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A Step Towards Realization of the Twenty-Seventh Right?: A Preliminary Analysis of the Proposed National Health Insurance for South Africa

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A Step Towards Realization of the Twenty-Seventh Right?: A Preliminary Analysis of the Proposed National Health Insurance for South Africa

Kelsey Fraser

26 November 2010

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Abstract

As part of a three-week social analysis study, the African National Congress' (ANC) proposal for a National Health Insurance (NHI) scheme was examined. Legal commitments in Section 27 of the Constitution and Section 3 of the National Health Act oblige the South African government to work progressively towards realization of the right to healthcare. The latest push for NHI can be interpreted as an attempt to broaden realization of this right.

Information on the NHI proposal was obtained primarily from documents released by the ANC and was supplemented by written analysis found through Internet research. A partial understanding of public opinion was achieved through interviews with South African citizens, including experts in various fields pertinent to the NHI. Time and other logistical constraints limited the amount of data incorporated into this paper. Biases resulting from personal views and/or desires of researchers or interviewees, as well as of the author, must be acknowledged in consideration of the findings.

Using the ANC discussion document released in September 2010, potential flaws in the policy were identified. These included questions of affordability; likely discontent amongst the public with services provided under NHI; a lack of concrete policy and program outlines; the potential for government mismanagement; a reliance on a failing public system; and a lack of information technology systems for collecting data to be used in system evaluation, cost estimation, and policy formulation.

Based on these potential problems and other findings, the author concluded that implementation of the NHI as proposed by the ANC within the suggested time frame is unlikely and would result in a probable system failure. Pursuit of an NHI based on the principles of universal coverage, the right to health, and social solidarity is a laudable and necessary action in the government's quest to broaden realization of the twenty-seventh right. Implementation of such a system is possible, but must not be rushed and should result from fully informed policies and programs that work gradually towards the complete implementation of a National Health Insurance scheme.

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1. Introduction

The South African Constitution, formulated in the post-apartheid era of the mid-nineties, is remarkable for its progressive approach to governance. Particularly notable is its Bill of Rights, which includes among many others a right to health. Popularly accepted in theory but rarely visible in practice, the concept of health as a right is controversial in large part because of questions about the feasibility of its implementation. Guaranteeing universal healthcare is no minute task, and questions about who has the responsibility of doing so plague the “health as a right” debate. By virtue of its inclusion of the right to health in the Bill of Rights, the South African government has appointed itself as the party responsible for ensuring its citizens’ access to medical facilities and other services related to health. Yet the current healthcare system in South Africa is fragmented, burdened by remnants of an inequitable apartheid system, and strangled by the world’s largest HIV/AIDS epidemic. Its recognition of health as a right places the South African state in unique and admirable territory, but a failure to achieve large-scale realization of this right raises questions about the government’s efforts and about the right’s ability to be implemented at all.

The South African government under ANC leadership has proposed a massive expansion of the healthcare system in the form of a National Health Insurance (NHI). While exact specifications are not finalized, the NHI aims to extend access to healthcare services to all South Africans. The scheme will create a single-payer health fund controlled by the Ministry of Health from which citizens will receive subsidized health insurance on the basis of need, covering primary through tertiary services. Enrollment in the NHI will be compulsory for all citizens, though only those whose incomes place them in the tax-paying sector of the population will contribute to the fund. Those who can afford it will also have the option of continuing with private medical aid schemes. Exact methods of financing for the NHI have yet to be determined. The NHI also calls for the renovation of many public hospitals, beginning with five major hospitals throughout the country that have been named as prototypes.

While the NHI appears to be an attempt by the state to assist in broader realization of the right to health, questions remain about the affordability, feasibility, and efficacy of the proposed policy. The plans for the policy remain vague and cost estimates, though very uncertain, are quite large. Recent attempts to implement national health insurance schemes by other countries like the United States have been met with opposition and difficulties in implementation. The South African view on a rights-based approach to health seems to be unique and relatively favorable, at least in comparison to the general American view, which could perhaps result in a more readily accepted national health insurance scheme. Yet with such a small sector of the population paying the taxes that will most likely finance this new scheme and with doubts about the government’s ability to effectively manage such a large health intervention, the feasibility of the NHI is in question.

This project aims to address some of the questions surrounding the proposed National Health Insurance. The NHI will be analyzed on a policy level for its ability to be implemented effectively, for potentially unforeseen consequences, and for its potential to provide solutions to some of the problems that currently plague the South African

healthcare system. In addition, the NHI will be analyzed as an effort by the government to further the realization of the twenty-seventh right. Incorporating knowledge and opinions from experts, academics, and South African citizens, the project will attempt to highlight the fortes of the NHI while also illuminating potential problems in the proposed scheme.

2. Methodologies

2.1 Primary Data

Primary data used in this project came in two forms. The first group consisted of written documents, including speech transcripts, press releases, policy documents, and newspaper/journal articles. The author conducted extensive Internet searches to obtain this data. Documents issued by the African National Congress (ANC) were used to obtain a basic understanding of the proposed scheme. This understanding was furthered using secondary sources, the collection of which will be discussed below. In addition to documents from the ANC, the author collected data from other online sources, particularly news sources like polity.org and Health-E News. Other primary sources included legal documents like the Constitution of the Republic of South Africa and the National Health Act of 2004.

The second category of primary data took the form of personal opinions expressed to the author during interviews and conversations with various people. The author conducted interviews with academics and experts, including professors of law, health outcomes research, and health statistics and with a medical manager of an urban hospital. These people provided valuable insight as their extensive knowledge offered an in-depth and insider's perspective on the NHI. In addition to these, the author also conducted conversations with South African citizens of various backgrounds to gather an understanding of public opinion regarding the NHI. Interviews were conducted as formal conversations in the case of the academics and experts and, as such, were scheduled ahead of time and conducted in the offices of the interviewees. Conversations with other citizens were more informal. Most were spontaneous and occurred in less formal settings, including a mall, a restaurant, and the interviewee's home.

2.2 Secondary Data

A large portion of the data used in this paper was collected from secondary sources. To find this data, the author mainly employed Internet searches, which led her to several collections of data on the NHI. The author was fortunate to come across collections of studies conducted by various groups on the proposed NHI, including a series of briefs from Strategies for Health Insurance Equity in Less Developed Countries (SHIELD). Conversations with experts led the author to the collection of materials surrounding NHI prepared by Innovative Medicines South Africa (IMSA), which included a series of briefs based on research by Heather McLeod as well as historical and background information. Further data was obtained from various Internet sources that provided access to opinions and analyses of the NHI based on releases from the ANC. Experts and academics interviewed by the author also provided secondary information as their analysis of the ANC proposals was relayed to the author in addition to personal opinions and other primary data. Further analysis of proposals and information regarding public opinion was obtained

from the media in the form of news sources such as the nightly television news broadcast as well as Internet sites like Polity.org and Health-e News.

2.3 Limitations and Biases

Inherent in all methods of data collection are biases of the researcher. The author's personal views on themes of the NHI, such as universal coverage, etc., influenced conclusions drawn from the evidence provided. These views have largely been shaped by the environments in which the author has previously encountered arguments over the prospect of national health insurance and the concept of a rights-based approach to health. The author's experience during a similar debate occurring recently in the author's home country of the United States of America instilled in the author skepticism of government-run national health insurance schemes. The author's experience studying global health at a relatively progressive university has provided the author with many arguments for universal coverage as a basic right. Both these experiences, as well as other supplementary ones, influenced the way in which the author interpreted all data collected and drew conclusions.

Data collection was significantly limited by logistical restraints. The three-week period in which most data collection took place was not nearly long enough to allow the author to locate and comprehensively analyze all available material on the NHI. Limited access to Internet resources further impeded the author from incorporating the complete scope of available resources. More time and greater access to Internet and print materials on the NHI would have afforded the reader the opportunity to delve more deeply into the proposal and its complexities. The author's understanding of the proposal and its feasibility would also be greatly furthered by a deeper understanding of the context and history surrounding universal coverage. As a foreigner, the author was not able to achieve a full understanding of the South African environment and the history of past policies in such a short time period. In addition, gaining access to South African citizens, in particular taxpayers, academics and experts, was often difficult. Because such a small portion of the South African population falls above the income tax threshold, taxpayers were much more difficult to converse with than non-taxpaying citizens. Access to experts and academics was limited by their busy schedules and prior commitments.

