**UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG**
**SCHOOL OF LAW**

# REALISING THE RIGHT TO HEALTHCARE: THE LEGISLATIVE FRAMEWORKS PERTAINING TO PRIVATE HEALTH ESTABLISHMENTS AND PRIVATE HEALTHCARE FUNDING MODELS IN SOUTH AFRICA

**Submitted in fulfilment of the requirements of the degree of Master of Laws (LLM) (Dissertation) in the Faculty of Commerce, Law and Management at the University of the Witwatersrand, Johannesburg.**

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**Date: 28 February 2024**

**DECLARATION**

I, Lindsie Labuschagne-Kom**,** declare that this Dissertation is my own, unaided work. It is submitted in fulfilment of the requirements of the degree of Master of Laws (LLM) (Dissertation) in the Faculty of Commerce, Law and Management at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in this or any other university. This dissertation represents the state of the law as at 29 February 2024.

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## ABSTRACT

The Universal Declaration of Human Rights recognises access to healthcare as a fundamental human right and is guaranteed by the South African Constitution. An analysis of this right reveals that it comprises of two main components, namely financing and delivery of healthcare services. These are fulfilled by the government in the public sector and by private healthcare funders and private health establishments in the private sector. However, an analysis reveals that access to healthcare is substantively inequitable due to the fragmentation of the health system and unveils significant inefficiencies in the private sector that impeded realisation of this right. This dissertation examines the cause of this fragmentation and the inefficiencies within the private healthcare funders and private health establishments market. It investigates how these issues can be resolved to realise the right to healthcare. This study applied a qualitative desktop review of governmental policies, direct and incidental legislation, and multidisciplinary fields of academic reviews such as competition, healthcare, constitutional law and international policies to evaluate the effect of historical, contemporary and prospective policies and legislation, on access to healthcare. This analysis reveals that access to healthcare was historically manipulated to achieve political ideology through a legislative framework that provided the foundation for private funding models and private health establishments to flourish. This occurred at the expense of the public sector and embedded the fragmentation and inefficiencies in the health system. Notwithstanding the enactment of the Constitution, which envisioned a transformed and equal society, access to healthcare remains substantively inequitable. This is due to governmental failings to regulate these stakeholders. Given this state of affairs, the government intends to enact legislative reform through the National Health Insurance Bill to meet its constitutional mandate to realise the right to healthcare. An analysis of the Bill's framework, however, reveals that it will have a cascading effect with the collapse of the private healthcare funders and private health establishment markets. This will ultimately cause a regression in access to healthcare and impede the practical realisation of this right. An investigation into alternative mechanisms to fulfil the right to healthcare reveals that incorporation and collaboration with private healthcare funders and private health establishments is a pragmatic alternative to the National Health Insurance Bill that will aid with the practical realisation and vindication of this right. These findings indicate the need for government to improve its stewardship of the health system and provide pragmatic solutions to reform the legislative and regulatory frameworks governing these stakeholders to resolve inefficiencies and to foster collaboration to fulfil the right to healthcare.

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## LIST OF ACRONYMS

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|---|---|
| **ARMS** | **ALTERNATIVE REIMBURSEMENT MODELS** |
| **COHSASA** | **COUNCIL OF HEALTH SERVICE ACCREDITATION OF SOUTH AFRICA** |
| **CON** | **CERTIFICATE OF NEED** |
| **CMS** | **COUNCIL FOR MEDICAL SCHEMES** |
| **CUPH** | **CONTRACTING UNIT FOR PRIMARY HEALTHCARE** |
| **DHMO** | **DISTRICT HEALTH MANAGEMENT OFFICE** |
| **DSP** | **DESIGNATED SERVICE PROVIDER** |
| **FFS** | **FEE-FOR-SERVICE** |
| **HIM** | **HEALTH MARKET INQUIRY** |
| **LIF** | **LOW-INCOME FUND** |
| **LCMS** | **LOW COST MEDICAL SCHEME** |
| **MCO** | **MANAGE CARE ORGANISATION** |
| **MSA** | **MEDICAL SCHEMES ACT** |
| **MSP** | **MEDICAL SERVICE PLAN** |
| **MTNF** | **MULTILATERAL TARIFF NEGOTIATING FORUM** |
| **NDOH** | **NATIONAL DEPARTMENT OF HEALTH** |
| **NHA** | **NATIONAL HEALTH ACT** |
| **NHIS** | **NATIONAL HEALTH INFORMATION SYSTEM** |
| **NHN** | **NATIONAL HOSPITAL NETWORK** |
| **NHSC** | **NATIONAL HEALTH SERVICES COMMISSION** |
| **NHPRL** | **NATIONAL HEALTH PRICE REFERENCE LIST** |
| **OHSC** | **OFFICE OF HEALTH STANDARDS COMPLIANCE** |
| **OMRO** | **OUTCOME MEASUREMENT AND REPORTING ORGANIZATION** |
| **OOPP** | **OUT-OF-POCKET PAYMENT** |
| **PDOH** | **PROVINCIAL DEPARTMENT OF HEALTH** |
| **PHC** | **PRIMARY HEALTHCARE** |
| **PHE** | **PRIVATE HEALTH ESTABLISHMENTS** |
| **PMB** | **PRESCRIBED MINIMUM BENEFITS** |
| **PPN** | **PREFERRED-PROVIDER-NETWORK** |
| **PPP** | **PUBLIC-PRIVATE PARTNERSHIPS** |
| **RAMS** | **REPRESENTATIVES ASSOCIATION OF MEDICAL SCHEMES** |
| **REF** | **RISK EQUALIZATION FUND** |

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|---|---|
| **RPL** | **REFERENCE PRICE LIST** |
| **SHI** | **SOCIAL HEALTH INSURANCE FUND** |
| **SARS** | **SOUTH AFRICAN REVENUE SERVICES** |
| **SASSA** | **SOUTH AFRICAN SOCIAL SECURITY AGENCY** |
| **SSHR** | **SUPPLY-SIDE HEALTH REGULATOR** |
| **UHC** | **UNIVERSAL HEALTHCARE** |
| **VBR** | **VALUE-BASED-REIMBURSEMENT** |
| **VHI** | **VOLUNTARY HEALTHCARE INSURANCE** |

# CHAPTER 1: RESEARCH PROBLEM AND BACKGROUND

## *1.1 INTRODUCTION*

The right of access to healthcare ('the right to healthcare') is a basic entitlement and human right that fosters equality and upholds human dignity.[1] In addition to complying with international normative standards, safeguarding the health of the population by providing healthcare services is indispensable for socio-economic development.[2] In the context of burgeoning wealth inequalities in South Africa,[3] progressively realising this right is invaluable to the country's development.

Notwithstanding the value of this right, access to healthcare was historically manipulated as a mechanism to further repugnant political ideologies that sought to segregate South Africa's population along racial lines.[4] This was achieved by reserving revenue to purchase quality healthcare in the private healthcare sector ('the private sector') for the white privileged elite. Simultaneously, policies sought to systematically dismantle the public healthcare sector ('the public sector'), being the sole source of healthcare services for the black population. The legislative framework that facilitated these objectives established the basis for the fragmentation that plagues South Africa's prevailing health system. Subsequent reform in the post-democratic era has done little to remedy the inequalities in access to healthcare or to unify the fragmented health system. Rather, the government's failure to effectively regulate the private sector has entrenched the 'bifurcation of the health system' and permitted the application of exclusionary policies to morph from race to affordability.[5] As the majority of South Africans are impoverished, access to quality healthcare remains substantively inequitable.[6]

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[1] The World Health Organization *Declaration of Alma-Ata* (1978); Article 25 of the United Nations Universal Declaration of Human Rights 1948; Article 12 of the International Covenant on Economic, Social, and Cultural Rights (1976).

[2] World Health Organisation 'Universal Health Coverage' available at *https://www.who.int/health-topics/universal-health-coverage#tab=tab_1 a*ccessed on 25 May 2019.

[3] Marlin Fortuin, Gerhard Grebe, & Patricia Makoni 'Wealth Inequalities in South Africa – The Role of Government Policy' (2022) 15 *Journal of Risk Financial Management* 243 at 243.

[4] Max Price 'Health Care as an Instrument of Apartheid Policy in South Africa' (1986) 1 *Health Policy and Planning* 158 at 158.

[5] Marius Pieterse *Can Rights Cure? The Impact of Human Rights Litigation on South Africa's Health System* (2014) 6; Paul Allen Wayburne '*Developing a Constitutional Law Paradigm for a National Health Insurance Scheme in South Africa*' (PhD thesis, University of the Witwatersrand, 2014) 9.

[6] Fortuin, Grebe & Makoni op cit note 3 at 243 and Aroop Chatterjee, Leo Czajka, Amory Gethin 'Wealth Inequality in South Africa, 1993-2017' (2021) 36 *The World Bank Economic Review* 19 at 20.

Accordingly, the government intends to unify the health system by enacting legislative reform to meet its constitutional obligation to realise the right to healthcare. The projected consequence of this reform, however, jeopardises the stability of the health system and will likely cause a regression in access to healthcare. Thus, the question of how to sustainably unify the health system, with the objective of increasing access to quality healthcare services, remains unanswered.

This dissertation will seeks to answer this question by considering how the right to healthcare can be realised through an analysing of the legislative framework governing private healthcare funding models and private health establishments, that function to finance and provide healthcare, and determining how they evolved in the pre- and post-democratic era and will consider what further transformation is needed to aid with the progressive realisation of the constitutionally enshrined right to healthcare

### *1.2 BACKGROUND*

Access to healthcare is a fundamental right that is enshrined in the Constitution.[7] Meaningful realisation of this right is essential for socio-economic development and the broader stability of South Africa's democratic order.[8] Government is compelled to take 'reasonable legislative and other measures' to progressively realise this right.[9] Government currently attempts to facilitate access to healthcare by providing services in the public sector and by regulating the private sector.[10] Consequently, provision for healthcare in the private sector occurs within the framework of the government's constitutional obligations.[11]

The private sector is comprised of different stakeholders that operate within diverse fields. In general, this sector comprises of private healthcare funders ('private funders'), which

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[7] The Constitution of the Republic of South Africa, 1996 stipulates that:
- Section 27(1)'Everyone has the right to have access to –
  (*a*) health care services…'.
- Section 28(1) of the Constitution provides that 'Every child has the right –
  (*c*) to … basic healthcare services…'.
- Section 35(2)(*e*) stipulates that every detained, including sentenced prisoners have the right to medical treatment.

[8] Sandra Liebenberg 'South Africa's Evolving Jurisprudence on Socio-Economic Rights: An Effective Tool in Challenging Poverty?' (2002) 6 *Law, Democracy & Development* 159 at 163-165; Marius Pieterse 'Legislative and Executive Translation of the Right to Have Access to Health Care Services' (2010) 14 *Law, Development and Democracy* 1 at 1.

[9] Section 27(2) of the Constitution.

[10] Competition Commission Health Market Inquiry *Provisional Findings and Recommendations Report* (5 July 2018) 24.

[11] Competition Act regulations in GN 116 *GG* 37062 of 29 November 2013 80.

includes medical schemes, medical scheme administration companies, and managed care organisations as well as healthcare service providers, such as doctors, nurses, and private health establishments ('PHEs').[12] The private sector has historically been financed by medical schemes.[13] The healthcare financing function provided by medical schemes is central to protecting their members from the financial risks emanating from the costs of seeking healthcare services.[14] PHEs consist of acute and sub-acute hospitals, mental healthcare facilities, rehabilitation hospitals and unattached operating theatre units that provide 'treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, [and] convalescent' healthcare services.[15] These establishments are among the main cost drivers in the private sector.[16] Other healthcare providers are inextricably interlinked to PHEs, as doctors 'determine the demand for hospital services through admissions, treatment, and confinement choices', while nurses primarily render services within a hospital setting.[17] Both private funders and healthcare providers are subject to legislative frameworks that govern their operations.[18]

While the quality of healthcare in the private sector is comparable with some of the strongest health systems in the world, excessive prices prevent the majority of South Africans from accessing such services.[19] These financial barriers mirror historical racial inequalities that precluded black communities from accessing quality healthcare.[20] These exclusionary practices cannot be excused by the mere fact that government provides healthcare services in the public sector. This is because meaningful enjoyment of the right to healthcare requires that such services effectively treat illnesses.[21] The public sector fails to meet this basic threshold as it faces a crisis in the quality of the healthcare services it renders.[22]

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[12] Competition Commission *Review of Competition in the South African Health System* (19 June 2012) 99-100.
[13] Wayburne op cit note 5 at 5.
[14] Institute of Development Studies Working Paper 232 *Social Protection for Transformation* (October 2004) 23; World Health Organization *Health Systems Financing: the Path to Universal Coverage* (2010) x.
[15] See the definition of a 'health establishment' at section 1 of the National Health Act 61 of 2003.
[16] Competition Commission op cit note 10 at 223.
[17] Ibid 61.
[18] Such as the Medical Schemes Act 131 of 1998; the National Health Act op cit note 15.
[19] Melody Brauns *Public Healthcare in a Post-Apartheid South Africa: a Critical Analysis of Governance Practices* (unpublished PhD thesis, University of Kwazulu-Natal, 2016) 73 and 159; Centre for Development and Enterprise *Reforming healthcare in South Africa. What Role for the Private Sector?* at 26 (2011) available at *https://www.cde.org.za/reforming-healthcare-in-south-africawhat-role-for-the-private-sector/*, accessed on 14 February 2019.
[20] Department of Health *Inquiry into the Various Social Security Aspects of the South African Health System: Policy Options for Future Coverage* (May 2002) 10; United Nations Research Institute for Social Development *Health Care Inequality in South Africa and the Public/Private Mix* (2003) 8.
[21] World Health Organization and the World Bank *Tracking Universal Health Coverage* (2017) 4.
[22] M Chopra, J Lawn & David Sanders et al 'Achieving the Health Millennium Goals for South Africa' (2009) 374 *The Lancet* 1023 at 1023.

Investigating the formative roots of private funders and PHEs is necessary to understand the disparities in the quality of healthcare in the public and private sectors. The only way to comprehend the sordid history of the health system and, consequently, recognise the scope and necessity of reform, is to delve into the past. Such an analysis will identify how private funders and PHEs were not only complicit in historical policies that sought to segregate the population along racial lines but also profiteered and thrived from them.[23] This analysis considers how access to healthcare, through codified legislative frameworks that regulated private funders and PHEs, were manipulated to assist with subjugating South Africa's black population and uphold white supremacy.[24] Further, consideration of the consequences of these policies will unveil the root cause of the fragmentation that plagues the existing health system which is divided between a well-resourced private sector and a public sector that has a paucity of basic supplies.

A critical review of the legislative framework that governs private funders and PHEs, in the post-democratic era, is indispensable to determine the cause of the disproportionally high prices that bedevils the private sector. Such an evaluation shall identify how the private sector continues to be inequitable in an era of constitutional supremacy that should guarantee substantive equality.[25] This will reveal the extent of government's delinquent regulation of the health system includes a failure to adopt the necessary legislative reforms to meet its constitutional mandate to fulfil the right to healthcare. The consequences of these omissions, which have entrenched the fragmentation of the health system and perpetuated the discrimination of the socio-economically disadvantaged, can only be understood through the analysis of the prevailing legislative framework.[26]

The immanent enactment of the National Health Insurance Bill ('the Bill') will then be considered.[27] The Bill embodies government's attempt to resolve its failure to meet its constitutional mandate to realise access to healthcare in the post-democratic era. The Bill intends to unify the private and public sector by consolidating healthcare financing under the administration of a single Fund that will be managed by the government.[28] This Fund will be responsible for purchasing healthcare services from providers for the benefit of particular

[23] The Truth and Reconciliation Commission of South Africa Report Volume 4 (1998) 24-27 and 155-157; Steven Ratner 'Corporations And Human Rights: A Theory of Legal Responsibility' (2001) 111 *The Yale Law Journal* 443 at 503.
[24] Price op cit note 4 at 158.
[25] Cathi Albertyn & Beth Goldblatt 'Facing Challenges of Transformation: Difficulties in the Development of an Indigenous Jurisprudence of Equality' (1998) 14 *SAJHR* 248 at 248.
[26] Pieterse op cit note 5 at 18, 50 and 56.
[27] National Health Insurance Bill [B11B-2019].
[28] Clause 10(1)(*b*) Ibid.

recipients.[29] Government is counting on the Bill to give this Fund enough market power to regulate the cost of private healthcare.[30] This policy, however, merely represents an contentious effort by the government to fulfil its constitutional mandate. In its present form, the Bill could be accused of being a covert attempt to seize control of the private sector rather than facilitate the appropriate reform to achieve the transformation envisioned by the Constitution. Instead, the manner in which the Bill intends to consolidate healthcare financing, and its proposed purchasing strategy, will destabilise the entire health system. This will cause a regression in access to healthcare that will both unjustifiably infringe upon existing entitlements to healthcare in the private sector and fall short of government's duty to progressively realise this constitutional right. Consequently, implementation of the Bill's draconian provisions is untenable and is unlikely to withstand constitutional scrutiny and review. The exact nature of the infringement and regression shall be canvassed in this dissertation.

Notwithstanding the Bill's misgivings, its core tenets accord with a growing international trend that recognises that access to healthcare is a fundamental human right.[31] Globally, heterogeneous methods have been implemented to fulfil this right.[32] Nevertheless, all precepts adhere to the basic prescripts of Universal Healthcare ('UHC').[33] UHC's principal doctrine aims to provide financial protection to individuals when accessing quality healthcare services, irrespective of their socio-economic status.[34] The appropriate method to achieve UHC is guided by assessing a country's health system's strengths and weaknesses. In this regard, South Africa's UHC programme should aspire to unify the health system through reform to the legislative framework.[35] This framework should aim to effectively regulate key stakeholders to leverage the strengths of the private sector to achieve equitable access to healthcare.[36] The

[29] Clause 10(1)(*c*) Ibid.
[30] Department of Planning, Monitoring and Evaluation *Socio-Economic Impact Assessment* (July 2017) 22-23.
[31] The international interpretation of the right to healthcare will inevitably influence South African courts, both in respect of Section 39 of the Constitution and the International Covenant on Economic, Social and Cultural Rights, which the South African government ratified. Sandra Liebenberg 'The International Covenant on Economic, Social and Cultural Rights and its Implications for South Africa' (1995) 11 *SAJHR* 359 at 359; Article 25 of the United Nations Universal Declaration of Human Rights 1948; Article 12 of the International Covenant on Economic, Social, and Cultural Rights (1976).
[32] Department of Health op cit note 20 at 4.
[33] Office of the United Nations High Commissioner for Human Rights and the World Health Organization *The Right to Health* (2008) 7.
[34] World Health Organization op cit note 14 at 9-11; the World Health Organisation 'Universal Health Coverage and Health Financing', available at *https://www.who.int/health_financing/universal_coverage_definition/en/*, accessed on 30 May 2019.
[35] Department of Health op cit note 20 at 4.
[36] Department of Health op cit note 20 at 4; Andy Gray & Yousuf Vawda 'Health Policy and Legislation' (2016) *South Africa Health Review in Health Systems Trust* 3 at 4.

core aim of this dissertation is to determine what reforms are necessary to utilise private funders and PHEs to progressively realise the right to healthcare.

### *1.3 RESEARCH QUESTIONS*

Given the fact that the right to healthcare is constitutionally enshrined and considering government's mandate 'to take reasonable and other measures… to achieve the progressive realisation' of this right, the following research questions are raised:

1. How did historical policies, including those fostered during apartheid, influence the formation and evolution of the legislative frameworks governing private funders and PHEs?

2.

    2.1. Do the existing legislative frameworks governing private funders and PHEs sufficiently take the health system's past into account?

    2.2. How has the private sector reformed in the post-democratic era and have these reforms addressed the inherited inequities and disparities in access to healthcare?

3. What effect will the proposed reform under the National Health Insurance Bill have on private funders, PHEs, and the health system in general? Concomitantly, what reforms are necessary to decrease prices in the private sector and realise access to quality healthcare?

### *1.4 RESEARCH OBJECTIVES*

The research seeks to determine the overall impact of the legislative framework governing private funders and PHEs in the context of the right to healthcare in South Africa. To assess the need for reform, an analysis is conducted into the historic and prevailing contextual factors that influence access to healthcare. This is done first, through an analysis of the historic development of these stakeholders to determine the extent of unfair discriminatory practices.

Secondly, the research aims to consider how the prevailing legislative frameworks impede the realisation of the right to healthcare in the context of regulatory failures. Thirdly, the effects of the National Health Insurance Bill, including its impact on private funders and PHEs, is considered to determine whether it will aid or impede the practical realisation of this right. This analysis provides a basis to consider what legislative amendments are needed to fulfil this constitutional right. It specifically considers how UHC has been accomplished globally and applies key insights gleamed during this review to proffer recommendations to transform and integrate the health system to meet the imperative set forth in section 27(2) of the Constitution.

### *1.5 RELEVANCE OF THE RESEARCH*

The dissertation seeks to contribute to the field of research on the right to healthcare in South Africa and the prospective implications of the National Health Insurance Bill. It provides a pragmatic focus on how private funders and PHEs can be leveraged to aid with the progressive realisation of the right to healthcare in terms of section 27(2) of the Constitution.

This research intends to enhance to the existing body of knowledge regarding historical inequalities in access to healthcare. It specifically considers how private funders and PHEs ('stakeholders') were complicit in political ideology and policies that upheld segregation in South Africa. It builds on existing research that considers government's failure to transform and unify the health system. It further seeks to advance the literature on the prospective impact and repercussions of the National Health Insurance Bill. Finally, the dissertation seeks to develop studies into sustainable and practical solutions for reform to the legislative frameworks governing these stakeholders as a means to leverage their resources and expertise to realise the right to healthcare.

### *1.6 METHODOLOGY*

This dissertation shall apply a desk-top based review of governmental policies as well as direct and incidental legislation that regulates private funders and PHEs. The research methodology shall extend to consider different fields of discipline such as competition, healthcare, and policy. Such a review shall employ the use of doctrinal research to investigate how political

ideology influenced policies and legislation governing these stakeholders and how these evolved in South Africa's constitutional dispensation.[37] McConville and Chui explain that

> '[d]octorical or theoretical legal research can be defined in simple terms as research which asks what the law is in a particular area. The research seeks to collect and then analyse the body of case law, together with any relevant primary legislation (so-called primary sources). This is done from a historical perspective and may also include secondary sources such as journal articles or other written commentaries on the case law and legislation.'[38]

Accordingly, the theoretical research will provide a basis to consider whether legislative frameworks have evolved to address historical inequities or have merely perpetuated the exclusion of sections of the population. This analysis is conducted through the lens of socio-economic rights that are enshrined in the Constitution. It will lay a foundation to consider what legislative reforms can be implemented to achieve substantive equality. The review shall then migrate to a comparative research methodology to consider the feasibility of pending legislative amendments in the context of international healthcare policies. Finally, the empirical study will conclude by reviewing different mechanisms employed internationally to improve access to healthcare to develop South Africa's legislative frameworks for the purpose of unifying the health system and progressively realising access to healthcare.

This methodology accords with the interpretation and development of legislation that considers that the law itself 'may be a contributor to or the cause of the social problem, and in the sense that while law may provide a solution or part of a solution, other non-law solutions, including political and social and political re-arrangements … may indeed be preferred'.[39] Accordingly, the review is premised on an investigation of 'social, political and economic implications of current and proposed legislation' that considers the 'law in context'.[40] This contextual interpretation is based on the progressive interpretation of the law that considers 'trans-jurisdictional instruments, such as Conventions relating to human rights [that] increasingly penetrate domestic legal systems'.[41]

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[37] M McConville & Francis Johns 'Qualitative Legal Research' in M McConville & WH Chui (eds) *Research Methods for Law* (2007) 19.
[38] Ibid 1.
[39] Ibid.
[40] Ibid.
[41] Ibid.

## *1.7 STUDY LIMITATIONS*

There are a multitude of stakeholders in the private sector that are subject to their own legislative and regulatory frameworks. Due to the diversity of the private sector, there will be restrictions that will be imposed on this study. Specifically, legislation governing doctors, nurses, pharmaceutical, and healthcare equipment will not be canvassed in this study. For the sake of clarity, this study will focus on the impact of private funders and PHEs legislative frameworks on the right to healthcare.

## *1.8 CHAPTER OVERVIEW AND STRUCTURE OF DISSERTATION*

In chapter two, the formative roots of policies and legislation that influenced the formation and evolution of private funders and PHEs are examined. The chapter reveals that access to healthcare was manipulated as a mechanism to uphold white supremacy and subjugate the black community. It unveils how private funders were complicit in upholding these abhorrent policies and how PHEs came into existence and profited from this framework.

Chapter three examines whether, and to what extent, access to healthcare has transformed in the democratic era of constitutional supremacy. It investigates the cause of the current pricing crisis in the private sector and determines how government's inadequate stewardship of private funders and PHEs has exacerbated the fragmentation of the health system. Finally, it considers whether government has facilitated or impeded access to quality healthcare services.

Chapter four considers the prospective reforms envisioned by the National Health Insurance Bill. It critically evaluates the Bill to determine whether it will achieve the constitutional imperative to progressively realise the right to healthcare. This chapter will also detail how the Bill will negatively impact private funders, PHEs, and the health system in general that will not only infringe on existing entitlements to healthcare services but also undermine the progressive realisation of this right.

Chapter five builds on the contextual analysis set forth in chapters two, three, and four by considering what mechanisms can be employed to unify the health system. It provides recommendations to amend the legislative frameworks that governs private funders and PHEs. It specifically identifies practical solutions to leverage the expertise of, and resources from,

these stakeholders to aid the government in its mission to meet its mandate to take progressive measures to fulfil the right to healthcare.

# CHAPTER 2: THE CREATION AND ESTABLISHMENT OF THE WESTERN HEALTH SYSTEM IN SOUTH AFRICA

If a health system reflects a country's values,[42] what can be said about the policies that ostracised and prevented sections of the population from accessing quality healthcare based on their racial identity? The only answer could only be an emphasis on the pervasiveness of inhumane treatment and subjugation of South Africa's black community. The exposé in this chapter will uncover how access to healthcare was manipulated to achieve abhorrent political objectives.[43] It will specifically canvas the way in which private funders and PHEs developed and benefited from a system that sought to entrench and perpetuate racial division and exclusion. This analysis will provide context to the constitutional right of access to healthcare ('right to healthcare').[44] Furthermore, it will identify the causes of systemic problems that plague the prevailing health system, such as fragmentation, high prices of healthcare, and the geographic maldistribution of healthcare providers. This is necessary as any future reform that intends to unify the health system 'will merely be temporary' if the causes of these systemic issues are not first determined.[45]

This chapter will be divided into three sections. The first section will investigate the formative roots of the western health system in South Africa during the period of 1652 to 1947. The second section will consider how healthcare policies were blatantly manipulated to uplift the white minority and subjugate the black majority from 1948 to 1960. The third and final section will consider the way access to healthcare was manipulated by the apartheid State ('the State') in an attempt to hold onto its last vestiges of power from 1970 to 1993. Each of these sections will canvass how various political policies impacted the formation and development of private funders and PHEs.

## 2.1. CREATING A WESTERN HEALTH SYSTEM – AN EXPLORATION OF THE FORMATION AND DEVELOPMENT OF PRIVATE HEALTHCARE FUNDING MODELS AND PRIVATE HEALTH ESTABLISHMENTS FROM 1652 TO 1947

[42] Shula Marks & Neil Andersson 'Issues in the Political Economy of Health in South Africa' (1987) 13 *Journal of Southern Africa Studies* 177 at 181-82.
[43] Max Price 'Explaining Trends in the Privatization of Health Services in South Africa' (1989) 4 *Health Policy and Planning* 121 at 122.
[44] Section 27(1)(a) and 28(1)(c) of the Constitution; Geoffrey Allsop 'Introduction to the Bill of Rights' in Ebrahim Abrahams (ed) *Constitutional Law for Students* (2020) 29 at 29.
[45] *#Unitebehind v the Minister of Transport* unreported case no 2058/2020 (25 August 2020) para 19.

Colonial rulers enforced a system that made individuals responsible for procuring healthcare services at their own cost. This manifested in the colonialist's failure to provide adequate healthcare services for its subjects. This was not happenstance as the authorities weaponised access to healthcare to conquer the black community. The consequent deplorable state of black communities' health has been described as tantamount to genocide.[46] This section will canvass how the colonial authority's refusal to provide healthcare services ravaged the black population's health, established the market for medical schemes, and how political policies served as a catalyst for the fragmentation of the health system.

### *2.1.1 The arrival and migration of white settlers*

When colonialists first arrived in South Africa in 1652, they sought to expand the protectorate's dominance by conquering the native black population through 'violent subjugation [and] appropriation of land and resources'.[47] Colonisers subsequently imported slaves from 'West Africa, Mozambique, Madagascar, India, and Indonesia' to work on farms that were established to exploit the land.[48] After slavery was abolished in 1833, indentured Indian and Chinese labourers were imported to work on these farms.[49]

By 1835, armed white settlers expanded their territorial claims as they migrated inland.[50] As the black population was forcibly dispossessed of their land, they were relocated to agricultural holdings in designated geographical areas ('reserves').[51] This disposition was formally regulated by the Glen Grey Act 25 of 1894 ('Grey Act'). The Grey Act aimed to destabilise black communities' subsistence farming by ensuring that the reserves were too

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[46] Peter Delobelle 'The Health System in South Africa. Historical Perspectives and Current Challenges' in C.C Wolhuter *South Africa in focus. Economic, Political and Social Issues* (2013) 159 at 177.

[47] Pierre H. Jaques & Sam G. Fehrsen 'A History of Health care in South Africa until 1997' (2007) 33 *Adler Museum Bulletin* 4 at 4; H.C Van Rensburg & David Harrison 'History of Health Policy' (1995) *South African Health Review: Health System Trust* 95 at 103; South African History online 'The Natives Land Act of 1913', available at *https://www.sahistory.org.za/article/natives-land-act-1913,* accessed on 5 July 2020.

[48] Hoosen Coovadia, Rachel Jewkes & Peter Barron et al 'The Health and Health Systems of South Africa: Historical Roots of Current Public Health Challenges' (2009) 374 *The Lancet* 817 at 818.

[49] Freed slaves, indentured labourers, and the native black population would form the foundation of black people as defined in the Employment Equity Act 55 of 1998. South African History Online 'History of Slavery and Early Colonization in South Africa', available at *https://www.sahistory.org.za/article/history-slavery-and-early-colonisation-south-africa,* accessed on 12 July 2020; Slavery Abolition Act of 1833 (3 & 4 Will. IV c. 73).

[50] Desmond Hobart Houghton *The Tomlinson Report, a Summary of the Findings and Recommendations in the Tomlinson Commission Report* (1956) 13.

[51] Ultimately, the black population was either 'reduced to being tenants on their own land' or waged migratory labourers. Van Rensburg & Harrison op cit note 47 at 107; South African History Online 'The Creation of Native Reserves and Migratory Labour System to South African mines', available at *https://www.sahistory.org.za/article/creation-native-reserves-and-migratory-labour-system-south-african-mines,* accessed on 24 May 2019.

small to produce sufficient food for their needs.[52] Concomitantly, the Grey Act imposed tax penalties on black males who failed to work outside of the reserves.[53] This ploy devastated the black community as it caused widespread poverty.[54] Consequently, black males were forced to seek work in white industries, that paid meagre wages, to either provide for their poverty-stricken families or to pay the required taxes.[55] Therefore, the Act was merely contrived to facilitate the supply of cheap migratory labour for white industries.

### *2.1.2 Foundation for medical schemes and hospitals*

Colonialists only financed the costs of healthcare in two instances. First was the cost of treatment to curb the spread of contagious diseases during pandemics.[56] Secondly, white British civil servants could access comprehensive healthcare at hospitals that were funded by colonisers.[57] The black population and all other white settlers were required to pay for healthcare services.[58] These restrictions cultivated a market for medical schemes to fund healthcare expenses.[59] Medical schemes negotiated healthcare benefits with doctors, who in exchange for monthly pre-payments, rendered healthcare services to the respective scheme's members.[60] Membership, however, was limited to the white elite who could afford to pay the monthly premiums to these medical schemes.[61]

Through the passage of time, healthcare providers that rendered westernised treatment expanded throughout the country. In metropolitan areas, mines and farms funded healthcare services either in response to obligations conferred by legislation or through privately initiated

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[52] Ibid.
[53] Ibid.
[54] Poverty causes and perpetuates ill-health due to over-crowding and poor nutrition. Paula Braveman & Sophia Gruskin 'Poverty, Equity, Human Rights and Health' (2003) 81 *Bulletin of the World Health Organisation* 539 at 539; Health Poverty Action 'The cycle of poverty and poor health' available at *https://www.healthpovertyaction.org/news-events/the-cycle-of-poverty-and-poor-health,/,* accessed on 12 July 2020.
[55] Houghton op cit note 50 at 13.
[56] K.N Ginwala *Health Legislation in South Africa* (unpublished master thesis, University of Kwa-Zulu Natal, 1981) 15; Public Health Act 4 of 1883; Contagious Disease Act 1 of 1856.
[57] The first hospital was established in 1652. A further two hospitals were established in 1755. Jaques & Fehrsen op cit note 47 at 4; Delobelle op cit note 46 at 16.
[58] Grietjie Verhoef 'From Friendly Society to Compulsory Medical Aid Association: The History of Medical Aid Provision in South Africa's Public Sector, 1905-1970' (2006) 30 *Social Science History* 601 at 603.
[59] Department of Health op cit note 20 at 8-10.
[60] This was a precursor capitation model of reimbursement which is utilised in the prevailing health system. Verhoef op cit note 58 at 601; Competition Commission op cit note 10 at 51.
[61] Verhoef op cit note 58 at 611.

systems.[62] Missionaries established clinics and hospitals in rural areas.[63] Simultaneously, a coterie of doctors, in conjunction with medical schemes, began to establish PHEs.[64] Mission hospitals and PHEs supplemented public hospitals which provided scant healthcare services.[65] As these providers operated without any regulatory control, their expansion was unsystematic and thus fragmented.[66]

### *2.1.3 Provision of healthcare in the Union of South Africa*

In 1910, colonialists formed the Union of South Africa ('the Union') and declared autarky from the protectorate.[67] Governance of the Union was conferred on four self-governing provincial authorities.[68] Pending the promulgation of the Public Health Act 36 of 1919 ('Health Act') healthcare provision continued to operate without any guiding framework.[69] The scope of the Health Act was, however, confined to the coordination of healthcare to control the spread of infectious diseases across the provinces.[70] The Health Act introduced a three-tiered system of governance that mirrors the administration of South Africa's prevailing public health system.[71] The Health Act's governance structure was divided between local and provincial authorities that were responsible to oversee and manage infectious diseases and hospital services while executive control of the health system was managed by the National Department of Health

[62] Rene le Roex 'The Development of Medical Tariffs in South Africa' (2004) 94 *South African Medical Journal* 261 at 261-262; Department of Health *Inquiry* op cit note 20 at 8-10.
[63] These hospitals were insufficient for the black populations needs. Delobelle op cit note 46 at 164; Nosipho Majeke *The Role of the Missionaries in Conquest* (1986) 201.
[64] The first private hospital was established in 1818. Further private hospitals were erected, in Port Elizabeth, Pietermaritzburg, and Bloemfontein in 1885, 1887, 1889 and 1909. Kwa-Zulu Natal Department of Health 'History of Grey's Hospital' available at *http://www.kznhealth.gov.za/Greys/history2.htm*, accessed on 23 April 2022; R.D.P De Villiers 'A History of Medical Services in the Orange Free State' (1944) XVIII *South African Medical Journal* 303 at 304, 306 and 308.
[65] Verhoef op cit note 58 at 604.
[66] Jaques & Fehrsen op cit note 47 at 4; Van Rensburg & Harrison note 47 at 95.
[67] Complete sovereignty was only declared when the Status of the Union Act 69 of 1934 was enacted. South Africa remained a member of the British Commonwealth until 1961.
[68] The Cape of Good Hope, Natal Colony, Transvaal Colony, and Orange River Colony. Delobelle op cit note 46 at 165; Jaques & Fehrsen op cit note 47 at 6
[69] Delobelle op cit note 46 at 165; Jaques & Fehrsen op cit note 47 at 6.
[70] Michelle Du Toit *An Evaluation of the National Health Insurance Scheme in Light of South Africa's Constitutional and International Law Obligations Imposed by the Right to Health* (unpublished LLM thesis, Stellenbosch University, 2017) 14.
[71] Marks & Andersson op cit note 42 at 181-82.

('NDoH').[72] The health system continued to operate without any regulatory control outside the scope of infectious diseases.[73]

By 1920 the health of the black community was deplorable as the majority of the population in the reserves were infected with preventable diseases such as tuberculosis.[74] These diseases were spread among black labourers who were forced to live in overcrowded and unsanitary slums while they worked for white industries.[75] Sick black labourers could not seek healthcare services where they were employed as the Union forcibly repatriated those who were too ill to work.[76] Despite a lack of resources and skills, these reserves' authorities were required to care for these labourers upon their deportation.[77] Several commissions of inquiries advocated for the Union to provide healthcare to these poverty-stricken black communities.[78] The Union initially disregarded these petitions, instead preferring to implement policies to uplift poor white communities to 're-establish a clear racial hierarchy'.[79] Ostensibly, the Union ultimately capitulated to increasing agitation for substantive healthcare reform by enacting the Public Health Amendment Act 57 of 1935, to make establish primary healthcare clinics in the reserves.[80] However, only three clinics were established as the deep-rooted policies that upheld racial segregation was more important than genuine healthcare reform.[81] Therefore access to healthcare in the black community was nothing more than a theoretical entitlement.

