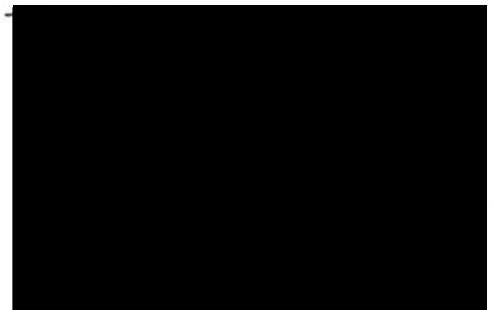


**The laws regulating National Health Insurance Scheme: prospects and challenges**

Justice Mpho Mathekgane

**A MINI-DISSERTATION SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF LAWS (LLM) IN LABOUR LAW IN THE SCHOOL OF LAW, FACULTY OF MANAGEMENT AND LAW, UNIVERSITY OF LIMPOPO (TURFLOOP CAMPUS)**

**SUPERVISOR: ADV. L.T NEVONDWE**



**2013**



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**ABSTRACT**

The current South African health system is comprised of two separate systems (public and private sectors). Majority of patients in the public sector are poor and unemployed while in private are employed and well-resourced to can be able to afford health care service of their own choice. The level of quality in both systems is totally different in that the private provide high quality health care, on the other the public sector one is that of lower quality. Section 27 of the Constitution guarantees “everyone” the right to have access to health care services (irrespective of one’s financial means). The South African government has now piloted the National Health Insurance scheme which seeks to address the current health care system status with the aim of ensuring equality and quality in both systems.

## DECLARATION BY SUPERVISOR

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

Signed 

Date 20/09/2013

**Adv. Lufuno Tokyo Nevondwe**

**2013**

## DECLARATION BY STUDENT

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

Signed



Date

16. September 2013

**Justice Mpho Mathekgane**

**2013**

## **DEDICATION**

This study is dedicated to my late grandmother, Mrs Maria Mmatshwene Rammutla, who acted as a mother for the past 28 years. My mother, Dinah Mmaphuti Mathekgane who have been with me throughout my studies. My wife to be, Ms Nonfundo Gama for pushing me to study where I lacked energy to do so. I express my profound gratitude for your comfort, encouragement, patience and support which made this project to be successful and enjoyable than it could have been without you.

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## LIST OF INTERNATIONAL INSTRUMENTS

Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights of 1988.

African Charter of Human and People's Rights, 27 June 1981.

American Declaration of the Rights and Duties of Man of 1948.

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

European Social Charter, 18 October 1961.

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

International Convention on the Elimination of all Forms of Racial Discrimination of 1966.

Universal Declaration of Human Rights, 10 December 1948.

## LIST OF ABBREVIATIONS

|        |   |
|--------|---|
| AIDS   | Acquired Immune Deficiency Syndrome                                   |
| ANC    | African National Congress   |
| ARV    | Antiretroviral  |
| BBP    | Basic Benefit Package   |
| CESCR  | Committee on Economic, Social and Cultural Rights                     |
| Codesa | Convention for a Democratic South Africa                              |
| FCBP   | Fully Comprehensive Benefit Package                                   |
| GDP    | Gross Domestic Product  |
| HIV    | Human Immunodeficiency Virus  |
| ICESCR | International Covenant on Economic, Social and Cultural Rights        |
| OSD    | Occupation Specific Dispensation                                      |
| NEC    | National Executive Council  |
| NGC    | National General Council  |
| NHI    | National Health Insurance   |
| PEPUDA | Promotion of Equality and the Prevention of Unfair Discrimination Act |
| PHC    | Primary Health Care   |
| PMB    | Prescribed Minimum Benefits   |
| PPP    | Public Private Partnership  |

|        |  |
|--------|--|
| TAC    | Treatment Action Campaign                              |
| TB     | Tuberculosis   |
| UDHR   | Universal Declaration of Human Rights                  |
| UNICEF | United Nations International Children's Emergency Fund |
| WHO    | World Health Organisation                              |

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## CHAPTER ONE: INTRODUCTION

### 1.1. Historical background to the study

South African community may be characterized into four socio-economic classes. These classes are comprised of the lower (those with no income at all, i.e. unemployed, job seekers, etc...), the middle (those with limited income, i.e. workers, grants dependents etc..), and the upper class (those with unlimited income). Within these classes there are those who can provide for their medical needs within their available means and those who are unable because of unemployment, poverty and other contingencies such ill health and disability. This creates a huge gap between the rich and the poor in as far as the health need is concerned. In trying to breach this gap, the government came with the concept of National Health Insurance (NHI).

However, due to these inequalities and inefficiencies in the health system, NHI system has been proposed and being placed under a as a mechanism for achieving equitable access to quality health services in South Africa. Inequality remains an enduring characteristic of the country's health system. Despite several policy measures, the public health system is still affected by the challenges of inadequate and inequitable access to health services attributable to delivery inefficiencies, poor-quality care, underfunding and a lack of social solidarity within the system.<sup>1</sup> The country is still characterised by wide disparities between the public and private health sector in the midst of escalating health costs.

Furthermore, access to medical aid is still racially unbalanced, with only 20% of the population having private insurance coverage, most of them white. The situation has been further exacerbated by the migration of health professionals and the Human

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<sup>1</sup> Botha C and Hendricks M, Financing South Africa's national health system through national health insurance: Possibilities and challenges., 2008, Colloquium proceedings, Human Sciences Research Council (HSRC) Press.

Immunodeficiency Virus and AIDS Acquired Immune Deficiency Syndrome (HIV and AIDS) pandemic.<sup>2</sup>

There is no question that health is important to the individual, the family, the community, the nation and at global level. Social security systems recognize the concept of entitlement to a benefit in his or her own right. In the absence of a mechanism to protect the health of the individual, we see the lack of this right already at the individual and family levels. A parent may forgo seeking care in favour of medical attention of a child, or an elderly dependent parent. Yet at national level, we find incompatibility in the importance given to health and the resources allocated to protecting health.<sup>3</sup>

Debate about the NHI predates 1994.<sup>4</sup> A point of disagreement, however, has been whether to choose NHI and Social Health Insurance (SHI) as a policy option. There have also been differences around funding models and the role of the private sector. The government's initial proposal in 1994 for an NHI system was severely criticised by the National Treasury and health professionals for being too costly and rigid.<sup>5</sup>

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<sup>2</sup> HIV stands for Human Immunodeficiency Virus. It is the virus that causes AIDS. AIDS stands for Acquired Immune Deficiency Syndrome. HIV can be transmitted through the blood, sexual fluids, or breast milk of an HIV-infected person. Hereinafter referred to as "HIV/AIDS".

<sup>3</sup> Ran Z "Extending Health Care Coverage in Social Security System" Regional Social Security Forum for Africa, Kigali, Rwanda, 18-20 November 2008, 1-10 – accessed at [www.issa.int/pdf.- 12 April 2011](http://www.issa.int/pdf.- 12 April 2011). See also Nevondwe L, Tshoose IC, Monye S, "Tackling social inequalities: the legal reforms in South African health care system, a paper submitted for publication at Malawi Law Journal, 2011.

<sup>4</sup> Botha C and Hendricks M, Financing South Africa's national health system through national health insurance: Possibilities and challenges. 2008, Colloquium proceedings, Human Sciences Research Council (HSRC) Press.

<sup>5</sup> Botha C and Hendricks M, *Ibid.* <sup>5</sup> HIV stands for Human Immunodeficiency Virus. It is the virus that causes AIDS. AIDS stands for Acquired Immune Deficiency Syndrome. HIV can be transmitted through the blood, sexual fluids, or breast milk of an HIV-infected person. Hereinafter referred to as "HIV/AIDS".

<sup>5</sup> Ran Z "Extending Health Care Coverage in Social Security System" Regional Social Security Forum for Africa, Kigali, Rwanda, 18-20 November 2008, 1-10 – accessed at [www.issa.int/pdf.- 12 April 2011](http://www.issa.int/pdf.- 12 April 2011). See also Nevondwe L, Tshoose IC, Monye S, "Tackling social inequalities: the legal reforms in South African health care system, a paper submitted for publication at Malawi Law Journal, 2011.

<sup>5</sup> Botha C and Hendricks M, Financing South Africa's national health system through national health insurance: Possibilities and challenges. 2008, Colloquium proceedings, Human Sciences Research Council (HSRC) Press.

This led to the establishment of the Committee of Inquiry into a National Health Insurance System in 1995. Its mandate was to investigate the appropriateness and economic feasibility of NHI in the South African context and to undertake detailed planning for its implementation. The Committee was also instructed to consider a range of structural and institutional frameworks for NHI, such as a single state or parastatal NHI system; a single privately administered.

NHI system; or an NHI system with the current medical aid schemes acting as the financial intermediaries. The Committee recommended medical schemes as a vehicle towards a national health system. Dissatisfaction with the 1995 Committee's inquiry led to the establishment of another committee of inquiry in 1997, which revised the 1995 Committee's recommendations. The 1997 committee of inquiry proposed a phased approach towards ensuring 'access to health for all' by means of SHI, with NHI as a second step.

In 2000, the Cabinet appointed a Committee of Inquiry into a Comprehensive System of Social Security for South Africa, which investigated how to secure and enhance social protection for all South Africans (the social protection concept is broader than the narrowly focused one of social security). Health services and health care funding formed part of this inquiry. With regard to health, as one of its recommendations, the Committee advocated an incremental approach towards an NHI system. This recommendation envisaged the integration of the public sector and medical schemes in the context of a contributory system based on multiple funds as opposed to a single-payer model.

The discussion about the NHI re-emerged again in the 52<sup>nd</sup> Conference of the African National Congress (ANC) where important resolutions were taken with

regard to health which includes the following: education and health should be the two key priorities of the ANC for the next years<sup>6</sup>,"reaffirm the implementation of the NHI system by further strengthening the public health care system and ensuring adequate provision of funding",<sup>7</sup> to develop a reliable single health information system<sup>8</sup>; government should intervene in the high cost of health provision;<sup>9</sup> there should be health cover for veterans of the struggle";<sup>10</sup>develop a recruitment and Human Resource Development strategy for health professionals<sup>11</sup>;develop a Memorandum of Understanding with foreign countries on the exodus of health professionals<sup>12</sup>.

The ANC should further consider the matter of making HIV and AIDS notifiable, accelerate the roll-out of the comprehensive health care programme, such as through the provision of antiretroviral (ARV)<sup>13</sup> at all health facilities, accelerate programmes for hospital revitalisation including through innovative solutions that accommodate partnerships<sup>14</sup>, intensify the efforts to create an environment that promotes positive individual behaviour in the communities, especially amongst young people<sup>15</sup>, there will be no need to adopt a special HIV and AIDS grant as this will be catered for by the comprehensive social security system<sup>16</sup>, the ANC should explore the possibility of a state-owned pharmaceutical company that will respond to

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<sup>6</sup> Resolution 52 of the 52<sup>nd</sup> ANC Conference in Polokwane, December 2007.

<sup>7</sup> Resolution 53.

<sup>8</sup> Resolution 54.

<sup>9</sup> Resolution 55.

<sup>10</sup> Resolution 56.

<sup>11</sup> Resolution 57.

<sup>12</sup> Resolution 58.

<sup>13</sup> ARV or antiretroviral is the drug used to strengthen the immune system of people living with HIV & AIDS. Herein referred to as "ARV".

<sup>14</sup> Resolution 61.

<sup>15</sup> Resolution 62.

<sup>16</sup> Resolution 63.



and intervene in the curbing of medicine prices<sup>17</sup>, more resources be allocated to programmes on sexual awareness.

