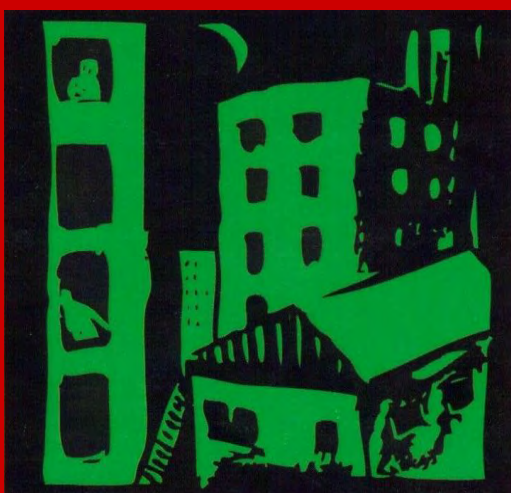


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Evaluating the potential impact of National Health Insurance on medical scheme **members' rights to have** access to health-care services in South Africa

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ABSTRACT

The National Health Insurance Bill proposes to establish a national health insurance scheme that aims to provide universal access to health-care services for everyone. Section 33 of the Bill also proposes to limit the provision of parallel services by medical schemes if such services are provided or covered by the tabled NHI scheme. The establishment of the NHI scheme is likely to have a negative effect on the existing access rights of general private health-care

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users, particularly members of medical schemes. The NHI scheme may enhance access to and the quality of health-care services for millions; however, enabling large portions of the population to access services currently provided by costly private practitioners – services at present almost exclusive to a minority – is not without its perils. It risks negatively impacting on existing access rights and reducing the quality currently enjoyed by users of private health-care services. The propriety of these potential infringements is not necessarily suspect, and may in fact be justifiable. However, this contribution argues that the limitation proposed under section 33 of the NHI Bill is cause for concern. The contribution explores the state’s constitutional duty to observe and respect the right of members of medical schemes to access health-care services. It uncovers the constitutional shortcomings of the limitation, and argues that it does not appear to serve any particular legitimate economic or legal purpose.

Keywords: national health insurance; duty to respect; medical schemes; right to access health-care services; socio-economic rights

1 INTRODUCTION

Everyone has the right to have access to health-care services including reproductive health care, and no one may be denied the right to emergency medical treatment.¹ These foundational tenets of modern South African law form part of the institution of human rights entrenched in the Constitution of the Republic of South Africa, 1996. However, in a society with high levels of socio-economic inequality like South Africa, the enjoyment of this right is not exactly equitable.² The levels at which members of South African society benefit from this constitutional guarantee remain disparate in terms of both quality and access.³ In response to these disturbing inequalities in health access and outcomes, the Department of Health (DOH) in 2011 published a green paper in which a universal health coverage (UHC) system was proposed.⁴ This proposed system, called the National Health Insurance (NHI), is intended to remedy these inequities and provide coverage to everyone irrespective of economic or social position or nationality.⁵ Subsequent iterations of the proposed system eventually restricted the original scope of

¹ Section 27(1)(a) and (3) of the Constitution of the Republic of South Africa, 1996.

² According to the World Bank, South Africa ranks first in the world for the most economically unequal country out of a total of 164 ranked countries (World Bank *Inequality in South Africa: An assessment of the Southern African Customs Union* (2022) at 7). See also International Monetary Fund “Six charts explain South Africa’s inequality” available at <https://www.imf.org/en/News/Articles/2020/01/29/na012820six-charts-on-south-african-persistent-and-multi-faceted-inequality> (accessed 23 September 2022).

³ Buisman L & García-Gómez P “Inequity in inpatient healthcare utilisation 10 years after apartheid” (2015) 32(2) *Development Southern Africa* 193 at 195–205.

⁴ Policy on National Health Insurance, 2011 at para 1 (GG 34523 (12 August 2011)).

⁵ Memorandum on the Objects of the National Health Insurance, 2019 at para 2.1.1 (GG 42598 (26 July 2019)).

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

coverage, perhaps in view of the potential costs of establishing and maintaining such a system.⁶

However, these restrictions to the proposed NHI scheme's scope have not reduced its overall ambition. As reflected in the National Health Insurance Bill (NHI Bill), which remains a subject of extensive debate at the time of writing, the proposed NHI system is still as bold today as it was when first conceptualised. So wide is its scope that it might not be implementable without running afoul of existing systems and rights. One such system is that of medical schemes, whose future under the proposed NHI remains uncertain.

This article explores the potential impact of adopting the proposed NHI Bill with its limiting provision under section 33 that restricts the services medical schemes may cover. The NHI's potential impact is explored within the broader matrix of the right to have access to health-care services, viewed from the perspective of current members and users of private health-care services, including medical scheme members. The article asks whether the proposed NHI would violate the rights of members of medical schemes to access health-care services. It argues that, although it is probable that some negative effects may arise, these limitations may be justifiable. However, it posits that restricting services covered by medical schemes may be problematic. The encroachment on the functions of medical schemes will result in an irrational limitation of users' ability to exercise their right to access health-care services. This contribution submits that the state has a duty to respect the exercise of constitutional rights, including the duty to respect people's choices on how to realise the objects of their rights on their own.

2 ACCESS TO HEALTH CARE IN SOUTH AFRICA

2.1 Current trends in health inequality: Public health

The Constitution states that access to health-care services and emergency medical treatment is a fundamental human right.⁷ The right to access health-care services does not exist in isolation, however. This right has sometimes been cited among those guarantees in the Bill of Rights that enhance the fundamental right to inherent dignity.⁸ Consequently, the realisation of the right not only fulfils the constitutional object of enabling better access to health care, but also gives effect to the right to human dignity.⁹

⁶ 2011 NHI Policy at para 64. See also White Paper on National Health Insurance, 2015 at paras 5.2 and 122 (GG 39506 (11 December 2015)); Labuschagne M & Slabbert M *Understanding National Health Insurance in South Africa: A legal perspective* (2021) 8–15.

⁷ Constitution of the Republic of South Africa, 1996.

⁸ Chaskalson A "Human dignity as a foundational value of our constitutional order" (2000) 16(2) *South African Journal on Human Rights* 193 at 204–205.

⁹ With regard to the value of inherent human dignity under the Constitution, Chaskalson writes: "As an abstract value, common to the core values of our Constitution, dignity informs the content of all the concrete rights and plays a role in the balancing process necessary to bring different rights and values

However, despite the formal existence of the right in South Africa's foundational laws, there are wide disparities in the quality of health-care access enjoyed by some as compared to that enjoyed by the rest of the population.¹⁰ As stated above, South Africa is a deeply unequal country. South Africa continues to grapple with economic inequalities which are among the most extreme in the world,¹¹ as well as with social and structural inequalities that stem primarily from the country's long history of apartheid and colonialism.¹²

During the National Party's 46-year regime, the basic health needs of Africans were neglected and considered of little importance next to those of Europeans. Coovadia et al. note that under apartheid, the government was responsible for the systematic fragmentation of social services provided to the different races.¹³ Health care for Africans in the Bantustans was, until the state assumed control in the 1960s, primarily a concern of missions and charitable organisations.¹⁴ Even so, Coovadia et al. argue, health care in the Bantustans remained underfunded.¹⁵ The same observations regarding the funding of health care in the Bantustans were made in 1988 by Naylor, who observed that black South Africans received a less-than-standard service from the

into harmony ... Nowhere is this more apparent than in the application of the social and economic rights entrenched in the Constitution. These rights are rooted in respect for human dignity, for how can there be dignity in a life lived without access to housing, health care, food, water or in the case of persons unable to support themselves, without appropriate assistance? ... As a consequence of our history, structural impediments remain to the achievement of 'dignity, equality and freedom'. Millions of people are still without houses, education and jobs, and there can be little dignity in living under such conditions. Dignity, equality and freedom will only be achieved when the socio-economic conditions are transformed to make this possible" (Chaskalson (2000) at 204–205). See also Liebenberg S "The value of dignity in interpreting socio-economic rights" (2005) 21(1) *South African Journal on Human Rights* 1 at 6–21.

¹⁰ Ataguba J "The impact of financing health services on income inequality in an unequal society: The case of South Africa" (2021) 19 *Applied Health Economics and Health Policy* 721 at 722; Mhlanga D & Garidzirai R "The influence of racial differences in the demand for healthcare in South Africa: A case of public healthcare" (2020) 17(14) *International Journal of Environmental Research and Public Health* 1 at 1–2. See also Obuaku-Igwe C "Health inequality in South Africa: A systematic review" 2015 19(2) *African Sociological Review* 96 at 124; Kon Z & Lackan N "Ethnic disparities in access to care in post-apartheid South Africa" 2008 98(12) *American Journal of Public Health* 2272 at 2272; McLaren Z, Ardington C & Leibbrandt M "Distance as a barrier to health care access in South Africa" (2013) 97 *Southern Africa Labour and Development Research Unit Working Papers* at 11.