By 1940, the Union had failed to establish a coordinated plan for healthcare.[82] This oversight was compounded by the absence of legislation to regulate private healthcare providers.[83] Consequently, healthcare providers appealed to the Union to establish a unified

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[72] The first draft of the Public Health Act of 1919 delegated 'control of virtually all health service functions' to the Union. However, amendments to the Act before its promulgation minimised the Union's authority and responsibility for healthcare. Delobelle op cit note 46 at 165; Van Rensburg & Harrison op cit note 47 at 97.
[73] Ibid.
[74] Randall M. Packard *White Plague Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (1989) 45.
[75] Coovadia, Jewkes & Barron et al op cit note 48 at 819.
[76] Packard op cit note 74 at 60.
[77] Coovadia, Jewkes & Barron et al op cit note 48 at 819; Department of Health op cit note 20 at 8-10.
[78] Steven Feierman & John M. Janzen *Social Basis of Health and Healing in Africa* (1992) 146-7; Centre for Social Science Research Working Paper 159 *The Carnegie Commission and the Backlash Against the Welfare State-Building in South Africa, 1931-1937* (2006) 5.
[79] William Pick, Laetitia Rispel & Shan Naidoo 'Poverty, Health and Policy: A Historical Look at the South African Experience' (2008) 29 *Journal of Public Health Policy* 165 at 167.
[80] Primary healthcare aims at treatment for disease prevention. Delobelle op cit 46 at 168; Van Rensburg & Harrison op cit note 47 at 99.
[81] Harry T Phillips 'The 1945 Gluckman Report and the Establishment of South Africa's Health Centres' (1993) 83 *American Journal of Public Health* 1037 at 1038.
[82] Each provincial department operated independently. Delobelle op cit note 46 at 169-70; Van Rensburg & Harrison op cit note 47 at 97.
[83] Ibid.

health system that provided comprehensive healthcare for the white community.[84] Concomitantly, providers rebuked the Union's policies that prioritised curative healthcare.[85] These policies promoted the development of, and fostered a demand for, specialist doctors that were expensive to train.[86] The ensuing increase in healthcare costs was passed onto the population, which further marginalised poor communities.[87] Consequently, providers championed reform to reorientate the health system from expensive curative healthcare to cost-effective preventative healthcare.[88] The Union dismissed these pleas, reasoning that the proposed reform was not financially feasible.[89] In its stead, the Union encouraged individuals to take responsibility for their needs by promoting the use of medical schemes to finance healthcare costs.[90]

In response to the Union's healthcare policies, private employers began contributing towards employees' medical scheme membership fees.[91] This spurred the expansion of private healthcare providers in white metropolitan areas.[92] The sustainability of this expansion was, however, threatened by an unabated increase in healthcare costs.[93] Medical schemes' attempts to contain these costs, by acting in consortium to coerce healthcare providers to reduce their tariff of fees, were unsuccessful.[94]

The Union sought to stabilise the private sector by appointing committees to investigate mechanisms to legitimise its reliance and promote the use of medical schemes. The Phillips Committee recommended that the Union establish a mandatory medical scheme for white civil servants.[95] While the Union accepted this proposition, its implementation was deferred until 1967 due to financial constraints.[96] The Social Security Committee was charged with determining the feasibility of making individuals responsible for their healthcare costs.[97] This committee recommended that the Union finance the costs of creating a comprehensive

[84] Ibid.
[85] Curative healthcare focuses on restoring the health of the sick. The Public Health Amendment Act 4 of 1897 and Jaques & Fehrsen op cit note 47 at 6.
[86] Jaques & Fehrsen op cit note 47 at 6.
[87] Ibid.
[88] Ibid.
[89] Price op cit note 40 at 122; Van Rensburg & Harrison op cit note 47 at 97.
[90] Verhoef op cit note 58 at 606.
[91] Ibid at 610.
[92] Ibid at 613-14.
[93] Ibid at 615.
[94] Medical schemes also sought to mitigate the financial uncertainties by underwriting their risk with reinsurance companies. Verhoef at op cit note 58 at 616; Competition Commission op cit note 10 at 39.
[95] Verhoef op cit note 58 at 608-610.
[96] Ibid.
[97] Ibid.

programme for social security benefits for all residing in the Union, regardless of race.[98] The Union rejected the committee's recommendations as it conflicted with policies that sought to subjugate the black community.[99] The Union eventually implemented a social security benefits scheme, however, this was confined to the white community.[100] A third committee recommended that the private sector be disbanded and proposed a scheme for free hospitalisation.[101] This committee defended its recommendations by reasoning doctors prioritised their private practices and neglected their duties in public hospitals.[102]

It is against this backdrop that a fourth commission was convened. The National Health Service Commission ('NHSC') identified various issues with the health system as well as obstacles to effective healthcare reform.[103] The NHSC found that there was an 'inappropriate emphasis on curative' healthcare services that was driven by a large private sector which caused a concentration of healthcare providers in white urban areas; and that PHEs exacerbated the existing fragmentation of the health system.[104] Radical transformation was proposed to unify the health system for the purpose of effectively planning and coordinating of healthcare services.[105] The transformed system envisioned a reorientation of healthcare services to provide cost-effective healthcare that would be rendered free of charge, regardless of a patient's race.[106] This system would be financed by implementing a new national health tax.[107] It was recommended that the private sector be gradually phased out as it was inimical to the spirit and purpose of the proposed reform.[108] The NHSC was ardent that extensive reform was the only mechanism to rectify the various issues in the health system.[109] It argued that 'anything less… would be idle tampering, unlikely to bring about any real change in the lives of those in the greatest need of healthcare'.[110]

Certain impediments proved to be deleterious to the reform proposed by the NHSC.[111] First, the proposed unified health system was diametrically opposed to the segregationist

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[98] Ibid.
[99] Ibid.
[100] The benefits were limited to old age and disability benefits. Ibid.
[101] F.R.C.S Cluver 'Boksburg-Benoni Hospital Fifteenth Annual Report' (1943) XVII *South African Medical Journal* 524 at 525.
[102] Ibid.
[103] Van Rensburg & Harrison op cit note 47 at 99.
[104] Delobelle op cit note 46 at 169-70.
[105] Phillips op cit note 81 at 1038.
[106] Delobelle op cit note 46 at 169-170.
[107] Van Rensburg & Harrison op cit note 47 at 98.
[108] Jaques & Fehrsen op cit note 47 at 7.
[109] Van Rensburg & Harrison op cit note 47 at 100.
[110] Ibid.
[111] Ibid at 113.

policies that sought to uphold the white community while subjugating the black population.[112] Secondly, healthcare providers opposed such a system as they feared that it would unduly interfere with their ability to earn an income from private practice.[113]

Significantly, the reform envisioned by the NHSC was comparable to modern tenets of policies that demand that access to healthcare services be treated as a fundamental human right.[114] Therefore, implementation of the NHSC recommendations would have created a health system that would have paralleled 'contemporary policy recommendations'.[115] Instead, the Union's policies were directed at furthering the interests of the white privileged elite.

## 2.2 PROLIFERATION OF THE PRIVATE SECTOR FROM 1948 TO 1969 – BLATANT MEANS TO UPLIFT THE WHITE COMMUNITY AND SUBJUGATE THE BLACK POPULACE

After the National Party emerged victorious in 1948 national elections, the apartheid State ('the State') undertook an aggressive plan to codify and refine historical policies that upheld white supremacy and subjugated the already marginalised black populace.[116] This entailed a massive feat of 'social engineering' that controlled and dominated 'every facet of life'.[117] Under this administration, planning for healthcare became bureaucratic as the State sought to exploit access to quality healthcare as an instrument to achieve its political ideology.[118] Consequently, healthcare policies were driven by 'political rather than by health criteria'.[119] The principal objective of these policies was to maintain and improve the white population's health.[120]

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[112] Delobelle op cit note 46 at 169-170.
[113] Jaques & Fehrsen op cit note 47 at 6-7.
[114] Van Rensburg & Harrison op cit note 47 at 100.
[115] Ibid at 97.
[116] Legislation was enacted to legitimise racial discrimination which included the Prohibition of Mixed Marriages Act 55 of 1949, Immorality Amendment Act 21 of 1950, Population Registration Act 30 of 1950, Group Areas Act 41 of 1950, Bantu Authorities Act 68 of 1951, Prevention of Illegal Squatting Act 52 of 1951, Native Laws Amendment Act 54 of 1952, and Reservation of Separate Amenities Act 49 of 1953. See Mickey Chopra & David Sanders 'From Apartheid to Globalisation: Health and Social Change in South Africa' (2004) 4 *Hygiea Internationalis: An Interdisciplinary Journal for the History of Public Health* 153 at 154; Cora Hoexter 'The Principle of Legality in South African Administrative Law' (2004) 8 *Macquarie Law Journal* 165 at 166.
[117] John M. Luiz 'The Evolution and Fall of the South African Apartheid State: A Political Economy Perspective' (1998) 26 *Ufahamu: A Journal of African Studies* 49 at 50; Veronica Ehrenreich-Risner *The effects of Apartheid Tribal Authorities on Chieftaincy and the Zulu People: Separate Development in Mtunzini District 1950-1970* presented at the History and African Studies Seminar (27 February 2013) 2.
[118] Price op cit note 4 at 158.
[119] Ibid.
[120] Ibid.

Conversely, the State sought to systematically undermine the black populace's health.[121] This section shall investigate how the State achieved these objectives and consider what effect these policies had on medical schemes and PHEs.

### *2.2.1 Provision of healthcare for the black population*

The political and legislative framework during this period was engineered to oppress and marginalise black communities by creating a vicious cycle of poverty and ill health.[122] It has been argued that 'apartheid [was] the cruellest governmental assault on health… ever known to man'.[123] Policies from the preceding centuries that manipulated access to healthcare were institutionalised and revised as the State continued to undermine the black communities' health to prevent the unification of the black populace that could oppose the apartheid regime.[124] Accordingly, the State refused to provide basic services to maintain health, such as sanitation and clean water, to the reserves that were re-engineered under the Bantu Authorities Act 91 of 1952 ('Bantustans').[125] This led to regular cholera and polio outbreaks and rampant poverty-related diseases within the Bantustans.[126]

Forced removal and reallocation of entire black communities were legitimised under the auspices that Bantustans would be independent states.[127] The success of this enterprise was premised on the Bantustans remaining impecunious. To achieve this objective, the State expanded the destruction of black subsistence farming and increased the rate of repatriation of the sick and unemployed to their designated ethnic homelands.[128] This reinforced the cheap migratory labour framework as the black population became increasingly dependent on employment within white industries.[129] The State's Machiavellian strategy to entrap and

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[121] It was thus argued that 'for all practical purposes', access to quality healthcare 'was an exclusively white enterprise'. Van Rensburg & Harrison op cit note 47 at 101; Price op cit note 4 at 158.
[122] Cedric De Beer *The South African Disease: Apartheid, Health, and Health Services* (1986) 12.
[123] World Health Organisation *The Health Implications of Racial Discrimination and Social Inequality: An Analytical Report on the Conference* (1981) 258.
[124] Marks & Andersson op cit note 42 at 181; Price op cit note 40 at 123.
[125] H.G.V Küstner & G. Du Plessis 'The Cholera Epidemic in South Africa 1980-1987. Epidemiological Features' (1991) 79 *South African Medical Journal* 539 at 539 and 543.
[126] See for example W.R Booth 'Paediatric Problems in a Rural Area of South Africa – A Study in Southern Lebowa' (1982) 24 *South African Medical Journal* 911 at 911.
[127] 'Poverty and poor health worldwide are inextricably linked' as the cause of poor health is rooted in political, social, and economic injustices. Braveman & Gruskin op cit note 54 at 539; Colins Tatz 'Dr Verwoerd's Bantustan Policy' (2008) 8 *The Australian Journal of Politics and History* 7 at 8.
[128] Bantustans were mostly inhabited by the 'very young, elderly, sick, or disabled'. De Beer op cit note 121 at 11-12; Chopra & Sanders op cit note 116 at 154.
[129] Coovadia, Jewkes & Barron et al op cit note 48 at 819; Luiz op cit note 117 at 51.

institutionalise poverty extended to designing a poor educational system for black youths' to limit their employment opportunities to 'menial positions in society' with meagre wages.[130]

The State simultaneously ensured that black communities could not access quality healthcare services.[131] This was achieved by systematically eroding preventative and promotive healthcare provided by clinics and by dismantling access to curative treatment. [132] The latter objective was accomplished by undercutting funding to non-profit missionary hospitals that operated within the Bantustans.[133] When on the precipice of collapse, the State assumed control over these hospitals only to later transfer the responsibility for their management to the Bantu authorities.[134] These authorities were then charged with providing healthcare to its populace, despite their indigence and lack of expertise and skill in planning and provisions for such services.[135] The State provided paltry financial assistance to the Bantustans to mitigate the risks of an 'uncontrollable influx' of black patients into white urban hospitals if their health systems collapsed.[136] Payment of this financial aid was manipulated to ensure that Bantu authorities supported and promoted the State's ideological framework of racial segregation.[137] The State then staged an insidious plan to divide the black populace along ethnic lines by politicising the provisioning of healthcare.[138] Specifically, the State ensured that Bantu healthcare providers were only 'staffed [and managed] by people [within the same] ethnic group'.[139] Due to the 'scarcity of resources', hospital staff would then refuse to treat patients who did not fall within the respective healthcare provider's ethnicity.[140]

Outside of the Bantustans, public healthcare facilities were segregated into separate clinics and hospitals.[141] These facilities were systematically underfunded to ensure that the quality of healthcare services remained subpar.[142] Consequently, public hospitals for black communities were under-resourced, understaffed, and overcrowded.[143] In comparison, white public hospitals received a greater portion of the budget despite only treating a small fraction

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[130] Coovadia, Jewkes & Barron at op cit note 48 at 819 and 823; Price op cit note 4 at 159.
[131] Chopra & Sanders op cit note 116 at 154.
[132] Van Rensburg & Harrison op cit note 47 at 111; Phillips op cit note 81 at 1038; Houghton op cit note 50 at 13.
[133] Marks & Andersson op cit note 42 at 181; Price op cit note 40 at 123.
[134] Delobelle op cit note 46 at 178.
[135] Houghton op cit note 50 at 13.
[136] Van Rensburg & Harrison op cit note 47 at 110; Price op cit note 4 at 164.
[137] It has been argued that the autonomy and independence of the Bantustans was a farce that aimed to legitimatise the State's ideology of separateness. In reality, the Bantustans were at best 'semi-automatous' authorities that were 'carefully manipulated' by the State. Price op cit note 4 at 164-65; Ehrenreich-Risner op cit note 117 at 3.
[138] Price op cit note 4 at 165-166.
[139] Ibid.
[140] Ibid.
[141] This was regulated by the Separate Amenities Act 49 of 1953. See Price op cit note 43 at 124.
[142] Price op cit note 43 at 127.
[143] Du Toit op cit note 70 at 17-18.

of the population.[144] The disparities in the availability of healthcare providers and quality of services had a devastating impact on the black populations' health as mortality rates were twice as high as the white community.[145] It is thus clear that the State's healthcare policies were engineered to entrench social inequalities in society.[146]

### *2.2.2 Provision of healthcare services for the white population*

State policies that sought to conserve white supremacy, during the period of 1948 to 1970, entrenched medical schemes as key stakeholders in the health system.[147] The State's economic policies were based on capitalism and aimed to promote white domination.[148] These policies not only ensured that the majority of the white population was gainfully employed but were also buttressed by significant income 'differentials between black and white workers'.[149] White affluence facilitated the expansion of the medical scheme market.[150] Nevertheless, the State sought to further aid this expansion by contributing to white civil servants' medical scheme membership costs.[151] Concurrently, the private business sector made medical scheme membership a mandatory term of employment for their white employees.[152] Thus, by 1960 approximately 80 per cent of the white population were members of medical schemes.[153] Despite the rapid uptake in membership, the medical scheme market operated without regulatory control.[154]

Ostensibly, the increase in medical scheme memberships compounded the demand for private healthcare services.[155] Hospital services, however, remained predominantly a public enterprise with the State financing the costs of establishing and maintaining hospitals in white urban regions.[156] Hence, by 1950, public hospitals were built and concentrated in all major

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[144] Price op cit note 43 at 127.
[145] Marks & Andersson op cit note 42 at 179.
[146] Delobelle op cit note 46 at 173.
[147] Wayburne op cit note 5 at 5.
[148] Price op cit note 4 at 158; P.G.K Panikar 'The Medical Crisis A Marxist Diagnosis' (1980) 15 *Economic and Political Weekly* 297 at 297.
[149] It was estimated that the majority of the white population held formal employment by 1960. Sampie Terreblanche & Nicoli Nattrass 'A Periodization of the Political Economy from 1910' in N Nattrass & E Ardington (eds) The Political Economy of South Africa (1990) 12 at 12.
[150] Panikar op cit note 148 at 1549.
[151] Competition Commission op cit note 10 at 39.
[152] Department of Health op cit note 20 at 18-19.
[153] Competition Commission op cit note 10 at 39.
[154] By 1950, there were 48 medical schemes. Ibid at 24 and 39.
[155] Department of Health op cit note 20 at 18-19.
[156] Van Rensburg & Harrison op cit note 47 at 113.

white metropolitan areas.[157] As the State allocated a disproportionally high budget to these hospitals, healthcare services were of an exceptionally high quality.[158] The costs of public hospital services were billed directly to patients' medical schemes and consequently, there were very few PHEs during this period.[159]

Although public hospitals were primarily responsible for healthcare services, high prices threatened the solvency of the medical scheme market.[160] Medical schemes attempted to mitigate financial losses by colluding and negotiating preferential reimbursement rates to pay healthcare providers.[161] In an attempt to gain an advantage, medical schemes made direct payments to providers on the condition that these providers unequivocally accepted the scheme's set tariff.[162] Those providers that elected to charge higher rates were required to recover their fees directly from their patients.[163] This, however, placed an undue administrative burden on providers.[164] Consequently, negotiations between medical schemes and providers became strained.[165] To resolve this impasse, medical schemes and providers established a new payment framework that enabled medical schemes to pay the providers based on their set tariff while the balance of the bill would be charged to the patients ('balancing-billing-practices').[166]

Notwithstanding this compromise with providers, medical schemes continued to experience 'regular operational losses'.[167] This was attributed to an increase in administration costs that eroded medical schemes' profitability.[168] Medical schemes accordingly attempted to improve their solvency by denying coverage to new members with pre-existing health conditions and using reserve funds to finance their operations.[169] More benign measures to

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[157] This would serve as the foundation of the geographical maldistribution of healthcare services that plagues the prevailing health system. Ibid.
[158] Marks & Andersson op cit note 42 at 179.
[159] Doctors advocated that hospital services should be free to poorer sections of the community while wealthier patients should be compelled to pay for such services. R.E Bauling 'The Responsibility of Public Authority in Providing Medical Services' (1968) XLII *South African Medical Journal* 5 at 7; Ritchie Thompson 'Comments by the Propaganda Committee on the Public Hospitals' Draft Ordinance of the Transvaal' (1946) XX *South African Medical Journal* 154 at 154.
[160] Alex Van Den Heever 'Towards a Theory of Market Failure in the South African Private Health System' (2015) *Economics, Medicine, Political Science* 10 at 10; Department of Health op cit note 20 at 18.
[161] Ibid.
[162] E.W. Turton 'Insurance Company Medical Aid' (1960) XXXIV *South African Medical Journal* 922 at 924.
[163] Competition Commission op cit note 10 at 43.
[164] F.H Counihan 'The Philosophy of Medical Practice as well as the Structure of a Medical Service' (1965) XXXIX *South African Medical Journal* 1070 at 1071.
[165] Turton op cit note 162 at 924.
[166] Maurice Shapiro 'Medical Service Plan' (1962) XXXVI *South African Medical Journal* 760 at 761.
[167] Verhoef op cit note 58 at 618; Maurice Shapiro 'Chairman's Report, Annual General Meeting, Medical Services Plan' (1965) XXXXIX *South African Medical Journal* 870 at 870.
[168] Department of Health op cit note 20 at 29; Competition Commission Health Market Inquiry *Final Findings and Recommendations Report* (2019) 119.
[169] Reserve funds are 'minimum accumulated funds that 'medical schemes must maintain to ensure their solvency. These funds ensure that 'the scheme is able to meet members claims as they arise'. If the reserve fund 'falls below

improve the solvency of medical schemes included underwriting financial risks with reinsurance companies, increasing membership fees, reducing members benefits, and improving administrative efficiencies by improving their organisational capabilities.[170] These measures, however, did not stabilise the medical scheme market. Accordingly, the Friendly Societies Act 25 of 1956 was enacted in an attempt to improve medical schemes' solvency.[171] The Act primarily regulated medical schemes financial operations and basic operational rules.[172] These rules, however, were merely formalistic in nature. The lack of substantive regulation meant that medical schemes continued to operate in a fragmented manner.[173]

During this period, doctors lobbied for reform that would entitle the white community to greater social benefits. This support called for the State to extend its liability from mere contributions to white civil servants' medical schemes to a mandatory medical scheme for 'the entire white population'.[174] It was reasoned that this would increase the financial viability of medical schemes by improving both the risk and income cross-subsidisation that is a cornerstone of healthcare insurance.[175] The State's disregard for this reform acted as a catalyst for a new rival medical scheme, the Medical Service Plan ('MSP'), in 1959.[176] Unlike existing medical schemes, the MSP provided comprehensive benefits for 'major medical, surgical, and hospital services'.[177] Membership was still limited to the white population that held formal employment and could thus afford to pay for membership fees.[178] The success of the MSP can be accredited to its ability to successfully entice doctors' participation, as it paid healthcare

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the prescribed … ratio' it indicates that the medical scheme is no longer solvent. Verhoef op cit note 58 at 618; The South African Institute of Charted Accountants *Medical Schemes Accounting Guide for the Year End 31 December 2022* (November 2022) 9; Council for Medical Schemes Circular 33 of 2022 *Understanding Medical Scheme Reserves* (8 May 2020); L.G Woods 'Medical Aid Schemes and Legislation' (1964) XXXVIII *South African Medical Journal* 466 at 466.

[170] Verhoef op cit note 58 at 618-20; Maurice Shapiro 'Chairman's Report, Annual General Meeting, Medical Service Plan' (1966) XL *South African Medical Journal* 1053 at 1053.

[171] Friendly Societies provided a range of benefits aside from indemnifying members' healthcare costs. Sections 2(1)(*a*) to 2(1)(*i*) of the Friendly Societies Act 25 of 1956; R. Impey 'Recommendations of the Snyman Commission' (1963) 37 *South African Medical Journal* 1029 at 1030.

[172] See for example sections 5(2)(*a*), 5(2)(*b*) and 7(2) of the Friendly Societies Act op cit note 171; Department of Health op cit note 20 at 28; Heather McLeod 'Mutuality and Solidarity in Healthcare in South Africa' (2005) 5 *South African Actuarial Journals* 135 at 142.

[173] Department of Health op cit note 20 at 18.

[174] Ibid at 18-20.

[175] Effective risk pooling and cross-subsidisation is essential for the financial feasibility of medical schemes. Department of Health op cit note 20 at 20; McLeod op cit note 172 at 136.

[176] Maurice Shapiro 'Chairman's Report, Annual General Meeting, Medical Service Plan' (1965) XXXIX *South African Medical Journal* 870 at 870-71.

[177] Maurice Shapiro 'Medical Service Plan' (1960) XXXIV *South African Medical Journal* 936 at 936.

[178] Medical Association of South Africa 'Medical Services Plan: Progress Report' (1960) XXXIV *South African Medical Journal* 35 at 35-36; Department of Health op cit note 20 at 18.

providers higher tariffs in comparison to other medical schemes.[179] Due to the popularity of the MSP, its services were extended to all regions of the country by 1963.[180]

### *2.2.3 Political response to a deteriorating economy– the State's drive to decrease expenditure on healthcare for the white population*

Following the Sharpeville Massacre of 1960,[181] the State's expenditure on defence increased exponentially as it sought to suppress political dissidents and liberation movements.[182] As a consequence of this political upheaval, an arms embargo was imposed against the State and South Africa was excluded from the Commonwealth.[183] Cumulatively, these events weakened the economy.[184] It is against this backdrop that the State sought to decrease its expenditure on healthcare for the white community.[185] The State had to cautiously navigate how to fulfil this mandate as it could not jeopardise its efforts to uphold white supremacy. Accordingly, commissions were appointed to develop a strategy to accomplish this goal.

These commissions determined that the State could reduce its welfare support of the white community by renouncing all responsibility of subsidising healthcare costs.[186] Instead, individuals would be expected to finance all of their healthcare costs.[187] This could be achieved by promoting enrolment with private voluntary medical schemes to facilitate healthcare privatisation.[188] This, however, required stringent and more comprehensive legislative control of medical schemes.[189] It was thus recommended that new legislation be enacted to prescribe

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[179] Ibid.
[180] Maurice Shapiro 'Medical Services Plan' (1963) XXXVII *South African Medical Journal* 1145 at 1146; South African Medical Association 'The Cape Medical Plan' (1961) XXXV *South African Medical Journal* 1054 at 1054.
[181] The Sharpeville massacre was pivotal to the oppose the apartheid regime as dissidents migrated away from peaceful demonstrations to acts of violence and sabotage. Terreblanche & Nattrass op cit note 149 at 113-114.
[182] During the period of 1960 to 1964, the State allocated approximately 79 million per annum to its defence expenditure. This increased to 211 million per annum during the period of 1965 to 1969. This expanded by more than 300 per cent by 1974. Nelisiwe Rejoice Mthethwa *Government Expenditure Growth in South Africa 1960-1993* (unpublished MSocSC dissertation, University of Kwa-Zulu Natal, 1998) 38-39.
[183] Terreblanche & Nattrass op cit note 149 at 14.
[184] Ibid.
[185] This decrease was part of the State's plan to finance the increasing costs of maintaining the apartheid regime. Mthethwa op cit note 182 at 18; Terreblanche & Nattrass op cit note 149 at 15.
[186] South African Institute of Race Relations *Commission of Inquiry into the High Costs of Medical Services and Medicines* (2013) 4.
[187] Ibid.
[188] Ibid.
[189] Department of Health op cit note 20 at 22.

that medical schemes provide mandatory minimum benefits,[190] that membership fees be premised on insurance principles of solidarity,[191] and that medical schemes be governed by a new regulatory authority.[192] These recommendations formed the foundation for the promulgation of the Medical Schemes Act 72 of 1967 ('MSA 1967').

### *2.2.4 Increase in private healthcare prices*

At the time these commissions were appointed to investigate healthcare privatisation, it was noted that private healthcare costs were rapidly increasing.[193] Several factors were identified to have attributed to these increases. First, it was alleged that patients would misuse the benefits provided by medical schemes.[194] Secondly, it was noted that doctors tended to subject patients to expensive and unnecessary treatment for financial gain ('over-servicing') and for professional prestige which increased healthcare costs.[195] Thirdly the premise of direct negotiations between medical schemes and providers, which was based on a fee-for-service ('FFS') model of reimbursement, was credited with increasing healthcare costs.[196] The largest cost contributor, however, was the expenditure on hospital services.[197] This was due to hospitals' investing in expensive medical technology and their focus on costly curative healthcare treatment.[198]

As the success of the MSA 1967 was premised on medical schemes ability to effectively contain costs, the State appointed the Board of Medical Aid Schemes ('the Tariff Commission') to consult with medical schemes and healthcare providers to determine a Standard Tariff for

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[190] This was the foundation of the legislative required prescribed minimum benefits that medical schemes are required to provide to their members. South African Institute of Race Relations op cit note 186 at 7-8; Department of Health op cit note 20 at 22.

[191] This makes provision for medical scheme contributions to be determined according to a members' income and not their risk profile. These provisions enable high-income members to pay higher premiums to effectively cross-subsidise low-income earners. More importantly, it would ensure medical schemes indemnify members regardless of their pre-existing health conditions. South African Institute of Race Relations op cit note 186 at 4-5; McLeod op cit note 172 at 142.

[192] Competition Commission op cit note 10 at 39.

[193] Impey op cit note 171 at 1029-30; Medical Association of South Africa 'Central Council for Medical Schemes' (1963) XXXVII *South African Medical Journal* 251 at 251.

[194] It was noted that members of medical schemes no longer held the responsibility to pay for treatment which would ordinarily act as a deterrent to seek inane healthcare services. H.W. Snyman 'The High Costs of Medical Services: A Summary' (1964) XXXVIII *South African Medical Journal* 195 at 197.

[195] M. Labuschaigne & M Slabbert 'Understanding National Health Insurance in South Africa: A Legal Perspective' (2022) 2 *Tydskrif vir die Suid-Afrikaanse Reg* 418 at 418; Snyman op cit note 194 at 197.

[196] Snyman op cit note 194 at 196-197; Competition Commission op cit note 10 at 42.

[197] Ibid.

[198] Shapiro op cit note 177 at 1145; H.M Segall 'The Economics of Medical Practice' (1961) 35 *South African Medical Journal* 632 at 632.

schemes to pay for healthcare services ('Standard Tariff').[199] The Tariff Commission was directed to submit the Standard Tariff to the Minister of Health for inclusion in the MSA 1967.[200] The investigation conducted by the Tariff Commission proved to be divisive as providers feared that it would quash the private sector market as they would be beholden to the State's regulatory authority.[201] Nevertheless, providers actively participated in the investigation process as they acknowledged that medical schemes were essential for the continued operation of the private sector.[202]

In 1964, providers collaborated and agreed to appoint their own committee to compose their own tariff of reimbursement.[203] It was reasoned that this consort would be capable of influencing engagements with the Tariff Commission.[204] After providers composed and submitted their own tariff to the Tariff Commission, the Minister of Health provisionally agreed to utilise this tariff for the purpose of composing legislation to regulate the Standard Tariff.[205]

When the MSA 1967 was enacted, it established the Central Council for Medical Schemes ('the Council').[206] Notwithstanding the Minister's undertaking to healthcare providers, the MSA 1967 made provision for the Standard Tariff to be unilaterally determined by the State.[207] Providers viewed this conduct as deceptive and disingenuous as it disregarded

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[199] As the success any reform required the cooperation of healthcare providers, the State could not unilaterally set the Standard Tariff. Medical Association of South Africa 'World Medical Association: Twelve Principles of Social Security' (1964) XXXVIII *South African Medical Journal* 960 at 961; Maurice Shapiro 'The Chairman's Report, Annual General Meeting, Medical Services Plan' (1964) XXXVII *South African Medical Journal* 809 at 810; Medical Association of South Africa 'Central Council for Medical Schemes' (1962) XXXVI *South African Medical Journal* 997 at 997.

[200] Medical Association of South Africa 'World Medical Association: Twelve Principles of Social Security' (1964) XXXVIII *South African Medical Journal* 960 at 961.

[201] I.C Verster 'Prepaid Medical Schemes' (1963) XXXVII *South African Medical Journal* 218 at 219.

[202] Ibid.

[203] The Standard Tariff would be utilised for all medical schemes and replace all negotiated tariffs. South African Medical and Dental Council 'Charges for Services Rendered by Registered Practitioners' (1963) XXXVII *South African Medical Journal* 310 at 310; Medical Association of South Africa 'Schedule of Fees' (1964) XXXVIII *South African Medical Journal* 903 at 904.

[204] M.K Tucker 'The Medical Association of South Africa and Pending Legislation' (1964) XXXVIII *South African Medical Journal* 419 at 419; Arnold Tonkin 'The Reorganization of the Medical Association' (1965) 24 *South African Medical Journal* 332 at 332.

[205] Healthcare providers demanded the deletion of the reference to Standard Tariffs and the removal of any restrictions that would limit a patient's choice of doctor from the Medical Schemes Bill. Medical Schemes Bill in *GG* 1048 of 26 February 1965; Medical Association of South Africa 'The Medical Schemes Bill' (1965) XXXIX *South African Medical Journal* 257 at 257; Medical Association of South Africa 'The Standard Tariff: Its Purpose and Summary of Events which Preceded its Preparation' (1966) XL *South African Medical Journal* 322 at 322.

[206] Section 4 of the Medical Schemes Act 72 of 1967.

[207] Sections 30(3), 33 (4), 44 (1) to (3) of the Medical Schemes Act op cit note 206; Medical Association of South Africa 'Medical Schemes Act' (1967) 41 *South African Medical Journal* 1152 at 1152; Medical Association of South Africa 'A Summary of the Important Events in the History of the Medical Schemes Act, Both Before and After its Promulgation on 1 July 1967' (1968) XLII *South African Medical Journal* 633 at 639.

the extensive consultative process that preceded the promulgation of the MSA 1967.[208] Providers' distrust of the State was compounded by the fact that the Act prevented medical schemes from making direct payments to providers if their fees exceeded the Standard Tariff.[209] This provision subverted the agreement between medical schemes and providers during the preceding decade that permitted balancing-billing-practices.[210] The State subsequently attempted to ease ongoing acrimony by amending the MSA 1967 to delete the reference to the Standard Tariff.[211] In its stead, the Act established the Representatives' Association of Medical Schemes ('RAMS') to determine the Standard Tariffs.[212] This, however, did little to quell ongoing tension as the State's conduct had marred providers' trust in the impartiality of any authority that sought to regulate their fees.[213]

### *2.2.5 Concluding remarks regarding the period of 1948 to 1969*

The period of 1948 to 1969 was characterised by overt policies that sought to suppress the black community while uplifting the white populace. The State enacted surreptitious legislative reform to uphold the racial hierarchy after the economic downturn resulting from internal unrest and international condemnation following the Sharpeville massacre. This entailed reducing the State's expenditure on healthcare for the white community by starting to shift to policies that favoured healthcare privatisation. In doing so, the State attempted to control healthcare providers by dictating what tariffs would be payable for services. These efforts proved to be abortive as they imbued seeds of distrust between healthcare providers and the State that is pervasive in the prevailing health system.

## 2.3 HEALTHCARE AFTER THE ECONOMIC CRISIS IN THE 1970S – SOPHISTICATED MEANS TO MAINTAIN WHITE SUPREMACY FROM 1970 TO 1993

[208] Ibid.
[209] Sections 28(7) and 29 of the Medical Schemes Act op cit note 206; Roex op cit note 62 at 262; Department of Health op cit note 20 at 22.
[210] Competition Commission op cit note 10 at 43.
[211] Amendment Act 95 of 1969.
[212] However, the failed to disclose how the tariff-of-fees would be negotiated. Roex op cit note 62 at 262; Department of Health op cit note 10 at 22.
[213] Roex op cit note 62 at 262.

After the economic crisis of 1970, the State embarked on an aggressive healthcare privatisation campaign. These efforts proved to be foundational for medical schemes and PHEs to flourish. This section examines the consequences of the State's rapid decline and eventual demise, elucidating how access to healthcare was strategically employed in an attempt to maintain its final remnants of power. The ensuing repercussions provided a fertile foundation for the expansive growth of medical schemes and the proliferation of PHEs.

### *2.3.1 Premise of privatisation in South Africa*

During the 1970s, the political climate in South Africa became overtly militant.[214] The State's persistent violent suppression of dissidents attracted greater international condemnation.[215] Consequently, international trade restrictions were imposed against South Africa.[216] The ramifications of these restrictions forced the State to increase its expenditure on industries such as electricity, fuel, and munition production to service its needs.[217] This increased expenditure, combined with the escalating fiscal requirements for defence to quell political dissidents, severely strained the fiscus.[218] Concurrently, foreign companies and banks withdrew their investments due to ongoing political unrest.[219] Cumulatively, these factors caused a rapid decline in the economy.[220] As the costs of maintaining the 'draconian monolith' of the apartheid framework became unaffordable, the State adopted a more subversive and sophisticated policy drive to support the racial divisions that it desperately sought to uphold, namely privatisation.[221]

Privatisation provided an opportunity to masquerade discrimination by changing the premise of exclusionary practices from race to affordability.[222] The State's aggressive pursuit of privatisation was aided by existing wealth within white communities and institutionalisation of privation in the black community from the preceding decades.[223] Consequently, any neutrality that is ordinarily associated with privatised commercial transactions was now

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[214] Bronwen Manby 'South Africa: The Impact of Sanctions' (1992) 46 *Journal of Economic Affairs* 193 at 196.
[215] Philip Levy 'Sanctions on South Africa: What Did They Do?' (1999) 89 *American Economic Review* 415 at 415.
[216] Luiz op cit note 117 at 55-56.
[217] Ibid.
[218] Mthethwa op cit note 182 at 18, and 34.
[219] Levy op cit note 215 at 415-16.
[220] Geoffrey Schneider 'Neoliberalism and Economic Justice in South Africa: Revisiting the Debate on Economic Apartheid' (2003) 61 *Review of Social Economy* 23 at 28.
[221] Ibid.
[222] Nkosana Mfuku *Privatization and Deregulation Policies in South Africa* (unpublished M.P.A research report, University of the Western Cape, 2006) 13.
[223] Michael Johannes Meyer *The Impact of Privatisation on Development in South Africa: A Review and Prognosis* (unpublished MA dissertation, Rand Afrikaans University, 1997) 51.

beholden to a political ideology that upheld racial discrimination.[224] Thus, the economic reform during the 1970s was 'held ransom to political motives'.[225]

### *2.3.2 Privatisation of healthcare*

It was estimated that approximately 75 per cent of the white community were members of medical schemes during the 1970s.[226] Therefore, the State could act with relative impunity in its pursuit of healthcare privatisation. The State accordingly devised and implemented policies to facilitate the privatisation process. This course of action had a devastating impact on the indigent's ability to access healthcare services.[227] These policies ultimately exacerbated the fragmentation and bifurcation of the health system.