ANC branches must be actively involved in these programmes<sup>18</sup>; introduce a policy on African traditional medicine<sup>19</sup>, caution should be exercised when deciding on Public Private Partnership (PPP) as a solution for the delivery of health services<sup>20</sup> and diseases such as tuberculosis (TB) and cancer should be given special attention<sup>21</sup>

Since then, the ANC National Executive Committee (NEC) has established a NEC Sub-committee on Health and Education to deal with the NHI<sup>22</sup> and liaise with the National Department of Health and the first discussion paper was discussed in the ANC National General Council (NGC) in 20-24 September 2010 in Durban and, among others, the following were discussed or noted in the first paper of NGC: the NGC noted the presentations to the commission on the Mid-Term Report and the NHI, the NGC further noted the resolution of meeting ANC Provincial Chairpersons and the Chairperson of the Portfolio Committees, that provinces should prepare ANC Quarterly Health Monitoring Reports, health as a national priority and support and implementation of NHI.<sup>23</sup>

The NGC noted the overwhelming support for the NHI. The implementation of NHI should be fast-tracked, but done correctly within a reasonable time frame. Widespread publicity on the NHI needs to be undertaken, involving road shows, TV

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<sup>17</sup> Resolution 64.

<sup>18</sup> Resolution 65.

<sup>19</sup> Resolution 66.

<sup>20</sup> Resolution 67.

<sup>21</sup> Resolution 68.

<sup>22</sup> The NEC Sub-Committee on Health and Education has subsequently conducted a diagnostic process of analysing the key challenges facing the health sector. The result of this process led to the development of the Road Map for Health, which was handed over to the National Department of Health.

<sup>23</sup> Nevondwe L T and Mhlaba MW, *Judicial Activism and Socio-Economic Rights in South Africa* (2012), 172.

and radio adverts for example, “NHI is here, feel it”.<sup>24</sup> According to NGC, ANC must lead the implementation of the NHI and its promotion among the general populace. The involvement and support of the Alliance is crucial. The roll out should begin in the rural areas. There should be freedom of choice of service providers. Accreditation shouldn’t disadvantage under-resourced hospitals and clinics.<sup>25</sup>

The South African government gazetted the Green Paper introducing the NHI on 12 August 2012. This policy seeks to progressively realize the right of access to quality health care services for everyone. Those who cannot provide for themselves will be assisted by government at the expense of the elite.<sup>26</sup> Currently the National Department of Health has roll out the NHI as a pilot project and it is now implemented in some of the areas. The NHI will ensure that everyone has access to appropriate or equal, efficient and quality health care services. It will be phased-in over a period of fourteen (14) years. This will entail major changes in the service delivery structures, administration and management systems.<sup>27</sup>

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

South Africa s health system is divided into “pubic” and “private” health care service. Majority of people in this country are poor and unemployed, while others are employed in informal sectors of employment. Only small percentage of people is employed in formal employment. Through the implantation of NHI, the government is trying to breach this gap between the rich and the poor by linking and closely

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<sup>24</sup> ANC: Report of the African National Congress, on the National General Council (2010) accessed at <http://www.polity.org.za> - 15 April 2011.

<sup>25</sup> ANC National General Council Additional Documents, Section 1: National Health Insurance (2010), 5-6.

<sup>26</sup> Nevondwe L, National Health Insurance Scheme: A progressive realization of the right of access to health care services in South Africa, *The Thinker Political Journal*, Vo. 132, October 2011, page 40.

<sup>27</sup> National Health Insurance in South Africa Policy Paper accessed from <http://www.info.gov.za/view/DownloadFileAction?id=148470> on 2012/05/10 at para 1.

aligning this dual health care system in order to provide equal quality health service to everyone.

It goes without saying that most diseases and illnesses nest on poverty, coupled with these current socio-economic problems at hand, majority of people do not afford quality and proper medical care while the formal employed minority does as they contribute to their private medical aid schemes. The later enjoy the privilege of high quality health care service in private health care service providers while the former have no choice but to resort to public health cares which offer a low and poor quality health care services.

Furthermore, like many other African countries, South Africa is also plagued by other clear health problems that have been described in the Lancet Report as the quadruple burden of disease. These are:

- HIV/AIDS and TB
- Maternal, infant and child mortality
- Non-communicable diseases
- Injury and violence.

In order to realize 'everyone's constitutional right to access to health care services it requires the state to put in place plans and programmes which will be conducive to that effect. Yet, today in most occasions this constitutional right is not met as the poor are still traveling long distances and stand in long queues of government health institutions to access this basic right which in most cases is of lower or poor quality. Whilst on the other hand the richer, because of their strong financial means enjoy the privileges of receiving a better and quality health service provided by the private

health care institutions. The introduction of NHI is also aimed at taking into account the burden of these diseases the country is currently experiencing.

### 1.3. Literature review

Powers M and Faden R state usefully that "... insofar as a standard view of the moral justification or moral point of public health as emerged, it goes something like the following, public health is the social institution charged with promoting human welfare by bringing about a certain kind of human good, the good of health. The moral foundation for public health thus rests on general obligations in beneficence to promote good or welfare. Depending on the interpretation, public health is further understood as having utilitarian commitments to bring about as much health as possible.

"Concerns about justice, like concerns about respect for individual liberties, are understood as ethical considerations external to the moral purpose of public health that served to balance the public health's single-minded function to produce the good of health with other, right making concerns."<sup>28</sup>

Hunt and Backman have argued that it is not possible to secure sustainable development, poverty reduction, economic prosperity and improved health for individuals and populations without building and strengthening health systems.<sup>29</sup>

Pierre de Villiers holds the opinion that there is also a huge discrepancy between health care in the public sector and health care in the private sector. According to him it is a well-known fact that the public health service is struggling, overburdened and not providing adequate health care to those dependent on it. The main reason is

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<sup>28</sup> The Moral Foundations of Public Health and Health Policy (2006) at pages 81 to 84.

<sup>29</sup> Hunt, P and Backman, G 2008. Health systems and the right to the highest attainable standard of health. 10(1) *Health and Human Rights: An International Journal* , p81.

a lack of staff, particularly nurses and doctors. On the other hand the private sector is providing “world class” services, but fast becoming unaffordable for members of medical schemes. It is estimated that the cost of private medical care is gulping 30% of salaries in the formal sector. Clearly something has got to give in both systems and nobody can argue for the retention of the status quo.<sup>30</sup>

De Villiers believes that NH is a collective effort. He further states that “we need to consider alternative models and variations on the proposals, do costing on the impact, and to look at the implications of the system as proposed by the government. Let us participate, the Academy, the College and private general practitioners groups. It is about talking more “us” and less “me”. It is about the realisation of quality health care for all our people and for family doctors to play their rightful and meaningful role in fulfilling that ideal”.

According to Nevondwe, the NHI fund will provide a comprehensive cover of health services primary, secondary, tertiary and quaternary (high-care services) which will be provided by accredited public and private providers to ensure quality health care standards.<sup>31</sup> At the core of the NHI will be primary health care, which is the first point of entry into the health system. Membership of the NHI will be compulsory for the whole population, but the public will be able to choose whether to continue with voluntary medical scheme cover.<sup>32</sup>

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<sup>30</sup> De Villiers P, National Health Insurance, threat or opportunity for family doctors? SAJP, 2009 Vol 51 No 5. p403.

<sup>31</sup> Nevondwe L, National Health Insurance Scheme: a progressive realization of the right of access to health care services in South Africa, The Thinker Political Journal, Vol. 32, October 2011, p41.

<sup>32</sup> Nevondwe L, *ibid* at page 41.

According to Nevondwe, Tshoose and Monye the role of private providers is important under the NHI system.<sup>33</sup> This has a significant bearing on issues of fees for service or capitation based payments, the negotiation of tariffs and the pricing of health commodities will need to be addressed well in advance of the implementation of NHI. The issue of the prices of commodities that are vital to health care is a crucial determinant of the extent to which people, particularly poor people, have access to health care services and the government's ability to realise this right progressively.<sup>34</sup>

They opined further that in a modern economy, non-state actors have come to occupy central positions in the provision of key services and goods essential for individuals. Thus, the government alone cannot realise the socio-economic rights enshrined in the Constitution. In essence, multi-actor responsibility denotes that the realisation of the right to have access to appropriate social assistance as enshrined in the Constitution is not the exclusive responsibility of the state. The *Grootboom* case emphasised that the Constitution does not require the state to be the sole provider of socio-economic rights.<sup>35</sup>

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

Basically the research will examine the previous and current South African medical health system position while also exploring the nature and effects of the government's initiative of NHI scheme within its medical health system.

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<sup>33</sup> Nevondwe L, Tshoose IC and Monye S, Tackling social inequalities: the legal reforms in South African health care system, an article submitted for publication in the Malawi Law Journal, 2011. See also Nevondwe L, Tackling social inequalities: the legal reforms in South African health care system and the introduction of the National Health Insurance Scheme (NHI), Law Week Conference, 29<sup>th</sup> August to 2<sup>nd</sup> September 2011, University of Limpopo (Turfloop Campus).

<sup>34</sup> Hassim A "National Health Insurance: Legal and Civil Society Considerations" (2010) 19- 20 accessed at <http://hst.org.za/upload> - 15 April 2011.

<sup>35</sup> Nevondwe L, Tshoose IC and Monye S, Tackling social inequalities: the legal reforms in South African health care system, an article submitted for publication in the Malawi Law Journal, 2011.

The main aim of the research will be to analyze whether the government's initiative of realizing the people's right to health care services through the implementation of NHI will be practically possible and continuously maintained, this will be done by also looking at some other international experience.

The research will also highlight the prospects and challenges (implications) which may be brought by the implementation of this scheme. The enforcement of the right to health care and other socio-economic rights by the courts will also form part of the objectives of this study.

The mini-dissertation will also seek to highlight on how private health care has made these basic rights inaccessible to many South Africans because of how the medical aid schemes and private hospital operates.

The study will also seek to assess whether the current South African health care system is in compliance with the section 27(1)(a)(1)(3) and section 28(1)(c) of the Constitution in particular and other pertinent rights by providing equal opportunity to access health care in times of need irrespective of socio-economic class and at the same time seeking to investigate whether the proposed health insurance will indeed bridge the medical health care gap between the rich and the poor.

In addition the study will further examine the international protection of the right to health care by looking on the relevant international instruments which requires compliance by states.

The study will also highlight how the implementation of the scheme will affect the contributors (taxpayers)'s freedom of choice since they will be forced to contribute

their money to the scheme and when they want further medical cover to add another medical aid scheme.

The study will further benefit law, medical, commercial and actuarial students and practitioners, legal practitioners, government, state-owned entities, non-governmental organizations, medical aid institutions, stakeholders from the medical health care industry and also to the general public on the implementation and operation of NHI.

Lastly, this study stands to assist academics who have just begun to contend and investigate on the same literature because it may also bring insight on their programs and research efforts.

### **1.5. Research Methodology**

Basically, the research methodology to be adopted in this study is qualitative. Consequently, a combination of legal comparative and legal historical methods, based on jurisprudential analysis, is employed.

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



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

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

The study consists of five interrelated chapters. The first chapter deals with the introduction which will lay down the foundation of the study. Chapter two deals with the Legislative framework. While chapter three deals with the National Health Insurance Scheme. Chapter four deals with the lessons learned from other countries. The last chapter concludes the study and also provides the recommendations.

