28 of the Constitution of the Republic of South Africa Act 108 of 1996 – rights enshrined in the Bill of Rights, Chapter 2 of the Constitution.

The Court found that the government was in violation of s.27 and s.28 in not making nevirapine widely available and not providing a comprehensive plan for the gradual elimination of MTCT of HIV. They ordered the government to provide nevirapine to all public hospitals and clinics that have the necessary testing and counselling facilities and to come up with a comprehensive plan for the further reduction of MTCT of HIV.

2.5 Legislative measures adopted by the government of South Africa

The government of South Africa has a constitutional obligation in terms of Section 27(2) which provides that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of this right. The International Covenant on Economic, Social and Cultural Rights, Article 2 of the Covenant also imposes a duty on the state to take steps to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the Covenant by all appropriate means, including particularly the adoption of legislative measures.[52] This is known as the principle of "progressive realisation". It is therefore that the government adopted the National Health Act to regulate the implementation of the National Health Insurance Scheme.[53]

2.5.1 The national health Act

The National Health Act (NHA) is arguably the most important Act passed by Parliament to give effect to the right of everyone to have access to health care services. This right is guaranteed by section 27 of the Constitution of the Republic of South Africa, 1996 (“the Constitution”), which places express obligations on the state to progressively realise socio-economic rights, including access to health care.

NHA is the culmination of key health system policies dating from 1994. It reflects elements of the ANC Health Plan of 1994 as well as the White Paper on Health

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[52] Article 2 of the International Covenant on economic, social and cultural rights imposes a duty on all parties to take steps... to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures. This is known as the principle of "progressive realisation". It acknowledges that some of the rights (for example, the right to health) may be difficult in practice to achieve in a short period of time, and that states may be subject to resource constraints, but requires them to act as best they can within their means. – www.who.int/hhr/ Economic social_cultural rights.

[53] Ibid.

Systems Transformation.[54] Some of these elements include: the decentralisation of health care services through the district health system, the need for improving quality and standards of health care in both the public and private sectors, the need for human resources planning and development, and increasing access to health care services for everyone. While the NHA sets the foundation of the health care system, it works in combination with other pieces of legislation which relate to other areas of the health care system such as the development, registration, regulation and access to medicines. Some of these legislations are as follows:

- The Choice of Termination of Pregnancy Act.[55]
- The Health Professions Act.[56]
- The Medicines and Related Substances Act.[57]
- The Medical Schemes Act.[58]
- The Nursing Act.[59]
- The Traditional Health Practitioners Act.[60]

In terms of health rights and laws in South Africa, 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

(c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights; and

(3) No one may be refused emergency medical treatment.

In terms of section 28(1)(c) of the Constitution every child has the right to basic health care services,[61] and in terms of section 24(a) of the Constitution everyone has the right to an environment that is not harmful to their health or well-being;[62]

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[54] Ibid.
[55] The Choice of Termination of Pregnancy Act no.92 of 1996.
[56] The Health Professions Act no. 56 of 1974.
[57] The Medicines and Related Substances Act no. 101 of 1965.
[58] The Medical Schemes Act no. 131 of 1998.
[59] The Nursing Act no. 33 of 2005.
[60] The Traditional Health Practitioners Act no. 22 of 2007.
[61] Section 28 (1) (c) of the Constitution of the Republic of South Africa Act 108 of 1996.
[62] Section 24 (a) of the Constitution of Republic of South Africa Act 108 of 1996.

The National Health Act is meant to be one of the legislative measures that will facilitate the progressive realisation of the right to health. Section 27 and other provisions of the Constitution set the parameters for health care planning and delivery. It is from the Constitution that the NHA gets its authority and essential content. The NHA and other health legislation only provide detail but they cannot in any way alter the constitutional promise of the right to have access to health care services.

The NHA provides the foundational structure of the national, provincial, and district health care system. It is designed to create the framework for delivering health care services for the entire country, including the opportunity for the national Department of Health (DoH) to form relationships between public and private hospitals and to regulate the minimum standard of care to which all people living in South Africa are entitled. It also creates the system to train, retain, and further build human resources for the delivery of health care. In particular, it sets the requirements for the DoH with regard to reporting and providing for the adequate provision and distribution of health professionals.

The objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation by-[63]

(a) Establishing a national health system which-

(i) Encompasses public and private providers of health services; and

(ii) Provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford;

(b) Setting out the rights and duties of health care providers, health workers, health establishments and users; and

(c) Protecting, respecting, promoting and fulfilling the rights of-

(i) The people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care;

(ii) The people of South Africa to an environment that is not harmful to their health or well-being;

(iii) Children to basic nutrition and basic health care services contemplated in section 28(1) (c) of the Constitution; and

[63] National Health Act no. 61 of 2003 – is regarded as a strategic legislative framework to guide the National Health Insurance Scheme, aimed at improving the national health system.

(iv) Vulnerable groups such as women, children, older persons and persons with disabilities.

The National Health Act provides a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services, and to provide for matters connected therewith. The then President Mbeki signed the NHA into law on 18 July 2004.

2.5.2 Choice of Termination of Pregnancy Act

The Act provides that termination of a pregnancy" means the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman. The termination of a pregnancy may only be carried out by a medical practitioner, except for pregnancy which may also be carried out by a registered midwife who has completed the prescribed training course. Any health facility that has a 24-hour maternity service, and which complies with the requirements which may terminate pregnancies of up to and including 12 weeks without having to obtain the approval of the Member of the Executive Council. The person in charge of a health facility contemplated must notify the relevant Member of the Executive Council that the health facility has a 24-hour maternity service which complies with the requirements.[64] Termination of a pregnancy may take place only at a facility which –

- Gives access to medical and nursing staff;
- Gives access to an operating theatre;
- Has appropriate surgical equipment;
- Supplies drugs for intravenous and intramuscular injection;
- Has emergency resuscitation equipment and access to an emergency referral centre or facility;
- Gives access to appropriate transport should the need arise for emergency transfer;
- Has facilities and equipment for clinical observation and access to in-patient facilities;

[64] Choice of termination of pregnancy Act no.92 of 1996.

- Has appropriate infection control measures;
- Gives access to safe waste disposal infrastructure;
- Has telephonic means of communication; and
- Has been approved by the Member of the Executive Council by notice in the Gazette.

2.5.3 Health Professional Act

The key objectives of this Act is to establish the Health Professions Council of South Africa and professional boards; to provide for control over the education, training and registration for and practising of health professions registered under this Act; and to provide for matters incidental thereto.[65]The objects and functions of the council are -

- To co-ordinate the activities of the professional boards established in terms of this Act and to act as an advisory and communicatory body for such professional boards;
- To promote and to regulate inter-professional liaison between health professions in the interest of the public;
- To determine strategic policy in accordance with national health policy as determined by the Minister, and to make decisions in terms thereof, with regard to the professional boards and the health professions, for matters such as finance, education, training, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, inter-professional matters and maintenance of professional competence;
- To consult and liaise with relevant authorities on matters affecting the professional boards in general;
- To assist in the promotion of the health of the population of the Republic;
- Subject to legislation regulating health care providers and consistency with national policy determined by the Minister, to control and to exercise authority in respect of all matters affecting the education and training of persons in, and the manner of the exercise of the practices pursued in connection with, the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in human kind;

[65] Health professional Act no. 56 of 1974.

- To promote liaison in the field of education and training referred to in both in the Republic and elsewhere, and to promote the standards of such education and training in the Republic;
- To advise the Minister on any matter falling within the scope of this Act in order to support the universal norms and values of health professions, with greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement;
- To communicate to the Minister information of public importance acquired by the council in the course of the performance of its functions under this Act.
- To serve and protect the public in matters involving the rendering of health services by persons practising a health profession;
- To exercise its powers and discharge its responsibilities in the best interest of the public and in accordance with national health policy determined by the Minister;
- To be transparent and accountable to the public in achieving its objectives and when performing its functions and exercising its powers;
- To uphold and maintain professional and ethical standards within the health professions;
- To ensure the investigation of complaints concerning persons registered in terms of this Act and to ensure that appropriate disciplinary action is taken against such persons in accordance with this Act in order to protect the interest of the public;
- To ensure that persons registered in terms of this Act behave towards users of health services in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action is taken against persons who fail to act accordingly; [66]
- To submit to the Minister-

- A five-year strategic plan within six months of the council coming into office which includes details as to how the council plans to fulfil its objectives under this Act;

[66] The Health professional Act no. 56 of 1974.

- Every six months a report on the status of health professions and on matters of public importance that have come to the attention of the council in the course of the performance of its functions under this Act; and
- An annual report within six months of the end of the financial year; and
- To ensure that an annual budget for the council and the professional boards is drawn up and that the council and3 the professional boards operate within the parameters of such budget.

2.5.4 Medicines and Related Substances Amendment Act

The Act amended the medicines and related substances Act [67], and its objectives are:

- To provide for the registration of medicines and related substances intended for human and for animal use;
- To provide for the establishment of a Medicines Control Council; to provide that such council shall be a juristic person;
- To make other provision for the constitution of the council;
- To provide that a member of the council or committee shall declare his or her commercial interest related to the pharmaceutical or health care industry;
- To provide that the appointment of members of the executive committee is subject to the approval of the Minister;
- To provide for the control of medicines and scheduled substances and medical devices;
- To make further provision for the prohibition on the sale of medicines which are subject to registration and are not registered;
- To provide for procedures that will expedite the registration of essential medicines, and for the re-evaluation of all medicines after five years;[68]
- To provide, for measures for the supply of more affordable medicines in certain circumstances;
- To provide that labels be approved by the council; to prohibit sampling and bonusing of medicines;

[67] Medicines and related substances Act 101 of 1965.
[68] Objectives of the Act - Medicines and related substances Act101 of 1965 as amended by the Medicine and related substances amendment Act no.59 0f 2002.

- To provide for the licensing of certain persons to compound, dispense or manufacture medicines and medical devices and also to act as wholesalers or distributors;
- To provide for the generic substitution of medicines;
- To provide for the establishment of a pricing committee;
- To regulate the purchase and sale of medicines by manufacturers, distributors, wholesalers, pharmacists and persons licensed to dispense medicines; to make new provisions for appeals against decisions of the Director-General or the council;
- To provide that the council may acquire and appropriate funds;
- To regulate the Minister's power to make regulations;
- To provide for the rationalization of certain laws relating to medicines and related substances that have remained in force in various territories on the territory of the Republic by virtue of item 2 of Schedule 6 to the Constitution of the Republic of South Africa, 1996; and to provide for matters connected therewith.