Information on the policy itself was limited by the lack of a concrete policy document from the ANC, who is putting forth the proposed scheme. While the party has released several statements and an official forty-seven-page discussion document in September 2010, it has yet to release anything resembling a draft of policy or legislation. Thus, there are few specifics available for analysis. In addition, the information put out by the ANC is influenced by the party's bias. As the proponent of this NHI scheme, the ANC is likely to put forth information leaning toward a positive tone regarding the proposal. All numbers presented in the discussion document, such as cost estimates, were put forth by the party hoping to implement this scheme and are based on data chosen by the party, increasing the likelihood of bias in the numbers presented.

Secondary analysis of the NHI proposal also may include bias. The author was only able to include a portion of all available analysis in this project, thus risking an effect similar to response bias in that the analysis examined may not reflect all views on the policy. The researchers conducting this analysis may also have been influenced in the

production of their data. For example, Di McIntyre was contracted by the ANC to estimate costs and thus her data may reflect an attempt to produce results favorable to the ANC. Personal views of the researchers may also have influenced their data in that they may have conducted their analysis with the goal of proving a certain point, thus inviting bias into the analysis.

Data collected during interviews and conversations may have been influenced both by the interviewer and the interviewee. The interviewer's presence may have restricted the amount or type of information interviewees were willing to share, particularly in instances where there was no previously established relationship of trust between the interlocutors or where the interviewee may have perceived the interviewer to hold a position of power. The interviewee may also have felt pressure to provide an answer they perceived as favorable to the interviewer, even if this answer did not fully reflect their honest opinion. Several interviewees did not have significant prior knowledge of the NHI; a reluctance to admit this limited knowledge and incorrect or incomplete understandings of the NHI may also have influenced their answers. The personal opinions obtained also reflect the opinions of a small portion of the South African population. Those interviewed were mostly either the currently uninsured (and thus likely to support a policy through which they would achieve free healthcare access) or academics in health fields, who are probably more likely than the general population to support cross-subsidization and universal healthcare coverage.

3. Literature Review

1. ANC Discussion Document on National Health Insurance, September 2010.

This document is the latest in a series of information released by the ANC on their plan to implement National Health Insurance. The forty-seven-page document identifies problems within the current health system and an incentive for government intervention. Following an establishment of the informing principles and goals of the NHI, the document outlines key facets of the proposal. The document also offers vague plans for the strengthening of the health system, delivery of service excellence, and rollout of NHI. While the document provides the most detailed description of the ANC's proposal, it is not a policy proposal itself and contains numerous ambiguities. Nonetheless, the document is key in understanding the ANC proposal for NHI and was consulted by the author as the basis from which information and upon which conclusions about the NHI were drawn.

2. Innovative Medicines South Africa National Health Insurance Library

A compilation of policy briefs, analysis, and links to information about the NHI, Innovative Medicines South Africa's (IMSA) National Health Insurance Library is likely the most extensive collection of data on NHI in a single location. With links to outside sources of information and to its own summaries of the policy, IMSA's library is a key resource for anyone interested in learning about the NHI. Professor Heather McLeod produced a series of policy briefs for IMSA, each of which analyzes a specific facet of the policy, such as funding or the future role of private medical insurers. The author used the IMSA resources to further her knowledge of the NHI and to obtain cost estimates and analysis from a source other than the ANC itself or a government-contracted researcher.

3. SHIELD Policy Briefs on the NHI

A series of briefs released by Strategies for Health Insurance Equity in Less Developed Countries (SHIELD) provided the author with greater understanding of the NHI policy. Di McIntyre, who was also contracted to produce costing estimates by the ANC, headed research and analysis. The briefs addressed whether a universal coverage system was the best option for South Africa and produced estimated resource requirements. They offered an interesting comparison of three possible routes of expanded health insurance cover and analyzed each in terms of financial feasibility. The author used the briefs as one source of cost estimates for the proposed policy and as one argument for the implementation of a universal coverage system.

4. Health-E News Service

A news service focusing exclusively on health, Health-E News published a series of articles on the NHI. Many of these were simply recaps of information put out by the ANC, but a series of analysis and opinion articles were put out as well. These included opinions from key researchers in the field like Di McIntyre and Heather McLeod, as well as other experts in health care, including Health-E News columnists. The articles provided the author with information on public opinion regarding the NHI and with further analysis of the policy itself.

5. Polity.org

An online record of South African policy and legislation, Polity.org was used by the author to trace developments in the formulation of NHI policy. While the author found no actual policy documents, Polity.org provided a compilation of statements released by the ANC and other releases from various government officials and stakeholders like COSATU. The author used Polity.org to further her understanding of the policy and to track reactions in the media to the NHI.

6. Constitution of the Republic of South Africa, National Health Act of 2004

Section 27 of the Constitution and Section 3 of the National Health Act outline the legal obligations that provide the theoretical incentive for the ANC's proposal of a National Health Insurance. Any evaluation of such policy must be conducted in the context of the commitments made by government in these two legal documents. The author used these documents as standards against which to measure the ANC's NHI proposal.

4. Findings and Analysis

4.1 Background

4.1.1 Access to Healthcare: A Legal Obligation

While disputes over who deserves access to healthcare and to what degree plague healthcare debates in many countries, these disputes are far less relevant in South Africa due to legal commitments for the provision of health care. The premise for universal access to healthcare provided by the government is ideologically founded in the idea that all citizens, regardless of ability to pay, are entitled to access to healthcare services. This ideology is manifested in the South African Bill of Rights, providing a "constitutional prerogative for government" to provide healthcare services.¹ Section 27 guarantees all

¹ Kirby, Neil. "National Health Insurance Scheme: What We Have and What May Be," July 2009, [Werksmans Incorporation Jan S. De Villiers](#), 19 November 2010

South African citizens the right to access to healthcare, realized progressively within the capability of the government:

- (1) Everyone has the right to have access to -
 - (a) health care services, including reproductive health care;
 - (b) sufficient food and water; and
 - (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
- (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
- (3) No one may be refused emergency medical treatment.²

Section 27 clearly identifies the South African government as the party responsible for ensuring all citizens are able to access healthcare services. While recognizing that the government can only act to ensure this right within its available resources, the progressive realization clause of Section 27(2) requires the government to actively pursue broader realization of the twenty-seventh right. Section 27 ensures the pursuit of universal access to healthcare services is a requirement for the state.

The state is further committed to the provision of access to health care services by the National Health Act of 2003 (NHA). Section 3 outlines the responsibility for health:

3. (1) The minister [of health] must, within the limits of available resources—
 - (a) endeavor to protect, promote, improve and maintain the health of the population;
 - (b) promote the inclusion of health services in the socio-economic development plan of the Republic;
 - (c) determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population;
 - (d) ensure the provision of such essential health services, which must at least include primary health care services, to the population of the Republic as may be prescribed after consultation with the National Health Council; and
 - (d) equitably prioritise the health services that the State can provide.
- (2) The national department, every provincial department and every municipality must establish such health services as are required in terms of this Act, and all health establishments and health care providers in the public sector must equitably provide health services within the limits of available resources.³

<http://www.werksmans.co.za/live/search.php?Query=national+health+insurance&button=Go&Session_ID=4fa5e9f4f69b77214a3ea9c67c1538e6>.

² Constitution of the Republic of South Africa. Section 27. 1996.

³ National Health Act. Republic of South Africa. Act No. 61, 2003. Section 3.

Combined with the responsibility given to the government by the twenty-seventh right, Section 3 of the National Health Act of 2003 leaves little question as to whether healthcare should be accessible, to whom, and on whom the burden of providing access to services should fall. The Bill of Rights and the NHA clearly define access to healthcare services as a basic right of all South African citizens. Healthcare should be universally accessible, and the South African state is responsible for taking all measures to ensure its citizens are able to progressively realize their right.