¹¹ World Bank (2022) at 7.

¹² Van Rensburg H & Fourie A "Inequalities in South African health care" (1994) 84 *South African Medical Journal* 95 at 97. See also Gilson L & McIntyre D "Post-Apartheid challenges: Household access and use of health care in South Africa" (2007) 37(4) *International Journal of Health Services* 673 at 673–674; Obuaku-Igwe (2015) at 124.

¹³ Coovadia H et al. "The health and health system of South Africa: Historical roots of current public health challenges" 2009 *The Lancet* 817 at 820–825.

¹⁴ Coovadia et al. (2009) at 825.

¹⁵ Coovadia et al. (2009) at 825.

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

public health system.¹⁶ These inequalities in health care did not disappear with the advent of democracy, but persisted in the new democratic constitutional state.

Although the constitutional project has been ongoing for nearly three decades, millions of people still contend with poverty and various forms of economic, social and structural exclusion.¹⁷ The current state of affairs does not mean that no attempts have been made to address many of these challenges.¹⁸ However, the initiatives so far have either failed to have the desired impact,¹⁹ or have perhaps not been far-reaching enough to properly confront the existing and growing equity challenges. As a result, many South Africans today have been deprived of the full and equal enjoyment of their rights and many other benefits of constitutional democracy. Few spheres of South African society reflect these imbalances in the enjoyment of constitutionally guaranteed rights than the health-care sector. As in many other societies that embrace market-economy practices,²⁰ the provision of health-care services in South Africa is divided between the government, representing the public health sector, and private entities, including organised private hospitals, pharmacies and independent practitioners.²¹ The cost associated with private health care in South Africa is relatively high,²² and many people simply cannot afford to bear such costs.

By contrast, the government's primary health-care services are free, and subject to a means test for hospital stays and specialised services.²³ The means test is used to determine a patient's financial capability to pay for health-care services. This threshold test is based on household income, and permits public hospitals to charge patients for services rendered, provided that they earn a minimum household income exceeding

¹⁶ Naylor C "Private medicine and the privatisation of health care in South Africa" 1988 27(11) *Social Science & Medicine* 1153 at 1155–1157.

¹⁷ Gilson & McIntyre (2007) at 673–689. See also Obuaku-Igwe (2015) at 96–125.

¹⁸ Knight L & Maharaj P "Use of public and private health services in KwaZulu-Natal, South Africa" (2009) 26(1) *Development South Africa* 17 at 17. See also Omotoso K & Koch F "Assessing changes in social determinants of health inequalities in South Africa: A decomposition analysis" (2018) 17 *International Journal for Equity in Health* 1 at 2; Buisman & García-Gómez (2015) at 195.

¹⁹ Kon & Lackan (2008) at 2272.

²⁰ Though technically a mixed economy, South Africa follows the economic philosophy of free enterprise which the framers seem to acknowledge with the inclusion of the section 22 right to freedom of trade and occupation in the Constitution. See Kurlantzick J *State capitalism: How the return of statism is transforming the world* (2016) at 11–23; Herbst J "Mbeki's South Africa" (2005) 84(6) *Foreign Affairs* 93 at 97–99. See also section 22 of the Constitution.

²¹ Competition Commission *Health Market Inquiry: Final findings and recommendations report* (2019) at 44. See also Gray A "Health care and pharmacy practice in South Africa" (2016) 69(1) *The Canadian Journal of Hospital Pharmacy* 36 at 36–37; Ataguba (2021) at 722.

²² Ataguba (2021) at 730.

²³ *HMI Report* at 44; Erasmus D et al. *Challenges and opportunities for health finance in South Africa: A supply and regulatory perspective* (2016) at 12.

that set by the DOH.²⁴ The existence of a public health system should generally prove the existence of health-care service access. However, upon an exploration of the system dynamics within the sector, many problems become apparent.

The public health sector in South Africa is notorious for poor delivery of health-care services. According to Maphumulo and Bhengu, it is plagued by numerous operational challenges, including the shortage of qualified personnel, equipment and medicines.²⁵ These shortages can seriously and negatively impact on the health of the public that utilises them. For example, a low supply of qualified personnel and equipment can result in long patient waiting times at health facilities.²⁶ In the same vein, research on medicinal shortages shows that issues such as risky medication prescription, readmission and even death may eventuate as a result.²⁷ Other challenges identified in the public sector include serious pathologies and poor hygiene and infection control measures.²⁸

2.2 Current trends in health inequality: Private health

In contrast to the public health-care system, the private health industry seems to operate on a different plane. Apart from the fact that it is perceived as providing far better health-care service than its state-financed counterpart,²⁹ many of the challenges encountered in public health are almost unheard of. It is not surprising that such challenges rarely present themselves in private health, considering the advantageous position users of private health-care services often find themselves in. According to Ashmore, the private health industry attracts a disproportionately higher number of medical practitioners than the public sector.³⁰ Citing an Econex report, he suggests that

²⁴ Approval of the Health Tariffs for the 2019/20 Financial Year, Eastern Cape Province, 2019 (*PG EC* 4215 (29 March 2019)) at para 4.

²⁵ Maphumulo W & Bhengu B “Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review” (2019) 42(1) *Curationis* available at <https://curationis.org.za/index.php/curationis/article/view/1901/2487> (accessed 11 August 2022). See also Schellack N et al. “Part II. Health and economic context” (2011) 101(8) *SAMJ* 558 at 560; *HMI Report* at 44.

²⁶ Maphumulo & Bhengu (2019) at 2. See also *HMI Report* at 44; Aikman N “The crisis within the South African healthcare system: A multifactorial disorder” (2019) 12(2) *SAJBL* 52 at 53.

²⁷ Truong P, Rothe C & Bochenek T “Drug shortages and their impact on patients and health care systems – how can systemic and organizational frameworks help to prevent or mitigate them?” in Barbosa-Povoa A, Jenzer H & Luís de Miranda J (eds) *Pharmaceutical supply chains – medicines shortages* (2019) at 60. See also McLaughlin M et al. “Effects on patient care caused by drug shortages: A survey” (2013) 19(9) *Journal of Managed Care Pharmacy* 783 at 784–787; Schellack et al. (2011) at 561.

²⁸ Maphumulo & Bhengu (2019) at 2.

²⁹ McIntyre D & Van den Heever A “Social or national health insurance” in Harrison S *South African Health Review 2007* (2007) at 83–84.

³⁰ Ashmore J “‘Going private’: A qualitative comparison of medical specialists’ job satisfaction in the public and private sectors of South Africa” (2013) 11(1) *Human Resources for Health* available at <https://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-11-1> (accessed 11 August 2022). See also *HMI Report* at 44; Knight & Maharaj (2009) at 18.

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

the sector employs nearly half of all general practitioners, more than half of all medical specialists, and over a quarter of all qualified nurses.³¹ The private health sector serves a unique segment of the South African economy. Only those patients who are willing to pay out-of-pocket and those who can afford the costs associated with private health insurance and medical scheme coverage enjoy the benefits of private health care.³² One might therefore be forgiven for assuming that only those who are financially secure or employed can access these services.

When checked against patient utilisation figures, the differences in essential medical personnel distribution between the private and public health sector is disquieting. The 2019 figures released by Statistics South Africa (Stats SA) indicate that nearly 26.5 per cent of households used a private health facility in the first instance immediately upon injury or falling ill.³³ In contrast, the statistics for public health facility usage for a household in the same year stood at 72.5 per cent of all households.³⁴ In fact, in eight out of the nine provinces, at least 65 per cent of the total provincial population first used a public health facility when injured or sick.³⁵ In view of the large number of patients who use public health facilities, it is reasonable to anticipate that resources in the public health sector will be overstretched and that the challenges identified above are inevitable.

Nevertheless, the notion that quality health care should be the preserve of an economically privileged minority is, frankly, objectionable. So too, are views that such inequalities are normal and inevitable, or that this ought to remain the standard of access in South Africa. Economic inequality, in general, is unsustainable in the long term. A continued lack of improvement in the economic outcomes of people can lead those belonging to such social groups to seek solutions from entities or individuals at the extremes of conventional socio-political discourse, potentially leading to social and political volatility.³⁶ From the perspective of health care, failure to improve public health may have unintended health consequences and can negatively affect human and economic development.³⁷ Additionally, approaching an issue as critical as health care in

³¹ Ashmore (2013) at 2; Knight & Maharaj (2009) at 18.

³² Ashmore (2013) at 2; Knight & Maharaj (2009) at 18.

³³ Statistics South Africa *Statistical Release P0318: General House Survey* (2020) at 24.

³⁴ Stats SA (2020) at 24.

³⁵ Stats SA (2020) at 24.