2.5.5 Medical Schemes Act

The Act aims to consolidate the laws relating to registered medical schemes; to provide for the establishment of the Council for Medical Schemes as a juristic person; to provide for the appointment of the Registrar of Medical Schemes; to make provision for the and control of certain activities of medical schemes; to protect the interests of members of medical schemes; to provide for measures for the coordination of medical schemes; and to provide for incidental matters.[69]

The Act is applied if any conflict, relating to the matters dealt with in this Act, arises between this Act and the provisions of any other law save the Constitution or any Act expressly amending this Act, the provisions of this Act shall prevail. This Act shall also apply to a medical scheme established by any organ of the State including those medical schemes established under section 28 (g) of the Labour Relations Act,[70] The Act provides for the establishment of the Council for Medical Schemes as a juristic person.[71] The Council shall be entitled to sue and be sued, to acquire, possess and

[69] Objectives of the Medical scheme Act no.131 of 1998.
[70] The Labor Relations Act, 1995 (Act No. 66 of 1995).
[71] Section 28(g) of the Labour relations Act no. 66 of 1995.

alienate moveable and immovable property and to acquire rights and incur liabilities. The Council shall, at all times, function in a transparent, responsive and efficient manner. The functions of the Council shall be to:

- Protect the interests of the members at all times;
- Control and coordinate the functioning of medical schemes in a manner that is complementary with the national health policy;
- Make recommendations to the Minister on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes, and such other services as the Council may from time to time determine;
- Investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this Act;
- Collect and disseminate information about private health care;
- Make rules, not inconsistent with the provisions of this Act for the purpose of the performance of its functions and the exercise of its powers;
- Advise the Minister on any matter concerning medical schemes; and
- Perform any other functions conferred on the Council by the Minister or by this Act.

2.5.6 The Nursing Act

This Act is called the Nursing Act, and came into operation in 2006.[72] The objects of the Council are:[73]

- To serve and protect the public in matters involving health services generally and nursing services in particular;
- Perform its functions in the best interests of the public and in accordance with national health policy as determined by the Minister;
- Promote the provision of nursing services to the inhabitants of the Republic that complies with universal norms and values;
- Establish, improve, control conditions, standards and quality of nursing
- education and training within the ambit of this Act and any other applicable laws;
- Maintain professional conduct and practice standards for practitioners within the ambit of any applicable law;

[72] Nursing Act no. 33 of 2005 founded the Nursing Council.
[73] The Nursing Council as established by the Nursing Act no. 33 of 2005.

- Promote and maintain liaison and communication with all stakeholders regarding nursing standards, and in particular standards of nursing education and training and professional conduct and practice both in and outside the Republic;
- Advise the Minister on the amendment or adaptation of this Act regarding matters pertaining to nursing;
- Be transparent and accountable to the public in achieving its objectives and in performing its functions;
- Uphold and maintain professional and ethical standards within nursing; and
- Promote the strategic objectives of the Council.

2.5.7 Traditional Health Practitioners Act

The purpose of this Act is to:

- Establish the Interim Traditional Health Practitioners Council of South Africa;
- Provide for the registration, training and practices of traditional health practitioners in the Republic; and
- Serve and protect the interests of members of the public who use the services of traditional health practitioners.[74]

This Act applies to:

- Traditional health practice in the Republic; and
- Traditional health practitioners and students engaged in or learning traditional health practice in the Republic.

The Act provides the establishment of the Traditional Health Practitioners Council, and its objectives are as follows:[75]

- Promote public health awareness;
- Ensure the quality of health services within the traditional health practice;
- Protect and serve the interests of members of the public who use or are affected by the services of traditional health practitioners;
- Promote and maintain appropriate ethical and professional standards required from traditional health practitioners;

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[74] Traditional Health Practitioners Act 22 of 2007.
[75] Objectives of Traditional Health Practitioners Act 22 of 2007.

- Promote and develop interest in traditional health practice by encouraging research, education and training;
- Promote contact between the various fields of training within traditional health practice in the Republic and to set standards for such training;
- Compile and maintain a professional code of conduct for traditional health practice; and
- Ensure that traditional health practice complies with universally accepted health care norms and values.

2.6 Conclusion

The Constitution of South Africa became the yard stick of every law in the land, and therefore there is a need to revisit on numerous health legislations that were in force before attaining our democracy. A number of these health legislations have to be amended in accordance with Constitutions. The National Health Insurance for instance responds to the constitutional obligation set on the government of South Africa in respect of the provision of health to its citizens. The constitutional imperative demands that every health legislation has to be given a constitutional scrutiny.

CHAPTER THREE: INTERNATIONAL LAW FRAMEWORKS AND COMPARATIVE STUDY

3.1 Introduction

South Africa re-joined the international community soon after a democratic government was restored in 1994, and ratified a number of conventions such as World Health Organisation, the Universal Declaration of Human Rights, and International Covenant on Economic, Social and Cultural Rights. The World Health Organisation's Constitution states that its objective is the attainment by all people of the highest possible level of health. World Health Organisation fulfils its objective through its functions as defined in its Constitution. South Africa having ratified the above conventions is bound by the constitution of each convention where it is regarded as a member state.

South Africa is adamant to learn from the prospects and challenges encountered by other African countries, including those in the world who have successfully restructured their health systems, especially though the implementation of the National Health Insurance Scheme or similar financing programs. In this case this chapter looks into the transformation taken by Ghana in transforming the health system, to cater for all its population through affordable and efficiency means. The chapter looks further into the 3M system adopted by Singapore into commercialisation of the health system to become one of the best health systems in the world.[76]

3.2 World Health Organisation

South Africa became a member of the World Health Organisation (WHO) The mission of the WHO in South Africa is to promote the attainment of the highest sustainable level of health by all people living in South Africa through collaboration with the government and other partners in health development and the provision of technical and logistic support to country programmes. The World Health Organization is a member of the United Nations Development Group.[77]As of 2013, the WHO had 194 member states. A state becomes a full member of WHO by ratifying the treaty known

[76] Lim MK "Health Care System in transition II" Singapore, Part I An overview of the health care systems in Singapore, Journal of public Health Medicine, 1998, 20 16-22; Lim Kim "Shifting the burden of health Care finance.

[77] World Health Organisation – Wikipedia, the free encyclopedia.htm#_note67.

as the Constitution of the World Health Organization. The WHO Constitution states that its objective "is the attainment by all people of the highest possible level of health".[78]

The World Health Assembly is the legislative and supreme body of WHO based in Geneva. The World Health Organization's primary objective in natural and man-made emergencies is to coordinate with Member States and other stakeholders to "reduce avoidable loss of life and the burden of disease and disability."WHO addresses government health policy with two aims: firstly, "to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches" and secondly "to promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health".[79]

The organization develops and promotes the use of evidence-based tools, norms and standards to support member states to inform health policy options. It oversees the implementation of the International Health Regulations, and publishes a series of medical classifications; of these, three are overreaching "reference classifications": the International Statistical Classification of Diseases (ICD), the International Classification of Functioning, Disability and Health (ICF) and the International Classification of Health Interventions (ICHI). Other international policy frameworks produced by WHO include the International Code of Marketing of Breast-milk Substitutes (adopted in 1981), Framework Convention on Tobacco Control (adopted in 2003) and the Global Code of Practice on the International Recruitment of Health Personnel (adopted in 2010). [80]

In terms of health services, WHO looks to improve "governance, financing, staffing and management" and the availability and quality of evidence and research to guide policy making. It also strives to "ensure improved access, quality and use of medical

[78] Constitution of the World Health Organization – constitution was adopted by the International health conference held in New York from 19 June to 22 July 1946, signed on the 22 of July 1946 by representatives of 61 states (Off. Rec. Wld Org,2,100), and entered into force on 7 April in 1948. Amendments adopted by the twenty sixth, twenty ninth, Thirty ninth and Fifty first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 andwha51.23) came into force on the 3rd of February1977,20 January1984, 11 July 1994, and 15 September 2005 respectively and are incorporated in the present test.

[79] World Health Organisation – Programmes of budget 2012 – 2013, WHO retrieved on the 24 May 2015.

[80] International health regulations adopted by the World Health Organization -www.who.int/../who_constitution_en.pdf.

products and technologies". WHO fulfils its objective through its functions as defined in its Constitution:

(1) To act as the directing and co-ordinating authority on international health work.

(2) To establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate.

(3) To assist Governments, upon request, in strengthening health services.

(4) To furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments.

(5) To provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories.

(6) To establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services.

(7) To stimulate and advance work to eradicate epidemic, endemic and other diseases.

(8) To promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries.

(9) To promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene.

(10) To promote co-operation among scientific and professional groups which contribute to the advancement of health.

(11) To propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform. WHO currently defines its role in public health as follows.[81]

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
- Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
- Setting norms and standards and promoting and monitoring their implementation,
- Articulating ethical and evidence-based policy options;

[81] Ibid – 51.

- Providing technical support, catalysing change, and building sustainable institutional capacity;
- And monitoring the health situation and assessing health trends.

3.3 The Universal Declaration of Human Rights

The United Nations' General Assembly proclaims the Universal Declaration of Human Rights[82] as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction. Member States have pledged themselves to achieve, in co-operation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms, Universal Declaration of Human rights Article 25 provides that[83]:

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

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[82] A customary convention, adopted in 1948.

[83] Universal Declaration of Human Rights, Article no. 25 - now, therefore the general assembly proclaims this universal declaration of human rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of member states themselves and among the peoples of territories under their jurisdiction.

3.4 International Covenant on Economic, Social and Cultural Rights

South Africa signed the conventions on 3 October 1994 and ratified it on 12th January 2015. The International Covenant on Economic, Social and Cultural Rights (ICESCR) is a multilateral treaty adopted by the United Nations General Assembly on 16 December 1966, and in force from 3 January 1976. It commits its parties to work toward the granting of economic, social, and cultural rights (ESCR) to the Non-Self-Governing and Trust Territories and individuals, including labour rights and the right to health, the right to education, and the right to an adequate standard of living.[84]

The ICESCR is part of the Declaration on the Granting of Independence to Colonial Countries and Peoples,[4]International Bill of Human Rights, along with the Universal Declaration of Human Rights (UDHR) and the International Covenant on Civil and Political Rights (ICCPR), including the latter's first and second Optional Protocols. The Covenant is monitored by the UN Committee on Economic, Social and Cultural Rights. The ICESCR include rights to:[85]

- Work, under "just and favourable conditions", with the right to form and join trade unions (Articles 6, 7, and 8);social security, including social insurance.
- Family life, including paid parental leave and the protection of children.
- An adequate standard of living, including adequate food, clothing and housing, and the "continuous improvement of living conditions".
- Health, specifically "the highest attainable standard of physical and mental health.
- Education, including free universal primary education, generally available secondary education and equally accessible higher education. This should be directed to "the full development of the human personality and the sense of its dignity", and enable all persons to participate effectively in society.
- Participation in cultural life.