## CHAPTER TWO: LEGISLATIVE FRAMEWORK

In terms of the Universal Declaration of Human Rights of 1948 (UDHR) the right to healthcare encompasses the right of everyone 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.<sup>36</sup>

The history of the idea of human beings having “rights” is a long one, and there have been many different approaches to and theories about human rights. Even though the international human rights machinery is stronger now than ever in history and the United Nations has many declarations about human rights, there are governments, religions and cultures that dispute or deny people some or many human rights. In this mini-dissertation, I do not dispute the idea of human rights. I believe that human beings are born equal and should – as a right – be treated with dignity and have access to health care services.<sup>37</sup>

International Covenant on Economic, Social and Cultural Rights in 1966, nearly 20 years after the adoption of the UDHR, the responsibility of governments in respect of the right to health was made even more specific in the *International Covenant on*

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<sup>36</sup> Universal Declaration of Human Rights, 1948, Art. 25.

<sup>37</sup> Marius Pieterse argues that the success of socioeconomic rights as tools with which to remedy the pernicious effects of material deprivation depends on the ability of the rights to connect concretely to the needs and experiences of their beneficiaries and to bring about a tangible improvement in their living conditions. That the justiciable socioeconomic rights in the South African Constitution have thus far been only partially successful in furthering the cause of social justice, See Marius Pieterse “Eating Socio-economic Rights: The Usefulness of Rights Talks in Alleviating Social Hardship Revisited” *Human Rights Quarterly*, Vol 29, 2007, 798-800. See also Nevondwe L, National Health Insurance Scheme: A progressive realization of the right of access to health care services in South Africa, *The Thinker Political Journal*, Vo. 132, October 2011, page 42.

*Economic, Social and Cultural Rights (ICESCR)*.<sup>38</sup> The ICESCR mandated governments ratifying the agreement to undertake these steps:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.
- (b) The improvement of all aspects of environmental and industrial hygiene.
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases.
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

The South African Constitution provides important provisions relating to the access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water.<sup>39</sup> The right to health is covered under section 27, together with rights to food, water and social security. This section provides that everyone has the right to have access to: health care services, including reproductive health care; sufficient food and water; and social security, including appropriate social assistance if they are unable to support themselves and their dependents.<sup>40</sup> The mini-dissertation requires

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<sup>38</sup> It is important to note that in 1994, in his first visit to the United States as head of state, Nelson Mandela signed the ICESCR on behalf of South Africa. By signing the treaty, South Africa indicated its intention to ratify the treaty and became obliged not to act against the object and spirit of the treaty. However, South Africa has since failed to ratify the instrument. It is only when a country ratifies a treaty that the treaty becomes legally binding on that country. Progressive realisation of human rights at a global level has been a long and much debated process. General comments on the ICESCR have been developed globally to further entrench and describe the requirements to realise Articles in the ICESCR. If South Africa signed at the time of ratification, it would have had 15 years of support at an international level on this important obligation. However, to date, only South Africa and the USA stand out as the two countries that have signed but not ratified the ICESCR – For more information see: [http://www.blackssh.org.za/index.php?option=com\\_content&task=view&id=1410&Itemid=187](http://www.blackssh.org.za/index.php?option=com_content&task=view&id=1410&Itemid=187). For further discussion on the ICESCR see Mbazira C “Litigating Socio-Economic Rights in South Africa: A choice between Corrective and Distributive Justice” Pretoria University Law Press (PULP), 2009, 15-55.

<sup>39</sup> Section 26 and 27 of the South African Constitution Act 108 of 1996.

<sup>40</sup> Section 27 (1) (c).

the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.<sup>41</sup>

The Constitution further stipulates that no one may be refused emergency medical treatment in public health facilities. The Constitution makes substantive provisions on other rights, including the right to housing and to a clean, healthy environment.<sup>42</sup>

Section 24 provides that everyone has the right to an environment that is not harmful to their health or well-being and it requires the state to take reasonable legislative and other measures to prevent pollution and ecological degradation.

Section 26 provides for the right to housing, stating that everyone has the right to have access to adequate housing and calling upon the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of this right. This section also protects citizens from eviction and requires that no one may be evicted from their home, or has their home demolished, without an order of Court made after considering all the relevant circumstances. It outlaws any legislation that permits arbitrary evictions.<sup>43</sup>

The Constitution also protects the right to health for specific groups. Under section 28, it makes it clear that every child has the right to basic nutrition, shelter, health care services and social services. Section 152 calls on the local government to promote a safe and healthy environment. It mandates the South African Human Rights Commission to require relevant organs of state to provide the Commission with information on the measures they have taken towards the realisation of the

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<sup>41</sup> Section 27 (2).

<sup>42</sup> Sections 26 and 27.

<sup>43</sup> Section 26 (3).

rights in the Bill of Rights concerning housing, health care, food, water, social security, education and the environment.

Thus far, there are only a few court cases that have interpreted these provisions, but they set out the core principles for state conduct.<sup>44</sup> Of these, at least two imperatives are worth bearing in mind as we embark on the process of developing the NHI policy. The first is that, however well-intentioned a policy, it should be careful to address the short, medium and long-term needs of people.

In the *Grootboom* case, even though the Housing Policy that was being challenged was very detailed, it failed to provide for those people who were in desperate need and who, because of their dire situations of homelessness, would possibly not even survive long enough to get access to housing eventually promised for all through the policy. The Constitutional Court was of the opinion that, for this reason, a one-size-fits-all policy for housing could not pass constitutional scrutiny. For example, for those who can afford to purchase house (even if basic), what may be needed is a way to unlock the door to the house financing system, yet for those who are poor or desperately poor other approaches would need to be considered

Against this background the social security system in South Africa has two main objectives. The first objective is to reduce poverty among people vulnerable to low income, such as the elderly, children, and people with disabilities who cannot participate fully in the labour market. The second objective is to increase investments in health, nutrition, and education, in order to increase human capital to accelerate

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<sup>44</sup> Government of RSA v Grootboom 2001 (1) SA 46 (CC); Minister of Health v Treatment Action Campaign (2) 2002 (5) SA 721 (CC).

economic growth and development. Other objectives of social security are to prevent destitution in the face of shocks, social compensation and re-distribution.<sup>45</sup>

Many South Africans cannot afford voluntary contributions to medical schemes and/or retirement funds, especially at the lower end of the income distribution, which results in an incomplete coverage. Hence, social cash transfers, both conditional as well as unconditional, has become an important strategy for reducing poverty and promoting social development. However, there exist many challenges in establishing social assistance transfers in sub-Saharan African countries. For example, first, there is fear that social cash transfers could lead to a decline in labour force participation. Second, there is fear that social assistance transfers could crowd out public investment in infrastructure, such as free provision of primary and secondary education and primary health care. Third, the fiscal sustainability of social transfer programmes requires strong political commitment and the potential of re-distribution of public spending.<sup>46</sup>

The National Department of Health had released a policy paper on NHI on 12 August 2011. This policy paper is a process of introducing an innovative system of health care financing with far reaching consequences on the health of South Africans.<sup>47</sup> The NHI will ensure that everyone has access to appropriate, efficient and quality health care services. It will be phased in over a period of fourteen years. This will entail major changes in the service delivery structures, administrative and management systems on the part of the Department of Health.<sup>48</sup> The NHI has since been

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<sup>45</sup> White Paper for Social Welfare of 1997, chapter 7 accessed at [www.info.gov.za](http://www.info.gov.za) – 6 April 2011; Woolard I et al “Southern Africa Labour and Development” Research Unit of the University of Cape Town, 2010, 1-5 accessed at: <http://erd.eui.eu/media/2010/>.pdf. – 7 April 2011.

<sup>46</sup> Samson W “Social Cash Transfers and Prof-Poor Growth” 2009, 47-50 accessed at <http://www.oecd.org/pdf>. – 6 April 2011.

<sup>47</sup> Department of Health Policy Paper on National Health Insurance in South Africa, 12 August 2012, p4.

<sup>48</sup> Ibid at page 4.

introduced with effect from 2012 and it is still a pilot project at this stage. It has not yet been rolled out in the whole country. These policy proposals will overhaul the whole system of South Africa health care which presents inequality when it comes to the provision of health care services. The services offered by the public sector where majority of people rely on it is far less quality compared to health care services offered by the private sector where the majority of beneficiaries are members of medical aid schemes.

The NHI is intended to bring about reform that will improve service provision. It will promote equity and efficiency so as to ensure that all South Africans have access to affordable, quality health care services regardless of their socio-economic status.<sup>49</sup>

The current system of health care financing is two-tiered, with a relatively large proportion of funding allocated through medical schemes, various hospital care plans and out of pocket payments. This current funding arrangement provides cover to private patients who have purchased a benefit option with a scheme of their choice or as a result of their employment conditions. It only benefits those who are employed and are subsidized by their employers-both the State and the private sector. The other portion is funded through the fiscus and is mainly for public sector users. This means that those with medical scheme cover have a choice of providers operating in the private sector which is not intended to the rest of the population.<sup>50</sup>

Prior to the 1994 democratic breakthrough, South Africa had a fragmented health system designed along racial lines. One system was highly resourced and benefited the white minority. The other was systematically under-resourced and was for the

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<sup>49</sup> *Ibid* at page 4.

<sup>50</sup> *Ibid* at page 4.

black majority. The Constitution has outlawed any form of racial discrimination and guarantees the principles of socio-economic rights including the right to health.<sup>51</sup>

Attempts to deal with these disparities and to integrate the fragmented services that resulted from fourteen health departments (serving the four race groups, coloureds, white, Indians and blacks, including the ten Bantustans governments) did not fully address the inequalities problems linked to health financing that are biased towards the privileged few have not been adequately addressed.<sup>52</sup>

The introduction of NHI should take into account the burden of disease the country is experiencing. South Africa is plagued by four clear problems that have been described in the Lancet Report as the quadruple burden of disease. These are HIV/Aids, TB, maternal, infant and child mortality, non-communicable disease, injury and violence.<sup>53</sup>

Significant improvements in health care services coverage and access since 1994 have been achieved. However, there are still notable quality problems. Among the commonly cited and experienced by the public are: cleanliness, safety, security of staff and patients, long waiting times, staff attitudes, infection control and drug stock-outs.<sup>54</sup>

Given that there are concerns about quality at public sector facilities there is preference by the public for services in the private sector which may largely be funded out of pocket. Various members of the public cannot afford to make these

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<sup>51</sup> Section 27(1)(a) of the South African Constitution.

<sup>52</sup> Department of Health Policy Paper on National Health Insurance in South Africa, 12 August 2012, p5.

<sup>53</sup> Ibid.

<sup>54</sup> Ibid.



payments. This type of arrangement is not suitable for the country levels of development. Therefore, improvement of quality in the public health system is at the centre of the health sector reform endeavours.<sup>55</sup>

The World Health Organisation (WHO) recommends that countries spend at least 5 percent of their GDP on health care. South Africa already spends 8.5 percent of its GDP on health, way above what WHO recommends. Despite this high expenditure the health outcomes remain poor when compared to similar middle income countries. This poor performance has been attributed mainly to the inequalities between the public and private sector.<sup>56</sup>

It has been reported that high-income countries spent an average of 7.7 percent of their GDP on health whilst middle income countries spent 5.8 percent, and low income countries spent 4.7 percent.<sup>57</sup>

The 8.3 percent of GDP spent on health is split as 4.1 percent in the private sector and 4.2 percent in the public sector. The 4.1 percent spend covers 16.2. Percent of the population (8.2 million people) who are largely on medical aid schemes. The remaining 4.2 percent is spent on 84 percent of the population (42 million) who mainly utilise the public health care sector.<sup>58</sup>

In 2011, the Minister of Finance in his budget speech has made the following proposals with regard to NHI. He said “proposals are under review for a national health insurance system, as part of the broader restructuring and enhancement of health services. There will be substantial cost implications. We will consider and consult on options for meeting the funding requirements, including a payroll tax

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<sup>55</sup> Ibid.

<sup>56</sup> Ibid.