The privatisation process began with the deliberate erosion of public hospitals. The State achieved this objective by drastically reducing the budget that was allocated to public hospitals.[228] As a result, public hospitals became overcrowded, and the quality of their services decreased drastically.[229] The process of defunding the public sector served a dual purpose. First, it enticed patients to seek treatment at PHEs that rendered better quality healthcare services.[230] Secondly, the decline in revenue encouraged a mass exodus of doctors and nurses from public hospitals.[231] These healthcare professionals migrated towards PHEs that provided better earning opportunities and working conditions.[232] Accordingly, the proliferation of PHEs occurred to the detriment of the public sector.

The second step in the privatisation process aimed to increase the uptake of voluntary medical scheme membership. This entailed drastically increasing public hospitals' fees to discourage the reliance on public healthcare services.[233] This increase in fees encouraged the white population to finance their healthcare costs through medical schemes.[234] This policy was

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[224] B.S Kantor & H.F Kenny 'The Poverty of Neo-Marxism: The Case of South Africa' (1976) 3 *Journal of Southern African Studies* 20 at 39; Price op cit note 43 at 128.
[225] Ronaldo Munck 'South Africa: The Great Free Market Debate' (1994) 15 *Third World Quarterly* 205 at 205.
[226] Price op cit note 43 at 126.
[227] Shivani Ranchod, Cheryl Adams & Aidin Aryankhsesal et al 'South Africa's Hospital Sector: Old Divisions and New Developments' (2017) *South Africa Health Review: Health Systems Trust* 101 at 119; Mfuku op cit note 222 at 63.
[228] Price op cit note 43 at 124.
[229] Competition Commission op cit note 10 at 40.
[230] C.D Naylor 'Private Medicine and the Privatisation of Healthcare in South Africa' (1988) 27 *Social Science and Medicine* 1153 at 1156; Price op cit note 40 at 126.
[231] The exodus of doctors and nurses exacerbated the public health crisis. Ranchod, Adams & Aryankhsesal op cit note 227 at 102.
[232] Ranchod, Adams & Aryankhsesal op cit note 227 at 102; Coovadia, Jewkes & Barron at op cit note 48 at 826.
[233] Ibid.
[234] Price op cit note 43 at 127.

contrived on account of the high rates of formal employment within the white community that could thus afford medical scheme membership costs.[235] The State, however, did not anticipate that there would be a drastic surge in medical scheme membership in the black community that would undermine its goals of racial discrimination.[236] The surge was fuelled by private businesses electing to contribute towards their black employees' medical scheme membership costs.[237] The actions of these businesses were not altruistic. Instead, these efforts were motivated by private businesses' own self-interests to improve profitability in three different ways. First, these contributions provided a means to improve international investment by illustrating that these businesses condemned racial discrimination.[238] Secondly, these businesses invested in the health of their skilled black labourers, who were too expensive to replace.[239] Thirdly, these contributions reduced expenses by shortening the duration of labour strikes by capitulating to trade unions' demands for better employment terms for black workers, such as medical scheme membership.[240] Nevertheless, racially discriminatory practices permeated the medical scheme sector as the black communities' healthcare benefits were significantly less than their white counterparts.[241]

The State sought to capitalise on the increase in medical scheme membership when the political climate became more unstable. Specifically, the State sought to hoodwink the black proletariat into believing that the division in society was based on economic class rather than race.[242] This was little more than propaganda that proved to be unsuccessful at dividing the black community.[243]

### *2.3.3 Legislative measures to facilitate privatisation of healthcare*

The surge in demand for PHEs' services caused an increase in the enrolment of medical scheme memberships and medical scheme memberships provided the financial means by which PHEs

[235] Meyer op cit note 223 at 51.
[236] Naylor op cit note 230 at 677; Centre for Actuarial Research *A Historical Study of Trends in Medical Schemes in South Africa: 1974 to 1999* (2001) 18.
[237] Price op cit note 43 at 126.
[238] Levy op cit note 215 at 415-16.
[239] Price op cit note 43 at 126.
[240] Terreblanche & Nattrass op cit note 149 at 15; Price op cit note 43 at 127-128.
[241] Even access to healthcare in PHEs remained subjection to discriminatory practices as black patients were treated in separate wards to white patients. Elizabeth Thomson 'The Private Hospital Industry in the Greater Cape Town Area' (1984) 66 *South African Medical Journal* 17 at 18.
[242] Price op cit note 43 at 124; Delobelle op cit note 46 at 178-9.
[243] Ibid.

could proliferate.[244] Therefore, the drastic uptake in medical scheme memberships and the expansion of PHEs were mutually beneficial. Nevertheless, the State sought to ensure that the private sector flourished by enacting a legislative framework to support its privatisation efforts.

The Health Act 63 of 1977 ('the Health Act') was enacted in pursuit of the privatisation of hospital services.[245] While the Act governed the licensing and expansion of PHEs, regulation of these hospitals was often only piecemeal and formalistic.[246] Consequently, adverse practices such as poaching healthcare personnel from public hospitals and the continued development of PHEs in the geographical confines of wealthy white urban areas went unchecked.[247] The geographical concentration was attributed, in part, to Provincial Departments of Health ('PDoH') maliciously preventing PHEs from accessing information on healthcare planning.[248] The acrimony between these PDoH and PHEs stemmed from the State's decision to defund public hospitals and PHEs' pilfering of public healthcare personnel.[249] Accordingly, these PDoH, that were tasked with overseeing public hospitals, withheld information on healthcare planning due to their inability to challenge PHE's growing dominance.[250] Thus the enactment of the Health Act and the State's policies that sought to undermine public hospitals exacerbated the fragmentation of healthcare services.[251]

The State subsequently amended the MSA 1967 in support of its privatisation efforts.[252] These amendments emanated from ongoing discontent with the State's control over healthcare providers' fees.[253] The first amendment abolished RAM's authority to determine reimbursement tariffs.[254] This amendment stemmed from providers' refusal to abide by the

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[244] Price op cit note 43 at 126; Thomson op cit note 241 at 17 and 20.
[245] Charles Ngwena 'Equity and the Development of the South African Healthcare System: From the Public Health Act of 1919 to the Present Day' (2003) 8 *Fundamina a Journal of Legal History* 121 at 131; Van Rensburg & Harrison op cit note 47 at 113.
[246] In terms of section 44 of the Health Act 63 of 1977, the Minister of Health was vested with the authority to promulgate regulations for the administration of PHEs. The Health Act regulations in GN 158 *GG* 6832 of 1 February 1980. This regulation was amended on three occasions in GN 696 of 3 April 1980, GN 2687 of 16 November 1990, and GN 434 of 19 March 1993.
[247] Thomson op cit note 241 at 18.
[248] Max Price 'The Consequences of Health Service Privatisation for Equality and Equity in Health Care in South Africa' (1988) 27 *Social Science and Medicine* 703 at 703.
[249] Thomson op cit note 241 at 19.
[250] Ibid.
[251] Attempts to unify the health system by appointing the Regional Health Organisation of Southern Africa in 1979 and the National Health Service Plan in 1980 were unsuccessful as State policy focused on white supremacy. Van Rensburg & Harrison op cit note 47 at 101-102; Price op cit note 43 at 121.
[252] Department of Health op cit note 10 at 23.
[253] Doctors viewed the Medical Schemes Act of 1967 as autocratic and aimed to manipulate and control of their profession. Roex op cit note 62 at 262; Competition Commission op cit note 10 at 44.
[254] RAMs' authority was limited to recommending reimbursement tariffs that were not binding on either medical schemes or providers. Medical Schemes Amendment Act 51 of 1978.

tariff that RAMs had determined.[255] The second amendment enabled providers to submit their accounts directly to medical schemes for reimbursement.[256] The third amendment re-established provisions that permitted medical schemes to pay providers directly, regardless of the tariff they charged.[257]

After the MSA 1967 was amended, healthcare providers' reimbursement tariff was determined through direct negotiations with providers and medical schemes.[258] The increased administrative demands associated with these tariff negotiations acted as a catalyst for medical schemes to outsource their administration services.[259] These administration companies ('Administrators') provided specialised services and were thus more adept and efficient at managing medical schemes' administrative operations.[260] The appointment of these Administrators successfully curtailed medical schemes' administration costs.[261] Over time, Administrators began investing in medical schemes to increase their profitability.[262] To secure their investment, Administrators appointed their own employees to manage medical schemes.[263] This cross-directorship undermined these medical schemes' autonomy and thus dampened the efficiency that occurs in a perfectly competitive market.[264] The State's failure to prevent this conduct is a systematic issues that plagues the prevailing health system.

Notwithstanding the reduction in administration costs, direct tariff negotiations with providers failed to contain healthcare costs.[265] This was because the legislative framework encouraged the use of hospital services which enabled PHEs to become the dominant healthcare provider.[266] Furthermore, the framework promoted the overserving of patients as the geographical concentration of PHEs stimulated supply-induced demand.[267] Ultimately, the private sector 'was perceived to be in crisis' due to these high costs.[268] To retain their profits, medical schemes passed these costs onto their members through increases in membership

[255] Department of Health op cit note 20 at 22-23; Competition Commission op cit note 12 at 28.
[256] Medical Schemes Amendment Act 42 of 1980; Competition Commission op cit note 10 at 29.
[257] Medical Schemes Amendment Act 59 of 1984; Competition Commission op cit note 168 at 29.
[258] Department of Health op cit note 20 at 23; Van den Heever op cit note 160 at 28.
[259] Competition Commission op cit note 10 at 39; Competition Commission op cit note 168 at 28-29.
[260] Ibid.
[261] Medical schemes had previously experienced financial losses due to high administrative costs. Verhoef op cit note 58 at 618; Naylor op cit note 230 at 675.
[262] Competition Commission op cit note 10 at 39.
[263] Ibid.
[264] Michele Grillo 'Market Competition, Efficiency and Economic Liberty' (2023) 70 *International Review of Economics* 437 at 442.
[265] Price op cit note 248 at 704.
[266] Naylor op cit note 230 at 674; Department of Health op cit note 20 at 63.
[267] Ibid.
[268] Jonathan Broomberg, Cedric De Beer & Max Price 'The Private Healthcare Sector in South Africa – Current Trends and Future Developments' (1990) 78 *South African Medical Journal* 139 at 139.

fees.[269] This resulted in a decline in medical scheme membership.[270] Consequently, the State appointed a commission of inquiry to determine how to expand its healthcare privatisation efforts given the diminished rate of medical scheme membership.[271] The main thrust of the commission's recommendations was orientated towards the de-regulation of the private sector. These recommendations included the removal of the legislated minimum benefits that medical schemes were required to provide members and by changing the basis for determining membership fees from solidarity to mutuality.[272] It was reasoned that such reform would make membership fees more affordable and increase the financial viability of medical schemes.[273] The State enacted these amendments before the election of the first democratic government in 1994.[274] The amendments were premised on the notion that deregulation would enable medical schemes to contain healthcare costs.[275] These notions were incorrect as healthcare prices continued to escalate.[276]

## 2.4 CONCLUSION

Access to healthcare was manipulated as a political tool to uphold the white community and marginalise and subjugate the black population. This was initially blatant as political policies maliciously perpetuated ill health in the black population while simultaneously withholding access to quality healthcare services. Later, more clandestine, and sophisticated mechanisms were employed to uphold racial discrimination. The State achieved this objective by systematically dismantling access to healthcare in public hospitals to support its healthcare privatisation policies. This enabled access to quality healthcare to be sold as a commodity that only the white privileged elite could afford. Ultimately, healthcare privatisation was a façade to maintain white supremacy. Medical schemes and PHEs flourished and became a cornerstone of the health system because of these privatisation efforts. These efforts caused the health system to become highly fragmented, spurred by geographical maldistribution of healthcare

[269] Jane Doherty & Heather McLeod 'Medical Schemes' (2002) *South African Health Review Health Systems Trust* 41 at 42.
[270] Ibid.
[271] Van Rensburg & Harrison op cit note 47 at 101.
[272] Broomberg, De Beer & Price op cit note 268 at 139; Doherty & McLeod op cit note 269 at 142.
[273] Council for Medical Schemes *Report of the Registrar of Medical Schemes* (31 December 1993) 3-4.
[274] The Medical Schemes Amendment Act 23 of 1993; Doherty & McLeod op cit note 269 at 143.
[275] Broomberg, De Beer & Price op cit note 268 at 139; Department of Health op cit note 20 at 27.
[276] Di McIntyre 'Financing and Expenditure' (1995) *South African Health Review: Health System's Trust* 134 at 138; Debbie Pearmain 'Impact of Changes to the Medical Schemes Act' (2000) *South African Health Review Health Systems Trust* 183 at 196.

providers, and encouraged by an increase in the costs of healthcare services. Cumulatively, the ramifications of the State's bureaucratic management of healthcare were responsible for the dysfunction in the prevailing health system. The analysis in this chapter thus reveals the need for and extent of reform that is required to address this tendentious legacy of racial exclusion and marginalisation.

## CHAPTER 3: HEALTHCARE IN A DEMOCRATIC SOUTH AFRICA

During the period of 1990 to 1994, the State engaged in negotiations with political dissidents to bring a peaceful end to apartheid.[277] The subsequent election of a democratic government ('government') heralded a new dispensation that was governed by a constitutional framework that is based on equality and fundamental socio-economic rights.[278] Government was hence charged with 'fundamentally reforming the entire policy tapestry' to achieve the transformation envisioned by the Constitution of the Republic of South Africa, 1996.[279] This transformation was guided by socio-economic rights that included the right of access to healthcare ('the right to healthcare').[280] Given the scope of this mandate, government had to overhaul the health system to address the vast inequalities in access to healthcare. This entailed redress to unify the fragmented health system, improve the quality of healthcare in the public sector, diversify the geographical distribution of healthcare providers, and contain the high costs of healthcare services that were inherited from the previous dispensation.[281]

This chapter will consider whether government has successfully transformed the health system to contend with its sordid history. This analysis will be divided into four sections that shall canvass the effects of government's stewardship and legislative reform. The first section will canvass what obligations the right to healthcare entails and what protection it provides its beneficiaries. This will briefly consider government's overarching strategy to fulfil this right. A more detailed analysis of reform to the legislative framework governing private funders and PHEs will then be considered. This review aims to determine whether the regulation of these stakeholders has been transformed to contend with their disreputable historical development and whether legislative reform has promoted or impeded access to healthcare. Finally, this chapter will consider the principal obstacle to realising the right to quality healthcare, namely the high costs of healthcare services. Ultimately this analysis will determine whether

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[277] Iain Currie & Johan De Waal *The New Constitutional and Administrative Law* 1 ed (2002) 59; Robert P. Inman & Daniel L. Rubinfeld 'Understanding the Democratic Transition in South Africa' (2013) 15 *American Law and Economics Review* 1 at 2.
[278] Tom Lodge 'The South African General Election, April 1994: Results, Analysis and Implications' (1995) 94 *African Affairs* 471 at 471; Section 9 of the Constitution.
[279] Brauns op cit note 19 at 103.
[280] Section 27(1)(*a*) of the Constitution; Marius Pieterse 'What Do We Mean When We Talk about Transformative Constitutionalism?' (2005) 20 *South African Public Law* 155 at 155-157.
[281] United Nations Research Institute for Social Development op cit note 20 at 8; African National Congress *A National Health Plan for South Africa, Johannesburg* (1994) 33; Broomberg, De Beer & Price op cit note 268 at 139.

government has successfully resolved disparities in access to healthcare and has thus met its constitutional mandate.

## 3.1 THE RIGHT TO HEALTHCARE

The right to healthcare encompasses specific components that confer obligations on the government for its fulfilment. However, the realisation of this right is impeded by resource constraints. Thus, government needed to formulate a strategy to navigate these resource limitations while still meeting its mandate to progressively realise its constitutional mandate. Each of these factors is expanded on below.

### *3.1.1 Obligation to respect, protect, promote, and fulfil the right to healthcare*

Government is mandated to achieve the transformative vision espoused by the Constitution. The socio-economic rights that are enshrined in the Constitution were prioritised to transcend the injustices of the past to achieve this metamorphosis.[282] These fundamental rights, which includes the right to healthcare, are intended to improve South Africans' quality of life based on a society that prioritises equality and dignity.[283]

In order to achieve its constitutional mandate, government is required to respect, protect, promote, and fulfil the right to healthcare.[284] The duty to respect requires that government 'refrain from infringing on existing rights' and entitlements to healthcare.[285] Government also holds a corresponding positive duty to realise the right to healthcare. This is premised on the conception that injustices that were entrenched by the previous dispensation cannot be overcome without 'positive action being taken' to reform the health system.[286] Accordingly, the obligation to protect and promote the right to healthcare requires that government take 'deliberate and reasonable measures' to progressively realise this right.[287] This imposes an obligation to establish comprehensive and coordinated legislative frameworks to regulate the

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[282] Etienne Mureinik 'Beyond a Charter of Luxuries: Economic Rights in the Constitution' (1992) 8 *SAJHR* 464 at 468-469.
[283] *Soobramoney v Minister of Health* 1998 (1) SA 46 (CC) para 8; Pieterse op cit note 280 at 155-58.
[284] Section 7(2) of the Constitution.
[285] Du Toit op cit note 70 at 37, S. Liebenberg 'The Interpretation of Socio-economic Rights' Stu Woolman & Michael Bishop (eds) *Constitutional Law of South Africa* 2 ed (2012) 151-154; *Law Society of South Africa v Minister of Transport* 2001 (1) SA 400 (CC) para 98.
[286] *Bato Star Fishing (Pty) Ltd v Minister of Environmental Affairs* 2004 (4) SA 490 (CC) para 74.
[287] *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) para 41; *Soobramoney* (supra) note 283 para 29; *Glenister v President of the Republic of South Africa* 2011 (3) SA 347 (CC) para 105.

health system, especially within the private sector.[288] Finally, the obligation to fulfil demands that government ensure that healthcare services are accessible.[289] This requires breaking down any barriers that prevent access to healthcare.[290]

### *3.1.2 The impact of resource constraints on the benefits provided by the right to healthcare*

The right to healthcare is considered a qualified socio-economic right,[291] and as such, it does not confer immediately claimable entitlements to healthcare services.[292] Therefore beneficiaries of this right cannot demand immediate access to healthcare. Rather the progressive realisation of this right, and thus material fruition of benefits, is dependent to the availability of resources.[293] Consequently, this right does not bestow minimum core entitlements.[294]

While resource constraints are the main impediment to realising the right to healthcare,[295] such limitations do not excuse government from meeting its constitutional mandate. Instead decisive and expeditious action is required to overcome this impediment.[296] Failure to take such action should not be condoned in the absence of evidence that government has enacted a framework to maximise the use of existing resources.[297] The use of resources is maximised when they are utilised efficiently and are distributed equitably.[298] The credibility of the

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[288] This positive duty necessitates a strong legislative to guard against interference with the right to healthcare from non-state actors, including the private sector. Section 27(2) of the Constitution; Adila Hassim, Mark Heywood & Jonathan Berger *Health and Democracy: a Guide to Human Rights, Health Law and Policy in Post-Apartheid South Africa* (2007) 33.

[289] Du Toit op cit note 70 at 39.

[290] D. Bilchitz 'Health' in S Woolman, Theunis Roux & Michael Bishop (eds) *Constitutional Law of South Africa* 2 ed (2012) 39.

[291] Liebenberg op cit note 8 at 163-165.

[292] *Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC) para 26 and 93.

[293] Section 27(2) of the Constitution.

[294] Sandra Liebenberg *Socio-Economic Rights Adjudication Under a Transformative Constitution* (2010) 148; *Grootboom* (supra) note 287 para 33.

[295] Resource constrains are inherent to health systems across the world. Jishnu Das, Liana Woskie & Ruma Rajbhandari et al 'Rethinking Assumptions about Delivery of Healthcare: Implication for Universal Health Coverage' (2018) 361 *Bio-medical Journal* 1 at 1; *R v Cambridge Health Authority, Ex Parte B* (1995) 2 All ER 129 (CA) 137d-g.

[296] Christopher Mbazira *Litigating Socio-Economic Rights in South Africa: A Choice Between Corrective and Distributive Justice* (2009) 134.

[297] The court's decision in *Soobramoney* illustrated a deference to government's discretion on how to allocate resources. However, this was premised on clear evidence that resource allocations were reasonable. *Khoza v Minister of Social Development, Mahlaule v Minister of Social Development* 2004 (6) SA 505 (CC) para 60 and 62; Christof Heyns & Danie Brand 'Introduction to Socio-Economic Rights in the South African Constitution' (1998) 2 *Law, Democracy & Development* 153 at 159-160, and 163-64.

[298] Pieterse op cit note 5 at 98.

Constitution, and the socio-economic rights it protects, would be undermined if government's failure to maximise the use of resources was simply condoned.[299]

### *3.1.3 Government's strategy to fulfil its constitutional mandate*

When government assessed its duty to realise the obligations prescribed by the Constitution, it determined that it was unable to meet the demand for healthcare due to ongoing fiscal constraints and political instability.[300] Accordingly, it chose to focus on economic reform to fulfil its constitutional mandate.[301] Government reasoned that equality could be achieved by redistributing wealth through employment opportunities to uplift the poor.[302] Based on this reasoning, government committed to the privatisation of industries to propel social reform.[303] However, unlike the apartheid regime, government undertook to re-regulate the health system to outline the obligations and duties of all stakeholders, including private funders and PHEs, to assist in the progressive realisation of the right to healthcare.[304]

Government, however, could not rely solely on privatisation due to pervasive poverty.[305] Therefore it had to finance the costs of healthcare services for the poor. Government sought to reform the public sector to achieve this mandate by reorientating funding from public hospitals to preventative clinics to maximise its limited budget for public healthcare.[306] This reduction in funding exacerbated overcrowding in public hospitals and encouraged a mass exodus of healthcare professionals who migrated to the private sector.[307] The consequences of this policy decision culminated in a 'a full blown crisis' in the public sector that led to a drastic decrease

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[299] Heyns & Brand op cit note 297 at 154.
[300] White Paper on Reconstruction and Development (GN 1954 *GG* 16085 of 23 November 1994) 22; Melody Brauns & Anne Stanton 'Reforming the Health Sector in South Africa – Post 1994' (2015) 5 *Risk Governance and Control: Financial Markets & Institution* 167 at 171.
[301] Ibid.
[302] United States Agency for International Development *The Dynamics of Policy Change: Health Care Financing in South Africa, 1994 to 1999* (1999) 41; Department of Health *White Paper on the Transformation of the Health Systems of South Africa* (1997) 5.
[303] Department of Health Ibid.
[304] Sandra Liebenberg 'The Protection of Economic, Social and Cultural Rights in Domestic Legal Systems' in A Eide, C Krause, A Rosas (eds) *Economic, Social, and Cultural Rights* (2001) 79; Sandra Liebenberg 'The Application of Socio-Economic Rights to Private Law' (2008) 3 *The South African Law Journal* 464 at 471; *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd* 2012 (2) SA 104 (CC) para 56.
[305] The Constitutional Court has held that 'unfair discrimination exists on the basis of poverty' which contravenes the socio-economic rights that are protected by the Constitution. *Social Justice Coalition v Minister of Police* 2022 JDR 2047 (CC) para 6; Fortuin, Grebe, & Makoni op cit note 3 at 243.
[306] Brauns & Stanton op cit note 300 at 168.
[307] Ranchod, Adams & Aryankhsesal op cit note 227 at 102; *Law Society of South Africa* (supra) note 285 para 95.

in the average life expectancy and caused the child mortality rate to double.[308] The public sector's inability to meet the basic quality healthcare standards is attributed to this policy mistake.[309] This stewardship of the public sector not only spurred the expansion of the private sector, by driving an increase in demand for services rendered by private healthcare providers but also perpetuated the fragmentation of the health system.[310] Therefore government's injudicious stewardship entrenched the bifurcation of the two-tier health system, divided between a well-resourced private sector and an over-burdened and under-resourced public sector.[311]

## 3.2 PRIVATE FUNDERS

Government's drive to facilitate healthcare privatisation endorsed the notion that access to healthcare should be sold as a commodity by perpetuating the ideology that individuals should take responsibility to finance their healthcare costs.[312] As medical schemes were the core financing mechanism for the private sector, government encouraged the use of voluntary membership with these private funders to spur its privatisation efforts.[313] The Medical Schemes Act 131 of 1998 ('MSA 1998') was thus enacted to regulate private funders, including medical schemes, medical scheme administrators ('Administrators'), and Managed Care Organisations.[314] Ultimately the MSA 1998 sought to expand the medical scheme market.[315] This section shall canvass the changes to the legislative framework as well as detail how government's indifference undermined the advancement of the right to healthcare.

### *3.2.1 Changes to the legislative framework regulating private funders*

When the democratic government was elected, the Medical Schemes Amendment Act 23 of 1993 ('MSA 1993') was the prevailing legislation that regulated private funders.[316] This Act

[308] Chopra, Lawn & Sanders op cit note 22 at 1023.
[309] Michael Edmeston & Kate Francis 'Beyond Band-Aids: Reflection on Public and Private Health Care in South Africa' research for the Helen Suzman Foundation available at *https://admin.hsf.org.za/publications/focus/focus-67/MEdmeston_KFrancis.pdf,* accessed on 25 November 2023; Siva Pillay 'Will our Public Healthcare Sector Fail the NHI?' (2012) 102 *South African Medical Journal* 817 at 817.
[310] Coovadia, Jewkes & Barron et al op cit note 48 at 817 and 829.
[311] Pieterse op cit note 5 at 6.
[312] Section 23(1)(*a*)(*i*) of the National Health Act op cote note 15.
[313] Wayburne op cit note 5 at 5.
[314] Pearmain op cit note 276 at 185, 189 and 191; Section 66 of the Medical Schemes Act 131 of 1998.
[315] Department of Health op cit note 20 at 63.
[316] McLeod op cit note 172 at 144-45.

withdrew provisions that compelled medical schemes to provide minimum benefits and permitted the risk-rating of members. Risk-rating endorsed the exclusion of members if they had pre-existing conditions or high claim patterns.[317] Such prospective members were thus considered uninsurable. This not only removed the 'social protection function' that medical schemes provided but also dampened the effectiveness of cross-subsidisation as the healthy stopped subsidising the ill and infirmed.[318] Government sought to resolve these inequities by reinstating principles of solidarity when promulgating the MSA 1998.[319] This reinstatement meant that medical schemes were required to accept prospective members regardless of their health status or claim patterns.[320]

To ease the 'demand on public sector resources', the MSA 1998 re-established the requirement that medical schemes indemnify a minimum range of healthcare benefits.[321] These prescribed minimum benefits ('PMBs') were basic services that medical schemes were required to pay for healthcare services, without imposing co-payments on their members.[322] Healthcare costs increased rapidly because PMBs focused on expensive curative healthcare, rendered by PHEs.[323] Consequently, it was recommended that the legislative framework governing PMBs be amended to migrate from curative healthcare services to cost-effective preventative healthcare.[324] These high costs for healthcare services constrained the growth of the medical scheme market which was contrary to the basic precepts of government's privatisation efforts.[325] Nevertheless, government disregarded this recommended reform to reorientate the health system to curb healthcare costs. Rather, government elected to encourage the proliferation of the medical scheme market by making provision for low-costs-medical-schemes ('LCMS') in the MSA 1998.[326] Instead of indemnifying PMBs, LCMS catered for

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[317] Competition Commission op cit note 10 at 144.
[318] Effective cross-subsidisation incorporates risk-subsidisation in the form of the young subsidising the old and the healthy subsidising the sick and income-subsidisation in the form of the rich subsidising the poor. Doherty & McLeod op cit 269; Department of Health op cit note 20 at 26.
[319] White Paper *Transformation of the Health System* op cit note 302 at 29.
[320] Section 29(1)(*n*) of the Medical Schemes Act op cit note 314; McLeod op cit note 169 at 142; *Steyn v Registrar of Medical Schemes* 2021 (3) SA 551 (WC) para 39-40; *Govender NO v Profmed Medical Scheme* unreported case no A900/2008 (30 November 2011) para 53.
[321] Regulation 7 and 8 and annexure A to the Regulations in GNR 1262 of 20 October 1999; Brauns & Stanton op cit note 300 at 187; Department of Health *The Determination of the Formula for the Risk Equalization Fund in South Africa* (2004) 6.
[322] Regulation 8 to the Medical Schemes Act regulations in GN 540 in *GG* 23379 of 30 April 2002; *Council for Medical Schemes v Genesis Medical Scheme* 2016 (1) SA 429 (SCA) para 28.
[323] Competition Commission op cit note 168 at 34 and 115.
[324] Ibid 237-38.
[325] National Assembly *Medical Research Council, Council for Medical Schemes & Office of Health Standards Compliance on their 2015 Strategic Plans* (15 April 2015) 2.
[326] Section 8(h) of the Medical Schemes Act op cit note 314.

limited preventative healthcare benefits.[327] These LCMS have been criticised for undermining the risk cross-subsidisation that is essential for the viability of the medical scheme market.[328] This criticism, however, appears to be moot as the expansion of the LCMS market has been impeded by regulatory failures in the private funder's market.[329]

Notwithstanding the enactment of the MSA 1998, government undermined effective cross-subsidisation by permitting medical schemes to provide different benefit options.[330] These different benefit packages included provision for PMBs and a separate savings account for non-PMB healthcare services.[331] Medical schemes motivated the use of savings accounts to discourage members from seeking unnecessary healthcare services.[332] These benefit packages, however, encouraged an adverse selection phenomenon where the young and healthy purchased low-cost packages while the ill and elderly opted for expensive benefit packages.[333] Adverse selection subverted the core aim of the MSA 1998 which sought to maximise the use of resources by encouraging competition based on improved efficiency within the medical schemes market rather than their member's self-assessed risk profiles.[334] It was thus proposed that different benefit options either be phased out,[335] or alternatively, that the savings account for non-PMB treatment be separated and regulated in terms of the Short-term Insurance Act 53 of 1998.[336] Government again failed to amend the regulatory framework to implement either of these recommendations.

Additional proposals to reform the legislative framework governing medical schemes were proposed. These proposals included that a Risk Equalisation Fund ('REF') be established.[337] The primary objective of the REF was to refine cross-subsidisation, enhance the efficiency of medical scheme operations, and improve the sustainability of the medical schemes' market in three different ways. First, the REF would improve the efficacy and

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[327] National Assembly Health Committee op cit note 325 at 2.
[328] Competition Commission op cit note 168 at 111.
[329] *Board of Healthcare Funders NPC v Council for Medical Schemes & others* unreported case no 2022/012058 (10 August 2023) para 1.
[330] By 2019 there were approximately 181 different benefit options. The multitude of benefit options stem from the incomplete regulatory framework. Competition Commission op cit note 168 at 109; Pieterse op cit note 5 at 48.
[331] Department of Health op cit note 20 at 121; Competition Commission op cit note 168 at 237-38.
[332] Department of Health op cit note 20 at 28, 87; Department of Health op cit note 321 at 9.
[333] Department of Health op cit note 20 at 64, 72-73, 91 and 123; Competition Commission op cit note 168 at 109-10 and 210.
[334] Ibid.
[335] Department of Health op cit note 20 at 141; Competition Commission op cit note 10 at 8-9.
[336] Department of Health op cit note 321 at 129 and 132-33; *Gaurdrisk Insurance Company Co Ltd v Registrar of Medical Schemes* 2008 (4) SA 620 (SCA) para 20-21; Alex Van den Heever 'Demarcations Between Medical Schemes and Health Insurance' (2014) 69 *South African Dental Journal* 344 at 334.
[337] Department of Health op cit note 321 at 131; Department of Health op cit note 20 at 72.

efficiency of cross-subsidisation by consolidating the various risk pools that were fragmented between each medical scheme into a single Fund.[338] This Fund would then allocate subsidies to each medical scheme.[339] Accordingly, the second function of the REF was to contain administrative costs as medical schemes would be compelled to improve their efficiency due to the limited subsidy that they would receive from the REF.[340] The expected decrease in healthcare costs would then reduce members' premiums and thus aid in the expansion of the medical scheme market.[341] Thirdly, the REF would enhance the sustainability of the medical scheme market by improving medical schemes' solvency.[342] Furthermore, it was recommended that a Social Health Insurance ('SHI') scheme be implemented to compel the formally employed to join medical schemes.[343] It was reasoned that the SHI would improve risk cross-subsidisation, reduce adverse selection, and thus aid with the viability and sustainability of the medical schemes market because of the rapid increase in membership.[344] Notwithstanding the significance and importance of these regulatory interventions, government was content to disregard these recommendations. Rather, government has elected to pursue reforms proposed by the National Health Insurance Bill.[345] The regulatory reforms proposed by the Bill shall be canvassed in Chapter 4.

### *3.2.2 Cumulative effects of governmental failures on the private funders market*

Notwithstanding the improvement in the demographics of medical scheme membership which has become more representative of the racial diversity in South Africa, government has failed to achieve its core objectives to expand the medical scheme market by enacting a

[338] There were approximately 76 risk pools which comprised of different medical schemes in 2020. Ibid and Council for Medical Schemes 'The Medical Schemes Industry in 2020' available at *https://www.medicalschemes.co.za/the-medical-schemes-industry-in-2020/#:~:text=How%20many%20medical%20schemes%20are,schemes%20and%2058%20restricted%20schemes*, accessed on 18 November 2023.
[339] Department of Health op cit note 321 at 131.
[340] Department of Health op cit note 20 at 63; Competition Commission op cit note 168 at 111.
[341] Department of Health op cit note 321 at 99; Department of Health op cit note 20 at 78.
[342] Each medical scheme would receive a subsidy from the REF to improve their solvency. Department of Health op cit note 321 at 130, Department of Health op cit note 20 at 145; Competition Commission op cit note 168 at 117.
[343] This mandatory membership would be introduced in phases starting with high income earners. Ultimately, the SHI would be incorporated into the envisioned National Health Insurance Fund. Department of Health op cit note 321 at 9-10, 65, 72-77, 121-27and 143; Department of Health op cit note 20 at 85, 125, 130 and 137.
[344] Department of Health op cit note 321 at 128 and 131; Department of Health op cit note 20 at 72.
[345] The Medical Schemes Amendment Bill GN 636 *GG* 41726 of 21 June 2018 made provision to establish the Risk Equalization Fund.

comprehensive framework to regulate private funders.[346] Conversely, the medical scheme market has contracted drastically since 1994.[347] This dereliction is attributed to government's ongoing disregard of prospective reforms to ameliorate the inefficiencies in the legislative framework governing private funders such as medical schemes. This has caused significant instability and contraction in the medical scheme market.[348] Consequently, the impact of government's stewardship has not only restrained the expansion of the medical scheme market but has also effectively impeded the realisation of the right to healthcare. This is exemplified by its failure to enact reform to standardise medical scheme benefit options to improve cross-subsidisation, establish the REF to improve medical schemes efficiency, and implement the SHI to expand the medical scheme market that was recommended more than two decades ago. It has thus failed to protect the right to healthcare.

### 3.3 PRIVATE HEALTH ESTABLISHMENTS

Government's commitment to healthcare privatisation was premised on reform to re-regulate healthcare providers.[349] Thus the National Health Act 61 of 2003 ('NHA') was enacted to 'provide a framework' to guide healthcare service delivery by regulating providers.[350] As hospitals are central to the health system, the NHA aimed to update the antiquated regulatory framework that had previously governed PHEs.[351] This required that government address historical issues that hindered the effective functioning and expansion of PHEs. These issues included a dearth of regulation regarding the quality of healthcare services and PHEs' geographical concentration in wealthy metropolitan areas that negatively impacted competition, cultivated the ineffective use of resources due to supply-induced demand and

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[346] Alex Van den Heever 'The Role of Insurance in the Achievement of Universal Coverage within a Developing Country Context: South Africa as a Case Study' (2012) 12 *BMC Public Health* 1 at 8.
[347] D.E. McIntyre & R.E. Dorrington 'Trends in the Distribution of South African Health Care Expenditure' (1990) 78 *South African Medical Journal* 125 at 126.
[348] The number of medical schemes decreased drastically from 2000 to 2021. *Green Paper on National Health Insurance in South Africa* (GN 657 in *GG 34523* of 12 August 2011) 11; the Council for Medical Schemes Circular 60 0f 2021 *Retrospective Evaluation of Cost Increase Assumptions by Medical Schemes for the 2021 Financial Year* (2021) 2.
[349] For example, the Pharmacy Amendment Act 88 of 1997 facilitated the expansion of pharmacies to underserviced rural areas and the Medicines and Related Substances Act in GN R553 *GG* 26304 of 30 April 2004, reduced dispensing fees to make medication more affordable. Further examples of the legislative framework include the Mental Health Care Act 17 of 2002, the Nursing Act 33 of 2005, the Prevention of and Treatment for Substance Abuse Act 70 of 2008, and the Medicines and Related Substances Control Amendment Act 59 of 2002. See also Pieterse op cit note 5 at 14.
[350] Du Toit op cit note 70 at 26-7.
[351] PHEs regulations merely prescribed the building specifications for hospitals. White Paper *Transformation of the Health System* op cit note 302 at 102 and 109; African National Congress National Health Plan op cit note 281 at 31.

overservicing, and increased healthcare costs.[352] While these objectives were well conceived, government conduct, which was characterised by lacklustre attempts to regulate PHEs, merely perpetuated inefficiencies in the health system.

