

Profile

National Health Insurance: legal and civil society considerations

20

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Introduction

The growth in health inequality and the deterioration of health outcomes (evident from numerous indicators that show the lack of progress against key Millennium Development Goals) make it clear that there is a need to unify the health system, so that both public and private health-care providers can contribute to meeting South Africa's public health challenges – particularly HIV, tuberculosis, the provision of primary health care (PHC) to all and management of the growing epidemic of non-communicable diseases.

The extent to which the National Health Insurance (NHI) system will strengthen equality in health, rapidly revitalise health services and ensure sufficient funding for health is still unknown. Given the strong legal architecture in the country, it is important that existing laws and, in particular, the guidance provided by the Constitution, are harnessed towards full and effective implementation of a NHI policy that advances access to quality health services.

According to the Minister of Health:

The fundamental change that must be initiated in the health sector is to overhaul our current financing system and to introduce a health system financing mechanism that explicitly takes into account the health needs of the national population and utilises key indicators ... to make resource allocations to health facilities. The introduction of a National Health Insurance within the South African health system founded, on the Primary Health Care Approach, provides an opportunity for significant transformation of the existing institutional and organisational arrangements in the health system.¹

This statement makes it clear that, at its core, NHI is a funding mechanism. It is also obvious that NHI should not be a substitute for the current health administration. Indeed, the Minister suggests that it must be “founded” on the PHC approach, which should lie at the heart of the administration of health services. It cannot be over-stressed that, in order for NHI to succeed, it needs to be embedded in a supportive legal, institutional and fiscal environment. This chapter will discuss the legal considerations that can guide the process of developing the content of an NHI policy – with particular emphasis on the tenets of the South African Constitution.

The legal environment

The Constitution

As the highest law in the country, the Constitution is the starting point and constant reference for other law. Unlike many constitutional democracies, the South African Constitution unambiguously imposes obligations on the state to realise progressively the right of access to health-care services.² The Constitution states that the state must take reasonable legislative and other measures, within available resources, to achieve this.

Thus far, there are only a few court cases that have interpreted these provisions, but they set out the core principles for state conduct.³ Of these, at least two imperatives are worth bearing in mind as we embark on the process of developing the NHI policy.

The first is that, however well-intentioned a policy, it should be careful to address the short, medium and long-term needs of people.³ In the *Grootboom* case, even though the Housing Policy that was being challenged was very detailed, it failed to provide for those people who were in desperate need and who, because of their dire situations of homelessness, would possibly not even survive long enough to get access to housing eventually promised for all through the policy. The Constitutional Court was of the opinion that, for this reason, a one-size-fits-all policy for housing could not pass constitutional scrutiny. For example, for those who can afford to purchase housing (even if basic), what may be needed is a way to unlock the door to the house financing system, yet for those who are poor or desperately poor other approaches would need to be considered.

The same approach has to be taken to the provision of financing for health. For this reason we welcome the approach that is hinted at in the ANC discussion document and supported by the Minister of Health who has indicated that the NHI policy would be implemented “in underserved areas first”. According to the Director-General of Health, “the NHI will start in 2012, with health teams visiting people in rural areas to assess their needs and providing transport to health facilities if necessary”.⁴

This is important for at least two reasons. One is that any policy that is pro-poor should prioritise the poor. Second, rural and other underserved areas might still face barriers to accessing NHI services, given that the participation of health facilities and providers (private and public alike) will depend on an accreditation process. If the implementation of NHI were to begin in one wave there is a risk that private and urban health facilities would be the first to be accredited, as generally these are better than those in rural or extremely poor areas. This would result in a perpetuation of the imbalance in access to health services between those that live in richer areas and those in poorer areas.

It is, therefore, essential that civil society maintains an intense focus on implementing the Department of Health's 10 Point Plan so that the quality of the public health infrastructure and service is rapidly improved. This, however, is likely to take years and identifying priority districts, based upon need, in which to implement the first phases of a final NHI plan may be worth serious consideration.

The second constitutional imperative is that for a policy to be deemed reasonable it should be capable of implementation. In other words, it should be budgeted for and accompanied by a detailed implementation plan. The question of the budget availability and the manner in which finances are managed throughout the health system will therefore have to be squarely addressed. The ten reports of the Integrated Support Teams (ISTs) that were established by former health minister Barbara Hogan are revealing in this respect.