<sup>57</sup> Ibid.

<sup>58</sup> National Treasury: Intergovernmental Fiscal Review, 2011.

(payable by employers), an increase in the VAT rate and a surcharge on individuals' taxable income. The fiscal and financial implications of health system reform, and alternative revenue sources, will be examined in the year ahead".<sup>59</sup>

In 2012, the Minister of Finance in his budget speech has made the following proposals with regard to NHI. NHI is to be phased in over a 14-year period beginning 2012/13. The new system will provide equitable health coverage for all South Africans. Over time, the new system will require funding over and above current budget allocations to public health. Funding options include an increase in the VAT rate, a payroll tax on employers, a surcharge on the taxable income of individuals, or some combination of the above. Alongside options for increased tax revenue, the role of user charges is also being investigated. It is expected that an additional revenue source will be needed in 2014/15 amounting to about R6 billion in that year, which is not currently provided for in the MTEF. Achieving an appropriate balance in the funding of national health insurance is necessary to ensure that the tax structure remains supportive of economic growth, job creation and savings.<sup>60</sup>

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<sup>59</sup> Budget Speech delivered by the Minister of Finance Pravin Gordhan in the National Assembly on 23 February 2011.

<sup>60</sup> Budget Speech delivered by the Minister of Finance Pravin Gordhan in the National Assembly on 22 February 2012.

## CHAPTER THREE: NATIONAL HEALTH INSURANCE SCHEME<sup>61</sup>

### 3.1. Introduction

Throughout the history of the struggle for freedom, ANC,<sup>62</sup> which celebrates its centenary this year (2012), fought for a free and democratic South Africa. The Bill of Rights adopted by the ANC in 1923, the Africa's Claims of 1943 and the Freedom Charter of 1955 reflect the ANC's deep rooted human rights culture which defined its character and structure as a liberation movement that fought for the emancipation of the disenfranchised majority against the tyranny of the apartheid regime.<sup>63</sup>

In South Africa, the Constitution is the supreme law of the country, any law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled.<sup>64</sup> All citizens are equally entitled to the rights, privileges and benefits of citizenship.<sup>65</sup> The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state<sup>66</sup> as such the people of South Africa are committed to the attainment of social justice and the improvement of the quality of life for everyone.<sup>67</sup> This chapter form the basis on which the Constitution of the Republic of South Africa, 1996 is premised.

This mini-dissertation analyses the proposed NHI against the backdrop of the principles of equity, universality and comprehensiveness as well as availability,

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<sup>61</sup>

<sup>62</sup> Which is the current South African ruling political party.

<sup>63</sup> Department of Justice and Constitutional Development Minister Jeffrey Thamsanqa Radebe, Department of Justice and Constitutional Development, Discussion document on the transformation of the judiciary in the developmental South African State (February 2012) (preface at ii).

<sup>64</sup> Section 2 of the Constitution.

<sup>65</sup> Section 3 (a) *ibid.*

<sup>66</sup> Section 8 (1) of the Constitution.

<sup>67</sup> *Government of the Republic of South Africa v Grootboom* (2001) 1 SA 46 (CC) at para 1.

accessibility and quality, all of which are implied by the right of access to health care services. In doing so, it also considers issues, such as the financing of the health system, which could pose challenges to implementing NHI.

### **3.2. The concept of NHI**

A national health system comprises all organisations, institutions and resources devoted to improving people's health. According to Freedman, an effective health system is a core institution in society, no less than a fair justice system or democratic political system.<sup>68</sup>

NHI offers a mechanism for providing equitable access to quality health services, thereby promoting equal access, redistribution and sharing of resources. It provides for both contributors and non-contributors in a universal system and ensures universal health coverage. 'National health insurance' should be distinguished from 'social health insurance' (SHI), another form of national health system. SHI benefits contributors only and is usually mandatory for a specified group, such as those in formal employment at a particular income level. SHI is therefore not universal and only those who contribute are beneficiaries. SHI could be the starting point to achieving NHI.

Currently, South Africa does not have a national or social health insurance system. Rather, it has medical aid schemes systems provided by private health insurance providers. Here, health coverage is linked to income and ability to pay. Over the years, the number of South Africans who can afford private health insurance has

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<sup>68</sup> Freedman, L 2005. Achieving the MDGs: Health systems as core social institutions. 48 *Development* P1.

fallen due to increases in health care costs.<sup>69</sup> As a result, a majority of the population cannot access private health care, hence the proposal for NHI.

### **3.3. The nature and scope of NHI scheme**

The intention of NHI is to promote equity and efficiency in the delivery of health care services. The introduction of the NHI system, will address the following key principles: NHI will be publicly funded and publicly administered and will provide the right of every South African with access to quality health care, which will be free at the point of delivery. People will have a choice of which service provider to use within a district; the social solidarity principle will be applied and those who are eligible to contribute will be required to do so, according to their ability to pay, but access to health care will not be according to payment; and participation of private doctors working in other health facilities, in group practices and hospitals, will be encouraged to participate in the NHI system<sup>70</sup>.

Quality of care as a separate component of a NHIS, however, stands as a secondary consideration when discussing a NHIS or even debating such a scheme. Quality of care is more ethereal in nature and difficult to pin down or encapsulate eloquently in a sentence or two and so is largely ignored by legislators. There is great difficulty in defining what it is that is quality healthcare, most commentators defer to the idea that quality of care is dependent on the emotional connection between an individual and his or her health service provider. Quality is thus defined by the individual based on the outcome of the healthcare service that he or she receives: a good outcome normally indicates good quality care while a bad outcome indicates the reverse.

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<sup>69</sup> C Botha and M Hendricks (eds), *Financing South Africa's national health system through national health insurance: Possibilities and challenges*. Colloquium proceedings. HSRC Press.

<sup>70</sup> ANC's 2009 Election Manifesto Policy Framework

Improving the quality of health care is an integral part of implementing NHI for the achievement of access to healthcare for all. In other words, the debate concerning quality is certainly one that appears centred on whether or not care provided produces the results that are desirable but the question remains -desirable to whom, patients or administrators or healthcare providers? It follows that quality does appear to have a place in the debate. Quality is especially important when consideration is given to what social ends healthcare is designed to achieve within a democracy or, more particularly, what co-ordinated healthcare such as a NHIS is designed to achieve in the context of a South African democracy premised upon the Constitution and the Bill of Rights.

An independent quality improvement and accreditation body will be established to set the quality national standards in both the public and private sectors. The body will be tasked with inspecting and sanctioning health facilities in line with professionally determined standards of health care, including staffing ratios, management, etc.<sup>71</sup>

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

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<sup>71</sup> ANC National General Council Additional Documents, Section 1: National Health Insurance (2010) 5-6

whole population, but the public can choose whether to continue with voluntary medical scheme cover<sup>72</sup>.

The 2009 ANC Election Manifesto identified health as one of the five priorities of the ANC in the next four years. The manifesto makes it clear that the NHI would help to reduce inequalities in the health system.<sup>73</sup> Although there have been many achievements in improving access to health care, much more needs to be done in terms of quality of health care, and by making services available to all South Africans through ensuring better health outcomes<sup>74</sup>. South Africa commands huge health care resources compared with many middle-income countries, yet the bulk of these resources are in the private sector and serve a minority of the population, thereby undermining the country's ability to produce quality care and improve health care outcomes. The ANC is determined to end the huge inequalities that exist in the public and private sectors by making sure that these sectors work together<sup>75</sup>. The ANC has identified the following ten priorities for a major improvement in our health care system: implement the national health insurance plan, improve quality of health services, overhaul management system, improved human resource management, physical infrastructure revitalization, accelerate implementation of the HIV and AIDS and STI plans, attaining better health for the population, social mobilization for better health, drug policy review and research and development<sup>76</sup>

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<sup>72</sup> These statements were uttered by Dr. Zweli Mkhize, Chairperson of the NEC Health and Education Sub-Committee at the ANC National General Council.

<sup>73</sup> The ANC Election Manifesto, 2009 states that the government will: "introduce the NHI system, which will be phased in over the next five years. NHI will be publicly funded and publicly administered and will provide the right of all to access quality health care, which will be free at the point of service. People will have a choice of which service provider to use a district.

<sup>74</sup> ANC's 2009 Election Manifesto Policy Framework.

<sup>75</sup> ANC National General Council Additional Documents, Section 1: National Health Insurance (2010) 5-6.

<sup>76</sup> Ibid.

The introduction of the NHI system, will address the following key principles: NHI will be publicly funded and publicly administered and will provide the right of every South African with access to quality health care, which will be free at the point of delivery. People will have a choice of which service provider to use within a district; the social solidarity principle will be applied and those who are eligible to contribute will be required to do so, according to their ability to pay, but access to health care will not be according to payment; and participation of private doctors working in other health facilities, in group practices and hospitals, will be encouraged to participate in the NHI system<sup>77</sup>.

Improving the quality of health care is an integral part of implementing NHI for the achievement of access to healthcare for all. An independent quality improvement and accreditation body will be established to set the quality national standards in both the public and private sectors. The body will be tasked with inspecting and sanctioning health facilities in line with professionally determined standards of health care, including staffing ratios, management, etc...<sup>78</sup>

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

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<sup>77</sup> ANC's 2009 Election Manifesto Policy Framework.

<sup>78</sup> ANC National General Council Additional Documents, Section 1: National Health Insurance (2010) 5-6.



whole population, but the public can choose whether to continue with voluntary medical scheme cover<sup>79</sup>.

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

Currently, the Department of Health has embarked on the first phase of piloting NHI in a number of selected district municipalities through the country. Ten districts municipalities are selected for NHI pilot programme from 1 April 2012. In Gauteng, Tshwane was selected for this purpose as the minister said Tshwane was suitable for the pilot as it covered rural and urban areas. In the Eastern Cape, the OR Tambo district had been selected and in Limpopo, the Vhembe district. Other districts chosen for the pilot included Pixley ka Seme in the Northern Cape, Eden district in the Western Cape, Dr K Kaunda district in the North West and Thabo Mofutsanyane in the Free State. In KwaZulu-Natal, the uMzinyathi and uMgungundlovu districts were selected because of the high population figures in the province.<sup>80</sup>

Motsoaledi said the ten districts were selected according to their socio-economic standing, their health service performance and demographics. "Pilots will develop and test the norms and standards for the packages to be provided in the district under the NHI, to ensure acceptable standards of care." This phase includes the

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<sup>79</sup> These statements were uttered by Dr. Zweli Mkhize, Chairperson of the NEC Health and Education Sub-Committee at the ANC National General Council.

<sup>80</sup> News 24, Districts named for NHI pilot 2012-03-22, accessed from <http://www.news24.com/SouthAfrica/Politics/Districts-named-for-NHI-pilot-20120322> on 2012/04/27.

strengthening of the health system and improving the service delivery platform as well as to reform the health industry policies and Legislation.<sup>81</sup>

The objectives of pilots will be to focus on the most vulnerable sections of society across the country; reduce high maternal and child mortality through district-based health interventions; strengthen the performance of the public health system in readiness for the full roll-out of NHI; strengthen the functioning of the district health system; to test ability of the districts to assume greater responsibilities associated with the purchaser-provider split required under a NHI; to assess the costs of introducing a fully-fledged District Health Authority as Contracting Agency and implications for scaling-up such institutional and administrative arrangements throughout the country; to assess utilization patterns, costs and affordability of implementing a Primary Health Care (PHC) service package.