### *3.3.1 Proliferation and regulation of PHEs in the post-democratic era*

It was estimated that there were more PHEs than public hospitals by 2019.[353] This was attributed to government's policies that prioritised healthcare privatisation and decreased funding for public hospitals.[354] PHE's expansion was aided by the financial stability provided by the PMB's framework that required medical schemes to pay for hospital services in full.[355] Notwithstanding the ensuing rapid expansion of PHEs, these establishments continued to operate within loose parameters with limited regulatory oversight.[356] The sole source of governance emanated from the inadvertent application of legislation that impacted PHEs' operations or through voluntary associations, such as the Hospital Association of South Africa, that provided discretionary guidelines for administration and operations.[357] Government's failure to regulate PHEs flouted the provisions of the NHA that enabled the National Department of Health ('NDoH') to plan for the efficient distribution of PHEs and the Provincial Department of Health ('PDoH') to regulate PHE licenses.[358] This dereliction frustrated the practical realisation of the right to healthcare as PHEs' obligations and duties remain undetermined.[359] Two examples of government's dereliction of duty shall be canvassed, namely, regulation of PHEs licensing and quality control assessments. Ultimately, this analysis will demonstrate that government has failed to transform the regulatory framework governing PHEs and consequently, has failed to meet its mandate to protect the right to healthcare.

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[352] Wayburne op cit note 5 at 7; White Paper *Transformation of the Health System* op cit note 302 at 102 and 109.
[353] Department of Health op cit note 20 at 10; Wayburne op cit note 5 at 7-8, Thulani Matsebula & Michael Willie 'Private Hospitals' (2007) *South African Health Review Health Systems Trusts* 159 at 159.
[354] Department of Health op cit note 20 at 62; Competition Commission op cit note 10 at 41.
[355] *Board of Healthcare Funders of Southern Africa v Council for Medical Schemes* 2012 JOL 28806 (GNP) para 18; *Margate Clinic (Pty) Ltd v Genesis Medical Scheme* 2007 (4) SA 639 para 642E; *Sechaba Medical Solutions v Sekete* 2015 JDR 0426 (SCA) para 21.
[356] M Pieterse 'Legislative and Executive Translation of the Right to have Access to Healthcare Services' (2010) 14 *Law, Democracy and Development* 231 at 238.
[357] This included the Health Profession Act 56 of 1974, as doctors drove demand for PHE treatment 'through admission, treatment and confinement choices'. Also see *Competition Commission v The Hospital Association of South Africa* unreported case no 24/CR/Apr04 (26 April 2004) para 5.2.1; Competition Commission op cit note 10 at 61.
[358] Section 36 to 40 of the National Health Act op cote note 15; White Paper *Transformation of the Health System* op cit note 302 at 13-15.
[359] Pieterse op cit note 5 at 46.

### *3.3.2 PHE Licensing framework*

Government delegated the authority to determine the PHE licensing framework to each PDoH in 1994,[360] however, only four provinces exercised this power.[361] The licensing of PHEs in the remaining five provinces remained subject to formalistic and antiquated regulations that prescribed how to apply for licenses and stipulated rudimentary building standards.[362] Governments only innovation was the creation of additional licensing procedures for PHEs that rendered specialised services.[363] These included sub-acute hospitals,[364] step-down facilities,[365] and hospitals that performed minor surgical procedures.[366] These specialised hospitals were created to containing costs by ensuring that PHEs' charges were commensurate with the type of healthcare services rendered.[367] The effect of these amendments, however, merely exacerbated the degree of fragmentation in the regulatory framework that governs the licensing of PHEs.

Accordingly, when the NHA was enacted, government undertook to reform PHEs' licensing framework.[368] Section 36 of the NHA envisioned that this reformed framework would be premised on a Certificate of Need ('CoN'). More than a decade after the NHA was enacted, the President signed a proclamation to enforce the CoN licensing framework.[369] This ratification was fatuous as government had failed to first promulgate the prerequisite

[360] Proc 152 of 1994 of 31 October 1994.
[361] Namely the Western Cape, Gauteng, Kwa-Zulu Natal, and the Free State. Western Cape Provincial Notice 187 in PN 5728 of 22 June 2001; Gauteng Provincial Notice 702 in PN 51 of 27 February 2015; and KwaZulu-Natal Health Act 1 of 2009. The promulgation of regulations in the Free State was subject to a partially successful application to review that set aside sections of the regulations. *Hospital Association of South Africa NPC v MEC for Health for the Free State Province* 2017 JDR 0803 (FB) para 5.
[362] Namely the Health Act regulations in GN 158 *GG* 6832 of 1 February 1980. This is in accordance with Section 11 of the Interpretation Act 33 of 1957 which stipulates that 'when a law repeals wholly or partly any former law … shall remain in force until the substituted provisions come into operation'.
[363] Such as Unattached Operating Theatre Units ('Day Hospitals'), Mental Healthcare Hospitals, Rehabilitation Hospitals, Step-down Facilities and Drug Treatment Centres. See for example the Mental Healthcare Act 17 of 2002 and the Prevention of and Treatment for Substance Abuse Act 70 of 2008.
[364] These are hospitals that provide 24-hour healthcare such as general sub-acute hospitals, post-natal sub-acute hospitals, Rehabilitation sub-acute hospitals, and psychiatric sub-acute hospitals. The Health Act regulations op cit note 362.
[365] For example, the licensing of residential and day care facilities for persons with mental illness or profound intellectual disabilities. National Health Act regulations in GN 218 *GG* 41498 of 16 March 2018.
[366] See section 35 of the National Health Act op cote note 15.
[367] Each PHE is allocated a practice code that corresponds with the type of healthcare services it renders. *Board of Healthcare Funders v Discovery Health Medical Scheme* 2016 JOL 35973 (GNP) para 10, 30, 38, and 44; Department of Health op cit note 20 at 95-97.
[368] Debbie Pearmain 'Health Minister's Ex-Legal Advisor Slams Certificate of Need law' (2014) 104 *South African Medical Journal* 841 at 841; Debora Pearmain *A Critical Analysis of the Law on Health Service Delivery in South Africa* (unpublished PhD thesis, University of Pretoria, 2004) 284.
[369] Proc 21 *GG* 37501 of 31 March 2014.

substantive regulations for the administration of the CoN framework.[370] Consequently, the PDoH was unable to process PHEs' licence applications.[371] In the interim, operating a PHE without the CoN was declared unlawful.[372] Consequently, the Constitutional Court set this proclamation aside.[373]

Seven years later, the requisite substantive regulation for the CoN licensing framework was gazetted.[374] Healthcare providers subsequently challenged the constitutionality of these regulations. These providers alleged that the CoN framework would impugn their right to freedom of movement, as government would dictate where providers could render services, and could arbitrarily deprive PHEs' of their rights of ownership of their facilities, as government could mero motu revoke existing licenses.[375] The court upheld these healthcare providers' contentions holding that the CoN regulations unjustifiably infringed on various constitutional rights.[376] Furthermore, the court found that the CoN framework was unreasonable as it would effectively cause a regression in access to healthcare services.[377] Consequently, the regulation was declared unconstitutional and set aside.[378]

Government's failure to modernise the licensing framework is not venial as it has exacerbated the inefficient use of resources due to PHEs' over-servicing of patients.[379] Consequently, urgent reform, in the form of constitutionally valid licensing regulations, is required. Pending such regulation, governance of PHEs' licensing will continue to be fragmented, formulistic, and antiquated. These new regulations will need to improve competitive practices within the PHE market, distribute the granting of new licenses to reduce the geographical concentration of PHEs to curb over-servicing, spur innovation, and incentivise cost-efficiency without compromising the quality of healthcare.[380] It is essential that such a framework be standardised and codified.[381] As the NDoH has insufficient capacity to

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[370] *President of the Republic of South Africa v South African Dental Association* 2015 JDR 0103 (CC) para 15.
[371] Ibid 3.
[372] Ibid 15.
[373] Ibid.
[374] National Health Act regulations in GN 528 *GG* 44714 of 15 June 2021.
[375] *Solidarity Trade Union v Minister of Health* 2022 JOL 57211 (GP).
[376] Ibid para 70, 77, 105, 113-118, 121-122 and 129.
[377] Ibid para 64-65, 70, 106, 112 and 124. This was analogous to *Minister of Health v New Clicks South Africa (Pty) Ltd* 2006 (2) SA 311 (CC) para 404 and 556.
[378] The judgment was subsequently rescinded based on a technicality regarding service on the Minister of Health. *Minister of Health v Solidarity Trade Union* 2022 JOL 57211 (GP) para 37.
[379] Competition Commission op cit note 168 at 81-7; Competition Commission 'Proposed Regulatory Interventions for Licensing' available at *https://www.compcom.co.za/wp-content/uploads/2020/02/Netcare-Regulatory-Presentation-Licensing-01-March-2018.pdf*, accessed on 12 August 2022.
[380] Ibid.
[381] There have been historical issues with fragmented and inconsistent enforcement of the provincial licensing framework. See for example *Member of the Executive Council for Health, Eastern Cape v Kirkland Investments (Pty) Ltd t/a span Eye and Lazer Institute* 2014 (5) BCLR 547 (CC).

adequately formulate and implement a centralised national plan for PHE licensing, it was recommended that a new regulatory authority be established to regulate this process.[382] However, four years later, government has yet to initiate the required reform to the licensing framework.

### *3.3.3 Regulation of the quality of PHEs services*

Regulating the quality of healthcare is more nuanced than merely assessing the standards of healthcare services. Instead, it should aims to promote the efficient use of resources by establishing and implementing standardised treatment protocols.[383] Accordingly, quality regulations ultimately promote access to healthcare services by maximising the use of scarce resources.[384] In stark contrast, government has permitted PHEs to operate inefficiently, which is evidenced by the prevalence of over-servicing of patients for financial gain.[385] Consequently, the use of resources has not been maximised to expand access to healthcare.[386] This wasteful use of resources is attributed to government's failure to regulate the quality of healthcare services which is an integral part of its constitutional mandate.[387]

Governments conduct, over a span of nearly three decades, demonstrates a remarkable lack of interest in regulating PHEs. This is exemplified by the two-decade delay in creating the legal framework to control the calibre of healthcare services. Specifically, while the National Health Amendment Act 12 of 2013 established the Office of Health Standards Compliance ('OHSC'), the requisite Norms and Standards Regulations for enforcement were only gazetted in 2018.[388] In an unanticipated turn of events, government failed to enforce these Norms and Standards Regulations in PHEs.[389] This failure exacerbated the degree of fragmentation between public hospitals and PHEs.

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[382] Competition Commission op cit note 168 at 85-7, 101-102, 211-218.
[383] Stuart Whittaker et al 'Quality Standards for Healthcare Establishments in South Africa' (2011) *South African Health Review Health Systems Trust* 59 at 60.
[384] Anubha Aggarwal, Himanshu Aeran & Manu Rathee 'Quality Management in Healthcare: The pivotal Desideratum' (2019) 19 *Journal of Oral Biology and Craniofacial Research* 180 at 180.
[385] Competition Commission op cit note 10 at 319.
[386] Pieterse op cit note 5 at 98.
[387] Marius Pieterse 'Indirect Horizontal Application of the Right to have Access to Health Care Services' (2007) 23 *SAJHR* 157 at 157.
[388] National Health Act regulations in GN 67 *GG* 41419 of 2 February 2018; Winnie Moleko, Elliot Bafana Msibi & Carol Marshall 'Recent Developments in Ensuring Quality of Care in Health Establishments in South Africa' (2014) *South African Health Review Health Systems Trust* 25 at 28.
[389] Hospital Association of South Africa 'Quality Measurement and Reporting in the South African Private Hospital Industry' at 15 available at *https://hasa.co.za/wp-content/uploads/2017/09/Final-Insight-Report-HASA-Quality-Measurement-Report-Updated-20170901.pdf*, accessed on 12 August 2022.

In a frenzied attempt to rectify these delays, government published the draft National Quality Improvement Plan and the Ideal Hospital Realisation and Maintenance Framework in 2018.[390] These policies sought to improve the use of resources and the quality of healthcare services.[391] But yet again, government failed to enforce these policies in PHEs. The lack of regulatory oversight over the quality of PHEs healthcare services led to the formation of voluntary associations, such as the Council of Health Service Accreditation of South Africa ('COHSASA').[392] While these associations have attempted to unify PHEs' operations,[393] enforcement of their quality assessment measures remains discretionary.[394]

Given government's ongoing failures, it was recommended that healthcare quality assessments be delegated to a new regulatory authority.[395] The OHSC would, however, monitor compliance with the Norms and Standards Regulations, once implemented in PHEs.[396] In keeping with its idiosyncrasies, government disregarded these recommendations. Consequently, PHEs continue to utilise resources inefficiently and are plagued with increasing costs due to over-servicing. This prevents the majority of South Africans from obtaining healthcare services rendered by PHEs.

### *3.3.4 Cumulative effects of governmental failures on PHEs*

Government's stewardship of the PHEs is characterised by a failure to establish the regulatory framework for licencing and inadequate implementation of quality control regulations. It has thus failed to establish a coherent framework to effectively regulate these establishments. Consequently, PHEs are effectively unregulated which creates uncertainty regarding their constitutional obligations. The ramifications of this dereliction has impeded the progressive

[390] National Department of Health *Ideal Hospital Realisation and Maintenance Framework Manuel* (2018); National Department of Health *National Health Quality Improvement Plan* (2021).
[391] Andy Gray & Yousuf Vawda 'Health Legislation and Policy' (2019) *South African Health Review Health Systems Trust* 3 at 10.
[392] Kerrin Begg, Punithasvaree Mamdoo & Lilian Dudley et al 'Development of a National Strategic Framework for a High-Quality Health System in South Africa' (2018) *South African Health Review Health Systems Trust* 77 at 80.
[393] COHSASA is an NGO that represents a collaborative initiative in academics and the private sector that is endorsed by the International Society for Quality in Healthcare. Stuart Whittaker et al 'Status of a Healthcare Quality Review Programme in South Africa' (2000) 12 *International Journal for Quality in Health Care* 247 at 248 and 250.
[394] Begg, Mamdoo & Dudley op cit note 392 at 79-80.
[395] Competition Commission op cit note 168 at 202.
[396] Gray op cit note 391 at 9; Competition Commission op cit note 168 at 202-204 and 212.

realisation of the right to healthcare as PHEs continue to utilise resources inefficiently.[397] Therefore government has failed to meet its constitutional mandate.

## 3.4 HIGH COSTS OF PRIVATE HEALTHCARE

The private sector consumes approximately half of all revenue that is raised for healthcare due to excessive costs.[398] Nevertheless, it only renders services to less than 20 per cent of the population.[399] Due to pervasive poverty, the majority of South Africans are unable to access quality healthcare rendered in the private sector.[400] Instead, access to healthcare is sold as a commodity through medical scheme membership that remains the purview of the wealthy.[401] However, as membership premiums continue to exceed inflation, access to the private sector is becoming increasingly unaffordable, even for more affluent sections of the population.[402] Accordingly, high costs not only hinder access to healthcare services but jeopardise the sustainability of the entire private sector.[403]

Government is mandated to fulfil the right to healthcare by eliminating barriers to access services.[404] This includes ensuring that access to quality healthcare is affordable by dismantling the financial barriers that restrict access to healthcare. Reducing these financial barriers requires that government effectively regulate the private sector to contain costs as a mechanism to expand access to healthcare.[405] This section will explore how government's dereliction has contributed to the present healthcare costs crisis.

### *3.4.1 Reimbursement models*

Private healthcare costs have historically been determined on a fee-for-service ('FFS') basis.[406] FFS are tariffs that are based on the medical procedure or product that is determined 'without

[397] Pieterse op cit note 5 at 48.
[398] 'South Africa's private hospitals charge prices comparable with countries that are considerably richer'. Sarah Barber, Ankit Kumar & Tomas Roubal et al 'Harnessing the Private Healthcare Sector by using Prices as a Policy Instrument: Lessons Learned from South Africa' (2018) 122 *Journal of Health Policy* 558 at 558.
[399] Ibid.
[400] Fortuin, Grebe & Makoni op cit note 3 at 243.
[401] Barber, Kumar & Roubal op cit note 398.
[402] Council of Medical Schemes Circular 60 of 2021 *Retrospective Evaluation of Cost Increase Assumptions by Medical Schemes for the 2021 Financial Year* (2021) 2; Competition Commission op cit note 12 at 69-70.
[403] Ibid.
[404] Bilchitz op cit note 290.
[405] Pieterse op cit note 387 at 157; N Kirby 'Access to Healthcare Services as a Human Right' (2010) 29 *Medicine and Law* 487 at 489; White Paper *Transformation of the Health System* op cit note 302 at 11.
[406] Competition Commission op cit note 10 at 42 and 50.

reference to the volume and quality of service rendered'.[407] This tariff determination has been criticised for fostering perverse incentives which resulted in the over-servicing of patients.[408] Therefore FFS not only undermines the effective utilisation of healthcare resources but also jeopardises the sustainability of the private sector.[409] Accordingly, government undertook to implement reforms to transform the reimbursement framework by migrating to alternative strategic purchasing models such as Designated Service Provider agreements ('DSP'),[410] Alternative Reimbursement Models ('ARMs')[411] and Managed Care Organisations ('MCO').[412]

The MSA 1998 regulates DSPs as a mechanism to contain healthcare costs.[413] DSPs consist of Preferred-Provider-Network agreements ('PPNs') with healthcare providers, who charge reduced tariffs in exchange for an increase in the volume of patients.[414] Medical schemes incentivise the use of DSPs by imposing co-payments on members who utilise healthcare providers that are not part of the PPN.[415] The value of DSPs, as a means to reduce healthcare costs, has been undermined by market-dominant healthcare providers, especially PHEs, that command the majority of PPNs.[416]

ARMs aim to contain healthcare costs by capping the tariff for healthcare services.[417] This compels healthcare providers to provide cost-effective services.[418] This is achieved by transferring any risk of inefficiencies, that invariably increase healthcare costs, to the

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[407] Michael Porter & Robert Kaplan 'How to Pay for Health Care' *Harvard Business Review* July-August 2016, available at *https://hbr.org/2016/07/how-to-pay-for-health-care,* accessed on 23 July 2023.

[408] Although fee-for-service tariff may create perverse incentives that lead to over-servicing, the practice of defensive medicine, where doctors aim to mitigate potential malpractice liabilities, is also likely to contribute to this phenomenon. Gboyega Ogunbanjo & Donna Knapp van Bogaert 'Ethics in Health Care: the Practice of Defensive Medicine' (2014) 56 *South African Family Practice* 56 at 56; Competition Commission op cit note 10 at 319.

[409] Competition Commission op cit note 168 at 227.

[410] Competition Commission op cit note 10 at 52.

[411] Marine Erasmus & Nicola Theron 'Market Concentration Trends in South Africa's Private Healthcare Sector' (2016) 19 *South African Journal of Economics and Management Sciences* 53 at 61.

[412] MCOs are tasked with negotiating tariffs, ARMs and DSPs with healthcare providers. Their operations were initially regulated by section 20B(5)(aA) of the Medical Schemes Act 23 of 1993. Later, provision for MCOs were incorporated in the definition of 'business of a medical scheme' in section 1 of the Medical Schemes Act op cit note 314.

[413] Regulation 7, 8(2) and (3) of the Medical Scheme Act regulations op cit note 321; Department of Health of cite note 319; Competition Commission op cit note 168 at 80.

[414] Ibid.

[415] Council for Medical Schemes Appeals Committee in *Medical Scheme and the Registrar of Medical Schemes* available at *https://www.medicalschemes.com/files/Judgements%20on%20Appeals/SSvsDiscovery.pdf*; unreported case by the Council for Medical Schemes Appeals Committee *Discovery Health Medical Scheme v Registrar of Medical Schemes and B* available *at http://www.medicalschemes.com/files/Judgements%20on%20Appeals/DiscoveryNRegistrarNB2012.pdf;* Regulation 8(3)(a) to (c) and 8 (5) of the Medical Scheme Act regulations op cit note 321.

[416] Competition Commission op cit note 168 at 226.

[417] Ibid at 225-227.

[418] Ibid.

healthcare providers.[419] Accordingly, ARMs curb perverse incentives that are fostered under the FFS model.[420] There are several forms of ARMs such as bundled payments,[421] capitation,[422] and value-based-reimbursement ('VBR').[423] Nevertheless, private funders are constrained to conclude ARMS with healthcare providers due to the Competition Act 89 of 1998 ('Competition Act') that prohibits collusive price setting conduct.[424] Accordingly, reforms were recommended to bolster the use of ARMS. These reforms include the establishment of an Outcome Measurement and Reporting Organisation ('OMRO') that will collect and collate data on the quality of healthcare providers' performance to distribute to private funders to conclude ARMs. It has been further recommended that an independent Multilateral Tariff Negotiation Forum ('MTNF') be established to replace the bilateral negotiations between private funders and providers.[425] A further statutory body, the Supply-side Health Regulator ('SSHR'), would then be established to set the parameters for tariff negotiations.[426] The SSHR would also be responsible for considering and ratifying any ARM contract that may be concluded.[427] Despite undertaking to transform the reimbursement framework, government has failed to establish the OMRO, the MTNF, and the SSHR to bolster the use of ARMs.[428]

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[419] Ibid.

[420] Ibid 225-226.

[421] Bundled payments include fixed-fee agreements such as Diagnosis-Related-Groups that are based payments that cap the fee that medical schemes pay providers. Such payment may, however foster barriers in access to healthcare such as increasing waiting time for patients to receive treatment. Competition Commission op cit note 10 at 49-51.

[422] This is a type of fixed-fee agreement that medical schemes pay to providers in advance for prospective treatment. Providers then assume the risk and costs of treating a patient. Capitation based payments have drawbacks as providers may attempt to minimise services to contain costs. Ibid 51.

[423] This comprises of results-based financing that makes payment contingent on the performance targets set by the medical scheme. VBRs are time-consuming to assess and are thus expensive and impractical to administer. Sophie Witter, Yotamu Chirwa & Pamela Chandiwana et al 'Results-Based Financing as a Strategic Purchasing Intervention: Some Progress but much further to go in Zimbabwe?' (2020) 20 *BMC Health Services Research* 1 at 1 and Atle Fretheim, Sophie Witter & Anne Lindah et al 'Performance-Based Financing in Low-and Middle-Income Countries: Still more Questions than Answers' (2012) 90 *Bulletin for the World Health Organization* 559 at 559.

[424] Competition Commission op cit note 10 at 9 and 30.

[425] Competition Commission op cit note 168 at 223-232; Competition Commission 'Collective Negotiations between Medical Scheme Administrators, Multi-lateral Tariff Negotiating Forum and Outcome Monitoring and Reporting' at 2 available at *https://www.spotlightnsp.co.za/wp-content/uploads/2020/10/Competition-Commission-Notice-to-Stakeholders-September-2020.pdf*, accessed on 8 August 2022.

[426] Alternatively, these functions should be conferred on the Council for Medical Schemes ('CMS'). This would require regulations be established under Section 90(1)(f), (u) and (w) of the National Health Act 2003 alternatively that amendments to the Medical Schemes Act 131 of 1998 be affected to extend the powers and functions of the CMS. Competition Commission op cit note 168 at 222, 225 and 229.

[427] These agreements would need to contain a performance clause to ensure that services are of a sufficient quality and include provision for risk transfer to providers to mitigate over-servicing of patients. Competition Commission op cit note 168 at 108, 225 and 229.

[428] African National Congress National Health Plan op cit note 281 at 87.

Accordingly, government has failed to curb the financial barriers that impeded access to healthcare.

### *3.4.2 Tariff determinations*

After the Competition Act was promulgated, collective tariff negotiations such as bundled payments and capitation, were declared unlawful.[429] These tariff negotiations contravened the Act by indirectly fixing prices.[430] Accordingly, private funders were prohibited from collaborating with healthcare providers to negotiate ARMs that could be interpreted as price fixing.[431] The Council of Medical Schemes, in consort with the NDoH, subsequently applied to the Competition Commission ('the Commission') to be exempted from the Competition Act in order to establish a tariff that would guide negotiations between funders and providers of healthcare.[432] The National Health Price Reference List ('NHPRL') was published after the Commission granted the requested exemption.[433] The NHPRL aimed to curb prices by providing an objective and impartial assessment of healthcare costs.[434] The publication of the NHPRL, however, did little to contain healthcare costs as it merely guided tariff negotiations.[435] Accordingly, providers persisted with imposing tariffs that exceeded the NHRPL.[436]

The NDoH ultimately assumed sole responsibility for the NHPRL.[437] Regulations were enacted to steer the tariff negotiations under the NdoH's stewardship in 2007.[438] A year later, the Minister of Health published the Reference Price List ('RPL').[439] A plethora of private healthcare providers subsequently challenged the lawfulness of RPL. In the ensuing judgment, the court found several grounds to review and set aside these regulations. First, the court determined that the NDoH had failed to fulfil its constitutional obligation to substantively

[429] Competition Commission op cit note 10 at 44.
[430] *Competition Commission* (supra) op cit 357 para 4.2.
[431] Competition Commission op cit note 10 at 64.
[432] Department of Health *Draft Policy Framework for Price Determination in the Private Health System* (28 October 2010) 12.
[433] Ibid.
[434] Competition Commission op cit note 10 at 45.
[435] Council for Medical Schemes Circular 1 of 2008 *Evaluation of Medical Schemes Cost Increases: Finding and Recommendations* (March 2008) 20.
[436] Competition Commission op cit note 168 at 226.
[437] Section 90(1) (v) of the National Health Act op cit note 15; Competition Commission op cit note 10 at 45.
[438] National Health Act regulations in GN R618 *GG* 30110 of 23 July 2007.
[439] National Health Act regulations in GN 1236 *GG* 31469 of 3 October 2008.

consult with affected stakeholders.[440] Secondly, the court held that the NDoH unreasonably restricted the rights of stakeholders to make submissions.[441] Thirdly, the court concluded that the RPL's pricing methodology was unreasonable and irrational.[442] This judgment stressed that it was unlawful for government to unilaterally impose price-control mechanisms.[443] Nevertheless, the concept of price-control measures has been upheld as 'constitutionally legitimate and necessary' provided that healthcare providers derive 'some recompense'.[444] Therefore, it is permissible for government to enact price-control mechanisms on the condition that it complies with the prescripts of its consultative duty and that the methodology is substantively reasonable.[445]

The NDoH subsequently abandoned the tariff guideline process after the court set aside the RPL. Accordingly, government has failed to discharge its duty to regulate and contain private healthcare costs.[446] Government's failure to establish a National Pricing Commission to regulate private sector tariffs exacerbated its failings.[447] This has sanctioned the use of financial barriers to prevent access to quality healthcare which mirrors historical racial inequalities.[448]

Reform was proposed to aid government in fulfilling the right to healthcare by reducing financial barriers to accessing healthcare.[449] These recommendations include exempting the private sector from provisions of the Competition Act and conferring specific duties on the SSHR, as a new regulatory authority, to regulate private sector costs.[450] This would include determining and enforcing a set tariff for reimbursement.[451] Such a delegation, however, would not be lawful as it would 'go beyond the powers expressly or impliedly' conferred by the NHA to establish a tariff guideline that is not binding.[452] Moreover, this delegation would constitute a redundant complication of the existing system that would merely increase the healthcare

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[440] *Hospital Association of SA Ltd v Minister of Health, ER24 EMS (Pty) Ltd v Minister of Health, SA Private Practitioners Forum v Director-General of Health* 2011 (1) All SA 47 (GNP) para 9 and 28.
[441] Ibid para 87-93.
[442] Ibid para 72-73 and 149.
[443] Ibid para 148.
[444] Pieterse op cit note 5 at 72; *Minister of Health v New Clicks* (supra) note 377 para 7, 404, 527, 645-655, and 678.
[445] *Minister of Health* (supra) note 444 para 183.
[446] Department of Health op cit note 20 at 97.
[447] Department of Health *Strategic Plan 2014/15-2018/19* (2014) 21.
[448] Wayburne op cit note 5 at 8; Ranchod, Adams & Aryankhsesal op cit note 227 at 101.
[449] *Minister of Health* (supra) note 444 para 706.
[450] Department of Health op cit note 20 at 90 and 144; Competition Commission op cit note 168 at 35-37, 212, and 223-24.
[451] Ibid.
[452] *Hospital Association* (supra) note 440 para 118-119; Cora Hoexter *Administrative Law in South Africa* 2 ed (2012) 258.

administrations costs that could be avoided if government simply complied with its statutory obligations.

### *3.4.3 Failure to regulate competition to encourage the efficient use of resources*

As resource constraints hinder the realisation of the right to healthcare, government is required to ensure that the use of resources are maximised.[453] Resource usage is maximised when they are utilised efficiently.[454] In the private sector, an effective competitive market enhances the efficient use of resources and decreases costs.[455] Therefore, it is part of government's mandate to improve competitive practices in the private sector through legislative reform.[456] Considering this mandate, shortcomings in the competitive market are attributed to government's failure to tackle competition inefficiencies. If inefficiencies are not rectified, more resources will be utilised than required.[457] Accordingly, government needs to improve competitive practices to improve efforts to enhance the efficient use of resources.[458] This demands a strong regulatory framework to effectively regulate competition.[459] This section shall briefly canvass competitive failures in the private funders and PHE market and consider the consequences thereof.

#### *3.4.3.1 Competition failures in the private funders market*

Medical schemes continue to outsource their administration services to administration companies ('Administrators') in the post-democratic era. These Administrators render services such as managing members' claims and engaging in tariff negotiations with healthcare providers.[460] The courts have thus described Administrators as 'the heartbeat' of the medical scheme industry.[461] Accordingly, government sought to regulate the relationship between

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[453] Albertyn & Goldblatt op cit note 25 at 254.
[454] A. Nahman, R. Wise, & W. de Lange 'Environmental and Resource Economics in South Africa: Status Quo and Lessons for Developing Countries' (2009) 105 *South African Journal of Science* 350 at 351.
[455] Erasmus & Theron op cit note 411 at 61-62.
[456] Richard Zerbe & Howard McCurdy 'The Failure of Market Failure' (1999) 18 *Journal of Policy Analysis and Management* 558 at 558 & Kenneth Shepsle & Barry Weingast 'Political Solutions to Market Problems' (1984) 78 *American Political Science Review* 417 at 420.
[457] Dirk Pilat *Competition, Productivity and Efficiency* (1996) *OECD Economic Studies* 108.
[458] John Vickers 'Concepts of Competition' (1995) 47 *Oxford Economic Publishers* 1 at 8.
[459] Ibid.
[460] Regulation 18 of the Medical Schemes Act regulations op cit note 319.
[461] *Ramba v Government Employees Medical Scheme* (GDP) unreported case no 88884/21 (5 May 2021) para 10.

medical schemes and these Administrators through the MSA 1998.[462] This intervention included the introduction of performance clauses for medical schemes to determine the value of Administrators' services.[463] Notwithstanding these provisions of the MSA 1998, the historical ties between Administrators and medical schemes that developed in the 1970s continued to reduce competitive practices in the private funders' market.[464] As a consequence, Administrators' services continued to be lax as there was insufficient competitive pressure to improve their efficiency.[465] This was exacerbated by mass mergers between Administrators during the period of 2005 to 2017.[466] This market concentration diminished Administrators' drive to reduce costs, improve their performance, and innovate service delivery.[467]

Accordingly, reform was proposed to amend competitive practices by improving accountability between medical schemes and Administrators.[468] These recommendations included that Administrators be compelled to publicise information regarding their costs and performance to improve competitive efficiency.[469] This would aid medical schemes to determine whether Administrators are providing value-for-money services.[470] Notwithstanding the potential benefits associated with such reform, government failed to implement this recommendation. Consequently, contractual relations between medical schemes and Administrators continue to be ineffective and surreptitious.

#### *3.4.3.2 Competition failures in the PHE market*

Independent ownership of PHEs decreased drastically under government's stewardship of the health system.[471] This was consequent upon the approval of several mergers that culminated in corporate ownership of PHEs being concentrated into three groups, namely Netcare, Life Hospital, and Medi-Clinic ('the oligopoly').[472] Independent PHEs attempted to compete with the oligopoly by collaborating to collusively negotiate tariffs with medical schemes through an

[462] Regulation 18 of the of the Medical Schemes Act regulations op cit note 319.
[463] Chijioke Okoli, Charles Ezenduka & Benjamin Uzochukwu et al 'Achieving Value for Money in Healthcare: Principles, Methods, and Empirical Applications' (2014) 3 *African Journal of Health Economics* 25 at 25 and Competition Commission op cit note 10 at 39.
[464] Competition Commission op cit note 10 at 114.
[465] Vickers op cit note 458 at 1.
[466] Competition Commission op cit note 168 at 104-108.
[467] Vickers op cit note 457 at 7; Competition Commission op cit note 10 at 9-11.
[468] Brauns & Stanton op cit note 300 at 191-192; Van Den Heever op cit note 346 at 6.
[469] Competition Commission op cit note 168 at 238-39.
[470] Ibid.
[471] Erasmus & Theron op cit note 411 at 56; Competition Commission op cit note 168 at 74.
[472] Erasmus & Theron op cit note 411 at 54 and 58; Competition Commission op cit note 10 at 169.

exemption granted by the Competition Commission to the National Hospital Network ('NHN').[473] The effect of the NHN exemption was attenuated as independent PHEs were unable to effectively decrease and offset their operational costs in the same manner as the oligopoly.[474]

Consequently, there is little competition in the PHE market. Instead, PHEs compete to lure doctors to their facilities through unnecessary investments in expensive technology and building luxurious facilities.[475] PHEs prioritised these investments to entice doctors to practice at their facilities in an effort to increase the demand for services.[476] Government's intervention to increase the efficient use of resources by regulating the purchasing of expensive technology was thus required.[477] Notwithstanding this necessity, government failed to intervene.

This lack of competition in the PHE market enabled the oligopoly to utilise its market dominance to commandeer DSP agreements and negotiate more advantageous tariffs for reimbursement.[478] As such, most tariff negotiations with the oligopoly are still premised on FFS.[479] Consequently, it was recommended that the SSHR review tariff negotiations to assist with the migration towards ARMs.[480] Unsurprisingly, government yet again failed to implement these recommendations.

Government's failure to effectively regulate competition in the PHE market has stifled competitive practices and reduced competitive pricing.[481] Instead of complying with its constitutional duty to ensure that the use of resources is maximised, government has enabled the PHE market to be dominated by an oligopoly that utilises resources ineffectively and dictates reimbursement tariffs. Without government intervention, PHEs will continue to be one of the main drivers of high private sector costs.[482]

### *3.4.4 Cumulative effects of government's failure to regulate private healthcare costs*

[473] Competition Commission op cit note 10 at 53 and 168.
[474] Competition Commission op cit note 168 at 72-75.
[475] Matsebula & Michael Willie op cit note 353 at 165 and 173.
[476] Competition Commission op cit note 10 at 61; Matsebula & Michael Willie op cit note 353 at 160 and 165.
[477] White Paper *Transformation of the Health System* op cit note 302 at 18 and 135; Department of Health op cit note 20 at 94 and 144; Competition Commission op cit note 168 at 79-82 and 221-222.
[478] Competition Commission op cit note 168 at 79, 82-83 and 226.
[479] Ibid at 79.
[480] Competition Commission op cit note 168 at 79, 108 and 222; Competition Commission op cit note 12 at 70.
[481] Erasmus & Theron op cit note 411 at 53; Competition Commission op cit note 168 at 30.
[482] Competition Commission op cit note 10 at 64; McIntyre op cit note 276 at 138; Competition Commission op cit note 168 at 100-101.

South Africa's private sector costs exceed that of more developed countries.[483] An interplay of governmental failures and inadequate stewardship have contributed to the current cost crisis, including its laxity regarding tariff regulations, its failure to ring-fence the private sector from the Competition Act to permit collusive price setting under ARMs, and its ineffective regulation of competitive markets to improve the efficient use of resources. Consequently, the high costs of healthcare in the private sector continue to escalate and impose financial barriers to access healthcare. As many South Africans cannot afford private sector costs, these financial barriers effectively constitute a denial of the right to healthcare.[484] Therefore, both price control and competitive practice regulations are imperative to increase access to healthcare by encouraging the efficient use of resources, making healthcare more affordable, and stabilising the private sector.[485] Such regulations will be lawful provided that government complies with the prescripts of procedural fairness, legality, and rationality as opposed to authoritarian control of the health system.[486]

## 3.5 CONCLUSION

While government has successfully deracialised the health system, its legislative apathy and lack of stewardship have both impeded the practical realisation of the right to healthcare and threatened the stability of the entire private sector. This is evident in the poor stewardship of private funders and the incomplete legislative framework governing PHEs. This conduct contravenes governments responsibility to adequately regulate the private sector to ensure the progressive and practical realisation, as well as the widest enjoyment, of the right to healthcare.[487] Thus regulation is needed for the effective oversight over private funders, PHEs, and to contain costs.