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[84] Rights and Value: Construing the International Covenant on Economic, Social and Cultural Rights as Civil Commons" by G. Baruchello & R.L. Johnstone, Studies in Social Justice, Vol 5, No 1 (2011): Special Issue: Life Value and Social Justice, 91–125.

[85] www.ohchr.org>OHCHR; www.who.int/hhr/Economicsocial_culturalrights - International Covenant on Economic Social and Cultural Rights adopted and opened for signature, ratification and accession by the General Assembly resolution 2200A(XX1) of 16 December 1966 entry into force 3 January 1976, in accordance with Article 27.

Many of these rights include specific actions which must be undertaken to realise them. Articles 16 – 25 govern reporting and monitoring of the Covenant and the steps taken by the parties to implement it.[86] It also allows the monitoring body, the Committee on Economic, Social and Cultural Rights to make general recommendations to the UN General Assembly on appropriate measures to realise the rights.

Article 2 of the Covenant imposes a duty on all parties to take steps to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.[87] This is known as the principle of "progressive realisation". It acknowledges that some of the rights (for example, the right to health) may be difficult in practice to achieve in a short period of time, and that states may be subject to resource constraints, but requires them to act as best they can within their means. The requirement to "take steps" imposes a continuing obligation to work towards the realisation of the rights. It also rules out deliberately regressive measures which impede that goal.

The Committee on Economic, Social and Cultural Rights also interprets the principle as imposing minimum core obligations to provide, at the least, minimum essential levels of each of the rights. If resources are highly constrained, this should include the use of targeted programmes aimed at the vulnerable. The Committee on Economic, Social and Cultural Rights regards legislation as an indispensable means for realising the rights which is unlikely to be limited by resource constraints.

Article 12 of the Covenant recognises the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health".[88] "Health" is understood not just as a right to be healthy, but as a right to control one's own health and body (including reproduction), and be free from interference such as torture or medical

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[86] Article 16 – 25 of the International Covenant on Economic, Social and Cultural Rights.

[87] Article 2 of the International Covenant on Economic, Social and Cultural Rights.

[88] Article 12 of the Covenant recognizes the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health". "Health" is understood not just as a right to be healthy, but as a right to control one's own health and body (including reproduction), and be free from interference such as torture or medical experimentation. States must protect this right by ensuring that everyone within their jurisdiction has access to the underlying determinants of health, such as clean water, sanitation, food, nutrition and housing, and through a comprehensive system of healthcare, which is available to everyone without discrimination, and economically accessible to all.

experimentation. States must protect this right by ensuring that everyone within their jurisdiction has access to the underlying determinants of health, such as clean water, sanitation, food, nutrition and housing, and through a comprehensive system of healthcare, which is available to everyone without discrimination, and economically accessible to all.[89]

The Committee on Economic, Social and Cultural Rights is a body of human rights experts tasked with monitoring the implementation of the Covenant. All states parties are required to submit regular reports to the Committee outlining the legislative, judicial, policy and other measures they have taken to implement the rights affirmed in the Covenant. The first report is due within two years of ratifying the Covenant.[90]

3.5 Lessons to be learnt from other countries

South Africa has the privilege to learn from other African countries who earlier adopted a similar policy. Ghana for instance adopted the National Health Insurance scheme in 2003, which was fully implemented in 2005. In 1994, Government of Nigeria responded to the infrastructural decay in all sectors of the economy by adopting a reform agenda embedded in the New Economic Empowerment and Development Strategy (NEEDS), (National Planning Commission, 2004). The health sector reform was part of the development strategy aimed at improving the standard of health care for all Nigerians. However, for the purpose of this study I shall look into the health insurance scheme and the health systems of Ghana and Singapore, as South Africa looks forward to learn, and to boost capacity of its health system.

3.5.1 Lessons to be learnt from Ghana

The Government of Ghana replaced the 'Cash and Carry' health financing system with a National Health Insurance Scheme, because the 'Cash and Carry' System, which made it compulsory for everybody to pay money immediately before and after treatment in the hospitals/clinics etc., was not within the means of most Ghanaians

[89] Article 12 of the International Covenant on Economic, Social and Cultural Rights.

[90] The Committee on Economic, Social and Cultural Rights is a body of independent experts that monitors implementation of the International Covenant on Economic, Social and Cultural Rights by its states parties. The Committee was established under ECOSOC Resolution1985/17 of 28 May 1985 to carry out the monitoring functions assigned to the United Nations Economic and Social Council (ECOSO) – www.ohchr.org/../cescrindex.aspx.

and many were not going to the hospitals and clinics resulting in needless deaths.[91]/[92] The health insurance allows everybody to make contributions into a fund so that in the event of illness contributors could be supported by the fund to receive affordable healthcare in the health facilities.

The Government of Ghana has already developed a policy framework to provide the general guidelines for the establishment of the National Health Insurance Scheme. A law has been passed to provide the legal framework necessary to facilitate the establishment of the National Health Insurance Scheme. The law makes it compulsory for all Ghanaians to join a health insurance scheme. There are three types of schemes available under the law:

- The District-Wide Mutual Health Insurance Scheme.
- The Private Mutual Health Insurance Scheme.
- The Private Commercial Health Insurance Scheme.

The Government of Ghana advocated support of the District Mutual Health Insurance Scheme concept to ensure that opportunity is provided for all Ghanaians to have equal access to the functional structures of Health Insurance, Ghanaians do not move from an unaffordable 'Cash and carry' regime to another unaffordable Health Insurance one. A sustainable Health Insurance option is made available to all Ghanaians and the quality of healthcare provision is not compromised under Health Insurance. Each district is divided into Health Insurance Communities so that Health Insurance could be brought to the door step of all Ghanaians.[93]

A Health Insurance Committee was formed in each Health Insurance Community to oversee the collection of contributions and supervise its deposit in the District Health Insurance Fund. The collector collects contributions from residents in the Health Insurance Community under close supervision of the other members of the committee. To ensure that the contributions of residents are safe and properly accounted for and facilitate access to quality health care by contributors, the Chairman or Secretaries of

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[91] Jehu-Appiah C, Aryeetey G, Agyepong I, Spaan E, Baltussen R: Household perceptions and their implications for enrolment in the National Health Insurance Scheme in Ghana. *Health Policy Plan* 2011, 27(3):222-233.

[92] James CD, Hanson K, McPake B, Balabanova D, Gwatkin D, Hopwood I, *and et al*.: To retain or remove user fees? Reflections on the current debate in low - and middle - income countries. *Appl Health Econ Health Policy* 2006, 5:137-153.

[93] Lagarde M, Palmer N: Evidence From Systematic Reviews to Inform Decision Making Regarding Financing Mechanisms that Improve Access to Health Services for Poor People: A Policy Brief Prepared for the International Dialogue on Evidence-Informed Action to Achieve Health Goals in Developing Countries (IDEA Health). World Health Organization: Geneva; 2006.

all Community Health Insurance Committees formed a District Health Insurance Assembly. The Health Insurance Assembly members, the board of trustees, the community health insurance collectors, and the management team of all Districts-Mutual Insurance Schemes and the health providers is trained to ensure the efficient management of the schemes in the districts.

Since the socio-economic condition of all residents in Ghana are not the same and the contributions must be affordable to all to ensure that nobody is forced to remain in 'cash and carry', there is no standard contribution for all Ghanaians in the country. This also means that contributions payable varies from one district to the other as even the disease burden is also not the same in all the districts. It must be noted that, all Ghanaians, pays 2.5% Health Insurance Levy on selected goods and services to put into a National Health Insurance Fund to subsidize fully paid contributions to the District Health Insurance Schemes.

The Government came out with a minimum benefit package of diseases which every district-wide scheme must cover; this package covers about 95% of diseases in Ghana. Diseases covered include among others Malaria, Diarrhoea, Upper Respiratory Tract Infection, Skin Diseases, Hypertension, Diabetics, Asthma, and a lot of other diseases ranging from head to toe. However, all district-wide schemes have the right under the law to organise their schemes to cover as many diseases and services as they desire, provided it is approved by the National Health Insurance Council. Certain diseases are however excluded from the benefit package. This is mainly because it may be too expensive to treat those diseases and therefore other arrangements are being considered to enable people get these diseases treated. Diseases currently not covered are: Optical aids, Hearing aids, Orthopaedic aids, Dentures, Beautification Surgery, Supply of ADIS drugs, treatment of Chronic Renal Failure, Heart and Brain Surgery, etc. All these constitute only 5% of the total number of diseases that attack the population.[94]

Residents who pay their contributions in full will have to wait for at most six months before their Health Insurance identification and Health facility attendance card are issued to them to enable them attend any public health facility or any private accredited

[94] Lagarde M, Palmer N: The impact of health financing strategies on access to health services in low and middle income countries (Protocol). Cochrane Database of Systematic Reviews. John Wiley & Sons; 2006.

health facility in Ghana for both inpatient and outpatient care in line with the scheme's benefit package.

There is a waiting period imposed, to avoid having only sick people contributing to the scheme and immediately after accessing health facilities for treatment to collapse the scheme at its inception. Again to ensure that enough money has been accumulated to take care of any possible huge cost burden which may occur at the beginning of the implementation of the Health Insurance Scheme. But it must be noted that the waiting period is only for the initial registration or contribution to the scheme.[95] Only those who do not renew their registration by contributing fully within 13 months of the period of enjoyment of benefits will have to wait for the specified waiting period according to scheme's constitution. Those who renew their Health Insurance Cards within the 13 months will not have to wait but can continue to enjoy their healthcare benefits under the scheme.

