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Access, equality and health

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National Health Insurance Bill

The current process to construct a national health insurance scheme for South Africa is currently underway. The first phase, of what will most certainly be a multi-phased process, has now been completed with the submission by the public of comments on the National Health Insurance Bill [B-2018] ("the NHI Bill") and its so-called twin, the Medical Schemes Amendment Bill [B-2018].

We are in an important phase of the overall construction of the National Health Insurance Scheme (*"the Scheme"*) as we now await a reaction from the Department of Health (*"the Department"*) to the public comments submitted on the twinned Bills. The current next step in the process is important in so far as the Department will be required to clarify certain important aspects of the proposed Scheme as set out in the Bills. These aspects include the universal health services, referred to in the NHI Bill, that are to be provided in terms of the Scheme as well as the basis for the mandatory prepayment system that is to fund the Scheme in its entirety.

Of the two critical outstanding issues, the most important, for purposes of the current debate concerning access to healthcare services, will be the services that are to be covered by the Scheme. Whilst much has been made of the need for universal health coverage in South Africa, the precise scope and ambit of such coverage is largely a matter steeped in debate as opposed to black letter law.

In terms of the NHI Bill, universal health coverage is not precisely what the NHI Bill envisages. The NHI Bill envisages rather universal health services. A somewhat different term and promise to that of universal health coverage. Therefore, whilst the NHI Bill refers to *"universal health coverage"* what the proposed definition means is *"a service that is available to all persons … regardless of socio-economic or health status of those persons"* (emphasis added).

The matter of health coverage is one that goes to the centre of the current healthcare debate and one that underscores the apparent need for a national health insurance scheme in South Africa. The issue is access to health services. The current debate has centred on the lack of access to health services by the vast majority of South Africans due to apparent disparities between the delivery of healthcare services as between the public and private health sectors in South Africa. In addition, the constitutional emphasis on healthcare is also one of access. Section 27 of the Bill of Rights refers expressly to access to healthcare services and the courts have opined on the view that the realisation of the right to access healthcare services is one that is to be progressively realised by the State. Therefore, the emphasis, for purposes of a South African national health insurance scheme, must legally fall on the issue of access:

> *"The concept of universality gives the idea of a social service available to all, but not in the sense that television sets or bottles of beer are available to all. It also implies some notion of ease of access and in some, perhaps most instances, equality or equity of access. Often it seems to be argued that providing services at reduced fees or free (zero-priced) at the point of consumption will provide ease of access or even equality of access. Yet there are clearly other potential barriers which can be present and which can vary across different groups in the community: distance, culture and socio-economic status of the potential users. Distance is an obvious barrier and cultural barriers, for example for indigenous people, can be problematical. Socio economic status can still be an influence even if fees are zero, as poor people are more likely to feel alienated by what are often middle-class staff in these services." (See G Mooney The Health of Nations (2012) at page 21)*

Measuring how one achieves access to health services is a very different exercise to deciding what services are to be accessed. Certainly, one is able to claim that a system would achieve universal health coverage where certain services are available to every member of the population. However, a system that provides access to all health services would arguably be an unwieldly system both in respect of its administration and its funding. If one accepts that there are obvious capacity constraints in the current system to provide universal health coverage for all health services, then one must accept that any particular scheme in South Africa must be restricted to a particular basket of services. In so far as one accepts that position, then the debate about healthcare in South Africa, the manner it is accessed and its effectiveness in respective outcomes changes.

The current debate is premised on the disparities in the money spent on healthcare between the public and private sectors or about access to all healthcare services and the provision of all healthcare services to all persons but that cannot be the parameters of the debate in respect of the construction of the national health insurance scheme. Such a debate must necessarily focus on how certain services are provided and accessed and whether or not the provision of those particular services is efficient and the outcomes, in respect of those services, are positive in so far as improving the health of the population is concerned.

