DRAFT 1

HASA NHI WHITE PAPER SUBMISSION

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EXECUTIVE SUMMARY

The purpose of this submission is to address the legal issues that arise in respect of the contents of the White Paper on National Health Insurance ("NHI") published under Government Notice No. 123 in *Government Gazette* 39506 dated 11 December 2015 ("the White Paper"). The White Paper contains both procedural and substantive deficiencies.

In so far as the procedural deficiencies are concerned, the White Paper lacks the necessary detail to enable interested parties meaningfully to comment on the White Paper. Notwithstanding the aforegoing, HASA has endeavoured to comment, as far as possible, on the salient aspects of the proposed NHI. However, as the White Paper has not been accompanied by proposed legislation, all aspects of the White Paper will have to be revisited if and when such legislation is conceptualised.

From a substantive perspective, various aspects of the White Paper, *prima facie*, infringe upon or unduly limit fundamental rights contemplated in the Constitution of the Republic of South Africa, 1996 ("Constitution"). In this regard, NHI is premised on universal healthcare coverage, which means that every South African will be required to join and pay for NHI, whether they wish to or not. Choices are further limited as a result of the reduced role for private healthcare funding contemplated in the White Paper. The mandatory nature of NHI, *prima facie*, offends against the right to freedom of association in section 18 of the Constitution as well as the rights to self-determination and security of a person in section 12 of the Constitution.

The White Paper also gives rise to concerns relating to a potential infringement of the right to healthcare (section 27 of the Constitution) as the White Paper envisages that the full range of current treatments available to South Africans will not readily be available under NHI. Even if all the services currently available to South Africans are provided for in terms of NHI, the right to healthcare may still unduly be limited as a result, *inter alia*, of the diminished role of medical schemes; the impact of NHI on service providers and hospitals and the redistribution of private resources.

The proposed NHI will also have far-reaching consequences for medical schemes as the White Paper provides that, in future, all medical schemes will only offer "complementary cover". The effective removal of the ability of medical schemes to provide and charge for benefits, *prima facie*, constitutes an unlawful infringement of a medical scheme's right to property in section 25 of the Constitution.

A further potential legal difficulty is that the White Paper appears to envisage the centralisation of healthcare regulation in favour of national authority – which centralisation is inconsistent with schedule 4 to the Constitution relating to concurrent national and provincial competencies.

The White Paper also seeks to establish and introduce payment mechanisms for each category of healthcare service provider. However, systems already exist and have been enacted by Parliament in section 90(1)(u) and (v) of the National Health Act No. 61 of 2003 ("the National Health Act") to allow for the regulation of pricing of healthcare. Accordingly, the pricing of healthcare should be regulated within the current legislative framework and in a fair and transparent manner. Similarly, the manner in which the NHI fund intends to purchase primary healthcare services must also properly be regulated.

Finally, in determining and promulgating legislation in respect of the proposed NHI scheme, the Minister of Health ("Minister") is required to pursue an appropriate, rational, reasonable and justifiable system of healthcare – which does not entail simply adopting a system or policy because it has found favour elsewhere. A particular problem must be identified and an appropriate solution formulated. Currently, however, a lack of rationality appears in the White Paper as between the problem identified in the White Paper and the measures that are being proposed to address the problem. In the circumstances, it is submitted that the NHI scheme, in its current formulation, is not legally sustainable.

1 PREFACE

1.1 HASA is a non-statutory, professional association that represents the vast majority of private hospitals in South Africa. In this regard, HASA is registered as an association incorporated under section 21 of the Companies Act No. 61 of 1973, read with the Companies Act No. 71 of 2008.

1.2 The purposes and objects of HASA are, broadly, first, to assist the private hospital industry in expanding access to healthcare and, secondly, preserving the quality of healthcare services in South Africa. HASA seeks to achieve these purposes and objects by engaging with regulatory bodies and stakeholders in the formulation of regulations and legislation governing the provision of healthcare services generally, and by private hospitals particularly. In light of the stated purpose of HASA, HASA welcomes the opportunity to engage with the Department on the White Paper. HASA also looks forward to engaging with the Department during all subsequent stages of the NHI process in an effort to ensure that NHI, if ultimately implemented, is effective and sustainable.

2 INTRODUCTION

2.1 The White Paper envisages the adoption, in a phased approach over the course of the next fourteen years, of NHI, which is defined in the White Paper as "a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status".[1]

2.2 In this regard, the underlying policy that appears to inform the White Paper, being the need to improve access to healthcare services for all South Africans, is obviously and unequivocally supported by HASA and its members.

2.3 The White Paper, as it is currently stands, however, gives rise to various fundamental legal issues, which detrimentally affect the rights of the members of HASA and third parties, including the general public. Accordingly, HASA

[1] Paragraph 1 of the White Paper.

cannot support the proposed NHI scheme as it is currently formulated in the White Paper. In this regard, many of the aforementioned issues were raised by HASA in its comments on the Green Paper on the NHI scheme, which Green Paper was published by the Minister on 12 August 2011 as Government Notice 657 ("the Green Paper"). The majority of HASA's comments, however, appear simply not to have been taken into account by the Department when publishing the White Paper notwithstanding the recordal by the Minister of Health ("the Minister") in paragraph 26 of the White Paper that -

> "The process of developing this White Paper was preceded by the publication of the Green Paper on NHI in August 2011. Over 150 written submissions were received from interested individuals and organisations and were carefully reviewed and considered as part of the drafting of this White Paper …".

2.4 The legal issues identified by HASA in this submission pertain both to the manner in which the White Paper has been published as well as the substantive features of the NHI scheme as contemplated in the White Paper. The aforementioned issues illustrate why the NHI scheme, as contemplated in the White Paper, is legally untenable, with reference both to the rights of HASA's members and the rights of third parties (including South African citizens and medical schemes). HASA has included commentary on the infringements of the White Paper on the rights of third parties on the basis that HASA cannot support the implementation of a policy which is legally unsustainable for any reason or in any manner.

2.5 The legal issues that will be addressed in this submission include –

2.5.1 the lack of particularity and the prevalence of unsubstantiated statements in the White Paper and the impact of the aforementioned deficiencies on the ability of interested parties to comment on the White Paper;

2.5.2 the status of the White Paper as policy and the need for legislation;

2.5.3 the constitutionality of the policy proposed in the White Paper which, *inter alia*, contemplates –

2.5.3.1 "universal health coverage for all South Africans"[2] in which individuals will "not be allowed to opt out of making … mandatory prepayment towards NHI";[3]

2.5.3.2 the provision of specific healthcare services in terms of the NHI scheme;

2.5.3.3 the relegation of medical schemes to a position in which they are prohibited from offering extensive services to the general public; and

2.5.3.4 the centralisation of healthcare regulation and delivery;

2.5.4 the problems associated with the payment mechanisms for service providers which have been introduced in the White Paper;

2.5.5 issues surrounding the purchasing of healthcare services by the State and the determination of criteria to be used by the State in order to identify the providers from whom services shall be purchased; and

2.5.6 issues of reasonableness, rationality and legality in relation to the NHI.

2.6 The legal issues highlighted above in paragraph 2.4 are dealt with below in detail. HASA's submissions have, however, been necessarily constrained by the deficiencies in the process of promulgation of the White Paper, as discussed below in paragraph 3.

3 **COMMENTARY ON THE WHITE PAPER**

3.1 Government Notice 1230, under cover of which the White Paper was published, records that interested persons are invited to submit any substantial comments or representations on the proposed policy in the White Paper within a period of three months from the date of publication of the White Paper, being on or before 10 March 2016. Having regard, *inter alia*, to the

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[2] Paragraph 107 of the White Paper.

[3] Paragraph 396 of the White Paper.

significance of the proposals contained in the White Paper, which require extensive analysis, research and expert-qualified commentary, HASA was - following the publication of the White Paper - concerned about the adequacy of the three-month commentary period.[4] HASA notes, however, that on 11 February 2016, the Minister sought to extend the commentary period to 31 May 2016.[5]

3.2 The importance of including processes of consultation and calling for meaningful public participation and comment on policy and proposed legislation has repeatedly been emphasised by our courts, in particular, by the Constitutional Court, as being a fundamental aspect of a participative constitutional democracy.[6] In this regard, in relation to the manner in which meaningful public participation may be achieved, the Constitutional Court has held that the basic elements of meaningful public involvement include –

> "The dissemination of information concerning legislation under consideration, invitation to participate in the process and consultation on the legislation. These three elements are crucial to the exercise of the right to participate in the law-making process. Without the knowledge of the fact that there is a bill under consideration, what its objective is and when submissions may be made, interested persons who wish to contribute to the law-making process may not be able to participate and make such contributions".[7]

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[4] HASA raised its concerns in a letter despatched to the Minister on **[CLIENT TO ADVISE]** regarding the adequacy of the commentary period. The concerns raised by HASA included (1) the White Paper was published immediately prior to the commencement of the festive season, during which period the vast majority of businesses were not operational; (2) the White Paper contains a significant amount of content which requires extensive analysis, research and expertly-qualified commentary which required sufficient time; (3) the recent revision of timeframes for the Health Market Inquiry restricted the ability of HASA and its members to adequately participate in both the HMI and NHI processes; and (4) various documents and research referred to in the White Paper could not be accessed by HASA or its members and therefore the documents were requested from the Minister. Accordingly, in terms of the letter, HASA requested an extension to the period for public commentary from the Minister. We note that HASA has not received a substantive reply from the Minister to this letter and, accordingly, HASA continues to await the requested documents and information.

[5] See Extension of comment Period for the White Paper on National Health Insurance published as Government Notice No. 165 in *Government Gazette* 39675 dated 11 February 2016 and the Correction Notice published on 23 February 2016 as Government Notice No. 2 in *Government Gazette* 39721.

[6] See in this regard *Doctors for Life International v Speaker of the National Assembly* 2006 (6) SA 416 (CC) ("*Doctors for Life International* judgement"); *Merafong Demarcation Forum v President of the RSA* 2008 (5) SA 171 (CC); *Matatiele Municipality v The President of the RSA* 2006 (5) SA 47 (CC) and *Matatiele Municipality v The President of the RSA (2)* 2007 (6) SA 477 (CC).

[7] See paragraph 221 of the *Doctors for Life International* judgement, quoted above.

3.3 Thus, in order for public participation in respect of a policy to be meaningful, sufficient detail regarding the policy as well as the processes that are envisaged for the implementation of the policy are required. HASA is, however, of the view that the White Paper fails adequately to provide such detail. In this regard, as with the Green Paper, the White Paper contains various statements that are simply unsubstantiated and are, therefore, unanswerable. By way of example, the following statements are made in the White Paper without any substantiating evidence –

3.3.1 "… households will … benefit from increased disposable income as a result of a significantly lower mandatory prepayment [to the NHI scheme]";[8]

3.3.2 "[i]n the current system of medical schemes, only those belonging to medical schemes are able to access health services in both the private and the public sectors. Even they are usually denied access to health care before the year ends because they are supposed to have run out of benefits";[9]

3.3.3 "… medical scheme members are not well protected from the escalating costs of health care. Benefits covered by medical schemes are usually not comprehensive resulting in medical scheme members having to make substantial out-of-pocket payments…";[10]

3.3.4 "… the private health sector is characterised by … [e]xorbitant costs due largely to a fee-for-service model";[11]

3.3.5 "[h]igh costs in the private health sector also contribute to high costs of labour in the public sector as the public sector attempts to match the high salaries in the private sector";[12]

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[8] At paragraph 5 of the White Paper.

[9] At paragraph 6 of the White Paper.

[10] At paragraph 66 of the White Paper.

[11] At paragraph 67 of the White Paper.

[12] At paragraph 68 of the White Paper.

3.3.6 "[i]n an attempt to remain viable, medical schemes have responded by increasing member contributions at levels that are higher than CPI over the past decade, whilst the health service benefits have been reducing significantly. The schemes['] contributions for members have been increasing with an annual average increase that is almost double the CPI for 2015 (9.2 % when CPI is approximately 4.6%)";[13]

3.3.7 "[t]he current health system is characterised by an emphasis on curative services that leaves prevention by the wayside. Furthermore, the entry level into accessing health services is mostly at an inappropriate level of care (secondary, tertiary and specialist services) rather than at a primary health care level. This has significantly contributed to the high costs of health care and the inefficiency of the health system";[14]

3.3.8 "[t]he main contributor to inequity in health care is the existence of a two-tier healthcare system …";[15]

3.3.9 "….international evidence indicates that co-payments, by placing a burden on patients at the point of services, disproportionately deters use for the most vulnerable…";[16]

3.3.10 "South Africa spends 8.5% of GDP on health and 4.1% of the GDP is spent on 84% of the population, the majority utilizing the public health sector whilst 4.4 % of its GDP is spent on only 16% of the population in 2015/16. …. The expenditure on medical schemes in South Africa is more than any [Organisation for Economic Co-operation and Development ("OECD")] country and represents more than 6 times the 2013 OECD average of 6.3%"[17]. The absence of evidence in this regard, is particularly concerning in light of the difficulties that arise in accessing and comparing expenditures in different countries. In this regard, K V Thai, E T Wimberley and S M McManus in *Handbook of International Health Care*

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[13] At paragraph 69 of the White Paper.