The Government of Ghana came out with a painless way for workers to join the District Wide Health Insurance Schemes through the enacted Law on Health Insurance. The law makes it mandatory for 2.5% of workers social security contributions to be put into the National Insurance fund to be subsequently disbursed to the District Mutual Health Insurance Schemes as their contributions to the scheme. Children under 18 years of formal sector workers are exempted from paying any contributions provided workers spouses in the informal sector, if any, also pay their own contributions. The idea to deduct workers contributions from their social security deduction instead of their salary earnings is to achieve the following:[96]

- To provide free health insurance coverage for workers within the minimum benefit package.
- To minimize the healthcare component of workers household budget to enable them have more disposable income during their working days.
- To minimize the healthcare component of workers household budget when they go on pension.

[95] Arhin-Tenkorang D: Health Insurance for the Informal Sector in Africa: Design Features, Risk Protection, and Resource Mobilization. 2001.

[96] Dixon J, Tenkorang EY, Luginaah I: Ghana's national health insurance scheme: helping the poor or leaving them behind? *Environment and Planning C: Government and Policy* 2011, 29(6):1102-1115.

- To enable them receive free treatment within the minimum benefit package for the typical old age chronic diseases like diabetes and hypertension.

3.5.2 Lessons to be learnt from Singapore

1n the 1980's Singapore government examined from first principles the role of the state in health care financing and provision, and concluded that it would continue to subsidies health care along with other important social areas such as housing and education, to bring the prices down to an affordable level.[97]

The health system of Singapore is highly ranked, and sits amongst the world's best health systems. It achieved these health outcomes through a comprehensive health care delivery and financing system principled on the followings:

- To promote good health and reduce illness, access to good and affordable health care, pursue medical excellence;
- To ensure that all Singaporeans have access to affordable basic, basic medical services at public hospitals and polyclinics and heavily subsidised by the government.

The system of health care in Singapore is based on the '3M system', under this system the individuals are encouraged to take responsibility for their own health by saving for medical expenses. The 3M originated from the:

- Medisave,
- Medishield, and
- Medifund

Medisave, Medishield and Medifund were implemented in 1984, 1990 and 1993 respectively. These tiers of protection forms the Counter-piece of Singapore health care financing system and was therefore premised on the philosophy of shared responsibility, and the economic principle that health care service should not be supplied freely on demand without reference to price.

[97] Lim MK "Health Care System in transition II" Singapore, Part I An overview of the health care systems in Singapore, Journal of public Health Medicine, 1998, 20 16-22; Lim Kim "Shifting the Burden of Health Care finance: A case study of public-private partnership in Singapore, Health policy, 2004, 69,83-9. Singapore has one of the highest medical standards across Asia. In fact, this highly industrialized nation is Asia's regional centre for medical excellence. The well-established health care system is composed of thirteen private hospitals, ten government hospitals and a number of specialist clinics, each one specialising in catering to the needs of different patients at varying costs. Patients are also free to choose their health care provider, both within the private and public health care system.

The first tier of protection is provided by government subsidies up to 80% of the total bill in acute public hospital wards, which all Singaporeans can access. The second tier of protection is provided by Medisave, which is compulsory individual medical savings account scheme which allows practically all Singaporeans to pay for their share of medical treatment without financial difficulty. Working Singaporeans and their employers contribute a part of the monthly wages into the account to save up for their future medical needs and this is portable across jobs and after retirement.[98]
The third level of protection is provided by Medishield, which is a relatively low cost medical insurance scheme. This allows Singaporeans to effectively risk pool the financial risks of major illnesses. Individuals who wish to be covered must subscribe and make payments into the Medishield.

For those with disability, especially catering for senior citizens, Eldershield is also made available for subscription to guard against the financial risks of suffering severe disability. There is also integrated shield plan where most middle and higher income earning Singaporeans are subscribed to for treatment in the private sector. Eldershield offers private insurance for disability as a result of old age. Eldershield supplements allow policy holders to enhance the disability benefits coverage offered by the basic elder shield products. However, they must subscribe to the basic Medishield products before they purchase private integrated shield plans. The 3M framework covers 85% of the Singaporeans, and is a component of a mandatory pension program. Employees pay 20% of their wages into the Central provident fund While employers pay 13 % towards the fund.

The primary aim of the Singaporean government is to encourage people to save in order to meet their medical expenses. Medisave accounts can be used by immediate family members of those who are subscribers, to pay for their hospital expenses. Medisave can also be used for expensive out-patient treatment such as chemotherapy, renal dialysis and HIV drugs. Nearly all Singaporeans contribute directly towards treatment, including prescription of drugs through co-payment of 20% for amount deductible which comes out from a person's Medisave account.

[98] Callick R "The City – State of Singapore may have a fix for Americans Health Care Woes" The journal of the American Enterprise institute 2008 – accessed at http://american.com/archive2008 - 14 April 2011.

Singapore continues to increase investment in the health facilities, broadening its market. It attracts a huge number of foreigners who visit its medical facilities for health care services. In 2003, a group of government agencies launched Singapore medicine, aimed at developing the country into a leading international destination of health care. The World Bank said the results of 3M, with its supplementary programs to protect the poor and to address potential market failures in the health financing have been impressive, with excellent health outcomes, low cost and full consumer choice of providers and quality of care.[99] It recommended that Medisave can be introduced in countries without national insurance, by requiring all employers and employees to set up accounts along the lines of Singapore's program.. In South Africa the concept of NHI is being considered and there are many lessons to be learnt from other countries, this includes Singapore and United States of America.

3.6 Comparative analysis between Singapore and South Africa's health systems

Health care in Singapore is mainly under the responsibility of the Singapore Government's Ministry of Health. Singapore generally has an efficient and widespread system of health care. It implements a universal health care system, and co-exists with private health care system. Singapore has a universal health care system where government ensures affordability, largely through compulsory savings and price controls, while the private sector provides most care. Overall spending on health care amounts to only 3% of annual GDP. of that, 66% comes from private sources.[100] Singapore currently has the lowest infant mortality rate in the world and among the highest life expectancies from birth, according to the World Health Organization.[101]

Singapore has "one of the most successful health care systems in the world, in terms of both efficiency in financing and the results achieved in community health outcomes," according to an analysis by global consulting firm Watson Wyatt.[102] Singapore's system uses a combination of compulsory savings from payroll deductions (funded by both employers and workers) a nationalized catastrophic health insurance plan, and government subsidies, as well as "actively regulating the supply and prices of health

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[99] Wagstaff A "Health system in Esat Asia: what can developing countries learn from Japan and Asian Tigers" 2005 World bank policy research working paper 3790 accessed at www-wds.worldback.org/external/pdf- 12 September 2015.

[100] "World Health Organization Statistical Information System: Core Health Indicators". Who.int. Retrieved 2015.08.20.

[101] World Health Organization, "World Health Statistics 2007: Mortality", based on 2005 data.

[102] John Tucci, "The Singapore health system – achieving positive health outcomes with low expenditure", Watson Wyatt Healthcare Market Review, October 2004.

care services in the country" to keep costs in check; the specific features have been described as potentially a "very difficult system to replicate in many other countries." Many Singaporeans also have supplemental private health insurance often provided by employers for services not covered by the government's programs.[103]

Singapore's well-established health care system comprises a total of 13 private hospitals, 10 public government hospitals and several specialist clinics, each specializing in and catering to different patient needs, at varying costs. Patients are free to choose the providers within the government or private health care delivery system and can walk in for a consultation at any private clinic or any government polyclinic. For emergency services, patients can go at any time to the 24-hour Accident & Emergency Departments located in the government hospitals. Singapore's medical facilities are among the finest in the world, with well qualified doctors and dentists, many trained overseas. Singapore has medical savings account system known as Medisave.

In South Africa, parallel private and public systems exist. The public system serves the vast majority of the population, but is chronically underfunded and understaffed. The wealthiest 20% of the population uses the private system and are far better served. This division in substantial ways perpetuates racial inequalities created in the pre-apartheid segregation era and apartheid era of the 20th century. In 2005, South Africa spent 8.7% of GDP on health care, or US$437 per capita. of that, approximately 42% was government expenditure.[104]About 79% of doctors work in the private sector.[105]

An estimated 80% of South Africans consult with traditional healers alongside general medical practitioners. The Medical Research Council (MRC) founded a traditional medicines research unit in 1997 to introduce modern research methodologies around the use of traditional medicines.[106] It also aims to develop a series of patents for promising new entities derived from medicinal plants.

The public sector uses a Uniform Patient Fee Schedule as a guide to billing for services. This is being used in South Africa, although in some instances, it is being

[103] Ibid.
[104] "WHO Statistical Information System". World Health Organization (Retrieved 23 September 2015).
[105] Ibid.
[106] The MRC's Traditional Medicines Research Unit founded in 1997.

implemented on a phased schedule. Implemented in November 2000, the UPFS categorises the different fees for every type of patient and situation. It groups patients into three categories defined in general terms, and includes a classification system for placing all patients into either one of these categories depending on the situation and any other relevant variables. The three categories include full paying patients - patients who are either being treated by a private practitioner, who are externally funded, or who are some types of non-South African citizens, fully subsidised patients - patients who are referred to a hospital by Primary Healthcare Services, and partially subsidised patients - patients whose costs are partially covered based on their income.

3.6.1 Doctor shortages in South Africa

In March 2012, 165 371 qualified health practitioners in both public and private sectors were registered with the Health Professions Council of South Africa, the health practitioner watchdog body. This includes 38 236 doctors and 5 560 dentists. The doctor to population ratio is estimated to be 0.77 per 1 000. But because the vast majority of GPs 73% work in the private sector, there is just one practising doctor for every 4 219 people.[107] In response, the Department of Health has introduced clinical health associates, midlevel health-care providers, to work in underserved rural areas. About 1 200 medical students graduate annually. In some communities, medical students provide health services at clinics under supervision. Newly graduating doctors and pharmacists complete a year of compulsory community service in understaffed hospitals and clinics.

In an attempt to boost the number of doctors in the country, South Africa signed a co-operation agreement with Cuba in 1995. South Africa has since recruited hundreds of Cuban doctors to practice here, while South Africa is able to send medical students to Cuba to study. South Africa believes the Cuban opportunity will help train the doctors it so desperately needs for the implementation of the National Health Insurance Scheme. Other agreements exist with Tunisia and Iran, as well as between Johannesburg Hospital and Maputo Central Hospital. The government has also made it easier for other foreign doctors to register here. The Allied Health Professions Council of South Africa had 3 773 registered "complementary health" practitioners in 2012.

[107] The Allied Health Professions Council of South Africa.