"The NHI is not yet a law. We are piloting voluntarily" said Motsoaledi. He said the pilot would help the department find out what interventions were necessary to implement the NHI. "We want to see how the NHI works for the 20% of the population of our country," said Motsoaledi.<sup>82</sup> The launch of the pilot programme was the first phase of the 14-year rollout plan of the NHI. In the next five years, the department would add more districts to the selected 10, the minister said.<sup>83</sup>

The focus of all these interventions is to ensure that South Africans have access to quality health services and reduction in the burden of disease, particularly that borne by women and children as well as improving the overall health system

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<sup>81</sup> See Minister of Health Dr Aaron Motsoaledi, Presentation on NHI pilot districts selection, 22 March 2012, page 4.

<sup>82</sup> News 24, Districts named for NHI pilot 2012-03-22, accessed from <http://www.news24.com/SouthAfrica/Politics/Districts-named-for-NHI-pilot-20120322> on 2012/04/27.

<sup>83</sup> Ibid.

performance.<sup>84</sup> A Conditional Grant established in Feb 2012 from the national treasury will be used to finance the first piloting phase.

### **3.4. Equity, universality, comprehensiveness and social solidarity**

Any reform in health care must pay particular regard to the glaring inequities highlighted above. Health policy should endeavour to conform to principles relating to equity, universality and comprehensiveness. This includes social solidarity and efficiency.

Health policy should also conform to the core elements of availability, accessibility, acceptability and quality.<sup>85</sup> Hence, in analysing the NHI package, the above aspects have to be taken into account.

There is no universally accepted definition of equity, but can mean that 'equal access to health-care according to need'. Equity measures inequalities using an ethical or moral judgment that is based on the broad concept of justice; it of their ability to pay, but should be available to all who need it on roughly equal terms. It is therefore a form of shared responsibility.

In NHI, the solidarity principle has the best chance of prevailing over market principles. As it is, South Africa's health insurance system through medical schemes commodifies health. The government owes its citizens protection against the subjection of health and sickness to the vagaries of demand and supply.

Pursuing an NHI system in which all citizens are guaranteed access to health services is one way of decommodifying health. This would also conform to the *Batho*

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<sup>84</sup> Minister of Health Dr Aaron Motsoaledi, Presentation on NHI pilot districts selection, 22 March 2012, page 4.

<sup>85</sup> Committee on Economic, Social and Cultural Rights, General Comment 14 on the right to health, UN doc. E/C.12/2000/4, para 12(a).

*Pele* (People First) principles which were developed to guide public service delivery. One of the prime aims of *Batho Pele* is to provide a framework for making decisions about delivering public services to the many South Africans who do not have access to them. It also aims to rectify the inequalities in the distribution of existing services.<sup>86</sup>

### **3.5. A comparative study on financing the NHI in South Africa**

As noted above, one area of concern in the NHI debate relates to financing. An NHI system can be funded in two ways: through tax or insurance. Hence, while some have argued for a tax-funded system, others have promoted an insurance system.<sup>87</sup> Another aspect of the financing debate relates to whether an NHI programme should adopt a single-payer or multiple payer system. It is clear from the recent Green Paper on NHI<sup>88</sup> that the core objective of the proposed health system changes is to move towards universal coverage. A key question is what kind of healthcare financing system should South Africa pursue if we are to achieve universal coverage?

It is helpful to look at other countries that are regarded as having universal health systems. Most of these are high-income Organisation for Economic Cooperation and Development (OECD) countries, although a few middle-income countries (such as Colombia, Costa Rica, Cuba and Thailand) are also frequently held up as examples of universal systems.<sup>89</sup>

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<sup>86</sup> Principle 3.

<sup>87</sup> Tshabalala-Msimang, M 2008. Health within a comprehensive system of social security: Is national health insurance an appropriate response? In C Botha and M Hendricks (eds), *Financing South Africa's national health system through national health insurance: Possibilities and challenges*. Colloquium proceedings. HSRC Press.

<sup>88</sup> Department of Health. National Health Act (Act 61 of 2003): Policy on National Health Insurance. Government Gazette 34523. Pretoria: Department of Health, 2011.

<sup>89</sup> World Health Organization. *Health Systems Financing: The Path to Universal Coverage*. World Health Report 2010. Geneva: WHO, 2010.

Some of examples of countries that have belonged to the OECD for the longest period (excluding some of the smallest countries such as Iceland) and are regarded as having universal health systems include countries such as Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Korea, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland and United Kingdom.

There is a striking pattern across these OECD countries and the middle-income countries that also have universal systems. First, mandatory prepayment financing mechanisms (i.e. general tax funding, in some cases supplemented by social or national health insurance) is the dominant funding mechanism, accounting for 70% or more of total healthcare expenditure in almost all cases. Second, private voluntary insurance is very limited, as are out-of-pocket payments in general. Private voluntary insurance exists in all countries listed above, but has a clearly defined role that supports the predominantly publicly financed health system. Those with the largest private insurance levels (over 10% of total healthcare expenditure) are Canada and France. In Canada, about two-thirds of the population have complementary private health insurance, mostly through employment-based group plans, to cover the services not covered through public funds (e.g. vision and dental care, and outpatient prescription drugs).<sup>90</sup> In France, almost 90% of the population has complementary private insurance through employment-based mutual associations, to cover the cost-sharing (co-payments) required by the social health insurance system.<sup>91</sup> Korea stands out as a country with high levels of out-of-pocket payments, as a result of the high levels of co-payments in its social health insurance system.

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<sup>90</sup> Thomson S, Osborn R, Squires D, Reed S, eds. *International Profiles of Health Care Systems*, 2011. New York: The Commonwealth Fund, 2011.

<sup>91</sup> *Ibid.*

This means limited access to healthcare for poorer groups and raises questions about whether Korea really has universal financial protection.

South Africa has a financing pattern that more resembles that of the United States of America (USA), which is not a health system that any sensible South African would wish to emulate, than countries with universal coverage. It is noteworthy that South Africa has the highest percentage share of private voluntary insurance in the world.<sup>92</sup> Yet, only 16% of the population benefits from these resources.

It is no accident that the 2010 World Health Report,<sup>93</sup> devoted to the issue of universal coverage, reached the conclusion that mandatory prepayment (or public funding) has to be the core of any universal health system. Mandatory prepayment funds in universal systems are 'public' in the sense that they are used for the benefit of all, they can be used to purchase needed healthcare for the whole population from public and private providers. The funds are also 'public' in the sense that they are pooled in such a way as to ensure that there are income and risk cross-subsidies. As indicated earlier, these cross-subsidies are central to universal coverage.

The issue of cross-subsidies is crucial, as some 'smart Alec' is bound to say, 'The answer is simple, just make medical schemes mandatory and then we would have over 80% of funding in the form of mandatory prepayment'. However, what would occur is that funds would be kept separate and only benefit those who are contributing to schemes (currently 16% of the population or about 40% if all formal-sector workers and their dependents were legally required to belong to these schemes); there would not be substantive income and risk cross-subsidies between

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<sup>92</sup> Drechsler D, Jutting J. Is there a role for private health insurance in developing countries? Berlin: German Institute for Economic Research, 2005.

<sup>93</sup> World Health Organization. Health Systems Financing: The Path to Universal Coverage. World Health Report 2010. Geneva: WHO, 2010.

the medical schemes' pool and the general tax funding pool. There seems to be consensus among stakeholders in South Africa that it is not affordable to create an integrated funding pool by means of covering the entire population through medical schemes.

Moving towards a predominantly publicly funded health system with a specified role for private voluntary health insurance will take time. What is required in the short term is for Treasury to be responsive to submissions to gradually increase the allocations to the health sector from general tax revenue, to enable the Department of Health to implement its plans to strengthen substantially both primary healthcare and hospital services, as outlined in the NHI Green Paper and other recent policy documents. It is likely that it will be necessary to supplement this with additional taxes dedicated to the health sector, such as an income tax surcharge, payroll tax on employers and/or 'sin taxes' on tobacco and alcohol, which can be phased in after initial improvements to the public health system have been achieved. When universal entitlements to specified services are formalised in legislation, it will be important to specify the complementary role of private voluntary insurance. Through this overall process, the relative distribution of healthcare funding across different financing mechanisms will shift gradually to the pattern that we see in countries that have already achieved universal coverage.

### **3.6. Projected possible prospects and challenges likely to be imposed by the full implementation of NHI**

There can be few who underestimate the challenges facing the national health department and individuals tasked with developing the policies and plans that are needed to support NHI implementation. Among other things they will need to

establish the content of the service benefit package, develop norms and standards to allow quality assurance, address the huge shortage of critical human resources, fix the deficits in existing health infrastructure, and expand plans for the reform of the health sector, particularly of district and hospital management. In all of these there will have to be a deliberate focus on the needs of children. A paediatric service benefit package has to consider the special needs of neonates as well as of adolescents. Similarly, norms and standards for paediatric wards, for instance, will differ from those in the adult service. A 2009 modelling exercise conducted in Gauteng, based on the United Nations International Children's Emergency Fund (UNICEF) 'Marginal budgeting for bottlenecks' approach, estimated that an additional (marginal) investment of R4 billion over 5 years (or R70 per capita) in maternal and child health could save the lives of 14 283 children and reduce the under-5 mortality rate by 50%, almost meeting the provincial Millennium Development Goal target for 2015.<sup>94</sup> This additional investment required less than 5% of the existing provincial health budget.<sup>95</sup> Not all of this needed to be 'new' money much, but not all, of the money could be obtained through reducing health system inefficiencies. The hope is that data of this kind, which have been largely ignored to date, will be used to quickly remedy fiscal deficiencies as the NHI takes hold.

Other than meeting the huge deficit in nurse availability, the NHI will also have to address the deficiencies in other categories of health staff. Integration of the public and private sectors will allow about 400 paediatricians currently in the private sector

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<sup>94</sup> Gauteng Department of Health, 'Marginal budgeting for bottlenecks' – unpublished report, 2009. See also National health insurance and health system restructuring – does it offer anything to children? SAJCH September 2011 VOL. 5 NO. 3 page 67-70.

<sup>95</sup> Gauteng Department of Health, 'Medium-term budget estimates, 2009/10' – unpublished.



to augment the services provided by 250 public sector paediatricians. However, even this measure cannot overcome the existing gross provincial inequity in this resource, with one paediatrician being available for 8 600 children in the Western Cape but one needing to serve over 200 000 children in Limpopo<sup>96</sup> Undoubtedly, many more doctors and paediatricians have to be trained to meet the current need. More importantly, smarter mechanisms will need to be identified to attract and retain health professionals in under-resourced settings. Of course, the NHI and the health ministry alone cannot secure health for all. Achieving good health requires not only a well-functioning health care system but also interventions from other sectors such as education, agriculture, social development, housing, agriculture and water and sanitation, to list a few.

The main focus is on an innovative funding mechanism that will transform the national health system. The aim is to promote equity, efficiency, and improve service provision, particularly at primary health care level,<sup>97</sup> i.e. the driving force is finance. I am reminded of the saying: "There is nothing that an accountant can't make a little bit cheaper and a little bit nastier". In that regard, it is estimated that during the first 14 year period a big stake of approximately R240 billion will be used to roll over the NHI. The money will be used to increase infrastructure and capacity, for example more health practitioners (doctors, nurses, pharmacists, etc...), and more public hospitals and clinics should be build.

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<sup>96</sup> Colleges of Medicine of South Africa, 'Project: Strengthening academic medicine and specialist training' – unpublished, 2009.

<sup>97</sup> See <http://www.doh.gov.za/list.php?type=National%20Health%20Insurance>.