³⁶ Cingano F "Trends in income inequality and its impact on economic growth", (2014) 163 *OECD Social, Employment and Migration Working Papers* at 19. See also Berg A & Ostry J "Inequality and unsustainable growth: two sides of the same coin?" (2011) *IMF Staff Discussion Note* at 9.

³⁷ Remes J, Wislon M & Ramdorai A "How investing in health has a significant economic payoff for developing economies" (2020) available at <https://www.brookings.edu/blog/future-development/2020/07/21/how-investing-in-health-has-a-significant-economic-payoff-for-developing-economies/> (accessed 11 August 2022).

such a manner is inconsistent with constitutional values in general and the content of section 27 of the Constitution in particular.³⁸

2.3 Current trends in health inequality: Medical schemes

Besides state and out-of-pocket patient spending, direct expenses for health care in South Africa are covered primarily by medical schemes. Medical schemes are not-for-profit entities established in terms of, and regulated under, the Medical Schemes Act (MSA).³⁹ The services rendered by medical schemes are subject to strict rules that impose principles of non-discrimination regarding membership.⁴⁰ Schemes organised under the MSA must be open to anyone who wants to join them.⁴¹ Irrespective of a person's pre-existing condition(s), medical schemes are not legally permitted to discriminate between people on the basis of existing illnesses or diseases.⁴² For example, there can be no difference in access to medical schemes and premiums paid for members on the same plan based on their pre-existing medical conditions.⁴³ The MSA further obliges medical schemes to provide the same minimum benefits to all members, irrespective of their medical aid plans.

In terms of section 29(1)(o) of the Act, medical schemes are not allowed to operate without, in their rules, providing for prescribed minimum benefits that are available to all members as may be prescribed by the Minister in regulations promulgated in terms of section 67(1)(g).⁴⁴

Although medical schemes evidently provide far better benefits than the public health sector,⁴⁵ they are largely means-exclusive and do not accommodate the majority of the population. Labuschaigne and Slabbert suggest that the cost of medical aid premiums increased markedly between 2006 and 2016 at an average rate of 2 per cent above the year-on-year salary increase.⁴⁶ The costs, they note, are exacerbated by the increase in the cost of private health care.⁴⁷

3 NATIONAL HEALTH INSURANCE: A PANACEA?

The NHI Bill, which proposes the establishment of a universal health coverage (UHC) system,⁴⁸ is an interesting proposition for resolving these concerning issues of equitable

³⁸ Chaskalson (2000) at 204–205. See also Liebenberg (2005) at 9.

³⁹ 131 of 1998. See also Labuschaigne M & Slabbert M “Unpacking the South African National Health Insurance Bill: Potential impact and legal issues” (2021) 83 *THRHR* 471 at 478.

⁴⁰ *HMI Report* at 45.

⁴¹ Labuschaigne & Slabbert (2021) at 478.

⁴² Section 24 of the MSA.

⁴³ Labuschaigne & Slabbert (2021) at 478.

⁴⁴ Section 29(1)(o) of MSA. See also Labuschaigne & Slabbert (2021) at 479.

⁴⁵ *HMI Report* at 134.

⁴⁶ Labuschaigne & Slabbert (2021) at 479.

⁴⁷ Labuschaigne & Slabbert (2021) at 479.

⁴⁸ Section 2 of the National Health Insurance Bill, 2019.

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

access to health care. According to the memorandum issued by the DOH, the system is based on two overarching principles. The first principle, “universality”, entails that everyone covered by the system will be able to access essential health-care services irrespective of their financial status.⁴⁹ The second, “social solidarity”, is that everyone will be able to “benefit from a national system of health care ... based on income cross-subsidies between the affluent and the impoverished and risk cross-subsidies between the healthy and the sick”.⁵⁰

This proposed UHC system purports to eliminate the disparities in quality and access between public and private health care. In other words, it would fund health-care services so that any beneficiary, regardless of their economic position, could receive medical treatment anywhere in the Republic. Such medical treatment would be received without incurring additional costs, irrespective of whether such services are received at private or public health facilities.⁵¹

What is certainly evident from the brief description above is that the scope of the proposed NHI is broad. A system that purports to cover every eligible person in a country the size of South Africa⁵² would certainly need to be in possession of significant financial resources to meet even its most basic targets. That its targets, be they basic or otherwise, are barely outlined in the existing NHI Bill and surrounding discourse is cause for concern. Consequently, most of the focus on the proposed NHI has been on its perceived unaffordability.⁵³ Questions have been raised about how the DOH intends to finance such an ambitious and resource-intensive project.⁵⁴

Another area of criticism concerns the elimination of certain services covered under medical schemes, which the NHI Bill currently proposes.⁵⁵ Opponents of this change have argued that it will impact deleteriously on the overall quality of health care.⁵⁶ They further contend that the gap would likely cause budgetary shortfalls, which would negatively impact the ability of the NHI to procure health-care services for the large

⁴⁹ NHI Bill Memorandum at para 5.1(a).

⁵⁰ NHI Bill Memorandum at para 5.1(b).

⁵¹ NHI Bill Memorandum at para 2.2.3.

⁵² Which was an estimated 60.14 million at mid-year in 2021 (see Statistics South Africa *Statistical release P0302: mid-year population estimates 2021* (2021) at 17).

⁵³ See “South Africa cannot afford the proposed NHI – expert” *The Citizen* 2018 available at <https://citizen.co.za/news/south-africa/1961509/south-africa-cannot-afford-the-proposed-nhi-expert/> (accessed 11 August 2022)). See also AfriForum *NHI Report* (2019) at 3.

⁵⁴ AfriForum (2019) at 3.

⁵⁵ Section 33 of the NHI Bill.

⁵⁶ See “Discovery sends medical aid warning to South Africa” *Business Tech* 2022 available at <https://businesstech.co.za/news/finance/555732/discovery-sends-medical-aid-warning-to-south-africa/> (accessed 11 August 2022).

cohort of potential beneficiaries.⁵⁷ Such deficits, so the argument goes, would have to be financed through extra taxes, which supposedly might be averted if the state does not interfere with the current system's functioning.⁵⁸ The limitation of services provided by medical schemes in terms of the proposed section 33 essentially means that they will only offer an auxiliary service to the NHI.⁵⁹ Thus, should a service be covered by the NHI, medical schemes will be precluded from similarly providing cover for the same service. According to Labuschaigne and Slabbert, the various tax credits and subsidies which the state currently provides to medical schemes "will [also] be identified and consolidated into the ... funding arrangement [for the NHI]".⁶⁰

3.1 Can redistribution of medical resources result in equitable access?

3.1.1 Existing Inequality in Access to Health-care Services

As discussed above, one of the more troubling issues in the current South African health-care services space is the outsized number of medical practitioners in the private sector relative to the public sector. Considering that nearly half of all medical practitioners service the private sector,⁶¹ the vast majority of the population has to rely on a limited number of qualified medical personnel for its health needs.⁶² The consequence of this inequitable distribution is that health-care services in the public sector suffer as patients are forced to endure delayed treatment, which could have fatal consequences.⁶³ The unfortunate reality, however, is that if the private sector attracts nearly half of this already-scarce resource, as it presently does, the likelihood of those remaining in public health efficiently servicing a larger patient population is improbable.

The NHI's health-care financing proposition is therefore critical. By providing health insurance for everyone, irrespective of their economic status, the NHI can enable millions of people to access medical care from practitioners they would otherwise never have had access to. As discussed below, there is also a potential benefit to easing the human resource burden on public health, as the large patient load characteristic of public health could ideally be spread evenly across both tiers of health care. Thus, rather than disproportionately servicing a financially well-off patient base or those who can afford medical aid cover, many available medical practitioners in South Africa could be shared amongst all South Africans, irrespective of their financial or economic status.

⁵⁷ See "Big 'NHI tax' expected for South Africa: Discovery" *Business Tech* 2022 available at <https://businesstech.co.za/news/finance/553898/big-nhi-tax-expected-for-south-africa-discovery/> (accessed 11 August 2022).

⁵⁸ Business Tech (2022) "Big 'NHI tax' expected".

⁵⁹ NHI Bill Memorandum at para 6.33. See also 2015 NHI White Paper at para 8.10.

⁶⁰ Labuschaigne & Slabbert (2021) at 480.

⁶¹ Ashmore (2013) at 2.

⁶² Ashmore (2013) at 2.

⁶³ Maphumulo & Bhengu (2019) at 2.

