“The thought of placing my wellbeing in the hands of a system that is beset with mismanagement, corruption and wasteful expenditure frightens me. Everyone I know speaks well of Dr Motsoaledi. They say his commitment and dedication is unparalleled. But he must know that his crusade against the high cost of private healthcare is completely misplaced. The people he needs to wag his finger at are the administrators, the policymakers and politicians who have no heart; those who have forgotten where they come from and have become superior and deaf to the cries of the suffering. The spin doctors have been hard at work assuring us that the "matter" will be resolved. I am sure it will be - one dead patient at a time,” radio personality Redi Thlhabi wrote in 2012 (Trying to cure a sick health system - one dead patient at a time. The Sunday Times, 12 February 2012).

The Venn diagram of people I know and people Ms Thlhabi knows must not overlap considerably because Health Minister Motsoaledi’s recent outbursts constitute a particularly colourful speech bubble, ballooning out into leftfield and making him sound, well, a bit unhinged. Shrillness, tears, belligerence and desperation have entered his discourse. He has styled himself as a revolutionary, he calls people monsters, and could be easily mistaken for Osama bin Laden in his verdict of American companies as the Great Satan. (See City Press, Private healthcare ‘a monster’, says minister. *City Press*, 11 October 2011; Fokazi S, Health Minister's NHI trauma, tears. *The Saturday Star*, 23 February 2013; Phillip de Wet, Motsoaledi: Big pharma's 'satanic' plot is genocide. *Mail & Guardian*, 17 January 2014).

With elections afoot it is likely that PR exercises extolling government’s contributions to improving the lot of the people, coupled with familiar denunciations of any dissenting voice, independent or partisan, will multiply. One recalls what activist Zachie Achmat of the Treatment Action Campaign said of government almost ten years ago: “Legislative developments have generally followed a pattern of long periods of delay with intermittent periods of rushed activity, inadequate consultation and a lack of openness. If the defects in regulations are to be cured, such a process would have to break this pattern.”

Stakeholders in the national healthcare debate will concur that this pattern has altered little, and when invitations to consultation, clarification and debate are extended on anything but the Minister’s terms, they are struck down and declined as “opportunistic.” The response published this week in the *Mail & Guardian* (Motsoaledi A, Physician, don’t fool yourself. February 7 to 13, 2014) to SAPPF CEO Dr Archer’s quite reasonable response in turn to the Minister’s unbecoming deportment in a November interview refers (Smith J, ‘This is a revolution'. The Star, 29 November 2013). “This is war. This is for the population to see how greed is fought. It’s naked, naked greed from powerful individuals who want a good life for themselves and a poor life for anybody else,” the Minister said.

It is not inconceivable that greed exists in private practice, just as it does in public sector administrations where hundreds of millions of rands mysteriously vanish while patients die of stock-outs, filth and bungled procedures. At least mechanisms exist to punish the former.

I leave it to Dr Archer to respond to the Minister’s *ad hominen* attack on his person. Hopefully I will warrant one in turn. While the debate is conducted ostensibly to enlighten audiences, allow me to provide, from a humble researcher’s perspective, some historical context that gives the lie to Minister Motsoaledi’s conflation of Britain’s National Health Service (1948), the World Health Organisation’s International Conference on Primary Health Care, Alma-Ata, USSR, (1978) and US President Barack Obama’s Patient Protection and Affordable Care Act (2010).

The Minister heaps praise on all three and all three are certainly milestones in the history of modern healthcare’s development out of rudimentary ‘poor relief’. Yet, while the Minister thinks them all species of universal healthcare roll-out, he fails to distinguish them as gradual evolutionary steps in

healthcare provision, demanding critical engagement, not parroted replication in a country, he reminds us, whose economy is 95 times smaller than that of the US.

The Minister condescendingly reminds Dr Archer of the WHO's definition of health, which he says was adopted at Alma Ata: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The fact that Motsoledi inverts it, beginning with "health is not just the absence of disease or infirmity," reveals his, and not the WHO's, knee-jerk rejection of curative services. The WHO's definition of health appears in the preamble to the Organisation's founding Constitution, adopted in 1946, not in a rural backwater of Kazakhstan in 1978. There is a lot in this definition that the Minister has chosen to gloss over. It is far more holistic and does not prioritise preventive over curative care. Associated guidelines combine with it to inform policy. For instance, the WHO counsels developing countries to spend at least five percent of their GDP on preventative primary health care provision. But one would do well also to look at the Abuja Accord. Four African Union member states in 2010 were compliant with the Abuja Accord (2001), committing the signatories to spend 15% of their national budget on health. Most of them have been spending 5% to 10%. South Africa for the 2010/11 Budget allocated 13%. So it is falling short, although the parlous state of public health is not exclusively a question of budgetary constraints.