4.1.2 Realities of the South African Healthcare System

Despite such a clear definition of the right of all citizens to accessible healthcare, the realities of the South African healthcare system prevent sufficient realization of the twenty-seventh right amongst the vast majority of the country's population. Riddled with high rates of unemployment and massive inequalities of wealth, the South African population provides a difficult setting for the equitable provision of healthcare services. Of the approximately 49 million South African citizens, 74.3% reported receiving no income in 2008. Only 9% of the population earned above the income tax threshold.⁴ In 2008, 15.9% of the population belonged to a medical scheme and thus enjoyed access to private healthcare facilities without out-of-pocket payments.⁵ The remaining 84% of the population was either reliant on the public sector for all healthcare services or chose to pay out-of-pocket, usually paying out-of-pocket for primary care services in the private sector and relying on the public sector for hospital and more advanced services. To further complicate matters, the population is plagued by a quadruple burden of disease. South Africa has the highest rates of HIV/AIDS in the world, is encumbered by epidemics of Tuberculosis and various other communicable diseases, and faces a rising prevalence of non-communicable diseases as its population ages.

The healthcare system itself is afflicted by a deep division between the public and private sectors. South Africa's private sector offers services on par with some of the best in the world. Hospitals provide care as advanced as any found in countries renowned for excellence in healthcare and the quality of facilities and medical personnel reveals little indication of the massive health burdens that persist throughout the population. Such quality of service comes at a price, and is available only to those with the ability to pay, namely those on medical schemes and/or those who choose to pay out-of-pocket. Medical schemes costs have been increasingly by 7% annually over the past decade and contributions exceed 10% of income for over 40% of members.⁶ Continued increases in the costs of medical schemes are likely and could result in a smaller portion of the population being able to afford access to private sector services. A government subsidy for medical

⁴ McLeod, Heather. "National Health Insurance Policy Brief 9: Affordability of Health Insurance." *Innovative Medicines South Africa*. 8 March 2010. Web. 19 November 2010. http://www.imsa.org.za/national_health_insurance_library.html. Pg 1

⁵ McLeod, Heather. "National Health Insurance Policy Brief 9: Affordability of Health Insurance." *Innovative Medicines South Africa*. 8 March 2010. Web. 19 November 2010. http://www.imsa.org.za/national_health_insurance_library.html. Pg 3

⁶ McIntyre, Di. "Modeling the Estimated Resources Requirements of Alternative Health Care Financing Reforms in South Africa." *SHIELD*. October 2010. Web. 8 November 2010. <http://www.health-e.org.za/news/article.php?uid=20032952>. Pg. 29.

scheme contributors provides some relief but is criticized for benefitting the highest-income earners more than the lower-income earners it was created to help. A shift in expenditure has directed more private funds towards specialist and hospital care and away from general practitioners and providers of primary care, thus increasing private health care costs. Further criticism of the private sector cites a fee-for-service reimbursement scheme, which provides incentives for medical personnel to order tests or procedures that may be excessive. Imbalances between medical schemes and a lack of competition amongst private hospital owners have also been cited as being detrimental to the overall effectiveness of the sector.⁷

Perhaps the most common criticisms of the private sector surround the misalignment of resources relative to the population served and discrepancies between the public and private sectors. Data from the Health Systems Trust's South African Health Review of 2005/06 estimates that each doctor in the private sector serves a population of 588 citizens while each doctor in the public sector serves a population of 4,193. Specialists in the private sector serve an estimated 470 people each, while those in the public sector serve 10,811. There are an estimated 102 people per nurse in the private sector, while the ratio of patients to nurse in the public sector is 616 to one. Pharmacists present the greatest misalignment of healthcare personnel, with each pharmacist in the private sector serving 1,852 people while those in the public sector serve 22,879 each. While the private sector often has an excess of hospital beds with a population of 194 per bed, the public sector sometimes faces shortages with a population of 399 per bed.⁸

Funding for the two sectors is similarly skewed. Total healthcare spending is currently about 8% of the country's gross domestic product (GDP).⁹ Approximately half of this, R97 billion or 4% GDP, is public spending, while private expenditure is about R104 billion.¹⁰ The perceived equality of funding for the sectors must be understood in the context of the number people served by each. While the private sector serves only about 16% of the population, its funding is greater than that of the public sector, which serves 84% of the population, thus creating great inequalities in resource allocation. Such misalignment results in great discrepancies in the quality of care accessible to different socioeconomic classes within the country; the wealthiest proportion of the population enjoys the high quality services of the private sector while the vast majority of citizens rely on an inadequate public sector. This inequality is recognized by Ataguba and McIntyre's 2009 paper, as quoted in the ANC's NHI discussion document:

⁷ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 12-13.

⁸ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 14.

⁹ McIntyre, Di. "Modeling the Estimated Resources Requirements of Alternative Health Care Financing Reforms in South Africa." *SHIELD*. October 2010. Web. 8 November 2010. <http://www.health-e.org.za/news/article.php?uid=20032952>. Pg. iv.

¹⁰ McIntyre, Di. "Modeling the Estimated Resources Requirements of Alternative Health Care Financing Reforms in South Africa." *SHIELD*. October 2010. Web. 8 November 2010. <http://www.health-e.org.za/news/article.php?uid=20032952>. Pg. 34.

There is a lack of cross-subsidies in the overall health system in South Africa. Although healthcare financing is 'progressive,' this is largely due to the richest groups bearing the burden of medical scheme funding; however, the richest groups are the exclusive beneficiaries of these funds. It is indisputable that benefit incidence in South Africa is inequitable; benefits from healthcare are not distributed according to the need for healthcare.¹¹

The allusion to "progressive" healthcare financing is a reference to the system by which the government raises the revenue for public healthcare spending. Funds are collected by the South African Revenue Service (SARS) as part of income taxes. This tax is paid by less than ten percent of the population. These contributors, who earn above the income tax threshold, in large part provide the funds for the provision of healthcare to the rest of the population. However, a large percentage of taxpayers also choose to purchase private medical schemes, increasing their contribution to healthcare expenditure. Because their status as members of medical schemes entitles them to a much higher quality of care than the segment of the population reliant on the government system, the wealthiest portion of the population enjoys the vast majority of healthcare benefits, though this group also suffers from a significantly lower burden of disease than its poorer counterpart.¹²

In addition to inadequate funding, the public sector faces many other challenges. As alluded to previously, there is a severe shortage of human resources in the public sector, compounded by low retention rates, high rates of emigration of educated health personnel and limited training facilities, resulting in vacancies in funded positions and an unequal distribution of doctors between urban and rural areas as well as between provinces.¹³ The public sector is severely under-resourced in other areas as well, including equipment and drug supply, failing infrastructure, and generally insufficient facilities (both in number and in quality). Poor management, corruption, and wasteful use of resources result in inefficient use of the resources available.¹⁴ Insufficient communication between provincial public sector departments and the national Department of Health as well as inconsistent compliance with the National Health Act prevent fulfillment of government's legal obligations in the public sector.¹⁵ An inadequate referral system results in ineffective use of resources. The system's flaws cover all levels of care, from the unavailability of emergency medical services and the poor quality of primary care services, to barriers between

¹¹ Ataguba and McIntyre, 2009. As quoted in: ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010.

<http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 16.

¹² ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 13.

¹³ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 12.

¹⁴ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 13.

¹⁵ SHIELD. "Should We Pursue a Universal Healthcare System or Something Else in South Africa?" 2010. Web. 8 November 2010. <http://www.health-e.org.za/news/article.php?uid=20032952>.

different levels of care and unnecessary visits to specialists or advanced care facilities when lower-level care would suffice.¹⁶

The realities of the South African healthcare system do not reflect the commitments made by the government regarding the provision of health services. The Congress of South African Trade Unions (COSATU) expressed its dissatisfaction with the current state:

South African citizens have a constitution and laws which give better guarantees of social justice, human rights and equality than almost anywhere in the world. Yet in practice millions are denied these rights, especially socio-economic rights, in what has become the most unequal nation in the world.¹⁷

4.1.3 Past Attempts at Increasing Access to Healthcare Services

The government's legal obligation to provide universal and equitable access to healthcare services is clearly not being met, as evidenced by a population burdened by high unemployment, disease, and inequality and by a divided and largely inadequate healthcare system. Incentive for government intervention is more than present and has not gone unnoticed. Several past attempts to expand access to healthcare services reflect government recognition of its responsibility to take action:

1. Health Care Finance Committee (similar to ANC plan), 1994: This plan collected revenue from all formal sector employees as part of a contribution from employers and used a community-rating mechanism.¹⁸ Revenue was collected by private insurers serving as intermediaries for the social health insurance (SHI) scheme. Only contributors and their dependents were covered by the insurance scheme, and risk equalization occurred only between individual insurers. The benefit package included comprehensive coverage of primary care and hospital services and providers were reimbursed by collectively negotiated payment rates. Providers were mainly from the public sector, though private providers had some role in primary care.¹⁹
2. 1995 Committee of Inquiry: This proposal collected funds from the same sources as the 1994 Health Care Finance Committee, but afforded a choice between a state-sponsored SHI fund and private insurers as the collection agencies. Again, only contributors and their dependents received coverage, but risk equalization

¹⁶ SHIELD. "Should We Pursue a Universal Healthcare System or Something Else in South Africa?" 2010. Web. 8 November 2010. <http://www.health-e.org.za/news/article.php?uid=20032952>.