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

However, it is questionable if such a redistribution of resources would prove sufficient to address the inequalities in health-care access, especially regarding the provision of an overall sufficient service. Moreover, would redistribution not just lead solely to the level and quality of existing access to health-care services for some being compromised? By enabling millions more patients to access services from the means-exclusive private health-care sector,⁶⁴ the NHI would indirectly impact the privileges currently enjoyed by those with money, medical aid coverage, or private health insurance.⁶⁵ The oft-uncontrolled and stratospheric costs associated with the current private health-care sphere⁶⁶ have the effect that these services are provided to an exclusive clique of economically advantaged minorities. Stats SA figures indicate that, by 2019, South Africa had approximately 10 million people with medical aid coverage.⁶⁷ In other words, only about 17 per cent of a population of about 60 million people could access private health services through funding provided by medical schemes.⁶⁸ Together with those patients who could manage out-of-pocket payments and the privately insured, these individuals contribute to the approximately 4.7 million (or approximately 26.5–28 per cent) households likely to utilise a private health-care facility or service at the onset of illness or injury.⁶⁹

Given that almost half (if not more) of all medical practitioners in South Africa operate in the private health-care industry, the distribution of essential human capital disproportionately favours the seemingly financially well-off.⁷⁰ Without question, this uneven distribution means a lower likelihood for users of private health services to encounter many of the challenges presented in public health.⁷¹ This does not mean that the private health sector is near-perfect or without its challenges. However, the daily occurrences of long patient waiting times due to limited medical personnel, shortages of hospital beds and medicines, as well as serious pathology amongst the patient population occurring in public health settings,⁷² are not characteristic of health-care service delivery in the private sector.

A report compiled by the fact-checking website Africa Check, relying on Stats SA and Health Systems Trust (HST) data, claims that patient loads of private sector medical

⁶⁴ *HMI Report* at 45; Knight & Maharaj (2009) at 19.

⁶⁵ *HMI Report* at 45.

⁶⁶ *HMI Report* at 101.

⁶⁷ Stats SA (2020) at 24.

⁶⁸ Stats SA (2020) at 24. See also *HMI Report* at 44 and Ashmore (2013) at 2.

⁶⁹ Stats SA (2020) at 24. See also *HMI Report* at 45.

⁷⁰ *HMI Report* at 45.

⁷¹ It makes sense that minimal intra-patient competition for services of a physician would have positive benefits for patients in any given situation. With fewer patients being serviced by a physician, for example, the competition for services is similarly reduced and a physician may have more time available for every patient.

⁷² Maphumulo & Bhengu (2019) at 2. See also *HMI Report* at 44.

practitioners may be between one physician for every 429 patients or 571 patients.⁷³ In contrast, the public health-care space is characterised by a significantly higher patient load, estimated at 2,457 patients per physician.⁷⁴ The Africa Check data is not too dissimilar to data published by the HST, which estimates the per capita ratio of 32 medical practitioners per 100,000 population in 2019 and 33.6 per 100,000 population in 2020.⁷⁵ The HST data suggests that one public physician is likely to have had a patient load of 3,125 patients in 2019 and approximately 2,976 patients in 2020, both of which are far higher than the Africa Check statistics.⁷⁶

This may be compared with figures published by the World Bank, which show that South Africa had a ratio of 0.792 physicians per 1,000 patients in 2019.⁷⁷ In other words, had physicians been evenly distributed across the general patient population, one physician would statistically have a patient load of approximately 1,263 patients at any point during the year of evaluation.⁷⁸ In theory, this would mean that the workload for private medical practitioners, whose current patient load is estimated at half the above-mentioned figure, would be more than double. However, a much more positive effect would be felt across the broader health-care spectrum, as public physicians' workload would hypothetically decrease by more than half. One should account for the possibility, nevertheless, that an increase in the patient load for private practitioners could occasion unwelcome changes as far as current users are concerned.⁷⁹ Private practitioners have to deal only with a fifth of the patients that a public physician is expected to, perhaps directly affecting patient waiting times and the quality of health-care delivery.

⁷³ Pretorius L "Does SA's private healthcare sector only serve 16% of the population?" *Africa Check* 2017 available at <https://africacheck.org/fact-checks/reports/does-sas-private-healthcare-sector-only-serve-16-population> (accessed 11 August 2022). See also "Africa Check puts together the numbers on doctor-patient ratios" *Juta Medical Brief* 2018 available at <https://www.medicalbrief.co.za/africa-check-puts-together-numbers-doctor-patient-ratios/> (accessed 11 August 2022).

⁷⁴ *Juta Medical Brief* (2018).

⁷⁵ Day C et al. "Health and related indicators" in Kathard H et al. (eds) *South African Health Review 2020* (2020) at 262; Day C et al. "Health and related indicators 2019: Interrogating the UHC service coverage index" in Moeti T & Padarath A (eds) *South African Health Review 2019* (2019) at 254 and 292.

⁷⁶ The dataset relied upon in the HST reviews is sourced from the government Personal and Salary System (PERSAL) system. See Day et al. (2020) at 254 & 292; Day et al. (2019) at 262.

⁷⁷ In contrast, however, the *HMI Report* suggests that there were approximately 0.3 medical practitioners per 1,000 patient population overall, but 1.75 medical practitioners per patient population in the private sector. It is accepted that the World Bank data is probably accurate. See "Physicians (per 1,000 people) – South Africa" *The World Bank* 2019 available at <https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=ZA> (accessed 11 August 2022). See also *HMI Report* at 135–136; Day et al. (2020) at 254 & 292; Day et al. (2019) at 262.

⁷⁸ Calculated by dividing the total per unit population (per capita 1,000 in this case) with the statistical number of available physicians (0.792).

⁷⁹ See the discussion under subheading 3.2.

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

It should be noted furthermore that many of the patients who use public health services in South Africa are often at the economic margins of society.⁸⁰ Glymour, Avendano and Kawachi indicate that income inequality has a direct impact on the health of people.⁸¹ Citing Link and Phelan, they note that people with higher household incomes consistently exhibit better health outcomes than those at lower levels of income or those living in poverty due to, inter alia, knowledge, “money and prestige”.⁸² This is because people living in poverty or with limited income are restricted in their ability to access things such as foods necessary for good physical health, and may not be able to afford a safe and healthy living environment.⁸³ Consequently, such people have higher levels of morbidity, and are often unable to access health-care services of a sufficient quality.⁸⁴ The unfortunate consequence is that poorer people have a higher mortality than the more affluent population.⁸⁵ In South Africa, where an overburdened public health-care system is the only available choice – the alternative being to go without medical treatment – the poor are forced to play a game that has been rigged from the beginning.

3.1.2 Increasing access: Potential consequences

To enable the poor to access services provided by private practitioners would allow them to access health-care services more widely. Moreover, it is rational and, perhaps, even practical for a system to utilise all available resources where underusage, as indicated below, may not work. As discussed above, the higher the pathology within the patient population, the greater the burden on the health-care system.⁸⁶ The issue will persist if the income disparities that plague the vast majority of South Africans remain unaddressed. It is difficult to estimate the precise impact this would have on the seemingly unburdened private health-care sector. Nonetheless, it is plausible to assume that this could increase the incidence of serious pathology, placing a greater strain on private health-care delivery than is currently the case. Ultimately, it seems likely that by opening an exclusive sector for health-care delivery to a broader, disadvantaged

⁸⁰ HMI Report at 44.

⁸¹ Glymour M, Avendano M & Kawachi “Socioeconomic status and health” in Berkman L, Kawachi I & Glymour M (eds) *Social Epidemiology* (2014) at 17.

⁸² Glymour et al. (2014) at 18. See also Link B & Phelan J “Social conditions as fundamental causes of disease” (1995) *Journal of Health and Social Behavior* 80 at 87.

⁸³ Williams D et al. “Race, socioeconomic status, and health: Complexities, ongoing challenges, and research opportunities” (2010) 1186(1) *Annals of the New York Academy of Sciences* 69 at 77–79; Singh G & Siahpush M “Widening socioeconomic inequalities in US life expectancy, 1980–2000” (2006) 35(4) *International Journal of Epidemiology* 969 at 977.

⁸⁴ See Dhai A & Mahomed S “Healthcare in crisis: A shameful disrespect of our Constitution” (2018) 11(1) SAJBL 8 at 8. See also Naicker N, Mathee A & Teare J “Food insecurity in households in informal settlements in urban South Africa” (2015) 105(4) *SAMJ* 268 at 270; Williams et al. (2010) 79.

⁸⁵ Dhai & Mahomed (2018) at 8; Naicker et al. (2015) at 270; Link & Phelan (1995) at 83–88; Glymour et al. (2014) at 18–19.

⁸⁶ Ashmore (2013) at 8.

audience, challenges will arise that may negatively impact the quality and level of existing access that the current patient population does not face.