Government's inadequate stewardship over private funders is manifest in its failure to reorientate PMBs from expensive curative healthcare to preventative healthcare; its disregard

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[483] Organisation for Economic Co-operation and Development Working Paper 85 *International Comparison of South African Private Hospitals Price Levels* (2015) 8; Competition Commission op cit note 12 at 22, & Mayosi Bongani & Solomon Benatar 'Health and Health Care in South Africa – 20 Years after Mandela' (2014) 371 *The New England Journal of Medicine'* 1344 at 1345-1346; Logan Rangasamy 'Healthcare Price Changes and Expenditure in Southern Africa: Some Implications for Economic Policy' (2021) 38 *Development of Southern Africa* 607 at 607.

[484] *Pharmaceutical Society of South Africa v Tshabalala-Msimang* 2005 (3) SA 238 (SCA) para 42.

[485] Other countries have 'established some form of price setting… to provide norms against which private sector prices can be compared'. Competition Commission op cit note 168 at 179; Organisation for Economic Co-operation and Development op cit note 483 at 14.

[486] Hoexter op cit note 116 at 172 to 177.

[487] *Grootboom* (supra) note 287 para 41-43; Pieterse op cit note 5 at 50.

of recommendations to standardise medical schemes benefit options to prevent adverse selection; and its indifference to establishing REF to stabilise the medical scheme market. Its substandard regulation of PHEs is apparent in the incomplete regulatory framework that governs PHEs; its ineffective implementation of the CoN process to regulate PHE licensing; and its inept governance of quality healthcare services. These failures are exacerbated by the dearth of regulatory control of private sector costs that are essential to ensure that access to healthcare is affordable and accessible. Consequently, costs in the private sector continue to escalate and effectively act as financial barriers to access healthcare that perpetuate the discrimination of the socio-economic disadvantaged sections of society.[488] Therefore, the basis of exclusionary practices has shifted from race to affordability. Finally, government's failure to adequately regulate competition in the private sector constitutes a contravention of its mandate to ensure that the use of resources is maximised.

Cumulatively, these failures have permitted a continuation of the 'pre-constitutional legislative and structural framework' as government has undermined the ability to leverage the private sector to aid in the practical realisation of the right to healthcare and has entrenched the fragmented two-tier health system.[489] Consequently, access to healthcare remains substantively inequitable. This dereliction of duty constitutes a failure to protect, promote, and fulfil the right to healthcare. Thus, government has failed to meet its constitutional mandate to reform the health system.[490]

[488] *Social Justice Coalition v Minister of Police* 2022 JDR 2047 (CC) para 6.
[489] Pieterse op cit note 5 at 56; South African Law Reform Commission Issue Paper 145 (Project 25) *Statutory Law Revision: Legislation Administered by the Department of Health* (2017) 160 to 180.
[490] Kirrisha Pillay 'Tracking South Africa's Progress on Health Care Rights: Are we Any Closer to Achieving the Goal? (2003) 7 *Law Democracy and Development* 55 at 73.

# CHAPTER 4: PROSPECTIVE LEGISLATIVE REFORM: GOVERNMENTS ENDEAVOUR TO ACHIEVE EQUITY IN ACCESS TO HEALTHCARE

Meaningful realisation of the constitutionally enshrined right to healthcare is indispensable to democracy, equality, and economic development.[491] Notwithstanding the importance of this right, access to healthcare remains substantively inequitable in the post-democratic era.[492] It is against this backdrop that government intends to restructure the health system by enacting the National Health Insurance Bill ('the Bill').[493] The Bill will reorganise the entire health system and has thus been touted as the panacea for all inequalities and inefficiencies in the public and private sectors. Under this revised system, government will assume the primary responsibility to finance and provide healthcare services. This constitutes a fundamental change of governmental policy that has historically foisted the responsibility to finance healthcare costs on individuals. Accordingly, the Bill will revise government's commitment to regulate the private sector to increase access to healthcare.[494] This chapter will examine how the Bill effect private funders, such as medical schemes, PHEs, and the health system in general. It will analyse the ideology underpinning the right to healthcare, the legal context for healthcare reform, systemic issues in healthcare service delivery, and conclude with a critical review of the Bill to determine whether its framework will aid in the progressive realisation of the right of access to healthcare.

## 4.1 UNIVERSAL HEALTHCARE AS A MECHANISM TO FULFIL THE RIGHT TO HEALTHCARE

Access to healthcare is viewed as a fundamental human right 'that advances equality and safeguards human dignity'.[495] This right comprises of four essential components, namely availability, accessibility, acceptability, and measurements of quality of healthcare services.[496]

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[491] Liebenberg op cit note 8 at 163-165.
[492] Pieterse op cit note 5 at 50.
[493] National Health Insurance Bill op cit note 27. Both the National Assembly and the National Council of Provinces have assented to the Bill.
[494] Department of Health op cit note 20 at 125.
[495] The World Health Organization *Declaration of Alma-Ata* (1978); Article 25 of the United Nations Universal Declaration of Human Rights 1948; Article 16 of the African Charter on Human and Peoples' Rights (1981).
[496] Office of the High Commissioner for Human Rights *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health* (2000) 4-5; African Commission on Human and Peoples' Rights *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights* (November 2010) 24.

Availability dictates that sufficient hospitals, clinics, and doctors be available to render healthcare services.[497] Accessibility requires that access to healthcare is equitable,[498] affordable,[499] and physically accessible.[500] Acceptability and quality encompass access to effective healthcare that is culturally appropriate and rendered by skilled healthcare providers.[501] Equitable health systems facilitate the practical realisation of this right by enacting legislation to regulate healthcare financing and service delivery.[502] The foundation of this regulatory framework requires shifting the perspective from access to healthcare being viewed as a privilege that can be sold as a commodity to a basic entitlement for all.[503]

Universal Healthcare ('UHC') encapsulates the principal policy process to guide countries in their quest to realise the right to healthcare.[504] UHC has three core tenants, namely equity in utilisation of healthcare services,[505] financial protection and equity in financing healthcare costs,[506] and that provision for healthcare services be of sufficient quality to effectively treat illnesses and improving health.[507] The quality of healthcare services is fundamental to meaningfully enjoy the right to healthcare.[508] These tenets are interlinked and can only be achieved by strengthening the health system's core functions namely, financing and service delivery.[509] Such strengthening occurs by improving the efficiency, resource distribution, and basic administration and governance of the health system.[510]

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[497] Office of the High Commissioner for Human Rights op cite 496 at 4, 7, and 11.
[498] Ibid 7.
[499] Payment should be premised on equitable financial contributions for healthcare, whether in the public or private sector. Ibid 7-8.
[500] Ibid 4 and 7.
[501] Ibid 4.
[502] Office of the United Nations High Commissioner for Human Rights op cit note 33 at 23.
[503] David Bloom, Alexander Khoury & Ramnath Subbaraman 'The Promise and Peril of Universal Healthcare' (2018) 176 *Science* 1 at 6.
[504] Office of the United Nations *CESCR General Comment* op cit note 496 at 1 and 3.
[505] This requires that healthcare services be used based on need rather than other considerations such as affordability or geographical location. World Health Organization op cit note 14 at 9-10.
[506] This entails fairness in financial contributions for healthcare expenditure to prevent financial hardship in the form of catastrophic and impoverishing expenditure. Accordingly, UHC does not entail provision for free healthcare. Rather, it requires that healthcare costs do not deter the sick from seeking treatment. David Evans, Justine Hsu & Ties Boerma 'Universal Health Coverage and Universal Access' (2013) 91 *Bulletin of the World Health Organization* 546 at 546.
[507] World Health Organization op cit note 21 at 4.
[508] Ibid.
[509] Theadora Koller, David Clarke & Taryn Vian 'Promoting Anti-Corruption, Transparency and Accountability to Achieve Universal Health Coverage' (2020) 13 *Global Health Action* 1 at 1.
[510] Good governance requires transparency and accountability which focuses on anti-corruption. Anna Rodney & Peter Hill 'Achieving Equity within Universal Health Coverage: A Narrative Review of Progress and Resources for Measuring Success' (2014) 13 *International Journal for Equity in Health* 1 at 6.

While UHC provides broad guidelines to realise the right to healthcare, there is no single path to accomplish this objective.[511] Rather, governments are required to develop and implement healthcare policies to steer their respective country towards UHC.[512] Appropriate healthcare policies are determined by a country's historical development, the health system's prevailing capacity, and the ability to implement reform given resource constraints.[513] Three factors must be assessed to determine the suitability of policies. First, the context and objectives of healthcare reform must be identified.[514] Secondly, the healthcare system's strengths and weaknesses must be assessed.[515] Thirdly, the appropriate mechanism to finance the required reform must be determined.[516] Accordingly, prospective healthcare financing reform is considered in conjunction with other measures to strengthen the health system.[517] This is a dynamic and ongoing 'process that must be constantly evaluated and re-evaluated'.[518] Therefore, progressive realisation of this right is not linear and should be gradually implemented to assess the government's policy interventions' feasibility, sustainability, and efficacy.[519]

## 4.2 LEGAL CONTEXT AND OBJECTIVES FOR HEALTHCARE REFORM

Achieving a society that is substantively equal is essential to resolving the injustices of the past.[520] Accordingly, equality drives all reform to transform society in accordance with the imperatives set forth in the Constitution.[521] The two core techniques to achieve this transformation include rationing access to healthcare and imposing constitutional obligations on the private sector to aid in the realisation of the right to healthcare. Each of these factors is canvassed below.

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[511] Bertus De Villiers 'The Protection of Social and Economic Rights: International Perspectives' (1996) 9 *Centre for Human Rights* 1 at 3; William Savedoff, David de Ferranti, Amy Smith et al 'Political and Economic Aspects of the Transition to Universal Health Coverage' (2012) 380 *Lancet* 924 at 924.
[512] Koller, Clarke & Vian op cit note 509 at 1.
[513] Eleanor Whyle & Jil Olivier 'A socio-economic history of South Africa's National Health Insurance' (2023) 22 *International Journal for Equity in Health* 1 at 21.
[514] Joseph Kutzin 'Anything Goes on the Path to Universal Health Coverage? No' (2012) 90 *Bulletin of the World Health Organization* 867 at 867.
[515] Ibid.
[516] Ibid.
[517] World Health Organization op cit note 21 at 16, 19, and 20.
[518] African National Congress op cit note 281 at 1-2.
[519] World Health Organization op cit note 21 at 19-20.
[520] Pieterse op cit note 280 at 155-157.
[521] Ibid.

### *4.2.1 Substantive Equality*

The metamorphosis envisioned by the Constitution requires that all forms of unfair discrimination be systematically eradicated.[522] To achieve this mandate, government is required to transform the public sector and regulate the private sector to achieve a substantively equal society, which is the core of transformative constitutionalism.[523] Substantive equality does not denote a formalistic interpretation of identical treatment but rather demands the cause of inequalities, being the product of historical violation of basic rights, be rectified.[524] Accordingly, determining the cause of inequalities in the health system is indispensable to gauge the necessity and extent of healthcare reforms that are required.[525]

The analysis of the health system, as outlined in Chapter 2, reveals that access to healthcare was manipulated to advance abhorrent political ideologies. Historically, black communities could either only access sub-standard healthcare services,[526] or were excluded from accessing healthcare due to prohibitive costs and regional inaccessibility to service providers.[527] Conversely, policies during the same period fostered wealth and guaranteed access to quality healthcare for the white community.[528] These policies aimed to reinforce inequalities by systematically violating black communities' basic human rights.[529]

The review in Chapter 3 reveals that access to healthcare in the post-democratic era remains substantively inequitable. This is due to the poor quality of healthcare services in the public sector which has caused a crisis in health outcomes.[530] Conversely, the calibre of healthcare in the private sector is comparable with some of the strongest health systems in the world.[531] However, as government has endorsed the sale of private-sector healthcare services as a commodity, access remains the exclusive purview of the affluent.[532] These financial

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[522] Albertyn op cit note 25 at 249.
[523] Pieterse op cit note 387 at 157; Heyns & Brand op cit note 297 at 158; *Minister of Finance v Van Heerden* 2004 (6) SA 121 (CC) para 23; *Bato Star Fishing (Pty) Ltd v Minister of Environmental Affairs* 2004 (4) SA 490 (CC) para 74; *Pharmaceutical Manufacturers Association of South Africa: In re Ex Parte President of the Republic of South Africa* 2000 (2) SA 674 (CC) para 20.
[524] Albertyn op cit note 25 at 250-53; Hassim, Heywood & Berger 288 at 128-29 and 172.
[525] Albertyn op cit note 25 at 249-50 and 261; De Villiers op cit note 511 at 3.
[526] Price op cit note 5 at 158.
[527] Healthcare providers were concentrated in white metropolitan areas, which black communities were prohibited from accessing. Coovadia, Jewkes & Barron et al op cit note 48 at 819 and 823.
[528] Department of Health op cit note 20 at 8-10.
[529] World Health Organization op cit note 123 at 258.
[530] Winnie Maphumulo & Busisiwe Bhengu 'Challenges of Quality Improvement in the Healthcare of South Africa Post-Apartheid A Critical Review' (2019) 42 *Curationis* 1 at 1.
[531] Centre for Development and Enterprise op cit note 19 at 26.
[532] James Smith 'Healthy Bodies and Thick Wallets: The Dual Relation between Health and Economic Status' (1999) 13 *Journal of Economic perspectives* 145 at 163.

barriers, which are equivalent to a deprivation of the right to healthcare, unfairly discriminate against the poor who are left at the mercy of the public sector.[533] High levels of disparities in wealth and increasing levels of poverty have exacerbated these inequalities.[534] These financial barriers contravene the basic premise of substantive equality that demands the protection of those who have endured unfair social, political, or legal discrimination.[535] Accordingly, government has not only preserved inequalities in the post-democratic era but has also failed to protect the vulnerable who have the greatest need for healthcare services.[536]

The poor outcomes in the public sector, combined with the financial barriers to accessing healthcare within the private sector, have caused a significant regression in access to, and utilisation of, healthcare services in the post-democratic era.[537] Government intends to resolve this regression by drastically altering the legislative landscape that governs the health system. The National Health Insurance Bill ('the Bill') intends to improve access to high-quality healthcare, irrespective of a person's socio-economic status, by reforming healthcare financing.[538] Whether the Bill will achieve its intended objectives will be measured in terms of its ability to rectify inequalities, which will invariably be tested through judicial review.[539] This review process is an important mechanism to ensure government is accountable to its citizens and to uphold the notation of constitutional legitimacy.[540] This demands that the government's conduct be measured against the principles of legality and rationality.[541] Moreover, it requires that government satisfy the court that the Bill is reasonable both in its concept and its implementation.[542] This requires that government 'strike a balance between the need' to

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[533] *Social Justice Coalition v Minister of Police* 2022 JDR 2047 (CC) para 6; *Pharmaceutical Society of South Africa v Tshabalala-Msimang* 2005 (3) SA 238 (SCA) para 42.
[534] Fortuin, Grebe, & Makoni op cit note 3 at 243; Chatterjee, Czajka, & Gethin op cit note 6 at 20.
[535] Albertyn op cit note 25 at 253; Liebenberg op cit note 8 at 160 and 165.
[536] Government had failed to achieve its mandate to ensure that healthcare was accessible to ordinary bearers of rights. Rather the current state of the health system has entrenched privilege and reinforced the 'subordination of disadvantaged groups'. Heyns & Brand op cit note 297 at 158.
[537] Nduduzo Ndebele, Victor Mlambo & John Molepo et al 'The South African Health Sector and the World Health Organization South Africa's health sector and its Preparedness for National Health Insurance (NHI): Challenges and Opportunities' (2021) *European Journal of Economics, Law and Social Sciences* 334 at 335.
[538] Paragraph 1.4 of the Memorandum on the Objects of the National Health Insurance Bill in *GG 42598* of 26 July 2019.
[539] *Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC) 77-78; Liebenberg op cit note 8 at 160 and 167.
[540] Ademola Oluborode Jegede, Annette Lansink, & Cornelius Hagenmeier 'Lessons on the Right to Health Litigation and MDGS for Implementing Health Related SDGS in South Africa' (2018) 15 *Ghana Journal of Development Studies* 1 at 6-8.
[541] While the courts are not arbiters of executive healthcare policies, it is nevertheless required to consider the lawfulness of the manner in which healthcare resources should be rationed. Hassim, Heywood & Berger 288 at 37 and 46; *Fedsure Life Assurance Ltd v Greater Johannesburg Transitional Metropolitan Council* 1999 (1) SA 374 (CC) para 56; *Rail Commuters Action Group v Transnet Ltd t/a Metrorail* 2005 (2) SA 359 (CC) para 78.
[542] *Grootboom* (supra) note 287 para 42.

improve access to healthcare for the population and the duty to ensure that healthcare providers remain in business.[543] The latter objective is important as the closure of providers will cause a regression in the availability of healthcare services.[544]

### *4.2.2 Mechanisms to realise the right to healthcare*

Rationing healthcare entails limiting the type of services that are available and restricting how to access healthcare providers. This is done to ensure that the health system can cater to the needs of as many people as possible. Rationing alone, however, is insufficient to realise the right to healthcare. Therefore, more novel, and perhaps controversial mechanisms, such as imposing constitutional obligations on the private sector, are required to fulfil this right. These two mechanisms are further expanded on below.

#### *4.2.2.1 Healthcare rationing*

Maximising the use of existing healthcare resources is indispensable for government to fulfil its mandate to realise the right to healthcare.[545] One method to improve resource utilisation is the practice of healthcare rationing.[546] Equitable rationing evaluates competing interests and prioritises healthcare services that serve the larger community.[547] Inappropriate rationing decisions may perpetuate inequalities in the utilisation of healthcare by focusing solely on expanding the number of people who can access healthcare while reducing the type of healthcare services that are available for consumption.[548] This type of reform merely substitutes

[543] *Minister of Health* op cit note 444 para 520.
[544] Ibid.
[545] Mbazira op cote note 296 at 134.
[546] Alan Parkin 'Allocating Health Care Resources in an Imperfect World' (1995) 58 *The Modern Law Review* 867 at 868-69.
[547] A cost to benefit analysis is conducted when determining which services to finance. However, there are inherent difficulties in determining the criteria to assess the effectiveness of healthcare priorities. Effectiveness could be measured in terms of treatment that extends lifespan versus improves quality of life which is complicated by considerations about what constitutes quality of life. Furthermore, effectiveness should consider whether healthcare should prioritise managing a patient's health or curing ailments and whether such analysis should include an economic assessment in terms of the value associated with a patient's ability to return to work. Roy Carr-Hill 'Allocating Resources to Health Care: Is the QALY (Quality Adjusted Life Year) a Technical Solution to a Political Problem?' (1991) 21 *International Journal of Health Services* 351 at 359-361; A.J Culyer 'The Nature of the Commodity 'Health Care' and its Efficient Allocation' (1971) 23 *Oxford University Press* 189 at 189-211.
[548] Rodney & Hill op cit note 510 at 2-3.

the basis of disparities and is thus inequitable and unlikely to withstand constitutional scrutiny.[549]

#### *4.2.2.2 Horizontal application of constitutional obligations to realise the right to healthcare*

The courts have been reluctant to either address the inequalities that are 'inherent to the health system' or to impose 'minimum core' obligations on the government to realise the right to healthcare.[550] This reluctance has frustrated the development of governmental policies to protect the segments of the population that are the most susceptible and vulnerable.[551] While the courts have remained reluctant to impose constitutional obligations on the private sector,[552] the pace and extent of reform will always be constrained if government is solely responsible for transforming society in accordance with socio-economic rights that are enshrined in the Constitution.[553] Therefore, it is imperative that the judiciary develop its interpretation of the right to healthcare to encompass obligations on the private sector.

Horizontal application of constitutional obligations on the private sector is equitable when three factors are considered.[554] First, it would be considered equitable for reparations, considering the private sector's historical development. This would be premised on private sector's complacency with apartheid policies that facilitated human rights violations.[555] Secondly, the private sector's role in perpetuating inequalities in the post-democratic era that undermine the right to health would support such horizontal application.[556] Thirdly, conferring constitutional obligations on the private sector would aid in realising the right of access to health if their considerable resources are leveraged in favour of the masses.[557]

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[549] Ibid.
[550] *N and Others v Government of the Republic of South Africa and others* 2006 (6) SA 534 (D) para 20*; Minister of Health v Treatment Action Campaign* 2002 (5) SA 703 (CC) para 37-38; Pieterse op cit note 5 at 50.
[551] Theunis Roux 'Understanding Grootboom – A Response to Cass R. Sunstein' (2002) 12 *Constitutional Form* 41 at 42; Liebenberg op cit note 8 at 160; Albertyn op cit note 25 at 250.
[552] Pieterse op cit note 31 387 at 158.
[553] Ratner op cit note 23 at 461.
[554] Marius Pieterse *A Benefit-Focus Analysis of Constitutional Health Rights* (unpublished PhD dissertation, University of Witwatersrand, 2005) 101.
[555] Ibid at 500-504.
[556] However, such violations are consequent upon government's apathic regulation of the private sector. *Pharmaceutical Society* (supra) note 533 para 42.
[557] Stephen Korbin 'Private Political Authority and Public Responsibility: Transnational Politics, Transnational Firms, and Human Rights' (2009) 19 *Business Ethics Quarterly* 349 at 349; Pieterse op cit note 280 at 159-162 and 168-170; Ratner op cit note 23 at 461-465 and 506-511; Kirby op cit note 405 at 489.

Considering government's ongoing failure to adequately regulate the health system, it is essential that the judiciary develop and expand the substantive interpretation of the right to healthcare. This imperative is all the more pressing as inequalities threaten the 'legitimacy of the South African constitutional order'.[558] Extending obligations to the private sector would be premised on an equipoise of competing individual rights and private sector interests.[559] Without judicial intervention, access to healthcare will remain substantively unequal given government's 'lack of political will' to adequately regulate the private sector.[560]

## 4.3 ISSUES WITH THE DELIVERY OF HEALTHCARE SERVICES

Improvements in service delivery aim to progressively realise the right to healthcare by increasing providers' capacity to render high-quality healthcare services.[561] This requires information about the health system to guide improvements to plan and coordinate service delivery.[562] Accordingly, the National Health Information System ('NHIS') is fundamental for meaningful reform.[563] The NHIS is required to collate and process information in an impartial, rational, and transparent manner.[564] Such information will be utilised to improve the availability, accessibility, and acceptability of services.[565]

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[558] M Heywood 'Debunking 'Conglomo-talk': A Case Study of the Amicus Curiae as an Instrument for Advocacy, Investigation and Mobilisation' (2001) 5 *Law, Democracy & Development* 133 at 147; Sandra Liebenberg 'The Value of Human Dignity in Interpreting Socio-economic Rights' (2001) 21 *SAJHR* 1 at 15; M Pieterse 'Coming to terms with Judicial Enforcement of Socio-Economic Rights' (2004) 20 *SAJHR* 383 at 387-88; Frans Viljoen 'National legislation as a Source of Justiciable Socio-Economic Rights' (2005) 6 *Economic and Social Rights Review* 6 at 8.

[559] Ratner at op cit note 23 at 511 and 513-515; Pieterse op cit note 387 at 168.

[560] Pieterse op cit note 8 at 21; Jacobus Frederick Daniel Brand *Courts, Socio-Economic Rights and Transformative Politics* (unpublished LLD dissertation, Stellenbosch University, 2009) 108-109 and 114.

[561] Bart Jacobs, Por Ir & Maryam Bigdeli et al 'Addressing Access Barriers to Health Services: An Analytical Framework for Selecting Appropriate Interventions in Low-Income Asian Countries' (2012) 27 *Health Policy and Planning* 288 at 288.

[562] Office of the United Nations High Commissioner for Human Rights and the World Health Organization *A Human Rights-Based Approach to Health* (2008) 3; Candy Day & Andy Gray 'Health and Related Indicators' (2007) *South African Health Review Health Systems Trust* 215 at 215.

[563] Government has taken more than two decades to establish the framework for the NHIS. Department of Health *National 2021 Normative Standards Framework for Interoperability in Digital Health* (GN 2667 IN *GG* 47337 of 21 October 2022); Department of the Presidency Republic of South Africa's National Planning Commission *National Development Plan 2030* (2012) 334.

[564] This will involve examining the quality and reliability of the data, assessing the merits of the data, and determining the sample size of the data before committing healthcare policy directions. The analysis of the data should focus on the required action needed to improve access to quality healthcare. Neff Walker, Jennifer Bryce, & Robert Black 'Interpreting Health Statistic for Policymaking: The Story Behind the Headlines' (2007) 369 *The Lancet* 956 at 956; Candy Day & Andy Gray 'Health and Related Indicators' (2013) *South African Health Review Health Systems Trust* 207 at 208.

[565] Jacobs, Ir & Bigdeli op cit note 561 at 290; Office of the High Commissioner *CESCR General Comment* op cit note 496 at 4-5.

### *4.3.1 Availability of healthcare services*

Availability considers the quantity of providers, such as hospitals and doctors, to render healthcare services.[566] Increasing the number of providers is constrained by the costs of training additional doctors and establishing new hospitals.[567] Accordingly, maximising existing providers' capacity is crucial to expand access to healthcare given government's limited fiscal capacity.[568] Rather than maximising providers capacity, the use of resources under the existing health system is inefficient. This is attributed to the fragmentation between a private sector with ample resources and an 'over-burdened and under-resourced public sector'.[569] It is impossible to develop a coherent strategy to utilise resources efficiently to 'serve as many people as possible' because of this fragmentation.[570]

Even within each sector, the use of resources is wasteful. In the public sector, inefficiencies are attributed to incompetent stewardship and rampant corruption.[571] Consequently, the demand for healthcare in the public sector cannot be met by the government.[572] In the private sector, resources are applied injudiciously and inefficiently which is evident in the prevalence of overservicing of patients. Government has utilised these inefficiencies to support its narrative that the private sector is inimical to realising the right to healthcare.[573] This argument, however, disregards the fact that these inefficiencies are not attributed to avarice but rather a lack of regulatory control and stewardship. Moreover, government cannot simply discard the private sector as it plays a significant role to supplement

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[566] Office of the High Commissioner *CESCR General Comment* op cit note 496 at 4, 7, and 11.
[567] Steve Reid '20 Years of Community Service in South Africa: What Have We Learnt?' (2018) *South African Health Review Health Systems Trust* 41 at 41.
[568] Ibid.
[569] Department of the Presidency *National Development Plan* op cit note 563 at 331; Katusha de Villiers 'Bridging the Health Inequality Gap: An Examination of South Africa's Social Innovation in Health Landscape' (2021) 19 *Infectious Diseases of Poverty* 1 at 3.
[570] *Green Paper on National Health Insurance in South Africa* op cit note 348 at 10, World Health Organization op cit note 21 at 14; A E Laher et al 'Getting Out of the Dark: Implications of Loadshedding on Healthcare in South Africa and Strategies to Enhance Preparedness' (2019) 109 *South African Medical Journal* 899 at 899.
[571] South African Law Reform Commission Discussion Paper 154 *(*Project 141) *Medico-Legal Claims* (October 2021) 25-26 and 144; *White Paper on National Health Insurance* (GN1230 in *GG* 39506 of 11 December 2015) 2.
[572] *White Paper on National Health Insurance* op cit note 571 at 5; The President Republic of South Africa *Twenty Year Review South Africa 1994-2014* (11 March 2014) 11; Kirby op cit note 405 at 494.
[573] Sanjay Basu, Jason Andrews & Sandeep Kishore et al 'Comparative Performance of Private and Public Healthcare Systems in Low-and Middle-Income Countries: A systematic Review' (2012) 9(6) *PLOS Medicine* 1 at 1; World Health Organization op cit note 21 at 14.

the paucity of services in the public sector.[574] Accordingly, government's proposal to phase out the private sector is neither feasible nor reasonable.[575]

Instead of perpetuating discord in the health system, government should facilitate integration through intersectoral collaboration and compromise between the public and private sectors, which is pivotal to achieving equitable healthcare reform.[576] Such reform should focus on resolving the inefficient use of resources within each sector and aim to foster strategic partnerships.[577] These partnerships would aid with the horizontal application of constitutional obligations.[578] A symbiosis between the public and private sectors is crucial to a unified health system.[579] Accordingly, government's failure to achieve this symbiosis constitutes a failure to realise the right to healthcare.[580]

### *4.3.2 Accessibility to healthcare services*

Accessibility is measured in terms of the ability to utilise healthcare services.[581] Utilisation is affected by the physical location of providers and financial barriers to accessing services. Private healthcare services are physically inaccessible due to the geographical concentration of providers in wealthy metropolitan areas.[582] Nevertheless, increases in urbanisation present an opportunity to expand access to healthcare by partnering with providers, such as PHEs, that are concentrated in these metropolitan areas.[583] However, the success of these types of partnerships requires removing financial barriers to the private sector that act as a form of inequitable healthcare rationing that unfairly discriminates against the poor.[584] This shift is vital

[574] Hassim, Heywood & Berger 288 at 166.
[575] Ibid.
[576] Audrey Chapman 'The Impact of Reliance on the Private Sector Health Services on the Right to Health' (2014) 16 *Health and Human Rights Journal* 122 at 122.
[577] Department of the Presidency *National Development Plan* op cit note 562 at 349-350; David Walwyn & Adolph Nkolele 'An Evaluation of South Africa's Public-Private Partnerships for the Localisation of Vaccine Research, Manufacture and Distribution' (2018) 16 *Health Research Policy and Systems* 1 at 1.
[578] Nojeem Amodu 'Business and Human Rights versus Corporate Social Responsibility: Integration for Victim Remedies' (2021) 21 *African Human Rights Law Journal* 853 at 854; Florian Wettstein 'CSR and the Debate on Business and Human Rights: Bridging the Great Divide' (2012) 22 *Business Ethics Quarterly* 739 at 742.
[579] Hassim, Heywood & Berger 288 at 169; United Nations High Commissioner *The Right to Health* op cit note 33 at 12.
[580] United Nations High Commissioner *The Right to Health* op cit note 33 at 12-13 and 16.
[581] Pieterse op cit note 387 at 166.
[582] Ndebele, Mlambo & Molepo op cit note 537 at 334.
[583] Day op cit note 562 at 220; Department of the Presidency *National Development Plan* op cit note 562 at 334.
[584] Hassim, Heywood & Berger 288 at 164; Mbazira op cit note 296 at 133.

considering the increasing rates of poverty.[585] Failure to address such inequitable healthcare rationing endorses a system where access to quality healthcare is considered a privilege that is reserved for the wealthy.[586]

Reducing financial barriers to private-sector healthcare services does not require that user fees be abolished. Instead, government is required to implement interventions that would make healthcare services more affordable.[587] Various regulatory interventions in the private sector would reduce healthcare costs, including standardising medical scheme benefit options, introducing of mandatory medical scheme memberships through Social Health Insurance, increasing equitable cross-subsidisation by establishing the Risk Equalisation Fund, reorientating the health system from costly curative healthcare to preventative healthcare, and by regulating private sector costs by facilitating the use of Alternative-Reimbursement Models.

### *4.3.3 Acceptability of healthcare services*

Equitable utilisation of healthcare can only be achieved if the population trusts the quality and effectiveness of healthcare services.[588] Such trust is established by implementing various quality control mechanisms.[589] Quality can be improved by implementing clinical protocols to improve patient outcomes following treatment.[590] Clinical protocols are crucial to increase the efficient use of resources by curtailing overservicing of patients in the private sector and by improving the calibre of healthcare services in the public sector.[591] Poor quality is often linked to a failure to implement clinical protocols, the inefficient use of resources, and poor staff morale.[592] Accordingly, simply increasing the availability of and accessibility to healthcare providers will be irrelevant if the quality of services is poor and ineffective.[593] Therefore,

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[585] International Monetary Fund 'Six Charts Explain South Africa's Inequality' available at *https://www.imf.org/en/News/Articles/2020/01/29/na012820six-charts-on-south-africas-persistent-and-multi-faceted-inequality*, accessed on 6 March 2023.
[586] Ebi Achigbe Okeng Ebi *Enforcing the Right of Access to Healthcare Services in South Africa* (unpublished LLM thesis, University of South Africa, 2016) 21-22.
[587] United Nations High Commissioner *The Right to Health* op cit note 33 at 7; World Health Organization op cit note 21 at 9-10.
[588] People will not utilise healthcare services if they doubt its effectiveness. Evans, Hsu, & Boerma op cit note 506 at 546; Jacobs, Ir & Bigdeli op cit note 561 at 291.
[589] Bloom, Khoury & Subbaraman op cit note 503 at 2.
[590] Andy Gray & Yousuf Vawda 'Health Policy and Legislation' (2018) *South African Health Review in Health systems Trust* 1 at 5 and Rodney op cit note 508 at 3.
[591] World Health Organization op cit note 21 at 11.
[592] Teurai Rwafa-Ponela, Jane Goudge, & Nicola Christofides 'Organizational Structure and Human Agency with the South African Health System: A Qualitative Case Study of Health Promotion' (2021) 36 *Health Policy and Planning* 46 at 47.
[593] Das, Woskie & Rajbhandari op cit note 295 at 1.

improving the quality of services is an essential component for the meaningful realisation of the right to healthcare.[594]

As the private sector commands a significant portion of healthcare resources, it provides health outcomes that are comparable to some of the strongest health systems in the world.[595] Conversely, poor quality of healthcare is pervasive in the public sector. Government attributes this poor quality solely to fragmentation in healthcare financing.[596] It thus intends to resolve these issues by promulgating the Bill.[597] This reasoning disregards the fact that there are other reasons for the poor quality of services such as maladministration, mismanagement, electrical outages, corruption, and theft.[598] Consequently, public hospitals are on the 'verge of collapse' as a surge in medical negligence claims threatens to bankrupt various Provincial Departments of Health that provide services in the public sector.[599] Therefore, government's theory that the Bill will remedy the poor quality in the public sector is irrational and unreasonable. Rather these issues should be solved independent of healthcare financing reform.[600] Failure to devise interventions to address these deficiencies will impede any progress that government intends to accomplish by promulgating the Bill.[601]

## 4.4 CRITICAL ANALYSIS OF THE NATIONAL HEALTH INSURANCE BILL

After several investigations to determine different avenues to realise the right to healthcare,[602] government concluded that the Bill would be the best mechanism to meet its constitutional mandate. The Bill aspires to unify the health system by transforming the administration of healthcare, consolidating revenue raised for healthcare under a monopsony, and constructing a

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[594] Office of the High Commissioner op cit 496 at 12.
[595] President Republic of South Africa *Twenty Year Review* op cit note 572 at 6; Competition Commission op cit note 10 at 41.
[596] Paragraph 2.1.2 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538.
[597] Mark Blecher, Jonatan Daven & Lilian Dudley et al 'National Health Insurance: Visions, Challenges and Potential Solutions' (2019) *South African Health Review Health Systems Trust* 29 at 39.
[598] B. Malakoane, J.C Heunis & P Kigozi et al 'Public Health System Challenges in the Free State, South Africa: A Situation Appraisal to Inform Health System Strengthening' (2020) 20 *BMC Health Service Research* 1 at 6; Laetitia Rispen, Pieter de Jager & Sharon Fonn 'Exploring Corruption in the South African Health Sector' (2016) 31 *Health Policy and Planning* 239 at 239.
[599] South African Law Reform Commission *Discussion Paper* op cit note 570 at 25.
[600] R Dixon 'Creating a Dialog about Socio-Economic Rights: Strong-Form versus Weak-Form Judicial Review Revisited' (2007) 5 *International Journal of Constitutional Law* 391 at 403.
[601] United Nations High Commissioner *The Right to Health* op cit note 33 at 24; Hassim, Heywood & Berger 288 at 128-132.
[602] Such as the Department of Health *Inquiry into the various Social Security Aspects of the South African Health System: Policy Options for Future Coverage* (May 2002) and Department of Health *The Determination of the Formula for the Risk Equalization Fund in South Africa* (2004).

new framework to purchase healthcare services.[603] This transformation will overhaul the entire health system as government will be solely responsible for financing and purchasing healthcare.[604] This section shall canvass whether government has the competence to meet this task and consider the Bill's effects on the health system. It will specifically seek to answer the following two questions. First, will the Bill aid in the realisation of the right to healthcare? Secondly, whether the Bill's framework is reasonable?

### *4.4.1 Administration and governance of the National Health Insurance Fund*

The 'exercise of administrative power' is central to realising the right to healthcare.[605] Accordingly, the Bill intends to bestow administrative powers over the entire health system to the National Health Insurance Fund ('the Fund').[606] However, upon scrutinising the Bill, it becomes apparent that this endowment is a pretence for the Minister of Health ('the Minister') to assume autocratic control of the health system.[607] There are several issues with this framework. First, it will make healthcare administration inherently political. This is not desirable considering South Africa's history of manipulating access to healthcare to pursue political ideologies. Secondly, the envisioned administrative framework will be so costly and complex to govern that it will consume a significant portion of revenue that is raised to purchase healthcare services. Finally, government lacks the competence and credibility to administer the monolith of the envisioned monopsony. Each of these issues is expanded on below.