¹⁷ COSATU. "Declaration by the Congress of South African Trade Unions on the Civil Society Conference." *Polity.org*. 28 October 2010. Web. 1 November 2010. <http://www.polity.org.za/article/cosatudeclaration-by-the-congress-of-south-african-trade-unions-on-the-civil-society-conference-28102010-2010-10-28>

¹⁸ "Community Rating" is defined as "The process of developing and charging contribution rates base on the overall community (or option or scheme) claims experience rather than on group or individual specific claims data." From: McLeod, Heather. "Glossary of Healthcare Financing Terms." *Innovative Medicines South Africa*. 27 October 2009. Web. 17 November 2010. http://www.imsa.org.za/national_health_insurance_library.html. Pg. 11.

¹⁹ McIntyre et al., 2007. As quoted in McLeod, Heather. "Comparison of NHI Proposals." *Innovative Medicines South Africa*. 15 October 2010. Web. 17 November 2010. http://www.imsa.org.za/national_health_insurance_library.html. Pg. 2.

- occurred between the state-sponsored fund and individual private insurers for the compulsory benefit package. Coverage was restricted to hospital services, leaving out the primary care covered under the previous proposal, and providers were reimbursed at rates determined by the cost of services within a public hospital. Contributors were offered a broader choice of provider, with competition between public and private hospitals.²⁰
3. Department of Health Social Health Insurance Working Group, 1997: Unlike previous proposals, funds were collected only from formal sector employees above the income tax threshold who did not belong to a medical scheme. Contribution was shared between employers and employees and a community-rating mechanism was again employed. Funds were collected by a state hospital fund for those not covered by medical schemes, with an “opt out” option for members of private insurance schemes. Coverage was again extended only to contributors and their dependents. No risk equalization occurred between the state fund and the private insurers, though there was an allocation from the state fund to government hospitals through the governmental budget. The state fund covered public hospital services and reimbursement occurred via the state budget. Coverage for private insurance schemes was unspecified and reimbursement in the private sector occurred on a fee-for-service basis. Members of the state SHI scheme were restricted to public hospitals, while the privately insured had a choice of providers.²¹
 4. Taylor Committee of Inquiry into Comprehensive Social Security, 2002: Contributions for this proposal were mandatory for all formal sector employees above the income tax threshold via medical schemes. Contribution was voluntary for low-income informal sector workers via a state-sponsored scheme. Other members of the population contributed through a dedicated payroll tax, resulting in income-related contributions for all South Africans. Community-rating mechanisms were once again employed. The Taylor Committee proposal mandated universal coverage, a breakaway from previous proposals. Risk equalization occurred between the state-sponsored scheme and individual private insurers for a uniform minimum benefit package. Benefits included a minimum package of primary care, chronic illness and hospital care for all. Providers were reimbursed via budgets and salaries for public facilities, while private primary health care providers were reimbursed via a state capitation scheme. Members whose income rendered them non-contributors were restricted to public hospitals as providers. Contributing members of the state scheme were afforded “differentiated amenities/private wards” in public

²⁰ McIntyre et al., 2007. As quoted in McLeod, Heather. “Comparison of NHI Proposals.” Innovative Medicines South Africa. 15 October 2010. Web. 17 November 2010.
http://www.imsa.org.za/national_health_insurance_library.html. Pg. 2.

²¹ McIntyre et al., 2007. As quoted in McLeod, Heather. “Comparison of NHI Proposals.” Innovative Medicines South Africa. 15 October 2010. Web. 17 November 2010.
http://www.imsa.org.za/national_health_insurance_library.html. Pg. 2.

- hospitals and were given the choice of private primary health care providers. Medical scheme members enjoyed a choice of provider.²²
5. Ministerial Task Team for Implementing SHI, 2002: Contribution was mandatory for all taxpayers and took the form of an SHI tax as a part of a composite social security tax. Voluntary community-rated contributions could also be made to medical schemes. Coverage was universal for a basic benefit package, but contributors and dependents enjoyed additional “top-up” coverage. A risk-adjusted subsidy was afforded to the public sector and schemes for a basic benefit package. Coverage included a basic benefit package of primary care the Prescribed Minimum Benefits (PMBs) outlined in the Medical Schemes Act of 1998. Non-contributors and low-income payers of the SHI tax were restricted to public facilities, though medical scheme members were afforded the choice of provider.²³

All of these proposals center on a multi-tier healthcare system and the idea of social health insurance—that is, health care coverage for contributors only and perhaps a move towards eventual universal coverage. The ANC Conference in Polokwane in December 2007 (hereafter referred to as “Polokwane”) resulted in a major shift in thinking. Post-Polokwane plans for the South African healthcare system focused on the idea of universal coverage from the outset, promoted through income and risk cross-subsidies.²⁴ It is this ideal that informs the current ANC proposal for National Health Insurance.

4.2 The Current ANC Proposal for National Health Insurance

4.2.1 Informing Principles

At the core of the ANC’s most recent proposal for National Health Insurance the author identifies two principles: the right to healthcare and social solidarity.

The Right to Healthcare

Defined in the Section 27 of the Constitution, the right to healthcare forms the basis of the ANC’s proposal. It is the idea that every citizen deserves access to healthcare services, regardless of ability to pay; thus, the right to healthcare leads to the principle of universal coverage as a key piece of the proposal. Di McIntyre sees the idea of universal coverage as resting on two principles within the scope of the right to healthcare. The first suggests that no one should have his or her livelihood threatened because of a need to pay for healthcare.²⁵ This principle lies at the base of the idea of universal coverage and care

²² McIntyre et al., 2007. As quoted in McLeod, Heather. “Comparison of NHI Proposals.” *Innovative Medicines South Africa*. 15 October 2010. Web. 17 November 2010.

http://www.imsa.org.za/national_health_insurance_library.html. Pg. 2.

²³ McIntyre et al., 2007. As quoted in McLeod, Heather. “Comparison of NHI Proposals.” *Innovative Medicines South Africa*. 15 October 2010. Web. 17 November 2010.

http://www.imsa.org.za/national_health_insurance_library.html. Pg. 2.

²⁴ McIntyre et al., 2007. As quoted in McLeod, Heather. “Comparison of NHI Proposals.” *Innovative Medicines South Africa*. 15 October 2010. Web. 17 November 2010.

http://www.imsa.org.za/national_health_insurance_library.html. Pg. 3.

²⁵ McIntyre, Di. “A Call for Frank Public Debate.” *Health-E News*. 30 September 2010. Web. 11 November 2010. <http://www.health-e.org.za/news/article.php?uid=20032952>

that is free at the point of service. The second principle, that all citizens should be able to access the healthcare they need, provides further basis for universal coverage and provides a foundation for a needs-based approach to access in which the greatest access is afforded to those in the greatest need.²⁶ A legal obligation of government, fulfillment of the right to healthcare should be central to any state action regarding the health of South Africans.

