The constitutional right to healthcare: National Health Insurance as a mechanism to increase access?

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With debates on health systems reform being very topical, it is important to look at how, from a human rights perspective, any reform has to measure up against constitutional scrutiny. It is well-known that in a number of cases healthcare professionals and others, such as NGO’s have called on the Constitution in relation to health sector reform, or the lack thereof.

1. THE RIGHT OF ACCESS TO HEALTHCARE

The South African Constitution awards every person the right of access to healthcare and simultaneously places a duty on government to realize these rights progressively:

(1) Everyone has the right to have access to:
   (a) health care services, including reproductive health care;
   (b) sufficient food and water; and
   (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.

It should be noted that this right applies to “everyone” (and not only citizens) and that it includes access to social security. Social security could take the form of social insurance (e.g. medical scheme cover and/or national health insurance) or social assistance (e.g. care provided for free at public facilities to pregnant women and children under the age of 7). However, these interventions appear to not have been sufficient, and South Africa is, according to the World Health Statistics, as released by the World Health Organization in 2011, still lagging behind in key health outcomes, whilst spending is comparable with that of the BRICS (Brazil Russia India China South Africa) countries, for example.

2. REALISATION OF THE RIGHT OF ACCESS TO HEALTHCARE

Section 27(2) provides more detail on the fulfilment of access to healthcare services. It obliges the state to:

• “take reasonable measures”
• “progressively realize” health rights
• undertake such realization “within available resources”

This means that these constitutional duties go beyond policy-making and the setting of guidelines. It also means that “resource constraints” should not be used as an “excuse” for non-delivery of services, but rather that the constitutional duty requires careful consideration of how the state will “progressively” realize health rights, within available resources. The Department of Health, in its most recent Strategic Plan acknowledges that there is, amongst others, lack of leadership, poor management, poor quality services and subsequent poor health outcomes, i.e. “inadequate outputs for the resources allocated … from the national fiscus”.

Given the contention that it is perhaps not only an issue of resources in the health sector (allocations from the fiscus may be sufficient), the how and where resources are spent may be of greater importance in the current debates. An investigation into “available resources” should therefore entail an analysis of the implications of resource-choices and access to healthcare from a wider perspective. As health budgets are often separated into “medicines”, “human resources”, “infrastructure”, “primary care” and “hospital-care”, the interrelated nature of the impact on resources is often understated or not considered at all.

According to Olivier et al. the constitutional duty entails “devising, formulating, funding and implementing, as well as constant review of comprehensive, co-ordinated and well-targeted programmes. Issues such as staff shortages at top level in the National Department of Health may indeed play a role in whether programmes to address access to healthcare are “co-ordinated” and “well-targeted”.

3. NHI AS A MEASURE TO REALIZE THE HUMAN RIGHT OF ACCESS TO HEALTHCARE

3.1 Health systems reforms

The NHI Green Paper (i.e. draft policy) was released on 13 August 2011 for public comment. It proposes a whole range of transformational measures designed to take South Africa, over a 14 year period into a new health system. It includes a number of previously proposed health system interventions, mainly aimed at addressing public sector challenges. These include:

• The establishment of an Office of Health Standards Compliance (OHSC): An amendment bill to the National Health Act was proposed earlier in 2011, but still needs to be passed by Parliament. This body will accredit all health establishments (i.e. including occupational health facilities) for compliance with standards published by the OHSC,
will conduct inspections and will also house the office of a complaints ombud.

- **Re-emphasis on primary healthcare:** Each health district will be supported by a specialist team, comprising specialists such as anaesthetists, paediatricians and family physicians. Appointments are envisaged for as early as February 2012. The school nursing system will also be re-introduced, and ten primary healthcare agents (community health workers) will be deployed in each municipal ward to undertake preventative and health promotion work.

- **Categorisation of health facilities into various levels of hospital-based care:** In addition to the categorisation and possible specialities associated with each hospital level, the Department of Health has released draft regulations that, amongst others, designate all hospitals in all provinces according to the categories of central (academic), tertiary (specialist), regional (general medical) and district hospitals.

A separate document has also been released for comment on health facility management, as well as a new Human Resources Policy. Comments on all these documents (including the Green Paper) are due in October.

### 3.2 Financing and costs

The Green Paper states that NHI costing work will continue in 2012 and 2013. The costing model will be based on the “public sector costing framework” and funding sources will include the current fiscal allocations to health, contributions by employers and employees, and income tax. The quantum of these figures is not known, and will most likely have an impact on the decisions of employers as to the level and extent of occupational health- and primary-care services rendered, as well as whether continued medical scheme support would be affordable. It is also not known when payroll taxes will be introduced.

The NHI Fund will be separate from the Department(s) of Health (which will be a service provider paid by the NHI as well as a policy-maker), but the Fund will be accountable to Parliament and the Minister of Health.

### 3.3 Package of care

Apart from the specialist fields alluded to in the hospital categorisation and school nursing system, the exact nature of the package of care is not known. The Green Paper does, however, state that the system will be set on “evidence-based medicine”, and that departures from treatment protocols and formularies will attract co-payments from NHI members.

### 3.4 Role of private providers

The document envisages contracting the services of private providers into the NHI, on a capitated basis (flat fee paid per patient per month). The capitation levels will be set taking into account international benchmarking, the risk profile of a population, and relevant indices.

Hospitals will get a so-called “global budget” from which they would have to fund NH services, on the basis of so-called DRGs – Diagnosis-Related Groups, i.e. a flat fee for all treatments associated with a specific diagnosis. Each District Health Authority will be responsible to contract in providers, and to manage their performance.

### 3.5 Beneficiaries

All South African citizens and all permanent residents will be NHI members. It is expected that all other persons take out their own health insurance. The document does not mention refugees, but it has recently been reported that refugees will no longer be able to access free public healthcare.

### 4. CONCLUSION

Many aspects in the NHI Green Paper, together with other health systems reforms, such as increasing the output of medical professionals from universities, will assist in addressing issues relating to access to quality care. A very positive aspect is the implementation of ten Pilot Sites for NHI over the next couple of years. This will provide South Africa with valuable lessons as to how implementation should proceed.

However, the Green Paper contains a number of gaps – most notably on the package of care and the funding model. Professionals in occupational health should also input into the role that occupational health and work-based primary care could play, and how these could slot into the various NHI elements.

The exact relationship of the NHI with other social security funds, such as the Compensation Commission and the Road Accident Fund is also not clear. Although the Departments of Health will continue to exist, the implications of a national system on provincial autonomy and administration resources is not clear yet.

### REFERENCES

4. Olivier et al Introduction to social security, Durban: LexisNexis; 2004. p.73

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