#### *4.4.1.1 Political autocracy*

The Minister will be granted unfettered authority to control the health system.[608] This authority will include discretionary powers to appoint officials to manage the Fund and its various

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[603] Blecher, Daven & Dudley et al cit note 597 at 30; The National Health Act Policy Schedule (published in *GG* 40955of 30 June 2017) 14.
[604] Historically, this responsibility was shared with the private sector as governments endorsed the sale of healthcare services as a commodity that enabled medical schemes to purchase healthcare services for its members. Section 23(1)(*a*)(*i)* of the National Health Act op cit note 15; Blecher, Daven & Dudley et al 597 at 37.
[605] Section 27 and Treatment Action Campaign *Submissions on the National Health Insurance Bill 2019* (29 November 2019) 2; United Nation's Human Rights Office of the High Commissioner 'About Good Governance' available at *https://www.ohchr.org/en/good-governance/about-good-governance* accessed on 19 June 2023.
[606] Clause 9 of the National Health Insurance Bill op cit note 27.
[607] Clause 13(1)(*b*) of National Health Insurance Bill op cit note 27.
[608] *White Paper on National Health Insurance* op cit note 570 at 3; Blecher, Daven & Dudley et al op cit note 597 at 30.

organisational structures.[609] These appointments will be inherently political. Concomitantly, the Minister will be granted unbridled discretion to set the national health budget, plan for and regulate hospital services in tandem with the National Department of Health ('NDoH'), and control the Fund's general operations.[610] Government has reasoned that this political autocracy will improve accountability.[611] However, the lack of 'adequate checks and balances' to constrain the Minister's exercise of power and prevent unscrupulous behaviour is incompatible with government's rhetoric.[612] Consequently, the Minister's exercise of administrative power will be susceptible to undue influence that is capable of violating constitutional rights.[613]

#### *4.4.1.2 Cost and complexity*

The Bill intends to drastically restructure the administration of the entire health system by either reconfiguring existing or establishing new departments.[614] For example, the responsibility to manage public healthcare costs will be reassigned from the NDoH to the reconfigured District Health Management Office ('DHMO') while revenue will be redirected from the NDoH to the Fund.[615] This reconfiguration will require considerable investment to improve government's capacity to administer the health system which will consume significant financial, human, and administrative resources.[616] These administrative costs will detract from governments ability to purchase services, which is fundamental to progressively realising the right to healthcare.[617]

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[609] Clause 12, 13(1)(*b*), 14(1), 25(1), 26(1) and 27 National Health Insurance Bill op cit note 27.
[610] Clauses 31(1)(*a*) and (*b*), 49(3), 55(1)(*c*), 55(*s*) and 55(*t*) of National Health Insurance Bill op cit note 27, Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 8, and the proposed amendments to Section 21(2)(*n*), 21(2)(*q*), 25(2)(*n*), 31A(3)(*o*) of the National Health Act at clause 58 of National Health Insurance Bill op cit note 27.
[611] *Dawood v Minister of Home Affairs* 2000 (3) SA 936 (CC) para 47 and 54; Department of Planning, Monitoring and Evaluation op cit note 30 at 22-23.
[612] Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 2; *Armbruster v Minister of Finance* 2007 (6) SA 550 (CC) 78; *Janse Van Rensburg NO v Minister of Trade and Industry NO* 2001 (1) SA (CC) para 29; Hoexter op cit note 452 at 262-264.
[613] Hoexter Ibid at 265.
[614] Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 16.
[615] Prospective amendments to sections 21(2)(n) and 31(5)(b) to the National Health Act at clause 58 of National Health Insurance Bill op cit note 27.
[616] Blecher, Daven & Dudley et al op cit note 597 at 34.
[617] Djavad Ghoddoosi-Nezhad, Ali Janati & Morteza Arab Zozani et al 'Is Strategic Purchasing the Right Strategy to Improve Health Systems Performance? A Systematic Review' (2017) 6 *Bali Medical Journal* 102 at 106.

The tenets of effective and efficient administration are premised on a framework that confers clear and precise roles and responsibilities.[618] In stark contrast, the Bill intends to establish a labyrinth of departments with overlapping functions.[619] For instance, health technology will be managed by both the National Health Council and the Committee on Health Technology Assessments.[620] This framework becomes more perplexing as broad obligations will be conferred on the various departments without any parameters for their fulfilment.[621] As such, the Bill will add undue complexity to the health system that will be practically impossible to regulate.[622]

#### *4.4.1.3 Government's competence to administer the Fund*

The Bill intends to drastically overhaul the administration of the health system without first establishing the prerequisite regulatory expertise and administrative capacity.[623] Government has thus abandoned its initial commitment to gradually build the Fund's operational capacity.[624] As such, the Fund will neither have the requisite expertise in healthcare financing and planning nor the capacity to administer the most basic operational tasks such as concluding and managing contracts with providers.[625]

These difficulties cannot be attenuated by simply recruiting personnel. In the first instance, the scale of the recruitment scheme that will be necessary to fill vacancies will require a bewildering investment to staff the Fund.[626] Even further revenue will be required to provide the staff complement with basic equipment for the Fund's operational requirements.[627] In the second instance, experts that may be recruited will not be capable of executing their mandate.

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[618] *Investigating Directorate: Serious Economic Offences v Hyundai Motor Distributors (Pty) Ltd, In re: Hyundai Motor Distributors v Smit No* 2001 (1) SA 545 (CC) para 24; Yu Keping 'Governance and Good Governance: A New Framework for Political Analysis' (2018) 11 *Fudan Journal of the Humanities and Social Sciences* 1 at 6.
[619] Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 19.
[620] Clause 57(3)(d) of National Health Insurance Bill read mutatis mutandis with section 23(1)(a)(v) of the National Health Act op cit note 15 and clauses 36, 37(2)(a), 37(2)(b), 37(2)(g), 37(2)(h) of National Health Insurance Bill read mutatis mutandis which the proposed amendment to sections 31A(3)(b), 31A(3)(f), 31A(3)(i) of the National Health Act at clause 58 of National Health Insurance Bill op cit note 27.
[621] For example, both the DHMO and CUPH are responsible to improve access to healthcare. Clause 37(2)(f) of National Health Insurance Bill, the proposed amendments to section 31A(3)(h) of the National Health Act at clause 58 of the National Health Insurance Bill op cit note 27; Hoexter op cit note 452 at 264.
[622] Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 6 and 19; Hoexter op cit note 452 at 356-357; *Affordable Medicines Trust v Minister of Health* 2006 (3) SA 247 (CC) para 108.
[623] Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 6.
[624] *Green Paper on National Health Insurance in South Africa* op cit note 348 at 49.
[625] Department of Planning, Monitoring and Evaluation op cit note 30 at 14-15; Julia Moorman 'Public-Private Partnerships' (2001) *South African Health Review Health Systems Trust* 83 at 92.
[626] Department of Planning, Monitoring and Evaluation op cit note 30 at 14 and 21.
[627] Ibid.

This is because these experts will be bereft of the requisite independence to effectively administer the Fund due to the envisioned political autocracy. This is compounded by the paucity of information for these experts to effectively plan to finance and purchase healthcare.[628] Accordingly, the Fund, qua government, will not be sustainable as it will neither have the competence nor operational capacity to utilise revenue to purchase healthcare.[629]

#### *4.4.1.4 Government's credibility to administer the Fund*

The political environment presents the biggest obstacle for government's administration of the Fund.[630] This is because the Executive's administration of the country is characterised by poor governance, ineffective leadership, and general ineptitude.[631] Consequently, corruption, mismanagement, and injudicious administration are ubiquitous.[632] As such, government lacks the credibility for its citizens to trust in its ability to enact and enforce legislative reform.[633] Accordingly, a general sense of disillusionment is pervasive among the citizenry and stakeholders alike, with the wealthy feeling exploited and the poor discarded.[634] Considering the pervasiveness of governance issues, it would be appropriate for the Bill to make provision for independent regulatory oversight.[635] This would encourage transparency and accountability in the administration of the health system.[636] Regrettably, such provisions are notably absent

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[628] Davis Tax Committee *Financing a National Health Insurance for South Africa* (March 2017) 42; Katarzyna Klasa, Scott Greer, & Ewout van Ginneken 'Strategic Purchasing in Practice: Comparing Ten European Countries' (2018) 122 *Health Policy* 457 at 458.
[629] Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 18; World Health Organization Department of Health Financing Working Paper No 8 *Strategic Purchasing for UHC: Key Policy Issues and Questions* (2017) 3.
[630] Ghoddoosi-Nezhad, Janati & Zozani et al op cit note 616 at 106.
[631] Shenaaz Gani *Factors Influencing the Financing of South Africa's National Health Insurance* (unpublished MPhil thesis, University of South Africa, 2015) 30.
[632] Blecher, Daven & Dudley et al op cit note 596 at 31; President Republic of South Africa *Twenty Year Review* op cit note 572 at 6; Gani op cit note 630 at 64.
[633] Klasa, Greer & van Ginneken op cit note 627 at 466.
[634] Tamar Kahn 'National Assembly Passes NHI Bill, Flaws and All' *Business Day* 13 June 2023, available at *https://www.businesslive.co.za/bd/national/health/2023-06-13-national-assembly-passes-nhi-bill-flaws-and-all/,* accessed on 23 July 2023; Jason Felix 'NHI Bill: Phaahla Hails it as "Revolutionary Legislation", but the Opposition Parties Disagree' *News 24* 13 June 2023, available at *https://www.news24.com/news24/politics/parliament/nhi-bill-phaahla-hails-it-as-revolutionary-legislation-but-opposition-parties-disagree-20230613,* accessed on 23 July 2023; Lehlohonolo Mashigo 'National Health Insurance Bill set for Heated Debate' *IOL* 6 June 2023, available at *https://www.iol.co.za/the-star/news/national-health-insurance-bill-set-for-heated-debate-0d6259a2-7bde-44c5-a431-2e4c400ff68f,* accessed on 23 July 2023.
[635] *South African Social Security Agency v Minister of Social Development* 2018 (10) BCLR 1291 (CC) para 47; Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 2.
[636] Keping op cit note 617 at 5.

in the Bill.[637] This omission comes at a time when citizens lack conviction in governments ability to supply essential services such as water and electricity.[638]

### *4.4.2 Raising and pooling of revenue for healthcare*

An 'effective financing system' is defined by its ability to raise sufficient revenue to purchase healthcare services.[639] The success of such a system is premised on the introduction of a compulsory prepayment process where revenue is raised in advance and not at the time when services are sought.[640] Revenue can be amassed through taxation, user charges, loans, grants, and donations.[641] The way in which revenue is raised necessitates that a balance be struck between the different mechanisms to generate income for healthcare by assessing the feasibility, sustainability, and reliability of the proposed financing framework.[642]Achieving this equilibrium is important as 'poorly conceived healthcare systems can bankrupt government'.[643] Notwithstanding these basic tenets, the Bill's framework to raise revenue is impractical, rigid, and unsustainable.

#### *4.4.2.1 Mechanisms to raise revenue*

The public and private sectors spend approximately R490 billion per annum on purchasing healthcare services.[644] While this is comparable with some of the most advanced health systems in the world, it has not translated into equitable access to healthcare.[645] Government contends that the fragmentation in healthcare revenue is the sole cause of this predicament.[646] Accordingly, the Bill aims to resolve such fragmentation by consolidating healthcare revenue

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[637] National Assembly *Report of the Portfolio Committee on the National Health Insurance Bill* (26 May 2023) 13.
[638] Tyanai Masiya, Yul Davids, & Mary Mangai 'Assessing Service Delivery: Public Perception of Municipal Service Delivery in South Africa' (2019) 14 *Theoretical and Empirical Research in Urban Management* 20 at 27-29.
[639] Elias Mossialos & Anna Dixon 'Funding Healthcare: An Introduction' in Elias Mossaialos, Anna Dixon, Joseph Figueras et al et al (eds) *Funding healthcare: options for Europe* (2002) 3.
[640] Such a system makes membership and payments mandatory. This is opposed to the voluntary contributions paid to medical schemes. World Health Organization Department of Health Systems Financing *Designing Health Financing Systems to Reduce Catastrophic Health Expenditure* (2005) 3; Di McIntyre & Alex Van Den Heever 'Social or National Health Insurance' (2007) *South African Health Review Health Systems Trust* 71 at 73.
[641] Gani op cit note 630 at 17.
[642] Ibid 2.
[643] Gani op cit note 630 at 25; Department of the Presidency *National Development Plan* op cit note 562 at 343.
[644] Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 31-32; Gani op cit note 630 at 3.
[645] Ibid.
[646] Paragraph 2.1.2 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538.

under a monopsony that will be administered by the Fund.[647] This monopsony will replace the existing multi-funder system.[648]

Government reasoned that the envisioned consolidation of revenue would enable the Fund to effectively control the health system.[649] This amalgamation, however, will be insufficient to realise the right to healthcare as additional revenue is required to meet the increasing demand for healthcare services,[650] address the rising costs of services,[651] and resolve the poor quality of services in the public sector.[652] In this regard, it has been projected that the Fund will have a shortfall of revenue that will exceed R108 billion.[653] Accordingly, the Bill intends to raise additional revenue by increasing direct taxation and ceasing tax rebates that are paid to members of medical schemes.[654] Both of these mechanisms present pragmatic difficulties. Specifically, government's ability to increase direct taxation will be severely constrained by high levels of unemployment, the ongoing economic contraction, the increasing fiscal deficit, and the reduction in the taxable population.[655] Concomitantly, redress cannot be found in the cessation of medical scheme tax rebates as this would only provide the Fund with an additional R17 billion of revenue per annum.[656] Accordingly, government will be hamstrung

[647] Blecher, Daven & Dudley et al op cit note 596 at 31 and 36-37; *White Paper on National Health Insurance* op cit note 570 at 15; paragraph 2.1.2 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538.
[648] The multi-funder framework was premised on government's inability to raise sufficient revenue to purchase healthcare. Paragraph 2.1.2 and 3.1 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538; *White Paper on National Health Insurance* op cit note 570 at 17; *Green Paper on National Health Insurance in South Africa* op cit note 348 at 40-41.
[649] Ibid.
[650] Gani op cit note 630 at 3.
[651] Rising healthcare costs is a global phenomenon that currently plagues the public and private sectors. Bloom, Khoury & Subbaraman op cit note 503 at 5; *White Paper on National Health Insurance* op cit note 570 at 12; Chapman op cit note 575 at 125.
[652] Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 35; paragraph 3.2.5 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538.
[653] Davis Tax Committee op cit note 627 at 30.
[654] Paragraph 2.2.6 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538, clause 49(2)(*a*)(*iii*) and 49(2)(*a*)(iv) of National Health Insurance Bill op cit note 27, *Green Paper on National Health Insurance in South Africa* op cit note 348 at 35; Gani op cit note 630 at 6-7.
[655] South Africa already has a progressive income taxation system to subsidise the poor. Blecher, Daven & Dudley et al op cit note 596 at 31; Gani op cit note 630 at 59; *Green Paper on National Health Insurance in South Africa* op cit note 348 at 36-40.
[656] The complete cessation of tax rebates is not proportional as lower-income household, whose residual income is predominantly used for necessitates of life, would suffer the same penalty as high-income households. Thus, the implementation of such a system would contravene the basic premise of fairness in financial contributions for healthcare. Further, this framework would cause a drastic and unsustainable increase in demand for healthcare in the public sector. Hassim, Heywood & Berger 288 at 196; Mossialos & Dixon op cit note 638 at 21-22; Davis Tax Committee op cit note 627 at 41.

by its inability to generate sufficient revenue for the Fund to purchase healthcare services.[657] Therefore the Bill's framework is not feasible.

Government could have mitigated the shortage of revenue by including provisions in the Bill for funding to be raised from a variety of sources.[658] This could have included additional revenue from user fees and hypothecated sin taxes.[659] The imposition of user fees would fall within the parameters of UHC that prescribes that financial contributions for services be equitable.[660] Nevertheless, the Bill's framework is premised on the misguided belief that an equitable health system is based on providing free healthcare.[661] Any potential disadvantages of user-fees could be mitigated by establishing a framework for appropriate exemptions.[662] Aside from raising additional revenue, the imposition of user fees serves to curb the abuse of healthcare benefits.[663] Accordingly, government has failed to consider other mechanisms to raise revenue which has cast doubts about the Fund's feasibility and thus its ability to realise the right to healthcare.[664] This omission is not venial given South Africa's bleak fiscal outlook.[665] Therefore, the proposed raising revenue mechanisms will be inherently unreliable.[666]

#### *4.4.2.2 Pooling of revenue*

Adequate income and risk cross-subsidisation are crucial for the pooling of revenue, that is used to purchase healthcare, to be sustainable.[667] Nevertheless, the Bill's pooling mechanism

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[657] Blecher, Daven & Dudley et al op cit note 596 at 31, *Green Paper on National Health Insurance in South Africa* op cit note 348 at 36-40; World Health Organization *Sustainable Health Financing Universal Coverage and Social Health Insurance* (2005) 139.
[658] Gani op cit note 630 at 163; Mossialos & Dixon op cit note 638 at 4 and 16.
[659] B.M. Mitchell & W.B. Schwartz 'Strategies for Financing National Health Insurance: Who Wins and Who Loses' (1976) 295 *New England Journal of Medicine* 866 at 867.
[660] Jacobs, Ir & Bigdeli op cit note 561 at 291; World Health Organization op cit note 21 at 24.
[661] Paragraph 6(a) of National Health Insurance Bill op cit note 27; paragraph 6.6 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538.
[662] Gani op cit note 630 at 45.
[663] World Health Report *Hypothecation of Tax Revenue for Health* (2010) 1 and 3.
[664] Gani op cit note 630 at 46; World Health Organization op cit note 21 at 29.
[665] Gani op cit note 630 at 49.
[666] Department of the Presidency *National Development Plan* op cit note 562 at 342; *White Paper on National Health Insurance* op cit note 570 at 9 and 17; Gani op cit note 630 at 38.
[667] Effective cross-subsidisation include the young subsidising the old, the healthy subsidising the sick, and the rich subsidising the poor. Doherty & McLeod op cit 269 at 43; American Academy of Actuaries 'Risk Pooling: How Health Insurance in the Individual Market Works' available at *https://www.actuary.org/sites/default/files/files/publications/RiskPoolingFAQ071417.pdf*, accessed on 22 June 2022.

is based solely on income-cross subsidisation, with the wealthy cross-subsidising the poor.[668] The disregard of risk cross-subsidisation effectively excludes the infirmed and elderly from the health system.[669] Instead, the Fund intends to exclusively pool revenue for preventative and promotive healthcare services.[670] Consequently, medical schemes shall become the sole financier for costly curative healthcare.[671] This will cause a ripple effect that will have a devastating impact on access to healthcare.

The first consequence of the envisioned pooling framework will be the drastic and unsustainable increase in medical schemes' membership costs. This will inevitably cause the medical scheme market to collapse.[672] In such instance, the Fund will truly become the sole financier of healthcare services.[673] When the provisions of the Bill are considered, it is evident that this framework is not accidental but is rather part of government's design to systematically eradicate the multi-funder market. This is evidenced by government's failure to enact legislation to exempt the private sector from the Competition Act 89 of 1998, while it intends to exempt the Fund from this Act.[674]

The second consequence of the pooling framework will be the drastic decrease in revenue to purchase healthcare services, as the collapse of the medical scheme market will result in the loss of approximately R207 billion of revenue.[675] Government cannot simply increase taxation to offset this loss absent significant economic growth. The repercussions of this shortage of revenue will be twofold. First, it will cause mass immigration of doctors and withdrawal of private investment in PHEs.[676] Accordingly, the Bill will merely serve to destabilise the entire health system. Secondly, there will be a drastic increase in catastrophic healthcare expenditure, with individuals being required to finance costly curative healthcare services themselves, which is not only contrary to the Bill's objectives but also the basic tenants of financial risk protection in UHC.[677] Thus, the Bill cannot be deemed to be rational and reasonable as it will

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[668] Clause 49(2)(a)(ii) of the National Health Insurance Bill op cit note 27 op cit note 491; *White Paper on National Health Insurance* op cit note 570 at 15.
[669] Competition Commission op cit note 10 at 8-9; Doherty & McLeod op cit 269 at 42.
[670] Paragraphs 2.1 to 2.4 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538.
[671] The proposed amendments to the Medical Schemes Act 131 of 1998 will prevent medical schemes from funding and purchasing preventative healthcare services. Clause 33 and 58 of the National Health Insurance Bill op cit note 27; McIntyre & Van Den Heever op cit note 639 at 73.
[672] National Assembly *Report of the Portfolio Committee* op cit note 636 at 12.
[673] Clause 2(a) of the National Health Insurance Bill op cit note 27.
[674] Clause 3(5) of the National Health Insurance Bill op cit note 27.
[675] National Assembly *Report of the Portfolio Committee* op cit note 636 at 12; Section 27 *Submissions on the National Health Insurance Bill* op cit note 604 at 32.
[676] Parkin op cit note 546 at 870.
[677] Paragraph 5.2(*b*) of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538; Bloom, Khoury & Subbaraman op cit note 503 at 2; Smith op cit note 532 at 145.

infringe on existing entitlements to healthcare, that emanate from the medical scheme market, which is neither reasonable nor justifiable.

### *4.4.3 Strategic purchasing of healthcare service*

Strategic purchasing is a dynamic process that entails actively determining healthcare needs and benefits and thereafter purchasing services in a manner that motivates providers to be more efficient and contain costs.[678] A critical analysis of the Bill reveals that it lacks the requisite framework to achieve these objectives.[679] Without this framework, government will revert to passive purchasing techniques that are inefficient and inequitable.[680] Therefore, the Bill's reference to strategic purchasing is 'not indicative of substantive policy' but rather a subterfuge to make its framework sound more appealing.[681]

#### *4.4.3.1 Governance of the strategic purchasing framework*

The governance framework to purchase healthcare is unnecessarily convoluted and complex. In this regard, strategic purchasing shall occur through the Benefits Advisory Committee ('Benefits Committee'), the Health Care Benefits Pricing Committee ('Pricing Committee'), the Fund, the DHMO, and the Contracting Unit for Primary Healthcare ('CUPH') which hold concurrent responsibilities.[682] For instance, the CUPH and the DHMO both hold concurrent responsibilities to manage providers and to implement and maintain the referral system from clinics to higher levels of care.[683]

The complexity of this framework is compounded by the convoluted purchasing framework that is fragmented between the CUPH, which is responsible for clinics, and the

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[678] Nigel Rice & Peter Smith 'Strategic Resource Allocations and Funding Decisions' in Elias Mossaialos, Anna Dixon, Joseph Figueras et al (eds) *Funding Healthcare: Options for Europe* (2002) 253 and World Health Organization op cit note 21 at 14.
[679] Ghoddoosi-Nezhad, Janati & Zozani et al op cit note 616 at 105.
[680] Paula Tran Inzeo, Brain Christens & Amy Hilgendorf et al 'Advancing Coalition Health Equity Capacity Using a Three-Dimensional Framework' (2019) 3 *Health Equity* 169 at 170.
[681] Klasa, Greer & van Ginneken op cit note 627 at 458.
[682] For example, clauses 11(1)(*g*), 25(5)(*a*) to (*c*) and clause 26(3) of the National Health Insurance Bill op cit note 27.
[683] Clauses 36, 37(2)(*b*), 37(2)(*g*), 37(2)(*h*) of the National Health Insurance Bill which details the Contracting Unit's obligations and clause 58 of the National Health Insurance Bill op cit note 27 which details the proposed amendment to sections 31A(3)(*f*) and 31A(3)(*i*) of the National Health Act that details the District Health Management Office's obligations.

Fund, which is responsible for procuring hospital services.[684] This fragmentation will make it difficult to establish a coherent purchasing strategy for healthcare services.[685] Concomitantly, the Minister will be responsible for purchasing and supplying healthcare services.[686] The Bill thus conflates the purchasing and providing of healthcare services.[687] This framework will cause significant instability in the health system as it will quash any competition in the healthcare provider market.[688]

Aside from issues with the broader administrative framework, the various organisational structures, that will be responsible for purchasing healthcare, will have insufficient autonomy to independently determine healthcare needs and purchase services.[689] The shortage of administrative expertise and structural capacity to manage basic functions such as legal drafting, contract management, and compliance to streamline and maximise the use of resources will only exacerbate the defective administrative framework.[690] This will cause a significant regression in access to healthcare as the organisational structures will neither have the expertise nor the capacity to strategically purchase healthcare.[691]

#### *4.4.3.2 Healthcare benefits*

Healthcare rationing, which is an invariable consequence of resource limitations, constrains the type of benefits the Fund will offer. Accordingly, benefits will be determined with reference to the healthcare budget. However, simply determining benefits will be meaningless unless

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[684] Clause 35(2) and 37(2)(*b*) read together with the definition of primary healthcare at clause 1 of the National Health Insurance Bill op cit note 27.

[685] The Fund will be responsible to purchase healthcare services subject to the Benefits Advisory Committee determination on healthcare benefits. Clauses 11(1)(*i*)(*i*), 15(3)(*b*), 31, and 32 of the National Health Insurance Bill op cit note 27; World Health Organization *Purchasing Health Services for Universal Health Coverage: How to make it more Strategic* (22 March 2019) at 3.

[686] Clause 31(1)(*a*) and 31(1)(*b*) of the National Health Insurance Bill op cit note 27; Section 3(1)(*d*) of the National Health Act op cit note 15, Sarah Stevenson, Jonathan Berger & Mark Heywood ed *The National Health Act Guide* 3 ed (2019) 53.

[687] Klasa, Greer & van Ginneken op cit note 627 at 467.

[688] The National Health Insurance Bill makes provision for the Fund to be exempt from the Competition Act 89 of 1998. This is in contravention of section 217(1) of the Constitution that demands that goods be procured in a manner that is fair, equitable and competitive. Proposed amendment to the Competition Act at clause 58 of the National Health Insurance Bill op cit note 27; National Assembly *Report of the Portfolio Committee* op cit note 636 at 10.

[689] Clauses 13(1)(*b*), 14(1), 25(1), 26(1) and 27 of the National Health Insurance Bill op cit note 27; Klasa, Greer & van Ginneken op cit note 627 at 467.

[690] Department of Planning, Monitoring and Evaluation op cit note 30 at 14, Blecher, Daven & Dudley et al op cit note 596 at 31; Klasa, Greer & van Ginneken op cit note 627 at 466.

[691] Rice & Smith op cit note 677 at 252; National Assembly *Report of the Portfolio Committee* op cit note 636 at 13.

government can deliver on these theoretical entitlements. An analysis of the Bill reveals major flaws in this key component in the strategic purchasing process, as canvassed below.

#### *4.4.3.2.1 Determining healthcare benefits*

The Benefits Committee will be tasked with establishing a healthcare plan that will set the parameters of what healthcare service benefits the Fund will purchase.[692] Determining these benefits requires that healthcare needs be identified and balanced against the limited resources that are available to purchase services.[693] This process necessitates that a budget be drawn to explicitly ration healthcare benefits to increase population coverage.[694] This task is strategic when benefits are proactively determined.[695]

The Bill envisions a framework for different benefit packages based on the identified needs of each healthcare district.[696] The mechanisms to determine healthcare needs are, however, unduly complex and uncertain, as CUPH and DHMO hold parallel responsibilities to fulfil this task.[697] The budget-setting process is as equally ambiguous as the Fund and the Director General for Health ('Director General') hold concurrent discretionary powers to fulfil this task.[698] Consequently, the Benefits Committee will be hamstrung by discord between CUPH and DHMO, regarding who is entitled to determine healthcare needs, and between the Fund and the Director General, regarding the budget setting process.

#### *4.4.3.2.2 Material realisation of healthcare benefits*

The Constitution mandates that the right of access to healthcare be progressively realised. Therefore, the core focus of the benefits package is to ensure that beneficiaries of the health

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[692] Any treatment that falls outside the scope of the healthcare plan benefits will be considered complementary cover for the user's own account. Clauses 25(5)(*a*) to (*b*) of the National Health Insurance Bill op cit note 27; Richard D. Lamm 'Rationing of Healthcare: Inevitable and Desirable' (1992) 140 *University of Pennsylvania Law Review* 1511 at 1519; Rice & Smith op cit note 677 at 250.

[693] Davis Tax Committee op cit note 627 at 21; Rice & Smith op cit note 677 at 252; *White Paper on National Health Insurance* op cit note 570 at 27.

[694] Davis Tax Committee op cit note 627 at 22; Klasa, Greer & van Ginneken op cit note 627 at 458.

[695] Rice & Smith op cit note 677 at 266; Ghoddoosi-Nezhad, Janati & Zozani et al op cit note 616 at 102.

[696] Proposed amendment to section 31A(3)(*g*) of the National Health Act at clause 58 of the National Health Insurance Bill op cit note 27.

[697] The process of determining healthcare needs is inherently complex and includes factors such as age, gender, geographical location, housing tenure, and other social factors and requires forecasting future needs. Clause 37(2)(a) of the National Health Insurance Bill and the proposed amendment to section 31A(3)(b) of the National Health Act at clause 58 of the National Health Insurance Bill op cit note 27; Rice & Smith op cit note 677 at 258-59 and 264-65.

[698] Clause 35(3) of the National Health Insurance Bill op cit note 27; section 21(3)(*b*) of the National Health Act.

system can utilise healthcare entitlements.[699] This requires translating theoretical entitlements into tangible and claimable services.[700] The Benefits Committee will be constrained to fulfil this mandate given government's inability to raise sufficient revenue to purchase healthcare.[701] Government sought to navigate this quagmire by prioritising the Fund's fiscal sustainability at the expenses of the healthcare benefit package.[702] Therefore, the benefits package will be confined to preventative and promotive services.[703]

Government has ambitions to gradually increase this benefit package as a means to progressively realise the right of access to healthcare.[704] This, however, is a mere ambition that cannot be achieved because of the bleak forecast regarding government's ability to raise additional revenue to purchase healthcare.[705] Accordingly, the Bill will merely shift the focus of inequities from healthcare being inaccessible to segments of the population to a reduction in the range of services.[706] Therefore, the Bill will cause a regression in access to healthcare that will infringe upon the rights of all beneficiaries who can access services under the prevailing health system, whether in the public or private sector.[707]

#### *4.4.3.3 Purchasing healthcare services*

The primary objective of strategic purchasing is to ensure that high-quality healthcare services are accessible.[708] This process requires distributing revenue in accordance with the benefit package through strategic contracting arrangements with providers.[709] This contracting framework should aim to improve the health system's performance so that it can endure resource limitations by coordinating service providers, increasing the efficient use of physical

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[699] Davis Tax Committee op cit note 627 at 6.
[700] Fatima Urooj 'Right to Health – A Comparative Analysis between South Africa and India' (2020) 3 *International Journal of Law, Management & Humanities* 306 at 306.
[701] Ibid 43.
[702] Clause 57(4)(*f*) of the National Health Insurance Bill op cit note 27; paragraph 4.5 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538; Davis Tax Committee op cit note 627 at 22.
[703] This would be confined to reproductive, maternal, paediatric, mental, oral, emergency, rehabilitation, and palliative healthcare with limited access to medications and radiology services. Department of Planning, Monitoring and Evaluation op cit note 30 at 28; Davis Tax Committee op cit note 627 at 6.
[704] Clause 57(3)(*d*) of the National Health Insurance Bill op cit note 27; paragraph 4.6 and 8.1(*c*) of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538.
[705] World Health Organization *Strategic Purchasing* op cit note 684 at 8; Bloom, Khoury & Subbaraman op cit note 503 at 3.
[706] Gani op cit note 630 at 58; Davis Tax Committee op cit note 627 at 5.
[707] For example, the Medical Schemes Act 131 of 1998 compels medical schemes to provide prescribed minimum benefits that will be more comprehensive than the Fund's benefit package. Regulation 7 and 8 and annexure A to the Medical Schemes Act Regulations op cit note 321.
[708] Ghoddoosi-Nezhad, Janati & Zozani et al op cit note 616 at 104.
[709] Rice & Smith op cit note 677 at 250-251; Blecher, Daven & Dudley et al op cit note 596 at 31.

resources and healthcare personnel, and decreasing costs.[710] Contracting arrangements thus shape the supply of healthcare services.[711] While the contracting process is multifaceted, two main processes guide the purchasing of services from healthcare providers. The first process requires identifying which provider to purchase services from.[712] The second process involves negotiating the terms of the contract with the provider.[713] This will occur through the accreditation and certification process set forth in the Bill.[714] Ultimately this framework should foster synergy between purchasers and providers to realise the right to healthcare.[715]

#### *4.4.3.3.1 Purchaser-provider-split*

An effective purchasing strategy requires a clear division between purchasers and providers.[716] This is necessary to motivate providers to compete by improving the efficiency of their operations to increase their profitability.[717] This can only be achieved when providers have sufficient autonomy from purchasers.[718] Notwithstanding the necessity of this division, government has elected to commandeer the health system rather than enact a framework to facilitate this purchaser-provider-split.[719] The consequences of this failure are twofold. First, providers will be impervious to payment mechanisms that are employed to incentivise improvements in their performance.[720] Secondly, the supply of healthcare will become entangled with political considerations.[721]

The purchaser-provider-split is also necessary to encourage the expansion of the healthcare provider market considering South Africa's shortage of doctors and hospitals.[722] Contrary to this imperative, the Bill's autocratic framework aims to eradicate private sector

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[710] Klasa, Greer & van Ginneken op cit note 627 at 467; Department of Health *Executive Summary of the report of the Committee of Inquiry into a National Health Insurance System* (1995) 3.
[711] Klasa, Greer & van Ginneken op cit note 627 at 459.
[712] Ibid at 458.
[713] Ibid at 469.
[714] Clause 39 of the National Health Insurance Bill op cit note 27.
[715] Section 27 *Health Reform Perspective and Proposals* (November 2021) 5.
[716] World Health Organization *Strategic Purchasing* op cit note 684 at 4.
[717] Ibid.
[718] Klasa, Greer & van Ginneken op cit note 627 at 467.
[719] Department of Planning, Monitoring and Evaluation op cit note 30 at 29-30, clause 7(2)(*f*)(*iii*) of the National Health Insurance Bill op cit note 27; paragraphs 4.10-4.11 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538; Blecher, Daven & Dudley et al op cit note 596 at 30.
[720] Klasa, Greer & van Ginneken op cit note 627 at 467.
[721] Rice & Smith op cit note 677 at 258-59.
[722] Nicolas Crisp 'South Africa Needs more Doctors and Dentists' (2011) 101 *South African Medical Journal* 517 at 517; Natalie Cowling 'Medical Doctors per 10, 000 population in South Africa from 2016 to 2021' *STATISTA* 19 September 2023 available at *https://www.statista.com/statistics/1413514/medical-doctors-per-10-000-population-in-south-africa/,* accessed on 3 July 2024.

providers from the health system.[723] This is evidenced by the Bill's exclusion of PHEs as healthcare providers from the envisioned contracting framework.[724] Instead, contracting for hospital services shall be confined to public hospitals, regardless of the poor quality of their services.[725] The viability of PHEs is therefore interconnected to medical schemes. Consequently, the collapse of the medical scheme market will cripple PHEs and ultimately result in their ruination. This anti-competitive conduct will extend to all providers in the private sector as the Bill has prioritised contracting with the public sector.[726] As such contracting will neither be based on merit nor the provider's performance, it will not be strategic.[727] Government devised this anti-competitive scheme as a method to simplify its control over healthcare costs.[728]

The envisioned purchasing framework will not only contravene section 217(1) of the Constitution that demands that procurement of services be fair and competitive, but will also destabilise the healthcare provider market. [729] This is consequent upon the skills migration and withdrawal of investment that will occur as a result of curtailing doctors' ability to practice and PHE's ability to generate profit.[730] This will compound the existing critical shortage of doctors and decrease the availability of hospital services.[731] As the envisioned contracting framework will impair access to healthcare services it is unlikely to withstand constitutional challenge.[732]

#### *4.4.3.3.2 Accreditation*

[723] Department of Planning, Monitoring and Evaluation op cit note 30 at 16; *Green Paper on National Health Insurance in South Africa* op cit note 348 at 11.
[724] This includes the intention to repeal legislation that entitles certain classes of individuals from accessing healthcare in the private sector and by limiting the Funds responsibility to pay for healthcare services to the public sector. Proposed amendments to the Occupational Diseases in Mines and Works Act 78 of 1973, Compensation for Occupational Injuries and Diseases Act 130 of 1993, and the Road Accident Fund Act 56 of 1996 at clause 58 of the National Health Insurance Bill op cit note 27.
[725] Clause 35(2) and 57(4)(*g*)(*iii*) of the National Health Insurance Bill op cit note 27; Department of Planning, Monitoring and Evaluation op cit note 30 at 28-9; Davis Tax Committee op cit note 627 at 26.
[726] The Bill only makes provision for contracting to a limited number of healthcare private healthcare providers. See the definition of primary healthcare providers at clause 1 of the National Health Insurance Bill op cit note 27. Although the Fund shall retain the sole authority to determine who to accredit, the CUPH, as a purchaser and provider of healthcare, is also responsible for determining who the Fund will contract with. Clause 37(2)(*b*), Clause 57(4)(g)(*iii*) of the National Health Insurance Bill op cit note 27; Blecher, Daven & Dudley et al op cit note 596 at 36.
[727] Clause 35(2) and 37(2)(*d*) of the National Health Insurance Bill op cit note 27; Davis Tax Committee op cit note 627 at 3; Klasa, Greer & van Ginneken op cit note 627 at 458.
[728] Department of the Presidency *National Development Plan* op cit note 562 at 341; Blecher, Daven & Dudley et al op cit note 596 at 36.
[729] National Assembly *Report of the Portfolio Committee* op cit note 636 at 10; World Health Organization *Strategic Purchasing* op cit note 684 at 9-10.
[730] Ndebele, Mlambo & Molepo op cit note 537 at 337.
[731] Department of Health op cit note 20 at 127; Department of the Presidency *National Development Plan* op cit note 562 at 51-52.
[732] *Minister of Health v New Clicks* (supra) note 377 para 403-404 and 651.