It is by no means clear that NHI will reduce the cost of health care for families and households, particularly given the huge costs that the establishment and implementation of NHI will entail. Moreover, if many South Africans elect to continue with their own private medical insurance in addition to making contributions to NHI, the net result for those persons will be a sizeable increase in health expenditure. A failure to place sufficient emphasis on the costs of NHI is to ignore the possible impact that the imposition of NHI will have on the economy as a whole.<sup>98</sup>

However, professor Servaas van der Berg and Professor Heather McLeod of Stellenbosch University found that even if the fund would provide only a basic benefit package, it would cost R5 140 per person per year, i.e. R251 billion for the full South African population. This can be compared to a more restricted and a more comprehensive package of benefits:

- Prescribed Minimum Benefits (PMBs) only: R156 billion
- Basic Benefit Package (PMBs plus primary care): R251 billion
- Fully Comprehensive Benefit Package (FCBP): R334 billion

Even if one accepts the optimistic view that public sector provision could be up to 30% cheaper (though this ignores service quality) and applies that 30% reduction across the board, the funding required to fund the NHI at Basic Benefit Package (BBP) benefit levels is a full R176 billion which is a massive amount compared to budgeted income tax revenue of R206 billion and public health expenditure of R84 billion. Van der Berg and McLeod found that a payroll tax of over 17% would be needed to fund such a conservatively estimated revenue need. Alternatively, to fund

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<sup>98</sup> South African Private Practitioner Forum, National Health Insurance in South Africa: SAPPF submissions on the Green Paper on National Health Insurance, 2011-12-06 P 19 para 11.2.

the NHI through an income tax would require tax rates to increase by 85% across the board, the top marginal tax rate of 40% would have to rise to 74%.<sup>99</sup>

The imposition of NHI will have far-reaching consequences for persons who are currently privately insured. It appears that they will be required to fund NHI through the payment of similar amounts to what they currently spending on private medical aid. Many of those persons will not be able to afford to continue to make payments for private medical aid on top of their compulsory payments to NHI. Those persons will, in effect, continue to make equivalent payments but they will no longer have ready access to services that they were previously able to access. A large group of people will thus be worse off under NHI as they will no longer be able to access the quality of care that they currently enjoy. It must be noted that these current medical scheme members (and their dependants) will then become dependent on the public sector, which, in turn, will have to meet its existing demands as well as an added burden previously shouldered by the private sector.<sup>100</sup>

The implication for medical schemes is also potentially dire, as they will be faced with declining membership (as members battle to meet their additional obligations to make NHI contributions), which could in turn lead to increasing prices. Declining medical scheme membership will, in turn, negatively impact on health care providers who are unable or unwilling to contract with the NHI, potentially resulting in these highly skilled persons exiting the profession or emigrating.<sup>101</sup>

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<sup>99</sup> David Carte National, Health Insurance Multi-billion rand NHI to be put on hold, Moneyweb's Personal Finance, December 2009, P5.

<sup>100</sup> South African Private Practitioner Forum, National Health Insurance in South Africa: SAPPF submissions on the Green Paper on National Health Insurance, 2011-12-06 page 19 Para 11.3.

<sup>101</sup> Ibid at Para 11.4-11.5.

According to David Carte, another challenge is that, South Africa does not have enough doctors, nurses, hospitals and clinics to be able to supply free medical services to all citizens. Indeed, a premature national health system could drive more doctors out of the country.<sup>102</sup>

For the reasons canvassed in these submissions, I am convinced that the implementation of NHI may impact adversely on the right of access to health care currently enjoyed by those persons who receive treatment in the private sphere. It must be noted that the constitutional right of access to health care, as contained in section 27 of the Constitution, requires the progressive realisation of this right by reasonable measures within the State's resources. Any policy which has the net effect of reducing or diminishing levels of access may therefore offend this constitutional right.<sup>103</sup>

Moreover, improving the quality of health care requires more real resources (doctor, nurses, hospitals and equipment, and that does not automatically follow funds, but depend on management and incentives in the public health system. History teaches us that improving such management is difficult to achieve in a moderate timeframe. Indeed, the most urgent need is to ensure that the public sector is well capacitated to deliver the envisaged services at all levels.<sup>104</sup>

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<sup>102</sup> David Carte National, Health Insurance Multi-billion rand NHI to be put on hold, Moneyweb's Personal Finance, December 2009, P4.

<sup>103</sup> South African Private Practitioner Forum, National Health Insurance in South Africa: SAPPF submissions on the Green Paper on National Health Insurance, 2011-12-06 page 19 Para 11.6.

<sup>104</sup> David Carte National, Health Insurance Multi-billion rand NHI to be put on hold, Moneyweb's Personal Finance, December 2009, P5.

## CHAPTER FOUR: LESSONS LEARNED FROM OTHER COUNTRIES

The key questions surrounding health care systems around the world include amongst other things; (a) how to raise revenues to pay for health care,(b) how to pool risks and resources, (c) how to organize and deliver health care in the most efficient and cost effective manner. Whether the strategies adopted rely on public sources like taxes and social insurance, or private sources like private insurance and out-of-pocket payment, will have a profound impact on health care costs, quality and access.<sup>105</sup>

In making the choice, technical efficiency is an important, but not the only consideration. Most health care systems in western industrialised countries assume a high degree of responsibility for personal health care because they are driven by values which lean heavily towards notions of equity, fairness and solidarity.<sup>106</sup> With the notable exception of the United States, all the Organisations for Economic Cooperation and Development (OECD) countries (including Japan and South Korea) have opted for publicly financed health care systems that provide universal coverage.

For the purposes of discussion in this article, Singapore's experiences offer valuable lessons for South Africa's health care reform system. In 1980s, the Singapore government re-examined from first principles the role of the state in health care

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<sup>105</sup> Berman P *et al* "Healthcare Financing in Eight Latin American Countries and Caribbean Nations: The First Regional National Health Accounts Network" (2009), 15-29 accessed at <http://www.who.int/nha> - 15 April 2011.

<sup>106</sup> Lim Kim "Transforming Singapore Health Care: Public-Private Partnership, 2005 – accessed at [www.annals.edu.sg/pdf](http://www.annals.edu.sg/pdf).

financing and provision, and concluded that a British style of the National Health Service was neither a viable nor a sustainable option. The government of Singapore decided that while it would continue to subsidise health care (along with other important social areas like housing and education) to bring prices down to an affordable level, the people would have to share in the costs of the services they consume.<sup>107</sup>

The state of health in Singapore is internationally regarded and consistently ranked by the World Health Organisation to be among the world's best.<sup>108</sup> One of the successes behind Singapore's government to achieve these health outcomes is based on a comprehensive healthcare delivery and financing system which is built on the following major principles, to promote good health and reduce illness, access to good and affordable healthcare, pursue medical excellence. To ensure that all Singaporeans have access to affordable basic healthcare, basic medical services at public hospitals and polyclinics are heavily subsidized by the government.<sup>109</sup>

The system of healthcare in Singapore is based on the "3M system". Under the "3M framework" individuals are encouraged to take responsibility for their own health by saving for medical expenses. The "3M system" which has its origins from the

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<sup>107</sup>Lim MK "Health Care Systems in Transition II" Singapore, Part I An Overview of 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 of medical excellence. The well-established healthcare 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 healthcare provider, both within the public and the private healthcare system. The medical facilities of Singapore are considered one of the best in the world. Medical practitioners are well-trained and qualified. Furthermore, pharmaceuticals are widely available from a number of pharmacies and outlets that include department stores, supermarkets, shopping centres, and hotels. Registered pharmacists normally work between 9am and 6pm and there are some pharmacies that open to 10pm. Also, most hotels have doctors on call 24 hours.

<sup>108</sup> The World Health Report 2000 – Health systems – at [www.who.int/whr/2000](http://www.who.int/whr/2000) - 9 April 2011.

<sup>109</sup> Maarse H *et al* "Six Countries, Six Health Reform Models? Health Care Reform in Chile, Israel, Singapore, Switzerland, Taiwan, and the Netherlands" (2010) *Journal of Comparative Policy Analysis*, Vol.12, Nos.1-2, 85-89.

following tiers of protection, the Medisave (1984), MediShield (1990) and Medifund (1993).<sup>110</sup> These tiers of protection forms the centrepiece of Singapore's health care financing system and was therefore premised on the philosophy of shared responsibility, and the economic principle that health care services should not be supplied freely on demand without reference to price. The first tier of protection is provided by government subsidies of up to 80 percent 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 a compulsory individual medical savings account scheme which allows practically all Singaporeans to pay for their share of medical treatment without financial difficulty.<sup>111</sup> 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.<sup>112</sup>

The third level of protection is provided by MediShield, a low cost catastrophic medical insurance scheme. This allows Singaporeans to effectively risk-pool the financial risks of major illnesses. Individual responsibility for one's healthcare needs is promoted through the features of deductibles and co-payment in MediShield. ElderShield, severe disability insurance, is also available for subscription by Singaporeans to risk-pool against the financial risks of suffering a severe disability. Many middle and higher income Singaporeans have also supplemented their basic coverage with integrated private insurance policies ("Integrated Shield

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<sup>110</sup> Ministry of Health, Singapore, State of Health – The Report of the Director of Medical Services 2001 – accessed at <http://www.moh.gov.sg/mohcorp/hcssystem.aspx?id=102> – 10 April 2011.

<sup>111</sup> Callick R "The City- State of Singapore May Have a Fix for Americans Healthcare Woes" *The Journal of the American Enterprise Institute* 2008 – accessed at <http://american.com/archive/2008-14> April 2011.

<sup>112</sup> Castro JM "Health Care in Singapore" 2009 – accessed at <http://www.expatform.com/articles-11> April 2011. According to the Singapore Ministry of Health in December 2008, the average Singaporean had ten thousand US dollars in his/her Medisave account. This is sufficient to pay for about 10-12 subsidized acute hospitalization episodes.

plans”) for treatment in the private sector. Singaporeans must subscribe to the basic MediShield product before they can purchase the add-on private Integrated Shield Plans. This industry structure preserves the national risk pool and guards against ‘cherry picking’ of healthy lives by private insurers. Similarly, “Elder Shield” allow policyholders to enhance the disability benefits coverage offered by the basic Elder Shield product.

As discussed above the Singapore health system has put in place the “3M” framework: Medisave, Medishield, and Medifund. Medisave, which covers about 85 percent of all Singaporeans, is a component of a mandatory pension program. Employees typically pay 20 percent of their wages into the Central Provident Fund (CPF), while employers pay 13 percent. (Since 1992, the self-employed have also participated.). At the beginning of 2007, CPF had over \$1 billion in surpluses.

In Singapore’s system, the primary role of government is to require people to save in order to meet medical expenses they don’t expect. Medisave accounts can be used to pay directly for hospital expenses incurred by an individual or his immediate family. Limits are in place on the extent of Medisave funds that can be used for daily hospital charges, physicians’ fees, and surgical fees. The idea is to cover fully the bills of most patients in state-subsidized wards of public hospitals. Beyond that, individuals dip into their own pockets or use benefits from insurance plans (see more on this below). Medisave can also be used for expensive outpatient treatments such as chemotherapy, renal dialysis, or HIV drugs.<sup>113</sup>

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<sup>113</sup> Shortt S “Medical Savings Accounts in Publicly Funded Health Care Systems: Enthusiasm versus Evidence” *Canadian Medical Association (CMAJ)* 2002, 159-161.



Medishield, the second part of the program, is a national insurance plan that covers the higher cost of especially serious illness or accident, which in Singapore's system is described as "catastrophic." Singaporeans can choose Medishield or several private alternatives, some offered by firms listed on the Singaporean stock exchange. Premiums for the insurance plans, including Medishield, can be paid using Medisave accounts.

Medifund, the third part, was established by the government for the roughly 10 percent of Singaporeans who don't have the means to pay for their medical needs, despite the government's subsidy of hospital and outpatient costs. The fund was set up in 1993 with \$150 million, with the budget surplus providing additional contributions since then. Only interest income, not capital, may be disbursed. Finally, there's Elder shield, an addition to the 3M structure that offers private insurance for disability as a result of old age. It pays a monthly cash allowance to those unable to perform three or more basic activities of daily living.