The emphasis, for purposes of constructing a national health insurance scheme in South Africa, must therefore lie on the identification of the particular health services to be provided under the Scheme. The selection of the services will have to then be tested against section 27 of the Bill of Rights in order to understand whether or not, constitutionally, the State will have fulfilled its constitutional mandate to realise progressively the access prerogatives of the Constitution. The NHI Bill, in its preamble, describes its purposes to:

- *"achieve the progressive realisation of the right of access to good quality personal health care services by South African citizens and permanent residents;*
- *ensure financial protection from the costs of health care and provide access to health care services by consolidating public revenue in order to actively and strategically purchase health care services based on the principles of universality and social solidarity;*
- *create a single framework throughout the Republic for the public funding and public purchasing of health care services, medicines, health goods and health related products, and to eliminate as far as is reasonably possible the fragmentation of health care funding in South Africa;*
- *promote sustainable, equitable, appropriate, efficient and effective public funding for the purchasing of health care services and the procurement of medicines, health goods and health related products from service providers within the context of the national health system; and*
- *ensure continuity and portability of financing and services throughout the Republic".*

The objectives of the NHI Bill, as currently framed, are, indeed, laudable. However, the question is whether or not the objectives will achieve both a practical healthcare effect and be constitutionally acceptable in light of the Bill of Rights.

The objectives of the NHI Bill are broadly stated and in line with the promises concerning universal health coverage. Such promises create the expectation that consumers will be entitled to achieve access to all needed health services at all levels of the provision of such services – primary, secondary, tertiary and quaternary – and that payment for those services will be effected by means of a single amount paid, presumably, monthly by members of the Scheme. Taking into account what is stated above, in respect of the ability of the State to provide such a vast Scheme, such expectations may be misplaced.

The NHI Bill proceeds on the assumption that the public and private sectors are providing the same product to consumers of healthcare. This does not appear to be the case if one examines the particular product offering supplied in the public sector to that supplied in the private sector. Therefore, consolidating health services as contemplated in the NHI Bill on the basis that such services will be provided exclusively in terms of the Scheme and by no other person including medical schemes or private health insurance products, then one must already anticipate a change in the scope and ambit of the product to be delivered and the process for its delivery.

Currently, members of medical schemes purchase a particular healthcare service delivery product and, to a large degree, the promise of access to acceptable and efficient health care services as per the definition of "business of a medical scheme" in section 1(1) of the Medical Schemes Act No. 131 of 1998, as amended (*"the MSA"*). The construction of that product is based on a willing seller willing buyer model in terms of which consumers are able to select the delivery method of health services and the amount that he or she is prepared to pay for access to that product.

Consumers are provided with a degree of choice in respect of accessing certain providers of health care services both at a primary and specialist level subject to the prescripts of the MSA, in respect of prescribed minimum benefits and designated service providers. The central feature of the private medical scheme, for the consumer, is arguably the ability to access immediately healthcare services as and when they

are needed, at a level that is appropriate for the healthcare needed and to provide for a particular positive outcome. In the public sector, however, the model is different in so far as consumers do not make payment of a premium or contribution but rather through taxes levied by the State and allocated, in accordance with budgetary requirements, by National Treasury. The product that is promised by the State is determined largely by the ability of the State to manage and maintain healthcare facilities and allocate appropriate human resources and expertise. The public health product carries with it no expectation of immediate access to health services or access to health services at all in so far as delays are experienced in the delivery of health services or expertise is simply absent to provide such health services, for example the current crisis in KwaZulu Natal in respect of the delivery of oncology services:

> *"In 2010, the US took an additional giant step towards a bureaucratized healthcare system, with even more power and control centralized at the federal level, with the passage of the Patient Protection and Affordable Care Act (ACA). This legislation is the only major social legislation (that is, social security, civil rights, and welfare reform) passed with a totally partisan vote. Seemingly, those who voted to pass the bill did not read it; and those who read it voted against it. Additionally, there were minimal congressional hearings on the bill and no pilot projects to test the key features of the law.*
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> *The American public has been continuously negative regarding the 2700–page law before, during, and after its passage. Moreover, thousands of pages of regulations to provide specific guidance for provider implementation were still being written as this book went to press in 2015. One major reason for the negative response of the American public is because the ACA was 90 percent health insurance expansion and only 10 percent healthcare system reform. A more appropriate and transparent title for the legislation would have been "The Health Insurance Expansion and Income Redistribution Act." (See M D Fottler, D Malvey & D J Slovensky (eds) Handbook of Healthcare Management (2017) at page 484)*

Bearing in mind the differences in the private sector health product and the public sector health product, and accepting the promises made in the NHI Bill, the question must be can the public sector deliver the product that is contemplated under the NHI Bill in so far as it is premised on the ability of the national health insurance scheme to deliver that particular product in much the same way as the current private healthcare sector delivers such a product: payment for immediate access to appropriate and needed healthcare services? Based on current capacity constraints within the public sector, the answer must be no. However, the solution may be to reduce the services available in terms of the Scheme and concentrate on providing better quality services albeit on a reduced service-delivery basis. However, the difficulty then is how one reconciles a reduced basket of healthcare services, in terms of the Scheme, with the provisions of section 27 of the Bill of Rights in respect of access to health services.

