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promoting liberal constitutional democracy

Submission to National Department of Health

National Health Insurance

Green Paper

Submitted by the **Helen Suzman Foundation**

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Executive Summary

The Helen Suzman Foundation (hereafter: Foundation) welcomes the opportunity to engage in an open debate on strategic health reform. The Foundation sees this opportunity as a way to foster greater collaboration and critical, yet constructive, dialogue between civil society and government in terms of the policy-making process.

Challenges facing South Africa's health system

The Department of Health has clearly made significant gains in certain areas of the health system. However, the situation analysis in this submission presents a picture of a South African health system which is underperforming in almost every area. South Africa spends similar, and in some cases more, on health care than its peer countries, and yet is experiencing poor health outcomes and a rise in the burden of major diseases. Although acknowledging many of the problems in the health system, the National Health Insurance (NHI) Green Paper fails to provide evidence-based links between the poor health outcomes and their causes. The Green Paper cites the two-tiered health system and inequalities between the public and the private sector as the root causes of the majority of South Africa's poor health outcomes. While these factors may undermine an attempt at creating equality in society, this proposition fails to take into account the systemic, institutional problems evident in both the public and the private health systems. The problems in the public health system include: lack of governance and accountability, ineffective monitoring and evaluation, poor management, over-centralisation, lack of implementation of existing policies, and corruption. The issues resulting in rising costs and inefficiencies faced by the private sector include: market imperfections, a lack of price competition and lack of effective regulation. Whether or not these issues can be resolved by the introduction of a NHI scheme remains unclear.

Review of the Green Paper

The Foundation finds that the Green Paper is characterised by statements and claims which are not supported by evidence or appropriate references. The Green Paper also lacks much of the detail required to provide a more engaged response to the policy proposals. A primary concern is that the apparent lack of a comprehensive, evidence-based plan could result in further deterioration of the health system. It is imperative that clear and reliable evidence is provided to demonstrate that the policy proposals of the Green Paper will improve the ability of South Africans to access health care.

Constitutional and human rights implications

"Section 2 of the Constitution reaffirms that the Constitution is the supreme law of the Republic and that law or conduct inconsistent with it is invalid and that the obligations imposed by it must be fulfilled. Thus, every citizen and every arm of government ought rightly to be concerned about constitutionalism and its preservation."[1] In this regard the Department of Health needs to show that the policy proposals outlined in the Green Paper will positively assist the state in the progressive realisation of the right to access health care enshrined in Section 27 of the Constitution. Similarly, the Department of Health needs to ensure that the Green Paper proposals are in accordance with the Constitution. A particular area of concern in this regard is the potential for the undermining of the constitutional rights and decision-making powers of the provinces.

The importance of public consultation

Public participation and consultation with regards to the proposed NHI still has a long way to go. Historical and international evidence of creating and implementing health care reform suggests that it is a complex process requiring an equal measure of open debate in the policy-making process and resource capacity in the implementation stage. The Department of Health appears to have presented an already defined proposal drafted with minimal public and stakeholder consultation. As a result, the Foundation sees the Green Paper rather as the first step towards health reform, with space reserved for further consultative development of the detail and scope for creative thought.

The goal of universal coverage

Universal coverage in health care can be described as a system whereby all citizens have access to quality health care when needed and are not exposed to ruinous financial risk when accessing it. It could be argued that South Africa already provides universal coverage by virtue of the current two-tiered health system: On the one hand, the tax funded public system provides coverage to those who are unable to afford private health care. On the other hand, formally employed individuals and those able to afford it, are covered by the private health sector via contributions to medical schemes. **The problem is thus rather one of access and quality than lack of coverage.** The key question then is: what are the most important and critical steps to take in working towards improving access to *quality health care* and what are the most relevant policy mechanisms for achieving them?

[1] Navsa JA in *Democratic Alliance v President of the Republic of South Africa and Others* (263/11)[2011]ZASCA 241 (1 December 2011)

The importance of management

Appropriate management across all levels of the health system is crucial for the successful reform of the health system. The introduction of the Green Paper provides an opportunity to finally and emphatically correct malfunctioning management structures and practices in the health sector. Health management needs to be clearly distinguished from administration, should be decentralised, and must take a long term view. Managers must be trained and granted the opportunity to make decisions in respect of the areas of the health care system that have been entrusted to them. Similarly, regarding decentralisation, the Foundation believes that the most effective decisions are those made closest to where problems and issues arise.

Conclusion

The Helen Suzman Foundation is positive that the correct reforms to the health care system can be decided on and implemented. It is vital however, that reforms are discussed and debated in a transparent manner, with broad-based consultation and sober acknowledgement of the real challenges facing the health care system. We trust that this is the start of an open discussion on the best way to move forward to ensure improvement in access to quality health care for all South Africans.

Key points made in this submission:

- The Green Paper for a NHI in South Africa must be seen as the first step in opening up genuine debate as how best to reform the health system and not as a final model requiring only minor adjustments.
- Systemic issues in the health system relating to lack of accountability and governance, poor management and inefficiencies – not the two tiered health system and inequalities between the private and public health system – need to be recognised as the primary reason for South Africa's ineffective and inefficient health system.
- Appropriate management across all levels of the health system and decentralised governance structures are crucial for effectively reforming South Africa's health care system.
- The issue of *access* to *quality* health care needs to be the driving force behind all reform efforts in the health sector and not simply the provision of universal coverage.
- The NHI must be seen as a long-term goal in improving the institutional efficiency of the health system and a complementary tool in the larger process of strategic health reform.

- Short-term goals attending to issues of quality and efficiency, particularly in the public health sector, should be prioritised above the broader reform strategy proposed in the Green Paper.
- Greater public consultation, engagement with key stakeholders and constant communication and dialogue is vital in order that civil society is provided with a true reflection of developments in the health care debate so as to avoid misinformation and disaffected public opinion.
- Given the importance of up-to-date data and information, the National Health Information System needs to be vastly improved and upgraded so as to ensure all policy proposals are based on reliable evidence and realistic assumptions.
- Human resource deficits across a wide range of functional areas need to be urgently addressed.
- A comprehensive framework and strategy for improving the relationship between the public and private health sectors needs to be developed and serve as the foundation for a national health reform programme.
- The exact sources of financing for the proposed system need to be outlined, and further debate needs to take place regarding decision between the implementation of a single- or multi-payer system.
- Tax implications a means of funding health care reform need to be clearly outlined.
- It is an imperative that any reform to the health care system at a national level complies with the Constitution. In particular, the constitutional rights and decision-making powers of the provinces need to be upheld.

Chapter 1: Introduction

1. The Foundation's submission and organisational mandate based on constitutional values

1.1. The mission of the Helen Suzman Foundation is to defend the values that underpin our liberal constitutional democracy and to promote respect for human rights. As a human right enshrined in the Constitution of South Africa, health care is an area that the Foundation has necessarily become involved in. In 2009 the Foundation broadened its scope of work and entered the health debate by holding a Roundtable entitled "Strategic Health Reform" in part as a consequence of the launch of the ANC's policy document on NHI. Since then, the Foundation's work around health has focused on unpacking the issue of health care and the health system in South Africa in preparation for the release of official policy documentation by the National Department of Health.

1.2. By all accounts the policy processes underpinning national health reform have thus far been fragmented and where sound, poorly implemented, while at the same time the South African health system continues to fall deeper into crisis. It is from this perspective that the Foundation has an interest in providing additional platforms and policy insight into the debate on health reform. As part of our work on health, the Foundation has been successful in drawing upon various experts for insight over the past two years and has established a wide network within the health sector. We are also proud of the number of highly respected Research Fellows who provide us with a constant connection to developments across the sector.

1.3. The release of the Green Paper marked an important point in terms of concentrating and channelling the Foundation's resources towards a common area of debate: reform of the health sector. Since its release, the Foundation has energetically focused itself on reviewing, analysing and formulating a response to the document.

2. Green Paper released – 12th August, 2011

2.1. The main purpose of the submission is to provide a response, which is underpinned and strongly informed by the values assumed by our constitutional democracy, to the policy options contained within the Green Paper. The Foundation sees this opportunity as a means of fostering greater collaboration and critical, yet constructive, engagement between civil society and government in terms of the policy-making process. Our objective

in this submission is to aid in opening up debate in order for the most appropriate policies concerning health care reform to be implemented.

3. The Foundation's initial response to the release of the Green Paper

3.1. The Foundation released a public statement on the 12th of August, 2011 following the release of the Green Paper. The statement commended the Department of Health's acknowledgement of the problems facing the health system and the government's intention to enhance the workings of the system. However, initial concerns were raised after reading the document. These concerns included the following:

3.1.1. NHI needs to be recognised as a complementary tool in the larger process of Strategic Health Reform and not a substitute for the health system itself.

3.1.2. The human capital deficits across a wide range of functional areas need to be urgently addressed and a coherent human resource strategy needs to be implemented.

3.1.3. The relationship between public and private sector health care providers needs to be debated and clarified.

3.1.4. There is uncertainty and lack of clarity about the tax implications of the introduction of NHI.

3.1.5. The exact source(s) of financing for the proposed system need to be outlined.

3.2. A further concern raised was the inappropriate period of only 2 months allocated for public consultation following the release of the Green Paper. Subsequently, the Helen Suzman Foundation submitted a letter to the Minister of Health on the 12th of September, 2011 urging the Department of Health to reasonably extend the time allocated for public consultation. After receiving a written response from the Minister of Health informing the Foundation that the consultation period was extended to the 31st of December 2011, we were satisfied and hopeful that the process of engaging with government on the matter of health reform indeed had potential to be fruitful.

4. Health Care Policy in South Africa and the NHI

4.1. The idea of a NHI for South Africa is not a new or, for that matter, a uniquely ANC policy proposal, with numerous policy initiatives having investigated the possibility of NHI options for South Africa since the late 1930s. Reference to a NHI system for South Africa is especially consistent in almost all health care policy initiatives post-1994.

4.2. However, the idea of implementing a NHI in South Africa, despite its historical mentionings, is difficult to justify given that it is widely noted that South Africa's health policy is in fact

comprehensive and sound on paper. As Still (2011) notes "there seems to be general consensus that while Department of Health Policies introduced since 1994 have been good they have been poorly implemented and that resources allocated have not been used optimally"[1].

4.3. This begs the question as to what relevance such an overarching and highly centralised bureaucratic policy proposal has in relation to reforming the ailing health sector. The main risk we believe the proposal for a NHI in South Africa poses is that of diverting attention away from the deeper structural and systemic problems in the health care sector. **It is thus the strengthening and re-orientation of the current institutional framework, and not the creation of policy that should be the focus of attention and first port of call for all involved in the health care system.**

5. How the Green Paper has been framed

5.1. Underlying and implicit (and at times explicit) proposals within any policy document is a set of values which prompt the drafting of the policy and the direction it takes. With the Constitution at the heart of South Africa's developmental ideals, the Green Paper assumes the proposed NHI is a suitable vehicle for the progressive realisation of rights and the progression towards equality in health care.

5.2. Although political values are inherently present in and inform policy, they cannot be overlooked. It is the Foundation's concern that certain political motives seem to be driving the present proposal, serving to undermine the noble intentions of a call for health care reform. The Foundation's concerns are the following:

5.2.1. Relative immediacy of implementation:

The Foundation sees the 14 year timeframe for implementation to be a positive approach which would allow for the maturing of health reform policy. However, the immediate implementation envisaged of what, at this stage, is an incomplete strategy or goal, is cause for concern. In light of the radical reforms contained in the Green Paper which form the core of the proposed NHI, namely,

"i) a complete transformation of healthcare service provision and delivery;

ii) the total overhaul of the entire healthcare system; i

ii) the radical change of administration and management;

[1] Still, L. 2011. Health Care in South Africa 2011. Profile Media, p 54.

iv) the provision of a comprehensive package of care underpinned by a re-engineered Primary Health Care"[2],

the time in which the commencement of the NHI legislative process is said to begin – January 2012 – is unreasonably premature. That the time period for public consultation has been extended to 31 December is a factor that should impact upon the proposed legislative process. However, simply putting that process out by a further number of months will not in itself suffice. Instead, a full review of the proposed policy is called for, with vigorous public consultation forming the basis upon which subsequent procedural steps are outlined.

5.2.2. Finger-pointing and fault finding

The Green Paper asserts that South Africa's two-tier health care system has resulted in the health sector itself becoming "unsustainable, destructive, very costly and highly curative or hospi-centric"[3]. While these observations may undermine attempts at creating equality in society, it cannot be cited as a primary reason for the current health care crisis. This does however seem to be the view contained within the Green Paper. The Green Paper states that "[t]he rationale for introducing National Health Insurance is therefore to eliminate the current tiered system where those with the greatest need have the least access and poor health outcomes"[4]. That this argument may be used to inform and motivate in favour of certain proponents of the proposed NHI, in particular the idea of a single-purchaser, single-payer system, is concerning. The main problem with this argument, in the context of health reform, is that it removes the emphasis from considering deeper structural problems which greatly influence the health care system and de-prioritises them. (These problems include poor management and corruption.)

5.2.3. Taking control of the health sector

It is important to differentiate between a health care system which is rendered by the state and one which is co-ordinated by the state. The former, although a model adopted by some countries, is certainly unsuitable for the South African context due to its demographic heterogeneity, strong rural-urban divide and high level of social inequality. Yet it appears to be what is being prescribed in the Green Paper. The idea that "the National Health Insurance Fund will be established as a government-owned

[2] National Department of Health. 2011. National Health Insurance in South Africa, Green Paper, p.5, paragraph6.
[3] *ibid*, p.6, paragraph12.
[4] *ibid*, p.15, paragraph50.

entity that is publically administered" and "a single payer entity"[5] is also concerning in light of the fact that despite South Africa's generally "strong rights-based policy documents... such high standards are often met with poor implementation outcomes and a political system which is still struggling to (achieve) transparency and accountability"[6]. Without trust and guarantees as to how funds will be managed, the system proposed in the Green Paper is open to corruption and poses a high risk of resources being wasted.

5.2.4. The passing of the obligation of health care provision onto the NHI

The implementation of a NHI for South Africa was the second item on the list of the Department of Health's 10 Point Plan. This gives the impression that the policy is not a stand-alone concept, but rather *part* of a broader process of health care reform. However, the Green Paper and various public comments made by the Department of Health point towards the proposed system as effectively synonymous with, and a substitute for, the national health system itself. Importantly, it is the Foundation's view that the proposed NHI should not be understood or touted as an end in itself, but rather explicitly defined as part of a strategic exploration into viable options for expanding access to health care and improving the institutional quality of the South African health system.

6. What is the ideal for South Africa?

6.1. An overarching policy framework for the reform of any national health system needs to be:

- Affordable
- Effective
- Efficient
- Sustainable over the long-term.

6.2. The ideal health policy for South Africa would indeed be one that addresses each of these factors in a single and comprehensive framework. Creating such a policy, particularly in the complex arena of public health, requires both sufficient time and participation as well as input from a multitude of stakeholders. Crucially, broad expert consultation and time-planning is evidently lacking in the current proposal for health reform for South Africa. It is unsurprising then that an analysis of the Green Paper reveals issues relating to each of

[5] *ibid*, p.41, paragraph132.
[6] Austin-Evelyn, K. 2011. Affordable Health Care for all South Africans: the National Health Insurance Green Paper. Available online at: http://www.consultancyafrica.com/.

what the Foundation identifies as the four prerequisites listed above, for an appropriate health policy for South Africa.

6.3. The motivation of this submission is, thus, to engage with the Department of Health's proposals in order to facilitate the establishment of an appropriate direction in which to steer the health care reform debate, as well as ensuring that the choices made regarding the selection of policy mechanisms are relevant to the health care needs of South Africa.

7. Structure of the Foundation's submission

7.1. The following submission deals with:

7.1.1. A paragraph by paragraph review of the Green Paper with comments and queries;

7.1.2. A Situation Analysis examining the performance of South Africa's health system;

7.1.3. A consideration of the constitutional imperatives that inform the health system in South Africa, and the possible constitutional implications that may arise if the National Health Insurance as envisaged in the Green Paper, is applied;

7.1.4. A discussion of the importance of public consultation in the development of policy;

7.1.5. An analysis of the idea of universal health coverage and its relation to the proposals in the Green Paper; and

7.1.6. An outline of the appropriate management required for health system reform.

Chapter 2: NHI Green Paper Review

In general;

- The Foundation finds that the Green Paper is characterised by statements and claims which are not supported by evidence or appropriate references.
- The Green Paper lacks the detail required to provide a more engaged response to the policy proposals.
- The Foundation is concerned that the apparent lack of a comprehensive, evidence-based plan will result in further deterioration of the health system.
- We are of the view that it should be the task of the Department of Health to provide evidence to prove that the intervention of the NHI will improve the ability of South Africans to access health care.

This section reviews the National Health Insurance Green Paper by addressing each section as it is laid out in the Green Paper. Unless otherwise stated we have no comments on the paragraphs of the Green Paper which are not referred to in this document.

1. Introduction

Paragraph 1

"South Africa is in the process of introducing an innovative system of healthcare financing with far reaching consequences on the health of South Africans. The National Health Insurance commonly referred to as NHI will ensure that everyone has access to appropriate, efficient and quality health services. It will be phased-in over a period of 14 years. This will entail major changes in the service delivery structures, administrative and management systems."

- The NHI is described here as *"an innovative system of healthcare financing*". Is the system envisaged a financing mechanism or a replacement/substitute/replication of the health care system itself?
- What is the proposed relationship between the NHI and the national health system?

Paragraph 2

"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 healthcare services regardless of their socio-economic status."

- Poor service provision in the (public) health care sector is indeed a major problem that needs to be addressed from a reform perspective. However, the NHI is not and cannot be

argued to be a necessary means of addressing this problem (and many others in the health care system). If service provision is poor prior to the implementation of the NHI, there is a high risk that it will continue to be poor and the system itself will fail.

Paragraph 3

"The current system of healthcare financing in South Africa 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 subsidised 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 extended to the rest of the population."

- The two-tiered structure of the health care sector in South Africa is described as creating a divide between those who can and cannot afford private health care. The implicit idea is that private health care is unjust and should essentially be extended to the entire population. However, this value-laden assumption diverts attention from the fact that:
    - A two-tiered system is not necessarily a negative approach to providing health care (it is in fact quite common in the provision of universal coverage), and
    - To a large extent the private health care sector exists as a response to the failed public health sector.

Paragraph 5

"The South African health system is inequitable, with the privileged few having disproportionate access to health services. There is recognition that this system is neither rational nor fair. Therefore, NHI is intended to ensure that all South African citizens and legal residents will benefit from healthcare financing on an equitable and sustainable basis. NHI will provide coverage to the whole population and minimise the burden carried by individuals of paying directly out of pocket for healthcare services. This model of delivering health and healthcare services to the population is well accepted, described and widely promoted by the World Health Organisation as universal coverage."

- The notion that "*The South African health system is inequitable"* and "*neither rational nor fair"* holds some truth. As a remedy however, the Green Paper effectively proposes the merging of a sector that is poor and dysfunctional with one that is largely sound, if expensive. The impact this would have on private sector health provision is potentially disastrous, and risks rendering it incapable of more effectively contributing to health care in the public sector if it were to remain under its currently functioning institutional framework. It also disregards the articulation of the public and private sectors, where they touch, are mutually supportive and are symbiotically intertwined.

- Referring to the NHI the Green Paper states *"This model of delivering health and healthcare services to the population is well accepted, described and widely promoted by the World Health Organisation as universal coverage."* This statement is misleading and incorrect. It suggests that a NHI system is synonymous with the provision of universal coverage.

  In fact the WHO clearly notes that "there are substantial differences across countries in the institutional and organisational arrangements used to ensure funds are raised, pooled and used to purchase or provide services. It is the combination of institutional arrangements and legislation relating to revenue collection, pooling and purchasing/provision that determine how equitable and efficient a system is rather than the name that is used to described it"[1]. Implying that what is proposed by the Green Paper is universal health coverage, rather than only an option and means to providing universal coverage, is concerning as it indicates the use of political rhetoric as opposed to the objective use of terminology and risks turning the debate into a political standoff.

2. Problem Statement

Two initial observations are necessary:

- This section ventures beyond policy into politics. This is polemical in nature and creates difficulties for responses on a policy level.
- There is limited discussion of the socioeconomic determinants of poor health, and medical issues are described in isolation from health-influencing societal issues (e.g. domestic violence, alcohol consumption, poverty, education etc.).

Paragraph 7

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

- The point that the South African health system is only *"designed along racial lines"* does not take into account the complex nature of the health system, or the historically rather perverse political "solutions" that were embodied in the arrangement.
- The Foundation rejects this racial reduction as the health system was also fractured along spatial, regional, geographical and class lines.

[1] Carrin, G., Mathauer, I., Xu, K. and Evans, D. 2008. Universal Coverage: Tailoring its Implementation. Bulletin of the World Health Organisation. Available online at: http://www.who.int/bulletin/volumes/86/11/07-049387/en/index.html

Paragraph 8

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

- The latter statement implies that there is a lack of cross-subsidisation in the health care system. Whether one finds suitable cross-subsidisation, however, depends on the assumptions used in the calculations:
- J. Ataguba and D. McIntryre (2009) support the statement in the Green Paper as they conclude that "there is a general lack of cross-subsidisation in the overall health system."[2]
- However, Dr Nicola Theron (Econex), Johann van Eeden (Econex) and Barry Childs (Lighthouse Actuarial Consulting) "demonstrate[] that if one were to analyse the financing and benefit incidence in the South African health sector using alternative assumptions and methods, the results would differ significantly from those derived in the [Ataguba and McIntyre] paper."[3]
- Theron *et al* show that "the conclusion reached by [Ataguba and McIntyre] that the distribution of funding contributions across socio-economic groups is very similar to the distribution of healthcare benefits, is not correct."[4]
- Theron *et al* "find that there is significant cross subsidisation in the total South African health system, from rich to poor"[5] as the richest quintile contributes 82.3 percent to total healthcare financing while receiving 36 percent of the health benefits, and the poorest quintile contributes 1 percent to total health care financing while receiving 12.5 percent of the total health benefits.[6]
- In addition, it is interesting to note the racial profile of those who are covered by Medical Aid:

[2] Theron, N. *et al.* 2009. 'Financing and Benefit Incidence Analysis in the South African Health System: An Alternative View Finding Significant Cross Subsidisation in the Health System from Rich to Poor', in *Private Hospital Review, 2009.* Hospital Association of South Africa, p1.
[3] i*bid.*
[4] *ibid*, p11.
[5] *ibid*, p12.
[6] *ibid*, p2.

Table 1: Medical aid coverage by race 2009[7]

9% of the African population of 39 136 200 = **3 522 258**
21.4% of the Coloured population of 4 433 100 = **948 683**
42.6% of the Indian population of 1 279 100 = **544 897**
74.3% of the White population of 4 472 100 = **3 322 770**

Paragraph 9

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

- Referring to attempts to transform the health system as *"thwarted"* is disingenuous and fails to take into account many of the failed initiatives and other shortcomings of the health system that are the responsibility of the Department of Health and the executing Provinces.
- Such shortcomings include:
    - the closing down of nursing colleges;
    - the lack of a human resources strategy since 1994;
    - poor strategic planning and leadership;
    - lack of skilled financial management;
    - poor monitoring and evaluation; and
    - cadre deployment of unqualified appointees to management posts.
- The term "thwarted" implies that the Department of Health was the "victim" of untoward forces completely out of its control. The term also fails to take into account the areas of current health policy that are sound but where the problem rather lies in poor implementation of that policy.
- The denialism and lack of intervention associated with the government's early response to HIV/AIDS was policy inertia and has nothing to do with plans being "*thwarted".*
- Justification needs to be made regarding the statement that the two-tiered health system *"perpetuate[s] inequalities in the current health system."*

[7] According to the *South African Survey 2009/2010*, published by the South African Institute for Race Relations. In 2010 the percentage of each race group population covered by medical aid was as follows: African – 10.3%, Coloured – 21.8%, Indian - 46.8% and white – 70.9% (www.healthlink.org.za/healthstats/77/data/eth).