Social Solidarity

The concept of social solidarity is particularly relevant in the South African context as deep divisions and massive disparities exist within the population. ANC leaders have heavily emphasized the importance of social solidarity in speeches, documents, and other material released on the subject of National Health Insurance. Social solidarity is essentially the idea that cross-subsidization is an essential component of a properly functioning society—that the “haves” are morally obliged to provide aid to the “have-nots.” In the context of healthcare, social solidarity means that both income- and risk-based cross-subsidization exist within the system. Thus, the wealthy must subsidize healthcare costs of the poor and the healthy (or low-risk) must subsidize healthcare costs of the sick (or high-risk). Professor Yousuf Vawda, member of the Faculty of Law at University of Kwazulu-Natal, Howard College, defines social solidarity in the context of the NHI as such: “The real meaning of social solidarity is subsidization. It’s people saying, ‘Well I have enough for myself and my family so therefore I should give some to the poor so that everyone may enjoy a decent standard of healthcare.’”²⁷

The ANC defines its informing principles thus:

The core principles on which the proposed NHI will be established include:

65. *The right to health:* The State must take reasonable legislative and other measures, within its resources, to achieve the progressive realization of the right to access health care services. A key aspect of ensuring access to health care is that services must be free of any charges at the point of use.

66. *Social solidarity and universal coverage:* There is a commitment to social solidarity in the South African health system, which means that:

- Mandatory contribution by South Africans to funding health care according to their ability to pay. Given the massive income inequalities, progressive funding mechanisms will be used.
- There should be universal access to health services that meet established quality standards so that everyone is able to use health services according to their *need* for health care and *not* on the basis of their ability to pay.

²⁶ McIntyre, Di. “A Call for Frank Public Debate.” *Health-E News*. 30 September 2010. Web. 11 November 2010. <http://www.health-e.org.za/news/article.php?uid=20032952>

²⁷ Vawda, Yousuf. Interviewee’s Office, Howard College Building, UKZN, Howard College Campus. Personal Interview. 4 November 2010.

67. Public Administration: A mandatory national health insurance system that is structured as a single purchaser public entity supports the strategies to achieve economies of scale, promote redistribution of health care resources and cost-containment.²⁸

4.2.2 Key Proposals

In accordance with the principles identified above, the ANC's latest discussion document on the NHI, released in September 2010, proposes the following key elements of the National Health Insurance scheme.

Coverage

As previously mentioned, universal coverage is the cornerstone of the ANC's latest proposal. All South African citizens and legal residents will be included in the state's health insurance plan, regardless of ability to pay. Those who can afford to may choose to supplement this coverage with enrollment in private medical schemes. Citizens will be entitled to a "defined, comprehensive package of healthcare services," including primary, secondary and tertiary care, that will not be "less than what [the public is] currently receiving." Quaternary health care will remain the responsibility of the National Department of Health.²⁹ While the specific benefits included in this comprehensive package are not yet defined, the discussion document identifies the following services as falling within NHI's realm: primary and preventive services; inpatient care; outpatient care; emergency care; prescription drugs; appropriate technologies for diagnosis and treatment; rehabilitation; mental health services; dental services, excluding cosmetic dentistry; substance abuse treatment services; basic vision care and vision correction, other than laser vision correction for cosmetic purposes; and hearing services, including provision of hearing aids.³⁰ The prescription drugs included in the coverage will be "linked to the Essential Drugs List (EDL) and updated on a regular basis."³¹ The exact scope of what constitutes a "comprehensive package" has not yet been defined and thus could lead to conflict. The ANC discussion document places only one limit on the benefit package, stipulating that "it will exclude medically unnecessary services and expensive therapies that have little impact on health care."³² The paper also notes that a successful NHI will employ the principle that "everyone is covered" not "everything is covered."³³ The Prescribed Minimum Benefits (PMBs), established as a base for coverage under current medical schemes, could serve as a basis for the definition of this benefit package.

²⁸ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 21-22.

²⁹ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 23.

³⁰ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 23-24.

³¹ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 24.

³² ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 24.

³³ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 20.

Enrollment of the population in the National Health Insurance scheme will be based on a “health facility approach.” People will be registered using the “green, bar-coded identity document or equivalent legal document.” Eventually, all citizens will be issued a NHI card recognizing their registration in the system. The card will contain health information history, allowing for easy access to patient information. All NHI cards will appear the same, regardless of the holder’s contributory status, so as to avoid stigma.³⁴

National Health Insurance Fund

A new institution within the Department of Health will handle administration of the National Health Insurance. The National Health Insurance Fund (NHIF) will be managed by a Chief Executive Officer reporting directly to the Minister of Health and supported by an executive management team, technical committees, and expert advisors. The NHIF will operate as a separate division of the Department of Health. The primary responsibility of the NHIF will be to “receive funds, pool these resources and purchase services on behalf of the entire population.”³⁵ The Fund will serve as the basis of a single-payer system, which the ANC claims “is effective in collecting revenue, distributing risks through one large risk pool; and offers government a high degree of control over total expenditure on health...A single payer is administratively more efficient (with costs around 3 percent) than a multi-payer system...[and] is better able to negotiate prices, purchase commodities in bulk and more importantly control utilization using various methods.”³⁶ The Department of Health will continue its role in overall stewardship and as a major service provider and will continue to develop overall health plans. The Minister of Health will be responsible for oversight of the NHIF, the development of national health insurance policy and legislation changes that may become necessary.³⁷

Funding

Funds for the NHI will come primarily from tax revenue. The amount of general tax revenue directed towards healthcare services will be increased (i.e. the government will increase its health budget). Preliminary estimates by the Costing Sub-Committee of the Ministerial Advisory Committee predict health spending will need to constitute 14-15% of total government budget.³⁸ Additional revenue will be collected from a supplementary tax contribution. The contribution will be mandatory for all citizens earning above the income tax threshold. The ANC explains the purpose of this mandatory contribution is to “establish a link between contributions that individuals make to public funds and the health service

³⁴ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 27.

³⁵ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 22.

³⁶ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 22.

³⁷ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 24.

³⁸ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 32.

benefits to which they will be entitled under the NHI...It provides a mechanism for cementing social solidarity in the health system.”³⁹ While the exact design of this tax remains unknown, suggestions include a surcharge on taxable income, payroll taxes, or an increase in Value Added Tax that is earmarked for the NHI. Costing analysis conducted by SHIELD estimates a progressive income tax, shared between employers and employees, would range from an increase of one percent for lower-income earners to eight percent for higher-income earners. A flat tax would require a maximum additional tax increase of four percent.⁴⁰ SARS would be responsible for the collection of this tax in addition to general tax revenue; SARS is thus responsible for all revenue collection for the NHI. Revenue from tax collection would be supplemented by additional funding resulting from the elimination of the current subsidy awarded to medical scheme members.⁴¹

The ANC recognizes the ambiguity and uncertainty present in its funding schemes as of now but emphasizes that contributions will not exceed those currently made to medical schemes:

The exact level of mandatory contribution to be introduced and the magnitude of general tax funding required for the proposed NHI are still being refined and discussed. However, at this stage it is necessary to indicate that a policy commitment to a considerable increase in public funding of health services (through an appropriate mix of general tax allocation and progressive mandatory contributions) is required, to reach a funding level consistent with the needs of a publicly funded health system. It is also important to emphasise that the progressive mandatory contributions from individuals should not exceed their current contributions levels to medical schemes for similar benefits.⁴²

Delivery of Healthcare Services

South African citizens will be able to access healthcare under the NHI from a variety of public and private providers, as long as they are accredited by the NHI. A National Office of Standards and Compliance will be created to establish the criteria for accreditation. Accreditation will be granted to facilities that meet these requirements, with guidelines as to what constitutes each level of service provision. Facilities will be accredited as a certain level of provider and a referral system will be designed based on these accreditation levels to assure continuity of care and effective cost containment. The accreditation process will be based on the principles of quality assurance and continuous quality improvement and

³⁹ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 26.

⁴⁰ McIntyre, Di. “Modeling the Estimated Resources Requirements of Alternative Health Care Financing Reforms in South Africa.” *SHIELD*. October 2010. Web. 8 November 2010. <http://www.health-e.org.za/news/article.php?uid=20032952>. Pg. iv.

⁴¹ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 26.