The ISTs were set up following reports of over-spending and financial mismanagement in the provinces. In 2009 the ISTs undertook an investigation into the administrative and financial capacity of each of the provinces and of the national Department of Health (NDoH). In its findings the ISTs reported each Province to be very weak, with some much worse than others. In relation to the report on the NDoH the ISTs found that:

There are *de facto* ten health departments in operation in South Africa and there is not a single national health vision and strategy for the achievement of population health outcomes and ongoing health system transformation in South Africa.⁵

and

The role of the NDoH in the process of determining the overall public sector health financial allocation and the capacity of the NDoH to analyse the existing health situation, determine accurate costs of health activities and interventions, and improve the annual health bidding processes and proposal to Treasury are sub-optimal.⁵

The IST reports demonstrate the levels of inefficiency in the system and make recommendations to address these. These inefficiencies have major implications, leading to both wastage of resources and widespread corruption. As the NHI is being planned, the NDoH will have to fix the financial and administrative management system to enable implementation of the NHI.

There are other provisions in the Constitution that are important in guiding both the process of developing the NHI policy and its content, such as the rights to administrative justice and equality. A concern raised at the Congress of South African Trade Unions (COSATU) Civil Society conference was, for instance, whether the NHI policy would only cover citizens and permanent residents. The NDoH, as steward of the policy, would have to consider whether this is a reasonable and justifiable limitation of the right to equality or of "everyone" to have access to health-care services.

Legislative framework for health

There are well over 100 statutes that the Department of Health administers. These range from framework legislation, such as the National Health Act, 2003, (NHA) to statutes that govern health professionals and workplaces, to the regulation of medical schemes.

All aspects of this intricate web of legislation will need to be reviewed in light of the NHI proposal. The purpose of the review ought not to be for the wholesale repeal or amendment of the laws, but to examine where there may be inconsistencies or gaps between those laws and the proposed policy, with a view to their reasonable resolution.

While the NHI Fund would be set up under new legislation, there may be an overlap between the Fund, the responsibilities of those who administer NHI and the officials who are responsible for the delivery of services. For example, the improvement and monitoring of quality of health services would be of importance to both the health department and the NHI authorities. The NHA currently provides for an Office of Standards Compliance to be established within the NDoH. While regulations have not been promulgated for the establishment of this Office, a rudimentary office already exists. However, civil society believes that quality assessment should be undertaken by an office that is independent of both the Department of Health and the NHI authorities. An independent unit would be able to provide objective information on the accreditation process – should it be determined that such a process is the best option.^a

^a At the TAC's Fifth National Congress a concern was raised about the efficiency of accreditation processes for Antiretroviral Treatment sites. The ultimate effect was to impede access to health care services, rather than improve it. Eventually accreditation was abandoned. This is not to suggest, however, that accreditation should not take place but that it should be carefully monitored, managed and resourced.

Another example would be the laws that govern medical schemes. These will also need to be considered depending on the role for medical schemes that the final NHI policy envisages. Similarly, the laws that govern health professionals (including the prohibition on general practitioners to dispense medicines) and the medicines laws may impact on how the policy is developed and implemented.

Furthermore, it is not only health-related legislation that will have to be reviewed. Other relevant legislation includes: intellectual property laws (in relation to the pricing of medicines and medical devices and the sustainability of supply); the Public Finance Management Act (for example to make provision for the governance of an ear-marked tax); and the Short Term Insurance Law (especially if the operation of medical schemes is affected). Failure to do this properly will either disrupt implementation or lead to legal challenges that cause delay.

The law and the private sector

While the main focus of NHI reform appears to be directed, correctly, at strengthening the public health sector, this should not be an excuse to avoid addressing inefficiencies and market distortions in the private health sector. The private sector is an important role player in the provision of health care services and the two sectors are intricately linked.

The Competition Tribunal, for example, has pointed to the flawed characteristics of the health system:

The reality – and possibly the only agreed certainty in the fraught debate surrounding the provision of health care in South Africa – is that the private health care system, and notably, although not exclusively, the private hospital network, is characterized by significant excess capacity, while the public health care system is simultaneously resource-constrained and increasingly unable to cope with the demands made of it.⁶

The role of private providers will be considerable under a NHI system. As a result, issues of fees-for-service or capitation-based payments, the negotiation of tariffs and the pricing of health commodities will need to be addressed well in advance of the implementation of NHI.