3.6.2 Increase mortality

Because of its abundant cases of HIV/AIDS among citizens, South Africa has been working to create a program to distribute anti-retroviral therapy treatment, which has generally been limited in low economic countries. An anti-retroviral drug aims to control the amount of virus in the patient's body. In November 2003 the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa was approved, which was soon accompanied by a National Strategic Plan for 2007–2011. When South Africa freed itself of apartheid, the new health care policy has emphasised public health care, which is founded with primary health care. The National Strategic Plan therefore promotes distribution of anti-retroviral therapy through the public sector, and more specifically, primary health care.[108]

South Africa is an under developed nation and because of this the sanitation facility access in urban areas is 16% unimproved while in rural areas the sanitation facility access is 35% unimproved.15% of South African infants are born with a low birth weight.[109]5% of South African children are so underweight they are considered to be wasted. Since the 1990s South Africa's malnutrition problem has remained fairly stable.[110]The 2014 CIA estimated average life expectancy in South Africa was 49.56 years.[111]

The 2010 maternal mortality rate per 100,000 births for South Africa is 410. This is compared with 236.8 in 2008 and 120.7 in 1990. The under 5 mortality rate, per 1,000 births is 65 and the neonatal mortality as a percentage of under 5's mortality is 30. The aim of this report is to highlight ways in which the Millennium Development Goals can be achieved, particularly Goal 4 – Reduce child mortality and Goal 5 – improve maternal health. In South Africa the number of midwives per 1,000 live births is unavailable and the lifetime risk of death for pregnant women 1 in 100.[112]

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[108] The HIV & AIDS and STI Strategic Plan for South Africa 2007 – 2011; www.tac.org.za/documents/NSP Draft1.
[109] UNAIDS South Africa, http//www.unaids.org/en/regions_countries/countriessouth_.africa.asp.
[110] Ibid.
[111] "CIA - The World Fact book Life Expectancy". *Cia.gov*. Retrieved 2015-09-25.
[112] "The State of the World's Midwifery". United Nations Population Fund. Retrieved September2015.

3.6.3 Medical Savings Accounts

South Africa has both a public health care system and a private health care system. For the most part, health care delivered through the public system is free of charge to users while patients pay for care delivered in the private sector. The private health care sector has been growing in the wake of public-sector cutbacks and issues relating to the quality of care.

After deregulation of the private insurance market in 1994, insurers began to offer a wide range of health insurance programs including medical savings account plans. Since their introduction, MSAs have grown to half of the private insurance market.[113]MSAs allow individuals to pay for medical expenses that are less than the deductible amount specified in their medical insurance policy as well as for certain types of health care that are not covered by insurance.MSAs are health care accounts, similar to bank accounts, set up to pay for the health care expenses of an individual (or family). They are often established in conjunction with high-deductible (or catastrophic) health care insurance. Money contributed to an MSA belongs to, and is controlled by, the account holder, accumulates on a tax-free basis and is not taxed if used for health care purposes. MSAs usually involve three levels of payment. First, money in the account is used for normal medical expenses. Next, if the account is exhausted and the deductible has not been reached, the expenses are paid out of pocket. Third, the insurance policy covers expenses beyond the deductible.

The general theory is that consumers would make more judicious and cost- effective decisions if they were spending their own money, rather than relying on the public purse. There are several different ways of structuring these accounts. MSA systems have been operating in a few countries, including South Africa and Singapore. The Singapore government's philosophy of health care delivery can be summed up in the following words individual responsibility coexisting with government subsidies to keep health care affordable. An overview of the Singapore health care system describes the system this way: Patients are expected to pay part of the cost of medical services which they use, and pay more when they demand a higher level of services. The principle of co-payment applies even to the most heavily subsidized wards to avoid the pitfalls of providing "free" medical services.

[113] htt://publication.gc.ca/collection-r/lopbdp/bp/prb-e.htm#%2812%29.

3.7 Comparative analysis between Ghana and South Africa's health systems

Over the past few decades, health sector reforms in many African and other low- and middle-income countries have increased inequities in access to affordable health care. A growing reliance on out-of-pocket payments and privately organized care has resulted in health care provided on the basis of ability-to-pay, which has disadvantaged lower-income socioeconomic groups.

The 2005 World Health Assembly called for universal coverage in health systems.[114] WHO defined this as securing "access to adequate health care for all at an affordable price". This definition allows for a high level of fragmentation in health-care provision and financing. Fragmentation refers to the existence of a large number of separate funding mechanisms (e.g. many small insurance schemes) and a wide range of health-care providers paid from different funding pools. Different socioeconomic groups are often covered by different funding pools and served by different providers. Fragmentation reduces the possibilities for income and risk cross-subsidies in the overall health system. Although WHO adds that a "crucial concept in health financing policy towards universal coverage is that of society risk pooling", this aspect appears to be ignored in many of the policy prescriptions directed at low- and middle-income countries in recent times.[115]

The aim of this analysis is to explore the extent of fragmentation within the health systems of Ghana and South Africa, how this developed; how each country has attempted to address the equity challenges arising from this fragmentation and what remains to be done to promote universal coverage. Under colonial rule, many African countries, including Ghana and South Africa, organized their health systems primarily to benefit a small elite group of colonials and their workers.[116]Health-care provision occurred mainly through hospitals in urban areas, with direct payment at the point of use. The rest of the population relied on services from a range of providers such as traditional healers and missionary health centres.

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114 *S*ustainable health financing, universal coverage and social health insurance *[World Health* Assembly Resolution WHA58.33]. Geneva: WHO; 2005.

115 The business of health in Africa: partnering with the private sector to improve people's lives. Washington, DC: The World Bank Group; 2008.

116 Arhin-Tenkorang D. Mobilizing resources for health: the case for user fees revisited [Working paper no. 81]. Cambridge, MA: Harvard University; 2001.

After independence, the governments of Ghana provided medical care free of charge to their populations at public health facilities. Health care was financed through general taxes and external donor support, user fees were removed and attention was directed to developing a wide range of primary health-care facilities across the country. Post-colonial South Africa, in contrast, did not usher in democratic elections, and apartheid policies reinforced inequities in the distribution of health services between the urban and rural population as well as along racial lines.[117] User fees remained in place, albeit relatively token. In addition, private voluntary insurance organizations, called medical schemes, were established by mining and other companies as a way to provide for the health-care needs of their "white" employees.[118]In the 1980s, Ghana initiated health sector reforms as part of broader structural adjustment programmes under the guidance of The World Bank and the International Monetary Fund.

These macroeconomic policies, embedded in neoliberal ideology, aimed mainly at reducing government spending to address budgetary deficits, introducing cost recovery mechanisms through user fees and liberalizing health services to allow private sector involvement. Although not under similar pressure from international financial institutions, the South African government subscribed to many of the prevailing neoliberal macroeconomic policies of the time and introduced similar reforms. In particular, South Africa increased the level of user fees substantially and vigorously promoted the growth of the private health sector.[119]

The reforms in both countries had a profound impact on the financing and organization of the health sector. The liberalization of the health sector led to a rapid increase in the number of private health providers, many of them informal and unregistered. In general, these health sector reforms undermined the potential for cross-subsidies in the overall health system and resulted in increased inequalities in access and utilization of health services.

By the end of the 1990s, public resources for the health sector had declined sharply and health system funding relied heavily on cost recovery policies and voluntary health insurance. Following the re-introduction of user fees, the utilization of health services

[117] McIntyre D, Thiede M, Nkosi M, Mutyambizi V, Castillo-Riquelme M, Goudge J, et al. *A critical* analysis of the current South African health system. Cape Town: University of Cape Town and University of the Witwatersrand; 2007.

[118] Inquiry into the various social security aspects of the South African health system: policy options for the future. Pretoria: Department of Health; 2002.

[119] McIntyre D, Thomas S, Cleary S. Globalization and health policy in South Africa. *Perspect Glob Dev Technol* 2004; 3: 131-52.

decreased significantly in Ghana, particularly among people on low incomes.[120] As well as the decline in utilization, user fees were also associated with delays in seeking treatment and increased reliance on self- medication. An additional component of financing reforms during this period was the introduction of risk sharing strategies through community based health insurance (CBHI) in Ghana and the dramatic increase of private voluntary health insurance in South Africa. These voluntary insurance schemes have fuelled health system fragmentation, with over a hundred individual medical schemes in South Africa and, similarly for CBHI, in Ghana even though they cover a small proportion of the population (less than 14% in South Africa, and less than 1% in Ghana.[121]

The current fragmentation of the health system into large numbers of small insurance risk pools, especially in South Africa and until recently in Ghana, and the relatively high share of out-of-pocket expenditures as a percentage of total expenditure on health (, 45% in Ghana and 11% in South Africa) severely limit the potential for universal coverage.[122] Out-of-pocket payments represent the most extreme form of fragmentation as they place the burden of health-care funding on an individual and translate into health service use, and hence benefits, being distributed according to ability-to-pay rather than need for health care. Health services for different socioeconomic groups and groups with varying health-care needs are not financed in the same way. For example, although CBHI schemes often cover relatively poor communities, they exclude the poorest.[123] Similarly, private voluntary insurance schemes in South Africa cover the wealthiest groups and have sought to exclude those with the greatest health risks who are then dependent on publicly funded health care for which they are generally required to pay user fees (except at the primary care level). This effectively prohibits risk-related and income-related cross-subsidies between groups of different socioeconomic status and health-care needs.

The effects of fragmentation are that: First, some households face a “catastrophic” burden of health-care payments, with expenditure that exceeds 10% of total household

120 Waddington C, Enyimayew K. A Price to Pay, Part 2: The Impact of User Charges in the Volta region of Ghana. Int J Health Plann Manage 1990; 5: 287-312doi.

121 Atim C. Contribution of mutual health organizations to financing, delivery and access to health care: synthesis of research in nine west and central African countries. Bethesda, MD: Partnerships for Health Reform; 1998.

122 National Health Accounts database. Geneva: WHO; 2007. Available from: http://www.who.int/nha/country/Annex1&2,%20March%205,%202007.xls [accessed on 25 August 2015].