⁴² ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 26.

will seek to accredit a quarter of all facilities every year for four years, with the goal of having all health facilities accredited within a five year period from implementation.⁴³

Strengthening of the Health System

Occurring simultaneously with the rollout of NHI, a massive plan to strengthen the health system will be implemented. The plan will focus on several weaknesses of the current system. A reengineered focus on primary health care will form the basis of this improvement plan. In accordance with Chapter Five of the National Health Act, the ANC seeks to improve primary health services so as to minimize the need for more specialized—and thus expensive—services and to most effectively provide healthcare to the greatest number given the country’s limited supply of highly-trained health professionals. The new focus envisions primary health care teams in a central role, each consisting of a doctor or clinical associate, a nurse, and three to four community health workers (CHWs) to provide community and home-based care services. Each team will be responsible for approximately 10,000 people; approximately 5,000 teams are required to serve the whole population. While doctors and nurses are in short supply, community health workers are abundant and the current supply allows for twice the proposed number of CHWs per team. The ANC hopes such a system will be able to provide 80% of necessary care with access to secondary and tertiary levels of care on a referral basis only.⁴⁴

The strengthening of system infrastructure will begin with a massive inventory of public and private facilities to assess current capacity, identify gaps, and mark facilities needed refurbishment. Based on this inventory, a plan for refurbishment and expansion will be developed.⁴⁵ This refurbishment has already begun in five hospitals throughout the country that have been identified as pilot hospitals to test the program.⁴⁶ In addition, improved management of healthcare facilities will be emphasized. The ANC seeks to address present issues by increasing accountability and improving political governance of district health councils as well as by focusing on better training of health facility managers.⁴⁷

A major focus of the strengthening plan will be improved staffing of the healthcare system. The ANC aims to increase the supply, quality, distribution, and retention of health workers. The plan will begin with a comprehensive audit of the current system to assess how many and where health workers are needed. The supply of nurses will be increased through an increase in the number of institutions offering nursing degrees and a de-emphasis on the necessity of nurses obtaining a university degree to increase the number

⁴³ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 24.

⁴⁴ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 33.

⁴⁵ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 32.

⁴⁶ Sapa. “Billions to be Spent to Upgrade Hospitals—Minister.” *Polity.org*. 27 Sept. 2010. Web. 18 October 2010. <http://www.polity.org.za/article/billions-to-be-spent-to-upgrade-hospitals-minister-2010-09-27>

⁴⁷ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 33.

of individuals with the qualifications to practice. The training of enrolled and auxiliary nurses in the public sector will be reprioritized with the goal of training approximately six times the current amount annually. The ANC will also work to develop programs to address the emotional and physical effects of the HIV/AIDS epidemic on nurses.⁴⁸

The shortage of doctors in the public sector will be similarly addressed, beginning with the rapid identification, assessment, and advertisement of vacant posts. The workload of doctors in the public service will be reduced by the introduction of more medical assistants and through the recruitment of the services of private sector doctors on a sessional basis. The ANC will attempt to provide incentives for the retention of doctors in rural areas and in the country as a whole through emphasis on research opportunities, personal satisfaction, and other benefits of working in such environments.⁴⁹ In addition to retaining South African doctors, the ANC will seek to recruit international health workers to the South African system. As a temporary measure, doctors and nurses from other African countries will be permitted to reside and practice in South Africa for specified periods of time defined by their residence status and by the demand for their particular specialty. Non-governmental organizations working to recruit international doctors will be given financial and moral support and foreign doctors will be encouraged to practice in South Africa.⁵⁰

Another key improvement in the system will be the installation of advanced information systems. The NHIF will contribute to an integrated and enhanced National Health Information System based on an electronic patient record platform. Electronic patient records will be linked to patients' NHI cards to provide easy access to patient histories at any medical facility. In addition to the electronic patient record, the information system will support the monitoring of the extension of coverage in all population sectors, the tracking of population health status and production of disease profile data for use in computing capitation for reimbursement schemes, financial and managerial functions, utilization of healthcare benefits, quality assurance, production of reports for health facilities and systems management, and research and documentation to support changes as healthcare need of the population evolve.⁵¹

Rollout of the NHI

Rollout of the National Health Insurance scheme is set to begin in 2012. The implementation will begin in rural and under-resourced areas and will take place over a period of fourteen years. Early phases will be characterized by assessment of the current system, rapid refurbishment and improvement of facilities, and review and drafting of

⁴⁸ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 36.

⁴⁹ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 36.

⁵⁰ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 37.

⁵¹ ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 28.

appropriate legislation. Concrete plans must be developed for all facets of the scheme, cost estimates must be obtained, outlines for the plan's implementation must be drafted, and provider accreditation must begin.⁵² The implementation of such a massive policy is daunting, particularly as it is set to begin in less than two years despite a lack of any concrete policy.

4.3 Potential Problems with the Proposed NHI

Every policy contains numerous flaws and even the most heavily analyzed policies result in unforeseen consequences. The ANC's proposed NHI is no different; due to time and other constraints, the author has chosen to highlight a few potential flaws.

Affordability

The proposed National Health Insurance scheme would more than double the current number of people covered by insurance. Cost estimates from SHIELD and ANC committees predict a necessary increase in the current year's health budget to R101.9 billion; a 2011/12 budget of R109.7 billion (a R3.1 billion increase); a 2012/13 budget of R116.6 billion (increase by R4.7 billion); 2013/14 budget of R127.1 billion. Resources required for the National Health Insurance are expected to increase from R128 billion in 2010 to R267 billion in 2020 and R376 billion in 2025. Though SHIELD and the ANC conclude that the NHI is ultimately affordable, this conclusion is based on assumptions such as a 7% annual increase in GDP.⁵³

Heather McLeod questions the legitimacy of the figures put forth by government and SHIELD, claiming they are based on bad statistics and some of the numbers, such as the proposed progressive income tax increases, have no basis. While the ANC and SHIELD proposed a progressive tax increase ranging from 1-8% would be sufficient to cover costs of the NHI, McLeod concluded that a tax progressing from 7.8-63.6% would actually be necessary to account for these same cost estimates.⁵⁴ McLeod's strongest criticism is not of the numbers themselves but of the lack of concrete cost estimates. Much more research must be conducted into potential costs before an adequate evaluation of the NHI can be produced. Such massive expansion of benefits will undoubtedly be expensive, and the ANC should be sure South Africa can afford the policy before considering implementation.

Public Discontent with Services Provided Under NHI

The current ANC proposal promises the South African public services the government will not be able to provide in the near future. The discussion document promises a comprehensive package of benefits, the scope of which could be very difficult to define. A disconnect in understanding of the definition of "comprehensive" between the public and the government is likely. A particular disconnect in the perception of quality

⁵² ANC National General Council. *National Health Insurance Discussion Document*. September 2010. Web. 7 November 2010. <http://www.anc.org.za/show.php?include=docs/pr/2010/pr0921.html&ID=6013>. Pg. 47.

⁵³ "Relentless Drive for NHI, says Gordhan." *Polity.org*. 27 October 2010. Web. 2 November 2010. <http://www.polity.org.za/article/relentless-drive-for-nhi-says-gordhan-2010-10-27>

⁵⁴ McLeod, Heather. "Comparison of NHI Proposals." *Innovative Medicines South Africa*. 15 October 2010. Web. 17 November 2010. http://www.imsa.org.za/national_health_insurance_library.html. Pg. 9.

care is likely to cause discontent amongst the public. While the ANC's approach relies heavily on a strong primary health care system, driven by community health workers and nurses, the public increasingly views adequate care as a visit to the doctor. Many citizens are likely to view treatment by a nurse or CHW as inadequate and thus to accuse the government of failing to fulfill its promises. Additional claims in the discussion document, such as that no citizen will pay more than they currently pay to a medical scheme for comparable services and that services provided will be comparable to those citizens received, seem unrealistic. These rely on the assumption that the government will be able to provide services on a level similar to that of the private sector simply by investing more money in public sector facilities over a short period of time and that the government will be able to achieve this level of quality at a lower cost.⁵⁵ It is highly unlikely that the government will be able to deliver on many of its promises to the satisfaction of much of the public within the time period laid out in its discussion document.

Reliance on Failing Health System

The success of the National Health Insurance system relies on the ability of providers to provide quality health care services to the population. While the private sector is largely successful in doing so for the population it serves, this represents a very small portion of the total population. The public sector struggles with many issues, as discussed previously, and is unable to adequately meet the demands of the population it currently serves. Broadening of health insurance coverage will greatly increase the number of citizens able to afford health care and thus will have a substantial impact on the volume of patients seeking treatment at public health facilities. As they stand now, public facilities lack the money and resources to handle the increases in volume that are inevitable once the barrier of cost is removed from access to healthcare.⁵⁶ While the ANC proposes a strengthening program for the struggling health system, the improvements necessary to achieve the promised standards of care are immense and not achievable within the proposed time period. Sources of funding for this refurbishment program have not been clearly identified, nor has a program for improvement been outlined.