[14] At paragraph 67 of the White Paper.

[15] At paragraph 77 of the White Paper.

[16] At paragraph 86 of the White Paper.

[17] At paragraph 92 of the White Paper.

Systems ("*Handbook of International Health Care Systems*"),[18] note that "…before comparisons can be made on the basis of expenditures, it is important to examine not only the sources of these expenditures, but also what is being purchased, and how the providers are being reimbursed. The variations among these factors are influential in the overall expenditure level";[19]

3.3.11 "[p]reliminary estimates indicate that the contribution by government to medical schemes (open and restricted) in 2015 is well-in-excess of R20 billion annually and these funds are mostly spent within the private health sector";[20]

3.3.12 "[m]iddle income countries that have implemented NHI have benefited economically from a healthier population. International evidence demonstrates that a properly implemented NHI in countries such as Turkey, Brazil, Costa Rica, Thailand and South Korea, has resulted in significant and sustainable economic and social benefits"[21]; and

3.3.13 "[t]he FFS model has been found not to [be] cost-effective and [to] incentivise for overprovision".[22]

3.4 Similarly, the White Paper lacks much of the detail required fully to comprehend the nature and extent of the proposed NHI scheme. In particular, and notwithstanding the effluxion of more than 4 years since the publication of the Green Paper and the request by HASA for such information, the White Paper proffers no meaningful information on, *inter alia* –

3.4.1 the cost of the NHI scheme, the manner in which the NHI scheme will be funded or by whom the NHI scheme will be funded;[23]

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[18] 1st ed (2002).

[19] At page 540 of *Handbook of International Health Care Systems*, quoted above.

[20] At paragraph 94 of the White Paper.

[21] At paragraph 110 of the White Paper.

[22] At paragraph 345 of the White Paper.

[23] Chapter 7 of the NHI deals with the "financing of NHI". However, no particular payment system is identified as constituting the payment system that will support the proposed NHI. Various options are examined including direct taxation, an increase in Value Added Tax, a payroll deduction by employers and the imposition of premiums (page 51 of the White Paper, Table 3: Potential revenue sources for NHI).

3.4.2 the healthcare services that will or will not be provided in terms of the NHI scheme; or

3.4.3 how the NHI fund will operate on a national and provincial level.

3.5 HASA has also been unable to locate various documents referred to in the White Paper. In this regard, examples of the aforementioned documents include -

3.5.1 the OECD and World Health Organisation ("WHO") International Comparison of South African Private Hospital Prices, 2015, referred to in footnote 11 of paragraph 70 of the White Paper; and

3.5.2 the Report and Recommendations Based on Submissions and Proceedings of the Public Hearings Conducted in 2007 – Public Inquiry: Access to Health Services, 2009, referred to in footnote 17 of paragraph 88 of the White Paper.[24]

3.6 In light of what is set out above, HASA contends that the public participation process contemplated in the White Paper has been hindered in so far as interested parties are unable to comment fully on the merits of the proposed system of NHI, as it is set out in the White Paper, under circumstances where all of the relevant information and documents applicable to the NHI system have not been disclosed by the Department. Notwithstanding the aforegoing, HASA has endeavoured to identify the salient aspects of the proposed NHI policy in the White Paper, and has, as far as is possible, sought to comment on those salient aspects in this submission. HASA, however, reserves its rights to augment this submission if and when the outstanding documentation and information become available.

[24] The documents referred to in paragraph 3.5 have been requested from the Minister by HASA and its members on numerous occasions. The documents have, however, not been forthcoming from the Minister.

4 STATUS OF THE WHITE PAPER

4.1 Government Notice 1230 records that the Minister intends, in terms of section 85 of the Constitution and section 3 of the National Health Act after consultation with the National Health Council, "to determine the policy in the Schedule". The White Paper is, in turn, attached to Government Notice 1230 as the schedule to Government Notice 1230. Accordingly, in terms of Government Notice 1230, the White Paper is the proposed policy to be implemented by the Minister.[25] In this regard -

4.1.1 section 85 of the Constitution[26] pertains to the executive authority of South Africa and vests that authority in the President who exercises the authority together with the Cabinet Ministers. Section 85, in turn, provides a number of means by which the executive authority is to be exercised, including through the developing and implementation of national policy;[27] and

4.1.2 section 3 of the National Health Act[28] assigns responsibility for overall healthcare within South Africa to the Minister, whose responsibilities

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[25] Currie and De Waal in *New Constitutional & Administrative Law* Vol 1 (2001), at page 170, confirm that the process of implementing policy commences with the publication of a Green Paper as "a draft policy" after which "the policy is published for public information in a document called a *White Paper* … [which] sets out government's policy on a particular subject".

[26] The wording of section 85, in full, is as follows -

"(1) The executive authority of the Republic is vested in the President.

(2) The President exercises the executive authority, together with the other members of the Cabinet, by-

(a) implementing national legislation except where the Constitution or an Act of Parliament provides otherwise;

(b) developing and implementing national policy;

(c) co-ordinating the functions of state departments and administrations;

(d) preparing and initiating legislation; and

(e) performing any other executive function provided for in the Constitution or in national legislation".

[27] Section 85(2)(b) of the Constitution.

[28] The full wording of section 3 of the National Health Act is as follows -

"(1) The Minister must, within the limits of available resources-

(a) endeavour 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;

include, in terms of section 3(1)(c), the determination of policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population.

4.2 The Supreme Court of Appeal has ruled as follows in relation to the status of policies in our law -

> "… laws, regulations and rules are legislative instruments, whereas policy determinations are not. As a matter of sound government, in order to bind the public, policy should normally be reflected in such instruments. Policy determinations cannot override, amend or be in conflict with laws (including subordinate legislation). Otherwise the separation between Legislature and Executive will disappear…".[29]

4.3 Thus, in order for a policy to bind members of the public, effect must be given to the policy in legislation or other legislative instruments. The policy contained in the White Paper has, however, not been accompanied by proposed legislation (despite various statements in the White Paper confirming the need for legislation)[30], except in relation to an amendment to the National Health Act to introduce the Office of Health Standards Compliance.

4.4 Additionally, the White Paper does not accord with the current provisions of the National Health Act or any other legislation currently in force.[31] This is so in relation to all aspects of the proposed policy as set out in the White Paper, including the three principle legs on which NHI will stand, being -

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(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

(e) 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".

[29] *Akani Garden Route (Pty) Ltd v Pinnacle Point Casino (Pty) Ltd* 2001 (4) SA 501 (SCA) ("*Akani Garden Route* case") at paragraph 7.

[30] See paragraphs 323, 324, 403, 410 and 434 of the White Paper.

[31] See HASA's submissions on Green Paper for reasons. This is supported by the statement in paragraph 2 of the White Paper that provides that "NHI represents a substantial policy shift that will necessitate a massive reorganisation of the current health care system, both public and private".

4.4.1 the establishment of the fund as a government-owned entity that is "publicly financed and publicly administered".[32] In this regard, no legislation presently exists that permits of the creation of such a fund or the channelling of payments into or out of such a fund;

4.4.2 the benefits that will be made available under the NHI scheme and the circumstances under which those benefits may be obtained. In this regard, the conferral of rights on members of the public to receive and be reimbursed for the cost of obtaining healthcare services may only be achieved through legislative enactment or subordinate legislation. The conferral of these rights must necessarily be commensurate with the reciprocal obligations imposed on healthcare service providers; and

4.4.3 the White Paper states that "[i]n order to ensure effective cost-containment and the future sustainability of NHI, it is critical that the existing provider payment mechanisms function with [*sic*] the budget and associated accountability processes are changed".[33] The changes envisaged in this regard would require the implementation of national legislation in order to give effect to the newly proposed provider payment mechanisms.

4.5 Accordingly, HASA submits that the White Paper cannot, as it currently stands, have any external legal effect or bind the public, including healthcare service providers. Moreover, any acceptance — either by HASA or members of the public generally — of the White Paper or the principles that underpin the White Paper cannot be binding in respect of future debates concerning legislation to be introduced. All aspects of the White Paper will have to be revisited by stakeholders if and when such legislation is conceptualised. Notwithstanding the aforegoing, HASA provides, in this submission, its comments on certain principled issues that arise in the White Paper on the basis that its comments will inform the contents of any proposed legislation which is required to be promulgated to give effect to the NHI scheme.

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[32] See paragraph 51 of White Paper.

[33] Paragraph 344 of the White Paper.

5 COMPULSORY MEMBERSHIP OF THE NHI FUND

5.1 The White Paper proposes the established of a national fund, to which all South Africans will contribute financially and from which all South Africans will be entitled to benefit in the form of the payment by that fund of the cost of healthcare services.

5.2 Importantly, in terms of the White Paper, membership of the NHI fund (and therefore the acquisition of health insurance) will be compulsory for all South African citizens and permanent residents who are legally in South Africa. In this regard, the White Paper does not permit a member of the public to opt out of NHI, but instead obliges members of the public to obtain healthcare insurance and to contribute to the NHI fund irrespective of whether they wish to or not. In fact, the statement is unequivocally made in the White Paper that the purpose of NHI is to provide "universal health coverage for all South Africans"[34] and that –

> "NHI will be mobilised through mandatory prepayment. Individuals will not be allowed to opt out of making the mandatory prepayment towards NHI, though they may choose not to utilise the benefits covered by the NHI Fund".[35]

5.3 The White Paper, therefore, requires that all South African citizens obtain and pay for health insurance. The White Paper, however, purports to permit members of the public to not utilise the benefits offered in terms of the NHI scheme. In this regard, in relation to the apparent ability of members of the public to choose not to utilise the benefits covered by NHI (and therefore the ability to obtain the services elsewhere ("alternative services")), the White Paper envisages that citizens may join a medical scheme in order to obtain financial cover for certain alternative services, alternatively, that citizens may choose personally to pay for the alternative services directly to the service provider.

5.4 The White Paper, however, specifically provides that -

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[34] Paragraph 107 of the White Paper.

[35] Paragraph 396 of the White Paper.

"In line with international experience, individuals and households will have the opportunity to purchase voluntary private medical scheme membership to complement this universal entitlement if they choose to. Private health insurance coverage, such as that offered by medical schemes can play various roles [being substitutive, complementary or supplementary] … within South Africa's universal coverage health system. As part of the transition process medial schemes will play a supplementary role. Once NHI is fully implemented, medical schemes will offer complementary cover to fill gaps in the universal entitlements".[36]

5.5 The types of cover referred to in the White Paper are, in turn, described in table 9 at page 81 of the White Paper as follows –

5.5.1 substitutive cover - "[p]rovides coverage that would otherwise be available from state. It is purchased by those who choose to opt out of statutory health insurance or are excluded from participating in some or all aspects of the national health insurance system (such as foreign visitors, professionals involved in extreme sports. etc)";

5.5.2 supplementary cover - "[u]sually covers the same range of services as statutory health insurance, aims to increase the choices of provider (e.g private providers or private facilities in public institutions) and level of inpatient amenities (e.g. a single room). By increasing the choices of provider it may also provide faster access to health care…"; and

5.5.3 complementary cover - "[p]rovides coverage for services excluded or not fully covered by statutory health insurance."

5.6 Thus, notwithstanding the claim made in paragraph 396 of the White Paper that citizens will be entitled to choose not to utilise the services offered in terms of the NHI scheme (despite the mandatory nature of the membership of NHI), the White Paper ultimately restricts, alternatively, precludes citizens from choosing to do so as –

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[36] Paragraph 399 of the White Paper.

5.6.1 the White Paper does not contemplate the provision of substitutive cover by medical schemes for South African citizens;

5.6.2 in relation to the provision of supplementary cover by medical schemes during the "transition process", whilst the White Paper permits members of the public to purchase supplementary cover from medical schemes, the White Paper specifically provides that South African citizens cannot opt out of contributing to the NHI, even if they retain their medical scheme membership. Accordingly, a person that cannot afford to be both a member of a medical scheme and the NHI scheme will still be required to contribute to NHI and will, thus, be precluded from purchasing medical scheme cover. The choice to obtain cover through a medical scheme for alternative services will, accordingly, be limited to the wealthy; and

5.6.3 the White Paper provides that medical schemes will ultimately be permitted only to offer top-up insurance in the form of "complementary cover". Medical schemes will, therefore, not be entitled to offer the services contemplated in terms of the NHI scheme and, thus, citizens will be compelled either to utilise the services offered in terms of the NHI scheme or personally to pay for the alternative services (directly to the service provider) – which, for most South Africans, is economically untenable.

5.7 The White Paper, thus, not only compels citizens to obtain NHI and fund the NHI scheme, but also - through the limitations imposed on the medical scheme industry - effectively compels citizens to utilise the services offered in terms of the NHI scheme. In this regard, based on the mandatory nature of membership of the NHI scheme, and for the reasons set out below, HASA is of the view that the White Paper *prima facie* offends against certain of the rights contained in the Bill of Rights in the Constitution.

5.8 **Freedom of association**

5.8.1 HASA contends that the NHI scheme proposed in the White Paper *prima facie* offends against, at least, the right to freedom of association as contemplated in section 18 of the Bill of Rights in the Constitution.