Despite the much-touted progress in health-care coverage that the NHI aims to achieve, there is a real possibility that this system will have negative effects on existing health-access quality, particularly for current users of private health insurance and medical schemes. As stated previously, the sheer disparity in the number of patients served by the public and private health-care systems frequently contributes to the substantial differences in quality and efficiency of health-care delivery between the two systems. On the one hand, the public health sector is estimated to serve approximately 75 per cent of the population.⁸⁷ On the other hand, private health-care providers serve a little more than a quarter of the same population.⁸⁸ Allowing more people access to private health facilities and practitioners may cause an increase in the time it takes for current users of private health care to access the same services. Even though studies indicate that improvements in health-care access can positively impact on the health and well-being of the general population, as well as economic growth,⁸⁹ these effects may not be immediately noticeable. The immediate repercussions of opening closed systems up to more users are likely to be negative for existing users. Opening up private health would essentially heighten competition among patients for the time of each available practitioner.

Additionally, if media speculation about the potential flight of private medical practitioners abroad as a result of the NHI domestically is to be believed,⁹⁰ and if it does materialise, the patient population burden could even be greater than anticipated. Indeed, the NHI's own preferred approach for bringing the private sector into the fold may prove inherently problematic. The proposed approach is essentially to use selective contracting, where providers are selected from an existing pool and incorporated into a network of health-care providers chosen by the NHI.⁹¹ Although this approach is used efficiently in similar systems across the world, and may even be useful in negotiating lower costs for health-care services with preferred carriers or providers,⁹² it is likely not to prove beneficial for potential NHI beneficiaries. This approach restricts the ability of a health financing system to widely utilise the services of available health providers, since not every available practitioner will be contracted if selective contracting is employed. As shown by the statistics on available medical

⁸⁷ Stats SA (2020) at 24; *HMI Report* at 44 & Ashmore (2013) at 2.

⁸⁸ Stats SA (2020) at 24; *HMI Report* at 44 & Ashmore (2013) at 2.

⁸⁹ Remes et al. (2020).

⁹⁰ See "More doctors expected to leave South Africa because of the NHI" *Business Tech* 2022 available at <https://businesstech.co.za/news/government/554006/more-doctors-expected-to-leave-south-africa-because-of-the-nhi/> (accessed 11 August 2022).

⁹¹ Labuschaigne & Slabbert (2021) at 474–475.

⁹² Van den Broek-Altenburg E & Atherly A "The relation between selective contracting and healthcare expenditures in private health insurance plans in the United States" (2020) 124 *Health Policy* 174 at 174–175.

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

practitioners,⁹³ South Africa does not have a broad pool of physicians at its disposal. Even if one were to disregard the media speculation above, South Africa does not have enough physicians to meet the World Health Organization-endorsed “golden finishing line” ratio of one physician for every 1,000 patients.⁹⁴

South Africa can ill afford to underutilise such a scarce resource. Be that as it may, the legal effect of the NHI’s proposed changes on existing access and quality of health-care services must still be considered. As discussed above, the establishment of the NHI entails a potential limitation of services covered by medical schemes.⁹⁵ Such a limitation will likely compel patients to rely solely on the services contracted by the NHI. If this is the case, this could mean that current beneficiaries of medical schemes will also be forced to utilise the services of this select cohort of providers. A scenario where not every available health provider is used under an NHI system may, to some degree, replicate the above-mentioned challenges present within the current public health-care system. Ultimately, what is evident is that if the proposed NHI is implemented in its current format, it will likely have a deleterious impact on the existing access enjoyed by current users of private health-care and medical schemes. There is an argument to be made that the increase in the number of users who would have access to services provided by private practitioners could impair the quality of existing access, even if the role of medical schemes is left unaffected by the NHI.

4 DETRIMENTAL EFFECTS ON EXISTING ACCESS RIGHTS

The immediate challenge the proposed NHI may need to contend with – in a scenario where it harms existing access to, and enjoyment of, the socio-economic right to have access to health care – is whether such detriment can be justified. Although no right in the Bill of Rights is absolute and may be limited with reference to section 36 of the Constitution, the state may not interfere willy-nilly with constitutionally protected human rights. In other words, the state may not interfere with people’s existing access to rights without reasonable cause. The entrenched foundations in the Constitution that require the state to not impede human rights are therefore fundamental and guaranteed.

4.1 The duty to respect the section 27(1) right to have access to health-care services

Section 27(1)(a) of the Constitution guarantees every person the right to have access to health-care services, including reproductive health care.⁹⁶ The Constitution further seizes the state with a positive duty to “take reasonable legislative and other measures

⁹³ Day et al. (2020) at 254 & 292; Day et al. (2019) at 262.

⁹⁴ Kuman R & Pal R “India achieves WHO recommended doctor population ratio: A call for paradigm shift in public health discourse!” (2018) 7(5) *Journal of Family Medicine and Primary Care* 841 at 841.

⁹⁵ Section 33 of the NHI Bill.

⁹⁶ Section 27(1) of the Constitution.

... to achieve the progressive realisation of each of these rights”.⁹⁷ Although section 27(1)(a) does not expressly state this, the Constitutional Court has held that, just as the state is required to refrain from interference with civil and political rights, the specific manner in which socio-economic rights are couched in the Constitution similarly includes an implied negative obligation on both state and non-state actors to respect such rights.⁹⁸ In *Grootboom and Others*, Yacoob J explained this implied negative obligation in the context of section 26(1), saying that:

[s]ubsection (1) aims at delineating the scope of the right ... Although the subsection does not expressly say so, there is, at the very least, a negative obligation placed upon the State and all other entities and persons to desist from preventing or impairing the right of access to adequate housing.⁹⁹

The court again restated this position in the context of the right to have access to health-care services in *Minister of Health and Others v Treatment Action Campaign*,¹⁰⁰ noting that the “negative obligation [applied] equally to the section 27(1) right of access to ‘health care services’ ...”. According to De Vos, the implied negative obligation imposed on the state in section 27(1)(a) amounts to the state’s duty to respect socio-economic rights.¹⁰¹ He notes that the duty to respect is among the most primary of obligations that a state has in respect of human rights.¹⁰² In this respect, De Vos argues that the obligation is the “easiest to grasp”, as it acts essentially as a “shield against [unjustified government] interference [with socio-economic rights]”.¹⁰³ Broadly speaking, the duty encompasses a state’s obligation to desist from administrative or legislative action interfering with people’s existing enjoyment of guaranteed rights.¹⁰⁴ Koch further suggests that, though the duty to respect is primarily negative, it contains something of a positive aspect which requires the state to maintain existing access.¹⁰⁵

The international law formulation of the duty to respect, as per the Committee on Economic, Social and Cultural Rights (CESCR), is worded in similar terms to proscribe direct and indirect state conduct that interferes with the enjoyment of socio-economic rights.¹⁰⁶ The duty safeguards people’s exercise or “enjoyment” of their rights against

⁹⁷ Section 27(2) of the Constitution.

⁹⁸ *In Re: Certification of The Constitution of the Republic of South Africa, 1996* 1996 (10) BCLR 1253 (CC) at 78C.

⁹⁹ *Grootboom* (1996) at para 34I.

¹⁰⁰ *Minister of Health and Others v Treatment Action Campaign and Others (1)* 2002 (10) BCLR 1033 (CC) at 46G-H.

¹⁰¹ De Vos P “Pious wishes or directly enforceable human rights? Social and economic rights in South Africa’s 1996 Constitution” (1997) 13(1) *South African Journal on Human Rights* 67 at 80.

¹⁰² De Vos (1997) at 80.

¹⁰³ De Vos (1997) at 80.

¹⁰⁴ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) at para 33.

¹⁰⁵ Koch I E “Dichotomies, trichotomies or waves of duties?” (2005) 5(1) *Human Rights Law Review* 81 at 89.

¹⁰⁶ General Comment No. 14 at para 33.

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

conduct by both state and non-state actors. In respect of the right to health, the CESCR notes that a violation of the duty to respect would occur where state conduct, laws or policies infringe on the standard set out in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).¹⁰⁷ Such infringement may include direct action, such as physically barring access to health facilities for certain groups of people or where the state “[suspends] ... legislation or ... [adopts] ... laws or policies that interfere with the enjoyment of any of the components of the right to health”.¹⁰⁸ Dafel notes that the duty to respect does not require state investment of resources in order to be fulfilled.¹⁰⁹ Rather, it merely requires that the state “do nothing or ... do no harm”.¹¹⁰

What may be inferred from the discussion above is that the duty to respect is tailored to protect the access that people already have to socio-economic resources. Thus, the extent to which individuals enjoy access to such resources will determine the state’s responsibility in realising socio-economic rights.¹¹¹ In this regard, Bilchitz writes that:

[t]he negative obligations flowing from socio-economic rights essentially protect people in their possession of the resources that they already have, requiring that no one harms their ability to use them to realize their socio-economic interests. An important inference from this line of reasoning is that once an individual has sufficient resources to realize their interests in housing, food, water, and healthcare, the only duty on the government and others is not to interfere with them in the possession of these resources and their utilization in the realization of their important capabilities.¹¹²

Bilchitz’s observation above accords with the view expressed by Koch that the duty is not only preventive but also protective. First, the state is prohibited from engaging in action that would violate people’s socio-economic rights. However, where people already have some form of access to a socio-economic right, the state must not interfere with people’s access to the resource enabling such access without a reasonable justification. The duty to respect under the Constitution may be understood in similar terms, particularly with regard to South Africa’s ratification of the ICESCR.¹¹³ Even

¹⁰⁷ Article 12 of International Covenant on Economic, Social and Cultural Rights (ICESCR) provides for the right to highest attainable standard of health, and enjoins state parties to take steps “to achieve the full realization of [the] right”.