So, the definition is perfectly commensurate with the view that freedom of the individual is paramount - from the oppression of disease certainly, but also from interference, restrictions of trade, association, or the pursuit of health and happiness. Empowering people from the bottom-up, not bringing everyone down to the same level, should be the object of policy.

Alma-Ata was important for introducing *Health for All* by 2000 and reaffirming member states' commitment to PHC, Primary Health Care. But talk of Alma-Ata without mentioning a Rockefeller Foundation-sponsored conference that took place just a year later in Italy (1979), is incomplete. The PHC model was reconsidered and reduced essentially to a subset of specific and cost-effective interventions defined by the acronym GOBI:

(G) rowth-monitoring,
(O) ral rehydration,
(B) reastfeeding,
(I) mmunisation.

This subset would be known as Selective Primary Health Care and would serve as a strategic interim step towards realising the kind of primary care-based public healthcare systems envisioned at Alma-Ata, while also reviving the focus on family planning and population control, which participants felt were no longer of much interest to international agencies.

The reader will have heard of the WHO's *Millennium Development Goals*. These replaced *Health for All*, which had missed its deadline, and have themselves fallen behind target. PHC was meant to release the developing world from donor aid. The persistence of malaria and the unforeseen, in 1978, coming scourge of HIV/Aids rendered it quaint and insufficient barely a year after it was unanimously accepted.

Interestingly, Alma-Ata was not as revolutionary as the Minister proclaims. It was a compromise. The Soviet Union at the time was at loggerheads with erstwhile ally Maoist China. It pre-empted a conference proposed by the Chinese to promote the kind of rural, population-specific healthcare interventions by community-health workers and outreach teams that China was putting forward as early as the 1930s to combat social ills. Instead, the USSR wished to show that a mix of hospicentric and primary care interventions along Soviet lines were responsible for improving the wellbeing of Kazakhstan's people, far more effectively than basic clinical care.

Then as now, the health outcomes relied on an unhealthy manipulation of statistics. It can be argued that the health advances in the region were mainly attributable to the massive influx of relatively privileged Russian workers sent to settle the region over previous decades; a divide-and-rule policy so successfully implemented elsewhere in the Union. In fact census results up until the USSR's collapse still conflated citizens of Russian extraction with native residents of the various republics to disguise how little was actually done from Moscow to empower tribal minorities such as the Kazakhs or Khirgiz.

In China in the early 1930s, before the Japanese invasion and post-war communist revolution, a South African epidemiologist came under the influence of the Chinese health centre movement. His name was Dr Harry Gear, a key figure on the South African National Health Service Commission in 1946 chaired, and unfairly christened exclusively after then Health Minister Dr Gluckman, when it was largely his colleagues who brought most to the table in terms of ideas. As the only alternative to the Commission was a call for MASA to establish a Democratic Health Service in which government would have had no say besides funding – i.e. over personnel appointment, the nature of services offered etc. – the Commission was allowed to table its proposals.

The current government finds it exceedingly convenient to style the collapse of the NHSC's proposals as a result of the Nationalist Party's rise to power in 1948 but, in truth, the PHC/Gluckman proposal for National Insurance in South Africa was dead in the water before it even came to parliament. And yet support for radical reshaping of the medical profession came from its top echelons in the 1940s. The majority of doctors were in fact English-speaking urban-dwellers with a strong presence within the Department of Public Health. They were unlikely to have voted Nationalist Party in the 1948 elections. MASA's President FR Luke reflected on the Commission's work and inevitable reception of its recommendations:

"Never in the history of this country had a Commission worked so hard, so continuously, or with such zeal and application. We travelled the length and breadth of this country in order to see conditions ourselves. We acquired a deep knowledge of health conditions in this country, and our survey forced us to the conclusion that present conditions in no way approached the ideal contemplated in our terms of reference, and that under the existing system of multitudinous agencies and divided control the attainment of such an ideal was impossible."

Dr Archer is not threatening to upset Motsoaledi's apple cart. He just wants clarity, as do all representatives, stakeholders and interest groups in South African healthcare. Paragraph X of the Alma-Ata Declaration asserts that "the people have the right and duty to participate individually and collectively in the planning and implementation of their health care."