5.8.2 Section 18 of the Bill of Rights provides that everyone has the right to freedom of association. Iain Currie and Johan De Waal in *The Bill of Rights Handbook* ("Currie and De Waal")[37] note four fundamental justifications for the right to freedom of association -

> "Firstly, associations make good the promise of a variety of other, correlative rights. Secondly, associational freedom recognises the many involuntary social formations that are constitutive of identity as well as the setting for all meaningful action. Thirdly, associational freedom enables us to protect figurative – and real – forms of property from capture by entities inimical to our preferred ways of being in the world. Fourthly, *associational freedom prevents the state and other powerful social actors from determining the most basic contours of our lives through coercion.*" (our emphasis)

5.8.3 The right to freedom of association is, thus, linked to freedom from coercion by the State in respect of personal decisions. Accordingly, a right *not* to associate or, as it has been described by our courts, the right to be different falls within the ambit of the right to freedom of association as contemplated in the Bill of Rights.[38] In this regard, Professor Thomas I Emerson in his article "Freedom of Association and Freedom of Expression"[39] contends that –

> "Association is an extension of individual freedom. It is a method of making more effective, of giving greater depth and scope to, the individual's needs, aspirations and liberties. Hence, as a general principle, the right of individuals to associate *or to refrain from association* ought to be protected to the same extent, and for the same reasons, as individual liberty is protected …**.** The extent of the power of government to compel association should be limited to

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[37] 6th ed (2013) at page 397.

[38] See *Minister of Home Affairs v Fourie (Doctors for Life Intl, Amici Curiae); Lesbian & Gay Equality Project v Minister of Home Affairs* 2006 (1) SA 524 (CC) at [61]. See also *Christian Education SA v Minister of Education* 2000 (4) SA 757 (CC); *Taylor v Kurtstag NO* 2005 (1) SA 362 (W).

[39] (1964) The Yale Law Journal Vol. 74 No. 1.

accomplishing such control of the individual as the government could impose directly."[40] (our emphasis)

5.8.4 The central purpose of section 18 of the Bill of Rights, which is to enable individuals freely to associate with others, would be limited if people are forced to associate with causes in which they do not believe – which, as HASA contends includes the NHI scheme. In this regard, in the case of the *Law Society of Transvaal v Tloubatla*,[41] the court held that "there is no reason … to restrict the meaning of … the freedom of association merely to the positive. The Constitution was intended to grant freedoms, not restrict them. I hold therefore that section 18 of the Constitution also protects the right to refrain from association".[42]

5.8.5 Jurisprudence from other jurisdictions is to a similar effect. This is important in that our courts will look to foreign jurisprudence in considering inquiries into the constitutionality or otherwise of legislation.[43] Due to the importance of the right to freedom of association to the concept of NHI as a whole, we quote extensively from certain of these findings.

5.8.6 Firstly, in the case of *Chassagnou v France*[44] the European Court of Human Rights held that the forced association of hunters and non-hunters, contemplated by French law, violated the right to associate. In this regard, the court held that the right to associate included the right not to belong to an association and that the State could not compel a person to join an association fundamentally at odds with that person's convictions.

5.8.7 Similarly, in the case of *Supreme Court of Ontario*[45] White J found that the guarantee of freedom of association included the right not to associate. White J reviewed the case law in Canada and in the United

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[40] Page 4 of Professor Thomas I Emerson's article, quoted above.

[41] 1999 (11) BCLR 1275 (T).

[42] Page 1281 of the *Tloubatla* judgement, quoted above.

[43] See *State v. Makwanyane* 1995 (6) BCLR 694 at paragraph 39.

[44] (2000) 29 EHRR 61.

[45] (1986), 55 O.R. (2d) 449.

States and concluded that "[i]f a governmental agent acts so as to force an individual to financially support a union when he opposes the union, its objects, and its methods, then his freedom of association has been abridged".[46]

5.8.8 In the Canadian case of *Lavigne v Ontario Public Service Employees Union*[47] the court held that -

> "It is axiomatic that there is a community interest in sustaining democracy, an essential element of which is associational activity. The question, then, is whether the protection of this community interest and the antecedent individual interest requires that freedom from compelled association be recognized under s. 2(*d*) of the *Charter* **.**... In my view, the answer is clearly yes. Forced association will stifle the individual's potential for self-fulfilment and realization as surely as voluntary association will develop it. Moreover, society cannot expect meaningful contribution from groups or organizations that are not truly representative of their memberships' convictions and free choice. Instead, it can expect that such groups and organizations will, overall, have a negative effect on the development of the larger community".[48]

5.8.9 The court in the *Lavigne* case also held that "a conception of freedom of association that did not include freedom from forced association would not truly be 'freedom' within the meaning of the *Charter*. This brings into focus the critical point that freedom from forced association and freedom to associate should not be viewed in opposition, one 'negative' and the other 'positive'. These are not distinct rights, but two sides of a bilateral freedom which has as its unifying purpose the advancement of individual aspirations".[49]

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[46] At page 508 of the *Supreme Court of Ontario* judgment, quoted above.

[47] [1991] 2 S.C.R. 211.

[48] At page 128 of the *Lavigne* judgment, quoted above.

[49] At page 129 of the *Lavigne* judgment, quoted above.

5.8.10 In *R v Big M Drug Mart Ltd*[50], Dickson J held that -

> "Freedom can primarily be characterized by the absence of coercion or constraint. If a person is compelled by the state or the will of another to a course of action or inaction which he would not otherwise have chosen, he is not acting of his own volition and he cannot be said to be truly free. One of the major purposes of the *Charter* is to protect, within reason, from compulsion or restraint. Coercion includes not only such blatant forms of compulsion as direct commands to act or refrain from acting on pain or sanction, coercion includes indirect forms of control which determine or limit alternative courses of conduct available to others. Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience.[51]

5.8.11 Finally, in the recent case of *US Citizens Association et al v Sebelius* ("the *Sebelius* case") in the United States of America,[52] the United States District Court Northern District of Ohio held that the existence of a health insurance plan on a federal basis for Americans could only be implemented where sufficiently justifiable reasons exist for the implementation of the plan and, even then, in limited circumstances. In this regard –

5.8.11.1 the *Sebelius* case concerned the constitutionality of the "individual mandate" provision of the Patient Protection and Affordable Care Act

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[50] [1985] 1 S.C.R. 295.

[51] At pages 336 to 337 of the *Big M Drug Mart* decision, quoted above.

[52] Case no. 11-3327/3798.

("PPACA")[53] on the basis of an alleged infringement of the right to freedom of association and liberty;[54]

5.8.11.2 the "individual mandate", similar to the proposed membership of the NHI scheme contemplated in the White Paper, was described in the *Sebelius* case as requiring "each individual to purchase a health insurance policy providing a minimum level of coverage or to make a shared responsibility payment";

5.8.11.3 having considered the facts of the case and the nature of the individual mandate, the court ultimately held that "[f]reedom of association plainly presupposes a freedom not to associate"[55] and that decisions to enter into and maintain certain intimate human relationships "must be secured against undue intrusion by the State because of the role of such relationships in safeguarding the individual freedom that is central to our constitutional scheme. In this respect, freedom of association receives protection as a fundamental element of personal liberty";[56] and

5.8.11.4 the court concluded, *inter alia*, that in so far as PPACA was promulgated for a justifiable reason and does not preclude American citizens from establishing relationships with medical professionals of their choice or associating with particular medical insurance, the individual mandate was not unconstitutional.

5.8.12 Having regard to what is set out above, the right to freedom of association and, in particular, the right not to associate with a cause that is contrary to a person's beliefs is clearly and expressly recognised in our law and in the law of foreign jurisdictions.

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[53] Pub.L. No. 111–148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act, Pub.L. No. 111–152, 124 Stat. 1029 (2010).

[54] This challenge was preceded by a variety of other challenges to the constitutionality of the health insurance plan - see for example *State of Florida et al v United States Department of Health and Human Services et al* case number.: 3:10-cv-91-Rv/Emt and *National Federation of Independent Business v Sebelius*, 13 S. Ct. 2566 (2012).

[55] At page 5 of the *Sebelius* case, quoted above.

[56] At page 4 of the *Sebelius* case, quoted above.

5.8.13 HASA is, thus, of the view that the requirement, in the White Paper, that every person belongs to the NHI scheme or purchases health insurance in accordance with the NHI fund, is *prima facie,* unconstitutional on the basis, at least, of a limitation on the right to freedom of association (which includes the right not to associate or to be different) in so far as –

5.8.13.1 the State, in terms of the White Paper, will be permitted to determine, through coercion, the contours of the healthcare choices of South African citizens;

5.8.13.2 being forced to join the NHI scheme will inhibit the ability of citizens to choose whether or not to purchase health insurance or to join (or remain a member of) a private medical scheme; and

5.8.13.3 citizens will be compelled to join the NHI scheme even if joining the scheme would be at odds with citizens' convictions or where citizens do not support the objects or methods of the NHI scheme. Additionally, citizens will also be required to join the NHI scheme irrespective of their state of health or the benefits to them in doing so.

5.8.14 Moreover, in relation to those members of the population who are employed with an income and are, as a result, compelled to belong to NHI and contribute to the fund, the obligation additionally to make direct contributions to the fund will impact negatively on the constitutionality of NHI in the context of –

5.8.14.1 the rights patients already enjoy to select their own health care providers;[57] and

5.8.14.2 the rights of medical schemes to select health care providers as part of managed care principles in the Medical Schemes Act.[58]

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[57] No. 131 of 1998. See sections 7, 8 and 9 of the National Health Act, quoted above, and the National Patients' Rights Charter published by the Health Professions Council of South Africa under the Health Professions Act No. 56 of 1974, as amended

5.8.15 HASA therefore contends that the proposed NHI scheme is subject to constitutional challenge. In this regard, no basis presently exists in law to compel every South African to join or to contribute to the NHI scheme, especially with reference to the Bill of Rights. Even if legislation is created making membership obligatory, that legislation must nonetheless pass constitutional scrutiny and must be accepted as a reasonable limitation - in terms of section 36 of the Constitution[59] - on the rights in section 18 of the Bill of Rights. Currently, the White Paper does not provide a reasonable justification for compelling every South African to belong to NHI and contribute to the fund despite the clear right to freedom of association. Until HASA sees proposed legislation to this effect, HASA cannot accept that the obligation of compulsory membership is legally valid or constitutionally sustainable.

5.9 Right to Self-Determination

5.9.1 In addition to the right entrenched under section 18 of the Bill of Rights to freedom of association, the right to self-determination is also relevant in relation to determining the constitutionality of the proposed NHI scheme. In this regard, in *Christian Lawyers' Association v National Minister of Health and others* ("the *CLA* case")[60], the concept of "self-determination" was dealt with in relation to the constitutional validity of sections 5(2) and 5(3) of the Termination of Pregnancy Act

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[58] See sections 29 and 32 of the Medical Schemes Act read with Regulation 7, 8, 15, 15A, 15D, 15E, 15H, 15I and 15J of the General Regulations promulgated in terms of the Medical Schemes Act (GNR 1262, dated 20 October 1999, as amended)

[59] Section 36 of the Constitution provides that –

"(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including –

(a) the nature of the right;

(b) the importance of the purpose of the limitation;

(c) the nature and extent of the limitation;

(d) the relation between the limitation and its purpose; and

(e) less restrictive means to achieve the purpose.

(2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights".

[60] [2004] 4 All SA 31 (T).

("the Termination Act")[61], read with the definition of "woman" in sections 1 and 5(1) of the Act. The Termination Act allows minor females to choose to have their pregnancies terminated without, *inter alia*, the consent of the parents or guardians.

5.9.2 The plaintiffs in the *CLA* case contended that girls of such a young age are not capable individually of making an informed decision regarding the termination of pregnancy. The plaintiffs, further, contended that the provisions of the Termination Act were in conflict with sections 23(1)(b),[62] 28(1)(b),[63] 28(1)(d)[64] and 9(1)[65] of the Constitution read with section 7(1) of the Constitution.

5.9.3 The Constitutional Court examined the issues in dispute from the perspective of the basis in law of the right of a woman to determine the fate of her pregnancy and ultimately dismissed the challenge that had been brought.[66] In this regard, in dismissing the challenge to the legislation, the Constitutional Court held that the recognition of the right of every individual to self-determination has now become an imperative under the Constitution, including in respect, *inter alia*, of -

5.9.3.1 section 12(2) of the Bill of Rights, which provides for the freedom and security of a person and in particular that "everyone" has the right to bodily and psychological integrity which includes the right "to make decisions concerning reproduction" and "the security and control over their body"; and

5.9.3.2 section 27(1)(a) of the Bill of Rights, which provides that "everyone" has the right to have access to "health care services", including "reproductive health care".

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[61] No. 92 of 1996.

[62] Rights of children to family or parental care.

[63] Right to be protected from maltreatment, neglect, abuse or degradation.

[64] Supremacy of the best interests of the child.

[65] Right to equality before the law.

[66] At page 39 of the *CLA* judgement, quoted above.

5.9.4 In this regard, Mojapelo J, at page 39 of the *CLA* judgement held that the Constitution not only permits the Termination Act to make a pregnant woman's informed consent the cornerstone of its regulation of the termination of her pregnancy, but indeed requires the Termination Act to do so. According to Mojapelo J, to provide otherwise would be unconstitutional.