The Bill purports that the selection of healthcare providers that will be contracted by the Fund to render services will be governed by an accreditation process. The decision of which provider to accredit, and thus to purchase services from, should be subject to a degree of discretion.[733] Such discretion should be exercised to determine how to secure services based on factors such as the quality of the provider's service and other performance benchmarks such as quantity, efficiency, and cost.[734] In stark contrast, the Bill requires a rigid and formalistic application of the accreditation criteria and thus removes the exercise of discretion from the process.[735] This includes limiting accreditation and contracting to specified healthcare providers.[736]

The accreditation process is the main mechanism to secure services by contracting with healthcare providers for two reasons. First, the Bill limits beneficiaries' access to healthcare by stipulating that services must be sought at accredited providers.[737] Secondly, providers are required to be accredited by the Fund before they receive payment for their services.[738] Therefore, the accreditation criteria aims to dictate how to access healthcare services, where services will be rendered, and who will render services.[739] Simultaneously, the Bill confines providers' ability to practice, dictates how services should be rendered, and sets the terms and conditions for payment to providers.[740] The Bill makes provision for several accreditation criteria.

The first accreditation criteria pertains to the type and range of services.[741] Although this should be determined by the Benefits Committee,[742] the Minister has been granted unfettered discretion to usurp the Committee's determinations regarding the services healthcare providers will be required to render.[743] Regardless of the Minister's interference, the range of services will be meagre as contracting will be confined to public sector providers notwithstanding its lack of infrastructure, equipment, and human resources to render the full ambit of healthcare

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[733] Hoexter op cit note 452 at 319-322.
[734] Blecher, Daven & Dudley et al op cit note 596 at 31; Klasa, Greer & van Ginneken op cit note 627 at 469.
[735] Blecher, Daven & Dudley et al op cit note 596 at 36.
[736] Clauses 55(1)(*m*) and 57(4)(*f*) of the National Health Insurance Bill op cit note 27; paragraph 4.6 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538.
[737] Clause 7(4)(*c*) of the National Health Insurance Bill op cit note 27; Davis Tax Committee op cit note 627 at 6.
[738] Clause 35(2) of the National Health Insurance Bill op cit note 27.
[739] Clauses 7(2)(*a*) to (*d*), 7(3), 57(4)(*f*) of the National Health Insurance Bill op cit note 27.
[740] Services will be limited to the benefit package, a prescribed treatment protocols, referral pathways between healthcare establishments, and to a formulary of medication, all of which shall be set by government. Clauses 7(2)(*e*), 7(4)(*c*), 11(1)(*i*)(*viii*), 25(5)(*b*), and 25(7) of the National Health Insurance Bill and the proposed amendments to the Health Professions Act 56 of 1974, the Allied Health Professions Act 63 of 1982, and the Medical Schemes Act 131 of 1998 at clause 58 of the National Health Insurance Bill op cit note 27.
[741] Clauses 39(2)(*c*)(*i*) and 39(2)(*c*)(*ii*) of the National Health Insurance Bill op cit note 27.
[742] Clause 25(5)(*a*) of the National Health Insurance Bill op cit note 27.
[743] Clauses 39(2)(*c*)(*i*) and 39(2)(*c*)(*ii*) of the National Health Insurance Bill op cit note 27.

services.[744] Accordingly, providers will be confined to rendering basic nursing services.[745] These limitations are unlikely to change for the foreseeable future due to ongoing fiscal constraints.[746] Accordingly, the Bill is not reasonably conceived as it will infringe on the right of access to healthcare due to regressive consequences of the envisioned framework.

The second accreditation criteria requires that providers adhere to treatment protocols.[747] The Benefits Committee in conjunction with the Office of Health Products Procurement will be responsible for formulating the requisite protocols.[748] These protocols aim to ration healthcare by controlling the demand for services, and thus costs, by limiting which services will be available and by stipulating how services shall be rendered.[749] Although this rationing process should be based on evidence-based treatment, it remains vulnerable to political interference by the Minister.[750] Treatment protocols are utilised internationally to assist and guide healthcare providers to optimise the use of resources and improve treatment decisions.[751] Nevertheless, the Bill requires strict compliance with these protocols if providers intend to obtain and retain their accreditation status.[752] Elevating protocols from guidelines to explicit rules not only interferes with doctors' clinical independence but also their autonomy.[753] Accordingly, doctors will likely refuse to contract with the Fund.[754] In such instance, there will be insufficient healthcare providers to render services.

The third accreditation criterion requires compliance with referral pathways.[755] The referral system aims to ration healthcare demands by limiting the choice of providers and restraining how service shall be accessed.[756] In this regard, basic healthcare services will be

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[744] Davis Tax Committee op cit note 627 at 10-11; Klasa, Greer & van Ginneken op cit note 627 at 469; Brand op cit note 559 at 127.
[745] R Surender, R Van Niekerk, & L Alfers 'Is South Africa Advancing Towards National Health Insurance? The Perspective of the General Practitioner in One Pilot Site' (2016) 106 *South African Medical Journal* 1092 at 1092.
[746] Davis Tax Committee op cit note 627 at 43.
[747] Clause 39(2)(*c*)(*iii*) of the National Health Insurance Bill op cit note 27.
[748] Clauses 25(5)(*b*), 38(4), and 55(1)(*o*) of the National Health Insurance Bill op cit note 27.
[749] Lamm op cit note 691 at 1519; Department of the Presidency *National Development Plan* op cit note 562 at 341.
[750] Clause 55(1)(*o*) of the National Health Insurance Bill op cit note 27; Klasa, Greer & van Ginneken op cit note 627 at 469; *Green Paper on National Health Insurance in South Africa* op cit note 348 at 16-17.
[751] T.S Sathyanarayana Rao & Abhinav Tandon 'Clinical Practical Guidelines: Principles for Clinical Practice (2017) 59 *Indian Journal of Psychiatry* 5 at 5.
[752] Clause 39(8)(*d*) of the National Health Insurance Bill op cit note 27.
[753] Rao & Tandon op cit note 750 at 5; Davis Tax Committee op cit note 627 at 11.
[754] During the pilot implementation of the Bill, doctors declined to contract with the Fund. National Department of Health *Evaluation Report on the Evaluation of the Phase 1 Implementation of the Interventions in the National Health Insurance Pilot Districts in South Africa NDOHl0/2017-2018* (July 2019) 98; Davis Tax Committee op cit note 627 at 11.
[755] Clause 39(2)(*c*)(*iv*) of the National Health Insurance Bill op cit note 27.
[756] Department of Planning, Monitoring and Evaluation op cit note 30 at 27; Blecher, Daven & Dudley et al op cit note 596 at 32.

accessed through clinics that will act as gatekeepers and referral agents to costly curative treatment rendered by public hospitals.[757] These referral pathways shall be determined by the Fund in conjunction with the National Health Council.[758] As the Bill requires strict and rigid compliance with the referral pathways, doctors who render primary healthcare services will be confined to referring patients to public hospitals if they wish to retain their accreditation status.[759] This referral-based system will not only interfere with these doctors' clinical independence but also have a devastating impact on specialist doctors who will be forced to close their practices when the medical scheme market collapses.[760] This closure is linked to the Bill's exclusion of specialist doctors from the health system.[761] Therefore, these referral pathways will infringe on doctors' constitutional right to freedom of trade, occupation, and profession.[762] This infringement will cause a mass immigration of doctors that will exacerbate the critical shortage of healthcare providers.[763] Therefore the Bill is not reasonably conceived as it will not only impact the quality of services but will cause a significant regression in access to healthcare.[764]

As the fundamental goal of strategic purchasing is to secure access to quality healthcare services, the fourth accreditation criteria pertain to specified performance standards.[765] Poor quality of healthcare is pervasive in the public sector with the majority of public hospitals failing to meet the performance requirements set by the Office of Health Standards Compliance ('OHSC').[766] Accordingly, there needs to be a drastic improvement in the quality of healthcare services if government intends to solely contract with public hospitals.[767] Government

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[757] Section 44(2) of the National Health Act op cit note 15; section 31A(3)(i) of the proposed amendment to the National Health Act at clause 58 of the Bill.
[758] Clauses 11(1)(*i*)(*viii*) and 39(8)(*e*) of the National Health Insurance Bill op cit note 27; section 23(1)(*a*)(*vii*) of the National Health Act cite note 15.
[759] Clause 57(4)(*f*) of the National Health Insurance Bill op cit note 27; Department of Planning, Monitoring and Evaluation op cit note 30 at 27; and *White Paper on National Health Insurance* op cit note 570 at 27.
[760] National Assembly *Report of the Portfolio Committee* op cit note 636 at 8 and 10; John Bryant & Julius Richmond 'Alma-Ata and Primary Healthcare: An Evolving Story' in Stella Quah & Kristian Heggenhougen (eds) *International Encyclopaedia of Public Health* (2017) 83 at 83.
[761] Clause 57(4)(*f*) of the National Health Insurance Bill op cit note 27.
[762] Furthermore, doctors have raised concerns about their inability to balance their ethical obligations to prioritise patients given the limitations on their ability to practice imposed by the Bill's framework. Section 22 of the Constitution; National Assembly *Report of the Portfolio Committee* op cit note 636 at 10; South African Medical Association *The South African Medical Association Submissions to: The Parliamentary Portfolio Committee on Health* (29 November 2019) 20-21.
[763] Department of the Presidency *National Development Plan* op cit note 562 at 51-52, 329; Ndebele, Mlambo & Molepo op cit note 537 at 337.
[764] National Assembly *Report of the Portfolio Committee* op cit note 636 at 8; Ndebele, Mlambo & Molepo op cit note 537 at 337.
[765] Clause 39(6) and 39(8)(*h*) of the National Health Insurance Bill op cit note 27.
[766] Davis Tax Committee op cit note 627 at 10; Blecher, Daven & Dudley et al op cit note 596 at 37.
[767] Klasa, Greer & van Ginneken op cit note 627 at 458.

mistakenly believes that the quality of public hospitals' services will improve by enforcing compliance with the set treatment protocols.[768] This logic disregards the dearth of infrastructure, equipment, and healthcare personnel in the public sector.[769] Hence, the resolution of these deficiencies will be significantly more complex than what government portrays for two reasons. First, performance improvements require significant investment from the dwindling healthcare budget.[770] Secondly, additional issues such as poor governance and management in public hospitals need to be resolved.[771] To date, government's attempts to improve the quality of services in the public sector have been unsuccessful.[772] Paradoxically, these efforts include publishing standard treatment guidelines for public hospitals that have failed to yield any improvements in the calibre of services.[773] As such, many public hospitals will not be capable of meeting the performance standards set by OHSC and thus cannot be accredited by the Fund.[774] Therefore there would be a significant regression in access to hospital-based healthcare services. The Bill enables the Minister to navigate this quandary by circumventing this accreditation criteria.[775] In such instance, the standards of public hospital services will continue to be poor which will undermine the utilisation of healthcare and realisation of this constitutionally enshrined right.

The final accreditation criteria pertains to the adherence to the national pricing regime.[776] This regime aims to control the supply of healthcare by ensuring that the Fund's expenditure on purchasing services does not exceed the set healthcare budget.[777] Accordingly, government has prioritised the Fund's fiscal sustainability at the expenses of purchasing healthcare.[778] This is contrary to a framework that increases access to healthcare by containing expenditure by designing reimbursement models to incentivise providers to render cost-effective services.[779] These reimbursement models would curb issues such as over-servicing and shift the risk for

[768] Department of Planning, Monitoring and Evaluation op cit note 30 at 24.
[769] Department of Planning, Monitoring and Evaluation op cit note 30 at 14 and 23; Davis Tax Committee op cit note 627 at 10.
[770] Department of Planning, Monitoring and Evaluation op cit note 30 at 14 and 23; Lamm op cit note 691 at 1519.
[771] Department of Planning, Monitoring and Evaluation op cit note 30 at 23; Blecher, Daven & Dudley et al op cit note 596 at 37; Department of the Presidency *National Development Plan* op cit note 562 at 336.
[772] Gani op cit note 630 at 6; South African Law Reform Commission *Discussion Paper* op cit note 570 at 25.
[773] Department of Health *Standard Treatment Guidelines and Essential Medicines List for South Africa* (2012).
[774] Clause 39(8)(*b*) of the National Health Insurance Bill op cit note 27.
[775] Clause 39(12) of the National Health Insurance Bill op cit note 27.
[776] Clause 39(2)(*c*)(*vi*) of the National Health Insurance Bill op cit note 27.
[777] Department of Planning, Monitoring and Evaluation op cit note 30 at 28; Rice & Smith op cit note 677 at 251.
[778] Paragraph 4.5 of the Memorandum on the Objects of the National Health Insurance Bill op cit note 538; Davis Tax Committee op cit note 627 at 22.
[779] Department of Planning, Monitoring and Evaluation op cit note 30 at 26 and 29; Klasa, Greer & van Ginneken op cit note 627 at 468-69

variations of expenditure onto providers to make them more sensitive to costs.[780] Instead of establishing a fair and reasonable reimbursement framework, government intends to manipulate its monopoly on healthcare financing to control providers' costs.[781] This is incompatible with effective strategic purchasing that leverages different payment techniques to encourage improvements in providers' performance.[782]

### *4.4.4 Overall effects of the Bill*

The politicising of healthcare, as envisioned by the Bill, will harken the health system back to the pre-democratic era. This will mean that access to healthcare will be vulnerable to manipulation to achieve political ideology. Autocracy aside, the basic premise of the administrative structure set forth in the Bill is neither reasonable nor sustainable as government lacks the expertise and operational capacity to administer the envisioned monolith of the monopsony. This will be compounded by the decrease in revenue to purchase healthcare services. Finally, the Bill's strategic purchasing framework will cause a regression in access to healthcare. Consequently, the healthcare administration, raising and pooling of revenue, and the strategic purchasing framework envisioned by the Bill is unreasonable and irrational.

## 4.5 CONCLUSION

The analysis in this chapter illustrates that access to healthcare is not merely a constitutional right but a fundamental human right. Realising this right is central to the transformative vision espoused by the Constitution to overcome the injustices of the past. Progressive realisation of the right to healthcare requires that government take active steps to reform the health system. This, however, does not mean that the court will merely endorse healthcare reform that is irrational and unreasonable, no matter how worthy its intentions may be.[783]

Facilitating access to healthcare is premised on reform that sustainably and progressively builds on the existing health system's strengths. Concomitantly, this reform should gradually resolve the health system's weaknesses which includes issues with healthcare service delivery.

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[780] Rice & Smith op cit note 677 at 255 and 267-68.
[781] Klasa, Greer & van Ginneken op cit note 627 at 469; National Assembly *Report of the Portfolio Committee* op cit note 636 at 10; Alan Cohen 'The Debate over Health Care Rationing: Déjà Vu All Over Again?' (2012) 49 *Inquiry* 90 at 96.
[782] Klasa, Greer & van Ginneken op cit note 627 at 459.
[783] *Minister of Health v New Clicks* (supra) note 377 para 651.

Contrary to these precepts, government intends to drastically and abruptly overhaul the entire health system. This will neither achieve the healthcare transformation that is desperately required, nor will it be sustainable. At best, the Bill represents a hostile attempt by government to realise its constitutional mandate under the fallacy of constitutionally valid healthcare reform.

The Bill's framework will cause the private sector to disintegrate, with the ruination of the medical scheme market and PHEs, which will ultimately destabilise the health system and cause a regression in access to healthcare. This regression will unjustifiably infringe upon existing entitlements to healthcare, both in the private and public sectors, and will fall short of government's duty to progressively realise this constitutional right. Accordingly, implementation of the Bill's draconian provisions is neither reasonable nor tenable.

## CHAPTER 5: THE PATH TO A UNIFIED NATIONAL HEALTH SYSTEM

The analysis in the preceding chapters evidences a dire need for healthcare reform. Chapter 2 reveals that reform is necessary to effect reparations to contend with the private sector's sordid history. Chapter 3 exhibits that the health system continues to be fragmented and that the private sector is rife with inefficiencies that have impeded the realisation of the right to healthcare. Accordingly, access to healthcare continues to be inequitable in the post-democratic era. Chapter 4 reveals that while the government is committed to healthcare reform, the vector that it has chosen, namely the National Health Insurance Bill,[784] will cause a regression in access to healthcare that will infringe upon existing entitlements and impede the progressive realisation of this right. Therefore, the question remains, how can the health system be unified to achieve equity in access to healthcare to fulfil this constitutional right?

International experience can guide South Africa to determine how to achieve such unification. This requires establishing a regulatory framework for healthcare reform that unifies the health system to realise the right to healthcare, and thus Universal Healthcare ('UHC'), based on collaboration between government and the private sector.[785] Such a framework should focus on leveraging and optimising the use of resources in the private sector, as the government cannot realise this constitutional right by solely relying on the public sector.[786] This framework requires a new approach to govern private funders and PHEs.[787] Based on this paradigm, the premise of the question changes to how do government and the private sector work together to realise the right to healthcare.[788] This chapter will analyse how such collaboration and cooperation can be achieved.

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[784] National Health Insurance Bill op cit note 27.
[785] Section 27 *Health Reforms Perspective and Proposals* (November 2021) 12; Janet Michel, Brigit Obrist & Til Barnighausen et al 'What We Need is Health System Transformation and Not Health System Strengthening for Universal Coverage to work: Perspectives from a National Health Insurance Pilot Site in South Africa' (2020) 62 *South African Family Practice* 1 at 10; United Nations *Addressing Inequalities: The Heart of Post-2015 Development Agenda and the Future We Want for All* (May 2012) 12.
[786] Mohanna Rajabi, Parvin Ebrahimi & Aidin Aryankhsesal 'Collaboration Between the Government and Nongovernmental Organizations in Providing Health-Care Services: A Systematic Review of Challenges' (2021) 30 *Journal of Education and Health Promotion* 1 at 1.
[787] Section 27 *Health Reforms* op cit note 785 at 19; World Health Organization *Engaging the Private Health Service Delivery Sector through Governance in Mixed Systems* (July 2020) 14.
[788] World Health Organization *Health Reforms Perspective and Proposals* (November 2021) 12.

## *5.1 MODELS OF UNIVERSAL HEALTHCARE ACROSS THE WORLD*

South Africa is required to devise its own path to progressively realise the right to healthcare. Formulating the appropriate strategy will invariably focus on improving the existing health system by balancing constitutional entitlements to avoid unjustified infringements of competing rights.[789] This will ensure that policies and legislation are specifically tailored to address issues within South Africa's health system.[790]

Internationally, heterogeneous methods have been applied to achieve UHC.[791] While South Africa cannot replicate other countries' pathways to achieve UHC, it is nonetheless instructive to analyse their respective successes and failures.[792] Experience gleaned from other countries reveals that expertise in UHC is not a necessary prerequisite for healthcare reform.[793] Rather, developing nations concentrated their efforts on improving their health systems' capacity, in the short-to-medium term, and focused on cohesion as a long-term objective.[794] This is evident in countries such as Mexico, South Korea, Turkey, and Ghana.[795] These reforms were premised on the specific objectives that are canvassed below.

### *5.1.1 Extent and pace of reform*

Appraisals of other countries' health systems reveal that the success of healthcare reforms is predicated on their government's unassailable commitment to establish a unified and coherent framework for UHC, combined with a vigorous implementation strategy.[796] This requires that healthcare be prioritised by adhering to and enforcing UHC legislation.[797] Ghana, a lower-middle-income country, made substantial progress with its UHC reforms because of its

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[789] Joseph Kutzin, Winnie Yip, & Cheryl Cashin 'Alternative Financing Strategies for Universal Health Coverage' in Richard Scheffler (ed) *World Scientific Handbook of Global Health Economics and Public Policy – The Economics of Health and Health Systems* (2016) 268-69.
[790] Ibid 274.
[791] Ibid 268.
[792] Chapman op cit note 575 at 125; Alexander Preker, Daniel Cotlear & Soonman Kwon et al 'Universal Health Care in Middle-Income Countries: Lessons from Four Countries' (2021) 11 *Journal of Global Health* 16004 at 16004.
[793] Anne Mills & Sara Bennett 'Lessons on the Sustainability of Health Care Funding from Low–and Middle-Income Countries' in Elias Mossaialos, Anna Dixon & Joseph Figueras (eds) *Funding Healthcare: Options for Europe* (2002) 208 at 208.
[794] William Hsiao 'Design and Implementation of Social Health Insurance' in R Paul Shaw (ed) *Social Health Insurance for Developing Nations* (2007) 30.
[795] Preker, Cotlear & Kwon op cit note 792 at 16006, 16012, and 16016-17.
[796] William Hsiao and R Paul Shaw 'Lessons Learned and Policy Implications' in R Paul Shaw (ed) *Social Health Insurance for Developing Nations* (2007) 171.
[797] Kutzin, Yip, & Cashin op cit note 789 at 268.

government's commitment to enforce the legislative framework that was enacted to realise the right to healthcare.[798] Conversely, Kenya's UHC programme was undermined by 'political contestation'.[799]

The pace of reform is dependent on factors such as the degree of political commitment, prioritisation of healthcare, and economic growth.[800] Typically, progressively improving the health system's capacity takes decades.[801] Mexico took 50 years to make substantial progress with its UHC reforms, South Korea took 26 years to fully integrate its multi-funder market, Turkey took 47 years to achieve high levels of enrolment in its UHC programme, and Thailand focused on building its government's capacity to regulate the health system over a period of two decades.[802] Conversely, countries that rapidly implemented drastic reforms, such as Ukraine and Zambia, serve as cautionary tales as the sustainability of these systems hang precariously on the brink of collapse.[803]

### *5.1.2 Healthcare financing*

Successful UHC programmes require that voluntary healthcare insurance ('VHI'), such as South Africa's private funders market, migrate to compulsory financing.[804] Compulsory financing combats adverse selection which is a common characteristic of VHI that invariably causes a drastic increase in membership fees and excludes the most vulnerable and poor in society.[805] Adverse selection decreases the diversity of cross-subsidisation, including income and risk cross-subsidisation, which is vital to sustainable healthcare financing.[806] Accordingly, a key objective of financing reform is the reduction of fragmentation in the pooling of revenue that is raised for healthcare.[807]

There are mixed reviews on whether a compulsory financing system should raise revenue through a single or multi-funder framework.[808] What is apparent, however, is that the type of

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[798] Gani op cit note 630 at 71; The World Bank 'Data for Lower-Middle-Income Countries' available at *https://data.worldbank.org/?locations=XN-GH,* accessed on 16 September 2023.
[799] William Hsiao and R Paul Shaw 'Introduction, Context, and Theory' in R Paul Shaw (ed) *Social Health Insurance for Developing Nations* (2007) 3 at 3.
[800] Preker, Cotlear & Kwon op cit note 792 at 16017 and 16008-16009.
[801] Ibid at 16016-17.
[802] Gani op cit note 630 at 65-67; Hsiao op cit note 794 at 14 and 35.
[803] Preker, Cotlear & Kwon op cit note 792 at 16006 and 16012.
[804] Kutzin, Yip, & Cashin op cit note 789 at 268.
[805] Ibid 276.
[806] Ibid 282.
[807] Ibid 270.
[808] Preker, Cotlear & Kwon op cit note 792 at 16017; Anita Ho 'Health Insurance' in Hen Have (ed) *Encyclopaedia of Global Bioethics* (2015) 1 at 3.

financing system is specific to each country's economic development and history.[809] In determining the suitability of the financing system, countries need to be aware that single-funded systems inevitably experience difficulties of increasing fiscal debts to finance the health system.[810] This is evident in countries such as Norway, Portugal, and the United Kingdom which have advanced economies and health systems.[811] However, a bleak picture arises when considering the effects of a single-funded health system in countries with less advanced economies. Ukraine, a previously lower-middle-income country, introduced reforms to establish a single-funded system that ultimately impeded access to healthcare.[812] This was due to its financial and political instability.[813] Consequently, reforms that were designed to ensure that healthcare was affordable had an inverse effect as both out-of-pocket-payments and catastrophic healthcare expenditure increased drastically.[814]

A successful multi-funder framework is based on comprehensive regulations to govern competition in the private funder and healthcare provider market.[815] This requires strong governmental stewardship of the health system.[816] Countries such as France, Japan, and the Netherlands provide UHC based on a well-regulated multi-funder system.[817] The trend in middle-income-countries, where fiscal constraints hinder the progress of UHC programmes, is to establish a tiered multi-funder financing system.[818] Such systems were implemented in Mexico, Thailand, Turkey, and South Korea.[819] Processes were established in these countries to ensure that there was adequate cross-subsidisation in each tier to safeguard the sustainability of the financing system.[820]

The manner in which financial reforms are formulated should be carefully considered. In Mexico and South Korea, poorly formulated policies increased inequalities in access to healthcare as the poor and vulnerable received the least protection.[821] This was due to the fact that citizens who were employed in the formal sector were the first beneficiaries of the UHC

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[809] Michael Tanner 'The Grass is Not Always Greener: A Look at National Care Systems around the World' (2015) 5 *American Journal of Industrial and Business Management* 1 at 6.
[810] Ibid 7 and 34.
[811] Ibid 18-19 and 24.
[812] Preker, Cotlear & Kwon op cit note 792 at 16007; The World Bank 'Data for Ukraine' available at *https://data.worldbank.org/?locations=UA-XN*, accessed on 9 September 2023.
[813] Preker, Cotlear & Kwon op cit note 792 at 16007.
[814] Ibid at 16011.
[815] Ibid at 16012 and 16016.
[816] Ibid at 16008.
[817] Tanner op cit note 809 at 9, 16, and 22.
[818] Mills & Bennett op cit note 793 at 208.
[819] Preker, Cotlear & Kwon op cit note 792 at 16013, 16008, 16009; Gani op cit note 630 at 68-69
[820] Preker, Cotlear & Kwon op cit note 792 at 16009.
[821] Ibid 16006 and 16012.

programmes.[822] Thailand addressed this problem by limiting the extent of its government's subsidy to those employed in the formal sector who were beneficiaries of its compulsory social health insurance scheme.[823] Concomitantly, the Thai government created and funded separate schemes for low-income households that were partially subsidised, and the poor who were fully subsidised by its government.[824] Turkey tackled this issue by establishing a separate Fund for poor and low-income households that provided limited healthcare benefits.[825] These Funds were heavily subsidised by the Turkish government.[826] This, however, came at the expense of high governmental expenditure.[827] Advanced economies such as Germany, Netherlands, and Switzerland which have a multi-funder framework and managed competition system, have similar subsidies for the poor.[828]

### *5.1.3 Strategic purchasing – mechanisms to contain costs*

Strategic and effective purchasing of healthcare services are of equal importance to UHC reforms.[829] This is evident in Ghana where its government's progress towards UHC goals was thwarted by its inability to strategically purchase healthcare services.[830] Strategic purchasing aims to contain costs by rationing access to healthcare. Rationing occurs by curtailing the healthcare benefits provided by the UHC programme as a mechanism to contain costs. This includes the implementation of out-of-pocket payments systems, controlling the way healthcare services are accessed, restricting which providers are contracted to render healthcare services, and leveraging different payment mechanisms for healthcare services.

#### *5.1.3.1 Determining healthcare benefits*

Regardless of the financing system, limiting the range of services according to a defined benefit package is vital to the fiscal sustainability of a health system.[831] The failure to confine the benefit package caused financial instability in Italy, Japan, Portugal, and the United

[822] Ibid.
[823] Gani op cit note 630 at 68-69; Mills & Bennett op cit note 793 at 211-12.
[824] Hsiao op cit note 794 at 27; Gani op cit note 630 at 68-69.
[825] Preker, Cotlear & Kwon op cit note 792 at 16006 and 16009.
[826] Ibid 16013.
[827] Ibid 16010.
[828] Tanner op cit note 809 at 22, 25, and 30.
[829] Kutzin, Yip, & Cashin op cit note 789 at 270.
[830] Gani op cit note 630 at 72; Hsiao op cit note 794 at 34.
[831] Tanner op cit note 809 at 8-9.

Kingdom.[832] In contrast, countries such as Norway, Netherlands, and Switzerland, which actively manage benefits through a defined benefit package, had financially stable health systems.[833] An expressed benefit package is particularly prudent for countries that face fiscal constraints.[834] Several countries, such as Mexico, Thailand, Turkey, and South Korea established a tiered benefit system.[835] These countries' benefit packages gradually increased when their governments' fiscal capacities improved.[836] France mitigated the adverse effects of a limited benefit package by permitting a VHI market to operate and finance complementary healthcare.[837] However, as this system was unregulated, the costs of VHI was generally unaffordable.[838]

#### *5.1.3.2 Selecting healthcare providers*

Countries that face fiscal constraints invariably purchase services from the private sector as these governments do not have the required resources to render sufficient healthcare services to their population.[839] This is exemplified in Mexico and South Korea.[840] The inclusion of the private sector in these countries was accompanied by reform to progressively invest in public infrastructure and concomitant decentralisation to achieve greater provider autonomy in the public sector.[841] Turkey utilised its private sector providers to strategically expand access to healthcare services while progressively building the public sector's capacity.[842] This was particularly relevant to healthcare services rendered by PHEs that were accredited by the Turkish government.[843] France employed a similar system to contract with PHEs, however, this was subject to providers confining their charges in accordance with the government-set tariff of reimbursement.[844]

Collaboration between the government and the private sector was critical during the COVID-19 pandemic. Internationally, countries such as the United Kingdom, India, Nigeria,

[832] Ibid 12, 17, 19, and 24.
[833] Ibid 19, 22, and 28.
[834] Mills & Bennett op cit note 793 at 210.
[835] Preker, Cotlear & Kwon op cit note 792 at 16013, 16008, 16009; Mills & Bennett op cit note 793 at 212.
[836] Preker, Cotlear & Kwon op cit note 792 at 16006.
[837] Tanner op cit note 809 at 8.
[838] Ibid 8.
[839] Mills & Bennett op cit note 793 at 207; Gani op cit note 630 at 65-66.
[840] Preker, Cotlear & Kwon op cit note 792 at 16015; Gani op cit note 630 at 65-66.
[841] Preker, Cotlear & Kwon op cit note 792 at 16008, 16014 and 16015; Gani op cit note 630 at 68-69.
[842] Preker, Cotlear & Kwon op cit note 792 at 16006 and 16015.
[843] Ibid at 16015.
[844] Tanner op cit note 809 at 9.

and Liberia collaborated with the private sector to treat patients infected with Covid.[845] Even the South African government collaborated with the private sector to increase the availability of laboratory services during the pandemic.[846] Accordingly, the COVID-19 crisis is testament to the importance and feasibility of collaboration among the government and the private sector.[847] Therefore, it is evident that successful UHC programmes are premised on incorporating the private sector into the health system.[848]

#### *5.1.3.3 Out-of-pocket-payments*

Various countries utilise varying degrees of out-of-pocket payments ('OOPP') to curb the misuse of benefits and to contain costs.[849] Certain countries such as Italy, Portugal, and the Netherlands impose OOPP for expensive services such as specialist and hospital-based treatment.[850] Zambia serves to demonstrate the importance of OOPP as its government focused on UHC reforms to provide free healthcare services.[851] The Zambian government's failure to implement mechanisms to curb the misuse of benefits caused significant financial strain that threatened the sustainability of the entire health system.[852] Consequently, its government was ultimately forced to impose OOPP in the form of user fees to stabilise the Zambian health system.[853] Aside from preventing the misuse of benefits, OOPPs can be used strategically to motivate compliance with the health system's rules. For example, OOPPs were imposed on low-income households that failed to enrol in Thailand's partially subsidised government financing scheme.[854] These OOPPs were utilised to propel enrolment, which was a rule of the Thai health system. Ultimately, governments are required to strike a balance when imposing OOPP as user fees may act as a financial barrier to access healthcare that can have a negative influence on the utilisation of services.[855]

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[845] World Health Organization *Engaging the Private Sector* op cit note 787 at 11, 24, 26, and 28.
[846] Ibid 11.
[847] Ibid.
[848] Kutzin, Yip, & Cashin op cit note 789 at 274.
[849] Tanner op cit note 809 at 8, 16, 18, and 19.
[850] Ibid 13, 19, and 23.
[851] Mills & Bennett op cit note 793 at 214.
[852] Ibid.
[853] Ibid.
[854] Ibid 211.
[855] Adam Wagstaff et al 'Measuring Progress Towards Universal Coverage with an Application to 24 Developing Countries' (2016) 32 *Oxford Review of Economic Policy* 147 at 151-52.

#### *5.1.3.4 Manner of access*

Countries such as France, Italy, and Mexico focused on preventative and primary healthcare ('PHC') and established referral systems to higher levels of care, such as hospitals, to contain costs.[856] Referral systems can be tailored to a country's specific healthcare system's strengths. For example, the Turkish government leveraged its excess of general practitioners to render PHC services and act as referral agents to higher levels of care.[857] The failure to establish a referral system often results in a costly hospital-centric health system, as demonstrated in South Korea and Japan.[858] Referral systems can extend beyond rudimentary levels of referrals from PHC to expensive hospital-based treatment. The referral system in Spain and Switzerland included a network of providers, that rendered specialised healthcare, to encourage the efficient use of resources.[859] Conversely, poorly conceived referral systems can cause inefficiencies and hinder access to healthcare. Greece illustrates this point, as its health system prevented private sector doctors from referring patients to public hospitals for treatment, notwithstanding the patients' inability to pay for PHE's services.[860]

#### *5.1.3.5 Payment mechanisms*

There are no set rules when it comes to reimbursing providers. Rather, a variety of payment mechanisms are usually applied in different countries. Even within a country, payment mechanisms vary according to a region's specific contextual needs. Mixed payment systems including performance-based payments were used in Mexico,[861] while South Korea experimented with different payment mechanisms at various pilot sites in poor regions, which included government-controlled tariffs.[862] Countries such as France utilised global budgets and fee caps as part of their payment mechanisms.[863] However, this resulted in providers under-servicing patients as a means to improve their profitability.[864] The Thai and Swiss governments utilised capitation-based payments as it saved costs while simultaneously improving the quality

[856] Preker, Cotlear & Kwon op cit note 792 at 16014; Tanner op cit note 809 at 10 and 13.
[857] Preker, Cotlear & Kwon op cit note 792 at 16014.
[858] Preker, Cotlear & Kwon op cit note 792 at 16015; Tanner op cit note 809 at 17.
[859] Tanner op cit note 809 at 14 and 26.
[860] Ibid 21.
[861] Preker, Cotlear & Kwon op cit note 792 at 16014.
[862] Ibid at 16006 and 16015.
[863] Tanner op cit note 809 at 10.
[864] Ibid.

of healthcare services.[865] Other countries such as Italy and Japan imposed some form of fee restrictions on costly hospital services such as fixed fees or global budgets.[866]

Caution should be applied when selecting payment mechanisms as inappropriate financing structures can impede access to healthcare services. In France, misguided payment mechanisms caused hospitals to refuse treatment to patients as a means to avoid exceeding their set budgets.[867] Germany faced similar problems as PHEs refused to treat public sector patients as it was not economically feasible based on the selected payment mechanism.[868] A further example is Greece's failure to incorporate some form of payment incentivisation. Consequently, the quality of healthcare services was poor as providers were not motivated to improve their performance.[869] Accordingly, determining the appropriate payment mechanism is premised on an equipoise between healthcare financiers and providers to improve access to quality healthcare services.

### *5.1.4 Concluding remarks on healthcare reform*

Regardless of a country's path to UHC, every health system presented with issues in access to healthcare.[870] This is indicative of the fact that there is no 'magic bullet' for healthcare reform.[871] Rather, progress to achieve UHC is premised on experimentation to determine the most equitable health system that can be realistically achieved with limited resources.[872]

## 5.2 SOUTH AFRICA'S PATH TO UNIVERSAL HEALTHCARE

It is evident from the analysis of other countries that establishing a single fund to purchase healthcare services presents many difficulties and may not achieve the desired equity in the health system.[873] Issues with solvency in more advanced economies, such as France and Italy, have caused these governments to re-evaluate and reform their health system's policies in favour of stricter regulation of the healthcare market.[874] Accordingly, it is not surprising that

[865] Hsiao op cit note 794 at 4; Mills & Bennett op cit note 793 at 212.
[866] Tanner op cit note 809 at 13 and 17.
[867] Ibid 10.
[868] Ibid 30.
[869] Ibid 21.
[870] Ibid 10 and 34.
[871] Hsiao & Shaw op cit note 796 at 171.
[872] Preker, Cotlear & Kwon op cit note 792 at 16018.
[873] Gani op cit note 630 at 79.
[874] Ibid 58 and 79.

as upper-middle income country, the South African government faces various pragmatic impediments to solely realise the right to healthcare.[875] These obstacles include poor governmental stewardship of the health system, insufficient administrative capacity to effectively regulate the healthcare market, and a general inability to meet the demand for healthcare due to fiscal constraints and resource scarcity.[876] Consequently, collaborating with the private sector is essential for the government to meet its constitutional mandate to realise the right to healthcare.[877] This does not preclude the government from taking the helm of the health system in the long term.[878] In the interim, establishing and implementing a cohesive plan for healthcare, based on intermediate goals and objectives, would reduce the inequities caused by the existing fragmentation in the health system. This would be premised on a scheme that incorporates and leverages the private sector's existing capacity and resources.[879] The proposed reform should focus on migrating towards compulsory healthcare financing, reducing fragmentation in risk pools, and establishing a strong framework to strategically purchase healthcare services.