¹⁰⁸ General Comment No. 14 at para 50.

¹⁰⁹ Dafel M “The negative obligation of the housing right: An analysis of the duties to respect and protect” (2013) 29(3) *South African Journal on Human Rights* 591 at 597.

¹¹⁰ Dafel (2013) at 597.

¹¹¹ Bilchitz D “Socio-economic rights, economic crisis, and legal doctrine” (2014) 12(3) *International Journal of Constitutional Law* 710 at 715.

¹¹² Bilchitz (2014) 715.

¹¹³ South Africa ratified the ICESCR on 12 January 2015. See OHCHR Ratification Status for CESCR – International Covenant on Economic, Social and Cultural Rights available at https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/treaty.aspx?treaty=cescr&lang=en (accessed 28 September 2022). Liebenberg also notes that the courts recently appear to directly apply some socio-economic rights protection principles developed by the CESCR. See Liebenberg S “Austerity

barring ratification thereof, the test for determining a violation of the protective aspect of the duty to respect under the Constitution is consistent with the international law formulation of the duty above,¹¹⁴ despite the differences in the rights concerned.¹¹⁵

Similarly, Brand posits that the content of the duty to respect under the Constitution entails a limitation on the state's ability to deprive people of their existing access to rights without justification.¹¹⁶ Accordingly, where such deprivation is necessary or perhaps unavoidable, the state is required to take steps to mitigate the extent of the interference.¹¹⁷ Importantly, he suggests that the state is precluded from imposing undue hardship on people as regards the attainment of constitutionally guaranteed rights.¹¹⁸ In *Jaftha v Schoeman*, the Constitutional Court held that "at the very least, any measure which permits a person to be deprived of existing access to adequate housing [amounts to a limitation of the right] ... protected in section 26(1)".¹¹⁹ Essentially, wherever state action causes a deprivation of the enjoyment of a right, such deprivation will be deemed to be a violation of the right and, by extension, the Constitution. Existing access or enjoyment implies that the rights-holder must have had some sort of access to (or enjoyment of) the right. After all, it would make little sense to dispossess someone of the enjoyment of something they did not already have. Notwithstanding such deprivation, however, the court in *Jaftha v Schoeman* accepted that state interference with a right might be justified in terms of the general limitation clause.¹²⁰

4.2 The NHI as an infringement of section 27(1)

in the midst of a pandemic: Pursuing accountability through the socio-economic rights doctrine of non-retrogression" (2021) 37(2) *South Africa Journal on Human Rights* 181 at 191–193.

¹¹⁴ Dafel has termed this test the "existing access test". See Dafel (2014) at 600.

¹¹⁵ The relevant right under the ICESCR is a "right to health", whereas the Constitution provides for a right to "have access to health care services including reproductive health care". The Constitutional Court in *Grootboom* explained that the right under the Constitution is much broader than under the ICESCR, noting the following: "The right delineated in section 26(1) is a right of 'access to adequate housing' as distinct from the right to adequate housing encapsulated in the Covenant. This difference is significant. It recognises that housing entails more than bricks and mortar. It requires available land, appropriate services such as the provision of water and the removal of sewage and the financing of all of these, including the building of the house itself. For a person to have access to adequate housing all of these conditions need to be met: there must be land, there must be services, there must be a dwelling ... A right of access to adequate housing also suggests that it is not only the State who is responsible for the provision of houses ... The State must create the conditions for access to adequate housing for people at all economic levels of our society. State policy dealing with housing must therefore take account of different economic levels in our society." See *Grootboom* (1996) at para 35.

¹¹⁶ Brand D "Socio-economic rights" in De Vos P & Freedman W (eds) *South African constitutional law in context* (2014) at 671.

¹¹⁷ Brand D (2014) at 671.

¹¹⁸ Brand D (2014) at 671.

¹¹⁹ *Jaftha v Schoeman and Others; Van Rooyen v Stoltz and Others* 2005 (1) BCLR 78 (CC) at 34D-E.

¹²⁰ *Jaftha* at 34D-I.

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

The preceding discussion under 3.1 explored the myriad possibilities that could arise from the implementation of the NHI as currently conceived. Insofar as existing access to health-care services is concerned, the effect of implementing the proposed system would depend on which side of the current health-care spectrum a patient belongs. The effect could be positive for patients who rely on the government-financed public health system for their health-care services. In contrast, it is posited above that those relying primarily on private health care, including members of medical schemes, are likely to experience a negative outcome consequent on the implementation of the NHI. In this context, the proposed NHI scheme presents an interesting case as state conduct interfering with existing access to the right to health-care services. On the one hand, the NHI is unmistakably a deliberate measure the state intends to take to promote improved access to and quality of health-care services for every beneficiary, irrespective of their socio-economic status or means.¹²¹ On the other hand, it represents state conduct that equally and deliberately meddles with existing access to health-care services currently enjoyed by those economically better positioned than the rest of the population.¹²²

On the face of it, the proposed NHI appears to both breach and equally fulfil the respective obligations of the state under section 27(1) and (2)¹²³ and as regards the state's duty to "respect ... and fulfil rights" contained in section 7(2).¹²⁴ Although the current public health-care system has many challenges negatively affecting the delivery and quality of health-care service, it should be noted that everyone, at least in theory, already has some basic access to health-care services.¹²⁵ The NHI is therefore not a measure intended to facilitate access where there is none,¹²⁶ but rather one that seeks to enhance the quality of existing access to health-care services, particularly for those who may not be able to afford the best available health services that patients currently using medical schemes enjoy.¹²⁷ However, this should not necessarily raise a constitutional issue. Nothing in the qualifying section 27(2) suggests that a measure

¹²¹ The DOH explains that "there is a need for reform of both health care financing and service delivery so that all South Africans can have equal access to affordable, quality personal health care services regardless of the socio-economic status within the context of the burden of disease of South Africa". See NHI Bill Memorandum, 2019 at 2.1.1.

¹²² As discussed under sub-heading 3.2, there is a strong possibility that the proposed legislation may, if enacted, indirectly increase, inter alia, the disease burden and patient load (and attendant wait times) in large parts of the private health sector and to levels that are much higher than the present.

¹²³ These are the implied duty to respect and the duty to fulfil the socio-economic right to have access to health-care services. See section 27(1) & (2) of the Constitution.

¹²⁴ Section 7(2) of the Constitution.

¹²⁵ *HMI Report* at 44; Erasmus et al. (2016) at 12.

¹²⁶ As noted at sub-heading 2.1 above, South Africans already have access to free access to health-care services provided by public health facilities and delivered through various medical personnel, including nurses, on the state's payroll.

¹²⁷ This may be distilled from the various media briefings and memoranda issued by the DOH in which the need for improving everyone's access to health care that is of sufficient quality is emphasised.

aimed at progressive realisation of the right to have access to health-care services cannot be one that improves upon the progress already made towards the full attainment of the right, even if such a measure were to infringe indirectly on existing access for others.

Concerning current users of private health care, implementing the proposed NHI would ostensibly impair their existing access to health-care services. It remains to be seen whether such potential impairment by the state is justifiable. Should the fact that the NHI intends to promote improved access for the majority at the risk of infringing on the existing access of a minority even matter? The current discussion demands that one understands what the NHI *intends to do* as opposed to its potential effects, however they may unfold. The NHI is intended to be a public health insurance system that will insure the entire population against the costs of health care.¹²⁸ It proposes to provide universal access to primary health-care services by, inter alia, contracting health-care providers, including those currently operating in the private health-care sector, at no added cost to the patient.¹²⁹

Such contracting is likely to lead to increased demand for health-care practitioners who in the past would have been inaccessible to the majority of the NHI's potential beneficiaries. Accordingly, people with existing access to this best available care would have to effectively share the same resources with a greater pool of users. Despite the likelihood of a sudden and significant increase in the number of eligible patients within the sector impacting negatively on existing access, this barely amounts to a breach of the negative obligation implied under section 27(1) and expressed in the state's duty to respect under section 7(2).¹³⁰ Even under circumstances where the level of access currently enjoyed is extensively intruded upon by such state conduct, it cannot be true that this intrusion is a violation of the state's duty to respect existing socio-economic rights. If anything, it is under these circumstances that an NHI scheme would be constitutionally sound and justifiable.¹³¹

As alluded to in the introduction to this contribution, the NHI Bill proposes to do more than just enable access to health-care services. At section 33, it proposes to limit the scope of health-care services currently covered by medical schemes. The initial draft of the NHI Bill gazetted in June 2018 did not contain a specific provision addressing the

¹²⁸ Section 2 of the NHI Bill. See also NHI Bill Memorandum at para 5.2.