Nearly all Singaporeans contribute directly toward each treatment, including prescription drugs, through patient co-payments of 20 percent for amounts above deductible levels. The money to meet deductibles and co-payments can come out of a person's Medisave account. In Singapore's system, the primary role of government is to require people to save in order to meet medical expenses they don't expect. While the Singaporean government does regulate prices and services, its hand is nowhere near as heavy as that of governments with extensive nationalized healthcare, such as the United Kingdom or Germany.

The public healthcare facilities in Singapore have been clustered, since 2002, into two integrated networks, each government-owned and managed as non-profits: the

National Healthcare Group (NHG) on the western side of the city-state, and Singapore Health Services (Sing Health) on the eastern side. Each provides a full range of services, running the public hospitals and specialty centres as private companies. The Health Ministry says that these clusters “provide cooperation amongst the institutions within the cluster, foster vertical integration of services, and enhance synergy and economies of scale. The friendly competition between the two clusters spurs them to innovate and improve the quality of care while ensuring that medical costs remain affordable.”

Each of the networks also benchmarks against international standards and publishes exhaustive performance figures. In its 2007 report, NHG says its vision is “adding years of healthy life.” The goal, the report says, “departs from merely healing the sick to the more difficult but infinitely more rewarding task of preventing illness and preserving health and quality of life.” Meanwhile, 80 percent of primary healthcare needs are met by private general practitioners and 20 percent by public outpatient “polyclinics” of hospitals, chiefly those run by the two clusters, NHG and Sing Health. Within the private general practitioner sector, a significant proportion of patients—about 12 percent of them—consult traditional Chinese practitioners.

Phua Kai Hong, associate professor of health policy and management at the Lee Kuan Yew School of Public Policy at the National University of Singapore,<sup>114</sup> describes the crucial social setting that enabled the country to create its remarkably successful health system: a dynamic economy (with 7.5 percent GDP growth in 2007 and an average income per person of about \$34,000, or three-quarters that of the United States), strong family ties and social support systems, a high propensity to

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<sup>114</sup> Phua, Kai Hong “Medical Savings Accounts and Health Care Financing in Singapore: Innovations in Health Care Financing, World Bank Discussion Paper No.365, 247-255.

save and invest, a rapidly aging and affluent population, and an absence of socialized models of social security, social insurance, or healthcare. He lists five core prerequisites for countries that may want to emulate Singapore's system: a willingness and ability to save; high participation in formal employment; effective payroll collection with efficient fund management and claims processing; a well-developed information system with strong security and accounting controls; and effective public education in the proper use of medical accounts.

Within the private-public mix, he says, most people lean toward the private system for primary care and the public system for hospital care. There are 13 public-sector specialty centres and hospitals in Singapore and 16 private-sector hospitals. But 74 percent of the beds are within the public sector. The government has also introduced low-cost community hospitals for intermediate healthcare for the convalescent and aged.

Why does Singapore's system work? Phua cites these principles: "the creation of incentives for responsible behaviour and the efficient delivery of services; the discouragement of overconsumption through cost-sharing; the regulation of hospital beds, doctors, and the use of high-cost medical technology; the promotion of personal responsibility; targeted government subsidies; and the injection of competition through a mix of public- and private-sector providers." Medical savings, he says, are now being accumulated to ensure that the Singaporean society of the future will be able to look after its own health needs even with a steady rise in the population of elderly people.

But, he adds, there remains room for further evaluation of clinical quality and outcomes as the system continues to evolve. Increased investment in health

facilities is encouraging a broadening of the market. More than 400,000 patients travelled to Singapore for healthcare in 2006. While 3M was designed to curb overconsumption rather than achieve a particular public-private mix, the result of the system has been to moderate the government's share of total health spending. The lesson here is that an efficient healthcare system will naturally come to rely on consumer, rather than government, decision-making.

Professor Lim Meng Kin of the department of community, occupational, and family medicine at the National University of Singapore says,<sup>115</sup> "Every dollar spent on healthcare is a dollar earned by healthcare providers, so there is inherently no incentive for healthcare providers to want to contain costs. Indeed, providers could be expected to exhibit entrepreneurial behaviour." In 1999, the system introduced case-mix—categorizing patients in order to assess the cost of treating them—as a move to address such supply-side "moral hazard." Since 2003, the Health Ministry has been publishing hospital bill amounts for common conditions and procedures to give patients more information on which to base their choices.

Meanwhile, the increased investment in health facilities is naturally encouraging a broadening of the market. Thus, in 2003, a group of government agencies launched Singapore Medicine, aimed at developing the country into a leading international destination for healthcare. In 2006, more than 400,000 patients travelled to Singapore specifically for healthcare. This internationalization of the country's health services is also now extending to export. Singapore hospital operator Thomson Medical Centre, for instance, which specializes in obstetric and paediatric care, is

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<sup>115</sup> Meng-Kin Lim "Shifting the burden of health care finance: a case study of public-private partnership in Singapore" *Health Policy* 69 (2004) 83-90 - accessed at [www.sciencedirect.com](http://www.sciencedirect.com) – 16 April 2011.

establishing, with a Vietnamese partner, a 260-bed, resort-style hospital for women and children, with a medical spa and a helipad, near Ho Chi Minh City, to meet a new market arising from Vietnam's economic surge. Many more Singaporean health providers are setting up shop in India, where they have already invested in hospitals and diagnostic centres.<sup>116</sup>

The three principal challenges, Lim says, are interrelated: containing cost, developing a medical hub, and ensuring quality. "A focus on costs without a corresponding focus on quality and patient safety is meaningless. Health Care that is cheap but of poor quality is surely not what Singaporeans want or deserve".<sup>117</sup> The right focus, he says, is on creating the conditions for competition, consumer choice, and provider cooperation. Alvin Soong, the immediate past president of the Singapore Insurance Institute, worries about rising medical inflation, which reached 6.2 percent in October—almost twice the national rate of price increases.

"Many Singaporeans," he says, "do not have adequate funds in their Medisave accounts to pay for their own medical bills because their Medisave funds have been used to pay the bills of spouses, parents, or siblings. The Baby Boomers have often had to take care of their parents' medical costs." He says the current average individual Medisave balance of \$23,260 will not be adequate for the post-retirement period, when people most need medical coverage, even with the added protection provided by Medishield insurance.

"After taking into account payment for the deductibles, co-insurance, and anything beyond the amount paid by the schedule of benefits...if the funds in Medisave are

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<sup>116</sup> *Ibid.*

<sup>117</sup> Meng-Kin Lim *Supra* n 108.

used to pay directly for medical bills, there may not be anything left to pay the Medishield premiums,” according to Soong. At the current rate of medical inflation, Medisave “will become totally inadequate,” he warns. The low proportion of government spending on health in Singapore helps the country maintain regular budget surpluses while reducing taxes.

Singapore’s health minister, Khaw Boon Wan, wants insurers to come up with more innovative policies. He says: “Give doctors and hospitals the incentive to focus on the health outcomes of your policyholders. Try piloting pay-for-performance measures that reward doctors based on the health of patients they care for, not the number of procedures performed.”<sup>118</sup>

The World Bank, in a paper assessing Singapore’s health system, says the results of 3M, with its supplementary programs to protect the poor and to address potential market failures in health financing, “have been impressive, with excellent health outcomes, low costs and full consumer choice of providers and quality of care.”<sup>119</sup> It says that Medisave—a key component of the system—could be introduced in countries without national insurance programs or well-developed private insurance, by requiring all employers and employees to set up accounts along the lines of Singapore’s program.

In countries such as Canada and Britain which have national insurance programs funded primarily by general tax revenue, Medical Savings Accounts (MSAs) could be introduced by directly allocating a portion of existing tax revenue spent on healthcare

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<sup>118</sup> Speech by Health Minister of Singapore Khaw Boon Wan, 2 August 2007, speech delivered at the South –East Asia Health Insurance Conference – accessed at <http://app.mfa.gov.sg>. – 15 April 2011.

<sup>119</sup> Wagstaff A “Health Systems in East Asia: What Can Developing Countries Learn From Japan and the Asian Tigers” 2005 World Bank Policy Research Working Paper 3790 accessed at [www.wds.worldbank.org/external/pdf](http://www.wds.worldbank.org/external/pdf) – 15 April 2011.

to individuals to set up MSAs. Such governments could then progressively reduce general taxes and replace them with Singaporean-style payroll deductions allocated to MSAs.

And, says the World Bank, in countries like the United States, with well-developed private health insurance covering basic services, consumers could be given the choice of opting for MSAs with a catastrophic-illness insurance provision instead of traditional insurance or managed care. “However, for MSAs to become truly universal, governments would have to allocate public funding—whether drawn from general tax revenue or payroll taxes—to individual MSAs.” Pilot programs with some MSA features have been introduced in the United States, with a focus on plans that enable employees to shift from traditional health insurance to voluntary MSAs with high-deductible health insurance. The critics in Singapore, unlike many in the United States, are calling for fine-tuning—not for a new engine. The structure developed 25 years ago still works. Compared with the American system, it keeps Singaporeans healthier for much less cost per person.

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 the United States of America. One of United States of America (USA) President, Barack Obama's reform plans involved the introduction of a national health system in the USA and this also caused a heated debate among the Americans, particularly as some felt this was bent on Government takeover of private healthcare. In Britain, on the other hand, the National Health Service (NHS) has been implemented since the 1940's and the British have nothing but praise for this system. The Britons claim that through the NHS, 1 million people gain access to healthcare every 36 hours. In response to an

attack against Obama, Prime Minister, Gordon Brown added his voice to a twitter campaign saying “the NHS often makes the difference between pain and comfort, despair and hope, life and death”.

According to Van den Heever, “the NHI is proposing spending much more money on health care although the amount that South Africa spend compares favourably with that spend by other countries with gross national incomes (GNIs) per person that are closest to ours”.<sup>120</sup>

The Ministerial Advisory Committee on NHI has already finalized a policy document that would shortly be submitted to the cabinet for approval. This shows that the government is serious about the implementation of the NHI.<sup>121</sup>

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<sup>120</sup> Du Preez L, op cit at page 13.

<sup>121</sup> Kahn T, Cabinet to see advisers' NHI policy soon, Business Day, 16 February 2011, accessed at [http://groups.google.com/group/cosatu-daily-news/browse\\_thread/thread/60e44445826ea460](http://groups.google.com/group/cosatu-daily-news/browse_thread/thread/60e44445826ea460) - on the 5 April 2011.



## CHAPTER FOUR: CONCLUSION AND RECOMMENDATIONS

While the ANC government's plans to fully introduce this universal health cover for all the country's citizens looks good on paper, the truth is that without proper planning, transparency and partnership with existing health care platforms, the plan is doomed to fail. It is worth to remember that the Bill of Rights contains rights that may influence and inform the quality of care process. Such rights may include: the right to dignity; the right to life; the right to equality; the right to proper and procedurally fair administrative justice; and the right to information. These rights may collectively inform what quality care is within the context of the NHI.

Many people are very excited about the implementation of NHI but, others like Professor Servaas van der Berg and Professor Heather McLeod of Stellenbosch University warned that the NHI will “fail to meet expectations of the poor, will leave medical scheme members (including the working poor) worse off, will be massively expensive or even completely fiscally unaffordable, and will require far more doctors and nurses than are available. The danger is that it could well become a highly costly failure that will further increase frustration with service delivery”.<sup>122</sup>

The fact is nobody will be left unaffected by the expected changes in the healthcare industry, ranging from insurance groups to medical schemes, hospital groups and others. But as to how will the scheme benefit the private sector is the question which seems to be complicated to an ordinary citizen. The greatest challenge facing medical schemes is to make health care more affordable to lower income workers.