Paragraph 10

"The two-tiered system of healthcare did not and still does not embrace the principles of equity and access and the current health financing mode does not facilitate the attainment of these noble goals."

- This is a sweeping statement which the Department of Health needs to justify with evidence.

Paragraph 11

"The 2008 World Health Report of the World Health Organisation (WHO) details three trends that undermine the improvement of health outcomes globally, namely:

- *Hospital centrism, which has a strong curative focus*
- *Fragmentation in approach which may be related to programmes or service delivery, and*
- *Uncontrolled commercialism which undermines principles of health as a public good"*

- This paragraph highlights some of the problems that undermine health outcomes but fails to include the key systemic problems relating to South Africa's public and private health systems.

Paragraph 12

"An analogy of the preceding description can be drawn with the negative attributes of the South African two-tier healthcare system, which are unsustainable, destructive, very costly and highly curative or hospi-centric."

- Does "hospi-centric" mean the same as "hospital centrism"?
- No evidence is presented in the Green Paper to justify the statement that the two-tiered health care system is "*unsustainable, destructive, very costly and highly curative or hospi-centric*".

Paragraph 13

"The national health system has a myriad of challenges, among these being the worsening quadruple burden of disease and shortage of key human resources. The public sector has underperforming institutions that have been attributed to poor management, underfunding, and deteriorating infrastructure."

- This is an accurate description of some of the key challenges in the national health system.
- The Foundation suggest that given the substantive nature of these challenges and the critical role they play in meeting the health needs of South Africans, the Green Paper neither interrogates them critically enough nor in significant detail.

Paragraph 14

"In many areas access has increased in the public sector, but the quality of healthcare services has deteriorated or remained poor. The public health sector will have to be significantly changed so as to shed the image of poor quality services that have been scientifically shown to be a major barrier to access (Bennett & Gilson, 2003)."

- The acknowledgement that the quality of services and service delivery in the public sector needs to be addressed is welcomed and crucial.

Paragraph 15

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

- Although it highlights several of the challenges facing the private sector, the Green Paper fails to consider the lack of functioning market forces, lack of price-competition and inadequate regulation as key problems in the private sector. These challenges are expanded in Chapter 3: Situation Analysis.

Paragraph 16

"To change these types of systems will require *transformation of the healthcare financing model, better regulation of healthcare pricing, improvement in quality of healthcare as well as the strengthening of the planning, information management, service provision and the overhauling of management systems."*

- It is difficult to determine how the Green Paper progresses from the problems highlighted to the reforms proposed in this paragraph. It is imperative that the suggested reforms are evidence-based and designed to address the actual systemic challenges facing the national health system.

2.1 The Burden of Disease in South Africa

- This section contains a welcome acknowledgment of the key challenges regarding South Africa's burden of disease, although the choice of topics appears a little arbitrary, and the reasons for their selection is unexplained.

2.2 Quality of Healthcare

Paragraph 23

"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 payments. This type of arrangement is not suitable for the country's level of development. Therefore, improvement of quality in the public health system is at the centre of the health sector's reform endeavours."

- The Foundation agrees *that "improvement of quality in the public health system is at the centre of the health sector's reform endeavours.* We disagree, however, on the means of realising this improvement in quality.

2.3 Healthcare Expenditure in South Africa

Paragraph 24

"The World Health Organisation recommends that countries spend at least 5% of their GDP on health care. South Africa already spends 8.5% 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 inequities between the public and private sector."

- The Foundation welcomes the acknowledgement that South Africa's health outcomes have remained poor despite high expenditure on health. However, this poor performance cannot be blamed entirely on the private sector, as is implied by the Green Paper.
- According to the 2008 DBSA Road Map Report "there is little evidence that the private system is systemically harmful to the public sector. [The] problems within the public system arise primarily from decisions of the public system itself. Private systems can however undermine public objectives where they emerge and flourish within a regulatory vacuum. "[8]

Paragraph 26

"Gross Domestic Product (GDP) – This is the market value of all final products (goods and services) produced in a country within a given period, usually a financial year. The 8.3% of GDP spent on health is split as 4.1% in the private sector and 4.2 % in the public sector. The 4.1% spend covers 16.2 % of the population, (8.2 million people) who are largely on medical schemes. The remaining 4.2% is spent on 84% of the population (42 million people) who mainly utilize the public healthcare sector (National Treasury: Intergovernmental Fiscal Review, 2011)."

- This claim is disingenuous.
- A recent report states that "a substantial minority use both the private sector and the public sector, so that the true percentage for those who use the private sector wholly or in part is around 35 per cent and the corresponding figure for those served exclusively by public expenditure is lower."[9]
- Given the figures in the report, it is not clear how the Green Paper arrives at the figures in paragraph 26. The figures appear to suggest that spending in the private sector is only done

[8] Development Bank South Africa. 2008 'A Roadmap for the Reform of the South African Health System'. Draft Final Report. Available online at: http://www.npconline.co.za/MediaLib/Downloads/Home/Tabs/Diagnostic/HumanConditions2/A%20roadmap%20for%20the%20reform%20of%20the%20South%20African%20health%20system.pdf, p24.

[9] Bernstein, A. (ed) 2011. 'Reforming Healthcare in South Africa. What role for the private sector?'. Johannesburg: Centre for Development and Enterprise, p10.

by the population covered by medical aid and thus disregards out-of-pocket payments which are not covered by medical aid.

Paragraph 27

"Over the past decade, private hospital costs have increased by 121% whilst over the same period, specialist costs have increased by 120% (CMS Report, 2008). This means that the private healthcare sector will have to accept that the charging of exorbitant fees completely out of proportion to the services provided have to be radically transformed. In real terms, contribution rates per medical scheme beneficiary have doubled over a seven-year period. This has not been proportionate with increased access to services. Simply put this has meant limited access to needed health service coverage mainly as a result of the design of the medical scheme benefit options, or due to early exhaustion of benefits."

- The method by which these numbers were arrived at is unclear.
- Have *costs* or *charges* increased, and are these real increases or inflation adjusted?
- Public sector price, salary and cost increases are not commented on at all.

2.4 Distribution of Financial and Human Resources

Paragraph 31

"The amount spent in the private health sector relative to the total number of people covered is not justifiable and defeats the principles of social justice and equity. Per capita annual expenditure for the medical aid group has been estimated at R11,150.00 in contrast to public sector dependant population where the per capita annual health expenditure is estimated at R2,766.00. This is not an efficient way of financing healthcare."

- The private sector may be spending a lot more per capita than the public system. However, the difference in expenditure should not be the issue as one could argue that spending in the private sector is inefficient. *How the money is spent in the public sector* is the real issue.

2.5 Medical Schemes Industry

- This section correctly identifies several problems in the medical schemes industry. However, it fails to accurately determine the causes of these problems such as over-pricing and cost escalation, rather blaming them on *"the uncontrolled commercialism of healthcare"* (34). Findings explored elsewhere in our submission show that the key challenges are actually systemic and relate to lack of regulation, non-price competition, market imperfections and inefficiency.

2.6 Out of Pocket Payments and Co-payments

- This section implies that the only people who have access to health cover are those who are members of medical schemes. This is clearly incorrect as the public sector provides access to

health care. The problem rather relates to the quality of health care which can cause public system users to pay out of pocket in the private system.

3. History of Proposals on Healthcare Financing Reform in South Africa

- As the Green Paper correctly recognises, "*the history of reforming the healthcare financing system in South Africa actually dates back more than 80 years"* (paragraph 38).
- Indeed, the concept of a NHI is a consistent health care policy theme in the decades preceding the Green Paper. The lack of contextual relevance of many of the historical accounts and policy summaries given in the Green Paper, however, creates a somewhat misleading picture, implying that the NHI has been consistently *recommended* when in fact it often forms only part of, or an option within the report or policy proposal. For example, in the account of the National Health Services Commission (NHSC) (1942-1944) of all the policy recommendations put forward by the NHSC, only its recommendation for *"the implementation of a Health Tax"* is noted in the Green Paper.
  Taking this extract out of context serves to misinterpret the overall recommendations put forward by the NHSC which, in fact was against the idea of implementing a NHI and "instead it focused on NHS approaches with the government of the day rejecting the establishment of a single national authority to finance and render all health services"[10].
- The Foundation believes that the Green Paper's historical account is disingenuous, whereby it has simply highlighted historical policy references as a means to justify its argument in favour of a NHI.
- Furthermore, while all developments relating to health reform policy, particularly since 1994, have looked into the option of a NHI (Health Care Finance Committee (1994)), or adamantly favoured it (Advisory Committee on National Health Insurance (2009)), they become redundant in light of the historically poor quality of the follow-up on policy proposals. Indeed, there is little benefit in making reference to policy proposals that were left to stagnate and not implemented due to disjointed policy development processes that informed their formulation.
- Without a fundamental change in the way policy for health care reform is drafted, intended and followed-up, simply drawing on sections of past policy documents where an NHI system is promoted does very little to instill a greater sense of legitimacy to what is currently being proposed.

[10] Van den Heever, A. 2009. Trends in government policies and programmes, with specific emphasis on national health insurance, p.6. Unpublished.

- Lessons that can be learnt from an historical account of health care reform in South Africa should not be related to finding a common policy theme. Instead, such an analysis should be seen as a way to gain insight as to how policy might be better developed and the process better facilitated, in order that the most appropriate policy for the time is outlined and implemented.

4. National Health Insurance

- This section is value-laden and vague:
    - The Foundation queries why the Green Paper states that the *"rationale for introducing National Health Insurance is … to eliminate the current tiered system"?* Surely it is more logical for the rationale to be the provision of improved health care to South Africans?
    - Furthermore, as discussed above, there is already significant cross-subsidisation in the health system and the onus is on the Department of Health to prove that NHI will improve cross-subsidisation further.

5. Principles of National Health Insurance in South Africa

The list of principles said to be guiding the NHI are in themselves fundamental. However, these principles are what should in fact underlie any national health system, regardless of its mechanics. Rather, the principles upon which any policy for health reform should be based ought to be utilitarian and not ideological, as we are speaking about a policy and not an ideology. Importantly, principles such as accountability, transparency and openness should underlie a system such as that proposed in the Green Paper.

Paragraph 52

"a) The Right to Access – *Section 27 of the Bill of Rights of the Constitution states that everyone has a right of access to health care services including reproductive health care and that the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights. The reform of healthcare is an important step towards the realisation of these rights and the key aspect of this is that access to health services must be free at the point of use and that people will benefit according to their health profile."*

- The idea that healthcare reform is necessary to realise the rights contained in section 27 of the constitution is valid. However, two important questions must be raised:
    - Is the NHI an appropriate means of realising these rights?
    - Is *free* health care a requirement implicit in the right to health care?

- What is meant by "available resources" in the context of NHI and other demands on the state fiscus?

"*b)* Social Solidarity – *this refers to the creation of financial risk protection for the entire population that ensures sufficient cross-subsidisation between the rich and the poor, and the healthy and sick. Such a system allows for the spreading of health costs over a person's lifecycle: paying contributions when one is young and healthy and drawing on them in the event of illness later in life.*

- The ideal for any insurance-based health system is indeed "*the spreading of health care costs over a person's lifecycle*". However, the context of South Africa does not necessarily allow for this to be realised very easily. The high youth unemployment rate coupled with the high burden of non-age related disease in South Africa creates the scenario where many people would necessarily draw significantly on resources, at a young age, whilst not contributing to its sustainability. The use of such a rational system of modelling should thus be reconsidered when developing a means to cater for the health of the entire population collectively.

6. Objectives of National Health Insurance

- This section makes several claims that National Health Insurance will improve South Africa's health outcomes. The Green Paper, however, does not provide evidenced-based research to defend these claims.
- This section also assumes that market mechanisms do not provide efficiency and that State mechanisms are preferable when it comes to providing efficiency. Such a claim is peculiar when the majority of economic evidence shows that the opposite is generally the case.

Paragraph 55 (b)

"b) To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund."

- The Department of Health needs to provide applicable definitions as well as evidence to defend the claim *that "equity and social solidarity will be achieved through the creation of a single fund."* (our emphasis)

It is worth noting that at about this point, the Green Paper appears to lose focus. It begins to wander between levels of high level policy to the minutiae of the make-up of particular health provision teams.

7. Socioeconomic Benefits of National Health Insurance

- Socioeconomic benefits stemming from enhancing the health of the population are the product and responsibility of a well-functioning health care system and the Department of Health. Stating that the NHI would have socioeconomic benefits is not a relevant justification for the proposed policy.
- The proposed health care reform should be described as a means to better facilitate the achievement of socioeconomic well-being.

Paragraph 58

"In other middle-income countries where National Health Insurance has been implemented it has resulted in the following benefits:

a) A healthier population contributes to better wealth creation. Each extra year of life expectancy raises a country's GDP per person by around 4% in the long run. Poor health reductions in adult mortality explain 10 to 15 percent of the economic growth that occurred from 1960 to 1990 in 52 countries (Bloom, D.E, Canning, D., & Sevilla, J (2003) The Effect of Health on Economic Growth: A Production Function Approach. World Development 32(1): 1-13).

b) Investments in health are important safety nets against poverty traps in times of economic upheaval. Lack of health insurance in India means that over 37 million Indians fall below the poverty line each year due to catastrophic health spending; families will often sell assets like livestock in order to meet medical expenses.

c) Public financing of health services frees the poor to use more money to improve their welfare and create jobs for others. For example, in South Africa, 48% of health spending flowed via private intermediaries in the way of private health insurance contributions (40.7%) and the remainder is out of pocket spending. If the households did not have to spend this on health, they would either save it or spend it on other goods and services including investing in other household assets, and other activities that create jobs in the economy."

- This section seems to posit the health sector as the only arbiter of economic well-being and disregards other important drivers such as education and "stage of development".
- Using the outcomes of a NHI system implemented in other countries is not necessarily a useful indicator of how effective such a system would be in South Africa due to its unique factors of demographic diversity, social inequality and geographical and spatial divisions, in particular the strong rural-urban separation. Outcomes in a mono-cultural homogeneous society may well be influenced by such lack of diversity.
- Paragraph 58a) is used out of context as there are less than 52 countries where a NHI system is in place. Using this statement in this manner also creates further confusion between the concept of universal coverage (which a large number of countries have in

some form, but not necessarily that of NHI) and NHI, which again is simply a means to achieving positive health outcomes.

Paragraph 60

"The country will have a healthier workforce at a lower cost in the long term, which increases employment and attracts foreign direct investment. For instance, Canada's provinces introduced national health insurance on a staggered basis from 1961 – 1975. Across 8 industries in 10 provinces, employment rose after the introduction of National Health insurance; wages increased as well, but average hours were unchanged. In addition, provinces with high initial levels of private insurance coverage had lower rates of employment and slower wage growth."

- A comparison with Canada's health care system and the effect the implementation of a NHI had on its employment statistic is misleading as it ignores other social and economic conditions which may have contributed to this rise in employment. For example, the enactment of legislation during the 1950s and 1960s, such as the removal of restrictions on the employment of married women in the federal Public Service, is noted to have influenced employment levels in Canada, with the percentage of women employed rising from 23.9 in 1960 to 40.8 in 1975[11].

7.1 Economic Impact Modelling

Paragraph 61

"Macro-economic modelling undertaken suggests that the implementation of National Health Insurance could have positive or negative implications, depending on the model utilized and its outcomes. When implemented successfully, the National Health Insurance can improve employment and growth in the long-run. The economic impact assessment indicates that the National Health Insurance can have positive impacts in the long-run provided that it succeeds in improving the health indicators of the country, including significant improvement in life expectancy and child mortality. The better health outcomes need to translate into significant labour productivity. In the long-run, the higher productivity can lead to growth improving by 0.5 percentage points. However for National Health Insurance to have this positive macro-economic implication it needs to address the current institutional and staff constraints, improve significantly South Africa's health indicators, achieve the productivity gains and remain affordable."

- *"The economic impact assessment indicates that the National Health Insurance can have positive impacts in the long-run provided that it succeeds in improving the health indicators of the country, including significant improvements in the life expectancy and child mortality."* Are improvements in health indicators and life expectancy not the very basis for any health care reform?
- Again, in this section the other social and economic drivers such education, inward and internal investment and current income distribution are excluded.

[11] Roberts, L. 2005. Recent Social Trends in Canada, 1960-2000, p.158-183, McGill-Queen's University Press.

8. The Three Dimensions of Universal Coverage

- Universal coverage is an ideal, not a policy position. Universal coverage is achieved via the implementation of numerous policy mechanisms in order to satisfy the three components that constitute its make up: population coverage, service coverage and financial risk protection.
- As it pertains to South Africa, there is already universal coverage in that the whole population has access to health care. The ideal is thus met, but where the health system does fail is in the quality of services offered. Consequently, reform for the health sector needs to focus not on achieving universal coverage, but rather on the more effective implementation of current policy.
- In light of the above, a definition of the concept of NHI is missing from the Green Paper and should perhaps be described here, differentiating it from the concept of universal health coverage.

Paragraph 63

"b) Breadth of the cube
This refers to services covered. The present system wrongly confuses healthcare with treatment of diseases. A comprehensive healthcare package includes:

- *Prevention of diseases, Promotion of health, Treatment of diseases where prevention has failed, Rehabilitative services."*

- The Green Paper states that "*The present system wrongly confuses healthcare with treatment of diseases.*" It would be more accurate to state that the high prevalence of disease in South Africa coupled with a weak and failing health care system has forced health care, in the public sector in particular, to be disease-focused as opposed to prevention-focused. This fact would place enormous initial pressure on a NHI system whereby even if it did drastically improve the orientation of the health care system towards preventative health, a focus on disease treatment would still necessarily have to be at the forefront of strategy.
- *"A comprehensive healthcare package includes: prevention of diseases, promotion of health, treatment of diseases where prevention has failed, rehabilitative services*." This should read "a comprehensive health care system" not "package" which is terminology associated with insurance and not the concept of universal coverage.

9. Population Coverage under National Health Insurance

Paragraph 64

"National Health Insurance will cover all South Africans and legal permanent residents. Short-term residents, foreign students and tourists will be required to obtain compulsory travel insurance and must produce evidence of this upon entry into South Africa. Refugees and asylum seekers will be covered in line with provisions of the Refugees Act, 1998 and International Human Rights Instruments that have been ratified by the State."

- Due to the high number of undocumented immigrants in South Africa, some sort of provision needs to be made for involving them in the health system. Not doing so, in some form or another, undermines the ethical nature of providing universal coverage. As Hassim (2010), notes "The NDoH, as steward of the policy, would have to consider whether [only providing coverage to legal citizens] is a reasonable and justifiable limitation of the right to equality or of "everyone" to have access to health-care services"[12]. Constitutional considerations will also need to be taken into account.
- This is also a particularly important issue to deal with in terms of the provision of emergency health services.
- The effect the high number of undocumented immigrants has on current modelling and costing of the health care system also influences costing estimates. This is something that is not made mention of in the Green Paper.
- The undocumented immigrant question is as much a political question as an economic one that must be dealt with.

10. The Re-engineered Primary Health Care System

- One must question whether in fact this is actually re-engineered or rather a restatement of current policy which is yet to be effectively implemented.
- Why is an effective primary health care system not yet fully implemented? It has been the domain of the Department of Health since 1994.
- Whether this detail belongs in a Green Paper dealing with institutional changes to the national health system is also debatable.

[12] Hassim, A. 2010. Chapter 20: National Health Insurance: legal and civil society considerations. South African Health Review 2010, p.206. Health Systems Trust.

10.1 District Clinical Specialist Support Teams

Paragraph 71

"In order to address high levels of maternal and child mortality and to improve health outcomes, an integrated team of specialists will be based in the districts. The specialities will include: ***a principal obstetrician and gynaecologist; a principal paediatrician; a principal family physician; a principal anaesthetist; a principal midwife and a principal primary health care professional nurse****. Others will be added over time as the need arises. The role of these teams will be to provide clinical support and oversight particularly in those districts with a high disease burden."*

- The Foundation would like clarity on whether *"an integrated team of specialists"* will be more effective than improving management and accountability systems at addressing *"high levels of maternal and child mortality and … improve health outcomes".*
- If these teams are to effectively provide clinical support and oversight, will there be a suitable accountability structure?

11. Health Care Benefits Under National Health Insurance

Paragraph 79

"The provision of a comprehensive benefit package of care under National Health Insurance will be fair and rational. The term "benefit package" describes how different types of services are organized into different levels of care in the public sector (J Doherty, 2010). It also defines the types of services that are considered as achievable for the country commensurate with its resources."

- The term "*benefit package*" should in fact read "service package" due to the fact that individuals will not be receiving benefits, but a limited number and predefined types of services determined by the NHI.
- The term *"benefits*" is conflated with the provision of services mandated by the Department of Health.

Paragraph 80

"The National Department of Health (NDOH) has over the number of years developed 'benefit packages' for primary health care, district hospital services, regional hospital services and tertiary services. Despite this, barriers to accessing these packages still exist."

- What are the barriers to accessing the benefit packages said to have previously been developed by the Department of Health, and what difference will a NHI make?
- What are these benefit packages?

Paragraph 81

"In the design of these packages, certain considerations should be made to overcome the identified barriers to access. A review of the international evidence on high-level strategies to promote health

and health equity found that comprehensive benefit packages should be determined first by considering which interventions are important in improving access, offering financial protection to less advantaged groups and enhancing redistribution of healthcare services. The comprehensiveness of the package of services to be provided must also demonstrate how well the health system is performing, and ensure timely referral of patients at different levels of care."

- In order to design comprehensive benefit/service packages for the entire population under one system a considerable amount of data is needed. This data is not currently available and thus an enhanced Health Information System (HIS) is required before such policies can be implemented.

11.1 The Service Package within the Context of District Health Service

Paragraph 83

"Services provided within the context of the district health system have shown mixed results purely because they have been viewed as a once off process of granting authority to lower levels of administration in a decentralised manner. Evidence shows that this must be a carefully planned process that requires good administrative systems with innovative service delivery approaches that would bring about efficiency, improved management including financial management."

- This is an undermining of decentralisation. It is not a *"once-off process of granting authority to lower levels of administration"* but rather should involve constant processes of monitoring, feedback and ongoing interaction on all levels.

11.2 Delivery of Primary Health Care Services through Private Providers

Paragraph 85

"In addition to the three streams, PHC services will be delivered through accredited and contracted private providers practicing within a District. A sizeable proportion of the population in the country uses private providers for their health care needs and more often than not it involves substantial out of pocket payment."

- *"A sizeable proportion of the population uses private providers..."* The Foundation suggests that the proportion is relatively small compared to the remainder of the population using public sector services. This statement also contradicts the previous statement in the Green Paper which states that "*A large part of the financial and human resources for health is located in the private health sector <u>serving a minority of the population</u>*".(our underlining)

11.3 Hospital-Based Benefits

Paragraph 87

"Services to be rendered at the hospital level will be based on a defined comprehensive package that is appropriate to the level of care and referral systems. The National Health Insurance will provide an

evidenced-based comprehensive package of health services which includes all levels of care namely: primary, secondary, tertiary and quaternary health care services."

- In order to provide an evidence-based package of health services, the evidence needs to be obtained and research carried out. When and how will this be done?

11.4 Designation of Hospitals

Paragraphs 88 – 96

- There is no indication of possible public-private-partnerships (PPPs) in terms of designation of hospitals. This will be necessary in terms of enhancing human resource capacities.