Significant progress in realising the right to healthcare can be achieved by reforming the existing health system, rather than exacting the drastic overhaul as envisioned by the National Health Insurance Bill.[880] This, however, is predicated on amendments to the legislative framework that governs the private and public sectors.[881] Prioritising cooperation between the public and private sectors through public-private partnerships ('PPPs') should be the main objective of such a framework.[882] These PPPs should aim to address the limitations present in the public sector and focus on improving efficiency in the private sector.[883] Such partnerships would conform with the private sector's desire for reform and its concomitant concession that access to healthcare is a right that should be capable of being exercised by all.[884] These PPPs would decrease inequalities in the health system and reduce the discrepancy between

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[875] Mongi James Jokozela *Public-Private Partnerships Contributions to Quality Healthcare: A Case Study for South Africa after 1994* (unpublished MCom thesis, University of Johannesburg, 2012) 106; The World Bank 'Data for South Africa' available at *https://data.worldbank.org/?locations=ZA-XT*, accessed on 16 September 2023.
[876] Kutzin, Yip, & Cashin op cit note 789 at 268, 274; Rajabi, Ebrahimi & Aryankhsesal op cit note 786 at 1.
[877] Jokozela op cit note 875 at 108.
[878] Kutzin, Yip, & Cashin op cit note 789 at 287.
[879] Mills & Bennett op cit note 793 at 222-223.
[880] Kutzin, Yip, & Cashin op cit note 789 at 268 and 275.
[881] Jokozela op cit note 875 at 107; Tanner op cit note 809 at 10.
[882] Maximus Asogwa & Severus Odozi Obodo 'Public Private Partnership in the Provision of Health Service for the Millennium Development Goals: The Imperative Need for Optimizing the Public-Private Mix' (2016) 12 *European Scientific Journal* 175 at 175-176.
[883] Ibid.
[884] Section 27 *Health Reforms* op cit note 785 at 12 and 15-17.

theoretical legal entitlements and the pragmatic utilisation of healthcare services.[885] This section shall canvass how the private sector can be utilised to achieve these goals.

### *5.2.1 Compulsory financing*

Countries, such as France, Japan, and the Netherlands, which have advanced economies with high levels of formal sector employment, established compulsory financing systems that were predominantly financed through dedicated payroll taxes for healthcare.[886] However, countries that have high levels of unemployment or large-scale employment in the informal sector, such as South Africa, are constrained in their ability to introduce similar financing systems.[887] Concomitantly, as the path to UHC is guided by the existing health system, the South African government cannot simply revoke existing entitlements to access healthcare that is conferred on members of medical schemes.[888] This issue, however, is not unique to South Africa. When Thailand and Mexico were confronted with similar constraints, and were thus unable to establish a single-funded system, they devised a solution that sought to close the gap between the number of people with and without insurance.[889] Both of these countries introduced a tiered compulsory financing system, with varying levels of government subsidisation, to generate additional revenue for healthcare.[890] A similar system can be adopted in South Africa to increase the portion of the population that is covered by this financing scheme.[891]

The first tier should establish a compulsory fund for those employed in the formal sector that generates revenue through payroll taxes that will be paid to selected medical schemes.[892] This is analogous to the Social Health Insurance ('SHI') that was proposed in 2002.[893] Thailand and Mexico's respective SHI schemes were adopted to avoid adverse selection that is prevalent among healthy sections of the population, that could afford VHI, but elected not to join as they deemed it unnecessary.[894] Adverse selection is more pervasive in South Africa as it extends to the different benefit packages provided by the various medical schemes. Under this system, the

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[885] Wagstaff op cit note 855 at 150 and 155; John Ataguba, Candy Day, & Di McIntyre 'Monitoring and Evaluating Progress towards Universal Health Coverage in South Africa' (2014) 11 *PLOS Medicine* 1 at 1.
[886] Tanner op cit note 809 at 8, 15-16, and 22.
[887] Kutzin, Yip, & Cashin op cit note 789 at 268.
[888] Ibid 283.
[889] Kutzin, Yip, & Cashin op cit note 789 at 283 and 293; Gani op cit note 630 at 68; Hsiao & Shaw op cit note 796 at 155 and 165.
[890] Kutzin, Yip, & Cashin op cit note 789 at 282 and 291; Hsiao op cit note 794 at 40.
[891] Wagstaff op cit note 855 at 149.
[892] Kutzin, Yip, & Cashin op cit note 789 at 283; Hsiao op cit note 794 at 16.
[893] Department of Health op cit note 20 at 85, 125, 130 and 137.
[894] Kutzin, Yip, & Cashin op cit note 789 at 276.

healthy opt for less costly benefit packages which ultimately reduces the effectiveness of risk cross-subsidisation. Accordingly, the recommendation to standardise medical scheme benefit options, as outlined in Chapter 3, is vital to the success of a SHI scheme. Limiting the scope of the different benefit options is required to force medical schemes to compete by improving the efficiency of their operations, rather than based on a member's self-assessed risk profile. Simultaneously, the Risk Equalisation Fund should be established to reduce the inefficiencies caused by the fragmentation across the various medical schemes' risk pools, as was proposed in 2004.[895] This will increase medical schemes' ability to contain costs.[896] The drastic increase in medical scheme membership from the SHI, with the concomitant ability to better control costs, would invariably decrease membership fees and consequently make membership more affordable.[897] As the South African Revenue Services ('SARS') is already responsible for monitoring the taxation of the formal sector, their services could be leveraged to establish the income threshold to identify which households will be compelled to join the SHI as well as monitor enrolment and enforcement of membership payments.[898] Under this system, government subsidisation for the SHI will decrease in accordance with a household's income level, with lower-income households receiving greater tax rebates.[899]

The second tier would establish a compulsory fund for low-income households.[900] The Low-Income Fund ('LIF') would comprise manual labourers employed in sectors such as farming and mining or other informal sector employment.[901] Revenue would be raised through employer and employee contributions that are partially subsidised by the government.[902] These contributions should be nominal to ensure that employers do not reduce salaries to accommodate such contributions.[903] This would be similar to schemes established in Zambia, Thailand, and South Korea.[904] To confer legitimacy, secure support, incentivise enrolment and ensure proper administration, the LIF should be managed by independent medical scheme Administration companies, as public confidence in government institutions is at an all-time

[895] Department of Health op cit note 321 at 128 and 131; Kutzin, Yip, & Cashin op cit note 789 at 283; Hsiao op cit note 794 at 32.
[896] Kutzin, Yip, & Cashin op cit note 789 at 287.
[897] Ibid 276.
[898] Kutzin, Yip, & Cashin op cit note 789 at 302; Preker, Cotlear & Kwon op cit note 792 at 1601; Section 4 of South African Revenue Services Act 34 of 1997; Income Tax Act 101 of 1990.
[899] Kutzin, Yip, & Cashin op cit note 789 at 291; Gani op cit note 630 at 68-69; Mills & Bennett op cit note 793 at 211-12.
[900] Kutzin, Yip, & Cashin op cit note 789 at 297.
[901] Mills & Bennett op cit note 793 at 212-213; Hsiao & Shaw op cit note 796 at 162.
[902] Kutzin, Yip, & Cashin op cit note 789 at 283.
[903] Hsiao op cit note 794 at 35.
[904] Mills & Bennett op cit note 793 at 214; Gani op cit note 630 at 66.

low.[905] This would be similar to Mexico, Ghana, and India which contracted with the private sector to render administration services as these governments lacked the practical skills and expertise to administer revenue to purchase healthcare.[906] As SARS is responsible for monitoring and collecting taxes from industries, such as farms and mines, its structural capacity could be leveraged to monitor enrolment and enforce contributions to the LIF.[907] As the success of this Fund is directly linked to the ability to enrol and collect revenue from this target population, contributions from the informal sector could be secured by enforcing OOPP on patients who do not hold the requisite documentation to receive healthcare from the third-tier Fund.[908] This would be similar to the system utilised by the Thai government.[909]

The final tier fund that would be for the poor and destitute and would be fully subsidised by the government through general taxation ('Government Fund').[910] Cambodia successfully established a similar fund by limiting free healthcare to those sections of the population that fell below the threshold of a means test.[911] This was enforced through a system that required the poor to produce a card that illustrated that they fell below the poverty line when seeking healthcare.[912] South Africa could employ a similar system by leveraging the means test already utilised by the South African Social Security Agency ('SASSA').[913] Patients seeking healthcare via the Government Fund would be eligible for free healthcare when they present documentation proving their registration with SASSA. As the private sector has volunteered to assist the government, its expertise on how to administer this Fund would be pivotal to its success.[914] This would aid in building the government's administrative capacity as well as garner public support for the third-tier Government Fund.[915] However, if the government wishes to retain responsibility for this Fund, reform should be enacted to ensure that the Fund is separated from government's responsibility to provide healthcare services.[916]

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[905] The Institute for Justice and Reconciliation 'South Africans Losing Faith in Public Institutions, Representatives: Study' 27 January 2022 available at *https://www.ijr.org.za/2022/01/27/south-africans-losing-faith-in-public-institutions-representatives-study/*, accessed on 3 September 2023; Mills & Bennett op cit note 793 at 215 and 220; Hsiao & Shaw op cit note 796 at 168.
[906] Kutzin, Yip, & Cashin op cit note 789 at 302; Preker, Cotlear & Kwon op cit note 792 at 16008.
[907] Kutzin, Yip, & Cashin op cit note 789 at 302.
[908] Kutzin, Yip, & Cashin op cit note 789 at 297; Mills & Bennett op cit note 793 at 214.
[909] Hsiao op cit note 796 at 166-167.
[910] Kutzin, Yip, & Cashin op cit note 789 at 283 and 294.
[911] Ibid 295.
[912] Ibid.
[913] South African Social Security Agency Act 9 of 2004; Legal Aid South Africa 'The Means Test for Adults Social Assistance Grants' available at *https://legal-aid.co.za/2018/09/26/the-means-test-for-adult-social-assistance-grants/*, accessed on 3 September 2023.
[914] Section 27 *Health Reforms* op cit note 785 at 14-15.
[915] Hsiao op cit note 796 at 158-59 and 164.
[916] Ibid 168.

The Council for Medical Schemes, which already has the operational capacity and expertise to regulate medical insurance schemes, should be responsible for regulating the various Funds. Each tier will undoubtedly encounter pragmatic issues with compliance and enforcement. Nevertheless, this system would make substantial progress towards achieving UHC by increasing the degree of population coverage and access to healthcare by raising additional revenue to purchase services across the socio-economic divide.[917] This system would also ensure that government's resources are focused on poorer sections of the population that require greater financial assistance.[918] While this would result in a degree of fragmentation in revenue pools, long-term goals could aim to merge the various Funds.[919]

### *5.2.2 Strategic purchasing*

The dominance of the private providers, combined with the governments lack of resources to meet the demand for healthcare, provides the bedrock for a mixed health system that is based on collaboration.[920] Examples of collaborations already exist in South Africa. This includes government's negotiations with the private sector to render laboratory healthcare services, at significantly reduced costs, during the COVID-19 pandemic.[921] The primary objective of collaboration would focus on how to realise the right to healthcare.[922] Premised on this objective, government and the private sector would collaborate to design policies, strategies, and market interventions based on defined goals and priorities for service delivery.[923] This process should establish a unified approach on how to effectively utilise finite resources to build a stronger health system and thus improve access to quality healthcare.[924] This requires synchronisation whereby the public and private sector providers complement and work in harmony with each other.[925] Marshalling political support for such a mixed system is crucial

[917] Kutzin, Yip, & Cashin op cit note 789 at 294; Wagstaff op cit note 855 at 149; Hsiao op cit note 796 at 155.
[918] Kutzin, Yip, & Cashin op cit note 789 at 282.
[919] Ibid 294.
[920] Yeonjoo La *The Role of Private Healthcare Providers in Building Universal Healthcare Systems: The Case of South Korea* (unpublished MPhil dissertation, University of Oxford, 2016) 17-21; World Health Organization *Engaging the Private Sector* op cit note 787 at 13.
[921] La Ibid at 11.
[922] World Health Organization *Engaging the Private Sector* op cit note 787 at 13; Section 27 *Health Reforms* op cit note 785 at 12.
[923] World Health Organization *Engaging the Private Sector* op cit note 787 at 15, 22 and 34; Section 27 *Health Reforms* op cit note 785 at 17.
[924] World Health Organization *Engaging the Private Sector* op cit note 787 at 15, 19, 20, 28 and 34; Mills & Bennett op cit note 793 at 221; Section 27 *Health Reforms* op cit note 785 at 17.
[925] World Health Organization *Engaging the Private Sector* op cit note 787 at 12 and 15.

for collaboration.[926] Enforcing accountability, increasing transparency, reducing information asymmetry, and building trust in the collaboration process are essential for constructive engagements.[927]

A major obstacle to the transformation of a mixed health system is the government's stymying of reforms.[928] Therefore, collaboration would require a strong regulatory and legislative framework that sets specific roles, responsibilities, and rules about what must be done, how it must be done, and by whom.[929] The success of Germany's healthcare system is a testament to the fact that UHC can be achieved by applying competition regulations, standardising benefit packages, and enforcing cost regulations.[930] South Africa, however, does not need to imitate international regulatory environments. Rather, government has the benefit of an investigative report from the Competition Commission Health Market Inquiry ('HMI') that provides the details of a bespoke framework to manage competition in South Africa.[931] This transformation requires that benefits be revised, providers be regulated, and that a framework be established for strategic contracting and purchasing of healthcare.

#### *5.2.2.1 Healthcare benefits*

A standardised benefit package should be set for the SHI, the LIF, and the Government Fund.[932] Such a benefit package should be based on basic PHC services.[933] Additional benefits should be tiered in a manner that is similar to Thailand, Mexico, Kenya, and Ghana.[934] This approach would avoid a situation where benefits are merely theoretical rights that cannot be exercised.[935] In this regard, guidance can be gleaned from the Columbian government's inability to deliver on its undertaking to provide the same healthcare benefits to the entire population due to fiscal constraints.[936] Ultimately, the Columbian healthcare system reverted to a tiered benefit

[926] World Health Organization *Engaging the Private Sector* op cit note 787 at 30-31; Section 27 *Health Reforms* op cit note 785 at 4.
[927] World Health Organization *Engaging the Private Sector* op cit note 787 at 12, 13 and 26; Section 27 *Health Reforms* op cit note 785 at 2.
[928] Section 27 *Health Reforms* op cit note 785 at 4.
[929] World Health Organization *Engaging the Private Sector* op cit note 787 at 15, 22, and 28; Section 27 *Health Reforms* op cit note 785 at 2; Jokozela op cit note 875 at 107.
[930] Gani op cit note 630 at 73.
[931] Section 27 *Health Reforms* op cit note 785 at 4.
[932] Section 27 *Health Reforms* op cit note 785 at 10; The Centre for Actuarial Research *Low-Cost Options in Medical Schemes* (December 2001) at 14; Chapman op cit note 575 at 132.
[933] Section 27 *Health Reforms* op cit note 785 at 13.
[934] Preker, Cotlear & Kwon op cit note 792 at, 16008, 16009; Mills & Bennett op cit note 793 at 212; and Hsiao op cit note 794 at 25.
[935] Wagstaff op cit note 855 at 152.
[936] Hsiao op cit note 794 at 25.

system.[937] Thus, a tiered benefit system is premised on an approach that considers what can be realistically achieved within the Funds' available resources.[938]

Determining what additional healthcare services should be indemnified under the tiered benefit system entails balancing the costs of a comprehensive benefit package against expanding coverage to larger sections of the population.[939] Accordingly, additional benefits should accord with each Fund's affordability, which is determined by its ability to generate revenue.[940] These benefits should be actively determined in conjunction with service providers that have greater insight into the population's current demographic and epidemiological needs.[941] This process should be subjected to experimentation at different pilot sites to determine the precise nature of the additional benefits, the costs thereof, and the feasibility and sustainability of different benefit designs.[942]

Under a tiered benefit system, the wealthier who contribute towards the SHI, and who are the least subsidised by the government, would receive additional benefits over and above the standardised benefit package.[943] These additional benefits should be similar to the prescribed minimum benefits provisions, that are imposed by the Medical Schemes Act 131 of 1998, to avoid infringing on existing constitutional entitlements to healthcare services. These additional benefits, however, should be standardised. Accordingly, the various benefit options provided by medical schemes should be integrated into a single additional benefit package. This would accord with the HMI's recommendations.[944]

The LIF's benefits could provide PHC in the private sector while imposing limitations on specialised and expensive healthcare services.[945] Such limitations could confine the type of treatment, such as exclusions on palliative care which would be similar to those imposed by Spain, or by confining expensive hospital-based treatment to public hospitals, which is similar to the Swiss health system.[946] Finally, the Government Fund's benefits would be confined to

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[937] Ibid.
[938] Preker, Cotlear & Kwon op cit note 792 at 16018; Hsiao op cit note 796 at 166; Wagstaff op cit note 855 at 150.
[939] Hsiao op cit note 794 at 21 and 25; Wagstaff op cit note 855 at 180.
[940] Hsiao op cit note 794 at 25.
[941] Michel, Obrist & Barnighausen op cit note 785 at 8.
[942] Hsiao & Shaw op cit note 796 at 163 and 170; Tanner op cit note 809 at 2.
[943] Hsiao op cit note 799 at 4; Mills & Bennett op cit note 793 at 212.
[944] Department of Health op cit note 20 at 141; Competition Commission op cit note 10 at 8-9.
[945] Kutzin, Yip, & Cashin op cit note 789 at 293; The Centre for Actuarial Research op cit note 932 at 15 and 42-43.
[946] Tanner op cit note 809 at 14-15 and 27; Mills & Bennett op cit note 793 at 212; The Centre for Actuarial Research op cit note 932 at 36 and 48.

PHC and more basic hospital services, generally rendered in the public sector.[947] Capping these benefits would ensure that more beneficiaries can be enrolled under the Government Fund.[948]

Although a tiered benefits system would not initially be equitable, it is not feasible to create a health system that is equal in all respects.[949] Accordingly, the concept of tiered benefits is premised on realistic progress towards equality.[950] This would comply with section 27(2) of the Constitution, as it would constitute a reasonable measure to progressively realise the right to healthcare.[951] With the progression of time, and as the government's fiscal capacity increases, additional revenue can be dedicated to increase the benefits available to the LIF and the Government Fund.[952]

#### *5.2.2.2 Healthcare providers*

As the government lacks the physical resources to render sufficient healthcare services, contracting with private sector providers will be vital to the success of healthcare reforms.[953] Even in countries with advanced economies and health systems, such as Italy, Japan, Netherlands, and Switzerland, services are purchased from a combination of public and private providers.[954] Moreover, as judicial interpretation of the right of access to healthcare develops, the South African judiciary may adopt a similar approach to Canadian and Italian courts that have compelled their respective governments to either pay for private sector providers' services or ordered that mechanisms be implemented to improve access to private sector providers.[955] Thus, each of the respective Funds in South Africa should be entitled to contract with public and private sector providers, subject to negotiations to contain costs.[956] Such a mixed contracting system already exists in South Africa. In particular, the government has contracted

[947] Hsiao op cit note 794 at 26 and 40.
[948] Hsiao & Shaw op cit note 796 at 166.
[949] Ibid 166.
[950] Hsiao & Shaw op cit note 796 at 161; Kutzin, Yip, & Cashin op cit note 789 at 294.
[951] Hsiao & Shaw op cit note 796 at 159.
[952] Mills & Bennett op cit note 793 at 210; Kutzin, Yip, & Cashin op cit note 789 at 283; Preker, Cotlear & Kwon op cit note 792 at 16006.
[953] World Health Organization *Engaging the Private Sector* op cit note 787 at 12.
[954] Tanner op cit note 809 at 13, 16, 23, and 27.
[955] Implicit rationing can take the form of long-waiting lists for treatment, shortages of access to medical technology, and regional inaccessibility to healthcare services. Tanner op cit note 809 at 10, 17, 18-19, and 27; Wagstaff op cit note 855 at 149; Colleen Flood & Steven Lewis 'Courting Trouble: The Supreme Court's Embrace of Private Health Insurance' (2005) 1 *Healthcare Policy* 26 at 26; Christopher P. Manfredi & Antonia Maioni 'The Last Line of Defence: Litigating Private Health Insurance in Chaoulli v Quebec' (2006) 44 *Osgoode Hall Law Journal* 249 at 251.
[956] The Centre for Actuarial Research op cit note 932 at 15.

with private pharmacies to dispense chronic medication for public sector beneficiaries.[957] The importance of such contracting is particularly salient for hospital services, as there are insufficient providers to render such treatment in South Africa.[958] Accordingly, contracting with PHEs is vital to expand access to hospital-based services.[959] International experience provides practical examples of how to leverage PHEs to increase access to healthcare. For example, the Indian government contracted with PHEs to treat patients with chronic medical conditions while the public sector managed acute-based healthcare services.[960] Local proposals include leveraging PHEs concentration in metropolitan areas to treat patients within urban regions.[961] Such strategic purchasing of healthcare would enable the government to focus on improving access to healthcare in less urbanised regions of the country.[962]

Significant legislative reform is required for the various Funds to contract with public providers, such as public hospitals. This reform should facilitate a purchaser-provider divide that would remove political influence over healthcare.[963] Concomitantly, additional reform would be needed to remedy the fragmented control over public hospitals' operations, which reduces the quality of healthcare services.[964] For example, the responsibility to maintain public hospitals should be centralised and conferred on hospital managers rather than the Department of Public Infrastructure, which is subject to a protracted tender and requisition processes for basic maintenance and repairs.[965] This should be accompanied by regulation to increase hospital managers' accountability, and improve oversight, to avoid procurement fraud.[966] Mechanisms to improve the quality of services, implement accounting systems, develop better administration, maintenance, procurement, supply-chain management, and staff training are also required in public hospitals.[967]

The purchaser-provider split requires that the government shift its responsibility from financing and delivering healthcare services to regulating the health system and healthcare

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[957] Mark Blecher et al 'National Health Insurance: Visions, Challenges, and Potential Solutions' (2019) *South African Health Review Health Systems Trust* 29 at 37.
[958] Ataguba, Day & McIntyre op cit note 885 at 1.
[959] Ibid.
[960] World Health Organization *Engaging the Private Sector* op cit note 787 at 22.
[961] Section 27 *Health Reforms* op cit note 785 at 14; Hsiao op cit note 794 at 2.
[962] Hsiao & Shaw op cit note 796 at 164.
[963] Section 27 *Health Reforms* op cit note 785 at 9 and 11, Michel, Obrist & Barnighausen op cit note 785 at 6 and 10; Hsiao & Shaw op cit note 796 at 158.
[964] Michel, Obrist & Barnighausen op cit note 785 at 5,6, 8 and 10.
[965] Ibid 5 and 6.
[966] Section 27 *Health Reforms* op cit note 785 at 9.
[967] Michel, Obrist & Barnighausen op cit note 785 at 5 and 7; World Health Organization *Engaging the Private Sector* op cit note 787 at 6.

providers.[968] This does not divest the government of its constitutional mandate to progressively realise the right to healthcare.[969] Instead, this process demands that the government facilitate the realisation of this right by ensuring providers operate effectively and efficiently by improving competition in the contracting process.[970] In this regard, urgent reform is required to update and unify the licensing framework for both public hospitals and PHEs to facilitate efficiency, foster innovation, increase competition, and ultimately contain costs.[971]

#### *5.2.2.3 Contracting framework for healthcare providers*

The success of the contracting process demands true competition between the private and public sectors.[972] Such competition should be managed through a contracting process that aims to facilitate inexpensive improvements in the quality of healthcare services in both the public and private sectors.[973] This process would ensure that providers pragmatically assist the government in progressively realising the right to healthcare.[974] The contracting process would be best managed by an independent Supply-Side Health Regulator ('SSHR'), as recommended by the HMI.[975] This would be similar to the multi-sector purchasing regulator established in Thailand.[976] The SSHR would promote competition by establishing a transparent contracting process that would disseminate information regarding the quality and pricing of services to the various Funds and competing healthcare providers.[977]

The sole accreditation criteria for this contracting process should be confined to regulating the quality of services.[978] Improvements in the quality of healthcare would best be managed through an overarching strategy to regulate the calibre of services. This could include regulation through the Norms and Standards Regulations Applicable to Different Categories of Health Establishments, the National Quality Improvement Plan, and the Ideal Hospital

[968] Chapman op cit note 575 at 128; Hsiao op cit note 796 at 165.
[969] Chapman Ibid at 122.
[970] Chapman Ibid at 786 at 130 and Hsiao op cit note 794 at 32.
[971] Competition Commission op cit note 168 at 81, 85 and 86-87; Competition Commission 'Proposed Regulatory Interventions for Licensing op cit note 379 at 2.
[972] Hsiao & Shaw op cit note 796 at 164.
[973] Kutzin, Yip, & Cashin op cit note 789 at 285.
[974] Chapman op cit note 575 at 127 and 130; Section 27 *Health Reforms* op cit note 785 at 13.
[975] Competition Commission op cit note 168 at 222, 225 and 229; Competition Commission op cit note 12 at 69-70.
[976] Kutzin, Yip, & Cashin op cit note 789 at 288.
[977] Competition Commission op cit note 168 at 202; Stuart Whittaker, R.W Green-Thompson & I McCusker et al 'Status of a Health Care Quality Review Programme in South Africa' (2000) 12 *International Journal for Quality in Health Care* 247 at 248.
[978] Hsiao & Shaw op cit note 796 at 156 and 170.

Realisation and Maintenance Framework.[979] Implementation of these regulations should be standardised and strictly enforced against public and private sector providers.[980] The proposed Outcome Measurement and Reporting Organisation ('OMRO') and the SSHR should be responsible for oversight of these quality control regulations.[981]

Notwithstanding the implementation of quality regulations, improvements in the quality of healthcare in public hospital services will be gradual. These improvements are essential for public hospitals to compete with PHEs.[982] In the interim, negotiating contracts with PHEs would be vital to increase access to healthcare while revenue is raised to upgrade public hospitals' infrastructure.[983] This process could be expedited by partnering with the private sector to guide skills transformation and improve financial management in public hospitals.[984] This could be regulated through a PPP framework.[985] Ultimately, improvements in the quality of services in public hospitals would boost competition and thus improve the efficient use of resources.[986]

Establishing and implementing treatment protocols would be indispensable to improve the quality of service in public hospitals by optimising treatment decisions.[987] These treatment protocols would have a concomitant benefit of curbing the over-servicing that is rife in PHEs while simultaneously managing prospective under-servicing that occurs when providers attempt to decrease services in an effort to boost their profits.[988] Such treatment protocols should be developed in conjunction with the providers, through the SSHR, as part of the transparent contracting process.[989] As medicine is a rapidly developing field, protocols are

[979] National Department of Health *Ideal Hospital Realisation and Maintenance Framework* op cit note 390, Draft National Quality Improvement Plan, available at *https://www.spotlightnsp.co.za/wp-content/uploads/2019/04/Draft-National-Quality-Improvement-Plan-24-August-2018.pdf*, accessed on 12 August 2022.
[980] Moleko, Bafana & Marshall op cit note 388 at 29; Begg, Mamdoo & Dudley op cit note 392 at 78-79.
[981] Competition Commission op cit note 168 at 230-232.
[982] Wagstaff op cit note 855 at 150-152.
[983] Section 27 *Health Reforms* op cit note 785 at 14.
[984] The private sector has volunteered to assist government with this process. Ibid 8 and 14.
[985] Jokozela op cit note 875 at 112.
[986] Section 27 *Health Reforms* op cit note 785 at 7; Hsiao op cit note 794 at 32.
[987] Section 27 *Health Reforms* op cit note 785 at 13; Hsiao & Shaw op cit note 796 at 164, Rao & Tandon op cit note 751 at 5.
[988] Whittaker, Green-Thompson & McCusker op cit note 977 at 60; Hsiao & op cit note 796 at 164.
[989] Section 27 *Health Reforms* op cit note 785 at 17.

intended to guide rather than dictate treatment decisions.[990] Accordingly, these protocols should not be elevated to a mandatory legislative requirement that requires strict compliance.[991]

The various Funds should aim to establish their own referral pathways as part of the contracting process. Such referral pathways should be innovative and aim to maximise the use of resources and contain costs. In this regard, lessons can be learnt from Greece's formalistic application of referral pathways that unreasonably withheld access to public hospital services for patients that sought treatment from doctors practising in the private sector.[992] The appropriate referral pathway will depend on various contextual issues such as the availability of providers within a specific region.[993] Accordingly, mandating the requisite referral pathway through a peremptory legislative framework that requires strict compliance is not feasible. Rather, referral pathways should aim to establish a network of providers to render services.[994] As Managed Care Organisations ('MCO') have established networks of providers, it would be advisable for the various Funds to engage their services. This would save additional administrative expenses that the Funds would incur if they were to establish new contracting networks. Accordingly, these MCOs would improve efficiency and contain unnecessary administrative costs.[995] This would be similar to the network-based referral system adopted by Spain and Switzerland.[996]

The final contracting criteria pertains to payment mechanisms. Payment mechanisms guide how healthcare should be purchased from providers.[997] These mechanisms utilise payment to motivate providers to operate efficiently and contain costs.[998] Accordingly, decentralisation through the purchaser-provider split is vital to ensure that public hospitals respond to financial incentives.[999] This requires that the government cease subsidising and funding public hospitals through budget allocations.[1000] Instead, these hospitals will receive

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[990] John Ware 'Conceptualization and Measurement of Health-Related Quality of Life: Comments on an Evolving Field' (2003) 84 *Physical Medicine and Rehabilitation* 43 at 44; Giovanni Briganti & Olivier Le Moine 'Artificial Intelligence in Medicine: Today and Tomorrow' (2020) 7 *Frontiers in Medicine* 1 at 1

[991] Utilising treatment protocols as mere guidelines would enable doctors to fulfil their ethical duties to prioritise their patient's best interest over criteria focused solely on costs containment. Regulation 29A of the Health Professions Act regulations in GN 717 *GG* 29079 of 4 August 2006.

[992] Tanner op cit note 809 at 20.

[993] Wagstaff op cit note 855 at 152.

[994] Competition Commission op cit note 168 at 105; The Centre for Actuarial Research op cit note 932 at 15 at 35.

[995] The Centre for Actuarial Research op cit note 932 at 14.

[996] Tanner op cit note 809 at 14 and 26.

[997] Kutzin, Yip, & Cashin op cit note 789 at 287.

[998] Ibid 286.

[999] Ibid 284.

[1000] Hsiao op cit note 796 at 168 and Tanner op cit note 809 at 7.

financing through the contracting process.[1001] Payment mechanisms ultimately aim to balance increasing the volume of patients that receive healthcare without compromising on the quality of services.[1002] As the appropriate payment mechanism depends on the specific objectives it intends to achieve, and is guided by the context within which it is concluded, it cannot be encapsulated in a stringent legislative framework that prescribes what mechanisms should be utilised.[1003] Accordingly, it is not feasible to remove the various Funds' ability to negotiate with providers to achieve a specific objective.[1004] Nevertheless, certain legislative amendments are required to improve competition and thus enhance the efficient and effective use of healthcare revenue.[1005] First, payment negotiations should be ringfenced from sections of the Competition Act 89 of 1998 to permit collusive price setting and thus facilitate the use of Alternative Reimbursement Models.[1006] This would aid with the migration from fees-for-service-based payments, which induces over-servicing, to arrangements that permit risk-sharing with providers such as capitation as a means to contain costs.[1007] Furthermore, legislative provisions that prohibit doctors from sharing fees outside of their profession needs to be repealed.[1008] This would permit the use of payment mechanisms such as bundled payments and global-provider budgets.[1009] Finally, tariffs should be regulated in accordance with Section 90(1)(v) of the National Health Act 61 of 2003.[1010] Cumulatively, these legislative amendments would enable the various Funds and providers to negotiate contracting terms that will contain healthcare costs, especially for expensive hospital-based services.[1011] To increase efficiency and transparency, these price negotiations should be facilitated by the Multilateral Tariff Negotiation Forum which the HMI recommended be established together with the SSHR.[1012] As the process becomes more transparent, competition will progressively migrate from the perceived quality of healthcare providers' services to a system that contracts based on providers' ability to contain costs by maximising the use of resources.[1013]

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[1001] Ibid.
[1002] Hsiao op cit note 794 at 32.
[1003] Kutzin, Yip, & Cashin op cit note 789 at 285.
[1004] Hsiao & Shaw op cit note 796 at 161; Kutzin, Yip, & Cashin op cit note 789 at 286.
[1005] Section 27 *Health Reforms* op cit note 785 at 7; Jokozela op cit note 875 at 107.
[1006] Erasmus & Theron op cit note 411 at 61; Department of Health op cit note 20 at 90 and 144.
[1007] Mills & Bennett op cit note 793 at 210 and 213; Kutzin, Yip, & Cashin op cit note 789 at 285.
[1008] Regulation 7(1) of the Health Professions regulations op cit note 991.
[1009] Competition Commission op cit note 168 at 49-51.
[1010] Competition Commission op cit note 168 at 179; Section 27 *Health Reforms* op cit note 785 at 10; Hsiao op cit note 794 at 34.
[1011] Hsiao op cit note 794 at 11; The Centre for Actuarial Research op cit note 932 at 15 43.
[1012] Competition Commission op cit note 168 at 223-222; Competition Commission op cit 425; and Hsiao op cit note 794 at 18.
[1013] Section 27 *Health Reforms* op cit note 785 at 7.

The exact combination of contracting criteria should be subject to experimentation.[1014] This would form part of each Funds' strategy that would vary in the different geographical regions.[1015] In this regard, the National Health Insurance pilot programme constituted a soft launch rather than a test to determine the most appropriate and feasible and strategic contracting criteria.[1016] This was evident as each site implemented the same purchasing and delivery strategies.[1017] Accordingly, it is only through experience and the application of knowledge gained through an experimental process that the health system's performance can improve.[1018]

## 5.3 CONCLUSION

This research demonstrates that urgent reformation and transformation to the legislative framework governing private funders and PHEs is necessary to realise the right of access to healthcare. This was established by first scrutinising the history of these stakeholders which indicates a need for reparations in the private sector to address historical manipulation of healthcare access, which perpetuated the unfair discrimination of the black population. Secondly, regulatory gaps in the private funders and PHE markets were identified by examining the types and cause of prevailing inefficiencies and governmental shortcomings. Thirdly, by evaluating the consequences of the National Health Insurance Bill, it was determined that the proposed reform would be ineffective at promoting access to healthcare. Finally, alternative methodologies to fulfil this right were identified by contrasting international perspectives and experiences. This comprehensive analysis of the historic, contemporary and prospective legislative frameworks provided a foundation to identify and compare alternative pragmatic solutions to transform and unify the health system to improve equitable access to healthcare in South Africa.

The proposed transformation needs to be comprehensive and cohesive, failing which any reformation will merely result in 'idle tampering' that is unlikely expand or improve access to healthcare.[1019] These proposed solutions include establishing a tiered financing and benefits system that takes into consideration fiscal constraints and maximises the use of existing

[1014] Wagstaff op cit note 855 at 183; Ataguba, Day & McIntyre op cit note 885 at 1; Hsiao & Shaw op cit note 796 at 170-171.
[1015] Michel, Obrist & Barnighausen op cit note 785 at 5.
[1016] The pilot implementation of the Bill used a limited experimentation framework with the same ten criteria applied across different districts. National Department of Health *Evaluation Report* op cit note 745 at 12-13; Section 27 *Health Reforms* op cit note 785 at 15.
[1017] Ibid.
[1018] World Health Organization *Engaging the Private Sector* op cit note 787 at 31-32.
[1019] Van Rensburg & Harrison op cit note 47 at 122.

financial resources, and collaboration and cooperation between the private sector and the government in the provision for healthcare services. This collaboration should not only prove to maximise the use of resources but also aid to decrease costs when purchasing healthcare services.[1020] The success of this framework is, however, dependent on genuine collaboration between the government and the private sector.[1021] The question of what legislative provisions are necessary to regulate the tiered financing system and enforce such collaboration should be a subject of future research. Nevertheless, this research illustrates that there are alternative and more sustainable strategies to transform the legislative framework governing these stakeholders to aid in the progressive realisation of the right to healthcare.

While urgent reform is necessary, the pace of implementation should be moderated to avoid any disruption or destabilisation of the health system.[1022] Realistically, unifying the health system to fulfil the right to healthcare will take several decades.[1023] It will take significant and persistent political commitment to strengthen the health system and improve the regulatory framework with the progression of time. In accordance with the adage that 'Rome wasn't built in a day, but they were laying bricks every hour', this commitment to reform will be the first of many steps that are required to unify the health system. Therefore, the recommendations that are posited in this chapter are only the first of many that are required to heal the divisions of the past, and thus, to build a unified and equitable health system to realise the right to healthcare.

(49928)

[1020] Jokozela op cit note 875 at 112.
[1021] Ibid.
[1022] Hsiao & Shaw op cit note 796 at 159.
[1023] Hsiao op cit note 794 at 36.

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