5.9.5 The relevance of the *CLA* judgment to the question of compulsory membership of the NHI scheme is readily apparent, in that compulsory membership of NHI may infringe on the right to self-determination on the basis that, within the requirement for compulsory membership, people are not free to make choices regarding the healthcare services they require or the manner in which they wish to be treated. Instead, the White Paper contemplates that South Africans will be forced to become members of the NHI scheme and will be limited to the confines of the fund.

5.9.6 The limitation of patient autonomy is counter-productive and irrational. In this regard, S McIver in her article "User Perspectives and User Involvement"[67] contends that –

> "There are two main arguments for the importance of involving users in treatment choices. The first relates to the ethical principle of autonomy which states that individuals have a right to exercise control over decisions which affect their lives. In many countries this has lead to legislation to support the clinical duty to obtain informed consent for treatment and participation and research. This means that if users believe that health professionals have abused their right to make informed choices about their care they can seek redress in court. However, legal standards and procedures differ between countries …. There has been an increase in the number of decision aids being constructed and tested. A systematic review identified seventeen that have been subject to demise control of trials to assess the impact on health outcomes (O'Connor et al

[67] McIver, S (2006) 'User perspectives and user involvement' in Walshe, K and Smith, J (eds), *Healthcare Management*, Maidenhead: Open University Press.

1999). A decision aid has the following features that distinguish it from more general patient information:

- information tailored to patient's health status; …
- examples of other patients;
- guidance or coaching a chair decision making;
- different mode;
- not educational or materials that inform about health issues in general way;
- not passive informed consent materials not designed to promote compliance with the recommended option."[68]

5.9.7 Having regard to what is set out above, and in the absence of a reasonable justification in the White Paper for compelling every South African to belong to the NHI, HASA cannot accept that the NHI scheme, as currently formulated, is constitutional.

5.10 The Right to Freedom and Security of the Person

5.10.1 As highlighted in the *CLA* case, the right to self-determination is closely aligned with other rights, including the right to freedom and security of a person as contemplated in section 12 of the Bill of Rights and, in particular, section 12(2) which provides that everyone has the right to "bodily and psychological integrity", including the right "to make decisions concerning reproduction" and the right "to security and control over their body". In this regard, the term "integrity", as used in section 12 of the Bill of Rights, has been described by Currie and De Waal as including ideas of "self-determination and autonomy" and the right to "control over one's mind".[69]

5.10.2 In so far as the right to "security in and control over one's body" is concerned, Currie and De Waal note that "in essence the right to freedom and security of the person is a right to be left alone. And, at least in relation to one's body, the right to create a sphere of individual

[68] See S McIver in her article entitled "User perspectives and user involvement" in Walshe et al, quoted above at pages 437 to 440

[69] See Currie and De Waal, quoted above, at page 288.

inviolability".[70] Additionally, Currie and De Waal note that the right contains two elements, namely "security in" one's body, which denotes "the protection of bodily integrity against intrusions by the State and others", and "control over" one's body, which denotes "the protection of what could be called bodily autonomy or self-determination against interference".[71] According to Currie and De Waal, "the former is a component of the right to be left alone in the sense of being left unmolested by others. The latter is a component of the right to be left alone in the sense of being allowed to live the life one chooses."[72]

5.10.3 HASA is, thus, of the view that the establishment of the NHI fund, as currently contemplated in the White Paper, also *prima facie* contravenes the right to freedom, and in particular, the right to control one's body in so far as the White Paper, *inter alia*, contemplates that citizens will not be entitled to "live the life" they choose in circumstances where the life they choose is one that excludes health insurance.

5.10.4 Additionally, in so far as the process of implementation of NHI will ultimately preclude members of the public from accessing alternative services - and particularly in circumstances where the services offered in terms of the NHI scheme are of poor quality[73] or result in the inability of citizens to obtain timeous healthcare - the NHI scheme will also infringe on the right to security in one's body.

5.10.5 In this regard, thus far, no South African Constitutional Court cases dealing with access to healthcare services have been adjudicated

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[70] See Currie and De Waal, quoted above, at page 287.

[71] See Currie and De Waal, quoted above, at page 287.

[72] See Currie and De Waal, quoted above, at page 287.

[73] In this regard, statements are made in the White Paper concerning the precise nature of the quality of healthcare services particularly in the public sector. Steps have been taken to introduce the Office of Health Standards Compliance in terms of the NHA. However, that office is yet to address directly and substantively quality concerns and the provision of healthcare in the public sector in South Africa. At paragraph 75 of the White Paper, the statement is made that "[q]uality of healthcare must be adequately addressed in both the public and private sectors. Public sector facilities are regularly assessed against core quality standards. This has revealed that there are quality problems in the areas of staff attitudes, waiting times, cleanliness, drugs stock outs, infection control and safety and security of staff and patients. In addition, significant increases in utilisation due to the high burden of disease and increased patient loads have further compromised the quality of care." Quality remains a concern and arguably a central reason for a distrust in the South African public in respect of receiving healthcare from a public institution.

primarily under section 12(2) of the Constitution.[74] However, cases from the Supreme Court of Canada support the argument that the impairment of health-related interests may implicate a residual right to security in one's body, when the impairment is substantial. In this regard, as demonstrated in the cases cited below, physical and psychological impact, adverse effects on the integrity of the human body and its wellbeing, and bodily self-determination feature prominently in substantiating a claim under section 7 of the Canadian Charter,[75] which similar to section 12(2) of the Constitution, provides that everyone has the "right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice".

5.10.6 In the Canadian case of *R v Morgentaler*,[76] three medical practitioners were charged for conspiring to perform illegal abortions. At the time, pregnant women who required therapeutic abortions in Canada faced difficulties in securing approval for the procedure in the public sector due to long waiting periods. The medical professionals asserted that these women had a right to a therapeutic abortion in cases where the State failed to facilitate access in the public system.[77]

5.10.7 The Supreme Court of Canada ultimately held that the delays in procuring a therapeutic abortion violated section 7 of the Canadian Charter. In coming to this conclusion Dickson CJ held that the phrase "security of the person" meant that the "human body ought to be protected from interference by others" and also provided for "respect for physical integrity". Dickson CJ held further that "interference with bodily integrity and serious State-imposed psychological stress" or significant "emotional stress" breached the security of the person. The psychological stress in this case was occasioned by the long waiting times endured by women who require therapeutic abortions before the State granted them certificates allowing the procedure. In the *Morgentaler* case, Beetz J emphasised this by stating that -

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[74] See M Pieterse "The Interdependence of Rights to Health and Autonomy in South Africa" (2008) 125 *SALJ* 553, 562-3 for a discussion of various High Court decisions on autonomy interests in the context of health.

[75] Canadian Charter of Rights and Freedoms (Canada).

[76] R v Morgentaler [1998] 1 S.C.R. 30.

[77] At paragraph 5 of the *Morgentaler* judgement, quoted above.

"Security of the person within the meaning of s. 7 of the Charter must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction. If an act of Parliament forces a pregnant woman whose life or health is in danger to choose between, on the one hand, the commission of a crime to obtain effective and timely medical treatment and, on the other hand, inadequate treatment or no treatment at all, her right to security of the person has been violated."[78]

5.10.8 Similarly, in *Chaoulli v Québec*[79], the applicants successfully challenged the constitutionality of legislative provisions prohibiting alternative private health insurance for services available in the public sector – a state of affairs ultimately proposed in terms of the White Paper in so far the requirement for "complementary cover" for medical schemes is concerned. In particular, the offending provisions were section 11 of the Hospital Insurance Act[80] and section 15 of the Health Insurance Act.[81]

5.10.9 According to the appellants, prohibiting parallel private health insurance prevented patients from accessing timely healthcare in the private sector in cases where the public sector failed to facilitate timely access.[82] The appellants submitted that this was inconsistent with section 7 of the Canadian Charter and section 1 of the Québec Charter,[83] which provides

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[78] At paragraph 68 of the *Morgentaler* judgement, quoted above.

[79] *Chaoulli v Quebec* [2005] 1 S.C.R. 791; 2005 SCC 35, 254 D.L.R. (4th) 577.

[80] Hospital *Insurance* Act, R.S.Q., c. A-28, which provides -

"(1) No one shall make or renew, or make a payment under a contract under which -

(a) a resident is to be provided with or to be reimbursed for the cost of any hospital service that is one of the insured services;

(b) payment is conditional upon the hospitalization of a resident; or

(c) payment is dependent upon the length of time the resident is a patient in a facility maintained by an institution contemplated in section 2".

[81] R.S.Q., c. A-29**.** Section 15 provides that "[n]o person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is furnished or under which all or part of the cost of such a service is paid to a resident or a deemed resident of Québec or to another person on his behalf".

[82] At paragraph 103 of the *Chaoulli* judgement, quoted above.

[83] Quebec Charter of Human Rights and Freedoms (Canada).

that "every human being has a right to life, and to personal security, inviolability and freedom."

5.10.10 The majority in the *Chaoulli* case held that –

5.10.10.1 the prohibition of purchasing private health insurance for services that were available in the public sector infringed on section 1 of the Québec Charter, with the court declaring that if no prohibition of private health insurance existed, then those inhabitants of the province of Quebec ("Quebeckers") who were able to purchase private health insurance should have been allowed to do so to avoid suffering the detrimental consequences of waiting lists;[84]

5.10.10.2 the limitation was not justifiable under section 9 of the Québec Charter. In this regard, whilst acknowledging the objective of the statutes was to promote healthcare of a high quality to all Quebeckers regardless of ability to pay, the majority held that "a health care service that does not attain an acceptable level of quality of care cannot be regarded as a genuine health care service. Low-quality services can threaten the lives of users"; and

5.10.10.3 the prohibition on private insurance created an "insurmountable" barrier preventing average-income earners from procuring timely health services in the private sector.[85]

5.10.11 The concurring majority held that the prohibition against private health insurance also violated section 7 of the Canadian Charter on the basis that –

5.10.11.1 the purpose of the Canada Health Act[86] was to "protect, promote and restore" the health of Canadian residents and "to facilitate reasonable access to health services without financial or other barriers";

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[84] At paragraphs 37 – 45 of the *Chaoulli* judgement, quoted above.

[85] At paragraphs 46-100of the *Chaoulli* judgement, quoted above.

[86] Canada Health Act R.S.C., 1985, c. C-6.

5.10.11.2 if government imposed a monopoly and then failed to promote reasonable access to health services then this "trigger[ed] the application of section 7 of the Charter";[87]

5.10.11.3 although private health services were not prohibited in terms of the legislation, by making a contract for parallel private insurance essentially ineffective, the government created a virtual monopoly for the public health system. Thus, only the "very rich, who can afford private care without the need of insurance would be able to access private health care";[88] and

5.10.11.4 accordingly, the relevant provisions of the Hospital Insurance Act and the Health Insurance Act violated section 7 to the extent that they resulted in patients suffering adverse physical or psychological consequences. The concurring majority held further, on the basis of *R v Morgentaler*, that waiting lists giving rise to psychological and physical suffering possibly violated section 7 of the Charter.[89] Put bluntly, the concurring majority recorded that "[a]ccess to a waiting list is not access to health care". However, the concurring majority qualified the finding of a violation of section 7 by requiring the impact of the delay to be "serious" and "clinically significant".[90]

5.10.12 The Canadian decisions of *Morgentaler* and *Chaoulli* show that health-related interests beyond physical freedom implicate rights to freedom and security in one's body as well as rights to physical and psychological integrity. Accordingly, in so far as the NHI scheme, as proposed in the White Paper, contemplates forced association with the fund as well as a prohibition against access to alternative healthcare services (in circumstances where the quality of the services to be

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[87] At paragraphs 105 of the *Chaoulli* judgement, quoted above. In saying this, the concurring majority was not pronouncing at this juncture on the constitutionality of the legislation or its effects, but merely saying that a government monopoly that fails to deliver adequate health care may possibly violate section 7 of the Canadian Charter.

[88] At paragraph 109 of the *Chaoulli* judgement, quoted above.

[89] [1998] 1 S.C.R. 30. In this matter, the Supreme Court held that delays in performing therapeutic abortions generated by the possible imposition of criminal offences on doctors violated section 7 of the Charter.

[90] At paragraph 123 of the *Chaoulli* judgement, quoted above.

provided in terms of the NHI are not guaranteed), the White Paper is *prima facie* susceptible to legal challenge on the basis, *inter alia*,[91] of a limitation of section 12 of the Bill of Rights.

6 SERVICES TO BE PROVIDED IN TERMS OF THE NHI SCHEME AND THE RIGHT TO HEALTHCARE

6.1 Right to healthcare

6.1.1 In addition to the potential infringements of the Constitution based on the mandatory nature of the NHI scheme, the White Paper (as alluded to in the *Morgentaler* and *Chaoulli* judgments) may also give rise to concerns relating to a potential infringement on the right to healthcare, as contemplated in section 27 of the Bill of Rights.[92]

6.1.2 Section 27(1) of the Bill of Rights provides that "[e]veryone has the right to have access to … healthcare services, including reproductive health care". Section 27(2), in turn, provides that "[t]he state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of [the right to healthcare]".