¹²⁹ Section 2 of the NHI Bill. See also NHI Bill Memorandum at para 5.2.

¹³⁰ Sections 7(2) & 27(1) of the Constitution.

¹³¹ One ought to guard against what Paul Wayburne calls the "equality of the graveyard". Such equality is manifest in circumstances where the state, faced with a choice between who gets to keep a certain limited benefit and who gets none, chooses to provide an equal but yet inadequate service to everyone. In such circumstances, Wayburne argues, it would be inappropriate for the state to level down one group's existing access to a right in order to create parity with another, if the resulting service for both groups would be inadequate. He states that "in this way, the state perpetuates an 'equality with a vengeance' that puts everyone in the same bad situation". See Wayburne P *Developing a constitutional law paradigm for a National Health Insurance scheme in South Africa* (PhD thesis, University of the Witwatersrand, 2014).

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

role of medical schemes under the NHI.¹³² However, numerous previous white papers have explored to some extent the question concerning the “future role of medical schemes”. For example, in the 2011 green paper on the NHI, and the 2017 White Paper, the DOH suggested that the role of medical schemes would probably “evolve to include ... [gap] cover”.¹³³ In contrast, the 2015 incarnation of the White Paper implies that medical schemes, in all likelihood, will only be allowed to offer complementary or auxiliary cover once the NHI has been “fully implemented”.¹³⁴ The document explores in detail the different types of cover that medical schemes and private insurers may potentially offer under a health-care financing system such as the NHI. The types of coverage identified were substitutive, complementary and supplementary.¹³⁵

Substitutive cover, as the name suggests, entails coverage for the same benefits that a statutory health insurance (SHI) scheme such as the NHI would ordinarily offer.¹³⁶ It is substitutive in the sense that those who purchase such insurance either opt not to be covered under the SHI scheme, or are excluded from coverage thereby.¹³⁷ The possibility of a substitutive framework for medical schemes has been emphatically rejected by the DOH, which asserts that all persons will be precluded from acquiring any alternative cover for any benefit covered by the NHI.¹³⁸

The supplementary model is one that considers the preference of consumers and accordingly focuses on diversifying consumer choice.¹³⁹ In a supplementary model, medical schemes may offer the same services but with a supposed added advantage of speedier access to care (whether in private or public facilities) and other amenities.¹⁴⁰ The 2015 white paper intimates that “medical schemes will play a supplementary role” during the transition process. That role will then change to providing “complementary cover to fill gaps in the universal entitlements offered by the State” once the NHI scheme is fully implemented.¹⁴¹

Whether the complementary cover to be offered by medical schemes means that they will only offer non-essential cover is not clear. Neither have the deliberations of the NHI

¹³² National Health Insurance Bill, 2018 (GG 41725 (21 June 2018)).

¹³³ 2011 NHI Policy at para 138. See also National Health Insurance Policy, 2017 (GG 40955 (30 June 2017)) at para 308.

¹³⁴ 2015 NHI White Paper at para 401.

¹³⁵ 2015 NHI White Paper at para 399.

¹³⁶ Goodwin N “National health systems: Overview” in Heggenhougen H (ed) *International Encyclopedia of Public Health* (2008) at 503.

¹³⁷ See Goodwin (2008) at 503.

¹³⁸ 2015 NHI White Paper at paras 396–397. See also 2011 NHI Policy at para 138; 2015 NHI White Paper at para 308.

¹³⁹ Stabile M & Townsend M “Supplementary private health insurance in national health insurance systems” in Culyer A (ed) *Encyclopedia of Health Economics* (2014) at 362.

¹⁴⁰ Stabile & Townsend (2014) at 362.

¹⁴¹ 2015 NHI White Paper at para 399.

Bill in Parliament helped in this respect. The lack of clarity has also been challenged in deliberations on section 33 by members of the Portfolio Committee on Health. In a 24 August 2022 Portfolio Committee afternoon session, the member from the Freedom Front Plus expressed concern about the vagueness of the clause and noted that it was “still not clear what the role and functions of medical aids and for private hospitals will be, and this raises many red flags”.¹⁴² His views were echoed by members from the Democratic Alliance and the Inkatha Freedom Party. The comments by the member from the African National Congress (ANC) did little to clarify the confusion. In his response, he noted that “the upper-middle class may still choose to purchase cover by medical schemes for benefits that the health system deems to be of unproven value or which the country cannot afford to pay for from taxes”.¹⁴³ Expressing the ANC’s stance on section 33, the member said:

Clause 33 provides that these services which will be excluded from the payment from the Fund may be provided through individuals through [sic] voluntary complementary cover. They will change over time as technology [inaudible] costs. Clearly it will take time for the NHI Fund to establish the equilibrium and settle on the benefits that it will pay for. As benefits are fully paid for the fund [sic] and providers are accredited to deliver the benefits to all, it will be inappropriate to have a duplicate funding stream. And therefore only the NHI Fund will pay for those inclusive benefits while the medical schemes will pay for excluded services.¹⁴⁴

It is telling that the ANC too cannot appreciate the NHI’s potential scope-of-benefits coverage, despite sponsoring and supporting the NHI Bill. To say that the NHI Fund needs to first experiment before it can settle on the types of benefits it will be able to cover speaks to both a social and legal ignorance about the gravity of section 33, which

¹⁴² All quotes are transcribed by the author from a recording of the session entitled “Portfolio Committee on Health (Afternoon Session), 24th August 2022” available at the Parliamentary Monitoring Group website and on the Parliament of the Republic of South Africa YouTube channel. See “National Health Insurance (NHI) Bill: Clause 23 to 33 deliberations, with Deputy Minister” available at <https://pmg.org.za/committee-meeting/35371/> (accessed on 24 May 2023).

¹⁴³ NHI Bill Clause 23 to 33 Deliberations.

¹⁴⁴ The full comment from the member from the ANC, Hon. Xaba, reads as follows: “Clause 33 is essential to achieving equity in access to the entire financial and non-financial resources to the national health system [sic], especially human resources for health. The introduction of the NHI Fund will strategically utilise its capabilities to purchase health care services on behalf of the population through utilising mechanisms to draw all health sector resources – public and private – by promoting equity, accessibility, affordability, and sustainability principles ... These provisions must be central tenets to the health sector reforms because the Constitution regards everyone equally before the law and enjoins the state to undertake rational and reasonable steps towards progressively ensuring that everyone – not only those with control of resources – have access to the needed health care services. Clause 33 provides that these services which will be excluded from the payment from the Fund may be provided through individuals through voluntary complementary cover. They will change over time as technology [inaudible] costs. Clearly it will take time for the NHI Fund to establish the equilibrium and settle on the benefits that it will pay for. As benefits are fully paid for the fund [sic] and providers are accredited to deliver the benefits to all, it will be inappropriate to have a duplicate funding stream. And therefore, only the NHI Fund will pay for those inclusive benefits while the medical schemes will pay for excluded services” (NHI Bill Clause 23 to 33 Deliberations).

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

should ordinarily be cause for concern. However, it is clear that the ANC prefers section 33 to remain as it is. To this end, medical schemes would only be permitted to provide coverage in those areas not covered by the SHI scheme. Although the Minister of Health has indicated that not all aspects of the proposed NHI scheme would be implemented immediately upon enactment, the prospect of having such a limitation at all is problematic.

As Ssenyonjo suggests, the duty to respect includes much more than refraining from conduct directly or indirectly impairing existing access.¹⁴⁵ Ssenyonjo's understanding of the nature of the state's duty to respect socio-economic rights finds further support in the writings of Fried and Bilchitz above. To reiterate, Bilchitz contends that, where persons possess socio-economic resources and are accordingly capable of fulfilling their socio-economic rights on their own, the negative duties created by socio-economic rights preclude the government from interfering with their ability to both possess and utilise those resources.¹⁴⁶ Similarly, in his classic distinction between positive and negative rights, Charles Fried explains that negative rights create a duty which ensures "something not be done to one, [or] that some particular imposition ... [is] withheld" as a consequence of the right.¹⁴⁷

Significantly, in *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v Nigeria*,¹⁴⁸ the African Commission interpreted the right to shelter under the African Charter on Human and Peoples' Rights (Banjul Charter)¹⁴⁹ as entailing an obligation on the state "at the very minimum ... not to destroy

¹⁴⁵ Ssenyonjo M *Economic, social and cultural rights In international law* (2009) at 23.