Paragraphs 94 and 95

- Given that there are currently three recognised categories of hospitals in South Africa (i.e. District; Regional; Tertiary)[13], it is important that the proposed re-designation of hospitals is more clearly defined. In particular, the distinction between tertiary and central hospital designations is unclear and confusing and needs to be explained further.

12. Accreditation of Providers of Health Care Services

12.1 The Office of Health Standards Compliance (OHSC)

- There is a key governance issue relating to the reporting lines on the OHSC which needs to be clarified.
- Clarity is required regarding the independence of the OHSC. If it is not independent from the NHI Fund, governance issues will arise.

Paragraph 99

"All health establishments (public and private) that wish to be considered for rendering health services to the population will have to meet set standards of quality. There are six core standards that form part of a comprehensive quality package. These standards deal with key quality principles that will improve safety and facilitate access to healthcare services. These standards will form only one aspect of accreditation, other criteria for accreditation will include service elements, management systems, performance standards and coverage."

- Specification is required regarding the *"six core standards that form part of a comprehensive quality package".*

[13] Cullinan, K. 2006. Health Services in South Africa: a basic introduction. Health-e News Service. Available online at: http://www.health-e.org.za/uploaded/cb1f388f3b351708d915c12cfb4fc3cf.pdf

12.2 Accreditation Standards

Paragraph 100

"The accreditation standards will specify the minimum range of services to be provided at different levels of care. Central to the accreditation is the provision of primary health care services that can demonstrate performance linked to health outcomes. This will entail involvement of competent health and medical staff with appropriate skills. In addition, providers at all levels of care must adhere to the referral procedures as defined by the National Health Insurance and the referral system will be clearly defined for services within and outside the health sub-district, district and province to assure continuity of care and effective cost containment."

- With regards to accreditation standards, clarity is required on whether private providers will have scope for independent action and whether the NHI will specify the range of services that they must provide.

13.Payment of Providers Under National Health Insurance

- In order to implement an effective payment system there needs to be accountability and oversight structures in place to avoid misuse of the system. Such structures need to be described.
- There are many risks to the health care sector as a whole should the payment structure for the NHI fail, as it would essentially render all service providers unable to do their jobs.
- The poor track record of managing financial transactions in the current health system makes the task of ensuring that the payment system for the NHI is effective an extremely difficult one.

Paragraph 102

"At the primary care level, accredited providers will be reimbursed using a risk-adjusted capitation system linked to a performance-based mechanism. The annual capitation amount will be linked to the size of the registered population, epidemiological profile, target utilization and cost levels."

- Determining capitation amounts using a risk-adjusted capitation system requires a detailed health information system, which is currently not in place.

13.2 Unit of Contracting Providers of Health Care Services

Paragraph 111

"A further role of the District Health Authority will be to ensure that services that are planned for are adequate and accessible for the population that is located within a defined health district. Initially all districts may not be able to participate in purchasing decisions due to capacity constraints. Nonetheless, over a period of time, District Management teams will be strengthened."

- *"Initially all districts may not be able to participate in purchasing decisions due to capacity constraints. Nonetheless, over a period of time, District Management teams will be strengthened."* Does this mean that over time that the proposed single-purchasing system will be devolved to the district level?
- What functions will the district management teams serve both at the initial stage of implementation and *"over a period of time*"?

Paragraph 112

"Accredited providers will be contracted and reimbursed on the basis of the payment levels determined by the National Health Insurance. Accreditation will also take into account the need for particular providers within a particular area, type of health services required as well as available resources within the district. The District Health Authority will monitor the performance of contracted providers within a district and performance will be linked to a reimbursement mechanism that is aimed at improving health outcomes in the district."

- The Green Paper mentions that *"The District Health Authority will monitor the performance of contracted providers within a district and performance of contracted providers".* In order to do this they will need to have the authority to intervene, be accountable and independent. Currently, lower level management in the health sector does not have such authority mandates, or the appropriate skills.

14. Principal Funding Mechanisms for National Health Insurance

It is difficult to comment on this section as it is lacking in detail. Clarity is required on where the funds for the NHI will come from. The burden to be placed on individuals and employers also needs to be specified.

Paragraph 115

"An important consideration is that the revenue base should be as broad as possible in order to achieve the lowest contribution rates and still generate sufficient funds to supplement the general tax allocation to the National Health Insurance. As the National Health Insurance matures, consideration will be given to the alignment and consolidation of health benefits offered by other relevant statutory entities."

The Foundation would like clarity on how the Department of Health aims to ensure that the *"revenue base should be as broad as possible"* given that;

- only approximately 12.8 million South Africans are employed; 70 percent in the formal sector and the remainder in the informal sector, agriculture or private households;[14] and

[14] Kane-Berman, J. (ed). 2010. *South Africa Survey 2009/2010.* Johannesburg: South African Institute of Race Relations, p181.

- there are only approximately 5.9 million registered taxpayers.[15]

15.How Much Will National Health Insurance Cost?

Paragraph 117

"The costing estimates presented in this section focus on providing an indication of the estimated resource requirements for achieving universal coverage, based on cost effective delivery of health services."

- In the past, there has been a consistent tendency to under-estimate the costs of delivering public service programmes by various government departments. This has significant implications for the sustainability of a vital public service.
- Making assumptions in terms of costing, despite modelled cost estimates, is premature at this stage of the policy process.

Paragraph 119

"The costing model used in this preliminary costing adopts the approach recommended by the International Labour Office (ILO), which is:
*Total expenditure = user population **X** service utilisation rates **X** unit costs*
It takes account of the population size and how population will grow over time as well as the age and sex composition of the current and future population (as young children, the elderly and women of childbearing age have greater health service needs). It also takes into account how frequently different groups use different health services and how this may change over time, particularly when financial barriers to access are removed under the National Health Insurance. Finally, it considers how much it costs (now and in future) to provide each type of health service drawing on the current costs of provision of public sector services and the need to dramatically improve resourcing of public sector health services."

- The costing model said to be used for preliminary costing requires service utilisation rates to be known and accurate for the total expenditure necessary for the implementation of the NHI. Large amounts of data will need to be collected to identify how frequently different groups use different health services.
- To calculate an accurate costing for health services when *"financial barriers to access are removed under the National Health Insurance"* is made even more problematic given the fact that essentially, under such conditions, demand will increase infinitely in relation to supply.

Paragraph 120

"The model presents the estimated resource requirements using a public sector framework. This implies that a defined comprehensive package of services is provided for all South Africans, but this

[15] *ibid*, p150.

package is not specified as in current medical schemes in terms of specific services that will be covered (e.g. whether or not chronic medicines for depression are covered). Instead, the comprehensive package is defined in terms of individuals having access to primary care facilities and to specialist and hospital care on referral. For each of these broad categories of services, there are norms in relation to the type of staff that should be employed, equipment that should be available and the range of services that should be provided. In addition, it is based on public sector unit costs, but at substantially improved resourcing levels than at present."

- Where are the additional health care professionals going to come from in order to meet the *"'norms' in relation to the type of staff that should be employed*"?
- There is no mention of the rationing of services which is important given the high demand which would result in response to the removal of financial barriers to access.

Paragraph 121

"The improvement in resourcing is phased in over the initial 7 year period (i.e. it is regarded as an urgent intervention). The model makes allowance for large increases in utilisation when financial barriers to service use are removed under the National Health Insurance (of over 70% in outpatient care and about 80% in inpatient care for those who are currently „uninsured" relative to their current utilisation levels). These projected increases in utilisation are comparable to the extent of utilisation increases experienced in Thailand when a universal health coverage system was introduced. It will take considerable time for the supply capacity (facilities and health professionals) to grow to accommodate such utilisation increases. For this reason, these increases are phased in over a 14 year period."

- Why is the example of Thailand used and how relevant is it to South Africa? Is it not more appropriate to use data from the 1996 introduction of free health care to children under 5 years and pregnant women?
- The fact that it will "*Take considerable time for the supply capacity... to grow to accommodate such utilization increases*" is extremely important to note. In recognising this, how will the NHI phase the opening up of services to the population?

Paragraph 125

"It should be noted that increased spending on the National Health Insurance will be partially offset by the likely decline in spending on medical schemes (as all South Africans will be entitled to benefit from National Health Insurance services). In addition, National Treasury is projecting real GDP growth of 3.1% in 2010/11, 3.6% in 2011/12 and 4.2% in 2012/13. National Health Insurance will require an increase in spending on health care from public resources (general tax revenue and a mandatory National Health Insurance contribution) that is faster than projected GDP increases. However, the ultimate level of spending on a universal health system relative to GDP (of 6.2%) is less than current spending by government and via medical schemes (of 8.5%)."

- The claim that there will a decline in spending on private medical schemes in the short- to medium-term following the implementation of NHI lacks any supporting evidence.

- Only when the health care provided by the public sector is significantly improved can this be expected. The fact that such a task necessarily will take many years means it is likely that those who can afford it will continue to spend on private medical schemes for the foreseeable future.
- It is stated previously in the Green Paper that South Africa already spends an above average percentage of its GDP on health care. To justify the idea that "*National Health Insurance will require an increase in spending on health care from public resources*" means eliminating the current poor management of funds in the health care sector. This will need to be a prerequisite in order for the NHI to justify access to additional financial resources.
- Surely a costing model cannot be based on GDP projections. Those forecasted numbers have already been slashed.

Paragraph 127

"The preliminary costing estimates provided above indicate that the National Health Insurance is affordable for South Africa. However, the present system of fragmentation, associated with the high cost, curative and hospi-centric approach and excessive and unjustifiable charges, especially within the private health sector is unsustainable. No amount of funding will be sufficient to ensure the sustainability of National Health Insurance unless the systemic challenges within the health system are also addressed."

- "*No amount of funding will be sufficient to ensure the sustainability of National Health Insurance unless the systematic challenges within the health system are also addressed."* The recognition of this fact needs to be expanded upon and used to guide reform in the health sector. Indeed, South Africa is already spending an above average percentage of GDP on health care and this should give rise to alternative options to reform as opposed to discussing only new health care financing mechanisms and ways of generating additional funds.
- It is an analysis and direct response to the deeper structural and systemic issues currently plaguing the health care system that need to be addressed – both of which are missing from the Green Paper.

Paragraph 129

"The high cost, curative and hospi-centric system cannot be sustainable not only for the implementation of National Health Insurance but also for any form of healthcare financing mechanism including the present medical schemes environment. In order to effectively implement such a large health systems reform programme, strengthening of the public health system and transformation of the health services delivery platform is critical for the success of National Health Insurance."

- "*In order to effectively implement such a large health systems reform programme, strengthening of the public health system and transformation of the health services delivery platform is critical for the success of National Health Insurance."* Again this fact needs to inform any proposed reform policy for South Africa. This needs to be expanded upon and play a more prominent role in future policy documents.

16. The Establishment of the National Health Insurance Fund

Paragraph 132

"The National Health Insurance Fund will be established as a government-owned entity that is publicly administered. It will be a single payer entity with sub-national offices to manage nationally negotiated contracts with all appropriately accredited and contracted healthcare providers. The covered services will be defined as a comprehensive package of services that includes personal care, health prevention and promotion services. The main responsibility of the National Health Insurance Fund will be to pool funds and use these funds to purchase health services on behalf of the entire population from contracted public and private health care providers. Nonetheless, a multi-payer system in a National Health Insurance will also be explored as an alternative to the preferred single-funder, single-purchaser publicly administered Fund."

- The Department of Health needs to provide evidence showing that a single payer system will be more efficient and effective than other systems.
- Where decentralisation has shown itself internationally to be efficient from a management perspective, the Foundation would like to query the use of *"nationally negotiated contracts"*.
- Mentioning that *"a multi-payer system in a National Health Insurance will also be explored"* raises the question of whether the Department of Health, by contemplating two different approaches, has another arrangement in mind. This appears unlikely however, given the emphasis on a single-payer system in the Green Paper. Is it perhaps mentioned as a sop to critics of the latter system?

Paragraph 133

"The National Health Insurance Fund will be an autonomous public entity reporting to the Minister of Health and Parliament. It will be governed by the relevant statutes. The Fund will be established through the passing of enabling legislation and supporting regulations. The Minister of Health will have oversight of the National Health Insurance Fund."

- As the NHI Fund *"will be an autonomous public entity reporting to the Minister of Health and Parliament",* it is assumed it will be subjected to scrutiny by the Standard Committee on Public Accounts (SCOPA)?

Paragraph 134

"The Department of Health will continue to play its overall stewardship role of the health system, such as development of overall health policy, planning to meet changes in the country's health care needs as determined by changes in population demography, epidemiological profile, health technology and any other relevant developments. The Department of Health will also remain a major provider of services through its national, provincial and district level structures and facilities. Furthermore, the Department of Health will continue to provide non-personal services including overall responsibility for infrastructure development and direction of health worker training and planning. The responsibility of coordinating the development of overall health plans including personal services will be retained within the Department of Health. The National Health Insurance Fund will purchase personal services in accordance with the approved plans by the National and Provincial Departments of Health."

- Clarity is required on the exact relationship between the NHI and the Department of Health and the ongoing role of the National and Provincial Departments of Health.

Paragraph 135

"At the national level, the National Health Insurance Fund will be managed by a Chief Executive Officer (CEO) who will report directly to the Minister of Health. The CEO will be supported by a competent Executive Management Team and specific technical committees including the technical advisory committee, audit committee, pricing committee, remuneration committee, benefits advisory committee and others."

- The Foundation is concerned that the political accountability structure implied by this paragraph is not a suitable structure when such large amounts of money are involved. Several governance issues also arise:
    - The reporting lines and oversight lines need to be clarified.
    - The appointment of the CEO needs to be clarified.
        - Will the CEO be appointed through tender or through deployment?
        - What will be the compensation rate of the CEO?

17.The Role of Medical Schemes

- The lack of reference to public-private-partnerships is concerning. This section should deal extensively with this; however it fails to do so.
- How does the proposed NHI system intended to make use of the relatively strong administrative and managerial skills and resource in private medical scheme sector?

Paragraph 137

"Membership to the National Health Insurance will be mandatory for all South Africans. Nevertheless, it will be up to the general public to continue with voluntary private medical scheme membership if they choose to. Accordingly, medical schemes will continue to exist alongside National

Health Insurance. However, there will be no tax subsidies for those who choose to continue with medical scheme cover."

- If medical schemes are to continue to exist alongside the NHI, why has the use of their expertise and administrative resources within a multi-payer environment not been explored?

Paragraph 139

"There is existing expertise residing in the health sector in the area of administration and management of insurance funds. Where necessary and relevant, this expertise may be drawn upon within the single payer publicly administered National Health Insurance, to ensure that adequate in-house capacity is developed."

- It is recognised that "*there is existing expertise residing in the health sector*." Does this refer specifically to that of the private health sector or the public health sector or both?
- In either case, why will this be drawn upon only "*where necessary and relevant"* as opposed to being used in an integrative fashion, such as the formation of public-private-partnerships?
- Given the fact that the public health sector is hugely under-resourced will this expertise not be necessary and relevant in all aspects of health reform?
- How will the skills of the private sector be accessed?

18. Registration of the Population

- Clarification is required regarding:
    - Who is going to register the population?
    - Will undocumented immigrants be denied health care?
    - Who is going to issue the card?

19.Information System for National Health Insurance

Paragraph 142

"The National Health Insurance will contribute to an integrated and enhanced National Health Information System. National Health Insurance information system will contribute towards the determination of the population's health needs and outcomes. The information system will also be essential for portability of services for the population. The National Health Insurance information system will be based on an electronic platform, with linkages between the National Health Insurance membership data base (with updated contribution status) and accredited and contracted health care providers. The information system will need to be adequately budgeted for in the initial stage to help ensure effective implementation. Developmental work will be conducted on a National Health Insurance patient card and supporting information platform."

- The NHI is said to *"contribute to an...enhanced National Health Information System."* What constitutes the current National Health Information System and what is the current state of the System?
- Is the NHI really necessary in order to enhance the current National Health Information System?
- Implementing a system of health reform based on an insurance model requires the existence of comprehensive data covering the entire population. Thus, the Health Information System essentially forms the foundation for what is proposed and will be a large determinant of the systems success. Providing only a paragraph on the role of the HIS is insufficient and this component needs to be expanded on significantly.
- What is the relevance of having an "updated contribution status" provided to health care providers if the objective of NHI is to provide free care at point of access and if membership is mandatory?
- How will rural hospitals and clinics and those with less infrastructural resources adapt or be upgraded in order to effectively make use of and benefit from the "*electronic platform"* proposed?

20. Migration from the Current Health System into the National Health Insurance Environment

Four initial observations are necessary as a precursor to the comments on the individual paragraphs:

- This is a poorly constructed 'catch all' section which gives the impression that some of the detail missing in the previous sections of the Green Paper has been added here as an afterthought.
- There is insufficient prioritising of key interventions.
- This section comprises claims where positions are not explained and arguments are not justified.
- Management of the public sector, arguably one of the key areas requiring improvement, is not discussed in any meaningful manner.

Paragraph 143

"The transitional process from the current to the proposed National Health Insurance environment within the South African health system will require a well-articulated implementation plan. The implementation of National Health Insurance will be done in a phased and systematic manner at both the national and sub-national levels. The migration period will occur in three phases over the fourteen years of implementation."

- Clarification is required to explain why a time period of fourteen years has been chosen for implementation. Fourteen years is equivalent to three terms of Presidency which could complicate implementation if there is no ministerial continuity or continuity of senior personnel and management staff.

Paragraph 150

"Implementation of hospitals management reforms that include governance reforms, improvements in financial management, decentralization of authority associated with hospital management autonomy and accountability;"

- The reference *to "decentralization of authority associated with hospital management autonomy and authority"* is welcomed. It does, however, contradict many of the sections which advocate centralisation and management on a national level.

Paragraph 154

"Refinement of the revenue mobilisation strategy and pooling systems that will be implemented to ensure National Health Insurance provides the appropriate financial risk protection for the entire population and yields the full economies of scale from the publicly administered monopsony structure to support the single-purchaser National Health Insurance. This will also include alignment of health benefits and tariff system under the Road Accident Fund, Compensation for Occupational Diseases and Injuries, Compensation Commission for Occupational Diseases and the Occupational Diseases in Mines and Works Act."

- This paragraph requires clarity. There is also the question of whether differentiation and competition will be allowed within the NHI?

Chapter 3: Situation Analysis

This section examines the performance of the health system in South Africa. It suggests that the South African health system is underperforming given the level of health expenditure. In the public health system, it appears that the key causes of poor performance are systemic and include inefficiency, lack of accountability and governance and poor management. On the other hand, the private health system is plagued by market imperfections, lack of price competition and ineffective regulation. In particular, the performance of the health system is examined in this section with regards to key health indicators and the country's burden of disease with a view to explaining the systemic causes of poor performance. It also assesses the challenges facing the public and the private health sectors.

1. Introduction: Trend – Poor health outcomes despite high expenditure on health

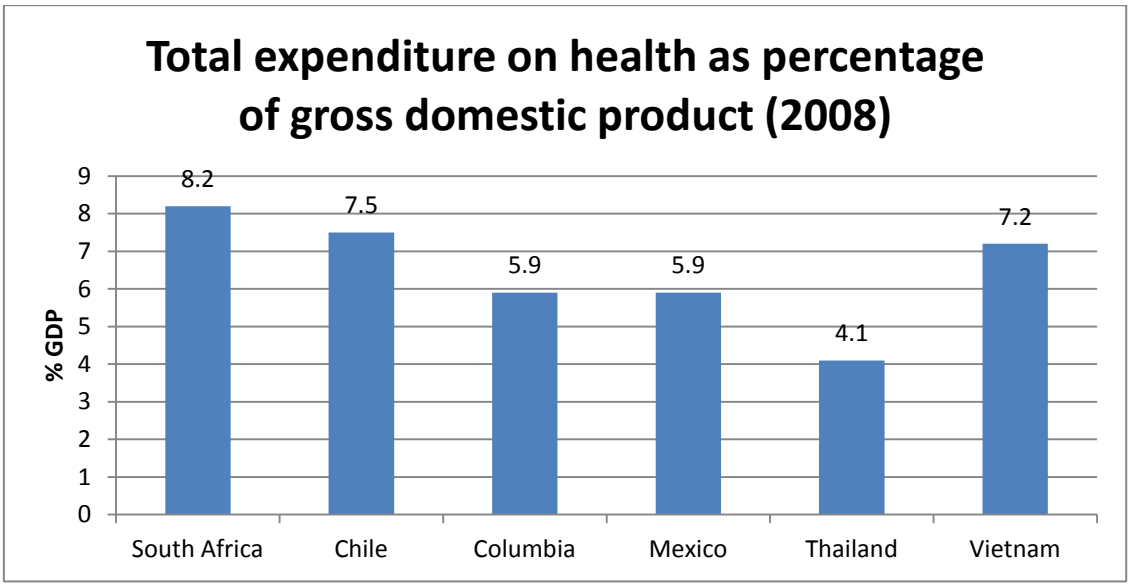
1.1 The health system in South Africa is underperforming considerably given the level of health expenditure. South Africa spends similar, and in some cases considerably more, on health care than its peer countries and yet is experiencing poor health outcomes and a rise in the burden of major diseases.

1.2 **Figures 1** and **2**[1] show that South Africa's general government expenditure on health as a percentage of gross domestic product (GDP) is similar to many of South Africa's peer countries and countries that South Africa is often compared to, namely Chile, Columbia, Mexico, Thailand, Cuba and Brazil, as South Africa's peer countries as they have similar per capita GDP. [2]

1.3 When comparing health indicators such as life expectancy and maternal mortality (**Figures 3** and **4**) it becomes apparent that South Africa's key health outcomes are significantly worse than its peer countries and comparable countries with similar public health expenditure as a percentage of GDP. In this regard, the Development Bank of Southern Africa (DBSA) Roadmap Report also provides further compelling evidence indicating that "in part poor performance is a function of inefficiency rather than resource constraints."[3]

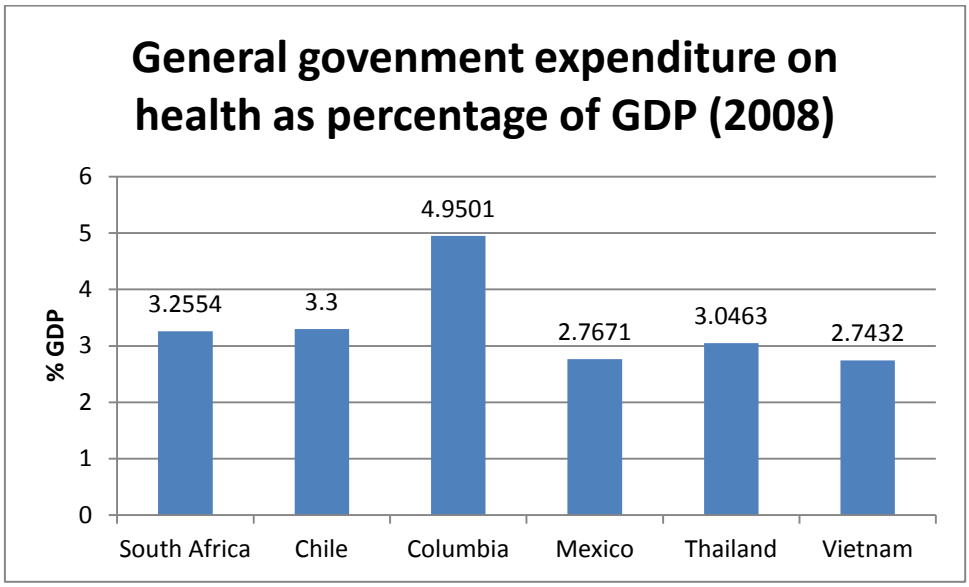
[1] The Foundation is aware that for some of the graphs, more recent data is available. However we have chosen to use all data from the World Health Organisation Statistics 2011 for consistency.
[2] CIA World Fact Book: https://www.cia.gov/library/publications/the-world-factbook/index.html
[3] Development Bank South Africa. 2008 'A Roadmap for the Reform of the South African Health System'. Draft Final Report. Available online at:

Figure 1: Country comparison of total expenditure on health as a percentage of gross domestic product (GDP) (2008)



Source: WHO Health Statistics 2011

Figure 2: Country comparison of general government expenditure on health as a percentage of Gross Domestic Product (2008)



Source: WHO Health Statistics 2011

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http://www.npconline.co.za/MediaLib/Downloads/Home/Tabs/Diagnostic/HumanConditions2/A%20roadmap%20for%20the%20reform%20of%20the%20South%20African%20health%20system.pdf, p45.