6.1.3 In relation to the manner in which the right to healthcare may be protected, the Constitutional Court in the *First Certification* case[93] held that socio-economic rights, such as the right to healthcare, should be both negatively and positively protected. In so far as the positive protection is concerned, section 27 creates an obligation on the State to promote and fulfil the right in terms of sections 27(2) by taking measures to fulfil the right which are reasonable and are subject to the criteria of resource availability and progressive realisation. In relation to the

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[91] Other constitutional challenges may include a challenge in respect of a constitutional taking of property under section 25 of the Constitution; the rights patients already enjoy to select their own health care providers in terms of see sections 7, 8 and 9 of the National Health; and the rights of medical schemes to select health care providers as part of managed care principles in the Medical Schemes Act in terms of sections 29 and 32 of the Medical Schemes Act read with regulation 7, 8, 15, 15A, 15D, 15E, 15H, 15I and 15J of the General Regulations promulgated in terms of the Medical Schemes Act (GNR 1262, dated 20 October 1999, as amended).

[92] This is despite the allegation made in paragraph 54 of the White Paper that "NHI will ensure access to health care as enshrined in the Bill of Rights, Section 27 of the Constitution …".

[93] *Ex Parte Chairperson of the Constitutional Assembly: In Re Certification of the Constitution of the Republic of South Africa*, 1996 1996 (4) SA 744 (CC).

negative protection, Currie and De Waal note that the negative protection contemplates -

> "A negative obligation not to interfere with someone who is doing something that they have the right to do …. Applied to socio-economic rights, negative protection means that a court can prevent the state from acting in ways that infringe the socio-economic rights directly…. The right to … healthcare may therefore not be subjected to what have been termed 'deliberately regressive measures'. A deliberately regressive measure is one that has the effect of denying individuals their existing access to … healthcare. A law prohibiting the purchase or use of anti-retroviral drugs by HIV-positive people would entail a direct negative infringement of the right to healthcare, for example, and could be remedied relatively simply by an order declaring the law invalid".[94]

6.1.4 Currie and De Waal also note that law or conduct leading to a decline in, rather than progressive improvement in, healthcare conditions would amount to a violation of the negative protection afforded in respect of the right to healthcare and could be declared invalid for this reason.[95] Importantly, a court considering a negative violation of the right to healthcare will not consider the standards in section 27(2) such as reasonableness, the availability of resources and progressive realisation.[96] Any measure that deprives a person of existing access to the right to healthcare is a limitation that must be justified under section 36 of the Constitution.[97]

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[94] See Currie and De Waal, quoted above, at page 568. The point has also been made in *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) at paragraph 20, in relation to the right to have access to adequate housing that "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". The Court in *Minister of Health v Treatment Action Campaign* (No 2) 2002 (5) SA 721 (CC), at paragraph 46, expressly applied the aforementioned dictum in *Grootboom* to the health right in section 27. Mokgoro J, on behalf of the Court at paragraphs 31-34 held that the right to have access to adequate housing comprised of a negative obligation that the state may not "prevent or impair existing access to adequate housing".

[95] See Currie and De Waal, quoted above, at page 569.

[96] See Currie and De Waal, quoted above, at page 569.

[97] See Currie and De Waal, quoted above, at page 569.

6.2 **Nature of the services contemplated in the White Paper**

6.2.1 Bearing in mind the nature of the right to healthcare, as contemplated in section 27, consideration must be given to the substantive features of the NHI scheme in so far as the provision of healthcare services is concerned. In this regard, the White Paper makes much reference to the universal nature of the proposed NHI and the extent of the coverage that is to be provided. The White Paper, however, lacks the requisite detail in respect, *inter alia*, of the scope and ambit of the services to be provided as well as the manner in which such services will be provided.

6.2.2 The White Paper provides –

6.2.2.1 at paragraph 125 that "NHI will provide a comprehensive package of personal health services. As resources are limited, the delivery of a comprehensive package will take into account the need to progressively realise the personal health benefits whilst undertaking priority setting. NHI will not cover everything for everyone;" and

6.2.2.2 at paragraph 400 that "it is necessary to take into account the reality that irrespective of how comprehensive the NHI entitlements will be, some personal healthcare services will not be covered. This may be as a result of these health services not fitting into the mainstream of medically necessary and efficacy-proven interventions approved for NHI".

6.2.3 The White Paper lists certain services which are described as being the services to be provided by NHI, albeit that a qualification is included in paragraph 131 that these are services to be *included* in a NHI. In this regard, the aforementioned services are described in the White Paper as follows -

"i. Preventive, community outreach and promotion services
ii. Reproductive health services
iii. Maternal health services
iv. Paediatric and child health services
v. HIV and AIDS and Tuberculosis services
vi. Health counselling and testing services

vii. Chronic disease management services
viii. Optometry services
ix. Speech and Hearing services
x. Mental health services including substance abuse
xi. Oral health services
xii. Emergency medical services
xiii. Prescription medicines
xiv. Rehabilitation care
xv. Palliative services
xvi. Diagnostic radiology and pathology services".

6.2.4 The description of the services is, however, vague and uncertainty exists in relation to the meanings of, for example "prescription medicines" and "palliative services". The White Paper does, however, make it clear that the services to be provided, ultimately, will not be similar to the prescribed minimum benefits currently provided by medical schemes as such benefits "cover a limited number of health conditions, are essentially hospi-centric without fully addressing the burden of disease."[98]

6.2.5 Additionally, the White Paper contemplates a focus on primary and preventive care, which is an approach that, according to the White Paper, is distinct to the current focus of the health system. In this regard, statements are made in the White Paper that –

6.2.5.1 "[t]he current health system is characterised by an emphasis on curative services that leaves prevention by the wayside. Furthermore, the entry level into accessing health services is mostly at an inappropriate level of care (secondary, tertiary and specialist services) rather than at a primary health care level. This has significantly contributed to the high costs of health care and the inefficiency of the health system";[99] and

[98] Paragraph 132 of the White Paper.

[99] Paragraph 76 of the White Paper.

6.2.5.2 in the NHI, "there should be a strong emphasis on disease prevention and health promotion and not only on curative services through a re-engineered Primary Health Care platform".[100]

6.2.6 Implicit in these statements, therefore, is that the full range of current treatments available (including curative as well as secondary, tertiary or quaternary care) will not be readily available under the NHI basket, which will result in the infringement of the negative protection afforded to the right to healthcare in terms of section 27 of the Bill of Rights for the reasons set out above in paragraph 6.1.[101]

6.2.7 At present members of the public are entitled to receive all such care as the State is able reasonably to provide within its available resources. [102] Such care includes healthcare at all levels, including tertiary and quaternary care.

6.2.8 Additionally, members of medical schemes presently have access to a wide range of treatment benefits and, particularly in the context of prescribed minimum benefits, are entitled to the benefit of payment in full for all such treatments received, irrespective of the scheme to which they belong and the amount that they pay for such medical scheme membership.[103]

6.2.9 Thus, to the extent that the defined basket of benefits available under the proposed NHI will be less than that which is presently available — either from the State or through membership of a medical scheme — then the policy underpinning the White Paper will not be advancing the progressive realisation of access to healthcare, but will be limiting rights of access to healthcare. To that extent the policy would be *prima facie*

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[100] Paragraph 393 of the White Paper.

[101] Even if these services are to be provided in terms of the proposed NHI scheme, the likelihood is that services classified as secondary, tertiary or quaternary will be subjected to more significant need-based rationing in terms of which NHI administrators will require a greater threshold of need and likelihood of benefit before authorising the provision of such a service. The primary health care approach as articulated in the White Paper, thus, undercuts a central purpose of NHI, which is to reduce demand for medical scheme membership by providing benefits of sufficient range and quality to South Africans.

[102] *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC).

[103] That is, in terms of the provisions of regulation 8(1) of the General Regulations promulgated by the Minister in terms of the Medical Schemes Act No. 131 of 1998.

unconstitutional and, at the very least, it would require a law of general application to effect this limitation.

6.2.10 Understanding the nature and extent of the defined basket of NHI benefits is therefore material to a proper consideration of whether or not the policy reflected in the White Paper is lawful and/or acceptable, whether in part or at all. In particular, the determination of the services included in or excluded from the NHI basket must be undertaken rationally and reasonably, all the while achieving the progressive realisation of the rights under section 27 of the Constitution.[104]

6.2.11 In this regard, even if all the services that are currently available to South Africans are provided for in terms of the NHI, the proposed manner in which the NHI is to be implemented, may result in various unintended consequences that may negatively impact upon the right to healthcare, as discussed below in greater detail.

6.3 Diminished role of medical schemes

6.3.1 Currently, medical schemes enable people to avoid the public health system and to access quality healthcare services in the private sector. A patient may seek to bypass the public health system and obtain access to healthcare directly from the private sector for a variety of reasons, for example –

6.3.1.1 the healthcare required by a patient may only be available in the private sector;

6.3.1.2 the appropriate healthcare may be available in the public sector, but poor quality services, long waiting lists and excessive queues exist at public hospitals; and

[104] *Minister of Health v Treatment Action Campaign (No 1)* 2002 (5) SA 703 (CC).

6.3.1.3 due to need-based rationing which occurs in the public sector, a patient may not qualify to receive treatment in a public hospital and will therefore seek private healthcare.[105]

6.3.2 Since medical schemes make it possible for members to access private healthcare, medical schemes enhance a patient's ability to access healthcare services, which is a constitutionally protected interest under section 27 of the Bill of Rights. However, as discussed above in paragraph 5.6, the White Paper seeks severely to limit the role of medical schemes in the healthcare system in South Africa by, prohibiting patients from opting out of payment towards NHI and, ultimately, limiting the services to be covered by medical schemes only to complementary care.

6.3.3 The effect of the NHI will, thus, likely result in the decrease of medical scheme membership in so far as many people, who currently subscribe to medical scheme options, will no longer be able to afford medical scheme cover in the face of an additional compulsory payment towards NHI. Additionally, membership of medical schemes will likely decrease as a result of the limitations placed on the services to be offered by the schemes.

6.3.4 The lessening demand for medical scheme membership will make risk pools weaker, resulting in less cross-subsidisation between members of medical schemes – which will result in medical schemes being increasingly unable to finance a broad range of quality healthcare. In this regard, in so far as the NHI system fills the void with a range of healthcare services that are easy to access, such a situation may not infringe on a patient's right to access healthcare. However, to the extent that NHI does not fill this void, the negative protection afforded by the health right in section 27 will be limited.[106]

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[105] See *Soobramoney v Minister of Health* 1998 (1) SA 765 (CC).

[106] Additionally, in creating a monopoly on access to health, the NHI forces individuals to assess the "quality" of healthcare services through one lens, rather than having sight of a myriad of other possible private healthcare insurance scheme providers. It is submitted that a plausible lack of competition, due to the gradual decline of private healthcare schemes, may result in a reduction in quality of healthcare services as there is no comparative gauge by which to measure the quality of healthcare services.

6.4 Impact on service providers and hospitals

6.4.1 Similarly, it is not clear from the White Paper how the structuring of the defined NHI basket will impact directly or indirectly on healthcare providers or on the availability of services that will be offered outside of the services offered in terms of NHI.

6.4.2 Clearly, the costs of some healthcare services will not be recoverable by service providers from the fund.[107] In this regard, if the provision of a health service is not reimbursable — whether at public or private level - then it effectively becomes unavailable to the majority of the members of the public. By reducing, through unavailability of the number of health services that are to be provided,[108] the practice of providing that health service is diminished and, with it, the capital and intellectual value of our health system as a whole.

6.4.3 If the Department is to restrict access to healthcare services by excluding those services from the NHI basket, then it risks foreclosing on any future recourse to those procedures and services. The result of such foreclosure would be the reduction in the intellectual capacity and prospects for growth of our health system as a whole. Put differently, the health system will not only stagnate but will regress. This too represents a significant limitation on, rather than the progressive realisation of, access to healthcare.

6.4.4 The nature and extent of the services may also indirectly impact upon the type of healthcare facilities - including hospitals - that may be established. Hospitals and healthcare institutions cannot function without sufficient skilled professionals and staff to provide the services required. These institutions also cannot function without the necessary critical mass

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[107] Paragraph 134 provides that "[c]hanges to the comprehensive service benefits including diagnostic tests covered by under NHI will be informed by changes in the burden of disease, the demographic profile of the population and the evidence on cost-effectiveness and efficacy of health treatments, interventions and/or technology development locally and internationally. Health technology assessment will be used in priority setting and therapies that have little impact on positive health outcomes will not be paid for under NHI whilst the most cost effective evidence-based strategies will be deployed. Changes and adjustments to the service benefits over time will be accompanied by a budget impact analysis."

[108] Or by inhibiting prospects for new health care treatments and procedures to evolve.

of patient turnover and procedures performed against which the cost of establishing the institution is amortised.

6.4.5 The exclusion of some services from the NHI basket may impact on the availability and cost-effectiveness of other services. Some service providers may be so marginalised that it is not feasible to provide a comprehensive range of services at all or no services within that defined area. This may lead to a concentration of these service providers in limited areas, with a concomitant diminution in access to those services and/or increased costs in attaining access to those services.