¹⁴⁶ Bilchitz's interpretation of the duty to respect is consistent with the interpretation put forward by the Constitutional Court in *Grootboom and Jaftha*. In *Grootboom*, the court observed that the state's negative obligation to respect socio-economic rights meant that it is "not only the State who is responsible for the provision of houses, but that other agents within our society, including individuals themselves ..." need to be allowed to also provide housing. The state also has a responsibility to "take account of different economic levels in our society". Importantly, the court affirmed that the need to take into account the different economic levels of people entailed a recognition of the "difference between the position of those who can afford to pay for housing, even if it is only basic though adequate housing, and those who cannot. For those who can afford to pay for adequate housing, the State's primary obligation lies in unlocking the system, providing access to housing stock and a legislative framework to facilitate self-built houses through planning laws and access to finance." Similarly in *Jaftha*, the court noted that the impugned section 66(1)(a) of the Magistrates' Court Act 32 of 1944 took "indigent people who ... [had] already" enjoyed access to adequate housing and, "worse than placing them at the back of the queue to benefit again from such subsidies in the future, put them in a position where they might never again acquire such assistance, without which they may be rendered homeless and never able to restore the conditions for human dignity." For that reason, the court found the provision to be "a severe limitation of ... [the] important right [to have access to adequate housing]". See Bilchitz D (2014) 715. See also *Grootboom* at paras 35C-D & 36E-F and *Jaftha* at 34E and 39F-H).

¹⁴⁷ Fried C *Right and wrong* (1978) at 110.

¹⁴⁸ Communication No. 155/96, 13-27 October 2001.

¹⁴⁹ South Africa is a signatory and has ratified it; it is therefore bound to the Charter.

the housing of its citizens and not to obstruct efforts by individuals or communities to rebuild lost homes”.¹⁵⁰ The Commission also expounded on the content of the duty to respect, noting that:

[w]ith respect to socio-economic rights, this means that the State is obliged to respect the free use of resources owned or at the disposal of the individual alone or in any form of association with others ... for the purpose of rights-related needs. And with regard to a collective group, the resources belonging to it should be respected, as it has to use the same resources to satisfy its needs.¹⁵¹

The Commission further held that the duty to respect required of the state to refrain from engaging in conduct or enacting measures in violation of individuals’ integrity or “*infringing upon ... [their] freedom to use those material or other resources available to them in a way they find most appropriate to satisfy individual, family, household or community housing needs*”.¹⁵² The Commission was at pains to stress that it would have reached the same conclusion even if the rights in question were those relating to the highest attainable standard of physical and mental health (article 15), to property (article 14) or protection of the family (article 18), each of which is contained in the Banjul Charter.¹⁵³ Accordingly, it is clear that the duty to respect entails the obligation on the state to respect a person’s choice and the ability to go about acquiring the object of a socio-economic right.¹⁵⁴

In this context, the NHI Bill endeavours not merely to facilitate access but to raise barriers to the means by which individuals can realise such access without direct assistance from the state. The NHI Bill’s limitation of medical schemes’ ability to provide coverage for covered benefits appears to be devoid of any specific, socio-economic or legally motivated reason. Save for criticism levelled against the spiraling costs of medical aid, costs which are often passed down to beneficiaries,¹⁵⁵ there has yet to be an official explanation for the drafters’ decision to limit the services to be covered by medical schemes. In fact, the Minister of Health, when asked by a Member of Parliament whether automated systems would be put in place to pay medical schemes, simply reiterated the position in the Bill, stating that:

[n]o funds [would] be allocated to medical schemes. The [NHI] Bill provides that medical schemes will be allowed to cover only those benefits that are not covered by the NHI Fund. The NHI Fund will be the “single” purchaser of all benefits that are covered by the NHI.¹⁵⁶

While the author agrees that a cessation of subsidies for medical schemes may be required for successful implementation of an NHI scheme, the same cannot be said of

¹⁵⁰ *SERAC & CESCR v Nigeria* at para 61.

¹⁵¹ *SERAC & CESCR v Nigeria* at para 45. Emphasis added.

¹⁵² *SERAC & CESCR v Nigeria* at para 61. Emphasis added.

¹⁵³ *SERAC & CESCR v Nigeria* at para 62.

¹⁵⁴ Ssenyonjo (2009) at 23.

¹⁵⁵ Labuschaigne & Slabbert (2021) at 479.

¹⁵⁶ See “Question NW1841 to the Minister of Health” available at <https://pmg.org.za/committee-question/16829/> (accessed 28 September 2022).

EVALUATING THE POTENTIAL IMPACT OF NATIONAL HEALTH INSURANCE

restrictions on the services covered by them. It remains an unexplained oddity. The framing of the Bill, together with the executive's characterisation of its purpose,¹⁵⁷ indicates that such a limitation serves no apparent legal or economic purpose. If anything, it merely compels, without any reason, current users of medical schemes to depend entirely on the NHI, as long as the same service is covered by it. It is evident that coverage for health-care service benefits by medical schemes is unlikely to prove detrimental to the proposed NHI scheme. The existence of medical schemes even as providers of services also covered by the NHI is simply tantamount to "uncompetitive" competition. It would not render the provision of such coverage through the scheme any more or less difficult than it would have been in their absence. This is especially true given the fact that the NHI Bill itself proposes the establishment of a Health Care Benefits Pricing Committee responsible for determining the pricing of health-care service benefits to be purchased by the proposed Fund.¹⁵⁸ Simply put, the NHI Fund can in fact be put in a position to benefit from reasonable pricing when purchasing health-care service benefits – which medical schemes may not necessarily enjoy.

The legitimacy of inserting the above-mentioned provision is questionable at best. Once enacted, the provision is likely to fail constitutional muster if impugned. According to the Constitutional Court in *Grootboom*, the obligation to realise the envisioned access to some socio-economic rights in the Bill of Rights does not fall entirely within the exclusive province of the state.¹⁵⁹ The state equally has an implied obligation to provide a legislative landscape that empowers other agents, including private individuals and organisations, to realise this right on their own.¹⁶⁰

Importantly, this obligation coexists with the duty of the state to refrain from restricting individuals' ability to realise socio-economic rights, as discussed above. Writing in the context of socio-economic rights under international law, Ssenyonjo argues that the duty incorporates an obligation to "respect rights-holders, their freedoms, autonomy, resources and liberty of action".¹⁶¹ Stated differently, the state is required not only to refrain from impairing the enjoyment of socio-economic rights, but also to respect the choices and usage of resources by rights-holders. Accordingly, conduct by the state that negatively affects people's choice as to how they go about realisation of their socio-economic right to have access to health-care services appears to be inconsonant with the state's section 27(1) obligation, and certainly falls foul of the duty to respect.

¹⁵⁷ The DOH has explained the limitation, noting that persons should not insure against the same health-care cost twice. It is, however, questionable if the department considered the reality that the NHI will not utilise all available resources as claimed, but only selected groups of providers, leaving non-contracted providers unable to provide service as long as the same are provided by the NHI or where the patient is willing to pay out-of-pocket. (2015 NHI White Paper at para 8.10).

¹⁵⁸ Section 15(3)(c) of the NHI Bill.

¹⁵⁹ *Grootboom* (1996) at para 35C–D.

¹⁶⁰ *Grootboom* (1996) at para 35C–D.

¹⁶¹ Ssenyonjo (2009) at 23.

5 CONCLUSION

The NHI Bill represents a remarkable shift in government policy in relation to health-care delivery and quality in South Africa. At its heart, the Bill and proposed scheme aim to both improve access to and enhance the quality of health-care services for everyone in the Republic, irrespective of economic means. Yet despite its laudable aims, the NHI Bill poses a threat to the existing access enjoyed by some members of our society – especially members of medical schemes. This contribution sought to investigate whether introducing an NHI scheme could lead to violations of the constitutional access rights of private health-care users, particularly medical scheme members. It was noted that the NHI Bill aims to facilitate access to previously exclusive medical personnel and facilities. Furthermore, it was argued that, although this object may result in the erosion of private health users' existing access, the negative impact arising from it would not breach the state's constitutional duty to respect socio-economic rights. In this regard, it was argued that the NHI is justified, as the state's fulfilment of access rights for the majority far outweighs those interests of a noticeable minority.

However, this article noted that the NHI Bill's proposed limitation of services provided by medical schemes is suspect. It contended that the realisation of access rights was not the sole preserve of the state. The state has a duty to respect socio-economic rights, and this duty entails the state's non-interference with people's existing access and their choice and usage of resources to achieve such access. Moreover, this contribution noted that there appears to be no justifiable purpose at present for the proposed limitation. Thus, by limiting the scope of services provided by medical schemes, the state will breach its duty to respect socio-economic rights and, consequently, the rights of medical scheme members to access health-care services.

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