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<sup>122</sup> David Carte National, Health Insurance Multi-billion rand NHI to be put on hold, Moneyweb's Personal Finance, December 2009, P5.

It is submitted that measuring quality of care in relation to outcomes is only one way of assessing whether or not healthcare or a NHI meets the state's obligations in terms of the Constitution. A more effective means may be to judge whether or not the NHI, when it is finally implemented, gives rise to a situation in which those persons subject to the Scheme are treated in such a manner that their other rights in the Bill of Rights are respected.

The role of quality cannot be underestimated and does, in fact, carry constitutional weight. Certainly South Africa may learn from the experience of other countries which have dealt with or are dealing with the implementation of a NHI. Quality of care issues have arisen in such jurisdictions, but post the systems' implementation.

Government finds itself in a position where, keeping a keen eye on the Bill of Rights, it must take measures to implement a NHI that accords with its responsibility in section 27(1)(a) of the Constitution, but that does not lose sight of the rights enjoyed by every individual in every circumstance of his or her life including, but not limited to, the receipt of quality healthcare services within whatever NHI context.

The implementation of NHI is excellent news for pharmacists as it means that more people will be able to afford to belong to medical schemes and potentially use private pharmacies. The challenge for all health care providers is to find ways to provide more cost-effective services and to adapt their businesses to being able to serve more people.

The health practitioners and doctors I usually associate with, who work in the public and the private sectors, seem to hold one of three views about the imminent introduction of NHI in South Africa. Proponents believe that it offers the country the ability to finally meet the health needs of all its citizens, since it promises a single,

integrated health care system strongly founded on the principles of a primary health care approach, the right to health care, social solidarity and universal coverage, and a not-for-profit and publicly administered NHI fund.

Opponents believe that it is a prohibitively expensive, complex and layered system that will deepen the failure of public health and reduce the benefits of private health. They view it as a mechanism for further destroying the health system, granting those most responsible for crippling the present public health system.

The majority, however, are uncertain about the development, appreciating that it offers the possibility of delivering much needed change, but unsure whether it can deliver on the promise of comprehensive and quality care to everyone and accessible free care (no user fees for services covered by NHI) at the point of service. However, Majority of health workers are unanimous that the present state of health care is unacceptable and that drastic health care reform must occur if the health of South Africans, especially the majority poor and children, is to be improved.

If patient satisfaction is key, the *modus operandi* will need to change dramatically. What will induce health staff to do this? There is little evidence, even anecdotal, that the occupation-specific dispensation (OSD), which has undoubtedly boosted health professional salaries and attracted staff back to public services, has improved quality of care. Can established norms and standards and monitoring of these by the Office of Health Standards Compliance do the trick? Will revitalised wards and clinics motivate individuals to perform better? Will greater local autonomy lead to better resource allocation and use by managers and Chief Executive Officers (CEOs)? In the absence of local evidence indicating that any of this can make a difference, one has to trust and seek inspiration from the international experience that suggests that

health systems can change for the better with the right blend of leadership, governance and accountability structures, financing strategies and a motivated workforce.<sup>123</sup>

South Africa come from a long history of struggle in demand for amongst others, adequate housing, health care, food, water, hospitals, schools, social security and a clean environment.<sup>124</sup> The objects of section 27 of the Constitution should be understood as a way of assisting those who are unable to provide for themselves and their families. In so far as these socio-economic rights are concerned, section 27 is one of the most important provisions in the Bill of Rights. This is because it guarantees everyone the right of access not only to important components of an adequate standard of living but also to things that are ordinarily regarded as basic necessities of life.<sup>125</sup> Rather than simply protecting members of the society from the heavy hand of the state power, socio-economic rights oblige the state to do as much as it can to secure for all members of society a basic set of social goods (education, health care, food, water, shelter, access to land and housing).<sup>126</sup>

To this end, many aspects of the NHI seem to be controversial and too complicated. As a law student public in a public university my concerns are less about the funding and remuneration issues, although I recognise that the livelihood of many private sector (health institutions and others) employees will depend heavily on how this scheme. Of critical importance to all is the development of measures and mechanisms to combat the systemic corruption within the health system and the

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<sup>123</sup> World Health Organization. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's framework*. Geneva: World Health Organization, 2007.

<sup>124</sup> Sandra Liebenberg and Karrisha Pillay, *Socio-Economic Rights in South Africa*, 190, see also, Nevondwe L.T, "*A Critical Analysis on the Judicial Enforcement of Socio-Economic Rights*", LLM dissertation, University of Venda (Unpublished), P 1.

<sup>125</sup> Mubangizi, JC, *The protection of Human Rights in South Africa (1st Edition) (2004) A Legal and Practical guide* P.132.

<sup>126</sup> Currie I and De Waal J, *Bill of Rights Handbook*, 2005, page 567.

looting of public health resources. A greater concern is the ability of the health system to tackle the rampant inefficiencies in the system. Fundamentally, this requires behaviour change. Managers, health professionals and health workers will need to change attitudes and mind-sets about much of what they do and how they operate.<sup>127</sup> I finally recommend that a key strategy is to step up training of health professionals and provision of health and constitutional law education to the communities more especially the poor. It is finally hoped that mechanisms proposed in this a work will serve as a benchmark for stimulating debate and generating new ideas on how to improve the lives of the poor in South Africa, in particular the NHI if properly fully implemented will give effect to the right to have access to health care as provided in the Constitution.

The NHI is a good policy and it is derived from the communists' perspective of having a balance. This is a system wherein the rich would subsidise the poor to have access to quality health care services. It has been debated over the years in South Africa that the public health care services are dysfunctional and the majority of people had been failed by the Government in this respect.

The introduction of the NHI is a good sign and it proves that the Government has learned from their past mistakes in the last sixteen years it has been in power. The statistician has already calculated the cost of having NHI in South Africa and the question will be whether South Africa can be able to afford it. Having witnessed lot of projects which the Government has completed in the last five years like FIFA 2010 World Cup Stadiums, one is convinced that the country has enough resources to implement the NHI and there is a need for a good relationship to be developed

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<sup>127</sup> Bateman C. Izindaba: Health corruption busters reveal the monster in our midst. South African Medical Journal 2011;101(1):14-15.

between Government, business and the private sector and other relevant stakeholders involved.

This article seeks to recommend that the Government must involve all stakeholders especially the health sector in the NHI and avoid centralising it with the ruling party, the ANC and the alliance partners, Congress of South African Trade Unions and South African Communist Party. The Government must hold an indaba which involves people from academia, civil society organisations, nurses, doctors, pharmacists, medical practitioners and all health professionals to make recommendations on how best the NHI can be implemented and which models is viable. The current state of the infrastructure South Africa have cannot be able to accommodate the NHI proposals and a way forward of establishing a Public Private Partnership might be the best option going forward.

This article seeks to recommend that the NHI proposals must be legislated and clearly state who will be the administrator of the NHI. This will remove lot of uncertainties amongst different stakeholders. The President after consultation with the cabinet ministers must appoint an independent task team not aligned to political parties to develop comprehensive policy on NHI and to work towards a bill which will guide the promulgation of the new Act or the amendments of the National Health Act.

Further, the Government must also look at the options of giving incentives to students to encourage them to further their careers in the health fraternity either as doctors, nurses, paramedics, pharmacists and social workers and psychologists to develop capacity which will strengthen the NHI. Further, the NHI must promote the

principle of corporate governance, accountability and transparency in the health sector.<sup>128</sup>

In conclusion, it could be argued that in order for the NHI discourse to be unleashed it should be grounded in “a substantive conception of the good society,” which should in turn facilitate the formulation of a coherent, need-focused theory of positive rights.<sup>18</sup> Robin West contends, for instance, that the state in a “good society” committed to affirmation of and respect for the inherent dignity of all human beings, must “ensure some minimal level of well-being because such a threshold is necessary if citizens are to live fully human lives and have the dignity to which their humanity entitles them.”<sup>129</sup>

This means that society must not only respect citizens’ moral agency and safeguard such civil and political liberties as are necessary for their individual and collective pursuit of the good life, but should also ensure that all individuals in society have meaningful access to such social amenities as enable them to live in accordance with their human dignity. It is in this context that the approach taken by ANC in its discussion documents relating to the introduction of the NHI finds support of the authors in the following respect. One is that any policy that is pro-poor should prioritise the poor. Secondly rural and other underserved areas that face barriers in accessing healthcare must be given special priority. Of course there are pitfalls that the NHI system will have to face, this relates to financial and administrative management.<sup>130</sup> These are challenges that can be won by creating systems that will

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<sup>128</sup> Nevondwe L T and Mhlaba MW, *Judicial Activism and Socio-Economic Rights in South Africa* (2012), 172.

<sup>129</sup> Marius P. “Eating Socioeconomic Rights: The Usefulness of Rights Talk in Alleviating Social Hardship Revisited” *Human Rights Quarterly*, Volume 29, Number 3, August 2007, 801-802.

<sup>130</sup> According to the Consolidated Report of the Integrated Support Team’s (IST) Review of the Public Health System released by the Minister of Health (Dr Motsoaledi). The report is the product of the

oversee the whole administration of the NHI. In this respect, according to the recommendations made in the Consolidated Report of the Integrated Support Team's (IST),<sup>131</sup> the following issues are crucial for the effective implementation of the NHI system;

- The need to accurately determine the exact amount of the financial backlogs in each province with the NDoH taking the lead,
- Before the implementation of the NHI, there must be accurate costing, guaranteed funding from a properly determined baseline budget,
- The Minister of Health in driving the development of the NHI, must engage the Provincial Health MEC's and health departments and other stakeholders,
- There should be alignment between the national vision and strategy, programme strategic plans and annual national health plan, as well as between targets and interventions within the NDoH. Secondly all plans should pay more attention to implementation, and such implementation should be aligned with each other and should contain a clear framework with performance targets,
- Proposed new structures should be carefully reviewed and restructured, with a view to establishing minimum staffing levels and optimal management and administrative positions. These processes should be undertaken based on objectively agreed benchmarks,

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ISTs that were commissioned by former Minister of Health Barbara Hogan, in February 2009. The report reveals failures by the provincial departments of health and finance; the NDoH and the National Treasury were to take appropriate action as provincial departments of health accumulated debts beginning in the 2006/2007 financial year. The accumulated debt was estimated to have been R7.5 billion by 1 April 2009.

<sup>131</sup> *Ibid.*



optimal application of scarce skills, the public health sector's strategic and service delivery priorities and resource availability.

- These recommendations by the Report of the Integrated Support Team's (IST).<sup>132</sup>

Having said all this, it is clear that the government is increasingly realising the need to look at new avenues to ensure greater inclusivity of the right to have access to health care. It is hoped that the possibilities presented in this article are also explored as new ways in which to widen the social security net. The NHI has a potential of identifying human rights based practices and methods for development efforts in fighting the scourge of poverty and other ills aggravating the realisation of two highly interrelated human rights, namely the right to dignity and the right to health care . The mechanisms proposed in this article will, it is hoped, serve as a benchmark for stimulating debate and generating new ideas on how to improve the lives of the poor in South Africa, in particular the NHI will give effect to the right to have access to health care as provided in the Constitution.<sup>133</sup>

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<sup>132</sup> Consolidated Report of the Integrated Support Team's (IST) Supra.

<sup>133</sup> Nevondwe L, National Health Insurance Scheme: A progressive realization of the right of access to health care services in South Africa, The Thinker Political Journal, Vo. 132, October 2011, page 40.

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