123 Ekman B. Community-based health insurance in low-income countries: A systematic review of the evidence. *Health Policy Plan* 2004; 19: 249-70doi.

income or 40% of non-food household expenditure.[124] For example, it was estimated that 1.3% of households in Ghana experience “catastrophic” payments (which is above average from a study of 59 countries).Second, poorer groups are not able to benefit from publicly funded health services to the extent that their relative burden of ill-health would suggest, as their utilization is deterred by user fees. For example, while the poorest quintile of the population in Ghana in the 1990s received 12% of the benefit of using public health services, the richest quintiles received 33%; finally, an effect of fragmentation in South Africa, which is not evident in the Ghana, is an uncontrolled cost spiral within the private sector. This is largely due to the inability of the many separate medical schemes to negotiate effectively with powerful collectives of private sector providers. Thus, fragmentation is not only of concern from an equity perspective, but also in relation to health system efficiency and affordability.

3.7.1 Promoting cross-subsidies

It is worthwhile considering whether and how both countries have set about addressing the equity problems of their highly fragmented health systems. User fee exemptions and waivers have been implemented as partial remedies for the lack of a comprehensive system of cross-subsidies in both countries, in an effort to reduce the economic burden of ill health on poor and vulnerable households and improve access to health care. The current South African health system features free health care for vulnerable groups (particularly pregnant women, children aged less than 6 years, the disabled and the elderly), waivers for the poor and free primary health services for all. In Ghana, exemptions focus mainly on diseases regarded as being of public health importance (e.g. leprosy, tuberculosis), specific services for children and pregnant women (e.g. immunizations, antenatal care) and people with extremely low incomes.

In both countries, exemptions for specific demographic groups and diseases have been implemented relatively successfully. However, waivers directed at protecting the poorest people have proven to be ineffective, largely due to the perennial problem of identifying them, as well as a lack of awareness on eligibility criteria and the deterrent of excessive “red-tape”. In addition, the issue of whether user-fee revenue lost from waivers is reimbursed influences the extent to which they are granted at facility level. For example, all exemptions and waivers in Ghana are meant to be reimbursed to

[124] Xu K, Evans D, Kawabata K, Zeramdini R, Klavus J, Murray C. Household catastrophic health expenditure: A multicountry analysis. *Lancet* 2003; 362: 111-7doi.

individual facilities out of pooled government and donor funds. Inadequate budgeting for exemption and waiver reimbursements and long delays in paying reimbursements has led to some facilities refusing to grant them.[125]

Developing effective mechanisms for identifying and protecting people with very low incomes is critical in both countries. Even if user fees were completely abolished, as is happening in a growing number of African countries, it would still be necessary to identify people with the lowest incomes to protect them in relation to other financing mechanisms (e.g. to partly or fully subsidize their health insurance contributions). In addition, if universal coverage is to be achieved, it is necessary to explore ways of achieving funding pools that are as large and integrated as possible, to maximize income and risk cross-subsidies and to allocate pooled resources in an equitable way.

The key pooled funding mechanisms for health care are tax (and donor) funding and health insurance schemes. Although African heads of state, through the 2001 Abuja Declaration,[126] committed themselves to allocating 15% of government budgets to the health sector, there has been progress towards this goal only in Ghana, where the health sector's share of the budget increased from 8.2% in 2004 to 15% in 2006.[127] A significant component of this growth results from increases in salaries and allowances in the health sector. In contrast, in South Africa the health sector's share of the government budget has in fact declined from 11.5% of the total government budget in 2000/2001 to 10.9% in 2007/2008.[128]In relation to health insurance schemes, there has been little progress in expanding insurance coverage within South Africa.

The uncontrolled spiral in medical scheme expenditure and contributions has in fact contributed to a decline in the proportion of the population covered from 17% in the 1990s to about 14% currently. The benefit package has also declined, with many schemes only covering inpatient care and chronic illnesses specified in the Prescribed Minimum Benefits regulation. In contrast, Ghana has made significant progress in

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[125] McIntyre D. Aligning exemption policy and practice with poverty reduction goals: report of the Annual Health Sector Review 2002. Accra: Ministry of Health; 2003.

[126] Abuja Declaration on HIV/AIDS. tuberculosis and other related infectious diseases. Nigeria: Organization of African Unity; 2001.

[127] The Ghana health sector 2007 programme of work. Accra: Ghana Ministry of Health; 2007.

[128] McIntyre D, Thiede M, Nkosi M, Mutyambizi V, Castillo-Riquelme M, Goudge J, et al. A critical analysis of the current South African health system. Cape Town: University of Cape Town and University of the Witwatersrand; 2007.

expanding insurance coverage.[129]In both countries, until the recent introduction of mandatory insurance, community-based health insurance had been the predominant form of health insurance and it had achieved very limited coverage. These schemes generally only cover outpatient care at primary health-care level.

Ghana has taken the boldest steps towards universal coverage by introducing an NHI scheme in 2003, which will ultimately cover all Ghanaians. By December 2007, 55% of the population had registered with the NHI and 44% had received their membership cards.[130] The mandatory health insurance schemes in both countries cover quite comprehensive outpatient and inpatient services at public sector and accredited nongovernment facilities. It is not only expansion of population coverage by pooled funding that is important from a universal coverage perspective but also the degree to which different funding pools are integrated. In South Africa, there has been some consolidation of insurance coverage, with the number of medical schemes declining over the past few years. Nevertheless, there remain over 120 schemes, each with several benefit options that operate as separate pools, severely fragmenting the pooling of risk across the insured population.[131] There is an intention to introduce a risk-equalization mechanism between these separate schemes but this is yet to be implemented.

In Ghana, each of the district mutual health insurance schemes that comprise the NHI effectively constitutes a separate risk pool. The NHI fund could assume risk-equalization responsibilities, but this has not been done explicitly to date. Instead, it simply transfers certain funds to individual district mutual health organizations. These include the payroll-based health contributions of formal sector employees and government funds used to subsidize the contributions of informal sector workers and the poor. Risk-equalization is a mechanism for allocating resources that are pooled via health insurance. Mechanisms are also required to ensure the equitable allocation of funds pooled via tax revenue. Both mechanisms for risk-equalization between insurance schemes and for the allocation of general tax resources ensure that the relative risk of ill-health or likely health-care needs of the population served are taken into account.

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129 Independent review: health sector programme of work, 2007. Accra: Ministry of Health, Ghana; 2008.

130 Annual Report *2006 -7*. Pretoria: Council for Medical Schemes; 2007.

131 Ibid.

Both Ghana and South Africa use some form of needs-based formula for guiding the allocation of tax resources between different geographic areas. For example, Ghana uses a formula including the regional population size, the population below the poverty line and rates of under-5 mortality to determine the allocation of tax and donor-pooled funds for non-salary budgets in the health sector. In South Africa, budgets for the full range of services provided by provinces are allocated to provinces on the basis of a formula which includes estimates of the relative need for these services, with the health component being based largely on the size of the population not covered by private health insurance.

There is growing international consensus that out-of-pocket payments are contrary to the goal of universal coverage, particularly given the ineffectiveness of fee waivers in providing financial protection to the poor. There is also consensus that universal coverage can only be achieved through prepayment funding mechanisms. However, it is of concern that financing strategies (such as CBHI and private voluntary health insurance) that inevitably further fragment health systems are still being promoted as useful financing mechanisms for low- and middle-income countries.[132]The analysis presented indicates that South Africa has made the least progress in addressing fragmentation, while Ghana appears to be pursuing a universal coverage policy in a more coherent way. To achieve universal coverage, the size of risk pools must be maximized. Further, resource allocation mechanisms must be put in place, whether these are to equalize risks between individual insurance schemes or to equitably allocate general tax (and donor) funds.

3.8 Conclusion

South Africa, as a member of the international community is bound by constitutions of its membership on respective international treaties. The World Health Organisation for instance obliges member states to prioritise issues in respect to provision of health services. The focus has been to meet the Millennium Development Goal set by the international community in respect to the provision of basic service delivery, including the provision of health services to the entire population. African states like their counter parts embarked on introducing policies that will change the completion of the health

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132 College of Health Sciences, University of Ghana, Accra, Ghana.

system to its entirety. Thus South Africa should be inspired by transformation that took place in countries such as Singapore, Ghana and Nigeria. The comparative study between countries has indicated that there is a lot South Africa can learn to improve its national health system. It has also highlighted the idea to investment in the health system, to the extent that potential investors are able to form partnership with government departments or institutions focused on delivering of health services to communities at large.

CHAPTER FOUR: PROSPECTS AND CHALLENGES

4.1 Introduction

The National Health Insurance Scheme is a huge project the government is manifesting its roll out. However, there are mixed feelings from opinions, suggestions and facts by academics, stakeholders, ordinary citizens, critics and those from different background including politicians from different political spectrum. They talk with different volumes, some suggest that the implementation of the NHI is curtailed with a magnanimous vision of a caring government, and so its success is inevitable. However, critics are concerned about issues that can hinder the success of this huge project, and cite fears of corruption, lack accountability, insufficient funding, and others as obstacles. This chapter looks into some of these aspects at length and form the basis of recommendations found later in chapter 5.

4.2 Prospects of the National Health Insurance Scheme in South Africa

South Africa has the capacity to host big events and programmes. In 2010, South Africa hosted the Soccer World Cup with great success. Prior to the world cup event, the government together with stakeholders built up stadiums, upgraded infrastructure, maintained roads and railway system. The security was beefed up and maintained at a high standard. There were no complaints from visitors who indeed commended the excellent hospitality displayed by South Africa. Prior to 2010, South Africa has also hosted many big events in 1995, such as the Rugby World Cup, Africa Cup of Nations (AFCON), the World Summit on Sustainable Development in 2002, and many other international conventions that were hosted at high standard.[133] So there is no doubt that the government together with stakeholders would fail to successfully implement and succeed in rolling out the national health insurance scheme programme.

The prospect of success of the national health insurance scheme may well depend on the leadership capabilities. South Africa has leaders with potential, the country has a history of producing remarkable leaders who were visionary and contributed immensely to the establishment of a democratic society, amongst them are the joint

[133] The Rugby World cup, Cricket World cup, A1 Grand Prix, Indian Premier League, World Cups of Golf, Athletics, Swimming, and the biggest of all was the 2010 FIFA World Cup.

noble prize winners namely, Nelson Mandela and F W De Klerk.[134] There is hope that with similar potential, human resources and vision the success of the National health insurance scheme cannot be doubted. The leadership, particularly in the African National Congress sought to make this a reality. The provisions and principles set in the freedom charter of 1955 dictates that South Africa must work towards implementing the establishment of a health scheme or programme that will ensure access to health services of all South Africans. With a similar objective to the notion of creating a non-sexist and non-racial democratic South Africa which was then realised in 1994, the leadership insist that a lot of work still lies ahead. The attainment of our democracy was achieved through magnanimous, good personality, well-disciplined and quality leadership, there was capacity.