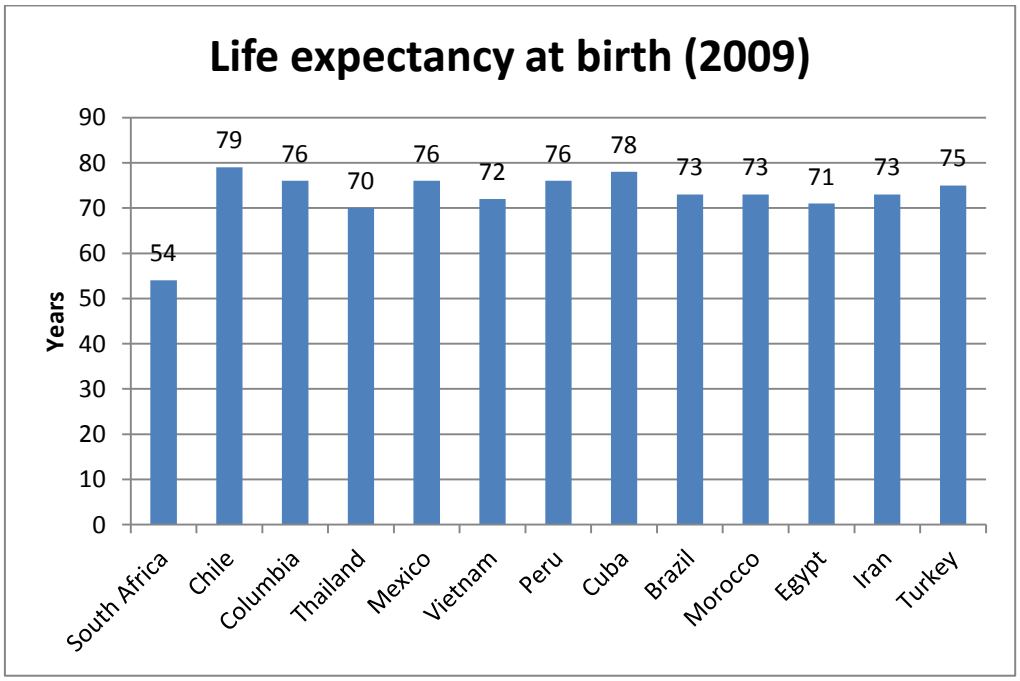
2. Health indicators

2.1. Life Expectancy at Birth

2.1.1 Chile, Mexico and Thailand spend 3.3, 2.7 and 3.05 percent of GDP on public health respectively (see **Figure 2**). South Africa spends around 3.3 percent of GDP, yet South Africans can expect to live around 20 years less on average than citizens of these countries. (See Figure 4 below: WHO Health Statistics: Life Expectancy at birth (years): Chile: 79, Mexico: 76, Thailand: 70, South Africa: 54)

2.1.2 Even after accounting for HIV/AIDS, South Africa significantly underperforms with regards to life expectancy.[4]

Figure 3: Country comparison of life expectancy at birth (2009)



Source: WHO Health Statistics 2011

[4] Bernstein, A. (ed) 2011. 'Reforming Healthcare in South Africa. What role for the private sector?'. Johannesburg: Centre for Development and Enterprise, p26.

2.2 Maternal, Neonatal, Infant and Under-five Mortality

2.2.1 Performance of the health system regarding maternal mortality

2.2.1.1 A brief review of maternal-related health policy shows positive and progressive results: There are no user fees for maternal and child primary health and South Africa has the Choice on Termination of Pregnancy Act[5].

2.2.1.2 However, maternal and child health outcomes do not reflect this progress. (See **Figure 4**) South Africa's maternal mortality rate has steadily increased from 230 in 1990, to 380 in 2000, and 410 in 2010 according to the latest World Health Organisation Statistics.[6] South Africa is also "one of only six countries in sub-Saharan Africa that made no progress in reducing maternal deaths by 2008"[7].

2.2.1.3 It was suggested that "38.4 percent of the deaths were clearly avoidable within the healthcare system"[8] and two of the major causes of maternal death, namely, hypertension and haemorrhage, "are preventable with good care before and during delivery".[9] In the era of effective ARVs, one could make a case that HIV/AIDS related deaths might also be avoidable.[10]

2.2.1.4 For South Africa to achieve the Millennium Development Goal (MDG) on maternal mortality the Maternal Mortality Rate (MMR) would have to be reduced to 38 per 100 000 by 2015.[11]

2.2.2 Systemic causes of high maternal mortality

Reports and investigations have shown that the causes of these poor maternal health outcomes are systemic and include poor quality of care by nurses, poor management, lack of appropriate and effective accountability and governance structures, and poor monitoring and evaluation.[12]

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[5] Chopra, M. *et al.* 2009. 'Achieving the health Millennium Development Goals for South Africa: challenges and priorities'. *The Lancet* 374, 1023-1031, p1023-1025.

[6] World Health Organisation. 2011. 'World Health Statistics 2011'. Available online at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2011_Full.pdf, p 70.

[7] Human Rights Watch. 2011. '"Stop Making Excuses". Accountability for Maternal Health Care in South Africa.' Available online at: http://www.hrw.org/sites/default/files/reports/sawrd0811webwcover.pdf, p13

[8] NCCEMD. 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available online at: http://www.doh.gov.za/docs/reports/2007/savingmothers.pdf

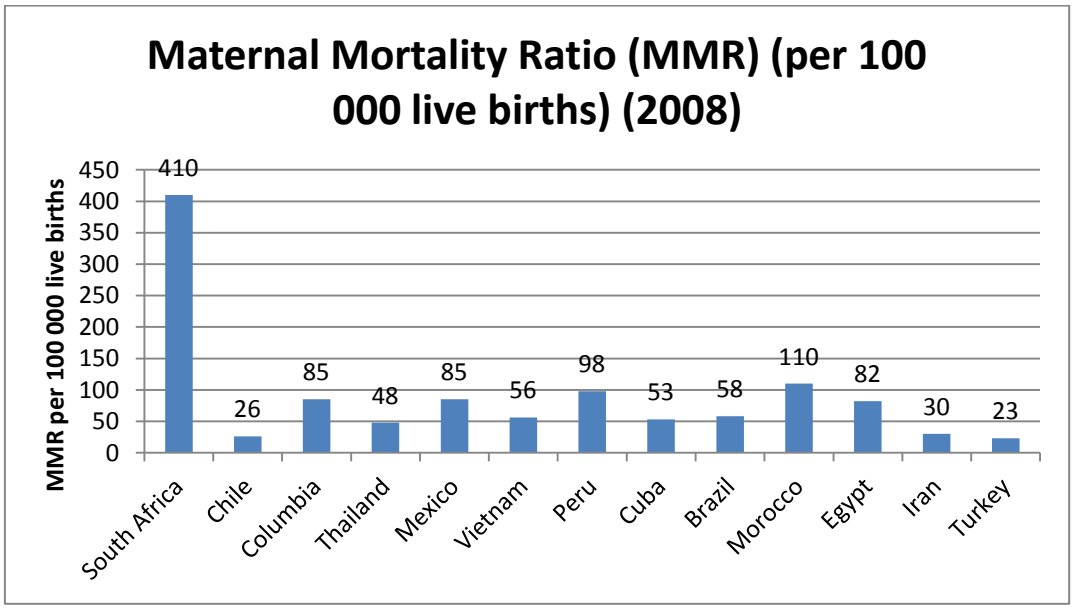
[9] Development Bank South Africa. 2008 'A Roadmap for the Reform of the South African Health System'. Draft Final Report, p5.

[10] Chopra, M. *et al.* 2009. 'Saving the lives of South Africa's mothers, babies, and children: can the health system deliver?'. *The Lancet* 374, 835-846, p 836.

[11] Chopra, M. *et al.* 'Achieving the health Millennium Development Goals for South Africa: challenges and priorities'. *The Lancet* 374, 1023-1031, p1024.

[12] NCCEMD. 'Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa'. Available online at: http://www.doh.gov.za/docs/reports/2007/savingmothers.pdf and Human Rights Watch. 2011. '"Stop Making Excuses". Accountability for Maternal Health Care in South Africa.' Available online at: http://www.hrw.org/sites/default/files/reports/sawrd0811webwcover.pdf and Chopra, M. *et al.* 2009a. 'Saving the lives of South Africa's mothers, babies, and children: can the health system deliver?'. *The Lancet* 374, 835-846.

Figure 4: Country comparison of Maternal Mortality Ratio (MMR) (per 100 000 live births) (2008)



Source: WHO Health Statistics 2011

2.2.3 Performance of the health system regarding neonatal, infant and under-five mortality

2.2.3.1 The neonatal, infant and under-five mortality rates all show South Africa's lack of progress in reducing these rates from 1990 to 2009. (See **Figures 5, 6 and 7** below).

2.2.3.2 In all cases for South Africa, the rates are either marginally reduced or remain the same, compared to the drastic reduction of rates in other comparable and developing countries.

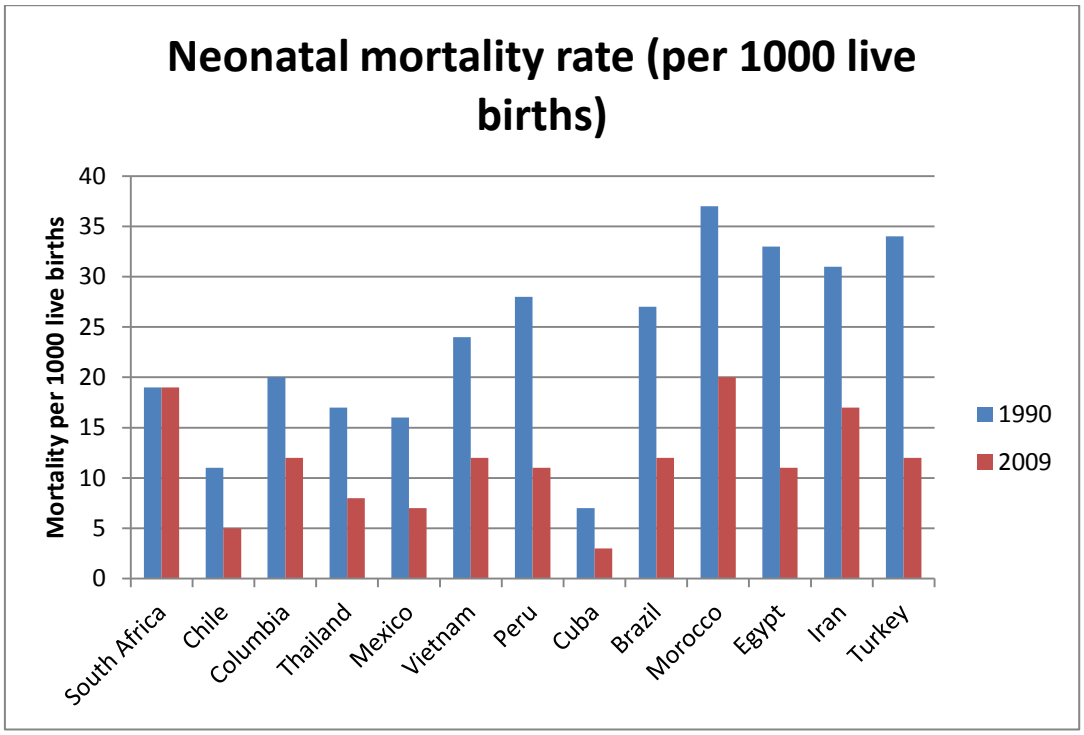
2.2.3.3 As is the case with maternal mortality, a striking number of neonatal, infant and under-five deaths are classified as avoidable.[13]

2.2.4 Systemic causes of poor neonatal, infant and under-five health outcomes

The poor health outcomes related to neonatal, infants and under-fives are largely attributable to poor management, lack of qualified health personnel and poor quality of nursing.[14]

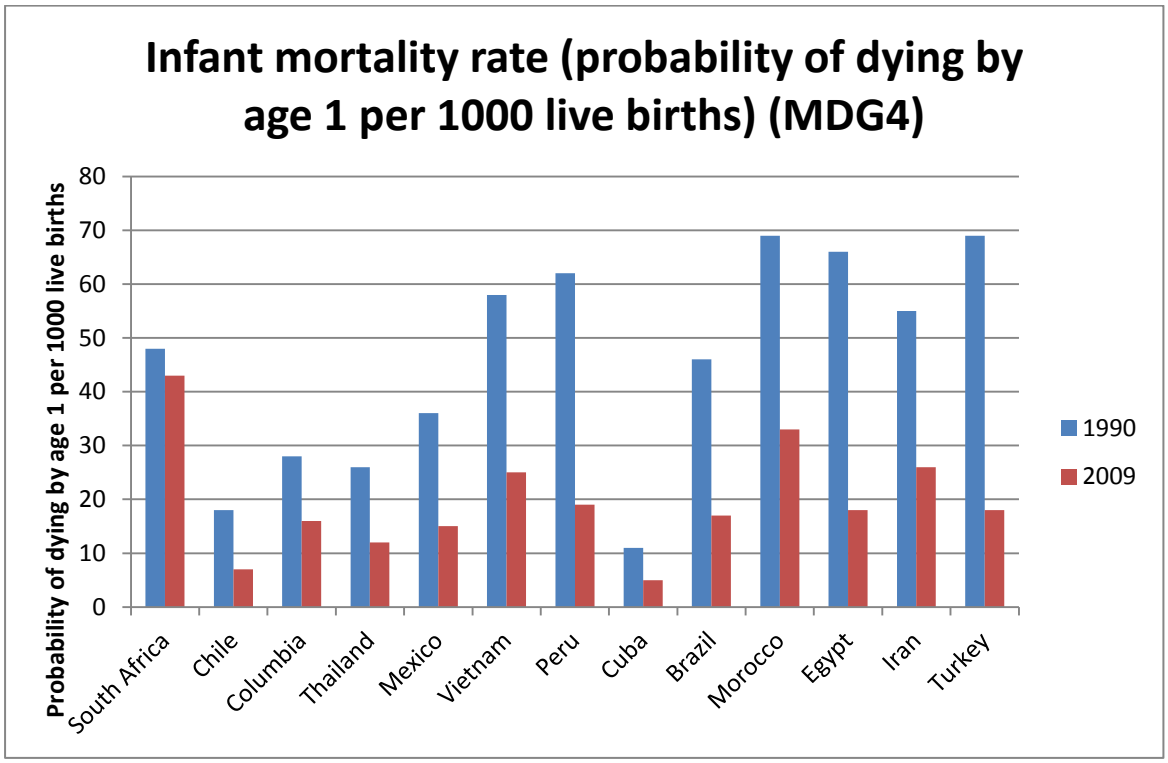
[13] Chopra, M. *et al.* 2009. 'Saving the lives of South Africa's mothers, babies, and children: can the health system deliver?'. *The Lancet* 374, 835-846, p836.
[14] *ibid.*

Figure 5: Country comparison of progress made in neonatal mortality rate (per 1000 live births) as at 1990 and 2009.



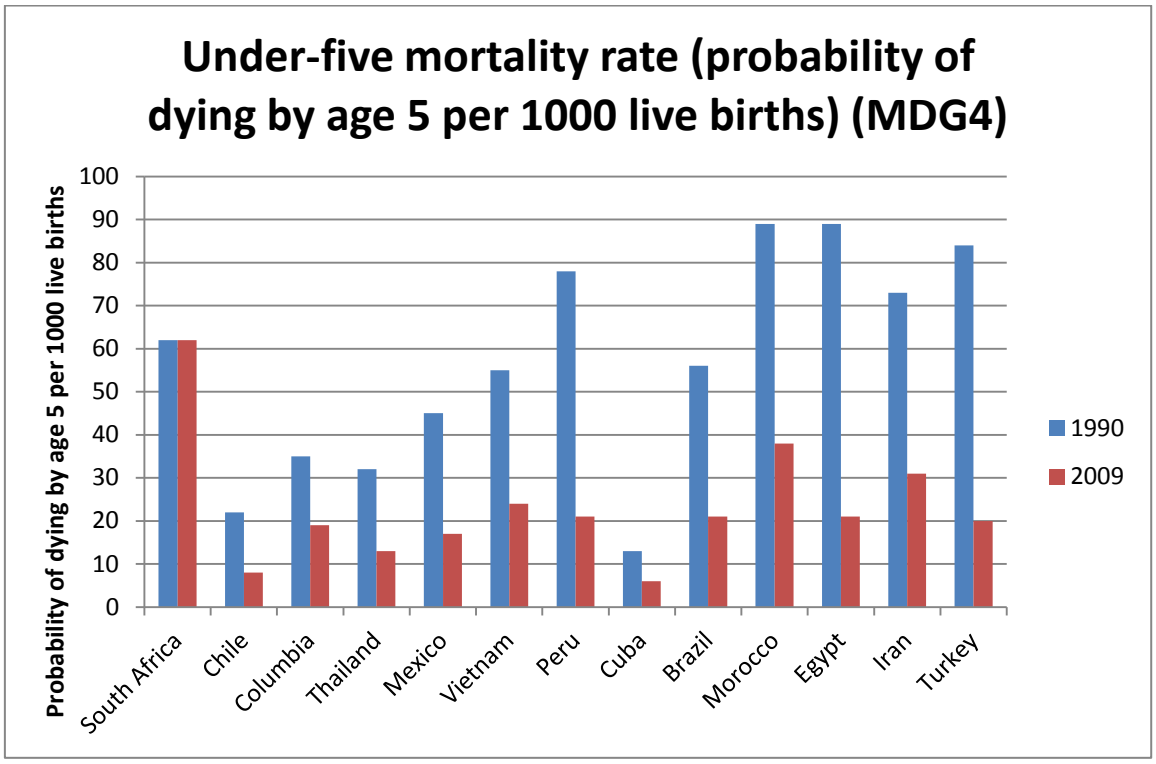
Source: WHO Health Statistics 2011

Figure 6: Country comparison of progress made in infant mortality rate (probability of dying by age 1 per 1000 live births) at 1990 and 2009



Source: WHO Health Statistics

Figure 7: Country comparison of progress made in under-five mortality rate (probability of dying by age 5 per 1000 live births) at 1990 and 2009



Source: WHO Health Statistics

2.3 HIV/AIDS

2.3.1 Performance of the health system regarding HIV/AIDS

17.8 percent of South African adults aged 15-49 are HIV positive. This is especially significant compared to the average for sub-Saharan Africa of 5.0 percent.[15]

2.3.2 Causes of the high percentage of HIV positive South Africans

2.3.2.1 The poor historical response to the epidemic, namely denial and ineptitude[16] is largely responsible for South Africa's high prevalence of HIV/AIDS. (See **Figure 8**)

2.3.2.2 "The change in administration in 2008 and the subsequent elections in 2009 … have created new hope that the country will rise to the challenges of HIV"[17]. Such progress is reflected in the Department of Health's HIV Counseling and Testing (HCT) campaign.

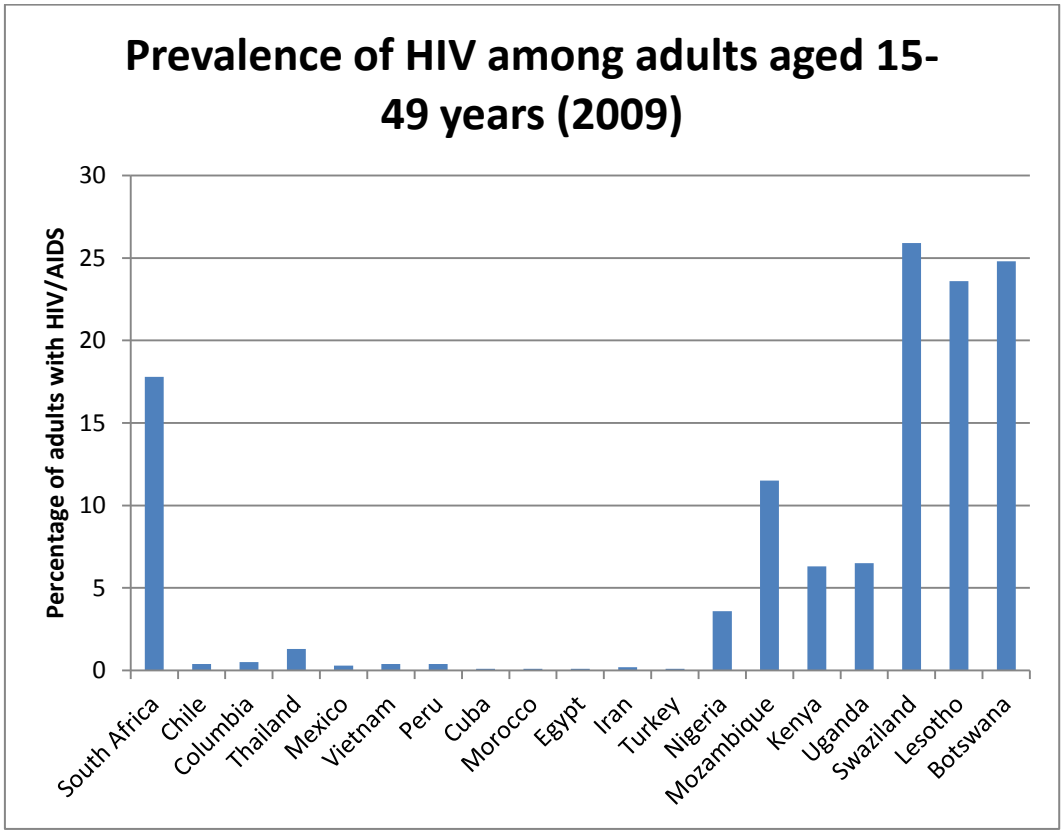
[15] UN AIDS. 'Global Report.' Available online at: http://www.unaids.org/documents/20101123_GlobalReport_Annexes1_em.pdf

[16] Abdool Karim, S.S. *et al.* 2009. 'HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response'. *The Lancet* 374, 921-933, p921

[17] *ibid*, p922.

"Available data indicates that by the end of the financial year [2012], over 11.4 million South Africans had been counseled and over 9.7 million had agreed to be tested."[18]

Figure 8: Country comparison of prevalence of HIV among adults aged 15-49 (2009)



Source: WHO Health Statistics 2011

2.4 Tuberculosis

2.4.1 Performance of the health system regarding tuberculosis

2.4.1.1 The prevalence of tuberculosis has risen alarmingly from 535 per 100 000 population in 2000 to 808 per 100 000 population in 2009.[19]

2.4.1.2 **Figure 9** clearly shows South Africa's lack of progress in curbing the prevalence of tuberculosis as the graph shows a clear rise in the prevalence compared to a decrease in all the other selected countries.