Potential Mismanagement by Government

The ANC's proposal calls for the establishment of another bureaucracy within government. As argued by Mike Waters in a piece for Health-E News Service, the ANC's response is often to create a new bureaucracy, yet rarely does it execute this well.⁵⁷ Bureaucracies often invite the "red tape" that limits the efficiency of government and increases administrative costs. Particularly in the environment of "corruption in healthcare" identified by COSATU, an additional bureaucracy provides more opportunities

⁵⁵ McLeod, Heather. "Comparison of NHI Proposals." *Innovative Medicines South Africa*. 15 October 2010. Web. 17 November 2010. http://www.imsa.org.za/national_health_insurance_library.html. Pg. 12.

⁵⁶ Mannie, Dr. Jay. Interviewee's Office and McCord Hospital, Durban, KZN. Personal Interview. 18 November 2010.

⁵⁷ Waters, Mike. "DA—State Intervention Not What the Doc Ordered." *Health-E News*. 11 October 2010. Web. 3 November 2010. <http://www.health-e.org.za/news/article.php?uid=20032966>

for unearned tenders and political corruption.⁵⁸ McLeod argues against the necessity of creating an additional bureaucracy in the form of the NHI Fund. The ANC proposal names SARS as the body responsible for revenue collection, the Department of Health retains most of the responsibilities regarding provision of care, and provincial departments of health could serve as adequate purchasers of services.⁵⁹ Thus creation of a new post within the Ministry of Health seems reasonable and necessary, but the addition of a bureaucracy seems to invite more problems than it would solve.

Lack of Concrete Proposal

Despite presenting a forty-seven-page discussion document and various other information releases on the National Health Insurance, the ANC has yet to produce any concrete proposals. The discussion document outlines key components of the NHI and recognizes the need to develop policies and programs of implementation but fails to do so. As McLeod argues, “The NHI proposals as released in September 2010 remain little more than a conceptual wish-list and there remains much more technical work to be done to describe a viable and implementable system.”⁶⁰

Lack of Adequate Information Technology Infrastructure Within the Health System

Many of the problems with the proposals discussed above can ultimately be attributed to a lack of information technology infrastructure within the current system. The South African health system lacks the technology and infrastructure necessary to collect data that could be used to evaluate its efficiency. There are no established methods of tracking patients across different levels of care or of obtaining solid statistics on many functions of the health system. This data is necessary to establish a basic understanding of the health system as it currently exists. In order to understand the inefficiencies in the system, researchers need to be able to obtain data that can be used to evaluate cost effectiveness and other measures of efficiency. This data is in turn necessary to predict future costs of expanding insurance coverage or potential utilization rates. Until data such as this is available, researchers cannot make accurate predictions upon which informed policies may be based. Until an information technology system is installed and used to collect data that may be used to predict future trends, creation of an informed National Health Insurance policy remains impossible. Attempting to formulate a policy without the data to inform its suggestions will result in a system that is “very likely to fail.”⁶¹

⁵⁸ COSATU. “Declaration by the Congress of South African Trade Unions on the Civil Society Conference.” [Polity.org](http://www.polity.org.za/article/cosat-declaration-by-the-congress-of-south-african-trade-unions-on-the-civil-society-conference-28102010-2010-10-28). 28 October 2010. Web. 1 November 2010. <http://www.polity.org.za/article/cosat-declaration-by-the-congress-of-south-african-trade-unions-on-the-civil-society-conference-28102010-2010-10-28>

⁵⁹ McLeod, Heather. “Comparison of NHI Proposals.” [Innovative Medicines South Africa](http://www.imsa.org.za/national_health_insurance_library.html). 15 October 2010. Web. 17 November 2010. http://www.imsa.org.za/national_health_insurance_library.html. Pg. 5.

⁶⁰ McLeod, Heather. “Comparison of NHI Proposals.” [Innovative Medicines South Africa](http://www.imsa.org.za/national_health_insurance_library.html). 15 October 2010. Web. 17 November 2010. http://www.imsa.org.za/national_health_insurance_library.html. Pg. 15.

⁶¹ Moodley, Indres. Interviewee’s Office, UKZN, Howard College Campus. Personal Interview. 17 November 2010.

4.4 Citizen Response to Proposed NHI

Public opinion regarding the NHI seems to be divided. The poor and currently uninsured seem to be largely in favor of the NHI, and understandably so as the policy will grant them access to healthcare services they do not currently have access to at little or no cost to them. The wealthy and currently insured seem more divided. A faction of these people opposes the NHI on the basis of resistance to the concept of social solidarity. They do not consider it a duty to subsidize the healthcare services for those who cannot afford them. Doctor A, medical director of a semi-private urban hospital in Durban, calls this group “selfish.”⁶²

An opposing faction of the wealthy and insured supports the concepts of social solidarity and of universal coverage. Professor Indres Moodley, director of the Health Outcomes Research Unit at the University of KwaZulu-Natal, Howard College, supports the NHI as a concept and sees cross-subsidization as a basic welfare principle.⁶³ He is joined in this view by Doctor A, who believes that everyone is entitled to healthcare, including the poor.⁶⁴ Both are skeptical however of the specifics of the NHI’s proposal. Doctor A saw the proposal as too ambitious, promising services beyond the financial and resource capacity of the state. Doctor A also foresaw difficulty in defining the benefit package, admitting that he does not have his own concept of what does or should constitute essential and/or comprehensive care.⁶⁵ Moodley’s concerns centered on the inability of the government to efficiently use resources, and he expressed particular concern about the lack of information technology system from which to obtain data to use in evaluating current systems and producing accurate cost estimates.⁶⁶

Other taxpayers reflected more pragmatic concerns. Brendan, a restaurant and bar owner, supported the idea of cross-subsidization but expressed concerns about corruption in government and an increase in taxes:

[The poor] should be looked after. I think it should work on a salary-based structure. The more you make, the less medical aide you get from the government because you can buy your own. The really poor people should get full aide and the rich ones shouldn’t get any. The government needs to use the money from the taxpayers better. As long as I can afford it, I don’t mind paying taxes for healthcare...The problem is that there’s so much corruption in government. I pay R2500 in taxes per month and I don’t know where any of it goes. I’d rather it go to helping a poor person get healthcare than into some politician’s back pocket. I believe [poor people] deserve to be healthy too. It’s not right that they go into these hospitals sick and come out dead. That’s not medicine. You should go in sick and come out cured. If I have to pay for them to be able to do that, I’m okay with it... As

⁶² Doctor A. Interviewee’s Office, Hospital, Durban, KZN. Personal Interview. 18 November 2010.

⁶³ Moodley, Indres. Interviewee’s Office, UKZN, Howard College Campus. Personal Interview. 17 November 2010.

⁶⁴ Doctor A. Interviewee’s Office, Hospital, Durban, KZN. Personal Interview. 18 November 2010.

⁶⁵ Doctor A. Interviewee’s Office, Hospital, Durban, KZN. Personal Interview. 18 November 2010.

⁶⁶ Moodley, Indres. Interviewee’s Office, UKZN, Howard College Campus. Personal Interview. 17 November 2010.

long as my taxes don't go up. Well, if it goes up to R3000 per month, that's okay. Five hundred rand more for someone's health—I can live with that. But not if it goes up to R3500. That's another thousand rand I could be using on something else.⁶⁷

Brendan's concerns are not unique. A mistrust of government and a highly negative perception of the public health system on which NHI will rely create understandable apprehension amongst the population of taxpayers. Personal concerns about increases in taxes are reasonable, particularly for those who will be required to contribute to the NHIF but fear a decrease in quality of care if they cannot afford to remain members of their private medical schemes.

5. Conclusions

Bounded by constitutional and legal commitments to actively pursue universal access to healthcare, the ANC government is acting not only within its rights but also within its obligations in proposing a healthcare reform. With a population ridden with disease, divisions, and massive inequities for which it must increase access to healthcare, the ANC seems to be making positive strides by advocating for a National Health Insurance system based on the principles of the right to healthcare, universal coverage, and social solidarity. Such a scheme, if implemented correctly and efficiently, would definitely be a step towards further realization of the twenty-seventh right.