6.5 Redistribution of private recourses

6.5.1 Furthermore, in so far as the White Paper contemplates the redistribution of private resources,[109] the redistribution will adversely affect access for current users of the private healthcare system in so far as more people will have access to private healthcare. In this regard, due to the increase in the number of people entitled to access accredited private healthcare services under NHI, the NHI administrators, will be required to develop rationing mechanisms to effectively manage patient load in a way that is presently not required of private hospitals.

6.5.2 By definition, rationing strategies either prevent access to beneficial healthcare services outright, in order to preserve resources or otherwise delay access to reduce and manage demand. Rationing is not by itself inconsistent with the Constitution. However, when some types of curative life-saving care, and treatment designed to prevent suffering are no longer readily accessible, constitutional interests protected under section 27 are unjustifiably limited.

6.5.3 Additionally, in so far as the White Paper does not prescribe a specifically defined list of benefits to be provided in terms of NHI, patients may also be unable to assert their rights in terms of access to particular healthcare services or to ensure accountability in terms of the NHI system. Without

[109] See paragraph 119 of the White Paper which provides that "there will be a need to promote equitable distribution of resources through a mix of accredited and contracted public and private providers".

a clear NHI basic package, administrators may ration the financing and provision of healthcare without justifying their decisions with reference to an objective and predetermined list of defined benefits.

6.5.4 In the absence of explicit, transparent, and procedurally as well as substantively fair rationing practices, patients may be unable to enforce and enjoy constitutional rights to have access to healthcare services because there is no clear basis defining the entitlement. The absence of a defined package may also be unreasonable in terms of section 27(2) of the Constitution. Furthermore, without explicit and procedurally fair rationing guidelines and practises, decisions taken may be inconsistent with the right to just administrative action protected under section 33 of the Constitution, and might also be susceptible to review under the Promotion of Administrative Justice Act No. 3 of 2000 ("PAJA").

6.6 **Costing**

6.6.1 The effect of a limitation of the rights of access to existing healthcare services may also be influenced by the corresponding cost associated with compulsory membership of the fund. In this regard, the White Paper contemplates that the fund will be financed through the possible payment of taxes and direct payments from individuals and employers.[110]

6.6.2 The imposition of a requirement to pay to join the NHI scheme contradicts one of the primary objectives of NHI, which is described in paragraph 107 of the White Paper as "[p]romoting equity and social solidarity through the pooling of risks and funds" read together with the statement in paragraph 1 concerning the need to make access to healthcare more affordable. The White Paper does not address the economic effects of the implementation and imposition of the potential revenue sources on the average South African and the effect of the imposition of such revenue sources on South Africa at large in the current and medium-term economic circumstances in which it finds itself.

[110] Chapter 7 of the White Paper.

6.6.3 Moreover, at paragraph 51 of the White Paper, a statement is made that "[f]unding will be linked to an individual's ability-to-pay and benefits from health services will be in line an individual's need for healthcare". The White Paper, thus, contemplates that individuals contribute according to their income as opposed to their reliance upon or use of services from NHI.

6.6.4 The linking of determining funding contributions to an individual's ability to pay is not an equitable manner of deciding what an individual should pay to belong to the NHI scheme. In so far as the White Paper has placed a direct emphasis on healthcare financing as opposed to healthcare services, it is the need that should be defined as the basis upon which payments are made and not the ability to make such payments. Therefore, the financing system would presuppose a degree of underwriting in relation to those who are healthier and who pay less for NHI as opposed to those who are unhealthier and must pay more. In this regard, the implementation of such a system, in so far as it is based on matters of economics such as underwriting (as opposed to the provision of healthcare services), potentially brings the NHI into conflict with the Constitution and existing legislation such as the Promotion of Equality and Prevention of Unfair Discrimination[111] as well as the Medical Schemes Act.[112]

6.6.5 In the circumstances, members of the public may find themselves paying significantly more than they were paying previously and, in return, receiving lesser benefits - once again, a limitation rather than progressive realisation of rights.

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[111] Act No. 4 of 2000.

[112] The approach that has been taken traditionally by the Department to the implementation of private healthcare funding is as currently contained in the Medical Schemes Act, one of community rating. Due to amendments effected to the Medical Schemes Act, underwriting an individual was fundamentally outlawed. The NHI scheme appears to find community rating to be an attractive option for the purposes both of the levying funds on potential members of the NHI scheme and the management of these funds in relation to payment expenses for those who need health services from funds pooled by those who do not cause expenditure – a classic community rating model. In so far as this is the case, the NHI scheme funding model brings itself into conflict with the funding model contained in the Medical Schemes Act: e is now a distinction drawn between the manner in which health care is funded in the public sector versus how health care is funded in the private sector. This differentiation gives rise to matters of unfair discrimination otherwise prohibited in terms of section 9 of the Constitution.

7 RIGHT, *INTER ALIA*, TO PROPERTY AND FREEDOM OF TRADE, OCCUPATION AND PROFESSION

7.1 In relation to the effect of the proposed NHI on medical schemes, paragraph 401 of the White Paper, provides that -

> "In future, all medical schemes will only offer complementary cover for services that are not included in the health service benefits and medicines approved by the NHI Benefits Advisory Committee. The cover provided by medical schemes must only complement (and not duplicate) the NHI service benefits. Part of this work will require a complete overhaul to the existing Prescribed Minimum Benefits regime, taking into account the burden of disease and changing population demographics. This will ensure that the population is granted greatest possible access to health care services by everyone within available resources".[113]

7.2 The White Paper also states, at paragraph 402, that the number of medical schemes in the country will reduce to "a much smaller number". In this regard, the effective removal of the ability of a medical scheme to provide benefits offered in terms of NHI and charge for such benefits accordingly, may give rise to a further constitutional infringement – being an infringement of a medical scheme's right to property.

7.3 Section 25(1) of the Constitution states, *inter alia*, that "[n]o one may be deprived of property except in terms of law of general application"[114] and on the basis that the deprivation is not arbitrary. Section 25, further, provides

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[113] Notably, in so far as the NHI is implemented, various amendments to the Medical Schemes Act will be required, not only in respect of the complementary cover envisaged in paragraph 22 of the White Paper but in a wide variety of aspects – this is particularly true in so far as the NHI fund, as it is currently contemplated will fall within the definition of the "business of a medical scheme" in section 1 of the Medical Schemes Act. Accordingly, the provisions of the Medical Schemes Act will be applicable to the fund, including section 20, which precludes a medical scheme from operation without being registered. Section 28 of the Medical Schemes Act prohibits a person from being a member of more than one medical scheme at a time, or from being admitted as a dependent of more than one member of a medical scheme or from claiming benefits from more than one medical scheme. This prohibition will require amendment if membership of a medical scheme is to coexist with membership of the fund. It will also be necessary to define when and in what circumstances benefits can be claimed from a medical scheme in addition to, as an increment to, or in the alternative to the payment of benefits from the fund. Until such time as the legislation is effected it is not possible for HASA to comment more constructively on the requisite amendments to the Medical Schemes Act.

[114] Section 8(4) of the Constitution provides that "[a] juristic person is entitled to the rights in the Bill of Rights to the extent required by the nature of the rights and the nature of that juristic person". Accordingly, the right to property in section 25 of the Bill of Rights applies both to natural and juristic persons, such as medical schemes.

that property may only be expropriated in terms of law of general application for a public purpose or in the public interest and subject to compensation, the amount, timing, and manner of which must be agreed, or decided or approved by a court.[115]

7.4 In relation to the definition of "property" for purposes of section 25, Currie and De Waal state that "property" may be defined as "any relationship or interest having an exchange value".[116] In this regard, in the case of *Law Society of South Africa v Minister of Transport,*[117] the Constitution Court included, within the definition of "property", particular claims against the Road Accident Fund for medical costs, loss of earning capacity and loss of support. Accordingly, our courts have accepted the even personal rights constitute property for purposes of section 25.

7.5 In so far as medical schemes are concerned, the Medical Schemes Act authorises registered medical schemes, *inter alia*, to assist beneficiaries in obtaining *any* relevant health service, in return for a premium or contribution payable to the medical scheme.[118] The term "relevant health service is, in turn, defined in section 1 of the Medical Schemes Act to mean "any healthcare treatment of any person by a person registered in terms of any law, which treatment has as its object –

(a) the physical or mental examination of that person;

(b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;

(c) the giving of advice in relation to any such defect, illness or deficiency;

(d) the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;

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[115] Section 25(2)(a) and (b).

[116] See Currie and De Waal, quoted above, at page 535.

[117] 2011 (1) SA 400 (CC) at paragraph 81.

[118] See definition of "business of a medical scheme".

(e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency of a pregnancy, including the termination thereof;

(f) nursing or midwifery;

and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy".

7.6 The Medical Schemes Act, thus, confers on medical schemes the right to facilitate the provision of all relevant health services to the public and to be compensated for such business. The Medical Schemes Act also confers on medical schemes the right to run their affairs and to be held accountable in terms of the Medical Schemes Act. Arguably, the aforementioned rights fall within the ambit of the definition of "property" for purposes of section 25. Accordingly, in so far as medical schemes are deprived of their property or their property is expropriated, such deprivation or expropriation must accord with the provisions of section 25.

7.7 In this regard, the term "deprivation" has been defined as any interference with the use, enjoyment or exploitation of property,[119] which does not result in the right-holder being disposed of the rights to the property.[120] According to the Constitutional Court, the purpose of a deprivation is to settle private disputes or to protect public health and safety (like criminal forfeiture) and is merely an instance of the State's police power.[121] Expropriation, on the other hand, has been defined as a form of deprivation in terms of which the State acquires property from a third party with the intended and express purpose of increasing State resources in order to realise a State enterprise - and which

[119] *First National Bank of SA Ltd T/A Wesbank v Commissioner, South African Revenue Services* 2002 (4) SA 768 (CC).

[120] See Currie and De Waal, quoted above, at page 548.

[121] *Harksen v Lane* 1998 1 SA 300 (CC).

has the effect of dispossessing the third party of his/her/its rights to the property.[122]

7.8 Until such time as NHI legislation is drafted and the nature of the role of medical schemes in the NHI scheme is defined with greater clarity, it is not possible for HASA to comment fully on any potential infringement of the NHI scheme on the right to property. HASA submits, however, that, *prima facie*, the structuring of the NHI so as to dispossess medical schemes of their right to provide and be reimbursed for a comprehensive range of healthcare services, constitutes an "expropriation" of property, as contemplated in section 25 of the Bill of Rights.

7.9 In this regard, the White Paper, at paragraph 107, stipulates that one of the key objectives of the NHI scheme is to create "one public health fund with adequate resources and funds to plan for and to effectively meet the health needs of the entire population". The White Paper seeks to achieve this objective by, *inter alia*, limiting the cover which may be provided by medical schemes to "complementary cover for services that are not included in the health service benefits and medicines approved by the NHI Benefits Advisory Committee"[123] and by enforcing mandatory payment by citizens for NHI membership. The White Paper, as currently formulated, thus, envisages an expropriation of the rights of medical schemes to provide and receive compensation for comprehensive healthcare services in favour of the State - which will acquire and use the rights to increase State recourses.

7.10 As such, the White Paper envisages an expropriation of property and, therefore, the expropriation must comply with the provisions of section 25 of the Constitution. The expropriation by the State must, therefore, be effected by a law of general application in order to give rise to the expropriation. Additionally, the law of general application must be implemented for a public purpose or in the public interest and subject to compensation. In this regard, currently, the White Paper does not explain or provide any proper justification for why the role of medical schemes must change under a NHI as proposed or even what is achieved through such a change other than the removal of the

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[122] *Agri South Africa v Minister for Minerals and Energy* [2013] ZACC 9 (18 April 2013).

[123] Paragraph 401 of the White Paper.

desire by consumers to purchase private medical scheme cover as opposed to belonging to a NHI.

7.11 The White Paper also does not contemplate the provision of compensation to medical schemes as a result of the proposed expropriation - as contemplated in section 25(2) of the Constitution. Accordingly, for the reasons set out above, and in the absence of NHI legislation, the implementation of NHI as it currently stands in the White Paper is subject to constitutional challenge.

7.12 Additionally, to the extent that White Paper proposes that the scope of available healthcare services in terms of NHI will be limited, then this will constitute a significant and far reaching limitation upon the rights of healthcare service providers to provide the full range and scope of their services—including professional services. It also impinges dramatically upon the ability of healthcare service providers to earn an income. To this extent, such limitations may infringe upon *inter alia* the following rights -

7.12.1 human dignity, including their own right to self-determination (section 10 of the Constitution),

7.12.2 freedom of trade, occupation or profession (section 22 of the Constitution); and

7.12.3 freedom of property and the right not to be deprived of property (section 25 of the Constitution).

7.13 For so long as it is contemplated or intended that the policies underpinning NHI will impinge upon any of the abovementioned rights, or if the effect of NHI will be to limit these rights then HASA cannot give its support to the NHI or to the White Paper.