2.4.1.3 There is also a "high proportion of TB-HIV co-morbidity" estimated at 73 percent.[20]

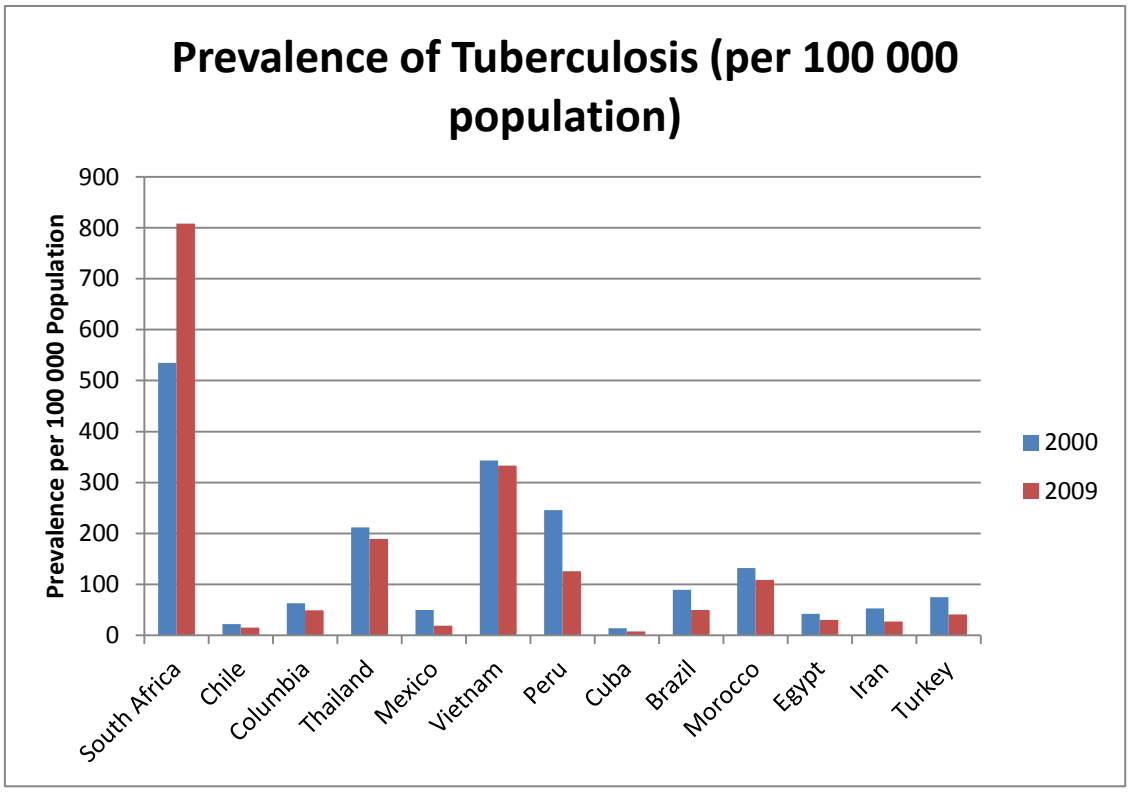
[18] Department of Health. 2011. 'Annual Report 2010/11'. Available online at: http://www.doh.gov.za/docs/reports/annual/2011/annual_report2010-11.pdf, p19.
[19] World Health Organisation. 2011. 'World Health Statistics 2011'. Available online at: http://www.who.int/gho/publications/world_health_statistics/EN_WHS2011_Full.pdf
[20] Department of Health. 2011. 'Annual Report 2010/11'. Available online at: http://www.doh.gov.za/docs/reports/annual/2011/annual_report2010-11.pdf

2.4.2 Causes of poor health outcomes regarding tuberculosis

2.4.2.1 The uncharacteristically high prevalence of tuberculosis in South Africa can generally be explained by poor and ineffective management, historical neglect and a fragmented health system.[21]

2.4.2.2 "The widespread emergence of multi-drug resistant (MDR) and extensively drug resistant (XDR) tuberculosis is a warning sign of serious problems in the health system."[22]

Figure 9: Country comparison of progress made on reducing the prevalence of tuberculosis (per 100 000 population) at 1990 and 2009



Source: WHO Health Statistics 2011

[21] Fourie, B. 'The Burden of tuberculosis in South Africa'. Available online at: www.sahealthinfo.org/tb/tbburden.htm
[22] Chopra, M. *et al.* 'Achieving the health Millennium Development Goals for South Africa: challenges and priorities'. *The Lancet* 374, 1023-1031, p1027.

2.5 Non-communicable Diseases

2.5.1 Performance of the health system regarding non-communicable diseases

2.5.1.1 Non-communicable diseases are also a growing problem in South Africa and the various policy interventions have not appeared to be effective at reducing the burden of disease.

2.5.1.2 Since 1994, various policies have been instituted such as the Mental Health Care Act (2002), the Tobacco Products Control Act of 1993, and the Liquor Act (Act 59 of 2003). The Department of Health has also published a national guideline for the management and control of non-communicable diseases in 2006. Even so, the "past 15 years of political transition in South Africa have seen a rise in non-communicable diseases [and] South Africans seem not to have derived all the benefits that were anticipated from progressive health care policies."[23]

2.5.2 Systemic causes of poor health outcomes regarding non-communicable diseases

2.5.2.1 Mayosi *et al* (2009) cite reasons for poor performance as barriers to implementation of policy which include centralised decision making, poor management, inadequate dissemination, lack of monitoring and evaluation.[24]

2.5.3 Mental Health

2.5.3.1 A key aspect of non-communicable diseases which is often overlooked is Mental Health Care. Burns (2011) notes that with regards to mental health, there is a significant gap between mental health related needs and the services provided by the health system.[25]

2.5.3.2 A key problem appears to lie in the poor implementation of existing mental health legislation and policy.[26] This is especially concerning given our high HIV/AIDS rate and that "HIV/AIDS is associated with a significantly increased burden of neuropsychiatric disease and disability including depression, anxiety, psychosis and dementia"[27]. "There is now substantial evidence that poverty, inequality, urbanisation, unemployment, trauma and violence and substance abuse are major environmental risk factors for mental illness and therefore increase the burden of mental illness and disability within a society."[28]

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[23] Mayosi, B.M. *et al*. 2009 'The burden of non-communicable diseases in South Africa'. *The Lancet* 374, 934-947, p934.
[24] *ibid*.
[25] Burns, J.K. 2011. 'The Mental Health Gap in South Africa – A Human Rights Issue'. *The Equal Rights Review* 6, 99-113, p106.
[26] *ibid*, p104.
[27] *ibid*, p102.
[28] *ibid*, p102.

2.6 Violence and Injury

2.6.1 Performance of the health system regarding violence and injuries

Violence and injuries, especially interpersonal violence, account for the second highest cause of all death and disability-adjusted life years (DALYs) in South Africa. The homicide rate is also around five times higher than the worldwide average and the road traffic mortality rate is around 39.7 per 100 000, which is almost double the global rate.[29]

2.6.2 Suggested causes of the poor performance regarding injuries and violence

2.6.2.1 Many of the poor outcomes regarding violence are related to dynamics of inequality and poverty and the patriarchal social structure of society.[30]

2.6.2.2 One could argue that the poorly functioning and fragmented emergency service is also largely responsible for these poor outcomes. This is particularly concerning given the absolute right to emergency health care as enshrined in our Constitution.

2.6.2.3 According to Seedat *et al* other causes relate to absence of leadership, poor use of research findings and lack of implementation of policy.[31]

3. Public Sector Health System

3.1. Human Resources

Many of the human resource challenges relate to the absence of a systematic human resources plan for the past 16 years. The Department of Health has, however, released a draft Human Resources Strategy for the Health Sector which, if implemented effectively, should address the key problems of:

- Attrition and migration
- Poor retention of health professionals by the public sector
- Moonlighting
- Low motivation and poor attitudes

3.2 Service delivery in public hospitals

3.2.1. Performance of the health system regarding public hospitals

Poor service delivery and inefficient functioning of public hospitals are key challenges for the health system. Von Holdt (2010) states that the commonly cited concerns in

[29] Seedat, M, R. *et al.* 2009. 'Violence and injuries in South Africa: prioritising an agenda for prevention'. *The Lancet* 374, 1011-1022.
[30] *ibid.*
[31] *ibid.*

public hospitals include poor maintenance, dirty wards, poor labour relations, budget overruns and inability to budget or control costs, failure to supply drugs or medicine sundries, ill discipline and lost records.[32] The DBSA Roadmap includes as some of the key challenges in public hospitals: poor infection-prevention and control, inadequate safety of patients and staff, a deficiency in availability of medical equipment, long queues and waiting times, transport trouble preventing people from getting to hospitals and ineffectual safety and functioning of buildings.[33]

3.2.2. Systemic causes of poorly functioning public hospitals

Reports have shown that the aforementioned problems in the public hospitals result from –

- Over-centralisation
- Low management capacity
- Understaffing[34]
- Lack of implementation of information systems
- Lack of accountability as a result of provincial or national government making "key decisions affecting quality of care while they are not directly accountable for patient outcomes"
- Lack of authority allocated to public hospitals.[35]

3.2.3 Other causes have also been linked to "'cadre deployment' whereby politically connected job candidates have been favoured at the expense of those with experience and qualifications."[36]

3.3 Infrastructure

3.3.1 Performance of the health system regarding infrastructure

The August 2011 Report of the Auditor-General of South Africa to Parliament on a performance audit of the infrastructure delivery process of the provincial departments of Education and Health highlighted key issues regarding infrastructure of health facilities. The key challenges noted included delays in planning phases of projects, widespread delays

[32] von Holdt, K. 2010. 'Nationalism, Bureaucracy and the Developmental State: The South African Case'. *South African Review of Sociology* 41 (1), 4-27, p9,10.
[33] Development Bank South Africa. 2008 'A Roadmap for the Reform of the South African Health System'. Draft Final Report, p20,21.
[34] von Holdt, K. 2010. 'Nationalism, Bureaucracy and the Developmental State: The South African Case'. *South African Review of Sociology* 41 (1), 4-27, p9,10.
[35] Development Bank South Africa. 2008 'A Roadmap for the Reform of the South African Health System'. Draft Final Report, p20
[36] Still, L. 2011. *Health Care in South Africa 2011*. Profile Media, p308.

in completion of projects, termination of some projects due to insufficient progress and poor quality workmanship[37], "projects being withdrawn after the design phase due to budgetary constraints", "insufficient project information at the identification stage of projects to ensure that realistic values were allocated on the infrastructure budgets"[38], a large percentage of projects in which procurement legislation and/or regulations were contravened[39].

3.3.2 Causes of poor performance regarding infrastructure

The Auditor-General Report also noted that the causes of this poor performance generally related to poor management and lack of capacity and qualified staff, lack of qualified implementing agents to ensure that comprehensive planning takes place in a timely manner, "lack of supervision and monitoring during the construction process"[40], action not being taken timeously against defaulting contractors, inspections not being conducted or poor quality of work not being identified during inspections, or being identified and not being addressed, and late payments to contractors.

3.4 Corruption

3.4.1. Corruption is often cited as a key challenge for South Africa's health system which results in poor service delivery and inefficient use of scarce resources.

3.4.2. Few comprehensive investigations have been conducted. However, in 2007 the Institute for Security Studies' (ISS) Corruption and Governance Programme, together with Transparency International-Zimbabwe, released a study on accountability and corruption in the prevention and treatment efforts relating to HIV/AIDS in South Africa.

3.4.3. The study was based on the premise that if increases in funding did not result in positive health outcomes, then one would have to look at what factors were negatively affecting health care delivery. Such factors included corruption, mismanagement, inadequate or lacking accountability and budget-tracking mechanisms and weak systems.[41]

3.4.4. "The report shows that corruption and poor oversight is a potentially lethal cocktail when combined with the rapacious AIDS disease."[42]

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[37] Report of the Auditor-General of South Africa to Parliament on a performance audit of the infrastructure delivery process at the provincial departments of Education and Health. 2011. Available online at: http://www.agsa.co.za/Reports%20Documents/performance%20audit%20of%20the%20infrastructure%20delivery%20process.pdf, p14.
[38] *ibid*, p9.
[39] *ibid*, p11.
[40] *ibid*, p14.
[41] Schulz-Herzenberg, C. 2007. *The Lethal Cocktail – Exploring the impact of corruption on HIV/AIDS prevention and treatment efforts in South Africa.* Cape Town: Institute for Security Studies and Transparency International (Zimbabwe).
[42] *ibid* pix.

4 Private Sector Health System

The private health sector in South Africa has seen a rise in real costs over the past decade. This, however, has not equated to an increase in service quality or benefits for medical scheme members and is rather as a result of market imperfections and inefficiency in the private sector coupled with a lack of effective regulation[43].

4.1 What we are seeing in the Private Hospitals

4.1.1 Private hospitals have been characterised by rising hospital costs[44], and an over-supply of acute beds and hospital based medical technology (such as Magnetic Imaging Units (MRIs) and Computed Tomography Scanners (CT Scanners)) resulting in over-servicing.[45]

4.1.2 Market power imbalances, which occur as a result of hospital market concentration (through corporate ownership of multiple hospitals), are a key cause of the rise in hospital costs.[46] The over-supply of beds and equipment can be attributed to hospitals competing on a non-price related basis. This results from hospitals competing for specialists, and not competing on price, cost or efficiency.[47]

4.2 What we are seeing with regards to out-of-hospital costs

Out-of-hospital costs remained stable from 2001 to 2004 but started to increase steeply from 2004. The rise in out-of-hospital costs is systemic and principally the result of specialist cost increases which began to occur after an intervention by the Competition Commission to prohibit centralised tariff negotiations between medical service providers and medical schemes. The intervention had the unintended consequence of a rise in specialists' costs as it did not prevent collusive opportunities for specialists.[48]

4.3 What we are seeing with regards to non-health care related expenditure – administration, managed care, broker commissions and service fees

4.3.1 The general trend in non-health care related costs shows significant real increases in the 1990s which leveled out in the 2000s around the time that the Medical Schemes Act (Act

[43] Council for Medical Schemes. 2008. 'Evaluation of Medical Schemes' Cost Increases: Findings and Recommendations'. Available online at: http://www.medicalschemes.com/publications/ZipPublications/Press%20Releases/ReportMedicalSchemeCostIncreases.pdf, p15.
[44] *ibid*, p23.
[45] *ibid*, p30-32,46.
[46] Council for Medical Schemes. 2008. 'Evaluation of Medical Schemes' Cost Increases: Findings and Recommendations', p26,27.
[47] Council for Medical Schemes. 2008. 'Evaluation of Medical Schemes' Cost Increases: Findings and Recommendations', p30.
[48] *ibid*, p35-40.

131 of 1998) was introduced. Reasons for such increases have been credited to members moving from low-cost restricted schemes to high-cost open schemes.[49] The Council for Medical Schemes 2011 Annual Report similarly notes that the rate of increase of non-health care expenditure has stabilised with an increase of 6.9 percent from R10.8 billion in 2009, to R11.6 billion in 2010, compared to the higher than CPI increases that occurred before 2006.[50]

4.3.2 Broker fees have been raised as a concern. "[B]rokers influence the cost of schemes directly and indirectly. Directly, where a fee is paid for their services, and indirectly through the quality of their advice. Many schemes and administrators attempt to influence brokers to advise clients to choose a particular scheme by bidding up broker commissions. … The conflicts substantially reduce the quality of advice in the market and permit schemes to avoid being wholly responsive to members and beneficiaries."[51]

4.3.3 Causes of non-health care costs:

Despite some problems in relation to specific schemes and the concern relating to high broker fees, the Foundation submits that the non-health care related problems are not systemic and can be addressed through interventions relating to governance rather than the regulation of fees. If the Risk Equalisation Fund becomes fully operational, this should also put a downward pressure on non-health costs.[52]

5 Summary of key health challenges

Although the Department of Health has clearly made significant gains in certain areas, especially regarding HIV/AIDS awareness, prevention and treatment, the evidence above has presented a picture of a South African health system which is underperforming in almost every area. The causes of these poor health outcomes are largely systemic and can be narrowed down to a few key problems. (See Table 1 below for a summary.)

[49] *ibid*, p11.
[50] Council for Medical Schemes, 2011. 'Annual Report 2010-2011'. p181
[51] Council for Medical Schemes. 2008. 'Evaluation of Medical Schemes' Cost Increases: Findings and Recommendations', p43.
[52] Council for Medical Schemes. 2008. 'Evaluation of Medical Schemes' Cost Increases: Findings and Recommendations', p44.

Table 1: Summary of health system challenges and their systemic causes

Health System Challenges	Systemic causes
Public system	
High and rising burden of disease Lack of medical supplies, drug and equipment Over and under-spending in the provinces Poor quality of care Poor service delivery Poor maintenance of infrastructure and delays in completion of projects Poor infection prevention and control Poor safety of patients and staff Long queues and waiting times	Lack of Accountability and corruption Poor Management Ineffective monitoring and evaluation Centralised decision making Lack of implementation of existing policies Understaffing and lack of capacity of staff Inefficiency Absence of appropriate governance structure
Private System	
Rising hospital and specialist costs Oversupply of acute beds and expensive hospital based medical technology Over-servicing of patients	Market imperfections • Market power imbalances due to hospital concentration Non-price competition Lack of effective regulation

Source: Helen Suzman Foundation

6. Problem Statement

6.1. In South Africa, the right to access health care is a constitutionally enshrined human right. Due to the evidently poor health outcomes experienced by the country, however, it is clear that many people are unable to realise this constitutional right.

6.2. The Green Paper acknowledges many of the problems in the health sector. It fails, however, to show evidence-based links between the poor health outcomes and the causes of these health outcomes. **The Green Paper cites the *two tiered health system* and *inequities between the public and the private sector* as the root causes of the majority of South Africa's poor health outcomes. This hypothesis fails to take into account the systemic, institutional issues evident in both the public and the private health system.**

6.3. Once we are clear that the public sector is responsible for its own poor health outcomes and the private sector is responsible for its own inefficiencies, we will be able to see where the major systemic problems lie and develop solutions more accurately. In this regard,

more accurate problem statements for the public and private health system would be as follows:

6.3.1. **Proposed Public Health System Problem Statement**

There are several systemic issues that are responsible for the poor health outcomes and poor performance of the public health system. These issues include: lack of accountability in the system, ineffective monitoring and evaluation, poor administrative and financial management, over-centralisation, lack of implementation of existing policies, and corruption.

6.3.2. **Proposed Private Health System Problem Statement**

Systemic issues are similarly responsible for rising costs and inefficiencies faced by the private sector. These issues include: market imperfections, a lack of price competition and lack of effective regulation.

7. Analysis

7.1. The evidence-based systemic problems identified above are in stark contrast to those identified in the Green Paper and highlight certain inaccuracies and omissions in the Green Paper.

7.2. Given the evidence that South Africa's health system is significantly underperforming with its relatively high expenditure, we must ask whether the proposals outlined in the Green Paper provide the appropriate response to these systemic problems.

7.3. If the challenges facing the public health system have more to do with inefficiency, poor management and lack of accountability than lack of financing resources and the private sector, we must question whether the establishment of a NHI is the correct mechanism to address these challenges.

7.4. The Green Paper acknowledges the importance of fixing the public sector before instituting the NHI. However, given that most of the challenges relate directly to management of the public sector, rather than financing of the health system, it is clear that fixing the public system needs to be the primary motivation for health care reform, rather than a means to assist in the establishment of the NHI.

7.5. If we accept that the challenges facing the health system are systemic, than the Green Paper misses a key opportunity to address these challenges by developing coherent, evidence-based policy solutions.

Chapter 4: Constitutional Implications

This section considers the constitutional imperatives that inform the health system in South Africa, and the possible constitutional implications that may arise if the National Health Insurance as envisaged in the Green Paper, is applied.

Navsa JA in *Democratic Alliance v President of the Republic of South Africa and Others* (263/11)[2011]ZASCA 241 (1 December 2011) reminds us that *"Section 2 of the Constitution reaffirms that the Constitution is the supreme law of the Republic and that law or conduct inconsistent with it is invalid and that the obligations imposed by it must be fulfilled. Thus, every citizen and every arm of government ought rightly to be concerned about constitutionalism and its preservation*."

1. Positive and Negative Duties

1.1. Section 7(2) of the Constitution[1] describes the state's positive and negative duties. These require that the state "respect, protect, promote and fulfil the rights in the Bill of Rights".

1.2. According to the non-governmental health organisation, *SECTION27*[2], in relation to health care services this means that government must:

1.2.1. Respect the right of access to health care services by not unfairly or unreasonably getting in the way of people accessing existing health care services, either in the public or private sectors;

1.2.2. Protect the right to access by developing and implementing a comprehensive legal framework to stop people who get in the way of the access of others;

1.2.3. Promote the right by creating a legal framework so that individuals are able to realise their rights on their own;

1.2.4. Fulfill the right by creating the necessary conditions for people to access health care, by providing positive assistance, benefits and actual healthcare services.

[1] The Constitution of the Republic of South Africa, 1996

[2] *SECTION27* Health & Democracy Chapter 2 The Constitution and public health policy 2.2 The right of access to health care services pp 33 - 34

2. Section 27 of the Constitution (Chapter 2 – The Bill of Rights)

2.1. Section 27(1)(a) of the Constitution states that everyone has the right to have access to health care services, including reproductive health care. Section 27(3) provides that no one may be refused emergency medical treatment. *(our underlining)*

2.2. Section 28(1)(c) provides that every child has the right to basic health care services. A child is defined for this section as 18 years or younger. *(our underlining)*

2.3. There is a distinction between the rights of the adult population and the rights of children. The former must be assured of right of access to healthcare services only. There is no clear, unambiguous right to receive those services or proper services once access has been granted. The duty to provide reasonable services, however, arises through other provisions of the Constitution and has been interpreted by the Constitutional Court.

2.4. For a child more than mere access is constitutionally enshrined. A child is entitled to receive basic health care services – be they good, bad or indifferent. The government is obliged to provide such services.

2.5. The State is obliged to "take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of" the right of access to health care (Section 27(2)). This means taking all reasonable steps to ensure that the right is protected, promoted and fulfilled. The ultimate aim is that universal access to quality and comprehensive health care be achieved. The means to achieve this include, but are not limited to, the passing of laws by Parliament and the provincial legislatures[3].

2.6. There are other direct and indirect provisions that create entitlements and impose both positive and negative obligations. They include "the right to bodily and psychological integrity" (section 12(2)), "the right to privacy" (section 14) and the right "to an environment that is not harmful to their health or wellbeing".

[3] *ibid* p34

3. Case Law Developing Section 27

3.1. In the *Soobramoney*[4] case the applicant was denied access to renal dialysis in the public sector. Dialysis is provided by the state, provided the patient meets strict medical criteria because the state cannot assist everyone. One requirement is eligibility for a kidney transplant. Soobramoney did not qualify.

3.2. The Constitutional Court had regard to the state's positive duties (in Section 27(2)) and held that the state had complied with its duties because the guidelines for limited access to dialysis were reasonable, and the application of those guidelines to *Soobramoney* had been made "fairly and rationally".

3.3. If the Court had interpreted section 27(2) in favour of *Soobramoney*, the state's obligation to ensure access to health care services for all would have been severely compromised. Instead, the Court held that the state took reasonable measures to ensure the progressive realisation of the right (as section 27(2) requires). Otherwise the state would be obliged constantly to provide immediate access to health care services wherever and whenever this was demanded.

3.4. The Court recognised that there are practical and societal limits to an absolute right to provide healthcare. How rights will manifest in practice will depend on the specific circumstances of the case. The state must prioritise based on the actual health needs of the population.

3.5. *Soobramoney* demonstrated that the reasonableness or otherwise of laws, policies and programmes is not just limited to their content. An otherwise reasonable policy may be implemented in an unreasonable manner. Justifiable laws, policies and frameworks are clearly only a starting point, albeit a very important one[5].