Such implementation does not seem possible at the current point in time, however. The proposals of the ANC's plan would call for a massive overhaul of the current healthcare system, a process that will take far more than the suggested fourteen years. The proposal itself suggests a conceptual framework on which a successful NHI could be built, but much work must be done before such a system stands a chance of succeeding. To begin, the government must implement an information technology system to collect data that can be used to evaluate the current system. This data must then be used to predict estimated costs and to inform the formulation of concrete policies and programs leading to the implementation of an NHI. The failing public health sector must be significantly strengthened before it will be equipped to handle the increased utilization in which an NHI system would result. Implementation of the proposals indicated in the ANC's September 2010 discussion document over the proposed time scale of fourteen years would result in an incompletely informed system based on few concrete policies and reliant upon a failing public health sector and a government with a poor record of bureaucracy management.

The ANC should continue in its pursuit of a National Health Insurance based on universal coverage, social solidarity and the right to healthcare. However, it must not hurry to implement a less than fully informed policy and should instead focus on gathering accurate data through the installation of information technology systems. This data should be used to develop informed plans and policies for the strengthening of the public health sector and the eventual implementation of a National Health Insurance. The transition is likely to occur slowly and should not be rushed so as to avoid failure due to the absence of a

⁶⁷ Brendan., La Bella Restaurant, Durban. Personal Interview. 26 September 2010.

strong base on which the system is built. The government must continue to conduct research while simultaneously working towards eventual implementation of the NHI through the gradual installation of necessary components like information technology systems. Successful implementation of a National Health Insurance system based on the right to healthcare, universal coverage, and social solidarity is indeed possible, but must derive from fully informed policies that are not rushed into existence without a strong base.

6. Recommendations for Further Study

Further study of the National Health Insurance scheme should build upon the work of the author up to this point. The sheer volume of information on the NHI, including analysis and opinion, was impossible to review in such a limited time period. Examination of this constantly expanding wealth of data would contribute to further understanding of the NHI. Additionally, as policies surrounding the NHI are still in the beginning stages of their formation, further research should track new developments as they are released into the public domain. Greater information on public opinion and deeper understanding of the proposal could be achieved through additional interviews and guided conversations with South African citizens and various experts. Collection of data on the functioning of the healthcare system could be used to produce the researcher's own system evaluation and/or cost estimates. Study of similar health insurance in other countries could be used to inform evaluations of proposed policies and could be used to predict consequences of the transition to National Health Insurance. Further research into past attempts at expansion of access to healthcare and of the historical context surrounding the debate would also better inform the researcher.

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Appendices

Appendix A: Consent to Use of Independent Study Project (ILP)

(The Box below to be included on the title page with the electronic version of the paper and in the file of any World Learning/SIT Study Abroad archive.

Student Name: __Kelsey Fraser__

Title of ISP: __A Step Towards Realization of the Twenty-Seventh Right?: A Preliminary Analysis of the Proposed National Health Insurance for South Africa____

Program and Term: __SIT South Africa: Community Health and Social Policy, Fall 2010____

1. When you submit your ILP to your Academic Director, World Learning/SIT Study Abroad would like to include and archive it in the permanent library collection at the SIT Study Abroad program office in the country where you studied and/or at any World Learning office. Please indicate below whether you grant us the permission to do so.
2. In some cases, individuals, organizations, or libraries in the host country may request a copy of the ILP for inclusion in their own national, regional, or local collections for enrichment and use of host country nationals and other library patrons. Please indicate below whether SIT/World Learning may release your ILP to host country individuals, organizations, or libraries for educational purposes as determined by SIT.
3. In addition, World Learning/SIT Study Abroad seeks to include your ILP paper in our digital online collection housed on World Learning’s public website. Granting World Learning/SIT Study Abroad the permission to publish your ILP on its website, and to reproduce and/or transmit your ILP electronically will enable us to share your ILP with interested members of the World Learning community and the broader public who will be able to access it through ordinary Internet searches. Please sign the permission form below in order to grant us the permission to digitize and publish your ILP on our website and publicly available digital collection.

Please indicate your permission by checking the corresponding boxes below:

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| <input checked="" type="checkbox"/> | I HEREBY GRANT PERMISSION FOR WORLD LEARNING TO INCLUDE MY ISP IN ITS PERMANENT LIBRARY COLLECTION. |
| <input checked="" type="checkbox"/> | I HEREBY GRANT PERMISSION FOR WORLD LEARNING TO RELEASE MY ISP IN ANY FORMAT TO INDIVIDUALS, ORGANIZATIONS, OR LIBRARIES IN THE HOST COUNTRY FOR EDUCATIONAL PURPOSES AS DETERMINED BY SIT. |
| <input checked="" type="checkbox"/> | I HEREBY GRANT PERMISSION FOR WORLD LEARNING TO PUBLISH MY ISP ON ITS WEBSITES AND IN ANY OF ITS DIGITAL/ELECTRONIC COLLECTIONS, AND TO REPRODUCE AND TRANSMIT MY ISP ELECTRONICALLY. I UNDERSTAND THAT WORLD LEARNING’S WEBSITES AND DIGITAL COLLECTIONS ARE PUBLICLY AVAILABLE VIA THE INTERNET. I AGREE THAT WORLD LEARNING IS NOT RESPONSIBLE FOR ANY UNAUTHORIZED USE OF MY ISP BY ANY THIRD PARTY WHO MIGHT ACCESS IT ON THE INTERNET OR OTHERWISE. |

Student Signature: __Kelsey G. Fraser__ Date: __25 November 2010__

Appendix B: Consent Form For Adult Respondents in English

I can read English. (If not, but can read Zulu or Afrikaans, please supply). If participant cannot read, the onus is on the researcher to ensure that the quality of consent is nonetheless without reproach.

I have read the information about this learnership project and had it explained to me, and I fully understand what it says. I understand that this learnership is trying to find out:

The objective of this learnership is to achieve a better understanding of the proposed National Health Insurance Scheme and to evaluate its legitimacy as a policy within the context of the right to health.

I understand that my participation is voluntary and that I have a right to withdraw my consent to participate at any time without penalty.

I understand and am willing for you to ask me questions about :

- The history of South African healthcare policy
- Specifics of the National Health Insurance Scheme
- Perception of the right to health and the government's attempts to achieve its realization
- Perception of the National Health Insurance Scheme including feasibility, efficacy, legitimacy, and general personal opinion
- Current problems in the South African healthcare system and the ability of the NHIS to address these
- Views on the NHIS as a government effort to broaden realization of the right to health

I do/do not require that my **identity (and name)** be kept secret. I understand that, if requested, my name will not be written on any questionnaire and that no one will be able to link my name to the answers I give. If requested, my individual privacy will be maintained in all published and written data resulting from this learnership project.

I do/do not give permission for a **photograph** of me to be used in the writeup of this learnership or for future publication. I understand that the learner will not use or provide any photographs for commercial purposes or publication without my permission.

I understand that I will receive no direct benefit for participating in the learnership.

I confirm that the learner has given me the address of the nearest School for International Training Study Abroad Office should I wish to go there for information. (18 Alton Road, Glenmore, Durban).

I know that if I have any questions or complaints about this learnership that I can contact anonymously, if I wish, the Director/s of the SIT South Africa Community Health Program (Zed McGladdery 0846834982).

I agree to participate in this learnership project.

Signature (participant) _____ Date: _____

Signature (learner) _____ Date: _____

Appendix C: Questions Used in Interviews and Guided Conversations

1. Who should be responsible for ensuring everyone has the ability to be healthy?
2. What is your opinion on the proposed National Health Insurance scheme?
3. Do you believe the proposed NHI is feasible? Affordable? Necessary?
4. Do you have any issue with the idea of government as the NHI's controlling body?
5. What are some potential problems you see with the NHI as proposed?
6. Do you support the concept of social solidarity?
7. Do you see the NHI as a step towards greater realization of the right to healthcare?
8. What effect, if any, do you think the NHI would have on you personally if it were to be implemented as proposed?
9. What is your sense of the general public opinion regarding NHI?
10. What impact will the proposed NHI have on the prices of pharmaceuticals?