Fundamentally, incorporating the private sector into the Scheme and forcing it to deliver on a constitutional mandate otherwise to be discharged by the State, may not be the most appropriate solution to the delivery of health services in South Africa. In so far as the public healthcare sector is unable to supply health services in terms of the proposed Scheme, in so far as public health establishments fail to meet the criteria determined by, for example, the Office of Health Standards Compliance, then the burden will simply fall on the private health sector to provide the services promised in terms of the Scheme until such time as public sector facilities are able to achieve accreditation and certification, as contemplated in the NHI Bill, to provide such services. Simply shifting the burden in respect of the delivery of health services from a largely failing public health sector to the private sector is constitutionally unacceptable. It also, as a proposal, does not necessarily solve health care problems in South Africa both in respect of delivery or outcome as was stated in paragraph 83 of the decision of the Constitutional Court in *Government of the Republic of South Africa v Grootboom and Others* 2001 (1) SA 46 (CC), in the context of the right to housing:

> *"But section 26 is not the only provision relevant to a decision as to whether State action at any particular level of government is reasonable and consistent with the Constitution. The proposition that rights are interrelated and are all equally important is not merely a theoretical postulate. The concept has immense human and practical significance in a society founded on human dignity, equality and freedom. It is fundamental to an evaluation of the reasonableness of State action that account be taken of the inherent dignity of human beings. The Constitution will be worth infinitely less than its paper if the reasonableness of State action concerned with housing is determined without regard to the fundamental constitutional value of human dignity. Section 26, read in the context of the Bill of Rights as a whole, must mean that the respondents have a right to reasonable action by the State in all circumstances and with particular regard to human dignity. In short, I emphasise that human beings are required to be treated as human beings. This is the backdrop against which the conduct of the respondents towards the appellants must be seen."*

The question remains whether or not a national health insurance scheme, as contemplated in the NHI Bill and as complemented by the Medical Schemes Amendment Bill, is indeed the appropriate solution for healthcare delivery in South Africa.

The overall design and implementation of any national health insurance scheme in South Africa must be dictated by the Constitution as the supreme law of the Republic. One is not simply able to reorganise the entire healthcare sector, both public and private, without due regard to the rights contained in the Bill of Rights both in respect of the stakeholders in the health sector as well as patients and consumers. The problem statements merely boil down to too much is spent on too few in respect of healthcare but the solution is not too little to be provided to too many as that solution does not address the effective delivery of health services to the population and permanent residents or satisfies the objectives currently stated in the NHI Bill or the Constitution.

The emphasis in this debate cannot be on money. Money may be a factor or an influence in respect of reflection on the manner in which a healthcare delivery system operates. The emphasis must be on the effectiveness and efficiencies of a health system in respect of its outcome for the population that it serves. Such an emphasis is consistent with the Constitution in so far as access is concerned as well as the services promised. The construction of an unduly overarching national fund and its intended bureaucracy on the basis that it will deliver a restricted basket of health services seems to be unduly onerous on the fiscus and the health sector as a whole especially when an obvious reasonable alternative would be to address delivery inefficiencies and failures in the public sector first and determine, once such inefficiencies and failures have been remedied, whether or not the State's constitutional duties can be fulfilled. In that regard, there is potentially a more progressive and productive role for the private healthcare sector to play in the construction and implementation of public private partnerships in order to assist the State in the realisation of its constitutional mandate. One would have thought that such a process would have preceded the introduction of the currently proposed Scheme and Fund. The debate, in this instance should perhaps be focusing not on managing the system but on achieving appropriate and positive health outcomes, not necessarily in respect of scale, such as a large overarching State run fund, but on appropriate healthcare delivery models tailored to specific populations with identified healthcare needs, and which is more reflective of the prerogatives of section 27 of the Bill of Rights.



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