Responsibility for this clarity has been partly offloaded onto the Treasury, which quashed as unaffordable, the Department of Health's universal healthcare proposals in the late 1990s, and will do so again. When Finance Minister Pravin Gordhan delivered his budget in February 2013, he said major new policy initiatives such as NHI would be affordable only if growth rose towards five percent a year and government revenue doubled in the next 20 years. If growth continued along its present trajectory, substantial spending commitments such as NHI would require far more than limited adjustments to tax policy.

Motsoaledi styles the NHS in Britain as the "biggest revolution that happened in the UK after the [sic] World War II." These revolutionary stirrings were not unique to Britain. They infused the thinking of the political echelons at all levels of the decaying Empire as it sought to find its feet in the post-war world. No more work went into the Beveridge Report that lead to the NHS in Britain than went into the Gluckman Commission Report (Beveridge's report is notorious for making very little reference to health and runs to 300 pages. The Gluckman Report to 12 000).

Why nothing came of the latter was not a lack of political will, but, as Margaret Thatcher would later say, "the problem with Socialism is that you eventually run out of other people's money."

Oxford University researcher Dr David Stuckler and colleagues say that reframing the health debate in terms of social, political and economic arguments, is often the best way for health ministers, who "typically occupy weak positions in government", to motivate for expanding coverage. (See Stuckler D, Feigl A, Basu S, McKee M, The political economy of universal health coverage. Background paper for the global symposium on health systems research 16-19 November 2010, Montreux, Switzerland). The existing system is first problematized as being *unsustainable* (based on runaway costs) or *inequitable* (insofar as it fails to provide efficient, appropriate or broad-based care). Is this not what Minister Motsolaedi has been doing since he took office?

"Prices have escalated to uncontrollable levels, and due to the absence of regulation, it may not be dramatic or an overexaggeration to describe the situation as the law of the jungle, where the principle is survival of the fittest," the Minister said in his keynote Speech At The 6th Annual Conference On Competition Law, September 2012, Wits University.

Then, barely a year later, in the rant reported by Janet Smith which occasioned this exchange, the Minister damned as "*zama-zama*" (opportunistic), regulatory reforms which industry experts have been calling for, and which constitute the bare minimum of an efficiently regulated private healthcare sector. Reforms like a Risk Equalisation Fund which could reduce medical aid premiums by as much as 20% and halt the ongoing consolidation of schemes, which the Minister identifies as a symptom of 'unsustainability' in the Medical Schemes' environment. His is a false conclusion contradicting every Council for Medical Schemes Annual Report for the past decade. In the words of Registrar Dr Monwabisi Gantsho: "For its 13th consecutive year in existence, the CMS looked after the best interests of members and medical schemes alike to ensure that the industry remains stable, financially sound, and sustainable in the long run while adhering to the principles of good governance." (2012/2013, pg42).

The rise in gap-cover and government's inability to outlaw it on the grounds of social solidarity is a familiar repeat of a situation that accompanied the introduction of managed care in the 1990s in South Africa. By 2000, over 5000 products offered by the assurance industry allowed people to 'buy-down' against the risk of catastrophic illness without having to opt for expensive medical aid. Medical Insurance, and the package of 'mandatory' benefits it promises to cover, are an insurance against bankruptcy, out-of-pocket co-payments and, above all, uncertainty. Government has not once, although it was supposed to every 2 years, revise with the CMS the current package of prescribed minimum benefits ALL medical aids in the country are legally obliged to pay in full. So, it shouldn't be surprising that Motsoaledi should rubbish the very notion of package benefits. (He accuses Dr Archer of living "36 years in the past", when he affirms that universal healthcare does not "consist of a series of packages").

Simple changes to the Medical Schemes Act that would have plugged these regulatory gaps have been in the offing for 13 years. However, since the ANC's 52nd elective conference in Polokwane in 2007, the government's change of focus has made the medical schemes industry a "regulatory orphan", says Christoff Raath, CEO of the Health Monitor Company. (Khan T, Medical schemes move to address regulatory backlog. *Business Day*, 20 August 2013).

The result is a "toxic" regulatory environment in which schemes cannot turn away sick consumers or base premiums on a risk assessment of members, but there is no provision for mandatory enrolment or a mechanism for equalising risk between schemes – essential to the creation of low-cost medical aid packages. (Khan T, Medical schemes move to address regulatory backlog. *Business Day*, 20 August 2013). Affordable cover depends on defined package of benefits, and an evidence-based understanding of what it would cost to provide them.

In a 2013 presentation, Raath reiterated his stand regarding regulatory completion. The social protection aspects in place (thanks to the Medical Schemes Act) – guaranteed benefits, open enrolment and community rating – are missing sustainability aspects – risk equalisation, mandatory cover, demarcation and risk-based solvency.