3.6. For the reasons set out above, the failure by the Green Paper to properly consider, evaluate and address systemic problems before considering financial models, may give rise

[4] *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC)
[5] SECTIION27 p37

to constitutional breaches. Furthermore, prioritisation is essential for both a rational and lawful approach to health reform.[6]

3.7. The *Grootboom*[7] case is based on section 26 of the Constitution which deals with access to adequate housing. Following *Soobramoney* the Court decided that section 26 does not entitle a person to housing at state expense as of right. Instead, section 26(2) "requires the State to devise and implement within its available resources a comprehensive and co-ordinated programme progressively to realise the right of access to adequate housing"[8] . The Court decided this had not been done. The Court did not, however, order any specific relief for the applicants.

3.8. The case established the principle that the Constitution imposes an obligation on the state to develop and implement reasonable plans to ensure that rights are realised. What is "reasonable" depends on the context and the demonstrable rationality brought to bear on the argument.

3.9. *Grootboom* notes that, while the needs of the poor require special attention, the state nevertheless has a duty to create the conditions for access to adequate housing for people at all economic levels of our society. Clearly, the state does not have to provide houses for all. For those who can afford to pay for adequate housing, government's duty is to ensure access to housing stock, to create the legislative framework to facilitate self-built houses and – perhaps most important – to ensure access to finance.

3.10. The *TAC* case[9] was set against the backdrop of the public challenge to the state response to HIV/AIDS, President Mbeki's denial of the link between HIV and AIDS, and a campaign of misinformation against the use of antiretroviral (ARV) medicines.

3.11. At issue in the case was the Department of Health's policy on the use of ARV medicines to "prevent mother-to- child transmission" of HIV infection (PMTCT). The Court was faced with two key issues:

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[6] On the full implications of lawfulness and rationality see the 2011 Helen Suzman Memorial Lecture delivered by Kate O'Regan: http://www.hsf.org.za/siteworkspace/helen-suzman-memorial-lecture-november-2011.pdf. For a definition of rationality, see the majority judgment in the *Glenister* case: http://www.hsf.org.za/siteworkspace/glensterjudgement17-03-2011.pdf.

[7] *Government of the Republic of South Africa v Grootboom 2001 (1) SA 46 (CC)*

[8] Ibid para 95

[9] *Minister of Health v Treatment Action Campaign (No 2)* 2002 (5) SA 721 (CC)

3.11.1 Was the state entitled to limit the provision of Nevirapine for the purposes of PMTCT to the 18 identified sites even if it was medically indicated and adequate facilities existed for the testing and counselling? and

3.11.2 Had the state "devised and implemented within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their new-born children to have access to PMTCT services"?[10]

3.12. On the first issue, the Court decided that government's policy to limit Nevirapine to the research and training sites was "an inflexible one". Where testing and counselling facilities were available, this "potentially life-saving drug could have been administered within the available resources of the state without any known harm to mother or child"[11]. The use of Nevirapine for PMTCT should thus be both permitted and facilitated if it was medically indicated (paragraph 80), effectively overturning the ban on the use of Nevirapine for PMTCT outside of the 18 "pilot sites"[12].

3.13. On the second issue, the Court decided that the state's inflexibility on the first issue "affected its policy as a whole". In short, the state had no reasonable PMTCT plan. The Court ruled that, where testing and counselling services already existed, counsellors should also be trained on the use of Nevirapine for PMTCT. In addition, it ordered the state to take reasonable measures to ensure that testing and counselling services were made available progressively throughout the public health system.[13]

3.14. The *TAC* case is a practical example of the implementation of the *Grootboom* principles. It helps to advance socio-economic rights in three main ways:

3.14.1. Confirming that the state must prioritise major public health needs;

3.14.2. Recognising that emergency, short, medium and long-term plans are complementary;

3.14.3. Clarifying the relationship between a general socio-economic right and the right relating to children in section 28.

3.15. In trying to rely on the *Grootboom* case, the state had argued that the right of every child to "basic health services" imposes a duty on the child's parents[14], not the state. The Court

[10] *SECTION27* p41
[11] Ibid p41
[12] Ibid p41
[13] Ibid p41
[14] Ibid p42

recognised that "the primary obligation to provide basic health care services no doubt rests on those parents who can afford to pay for such services". However, it decided that where parents are unable to provide access to these services themselves, the duty clearly rests on the state.

3.16. The *Khosa* and *Mahlaule*[15] cases dealt with whether it is constitutional to limit the awarding of social grants on the basis of citizenship, given that the right of access to social security applies to everyone and not just citizens.

3.17. In examining the relationship between the rights to social security and equality, the Court decided that the "means chosen by the Legislature to give effect to … its positive obligation under Section 27 were not reasonable"[16]. The relevant provisions were therefore declared unconstitutional to the extent that they excluded permanent residents.

3.18. Importantly, the decision deals with the costs of extending social security to all. It noted "there are compelling reasons why social benefits should not be made available to all who are in South Africa irrespective of their immigration status".[17] *Khosa* and *Mahlaule* stress the need for the state to act proportionately.

3.19. The case law reveals that that the Constitutional Court has:

3.19.1. enunciated clear rights of citizens (and sometimes others) to the provision of socio-economic rights provided in the Constitution, such as section 27 - the right to health;

3.19.2. clarified that it is not mere access to health care that is required of the government - it is a reasonable level of care and service;

3.19.3. not sought to impose obligations on government that it cannot afford or manage. It recognises that there are practical limitations to a right as sweeping as health and adopts a common sense approach to this;

3.19.4. recognised both the State's obligations and the limitations it faces "to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of" this right (Section 27(2)).

[15] *Khosa v Minister of Social Development* and *Mahlaule v Minister of Social Development* 2004 (6) SA 505 (CC)
[16] *SECTION27* p44
[17] Ibid p44

3.20. As *SECTION27* has said, the government has to make out a case that it is indeed limited by resources. In practice, this should result in better evidence-based decision-making. The cost of programmes has to be properly determined before being dismissed as unaffordable.

4. Co-operative Government – Chapter 3 of the Constitution

4.1 By regulating the structure of the state, the Constitution determines which branch or sphere is responsible for developing and implementing particular aspects of health law and policy.

4.1 Section 40 of the Constitution provides for the constitution of the government into national, provincial and local spheres which are distinctive, interdependent and interrelated.

4.2 Section 41 provides that all spheres of government and all organs of state within each sphere must, *inter alia*:

4.2.1 secure the well-being of the South African people;

4.2.2 be loyal to the Constitution, the Republic and the people;

4.2.3 respect the constitutional status, institutions, powers and functions of government in the other spheres, including;

4.2.3.1 not assuming any power or function except those conferred on them in terms of the Constitution;

4.2.3.2 not encroaching on the geographical, functional or institutional integrity of government in another sphere;

4.2.3.3 co-operating with one another in mutual trust and good faith by co-ordinating their actions and legislation with one another, and adhering to agreed procedures.

4.3 Sections 40 and 41 recognise that provincial and local government are distinctive from, yet interrelated and interdependent on each other and on national government. In many respects national government cannot possibly meet its national constitutional obligations and give effect to the Bill of Rights at a national level only. All three spheres of government are enjoined to meet their obligations in terms of the Bill of Rights.

4.4 This is especially significant in the context of the allocation of concurrent powers to the national and provincial spheres of government under Part A of Schedule 4 of the

Constitution. In terms of Schedule 4, the provision of healthcare services is a duty concurrent to national and provincial powers. The assumption here is that the constitutional imperative of health care cannot be provided at a national level only. This is a rational provision as health care is a service that needs to be provided close to the served population.

5 Legislative and Executive Authority of Provinces – Chapter 6 of the Constitution

5.1 The legislative authority of a province is vested in its provincial legislature, and confers on the provincial legislatures the power, *inter alia,* to pass legislation for its province with regard to:

5.1.1 any matter within a functional area listed in Schedule 4 including health;

5.1.2 any matter outside those functional areas, and that is expressly assigned to the province by national legislation;

5.1.3 any matter for which a provision of the Constitution envisages the enactment of provincial legislation; and

5.1.4 assigning any of its legislative powers to a Municipal Council in that province. *(our underlining)*

5.2 Section 125 (*Chapter 6 on Provincial Executives (sections 125 – 141))* provides that the Premier and the Members of the Executive Council (MECs) exercise executive authority by, *inter alia,* implementing all national legislation within the functional areas listed in Schedule 4 or 5, except where the Constitution or an Act of Parliament provides otherwise. One of those areas is health.

5.3 The Green Paper appears broadly, but incoherently, to accept the implementation of health policy to the national, provincial and local government levels, but seems to withhold the financial administration and procurement in all its aspects and vest it in the national level. This would remove from provinces much of their delegated authority in terms of section 125 and the National Health Act No. 61 of 2003 (the NHA).

5.4 Legislation (and common sense) suggests that health is too intricate and immediate a concern to be determined and governed solely at the national level. Each province, and

even each municipal district, has health needs that differ from one to another. By virtue of its urban density and incidents related to traffic and criminal violence, Gauteng would likely require a greater emphasis on tertiary health care than, say, Limpopo or the Eastern Cape.

5.5 Provincial legislatures have a fundamental role to play in various Parliamentary processes. This role was briefly described by the Constitutional Court in the case of *Matatiele Municipality*[18] as follows:

> *"The role of a provincial legislature goes beyond legislating for the province; it includes taking part in the national legislative process. …*
>
> *The Constitution contemplates the provincial legislatures, consistent with our constitutional scheme, will be involved in the law-making process at national level, such as when they are required to confer voting mandates on their NCOP delegations or when they consider whether or not to approve proposed constitutional amendments that alter their boundaries." (*paragraph 47).

5.6. Currently the provision of health in South Africa is governed by the National Health Act No. 61 of 2003 (NHA) which provides, and it is worth setting out in full, –

> **"Provincial health services, and general functions of provincial departments**
>
> ***25.*** (1) The relevant member of the Executive Council must ensure the implementation of national health policy, norms and standards in his or her province.
> (2) The head of a provincial department must, in accordance with national health policy and the relevant provincial health policy in respect of or within the relevant province-
> *(a)* provide specialised hospital services;
> *(b)* plan and manage the provincial health information system;
> (c) participate in interprovincial and intersectoral (sic) co-ordination and collaboration;
> *(d)* co-ordinate the funding and financial management of district health councils;
> (e) provide technical and logistical support to district health councils;

[18] *Matatiele Municipality v President of the Republic of South Africa (2), CCT 73/05 (18 August 2006)*

(f) plan, co-ordinate and monitor health services and must evaluate the rendering of health services;

(g) co-ordinate health and medical services during provincial disasters;

(h) conduct or facilitate research on health and health services;

(I) plan, manage and develop human resources for the rendering of health services:

(j) plan the development of public and private hospitals, other health establishments and health agencies;

(k) control and manage the cost and financing of public health establishments and public health agencies;

(l) facilitate and promote the provision of port health services, comprehensive primary health services and community hospital services;

(m) provide and co-ordinate emergency medical services and forensic pathology, forensic clinical medicines and related services, including the provision of medico-legal mortuaries and medico-legal services;

(n) control the quality of all health services and facilities;

(o) provide health services contemplated by specific provincial health service programmes;

(p) provide and maintain equipment, vehicles and health care facilities in the public sector;

(q) consult with communities regarding health matters;

(r) provide occupational health services;

(s) promote health and healthy lifestyles;

(t) promote community participation in the planning, provision and evaluation of health services;

(u) provide environmental pollution control services;

(v) ensure health systems research;

(w) provide services for the management, prevention and control of communicable and non-communicable diseases programmes;

(3) The head of a provincial department must-

(a) prepare strategic, medium term health and human resources plans annually for the exercise of the powers of, the performance of the duties of and the provision of health services in the province by the provincial department; and

(b) submit such plans to the Director-General within the time frames and in accordance with the guidelines determined by the National Health Council.

(4) Provincial health plans must conform with national health policy."

5.7 **The Green Paper fails to clarify the extent to which its proposals in respect of national government do or do not encroach on the provincial obligation to provide health.** The NHA states it has been enacted to:

5.7.1 unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa;

5.7.2 provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health care services;

5.7.3 establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourages participation; and,

5.7.4 promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans.

5.8 The NHA specifically recognises the need for health to be provided and managed on a decentralised basis. The Green Paper proposes to interfere with this obligation which conflicts with the right to health being derogated to the provinces.

5.9 It is worth noting that the rational role of national government has never been exercised as national government has failed to establish norms and standards.

5.10 Section 32 of the NHA authorises provincial governments to enter into service level agreements with local authorities.

5.11 It is apparent from the NHA that almost all elements of the practical provision of health to South Africans have been in the hands of the provinces, (with some functions delegated to local authority level while the provinces still retain the authority for functions). Little actual health provision occurs under the direct authority of the national government.

5.12 The Green Paper is vague on the detail of the interrelationship between the different levels of governance. All through the Green Paper there is reference to a variety of levels of health care: district, school, municipal ward, regional hospital, tertiary, central, specialised.

5.13 The Green Paper, however, provides no detail as to which level is responsible for what. The only clear intention appears to be that the allocation of funding and the determination of skills would come from national government. What role, if any, that the provinces would play in determining needs, constructing budgets and recognising staff requirements, is not specified.

5.14 Currently, virtually the entire provision of health services, including the budgeting and allocation of funds to public health institutions, is located in the provinces and within their functional authority and responsibility.

6. Procurement

6.1 Section 217 of the Constitution provides that national, provincial and local government must contract for goods and services in accordance with a system that is fair, equitable, competitive and cost-effective. This is subject to these institutions being entitled to implement a procurement policy that provides for "categories of preference in the allocation of contracts and the protection or advancement of persons, or categories of persons, disadvantaged by unfair discrimination."

6.2 The Green Paper, at paragraph 131, proposes that the NHI will be a government-owned entity that is publicly administered. It is a single payer entity with "sub-national" offices to manage nationally negotiated contracts. All funding will be pooled at the national level and be used to "purchase health services on behalf of the entire population from contracted public and private health care providers".

6.3 It is difficult to see how the procurement of all health services can be made at a centralised level and still result in fair, equitable and appropriate treatment given the complexities and differences of health care needed across the country. Central government may negotiate prices on goods and services that can be sourced by the provinces. However, to negotiate the needs of a provincial budget at central level is likely to result in inappropriate

purchases, funding negotiations taking too long to be concluded, as well as funds not reaching the appropriate level.

7. Public Administration (Sections 195-197) – Chapter 10

7.1 **“195. Basic values and principles governing public administration**

1. Public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles:
    a. A high standard of professional ethics must be promoted and maintained.
    b. Efficient, economic and effective use of resources must be promoted.
    c. Public administration must be development-oriented.
    d. Services must be provided impartially, fairly, equitably and without bias.
    e. People's needs must be responded to, and the public must be encouraged to participate in policy-making.
    f. Public administration must be accountable.
    g. Transparency must be fostered by providing the public with timely, accessible and accurate information.
    h. Good human-resource management and career-development practices, to maximise human potential, must be cultivated.
    i. Public administration must be broadly representative of the South African people, with employment and personnel management practices based on ability, objectivity, fairness, and the need to redress the imbalances of the past to achieve broad representation.
2. The above principles apply to-
    a. administration in every sphere of government;
    b. organs of state; and
    c. public enterprises.
3. National legislation must ensure the promotion of the values and principles listed in subsection (1).

4. The appointment in public administration of a number of persons on policy considerations is not precluded, but national legislation must regulate these appointments in the public service.
5. Legislation regulating public administration may differentiate between different sectors, administrations or institutions.
6. The nature and functions of different sectors, administrations or institutions of public administration are relevant factors to be taken into account in legislation regulating public administration."

7.2 The provisions in Section 195(1) are essentially directives about the way in which public administration should be exercised. Although Section 195(1) contains particular directives, the fundamental rights contained in the Bill of Rights play the primary role in realising the purpose of these directives.

7.3 By implication, the Constitution impels public officials to exercise public administration, subject to the principles of the constitutionally entrenched fundamental rights. This constitutional rule is obligatory and any conduct that falls short of the set parameters is unconstitutional and, accordingly, invalid[19].

7.4 In the *Kimberley Girls' High School*[20] case the High Court had to consider whether the decision by a head of department of education not to appoint candidates as teachers at the Kimberley Girls' High School was irregular or not. The head of department of education of the Northern Cape Province failed to appoint two candidates recommended by the school's governing body because the governing body had failed to consider its duties to promote affirmative action.

7.5 In determining whether the head of department's decision was reviewable or not, the Court had regard to, *inter alia*, section 7(1) of the Employment of Educators Act 76 of 1998 (the "Employment Act"), which provides that regard shall be had to the democratic principles contemplated in section 195(1) of the Constitution when making an educator appointment. The court held that regardless of how much compliance there may have

[19] van Heerden, M "The Constitutional Obligation on Government to Perform Public Administration Efficiently and Effectively" (2009) *Politeia* Vol 28 No 1 p52).
[20] *Kimberley Girls' High School and Another v Head, Department of Education,* Northern Cape Province and Others 2005 (5) SA 251 (NC)

been by the governing body with regard to procedural guidelines, norms and criteria of the Department in the selection process, the entire exercise is rendered futile if the constitutional and legislative imperatives contained in the Employment Act and the Constitution are overlooked.

7.6 Although Section 195(1) contains particular directives, the fundamental rights in the Bill of Rights play the primary role in realising the purpose of these directives. The Constitution compels public officials to exercise public administration, subject to the principles of constitutionally entrenched fundamental rights. This constitutional rule is obligatory and any conduct that falls short of the set parameters is unconstitutional and, accordingly, invalid.

7.7 In *Nyathi v Member of the Executive Council for the Department of Health Gauteng and Another T26014/05 (NGD Pretoria)* Davis, AJ held from page 127:

> "[11] This "*moral obligation*" of the State, with regard to public administration, has subsequently become entrenched in, *inter alia,* Section 195 of the Constitution of the Republic of South Africa, Act 108 of 1996. Various instances of responsible and fair public administration in the interests of those who the government serve, including proper attention to their needs, are detailed and prescribed in the relevant section.
>
> [12] From a reading of all the above mentioned cases and the numerous instances referred to therein, it is sadly, however quite clear that the State and its officials all too often, be it as a result of pure negligence, incompetence or "laziness" fail to honour their constitutional obligations as well as the aforesaid moral obligations (which must certainly still exist) and fail to comply with court orders, be they orders *ad factum praestandum* of(sic), more often *ad pecuniam, solvendam.*
>
> [13] In the present instance, the First Respondent's failure has, ... therefore also effectively encroached on or prejudiced his right of access to the court as enshrined in Section 34 of the Constitution. Although such a consequential encroachment would not apply in each instance, there are other constitutional inroads made by Section 3 of the State Liability Act which are of general application as discussed hereunder."

7.8 In the subsequent *Nyathi*[21] case which dealt with contempt of court proceedings arising from the earlier case, Madala J held:

> "[63] … But we now have some officials who have become a law unto themselves and openly violate people's rights in a manner that shows disdain for the law, in the belief that as state officials they cannot be held responsible for their actions or inaction…
>
> …
>
> [75] …The state needs to take responsibility for its employees and ensure that defaulting state officials are subject to the disciplinary action as envisaged in the legislation and regulations…
>
> [78] Secondly, state administration is inefficient and ineffective. The conduct of state officials undermines the legitimacy of …the state. Generally, relevant state departments are in the best position to assess the magnitude of the problems faced by their personnel and are similarly in the best position to address the systemic failure of state officials to perform their duties."

7.9 These cases represent both the importance of sound administrative procedures in the conduct of the state's business and the importance of both transparency and accountability in the exercise of public administration. The importance of accountability here is reflected in the majority judgment in *Glenister*[22] which argues for independence of reviewing bodies.

8. The Relationship between Public Administration and Entrenched Fundamental Rights

8.1. The right to just administrative action is one important part of the broader category dealing with the regulation of the exercise of public power. Not every exercise of public power is administrative action, meaning that the right to just administrative action does not apply to every exercise of public power. But where the right is not applicable, the exercise of public power can still be challenged.

[21] *Nyathi v Member of the Executive Council for the Department of Health, Gauteng and Another* CCT 19/07[2008] ZACC 8
[22] *Hugh Glenister v President of the Republic of South Africa and Others*. Case CCT 48/10 [2011] ZACC 6.

8.2. A decision taken by the Director-General of Health in terms of section 36 of the NHA falls clearly into the definition of administrative action. Section 36 deals with applications for "certificates of need," which are necessary for the provision of health services and a range of service-related activities.

8.3. In the *Pharmaceuticals*[23] case, the Constitutional Court said that the "exercise of all public power must comply with the Constitution which is the supreme law".

8.4. In this and other cases, the Constitutional Court has identified as the three key constitutional principles that regulate the exercise of public power, namely, legality, rationality, and accountability. These principles apply regardless of who exercises the particular power in question, the specific source of the power, and whether or not the case involves entrenched constitutional rights.

8.5. In summary, when exercising any power given by law, the Constitution requires everyone – including the President – to act lawfully, rationally and accountably. This applies even in cases where no fundamental rights are involved.

8.6. The principle of *rationality* means that there must be a logical connection between a decision and the purpose for which the power was given. Irrational decisions are inconsistent with the requirement of the rule of law that the exercise of public power should not be arbitrary.

8.7. The principle of *accountability* may not always give rise to a legal duty to act, but it is a useful tool in determining in which circumstances the state has a legal duty to act[24].

8.8. When the TAC relied on the right of access to information in the *Annexure A* case[25], Acting Justice Ranchod noted that section 195 "creates justiciable rights". This means that courts

[23] *Pharmaceutical Manufacturers Association of South Africa: In re Ex Parte President of the Republic of South Africa* 2000 (2) SA 674 (CC)

[24] *Rail Commuters Action Group v Transnet Ltd t/a Metrorail* 2005 (2) SA SA 359 (CC).

[25] When the Government's *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* (including ARV treatment) was adopted and published in November 2003, it referred to – but did not include – an implementation plan timetable which it referred to as Annexure A. It described it as "a detailed schedule for the next six months that describes the tasks that need to be accomplished in parallel in order for this plan to work". In February 2004, the TAC asked the Minister of Health to release Annexure A. In its view, the information was necessary to enable it to play its role in ensuring the speedy and reasonable implementation of the Operational Plan. The Minister's failure to respond to the initial request was followed by several additional formal and informal requests for her to make the implementation

can hold public officials to account for a failure to comply with the provisions of this section. In support of this conclusion, the judge referred to numerous decisions from the Constitutional Court, the Supreme Court of Appeal and other courts.

8.9. It is widely acknowledged that one of, if not the fundamental crises in the provision of public health care in South Africa today is maladministration of hospitals and the poor provision of health care. Thus inadequate medical skills, poor administration and planning, incompetent management, a failure to implement proper, existing industrial relations and human resources procedures, idle and uncaring nursing, and disincentives to the retention of medical doctors compound the crisis inexorably despite adequate resources.

8.10. **This submission argues that addressing these shortcomings – poor management, maladministration and lack of accountability – is government's obligation and needs to be the real priority of government. These obligations can be met within the current institutional and resource parameters. Without addressing these specific problems, in detail and urgently, the NHI or the system arising from it will be subject to constitutional challenge.**

plan timetable publicly available. It was only seven months later – in September 2004 and in answer to legal papers filed in the Pretoria High Court – when her department informed the TAC that Annexure A was a draft that had not been adopted, and that all references to it in the Operational Plan were made in error.