8 **CONCURRENT COMPETENCE**

8.1 A further issue that arises in respect of the proposed NHI scheme, is the effect of the scheme on the concurrent legislative competencies of the provincial legislatures and national parliament. In this regard, in terms of the Constitution, provincial legislatures share a concurrent legislative competence

with national parliament in all the functional areas listed in Schedule 4 of the Constitution, including "[h]ealth services".[124]

8.2 Accordingly, provincial legislatures are entitled to promulgate provincial legislation and regulate, *inter alia*, the delivery and financing of health services within their specific provinces. The White Paper, however, -

8.2.1 seeks to introduce a single financing system to be implemented in all provinces within South Africa;[125]

8.2.2 envisages the centralisation of healthcare regulation and delivery, which suggests a shift from provincial autonomy of healthcare budgets and the ability of the provinces to determine health-specific policy at provincial level, in favour of a national authority; and

8.2.3 at paragraph 433 of the White Paper, refers to the "transformation and reconfiguration of institutions for pooling of funds and purchasing of services to achieve income and risk cross-subsidisation whilst improving the efficiency in purchasing of personal health services".

8.3 In this regard, in so far as the features of the NHI, as set out above in paragraph 8.2, involve a change in the functional competencies of national and provincial government, such a change would be contrary to the provisions of the Constitution.

9 PROVIDER REIMBURSEMENT RATES AND PURCHASING OF SERVICES BY THE STATE

9.1 An additional issue of concern to HASA in respect of the proposed NHI scheme is the matter of the provider reimbursement rates contemplated in the White Paper. In this regard, the White Paper, in chapter 3, lists the apparent structural problems in the healthcare sector, which have been identified by the Department and that, apparently, give rise to the need to implement the proposed NHI scheme. In this regard, one such structural problem identified

[124] See schedule 4 of the Constitution and page 210 of Currie and De Waal, quoted above.

[125] See paragraph 51 of the White Paper.

in the White Paper is the "costly private sector", which has arisen, *inter alia*, as a result of the "Fee-For-Service (FFS) Environment"[126]. In this regard, Fee—For-Service ("FFS") is described in the White Paper as follows –

> "Fee-for-service (FFS) is a method of provider payment where there is separate payment to a health care provider for each medical service rendered to a patient. Medical schemes reimburse for all services regardless of their impact on patient health. In a FFS environment, there is little countervailing pressure to discourage providers delivering these unnecessary services. This has been identified as one of the contributors to escalating costs in the health care system…".[127]

9.2 Having regard to the challenges that have apparently arisen as a result of the FFS mechanism, the White Paper provides that "[t]he NHI Fund in consultation with the Minister will determine its own pricing and reimbursement mechanisms" and that "[p]roviders who wish to contract with the NHI Fund must comply with the stipulated pricing and reimbursement mechanisms".[128]

9.3 The payment mechanisms for providers are, in turn, proposed in chapter 8.5 of the White Paper, as follows –

9.3.1 in relation to provider payment at primary healthcare level, the White Paper provides that the main mechanism that will be used to pay providers for health services will be a risk-adjusted capitation system with an element of performance-based payment. The capitation amount will be a uniform amount for the defined levels of providers, regardless of public or private ownership;

9.3.2 in so far as ambulatory private specialist services are concerned, the White Paper provides that, NHI will initially use a capped case-based fee adjusted for complexity where appropriate for reimbursement;

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[126] See page 13 of White Paper.

[127] Paragraph 71 of the White Paper.

[128] Paragraph 336 of the White Paper.

9.3.3 in relation to provider payment at hospital level, the White Paper contemplates a move towards case-mix activity adjusted payments (such as Diagnosis-Related Groups or DRG5) to public and private hospitals with a gradual transition to global budgeting based on crude activity estimates and eventually a case-mix reimbursement system; and

9.3.4 finally, the White Paper contemplates that payments for emergency medical services will largely be a capped case-based fee with some adjustments made for case severity where necessary.

9.4 Notably, whilst the White Paper seeks to establish and introduce payment mechanisms for each category of healthcare service provider (which payment mechanisms contemplate either a fixed or capped service fee), provision is already contained in sections 90(1)(u) and 90(1)(v) of the National Health Act that allows for a system to be implemented by the Minister, in terms of appropriate regulations, to control or address issues concerning healthcare pricing. In this regard –

9.4.1 section 90(1)(u) of the National Health Act provides that the Minister may promulgate regulations relating to the processes and procedures to be implemented by the Director-General of Health ("Director-General") in order to obtain prescribed information from stakeholders relating to the pricing of health services; and

9.4.2 section 90(1)(u) provides that the Minister may promulgate regulations relating to the processes of determination and publication by the Director-General of one or more reference price lists ("RFL") for services rendered, procedures performed and consumable and disposable items utilised which may be used by a medical scheme as a reference to determine its own benefits; and by health establishments, healthcare providers or health workers in the private health sector as a reference to determine their own fees.

9.5 Accordingly, in so far as a system already exists and has been implemented by Parliament in section 90 of the National Health Act to allow for the regulation of pricing of healthcare in South Africa, then it is submitted that the NHI system is not the appropriate reply or response to health pricing in South Africa.

9.6 In this regard, HASA is of the view that, in order to ensure the integrity of the process, the regulation of pricing of healthcare services in South Africa should be implemented in terms of the existing legislative framework and having regard to the case law that has informed the nature of such an exercise, including the judgements in the *Minister of Health and another v New Clicks (Pty) Ltd and others* ("*New Clicks* case")[129] and *the Hospital Association of South Africa Ltd v the Minister of Health* ("*HASA* case"),[130] as discussed below in greater detail.

9.7 In the *New Clicks* case, which involved a dispute between the Minister and pharmacists concerning the reasonableness of dispensing fees introduced as part of the single exit price legislation for medicines pursuant to section 22G of the Medicines Act,[131] the Constitutional Court –

9.7.1 ultimately held that the imposition of a particular fee on a particular healthcare profession, in this instance, pharmacies, must be sufficient to enable that profession to operate viably and to make a reasonable profit. In this regard, notably, the Constitutional Court held that the imposition of any capped or fixed fee in respect of the provision of healthcare services must allow for healthcare professionals to operate reasonably and to make a living from their profession;[132] and

9.7.2 criticised the manner in which the pricing committee set about determining the single exit pricing for medicines and set out the process that would need to be followed in order for such a pricing system to be implemented lawfully, as follows -

> "The Pricing Committee has provided no models or other evidence to demonstrate how the dispensing fee was calculated or how the members of the Pricing Committee satisfied themselves that it was appropriate. It has not told us what assumptions it made about

[129] 2006 (1) BCLR 1 (CC).

[130] *The Hosital Association of South Africa Ltd v The Minister of Health* 2010 (10) BCLR 1047 (GNP).

[131] Medicines and Related *Substances* Act No. 101 of 1965, as amended.

[132] In this regard see paragraph 317 of the *New Clicks* case, quoted above.

> probable [Single Exit Prices] in calculating the dispensing fee, or how it assessed the dispensing fee when it seems to have had no data dealing with the dispensary revenue and expenses which it considered to be essential for that purpose. It has not addressed in any meaningful way the contention that the dispensing fee will lead to pharmacy closures that will impair accessibility to health care particularly in rural areas…." [133]

9.8 The *New Clicks* decision provides a clear indication that additional economic controls over any aspect of the delivery of healthcare services constitutes an important part of the assessment of both the manner in which access to healthcare is exercised by members of the public; and the participation in providing such access by healthcare providers. The *New Clicks* case, thus, confirms that the State must balance carefully the interests of those providing medical or healthcare service with the interests of the public and the access by members of the public to such healthcare services. The *New Clicks* decision also confirms that any pricing system developed by the State must ultimately be reasonable and capable of justification based on available information and evidence.

9.9 Similarly, in the *HASA* case, which concerned the issue of the reasonableness of the imposition of a proposed national health reference price list on healthcare providers in terms of the National Health Act, the High Court took cognisance of the impact of pricing regulations on access to healthcare services in relation to a potential decline in the availability of healthcare providers, remarking that –

> "Ultimately, there was the real risk that the effect of the RPL Decision would play out on patients who may face the burden of a declining number of doctors within the country, and who may be confronted with general and specialist practitioners who, in an attempt to make ends meet, would be forced to focus on high volume turnover of patients at the expense of quality provision of medical services".[134]

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[133] At paragraph 403 of the *New Clicks* case, as quoted above.

[134] At paragraph 118 of the *HASA* case, as quoted above.

9.10 The High Court, additionally, held that the exercise of determining the pricing of healthcare services in terms of the National Health Act was subject to a process of public participation and consultation pursuant to the provisions of the Constitution and PAJA, noting that -

> "Furthermore, the regulations were subject to review under the provisions of PAJA as well as review for rationality and reasonableness under the Constitution. In addition, the exercise by the Minister of her powers under the [National Health Act] to promulgate the Regulations was subject to the requirement of legality that derived from section 1 of the Constitution. …
>
> To the extent that the Regulations contained within them provisions that offended against the rights contained in the Constitution, then they would additionally be liable to be set aside to the extent of such conflict in accordance with sections 2, 7, 8, 36(2), and 172(1)(a) of the Constitution".[135]

9.11 On the basis set out above, the High court ultimately found that the imposition of the national health reference price list, as an administrative system, was compromised, due *inter alia* to deficiencies in the consultation process, and overturned the system.

9.12 Having regard to what is set out above, and in the absence of any reasons for why and how the provider reimbursement rates have been determined in the White Paper, HASA submits that the provisions of section 90 of the National Health Act should, instead, be utilised to establish a mechanism for the pricing of healthcare services and that such a mechanism should be equitable and adequately compensate healthcare providers for the intellectual and capital investment made by providers and the true costs of providing the service. [136]

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[135] At paragraphs 60 and 61 of the *HASA* case, as quoted above.

[136] HASA is concerned that the failings of the process implemented by the then Minister and Director General, in terms of the regulations promulgated by the Minister under section 90(1) of the National Health Act and which were set aside by the High Court, should not be repeated. The decision of the High Court sets out a veritable litany of failings in the process then undertaken. It is plain that unless the integrity of a revised process under NHI could be ensured, the prospect of the entire NHI system failing is a very real one.

9.13 This is particularly important in so far as the NHI fund, if implemented, will have substantial buying-power relative to service providers to the point of approximating a monopoly or virtual monopoly on the funding of healthcare treatment. This inequality of power leaves healthcare service providers vulnerable to, dependent upon, and financially exposed to the NHI fund. Any pricing mechanism must therefore be impartial and independent and must ensure that interested and affected parties are consulted and afforded an opportunity to participate in the determination of prices.

9.14 Similarly, the manner in which the NHI fund intends to purchase primary healthcare services from certified and accredited public and private providers, which is not described in detail in the White Paper, must also properly be regulated. This is particularly so in the absence of any clarity in the White Paper or any legislation that proposes such purchase power.

9.15 A failure to implement a system that defines the rights of, has built into it safeguards and protections for, and which fairly compensates service providers would be irrational and unreasonable and will result in the failure of the system.[137]

10 **REASONABLENESS, RATIONALITY AND LEGALITY**

10.1 The Department, along with other functionaries responsible for the delivery of health services including, but not limited to, the Minister must, in accordance with the precepts of South African constitutional law, conduct themselves in a manner that is lawful, reasonable and rational in relation to the tasks that they assume.

10.2 In so far as concerns the requirement of legality, the Minister and the Department may not undertake any conduct or actions that are not authorised by applicable empowering legislation. In this regard, the Minister has sought to publish the White Paper pursuant to the provisions of section 3 of the National Health Act.[138] In as much as the Minister has identified, in Government Notice 1230, that the White Paper refers to proposed policy, it is

[137] See *New Clicks* case, quoted above.

[138] Government Notice 1230.

assumed that the Minister is purporting to exercise his powers under section 3(1)(c) to develop the policy.

10.3 The provisions of section 3 of the National Health Act have not been dealt with in litigation and thus have not been interpreted by South African courts. Therefore, one is required to lend to section 3 an interpretation that is based on the acceptable principles of interpretation in South African law. In this regard, fitting the White Paper into section 3 of the National Health Act requires one to accept that the White Paper complies with the criteria contained in section 3(1)(c) of the National Health Act.

10.4 The White Paper is, however, entirely silent as to the particular manner in which it complies with the criteria contained in section 3(1)(c) of the National Health Act. Certainly, the White Paper does not ascribe to itself the mantle of a policy or a measure "to protect, promote, improve and maintain the health and well-being of the population" - particularly in so far as the White Paper specifically provides that the NHI scheme is a "health financing system"[139] for healthcare and not a mechanism for the delivery of healthcare services to the population. Consequently, the White Paper does not find a comfortable footing in section 3(1)(c) of the National Health Act or in the National Health Act at all - having regard to the objectives of the National Health Act as set out in section 2 of the National Health Act. [140]

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[139] Paragraph 1 of the White Paper.

[140] The objects of the National Health Act are defined as follows –

"2. Objects of Act.—The objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation by—

(a) establishing a national health system which—

(i) encompasses public and private providers of health services; and

(ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford;

(b) setting out the rights and duties of health care providers, health workers, health establishments and users; and

(c) protecting, respecting, promoting and fulfilling the rights of—

(i) the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care;

(ii) the people of South Africa to an environment that is not harmful to their health or well-being;

(iii) children to basic nutrition and basic health care services contemplated in section 28 (1) (c) of the Constitution; and

(iv) vulnerable groups such as women, children, older persons and persons with disabilities".