Today, the government led by the African National Congress is on the forefront of implementing the principles and demands set in the freedom charter of 1955, which is now enshrined in the Bill of Rights of our Constitution. Since the appointment of Dr Aaron Motswaledi as the Health Minister a lot of obstacles have been identified and solutions are being found to ensure that the health system caters for all South Africans regardless of their degree of affordability. He has worked tirelessly to reduce both the trends of HIV/AIDS and TB, and prioritize the building of health care facilities. The government executive mandates that ministers should prioritise service delivery and appoints leadership with great potential and expertise. In regards to the National Health Insurance Scheme, South Africa has a lot of pool of potential leaders with capacity to lead the implementation.

4.3 Challenges of the National Health Insurance Scheme in South Africa

The National Health Insurance Scheme faces a number of challenges ranging from efficiency, funding system, skill shortages, corruption, failing to meet the millennium development goal deadline etc. The government need to contain all these possible challenges if the national health insurance scheme is to succeed. The government of South Africa should take lessons from countries like Ghana and Nigeria where a similar project was implemented. As things stands, it is clear that South Africa will walk

[134] The Nobel Peace prize winners in 1993 were awarded jointly to Nelson Mandela and F W De clerk. - www.nobelprize.org/.../1993/.

on the same path as done by Ghana and Nigeria, and experience similar challenges as mentioned above.

4.3.1 Elements hindering efficiency

The NHI scope is governed and guided by Section 27 of Constitution; thus it observes these principles: the right to access, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency.[135]The public has lost faith in the health-care system of South Africa and its service providers, particularly in those working for the state. The NHI policy focuses predominantly on the creation of a prodigious health-care system; however, it does not address the behavioural issues and the shortage of efficient, skilled and professional health-care workers.

The majority of small community clinics and public hospitals, particularly in the rural or semi-urbanised areas, are staffed by health-care workers who possess neither skills nor a professional code of practice. Most low-income citizens are dissatisfied by the quality of service they receive from these facilities, mainly owing to the negligent attitude of the staff. There is little chance that those who are on medical aids will abandon private hospitals, and, it is unrealistic for the planners of the NHI to suppose that the private sector will suffer long-term effects from the implementation of the NHI.[136]Implementation is progressing positively in many areas however, there are considerable issues that require serious attention, particularly the financing and service delivery aspects, and thus require thoughtful management.

Accessibility to health services is a major development problem facing sub-Saharan African countries. The prevalence of poverty and unemployment is a major hindrance to making health services accessible to the population especially the poor. Many development theories have been on how to make basic services affordable and accessible to the poor. The World Development Report 2004 focuses on making services work for the poor.[137] The government of Ghana for instance introduced

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135 Section 27 of the Constitution of the Republic of South Africa Act 108 of 1996.

136 The implementation of the National Health Insurance Scheme would not have an impact on the day by day running of the Private health sector, because the public sector where the National Health Insurance is based lacks efficiency, and is characterised with poor service.

137 World Bank (2004) World Development Report, 2004 making basic services work for poor people, World Development Report 2004 says poor must be put at centre of service provision. The World Bank released its report, which addresses why government services fail poor people and how they can be improved. Drawing on successful examples from around the globe, the report recommends putting poor people at the centre of the provisions of basic services such as health, education, water, and electricity.

nationwide National Health Insurance Scheme (NHIS) with the aim of providing health insurance and making health services accessible and affordable to the average Ghanaian. The 'cash and carry system' that existed before the introduction of the National Health Insurance Scheme made health services quite inaccessible to the poor. The 'cash and carry system' compelled patients to pay for the cost of health services before they were given the desired medication. The poor resorted to self-medication with its accompanied complications and problems.

4.3.2 Shortage of doctors

In March 2012, South Africa had 165 371 qualified health practitioners in both public and private sectors were registered with the Health Professions Council of South Africa, the health practitioner watchdog body. This includes 38 236 doctors and 5 560 dentists. The doctor-to-population ratio is estimated to be 0.77 per 1 000. But because the vast majority of GPs – 73% – work in the private sector, there is just one practising doctor for every 4 219 people. In response, the Department of Health has introduced clinical health associates, midlevel health-care providers, to work in underserved rural areas. About 1 200 medical students graduate annually. In some communities, medical students provide health services at clinics under supervision. Newly graduating doctors and pharmacists complete a year of compulsory community service in understaffed hospitals and clinics.

In an attempt to boost the number of doctors in the country, South Africa signed a co-operation agreement with Cuba in 1995. South Africa has since recruited hundreds of Cuban doctors to practice here, while South Africa is able to send medical students to Cuba to study. South Africa believes the Cuban opportunity will help train the doctors it so desperately needs for the implementation of the National Health Insurance Scheme. Other agreements exist with Tunisia and Iran, as well as between Johannesburg Hospital and Maputo Central Hospital. The government has also made it easier for other foreign doctors to register here.[138]The Allied Health Professions

[138] Health Care South Africa – South Africa's health system consists of a large public sector and small but entered into an agreement to recruit 2000 Tunisian doctors, and in addition 450 doctors from Cuba and Iran have also been employed by the health department of South Africa - www.mediaclubsouthafrica.com/compon...

Council of South Africa had 3 773 registered "complementary health" practitioners in 2012.

4.3.3 Meeting targets of the Millennium Development Goals

South Africa is a signatory to several international commitments such as the UN's Millennium Development Goals (MDGs), which seeks to address the health needs of women and children. However, in South Africa the health of mothers and children remains poor.[139]According to statistics from WHO, South Africa has a maternal mortality ratio of 310 deaths per 100 000 lives births. The infant (under-1) mortality rate in 2010 was 41 deaths per 1 000 live births, while the under-5 mortality rate was 57 per 1 000 live births.

Under the national prevention of mother-to-child (PMTCT) programme, every pregnant woman is offered HIV testing and counselling. If a woman tests positive for HIV, she is put on to a regime of anti-retroviral therapy to avoid transmitting the virus to her baby, and is offered a continuum of treatment, care and support for herself and her infant. But it is really access and utilisation of antenatal care services that most influence pregnancy outcome, child survival and maternal health. The renewed focus on primary health and the improving and expanding the health system infrastructure should go some way to addressing the high mortality rates – and get South Africa closer to the MDG target of reducing infant mortality to 20 by 2015.

The Department of Health has a strategic plan in place which identifies "priority interventions" that will have the greatest influence on reducing mortality rates, as well as enhancing gender equity and reproductive health. The campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), an African Union initiative, was launched in May 2012 and aims to reduce maternal and infant mortality rates. However, the interventions may fail to meet the time frame set in accordance of the Millennium development goal targets.

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139 The Millennium development goals for 2015 are to eradicate hunger and poverty, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, ensure environmental sustainability, develop a global partnership for development – www.za.undp.org/.../mdgoveriew.html.

4.3.4 Corruption

The government has to root out corruption in its ranks if the National health insurance scheme is to be a successfully project. The project requires a huge amount of funds for its implementation. There is great need for those responsible to be accountable. In previous occasions government enterprises has failed to produce required and expected results due to corruption and partly due to mismanagement of funds. There is fear that if this is not closely monitored corruption can cripple the hopes of a huge project which is expected to transform the health system from its fragmented state, so that it caters for all regardless of reasons of affordability.

Fears of corruption and mismanagement brew from current instances where government enterprises are struggling to excel. South African post office has been tainted with controversies of corruption and mismanagement. Thus the year 2013-2014 it was crippled by labour unrest and protests which took long to be resolved. The workers led by their union representatives identified elements of corruption and mismanagement within the ranks of management of the South African post office. It did not end there, in another instance South African Airways was at some point reported bankrupt and requested government to bail it out when its operation nearly came to a standstill. It is not understood as why and how an entity as big as the South African Airways could go bankrupt and unable to fund its operations. The latest instance is about Eskom where even today its operations are still in doubt to restore the investors' confidence to carryout business in South Africa.

The continuous load shedding experienced throughout has not been given a comprehensive explanation and it is suspected that the government owned utility maybe facing a crisis within its management ranks and mismanagement has never been a lonely factor if it is not accompanied with corruption.[140] The essence of the matter is that government appoints people who are money hungry to run and head its businesses, where as a result these incumbent would sought an opportunity to benefit themselves of funds at their disposal met to be used to implement programs of the projects. Thus the implementation of the National Health Insurance fund must be

[140] State Owned Enterprises compete with private companies and should therefore be subject to the same high standard with regards to accounting, auditing and reporting. In addition to corruption risks facing companies in general, State Owned Companies are also exposed to specific governance challenges due to their proximity to policy makers and market regulators.

closely monitored and elements of corruption must be dealt with severely to promote its success.

4.3.5 Lack of sustainable methods of funding

The project is expected to cost an estimated amount of R376 billion by 2025. It is clear that the amount of money required is huge yet government lacks a sustainable source of funding method. Government has sought that the National Health Insurance Scheme is to be funded by means of taxable income payroll for employers and employees, and an increase value added tax.[141] There is great concern from the workers federation, COSATU that it does not support taxable income payroll for employees' contribution to the scheme. COSATU feels that this notion will put the workers under huge financial constraints, it will jeopardize the financially circumstances of the people who are supposed to benefit from the project. The government cannot rely on funds from donors or foreign financial assistance as a method to fund the project because if the donors or foreign aid is withheld, then the project will starve and cease on its implementations.

4.3.6 The National Health Insurance Scheme as a socialist model

There are doubts to the success of the National Health Insurance Scheme project. The NHI is regarded as a project derived a collective socialist ideology to provide health service to all South Africans. The confrontation of political ideology between the capitalists and socialists has not yet ceased to exist, and continues to exist even beyond the 21st century. Fears are that the capitalists may be reluctant to support a socialist programme but ensure that it does not succeed.[142] The capitalists seem to be in a stable position in terms of their economic cap-standing. They have resources at their disposal, and their lack of support will be detrimental to the NHI project. In previous instances, the capitalists failed to rally behind government's Reconstruction and Development Programme. They found no interest in this socialist policy and partly influenced government to abandon it at a later stage, the RDP ultimately failed.

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141 Bauer N 2011. Pushing up VAT the lest damaging way to fund NHI. http://mg.co.za/article/2011-09-12-push-up-vat-its-the-right-thing-to-do. (Retrieved on the 21 March 2015).