The issue of the prices of commodities that are vital to health care is a crucial determinant of the extent to which people, particularly poor people, have access to health-care services and the government's ability to realise this right progressively.

But pricing is not just an issue in relation to medicines. Unjustifiably high prices for medical services and technologies in private hospitals drive up the cost of health care for

the insured population and limit the numbers who can afford insurance. This leaves more people dependent on the public sector, thereby reducing capacity and impacting on quality of services. It therefore falls on the government to reasonably regulate all the drivers of high prices, recognising that health is not an ordinary commodity over which consumers can exercise ordinary choices.

The acceptability of regulation has also been recognised by the Constitutional Court in the *New Clicks* case.⁷ This case concerned the lawfulness of the Regulations for the Transparent Pricing of Medicines that dealt with, amongst other things, a fixed dispensing fee for pharmacists. The Court stated that it “unanimously accepted the validity” of a regulatory structure to control the price of medicines.⁷ By implication, it will also accept the reasonable regulation of prices in other aspects of health care.

More recently, however, HASA, Netcare911, ER24 EMS and private practitioners challenged an aspect of the regulation of private sector pricing by the Department of Health. Specifically, they challenged the lawfulness of the Regulations Relating to the Obtainment of Information and the Process of Determination and Publication of the Reference Price List. In July 2010, the North Gauteng High Court found that the Regulations were unlawful because a fair process was not followed in their development and on other administrative justice grounds. The judge (Ebersohn AJ) also found that using provisions of the NHA that facilitate the acquisition of information regarding pricing from the private sector cannot be used to regulate the private sector.⁸ In other words, while the Department of Health may garner information from the private sector, it cannot rely on that information in order to establish benchmark prices.

While the court was correct in relation to the process that was followed, it is questionable whether other aspects of this judgment would have withstood appeal before the Supreme Court of Appeal or the Constitutional Court. The Department of Health chose not to appeal. However, it does provide an indication of the stance of the private sector in relation to even the weakest form of regulation – the National Health Reference Price List was non-binding – it simply provided a reference benchmark. This reality needs to be borne in mind in relation to the process of legislative development for NHI. Every major piece of health reform since 1994 has been challenged by vested interests in the private sector. This has often been possible only because of poor legislative drafting, short-circuiting public participation processes, and ignoring reasonable recommendations. The same cannot be risked with the NHI.

NHI and civil society

The release of the African National Congress's discussion document introducing a NHI for South Africa has resulted in a resurgence of debate and engagement on the details of such an intervention within civil society. This document sets out some key elements of the proposed NHI policy, much of it similar to earlier unpublished drafts that were circulating in 2009. The document was the subject of discussion at the Treatment Action Campaign's (TAC) 5th National Congress, as well as at the joint COSATU-Civil Society conference, attended by 350 delegates representing all of COSATU's affiliate unions and 60 civil society organisations. A clear common position that emerged from both these meetings was that the implementation of an NHI policy that increases access to quality health-care services for all will be welcomed and supported, while scepticism remains about when and how this will happen.

The Conference Declaration of the COSATU-Civil Society Conference, for example, held that the “[c]onference supported the National Health Insurance in principle, but expressed concerns regarding the model to be used, the implementation strategy and the many unknowns around the content of the NHI envisaged”⁹ and called for government to release a policy document on the NHI for public engagement.

Similarly, the Resolutions from the TAC 5th National Congress notes that TAC “support(s) an NHI plan that is incremental, begins with primary health care, ensures that patient transportation is available, and builds confidence in the system”.¹⁰

The TAC, COSATU and SECTION27 have signalled their intention to closely analyse and provide input into any official government policy regarding NHI. The group will also launch campaigns and undertake community education regarding the purpose and implications of the NHI policy once further details are worked out.

Conclusion

While the ANC discussion document brings NHI into the public domain, there remain many gaps in the document. As the country embarks on the process of developing the policy, we would do well to use the Constitution as our guide. The first step, as identified at the Cosatu-Civil Society Conference, is for the Department of Health to drive the process and open the space for transparent and inclusive engagement by all sectors of society. From the perspective of civil society the policy still remains elusive and confusing. An ongoing public forum, led by government, that seeks to answer the many questions that exists is now imperative.

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