Chapter 5: Public Consultation and the NHI Green Paper

1. Why is it important that the NHI proposal involves strong public participation?

1.1. Within the context of policy-making, section 195 of the Constitution (Chapter 10 on Public Administration) states that:

> *"Public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles:*
>
> *...*
>
> *e) People's needs must be responded to, and the public must be encouraged to participate in policy-making."*[1]

1.2. Thus, a primary justification for involving the public in the policy-making process is that it is a democratic requirement to allow citizens to engage in the decisions about public policy[2]. Facilitating public participation, however, does not involve a concrete set of guidelines. Instead, "the method and degree of public participation that is reasonable in a given case depends on a number of factors, including the nature and importance of the legislation and the intensity of its impact on the public"[3].

1.3. The nature of the policy proposed in the Green Paper and the subsequent public interest it has attracted necessarily means that the issue of public involvement in the policy process needs to be evaluated. Most significant are the following issues which warrant the facilitation of public participation and broad consultation with the public:

- Possible financial implications for tax-payers;
- The multiplicity of stakeholders (private sector, public sector, urban citizens, rural citizens, employed, unemployed) that will be affected by the policy;
- The amount of public interest generated;
- The constitutional implications of such a policy;

[1] Constitution of the Republic of South Africa. Act 108 of 1996, ch. 10, sec. 195.
[2] Hemson, D. 2007. In Buccus, I. and Hicks, J. (eds.), Can Participation Make a Difference? Prospects for People's Participation in Planning. Critical Dialogue 3 (1), 9–15.
[3] Merafong Demarcation Forum and Others v President of the Republic of South Africa and Others (CCT 41/07) [2008] ZACC 10; 2008 (5) SA 171 (CC); 2008 (10) BCLR 968 (CC) (13 June 2008), para 27, p. 15.

1.4. Consequently, and, given the nature of the issue of health as one directly impacting on society and the well-being of the country, public consultation must form an integral part of any policy process related to the health sector. At its core the NHI is ultimately a proposal meant to right the wrongs of the past, remedy social injustices and uphold human rights. Public participation by default then needs to be seen as a complementary process and built-in aspect of the policy-making process as opposed to a tokenistic or adjunct part of the process.

2. What actions have been taken by the Department of Health in terms of consulting the public?

2.1. The Green Paper was released for public viewing on the 12th of August, 2011, preceded by a media briefing at the Department of Health in Pretoria on 11th August.

2.2. Contained within the document was an invitation to comment as follows:

> "Interested persons are invited to submit any substantiated comments or representations on the proposed policy to the Director-General: Health ... within a period of two months from the date of publication of this notice"[4]

2.3. A number of 'public' discussions have taken place involving the Minister of Health and members of the Department of Health. These have mainly involved professional medical bodies and related organisations such as insurance providers. The following formal discussions have been noted:

- NHI Policy Forum held at PPS, 8th September, 2011
- NHI Discussion for Deans of Medical Schools and specialists with the Minister of Health, held at the Department of Health in Pretoria, 8th September, 2011
- NHI Discussion for SAMA, held at Wits Medical School, 21st September, 2011
- NHI Discussion with Minister of Health, held at GIBS, 4th October, 2011
- NHI Conference - National Consultative Health Forum: Lessons for South Africa, 7th – 8th December, 2011.

3. Interpretation of and response to the level of public consultation and its meaning

3.1. Public participation and the process of public consultation can essentially be "embellished with misleading rhetoric" and an "empty ritual of participation" or "the means by which

[4] National Department of Health. 2011. National Health Insurance in South Africa, Green Paper.

(the public) can induce significant social reform which enables them to share in the benefits of the affluent society"[5]. Unfortunately, given the nature of society and the policy-making process, the former is seemingly the norm.

3.2. As far as can be ascertained, the process of compiling a policy document for a NHI began in 2007 within a closed ANC structure. Four years later a firmly grounded proposal has been presented, preceded by no public consultation in terms of formulating a policy. Evidence that the drafting process was done within the confines of the ANC is found in the fact that prior to the release of the NHI Green Paper, three NHI documents were released to the media and other interested parties[6].

3.2.1. Where an ideal policy-making process involves the executive engaging with the public when *drawing up* and *formulating policy*[7], this has clearly not been the case with the Green Paper. As Still (2011) notes "the first NHI proposals were drafted by an ANC task team (*not through the normal government process* (emphasis added)), led by the CEO of the Human Sciences Research Council"[8].

3.3. The effect that the lack of public consultation has had can be seen in the multiple scenario possibilities that have been contemplated, guessed at and mapped out by various concerned organisations and professional bodies.

3.3.1. Confusion and anxiety, both before and after the publishing of the Green Paper, plagues the debate, while resentment towards government's seeming desire to take full control of the health sector grows. Indeed, perhaps the most damaging of the effects has been the polarisation of different groups, in particular those who see it as an inadequate solution and those with vested interests in the implementation of the NHI: "responses to NHI proposals range from ideological support through to sceptical pragmatism"[9].

3.3.2. Had a more consultative process taken place in the drafting of the document, less guessing would be necessary and the confusion and anxiety reduced.

3.4. That this stage in the policy-making process has been missed as far as consultation is concerned is worrying. It suggests the possibility of the policy-makers having gone so far as to have a fixed mind that is now inflexible to outside criticism and recommendation. As stated by Sachs LJ in *Sinfield and Others v London Transport Executive*, "any right to be consulted is something that is indeed valuable and should be implemented by giving those

[5] Arnstein, Sherry R. 1969. A Ladder of Citizen Participation. *JAIP*, 35 (4), p. 216-224.
[6] Still, L. 2011. Health Care in South Africa 2011. Profile Media, p.90.
[7] De Villiers, S. 2011. A People's Government, the People's Voice: a Review of Public Participation in the Law and Policy-Making Process in South Africa. The Parliamentary Support Programme, p.90. Available online at: http://www.idasa.org/.
[8] Still, L. 2011. Health Care in South Africa 2011. Profile Media, p.90.
[9] *ibid*, p.93.

who have the right an opportunity to be heard at the formative stage of proposals before the mind of the executive becomes unduly fixed"[10].

3.5. The greatest concern over inadequate consultation in the case of the NHI is that:

- Policy-makers lack a full understanding of the relevant issues pertaining to health resulting in inefficient policy; and
- It sets up a scenario whereby contestation and the possibility of litigation slows down the implementation of critically needed reform.

3.6. Past examples of publicly contested and controversial policy decisions and proposals demonstrate the effect that inadequate consultation with all stakeholders can have. The most common being an application to the Constitutional Court and a protracted legal, and more concerning, political battle (see Box 1).

Box 1: *Doctors for Life International v the Speaker of the National Assembly and Others*[11]

> *In February 2005 DFL made direct application to the Constitutional Court seeking to strike down among others the recent Choice of Termination of Pregnancy Amendment Act (CTOP Amendment) and the Traditional Health Practitioners Act (THPA). The basis for the action is that Parliament had failed in its duty under the Constitution to 'facilitate public involvement'. In August 2006 the Constitutional Court ruled in an 8-3 Judgment that both the CTOP Amendment and the THPA were unconstitutional. The order was suspended for 18 months, during which the National Council of Provinces may re-enact the said statutes after "meaningful public participation" was facilitated.*

3.7. These cases highlight that consultation needs to occur not only between government and its citizens, but also within government itself - between national and provincial legislatures. Indeed, there are many legal constitutional factors regarding communication and co-operation when proposing and implementing new policy.

3.8. In light of the Green Paper, it is the Foundation's view that such issues have not been adequately addressed.

3.8.1. A specific issue to be aware of is the possibility of conflict between national and provincial government arising as a result of implementing a policy which at this stage undermines the constitutional rights and decision-making powers of the provinces by

[10] Sinfield and Others v London Transport Executive [1970] 2 All ER 264, (CA)
[11] Summary posted on Doctor's For Life website. Available online at: http://www.doctorsforlife.co.za/index.php/category/departments/legal-department/

forcing them to surrender control of resource allocation (see Chapter 4: Constitutional Implications).

3.8.2. Litigation, on the one hand, and attempted implementation of a NHI as currently proposed, are potential negative outcomes of the process thus far.

3.9. In the immediate short-term the invitation to respond to the Green Paper, while in-line with constitutional requirements is, by default, flawed due to the inadequate and incomplete nature of the policy document. After outlining the various possible sources of funding most often attributed to financing a system of universal coverage the Green Paper states "The precise combination of these sources is the subject of continuing technical work and will be further clarified in the next 6 months in parallel to the public consultation"[12].

3.9.1. However, **the time given for public comment, which was originally two months and now extended to four and a half months, means that the public is excluded from giving input on the most important aspect of the policy[13]. Furthermore, not only will the public be excluded, but an appropriate response to the Green Paper itself is made difficult given the lack of clarity as to what policy mechanisms are proposed.**

3.10. Launching the policy proposal without any form of prior public consultation has caused unnecessary confusion in the public domain, in large part due to this lack of clarity. More importantly, the wasted time and resources that have been and will, be spent on reaching a more universally satisfactory policy agreement, is something that could have been avoided and needs to be taken into account going forward.

4. Recommendations for furthering the public consultation and participation process

4.1. In the case of the NHI, public consultation in the form of government representatives directly 'educating', 'informing' or 'work shopping' the public is an inadequate approach for a policy of this nature. Such an approach, while appropriate in some cases, would allow, if not encourage, coercion and manipulation, particularly during interaction with the lay voting public.

4.2. An appropriate first step in the policy-making process going forward would be to ensure greater communication between various government bodies: national, provincial and local. Instead of viewing the role of public participation in the process of policy-making as

[12] National Department of Health. 2011. National Health Insurance in South Africa, Green Paper, paragraph 114, p.35.
[13] Matlala, N. 2011. Follies the NHI Should Avoid. The Mail & Guardian. Published on August 19, 2011.

something implying only a dialogue between the executive and the people, "a modern constitutional democracy should rather promote participatory governance between the electorate and their representatives in Parliament, provincial legislatures and local councils. This would break a growing tendency, where the President and his cabinet alone are seen to be a voice of authority which can address the problems of ordinary people"[14] (see Chapter 4: Constitutional Implications).

4.3. It is also worth taking note of past ways of informing policy in the health sector. For instance, the Gluckman Commission (appointed to inquire into, advise and report on a National Health Service for South Africa in 1945), conducted a 3 and a half month tour of the country to learn firsthand – through observation, evidence and discussion – about the conditions that prevailed in the health sector[15].

4.4. The Committee of Inquiry into a Comprehensive System of Social Security, commissioned in 2002, also documents stakeholder views obtained in its subcommittee findings regarding the South African health sector: "The views of a range of stakeholders were obtained on various aspects of the health system and possibility of some form of mandatory contribution for health cover"[16]. These were obtained through a "willingness to pay" survey conducted on around 1000 individuals.

4.5. With regards to the current proposal for a NHI in South Africa, it is clear that public consultation and participation has a long way to go. This is especially clear in terms of eliciting public and stakeholder opinion rather than presenting an already defined policy proposal.

4.5.1. As both historical and international evidence of creating and implementing a NHI system suggest, it is a complex process requiring an equal measure of open debate in the policy-making process, and sufficient resource capacity in the implementation stage[17]. The Foundation is thus of the view that the current policy proposal is merely the first step on the long road towards health reform and is in agreement with the view

[14] Selebalo, H. 2011. Challenges to Public Participation in South Africa's Parliament. Institute for Security Studies. Published on 29 March, 2011. Available online at: http://www.iss.co.za/iss_today.php?ID=1256

[15] Phillips, H. 1993. The 1945 Gluckman Report and the Establishment of South Africa's Health Centres. *American Journal of Public Health*, 83, (7), 1037-1039.

[16] Department of Health. Inquiry into the Various Social Security Aspects of the South African Health System. Policy Options for the Future. Department of Health, 2002. Available online at: http://www.info.gov.za/view/DownloadFileAction?id=123928

[17] World Health Organisation. 2007. Everybody's Business: Strengthening Health System Outcomes to Improve Health Outcomes, WHO's Framework for Action. Available online at: http://www.who.int/healthsystems/strategy/everybodys_business.pdf

that it is a work in progress, with many details still uncertain and much scope for creative thought[18].

4.5.2. Ultimately, the only way to successfully build on the momentum provided by the Green Paper will be through greater consultation and a more active engagement between the Department of Health, other government departments, key stakeholders and civil society to ensure it is widely supported and thus balanced and effective – a view strongly advocated by the WHO:

> *"A national health sector strategy is one way to reconcile multiple objectives and competing demands. To be robust, a sector strategy requires sound logic and sufficient support. Plans need to be costed; budgets have to balance ambition with realism. The necessary processes have to be managed in an inclusive way, and linked with national development planning processes such as poverty reduction strategies. These, together with transparent systems to track effects, are the key to unlocking more resources"*[19].

[18] Bernstein, A. (ed) 2011. 'Reforming Healthcare in South Africa. What role for the private sector?'. Johannesburg: Centre for Development and Enterprise, p26.

[19] World Health Organisation. 2007. Everybody's Business: Strengthening Health System Outcomes to Improve Health Outcomes, WHO's Framework for Action, p.7. Available online at: http://www.who.int/healthsystems/strategy/everybodys_business.pdf

Chapter 6: Universal Health Coverage: South Africa's health system and the proposed NHI

1. Health Care Reform: A global policy agenda

1.1. As any historical overview of health care policy in South Africa reveals, the idea of a national health insurance is by no means a new policy proposal for South Africa. In addition, neither is a proposal aimed at health care reform at this time a particularly unique idea from a global perspective. Currently, both China and the United States are reviewing their health care systems[1]. In addition, more than 8 countries worldwide have initiated wide ranging health care reform over the last five years[2].

2. What is universal coverage?

2.1. Current global thinking regarding national health system policy shares, to a significant extent, the common ideal of providing universal health coverage. As the World Health Organisation notes, "at a time when many countries... are reviewing the way they meet the health-care needs of their populations, universal health coverage – what is it, how much does it cost and how is it to be paid for? – dominates discussions on health service provision"[3].

2.2. Universal health coverage can be described as a health care system whereby all citizens have access to quality health care when needed and are not exposed to financial risk when accessing it. In 2005 all member states of the WHO adopted a resolution to develop health care financing systems that are capable of ensuring and sustaining universal coverage[4]. Universal coverage was defined as ''securing access for all to appropriate promotive, preventative, curative and rehabilitative services at an affordable cost"[5].

[1] The World Health Report: Health System Financing- The Path to Universal Coverage. 2010. World Health Organisation. Available online at: http://www.who.int.
[2] Still, L. 2011. Health Care in South Africa 2011. Profile Media.
[3] The World Health Report: Health System Financing- The Path to Universal Coverage. 2010. World Health Organisation, pp.3. Available online at: http://www.who.int.
[4] Sustainable Health Financing, Universal Coverage and Social Health Insurance. 2005. World Health Assembly Resolution 58.33. Available online at: http://www.who.int/health_financing/documents/cov-wharesolution5833/en/.
[5] Carrin, G., Mathauer, I., Xu, K. and Evans, D. 2008. Universal Coverage: Tailoring its Implementation. Bulletin of the World Health Organisation. Available online at: http://www.who.int/bulletin/volumes/86/11/07-049387/en/index.html.

2.3. Essentially, three fundamental questions inform the goal of universal coverage and subsequently all policy decisions[6]:

- How to obtain the financial resources?
    - Taxes (what kind: income, consumption?)
    - Borrowing
- How to protect citizens from financial consequences of ill health?
- How to make optimum use of resources?

2.4. There is no one-size fits all policy model for implementing a health care system geared towards universal coverage. Most often, financing of health care combines general taxation, social insurance, private insurance, out-of-pocket expenditure and, in poorer countries, donor funding[7]. Furthermore, an important point to make is that most reforms towards universal coverage have been gradual, involving the expansion of the health system (in terms of coverage, access and services provided) over time[8]. Quality improvement of existing service offerings can be added to this list.

3. What about universal access?

3.1. From a policy perspective an important point concerning the attempt to provide universal coverage is the fact that the counterpoint to the concept of universal coverage is that of universal access. Often implied in the discourse of universal health coverage is the idea that access to quality health care will be available. This assumes the availability of a health care provider pool equal to the task of providing services to millions of individuals, as well as the availability of infrastructural resources to accommodate the natural increased influx should a policy promising universal coverage be implemented. However, this is often not the reality, in which case simply offering coverage will not solve health care problems. In parallel to policy promoting universal health coverage then, "there must be access to care, which means someone involved in the discussion should be addressing the need to expand the provider pool"[9].

3.2. When considering implementing a policy aimed at achieving universal access to health care it is worth noting that the poor and those most in need of health care are often the last to

[6] The World Health Report: Health System Financing- The Path to Universal Coverage. 2010. World Health Organisation. Available online at: http://www.who.int.
[7] Still, L. 2011. Health Care in South Africa 2011. Profile Media.
[8] Carrin, G., Mathauer, I., Xu, K. and Evans, D. 2008. Universal Coverage: Tailoring its Implementation. Bulletin of the World Health Organisation. Available online at: http://www.who.int/bulletin/volumes/86/11/07-049387/en/index.html.
[9] Managed Care Outlook. 2009. Universal coverage remains a hot issue, but what about universal access to care? Managed Care Outlook, 22 (8). Available online at: http://www.hospitalist.com/assets/004/6419.pdf.

benefit (there will effectively be a lag effect between the time of the implementation of a policy promising universal coverage and the time in which it takes for the provision of services to be up-scaled in order to provide coverage to the entire population).

3.2.1. As the WHO notes, "during the transition process, population coverage often remains incomplete and sometimes may even become more unequal, with the poorest groups the least likely to be protected and often the last to benefit from extended coverage"[10]. This point is significant as it highlights that *universal coverage* is not synonymous with *universal access*. In order for any health care policy to be effective in genuinely providing universal coverage, the capacity and resource availability of a country needs to be assessed and carefully managed if such a policy is to be effective. Ultimately, for any policy aimed at providing coverage to successfully improve health indicators, there needs to be an equal focus on ensuring the resources to attend to the health needs of an entire population are up to the task.

4. Universal coverage as a value statement

4.1. In addition to these practical policy dimensions for moving towards an effective system of universal coverage, the very idea of universal health coverage is underpinned too by a set of values. As a generic concept, the principle of universal coverage is informed by values common to most democracies. Most significant in this sense are the values of social justice and the realisation of human rights. In essence, universal coverage can be understood as a fundamental policy norm motivated by Article 25 of the Universal Declaration of Human Rights, which states: "Everyone has the right to a standard of living adequate for himself and his family, including...medical care...and the right to security in the event of unemployment, sickness, disability..."[11]

4.2. The values that motivate a particular government to develop a health system based on universal health coverage, however, are far more complex than the alignment with an internationally accepted set of fundamental rights. In the context of South Africa, history and current social inequities are perhaps the two major factors that influence and motivate the expressed need to move towards a policy of universal coverage. Consequently, any policy looking to deepen universal coverage in South Africa must be strictly aligned with the Constitution.

[10] Carrin, G., Mathauer, I., Xu, K. and Evans, D. 2008. Universal Coverage: Tailoring its Implementation. Bulletin of the World Health Organisation. Available online at: http://www.who.int/bulletin/volumes/86/11/07-049387/en/index.html.
[11] UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III). Available online at: http://www.unhcr.org/refworld/docid/3ae6b3712c.html.

5. What the Green Paper says about achieving universal coverage in South Africa

5.1. In essence, the Green Paper proposes the implementation of a national health insurance as the mechanism for achieving the goal of universal coverage. In terms of the objectives of National Health Insurance, the Green Paper states that "National Health Insurance is aimed at providing universal coverage"[12].

5.2. The desire to achieve universal coverage and the idea that the NHI will be able to provide this is, however, is a misconception and possibly misleading, as it can reasonably be argued that South Africa already provides universal health coverage by virtue of the current two-tiered health system. On the one hand, the tax-funded public system provides coverage to those who are unable to utilise private health care for financial reasons. On the other hand, formally employed individuals and those able to afford it, are covered by the private health sector via contributions to medical schemes, as well as having access to the public health system under certain conditions. Essentially, the whole population is already covered (at least to some extent) via one of the two arms of the health system. The question of improving access to (both in terms of at point-of-service and reaching a point-of-service), and quality of health care provision, is where our attention should be aimed and prioritized.

5.3. Furthermore, it appears that the argument put forth by the Green Paper is that universal coverage and the NHI are synonymous: "*This model of delivering health and healthcare services to the population is well accepted, described and widely promoted by the World Health Organisation as universal coverage"*[13]*.*

5.4. However, as noted above and confirmed by the WHO, there is no one particular way of achieving universal coverage. Indeed, only a small number of countries worldwide have managed, relatively successfully, to provide universal coverage through the adoption of a national health insurance model (e.g. South Korea). Making comparisons in terms of policy mechanisms is thus not necessarily helpful and doing so risks steering the development of an appropriate health system in the wrong direction given South Africa's unique economic, social and political context.

5.5. What can be learnt from international experience though is the following:

- Most reforms in the health sector have been gradual, and

[12] National Department of Health. 2011. National Health Insurance in South Africa, Green Paper, p.18, paragraph 53.
[13] National Department of Health. 2011. National Health Insurance in South Africa, Green Paper, p.5, paragraph 5.

- There are substantial differences across countries in the institutional and organisational arrangements to ensure funds are raised, pooled and used to purchase or provide services[14].

5.6. The most relevant question to ask in terms of any proposed reform to the health system in South Africa then is:

What are the most important and critical steps to take in working towards improving access to health care and what are the most relevant policy mechanisms for achieving them?

6. Re-conceptualising healthcare reform and the needs of the health care system in South Africa

6.1. There are a multitude of problems within the health system in South Africa. The Green Paper identifies the following as the most pressing problems affecting the provision of quality health care for the whole population:

- Shortage of human resources in public sector;
- Underperforming institutions in the public sector attributed to poor; management, underfunding and deteriorating infrastructure;
- Deteriorating or consistently poor quality of health care services in the public; sector
- High costs of private health care and private medical schemes;
- Out-of-pocket payments and co-payments;
- A two-tiered system of health care which does not embrace the principles of equity and access.

6.2. This list of problems in the health care system as described by government is not a unique perspective, finding support beyond the state too. For example McIntyre and van den Heever (2007) note that a "problem facing the private voluntary insurance sector in South Africa, which is related to the cost spiral, is the inability to extend coverage to a greater section of the population"[15]. More broadly, they also state that "the key challenge facing the South African health system is not a lack of financial resources, but to improve the efficiency and equity of the use of these resources.

[14] Carrin, G., Mathauer, I., Xu, K. and Evans, D. 2008. Universal Coverage: Tailoring its Implementation. Bulletin of the World Health Organisation. Available online at: http://www.who.int/bulletin/volumes/86/11/07-049387/en/index.html.
[15] McIntyre, D and van den Heever, A. (2007). Social or National Health Insurance. In S. Harrison, R. Bhana & A. Ntuli (eds.), South African Health Review 2007. Health Systems Trust, p.74.

6.3. Clearly, the problem of inequity in terms of being able to access *quality* health care *per se* is perhaps the overarching issue facing the health care system. Distilled from the above then, three issues need to be dealt with:

- Inefficient and poor quality of health care offered by the public sector;
- Spiralling and unsustainable costs of health care;
- Disparity between public and private sectors resulting in the perpetuation of social inequality.

6.4. The Green Paper makes clear the objective of a NHI, stating that "the rationale for introducing National Health Insurance is therefore to eliminate the current tiered system where those with the greatest need have the least access and have poor health outcomes"[16]. Undeniably, creating a system whereby those with the greatest need and least means are able to access quality health care is vital for the simple reason that access to health care is a constitutionally guaranteed right. Yet, it is equally important, from a practical point of view, to note that the South African Constitution works from the premise of the progressive realisation of rights. In opposition to this idea, the Green Paper seemingly takes a firm stance in presenting a policy which has an implicit and explicit determination to 'do it all at once', despite being said to be implemented "in a phased and systematic manner at both the national and sub-national levels" occurring "in three phases over the fourteen years of implementation"[17]. There are, however, obvious gaps in the proposed policy and this makes any timeline regarding implementation a premature approach. Thus, considering the inherent complexity of implementing universal coverage and the fact that international experience tells us that increasing the access and quality of health care is a gradual process, often achieved over decades, it is proposed here that a more strategically prioritised approach to health care reform needs to be created.