10.5 Therefore, to attempt to construct the NHI scheme on the provisions of the National Health Act is incorrect and may render the NHI scheme *ultra vires* the National Health Act and susceptible to constitutional challenge pursuant to the provisions of at least section 33 of the Constitution read together with the provisions PAJA.[141]

10.6 As has been set out above, it is also not possible for the Minister to advance the proposed NHI scheme any further in the absence of legislation - either original or delegated in the form of regulations, or by way of amendment/s to current legislation. In determining and promulgating legislation, both the Minister and Parliament are required to consider and pursue an appropriate, rational, reasonable and justifiable system of healthcare delivery within the confines of the Constitution. This does not entail adopting a system or policy simply because it has been promoted by the WHO or because it has found favour elsewhere, but would require that a particular problem be identified and that an appropriate solution be formulated for South Africa.[142] In this regard –

10.6.1 in terms of paragraph 47 of the White Paper, a statement is made that "[h]ealth care financing is the one building block that has presented a challenge to good performing health systems. Previous attempts of healthcare reform worldwide that did not encompass reforms to healthcare financing have not always been successful in some countries whilst countries such as Mexico and Thailand are examples of countries where attempts to transform health financing have been positive";

10.6.2 in paragraph 49, a statement is made that "[c]ountries such as Brazil, Canada, Finland, Norway, Sweden, Thailand, Turkey and the United Kingdom have successfully implemented UHC systems. Access to health services and health outcomes in these countries has improved significantly taking them closer to UHC…"; and

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[141] *Merafong Demarcation Forum v President of the RSA* 2008 (5) SA 171 (CC) at [62]. In addition to the cases cited in *Merafong* at fn 47, see also *Minister of Health v New Clicks South Africa (Pty) Ltd* 2006 (2) SA 311 (CC); *Doctors for Life International* judgement, as quoted above.

[142] See Chapter 1.3 of the White Paper.

10.6.3 paragraph 110 of the White Paper records that "[m]iddle income countries that have implemented NHI have benefited economically from a healthier population. International evidence demonstrates that a properly implemented NHI in countries such as Turkey, Brazil, Costa Rica, Thailand and South Korea, has resulted in significant and sustainable economic and social benefits. These benefits include having a healthier population, which in turn translates into a productive and effective workforce that grows local business, attracts foreign investors and grows the domestic economy".

10.7 No basis exists upon which to accept that the results that are identified above in paragraph 10.6, in relation to the implementation of NHI systems in middle-income countries, will necessarily eventuate in South Africa. In this regard, in so far as international health comparisons are concerned, it has been noted in the *Handbook of International Health Care Systems* that –

> "International health comparisons are difficult for the following reasons:
>
> 1. Data are not generally comparable.
> 2. Systems performance cannot be easily evaluated because of the inability to measure outcomes.
> 3. It is difficult to measure and control for social, medical, cultural, demographics, and economic differences across countries.
> 4. Transferability of policies across countries is problematic."[143]

10.8 The difficulties that arise in respect of accepting that the results referred to above in paragraph 10.6 will eventuate in South Africa are compounded when one has regard to the particular problems which the NHI system, as proposed in the White Paper, seeks to address in South Africa, being the "structural imbalances [in South Africa] in the health system and to reduce the burden of disease".[144]

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[143] At page 543 of the *Handbook of International Health Care Systems*, as quoted above.

[144] Paragraph 51 of the White Paper.

10.9 The burden of disease in South Africa, is, in turn, described in paragraph 96 of the White Paper, as follows –

> "South Africa is faced with a quadruple burden of disease in the form of communicable diseases such as HIV and AIDS and TB; maternal and child mortality; NCDs [non-communicable diseases] such as hypertension and cardiovascular diseases, diabetes, cancer, mental illnesses, chronic lung diseases such as asthma; as well as Injury and Trauma. The combined impact of these epidemics has had an effect on the doubling of death rate between 1997 and 2006 in South Africa".

10.10 The burden of disease recognised in the White Paper does not reflect the healthcare circumstances and realities shared with other countries so as to produce a comparable and reasonable analysis between South Africa and the countries identified above in paragraph 10.6. Additionally, different models of universal coverage have been implemented in the different countries identified in the White Paper[145] and therefore one cannot simply accept the results referred to above in paragraph 10.6 as the basis to implement NHI.

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[145] For example, the model of universal coverage in Mexico has been described in the *Handbook of International Health Care Systems*, quoted above at page 227, as follows "[t]he right to healthcare is guaranteed in article 4A (amended in 1983) of the [Mexican] Political Constitution, which states that every person has the right to health protection and that the law will define the conditions for access to the services. This concept was widely disseminated in 1995 during the preparation of the Health Sector Reform Program 1995 – 2000. Two methods for expanding the coverage of public health services are envisioned: (1) Facilitating voluntary social security affiliation for people able to pre-pay family health insurance. (2) Bringing essential health services to marginalized populations through the basic package of health services".

The proposals concerning the Mexican system do not highlight universal coverage as a priority within that system but rather the tailoring of specific health benefits to be accessed by different sectors of the population depending on socio-economic standing. In so far as health system delivery and universal coverage are concerned, the model being debated in Turkey appears to be closer to that set out in the White Paper. In this regard, model being debated in Turkey has been described in the *Handbook of International Health Care Systems* at page 455 as follows -

> "The model is based on the principles of social insurance.
>
> Membership will be open to citizens of Turkey with no coverage under current status.
>
> Members will be entitled to a package of comprehensive services.
>
> Contributions will be related to ability to pay and will be zero for the very poor. The difference between the actuarial premium and the member's contribution will be met from the general tax revenues.
>
> [General Health Insurance Scheme] will transfer its premium income to Provincial Health Directorates, which will be directly responsible for making contracts with service providers both public and private on behalf of the insured population.
>
> Some sort of copayment is recommended both to raise revenue and to limit unnecessary utilization".

In so far as one accepts that the Turkish model does appear to be closer to that proposed in the White Paper then the model proposed in Mexico, then one should take into account the comments made by

10.11 The White Paper does not contain sufficient clarity on why South Africa would be in the same position as other countries in respect of the application of a NHI system such as the NHI.[146]

10.12 According to the White Paper, the objectives which the NHI scheme seeks to achieve are to be achieved through the application of the so-called "three dimensions of universal coverage".[147] No reasonable or rational connection, however, exists between the proposals contained in the White Paper - to implement a system of NHI - and the problems that have been identified as necessitating a reform of healthcare in South Africa. To this extent, the policy falls short of the Constitutional standards of rationality and reasonableness.

10.13 Paragraph 5 of the White Paper provides that -

> "The South African health system has been described as a two-tiered system divided along socio-economic lines. NHI will create a unified health system by improving equity in financing, reducing fragmentation in funding pools, and by making healthcare delivery more affordable and accessible for the population. NHI will eliminate out-of-pocket payments when the population needs to access health care services".

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commentators in respect of the Turkish model, being F Tatar and T Dinçer in their article "Health Care System in Turkey" in *Handbook of International Health Care Systems* at pages 455 to 456:

> "The Turkish health care system in under significant pressure to change. It seems that the population in general and its various segments such as patients, providers, and policymakers are not satisfied with the system. However, the health care scene since the mid-1980s has been dominated by intensive rhetoric but no action. The reforms that are designed to address the widely accepted ills of the system, such as gross inequities, inefficiencies at both macro and micro levels, and low quality, have taken the cue from some international tendencies. Reliance on market forces and processes such as competition in a controlled manner, the separation of purchases and providers, regionalisation in planning and management, and a greater emphasis on management rather than administration are the main pillars of the current health care reform proposals in Turkey. The main challenge that faces the reforms, however, is to overcome the forces and processes that have over decades created the current health care system. It is clear that reform proposals would upset the balance of powers. The expectations of those groups with a strong vested interest in the current health care system, including medical professionals, would have to be balanced against the interests of the entire population. This would undoubtedly require a strong government with matching political will and commitment to purse the health care reforms. Whether Turkey would have a strong government with strong will and commitment to redress the current imbalances among various stakeholders in [the] health care system for the *benefit of all* remains to be seen".

[146] See also in this regard, the comments on the reforms in health care services in Turkey and Hungary, Russia and Greece in *Handbook of International Health Care Systems*, quoted above at pages 29 (Hungary), 395 (Greece), 431 (Turkey) and 59 (Russia). The reforms proposed in each of these countries are different in relation to the prevailing socio-economic services in these countries. However, what does emerge from a comparison of health reforms in economies that are described, within the OECD, as middle to low income economies is that health care reforms are divergent and incapable of comparison.

[147] Paragraph 116 of the White Paper.

10.14 A primary objective of the implementation of the NHI scheme is therefore also to eliminate the current tiered healthcare system in South Africa. However, nothing appears in the White Paper to indicate that any of the measures contemplated as part of NHI will, in fact or in law or at all, address the problems identified in the White Paper in respect of the tiered system. There is accordingly a lack of rationality present as between the problem that has been identified and the measures that are being proposed to address the problem.

10.15 HASA is particularly anxious that the solution that is adopted is one which continues to advance the progressive realisation of access to healthcare both in the private and public setting. It would be counterproductive for measures to be adopted that damage or retard an existing functional and highly efficient healthcare system as exists in the private sphere, because of failings in the delivery of health in the public sphere.

10.16 In addition, any such measures must be forward looking and must not sacrifice long-term goals on short-term solutions. HASA is concerned that the lack of detail in the White Paper points to a lack of long-term vision as to how the proposed NHI scheme can and will be implemented. In this regard, the following is informative -

> "Good regulation in the health sector should always have a clear long-term purpose. Just as all large private for-profit corporations use strategic planning to maximise their ability to achieve their objectives, so should public regulators, particularly in dealing with a sector as complex and with as many powerful actors as the health sector (Walt 1998). If regulation is to successfully stimulate entrepreneurial behaviour while still sustaining core social and economic policy objectives, it should be thought through and adopted on a long-term basis".[148]

10.17 With this in mind, the Department must look at the objects that are sought to be achieved in South Africa and must tailor its response so as to meet those

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[148] See R B Saltman, R Busse and E Mossialos *Regulating Entrepreneurial Behaviour in European Health Care Systems* 1st ed. (2003) at page 45.

needs. To the extent that legislation is enacted for those purposes, it too must satisfy the tests of rationality and reasonableness. In the absence of a meaningfully defined plan of action, the publication of a paper proposing NHI is not reasonable or rational. Neither HASA nor members of the public generally can plausibly be expected to give the White Paper their imprimatur without knowing what it will eventually entail. The deficiencies in the White Paper are evident, *inter alia*, in –

10.17.1 the failure by the Department to take into account all relevant considerations when determining and assessing the cost projections for the NHI scheme;[149]

10.17.2 the failure of the White Paper to set out the cost for individuals of implementing the proposed NHI policy as compared with the benefits that will be derived from the policy;

10.17.3 the failure of the White Paper to define the package of services that will be available under NHI. In so far as the costs of the NHI are directly related to the types of services to be provided, the absence of the specified services that constitute the primary care benefit package is a glaring omission from the White Paper.

10.18 The abovementioned omissions effectively prohibit –

10.18.1 proper comment on the viability and existence of an NHI scheme;

10.18.2 a determination of its suitability for the South African healthcare environment, whether public or private; and

10.18.3 an assessment of the reasonableness of introducing an NHI scheme to address healthcare needs in South Africa.

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[149] See chapter 7 of the White Paper and the comments on chapter 7, as prepared by Nicola Theron of Econex in her report entitled "Comments on Select Aspects of the NHI White Paper". In this regard, the aforementioned report deals with specifics around methodologies for the pricing of healthcare services in South Africa and the cost projection for the NHI scheme. The report states that the White Paper does not engage in any meaningful economic impact modeling of NHI and fails to demonstrate that NHI is affordable. We submit that it is axiomatic that Government should not embark on such an ambitious and costly project without a demonstrable assurance that South Africa can afford it.

10.19 A lack of clarity around the scope and nature of the benefits to be availed under NHI is also illustrative of a further apparent shortcoming in the policy proposal: namely, the way in which the White Paper gives rise to more questions than it does answers.

10.20 In so far as a benefit package contemplates the provision of certain types of benefits to certain types of people, then the distinction between the benefits and the population to receive them must be explained. This explanation is required in order to understand how the differentiation is justifiable and rational for purposes of the Constitution.[150]

10.21 Whilst there appears to be an emphasis on improving access to health services, the determination and application of benefit packages must also address the issue of maintaining access to health services for those persons who are forced onto the NHI and who currently already enjoy access to health services by virtue of an existing commercial relationship between themselves and a medical scheme.

10.22 Therefore, the White Paper should not emphasise only improving access to health services as an objective but also ensuring that rights enjoyed currently by members of the population to health services are not limited unduly by the Department forcing such persons to join NHI with a consequential limitation on their access to the health services currently enjoyed by them.

10.23 In all of the circumstances, HASA does not support the White Paper in its current form as it cannot give rise to any legally cognisable rights or obligations as described in the *Akani Garden Route* case, as quoted above, and does not lay a sound platform from which any legislative or regulatory enactments may be successfully developed.

11 **CONCLUSION**

For the reasons set out above, the current formulation of the NHI scheme in the White Paper is susceptible to legal and constitutional challenge.

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[150] See sections 9 and 27 of the Constitution and sections of the Constitution dealing with legality.