142 The National Health Insurance Scheme initiative is a socialist model, but the conditions in which South Africa operates is capitalist, and they ask how the NHI is going to operate under such conditions – pmg.org.za/committee-meeting/15944/.

The capitalists funds the private health sector which serves slightly above 20% of the population, and the private health sector is doing well though. The NHI project is aimed at making health service accessible to all South Africans regardless of reasons of affordability. This might well clash and interfere with the capitalists' ambitions that have already invested in the private health sector and skimming off profit. There is no doubt that the government's implementation of the NHI will be detrimental to the capitalists who already depended in making profit from the private health sector.[143]

After government abandoned the RDP it adopted the Growth Employment and Redistribution.[144] The later gained support of both since it benefited business and created employment, thus it succeeded. In this instance it is therefore to be seen as to whether the two will cooperate to further a common interest and set aside their political ideologies. The government 's implementation of the NHI project can only be successfully if it is supported by all stakeholders regardless of their political beliefs, affiliation, business, employees, employers investors, government, and non-governmental organisations.

4.3.7 Enforceability and justiciability of objects of the National Health Insurance and National Health Act

The objectives of the NHI and NHA coincides, it both aim at ensuring that all South Africans have access to health care services regardless of their reasons of affordability. The Constitution set an obligation on the state to ensure that progressive realisation of rights enshrined in the bill of right are protected and realised. The government is required by the Constitution to provide with available legislative frameworks and to enforce the delivery of health care services to all South Africans, thus the Parliament promulgated the National health Act no. 61 of 2003 and other related legislations to regulate the National Health Insurance Scheme.[145]

The essence of the matter is as to whether the right of access to health care service is enforceable. Section 38 of the Constitution provides enforcement of rights and encourages that anyone whose right has been infringed and threatened may approach

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143 Ibid.

144 Reconstruction and Development plan (RDP) together with Growth Employment, and Redistribution (GEAR) were Government policies adopted to facilitate basic service delivery, economic growth and creation of employment.

145 Constitution of the Republic of the South Africa Act no.108 of 1996, the National Health Act 61 of 2003, other legislative frameworks and international conventions.

the court alleging that his / her right has been infringed, and the court may grant appropriate relief, including declaration of right.[146] The provision of health care service is a socio – economic right, and the question is as to whether socio – economic rights are enforceable through court action. The courts have a responsibility to hear and adjudicate on case brought before it alleging that such a right has been infringed.

In the previous instance of *Soobramoney v Minister of health (Kwazulu Natal),* the Constitutional court discussed the nature of socio – economic rights and problems of them in the first certification judgment and responded to some of these arguments.[147] It is true that the inclusion of socio – economic rights may result in courts making orders which have direct implications for budgetary matters. However, even when a court enforces civil and political rights such as equality, freedom of speech and the right to a fair trial, the order it makes will often have such implications. A court may require the provision of legal aid, or the extension of state benefits to a class of people who formerly were not beneficiaries of such benefits. In my view it cannot be said that by including socio - economic rights within the bill of rights, a task is conferred upon the courts so different from that ordinary conferred upon them by the bill of rights that results in a breach of separation of powers.

Mr *Soobramoney 's case* must be seen in the context of the needs which the health services have to meet, for if treatment has to be provided to Mr *Soobramoney* would also to be provided to all other persons similarly placed. Although the renal clinic could not keep open for long hours, it would involve additional expense in having to pay the clinic personnel at overtime rates, or having to employ additional personnel working on shift basis. It would also put a great strain on the existing dialysis machine which already shows signs of wear. It is estimated that the cost to the state of treating one chronically ill patient by means of renal dialysis provided twice a week at state hospital is approximately R60 000 per month. If all the persons in South Africa who suffer from chronic renal failure were to be provided with renal dialysis treatment, the cost of doing so would make some substantial inroads into to the health budget. And if this principle were to be applied to all patients claiming access to expensive medical treatment or expensive drugs, health budget would have to be dramatically increased to prejudice of other needs which the state has to meet.

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146 Section 38 of the Constitution of the Republic of South Africa Act no.108 of 1996.

147 *Soobramoney v Minister of health (Kwazulu Natal) (CCT32/97), Minister of Health v Treatment Action Campaign (2) 2002 (5) SA 721 (CC).*

The Constitutional court confirmed that the socio – economic rights in the bill of rights are justiciable, at the least be negatively protected from improper invasion. Negative protection is merely the minimum extend to which the rights can be judicially protected and does not exhaust the possibilities of justiciability.[148] The constitutional court cautions approach to reviewing government compliance with social economic rights. The socio – economic rights are further limited by the qualification that they are only available to the extent that state resources permit. In the absence of available state resources, the failure of the state to address socio economic rights is therefore a violation of rights. However, the court made no references to the limitation clause in the Treatment action campaign case to justify the deficiencies in the state programme for the prevention of mother to child transmission of HIV as legitimate limitations of right to health care service. In the *Treatment action campaign case* the violation Section 27(2) was caused by a failure to develop a comprehensive programme to combat mother to child transmission of HIV.[149]

4.4 Conclusion

On paper, the National Health Insurance Scheme seems a good policy. However, the implementation of this policy might become difficult, and can be met with numerous challenges that includes, lack of resources required in the implementation, lack of competent leadership, political instability, and corruption to mention a few. Though South Africa has resources and capable of mastering projects to the magnitude of the National Health Insurance Scheme, history has shown that the government has failed to master any of its policies since 1994. The failure of the Reconstruction and Development Programme (RDP), Growth Employment and Reconstruction (GEAR) simple gives an impression that the success of the National Health Insurance Scheme can be in doubts. The success of the National Health Insurance Scheme can be achieved if all these challenges are countered, and stringent conditions should be put in place to ensure that the National Health Insurance policy is implemented with success.

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148 Bill of Rights handbook, Iain Currie & Johan de Waal – Fifth addition.

149 Section 27 (2) of the Constitution of the Republic of South Africa Act 108 of 1996.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Admittedly, South Africa's health care system is very much challenged and constrained in providing quality health care to all her citizens, most especially the unemployed and the poor. Contrary to its stated objectives, the NHIS coverage is still very limited and exclusive, as only the health needs (partial) of South Africans in the formal sector are covered at present. Thus the vast majority of South Africans who are either unemployed or earn their living in the informal sector are not included.

The objective of government in providing for the health care needs of the people is lauded. Yet its attainment is contingent upon the resolution of the challenges as listed above. The resolution of the challenges is located in the establishment and operations of the health insurance scheme which was inaugurated in 2012. The objectives of the scheme are also commendable and achievable. However it is also challenged in many fronts, with the possibility of diminishing its successful implementation. The key challenge for South Africa's Health Sector is to achieve the targets of the Millennium Development Goals (MDGs), (Millennium Development Goal Summit, 2000), and they include:[150]

- Reducing maternal mortality by three-quarters by 2015;
- Halting by 2015 and reversing the incidence of malaria and other major diseases;
- Reducing the under-five mortality rate by two-thirds by 2015; and
- Halting by 2015 and reversing the spread of HIV/AIDS. (NPC, 2004).

In conclusion, there is no doubt that and NHI could prove to be a sustainable method for rolling out an accessible and affordable health-care system; however, stringent caution must be exercised and the project monitored closely to eliminate failures like those of the past.

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150 The Millennium development goals for 2015 are to eradicate hunger and poverty, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, ensure environmental sustainability, develop a global partnership for development – www.za.undp.org/.../mdgoveriew.html.

5.2 Recommendations

For the NHI to thrive, the government will need to carefully reconsider the causes of the deteriorating conditions in the government hospitals, the poor service and increased mortality, and eradicate corruption and mismanagement of state facilities, resources and fiscal funds. In view of past failures in the implementation of such initiatives and their viability in South Africa, it is important for government to understand that little is known and understood by the service providers and users; thus it is important that the government ensure that both users and providers understand the policy. To address these challenges it is imperative that the following steps are taken:

- Intensify public awareness. More intensive public intensive awareness programmes should be created to enlighten the people and relevant groups on the positive values of the scheme. The attributes of the scheme should be well publicised by translating it into the major South African languages to enable the people to understand and appreciate its values and objectives.
- Diversify source of funding. It should be noted that pay-roll contributions by employers and employees are not the only way possible to fund the provision of health for the people. People's health care can also be insured through special tax contributions. For example, a health trust can be created to bridge subsidy gaps. Such a fund can be derived from incomes that accrue from petroleum products and customs duties, etc. This will remove the problem of funding on the part of and affordability by would-be participants, which for now deny majority of the populace universal access to health care. However until this is attained, government should increase its funding of the scheme in order to provide qualitative health services to the poor and fast-track the attainment of universal health in the country.
- Increased coverage. The scheme should be expanded to ensure that basic health needs of all citizens, irrespective of their social class and status are met. There is therefore the need for a legislation to make the scheme compulsory for all South Africans. In furtherance of this, a community health insurance scheme should be put in place for implementation by all the three tiers of government- National, Provincial and Local governments, as well as Non-governmental organizations (NGOs) and Community-based organizations (CBOs). mini-dissertation

Optimal and sustainable distribution of technological, physical, managerial and financial resources must be ensured in order to eliminate inequalities that exist within

the health institutions. To this end, basic elements or determinants (i.e. housing, water, livelihoods and sanitation) that contribute towards a healthy lifestyle should be taken into consideration. The overall objective of the study is to assess the contribution of the NHIS to health care delivery in the country and examine the sustainability challenges of the scheme. The study reveals that the NHIS has an objective of increasing Out-Patients-Department (OPD) attendance, reduction of self-medication and make health services more assessable to the poor. It is however, observed that for a sustainable national health insurance scheme to be achieved, issues such as maintaining and expanding the client base, regular payment of the services providers and ensuring the requisite institutional capacity should be given the deserved attention.

Government and the NHI district managers concerned need to strictly monitor and evaluate the pilot districts in order to detect and curb possible gaps for fraud or an enabling environment for corruption. Given the high unemployment rate in South Africa, the NHI budget should be tightly controlled, because there is a possibility that it may collapse due to lack of finances, as affordability of this insurance has been a major challenge in the past. Due to the shortage of general practitioners (GPs), the NHI proposes to source out 600 private GPs to provide services to NHI pilot districts. This is more likely to cause private GPs to raise their service-delivery prices, in view of the conditions they will have to serve under, particularly in the rural areas. Therefore, the NHI should rather consider utilising a high percentage of internships.

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