Government at one time or another would appear to agree. Here is Minister Tshabalala-Msimang, quoting Prof Heather McLeod in 2005: "South Africa is unusual in having open enrolment and community rating without risk equalisation. This was not a policy oversight, but a question of timing, and the [NDoH] considers that the environment is now ready for the introduction of a Risk Equalisation Fund." Stakeholders who took the Ministry at its word in 2005 could understandably have expected it to work gradually towards a holistic and balanced outcome – easily achievable by passing simple agreed-upon amendments.

The only way healthcare can be provided without reference to procedures or packages of services, to which a complex and debatably appropriate fee-for-service coding structure applies, is through a covert nationalisation of practitioners. As salaried servants of the state, doctors will receive a capped remuneration – a ceasefire agreement, ordained by the victors in the Minister's "war waged against exorbitant fees". In return the doctor will work his four or 8 or 12 hours, according to the contract. Something of this nature operates (Uniform Patient Fee Schedule (UPFS) as a guide to billing for service) in the public sector already, albeit poorly, which is why the Minister and his Department have a very inaccurate grasp of what it costs to provide healthcare services to the South African citizen.

This is why, under NHI, waiting times (not to see a doctor, but to be referred to a specialist) will grow and grow as a way of curbing costs in any given year. The NHS offers hip replacements, generally after an 18-month wait, and this is why Dr Archer mentioned them as a possible package item. The Minister suggests that NHI will not offer such a procedure, but in driving away the specialists that provide it, will mean that it may never be available. Provided that government can improve its supply-chain management to curb stock-outs, you will however receive a Panado and set of dilapidated crutches in your 'revolutionary' primary care facility.

The Minister also namedrops Barack Obama's Affordable Care Act (ACA) and styles Dr Archer "and his ilk" as Republican opponents to his (the Minister's) own challenge to the private healthcare "monster" (See City Press, Private healthcare 'a monster', says minister. City Press, 11 October 2011. South Africa's own Medical Schemes Act (2000) dealt with the issues that Obama's administration is only now pushing through. The ACA's express aim is to expand coverage to some 30 million Americans without health insurance. A recent survey suggests that, because reimbursement rates for the state of California (geographical considerations don't enter into the calculation which partly accounts to unjustifiable fluctuations between states) are about 30% lower than the nation average, "about 70 percent of California's 104,000 doctors are reportedly planning to stay out of the state's health insurance exchange, a move that could have significant impact on implementation of the Affordable Care Act." (McCarten P, 70 percent of California doctors plan to boycott Obamacare exchanges. *Reuters* via RT.com, December 09, 2013).

This was the point Dr Archer was making. The figures provided were drawn from government's own Green Paper on NHI (2011) and followed its logic - so that we'd all be on the same page - and were updated with latest figures from the OECD and WHO, so if Motsoledi's counterargument that the "figures deliberately omit crucial information that would help readers to draw their own conclusions", or that Dr Archer is "simply ignorant", then his point rightly can be reflected on the regulations government puts out for public consumption.

Furthermore, it gives the reader some indication of how frustrating it can be to deal with government's absurd reasoning. One can pardon expedient clichés in media releases, says Professor Alex van den

Heever, but these have no place in draft legislation. (See Prof Alex van den Heever in Kahn T, Cabinet set to approve NHI policy document. *Business Day*, 13 July 2011 and especially, Van den Heever A, Evaluation of The Green Paper On National Health Insurance. Graduate School of Public and Development Management, 20 December 2011). After walking away from the NHI Advisory Committee before the draft legislation was gazetted, saying "the proposals that were discussed were ludicrous. There were so many things that were technically wrong that it was difficult to know whether to walk away or try to engage them", van den Heever subsequently has been denounced as a "neoliberal consultant" and "a presumptuous expert" on a "misinformation warpath".

This is the kind of hectoring demagoguery that spoilers for a fight enjoy. But there is no war. There is no revolution. There are only officials out of their depth, like privates given a crash course in field medicine, and sent into no-mans land with bedsheets for bandages and sulphur to staunch the bleeding - which is what PHC and Alma Ata are to a 2014 battlefield cratered by a quadruple burden of disease.

Occasionally it breaks down, this defiance, and we glimpse frank admissions of failure. Before the parliamentary oversight committee on appropriations in February 2013, Motsoaledi frankly admitted that if anyone wanted to assess, right now, the progress of the NHI, his department would probably get zero. "If the committee wants to assess us on our performance please do it after April," he pleaded (Fokazi S, Health Minister's NHI trauma, tears. *The Saturday Star*, 23 February 2013).

Because it certainly wouldn't do to invite criticism before national elections.