7. Prioritising the improvement of the health care system in South Africa

7.1. The health care system in South Africa has been (optimistically) summarised by Yach and Kistnasamy (2007) as follows:

> *"The fact that one can access health care in the public sector during times of need and it is free in most cases is viewed positively. The public health system does deliver services albeit with some inefficiencies, inadequate quality of care in some facilities*

[16] National Department of Health. 2011. National Health Insurance in South Africa, Green Paper, p.15, paragraph 50.
[17] *ibid*, p.44, paragraph 143.

and poor infrastructure in some places. For those that have the ability to pay, the South African private health system is viewed amongst the top four in the world."[18]

7.2. While this interpretation does not necessarily provide an accurate reflection of the problems in the public health sector in particular, it is helpful in providing us with an understanding of where a process of health care reform might best take root. In the first instance, it points towards the immediate attention that needs to be focused on attending to the public health sector. This can be seen from a strategic point of view as attending to the problems of the health sector in the most practical and efficient way.

7.3. The National Budget Review 2011 states "The 2011 Budget takes the first steps in establishing national health insurance (NHI), which is part of the Minister of Health's 10-point plan for improving health outcomes in South Africa"[19]. The measures it cites in regard to the steps include: R1.2 billion allocated for primary health care; R2.7 billion for improving quality of (public) hospitals; R117 million allocated for the establishment of the Office of Standards Compliance.

7.4. While this budgetary notice is made in light of the proposed launch of a NHI, such measures are surely absolute minimum requirements, regardless of a NHI and arguably "these expenses should be undertaken independent of any proposed policy shift to a NHI system"[20].

7.5. As runner-up to these most pressing items on the health agenda is the inequity that a less than adequate public health sector running parallel to a high performing, yet financially restrictive private health sector, not only creates, but perpetuates. Consequently, attending to the challenge of the inequitable "distribution of financial and human resources between the public and private health sectors relative to the population served by each sector"[21] is a problem which requires an equal degree of attention. Yet, because this problem is not only practical but theoretical, it is that much more complex and undoubtedly requires far more strategic deliberation. Therefore, attempts to tackle this problem should not be allowed to delay the need to undertake some sort of health reform.

7.6. Ultimately, the question is how to balance measures towards health care reform. What would have the most impact in the shortest time and which are the most sustainable

[18] Yach, D. And Kistnasamy, B. 2007. Healthcare in a Democratic South Africa. Paper presented at 'After Apartheid' Conference, Yale University, New Haven CT, April 2007, p.4. Available online at: http://www.yale.edu/macmillan/apartheid/yachkistnasamyp2.pdf.

[19] Budget Review 2011. Prepared by National Treasury, Republic of South Africa. Chapter 7, p. 108. Available online at: http://www.treasury.gov.za

[20] Still, L. 2011. Health Care in South Africa 2011. Profile Media, p88.

[21] McIntyre, D and van den Heever, A. (2007). Social or National Health Insurance. In S. Harrison, R. Bhana & A. Ntuli (eds.), South African Health Review 2007. Health Systems Trust, p74..

initiatives? From an analysis of the Green Paper, it does not seem likely that the measures proposed would guarantee either sustainability over time or have an impact in the short term. Due to the complexity of implementing a policy of NHI, certain fundamental prerequisites need to be in place in order to ensure the policy's long term viability. This includes a sufficient number of medical professionals in order to deal with an increase in demand for health care. Equally, because of the intensive administrative procedures that need to be in place prior to the actual implementation, scarce resources would necessarily be directed towards establishing new institutional dimensions, where they would be better used to upgrade and enhance components of the current public health system allowing immediate (and effective) outcomes to be more readily guaranteed.

7.7. Thus, it is strategically logical that before any significant institutional changes are made or policy implemented, the current health system as the foundation of health care provision must be strengthened.

Chapter 7: Appropriate Management for a Health Care System

1. Introduction

1.1. Appropriate management across all levels of the health care system is crucial for the successful reform of the South African health care system as a whole. In the Green Paper the word "management" is mentioned no fewer than 27 times in the document as a whole, while the section *The Migration from the Current Health System to the National Health Environment*[1] has seven citations. Obviously the issue of management is seen as being extremely important for successful migration from the current system to the proposed one. With this as the context, the introduction of the Green Paper provides the opportunity to examine the best way to finally and emphatically correct malfunctioning management structures and practices in the health sector.

1.2. It is important to note, however, that a NHI is not a necessary prerequisite for addressing management issues in the health care sector. Nor should it be assumed that such issues will disappear automatically with the implementation of the system. Indeed, even if the proposed NHI is not fully or immediately introduced, improvements in health care management would go a long way to maximising what is extracted from health budgets by provincial and national civil servants charged with this responsibility. This alone makes giving close attention to health management very important.

1.3. Tightening up and improving health management across all the players in, at least, the public sector is essentially an Organisational Development (OD) intervention. In this respect, an *Organisation* is in place, but recent history and experience with it has indicated that a deep and thoroughgoing *Development* phase needs to be undertaken, systematically, and as quickly as possible.

1.4. OD initiatives which are not successful have very long hangover periods in organisations that have attempted them. The lack of success embeds itself, negatively, deeply in the DNA of the organisations. The failed attempts are remembered by staff as the disappointments which they were, and as such make any subsequent OD endeavour even more problematic and difficult to implement.

[1] National Department of Health. 2011. National Health Insurance in South Africa, Green Paper, p.44-45, paragraphs 143-150.

1.5. Thus, in a very real sense, with or without the implementation of a fully formed NHI scheme, the successful placement of efficient and effective management structures and procedures has just one chance *for a very long time into the future*. Success or failure in doing so now, will have long term consequences which must be very seriously considered, even before implementing such an overarching health reform programme.

2. The issues

2.1. The Foundation believes that to be successful, health management should conform to the following broad positions. It should:

- Be clearly distinguished from administration;
- Be decentralised;
- Take a long term view.

2.2. Management and administration

2.2.1. A forerunner to any discussion of management as a potentially serious contributor to the efficacy of a NHI scheme must be the acknowledgement that managers must be trained, and granted the opportunity to make decisions in respect of the areas of the health care system that have been entrusted to them.

2.2.2. There have been periods in our history when decision making was highly centralised. During those times the titles of officials in the public health care sector reflected their powerlessness and reliance on supervisors and superordinate managers. Mid-level managers channelled paper from lower levels of the system to layers above, and then transmitted the decisions of those higher levels back down to the subordinate ones. This severely circumscribed the authority of lower levels, as well as the decision making of the intermediary levels, since participants were reduced to either acting as mailboxes for channelling bidirectional communications, or being the "dumb limbs" for actual decision makers who occupied the upper reaches of the structures.

2.2.3. The essence of a *management structure* rather than an *administration* is that managers must be given the training, authority and independence to manage, with the attendant responsibility and accountability. If the NHI scheme is to be any improvement on the present, trust and authority, as well as the appropriate skills, must be devolved so that managers *can* manage, rather than being reduced to administrators on behalf of supervising bureaucratic layers. *Administrators* are agents of their superiors, while *managers* have budgets for which they are accountable, policies to implement and results

to achieve, and if failure follows, responsibility for it. These results are the product of their informed work and their own decision-making within their own realm of responsibility.

2.2.4. If the vision of *'... what management is'* differs from this, and a NHI structure seeks to achieve the goals which it seems to have set for itself, it is virtually guaranteed to fail if personnel who could *manage* are turned into *administrators*.

2.2.5. In the management sphere, more than anything, the proposed NHI requires commitment to *strengthen management* appropriately for the decision-making that will fall on the shoulders of the levels in question***.***

2.3. Decentralisation

2.3.1. The Foundation believes that the most effective decisions are made closest to where problems and issues arise. As a management principle this best reflects a commitment to the liberal democratic values as entrenched in the Constitution. More generally, this approach is well-accepted ***as sound management practice.***

2.3.2. The implication of this is that managers must be trained and given authority to resolve issues which arise, first, in their geographical areas and, second, for the line functions within the health system for which they carry responsibility. Any other arrangement which might water down a manager's ability and authority to fully engage with local difficulties and issues is undermining her/his ability to manage. This should be guarded against most strenuously.

2.3.3. Promoting the idea that there is both a need for specialised management training programmes and decentralisation is the fact, noted by Engelbrecht and Crisp (2010), that previous "national level attempts to develop effective management training programmes for hospital managers have largely failed"[2]. The lack of decentralised, accredited, provincial level programmes is largely seen as the missing ingredient in the design of past management training programmes[3]. This is ultimately the approach advocated for, due to its inherent ability to be responsive and relevant to local health challenges[4].

2.3.4. In the context of the intended NHI this is particularly significant because of the proposed "Purchaser - Provider" separation. A commitment to decentralisation will require that significant training and skills be devolved to quite small elements of the Local Government level. This will enable them to make decisions on what services should be "purchased" with

[2] Engelbrecht, B. and Crisp, N. 2010. Chapter 19: Improving the performance of the health system. In South African Health Review 2010, p.198. Health Systems Trust.
[3] *ibid*.
[4] *ibid.*

the funds at their disposal. Any other arrangement will entrench a centralised approach which, managerially, would make for a less efficient and poorer allocation of resources.

2.3.5. Such devolution may seem to be a pipe-dream, and could be thought to be impossible for innumerable logistical and practical reasons. While this might be a difficult process, such decentralisation has never been seriously tried and the current debate regarding health reform provides an opportunity to give effect to it. Certainly the positive effect of such delegations, with suitable checks and balances in place, will be felt in the furthest corners of our democracy.

2.4. A longer term view

2.4.1. The type of management referred to above will be the product of a long term view, which is why the Foundation is encouraged to see that the Green Paper proposes an implementation plan over a period of fourteen years.

2.4.2. During this time it may be possible to grow a cohort of managers steeped in the goals and values required to successfully reform the health system. However, in order to do this it will be necessary to quite radically alter norms as they apply to current management training and practices.

2.4.3. The first seventeen years of the democratic dispensation has, again and again, seen managers being parachuted into positions without skills required to do the jobs to which they have been appointed. There have been a variety of reasons for this, but for a successful NHI *this can no longer be endured*. Managers need the appropriate education and training to acquire suitable skills for the jobs they have, or the jobs they are being groomed for. While this is taking place these managers need to have more junior and 'smaller' jobs and tasks. In these lower level positions they need to undergo learning as well as being given opportunities to put into practice the art and craft of management, with authority to do the 'lesser' jobs. They should also be responsible for the consequences should they fail or not be successful. There must be occasion where failure is not critical, and these episodes must be viewed as learning opportunities.

2.4.4. All of this *must* take place in lower-ranking positions. Successful junior managers need to be spotted and sent for further training to fit them for the advancement and more responsible positions in which broader ranges of skills and experience will be required. This necessitates an eye to the future, and an attitude which has the long term careers of the managers in question as an explicit focus. It also requires that supervisory staff take responsibility for the performance of their subordinates and catch mismanagement early,

in a smaller environment, where the impact is reduced and does not threaten large sections of the health structure.

2.4.5. Ideally the skills for the succeeding level need to be learnt during the time occupying the prior one, so that elevated individuals are not confronted with pressure with which they cannot cope when they are out of their depth following promotion, at the same time as staff have to acquire the requisite skills for the new positions. This latter approach leads to failure and is demoralising, both for the individuals involved, as well as the parts of the system where they eventually come to rest.

2.4.6. This means that *quick fixes* must be avoided, because while they may be *quick*, they rarely are *fixes*. A much longer term view must be taken with succession planning reaching much deeper into the elements and institutions which make up the health system. Monitoring of subordinates must be closely done with selection and nurturing of future managers a clear part of supervisors' job descriptions. Training opportunities must be built by human resource departments and entered into their workplans, as well as the regular workplans of line managers. Talented staff should not fall into suitable training by default, inappropriate training by design, or personnel simply be overlooked.

2.4.7. There is, quite simply, no other way of building a robust, accountable and sustainable organisation than by "growing your own wood" and in so doing instilling in staff the vision for the organisation as well as the appropriate skills to realise the articulated vision for the health system.

2.4.8. Deployment and "parachuting in" can play no part in such an OD process.

3. Imperatives for the installation of appropriate management skills for an effective health system

3.1. Training Needs Analysis

3.1.1. Research on the skills gap between what is available as the management capacity in all the levels of the health system now, and what will be required for an improved system, needs to be undertaken. Such surveys have been done in the past and an up-to-date confirmation or modification of these results must be carried out.

3.1.2. Part of this Training Needs Analysis should include a *clear understanding of the numbers involved* for the initial period of any proposed pilot, as well as for the subsequent stages of rollout of the scheme.

3.2. Curriculum, syllabus and training providers

3.2.1. The complex questions of Goals and Outcomes for a viable health system must be agreed upon and codified. Following this:

- Matters of curriculum and syllabus can be finalized;
- Appropriate training materials acquired;
- Competent, experienced, training providers engaged to plan and install the training.

3.3. A final caution

The amount of time required to properly plan and execute a successful and effective management structure for the health system should not be underestimated, bearing in mind the risks and long-term negative effects should such an intervention be improperly designed and implemented.

Chapter 8: Conclusion

1. The Helen Suzman Foundation's undertakings in response to the Green Paper

1.1. The Green Paper has many fundamental flaws creating a situation whereby the initiative taken by the Department of Health is at risk of being undermined by a lack of strategic and practical solutions essential for translating intention into action. In order not to continue along what has been an historical path of poor follow-up on policy proposals, a lack of willingness to engage with alternative options and poor implementation standards, it is imperative that the next steps in reforming the health system are carefully thought through.

1.2. At the same time we are not calling for the implementation of any policy for health care reform at this stage. Rather we hope that the dialogue initiated by the release of the Green Paper is seen as an opportunity to begin working towards a coherent policy that attends to the context of South Africa and involves greater partnership between the public and private sectors, medical professionals themselves and civil society stakeholders.

2. Summary of Concerns and Issues

2.1. The Foundation has serious concerns about what the proposed NHI is envisaged to entail and the potential consequences of the policy proposal. The following are our main concerns and questions that require special attention:

2.1.1. How is the NHI seen in relation to the National Health System?

The question as to whether the NHI is envisioned as a replacement to the national health system or complimentary to it is unclear.

2.1.2. Differentiating universal coverage from a National Health Insurance System

The distinction between ideology and policy is important so as not to create a debate informed by politics. It seems that the concept of NHI is promoted as synonymous with that of universal coverage when, in fact, it may simply be an institutional arrangement and policy mechanism with universal coverage being the objective outcome of the policy itself. What is lacking in the Green Paper therefore, is what exactly is meant by a NHI system for the provision health care. Is it a form of financing health care provision or is it actually a health care provision system?

2.1.3. Lack of evidence-based research and statements to support the policy

Many statements and justifications put forth for the promotion of a NHI system in South Africa lack appropriate supporting evidence. Most significant is the proposal's suggestion that the two-tiered health system is destructive and unsustainable. The fact that there is significant expertise in the private sector and that a number of countries with universal health coverage have a two-tiered health system indicates otherwise. This statement is concerning as it serves to take emphasis away from dealing with the systemic problems eroding the health system (inefficient use of resources, poor management, corruption, a shortage of human resources) and argues for the establishment of new institutional arrangements which, the Foundation believes would undoubtedly be undermined by the very same problems.

2.1.4. Lack of detail on a National Health Information System

2.1.4.1. The current state of the National Health Information System (NHIS) in South Africa makes policy-making in the health sector especially difficult. Although the establishment of a NHIS in the public sector has been given high priority and a lot of money has been invested in it, the quality of data has been poor and cannot be used optimally to plan, manage or monitor health services[1]. Consequently, far more work on the improvement of the National Health Information System is required. This should form an integral part of the proposal as it is the foundation for any health reform policy.

2.1.4.2. Of particular concern is the proposal to implement an electronic platform and database in order to capture all data regarding health care in South Africa. The fact, however, is that implementing such an individual electronic platform involves complying with a multitude of standards, co-ordinating and integrating the system between different service providers and dealing with the constitutional problem where provinces cannot be forced to adopt centralised policies[2]. Initiating a programme effective enough to deal with what is proposed by the NHI requires huge amounts of financial and technical resources, sufficient time and human resources. Such a programme would have to be implemented well before, not in parallel with, the roll out of a NHI system.

2.1.5. Difficulties in making cost estimates given the lack of a National Health Information System

Making cost estimates for a system as complex as the one proposed by the Green Paper requires a vast amount of quantitative data. In particular, the disease burden and

[1] Loveday, M., Smith, J. and Monitcelli, F. 2006. Health Information Audit Report South Africa. Health Systems Trust.
[2] Vegter, I. 2009. National Health Information System in South Africa – "Mission Impossible". Available online at: http://isiafrica.net/?p=284.

service utilisation rates need to be accurately gauged. Given the previously noted state of the NHIS, making cost estimates is therefore extremely difficult. The danger in this case is under-estimating the costs which will only serve to jeopardise the health system even further. In addition, the difficulty of cost estimation is made worse due to the number of undocumented immigrants currently utilising public health services and the number of individuals who do not make use of the public health sector as a result of its shortage of resources and other difficulties faced in accessing health care. Of further consideration is the fact that "the emphasis of the health information system development and implementation strategy has largely been on the public sector rather than on the private sector as per government strategy on health information systems. As a consequence, health information systems in both sectors have developed in different directions"[3]. This issue is one which also demands further attention.

2.1.6. Lack of attention given to fixing fundamental systemic problems in the health care system

The Green Paper outlines what may ultimately be a case for uprooting of the current institutional framework of the South African health system and replacing it with one informed by a unique form of National Health Insurance. This bold move, however, would attempt to by-pass the task of addressing one by one the deep structural and systemic problems plaguing the health sector currently. Without significant action geared towards fixing such problems, no broad overarching institutional or policy framework will ever be successful. Outlined in the Consolidated Report of the Integrated Support Team (2009) some of the major problems identified include:

- *Poor financial management*: There is a huge amount of overspending in the sector which has resulted in a "significant deficit which needs to be settled in order to allow space to improve overall health system performance and effectiveness of service delivery."
- *Lack of leadership*: The Department of Health is seen to have provided, "insufficient leadership and stewardship to solve the fundamental problem of ensuring that the health resources available are sufficient for the levels of service and targets envisaged by a range of national policies."
- *Human resources*: It was found that there exists no "alignment of affordable human resources planning and budgeting, to fulfil the public health sector's strategic plans."

[3] Matshidze, P. and Hanmer, L. 2007. Chapter 6: Health Information Systems in the Private Sector. In South African Health review 2007. Harrison S, Bhana R, Ntuli A (eds.). Health System Trust, pp.90.

- *Governance and accountability*: "There is a lack of managerial accountability for the attainment of service related targets" and "inadequate linkages, coordination and integration among clusters within national health and sometimes between directorates within the same cluster."[4]

These observations are reflected in the Foundation's Situation Analysis.

2.1.7. Lack of detail for public-private-partnerships and the role of private sector

While the Green Paper recognises the expertise is the private sector and the shortages of human resources in the public sector, there is a lack of actual strategy as to how both sectors might complement one another in the provision of health care. Particularly concerning is that there is no mention of public-private-partnerships even though the Minister of Finance, in his 2010 Budget Speech, explicitly stated that "we will continue to broaden the use of public private partnerships in the health sector, in particular to improve our hospital system"[5].

2.1.8. Absence of conceptualisation on human rights and the right to health care in light of South Africa's progressive Constitution

The Green Paper clearly states that NHI will be guided by the right to access health care. However, very little is said to explain how the policy proposals outlined in the Green Paper will positively assist the state in the progressive realisation of the right of access to health care.

3. A way forward

3.1. The Green Paper proposals do not appear to lay a sufficient foundation for the drafting or release of a White Paper on a NHI for South Africa. While the Foundation is adamant in our desire for greater implementation of policy and action in the health sector in order to break from the historic lack of policy implementation, it is important that the present juncture is seen as an opportunity to further open up the debate over what action to take in reforming the health care sector.

3.2. The Foundation is of the view that two processes need to be undertaken in parallel to revitalise South Africa's health care system:

[4] Consolidated Report of the Integrated Task Team. 2009. Review of health overspending and macro-assessment of the public health system in South Africa, p. 9-14. Available online at: http://www.section27.org.za/wp-content/uploads/2010/06/Consolidated-IST-Report1.pdf.

[5] Budget Speech 2010. Minister of Finance, Pravin Gordhan. 17 February 2010. Available online at: http://www.environment.gov.za/greeneconomy_summit/docs/Budget_speech2010.pdf.

- An immediate short-term response focusing on improving public sector health provision
- A long-term solution aimed at improving the institutional arrangements and financing provisions for the entire health care system

3.3. Such an approach is endorsed by the WHO, which strongly advocates the need for short-term responses in order to achieve the longer-term goal of universal coverage[6]. Firstly, in the short- to medium- term, attention needs to be devoted to dealing with the systemic challenges facing the public health sector. The Foundation recognises that the private health sector is not without its problems, yet improving the provision of care for those who rely solely on the public health care system is imperative and can be a "do or die" situation.

3.4. Secondly, a longer-term project needs to be devised whereby the institutional aspects of the health system are looked at. This would involve devising strategies for dealing with the issues facing both the public and private health sectors individually, and in terms of their relationship to the health system as the overarching institution for health care in South Africa.

3.5. Additionally, the National Health Information System needs to be re-implemented with an eye to refining policy and developing the institutional and human resource capacity in order for public-private-partnerships to be established. Imperative in this process would be greater consultation with a multitude of stakeholders, most importantly health care professionals.

3.6. In conclusion, it is ultimately about working with what we have at present and taking small steps and calculated risks on what is a long, challenging journey. As we are only at the beginning of this journey towards reforming the health system, it is critical that stakeholder engagement, communication, and active dialogue and debate are encouraged. Taking the NHI, as outlined in the Green Paper, as the "X that marks the spot" and believing that all we need to do now is start implementing, would be a compromising move.

3.7. It is encouraging to note the views expressed in the National Planning Commission's recent National Development Plan regarding the national health system and its recommendations for promoting health and preventing and managing problems. Chapter 10 of the Plan entitled 'Promoting Health', essentially proposes a framework divided into three distinct categories from which the problems in the health system should be understood and addressed. These include the demographics of health, the environmental and social

[6] Carrin, G., Mathauer, I., Xu, K. and Evans, D. 2008. Universal Coverage: Tailoring its Implementation. Bulletin of the World Health Organisation. Available online at: http://www.who.int/bulletin/volumes/86/11/07-049387/en/index.html.

determinants of health and the health system as an institution. Crucially, the Plan expresses "greater inter-sectoral and inter-ministerial collaboration"[7] as being central to the proposals put forward.

3.8. The National Development Plan, along with the multiple views and debates that have taken place since the release of the Green Paper, regarding reform of the national health system, are what the Foundation believes should form the cornerstone for taking the process forward. Indeed, South Africa is only at the beginning of what must be viewed as a process of health reform, whereby the willingness of numerous parties to publically engage in the debate should be seen as healthy and helpful. As noted by Mr. Kwesi Eghan at the National Health Insurance Conference earlier this year: while competing political and policy goals are undesirable during the implementation of any health reform programme, debate and disagreement is not to be discouraged when attempting to design what might be the most appropriate intervention. South Africa's policy makers need to be open to alternative strategies.

[7] National Development Plan: Vision for 2030. Chapter 10: Promoting Health. National Planning Commission, p.322.

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